2.00 Heraya Clinical Record Quality Standards

High quality clinical care is reflected in high quality clinical documentation. Heraya is committed to assisting providers to achieve the highest levels of competency with respect to clinical record keeping. These standards establish Heraya's performance expectations for record keeping and processes to improve record keeping competency. In compliance with the National Committee on Quality Assurance, Heraya requires all network providers to ensure that a contemporaneous clinical record is established and maintained for each member who receives services from a Heraya provider. Clinical records must be maintained in accordance with all applicable professional, state, and federal standards, as well as the Heraya standards outlined in this section. These best practices facilitate record keeping to ensure clinical documentation is current, detailed, and organized to promote communication, maintain member confidentiality, deliver effective member care, permit quality improvement, and document medical necessity.

Definitions

Clinical Records:
The term "clinical record" means a record created by or on behalf of a provider of health care for services provided to a member. This record includes information that the member may provide concerning personal identification, demographics, social and family history, symptoms, and medical history. Information entered into the medical record by the provider includes the history reported by the member, the results of examinations, reports of tests and consultations, diagnoses, clinical assessments, treatment plans, treatments rendered including modalities, instructions, and advice, and recommended follow-up.

Protected Health Information (PHI):
Under HIPAA, protected health information is considered to be individually identifiable information relating to the past, present, or future health status of an individual that is created, collected, transmitted, or maintained by a HIPAA-covered entity in relation to the provision of healthcare, payment for healthcare services, or use in healthcare operations.

Health information such as diagnosis, treatment information, medical test results, and prescription information are considered protected health information under HIPAA, as are national identification numbers and demographic information such as birth dates, gender, ethnicity, and contact and emergency contact information. PHI relates to physical records, while ePHI is any PHI that is created, stored, transmitted, or received electronically.

PHI is only considered PHI when an individual could be identified from the information. If all identifiers are stripped from health data, it ceases to be protected health information and the HIPAA Privacy Rule's restrictions on uses and disclosures no longer apply.

Other examples of where PHI may be documented include completed health care claim forms, detailed claim reports, explanations of benefits (EOB), and notes documenting discussions with members.

Occasionally Heraya requires you to submit clinical records for various purposes. When responding to these requests, it is imperative that you comply with Federal rules that protect member confidentiality.

Note: These rules do not apply to clinical records submitted to support billing, for Treatment Extension Requests, appeals, and other aspects of payment.

The following are the 18 identifiers that create the definition of "individually identifiable" and can be used to identify a specific individual.

1. Names of members, spouses, relatives.
2. All geographic subdivisions smaller than a state, including street address, city, county, precinct, ZIP code, and their equivalent geocodes. The exceptions are for the initial three digits of a ZIP code if, according to the current publicly available data from the Bureau of the Census (a) the geographic unit formed by combining all ZIP codes with the same three initial digits contains more than 20,000 people; and (b) the initial three digits of a ZIP code for all such geographic units containing 20,000 or fewer people is changed to 000.
3. Day and month elements of dates directly related to an individual, such as birth date, admission date, discharge date, date of death; and all ages over 89 and all elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of "age 90 or older." **Note: this does not apply to dates of service in the chart notes.**
4. Telephone numbers.
5. Fax numbers.
6. Email addresses.
7. Social Security numbers.
8. Medical record numbers.
9. Health plan beneficiary numbers.
10. Account numbers.
11. Certificate/license numbers.
12. Vehicle identifiers and serial numbers, including license plate numbers.
13. Device identifiers and serial numbers.
14. Web Universal Resource Locators (URLs).
15. Internet Protocol (IP) addresses.
16. Biometric identifiers, including finger and voice prints.
17. Full-face photographic images and any comparable images.
18. Any other unique identifying number, characteristic, or code.

2.01 Heraya Clinical Record Criteria

Confidentiality of Clinical Records

PHI is legally protected and must be handled in a confidential manner. Unless otherwise required by law, including those laws that apply to minors, disclosure of member-specific health information can be only to:

1. The individual to whom the information relates.
2. Heraya and/or a health plan contracted with Heraya to perform health care delivery, payment, administration and/or management functions on their behalf.
3. A third party only if specific authorization is obtained from the individual to whom the information relates.

Heraya providers will make available to member's (and members' minor children's eligible dependents) member-specific health information for inspection and copying, except as otherwise provided by law.

Clinical Record Keeping System and Standards for Availability

1. Clinical records must be organized and stored in a manner that allows easy retrieval.
2. Clinical records must be stored in a secure manner that allows access by authorized personnel only.
3. Each member will have a centralized clinical record containing all clinical records for that member. Records are organized in date-order.
4. This record will be opened at the time of a member's first visit. Entries into the record will be contemporaneous with the encounter.
5. The provider will store, retain, and maintain such records for a period consistent with applicable state and federal law.
6. The obligations of the provider regarding clinical records will survive the termination of Heraya's Professional Services Agreement, regardless of the cause giving rise to such termination.
7. There is evidence of continuity and coordination of care. Records from other providers and outside consultants will be maintained in the member's record.
8. Consultation, laboratory, and diagnostic imaging reports filed in the records will be initialed by the provider to signify review.
9. Abnormal lab and imaging results will have an explicit notation in the record of follow-up plans for notifying the member as well as the clinical intervention.
10. Records will be maintained in ink or appropriate Electronic Health Record (EHR) system.

Clinical Records Documentation Standards: "Best Practices" in Record Keeping

- Legibility
  - The record is legible to someone other than the writer.
  - Type written is preferred.
  - Abbreviations used are standard and comprehensible by a peer or are accompanied by a key that explains their meaning.
- Identification
  - The record contains identifying personal biographic and demographic data of the member including address, home and work telephone number, marital status, employer, and alternate/emergency contact person.
  - Each side of each page of the record contains the member's name and date of birth (or unique identifier), the provider's name and clinic of origin by name, physical address, and telephone number.
  - Each entry is dated by month, day, and year.
  - The author of each entry is identified by name. Services that are provided or ordered must be authenticated for each entry by the provider of or ordering provider using a valid signature. Signatures are to be handwritten, electronic, or stamped (only permitted where the author has a physical disability and who can provide proof of an inability to sign due to the disability).
    - **Handwritten Clinical Record**: For a signature to be valid it must be legible. Alternatives include an illegible signature or initials next to a typed/printed legible identification of the author; illegible signature where the letterhead, addressograph or other information on the page indicates the identity of the

signatory; where multiple providers are listed the author of record is specifically identified; illegible signature or initials accompanied by a signature log or attestation statement.

- **Electronic Clinical Record**: For a signature to be valid, systems and software products must include protections against modification (e.g., time and date stamp), and administrative safeguards should be applied that correspond to standards and laws, e.g., using signature and secure login functions appropriately. Best practice would include the following elements:
    - Full printed name of the author at the end of the entry.
    - Date.
    - Time.
    - Digitized signature or signature statement, e.g., electronically signed by, signed by, authenticated by, reviewed by, etc.

. Clinical Information
    . The complaint prompting the member to seek care is noted. The mode of onset, location, nature, duration, aggravating/palliating factors (OPQRST) are documented.
    . Prior interventions and outcomes of previous treatment of the presenting condition are indicated.
    . Other pertinent current medical history, system review, past medical history, family, and socioeconomic history are noted.
    . Notations of all significant illnesses, surgeries, and injuries. For children and adolescents, pre-natal care, birth, operations, and childhood illnesses are documented.
    . Clinical indications for laboratory and diagnostic imaging studies are documented.
. Member Safety
    . Current and significant past medication (including Rx, OTC, and natural medicines) use is documented.
    . Allergies, medication allergies, intolerances, adverse reactions, and contraindications to potential treatments are clearly noted.
    . Informed consent is obtained and properly documented and included in the clinical record. This process includes a verbal discussion to include the following elements often referred to as the “PARQ” conference:
        - (P) explanation of proposed examination, procedure, or treatment in general terms,
        - (A) viable alternatives,
        - (R) material risks,
        - (Q) ask if the member has any questions.

      This can be documented in the clinical record as PARQ. If the member requests further information or has specific questions the provider can underline PARQ and should note the question and the more detailed information provided. It is also recommended that the member sign a document acknowledging they have been part of the informed consent process, that the material risks have been disclosed, including a description of those risks, and that the member has agreed to the procedures, understands the risks, understands the alternatives, and the opportunity to ask questions has been provided. This could be accomplished using a prepared written consent form or other format that must be signed by the member and should be signed by the provider. It is important that

providers have a discussion directly with the member and not rely exclusively on these forms.

. Preventive Health Care
   a. There is documentation and advice when appropriate for routine preventive health measures, such as:
      - Tobacco use.
      - Alcohol use.
      - Exercise habits.
      - Diet.
      - Screening for obesity.
      - Hypertension.
      - Cholesterol.
      - Sleep habits.
      - Known allergies.
      - Mammography.
      - PAP.
      - Stress.
      - Assessment of behavioral health status.
   b. Inquiry about and referral for significant chronic conditions (CAD, heart failure, diabetes, asthma, etc.) is noted.

. Integrated Care
   . Member's other health care providers (PCP, specialists, IH) are identified.
   . Permission to contact member's other care providers is documented.
   . Contact with other care providers (written, telephone, etc.) is documented.

. Evaluation
   . Vital signs are recorded.
   . Findings of abnormal and pertinent negative physical and laboratory examinations and diagnostic imaging are documented. The examinations are appropriate for the presenting condition. The test results are clearly documented in the record by being adequately described and results properly qualified and quantified.
   . Appropriate outcomes assessments are used, such as functional (ADL) assessment, physiologic measurements, and outcome assessment tools (VAS, pain drawing, etc.).

. Assessment
   . The provider's initial assessment of the member's condition, whether a working diagnosis, clinical assessment or impression is clearly indicated.
   . Progress of the members' condition is noted in every chart note.
   . The initial and ongoing assessments are consistent with the history, complaints, and examination findings.

. Treatment Plan
   . The treatment plan is documented.
   . Expected visit frequency, duration, and interventions are noted.
   . Goals/expected outcomes of treatment are identified.
   . Obstacles to recovery and strategies to overcome them are documented.

. Follow-up Visits
   . Each entry in the clinical record is visit specific where all components of a routine visit with an established member are documented.

- . Review of chief complaint, effect of the prior treatments, changes since the last visit and pertinent interim history are documented.
- . Relevant examination findings are noted.
- . Current clinical assessment of the member's condition and the member's progress are noted.
- . The treatment rendered, recommendations and instructions to the member at the visits are documented.
- . Follow-up is documented.

. The patient record should never be backdated, erased, deleted, or altered in any way. If corrections need to be made or addendums added to a written record, a line should be drawn through the correction, or the addendum inserted and the change initialed and dated. In the case of electronic patient records, corrections or amendments should be made using an addendum that is signed or initialed and dated. In both cases, the original record should be preserved.

2.02 Performance Goals for Clinical Record Quality Improvement and the Clinical Record Quality Improvement Program (CRQIP)

Performance Goals

Assessing the Quality of Clinical Records

Clinical record keeping quality is measured by discipline-specific scoring tools that were developed by provider focus groups. A minimum quality threshold has been established for each discipline and noted on the applicable scoring tool.

Initial Applicants

Initial applicants are required to submit clinical records at the time of application for initial credentialing and are required to meet the minimum quality threshold prior to acceptance on the network. Initial applicants are notified of this requirement and provided a copy of the scoring tool in the credentialing application for awareness of the scored elements.

Heraya Contracted Providers

For contracted providers, clinical records are routinely monitored for quality improvement purposes, in concert with record reviews related to claims submissions and Heraya's Utilization Management Program. Heraya contracted providers who do not meet threshold will be allowed to enroll and participate in the CRQIP twice. Failure to pass CRQIP or maintain clinical record quality standards may result in Heraya offering the contracted provider the opportunity to resign. Otherwise, Heraya will terminate their participation for breach of contract in accordance with the Professional Services Agreement.

All Heraya contracted providers who meet threshold are assigned to one of three categories below and are notified in writing of their status.

- ***Audit Pool***: This pool is comprised of 1) contracted providers who have met or exceeded the scoring tool threshold specific to their discipline and 2) initial applicants who met the threshold are automatically placed in this pool since only one clinical record review has occurred. The providers in this pool will be required to submit clinical records periodically at Heraya's request.
- ***Exempt Status***: Heraya providers who have consistently demonstrated the ability to keep quality clinical records by scoring at least 85% twice consecutively, without being enrolled in CRQIP, may be exempted from further clinical record quality reviews. This status requires approval by a clinician reviewer or a Heraya Medical Director. All exempt providers may be subject to periodic random clinical record quality reviews if deemed necessary by a Heraya Medical Director.
- ***Exception Status***: Exceptions to meeting the minimum quality threshold may be granted by the Heraya Chief Clinical Officer. Criteria for determining an exception include:
    a. Number of current active members.
    b. Geographical location.
    c. Number of other providers in the geographic area meeting threshold standards.
    d. Tenure on network.
    e. Business needs.

Change of Status

A clinician reviewer or a Heraya Medical Director has the right to change a provider's status. This change will be communicated to the provider by letter. Medical necessity reviews performed by Heraya or its contracted health plans or related activities which indicate non-compliance with maintaining threshold standards will result in auditing of the providers' clinical records. This policy will apply to all contracted providers, including those who may have been previously exempt from clinical record audits.

Initial applicants and Heraya contracted providers whose clinical records do not meet the established minimum thresholds are enrolled in and must successfully complete the CRQIP which is described below.

CRQIP Process

Clinical records not meeting the established thresholds will result in provider enrollment in the CRQIP. The following process applies to both initial applicants and contracted providers:

1. Heraya notifies the provider in writing of the CRQIP enrollment. This notification will contain the following:
    . Instructions on when and how to submit a new set of clinical records. All enrollees are provided 60 days to finish the program from the initial date of notification.
    . A copy of completed scoring tool and notes scored.
    . Quality Improvement Guide to Clinical Record Keeping containing information relating to areas where the applicant scored low.
    . A copy of the blank applicable scoring tool and guidelines.
2. Clinical records are submitted to Heraya by the provider within 45 days of enrollment.
3. Clinician reviewers audit clinical record quality utilizing scoring tools based on the discipline specific performance criteria.
4. Heraya notifies the provider in writing of scored results. The course of action for those providers whose scores pass threshold and for those who do not is outlined below.
5. Heraya scans all relevant CRQIP information to the provider database.

Scores At or Above Threshold

Initial Applicants: Clinical records meeting the minimum quality threshold for initial applicants will result in the continuation of the credentialing process. The provider is notified of the passing score, provided a copy of the scoring tool, notified of placement in the Audit Pool for future periodic clinical record reviews and that the credentialing process will be completed.

Contracted Providers: Clinical records meeting the minimum quality threshold for contracted providers will result in notification of the passing score. The provider will be given a copy of the scoring tool and, if applicable, notified of a status change.

Scores Below Threshold

Initial applicants or contracted providers whose clinical records do not meet the minimum quality threshold after the CRQIP review will be given the following two options:

1. The provider will be given the opportunity to work with a mentor to meet Heraya's minimum threshold requirements.
2. If the provider should choose not to work with a mentor, Heraya may proceed to terminate their participation for breach of contract in accordance with the Professional Services Agreement or for initial applicants, may proceed with application closure.

Clinical Record Mentors

If the initial applicant or contracted provider chooses the option to work with a mentor to meet Heraya's minimum quality threshold, the provider will be contacted by the assigned mentor and repeat the CRQIP process described above.

2.03 Clinical Record Quality Improvement: Visit Specific Clinical Records Program

Clinical records not meeting the visit specific requirement will result in provider enrollment in the Clinical Record Quality Improvement: Visit Specific Clinical Records Program.

Performance Goals for Clinical Record Quality Improvement: Visit Specific Clinical Records Program

Assessing the Quality of Clinical Records

Requirements have been established for all Heraya providers to document visit specific entries in the clinical record. This is noted on the applicable scoring tool and scoring guidelines.

Initial Applicants

Initial applicants are required to submit clinical records at the time of application for initial credentialing and are required to meet the visit specific requirement in their clinical record keeping. Initial applicants are notified of this requirement and provided with a copy of the scoring tool and scoring guidelines in the credentialing application for awareness of the scored elements.

Heraya Contracted Providers

Contracted providers are required to meet the visit specific requirement in their clinical record keeping in concert with record reviews related to claims submissions and Heraya's Utilization Management Program.

Initial applicants and Heraya contracted providers whose clinical records do not meet the visit specific requirement are enrolled in and must successfully complete the Visit Specific Clinical Records Program which is described below.

Visit Specific Clinical Records Program Process

The following process applies to both initial applicants and Heraya contracted providers:

1. Heraya notifies the provider in writing of their enrollment in the Visit Specific Clinical Records Program. This notification will contain the following:
    - A memo detailing the visit specific requirements and instructions on the next step. All enrollees are provided six (6) months to finish the program from the initial date of notification.
    - A copy of the completed scoring tool and notes scored.
    - A copy of Best Practices in Clinical Record Keeping: Visit Specific Chart/Progress/Encounter Notes.
2. A follow up memo is sent six (6) months from the initial date of notification to request a new set of clinical records.
3. Clinical records are submitted to Heraya by the provider.
4. The Regional Medical Director or clinical reviewer of the same discipline will audit clinical record quality on the explicit discipline specific performance criteria.
5. Heraya notifies the provider in writing of the results. The course of action for those providers who meet the visit specific requirement and for those who do not is outlined below.
6. Heraya scans all relevant information to the provider database.

Providers meeting the requirements

Clinical records meeting the visit specific requirements will result in notification of successful completion of the program.

Providers not meeting the requirements

Clinical records that do not meet the visit specific requirements will be given the following two options:

1. The provider will be given the opportunity to work with a mentor to meet Heraya's requirements for visit specificity.
2. If the provider should choose not to work with a mentor, Heraya may proceed to terminate their participation for breach of contract in accordance with the Professional Services Agreement or for initial applicants, may proceed with application closure.