Amerigroup RealSolutions in healthcare

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Member List for Medical Record Review

Quality Management department

Auditor: _____ Date: _____

Group/provider name: _____ Facets provider ID: _____

Specialty: _____

Type of chart: _____

Languages spoken: _____

Race/ethnicity: _____

Method of data exchange: _____

#	ID	Name (last, first)	Sex	Age	DOB	Primary language	Race/ ethnicity	1			2			3		
								Legibility — The record is legible to someone other than the writer.			Member name or an ID number noted.			Personal biographical data noted.		
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	Documentation of an allergy or absence of allergies and adverse reactions noted.			All entries must be dated and signed.			Current problem list maintained.			Medication list maintained.			Past medical history noted.			Smoking, ethyl alcohol/ substance abuse noted.			History and physical examination noted.			Functional or cognitive deficits noted for age 66 or older. Documentation must include an assessment of member's ability to perform activities of daily living and instrumental activities of daily living.		
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	Plan of treatment is appropriate to findings, and member is not at risk by diagnostic or therapeutic problem.			Consultations, referrals and specialist reports noted.			Plan for abnormal findings noted.			Emergency care — Copies of emergency treatment documentation such as ER summary sheet are noted in the medical record.			Hospital discharge summaries — Copies of inpatient hospital discharge summaries are noted in the medical record.			Diagnostic tests noted.			Documentation of therapies and other prescribed regimens (physical therapy, occupational therapy, electrical stimulation, etc.) noted.			Notations about follow-up care, calls or visits with specific time of returned noted in days, weeks or months documented.		
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	Timely record transfer documented (when applicable).			Advance directives for age 21 and older — Documentation of an advanced care planning discussion between the provider and member with the date when it was discussed noted.			Documentation that unresolved problems from previous visits are addressed in subsequent visits.			Documentation of BMI value is noted in the medical record.			Documentation of referral for breast cancer screening biennial for women ages 50-74 and aged, blind and disabled population for ages 65-75 noted.			Documentation of the last HgbA1c test result noted in the medical record for adults identified as having diabetes.			If yes, is the HgbA1c result less than 8% for adults identified as having diabetes?			Documentation of blood pressure screening less than 140/90 from last office visit is noted in the medical record for adults identified as having diabetes.		
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	Documentation of annual dilated or retinal exam is noted in the medical record for adults identified as having diabetes.			Documentation of annual nephropathy screening test is noted in the medical record for adults identified as having diabetes.			Documentation of adults 21-64 years of age who were identified as having persistent asthma and who were appropriately prescribed medication is noted.			Documentation of annual influenza vaccine noted.			Documentation of pneumococcal vaccine for adults age 65 and older is noted; earlier if high risk.			Documentation of adults who were hospitalized for treatment of selected mental illness is noted. (Behavioral Health [BH] provider)			Documentation of a follow-up visit within seven days of discharge for adults who were hospitalized for treatment of selected mental illness is noted. (BH provider)			Documentation of a follow-up visit within 30 days of discharge for adults who were hospitalized for treatment of selected mental illness is noted. (BH provider)		
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	Documentation of height, weight and BMI percentile for children ages 3-20 is noted.			Documentation of counseling for nutrition or referral for nutrition education for children ages 3-20 is noted.			Documentation of counseling for physical activity or referral for physical activity for children ages 3-20 is noted.			Documentation of female adolescents who had 3 doses of HPV vaccine on or between their 9th-13th birthday is noted.			Documentation of completed immunizations is present, or a notation that immunization is up-to-date is acceptable.			Documentation of children ages 6-12 newly prescribed ADHD medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed.			Documentation of children 5-20 years of age who were identified as having persistent asthma and who were appropriately prescribed medication is noted.			Documentation of age-appropriate health education/ anticipatory guidance being given is noted.		
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	Documentation of children ages 6 and older who were hospitalized for treatment of selected mental illness is noted. (BH provider)			Documentation of a follow-up visit within seven days of discharge for children ages 6 and older who were hospitalized for treatment of selected mental illness is noted. (BH provider)			Documentation of a follow-up visit within 30 days of discharge for children ages 6 and older who were hospitalized for treatment of selected mental illness is noted. (BH provider)		
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