7/12/2013

Re: Well-child Exams

Dear Providers,

The Medicaid Health Plans in Florida would like to take this opportunity to thank you for taking care of our members and share some important information. As part of our annual Healthcare Effectiveness Data and Information Set (HEDIS) reviews we have found that many providers are conducting well-child exams but fail to document one or two important aspects of care in the medical record. As a reminder, all well-child exams should include a health and developmental history (physical and mental), a physical exam and health education which MUST include anticipatory guidance.

After speaking with several of the providers in our plans, one common theme was noted by all of us; a standard medical record documentation form for use with all health plans. As such, the health plans listed on the left are encouraging you to use the American Academy of Pediatrics Bright Futures forms. Copies of these forms are attached and can also be found on the Bright Futures website at: http://brightfutures.aap.org/tool_and_resource_kit.html.

We have also attached the general medical record documentation requirements for your review. These are state mandated requirements that are not plan specific.

As a reminder for those who have begun or are looking to begin using Electronic Medical Records (EMR) please ensure all aspects of the Bright Futures forms as well as the above contractually required medical record elements are captured in your EMR systems.

Should you have any questions, please contact the Provider Relations or Quality team staff at your contracted health plan.

Sincerely,

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Medical Record Documentation Requirements

A. Include the enrollee's identifying information, including name, enrollee identification number, date of birth, sex and legal guardianship (if any);
B. Each record shall be legible and maintained in detail;
C. Include a summary of significant surgical procedures, past and current diagnoses or problems, allergies, untoward reaction to drugs and current medications;
D. All entries shall be dated and signed by the appropriate party;
E. All entries shall indicate the chief complaint or purpose of the visit, the objective, diagnoses, medical findings or impression of the provider;
F. All entries shall indicate studies ordered (e.g., Laboratory, x-ray, EKG) and referral reports;
G. All entries shall indicate therapies administered and prescribed;
H. All entries shall include the name and profession of the provider rendering services (e.g., MD, DO, OD) including the signature or initials of the provider;
I. All entries shall include the disposition, recommendations, instructions to the enrollee, evidence of whether there was follow-up and outcomes of services;
J. All records shall contain an immunization history;
K. All records shall contain information relating to the enrollee's use of tobacco products and alcohol/substance abuse;
L. All records shall contain summaries of all emergency services and care and hospital discharges with appropriate medically indicated follow up;
M. Document referral services in enrollees' medical records;
N. Include all services provided. Such services must include, but not necessarily be limited to, family planning services, preventive services and services for the treatment of sexually transmitted diseases;
O. All records shall reflect the primary language spoken by the enrollee and any translation needs of the enrollee;
P. All records shall identify enrollees needing communication assistance in the delivery of health care services;
Q. All records shall contain documentation that the enrollee was provided with written information concerning the enrollee's rights regarding advance directives (written instructions for living will or power of attorney) and whether or not the enrollee has executed an advance directive;
R. Copies of any advance directives executed by the enrollee;
S. Copies of any consent or attestation form used or the court order for prescribed psychotherapeutic medication for a child under the age of thirteen (13).
T. Include the following items for services provided through telemedicine:
    (1) A brief explanation of the use of telemedicine in each progress note;
    (2) Documentation of telemedicine equipment used for the particular covered services provided; and
    (3) A signed statement from the enrollee or the enrollee's representative indicating their choice to receive services through telemedicine. This statement may be for a set period of treatment or one-time visit, as applicable to the service(s) provided.