Medical Record Documentation Review Guidelines

The Humana Healthy Horizons® in Louisiana quality improvement team performs medical record reviews as part of regulatory requirements and can provide insights into healthcare provider strengths as well as areas of opportunity. The team conducts these reviews every two years. The acceptable compliance score is 85%, with a goal of 90%. A compliance rate below 85% will result in reassessment of medical record documents within six months. This document lists the medical record elements reviewed in randomly selected records.*

Medical record documentation review elements

- **Patient identification**: Each page in the medical record must contain the patient's name or identification number assigned by your office. Records should include the patient's name, identification number, date of birth, gender and parent or legal guardianship (if applicable).
- **Primary language**: Use of the patient's primary language should be documented along with any communication assistance provided.
- **Provider identification**: All entries must include identification of the author, including dictation and the author should authenticate each entry. Authentication may include a signature or initials, thereby verifying the report is complete and accurate.
- **Services information**: Include dates of service (including begin and end times), service site and name of service provider for all services.
- **Consent forms**: Include signed and dated consent forms (as applicable).
- **Legibility**: The medical record must be legible to someone other than the writer.
- **Allergies**: Document allergies or no known allergies (NKA) in a uniform location on the medical record. List medications used for treatment and other adverse reactions as applicable.
- **Chief complaint or purpose of visit**: Chief complaint or purpose of visit is documented.
- **Medical history**: For patients seen three or more times, medical history should be easily identifiable and include serious accidents, operations, illnesses, and familial/hereditary disease, medical history, diagnoses, treatment prescribed, therapy prescribed and drugs administered or dispensed.
- **Advance directive(s)**: For patients ages 21 and older, document that the patient was asked if he or she has an advance directive (written directions about healthcare decisions) and the patient's answer (yes or no). If the response is yes, the medical record must include a copy of the advance directive.
- **Physical exam (complete)**: All body systems should be reviewed within two years of the first clinical encounter, including HEENT (head, eyes, ears, nose and throat), teeth, neck, heart, lungs, neurological and musculoskeletal. Document height, weight, blood pressure and temperature during the initial visit.

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- **History and physical**: Document subjective and objective information regarding the presenting complaints.
- **Working diagnosis**: The working diagnosis should be consistent with findings (i.e., the physician's medical impression).
- **Plan/treatment**: Documentation of plan of action and treatment should be consistent with diagnosis. In addition, all entries should include the disposition, recommendations, patient instructions, health education provided, evidence of follow-up (if applicable) and outcome of services.
- **Records (e.g., consultation, discharge summaries and emergency room reports)**: File reports from other providers in the medical record with the primary care physician's initials, thereby signifying review.
- **Referrals (e.g., consultation, therapy)**: Medical record must include referral information, including follow-up and outcome of referrals.
- **X-ray/lab/imaging**: Record should show documentation of X-ray, lab, imaging or other studies ordered. File results in the medical record with the primary care physician's initials, thereby signifying review. Abnormal X-ray, lab and imaging study results should have an explicit notation in the medical record regarding follow-up plans and notification to patient of all results (positive and negative).
- **Health education**: Records must include documentation of any education or materials provided to the patient.
- **Tobacco/vaping**: For patients seen three or more times, records must include a notation about patient tobacco/ vaping use.
- **Alcohol**: For patients seen three or more times, records must include a notation about patient alcohol use.
- **Substance use**: For patients seen three or more times, records must include a notation about patient substance use.
- **Immunization record**: Records must include current list of immunizations.
- **Prescribed medications**: Records must include a list of current medications, including dose and date of initial prescription or refills.
- **Prescription monitoring program (PMP)**: For prescriptions of controlled substances, records must include verification that the PMP was checked in accordance with the Louisiana Board of Pharmacy requirements.
- **Behavioral health assessment/screening**: A standardized behavioral health assessment/screening is performed and documented.
- **Behavioral health follow-up**: If appropriate, document the behavioral health follow-up.

* Other areas of Humana also may request and review medical records for specific operational and compliance needs. Depending on their purpose, such reviews may examine additional or different medical record elements and use different review criteria than those described here.

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