

Medical Record Review Survey Urgent Care Clinic

Site ID:		Phone:		Fax:		Review Date:	
Facility Name:				Contact Name/Title:			
Full Address:							
Reviewer Name/Title:							
Staff on Site: __ MD __ PA __ NP __ LCSW __ RD __ RN __ LVN __ MA __ CNM __ Clerical Other							
Visit Purpose			Certifications			Clinic Type:	
<input type="checkbox"/> Initial Full Scope		<input type="checkbox"/> Monitoring		<input type="checkbox"/> AAAHC		<input type="checkbox"/> Free Standing Urgent Care	
<input type="checkbox"/> Periodic Full Scope		<input type="checkbox"/> Follow Up		<input type="checkbox"/> JC			
<input type="checkbox"/> Focused Review		<input type="checkbox"/> Ed/TA		<input type="checkbox"/> CHDP			
<input type="checkbox"/> Other				<input type="checkbox"/> NCQA			
				<input type="checkbox"/> CPSP			
				<input type="checkbox"/> None			
				<input type="checkbox"/> PCMH			
				<input type="checkbox"/> Other			
Medical Review Scores					Scoring Procedure		Compliance Rate
	Pts. Poss. x # of Records	Yes Pts. Given	No's	N/A's	Section Score %	<p>Scoring is based on 10 medical records.</p> <p>1) Add points given in each section.</p> <p>2) Add total points given for all ten sections</p> <p>3) Adjust score for "N/A" criteria (if needed). Subtract "N/A" points from total points possible.</p> <p>4) Divide total points given by "adjusted" total points.</p> <p>5) Multiply by 100 to get the compliance (percent) rate.</p> <p style="text-align: center;"> _____ / _____ = _____ X100= _____ % Pts. Total/ Decimal Comp. given Adj. Score Rate </p>	
I. Format	(8) x 10=80						
II. Documentation	(7) x 10=70						
III. Coordination of Care	(7) x 10=70						
	Total Pts. Poss.	Total Yes Pts.	Total No Pts.	Total N/A Pts.			
						<p>Note: Any section score of <80% requires a CAP for the entire MRR, regardless of the Total MRR score.</p> <p>Exempted Pass: 90% or above: (Total score is ≥ 90% <i>and</i> all section scores are 80% or above)</p> <p>Conditional Pass: 80-89%: (Total MRR is 80-89% <i>OR</i> Any section(s) score is <80%)</p> <p>Fail: 79% and Below</p> <p>_____ CAP Required</p> <p>_____ Other Follow-Up</p> <p>Next Review Due: _____</p>	

Medical Records Reference

Medical Record	CIN	Age	Gender	County	Level of Care
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

I. Format Criteria

Criteria Met = Yes Criteria not Met = No Not applicable = N/A	wt	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	Score
Age												
Gender												
Date of Service												
A. Member identification is on each page. <ul style="list-style-type: none"> Member identification includes first and last name, and a unique identifier established for use on clinical site. Electronically maintained records and printed records from electronic systems must contain member identification. 	1											
B. Individual personal biographical information is documented. Personal biographical information includes: <ul style="list-style-type: none"> Date of birth Current address Home/work phone numbers Name of parent(s)/legal guardian if member is a minor If member refused to provide information, "refused" is documented in the medical record. Do not deduct points if member has refused to provide all personal information requested by the practitioner.	1											
C. Emergency "contact" is identified. The name and phone number of an "emergency contact" person is identified for all members. Listed emergency contacts may include: <ul style="list-style-type: none"> Spouse, relative or friend, and must include at least one of the following:<ul style="list-style-type: none"> Home, work, pager, cellular, or message phone number. If the member is a minor, the primary (first) emergency contact person must be a parent or legal guardian and then other persons may be listed as additional emergency contacts. Adults and emancipated minors may list anyone of their choosing. If a member refuses to provide an emergency contact, "refused" is noted in their record. Do not deduct points if member has refused to provide personal information requested by the practitioner. Next of kin category is not considered as an emergency contact. The member's emergency contact may be different from the next of kin. 	1											
D. Medical Records are maintained and organized. <ul style="list-style-type: none"> Contents and format of printed and/or electronic records within the practice site are uniformly organized, securely fastened, attached or bound to prevent medical record loss. Hard copy printed documents shall belong to the medical record established for each member (e.g., reusing the blank side of printed documents from another member is not acceptable and should be scored a "0"). Medical Record information should be readily available. 	1											
E. Member's assigned and/or rendering primary care physician (PCP) is identified. <ul style="list-style-type: none"> The member's assigned PCP is identified in the chart for continuity of care 	1											
F. Primary Language and linguistic service needs of non- or limited-English proficient (LEP) or hearing/speech-impaired persons are prominently noted. <ul style="list-style-type: none"> The primary language is prominently documented at least once in the medical record. Language documentation is not necessary, score "N/A," if English is the primary language. However, if "English" is documented, the point may be given. 	1											

<p>G. Person or entity providing medical interpretation is identified. Requests for language and/or interpretation services by a non-or limited-English proficient member are documented.</p> <ul style="list-style-type: none"> • Member refusal of interpreter services may be documented at least once and be accepted throughout the member’s care unless otherwise specified. • If bilingual staff are asked to interpret or translate, they should be qualified to do so. Assessment of ability, training on interpreter ethics and standards, and clear policies that delineate appropriate use of bilingual staff, staff or contract interpreters and translators, will help ensure quality and effective use of resources. • Those utilizing the services of interpreters and translators should request information about certification, assessments taken, qualifications, experience, and training. Quality of interpretation should be a focus of concern for all recipients. • Family or friends should not be used as interpreters, unless specifically requested by the member and documented in the member’s chart. • Minors (under 18 years old) accompanying member shall not be used as an interpreter. 	1											
<p>H. Signed Copy of the Notice of Privacy.</p> <ul style="list-style-type: none"> • The HIPAA Privacy Rule establishes national standards to protect individuals' medical records and other personal health information and applies to health plans, health care clearing houses, and those health care providers that conduct certain health care transactions electronically. The right to inspect, review and receive a copy of the medical records is covered by the Privacy Rule. 	1											
	Yes											
	No											
	N/A											

Comments:

II. Documentation Criteria

Criteria Met = Yes Criteria not Met = No Not applicable = N/A	wt	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	Score
Age												
Gender												
Date of Service												
A. Allergies are prominently noted. • Allergies and adverse reactions are listed in a prominent, easily identified, and consistent location in the medical record. • If member has no allergies or adverse reactions, “No Known Allergies” (NKA); “No known Drug Allergies” (NKDA).	1											
B. Medical record contains signed HIPAA notification. • Documentation may be on a separate “problem list,” or a clearly identifiable problem list in the progress notes. • All chronic or significant problems are considered current if no “end date” is documented.	1											
C. Chronic Problems and/or significant conditions are listed. • Documentation may be on a separate “medication list,” or a clearly identifiable medication list in the progress notes. • List of current, on-going medications identifies the medication name, strength, dosage, route (if other than oral), and frequency. • Discontinued medications are noted on the medication list or in progress notes.	1											
D. Appropriate consents are present:												
1. Release of Medical Records • Consent must be obtained prior to release of patient information.	1											
2. Informed Consent for Invasive procedures • Adults, parents/legal guardians of a minor or emancipated minor may sign consent forms for operative and invasive procedures. Persons under 18 years of age are emancipated if they have entered into a valid marriage, are on military active duty, or have received a court declaration of emancipation under the CA Family Code, Section 7122.	1											
E. All entries are signed, dated, and legible. Signature includes: • First initial, last name, and title of health care personnel providing care, including Medical Assistants. • Initials and titles may be used only if signatures are specifically identified elsewhere in the medical record (e.g. signature page). • Stamped signatures are acceptable, but must be authenticated, meaning the stamped signature can be verified, validated, confirmed, and is countersigned or initialed. Dated entries include: • Month/day/year. • Entries are in reasonably consecutive order by date. • Handwritten documentation does not contain skipped lines or empty spaces where information can be added. Entries are not backdated or inserted into spaces above previous entries. • Omissions are charted as a new entry. • Late entries are explained in the medical record, signed and dated. Legibility means the record entry is readable by a person other than the writer. Handwritten documentation, signatures, and initials are entered in ink that can be readily/clearly copied. Only standard abbreviations are used. All medical record documentation must be in English.	1											

F. Errors are corrected according to legal medical documentation standards. • The person that makes the documentation error corrects the error. Example correction methods: • Single line drawn through the error, with the writer's initial and date written above or near the lined-through entry. • Single line and initial. • The corrected information is written as a separate entry and includes date of the entry, signature (or initials), and title. There are no unexplained cross-outs, erased entries or use of correction fluid. Both the original entry and corrected entry are clearly preserved.	1											
	Yes											
	No											
	N/A											

Comments:

III. Coordination of Care Criteria

Criteria Met = Yes Criteria not Met = No Not applicable = N/A	wt	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	Score
Age												
Gender												
Date of Service												
A. History of present illness or reason for visit is documented. Visit includes a documented history of present illness or reason for visit.	1											
B. Working diagnoses are consistent with findings. Visit has a documented "working" diagnosis/impression derived from a physical exam, and/or "Subjective" information such as chief complaint or reason for the visit as stated by member/parent. The documented "Objective" information (such as assessment, findings and conclusion) relate to the working diagnoses.	1											
C. Treatment plans are consistent with diagnoses. A plan of treatment, care and/or education related to the stated diagnosis is documented for each diagnosis.	1											
D. Instruction for follow-up care is documented. • Specific follow-up instructions and a definite time for return visit with PCP. • Time period for follow-up visits is definitively stated in number of days, weeks, months, or PRN (as needed). • Every visit with the provider shall have follow-up instructions.	1											
E. There is evidence of practitioner review of diagnostic test results. • There is documented evidence of practitioner review of records such as diagnostic studies, lab tests, X-ray reports, consultation summaries, inpatient/discharge records, emergency and urgent care reports, and all abnormal and/or "STAT" reports. • Evidence of review may include the practitioner's initials or signature on the report, notation in the progress notes, or other site-specific method of documenting practitioner review.	1											
F. There is evidence of follow-up of results/reports of diagnostic tests, when appropriate. Documentation includes: • Diagnostic test results for ordered requests. • Abnormal test results/diagnostic reports have explicit notation in the medical record or separate system, including attempts to contact the member/guardian, follow-up treatment, instructions, return office visits, outreach to assigned PCP and/or other pertinent information. • All missed or broken appointments for diagnostic procedures and laboratory tests should be documented. Documentation must include attempts to contact the member/guardian, and	1											
G. Outreach efforts and follow-up is documented. • Documented attempt to schedule same-day appointment with assigned PCP. • Documentation of completed urgent care visits and diagnostic studies are forwarded to the assigned PCP.	1											
Yes												
No												
N/A												

Comments:

If more than one Reviewer, both must sign here:

Reviewer Signature: _____

Reviewer Signature: _____

Reviewer Name: _____

Reviewer Name: _____

Reviewer Title: _____

Reviewer Title: _____

Reviewer Comments: