Policy and Procedure No: QM 102.2	**Revision No:2**
Division: Care Management	
Department: Quality Management	
Title: PHP Member Health Record	
Effective Date: 1/1/2006	
Supersedes Policy No: 95013, QM 2.2, QM 102.1	
Reviewed/Revised by: Karen Haughey	**Review/Revision Date: 12/10/2025**
Approving Committee: Quality Management Committee	**Date: 12/11/2025**
Executive Oversight Committee Date: 12/16/2025	

Purpose:

To establish PHP's (the Health Plan) guidelines for contracted providers regarding medical record storage, filing, collection, processing, maintenance, retrieval identification, distribution and handling. To ensure that all patient medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with policies and procedures.

Policy:

It is the policy to the Health Plans to require its providers to follow guidelines regarding medical record documentation, authentication, storage, filing, collection, processing, maintenance, retrieval identification, distribution and handling.

Procedure:

1. The Health Plan requires contracted Provider Sites to do the following:

    a. Maintain an electronic and/or paper medical record system from which clinical information can be retrieved promptly by authorized personnel/health care providers.

    b. Maintain one (1) medical record for each member.

    c. Implement measures to protect the medical records from loss, tampering, alteration, and destruction electronically and/or physically.

    d. Comply with all Federal and State regulations, relevant accreditation standards, AHF policies related to patient confidentiality and release of member's record.

    e. Use a consistent organized format of its medical records.

    f. Update and sign member medical record in a timely manner. Discharged patient records are to be completed and filed within thirty (30) days after termination.

    g. All medical records shall be legible and readily available to authorized personnel as stipulated by law.

    h. Designate a staff member delegated the responsibility of securing and maintaining medical records to ensure that the medical records are handled in accordance with all applicable Federal and State regulations and the Health Plan policies and procedures.

i. Keep medical record for a minimum of ten (10) years regardless of contract status including exposed X-ray film.

j. Make medical record available to the Health Plan or new providers if needed, such as for quality improvement activity and reporting, and utilization management etc.

k. Store medical records so as to protect against loss, destruction or unauthorized use.

l. File medical records in an easily accessible manner in the clinic. Storage of records shall provide for prompt retrieval when needed for continuity of care. Prior approval of the Department is required for storage of inactive medical records away from the facility.

m. Medical records shall be the property of the facility and shall be maintained for the benefit of the patient, health care team and clinic and shall not be removed from the clinic except for storage purposes after termination of services.

n. If a clinic ceases operation, arrangements shall be made for the safe preservation of the patients' health records. The Health Plan shall be informed by the clinic of the arrangements within forty-eight (48) hours before cessation of operation.

o. The Health Plan shall be informed within forty-eight (48) hours, in writing, by the licensee whenever patient health records are defaced or destroyed before termination of the required retention period.

p. It the ownership of a clinic changes, both the licensee and the applicant for the new license shall, prior to change of ownership, provide the Department with written documentation stating:

    i. The new licensee shall have custody of the patients' health records and these records shall be available to the former licensee, the new licensee and other authorized persons; or

    ii. That other arrangements have been made by the current licensee for the safe preservation and location of the patients' health records, and that they are available to both the new and former licensees and other authorized persons.

2. The following information is required in each member's medical record:

    a. A unique medical record number. Member identification on each page; personal/biographical data in the record.

    b. Demographic information: name, identification number, date of birth, gender, primary language, communication needs (vision, hearing etc.), emergency contact and preferred language (if other than English) prominently noted in the record, as well as the request or refusal of language/interpretation services.

    c. Primary care provider (if applicable)

    d. Allergies or absence of allergies and untoward reaction to drugs and materials in a prominent location

e. Histories and physicals that are updated annually or as needed

f. A problem list, a complete record of immunizations and health maintenance or preventive services rendered.

g. Advance directive information and/or executed.

h. Consent forms where applicable including the human sterilization consent procedures.

i. Health education behavioral assessment and referrals to health education services.

j. Significant medical advice given to a member by phone, including after-hours telephone information

k. Members involved in any research activity is identified

l. Reports of emergency care provided (directly by the contracted Provider or through an emergency room) and the hospital discharge summaries for all hospital admissions.

m. Consultations, referrals, Specialists', pathology, and laboratory reports. Any abnormal results shall have an explicit notation in the record.

n. Records are be kept current in detail consistent with good medical and professional proactive and shall describe the services provided to each patient.

o. All entries shall be dated and be authenticated with name, professional title and classification of person making the entry.

3. Progress note are required to be updated in each patient encounter and include the following where applicable:

a. Date of the encounter and department

b. Member's chief complaint or purpose of visit

c. Medication reconciliation including over-the-counter products and dietary supplements

d. Physical, mental exams and clinical findings

e. Studies ordered, such as laboratory or diagnostic imaging and the results

f. Referrals/consultation ordered and the results

g. Objective Findings/Diagnosis

h. Plan for Findings/Diagnosis

i. Treatment Plan

j. Care rendered and therapies administered including preventive care provided or refusal of care or therapies

k. Documentation of follow-up instructions and a definite time for return visit or other follow-up care. Time period for return visits or other follow-up care is definitely stated in number of days, weeks, months or PRN (as needed).

l. Previous complaints and unresolved or chronic problems are addressed in subsequent notes until problems are resolved or a diagnosis is made. Each problem need not be addressed at every visit but all problems must be addressed within the calendar year. Documentation must demonstrate that provider follows-up with member about treatment regimens, recommendations and counseling.

m. Care plan or discharge plan including prescriptions, recommendations, education, instructions, necessity of surgery or other procedures etc.

n. Provider signature

4. Provider sites are required to contact the Plan member and document in medical records when there is:
    a. Missed appointments;

    b. Abnormal laboratory or imaging results with notation that Member was notified of the result;

    c. Referral results that require attention with notation that Member was notified of the result;

    d. Discharge from an institution such as hospital, emergency room, or skilled nursing facility;

    e. Inquiry that occurred out of regular business hours.

Definitions:

1. Health Record: The collection of information concerning a patient and his or her health care that is created and maintained in the regular course of treatment by a provider with knowledge of the acts, events, opinions or diagnoses relating to the patient, and made at or around the time indicated in the documentation.

    a. The medical record may include records maintained in an electronic medical / record system, e.g., an electronic system framework that integrates data from multiple sources, captures data at the point of care, and supports caregiver decision making.

    b. Each medical record contains sufficient, accurate information to identify the patient, support the diagnosis, justify the treatment, document the course and results, and promote continuity of care among health care providers.

    c. Information may be from any source and in any format, including, but not limited to print medium, audio/visual recording, and/or electronic display.

Monitoring:

1. Monitoring occurs for all providers during HEDIS record review and over reads, medical record review performed for peer review, various investigations and risk adjustment record review to name a few.

2. The Policy is updated, as necessary, reviewed and approved at least annually by the Quality Improvement and Health Equity Committee (QIHEC).

Reference(s):

1. 42 USC 1396a(w)