Paramount
Paramount *Advantage*
Paramount Care of Michigan, Inc.

Medical Record Documentation Standards – Pediatrics

	Standard	Performance Measures
A	**General Requirements**	
1	Oversight of medical records system	• There is a designated staff person who is qualified by training or experience for the oversight of, and access to, the medical records system.
2	**Medical records confidentiality policy**	• **Provider site maintains a policy regarding the confidentiality of medical records which ensures records are handled to preclude loss, tampering, alteration, destruction, and unauthorized or inadvertent disclosure of health information.** • **Policy should address the training/education of personnel in regards to patient confidentiality** • **Policy should include compliance with and adherence to Federal HIPAA privacy and security regulations.** • **In addition, personnel must hold all information obtained about patients related to their examination, care and treatment confidential and not divulge the information without the patient's authorization, unless such information is:** ➢ **Required by law,** ➢ **Necessary to coordinate the patient's care with physicians, hospitals or other health care entities, or to coordinate insurance or other matters pertaining to payment, or** ➢ **Necessary in compelling circumstances to protect the health or safety of an individual** • **Any release of information in response to a court order must be reported to the patient in a timely manner.** • **Policy addresses authorized access to the EMR system (where applicable) and how access is controlled (i.e. unique log-ins and passwords for users, log-off procedures, etc.)**
B	**Structural Integrity**	
1	Elements in the medical record are organized in a consistent manner	• Medical record is clearly organized • Records are organized in chronological order • Medical record does not contain information for other patients • If family members are in one record, each family member must be clearly separated • All EMR entries (where applicable) are indexed consistently
2	Pages are secured	• All pages, reports and forms are maintained in such a way to prevent loss and misfiling
3	Demographic sheet included in medical record	• Personal demographic sheet to include the address, parent/guardian name(s), parent/guardian employer, insurer, emergency contact and parent/guardian home/work telephone numbers

4	All pages contain patient identification	• All pages in medical record will contain at least one of the following for patient identification purposes: ➢ Patient's full name ➢ Identification number
5	All entries dated	• All entries, updates, and addendums in the record must be dated
6	All entries signed by author	• All entries in medical record must be signed by the author • Author identification may be a handwritten signature, unique electronic identifier or initials • A signature & initial log must be maintained by the office • Timely, signed approval of all EMR entries (where applicable) is evident
7	Entries are legible	• Entries are legible to a reader other than the author • Content of records is presented in a standard format that allows a reader, other than the author, to review without the use of separate legend/key • Scanned images of documents (in EMR where applicable) are clear and legible
C	**Health Maintenance**	
1	**Updated problem list is maintained**	• **A problem list (patient summary) which summarizes significant illnesses and medical/psychological conditions, including those that are chronic, is updated and maintained on the chart** • **All notations on the problem list (patient summary) are dated**
2	Current medication(s) are documented and reviewed annually by practitioner	• Information regarding current medications is readily apparent • Changes to medication regimen are noted as they occur • Documentation of at least annual review of medications by practitioner
3	**Medication allergies and adverse reactions are prominently noted in the record**	• **Medication allergies are noted in a prominent place** • **Adverse reactions (such as rash, vomiting, etc.) are also noted; history of an <u>unknown</u> adverse reaction should be indicated as such** • **If patient has no known allergies or history of adverse reactions, there is appropriate documentation of "none" or "NKDA"**
4	Documentation regarding the use of tobacco, alcohol, and drug/substance abuse	• Must have documentation in the medical record regarding smoking habits, history of alcohol use and drug/substance abuse for patients 12 years of age and older • Should be documented when patient establishes care and updated/reviewed annually • Prevention and/or education should also be documented in the record
D	**History and Physical**	
1	**Family, pregnancy and newborn history**	• **Family history should document any significant and/or chronic illnesses (i.e. diabetes, cancer, etc) of patient's immediate family members** • **Pregnancy history should document significant information with regard to complications of pregnancy or illness of the mother during pregnancy, especially those**

		with potential impact on the fetus • **Newborn history should document pertinent information with regard to the delivery itself (vaginal or Cesarean), any complications during delivery, and health of the newborn**
2	**Past medical, surgical and immunization history**	• **All pertinent medical history should be documented in the medical record and will include serious accidents, operations, and illnesses** • **Immunization records from prior health care providers are documented in the chart (the presence of "up to date" or "UTD" is not sufficient documentation for immunization history)**
3	Comprehensive Physical exam/ Well Child exams	• Unclothed physical exam to include: head circumference through age 2, weight and length to 18 months, with accurate plotting of head circumference, length and height on a growth chart • Annual height, weight and BMI calculation for ages 3-18, with accurate plotting of height and weight on a growth chart and BMI on a Body Mass Index-for-age Percentile chart (or at minimum BMI with documented percentile) • EMR growth charts (templates) must include a percentage for BMI documentation • Documentation of general appearance, head, eyes, ENT, neck, chest, lung sounds, heart sounds, abdomen, umbilicus, genitalia, hips/pelvis, extremities, neurological and skin examinations • Documentation of Developmental Milestones, at each well exam, which are a set of functional skills or age-specific tasks that most children can do at a certain age range, including: ➢ Gross motor: using large groups of muscles to sit, stand, walk, run, etc., keeping balance, and changing positions ➢ Fine motor: using hands to be able to eat, draw, dress, play, write, and other such activities ➢ Language: speaking, using body language and gestures, communicating, and understanding of what others say ➢ Cognitive: thinking skills, including learning, understanding, problem-solving, reasoning, and remembering ➢ Social: interacting with others, having relationships with family, friends, and teachers, cooperating, and responding to the feelings of others
4	Vision, Hearing, Dental and Lead Exposure	• **Vision:** Examine eyes; assess ability to fix and follow with each eye, alternate occlusion, corneal light reflex, red reflex • **Hearing:** Conduct initial hearing screening if not previously done; otherwise assess for possible hearing loss, with follow-up screening as needed or refer to a specialist for hearing screen • **Dental:** Documentation of referral to dentist annually • **Lead exposure:** ➢ All children should be assessed for risk of lead exposure at age one (1) and at age two (2)

		➢ Perform a blood lead test at age one (1) and again at age two (2) for all Medicaid children and those children who live in a high risk zip code or are assessed as being high risk for exposure (i.e., lives in a house built before 1950, frequently comes in contact with an adult who works with lead, etc.); repeat testing as needed for children with high blood lead levels or who are at risk for exposure
E	**Documentation For Each Visit/Encounter**	
1	Reason for visit/chief complaint is clearly documented	• The reason for each encounter is clearly documented; may include the patients own words
2	**Objective findings/clinical assessment is documented**	• **Objective findings/clinical assessment and physical examination are documented and correspond to the patient's chief complaint, purpose for seeking care and/or ongoing care for chronic illnesses**
3	**Working diagnoses are documented and consistent with findings**	• **Working diagnoses that logically follow from the clinical assessment and physical examination are documented**
4	**Plan of action/treatment is documented and consistent with diagnosis(es)**	• **Proposed treatment plans, therapies or other regimens are documented and logically follow previously documented diagnoses** • **Rationale for treatment decisions appear medically appropriate and substantiated by documentation in the medical record** • **Laboratory and other studies are ordered as appropriate**
5	**There is no evidence patient is placed at inappropriate risk by a diagnostic or therapeutic procedure**	• **Clear justification for diagnostic and therapeutic procedures is documented in the medical record**
6	Unresolved problems from previous visits are addressed in subsequent visits	• Continuity of care from one visit to the next is demonstrated when follow-up of unresolved problems from previous visits is documented in subsequent visit notes
7	Follow-up instructions and time frame are documented	• Specific follow-up visits/instructions should be documented and time frame should be documented in days, weeks, months, or as needed (prn)
F	**Continuity of Care**	
1	Consultation, lab and imaging/test results reflect provider review	• Consultation, lab and imaging/test results are initialed by the practitioner who ordered them, to signify review (review and signature by professionals other than the ordering practitioner do not meet this requirement) • If reports are presented electronically or by some other method, there is also representation of review by the ordering practitioner • EMR scanned reports should be initialed prior to scanning/indexing or have electronic signature with date stamp • Consultation and abnormal laboratory and imaging study results have an explicit notation in the record of follow-up plans

2	Hospital discharge summaries are filed in medical record and reviewed by PCP within 30 days of discharge	• Hospital discharge summaries are included as part of the medical record for all hospital admissions • Review of discharge summary by PCP within 30 days of discharge is documented by practitioner's initials and dated (electronic signature with date stamp for EMR)
3	Parent/Patient noncompliance addressed by provider	• Parent/Patient noncompliance is documented • Continued noncompliance is readdressed periodically
G	**Preventive Care and Counseling**	
1	Complete immunization record	• Medical record includes documentation of immunizations administered, including flu shots; or, there is documentation that immunization status was addressed
2	Injury prevention	• Documentation of discussion regarding areas such as car seats, seat belts, smoke detectors, pools/water safety, toxic chemicals, safe drug storage, toy safety, gun safety, and other injury prevention measures
3	Diet & exercise	• **Birth-18 months:** focus on breast feeding, formula feeding, introduction of solid foods • **Ages 2-18:** caloric balance, snacks, fat and cholesterol • **Exercise:** age appropriate activities, sports and exercise
4	Anticipatory guidance	• Documentation of age appropriate counseling in healthy habits, social competence, family relationships, community interactions, school entry, responsibility, school achievement, sexual practices/precautions, and prevention/education relative to tobacco, alcohol and drug abuse (including parent education/guidance in regard to second hand smoke exposure)

Critical Documentation Standards are bolded