ROCKY MOUNTAIN HEALTH PLANS®
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Office Record Guidelines

Primary Care Physicians

General Maintenance of Office Records - The medical record is an important source of patient information vital to the provision of quality medical care. Primary Care Physicians will be responsible for the maintenance of adequate medical records that are to be secure, complete, legible, accurate, accessible, organized and maintained in a format which facilitates retrieval of information and assures confidentiality.

1. All records should include:
   a) A basic information sheet containing name, age (date of birth) and sex; parental and custodial information should be included for children
   b) A medical history, a family history and a personal history
   c) Allergies or drug reactions
   d) An up-to-date list of patient's medical problems
   e) An up-to-date list of patient's ongoing medications
   f) Each page in the record contains the patient's name or ID number
   g) All entries are dated and contain the author's identification
   h) Immunization status assessed and tracked

2. The records should include an entry for each office encounter, containing:
   a) The primary problem for which the physician was consulted
   b) Any pertinent history or other subjective data
   c) Physical examination and / or other objective data
   d) A diagnosis, impression or assessment and subsequent data
   e) A plan including any medications or tests ordered and notation on follow-up care as indicated
   f) Documentation of patient instructions regarding care and treatment
   g) Chronic or unresolved problems are addressed in subsequent office visits

3. The record should include current reports related to patient's care:
   a) Dated laboratory, radiology and pathology reports
   b) Consultation reports
   c) Hospital discharge summaries / ER reports

4. Office procedures are to be documented, and:
   a) EKGs are to be mounted, labeled and read
   b) Office x-rays are to have an interpretation in the chart

c) Any procedure or study for which there is a separate charge made, such as pulmonary function studies, audiograms, A and B scans, allergy testing, EMGs, etc., should have a report in the chart. The report should be recorded in a fashion that a physician trained to do so would be able to retrieve and interpret the data

5. There must be an entry in the patient's record for office surgical procedures including a verbal or written consent as appropriate, anesthetic used (if any), if a specimen was submitted for pathologic examination, with documentation of patient instructions and follow up care.

6. Periodic health screening examinations are to include:
   a) Health history changes or new complaints (if any) since the last examination
   b) A physical examination describing all systems examined

7. Consults - The primary care physician should made copies of pertinent tests, report, and medical records and make them available to a consulting provider and document this in the medical record

8. Telephone conversations with the patient involving medical advice or a change in treatment should also be documented in the chart as to their basic content, prescriptions refilled, etc.

9. Advance Directives, if executed, are documented

Health Maintenance and Health Screening - Health screening is an important part in the provision of continuing comprehensive and quality medical care of the Rocky Mountain Health Plans. Physicians providing primary care are expected to provide their patients with information regarding appropriate health screening. In addition, specialty physicians should also provide information and carry out testing for health screening that is appropriate to their specialty in cases where they assume management for a particular problem for which they have been consulted. In addition to the general patient record guidelines, evidence of attempts at health screening should appear in the patient's clinical record in addition to a well-documented history and physical examination as follows:

1. Well Child Care - Health maintenance in children is perhaps the most important aspect of well-child care and anticipatory guidance. The record should contain evidence of health maintenance including, but not limited to:
   a) Immunizations – a complete immunization record, including all immunizations the child has had from any provider
   b) Growth charts, measurements of height, weight and head circumference
   c) Screening tests as appropriate for age
   d) Evidence of developmental screening during the first five years of life
   e) Pertinent physical examination to detect problems such as visual or hearing deficits

f) Documentation of appropriate age-specific anticipatory guidance (e.g. safety, nutrition, behavior)

2. Health Maintenance for Adult Females - The health services record for adult females should include evidence of health maintenance including, but not limited to:
   a) Breast examinations
   b) Pelvic examinations including PAP smears if indicated
   c) Mammograms if indicated
   d) Blood pressure screening
   e) Colorectal cancer screening, and other age appropriate interventions as recommended by the USPSTF

3. Health Maintenance for Adult Males - The health services record for adult males should include evidence of health maintenance including, but not limited to:
   a) Blood pressure screening
   b) Colorectal cancer screening, and other age appropriate interventions as recommended by the USPSTF

Specialty Care Physicians

Maintenance of Specialists' Office Records - The medical record is an important source of patient information vital to the provision of quality medical care. Rocky Mountain Health Plans specialist physicians will be responsible for the maintenance of adequate medical records which are to be secure, complete, legible, accurate, accessible, organized and maintained in a format which facilitates retrieval of information. Communication with the Primary Care Physician is likewise important, and Rocky Mountain Health Plans expects to find evidence of such communication in the charts, either in the form of a letter to the Primary Care Physician or a copy of the office notes

1. All records should include:
   a) A basic information sheet containing name, age, (date of birth), sex, and address
   b) A medical history, family history, personal history and medication list
   c) Allergies or drug reactions
   d) An up-to-date list of the patient's medical problems
   e) An up-to-date list of the patient's current medications
   f) Dated laboratory and radiology reports
   g) Consultation reports and any material provided by the Primary Care Physician
   h) Hospital discharge summaries, history and physical examination, and operative notes where applicable
   i) Each page in the record contains the patient's name or ID number
   j) All entries are dated and contain the author's identification

2. Records should include an entry for each office encounter containing:
   a) The primary problem for which the specialist was consulted
   b) Pertinent history (subjective data)

c) Pertinent objective data to include physical examination and any laboratory, x-ray or other tests
d) An impression or assessment
e) Recommendations to the Primary Care Physician or a plan by the specialist to implement any indicated therapy with communication to the Primary Care Physician
e) Documentation of patient instruction regarding the diagnosis and its management, or a recommendation to return to the Primary Care Physician for such instructions
f) Telephone conversations with the patient involving medical advice or a change in treatment should also be documented in the chart as to their basic content, prescriptions refilled, etc.
g) Office diagnostic tests, EKGs and other office tests (such as radiology, pulmonary function tests, allergy tests, EEGs, ultrasound, etc.,) are to be documented and interpreted in the chart and maintained and mounted in such a way as to make them easy to retrieve and review

Mental Health Providers

Mental Health Providers

A. In addition to general record maintenance, communication with referring primary care physicians is important.

1. Record Guidelines
    a. Each patient must have an individual record
    b. The patient record should contain an appropriate patient history, including past history, medication history, and a history of present problem, when applicable
    c. The diagnosis must be recorded and appropriate
    d. Treatment plan must be recorded and appropriate
    e. Documentation in the patient record and interpretation of psychological testing when performed is required
    f. Office or hospital follow-up must be timely and documented appropriately
    g. The Primary Care Physician will be informed of patient's diagnosis, treatment plan and progress as is appropriate for optimum patient care, assuming proper release forms have been signed by the patient
    h. The Primary Care Physician should be informed of patient’s diagnosis, treatment plan and medications as is appropriate for optimum patient care – assuming the patient has signed the appropriate release documentation.

IV. Confidentiality and Security of medical records - all providers

A. All providers will maintain medical records in a secure environment as applicable by law.

1. Maintenance of medical record
    a. Patient medical records are adequately maintained in a secure environment, including electronically stored medical records
    b. Signed authorizations for patient release of medical records are present
    c. Filing system utilized avoids misplaced or misfiled medical records
    d. Staff maintains confidentiality of member information and records