MEDICAL RECORD DOCUMENTATION STANDARDS CHECKLIST

Comprehensive, consistent and timely documentation in the patient medical record is an integral component of quality patient care. Anthem Blue Cross recognizes the importance of the patient medical record and has established minimum documentation and review standards as follows:

Note: Nurse Reviewers are evaluating and reviewing documentation and documentation processes of the criteria included in the medical record review survey.

Format Criteria	Yes	No	Comments
1. An individual medical record is established for each member.			
2. Member identification is on each page.			
3. Individual personal biographical information is documented.			
4. Emergency "contact" is identified.			
5. Medical records on site are consistently organized.			
6. If not EMR, chart contents are securely fastened.			
7. Member's assigned primary care physician (PCP) is identified (i.e. health plan ID Card or Eligibility Print Out)			
8. Primary language and linguistic service needs of non or limited English proficient (LEP) or hearing- impaired persons are prominently noted. (e.g. If primary language is English, document "English" as primary language)			
Documentation Criteria	**Yes**	**No**	**Comments**
1. Allergies are prominently noted.			
2. Chronic problems and/or significant conditions are listed.			
3. Current continuous medications are listed.			
4. Signed Informed Consents are present when any invasive procedure is performed.			
5. Advance Health Care Directive Information is offered to adults18 years/older and emancipated minors. This is documented in the medical record.			
6. All entries are signed, dated and legible. Signatures include first initial, last name and title of health person providing care including Medical Assistants. Initials may be used if there is a signature page available. Stamped signatures must be countersigned or initialed. EMR must also include who completed the documentation.			
7. Errors are corrected according to legal medical documentation standards (e.g. Errors are corrected using single line, initial, date and not correction fluid/tape).			
Coordination of Care Criteria	**Yes**	**No**	**Comments**
1. History of present illness is documented.			
2. Working diagnoses are consistent with findings.			
3. Treatment plans are consistent with diagnosis.			
4. Instruction for follow-up care is documented at all visits. (e.g. "RTC in 1 yr for PE", "RTC PRN")			
5. Unresolved/continuing problems are addressed in subsequent visit(s).			
6. There is evidence of practitioner review of consult/referral reports and diagnostic test results with initials and date.			
7. There is evidence of follow-up of specialty referrals made, and results/reports of diagnostic tests, when appropriate.			
8. Missed PCP appointments and outreach efforts/follow-up contacts are documented. (e.g. Document both missed appointments and outreach efforts)			

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Pediatric Preventive Care Criteria	Yes	No	Comments
1. History and physical (H&P): An H&P is completed within 120 days of the effective date of enrollment into the Plan or documented within the 12 months prior to Plan enrollment. Must be done within 60 days if under 15 months.			
2. Individual Health Education Behavioral Assessment (IHEBA) or Staying Healthy Assessment Tool (SHAT) completed within 120 days from enrollment (with intervention codes/dates/initials) and reviewed annually (with dates/initials).			
3. Subsequent Periodic IHEBA/SHAT: An age-appropriate IHEBA is re-administered when the member has reached the next specific age interval as indicated on the forms.			
4. Medi-Cal patients shall receive age-appropriate physical exams according to the American Academy of Pediatrics (AAP) schedule. (e.g. Patients ages 3-20 years old shall receive an annual well exam or physical)			
5. Anthropometric measurements: Height and weight are documented on graph at each well-child exam. Include head circumference for infants up to 24 months.			
6. BMI percentile: BMI percentile is plotted on an appropriate CDC growth chart for each well-child exam ages 2-20 years.			
7. Developmental screening: Developmental surveillance and screening for developmental disorders at each visit. Children identified with potential delays require further assessment and/or referral.			
8. Anticipatory guidance: Includes age appropriate counseling/health education provided to parent and/or pediatric member.			
9. STI (sexually transmitted infections) screening on all sexually active adolescents, including Chlamydia for females.			
10. Vision screening at each well visit. (including annual visual acuity (Snellen) testing for ages 3-20 years old)			
11. Hearing screening at each well visit (including annual audiometric testing for ages 3-20 years old)			
12. Nutrition Assessment at each well visit.			
13. Dental screening at each well visit including annual referral to dentist for ages 3-20 years old. Also document fluoride varnish if given.			
14. Lead screening at age 1 and 2 years old or baseline up to 6 year birthday.			
15. Tuberculosis screening: Risk Exposure Assessment shall be done at each well visit for all ages.			
16. Childhood Immunizations given according to Advisory Committee on Immunization Practices (ACIP) guidelines.			
17. Vaccine administration documentation: Name of vaccine, manufacturer and lot number of each vaccine given recorded in the medical/electronic record or on medication logs, including immunization registry.			
18. Vaccine Information Statement (VIS) documentation: The date the VIS was given and the VIS publication date are documented in the medical record.			

MEDICAL RECORD DOCUMENTATION STANDARDS CHECKLIST

Adult Preventive Care Criteria	Yes	No	Comments
1. History and physical (H&P): H&P completed within 120 days of effective date of enrollment into the Plan or documented within the 12 months prior to Plan enrollment.			
2. Individual Health Education Behavioral Assessment (IHEBA) or Staying Healthy Assessment Tool (SHAT) completed within 120 days from enrollment (with intervention codes/dates/initials) and reviewed annually (with dates/initials).			
3. Subsequent Periodic IHEBA/SHAT: An age-appropriate IHEBA is re-administered when the member has reached the next specific age interval as indicated on the forms.			
4. Periodic Health Evaluation according to USPSTF recommendations (conduct well visits every 3 years for patients ages 21-39 years; every 2 years for patients ages 40-49 years; annually for patients 50 years and older or high risk patients)			
5. High Blood Pressure Screening: All patients 18 years and older including those without known hypertension are screened.			
6. Obesity Screening: Includes weight, height and body mass index (BMI).			
7. Lipid Disorders Screening: Lipid panel is obtained for males 35 years and older; females 45 years and older			
8. Tuberculosis screening: Adults screened for TB risk factors upon enrollment and at periodic physical exams.			
9. Breast Cancer Screening: Mammograms for females 50 years and over at least every 2 years up to 75 years old.			
10. Cervical Cancer Screening (applies to women with no history of abnormal PAPs or no history of positive HPV, regardless of sexual history): • 21-65 years of age – cytology screening once every 3 years • 30-65 years of age – cytology screening & HPV testing once every 5 years (a reasonable alternative for women in this age group who would prefer to extend the screening interval) Note: Screening is not needed for women over 65, if adequately screened before age 65; and women who have had their complete cervix removed. Documentation must be evident in the medical record.			
11. Chlamydia screening for females 25 years and under.			
12. Colorectal Cancer Screening starting at age 50 up to 75 years of age.			
13. Adult Immunizations given according to Advisory Committee on Immunization Practices (ACIP) guidelines.			
14. Vaccine administration documentation: Name of vaccine, manufacturer and lot number of each vaccine given recorded in the medical/electronic record or on medication logs, including immunization registry.			
15. Vaccine Information Statement (VIS) documentation: The date VIS was given and VIS publication date documented in the medical record.			

MEDICAL RECORD DOCUMENTATION STANDARDS CHECKLIST

OB/GYN Criteria	Yes	No	Comments
1. Initial Comprehensive Prenatal Assessment (ICA) completed within 4 weeks of entry to prenatal care.			
2. Obstetrical and Medical History (Health, OB history, LMP and estimated date of delivery.			
3. Physical Exam: Includes breast and pelvic exam.			
4. Lab Tests: Hemoglobin/hematocrit, urinalysis, urine culture, ABO blood group, RH type, rubella antibody titer, STI (sexually transmitted infections) screen			
5. Nutrition: Anthropometric (height/weight), dietary evaluation, prenatal vitamin/mineral supplementation.			
6. Psychosocial: Social and mental health history (past/current), substance use/abuse, support systems/resources.			
7. Health Education: Language and education needs.			
8. Screening for Hepatitis B Virus: All pregnant women are screened for Hepatitis B during 1st trimester or prenatal visit, whichever comes first			
9. Screening for Chlamydia Infection: Increased risk screened at their first prenatal visit			
10. Second Trimester Comprehensive Re-assessment: Includes Obstetric/medical, Nutrition, Psychosocial and Health Education re-assessments.			
11. Third Trimester Comprehensive Re-assessment: Includes Obstetric/medical, Nutrition, Psychosocial and Health Education re-assessments.			
12. Screening for Strep B: Screening for Group B Streptococcus between 35th and 37th week of pregnancy.			
13. Prenatal care visit periodicity according to most recent ACOG standards.			
14. Individual Care Plan (ICP)			
15. Referral to WIC and assessment of Infant Feeding status			
16. HIV-related services offered			
17. AFP/Genetic screening offered			
18. Domestic Violence/Abuse screening			
19. Family Planning evaluation			
20. Postpartum Comprehensive assessments are completed within 21 and 56 days after delivery.			