

## 15: Health Plan Standards

### 15.1 Access Standards

Unison confirms that practitioners are accessible to our members. Compliance with accessibility standards are monitored by reviewing data collected from various sources including: member complaints, office reviews, member satisfaction surveys, monthly random availability phone checks, and calls to the Member Services Department. This data is presented to the QI/UM Committee for barrier analysis and development of interventions when the results suggest that it is required. Follow-up is provided by the Provider Relations Department who educates offices that are not in compliance with the standards.

Unison has established the following standards relative to accessibility:

- Primary Care Providers (PCPs):
  1. Emergency cases must be triaged and treated immediately on presentation at the PCP site
  2. Urgent cases must be scheduled within 24 hours
  3. Routine Asymptomatic Appointments must be scheduled within 6 weeks.
  4. Routine care-persistent symptoms must be treated no later than the end of the following working day after their initial contact with the PCP site
  5. Preventive/General physical appointments must be scheduled within 6 weeks.
- Obstetrician/Gynecologist and Certified Nurse Midwife (CNM) standards:
  1. Initial prenatal care appointments are accessible within 2 weeks
  2. First trimester: within ten (10) business days of request.
  3. Second trimester: within five (5) business days of request.
  4. Third trimester: within four (4) business days of request.
  5. High-risk pregnancies: within 1 week unless urgent need exists then within 24 hours.
- Orthopedic surgeon, allergist, dermatologist, otolaryngologist and neurologist accessibility standards:
  1. Urgent care appointments are seen within 48 hours of referral.
  2. Routine appointments for new patients are accessible within 6 weeks
  3. Routine appointments for established patients within 4 weeks
- Accessibility standards for all other specialty provider types:
  1. Urgent care appointments are seen within 24 hours of referral.
  2. Routine appointments for new patients are accessible within 4 weeks
  3. Routine appointments for new patients are accessible within 3 weeks
- Office Wait Times: The member's wait time should be no more than 45 minutes or up to one hour when the physician encounters an unanticipated urgent visit or is treating a member with a difficult medical need. Emergency cases should be seen immediately.
- Physician Coverage: All Primary Care Physicians (PCPs) are contractually required to be available to their members twenty-four (24) hours a day, seven (7) days a week to make certain the members have timely access to necessary care, for emergency care, and to allow the PCP continues to act as the "medical home." Offices must have a phone message or answering service available to members after office hours that instruct the member on how to contact the physician for urgent or emergency conditions.

## 15.2 Medical Record Documentation Standards

The Unison Quality Improvement (QI) Plan confirms that medically necessary services are provided to members in both a timely and confidential manner. Medical records must be maintained in a manner that is current, detailed and organized, and that permits effective and confidential patient care and quality review. The Medical Record Documentation Standards were developed by the QI Department and approved by the Unison Quality Improvement Committee and Board of Directors.

Per the Unison Health Plan provider agreements, all records, including medical records and financial documents shall be maintained and available for review, audit or evaluation by authorized State personnel or their representatives. Providers shall retain the source records for operational data reports for a minimum of seven (7) years and have written policies and procedures for storing such information.

PCPs, OB/GYN Practitioners, and other high volume consulting physicians are evaluated on the medical record standards at the time of initial credentialing and every 24 months. Providers will receive feedback at the conclusion of the audit indicating the level of compliance with medical record documentation standards. The score required to pass is 80% or greater. The reviewers will give clear and concise instructions to the provider via the Feedback Form, which serves as a corrective action plan for any noted deficiencies.

The review includes an evaluation of the medical record keeping practice(s). Up to 10 medical records of various patient ages will be reviewed for each practice. The reviewer will investigate quality of care, continuity and coordination of care, under and over utilization, and preventative health care, as well as other medical recording keeping practices.

### **Standards:**

#### **Demographics**

- Each page of a medical record should contain a name or medical record number as an identifier.
- An address where patient can be reached by mailings should be noted as well as the home phone number. If there is no phone, a neighbor, family member or friend should be listed.
- Birth date should be documented in the medical record. Emergency contact and phone number should be listed in the medical record.
- Each entry needs to contain the author's identification. Signature can be electronic, hand written or initialed.
- All entries in the medical record should be dated.
- The medical record should be legible to someone other than the writer. If questionable Unison reserves the right for medical records to be released to our medical director for review.

#### **Patient History**

- Each medical record should contain a problem list. This area, where significant illnesses or medical conditions can be documented, should be updated frequently to show both active and inactive conditions.
- A medication list should be incorporated into the charting system. This section should be a current list of maintenance type medications.
- Allergies need to be noted in a prominent place in the chart. Such prominent areas could be the covers of the chart or an area easily identified when the chart is opened. If the patient has no allergies then NKA needs to be documented.
- There should be a detailed past medical history including illnesses, operations, injuries, disabilities, family history and any information pertinent to patient's health.

- A medical record should contain documentation that smoking, alcohol and substance abuse have been addressed. If patient is under 12 years old documentation should be related to smoking in the home, if 12 years and older documentation should be patient specific.

### **Diagnosis and Treatment Plan**

- Lab and other studies ordered are appropriate to patient symptoms and physical findings.
- Working diagnosis should be consistent with physical, x-ray, lab and consult findings.
- Action and treatment plans should be consistent with diagnosis.
- Follow up visits should be documented in days, weeks or months when clinically appropriate. Follow up visits can be noted in chart, appointments scheduled at time of visit, reminder card system or super billing system.
- Unresolved problems from previous visits should be documented in the subsequent visit.

### **Continuity**

- There should be evidence to support the use of consultations.
- If referred to by the primary doctor, documentation of consulting physician's findings, inpatient discharge summaries, skilled nursing facility progress notes or discharge summaries and home health care notes and discharge summaries should be noted in the medical record.
- All consults, summaries, lab and imaging studies need to be initialed or have explicit notation of review in the medical record.
- Abnormal labs, consults, imaging studies and summaries should have explicit notations of a follow up treatment plan.

### **Prevention**

- A completed immunization record should be present in all children's medical records.
- Height, weight and BMI should be noted
- An appropriate immunization record should be present in adult medical records.
- Preventive health issues should be appropriately addressed in the medical record and are audited using the applicable Preventive Health audit tools. These preventive health guidelines by age appropriateness are located in the provider service manual.
- Documentation of the presence or absence of an advance directive should be present on the chart of patients' 65 years and older.

## 15.3 Access and Safety Review

At the time of medical record review, Unison QI nurse reviewers will also assess compliance with appointment access standards and patient safety regarding medication administration. This focused review will also be discussed with the office staff and recommendations for improving deficiencies will be noted. Those providers falling below threshold will be referred to the Medical Director for further action. Both medical record reviews and the focused access/safety review will become part of the providers credentialing file.

## 15.4 Credentialing Standards

Unison will credential and re-credential all participating providers according to the regulations set forth by the Ohio Department of Job and Family Services (ODJFS) and by the accrediting body, the National Committee of Quality Assurance. The following key elements are required to begin the credentialing process:

- A completed Credentialing Application

- Copy of current Medical License
- Copy of current DEA Certificate
- Copy of the Malpractice Insurance face sheet showing the policy number, coverage limitations, and expiration dates
- Copy of current W-9 Form

Information from primary sources regarding clinical privileges, education and training, board certification, and malpractice claims history will be verified as part of the credentialing process.

#### *15.4.1 Facility Review*

Unison has established specific guidelines for conducting an initial facility review, including medical record keeping practice standards, at primary care and OB/GYN offices. The purpose of the facility review is to confirm that providers comply with the Unison facility standards.

Each facility review will measure accessibility, availability of appointments, and adequacy of waiting and examining room space. The score required to pass is 80%. A copy of the Facility Review Audit Tool can be found in this section.

Providers who meet the credentialing criteria will be submitted to the Credentialing Committee for approval. The committee will provide final decision to accept or reject the credentialing application. Upon committee approval, providers will be notified of their participating status and effective date.

#### *15.4.2 Adverse Credentialing*

Providers that do not meet the criteria set forth by the Credentialing Committee will be notified in writing via certified mail. The letter will define the Committee's determination, along with the right to Appeal, a copy of the Appeals Process. Possible factors that would prohibit a provider from meeting the Committee's criteria include: Lack of Admitting Privileges to a Unison Participating Hospital(s), Non-Compliance to providers' Medical Standards and members' Benefits and criteria included in the Better Health Quality Improvement Program.

#### *15.4.3 Re-credentialing*

The re-credentialing process will be conducted at least every three years for PCP and OB/GYN practices. The process will include evaluation of the following key elements:

- A completed re-credentialing application
- Copy of current Medical License
- Copy of current DEA Certificate
- Copy of the Malpractice Insurance face sheet showing the policy number, coverage limitations, and expiration dates
- Member complaints
- Quality improvement activities
- Encounter claims data audit
- Utilization management information
- Member satisfaction

Providers who meet the re-credentialing criteria will be submitted to the Credentialing Committee for approval. The committee will provide final decision to accept or reject the re-credentialing application. Upon committee approval, providers will be notified of their participating status. Providers not meeting criteria will be notified and may appeal the decision as outlined above.