Select Health of South Carolina | Healthy Connections

Guidelines for Evaluation of Medical Records

Standard	Performance Measure Requirements for a PASS
1. The member's medical record is kept in a separate file and located in a secure confidential area.	Member's medical record is in department in a separate file, and all papers are fastened together. All medical records are kept in a secure, confidential area.
2. Member record contains the patient's name, Medicaid ID number, date of birth, sex, address, phone number, employer and next of kin, sponsor or responsible party.	Record includes a page or form on which it includes the member's name, Medicaid identification number, date of birth, sex, address, telephone numbers, employer and next of kin, sponsor or responsible party.
3. The medical record shall commence on the date of the first patient examination made through or by the MCO.	The member record will show the date of the first patient exam made through or by the MCO.
4. Member record contains the following information for each visit: date, purpose of visit, diagnosis or medical impression, objective finding, assessment of patient's findings, plan of treatment, diagnostic tests, therapies and other prescribed regimens, medications prescribed, health education provided, signature and title or initials of the provider rendering the service. If more than one person documents in the medical record, there must be a record on file as to what signature is represented by which initials; services provided through the MCO, date of service, service site and name of service provider.	Medical record contains the following for each visit: o Date o Purpose of visit o Diagnosis or medical impression o Objective findings o Assessment of patient's findings o Plan of treatment, diagnostic tests, therapies and other prescribed regimens o Medications o Health education o Signature and title or initials of each provider that documents in the medical record o Services, dates of service, service site and name of provider for services provided through the MCO
5. The record is legible by someone other than the writer. A second surveyor examines any record judged to be illegible by one surveyor.	o Handwritten entries are legible to a reader other than the author. o Content of records is presented in a standard format that allows a reader other than the author to review without the use of a separate legend/key.
6. Each page in the record contains the patient's name or ID number.	Patient name or identification number is found on each page in the record.
7. All entries, including each office or telephone encounter, are clearly dated and initialed or signed by the service provider or author. * If more than one person documents in the medical record, there must be a record on file as to what is represented by which initials.	o All entries and or updates to the record are dated. o All entries are initialed or signed by the author. Electronic medical records indicate authors by initials or automated system generated names. This applies to practitioners and members of their office staff who contribute to the records. o When initials are used, there is a designation of signatures and status maintained in the office. o Documentation of medical encounters must be in the record within 72 hours or three business days of the occurrence.
8. Allergies and adverse reactions are prominently listed. If the patient has no known allergies or history of adverse reactions, this is appropriately noted in the record as "NKA" or	A record of allergies or the statement, "no known allergies" or "NKA," should be clearly found at a standard place on the chart (e.g. on the cover of the chart, on the first page of the chart, on a medication list or the problem list). There should be an inquiry about allergies on the first visit.

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"None."	
9. Past medical history is listed, includes operations, treatment and therapy prescribed, and any medications administered or dispensed. For children and adolescents (18 years and younger), past medical history relates to prenatal care, birth, operations, immunization record and childhood illnesses.	Initial history and physical exam for new patient are recorded within 12 months of a patient first seeking care or within three visits, whichever comes first. If applicable, there is written evidence that the practitioner advised the patient to return for a physical exam.
10. A current problem list is in the chart, identifying health-related conditions.	Each patient record includes a problem list, documenting any health-related conditions or chronic conditions requiring ongoing monitoring and treatment. => N/A if patient has no chronic condition.
11. Current medications are documented in the record and notes reflect that long-term medications are reviewed at least annually by the practitioner and updated as needed.	o Information regarding current medication is readily apparent from review of the record. o Changes to medication regimen are noted as they occur. When medications appear to remain unchanged, the record includes documentation of at least annual review by the practitioner.
12. There is evidence that preventive screening and services are offered in accordance with Select Health practice guidelines.	Each patient record includes documentation that preventive services were ordered and performed or that the practitioner discussed preventive services with the patient and the patient chose to defer or refuse them. Practitioners may document that a patient sought preventive services from another practitioner (e.g. GYN).
13. Patient's chief complaint or purpose for visit is clearly documented.	o A patient's chief complaint or purpose for a visit as stated by the patient is recorded. The documentation supports that the patient's perceived needs and expectations were addressed. o Telephone encounters relevant to medical issues are documented in the medical record and reflect practitioner review.
14. Clinical/physical assessment and/or objective findings are recorded.	Clinical/physical assessment and objective findings are documented and correspond to the patient's chief complaint, purpose for seeking care and/or ongoing care for chronic illnesses.
15. Appropriated working diagnoses or medical impressions are recorded.	Working diagnoses or medical impressions that logically follow from the clinical/physical examination are recorded.
16. Plan of treatment: diagnostic tests, therapies, laboratory, medications and other prescribed regimens are listed for each visit.	Treatment plans, diagnostic tests, therapies, laboratory tests, medications and other prescribed regimes are clearly documented for each visit and follow previously documented diagnoses and medical impressions.
17. Plan of action and treatment are consistent with diagnosis.	o Rationale for treatment decisions appears medically appropriate and substantiated by documentation in the record. o Laboratory tests are performed at appropriate intervals.
18. Follow-up instructions and time frame for	o Return to office in a specific amount of time is recorded at the time of visit,

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follow up or next visit are recorded as appropriate.	**or as follow up to consultation, laboratory or other diagnostic reports.** o **Patient involvement in the coordination of care is demonstrated through patient education, follow up and return visits.**
19. Relevant hospital discharge summaries are included with the medical record.	o **If the patient has been hospitalized, a discharged summary from the facility is included in the chart.** o **The discharge summary should include the reason for admission, the treatment provided and the instructions given to the patient on discharge.** o **The discharge summary should be initialed or signed by the practitioner to indicate the practitioner's review.** o **If the patient has not yet been discharged or only discharged within the previous two weeks, the review should indicate a N/A.**
20. If a consultation is requested, there is a note from the consultant in the record. Consult reports reflects practitioner's review with initials or signature.	o **If a consult has been ordered by the practitioner, a report from the consulting provider has been placed in the record.** o **The report should be initialed or signed by the practitioner to indicate the practitioner's review of the results of the consult and placed in the record.** o **If the request is less than three weeks old, reviewer should indicate a N/A.**
21. Documentation of referrals and results from specialists.	o **Each member record has documentation of referrals and results from each specialist.**
22. Diagnostic and laboratory reports reflect practitioner's review with initials or signature.	o **Results of all diagnostic and laboratory reports are documented in the medical record.** o **Records demonstrate that the practitioner reviews diagnostic and laboratory reports and makes treatment decisions based on report findings. Reports with the review are initialed and dated by the practitioners or other system ensuring practitioner review is in place. Electronic medical records indicate practitioner's review by initials or automated system-generated names.**
23. For patients 12 years and older, there is appropriate notation concerning the use of cigarettes, alcohol and substances.	**The practitioner must have documentation in the record regarding smoking habits and history of alcohol use and substance abuse for patients 12 years of age and older.**
24. Discussion of a living will or advanced directives, as appropriate.	**A note regarding discussing a living will or advance directives should be present in the medical record, if appropriate.*** **Defined as patients who are terminally ill or those with a serious chronic illness. Terminally ill may be defined as advanced stages of cancer, Alzheimer's disease, severe stroke, heart disease, lung disease, renal failure or other fatal illnesses, all of which have a very limited prognosis. A serious chronic condition causes suffering and/or disability every day that will worsen over time and eventually cause death.*
25. Documentation in record of after-hour services to include: emergency care, after-hour encounters, follow up.	**Practitioners must document any after-hour services and/or telephone encounters with the patient in the permanent record. Emergency encounters should also be documented either in the form of the hospital emergency room record or a signed and dated notation as to when the patient was seen in the ER, the diagnosis and any recommendation.**
26. Signed and dated consent forms, if applicable.	**Practitioners must have on file signed and dated consent forms by members.**