

Critical Factors in the Medical Record Review Standards

Please note:

The medical record standards have 13 critical indicators which are marked with an asterisk (*). These indicators must be included in every chart or you will be scored zero for that medical record. Medical records are reviewed by NCQA on behalf of the Department of Public Welfare, and these critical factors are a requirement

To improve the documentation of standards of care, 13 “critical” elements were identified within the standards. **The critical elements for the PCP are:**

- Individual medical record;
- Each page in the record contains the member’s name;
- Record contains biographical data;
- All entries have entry identification numbers;
- All entries are dated;
- The record is legible;
- The record has a current problem list;
- The record has a medication list;
- Presence/absence of allergies or adverse reactions are prominently displayed;
- Use/nonuse of tobacco, chew, pipe and/or snuff is noted;
- Each visit has a working diagnosis;
- Continuity and coordination of care is noted;
- There is an annual review of advance directive.

These elements are required to be present in every chart.

The critical elements for all specialists with the exception of Obstetrics include:

- Individual medical record;
- Record contains biographical data;
- All entries have entry identification numbers;
- All entries are dated;
- The record is legible;
- The record has a medication list;
- Presence/absence of allergies or adverse reactions are prominently displayed;
- Use/nonuse of tobacco, chew, pipe and/or snuff is noted;
- Each visit has a working diagnosis;
- Continuity and coordination of care is noted;
- All care is medically appropriate and necessary (There is no evidence that the member was placed at inappropriate risk by a diagnostic or therapeutic modality. If questions the record is reviewed by the Physician Advisor)

The critical elements for Obstetrics are:

- Individual medical record;
- Record contains biographical data;

- All entries have entry identification numbers;
- All entries are dated;
- The record is legible;
- The record has a medication list;
- Presence/absence of allergies or adverse reactions are prominently displayed;
- Past medical history;
- Use/nonuse of tobacco, chew, pipe and/or snuff is noted;
- Each visit has a working diagnosis;
- There is a notation concerning follow-up care;
- Continuity and coordination of care is noted.

These elements are required to be present in every chart.