Medical Record Documentation Standards Policy

BlueShield of Northeastern New York

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Policy: Medical Records Documentation Standards for Primary Care

Criteria for File Pull:

1. Identify at least one member per primary care provider who has had a minimum of two (2) office visits in a 24-month period, with at least one (1) visit in the last 12 months.
2. Member must have 18 months of continuous enrollment.
3. Members identified also have had a visit with a specialist during the past 12-month period, (Provider Specialty is chosen by the Clinical Team).

Procedure:

A sample of one (1) to five (5) records from a primary care provider is rated according to the scale below. A minimum of four (4) out of five (5) points must be achieved for a successful rating. If the average of all the points is less than four (4), a corrective action is requested from the provider. Critical elements must be met. **Critical elements are noted with an asterisk and are in bold print.**

The presence of each element in the medical record is scored using the following ratings. The ratings are averaged to achieve the final score. All reviews are archived in an internal access database, which is maintained and backed up by an information systems analyst.

5 = always (yes/100 percent)
4 = frequently (75 percent)
3 = generally (50 percent)
2 = occasionally (25 percent)
1 = never (no/0 percent)

Record Standards:

Consistent and complete documentation in the medical record is an essential component of quality patient care.

1. Each page in the record contains the patient's full name or identification (ID) number.
2. Personal/demographic data includes the address, employer, home and work telephone numbers, marital status, gender, and emergency contact (*demographics/registration sheet/face sheet*).
3. All entries in the medical record have author's identification. Author's identification may be a handwritten signature, a unique electronic identifier, or initials. (*Each entry should be signed by the writer. A solo practitioner does need to sign their notes. This is a legal document and will be treated as such.)*
4. All entries are dated.
5. The record is legible to someone other than the writer. A second reviewer will examine any record judged to be illegible by the first reviewer.

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6. ***Significant illnesses and medical conditions are indicated on the problem list.** (May be on separate sheet, or written and updated in progress notes at each visit.)
7. ***Medication allergies, adverse reactions, or no known allergies (NKA) are prominently noted in the record.**
8. ***Current medications are documented.** (medication sheet and/or progress notes.)
9.
    a. ***For patients seen three or more times, past medical history, including family history, is easily identified and includes serious accidents, operations, and illnesses.**

    For children and adolescents (18 years old and younger), past medical history relates to prenatal care, birth, operations, and childhood illnesses.

    b. For adult patients seen three or more times, there is appropriate documentation concerning:
        - Smoking
        - Alcohol
        - Substance use
        - Sexual activity
        - Body mass index (BMI)
10. ***Complete physical exam is documented and updated (as indicated). Documentation supporting an attempt to schedule patient for complete H&P is acceptable.**

Physical examination includes eight (8) or more organ systems	
Constitutional (vital signs, general appearance)	Genitourinary
Eyes*	Musculoskeletal
Ears, nose, mouth, and throat*	Skin
Cardiovascular	Neurological
Respiratory	Psychiatric
Hematologic/lymphatic/immunologic	Gastrointestinal
*"HEENT" is acceptable	

11. The encounter history and physical identify appropriate subjective and objective information pertinent to the patient's presenting complaints.
12. Appropriate laboratory and other studies are ordered according to national standards of care (*example: HgbA1c for a diabetic patient).*
13. ***Documentation of clinical findings and evaluation for each visit are present in the record. Working diagnoses are consistent with findings**.

14. ***Treatment plans are consistent with diagnoses**.
15. Encounter forms or notes have a notation regarding follow-up care, calls, or visits. The specific time of return is noted in weeks, months, or as needed. (*Progress notes.*)
16. Unresolved problems from previous office visits are addressed in subsequent visits.
17. Under or overutilization of consultants is <u>not</u> present in the judgment of the reviewer/medical director.
18.
    a. Consultation, discharge summaries, ER and urgent care visit notes, and lab and imaging reports found in the chart are initialed by the primary care physician/clinician to signify review. If the reports are presented electronically, or by some other method, there is also representation of provider review.
    b. Consultation, abnormal lab, and imaging study results have an explicit notation in the record of follow-up plans.
    c. A note from the consultant is in the record for all consultations.
19. ***There is no evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic problem in the judgment of the reviewer/medical director.** (*Evidence of inappropriate care will be referred and addressed as a quality of care investigation.)*
20. The childhood/adolescent immunization record is current/complete, from birth to age 18. A note such as "up to date" is <u>not</u> appropriate.
21. Documentation of adult immunization history detail (age 19 and over). A note such as "up to date" is <u>not</u> appropriate.
22. ***There is evidence that preventive screening and services are offered in accordance with the Centers for Disease Control (CDC) and the New York State Department of Health (NYSDOH) preventive health guidelines** *(Cancer screenings, immunizations, smoking cessation, cholesterol screening, etc.)*
23. For all adults (age 18 and over), a health care proxy/advance directive has been signed or discussed and documentation is present in a prominent part of the member's medical record.
24. Documentation in the medical record reflects that the member has been included in the planning and implementation of their care or, if applicable, withholding resuscitative services or declining/withdrawing life-sustaining treatment. If unable to fully participate, the member is represented by parents, guardians, family members, or health care proxy agent.
25. Culturally competent care is addressed by documented evidence of at least one of the following:
    a. Race, ethnicity, or culture of the patient
    b. Language the patient speaks
    c. Use of interpreter
    d. Any communication or cultural issues considered in the patient care

26.

a. For all children and adolescents (ages 2-18) with at least one comprehensive well care visit, assessment, counseling or education on the following components of care are documented:
   - Body mass index (BMI)
   - Body mass index percentile
   - Nutrition
   - Physical activity

b. In addition for adolescents (ages 12-18), there are appropriate notations concerning:
   - Risk behaviors/sexual activity
   - Depression
   - Tobacco
   - Substance use/alcohol

Sources:

1. CMS: 1997 Documentation Guidelines for Evaluation and Management Services (updated 8/2017).
2. NYS Quality Assurance Reporting Requirements Specifications Manual.
3. CMS 42 C.F.R§422.112(b) (4) (ii).
4. Medicare Managed Care Manual chapter 4, section 110.6.
5. American Academy of Pediatrics: https://www.aap.org.