7. MEDICAL RECORDS REQUIREMENTS

A. Provider and IPA Medical Record Requirements

APPLIES TO:

A. This policy applies to all IEHP DualChoice Providers and IPAs.

POLICY:

A. All Provider offices must comply with IEHP, local, state, and federal regulatory standards for maintenance of Member medical records.

PROCEDURES:

IPA Responsibilities

A. IPAs are responsible for monitoring contracted Providers for compliance with all applicable IEHP and Department of Health Care Services (DHCS) standards related to medical records.
   1. IPA medical record policies and procedures must be consistent with IEHP requirements.
   2. IPAs must ensure that contracted Providers have copies of IEHP medical record policies and procedures available at the practice site. See Policy 7B, "Information Disclosure and Confidentiality of Medical Records."
   3. IPAs may assess medical record documentation and maintenance during the initial credentialing and recredentialing site review, though Facility Site Reviews (FSR) and Medical Record Review (MRR) activities are not delegated to IPAs.
   4. IPAs must provide support for Corrective Action Plans (CAPs) issued by IEHP for medical record deficiencies as appropriate.

IEHP Medical Record Standards

A. **Individual Medical Records** – An individual medical record is created for each Member treated by an IEHP Provider. The medical record is designed to maintain a Member's documented medical information of the care provided, as well as all ancillary services/diagnostic tests ordered by a Provider and all referred diagnostic and therapeutic services in a consistent, logical, and uniform manner. The same medical record may be used by other treating Providers within the same group to provide conformity and coordination of Member care. This unique medical record must be updated by the Provider or their office staff with each Member visit or contact. Sensitive medical information, such as detailed behavioral health and substance use records, may be filed separately to maintain confidentiality. Medical records must meet at minimum the following requirements:
   1. Correct Beneficiary;
   2. Acceptable risk adjustment Provider type, source, and Provider specialty providing the face-to-face encounter;
   3. Dates of service within the data collection period under review;
   4. Valid signatures and credentials; and

5. Coded according to the official conventions and instructions provided within ICD-CM.

B. **Member (Patient) Identification** – Members should be linked to their individual medical records through an assigned unique identifier for filing purposes and to distinguish that record from any other Member record. Each page, test result, letter, and item of correspondence regarding that individual Member must contain the unique identifier, and Member (patient) name as a means of Member identification.

C. **Member Demographics** – Each medical record must contain a section for Member identification that includes name, age, employer, occupation, work and home telephone numbers, address, insurance information, marital status, and emergency contact person and name of parent(s)/legal guardian if Member is a minor.

D. **Responsible Party** – Providers designate individuals responsible for record maintenance. Responsible parties must follow established protocols for the daily collection, research, retrieval, securing, maintaining, and transporting of medical records within the Provider setting.

E. **Legal Document –** The medical record is a legal document and all contents must be maintained in a confidential manner.

F. **Medical Record Maintenance –** The Member medical record must be maintained in a current and detailed organized manner that reflects effective care of the Member and facilitates quality review.

G. **Legibility and Maintenance** – Providers must establish a uniform format to organize medical records and maintain all medical records in a consistent and comprehensive manner. Medical record entries are to be legible, made in a timely manner, dated, and signed by the appropriate Provider/Practitioner or staff. Records may be maintained in hard copy format or electronically as long as they are easily accessible, have sufficient backup to prevent loss of information and have a unique electronic identifier for the author. The medical record must be legible to a person other than the author.

H. **Protection and Confidentiality** – Providers must limit medical records access to authorized and associated staff. Records must be maintained in a protective and confidential manner and are not readily accessible to unauthorized persons or visible to the general public. Providers must maintain policies and procedures to ensure appropriate record processing to prevent breach of protection or confidentiality or the unauthorized release of Member information to any internal or external person. Providers must educate staff regarding confidentiality and record maintenance policies and procedures and ensure that confidentiality statements are signed.

I. **Storage, Filing and Availability** – Providers must maintain an organized record-keeping system to make the individual medical record available for each Member visit or contact including collection, processing, maintenance, storage, retrieval, identification, and distribution. Providers must maintain procedures to assign the unique identifier to each individual record and ensure that the appropriate record is pulled for each Member. Filing of records must be done in a consistent manner either alphabetically or by Member identifier

number. In addition, procedures must outline the methodology for pulling requested records, methodology for tracking, the amount of notification time required, and system of distribution and collection. Providers must have provisions for obtaining medical records on an emergency basis. Medical records are to be kept in a clean, secure environment and in good condition.

K. **Record Retention** – Providers must retain medical records pertaining to Members for a period of ten (10) years from the end of the fiscal year in which IEHP's contract expires or is terminated. Pediatric medical records must be maintained for a minimum of ten (10) years or until the Member's 19th birthday, but in no event for less than ten (10) years. All medical records, medical charts and prescription files, and other documentation pertaining to medical and non-medical services rendered to Members are subject to this requirement.

L. **Informed Consent for Treatment** – Providers must obtain appropriate written consent for treatment prior to actual procedure performance including the human sterilization consent procedures. If someone other than the Member signs the consent, the legal relationship should be noted on the consent form. Provider/Practitioner staff must witness, sign, and date consent forms.[1] See Policy 7C, "Informed Consent," for more information.

M. **Release of Information** – Medical records contain confidential information that is not to be released to another party without the expressed consent, written in ink, of the Member or legal representative. Any adult patient, or any minor patient who by law can consent to medical treatment is entitled to inspect patient records upon written request within five (5) working days after receipt of the written request.[2] Members are also entitled to copies of all or any portion of his or her records upon written request.[3]

Providers must provide Members with copies within fifteen (15) days of the receipt of a written request.[4] Providers receiving medical records request from other Providers must submit the medical records within fifteen (15) days of receiving the written request to avoid any delay in the Member's care.[5] See Policy 7B, "Information Disclosure and Confidentiality of Medical Records" for more information. As it is customary for Providers not to charge, IEHP encourages its Providers to offer this as a complimentary service to other Providers. When absolutely necessary to charge another Provider, the law allows only $0.25 per page,[6] and to limit a total charge to $20.

N. **Exam Information** - Each medical record entry must contain all pertinent information related to the Member contact including: complaints, symptoms, examination results, medical impressions, treatments, Member conditions, test results, and proposed follow-up. A subjective complaints, objective findings, assessment, and plan (SOAP) format may be used to satisfy this requirement.

[1] Title 22 of the California Code of Regulations (CCR), §§ 51305.1-51305.4
[2] California Health & Safety Code (Health & Saf. Code), § 123110
[3] Ibid.
[4] CA Health & Saf. Code § 123110
[5] Ibid.
[6] Ibid.

7. MEDICAL RECORDS REQUIREMENTS

A. Provider and IPA Medical Record Requirements

O. **Medical Record Contents** – Providers must maintain a complete and comprehensive medical record for each Member. The record must include all Provider services rendered including all but not limited to: examinations, Member contacts, health maintenance or preventive services, laboratory and radiology test results or reports, procedures, ancillary services, off-site treatments, emergency room records, and hospital admission and discharge information. Correspondence regarding the Member's medical condition, such as consultation records, specialist reports, and referrals, must also be included in the Member record. Pathology and laboratory/radiology reports must be included in the record with a special notation for all abnormal findings. Each page, insert, test, and lab entry must be identified by Member name and/or Member identifier. The medical record must include Member identification, biographical data, emergency contact information, and informed consents.

P. **Documentation Standards –** The IEHP documentation standards and goals for medical record maintenance are as follows:

1. Each page in the record contains the Member's name and a second identifier.
2. Medication allergies and adverse reactions are noted in a consistent, prominent place; otherwise, no known allergies or history of adverse reactions is noted.
3. Past medical history for the Member is documented. This documentation includes serious accidents, operations, and childhood illnesses. For children and adolescents (20.99 years and younger), past medical history relates to prenatal care, birth, operations, and childhood illnesses.
4. The use of cigarettes, alcohol and history of substance use noted for Members age 11 and older (substance use history is queried for Members seen three (3) or more times).
5. Problem lists are maintained for Members with significant illnesses and/or conditions that are monitored. A chief complaint and diagnosis or probable diagnosis is included.
6. The history and physical examination records must include appropriate subjective and objective information pertinent to the Member's presenting complaints.
7. Documentation of exams is appropriate for the medical condition.
8. Copies of signed informed consent forms.
9. All medications prescribed include the name, dosage, frequency, and route unless medication only comes in oral form.
10. Medications given on-site must document name, dosage, route and whether the Member had a reaction to the medication.
    a. Immunizations administered on-site must document name, dosage, and route, as well as the injection site, manufacturer's name, and lot number.
11. Laboratory and other studies are ordered and documented, as appropriate.
12. All treatments, procedures, and tests, with results, are documented.

13. Working diagnoses are consistent with findings.
14. Treatment plans are consistent with diagnoses.
15. Notes have a notation, when indicated, regarding needed follow-up care, calls or visits. The specific time of return is noted in weeks, months, or as needed.
16. Unresolved problems from previous office visits are addressed in subsequent visits.
17. Member education, recommendations and instructions given are included.
18. Pediatric Members' (age 20.99 and under) records have a completed immunization record or notation of immunizations up to date.
19. An immunization history has been noted for adults.
20. There is no evidence that the Member is placed at inappropriate risk by a diagnosis or therapeutic procedure.
21. Preventive screening and services are offered and documented in accordance with IEHP standards.
22. Referrals for specialty care or testing are noted, when appropriate.
23. Consultant notes are present, as applicable.
24. Consultation, lab, and imaging reports filed in the chart are initialed by the Provider who ordered them to signify they have been reviewed. A Provider may also designate this task to a non-physician medical practitioner under their supervision only if it is part of their practice agreement. If the reports are presented electronically or by some other method, there is also representation of review by the ordering Provider. Consultation, abnormal lab and imaging study results have an explicit notation in the record of follow-up plans.
25. Evidence of practitioner review of referral reports and diagnostic test results.
26. Evidence of follow-up of specialty referrals made, and results/reports of diagnostic tests, when appropriate.
27. Missed primary care appointments and outreach efforts/follow-up contacts are documented.
28. For Members age 18 years and older, as well as Emancipated Minors, documentation of Advance Directives discussion or offered is present.

Q. **Completeness of the Medical Record –** The medical record must be checked to assure that all ordered procedure and referral notes are returned and filed in the chart within three (3) working days of the visit, procedure, or receipt of the report/progress notes from any outside Provider or Practitioner into the Provider office. The Provider/Practitioner must review and initial all test results and consultations and document follow-up treatment for abnormal lab results.

R. **Laboratory and Radiology Results** – Providers must maintain procedures for filing laboratory and radiology results in the Member's medical record. STAT tests are to be

performed and reported within twenty-four (24) hours. Providers must have procedures for review of test results, notation of normal and abnormal results in the medical record, and documentation of instructions for follow-up. Providers must have guidelines identifying which staff member is authorized to notify Members of test results. Tests performed by the Provider or Practitioner must have results documented in the medical record.

S. **Language Preference –** Each medical record must include designation of primary language and documentation of request or refusal of language interpretation services. Person or entity providing medical interpretation is identified. Provider/Practitioner documentation must be in English.

T. **Providers and Staff Entries and Signatures** – Each entry including chief complaint and vital signs or Member contact, including telephone conversation/advice noted in a Member's medical record must be dated and signed by the Provider and/or staff, if applicable, including the title of the person making the chart entry. This includes all therapies, procedures, and medications administered to a Member. When documentation errors occur, the person that makes the error must correct the error in the following manner:

1. A single line is drawn through the error;
2. The corrected information is written as a separate entry and includes the following:
    a. Date of the entry;
    b. Signature (or initials, if authenticated in other area of chart); and
    c. Title.
3. There are to be no unexplained cross-outs, erased entries or use of correction fluid or tape. Both the original entry and corrected entry are to be clearly preserved. One method used for correcting documentation errors is the S.L.I.D.E Rule: Single Line, Initial, Date and Error.

U. **Follow-Up Care Documentation –** Specific follow-up care instructions and a definite time for return visit or other follow-up care is appropriately documented in the Member's medical record. The time period for return visit or other follow-up care is definitively stated in number of days, weeks, months or as needed (PRN).

V. **Advance Directives** – Adult medical records that contain information regarding execution of advance directives such as a living will or Advance Health Care Directive, for Members 18 years or older, as well as Emancipated Minors, must be prominently noted. Refer to Policy 7D, "Advance Health Care Directive," for more information.

W. **Preventive Health Screening and Individual Health Education Behavioral Assessment** - PCPs must maintain documentation of the Individual Health Education Behavioral Assessment (IHEBA) and/or any appropriate screening tool in the Member's medical records. Please refer to Policies 10A, "Initial Health Assessment and 15F, "Individual Health Education Behavioral Assessment and Staying Healthy Assessment" for more information.

7. MEDICAL RECORDS REQUIREMENTS

A. Provider and IPA Medical Record Requirements

X. **Follow-up Care for Referrals, Emergency Treatment, Hospitalization, Home Health Care, Skilled Nursing Facility (SNF) or Surgical Treatment Rendered at Surgical Center** – The medical record must reflect continuity of care for any treatment, emergency or otherwise, rendered in a hospital, emergency room, urgent care, home health, SNF, or surgical center setting. Documentation must include the provisions for follow-up or continued treatment. Providers must document referrals to specialists or waiver programs, treatments rendered, or recommendations made and follow-up care to be instituted.

Monitoring

A. Facility Site Review (FSR) and Medical Record Review (MRR)

1. New and current Providers are required to undergo a full scope FSR and MRR survey initially and at a minimum of every three (3) years.
2. The MRR consists of an evaluation of a Provider's medical record system and information kept in the medical record to ensure Provider's medical record compliance with IEHP and regulatory standards. See policy 6A, "Facility Site Review and Medical Record Review Survey Requirements and Monitoring."
3. Medical record reviews for any other contracted or specialty care Providers are conducted as directed by the IEHP Chief Medical Officer, Quality Management (QM) Committee, Quality Improvement Subcommittee (QISC), Peer Review Subcommittee, or Credentialing Subcommittee.

B. Other monitoring includes Interim FSR Reviews, as well as the use of both internal quality management systems and external sources of information, as outlined in Policy 6H, "Interim FSR Monitoring for Primary Care Providers." All deficiencies require the completion of corrective action plan according to established timelines.

C. IPA medical record compliance is monitored through the Annual Delegation Oversight Audit (DOA). Please see Policy 25A2, "Delegation Oversight – Audit" for more information.

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7. MEDICAL RECORDS REQUIREMENTS

C. Informed Consent

APPLIES TO:

A. This policy applies to all IEHP DualChoice Members and Providers.

POLICY:

A. Informed consent for treatment, procedures or other interventions must be obtained by IEHP Providers prior to initiation of the procedure.

DEFINITIONS:

A. IEHP Providers - IEHP Providers, in this policy, are defined as but not limited to Primary Care Providers (PCPs), Specialists, Behavioral Health Providers, Behavioral Health Treatment Providers (BHT), Vision Providers, Urgent Care Centers, Ancillary Providers, Facilities, Pharmacies, and other Providers (e.g. Nurse Practitioners, Physician Assistants, Acupuncturists, Certified Nurse Midwives and Dentists).

PROCEDURES:

A. IEHP Providers must obtain appropriate written consent from Members before the actual performance of any diagnostic or treatment procedure of an intrusive nature[1] (See Attachments, "Consent for Special Procedure – English" and "Consent for Special Procedure – Spanish" in Section 7).

B. In the event the appropriate consent form is unavailable in the Member's primary language, Members have the right to request an interpreter at no charge. See Policies 9H1, "Cultural and Linguistic Services – Foreign Language Capabilities" and 9C, "Access to Care Members with Access and Functional Needs."

C. In the event a Member lacks legal authority to sign the consent due to either the Member's legal status as a minor or because of mental incapacitation, an agent may sign the consent on behalf of the Member. The signing agent must document their relationship to the Member on the consent form. A copy of any authorizing document or court order should be maintained in the Member's file. Examples of authorized agents include:

   1. A person appointed pursuant to a valid advance health care directive.
   2. A conservator, guardian, or interested person with a court order authorizing the particular treatment of the Member.
   3. A conservator or guardian authorized by a court to make health care decisions for the Member.
   4. The Member's parents, spouse, registered domestic partner, or close family relatives.

[1] Title 45 Code of Federal Regulations (CFR) § 46.116(a)

7. MEDICAL RECORDS REQUIREMENTS

C. Informed Consent

D. The consent form must include the following:[2]

1. Member name;
2. ID #;
3. Procedure;
4. Diagnosis;
5. Risks;
6. Benefits;
7. A statement signed by the Member or Agent that the procedure has been explained to the Member or Agent, and that the Member or Agent fully understands the procedure, benefits, and risks;
8. A witness' signature; and
9. PCP/Practitioner's signature.

E. Informed consent is required whenever any surgical or invasive diagnostic procedure is to be performed or when general, local, or regional anesthesia is to be used.

F. Informed consent information must be provided with consideration of the Member's linguistic needs and literacy level.

G. A special informed consent procedure must be followed in the case of sterilization for Members enrolled in IEHP DualChoice (See Attachments, "PM 330 Sterilization Consent Form" in Section 10).

H. Providers must provide informed consent forms in English and Spanish. Special consent forms can be found in Section 10 (See Attachments for Consent for special procedures in Section 10) or on the IEHP Website at www.iehp.org/providers/provider-resources.

I. /An informed consent procedure must be in place for Members who seek out-of-plan Sexually Transmitted Infection (STI), Family Planning and HIV testing services, and who wish to maintain medical record confidentiality but allow for transmission of information necessary for billing purposes.

J. Providers are required to keep copies of signed informed consent forms in the Member's medical record as well as submit these with any claim forms.

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[2] Title 45 Code of Federal Regulations (CFR § 46.116(b)

7. MEDICAL RECORDS REQUIREMENTS

D. Advance Health Care Directive

APPLIES TO:

A. This policy applies to all IEHP DualChoice Members and Providers.

POLICY:

A. IEHP requires that all Health Care Providers (i.e., healthcare facilities and Practitioners) comply with the Patient Self Determination Act (PSDA) of 1990, which states that all Health Care Providers must:[1]

1. Inform Members of their right to formulate an advance directive in writing. This policy, regarding PSDA, applies to all Health Care Providers and Members age 18 and older, as well as Emancipated Minors.
2. Periodically inquire as to whether a Member executed an advanced directive and document the Member wishes regarding their medical care;
3. Not to condition the provision of care or otherwise discriminate against persons who have or have not executed an advanced directive;
4. Ensure that legally valid advance directives and documented medical care wishes are implemented to the extent permitted by State law; and
5. Provide education to staff, Members and the community on ethical issues concerning patient self-determination and advance directives.

DEFINITION:

A. **Advance Health Care Directive** - Written legal document that details treatment preferences for any health care decisions when a Member is unable to speak for his or herself. Examples of advance directives include (but are not limited to): an Advance Health Care Directive form, a living will, a Durable Power of Attorney for Health Care form, a health care proxy, a Physician Orders of Life Sustaining Treatment (POLST), Five Wishes, and surrogate decision maker. This document must comply with State and Federal law.

PROCEDURES:

A. The provisions of the PSDA that affect Health Care Providers (i.e., healthcare facilities and Practitioners) are as follows:[2,3]

1. Every Health Care Provider that receives payments from Medicare or Medi-Cal must give each Member a statement of rights regarding making healthcare decisions.

[1] Patient Self Determination Act (PSDA) of 1990
[2] Ibid.
[3] California Probate Code § 4670 et. Seq

2. The Health Care Provider must offer information to all Members age 18 and older, as well as Emancipated Minors, regarding advance directives. A response must be documented in the Member's medical record. Healthcare may not be withheld or delayed for lack of an advance directive.
3. If the Member has an advance directive, the Health Care Provider must request that the Member bring the Provider a copy to be placed in the Member's medical record.
4. If the Member does not have an advance directive and requests further information, the Health Care Provider must have written educational materials on hand regarding the PSDA (See Attachments, "Advance Health Care Directive FAQs - English" and "Advance Health Care Directive FAQs - Spanish" in Section 7).
5. Health Care Providers are not required to assist Members with formulating advance directives. They are only required to offer information to Members 18 and older, as well as Emancipated Minors of advance directives.
6. A Member may change, cancel and/or amend an advance directive at any time.
7. The "Advance Health Care Directive" form can be utilized in the medical record to satisfy the advance directive requirement (See Attachments, "Advance Health Care Directive – English" and "Advance Health Care Directive – Spanish" in Section 7).

B. Neither IEHP nor the IPA is required to provide care that conflicts with an advance directive.

C. IEHP and/or the IPA allows a Member's representative/caregiver to facilitate care or treatment decisions for a Member who is unable to do so. IEHP and/or the IPA will allow the Member or the Member's representative/caregiver to be involved in decisions about withholding resuscitative services or declining/withdrawing life-sustaining treatment.

D. Through its written Member materials, IEHP must periodically inform Members of their right to accept or refuse treatment and to complete an advance directive and inform the Member how to implement that right.

E. IEHP and/or the IPA must have a policy for medical record documentation of advance directives that require:

1. Documentation of whether the Member has been offered Advance Care Directives or has executed an Advance Health Care Directive.[4,5,6,7]
2. The Physician Orders for Life-Sustaining Treatment (POLST) form[8] and Five (5) Wishes are acceptable if appropriately completed and signed by necessary parties.

[4] California Probate Code § 4701
[5] Title 42 Code of Federal Regulations (CFR) § 422.128
[6] 42 CFR § 489.100
[7] Department of Health Care Services (DHCS) APL 05-101, "Advanced Directive Form"
[8] California Probate Code § 4780

3. Advanced Health Care Directive information is reviewed with the Member at least every five (5) years and as appropriate to the Member's circumstances.

F. IEHP shall demonstrate that it provides education for staff on issues concerning advance directives.

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