Medical Record Review Survey

Common Medical Record Deficiencies

I. Format Criteria

D. "Emergency contact is identified."

It is common for an emergency contact to not be included in the member's chart. The name and phone number of an "emergency contact" must be identified for all members. If member is a minor, the emergency contact must be a parent/legal guardian. If member refused to provide an emergency contact, "refused" must be noted in the record.

H. "Primary language and linguistic service needs of non-or limited-English proficient (LEP) or hearing-impaired persons are prominently noted."

It is common to find that the member's primary language and/or requests for interpreter services is not documented. This must be documented in member's chart, if member refused an interpreter and requested a family member or friend to translate this must be noted. If member's primary language is English it should be documented, N/A is not accepted.

II. Documentation Criteria

E. "Advance Health Care Directive information is offered (Adults 18 years of age or older; Emancipated minors)."

Documentation that an Advance Directive was offered must be included in member's chart- specify if member refused or if AD was given to be filled and will be brought back in a future appointment. FSR binder includes an example of an Advanced Directive explanation that can be used and is compliant if documented as given.

III. Coordination/ Continuity of Care Criteria

G. "There is evidence of *follow-up* of specialty referrals made, and results/reports of diagnostic tests."

Consultation reports and diagnostic test results must be documented for ordered requests. Abnormal tests have explicit notation in the medical record, including attempt to contact member, follow-up treatment along with any instruction/ pertinent information. Missed appointments following up a procedure/ consult are documented along with notation of attempts to contact member and results of follow up actions.

H. "Missed primary care appointments and outreach efforts/ follow-up contacts are documented."

Missed/ no show/ cancelled appointment are documented, along with attempts to contact member and reschedule.

IV. Pediatric Preventive Criteria

J. "Childhood Immunizations."

All immunizations must be documented, including name, manufacturer, and lot number of each vaccine. HPV must be given to boys and girls (2 or 3 dosage). Follow CDC guidelines.

V. Adult Preventive Criteria

A2. “Individual Health Education Behavioral Assessment (IHEBA).”

An age appropriate SHA is required within 120 days of the enrollment date or within 12 months prior to enrollment. A SHA is required annually. Must be signed by provider. If SHA not in records a note specified why it was not conducted, such as member refusal, is required.

B. “Subsequent Periodic IHEBA.”

Read A2.

G. “Tuberculosis Screening.”

Tb testing must be conducted upon enrollment and at periodic physical evaluations (q4 years). A Mantoux skin test is acceptable, if member had a positive Mantoux test documented request a CXR. F/u with results as needed. If member tests positive for HIV or immunosuppressed screening is required annually.

L. “Adult Immunizations.”

Practitioners are required to ensure the provision of immunizations according to CDC’s guidelines. Make sure the name, manufacturer and lot number are included after each administration. Document the VIS publication date and date it was given. The FSR binder contains a copy of the VIS and logs that can be used to record immunizations.