

Subject: Review of Medical Record

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Objective:

To ensure compliance of medical recordkeeping by systematically reviewing a random sample of medical records (electronic or hard copy) at least every two years from primary care practice sites.

Policy:

- I. THA establishes standards for medical record reviews to facilitate communication, coordination and continuity of care and to promote efficient and effective treatment.
- II. Reviews of provider record keeping systems will include monitoring the maintenance and security of records as required by the Oregon Administrative Rules, (OAR), the Health Insurance Portability and Accountability Act (HIPPA), the American Recovery and Reinvestment Act (ARRA), the Health Information Technology for Economic and Clinical Health (HITECH) Act, 42 USC § 1320-d et seq., and the federal regulations implementing the Act. Medical record reviews will document compliance with these policies and procedures.
- III. Consistent and complete documentation in the medical record is an essential component of quality patient care. The review will include monitoring for the following:
 - A. Medical Records are kept secure and confidential.
 - B. Each page in the record contains the patient's name or ID number.
 - C. The records contain appropriate personal biographical data including the address, employer, home and work telephone numbers, and marital status. Advance Directives and Physician Order for Life Sustaining Treatment (POLST) should be located in a prominent part of the chart easily visible and accessible. Also included should be next of kin, legal guardian and Power of Attorney for Healthcare Decisions or responsible party contact information.
 - D. All entries in the medical record contain the author's identification which may be a handwritten signature, a unique electronic identifier, or initials.
 - E. Errors in the written record will be corrected as follows:
 1. Incorrect data shall be crossed through with a single line

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2. Correct and legible data shall be added followed by the date corrected and initials of the person making the correction.
 3. Removal or obliteration of errors is prohibited.
- F. All entries are dated and timed.
- G. The record is legible to someone other than the author.
- H. Medical, dental, and/or psychosocial history as appropriate
- I. The clinical record shall include data that forms the basis of the diagnostic impression of the member's chief complaint sufficient to justify any further diagnostic procedures, treatments, recommendations for return visits, and referrals.
1. Dates of service names and titles of persons performing the services
 2. Physicians' orders
 3. Pertinent findings on examination and diagnosis
 4. Description of medical services provided, including medications administered or prescribed; tests ordered or performed and results
 5. Goods or supplies dispensed or prescribed
 6. Description of treatment given and progress made
 7. Recommendations for additional treatments or consultations
 8. Evidence of referrals and results of referrals
 9. Copies of the following documents if applicable:
 - a. Mental health, psychiatric, psychological, psychosocial or functional screenings, assessments, examinations or evaluations
 - b. Plans of care including evidence that the member was jointly involved in the development of his/her mental health treatment plan
- J. The clinical record keeping system developed and maintained by the participating provider shall include sufficient detail and clarity to permit internal and external clinical audit to validate encounter submissions and to assure medically appropriate services are provided consistent with the documented needs of the member. The system shall conform to accepted professional practice and facilitate an adequate system for follow up treatment
- K. The PCP or clinic shall have policies and procedures that accommodate members requesting to review and correct or

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amend their clinical record.

- IV. The clinical record will indicate or include the presence of a signed and dated authorization for treatment form completed by the member, his/her legal guardian or the Power of Attorney for Health Care Decisions for any invasive treatments.
- V. If the member is receiving mental health services the following information should be present:
 - A. Mental health, psychiatric, psychological, psychosocial or functional screenings, assessments, examinations or evaluations.
 - B. Plan of care including evidence of the members' involvement in the development of his/her mental health treatment plan.
- VI. For inpatient and outpatient hospitalizations, there should be history and physical, dictated consultations, and discharge summary
 - A. Emergency department and screening services reports
 - B. Consultation reports
 - C. Medical education and medical social services provided
 - D. Copies of signed authorizations for release of information forms
 - E. Copies of medical and/or mental health directives
- VII. All THA clinical records will be retained for seven years after the date of service for which a claim is made. If action is taken which involves stored records (prior to the end of the seven year period) the records must be available for review until all issues are resolved.

Reference: THA policy X-5 Site Review
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THA Plan Director

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