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2022 Medical Record Review Results Now Available

Each year, we conduct a review of primary care practices' medical records, formally known as the Documentation of Care (DOC) Medical Record Review program. This initiative is intended to help improve record-keeping practices to foster patient safety and improve continuity, coordination, and transition of care.

The DOC Medical Record Review program follows regulatory requirements by the National Committee for Quality Assurance (NCQA), the Agency for Health Care Administration (AHCA), and the Florida Administrative Code, Standards for Practice for Medical Doctors. The DOC process aligns with the NCQA review of the plan's medical record files for survey regulatory purposes.

Methodology and Results

A team of registered nurses conducted the annual medical record review. A representative sample of 51 records from our HMO line of business was randomly pulled from standardized tables. The population sample included Health Options, Inc, Truli for Health, and Florida Blue Medicare Advantage HMO plans. Primary care providers included in the medical record audit will receive results along with the medical record guidelines in the mail.

Our DOC 2022 Medical Record Review overall average score is 93.34%. This score is shown in the table below while more details of the results are available here.

Description 51 Medical Records	Total	Percent
Number of medical records scored 100%	13	25%
Number of medical records scored 90%-99%	30	59%
Number of medical records scored 89% or less	8	16%
Average overall score = 93.34%		

Compliance Improvement Opportunities

This year's results are 2.84 percentage points lower than the 2021 results of 96.15%. We encourage providers to seek ways to improve their medical record documentation practices. **Please review the following opportunities for improving documentation compliance**.

Opportunities for Improved Compliance

The Florida Blue DOC 2022 Medical Record Review audit identified the following areas of opportunity for improved compliance:

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- **Advance Directives**
  To meet our regulatory responsibilities, we check to see if advance directives, including a living will, are documented in the member's medical records. Do you know your patients' wishes if they and their families face a health crisis? We encourage you to ask your patients who are 18 years or older, if they have advance directives or living wills. Please be sure to record their responses, yes or no, in their medical records and keep a copy of the advance directive and/or living will in their medical file.

- **Documentation of Substance Abuse Inquiry and Counseling in the Medical Records for Persons 12 Years of Age and Older**
  Routine medical care provides an excellent opportunity for a physician to determine if patients have problems with substance abuse. Screening provides an opportunity for early intervention and can positively impact patients' overall health.

- **Pediatric and Adolescent Immunization Records Complete and Up to Date**
  During the annual well care visit, the primary care physician (PCP) has an opportunity to assess immunization status for patients 16 years of age or younger. Ensuring immunizations are up to date and completed in the patient's record is crucial to their overall health. The PCP can explain the significant importance of immunizations for prevention of certain medical conditions and diseases.

Your Help is Critical
Thank you for ensuring this important information is captured in your patients' medical records.

Results and guidelines were mailed to PCPs included in the medical record audit. If you have any questions, please contact Angela Nightingale, RN, at **800-555-8228**, ext. 50158 or Angela.Nightingale@bcbsfl.com

For more information, refer to the *Documentation of Care Review* in our Manual for Physicians and Providers (enter *Documentation of Care Review* in the search bar).

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