

Overview

The Plan conducts reviews of medical records of Primary Care Providers (PCPs) and OB/GYN physicians to determine compliance with established documentation standards and goals that are adopted by the Quality Improvement Committee (QIC). An average score of 80 percent or greater is considered to meet documentation standards. A physician who scores less than 80 percent will receive a letter outlining the deficiencies and a corrective action plan will be requested. If the physician fails to improve the score to 80 percent during a re-audit, the information will be forwarded to the QIC for review.

Requirements and Guidelines

Medical record requirements and guidelines are as follows:

- Each provider shall maintain an adequate and complete patient record for each patient and may maintain electronic medical records provided the record keeping format is capable of being printed for review;
- Safeguard member confidentiality in accordance with HIPAA state and federal guidelines, the Plan's Quality Improvement and Risk Management programs and professional practice standards. This requirement includes the confidentiality of a minor's consultation and the examination and treatment for a sexually transmissible disease;
- Make the medical records available for quality care review studies by Plan reviewers, authorized representatives of the Ohio Department of Job & Family Services (ODJFS), Centers for Medicare & Medicaid Services (CMS), Plan member, organizations conducting accreditation audits and HEDIS[®] medical record reviews;
- Comply with corrective action plan requirements imposed as the result of any review or audit;
- When a member changes his/her PCP, the provider must forward a copy of a transferring member's medical record to the new PCP, without charge and within 10 business days;

- Patient records remaining under the care, custody and control of the physician shall be maintained by the physician, or the physician's designee, for minimum of six years from the date of termination of the agreement with the Plan or at the conclusion of an investigation, whichever is later;
- Any correction, addition or change in any patient record made more than 48 hours after the final entry is entered in the record and signed by the physician shall be clearly marked and identified as such, and the date, time and name of the person making the correction, addition or change shall be included, as well as the reason for the correction, addition or change;
- A consultative report shall be considered an adequate medical record for a radiologist, pathologist or a consulting physician;
- The member's medical record is the property of the provider who generates the record;
- The state agency is not required to obtain written approval from a member before requesting the member's record from the provider.

**Content
and Review**

The following information applies to medical records for members.

- A member's medical record should contain the quality, quantity, appropriateness and timeliness of services performed.
- All entries in the medical record are signed. All entries must include the name and profession of the practitioner rendering services, for example: RN, MD, DO, including signature or initials of the practitioner.
- All entries in the medical record must be dated and recorded in a timely manner.

- Medical records must be legible to readers and reviewing parties, and maintained in an orderly and detailed manner.
- The following personal and biographical data must be included in the record: name, member ID number, date of birth, sex, address and telephone number, emergency contact and legal guardianship. This may include: marital status, name of spouse, next of kin or closest relative, address, employer, telephone numbers, insurance information or family history.
- Medication allergies or “no known allergies” and untoward reactions to drugs, are to be prominently noted in the record. This may include a sticker inside of the chart or a prominent notation in a conspicuous place in the record.
- Medical records from the previous provider have been obtained and are easily accessible. Old records include past medical history, physical examinations, necessary tests and a list of possible risk factors for the member relevant to treatment, used to assess the periodicity schedule and to maintain continuity of care.
- An immunization history and/or record are on the chart, as appropriate.
- A listing of all current and past medications the member is taking is in the chart. This includes prescribed medications, including dosages and dates of initial or refill prescriptions or sample medications.
- A problem list, in the chart, of past and current diagnoses with procedures used to provide continuity of care. This includes a summary of significant surgical procedures, past and current diagnoses or problems, medication reactions, etc.
- Screening for substance abuse of tobacco, alcohol and drugs with appropriate counseling/referrals, if needed, and documented follow-up.

- There is documentation of screening for domestic violence with appropriate counseling/referrals, if needed, and follow-up.
- There is evidence the member was asked about advance directives and documentation of acceptance or refusal. **Note:** The record must contain evidence that the member was provided written information concerning the member's rights regarding advance directives and whether or not the member has executed an advance directive. The record may also have evidence that the member does not need to have advance directives completed. A signed statement that a member has been asked if he/she has advance directives, and if not, asked if he/she wants advance directives will suffice.
A stamp may be utilized. The provider shall not, as a condition of treatment, require the member to execute or waive an advance directive.
- All records must reflect the primary language spoken by the member and translation/communication needs of the member, if any. Translation/communication needs could reflect the need for an interpreter, sign language or Braille materials, etc., as appropriate.
- Documentation indicating diagnostic or therapeutic intervention as part of a clinical research study is clearly contrasted from those entries pertaining to usual care.
- There is documentation of member missed appointments and follow-up by the PCP staff.

**Continuity
of Care
Requirements
Screen**

The medical record must show the physician's knowledge of the patient's course of care as evidenced by the following:

- There is documentation and reports of consultations and referrals to specialty physicians, if indicated;
- There are reports of diagnostic testing in the medical record. The medical record will show documentation of reports for diagnostic testing that was ordered: lab

results, X-ray reports, MRI/CT reports, etc;

- There is documentation and records for emergency room care. There is documentation in the record if a member was seen in the emergency room and the records from the emergency room visit are in the medical record;
- There is documentation of hospitalizations to include discharge summary and discharge planning. There is documentation of a plan for hospital discharge and a copy of the hospital discharge summary on the medical record for members who were hospitalized;
- Assessment and clinical impression of diagnosis;
- Any informed consent for office procedures.

The following patient information must be documented in the medical record for each visit:

- History and physical examination as related to the visit, chief complaint or purpose of the visit, objective findings of the practitioner, diagnosis or medical impression are documented for each visit.
- Plan of treatment with documentation of patient's input, referrals, disposition, diagnostic testing, studies ordered, therapy administered and prescribed regimens are documented for each visit, as indicated.
- There is documentation of follow-up plans for abnormal testing/consultation reports, referrals or missed/cancelled appointments. There is documentation that the abnormal results or consultations were reviewed by the provider and documentation of the follow-up to be done.
- There is documentation of patient education and instruction whether verbal, written or via telephone. The member is provided with verbal and/or written education/instruction as indicated and appropriate. Significant medical advice given via telephone is

entered in the member's record and appropriately signed and initialed (this includes medical advice provided by after-hours telephone patient information or triage telephone services).

- All entries must include the disposition, recommendations, instructions to the patient, evidence of whether there was follow-up and outcome of services.

Medical Record Documentation

The physician's medical records should be available for utilization and quality review studies.

Implementing the following documentation guidelines can reduce practice risks:

- **Documentation should be descriptive.**
Clinical observations and/or patient symptoms should be documented in detail. Use of anatomical forms or drawings should be considered when documenting the presence, size, color and/or location of a lesion or deformity.
- **Clearly document follow-up instructions.**
This includes activity limitations, medications, referrals to specialists, further testing and subsequent appointments. Make sure patients understand instructions given.
- **Obtain and document informed refusal.**
Inform patients of adverse outcomes and consequences of not undergoing recommended tests or procedures.
- **Use of a problem list is recommended.**
This is a significantly important documentation tool and is helpful only if used consistently. It should contain space for chronic diseases/conditions and any acute problems for follow-up. Columns for date and for problem identification and resolution should be included.

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- **Document all telephone calls from the patient and response to them.**

The date and time the call was received, by whom and the date and time it was returned needs to be detailed. Fully document any advice given or diagnosis made.
 - **A follow-up/recall system needs to be in place.**

To avoid failure to diagnose a system to follow-up on abnormal lab results, assure that the patient returns to re-check conditions as indicated by the physician and to assure that the patient sought consultation after referral needs to be established. Also, patients like to know if test results are normal. In addition, the physician should initial all test results to show verification of review.
 - **Always document attempts to contact the patient.**

Depending on the seriousness of the condition, physicians may want to send a certified letter with return receipt.
 - **Consistently adhere to standard medical record documentation guidelines, specifically:**
 - All entries should be neat, complete, clear, concise and timely; include all recommendations and essential findings;
 - Sign entries with complete name, date, time of occurrence, time of documentation and professional designation;
 - Records should not be altered. Corrections are to be made by a single line through the inaccurate material, dated and initialed;
 - Use only standard abbreviations and symbols;
 - If records are hand written, they must be legible;
 - Late entries should include date and time of occurrence and date and time of documentation;

- Record details of informed consent discussions.

All participating PCPs should maintain complete and accurate fiscal records, as well as medical and social records for all Plan members. Records should be made available for quality care review studies by the Plan, authorized representatives of ODJFS, CMS, accreditation agencies and should comply with requirements issued as a result any such review or audit.

Medical Record Review Audits

- Medical Record Content
- Continuity of Care
- Pediatric Health Screening/EPSTD Services
- Adult Health Screening

Diagnosis Specific Audits

- Maternity Care Review (OB/GYN only)
- Asthma Review
- Diabetes Review
- Healthcare Effectiveness Data and Information Set (HEDIS) Reviews

**Maternity Care
(OB/GYN
Review)**

Medical record requirements and guidelines:

1. Pre-term delivery risk assessment is rendered by the 28th week.
2. The member will be seen by an obstetrician **within the first trimester** of the pregnancy with the following assessments performed and documented:
 - Weight
 - Blood Pressure
 - Fetal Heart Tones
 - Hemoglobin and Hematocrit (H&H)
 - Urinalysis for protein and glucose levels
 - Blood Typing and Antibody screening
 - Rubella Antibody titer
 - Syphilis screening
 - HBsAG screening
 - Pap smear
 - Uterine Size

- Nutrition assessment
3. The member will be seen **once every month in the second trimester** of pregnancy with the following assessments performed and documented:
- Weight
 - Blood Pressure
 - Fetal Heart Tones
 - Uterine Size
 - Hemoglobin and Hematocrit (H&H)
 - Urinalysis
 - Alpha-fetoprotein (between 15-20 weeks)
 - Diabetes screening/GTT (between 24-28 weeks)
 - Repeat antibody test for unsensitized RH negative patients (28 weeks)
 - Prophylactic administration of Rho(D) immune globulin (28 weeks), if indicated
4. The member will be seen **twice every month in the third trimester** of pregnancy and **one visit per week in the ninth month** with the following assessments performed and documented:
- Weight
 - Blood Pressure
 - Fetal Heart Tones
 - Uterine size
 - Hemoglobin and Hematocrit (H&H)
 - Urinalysis
 - Testing for STDs and HBsAg for high-risk members
 - Group B Strep screening for high-risk members (35-37 weeks)
5. The Maternity chart will contain documentation of the following:
- Physical findings on each visit with a plan of treatment and follow-up for any abnormalities;
 - Member education (childbirth/maternal care, avoidance of alcohol, smoking cessation if

needed, signs of labor, nutrition, signs and symptoms that should be reported);

- Postpartum care – at least one complication-free visit, or appropriate follow-up if complications exist;
- Family planning counseling and services for all pregnant women and mothers;
- HIV testing/counseling is offered; and
- Referrals to the Prenatal Program.

Healthchek Program

The Healthchek Program screens, for ages 0 to 21 years, are to provide comprehensive, preventive, well-child care on a regularly scheduled basis and to ensure entry into the health care system.

Healthchek Periodicity Schedule:

Birth or neonatal examination in the hospital:

1 month
2 months
4 months
6 months
9 months
12 months
15 months
18 months

Once per year for two through 21 year olds

The child may enter the periodicity schedule at any time. For example, if a child has an initial screening at age 4, then the next periodic screening is performed at age 5.

A member should have an initial screening within 90 days of entering the Plan, within 24 hours of birth or when the member has changed to a new PCP. The medical record must contain documentation of a comprehensive health history, in addition an unclothed physical examination to determine if the child's development is within the normal

range for the child's age and health history.

The following elements as appropriate for the child's age and health history should be addressed:

- Skin
- Head
- Eyes, ears, nose, mouth, throat, teeth, gums
- Nodes
- Height
- Weight
- Head circumference for infants 0 through 24 months
- Blood pressure beginning at 3 years and as indicated
- BMI
- Heart and femoral pulses
- Pulse and respiration
- Lungs
- Abdomen
- External genitalia
- Pelvic examination on all sexually active females and if not sexually active, may wish to consider beginning at age 18 (provider may wish to refer female recipients for this service)
- Hip abduction
- Gait
- Extremities
- Spine
- Neurological evaluation
- Nutrition
- Cardiovascular disease risk assessments and cholesterol screening from ages 2 through 21 years old
- Hearing and vision screening
- Sexually transmitted infections testing from age 11 through 21 years old
- Immunizations

There must be assessment of past medical history, developmental history and behavioral health status.

May include such information as: sibling history, growth history, conditions experienced by blood relatives, previous medications, immunizations or allergies or developmental history of the child or other family members.

There must be documentation that a developmental assessment was performed. The developmental assessment consists of a range of activities to determine whether the child's physical, cognitive and emotional developments are within the normal range for the child's age and cultural background.

The following elements as appropriate for age and cultural background should be considered:

- Gross motor development;
- Fine motor development;
- Communication skills or language development;
- Self-help and self-care skills;
- Social-emotional development; and
- Cognitive skills.

Through school age: Focus on visual motor integration, visual spatial organization, visual-sequential memory, attention skills, auditory processing skills and auditory sequential memory.

For adolescents: Focus on areas of special concern, such as potential learning disabilities, peer relations, psychological, psychiatric problems and vocational skills.

1. Vision screening: Vision status is assessed and the findings are documented in the medical record at each child health check-up.* This includes age appropriate testing to determine if the child's vision is within the normal range.

* *Document in the medical record if the child is uncooperative and re-screen at the next child health check-up or sooner if medically indicated.*

2. Dental screening is documented: Dental status is assessed and the findings are documented in the medical record. It is recommended that the provider refer children who are 6 months or older for an assessment by a dentist and document this referral in

the child's medical record.

3. Hearing screening: Hearing is assessed and the findings are documented in the medical record at each screen.*

* *Document in the medical record if the child is uncooperative and re-screen at the next Well-Child screen or sooner if medically indicated.*

4. Nutritional assessment: Nutritional status is assessed and the findings are documented in the medical record at each screen.

This includes height and weight (measured and plotted on standard chart), head circumference if 24 months or younger, dietary intake, eating habits, use of alcohol, drugs or tobacco

5. Lead Risk Assessment: All children are to be screened for lead poisoning. A Lead Risk Assessment is done at each screening between ages 6 months to 72 months and blood lead testing is performed as noted below. Recommended that providers use a verbal lead risk assessment to assess risk on children who are six months to six years of age. Federal regulation requires that all children receive a blood lead test screening at 12 months and 24 months of age, and for children between 36 and 84 months who have not been previously screened for lead poisoning.

6. Anemia screening: Hemoglobin and Hematocrit (H&H) recommended at the following ages with results documented in the child's medical record.

- 4,18,24 months (consider earlier for children at high risk)
- 3 years through 21 years old
- All menstruating adolescents should be screened annually
- When medically indicated

7. Annual Tuberculosis (TB) skin testing is done if the member is in a high-risk category. Only those children identified at high risk for TB disease should be recommended for testing. Results of tuberculosis

testing should be documented in the child's medical record.

8. Urinalysis: Urinalysis is recommended for children at age 5 and 16 and as indicated. Performing urine dipstick urinalysis for leukocytes is recommended annually for sexually active male and female adolescents.

9. Serum cholesterol screening: A serum cholesterol determination is recommended on children with a family history of familial hyperlipidemia.

10. Immunizations administered at required age parameters and intervals with dates documented. If the immunizations are not up to date according to age and health history, the provider should document why immunizations were not given at the time of the screen. "Catch up" on any shots that have been missed at an earlier age.

11. Health education: Health education, anticipatory guidance and counseling are provided to parent/guardian and child at each screen and documented in the child's medical record.

12. Family planning: Family planning services/counseling will be offered to appropriate members and documented in the medical records.

13. Diagnostic services: All members should be referred for further diagnostic and/or treatment services to correct or ameliorate defects and physical or mental illnesses and conditions discovered by the screens. Referral and follow-up may be made to the provider conducting the screening or another provider as appropriate.

Adult Health Screening

An adult health screening is performed by a physician to assess the health status of a member, age 21 or older. It is used to detect and prevent disease, disability and other health conditions or monitor their progressions. The adult member will receive an appropriate assessment and

intervention as indicated or upon request.

Adult Health Screening Periodicity Schedule

Recommended periodicity (one screening allowed every 365 days):

- After age of 19 through 39 , every one to three years;
 - Ages 40 through 64, every one to two years based on risk factors; and
 - Ages 65 and over, every year.
1. There is documentation of an initial health screening performed within 90 days of entering the Plan. If the member is seeing a new PCP there must be a screening within 90 days.
 2. There is a health history documented.
See required content in this section.
 3. There is documentation of a physical examination.
See required content in this section.
 4. There is documentation of a visual acuity testing. At a minimum, visual acuity testing must document a recipient's ability to see at 20 feet. Vision screening 65 years and older, periodically.
 5. There is documentation of a hearing screening. At a minimum, a hearing screen must document a member's ability to hear by air conduction.
 6. Tuberculosis (TB) skin testing is done if the member is in a high-risk category and the results are documented in the member's medical record.
 7. Annual influenza vaccination documentation for members 50 years of age or older or persons with pre-existing medical indications.

Medical indications: chronic disorders of the cardiovascular or pulmonary systems including asthma; chronic metabolic diseases including diabetes

mellitus, renal dysfunction, hemoglobinopathies, immunosuppression (including causes by medications or by HIV (human immunodeficiency virus), requiring regular medical follow-up or hospitalization during the preceding year; women who will be in the second or third trimester of pregnancy during the influenza season.

8. Pneumococcal vaccination is documented for members 65 years of age or older or for younger members with high-risk medical conditions.

Medical indications: chronic disorder of the pulmonary system (excluding asthma), cardiovascular diseases, diabetes mellitus, chronic liver diseases including liver disease as a result of alcohol abuse (e.g., cirrhosis), chronic renal failure or nephrotic syndrome, functional or anatomic asplenia (e.g., sickle cell disease or splenectomy), immunosuppressive conditions (e.g., congenital immunodeficiency, HIV infection, leukemia, lymphoma, multiple myeloma, Hodgkins disease, generalized malignancy, organ or bone marrow transplantation), chemotherapy with alkylating agents, anti-metabolites, or long-term systemic corticosteroids.

9. Screening for dyslipidemia is documented as indicated.

A complete fasting lipoprotein profile including major blood lipid fractions {total cholesterol, LDL, HDL and triglycerides}, should be obtained at least once every five years in adults ages 20 and over.

However, for persons with multiple (2+) risk factors, lipoprotein measurement is recommended as a guide to clinical management.

Major Risk Factors:

- Diabetes;
- History of coronary artery disease (CAD) or prior cardiac event;
- Cigarette smoking;
- Hypertension (BP greater than or equal to

140/90 mmHg or on antihypertensive medication);

- Low HDL cholesterol (less than 40 mg/dL); and
- Family history of premature coronary heart disease (CHD) (CHD in male first-degree relative less than 55 years; CHD in female first-degree relative less than 65 years) Age (men older than 45 years; women older than 55 years).

10. Colorectal cancer screening is documented.

Beginning at age 50, both men and women should follow one of these five testing schedules:

- Yearly fecal occult blood test (FOBT);
(The take-home multiple sample method should be used.)
- Flexible sigmoidoscopy every five years;
- Yearly fecal occult blood test plus flexible sigmoidoscopy every five years;
(The combination of FOBT and flexible sigmoidoscopy is preferred over either of these two tests alone.)
- Double-contrast barium enema every five years; and
- Colonoscopy every 10 years. All positive tests should be followed up with colonoscopy.

11. Urinalysis dipstick for blood, sugar and acetone.
Manual or automated dipstick urine.

12. Hemoglobin and Hematocrit (H&H) testing is done.

13. Mammogram is done as indicated.
Yearly mammograms starting at age 40 and continuing for as long as a woman is in good health. Clinical breast exams (CBE) should be part of a periodic health exam, about every three years for women in their 20s and 30s and every year for women 40 and older.

14. Pap test as appropriate.

- All women should begin cervical cancer screening about three years after they begin having vaginal intercourse, but no later than when they are 21 years old. Screening should be done every year with the regular Pap test. Beginning at age 30, women who have had three normal Pap test results in a row may get screened every 2 to 3 years. Women who have certain risk factors should continue to be screened annually.
- Women 70 years of age or older who have had three or more normal Pap tests in a row and no abnormal Pap test results in the last 10 years may choose to stop having cervical cancer screening. Women with a history of cervical cancer, diethylstilbestrol (DES) exposure before birth, HIV infection or a weakened immune system should continue to have annual screening as long as they are in good health.

**Diabetes
Specific
Screens**

Symptoms of diabetes and a casual plasma glucose greater than or equal to 200 mg/dL. Casual is defined as any time of day without regard to time since last meal. The classic symptoms of diabetes include polyuria, polydipsia and unexplained weight loss.

- Fasting Plasma Glucose of greater than or equal to 126 mg/dL. Fasting is defined as no caloric intake for eight hours;
- Two-hour Plasma Glucose greater than or equal to 200 mg/dL during OGTT (Oral Glucose Tolerance Test);
- On oral or parenteral medication or dietary restrictions to treat Diabetes Mellitus.

Medical Record Documentation:

1. There is evidence of attempt to control the disease process through pharmacological or dietary

intervention as indicated by an individualized management plan with routine diabetes visits scheduled quarterly for patients who are not meeting goals and semiannually for other patients.

2. There is evidence of comprehensive education in self-management of blood glucose, nutrition therapy, insulin or oral medication therapy regimens, prevention and treatment of hypoglycemia and exercise.
3. The member's HbA1c level is less than 7 percent. (Two to four times an annually base on individual therapeutic goals)
4. The member will receive Lipid Profile testing at least once per year with the results documented in the medical record. LDL less than 100 mg/dl; HDL greater than 40 (men); HDL greater than 50 (women).
5. A dilated eye examination (screen for retinopathy) was performed within the last year with the results documented in the medical record.
6. Urinalysis for microalbuminuria (screen for nephropathy) was performed within the last year with the results documented in the medical record.
7. A comprehensive foot exam (including microfilament testing) is performed at every office visit. Foot exam includes sensation, structure and biomechanics, vascular status and skin integrity.
8. Blood pressure management less than 130/80, any changes in treatment, patient counseling/education and follow-up instructions.

**Chronic
Pulmonary
Disease/Asthma**

The patient with chronic pulmonary disease will receive a timely evaluation and appropriate medical intervention as evidenced by the following:

1. On each visit the member will receive a complete respiratory assessment, which will include

auscultation of breath sounds, use of accessory muscles and respiratory rate.

2. The member's medication is monitored and evaluated.
3. There is evidence of attempt to control the member's disease process as evidenced by ongoing assessments beyond the acute phase of illness.
4. There is evidence of member education related to disease process and self-management.

For diagnosis of Asthma only:

There is evidence of management of the member's disease process through the use of long-acting therapies.

**Review
Criteria**

The criteria utilized for medical record standards and standards of care are not authored by the Plan. The criterion is based on regulatory requirements outlined in regulatory contracts, accreditation guidelines and accepted national organizations.

Reviews in a physician office may conclude with an Exit Review, to include the physician and designated office staff. The physician will be given the preliminary results of the review. Any area that is not compliant with regulatory standards will require a plan of correction.

**Corrective
Action Plan**

In the event a corrective action plan is not received in the stated time frame a second request will be sent to the physician.

References

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 4. Guide to Clinical Preventive Services, 2007 Report of the U.S. Preventive Services Task Force, 2007
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 5. Guidelines for Prenatal Care, American Academy of Pediatrics, The American College of Obstetricians and Gynecologists
 6. HEDIS® Guidelines
Web site: <http://www.ncqa.org>
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 8. Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC 7), August 2004 National Heart, Lung, and Blood Institute (NHLBI), National Institutes of Health, 2003. Web site:
<http://rover.nhlbi.nih.gov/guidelines/hypertension/index.htm>
 9. The National Asthma Education and Prevention Program (NAEPP), National Heart, Lung, and Blood Institute (NHLBI), National Institutes of Health, 2003
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Web site: <http://www.cdc.gov>
 11. QISMC Medical Record Review (Centers for Medicare and Medicaid Services)
 12. Managed Care Organization Policies and Procedures

13. National Committee on Quality Assurance. Standards for the Accreditation of Managed Care Organizations. Website: www.ncqa.org/communications/publications.