5.2 Medical Record Reviews and Documentation Standards

Well-documented medical records facilitate the retrieval of clinical information necessary for the delivery of quality care. In private office or clinic settings, the medical record is an essential tool for communication between providers.

Providers should be in compliance with professional standards and should take steps to safeguard confidentiality when sharing medical record information with other network providers.

Periodically, Healthfirst requests medical records and conducts reviews to evaluate practice patterns, to identify opportunities for improvement, and to ensure compliance with quality standards. In many instances such reviews are required under the Medicaid, CHPlus or Medicare Advantage programs. All Healthfirst medical record reviews are conducted by clinical professionals, and all information contained in the records is kept strictly confidential. Providers must make medical records available upon request by Healthfirst or by CMS, NYSDOH, or any other regulatory agency with jurisdiction over Medicaid, CHPlus, or Medicare Advantage programs.

The provision of enrollee personal health information and records for the purposes listed below constitute healthcare operations pursuant to 45 CFR 501, and therefore the member's explicit consent is not required for the release of such records and information to Healthfirst. However, the member's authorization to allow Healthfirst to review records is also obtained by Healthfirst at the time of the member's enrollment with Healthfirst.

Healthfirst reviews medical records as part of the following activities:

- Credentialing and recredentialing
- Clinical quality of care investigations
- Monitoring utilization to validate prospective and concurrent review processes, identify trends, assess level of care determinations, and review billing issues
- Monitoring for accuracy and completeness of coding
- Monitoring for compliance with approved Practice Guidelines and Standards of Care
- Reporting for Quality Improvement and Peer Review Organization studies and HEDIS® /QARR measure compliance
- Monitoring of provider compliance with public health regulations on reporting requirements
- Monitoring for compliance with Healthfirst Medical Record Documentation Standards

In addition, NYSDOH and Peer Review Organizations audit medical records as part of their respective quality review processes. If deficiencies are found after an internal medical record review or a review conducted by regulatory agencies, providers will be required to participate in a corrective action plan, as necessary.

Medical records must be maintained by practitioners who are providing primary care and referral services. They must be maintained for a period of six (6) years after the last visit date or, in the case of minor children, for six (6) years from the age of majority for New York State programs and ten (10) years for Medicare programs and for New York State of Health (NYSOH) enrollees.

Transfer of Medical Records

When transferring medical records from one participating PCP to another, a release of information form is not required. However, a release form must be signed when the member requests records to be sent to other entities outside of Healthfirst, such as other insurance companies. When a member transfers PCPs, providers must facilitate the transfer of medical records in a timely manner.