2020-2021 Medical Record Standards
(Commercial, Medicare and Marketplace Product Lines)

	Audit Elements	Acceptance Criteria
	Medical Record Structural Integrity	
1	All entries in the medical record contain the author's identification. Author identification may be a handwritten signature, an initials-stamped signature, or a unique electronic identifier.	MET: All entries in the member's MR contain the author's identification Not MET: Evidence exists that not all entries in the medical record contain the author's identification as prescribed by the standard N/A No exceptions
2	Each page in the record contains the patients name or ID number	MET: Each page of the medical record contains the information as prescribed by the standard Not MET: Evidence exists in the medical record that pages within the patient's medical record do not contain the information as prescribed by the standard N/A No exceptions
3	Personal biographical data include the member name, member identification number, DOB, gender, address, employer, home and work telephone numbers and marital status. Note: Pediatric members are not required to have employer, work telephone number or marital status. For pediatric members the name of the parent or legal guardian must be present.	MET: Member medical record contains the information as prescribed by the standard. Not MET: Evidence exists that the member's medical record does not contain the minimum personal and biographical data as prescribed by the standard. N/A No exceptions.
4	All entries are dated	MET: All entries in the member's medical record are dated Not MET: Evidence exists, that entries in the member's medical record that are not dated as prescribed by the standard. N/A No exceptions
5.	Advanced Directives; ≥ to 18 years of age	MET: Documentation of advance directives are displayed in a prominent part of the member's record that he/she has/has not executed an advanced directive. The provider shall not, as a condition of treatment, require the member to execute or waive an advance directive in accordance with section 765.110, F.S. Not MET: NO documentations exist in member's record documenting if he/she has executed an advanced directive (written instructions for living will or power of attorney). N/A Less than 18 years of age.
	Medical Management	
6	Past medical history (for patients seen three or more times) is appropriate to age, and is easily identified and includes serious accidents, operations and illnesses. For children and adolescents (18 years and younger), past medical history relates to prenatal care, birth, operations, and Childhood illnesses.	MET: For patients seen three or more times the medical record contains information as prescribed by the standard Not MET: Evidence exists that patients seen three or more times do not Have information in the medical record as prescribed by the standard N/A Patient not seen by PCP at least three times

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7	The reason for the visit/chief medical complaint is documented on each visit	MET: Evidence exists in the medical record that the reason of the visit/chief complaint is documented on each visit. Not MET: No evidence exists in the medical record that the reason of the visit/chief complaint is documented on each visit. N/A: No exceptions
8	A summary of Significant surgical procedures, past and current diagnoses illnesses and medical conditions are indicated on the problem list (EMR) or in the office notes. This includes any chronic or acute co-morbidity that have occurred in the member's medical history.	MET: Evidence of a completed problem list is found in the medical record or, Health Maintenance Flow for members without problems or, Flow Chart indicating a problem is found on the medical record Not MET: No evidence of a completed problem list is found in the medical record or, No flow Chart indicating a problem is found on the medical record N/A No exceptions
9	All Medications prescribed are indicated on the Medication/Problem list (EMR) or in the office notes	Met: Evidence of a completed medication prescribed in found in the medical record. Not MET: No evidence medications are documented when prescribed. N/A No exceptions
10	The evaluation of the patient includes a pertinent history and physical exam.	MET: Documentation exists of subjective assessment, (e.g., of how or when symptoms or injury first occurred, the severity, etc. and, the patient is being seen for a routine history and physical exam. Documentation exists of an objective assessment, (e.g., physical assessment (exam) relevant to the complaint) Not MET: No evidence exists of how or when symptoms or the injury occurred, and/or, the physical exam is not relevant to the complaint N/A No exceptions
11	Continuity of care is evidenced if consultation is requested and there is a note from the consultant in the record (includes but is not limited to: Pharmacy Utilization, Home Health, Specialty Physicians, Hospital Discharges, Physical Therapy, Preventive Services/ Risk Assessment).	MET: Documentation of either communication or consultation exists in the medical record that as prescribed by the standard within 90 days of the date of referral. Not MET: Evidence exists that neither documentation of communication or consultation exists in the medical record that as prescribed by the standard within 90 days of the date of referral. N/A No specialists were used in patient's care or, the review is within 90 days of referral or, There is a written attempt by the PCP to obtain the information.

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12	Consultations, Lab/ Imaging, EKG, therapies administered and prescribed, and other reports reflect PCP's Initials To Signify Review Note: Review and signature by professionals other than the PCP, such as the nurse practitioners and physician assistants, do not meet this requirement. If the reports are presented electronically or by some other method, there is also representation of physician review.	MET: Not MET: N/A	Consultation, lab and imaging reports filed in the chart are initialed as prescribed by the standard, and consultation, abnormal lab, and imaging study results have an explicit notation in the record as prescribed in the standard. Evidence exist that consultation, lab and imaging reports filed in the chart are not initialed as prescribed by the standard nor consultation, abnormal lab, and imaging study results have an explicit notation in the record as prescribed in the standard. No consultations or test were ordered.
13	Encounter forms or notes have a notation, when indicated, regarding recommendations, patient instructions, evidenced follow-up care, calls or visits. The specific time of return is noted in days, weeks, months or as needed.	MET: Not MET: N/A	Notations referencing follow-up care, calls or visits are documented as prescribed by the standard Evidence exists in the medical record that notations referencing follow-up care, calls or visits are not documented as prescribed by the standard No exceptions
14	Allergies and adverse reactions are prominently noted in the record. If the patient has no known allergies or history of adverse reactions, this is appropriately noted in the record.	MET: Not MET: N/A:	Medical record contains information as prescribed by the standard Evidence exists that the medical record does not contain the information as prescribed by the standard No exceptions
15	Diagnoses or Medical Impressions are Consistent with objective Findings.	MET: Not MET: N/A	Diagnosis would be deemed within the standard of care for the findings documented in the medical record. No evidence exists to support the primary diagnosis. Visit is a well visit
16	Appropriate Treatment Consistent with Diagnoses	MET: Not MET: N/A	The treatment prescribed for the diagnosis is the most effective treatment for documented diagnosis Care does not fall within the standard of care for documented diagnosis No treatment available for diagnosis
17	Plans for Further Treatment	MET: Not MET: N/A	If necessary, plans for further treatment are clearly documented in the record. It is not documented in the record that ailment has been healed and there is no evidence of further treatment plans. Evidence that ailment has been healed and there is no need for further treatment