BlueCross BlueShield Nebraska

Medical Record Standards for Physicians Offices (MD/DO)

Each physician office/facility shall maintain the medical records of health plan member in a manner that is current, detailed, organized and permits effective and confidential patient care and quality review.

These standards are approved by the Blue Cross and Blue Cross and Blue Shield of Nebraska (BCBSNE) Quality Management Committee.

An on-site review for medical record quality may be performed in response to a pattern of member complaints or internal BCBSNE concerns related to a practitioner's office facility and/or documentation practices. The Quality Management Committee, during its reviews, may also request an on-site visit in response to identified potential quality of care or service issues.

STANDARD	DETAIL
The office develops and maintains a system for the proper collection, processing, maintenance, storage, retrieval and distribution of clinical records.	Except when otherwise required by law, the content and format of clinical records, including the sequence of information, are uniform. Records are organized in a consistent manner that facilitates continuity of care.
A designated person is in charge of clinical records.	This person's responsibilities include, but are not limited to: • The confidentiality, security and physical safety of records, • The timely retrieval of individual records upon request, • The supervision of the collection, processing, maintenance, storage and appropriate access to and usage of records, • Security of the clinical record including a method of tracking who accesses the record to block unauthorized use.
An individual clinical record is established for each person receiving care.	Each record includes, but is not limited to: • Name (First, Middle, Last) • Identification number: Office generated unique patient identifier or Social Security number. • Date of birth • Gender • Responsible party, if applicable

Clinical record entries are legible and easily accessible within the record by the clinic's personnel.	Record entries are legible to the reviewer.
The medical record contains the name and telephone number of a person(s) to be contacted in case of an emergency.	Emergency contact information is documented.
An appropriate patient problem list is documented including significant illnesses/ medical conditions and procedures.	The problem list should be initiated after three or more visits, or the clinical record is complex and lengthy. A summary of past and current diagnoses or problems, including past procedures is documented in the patient's record to facilitate the continuity of care.
An appropriate family history should be documented after the patient has been three or more times.	Family history may be included in the problem list or on a medical history form completed by the patient, H&Ps, annual physical examinations, etc.
The appropriate use of preventive health services is documented for Primary Care Physician offices.	The appropriate use of preventive health screenings as recommended by the United States Preventive Services Taskforce (A and B Recommendations) is documented, including, but not limited to: • Cervical cancer screening • Breast cancer screening • Colorectal cancer screening • BMI measurement • Blood pressure reading • Cholesterol • Glucose • Age-appropriate immunizations
Medication allergies and adverse reactions to drugs and materials are prominently noted in a consistent location in all clinical records.	The presence or absence of allergies and untoward reactions to drugs or materials is recorded in a prominent and consistently defined location, verified at each patient encounter and updated when new allergies or sensitivities are identified.
Documentation regarding missed and cancelled appointments must be added to the patient's clinical record.	Notations should be made for missed/cancelled appointments.

Evidence of discussion regarding advance directives should be noted for Primary Care Physicians and other appropriate specialties.	Beginning at age 50, or when diagnosed with a "significant" disease, per the Nebraska state-wide workgroup on advance directives.
Entries in a patient's clinical record should include the following information:	• Dated by month, day and year (and department, if departmentalized) • Chief complaint or purpose of visit (Subjective) • Clinical findings (Objective), • Studies ordered, such as laboratory or x-ray studies, • Discharge diagnosis or impression (Assessment) • Care rendered and therapies administered (Plan) • Any changes in prescription and non-prescription medication with name, dosage and duration of treatment. • Medications administered on-site are documented by dosage, route given and the person who administered the medication. • Any medication samples distributed should be documented in the medical record with drug, dosage and quantity. • Disposition, recommendations and instructions given to the patient. • Documentation of need for follow-up care should be noted in weeks, months or PRN. • Verification of contents by health care professionals (All entries in the medical record by authorized personnel contain author identification, e.g. nursing assessments, vital signs), • Signature of, or authentication by, the health care professional on all clinical record entries.
Reports, histories and physicals, progress notes and other patient information (such as laboratory reports, x-ray readings, operative reports and consultations, are reviewed and incorporated into the records, as required by the organization's policies.	• The date of this information is documented in the patient's record. • All entries should reflect practitioner review and/or patient notification of findings.
Significant medical advice given to the patient by test, email or telephone, including medical advice provided after-hours, is permanently entered in the patient's clinical record and appropriate signed or initialed.	

If applicable, the record reflects discussions with the patient concerning the necessity, appropriateness and risks of proposed care, surgery or procedure, as well as discussions of treatment alternatives and advance directives as applicable.	
The organization is responsible for ensuring a patient's continuity of care. If the patient's primary or specialty care provider(s) or health care organization is elsewhere, the organization ensures that timely summaries or pertinent records necessary for continuity of care are:	• Obtained from the other (external) provider(s) or organization and incorporated into the patient's clinical record • Provided to the other (external) health care professional(s) and, as appropriate, to the organization where future care will be provided.
Except when otherwise required by law, any record that contains clinical, social, financial, or other data on a patient is treated as strictly confidential and is protected from loss, tampering, alteration, destruction and unauthorized or inadvertent disclosure. Patients are given the opportunity to approve or refuse release of records, except when release is permitted as required by law.	
All clinical information relevant to a patient is readily available to authorized personnel any time the organization is open to patients.	
Written policies in compliance with State and Federal laws and accepted standards concerning clinical records address but are not limited to:	• The retention of active records. • The retirement of inactive patient records. • The retention/transfer of records in the event of practitioner resignation/retirement from the practice. • The release and security of information including accountability for editing, deletion and access of clinical record content is clearly defined. • Destruction of Protected Health Information in a safe and secure manner consistent with applicable regulations.