Medical Record Standards for Practitioners and Providers

HAP and HAP CareSource practitioners and providers are required to maintain member health records (medical records) in a manner that is current, detailed and organized to facilitate communication and coordination of care. Medical record audits are completed during site visits based on member complaints. A passing score is 90%. Providers receive education if they are deficient with our standards. For more detailed information, please see our *Medical Record Confidentiality, Maintenance and Retrieval Guidelines for Practitioners and Providers Policy* which can be found when you log in at **hap.org.** Below are our medical record guidelines.

General

1. Medical records must be maintained in a manner that is current, detailed and organized to facilitate communication and coordination of care.
2. Medical records must be complete, documented accurately, updated in a timely manner, readily accessible, and permit prompt and systematic retrieval of information.
3. Medical records must be maintained in English, legible and fully disclose and document the extent of services provided to members.
4. Medical records should be in a detailed, comprehensive manner that conforms to good professional medical practice, allows effective professional medical review and medical audit processes, and facilitates a system for follow-up treatment.
5. Practitioners and providers must abide by all Federal and State laws and regulations regarding confidentiality and disclosure of medical records, or other health and enrollment information. These laws require providers to fully disclose the extent of the services, care, and supplies furnished to our members, as well as support claims billed.

Content and organization

1. Each page in the record contains the patient's name or ID number.
2. Patient's address, employer, home and work telephone numbers and marital status
3. All entries contain the author's identification, which may be a handwritten signature, unique electronic identifier or initials. Per CMS, a valid signature must be for:
   - For services provided or ordered
   - Handwritten or electronic (note: stamped signatures are allowed if you have a physical disability and can prove to a CMS contractor that you're unable to sign due to that disability)
   - Legible or can be confirmed by comparing it to a signature log or attestation statement
4. Content is in chronological order.
5. The record is legible to someone other than the writer.
6. Must be signed and dated.
7. Medical records must contain, at a minimum:
   a. Outpatient and emergency care
   b. Specialist referrals
   c. Ancillary care
   d. Diagnostic test findings including laboratory and radiology
   e. Prescriptions for medications
   f. Allergies and adverse reactions (also documented if no known allergies)
   g. Problem list (including significant illnesses and medical conditions)
   h. Inpatient discharge summaries
   i. Histories and physicals
   j. Immunization records
   k. Documentation of clinical findings and evaluation of each visit
   l. Working diagnosis consistent with findings
   m. Treatment plans consistent with diagnosis
   n. Preventive services/risk screenings
   o. Other documentation sufficient to fully disclose the quantity, quality, appropriateness, and timeliness of services provided.

8. Primary care health records must reflect the following information:
    a. All services provided directly by a practitioner who provides primary care services.
    b. All ancillary services and diagnostic tests ordered by a practitioner.
    c. Reports of all diagnostic and therapeutic services for which a member was referred by a practitioner, (e.g., home health nursing, specialty physician, hospital discharge, PT).
9. Advanced Directives (required for hospitals, critical access hospitals, skilled nursing facilities, nursing facilities, home health agencies, providers of home health care, hospices)–whether or not an advance directive has been executed.

Retention, Confidentiality and Accessibility

1. All medical records must be retained for at least 10 years.
2. Records are stored securely.
3. Only authorized personnel have access to records.
4. Staff receive periodic training in member information confidentiality.

Sharing medical record information

1. Practitioners and providers share health record information, as appropriate and in accordance with professional standards.
2. Medical records shall be made available to members, any provider treating a member, and State and Federal agencies as necessary. At a minimum, HAP requests medical records for record content and quality; peer review; grievance review, and audit reviews.
3. To the extent required by law, appropriate State and Federal agencies shall have the right, upon request, to inspect records at reasonable times, including all accounting and administrative records maintained by the provider.
4. When a patient changes PCP, the former PCP must forward the patient's medical records or copies of medical records to the new PCP within 10 working days from receipt of a written request

Behavioral Health Records

In addition to the standards above, behavioral health records shall contain the information below.

1. Each patient must have an individual treatment plan, completed by the second visit and include:
    a. Strengths and weaknesses
    b. Patient input
    c. Diagnosis
    d. Short and long-term goals
    e. Treatment time frames and reassessment dates
    f. Risk behaviors
    g. Specific treatment modalities
    h. Treatment referrals
    i. A written consent for treatment must be signed by the patient or legally responsible individual

    Note: Records must be revised as clinically appropriate and be individualized to the patient.

2. Progress notes must contain the following:
    a. Entries by behavioral health professional responsible for care
    b. Entries by Allied Health professionals participating in the patient's treatment
    c. Entries documenting each patient encounter
    d. Session type identified for each patient encounter
    e. Documentation for "no show" appointments
    f. Evidence of communication with the PCP as well as a signed Release of Information or refusal

Training Resources

Below are some helpful resources for medical records.

CMS resources	• Signature requirements • Medical Record Maintenance & Access Requirements • Complying With Medical Record Documentation Requirements • Advance Directives
Medicaid	• MedicaidProviderManual.pdf (state.mi.us)
Michigan Public Codes	• 333.16213 Retention of records • 333.20175 Maintaining record for each patient, confidentiality