Continuous Improvement of Medical Record Documentation

Policy ID: 70.1.1.26

Version: 1
Published Date:
Compliance Date:
Policy Number:
Policy Entity: BSC
Plan/Group Type:

Policy Statement

A. Blue Shield requires medical record reviews to assess compliance with Blue Shield requirements, including the following:

1. Confidentiality of medical records
2. Medical record documentation standards
3. An organized medical record-keeping system and standards for the availability of medical records
4. Performance goals to assess the quality of medical record-keeping

B. Medical records of primary care practitioners (PCPs) reflect the following:

1. All services provided directly by the primary care practitioner (PCP)
2. All ancillary services and diagnostic tests ordered by the PCP
3. All diagnostic and therapeutic services for which a member was referred by a PCP

C. Blue Shield institutes corrective actions when necessary and when standards are not met.

Purpose

To improve the quality of medical record documentation to meet requirements of Blue Shield of California, which align with accreditation and regulatory requirements, including the following:

1. Medical record content

2. Medical record organization
3. Information filed in medical records
4. Ease of retrieving medical records
5. Confidential patient information
6. Standards and performance goals for participating practitioners

Scope (Departments)

Quality can use this for the Departments: Only list the departments within the scope

☒ Clinical Quality Review
☒ Quality Assurance

Roles and Responsibilities

Definitions

Policy

A. Blue Shield utilizes a medical record review tool that combines and includes the critical elements:

1. Problem list
    a. Significant illnesses
    b. Significant medical conditions
    c. Idiosyncratic medical problems are conspicuously noted
2. Allergies are prominently noted
    a. Medication allergies
    b. Adverse reactions
    c. No known allergies noted if applicable
3. History
    a. Past medical history
    b. Includes serious accidents, operations, and illnesses
    c. For <18 years, relates to prenatal care, birth, operations, and childhood illnesses

d. Pathology, laboratory, and other reports are recorded

e. Any necessary consultation and progress notes are evidenced as indicated

4. Physical Examination

   a. Includes subjective and objective information pertinent to the patient's presenting complaint(s)

   b. Must be documented in practitioner history as well

5. Diagnoses

   a. Are established by the record entries

   b. Are consistent with findings

   c. Important diagnoses are summarized or highlighted (important diagnoses are those that influence future clinical management)

   d. Treatment plans are consistent with diagnoses

6. Appropriate treatment

   a. No evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic procedure

   b. Therapies reflect an awareness of current therapies

7. Consultations

   a. Includes a note from the consultation in the record

   b. Electronic medical records contain either scanned-in reports that come from outside the practice, or the practice provides hard copy files for these records

8. Identifying information of the member

   a. Includes evidence of practitioner review of consultation, lab, imaging reports or other external reports filed in the chart

   b. Practitioner responsible for each entry is identifiable

9. Execution of follow-up plan

   a. Includes an explicit notation in the chart of follow-up plans for consultation, abnormal lab, and/or imaging study results

10. Prescribed medications
    a. Dosages
    b. Initial or refill prescriptions
11. Information on the presence or absence of an Advance Directive for adult members (over 18 years of age) in a prominent part of the medical record
    a. Includes documentation of whether the member has executed an advance directive
12. If an adult patient has an advance directive, a copy of the advance directive is included in the medical record

B. Licensed health care professionals, (i.e. RN, LVN, and MDs) must perform all medical record reviews.

C. Blue Shield will conduct medical record reviews at least annually through the assessment of a sample of records selected for review of HEDIS measures. Assessment of compliance will be based on selected indicators from the medical record standards outlined above.

D. Blue Shield will conduct focused follow-up to improve medical records of PCPs who perform poorly against established medical record standards. 90% is considered a passing score. Additionally, Blue Shield will provide interventions to improve medical record-keeping practices to the entire practitioner network.

E. Corrective actions may include, but may not be limited to the following:
    1. Individual physician follow-up
    2. Distribution of sample forms and model record keeping aids or best practices
    3. Physician correspondence through the provider website

F. Findings of medical record reviews and corrective actions shall be considered at the time of recredentialing when indicated for individual physicians.

Blue Shield will distribute the medical record standards and tools to all practitioners and appropriate staff members through publication in the online provider manual.

References

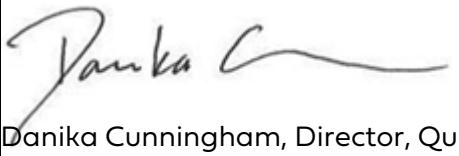
Reference Type	Name
Policies	(Related policies)
Additional Related Policies	(Related policies)
Standards	**Citations:** DMHC Standards: 28 CCR 1300.67.1(d), 28 CCR 1300.80(b)(4) (b), 28 CCR 1300.80(b)(5)(E) CMS Medicare Managed Care Manual Ch. 6 Section 60.3
Frameworks & Regulations	
Accrediting/ Regulatory Body	List any regulatory body this policy is used for DMHC, CMS
Line of Business Impacted	(Clinical Quality this will be blank)
Regulatory Product Type	**Clinical Quality will use this for the Lines of Business** ☒ Commercial - ☒ HMO ☐ POS ☒ PPO ☐ EPO ☐ FEHBP (HMO) ☐ FEP-PPO ☐ ASO ☒ Exchange - ☒ HMO ☒ PPO ☒ Other please specify: Medicare

Contact Information

If you have questions about this policy, contact Danika Cunningham.

Revision History

Summary of Changes	Version #	Revisor	Revision Date	Published Date
Origination Date: 7/96		Danika Cunningham	10/2021	
Policy owner updated		Heather Smalley	12/2022	
Added additional elements to the "Medical Record Review Tool" section to align with the tool document.		Daniel Garcia/Heather Smalley	4/2023	
Removed CMS citation		Daniel Garcia/Heather Smalley	6/2024	
Added the correct CMS citation that Compliance confirmed applies		Daniel Garcia/Heather Smalley	9/2024	

Approver	Approval Date
 Danika Cunningham, Director, Quality Management	10/2/2024