

MEDICAL RECORDS STANDARDS
(For Audit Purposes)

Providers shall maintain medical records for each enrollee in accordance with this section. Medical records shall include the quality, quantity, appropriateness, and timeliness of services.
Providers must include/follow the medical record standards set forth below for each enrollee's medical records, as appropriate:

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| a. Medical records will be secured and inaccessible to patients |
| b. Only authorized personnel have access to records |
| c. The enrollee's identifying information, including name, enrollee identification number, date of birth, sex and legal guardianship (if any) |
| d. Each record must be legible and maintained in detail |
| e. A summary of significant surgical procedures, past and current diagnoses or problems, allergies, untoward reactions to drugs and current medications |
| f. All entries must be dated and signed by the appropriate party |
| g. All entries must indicate the chief complaint or purpose of the visit, the objective, diagnoses, medical findings or impression of the provider |
| h. All entries must indicate studies ordered (e.g., laboratory, x-ray, EKG) and referral reports |
| i. All entries must indicate therapies administered and prescribed |
| j. All entries must include the name and profession of the provider rendering services (e.g., MD, DO, OD), including the signature or initials of the provider |
| k. Supervision of health care assistants who provide services is documented in the medical record |
| l. All entries must include the disposition, recommendations, instructions to the enrollee, evidence of whether there was follow-up and outcome of services |

(Source)

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m. All records must contain an immunization history
n. All records must contain information relating to the enrollee's use of tobacco products and alcohol/substance abuse
o. All records must contain summaries of all emergency services and care and hospital discharges with appropriate medically indicated follow up
p. Documentation of referral services in enrollees' medical records
q. All services provided by providers. Such services must include, but not necessarily be limited to, family planning services, preventive services and services for the treatment of sexually transmitted diseases.
r. All records must reflect the primary language spoken by the enrollee and any translation needs of the enrollee
s. All records must identify enrollees needing communication assistance in the delivery of health care services
t. All records must contain documentation that the enrollee was provided written information concerning the enrollee's rights regarding Advance Directives (written instructions for living will or power of attorney) and whether or not the enrollee has executed an Advance Directive. No provider shall, as a condition of treatment, require the enrollee to execute or waive an Advance Directive.
u. Copies of any advance directives executed by the enrollee.