

WellCare Health Plans, Inc.
WellCare of Georgia, Inc
The WellCare Group of Companies

Medical Record Review Tool Standards with Definitions

Item #	STANDARD	DEFINITION	SOURCE
All Medical Records:			
1	Patient Name	Each page of the medical record will have the member's name.	DCH ¹ DHR ⁴
2	Legible	Each entry will be legible and in standard English. If the documentation can't be clearly understood because it's not legible or the entire entry is not legible, then the standard is marked "No".	DCH ¹
3	Organized	Each medical record will be set up in a chronological order	DCH ¹ DHR ⁴
4	Date of Birth	The date of birth will be located in a prominent location in each medical record at least once	DCH ¹ DHR ⁴
5	Address/phone#	The member's primary address and phone number will be located in a prominent place of the medical record at least once.	WCG ² DHR ⁴
6	Advanced directives	All members aged 20 years or older will have an advanced directive in the medical record or there will be evidence that the member was educated on advanced directives and given the opportunity to accept or decline.	DCH ¹ Fed ⁵
7	Allergies with Adverse Reaction	Each medical record will have a list of the member's allergies and the adverse reaction. In the event that the member does not have any allergies related to medication, the medical record will be marked as "No Known Allergies," or "NA" or "None". Either designation will be located in prominent and consistent location in the medical record, i.e. on the front or inside the front cover. The reviewer should not have to search for this information.	DCH ¹ NCQA ⁶
8	Medication List	Each medical record will have a list of the chronic medications in a prominent location.	WCG ² NCQA ⁶
9	Chronic Problem List	Each medical record will have a list of the chronic conditions. For example: diabetes.	DHR ⁴ NCQA ⁶
10	Initial health screening	Within 90 days of entering/joining the health plan, there must be evidence that the member had an initial health screening visit.	DCH ¹

11	Health History	Each medical record will contain a completed health history. The history must contain, but is not limited to: present and past health status, developmental information (for child), family health history, dietary history (child), and risk of lead exposure child). The history may be obtained from a written form that the member (parent/guardian, if child) has completed.	DCH ¹ DHR ⁴ NCQA ⁶
12	Social History	Each medical record will show evidence that the member has been assessed for past or current use of tobacco, alcohol, and illegal drugs.	DHR ⁴ NCQA ⁶
13	Findings on Exam	There should be documentation of what was found at the time the member was examined that's consistent with the diagnosis.	DHR ⁴ NCQA ⁶
14	Recommendations for Referrals	There should be a notation of any recommendations for referrals to specialists/consultants.	DHR ⁴
15	Consultant/referral note reviewed	Once a member has been seen by a consultant, there should be <u>a note from the consultant in the medical record within 14 days after the completion of services</u> . In addition, the primary care provider should acknowledge review of the document by signing or initialing and dating the document.	DHR ⁴
16	Tests ordered, reviewed	Once a member has had the recommended test (i.e. labs, x-rays, etc). there should be a note from the provider. The primary care physician should acknowledge review of the document by signing or initialing and dating the document within 14 days of the member's completion of the test(s).	DHR ⁴
17	Patient notification of tests	Instructions for office staff, i.e. contacting the member with results or for follow-up visit will be documented as being completed with the date and signature/initials of the staff member.	DHR ⁴
18	Plan of Care/Outcome	For each member visit the record will show the plan of care and the outcome of the care rendered, appropriate and consistent with the diagnosis.	DHR ⁴
19	Appropriate Care	There's no evidence that the member was placed at risk by diagnostic or therapeutic procedure(s).	DCH ¹ NCQA ⁶
20	Patient Input	There will be evidence indicting that the patient (member) has been given the opportunity to discuss treatment options.	DHR ⁴
21	Practitioner's signature and title on record	The practitioner (physician, nurse practitioner, physician's assistance) name and title will be recorded at each entry. If only the practitioner's initials are used, then there will be signature log in the office with practitioner's signature, title, and initials. This applies to group and solo practices.	WCG ²
Adult Preventive Health			
22	BP, Height, BMI	Completed once every 1-2 years or as determined by practitioner and documented in the chart.	WCG ²

23	Pneumococcal Vaccine	The record will show that member's age 19-64, at high risk for pneumonia and member 65+ years will/have received 1-2 doses for ages 19-64 if at risk, 1 dose age 65 + years and/or been offered a pneumococcal vaccine.	WCG ²
24	Influenza Vaccine	Annually for high risk, annually for 50 + years.	WCG ²
25	Cervical Cancer Screening	The record will show that women age 21-64 years had or were offered a cervical cancer screening.	HEDIS WCG ²
26	Colorectal Screening	Beginning at age 50 years and older, there should be evidence that a colorectal screening was done annually at minimum and as needed at other times. Colorectal Screening should include one or more of the following: <ul style="list-style-type: none"> ▪ Fecal Occult Blood Test (FOBT) – annually ▪ Flex Sig during the measurement yr or the 4 yrs prior to the measurement yr, ▪ Double contrast barium enema (DCBE) during the measurement yr or 4 yrs prior to the measurement year. Colonoscopy during the measurement yr or 9 years prior to the measurement yr. 	HEDIS WCG ²
Diabetes – members with diabetes w ill have the following documented in the medical record:			
27	HbgA1c	Hemoglobin A1c quarterly until stable and then every 6 months.	HEDIS
28	LDL Testing	An annual LDL test.	HEDIS WCG ²
29	LDL Level <100 mg/dl	The reviewer will note if the target level for the most recent LDL is less than 100 mg/dl. The reviewer will note the date and results of the most recent LDL-C. If the LDL Test was NOT completed, score the LDL Level as “N/A”.	HEDIS WCG ²
30	Dilated Eye Exam	The member had a dilated eye exam by an eye care specialist within the past 1 year or a negative retinal exam by an eye care professional within the past 2 years.	HEDIS WCG ²
31	Microalbuminuria	There’s evidence that the member was annually tested for the presence of albumin in the urine.	HEDIS WCG ²
COPD/Asthma – members with COPD and/or asthma will have evidence of the following on their medical record			
32	Pulmonary Assessment with each visit	The member will have a pulmonary assessment by auscultation at each visit.	WCG ²
33	Medication monitoring	The practitioner will monitor the utilization of medication. Short-acting bronchodilators used more than twice per week may indicate need for medication adjustment.	WCG ²

34	Medication Adjustments	Members who frequently use “rescue” medications and/or have frequent ER visits are evaluated for an adjustment to their medication.	WCG ²
35	Education	Member receives education related to the disease process and self management.	WCG ²
Chronic Kidney Disease			
36	Annual eGFR	Evidence that members identified with diabetes and hypertension received an annual eGFR (estimated <u>G</u> lomerular <u>F</u> iltration <u>R</u> ate) based on their serum creatinine levels.	WCG ²
Cholesterol Management for Acute Cardiovascular Conditions – members 18-75 years who were discharged alive for an acute myocardial infarction (AMI), coronary artery bypass (CABG), Percutaneous Transluminal Coronary Angioplasty (PTCA) or who had a diagnosis of Ischemic Vascular Disease (IVD) from Jan 1 – Nov 1 of the current year.			
37	LDL-C after discharge	Evidence that the LDL-C screening was completed during the current year.	HEDIS
38	LDL-C Screening is < 130	Evidence that the most recent LDL-C screening during the current year was < 130	HEDIS
39	LCL-C date and result	Reviewer to insert the date and results of the member’s LDL-C	HEDIS
40	Date of discharge	Reviewer inserts the date of the member's discharge from the facility after an acute cardiovascular event.	HEDIS
41	Rx with Beta-blocker (post AMI)	Evidence that the member, age 35 years or older was discharged alive from January 1 – December 24 of the measurement year with a diagnosis of acute myocardial infarction (AMI) and who received a prescription for beta-blocker treatment	HEDIS
Hypertension (PCP)			
42	Blood pressure reading documented	BP documented at each visit. Reviewer inserts most recent BP	HEDIS
43	Weight documented	Weight documented at each visit	WCG ²
44	Evidence of BP control	Documentation that BP is in control either through medication or diet.	WCG ²
45	Education	Related to medication, diet, lifestyle changes, alcohol/drug use, wt and stress reduction as appropriate and indicated.	WCG ²
46	Follow up visits	Done according to the recommended timeframe based on initial blood pressure measurements.	WCG ²

1DCH GA Department of Community Health – Georgia Healthy Families Report Specifications

²WCG WellCare of Georgia requirement

- ³HEDIS Health Plan Employer Data and Information Set 2006/2007
- ⁴DHR The Georgia Department of Human Resources (DHR) is authorized by the Georgia Health Maintenance Organization Act of 1979, GA Laws of 1979, or promulgate Rules and Regulations necessary to establish and control the standards of health care which any HMO created under that Act shall be required to maintain. The Rules Regulations may be found in Chapter 290-5-37-.05.
- ⁵Fed Federal Laws/Regulations, i.e. Advance Directives is located in 42 CFR 438.6 (i) (1)-(2) and 42 CFR 422.128
- ⁶NCQA National Committee on Quality Assurance. Medical Record Review Standard: MR2