Medical Record Documentation - Common Problem Areas

All Charts must include:

- **Primary Language Assessment** (if other than English) and requests for interpreter services must be documented. Refusal of interpreter services, when appropriate, is documented.

- **120-day Initial Health Assessment** must include a complete physical exam, a comprehensive medical history and a completed/reviewed IHEBA with interventions documented and initials of reviewer. (EMR systems must have scanned form or incorporate all questions of the IHEBA. Practitioner review of each form must be documented.)

- Specific follow-up instructions with a definitive time frame for a return visit or other follow-up care documented at each visit (return PRN is acceptable)

- Written documentation that Advanced Directives information has been offered to all persons over the age of 18 and emancipated minors. (Several EMR systems have a place to document this information, but the fields are frequently blank)

- **Chronic Problem List is kept current** (i.e. Diabetes, Hypertension, Asthma, etc.).

- **Continuous Medication List** with name, route (if other than oral), dosage, and frequency is kept current (i.e. medications for chronic conditions: Diabetes, Hypertension, Asthma, etc.)

- Errors corrected with SLIDE system (Single Line, Initials, Date, Error). Scratch-outs, write-overs and liquid paper cover-up are unacceptable means of correction. (Not applicable to EMR, but there must be a system in place to document any changes to original entries, who made them, and when.)

- **Signature page** with printed name, signature, title and initials of all staff members (including MDs, NPs, PAs, RNs, LVNs, MAs) documenting in the chart, must be kept on file in the office and updated as new staff is added. (EMRs must have a means to identify the person who made each entry and when any entry is edited. EMR documents that are scanned-in with signatures must have those signatures identified on a Signature Page.)

- **Emergency contact** is identified. (For Pediatric Members, must be parent or guardian. For adult members if there is no identified emergency contact, enter ‘none’.)

- **Immunization documentation** must include: Site of injection, date, manufacturer’s name and lot number, VIS (Vaccine Information Sheet) publication date, and signature. Documentation needs to be done on immunization record. VIS publication date can be found at the bottom of each page and must be the most current edition.

- All diagnostic tests/consult reports are date stamped when received and evidence of review by physician is documented. Abnormal test results/diagnostic tests/consult reports have explicit notation in the medical record (including patient contact, follow-up treatment, instructions, return to office visits, referrals and/or other pertinent information).

- All patient noncompliance with or refusal of services must be documented to receive credit.

Updated Feb 2013
Pediatric charts must include:

- Age specific IHEBA forms must be in each record with documentation of physician review and interventions. IHEBA forms must be reviewed, initialed and dated by the physician annually for all children under 21, with a new IHEBA form filled out as child enters next age range. (EMR systems must have scanned form or incorporate all questions of the IHEBA. Practitioner review of each form must be documented.)

- BMI for age percentile assessment and graphing of results beginning at age 2 yrs. (While many EMR systems automatically graph the BMI for age percentile, height and weight must be accurately measured and entered for the graph to be accurate.)

- Appropriate lab tests are performed (Hgb/Hct, urinalysis, etc.) according to AAP guidelines.

  TB Risk Assessment documented at each annual well child exam. Mantoux test or other approved TB infection screening test per local regulation, or by CDC and American Thoracic Society guidelines or for at-risk members.

- Immunization history must be documented. Obtain copy of immunization card from previous physician. Assess immunization status at each well child visit. Document all refusals of immunizations offered.

- All Pediatric charts must have completed nutritional assessment forms, or detailed list of dietary intake. All children, up to age 5, at nutritional risk must be referred to WIC.

- Documentation of vision and hearing assessments at each well child visit. Starting at age 3 years, vision and audiometric screening must be performed at each well child visit with results documented in the medical record. Parental refusal or uncooperative child must be documented in the medical record.

- Documentation of dental assessment at each well child visit. Starting at age 1 year, all children up to age 21 years, must also be referred annually to a dentist. Medical records must reflect proof of dental referral.

- Mandatory lead level done on all Members at age 12 months and 24 months. If no prior lead level was performed, or proof of previous lead level cannot be obtained, a blood lead level must be completed on children up to age 6 years. Children at risk should be tested as needed. Parent’s noncompliance or refusal must be documented.

- Sexually active adolescents must be assessed and screened for sexually transmitted diseases (STDs).

- Members age 0-21 are considered Pediatric Members by the Department of Health Care Services (DHCS) and the Alliance and must be offered the age appropriate well child services.

- Developmental Screening: Developmental disorder screening (including autism) must be documented at ages 9 months, 18 months and 30 months.
Medical Record Documentation- Common Problem Areas

**Adult charts must include:**

- Adult **IHEBA** forms must be in each record with documentation of physician review and interventions. Adult IHEBA forms must be reviewed, initialed and dated by the physician as specified on the form. (EMR systems must have scanned form or incorporate all questions of the IHEBA. Practitioner review of each form must be documented.)

- **Adult BMI** assessed at each periodic physical.

- **TB Risk Assessment** documented at each periodic physical. Mantoux test or other approved TB infection screening test per CDC and American Thoracic Society guidelines and for at-risk members.

- **Immunization history** of vaccination administration according to the ACIP guidelines, including Td/Tdap, influenza, HPV, pneumococcal and zoster, etc. must be documented. History of measles and chickenpox must be documented for women of childbearing age and immunizations offered as needed. Document date of last tetanus and offer booster if needed (tetanus must be given every 10 years). Assess and document immunization status at each periodic physical. Document all refusals of immunizations offered.

- **Total Cholesterol level** and HDL-C beginning at age 35 years for men and age 45 years for women, or sooner based on risk factors.

- **Chlamydia screening** for all women from onset of sexual activity to age 25 years annually. Women over 25 years with documented risk factors require screening.

- **Pap smear** - initiate at age 21 years, then every 1-3 years, depending on individual risk factors, and latest USPSTF Guidelines. Document date of last Pap with results. Document all refusals. If referred to Gyn, date of Pap with results must be noted in medical record. Document if patient has a hysterectomy with removal of the cervix.

- **Mammogram** - initiate age 50 then every 1-2 years, or according to latest USPSTF Guidelines. Document date of last mammogram with results. Document all refusals.

*Guidelines per: AAP (American Academy of Pediatrics), USPSTF (US Preventive Services Task Force), ACIP (Advisory Committee on Immunization Practices)*