2010 MEDICAL RECORD DOCUMENTATION GUIDELINES

PUP, in conjunction with network providers who serve on the Medical Advisory Committee, reviews and updates medical record documentation guidelines on an annual basis. The guidelines are evidence-based and comply with regulatory requirements and URAC accreditation standards. Below are the Medical Record Documentation Guidelines approved for 2010. Should you have questions regarding this edition of the guidelines or wish to participate in future updates, please contact the Senior Director of Health Services, Judy Conely, or our Medical Director, Dr. Robert Sutton, at 321-460-1882.

Physicians United Plan Medical Record Documentation Guidelines

Std #	Documentation Standard	Audit Application Guidelines
1	Member name and biographical data	Member name, identification number, gender, date of birth, phone number and address are recorded in the record.
2	Member identification present on all pages	All medical record pages include member identification information, name or ID number.
3	Communication needs assessed	Assessment for special communication needs documented.
4	Entries signed and dated	All clinical entries, triage notes, addendum notes are dated and signed. Authors of entries are identified by profession e.g. MD, DO, RN, MA, etc.
5	Entries legible	Record is legible to the reviewer, PUP, or office staff that is available to assist with the review. Illegible records that cannot be audited should copied and submitted with the audit report.
6	Allergies documented	Allergies, or the absence of allergies, are prominently noted in the record. With the documentation of allergies, the type of adverse reaction is noted in the record at least once.
7	Advance directive documentation	Documentation includes whether or not the member has an advance directive OR education regarding advance directives.
8	Medical history documented	A health history, to include current medications, is documented.
9	Significant medical conditions and surgical events are documented on a problem list	A problem list is maintained and includes significant medical and surgical history. N/A if documented health history indicates no chronic conditions or significant surgical history.
10	Tobacco/substance use/abuse noted	Risk assessment includes documentation of tobacco, alcohol and drug use/abuse.
11	Subjective complaints documented	Chief complaint or purpose of the visit is documented.
12	Objective findings documented	Objective findings appropriate for the chief complaint are documented.
13	Diagnosis documented	Diagnosis or clinical impression consistent with findings is documented.
14	Treatment plan documented	Plan of care, to include prescribed medications is documented at each visit.
15	Member education documented	Member education regarding plan of care and patient risk factors is documented.

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16	Unresolved problems addressed	Unresolved problems from prior visits are addressed at subsequent visits. N/A if there are no problems or no unresolved problems.
17	Consultant and diagnostic test results initialed and filed	Evidence that ordered consultations and diagnostic testing were accomplished and results reviewed by the PCP. Reports are initialed by provider. Filed or verbal reports are acceptable. • Consult reports: allow 6 weeks; • Lab, routine: allow 2 weeks; • Lab, non-routine: allow 4 weeks; • Radiology studies: allow 2 weeks N/A if none ordered.
18	Emergency room and hospital discharge summaries present	Information regarding emergency visits and hospitalizations is documented. Facility discharge summaries or progress note entries meet requirements. N/A for no known ER visits or hospitalizations.
19	Immunizations current	Age appropriate immunizations are documented. • Influenza, annually, beginning age > 50 • Pneumococcal at least once, age > 65 N/A Influenza if <51 years; N/A Pneumococcal if < 66 and without chronic illnesses
20	Cholesterol screening	TC and HDL-C screening, every 5 years: • Men > 35 years; N/A men < 36 years.
21	Hypertension screening	BP measurement at least every 2 years for all adults. Note: This indicator is for BP screening, for adults with BP >130/85 mmHg, evidence of periodic monitoring is scored with item #16.
22	Colorectal cancer screening	Colorectal cancer screening beginning at age 50 years and continuing through age 75 and may be accomplished by any of the following: • Colonoscopy, every 10 years; • Flexible sigmoidoscopy, every 5 years, combined with high-sensitivity fecal occult blood test (FOBT) every 3 years; • Annual, high sensitivity, fecal occult blood test (FOBT). N/A prior to 51 years and older than 74 years.
23	Breast cancer screening*	Screening mammogram within the current or previous calendar year for women > 40 < 70 years old (breast biopsies, ultrasounds or other diagnostic mammograms do not meet the criteria for a screening mammogram). N/A for women < 41 or > 69 years; N/A for women with documented bilateral mastectomies; N/A males.
24	Cervical cancer screening	Cervical cancer screening for women <65 years via Pap test during the current calendar year or previous two calendar years (screening every 3 years); N/A for women with a history of hysterectomy unless residual cervix is documented (complete, total and radical hysterectomies indicate no residual cervix); N/A for women >66 years with documented history of negative cervical cancer screening with in the previous 10 years; N/A for males.

* PUP acknowledges the recent discussion regarding new USPSTF recommendations for mammography and continues with annual screening recommendations as described in these guidelines.