MEDICAL RECORD GUIDELINES

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In this chapter, you will find policies on how to maintain member medical records including medical record standards and contractual requirements regarding retention and disclosure of information

MEDICAL RECORD GUIDELINES

EmblemHealth requires its practitioners to maintain accurate medical records.

The medical record contains information about each member, identifies the patient's complaints/symptoms or lack thereof, contains the diagnosis and basis for the diagnosis, the communication and discussion of treatment options, side effects, decisions made and treatments rendered. The primary purpose of the record is to document the course of the member's health or illness and treatments and serve as a mode of communication between physicians and other professionals participating in the care rendered. The entire medical record of an active member must remain in the primary care physician's office and must be consistent with all relevant local, state and federal laws, rules and regulations.

The following guidelines assist EmblemHealth in assuring the appropriate exchange and retention of member medical data and are used to perform clinical audits in conjunction with ongoing quality assurance activities.

Please note that EmblemHealth may request a copy of, or make an on-site visit to review, your medical records for internal and regulatory chart audits.

Access to medical records

A member has the right to review, copy and request amendments to his or her medical record. Any member or qualified person who desires a copy of the medical record may obtain one by submitting a written request to his or her participating practitioner or facility.

Our member handbook tells members how to give consent to the collection, use and release of personal health information, how to obtain access to their medical records and what we do to protect access to their personal information.

A member or qualified person may challenge the accuracy of the information in the medical record. In addition, he or she may require that a statement describing the challenge be added to the record.

Access by a member or qualified person to information in the medical record may be denied, but only if the participating provider or facility determines that:

Access can reasonably be expected to cause substantial harm to the member or to others; or

Access would have a detrimental effect on the participating practitioner's or facility's professional relationship with the member, or on their ability to provide treatment.

MEDICAL RECORD CONTENT AND FORMAT

Each member should have a unique medical record, which contains at least the following information:

PCP Coordinates Care

Where the member's plan requires PCP assignment, the record verifies that the PCP coordinates and manages the member's care.

Personal

- Name
- EmblemHealth ID number
- Date of birth
- Address and phone number
- Employer's name, address and phone number
- Marital status
- Benefit plan participation and copayment (if applicable)
- Name of the primary care physician (PCP)
- List of allergies and/or adverse reactions, or "No Known Allergies" (NKA)

Medical

- Biographical information
- Comprehensive baseline history and physical (see details below)
- Diagnostic test results
- Consult reports
- Progress notes
- Medication records
- Problem list
- Allergy documentation
- Telephone/communication log
- Immunization records
- Preventive health screening records
- Inpatient/ER discharge summary reports, if applicable**
- Operative reports, if applicable

** The PCP must also clearly document any follow up on the member's ER visit and/or hospitalization, whether an office visit, written correspondence, or telephone conversation.

The comprehensive baseline history and physical must include a review of:

- Subjective and objective complaints/problems
- Family history
- Social history (i.e., occupation, education, living situation, risk behaviors)
- Significant accidents, surgeries, illnesses and mental health issues
- Complete and comprehensive review of systems (including patient's presenting complaint, as applicable)
- Prenatal care and birth information (baseline, 18 years and younger only) in cases where the member has both a PCP and an OB/GYN, they must coordinate to ensure there is a centralized medical record for the provision of prenatal care and all other services.

Periodic history and physicals review should be repeated in accordance with age appropriate preventive care guidelines.

Within the record jacket, reports of similar type (i.e., progress notes, laboratory reports) should be filed together in chronological or reverse chronological order permitting easy retrieval of information and initialed by the physician to indicate they have been read. Each progress note filed should be legibly written or typed, signed and dated by the author, and contain at least the following items:

- The reason for visit as stated by the member
- The duration of the problem
- Findings on physical examination
- Laboratory and X-ray results, if any
- Diagnosis or assessment of the member's condition
- Therapeutic or preventive services prescribed, if any
- Dosage, duration and side effect information of any prescription given, with medication allergies and adverse reactions noted prominently (updated during a physical, when a prescription is written, or annually, whichever comes soonest)
- Follow-up plan (including self-care training) or that no follow up is required

Reports generated as a result of a request for a test or consultation must be filed immediately in the medical record with the member's name, ID number and date of birth on each document page.

Test results should be reported to the member within a reasonable time after physician receipt and review and filed with a progress note indicating when the member was notified, by whom, and the next steps in the treatment plan.

Provider Signature Attestation

The Centers for Medicare and Medicaid Services (CMS) requires each date of service in a member's medical record to be accompanied by a legible provider signature and credentials. Some examples of appropriate credentials are MD, DO and Ph.D. In general, for your medical records to be deemed compliant, you must authenticate each note for which services were provided. Acceptable physician authentication includes handwritten and electronic signatures or signature stamps. Please review the tables that follow for examples of acceptable and unacceptable signatures and credentials.

ACCEPTABLE PHYSICIAN SIGNATURES AND CREDENTIALS	
Signature Type	**Acceptable**
Handwritten signature or initials, including credentials	• Mary C. Smith, MD or John J. Smith, DO or, for initialing MCS, MD or JJS, DO
Signature stamp, including credentials	• Must comply with state regulations for signature stamp authorization
Electronic signature, including credentials	• Must be password protected and used exclusively by the individual physician • Requires authentication by the responsible physician, statements including but not limited to: ○ Approved by

	○ Signed by ○ Electronically signed by

UNNACCEPTABLE PHYSICIAN SIGNATURES AND CREDENTIALS WITH CORRECTIVES	
Signature Type	**Unacceptable Unless**
Provider signature without credentials	• Name is linked to provider credentials or name on physician stationary
Typed name	• Name is authenticated by the provider
Signed by a non-physician or a non-physician extender (e.g., medical student)	• Signature is co-signed by responsible physician

AUDITING PRIMARY CARE PHYSICIAN (PCP) MEDICAL RECORDS

The Quality Review Operations department conducts ongoing audits, based on randomly selected charts, of a PCP's medical record documentation procedures. We inform PCPs of their results at the time of the audit.

Those PCPs who do not score at least 90 percent are offered a means of correcting a deficiency immediately after review and are enrolled in one-year of monitoring, during which EmblemHealth will educate and provide practitioners with record-keeping aids. A nurse reviewer will then re-audit by viewing at least three records seen by the PCP during the monitoring period.

ACCESSING MEDICAL RECORDS

Responsibility for maintaining and securely storing a member's medical record lies with the office of the Primary Care Physician. An active member's record should be available for review both at the time of the member's appointment and when requested by EmblemHealth, the NYSDOH, CMS (and LDSS for Medicaid only) or other authorized entity for utilization review and for quality and other applicable audits.

Practitioners are responsible for maintaining a patient's original medical records for six years (or 10 years for Medicare members) after either the last date of service rendered or the date the member no longer seeks care from that provider. In the case of a minor, the records shall be retained for three years after the member reaches the age of majority or six years after the date of service, whichever is later. This timeline applies even if the patient has terminated his/her EmblemHealth coverage.

All practitioners must observe applicable state and federal laws, rules and regulations concerning the confidentiality of medical records.

RELEASE OF INFORMATION TO MEMBERS

Members are entitled access to or copies of records concerning their health care. All or part of

the medical record may be released to the member or other "qualified persons" with written authorization from the member and in accordance with applicable state and federal law.

"Qualified persons" are appointed by members or the court to handle specific areas of concern on the member's behalf. Examples of "qualified persons" include, but are not limited to:

- Court appointed committee for an incompetent
- Parent of a minor
- Court appointed guardian of a minor
- Other legally appointed guardian

The Authorization to Use or Disclose Protected Health Information form should be completed in order to provide authorization. If this form is not used, the written consent must include the following information:

- Name of the physician from whom the information is requested
- Name and address of the institution, agency or individual that is to receive the information
- Member's full name, address, date of birth and EmblemHealth ID number
- The extent or nature of the information to be released, including dates of treatment
- Date of initiation of authorization
- Signature of the member or qualified person

Member requests should be honored within 10 days of the receive date of the written authorization.

A member or qualified person may challenge the accuracy of information in the medical record and may require that a statement describing the challenge be included in the record.

Access to member information may be denied only if the provider determines that access can reasonably be expected to cause substantial harm to the member or others, or would have a detrimental effect on the provider's professional relationship with the patient or his or her ability to provide treatment.

The physician may place reasonable limitations on the time, place and frequency of any inspections of the patient information. Personal notes or observations may be excluded from any disclosure based on the provider's reasonable judgment.

Special authorizations, forms and procedures are required for HIV-related testing (both before and after the test is performed) and for release of any HIV-related information from the medical record. In order to release confidential HIV-related information, consent forms created or approved by the New York State Department of Health (NYSDOH) must be used. All authorizations requesting the release of behavioral health records must specify that the information requested concerns behavioral health treatment.

We recommended that providers consult legal counsel with regards to records disclosure issues.

ADVANCE DIRECTIVES

Advance directives are written instructions, recognized under state law, which relate to the provision of health care when the individual is incapacitated and unable to communicate his/her desires. Examples include such documents as a living will, durable power of attorney for health care, health care proxy or do not resuscitate (DNR) request.

EmblemHealth counts on its practitioners to honor a member's request regarding the type of care stipulated under an advance directive.

Upon enrollment, and consistent with relevant federal and state laws, each member receives the following:

- "Planning in Advance for Your Medical Treatment," a NYSDOH article which describes an individual's rights in New York State with respect to health care decision making.
- "Appointing Your Health Care Agent - New York State's Proxy Law," a NYSDOH article which provides information and a sample form to be used to appoint a "health care agent."
- A letter describing EmblemHealth's policy implementing the requirements under the law and regulations.

Our practitioners should discuss advance directives with their patients (as appropriate) and file a copy of any advance directive document in the medical record. Each medical record that contains an advance directive should clearly indicate that said document is included.

TELEPHONIC MEDICINE

Telephonic medicine includes, but is not limited to, diagnosis, treatment, advice and instruction given to patients over the phone. EmblemHealth does not pay for telephonic consultations as a separate billable service.

We expect the highest quality of care, including face-to-face interaction between the patient and provider whenever possible. To reduce liability and the risk of medical errors made possible by telephonic consultations, we require practitioners to adhere to the following procedures:

- Document every phone call in the patient's medical record.
- Base notes on the same principles of documentation as during face-to-face interaction.
- Whenever practical, have the patient's medical records available when telephone interaction is conducted from the practitioner's office.
- All covering physicians should provide the attending physician's office with clearly labeled notes of telephonic interactions.
- Office staff who interact with patients telephonically regarding medical issues including, but not limited to, appointment reminders, refills and diagnostic reports should also document these interactions in the medical record.

PATIENT-CLINICIAN ELECTRONIC MAIL POLICY

We expect the highest quality of care, including face-to-face interaction between the patient and provider whenever possible. To reduce liability and the risk of medical errors made

possible by electronic mail consultations, EmblemHealth has adopted the following guidelines set forth by the American Medical Association:

Communication Guidelines:

- Establish turnaround time for messages. Exercise caution when using e-mail for urgent matters.
- Inform patient about privacy issues.
- Patients should know who, besides addressee, processes messages during addressee's usual business hours and during addressee's vacation or illness.
- Whenever possible and appropriate, retain electronic and/or paper copies of e-mails communications with patients.
- Establish types of transactions (prescription refill, appointment scheduling, etc.) and sensitivity of subject matter (HIV, mental health, etc.) permitted over e-mail.
- Instruct patients to put the category of transaction in the subject line of the message for filtering: prescription, appointment, medical advice, billing question.
- Request that patients put their name and patient identification number in the body of the message.
- Configure automatic reply to acknowledge receipt of messages.
- Send a new message to inform patient of completion of request.
- Request that patients use auto-reply feature to acknowledge reading clinician's message.
- Develop archival and retrieval mechanisms.
- Maintain a mailing list of patients, but do not send group mailings where recipients are visible to each other. Use blind copy feature in software.
- Avoid anger, sarcasm, harsh criticism and libelous references to third parties in messages.
- Append a standard block of text to the end of e-mail messages to patients which contains the physician's full name, contact information, and reminders about security and the importance of alternative forms of communication for emergencies.
- Explain to patients that their messages should be concise.
- When e-mail messages become too lengthy or the correspondence is prolonged, notify patients to come in to discuss or call them.
- Remind patients when they do not adhere to the guidelines.
- For patients who repeatedly do not adhere to the guidelines, it is acceptable to terminate the e-mail relationship.

Legal and Administrative Guidelines:

Develop a patient-clinician agreement for the informed consent for the use of e-mail. This should be discussed with and signed by the patient and documented in the medical record. Provide patients with a copy of the agreement. Agreement should contain the following:

- Communication guidelines (stated above).
- Instructions for when and how to convert to phone calls and office visits.
- Clauses which hold harmless the health care institution for information loss due to technical failures.
- Waivers of the encryption requirement, if any, at patient's insistence.
- Descriptions of security mechanisms in place, including:
  - Using a password-protected screen saver for all desktop workstations in the office, hospital

and at home.
- Never forwarding patient-identifiable information to a third party without the patient's express permission (in writing).
- Never using patient's e-mail address in a marketing scheme.
- Not sharing professional e-mail accounts with family members.
- Not using unencrypted wireless communications with patient-identifiable information.
- Double-checking all "To" fields prior to sending messages.
- Performing at least weekly backups of e-mail onto long-term storage. Define long-term as the term applicable to paper records.
- Commit policy decisions to writing and electronic form.

The policies and procedures for e-mail should be conveyed to all patients who wish to communicate electronically.

The policies and procedures for e-mail should be applied to facsimile communications, where appropriate.

EMBLEMHEALTH-ADOPTED MEDICAL RECORD REVIEW TOOLS

Medical record review tools can help ensure that your medical records adhere to our standards. The medical record tools approved by EmblemHealth are at **www.emblemhealth.com** and are listed below. We ask our providers to check our website periodically for updates.

- **Adult Medical Record Review Tool**
- **Maternity Medical Record Review Tool**
- **Pediatric and Adolescent Medical Record Review Tool**

CONTRACTUAL OBLIGATIONS

The following text outlines the legal agreement between the Practitioner and EmblemHealth with regards to the above information.

The term "Practitioner" hereunder shall refer to any contracted primary care physician, specialist, hospital facility and physician practicing within a physicians' group or hospital facility, unless otherwise noted.

Records and Reports

Practitioner shall document all Covered Services provided to Members in a format which is easily retrievable and which conforms with federal, state and local laws and regulations applicable to medical records. Practitioner shall permit the Plan's representative(s) access on-site at Practitioner's practice, upon reasonable prior notice and during regular business hours, to inspect and copy all medical, billing, and financial and statistical records relating to the provision of Covered Services to Members in accordance with all applicable laws and regulations and usual policies and procedures for the maintenance of such records.

Practitioner shall make Members' medical records available to the Plan or its designated representative(s) for, among other purposes, conducting utilization review and assessing quality of care and the Medical Necessity and appropriateness of care provided to Members. Practitioner shall comply with all federal, state and local laws and regulations applicable to the confidentiality, privacy, and maintenance of patient records, including requirements for maintaining such records for six (6) years (10 years for Medicare members) from the last date of treatment or, in the case of a minor, for six (6) years after the minor reaches the age of majority, or for such period of time as required by law, whichever is longer. Record maintenance and audit access shall survive the termination of this Agreement regardless of the cause giving rise to such termination.

Practitioner shall, no later than ten (10) business days after receipt of written request, provide a copy of a Member's medical records, encounter data or financial and statistical records relating to services rendered to Members to the Plan, NYSDOH, and to any other federal, state or local governmental agency, e.g., CMS or LDSS (for Medicaid only), involved in assessing the quality of care or investigating Member grievances or complaints, including the Comptroller General of the State of New York, the Department of Health and Human Services and the Comptroller General of the United States and their authorized representatives. Upon such request from any federal, state, or local government, Practitioner shall provide written notice of such request to the Plan within four (4) business days of such request. All requests for records shall be supplied to the Plan at Practitioner's expense. This provision shall survive termination of this Agreement regardless of the cause giving rise to such termination.

In the event that a Member transfers to another Participating Provider, Practitioner shall, within ten (10) days of a Member's authorization, provide a copy of the Member's medical records to the Member's new Participating Provider without charge. Moreover, Members shall be provided with a copy of their medical records, upon appropriate request, without charge from Practitioner. This procedure will ensure that the new PCP will have a continuous medical record of the member and that there should not be a lapse in continuity or treatment.

Non-Emergent Medical Record Transfer

Upon any change of PCP, the member should be asked to sign a Request for Medical Information. Dates of treatment would be inclusive of current and outstanding laboratory and/or x-ray reports. The Request for Medical Information will be sent to the previous PCP, and the copy of records will be forwarded to the new PCP's office as soon as possible.

Emergent Medical Record Transfer

In the event of a change in PCP in an emergency situation, the Plan may call the previous PCP office directly and request, by phone, that a copy of the medical records be forwarded to the new PCP. A written request would follow by mail within 24 hours of the initial phone contact.

Practitioner shall maintain and provide any other records the Plan may request for regulatory compliance or program management purposes and shall cooperate with the Plan in all fiscal and medical audits, site inspections, peer review, Utilization Management, credentialing and recredentialing and any other monitoring required by federal, state or local regulatory or accreditation agencies, including Utilization Review Accreditation Commission ("URAC") and

the National Committee for Quality Assurance ("NCQA"). Any record required by a regulatory or accreditation agency shall, at Practitioner's expense, be delivered to the Plan within the time frame requested by the requesting agency, but in no event more than four (4) business days of its request. Practitioner shall promptly comply with all directives and recommendations issued as a result of any such inspection or audit. Practitioner shall retain all financial and administrative records relating to this Agreement for seven (7) years after the termination of this Agreement, or for such period of time as required by law, whichever is longer. This provision shall survive termination of this Agreement regardless of the cause giving rise to such termination.

Providing Access to Medical Records

Within ten days of a written request, a health care provider must provide an opportunity, for an individual to inspect any patient information (in the provider's possession) relating to the examination or treatment of an individual. The request may come from any qualified person. A "qualified person" means any properly identified subject, or an appointed guardian under article 81 of the mental hygiene law, a parent of an infant, a guardian of an infant appointed pursuant to article 17 of the surrogate's court procedure act (or other legally appointed guardian of an infant who may be entitled to request access to a clinical record) or an attorney representing or acting on behalf of the individual or the individual's estate.

A parent or guardian is not entitled to inspect or make copies of any patient information concerning the care and treatment of an infant where the health care provider determines that access to the information requested by the parent or guardian would have a detrimental effect on the provider's professional relationship with the infant, or on the care and treatment of the infant, or on the infant's relationship with his or her parents or guardian.

Note that a provider may refuse to provide access to information if the provider believes that (i) "review of the requested information can reasonably be expected to cause substantial and identifiable harm to the subject or others which would outweigh the qualified person's right to access to the information, or (ii) the material requested is personal notes and observations, or the information requested would have a detrimental effect as defined by law".

Providers should be familiar with Public Health Law sections 17 and 18 which further define when providers must provide access, timeframes, frequency, when charges may be imposed, etc.