HIGHMARK FACILITY MEDICAL/TREATMENT RECORD EVALUATION

1. An individual clinical record is established, organized, easily located, and data is easily retrievable for each patient.
2. Each page in the medical record contains the patient's name. Another form of patient identification (e.g., birth date, social security number, identification number, etc.) is documented on the medical record.
3. Each record indicates which medicines have been prescribed, the dosage of each, the date of the initial prescription and/or refill, and the date the medication was discontinued, as applicable.
4. Medication and other allergies, adverse reactions, and relevant medical conditions are clearly documented and dated prominently in the record. It is noted if the patient has no known allergies, no history of adverse reactions, or no relevant medical conditions.
5. The medical record includes notes from each visit.
6. Vital signs for each visit are documented.
7. For patients 12 years and older, documentation includes past and present use of cigarettes (or other tobacco), alcohol, as well as illicit, prescribed, and over-the-counter drugs or other substance abuse. (Assessed at least annually.)
8. Past medical history (patients seen three or more times) is updated every three years and includes serious accidents, surgeries, and illnesses. For patients 18 years and younger, past medical history relates to prenatal care, birth history, surgeries, and childhood illnesses.
9. The history and physical exam identifies appropriate subjective and objective data for each visit relevant to the patient's presenting complaints.
10. The assessments or diagnostic impressions (working diagnoses) are consistent with the findings.
11. Medical record notes are tied to the treatment or therapy plan/goals and are consistent with the diagnoses.
12. The records contain documentation that the patient/caregiver received and understood instructions regarding the plan of care.
13. All entries in the record contain a valid, legible author's signature, which may be a handwritten signature with credentials, printed name and credentials accompanied by handwritten provider initials, or unique electronic identifier with credentials.
14. All entries in the record are dated and legible to someone other than the writer.
15. The medical/treatment records have a notation regarding follow-up care, calls, or visits when indicated. The specific time of return is noted in weeks, months, or as needed.
16. Consultations, laboratory, imaging, and other studies (including mammograms and pap smears) are ordered, as appropriate. The reports are filed in the chart and initialed by the ordering practitioner to signify review, with explicit notation of follow-up plans relating to abnormal laboratory and imaging results.
17. There is no evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic procedure. Possible risk factors for the member, relevant to the particular treatment, were documented, as applicable.
18. There is evidence of communication and collaboration from the facility to the PCP or referring provider, including documentation that a copy of the patient's exam with pertinent information has been forwarded (e.g., letters, reports, etc.).
19. There is documentation in the medical record that patients are notified of abnormal test results.