Medical Records
Documentation Standards

A. NMAC and HSD Documentation Standards
1. Maintain each medical record on paper and/or in electronic format in a manner that is timely, legible, current, and organized that permits effective and confidential patient care and quality review.
2. Two forms of patient identification information must be noted on each printed page (e.g., name and date of birth).
3. Contain documentation for both encounter and entry dates.
4. Provide for clear identification of authors for all entries.
5. Document the member’s current problem.
6. Document a history and/or physical examination for the presenting complaint(s) or problem(s).
7. Document discussion of advance directives at least annually.

B. BCBSNM Documentation Standards
In addition to the NMAC and HSD standards, BCBSNM has established the following standards with which its providers are also expected to comply:
1. Have appropriate safeguards in place to protect the confidentiality of the medical record in compliance with applicable state and federal laws, including HIPAA.
2. Store records in a centralized secure location, accessible only to authorized personnel and retrievable in timely manner by office staff and practitioners.
3. Periodically provide training to office staff and practitioners for maintaining the confidentiality and security of patient information.
4. Only release confidential information in accordance with applicable state and federal laws.
5. Ensure the medical record contains sufficient biographical and demographic information (i.e., date of birth, sex, race/ethnicity, mailing/residential address, emergency contact information).
6. Allergies and the adverse reactions in a uniform location of the record; or notation of no known allergy (NKA) or no known drug allergy (NKDA), if applicable.
7. For medications prescribed, documentation must include name, strength, amount, direction for use, and refills. Effectiveness should be documented upon follow-up.
8. Treatment/follow-up plan and patient discharge instructions for each encounter.
9. Preventive health services reviewed and documented for patients of all ages, such as but not limited to, immunizations, well visits, weight counseling, and BMI assessment, etc. (physical health only).
10. Diagnostic test results and other prescribed therapies with evidence of practitioner review and patient notification of abnormal results.
11. Coordination of care between practitioner to include, as applicable, referrals and evidence of practitioner review reports, signed release of information allowing for communication between practitioners.