Policy:
The Blue Cross and Blue Shield of Illinois (BCBSIL) onsite audit staff will adhere to Quality Site Visit Standards when conducting quality onsite audits for participating HMO Illinois and BlueAdvantage HMO Primary Care Physicians (PCPs), high volume Behavioral Health (BH) Practitioners, and Blue Precision HMO PCPs.

Quality site visits are performed for HMO PCPs at least every three years in order to assess compliance with Illinois Department of Public Health requirements. A site visit may be performed within two years if the practitioner scores greater than or equal to 90 percent and less than 94 percent on a site visit.

Quality site visits are performed for HMO high volume BH practitioners at least every three years. A site visit may be performed within two years if the practitioner scores greater than or equal to 90 percent and less than 94 percent on a site visit.

A site visit review will be performed when BCBSIL receives one member complaint regarding office appearance for any network practitioner. The site visit will be completed within 60 days of receipt of the complaint by the quality onsite review department. (See policy CR08 Investigation of Complaints related to Practitioner Office Site.)

High volume Behavioral Health Practitioners (defined as those practitioners who see greater than 50 unique BCBSIL patients per year are determined on an annual basis through IPA reporting and/or analysis of claims or encounter data of unique patient visits for each Behavioral Health Practitioner. BH Practitioners who will be audited include psychiatrists, psychologists, LCSWs, LCPCs and LMFTs.
**Purpose:**
To audit practitioners against established Quality Site Visit standards including information related to the following:
- Physical Accessibility;
- Office site; **Physical Appearance**
- Emergency Preparedness;
- Medical Record Review; and **adequacy of record keeping**
- **Safety Measures**
- 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 physical accessibility, physical appearance, adequacy of waiting and examination room space, and other areas of the facility to evaluate compliance with office site standards.
3. Medical record review of at least five medical records per Practitioner to evaluate compliance with medical record and preventive care standards.

I. ACCESSIBILITY STANDARDS

**Purpose:**
To evaluate whether members have appropriate access to health care services.

The IPA Physician shall practice in a place(s) acceptable to the HMO and distinctly identifiable as a medical facility at which services in the areas of Adult Medicine, Pediatrics, and Obstetrics-Gynecology shall be available to Members.

a) Ensure that all IPA Physicians provide reasonable access for all Members enrolled with the IPA including, but not limited to, the following:
   1) Appointment for Preventive Care within four (4) weeks of request for members 6 months of age and older;
   2) Appointment for Preventive Care within two (2) weeks of request for infants under 6 months of age; **
   3) Appointment for Routine Care within ten (10) business days or two (2) weeks of request, whichever is sooner;
   4) Appointment for Immediate Care within twenty-four (24) hours of request;
   5) Response by IPA Physicians within thirty (30) minutes of an Emergency call;
   6) Notification to the Member when the anticipated office wait time for a scheduled appointment may exceed thirty (30) minutes; **

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** Indicates non-scored item.
7) Schedule a prenatal visit: appointment within 2 weeks if first trimester within 1 week if second trimester and within 3 days if third trimester (applies to Medicaid providers). **

b) Ensure that HMO Members enrolled with the IPA have access to PCP medical services including, but not limited to, the following:

1) Routine Care – Each PCP or PCP office is required, at a minimum, to be available to provide routine care to HMO Members enrolled with the IPA for at least eight hours per month outside the hours of 9:00 am – 6:00 pm Monday through Friday. PCP office is defined as a specific office location at which one or more PCPs are marketed to HMO Members as a location where primary care services are available.

2) Immediate Care – Each PCP or PCP office is required, at a minimum, to provide or arrange access to care for HMO Members with immediate medical needs as outlined below:
   a) Early morning or evening office hours three or more times per week.

      Early morning hours are defined as hours beginning at 8:00 a.m. and extending until 9:00 a.m. Evening hours are defined as hours beginning at 6:00 p.m. and extending until 8:00 p.m.

   b) Weekend office hours of at least three hours two or more times per month.

      Alternate arrangements for ensuring HMO Members access to immediate care must meet the minimum access requirements outlined above and be approved in writing by the HMO. Facilities billing Immediate Care services as an emergency room visit shall not be considered an alternate arrangement for access to Immediate Care.

   c) Maintain a twenty-four (24) hour answering service and ensure that each PCP and WPHCP provides a twenty-four (24) hour answering arrangement and a twenty-four (24) hour on-call PCP arrangement for all Members enrolled with the IPA.

   d) Maintain answering service log of PCP, WPHCP practitioner calls for ten years **

   e) Office should have their office hours posted in a prominent place for members to see. **

II. SITE REVIEW STANDARDS

Purpose:
Assess whether members have appropriate access to healthcare services in a clean and safe environment.

Procedure:

* Restricted Patient Area – a separate storage space away from the patient care area or a locked receptacle within the patient care area.
** Indicates non-scored item.
1. Environment:
   - The site should be clean, well organized and well lit to accommodate patient services.
   - Restrooms, doorways and hallways should be easily accessible and uncluttered.
   - Corridors leading to exits are clear. No storage of any kind is present in the exit hallways.
   - The waiting room should have adequate seating for the volume of patients and adequate lighting to read.
   - There should be an adequate number of exam rooms based on the number of practitioners. Exam room space includes provision for privacy during examinations or procedures.
     - The site should be accessible to those with disabilities. Please note: The building must be compliant with ADA (American Disabilities Act) guidelines. 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. This restroom should have signage in high contrast raised lettering and be in braille. **
     - Exit signs and signs in the facility must be high contrast (for example: red on green, black on white or red on white). **
     - Handicap parking signs must be 60 inches above the ground. **
     - Accessibility around public transportation routes which refers to walkways leading to the physician office from the bus or subway stop must be sidewalks, not gravel, not cracked; a member must be able to use walkers or wheelchairs from the drop off to the entrance. **
     - Parking: if the office has a private parking lot (lot specific to doctor’s office) it must have designated handicapped parking spots. **
     - If the office is in a doctor’s house, was built after 1991 and has private parking, it must have designated handicapped parking spots. If there is not a private lot, such as in City Street parking, there is NO requirement regarding handicapped parking spots. **
     - There should be overhead lifts, transfer boards, or an exam room table that is low to the floor for people to move from the wheelchair to the exam table. **
     - There should be a scale that can weigh members unable to stand independently**

2. Safety Measures:
   - The Practitioner and his/her staff should follow the Centers for Disease Control and Prevention Universal Precautions 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:

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** Indicates non-scored item.
– 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.*
– Offices should have policies and procedures for checking medications for expiration dates and for discarding expired medications.
– All medications should be routinely monitored for expiration dates.
– Opened medications should be labeled with the date the item was opened.
– Opened multi-dose vials must be discarded after 28 days since first use, except for vaccinations or other drugs with packaging information labeled with different discard recommendations.
– 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 and Equipment Maintenance/Storage:
  – Sharps should be stored in restricted patient areas.*
  – Prescription pads should be stored in restricted patient areas.*
  – Medical equipment should be monitored for sterilization and a maintenance log should be maintained for equipment.
  – Sterile supplies should be monitored for package integrity and dryness.

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 office must have a confidentiality of medical records policy and follow the policy.
  – 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 mammography, Pap smears, pediatric immunizations, smoking cessation, flu shots, or coronary risk reduction. 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.

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.

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** Indicates non-scored item.
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:

Please note: A history form can include many of the required documentation items. This form can be completed by the patient, office staff or physician. The physician, nurse practitioner, or physician assistant should review the form for completeness, sign and date the form. Blank areas on the form will be scored as non-compliant. The form must be updated at least every three years for adult and pediatric patients. Preventive care services must be performed according to the dates required per element.

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 medical history should be updated at least every three years for adult and 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 adult and pediatric patients.

3. Social History: There should be documentation of a social history (including, but not limited to, information about family and occupation, and assessment of tobacco, alcohol and illicit substance use) obtained by the third visit or within one year of the 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 adult and 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).

5. Body Mass Index (BMI): There should be documentation of the patient’s BMI (BMI percentile for children) by the third visit or within one year of first visit, whichever comes first. The BMI should be updated at least every two years for ages 18-74 and the BMI percentile updated at least every year for children ages 2-17.

6. Weight Management Counseling: There should be documentation of education regarding weight management (diet and exercise) for adults with a BMI over 30 and children with a BMI percentile over 85% by the third visit or within one year of first visit, whichever comes first. This should be performed at least every 2 years for adults and annually for pediatrics.**

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** Indicates non-scored item.
7. Nutrition Counseling for Children: There should be documentation of nutrition counseling every year for patients ages 2-17 years.

8. 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 annually.

9. Utilization of a Standardized Alcohol Assessment Tool for an Adult: There should be documentation of the use of a standardized alcohol assessment tool if the patient answers "yes" to any alcohol use.

10. 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 year. **

11. Utilization of a Standardized Alcohol Assessment Tool for an Adolescent: There should be documentation of the use of a standardized alcohol assessment tool if the patient answers “yes” to alcohol use. **

12. Adult Inappropriate/Illicit Substance Use: There should be documentation regarding inappropriate/illicit substance 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 substances, it should be noted. The history of substance use should be updated every three years.

13. Recommendation for Adult Inappropriate/Illicit Substance Use Treatment: Instructions and/or education about recommendation for treatment should be provided to members who are identified as using inappropriate/illicit substances.

14. Adolescent Inappropriate/Illicit Substance Use: There should be documentation regarding inappropriate/illicit substance 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 substances, it should be noted. The history of substance use should be updated at least every year. **

15. Recommendation for Adolescent Inappropriate/Illicit Substance 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 substances. **

16. 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. Documentation that the patient has been a non-smoker for more than 5 years meets the intent and additional updates are not required.

17. 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.

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** Indicates non-scored item.
18. 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. **

19. Recommendation for Smoking Cessation for Adolescents: Instructions and/or education about smoking cessation should be provided to adolescents age 12-17 that 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. **

20. 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.

21. 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.

22. 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.

23. Physical Examination: A pertinent physical examination, relevant to the problem, should be documented.

24. Vital Signs: Vital signs, consistent with the patient’s chief complaint, relevant problem and/or diagnosis, should be documented.

25. Diagnosis/Assessment: A diagnosis and/or assessment, consistent with the findings, should be documented.

26. 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. If an abnormal lab or x-ray finding is identified in the medical record, the plan of care should address these findings.

   Education relevant to the patient’s conditions or treatment must be documented at least annually.

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 physician,

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nurse practitioner or physician assistant 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 and consistently noted. Allergies to environmental allergens, food, pets, etc., should also be noted. Allergy histories should be obtained and documented annually.

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 practitioner’s 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 physician, nurse practitioner or physician assistant and/or there should be a notation in the progress notes indicating that they have been reviewed.

V. PREVENTIVE SERVICES

Purpose:

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

Procedure:

* Restricted Patient Area – a separate storage space away from the patient care area or a locked receptacle within the patient care area.
** Indicates non-scored item.
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. Cervical cancer screening (Pap)
   - Screen for cervical cancer with cytology (Pap smear) every three years in women age 21 to 65. An option for women ages 30 to 65 who want to lengthen the screening interval is screening with a combination of cytology and HPV testing every five years.
   - Screening is not recommended for women younger than age 21.
   - For women older than age 65 years who have had adequate prior screening and are not otherwise at high risk for cervical cancer, screening is not recommended.
   - For women who have had a hysterectomy with removal of the cervix and do not have a history of a high grade precancerous lesion or cervical cancer, screening is not recommended.
   - Screening with HPV testing is not recommended for women younger than age 30 years.

2. Chlamydial infection screening should be done annually for all sexually active young women ages 16-24. **

3. Mammography should be performed every one to two years for members age 50 to 74, 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 51-75 will be audited for this measure.

4. Colorectal cancer screening should be performed for members age 50-75, by means of ONE of the following screening options:
   - Fecal occult blood test within the past 12 months (FOBT or FIT 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
   - Colonoscopy within the past 10 years
   - Only medical records for members age 51-75 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 all members age 18 and older.

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

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** Indicates non-scored item.
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.

6. Bone Density Testing for Osteoporosis should be performed at least once for women after age 65.

7. Discussion of the Use of ASA in adults: There should be documentation of discussion of the risks and benefits of low dose aspirin for females ages 55-79 at least every two years, or documentation that member is taking or was prescribed aspirin or another antiplatelet drug, or documentation of why it is contraindicated for the member, or evidence that the risk of cardiovascular disease was assessed and aspirin was not recommended based on this assessment. **

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 screening options:
   - Fecal occult blood test (FOBT) within the past 12 months (FOBT or FIT 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
   - Colonoscopy within the past 10 years
   - Only medical records for members age 51-75 will be audited for this measure. The chart must include the date, type of test and results.

3. Influenza Vaccinations should be administered annually to all members age 18 and older.

   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 of the Use of ASA in adults: Discussion of the Use of ASA in adults: There should be documentation of discussion of the risks and benefits of low dose aspirin for males ages 45-79 at least every two years, or documentation that member is taking or was prescribed aspirin or another antiplatelet drug, or documentation of why it is contraindicated for the member, or evidence that the risk of cardiovascular disease was assessed and aspirin was not recommended based on this assessment. **

C. Children:

1. Immunizations should be performed according to 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. These will be scored as non-compliant.
- 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.
- All records for children between the ages of two to five years will be audited. The medical records will be audited and scored for immunizations due between the ages of six months and two years as identified in Table A. The immunizations audited are: DTaP, IPV, Hib, MMR, Hep B, Varicella, and Pneumococcal.

Information will be collected for:
- For children over 6 months of age and older the record will be reviewed for influenza vaccination given within one year. **
- Records will be audited for at least one Hepatitis A given between one and two years of age for children between two and five years of age.
- Records will be audited for at least one rotavirus given before the first birthday.
- Records for 13 year olds will be audited for Meningococcal Conjugate Vaccine**.

### Table A

<table>
<thead>
<tr>
<th>Immunization</th>
<th>Birth</th>
<th>2 mo.</th>
<th>4 mo.</th>
<th>6 mo.</th>
<th>12 mo.</th>
<th>15 mo.</th>
<th>18 mo.</th>
<th>2 yr.</th>
<th>4 – 6 yrs.</th>
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<tbody>
<tr>
<td>DTaP</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>Between 15-18 months</td>
<td>Between 6-18 months</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IPV</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>Between 15-18 months</td>
<td>Between 6-18 months</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hib</td>
<td>X</td>
<td>X</td>
<td>(X)+</td>
<td>Between 12-15 months</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MMR</td>
<td>X</td>
<td>X</td>
<td>(X)+</td>
<td>Between 12-15 months</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>Between 6-18 months</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Varicella</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>Between 6-18 months</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Rotavirus</td>
<td>X</td>
<td>X</td>
<td>(X)+</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis A</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>First dose between 12 and 23 months, with second dose given 6-18 months later.</td>
<td></td>
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<td></td>
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<tr>
<td>Pneumococcal Conjugate (Prevnar)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>Between 12-15 months</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Influenza</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>Annually age 6 months and older</td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

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

Table B:

Combination Vaccines

<table>
<thead>
<tr>
<th>Immunization</th>
</tr>
</thead>
<tbody>
<tr>
<td>DTaP + Hep B + IPV</td>
</tr>
</tbody>
</table>

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** Indicates non-scored item.
<table>
<thead>
<tr>
<th>Immunization</th>
<th>Contraindication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any particular</td>
<td>Anaphylactic reaction to the vaccine or its components</td>
</tr>
<tr>
<td>vaccine</td>
<td></td>
</tr>
<tr>
<td>DTaP</td>
<td>Encephalopathy</td>
</tr>
<tr>
<td>IPV</td>
<td>Anaphylactic reaction to streptomycin, polymyxin B or neomycin</td>
</tr>
<tr>
<td>MMR, VZV and</td>
<td>Immunodeficiency, including genetic (congenital) immunodeficiency syndromes</td>
</tr>
<tr>
<td>influenza</td>
<td></td>
</tr>
<tr>
<td>MMR, VZV and</td>
<td>HIV disease; asymptomatic HIV</td>
</tr>
<tr>
<td>influenza</td>
<td></td>
</tr>
<tr>
<td>MMR, VZV and</td>
<td>Cancer of lymphoreticular or histiocytic tissue</td>
</tr>
<tr>
<td>influenza</td>
<td></td>
</tr>
<tr>
<td>MMR, VZV and</td>
<td>Multiple myeloma</td>
</tr>
<tr>
<td>influenza</td>
<td></td>
</tr>
<tr>
<td>MMR, VZV and</td>
<td>Leukemia</td>
</tr>
<tr>
<td>influenza</td>
<td></td>
</tr>
<tr>
<td>MMR, VZV and</td>
<td>Anaphylactic reaction to neomycin</td>
</tr>
<tr>
<td>influenza</td>
<td></td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>Anaphylactic reaction to common baker’s yeast</td>
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</tbody>
</table>

**STANDARDS FOR BEHAVIORAL HEALTH PRACTITIONERS**

**I. ACCESSIBILITY STANDARDS**

**Purpose:**
Evaluate whether members have appropriate access to Behavioral Health services.

**Procedure:**

* Restricted Patient Area – a separate storage space away from the patient care area or a locked receptacle within the patient care area.
** Indicates non-scored item.
BCBSIL has specific service expectations for participating Behavioral Health Care Practitioners. They are as follows:

Provide and/or refer for life-threatening emergency care.

Provide and/or refer for non-life-threatening emergency care within six (6) hours.

Schedule appointments for Immediate Care within 24 hours of request. “Immediate Care” means medically necessary services that are required for an illness or injury that would not result in further disability or death if not treated immediately, but requires professional attention within 24 hours.

Schedule appointments for Routine Care within 10 business days or 2 weeks of request, whichever is sooner. “Routine Care” means follow-up care for an existing condition, or care for a new healthcare problem that is not considered urgent. This includes initial evaluation.

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.

Maintain answering service log of Behavioral Health practitioner calls for one year**

II. SITE STANDARDS FOR BEHAVIORAL HEALTH

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

Procedure:
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 and be well lit for reading.
- 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: The building must be compliant with ADA (American Disabilities Act) guidelines. 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.
  - Exit signs and signs in the facility must be high contrast, (for examples, red on green, black on white or red on white). **
  - Handicap accessibility for bathrooms must be high contrast, (raised lettering and in braille)**
  - Handicap parking signs must be 60 inches above the ground. **

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Accessibility around public transportation routes which refers to walkways leading to the practitioner office from the bus or subway stop must be sidewalks, not gravel, or not cracked; a member must be able to use walkers or wheelchairs from the drop off to the entrance. **

Parking: if the office has a private parking lot (lot specific to practitioner’s office) it must have designated handicapped parking spots. **

If the office is in a practitioner’s house and was built after 1991 and has private parking, it must have designated handicapped parking spots. If there is not a private lot, such as in City Street parking, there is NO requirement regarding handicapped parking spots. **

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

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.*
- Offices should have policies and procedures for checking medications for expiration dates, and for discarding expired medications.
- All medications should be routinely monitored for expiration dates.
- Opened medications should be labeled with the date the item was opened.
- Opened multi-dose vials must be discarded after 28 days since first use, except for vaccinations or other drugs with packaging information labeled with different discard recommendations.

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)

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 office must have a confidentiality of medical records policy and follow the policy.
- The practitioner should have a written policy/procedure detailing how medical record information is to be released.

Patient Education:
- Educational materials or literature regarding at least two (mental health or substance use disorder related conditions) medical conditions relevant to the practitioner’s practice must be available for patient use.

III. EMERGENCY PREPAREDNESS

Procedure:
* Restricted Patient Area – a separate storage space away from the patient care area or a locked receptacle within the patient care area.
** Indicates non-scored item.
Emergency Preparedness

- The Practitioner should have a written procedure on how to handle medical and psychiatric emergencies 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:

Please note: A history form can include many of the required documentation items. This form can be completed by the patient, office staff or practitioner. The practitioner should review the form for completeness, sign and date the form. Blank areas on the form will be scored as non-compliant. The form must be updated at least every three years for adults and at least every three years for the pediatric patient.

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 medical history should be updated at least every three years for adults and 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 pediatric patients.

3. Social History: There should be documentation of a social history (including, but not limited to, information about family and occupation, and assessment of cigarette, tobacco, alcohol and illicit substance use) 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 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 annually.

5. 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 year. **

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** Indicates non-scored item.
6. 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. Documentation that the patient has been a non-smoker for more than five years meets the intent and additional updates are not required.

7. 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.

8. 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. **

9. 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. **

10. Adult Inappropriate/Illlicit Substance Use: There should be documentation regarding inappropriate/ illicit substance 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 substances, it should be noted. The history of substance use should be updated at least every three years.

11. Recommendation for Adult Inappropriate/Illlicit Substance Use Treatment: Instructions and/or education about recommendation for treatment should be provided to members who are identified as using inappropriate/illicit substances.

12. Child/Adolescent Inappropriate/Illlicit Substance Use: There should be documentation regarding inappropriate/ illicit substance use obtained by the third visit or within one year of the first visit, whichever comes first, for children/ adolescents age. If the child/adolescent is currently using substances, it should be noted. The history of substance use should be updated at least every year. **

13. Recommendation for Child/Adolescent Inappropriate/Illlicit Substance Use Treatment: Instructions and/or education about recommendation for treatment should be provided to children/adolescents age who are identified as using inappropriate/illicit substances. **

14. Chief Complaint/History Relevant to Problem: Subjective information identifying why the patient is seeking Behavioral Health services should be documented. The description should include pertinent history, symptoms, and other related information.

15. Mental Status Examination: A pertinent mental status examination, relevant to the problem should be documented. Mental Status Examination should include a risk assessment documenting the patient’s potential for danger to self, danger to others and/or gross impairment. Additional information that should be documented includes at least three of the following assessments: appearance, motor evaluation, speech, affect,
thought content, thought process, perception, intellect, insight (awareness of illness), orientation, attention span, memory, and judgment.

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

17. 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.

18. Education relevant to the patient’s conditions or treatment must be documented at least annually.

19. 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.

20. 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.

21. 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.

22. 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.

23. Patient Identifiers: Patient identifiers should appear on each page of the medical record (patient name or unique ID number).

24. 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.

25. Legibility: All entries should be legible.

26. 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 and consistently noted. Allergies to environmental allergens, food, pets, etc., should also be noted, as they can affect patient behavior. Allergy histories should be obtained and documented annually. (This will be scored only for those practitioners who prescribe medication).

27. 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.

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28. 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.

29. 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.

30. Lithium Assessment: If Lithium is prescribed, documentation of annual creatinine, Lithium level and thyroid test results with documentation of any follow-up (Psychiatrists only).

31. Depakote Assessment: If Depakote is prescribed, documentation of annual liver function test results with documentation of any follow-up. (Psychiatrists only).

32. Coordination between Behavioral Health Care and Referring Practitioner: There should be documentation of communication **every 2 years**, 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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** Indicates non-scored item.
MINIMUM SCORE TO PASS SITE VISIT
HMOs of Blue Cross and Blue Shield of Illinois and BlueChoice

Effective January 1, 2016

HMO IPAs and PCPs

2016 Passing Thresholds

<table>
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<th>Standards Category</th>
<th>Current HMO IPA</th>
<th>Current HMO PCP</th>
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<tr>
<td>Accessibility, Facility, Emergency Care</td>
<td>90%</td>
<td>90%</td>
</tr>
<tr>
<td>Medical Record Review, Preventive</td>
<td>90%</td>
<td>90%</td>
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NOTE:

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

Any practitioner scoring greater or equal to 90 percent or less than 94 percent will be audited within two years.

****Any practitioner failing two consecutive site visits must submit a written corrective action plan (CAP) within 30 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.

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