Title: Medical Record Keeping and Review  
Policy Number: 8.06  
Version Number: 4  
Regulation Reference: NCQA, Joint Commission  
Effective Date: 7/2007  
Original Approval: 4/2005

POLICY STATEMENT:

It is the policy of TTUHSC School of Medicine (SOM) to periodically review medical records for completeness, accuracy and appropriateness. This policy and procedure is designed to assure all clinics’ medical record keeping and medical record documentation are in compliance with SOM standards and to satisfy Joint Commission Accreditation, Delegated Credentialing (NCQA office site standards), and Performance Improvement (PI) activities of the SOM.

SCOPE:

This policy applies and will be distributed to all TTUHSC School of Medicine Clinics in Lubbock, also known as Texas Tech Physicians of Lubbock.

PROCEDURE:

1. Medical Record Keeping standards are as follows:
   a. TTUHSC is committed to maintenance of confidentiality, protection and appropriate disclosure of all patient information in accordance with applicable federal and state laws. See TTUHSC HIPAA, Policies and Procedures.
   b. Confidentiality statements are signed by all employees upon employment with TTUHSC. See HSC OP 52.02, Privacy and Security of Health Information.
   c. Process for confidentiality breach
   d. TTUHSC will notify the patient should a breach of PHI or SPI occur.
   e. Release of patient information occurs in accordance with applicable federal and state law. See Ambulatory Clinic Policy 5.09, Release of Health Record Information.
   f. Disposal of medical records occurs in accordance with applicable federal and state law. See Ambulatory Clinic Policy 5.10, Guidelines for Destruction and Disposal of Protected Health Information.

2. Medical Record Review:
   a. The criteria and thresholds for Medical Record Review will be established by the SOM PI Director and approved by the Clinic Operations/PI committee.
   b. As a part of the initial credentialing and recredentialing process for PCP’s, OB/GYN’s, Behavioral Health providers and other specialists, medical record review will be performed. For new providers, the TTUHSC/UMC Medical Staff Office should notify the SOM PI Director when the credentialing process has been initiated for new providers and request a POR/MRR Report. For recredentialing, the SOM PI office will provide the Medical Staff Office medical review data as part of 8.06.B, Physician Profile.
c. Medical Record Reviews should be performed annually using [8.06.A, Medical Record Review Assessment Tool]; criteria falling below 90 should then audited quarterly.

d. Medical Record Review data reports will be maintained in the SOM Office of Performance Improvement.

e. The threshold for compliance will be 90% on all criteria. Should the standard not be met, written notice will be provided to the provider of all deficiencies. The provider (or department leadership representing the provider) will be required to submit a written action plan addressing the areas of concern within 14 days. The SOM PI Director shall review the merits of the provider’s action plan for correcting the area(s) of deficiency to determine if the provider has corrected the deficiency(ies) to the extent that a follow-up site review would result in a passing score of 90% or higher.

f. If the SOM PI Director’s review of the action plan is favorable; MRR will continue quarterly. Follow-up reports will be filed in the SOM PI office and forwarded to the HSC/UMC Medical Staff Office for the provider’s credentialing file.

g. Failure to obtain a passing score on the follow-up site review will be considered a failure of the provider to meet TTUHSC SOM’s minimum standards for office site and medical record keeping practices, the provider’s application for network participation will be considered incomplete.

h. If a(n) office/clinic is shared, medical record review data collected within the past year will be used to satisfy this requirement (if compliance rate is 90% or above).

**APPROVAL AUTHORITY:**

This policy shall be reviewed and approved by the Chief Medical Officer.

**RESPONSIBILITY AND REVISIONS:**

It is the responsibility of the Director of Performance Improvement to initiate necessary revision to this policy.

**ATTACHMENTS:**

- [8.06.A – Medical Record Review Assessment Tool](#)
- [8.06.B – Physician Profile](#)

Signatory approval on file by: Dale M. Dunn, MD
Chief Medical Officer