TUFTS Health Plan

# Medical Record Documentation Tool 2015

**Health Plan**: ***Tufts Health Plan Medicare Preferred and Tufts Health Public Plans***

Date of Review: _____ Time of Review: _____

Practitioner Name: _____ Member ID: _____
Office Manager: _____ Member Last Name: _____
Complete Office Address: _____ Member First Name: _____
_____ Member DOB: _____
Telephone Number: _____ Gender: _____
Review Completed By: _____

| **Access to Care** | **YES** | **NO** | **N/A** |
|---|---|---|---|
| 1. Is there an After Hours policy and procedure in place? | ☐ | ☐ | ☐ |
| **Medical Record Documentation** | **YES** | **NO** | **N/A** |
| 2. Is the record legible to person other than author? Please refer to job aid if answering NO. | ☐ | ☐ | ☐ |
| If **NO**, explain: | | | |
| 3. Is the member's name and/or ID number on each page? | ☐ | ☐ | ☐ |
| If **NO**, explain: | | | |
| 4. Does the member's name appear in the demographic area? | ☐ | ☐ | ☐ |
| If **NO**, explain: | | | |
| 5. Does the member's address appear in the demographic area? | ☐ | ☐ | ☐ |
| If **NO**, explain: | | | |
| 6. Does the home phone/cell phone number appear in the demographic area? | ☐ | ☐ | ☐ |
| If **NO**, explain: | | | |
| 7. Does the member's name of employer appear in the demographic area (if applicable)? | ☐ | ☐ | ☐ |
| If **NO**, explain: | | | |

| Medical Record Documentation | YES | NO | N/A |
|---|---|---|---|
| 8. Does the member's marital status appear in the demographic area? | ☐ | ☐ | ☐ |
| If **NO**, explain: | | | |
| 9. Is the member's D.O.B documented? | ☐ | ☐ | ☐ |
| If **NO**, explain: | | | |
| 10. Is the member's primary/preferred spoken language documented? | ☐ | ☐ | ☐ |
| If **NO**, explain: | | | |
| 11. Is the member's disabilities documented (if applicable)? | ☐ | ☐ | ☐ |
| If **NO**, explain: | | | |
| 12. Is the member's emergency contact information documented? | ☐ | ☐ | ☐ |
| If **NO**, explain: | | | |
| 13. Are all entries dated? | ☐ | ☐ | ☐ |
| If **NO**, explain: | | | |
| 14. Are all entries signed? | ☐ | ☐ | ☐ |
| If **NO**, explain: | | | |
| 15. Does the health record contain information on allergies and adverse reactions (or a notation that the patient has no known allergies or history of adverse reactions)? | ☐ | ☐ | ☐ |
| If **NO**, explain: | | | |
| 16. Is there a current medication list with evidence of updates including dosages and dates of initial or refill prescriptions? | ☐ | ☐ | ☐ |
| If **NO**, explain: | | | |
| 17. Is there a current and complete problem list including significant illnesses and medical and psychological conditions? | ☐ | ☐ | ☐ |
| If **NO**, explain: | | | |
| 18. Does the health record contain presenting complaints, diagnoses, and treatment plans? | ☐ | ☐ | ☐ |
| If **NO**, explain: | | | |

| Medical Record Documentation | YES | NO | N/A |
|---|---|---|---|
| 19. Is there documentation of member's past medical history? | ☐ | ☐ | ☐ |
| If **NO**, explain: | | | |
| 20. Is there an immunization record (for children) that is up to date? | ☐ | ☐ | ☐ |
| If **NO**, explain: | | | |
| 21. For members age 21 and under, is there evidence that preventive screenings and services were offered in accordance with the EPSDT Periodicity Schedule? | ☐ | ☐ | ☐ |
| If **NO**, explain: | | | |
| 22. For members over age 21, is there evidence that preventive screenings and services were offered in accordance with the Provider's own practice guidelines? | ☐ | ☐ | ☐ |
| If **NO**, explain: | | | |
| 23. Is there evidence that unresolved problems from previous office visits were addressed in subsequent visits (if applicable)? | ☐ | ☐ | ☐ |
| If **NO**, explain: | | | |
| 24. Is there documentation of physical examinations? | ☐ | ☐ | ☐ |
| If **NO**, explain: | | | |
| 25. Is there documentation of member's necessary treatments and possible risk factors for the member relevant to the particular treatment? | ☐ | ☐ | ☐ |
| If **NO**, explain: | | | |
| 26. Is there evidence that the member was involved in his/her plan of care? | ☐ | ☐ | ☐ |
| If **NO**, explain: | | | |
| 27. Is there evidence of discussion and instructions on Advance Directive wishes, and/or a completed and signed Advance Directive? | ☐ | ☐ | ☐ |
| If **NO**, explain: | | | |
| 28. Is there appropriate notation concerning the use of cigarettes, alcohol, and substances? | ☐ | ☐ | ☐ |
| If **NO**, explain: | | | |
| 29. Is there any evidence of under- or over-utilization of specialty services or pharmaceuticals? | ☐ | ☐ | ☐ |
| If **NO,** explain: | | | |

| Medical Record Documentation | YES | NO | N/A |
|---|---|---|---|
| 30. Is there evidence of a standardized wellness screening form to track age-appropriate screening services? | ☐ | ☐ | ☐ |
| If **NO**, explain: | | | |
| 31. Is there evidence that laboratory and imaging reports filed in the chart are initialed by the provider who ordered them to signify review? | ☐ | ☐ | ☐ |
| If **NO**, explain: | | | |
| 32. Is there evidence that there has been contact with the member's family, guardian, or significant other (if applicable)? | ☐ | ☐ | ☐ |
| If **NO**, explain: | | | |
| 33. Is there documentation of all contact with state agencies (if applicable)? | ☐ | ☐ | ☐ |
| If **NO**, explain: | | | |
| 34. Is there evidence of communication between Specialists and PCP for continuity of care? | ☐ | ☐ | ☐ |
| If **NO**, explain: | | | |
| 35. Is the reason for Specialist consult documented? | ☐ | ☐ | ☐ |
| If **NO**, explain: | | | |
| 36. Is there evidence that the physician has reviewed all consultation reports? | ☐ | ☐ | ☐ |
| If **NO**, explain: | | | |
| 37. Did the member request to see an OB/GYN specialist (if applicable)? | ☐ | ☐ | ☐ |
| If **NO or N/A**, continue to Question 39. | | | |
| 38. If **YES**, was the referral made for the member to see an OB/GYN specialist? | ☐ | ☐ | ☐ |
| 39. Is there evidence of the follow-up plan including time of return noted in weeks or months? | ☐ | ☐ | ☐ |
| If **NO**, explain: | | | |

| Confidentiality (Attestation) | YES | NO | N/A |
|---|---|---|---|
| 40. Did the Provider return a signed Attestation form confirming that the medical records are in a space staffed by office personnel? | ☐ | ☐ | ☐ |
| If **NO**, explain: | | | |
| 41. Did the Provider return a signed Attestation form confirming that the medical records are in a locked office when the staff is not present? | ☐ | ☐ | ☐ |
| If **NO**, explain: | | | |
| 42. Did the Provider return a signed Attestation form confirming that they prohibit unauthorized review and/or removal of medical records? | ☐ | ☐ | ☐ |
| If **NO**, explain: | | | |
| 43. Did the Provider return a signed Attestation form (with a copy of the office's policy) confirming that they maintain and adhere to policies and procedures regarding patient confidentiality (HIPPA)? | ☐ | ☐ | ☐ |
| If **NO**, explain: | | | |

| Comments: |
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