Medical Record Documentation Standards

1. Freedom Health Providers comply with the following medical record standards:
   - 1.1. Each and every page in the record contains the member's name (or ID/chart number) and birth date.
   - 1.2. Personal/biographical data including age, sex, address, employer, home and work telephone numbers, marital status and legal guardianship.
   - 1.3. All entries are dated.
   - 1.4. All entries in the medical record contain legible author identification. Author identification is a handwritten signature, stamped signature, or a unique electronic identifier. Signature is accompanied by the authors title (MD, DO, ARNP, PA, MA).
   - 1.5. The record is legible to someone other than the writer.
   - 1.6. Medication allergies and adverse reactions are prominently noted in the record. If the member has no known allergies or history of adverse reactions, this is noted in the record (no known allergies = NKA).
   - 1.7. Past medical history (for members seen three or more times) easily identified and include serious accidents, significant surgical procedures, and illnesses. For children and adolescents (21 years and younger), past medical history relates to prenatal care, birth, operations, and childhood illnesses.
   - 1.8. The immunization record is up to date.
   - 1.9. Diagnostic information, consistent with findings, is present in the medical record.
   - 1.10. A treatment plan, including medication information, is reflected in the medical record.
   - 1.11. A problem list including significant illnesses, medical conditions, health maintenance concerns and behavioral health issues are indicated in the medical record.
   - 1.12. For members 12 years and over, notation concerning the use of cigarettes and alcohol use and substance abuse is present (for members seen three or more times).
   - 1.13. If a consultation is requested, a note from the consultant is in the record.
   - 1.14. Emergency Room discharge notes and hospital discharge summaries (hospital admissions which occur while the member is enrolled in Freedom Health, and prior admissions, as necessary) is included as part of the medical record.
   - 1.15. There is evidence that preventive screening and services are offered in accordance with the Freedom Health Care preventive services policies, procedures, and guidelines.
   - 1.16. The record contains documentation of whether or not the individual has executed an advance directive.
   - 1.17. The record documents members seeking assistance with special communications needs for health care services.

2. Documentation of individual encounters provides adequate evidence of:
   - 2.1. The history and physical expression of subjective and objective presenting complaints.
   - 2.2. Treatment plan.
   - 2.3. Laboratory and other diagnostic studies used.
   - 2.4. Therapies and prescribed regimens.

- 2.5. Encounter forms or notes regarding follow up care, calls, or visits.
- 2.6. Unresolved problems from previous visits.
- 2.7. Consultation, lab, and imaging reports filed in the chart initialed by the PCP to signify review.

3. Medical records are secured in a safe place to promote confidentiality of member information.

4. Medical records and information are maintained in a confidential manner.
   - 4.1. Minor members' consultations, examinations, and treatment for sexually transmissible diseases are maintained confidentially.

5. Additional medical record recommendations include:
   - 5.1. All entries are neat, legible, complete, clear, and concise, written in black ink.
   - 5.2. Entries are dated and recorded in a timely manner.
   - 5.3. Records are not altered, falsified or destroyed.
   - 5.4. Incorrect entries are corrected by:
     - 5.4.1. Drawing a single line through the error.
     - 5.4.2. Avoiding correction fluid or markers that will obscure writing.
     - 5.4.3. Dating and initialing each correction.
     - 5.4.4. Making no additions or corrections to a medical record entry if a medical chart has been provided to outside parties for possible litigation.
   - 5.5. All telephone messages are documented.
   - 5.6. All telephone consent discussions are documented.