BCBSRA Medical Record Review Tool Guidelines for Use with Excellus Medical Record Documentation Tool

Biographical/Personal Data

1. **Patient ID on all pages**
   Each and every page of the medical record should have the patient’s name or an ID number (this could be an insurance number, SS number or office MR number). The practitioner needs to be 100% compliant with this standard to receive credit.

2. **Date of Birth**
   The patient's date of birth should be listed in the record in an easy-to-find and logical location: the front sheet, insurance sheet, health history questionnaire, problem list, any standard form used by the practitioner. Often it is listed on the “tab” of the medical record, with patient’s name and/or medical record number.

3. **Current address**
   As with the DOB info, this should be listed somewhere on a standard form that is easily accessible. Occasionally this information is stored in the computer database --- if this is the case, ask to verify one patient address from the group of medical records you are reviewing.

4. **Work or home phone number (as applicable)**
   Home number should be listed on front sheet or any other standard informational sheet used by practitioner. If it is documented that patient works outside the home, work number should also be listed. Minimum requirement to receive credit is either home or work number be listed.

5. **Employer**
   If the patient is over 18 and employed, the employer’s phone number should be listed. The phone numbers should be listed in an easily accessible location, on any of the standard forms used by the practitioner.

6. **Marital status**
   Marital status for patients over the age of 18 should be listed in the record; it should be easily accessible, on any of the standard forms used by the practitioner. It is acceptable if documented in the progress notes, but reviewer should not have to spend a great amount of time searching for this info in the progress notes.

7. **OB/GYN name (as applicable)**
   For Rochester Plan, this is not applicable, as we have OB/GYNs listed as alternate PCPs.

8. **Advanced Directive discussion**
   Any form of Advanced Directive discussion (Health Care Proxy, Living Will or Advanced Directive) is acceptable, as long as it is documented. Documentation of AD/HCP discussion can often be found on a patient questionnaire, on the cover of the record, or on a standard form used by practitioner. A completed Advance Directive form is not necessary to receive credit on this standard, but documented discussion of any form of Advance Directive must be present. Obviously, if there is a completed Advance Directive form in the
chart, credit is given for this standard. This standard applies to adults over the age of 18, emancipated minors, and minors with children.

**General Chart Organization**

9. **All entries signed**
   All entries need to be signed by the writer --- full name is ideal, but initials are acceptable. Dictated and computer generated notes may have electronic signature/initials or typed signature/initials. If 2 or more entries are not signed, provider does not get credit for this standard.

10. **All entries dated**
    Each entry by the physician’s office should have a complete date on it, including day, month and year. This includes entries by the PCP, nurses and other office staff.

11. **Record is organized**
    All entries should follow some form of a sequential timeframe; some offices place the most recent visit on the top sheet of progress notes, while other offices have the most recent visit on the last page of the progress notes. Either format is acceptable, as long as the entries are in sequential order and the reviewer is able to follow the sequence without difficulty. The same should apply to all lab work, consults and correspondence. The reviewer should not have to spend time determining the sequence of visits and patient data – it should readily apparent.

12. **Record is legible**
    The notes written by the practitioner need to be discernable to the nurse reviewer. If the content of multiple notes (or an entire record) is not apparent because of consistently illegible handwriting, the nurse reviewer should deem the record illegible. An occasional illegible word or two that do not interfere with understanding an entry should not deem a record illegible. If the review is a re-review for legibility, the nurse reviewer should examine only the time period after the practitioner was notified that improvement must occur.

    If the nurse reviewer deems the records illegible, request copies of (or sends a letter requesting copies) three medical records, including progress notes for the past 12 months. A Medical Director, and, if necessary, the delivery system will then review the records for legibility.

    Illegible medical records are an automatic failure of the medical record review.

**Personal History**

13. **Completed problem list**
    This standard requires that significant illnesses/diagnoses be listed in a manner that is easily discernable to the nurse reviewer. Often there is a section on the practitioner’s standard forms for a problem list, or an entire sheet is devoted to the problem list. Some practitioners list the patient’s problems at each visit --- this is acceptable if it is a complete list of significant illnesses, and is easily located by the reviewer. Another way problem lists are documented is on the inside of the front cover – this is also acceptable. Routine Health
Maintenance (RHM)/Well Child Visits “No Problems” need to be noted on problem list if patient has no diagnosis other than health/preventive visits. Problem lists should be kept current by eliminating issues that have been resolved and adding new diagnoses or illnesses to the list. The nurse reviewer should check the record to make sure that any significant illness/diagnoses discussed in progress notes, correspondence and labs/tests are catalogued in the problem list.

14. **Current medication list**

Patients’ current medications should be listed in an easily accessible spot in the record. Both prescription drugs and over-the-counter drugs should be included. Use of a standard form for medications is the usual (and ideal) practice, but some practitioners may document medications at each visit. This is acceptable, if the information is current and complete.

15. **Allergies/adverse reactions noted**

Allergies and adverse reactions to medications and other substances (like latex) should be listed in a prominent and easily located spot in the medical record. If the patient has no known allergies, that should also be documented. In order to receive credit for this standard, specific allergies/adverse reactions must be noted, or NKA/NKDA noted. This information can be found in various places within the medical record: on the outside/inside cover of some records, on patient information/questionnaire sheet, medication sheet, or any other standard information sheet used by practitioner.

16. **Past medical history**

Prenatal, birth and childhood illness information should be a part of patient history for children aged 6 and younger, in order to receive credit for this measure. A report of labor and delivery, or a hospital discharge note/form after birth is acceptable to document perinatal information.

Past medical history information can often be found in either a health questionnaire filled out by the patient/parent, or on the standard history or other informational forms used by the practitioner. Some practitioners document past history at the patient’s first visit or first CPE, within the progress notes. This is acceptable, if it is easily identified and not “buried” in pages of progress notes, requiring extensive searching by the reviewer. Patient history needs to be documented at each CPE/Well Child Visit, or “no change from last (interval/CPE/Well Child Exam) exam” noted.

17. **Family history**

Family history should include, at a minimum, health history of parents and siblings. As with standard #16, this information can often be found in a health questionnaire filled out by the patient or parent, or on the standard history or informational forms used by the practitioner. Some practitioners fill in family history at the patient’s first visit or first CPE, within the progress notes. This is acceptable, if it is easily identified and not “buried” in pages of progress notes. Family history must include at least siblings and parents, and should be recorded at each (interval/CPE/Well Child Exam), or “no change from last exam” noted.

18. **Social history**

Social history should include at a minimum, patient occupation, education and living situation. Other elements that may be included are hobbies, and status of patient’s personal relationships (for example, recently divorced, estranged from parents, stressful work environment). Some practitioners fill in social history at the patient’s first visit or first CPE, within the progress notes. This is acceptable, if it is easily identified and not “buried” in
pages of progress notes. Social history should be recorded at each (interval/CPE/Well Child Exam), or “no change from last exam” noted.

**Social habits for all patients, aged 11 and older:**

19. **Tobacco use**
   This standard requires documentation of smoking history (current or past smoker, number of years, PPD), and/or counseling re tobacco cessation. If there is a smoking question/section on a standard form, it must be answered “yes” or “no” to receive credit; do not assume patient is a non-smoker if this field is left blank. Can be found on standard form, patient questionnaire or in progress notes at patient’s first visit or CPE. Tobacco use should be recorded at each (interval/CPE/Well Child Exam), or “no change from last exam” noted.

20. **Alcohol use**
   This standard requires documentation of history of alcohol use/abuse, and/or counseling re stopping alcohol use/abuse. If this is a question on a standard form or patient questionnaire, it must be filled in – if left blank, no credit can be given. Alcohol history may also be found in progress note at first visit or CPE. This information should be recorded at each (interval/CPE/Well Child Exam), or “no change from last exam” noted.

21. **Substance use**
   This standard requires documentation of drug/substance use/abuse, and/or counseling re cessation of drug use/abuse. Substance abuse may be documented as “illegal drugs”, “street drugs”, or by specific name of drug, such as cocaine, marijuana, etc. If this is a question on a standard form or patient questionnaire, it must be filled in – if left blank, no credit can be given. Drug/substance history may also be found in progress note at first visit or CPE. This information should be recorded at each (interval/CPE/Well Child Exam), or “no change from last exam” noted.

22. **HIV/STD risk**
   This is both an assessment of risk for HIV/STDs and/or counseling re avoiding HIV/STDs. Ideally it should include sexual activity (is patient sexually active or abstinent), number of partners in given time period, sexual orientation, and if protection is used consistently. May be found on standard forms or questionnaire or in progress at first visit or CPE. This information should be recorded at each (interval/CPE/Well Child Exam), or “no change from last exam” noted.

**Office Visit/Follow up**

23. **Pertinent subjective and objective information**
   Patient’s complaints/reason(s) for visit are recorded at each visit, including well visits for CPE, annual OB/GYN exams and other preventive services such as immunizations, screenings, etc. Practitioner’s findings from physical assessment and discussion with patient are described at each visit. For CPE, well-child visits, a checklist format is acceptable, as long as it is filled in.

24. **Lab and other studies ordered as appropriate**
   Tests ordered are appropriate and timely, given patient’s complaints and diagnosis.

25. **Diagnosis/impression consistent with findings**
Diagnosis or practitioner’s impression of patient’s condition is in keeping with the both the patient’s complaints, history and the results of the physical/psychological assessment by practitioner.

**Plans/actions consistent with diagnosis:**

26. **Timeframe for return visit**
   Each visit should have a notation regarding when patient should return; responses can include: next preventive health screening (for example, 12-month check up, next CPE), a specific number of days, weeks, months or years, or PRN.

27. **Appropriate use of referrals/specialists**
   Practitioner’s use of referral/consultants is appropriate – that is, for simple uncomplicated problems that might require some basic knowledge in specialty areas, the PCP attempts to resolve the issue without specialist. Examples of this might be a simple skin rash that the PCP treats, instead of referring patient to dermatologist immediately; or, a patient with a one-time uncomplicated UTI. On the other hand, complicated problems that may be out of the realm of many PCP’s expertise (unresolved skin rash after 2-3 visits to PCP, or a patient with 3 or more UTI’s within a 6 month timeframe), may require referrals to a dermatologist or urologist.

28. **Unresolved problems addressed.**
   Unresolved or ongoing conditions/problems from earlier visits should be included in the assessment of patient’s current condition, when appropriate. Resolved issues, such as short term/self limiting conditions like viruses, and issues completely resolved with previous treatment/surgery (for example, appendicitis), are excluded from this standard.

29. **No shows/missed appointments documented**
   If patient fails to show up for a scheduled appointment, it should be documented in the record. Abbreviations are often used to indicate no-shows; some of them are: FTKA (failed to keep appointment), DNKA (did not keep appointment), etc.

30. **Continuity/coordination of care documented**
   If the patient has been referred to a specialist, there should be documentation (in the form of a letter or report from the specialist’s office) regarding any testing, evaluation and treatment. There also may be written documentation in the progress notes of telephone conversations with the specialist. Discharge summaries from hospitalizations and ER visits should also be in the medical record.

31. **Tests, labs, summaries reviewed by PCP**
   The practitioner must have a way to demonstrate that he has reviewed the results of labs, test, and reports. Initialing is the usual practice, but other ways are acceptable, as long as it is obvious the practitioner has reviewed the results.

32. **Care rendered is medically appropriate**
   No inappropriate risk to the patient is identified from the care provided. If the reviewer believes that the patient has been placed at risk, a copy of that medical record will be requested shortly after the review. The record/issue will then go through the formal Quality Concern Process.
Preventive Services Offered

33. Exercise
Any references to formal exercise programs, sports participation, regular exercise (or attempts at regular exercise), documentation of “no exercise”, or practitioner counseling regarding exercise is acceptable. Many standard forms or patient questionnaires have a section on exercise, or this info may be in progress notes at first visit/CPE.

34. Diet/Nutrition
Any reference to patient’s nutritional intake, specific diets such as low calorie, low fat, low sodium, low cholesterol, food allergies/intolerances, or counseling by practitioner regarding diet or nutrition is acceptable. Many standard forms or patient questionnaires have a section on nutrition/diet, or this info may be in progress notes at first visit/CPE.

35. Injury Prevention
For adults, the minimum requirement is discussion of seatbelt use; other types of basic injury prevention like bike/motorcycle helmets, rollerblading protective gear, etc., are occasionally found in records. For children, injury prevention should include age-appropriate measures, such as car seats for infants and toddlers, household accident/poisoning prevention, bicycle safety, rollerblading safety, stranger danger, etc.

36. Age Appropriate Preventive Health
Complete physical exams, well child visits, immunizations, pap smears, mammography, colorectal cancer screening, etc., should be offered to patient as per HMO preventive health guidelines. For more specific information and timeframes please refer to:
- BCBSRA Guideline for Preventive Care of Adults, Ages 18 and Older, Healthy and at Risk
- Preventive Health Services: Healthy Children to Age 18

37. Immunization Record
For children up to age 18, a complete record of immunizations (MMR, DPT, HepB, varicella, Hib, etc) should be part of the medical record; for adults, the date of most recent tetanus booster, influenza vaccine and pneumococcal vaccine (if appropriate) should be documented. For adults, the minimum requirement is the date of last tetanus (year only is OK), and influenza and pneumococcal vaccine, if applicable.

General Rules/Information for Medical Record Review Tool

- Standard forms include any pre-printed forms used by practitioner for the purpose of obtaining specific information regarding patients; “front sheets”, patient questionnaires, medication sheets, problems list sheets, immunization sheets, insurance sheets, etc., are all examples of standard forms.

- It is not acceptable for the reviewer to obtain patient biographical or historical information from a consultant’s write-up or hospital/ER records, or any other specialist’s documentation, unless noted in the above guidelines. This information should be documented in the record notes or forms from the PCP’s office.

- If patient demographic information is stored electronically, verify by reviewing the computer data on one patient.

- Information obtained from patient or physician-answered questionnaires must either be signed or initialed by the MD (to show that he/she has reviewed the answers), or items must be specifically referenced in the progress notes. No credit can be given for measures that are found on a questionnaire that is completed, but not signed/initialed by the MD, unless that item is specifically addressed in the progress note.
Generally speaking, nurse reviewers will be looking for the medical record standards documentation within the provider's current credentialing timeframe (two years presently). For example, if the PCP is due for recredentialing in December of 2001, the nurse reviewer will be concentrating on the data in the medical records for the years 2000 and 2001.