Fulcrum Health, Inc.

Policy Title:	**Record Keeping Requirements**		
Policy Number:	CRM - 005	**Effective Date:**	05/06/2010
		Last Revision Date:	03/04/2019
		Last Approval Date:	04/04/2019
Responsible Area/Individual:	Practitioner		
Purpose:	To outline the components necessary for record keeping justifying the need for clinical care.		
Regulation Reference:	Minnesota Statute 148.107 – Record Keeping Helpful information can also be found at DHHS/CMS publication ICN 905364 as well as DHHS/CMS publication ICN 909160		

Policy:
It is the policy of Fulcrum Health, Inc. that network providers maintain quality medical record documentation that meet State and Federal requirements.

Background:
Consistent and complete documentation is an essential component of quality patient care. Network providers must request the following information and maintain documents as outlined below. Failure to maintain adequate medical records could result in increased case audits and/or change in network participation status.

Procedure:
1. Each patient file should include the patient's date of birth, sex, height & weight, marital status, occupation, employer's name, home/cell phone number and if applicable, work phone number.

2. Each page in the patient's file must contain the either the patient's name or a unique assigned ID number.

3. File entries must be dated and contain author identification. The author identification can be stamped, electronic or hand written.

4. The patient file must contain a description of past conditions and trauma, past treatment received, current treatment being received from other health care providers, description of the patient's current condition including onset and description of trauma if trauma occurred.

5. Examinations performed to determine a preliminary diagnosis based on indicated diagnostic tests, with an indication of all findings of each test performed must be contained in the patient record.

6. The patient file must contain results of re-examinations that are performed to evaluate significant changes in a patient's condition, including tests that were positive or deviated from results used to indicate normal findings.

7. A diagnosis supported by documented subjective and objective findings or clearly qualified as an opinion must be recorded in the patient file.

8. The patient file must include a treatment plan that describes the procedures and treatment used for the conditions identified, including approximate frequency of care for a specified plan start and end date. The plan must include short- and long-term goals. Care plans should demonstrate functional improvement assessment, a suggestion is to use standardized outcome measures to validate patient response to care.

9. Adverse reactions, history of adverse reactions and/or contraindications to care must be prominently noted in the file.

10. The file must contain a description by the chiropractor or written description by the patient each time an incident occurs that results in an aggravation of the patient's condition or a new developing condition.

11. X-rays taken by the chiropractor should have the resultant findings recorded in the patient record. Consultant or outside x-ray and lab reports must be in the file and initialed or signed by the treating chiropractor to signify review either manually or electronically.

12. File/patient records must be organized and legible to those other than the author. When symbols or abbreviations are used, a key that explains their meaning must accompany the file. Records must be chronological order and written in permanent ink if maintained in written format. Amended records entries should be crossed out, yet readable. Corrected record entries should contain a date and signature.

13. Daily notes documenting current subjective complaints as described by the patient, any change in objective findings if noted during that visit, a listing of all procedures provided during that visit and information that is exchanged and will affect that patient's treatment must be recorded in the patient file. The daily notes should be SOAP type format and shall contain date for return visits or a follow-up plan. An expected time for a return visit or a follow- up plan for each encounter should be in the

record. This can be noted by a return visit date following each entry in the daily record or a treatment plan initiated with the onset of care. No-show and recall efforts should be documented in the file.

14. Patient file should include a discharge record that includes the reason for discharge with the patient health status noted.

15. The patient record must have documentation that family history has been evaluated.

16. Patient files must be stored so they are not readily accessible to unauthorized uses.

Variable Items:

1. Appointment Calendar
    - Name of each patient and date scheduled to be seen in an appointment calendar.

2. External Documentation
    - Documentation to and from external sources is part of the patient's record (i.e. correspondence to another physician, general correspondence to payers, attorneys etc.)

3. Financial Record
    - Each patient should have a financial record that includes:
    - Date and type of service provided.
    - Fee for service(s)
    - Payment received and source of payment
    - Current balance of the account

4. Confidentially of Records
    - Retained for the length of time prescribed by law.

Reference/Attachments

None

Document History:

Date	**Update**
05/06/2010	Policy effective date
08/02/2016	Document updated

9/22/2016	Fulcrum Health, Inc. brand
9/21/2017	Yearly Review
3/21/2019	Approved by Credentialing Subcommittee
4/4/2019	Approved by the Quality Committee of the Board