Documentation of Care
Guidelines for Primary Care Physician Medical Record Review

All 25 indicators are to be measured from 24 months prior to the review date, unless otherwise specified. Review of medical records for patients preferably seen three or more times by the primary care physician is recommended:

- Indicators 1 through 13 are to be reviewed two years prior to review date.
- Indicators 14 through 25 can be found anywhere in the medical records.

1. **Is the record legible?** *(Referenced in Agency for Health Care Administration [AHCA] - HMO 5 Medical Records and Department of Health Board of Medicine 64B8-9.003)*. The record is legible to someone other than the writer. Someone in the physician’s office can interpret the record for you.
   
   Mark as “N” if not legible.

2. **Does each page of the office progress notes contain the patient’s name and identification number?** *(Referenced in AHCA – HMO 8 MR)*
   
   One side of every page reviewed in the record must contain the patient’s name and identification (ID) number (e.g., Florida Blue member ID, Social Security number, date of birth, or physician office medical record ID number). The name and/or ID must be in ink, addressograph or typed. This does not count for individual post-it-notes, phone messages, etc., unless they cover an entire page, nor information received from outside sources, (e.g., consultation reports, diagnostic results).
   
   Mark as “N” if not present on all progress notes over the last two years.

3. **Does each entry identify the provider by signature or initials (signed, stamped, or typed) rendering services?** *(Referenced in AHCA - HMO 10 [g] MR)*
   
   All entries in the medical record contain author identification (e.g., physician, physician assistant (PA), medical assistant (MA), advanced registered nurse practitioner (ARNP) or registered nurse (RN)).
   
   Mark as “N” if not present on all progress notes over the last two years.

4. **Are current medications documented on a separate medication list or listed in progress notes?** *(Referenced in AHCA - HMO 9 MR, HMO 10 [f] MR, Department of Health Board of Medicine 64B8-9.003)*
   
   Are prescribed and over the counter medications reviewed at the time of each encounter? This can be noted in the progress notes or on a separate medication list. It does not include medications prescribed at the current visit.
   
   Mark as “N” if not present in the record.
5. **Is the main complaint or reason for each office visit clearly stated?** *(Referenced in AHCA - HMO 10 [b] MR and, Department of Health Board of Medicine 64B8-9.003)*

   Reasons for encounters and presenting complaints are documented.

   **Mark as “N” if not present on all progress notes over the last two years.**

6. **Are all entries of the progress notes dated?** *(Referenced in AHCA - HMO 10 [a] MR and, Department of Health Board of Medicine 64B8-9.003)*

   Each entry of the progress notes in the record are to be dated with month, day and year. Problem lists are not considered entries.

   **Mark as “N” if not present on all progress notes over the last two years.**

7. **Are problems from previous visits addressed?** *(Referenced in AHCA - HMO 10 [h] [i] MR and Department of Health Board of Medicine 64B8-9.003)*

   Unresolved problems from previous office visits are recorded and acknowledged in subsequent visits.

   **Mark as “N” if not present in the progress notes over the last two years,**

8. **Are objective findings documented, including appropriate vital signs?** *(Referenced in AHCA - HMO 10 [c] MR and, Department of Health Board of Medicine 64B8-9.003)*

   Appropriate subjective and objective findings relating to the chief complaint or reason for the visit are documented for each visit, including appropriate vital signs (e.g., complaints of flu, cough, etc., should show a temperature and respiration check with lung assessment. A complaint of symptoms relating to hypertension should show a documented blood pressure.).

   **Mark as “N” if not present on all progress notes over the last two years.**

9. **Is the diagnosis supported by subjective and objective findings?** *(Referenced in AHCA - HMO 10 [c][d] MR and Department of Health Board of Medicine 64B8-9.003)*

   Findings obtained from the history, physical exam, lab, radiology, diagnostic studies and consultations appear to be consistent with the diagnosis.

   **Mark as “N” if not present on all progress notes over the last two years.**

10. **Is there a documented treatment plan that is consistent with the diagnosis?** *(Referenced in AHCA - HMO 10[d] [h] [i] MR and Department of Health Board of Medicine 64B8-9.003)*

    Treatment plans, including lab, radiology, diagnostic studies, consultation procedures, prescriptions, physical therapy, etc., and return visits are consistent with the diagnosis.

    **Mark as “N” if not present on all progress notes over the last two years.**

11. **Are lab, x-ray and diagnostic studies present in the record and do they reflect primary care review?** *(Referenced in AHCA - HMO 10 [e] [g] [h] [i] MR and Department of Health Board of Medicine 64B8-9.003)*

    All test results are to be acknowledged by the primary care practitioner (e.g., signature, initials or comments in the progress notes). The record reflects follow-up plans to address abnormal imaging and diagnostic study results.
Mark as “N” if missing primary care review. Mark as “NA” if no labs or diagnostic studies present in record over the last two years.

12. Do consultations present in the record reflect primary care review? (Referenced in AHCA - HMO 10 [g] [h] [i] MR, HMO 17 [a] [b] 4 [c] QC, HMO 28 QC, HMO 29 QC and Department of Health Board of Medicine 64B8-9.003)

Consultative notes are reviewed and acknowledged by a primary care practitioner by way of signature, initials or comments in the progress notes.
Mark as “N” if missing primary care review. Mark as “NA” if no consultations present in record over the last two years.

13. Are there follow-up plans? (Referenced in AHCA - HMO 10 [h] [i] MR and Department of Health Board of Medicine 64B8-9.003)
There is notation of a follow-up plan at each visit. Recommendations for return visits are documented in the medical record.
Mark as “N” if not present on all progress notes over the last two years. May be found on the super bill, if found in record.

14. Does biographical data include the following anywhere in the medical record: date of birth, name, member ID number and sex? (Referenced in AHCA - HMO 8 [a] [b] [c] [d] MR)
Elements do not have to be on the same page. Areas to find this information may include initial history, biographical billing data or copy of driver's license (adult). Patients less than 18 years of age should contain a parent(s) name, address and phone.
Mark as “N” if not present in record.

15. Does the record contain a current summary of significant problems, medical diagnoses, and/or conditions and operative/invasive procedures? (Referenced in AHCA - HMO 9 MR)
Significant illnesses, medical conditions, recurrent acute episodes, major surgeries and psychological conditions are noted on the problem list. Problem lists will be accepted if listed on the current progress note or on a separate page. Hospital summaries and consultation notes do not meet the intent of this indicator.
Mark as “N” if not present in record. Mark as “NA” only if no significant illnesses, medical conditions or major surgeries are identified (this should be a rare occurrence).

16. Are allergy/adverse medication reactions displayed clearly? (Referenced in AHCA - HMO 9 MR)
Allergies are prominently noted; either on the front of the record in writing, with an identifying sticker at the beginning of the medical record, at the top of the information sheet or on the problem list. If the patient has no known allergies or history of adverse reactions, this is noted in the record.
Mark as “N” if not present in record.

17. Does the record clearly indicate whether or not the adult patient has an advance directive? (Referenced in AHCA - HMO 11, HMO 12 and CMS CC03)
Yes or no is sufficient and should be found easily accessible in the medical record.
Mark as “N” if not present in record. Mark as “NA” if less than 18 years old.
18. Are immunizations records complete and up to date? *(Referenced in AHCA – HMO 14 Quality of Care [QC], HMO 16 QC CDC and USPSTF)*

*Are pediatric/adolescent immunizations records complete and up to date?*
For children 16 years of age and under, there is a completed immunization record or notation that immunizations are up to date. This may be found on the physical or history form. Refer to CDC for the immunization schedule.

*Are adult immunizations records complete and up to date?*
Tetanus, Diphtheria, Pertussis (Td/Tdap) - Ages 19+: Booster every 10 years
FLU (Influenza) – Every year
Pneumococcal - Ages 65+: 1 dose (per CDC)
Shingles (Zoster) Ages 60+: 1 dose (per CDC)
Hepatitis A, Hepatitis B, Meningococcal Ages 19+: if risk factors are present
Human Papillomavirus (HPV) Women (19-26 years of age) and Men (19-21 years of age)
Mark as “Y” if immunizations are up-to-date. Mark as “N” if all immunizations are not up to date.

19. Is there a medical history present anywhere in the record? *(Referenced in AHCA - HMO 17 [c] 1 QC and Department of Health Board of Medicine 64B8-9.003)*

For newborns, past medical history relates to prenatal care. Past medical history (for patients seen three or more times) is easily identified and includes serious accidents, operations, illnesses and diseases. For children and adolescents 18 and younger, past medical history relates to operations and childhood illnesses. A medical history is accepted from old medical records, from a previous physician or hospital admission, discharge summary, previous physical or consultant physical.
Mark as “N” if not present in the record. Mark as “NA” if not seen three or more times; unless it is there, then score “Y.”

20. Is there documentation (anywhere in the medical record) for patients 12 years of age and greater seen three or more times regarding inquiry/counseling regarding tobacco use? *(Referenced in AHCA - HMO 17 [c] 1, 17 [d] 2 QC)*

This may be found in the baseline history or physical.
Mark as “N” if not present in the record. Mark as “NA” if less than 12 years old or patient has not seen the doctor three or more times.

21. Is there documentation (anywhere in the medical record) for patients 12 years of age and greater seen three or more times regarding inquiry/counseling regarding history of alcohol/substance abuse? *(Referenced in AHCA - HMO 17 [c] 1, 17 [d] 4 QC)*

This may be found in the baseline history or physical.
Mark as “N” if not present in the record. Mark as “NA” if less than 12 years old or patient has not seen the doctor three or more times. Mark as “Y” if both categories (alcohol and substance abuse) are present in the record.
22. Does the record contain a complete physical examination? (Referenced in AHCA - HMO 14 QC, HMO 17 [c] 1 QC, Department of Health Board of Medicine 64B8-9.003 and USPSTF)

The medical record contains a complete physical, including systems review for patients seen three or more times within a three year period. Information can be reviewed from old medical records, from a previous physician or hospital admission, discharge summary, previous physical or consultant physical. Examinations should be age appropriate and include discussion and counseling. Pediatric examinations should include periodic documentation of growth and development for pediatrics (growth chart for newborns to 24 months).

Mark as “N” if not present in the record. Mark as “NA” if not seen three or more times (unless physical is there, and then score “Y”).

23. Are preventive services/screenings offered, ordered or completed? (Referenced in AHCA - HMO 14 QC, HMO 17 [c] 2, 3 QC, HMO 17 [d] 1, 2, 3, 4 QC, Department of Health Board of Medicine 64B8-9.003 CDC and USPSTF)

There is evidence that preventive screenings and services are offered, ordered or completed for adults and children in accordance with the organization’s practice guidelines (USPSTF and American Academy of Pediatrics [AAP]).

- **Women** - cervical cancer (Pap smear), chlamydial, breast cancer (mammography), cholesterol (HDL and LDL), high blood pressure, colorectal cancer screening, bone density (osteoarthritis) screening and BMI
- **Men** - cholesterol (HDL and LDL), high blood pressure, colorectal cancer screenings and BMI
- **Pediatric** - age appropriate full physical evaluation (well child care) as recommended by AAP (including counseling and/or screening for sickle cell disease, safety/risk behavior, nutrition, BMI, lead, hearing, vision and dental)

Refer to the attached Preventive Screening Criteria document for additional information.

Mark as “N” if more than one is missing. Mark as “NA” if not applicable to specified age group or gender. Mark as “NA” if no routine Pap smear screenings in women who had a total hysterectomy for benign disease.

24. Electronic Medical Record (EMR) is used?

Florida Blue internal use only and is not part of the physician’s scoring.

Mark as “N” if not present.

25. Is there confidentiality of medical records? (Referenced in AHCA - HMO 6 and Medicare Managed Care Manual Chapter 4 10.5.4)

Records are stored securely. Only authorized personnel have access to records. Staff receives periodic training in member information confidentiality.

All three categories are present, score as “Y.”

Mark as “N” if not present.
**Note:** This form supports the Centers for Disease Control and Prevention, Florida’s Agency for Health Care Administration’s interpretive guidelines for managed health care and Florida Administrative Code for Standards for Practice for Medical Doctors. These are recommendations for providers to document, as part of the subscriber’s medical record.

Source:
Centers for Disease Control and Prevention –www.cdc.gov
Florida’s Agency for Health Care Administration’s interpretive guidelines for managed health care effective 7/31/10
Florida Administrative Code (F.A.C) Department of Health: Chapter 64 Standards for Practice for Medical Doctors Rule: 64B8-9.003 effective 9/9/2013
U.S Preventive Services Task Force (USPSTF)