

## BlueSalud<sup>SM</sup>

# Medical Records Documentation Standards

### Medical Record Organization

Medical records must be organized with the following elements:

- **Patient identification** – Each chart contains demographic (biographic) and personal data sufficient to allow information transfer in case of emergencies.
- **Separate records** – Each patient has a separate medical record.
- **Dated records** – Each encounter between the physician and the patient is dated.
- **Treating practitioner identification** – Each encounter between the physician (or other licensed health care provider) and patient is documented so that the health care professional's identity is clear.
- **Data integrity** – Each page of the medical record contains patient identification sufficient to allow it to be returned to the chart if lost.
- **Legibility** – Medical records must be sufficiently legible to allow transfer of critical patient care information when needed.

### Retrieving Medical Records

Medical records must be easy to retrieve.

- **Identification** – Each record must be labeled or identified so that it can be retrieved by office staff and practitioners in a timely manner relative to the clinical needs of patients.
- **Systematic storage** – Records must be kept in a systematic file system. While not required, computerized medical records or retrieval systems are considered evidence of superior practice.

### Confidentiality of Member Information

Confidential patient information is subject to the following:

- **Treat as confidential** – Medical records are treated as confidential information.
- **Safeguards** – Appropriate safeguards are in place to protect the confidentiality of the medical record, in compliance with applicable state and federal laws, including the Health Insurance Portability and Accountability Act (HIPAA).
- **Release** – Confidential information is released only in accordance with applicable state and federal laws.
- **Advance directives** – Advance directives, or the documentation of discussion with the member about advance directives, are documented.

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## Medical Record Content

The following information must be filed in the member's medical records.

- **Allergy and adverse reactions** – Each chart clearly identifies that the patient is either (a) not allergic to any drug or medication; or, (b) identifies what allergies or adverse reactions the patient does have.
- **Medications** – Current information about the medications the patient is taking, including dosages, dates, and medication effectiveness.
- **History of present illness** – Each encounter documents history or other subjective data that are appropriate to the reason for the encounter.
- **Physical examination** – Each encounter documents physical exam or other objective data that are appropriate to the reason for the encounter.
- **Important medical background data** – The documentation used at the time of patient encounters contains sufficient background data relative to the patient's condition. Most commonly, this information will be categorized as past medical history, review of systems, social history, risk factors, and any history of tobacco use, alcohol use, or substance abuse. The intent is met when the documentation includes sufficient information to identify conditions that would potentially affect the treatment plan or require coordination of care with other practitioners.
- **Working diagnosis** – For each encounter, working diagnoses are either documented explicitly, or the records would make such a diagnosis implicitly clear, including diagnostic information.
- **Follow-up** – A follow-up plan of action including further diagnostics, treatment, and/or education is documented. If therapeutic or diagnostic procedures/services are furnished at the time of the visit, the indication for such services is clear from the documentation. Include documentation of member notification of abnormal results and follow-up plan of action.
- **Coordination of Care** – If the physician was sent information from another practitioner or provider, that information has been reviewed by the physician and placed into the record as appropriate. Include reports of emergency care, to the extent possible.
- **Continuity of Care** – If laboratory, radiographic, or other studies have been ordered, there is evidence in the record as to the rationale for the studies, and evidence that the results have been tracked, reviewed, and acted upon as indicated.

## **Additional Standards for Primary Care Physicians**

Primary Care Physicians (PCPs) have these additional standards:

- **Vital signs** – At every encounter, age appropriate vital signs are recorded.
- **Problem list** – There is a complete and current problem list including a patient's relevant and significant illnesses, medical, and psychological conditions.
- **Complete medical information** – There is documentation that the physician/practitioner obtained a past medical history and review of systems that, relative to the patient's clinical condition, is sufficiently comprehensive to identify all problems that require follow-up.
- **Ongoing tracking** – Problems from previous visits are addressed or tracked for later consideration. Any systematized method for tracking and monitoring chronic disease conditions will be considered evidence of superior practice.
- **Consultation review** – The results of consultations (including lab tests, specialist consultations, hospital discharge reports, home health nursing reports, physical therapy reports, and behavioral health reports) are reviewed and integrated as appropriate into the care plan.
- **Immunization** – The medical record documents immunizations to identify if the patient's age-appropriate immunization status is up-to-date.
- **Preventive health** – There is documentation of the provision of preventive health services, referral, or advice where appropriate, including preventive health counseling when rendered. The status of preventive services provided are to be documented in a single sheet form in the medical record within six months of enrollment.