

GATEWAY HEALTH PLAN®
MEDICAL RECORD REVIEW STANDARDS
SPECIALISTS

1. MEMBER ID*	Each page in the record contains member name or member ID number
2. BIOGRAPHICAL DATA*	Personal data includes address, employer, telephone numbers, emergency contact, marital status, etc.
3. 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.
4. ENTRY DATA*	All entries are dated.
5. LEGIBILITY*	The record is legible to someone other than the physician or physician's staff.
6. MEDICATION LIST*	Prescribed medications and prescription refills documented on a separate medication list.
7. ALLERGIES*	Presence/absence of allergies or adverse reactions to medications are prominently noted on each member chart after one year of age.
8. PAST MEDICAL HISTORY	Includes serious injuries, operations and illnesses of member. For children and adolescents, this includes prenatal care, birth, and childhood illnesses.
9. TOBACCO USE*	Use/nonuse of tobacco products is documented on members age 11 and older.
10. TOBACCO USER	Documentation that the member was advised to quit.
11. TOBACCO USER	Documentation that nicotine replacement medications were discussed.
12. TOBACCO USER	Documentation that smoking cessation strategies were discussed.
13. ALCOHOL/DRUG USE	Use/nonuse of alcohol and illicit drugs is documented on members age 11 and older.
14. HISTORY & PHYSICAL	A complete history and physical exam for new patients are recorded. Appropriate subjective and objective information is recorded for presenting complaints.
15. PRE-OP STATUS	Documentation of medical clearance is on the record with respiratory and cardiac status.
16. LAB & OTHER STUDIES	Labs and other studies must be appropriate to the presenting complaint, or diagnosis.
17. DIABETIC SCREENS	Documentation of at least annually HBA1c, LDL-C, microalbuminurea/medical attention to nephropathy, and eye exam.
18. CARDIAC/IVD AND HYPERTENSION SCREENS	Documentation of annual LDL-C screening.
19. 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.
20. WORKING DIAGNOSIS*	There is a clearly documented diagnostic impression by the Specialists that is consistent with findings for each member visit.
21. 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.
22. 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 their PCP.
23. UNRESOLVED PROBLEMS	Ongoing or unresolved problems from prior visits must be addressed.
24. CONTINUITY/COORDINATION OF CARE *	Chart contains notations of any instructions/education given to member regarding follow-up visits, care, treatment, and medication, diagnostic and therapeutic services where the member was referred for services by the specialists. Home Health, skilled nursing facility, hospital discharges, and outpatient/ambulatory surgery reports need to be included in the record.
25. COMMUNICATION WITH PCP *	There is documentation of communication with the PCP as well as suggested plan of treatment.

*Indicates Critical Factors

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26. CONSULTS/XRAYS/LAB/ IMAGING STUDIES	Reports are filed in the chart and have been reviewed and initialed by physician.
27. CONSULTS AND ABNORMAL RESULTS	Consultation and abnormal study results have explicit notation in the record of follow-up plans.
28. 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.
29. TREATMENT OPTIONS	There is documentation that treatment options, e.g. medical versus surgical, etc. have been discussed with the member, regardless of the member's benefits through Gateway.