

Overview

Each provider will maintain a complete medical record for each Plan member according to professional practice standards, as well as state and federal requirements.

To comply with regulatory and accreditation requirements, the Quality Improvement department may conduct annual medical record audits in physician offices. A patient's record will be reviewed for content and evidence that care and screenings have been documented, as applicable. Physicians will be given results at the time of the audit and a corrective action plan will be required if the score is not above 80 percent.

The goal of conducting medical record reviews is multifold, including the ability for the Plan to assess the level of provider compliance to documentation standards and clinical guidelines (disease and preventive), and to gauge quality of care and patient safety practices.

General Requirements and Guidelines

Medical Record requirements and guidelines are as follows:

- Maintain the confidentiality of medical records in accordance with HIPAA state and federal guidelines, the Plan Quality Improvement and Risk Management Programs and professional practice standards, including the confidentiality of a minor's consultation, examination and treatment for a sexually transmissible disease.
- Make the medical records available free of charge and to the extent permitted by state and federal law for various quality improvement program initiatives, as may be requested by the Plan, its designated representatives, DCH, Centers for Medicaid Services (CMS), Plan member, and organizations conducting accreditation audits.
- Enable medical record access only by authorized users and facilitate easy retrieval.

- Provide sufficient space for record processing and storage.
- Create an individual record for each patient.
- Maintain medical record documentation for the time frame prescribed by law.
- Incorporate consultation notes, referral requests and responses from other providers into the medical record in accordance with state law.
- Have a process to add other records, such as test reports, into the medical record in a timely manner.
- Comply with Corrective Action Plan requirements imposed as the result of any such review or audit.
- When a member changes his PCP, to provide without charge, and in a timely manner, a copy of a transferring member's medical record to the new PCP.

Basic Content Requirements

The following information applies to medical records for Medicaid members.

- A member's medical record should be organized in a manner to enable easy access to its content, neat, complete, clear, concise and timely and include all recommendations and essential findings.
- All entries in the medical record must be signed. All entries must include the name and profession of the practitioner rendering services, for example: RN, MD, DO including signature or initials of practitioner.
- All entries in the medical record must be dated and recorded in a timely manner.

- Late entries should include date and time of occurrence and date and time of documentation.
- Records should not be altered. Corrections are to be made by a single line through the inaccurate material, dated and initialed.
- Only standard abbreviations and symbols should be used.
- Medical records must be legible to readers and reviewing parties and maintained in an orderly and detailed manner.
- The following personal and biographical data must be included in the record: name, member ID#, date of birth, sex, emergency contact and legal guardianship. This may include: marital status, name of spouse, next of kin or closest relative, address, employer, phone numbers, insurance information or family history.
- All records must reflect the primary language spoken by the member and translation or communication needs of the member. Translation or communication needs could reflect the need for an interpreter, sign language or Braille materials, etc., as appropriate.
- Medication allergies or “no known allergies” and known reactions to drugs, are prominently noted in the record. This may include a sticker inside of the chart or prominent notation in a conspicuous place in the record.
- The past medical history (for members seen three or more times) is easily identified and includes serious accidents, operations, illness, prenatal care and birth as appropriate. As appropriate, medical records from the previous provider have been obtained and are easily accessible.

Old records include past medical history, physical examinations, necessary tests and possible risk factors for the member relevant to treatment and, are used to assess the periodicity schedule and maintain continuity of care.

- A current immunization record is maintained in the chart.
- A current medication list is available within the chart. This includes prescribed medications, including dosages and dates of initial or refill prescriptions or sample medications.
- A problem list, with past and current diagnoses and procedures is used to provide continuity of care in the chart. This includes a summary of significant surgical procedures, past and current diagnoses or problems, medication reactions, etc.
- Screening for substance abuse of tobacco, alcohol and drugs is conducted, with appropriate counseling/referrals if needed, and follow-up is documented.
- There is documentation of screening for domestic violence with appropriate counseling/referrals if needed and follow-up.
- There is evidence the member was asked about advance directives and there is documentation of acceptance or refusal. **Note:** The record must contain evidence that the member was provided written information concerning the member's rights regarding advance directives and whether or not the member has executed an advance directive. The member does not have to have advance directives completed, a signed statement that they have been asked if they have them and if not, do they want them will suffice. A stamp may be utilized. The provider shall not, as a condition of treatment, require the member to execute or waive an advance directive.

- Informed consent discussions, where appropriate, are detailed.

Documentation indicating diagnostic or therapeutic intervention as part of a clinical research study is clearly contrasted from those entries pertaining to usual care.

**Every Visit
Documentation
Requirements**

The following patient information must be documented in the medical record for each visit:

- History and physical examination as related to the visit, chief complaint or purpose of the visit, objective findings of the practitioner, diagnosis or medical impression consistent with findings, are documented for each visit.
- Plan of treatment, referrals, disposition, diagnostic testing, studies ordered and therapies administered and prescribed regimens are documented for each visit as indicated and are consistent with diagnoses. NOTE: Upon medical record review, the appropriateness of the plan of treatment will be assessed to ensure that the member has not been placed at inappropriate risk by a diagnostic or therapeutic procedure.
- Consultation, laboratory and imaging reports filed in the chart are initialed by the practitioner who ordered them to signify review.
- There is documentation of follow-up plans for abnormal testing/consultation reports, referrals or missed/cancelled appointments. There is documentation that the abnormal results or consultations were reviewed by the provider and documentation of the follow up to be done.
- There is documentation of patient education and instruction whether verbal, written or via telephone. The member is provided with verbal and/or written education/instruction as indicated

and appropriate. Significant medical advice given via telephone is entered in the member's record and appropriately signed and initialed.

(This includes medical advice provided by after-hours telephone patient information or triage telephone services.)

All entries must include the disposition, recommendations, instructions to the patient, evidence of whether there was follow-up and outcome of services.

Continuity of Care Requirements

The medical record must show the physician's knowledge of the patient's course of care, as evidenced by the following:

- There is documentation and reports of consultations and referrals to specialty physicians if indicated.
- There are reports of diagnostic testing in the medical record. The medical record will show documentation of reports for diagnostic testing that was ordered: lab results, x-ray reports, MRI/CT reports, etc. Reports are initialed by the physician.
- There is documentation and records for emergency room care. There is documentation in the record if a member was seen in the emergency room and the records from the emergency room visit are in the medical record.
- There is documentation of hospitalizations to include discharge summary and discharge planning. There is documentation of a plan for hospital discharge and a copy of the hospital discharge summary on the medical record for members who were hospitalized.

**General
Documentation
Recommendations**

There is evidence that practice of the following documentation guidelines can potentially reduce practice risks:

1. **Make documentation descriptive.** Clinical observations and/or patient symptoms should be documented in detail. Use of anatomical forms or drawings should be considered when documenting the presence, size, color, and/or location of a lesion or deformity.
2. **Clearly document follow-up instructions.** This includes activity limitations, medications, referrals to specialists, further testing, and subsequent appointments. Make sure patients understand instructions given.
3. **Obtain and document informed refusal.** Inform patients of adverse outcomes and consequences of not undergoing recommended tests or procedures.
4. **Document all telephone calls from the patient and response to them.** The date and time the call was received, by whom, and the date and time it was returned needs to be detailed. Fully document any advice given or diagnosis made.
5. **Establish a follow-up/recall system.** Some benefits of a recall system include: reduction in potential for failure to diagnose based on abnormal lab results prompt patient returns for recheck of conditions as indicated by the physician, and to assure that the patient sought consultation after referral needs to be established.

Always document attempts to contact the patient. Depending on the seriousness of the condition, you may want to send a certified letter with return receipt.

**Health Check
Screens –
Pediatric
Health Screening**

Health Check screens, for Medicaid children from birth to 21 years and for PeachCare for Kids children from birth to 19 years are to provide comprehensive, preventive, well-child care on a regularly scheduled basis; and to ensure entry into the health care system.

Health Check Screen Periodicity Schedule

The preventive health guidelines for children are located in the **Provider Educational Materials** section of this handbook. In addition, the periodicity schedule can be found in the **EPSDT Guidelines** section of this handbook. Please refer to the document titled American Academy of Pediatrics (AAP), Recommendations for Preventive Pediatric Health Care.

The child may enter the periodicity schedule at any time. For example, if a child has an initial screening at age four, then the next periodic screening is performed at age five.

A member should have an initial health check screening in the following situations:

- Within 90 days of entering the Plan or upon change to a new PCP, if prior medical records do not indicate current compliance with the periodicity schedule; and
- Within 24 hours of birth.

The medical record must contain documentation of a comprehensive health history, in addition to an unclothed physical examination to determine if the child's development is within the normal range for the child's age and health history.

Each provider office is required to have the following equipments to provide a complete health check.

- Weight scale for infants;
- Weight scale for children and adolescents;

- Measuring board or device for measuring length or height in the recumbent position for infants and children up to age two;
- Measuring board or device for measuring height in the vertical position for children who are two years old or older;
- Blood pressure apparatus with infant, child and adult cuffs;
- Screening audiometer;
- Centrifuge or other device for measuring hematocrit or hemoglobin;
- Eye charts appropriate to children by age;
- Developmental and behavioral screening tools; and
- Ophthalmoscope and otoscope.

Addition points of emphasis regarding Health Check screens include the following:

1. **Immunizations** are administered at required age parameters and intervals with dates documented. If the immunizations are not up to date according to age and health history, the provider should document why immunizations were not given at the time of the Health Check screen. For the immunization schedule refer to the Advisory Committee on Immunization Practices (ACIP) schedule, among with legal disclaimer for HPV found in the **Provider Education Materials section** of this handbook. Note that certain immunizations may not be covered in the context of covered benefits.

WellCare of Georgia, Inc. network contracted

providers are required to participate in the Vaccines for Children (VFC) program to help raise childhood immunization rates and report all immunizations to the Georgia Registry of Immunization Transactions and Services (GRITS).

A PCP is responsible to perform all required components of an EPSDT health screen, as per the AAP and ACIP periodicity schedules, and document appropriately in the member's medical record. If a PCP chooses not to provide the immunization component of the screen, he/she has accountability to refer the member to another network provider such as a health department entity who can provide this service in a timely manner. WellCare will expect that the PCP follow-up with the referred provider to receive documentation regarding the provision of the immunization(s) and confirmation of GRITS entry in order to maintain an accurate and complete medical record.

WellCare will monitor for compliance to this policy through the following protocol:

- Review immunization rates/PCP, and
- If the rate is less than the network average, the Plan will:
 - A. Assess for practice access and availability by:
 - Conducting an audit to verify compliance with access and availability, and
 - Requiring adoption of a corrective action plan if access and availability standards are not met.
 - B. Perform a focused medical record review:
 - Based on negative findings, a corrective action plan (CAP) will be requested.

- If compliance to CAP not demonstrated, assess for a fee reduction.
 - If lack of compliance continues, petition for removal from network participation.
2. **Lead Risk Assessment** is done at each screening between 36 to 72 months of age. Please refer to the Lead Risk Assessment Questions for required content, found in the **EPSDT Guidelines** section of this handbook.

Any resulting risk identified through lead risk assessment should be both documented in the medical record and acted on by obtaining a blood lead level.

3. **Annual Tuberculosis (TB) skin testing** is done if the member is in a high-risk category. Please refer to the **EPSDT Guidelines** section for the required content.

Only those children locally identified at high-risk for TB disease should be tested. Results of TB risk assessment and testing as needed should be documented in the child's medical record.

4. **Developmental Delay** is to be assessed by use of a formalized tool at 9 and 18 months and at 2 and 3 years. Please refer to the **EPSDT Guidelines** section for information regarding acceptable screening tools.

5. **120-day non-compliant Report:** The Plan will send providers a monthly membership list of Health Check-eligible children who have not had a Health Check screen within 120 days of enrolling in the Plan or are not in compliance with the Health Check periodicity schedule. The PCP shall contact these members' parents or guardians to schedule an appointment.

For additional “120-day” Report information refer to the **EPSDT Guidelines** section of this handbook. The Plan will also send letters to the parents and guardians of Health Check eligible children to remind them of preventive services needed based on the child's age.

Clinical Practice Guidelines

Clinical Practice Guidelines have been adopted that are based on the health needs of our member population. Clinical guidelines are reviewed, revised and adopted on a yearly basis, utilizing nationally recognized, evidence based sources.

The guidelines are developed with input from community physicians and reviewed and approved annually by the appropriate QI Program committees. Member educational materials, benefit plans and coverage parameters are reviewed against the guidelines annually to ensure consistency. The plan will periodically assess for evidence of compliance to these guidelines through a review of medical record content. Please refer to the **Provider Education Materials** section for copies of current guidelines, which include: perinatal, adult preventive, asthma, diabetes, congestive heart failure, and chronic kidney disease.

Perinatal Care Guidelines

Clinical practice guidelines for perinatal care have been adopted based on content from nationally accepted standards, including those of the American College of Obstetrics and Gynecology (ACOG), and input from the Georgia-based Medical Advisory Committee. These guidelines are reviewed for potential revision annually. Member educational materials, benefit coverage parameters and Utilization Management criteria will be reviewed against the guidelines annually to ensure consistency. Please refer to the **Provider Education Materials** section for copies of the current Prenatal Care Guidelines.

Adult Preventive

An adult preventive health visits are performed by a physician to assess the health status of a member age

**Health Practice
Guidelines**

21 or older. It is used to detect and prevent disease, disability and other health conditions or monitor their progressions. The adult member will receive an appropriate assessment and intervention as indicated or upon request. Please refer to the **Provider Education Materials section** for copies of the Adult Preventive Health Guidelines.