

**GATEWAY HEALTH PLAN®
MEDICAL RECORD REVIEW STANDARDS
OB/GYN**

1. MEMBER ID	Each page in the record contains member name or member ID number.
2. BIOGRAPHICAL DATA	Personal data includes address, employer, telephone numbers, emergency contact and marital status.
3. ENTRY ID	All entries are signed, initialed, or electronically signed by the physician or assistant.
4. ENTRY DATE	All entries are dated.
5. LEGIBILITY	The record is legible to someone other than the physician or physician's staff.
6. MEDICATION LIST	Medication list is up-to-date reflecting current diagnoses.
7. ALLERGIES	Presence/absence of allergies to medications is documented.
8. PAST MEDICAL HISTORY	Includes LMP and past pregnancies. For OBs, family history includes inquiry regarding genetic disorders.
9. SMOKING/ALCOHOL/ DRUG USE	Notation concerning tobacco, alcohol, and illicit drug use/non-use is prominently displayed for members age 14 years and older.
10. HISTORY & PHYSICAL	Includes vaginal/rectal exam, pap smear, and breast exam. History includes inquiry regarding infections, such as: STD, AIDS, TB, and Hepatitis. OB patients also have a risk assessment.
11. LAB & OTHER STUDIES	Gyn tests include an annual Pap and a Rubella Antibody titer for all members of child-bearing age and ability. OB tests include a Pap, STD screen, Rubella Antibody Titer and Hepatitis B virus screen.
12. WORKING DIAGNOSES	There is a clearly documented diagnostic impression whenever the member presents for care. If the member is being seen for a routine physical, this notation as diagnosis is adequate.
13. PLAN OF ACTION/ TREATMENT	Each member visit is finalized with a plan of action and/or treatment plan that is consistent with diagnosis.
14. RETURN VISIT	There is a notation concerning follow-up care, i.e. to call with problems or time frame for next visit.
15. UNRESOLVED PROBLEMS	Ongoing or unresolved problems from prior visits are addressed.
16. CONTINUITY & COORDINATION OF CARE	For GYN patients, evidence that pap smear results, etc. were communicated to the PCP. For OB patients, evidence that risk assessments and pap smear results were sent to the PCP.
17. CONSULTS/X-RAYS/LAB/ IMAGING STUDIES	Reports filed in the chart have evidence reflecting physician review. Abnormal study results have explicit notation in the record of follow-up plans.
18. CARE MEDICALLY APPROPRIATE	All care is medically appropriate and necessary. There is no evidence that the member has been placed at inappropriate risk.
19. IMMUNIZATIONS	For non-immune OB patients, there is a notation of counseling i.e. risks if disease is contracted, and a notation that immunization should be received post-delivery. For non-immune Gyn patients, there should be a referral to PCP for immunization (if member immune, NA).
20. PREVENTIVE SERVICES	There is evidence that preventive services appropriate to women's health are offered in accordance with Gateway Health Plan's® practice guidelines.