Medical Record Review Policy

Last Reviewed: June 22, 2018

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Policy:

Primary Care Providers

Medical record documentation will be assessed using the Corporate Medical Record Documentation Standards that are based on the most recent Centers for Medicare and Medicaid Services (CMS)/New York State Department of Health (NYSDOH) Guidelines. Medical records from primary care practitioners are reviewed for compliance with documentation standards and evidence-based care.

OB-GYN Providers

Medical record documentation will be assessed using the most recent New York State Department of Health (NYSDOH) Prenatal Guidelines. These standards will be used to evaluate compliance in appropriate prenatal medical care for pregnant women.

Purpose:

Review of these medical records will enable BlueShield of Northeastern New York to target areas of opportunity to provide education to practitioners on their documentation and areas where medical care can be improved.

Procedure: Primary Care Provider Records

1. BlueShield Corporate Medical Record Documentation Standards are based on CMS/NYSDOH Guidelines. The standards are reviewed and updated annually, and approved at least once a year at the Quality Management Committee.

   The single practitioner record must have enough elements to qualify as a complete record for a Documentation Standards review. The Medical Records for review can be derived from any of the following sources:

   - **HEDIS/QARR/QRS Review** – Healthcare Effectiveness Data and Information Set/Quality Assurance Reporting/Quality Rating System.
   - **Quality Concern review** – Records obtained in response to member complaints of quality of care/access to care and quality investigations.
   - **Internal department referrals** – Records identified by Utilization Management, Case/Disease/Preventive Health/Wellness, Provider Relations and Contracting, Credentialing, and Special Investigations Unit as needing Health Care Quality Improvement (HCQI) Medical Record review.
   - **Continuity and Coordination of Care** – Designated projects will coordinate with Medical Record Review to obtain medical records.
   - **Live Birth File** – Records are identified for inclusion in the prenatal medical record review.

2. The single practitioner record will be scored against approved Medical Record Documentation Standards (HCQI 606) and must include all the critical elements to be considered compliant.

3. Should a single record fail review for standards, a random sample of three (3) to five (5) additional medical records will be requested from the practitioner. A full review against corporate Medical Record Documentation Standards will ensue.

   a. The following will be sent to the practitioner:

      - A letter requesting medical records.
      - A list of five members' records to be submitted by the provider for review.
      - A copy of the corporate Medical Record Documentation Standards.

   b. For each member, the requested medical record should fulfill requirements for a full standards review.

   c. A second medical record request is sent to offices after ten (10) business days if records have not been received as requested. A phone call may be made to the office to confirm receipt of the request and arrange for an on-site review, or request to fax/mail record.

   d. When reviewing the medical record in-house or on-site, absent documentation should not be assumed to be lacking (e.g., if the reviewer cannot find the lab results, they could be kept in a separate logbook). For records that are copied, the results may not have been copied. The reviewer should confirm the absence or presence of pertinent documentation with office staff.

   e. If a quality of care issue is identified, the HCQI Quality Review Process will be implemented. (Refer to Policy HCQI 302 Healthcare Quality Investigation/Resolution Process).

   f. Scoring

      The medical record components are rated as follows:

      5 = always/yes (100 percent)
      4 = frequently (75 percent)
      3 = generally (50 percent)
      2 = occasionally (25 percent)
      1 = never (no/none)

      Practitioners who rate 4 or lower for the overall record score or are lacking a critical element (as indicated in the Medical Record Documentation Standards) will be invited to respond with additional information or clarification or a Corrective Action Plan within fourteen (14) days and will be re-reviewed in one (1) year to determine if compliance has been achieved.

   g. Further action

      - If a practitioner shows no significant improvement after the one-year review (a rating equal to or greater than 4), the Medical Director is notified. Action may include referral to a subcommittee.
      - Upon completion of the Medical Record Review, a final outcome letter is sent to the practitioner identifying the final score of the review and recommendations for corrective action plan/ improvement as necessary.
      - Scores reported for statistical analysis are stored in a shared departmental database.
      - Results of the Medical Record Reviews are reported at least annually to the Quality Management Committee.
      - Medical Record Review aggregate data results and general recommendations for improvement are reported to providers on an annual basis via a provider newsletter article.