POLICY AND PROCEDURE

DEPARTMENT: Quality Improvement	**DOCUMENT NAME:** Medical Record Review
PAGE: 1 of 27	**REPLACES DOCUMENT:**
APPROVED DATE: 09/11	**RETIRED:**
EFFECTIVE DATE: 01/12, 2/15,12/15	**REVIEWED/REVISED:** 1/14, 3/14, 10/14, 12/14, 10/15, 10/16, 12/16, 3/17, 3/18, 1/19, 1/20, 1/21, 2/21
PRODUCT TYPE: All	**REFERENCE NUMBER:** LA.QI.13

POLICY AND PROCEDURE

SCOPE:
Louisiana Healthcare Connections (Plan) Quality Improvement Department

PURPOSE:
To outline the process by which the Plan monitors its practitioners ensuring medical records are maintained in a detailed and organized manner while maintaining patient confidentiality and facilitating a quality review.

POLICY:
The Plan's minimum standards for practitioner documentation and maintenance of medical records includes: medical record content and organization, ease of medical record retrieval, and maintaining confidentiality for all PHI. These standards are outlined in the Plan Provider Manual and at a minimum, include the following:

- Practitioners must maintain complete and up-to-date medical records at the site where services are provided, including, but not limited to, x-rays, laboratory tests, results, examinations and notes that document all medical services received by the member. These standards apply to all areas of service including inpatient, ambulatory, ancillary, and emergency care
- Medical records must be accurate, legible and maintained in detail consistent with good medical and professional practice which permits effective internal and external quality review and/or medical audit and facilitates an adequate system of follow-up treatment.
- Records must be prepared in accordance with all applicable State and Federal rules and regulations and signed by the medical professional rendering the services
- LDH or its designee shall have immediate and complete access to all records pertaining to the health care services provided to Plan members.
- Providers must maintain confidentiality of medical records in accordance with 42 CFR § 438.224 and 45 CFR Parts 160 and 165 subparts A and E. Medical records should be kept in a secure location and only accessed by authorized personnel. Providers' staff must receive periodic HIPAA and PHI training.
- Practitioners are required to maintain all member records for at least ten (10) years.

Medical record content standards are outlined in the attached medical and treatment record review tools (Attachment A) and are disseminated to all practitioners in the Provider Manual. When there are significant changes in the requirements, the revisions may be distributed through the Provider newsletter, through direct mailing and the Plan website.

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At least annually, Plan will assess network medical record keeping practices against the established standards. Physicians sampled must meet 80% of the requirements for medical record keeping or be subject to corrective action as outlined below.

PROCEDURE:

1. Plan will assess network medical record keeping practices against the established standards. Assessment may be accomplished by any of the following processes:
   a. Review a sample of records for compliance with HEDIS measures and identify deficiencies
   b. Review a sample of practitioner records that did not meet HEDIS standards or where other deficiencies were noted
   c. Review a sample of medical records based on past documentation deficiencies or other criteria.
   d. Additionally, any practitioner may be chosen throughout the year for focused chart reviews for purposes including but not limited to utilization review, quality management, medical claim review, or member complaint/appeal investigation

2. Plan will conduct reviews at all Primary Care Physicians (PCP) sites with 50 or more linked members and practice sites which include both individual offices and large group facilities. Plan will review each site at least one (1) time during each two (2) year period.

3. The Plan's staff will **perform an annual data pull of providers requiring a potential audit. The plan will** generate a list quarterly of providers who have not had a medical record review within the last 24 months **and bump it against the respective annual data pull list for accuracy**. The list will contain members that have received services during the selected time period for the review which is determined by the specific areas being reviewed. The list will be comprised of all members ~~currently~~ assigned to the Prim**ary Care Physician (PCP) during the selected audit timeframe** ~~ary Care Physician (PCP) targeted for review and who have been with the PCP during the entire period of time established as the review period.~~

4. The Quality Staff will select at least five (5) records per PCP and 3 records per PCP for large group practices (six or more providers in a group) to determine compliance. Member records chosen for review may include, but are not limited to:

   - Members who have had claims for emergency room or in-patient services.

- Members within a targeted age range or with a specific diagnosis, depending on the focus of the audit (i.e. children to assess components of EPSDT visits, asthmatics to assess compliance with associated clinical practice guidelines).

5. Providers identified for an audit are notified in writing that a medical record review will be conducted (Attachment B1 or Attachment B2). A list of the members selected for review is provided with the notification letter.

6. The staff may schedule the audit at the practitioner's office location or request that medical records or components thereof be mailed, faxed, or scanned to the Plan.

7. Staff conducting the audit are qualified Plan employees or contractors who have signed and dated confidentiality agreements that are on file. HIPAA standards will be maintained throughout the process.

8. The staff performing the review will utilize the Plan's standardized Medical Record Review Tool (Attachment A).

9. On completion of the audit, the Staff reviews preliminary results with the designated office contact person. At this time, the Staff and the office contact person can work together to resolve any inconsistencies or disputes in the audit findings. The contact person and the Staff sign and date the form (Attachment E) indicating agreement of preliminary results.

10. Upon return to the office, the audit tool is scored. The provider will be notified of the outcome of the review by mail within 30-45 days of the audit. The documents (Attachment C and D) shall include the overall score, any areas of deficiency and a copy of the completed/scored audit tool.
    a. Elements scoring below 80% are considered deficient and in need of improvement.
    b. The letter may also suggest action plan for improvement or include model record-keeping aids, such as standardized documentation forms, as applicable.
    c. A follow-up audit will be conducted with providers who do not pass with an 80% score to review results and discuss areas requiring improvement.

11. Provider will be re-audited within the year, (see below), resulting in two medical record reviews being done over the two year timeframe. The provider will be re-audited 180 days (6 months) from the date of their first audit.

~~**Another audit will be completed within the year, requiring two medical record**~~

~~**Audits instead of one over the two year audit period.The provider will be re-audited 180 days (6 months) from the date of their first audit.**~~

12. The plan will strive to achieve 80% compliance for 90% of our network practitioners. Practitioners whose medical record compliance review score remains below 80% at the follow-up review **as well as those providers who have refused to provide the requested medical records for review after three or more requests,** will be **referred to and** discussed with, ~~-~~both the VP of Network and Contracting and ~~-aa~~ Plan Medical Director **on how to proceed further.** ~~**for further action. Secondly, Practitioners who refuse to provide requested medical records for review after three request within the quarter will be discussed with both the VP of Network and Contracting and a Plan Medical Director for further action.**~~ **Such a**~~A~~ctions recommended may include, but are not limited to:
    a. Referral to the Plan Quality Assessment Performance Improvement Committee (QAPIC) and/or Provider Engagement Committee with oversight by a Plan Medical Director
    b. Review of contract for possible assessment for network limitations, financial penalties or possible termination from the network

13. Medical record review results are filed in the Quality Improvement department and shared with the Credentialing department to be considered at the time of re-credentialing.

14. An aggregate summary of medical record reviews completed are reported monthly to the Performance Improvement team and quarterly to the Plan QAPIC and LDH. A summary and analysis of the results is included in the Plan's QAPI Annual Evaluation.

15. Medical record review results are trended by the Quality Improvement department to determine plan-wide areas in need of improvement. Issues may be addressed via network-wide and/or provider-specific education to improve elements of medical record documentation.

REFERENCES
DHH CCN-P RFP, Section 15.6
DHH MCO RFP 2014, Section 8.2.2.9

ATTACHMENTS
Attachment A Medical Record Review Tool (PCP)
Attachment B1 Notice of Medical Record Audit Letter (No Access)
Attachment B2 Notice of Medical record Audit Letter (Access)

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Attachment C Notice of Medical Record Review Findings
Attachment D Notice of Medical Record Audit Score
Attachment E Confirmation of Onsite Comprehensive Medical Records review
Attachment F 2021 MRR CAP Process
~~**Attachment G MRR Score letter Template**~~
~~**Attachment I 2020 MRR Audit Tool Questions**~~
Attachment J 2020 MRR CAP Process
~~**Attachment K 068 LHC MRR Strategy**~~

DEFINITIONS:
High-volume specialists may be defined or identified by one of the following:

- Specialists located in an expected high-volume geographic are or in high-volume disciplines (OB/GYN), or both
- Available prior authorization data
- Certain types of specialists most likely to provide services to the largest segment of the membership (OB/GYN)

REVISION LOG

REVISION	DATE
Removed that standards are on Plan website. Changed QI Coordinator to PCMH Staff. Added that offices may fax or scan records. Changing tool by taking out HEDIS measures and point values. Changed from 15 to 30 days after audit, provider will receive copy of score. Revised actions on #12. Added that summary will be reported monthly to PIT. Revisions to follow up audit process.	1/2014
Added: the plan will strive to achieve 80% compliance for 90% of our network.	3/2014
The PCMH Staff will select at least five (5) to ten (10) records for sites with a panel <500 and 3 records per provider for large group practices (six or more providers in a group) for sites with a panel ≥500.	10/2014
Added to attachments A, B and C: Documentation of emergency and/or after-hours encounters and follow-up; Documentation of advance directives, as appropriate Added attachment D	12/2014
Added language to include the LMHP Medical and Treatment Record Review Added Attachment A1	9/15
Added: Secondly, Practitioners who refuse to provide requested medical records for review after three request within the quarter will be discussed with the Plan Chief Medical Director for further action. Changed DHH to LDH	10/16
Clarified language in Medical Record Documentation Standards to ensure medical history is captured and maintained for patients from the first visit.	12/16
Replaced PCMH staff with staff Added VP of Network and Contracting to Plan Medical Director as reviewers of practitioners that fall below 80%	3/17

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Remove all reference to LMHP and Behavioral Health Medical Record and Treatment Reviews Change Peer Review Committee to Provider Engagement Committee Removed Attachment A1 Updated Attachment A, Attachment B, and Attachment C	3/18
Removed all reference to panel size (ie. 500 members etc), Removed the need to review OB/GYNs operating as PCPs and Decreased the minimum number of records to be reviewed for solo practitioners	1/23/2019
• Attachment A 068 LHC MRR Stratey revised and renamed Attachment K. • Attachment A Medical Record Review Tool (PCP) revised. • Attachment B revised and renamed Attachment B2. Added Attachment B1. Attachment J MRR CAP Process removed and renamed Attachmennt J 2020 CAP Process. • Attachment B MRR 23 Standards Letter Template, • Attachment F and H removed (duplicated). • Attachment C 2019 MRR Audit Tool Questions removed, replaced with Attachment I. Attachment C (cont) revised and renamed Attachment D, Attachment D renamed Attachment E. • Added The provider will be be re-audited in 180 days (6 months) from the day of the first audit. • Changed "provider will be notified of outcome of review from 30 days to 30-45 days". • Revised practitioner record retention from (6) to (10) years of last treatment • Changed Attachment B "Providers identified for an audit are notified in writing that a medical record review will be conducted to (Attachment B1 or B2). Changed "The contact person and staff sign and date form (Attachment D) to (Attachment E) indicating agreement of preliminary results. • Revised Attachments C and D. • Procedure step number 11 moved under step number 10 and labeled c. Remaining steps renumbered.	1/20/2020
• **Procedure step number 11 added and procedure step revised**	**1/21/2021**

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• **Attachment A Medical Record Review Tool (PCP) revised.** • **Attachment BI Notice of Medical Record Review (No Access) revised and renamed Attachment B1 Notice of Medical Record Review (Access)** • **Attachment B2 Notice of Medical Record Review (Access) revised and renamed Attachment B2 Notice of Medical Record Review (No Access)** • **Attachment C Notice of Medical Record Review Findings revised** • **Attachment D Notice of Medical Record Audit Score revised** • **Attachment E Confirmation of Onsite Comprehensive Medical Records Review revised** **Attachment J 2020 MRR CAP Process revised and renamed Attachment F 2021 MRR Cap ~~Workflow~~ Process** • ~~**Attachment K 068 LHCC MRR strategy revised and renamed Attachment G 068 LHCC MRR Strategy**~~ • **Attachment G 2020 MRR Score Letter Template and Attachment I 2020 MRR Audit Tool Questions deleted due to duplication**	
• **Updated attachment B2 letter addressing one of our dept. goals for obtaining more EMR access.**	**2/21**

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in Archer GRC, ~~**Centene's P&P management software,**~~ is considered equivalent to a physical signature.

~~**Director of Quality Improvement: _____ Signature on file**~~

~~**Chief Medical Officer: _____ Signature on file**~~

Responses: Met (M)=1, Needs Improvement (NI)=0.5, Not Met (NM)=0, Not Applicable (NA)=1
Physician/Clinic Medical Record Review Tool

CLINIC SITE &/OR PHYSICIAN NAME:			SURVEYOR:			DATE:						Total Points:		
STANDARD #	**POINTS POSSIBLE**	**STANDARD DESCRIPTOIN**	**MEMBER #1**	**MEMBER #2**	**MEMBER #3**	**MEMBER #4**	**MEMBER #5**	**MEMBER #6**	**MEMBER #7**	**MEMBER #8**	**MEMBER #9**	**MEMBER #10**	**TOTAL POINTS**	**TOTAL POSSIBLE**	**% / STANDARD**
1	1	Each and every page in the ~~Medical~~ record contains the patient's name or ID number.													
2	1	Personal/biographical data includes date of birth, sex, legal guardianship, address, employer, home and work telephone numbers, and marital status as well as assessment of cultural and/or linguistic needs such as primary language spoken, translation needs or communication assistance,deaf/blind, etc.													
3	1	All entries in the m~~M~~edical r~~R~~ecord contain author identification including name, credentials, initials and correlating signatures.													
4	1	All entries must be dated and signed, or dictated by the provider rendering care~~.~~													
5	1	The ~~Medical~~ medical r~~R~~ecord is legible to someone other than the writer.													
6	1	Significant illnesses and medical conditions are indicated on a problem list for all past and current diagnoses													

7	1	All allergies (medication, food and/or tactile) and adverse reactions are prominently noted in the mMedical rRecord in a~~n~~ uniform location. If the patient has no known allergies or history of adverse reactions, this is appropriately noted in the mMedical rRecord as NKA or NKDA.														
8	1	Medication l~~L~~ist includes instructions to member regarding dosage, initial date of prescription, possible side effects and number of refills.														
9	1	Past medical history (for patients seen three or more times) ~~-~~is easily identified and includes serious accidents, operations or illnesses, discharge summaries and ER encounters. For children and adolescents 18 years or younger, past medical history relates to prenatal care, birth, operations, and childhood illnesses.														
1	1	For patients 1~~0~~ years and older, there are appropriate notations concerning use of tobacco, alcohol and/or ~~or~~ substance abuse (for patients seen three or more times a substance abuse history should be queried).														
1	1	The history and physical exam records incorporates subjective and objective information for presenting complaints. ~~Clinical findings and evaluations for each visit are documented in the Medical record.~~														
1	1	~~Patients~~ Patients 2 years and younger have had a lead screening ordered.														
1	1	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 ~~as needed (~~PRN~~)~~.														
1	1	Unresolved problems from previous office visits are addressed in subsequent visits and annotated in the mMedical rRecord.														

1	1	Documentation of emergency and/or after-hours encounters and follow-up are documented in the medical record.														
1	1	If a consultation is requested, there is a note from the consultant in the mMedical rRecord.														
1	1	Consultations,-labs, imaging/diagnostic reports, ancillary and therapeutic reports are filed in the chart andre initialed by the ordering practitioner to signify review. If the reports are presented electronically or by some other method, there is also representation of review by the ordering practitioner. Consultations, and abnormal labs and imaging study results have an explicit notation of follow-up plans in the mMedical rRecord.														
1	1	An up-to-date immunization record has been established for pediatric patients or an appropriate history has been made in the chart for adults.														
1	1	EPSDT specific requirements include: Comprehensive health history Developmental history General Developmental screening Autism screening Unclothed physical exam Vision, hearing and dental screening Appropriate immunizations Appropriate lab testing including _lead screening Health education and anticipatory guidance														
2	1	Medical rRecords are stored securely with access limited to– authorized personnel -and easily retrievable upon request. All patient information is kept confidential.														
2	1	Medical rRecord format is organized and consistent.														

2	1	All consent forms are signed and dated.													
2	1	Evidence that an advance directive~~s~~ has been offered to adults 18 years of age and older.													
		SCORE:													

Attachmnet B1.
Notice of Medical Rec

Click here to enter a date.

<Name of Provider>
<Street Address>
<City>, <State> <Zip Code>

Dear Provider,

As part of our Quality Improvement Program, and in compliance with state contractual requirements, Louisiana Healthcare Connections routinely evaluates our members' medical records in an effort to ensure quality services are being rendered. We are required to evaluate the medical record practices of our primary care providers (PCPs) and/or practice sites with fifty or more members assigned and/or linked bi-annually. This includes individual offices and large group facilities.

Please read this letter and all attachments in their entirety to ensure you are aware of ALL documentation being reviewed.

Enclosed is a list of randomly selected members who were seen by you during the previous year <YEAR> and whose medical records will be reviewed. We will utilize the Medical Records standards adopted by Louisiana Healthcare Connections to perform the review. These standards are enclosed for your review and can be accessed at **www.LouisianaHealthConnect.com** ~~and are also enclosed for your reference.~~ Once review is completed and results have been tabulated, you will receive an explanation letter of the results and consultative feedback as needed or requested.

Designated Louisiana Healthcare Connections staff have been granted access to your network for auditing purposes only. This letter serves as notification of those patient records, (our members) we have selected for review. These audits will be performed remotely through secure access to your EMR, while ensuring compliance with HIPAA regulations. This will eliminate the need to submit this request to a 3rd party copying service. ~~A roster of 3-5 randomly selected members will be reviewed is enclosed. Please do not submit this request for records to a third party copying service as this will incur unnecessary fees.~~

As a reminder, protected health information (PHI) that is used or disclosed for purposes of treatment, payment or health care operations is permitted in accordance with HIPAA Privacy Rules (45 CFR 164.506) and does not require consent or authorization from the member/patient. Medical records and associated comments submitted for review are "Privileged and Confidential".

Please contact the Abstractor listed below if you have any questions:

Phone	Fax	Mail
<Abstractor> 1-866-595-8133 ext. XXXXX <Cell>	Louisiana Healthcare Connections ATTN: <Abstractor> 1-866-704-3070	Louisiana Healthcare Connections Quality Department Attn: <Abstractor> 8585 Archives Blvd., Suite 310 Baton Rouge, LA 70809

We appreciate your participation and cooperation with our quality improvement activities. As always, our goal is to partner with you to obtain the highest quality of care while ensuring the safety of your patients –our members. Meanwhile, should you have questions, please feel free to contact the Abstractor listed below.

Sincerely,

<Abstractor's name> Quality Improvement Abstractor ~~*Andrea Harrison, Project Coordinator II*~~

Enclosure(s): Medical Records Documentation Standards, Confirmation of Comprehensive On-site Medical Records Review and Member List.

MEDICAL RECORDS DOCUMENTATION STANDARDS

1. Each and every page in the Medical Record contains the patient's name or ID number.
2. Personal/biographical data includes date of birth, sex, legal guardianship, address, employer, home and work telephone numbers and marital status as well as assessment of cultural and/or linguistic needs such as primary language spoken, translation needs or communication assistance, deaf/blind, etc.
3. All entries in the Medical Record contain author identification including name, credentials, initials, and correlating signatures.
4. All entries must be dated and signed, or dictated by the provider rendering care.
5. The Medical Record is legible to someone other than the writer.
6. Significant illnesses and medical conditions are indicated on a problem list for all past and current diagnoses.
7. All~~ny~~ allergies (medication, food and/or tactile) and adverse reactions are prominently noted in the Medical Record in a uniform location. If the patient has no known allergies or history of adverse reactions, this is appropriately noted in the Medical Record as NKA or NKDA.
8. Medication List includes instructions to member regarding dosage, initial date of prescription, possible side effects and number of refills.
9. Past medical history (for patients seen three or more times) is easily identified and includes serious accidents, operations or illnesses, discharge summaries and ER encounters. For children and adolescents age 18 years or younger, past medical history relates to any prenatal care, birth, operations or childhood illnesses.
10. For patients 11~~0~~ years and older, there are appropriate notations concerning use of any tobacco, alcohol and or substance abuse (for patients seen three or more times substance abuse history should be queried).
11. The history and physical exam records incorporate subjective and objective information for presenting complaints. Clinical findings and evaluations for each visit are documented in the Medical Record.
12. Patients 2 years and younger have had a lead screening ordered.
13. 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. ~~as needed (P.R.N.)~~
14. Unresolved problems from previous office visits are addressed in subsequent visits and annotated in the Medical Record.
15. Documentation of emergency and/or after-hours encounters and follow-up are documented in the Medical Record.
16. If a consultation is requested, there is a note from the consultant in the Medical Record.
17. Consultations, labs, imaging/diagnostic reports, ancillary and therapeutic reports are filed in the chart and initialed by the ordering practitioner to signify review. If the reports are presented electronically or by some other method,

there is also representation of review by the ordering practitioner. Consultation and abnormal lab and imaging study results have an explicit notation of follow-up plans in the Medical Record.

18. An up-to-date immunization record has been established for pediatric patients or an appropriate history is made in the chart for adults.
19. EPSDT-specific requirements include: comprehensive health history, developmental history, general developmental screening, autism screening, unclothed physical exam, vision, hearing and dental screening, appropriate immunizations, appropriate lab testing including lead screening, and health education and anticipatory guidance.
20. Medical Records are stored securely with access limited to authorized personnel and easily retrievable upon request. All patient information is kept confidential.
21. Medical Record format is organized and consistent.
22. All consent forms are signed and dated.
23. Evidence that an advanced directive has been offered to adults 18 years of age and older.

Attachment B2

Click here to enter date

< Name **of Provider**>
<**Street** Address>
<**City>, <State> <Zip Code>**

Dear Provider;

As part of our Quality Improvement Program, and in compliance with state contractual requirements, Louisiana Healthcare Connections (LHCC) routinely reviews ~~evaluates~~ our members' medical records ~~in an effort~~ to ensure quality services are being rendered. We are required to evaluate the medical record practices of our primary care providers (PCPs) and/or practices sites ~~-~~with fifty (50) or more members assigned and /or linked bi-annually. This includes individual offices and large group facilities.

Please read this letter and all attachments in their entirety to ensure you are aware of ALL documentation being reviewed.

Enclosed is a list of selected randomly members chosen for review, all of which ~~who~~ were seen by you during the previous year <YEAR> ~~and whose medical records will be reviewed~~. The enclosed standards, which were adopted by ~~We will utilize the Medical Records standards adopted by Louisiana Healthcare Connections~~ LHCC will be utilized for the review~~to perform the review~~. You may access t~~T~~hese standards ~~are enclosed for your review and can also~~ can be accessed at ~~via our website at~~ www.LouisianaHealthConnect.com. ~~and are also enclosed for your reference.~~ Upon completion of the review,~~Once review is completed and results have been tabulated,~~ you will receive a letter explaining your results and any ~~an explanation letter of the results and~~ consultative feedback a~~s needed or requested~~. ~~In the coming days, w~~

We will ~~be~~ contact~~ing~~ your office to schedule a mutually acceptable date and time for t~~o conduct~~ the review soon. ~~for review of your previous year Medical Records.~~ **Approximately 2-3 hours are allotted to complete the review.** ~~The average length of time to conduct the our review is approximately 2-3 hours.~~ If performed onsite, it will not be ~~While it is not~~ necessary for you or your office staff to be present during the entire review. However, it will prove beneficial to have someone available upon completion ~~I would like a few minutes at the end of the review~~ to discuss ~~summarize~~ preliminary findings.

~~A roster of 3-5 randomly selected members whose records will be reviewed is enclosed. You will be given verbal feedback at the conclusion of the review followed by a formal, summary report.~~ **Please submit the requested medical records via fax or mail within 14 calendar days from receipt of this letter. Please note that we cannot accept requested records on any portable storage device such as CDs or USB drive.**

We at (LHCC) know how exhausting medical record requests can be, from demands on staff time to delays in claims processing. COVID 19 has taught us all many lessons as we have all had to change how we conduct business. Let us help with making it easier. You can grant us access to your EMR system to meet this contractual requirement, be it limited or full access. Upon approval of access, we can remotely access your EMR system in a way that is compliant with HIPAA and all privacy regulations.

As a reminder, protected health information (PHI) that is used or disclosed for purposes of treatment, payment or health care operations is permittedin accordance with HIPPA Privacy Rules (45 CFR 164.506) and does not require consent or authorization from the member/patient. Medical Records and associated comments submitted for review are "Privileged and Confidential"

Should you have any questions at all, please contact the Abstractor listed below if you have any questions:~~**Please contact the Abstractor listed below if you have any questions:**~~

Attachment B2

Phone	Fax	Mail
<Abstractor> **1-866-595-8133 ext. XXXXX** **<Cell>**	Louisiana Healthcare Connections ATTN: <Abstractor> **1-866-704-3070**	Louisiana Healthcare Connections Quality Department Attn: <Abstractor> 8585 Archives Blvd., Suite 310 Baton Rouge, LA 70809

We appreciate your participation and cooperation with our quality improvement activities. As always, our goal is to partner with you to obtain the highest quality of care while ensuring the safety of your patients-our members. ~~Meanwhile, should you have questions, please feel free to contact the Abstractor listed below:~~

Sincerely,

<Abstractor's name> Quality Improvement Abstractor~~Andrea Harrison. *Project Coordinator II*~~

Enclosure(s): Medical Records Documentation Standards, Confirmation of Comprehensive Onsite Medical Records Review, Member List.

Attachment B2

MEDICAL RECORDS REVIEW STANDARDS

1. Each and every page in the Medical Record contains the patient's name or ID number.
2. Personal/biographical data includes date of birth, sex, legal guardianship, address, employer, home and work telephone numbers, and marital status as well as assessment of cultural and/or linguistic needs such as primary language spoken, translation needs or communication assistance, deaf/blind, etc.
3. All entries in the Medical Record contain author identification including name, cred~~n~~entials, initials, and correlating signatures.
4. All entries are dated and signed, or dictated by the provider rendering care.~~.~~
5. The Medical Record is legible to someone other than the writer.
6. Significant illnesses and medical conditions are indicated on a problem list for all past and current diagnoses.
7. All~~lny~~ allergies (medication, food and/or tactile) and adverse reactions are prominently noted in the Medical Record in a uniform location. If the patient has no known allergies or history of adverse reactions, this is appropriately noted in the Medical Record as NKA or NKDA.
8. Medication List includes instructions to member regarding dosage, initial date of prescription, possible side effects and number of refills.
9. Past medical history (for patients seen three or more times) is easily identified and includes serious accidents, operations or illnesses, discharge summaries and ER encounters. For children and adolescents age 18 years or younger, past medical history relates to any prenatal care, birth, operations or childhood illnesses.
10. For patients 1~~0~~ years and older, there are appropriate notations concerning use of ~~any~~ tobacco, alcohol and/or ~~or~~ substance abuse (for patients seen three or more times substance abuse history should be queried).
11. The history and physical exam records incorporate subjective and objective information for presenting complaints. ~~Clinical findings and evaluations for each visit are documented in the Medical Record.~~
12. ~~Patients~~ Patients 2 years and younger have had a lead screening ordered.
13. 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 ~~as needed (P.R.N.).~~ PRN.
14. Unresolved problems from previous office visits are addressed in subsequent visits and annotated in Medical Record.
15. Documentation of emergency and/or after-hours encounters and/or follow-up~~;~~ are documented in the Medical Record.
16. If a consultation is requested, there is a note from the consultant in the Medical Record.
17. Consultations, labs, imaging/diagnostic reports, ancillary and therapeutic reports are filed in the chart and~~re~~ initialed by the ordering practitioner to signify review. If the reports are presented electronically or by some other method, there is also representation of review by the ordering practitioner. Consultation and abnormal lab and imaging study results have an explicit notation of follow-up plans in the Medical Record.
18. An up-to-date immunization record has been established for pediatric or an appropriate history is made in the chart adults..

19. EPSDT-specific requirements include: comprehensive health history, developmental history, general developmental screening, autism screening, unclothed physical exam, vision, hearing and dental screening, appropriate immunizations, appropriate lab testing including lead screening, and health education and anticipatory guidance.
20. Medical Records are stored securely with access limited to authorized personnel and easily retrievable upon request. All patient information is kept confidential.
21. Medical Record format is organized and consistent.
22. All consent forms are signed and dated .
23. Evidence that an advance directive has been offered to adults 18 years of age or older.

Medical Record Review Summary by Facility

Date of audit **(All)**

Facility **Client Provider #** **Provider Name**

Row Labels **(All)**

Primary Contact

Facility Overall Score

Audit Completed By

Standard	Total Points	Possible Points	Percentage by Standard
Standard #1 Each and every page in the record contains the patient's name or ID number			
Standard # 2 - Personal/biographical data includes date of birth, sex, legal guardianship, address, employer, home and work telephone numbers, and marital status as well as assessment of cultural and/or linguistic needs such as primary language spoken, translation needs or communication assistance, deaf/blind, etc~~(see Documentation Standards)~~.			
Standard #3 All entries in the medical record contain author identification including name, credentials, initials and correlating signatures.			
Standard #4 All entries must be dated and signed, or dictated by the provider rendering care.			
Standard #5 The m~~M~~edical record is legible to someone other than the writer.			
Standard #6 Significant illnesses and medical conditions are indicated on a problem list for all past and current diagnoses.~~Any~~			

Standard #7 All~~ny~~ allergies (medication, food and/or tactile) and adverse reactions are prominently noted in the m~~M~~edical r~~R~~ecord in a uniform location. If the patient has no known allergies or history of adverse reactions, this is appropriately noted in the m~~M~~edical r~~R~~ecord as NKA or NKDA.			
Standard #8 Medication l~~L~~ist includes instructions to member regarding dosage, initial date of prescription, possible side effects and number of refills.			
Standard #9 Past medical history (for patients seen three or more times) is easily identified and includes serious accidents, operations or illnesses, discharge summaries and ER encounters. For children and adolescents 18 years or younger, past medical history relates to prenatal care, birth, operations, and childhood operations. ~~(see Documentation Standards)~~			
Standard # 10 For patients 11~~0~~ years and older, there are appropriate notations concerning use of tobacco, alcohol and/or ~~or~~ substance abuse (for patients seen three or more times a substance abuse history should be queried).			
Standard #11 The history and physical exam records incorporates subjective and objective information for presenting complaints. ~~Clinical findings and evaluations for each visit are documented in the Medical Record~~			
Standard #12 ~~Patients~~ Patients 2 years and younger have had a lead screening ordered.			
Standard #13 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 ~~as needed (~~PRN~~)~~.			
Standard # 14 Unresolved problems from previous office visits are addressed in subsequent visits annotated in the m~~M~~edical record.			

Standard # 15 Documentation of emergency and/or after-hours encounters and follow-up are documented in the medical record.			
Standard # 16 If a consultation is requested, there is a note from the consultant in the mMedical rRecord.			
Standard #17 Consultations, labs, imaging/diagnostic reports, ancillary and therapeutic reports filed in the chart are initialed by the ordering practitioner to signify review. If the reports are presented electronically or by some other by some other method, there is also represenatation of review by the ordering practitioner. Consultations, and abnormal labs and imaging study results have an explicit notation of follow-up plans in the mMedical record.			
Standard #18 An up-to-date immunization record has been established for pediatric patients or an appropriate history is has been made in the chart for adults.			
Standard # 19 EPSDT specific requirements include: Comprehensive health history Developmental history General Deelopmental screening Autism screening Unclothed physical exam Vison, hearing and dental screening Appropiate immunizations Appropiate lab testing including lead screening Health education and anticipatory guidance (see Documentation Standards)			
Standard # 20 Medical rRecords are stored securely with access limited to authorized personnel and easily retrievable upon request. All patient information is kept confidential.			
Standard #21 Medical record format is organized and consistent.			

Standard #22 All consent forms are signed and dated.			
Standard #23 Evidence that an advance directive has been offered to adults 18 years of age or older.			

Provider signature Date

Attachment ~~E~~ D
Notice of Medical Record Audit Score

Date

Provider Name

Address

City, State, Zip code

Dear Provider,

Louisiana Healthcare Connections recently completed a compliance audit of your Medical Records practices in _____. In general; Medical Records were maintained in a detailed and organized manner. **Your overall score(s) for Medical Records audited is 0.00~~XX~~% and Clinical Practice Guidelines audited is 0.00%.**

Enclosed are detailed audit findings for your review. Areas scoring below 80% are considered "deficient and in need of improvement." If the overall score is below 80%, please sign and date the enclosed *Completed Medical Record Review Summary* and fax to Louisiana Healthcare Connections at (**866)704-3070.**

Because the overall score is less than 80%, you are required to complete a Corrective Action Plan (CAP) (attached). This CAP should be returned to Louisiana Healthcare Connections within 10 days of receipt of this letter and address all areas that scored less than 80%. You will have 60 days to fully implement your CAP. Louisiana Healthcare Connections will conduct a re-audit 6 months from the date of the original Medical Records~~/Medical Records Treatment~~ audit in order to monitor progress towards improvement. If the overall score remains below 80% upon re-audit, the findings will be presented to both our VP of Network and Contracting and the Plan Medical Director on how to proceed further. ~~Senior Vice President of Medical Affairs for further action~~. *(REMOVE THIS PARAGRAPH IF SCORE IS PASSING)*

If you have any questions regarding your Medical Records~~/Medical Records Treatment~~ and Clinical Practice Guidelines audit findings, and/ or overall score, ~~I~~you ~~may be reached~~ contact me directly **at <abstractor phone number>**~~by calling (866)595-8133 ext. 84716~~**.**

Respectfully,

Name, Quality Improvement Abstractor~~Medical Record Project Coordinator~~

Quality Improvement Department

Attachment:

Completed Medical Record Review Summary

Attachment E

CONFIRMATION OF ONSITE COMPREHENSIVE MEDICAL RECORDS REVIEW

Date: _____

Provider: _____

Your comprehensive Medical Records review has been completed. Preliminary results indicate your score to be _____%. You and/or the designated office contact person have been provided~~The Louisiana Healthcare Connections staff member completing this review has given you (or your designated office contact person)~~ the opportunity to resolve any inconsistencies and/~~-~~or disputes regarding ~~in~~ the review findings while on site. You will receive a full, formal report by mail within 30-45 days of this review. Thise report ~~you receive~~ will include the overall score, any noted areas of deficiency, and a copy of the completed/scored review tool. Your signature below indicates you have been given the opportunity to participate in this process and are in agreement with the preliminary results.

Comments:

_____

_____

_____

_____

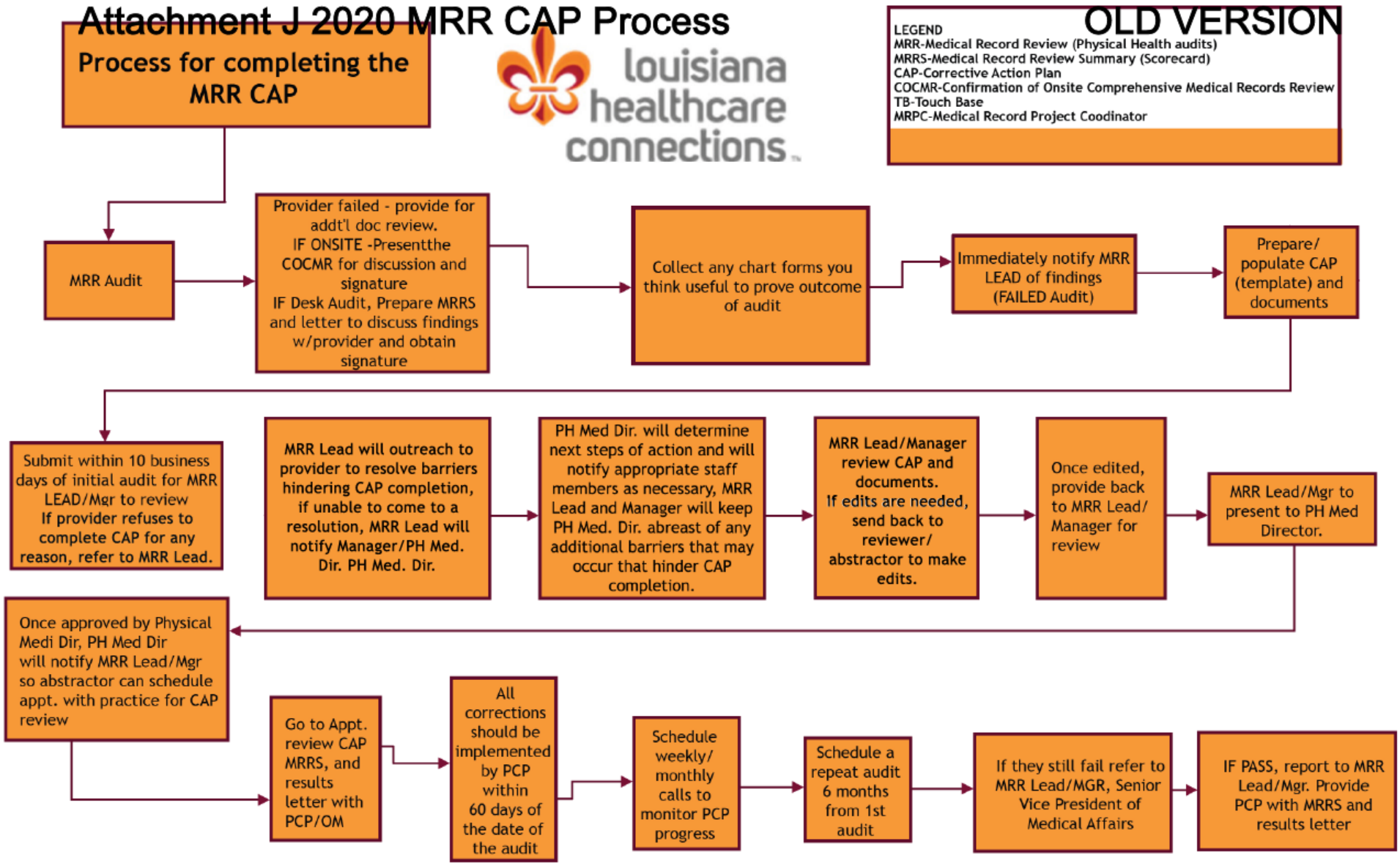
_____

Signature:

_____ _____

Provider or Provider Designee *Louisiana Healthcare Connections Staff*

Attachment J
2020 MRR CAP Process



Attachment F

2021 MRR CAP Process