Medical Record Documentation

UPMC Health Plan requires participating network physicians to maintain member medical records in a manner that is accurate and timely, well-organized, readily accessible by authorized personnel, and confidential. Per UPMC Health Plan policy, all Medical records must be maintained for ten (10) years for adults and age of majority plus seven (7) years for children.

Consistent and complete documentation in the medical record is an essential component of quality patient care. Medical records should be maintained and organized in a manner that assists with communication among providers to facilitate coordination and continuity of patient care. UPMC Health Plan has adopted certain standards for medical record documentation, which are designed to promote efficient and effective treatment. UPMC Health Plan periodically reviews medical records to ensure that they comply with the guidelines. Performance is evaluated as follows:

Category	Score	Action
Level 1:	Pass = 10 or more points including Required Element*	Compliant - no follow-up required
Level 2:	Fail = 0 to 9 points	Requires a corrective action plan and follow-up review in 6 months
Level 3:	Fail = Automatic fail if missing Required Element*	Requires a corrective action plan and follow-up review in 3 months
***Required element = Organization and secure storage of medical records**		

Medical Record Confidentiality and Security

- Store medical records in a secure location that can be locked and protected when not being used, but still permits easy retrieval of information by authorized personnel only.
- Periodically train medical office staff and consistently communicate the importance of medical record confidentiality.

Basic Information

- Place the member's name or ID number on each page of the medical record.
- Include marital status and address, the name of employer, and home and work telephone numbers.
- Include the author's identification in all entries in the medical record. The author identification may be a handwritten signature, a unique electronic identifier, or his or her initials.
- Date all entries.
- Ensure that the record is legible to someone other than the writer.

Medical History

- Indicate significant illnesses and medical conditions on the problem list. If the patient has no known medical illnesses or conditions, the medical record should include a flow sheet for health maintenance.
- List all medications and prominently note medication allergies and adverse reactions in the record. If the patient has no known allergies or history of adverse reactions, providers should appropriately note this in the record.
- Document in an easily identifiable manner past family, social, and medical history, which may include serious accidents, operations, and illnesses. For children and adolescents (18 years old and younger), past medical history should relate to prenatal care, birth, operations, and childhood illnesses.
- For members 14 years old and older, note the use of cigarettes, alcohol, and substances, and query substance abuse history.

Medical Record Documentation

Medical History, continued

- Maintain an updated immunization record for patients aged 17 and under.
- Include a record of preventive screenings and services in accordance with the UPMC Health Plan Preventive Health Guidelines.
- Include, when applicable, summaries of emergency care, hospital admissions, surgical procedures, and reports on any excised tissue.

Treatment

- Document clinical evaluation and findings for each visit. Identify appropriate subjective and objective information in the history and physical exam that is pertinent to the member's complaints.
- Document progress notes, treatment plans, and any changes in a treatment plan, including drugs prescribed.
- Document prescriptions telephoned to a pharmacist.
- Document ancillary services and diagnostic tests that are ordered and diagnostic and therapeutic services for which a member was referred.
- Address unresolved problems from previous office visits in subsequent visits.
- Document the use of Developmental Delay and Autism Spectrum Disorder screening tools.
- Document referrals to CONNECT for Medical Assistance children under 5 years old, if developmental delays are suspected and the child is not receiving CONNECT services at the time of screening.

Follow-up

- Include on encounter forms or notes a notation regarding follow-up care, calls, or visits. Providers should note the specific time of recommended return visit in weeks, months, or as needed.
- Keep documentation of follow-up for any missed appointments or no-shows.
- Physicians should initial consultation, lab, imaging, and other reports to signify review. Review by and signature of another professional, such as a nurse practitioner or physician assistant, does not meet this requirement.
- Consultation, abnormal lab, and imaging study results must have an explicit notation of follow-up plans in the record.

UPMC Health Plan

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UPMCHP Medical Record Documentation webrev 120414