MEDICAL RECORDS

Overview

It is the policy of the Plan to ensure that providers maintain adequate medical records and promptly give access to medical records of members upon request. Harmony shall ensure that providers maintain medical records in a detailed and comprehensive manner that conforms to good professional medical practice, permits effective professional medical review and medical audit processes, and facilitates an adequate system for follow-up treatment.

Medical records must be legible, signed and dated. The adequacy of the medical records will be assessed by the Plan as outlined in the Medical Record Review Policy and Procedure # C7QI 04-15.

Harmony conducts reviews of medical records of PCPs and OB/GYN providers to determine compliance with established documentation standards and goals that are adopted by the Quality Improvement Committee (QIC). An average score of 80 percent or greater is considered to meet documentation standards.

A provider who scores less than 80 percent will be re-audited within six (6) months of notification of the medical record review score. If any provider scores less than 80 percent on a re-audit, a corrective action plan will be requested. A re-audit will be conducted within six (6) months after the corrective action plan is received by Harmony. If the provider fails to improve the score to 80 percent during this re-audit, the information will be forwarded to the QIC for review.

Requirements and Guidelines

Medical Record Requirements and Guidelines

- Each provider shall maintain an adequate and complete patient record for each patient and may maintain electronic medical records provided the record keeping format is capable of being printed for review;

- Safeguard member confidentiality in accordance with HIPAA state and federal guidelines, the Plan Quality Improvement and Risk Management Programs and professional practice standards, including the confidentiality of a minor's consultation, examination and treatment for a sexually transmissible disease;

- Make the medical records available for quality care review studies by Plan reviewers, authorized representatives of DSS, Centers for Medicare & Medicaid Services (CMS), Plan member, organizations conducting accreditation audits and HEDIS® medical record reviews;

- Comply with Corrective Action Plan requirements imposed as the result of any such review or audit;

- When a member changes his PCP, to provide without charge, and within ten (10) business days, a copy of a transferring member's medical record to the new PCP;

- Patient records remaining under the care, custody, and control of the provider shall be maintained by the provider, or the provider's designee, for minimum of seven (7) years from the date of when the last professional service was provided;

- Any correction, addition, or change in any patient record made more than forty-eight (48) hours after the final entry is entered in the record and signed by the provider shall be clearly marked and identified as such, and the date, time, and name of the person making the correction, addition, or change shall be included, as well as the reason for the correction, addition, or change;

- A consultative report shall be considered an adequate medical record for a radiologist, pathologist, or a consulting provider;
- The member's medical record is the property of the provider who generates the record; and
- The state agency is not required to obtain written approval from a member before requesting the member's record from the provider.

Content and Review

Medical Records for Members

- A member's medical record should contain the quality, quantity, appropriateness and timeliness of services performed;
- All entries in the medical record are signed. All entries must include the name and profession of the practitioner rendering services, for example: RN, MD, or DO, including signature or initials of practitioner;
- All entries in the medical record must be dated and recorded in a timely manner;
- Medical records must be legible to readers and reviewing parties and maintained in an orderly and detailed manner;
- The following personal and biographical data must be included in the record: name, member ID number, date of birth, sex, address and telephone number, emergency contact, and legal guardianship. This may include: marital status, name of spouse, next of kin or closest relative, address, employer, phone numbers, insurance information, family history;
- Medication allergies or "no known allergies" and untoward reactions to drugs, are

prominently noted in the record. This may include a sticker inside the chart or prominent notation in a conspicuous place in the record;

- Medical records from the previous provider have been obtained and are easily accessible. Old records include past medical history, physical examinations, necessary tests and possible risk factors for the member relevant to treatment and are used to assess the periodicity schedule and maintain continuity of care;

- An immunization record is in the chart as appropriate;

- A listing of all medications the member is taking is in the chart. This includes prescribed medications, including dosages and dates of initial or refill prescriptions or sample medications;

- A problem list, with past and current diagnoses and procedures used to provide continuity of care is in the chart. This includes a summary of significant surgical procedures, past and current diagnoses or problems, medication reactions, etc.;

- Screening for substance abuse of tobacco, alcohol and drugs with appropriate counseling/referrals, if needed, and follow-up is documented;

- There is documentation of screening for domestic violence with appropriate counseling/referrals, if needed, and follow-up;

- There is evidence the member was asked about Advance Directives and documentation of acceptance or refusal.

  Note: The record must contain evidence that the member was provided written information

concerning the member's rights regarding Advance Directives and whether or not the member has executed an Advance Directive. The member does not require Advance Directives completed. A signed statement that they have been asked if they have them and if not, do they want them will suffice. A stamp may be utilized. The provider shall not, as a condition of treatment, require the member to execute or waive an Advance Directive;

- All records must reflect the primary language spoken by the member and translation/communication needs of the member. Translation/ communication needs could reflect the need for an interpreter, sign language or Braille materials, etc., as appropriate;

- Documentation indicating diagnostic or therapeutic intervention as part of a clinical research study is clearly contrasted from those entries pertaining to usual care; and

- There is documentation of member missed appointments and follow-up by the PCP staff.

Continuity of Care Requirements Screen

The medical record must show the provider's knowledge of the patient's course of care as evidenced by the following:

- There is documentation and reports of consultations and referrals to specialty providers if indicated;

- There are reports of diagnostic testing in the medical record. The medical record will show documentation of reports for diagnostic testing that was ordered: lab results, x-ray reports, MRI/CT reports, etc.;

- There is documentation and records for emergency room care. There is

documentation in the record if a member was seen in the emergency room and the records from the emergency room visit are in the medical record;

- There is documentation of hospitalizations to include discharge summary and discharge planning. There is documentation of a plan for hospital discharge and a copy of the hospital discharge summary on the medical record for members who were hospitalized;

- Assessment and clinical impression of diagnosis; and

- Any informed consent for office procedures.

The following patient information must be documented in the medical record for each visit:

- History and physical examination as related to the visit, chief complaint or purpose of the visit, objective findings of the practitioner, diagnosis or medical impression are documented for each visit;

- Plan of treatment, referrals, disposition, diagnostic testing, studies ordered, therapies administered and prescribed regimens are documented for each visit as indicated;

- There is documentation of follow-up plans for abnormal testing/ consultation reports, referrals or missed/cancelled appointments. There is documentation that the abnormal results or consultations were reviewed by the provider and documentation of the follow-up to be done;

- There is documentation of patient education and instruction whether verbal, written or via telephone. The member is provided with verbal and/or written education/instruction as indicated and appropriate. Significant medical

advice given via telephone is entered in the member's record and appropriately signed and initialed. (This includes medical advice provided by after-hours telephone patient information or triage telephone services.); and

- All entries must include the disposition, recommendations, instructions to the patient, evidence of whether there was follow-up and outcome of services.

Medical Record Documentation

The provider's medical records should be available for utilization and quality review studies. Implementing the following documentation guidelines can reduce practice risks:

- Documentation should be descriptive. Clinical observations and/or patient symptoms should be documented in detail. Use of anatomical forms or drawings should be considered when documenting the presence, size, color, and/or location of a lesion or deformity;

- Clearly document follow-up instructions. This includes activity limitations, medications, referrals to specialists, further testing, and subsequent appointments. Make sure patients understand instructions given;

- Obtain and document informed refusal. Inform patients of adverse outcomes and consequences of not undergoing recommended tests or procedures;

- Use of a problem list is recommended. This is a significantly important documentation tool and is helpful only if used consistently. It should contain space for chronic disease/ condition and any acute problems being followed. Columns for date and for problem identification and resolution should be included;

- Document all telephone calls from the patient and respond to them. The date and time the call was received, by whom, and the date and time it was returned needs to be detailed. Fully document any advice given or diagnoses made;

- A follow-up/recall system needs to be in place. To avoid failure to diagnose a system to follow-up on abnormal lab results, assure that the patient returns to recheck conditions as indicated by the provider, and to assure that the patient sought consultation after referral needs to be established. Also, patients like to know if test results are normal. In addition, the provider should initial all test results to show verification of review;

- Always document attempts to contact the patient. Depending on the seriousness of the condition, you may want to send a certified letter with return receipt;

- Consistently adhere to standard medical record documentation guidelines, specifically:

  - All entries should be neat, complete, clear, concise and timely. Include all recommendations and essential findings;

  - Sign entries with complete name, date, time of occurrence, time of documentation and professional designation;

  - Records should not be altered. Corrections are to be made by a single line through the inaccurate material, dated and initialed;

  - Use only standard abbreviations and symbols;

  - If records are hand written, they must be legible;
  - Late entries should include date and time of occurrence and date and time of documentation; and
  - Record details of informed consent discussions.

- All participating PCPs should maintain complete and accurate fiscal records, as well as medical and social records for all Plan members. Records should be made available for quality-of-care review studies by the Plan, authorized representatives of the Office of Medicaid Policy and Planning (OMPP), CMS, accreditation agencies, and should comply with requirements issued as a result of any such review or audit.

  Medical Record Review Audits:

  Medical Record Content
  Continuity of Care
  Pediatric Health Screening / EPSDT Services
  Adult Health Screening

  Diagnosis Specific Audits:

  Maternity Care Review (OB/GYN only)
  Asthma Review
  Diabetes Review

Maternity Care (OB/GYN Review)

Medical Record Requirements and Guidelines

Pre-term delivery risk assessment is rendered by the 28th week.

The member will be seen by an obstetrician within the first trimester of the pregnancy with the following assessments performed and documented:

- Weight;
- Blood Pressure;
- Fetal Heart tones;
- Hemoglobin & Hematocrit (H&H);
- Urinalysis;
- Blood Typing and Anti-body screening;
- Rubella Anti-body titer;
- Syphilis screening;
- HBsAG screening;
- Pap smear; and
- Nutrition assessment.

The member will be seen once every month in the second trimester of pregnancy with the following assessments performed and documented:

- Weight;
- Blood Pressure;
- Fetal Heart Tones;
- Hemoglobin & Hematocrit (H&H) ;
- Urinalysis;
- Alpha-fetoprotein (between 15–20 weeks) ;
- Diabetes screening/GTT (between 24–28 weeks) ;
- Repeat antibody test for unsensitized, RH-negative patients (28 weeks); and
- Prophylactic administration of Rho(D) immune globulin (28 weeks), if indicated.

The member will be seen twice every month in the third trimester of pregnancy and one visit per week in the ninth month with the following assessments performed and documented:

- Weight;
- Blood Pressure;
- Fetal Heart Tones;
- Hemoglobin & Hematocrit (H&H) ;
- Urinalysis;

- Testing for STDs and HBsAg for high-risk members;
- Group B Strep screening for high-risk members (35–37 weeks).

The Maternity chart will contain documentation of the following:

- Physical findings on each visit with a plan of treatment and follow-up for any abnormalities;
- Member education (childbirth, maternal care);
- Postpartum care—at least one complication-free visit, or appropriate follow-up if complications exist;
- Family planning counseling and services for all pregnant women and mothers;
- HIV testing/counseling is offered; and
- Referrals to the Harmony HUGS Program.

Healthy Children and Youth Program/Early Periodic Screening – Diagnostic Testing

The Healthy Children and Youth Program screens for ages 0–20 years to provide comprehensive, preventive, well-child care on a regularly scheduled basis; and to ensure entry into the health care system.

Healthy Children and Youth Program Periodicity Schedule (by age)

- Birth or neonatal examination in the hospital
- 1 month
- 2–3 months
- 4–5 months
- 6–8 months
- 9–11 month
- 12–14 months
- 15–17 months
- 18–23 months
- 24 months
- 3 years
- 4 years
- 5 years
- 6–7 years
- 8–9 years
- 10–11 years
- 12–13 years
- 14–15 years
- 16–17 years
- 18–19 years
- 20 years

A full HCY/EPST well-child visit includes all the components listed below. A partial HCY/EPSDT well-child visit includes the first six components.

- A comprehensive health and developmental history including assessment of both physical and mental health developments;
- A comprehensive unclothed physical exam;
- Health education (including anticipatory guidance);
- Laboratory tests as indicated (appropriate according to age and health history unless medically contraindicated);
- Appropriate immunizations according to age;
- Verbal lead assessment/mandatory blood tests as required;
- Vision screening;
- Hearing screening; and
- Dental screening (oral exam by a PCP as part of a comprehensive exam):
  - It is recommended that preventive dental services begin at age six through twelve (12) months and be repeated every six (6) months.

If a suspected problem is detected during a well-child visit, the child must be evaluated as necessary using the required assessment protocol for further diagnosis. The diagnosis is used to determine treatment needs. All follow-up diagnostic and treatment services deemed medically necessary to correct a problem discovered during an HCY/EPSDT well child visit will be provided as long as they are Medicaid-covered expenses.

A member should have an initial screening within 90 days of entering the Plan, within 24 hours of birth, or if the member has changed a PCP. The medical record must contain documentation of a comprehensive health history, in addition to an unclothed physical examination to determine if the child's development is within the normal range for the child's age and health history.

The following elements should be addressed, as appropriate, for the child's age and health history:

- Skin
- Head
- Eyes, ears, nose, mouth, throat, teeth, gums
- Nodes
- Height
- Weight
- Head Circumference for infants
- Blood pressure beginning at three years of age and as indicated
- BMI
- Heart and femoral pulses
- Pulse and respiration
- Lungs
- Abdomen
- External genitalia
- Pelvic examination on all sexually active females. If not sexually active, consider beginning at age 18. (The provider may refer female patients for this service)
- Hip abduction
- Gait
- Extremities
- Spine
- Neurological evaluation

There must be an assessment of past medical history, developmental history, and behavioral health status, which may include such information as: sibling history, growth history, conditions experienced by blood relatives, previous medications, immunizations or allergies, developmental history of the child or other family members.

There must be documentation that a developmental assessment was performed. The developmental assessment consists of a range of activities to

determine whether the child's physical, cognitive, and emotional developments are within the normal range for the child's age and cultural background. The following elements, as appropriate for age and cultural background, should be considered:

- Gross motor development—focusing on strength, balance, and locomotion;
- Fine motor development—focusing on eye-hand coordination;
- Communication skills or language development—focusing on expression, comprehension, and speech articulation;
- Self-help and self-care skills;
- Social-emotional development—focusing on the ability to engage in social interaction with other children, adolescents, parents and other adults; and
- Cognitive skills-focusing on problem solving or reasoning.

Through School Age

Focus on visual-motor integration, visual-spatial organization, visual-sequential memory, attention skills, auditory processing skills and auditory sequential memory.

Adolescents

Focus on areas of special concern, such as potential learning disabilities, peer relations, psychological, psychiatric problems and vocational skills.

Vision Screening

Vision status is assessed and the findings are documented in the medical record at each child's health check-up. This includes age-appropriate testing to determine if the child's vision is within the

normal range. The following should be included in the vision assessment:

- General external examination and evaluation of ocular motility;
- Gross visual acuity with fixation test;
- Testing light sense with pupillary light reflex test; and
- Intraocular examination with ophthalmoscope.

Standardized Testing

- Visual acuity for distance should be tested separately for each eye;
- The illiterate E test, the STYCAR or Lipman Matching symbol chart—HOTV may be used;
- Four and five (4 and 5) years of age should be tested at 10-15 feet;
- To determine muscle balance, a cover test and Hirschberg test (corneal light reflex) should be given;
- Ages 5 to 20 should be tested for distance visual acuity utilizing the illiterate E or Snellen letters for a linear fashion;
- Testing should be done at 20 feet;
- Testing should take place with glasses on if applicable.

Periodicity Schedule

- Subjective by history from birth through three (3) years;
- Objective vision testing at a minimum when the child is the following ages:

3 years*	6–7 years	12–13 years
4 years*	8–9 years	14–15 years
5 years*	10–11 years	18–19 years

Document in the medical record if the child is uncooperative and re-screen at the next child health check-up or sooner if medically indicated.

- Dental screening is documented—dental status is assessed and the findings are documented in the medical record:
  - The screening should consist of a visual and tactile examination to check for obvious abnormalities, such as cavities, inflammation, infection or malocclusion. It is recommended that the provider refer children who are six to twelve (6–12) months old or older for an assessment by a dentist and document this referral in the child's medical record. Following the initial dental referral, subsequent examinations by a dentist are recommended every six (6) months, or more frequently as prescribed by a dentist.
- Hearing screening—hearing is assessed and the findings are documented in the medical record at each screen:
  - This includes age appropriate testing (i.e., Hear Kit, Weber, Rinne, Puretone) to determine if the child's hearing is within the normal range along with history from the parent or guardian. (See below for periodicity schedule);

- Objective hearing testing must be performed at a minimum when the child is the following ages:

4 years*	10-11 years
5 years*	12-13 years
6-7 years	14-15 years
8-9 years	18 years

*Document in the medical record if the child is uncooperative and re-screen at the next well-child screen or sooner if medically indicated.

- Nutritional assessment—nutritional status is assessed and the findings are documented in the medical record at each screen:
  - This includes height and weight (measured and plotted on standard chart), head circumference if twenty-four (24) months or younger, dietary intake, eating habits, use of alcohol, drugs or tobacco.

    Evaluation is suggested for the following groups: children who demonstrate weight loss or no gain over a period of time, children who are overweight in proportion to their height (greater than 95th percentile, weight for height variation from expected growth parameters, height below 5th percentile), presence of diseases in which nutrition plays a key role (such as cardiovascular disease, hyperlipidemia, GI disorders, hypertension, metabolic disorders, physical and mental handicaps affecting feeding, allergies, surgery and burns).

- Lead Risk Assessment—a Lead Risk Assessment is done at each screening between ages six (6) months to six (6) years and blood lead testing is done as noted

below. All DHSS children are to be screened for lead poisoning:

- Documented oral or written assessment for risk from ages six (6) months to six (6) years of age. Regardless of risk, lead blood levels should be obtained as below;

- Recommended that providers use a verbal lead risk assessment to assess risk on children who are six months to six years of age;

- Federal regulation requires that all children receive a screening blood lead test at 12 months and 24 months of age and for children between three and seven years of age who have not been previously screened for lead poisoning, or annually if residing in a high-risk area of Missouri as defined by DHSS regulation 19CSR20-8.030;

- The Division of Medical Services requires the use of the Lead Screening Guide (MO 886-2998);

- Results: A blood test result equal to or greater than 10 micrograms per deciliter (ug/dL) obtained by capillary specimen (fingerstick) must be confirmed using a venous blood sample. If a child is found to have blood levels equal to or greater than 10 micrograms per deciliter (ug/dL), providers should use their medical discretion with reference to the Missouri State Department of Health Lead Screening Requirements covering patient management and treatment, including follow up blood tests and initiating investigations as to the source of lead where indicated. These children will be enrolled in the Lead Case

Management program to be followed up.

- Anemia screening was done with a report on hemoglobin and hematocrit (H&H) in the record. H&H recommended at the following ages with results documented in the child's medical record:

  - Nine to 12 months (consider earlier for children at high risk);
  - Thirteen years;
  - All menstruating adolescents should be screened annually;
  - When medically indicated.

- Annual Tuberculosis (TB) skin testing is done if the member is in a high-risk category.

  Only those children locally identified as high-risk for TB disease should be recommended for testing. Results of TB testing should be documented in the child's medical record. The CDC recommends screening persons with the following risk factors:

  - Close contacts (i.e., those sharing the same household or other enclosed environments) of persons known or suspected to have TB;
  - Persons infected with HIV;
  - Persons who inject illicit drugs or other locally identified high-risk substance users (e.g., crack cocaine users);
  - Persons who have medical risk factors known to increase the risk for disease if infection occurs;

- Residents and employees of high-risk congregate settings (e.g., correctional institutions, nursing homes, mental institutions, other long-term residential facilities, and shelters for the homeless);

- Health care workers who serve high-risk clients;

- Foreign-born persons, including children, recently arrived (within five years) from countries with a high TB incidence or prevalence;

- Some medically underserved, low-income populations;

- High-risk racial or ethnic minority populations, as defined locally; and

- Infants, children, and adolescents exposed to adults in high-risk categories.

- Urinalysis—Urinalysis is recommended for children at age 5 and 16 and as indicated. Performing urine dipstick urinalysis for leukocytes is recommended annually for sexually active male and female adolescents:

  - Serum cholesterol screening—a serum cholesterol determination is recommended on children with a family history of familial hyperlipidemia.

- Immunizations—administered at required age parameters and intervals with dates documented. If the immunizations are not up to date according to age and health history, the provider should document why immunizations were not given at the time of the screen. The current schedule appears in the Missouri Medicaid Provider Manuals that

may be found on the Internet at the Division of Medical Services Web site, http://www.medicaid.state.mo.us/index/html. Look under Missouri Medicaid Provider Manuals, Lists of Forms, Recommended Childhood Immunization Schedule. All providers must enroll and obtain vaccines through the Missouri Department of Health and Senior Services Vaccines for Children (VFC) Program, or any such vaccine supply program, as designated by the State Agency;

- Health education—health education, anticipatory guidance and counseling is provided to parent/guardian and child at each screen;

- Required content:

    - The provider must provide age-appropriate health education including anticipatory guidance to all children and their parents or caregivers and document in the child's medical record that health education was provided. This can be through a checklist or brochures if noted in record that brochures were given.

- Family planning—family planning services/counseling will be offered to appropriate members. The Plan shall make available and encourage all pregnant women and mothers to receive, and provide documentation in the medical records to reflect, counseling and services for family planning to all women and their partners. Members may access out-of-network providers for family planning without PCP or plan approval;

- Diagnostic services—all members should be referred for further diagnostic and/or treatment services to correct or ameliorate

defects and physical or mental illnesses and conditions discovered by the screens. Referral and follow up may be made to the provider conducting the screening or another provider as appropriate;

Adult Health Screening

An adult health screening is performed by a provider to assess the health status of a member 21 or older. It is used to detect and prevent disease, disability and other health conditions or monitor their progressions. The adult member will receive an appropriate assessment and intervention as indicated or upon request.

Adult Health Screening Periodicity Schedule

Recommended periodicity (one screening allowed every annually):

- Age 21–39, one screening every five years;
- Age 40–64, one screening every two years;
- Age 65 and over, one screening annually;
- There is documentation of an initial health screening within 90 days of entering the Plan. If the member is seeing a new PCP, there must be a screening within 90 days;
- There is a health history documented. See required content in this section;
- There is documentation of a physical examination. See required content in this section;
- There is documentation of a visual acuity testing. At a minimum, visual acuity testing must document a recipient’s ability to see at 20 feet;
- There is documentation of a hearing

screening. At a minimum, a hearing screen must document a member's ability to hear by air conduction;

- TB skin testing is performed if the member is in a high-risk category. The results are documented in the member's medical record:
  - The CDC recommends screening of persons with the following risk factors: close contacts (i.e., those sharing the same household or other enclosed environments) of persons known or suspected to have TB; persons infected with HIV; persons who inject illicit drugs or other locally identified high-risk substance users (e.g., crack cocaine users); persons who have medical risk factors known to increase the risk for disease if infection occurs; residents and employees of high-risk congregate settings (e.g., correctional institutions, nursing homes, mental institutions, other long-term residential facilities, and shelters for the homeless); health care workers who serve high-risk clients; foreign-born persons, including children, recently arrived (within five years) from countries that have a high TB incidence or prevalence; some medically underserved, low-income populations; high-risk racial or ethnic minority populations, as defined locally; and infants, children, and adolescents exposed to adults in high-risk categories.
- Annual influenza vaccination - documentation for members 50 years of age or greater or persons with pre-existing medical indications;
- Medical indications: chronic disorders of the cardiovascular or pulmonary systems including asthma; chronic metabolic diseases

including diabetes mellitus, renal dysfunction, hemoglobinopathies, immunosuppression (including causes by medications or by HIV (human immunodeficiency virus), requiring regular medical follow-up or hospitalization during the preceding year; women who will be in the second or third trimester of pregnancy during the influenza season;

- Pneumococcal vaccination is documented for members 65 years of age or greater or for younger members with high-risk medical conditions:
  - Medical indications: chronic disorder of the pulmonary system (excluding asthma), cardiovascular diseases, diabetes mellitus, chronic liver diseases including liver disease as a result of alcohol abuse (e.g., cirrhosis), chronic renal failure or nephrotic syndrome, functional or anatomic asplenia (e.g., sickle cell disease or splenectomy), immunosuppressive conditions (e.g., congenital immunodeficiency, HIV infection, leukemia, lymphoma, multiple myeloma, Hodgkins disease, generalized malignancy, organ or bone marrow transplantation), chemotherapy with alkylating agents, anti-metabolites, or long-term systemic corticosteroids.
- Screening for dyslipidemia is documented as indicated:
  - A complete fasting lipoprotein profile including major blood lipid fractions (total cholesterol, LDL, HDL and triglycerides), should be obtained at least once every five years in adults 20 years of age and older. More frequent measurements are required for persons with multiple risk factors or, in those with 0–1 risk factor, if the LDL level is

only slightly below the goal level. In otherwise low-risk persons (0–1 risk factor), further testing is not required if the HDL-cholesterol level is 40 mg/dL and total cholesterol is <200 mg/dL. However, for persons with multiple (2+) risk factors, lipoprotein measurement is recommended as a guide to clinical management.

- Major Risk Factors:
    - Diabetes;
    - History of CAD or prior cardiac event;
    - Cigarette smoking;
    - Hypertension (BP ≥ 140/90 mmHg or on antihypertensive medication);
    - Low HDL cholesterol (<40 mg/dL);
    - Family history of premature CHD (CHD in male first degree relative younger than 55 years of age; CHD in female first degree relative younger than 65 years);
    - Age (men under 45 years; women under 55 years).
- Colorectal cancer screening is documented. Beginning at 50 years of age, both men and women should follow one of these five testing schedules:
    - Yearly fecal occult blood test (FOBT). The take-home multiple sample method should be used;
    - Flexible sigmoidoscopy every five years;

- ○ Yearly fecal occult blood test plus flexible sigmoidoscopy every five years. (The combination of FOBT and flexible sigmoidoscopy is preferred over either of these two tests alone.);
- ○ Double-contrast barium enema every five years;
- ○ Colonoscopy every 10 years.

All positive tests should be followed up with colonoscopy.

- People should begin colorectal cancer screening earlier and undergo screening more often if they have any of the following colorectal cancer risk factors:
  - ○ A personal history of colorectal cancer or adenomatous polyps;
  - ○ A strong family history of colorectal cancer or polyps (cancer or polyps in a first-degree, relative younger than 60, or in two first-degree relatives of any age).

    Note: a first-degree relative is defined as a parent, sibling, or child;
  - ○ A personal history of chronic inflammatory bowel disease; and
  - ○ A family history of hereditary colorectal cancer syndromes (familial adenomatous polyposis and hereditary non-polyposis colon cancer).

- Urinalysis dipstick for blood, sugar and acetone; manual or automated dipstick for urine;

- Hemoglobin and hematocrit (H&H) testing is done;

- Mammogram as indicated:

    - Yearly mammograms starting at 40 years of age and continuing for as long as a woman is in good health. Clinical breast exams (CBE) should be part of a periodic health exam—about every three years for women in their 20s and 30s and annually for women 40 years of age and older.

- PAP test as appropriate:

    - All women should begin cervical cancer screening about three years after they begin having vaginal intercourse, but no later than 21 years of age. Screening should be performed annually with the regular Pap test. Beginning at 30 years of age, women who have had three normal PAP test results in a row may be screened every two to three years. Women who have certain risk factors should continue to be screened annually;

    - Women 70 years of age or older, who have had three or more normal PAP tests in a row and no abnormal PAP test results in the previous 10 years may choose to stop having cervical cancer screening. Women with a history of cervical cancer, DES exposure before birth, HIV infection or a weakened immune system should continue to have annual screening as long as they are in good health;

    - Women who have had a total hysterectomy (removal of the uterus

and cervix) may also choose to stop having cervical cancer screening, unless surgery was performed as a treatment for cervical cancer or pre-cancer. Women who have had a hysterectomy without removal of the cervix should continue to follow the guidelines above.

Diabetes-Specific Screens

Symptoms of diabetes and a casual plasma glucose level of 200 mg/dL. Casual is defined as any time of day without regard to time since the last meal. The classic symptoms of diabetes include polyuria, polydipsia, and unexplained weight loss:

- Fasting Plasma Glucose of 126 mg/dL. Fasting is defined as no caloric intake for eight hours;
- Two-hour Plasma Glucose 200 mg/dL during OGTT (Oral Glucose Tolerance Test);
- On oral or parenteral medication or dietary restrictions to treat Diabetes Mellitus:
    - When there is evidence of an attempt to control the disease process through pharmacological or dietary intervention as indicated by an individualized management plan with routine diabetes visits scheduled quarterly for patients who are not meeting goals and semiannually for other patients;
    - When there is evidence of comprehensive education in self-management including self-monitoring of blood glucose, nutrition therapy, insulin or oral medication therapy regimens, prevention and treatment of hypoglycemia, and exercise;
    - A1C testing (glycosylated hemoglobin)

quarterly if a change in treatment has occurred or if a patient is not meeting the goals of therapy. Twice per year if stable;

- ○ The member's A1C level is ≤7.0%. ADA 2003 position statement: "develop or adjust the management plan to achieve normal or near-normal glycemia with an A1C test goal of ≤7%." The member will receive Lipid Profile testing at least annually with the results documented in the medical record; and

- ○ The member's LDL level is <100 mg/dL. ADA 2003 position statement "Lower LDL Cholesterol to <100 mg/dL as the primary goal of therapy for adults."

Summary of Recommendations for Adults with Diabetes Mellitus:

Glycemic control	A1C	<7.0%
	Preprandial plasma glucose	90–130 mg/dL
	Peak postprandial plasma glucose	<180 mg/dL
	Blood pressure	<130/80 mmHg
Lipids	LDL	<100 mg/dL
	Triglycerides	<150 mg/dL
	HDL	>40 mg/dL

- A dilated eye examination was performed within the last year with the results documented in the medical record;

- Urinalysis for microalbuminuria was performed within the last year with the results documented in the medical record. While screening for microalbuminuria can be performed by three methods: 1) measurement of the albumin-to-creatinine ratio in a random,

spot collection; 2) 24-hour collection with creatinine, allowing the simultaneous measurement of creatinine clearance; and 3) timed (e.g., four-hour or overnight) collection—the analysis of a spot sample for the albumin-to-creatinine ratio is strongly encouraged. The role of annual microalbumuria assessment is less clear after diagnosis of microalbuminuria and institution of ACE inhibitor or ARB therapy and blood pressure control. Many experts, however, recommend continued surveillance to assess both response to therapy and progression of disease; and

- A comprehensive foot exam is performed at every office visit. Foot exam includes sensation, structure and biomechanics, vascular status, and skin integrity.

A patient with chronic pulmonary disease will receive a timely evaluation and appropriate medical intervention as evidenced by the following:

- On each visit, the member will receive a complete respiratory assessment that will include auscultation of breath sounds, use of accessory muscles and respiratory rate;
- The member’s medication is monitored and evaluated;
- There is evidence of an attempt to control the member’s disease process as evidenced by ongoing assessments beyond the acute phase of illness; and
- There is evidence of member education and self-management related to the disease process.

For the diagnosis of Asthma only:

- There is evidence of management of the

member's disease process through the use of long-acting therapies.

The criteria utilized for medical record standards and standards of care are not authored by the Plan. The criterion is based on regulatory requirements outlined in the Department of Social Service regulatory contracts, accreditation guidelines and accepted national organizations.

Reviews in a provider's office may conclude with an Exit Review, to include the provider and designated office staff. The provider will be given the preliminary results of the review. Any area that is not compliant with regulatory standards will require a plan of correction. In the event a CAP is not received in the stated time frame, a second request will be sent to the provider.

American Academy of Pediatrics
"Recommendations for Pediatric Preventive Health Care"; "Recommended Childhood and Adolescent Immunization Schedule"
Web site: http://www.aap.org

American Cancer Society Cancer Detection Guidelines
Web site: http://www.cancer.org

American Diabetes Association
"Standards of Medical Care for Patients with Diabetes Mellitus"
Web site: http://diabetes.org

Guide to Clinical Preventive Services, 3rd Edition
2000-2003 Report of the U.S. Preventive Services Task Force
Web site: http://www.ahrq.gov/clinic/prevnew.htm

Guidelines for Perinatal Care
American Academy of Pediatrics
The American College of Obstetricians and Gynecologists

HEDIS® Guidelines
Web site: http://www.ncqa.org

Recommended Adult Immunization Schedule
United States 2002–2003
Department of Health and Human Services
Centers for Disease Control and Prevention
Web site: http://www.cdc.gov

Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC 7); National Heart, Lung, and Blood Institute (NHLBI); National Institutes of Health, 2003
Web site:
http://rover.nhlbi.nih.gov/guidelines/hypertension/index.htm

The National Asthma Education and Prevention Program (NAEPP)
National Heart, Lung, and Blood Institute (NHLBI)
National Institutes of Health, 2003
Web site: http://rover.nhlbi.nih.gov/about/naepp

Centers for Disease Control and Prevention (CDC) Web site: http://www.cdc.gov

QISMC Medical Record Review
(Centers for Medicare and Medicaid Services)

Managed Care Organization Policies and Procedures

National Committee on Quality Assurance Standards for the Accreditation of Managed Care Organizations
Web site:
www.ncqa.org/communications/publications