

MEDICAL RECORD DOCUMENTATION AUDIT TOOL

Physician Name _____ **Office Name** _____
Office Address _____
Office Contact _____ **Office Phone** _____ **Office Fax** _____
Date of Onsite Audit: _____ **Type of Audit:** _____

Providers must maintain complete medical records for members in accordance with MHS adopted Medical Record Documentation Standards.
 These guidelines are listed in the Provider Manual or a printed copy is available upon request.

Responses: Met (M), Needs Improvement (NI), Not Met (NM), Not Applicable (NA)
 M = 1 point NI = 0.5 point NM = 0

Standard	Member ID(s)										Comments	Element Score
1. Confidentiality of member information and records are protected through secure storage and limited access.												
2. Records are organized and easily retrieved at the time of each visit.												
3. Problem List documenting significant illnesses and/or medical conditions.												
4. Medication List												
5. Allergies and adverse reactions are prominently documented in a uniform location in the medical record; If no known allergies, NKA or NKDA is documented.												
6. An immunization record is established for pediatric members or an appropriate history is made in chart for adults.												
7. Evidence that preventive services/risk screening are offered in accordance with established clinical practice guidelines.												

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Standard	Member ID(s)										Comments	Element Score
8. Past medical history is easily identified and includes any serious accidents, operations and/or illnesses, discharge summaries, and ER encounters; For children and adolescents (18 years and younger) past medical history relating to prenatal care, birth, any operations and/or childhood illnesses.												
9. Physical, clinical findings and evaluation for each visit are clearly documented including appropriate treatment plan and follow-up schedule as indicated.												
10. Ancillary services and diagnostic tests ordered by practitioner.												
11. Abnormal lab and imaging study results have explicit notations in the record for follow up plans; All entries are initialed by the ordering practitioner to signify review.												
12. All diagnostic and therapeutic service for which a member was referred are documented including follow up of outcomes and summaries of treatment rendered elsewhere.												
13. Health teaching and/or counseling is documented.												
14. For members ten (10) years and over, appropriate notations concerning use of tobacco, alcohol and substance use (for members seen three or more times substance abuse history should be queried).												
15. Documentation of failure to keep an appointment.												
16. Evidence that an advance directive has been discussed with adults 18 years of age and older.												

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Total # Charts Reviewed _____	Total Possible Points _____	Final Audit Score: _____
Recommendations: _____		

PCP notified by/date: _____		
MHS Reviewer: _____		