BlueCross BlueShield of New Mexico

Medical Records
Documentation Standards

A. Confidentiality and Security Standards

1. Maintain each medical record on paper and/or in electronic format in a manner that is timely, legible, current, and organized that permits effective and confidential patient care, quality review, and compliance with applicable state and federal laws, and including HIPAA.
2. Two forms of patient identification information must be noted on each printed page (e.g., name and date of birth).
3. Contain documentation for both encounter and entry dates.
4. Provide for clear identification of authors for all entries.
5. Document the member's current problem.
6. Document a history and/or physical examination for the presenting complaint(s) or problem(s).

B. BCBSNM Documentation Standards

In addition to the NMAC and HCA standards, BCBSNM has established the following standards with which its providers are also expected to comply:

1. Ensure the medical record contains sufficient biographical and demographic information (i.e., date of birth, sex, race/ethnicity, mailing/residential address, emergency contact information).
2. Allergies and the adverse reactions in a uniform location of the record; or notation of no known allergy (NKA) or no known drug allergy (NKDA), if applicable.
3. For medications prescribed, documentation must include name, strength, amount, direction for use, and refills. Effectiveness should be documented upon follow-up.
4. Treatment/follow-up plan and patient discharge instructions for each encounter.
5. Preventive health services reviewed and documented for patients of all ages, such as but not limited to, immunizations, well visits, weight counseling, and BMI assessment, etc. (physical health only).
6. Preventive health well visits and screening reviewed and documented for EPSDT population (all patients age 0-20), in adherence to the guidelines of the American Academy of Pediatrics/Bright Futures table. When applicable, documentation of referral for additional EPSDT services is required.
7. Diagnostic test results and other prescribed therapies with evidence of practitioner review and patient notification of abnormal results.
8. Coordination of care between practitioner to include, as applicable, referrals and evidence of practitioner review reports, signed release of information allowing for communication between practitioners.
9. Document discussion of advance directives applicable per state law.