
Overview

Harmony Health Plan of Illinois conducts reviews of medical records of primary medical providers and OB/GYN physicians to determine compliance with established documentation standards and goals that are adopted by the Quality Improvement Committee (QIC). The standards for this guideline were based on published guidelines from the Illinois Department of Healthcare and Family Services (HFS) and the National Committee on Quality Assurance (NCQA). An average score of 80 percent or greater is considered to meet documentation standards. Physicians who score 80 percent or greater are reviewed every two years. A corrective action plan will be supplied to physicians who scores less than 80 percent. A re-audit will be conducted within 90 days of notification of the medical record review score and receipt of the corrective action plan. If after 90 days there are not enough charts for a valid sample then the re-audit will be conducted six months from the receipt of the corrective action plan. In the event the physician scores less than 80 percent on the re-audit additional disciplinary action will be considered.

Requirements and Guidelines

Medical Record requirements and guidelines are as follows:

- Safeguard member confidentiality in accordance with HIPAA state and federal guidelines, the Plan Quality Improvement and Risk Management programs and professional practice standards. Including the confidentiality of a minor's consultation, examination and treatment for a sexually transmittable disease.
- Make the medical records available for quality-of-care reviews, quality studies and other quality focused initiatives. Medical record reviews may be conducted by Plan staff, authorized representatives of OMPP, the Centers for Medicare and Medicaid Services (CMS), external quality review organizations, the Plan member, organizations conducting accreditation audits and HEDIS[®] medical record review vendors.

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- Comply with Corrective Action Plan requirements imposed as the result of any such review or audit.
- When a member changes his PCP a copy of a transferring member's medical record will be provided free of charge and in a timely manner.
- A member's medical record should contain the quality, quantity, appropriateness and timeliness of services performed per nationally recognized clinical documentation guidelines and/or per Plan policies and procedures.

Content and Review

The following information must be included in members medical records:

- Medical records must be legible to readers and reviewing parties and maintained in an orderly and detailed manner.
- All entries in the medical record must be recorded in a timely manner, dated and signed by the individual providing the services and/or signed by the individual reviewing the service result with the member.
- All entries must include professional training designation of the practitioner rendering services, for example: RN, CNP, MD, and DO.
- The following personal and biographical data must be included in the record:
 - Member full name
 - Member ID number
 - Date of birth
 - Sex
 - Language spoken
 - Ethnicity
 - Emergency contact
 - Legal guardianship.
 - This may include: marital status, name of spouse, next of kin or closest relative, address, employer, phone numbers,

insurance information, family history.

- Medication allergies or “no known allergies” and untoward reactions to drugs, are prominently noted in the record.
- Medical records from the previous provider have been obtained and are easily accessible.
- A listing of all medications the member is taking with start and stop dates is in the chart.
- A problem list, with past and current diagnoses and procedures used to provide continuity of care is in the chart.
- Screening for substance abuse of tobacco, alcohol and drugs with appropriate counseling/referrals, if needed, and follow-up is documented.
- There is evidence the member was asked about Advance Directives and documentation of acceptance or refusal.
- All records must reflect the primary language spoken by the member and translation/communication needs of the member. Translation/communication needs could reflect the need for an interpreter, sign language or Braille materials, etc., as appropriate.
- There is documentation of screening for domestic violence with appropriate counseling/referrals, if needed, and follow-up.

Continuity of Care Requirements Screen

The medical record must show the physician’s knowledge of the patient’s course of care as evidenced by the following:

- There is documentation and reports of consultations and referrals and any follow-up care to specialty physicians if indicated.

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- There are reports of diagnostic testing in the medical record. The medical record will show documentation of reports for diagnostic testing that was ordered: lab results, X-ray reports, MRI/CT reports, etc.
- There is documentation of follow-up plans for abnormal testing, consultation, referrals, results or missed or cancelled appointments.
- There is documentation and records for emergency room care.
- There is documentation of hospitalizations to include discharge summary and discharge planning.

The following patient information must be documented in the medical record for each visit:

- History and physical examination as related to the visit, chief complaint or purpose of the visit, objective findings of the practitioner, diagnosis or medical.
- Plan of treatment, referrals, disposition, diagnostic testing, studies ordered and therapies administered and prescribed regimens.
- Patients input into their course of care or treatment plan.
- The member is provided with verbal and/or written education and instruction as indicated and appropriate - whether verbal, written or via telephone.

Early and Periodic Screening, Diagnosis and Treatment Testing

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screening is a federally mandated comprehensive child health program for Medicaid recipients from birth through age 20. It is designed to identify physical and mental defects and provide treatment (or referral when indicated) to correct or ameliorate defects and chronic conditions.

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The American Pediatric Association recommends that a member should also have EPSDT visits on or before the following:

- Initial visit, newborn, within the first week, 1 month, 2 months, 4 months, 6 months, 9 months, 1 year, 15 months and 18 months.
- Then once a year for 2 through 20 year olds.
- A complete history and physical examination within the first 90 days of entering the Plan.

Please note that an EPSDT visit can be completed during a sick visit.

The EPSDT program, in accordance with section 1905 of the Omnibus Budget Reconciliation Act of 1989 (OBRA 89), must include provision and documentation of all of the following services:

- Height, weight and growth charting
- Head circumference and blood pressure (when appropriate)
- Unclothed physical examination
- Health history and developmental history
- Periodic developmental and social emotional screening (using a recognized, standardized developmental screening tool)
- Objective vision and hearing screening including exam and standardized testing
- Nutritional assessment
- Laboratory procedures (including lead toxicity testing and anemia screening)
- TB testing (high risk category)
- Immunization record that contains immunizations and dates
- Injury prevention, health education and counseling
- Family planning counseling and services (as appropriate)
- Risk assessment screening
- Referral to WIC, FCM and other community agencies (as appropriate)

Adult Health Screening

An adult health screening is performed by a physician to assess the health status of a member age 21 or older. It is used to detect and prevent disease, disability and other health conditions or monitor their progressions. The adult member will receive an appropriate assessment and intervention as indicated or upon request.

A complete health history and physical examination should be conducted every 1-3 years, as indicated by the member's need and clinical care guidelines. If a member is new to the Plan they should have a complete history and physical examination within the first 90 days of entering the Plan.

A complete health history and physical examination shall include provision of and documentation of the following health services:

- A health history, including obstetrical history
- A physical examination including height, weight, blood pressure and pulse
- Health education and anticipatory guidance
- Nutritional assessment and counseling
- Vision screening for members that are age 65 years and older
- Hearing screening for members that are 65 years old and older
- Tuberculosis (TB) skin testing is done (if in a high-risk category)
- Counseling regarding lifestyle, risk and family planning
- Vaccinations including - Tetanus-diphtheria (Td) booster, annual influenza vaccination and Pneumococcal vaccination (as appropriate)
- Pap test for members ages 21 through 65
- Mammogram orders and results baseline 35 through 39 years of age, annually 40 and older, or when family history indicates
- Colorectal cancer screening for members ages 50 and older
- Prostate screening should be completed for African American males with family history, males ages 40 and older and asymptomatic males ages 50 and older

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- Counseling regarding Hormone Replacement Therapy (HRT) for peri/post menopausal women
 - Dyslipidemia screening orders and results (men age 35 and older and women ages 45 and older)
 - Urinalysis dipstick for blood, sugar and acetone screening orders and results of (ages 65 and older)
 - Hemoglobin and Hematocrit (H&H) screening orders and results of testing
 - Osteoporosis screening orders and results
 - Thyroid function screening orders and results (for females ages 65 and older)

**Maternity Care
(OB/GYN
Review)**

Medical Record requirements and guidelines.

- The member will be seen by an obstetrician within the first trimester (or within 42 days of enrollment) of the pregnancy with the following assessments performed and documented:
 - Obstetric panel
 - TORCH antibody panel
 - Rubella anti-body titer
 - Blood typing and anti-body screening
 - Ultrasound
 - Height, weight, blood pressure
 - Fetal heart tones
 - Hemoglobin & Hematocrit (H& H)
 - Urinalysis
 - Syphilis screening
 - HBsAG screening
 - Pap smear
 - Nutrition assessment
 - Pre-term delivery risk assessment
- The member will be seen once every month in the second trimester of pregnancy with the following assessments performed and documented:
 - Weight, blood pressure
 - Fetal heart tones
 - Hemoglobin & Hematocrit (H& H)
 - Urinalysis
 - Alpha-fetoprotein (between 15-20 weeks)
 - Diabetes screening/GTT (between 24-28)

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- weeks)
 - Repeat anti-body test for unsensitized RH negative patients (28 weeks)
 - Prophylactic administration of Rho(D) immune globulin (28 weeks), if indicated
- The member will be seen twice every month in the third trimester of pregnancy and one visit per week in the ninth month with the following assessments performed and documented:
 - Weight, blood pressure
 - Fetal heart tones
 - Hemoglobin & Hematocrit (H&H)
 - Urinalysis
 - Testing for STDs and HBsAg for high-risk members
 - Group B Strep screening for high-risk members (35-37 weeks)
- The Maternity chart will contain documentation of the following:
 - Physical findings on each visit with a plan of treatment and follow-up for any abnormalities;
 - Member education (childbirth/maternal care);
 - Postpartum care/Pelvic exam 21-56 days post delivery – at least one complication-free visit, or appropriate follow-up if complications exist;
 - Family planning counseling and services for all pregnant women and mothers;
 - HIV testing and counseling is offered;
 - Referrals to the Harmony HUGS Prenatal Program.

**Diabetes
Specific
Screens**

The patient requiring comprehensive diabetes care will receive a timely evaluation and appropriate medical intervention. The classic symptoms of diabetes include:

- Polyuria, Polydypsia, and unexplained weight loss;
- Fasting Plasma Glucose of ≥ 126 mg/dL. Fasting is defined as no caloric intake for eight hours;
- A Casual (anytime without regard to last meal) plasma glucose screening with a result ≥ 200 mg/dL;
- 2-hour Plasma Glucose ≥ 200 mg/dL during OGTT (Oral Glucose Tolerance Test);
- On oral or parenteral medication or dietary restrictions to treat Diabetes Mellitus.

Documentation of evaluation and appropriate medical intervention should include the following:

- There is evidence of attempt to control the disease process through pharmacological or dietary intervention as indicated by an individualized management plan with routine diabetes visits scheduled quarterly for patients who are not meeting goals and semiannually for other patients.
- There is evidence of comprehensive education in self-management including self-monitoring of blood glucose, nutrition therapy, insulin or oral medication therapy regimens, prevention and treatment of hypoglycemia, and exercise.
- HbA1C testing (Glycosylated Hemoglobin) quarterly if a change in treatment has occurred or if patient is not meeting goals of therapy. Twice per year if stable.
- The member's HbA1C level is less than or equal to 7.0 percent.

- The member will receive Lipid Profile testing at least once per year.
- The member's LDL level is <100mg/dL.
- A dilated eye examination order and screening were performed within the last year
- Urinalysis for microalbuminuria was performed within the last year
- A comprehensive foot exam is performed at every office visit. Foot exam includes sensation, structure and biomechanics, vascular status, and skin integrity.

**Chronic
Pulmonary
Disease/Asthma**

The patient with chronic pulmonary disease will receive a timely evaluation, and appropriate medical intervention as evidenced by the documentation of the following:

- On each visit the member will receive a complete respiratory assessment, which will include auscultation of breath sounds, use of accessory muscles, and respiratory rate.
- There is evidence of member education related to disease process and self-management.
- The member's medication is monitored, evaluated and adjusted accordingly.
- There is evidence of attempt to control the member's disease process through ongoing assessments beyond the acute phase of illness.

For diagnosis of Asthma only:

- There is evidence of management of the member's disease process through the use of long-acting therapies.

**Review
Criteria**

The criteria utilized for medical record standards and standards of care are not authored by the Plan. The criterion is based on local, state and federal regulatory requirements, accrediting bodies and accepted national organizations.

Reviews in a physician office may conclude with an Exit Review, to include the physician and designated office staff. The physician will be given the preliminary results of the review. Any area that is not compliant with regulatory standards will require a plan of correction.

**Corrective
Action Plan
(CAP)**

A corrective action plan is included with the letter notifying the physician of a score of less than 80 percent. A copy of the corrective action plan should be submitted to the Plan within 15 business days from the date of the letter. In the event that the corrective action plan is not received the Plan will consider that the physician is in agreement with the CAP.

References

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2. American Cancer Society Cancer Detection Guidelines. Web site: <http://www.cancer.org>
3. American Diabetes Association, "Standards of Medical Care for Patients with Diabetes Mellitus".
Web site: <http://diabetes.org>
4. Guide to Clinical Preventive Services, 3rd Edition, 2000-2003 Report of the U.S. Preventive Services Task Force
Web site: <http://www.ahrq.gov/clinic/prevnew.htm>
5. Guidelines for Perinatal Care, American Academy of Pediatrics, The American College of Obstetricians and Gynecologists

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Web site: <http://www.ncqa.org>
7. Recommended Adult Immunization Schedule United States, Department of Health and Human Services, Centers for Disease Control and Prevention
Web site: <http://www.cdc.gov>
8. Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC 7), National Heart, Lung, and Blood Institute (NHLBI), National Institutes of Health, 2003
Web site:
<http://rover.nhlbi.nih.gov/guidelines/hypertension/index.htm>
9. The National Asthma Education and Prevention Program (NAEPP), National Heart, Lung, and Blood Institute (NHLBI), National Institutes of Health Web site: <http://rover.nhlbi.nih.gov/about/naepp>
10. Centers for Disease Control and Prevention (CDC)
Web site: <http://www.cdc.gov>
11. QISMC Medical Record Review (Centers for Medicare and Medicaid Services)
12. Illinois Department of Public Aid Handbook for Providers of Medical Services Web site:
<http://www.hfs.illinois.gov/handbooks/>
13. Managed Care Organization Policies and Procedures
14. National Committee on Quality Assurance. Standards for the Accreditation of Managed Care Organizations. Web site:
www.ncqa.org/communications/publications
15. Illinois Department of Healthcare and Family Services Web site: <http://www.hfs.illinois.gov/>