

Policy Name:	Quality Site Visit Standards	
Policy Number:	Quality Improvement – 1	
Effective Date:	1/1/01	
Revision Date:	1/1/08	Review Date:

Approval

Signature: 

Medical Director

HMOI, BA HMO, BlueChoice, BlueChoice Select, PPO

Approved QI: 3/5/08

Approved P&P: 1/24/08

Policy:

The Managed Care Products of Blue Cross and Blue Shield of Illinois (BCBSIL) onsite audit staff will adhere to Quality Site Visit Standards when conducting quality onsite site visit audits for participating Primary Care Physicians (PCPs) (for HMO Illinois, BlueAdvantage HMO and BlueChoice) and high volume Behavioral Health Practitioners (for HMO Illinois and BlueAdvantage HMO only). Quality site visit audits are performed for PCPs at the time of initial credentialing into the Network. **Effective 7/1/2008, quality site visits for HMO PCPs will NOT be performed at the time of initial credentialing. Quality site visit audits will be performed for BlueChoice PCPs that are not in the HMO, at the time of initial credentialing into the Network. Quality site visits are performed for all HMO PCPs every two years to comply with Illinois Department of Public Health requirements. Effective 7/1/08, a site visit review and/ or medical record review will be performed when the HMO receives a member complaint.**

High volume Behavioral Health practitioners (those practitioners who see greater than unique 25 patients per year) are determined on a biennial basis through IPA reporting of unique patient visits for each Behavioral Health specialist.

Purpose:

To audit managed care practitioners against established Quality Site Visit standards including information related to the following:

- Accessibility;
- Facility Inspection;
- Emergency Preparedness;
- Medical Record Review; and
- Preventive Services. (Not audited for Behavioral Health)

Procedure:

A. BCBSIL auditors will schedule a visit with the provider office, send a copy of the onsite standards by which the practitioner will be evaluated and conduct an inspection of the facility which includes, but is not limited to:

1. Member's ability to access health care.
2. Inspection of facility including a patient examination room to evaluate compliance with standards.
3. Medical record review of **five** charts per PCP to evaluate compliance with medical record standards and preventive care.

I. ACCESSIBILITY STANDARDS

Purpose:

- To evaluate whether members have appropriate access to medical services.

Procedure:

- A. BCBSIL has specific service expectations for participating Managed Care Practitioners. They are as follows:
1. **Physician** response to an emergency call within 30 minutes.
 2. Schedule urgent visits within 24 hours.
 3. Schedule routine appointments within 10 business days or two weeks of request, whichever is sooner.
 4. Schedule extended visits (i.e., comprehensive exam, preventive care appointment, etc.) within four weeks of request.
 5. Schedule non-urgent, symptomatic visits within four calendar days.
 6. Arrange for an answering system after office hours that members can access through the usual office protocol:
 - ⇒ Response to emergency phone calls should be within 30 minutes.

II. FACILITY REVIEW STANDARDS

Purpose:

- To assess whether members have appropriate access to healthcare services in a clean and safe environment.

Procedure:

1. Environment:

- The facility should be clean and well organized to accommodate patient services.
- Restrooms, doorways and hallways should be easily accessible.
- The waiting room should have adequate seating for the volume of patients.
- There should be adequate exam rooms for the number of practitioners.
- The facility should be accessible to those with disabilities:
 - There should be at least one entrance to the office that is accessible to those with impaired mobility or those in a wheel chair.
 - There should be at least one exam room that can be accessed by doorways and hallways that are at least 36 inches wide.
 - There should be at least one restroom that can be accessed by doorways and hallways that are at least 36 inches wide.

2. Safety Measures:

- The Practitioner and his/her staff should follow the Center for Disease Control Universal Precaution guidelines when providing patient care.
- Bio-hazardous waste must be discarded according to OSHA guidelines.

- Sharp disposal containers must be available.
- Fire Extinguisher must be accessible.

3. Lab Specimens and Medication Maintenance/Storage:

- Sample drugs, over-the-counter medications, prescription drugs, and vaccines should be stored in restricted patient areas.*
- Controlled substances, if present, should be stored in a locked area along with an inventory list.
- All medications should be routinely monitored for expiration dates.
- Medication and/or lab refrigerators should be free of food. (Medications and lab specimens may be stored in the same refrigerator if stored in separate areas).

4. Medical Supply Maintenance/Storage:

- Sharps should be stored in restricted patient areas.*
- Prescription pads should be stored in restricted patient areas. *

5. Medical Record System:

- Medical records should be handled in a confidential manner. The office **MUST** have a written policy that addresses **Health Insurance Portability and Accountability Act (HIPAA)** requirements regarding Protected Health Information (PHI).
- The Practitioner should have a written policy/procedure detailing how medical record information is to be released.

6. Patient Education:

- Educational materials or literature regarding at least three preventive services and at least two medical conditions relevant to the practitioner's practice must be available for patient use. Examples of preventive materials might be: information about breast self-exam, mammography, Pap smears, pediatric immunizations, coronary risk reduction, or prostate screening. Materials about conditions relevant to the practitioner's practice could cover topics such as asthma management, diabetes management, management of abnormal Pap smears, and pregnancy care.

*Restricted Patient Area – a separate storage space away from the patient care area or a locked receptacle within the patient care area.

III. EMERGENCY PREPAREDNESS

Procedure:

1. Emergency Preparedness

--- The Practitioner should have a written procedure on how to handle a medical emergency for members accessing care at his/her facility. This procedure must be posted in a prominent location or easily accessible through a central file/manual.

--- At least one staff member who has Cardiopulmonary Resuscitation (CPR) Certification should be available during patient care hours. This certification must be kept current and documentation of certification must be available for verification upon request. A valid CPR card will be accepted via fax within one week of the onsite visit

IV. MEDICAL RECORD REVIEW

Purpose:

BCBSIL requires member medical records to be maintained in a manner that is current, detailed, organized, and easily accessible. All patient data should be filed in the medical record, (i.e., lab, x-ray, consultation notes, etc.) Documentation of a member's care should facilitate communication, coordination and continuity of care and promote efficiency and effectiveness of treatment.

Procedure:

- 1. Past Medical History:** There should be documentation of a past medical history obtained by the third visit or within one year of the first visit, whichever comes first. The medical history should be updated at least every three years for adults and every five years for pediatric patients.
- 2. Family History:** There should be documentation of a family medical history obtained by the third visit or within one year of the first visit, whichever comes first. The family medical history should be updated at least every three years for adults and every five years for pediatric patients.
- 3. Social History:** There should be documentation of a social history (including, but not limited to, information about family and occupation, and the assessment of cigarette and alcohol use and/or substance abuse) obtained by the third visit or within one year of first visit, whichever comes first. For Pediatric patients, the developmental milestones may be included. The social history should be updated at least every three years for adults and every five years for pediatric patients.
- 4. Physical Activity Assessment/Counseling:** There should be documentation of assessment and/or counseling regarding physical activity obtained by the third visit or within one year of the first visit, whichever comes first. The physical activity assessment/counseling should be updated at least every three years.
- 5. Adult Alcohol Use:** There should be documentation **regarding** alcohol use obtained by the third visit or within one year of the first visit, whichever comes first, for adults age 18 and over. If the member is currently using alcohol, it should be noted. The history of alcohol use should be updated at least every three years.
- 6. Adolescent Alcohol Use:** There should be documentation **regarding** alcohol use obtained by the third visit or within one year of the first visit, whichever comes first, for adolescents age 12-17. If the adolescent is currently using alcohol, it should be noted. The history of alcohol use should be updated every three years. **
- 7. Adult Inappropriate/ Illicit Drug Use:** There should be documentation **regarding** inappropriate/ illicit drug use obtained by the third visit or within one year of the first visit, whichever comes first, for adults age 18 and over. If the member is currently using illicit drugs, it should be noted. The history of drug use should be updated every three years.

- 8. Adolescent Inappropriate/Illicit Drug Use:** There should be documentation *regarding* inappropriate/ illicit drug use obtained by the third visit or within one year of the first visit, whichever comes first, for adolescents age 12-17. If the member is currently using illicit drugs, it should be noted. The history of drug use should be updated at least every three years. **
- 9. Smoking History for Adults:** There should be documentation of a smoking history obtained by the third visit or within one year of the first visit, whichever comes first, on adults age 18 and over. If the member is currently smoking, it should be noted. The smoking history should be updated every three years.
- 10. Recommendation for Smoking Cessation for Adults:** Instructions and/or education about smoking cessation should be provided to members age 18 and over who are identified as smokers. The recommendation should be made by the third visit or within one year of the first visit, whichever comes first.
- 11. Smoking History for Adolescents:** There should be documentation of a smoking history obtained by the third visit or within one year of first visit, whichever comes first, on adolescents age 12-17. The smoking history should be updated at least every three years. **
- 12. Recommendation for Smoking Cessation for Adolescents:** Instructions and/or education about smoking cessation should be provided to members age 12-17 who are identified as smokers. The recommendation should be made by the third visit or within one year of the first visit whichever comes first. **
- 13. Coordination Between Medical and Behavioral Health Care:** If the member is seeing a Behavioral Health Specialist, there should be documentation of communication between the Behavioral Health Specialist and the referring physician. Documentation should include, but not be limited to, follow-up regarding coexisting medical and behavioral disorders and medication management. If the member refuses to allow such communication, this should be documented.
- 14. Immunization Documentation:** Documentation of immunizations administered by the Office should include the date the vaccine was administered, the manufacturer and lot number, and the name and title of the person administering the vaccine.
- 15. Chief Complaint/History Relevant to Problem:** Subjective information identifying why the patient is seeking medical attention should be documented. The description should include pertinent history, symptoms, and other related information.
- 16. Physical Examination:** A pertinent physical examination, relevant to the problem, should be documented.
- 17. Vital Signs:** Vital signs, consistent with the patient's chief complaint, relevant problem and/or diagnosis, should be documented.
- 18. Diagnosis/Assessment:** A diagnosis and/or assessment, consistent with the findings, should be documented.
- 19. Treatment Plan/Plan of care:** A plan of diagnosis (lab testing, x-rays, etc.) and management (medication dose, frequency, and duration, as well as other interventions), consistent with the assessment, should be documented.

20. **Previous Problems:** Unresolved problems and/or chronic problems from previous office visits should be addressed in subsequent visits.
21. **Continuity of Care, Follow-Up Care, Calls or Visits:** Follow-up care, communication of test results, calls/visits should be documented to indicate continuity of care.
22. **Consultations:** Documentation of response/feedback from a referral for consultation to a specialist should be present in the record and should be signed/initialed by the practitioner and/or there should be a notation in the progress notes indicating that the feedback from the specialist has been reviewed.
23. **Chart Organization:** The Practitioner should maintain a uniform medical record system of clinical recording and reporting with respect to services which includes separate sections for progress notes and the results of diagnostic tests.
24. **Biographical Information:** Each medical record should contain the patient's address, employer, home and work telephone numbers including emergency contacts, marital or legal status, appropriate consent forms and guardianship information, if relevant. ***Biographical information should be updated at least every three years.*****
25. **Patient Identifiers:** Patient identifiers should appear on each page of the medical record (patient name or unique ID number).
26. **Date and Signature:** All entries are to be dated and signed/initialed by the author. Author identification may be a handwritten signature, unique electronic identifier or initials.
27. **Legibility:** All entries should be legible.
28. **Allergy Status:** Medication allergies should be noted in a prominent location in the medical record. If the member has no known allergies or history of adverse reactions, this should be prominently noted. Allergies to environmental allergens, food, pets, etc., should also be noted. Allergy histories should be obtained every three years for adults and every five years for pediatric patients.
29. **Problem List:** There should be a current problem list, either kept separately or within each practitioner progress note, which includes significant illnesses and medical conditions. A health maintenance record should be present if there are no documented relevant problems. The problem list must be inclusive of all problems whether a separate list or within each practitioners note.
30. **Medication List:** There should be a current medication list, either kept separately or within each practitioner progress note. The medication list must be inclusive of all medications, whether a separate list or within each Practitioner progress note, and include prescription initial or refill dates.
31. **Lab/X-Ray/Diagnostic Results:** The results of all labs, x-rays and diagnostic testing, should be posted in the chart. The reports should be signed or initialed by the practitioner and/or there should be a notation in the progress notes indicating that they have been reviewed.

** This standard will not be included in the scoring results.

V. PREVENTIVE SERVICES

Purpose:

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

Procedure:

- BCBSIL has specific Preventive Health Care Guidelines. Practitioners should provide services in accordance to these guidelines. The offer of services and the subsequent results or the member's refusal to accept services should be documented in the member's medical record. If the service was provided by another practitioner (example: OB/GYN), document in the medical record that the service was provided, with the date and the results. Preventive care services should be provided by the third visit or within one year of the first visit, whichever comes first. The date of service and results or findings should be documented in the medical record. The medical records will be reviewed for performance of the following preventive care services:

A. Adult Female:

1. **Non-fasting cholesterol** should be performed every five years on members over age 45. The medical record should document the date and results or findings. Only medical records for members age 46 and over will be audited for this measure.
2. **Pap Smear(s)** (Age 21-64) or within three years of becoming sexually active, should be performed annually until three consecutive tests are negative and then every one to three years. The medical record should document the date of Pap smear service and results or findings. Members who have had a hysterectomy with removal of the cervix may be excluded from screening, and should have the dated history of hysterectomy, documented in the medical record. Only medical records for members age 22-64 will be audited for this measure.
3. **Mammography** should be performed every one to two years for members age 40-69, and date of service and results or findings, should be documented in the medical record. Members who have had bilateral mastectomies should be excluded from screening, and should have the dated history of bilateral mastectomies documented in the medical record. ***Medical records for members age 42-69 will be audited for this measure.***
4. **Colorectal cancer screening** should be performed for members age 50 and over, by means of ONE of the following five screening options:
 - Fecal occult blood test within the past 12 months (FOBT performed during a physical exam on a specimen obtained from a digital rectal exam does not count, because it is not specific or comprehensive enough to screen for colorectal cancer.)
 - Flexible sigmoidoscopy within the past **five** years
 - Fecal occult blood annually plus flexible sigmoidoscopy within the past **five** years
 - Double-contrast barium enema within the past **five** years
 - Colonoscopy within the past 10 yearsOnly medical records for members age 52 and over will be audited for this measure. The chart must include the date, type of test and results.

5. **Influenza vaccinations** should be administered annually to members at high risk for complications from influenza and to those members age 65 and over. (The medical records audited will include adult members with asthma, diabetes, and **Cardiovascular Disease (CVD)** and members age 65 and over). Documentation of immunizations administered by the office should include the date the vaccine was administered, the manufacturer and lot number, and the name of the person administering the vaccine.

B. Adult Male:

1. **Non-fasting cholesterol** should be performed every five years on members over the age of 35. The medical record should document the date and results or findings. Only medical records for members age 36 and over will be audited for this measure.
2. **Colorectal cancer screening** should be performed for members age 50 and over, by means of ONE of the the following five screening options:
 - Fecal occult blood test within the past 12 months (FOBT performed during a physical exam on a specimen obtained from a digital rectal exam does not count, because it is not specific or comprehensive enough to screen for colorectal cancer.)
 - Flexible sigmoidoscopy within the past **five** years
 - Fecal occult blood annually plus flexible sigmoidoscopy within the past **five** years
 - Double-contrast barium enema within the past **five** years
 - Colonoscopy within the past 10 yearsOnly medical records for members age 52 and over will be audited for this measure. The chart must include the date, type of test and results.
3. **Influenza Vaccinations** should administered annually to members at high risk for complications from influenza and to those members age 65 and over. (The medical records audited will include adult members with asthma, diabetes, and **CVD** and members age 65 and over). Documentation of immunizations administered by the office should include the date the vaccine was administered, the manufacturer and lot number, and the name and title of the person administering the vaccine.

C. Children:

1. **Immunizations** should be performed according to the Preventive Healthcare Guidelines, which are based on the Recommended Childhood Immunization Schedule, United States, as approved by the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP).

Parent refusal of such services should be documented in the medical record. For members who have transferred from another practitioner, immunization records should be obtained and reviewed for completeness.

Documentation of immunizations administered by the office should include the date the vaccine was administered, the manufacturer and lot number, and the name and title of the person administering the vaccine.

All children between the ages of six months to five years will be audited.

The medical records will be audited and scored for immunizations due between the ages of one and two as identified in Table A. The immunizations audited are: DTaP, IPV, Hib, MMR, Varicella, and Pneumococcal.

Information will be collected for:

- A.) For children born between 1/1/03 and 12/31/06, the record will be reviewed for an influenza vaccination given between the dates 1/1/07 and 3/1/08.****
- B.) Records will be audited for 1 Hepatitis A given between one and two year of age.****

****Denoted non-scored item.**

TABLE A

Immunization	Birth	2 mo.	4 mo.	6 mo.	12 mo.	15 mo.	18 mo.	2yr.	4 – 6 yrs.
DTaP		X	X	X		Between 15-18 months			X
IPV		X	X		Between 6-18 months				X
Hib		X	X	(X)+	Between 12-15 months				
MMR					Between 12-15 months				X
Hepatitis B	X	X			Between 6-18 months				
Varicella					Between 12-15 months				
Rotavirus		X	X	X					
Hepatitis A					Two doses between 12 and 23 months				
Pneumococcal Conjugate (Prevnar)		X	X	X	Between 12-15 months				
Influenza					Annually age 6-59 months				

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

STANDARDS FOR BEHAVIORAL HEALTH PRACTITIONERS

I. ACCESSIBILITY

Purpose:

To evaluate whether members have appropriate access to Behavioral Health services.

Procedure:

BCBSIL has specific service expectations for participating Behavioral Health Care Practitioners. They are as follows:

- Provide and/or refer for life-threatening emergency care immediately
- Provide and/or refer for non-life-threatening emergency care within six hours.
- Schedule and provide urgent care within 24 hours.
- Schedule routine appointments within 10 business days or within **two** weeks of request, whichever is sooner. This includes initial evaluation.
- Arrange for an answering system after office hours that members can access through the usual office protocol:
 - ⇒ Response to emergency phone calls should be within 30 minutes.
 - ⇒ Response to urgent phone calls should be within one hour.
 - ⇒ For life-threatening emergencies, members should be referred to the appropriate Health Care Facility.
- Arrange for telephone access to screening and triage, if applicable, as follows:
 - ⇒ Callers reach a non-recorded voice within 30 seconds and
 - ⇒ Abandonment rates do not exceed five percent at any given time.

II. FACILITY REVIEW STANDARDS FOR BEHAVIORAL HEALTH

Purpose:

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

Procedure:

1. Environment:

- The facility should be clean and well organized to accommodate patient services.
 - Restrooms, doorways and hallways should be easily accessible.
 - The waiting room should have adequate seating for the volume of patients.
 - The facility should be accessible to those with disabilities:

- There should be at least one entrance to the office that is accessible to those with impaired mobility or those in a wheel chair.
- There should be at least one exam room that can be accessed by doorways and hallways that are at least 36 inches wide.
- There should be at least one restroom that can be accessed by doorways and hallways that are at least 36 inches wide.

2. Safety Measures:

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

3. Medication Maintenance/Storage:

- Sample drugs, over-the-counter medications, prescription drugs, and vaccines (if applicable) should be stored in restricted patient areas
- Controlled substances, if present, should be stored in a locked area along with an Inventory list.
- All medications should be routinely monitored for expiration dates

4. Medical Supply /Storage:

- Sharps should be stored in restricted patient areas* (if applicable)
- Prescription pads should be stored in restricted patient areas* (if applicable)

5. Medical Record System:

- Medical records should be handled in a confidential manner. The office **MUST** have a written policy that addresses HIPAA requirements regarding Protected Health Information (PHI).
- The Practitioner should have a written policy/procedure detailing how medical record information is to be released.

6. Patient Education:

- Educational materials or literature regarding at least two (mental health or chemical dependency related conditions) medical conditions relevant to the practitioner's practice must be available for patient use.

* *Restricted Patient Area – a separate storage space away from the patient care area or a locked receptacle within the patient care area.*

III. Medical Record Review for Behavioral Health Practitioners

Purpose:

Behavioral Health Practitioners will provide members reasonable access to appropriate medical services based on the level of need. To ensure that members have appropriate access to Behavioral Health services.

Procedure:

1. Past Medical History: There should be documentation of a past medical history obtained by the third visit or within one year of the first visit, whichever comes first. The medical history should be updated at least every three years for adults and every five years for pediatric patients.

2. Family History: There should be documentation of a family medical history obtained by the third visit or within one year of the first visit, whichever comes first. The family medical history should be updated at least every three years for adults and every five years for pediatric patients.

3. Social History: There should be documentation of a social history (including, but not limited to, information about family and occupation, obtained by the third visit or within one year of first visit, whichever comes first. For Pediatric patients, the developmental milestones may be included. The social history should be updated at least every three years for adults and every five years for pediatric patients.

4. Adult Alcohol Use: There should be documentation **regarding** alcohol use obtained by the third visit or within one year of the first visit, whichever comes first, for adults age 18 and over. If the member is currently using alcohol, it should be noted. The history of alcohol use should be updated at least every three years.

5. Adolescent Alcohol Use: There should be documentation **regarding** alcohol use obtained by the third visit or within one year of the first visit, whichever comes first, for adolescents age 12-17. If the adolescent is currently using alcohol, it should be noted. The history of alcohol use should be updated at least every three years.**

6. Adult Inappropriate/Illicit Drug Use: There should be documentation **regarding** inappropriate/ illicit drug use obtained by the third visit or within one year of the first visit, whichever comes first, for adults age 18 and over. If the member is currently using drugs, it should be noted. The history of drug use should be updated at least every three years.

7. Recommendation for Adult Inappropriate/Illicit Drug Use Treatment:
Instructions and/or education about recommendation for treatment should be provided to members who are identified as using illicit drugs. The recommendation should be made by the third visit or within one year of the first visit, whichever comes first.**

8. Adolescent Inappropriate/Illicit Drug Use: There should be documentation **regarding** inappropriate/ illicit drug use obtained by the third visit or within one year of the first visit, whichever comes first, for adolescents age 12-17. If the adolescent is currently using drugs, it should be noted. The history of drug use should be updated at least every three years.**

9. Recommendation for Adolescent Inappropriate/Illicit Drug Use Treatment:
Instructions and/or education about recommendation for treatment should be provided to members age 18 and over who are identified as using illicit drugs. The recommendation should be made by the third visit or within one year of the first visit, whichever comes first.**

- 10. Chief Complaint/History Relevant to Problem:** Subjective information identifying why the patient is seeking **BH services** should be documented. The description should include pertinent history, symptoms, and other related information including documentation of an assessment of suicidal ideation.
- 11. Diagnosis/Assessment:** A diagnosis and/or assessment, consistent with the findings, should be documented. Include documentation of a DSM_IV diagnosis.
- 12. Treatment Plan/Plan of care:** A plan of diagnosis (lab testing, x-rays, etc.) and management (medication dose, frequency, and duration, as well as other interventions), consistent with the assessment, should be documented. Document goals and estimated timeframes for goal attainment or problem resolution.
- 13. Previous Problems:** Unresolved problems from previous office visits should be addressed in subsequent visits.
- 14. Continuity of Care, Follow-Up care, Calls or Visits:** Follow-up care, communication of test results, calls or visits should be documented to indicate continuity of care.
- 15. Consultations:** Documentation of response/feedback from a referral for consultation to a specialist should be present in the record and should be signed or initialed by the practitioner and/or there should be a notation in the progress notes indicating that the feedback from the specialist has been reviewed.
- 16. Chart Organization:** The Practitioner should maintain a uniform medical record system of clinical recording and reporting with respect to services which includes separate sections for progress notes and the results of diagnostic tests.
- 17. Biographical Information:** Each medical record should contain the patient's address, employer, home and work telephone numbers including emergency contacts, marital or legal status, appropriate consent forms and guardianship information, if relevant.
- 18. Patient Identifiers:** Patient identifiers should appear on each page of the medical record (patient name or unique ID number).
- 19. Date and Signature:** All entries are to be dated and signed/initialed by the author. Author identification may be a handwritten signature, unique electronic identifier or initials. Include the responsible clinician's name, professional degree.
- 20. Legibility:** All entries should be legible.
- 21. Allergy Status:** Medication allergies should be noted in a prominent location in the medical record. If the member has no known allergies or history of adverse reactions, this should be prominently noted. Allergies to environmental allergens, food, pets, etc, should also be noted, as they can affect patient behavior. Allergy histories should be obtained by the first visit and updated at least every three years for adults and every five years for pediatric patients. (This will be scored only for those practitioners who prescribe medication).
- 22. Problem List:** There should be a current problem list, either kept separately or within each practitioner progress note. The problem list must be inclusive of all problems whether a separate list or within each practitioner progress note.

- 23. Medication List:** There should be a current medication list, either kept separately or within each Practitioner progress note. The medication list must be inclusive of all medications whether a separate list or within each Practitioner progress note, and include prescription initial or refill dates.
- 24. Lab/X-Ray/Diagnostic Results:** The results of all labs, x-rays and diagnostic testing, should be posted in the chart. The reports should be signed or initialed by the practitioner and/or there should be a notation in the progress notes indicating that they have been reviewed.
- 25. Coordination between Behavioral Health Care and Referring Practitioner:** There should be documentation of communication with a signed release of information form allowing for communication between the Behavioral Health Specialist and practitioner. Documentation should include, but not be limited to, follow-up regarding coexisting medical and behavioral disorders and education management. If the member refuses to allow such communication, this should be documented.

**MINIMUM SCORE TO PASS SITE VISIT
HMOs* of Blue Cross and Blue Shield of Illinois and BlueChoice**

Effective January 1, 2008

NEW HMO IPAs, BlueChoice Groups and PCPs

2008 Passing Thresholds

Standards Category	New/ Current HMO IPA or BlueChoice Group	New/ Current PCP (HMO & BlueChoice)
Accessibility, Facility, Emergency Care	90%	90%
Medical Record Review, Preventive	90%	90%

NOTE:

- Any practitioner failing to meet the minimum passing threshold requirement will be re-audited within **six** months.
- Any practitioner failing **three** consecutive site reviews may be departed from all Networks.