

Midlands Choice Office Medical Records Review Criteria

Indicator	Met	Not Met
1. Member identification is noted on every page and document.	Every page/document contains the member's identification to include the patient's first and last name <u>OR</u> the patients social security number <u>OR</u> a unique patient identification number. If information appears on both sides of a page the name should also appear on both sides.	Patient name or ID number is not documented on each page of the medical record.
2. All entries in the medical record are dated.	The month, day, and year are documented for each entry in the medical record to include, but not limited to, progress notes, prescription requests/refills, phone encounters, diagnostic results, correspondence etc.	The month, day, and year are not documented for each entry as described under 'Met'.
3. All entries in the medical record are legible to someone other than the author.	The reviewer is able to read sufficient words in each entry in the progress note in order to understand the content. This also includes faxes and other documents placed in the record.	Two reviewers are not able to read sufficient words in order to understand the content.

Indicator	Met	Not Met
4. All entries in the medical record contain author identification.	All entries in the medical record by the physician contain author initials and/or signatures that are typed, handwritten or electronically designated <u>OR</u> a number that identifies the individual provider/physician. All entries in the medical record by authorized office personal contain author identification.	Entries in the medical record do not contain author identification as described.
5. The medical record contains patient biographical/personal data.	Biographical/personal data is documented in the medical record and includes address, employer, home and work telephone numbers, and marital status/or accessible by a computer printout.	Biographical/personal data are not documented in the medical record.
6. Ongoing/chronic illness and medical conditions are indicated on a problem list.	A current problem list is included in the file which documents ongoing/chronic medical illnesses or conditions. The problem list should be updated as new problems are encountered and should be located in an established location in the medical record.	A current problem list is not included in the medical record documenting ongoing/chronic medical illnesses or conditions.
7. The presence or absence of allergies and/or adverse reactions is consistently documented in a prominent and uniform location of the medical record.	Documentation is in a prominent and uniform location, e.g., in the same place on every record. You should not have to search for this information.	Prominent documentation of allergy status and/or adverse reactions status is not present. Notation of allergy status and/or adverse reaction status in other areas not included under 'Met' is not adequate.

Indicator	Met	Not Met
<p>8. For Adults (over 18 years) seen three or more times, past medical and significant family history is documented in the medical record.</p>	<p>The patient history should be easily identifiable in the medical record. Easily identifiable means it should be located in a central location, not scattered throughout the record. The patient history should include :</p> <ul style="list-style-type: none"> • Significant medical conditions and illnesses • Accidents • Surgeries • Pregnancies (if applicable) • Family history of contributory diseases/medical conditions. <p style="text-align: center;">Or</p> <p>Documentation of PMH and/or Family history as negative.</p>	<p>No documentation regarding past medical conditions or family history is present.</p>

Indicator	Met	Not Met
<p>9. For Children (18 years and younger) seen three or more times, past medical history is documented in the medical record.***</p>	<p>The patient history should be easily identifiable in the medical record. Easily identifiable means it should be located in a central location, not scattered throughout the record. The patient history should include :</p> <ul style="list-style-type: none"> • Significant medical conditions and illnesses • Accidents • Surgeries • Pregnancies (if applicable) • Prenatal care • Birth history • Childhood illnesses • Family history of contributory diseases/medical conditions. <p style="text-align: center;">Or</p> <p>Documentation of PMH and/or Family history as negative.</p>	<p>No documentation regarding past medical conditions is present.</p>

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<p>10. For patients twelve years and older, seen three or more times, the medical record contains a notation regarding smoking habits and the use of alcohol, drugs or other substances.</p>	<p>Documentation of smoking habits, alcohol use, street drug use, and use of other substances <u>OR</u> a notation that the patient states he/she does not use any of the above <u>OR</u> documentation that the patient has received health education regarding alcohol, drug, and substance abuse.</p>	<p>No documentation reflecting that the patient is questioned and/or has received health education about the use of alcohol, drugs, or other addictive substances.</p>
<p>11. An immunization record for children (12 years and younger) is current, or an appropriate history is documented in the medical record for adults (over 18).</p>	<p>For children, a completed, current (age appropriate) immunization record <u>OR</u> documentation that the parents refuse immunizations, <u>OR</u> documentation of the child’s previous adverse reaction <u>OR</u> documentation of illness preventing immunization <u>OR</u> documentation that the immunizations were administered by another physician <u>OR</u> clinic or documentation that immunizations are up to date.</p> <p>For adults, a completed immunization record <u>OR</u> documentation in the medical record that the immunizations are current or documentation to support objection to the immunizations. These immunizations can include tetanus, influenza, and pneumovax.</p>	<p>For children, documentation of immunizations administered elsewhere without specific dates or specific immunizations does not meet the criteria.</p> <p>This standard is considered not met if the patient falls under the following category:</p> <ul style="list-style-type: none"> •over age 65, • has chronic condition (i.e., DM, COPD, CHF) or is immunosuppressed; •has a penetrating injury with trauma to tissue (i.e., puncture of skin with knife or foreign object) for which reason the patient has sought treatment.

Midlands Choice Medical Records Survey Criteria

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12. Consultant summaries/referral, laboratory, and imaging results reflect the primary care physician's (PCP) review.	The primary care/referring physician's signature/initials/electronic designation is noted on the reports <u>OR</u> a copy of a letter to the patient from the primary care/referring physician regarding the date of testing and results is in the chart <u>OR</u> there is a note in the medical record referring to the results and reflecting the physician's review.	Laboratory, x-ray, or consultation reports ordered are not signed, initialed, referenced in the progress note, or included in a letter to the patient.
13. Consultation, abnormal lab, and imaging study results have an explicit notation in the record for follow-up plans.	There is a notation in the medical record regarding the results of the consultation and/or abnormal lab and imaging studies with a specific treatment and/or follow up plan.	Notation of the consultation and abnormal findings without addressing a treatment and/or follow up plan does not meet this criteria.
14. If a consultation is requested, there is documentation from the consultant in the record.	The medical record contains a report/letter from the consultant. For acute problems, the report/letter should be received within 10-14 days of the referral. For chronic problems, the report/letter should be received within 4-6 weeks.	The medical record does not contain a notation, letter, or report from the consultant <u>OR</u> the report/letter is not received within the time frames specified under 'Met'.
15. A chief complaint or the purpose for the visit is clearly stated.	The reason for the patient visit is noted <u>OR</u> the chief complaint is clearly documented for each visit.	The reason for the patient being seen is not documented at each visit.
16. The provider's objective findings are documented.	Physical examination results are documented at each visit to include objective information pertinent to the patient's presenting complaints/purpose for the visit.	Physical examination findings are not documented. Documentation of vital signs alone does not meet the criteria.

Indicator	Met	Not Met
<p>17. Diagnosis or medical impression consistent with subjective and objective findings is documented.***</p>	<p>Documentation of a working diagnosis or medical impression is consistent with the physical findings and is clearly documented.</p>	<p>The working diagnosis or medical impression is not documented or is not consistent with the physical findings.</p> <p>If the reviewer is unable to determine if the diagnosis or medical impression is consistent with the subjective and objective findings, a referral will be made to the medical director.</p>
<p>18. A treatment plan consistent with the diagnosis(es) or medical impression is documented for the patient encounter. ***</p>	<p>Documentation of a treatment plan consistent with the diagnosis/medical impression consisting of, but not limited to, diagnostic tests, therapies or treatments, referrals or consultations, follow up care, medications prescribed etc.</p>	<p>A treatment plan is not documented after each visit and/or is not consistent with the diagnosis of medical impression.</p> <p>If the reviewer is unable to determine if the treatment plan is consistent with the diagnosis/medical impression, a referral will be made to the medical director.</p>
<p>19. Follow up care is documented for each patient encounter.</p>	<p>Follow-up care is specific and noted in days, weeks, months, or PRN.</p>	<p>Plans for follow up care are not documented in the record.</p>

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20. Unresolved medical problems from previous patient encounters are addressed at subsequent visits until resolved.	Documentation of unresolved or ongoing medical problems noted at previous patient encounters are addressed at following patient visits until resolved.	The medical record does not contain documentation of unresolved medical problems at subsequent visits.
21. There is no evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic treatment. ***	Diagnostic or therapeutic treatments do not place the patient at an inappropriate risk. i.e., testing appropriate for diagnosis, medications/prescriptions appropriate for diagnosis, treatments appropriate for diagnosis.	<p>The patient is placed at inappropriate risk by a diagnostic or therapeutic treatment i.e., testing inappropriate for diagnosis, medications/prescriptions inappropriate for diagnosis, treatments inappropriate for diagnosis.</p> <p>If the reviewer is unable to determine if a diagnostic or therapeutic treatment places the patient at inappropriate risk, a referral will be made to the medical director.</p>
22. If the practitioner treats patients over 65 years of age, the medical record should have supporting documentation on the discussion of advanced directives.	If documentation is found in the medical record that includes the discussion of advanced directives, i.e., DNR order, living will, etc. for the member seen three (3) or more times.	If the member has been seen three (3) or more times, and documentation can't be found to support that advanced directives has been addressed.