


<b>SUBJECT:</b>	Site Visit and Medical Record Keeping Policy	
<b>BUSINESS OWNER:</b>	Quality Improvement	<b>Page 1 of 7</b>
<b>APPROVED BY ACCREDITATION TEAM</b>		
 _____ Joshua Plavin, MD MPH Vice President and Chief Medical Officer	<b>ORIGINALLY EFFECTIVE:</b> 8/31/2000	
	<b>LAST REVISED:</b> June 2021 (formerly titled "Medical & Treatment Record Standards")	
	<b>NEXT REVIEW DATE:</b> June 2022	
	<b>APPLIES TO:</b> All Lines of Business	
<b>REGULATORY / ACCREDITATION LINKS:</b> 2021 NCQA HP Standards: CR 5 State of Vermont Rule: H-2009-03 Section 6.1		
<b>POLICY LINKS:</b> Quality of Care and Risk Investigations Policy Member Complaints Policy Access Policy Professional Credentialing Policy		

## I. Scope

Blue Cross and Blue Shield of Vermont (Blue Cross; the Plan) requires network providers to maintain medical and mental health and substance use disorder (MHSUD) office facilities that provide a safe, high quality and accessible environment that is conducive to the delivery of effective patient care for members as well as the protection of the office staff. Blue Cross sets standards for physical accessibility, physical appearance, adequacy of waiting and examining room space and the adequacy of medical/treatment record keeping. Appointment scheduling must meet the Plan's availability requirements as explained in the Plan's *Access Policy*.

Plan requires all providers to maintain member records in a manner that is current, detailed, and organized permitting effective member care and quality review. Records may be written or

electronic. Plan reserves the right to review records of any provider of any specialty at any time.

The Plan reserves the right to conduct an office site review of primary care and specialty providers when an identified need arises. This assessment can occur upon receipt of a new application to the network or due to a relocation of an existing network provider. Member complaints concerning any of the following which are corroborated and not resolved by our initial investigation will initiate an office site review within 60 days:

1. Physical accessibility
2. Physical appearance
3. Adequacy of waiting and/or examining room space
4. Adequacy of medical or treatment record keeping

Issues categorized here include, but are not limited to, breaks in infection control procedures, unsafe facility aspects, noncompliance with requirements of the *American with Disabilities Act* (ADA), and loss of medical records.

Blue Cross expects all network offices, both medical and MHSUD to adhere to the office site guidelines consistent with the services provided in individuals offices. Blue Cross will disregard any standards not relevant to a particular site as non-applicable.

## **II. Office Facilities and Environment Assessment Standards**

Blue Cross reviews facilities against each applicable standard as follows:

- A. General Standards for Physical Accessibility, Safety and Appearance
  1. The office shall be accessible to individuals with disabilities consistent with ADA guidelines.
  2. Patient examining rooms/consulting rooms/waiting rooms ensure patient comfort and privacy.
    - a. Adequate waiting room space
    - b. Adequate lighting
    - c. Adequate seating for patient and caregivers
    - d. Adequate privacy during exchange of medical information

## **III. Medical & Treatment Record Standards**

### **A. Confidentiality, organization, and storage of medical and treatment records**

A provider must have office policies and procedures related to organization, storage, retrieval, and confidentiality of records to ensure compliance with the standards below:

1. Records are stored securely.
2. Records are organized and stored for easy retrieval.

3. Only authorized personnel have access to records.
4. Staff receives periodic training in member information minimum content and confidentiality protections.
5. Records must be safeguarded against loss or destruction and are maintained in accordance with state requirements.
6. Practices give members and Plan the right to see individual treatment records upon request during regular business hours and to copy those records for a fee that is consistent with legal requirements.
7. Upon closure of the practice, or termination from Plan's networks, a provider must inform Plan where Plan members' medical records will be stored and how Plan may access such records for purposes of audit or to respond to a request for records from a member or other authorized entity. Plan expects a provider will follow all applicable state guidelines for medical record retention.

## **B. Documentation Standards**

1. The problem list includes significant illnesses and medical conditions when applicable.
2. The record prominently notes Do Not Resuscitate (DNR) orders, medication allergies, adverse reactions, or no known history related to these.
3. Past medical history is easily found and includes accidents, operations or illnesses. For children and adolescents (18 years and younger), past medical history relates to prenatal care, birth, operations, immunization history, and childhood illnesses.
4. The record contains a list of current medications. For each prescribed medication, the record must document the dose, frequency, duration, and route of administration. Dates for start of the medication, change(s) in dosage, and discontinuation should be noted. The patient's response to each medication should also be documented.
5. Clinical evaluation and findings are documented for each visit.
6. Personal biographical data includes address, employer, home and work telephone numbers, and marital status.
7. Working diagnoses are consistent with findings.
8. Treatment plans are consistent with diagnoses.
9. Consultation, lab, and imaging reports filed in the chart are initialed by the practitioner who ordered them, either in writing or by some other method (i.e., electronic) to signify review. Copies of test requisitions should be in the medical record.
10. Consultation and abnormal lab and imaging study results have an explicit notation for follow up in the record.
11. There must be evidence in the medical record that a written report of a consultant's findings and opinion or recommendation is communicated to the requesting physician or other appropriate source was completed.

- 12.** The record contains no evidence that a diagnosis or therapeutic treatment places the member at inappropriate risk for harm.
- 13.** Every form and page in the record contains the patient's name and one other means for identification (ID number or Date of Birth).
- 14.** For paper records, the author signs the record/treatment/progress note; the signature is legible and includes the author's professional credentials (MD, APRN, etc.). Provider codes and stamps are not acceptable. Unsigned notes and documentation will not be accepted as verification of services provided. In the case of electronic health records (EHR), the electronic signature and date must appear.
- 15.** All entries must be dated.
- 16.** The existence of an advance directive is documented in each adult's record (and whether it has been executed).
- 17.** Electronic medical records, such as template records, are updated and individualized with each patient encounter.
- 18.** Patient records will not contain "cut and paste/copy forward" entries; these cannot be supported as valid for the patient record.
- 19.** The medical records should be written in English and contain only industry standard abbreviations.
- 20.** In cases of paper records, the record is legible to someone other than the writer.
- 21.** Unresolved problems from previous visits are noted and the record documents that these were addressed at subsequent visits.
- 22.** Documentation includes a notation, when indicated, regarding follow-up care, calls or visits. The notes include the specific time of return communication in weeks, months years or PRN (i.e., as needed).
- 23.** The record contains appropriate notations concerning the use of alcohol, tobacco, and other substance use, if appropriate.
- 24.** For adolescent patients, documentation includes appropriate screening with a tool to screen for substance use. For youth identified as at risk, the record includes an appropriate intervention by noting an implementation or referral.
- 25.** The history and physical for acute, chronic or preventive issues document the appropriate subjective and objective information for presenting complaints.
- 26.** The provider orders labs and tests consistent with currently published standards of care.
- 27.** Documentation in the record demonstrates the appropriate use of consultants.
- 28.** If the primary care provider requests a consultation from another provider, there is a note from the consultant in the record.
- 29.** All services provided by the practitioner and all ancillary services and diagnostic tests ordered by the treating practitioner are clearly documented in the record.
- 30.** Summary reports for all diagnostic and therapeutic services a member utilized, such as home health nursing reports, specialty physician reports, physical therapy reports, emergency room reports, and hospital discharge summaries are maintained in the patient record.

- 31.** Documentation for intravenous therapy includes the date and time of insertion, type, catheter length and gauge, name of vein cannulated, number of attempts, and type of dressing.
- 32.** Primary care practices initiate an immunization record for each member.
- 33.** Immunization record is up to date or appropriate history is made in the record for adults.
- 34.** The practice conducts preventive screening and services in accordance with the Plan's practice guidelines.
- 35.** Records for patients receiving therapy include:
  - i.** Measurable, individualized, patient-centered goals. Goals should be S.M.A.R.T.:
    - 1.** Specific – use specific rather than generalized language, stating the issue, the target group, and the time and place of the program.
    - 2.** Measurable – to make evaluation easier, goals should be clear in the objective about what will be changed and by how much
    - 3.** Achievable – goals should be realistic about what the program can achieve in terms of scale/scope of what is being done and the time and resources available
    - 4.** Relevant/Realistic – objectives must relate to and be relevant to the goals
    - 5.** Time-Specific – be clear about the timeframe in which the program/activities, as well as expected changes will occur
  - ii.** Individualized treatment plans that:
    - 1.** Are consistent with the diagnoses and the evidence-based interventions used;
    - 2.** Show how outcomes will be demonstrated, how change will be measured, and the frequency of treatment procedures;
    - 3.** Reflect any treatment failure or a change in diagnosis and/or a change in treatment plan;
    - 4.** Treatment plan goals and objectives are well defined;
    - 5.** Contain re-evaluations of the treatment plan driven and determined by the measurable patient centered goals;
    - 6.** Reflect treatment frequency and duration driven by the patient's acuity level;
  - iii.** Progress notes with patient assessments documenting patient's strengths and barriers to achieving treatment plan goals and discharge planning. Progress notes must clearly demonstrate that the patient displays evidence of improvement (note progress the patient is making) and/or lack of improvement or regression.

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- iv. A late entry applies only to documentation within the EHR that is entered after the point of care. Late entries should
  - 1. Identify the new entry as such;
  - 2. Bear the current date of time (should not give the appearance the entry was made on a previous date or an earlier time);
  - 3. Identify or refer to the date and incident for which the late entry is written;
  - 4. Identify any sources of information supporting the late entry; and
  - 5. Be completed as soon after the original note as possible.
- v. Completion is the process of completing an entry in the record by applying the provider's signature, either electronic or manual. Once the signature is applied, the entry is considered complete and the only opportunity to make changes is through amendment or addendum. All entries should be completed within two business days of the time of service.

#### **IV. Performance Goals**

Compliance with all elements requires no intervention. Offices can only pass the survey if they meet all standards. The Plan provides written feedback to the practitioner detailing the findings. Should the office fail to meet all standards, the Plan provides feedback to the practitioner and requests a performance improvement plan (PIP). If the site fails a review prior to initial credentialing or re-credentialing and requires a PIP, the provider will not qualify for admittance into or continuation in the network until a successful follow up site visit is completed.

#### **V. Site Visit Procedure**

Blue Cross can choose to conduct a site visit based on a member complaint if such an activity is necessary to complete an investigation. Notification of the planned visit is not necessary if the complaint originated with a member. A Plan representative conducts the office site review using the approved survey form attached here.

Upon completion of the site visit, Blue Cross calculates the score to determine provider compliance with the Plan standards. The quality improvement staff provides the office with the outcome of the review in writing within fourteen (14) calendar days and assists with the formulation of any PIP needed.

The provider must submit the PIP within thirty (30) calendar days of the review. The Plan will conduct a follow up review approximately three months after the initial review. Failure to provide the PIP or failing the follow-up review will result in Blue Cross reporting the deficiencies to the state and scheduling a third review. Continued failure at this third review may result in suspension or dismissal from the network. The provider will not qualify for admittance into or continuation in the network until a successful site visit is complete.

The following rules apply for office site review:

1. If a multiple site practice has the same medical record keeping process at all sites, the Plan only reviews medical record keeping practices at one site.
2. If a practitioner practices at more than one site, a site visit may be conducted at all additional sites if needed.

## **VI. Reporting Requirements**

The quality improvement staff will compile and analyze member complaints from all available sources every six months and report to the Member Experience Team. This will include any results and follow-up actions from office site reviews.

## **VII. Distribution of Policy to Providers**

The Plan distributes this policy and office site criteria to network practitioners and appropriate staff members. The quality improvement department facilitates publication of these criteria in the provider newsletter, in the provider manual, and on the provider web site.

## **VIII. Annual Review**

The Accreditation Team reviews this policy and procedure annually to ensure consistency with current business practice and to incorporate the latest regulatory and accreditation standards.

## **IX. Attachment**

- Office Site Survey Form