Anthem Blue Cross and Blue Shield Plans in Connecticut, Maine and New Hampshire

Medical Record Standards

Goal
Medical record standards are established to help facilitate communication, coordination and continuity of care, and to help promote good professional medical practice and appropriate health care management.

Anthem Blue Cross and Blue Shield in Connecticut, Maine and New Hampshire (each referred to as the organization) has established medical record standards to facilitate communication, continuity and coordination of care, and to promote efficient and effective treatment. The organization makes these standards available to practices in order to address: the confidentiality of medical records; medical record documentation standards; an organized medical record keeping system; standards for the availability of medical records; and, performance goals to assess the quality of medical record documentation. Also, the organization has developed procedures to improve medical record documentation.

Medical Record Guidelines
Consistent and complete documentation in the medical record is an essential component of quality patient care. Medical records at primary care offices must be reflective of all services performed by the primary care practitioner (PCP), all ancillary and diagnostic tests ordered by a practitioner, and all services for which a member has been referred to another provider by a PCP (see coordination of care). The organization’s medical record review is based on the best judgment of the reviewer against these medical records standards. Any patterns or trends are also taken into consideration prior to arriving at the final score. In addition, the organization gives practices the opportunity to make sure that all documentation is provided to the organization before a final score is determined.

The following ratings are used to indicate the % of time the standards are documented in the medical record:

Never = 0% of the time
Occasionally = 25% of the time
Generally = 50% of the time
Frequently = 75% of the time
Always = 100% of the time
NA = Non-applicable
To help ensure that medical records are maintained in a manner which is current, detailed, legible and organized for the organization’s members who are treated by a health care practitioner, the following Performance Standards are employed:

**Performance Goal**
The organization’s documentation standards will be met in all medical records.

**Access and Availability**
Practitioner/practice sites shall maintain organized records in such a manner that permits timely and easy retrieval of patient information for each patient/practitioner encounter or, upon request, by other legitimate users.

**Confidentiality**
Patient care offices or sites shall meet or exceed state and federal confidentiality requirements, including HIPAA and are expected to have implemented mechanisms that guard against unauthorized or inadvertent disclosure of confidential information. Records must be stored securely with only authorized personnel having access to the medical records. Patient care offices must ensure that the staff receives periodic training in confidentiality of member information.

Medical records should be kept in a secure environment, away from public access, that allows access by authorized personnel only.

Patient care offices or sites should be able to provide the organization, upon request, a written Policy and Procedure for the Release of Patient Information that demonstrates confidentiality of all patient information in accordance with applicable state and federal laws and evidence of continued training of office staff on confidentiality.

**DOCUMENTATION STANDARDS**

The following standards will be met in the medical records at least 85% of the time:

**Patient Identification**
- Patient name or ID number (identification number) on all pages
- Personal/biographical information (i.e., date of birth, patient address, employer, home/ work telephone number(s) and
- Patient’s ethnicity is documented on an intake form or with biographical information

**Overall Quality of Medical Records**
All medical record entries:
- Are signed or co-signed
- Are dated
- Are legible
- History of current medical conditions are noted and dated
- Past medical history noted, easily identifiable, and includes serious accidents, operations, and illnesses for members having at least three (3) visits.
- Health maintenance is noted
- Problem list is updated as necessary
- Medication list (includes both current and PRN medication) is updated as necessary
- Tobacco, alcohol, substance use, and sexual activity are noted for patients 14 years and older
- Physical exams are documented
- Clinical findings and evaluation for each visit is documented
- Documentation of advance directive discussion in a prominent part of the
medical record for adult patients who are Medicare Advantage members; and documentation on whether or not the patient has executed an advance directive with a copy to be included in the medical record. We encourage providers to maintain documentation of advance directive discussions and copies of executed advance directives in patients’ files for other members.

<table>
<thead>
<tr>
<th>Allergies/Adverse Reactions</th>
<th>Medication allergies and adverse reactions are prominently noted and dated in the record. If no known allergies, NKA or NKDA is noted.</th>
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<tbody>
<tr>
<td>Labs/tests:</td>
<td>Results of all ancillary services and diagnostic tests or studies ordered by a practitioner are reviewed by the PCP. They may be initialed or a note indicating the lab work was reviewed may be present in the progress/office note.</td>
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<td>Indication that the patient has been notified of abnormal test or lab results and explicit follow-up plans for all abnormal labs or test results.</td>
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<td>Consults</td>
<td>Consultant’s reports or documentation of discussions with consulting physicians should be in the medical record.</td>
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<td>The consultant’s reports and/or specialty care providers summary has been reviewed by the provider. They may be initialed or a note indicating the summary was reviewed may be present in the progress/office note.</td>
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<td>Encounter forms or notes have a notation, when indicated, regarding follow-up care, calls, or visits. The specific time of return is noted in weeks, months, or PRN.</td>
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<td>There is a notation of any instructions/education given to patients regarding follow-up visits, care, treatment, or medication schedules, and diagnostic and therapeutic services where members are referred for services.</td>
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<td>- Home health nursing reports</td>
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<td>- Specialty physician reports</td>
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<td>- Hospital discharge reports</td>
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<td>- Outpatient/ambulatory surgery reports</td>
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<tr>
<td>Immunization Record</td>
<td>Childhood, adolescent and adult immunizations per the Organization’s Preventive Health Guidelines</td>
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<tr>
<td>Lead Screening</td>
<td>Lead screening per state requirements and at the physicians discretion based on community or individual risks</td>
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<tr>
<td>Preventive Services</td>
<td>There is evidence of required age-specific preventive screenings based on approved practice guidelines and State Requirements.</td>
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**ADMINISTRATIVE FOLLOW UP**

**Review Results**

Written results of the medical record review will be provided the day of the audit for on-site reviews. The practitioner/office must meet a performance goal of 85%.

A written summary will be sent to all practitioners/offices within fifteen (15) business days of completion of the review for records mailed/faxed to the Plan. Any identified deficiencies will be noted in the letter in order for the office to implement improvement plans.
### Medical Record Improvement Plan

For those offices that score 66%-84%, education will be provided on areas that require improvement in documentation. The Plan can make available medical record keeping tools and provide counseling on medical record standards or prevention monitoring. A medical record review will be conducted within six (6) to twelve (12) months.

### Follow-up to Medical Record Quality Improvement Plan

Those practice sites that score 65% or below will be required to submit a Quality Improvement Plan (QIP) detailing how they will address the identified deficiencies. The QIP will be reviewed by the Plan, and a medical record review will be conducted again within six (6) to twelve (12) months. Those practices that, upon re-review, fail to take appropriate actions to improve their medical record keeping practices will be referred to the organization’s Medical Director.

For additional information on the Medical Record Standards for EPSDT, please visit the State of Connecticut’s website at [https://www.ctdssmap.com/ctportal/](https://www.ctdssmap.com/ctportal/) > Publication > Chapter 5 > 5.11 > page 142.