#	Enrollee Medical Record Standards - as applicable (* core standards)	Regulator Agency	Accrediting Agency
1.	Each page in the record contains the patient's name, ID number, date of birth, and gender.	X	X
2.	Personal/biographical data includes address, employer, home and work telephone numbers, and marital status as well as assessment of cultural and/or linguistic needs such as deaf/blind, etc. Includes legal guardianship.	X	X
3.	Reflects the primary language spoken, any translation need, and communication assistance needed in delivery of health care services.	X	
4.	All entries must include the name and profession of the provider rendering services (e.g., MD, DO, OD), including the signature or initials of the provider which maybe a handwritten signature or a unique electronic identifier or initials.		X
5.	All entries are dated with the dates of service and signed by the appropriate party within two business days from the date and time of service, or otherwise authenticate the record by signature, written initials, or computer entry; initial rubber-stamped signature.	X	X
6.	The record is legible to someone other than the writer, maintained in detail and in ink		X
7. *	**Problem List**: Significant illnesses and medical conditions are indicated on a problem list.		X
8. *	**Allergies** are noted prominently: Medication allergies and adverse reactions are prominently noted in the record. If the patient has no known allergies or history of adverse reactions, this is appropriately noted in the record.		X
9. *	**Past medical history** (for patients seen three or more times) are easily identified and include serious accidents, operations, and illnesses. For children and adolescents (18 years or younger), past medical history related to prenatal care, birth, operations, and childhood illnesses.		X
10.	For patients 12 years and over, there are appropriate notations concerning use of tobacco products and alcohol/substance abuse.	X	X
11.	History and Physical Assessment. The history and physical exam records appropriate subjective and objective information for presenting complaints.	X	X
12.	Laboratory studies are ordered, as appropriate.		X
13. *	**Each entry must indicate the chief complaint or purpose of the visit, the objective, diagnoses, medical findings or impression of the provider; working diagnoses are consistent with findings.**	X	X
14. *	**Treatment plans are consistent with diagnoses.**	X	X
15.	Encounter forms or notes have a notation, when indicated, regarding follow-up care, calls, or visits and scheduling frequency. The specific time of return is noted in weeks, months,or PRN.	X	X
16.	Unresolved problems from previous office visits are addressed in subsequent visits.		X
17.	No evidence of under and over utilization of consultants (evidence of appropriate use of consultants).		X

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18.	If a consultation is requested/referral made, there is a consultative report from the consultant in the record.	X	X
19.	Consultation, lab and imaging reports/diagnostic test and results filed in the chart are initialed by the practitioner who ordered them to signify review. If the reports are presented electronically or by some other method, there is also representation of review by the ordering practitioner. Consultation and abnormal lab and imaging study results have an explicit notation in the record of follow-up plans.	X	X
20. *	**No evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic procedure** (does the care appear to be medically appropriate?).		X
21.	All records must contain an immunization history -- An immunization record has been initiated for children, or an appropriate history has been noted in the enrollee record for adults.		X
22.	Evidence that preventive screening and services are offered in accordance with Sunshine Health's practice guidelines. *Includes screening for domestic violence and referral to prenatal care/WIC when appropriate.*		X
23.	All entries include the description of services rendered, disposition, recommendations, instructions to the patient, evidence of whether there was follow-up, and outcome of services.	X	
24.	All records must contain summaries of all emergency services, emergency care encounters, and hospital discharges with appropriate medically indicated follow up.	X	
25.	Evidence that the patient was provided with written information concerning their rights regarding Advance Directives (written instructions for living will or power of attorney) and whether or not the patient has executed an Advance Directive. *(Neither Sunshine Health, nor any of its providers shall, as a condition of treatment, require the patient to execute or waive an advance directive.)*	X	
26.	Prescribed or provided medications and supplies (as applicable)	X	
27.	Medication List: Current medication information list includes instructions to the patient regarding dosage, initial date of prescription, and number of refills.	X	
28.	Documentation of the express written and informed of the enrollee's authorized representative prescriptions for psychotropic medication (i.e., antipsychotics, antidepressants, antianxiety medication, and mood stabilizers) prescribed for an enrollee under the age of thirteen (13) years. • Prescriber must document the consent in the child's medical record and provide the pharmacy with a signed attestation of the consent with the prescription. • Prescriber must ensure completion of an appropriate attestation form. Consent/attestation forms that may be used and pharmacies may receive	X	

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	• The completed form must be filed with the prescription (hardcopy or imaged) in the pharmacy and held for audit purposes for a minimum of six (6) years. • Pharmacies may not add refills to old prescriptions to circumvent the need for an updated informed consentform. • Every new prescription will require a new informed consent form. • The 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. attestation of the consent with the prescription.		
29.	Documentation of preterm delivery risk assessments by week twenty-eight (28) of pregnancy.	X	
30.	Copy of completed screening instrument(s) with documentation that a copy has been provided to the member.	X	
31.	Documentation of telemedicine services when provided to include: • A brief explanation of the use of telemedicine in each progress note • Documentation of telemedicine equipment used for the particular covered services provided. • A signed statement from the member or member representative indicating their choice to receive services through telemedicine; this statement may be for a set period of treatment or a one-time visit as applicable. • Complies with HIPAA and other State and federal laws pertaining to patient privacy	X	
32.	Medical necessity is established for the extent of services provided.	X	
33.	Progress reports are documented.	X	
34.	Records include copies of any completed consent or attestation form(s) used by the SHP.	X	
Electronic Records (applicable to providers with electronic records)			
35.	Electronic records policy complies with the applicable state and federal laws, rules, and regulations to ensure the validity and security of electronic records.	X	
36.	Electronic record policies address the technical safeguards required by Title 45, Code of Federal Regulations, section 164.312.	X	
37.	Provider has the ability to produce electronic records in a paper format within a reasonable time, upon request.	X	
Record Keeping Requirements Providers must retain all business records, medical-related records, and enrollee records, as defined in Rule 59G-1.010, F.A.C., according to the requirements specified below, as applicable:			

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38.	Maintain records on paper, magnetic material, film, or other media including electronic storage, except as otherwise required by law or Florida Medicaid requirements. All records must be accessible, legible, and comprehensible.	X	
39.	Retain all records related to services rendered to Florida Medicaid recipients for a period of at least five (5) years from the date of service. Medicare crossover-only providers must retain health care service records for six (6) years.	X	
Copying or Transferring Records/Right to Review Records			
40.	Provider policies comply with copy and transferring recordsand review of records per 59G-1.054.	X	