Medical Records Standards

A comprehensive, detailed medical record is a key to promoting quality medical care and improving patient safety.

UnitedHealthcare recommends that you have signed, written policies to include:
1. Maintenance of a single, permanent medical record that is current, organized and comprehensive for each patient and available at each visit.
2. Protection of patient records against loss, destruction, tampering or unauthorized use. This includes having adequate security safeguards in electronic medical records to prevent unauthorized access or alteration of records. Such safeguards must not be able to be overridden or turned off.
3. Periodic staff training regarding confidentiality.
4. Records storage to ensure privacy and security while allowing easy retrieval by authorized persons.
5. Mechanisms for monitoring and handling missed appointments.

We also expect you to follow these commonly accepted guidelines for medical record information and documentation:
- Include patient’s identifying information on each page.
- Ensure that records reflect all services provided, ancillary services/tests ordered, and all diagnostic/therapeutic services referred by the physician/health care professional. This includes hospital discharge summaries and consultations from other physicians/health care professionals.
- Document physician review of all lab, x-rays, consultation reports, behavioral health reports, ancillary providers’ reports, hospital records and outpatient records.
- Make it easy to identify the medical history, and include chronic illnesses, accidents, operations, family and social history: cite medical conditions and significant illnesses on a problem list and document clinical findings and evaluation for each visit.
- Include evidence of periodic depression screening.
- Include documentation of smoking, ETOH and substance use/abuse history beginning at age 11.
- For medication record, include name of medication and dosages. Also, list over-the-counter drugs taken by the member.
- Give prominence to notes on allergies and adverse reactions or note that the member has no known allergies or adverse reactions.
- Date all entries, and identify the authors. Documentation of records generated by word processing software or electronic medical records software should include all authors and their credentials. It should also be apparent from the documentation which individual performed a given service.
- Clearly label additions or corrections to a medical record entry with the author and date of change and maintain the original entry.
- Generate documentation at the time of service or shortly thereafter.
- Clearly label any documentation generated at a previous visit as previously obtained, if it is included in the current record.
- Prominently displayed information on advance directives.
Documentation that is not reasonable and necessary for the diagnosis or treatment of an injury or illness or to improve the function of a malformed body member should not be considered when selecting the appropriate level of an E&M service. Only the medically reasonable and necessary services for the condition of the particular patient at the time of the encounter as documented can be considered when selecting the appropriate E&M level.