

MEDICAL RECORD KEEPING PRACTICES

PURPOSE:

Ensure that practitioners in the CHP network meet or exceed established standards for medical record documentation.

POLICY:

CHP will evaluate compliance with established medical record standards.

PROCEDURES:

CHP's medical record standards are reviewed and re-approved by the Quality Improvement Committee on at least an annual basis.

Record keeping standards for Primary Care Physicians and Behavioral Health Practitioners are printed annually in the practitioner newsletter, *Network News*. They are posted on the CHP Staff Practice Intranet and on *CHPConnect* for all practitioners.

CHP has established a performance goal of 90% for medical record keeping practice reviews. Office practices that obtain a score less than 90% are required to submit an improvement plan, and a follow-up medical record review is conducted within six months. Improvement plans are monitored and reported to the Credentials Committee.

Medical Record Review:

A medical record review is conducted on an annual basis during the HEDIS review for PCPs with patients included in the HEDIS samples. The office policies for medical record practices are reviewed, and one chart per physician is evaluated for compliance with standards. If the representative medical record does not meet criteria for any standard, four additional records are reviewed for all standards. If the medical record review is scored at 90% or less, the results are communicated to Credentialing for follow-up on corrective actions.

A medical record review is conducted for at least high volume behavioral health practitioners¹ every three years. The office policies for medical record practices are reviewed, and five charts per practitioner are evaluated for compliance with standards. If the overall medical record review is scored at 90% or less, the results are communicated to Credentialing for follow-up on corrective actions.

Deficiencies in medical record practices may also be identified through sources such as member complaints, member satisfaction data etc. These improvement opportunities are communicated to Credentialing for follow-up on corrective actions.

¹ High volume is defined as >500 patient contacts annually.

Follow-up Medical Record Reviews:

If the need for a follow-up review is identified, it is conducted no later than six months following the identification of the deficiency.

During a follow-up review, the office policies for medical record practices are reviewed, and five charts per practitioner are evaluated for compliance with standards. The charts that are reviewed are randomly selected from patient visits completed 4-8 weeks prior to the review.

If the follow-up review is scored at less than 90% the practitioner is notified of the results, the need to develop an improvement plan, and the scheduling of an additional follow-up review.

After the completion of the follow-up review, the results are discussed at the next regularly scheduled Credentials Committee meeting. The committee will recommend any additional corrective actions or follow-up reviews that need to be conducted before the practitioner's next re-credentialing date.

Results of follow-up visits, corrective action plans, and the current status of the practitioner's medical record practices are incorporated into the Credentials Committee's decision to re-credential the practitioner at the next scheduled date.

Attachments:

- Medical Record Standards, Primary Care Physicians (PCPs)
- Ongoing Monitor Data Collection Tool, PCPs
- Medical Record Standards, Behavioral Health (BH) Practitioners
- Ongoing Monitor Data Collection Tool, BH Practitioners

NCQA Standards 2008: QI 12, CR 6

Approved QIC 2/93, 3/94, 4/95, 1/96, 10/96, 11/97, 10/98, 9/99, 10/00, 4/01, 3/26/02, 4/22/03, 5/25/04, 8/24/04, 4/5/05, 6/13/06, 4/10/07, 2/12/08

MEDICAL RECORD STANDARDS

Primary Care Physicians

1. An adequate confidentiality policy is in place and procedures have been implemented within the physician practice.
2. Each employee in the practice signs a confidentiality statement, and receives periodic training in confidentiality of member information.
3. The practice obtains written permission from patients before releasing medical information outside of that needed for treatment, payment, or operations.
4. Medical records are stored in a secure manner that allows access by authorized personnel only.
5. A medical record is maintained for each patient, and is always available at the time of a patient visit.
6. The practice obtains documentation of advance directives for appropriate patients (including all Medicare members).
7. Medical record is complete, and is organized so that care can be monitored effectively (e.g. pages are secured in chart, in time sequence, and/or with dividers to direct to certain types of documentation, reports).
8. Medical record documentation contains appropriate patient demographic information (i.e., name, address, phone numbers, ID number).
9. Documentation is legible to someone other than the writer.
10. There is a progress note documented for each patient visit. Entries in the progress notes contain date and author's identification (typed name, handwritten or stamped signature or initials, unique computerized identifier).
11. General allergies, medication allergies, and adverse reactions/events are documented; if none, this is documented.
12. The physician documents risk screening and preventive services.
13. The physician documents significant illnesses, medical and psychological conditions in the medical record (an up-to-date problem list would suffice).
14. The patient's presenting complaints, physical exam, diagnoses, and treatment plans are documented for each patient encounter in the medical record.
15. The record documents possible risk factors for the member relevant to the particular treatment recommended.
16. Prescribed medications, including dosage and dates of initial or refill prescriptions are documented.
17. The documentation identifies all practitioners and providers involved in the member's care; the medical record includes documentation of all diagnostic and therapeutic services (including specialty practitioners, home health, physical therapy and hospital care).
18. Documentation of advance directives is placed in a prominent part of the medical record. Medical records contain documentation on whether or not members have executed an advance directive.
19. If the practice utilizes a physician assistant (PA), the physician co-signs all progress notes written by the PA within 30 days.

MEDICAL RECORD KEEPING PRACTICES - Primary Care Physicians

Policies	YES	NO	COMMENTS
1. An adequate confidentiality policy is in place and procedures have been implemented within the physician practice.			
2. Each employee in the practice signs a confidentiality statement , and receives periodic training in confidentiality of member information.			
3. The practice obtains written permission from patients before releasing medical information outside of that needed for treatment, payment, or operations.			
4. A medical record is maintained for each patient, and is always available at the time of a patient visit.			
5. Medical records stored in a secure manner that allows access by authorized personnel only.			
6. The practice obtains documentation of advance directives for appropriate patients, including all Medicare members.			

Review 1 record. If deficiency is found, review 4 additional records for all standards. CHP ID #:	Chart #1	Chart #2	Chart #3	Chart #4	Chart #5
7. Medical record is complete , and is organized so that care can be monitored effectively (e.g., pages are secured in chart, in time sequence , and/or with dividers to direct to certain types of documentation, reports).					
8. General allergies , medication allergies, and adverse reactions/events are documented; if none, this is documented.					
9. If the practice utilizes a PA , the physician co-signs all progress notes written by the PA within 30 days.					
10. Medical record documentation contains appropriate patient demographic information (i.e., name, address, phone #, ID number)					
11. Documentation is legible to someone other than the writer.					
12. There is a progress note documented for each patient visit. Entries in the progress notes contain date and author's identification (typed name, handwritten or stamped signature or initials, unique computerized identifier).					
13. The physician documents risk screening and preventive services .					
14. The physician documents significant illnesses, medical and psychological conditions in the medical record (an up-to-date problem list would suffice).					
15. Patient's presenting complaints , physical exam, diagnosis and treatment plans are documented for each patient encounter in the record. (SOAP)					
16. Record documents possible risk factors for the member relevant to the particular treatment recommended.					
17. Prescribed medications , including dosage and dates of initial or refill prescriptions are documented.					
18. Documentation identifies all practitioners and providers participating in care; record contains documentation of all diagnostic/therapeutic services provided.					
19. Documentation of advance directives is placed in a prominent part of the medical record. Medical records contain documentation on whether or not members have executed an advance directive.					

 CHP Reviewer's Signature

 Date

QIC 2/08

Score: _____ Standards met _____ Standards applicable _____ % Total Score



MEDICAL RECORD STANDARDS Behavioral Health Practitioners

1. An adequate confidentiality policy is in place, and procedures have been implemented within the practice.
2. If the behavioral health practitioner employs staff, each employee in the practice signs a confidentiality statement and receives periodic training in confidentiality of member information.
3. A behavioral health record is maintained for each client, and is always available at the time of a client visit.
4. Records are stored in a secure manner that allows access by authorized personnel only.
5. Records are organized so that care can be monitored effectively (e.g., pages are secured in chart, in time sequence, client name and ID# on each page, and demographic information is present).
6. Documentation is legible to someone other than the writer.
7. There is an intake assessment, DSM diagnosis, treatment plan and progress note (reflecting treatment plan) documented for each visit.
8. Entries in the progress notes contain date and author's signature (or electronic identifier).
9. The clinician documents past medical and behavioral health conditions and treatment in the record.
10. The client's current behavioral health status and treatment plans are documented for each encounter in the record.
11. High risk behaviors, i.e., risk of harm to self or others, are documented along with safety plan.
12. Medication allergies and adverse reactions to psychotropic and other behavioral health medications are documented; if none, this is documented.
13. The practice obtains written permission from clients before releasing behavioral health information outside that needed for treatment, payment or operations.
14. The clinician shares appropriate basic medical information with the client's primary care physician.

MEDICAL RECORD KEEPING PRACTICES – Behavioral Health Practitioners

MEDICAL RECORD KEEPING POLICIES/ PRACTICES	YES	NO	N/A	COMMENTS
1. An adequate confidentiality policy is in place, and procedures have been implemented within the practice.				
2. If the BH practitioner employ staff, each employee signs a confidentiality statement and receives periodic training in confidentiality of member information.				
3. A record is maintained for each client, and is always available at the time of a client visit.				
4. Records are stored in a secure manner that allows access by authorized personnel only.				

MEDICAL RECORD REVIEW Review five records for all standards.	Chart #1	Chart #2	Chart #3	Chart #4	Chart #5
5. Record is organized to that care can be monitored effectively (pages secured, name & ID on each page, in time sequence, demographic information present).					
6. Documentation is legible to someone other than the writer.					
7. There is an intake assessment, DSM diagnosis, treatment plan and progress note reflecting treatment plan documented for each visit.					
8. Entries in the progress notes contain date and author's signature (or electronic identifier).					
9. Clinician documents past medical and behavioral health conditions and treatment in the record.					
10. Client's current behavioral health status and treatment plans are documented for each encounter in the record.					
11. High risk behaviors, i.e., risk of harm to self or others, are documented along with a safety plan.					
12. Medication allergies and adverse reactions to psychotropic and other BH medications are documented; if none, this is documented.					
13. There is evidence in the record that client's written permission was obtained before releasing BH information outside of that needed for treatment, payment or operations.					
14. There is evidence that the clinician shares appropriate basic medical information with the client's PCP.					

CHP Reviewer's Signature

Date

Score: _____ Standards met / _____ Standards applicable _____ % Total score