Medical Records

Health partners are required to maintain member records on paper or in an electronic format. Member medical records shall be timely, legible, current, detailed and organized to permit effective and confidential patient care and quality review. Complete medical records include, but are not limited to, medical charts, applicable directives, prescription files, hospital records, health partner specialist reports, consultant and other health care professionals' findings, appointment records and other documentation sufficient to disclose the quantity, quality, appropriateness and timeliness of services provided under the contract. Medical records shall be signed by the health partner of service.

The PCP also must maintain a primary medical record for each member that contains sufficient medical information from all health partners involved in order to ensure quality of care. The medical chart organization and documentation shall, at a minimum, require the following:

a. Member/patient identification information, on each page;
b. Personal/biographical data, including date of birth, age, gender, marital status, race or ethnicity, mailing address, home and work addresses and telephone numbers, employer, school name and telephone numbers (if no phone, contact name and number) of emergency contacts, consent forms, identification of language spoken and guardianship information;
c. Date of data entry and date of encounter;
d. Health partner identification by name;
e. Allergies, adverse reactions and known allergies shall be noted in a prominent location;

f. Past medical history, including serious accidents, operations and illnesses (For children, past medical history includes prenatal care and birth information, operations and childhood illnesses [e.g., documentation of chickenpox]);
g. Identification of current problems;
h. The consultation, laboratory and radiology reports filled in the medical record shall contain the ordering health partner's initials or other documentation indicating review;
i. Documentation of immunizations pursuant to 902 KAR 2:060;
j. Identification and history of nicotine, alcohol use or substance abuse;
k. Documentation of reportable diseases and conditions submitted to the local health department serving the jurisdiction in which the patient resides or Department for Public Health pursuant to 902 KAR 2:020;
l. Follow-up visits provided and (secondary) reports of emergency room care;
m. Hospital discharge summaries;
n. Advanced medical directives, for adults;
o. All written denials of service and the reason for the denial; and
p. Record legibility to at least a peer of the writer. Records judged illegible by one reviewer shall be evaluated by another reviewer.

A member's medical record shall include the following minimal detail for individual clinical encounters:

a. History and physical examination for presenting complaints containing relevant psychological and social conditions affecting the patient's medical/behavioral health, including mental health and substance abuse status;
b. Unresolved problems, referrals and results from diagnostic tests including results and/or status of preventive screening services (i.e., EPSDT) addressed from previous visits;
c. Plan of treatment including:
    1. medication history, medications prescribed, including the strength, amount, directions for use and refills;
    2. therapies and other prescribed regimen; and
    3. follow-up plans including consultation and referrals and directions, including time to return.

A member's medical record shall include the following minimal detail for hospitals and mental hospitals:

a. Identification of the beneficiary
b. Physician name
c. Date of admission and dates of application for and authorization of Medicaid benefits, if application is made after admission, and the plan of care, as required under 42 CFR 456.172 (mental hospitals) or 42 CFR 456.70 (hospitals)
d. Initial and subsequent continued stay review dates, described under 42 CFR 456.233 and 42 CFR 465.234 (for mental hospitals) and 42 CFR 456.128 and 42 CFR 456.133 (for hospitals)
e. Reasons and plan for continued stay, if applicable
f. Other supporting material the committee believes appropriate to include
g. For nonmental hospitals only:
    1. Date of operating room reservation
    2. Justification of emergency admission, if applicable

Prenatal and Postpartum Care Documentation

To ensure accurate documentation of prenatal and postpartum care, please be sure to document the following in patient records:

- Evidence of prenatal teaching — This includes education on infant feeding, the Women, Infant and Children nutrition program (WIC), birth control, prenatal risk factors, dietary/nutrition information and childbirth procedures.
- Components of the postpartum checkup — This includes documenting the pelvic exam, blood pressure, weight, breast exam and abdominal exam.

Well Child Care/EPSDT Program

The Well-Child/Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program is a child-health program of early and periodic screening, diagnosis and treatment services for beneficiaries under the age of 21. All Humana – CareSource members under age 21 must receive well-child/EPSDT exams. The program supports two goals: to ensure access to necessary health resources and to assist parents and guardians in appropriate use of those resources. For the complete listing of the American Academy of Pediatrics (AAP) Preventive Health Guidelines visit **AAP.org**.

High-Risk Children

Children at high risk should be tested according to AAP guidelines. Problems found or suspected during a well-child visit must be diagnosed and treated as appropriate. Referrals must be made based on standards of good practice and the AAP's recommendations for preventive pediatric health care or presenting need.

Blood Lead Level Testing

The Kentucky Medicaid program requires that all children have at least one blood lead level test by the age of 2. Filter paper testing is an accepted method to obtain blood lead levels and is covered by Humana – CareSource.

Immunization Schedule

Immunizations are an important part of preventive care for children and should be administered during well-child/EPSDT exams as needed. Humana – CareSource endorses the same recommended childhood immunization schedule that is recommended by the Centers for Disease Control and Prevention and approved by the Advisory Committee on Immunization Practices (ACIP), the AAP and the American Academy of Family Physicians (AAFP). The recommended schedule is included in this section of the manual. This schedule is updated annually and the most current updates can be found on the AAP website at www.aap.org.

Clinical Practice Registry

With quick and easy access on our secure provider portal, the clinical practice registry helps PCPs improve patient health outcomes. The primary use of the registry is to help PCPs manage member population. PCPs can quickly sort their Humana – CareSource membership into actionable groups to identify areas of focus. The clinical practice registry is a proactive approach to patient care and helps place emphasis on preventive care.

Key Benefits of the Registry

- Once historical data is collected, the registry is color coded and will provide easy identification of members in need of tests and/or screenings.
- The information can be downloaded as a PDF or in an Excel spreadsheet format (the Excel spreadsheet contains patient contact information).