FACEY MEDICAL FOUNDATION
POLICIES AND PROCEDURES

Originator:	**HIM Audit & Compliance**	**Issue Date: 8/98**
Subject:	**Guidelines for Physician Documentation Audits**	**Revision Date(s): 8/99; 11/00; 8/01; 9/02; 8/03; 11/04; 8/06; 10/07** **Review Date: 8/06; 10/07; 2/09 2/10, 2/11, 2/12, 2/13, 10/13**
Scope:	**Physicians and Nursing Staff**	**Approval/s: on file**

I. POLICY

In an effort to improve the quality of medical record documentation it is the policy of Facey Medical Foundation to review and audit medical records by a certified coding auditor utilizing the NCQA documentation standards (Ambulatory Medical Record Review) and report these findings to all providers. External provider records may also be audited for adherence to these standards.

II. PROCEDURE

Consistent and complete documentation in the paper and electronic medical record is an essential component of quality patient care. The guidelines below will be followed when utilizing the Physician Documentation Audit Tool and auditing medical records.

1. Each page in the record contains the patient's name or ID number.

2. Personal biographical data (Facesheet) must be updated every 6 months within the GE/IDX Practice Management System and must include the following information: name, date of birth, address, employer, home and work telephone numbers, emergency contact, gender, marital status, and primary language spoken.

3. All entries in the medical record contain the author's identification. Author identification may be a handwritten signature or electronic signature.

4. All entries are dated.

5. The record is legible to someone other than the author/writer. A second surveyor examines any record judged to be illegible by one physician surveyor.

6. Significant illnesses and medical conditions are indicated on the problem list.

7. Medication allergies and adverse reactions are prominently noted in the record. If the patient has no known allergies or history of adverse reactions, this is appropriately noted in the record.

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8. Past medical history (for patients seen three or more times) is easily identified and includes serious accidents, operations, and illnesses. For children and adolescents (18 years and younger), past medical history relates to prenatal care, birth, operations and childhood illnesses.

9. For patients 14 years and older, there is appropriate notation concerning the use of cigarettes, alcohol, and substances (for patients seen three or more times, query substance abuse history).

10. The history and physical exam identifies appropriate subjective and objective information pertinent to the patient's presenting complaints.

11. Laboratory and other studies are ordered, as appropriate.

12. Working diagnoses are consistent with findings.

13. Treatment plans are consistent with diagnoses.

14. Follow up care is documented by a note, regarding follow-up care, calls or visits. The specific time of return is noted in weeks, months, or as needed.

15. Unresolved problems from previous office visits are addressed in subsequent visits.

16. Review for underutilization and over utilization of consultants.

17. If a consultation requested, that there is a note from the consultant in the record.

18. Consultation, lab, and imaging reports filed in the chart are initialed by the PCP to signify review. Review and signature by professionals other than PCPs, such as nurse practitioners and physician assistants, do not meet this requirement. If the reports are presented electronically, or by some other method, there is also representation of physician review. Consultations, abnormal labs, and imaging study results have an explicit notation in the record of follow-up plans.

19. There is no evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic problem. This question will not be answered by the Auditor and will be answered as non-applicable. Appropriateness of care will be referred through the Peer Review and Quality Assurance/Risk Management process.

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20. An immunization record for children is up to date, or an appropriate history has been made in the medical record for adults.
21. There is evidence that preventive screening and services are offered in accordance with the organization's practice guidelines.

22. Evaluation and management charges are supported by documentation.

23. Diagnostic charges are supported by documentation and to the highest level of specificity.

24. The Fee Coding Compliance Committee (HITS) has established a benchmark of 95% on the composite score. 30 records are reviewed each calendar year (per M.D.); unless a focused review is requested.

25. All physicians who fall below the standard will be reported to the Fee & Coding Committee and Credentialing Committee on a quarterly basis.

26. Individual physician scores are distributed to each physician on a quarterly basis.

27. The Physician Documentation Audit Review results will be placed on the Credentialing Committee agenda for review and a corrective action plan will be requested from the providers to correct all deficiencies and whom also failed to meet the required standards.

28. The Fee Coding Compliance Committee will be responsible for monitoring improvement on a quarterly basis and for forwarding that information to the Credentialing Committee.

29. The Credentialing Committee will be responsible for notifying physicians for a corrective action plan if applicable.

30. The Credentialing Committee is to send a letter of acknowledgement to the Fee Coding Compliance Committee regarding the timeframe for a corrective action plan implementation.

31. The Physician Documentation Review Audit results will be posted on the Facey shared folders network under the Physician Documentation Review Audits shared folder for physicians to review the overall composite scores by site.