

NHP/NHIC-Medical Record Review Process

Abstract/Purpose:

Network Health Plan/Network Health Insurance Corporation (NHP/NHIC) has established medical record documentation standards to assure that records are well-documented in order to facilitate communication, coordination and continuity of care and promote the efficiency and effectiveness of treatment.

I. POLICY:

NHP/NHIC systematically reviews medical records on all HMO/POS primary care practitioners (PCPs) with fifty (50) or more members who have selected them as their PCP and all Medicare practitioners with fifty (50) or more members using their services within the previous year, to ensure compliance with its medical record review documentation standards (see related document Medicare Specialists Included in Medical Record Review).

NHP/NHIC has established a performance standard of 90% for each criterion reviewed and will institute actions for improvement when the performance standard on any of the criteria is not met. The medical record review must occur within a 36 month timeframe before the practitioner's recredentialing decision.

II. PROCEDURE:

A medical record review is scheduled and conducted by a NHP/NHIC reviewer. The reviewer randomly selects ten (10) members from a monthly claims report for the previous year and the members' medical records are reviewed against established criteria and results are recorded and scored on the Medical Record Audit Tool (see related documents NHP/NHIC Medical Record Review Tool, NHP/NHIC Medicare Medical Record Review Tool and CMS MRR Tool Criteria Definitions). NHP/NHIC's performance standard is 90% or above for each criterion reviewed.

Results of the medical record review will be sent to the practitioner and placed in the practitioner's credentials file to become part of his/her performance monitoring information summary at recredentialing. If the percentage of any of the criterion reviewed is less than 90%, medical record review results noting the deficient areas, and a proposed action plan for improvement will be forwarded to the practitioner. The practitioner will be given the opportunity to respond to the action plan and such response will be included in the review by the Centralized Credentials Committee at the time of recredentialing.

A follow-up medical record review on deficient criteria only, will be conducted in six months to assess for improvement in medical record documentation. A follow-up review

will be conducted on the criteria continuing to be deficient every six months until the practitioner meets the performance standard. If a practitioner fails to meet the 90% standard on 3 or more consecutive reviews, a summary of those reviews are sent to the appropriate medical director for further action. If requested by the medical director, the Centralized Credentials Committee provides recommendations for action to improve items that continue to have a score of less than 90% plan-wide to the Quality Management Committee. The Quality Management Committee will make final decisions on action taken.

Network Health Plan/Network Health Insurance Corporation standards and performance goals for participating practitioner medical records are communicated to the participating practitioner at the time of orientation and on an annual basis. Overall aggregate medical record review results are reviewed annually on a plan-wide basis.

**Network Health Plan/Network Health Insurance Corporation
 MEDICARE MEDICAL RECORD REVIEW
 GOAL--- 90%**

PROVIDER: LOCATION: AUDIT DATE:

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CRITERIA	MEMBERS										COMMENTS	SCORE	≥90%
	1	2	3	4	5	6	7	8	9	10			
1. Significant illnesses and medical and psychological conditions are indicated on the problem list.													
2. Medication allergies and adverse reactions are prominently noted in the record. If the patient has no known allergies or history of adverse reactions, this is appropriately noted in the record.													
3. Medical records are legible, organized and signed.													
4. Patient identification and past medical history, physical examinations, necessary treatment, and risk factors for the member relevant to the particular treatment.													
5. Diagnoses are consistent with findings and complaints. Patient involvement is considered in development of the treatment plan.													
6. There is no evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic problem.													
7. Identification of all providers participating in the patient's care and information on services furnished by these providers.													
7. Prescribed medications include dosages and dates of initial or refill prescriptions.													
8. Information on advance directives (completed document or documentation of discussion)													

 Auditor's Signature

 Date