COMMUNITY FIRST HEALTH PLANS
PCP MEDICAL RECORD DOCUMENTATION AND CONTINUITY GUIDELINES

Community First has established guidelines for medical record documentation. Individual medical records for each family member are to be maintained. The medical records must be handled and maintained in a confidential manner and must be organized in such a manner that all progress notes, diagnostic tests, reports, letters, discharge summaries and other pertinent medical information are readily accessible. In addition, each office should have a written policy in place to ensure that medical records are safeguarded against loss, destruction, or unauthorized use.

Criteria	Requirements
	A. Documentation
1. Patient Identification	Each page of the medical record must include a unique identifier, which may include patient identification number, medical record number, first and last name.
2. Personal Data	Personal/biographical data including the age, sex, address, employer, home and work telephone numbers, marital status of the patient, and emergency contacts must be included in the medical record.
3. Allergies	Medication allergies and adverse reactions (including immunization reactions) should be prominently noted in the record. If the patient has no known allergies or history of adverse reactions, this should be appropriately noted in the record.
4. Problem List	For patients seen three (3) or more times, a separate list of all the patient's chronic/significant problems must be maintained. A chronic problem is defined as one that is of long duration, shows little change or is of slow progression.
5. Medication List	For patients seen three (3) or more times, maintenance/ongoing medications should be listed on a medication sheet and updated as necessary with dosage changes and the date the change was made. A separate medication sheet is recommended but if a physician chooses to write out all current medications at each visit, this is acceptable. The medication list should include information/instruction to the member.
6. Chart Legible	Medical records must be legible to someone other than the author. A record that is deemed illegible by the reviewer should be evaluated by a second person.
7. Author Signature	All entries in the medical record must be signed by the author/performing provider.
8. Entries Dated	Each and every entry must be accompanied by a date (month, day and year).
9. Advance Directive	For medical records of Medicaid adults, 18 years and older, the medical record must document whether or not the individual has executed an advance directive. An advanced directive is a written instruction such as a living will or durable power of attorney for health care relating to the provision of health care when the individual is incapacitated.

	B. CONTINUITY OF CARE
10. Past Medical History	For patients seen three (3) or more times, a past medical history should be easily identified and should include serious accidents, operations, and illnesses. For children and adolescents (18 years and younger), past medical history should relate to prenatal care, birth, operations, and childhood illnesses.
11.Chief Complaint	Every visit should have a notation identifying the current problem (significant illnesses, medical and behavioral health conditions and health maintenance concerns).
12.History And Physical Relevant To Chief Complaint	The history and physical records should reflect appropriate subjective and objective information pertinent to the patient's presenting complaints.
13. Working Diagnosis Consistent with Findings	The diagnosis identified during each visit should be documented and should be consistent with findings. ICD-10 code(s) may be used but must include the written description of the diagnosis.
14. Basic Teaching Provided	The medical record should reflect that the member is provided with basic teaching/instructions regarding their physical and/or behavioral health condition.
15. Appropriate Plan Of Treatment	Based on the chief complaint, physical exam findings and diagnosis, the treatment plan should be clearly documented.
16. Appropriate Use Of Consultants	If a patient problem occurs which is outside the physician's scope of practice, there must be a referral to an appropriate specialist.
17. Appropriate Studies Ordered	The laboratory and other studies ordered should be consistent with the treatment plan as related to the documented working diagnosis and should be documented at the time of the visit. Abnormal findings must have an explicit notation of follow-up plans.
18.Unresolved Problems From Previous Visits Addressed	Documentation should reflect that the physician provides continuous evaluation of problems noted in previous visits.
19.MD Review Of Studies	There must be evidence that the physician has reviewed the results of diagnostic studies. Methods can vary, but often the physician will initial the lab report or mention it in the progress notes.
20. Results Of Consultations	When the patient is referred to another physician for consultation, there must be a copy of the results of the consult report and any associated diagnostic work-up in the medical record. Primary physician review of the consultation must be documented. Often the physician initials the consult report.
21. Date Of Next Visit	Encounter forms or notes should have a notation, when indicated, regarding follow-up care, calls, or visits. Specific time of return should be noted in weeks, months, or as needed.
22. ER And Hospital Records	Pertinent inpatient records must be maintained in the office medical record. These records may include but are not limited to the following: H&P, surgical procedure reports, authorizations, ER reports and hospital discharge summaries. For pediatric patients seen since birth, the labor and delivery records, including the newborn assessment, should be in the medical record.

23. Evidence That Patient Was Not Placed At Risk	The record should reflect that the patient has not been placed at inappropriate risk by a diagnostic or therapeutic problem.
24. Evaluation for abuse / neglect or other socio-environmental factors (Medicaid only)	Medical records of Medicaid adults should reflect evidence that the provider evaluates for signs / symptoms or behaviors associated with abuse / neglect or other significant socioenvironmental factors.
25. Annual Reminders	Annual reminders to be sent to members regarding preventive care, well child/annual physical
26. Diagnosis Validation	The record should reflect that the billing diagnosis is consistent with that of the chief complaint.
27. Claims Validation	The record should reflect the documented encounter is appropriate for the level of E/M services billed.

COMMUNITY FIRST HEALTH PLANS
ADULT PREVENTIVE DOCUMENTATION GUIDELINES

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Criteria	Requirements
1. Routine Check-up	Annually. Unclothed.
2. Blood pressure screening in adults	The USPSTF recommends screening for high blood pressure in adult's age 18 years and older.
3. Obesity screening and counseling: adults	The USPSTF recommends screening all adults for obesity. Clinicians should offer or refer patients with a body mass index (BMI) of 30 kg/m^2 or higher to intensive, multicomponent behavioral interventions.
4. Cholesterol Lipid Disorder screening for men/women at increased risk for coronary heart disease (CHD).	The USPSTF strongly recommends screening: • Men ages 20 to 35 years • Men age 35 years and older. • Women age 45 years and older • Women ages 20 to 45 years
5. Aspirin chemoprophylaxis counseling	The USPSTF recommends the use of aspirin for: • Men when the potential benefit due to a reduction in myocardial infarctions outweighs the potential harm due to an increase in gastrointestinal hemorrhage. • Women ages 55 to 79 years when the potential benefit of a reduction in ischemic strokes outweighs the potential harm of an increase in gastrointestinal hemorrhage.
6. Type II Diabetic Screening	The USPSTF recommends screening for Type 2 diabetes in asymptomatic adults with sustained blood pressure (either treated or untreated) greater than 135/80 mm Hg.
7. Member with diagnosis of DM	Monitor for HbA1c, Dilated Eye exam and Evidence of Nephrophathy (Urine albumin/ACE inhibitor)
8. Colorectal Cancer Screening	The USPSTF recommends colorectal cancer screening using one of the following: • High Sensitivity Fecal Occult blood • Flexible Sigmoidoscopy • Colonoscopy in adults (50-75 years).

	Note: The risks and benefits of these screening methods vary.
9. Depression screening: adults	The USPSTF recommends screening adults for depression **when staff-assisted depression care supports are in place** to assure accurate diagnosis, effective treatment, and follow-up.
10.a.Tobacco, alcohol,& other substance use assessed (>18)	The USPSTF recommends that clinicians ask all adults about tobacco, alcohol and other substance use.
b. Screening & Behavioral Counseling Interventions (Adults)	The USPSTF recommends that clinicians ask all adults about Tobacco/alcohol/substance /use, advise them to stop using tobacco, and provide behavioral interventions and U.S. Food and Drug Administration (FDA)–approved pharmacotherapy for cessation to adults who use tobacco.
10. STD/ Syphilis screening	The USPSTF recommends screening for all sexually active adolescents and for adults who are at increased risk for sexually transmitted infections (STIs) and syphilis infections.
12. HIV screening: nonpregnant adults	The USPSTF recommends that clinicians screen for HIV infection in adults up to age 65 years. Younger adolescents and older adults who are at increased risk should also be screened.
13.Behavioral Counseling to prevent STI	The USPSTF recommends intensive behavioral counseling for all sexually active adolescents and for adults who are at increased risk for sexually transmitted infections (STIs) and syphilis infections
14.Breast cancer screening: Using film Mammography	The USPSTF recommends biennial screening mammography for women aged 50 to 74 years.
15. Genetic Risk Assessment & Breast Cancer Susceptibility Gene	Women whose family history is associated with an increased risk for deleterious mutations in the BRCA 1 or BRCA 2 gene. (Recommendation: Refer patients for genetic counseling and evaluation for BRCA Testing.)
16. Cervical cancer screening	The USPSTF recommends screening for cervical cancer in women ages 21 to 65 yrs with cytology (Pap smear) every 3 yrs or, for women ages 30 to 65 yrs who want to lengthen the screening interval, screening with a combination of cytology and human papillomavirus (HPV) testing every 5yrs.
17. Chlamydial infection screening: non pregnant women	The USPSTF recommends screening for chlamydial infection in all sexually active nonpregnant young women age 24 years and younger and for older non pregnant women who are at increased risk.
18. Gonorrhea screening: women	The USPSTF recommends that clinicians screen all sexually active women, including those who are pregnant, for gonorrhea infection if they are at increased risk for infection (that is, if they are young or have other individual or population risk factors).
19.Osteoporosis screening: women	The USPSTF recommends screening for osteoporosis in women age 65 years and older without previous known fractures or secondary causes of

	osteoporosis and women < 65 years whose fracture risk is equal to or greater than that of a 65-year-old white woman who has no additional risk factors.
20. Abdominal aortic aneurysm screening: men	The USPSTF recommends one-time screening for abdominal aortic aneurysm by ultrasonography in men ages 65 to 75 years who have ever smoked.

COMMUNITY FIRST HEALTH PLANS
PEDIATRIC PREVENTIVE DOCUMENTATION GUIDELINES

Community First has established guidelines for medical record documentation. Individual medical records for each family member are to be maintained. The medical records must be handled and maintained in a confidential manner and must be organized in such a manner that all progress notes, diagnostic tests, reports, letters, discharge summaries and other pertinent medical information are readily accessible. In addition, each office should have a written policy in place to ensure that medical records are safeguarded against loss, destruction, or unauthorized use.

Criteria	Requirements
1. Family history	Per THSteps a comprehensive new patient personal and family history form of the provider's choosing is completed at the initial checkup as a separate form. It must be retained in the medical record for reference at future checkups.
2. Neonatal history (< 5 yrs. (THSteps only)	Please see THSteps Medical Checkup Periodicity Schedule for Infants, Children & Adolescents
3. Interval History (THSteps only)	Per THSteps this section is completed as an interim history to supplement the initial history and includes documentation of mental health, developmental, nutritional, and tuberculosis screening. It also includes items that may have changed since the comprehensive personal and family health history was recorded or may include additional information that would impact the current checkup. List all known visits to hospitals, other providers such as specialists, primary care physician (PCP) if this checkup is not performed by the PCP, or facilities, such as radiology or other outpatient facilities.
4. Physical, mental health & developmental history	Per THSteps a comprehensive health and developmental history is a federally mandated component of the medical checkup and must be completed at every checkup. For the initial checkup, this box may be checked without the need for further completion of the interval history section. The box is checked at all subsequent checkups to indicate there is a comprehensive new patient personal and family health history completed and in the record.
5. Physical examination	A comprehensive unclothed physical examination including a graphic recording over time of measurements for comparison to national norms for the patient's age is a federally required component of the checkup.
6. Length/Height	Please see THSteps Medical Checkup Periodicity Schedule for Infants, Children & Adolescents

7. Weight	Please see THSteps Medical Checkup Periodicity Schedule for Infants, Children & Adolescents
8. Obesity Screening/BMI Measurement (3-20 yrs.)	The USPSTF recommends screening children 6 years and older for obesity. Offer or refer for intensive counseling and behavioral interventions. BMI is calculated from the weight in kilograms divided by the square of the height in meters. BMI percentile can be plotted on a growth chart or obtained from online calculators. **Grade B.**
9. Head circumference	Please see THSteps Medical Checkup Periodicity Schedule for Infants, Children & Adolescents
10. Blood Pressure measurement (Screen for high blood pressure	Please see THSteps Medical Checkup Periodicity Schedule for Infants, Children & Adolescents
11. Physical activity counseling/discussion	Based on new evidence that children and adolescents can be effectively treated for obesity, the U.S. Preventive Services Task Force now recommends that clinicians screen children ages 6 to 18 years for obesity and refer them to programs to improve their weight status. • Counseling for weight loss or healthy diet • Counseling for physical activity or a physical activity program
12. Nutrition screening / Counselling	Based on new evidence that children and adolescents can be effectively treated for obesity, the U.S. Preventive Services Task Force now recommends that clinicians screen children ages 6 to 18 years for obesity and refer them to programs to improve their weight status./discussion • Counseling for weight loss or healthy diet • Counseling for physical activity or a physical activity program
13/14. Developmental screening (Physical/Mental)	The American Academy of Pediatrics recommends that all children be screened for developmental delays and disabilities during regular well-child doctor visit. Please see THSteps Medical Checkup Periodicity Schedule for Infants, Children & Adolescents
15.Autism Screening (M-CHAT-18 months)	At ages that do not require a standardized screening tool, the checkup must include a review of milestones as listed on the form. Check the box in front of "Developmental Surveillance" to document review of milestones.
16..Tobacco, alcohol, & other substance abuse (assessment and/or brief Counseling /intervention) 18 & above	Please see THSteps Medical Checkup Periodicity Schedule for Infants, Children & Adolescents.
17. Screen for depression (Adolescents 12-18 yrs.	The USPSTF recommends screening for depression when systems for diagnosis, treatment, and follow up are in place. **Grade B**
18. Metabolic monitoring of children/ adolescents on **antipsychotic** medication:	Monitor the blood glucose / HbA1c, LDL cholesterol / Total cholesterol, follow up visit/ care.
19. Screening for children with diagnosis of asthma and on asthma controller medication	Evaluate the children with the diagnosis of asthma for- long-term medications; response to medication; education given regarding triggering/risk factors.

20. Vision screening	Standardized sensory screenings for vision and hearing are required as part of the physical examination, including visual acuity and audiometric screening tests at specific ages. Visual acuity and audiometric screening tests performed during the checkup may be documented on the lines provided or maintained as supplemental documentation in the medical record.
21. Hearing screening	Documentation of test results received from a school vision and hearing program or other source may replace the required visual acuity or audiometric screening if conducted within the 12 months prior to the checkup. If testing was completed elsewhere, documentation of the results including the date and the name of the provider who completed the screening must be retained in the medical record.
22. Tuberculosis screening (PPD) yearly starting @ 1year	Per THSteps screening for tuberculosis (TB) is a required part of the history at certain ages. The questions contained in the THSteps TB questionnaire are located on the back of the checkup forms for specific ages and can serve as documentation for TB screening.
23. Newborn hereditary/metabolic testing	The USPSTF recommends screening for congenital hyperthyroidism (2 & 4 days TSH with backup T4, primary T4 with backup TSH). **Screening for congenital hypothyroidism (CH) is mandated in all 50 states and the District of Columbia.**
24. Hemoglobin or Hematocrit (Anemia 6-12 months at risk;	The USPSTF recommends screening asymptomatic children ages 6 to 12 months who are at increased risk for iron deficiency anemia. **Provide routine iron supplementation.**
25. Lead screening	Per THSteps lead risk assessment should be done beginning at six months to 2yrs of age (venous sample should be done) and questionnaire for age two through six years through anticipatory guidance. The back of the form contains questions related to lead risk factors and information about Form Pb-110, Lead Risk Questionnaire.
26. STD screening (11 & older)	Please see THSteps Medical Checkup Periodicity Schedule for Infants, Children & Adolescents
27. HIV screening Adolescents age 15-20 & younger if at increased risk	Please see THSteps Medical Checkup Periodicity Schedule for Infants, Children & Adolescents
28. Behavioral Counseling to prevent sexually transmitted infections (STI) (Not scored)	Please see THSteps Medical Checkup Periodicity Schedule for Infants, Children & Adolescents
29. Cholesterol profile	Please see THSteps Medical Checkup Periodicity Schedule for Infants, Children & Adolescents
30. Diabetes screening (Medicaid/THSteps only)	Please see THSteps Medical Checkup Periodicity Schedule for Infants, Children & Adolescents
31.Dental Caries Prevention /Assessment	Per THSteps beginning at 6 months of age, a dental referral is a required component of the checkup until a dental home is established and may be documented here or with supplemental information maintained in the medical record.

32. Anticipatory guidance: (Safety, Preventive Health)	Per THSteps Health Education Including Anticipatory Guidance is a federally required component of the checkup. The back of each form includes age-appropriate Health Education and Anticipatory Guidance, and modified versions of screening questionnaires.
IMMUNIZATIONS	**Age-appropriate screening and administration of immunizations according to the schedule established by the Advisory Committee on Immunization Practices (ACIP) is a federally mandated component of the checkup. The form allows space for documenting up-to-date or deferred immunizations, including rationale for deferral. Each form also includes the age-appropriate vaccine choices. Check the box for any vaccines given the day of the checkup. The separate immunization record also serves as sufficient documentation.**
33.. Hepatitis B	Please see CDC 2020 Recommended Immunizations for Children from Birth to 18 years old
34. Rotavirus	Please see CDC 2020 Recommended Immunizations for Children from Birth to 18 years old
35. DTP/DTaP/Tdap	Please see CDC 2020 Recommended Immunizations for Children from Birth to 18 years old
36. Hib	Please see CDC 2020 Recommended Immunizations for Children from Birth to 18 years old
37. Pneumococcal (PCV)	Please see CDC 2020 Recommended Immunizations for Children from Birth to 18 years old
38. IPV	Please see CDC 2020 Recommended Immunizations for Children from Birth to 18 years old
39. Influenza	Please see CDC 2020 Recommended Immunizations for Children from Birth to 18 years old
40. MMR	Please see CDC 2020 Recommended Immunizations for Children from Birth to 18 years old
41. Varicella	Please see CDC 2020 Recommended Immunizations for Children from Birth to 18 years old
42. Hepatitis A	Please see CDC 2020 Recommended Immunizations for Children from Birth to 18 years old
43. Meningococcal	Please see CDC 2020 Recommended Immunizations for Children from Birth to 18 years old
44. HPV (2 doses within 150 days)	Please see CDC 2020 Recommended Immunizations for Children from Birth to 18 years old