EVOLENT HEALTH LLC
POLICY AND PROCEDURE

POLICY NUMBER: QI.033.E.KY
REVISION DATE: March 2019

POLICY TITLE: **Medical Record Standards and Review**
DEPARTMENT: **Quality Improvement**
ORIGINAL DATE: **July 2016**

Approver(s): **Betsy Simpson, Director Quality Improvement**

Policy Review Committee Approval Date:

Product Applicability: mark all applicable products below:

COMMERCIAL	[ ] HMO [ ] PPO *Products:* [ ] Small [ ] Indiv. [ ] Large *Exchange:* [ ] Shop [ ] Indiv. [ ] All States: [ ] GA [ ] MD [ ] OH [ ] TX [ ] __________
GOVERNMENT PROGRAMS	[ ] MA HMO [ ] MA C-SNP [ ] MA D-SNP [ ] MSSP [ ] Next Gen ACO [ ] MA All
	[X] Medicaid *States:* [ ] DC [X] KY [ ] MD [ ] ________
OTHER	[ ] Self-funded/ASO

Regulatory Requirements: Department for Medicaid Services (DMS) Contract Section28.9 and 39, National Committee for Quality Assurance (NCQA) Guidelines for Medical Record Review

PURPOSE

The purpose of this policy is to define the process for 1) adopting medical record standards, 2) notifying providers of the adopted standards, 3) determining providers that will be reviewed, 4) defining the goal of provider compliance, and 5) determining any corrective actions that may be needed.

DEFINITIONS

Healthcare Effectiveness Data and Information Set (HEDIS®) - A set of standardized performance measures designed to ensure that purchasers and consumers have the information they need to reliably compare the performance of managed health care organizations. A national tool used to measure performance on important dimensions of care of services.
Primary Care Physicians (PCPs) – include the areas of internal medicine, general practice, family practice, and pediatrics.
Health Insurance Portability and Accountability Act (HIPAA) - provides national standards to protect the privacy of personal health information. The Health Insurance Portability and Accountability Act of 1996, and the implementing

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regulations (45 C.F. R. Sections 142, 160, 162, and 164), all as may be amended.
Quality Medical Management Committee (QMMC) – A committee that provides direction to, and oversight of management and subcommittee functions responsible for the provision of clinical care and services.

Medical Record - a single complete record that documents all of the treatment plans developed for, and medical services received by, the Member including inpatient, outpatient, referral services and Emergency Care whether provided by Contractor's Network or Out of Network Providers.

Credentialing Committee – A committee consisting of practitioners participating in an organization's network that uses a peer review process to make recommendations regarding credentialing decisions.

POLICY

It is the policy of Evolent Health (Evolent) to complete a Quality Improvement (QI) Work Plan and to do statutory reporting to the DMS and NCQA, regarding the medical record review audit that is conducted annually by a Quality Improvement Nurse. The review elements directly correspond to the DMS contract, the Health Plan's Provider Manual, and the NCQA guidelines (see appendix A). The sample includes Primary Care Providers and Hospitals as defined in the contract. Results are submitted to the Health Plan's Quality Medical Management Committee (QMMC) annually. The QI reviewer has the discretion to submit any documentation that warrants further review to the Program Integrity Unit (PIU) or Reimbursement Department for overpayment when submitted documentation may not fully support the claim.

PROCEDURE

1. Evolent has adopted medical record keeping standards that address confidentiality, organization, documentation, access and availability of records, and continuity and coordination of care. These standards are determined by the NCQA and the DMS.
2. The medical record keeping standards and performance goals for adherence to the standards are made available to all new and existing participating practitioners via the provider manual.
3. PCP's and hospitals are assessed for compliance with the medical record documentation standards once every three years. The audit is retrospective in that medical record documentation is reviewed from the prior year.

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Primary Care Practitioners selected for review are pulled by group and meet the following criteria:

- Participating PCP agreement during the entire measurement year being reviewed.
- Have a panel count of 50 or more members.
- Have a primary address within the state of Kentucky.
- Have at least 40 members with 3 or more distinct dates of service identified as ambulatory care during the measurement year.
- PCP was not assessed the previous three years unless they received a score below 80 percent.

Hospitals selected for review meet the following criteria:

- Participating facility agreement during the entire measurement year being reviewed.
- Have a primary address within the state of Kentucky.
- Have at least 40 members with three or more distinct ER dates of service, one of which resulted in an inpatient stay at the same hospital during the measurement year.
- Exclude Medicare primary members.
- Hospital was not assessed the previous three years unless they received a score below 80 percent.

Mental Hospital Review (per third party administrator quality review procedure):

- Review will be performed via delegation oversight.

4. The Quality Improvement team member will contact the Practitioners'/Hospital's designated representative to request medical records for the audit. The review list will be sent to the appropriate contact person and will indicate the member's name, member's Health Plan ID number, member's date of birth, and up to three dates of service.

5. Medical Record Documentation Requests

   a. The Quality Department generates the first medical record request letter.
   b. If a response is not received within ten (10) business days from the date of the original request, the Quality Department sends out a second request. The Health Plan's Provider Relations Representative assigned to the facility or practitioner receives a copy of the letter and a request for assistance is made in obtaining the medical record for quality review.

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c. If a response is not received within five (5) business days from the date of the second request, the Quality Improvement Nurse will conclude the audit with a default score of zero percent. The Quality Department will send a Non-Compliance letter to the provider or designated hospital representative and refer the results to Program Integrity. The provider will be considered a failing audit and will be re-reviewed the following calendar year. Dates of service for the re-review should fall after the date noted on the Non-Compliance letter.

6. Medical Record Review Process

Techniques of the "8 and 30" File Sampling Procedure are used to determine the sample size for the Medical Record Review and to classify practitioners/hospitals into one of three performance categories: HIGH (91-100); MEDIUM (80-90) or LOW (below 80). Once the Practitioners/Hospitals have been selected for review, thirty members, along with ten alternates are randomly selected for review. Initially, eight records are reviewed, and an average is determined. If the score is 80 percent or higher, the review is complete. If the score is below 80 percent, the review may expand (as determined by the QI Nurse) and as a result, the remaining twenty-two charts may be reviewed. The goal is to achieve 80% or greater on the Medical Record Review Audit.

a. If after the initial audit, it is determined that the Provider/Hospital will require additional information to pass, the Quality Department will contact the Practitioners'/Hospital's designated representative to discuss the results and inform them that we will be sending them a request letter for additional information.
b. A onetime request letter for additional information will be generated and sent to the Provider/Hospital.
c. If a response is not received within five (5) business days of notification, the audit will conclude with their current score. They will be asked to sign the Performance Evaluation respectively, acknowledging their score and areas of documentation needing improvement and will be provided with a copy of the results.
d. If the provider does not return the signature page or refuses to sign the document within ten (10) days of receipt of their audit results, the audit will be closed.
e. All findings are logged and maintained in a database to facilitate detailed analysis.

7. Once the Medical Record Review is complete, the Quality Improvement Nurse reviews the results with the Practitioner/Hospital designated

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representative. They will be asked to sign the Performance Evaluation respectively, acknowledging their score and areas of documentation needing improvement and will be provided with a copy of the results. If the provider does not return the signature page or refuses to sign the document within ten (10) days of receipt of their audit results, the audit will be closed.

8. Practitioners'/Hospitals meeting the goal of 80% or greater (in the High/Medium performance category) shall be removed from the review cycle for 3 years.

9. Practitioners'/Hospitals not meeting the goal of 80% (in the low performance category) will be reviewed the following calendar year. Dates of service for the re-review should fall after the date noted on the initial Performance Evaluation form.

10. If the Practitioner/Hospital does not meet the 80% threshold for the medical record review audit for two consecutive years, the Provider/Hospital will be informed via certified letter that they must submit a Corrective Action Plan (CAP). The Practitioner/Hospital must submit the CAP within ten (10) calendar days from the date the results were reviewed. Due to falling below the 80% threshold two years in a row, the Provider Relations Specialist will be informed of the results.

11. If the Provider/Hospital has not submitted a CAP within thirty (30) calendar days from the allotted timeframe, a member of the Quality Department will send a certified letter to the practitioner informing them of the previous attempts, reminding them of the CAP requirement.

12. Once the CAP is received, the Quality Improvement Nurse will review the CAP and submit it to the Credentialing Committee within sixty (60) calendar days of receipt.

13. In the event the Credentialing meeting does not have a quorum, the meeting will be rescheduled.

14. If the Credentialing Committee approves the CAP, the Provider/Hospital will be notified via letter within fourteen (14) calendar days that the CAP has been approved and they will be reassessed 6 months from the date the CAP was approved by the Credentialing Committee. Dates of service for the re-review should fall after the notification date to the Provider/Hospital of the CAP approval.

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15. If the Credentialing Committee does not approve the CAP, the Provider/Hospital will be notified via letter, within fourteen (14) calendar days that the CAP has not been approved. The letter will explain why it was not approved and the steps they need to take to submit another CAP. This process will continue until the CAP is approved by the Credentialing Committee.

16. When the Quality Improvement Nurse reviews the Provider/Hospital a third time (after the Corrective Action Plan was approved), the look back period will be from the date the CAP was approved by the Credentialing Committee to the date of the review.

17. During the 4th quarter of each calendar year, the QI Department assesses the findings from the medical record review and identifies opportunities for improvement, both at the individual practitioner and total practitioner population level. Results are then presented to the Health Plan's Quality Medical Management Committee (QMMC) for review, recommendations and approval.

18. Any trend related to a Provider's/Hospital's medical records not previously resolved shall be submitted for review by the Health Plan's Credentialing Committee at the time of re-credentialing.

RECORD RETENTION

Records Retention for Evolent Health documents, regardless of medium, are provided within the Evolent Health records retention policy and as indicated in CORP.028.E Records Retention Policy and Procedure.

REVIEW HISTORY

DESCRIPTION OF REVIEW / REVISION	REVISION DATE
New Policy	11/16
Annual Review	12/17
Addition of DMS Contract Language in Appendix	03/19

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APPENDIX A: 28.9 PROVIDER MAINTENANCE OF MEDICAL RECORDS

The Contractor shall require their Providers to maintain Enrollee medical records on paper or in an electronic format. Enrollee medical records shall be maintained timely, legible, current, detailed and organized to permit effective and confidential patient care and quality review. Complete medical records include, but are not limited to, medical charts, prescription files, hospital records, provider specialist reports, consultant and other health care professionals' findings, appointment records, and other documentation sufficient to disclose the quantity, quality, appropriateness, and timeliness of services provided under the Contract. The medical record shall be signed by the provider of service.

The Enrollee's medical record is the property of the Provider who generates the record. However, each Enrollee or their representative is entitled to one free copy of his/her medical record. Additional copies shall be made available to Enrollees at cost Medical records shall generally be preserved and maintained for a minimum of five (5) years unless federal requirements mandate a longer retention period (i.e. immunization and tuberculosis records are required to be kept for a person's lifetime)

The Contractor shall ensure that the PCP maintains a primary medical record for each Enrollee, which contains sufficient medical information from all providers involved in the Enrollee's care, to ensure continuity of care. The medical chart organization and documentation shall, at a minimum, require the following:

A. Enrollee/patient identification information, on each page,
B. Personal/biographical data, including date of birth, age, gender, manta! status, race or ethnicity, mailing address, home and work addresses and telephone numbers, employer, school, name and telephone numbers (If no phone contact name and number) of emergency contacts, consent forms, identify language spoken and guardianship information,
C. Date of data entry and date of encounter,
D. Provider identification by name,
E. Allergies, adverse reactions and any known allergies shall be noted in a prominent location,
F. Past medical history, including serious accidents, operations, illnesses. For children, past medical history includes prenatal care and birth information, operations, and childhood illnesses (i.e. documentation of chickenpox),
G. Identification of current problems,
H. The consultation, laboratory, and radiology reports filed in the medical record shall contain the ordering provider's initials or other documentation indicating review,
I. Documentation of immunizations pursuant to 902 KAR 2 060,
J. Identification and history of nicotine, alcohol use or substance abuse,
K. Documentation of reportable diseases and conditions to the local health department serving the Jurisdiction in which the patient resides or Department for Public Health pursuant to 902 KAR 2 020,
L. Follow-up visits provided secondary to reports of emergency room care,
M. Hospital discharge summaries,
N. Advanced Medical Directives, for adults,

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O. All written denials of service and the reason for the denial, and
P. Record legibility to at least a peer of the writer. Any record judged illegible by one reviewer shall be evaluated by another reviewer

An Enrollee's medical record shall include the following minimal detail for individual clinical encounters

A. History and physical examination for presenting complaints containing relevant psychological and social conditions affecting the patient's medical/behavioral health, including mental health, and substance abuse status,
B. Unresolved problems, referrals and results from diagnostic tests including results and/or status of preventive screening services (EPSDT) are addressed from previous visits,
C. Plan of treatment including
    1. Medication history, medications prescribed, including the strength, amount, directions for use and refills,
    2. Therapies and other prescribed regimen, and
    3. Follow-up plans including consultation and referrals and directions, including time to return

An Enrollee's medical record shall include at a minimum for hospitals and mental hospitals

A. Identification of the beneficiary
B. Physician name
C. Date of admission and dates of application for and authorization of Medicaid benefits if application is made after admission, the plan of care (as required under 42 C F R 456 172 (mental hospitals) or 42 CF R 456 70 (hospitals)
   Initial and subsequent continued stay review dates (described under 42 CF R 456 233 and 42 C F R 465 234 (for mental hospitals) and 42 C F R 456 128 and 42 C F R 456 3 (for hospitals)
D. Reasons and plan for continued stay if applicable
E. Other supporting material appropriate to include
F. For non-mental hospitals only
    1. Date of operating room reservation
    2. Justification of emergency admission if applicable

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Appendix A

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