BlueCross BlueShield of Texas

Blue Essentials℠, Blue Advantage HMO℠, Blue Premier℠ and MyBlue Health℠ Provider Manual - Quality Improvement Program

Please Note

Throughout this Blue Cross and Blue Shield of Texas provider manual there will be instances when there are references unique to the **Blue Essentials, Blue Advantage HMO, Blue Premier** and **MyBlue Health.** These specific requirements will be noted with the plan/network name. If a plan/network name is not specifically listed or the "**Plan**" is referenced, the information will apply to **all** HMO products.

In this Section

The following topics are covered in this section:

Blue Essentials, Blue Advantage HMO, Blue Premier and MyBlue Health Provider Manual - Quality Improvement Program

In this Section, cont.

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Blue Essentials, Blue Advantage HMO, Blue Premier and MyBlue Health Provider Manual - Quality Improvement Program

Quality: A Key Concept with the BCBSTX Networks

Quality improvement is an essential element in the delivery of care and services by **Plan** participating health care providers. To define and assist in monitoring quality improvement, the Blue Cross and Blue Shield of Texas **Plan's** Quality Improvement Program focuses on measurement of clinical care and service delivered by **Plan** participating health care providers against established goals.

Information regarding the Quality Improvement Program documents is available by contacting the QIP Department:

800-863-9798

Objective Goals of the Quality Improvement Program

The **Plan** Quality Improvement Program is an integrated process designed to continually monitor, evaluate, and improve the care and service provided to the **Plan** member.

The **Plan** Quality Improvement Program objectives are designed to assist in meeting **Plan** goals.

Following are the objective's goals:

- Facilitate the achievement of public health goals for disease prevention, wellness and safety
- Identify opportunities to improve the outcomes of medical and behavioral health care and service available to the **Plan** member
- Analyze the existence of health care disparities in clinical areas, including behavioral health and supported by pharmacy and lab data, in order to reduce health disparities and achieve health equity
- Assess the cultural, ethnic, racial and linguistic needs of member to deliver culturally competent services
- Monitor and support the needs of members who have disabilities, to help improve their access to health care
- Use the practitioner and provider chart reviews and interviews to understand the differences in care provided and outcomes achieved
- Conduct patient-focused interventions with culturally competent outreach materials that focus on race/ethnicity/language specific risks

Objectives of the Quality Improve-ment Program, cont.

- Conduct patient-focused culturally competent outreach materials that focus on race, ethnicity and language needs
- To implement a standardized and comprehensive QI Program which will address and be responsive to the health needs of the member population, inclusive of serving the culturally and linguistically diverse membership
- Assess network adequacy and develop networks to meet the needs of the underserved populations
- To develop a comprehensive, meaningful and soundly executed Population Health Management strategy
- Provide staff with training, information and tools that help identify cultural and linguistic barriers and support culturally competent communications
- Develop, implement, and monitor action plans to improve medical and behavioral health care as well as services for the **Plan**
- Provide communication to **Plan** practitioners and providers on issues of medical care to promote improvements in the health status of members and satisfaction with **Plan**
- Develop and distribute information to members that improve knowledge regarding clinical safety, general wellness and disease prevention as it relates to self-care
- Identify opportunities to improve the outcomes, promote delivery and effective management for populations with complex health needs, which may include the following conditions: physical or developmental disabilities, multiple chronic conditions, serious mental illness, organ transplants, HIV/AIDS, progressive degenerative disorders, metastatic cancers and severe behavioral health conditions
- Monitor and ensure compliance with State and Federal regulatory requirements and accreditation standards

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Quality Initiatives

The Plans conduct interventions/initiatives which are designed to improve the overall health of **Plan** members. Examples include:

- Preventive Care/Wellness Guidelines

- Clinical Practice Guidelines

- Product Solution Group Communications: Holistic Health Coordinators provide the member with resources and guidance that meets their needs. The goal is to empower the member to be an active participant in follow-up visits, to follow-up on any additional medical appointments, and to educate members so that they are able to self-manage their own care. Web-based Management automated communications include standard, chronic and preventive messages:
  - Standard Messages: Designed to engage and inform members about programs that help them make the most of their health care dollars. These are sent to all subscribers and spouses.
  - Targeted Chronic Condition Messages: Automated monthly reminders help members stay on track with appointments, tests and medications for chronic conditions. These are sent to the individual.
  - Age and Gender-based Preventive Messages: Automated monthly reminders help members stay on track with preventive services, tests and appointments. These are sent to the individual.

- Birthday reminder card for men 50 years of age and older to encourage preventive screenings such as prostate screenings, cholesterol screening, and colon cancer screening

- Birthday reminder card for women 40 years of age and older to encourage preventive screenings such as clinical breast examination, Pap test, mammogram, cholesterol screening and colon cancer screening

- Targeted outreach to encourage members to receive breast, cervical and colorectal cancer screening as well as other preventive care initiatives as opportunities are identified

- Childhood immunization reminders at 4 and 14 months of age to encourage compliance with the childhood immunization schedule and well-child visits

Quality Initiatives, cont

- BCBSTX website, which provides information related to health and wellness (bcbstx.com/provider).

- Create quality improvement tip sheets to help you satisfy Healthcare Effectiveness Data and Information Set (HEDIS®) measures. These measures from the National Committee for Quality Assurance help ensure our members receive appropriate care. View the HEDIS Tip Sheets on the provider website.

For additional information about the above mentioned interventions or to request samples, please contact the **Plan** Quality Improvement Program Department:

800-863-9798

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Support Provided to the Quality Improve-ment Program

The Quality Improvement Program is supported by the Quality Improvement Department, Medical Directors, Texas Medical Advisory Committee, Texas Peer Review Committee, Network Management Representatives, Office of Physician Advocacy and on-site Physician Office Review nurses.

Medical Director Involvement

- Facilitates communication of quality improvement activities with participating **Plan** health care providers
- Serves as a liaison between **BCBSTX** and participating **Plan** health care providers
- Chairs the Texas Medical Advisory Committee and the Texas Peer Review Committee to facilitate initiatives, including credentialing and review of quality of care issues
- Participates in the Quality Improvement Committee, which supports the development and periodic review of policies, procedures, practice guidelines, clinical criteria, QI outcomes study and initiatives utilized in the **Plan** Quality Improvement Program

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Quality Improvement Committee

The **Plan** Clinical Quality Improvement Committee establishes priorities for the QI Program, evaluates the clinical and operational quality and integrates quality improvement activities among all **Plan** departments. The CQIC monitors QI activities for consistency with **Plan**-wide goals and business objectives. The CQIC provides comprehensive reports on QI program activities to the Enterprise Quality Improvement Oversight Committee at least twice a year annually.

The responsibilities of the committee include but are not limited to the following:

- Centralize and coordinate the integration of all quality improvement activities
- Provides guidance on quality management priorities and projects; approves the quality projects to undertake, and monitoring progress in meeting goals
- Adopt clinical practice guidelines, general standards of care, clinical review criteria and policies of medical practice based on current medical evidence, the demographics of BCBSTX and other local/regional factors
- Analyze and evaluate summary data from quality improvement activities and make recommendations for improvement utilizing:
  - quality measurement studies
  - quality improvement projects
  - quality of care and service data including access to services
  - member, physician and provider satisfaction surveys
  - physician office review
  - complaint and appeal review
  - pharmacy programs review
  - utilization and case management review
  - condition and lifestyle management
  - administrative services
- Recommend policy decisions
- Identifies needed actions
- Ensure follow-up, as appropriate
- Review and approve the annual QI Program Evaluation
- Work plan and updates to the QI Program Description.

Quality Improvement Committee, cont.

- Monitor QI activities of all contractors to which **Plan** delegates quality improvement, utilization management, case management, condition management, credentialing, physician office review, claims processing or customer member services activities.
- Review, approve/deny, and recommend actions and communications to delegates when a delegate is determined to be non-compliant with BCBSTX performance requirements, regulatory, certification or accreditation requirements and standards.
- Provide an annual QI Program Evaluation and regular reports to the Enterprise Quality Improvement Oversight Committee.
- Review outcome measurements and improvement results.
- Ensure that the implementation of action plans has received the support of management.
- Reassess activities continuously to determine whether optimal results have been achieved and are sustained. Review results from population-based studies to assess patterns/trends derived from statistical data, which identify opportunities for improvement.
- Review and approve any recommendations/action plans provided by the sub-committees.
- Provide coordination and monitoring of the Medical Management Programs including review and approval of the Medical Management Program Description, goals and objectives, clinical review criteria, quality management projects, performance measures, annual Program Evaluation and program impact.

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Texas Medical Advisory Committee and Texas Peer Review Committee

The Texas Medical Advisory Committee and the Texas Peer Review Committee serves in an advisory capacity to the BCBSTX Medical Director responsible for peer review of credentialing and recredentialing (TMAC/ TPRC Chair) and the **Plan** regarding health care delivery issues that affect members and network physicians and health care professional/practitioners. Additionally, the TMAC and TPRC participants in the development, implementation and evaluation of required peer review activities to include credentialing and recredentialing activities designed to evaluate the credentials of a physician or other health care professional/practitioner (e.g., physical therapist, speech therapist, occupational therapist, etc.) for participation in **Plan** network(s). The TMAC/TPRC serves a peer review function by evaluating the clinical health care services delivered by participating physicians and health care professional/practitioners. The responsibilities include but are not limited to the following:

- Review and act upon completed credentialing files of applicants that have been recommended for participation
- Make recommendations regarding continued physician or health care professional/practitioner.
- Access, monitor and evaluate utilization, quality of care and service issues related to specific physicians or health care professional/ practitioners
- Recommend corrective action plans when opportunities to improve care or service are identified for specific physicians or health care professional/practitioners
- Review appeals from physicians and other health care practitioners of adverse credentialing/recredentialing determinations by TMAC and TPRC.
- Recommend one of the following actions for each applicant:
  - approve for participation
  - defer the decision, pending receipt of additional information
  - deny for participation for not meeting credentialing criteria

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Network Management Representative Involvement

- Facilitate adequate access for members to a full continuum of appropriately credentialed health care providers
- Coordinate the health care provider's recruitment, servicing and credentialing activities
- Communicate policies, procedures and guidelines established by **Plan** to participating health care providers and disseminate information regarding the results of Quality Improvement Program activities

On-Site Physician Office Review (POR) Nurses

The POR nurses conduct site reviews to determine if office sites meet accepted standards and to assess medical recordkeeping practices. They also perform medical record review to assess documentation and collect data for QI studies.

Responsibilities of the Quality Improvement Programs Department

The Quality Improvement Programs Department responsibilities include, but are not limited to the following:

- Initiate quality of care complaint investigation and resolution
- Perform HEDIS data collection analysis and interventions
- Develop and maintain QI studies/interventions for clinical and service issues
- Perform analysis and develop interventions related to covered person/ physician and professional provider satisfaction
- Maintain compliance with state, federal and other regulatory requirements through periodic assessment.

Responsibilities of Providers

Practitioners/providers will cooperate with BCBSTX QI activities, to improve the quality of care and services and the member experience including:

- Allowing the organization to use their performance data.
- Communicating patient’s treatment regardless of benefit coverage limitations.

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Patient Appointment Access Standards

The **Plans** have established the following patient appointment access standards (business days unless otherwise noted):

Access Measure	Standard	Performance Goal
Initial New Patient Visit	Within 30 days of request	90% of physicians evaluated meet or exceed the standard
Preventive Care Primary Care Provider (PCP) only (annual physical)	Within 30 days of request	90% of physicians evaluated meet or exceed the standard
Routine Primary Care	Within 15 days of request	90% of physicians evaluated meet or exceed the standard
Urgent Care	Within 24 hours of request	90% of physicians evaluated meet or exceed the standard
Emergency Care ➢ During Office Hours ➢ After Office Hours	Immediate exceed the standard	90% of physicians evaluated meet or
After Hours Care ➢ Urgent care ➢ Alternative Care	24 hours per day, 7 days per week	90% of physicians evaluated meet or exceed the standard
In Office Wait Time	Within 30 minutes of appointment time	90% of physicians evaluated meet or exceed the standard
High Impact or High Volume Specialists ➢ Urgent care ➢ Routine care (Non-urgent)	Within 5 days of request Within 30 days of request	90% of physicians evaluated meet or exceed the standard

Patient Appointment Access Standards Definitions

- **Initial New Patient Visit:** A “get acquainted” visit with primary care provider or initial specialty care provider or professional provider visit for non-urgent.
- **Preventive Care:** A preventive health evaluation, without medical symptoms, which may include recommended health screenings such as well-woman exams and well-child exams.
- **Routine Care:** Symptomatic non-routine medical care provided to treat symptoms which are non-life or limb threatening and may include, but are not limited to, intermittent headache, fatigue, colds, minor injuries and joint/muscle pain.

Patient Appointment Access Standards - Access Standard Definitions

- **Urgent Care:** Medical care provided to treat symptoms that are non-life threatening, but which, if left untreated, within 24 hours could lead to a potentially harmful outcome such as acute abdominal pain.

- **Emergency Care:** Health care services provided in a hospital emergency facility or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity that would lead a prudent layperson possessing an average knowledge of medicine and health to believe his or her condition is of such a nature that failure to get immediate medical care could result in:

  — placing the patient's health in serious jeopardy
  — serious impairment to bodily functions
  — serious dysfunction of any bodily organ or part
  — serious disfigurement or
  — in the case of a pregnant woman, serious jeopardy to the health of the fetus.

- **After Hours Care/Access:** PCPs and SCPs will have a verifiable mechanism in place, for immediate response, for directing patients to alternative after hours care based on the urgency of the patient's need. Acceptable Mechanisms may include: an answering service that offers to call or page the physician or on-call physician; a recorded message that directs the patient to call the answering service and the phone number is provided; or a recorded message that directs the patient to call or page the physician or on-call physician and the phone number is provided.
- **In-Office Wait Time:** The average number of minutes the member must wait from the scheduled appointment time until the time the member is actually seen by the physician or professional provider.
- **High Volume Specialists:** Practitioner types as determined by annual high volume report are comprised of, **but not limited to**, the following:
  - Obstetrics/Gynecology
  - Cardiovascular Disease
  - Orthopedic Surgery
  - Psychiatry
  - Psychology
  - Licensed Professional Counselors
  - Licensed Marriage and Family Therapist
  - Licensed Medical Social Workers-Advanced Clinical Practice

Patient Appointment Access Standards- **Access Standard Definitions** cont.

- **High Impact Specialists**: Practitioner types that treat conditions that have high mortality and morbidity rates or practitioner types where treatment requires significant resources comprised of, but not limited to, the following:
  - Neurology
  - Oncology
- **Performance Goals:** The performance goals are monitored through the Physician Office Review (POR) program, member satisfaction surveys, complaints and focused audits.

Physician Office Review Program

The **Plan** recognize physicians as participants in the health care improvement process. One of the main objectives of the Quality Improvement Program is to provide physicians with meaningful and constructive data to improve their practice patterns as necessary.

Evaluating the care provided in the physician's office focuses on documentation of clinical care, as well as the assessment of the physical structure and medical recordkeeping practice. The following are evaluated during the Physician Office Review:

- Safety and environment
- Medical recordkeeping practices
- Laboratory services
- Radiology services

A sample of the Physician Office Review Site Visit form is located further in this section and can be copied for your use.

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Goals of the Office Review Program

- Use objective guidelines to monitor the structural and medical recordkeeping practices in the physician's office
- Provide a practical approach for evaluating and improving the documentation of the care delivered in the office setting
- Involve physicians in the improvement process by offering appropriate feedback
- Utilize the results of the program in the ongoing managed care contract renewal process

Safety and Environment Component

The primary objective is to assist in ensuring that patient care is accessible, provided in a safe and hazard-free environment and that the office site provides comfort and privacy for the patient. A physician's staff is expected to maintain office procedures that safeguard against such risks as exposure to infectious disease, theft, abuse or accidental use of drugs and faulty or contaminated patient care equipment.

Laboratory Services Component

The primary issue concerning the provision of lab services is the accuracy of test results, which can be affected by such factors as training of personnel, equipment maintenance and calibration and expiration date of testing reagents.

The Clinical Laboratory Improvement Amendment requires that all laboratories be certified by the Department of Health and Human Services as meeting minimum performance specifications. Evidence of CLIA certification is required to meet **Plan** review criteria as well as the state of Texas requirements.

Radiology Services Component

Issues associated with radiology services include calibration and maintenance of equipment, exposure to radiation, film quality and staff training. The state of Texas requires inspection of radiology equipment every three years and documentation of the training for operation of the equipment. The physician is required to register the equipment with the state, which grants a certificate of registration. Following each inspection, a letter of compliance is issued.

This review is limited to the radiology services component.

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Medical Recordkeeping Practice Component	The organization and adequacy of medical recordkeeping are assessed in order to assure patient confidentiality and consistency of documentation practices. One (1) to five (5) medical records are evaluated at each office site of potential network primary care physicians and OB/GYNs.
Medical Record Documentation Component	The medical record serves as a primary source for evaluating the appropriateness and cost-effectiveness of care, in addition to serving as important evidence in the event of litigation. The medical record documentation review consists of reviewing one (1) to five (5) medical records at each office site during focused medical record review.
Performance Goals	The expected performance goals for the review are 85% for medical recordkeeping practice; 85% for medical record documentation; 90% for safety and environment, and 90% for laboratory and radiology, if applicable.
Frequency of the Office Review	The Physician Office Review Program includes a review of all office facilities of all PCP and OBGyns who initially contract with the **Plan**. If a physician fails to meet the established goals, a corrective action plan may be requested. A rereview is conducted in six months from the date of the CAP or at the discretion of the Medical Director. If a practitioner fails to meet the compliance goal on the reaudit, the results are reported to the Texas Peer Review Committee for recommendations. An ad hoc review may be conducted if there is an indication that a potential quality of care concern exists. A high number of member complaints, a high rate of member turnover or utilization outlier status are examples of such concerns.

Feedback to Physicians on the Office Review

The Physician Office Review Program is designed to foster continuous quality improvement. The reviewer will conduct an exit interview with the physician or designated staff immediately following the review and if any deficiencies are identified they are reviewed at this time. Copy(s) of the Physician Office Review Summary forms are left with office staff upon completion of the Physician Office Review.

The Medical Director evaluates any significant issues and recommends action, if necessary. A copy of the review and all associated correspondence is maintained in the physician's file for consideration by the Medical Advisory Committees at the time of recredentialing.

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Sample Physician Office Review Worksheet

BLUE CROSS BLUE SHIELD OF TEXAS
PHYSICIAN OFFICE REVIEW ACCESS/SITE VISIT/MEDICAL RECORD REVIEW CRITERIA

Physician:_____ Prov. ID_____ Date of review:_____

Address:_____ City:_____

Survey ID: _____ HMO PPO/POS MCA MCAID BAV Type: QM I F Q

ACCESS

Average number of weekly encounters _____
Average number of complete physical exams per week _____
Average in office wait time within 30 minutes _____ Y N NA
Initial new patient visit within 30 days _____ Y N NA
Preventive care within 30 days _____ Y N NA
Symptomatic non-urgent care within 15 days _____ Y N
Urgent care within 24 hours _____ Y N
Emergency triage during office hours Y N
After hours: Urgent care/emergency/crisis Y N
After hours: Method of directing patients to alternative care Y N
TDI complaint process/phone # prominently displayed Y N NA

ADEQUACY OF FACILITY

Clearly marked office sign Y N
Facility accessible to persons with disabilities Y N
Fire alarms/sprinklers Y N
Fire extinguishers visible and accessible Y N
CPR certified staff available Y N
Mechanism for informing patient of office hours Y N
Exam rooms designed to assure patient privacy Y N
Exam rooms equipped with supplies Y N
Biohazard disposal Y N NA
Sharps containers Y N NA
Equipment/instruments sterilized/disposable Y N

WRITTEN POLICIES

Triage of patient emergencies Y N
Emergency drugs/equipment Y N NA
OSHA guidelines Y N
Duties of physician assistants/nurse practitioners Y N NA
Patient obtains written information regarding Non-Physician Practitioner Y N NA

MEDICATION ADMINISTRATION

Drugs/Rx pads/needles accessible only to medical personnel Y N NA
Procedure for control of narcotics Y N NA
Pre-drawn injections properly labeled Y N NA
Expiration dates checked Y N NA
Refrigerator maintained at 36°F to 46°F (2°C to 8° C) Y N NA
Freezer maintained at -58°F to +5°F (-50°C to -15°C) Y N NA

ON-SITE RADIOLOGY SERVICES

Certificate of registration with Bureau of Radiation Control Y N
BRC #_____
BRC Expiration Date: _____
BRC compliance letter or written proof of on-site Y N NA
BRC inspection within past three years Y N NA

ON-SITE LAB SERVICES

Area clean Y N
Area organized Y N
Area separate from patient areas Y N
CLIA certificate # _____ Y N
CLIA Expiration Date _____

MEDICAL RECORDKEEPING PRACTICE

Number of Charts Reviewed_____
Patient notification of lab and test results 1 2 3 4 5
Problem list 1 2 3 4 5
Immunizations/vaccines 1 2 3 4 5
Current therapies/medication list 1 2 3 4 5
Treatment plan in chart each visit 1 2 3 4 5
Blood pressure documented 1 2 3 4 5
BMI documented yearly (24 months -17 years) 1 2 3 4 5
BMI documented every 1- 3 years (18 - 65+ years) 1 2 3 4 5
Entries legible 1 2 3 4 5
Appropriate preventive health screenings 1 2 3 4 5
Consultation/lab/x-ray record in the chart 1 2 3 4 5
Consultation/lab/x-rays addressed 1 2 3 4 5
Patient education (diagnosis specific) 1 2 3 4 5
Continuity and Coordination of Care (COC) 1 2 3 4 5
Advance Directives (Medicare Only) 1 2 3 4 5

MEDICAL RECORDS

Medical records are available during office hours Y N
Records are protected from public access/inadvertent exposure Y N
Medical records are individualized by patient name/ID Y N
Medical records are secured and organized Y N
Mechanism for notifying patient of lab/test results Y N

OFFICE SIGNATURE	DATE	REVIEWER SIGNATURE	DATE

ISSUE:	ACTION NEEDED:	Completed

COMMENTS/Education:

OFFICE Initials:_____

REVIEWER Initials:_____

CORRECTIVE ACTION PLAN REQUIRED: Y N

CAP NEEDED FOR (*circle applicable areas*): Due Date: _____

Access, Site, Lab, XRay, Medical Record Review

Reference Sources: Other references available upon request
BCBS: Blue Cross Blue Shield CQIC Policy
NCQA: National Committee for Quality Assurance
OSHA: Occupational Safety and Health Association
TDI: Texas Department of Insurance
TDH: Texas Department of Health
TX HHSC UMCM: Texas HHSC UM/CM

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Principles of Medical Record Documentation Introduction

The following *Principles of Medical Record Documentation* were developed jointly by representatives of the American Health Information Management Association, the American Hospital Association, the American Managed Care and Review Association, the American Medical Association, the American Medical Peer Review Association, the Blue Cross and Blue Shield Association and the Health Insurance Association of America. Although their joint development is not intended to imply either endorsement of or opposition to specific documentation requirements, all seven groups share the belief that the fundamental reason for maintaining an adequate medical record should be its contribution to the high quality of medical care.

What is Documentation and Why is it Important?

BCBSTX requires medical records to be maintained in a manner that is current, detailed and organized, and which permits effective and confidential patient care and quality review.

How does the Documentation in Your Medical Record Measure Up?

1. Is the reason for the patient encounter documented in the medical record?
2. Are all services that were provided documented?
3. Does the medical record clearly explain why support services, procedures and supplies were provided?
4. Is the assessment of the patient's condition apparent in the medical record?
5. Does the medical record contain information on the patient's progress and on the results of treatment?
6. Does the medical record include the patient's plan for care?
7. Does the information in the medical record, describing the patient's condition, provide a reasonable medical rationale for the services and the choice of setting that are to be billed?
8. Does the information in the medical record support the care given in the case where another Provider must assume care or perform medical review?
9. Does the information in the medical record include communication between providers?

Principles of Documentation

1. The medical record should be complete and legible.
2. The documentation of each patient encounter should include: the date; the reason for the encounter; appropriate history and physical exam; review the of lab, X-ray data and other appropriate ancillary services; assessment; and plan for care (including discharge plan, if appropriate).
3. Past and present diagnoses should be accessible to the treating and/or consulting Physician.
4. The reasons for and results of X-rays, lab tests and other ancillary services should be documented or included in the medical record.
5. Relevant health risk factors should be identified.
6. The patient's progress, including response to treatment, change in treatment, change in diagnosis and patient non-compliance, should be documented.
7. The written plan for care should include when appropriate: treatments and medications specifying frequency and dosage; any referrals and consultations; patient/family education; and specific instructions for follow-up.
8. The documentation should support the intensity of the patient evaluation and/or the treatment, including thought processes and the complexity of medical decision-making.
9. All entries to the medical record should be dated and authenticated.
10. The CPT/ICD-10 codes reported on the health insurance claim form or billing statement should reflect the documentation in the medical record.

Such documentation is expected in all medical records, to include electronic medical records, of all member for whom the provider is billing for services.

Principles of Medical Record Documentation

SAMPLE MEDICAL RECORDKEEPING DOCUMENTATION Worksheet

This worksheet to be used for RN Initial/Ad hoc/Reviews/QI Reviews of Primary Care Physicians (PCPs) and Specialty Care Physicians

RECORD #						MET CRITERIA	CHARTS REVIEWED	PERCENT COMPLIANCE
DEMOGRAPHICS								
PAST MEDICAL HISTORY								
PROBLEM LIST								
IMMUNIZATIONS/VACCINES								
ALLERGIES & ADVERSE REACTIONS **PROMINENTLY DISPLAYED**								
ALL PAGES CONTAIN PATIENT ID								
CURRENT THERAPIES/MEDICATION LIST								
CHIEF COMPLAINT each visit								
PERTINENT PHYSICAL EXAM each visit								
DIAGNOSIS IN CHART each visit								
TREATMENT PLAN IN CHART each visit								
HEIGHT DOCUMENTED								
WEIGHT DOCUMENTED								
BLOOD PRESSURE DOCUMENTED								
BMI DOCUMENTED EVERY YEAR (2 – 17 years old)								
BMI DOCUMENTED EVERY 1-3 YEARS (18 -65+ years old)								
ENTRIES LEGIBLE								
ENTIES DATED								
ENTRIES AUTHOR INITIALED								
APPROPRIATE PREVENTIVE HEALTH SCREENINGS								
CONSULTATION/LAB/X-RAY RECORD IN CHART								
CONSULTATION/LAB/X-RAYS ADDRESSED								
UNRESOLVED PROBLEM(S) FROM PREVIOUS VISIT(S) ADDRESSED								
PATIENT EDUCATION (Diagnosis specific)								
CONTINUITY AND COORDINATION OF CARE								
EVIDENCE OF APPROPRIATE COORDINATION OF HOME HEALTH CARE								
EVIDENCE OF APPROPRIATE COORDINATION OF SNF								
EVIDENCE OF APPROPRIATE COORDINATION OF INPATIENT CARE								
EVIDENCE OF APPROPRIATE COORDINATION OF AMBULATORY SURGERY								
TOTALS:								

LEGEND:

CRITERIA MET
CRITERIA NOT MET
X CRITERIA NOT APPLICABLE

Medical Record/Health Management Documentation Review Worksheet Scoring Instructions:

Total "Yes" responses across each row; enter total in Met Criteria column
Total "Yes" and "No" responses across each row; enter total in Charts Reviewed column
Divide criteria met by charts reviewed and multiply by 100; enter the score in Percent Compliance Column Divide Met Criteria total by Charts Reviewed total and multiply by 100; enter score in Percent Compliance column in the Totals row.

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Frequently Asked Questions About On-Site Office Reviews

Why Do the Plans Need to Do Office Reviews?	The **Plans** have a responsibility to our members to help ensure that their care is provided in a safe, professional environment and that medical records are maintained in such a way as to be confidential and secure and to document the care provided.
Are We Obligated to Allow This Review?	Yes, according to the contract the physician signed, the **Plans** will have access, at reasonable hours and times, to the treatment and billing records of members in order to verify claims information, and to review other records necessary for verifying compliance with the terms of the agreement, i.e., practice standards for quality and utilization.
How Long Will the Review Take?	The office and medical record review will take approximately one to one and a half hours. If lab and/or X-ray services are provided, the review will take longer.
What Do We Have to Do To Be Ready?	Provide five **Plan** member medical records, or a mock record or template, as requested in the confirmation letter provided before the review date. Have one person from the office available to tour the office with the reviewer and to be available for information, if needed.
What Happens If We Get a Bad Review	If deficiencies are found, a corrective action plan may be requested and a reaudit may be conducted within six months.

Frequently Asked Questions About On-Site Office Reviews, cont.

Will the Results Be Kept Confidential?

Yes, all results will be kept confidential from other physicians.

We are required by applicable federal and state law to maintain the privacy of certain of our records. The **Plans** have policies and procedures in place specific to confidentiality of provider information to the extent required by law. Information that is gathered during the course of physician office reviews is kept confidential according to applicable policy. Peer review information is protected under the Texas peer review statutes and may not be released except in accordance with Blue Cross and Blue Shield of Texas, **Plan** peer review policy and procedure, or upon advice of legal counsel. Results of the on-site review will be included in the provider's confidential credentialing file.

When Will the Review Be Scheduled?

The on-site review will be scheduled at a mutually convenient time for your office manager and On-Site Review Specialist.

Does the Doctor Need to be Available

No, the physician can schedule patients routinely; however, one office person should be available to accompany the reviewer on a tour of the office and be available for questions.