

Unison Health Plan
Practitioner Medical Record Review
Score Required to pass is 80% and above

Practice Name:

Practitioners in Practice:

	Name:	Specialty:
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

Location of Medical Record Review:

Address:

County:

Telephone:

Interview conducted with

Name:

Title:

Audit completed by

Name:

Title:

Date of Review

Date:

Unison Health Plan

Medical Record Review

Overall Score:

Provider Name:

Location:

Comments:

EPSDT education material reviewed and given to office personnel

Reviewer:

Documentation appears to meet Plan Standards

Yes _____

No _____

If no, explain:

Recommended Action Plan:

*Medical Director Signature

Date

*Signature is only needed if score is below 80%

Practitioner: _____

Unison Health Plan

Medical Record Review Feedback Form

Score required to pass is 80% and above.

- 1.0 ___/___ Each page of a medical record should contain a name or medical record number as an identifier.
- 2.1 ___/___ Patient first and last name should be present on the demographic sheet.
- 2.2 ___/___ An address where patient can be reached by mailings should be noted in the medical record.
- 2.3 ___/___ Medical record should contain a home phone number. If there is no phone, a neighbor, family member or friend should be listed. The number should be that of someone who has close contact with the patient.
- 2.4 ___/___ Birth date and age should be documented in the medical record. This can be helpful when an office has more than one person with the same name.
- 2.5 ___/___ Emergency contact and phone number should be listed in the medical record. (Including someone not residing in patient's home)
- 2.6 ___/___ Sex/gender should be noted.
- 3.0 ___/___ Each entry needs to contain the author's identification. Signature can be electronic, hand written or initialed.
- 4.0 ___/___ All entries in the medical record should be dated.
- 5.0 ___/___ The medical record should be legible to someone other than the writer. If questionable Unison Health Plan reserves the right for medical records to be released to our medical director for review.
- 6.0 ___/___ Each medical record should contain a dated problem list. This area, where significant illnesses or medical conditions can be documented, should be updated frequently to show both active and inactive conditions.
- 7.0 ___/___ A medication list should be incorporated into the charting system. This section should be a current list of maintenance type medications.
- 8.0 ___/___ Allergies need to be noted in a prominent place in the chart. Such prominent areas could be the covers of the chart or an area easily identified when the chart is opened. If the patient has no allergies then NKA needs to be documented.
- 9.0 ___/___ There should be a detailed, updated past medical history including illnesses, operations, injuries, disabilities, family history and any information pertinent to patients health.
10. ___/___ A medical record should contain documentation that smoking, alcohol and substance abuse have been addressed. If patient is under 12 years old documentation should be related to smoking in the home, if 12 years and older documentation should be patient specific.
11. ___/___ Documentation should include subjective and objective data.
12. ___/___ Lab and other studies ordered are appropriate to patient symptoms and physical findings.
13. ___/___ Working diagnosis should be consistent with physical, x-ray, lab and consult findings.
14. ___/___ Action and treatment plans should be consistent with diagnosis.
15. ___/___ Any emergency care that is rendered and physician follow-up should be noted.
16. ___/___ Follow up visits should be documented in days, weeks or months when clinically appropriate. Follow up visits can be noted in chart, appointments scheduled at time of visit, reminder card system or super billing system.
17. ___/___ Unresolved problems from previous visits should be documented in the subsequent visit.

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Medical Record Review Feedback Form

Practitioner: _____

- 18. ___/___ There should be evidence to support the use of consultations. Over utilization- if practitioner refers for consult prior to plan course of treatment. Under utilization- if patient has unresolved condition that warrants consultant but is not referred.
- 19. ___/___ If referred to by the primary doctor, documentation of consulting physicians findings should be noted in the medical record. This includes inpatient hospital discharge summaries, skilled nursing facility reports, home health discharge summaries and reports from freestanding surgical centers.
- 20. ___/___ All consults, summaries, lab and imaging studies need to be initialed or have explicit notation of review in the medical record.
- 21. ___/___ Abnormal labs, consults, imaging studies and summaries should have explicit notations of follow up treatment plan. This can be noted on the abnormal report or in the progress notes.
- 22. ___/___ There should be no evidence that the patient is placed at inappropriate risk by a treatment plan.
- 23. ___/___ A completed immunization record should be present in all children's medical records, including a notation of chicken pox history or vaccination.
- 24. ___/___ An appropriate immunization record should be present in adult medical records. This should include, but not be limited to, TD every 10 years, flu vaccine for those with chronic illnesses and over the age of 65 and hepatitis vaccination if at risk. If patient refuses vaccine, this should be documented.
- 25. ___/___ Preventive health issues should be appropriately addressed in the medical record and are audited using the applicable Preventive Health audit tools. These preventive health guidelines by age appropriateness are located in the provider service manual and/or Plan website.
- 26. ___/___ There should be evidence of patient/ 'significant other' teaching.
- 27. ___/___ Documentation of the presence or absence of an advance directive should be present on the chart of patients' 65 years and older.

COMMENTS: _____

Reviewer _____
Date _____

Office personnel _____
Title _____
Date _____