

#### **Overview**

Each physician must maintain a complete medical record for each Plan member according to professional practice standards, as well as state and federal requirements.

To comply with regulatory and accreditation requirements, the Quality Improvement department conducts annual medical record audits in physician offices. A patient's record will be reviewed for content and screenings as applicable. Physicians will be given results at the time of the audit and a corrective action plan will be required if the score is not above 85 percent.

Contracted providers are to have a person designated in charge of clinical records whose responsibilities include, but are not limited to:

- The confidentiality, security and physical safety of records;
- The timely retrieval of individual records upon request;
- The unique identification of each member's record,
- The supervision of the collection, processing, maintenance, storage, retrieval and distribution of records; and
- The maintenance of a predetermined, secured and organized record format.

#### **Requirements and Guidelines**

All contracted providers must have clinical records policies and procedures that address, but are not limited to, the following: retention of active records; retirement of inactive records; timely entry of data in records; and release of information contained in records.

Medical record requirements and guidelines are as follows:

- Medical records must be maintained and stored in such a manor that safeguards member confidentiality in accordance with HIPAA state and

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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 in accordance with Section 384.30, FS.

- Providers must retain all patients' medical records for the following time frames:
  - **Medicaid**: 5 years
  - **Medicare**: 10 years
- Make the medical records available for quality care review studies by Plan reviewers, authorized representatives of the Agency for Health Care Administration (AHCA), the Department of Health and Human Services (DHHS), Department of Financial Services, Centers for Medicare & Medicaid Services (CMS), Plan member and organizations conducting accreditation audits.
- Make clinical information relevant to a member readily available to authorized health care professionals anytime the organization is open to members.
- Comply with Corrective Action Plan requirements imposed as the result of any such review or audit.
- When a member changes his/her PCP, to provide without charge and in a timely manner, a copy of a transferring member's medical record to the new PCP.
- Any notation in a member's medical record indicating diagnostic or therapeutic intervention as part of clinical research is clearly contrasted with entries regarding the provision of non-researched related care (this requirement does not hold WellCare responsible for the payment of therapeutic intervention as part of clinical research).

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**Content  
and Review**

The following information applies to medical records for Medicaid, Medicare and Healthy Kids members.

An individual medical record must be kept for each member and the record must contain the following when applicable:

(Ref. 1, 6)

- 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, 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 patient's name and identification number on each page of the medical record.
- The following personal and biographical data must be included in the record: date of birth, gender, emergency contact and legal guardianship. This may include: marital status, name of spouse, next of kin or closest relative, address, employer, telephone numbers, insurance information and family history.
- Medication allergies or "no known allergies" and untoward reactions to drugs and materials, are prominently noted in the record. This may include a sticker inside of the chart or prominent notation in a conspicuous place in the record.
- Allergies or "no known allergies" must be verified at each patient encounter and updated whenever new allergies or sensitivities are identified.

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- Medical records from the previous provider have been obtained and are easily accessible.
  - 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.
  - A list of significant illnesses and medical conditions.
  - Diagnoses that are consistent with findings.
  - Treatment plans that are consistent with diagnoses.
  - An immunization record is on 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 or referrals if needed, and follow-up is documented.
  - There is documentation of screening for domestic violence with appropriate counseling or 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 have to have Advance Directives completed. A signed statement that they have been asked and if not, do they want Advance Directives 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 in accordance with Section 765.110, F.S. (20 years and older)

- 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.

**Continuity  
of Care  
Requirements  
Screen**

The medical record must show the physician'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 physicians 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 are summaries or records of health care services provided for a member treated elsewhere (such as by another physician, hospital, ambulatory surgical service, nursing home or consultant).

- 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.
- Complex and lengthy clinical records of members include a documented summary of past surgical procedures as well as past and current diagnoses or problems to facilitate the ongoing provision of care.

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/clinical findings of the practitioner, diagnosis or medical impression are documented for each visit.
- Plan of treatment, referrals, disposition, diagnostic testing, studies ordered, care rendered/therapies administered and prescribed regimens are documented for each visit as indicated.
- There is documentation of follow-up plans for abnormal testing or 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, recommendations and instruction whether verbal, written or via telephone given to the member. The member is provided with verbal and/or written education/recommendations/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).
- All entries must include the disposition, recommendations, instructions to the patient,

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evidence of whether there was follow up and outcome of services.

### **Medical Record Documentation**

The physician's medical records should be available for utilization and quality review studies as well as readily available to authorized health care professionals anytime the organization is open to members. Implementing the following documentation requirements can reduce practice risks:

1. **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.
2. **Clearly document follow-up instructions.**  
This includes activity limitations, medications, referrals to specialists, further testing and subsequent appointments. Make sure patients understand instructions given.
3. **Obtain and document informed refusal.**  
Inform patients of adverse outcomes and consequences of not undergoing recommended tests or procedures.
4. **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 diseases or conditions and any acute problems being followed. Columns for date and for problem identification and resolution should be included.
5. **Document all telephone calls from the patient and response 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 diagnosis made.

**6. A follow-up or 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 re-check conditions as indicated by the physician, 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 physician should initial all test results to show verification of review.

**7. 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.

**8. The content of and format of the medical records, including the sequence of information, are uniform.**

Records are organized in a consistent manner that facilitates continuity of care. Any abbreviations and dose designations must be standardized.

**9. Always document discussions with patients concerning the necessity, appropriateness and risks of proposed surgery, as well as alternative treatment alternatives.**

**10. 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.
- Record details of informed consent discussions.

All participating Primary Care Physicians (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 care review studies by the Plan, authorized representatives of AHCA, DHHS, DFS, CMS, accreditation agencies and should comply with requirements issued as a result any such review or audit.

**Medical Record Review Audits**

- Medical Record Content
- Continuity of Care
- Pediatric Health Screening
- Adult Health Screening

**Diagnosis Specific Audits**

- Maternity Care Review (OB/GYN only)
- Hypertension Review
- Diabetes Review
- Chronic Pulmonary Disease/Asthma Review
- Review of Cholesterol Management After Acute Cardiovascular Events

**Maternity Care  
(OB/GYN  
Review)**

Medical record requirements and guidelines.

- Pre-term delivery risk assessment is rendered by the 28<sup>th</sup> 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 and Hematocrit (H & H)
- Urinalysis
- Blood typing and anti-body screening
- Rubella anti-body titer
- Syphilis screening
- HBsAG screening
- Pap smear
- 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 and Hematocrit (H & H)
- Urinalysis
- Alpha-fetoprotein (between 15-20 weeks)
- Diabetes screening/GTT (between 24-28 weeks)
- Repeat anti-body test for unsensitized RH negative patients (28 weeks)
- 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 and Hematocrit (H & H)
- Urinalysis
- Testing for STDs and HBsAg for high-risk members

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- 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.
  - Nutritional assessment and counseling for all pregnant members that includes:
    - promotion of breastfeeding and the use of breast milk substitutes to ensure the provision of safe and adequate nutrition for infants.
    - Offering a mid-level nutrition assessment.
    - Providing individual diet counseling and a nutrition care plan by a public health nutritionist.
    - A nurse or physician following the nutrition assessment
    - Ensuring documentation of the nutrition care plan in the medical record by the person providing counseling.
  - 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 - **Required for Medicaid.**
  - HIV testing/counseling is offered at the initial prenatal care visit and again at 28 weeks and 32 weeks.
    - The provider will attempt to obtain a signed objection if a pregnant women declines an HIV test and keeps this signed objection in the medical record.

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- All HIV infected women are counseled about and offered the latest antiretroviral regimen recommended by the U.S. Department of Health & Human Services (Public Health Service Task Force Report entitled Recommendations for the Use of Antiretroviral Drugs in Pregnant HIV-1 Infected Women for Maternal Health and Interventions to Reduce Perinatal HIV-1 Transmission in the United States.-

***Required for Medicaid.***

- Screening for Hepatitis B
  - Providers must screen all pregnant members during their first prenatal visit for Hepatitis B and again between 28 and 32 weeks for members who test negative and are considered high-risk for Hepatitis B.
  - All HBsAG-positive women are to be reported to the local county health department and to Healthy Start, regardless of the Healthy Start Screening score.
- Healthy Start Prenatal Screening-referral to CPHU, if high risk –  
***Required for Medicaid.***
- **Healthy Start** pregnant women will receive a prenatal risk screening as part of their first prenatal visit. Providers will use the DOH Prenatal Risk form (DH 3134 form), retain a copy in the medical record and forward a copy within 10 business days, to the county health department, where the screening was performed. Providers will maintain documentation of Healthy Start screenings, assessments, findings and referrals in the enrollee's medical record. A copy of the prenatal risk screening will also be provided to the member.
- **Healthy Start** Infant (Postnatal) Risk Screening Instrument (form DH 3135) is to be completed with the certificate of live birth and submitted to the county health department in the county

where the child was born within 10 business days of the birth. The Provider must retain a copy in the member's medical record and provides a copy to the member.

- Pregnant enrollees or infants who do not score high enough to be eligible for Healthy Start care coordination may be referred for services, regardless of their score on the Healthy Start screen, in the following ways:
  - If the referral is to be made at the same time the Healthy Start risk screen is administered, the provider may indicate on the risk screening form that the enrollee or infant is invited to participate based on factors other than score
  - If the determination is made subsequent to risk screening, the provider may refer the enrollee or infant directly to the Healthy Start care coordinator based on assessment of actual or potential factors associated with high risk, such as HIV, Hepatitis B, substance abuse or domestic violence.
- Providers refer all pregnant, breastfeeding and postpartum women to the local WIC office.
  - Providers provide a completed Florida WIC program medical referral form with the current height or length and weight (taken within 60 calendar days of the WIC appointment).
  - Hemoglobin or hematocrit
  - Any identified medical/nutritional problems.
  - Give a copy of the completed form to the member.
  - Retain a copy of the completed form in the member's medical record.
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**Pediatric Health**

This applies to Medicaid and Healthy Kids members.  
(Ref. 1, 5, 6)

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**Screening**

Child Health Check-ups, ages 0 to 20 years, are to provide comprehensive, preventive, well child care on a regularly scheduled basis; and to ensure entry into the health care system.

**Child Health Check-up Periodicity Schedule: (Ref. 2)**

- Birth or neonatal examination
- 1 month
- 2 months
- 4 months
- 6 months
- 9 months
- 12 months
- 15 months
- 18 months
- Once per year for 2-year-olds through 20-year-olds

The child may enter the periodicity schedule at any time. For example, if a child has an initial screening at age 4, then the next periodic screening is performed at age 5.

A member should have an initial health screening within 90 days of entering the plan or if the member has changed to a new PCP. The medical record must contain documentation of a comprehensive health history, in addition 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 as appropriate for the child's age and health history should be addressed:

- Skin
- Head
- Eyes, ears, nose, mouth, throat, teeth, gums
- Nodes
- Blood pressure beginning at 3 years and as indicated
- Heart and femoral pulses
- Pulse and respiration
- Lungs
- Abdomen
- External genitalia
- Pelvic examination on all sexually active females and if not sexually active, may wish to consider

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beginning at age 18 (provider may wish to refer female recipients for this service)

- Hip abduction
- Gait
- Extremities
- Spine
- Neurological evaluation

***There must be assessment of past medical history, developmental history and behavioral health status. 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.

**For adolescents:** focus on areas of special concern, such as potential learning disabilities, peer relations, psychological, psychiatric problems and vocational skills.

Referrals to Florida Diagnostic and Learning Resources System should be made for Medicaid members, if applicable.

1. Vision screening: Vision status is assessed and the findings are documented in the medical record at each Child 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
- 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.
- Ages 4 and 5 years 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 3 years  
Objective vision testing at a minimum when the child is the following ages:

3 years*	10 years
4 years*	12 years
5 years*	15 years
6 years	18 years
8 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.

2. 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. The provider must refer children who are 3 years and older (or a younger child if medically necessary) 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 months, or more frequently as prescribed by a dentist. A formal written referral to a dentist from the PCP is not necessary. Documentation of recommendation to see a dentist is sufficient.

3. Hearing screening: Hearing is assessed and the findings are documented in the medical record at each Child Health Check-up.

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 years
5 years*	12 years
6 years	15 years
8 years	18 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.

4. Nutritional assessment: Nutritional status is assessed and the findings are documented in the medical record at each Child Health Check-up.

This includes height and weight (measured and plotted on standard chart), head circumference if 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 95<sup>th</sup> percentile, weight for height variation from expected growth parameters, height below 5<sup>th</sup> 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).

5. A Lead Risk Assessment is done at each screening between ages 6 months to 72 months and blood lead testing is done as noted below.

- Documented verbal or written assessment for risk from ages 6 to 72 months. Lead blood levels if the member is deemed to be at high risk.
- **Medicaid:** Recommended that providers use a verbal lead risk assessment to assess risk on children who are 6 months to 6 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 36 and 72 months who have not been previously screened for lead poisoning. Lead blood levels if the member is deemed to be at high risk at the time the risk is identified.

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 current Centers for Disease Control and Prevention (CDC) guidelines covering patient management and treatment, including follow up blood tests and initiating investigations as to the source of lead where indicated.

6. 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.

- 9-12 months (consider earlier for children at high risk)
- 13 years
- All menstruating adolescents should be screened annually
- When medically indicated

7. Annual Tuberculosis (TB) skin testing is done if the

member is in a high-risk category. (Ref. 15)

Only those children locally identified at high risk for TB disease should be recommended for testing. Results of tuberculosis testing should be documented in the child'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.
8. A urinalysis is done if indicated. Urinalysis is recommended for children at ages 5 and 16 and as indicated. Performing urine dipstick urinalysis for leukocytes is recommended annually for sexually active male and female adolescents.
9. Serum cholesterol screening is done if indicated. A serum cholesterol determination is recommended on children with a family history of familial hyperlipidemia.

10. Immunizations are 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 Child Health Check-Up.
11. Health education, anticipatory guidance and counseling are provided to the parent or guardian and child at each Child Health Check-up.

**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.

12. 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.
13. Providers refer all infants, children up to age 5, and pregnant, breastfeeding and postpartum women to the local WIC office.
  - a. Providers provide a completed Florida WIC program medical referral form with the current height or length and weight (taken within 60 calendar days of the QIC appointment).
  - b. Hemoglobin or hematocrit
  - c. Any identified medical/nutritional problems.
  - d. For subsequent WIC certifications the provider coordinates with the local WIC office to provide the above referral data form the most recent child health check-up.
  - e. For each WIC referral the provider gives a copy of the form to the member and keeps a copy in the member's medical record.

**Adult Health Screening**

An adult health screening is performed by a physician to assess the health status of a member age 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. (Ref. 1, 6, 7, 8)

**Adult Health Screening Periodicity Schedule**

Recommended periodicity (one screening allowed every 365 days):

- Ages 19 through 39, one screening every one to three years (annual Pap smears are indicated for females unless three consecutive normal smears, allowing Pap smears every three years)
- Ages 40 through 64, one screening every one to two years
- Ages 65 and over, one screening every year
  - There is documentation of an initial health screening performed 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.
  - There is documentation of a physical examination.
  - 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.

- Tuberculosis (TB) skin testing is done if the member is in a high-risk category and documents the results in the member's medical record. (Ref. 11)

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. (Ref. 11)

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 2<sup>nd</sup> or 3<sup>rd</sup> trimester of pregnancy during the influenza season.

- Pneumococcal vaccination is documented for members 65 years of age or older or for younger members with high-risk medical conditions.

(Ref. 11)

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. (Ref. 12)

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 age 20 and over. 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 greater than or equal to 40 mg/dL and total cholesterol is less than 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 coronary artery disease (CAD) or prior cardiac event
- Cigarette smoking
- Hypertension (BP greater than or equal to 140/90 mmHg or on antihypertensive medication)
- Low HDL cholesterol (less than 40 mg/dL)

- Family history of premature coronary heart disease (CHD) (CHD in male first degree relative less than 55 years;
- CHD in female first degree relative less than 65 years)
- Age (men greater than 45 years; women greater than 55 years)
- Colorectal cancer screening is documented (Ref. 3)

Beginning at age 50, both men and women should follow one of these five testing schedules:

1. Yearly fecal occult blood test (FOBT).  
The take-home multiple sample method should be used.
2. Flexible sigmoidoscopy every five years
3. 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).
4. Double-contrast barium enema every five years
5. Colonoscopy every 10 years.

All positive tests should be followed up with colonoscopy. People should begin colorectal cancer screening earlier and/or 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;

- 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 urine;
- Hemoglobin and Hematocrit (H&H) testing is done.

Mammogram is done as indicated. (Ref. 3)

- Yearly mammograms starting at age 40 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 every year for women 40 and over.

Pap test as appropriate. (Ref. 3)

- All women should begin cervical cancer screening about three years after they begin having vaginal intercourse, but no later than when they are 21 years old. Screening should be done every year with the regular Pap test. Beginning at age 30, women who have had three normal Pap test results in a row may get 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 last 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 the surgery was done as a treatment for cervical cancer or precancer. Women who have had a hysterectomy without removal of the cervix should continue to follow the guidelines above.

Baseline screening for osteoporosis. The U.S. Preventive Services Task Force (USPSTF) recommends that women aged 65 and older be screened routinely for osteoporosis. The USPSTF recommends that routine screening begin at age 60 for women at increased risk for osteoporotic fractures.

The following are risk factors for osteoporotic fracture:

- Body habitus (weight less than 127 pounds; or body mass index [BMI] less than 20);
- Caucasian or Asian race;
- Family history of osteoporosis;
- Hypogonadism (estrogen deficiency);
- Sedentary lifestyle;
- Smoking (greater than or equal to one pack per day);
- Excessive alcohol intake (greater than two drinks per day);
- Diet deficient in calcium or vitamin D without adequate supplementation;
- Increased likelihood of falling.

**Hypertension-Specific Screens**

*High blood pressure* is defined as systolic blood pressure (SBP) greater than or equal to 140 mmHg or diastolic blood pressure (DBP) greater than or equal to 90 mmHg or taking antihypertensive medication.

The classification is based on the average of two seated readings, five minutes apart. Confirm elevated reading in contralateral arm.

The member with hypertension will receive an appropriate assessment and intervention as indicated and as evidenced by having the following assessments on each visit.

- A blood pressure reading is taken and documented.
- Weight is checked and documented.
- There is evidence of control of the member's blood pressure through pharmacological or dietary intervention.
- There is evidence of education related to medication, diet, lifestyle changes, alcohol/drug use, smoking, weight reduction, regular exercise program and stress reduction as appropriate.
- There is evidence of blood pressure control indicated by the most recent blood pressure reading being less than 140/90mmHg or BP less than 130/80 mmHg in patients with diabetes or chronic kidney disease.
- Follow-up visits are done according to the recommended timeframe based on initial blood pressure measurements.

Follow-up and monitoring should occur as follows:

- Once antihypertensive drug therapy is initiated, most patients should return for follow-up and adjustment of medications at approximately monthly intervals until the BP goal is reached.
- More frequent visits will be necessary for patients with stage 1 hypertension or with complicating co-morbid conditions.
- Serum potassium and creatinine should be monitored at least one to two times per year.

- After BP is at goal and stable, follow-up visits can usually be at three to six month intervals.
- Co-morbidities, such as heart failure, associated diseases such as diabetes and the need for laboratory tests influence the frequency of visits. Other cardiovascular risk factors should be treated to their respective goals and tobacco avoidance should be promoted vigorously. Low-dose aspirin therapy should be considered only when BP is controlled, because the risk of hemorrhagic stroke is increased in patients with uncontrolled hypertension. (Ref. 13)

**Diabetes-Specific Screens**

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

- Fasting Plasma Glucose of greater than or equal to 126 mg/dL. *Fasting* is defined as no caloric intake for eight hours.
  - 2-hour Plasma Glucose greater than or equal to 200 mg/dL during OGTT (Oral Glucose Tolerance Test).
  - On oral or parenteral medication or dietary restrictions to treat Diabetes Mellitus.
1. There is evidence of 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.
  2. 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.

3. A1C testing (glycosylated hemoglobin) quarterly if a change in treatment has occurred or if patient is not meeting goals of therapy. Twice per year if stable.
4. The member's A1C level is less than or equal to 7.0 percent.

ADA 2003 Position Statement: "Develop or adjust the management plan to achieve normal or near-normal glycemia with an A1C test goal of less than or equal to 7 percent."

5. The member will receive Lipid Profile testing at least once per year with the results documented in the medical record.
6. The member's LDL level is less than 100mg/dL.

ADA 2003 Position Statement: "Lower LDL Cholesterol to less than 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

7. A dilated eye examination was performed within the last year with the results documented in the medical record.
8. 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., 4-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 angiotensin converting enzyme inhibitor (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy and blood pressure control. Many experts, however, recommend continued surveillance to assess both response to therapy and progression of disease.

9. A comprehensive foot exam is performed at every office visit. Foot exam includes sensation, structure and biomechanics, vascular status and skin integrity. (Ref. 4)

**Chronic  
Pulmonary  
Disease/Asthma**

The 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, which 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 attempt to control the member's disease process as evidenced by ongoing assessments beyond the acute phase of illness.
- There is evidence of member education related to disease process and self-management.

*For diagnosis of asthma only:*

- There is evidence of management of the member's disease process through the use of long-acting therapies. (Ref. 14)

**Cholesterol Management After Acute Cardiovascular Events**

Applies only to those members identified within the previous year as having had a hospital admission for the following:

- Acute Myocardial Infarction;
- Coronary Artery Bypass Surgery; or
- PTCA (Angioplasty)
  
- There is evidence of LDL-C screening within 60-365 days after discharge from the hospital.
  
- The LDL-C screening performed within 60-365 days after discharge from the hospital was less than 100 mg/dL.

For members post AMI only:

- An ambulatory prescription for a beta blocker is given to the member—unless there is a contraindication. (Ref. 10)

**Review Criteria**

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 Medicaid handbook, regulatory contracts, accreditation guidelines and accepted national organizations. They are subject to change based on nationally recognized clinical practice guidelines.

Reviews in a physician office may conclude with an Exit Review, to include the physician and designated office staff. The physician will be given the results of the review along with a plan of correction requested for any deficiencies. Any area that is not compliant with regulatory standards will require a Plan of Correction.

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**Plan of Correction**

The Plan of Correction (POC) will be given to the physician at the time of the Exit Review. The POC is executed by the physician and faxed or mailed at that time or within 10 days of the review.

In the event a POC is not received in the stated time frame a second request will be sent to the physician. In the event a POC is not received after the second request, a final request will be sent to the physician informing him/her that new member assignments will be deferred until which time the signed POC is received.

Re-credentialing will not occur with any outstanding POCs until they are signed and returned.

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5. Florida Medicaid Child Health Check-Up Coverage and Limitations Handbook  
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11. Recommended Adult Immunization Schedule United States 2007, Department of Health and Human Services, Centers for Disease Control and Prevention  
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Web site: <http://rover.nhlbi.nih.gov/guidelines/hypertension/index.htm>
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Web site: <http://rover.nhlbi.nih.gov/about/naepp>

15. Centers for Disease Control and Prevention (CDC)

Web site: <http://www.cdc.gov>

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

17. Resource for Advance Directives (AHCA Web site)

[http://www.fdhc.state.fl.us/MCHQ/HealthFacilityRegulation/HC\\_Advance\\_Directives](http://www.fdhc.state.fl.us/MCHQ/HealthFacilityRegulation/HC_Advance_Directives)

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