Provider's Guide for the Medical Review Documentation Standards

Member records

Providers are required to maintain medical records that conform to good professional medical practice and appropriate health management. A permanent medical record will be maintained at the primary care site for every member — It will be available to the PCP and other providers. Medical records must be kept in accordance with the following Amerigroup Community Care and state standards.

Medical record standards

The records reflect all aspects of patient care, including ancillary services. These standards will, at a minimum, meet the following medical record requirements.

Documentation of each visit must include:

1.	Cultural and linguistic needs are being met, including documentation of interpretation service provided.
2.	Legibility — Each record must be legible to someone other than the writer. A second reviewer should evaluate any record judged illegible by one physician reviewer.
3.	Patient identification information — Each page or electronic file in the record must contain the patient name and/or patient ID number.
4.	Personal/biographical data — The record must include the patient's age, sex, address, employer, home and work telephone numbers, and marital status.
5.	Allergies — Prominent notation of medication allergies and adverse reactions are required on the record. In the absence of allergies, notation of no known allergies is required in an easily recognizable location.
6.	Provider identification — All entries must have a signature and identify the author.
7.	Entry date — All entries require a date.
8.	Identification of current problems — Significant illnesses, medical and behavioral health conditions, and health maintenance concerns must be identified in the medical record. Include conditions that may affect the member from performing both activities of daily living and instrumental activities of daily living.
9.	Medication information — Current medications need to be clearly identified in a list in each patient's record. The dosage and date initially prescribed or refilled for each medication listed must be present for best practice.
10.	Past medical history (for patients seen three or more times) — Past medical history must be easily identified, including serious accidents, operations and illnesses. For children, include past medical history related to prenatal care and birth.
11.	Smoking, alcohol and substance abuse — A notation concerning cigarettes, tobacco products, alcohol use and substance abuse must be stated if present for patients ages 12 and older. Abbreviations and symbols may be appropriate.
12.	History and physical examination — The medical record must have history and physical exam. Appropriate subjective and objective information is obtained for the presenting complaints. Physical exam must consist of more than one body system.

13. Functional or cognitive deficits — Documentation must include an assessment of all members' ability to perform activities of daily living and instrumental activities of daily living.
14. Plan of treatment — Documentation for each visit supports presenting complaints, clinical findings, evaluation, treatment plan and follow-up recommendations.
15. Consultations, referrals and specialist reports — Notes from any referrals and consultations must be in the record. Consultation, lab and X-ray reports filed in the chart must have the ordering physician's initials or other documentation signifying review. Consultation and any abnormal lab and imaging study results must have an explicit notation in the record of follow-up plans.
16. Plan for abnormal findings — Consultations, lab results, X-rays and other studies must be noted in the record and indicate provider reviewed.
17. Emergency care — Medical record should include copies of emergency treatment documentation such as the *ER Summary Sheet*.
18. Hospital discharge summaries — Discharge summaries are required as part of the medical record for all hospital admissions that occur while the patient is enrolled and for prior admissions as appropriate.
19. Diagnostic tests — Documentation of tests such as electrocardiogram, MRI, CT scan, labs, etc. are required in the member's chart when applicable.
20. Therapies and other prescribed regimens — Documentation of therapies and other prescribed regimens (e.g., physical therapy, occupational therapy, electronic stimulation, etc.) must be noted.
21. Follow-up care — Notations about follow-up care, calls or visits with specific time of return noted in days, weeks or months are documented in the medical record.
22. Exchange of confidential information — There is a process in place for the exchange of confidential information from specialists or post-hospitalization referral/care in a timely manner.
23. Advance directive — For adult patients 21 and older, evidence of advance care planning must include either the presence of a dated advance care plan in the medical record or documentation of an advance care planning discussion between the provider and member with the discussion date included. An advance directive is a written instruction such as a living will or durable power of attorney that directs health care decision making for individuals who are incapacitated.
24. Unresolved problems — Medical records should include documentation that unresolved problems from previous visits are addressed in subsequent visits.
25. Dental screening documented — Dental services may not be limited to emergency services. Dental screening by the PCP in the context means, at a minimum, observation of tooth eruption, occlusion pattern, presence of caries or oral infection for all members.
26. Dental referral documented — A referral to a dentist by age 1 or soon after the eruption of the first primary tooth is mandatory.
27. Coordination and continuity of care between behavioral health (BH) and physical/medical health providers — Documentation in the medical record must include evidence that the PCP works together with the BH provider to ensure continuity of care when a BH issue is identified.
28. Immunizations — For pediatric records of patients ages 12 and under, a completed immunization record or a notation of prior immunization is required and must include vaccines and their dates of administration when possible.