STANDARDS FOR MEDICAL RECORD DOCUMENTATION

Medical Records, whether electronic or on paper, communicate the member’s past medical treatment, past and current health status, and treatment plans for future healthcare. Good documentation facilitates communication, coordination and continuity of care, and promotes the efficiency and effectiveness of treatment.

Fidelis Care standards are as follows:

A. Fidelis Care requires that providers maintain medical records in a manner that is current, detailed, legible and organized and permits effective and confidential member care and quality review. A separate, distinct medical record is required for each member.

B. Fidelis Care requires that providers have an organized medical record keeping system.

C. Content of the Medical Record -- Primary care medical records must reflect all services provided directly by the Physician, all ancillary services and diagnostic tests ordered by the Physician, and all diagnostic and therapeutic services for which the member was referred by the Physician (e.g. home health nursing reports, specialty physician reports, hospital discharge reports and physical therapy reports). Specific content standards are as follows:

1. Adequacy of the Medical Records Filing System (includes maintenance of confidentiality, procedures for review of diagnostic test results, etc.).
   a. Medical Records are stored in a secure location not accessible to members
   b. There is a unique medical record for each member identified by a medical record identifier (either name or number) on each page
   c. Records are organized with a filing system to ensure easy retrievability

2. Adequacy of Medical Record Keeping
   a. Identifying information present on each page of the medical record
   b. Biographical data is identified on each entry
   c. The provider is identified on each entry
   d. All recorded entries are dated
   e. The record is legible

Clinical Content
   f. Significant illnesses and medical conditions are indicated on the problem list.
   g. Medication history (past and current) must be reviewed at each visit, documented and dated. Medication allergies and adverse reactions are prominently noted in the record. If the member has no known allergies or history of adverse reactions, this is appropriately noted in the record.
   h. Past medical history (for members 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, operation, and childhood illnesses.

3. Retention of Medical Records
   Medical records must be retained for at least ten (10) years for adults, and six (6) years from the age of majority for children.
4. Confidentiality
   a. Access to medical records is permitted only to those individuals who are part of the team providing healthcare to the individual. Such information contained in the medical record may be provided to Fidelis Care for purposes directly connected with the performance of Fidelis Care's obligations. Access may additionally be permitted consistent with the HIPAA/HITECH and all other State and Federal regulations.
   b. The healthcare provider's Notice of Privacy Practices must describe the individual's rights regarding: receipt of a copy of their personal medical record; practices regarding disclosure of their Protected Health Information; ability to request modification of their personal medical record; and, all other rights provided in the HIPAA/HITECH and all other State and Federal regulations.
   c. Confidentiality of HIV-Related Information: Providers must develop policies and procedures to assure confidentiality of HIV-related information, as required by Article 27-F of the New York State Public Health Law. These policies must include:
      - Initial and annual in-service education of the providers’ staff and/or contractors.
      - Identification of those staff members allowed access, and the limits of their access to HIV-related information.
      - A procedure to limit access to trained staff (including contractors).
      - A protocol for secure storage (including electronic storage).
      - Procedures for handling requests for HIV-related information.
      - Protocols to protect persons with or suspected of having HIV infection from discrimination.

5. Fidelis Care's Process for Improving Medical Records
   a. Letters sent to providers that include specific deficiencies identifying the compliance issues and a suggested action plan for improvement.
   b. Suggested models of records such as forms, problem lists or medication allergies documentation forms.
   c. Re-education information, highlights of best practices or blinded records that meet Fidelis Care's standards particularly well.

Fidelis Care uses medical record review staff to conduct onsite reviews. Providers and their office staffs receive verbal feedback and education, which includes, but is not limited to, Fidelis Care’s requirements, various Department of Health reporting requirements, medical record documentation, and member education. Providers receive a written report card following the onsite review.

Access to Medical Records
Copies of medical records must be made available, without charge (unless otherwise noted), to other participating providers, consultants, or physicians involved with the member's care and treatment. Copies of medical records must also be made available upon request, and without charge (unless otherwise noted), to Fidelis Care (e.g., Chief Medical Officer, Quality Health Care Management Staff) for quality assurance and utilization review activities. The handling of medical records must comply with all Federal and State laws and regulations regarding confidentiality of member records.
Section Seven Standards for Medical Record Documentation

Copies of medical records must be made accessible to the Local Department of Social Services (LDSS), New York State Department of Health, and/or the Centers for Medicare and Medicaid Services (CMS) upon request.