HIGHMARK WHOLECARE

MEDICAL RECORD REVIEW STANDARDS OB/GYN

1. MEMBER ID*	Each page in the record contains member name of member ID number.
2. BIOGRAPHICAL DATA*	Personal data includes address, employer, telephone numbers, emergency contact, marital status, etc.
3. ENTRY ID*	All entries, included dictation, are signed (electronically) or initialed by the physician, PA or nurse practitioner, as appropriate.
4. ENTRY DATA*	All entries are dated.
5. LEGIBILITY*	The record is legible to someone other than the physician or physician's staff.
6. MEDICATION LIST*	Prescribed medications and prescription refills documented on a separate medication list.
7. ALLERGIES*	Presence/absence of allergies or adverse reactions to medications are prominently noted on each member chart after one year of age.
8. PAST MEDICAL HISTORY	Documentation at the first OB/GYN visit includes serious injuries, operations, illnesses, LMP, and past pregnancies of the member. Family history includes inquiry regarding genetic disorders.
9. TOBACCO USE*	Use/nonuse of tobacco products is documented on members age 11 and older.
10. TOBACCO USER – Cessation	Documentation that nicotine replacement medications and/or cessation strategies were discussed.
11. ENVIRONMENTAL TOBACCO SMOKE EXPOSURE	Documentation of assessment of second hand smoke is included in the record whether the member smokes or not.
12. ALCOHOL/DRUG USE	Use/nonuse of alcohol and illicit drugs is documented on members age 11 and older.
13. HISTORY & PHYSICAL	A complete history and physical exam for new patients are recorded which includes BP, breast, abdomen, external genitals, vagina, cervix, rectal, pap (if appropriate), inquiries regarding existing or prior infections (e.g. STD, HIV, TB, etc.)
14. PRENATAL DEPRESSION SCREEN	Documentation of prenatal depression screening is required on all OB members.
15. POSITIVE PRENATAL DEPRESSION	Documentation that the member who screened positive for depression received counseling, or treatment and/or referral.
16. POSTPARTUM DEPRESSION SCREEN	Documentation of postpartum depression screening is required on all OB members.
17. POSITIVE POSTPARTUM DEPRESSION	Documentation that the member who screened positive for depression received counseling, or treatment and/or referral.
18. RISK ASSESSMENT	Documentation of a risk assessment is required.
19. LAB & OTHER STUDIES	For gyn patients, lab tests and other diagnostic studies are ordered as appropriate to the member's complaint or diagnoses.
20. WORKING DIAGNOSIS*	There is a clearly documented diagnostic impression by the Specialists that is consistent with findings for each member visit.

21. TREATMENT PLAN*	Each visit is finalized with a plan of action and/or treatment plan that are consistent with diagnosis. Options and risks of treatments discussed as appropriate.
22. RETURN VISIT	There is a notation concerning follow-up care (i.e. to call with problems, to return within a specific time frame or as needed, or to see their PCP).
23. FIRST PRENATAL VISIT	Documentation of the first prenatal visit in the first trimester or within 42 days of enrollment.
24. POSTPARTUM VISIT	Documentation of postpartum visit 7-84 days post-delivery.
25. UNRESOLVED PROBLEMS	Ongoing or unresolved problems from prior visits must be addressed.
26. CONTINUITY / COORDINATION OF CARE*	Chart contains notations of any instructions/education given to member regarding follow-up visits, care, treatment, medication, diagnostic and therapeutic services where the member was referred for services by the specialists. Home Health, skilled nursing facility, hospital discharges, and outpatient/ambulatory surgery reports need to be included in the record.
27. COMMUNICATION WITH PCP*	There is documentation of communication with the PCP, as well as suggested plan of treatment, if applicable.
28. CONSULTS / XRAYS / LAB / IMAGING STUDIES	Reports are filed in the chart and have been reviewed and initialed by physician.
29. CONSULTS ANY ABNORMAL RESULTS	Consultation and abnormal study results have explicit notation in the record of follow-up plans.
30. APPROPRIATE TREATMENT*	All care must be medically appropriate and necessary, and there is no evidence that the member has been placed at inappropriate risk.
31. IMMUNIZATION HISTORY	There is documentation of Rubella and TDAP.
32. VARICELLA TITER	There is documentation of varicella titer, varicella immunization or provider documentation of varicella diagnosis or history of varicella disease or herpes zoster.
33. INFLUENZA VACCINE	Documentation that the member was offered influenza vaccine or referral to PCP/health agencies for the vaccine. (October through March)
34. COUNSELING FOR NUTRITION, FOLIC ACID AND OBESITY	Documentation that counseling was offered.
35. SCREENING/COUNSELING FOR DOMESTIC VIOLENCE	Documentation that screening/counseling for domestic violence was offered.

***Indicates Critical Factors**

Rev. 4/2025