



Medical Record Standards

The following AHCA medical/case record standards must be followed in each enrollee medical/case record:

- Each record must contain identifying information on the enrollee, including name, enrollee identification number (Medicaid #), date of birth , gender and legal guardianship (if any);
- Entries should be recorded timely, at the time care is given or as soon as is feasible given the situation
- Each record must contain a summary of significant surgical procedures, past and current diagnosis or problems, allergies, untoward reactions to drugs and current medications and should be updated to reflect new allergies/problems/diagnoses.
- All records must contain all services provided by providers; such services must include, but not necessarily be limited to, family planning services, preventive services and services for the treatment of sexually transmitted diseases.
- All records must contain documentation of referral services (including Health & Wellness Program if applicable), including reports of the results from the referral.
- Each record must be legible and maintained in detail.
- Each record must contain an immunization history.
- Each record must contain information on use of tobacco, alcohol, and drug/substances.
- Each record must contain a medication list and changes in prescription and non-prescription medication(s) with name and dosage, when available.
- Each record must contain a record of emergency services and care hospital discharges with appropriate, medically indicated follow up.
- All records must reflect the primary language spoken by the enrollee and translation needs of the enrollee.
- All records must identify enrollees needing communication assistance in the delivery of health care services.
- All entries in each record must be dated and signed by appropriate party;
- All entries in each record must indicate the chief complaint or purpose of the visit; the objective findings of practitioner, diagnosis, or medical impression.
- All entries in each record must indicate studies ordered, for example: lab, x-ray, EKG, and referrals and reports of completed studies/referrals should be contained in the record and acknowledged by the provider.
- All entries in each record must indicate therapies administered and prescribed.
- All entries in each record must include the name and profession of practitioner rendering services, for example: M.D., D.O., and O.D., including signature or initials of practitioner.



- All entries in each record must include the disposition, recommendations, instructions to the patient, evidence of informed consent including risk and adverse outcome, whether there was follow-up, and outcome of services. Including medication reconciliation. A copy of completed screenings is included in the enrollee record and is provided to the enrollee.
- Records must contain copy of any express written and informed consent of the enrollee's authorized representative or attestation form(s) for psychotropic medications (i.e. antipsychotics, antidepressants, antianxiety medications, and mood stabilizers) prescribed for an enrollee under the age of thirteen (13) years. In accordance with s.409.912(13),F.S., CCP ensures the following requirements are met:
 - Prescriber documents the consent in the child's medical record and provides the pharmacy with a signed consent with the prescription
 - Prescriber ensures completion of the appropriate attestation form from:
http://ahca.myflorida.com/Medicaid/Prescribed_Drug/med_resource.shtml
 - The completed form is filed with the prescription in the pharmacy for a minimum of six (6) years.
 - Pharmacies will not add refills to old prescriptions but will seek an updated informed consent
 - Every new prescription requires a new informed consent form
 - Informed consent forms do not replace prior-authorization requirements for non-PDL medications or prior authorized antipsychotics for children and adolescents under the age of eighteen (18) years.
- All records must contain documentation that the enrollee was provided written information concerning the enrollee's rights regarding advanced directives (written instructions for living will or power of attorney), including information on Chapter 765, F.S., and whether or not the enrollee has executed an advanced directive. The provider shall not, as a condition of treatment, require the enrollee to execute or waive an advanced directive in accordance with Section 765.110, F.S. All records must contain copy of any advance directives executed by the enrollee (ages 18 and older including emancipated minors / for enrollees under 18 or not emancipated – documentation of offered/discussion with parent/guardian).
- All records must contain a Health Risk Assessment Form when one is returned by the enrollee and sent to the provider. This includes documentation of preterm delivery risk assessment by week twenty-eight (28) of pregnancy. A copy of the completed screening tool becomes part of the medical record and a copy is provided to the enrollee.
- All records must contain documentation of significant findings and medical advice given to enrollee in person, by telephone, online or provided after-hours.



- Records of enrollee treated elsewhere or transferred to another health care provider are present.
- All records must contain a brief explanation of the use of telemedicine in each progress note; documentation of telemedicine equipment used for the particular covered services provided; and 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), for services provided through telemedicine.
- Environmental and/or or special needs (e.g. safety, sanitation, need for physical adaptations, general condition of the home, amount of space, adequacy of sleeping area, access to bathroom, temperature, availability of food, etc.).
- Documentation of missed or cancelled appointments and subsequent follow up