Medical Record Review Standards and Criteria

#	Standard	Criteria
1	Every page in the record contains the patient's name or ID number.	Same
2	The record contains personal biographical data including the members address and telephone number(s).	Same
3	All entries in the medical record contain the author's identification.	Author identification may be a handwritten signature, or a unique electronic identifier.
4	All entries are dated.	Same
5	The record is legible.	All entries are to be legible by someone other than the writer.
6	**There is a current problem list in the chart.***	**Significant illnesses and medical conditions are indicated on the problem list. A current problem list is found in the chart. ***
7	**Allergies to medication and adverse reactions are prominently noted in the record.***	**If no allergies, NKA (No Known Allergies) is documented.***
8	Prescribed medications, including dosage, frequency and date of initial prescription is documented.	Same
9	**There is medical/surgical history documentation.***	**Past medical history is identified and includes serious accidents, surgeries, and illnesses.***
10	There is appropriate notation concerning use of substances, alcohol, and cigarettes.	The patient should be screened and counseled as needed for substance use, alcohol and tobacco use once a year.
11	The history and physical exam identifies appropriate subjective and objective information pertinent to the patient's presenting complaints.	All appropriate objective and subjective information obtained during the history taking and physical exam that is pertinent to the presenting problem is noted in the medical record.
12	Laboratory and other studies are ordered, as appropriate.	All laboratory and other studies are ordered in accordance with the patient's diagnosis(es).
13	**Working diagnoses are consistent with findings.***	**There is a documented reason for the visit. The progress note contains appropriate subjective and objective information pertinent to the patient's presenting complaints for each visit.***
14	**Treatment plans are consistent with diagnoses.***	**Treatment plans are documented in the progress notes.***
15	There is evidence of follow-up as needed.	Progress notes have a notation, when indicated, regarding follow-up care, calls, or visits. The specific time of return is noted in weeks, months, or as needed.
16	If a consultation is requested, there is a note from the consultant in the record.	The consultant's report is in the medical record. The PCP indicates that it has been reviewed.
17	There is evidence of PCP review of labs, imaging reports and consultations filed in the chart.	Same

18	**There is no evidence that patient is placed at inappropriate risk by a diagnostic or therapeutic problem.***	**The chart documentation is appropriate for each diagnosis with evidence that the patient received treatment and or advice.***
19	An immunization record is up to date.	Same
20	There is evidence of preventive screenings.	The record indicates preventive screenings and services are offered in accordance with age specific practice guidelines.
21	There is chart documentation of prevention /harm reduction education.	Harm reduction education in the chart includes STD's; unprotected sex; IVDU.
22	Documentation of Advanced Directives is available in the medical record.	Same
23	There is documentation in the record that PCP follow-up with the member has occured after an inpatient hospitalization.	Same

*NCQA has identified six elements as critical for medical documentation.