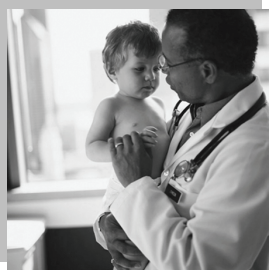
Medical Records



Buckeye providers must keep accurate and complete medical records. Such records will enable providers to render the highest quality healthcare service to members. They will also enable Buckeye to review the quality and appropriateness of the services rendered. To ensure the member's privacy, medical records should be kept in a secure location. Buckeye requires providers to maintain all records for members for at least seven years.

Required Information

Providers must maintain complete medical information for members in accordance with the following standards:

- Patient's name, and/or ID number on all chart pages or electronic file.
- Personal/biographical data is present (i.e. age, sex, address, employer, home and work telephone number, spouse, etc.).
- All entries must be legible to someone other than the writer. In states that mandate medical record reviews, a second surveyor examines any record judged to be illegible by one physician surveyor. All entries in the medical record contain the author's identification, which may be a handwritten signature, unique electronic identifier or initials.
- All entries must be dated and signed, or dictated by the provider rendering the care.
- Significant illnesses and/or medical conditions are documented on the problem list.
- Medication, allergies, and adverse reactions are prominently documented in a uniform location in the medical record. If no known allergies, NKA or NKDA is documented.
- An immunization record is established for pediatric patients or an appropriate history is made in chart for adults (full Healthchek documentation for pediatric patients). .
- Evidence that preventive screening and services are offered in accordance with Buckeye's practice guidelines.
- Appropriate subjective and objective information pertinent to the patients presenting complaints is documented in the history and physical.
- Past medical history (for patients seen three or more times) is easily identified and includes any serious accidents, operations and/or illnesses, discharge summaries, and ER encounters. For children and adolescents (18 years and younger) past medical history relating to prenatal care, birth, any operations and/or childhood illnesses. For patients 10 and older, there is appropriate notation concerning the use of cigarettes, alcohol, and substances (for patients seen three or more times, there is evidence of substance abuse query).Working diagnosis is consistent with findings. Treatment plan is appropriate for diagnosis.
- Encounter forms or notes have a notation regarding follow-up care, calls or visits, when indicated. The specific time of return is noted in weeks, months or as needed.
- Unresolved problems from previous visits are addressed in subsequent visits.
- Laboratory and other studies ordered as appropriate.
- There is review for under-or over-utilization of consultants.
- If consultation is requested, there is a note from the consultant in the record.
- Consultation, laboratory and imaging reports filed in the chart are initialed by the practitioner who ordered them, to signify review. (Review and signature by professionals other than the ordering practitioner do not meet this requirement.) If the reports are presented electronically or by some other method, there is representation of review by the ordering practitioner. Consultation and abnormal laboratory and imaging study results have an explicit notation in the record of follow-up plans.

- There is no evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic procedure.
- Referrals to specialists and ancillary providers are documented including follow up of outcomes and summaries of treatment rendered elsewhere.
- Health teaching and/or counseling is documented.
- Evidence that an Advance Directive has been offered to adult patients.

Providers are required to have an organized medical recordkeeping system and have records available in the office. Confidentiality of patient information and medical records will be protected at all times.

Medical Records Release

All medical records of covered persons shall be confidential and shall not be released without the written authorization of covered person or a responsible covered person's legal guardian. When the release of medical records is appropriate, the extent of that release should be based upon medical necessity or on a need to know basis.

Written authorization is required for the transmission of the medical record information of a current Buckeye member or former Buckeye member to any physician not connected with Buckeye.

Providers are required to make member records available to Buckeye as requested at no cost to Buckeye.

Medical Records Transfer for New Patients

All PCPs are required to document, in the member's medical record, attempts to obtain old medical records for all new Buckeye members. If the member or member's guardian is unable to remember where they obtained medical care, or are unable to provide an appropriate address, then this should also be noted in the medical record. Providers are required to make medical records for Medicaid-eligible individuals available for transfer in a timely manner to new providers at no cost to the individual.

Medical Records Audits

Medical records may be audited to determine compliance with Buckeye's standards for documentation. The coordination of care and services provided to members, including over/under utilization of specialists, as well as the outcome of such services may also be assessed during a medical record audit.