Network Notification

Date: October 2, 2015

To: Kentucky physicians

From: Humana – CareSource®

Subject: Medical Record Network Notice

Humana – CareSource requires that all contracted health care providers maintain patient records for our members on paper or in an electronic format. Member medical records need to be timely, legible, detailed and organized to facilitate effective and confidential patient care and quality review.

The primary care physician (PCP) also must maintain a primary medical record for each patient that contains sufficient medical information from all health care providers involved in that patient's care to ensure quality and continuity of care. Additionally, medical records need to be signed by the health care service provider.

At a minimum, a patient's medical chart documentation and organization requires the following:

- Member/patient identification information on each page
- 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
- Date of data entry and date of encounter
- Provider identification by name
- Known allergies and adverse reactions noted in a prominent location
- Past medical history, including serious accidents, operations, illnesses
  - For children, past medical history includes prenatal care and birth information, operations and childhood illnesses (e.g., documentation of chickenpox)
- Identification of current problems
- Consultation, laboratory and radiology reports filed in the medical record that contain the ordering provider's initials or other documentation indicating review
- Documentation of immunizations pursuant to 902 KAR 2:060
  Identification and history of nicotine, alcohol and/or substance abuse
- Documentation of reportable diseases and conditions submitted to the local health department serving the jurisdiction in which the patient resides or to the Kentucky Department for Public Health pursuant to 902 KAR 2:020
- Follow-up visits provided and secondary reports of emergency room care
- Hospital discharge summaries
- Advance medical directives (for adults)
- All written denials of service and reason(s) for the denial

- Attestation to legibility of records judged by a peer of the writer. (Records judged illegible by one reviewer should be evaluated by another reviewer.)

For individual clinical encounters, a member's medical record should include the following additional details:

- 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.
- Unresolved problems, referrals and results from diagnostic tests including results and/or status of preventive screening services (i.e., Early and Periodic Screening, Diagnostic and Treatment [EPSDT] services) addressed from previous visits.
- Plan of treatment, including:
  - Medication history, medications prescribed, including the strength, amount, directions for use and refills.
  - Therapies and other prescribed regimen.
  - Follow-up plans including consultation, and referrals and directions, including time to return.

If you have questions regarding medical record standards, please contact your respective provider representative.

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For more information, please refer to our provider manual at https://www.caresource.com/documents/kentucky-provider-manual/.