

**MDWISE HOOSIER ALLIANCE  
MEDICAL RECORD REVIEW ANALYSIS**

RECORD CRITERIA	Target	2010 Total Network Result	Territory Results	Provider Site Results	
1. <b>Medications list</b> current and easily accessible	90%				
2. <b>Allergies and adverse reactions</b> to medications are prominently displayed. If patient has no known allergies or history of adverse reactions, these are noted in record	90%				
3. <b>Problem list</b> is completed with significant illness or medical conditions.	90%				
4. <b>Preventive health services</b> (i.e. immunization record form, well-child form, or risk screening) are offered in accordance with the practice/ preventive care guidelines/EPSTD.	90%				
5. Immunization records are included for children and adolescents, either as part of medical history, or as a separate standard	90%				
6. <b>Personal/biographical data</b> are present in record (i.e. address, employer, home and work phone number, marital status).	90%				
7. <b>History and physical exam</b> 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.)	90%				
8. <b>Record format</b> is conducive to recording subjective & objective information, documenting clinical findings and evaluation and plan of treatment pertaining to presenting complaints during each visit.	90%				
9. <b>Patient Education Materials</b> are available/utilized	90%				
10. Patient name or ID# on each page of record.	90%				
11. Entries are signed and dated by authorized personnel.	90%				
12. Records are legible to someone other than reviewer.	90%				
13. Information regarding the use of tobacco, alcohol and substance abuse for patients 10 years and older.	90%				
14. Labs and other studies are ordered as appropriate.	90%				
15. Working diagnosis is consistent with findings.	90%				
16. Treatment plans/Plans of actions are consistent with diagnosis (e.g. labs, medications, etc.).	90%				
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.	90%				

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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.	90%				
19. Use of consultants/specialists is appropriate (e.g. under or over utilized.)	90%				
20. Record contains <b>note</b> from consultant, lab and other studies whenever consultation is requested.	90%				
21. Consultation, lab and/or imaging reports in chart indicate <b>review by</b> evidence of <b>practitioner</b> initials. Abnormal results have notation in record of f/up plans.	90%				
22. Documentation in record includes:	90%				
- 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.	90%				
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 when the patient is incapacitated and has such a document.	90%				
25. Missed appointments and any follow-up activities are documented in the medical record.	90%				