

HEALTH PLUS MEDICAL RECORD REVIEW  
STANDARDS & CRITERIA

STANDARD	CRITERIA
1.) Each page in the record contains the patient's name or ID number.	1.) The patient's name and or ID number needs to be on all notes, lab reports, and consult reports that go into the medical record.
2.) Personal biographical data including the address, employer, home and work telephone numbers, and marital status.	2.) All patients will have their own chart, no family charts.
3.) All entries in the Medical Record contain the author's identification.	3.) Author identification may be a handwritten signature, or a unique electronic identifier.
4.) All entries are dated.	4.) All entries have the month, day and year they are entered.
5.) The record is legible.	5.) All entries are to be legible by someone other than the writer.
<b>6.) There is a current problem list in the chart. *</b>	<b>6.) Significant illnesses and medical conditions are indicated on the problem list. A current problem list is found in the chart. The provider may list problems on separate list. *</b>
<b>7.) Allergies to medication and adverse reactions are prominently noted in the record. *</b>	<b>7.) Allergies and adverse reactions are noted on the chart. If no allergies, NKA (No Known Allergies) is documented. The physician should be consistent with the placement of this information in all charts. *</b>
<b>8.) There is an initial visit medical/surgical history. *</b>	<b>8.) Past medical history is easily identified and includes serious accidents, surgeries, and illnesses. For children and adolescents (18 years and younger), past medical history relates to prenatal care, birth, surgeries, and childhood illnesses. *</b>
9.) For patients 12 years and older, there is appropriate notation concerning the use of cigarettes, alcohol, and substances (for patients seen three or more times, query substance abuse history).	9.) The patient should be screened or counseled for alcohol, substance use and tobacco use once a year. (Screening is defined as a system for gathering and assessing information from the patient. Counseling is defined as guidance, direction, and/or discussion by the PCP or a designee which identifies the actual or potential health problem(s) caused by substance use, and assists the member in abstaining from or altering the current behavior.)

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10.) The history and physical exam identifies appropriate subjective and objective information pertinent to the patient's presenting complaints.	10.) All appropriate objective and subjective information obtained during the history taking and physical exam that is pertinent to the presenting problem is noted in the medical record.
11.) Laboratory and other studies are ordered, as appropriate.	11.) All laboratory and other studies are ordered in accordance with the patient's diagnosis(es).
<b>12.) Working diagnoses are consistent with findings. *</b>	<b>12.) There is a documented reason for the visit. The progress note contains appropriate subjective and objective information pertinent to the patient's presenting complaints for each visit. An appropriate physical exam with review of systems is done at the time of each visit. *</b>
<b>13.) Treatment plans are consistent with diagnoses. *</b>	<b>13.) Treatment plans are documented in the progress notes. What is the provider's plan in treating the diagnosis? *</b>
14.) There is evidence of follow-up as needed.	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 as needed.
15.) There is evidence of follow-up for unresolved problems from previous office visits.	15.) Unresolved problems from previous office visits are addressed in subsequent visits. There are follow-up notes concerning previous visits in the chart.
16.) If a consultation is requested, is there a note from the consultant in the record.	16.) The consultant's report is in the medical record. The consultant signs it. The PCP signs or initials the report indicating that it has been reviewed.
17.) The PCP, to signify review, initials consultation, lab, and imaging reports filed in the chart.	17.) Review and signature by professionals other than PCPs, such as nurse practitioners and physician assistants do not meet the requirement. If reports are presented electronically, or by some other method, there is also representation of physician review. Consultations, abnormal lab, and imaging study results have an explicit notation in the record of follow-up plans.

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<p>18.) <b>There is no evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic problem. *</b></p>	<p>18.) <b>The chart needs to be documented with appropriate treatment for each diagnosis with evidence that the patient received treatment and or advice. *</b></p>
<p>19.) An immunization record for children is up to date, or an appropriate history has been made in the medical record of adults who are at risk.</p>	<p>19.) The immunization record for children is documented in the chart and is up to date. All childhood immunizations should be given within the recommended age ranges.</p>
<p>20.) There is evidence of preventive screenings.</p>	<p>20.) Preventive screening and services are offered in accordance with Health Plus's age specific practice guidelines.</p>
<p>21.) Well child and well adolescent visits. (Newborn-age 21)</p>	<p>21.) Documentation must include a note indicating a visit to a PCP, the date the visit occurred and evidence of the following:</p> <ul style="list-style-type: none"> <li>• A health and developmental history (physical and cognitive);</li> <li>• A physical exam; and</li> <li>• Health education/anticipatory guidance.</li> </ul> <p>(Note: For ages 12-21 PCP and or OB/GYN)</p>
<p>22.) HIV (Human Immunodeficiency Virus) early identification and promoting prevention.</p>	<p>22.) The chart documents screening for HIV. HIV education documentation in chart that includes the following: -Sexually Transmitted Diseases (STD); -Multiple sex partners; -Intravenous Drug Use (IVDU) -with the need for HIV pre-test counseling.</p>
<p>23.) PCP follow-up with the member occurs after an inpatient hospitalization or ER visit.</p>	<p>23.) The chart should document a follow-up visit when the member has had either an inpatient admission or ER visit.</p>

(\* NCQA has identified six elements as critical for medical record documentation)