COMMUNITY FIRST HEALTH PLANS

OB/GYN MEDICAL RECORD DOCUMENTATION GUIDELINES

Community First has established guidelines for medical record documentation. Individual medical records for each family member are to be maintained. The medical records must be handled and maintained in a confidential manner and must be organized in such a manner that all progress notes, diagnostic tests, reports, letters, discharge summaries and other pertinent medical information are readily accessible. In addition, each office should have a written policy in place to ensure that medical records are safeguarded against loss, destruction, or unauthorized use.

Criteria	Requirements
1. Patient Identification	Each page of the medical record must include a unique identifier, which may include patient identification number, medical record number, first and last name.
2. Personal Data	Personal/biographical data including the age, sex, address, employer, home and work telephone numbers, marital status of the patient, and emergency contacts must be included in the medical record.
3. Allergies	Medication allergies and adverse reactions (including immunization reactions) should be prominently noted in the record. If the patient has no known allergies or history of adverse reactions, this should be appropriately noted in the record.
4 Problem List	For patients seen (3) or more times, a separate list of all the patient's chronic/significant problems must be maintained. A chronic problem is defined as one that is of long duration, shows little change or is of slow progression.
5. Medication List	For patients seen (3) or more times, maintenance/ongoing medications should be listed on a medication sheet and updated as necessary with dosage changes and the date the change was made. A separate medication sheet is recommended but if a physician chooses to write out all current medications, at each visit this is acceptable. The medication list should include information/instruction to the member.
6. Chart Legible	Medical records must be legible to someone other than the writer. A record that is deemed illegible by the reviewer should be evaluated by a second person.
7. Author Signature	All entries in the medical record must be signed by the author/performing provider.
8. Dated Entries	Each and every entry must be accompanied by a date (month, day and year).
9. Advance Directive (OB/PCPs)	For medical records of Medicaid adults, 18 years and older, the medical record must document whether or not the individual has executed an advance directive. An advanced directive is a written instruction such as a living will or durable power of attorney for health care relating to the provision of health care when the individual is incapacitated.
10. Past Medical History	For patients seen three (3) or more times, a past medical history should be easily identified and should include serious accidents, operations, illnesses and psychosocial/behavioral conditions. For children and adolescents (18 years and younger), past medical history should relate to prenatal care, birth, operations, and childhood illnesses.
11. Tobacco, Alcohol, & Other Substance Use	For patients 12 years and older, assessment of tobacco, alcohol, and other substance use should be documented in the medical record.
12. Chief Complaint	Every visit should have a notation identifying the current problem (significant illnesses, medical and behavioral health conditions and health maintenance concerns).
13 History And Physical Relevant To Chief Complaint	The history and physical records should reflect appropriate subjective and objective information pertinent to the patient's presenting complaints.

Criteria	Requirements
14. Diagnosis/ Impression For Chief Complaint	The diagnosis identified during each visit should be documented and should be consistent with findings. ICD-9 code(s) may be used but must include the written description of the diagnosis.
15. Basic Teaching Provided	The medical record should reflect that member is provided with basic teaching/instructions regarding physical and/or behavioral health condition.
16. Appropriate Plan Of Treatment	Based on the chief complaint, physical exam findings and diagnosis, the treatment plan should be clearly documented.
17. Appropriate Use Of Consultants	If a patient problem occurs which is outside the physician's scope of practice, there must be a referral to an appropriate specialist.
18. Appropriate Studies Ordered	The laboratory and other studies ordered should be consistent with the treatment plan as related to the documented working diagnosis and should be documented at the time of the visit. Abnormal findings must have an explicit notation of follow-up plans.
19. Unresolved Problems From Previous Visits Addressed	Documentation should reflect that the physician provides continuous evaluation of problems noted in previous visits.
20. MD Review Of Studies	There must be evidence that the physician has reviewed the results of diagnostic studies. Methods can vary, but often the physician will initial the lab report or mention it in the progress notes.
21. Results Of Consultations	When the patient is referred to another physician for consultation, there must be a copy of the results of the consult report and any associated diagnostic work-up in the medical record. Primary physician review of the consultation must be documented. Often the physician initials the consult report.
22. Date Of Next Visit	Encounter forms or notes should have a notation, when indicated, regarding follow-up care, calls, or visits. Specific time of return should be noted in weeks, months, or as needed.
23. ER And Hospital Records	Pertinent inpatient records must be maintained in the office medical record. These records may include but are not limited to the following: H&P, surgical procedure reports, Authorizations, ER reports and hospital discharge summaries. For pediatric patients seen since birth the L&D records, including the newborn assessment, should be in the medical record.
24. Evidence That Patient Was Not Placed At Risk	The record should reflect that the patient has not been placed at inappropriate risk by a diagnostic or therapeutic problem.
25. Evaluation for abuse / neglect or other socio environmental factors (Medicaid)	The medical reocord should reflect evidence that the provider evaluates for signs / symptoms or behaviors associated with abuse / neglect or other significant socioenvironmental factors.
26. Diagnosis Validation	The record should reflect that the billing diagnosis is consistent with that of the chief complaint.
27. Claims Validation	The record should reflect the documented encounter is appropriate for the level of E/M services billed.

Criteria	Requirement
PRENATAL CARE	
1. Comprehensive History	There must be evidence on the initial OB visit that the patient has been questioned regarding: family, genetic and obstetric history; dietary history; risk factors for intrauterine growth retardation and low birth weight; prior genital hepatic lesions; psychosocial history; and behavioral health conditions.
2. Complete Physical Exam	There must be evidence on the first examination that a patient has a complete OB physical examination including a pelvic examination. Particular attention should be paid to the thyroid, breasts, lungs, heart, extremities and abdomen.
INITIAL LAB WORK	
3. Hematocrit or Hemoglobin	Hemoglobin and hematocrit measures should be performed as early as possible in the pregnancy.
4. Urinalysis	A urinalysis for bacteriuria should be performed as early in the pregnancy as possible.
5. ABO/RH Typing & Antibody Screening	Determination of blood type and Rh factor should be performed as early as possible in the pregnancy.
6. Rubella Screening	A rubella antibody titer should be performed as early in the pregnancy as possible for women lacking evidence of immunity (proof of vaccination after the first birthday or laboratory evidence of immunity).
7. VDRL, Gonorrhea* & Chlamydia* Testing (* = optional)	A serological test for syphilis (VDRL) and cultures for gonorrhea* and chlamydia* should be performed as early as possible in the pregnancy. (* = optional)
8. Cervical Cytology (as needed)	A Papanicolaou (Pap) smear /Cervical Cytology should be performed as needed.
9. Hepatitis B Surface Antigen	Initial screening for Hepatitis B should be performed as early in the pregnancy as possible.
10. HIV Screening	HIV Status should be determined on first prenatal visit for high risk patients.
FOLLOW-UP VISITS	
11. Vital Signs and Weight	Vial signs, including blood pressure and weight, to be obtained at each visit.
12. Urine Checks for Protein and Glucose	Testing for urinary protein, glucose, and ketones should be done at each prenatal visit.
13. Fundal Height	Fundal height should be measured and recorded at each visit.
14. Edema Check	The patient should be checked for edema of the hands, face and lower extremities at each visit.
15. Signs & symptoms of preterm labor; or other risk factors	Signs and symptoms of preterm labor or other risk factors are assessed and/or counseled with the patient.
16. Fetal Heart Tones	FHTs can usually be heard by 10-12 postmenstrual weeks using a hand-held Doppler device and should be documented at each visit.
17. Fetal Movement	The first fetal movement is usually appreciated at 17 weeks in the average multipara and at 18 weeks in the average primipara. Documentation of fetal activity should be documented at each visit.
FOLLOW-UP LABS	
18. Triple Screen	Maternal serum alpha-fetoprotein (AFP) should be obtained between 8-20 weeks gestation.
19. Glucose Challenge /H&H/AbScreen	Routine screening consists of determining blood sugar 1 hour after a 50gram oral glucose load. If the plasma blood sugar level is over 135-140mg/dL, a 3 hour glucose tolerance titer should be performed. This screening should occur at 24-28 weeks gestation.

Criteria	Requirement
20. GroupB Strep/H&H/VDRL	Cultures of the lower vaginal tract for group B streptococcus should be obtained between 35-37 weeks gestation.
POST PARTUM CARE	
21. Interim History & Physical Exam	The first post partum visit should include a nutritional assessment and history of activities post delivery. Physical examination should include a breast examination and a complete rectovaginal evaluation.
22. Evaluation of weight	The patient's weight should be recorded.
23. Vital Signs	The patient's vital signs including blood pressure should be recorded.
24. Cervical Cytology (as needed)	The cervix should be inspected and a Papanicolaou (Pap) smear obtained during the post partum visit. (as needed)
25. Family Planning / Contraceptive Practices	Contraceptive and family planning methods should be discussed and the patient advised of the relative risks of conception.
26. STD Prevention	STD prevention should be discussed in patient physician interview as indicated.
27. Postpartum Depression	Assessment for postpartum depression should be recorded.
GYN PREVENTIVE CARE	
28. Pelvic & Pap Smear	A pelvic examination and pap smear should be performed every 2 years between ages 21-29 and every 3 years between ages 30-64 after 3 conscective normal pap tests. Stop screening between ages 65-70, if no abnormal pap tests in 10 years.
30. Mammogram	A mammogram should be obtained every 1-2yrs for women 50 & older
31. Rubella Antibody Titer	A rubella antibody titer should be performed for women lacking evidence of immunity (proof of vaccination after the first birthday or laboratory evidence of immunity).
32. Family Planning / Contraceptive Practices	Contraceptive and family planning methods should be discussed and patient advised of the relative risks of conception.
33. STD Prevention	STD prevention should be discussed in patient/physician interview as indicated.