Subject: Review of the Medical Record (Page 1 of 3)

Objective:

I. To ensure that Tuality Health Alliance (THA) has a process of evaluating primary care practices with regard to their medical recordkeeping accuracy and compliance with State and Federal recordkeeping regulations and THA policy.

The medical record should facilitate communication, coordination, and continuity of care, and should promote efficient and effective treatment.

THA will systematically review a random sample of medical records (electronic or hard copy) at least every two years.

Policy:

I. Reviews of medical records and recordkeeping systems will include monitoring the maintenance and security of records as required by Oregon Administrative Rules (OAR), the Health Insurance Portability and Accountability Act (HIPPA), the American Recovery and Reinvestment Act (ARRA), the Health Information Technology for Economic and Clinical Health (HITECH) Act, and other applicable State and Federal regulations. Medical record reviews will further document compliance with THA policies and procedures.

II. Consistent and complete documentation in the medical record is an essential component of quality patient care. The review will include monitoring for the following criteria:

- The medical record is kept secure and confidential;
- Each page in the record contains the member/patient name or ID number;
- The records contain appropriate personal biographical data, including address, employer, home and work telephone numbers, and marital status;
- Advance Directives and Physician Order for Life Sustaining Treatment (POLST), if applicable, should be located in a prominent part of the chart, easily visible and accessible;
- The contact information for the next of kin, legal guardian, Power of Attorney for Healthcare Decisions, or responsible party is included, if applicable
- All entries in the medical record contain the author's identification, which may be a handwritten signature, a unique electronic identifier, or initials;
- Errors in the written record will be corrected as follows:
  - Incorrect data shall be crossed through with a single line;
  - Correct and legible data shall be added, followed by the date of correction and initials of the person making the correction;
  - Removal or obliteration of errors is prohibited;
- All entries are dated and timed;
- The record is legible to someone other than the author; and
- Medical, dental, and/or psychosocial history is included, if applicable.

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III. The record shall include data that forms the basis for diagnosis/es pertaining to the patient's chief complaint; the record shall justify any further diagnostic procedures, treatments, recommendations for return visits, and referrals. Accordingly, the record shall contain:

- Date(s) of service;
- Names and titles of persons performing the services;
- Physicians' orders;
- Pertinent findings on examination and diagnosis;
- Description of medical services provided, including medications administered or prescribed, tests ordered or performed, and results;
- Goods or supplies dispensed or prescribed;
- Description of treatment given and progress made;
- Recommendations for additional treatments or consultations;
- Evidence of referrals and results of referrals;
- Copies of the following documents, if applicable:
  - Mental health, psychiatric, psychological, psychosocial, or functional screenings, assessments, examinations or evaluations;
  - Plans of care, including evidence that the member was jointly involved in the development of his/her mental health treatment plan; and
- The presence of a signed and dated Authorization for Treatment form completed by the patient, his/her legal guardian, or the Power of Attorney for Healthcare Decisions, if applicable for any invasive treatments.

IV. For inpatient and outpatient hospitalizations, the medical record should include:

- Patient history, physical evaluation notes, dictated consultation notes, and a discharge summary;
- Medical education and medical social services provided;
- Copies of signed authorizations for release of information forms; and
- Copies of medical and/or mental health directives.

V. The medical recordkeeping system developed and maintained by the provider shall include sufficient detail and clarity to permit internal and external audits, as done to validate encounter submissions and to ensure that medically appropriate services are provided in a manner that is consistent with the documented needs of the member.

VI. The healthcare facility/clinic shall have policies and procedures that accommodate member requests to review and correct/amend clinical records.

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VII. All records will be retained for seven years after the date of service for which a claim is made. If action is taken prior to the end of the seven year period and it involves stored records, the records must be available for review until all action-related issues are resolved.

References: OAR 410-141-0180
THA Policy X-5: Site Review

Formulated:	February 2000
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