

Passport Advantage
Provider Manual
Section 4.0
Office Standards

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4.0 Office Standards

4.1 Appointment Scheduling Standards

Providers must adhere to the following appointment scheduling standards to ensure timely access to quality medical care as required by the Centers for Medicare & Medicaid Services. Compliance with these standards will be audited by periodic on-site review of provider offices and chart sampling.

Appointments with providers must:

- Be scheduled within 30 business days for routine care and preventive care visits.
- Be scheduled within 7 days for non-urgent care, but in need of attention.

Other appointments must:

- Be scheduled within 24 hours for urgent care services.
- Be immediately provided for emergency care.
- Be provided within 14 days of request for pregnant women in their first trimester.
- Be provided within 7 days of request for preventive care visits for pregnant women in their second trimester.
- Be provided within 3 days of request for preventive care visits for pregnant women in their third trimester.

Appointments with Behavioral Health Care providers must:

- Be scheduled within 10 business days for routine care visits.
- Be scheduled within 6 hours for non-life threatening emergencies.
- Be scheduled within 48 hours for urgent care visits.

4.2 After-Hours Telephone Coverage

As outlined in Section 3.3, Passport Advantage members are not required to select a primary care provider, but members are encouraged to choose a Provider of Choice. Providers of Choice are required to provide coverage for Passport Advantage members 24 hours a day, 7 days a week. When a Provider of Choice is unavailable to provide services, the Provider of Choice must ensure that he or she has coverage from another participating provider. Hospital emergency rooms or urgent care centers are not substitutes for coverage from another participating provider. Participating providers can consult their Passport Advantage Provider Directory, or contact Passport Advantage Provider Services with questions regarding which providers participate in the Passport Advantage network. After hours, telephones may be:

- Answered by an answering service that can contact the Provider of Choice or another designated medical provider who can return the call within a maximum of 30 minutes.

- Answered by a recording directing the member to call another telephone number to reach the Provider of Choice or another medical provider whom the provider has designated to return the call within a maximum of 30 minutes.
- Transferred to another location where someone will answer the telephone and be able to contact the Provider of Choice or another designated medical provider who will return the call within a maximum of 30 minutes.

Unacceptable after-hours telephone coverage in a provider's office includes:

- No answer after office hours.
- Telephones answered after hours by a recording that instructs members to leave a message.
- Telephones answered after hours by a recording that directs members to go to the emergency room for non-emergency services.

4.3 Provider Office Standards

- The provider must not differentiate or discriminate in the treatment of any member because of the member's race, color, national origin, ancestry, religion, health status, sex, marital status, age, political beliefs, or source of payment.
- The office waiting time should not exceed 45 minutes.
- Appointments for members should be scheduled at the rate of 6 or less per hour per provider.
- Health assessments/general physicals should be scheduled within 30 days.
- Providers should have a "no show" follow-up policy. For example, the provider might send two notices of missed appointments to the member, followed up by a telephone call to the member. Any actions for missed appointments should be documented in the member's medical record.
- Member medical records must be maintained in an area that is not accessible to persons not employed by the practice. When releasing a member's medical record to another practice or provider, providers are required to first obtain written consent from the member.
- Any provider's office administering care that may have an adverse effect must obtain the member's signature on a form that describes the treatment and includes the medical indication and the possible adverse effects.
- Providers must complete appropriate consent forms, as required by state and federal regulations and laws.

4.4 Medical-Record-Keeping, Continuity, and Coordination of Care Standards

Passport Advantage has adopted the following medical-record-keeping standards, which cover confidentiality, organization, documentation, access, and availability of records. These standards are based on the National Committee for Quality Assurance (NCQA) and may be revised as needed to conform to new NCQA and/or federal recommendations. Compliance with these standards will be

audited by periodic on-site review of practitioner's offices and chart samplings. Practitioners must achieve an average score of 80% or higher on the medical records review. Passport Advantage will assist practitioners' scoring less than 80% through corrective action plans and re-evaluation.

Confidentiality of Records

- Medical records are maintained in an area that is only accessible to practitioner office staff.
- Staff receive periodic training in member information confidentiality.
- Records are stored securely.

Organization of Records

- There is only one medical record per patient.
- The medical record is bound or pages fastened to prevent loss of medical information.
- Each and every page in the record contains the member's name or ID number.
- The medical record is organized in chronological order with the most recent information appearing first. The record includes separate sections for progress notes, lab results, x-ray and other imaging studies, hospital records (ER report and discharge summaries), home health nursing reports, physical therapy reports, etc.
- All charts contain flow sheets for health maintenance.

Documentation

- The record is legible.
- Personal data includes social security number, date of birth, address, employer, home and work telephone numbers, marital status, emergency contact information, and guardianship/custodial arrangements.
- Entries are done in non-smearable, non-erasable ink.
- Medication allergies and adverse reactions are prominently noted in the record.
- There is a completed immunization record in all records.
- All charts contain a problem and medication list. Significant illnesses and medical conditions are indicated on the problem list.
- Medical history (for members seen three or more times) is easily identified and includes medical, surgical, and obstetric histories. For children and adolescents (18 years of age and younger), medical history includes prenatal care, birth, operations, and childhood illnesses
- Documentation of physical examination.
- Documentation of clinical findings and evaluation for each visit.
- All entries in the medical record are signed or initialed and dated.
- Encounter forms or notes have a notation, when indicated, regarding follow-up care, calls, or visits. The specific time of return is noted in weeks, months, or PRN.
- For members 12 years of age and older seen three or more times, documentation will reflect assessment of and counseling for tobacco, alcohol, substance abuse, and risk of sexually transmitted diseases.
- If a consultation is requested, there is a note from the consultant in the record.
- Consultation, lab, and x-ray reports filed in the chart are initialed by the practitioner to indicate review. Consultation and abnormal lab and imaging study results have a specific notation in the record of follow-up plans.
- Emergency care provided is documented in the medical record.

- Evidence of reportable diseases and conditions are documented and reported appropriately to local or state health departments.
- There is evidence that preventive screenings and services are offered in accordance with Passport Advantage's Clinical Practice Guidelines. Use of risk assessments, disease maintenance, and preventive health sheets are encouraged (see Section 19, "Forms and Documents," for samples).
- Copies of consent forms, when applicable, are maintained in the record.
- The medical record also contains an indication of the member's advance directive as appropriate.
- Written denials for service and the reason for the denial is documented in the medical record.

Access and Availability of Records

- Provider permits Passport Advantage, on request, access to member medical records to inspect, review, and copy within five working days of receipt of request.
- Members have the right to all information contained in the medical record as required by law. Medical records must be made available to a member upon request.
- When a member changes Provider of Choice, the medical records or copies of medical records shall be forwarded to the new Provider of Choice within ten (10) business days from receipt of request.
- When releasing records to an entity other than the Plan, providers are first required to obtain written consent from the member.
- Providers must maintain medical records for ten (10) years.

Continuity and Coordination of Care

While there are some indicators of continuity and coordination of care included within the documentation standards, the Plan will also assess medical records for evidence of continuity and coordination of care using the following criteria:

- The record is legible to someone other than the writer. Any record determined illegible by one reviewer shall be evaluated by a second reviewer.
- At each office visit, the history and the physical performed are documented and reflect appropriate subjective and objective information for presenting complaints.
- The working diagnosis is consistent with the clinical findings.
- The plan of action and treatment is consistent with the diagnosis.
- Lab and other studies are ordered as appropriate.
- Unresolved problems from previous office visits are addressed in subsequent visits.
- There is a review for the under- and over-utilization of consultations.
- Age or disease-appropriate direct access services must be documented in the medical record, for example, immunizations, diabetic retinal eye exams, family planning, and cancer screening services.
- There is no evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic problem.

4.5 **Translator and Interpreter Services**

As discussed in Section 2.3, federal law requires providers to ensure that communications are effective. Please review the federal requirements documented in Section 2.3.