BLUE CROSS BLUE SHIELD OF NEBRASKA ON-SITE REVIEW PROGRAM
MEDICAL RECORD STANDARDS FOR PHYSICIANS (MD/DO)

GOAL: Each physician office/facility shall maintain the medical records of members in a manner that is current, detailed and organized and permits effective and confidential patient care and quality review.

The standards are based on the National Committee for Quality Assurance (NCQA) "Guidelines for Medical Record Review". Each standard has a relative weight assigned to it. The standards and weight assignments have been approved by the Blue Cross Blue Shield of Nebraska Credentialing Committee and Quality Improvement Committee.

The selection of records for review should be representative of care provided in the physician's office/facility during the previous two years or from the date of the last review. Each record is reviewed against each applicable standard. A score is calculated based on the numbers of records reviewed for each standard. A final score based on the score and the relative weight of each standard is then calculated. **Blue Cross Blue Shield of Nebraska compliance score for medical record review is 85%.**

Effective Date: January, 1995
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ON-SITE REVIEW PROGRAM
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ORGANIZATION OF THE MEDICAL RECORD STANDARDS

STANDARD	MET	NOT MET
1. All pages in the medical record shall contain patient identification.	The front or back of every page in the record contains: • patient's first and last name, **OR** • patient's first initial and last name, **OR** • patient's social security number, **OR** • any physician office generated number that remains unique to that patient as designated. (If family charts are used, medical documentation for each family member will be located in a distinctly separate section of the medical record).	If the front or back of every page in the medical record does not contain patient identification as stated in the "Met" column, or if patient's initial only, or patient's birthday only are used for identification. If all information within a family chart is not separate for each family member.
2. All pages in the medical record shall be fastened securely.	All pages in the medical record are secured by fasteners or pockets to keep all pages contained within the medical record file.	Pages within the medical record are not secured.
3. All entries in the medical record shall be legible.	All entries in the medical record are legible to the reviewer.	The medical record is illegible.
4. All entries in the medical record shall be dated by month, day, and year.	All entries in the medical record are dated by month, day and year. The entries include any personnel in the office/facility authorized to enter information in the medical record, e.g., progress notes, patient examination forms, prescription requests/refills, patient telephone calls, etc. Reports generated by separate agencies are not considered entries, e.g., radiology reports, laboratory reports, emergency room reports, etc.	All entries are not dated as described in the "Met" column.

STANDARD	MET	NOT MET
5. All entries in the medical record made by the physician shall contain author identification.	All entries in the medical record by the physician contain author identification as follows: • author initials and/or signature typed, handwritten or stamped, **OR** • a number assigned by that office that remains unique to that physician. This number may be used by the office for dictation identification, and should be available to the reviewer upon request. Note: Handwritten notes that are on a separate page from the dictation for a specific date of service must be author identified.	All entries by the physician do not contain author identification as stated in the "Met" column.
6. All entries in the medical record by authorized personnel shall contain author identification.	All entries in the medical record by authorized personnel contain author identification, e.g., nursing assessments, vital signs. Reports generated by separate agencies are not considered entries, i.e., radiology reports, laboratory reports, emergency department encounter forms, etc.	All entries in the medical record do not contain author identification as stated in the "Met" column.
7. Medication allergies and adverse reactions are prominently noted in the medical record. If the patient has known allergies or history of adverse reactions, this is appropriately noted in the medical record.	If there is a notation in the medical record on: • the outside cover of the chart **OR** • the inside cover of the chart **OR** • a tab/division in the record that indicates allergies or drug allergies handwritten in the medical record in a uniform place, e.g., on problem list, progress notes **OR** • a form in the record that addresses allergies and is recorded using the following abbreviations: NKA, NKDA, NKMA, "O" neg. allergies, no allergies.	Prominent and uniform documentation of allergy status and/or adverse reaction status is not present. Note: When environmental allergies, e.g., grass, pollen, dust, etc., are documented with no reference to drug allergies, the indicator is considered "Not Met".

STANDARD	MET	NOT MET
8. The medical record shall contain documentation of each patient's personal and biographical data.	If there is a form or designated place in the record initiated at any time and kept current (within the past two (2) years) that contains but is not limited to the following non-medical information: • address, employer (if applicable), home/work telephone number (if applicable), marital status (if applicable) **OR** • the same information is maintained in the computer, with print out available prior to the patient examination each time the patient is seen (reviewer may request current print out), **AND** • a policy (written or verbal) stating the procedure utilized by the office/facility, e.g., if and when form is placed on chart. Note: Computer Patient Record's will be reviewed on an individual basis.	The medical record does not include a form or computer generated print-out that contains the patient's personal, non-medical information as stated in the "Met" column. If a computer print-out cannot be generated, the standard is not met.
9. The medical record shall contain the name and telephone number of a person(s) to be notified in case of an emergency.	The medical record contains a form or a data element exists within a computerized system that includes the name and telephone number of a person(s) to be notified in case of an emergency.	The name and telephone number of an emergency contact is not included on the patient personal information form or available in a computerized system.

For the following Standards, Number 10 through 13, a single patient visit from each record is selected for review.
CLINICAL STANDARDS

STANDARD	MET	NOT MET
10. The reason for the patient's visit shall be clearly documented.	There is documentation of the pt.'s subjective complaint, e.g., "I have had a headache for 3 days," pt. states he fell and hurt his back, "I have been depressed for several months," or "I am here for follow-up of cold and cough,", etc., **OR** If the pt. is unable to communicate his/her C/O another party may do so, **OR** When no other party is available, the physician's objective assessment is acceptable.	There is no clear documentation of the reason for the patient's visit as described in the "Met" column.

STANDARD	MET	NOT MET
11. There shall be documentation that the history and physical exam identifies appropriate subjective and objective information pertinent to the patient's presenting complaints recorded for each visit.	There is documentation by the physician of an History & Physical (H&P) exam related to the pt.'s complaint(s), i.e., if the patient came in with a complaint of a sore throat, there is documentation that the throat was examined, if the chief compliant was cough, cold, difficulty breathing, documentation that the temperature was taken, lungs examined, etc.	There is no documentation of the physician's objective findings as described in the "Met" column.
12. There shall be a medical impression/working diagnosis (behavioral health assessment for behavioral health providers) recorded for each visit.	There is a medical impression/working diagnosis and/or behavioral health assessment clearly documented for each patient visit, e.g., otitis media, R/O strep throat, mental status stable, reality based and gaining insight, etc. Etiology unknown … diagnostic studies pending, **OR** When diagnostic codes are used in lieu of a narrative diagnosis, the Diagnostic/Statistical Manual of Mental Disorders, (DSM-IV) codes and/or the International Classification of Diseases, Clinical Modification (ICD-9-CM) codes are acceptable.	There is no medical impression/working diagnosis and/or mental status assessment clearly documented as described in the "Met" column.
13. There shall be a clear plan of action/treatment consistent with the diagnosis(es) including specific documentation of therapeutic interventions and/or scheduled or performed procedures at each patient visit.	There is documentation of a clear plan of treatment, e.g., "plan x-rays of spine, if (+) will consider CAT scan." "Pt. is to cont. on the same treatment," "will get lab and go from there," "will remove mole in office today," Pt. will be referred for psychological testing," etc.	There is no documentation of a clear plan of treatment as described in the "Met" column.
14. There shall be documentation of an appropriate patient problem list which includes significant illnesses/medical conditions. If the patient has no known medical illness or conditions, there is documentation of a flow sheet for health maintenance.	There is a patient problem list (initiated after the patient has been seen three (3) or more times by the same physician) that includes but is not limited to significant illnesses/medical conditions and/or a flow sheet for health maintenance.	There is no patient problem list or health maintenance flow sheet initiated after the patient has been seen three (3) or more times by the same physician.

STANDARD	MET	NOT MET
15. For patients 14 years and over, having been seen three (3) or more times, there shall be documentation of: a. tobacco use b. history of alcohol use c. history of substance abuse	There is documentation of tobacco use, history of alcohol use and substance abuse for patients 14 yrs and over after they have been seen three (3) or more times. This documentation may be recorded separately, or together on progress notes, problem lists, H&Ps, medical history forms, etc.	There is no documentation of tobacco use, history of alcohol use or substance abuse as described in the "Met" column.
16. There shall be documentation of a past medical history for patients seen three (3) or more times to include: a. serious accidents/illnesses, or if under 18 years, prenatal records, birth records and childhood illnesses, operations b. current medication list	There is a patient past medical history documented for patients seen three (3) or more times to include serious accidents/illnesses, or if under 18 yrs, prenatal/birth records and childhood illnesses, operations, and current medications. This documentation may be recorded in the progress notes, H&Ps, problem lists, an initial exam form, consultations, letters, etc. The items may be recorded together or separately.	There is no documentation of a past medical history as described in the "Met" column.
17. There shall be documentation of a completed immunization record for pediatric ages 13 years and younger. (This applies to FP, IM, & Peds)	There is a completed immunization record in the chart, e.g. a form or reference to where the information is recorded.	All recommended immunizations are not documented in the medical record.
18. There shall be evidence that Preventive Health Services are used appropriately.	There is documentation of appropriate health service screenings as recommended by the Blue Cross Blue Shield of Nebraska Preventive Health Guidelines for the appropriate age group, i.e., Pap Smear, breast exams, mammograms, blood pressure checks, cholesterol level, testicular exam, immunizations and well child visits, etc.	There is no documentation of Preventive Health Services documented in the chart as described in the "Met" column.
19. There shall be documentation of a patient's family medical history after the patient has been seen three (3) or more times.	There is documentation of a patient's family medical history after the patient has been seen three (3) or more times. This may be recorded in the progress notes as "non contributory", or "unremarkable" or on the problem list, medical history form filled in by the patient, H&Ps, physical exam forms/or annual physical exams, etc.	There is no documentation of a patient's family medical history as described in the "Met" column.

STANDARD	MET	NOT MET
20. All consultation summaries, laboratory and imaging studies filed in the chart, shall reflect physician review.	All consultation summaries/letters, laboratory and imaging reports, are initiated by the physician, stamped "reviewed", or some other electronic method used to signify review **AND/OR**, a letter to the patient with the date of the test and results (normal or abnormal) with follow-up care plan communicated **AND/OR**, documentation of telephone call to the patient to communication findings and follow-up care, **AND/OR**, documentation of test results discussed with patient in progress notes at a patient visit.	There is no method to reflect physician review as described in the "Met" column.
21. There should be documentation that any unresolved problem(s) from the previous office visits (episodic care) are addressed in subsequent visits.	There is documentation that any unresolved problem(s) from previous visits are addressed, e.g., "the last time you were here you had a back ache, how is it now?" "how is your weight loss program going? Let's weigh you." Is the antibiotic working for your sinus infection?" "you're here for your BP check?", etc.	There is no documentation that any unresolved problem(s) from previous visits were addressed as described in the "Met" column.
22. There shall be documentation of follow-up care noted in weeks, months or PRN.	There is a notation of follow-up care for each patient visit, noted in weeks, months, or PRN. May see recorded as: "give me a call in 48 hours and let me know how you are." "Recheck one (1) week, or RTC 1 week," "call if problems persist," "continue same medications, see one (1) month." "Recheck PRN."	There is no notation of follow-up care for each visit as described in the "Met" column.
23. When medications are administered on-site during an office visit, the medication, the dosage, route given, and the person who administered the medication shall be documented.	This standard is **not applicable** if medication is not administered during the office visit.	This standard is not met if medication is administered during an office visit and there is no documentation of the medication given, the dosage, administration route, and the person who administered the medication.
24. When medications are prescribed during an office visit, the medication, dosage, and the duration of the treatment shall be documented.	This standard is **not applicable** if medication is not prescribed during the office visit.	This standard is not met if medication is prescribed during an office visit and there is no documentation of the medication given, the dosage, and the duration of the treatment.

QUALITY OF CARE STANDARDS

STANDARD	MET	NOT MET
25a. Laboratory and other diagnostic testing shall be ordered as appropriate for each patient visit. b. Results of all diagnostic testing are incorporated into the medical record. c. When diagnostic test results are reported as abnormal, there is a notation in the progress notes of the physician's follow up plan.	There is documentation of diagnostic tests, e.g., laboratory, x-ray, stress test, etc., ordered or performed appropriate to the pt. visit. This standard is **not applicable** when diagnostic testing was not appropriate for the patient visit, e.g., pt. presented with cold & flu symptoms (medications prescribed), pt. cut self on knife, wound sutured, etc. **When the reviewer is unable to determine if/when a test is appropriate, a copy of the medical record will be made at the time of the review and brought back to Blue Cross Blue Shield of Nebraska for review by a Medical Director.**	Medical Director to determine the appropriateness of diagnostic/laboratory testing. Laboratory and other diagnostic testing are not being incorporated into the medical record. There was no documentation in the medical record regarding abnormal diagnostic/ laboratory test(s) including a follow-up plan.
26. There shall be documentation of appropriate use of consultants.	There is documentation of appropriate use of referrals to specialists. If a question arises for the reviewer regarding **over** utilization or **under** utilization, a copy of the medical record documentation may be brought back to Blue Cross Blue Shield of Nebraska for review by the Medical Director.	Medical Director to determine inappropriate use of referrals to the specialists.
27. There shall be no evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic problem.	There is no evidence that the pt. is placed at inappropriate risk, i.e., by testing inconsistent with the diagnosis, medical Rx's written for medication inappropriate to the Diagnosis, blood tests/ radiology results inappropriate to the Diagnosis. If the reviewer has a question regarding the documentation, copies of the record will be brought back to Blue Cross Blue Shield of Nebraska for review by a Medical Director.	Medical Director to determine if the patient is placed at risk.
28. There shall be documentation in the record that the patient was provided education concerning the prescribed treatment where appropriate.	There is documentation in the record that the pt. was provided with education concerning the prescribed Treatment, either verbally, or in form of printed educational material. This standard is **not applicable** if this is a follow-up visit and the condition is not new and/or there is documentation that the pt. has received previous education on the condition.	There is no patient education documented as described in the "Met" column, or if this is a new condition for the patient and there is no patient education documented.

STANDARD	MET	NOT MET
29. There is evidence of discussion regarding advance directives for all patients 65 and older and/or receiving Medicare benefits.	Documentation in medical record that the patient has an advance directive and that a copy has been requested/provided or documentation that advance directives were discussed.	There is no documentation of discussion of advance directives.