2007 GUIDELINES FOR MEDICAL RECORD REVIEW

Consistent and complete documentation in the medical record is an essential component of quality patient care. The following 18 elements reflect a set of commonly accepted standards for medical record documentation. Although all 18 elements are required for good medical record keeping practices, only the eight-bolded items will be reviewed during the ten chart medical record audit. **The medical record audit will be performed at a minimum of every two years, where applicable per state requirements, with a passing score of 90% or higher. A score of 89% or lower will require a re-audit with in 6 months of the original audit date.**

1. Each and every page in the record contains the member's name or ID number. This includes double sided pages of the medical record; both sides must have the member ID.

2. Personal biographical data includes address, employer, home and work telephone numbers and marital status.

3. All entries in the medical record contain author identification, which may be a handwritten signature, initials or a unique electronic identifier.

4. All entries are dated.

5. The record is legible to someone other than the writer. A second reviewer should evaluate any record judged illegible by one reviewer.

6. **Significant illnesses and medical conditions are indicated on the problem list. On PCP charts, health care maintenance should be included.**

7. **Medication allergies and adverse reactions are prominently noted/displayed in the record. If the member does not have allergies, this should also be noted (Examples: NKA, None, NKMA, etc.).**

8. **Significant past medical history (for patient seen three or more times) is easily identified and include serious accidents, operations, illnesses. For children and adolescents (12 years and younger), past medical history relates to prenatal care, birth operations and childhood illnesses. For specialists, a general past medical history should be obtained along with a focused past medical history pertaining to the specialty.**

9. **For patient's 12 years and over, notation concerning use of cigarettes, alcohol and substance abuse is present (following first appropriate health maintenance visit).**

10. The history and physical documents appropriate subjective and objective information for presenting complaints.

11. Lab and other studies are ordered as appropriate
12. **Working diagnoses are consistent with findings.**

13. **Plans of action/treatment are consistent with diagnosis (es).**

14. Encounter forms or notes have a notation, when indicated, regarding follow-up care, calls or visits. The specific time of return is noted in weeks, months or PRN.

15. Unresolved problems from previous office visits are addressed in subsequent visits.

16. Consultation, lab and x-ray reports filed in the chart are initialed by the physician or some other electronic method is used to signify review. Consultation and abnormal lab and imaging study results have an explicit notation in the record of patient notification and follow-up plans.

17. **There is no evidence that the member is placed at inappropriate risk by diagnostic or therapeutic problem.**

18. **There is a completed immunization record for all patients. A completed immunization record would include the following:**

    Birth to 11 years old: DTaP, Hib, Hep B, IPV, MMR, Prevnar and Varicella (vaccine or date of disease)

    12 years old to 18 years old: DTaP or TD, second MMR, Hepatitis B series and Varicella (vaccine or date of disease)

    19 years and older: Date or approximate year of last known tetanus and any other immunization as appropriate