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Medical record documentation review elements

Humana Healthy Horizons in Florida annually conducts random medical record documentation reviews (MRDRs) to monitor compliance with regulatory agencies. This document lists the evaluated record elements and the criteria for satisfactory performance.* Please note: "Members" in this document refers to patients with Humana healthcare coverage.

Member identification: Each page in the medical record must contain the member's name or identification number. Records for members should include identifying information, including name, member identification number, date of birth, sex, and name of parent or legal guardian (if applicable).

Provider identification: The author must be identified for all entries (including dictation) and have authenticated each entry as complete and accurate. Authentication may include signatures or initials.

Entry date: All entries must be dated. Each entry for member records must be signed and dated within two business days from the date and time of service or otherwise authenticated by signature, written initials, computer entry or electronic signature. Rubber-stamped signatures must be initialed.

Legibility: The medical record must be legible to someone other than the writer.

Problem list: Significant illnesses and medical conditions are indicated on the problem list.

Allergies: The presence or absence of allergies (no known allergies, or NKA) must be documented in a uniform location on the medical record. Medication allergies and other adverse reactions must be listed if present.

Past medical history: For members seen three or more times, past medical history should be easily identifiable and include details regarding serious accidents, operations, illnesses and familial/hereditary diseases. Records for members should include a summary of significant surgical procedures, past and current diagnoses or problems, allergies, adverse reactions to drugs, and current medications.

Physical exam (complete): All body systems should be reviewed within two years of the first clinical encounter, including head, eyes, ears, nose and throat (HEENT), teeth, neck, heart, lungs, and neurological and musculoskeletal systems. Height, weight, blood pressure and temperature must be documented on the initial visit.

History and physical: Subjective and objective information regarding presenting complaints should be obtained and noted.

Working diagnosis: The working diagnosis should be consistent with findings (i.e., the physician's medical impression).

Plan/treatment: Documentation of a plan of action and treatment should be consistent with diagnoses. Records for members should include all prescribed or provided services, medications and supplies. Such services must include, but are not necessarily limited to, family planning services, preventive services and services for the treatment of sexually transmitted diseases. In addition, all entries must include the disposition, recommendations, member instructions, evidence of any follow-up and outcome of services.

Records (e.g., consultation, discharge summaries and emergency room [ER] reports): Reports should be filed in the medical record and initialed by the primary care physician (PCP) to signify review. Past medical records and hospital records (e.g., operative and pathology reports, admission and discharge summaries, consultations, and ER reports) should be filed in the medical record.

Referrals (e.g., consultation, therapy): Referrals should be filed in the medical record.

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X-ray, lab, imaging: Records should show documentation of lab, X-ray, imaging or other ordered studies. Results should be filed in the medical record and initialed by the PCP to signify review. Abnormal X-ray, lab and imaging study results should have explicit notation in the medical record regarding follow-up plans and member notification of all results (positive and negative).

Smoking: For members seen three or more times, a notation concerning cigarette use must be present.

Alcohol: For members seen three or more times, a notation concerning alcohol use must be present.

Substance use: For members seen three or more times, a notation concerning substance use must be present.

Immunization record: A current record of immunizations should appear in the member chart.

Advance directives: For members 21 and older, records should contain evidence that the member has been asked if he or she has an advance directive (written directions about healthcare decisions), with a yes-or-no response documented. If the response is yes, a copy of the advance directive must be included in the medical record. Records for members should indicate that neither the managed care plan nor any of its providers, as a condition of treatment, require the member to execute or waive an advance directive.

Prescribed medication: All current medications, including dose and date of initial prescription or refills, should be present in the medical record. Records for members should include copies of all consent or attestation forms used or the court order for prescribed psychotherapeutic medication for a child younger than 13.

Primary language: Use of the member's primary language should be documented, along with any communication assistance provided.

Humana Healthy Horizons® in Florida obstetrical providers: Records should include a copy of the completed screening instrument and documentation that a copy was provided to the member. Records should include documentation of pre-term delivery risk assessments by week 28 of pregnancy.

* Please note: Other Humana departments may request and review medical records for operational and/or compliance purposes. Such reviews may examine additional or different medical record elements and use different review criteria than those described here.