MEDICAL RECORD DOCUMENTATION STANDARDS

- There is an organized medical record filing system.
- Personal/biographical data is present and includes the date of birth, sex, marital status, address, employer, home and work telephone numbers.
- Every page contains patient identification.
- All entries are dated.
- Each entry contains author identification (signed or initialed by practitioner). Electronic signatures are acceptable provided authorization for its use is included in the signature line.
- A family/social history is noted in the record.
- The medical record is legible to the reviewer.
- ***Medication allergies and/or adverse reactions or, if applicable, no known allergies (NKA) are noted.**
- ***There is a past medical history (PMH) present for members seen on ≥ 3 visits which includes serious accidents, operations and illnesses; Member ≤ 18 years, have a PMH present which includes prenatal care/birth information, operations and illnesses.**
- ***A problem list is present and notes significant illnesses and medical conditions.**
- Members ≥ 12 years, and who have been seen on ≥ 3 visits, will have notations that address smoking/ETOH/substance abuse.
- Immunization records are current or note indicates immunizations are up to date.
- There is a medication list present.
- ***Visit notes include: a reason for the visit, physical findings, appropriate diagnostic tests, and a plan of treatment.**
- ***Follow-up care and plans are documented.**
- Unresolved problems are addressed in subsequent visits.
- The practitioner initials consult, ancillary services, lab, and imaging study reports.
- If the member is hospitalized the record will include the following: operative report (if applicable) and hospital discharge summary.
- There is evidence of continuity and coordination of care between primary and specialty practitioners.
- Preventive services are provided in accordance with BCBSOK guidelines.
- Confidentiality policy regarding PHI and Informed Consent for release of records utilized.

***Five core items**

MENTAL HEALTH AND SUBSTANCE ABUSE MEDICAL RECORD DOCUMENTATION STANDARDS

- There is an organized medical record and filing system.
- Personal/biographical data is present and includes the date of birth, sex, marital status, address, employer, home and work telephone numbers.
- Every page contains patient identification.
- All entries are dated.

MENTAL HEALTH AND SUBSTANCE ABUSE MEDICAL RECORD DOCUMENTATION STANDARDS (Continued)

- Each entry contains author identification (signed or initialed by practitioner). Electronic signatures are acceptable provided authorization for its use is included in the signature line.
- A family/social history is noted in the record.
- The medical record is legible to the reviewer.
- ***Medication allergies and/or adverse reactions or, if applicable, no known allergies (NKA) are noted.**
- ***Personal Health History includes complete medical and behavioral health history.**
- ***Problem list is present and notes significant illnesses and medical conditions.**
- Documentation addresses smoking/ETOH/substance abuse of member and family.
- Medication list is present including initial prescription and refill dates if prescribed by the provider.
- ***Visit notes include: history and description of presenting problems, including precipitating factors, mental status evaluation, physical status evaluation if appropriate, psychosocial history including an appropriate developmental history for children and adolescents, risk assessment of severity and possibility of potential harm to self or others accompanied by a referral to a level of care which is appropriate to the level of risk, and appropriate diagnostic tests.**
- ***Notes indicate follow-up care/plans including dates of subsequent appointments and when applicable, a complete discharge plan.**
- Unresolved problems are addressed in subsequent visits.
- Consult, ancillary services, lab, imaging study reports are initialed by the practitioner.
- If the member is hospitalized, the record will include the hospital discharge summary.
- Working diagnoses are consistent with findings and appropriate Axis DSM-IV diagnoses are documented.
- There is evidence of continuity and coordination of care between primary and specialty practitioners.
- Telephone calls are properly documented.
- "No shows" for appointments are properly recorded and follow-up rescheduling is initiated by practitioner.
- There is documented evidence of family member or caregiver involvement in member's treatment.
- There is documented evidence of family member or caregiver's capacity to care/protect member.
- Confidentiality policy regarding PHI and Informed Consent for release of records utilized.

***Five core items**