

## **Office Records Guidelines**

### **Office Records — Primary Care Physician**

The medical record is an important source of patient information vital to the provision of quality medical care. Providers are responsible for the maintenance of adequate medical records, which are to be secure, complete, legible, accurate, accessible, organized, and maintained in a format that facilitates retrieval of information. Additional details about these requirements are located in the RMHP Medical Record Composition and Availability Policy and Procedure which is available upon request. All records should include:

#### **General Information**

- A basic information sheet containing name, age (date of birth), and sex
- A medical history, a family history, and a personal history
- Allergies or drug reactions
- Immunization status
- An up-to-date list of the patient's medical problems
- An up-to-date list of the patient's current medications
- Each page in the record contains the patient's name or ID number
- All entries are dated and contain the author's identification

#### **Office Visit Information**

- The primary problem for which the physician was consulted
- Any pertinent history or physical examination data
- A diagnosis, impression, or assessment and subsequent data
- A plan including any medications or tests ordered
- EKGs mounted, labeled, and interpreted
- Interpretation of office x-rays
- Any procedure or study for which there is a separate charge made — such as pulmonary function studies, A and B scans, allergy testing, and EMGs — 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.
- Surgical procedures, including anesthetic used and specimens submitted for pathologic examination
- Documentation of patient instructions regarding the diagnosis and its management
- Telephone conversations with the patient involving medical advice or a change in therapy

## **Periodic Health Screening Examinations**

- Health history changes or new complaints, if any, since the last examination
- A physical examination describing all systems examined
- The primary care physician should make copies of pertinent tests, reports, and medical records and make them available to a consulting provider and document this in the medical record

## **Reports and Summaries**

- Dated laboratory and radiology reports
- Consultation reports
- Hospital discharge summaries

## **Primary Care Physician**

Each RMHP member selects a participating physician as his or her Primary Care Physician (PCP) upon enrollment. The PCP is responsible for the patient's total care and coordinates all medical care provided to the member. The PCP agrees to provide primary, preventive, acute, chronic care, and comprehensive health care management for that member. Additionally it is important for our members to become familiar with their rights to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment. This right includes the preparation of advance directives, written instructions expressing the members' wishes about his/her medical treatment should he/she become unable to make those decisions on his/her own. The PCP is also responsible for the following:

- Maintain a complete, accurate central record of the member's health and health care;
- Refer the member to specialty physicians and other health care providers when appropriate (if required by the specific health plan);
- Record all referrals in the patient's chart appropriately (if required by the specific health plan);
- Arrange for copies of laboratory results and other health records to accompany the patients referred to specialty physicians, and other service providers as appropriate, in order to enhance continuity of care and to reduce the need for duplication of diagnostic procedures;
- Evaluate and incorporate into the member's health record information received from specialty physicians and other providers;
- Arrange for an elective admission of the member to inpatient hospital care when appropriate, including completion of the steps required to demonstrate the necessity for such admission;
- Take responsibility for case management (solely or jointly with the specialist) as soon as possible after receiving information that a member of his or her primary care practice has been hospitalized within the service area on an emergency basis;
- Maintain and operate his or her practice in a manner, which protects the health and safety of RMHP/RMPC members with reasonable access for acute and scheduled appointments.

## **Primary Care Physician/Consultant Relationship**

The PCP should make copies of pertinent tests, reports or medical records available to any provider utilized as a consultant. Proper documentation of the type of information and date sent should be included in the medical record.

The consulting physician is responsible for reporting findings and recommendations to the PCP in writing prior to any elective procedure performed on the patient.

In the event that the consult is done on an emergency basis, efforts should be made to contact the PCP by telephone. A written report is to follow and will be documented in the medical record.

## **Office Records — Specialist**

In addition to the general record maintenance points above, communication with the referring or primary care physician is important. RMHP expects to find evidence of such communication in the charts, either in the form of a letter to the referring or primary care physician or a copy of office notes. This communication should occur after the initial evaluation and periodically thereafter whenever recommendations or therapy are changed, and at minimum, yearly for a stable patient. Additional details about these requirements are located in the RMHP Medical Record Composition and Availability Policy and Procedure which is available upon request. All records should include:

### **General Information**

- A basic information sheet containing name, date of birth, and sex
- A medical history, family history, personal history, and current medication list
- Allergies and/or drug reactions
- An up-to-date list of the patient's medical problems
- An up-to-date list of the patient's current medications
- Each page in the record contains the patient's name or ID number
- All entries are dated and contain the author's identification
- Consultation reports and any material provided by the referring or primary care physician
- Hospital discharge summaries, history, physical examination, and operative notes where applicable

### **Office Visit Information**

- The primary problem for which the specialist was consulted
- Pertinent history (subjective data)
- Pertinent objective data to include any laboratory, x-ray, or other tests
- An impression or assessment
- Recommendations or a plan of therapy with a written copy forwarded to the referring or primary care physician
- Documentation of patient instructions regarding the diagnosis and its management
- Recommendation to return to the referring or primary care physician, if applicable
- Telephone conversations with the patient involving medical advice or a change in therapy

## **Reports and Summaries**

- 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.
- There must be an entry in the patient's record for office surgical procedures, including the indications, anesthetic used (if any), and the specimen(s) submitted for pathologic examination (if any).

## **Office Records - Mental Health Providers**

In addition to the general record maintenance points above, communication with the referring or primary care physician is important. Additional details about these requirements are located in the RMHP Medical Record Composition and Availability Policy and Procedure which is available upon request. All records should include:

- Each patient must have an individual record
- The patient record should contain an appropriate patient history, including past history, medication history, and a history of present problem, when applicable
- The diagnosis must be recorded and appropriate
- Treatment plan must be recorded and appropriate
- Documentation in the patient record and interpretation of psychological testing when performed is required
- Office or hospital follow-up must be timely and documented appropriately
- The Primary Care Physician will be informed of patient's diagnosis, treatment plan and progress as is appropriate for optimum patient care
- The Primary Care Physician will be notified of treatment recommendations as appropriate for optimum patient care

## **Confidentiality and Security of Medical Records - All Providers**

All providers will maintain medical records as follows:

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