HEALTH PLAN POLICY	
Policy Title: Medical Records Standards and Review Process	**Number:** MQM18 **Revision:** E
Department: Medical Management	**Sub-Department:** Quality Management
Applicable Lines of Business: ☐ Children's Health Insurance Plan ☒ Medicare ☒ Commercial Insured ☐ Non-Insured Business ☒ Health Insurance Exchange ☒ USFHP ☐ Medicaid	
Effective Date: 02/22/2018	
Revision Date(s): 04/24/2019, 05/28/2020, 05/28/2021, 05/23/2022, 08/31/2023	

PURPOSE:

CHRISTUS requires providers to have medical record retention practice and standard that complies with the regulatory requirements regarding confidentiality, availability, organization, medical record documentation standards, and performance goals to assess the quality of medical record maintenance. All medical records are evaluated during regular quality reviews and analysis oversight efforts, including annual HEDIS evaluation, monthly Patient Safety Indicator (PSI) reporting, Hospital Acquired Condition (HAC) reporting, Serious Reportable Event (SRE) reporting, Potential Quality Issue (PQI) identification/reporting, evaluation and analysis, and special audits and completion of clinical research studies/initiatives and ambulatory record reviews.

DEFINITIONS AND ACRONYMS:

- **Healthcare Effectiveness Data Information Set (HEDIS) –** A set of standardized performance measures developed by the National Committee for Quality Assurance (NCQA) which allows direct, objective comparison of quality amongst health plans.
- **Health Insurance Portability and Accountability Act (HIPAA) of 1996** – A federal law that requires the creation of national standards to protect sensitive member health information from being disclosed without the members consent or knowledge.
- **Patient Safety Indicators (PSI)** – Indicators that focus on potentially preventable instances of complications, and other iatrogenic events resulting from exposure to the health care system.
- **Potential Quality Issue (PQI)** – A concern received by the health plan from internal or external sources, which requires investigation as to whether the competence or professional conduct of an individual health plan network practitioner, facility, or ancillary providers adversely affects, or could adversely affect, the health or welfare of a member.

POLICY:

CHRISTUS requires practitioners under contract to have medical record standards in place for both paper-based and/or electronic medical record (EMR) that comply with standards regarding confidentiality, availability, organization, and content.

A. Confidentiality

1. Medical records and health information are required to be stored in a secure location. They may not be accessible to individuals who do not have legal authority to access the information contained in the records. For Electronic Medical Records, access control and validation procedures must be in place to validate an individual's access to the system based on role or function. Medical groups must ensure that the Electronic Medical Records systems has

appropriate security measures in place and are monitored.

2. Release of medical record information is granted only with the express permission of the member or a legally authorized representative, except as permitted by applicable state or federal law. Electronic Medical Records must be transmitted in a method that minimizes the risk of a breach of security and protects the member's privacy as defined by Health Insurance Portability and Accountability Act (HIPAA) privacy and security standards and the privacy and security policies of the practitioner.
3. Written policies and procedures are in place that reflect the medical group's internal policies and procedures related to the confidentiality of, and access to medical records.

B. Availability

1. Medical records are accessible and available to practitioners at the time care is rendered, and at other times as needed to coordinate service delivery.
2. Written policies and procedures exist to ensure the timely, effective, and confidential exchange of member information between primary care practitioners, behavioral health care practitioners, specialists, and organizational providers. The Electronic Medical Record reflects the continuous chronology of the member's healthcare. Tools need to be available for caregivers to view episode-based information.
3. Written standards or procedures exits to address archiving and destruction of inactive medical records in compliance with applicable state and federal law.

C. Organization

1. Health information is maintained in an accurate, organized manner that supports effective member care.
2. Written standards or procedures exist to address the following:
   a. Order of the medical record
   b. List of documents to be filed in each section of the record and
   c. Timely filing of medical information
3. All scanned documents must be date and time stamped.

D. Content/Documentation Guidelines:

1. Each individual medical record must include the following information:
   - Member Name, Date of Birth, and Health Care ID
   - History and Physical
   - Allergies and adverse reactions
   - Mental Health review, if applicable
   - Clinical findings and evaluation for each visit
   - Diagnoses/Problem list
   - Review and reconciliation of medications prescribed/ to include prescription, over the counter medications and dietary supplements. .

- Any vaccines/immunizations prescribed/administered.
- Studies/tests, Laboratory and diagnostics ordered/follow up for studies/tests.
- Preventive service(s)/risk screening(s)
- Any invasive procedure completed in-office.
- Member education/instructions/notifications for each diagnosis, use/side effects of any new medications, self-care/preventive care, therapy/procedures, study/testing/special procedure results, etc.
- Follow up plan, if applicable
- Documentation of teaching and instructions and the presence of advance directives.
- Any referrals
- Encounter signed by licensed healthcare professional.
- Appropriate coding for each diagnosis, test, procedure
- Consistency in medical record entries to ensure the diagnosis and treatment align with initial assessment as well as impressions, treatment, therapies, referrals, consultations, and continuity of follow up care.

2. Primary Care Providers' medical records should reflect the following:
   - All services provided directly by a practitioner who provides primary care services.
   - All ancillary services and diagnostic tests ordered by a practitioner.
   - All diagnostic and therapeutic services for which a member was referred by a practitioner, such as specialist providers, home health nursing reports; specialty physicians reports; hospital discharge reports; and physical therapy reports.
   - Met medical necessity and appropriateness of assessment, treatment, care and follow up.
   - Advance directives/living will document in a prominent location of the medical record.
3. Hospital or Facilities related records should reflect the following:
   - Medical Record content meet all State and Federal laws, Medicare Conditions of Participation, and Regulatory Accreditation Requirements.
   - All hospital records and hospital-based clinic records must comply with CHRISTUS policies and procedural requirements, timely completion, and consistent content.
4. Telephonic interactions
   - Verify providers are documenting provision of significant medical advice given by telephone inclusion medical advice provided by afterhours information or triage services.
5. Monitoring
   - Compliance is measured during clinical records audits.
   - Interventions are implemented when areas for improvement are identified.
6. HEDIS specific evaluation on the documents must reflect the following:

Effectiveness of Care: Prevention and Screening	Documentation must include evidence in the record of height, weight, and BMI annually if < 20 years, documentation of BMI percentile. Medical record must include name of the specific antigen, date of the immunizations administered, and the name of the authorized healthcare provider, or agency that prepared and administered the dose. Medical record should include documentation that preventive services, screenings (i.e., colonoscopy, cervical cancer screening, mammograms etc.) were ordered, and performed.
Effectiveness of Care: Utilization	Documentation must include visit with PCP, the date of the visit and evidence of health and development history, exam, and health education and anticipatory guidance.
Effectiveness of Care: Cardiovascular Conditions	Documentation in the medical record must include visit with PCP, documentation of the qualifying diagnosis, and an adequately controlled disease process. Medical record for members diagnosed with AMI must include treatment with beta blockers, and 135 calendar days of medication compliance. Medical record for members diagnosed with ASCVD must include dispensed statins, and member compliance with medication administration at least 80 percent of the calendar year.
Effectiveness of Care: Diabetes	Documentation in the medical record must include the collection, reported, and received date of required lab values; medical attention for nephropathy, and evidence of prescription for ACE inhibitors/ARBs; Vital signs including blood pressure. Documentation of eye exams must be prepared, signed, dated, with the result, by a qualified medical professional or other health care provider.
Effectiveness of Care: Behavioral Health	Documentation must include a diagnosis of a serious mental health diagnosis, dispensed medication, with medication compliance for at least 84 days (acute) or 120 days (continuous).

Effectiveness of Care: Medication Management	□ Documentation must include medication therapy in the record for select therapeutic agents, and a therapeutic monitoring event. □ Medication reconciliation documentation in the medical record must include a qualifying practitioner or provider review of medications, signature, and date.
Effectiveness of Care: Musculoskeletal Conditions	□ Documentation in the record must include a diagnostic test, and/or a prescription for a qualifying disease-modifying drug, or a drug to treat the condition.
Effectiveness of Care: Respiratory Conditions	□ Documentation in the medical record or encounter identifies members with a persistent qualifying respiratory disease diagnosis, dispensed appropriate medications, and compliance for a specified/required time frame.

E. Procedure

1. Monitor practitioner performance against established medical record documentation standards on an annual basis during HEDIS, PQI reviews and validation and Continuity and Coordination of medical care audits.
2. CHRISTUS reserves the right to complete a full medical record review if the results of the audits are not compliant with the standards.
3. If CHRISTUS receives a complaint concerning the practitioner's medical record standards or practices, a full medical record review will be completed.
4. Provide recommendations and consultation to improve with standards.
5. Follow up with the practitioner regarding appropriate performance if standards are not met.

REFERENCES:

- Agency for Healthcare Research & Quality (AHRQ): Advancing Excellence in Health Care, US Department of Health and Human Services, 1 Jan. 2017, www.ahrq.gov/.
- HEDIS Technical Specifications. Vol. 2, National Committee for Quality Assurance, 2023.
- Retention and Destruction of Health Information (2013 Update) / AHIMA, American Health Information Management Association, The American Health Information Management Association, 1 Jan. 2017, library.ahima.org/doc?oid=107114#. Wm9JT6inHIU.
- TRICARE Manuals - Home, Military Health System, 29 Dec. 2020, manuals.tricare.osd.mil/.
- NCQA, National Committee for Quality Assurance, 12 Dec. 2020, www.ncqa.org/Portals/0/HEDISQM/HEDIS2018/Summary%20of%20Changes%20for%20Physician%20Measurement%202018.pdf?ver=2017-12-15-070645-503.

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RELATED DOCUMENTS:

None

REVISION HISTORY:

Revision	Date	Description of Change	Committee
New	02/22/2018	Initial release.	Executive Leadership
A	04/24/2019	Annual review. No change to content. Made corrections to minor typos.	Executive Leadership
B	05/28/2020	Annual review. Non-DRG validation deleted, as it is no longer a DHA/USFHP requirement.	Executive Leadership
C	05/28/2021	Annual review. No change to policy content.	Executive Leadership
D	05/23/2022	Annual review. Additions to scope, added bullets to content/documentation guidelines.	Executive Leadership
E	08/31/2023	Annual review. Updated template, definitions, and policy content to better reflect current process.	Executive Leadership