

Random medical record review process

Anthem Blue Cross and Blue Shield (Anthem) has medical record standards that require practitioners to maintain medical records in a manner that is current, organized and facilitates effective and confidential member care and quality review. Anthem performs reviews of network primary medical providers' (PMP) medical records relative to current medical record standards. Anthem recognizes the importance of medical record documentation in the delivery and coordination of quality care. Anthem requires practitioners to comply with the standards for medical record documentation.

In accordance with regulatory requirements, medical record reviews are performed annually on a percentage of randomly selected contracted PMPs for Anthem managed care products –Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect. For purposes of medical record reviews, a PMP is defined as a practitioner of family medicine, general medicine, internal medicine, pediatrics or obstetrics/gynecology. The random sampling of these PMPs will be identified via claim history from the two years prior to the current year.

In order to pass the review, an office must attain an overall score of 80% or greater in the medical record audit. If a practitioner fails to meet the Anthem standard of 80%, practice consultants will provide individual practitioners education and quality improvement tools. A re-review is conducted within six months. Should the practitioner continue to score less than 80% in the medical record re-review, the practitioner will be placed on corrective action that could result in termination from the network.

Medical record criteria

The medical record will be evaluated for the following criteria:

- **Format**
 - Every page in the record contains the patient name or ID number.
 - The chart contains individual biographical information; date of birth, gender, name, address, home or work phone, name of parents (if a minor) and emergency contact information
- **Documentation**
 - Patient's primary language (if other than English) is listed and any special interpreter needs are identified.
 - Allergies/no known drug allergies (NKDA) and adverse reactions are prominently displayed in a consistent location.
 - All presenting symptom entries are legible, signed and dated, including phone entries. Dictated notes should be initialed to signify review. Signature sheet for initials are noted.
 - A problem list is maintained and updated for significant illnesses and medical conditions.
 - A medication list or reasonable substitute is maintained and updated for chronic and ongoing medications.
 - Discussion about advance health care directive may be noted in the medical record, on the intake form, progress notes and advance directive form or stamped in the medical record.
 - All necessary informed consents are completed and placed in the medical record (i.e., invasive procedures and other contractually required forms).
 - History and physical exam identifies appropriate subjective and objective information pertinent to the patient's presenting symptoms and the treatment plan is consistent with findings.
 - Laboratory tests and other studies are ordered, as appropriate, with results noted in the medical record. When diagnostic studies are abnormal, it should be documented that the results have been conveyed to the patient/parent/guardian and any questions were addressed. The chart shall document the physician's review of any studies (labs, X-rays, etc.).
 - Age appropriate routine preventive services/risk screening is consistently noted (i.e., childhood immunizations, adult immunizations, evidence of serum lead testing, mammograms, Pap tests, chlamydia screening, colonoscopy, cholesterol testing, etc.).
 - Periodic age-appropriate health assessments must be provided according to the AAP/EPSTDT recommended schedule for pediatric preventive health care. A physical examination is completed at each health assessment visit along with developmental/neurological/behavioral assessment of a child or the refusal by the patient, parent or legal guardian, of such screenings/immunizations are noted in the medical record. Women and infant care (WIC) referrals are documented.
 - Smoking history for patients should be documented in the medical record. Documentation should include passive smoke exposure for children and adults.

- For patients 11 years and older, appropriate notation appears annually concerning the use of cigarettes, alcohol and substances.
- For patients 11 to 21 years, or if relevant, there is appropriate notation concerning sex education, including such topics as abstinence, sexually transmitted diseases, pregnancy prevention, use of condoms, etc.
- Tuberculosis screening to be performed for high-risk populations.
- Age appropriate health education and anticipatory guidance offered and documented at each well examination.
- A complete history and physical is completed on new patients. On the initial visit, documentation related to past surgeries, serious accidents, injuries, psychosocial history, presence of medical problems or illnesses must be recorded in the medical record.
- A plan of treatment, care and/or education related to the stated diagnosis must be documented for each diagnosis.
- Documentation should reflect an evaluation of unresolved problems noted in previous visits.
- Specific follow-up instructions and a definite time for return visit or other follow-up care is documented. If a patient has canceled or is a no show for an appointment, this should be noted in the medical record with follow-up contacts or outreach efforts documented.
- When a patient is referred to and seen by a consulting physician, there must be documentation of communication between the consultant and the PMP. Results of a diagnostic workup such as any procedures, laboratory and radiology studies should be reviewed and noted in the record or on the computer. If the patient is referred to and seen by a behavioral health specialist, there must be documentation of communication between the specialist and the PMP and any associated pertinent inpatient records must be maintained in the office medical record.

Prenatal preventive care

- Prenatal assessment and comprehensive health history needs to be completed and documented, a risk assessment should be included and documented. The frequency of visits should meet the most recent ACOG guidelines for prenatal care.
- Postpartum visits should occur within 4-8 weeks after delivery. If the recommended ACOG schedule is not met, document missed appointments and attempts to contact patient.
- Health education and anticipatory guidance is documented in the medical record, including family planning and nutritional counseling.
- Screening for domestic violence and/or abuse is provided.
- Newborn anticipatory guidance is provided. Mother is informed/counseled regarding the following:
 - Newborn physician visit
 - Immunizations
 - Well baby screenings
 - WIC

Behavior health coordination

- Is there documentation of anticipatory guidance discussion regarding depression/anxiety beginning at seven years of age or sooner or at any time the physician feels the need for referral?
- Behavioral/developmental screening:
 - General screening (i.e., PEDS or other tool)
 - School readiness activities (risk level) for all ages
 - For those patients with any of the following:
 - Diabetes
 - Post myocardial infarction/cardiac event
 - Coronary artery diseases
 - Chronic obstructive pulmonary disease
 - Two or more medical conditions
- Is there evidence that the PMP screened for the presence of depressive symptoms? Include the screening method (e.g., interview, use of tool, etc.non-scored).
- Is there evidence that the PMP screened for the presence of alcohol abuse symptoms? Include screening method (e.g., CAGE, AUDIT, AUDIT-C, BMAST, TWEAK, medical history, progress note, non-scored).
- Is there evidence that the PMP screened for depression? Include the screening method (e.g., PHQ-9, HADS, GHQ, Beck, Zung, HAM-D, CES-D, Whooley, medical history, progress note non-scored).

Access to care

- Physician is accessible during non-office hours (processing after hour phone calls either by recorded message, answering service or pager, etc.)
- Emergent appointments are available immediately
- Urgent care appointments are available within 24 hours and same-day appointments are available: regular and routine nonurgent appointments are available per state requirements
- Patients wait in the waiting room 30 minutes or less to be seen by a physician
- Medical records are organized and stored in a secure manner that allows easy retrieval by authorized personnel only
- Medical records are retained for a period of seven years after last patient encounter
- Staff receives periodic training in member safety
- Infection control/universal precautions
- Blood borne pathogens exposure prevention
- Biohazard waste handling
- Staff receives periodic training on member information and confidentiality
- Requests for medical records
- Storage and handling of in-house records

- Written policies address confidentiality of patient information, release of patient information, signed informed consents, transfer of patient records and non-discriminative delivery of care
- Errors are corrected according to legal medical documentation standards as follows:
 - Draw line through entry, the inaccurate information must remain legible
 - Initial and date entry
 - State the reason for the error in the margin or above the note as room permits
 - Document the correct information