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 health care. Good documentation facilitates communication, coordination and continuity of care, and promotes the efficiency and effectiveness of treatment.

All Fidelis Care participating providers are required to participate in the Fidelis Care Quality Management and Improvement Program. Providers are obligated by contract to allow inspection of their records, and are expected to meet Federal and State regulatory requirements enabling Fidelis Care to access and review their records.

Fidelis Care’s Medical Record Documentation Standards

A. Fidelis Care requires that providers maintain members’ medical records in a manner that is current, detailed, organized, and legible facilitating 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.

   1. Adequacy of the Medical Records Filing System (includes maintenance of confidentiality, procedures for review of diagnostic test results, etc.).
      a. Storage: medical Records are stored in a secure location not accessible to members and unauthorized personnel.
      b. Patient Identification: there is a unique medical record for each member identified by a medical record identifier (either name or number) on each page
      c. Access and Availability: records are organized with a filing system to ensure easy and timely retrievability upon request by legitimate users.

   2. Adequacy of Medical Record Keeping
      a. A minimum of two pieces of patient identifying information present on each page of the medical record
      b. Biographical data is identified on each intake form (i.e.: DOB, patient address, employer, home/work telephone number, ethnicity)
      c. The provider is identified on each entry
      d. All recorded entries are dated, signed or cosigned.
      e. The record is legible

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

      a. Significant illnesses and medical conditions are indicated on the problem list and updated as necessary.
      b. 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.

c. Past medical history (for members seen three or more times) is easily identified and includes serious accidents, operations, and illnesses. For children and adolescents (eighteen (18) years and younger), past medical history relates to prenatal care, birth, operation, and childhood illnesses.

d. Health maintenance is noted updated and updated as necessary.

e. BMI, nutrition, exercise, depression assessment, tobacco and alcohol use, substance use, and sexual activity are noted for patients fourteen (14) years and above.

f. Physical exams are performed at least once a year and documented accordingly.

g. Clinical findings and evaluation are documented for each visit.

h. Documentation in the medical record of discussion of advance directive for adult patients who are Medicare Advantage members and documentation on whether or not a patient has executed an advance directive with a copy of such to be in the medical record. Documentation of advance directive discussions and copies of advance directive may be filed for other members.

i. Evidence of review of results of ancillary services, diagnostic tests and studies by the PCP. Labs may be initialed or notation in progress note indicating review of labs.

j. Reviewed consultation reports or documentation of discussions with consulting physicians are to be part of the medical record. Reports may be initialed or notation in progress notes indicating the review must be documented. Documented evidence of instructions/education given to members regarding follow-up visits, treatment, care, medication use and schedules, diagnostic and therapeutic services where members are referred for services.

k. Lead screening per ‘New York State requirements and at the physician’s discretion based on community or individual risks.

l. Documentation of childhood, adolescent and adult immunizations per National and New York State Health Department guidelines.

m. Documented age specific preventive screenings according to National and State practice guidelines and requirements.

D. 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.

E. Confidentiality

a. All offices are required to meet and exceed state and federal confidentiality requirements such as HIPPA and must protect confidential information against unauthorized disclosure. Provider offices are to ensure periodic confidentiality training of staff members.

b. 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.
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.

Fidelis Care’s providers are to provide upon request written policies and procedures for patient information release protocols showing compliance with state and federal laws and evidence of periodic confidentiality training of staff members.

**Fidelis Care’s Process for Medical Record Improvement**

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 medical record documentation, New York City and State Department of Health and CMS reporting requirements. Providers receive a written report following the onsite review.

Upon review, providers are rated according to the following performance goals:

a. 85%-100% compliance -- compliant with standards
b. Below 85 % compliance requires a corrective action plan

Any provider below 85% compliance with Medical Records Standards will require corrective action. Within the Corrective Action Plan request, Providers will be asked to:

a. Investigate compliance issues and articulate plans for improvement.
b. Discuss the status of Electronic Medical Record use.
c. If not using a medical record, discuss the use of standardized medical record forms.

Where reasonably possible, Fidelis Care will make best practices known and will provide copies of medical record form templates.

Providers who do not meet expected goals will be referred to the Fidelis Care Credentialing Committee. Committee actions may include counseling actions, focused
reviews, suspension and in some cases termination from the Fidelis Care provider network.

I. **Access to Medical Records** Copies of medical records must be made available, without charge, to other participating providers, consultants, or physicians involved with the member’s care and treatment. Copies of medical records must be made available to assist in orderly transfer of medical records if member changes their PCP. Copies of medical records must also be made available upon request, and without charge (unless otherwise noted in a Providers contract), 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.

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.