Chiropractic Care of Minnesota, Inc.

Policy Title:	Clinical Chart and Clinic Location Scoring Criteria		
Policy Number:	CRM-015	Effective Date:	05/12/2011
		Last Revision Date:	07/07/2011
		Last Review Date:	07/07/2011
Purpose:	Document the scoring process to be used to complete clinical chart reviews and/or on-site facility audits of credentialed providers		
Regulation Reference:	Consensus Credentialing Committee		

Policy: It is ChiroCare's policy that network providers' clinical charts or clinic locations are audited every three years. These audits are used to minimize the probability of events that have adverse effects and ensure ChiroCare's requirements are met on an ongoing basis. Review outcomes are determined according to the scoring values outlined below.

Each statement listed under Office Standards, Route Office Procedures, Availability and Advertising in the *Site Visit Checklist*, has been assessed a value score of 1-4. The same value system has been utilized to assess each statement listed under Required Documentation in the *Chart Review Checklist*.

A value of 1 is considered a minor infraction whereas a value of 4 is considered severe.

Site Visit and Chart Review outcome determination are defined as:

(1) PASS
   a. ALL criteria received a "pass" notation from reviewer.

(2) ATTESTATION
   a. Less than eight (8) criteria with value scores of 1 or 2 received a "fail" notation from reviewer - ***AND*** –
   b. NO criteria with value scores of 3 or 4 received a "fail" notation from reviewer.

(3) FAIL
   a. Eight (8) or more criteria with value scores of 1 or 2 received a "fail" notation from reviewer – ***OR*** –
   b. One (1) or more criteria with value scores of 3 or 4 received a "fail" notation from reviewer.

(4) TERM
   a. Patient safety or fraudulent billing practices were noted by reviewer. Reviewer must document, to the fullest extent possible, observations made during the visit / review.

Correction of Site Visit / Chart Review deficiencies:

Attestation Outcomes:

a. Provider must correct each noted deficiency and return the signed Attestation to ChiroCare that was sent along with the review findings letter within 60 days. The

signed Attestation serves as an agreement that the provider has been made aware of the deficiencies and has made the necessary changes to correct them.

b. Failure to meet the above criteria may result in suspension or termination of the Provider Agreement.

Fail Outcomes:

a. Provider must correct each noted deficiency and submit to ChiroCare, in writing, a detailed explanation of correction actions taken to address each item noted. All corrections must be made within 30 days of receipt of the review findings letter.
b. ChiroCare reserves the right to perform a follow-up site visit or chart review to verify implementation of corrective actions.
c. All documentation received from providers on "Fail" outcomes will be submitted to the Credentialing Committee for approval (see policy CRM-014).
d. Failure to meet the above criteria may result in suspension or termination of the Provider Agreement.

Term Outcomes:

a. Reviews that receive a Term recommendation from the reviewer will be submitted immediately to the Credentialing Committee for consideration in accordance with policy CRM-001.

Attachments:

A. Scoring for Site Visit Checklist
B. Scoring for Chart Review Checklist
C. Site Visit & Chart Review Decision Tree

Attachment A:

Chiropractic Care of Minnesota Inc.
Site Visit Checklist

Date: _____ Reviewer: _____

Name of Provider: _____ Name of Clinic: _____

Address: _____ Phone#: _____

ChiroCare#: _____

Office Standards

(2) □ Safe, clean environment for patients, visitors and staff.

(1) □ Professional appearance

(2) □ Seating in reception/waiting room (at least 3 chairs)

(3) □ Non-smoking

(4) □ At least one examination/treatment room

(1) □ Clearly marked office sign(s)

(2) □ Exam room: clean, neat a properly equipped.

(2) □ Meets HIPAA requirements

(3) □ At least one-full time equivalent staff person who is present during patient contact hours

(4) □ Cannot only offer open-bay treatment arrangements

(2) □ Appropriate hygienic measures

(4) □ If clinic is located in a private home, gym or health club, it is properly licenses and meets required standards.

(4) □ Can not be a mobile service vehicle

(1) □ One current portable fire extinguisher

(2) □ General liability insurance

(1) □ Rest room is clean, neat and available for patients

(2) □ Patient files/records protected

(1) □ Safe storage of nutritional supplements (e.g.: out of the reach of children).

(3) □ On average doesn't treat more than ten patients per hour

Availability

(2) □ Wait for non-emergency appointment is not more than five (5) days from the time a request for appointment until treatment is rendered

(2) □ Urgent needs must not wait more than twenty-four hours from the time of request for appoint until treatment is rendered.

(3) □ Available to render services in each facility that they are credentialed a minimum of four hours per day, three days per week, twelve hours per week.

(1) □ Patient must not wait in the reception room for treatment for more than an average of thirty minutes.

(1) □ Return urgent patient calls within thirty minutes with appropriate instructions

(3) □ Answering machine or service available 24 hours per day seven days per week that contains directions for obtaining care if the chiropractic is not available and with instructions regarding emergency services care

Advertising

(3) □ No free or discounted services such as examinations, x-ray or manual therapy.

Attachment B:

Chiropractic Care of Minnesota Inc.
Chart Review Checklist

Date: _____ Reviewer: _____

Name of Provider: _____ Name of Clinic: _____

Address: _____ Phone#: _____

ChiroCare#: _____

Patient Name: _____

Required Documentation

(2) □ Patient's date of birth, marital status, occupation, employer's name, home/cell phone number and work phone number.

(2) □ Each page contains the either the patient's name or assigned ID number.

(2) □ Dated and contain author identification. The author identification can be stamped, electronically or hand written.

(2) □ Description of past conditions and trauma, past treatment received, current treatment being received from other health care providers, description of the patient's current condition including onset and description of trauma if trauma occurred, vital signs including blood pressure, height, weight and/or BMI.

(3) □ Examination(s) performed - a preliminary diagnosis based on indicated diagnostic tests, with an indication of all findings of each test performed must be contained in the patient record.

(2) □ Results of re-examinations that are performed to evaluate significant changes in a patient's condition, including tests that were positive or deviated from results used to indicate normal findings.

(3) □ Diagnosis supported by documented subjective and objective findings or clearly qualified as an opinion must be recorded in the patient file.

(3) □ Treatment plan.

(3) □ Adverse reactions, history of adverse reactions and/or contraindications to care must be prominently noted in the file i.e. pregnancy, strokes, history of clots, use of blood thinners etc.

(3) □ Description by the chiropractor or written description by the patient each time an incident occurs that results in an aggravation of the patient's condition or a new developing condition.

(2) □ X-rays taken by the chiropractor - resultant findings.

(2) □ Consultant reports must be in the file and initialed by the treating chiropractor to signify review.

(2) □ Organized and legible. If they contain symbols or abbreviations - a key must accompany the file.

(2) □ Chronological order and written in permanent ink.

(2) □ Amended / corrected record entries should be crossed out, yet readable, contain a date and signature.

(2) □ Daily notes documenting current subjective complaints as described by the patient, any change in objective findings if noted during that visit, a listing of all procedures provided during that visit and information that is exchanged and will affect that patient's treatment must be recorded in the patient file. The daily notes should be SOAP type format and shall contain date for return visits or a follow-up plan. An expected time for a return visit or a follow- up plan for each encounter should be in the record. This can be noted by a return visit date following each entry in the daily record or a treatment plan initiated with the onset of care. No-show and recall efforts should be documented in the file.

(1) □ Discharge record that includes the reason for discharge with the patient health status noted.

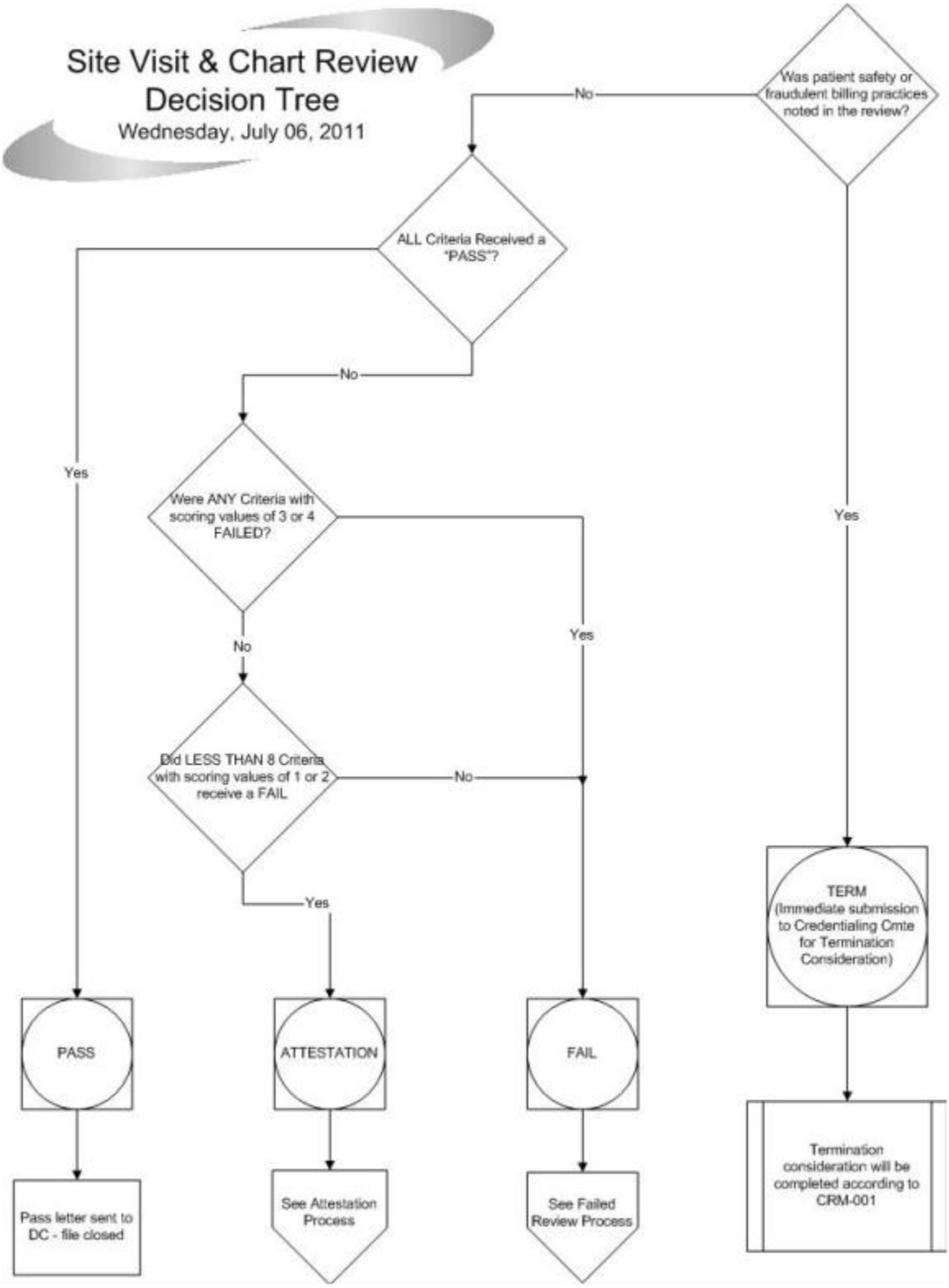
(1) □ Documentation that family history has been evaluated.

(1) □ External Documentation - Documentation to and from external sources is part of the patient's record (i.e. correspondence to another physician, general correspondence to payers, attorneys etc.)

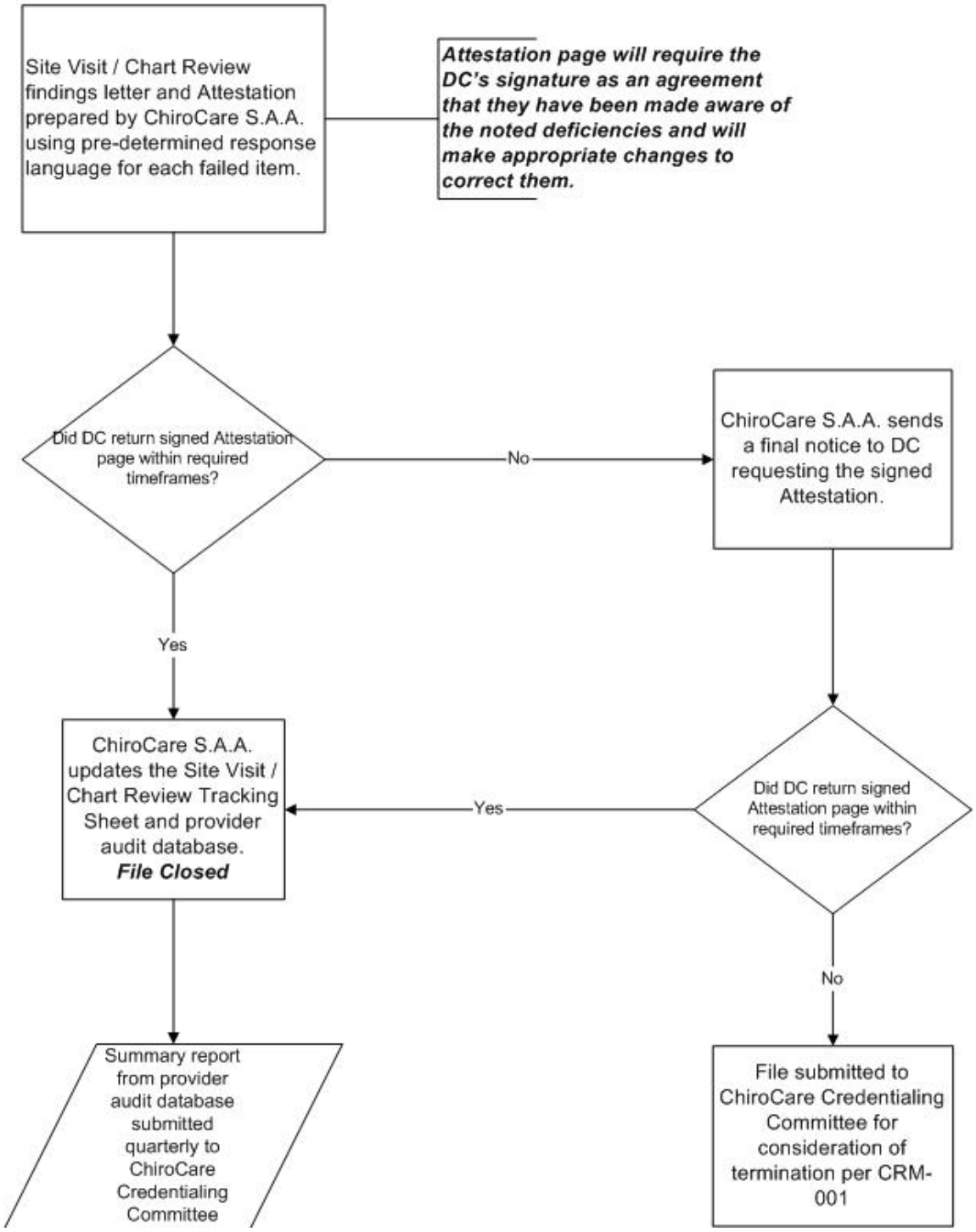
(3) □ Provider incorporates differential diagnosis as necessary.

(3) □ Provider demonstrates referrals for patients as appropriate and when requested to other health care professionals.

Attachment C:



Attestation Process



Failed Review Process