Amerigroup RealSolutions in healthcare

Physician Name: _____ Office Manager: _____

Office Address: _____

Specialty: _____ Date: _____ Reviewer Name: _____

Patient Name: _____ Chart/Member ID: _____

		Point Value	Yes	No	Point Score
1	Is the chart accessible?	3			
2	Do all pages contain patient ID (name/ID #)?	4			
3	Is there personal/biographical data?	3			
4	Is the provider identified on each entry?	4			
5	Are all entries dated?	3			
6	Is the record legible?	4			
7	Are significant illnesses and medical conditions indicated on the problem list?*	4			
8	Are allergies and adverse reactions to medications prominently displayed or, if the patient has no known allergies or history of adverse reaction, is this appropriately noted in the record?*	4			
9	Is there an appropriate past medical history in the record (for patients seen three or more times), which includes serious accidents, operations or illnesses, emergency care, and discharge summaries? Age 18 and under should include prenatal care, birth, operations and childhood illnesses.*	4			
10	Is there documentation of smoking habits and history of alcohol or substance abuse (age 12 and older)?	3			
11	Is there a pertinent history and physical exam?	4			
12	Are labs and other studies ordered, as appropriate, and reflect PCP review?	4			
13	Are working diagnoses consistent with findings?*	4			
14	Do plans of action/treatments appear consistent with diagnosis(es)?*	4			
15	Is there a date for a return visit or other follow-up plan for each encounter?	4			

		Point Value	Yes	No	Point Score
16	Are problems from previous visits addressed?	3			
17	Is there evidence of appropriate use of consultants?	3			
18	Is there evidence of continuity and coordination of care between primary and specialty physicians?	4			
19	Do consultant summaries, lab and imaging study results reflect PCP review?	3			
20	Does the care appear to be medically appropriate? (There is no evidence that the patient was placed at inappropriate risk by diagnostic or therapeutic procedure.)*	4			
21	Is there a completed immunization record (age 13 and under)?	4			
22	Are preventive services appropriately used?	3			
23	Are advance directives present on the chart (age 21 and older)?	3			
24	Does pediatric documentation include: (4 points total)				
	– Growth chart (1.5 pts.)	1.5			
	– Head circumference chart (1 pt.)	1			
	– Developmental milestones (1.5 pts.)	1.5			
25	Is there a list of current medications?	4			
26	Are copies of any emergency treatment and/or hospital admission present in the chart?	1			
27	If a mental health problem is noted, was a referral made, or did the PCP perform treatment?	3			
28	If a substance abuse problem is noted, was a referral made, or was treatment or education noted?	3			
29	If smoking is noted, was patient advised to quit (age 12 and older)?	1			
30	Is there evidence of blood lead risk assessment (verbal assessment or blood lead test, ages 6 months to 6 years)?	1			
	TOTAL	100			

*These critical elements must be met in addition to receiving an average score of 80 percent to achieve an acceptable rating on the Clinical Medical Record Review.