



***** **High Priority** *****

Service Alert Notification

Subject: First Coast Advantage (FCA) Medical Record Audit Analysis from the State

Date: January 22, 2010

The Agency for Healthcare Administration (AHCA) completed an Audit of FCA's Primary Care Provider's Medical Records in late August 2009. FCA received the final results of the audit in early December 2009 and AHCA found no discernible deficiencies in FCA's Case and Disease Management records. However, there were consistent deficiencies in the Primary Care Physician's medical records in the following areas:

- Documentation of the Member's primary language or communication needs.
- Documentation of the Member's advanced directives.
- FCA has to provide a corrective action plan to AHCA outlining how FCA and it's contracted PCP's plan to correct the deficiencies noted.

FCA would like to remind all providers about the importance of medical record documentation. Below is FCA's policy on Medical Record Documentation, which can be found in the FCA Provider Manual located on FCA's website at www.firstcoastadvantage.com under **Provider Information / Provider Manual**.

Medical Records Documentation: The following medical record standards apply to each member's record:

- Must contain identifying information on the member, including name, member identification number, date of birth, sex, and legal guardianship, address, marital status, occupational history, and home/work telephone numbers.
- Be legible and maintained in detail.
- Contain a summary of significant surgical procedures, past and current diagnosis or problems, allergies, untoward reactions to drugs and current medication.
- All entries must be dated and signed.
- All entries must indicate the chief complaint or purpose of the visit, the objective findings of practitioner, and diagnosis or medical impression.
- All entries must indicate studies ordered, for example lab, x-ray, EKG, and referral reports and follow-up on abnormal studies.
- All entries must indicate therapies administered and prescribed.
- All entries must include the name and profession of practitioner rendering services, for example M.D., D.O., O.D., including signature or initials of practitioner.

- All entries must include coordination of care, the disposition, recommendations, instructions to the member, evidence of whether there was follow-up and outcome of services.
- Each record must contain an immunization history and preventive screenings performed.
- Each record must contain information on smoking/ETOH alcohol substance abuse for 14 years and older.
- Each record must contain a record of emergency care and hospital discharge summaries.
- Family social history.
- Documentation of referral services in members medical records
- All services provided by providers. Such services for the treatment of sexually transmitted diseases.
- **All records must reflect the primary language spoken by the member and any translation needs of the member.**
- **All records must contain documentation that the member was provided written information concerning the member's rights regarding advance directives (written instructions for living will or power of attorney) and whether or not the member has executed an advance directive. Neither FCA nor any of its providers shall, as a condition of treatment, require the member to execute or waive an Advance Directive.**
- FCA will maintain written policies and procedures for advance directives.
- Make it easy to identify the medical history and include serious illnesses, injuries and operations for members seen three or more times. For children and adolescents (to age 18), history includes prenatal care, birth, operations and childhood illnesses.
- For medication record, include name of medication, dosage and amount dispensed and dispensing instructions.
- All pages must contain member identification.