



## 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 Management Team on at least an annual basis. Standards address content, organization, ease of retrieval and confidentiality of member records.

Primary care records must include documentation of all services provided by the primary care physician, results of all diagnostic tests ordered by the physician and all therapeutic services for which the member was referred. Record keeping standards for Primary Care Physicians are accessible by all practitioners, posted on the CHP Staff Practice SharePoint site, *CHPConnect*, and at [www.capitalhealth.com](http://www.capitalhealth.com).

#### 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 recommendation.

Member complaints related to accessibility, appearance and record keeping at any network practitioner office are monitored monthly. If CHP receives three complaints in a calendar year involving any combination of these issues, a comprehensive site visit is performed within 60 calendar days. Included in the review is an assessment of medical record-keeping practices.

#### Attachments:

- Medical Record Standards, Primary Care Physicians (PCPs)
- Ongoing Monitor Data Collection Tool, PCPs
- Medical Practitioner Office Site Visit Standards/Review Sheet

NCQA Standards 2014 MA 17, 2015 CR 5

Approved QIMT 12/9/10, 10/26/11, 10/25/12, 10/24/13, 10/23/14

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, 1/13/09, 9/8/09



## **MEDICAL RECORD STANDARDS Primary Care Physicians**

1. An adequate confidentiality policy is in place and procedures have been implemented within the physician practice, to include periodic staff training in member information confidentiality.
2. The practice obtains written permission from patients before releasing medical information outside of that needed for treatment, payment, or operations.
3. The practice verbalizes a process for delivering language services.
4. Medical records contain documentation on whether or not members have executed an advance directive.
5. Medical records are stored in a secure manner that allows easy retrieval for access by authorized personnel only.
6. The practice obtains documentation of advance directives for appropriate patients (including all Medicare members), placing it in a prominent part of the medical record.
7. Medical record is organized so that care can be monitored effectively.
8. The record includes a problem list.
9. Allergies and adverse reactions are documented.
10. Current medications are listed.
11. There is a progress note documented for each patient visit.
12. The patient's presenting complaints, physical exam, diagnoses, and treatment plans are documented for each patient encounter in the medical record.
13. The documentation identifies all practitioners and providers involved in the member's care, all diagnostic and therapeutic services.
14. The physician documents preventive services/risk screening.



## MEDICAL RECORD KEEPING PRACTICES – Primary Care Physicians

Policies	YES	NO	Comments
1. An adequate <b>confidentiality policy</b> is in place and procedures have been implemented within the physician practice.			
2. The practice obtains written permission from patients before <b>releasing medical information</b> outside that needed for treatment, payment, or operations.			
3. The practice verbalizes a process for delivering <b>language services</b> . <i>Please specify:</i>			
4. Medical records contain documentation on whether or not members have executed an <b>advance directive</b> .			
5. Physician has appropriate provision for <b>back-up coverage</b> in his/her absence from the office.			

<b>Review 1 record. If deficiency is found, review 4 additional records for all standards. (Medicare member, if available) CHP ID #:</b>	Chart #1	Chart #2	Chart #3	Chart #4	Chart #5
6. Documentation of <b>advance directives</b> is placed in a prominent part of the medical record for appropriate patients, including all Medicare members.					
7. Documentation identifies <b>all</b> practitioners and providers <b>participating</b> in care; record contains documentation of all diagnostic/therapeutic services provided.					
8. The physician documents <b>preventive</b> services/risk screening.					
<b>!! Stop!! Does this office utilize an electronic record? ___ yes ___ no</b> If yes, please <b>record the name of the system</b> , and skip #9-15. <b>If no, complete #9-15.</b> EMR/EHR name: _____					
9. Records are stored in a <b>secure</b> manner, allowing access only by authorized personnel.					
10. Medical record is <b>organized</b> so that care can be monitored effectively.					
11. Record includes a <b>problem list</b> .					
12. <b>Allergies</b> and adverse reactions are documented.					
13. Current <b>medications</b> are listed.					
14. There is a progress note documented for <b>each patient visit</b> .					
15. Patient's presenting complaints, physical exam, diagnosis and treatment plans are documented for each patient encounter in the record. ( <b>SOAP</b> )					

\_\_\_\_\_  
CHP Reviewer's Signature

\_\_\_\_\_  
Date

Score: \_\_\_\_\_ Standards met \_\_\_\_\_ Standards applicable \_\_\_\_\_ % Total score



**MEDICAL PRACTITIONER OFFICE SITE VISIT STANDARDS/ REVIEW SHEET**

Date of Review \_\_\_\_\_

Practice Name \_\_\_\_\_ Practitioner Name(s) \_\_\_\_\_

CRITERIA	YES	NO	COMMENTS
<i>Accessibility/Appearance</i>			
1. Parking lot includes at least one handicapped parking space.			
2. Office is accessible to the handicapped.			
3. Waiting area seating is adequate for the size of the practice.			
4. Waiting room appears clean and organized.			
5. Exam rooms are adequate in number and size.			
6. Exam and treatment rooms are clean and organized.			
<i>Record Keeping</i>			
7. An adequate confidentiality policy is in place and procedures have been implemented within the physician practice.			
8. Practice obtains written permission from patients before releasing medical information outside that needed for treatment, payment or operations.			
9. Medical records are stored in a secure manner that allows access by authorized personnel only.			
10. A sample patient record is organized, so that care can be monitored effectively.			
11. A sample patient record includes presenting complaints, physical exam, diagnoses and treatment plans for each visit.			
12. A sample patient record includes risk screening and preventive services.			
<i>Safety</i>			
13. Practice has a process in place for 24 hour telephone coverage.			
14. Plan for handling medical emergencies is adequate.			
15. Fire detection equipment is adequate and available.			
<i>Policies</i>			
16. The practice obtains documentation of advance directives for appropriate patients.			
17. The practice has a process for delivering language services.			
18. Physician has appropriate provision for back-up coverage in his/her absence from the office.			
OFFICE SITE VISIT SCORE:  _____ met; _____ applicable = _____ %			Passing Score: ≥ 85%; < 85%: Corrective Action Plan and follow-up site visit within 6 months

Signature, CHP Reviewer \_\_\_\_\_

Additional Comments: \_\_\_\_\_