Medical Record Keeping Standards

A medical record documents a Member's medical treatment, past and current health status, and treatment plans for future health care and is an integral component in the delivery of quality health care. As such, we established medical record standards in 1996 and routinely distribute these standards to PCPs and specialists.

We regularly assess compliance with these standards and monitor the processes and procedures physicians' offices use to facilitate the delivery of continuous and coordinated medical care. We have established a performance goal of 90 percent compliance with our medical record standards. The standards are as follows:

Medical Record Content

- A separate problem list in each medical record documents significant illnesses and medical conditions.
- Medication allergies and adverse reactions are prominently displayed in the record. If the patient has no known allergies or history of adverse reactions, this is appropriately noted in the record.
- Past medical history (for patients seen three or more times) is easily identified and includes serious accidents, operations, and illnesses. For children and adolescents (18 years and younger), past medical history relates to prenatal care, birth, operations, and childhood illnesses.
- For patients 14 years and over, there are appropriate notations concerning use of cigarettes, alcohol, and substance abuse (for patients seen three or more times).
- The history and physical documents appropriate subjective and objective information for presenting complaints.
- Working diagnoses are consistent with findings.
- Treatment plans are consistent with diagnoses.
- Unresolved problems from previous office visits are addressed in subsequent visits.
- Review for appropriate utilization of consultants.
- There is no evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic procedure.
  An immunization record for children is up to date or an appropriate history is made in the medical record for adults.
- There is evidence that preventive screening and services are offered in accordance with AmeriHealth's practice guidelines.

Medical Record Organization

- Each page in the record contains the patient's name or ID number.
- Personal/biographical data includes address, employer, home and work telephone numbers, and marital status.
- All entries in the medical record contain the author's identification. Author identification may be a handwritten signature, a unique electronic identifier, or initials.
- All entries are dated.
- The record is legible to someone other than the writer.

Information Filed in Medical Records

- Laboratory and other studies are ordered, as appropriate.
- Encounter forms or notes have a notation, when indicated, regarding follow-up care, calls, or visits. The specific time of return is noted in weeks, months, or PRN (as needed).
- If a consultation is requested, there is a note from the consultant in the record.
- Specialty physician, other consultation, lab, and imaging reports filed in the chart are initialed by the practitioner who ordered them to signify review. Review and signature by professionals other than the ordering practitioner do not meet this requirement. If the reports are presented electronically, or by some other method, there is also representation of review by the ordering practitioner. Consultation and abnormal lab and imaging study results have an explicit notation in the record of follow-up plans.
- The existence of an advance directive is prominently documented in each adult (>18) Member's medical record. Information as to whether the advanced directive has been executed is also noted.
- Records of hospital discharge summaries, emergency department visits, home health nursing reports, and physical therapy reports are maintained in the Member's record.

Ease of Retrieving Medical Records

Medical records are organized and stored in a manner that allows easy retrieval and are to be made available to us as defined in the Professional Provider Agreement.

Confidentiality of Information

Medical records are stored in a secure manner that allows access to authorized personnel only. Protected Health Information (PHI) is protected against unauthorized or inadvertent disclosure and staff receive periodic training in confidentiality of Member information. Medical records are safeguarded against loss or destruction and are maintained according to state requirements. At a minimum, medical records must be maintained for at least 11 years or until the Member reaches the age of majority plus six years, whichever is longer.

Maintenance of Records and Audits
Medical and Other Records

Providers must maintain all medical and other records in accordance with the terms of their Professional Provider Agreement with AmeriHealth HMO, Inc. and this Provider Manual. Subject to applicable state or federal confidentiality or privacy laws, AmeriHealth or its designated representatives, and designated representatives of local, state, and federal regulatory agencies having jurisdiction over AmeriHealth, shall have access to provider records, on request, at the provider's place of business during normal business hours, to inspect and review and make copies of such records at no cost to the Plan. When requested by AmeriHealth or its designated representatives, or designated representatives of local, state, or federal regulatory agencies, the provider shall produce copies of any such records and will permit access to the original medical records for comparison purposes within the requested time frames and, if requested, shall submit to examination under oath regarding the same.