Policy and Procedure No: QM 21.3	**Revision No: 3**
Division: Care Management	
Department: Quality Management	
Title: PHC-CA Facility Site Review and Medical Records Review	
Effective Date: 6/17/2010	
Supersedes Policy No: 95030, 95031, QM 21.0, QM 21.1, QM 21.2	
Reviewed/Revised by: Sandra Holzner	**Review/Revision Date: 12/10/2025**
Approving Committee: Quality Management Committee	**Date: 12/11/2025**
Executive Oversight Committee Date: 12/16/2025	

Purpose:

To establish a process by which PHC California (the Health Plan) assesses the facilities and medical records of all Primary Care Providers (PCP).

Policy:

1. The Health Plan conducts Facility Site Reviews (FSR) and Medical Record reviews, initially and every three (3) years, on all PCP sites in accordance with the Department of Health Care Services (DHCS) All Plan Letter (APL) 22-017. Contractor must ensure that Network Providers, Subcontractors, and Downstream Subcontractors have the capacity to provide Primary Care services, appropriate Preventive Care services, coordination and continuity of care in accordance with 42 CFR section 438.207.

2. The Health Plan ensures that Network Providers provide physical access, reasonable accommodations, and accessible equipment for Members with physical or mental disabilities. Contractor must also conduct facility site physical accessibility reviews on PCP sites, Provider sites which serve a high volume of SPD Members, and all Provider sites including CBAS and ancillary service Providers, in accordance with Policy Letter (PL) 12-006 and W&I section 14182(b)(9).

3. Preoperational Site Reviews

    a. The number of Site Reviews to be completed prior to initiating or operating in a Service Area must be based upon the total number of new Primary Care sites in the Network. For more than thirty (30) sites in the Network, a five (5) percent sample size or a minimum of thirty (30) sites, whichever is greater in number, must be reviewed six (6) weeks prior to Contractor operation. Site Reviews must be completed on all remaining sites within six (6) months of operation. For thirty (30) or fewer sites, reviews must be completed on all sites six (6) weeks prior to operation.

    b. The Health Plan conducts an initial facility site review (FSR) of all new PCPs that are undergoing contracting and credentialing with the Health Plan; these must receive a minimum passing score of 80%. The Health Plan conducts a medical record review (MRR) on new PCPs within ninety (90) calendar days of the date the first member is assigned to the new PCPs.

4. Credentialing Site Review

    a. The Health Plan ensures that a Corrective Action plan is developed to correct cited deficiencies and that corrections are completed and verified within the established guidelines as specified in DHCS APL 22-017. PCP sites that do not correct cited

deficiencies must be terminated from the Health Plan's Network; the Health Plan must assign Members to other Network Providers in accordance with DHCS APL 21-003.

5. The Health Plan shall participate in L.A. Care FSR Collaborative and Los Angeles County FSR Collaborative and follow collaborative policies and procedures.

6. The Health Plan shall issue a Certificate of Completion to providers that successfully complete both the FSR and MRR and close all corrective action plans (CAP). The certificate is dated based on the most recent FSR and is valid for three years.

7. The Health Plan ensures that offices and facilities of Health Plan staff model and network providers comply with the requirements of Title III of the Americans with Disabilities Act of 1990, state regulatory requirements and accreditation standards.

8. The Health Plan shall employ a DHCS-Master Trainer (MT).

9. Data Submission

    a. The Health Plan must submit the Site Review data to DHCS up to quarterly, or in a manner or timeframe specified by DHCS. All data elements defined by DHCS must be included in the data submission report.

10. Medical Record Documentation

    a. The Health Plan must ensure the documentation of appropriate Medical Records for Members and that Medical Records are available to Providers at each Encounter in accordance with 42 USC section 1396a(w), 28 CCR section 1300.67.1(c), and APL 20-006.

    b. The Health Plan must have policies and procedures for developing, implementing and maintaining written procedures for all forms of Medical Record retention including but not limited to:

        i. For storage and filing of Medical Records including: collection, processing, maintenance, storage, retrieval, identification, and distribution;

        ii. To ensure that Medical Records are protected and confidential in accordance with all federal and State law;

        iii. For the release of information and obtaining consent for treatment; and

        iv. To ensure maintenance of Medical Records in a legible, current, detailed, organized and comprehensive manner (records may be electronic or paper copy).

    c. Onsite Medical Records

        i. The Health Plan must have policies and procedures to ensure that an individual is delegated the responsibility for securing and maintaining the security of Medical Records at each site.

    d. Member Medical Record

i. The Health Plan ensures that a complete, legible Medical Record is maintained for each Member in accordance with 22 CCR section 53861, which reflects all aspects of patient care, including, but not limited to, ancillary services, and at a minimum includes:

1. Member identification on each page; personal/biographical data in the record;

2. Member's preferred language (if other than English) prominently noted in the record, as well as the request or refusal of language/interpretation services in accordance with Title VI of the Civil Rights Act of 1964;

3. All entries dated with the author identified. For Member visits, all entries must include at a minimum, the documentation of subjective complaints, the objective findings, the plan for diagnosis and treatment, and follow-up care;

4. A problem list, a complete record of immunizations and health maintenance or preventive services rendered, and documentation of any outreach efforts surrounding any missed appointments;

5. Allergies and adverse reactions prominently noted;

6. All appropriate informed consent documentation, including the human sterilization consent procedures required by 22 CCR sections 51305.1 - 51305.6, if applicable;

7. Reports of Emergency Services provided (directly by the Network Provider or through an emergency room) and the hospital discharge summaries for all hospital admissions, including any follow-up after the provision of Emergency Services or hospitalizations;

8. Consultations and referrals, including for Complex Care Management (CCM), Enhanced Care Management, and Specialists, as well as evidence of review of specialty referrals, pathology, and laboratory reports. Any abnormal results must have an explicit notation in the Medical Record, including follow-up or outreach;

9. For Medical Records of adults, documentation of whether the individual has been informed and has executed an Advance Directive, such as a durable power of attorney, for health care for Members ages 18 and over;

10. Health education behavioral assessment and referrals to health education services where appropriate; and

11. Documentation of blood lead screening, immunizations, and other preventive services provided in accordance with the American Academy of Pediatrics Bright Futures Periodicity Schedule, the United States Preventive Services Task Force Grade A and B recommendations, the American College of Obstetrics and Gynecologists, and the Advisory Committee on Immunization Practice recommendations. Member refusal to receive blood lead screening, immunizations, or other preventive services must also be documented in the

Member's Medical Record as described in Exhibit A, Attachment III, Section 5.3 (Scope of Services).

Procedure:

1. New Primary Care Providers

    a. The Provider Relations and Credentialing Departments notify the Quality Improvement Department when a new provider is being contracted and undergoing credentialing in California.

    b. Quality Improvement Department or Provider Relations verifies that the provider site passed a FSR and MRR in the past three years.

        i. The Health Plan's qualified reviewer searches Los Angeles FSR collaboratives' database for valid FSR and MRR and obtains copy of completion certificate from the provider for the Credentialing department to retain on file.

    c. If no FSR and MRR is found for the past three (3) years, the qualified reviewer performs the initial reviews.

        i. Working collaboratively with Health Plan's Provider Relations and Credentialing Departments, the qualified reviewer schedules and performs the initial FSR.

        ii. The FSR is scheduled as soon as possible and before credentialing and contracting

        iii. If the provider passes the site review, the qualified reviewer provides PR and Credentialing a written statement of the result.

        iv. If the facility scored below 80% on the FSR:

            1. The qualified reviewer turns the initial FSR into an education session and provides technical assistance to the provider.

            2. The qualified reviewer schedules another initial FSR with the provider site.

            3. The qualified reviewer notifies Credentialing not to present the provider to the Credentialing Committee until further notice.

            4. If the provider fails the next initial FSR, the qualified reviewer stresses the importance of the passing the FSR and schedules another one. The qualified reviewer informs PR and Credentialing of the second fail. PR and Credentialing inform the qualified reviewer to cancel the third FSR if deemed necessary.

            5. If the provider fails the third initial FSR, the provider is not be credentialed or contracted.

        v. The qualified reviewer performs the MRR within ninety (90) calendar days of the date the first Health Plan enrollee is assigned to the provider. If the provider does not have enough medical records to be reviewed, another ninety (90) days may be

granted. The MRR must be completed within six months of the first member assignment.

2. Existing Primary Care Providers

    a. The qualified reviewer, Provider Relations and Credentialing Departments track the FSR and MRR of contracted PCPs.

    b. The qualified reviewer schedules and performs a subsequent FSR and MRR before the three (3) year period ends.

    c. The qualified reviewer informs provider of the preliminary score and discusses a corrective action plan (CAP), if necessary, with the provider at the conclusion of the FSR and MRR.
    d. The qualified reviewer informs PR and Credentialing about the result of FSR and MRR

        i. If the provider did not achieve 80% on either FSR or MRR, no new members are assigned to the provider until the CAP is closed. The Provider Relations and Credentialing Departments may decide to remove the provider from network.

3. PCP Site Relocation

    a. The qualified reviewer conducts an initial FSR within sixty (60) days of notification or discovery of the completed move.

    b. The Health Plan allows enrollees assigned to the provider to continue to see the provider.

    c. The Health Plan does not assign new members to the provider until the site receives passing FSR and MRR scores.

4. Review Scoring and Corrective Action Plans (CAP)

    a. The FSR tool is composed of both critical and non-critical elements. Critical elements (CE) are indicated by bold and underlined text in the FSR tool. CEs have the largest potential for adverse effects on patient health or safety and therefore have a scored weight of two (2) points, while non-critical review elements have a scored weight of one point. All MRR tool review elements have a scored weight of one point each.

    b. Exempted Pass – No CAP Required

        i. FSR Score of 90% and above with no deficiencies in CEs, infection control, or pharmacy

        ii. MRR Score of 90% and above, with all section scores at 80% and above

    c. Conditional Pass CAP Required

        i. FSR Score of 90% and above with deficiencies in CEs, infection control, or pharmacy

        ii. FSR Score of 80%- 89%, regardless of deficiencies

iii. MRR Score of 90% and above with one or more section below 80%

iv. Score of 80%-89%

d. Fail

i. FSR Score of 79% or below

ii. MRR Score of 79% or below

e. The Health Plan may require a CAP regardless of score for other findings identified during the survey that require correction.

f. The Health Plan develops a CAP for all cited deficiencies within one business day for critical elements and ten (10) business days for non-critical elements from the date of the completed FSR.

i. The Health Plan verifies that all aspects of CE CAPs are completed within ten (10) business days of the FSR completion.

ii. The Health Plan verifies that all aspects of non-critical CAPs are completed within thirty (30) business days of the FSR completion.

iii. Providers can request a definitive, time-specific extension period to correct CE deficiencies, and to be granted at the discretion of the Health Plan, not to exceed sixty (60) calendar days from the date of the FSR.

5. Executive Orders

a. Executive orders temporarily affecting these procedures will supersede these procedures during catastrophic events.

Definitions:

1. All Plan Letter (APL) or Policy Letter (PL) means a binding document that has been dated, numbered, and issued by Department of Health Care Services (DHCS) that provides clarification of the Health Plan's contractual obligations, implementation instructions for the Health Plan's contractual obligations due to changes in State and federal law or judicial decisions, and/or guidance with regulatory force and effect when DHCS interprets, implements, or makes specific relevant State statutes under its authority.

2. Authorized Representative (AR): means any individual appointed in writing by a competent Member or Potential Member, to act in place or on behalf of the Member or Potential Member for purposes of assisting or representing the Member or Potential Member with Grievances and Appeals, State Hearings, Independent Medical Reviews, and in any other capacity, as specified by the Member or Potential Member.

3. Complex Care Management (CCM): means an approach to care management that meets differing needs of high and rising-risk Members, including both longer-term chronic Care Coordination for

chronic conditions and interventions for episodic, temporary needs. Contractors must provide CCM in accordance with all National Committee for Quality Assurance (NCQA) CCM requirements.

4. Corrective Actions: means specific identifiable activities or undertakings of the Health Plan which address Contract deficiencies or noncompliance.

5. Credentialing: means the process of determining a Provider or an entity's professional or technical competence, and may include registration, certification, licensure, and professional association membership.

6. Department of Health Care Services (DHCS) or Department: means the single State department responsible for the administration of the Medi-Cal Program, California Children's Services (CCS), Genetically Handicapped Persons Program (GHPP), and other health-related programs, as provided by statute and/or regulation.

7. Medical Records: means the record of a Member's medical information, including but not limited to medical history, care or treatments received, test results, diagnoses, and prescribed medications.

8. Member or Enrollee: means a Potential Member who has enrolled with the Health Plan.

9. National Committee for Quality Assurance (NCQA): is an organization responsible for the accreditation of managed care plans and other health care entities and for developing and managing health care measures that assess the Quality of Care and services that Members receive.

10. Network: means Primary Care Providers (PCPs), Specialists, hospitals, ancillary Providers, facilities, and other Providers with whom Contractor enters into a Network Provider Agreement.

11. Network Provider: means any Provider or entity that has a Network Provider Agreement with the Health Plan, the Health Plan's Subcontractor, or Contractor's Downstream Subcontractor, and receives Medi-Cal funding directly or indirectly to order, refer, or render Covered Services under this Contract. A Network Provider is not a Subcontractor or Downstream Subcontractor by virtue of the Network Provider Agreement

12. Primary Care Provider (PCP) means a Provider responsible for supervising, coordinating, and providing initial and Primary Care to Members, for initiating referrals, for maintaining the continuity of Member care, and for serving as the Medical Home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, non-physician medical practitioner, or obstetrician-gynecologist (OB-GYN). For Senior and Person with Disability (SPD) Members, a PCP may also be a Specialist or clinic.

13. Qualified reviewer: a physician or registered nurse who is certified by DHCS as a DHCS-Master Trainer (MT) or DHCS-Site Reviewer.

Monitoring:

1. The qualified reviewer presents an FSR MRR summary report to the Quality Improvement and Health Equity Committee (QIHEC) at least annually.

2. This policy is reviewed, updated, if needed, and approved at least annually QIHEC or as needed for regulatory, accreditation or contract changes.

3. The Health Plan follows DHSC FSR reporting requirements and reports FSR MRR results bi-annually to MMCD and at least annually to QIHEC.

4. Managed Care Plan Medical Directors are responsible for site review activities.

References:

1. DHCS All Plan Letter 22-017 (Supersedes APL 20-006), Primary Care Provider Site Reviews: Facility Site Reviews and Medical Record Review, published September 22, 2022.

2. Americans with Disabilities Act of 1990 (ADA), including changes made by the ADA Amendments Act of 2008 (P.L. 110-325), which became effective on January 1, 2009. http://www.ada.gov/pubs/adastatute08.htm.

Regulatory Agency Approvals:

Date	Version	Agency	Purpose	Response