Medical Record Standards

Clinical Policy

Policy Number HI-001-All

Owner & Approvers

	Owner	Title	Department
Business Owner	Vinod Mitta	Interim Chief Medical Officer	Clinical Review

	Approver	Title	Department
Approving Manager	Vinod Mitta	Interim Chief Medical Officer	Clinical Review
Compliance	Joel Levi	Director of Compliance	Compliance

Applicable Lines of Business

	Applicable?
All	X
On Exchange	
Off Exchange	
Individual	
Small Group	
Self Insured	
Internal	

	Applicable?
All Markets	X
New York	
New Jersey	
California	
Texas	

Status & Details

	Details
Status	Board Approved
Effective Date	2016.09
Latest Review Date	2016.06.30

Review & Revision History

Type	Version	Date	JIRA Key
Original	N/A	2016.09	N/A
Revision	1	2017.06.15	N/A

Time to update this policy?

1. Create a copy
2. Follow the "Creating and Updating Policies" procedures

Purpose

In order to support processes to monitor and take action when necessary, to improve continuity and coordination of care across the health care network.

Procedure

Medical record reviews shall be performed annually in the fourth quarter of each calendar year on a percentage of randomly chosen primary care providers (PCPs) contracted for Oscar's products in states with medical record regulatory requirements. For purposes of medical record reviews, a Primary Care Provider is defined as family medicine, general medicine, internal medicine, pediatrics and obstetrics/gynecology (when acting as a PCP). Medical record review standards include:

1. Instructions to PCPs that medical record reviews are conducted on a random basis
2. Maintenance and availability of medical records
3. Availability of records to members
4. Medical record standards are disseminated to providers via the provider manual which is available on the provider portal of the Plan's web site
5. Medical record audits are conducted by the Quality Improvement Coordinators at the time any medical record is obtained through various means which may include but not be limited to:
    a. HEDIS reviews
    b. HCC (hierarchical condition category) reviews
    c. RAF (risk adjustment factor) reviews
    d. Peer Review
    e. Focused QI studies
    f. Grievance or appeal reviews
    g. Claims review of record reconciliations
6. Medical Record keeping practices, such as records maintained in a secured area, are assessed during office site visits by the Network Management team members or during any site review triggered by a complaint or grievance investigation
7. When standards are not met and opportunities for improvement are identified, the PCP will be issued a corrective action plan with objective interventions needed and target completion dates
8. Specific to the diagnosis and treatment of members with autistic spectrum disorder (ASD), the Plan delegates to the Behavior Health entity review to timely evaluation, screening and diagnosis
9. The Plan, in collaboration with the BH entity establishes processes for communication and the sharing of necessary information. This collaboration is facilitated through the Case Management process and recorded in the Case Management system

a. Coordination and collaboration between Case Managers for medical and BH services include communication for transition between levels of care, i.e.: inpatient, intensive outpatient, and day and residential treatment settings
b. The Case Managers of the Plan and the BH entity are responsible for collaboration to promote communication between medical and BH providers where necessary, along with maintaining current communication between the Case Managers
c. The Case Managers facilitate communication between medical and BH providers to promote and support appropriate evaluation, screening, diagnosis and treatment for severe mental illness (SMI)*, severe emotional disturbance (SED), and treatment of members with autistic spectrum disorder

10. Although the Plan retains full responsibility for making certain that continuity of care is delivered to members, the Plan relies on input and monitoring from the BH entity

* SMI includes:
Anorexia Nervosa
Bipolar Disorder
Bulimia Nervosa
Major Depressive Disorder
Obsessive-Compulsive Disorder
Panic Disorder
Pervasive Developmental Disorder
Schizoaffective Disorder
Schizophrenia

Medical Record Criteria

Medical records will be evaluated for the following criteria:

1. Every page in the record contains the patient name or ID number.
2. Documentation of allergies or No Known Drug Allergies (NKDA) and adverse reactions are prominently displayed in a consistent location.
3. All presenting symptom entries are legible, signed, and dated, including phone entries.
    a. Dictated notes should be signed or initialed to signify review. (If initialed, a signature sheet for initials are noted.)
4. The important diagnoses are summarized and highlighted.
5. A problem list is maintained and updated for significant illnesses and medical conditions.
6. A medication list or reasonable substitute is maintained and updated for chronic and ongoing medications.
7. History and physical exam identifies appropriate subjective and objective information pertinent to the patient's presenting symptoms, and treatment plan is consistent with findings.
8. Past medical history is documented including significant illnesses, accidents, and operations, and prenatal and birth information for pediatric members
9. Each visit notation includes the following:
    a. Subjective Data: Chief complaint (or reason for visit)

    b. Objective Data: Focused (Problem specific) Physical examination
    c. Assessment: Diagnosis or Impression
    d. Plan: Treatment plan, goals
10. Laboratory tests and other studies are ordered, as appropriate, with results noted in the medical record. (The clinical reviewer should see documentation of appropriate follow-up recommendations and/or non-compliance to care plan.)
    a. Follow up care is scheduled for abnormal findings
11. Referrals to specialists are clearly documented
    a. Follow up report received and acknowledged when referred specialist care was obtained
12. Documentation of Advance Directive or Living Will or Power of Attorney discussion in a prominent part of the medical record for adult patients is encouraged.
    a. Should the member decline an Advance Directive, documentation of the member decision shall be documented.
13. Continuity and coordination of care between the PCP, specialty physician(s) (including BH specialty) and/or facilities if there is reference to referral or care provided elsewhere. The clinical reviewer will look for a summary of findings or discharge summary in the medical record. Examples include, but are not limited to, progress notes/reports from consultants, discharge summary following inpatient care or outpatient surgery, physical therapy reports, and home health nursing/provider reports.
14. Age appropriate routine preventive services/risk screenings are consistently noted, i.e. childhood immunizations, adult immunizations, mammograms, pap tests, etc., or the refusal by the patient, parent or legal guardian, of such screenings/immunizations, in the medical record.
15. Medical records are stored securely and only authorized personnel have access
16. There is evidence of annual staff confidentiality training
17. There is evidence that the member was informed of their rights and responsibilities as a member

Record Retention

Records shall be maintained by Oscar for ten years. For additional information, refer to Oscar's Record Retention Policy.

Questions and Further Guidance

If you have any questions or need further guidance regarding any aspect of this Policy, please contact Quality Improvement at quality@hioscar.com.

Documentation Standards and Review Tool for Medical Records

Name of Provider	Medical Group / IPA	Specialty
Provider Address	Provider Phone:	NPI:
may delete this row if provider's records being audited at a HIM/Medical Records central location		
Auditor Name & Title	Type of Record. If Electronic, Vendor:	Provider Contact Person/phone:

Review Date	# Charts Audited	Overall Compliance	Is CAP Required (C< 80%) Yes No
Narrative			

	Key: Y = Yes N = No N/A = Not Applicable														Comments
Medical Record Identifier	MR # 1	MR # 2	MR # 3	MR # 4	MR # 5	MR # 6	MR # 7	MR # 8	MR # 9	MR # 10	MR # 11	MR # 12	MR # 13	MR # 14	MR # 15	
Chart organization and demographics																

Documentation Standards and Review Tool for Medical Records																
Charts are stored securely and only authorized personnel have access. There is evidence of periodic staff confidentiality training.																
Each page contains the member's name or ID number.																
The record is legible to someone other than the writer.																
There is evidence the member was informed of their rights and responsibilities.																
Demographic information is documented, including:																
Name																
Address																
Telephone number																
Primary /Preferred spoken language																
Date of birth																
Disabilities (if applicable)																
Advance directive is either present in the medical record or there is evidence of it being discussed with or declined by the member.																
Emergency information (contact name/address/phone) is noted.																
Medication allergies and adverse reactions are prominently noted in the record and are notated in the progress note with every new encounter, or are prominently displayed in electronic format on electronic medical records such as in Red font. If the member has no known allergies or history of adverse reactions this information is appropriately noted.																

Documentation Standards and Review Tool for Medical Records

Clinical Information															
A medication list is present (if prescriptions ordered).															
Significant medical conditions/illnesses are noted on the health problems list.															
Past medical history is documented, including significant illnesses, accidents, and operations, and prenatal and birth information for pediatric members.															
The history and physical exam identifies appropriate subjective and objective information pertinent to the member's presenting complaints.															
The visit notation clearly indicates															
Subjective data: Chief complaint															
Objective data: Focused physical exam															
Assessment: Diagnosis or Impression															
Plan: Treatment plan, goals															
The record includes sufficient information identifying dates of encounters and pertinent information documenting the member's diagnosis(es).															
A standardized wellness screening form is used to prompt and track age- appropriate screening services.															
Consultation, laboratory, and imaging reports filed in the chart are initialed or acknowledged by the provider who ordered them to signify review.															

Documentation Standards and Review Tool for Medical Records																
Contacts with member's family, guardian, or significant other are noted (if applicable).																
Coordination and Continuity of Care																
Primary care follow-up is provided when indicated (e.g., calls, visits, tests). The time of return is noted in weeks or months (if applicable).																
Continuity and coordination of care between the PCP, specialty physician(s) and other facilities is contained within the medical record, if indicated. Examples include, but are not limited to, progress notes/reports from consultants, discharge summary following inpatient care or outpatient surgery, physical therapy reports, and home health nursing/provider reports.																

Documentation Standards and Review Tool for Medical Records															
Evidence of continuity of care for patients with behavioral health (BH) issues is contained within the medical record, if indicated. Examples include, but are not limited to: Evidence of coordination and collaboration from health plan and BH case managers for the transition of patients between levels of care, (i. e.: inpatient, intensive outpatient, and day and residential treatment settings), evidence of ongoing and relevant communication between the PCP and the BH provider, evidence of coordination between the PCP and the BH provider for the appropriate evaluation, screening, diagnosis and treatment for severe mental illness (SMI), severe emotional disturbance (SED), and autistic spectrum disorders (ASD).														
Scoring Totals															
Total # of Yes responses															
Total # of No responses															
Total # of N/A responses															
Total (must = 28)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Comments (Indicate Chart #)															

Documentation Standards and Review Tool for Medical Records

Compliance Calculation															
Total # of Yes responses															
Total # of Yes + No responses	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
% Compliant Elements (# Yes / # Yes + No) x 100	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

Stratification of Score and Action Requirement

Sum of Compliance Scores	Average Compliance Score
#DIV/0!	#DIV/0!
Total number of records audited	

Compliance Determination: Score ≥ 80% indicates compliance. Designate a compliant record with the letter "C" and designate noncompliant records with the letters "NC".According to Oscar's Medical Records Standard Policy, when medical record standards are not met and opportunities for improvement are identified, the PCP will be issued a corrective action plan (CAP) with objective interventions and target completion dates.
A corrective action plan will be issued when 80% of reviewed records do not meet the individual record compliance standard of 80%.

DOCUMENTATION STANDARDS AND REVIEW TOOL FOR MEDICAL RECORDS

(Revised: June 2017)

Today's date _____

Oscar Health Plan Reviewer _____**Date of Review**_____

Record # _____ **of** _____	**Medical/Treatment record documentation score:** _____ ☐ **Compliant (≥80%)** ☐ **Noncompliant (<80%)**

Provider name _____

Group practice name (if applicable)_____

Provider address_____

City_____ **State** _____ **ZIP**_____

Phone ( ) _____ - _____ E-mail_____

Provider specialty ☐ Family practice ☐ Internal medicine ☐ General practice ☐ OB/GYN ☐ Pediatrics ☐ Other specialty

#	Assessment standards	Yes	No	N/A	Comments
	Chart organization and demographics				
1	Charts are stored securely and only authorized personnel have access. There is evidence of periodic staff confidentiality training.	☐	☐	☐	
2	Each page contains the member's name or ID number.	☐	☐	☐	
3	The record is legible to someone other than the writer.	☐	☐	☐	
4	There is evidence the member was informed of their rights and responsibilities.	☐	☐	☐	
	Demographic information is documented, including:				
5	• Name	☐	☐	☐	
6	• Address	☐	☐	☐	

#	Assessment standards	Yes	No	N/A	Comments
7	• Telephone number	☐	☐	☐	
8	• Primary/preferred spoken language	☐	☐	☐	
9	• Date of birth	☐	☐	☐	
10	• Disabilities (if applicable)	☐	☐	☐	
11	Advance directive is either present in the medical record or there is evidence of it being discussed with or declined by the member.	☐	☐	☐	
12	Emergency information (contact name/address/phone) is noted.	☐	☐	☐	
13	Medication allergies and adverse reactions are prominently noted in the record and are notated in the progress note with every new encounter, or are prominently displayed in electronic format on electronic medical records such as in Red font. If the member has no known allergies or history of adverse reactions this information is appropriately noted.	☐	☐	☐	
Clinical Information					
14	A medication list is present (if prescriptions ordered).	☐	☐	☐	
15	Significant medical conditions/illnesses are noted on the health problems list.	☐	☐	☐	
16	Past medical history is documented, including significant illnesses, accidents, and operations, and prenatal and birth information for pediatric members.	☐	☐	☐	
17	The history and physical exam identifies appropriate subjective and objective information pertinent to the member's presenting complaints.	☐	☐	☐	
	The visit notation clearly indicates:	Yes	No	N/A	Comments
18	• Subjective data: Chief complaint	☐	☐	☐	
19	• Objective data: Focused physical exam	☐	☐	☐	
20	• Assessment: Diagnosis or Impression	☐	☐	☐	

21	• Plan: Treatment plan, goals	☐	☐	☐	
22	The record includes sufficient information identifying dates of encounters and pertinent information documenting the member's diagnosis(es).	☐	☐	☐	
23	A standardized wellness screening form is used to prompt and track age-appropriate screening services.	☐	☐	☐	

#	Assessment standards	Yes	No	N/A	Comments
24	Consultation, laboratory, and imaging reports filed in the chart are initialed or acknowledged by the provider who ordered them to signify review.	☐	☐	☐	
25	Contacts with member's family, guardian, or significant other are noted (if applicable).	☐	☐	☐	
Continuity and coordination of care					
26	Primary care follow-up is provided when indicated (e.g., calls, visits, tests). The time of return is noted in weeks or months (if applicable).	☐	☐	☐	
27	Continuity and coordination of care between the PCP, specialty physician(s) and other facilities is contained within the medical record, if indicated. Examples include, but are not limited to, progress notes/reports from consultants, discharge summary following inpatient care or outpatient surgery, physical therapy reports, and home health nursing/provider reports.	☐	☐	☐	

28	Evidence of continuity of care for patients with behavioral health (BH) issues is contained within the medical record, if indicated. Examples include, but are not limited to: Evidence of coordination and collaboration from health plan and BH case managers for the transition of patients between levels of care, (i.e.: inpatient, intensive outpatient, and day and residential treatment settings), evidence of ongoing and relevant communication between the PCP and the BH provider, evidence of coordination between the PCP and the BH provider for the appropriate evaluation, screening, diagnosis and treatment for severe mental illness (SMI), severe emotional disturbance (SED), and autistic spectrum disorders (ASD).	☐	☐	☐	

Medical Record Audit Compliance Assessment

Scoring Totals

Total number of "yes" responses		Must total 28
Total number of "no" responses		
Total number of "N/A" responses		

Compliance Calculation

A. Total number of "yes" responses from above		(A/B) x 100 = _____%
B. Total number of "yes" plus "no" responses from above		

Stratification of Score and Action Requirement

Score	Result	Action	Result (√)
Score ≥ 80%	Compliant	No action	
Score < 80%	Non-compliant	*	

*

1. According to Oscar's Medical Records Standard Policy, when medical record standards are not met and opportunities for improvement are identified, the PCP will be issued a corrective action plan (CAP) with objective interventions and target completion dates.
2. A corrective action plan will be issued when 80% of reviewed records do not meet the individual record compliance standard of 80%.