OFFICE SITE AND MEDICAL RECORD REVIEW STANDARDS

MEDICAL/SURGICAL

Medical Mutual of Ohio®
Office Site and Medical Record Review Standards

MEDICAL/SURGICAL

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Disclaimer for Website standards

Medical Mutual has provided these office site and medical record keeping review standards for informational purposes only. They are intended to provide an overview of the standards used by Medical Mutual when conducting office site and medical record keeping reviews.

Compliance with these standards does not ensure admission into the Company Network(s) or represent a minimal standard of care or treatment. These standards are not the exclusive criteria used by the Company in the credentialing process.

Medical Mutual reserves the right to use other standards and to interpret any standard as it deems appropriate based on the facts and circumstances of a particular case. Medical Mutual also reserves the right to change these standards at any time with or without notice as it deems necessary in its sole discretion.
Patient allergies or drug reactions are prominently noted in the medical record. The presence of an allergy or no known drug allergy (NKDA) is prominently and/or consistently noted in a specified area of the medical record. Preference is that this information is noted in RED or other prominent color.

Past medical history is documented. A past medical history is present for patients who are seen three or more times. The information is comprehensive in proportion to the Practitioner's specialty. Primary Care Practitioners record a thorough review of systems specific history, which is updated periodically. The past medical history is in a central location in the medical record. For children 18 years of age and younger, the past medical history includes information related to prenatal care, birth, developmental history, surgeries and illnesses. For obstetric patients, a prenatal risk assessment is documented.

A standardized tool is utilized to screen patients for depression, if depression is being addressed. A standardized tool is utilized to screen patients who are seen three or more times for symptoms of depression. (The most commonly used depression screening tools are: Patient Health Questionnaire (PHQ-9), Hamilton Depression Rating Scale (HAM-D), Beck Depression Inventory (Beck), Burns Depression Checklist, Zung Self Rating Depression Scale (ZUNG) and Whooley questions.

A standardized tool is utilized to screen patients for alcohol abuse/dependence, if alcohol abuse/dependence is being addressed. A standardized tool is utilized to screen patients who are seen three or more times for symptoms of alcohol abuse/dependence. (The most commonly used alcohol abuse/dependence screening tools are: Michigan Alcohol Screening Test (MAST)/Brief Michigan Alcohol Screening Test (BMAST), CAGE, Alcohol Use Disorders Identification Test (AUDIT) or Tolerance, Worried, Eye-opener, Amnesia, and K/Cut down test (TWEAK).

A height is documented. There is documentation in the medical record of a height taken periodically as a screening measure for the adult patient. For children ages 0-24 months, a height is documented at each well child visit. The height of children ages 2-17 years is documented annually. This standard is not applicable when the patient has been seen less than three times.

A weight is documented. There is documentation in the medical record of a weight taken periodically as a screening measure. This standard is not applicable when the patient has been seen less than three times.
A Body Mass Index (BMI) is documented annually. There is an annual calculated BMI recorded as a screening measure. The notation of the patient’s height and weight only is not sufficient to meet this standard.

Biographical/personal data is documented. At a minimum, there is a patient address, employer, daytime and home phone numbers (if different), gender, birth date, marital status and emergency contact name and phone number noted in the medical record.

Applicable family medical history is documented. For patients who are seen three or more times, Primary Care Practitioners record a thorough family history or identify it as noncontributory. Specialists address major family medical history in general form, with a detailed family history pertinent to the specialty. Documentation of any illnesses in family members including, but not limited to, cancer, heart disease, high blood pressure, glaucoma, lung disease, and vascular disease.

A query for alcohol use beginning at 11 years of age is documented. Beginning at 11 years of age, there is documentation of a query regarding alcohol use. This standard is not applicable for children under 11 years of age, or patients who have been seen less than three times.

A query for drug use beginning at 11 years of age is documented. Beginning at 11 years of age, there is documentation of a query regarding drug use. This standard is not applicable for children under 11 years of age, or patients who have been seen less than three times.

Annual query for tobacco use beginning at 11 years of age is documented. Beginning at 11 years of age, and then on an annual basis thereafter, there is documentation of a query regarding tobacco use. This standard is not applicable for children under 11 years of age, or patients who have been seen less than three times.

Current medication, dosage, and frequency are documented. Ongoing medications, to include over the counter and herbal supplements, are clearly listed and consistently noted in a specified area within the medical record.

Written reports for laboratory, x-ray, pathology, and home health care are filed in the patient’s medical record or documented on flow sheet maintained in the medical record. Copies of written reports for diagnostic and therapeutic ancillary services are contained in the patient’s medical record, listed on a flow sheet, or documented in the progress notes. The results of any testing performed in the Practitioner’s office are noted in some manner, by flow sheet, written report, etc. in the patient’s medical record. This standard is not applicable when no diagnostic or therapeutic ancillary services have been ordered for the patient.

There is a completed and up-to-date problem list. There is an up to date problem list in the patient medical record listing significant illnesses and medical conditions. This problem list is placed prominently within the medical record, and should include both chronic, acute, and health maintenance issues identified. This standard is not applicable when the patient has been seen less than three times.
The patient ID or name is on all pages of the medical record. All pages within the medical record contain the patient name (first and last) or ID number.

All practitioner entries are legible. All practitioner medical record entries can be read by the nurse reviewer without seeking assistance from the office staff or the Practitioner. *Note: Initial assistance is acceptable to identify abbreviations, written entries, or writing style, but the reviewer must be able to read the content of the medical record notes unassisted after this initial discussion.

Beginning at age 18, there is documentation as to whether or not a patient has executed an advance directive or living will to be included in the medical record. Documentation is noted in the medical record as to whether or not an advance directive has been executed. This standard is not applicable when the patient has been seen less than three times.

The documentation of the advance directive is in a prominent and/or consistent location of the medical record. There is documentation of the patient’s advance directive in a prominent and/or consistent location of the medical record

II. PLAN OF CARE

There is a detailed clinical history of the chief complaint. The history of the present illness or chief complaint is recorded. Medical assistant/staff personnel can record the chief complaint with the Practitioner documenting the remainder of the essential elements of the encounter.

The components of the physical examination are documented. The physical examination identifies the organ and system being evaluated and the results of the examination. The examination can be limited to the body system pertinent to the specialty and/or chief complaint. The physical examination correlates with the chief complaint/history of the present illness or chronic condition being addressed. A physical examination may not be required at every visit based on one or more of the following: the visit is related to management planning, related to consultation follow-up to discuss test results, and/or for educational purposes only.

Diagnosis is consistent with history and examination. The acute diagnosis is listed in the note for that visit. On a follow-up visit to address an existing problem, the diagnosis or symptoms are listed, with the updated status or resolution noted. A chronic diagnosis, requiring repeated visits need not be noted for each acute visit (i.e. hypertension, diabetes mellitus) but the diagnosis correlates with the chief complaint and physical examination.

A treatment plan is documented. There is documentation of a patient treatment plan that includes: all laboratory tests ordered, medications prescribed, referrals recommended, education provided, recommendations for home treatment and monitoring, and recommendations for necessary follow-up visits, tests, and screenings.
Treatment plan is consistent with diagnosis. There is a correlation between the diagnosis, impression/symptoms, treatment plan, and the physical examination findings. When a Practitioner is uncertain of the diagnosis, a notation of current thoughts and plan is acceptable, i.e., ruling out conditions.

Appropriate adult patient (> 18 years) preventive services /risk screenings are performed. For adult patients seen three or more times by the Primary Care Practitioner, recommended preventive services /risk screenings have been completed appropriate to the current age and condition of the patient. Refer to the Company’s preventive guidelines for adults as defined by the United States Preventive Services Task Force. Visit MedMutual.com.

Appropriate pediatric patient (< 18 years) preventive services /risk screenings are performed. For pediatric patients seen three or more times by the Primary Care Practitioner, recommended preventive services /risk screenings have been completed appropriate to the current age and condition of the patient. Refer to the Company’s preventive guidelines for children as defined by the United States Preventive Services Task Force and the American Academy of Pediatrics. Visit MedMutual.com.

III. OFFICE INTERVIEW

MEDICAL RECORD STANDARD – PAPER BASED

The medical record is organized to facilitate easy retrieval of patient information. Medical records are organized in a manner that allows easy retrieval of patient information and may include section dividers. Patient information is stored in a chronological order.

The medical record is stored in a manner to allow for easy retrieval. Legible file markers or an identification system is utilized to provide easy retrieval of records.

The security of the patient’s information is maintained. Only authorized personnel have access to medical records.

Medical records are readily retrievable to the practitioner during normal office hours. Medical records stored at other office sites are easily retrievable.

MEDICAL RECORD STANDARD – ELECTRONIC

Patient health information and data are readily available to the medical practitioner. An electronic medical record is easily retrievable to the practitioner.

The security of the patient’s health information and data is maintained by the electronic health system. A password protected system limits access to appropriate practitioners.
Test ordering and results are organized and managed within the electronic medical record. Test requests and results are organized chronologically and permit ease in monitoring.

Reminders, prompts, and/or alerts are available to support the practitioner decision making activity. The use of system reminders provides help to improve compliance with best practices and ensure regular screening/preventive practices.

CONFIDENTIALITY

A statement of confidentiality/HIPAA is signed by all office staff. The office’s confidentiality policy is shared with all office staff who are then to sign attesting to their agreement to abide by the confidentiality policy.

The office staff receives periodic training in the confidentiality of member information. This periodic training needs to be documented and can occur as a part of the staff meeting.

PATIENT RIGHTS AND RESPONSIBILITIES

The office has a written policy that members are not discriminated against in the delivery of healthcare services based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, claims experience, medical history, evidence of insurability, genetic information or source of payment.

APPOINTMENT ACCESSIBILITY

LIFE-THREATENING EMERGENCY: The office can produce a written policy indicating that the patient is immediately seen or triaged.


Examples: chest pain, new onset dyspnea

If contact is made with the office or the Practitioner, members are scheduled to be seen immediately or will be directed to the closest appropriate practitioner for emergency treatment.

URGENT CARE: An appointment time for an urgent care problem is offered within 24 hours.

Definition: The onset of acute symptoms that require medical attention soon

Examples: Children with ear pain and fever; signs or symptoms of urinary tract infection; unrelieved fever for 2 days
For ROUTINE PRIMARY CARE, office can offer an appointment within 7 days for new, non-urgent symptoms
Definition: New and non-urgent symptoms

Examples. Visit to treat the course of a new non-urgent problem (e.g., cold, knee pain, etc.).

ROUTINE PRIMARY CARE: An appointment time for routine care is offered within 3 calendar weeks.
Definition: Non acute symptoms or follow up care

Examples: Follow-up visits to monitor the course of an ongoing problem (e.g., blood pressure, weight checks.)

PREVENTIVE CARE: An appointment time for preventive care services is offered within 6 calendar weeks.
Definition: Periodic health assessment for children and adults

Examples: Routine well-child and adolescent visits; adult physical or gynecological examination

The average office wait time does not exceed 30 minutes.
Definition: Wait time for a patient who arrives for an appointment on time.

There is an on call system in place for care provided “After Hours” – The office has a staffed answering service or an answering machine/voice mail/recorded message with emergency instructions available for patients who call outside the office’s business hours.

When the practitioner’s office is closed, there is an answering system in place providing a process for making contact with the on-call practitioner for urgent or pressing issues.

Practitioners have arrangements for medical services back-up when unavailable. Practitioners who are unavailable must have specific arrangements for another Practitioner to provide care and treatment in their absence.

IV. Office Site

PHYSICAL APPEARANCE

Building area, waiting area and exam rooms and floors are clean and uncluttered.

Corridors leading to exits are clear. No storage of any kind is present in the exit hallways.
Storage areas are separate from exam/counseling rooms. Any supplies stored within the exam/counseling area should be stored in enclosed areas such as closet or cupboards with doors that can be closed or locked if needed.

Office hours are posted at the office entrance for patient viewing. ADEQUACY OF WAITING AND EXAM ROOM

At least one exam room is present for each practitioner.

Adequate waiting areas are present with enough seats for the usual number of patients present.

Waiting and examining rooms have enough lighting to permit patients to see reading material.

PHYSICAL ACCESSIBILITY

Handicap parking is available or a written alternative plan is present.

Wheelchair access/ramp to the office is present or a written alternative plan is present.

Minimal or no-hands access entry to the building is available or a written alternative plan is present.

All hallways and office doors are wide enough for wheelchair access or written alternative plan is present.

Handrail assist is present in patient restrooms or a written alternative plan is present.