Policy Name: **Quality Site Visit Standards *for Primary Care Physicians (PCP)***
Policy Number: Quality Improvement – 01
Effective Date: 01/01/11
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Approval Signature

3/13/2020

Derek Robinson VP, CMO BCBSIL Quality Improvement and Medical Management **Date**

Line of Business

Commercial	Exchange	Government
☒ HMO	☒ HMO	☐ HMO
☐ PPO	☐ PPO	☐ PPO

Approving Body

☒ Policy and Procedure Committee Date: 2/27/2020

Details

Policy:

The Blue Cross and Blue Shield of Illinois (BCBSIL) onsite audit staff will adhere to Quality Site Visit Standards when conducting quality onsite audits for participating HMO Illinois

Quality onsite visits are performed on IPA providers randomly sampled with a goal of a 95% confidence interval sampling per IPA in cohort over a three-year cycle. *individual sampling results may vary

Purpose:

To audit providers against established Quality Site Visit standards including information related to the following:

- Physical Accessibility;
- Office site; Physical Appearance
- Emergency Preparedness;
- Medical Record Review and adequacy of record keeping
- Safety Measures
- Preventive Services
- American Disability Act (ADA) requirements

Procedure:

A. BCBSIL auditors will schedule *an onsite* visit with the provider office, provide a copy of the onsite standards and checklist by which the provider will be evaluated and conduct an inspection of the office site which includes, but is not limited to:

1. Member's ability to access health care.
2. Inspection of the office site including physical accessibility, physical appearance, adequacy of waiting and examination room space, and other areas of the facility to evaluate compliance with office site standards.

3. Medical record review consists of at least five medical charts per provider, chosen from a roster of current members provided by the ***auditor*** at the time of the audit. This ensures compliance with medical record and preventive care standards.

I. ACCESSIBILITY STANDARDS

Purpose:

To evaluate whether members have appropriate access to health care services.

The IPA Physician shall practice in a place(s) acceptable to the HMO and distinctly identifiable as a medical facility at which services in the areas of Family ***Medicine***, Internal Medicine, Pediatrics, and Obstetrics-Gynecology shall be available to Members.

a) Ensure that all IPA Physicians provide reasonable access for all Members enrolled with the IPA including, but not limited to, the following:

   1) Appointment for Preventive Care within four (4) weeks of request for members 6 months of age and older;

   2) Appointment for Preventive Care within two (2) weeks of request for infants under 6 months of age

   3) Appointment for Routine Care within ten (10) business days or two (2) weeks of request, whichever is sooner;

   4) Appointment for Immediate Care within twenty-four (24) hours of request;

   5) Response by IPA Physicians within thirty (30) minutes of an Emergency call;

   6) Notification to the Member when the anticipated office wait time for a scheduled appointment may exceed thirty (30) minutes;

b) Ensure that HMO Members enrolled with the IPA have access to PCP medical services including, but not limited to, the following:

   1) Routine Care – Each PCP or PCP office is required, at a minimum, to be available to provide routine care to HMO Members enrolled with the IPA for at least eight hours per month outside the hours of 9:00 am – 6:00 pm Monday through Friday. PCP office is defined as a specific office location at which one or more PCPs are marketed to HMO Members as a location where primary care services are available.

   2) Immediate Care – Each PCP or PCP office is required, at a minimum, to provide or arrange access to care for HMO Members with immediate medical needs as outlined below:

      a) Early morning or evening office hours three or more times per week.

         Early morning hours are defined as hours beginning at 8:00 a.m. and extending until 9:00 a.m. Evening hours are defined as hours beginning at 6:00 p.m. and extending until 8:00 p.m.

      b) Weekend office hours of at least three hours two or more times per month.

         Alternate arrangements for ensuring HMO Members access to immediate care must meet the minimum access requirements outlined above and be approved in writing by the HMO. Facilities billing Immediate Care services as an emergency room visit shall not be considered an alternate arrangement for access to Immediate Care.

c) Maintain a twenty-four (24) hour answering service and ensure that each provider has a twenty-four (24) hour answering arrangement and a twenty-four (24) hour on-call PCP arrangement for all Members enrolled with the IPA.

d) Maintain answering service log of provider calls for *ten (10) years. If an answering service is used, service must provide a policy that states the service will keep answering service logs for at least 10 years. Call logs should be available to the provider if needed. Policy needs to be available to the auditor at the time of the audit.*

e) Office should have their office hours posted in a visible place for members to see.

II. SITE REVIEW STANDARDS

Purpose:

Assess whether members have appropriate access to healthcare services in a clean and safe environment.

Procedure:

1. Environment:
   - The site should be clean, well-organized and well-lit to accommodate patient services.
   - Restrooms, doorways and hallways should be easily accessible and uncluttered.
   - Corridors leading to exits are clear. No storage of any kind is present in the exit hallways.
   - The waiting room should have adequate seating for the volume of patients and adequate lighting to read.
   - There should be an adequate number of exam rooms based on the number of providers. Exam room space includes provision for privacy during examinations or procedures.
     - The site should be accessible to those with disabilities. Please note: The building must be compliant with ADA (American Disabilities Act) guidelines.
     - Exterior of Building, all criteria need to be met:
       - There should be at least one entrance to the office that is accessible to those with impaired mobility or those in a wheel chair.
       - Curb ramp must be 36 inches wide.
       - Exterior entry door is 32 inches wide and opens to 90 degrees.
       - Entry door hardware is operable with one hand; does not require tight twisting, grasping or pinching. ("closed fist" test)
       - Interior of building: Interior entry door to office 32 in wide and opens at 90 degrees.
       - Office reception area is at least open space 36 in wide by 48 in. long for a wheelchair.
     - There should be at least one exam room that can be accessed by doorways
       - At least 32 in wide and hallways that are at least 36 inches wide.
       - At least one side of exam table has 30 in by 48 in of space.
     - Elevator available:

  - Call buttons no higher than 54 inches from the floor.
  - Sliding door reopens automatically when obstructed by an object (if constructed before 3/15/12 and manually operated, door is not required to reopen automatically.
  - In car buttons are no greater than 48 in from the floor.
  - In car buttons have raised characters and in braille.
  - Audible signals when care passes or stops at a floor
- There should be at least one restroom that can be accessed by doorways and hallways that are at least 36 inches wide. This restroom should have signage in high contrast raised lettering and be in braille. If a pictogram is used, it must be accompanied by raised characters and braille
  - Restroom with stalls has space for a wheelchair to turn around in a circle 60in in diameter
  - Restroom without stalls has clear floor space 30 in by 48 in beyond the swing of the door.
  - Grab bar is at least 42 in long on the side wall.
  - Grab bar is at least 36 in long on the rear wall Exception: the rear grab shall be permitted to be 24" long minimum, due to location of recessed fixture adjacent to the water closet
  - Toilet paper dispenser is no greater than 48 in above the floor below the side of grab bar.
  - Sink has a clear space 30 in wide by 48 in long
  - Faucet can be operated without tight twisting, grasping or pinching.
  - Soap dispenser is not over an obstruction. Soap dispenser is no higher than 48 in above the floor.
- Exit signs and signs in the facility must be high contrast (for example: red on green, black on white or red on white).
- Handicap parking signs must be 60 inches above the ground.
- Accessibility around public transportation routes which refers to walkways leading to the physician office from the bus or subway stop must be sidewalks, not gravel, not cracked; a member must be able to use walkers or wheelchairs from the drop off to the entrance.
- Parking: if the office has a private parking lot (lot specific to doctor's office) it must have designated handicapped parking spots. There is an adequate location and number of spaces available with required signage. One van accessible space needed for every 25 spaces in the lot. (ADA Medicaid Standard)
- If the office is in a doctor's house, was built after 1991 and has private parking, it must have designated handicapped parking spots. If there is not a private lot, such as in City Street parking, there is NO requirement regarding handicapped parking spots.
- There should be overhead lifts, transfer boards, or an exam room table that is low to the floor for people to move from the wheelchair to the exam table.

- There should be a scale that is integrated into a patient lift or on an exam table or wheelchair accessible with a platform

2. Safety Measures:
   - The provider and his/her staff should follow the Centers for Disease Control and Prevention Universal Precautions guidelines when providing patient care.
   - Bio-hazardous waste must be discarded according to OSHA guidelines.
   - Sharp disposal containers must be available.
   - Fire Extinguisher or sprinkler system must be accessible.

3. Lab Specimens and Medication Maintenance/Storage:
   - Sample drugs, over-the-counter medications, prescription drugs, and vaccines should be stored in restricted patient areas. *
   - Controlled substances, if present, should be stored in a locked area along with an inventory list. *
   - Offices should have policies and procedures for checking medications for expiration dates and for discarding expired medications.
   - All medications should be routinely monitored for expiration dates.
   - Opened medications should be labeled with the date the item was opened.
   - Opened multi-dose vials must be discarded after 28 days since first use, except for vaccinations or other drugs with packaging information labeled with different discard recommendations.
   - Medication and/or lab refrigerators should be kept separate and free of food.

4. Medical Supply and Equipment Maintenance/Storage:
   - Sharps should be stored in restricted patient areas. *
   - Prescription pads should be stored in restricted patient areas. *
   - Medical equipment should be monitored for sterilization and a maintenance log should be maintained for equipment.
   - Sterile supplies should be monitored for package integrity and dryness.

5. Medical Record System:
   - Medical records should be handled in a confidential manner. The office must have a written policy that addresses Health Insurance Portability and Accountability Act (HIPAA) requirements regarding Protected Health Information (PHI).
   - The office must have an employee confidentiality of release of medical information policy and follow the policy.
   - The provider should have a written policy/procedure detailing how medical record information is to be released.

6. Patient Education:
   - Educational materials or literature regarding preventive services and medical conditions relevant to the provider's practice must be available for patient use. Examples of preventive materials might be: information about mammography, Pap smears, pediatric immunizations, smoking cessation, flu shots, or coronary risk reduction. Materials about conditions relevant to the provider's practice could cover topics such as asthma management, diabetes management, management of abnormal Pap smears, and pregnancy care.
   - The office provides patient education materials and member resources are available in large print. (16 font)

III. EMERGENCY PREPAREDNESS

Procedure:

1. Emergency Preparedness
   - The provider should have a written procedure on how to handle a medical emergency for members accessing care at his/her facility. This procedure must be posted in a prominent location or easily accessible through a central file/manual.
   - At least one staff member who has Cardiopulmonary Resuscitation (CPR) Certification should be available during patient care hours. This certification must be kept current and documentation of certification must be available for verification upon request.

IV. MEDICAL RECORD REVIEW

Purpose:

BCBSIL requires member medical records to be maintained in a manner that is current, detailed, organized, and easily accessible. All patient data should be filed in the medical record, (i.e., lab, x-ray, consultation notes, etc.) Documentation of a member's care should facilitate communication, coordination and continuity of care and promote efficiency and effectiveness of treatment.

Procedure:

Please note: A history form can include many of the required documentation items. This form can be completed by the patient, office staff or physician. The physician, nurse practitioner, or physician assistant should review the form for completeness, sign and date the form. Blank areas on the form will be scored as non-compliant. The form must be updated at least every three years for adult and pediatric patients. Preventive care services must be performed according to the dates required per element.

1. Past Medical History: There should be documentation of a past medical history obtained by the third visit or within one year of the first visit, whichever comes first. The medical history should be updated at least every three years for adult and pediatric patients.

2. Family History: There should be documentation of a family medical history obtained by the third visit or within one year of the first visit, whichever comes first. The family medical history should be updated at least every three years for adult and pediatric patients.

3. Social History: There should be documentation of a social history (including, but not limited to, information about family and occupation, and assessment of tobacco, alcohol and illicit substance use) obtained by the third visit or within one year of the first visit, whichever comes first. For pediatric patients, the developmental milestones may be included. The social history should be updated at least every three years for adult and pediatric patients.

4. Physical Activity Assessment/ Counseling: There should be documentation of assessment and/or counseling regarding physical activity obtained by the third visit or within one year of the first visit, whichever comes first. The physical activity assessment/ counseling should be updated at least every two years (ages 18 and above) or every year (ages 3-17).

5. Body Mass Index (BMI): There should be documentation of the patient's BMI (BMI percentile for children) by the third visit or within one year of first visit, whichever comes first.

The BMI should be updated at least every two years for ages 18-74 and the BMI percentile updated at least every year for children ages 2-17.

6. Weight Management Counseling: There should be documentation of education regarding weight management (diet and exercise) for adults with a BMI over 30 and children with a BMI percentile over 85% by the third visit or within one year of first visit, whichever comes first. This should be performed at least every 2 years for adults and annually for pediatrics.

7. Nutrition Counseling for Children: There should be documentation of nutrition counseling every year for patients ages 2-17 years.

8. Adult Alcohol Use: There should be documentation regarding alcohol use obtained by the third visit or within one year of the first visit, whichever comes first, for adults age 18 and over. If the member is currently using alcohol, it should be noted. The history of alcohol use should be updated annually.

9. Utilization of a Standardized Alcohol Assessment Tool for an Adult: There should be documentation of the use of a standardized alcohol assessment tool if the patient answers "yes" to any alcohol use.

10. Adolescent Alcohol Use: There should be documentation regarding alcohol use obtained by the third visit or within one year of the first visit, whichever comes first, for adolescents age 12-17. If the adolescent is currently using alcohol, it should be noted. The history of alcohol use should be updated every year.

11. Utilization of a Standardized Alcohol Assessment Tool for an Adolescent: There should be documentation of the use of a standardized alcohol assessment tool if the patient answers "yes" to alcohol use.

12. Adult Inappropriate/ Illicit Substance Use: There should be documentation regarding inappropriate/ illicit substance use obtained by the third visit or within one year of the first visit, whichever comes first, for adults age 18 and over. If the member is currently using illicit substances, it should be noted. The history of substance use should be updated every three years.

13. Recommendation for Adult Inappropriate/Illicit Substance Use Treatment: Instructions and/or education about recommendation for treatment should be provided to members who are identified as using inappropriate/illicit substances.

14. Adolescent Inappropriate/Illicit Substance Use: There should be documentation regarding inappropriate/ illicit substance use obtained by the third visit or within one year of the first visit, whichever comes first, for adolescents age 12-17. If the member is currently using illicit substances, it should be noted. The history of substance use should be updated at least every year.

15. Recommendation for Adolescent Inappropriate/Illicit Substance Use Treatment: Instructions and/or education about recommendation for treatment should be provided to adolescents age 12-17 who are identified as using inappropriate/ illicit substances.

16. Smoking History for Adults: There should be documentation of a smoking history obtained by the third visit or within one year of the first visit, whichever comes first, on adults age 18 and over. If the member is currently smoking, it should be noted. The smoking history should be updated every two years. Documentation that the patient has been a non-smoker for more than 5 years meets the intent and additional updates are not required.

17. Recommendation for Smoking Cessation for Adults: Instructions and/or education about smoking cessation should be provided to members age 18 and over who are identified as smokers. If the patient smokes, update the smoking history at least every two years and provide smoking cessation advice at least annually.

18. Smoking History for Adolescents: There should be documentation of a smoking history obtained by the third visit or within one year of first visit, whichever comes first, on adolescents age 12-17. The smoking history should be updated at least every two years.

19. Recommendation for Smoking Cessation for Adolescents: Instructions and/or education about smoking cessation should be provided to adolescents age 12-17 that are identified as smokers. If the patient smokes, update the smoking history at least every two years and provide smoking cessation advice at least annually.

20. Coordination between Medical and Behavioral Health Care: If the member is seeing a Behavioral Health provider, there should be documentation of communication between the Behavioral Health provider and the referring physician. Documentation should include, but not be limited to, follow-up regarding coexisting medical and behavioral health disorders and medication management. If the member refuses to allow such communication, this should be documented in the medical records. A release of information form is not sufficient.

21. Coordination between Medical and Behavioral Health Care Providers should show documented evidence that a depression screening was conducted using a patient health questionnaire (PHQ). This should be conducted annually for patients 12 and older.

22. Immunization Documentation: Documentation of immunizations administered by the office staff should include the date the vaccine was administered, the manufacturer and lot number, and the name and title of the person administering the vaccine. If the office maintains an immunization log, the medical record must have documentation of the site, the name and title of the person administering the vaccine, and the type of vaccine. The lot number may be documented in the log. The log must be provided for review.

23. Chief Complaint/History Relevant to Problem: Subjective information identifying why the patient is seeking medical attention should be documented. The description should include pertinent history, symptoms, and other related information.

24. Physical Examination: A pertinent physical examination, relevant to the problem, should be documented.

25. Vital Signs: Vital signs, consistent with the patient's chief complaint, relevant problem and/or diagnosis, should be documented.

26. Diagnosis/Assessment: A diagnosis and/or assessment, consistent with the findings, should be documented.

27. Treatment Plan/Plan of Care: A plan of diagnosis (lab testing, x-rays, etc.) and management (medication dose, frequency, and duration, as well as other interventions), consistent with the assessment, should be documented. If an abnormal lab or x-ray finding is identified in the medical record, the plan of care should address these findings.

28. Education relevant to the patient's conditions or treatment must be documented at least annually.

29. Continuity of Care, Follow-Up Care, Calls or Visits: Follow-up care, communication of test results, calls/visits should be documented to indicate continuity of care.

30. Continuity and Coordination of Care: Documentation of member movement across settings, (hospital to rehab, hospital to nursing home, etc) should show evidence indicating information was sent/received to another provider.

31. Referrals: When referred, the provider should have a referral process in place.

32. Consultations: Documentation of response/feedback from a referral for consultation to a specialist should be present in the record and should be signed/ initialed by the physician, nurse practitioner or physician assistant and/or there should be a notation in the progress notes indicating that the feedback from the specialist has been reviewed.

33. Chart Organization: The provider should maintain a uniform medical record system of clinical recording and reporting with respect to services which includes separate sections for progress notes and the results of diagnostic tests.

34. Biographical Information: Each medical record should contain the patient's address, employer, home and work telephone numbers including emergency contacts, marital or legal status, appropriate consent forms and guardianship information, if relevant. Biographical information should be updated at least every three years.

35. Patient Identifiers: Patient identifiers should appear on each page of the medical record (patient name or unique ID number).

36. Date and Signature: All entries are to be dated and signed/initialed by the author. Author identification may be a handwritten signature, unique electronic identifier or initials.

37. Legibility: All entries should be legible.

38. Allergy Status: Medication allergies should be noted in a prominent location in the medical record. If the member has no known allergies or history of adverse reactions, this should be prominently and consistently noted. Allergies to environmental allergens, food, pets, etc., should also be noted. Allergy histories should be obtained by the first visit and documented annually.

39. Problem List: There should be a current problem list, either kept separately or within each provider progress note, which includes significant illnesses and medical conditions. A health maintenance record should be present if there are no documented relevant problems. The problem list must be inclusive of all problems whether a separate list or within each provider's note.

40. Medication List: There should be a current medication list, either kept separately or within each provider's progress note. The medication list must be inclusive of all medications, whether a separate list or within each provider's progress note, and include prescription initial or refill dates.

41. Lab/X-Ray/Diagnostic Results: The results of all labs, x-rays and diagnostic testing, should be posted in the chart. The reports should be signed or initialed by the physician, nurse provider or physician assistant and/or there should be a notation in the progress notes indicating that they have been reviewed.

V. PREVENTIVE SERVICES

Purpose:

To ensure that members have appropriate access to preventive care services.

Procedure:
BCBSIL has specific Preventive Health Care Guidelines based on national recommendations. providers should provide services in accordance with these guidelines. The offer of services and the subsequent results or the member's refusal to accept services should be documented in the member's medical record. If the service was provided by another ***provider's*** (example: OB/GYN), document in the medical record that the service was provided, with the date and the results. Preventive care services should be provided by the third visit or within one year of the first visit, whichever comes first. The date of service and results or findings should be documented in the medical record. The medical records will be reviewed for performance of the following preventive care services:

A. Adult Female:

1. Cervical cancer screening (Pap)
    - Screen for cervical cancer with cytology (Pap smear) every three years in women age 21 to 65. An option for women ages 30 to 65 who want to lengthen the screening interval is screening with a combination of cytology, HPV and hrHPV testing every five years.
    - Screening is not recommended for women younger than age 21.
    - For women older than age 65 years who have had adequate prior screening and are not otherwise at high risk for cervical cancer, screening is not recommended.
    - For women who have had a hysterectomy with removal of the cervix and do not have a history of a high grade precancerous lesion or cervical cancer, screening is not recommended.
    - Screening with HPV testing is not recommended for women younger than age 30 years.
2. Chlamydial infection screening should be done annually for all sexually active young women ages 16-24. Please use clinical judgement assessing sexual activity and a need for this screening on young women outside this age range.

3. Mammography should be performed everyone to two years for members age 50 to 74, and date of service and results or findings, should be documented in the medical record. Members who have had bilateral mastectomies should be excluded from screening, and should have the dated history of bilateral mastectomies documented in the medical record. Medical records for members age 51-74 will be audited for this measure.

4. Colorectal cancer screening should be performed for members age 50-75, by means of ONE of the following screening options:
    - Fecal occult blood test within the past 12 months (FOBT or FIT performed during a physical exam on a specimen obtained from a digital rectal exam does not count, because it is not specific or comprehensive enough to screen for colorectal cancer.)
    - FIT-DNA "multi-targeted stool DNA test, Cologuard" within past 3 years.
    - Flexible sigmoidoscopy within the past five years.
    - Colonoscopy within the past 10 years.
    - Only medical records for members age 51-75 will be audited for this measure. The chart must include the date, type of test and results.

5. Influenza Vaccinations should be administered annually to all members age 18 and older.

   Documentation of immunizations administered by the office should include the date the vaccine was administered, the manufacturer and lot number, and the name and title of the person administering the vaccine. If the office maintains an immunization log, the medical record must have documentation of the site, the name and title of the person administering the vaccine, and the type of vaccine. The lot number may be documented in the log. The log must be provided for review.

6. Bone Density Testing for Osteoporosis should be performed at least once for women after age 65.

B. Adult Male:

1. Non-fasting cholesterol should be performed every five years on members over the age of 35. The medical record should document the date and results or findings. Only medical records for members age 36 and over will be audited for this measure.
2. Colorectal cancer screening should be performed for members age 50-75, by means of ONE of the following screening options:
   - Fecal occult blood test (FOBT) within the past 12 months (FOBT or FIT performed during a physical exam on a specimen obtained from a digital rectal exam does not count, because it is not specific or comprehensive enough to screen for colorectal cancer.)
   - FIT-DNA "multi-targeted stool DNA Test, Cologuard" within the past 3 years.
   - Flexible sigmoidoscopy within the past five years.
   - Colonoscopy within the past 10 years.
   - Only medical records for members age 51-75 will be audited for this measure. The chart must include the date, type of test and results.

3. Influenza Vaccinations should be administered annually to all members age 18 and older.

   Documentation of immunizations administered by the office should include the date the vaccine was administered, the manufacturer and lot number, and the name and title of the person administering the vaccine. If the office maintains an immunization log, the medical record must have documentation of the site, the name and title of the person administering the vaccine, and the type of vaccine. The lot number may be documented in the log. The log must be provided for review.

C. Children:

1. Immunizations should be performed according to the Recommended Childhood Immunization Schedule, United States, as approved by the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP).
   - Parent refusal of such services should be documented in the medical record. These will be scored as non-compliant.
   - For members who have transferred from another provider, immunization records should be obtained and reviewed for completeness.
   - Documentation of immunizations administered by the office should include the date the vaccine was administered, the manufacturer and lot number, and the name and title of person administering vaccine.

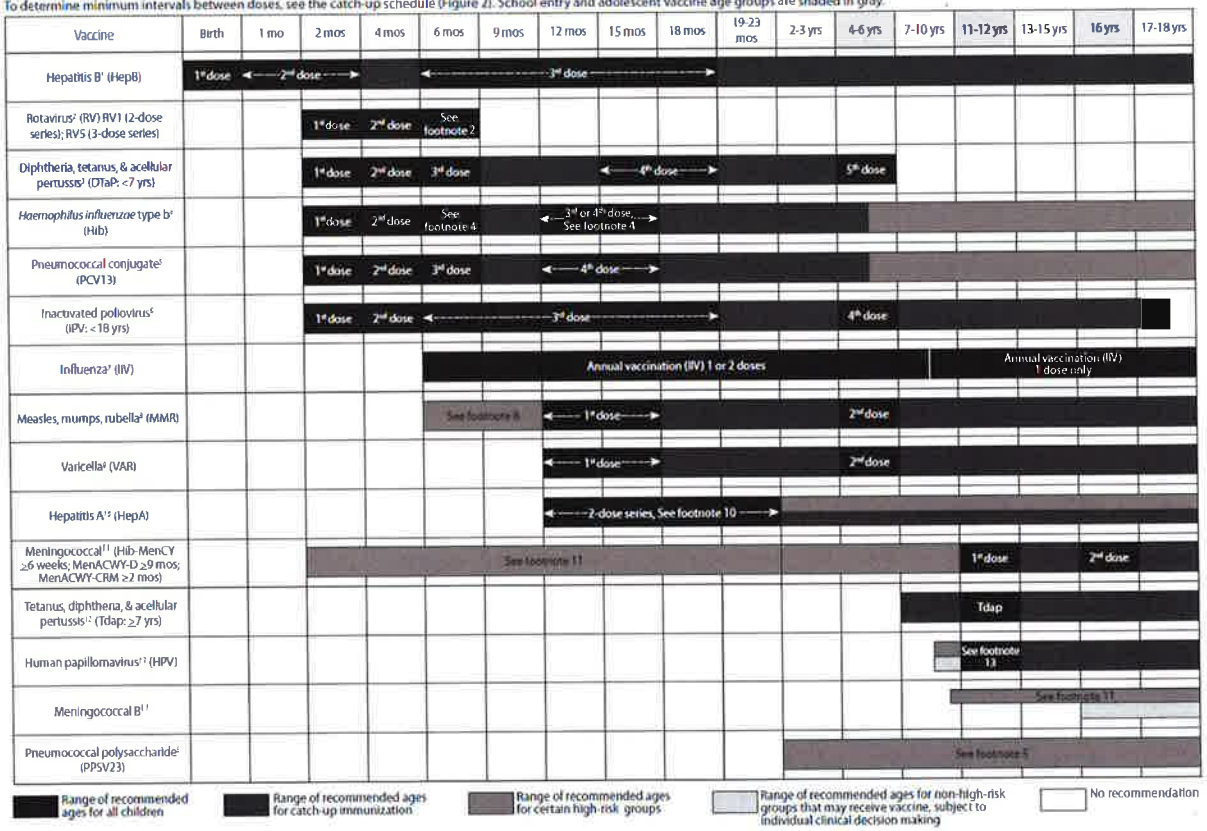
- The medical records will be audited and scored for immunizations due by the age of 2 years old as identified in Table A. The immunizations audited are: DTaP, IPV, Hib, MMR, Hep B, Varicella, and Pneumococcal.

Information will be collected for:

- For children over 6 months of age and older the record will be reviewed for influenza vaccination given annually.
- Records will be audited for two Hepatitis A given on or before the 2nd birthday and at least 6 months apart.
- Records will be audited for a series of rotavirus/rototec/rotarix vaccine given before the first birthday and in accordance with Table A.
- Records will be audited for one Meningococcal Conjugate Vaccine given to patients between the 11th and 13th birthday.
- Records will be audited for at least 2 or 3 HPV vaccines administered on or between the members 9th and 13th birthday.
- Records will be audited for at least one TDAP vaccine on or between the members 10th and 13th birthday.

TABLE A

Figure 1. Recommended Immunization Schedule for Children and Adolescents Aged 18 Years or Younger—United States, 2017.
(FOR THOSE WHO FALL BEHIND OR START LATE, SEE THE CATCH-UP SCHEDULE (FIGURE 2)).
These recommendations must be read with the footnotes that follow. For those who fall behind or start late, provide catch-up vaccination at the earliest opportunity as indicated by the green bars in Figure 1. To determine minimum intervals between doses, see the catch-up schedule (Figure 2). School entry and adolescent vaccine age groups are shaded in gray.



NOTE: The above recommendations must be read along with the footnotes of this schedule.

Table B:

Combination Vaccines

Immunization
DTaP + Hep B + IPV (Pediarix)
Hep B + HiB (Comvax)
MMR + VZV (ProQuad)
DtaP + IPV (Kinrix)
DTaP + IPV+HiB (Pentacel)

Table C:

*Contraindications for Childhood Immunizations-for a more comprehensive list please refer to www.cdc.gov/vaccines/recs/vac-admin/contraindications.htm.

Immunization	Contraindication
Any particular vaccine	Anaphylactic reaction to the vaccine or its components
DTaP	Encephalopathy
IPV	Anaphylactic reaction to streptomycin, polymyxin B or neomycin
MMR, VZV and influenza	Immunodeficiency, including genetic (congenital) immunodeficiency syndromes
MMR, VZV and influenza	HIV disease; asymptomatic HIV
MMR, VZV and influenza	Cancer of lymphoreticular or histiocytic tissue
MMR, VZV and influenza	Multiple myeloma
MMR, VZV and influenza	Leukemia
MMR, VZV and influenza	Anaphylactic reaction to neomycin
Hepatitis B	Anaphylactic reaction to common baker's yeast

MINIMUM SCORE TO PASS ON-SITE VISIT

HMO Illinois®, Blue Advantage HMO℠, BlueCare Direct℠, Blue Precision HMO℠ and Blue FocusCare℠,

2020 Passing Thresholds

Standards Category	Current HMO IPA	Current HMO PCP
Accessibility, Facility, Emergency Care	90%	90%
Medical Record Review, Preventive	90%	90%

NOTE:
Each standard has a passing threshold of 90%

Any Provider failing to meet the minimum passing threshold of 90% will be placed on corrective action and re-audited within six months.
Any Provider failing two consecutive site visits must submit a written corrective action plan (CAP) within 30 days of receipt of the letter requesting a CAP. Failure to submit a CAP may result in de-participation from the network without a third site visit.
Any Provider failing three consecutive site reviews may be departed from all networks.