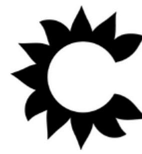

DEPARTMENT:	Provider Relations	ORIGINAL APPROVAL:	04/23/2010
POLICY #:	PR.131	LAST APPROVAL:	04/23/2010
TITLE:	Medical Record Standards		
APPROVED BY:	Julie Keeffe, Director of Provider Relations		
DEPENDENCIES:	PR.132 – Medical Record Audits Procedure PR.103 – Provider Orientation, Site Visit, and Monitoring Policy		

PURPOSE 1

POLICY 1

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PURPOSE

This document outlines Community Health Plan (CHP) member health record requirements as relates to its network of providers.

POLICY

It is a policy of CHP to protect member safety and the privacy and security of member protected health information (PHI). Further, it is CHP's policy to require safeguards for all member medical information including the paper medical record and/or electronic health record (EHR) against loss, defacement, theft and tampering, and from use by unauthorized individuals.

CONFIDENTIALITY AND SECURITY OF MEDICAL RECORDS AND INFORMATION

CHP shall require the following of all its contracted providers:

- All protected health information must be kept strictly confidential in compliance with HIPAA. Notices of Privacy Practices must be signed by the patient and filed in the record. Non-clinical information, such as patient identity and demographic information must be recognized as sensitive for some individuals and increased confidentiality of this information must be available to any patient upon request.

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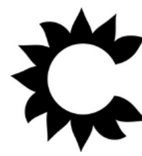

- All employees must be trained and oriented to confidentiality policies upon employment and required to sign a "Confidentiality Agreement." Staff must receive periodic retraining in member information confidentiality.
- Access to electronic patient information must be controlled with appropriate security settings and passwords.
- Service entities with which the practitioner office transacts business (e.g., medical transcription, off-site storage) must be required to adhere to similar confidentiality requirements.
- When medical records or radiology films and other patient identifiable information are to be destroyed, methods of disposal which assure confidentiality must be used. Such methods include incineration and shredding.
- Patient record keeping area(s) must provide for physical security of patient records by means of stringent controls on circulation of the record. Medical record storage area(s) must be secured.
- All requests (walk-ins, telephone, written) for patient and clinical information should be processed according to prescribed routines. Responses to routine requests should be fulfilled within 30 days. Urgent requests should be fulfilled according to the clinical situation.
- All requests for health records or health information should be directed to the appropriate staff. A properly completed and signed HIPAA-compliant patient authorization for release of information must be required for release of all protected health information as required by state and federal law.

MEDICAL RECORD DOCUMENTATION STANDARDS

The following standards correspond to the specific items on the CHP *Site Visit Tool*, which is the instrument used by PR department reviewers to conduct and score the performance of offices and practitioners for compliance to the medical record documentation standards.

Paper Files

CHP's contracted providers are required to maintain the following standards as pertains to paper records:

- Medical Records are kept in a confidential manner
- Only authorized personnel have access to records
- Staff receive periodic training in member information confidentiality
- All pages securely attached in the medical record: No loose notes
- Patient name on all pages in record
- Missed appointments are documented

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- Medical records are organized and include the following:
  - History and physicals
  - Allergies and adverse reactions
  - Immunization records
  - Medications
  - Problem list
  - Past medical history
  - Lab notes
  - Hospital admissions
  - Documentation of clinical findings and evaluation for each visit
  - Preventive services/risk screening
- Tracking system to facilitate medical record location at all times
- Off-site storage, purging criteria, where stored, security measures, who has access

Electronic Files

CHP's contracted providers are required to maintain the following standards as pertains to electronic records:

- Secure confidential filing system
- Password protected
- User has appropriate authorization and user levels. Access to confidential information is restricted.
- Tracking system for who accesses records
- Tracking system for all missed appointments, changes/updates to the records
- Medical records are organized and include the following:
  - History and physicals
  - Allergies and adverse reactions
  - Immunization records
  - Medications
  - Problem list
  - Past medical history
  - Lab notes

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  - Hospital admissions
  - Documentation of clinical findings and evaluation for each visit
  - Preventive services/risk screening
- Back up server/plan in the event of an emergency to ensure that electronic records are preserved and secure
- Plan for handling old paper files

SYSTEMS AND STANDARDS FOR AVAILABILITY OF MEDICAL RECORDS

A medical record shall be constructed for each CHP member and maintained by the practitioner while the member is an active patient. If the member becomes an inactive patient, the medical record can be moved to storage. Current Washington State regulations require practitioners to keep the medical record for 10 years after the last visit if the member is 18 years old or above and for 10 years past the age of majority if the member was a child at the time of the last visit.

All medical records, x-ray films, tissue specimens, slides, and photographs are the property of the practitioner.

It is at the discretion of the practitioner's office to determine the method of filing the medical records, i.e. alphabetical order, terminal digit order, or other numbering system. The record itself should be organized to allow for easy access to information. For example, the record may be organized with dividers to separate notes and laboratory reports.

All paper-based notes, reports, etc. in the medical record must be secured in the member's folder or electronically attached to the member's file/record.

A member's medical record should be kept at each practitioner's office. If the member becomes an inactive patient, the purged medical record may be kept off site. Records should be easily retrievable. All medical records, active and inactive, should be supplied within 30 days of a request. Urgent requests should be met according to the clinical situation.

Compliance with all federal, state, and local regulations pertaining to medical records must be maintained.

All medical record information must be released only by properly trained personnel and only with a HIPAA-compliant patient authorization for release of information form.

POLICY ADMINISTRATION & OVERSIGHT

This policy shall be maintained and administered by Provider Relations.

CHP shall ensure that its network providers are meeting the provisions of this policy by conducting routine audits as outlined in Provider Relations policy PR.103 – *Provider Orientation, Site Visit, and Monitoring* and procedure PR.132 – *Medical Record Audits.*

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LIST OF APPENDICES

None.

CITATIONS & REFERENCES

CFR	
WAC	
RCW	
CONTRACT CITATION	☒ HO/SCHIP (HO, SCHIP, S-MED, BH+) ☒ BH (BHS, BH-SUB, BH-HCTC) ☒ MA ☒ GA-U
OTHER REQUIREMENTS	–
NCQA ELEMENTS	2010 NCQA MA 12, QI 12

REVISION HISTORY

REVISION DATE	REVISION DESCRIPTION	REVISION MADE BY
12/31/2009	Original draft	Barbara Mangelsdorf
01/04/2010	Moved to template; edit for style and clarity; add admin & oversight sections	Jennifer Carlisle
04/23/2010	Approval	Julie Keeffe

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