Policy: **Evaluation of Medical Records**

Date of Implementation: **February 18, 2003**

Product: **Specialty**

Appropriate medical record maintenance and documentation practices are an integral component of a practitioner's practice. Similarly, the ongoing evaluation of practitioners' medical records is a key component of the American Specialty Health (ASH) Clinical Performance Program. Medical records must comply with ASH guidelines, as well as all applicable federal and state statutes and regulations in accordance with standards set forth for the licensed practitioner's specialty and facility type.

ASH credentialed practitioners are required to meet minimum standards of medical record documentation. A thorough evaluation of a practitioner's medical records occurs throughout clinical and customer service operations. In the absence of any evidence placing a member at risk, an educational approach is taken to assist each practitioner in enhancing medical record documentation and management practices to meet or exceed industry and contractual standards.

Medical record documentation criteria were compiled after a thorough review of available professional literature, industry accreditation standards, and clinical peer opinion (See the *Medical Record Maintenance and Documentation Practices (CPG 110 – S*) clinical practice guideline). Providers/practitioners are advised to review the medical record documentation criteria and ensure their documentation and medical record storage practices comply prior to submitting an application.

Monitoring and trending of medical record quality are integrated into the daily clinical services process; the investigation of member and provider/practitioner appeals, complaints, and grievances; and other routinely performed clinical performance processes.

In addition to assessing the practitioner's compliance with medical record standards, medical records are also reviewed to identify:

- Patients who appear to be placed at inappropriate risk (e.g., by a diagnostic or therapeutic procedure, possible missed diagnosis, inaccurate assessment, etc.);
- Potential instances of under-utilization (withholding appropriate services, recidivism, failure to or delay in referral, etc.); and
- Potential instances of over-utilization (embellished records, malingering, treatment/service intensity exceeds complexity of complaint, etc.).

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Medical Record Documentation and Storage Assessment

During the application process, providers/practitioners are provided with and encouraged to review the medical record documentation and storage requirements to ensure their practices comply with these requirements. By reviewing these online documents as well as the applicable sections of the service agreement, potential applicants are informed of ASH's documentation expectations.

Ongoing Monitoring of Medical Records

Throughout participation, the clinical quality components of medical records (See the *Medical Record Maintenance and Documentation Practices (CPG 110 – S*) clinical practice guideline) are evaluated by licensed peer clinicians. Medical records received, including Medical Necessity Review Forms (MNR Form) and medical records submitted for appeals, grievances, clinical services investigations, and post-service review, are included in the medical record evaluation process. Cases for medical record evaluation may also be selected at random or following claims submission.

Medical records received, as stated above, are subjected to the Clinical Services review process and/or are reviewed against the minimum standards for medical records for a practitioner to meet credentialing criteria for ASH participation. Medical record reviews are conducted by a peer clinician and include components such as documentation of chief complaint, pertinent history and physical exam, working diagnosis is present, treatment plan is documented, diagnostic studies reflect review, and that daily treatment notes are appropriately documented.

If data reported on MNR Forms submitted for verification of medically necessary services does not meet or exceed industry and contractual standards, the clinical quality evaluator will communicate deficiencies and appropriate standards to the provider/practitioner. If the practitioner's documentation practices are consistently below standard, the clinical quality evaluator submits this information to the Clinical Service Investigation Team (CSIT). If a practitioner is reported to CSIT two (2) or more times within a six-month period, an education letter addressing appropriate MNR Form documentation is sent to the provider/practitioner; if the same practitioner is reported twice again in any continuous six (6) month period, an "Audit Warning" education letter is sent, advising that further reports will result in an audit of medical records. If the provider/practitioner has received both education letters and is again reported twice in any continuous six (6) month period, three (3) complete sets of medical records shall be requested from the practitioner's patient base for evaluation.

Upon receipt of the practitioner's medical records, the content is scored against pre-determined criteria by a peer clinician. Each criterion is assigned a weighted point value based on the significance of the criterion. Greater significance (higher point value) is placed on criteria that reflect the clinical quality of the practitioner/member encounter (e.g., documentation of history, physical examination/evaluation, and treatment plan). A lesser point value is assigned

to non-clinical criteria (e.g., demographic data is contained in each file). Results from the medical record evaluation are placed in the applicant's quality management file and may be reviewed by the Practice Review Committee (PRC).

- Practitioners whose medical records receive a score of 80% or greater are considered to meet criteria.
- Practitioners whose medical records receive a score of 60-79% are also considered to meet minimum criteria; however, the provider/practitioner also receives education that identifies the deficiencies and provides written corrective feedback.
- Practitioners whose medical records receive a score below 60% fail to meet minimum criteria. Such practitioners generally first receive medical record education that identifies the deficiencies and provides written corrective feedback. A follow-up medical record request may be scheduled within six (6) or 12 months to assess compliance. Ongoing non-compliance may result in a Corrective Action Plan (CAP), a Clinical Services Investigation Team (CSIT) investigation, or other sanction.

Practitioner Education

Following a review of any medical records, the provider/practitioner may receive an education letter identifying elements that were lacking in the medical records, and providing information on how to improve documentation, including on MNR Forms. If more serious issues are identified, an inquiry letter may be sent to the provider/practitioner. The response to the inquiry letter is reviewed by CSIT; who may forward the issue to the PRC with a recommendation to issue a CAP to the provider/practitioner. [See the applicable *Clinical Services Alerts, Clinical Performance Alerts, and Corrective Action Plans (Practitioner/Provider Clinical Issues) (QM 2 – S*) policy.]

In an effort to educate providers/practitioners regarding any enhancements or changes in medical record keeping requirements, the criteria are published in periodic articles in newsletters, distributed in specialty-specific educational letters and CAPs, and posted on ASHLink.

Medical record quality improvement initiatives include education, monitoring, trending, management, and continuous improvement of the quality and thoroughness of medical record documentation. The knowledge gained from these processes is used to continually evaluate medical record standards as well as in the development of more effective and efficient methods to record the patient/practitioner encounter.

Ownership of Medical Records and ASH Intellectual Property

ASH acknowledges that it does not own medical records kept by providers/practitioners that are sent to ASH; however, ASH has the right to request and receive medical records from a credentialed practitioner, or a non-credentialed practitioner submitting a claim for payment based on an assignment by the ASH member to the non-credentialed practitioner, for purposes

required by law, for other customary purposes such as disease management, patient management, medical necessity review, quality assurance, quality review, quality management, and audit, including any audit activities undertaken by ASH to comply with National Committee for Quality Assurance (NCQA) and URAC accreditation requirements; and to review them for treatment, payment, or health care operations purposes. The release of a member's medical records to ASH by a provider/practitioner does not convey to that provider/practitioner any property interest in:

- ASH's data or intellectual property;
- Products or services offered or provided now or in the future; or
- Any business, systems, or information management process that incorporates any medical records or related data obtained by ASH from the provider/practitioner or any reports or data resulting from those data or processes.

ASH is limited in requesting information or cooperation from a non-credentialed practitioner to the same information or cooperation ASH may request from the member upon whose assignment of benefits the non-credentialed practitioner is submitting a claim for payment or from a health plan who has delegated to ASH medical necessity review, quality management, or claims payment functions on behalf of the member.

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