MEDICAL RECORD REVIEW STANDARDS
PRIMARY CARE PHYSICIANS & SPECIALISTS

1. INDIVIDUAL RECORD*	Each member's individual medical record is maintained separately.
2. MEMBER ID*	Each page in the record contains member name of member ID number.
3. BIOGRAPHICAL DATA*	Personal data includes address, employer, telephone numbers, emergency contact, marital status, etc.
4. ENTRY ID*	All entries, included dictation, are signed (electronically) or initialed by the physician or nurse practitioner, as appropriate. PA notes are to be cosigned by physician.
5. ENTRY DATA*	All entries are dated.
6. LEGIBILITY*	The record is legible to someone other than the physician or physician's staff.
7. PROBLEM LIST* **(PCPs)**	A separate problem list is current and completed for each member, including significant illness, medical conditions and health maintenance concerns are identified in the medical record.
8. EMERGENCY CARE **(A requirement for providers of Medicaid in West Virginia only)**	
9. MEDICATION LIST*	Prescribed medications and prescription refills documented on a separate medication list.
10. ALLERGIES*	Presence/absence of allergies or adverse reactions to medications are prominently noted on each member chart after one year of age. Absence of allergies (no known allergies – NKA) is noted in a easily recognizable location.
11. MEDICAL HISTORY*	Includes serious injuries, operations and illnesses of member. For children and adolescents, this includes prenatal care, birth, and childhood illnesses.
12. TOBACCO USE*	Use/nonuse of tobacco products is documented on members age 11 and older.
13. ALCOHOL/DRUG USE	Use/nonuse of alcohol and illicit drugs is documented on members age 11 and older.
14. HISTORY & PHYSICAL	A complete history and physical exam for new patients are recorded within 12 months of the member seeking care, or within 3 visits, whichever occurs first. Appropriate subjective and objective information is recorded for presenting complaints.
15. LAB, DIAGNOSTIC TESTS & OTHER STUDIES	Labs and other studies must be appropriate to the presenting complaint, or diagnosis.
16. WORKING DIAGNOSIS*	There is a clearly documented diagnostic impression by the PCP that is consistent with finding for each member visit.
17. PLAN OF ACTION /THERAPIES /TREATMENT/ PRESCRIBED REGIMENS	Each visit is finalized with a plan of action and/or treatment plan that are consistent with diagnosis. Treatment options (e.g. medical versus surgical, etc.) and risks of treatments are discussed as appropriate.
18. FOLLOW-UP VISIT	There is a notation concerning follow-up care, including encounter forms with notations concerning follow-up care or visits; return times noted in weeks, months or PRN; or to see a specialist.
19. UNRESOLVED PROBLEMS	Ongoing or unresolved problems from prior visits must be addressed.

***Indicates Critical Factors**

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20. CONSULTATION, REFERRAL AND SPECIALIST REPORTS	Review for under/over utilization of consultation. Notes from consultations, lab, and x-ray reports with the ordering physician's initials or other documentation signifying review, explicit notations in the record and follow-up plans for significantly abnormal lab and imaging study results.
21. CONTINUITY / COORDINATION OF CARE* (PCPs)	Chart contains consult reports, inpatient and ER discharge summary, records transferred from prior care and documentation from skilled nursing facilities and home health care agencies.
22. COMMUNICATION WITH PCP* (Specialists)	There is documentation of communication with the PCP, as well as suggested plan of treatment.
23. DISCHARGE SUMMARY	In the member was in the hospital, there is a discharge summary signed and dated within 30 days. Hospital discharge summaries should be present for all hospital admissions which occur while the patient is enrolled in the plan, and prior admissions as necessary.
24. CARE MEDICALLY APPROPRIATE	All care must be medically appropriate and necessary, and there is no evidence that the member has been placed at inappropriate risk.
25. IMMUNIZATIONS (A requirement for providers of Medicaid in West Virginia only)	For pediatric records (ages 12 and under) there is a completed immunization record or a notation that immunizations are up-to-date, and when subsequent immunizations, if any, are required.
26. INFLUENZA AND PNEUMOCOCCAL VACCINES	For members 65 and older and at a high risk record must indicate immunization status for influenza and pneumococcal. Documentation needs to also include past immunization history and of PCP's intent to immunize.
27. ADVANCE DIRECTIVE*	There is annual documentation of whether the member has executed an advance directive (ages 21 and older), and if "yes" a copy must be included in the medical record. If age 65 and older, need documentation of annual review.

***Indicates Critical Factors**