

<b>Policy Name:</b>	<b>Quality Site Visit Standards</b>	
<b>Policy Number:</b>	Quality Improvement – 1	
<b>Effective Date:</b>	1/1/01	
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**Approval Signature:** 

**Medical Director**

HMOI, BA HMO, BlueChoice, BlueChoice Select, PPO

Approved QI: 12/3/08

Approved P&P: 12/11/08

**Policy:**

The Managed Care Products of Blue Cross and Blue Shield of Illinois (BCBSIL) onsite audit staff will adhere to Quality Site Visit Standards when conducting quality onsite site visit audits for participating Primary Care Physicians (PCPs) (for HMO Illinois, BlueAdvantage HMO and BlueChoice) and high volume Behavioral Health Practitioners (for HMO Illinois and BlueAdvantage HMO only). **Quality site visits will be performed for BlueChoice PCPs who are not in the HMO at the time of initial credentialing into the Network.** Quality site visits are performed for all HMO PCPs every two years to comply with Illinois Department of Public Health requirements. **A site visit review will be performed when the HMO receives at least two member complaints within 12 months for a network practitioner. If the complaint indicates a potential patient safety issue, a site visit will be done after the one complaint. The site visit will be completed within 60 days of receipt of the complaint in the quality onsite review department.**

High volume Behavioral Health Practitioners (those practitioners who see greater than 25 unique patients per year) are determined on a biennial basis through IPA reporting of unique patient visits for each Behavioral Health **Practitioner**.

**Purpose:**

To audit managed care practitioners against established Quality Site Visit standards including information related to the following:

- Accessibility;
- **Office site;**
- Emergency Preparedness;
- Medical Record Review; and
- *Preventive Services. (Not audited for Behavioral Health)*

**Procedure:**

A. BCBSIL auditors will schedule a visit with the **practitioner** office, **provide** a copy of the onsite standards by which the practitioner will be evaluated and conduct an inspection of the **office site** which includes, but is not limited to:

1. Member's ability to access health care.
2. Inspection of **the office site** including a patient examination room to evaluate compliance with standards.
3. Medical record review of five charts per PCP to evaluate compliance with medical record standards and preventive care.

## **I. ACCESSIBILITY STANDARDS**

### **Purpose:**

- To evaluate whether members have appropriate access to medical services.

### **Procedure:**

- A. BCBSIL has specific service expectations for participating Managed Care Practitioners. They are as follows:
1. Physician response to an emergency call within 30 minutes.
  2. Schedule urgent visits within 24 hours.
  3. Schedule routine appointments within 10 business days or two weeks of request, whichever is sooner.
  4. Schedule extended visits (i.e., comprehensive exam, preventive care appointment, etc.) within four weeks of request.
  5. Arrange for an answering system after office hours that members can access through the usual office protocol:
    - ⇒ Response to emergency phone calls should be within 30 minutes.

## **II. SITE REVIEW STANDARDS**

### **Purpose:**

- To assess whether members have appropriate access to healthcare services in a clean and safe environment.

### **Procedure:**

#### **1. Environment:**

- The **site** should be clean and well organized to accommodate patient services.
- Restrooms, doorways and hallways should be easily accessible.
- The waiting room should have adequate seating for the volume of patients.
- There should be **an** adequate **number of** exam rooms **based on the** number of practitioners.
- The **site** should be accessible to those with disabilities. **Please note: If the practitioner has ownership interest in the building, the building must be compliant with ADA (American Disabilities Act) guidelines. If any ADA guideline is not met, the practitioner will have two years from the date of the site review to become compliant with the ADA guideline. Continued non-compliance with the guideline(s) may result in departicipation from the HMO network(s).**
  - There should be at least one entrance to the office that is accessible to those with impaired mobility or those in a wheel chair.
  - There should be at least one exam room that can be accessed by doorways and hallways that are at least 36 inches wide.

- There should be at least one restroom that can be accessed by doorways and hallways that are at least 36 inches wide.

## **2. Safety Measures:**

- The Practitioner and his/her staff should follow the Center for Disease Control Universal Precaution guidelines when providing patient care.
- Bio-hazardous waste must be discarded according to OSHA guidelines.
- Sharp disposal containers must be available.
- Fire Extinguisher must be accessible.

## **3. Lab Specimens and Medication Maintenance/Storage:**

- Sample drugs, over-the-counter medications, prescription drugs, and vaccines should be stored in restricted patient areas.\*
- Controlled substances, if present, should be stored in a locked area along with an inventory list.
- All medications should be routinely monitored for expiration dates.
- Medication and/or lab refrigerators should be free of food. (Medications and lab specimens may be stored in the same refrigerator if stored in separate areas).

## **4. Medical Supply Maintenance/Storage:**

- Sharps should be stored in restricted patient areas.\*
- Prescription pads should be stored in restricted patient areas.\*

## **5. Medical Record System:**

- Medical records should be handled in a confidential manner. The office **must** have a written policy that addresses Health Insurance Portability and Accountability Act (HIPAA) requirements regarding Protected Health Information (PHI).
- The Practitioner should have a written policy/procedure detailing how medical record information is to be released.

## **6. Patient Education:**

- Educational materials or literature regarding at least three preventive services and at least two medical conditions relevant to the practitioner's practice must be available for patient use. Examples of preventive materials might be: information about breast self-exam, mammography, Pap smears, pediatric immunizations, coronary risk reduction, or prostate screening. Materials about conditions relevant to the practitioner's practice could cover topics such as asthma management, diabetes management, management of abnormal Pap smears, and pregnancy care.

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\*Restricted Patient Area – a separate storage space away from the patient care area or a locked receptacle within the patient care area.

# **III. EMERGENCY PREPAREDNESS**

## **Procedure:**

### **1. Emergency Preparedness**

--- The Practitioner should have a written procedure on how to handle a medical emergency for members accessing care at his/her facility. This procedure must be posted in a prominent location or easily accessible through a central file/manual.

--- At least one staff member who has Cardiopulmonary Resuscitation (CPR) Certification should be available during patient care hours. This certification must be kept current and documentation of certification must be available for verification upon request. A valid CPR card will be accepted via fax within one week of the onsite visit

## **IV. MEDICAL RECORD REVIEW**

### **Purpose:**

BCBSIL requires member medical records to be maintained in a manner that is current, detailed, organized, and easily accessible. All patient data should be filed in the medical record, (i.e., lab, x-ray, consultation notes, etc.) Documentation of a member's care should facilitate communication, coordination and continuity of care and promote efficiency and effectiveness of treatment.

### **Procedure:**

- 1. Past Medical History:** There should be documentation of a past medical history obtained by the third visit or within one year of the first visit, whichever comes first. The ***past*** medical history should be updated at least every three years for adults and every five years for pediatric patients.
- 2. Family History:** There should be documentation of a family medical history obtained by the third visit or within one year of the first visit, whichever comes first. The family medical history should be updated at least every three years for adults and every five years for pediatric patients.
- 3. Social History:** There should be documentation of a social history (including, but not limited to, information about family and occupation, and the assessment of cigarette and alcohol use and/or substance abuse) obtained by the third visit or within one year of first visit, whichever comes first. For ***pediatric*** patients, the developmental milestones may be included. The social history should be updated at least every three years for adults and every five years for pediatric patients.
- 4. Physical Activity Assessment/ Counseling:** There should be documentation of assessment and/or counseling regarding physical activity obtained by the third visit or within one year of the first visit, whichever comes first. The physical activity assessment/ counseling should be updated at least every ***two*** years (***ages 18 and above***) or ***every one year (ages 3-17)***. ***Note: scoring will be based upon updates at least every third year for 2009. In 2010, scoring will be based upon updates every one to two years depending on age category.***\*\*
- 5. Body Mass Index (BMI):** ***There should be documentation of the patient's BMI (or BMI percentile for children) by the third visit or within one year of first visit, whichever comes first. The BMI should be updated every two years for ages 18-74 and the BMI percentile every year for children ages 2-17.***\*\*
- 6. Nutrition Counseling for Children:** ***There should be documentation of nutrition counseling every year for patients ages 2-17 years.***\*\*

- 7. Adult Alcohol Use:** There should be documentation regarding alcohol use obtained by the third visit or within one year of the first visit, whichever comes first, for adults age 18 and over. If the member is currently using alcohol, it should be noted. The history of alcohol use should be updated at least every three years.
- 8. Utilization of an Alcohol Assessment Tool for an Adult:** *There should be documentation of the use of an alcohol assessment tool if the patient answers “yes” to alcohol use. \*\**
- 9. Adolescent Alcohol Use:** There should be documentation regarding alcohol use obtained by the third visit or within one year of the first visit, whichever comes first, for adolescents age 12-17. If the adolescent is currently using alcohol, it should be noted. The history of alcohol use should be updated every three years.\*\*
- 10. Utilization of an Alcohol Assessment Tool for an Adolescent:** *There should be documentation of the use of an alcohol assessment tool if the patient answers “yes” to alcohol use. \*\**
- 11. Adult Inappropriate/ Illicit Drug Use:** There should be documentation regarding inappropriate/ illicit drug use obtained by the third visit or within one year of the first visit, whichever comes first, for adults age 18 and over. If the member is currently using illicit drugs, it should be noted. The history of drug use should be updated every three years.
- 12. Recommendation for Adult Inappropriate/Illicit Drug Use Treatment:** *Instructions and/or education about recommendation for treatment should be provided to members who are identified as using inappropriate/illicit drugs.\*\**
- 13. Adolescent Inappropriate/Illicit Drug Use:** There should be documentation regarding inappropriate/ illicit drug use obtained by the third visit or within one year of the first visit, whichever comes first, for adolescents age 12-17. If the member is currently using illicit drugs, it should be noted. The history of drug use should be updated at least every three years.\*\*
- 14. Recommendation for Adolescent Inappropriate/Illicit Drug Use Treatment:** *Instructions and/or education about recommendation for treatment should be provided to adolescents age 12-17 who are identified as using inappropriate/ illicit drugs.\*\**
- 15. Smoking History for Adults:** There should be documentation of a smoking history obtained by the third visit or within one year of the first visit, whichever comes first, on adults age 18 and over. If the member is currently smoking, it should be noted. The smoking history should be updated every **two** years.
- 16. Recommendation for Smoking Cessation for Adults:** *Instructions and/or education about smoking cessation should be provided to members age 18 and over who are identified as smokers. If the patient smokes, update the smoking history at least every two years and provide smoking cessation advice at least annually. Note: In 2009, scoring will be based upon advice to quit smoking within a three year period. \*\**
- 17. Smoking History for Adolescents:** There should be documentation of a smoking history obtained by the third visit or within one year of first visit, whichever comes first, on adolescents age 12-17. The smoking history should be updated at least every **two**

years.\*\*

- 18. Recommendation for Smoking Cessation for Adolescents:** Instructions and/or education about smoking cessation should be provided to **adolescents** age 12-17 who are identified as smokers. ***If the patient smokes, update the smoking history at least every two years and provide smoking cessation advice at least annually.*** \*\*
- 19. Coordination Between Medical and Behavioral Health Care:** If the member is seeing a Behavioral Health **Practitioner**, there should be documentation of communication between the Behavioral Health **Practitioner** and the referring physician. Documentation should include, but not be limited to, follow-up regarding coexisting medical and behavioral **health** disorders and medication management. If the member refuses to allow such communication, this should be documented.
- 20. Immunization Documentation:** *Documentation of immunizations administered by the office staff should include the date the vaccine was administered, the manufacturer and lot number, and the name and title of the person administering the vaccine. **If the office maintains an immunization log, the medical record must have documentation of the site, the name and title of the person administering the vaccine, and the type of vaccine. The lot number may be documented in the log. The log must be provided for review.***
- 21. Chief Complaint/History Relevant to Problem:** Subjective information identifying why the patient is seeking medical attention should be documented. The description should include pertinent history, symptoms, and other related information.
- 22. Physical Examination:** A pertinent physical examination, relevant to the problem, should be documented.
- 23. Vital Signs:** Vital signs, consistent with the patient's chief complaint, relevant problem and/or diagnosis, should be documented.
- 24. Diagnosis/Assessment:** A diagnosis and/or assessment, consistent with the findings, should be documented.
- 25. Treatment Plan/Plan of care:** A plan of diagnosis (lab testing, x-rays, etc.) and management (medication dose, frequency, and duration, as well as other interventions), consistent with the assessment, should be documented.
- 26. Previous Problems:** Unresolved problems and/or chronic problems from previous office visits should be addressed in subsequent visits.
- 27. Continuity of Care, Follow-Up Care, Calls or Visits:** Follow-up care, communication of test results, calls/visits should be documented to indicate continuity of care.
- 28. Consultations:** Documentation of response/feedback from a referral for consultation to a specialist should be present in the record and should be signed/initialed by the practitioner and/or there should be a notation in the progress notes indicating that the feedback from the specialist has been reviewed.
- 29. Chart Organization:** The Practitioner should maintain a uniform medical record system of clinical recording and reporting with respect to services which includes separate sections for progress notes and the results of diagnostic tests.

- 30. Biographical Information:** Each medical record should contain the patient's address, employer, home and work telephone numbers including emergency contacts, marital or legal status, appropriate consent forms and guardianship information, if relevant. Biographical information should be updated at least every three years.
- 31. Patient Identifiers:** Patient identifiers should appear on each page of the medical record (patient name or unique ID number).
- 32. Date and Signature:** All entries are to be dated and signed/initialed by the author. Author identification may be a handwritten signature, unique electronic identifier or initials.
- 33. Legibility:** All entries should be legible.
- 34. Allergy Status:** Medication allergies should be noted in a prominent location in the medical record. If the member has no known allergies or history of adverse reactions, this should be prominently noted. Allergies to environmental allergens, food, pets, etc., should also be noted. Allergy histories should be obtained every three years for adults and every five years for pediatric patients.
- 35. Problem List:** There should be a current problem list, either kept separately or within each practitioner progress note, which includes significant illnesses and medical conditions. A health maintenance record should be present if there are no documented relevant problems. The problem list must be inclusive of all problems whether a separate list or within each practitioners note.
- 36. Medication List:** There should be a current medication list, either kept separately or within each practitioner progress note. The medication list must be inclusive of all medications, whether a separate list or within each Practitioner progress note, and include prescription initial or refill dates.
- 37. Lab/X-Ray/Diagnostic Results:** The results of all labs, x-rays and diagnostic testing, should be posted in the chart. The reports should be signed or initialed by the practitioner and/or there should be a notation in the progress notes indicating that they have been reviewed.

\*\* This standard will not be included in the scoring results.

## **V. PREVENTIVE SERVICES**

### **Purpose:**

To ensure that members have appropriate access to preventive care services.

### **Procedure:**

BCBSIL has specific Preventive Health Care Guidelines ***based on national recommendations***. Practitioners should provide services in accordance **with** these guidelines. The offer of services and the subsequent results or the member's refusal to accept services should be documented in the member's medical record. If the service was provided by another practitioner (example: OB/GYN), document in the medical record that

the service was provided, with the date and the results. Preventive care services should be provided by the third visit or within one year of the first visit, whichever comes first. The date of service and results or findings should be documented in the medical record. The medical records will be reviewed for performance of the following preventive care services:

A. **Adult Female:**

1. **Non-fasting cholesterol** should be performed every five years on members over age 45. The medical record should document the date and results or findings. Only medical records for members age 46 and over will be audited for this measure.
2. **Pap Smear(s)** (Age 21-70) *should be performed approximately three years after becoming sexually active, but no later than age 21. Screen every year with conventional PAP tests or every two years using liquid-based Pap tests. At or after age 30, women who have had three consecutive normal tests may get screened every two to three years with cervical cytology or every three years with an HPV DNA test plus cervical cytology. Women 70 years of age and older who have had three or more normal Pap tests and no abnormal Pap tests in the last ten years may choose to stop cervical cancer screening. Women who have had a total hysterectomy may choose to stop screening.* The medical record should document the date of Pap smear service and results or findings. Only medical records for members age 22-64 will be audited for this measure. **Non-scored for 2009 – ages 65-70.\*\***
3. **Mammography** should be performed every one to two years for members age 40 **and over**, and date of service and results or findings, should be documented in the medical record. Members who have had bilateral mastectomies should be excluded from screening, and should have the dated history of bilateral mastectomies documented in the medical record. Medical records for members age 42-69 will be audited for this measure. **Non-scored for 2009 – ages 70 and over.**
4. **Colorectal cancer screening** should be performed for members age 50-75, by means of ONE of the following five screening options:
  - Fecal occult blood test within the past 12 months (FOBT performed during a physical exam on a specimen obtained from a digital rectal exam does not count, because it is not specific or comprehensive enough to screen for colorectal cancer.)
  - Flexible sigmoidoscopy within the past five years
  - Fecal occult blood annually plus flexible sigmoidoscopy within the past five years
  - Double-contrast barium enema within the past five years
  - Colonoscopy within the past 10 yearsOnly medical records for members age 52-75 will be audited for this measure. The chart must include the date, type of test and results.
5. **Influenza vaccinations** should be administered annually to members at high risk for complications from influenza and to those members age 65 and over. (The medical records audited will include adult members with asthma, diabetes, and cardiovascular *d*isease (CVD) and members age 65 and over). Documentation of immunizations administered by the office should include the date the vaccine was administered, the manufacturer and lot number, and the name of the person administering the vaccine. ***If the office maintains an immunization log, the medical record must have documentation of the site, the name and title of the person administering the vaccine, and the type of vaccine. The lot number may be documented in the log. The log must be provided for review.***

**B. Adult Male:**

1. **Non-fasting cholesterol** should be performed every five years on members over the age of 35. The medical record should document the date and results or findings. Only medical records for members age 36 and over will be audited for this measure.
2. **Colorectal cancer screening** should be performed for members age 50-75, by means of ONE of the following five screening options:
  - Fecal occult blood test (**FOBT**) within the past 12 months (FOBT performed during a physical exam on a specimen obtained from a digital rectal exam does not count, because it is not specific or comprehensive enough to screen for colorectal cancer.)
  - Flexible sigmoidoscopy within the past five years
  - Fecal occult blood annually plus flexible sigmoidoscopy within the past five years
  - Double-contrast barium enema within the past five years
  - Colonoscopy within the past 10 yearsOnly medical records for members age 52-75 will be audited for this measure. The chart must include the date, type of test and results.
3. **Influenza Vaccinations** should administered annually to members at high risk for complications from influenza and to those members age 65 and over. (The medical records audited will include adult members with asthma, diabetes, and CVD and members age 65 and over). Documentation of immunizations administered by the office should include the date the vaccine was administered, the manufacturer and lot number, and the name and title of the person administering the vaccine. ***If the office maintains an immunization log, the medical record must have documentation of the site, the name and title of the person administering the vaccine, and the type of vaccine. The lot number may be documented in the log. The log must be provided for review.***
4. **Discussion Regarding PSA should be documented for males age 50 and over. Discussion should include information regarding their risk of prostate cancer and potential benefits and harms of prostate cancer screening. Only medical records for members age 52 and over will be audited for this measure. \*\***

**C. Children:**

1. **Immunizations** should be performed according to the Preventive Healthcare Guidelines, which are based on the Recommended Childhood Immunization Schedule, United States, as approved by the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP).

Parent refusal of such services should be documented in the medical record. For members who have transferred from another practitioner, immunization records should be obtained and reviewed for completeness.

Documentation of immunizations administered by the office should include the date the vaccine was administered, the manufacturer and lot number, and the name and title of the person administering the vaccine.

All **records for** children between the ages of six months to five years will be audited. The medical records will be audited and scored for immunizations due between the ages of one and two as identified in Table A. The immunizations audited are: DTaP, IPV, Hib, MMR, **Hep B**, Varicella, and Pneumococcal.

**Information will be collected for:**

- A.) For children born between 1/1/**04** and 12/31/**07**, the record will be reviewed for **at least one** influenza vaccination given between the dates 1/1/**08** and 3/1/**09**.\*\*
- B.) Records will be audited for **at least one** Hepatitis A given between one and two year of age.\*\*
- C.) **Records will be audited for at least one rotovirus given before the first birthday.**\*\*

\*\*Denotes non-scored item.

**TABLE A**

Immunization	Birth	2 mo.	4 mo.	6 mo.	12 mo.	15 mo.	18 mo.	2yr.	4 – 6 yrs.
DTaP		X	X	X		Between 15-18 months			X
IPV		X	X	Between 6-18 months					X
Hib		X	X	(X)+	Between 12-15 months				
MMR					Between 12-15 months				X
Hepatitis B	X	X		Between 6-18 months					
Varicella					Between 12-15 months				
Rotavirus		X	X	X					
Hepatitis A					Two doses between 12 and 23 months				
Pneumococcal Conjugate (Pevnar)		X	X	X	Between 12-15 months				
Influenza				Annually age 6-59 months					

(X)+ = Whether this dose is needed depends on the brand of Hib vaccine used.

**Table B:**

**Combination Vaccines**

Immunization
<b>DTaP + Hep B + IPV</b> <b>(Pediatrix)</b>
<b>DTaP + HiB</b> <b>(TriHIBit)</b>
<b>Hep B + HiB</b> <b>(Comvax)</b>
<b>MMR + VZV</b> <b>(ProQuad)</b>
<b>DTaP + IPV+HiB</b> <b>(Pentacel)</b>

**Table C:**

**Contraindications for Childhood Immunizations**

<b><i>Immunization</i></b>	<b><i>Contraindication</i></b>
<b><i>Any particular vaccine</i></b>	<b><i>Anaphylactic reaction to the vaccine or its components</i></b>
<b><i>DTaP</i></b>	<b><i>Encephalopathy</i></b>
<b><i>IPV</i></b>	<b><i>Anaphylactic reaction to streptomycin, polymyxin B or neomycin</i></b>
<b><i>MMR and VZV</i></b>	<b><i>Immunodeficiency, including genetic (congenital) immunodeficiency syndromes</i></b>
<b><i>MMR and VZV</i></b>	<b><i>HIV disease; asymptomatic HIV</i></b>
<b><i>MMR and VZV</i></b>	<b><i>Cancer of lymphoreticular or histiocytic tissue</i></b>
<b><i>MMR and VZV</i></b>	<b><i>Multiple myeloma</i></b>
<b><i>MMR and VZV</i></b>	<b><i>Leukemia</i></b>
<b><i>MMR and VZV</i></b>	<b><i>Anaphylactic reaction to neomycin</i></b>
<b><i>HiB</i></b>	<b><i>None</i></b>
<b><i>Hepatitis B</i></b>	<b><i>Anaphylactic reaction to common baker's yeast</i></b>
<b><i>Pneumococcal conjugate</i></b>	<b><i>None</i></b>

## **STANDARDS FOR BEHAVIORAL HEALTH PRACTITIONERS**

### **I. ACCESSIBILITY STANDARDS**

**Purpose:**

To evaluate whether members have appropriate access to Behavioral Health services.

**Procedure:**

- A. BCBSIL has specific service expectations for participating Behavioral Health Care Practitioners. They are as follows:
1. Provide and/or refer for life-threatening emergency care.
  2. Provide and/or refer for non-life-threatening emergency care within six hours.
  3. Schedule and provide urgent care within 24 hours.
  4. Schedule routine appointments within 10 business days or within two weeks of request, whichever is sooner. This includes initial evaluation.
  5. Arrange for an answering system after office hours that members can access through the usual office protocol:
    - ⇒ Response to emergency phone calls should be within 30 minutes.
    - ⇒ Response to urgent phone calls should be within one hour.
    - ⇒ For life-threatening emergencies, members should be referred to the appropriate Health Care Facility.
  6. Arrange for telephone access to screening and triage, if applicable, as follows:
    - ⇒ Callers reach a non-recorded voice within 30 seconds and
    - ⇒ Abandonment rates do not exceed five percent at any given time.

### **II. SITE STANDARDS FOR BEHAVIORAL HEALTH**

**Purpose:**

To assess whether members receive Behavioral Health care services in a clean and safe environment.

**Procedure:**

**1. Environment:**

- The **site** should be clean and well organized to accommodate patient services.
- Restrooms, doorways and hallways should be easily accessible.
- The waiting room should have adequate seating for the volume of patients.
- The **site** should be accessible to those with disabilities:
  - There should be at least one entrance to the office that is accessible to those with impaired mobility or those in a wheel chair. **Please note: If the practitioner**

***has ownership interest in the building, the building must be compliant with ADA (American Disabilities Act) guidelines. If any ADA guideline is not met, the practitioner will have two years from the date of the site review to become compliant with the ADA guideline. Continued non-compliance with the guideline(s) may result in deparicipation from the HMO network(s).***

- There should be at least one exam room that can be accessed by doorways and hallways that are at least 36 inches wide.
- There should be at least one restroom that can be accessed by doorways and hallways that are at least 36 inches wide.

## **2. Safety Measures:**

- Sharp disposal containers must be available (if applicable).
- Fire Extinguisher must be accessible.

## **3. Medication Maintenance/Storage:**

- Sample drugs, over-the-counter medications, prescription drugs, and vaccines (if applicable) should be stored in restricted patient areas\*
- Controlled substances, if present, should be stored in a locked area along with an Inventory list.
- All medications should be routinely monitored for expiration dates

## **4. Medical Supply Maintenance/Storage:**

- Sharps should be stored in restricted patient areas\* (if applicable)
- Prescription pads should be stored in restricted patient areas\* (if applicable)

## **5. Medical Record System:**

- Medical records should be handled in a confidential manner. The office ***must have a written policy that addresses HIPAA requirements regarding Protected Health Information (PHI).***
- ***The practitioner*** should have a written policy/procedure detailing how medical record information is to be released.

## **6. Patient Education:**

- Educational materials or literature regarding at least two (mental health or chemical dependency related conditions) medical conditions relevant to the practitioner's practice must be available for patient use.

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\* *Restricted Patient Area – a separate storage space away from the patient care area or a locked receptacle within the patient care area.*

### **III. EMERGENCY PREPAREDNESS**

#### **Procedure:**

##### **1. Emergency Preparedness**

***--- The Practitioner should have a written procedure on how to handle a medical emergency for members accessing care at his/her facility. This procedure must be posted in a prominent location or easily accessible through a central file/manual.\*\****

### **IV. Medical Record Review for Behavioral Health Practitioners**

#### **Purpose:**

***BCBSIL requires member medical records to be maintained in a manner that is current, detailed, organized, and easily accessible. All patient data should be filed in the medical record, (i.e., lab, x-ray, consultation notes, etc.) Documentation of a member's care should facilitate communication, coordination and continuity of care and promote efficiency and effectiveness of treatment.***

#### **Procedure:**

- 1. Past Medical History:** There should be documentation of a past medical history obtained by the third visit or within one year of the first visit, whichever comes first. The ***past*** medical history should be updated at least every three years for adults and every five years for pediatric patients.
- 2. Family History:** There should be documentation of a family medical history obtained by the third visit or within one year of the first visit, whichever comes first. The family medical history should be updated at least every three years for adults and every five years for pediatric patients.
- 3. Social History:** There should be documentation of a social history (including, but not limited to, information about family and occupation, ***and the assessment of cigarette and alcohol use and/or substance abuse***) obtained by the third visit or within one year of first visit, whichever comes first. For ***pediatric*** patients, the developmental milestones may be included. The social history should be updated at least every three years for adults and every five years for pediatric patients.
- 4. Adult Alcohol Use:** There should be documentation regarding alcohol use obtained by the third visit or within one year of the first visit, whichever comes first, for adults age 18 and over. If the member is currently using alcohol, it should be noted. The history of alcohol use should be updated at least every three years.
- 5. Utilization of an Alcohol Assessment Tool for an Adult:** ***There should be documentation of the use of an alcohol assessment tool if the patient answers yes to alcohol use.\*\****
- 6. Adolescent Alcohol Use:** There should be documentation regarding alcohol use obtained by the third visit or within one year of the first visit, whichever comes first, for adolescents age 12-17. If the adolescent is currently using alcohol, it should be noted.

The history of alcohol use should be updated at least every three years. \*\*

**7. Utilization of an Alcohol Assessment Tool for an Adolescent:** *There should be documentation of the use of an alcohol assessment tool if the patient answers yes to alcohol use.* \*\*

**8. Adult Inappropriate/Illicit Drug Use:** There should be documentation regarding inappropriate/ illicit drug use obtained by the third visit or within one year of the first visit, whichever comes first, for adults age 18 and over. If the member is currently using drugs, it should be noted. The history of drug use should be updated at least every three years.

**9. Recommendation for Adult Inappropriate/Illicit Drug Use Treatment:** *Instructions and/or education about recommendation for treatment should be provided to members who are identified as using inappropriate/illicit drugs.* \*\*

**10. Adolescent Inappropriate/Illicit Drug Use:** There should be documentation regarding inappropriate/ illicit drug use obtained by the third visit or within one year of the first visit, whichever comes first, for adolescents age 12-17. If the adolescent is currently using drugs, it should be noted. The history of drug use should be updated at least every three years. \*\*

**11. Recommendation for Adolescent Inappropriate/Illicit Drug Use Treatment:** *Instructions and/or education about recommendation for treatment should be provided to adolescents age 12-17 who are identified as using inappropriate/illicit drugs.* \*\*

**12. Chief Complaint/History Relevant to Problem:** Subjective information identifying why the patient is seeking BH services should be documented. The description should include pertinent history, symptoms, and other related information including documentation of an assessment of suicidal ideation. ***Assessment of risk to others must be documented, but will not be scored for 2009\*\****

**13. Diagnosis/Assessment:** A diagnosis and/or assessment, consistent with the findings, should be documented. Include documentation of a DSM\_IV diagnosis.

**14. Treatment Plan/Plan of care:** A plan of diagnosis (lab testing, x-rays, etc.) and management (medication dose, frequency, and duration, as well as other interventions), consistent with the assessment, should be documented. Document goals and estimated timeframes for goal attainment or problem resolution.

**15. Previous Problems:** Unresolved problems from previous office visits should be addressed in subsequent visits.

**16. Continuity of Care, Follow-Up care, Calls or Visits:** Follow-up care, communication of test results, calls or visits should be documented to indicate continuity of care.

**17. Consultations:** Documentation of response/feedback from a referral for consultation to a specialist should be present in the record and should be signed or initialed by the practitioner and/or there should be a notation in the progress notes indicating that the feedback from the specialist has been reviewed.

- 18. Chart Organization:** The Practitioner should maintain a uniform medical record system of clinical recording and reporting with respect to services which includes separate sections for progress notes and the results of diagnostic tests.
- 19. Biographical Information:** Each medical record should contain the patient's address, employer, home and work telephone numbers including emergency contacts, marital or legal status, appropriate consent forms and guardianship information, if relevant. Biographical information should be updated at least every three years.
- 20. Patient Identifiers:** Patient identifiers should appear on each page of the medical record (patient name or unique ID number).
- 21. Date and Signature:** All entries are to be dated and signed/initialed by the author. Author identification may be a handwritten signature, unique electronic identifier or initials. Include the responsible clinician's name, professional degree.
- 22. Legibility:** All entries should be legible.
- 23. Allergy Status:** Medication allergies should be noted in a prominent location in the medical record. If the member has no known allergies or history of adverse reactions, this should be prominently noted. Allergies to environmental allergens, food, pets, etc, should also be noted, as they can affect patient behavior. Allergy histories should be obtained by the first visit and updated at least every three years for adults and every five years for pediatric patients. (This will be scored only for those practitioners who prescribe medication).
- 24. Problem List:** There should be a current problem list, either kept separately or within each practitioner progress note. The problem list must be inclusive of all problems whether a separate list or within each practitioner progress note.
- 25. Medication List:** There should be a current medication list, either kept separately or within each practitioner progress note. The medication list must be inclusive of all medications whether a separate list or within each practitioner progress note, and include prescription initial or refill dates.
- 26. Lab/X-Ray/Diagnostic Results:** The results of all labs, x-rays and diagnostic testing, should be posted in the chart. The reports should be signed or initialed by the practitioner and/or there should be a notation in the progress notes indicating that they have been reviewed.
- 27. Coordination between Behavioral Health Care and Referring Practitioner:** There should be documentation of communication with a signed release of information form allowing for communication between the Behavioral Health **Practitioner** and **referring** practitioner. Documentation should include, but not be limited to, follow-up regarding coexisting medical and behavioral disorders and education management. If the member refuses to allow such communication, this should be documented.

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**MINIMUM SCORE TO PASS SITE VISIT  
HMOs of Blue Cross and Blue Shield of Illinois and BlueChoice**

***Effective January 1, 2009***

**NEW HMO IPAs, BlueChoice Groups and PCPs**

**2009 Passing Thresholds**

<b>Standards Category</b>	<b>New/ Current HMO IPA or BlueChoice Group</b>	<b>New/ Current PCP (HMO &amp; BlueChoice)</b>
Accessibility, Facility, Emergency Care	90%	90%
Medical Record Review, Preventive	90%	90%

**NOTE:**

**Any practitioner failing to meet the minimum passing threshold requirement will be re-audited within *six* months.**

**\*\*\*\*Any practitioner failing two consecutive site visits must submit a corrective action plan (CAP) within 60 days of receipt of the letter requesting a CAP. Failure to submit a CAP may result in de-participation from the network without a third site visit.**

**Any practitioner failing three consecutive site reviews may be departed from all networks.**