

**GATEWAY HEALTH PLAN®
MEDICAL RECORD REVIEW STANDARDS
PRIMARY CARE PHYSICIANS**

1. INDIVIDUAL RECORD	Each member's individual medical record is maintained separately.
2. MEMBER ID	Each page in the record contains member name or member ID number.
3. BIOGRAPHICAL DATA	Personal data includes address, employer, telephone numbers, emergency contact, marital status, etc.
4. ENTRY ID	All entries are signed (electronically) or initialed by the physician or nurse practitioner, as appropriate. PA notes are to be cosigned by physician.
5. ENTRY DATE	All entries are dated.
6. LEGIBILITY	The record is legible to someone other than the physician or physician's staff.
7. PROBLEM LIST	A problem list is completed for each member, including significant diseases and medical conditions.
8. MEDICATION LISTING	Documentation of prescribed medications and prescription refills documented.
9. ALLERGIES	Presence/absence of allergies or adverse reactions to medications are prominently noted on each member chart after one year of age.
10. PAST MEDICAL HISTORY	Includes serious injuries, operations and illnesses of member. For children and adolescents, this includes prenatal care, birth, and childhood illnesses.
11. TOBACCO USE	Use/nonuse of tobacco is documented on members age 14 and older.
12. ALCOHOL/DRUG USE	Use/nonuse of alcohol and illicit drugs is documented on members age 14 and older.
13. HISTORY & PHYSICAL	Appropriate subjective and objective information is recorded for presenting complaints.
14. LAB & OTHER STUDIES	Labs and other studies must be appropriate to the presenting complaint, or diagnosis.
15. WORKING DIAGNOSES	There is a clearly documented diagnostic impression by the PCP that is consistent with findings for each member visit.
16. PLAN OF ACTION/TREATMENT	Each visit is finalized with a plan of action and/or treatment plan that is consistent with diagnosis. Options and risks of treatments discussed as appropriate.
17. RETURN VISIT	There is a notation concerning follow-up care, i.e. to call with problems, to return within a specific time frame or as needed, or to see a specialist.
18. UNRESOLVED PROBLEMS	Ongoing or unresolved problems from prior visits must be addressed.
19. CONSULTATION	Review for under/over utilization of consultation.
20. CONTINUITY/COORDINATION OF CARE	Chart contains consult reports, inpatient and ER discharge summary, records transferred from prior care and documentation from skilled nursing facilities and home health care agencies.
21. CONSULTS/X-RAYS/LAB/IMAGING STUDIES	Reports are filed in the chart and have been reviewed and initialed by physician. Consultation and abnormal study results have explicit notation in the record of follow-up plans.
22. CARE MEDICALLY APPROPRIATE	All care must be medically appropriate and necessary, and there is no evidence that the member has been placed at inappropriate risk.
23. IMMUNIZATION HISTORY	Under 21 years of age, there is a completed, up to date immunization record, or notation concerning lack of this. Adult members have a notation of past immunization history and of PCP's intent to immunize as appropriate based upon Gateway Health Plan's® (Gateway) guidelines.
24. PREVENTIVE SERVICES	Preventive screening and services are offered in accordance with Gateway's preventive health guidelines.
25. ADVANCE DIRECTIVE	There is documentation of whether the member has executed an advance directive (ages 21 and older), and of advance directives in a prominent part of the member's medical record as appropriate.