Purpose: This chapter provides an overview of the current provider practice standards and guidelines used by Health Partners Plans.

Topics:

- Access & Appointment Standards
- Provider Office Practice Standards
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Overview

Providers that participate in Health Partners Plans must adhere to certain standards and guidelines in order to remain a participating provider. This chapter provides documentation of these contractual requirements.

Access & Appointment Standards

The following table specifies the office access and appointment standards Health Partners Plans requires provider practices to meet.

Table 1: Provider Access & Appointment Standards

<table>
<thead>
<tr>
<th>Criteria</th>
<th>PCP</th>
<th>OB-GYN</th>
<th>Specialist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine Office Visits</td>
<td>Within 7 days</td>
<td>OB - Initial prenatal visit within 24 hours of identification of high risk by Health Partners Plans or maternity care provider, or immediately if emergency exists. First prenatal visit (pregnant 1-3 months): Within 10 days First prenatal visit (pregnant 4-6 months): Within 5 days First prenatal visit (pregnant 7-9 months): Within 4 days GYN: Within 10 days OB/GYN: Within 5 days of effective date of enrollment</td>
<td>Within 10 days</td>
</tr>
<tr>
<td>Routine Physical</td>
<td>Within 3 weeks</td>
<td>Within 3 weeks</td>
<td>N/A</td>
</tr>
<tr>
<td>Preventive Care</td>
<td>Within 3 weeks</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>Within 24 hours</td>
<td>Within 24 hours</td>
<td>Within 24 hours</td>
</tr>
<tr>
<td>Emergency Care</td>
<td>Immediately and/or refer to ER</td>
<td>Immediately and/or refer to ER</td>
<td>Immediately</td>
</tr>
<tr>
<td>First Newborn Visit</td>
<td>Within 2 weeks</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>
Table 1: Provider Access & Appointment Standards

<table>
<thead>
<tr>
<th>Criteria</th>
<th>PCP</th>
<th>OB-GYN</th>
<th>Specialist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient with HIV Infection</td>
<td>Within 7 days of enrollment for any member known to be HIV positive unless the member is already in active care with a PCP or specialist regarding HIV status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>EPSDT</td>
<td>Within 45 days of enrollment unless the member is already under the care of a PCP and the member is current with screenings and immunizations</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>SSI Recipient</td>
<td>Within 45 days of enrollment unless the enrollee is already in active care with a PCP/specialist</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Office Wait Time</td>
<td>30 minutes, or up to one hour if urgent situation arises</td>
<td>30 minutes, or up to one hour if urgent situation arises</td>
<td>30 minutes, or up to one hour if urgent situation arises</td>
</tr>
<tr>
<td>Weekly Office Hours</td>
<td>At least 20 hours per site</td>
<td>At least 20 hours per site</td>
<td>At least 20 hours per site</td>
</tr>
<tr>
<td>Maximum Appointments per Hour</td>
<td>6</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

**Telephone Availability Standards**

- Telephone availability standards are closely monitored through the Health Partners Plans Member Satisfaction Surveys, site reviews, and member complaints. These standards include: All PCPs must be available to members for consultation regarding an emergency medical condition 24 hours a day, seven days a week.
- After regular office hours, the PCP shall return member calls within one hour of when the member called. Coverage may be shared with another PCP participating with Health Partners Plans.
- If a PCP uses an answering service, the assigned service person must be capable of taking a message, and contacting the physician directly and immediately.
- An appointment system for scheduling all routine visits is also a requirement. At a minimum, this includes an appointment book and written notice given to patients stating date and time of next appointment. Evidence of compliance with these minimum access standards is sought at the time of initial credentialing, at re-credentialing, and at interim periods if non-compliant activity is noted.
- For any missed appointment, the PCP or specialist should send two notices of the missed appointment and make a follow-up telephone call to the member. Documentation of the notices and telephone call should be placed in the medical record.
- The PCP or specialist should ensure that the average office waiting time does not exceed 30 minutes, or up to one hour when the physician encounters an unanticipated urgent visit or is treating a patient with a difficult medical need.

School-based Services
School-based Services School districts sometimes provide some basic health services or offer programs to promote healthy behaviors. These programs may vary from district to district and are too many, state-wide, to successfully list here. Our Special Needs Unit is available to assist if you need help finding services in your area.

Practice Changes
The Network Management department must be immediately notified in writing when any of the following occurs:

- additions/deletions of providers
- change in payee information
- change in hours of operation
- provider practice name change
- change in practice ownership
- telephone number change
- site relocation
- change in patient age restrictions
- Tax ID change (must be accompanied by W-9)

Health Partners Plans uses the Council for Affordable Quality HealthCare (CAQH) online provider application tool. It is important for you to maintain current and accurate information on CAQH and re-attest to the information in your CAQH application as required.

Medical Information - Confidentiality
Issues of confidentiality concerning medical information are addressed in Health Partners Plans’ Notice of Privacy Practices, among other areas. This notice is distributed to all Health Partners Plans members as required by the federal government. It describes how medical information about members may be used, and how members can access this information. This policy is also posted on www.HealthPartnersPlans.com under “Notice of Privacy Practices.”

How Does Health Partners Plans Protect Member Health Information?
Health Partners Plans must make reasonable efforts to protect member privacy regarding Protected Health Information (PHI). We use appropriate safeguards to limit PHI used or disclosed to the minimum necessary to accomplish the intended purpose. We will identify the persons or departments within Health Partners Plans that require access to PHI to carry out their job responsibilities. We also review the categories or types of PHI that each person or department requires access to, and under what conditions they require this access. This is done before allowing any access to PHI.

In addition, all Health Partners Plans employees must read and sign a Confidentiality Statement of Understanding before starting work at Health Partners Plans. They must also sign a new statement
once a year. This requirement ensures that each employee is reminded of the importance of always maintaining confidentiality, not only through protecting PHI but also safeguards in other areas of confidentiality. We also require all Health Partners Plans staff to undergo confidentiality training every year.

As a general rule, Health Partners Plans will not use the entire health record of a member. Access to the entire health record will be allowed only if this is specifically identified as reasonably necessary to satisfy the purpose. When Health Partners Plans receives an internal request for PHI, we will share information on a “need-to-know” basis. This helps to protect confidentiality and ensure a member’s privacy. Management is responsible to enforce and document the minimum necessary standard for such uses. Any questions about PHI or the access to such information by the workforce will be directed to Health Partners Plans’ Privacy Official or designee.

Notice of Privacy Practices

*Note: The following information is communicated to all plan members.*

At Health Partners Plans, we respect the confidentiality of your health information and will protect your information in a responsible and professional manner. We are required by law to maintain the privacy of your health information and to send you this notice.

This notice explains how we use information about you and when we can share that information with others. It also informs you about your rights with respect to your health information and how you can exercise these rights.

When we talk about “information” or “health information” in this notice we mean the following:

- Any kind of information about you and your health care
- Claims information
- Your address and phone number
- Your social security number

**How We Use or Share Information**

The following are ways we may use or share information about you:

- We may use the information to help pay your medical bills that have been submitted to us by doctors and hospitals for payment.
- We may share your information with your doctors or hospitals to help them provide medical care to you. For example, if you are in the hospital, we may give them access to any medical records sent to us by your doctor.
- We may use or share your information with others to help manage your health care. For example, we might talk to your doctor to suggest a disease management or wellness program that could help improve your health.
- We may share your information with others who help us conduct our business operations.

*Note: We will not share your information with these outside groups unless they agree to keep it protected.*

- We may use or share your information for certain types of public health or disaster relief efforts.
- We may use or share your information to send you a reminder if you have an appointment with your doctor.
- We may use or share your information to give you information about alternative medical treatment and programs or about health-related products and services that may interest you. For example, we might send you information about smoking cessation or weight loss programs.

There are also state and federal laws that may require us to release your health information to others. We may be required to provide information for the following reasons:

- We may report information to state and Federal agencies that regulate us, such as the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services and the Pennsylvania Departments of Health, Insurance and Human Services.
- We may share information for public health activities. For example, we may report information to the Food and Drug Administration for investigating or tracking of prescription drug and medical device problems.
- We may report information to public health agencies if we believe there is a serious health or safety threat.
- We may share information with a health oversight agency for certain oversight activities (for example, audits, inspections, licensure and disciplinary actions).
- We may provide information to a court or administrative agency (for example, pursuant to a court order, search warrant or subpoena).
- We may report information for law enforcement purposes. For example, we may give information to a law enforcement official for purposes of identifying or locating a suspect, fugitive, material witness, or missing person.
- We may report information to a government authority regarding child abuse, neglect or domestic violence.
- We may share information with a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also share information with a funeral director as necessary to carry out his/her duties.
- We may use or share information for procurement, banking or transplantation of organs, eyes or tissue.
- We may share information relative to specialized government functions, such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.
- We may report information on job-related injuries because of requirements of your state worker compensation laws.

There may be other times that we may share information that is not mentioned above; however, if these reasons do not apply, we must get your written permission to use or disclose your health information. If you give us written permission and change your mind, you may take back that written permission at any time. Once you give us the proper authorization to release your health information, we cannot guarantee that the person to whom the information is provided will not disclose the information.

We are also not allowed to use or disclose your health information as follows:

Health Partners Plans must ensure that we do not disclose any confidential information in accordance with all laws, regulations, and policies of the Pennsylvania Department of Health, the
Pennsylvania Insurance Department and the Centers for Medicare & Medicaid Services. In addition, we must comply with all rules governing the disclosure of information related to HIV/AIDS, Drug and Alcohol and Mental Health services.

Member Rights
The following are our members’ rights with respect to their health information. If they would like to exercise the following rights, they must contact Health Partners Member Relations at 1-800-553-0784 or KidzPartners Member Relations at 1-888-888-1211 or Health Partners Medicare Member Relations at 1-866-901-8000 or Health Partners Essential Member Relations at 1-855-215-7077.

Providers and their staff must also take these rights and protections into account when furnishing services to members.

- You have the right to receive information on available treatment options and alternatives.
- You have the right to participate in healthcare decisions, including the right to refuse treatment.
- You have the right to be free from restraint or seclusion.
- You have the right to request and receive a copy of your medical records and to request that they be amended or corrected.
- You have the right to ask us to restrict or limit how we use or disclose your information for treatment, payment, or healthcare operations. You also have the right to ask us to restrict information that we have been asked to give family members or to others who are involved in your health care or payment for your health care. Please note that while we will try to honor your request, we are not required to agree to these restrictions.
- You have the right to ask to receive confidential communication of information. For example, if you believe that you would be harmed if we send your information to your current mailing address (for example, in situations involving domestic disputes or violence), you can ask us to send the information by alternative means (for example, by fax) or to a different or additional address. We will work with you on any reasonable requests by you as explained above.
- You have the right to inspect and obtain a copy of information that we maintain about you in your designated record set. A “designated record set” is a group of records maintained by or for Health Partners Plans that is (1) the medical records and billing records about you; (2) the enrollment, payment, claims adjudication, and case or medical management record; (3) and any information we use to make decisions about you and your health care.

However, you do not have the right to access certain types of information and we may decide not to provide you with copies of the following information:

- Contained in psychotherapy notes;
- Gathered for possible use for or in connection with a civil, criminal or administrative action or proceeding; and
- Subject to certain federal laws governing biological products and clinical laboratories.

Additionally, in certain other situations, we may deny your request to inspect or obtain a copy of your information. If we deny your request, we will notify you in writing and may provide you with a right to have the denial reviewed.
You have the right to ask us to amend information we maintain about you in your designated record set. We may require that your request be in writing and that you provide a reason for your request. We will respond to your request no later than 30 days after we receive it. If we are unable to act within 30 days, we may extend that time by no more than an additional 30 days. If we need to extend this time, we will notify you of the delay and the date by which we will complete the action on your request.

If we make the amendment, we will notify you that it was made. In addition, we will provide the amendment to any person that we know has received your health information. We will also provide the amendment to other persons identified by you.

If we deny your request to amend, we will notify you in writing of the reason for the denial. The denial will explain your right to file a written statement of disagreement. We have a right to contest (argue) your statement. However, you have the right to request that your written request, our denial and your statement of disagreement be included with your information for any future disclosures.

You have the right to receive an “accounting” or a summary/report of certain disclosures of your information made by us during the six years prior to your request.

Please note that we are not required to provide you with an accounting of the following information:

- Any information collected before April 14, 2003;
- Information disclosed to be used for treatment, payment, and healthcare operations purposes;
- Information disclosed to you or pursuant to your authorization;
- Information that is incidental to a use or disclosure otherwise permitted;
- Information disclosed for a facility directory or to persons involved in your care or other nonfiction purposes;
- Information disclosed for national security or intelligence purposes;
- Information disclosed to correctional institutions, law enforcement officials or health oversight agencies; and
- Information that was disclosed or used as part of a limited data set for research, public health, or healthcare operations purposes.

We require that your request be in writing. We will act on your request for an accounting within 30 days. We may need additional time to act on your request, and therefore, may take up to an additional 30 days. Your first accounting will be free, and we will continue to provide to you one free accounting upon request every 12 months. However, if you request an additional accounting within 12 months of receiving your free accounting, we may charge you a fee. We will inform you in advance of the fee and provide you with an opportunity to withdraw or modify your request.

**Exercising Your Rights**

You have a right to receive a copy of this notice upon request at any time.

You can also view a copy of the notice on our website at [www.HealthPartnersPlans.com](http://www.HealthPartnersPlans.com). Should any of our privacy practices change, we reserve the right to change the terms of this notice and to make the
new notice effective for all protected health information we maintain. Once revised, we will provide the new notice to you by direct mail and post it on our website.

If you have any questions about this notice or about how we use or share information, please contact Health Partners Member Relations at 1-800-553-0784 or KidzPartners Member Relations at 1-888-888-1211 or Health Partners Medicare Member Relations at 1-866-901-8000 or Health Partners Essential Member Relations at 1-855-215-7077. You can call anytime, 24 hours a day, seven days a week. You can also send us questions by e-mail at www.HealthPartnersPlans.com.

If you believe your privacy rights have been violated, you may file a complaint with us by contacting Health Partners Member Relations at 1-800-553-0784 or KidzPartners Member Relations at 1-888-888-1211 or Health Partners Medicare Member Relations at 1-866-901-8000 or Health Partners Essential Member Relations at 1-855-215-7077. You may also notify the Secretary of the U.S. Department of Health and Human Services of your complaint.

We will not take any action against you for filing a complaint.

If members need help reading policies, they can call our 24-hour Member Relations line at 1-800-553-0784 for Health Partners, 1-888-888-1211 for KidzPartners, 1-866-901-8000 for Health Partners Medicare, or 1-855-215-7077 for Health Partners Essential (TTY 711).

Health Partners Plans’ policy on Confidentiality protects both members and providers. It encompasses the following guidelines and legal restrictions.

**Member Confidentiality**

All Health Partners Plans contracts with healthcare providers contain a provision titled “Safeguarding of Information.” This provision states that the provider shall not use or disclose any information concerning a Health Partners Plans member in a manner prohibited by law. When disclosing member information, legal restrictions include those mandated by:

- Health Insurance Portability and Accountability Act (HIPAA).

It is Health Partners Plans’ policy that:

- Privacy of any information that identifies a particular member must be safeguarded. Information from, or copies of, records may be released only to authorized individuals, and providers must ensure that unauthorized individuals cannot gain access to or alter member records. Original records must be released only in accordance with federal or state laws, court orders, or subpoenas. Providers must have policies and procedures on safeguarding, releasing, and office procedures on patients’ confidential medical records.
- Records and information must be maintained in an accurate, confidential, and timely manner.
- Members must be given timely access to their records and information. (If requested, the provider must supply the member with a copy of his/her paper medical record, at no charge, unless the provider believes that supplying such record is not medically advisable.)
- All federal and state laws regarding privacy, confidentiality and disclosure for mental health records, medical records, other health information, and member information must be adhered to.

**Provider Confidentiality**

All of Health Partners Plans’ Credentialing department policies specify that all provider information is maintained in strict confidence, and that all provider files are maintained in a secured storage area and are shredded before disposal.

All healthcare information presented to Health Partners Plans’ peer review committees (Utilization Management, Pharmacy & Therapeutics and Quality Management) is blinded prior to presentation to the committee members in order to protect the identity of the individual healthcare provider.

Healthcare provider information will be disseminated as required by law, in response to a court order or subpoena. This process is handled in conjunction with Health Partners Plans’ Legal Affairs department and follows the rules established by state law. When disclosing provider information, legal restrictions include those mandated by:

- Title IV of Public Law 910-660, the Health Care Quality Improvement Act of 1986.
- The Peer Review Protection Act.

**Confidentiality of Other Information**

Health Partners Plans participating providers may not disclose (by oral, written, electronic or other means) any financial or other proprietary information except as required by the Department of Public Welfare, the Pennsylvania Insurance Department, or by law.

**Credentialing/Recredentialing**

As part of the Health Partners Plans Quality Management program, as well as National Committee for Quality Assurance (NCQA), DHS, DOH, PID and CMS guidelines, participating PCP, specialist, allied health, ancillary and hospital providers undergo an initial credentialing process. Practitioners are recredentialed every three years and must show evidence of satisfactorily meeting Health Partners Plans’ quality of care and service measures for their members.

Health Partners Plans has partnered with Aperture Credentialing to manage the primary source verification (PSV) function of our credentialing/re-credentialing process. Providers who wish to be credentialed by Health Partners Plans must submit a complete application and a signed Provider Data Collection form to release information.

Health Partners Plans accepts and prefers the use of the CAQH (Council for Affordable Quality Healthcare) application, but will also accept the Pennsylvania standard paper application. Other documents and information required to be submitted are as follows:

- Current State Medical License
- Current DEA Certificate
- Board Certification Certificate or Residency Certificate, as applicable
- Official documentation of ongoing CME activity (Note: this only applies to Nurse Midwives and Physician Assistants)
- Current copy of professional liability insurance coverage face sheet
- Malpractice history, if applicable
- W-9
- Medical Assistance Identification Number (To obtain an active Medical Assistance identification number, contact DHS’s Provider Enrollment department at 717-772-6140 or 717-772-6456)
- Medicare (CMS) Identification Number
- NPI Number (Individual and Billing)
- VFC PIN Number (PCPs who see members 0-18 years of age only)
- ECFMG Certificate, if applicable
- Curriculum Vitae
- Education and Training
- Work History (for previous 5 years)
- Hospital Privileges (need signed hospital attestation for a participating Health Partners Plans hospital). All specialists need to have admitting privileges, PCPs can have covering arrangement with participating provider.
- Cross Coverage for Practice
- Signed and dated agreement or exhibit C if the provider is joining an existing group agreement.
- Accreditation Certificate (ancillaries and hospitals)
- Group Roster for ancillary providers
- Site visits and Medical Record Reviews needed for all PCP and high-volume specialist addresses
- Medicaid Sanctions (Medicheck, OIG, SAM)

The process for providers due for re-credentialing is initiated four (4) months prior to their re-credentialing due date. Aperture will use the CAQH application to verify and update information for re-credentialing purposes. If a CAQH application is not on file, Aperture will outreach to the provider to obtain an updated application.

Information that will be required/verified at the time of re-credentialing is as follows:
- Signed and dated Provider Data Collection form
- Signed and dated Provider Questionnaire and Attestation Statement.
- Current State Medical License
- Current DEA Certificate
- Recertification of board certificate, as applicable
- Official documentation of ongoing CME activity (for Nurse Midwives and Physician Assistants only)
- Current copy of professional liability insurance face sheet
- Malpractice history, if applicable
- Accreditation Certificate (ancillaries and hospitals)
- Hospital Privileges (need signed hospital attestation for a participating Health Partners Plans hospital). All specialists need to have admitting privileges; PCPs can have covering arrangement with participating provider.
- Medical Assistance ID Number (To obtain an active Medical Assistance ID Number, visit the DHS website at www.dpw.state.pa.us/provider/promise/enrollmentinformation/index.htm)
- Medicaid Sanctions (Medcheck, OIG, SAM)
- Medicare Opt-Out report

For all participating PCPs, Health Partners Plans will send a representative to conduct an onsite review and medical record audit every two years to assess compliance with medical record keeping practices and practice site standards. Compliance with appointment availability standards will also be assessed. Quality review audits are completed every two years and are incorporated into the credentialing and recredentialing process.

Primary source verifications are constructed as applicable, after which Health Partners Plans’ Medical Director will review all the information gathered, including the results of quality monitoring, and present a recommendation to the Credentialing Committee for consideration, discussion, and action.

The decision of the Credentialing Committee to accept or deny a practitioner into the network will be communicated in writing by Health Partners Plans’ Medical Director. If a provider is denied, information regarding the appeal process is noted in the denial letter.

Health Partners Plans offers each practitioner the right to review any of the information submitted in support of their credentialing/re-credentialing application. Additionally, the practitioner has the right to correct any erroneous information by supplying the corrected information in writing to the Credentialing department. The provider also has the right to appeal the decision of the Credentialing Committee.

In compliance with DHS, PID and CMS regulations, Health Partners Plans will not employ or contract with any provider who is excluded from participating in Medicaid or Medicare for the provision of any of the following: health care, utilization review, medical social work, and/or administrative services.

**Role of the Primary Care Provider**

The Primary Care Provider (PCP) is usually the starting point for a member to receive medical care and acts as the gatekeeper for all future care provided. It is important for the PCP to stay connected with all of their members and encourage them to utilize the primary care services available to them.

While we expect that much of our members needs can and will be addressed by their PCP, we also acknowledge the need for more specialized services and that the member’s PCP will use his/her education, experience and best medical judgment to refer members out for additional care when needed.

Health Partners Plans stresses to our members the need to stay connected to their PCP and in cases where they are receiving care from other medical professionals, including but not limited to prescription care, that they continue to maintain the relationship with their PCP and ensure that their PCP has access to their most current medical condition and services received.

Access to PCP care is vitally important to maintaining the health of our members and, when possible, steering them away from the use of emergency rooms when their condition can more appropriately be managed in a PCP office environment. A PCP is required to provide access to care as outlined in the Access and Appointment Standards section of this manual. In addition, a PCP must be accessible 24 hours per day, 7 days a week.
Each PCP must follow all periodicity schedules and use appropriate health assessments/documentation and maintain an individual medical record for all patients. In addition, any PCP providing care to members up to the age of 18 years of age must participate in the Vaccines for Children (VFC) program.

**Note:** In addition, Health Partners Plans also utilizes the System for Award Management (SAM) to access the Government Service Administration (GSA) precluded list, the OIG system and the MediCheck system. These lists are reviewed for sanction activity at the time of credentialing and recredentialing and twice monthly by Aperture. Any provider who is identified as being precluded will be immediately terminated by Health Partners Plans, according to the terms of their agreement with Health Partners Plans.

**Health Partners Plans Medical Record Documentation Standards**

Consistent and complete documentation in the medical record is an essential component of quality patient care. Health Partners Plans standards have been developed utilizing the standards of the National Committee for Quality Assurance (NCQA), DHS, PID, CMS, and the Pennsylvania Medical Society Guidelines for documentation. As the Health Partners Plans staff completes the site evaluation process, the standards with an asterisk (*) following the measure are weighted more heavily within the measurement tool.

- Each page in the record contains the patient's name or I.D. number
- Each record contains appropriate biographical/personal data
- Each author is identified on each entry
- All entries are dated
- The record is legible to someone other than the writer
- There is a completed problem list*
- A listing of medications is easily found and lists all medications currently used
- Allergies and adverse reactions to medications are prominently noted*
- There is an appropriate past medical history*
- There is documentation of tobacco habits for members > 11 years
- There is documentation of alcohol use for members > 11 years
- There is documentation of substance abuse for members > 11 years
- There is a pertinent history and physical exam
- Lab and other studies are ordered as appropriate
- Working diagnoses are consistent with findings*
- Plans of action/treatment are consistent with findings*
- There is evidence of patient teaching
- There are dates for return visits or other follow-up plans
- There is documentation and follow-up of “no-shows”
- Problems from previous visits are addressed
- There is evidence of appropriate use of consultants
- There is continuity and coordination of care between PCPs and specialists
- Consultant summaries, lab and imaging study results, and surgical procedure summaries reflect PCP review
- Care appears medically appropriate for the diagnosis/conditions*
- There is a completed immunization record*
- Preventive services are appropriately used*
- There is documentation of discussion of a living will or advance directives
- There is documentation of discussions about domestic violence and safety at home
- Phone calls to and from the patient are documented
- Evidence of hospital discharge summary in medical record
- Evidence of review of hospital discharge by physician
- Evidence of communication between home care agency and physician in medical record.

**Additional Medical Records Requirements**

- In order to meet all regulatory requirements related to retention of medical records, all medical records must be legible, signed and dated and must be maintained for a minimum of seven (7) years from expiration of a provider's participating agreement with the plan.
- The provider shall, at his/her own expense, make all records available for audit, review or evaluation by any and all regulatory entities and its designated representatives or federal agencies, in such detail as is reasonably necessary for the determination of the member's eligibility for medical services and for utilization management and quality improvement. Access shall be provided either onsite at Health Partners Plans or at the provider's office during normal business hours, or through the mail or secured fax. All records to be sent by mail shall be sent to the requesting entity in the form of accurate, legible paper copies, unless otherwise indicated, within fifteen (15) calendar days of such request and at no expense to the requesting entity.
- Each member is entitled to have access to his/her medical records in accordance with federal and state laws. Members also have a right to have a copy of their medical record. Members may be charged a nominal fee to have medical records copied. Members can call Health Partners Member Relations (1-800-553-0748) or KidzPartners Member Relations (1-888-888-1211) or Health Partners Medicare Member Relations (1-866-901-8000) or Health Partners Essential Member Relations (1-855-215-7077) for help, or call their physician's office directly. The Member Relations staff will advise members that they must sign a release to obtain their medical record or have a copy sent to a new doctor. Health Partners Plans providers cannot charge the member for a copy of his/her medical record sent directly to another provider.

**Flow Sheet Guidelines**

Health Partners Plans has observed that offices using flow sheets are more successful in documenting ongoing preventive care. These sheets serve as a reminder to the physician that it is time to reorder diagnostic studies or reconsider continuing a specific medication regimen.

The flow sheets are designed to provide the physician with a central reference for significant information such as a record of allergies, a problem list, a medication list, an immunization record, and a log of preventive screening dates. It saves the physician time otherwise spent reviewing progress notes for this data. The tool assists the physician in attaining compliance with Health Partners Plans' documentation standards.

Health Partners Plans flow sheets are available for participating physicians upon request by contacting Health Partners Plans at 215-991-4350 or 888-991-9023. They may also be accessed online at [www.HealthPartnersPlans.com](http://www.HealthPartnersPlans.com), under **Clinical Info**. Completed flow sheets should be incorporated into the medical records of each Health Partners Plans member and updated with each visit. If a member's flow sheet indicates he/she has not been seen recently and needs preventive screenings, an effort should be made to contact the member.
Pediatric, Adolescent, and Adult/Well Elderly Flow Sheets

The Pediatric and Adolescent Flow Sheets and the Pediatric/Adolescent Problem and Medication List place special emphasis on immunizations and other important screening procedures. For copies, visit www.HealthPartnersPlans.com.

If the flow sheet indicates that a child/adolescent is not up-to-date with necessary preventive screenings or immunizations, including EPSDT scheduled screenings, an effort should be made to contact the parent(s) or guardian about the missed treatment or procedure.

Advance Directives

Advance Directives are written documents designed to allow competent patients the opportunity to guide future healthcare decisions in the event that they are unable to participate directly in medical decision making. The Patient Self-Determination Act requires that patients are informed about their right to participate in healthcare decisions, including their right to have an advance directive.

The Health Partners Plans member handbooks contain information concerning advance directives. Providers must note the presence of an advance directive in the member's medical record, and follow all applicable state and federal laws regarding the execution of these directives.

Each state has different regulations for the use of advance directives. Two common forms used for advance directives are the Living Will and the Durable Power of Attorney for Health Care Decisions. Health Partners Plans requires participating providers to document discussion of a living will or advance directive.

If you require more information regarding advance directives, there are several sources of information available:

- American Academy of Family Physicians at www.aafp.org
- Patient information at www.familydoctor.org
- American College of Physicians Tips on Talking to Your Patients at www.acponline.org/journals/news/mar99/admdir.htm

Americans with Disabilities Act (ADA)

Section 504 of the Rehabilitation Act of 1973 states that: “No otherwise qualified handicapped individual in the United States . . . shall, solely by reason of . . . handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance.” Section 504 applies to programs or activities that receive Federal financial assistance. Title II of the ADA covers all of the services, programs, and activities conducted by public entities (state and local governments, departments, agencies, etc.), including licensing. For more information regarding the ADA, go to the U.S. Dept. of Health and Human Services website at www.hhs.gov.

Health Partners Plans requires practitioners to abide by ADA requirements.

- Handicapped parking spaces with curb cuts, if applicable
- Handicapped accessible restrooms
- Access ramps where applicable
- Access ramps to entrance of the building
- Access ramps to provider office, if different entrance than building (i.e., hospital)
If a practitioner's site does not meet ADA standards, there are reasonable alternatives to accommodate those with disabilities. These include:

- Home visits
- Access at another site that meets ADA requirements
- Bathroom facilities elsewhere in the building that meet ADA requirements or portable bathroom facilities

**Provider Office Practice Standards**

On the following pages you will find a table listing Health Partners Plans’ mandatory and recommended Provider Office Standards:

Please first note the Mandatory and Recommended Emergency Procedures.

**Mandatory Standards**

Staff members who are licensed or administer patient care must be CPR-trained and available during patient hours.

Emergency equipment and supplies must be present and appropriately maintained.

All primary care and specialty practices that administer injectable medications with a potential for anaphylactic reaction must maintain adrenaline or epinephrine, and an appropriate means and qualified staff to administer mechanical ventilation (i.e., Ambu bag or Resuscitation Mouthpiece). Exceptions include offices connected to hospitals where CPR/code teams respond to medical emergencies.

Staff must be able to describe who is responsible and the frequency with which emergency supplies are checked for availability and expiration. Offices must schedule supply checks as a routine office procedure, rather than as optional or random events.

Offices that perform stress tests must have a defibrillator. At minimum, there should be documentation of quarterly inspection.

For offices that have a defibrillator, the staff must be able to produce a record of daily defibrillator checks and communicate that staff have been trained on proper use of the equipment.

Other equipment and supplies should be available for practice location, specialty, patient population/environment, and accessibility to advanced medical care.

If the practice performs cardiac stress tests, the following must be available:

- Calibrated defibrillator
- “Banyon” kit or Nitroglycerin
- IV Furosemide (Lasix)
- 50% Glucose
- Sodium bicarbonate
- Lidocaine
- Atrophine
- Epinephrine (Adrenaline)
- IV set-up
- Oxygen equipment
- Operating manuals

Operating manuals for equipment such as EKGs must be available, and the equipment must be maintained per the manual.

**Recommended Emergency Procedures**

Recommended emergency procedures include the following:

- There should be written or verbal emergency procedures.
- There should be periodic training for staff in emergency procedures.
- The practice should have oxygen available and personnel trained to administer it.

**Office Practice Standards**

The following table provides an overview of Office Practice Standards used by Health Partners Plans’ provider network.

<table>
<thead>
<tr>
<th>Standards</th>
<th>Mandatory Requirements</th>
<th>Recommended Standards</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection Control</td>
<td>1. Infectious material is separated from other trash and disposed of appropriately</td>
<td>1. Standard precautions are reviewed with staff and documented annually</td>
</tr>
<tr>
<td></td>
<td>2. Medical instruments used on patients are disposable or properly disinfected and/or</td>
<td>2. The practice site has an OSHA manual</td>
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<tr>
<td></td>
<td>sterilized after each use</td>
<td>3. Hand washing facilities or antiseptic</td>
</tr>
<tr>
<td></td>
<td>3. Needles and sharps are disposed of directly into rigid, sealed container(s) that</td>
<td>4. Hand sanitizers are available in each exam room</td>
</tr>
<tr>
<td></td>
<td>cannot be pierced and are properly labeled</td>
<td></td>
</tr>
<tr>
<td>Medication Management</td>
<td>1. Pharmaceuticals, including samples and needles/syringes, are stored in a secure</td>
<td>1. Expired items are disposed of appropriately</td>
</tr>
<tr>
<td></td>
<td>location away from patient access</td>
<td>2. There is a separate refrigerated area for medications</td>
</tr>
<tr>
<td></td>
<td>2. Controlled substances are located in spaces with access restricted to authorized</td>
<td>3. Refrigerator temperatures are logged daily</td>
</tr>
<tr>
<td></td>
<td>individuals</td>
<td></td>
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<tr>
<td></td>
<td>3. A dispensing log is maintained for controlled substances</td>
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<tr>
<td></td>
<td>4. Expiration dates of all medications, including vaccines and samples, are checked on</td>
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<tr>
<td></td>
<td>a regular basis</td>
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<tr>
<td></td>
<td>5. Prescription pads are controlled and kept secure from unauthorized use</td>
<td></td>
</tr>
</tbody>
</table>
### Standards | Mandatory Requirements | Recommended Standards
--- | --- | ---
**Fire Safety** | 1. Fire extinguishers are appropriately identified and properly maintained 2. Exits are clearly marked and are unobstructed | There are functioning smoke detectors and/or building alarms

**Office Layout & Design** | 1. The physical layout safeguards confidentiality of patient information 2. Patient treatment rooms are designed to safeguard patient privacy 3. There is one exam room per practitioner seeing patients at any given time | 1. There is adequate seating in the reception area 2. Patient education materials are available 3. The practice site is clean, well maintained, uncluttered, well lit, and free of danger areas

**Physical Accessibility** | 1. The office meets the minimum standards of accessibility for those individuals with physical disabilities 2. OR there are reasonable alternatives to accommodate those members with disabilities. Accommodations include: home visits, access at other sites, additional bathroom facilities, portable bathroom facilities, other as approved by the Credentialing Committee 3. OR the office has proof of ADA Title III exemption (U.S. Dept. of Justice 1-800-514-0301) | 1. The practice has standard procedures regarding scheduling appointments (See “Access Standards” in this Provider Manual) 2. The practice has a standard for a maximum patient load of 6 per hour, per provider 3. There are written and/or verbal guidelines for telephone answering 4. There is a recall system for missed appointments to include documentation in the medical record of 3 outreachs, 2 of which must be written notices

**Patient Access to Appointments and Medical Advice** | 1. There is 24-hour coverage of the practice by comparably qualified physicians 2. There is a defined system for medical record keeping 3. There is a preventive health recall system to ensure timely member follow-up for preventive screenings | 1. The practice has written key policies and procedures

**Written Key Policies and Procedures** | 1. Patient confidentiality 2. Release of patient information |
These standards are to be used in conjunction with guidelines for the Pennsylvania Site Visit Protocol, which were developed in coordination with the Pennsylvania Medical Society.

**Preventive Care and Clinical Guidelines**

Health Partners Plans' Quality Management Committee periodically reviews preventive care standards for members, and approves/updates them according to the most current guidelines published by nationally recognized medical and professional societies. The guidelines are mailed to all Health Partners Plans participating PCPs. They are also available on our website, [www.HealthPartnersPlans.com](http://www.HealthPartnersPlans.com).

Provider offices without internet access, or those that need extra copies of the guidelines, can call Health Partners Plans at **215-991-4350** or **888-991-9023**. The copies will be printed out and mailed to the requesting provider office.

The Preventive Care Guidelines include:

- Adolescent & Child Preventive Care
- Adult and Well Elderly Preventive Care

Clinical guidelines are also reviewed and/or updated by Health Partners Plans' Quality Management Committee on a regular basis, in accordance with the most current information from nationally recognized medical and professional societies. The guidelines are mailed to all Health Partners Plans participating PCPs. They are also available on our website, [www.HealthPartnersPlans.com](http://www.HealthPartnersPlans.com).

Provider offices without internet access, or those that need extra copies of the guidelines, can call Health Partners Plans at **215-991-4350** or **888-991-9023**. The copies will be printed out and mailed to the requesting provider office.

The Clinical Guidelines include:

- ADHD
- Asthma
- Chronic Obstructive Pulmonary disease
- Heart Failure
- High Blood Cholesterol
- Diabetes
- HIV
- Hypertension
- Obesity
- Sexually Transmitted Diseases
- Tobacco Use and Dependence

Confidential, free testing and treatment are available for partners of infected individuals through the Department of Public Health STD Clinics. Below are numbers of STD control programs by county.

- Philadelphia County
  1400 Lombard Street
  (Broad and Lombard Streets)
  **215-685-6737**
- Bucks County
  **215-345-3318**
• Chester County  
  610-344-6225  
• Montgomery County  
  610-278-5117  
• Delaware County  
  610-447-3250  

Conscience Rights

Health Partners Plans respects the conscience rights of individual providers and provider organizations, as long as these conscience rights are made known to Health Partners Plans in advance, and comply with the current Pennsylvania laws prohibiting discrimination on the basis of the refusal or willingness to provide healthcare services on moral or religious grounds.

In order to provide options to our members, the provider will contact Health Partners Plans’ Utilization Management department to arrange for alternative care for the member. Utilization Management will work with Network Management to identify an alternative provider who can offer the care to the member.

Reportable Conditions

All providers including labs, practitioners and facilities are required to appropriately report in accordance with 28 PA Code Chapter 27 reported conditions to PA/county/municipal health departments. For complete information about this requirement please refer to Chapter 27 of the PA Code at [www.pacode.com/secure/data/028/028toc.html](http://www.pacode.com/secure/data/028/028toc.html).