

MEDICAL RECORD AUDIT: PHYSICIAN SUMMARY

Provider Site Location:															Date:			
Reviewer:															Record 5 - Patient Name:			Site Total
Delivery System: Hoosier Alliance															Record 4 - Patient Name:			Standard
Physician(s):															Record 3 - Patient Name:			% Compliant
DOB:			DOB:			DOB:			DOB:			DOB:						
YES	NO	N/A	YES	NO	N/A	YES	NO	N/A	YES	NO	N/A	YES	NO	N/A	YES	NO	N/A	
1. Medications list is current and easily accessible.																		
2. Allergies and adverse reactions to medications are prominently displayed. If patient has no known allergies or history of adverse reactions, these are noted in record.																		
3. Problem list is completed with significant illness or medical conditions.																		
4. Preventive health services (i.e., immunization record form, well-child form or risk screening) are offered in accordance with the practice/preventive-care guidelines/EPSTD.																		
5. Immunization records are included for children and adolescents, either as part of medical history or as a separate standard.																		
6. Personal/biographical data are present in record (i.e., address, employer, home and work phone number, marital status).																		
7. History and physical exam identifies appropriate subjective & objective information pertinent to presenting complaint(s) / health maintenance concerns. (History includes serious accidents, operations and illnesses. For children and adolescents, past medical history relates to prenatal care, birth operations and childhood illnesses.)																		
8. Record format is conducive to recording subjective and objective information, documenting clinical findings and evaluation and plan of treatment pertaining to presenting complaints during each visit.																		
9. Patient Education Materials are available/utilized.																		
10. Patient name or ID# is on each page of record.																		
11. Entries are signed and dated by authorized personnel.																		
12. Records are legible to someone other than reviewer.																		
13. Information regarding the use of tobacco, alcohol and substance abuse for patients 10 years and older is present.																		
14. Labs and other studies are ordered as appropriate.																		
15. Working diagnosis is consistent with findings.																		
16. Treatment plans/plans of action are consistent with diagnosis (e.g., labs, medications, etc.).																		
17. Encounter form or notes have a notation regarding follow-up care, calls or visits, when indicated. The specific time is noted in days, weeks, months, or as needed.																		
18. Unresolved problems from previous visits are addressed in subsequent visits. Reflects services provided directly by PMP, ancillary services and diagnostic tests ordered by PMP and diagnostic and therapeutic-service referrals.																		
19. Use of consultants is appropriate (e.g., under or over utilized).																		
20. Record contains consultant note whenever consultation is requested.																		
21. Consultation, lab and/or imaging reports in chart indicate review by evidence of practitioner initials. Abnormal results have notation in record of follow-up plans.																		
22. Documentation in record includes: - Specialty Referrals - Inpatient (discharge summaries)																		

- Emergency care - Outpatient services (diagnostic and ancillary)																
23. Patient does not appear to be placed at inappropriate risk by a diagnostic or therapeutic procedure.																
24. Advanced directives have been discussed and documented for every patient 21 years and older. If an advance directive has been executed, a copy should be present in the medical record. Written instructions for a living will or durable power of attorney for health care and are present when the patient is incapacitated and has such a document.																
25. Missed appointments and any follow-up activities are documented in the medical record.																
TOTALS:	Numerator:	Denominator:		Numerator:	Denominator:		Numerator:	Denominator:		Numerator:	Denominator:		Numerator:	Denominator:		
SCORE:																
	%			%			%			%			%			

COMMENTS:

General Practices for Medical Records (obtain through observation, discussion or collecting hard copies during site visit):

Office has defined practice and/or written guidelines for:

	Standard	What to look for	Method of Collection (O, D, W)**	YES	NO	N/A
1.	Maintaining confidentiality of patient information (personal health information – PHI) in accordance with HIPAA and all other applicable State and Federal requirements - includes periodic training for staff	Does the office have a P&P written regarding PHI? Do they have evidence of training staff on PHI and confidentiality?				
2.	Release of information (form/process)	Does the office have and use a release of information form?				
3.	Telephone encounters (includes physician notification and documentation in medical record)	Look in the chart for evidence – may be "N/A."				
4.	Filing/tracking of medical records within the office/system	Is there a filing cabinet?				
5.	Organization of medical records	Do the charts appear to have a general order (i.e., chronological)?				
6.	Protection of record from public access	Are medical records kept where only authorized personnel have access? Are records stored securely? Do only authorized personnel have access?				
7.	Maintenance of record for each individual patient					
8.	Patient record available at each encounter					
9.	Record to reflect services provided directly by PMP, ancillary services and diagnostic tests ordered by PMP and diagnostic and therapeutic service referrals	Is the standard of care met by the appropriate skill level?				
10.	Requesting records of care received as inpatient (hospital discharge summary), in ER or as outpatient	See # 22.				
11.	Providing copy of patient's medical record upon reasonable request by member at no charge	Q: Can you verify that a copy of the patient's medical record is provided upon reasonable request by member at no charge?				
12.	Facilitating the transfer of patient's record to another provider at the member's request	Q: Can you verify that you facilitate the transfer of patient's record to another provider at the member's request?				
13.	Facilitating transfer, at the request of the OMPP or MDwise, of a summary or copy of the member's medical records to another PMP if the member is reassigned	Q: Can you confirm that you facilitate the transfer, upon request from OMPP or MDwise, by sending a summary or copy of the member's medical records to another PMP if the member is reassigned?				
14.	Facilitating communication between primary-care physician and behavioral-health provider.	Q: Can you confirm that the primary-care physician facilitates communication and coordination of care with the behavioral-health provider?				
15.	Maintenance of records for at least seven years	Q: Can you confirm that you maintain the patient records for at least 7 years?				

** O = Observation
D = Discussion with staff
W = Written documentation