

**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 and marital status.
3. ENTRY ID	All entries are signed, initialed, or electronically signed by the physician or assistant.
4. ENTRY DATE	All entries are dated.
5. LEGIBILITY	The record is legible to someone other than the physician or physician's staff.
6. MEDICATION LIST	Medication list is in record, reflecting chronic medications and those for current illness/injury.
7. ALLERGIES	Presence/absence of allergies to medications is documented.
8. PAST MEDICAL HISTORY	Notation of member ' s current and past illnesses/injuries, especially as pertain to presenting problem.
9. TOBACCO USE	Notation of use/non-use of tobacco is prominently displayed for members age 14 years and older.
10. ALCOHOL & DRUG USE	Notation of use/non-use of alcohol/illicit drugs prominently displayed for members age 14 years and older.
11. HISTORY & PHYSICAL	Relevant to presenting illness/injury. If pre-op, assessment of cardiac and respiratory status, including BP, P and R, is required.
12. LAB & OTHER STUDIES	Appropriate to presenting illness/injury.
13. WORKING DIAGNOSES	There is a clearly documented diagnostic impression whenever the member presents for care.
14. PLAN OF ACTION/ TREATMENT	Each member visit is finalized with a plan of action and/or treatment plan that is consistent with diagnosis.
15. RETURN VISIT	There is a notation for follow-up care, i.e. to call with problems, follow-up with PCP or next visit.
16. UNRESOLVED PROBLEMS	Ongoing or unresolved problems from prior visits are addressed.
17. CONTINUITY & COORDINATION OF CARE	Chart contains inpatient summaries and reports for related illness/injury/surgery while under specialist ' s care. Also, evidence of communication with PCP.
18. CONSULTS/X-RAYS/LAB/ IMAGING STUDIES	Reports filed in the chart have evidence reflecting physician review. Abnormal study results have explicit notation in the record of follow-up plans.
19. CARE MEDICALLY APPROPRIATE	All care is medically appropriate and necessary. There is no evidence that the member has been placed at inappropriate risk.
20. TREATMENT OPTIONS	Notation of discussion of treatment options available to member.