



MEDICAL RECORDS

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Overview

Each provider will maintain a complete medical record for each 'Ohana (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 higher than 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:

- As long as access to medical records, including behavioral health and substance abuse records, is needed to perform 'Ohana Health plan's duty under its contract with DHS to administer the QUEST Expanded Access (QExA) program, approval or member consent is not needed for access by authorized State of Hawai'i Department of Human Services (DHS) personnel or personnel contracted by the DHS;
- 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;



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- Make the medical records available prompt, 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, DHS, Centers for Medicaid Services (CMS), the State Medicaid Fraud Control Unit, the Plan member and organizations conducting accreditation audits. Refusal to provide medical records, access to medical records or inability to produce the medical records to support claims or encounters shall result in recovery of payment;
- Medical records must be maintained in accordance with Hawai'i Revised Statutes (HRS) §622-51 and §622-58, for a minimum of seven years from the last date of entry in the records. For minors, the records must be preserved and maintained during the period of minority plus a minimum of seven years after the age of majority.

During the period that records are retained under these rules, the provider shall allow the state and federal governments full access to such records to the extent allowed by law;

- 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 within seven business days of the request, a copy of a transferring member's medical record to the new PCP;
- Provide members with the right to request and receive a copy of their medical records and to request they be amended as specified in 45 CFR, part 164; and
- Medical records may be paper or electronic records.

Basic Content Requirements

The following information applies to medical records for QExA members.

1. A member's medical record should be organized in a manner to enable easy access to its content: neat, complete, clear, concise, detailed, comprehensive and timely and include all recommendations and essential findings in accordance with good professional practice.
2. All medical records are maintained in a manner that permits effective professional medical review and medical audit processes.
3. All medical records are maintained in a manner that facilitates an adequate system for follow-up treatment.
4. 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.



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5. Medical records must be legible to readers and reviewing parties and maintained in an orderly and detailed manner.
6. All entries in the medical record must be dated and recorded in a timely manner.
7. Late entries should include date and time of occurrence and date and time of documentation.
8. Records should not be altered. Corrections are to be made by a single line through the inaccurate material, dated and initialed.
9. Only standard abbreviations and symbols should be used.
10. Each page of the electronic or paper record must include the patient's name or ID number.
11. The following personal and biographical data must be included in the record: name, member ID#, age, date of birth, sex, address, home and work telephone numbers, emergency contact, legal guardianship, marital status, name of spouse, next of kin or closest relative, employer, insurance information or family history as applicable.
12. 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.
13. Any adverse drug reactions and/or food 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.
14. The past medical history is easily identified

and includes serious accidents, hospitalizations, 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.

15. A current immunization record is maintained in the chart.
16. 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.
17. 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, health maintenance concerns, etc.
18. All medical records contain information about consultations, referrals and specialist reports.
19. All forms or notes have a notation regarding follow-up care, calls or visits, when indicated.
20. Screening for substance abuse of tobacco, alcohol and drugs is conducted, with appropriate counseling/referrals if needed, and follow-up is documented.
21. There is documentation of screening for domestic violence with appropriate counseling/referrals if needed and follow-up.
22. For all members older than 18, there is evidence the member was asked about or executed an advance directive, including a mental health

directive, 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.

23. 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.
- Documentation of the provisional or confirmed diagnoses consistent with findings.
- Plan of treatment, progress and changes in treatment plan, 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.

- Laboratory and other studies ordered, as appropriate.
- Treatment, therapies and other prescribed regimens.
- Written documentation of a rendered, ordered or prescribed service, including documentation of medical necessity.
- Documentation concerning follow-up care, telephone calls or visits, when indicated.
- Documentation reflecting that any unresolved concerns from previous visits are addressed in subsequent visits.
- Consultation, laboratory, imaging and other diagnostic test reports filed in the chart are initialed by the practitioner who ordered them to signify review and appropriate follow-up.
- Documentation of all other aspects of patient care, including ancillary services.
- 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



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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:

1. There are documentation and reports of consultations and referrals to specialty physicians if indicated.
2. 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.
3. There are documentation and records for emergency room care and requirements for physician follow-up. 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.
4. 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 while the member is enrolled and for prior admissions as appropriate.

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 ensure 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.

EPSDT – Pediatric Health Screening

Early Periodic Screening and Diagnostic Testing (EPSDT) screens, for Medicaid children from birth to 21 years, are meant to provide comprehensive, preventive, well-child care on a regularly scheduled basis; and to ensure entry into the health care system.

EPSDT Screen Periodicity Schedule

The preventive health guidelines for children are located in the **Provider Educational Materials** section of this manual. In addition, the periodicity schedule can be found in the **EPSDT Guidelines** section of this manual. 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 4, then the next periodic screening is performed at age 5.

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 for newborns

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 equipment 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 2;
- 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.

Additional points of emphasis regarding EPSDT 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 EPSDT screen. For the immunization schedule, refer to the Advisory Committee on Immunization Practices (ACIP) schedule found in the **Provider Education Materials** section of this manual. Note that certain immunizations may not be covered in the context of covered benefits.

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. 'Ohana will expect that the PCP follow up with the referred provider to receive documentation regarding the provision of the



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immunization(s) in order to maintain an accurate and complete medical record.

'Ohana 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.
- 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.

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.
5. **180-day non-compliant Report:** The Plan will send providers a monthly membership list of EPSDT-eligible children who have not had a screen within 180 days of enrolling in the Plan or are not in compliance with the EPSDT periodicity schedule. The PCP shall contact these members' parents or guardians to schedule an appointment.

The Plan will also send letters to the parents and guardians of EPSDT-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, child preventive, asthma, diabetes, congestive heart failure hypertension, obesity, cardiovascular disease and chronic kidney disease.



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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). 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 Perinatal Care Guidelines.

Adult Preventive Health Practice Guidelines

Adult preventive health visits are performed by a physician to assess the health status of a member age 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.