

Medical Record Assessment Tool for Managed Care Plans

Introduction and Overview:

The North Carolina Association for Health Plans (NCAHP) Medical Director's Committee is pleased to introduce The Medical Record Assessment Tool for Managed Care Organizations. It is the result of a significant collaborative effort between managed care entities and organizations representing physicians in North Carolina. This tool introduces a standardized format for the evaluation of important elements of medical chart documentation. The ultimate goal of this tool is to reduce the administrative burden to physician/providers offices and managed care organizations.

The motivation to develop this tool grew out of the realization that managed care organizations and providers have a common interest in standardizing certain administrative processes that accreditation agencies require. Physicians/Providers who practice good risk management can use this tool in their quality improvement programs to perform an assessment of their medical records. By developing a common standard tool, practitioners, office managers and managed care organizations will be looking for the corresponding quality indicators.

Development of the Tool

The tool was developed by the North Carolina Alliance for Healthy Communities (NCAHC) by consolidating managed care data collection tools as well as requirements of the National Committee for Quality Assurance (NCQA) and the Joint Commission for Accreditation of Health Care Organizations (JCAHO). The Medical Director's ad hoc committee which included representatives from organization of physicians, office managers and representation of health plan medical directors guided the development.

Important Principles

- The tool does not represent nor does it guarantee that the medical record documentation meets the standards of the individual health plan. There may be individual agreements between the provider and the MCO that requires additional information.
- The tool does not guarantee a passing score; however, if all elements are met the office practice has established a good foundation.
- The tool excludes specialized product requirements i.e. Medicaid and Medicare. Some unique product line requirements may not be covered in this document.

While it is expected that this tool will evolve over time, it has both near term and long term potential to decrease the administrative burden for both physicians/providers and health plans, and to improve documentation quality.

Thank you for being a part of this endeavor to work collaboratively to improve the communication and cooperation between managed care organizations and health care providers.

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MANAGED CARE ORGANIZATION (MCO) MEDICAL RECORD ASSESSMENT TOOL					
Date of Review:			Managed Care Organization (MCO):		
Accreditation (s) Held:					
DEMOGRAPHICS					
Name of Practice/Clinic:			Phone Number		
Street Address:			FAX Number:		
Mailing Address:			Office Contact:		
City:		State:	ZIP:	County:	
E-mail Address:		Web Site:		Medical/Geographic Service Area:	
Physician Hours:		Office Hours:		Site:	Type of Review:
STAFFING					
Total number of full time Physician/Providers at this Site: _____	Total number of Physicians/ Providers at this Site: _____	Total number of part time Physician/Providers: _____	Total number of Medical Staff: _____	Total number of Administrative Staff: _____	
List all physicians at this site or attach a list of providers with the specific requested information listed below.					
Physician Mid-Level Practitioner	Specialty	Tax ID	UPIN	Other	Taking New Patients?

The MCO is encouraged to populate this page with as much information as possible prior to the review.

ACCESSIBILITY OF SERVICES						
Site: _____ Primary Care <input type="checkbox"/> Specialist <input type="checkbox"/>	Preventive Care	Urgent Care	Routine Care	After hours Care	Emergency Care	Comments
Appointment Waiting Time:						
Time in the Waiting Room:						
Response Time Returning Calls after hours:						
Site: _____ Primary Care <input type="checkbox"/> Specialist <input type="checkbox"/>	Preventive Care	Urgent Care	Routine Care	After hours Care	Emergency Care	Comments
Appointment Waiting Time:						
Time in the Waiting Room:						
Response Time Returning Calls after hours:						
Site: _____ Primary Care <input type="checkbox"/> Specialist <input type="checkbox"/>	Preventive Care	Urgent Care	Routine Care	After hours Care	Emergency Care	Comments
Appointment Waiting Time:						
Time in the Waiting Room:						
Response Time Returning Calls after hours:						
				Record 1 Score	Record 2 Score	Record 3 Score
DEMOGRAPHIC INFORMATION AND CHART STRUCTURE						
1. The medical record is organized in a standard, consistent manner. Information in the charts should be organized to allow easy access to office notes, labs, x-ray, consults etc. – Maximum Score: 1						
2. All pages contain patient ID. All of the following elements must be present: 1. Individual medical record must be maintained for every patient. 2. Individual chart pages are secured within the medical record 3. The page must contain either the patient’s name or identification number. – Maximum Score: 1						
3. There is biographical / personal data in the file This information may include gender, date of birth, marital status, name of spouse or relative, address, employer, home phone, insurance information and family history. – Maximum Score: 1						
4. All entries have a date All entries must be dated with date, month, and year. – Maximum Score: 1						

	Record 1 Score	Record 2 Score	Record 3 Score	Comments
5. The chart is legible All entries in record are legible by someone other than writer. An illegible record will result in an incomplete review. – Maximum Score: 1				
6. The physician is identified on each entry All entries must contain the author’s identification – Maximum Score: 1				
RECORDS AND LISTS				
1. There is a completed immunization record An immunization record for children is up-to-date or an appropriate history has been made in the medical record for adults who have been seen two or more times. Score N/A for patients seen < 2 times – Maximum Score: 1				
2. There is a completed problem list *Critical Standard Significant illnesses and medical conditions are indicated on the problem list for patients seen 3 or more times. – Maximum Score: 1				
3. The allergies are listed *Critical Standard Allergies/adverse reactions are prominently noted in the medical record. Allergy sticker is present on the front of the chart or on the inside cover. “NKA” for no allergies is prominently displayed. – Maximum Score: 1				
4. There is a past medical history *Critical Standard The past medical history (for patients seen 3 or more times) is easily identified and includes serious accidents, operations and illnesses. For children and adolescents (18 years or younger) past history relates to prenatal care, birth, operations and childhood illnesses. If patient has been seen <3 times, score N/A. – Maximum Score: 1				
5. Alcohol and tobacco use are documented For patients 14 years of age and over, there is appropriate notation concerning the use of cigarettes, alcohol and substances. For patients seen three or more times, query substance abuse history. – Maximum Score: 1				
6. There is a pertinent history and physical History and physical exam records appropriate subjective and objective information pertinent to patient’s presenting complaints. – Maximum Score: 1				
7. Diagnosis is consistent with findings *Critical Standard Working diagnosis must be consistent with the findings. – Maximum Score: 1				
8. Treatment plans are consistent with diagnosis *Critical Standard Plan of action / treatment are consistent with diagnosis. Dosage and frequency and/or administration site of prescribed medication is documented in the chart. Score N/A if routine well visit, no action/treatment needed or no indication that medication had been prescribed or administered to the patient. – Maximum Score: 1				

	Record 1 Score	Record 2 Score	Record 3 Score	Comments
RECORDS AND LISTS (CONTINUED)				
9. Labs and other studies are ordered as appropriate Labs and other studies are ordered when appropriate and necessary. – <i>Maximum Score: 1</i>				
10. Consults have been appropriately used 1. Reason for consultation must be noted in the patient record. 2. If a consult is requested, there is a note from the consultant in the record. (Auditor should assess record for over and under utilization of consultants). – <i>Maximum Score: 2</i>				
11. There is a plan for a return visit There is a notation in the record when indicated regarding follow-up care or visit. Score N/A if no follow-up care is needed. The specific time of return should be noted in weeks, months, or PRN. – <i>Maximum Score: 1</i>				
12. Problems from previous visits have been addressed Unresolved problems from previous visits must be addressed and documented during subsequent visits. Score N/A if there were no unresolved problems from prior visits, or no prior visits. – <i>Maximum Score: 1</i>				
13. Labs, imaging studies, and consult notes have been reviewed by the physician Consultation, lab and imaging reports filed in the chart are initialed by the practitioner who ordered them to signify review. Review and signature by professionals other than the ordering practitioner do not meet this requirement. If the reports are presented electronically or by some other method, there is also representation of review by the ordering practitioner. Consultation and abnormal lab and imaging study results have an explicit notation in the record of follow-up plans. Score N/A if there is no evidence of abnormal studies in the record. – <i>Maximum Score: 1</i>				
14. There has been coordination of care between primary and specialty physicians Record should contain note from consultant. I.e. hospital discharge reports, physical therapy reports, home health reports. Score N/A if a consult has not been requested. – <i>Maximum Score: 1</i>				
15. The care appears to be appropriate *Critical Standard To score yes, there is no evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic procedure. – <i>Maximum Score: 1</i>				
16. The patient has been counseled on Preventive Care. There is evidence that preventive screening and services are offered in accordance with the organization's practice guidelines. (This question does not apply to specialist) – <i>Maximum Score: 1</i>				
17. The medical chart contains discharge summaries for all hospital admissions. – <i>Maximum Score: 1</i>				
18. Documentation is in a prominent part of patient's record indicating whether or not the individual has executed an advanced directive. – <i>Maximum Score: 1</i>				

REQUIRED POLICY AND PROCEDURES	
	Comments
INFECTION CONTROL	
1. A written infection control policy/program must be maintained by the practice which includes: • Policy for cleaning, disinfecting and/or sterilizing reusable equipment. • A procedure for handling patients with potentially contagious illnesses; e.g., separate waiting room, separate entrance. • A procedure for periodic testing of the autoclave.	
OFFICE EQUIPMENT	
1. There is a policy for preventive maintenance of equipment.	
2. There is a quality control policy on equipment maintenance.	
CLINICAL COMPETENCY	
1. There is a policy that ensures that all licensed personnel have a current valid license.	
2. There is a written procedure for oversight of mid-level providers; i.e., physician assistant, nurse practitioner.	
CONFIDENTIALITY	
1. Employees must sign a written confidentiality statement.	
2. There is a policy to protect medical record confidentiality.	
3. There is a policy for the written release of medical records.	
PATIENT SAFETY	
1. There is a written policy and procedure in place to handle fire/safety issues.	
2. There is a policy regarding detection and reporting of suspected cases of neglect and abuse.	
3. Staff is knowledgeable of process for detection and reporting of suspected cases of abuse and neglect.	
4. There is a policy for handling medical emergencies.	
EDUCATION	
1. Patient education materials, including preventive health are made available.	

The Policies and Procedures listed are the minimum expected. The office may have other policies that direct the operations of the practice and are expected to be available to the MCO at the time of the on site assessment.

