PrimeWest HEALTH™
Your greater Minnesota health plan

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2026 Health Record Documentation Standards

Gray text indicates quoted, statutory, or other language not subject to change

Element	Standard	Regulatory Requirement
A. Record Format		
1. Elements in the health record are organized in a consistent manner.	The contents of the health record are affixed and organized in a logical and consistent manner. The record is organized in chronological order. Member name is present on each page and the author is identified on each page. Entries are dated and timed and legible to someone other than the author.	• National Committee for Quality Assurance (NCQA) guidelines • MN Rules part 9505.2175, subp. 2 (B) (C) • MN Stat. sec. 221.173 • Centers for Medicare & Medicaid Services (CMS) Manual System, Pub 100-08, CR 6698 • Title 42 Code of Federal Regulations (CFR) 485.638 (a) (4) (iv)
2. Medical and mental health providers can access each other's notes through a fully integrated electronic health record (EHR).	Providers can accommodate the timely, effective, and confidential exchange of patient information between primary care providers, mental health care professionals, specialists, and organizational providers. (Individual health care providers in private practice with no other providers are excluded from the requirements.)	• MN Stat. sec. 62J.495
B. Basic Record Content		
1. Personal biographical and demographic data includes member address, employer, home and work phone numbers, and marital status.	Personal biographical is documented in a prominent location in each health record and includes the member's address, employer, home and work phone numbers, and marital status. Demographic data includes preferred language, sex, race, ethnicity, and date of birth.	• NCQA guidelines • 45 CFR 170.207 (f) (g)
2. Health Care Directives are documented in the health record for members age 18 and over.	Documentation is in a prominent part of the member's current health record, for those age 18 and over, whether or not the member has executed a Health Care Directive. If not executed, there is documentation that Health Care Directive information was offered.	• 2026 Minnesota Department of Human Services (DHS) Families and Children contract, article 14 • 2026 DHS Minnesota Senior Health Options (MSHO)/Minnesota Senior Care Plus (MSC+) contract, article 14

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		• 2026 DHS SNBC contract, article 14 • MN Stat. sec. 145C.01 • MN Stat. sec. 145C.02 • MN Stat. sec. 145C.03 • 42 CFR 422.128 (b) (1) (ii) (E)
3. Significant illnesses and medical conditions are indicated on a problem list. History and physical exam identify appropriate subjective and objective information pertinent to member's presenting complaints.	A problem list that summarizes important member medical information, such as major diagnoses, past medical and/or surgical history, and recurrent complaints is documented in a specific location. There is a current problem list, kept either separately or within each practitioner progress note.	• MN Rules part 4685.1110, subp. 13 (A) • MN Rules part 9505.2175, subp. 2 (D) (1) • NCQA guidelines • PrimeWest Health standard
4. Absence or presence of medication allergies and adverse reactions is prominently noted in the health record.	Documentation of presence of medication allergies, including adverse reactions, is consistently and clearly documented in a prominent location in all health records. If the member has no known allergies or history of adverse reactions, this is also prominently noted in the health record. Allergies to environmental allergens, food, pets, etc., are also noted.	• NCQA guidelines • PrimeWest Health standard
5. Past medical history for members age 18 and over (seen three or more times) is easily identified and includes serious accidents, operations, and illnesses. For members under age 18 there is information related to medical history such as prenatal care, birth, operations, and childhood illnesses.	There is documentation of a past medical history obtained by the third visit that includes serious accidents, operations, and illnesses for members age 18 and over.	• MN Rules part 4685.1110, subp. 13 (A) • MN Rules part 9505.2175, subp. 2 (D) (1) • NCQA guidelines • PrimeWest Health standard
C. Preventive Screening and Services		
1. There is evidence that preventive screening and services are recommended in accordance with PrimeWest Health's clinical practice guidelines.	Preventive services must be recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice. A summary of preventive screening and services is documented in a consistent place in the health record. Preventive health guidelines should comply with the Minnesota C&TC Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) periodicity schedule for members under age 21.	• 2026 DHS Families and Children contract, article 6.1.5 • 2026 DHS SNBC contract, article 6.1.7 • DHS C&TC Program • MN Rules part 9505.0175, subp. 25 (C) • MN Rules part 9505.0355 • 42 CFR 441, subp. B • 42 CFR 438.236

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	For members age 21 and over, utilize standards of care and clinical guidelines adopted by PrimeWest Health (United States Preventive Services Task Force [USPSTF] A and B Recommendations).	• 42 CFR 440.130 (c) • NCQA guidelines • PrimeWest Health standard
D. Social Determinants of Health (SDOH)		
1. Members were screened, using prespecified instruments, at least once during the measurement period for unmet food, housing, and transportation needs.	Certain social risk factors can lead to unmet social needs that directly influence an individual's physical, psychosocial, and functional status.	• American Academy of Family Physicians • American Academy of Pediatrics • American Diabetes Association • NCQA guidelines • CMS 42 CFR Vol. 87, No. 89
2. Member received a corresponding intervention if they screened positive.	Certain social risk factors can lead to unmet social needs that directly influence an individual's physical, psychosocial, and functional status.	• American Academy of Family Physicians • American Academy of Pediatrics • American Diabetes Association • NCQA guidelines • CMS 42 CFR Vol. 87, No. 89
E. Assessment, Plan, and Follow-Up		
1. Working diagnoses and corresponding treatment plans are consistent with findings.	Working diagnoses or medical impressions that logically follow from the clinical assessment and physical exam are recorded. Proposed treatment plans, therapies, or other regimens are documented and logically follow previously documented diagnoses and medical impressions. There is evidence of provider consideration of member input into the proposed treatment plan, and in consultation with any specialists caring for the member.	• MN Rules part 4685.1110, subp. 13 (A) • MN Rules part 9505.2175, subp. 2 (D) (3) (H) • NCQA guidelines • PrimeWest Health standard
2. Prescribed medications are clearly visible in the health record.	Ongoing documentation and medication reconciliation of prescribed medications, including quantity, dosage (actual rather than prescribed), name of prescribed medication, and dates of initial or refill prescriptions, is clearly visible in the health record and listed in a composite form. Over-the-counter and herbal preparations should also be clearly noted.	• MN Rules part 9505.2175, subp. 2 (E) • NCQA guidelines • PrimeWest Health standard
3. Unresolved problems from previous visits are addressed in subsequent visits.	Continuity of care from one visit to the next is demonstrated when follow-up of unresolved problems from previous visits is documented in subsequent visit notes. The record must report the member's progress	• MN Rules part 9505.2175, subp. 2 (H) • NCQA guidelines

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	or response to treatment and changes in the treatment or diagnosis.	
4. Encounter forms or notes include information about follow-up care, calls, or visits when indicated. Specific time of return is noted in weeks, months, or as needed.	Follow-up is documented for members who require periodic visits for a chronic illness and for members who require reassessment following an episodic illness. Telephone encounters (phone contact) relevant to medical issues are documented in the health record and reflect practitioner review. The member's return to the office in a specified amount of time is recorded at the time of the visit, or as follow-up to consultation, laboratory, or other diagnostic reports. Clinically significant consultation and abnormal laboratory and imaging reports have an explicit notation of follow-up plans. Follow-up care, communication of test results, and calls/visits are documented to indicate continuity of care. Subsequent visit notes (treatment plans) reflect results of the reports as may be pertinent to ongoing care.	• MN Rules part 9505.2175, subp. 2 (G) • MN Rules part 9505.0175, subp. 35 (A) (B) • NCQA guidelines • PrimeWest Health standard