

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 including dictation are signed (electronically) or initialed by the physician or nurse practitioner, as appropriate. PA notes are to be cosigned by physician.
5. ENTRY DATA*	All entries are dated.
6. LEGIBILITY*	The record is legible to someone other than the physician or physician's staff.
7. PROBLEM LIST*	A separate problem list is current and completed for each member, including significant diseases and medical conditions.
8. MEDICATION LIST*	Prescribed medications and prescription refills documented on a separate medication list.
9. MEDICATION REVIEW	Documentation of medications review annually and after discharge.
10. MEDICATION RECONCILIATION	Documentation that the medications were reviewed post discharge, discharge summary signed and dated on members age 65 and older.
11. USE OF APPROPRIATE MEDICATIONS FOR PEOPLE WITH ASTHMA	Documentation the member on a controller medication.
12. ALLERGIES*	Presence/absence of allergies or adverse reactions to medications are prominently noted on each member chart after one year of age.
13. PAST MEDICAL HISTORY	Includes serious injuries, operations and illnesses of member. For children and adolescents, this includes prenatal care, birth, and childhood illnesses.
14. TOBACCO USE*	Use/nonuse of tobacco products is documented on members age 11 and older.
15. TOBACCO USER	Documentation that the member was advised to quit.
16. TOBACCO USER	Documentation that nicotine replacement medications were discussed.
17. TOBACCO USER	Documentation that smoking cessation strategies were discussed.
18. ALCOHOL/DRUG USE	Use/nonuse of alcohol and illicit drugs is documented on members age 11 and older.
19. HISTORY & PHYSICAL	A complete history and physical exam for new patients are recorded within 12 months of the member seeking care, or within 3 visits whichever occurs first. Appropriate subjective and objective information is recorded for presenting complaints.
20. CARE OF THE OLDER ADULT	Documentation of annual assessment of functional status age 65 and older.
21. CARE OF THE OLDER ADULT	Documentation of annual comprehensive pain assessment age 65 and older.
22. LAB & OTHER STUDIES	Labs and other studies must be appropriate to the presenting complaint, or diagnosis.
23. BLOOD LEAD SCREEN	Documentation of blood lead screening by age 2.
24. DIABETIC SCREENS	Documentation of at least annually HBA1c, LDL-C, microalbuminuria/medical attention to nephropathy, and eye exam.
25. CARDIAC/IVD AND HYPERTENSION SCREENS	Documentation of annual LDL-C screening.
26. ANNUAL MONITORING FOR MEMBERS ON PERSISTENT MEDICATIONS	Members on digoxin, diuretics, and /or ACEs/ARBs have documentation of annual serum potassium and serum creatinine/blood urea nitrogen.
27. PHARYNGITIS SCREEN	Members' age 2-18 years have a strep test if diagnosed with pharyngitis.
28. WORKING DIAGNOSIS*	There is a clearly documented diagnostic impression by the PCP that is consistent with findings for each member visit.

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29. PLAN OF ACTION/TREATMENT	Each visit is finalized with a plan of action and/or treatment plan that are consistent with diagnosis. Options and risks of treatments discussed as appropriate.
30. 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.
31. UNRESOLVED PROBLEMS	Ongoing or unresolved problems from prior visits must be addressed.
32. CONSULTATION	Review for under/over utilization of consultation.
33. 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.
34. DISCHARGE SUMMARY	If the member was in the hospital, there is a discharge summary signed and dated within 30 days.
35. CONSULTS/XRAYS/LAB/IMAGING STUDIES	Reports are filed in the chart and have been reviewed and initialed by physician.
36. CONSULTS AND ABNORMAL RESULTS	Consultation and abnormal study results have explicit notation in the record of follow-up plans.
37. 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.
38. CHILDHOOD IMMUNIZATION HISTORY	Under 21 years of age, there is a completed, up to date immunization record, or notation concerning lack of this. By the age of 2 there needs to be 4 DTAP, 3 IVP, 1MMR, 3 HIB, 3 HEP B, 1VZV, 4 PCV, 2 HEP A, 2-3 Rotovirus, and 2 influenza. By 13- 1Tdap and 1 meningococcal vaccine. Documentation needs to also include past immunization history and of PCP's intent to immunize.
39. IMMUNIZATION FOR AGE 21 AND OLDER	For adult members record must indicate member's immunization status for TD/Tdap. Documentation needs to also include past immunization history and of PCP's intent to immunize.
40. INFLUENZA AND PNEUMOCOCCAL VACCINES.	For members 65 and older and at high risk record must indicate immunization status for influenza and pneumococcal. Documentation needs to also include past immunization history and of PCP's intent to immunize.
41. PREVENTIVE SERVICES	Preventive screening and services are offered in accordance with Gateway's preventive health guidelines. For members under the age 21, preventive services must be provided according to the State's mandated periodicity schedule. Examples: <ul style="list-style-type: none"> • Age 3-17- Well child visit include: BMI percentile, counseling for physical activity and nutrition • Age 12-17 Visit includes: Health & developmental history, physical exam, and health education/guidance • Age 18-74 visit includes: BMI biannually • Age 21-64 Women have Pap recorded within the past three years • Age 40-69 Women have mammogram within past two years • Age 50-75 Men & Women have either sigmoidoscopy within 5years, colonoscopy within 10 years, or fecal occult blood test • Age 40 -75 Men have documentation of discussion of prostate cancer
42. ADVANCE DIRECTIVE	There is annual documentation of whether the member has executed an advance directive (ages 21 and older), and if "yes" a copy must be included in the medical record. If age 65 and older, need documentation of annual review.