AMERIGROUP

Maryland Practitioner Clinical Medical Record Audit

Physician Name: _____ Office Manager: _____

Office Address: _____

Specialty: _____ Date:_____ Reviewer Name: _____

Patient Name: _____ Chart/Member #: _____

		Point Value	Y	N	N/A	Point Score
1	Is chart accessible?	3				
2	Do all pages contain patient ID (name/ID #)?	4				
3	Are 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 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 3 or more times) that includes serious accidents, operations or illnesses, emergency care and discharge summaries? 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 over)?	3				
11	Is there a pertinent history and physical exam?	4				
12	Were labs and other studies ordered, as appropriate, and reflect Primary Care Provider 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				
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 Primary Care Provider review?	3				

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20	Does the care appear to be medically appropriate? (There is no evidence that patient was placed at inappropriate risk by diagnostic or therapeutic procedure.) *	4				
21	Is there a completed immunization record (ages 13 and under)?	4				
22	Are preventive services appropriately used?	3				
23	Are advance directives present on the chart (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 (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%, to achieve an acceptable rating on the Clinical Medical Record Review.