Medical Record Review Guidelines

California Department of Health Services
Medi-Cal Managed Care Division

Purpose: Medical Record Survey Guidelines provide standards, directions, instructions, rules, regulations, perimeters, or indicators for the medical record survey, and shall used as a gauge or touchstone for measuring, evaluating, assessing, and making decisions..

Scoring: Survey score is based on a review standard of 10 records per individual provider. Documented evidence found in the hard copy (paper) medical records and/or electronic medical records are used for survey criteria determinations. Full Pass is 100%. Conditional Pass is 80-99%. Not Pass is below 80%. The minimum passing score is 80%. A corrective action plan is required for ***all*** medical record criteria deficiencies. Not applicable ("N/A") applies to any criterion that does not apply to the medical record being reviewed, and must be explained in the comment section. Medical records shall be randomly selected using methodology decided upon by the reviewer. Ten (10) medical records are surveyed for each provider, five (5) adult and/or obstetric records and five (5) pediatric records. For sites with *only* adult, *only* obstetric, or *only* pediatric patient populations, all ten records surveyed will be in *only* one preventive care service area. Sites where documentation of patient care by all PCPs on site occurs in universally shared medical records shall be reviewed as a "shared" medical record system. Scores calculated on shared medical records apply to each PCP sharing the records. A minimum of ten shared records shall be reviewed for 2-3 PCPs, twenty records for 4-6 PCPs, and thirty records for 7 or more PCPs. Survey criteria to be reviewed *only* by a R.N. or physician is labeled "**RN/MD Review only".**

Directions: Score one point if criterion is met. Score zero points if criterion is not met. Do not score partial points for any criterion. If 10 shared records are reviewed, score calculation shall be the same as for 10 records reviewed for a single provider. If 20 records are reviewed, divide total points given by 640 or by the "adjusted" total points possible. If 30 records are reviewed, divide total points given by 960 or by the "adjusted" total points possible. Multiply by 100 to calculate percentage rate. Reviewers have the option to request additional records to review, but must calculate scores accordingly. Reviewers are expected to determine the most appropriate method(s) on each site to ascertain information needed to complete the survey.

Scoring Example:

Step 1: Add the points given in each section.	**Step 2**: Add points given for all six (6) sections. 72 (Format) 54 (Documentation) 58 (Coordination/Continuity-of-care) 43 (Pediatric Preventive) 40 (Adult Preventive) **267 (POINTS)**
Step 3: Subtract the "N/A" points from 320 total points possible. 320 (Total points possible) –15 (N/A points) 305 ("Adjusted" total points possible)	**Step 4**: Divide total points given by 320 or by the "adjusted" points, then multiply by 100 to calculate percentage rate. Total points / 320 or "Adjusted" points: 267 / 305 = 0.875 X 100 = **88%**

Rationale: A well-organized medical record keeping system supports effective patient care, information confidentiality and quality review processes.

Criteria	Format Reviewer Guidelines
A. An individual medical record is established for each family member.	Providers are able to readily identify each individual treated. A medical record is started upon the initial visit. "Family charts" are not acceptable.
B. Member identification is on each page.	Member identification includes first and last name, and/or a unique patient number established for use on clinical site. Electronically maintained records and printed records from electronic systems contain patient identification.
C. Individual personal biographical information is documented.	Personal biographical information includes date of birth, current address, home/work phone numbers, and name of parent(s) if patient is a minor. If patient refused to provide information, "refused" is noted in the medical record. If portions of the personal biographical information are not completed (left blank), reviewer should attempt to determine if patient has refused to provide information. Do not deduct points if member has refused to provide all personal information requested by the provider.
D. Emergency "contact" is identified.	The name and phone number of an "emergency contact" person is identified for all patients. Listed emergency contacts may include a relative or friend, or a home, work, pager, cellular or message phone number. If the patient is a minor, the contact person must be a parent or legal guardian. Adults and emancipated minors may list anyone of their choosing. If a patient refuses to provide an emergency contact, "refused" is noted in the record. Do not deduct points if member has refused to provide personal information requested by the provider.
E. Medical records are consistently organized.	Contents and format of printed and/or electronic records within the practice site are uniformly organized.
F. Chart contents are securely fastened.	Printed chart contents are securely fastened, attached or bound to prevent medical record loss. Electronic medical record information is readily available.
G. Patient's assigned primary care physician (PCP) is identified.	The assigned PCP is ***always*** identified when there is more than one PCP on site and/or when the patient has selected health care from a non-physician medical practitioner. If there is only one PCP on site, the provider's documentation and signature in the record identifies the primary care physician/provider of services. Since various methods are used to identify the assigned PCP, reviewers must identify specific method(s) used at each individual site.
H. Primary language and linguistic service needs of non-or limited-English proficient (LEP) or hearing-impaired persons are prominently noted.	The primary language and requests for language and/or interpretation services by a non-or limited-English proficient person is documented. The PCP and/or appropriate clinic staff member who speaks the person's language fluently can be considered a qualified interpreter. Friends or family members should not be used as interpreters, unless specifically requested by the member. Member refusal of interpreter services is documented. If English is the primary language, then language documentation is not necessary. **Note:** Title VI of the Civil Rights Act of 1964 prohibits recipients of federal funds from providing services to LEP persons that are limited in scope or lower in quality than those provided to others. Since Medi-Cal is partially funded by federal funds, ***all*** Plans with Medi-Cal LEP members must ensure that these members have equal access to all health care services (MMCD Policy Letter 99-03).

Rationale: Well-documented records facilitate communication and coordination, and promote efficiency and effectiveness of treatment. **RN/MD Review only**

Criteria	Documentation Reviewer Guidelines
A. Allergies are prominently noted.	Allergies and adverse reactions are listed in a consistent location in the medical record. If member has no allergies or adverse reactions, "No Known Allergies" (NKA), "No known Drug Allergies" (NKDA), or ∅ is documented.
B. Chronic problems and/or significant conditions are listed.	Documentation may be on a separate "problem list" page, or a clearly identifiable problem list in the progress notes. All chronic or significant problems are considered current if no "end date" is documented. **Note:** Chronic conditions are current long-term, on-going conditions with slow or little progress
C. Current continuous medications are listed.	Documentation may be on a separate "medication list" page, or a clearly identifiable medication list in the progress notes. List of current, on-going medications identifies the medication name, strength, dosage, route, and start/stop dates. Discontinued medications are noted on the medication list or in progress notes.
D. Signed Informed Consents are present, when appropriate.	Adults, parents/legal guardians of a minor or emancipated minors may sign consent forms for medical treatment. Informed Consents are signed for operative and invasive procedures. Human sterilization requires DHS Consent Form 330. Signed authorization is documented in the medical record for release of medical information. **Note:** Persons under the age of 18 years 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.
E. Advance Health Care Directive information is offered (Adults (18 years); Emancipated minors).	Adult medical records include documentation of whether member has been offered information or has executed an Advance Health Care Directive (California Probate Code, Sections 4701).
F. Entries are made in accordance with acceptable legal medical documentation standards.	All entries are signed, dated and legible. Signature includes the first initial, last name and title. Initials 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. Methods used to authenticate signatures in electronic medical records will vary, and must be individually evaluated by reviewers. Date includes the month/day/year. Only standard abbreviations are used. Entries are in reasonable consecutive order by date. Handwritten documentation, signatures and initials are entered in ink that can be readily copied. 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. **Note:** Legibility means the record entry is readable by a person other than the writer. Authentication means that stamped signature can be verified, validated, confirmed, and is countersigned/initialed.
G. Errors are corrected according to legal medical documentation standards.	The person that makes the documentation error corrects the error. A single line is drawn through the error, with "error" written above or near the lined-through incorrect entry. 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. Reviewers must determine method(s) used for correction of documentation errors of computerized records on a case by case basis. **Note:** The **S.L.I.D.E**. rule is one method used to correct documentation errors: Single Line, Initial, Date, and Error.

Rationale: Medical records support coordination and continuity-of-care with documentation of past and present health status, medical treatment and future plans of care.
RN/MD Review only

Criteria	Coordination/Continuity of Care Reviewer Guidelines
A. History of present illness is documented.	Each focused visit (e.g., primary care, urgent care, acute care, etc.) includes a documented history of present illness.
B. Working diagnoses are consistent with findings.	Each 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 patient/parent. "Objective" information such as assessment findings and conclusion that is documented relate to the working diagnoses. **Note:** For scoring purposes, reviewers shall ***not make determinations*** about the "*rightfulness or wrongfulness*" of documented information, but shall initiate the peer review process as appropriate.
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. **Note:** For scoring purposes, reviewers shall ***not make determinations*** about the "*rightfulness or wrongfulness*" of treatment rendered or care plan, but shall initiate the peer review process as appropriate.
D. Instruction for follow-up care is documented.	Specific follow-up instructions and a definite time for return visit or other follow-up care is documented. Time period for return visits or other follow-up care is definitively stated in number of days, weeks, months, or PRN (as needed).
E. Unresolved and/or continuing problems are addressed in subsequent visit(s).	Previous complaints and unresolved or chronic problems are addressed in subsequent notes until problems are resolved or a diagnosis is made. Each problem need not be addressed at every visit. Documentation demonstrates that provider follows up with patients about treatment regiments, recommendations, counseling, and/or referrals.
F. A physician reviewed consult/referral reports, and diagnostic test results.	Consultation reports and diagnostic test results are documented for ordered requests. 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 show documented evidence of physician review. Evidence of review may include the physician's initials or signature on the report, notation in the progress notes, or other site-specific method of documenting physician review. Abnormal test results/diagnostic reports have explicit notation in the medical record. Documentation includes patient contact or contact attempts, follow-up treatment, instructions, return office visits, referrals and/or other pertinent information. Electronically maintained medical reports must also show evidence of physician review, and may differ from site to site.
G. Missed appointments and follow-up contacts/outreach efforts are noted.	Documentation includes incidents of missed/broken appointments (cancellations or "No shows") for PCP examinations, diagnostic procedures, lab tests, specialty appointments, and/or other referral services. Attempts to contact the patient and/or parent/guardian (if minor), and the results of follow-up actions are also documented.

Rationale: Pediatric preventive services are provided in accordance with the American Academy of Pediatrics Guidelines (AAP). **RN/MD Review only**

Criteria	Pediatric Preventive Reviewer Guidelines
A. Initial Health Assessment (IHA).	An IHA must be completed on all members within 120 days of the effective date of enrollment into the Plan, or documented within the past 12 months prior to member's enrollment. The IHA is a comprehensive history and physical that includes an Individual Health Education Behavioral Assessment (e.g. "Staying Healthy" or other DHS-approved tool) at age-appropriate intervals. The IHA must include a core set of preventive services. If evidence of an IHA is not present in the medical record, the reason must be documented in the record (member's refusal, missed appointments, etc.)
B. Individual Health Education Behavioral Assessment (IBEHA).	**New Members:** Age-appropriate IHEBA is conducted within 120 days of effective enrollment date as part of initial health assessment. **Existing members:** Age-appropriate IHEBA is conducted at member's next non-acute care visit, but no later than the next scheduled health-screening exam. The IHEBA tool is re-administered at appropriate age intervals: 0-3 years, 4-8 years, 9-11 years, 12-17 years and 18 years and older. The IHEBA tool and risk-reduction plan is reviewed at least annually with members who present for a scheduled visit (see documented date and PCP initials). Provision of health education and anticipatory guidance is documented at each health assessment visit, which includes providing appropriate educational materials and/or providing or referring to counseling. Problems, interventions and referrals are documented in the progress notes or elsewhere in the medical records.
C. Age-appropriate physical exams according to most recent AAP schedule.	Periodic health assessments are provided according to the AAP recommended schedule for pediatric preventive health care. Where the AAP periodicity exam schedule is more frequent than the Child Health and Disability Prevention (CHDP) periodicity examination schedule, the AAP scheduled assessment must include all components required by the CHDP program for the lower age nearest to the current age of the child. A physical examination is completed at each health assessment visit which includes: 1) anthropometric measurements of weight and length/height, and head circumference of infants up to age 24 months, 2) physical examination/body inspection, including screen for sexually transmitted infection (STI) on sexually active adolescents, 3) urine test (Urine Dipstick or urinalysis) at each health assessment visit starting at age 4-5 years. Assessments and identified problems recorded on the PM160 form are documented in the progress notes. Follow-up care or referral is provided for identified physical health problems as appropriate.
D. Vision screening.	Age-appropriate visual screening occurs at each health assessment visit, with referral to optometrist/ophthalmologist as appropriate. **Note:** Although specific screening details are not generally documented in the medical record, screening for infants and children (birth to 3 years) may consist of evaluations such as external eye inspection, ophthalmoscopic red reflex examination, or corneal penlight evaluation. Visual acuity screening usually begins at age 3 years.
E. Hearing screening.	Non-audiometric screening for infants/children (2 months to 3 years) includes family and medical history, physical exam and age-appropriate screening. Audiometric screening for children and young adults (3-21years) is done at each health assessment visit and includes follow-up care as appropriate. Failed audiometric screenings are followed up with a repeat screening. Children who fail to respond on 2 screenings separated by an interval of at least 2 weeks and no later that 6 weeks after the initial screening are referred to a specialist.
F. Nutrition assessment.	Screening includes: 1) Anthropometric measurements, 2) Laboratory test to screen for anemia (hematocrit or hemoglobin), 3) Breastfeeding/infant feeding status, food/nutrient intake and eating habits. Based on problems/conditions identified, nutritionally at-risk children under 5 years of age are referred to the Women, Infants and Children (WIC) Supplemental Nutrition Program, for medical nutrition therapy or other in-depth nutritional assessment as appropriate. **Note:** Assessment of infant feeding status includes evaluation of problems/conditions/needs of the breastfeeding mother.

Rationale: Pediatric preventive services are provided in accordance with the American Academy of Pediatrics Guidelines. **RN/MD Review only**

Criteria	Pediatric Preventive Reviewer Guidelines
G. Dental assessment.	Inspection of the mouth, teeth and gums is performed at every health assessment visit. Children are referred to a dentist at any age if a dental problem is detected or suspected. Beginning at age 3 years, all children are referred annually to a dentist regardless of whether a dental problem is detected or suspected.
H. Lead screening.	Children receiving health services through Medi-Cal Managed Care Plans must have blood lead level (BLL) testing as follows: 1) at 12 months ***and*** 24 months of age, 2) between 12 months and 24 months of age if there is no documented evidence of BLL testing at 12 months or thereafter, 3) between 24 months and 72 months of age if there is no documented evidence of BLL testing at 24 months or thereafter. All screening results indicating an elevated BLL of 10 micrograms of lead per deciliter (µg/dL) of blood (or greater) require additional follow-up and blood lead testing in accordance with current DHS policy letter or as summarized below: • BLL of 10-14 µg/dL: Confirm with venous sample within 3 months of original test. • BLL of 15-19 µg/dL: Confirm with venous sample within 2 months of original test, then retest at 2 months following the confirmatory testing. • BLL of 20-44 µg/dL: Confirm with venous sample in 1 week to 1 month, depending on severity of BLL. • BLL of 45-59 µg/dL: Retest with venous sample within 48 hours. • BLL of 60-69 µg/dL: Retest with venous sample within 24 hours. • BLL of ≥ 70 µg/dL: EMERGENCY. Retest immediately with venous sample. Children with elevated BLLs are referred to local Childhood Lead Poisoning Prevention Branch or, if none, to the local health department. All children with confirmed (venous) BLLs of ≥ 20 µg/dL must be referred to CCS.
I. Tuberculosis screening.	All children are screened for risk of exposure to tuberculosis (TB) at each health assessment visit. The Mantoux skin test is administered during health assessment visits at age 4-5 years and age 11-16 years. The Mantoux skin test is administered to ***all*** asymptomatic persons at increased risk of developing TB irrespective of age or periodicity if they have not had a test in the previous year. The Mantoux skin test is not administered if the child has had a previously documented positive Mantoux skin test. For all positive skin tests, there is documentation of follow-up care (e.g. further medical evaluation, chest x-ray, diagnostic laboratory studies and/or referral to specialist). **Note:** Providers are required to follow the American Thoracic Society and Centers for Disease Control (CDC) guidelines for TB diagnosis and treatment.
J. Childhood Immunizations.	Immunization status is assessed at each health assessment visit. The date the Vaccine Information Sheet (VIS) was given ***and*** the publication date of the VIS is documented. The name of each vaccine given, the manufacturer, and lot number is recorded in the medical record, by electronic record or on medication logs. **Note:** Providers are required to administer immunizations according to the most recent guidelines established by the Public Health Service Advisory Committee on Immunization Practices (ACIP), unless medically contraindicated or refused by the parent.

Rationale: Guide to Clinical Preventive Services, U.S. Preventive Services Task Force (USPSTF) Report is the minimum standard for adult preventive health services.

RN/MD Review only

Criteria	Adult Preventive Reviewer Guidelines
A. Initial Health Assessment (IHA).	An IHA is completed on all adult members within 120 days of the effective date of enrollment into the Plan, or documented within the past 12 months prior to member's enrollment. The IHA includes a past health history, a comprehensive physical examination and the IHEBA. If an IHA is not present in the medical record, member's refusal, missed appointments or other reason must be documented. The IHA consists of a core set of services as described in the contract and as outlined below.
B. Individual Health Education Behavioral Assessment (IHEBA).	The "Staying Healthy" Assessment Tool or other DHS-approved assessment tool is completed initially on all adults within 120 days of enrollment into Health Plan, or as part of the IHA. For adults age 18 and older, the IHEBA is re-administered every 3-5 years, or more frequently for young adults. Intervention codes, dates and PCP signature is documented directly on the assessment form. Follow-up clinical interventions, health education and counseling and/or referrals are noted in the progress notes or other areas of the medical record. **Note:** Age-appropriate, gender-specific preventive health education and/or clinical counseling will depend on the identified problems and specific needs of each individual patient.
C. Periodic Health Evaluation.	Periodic health evaluations occur in accordance with the frequency that is appropriate for individual risk factors. The type, quantity and frequency of preventive services will depend on the most recent USPSTF recommendations. Public health evaluations are scheduled as indicated by the patient's needs and according to the clinical judgement of the provider. **Note:** Example: A patient with elevated cholesterol levels and other risk factors for coronary heart disease (CHD) may be evaluated more frequently than other persons of the same age without similar risk factors.
D. Tuberculosis screening.	Adults are screened for tuberculosis (TB) risk factors upon enrollment. The Mantoux skin test is administered to ***all*** asymptomatic persons at increased risk of developing TB irrespective of age or periodicity if they have not had a test in the previous year. The Mantoux is not administered if the individual has had a previously documented positive Mantoux skin test. When a positive skin test is noted, there is documentation of follow-up care (e.g. further medical evaluation, chest x-ray, diagnostic laboratory studies and/or referral to specialist). **Note:** Providers are required to follow the American Thoracic Society and Centers for Disease Control (CDC) guidelines for TB diagnosis and treatment.
E. Blood Pressure.	A blood pressure (B/P) measurement for the normotensive adult is documented at least once every 2 years if the last diastolic B/P reading was below 85 mm Hg and systolic B/P reading was below 140 mm Hg. B/P is measured annually if the last diastolic reading was 85-89/above.
F. Cholesterol.	Men (aged 35 years and older) and women (aged 45 years and older) are screened for lipid disorders, which includes measurement of total cholesterol (TC) and high-density lipoprotein cholesterol (HDL-C). **Note:** Providers may screen men (aged 25-35 years) and women (aged 20-45 years) for lipid disorders if they have other risk factors for CHD such as family history of myocardial infarction before age 50 or family hypercholesterolemia.

Rationale: Guide to Clinical Preventive Services, U.S. Preventive Services Task Force (USPSTF) Report is the minimum standard for adult preventive health services.
RN/MD Review only

Criteria	Adult Preventive Reviewer Guidelines
G. Chlamydia screening.	Women who are sexually active are screened from the time they become sexually active until they are 25 years of age. Providers may screen women older than 25 years of age if the provider determines that the patient is at risk for infection. Lab results are documented.
H. Mammogram.	A routine screening mammography for breast cancer is completed every 1-2 years on all women starting at age 50, concluding at age 75 unless pathology has been demonstrated.
I. Pap Smear.	Routine screening for cervical cancer with Papanicolaou (Pap) testing is done on all women who are or have been sexually active and who have a cervix. Pap smears should begin with the onset of sexual activity and repeated at least every 1-3 years depending on individual risk factors. Follow-up of abnormal test results is documented. According to the USPSTF, routine Pap testing may not be required for the following: 1) women who have undergone hysterectomy in which the cervix is removed, unless the hysterectomy was performed because of cervical cancer or its precursors, 2) women after age 65 who have had regular previous screening in which the smears have been consistently normal.
J. Adult Immunizations.	Immunization status and/or immunizations administered, date Vaccine Information Sheet (VIS) was given ***and*** publication date of the VIS are documented in the medical record. The name of each vaccine, date given, the manufacturer, and lot number is recorded in the medical record, by electronic record or on medication logs. **Note:** Providers are required to administer immunizations according to the most recent guidelines established for adults by the USPSTF.

Rationale: Perinatal assessments are provided according to the American College of Obstetrics and Gynecologists (ACOG) standards and Comprehensive Perinatal Services Program (CPSP) Guidelines. **RN/MD Review only**

Criteria	Perinatal Preventive Reviewer Guidelines
A. Initial Comprehensive Assessment (ICA).	The ICA, completed within 4 weeks of entry to prenatal care, includes the following assessments: Obstetric/medical: Health and obstetrical history (past/current), LMP, EDD. • Physical exam: includes breast and pelvic exam • Lab tests: hemoglobin/hematocrit, urinalysis, urine culture, ABO blood group, Rh type, rubella antibody titer, STI screen. Nutrition: Anthropometric (height/weight), dietary evaluation, prenatal vitamin/mineral supplementation. Psychosocial: Social and mental health history (past/current), substance use/abuse, support systems/resources. Health education: Language and education needs.
B. Subsequent Comprehensive Prenatal trimester re-assessments.	Subsequent comprehensive prenatal re-assessments include Obstetric/medical, Nutrition, Psychosocial and Health Education re-assessments are completed during the 2nd trimester and 3rd trimester.
C. Prenatal care visits according to most recent ACOG standards.	ACOG's *Guidelines for Perinatal Care* recommend the following prenatal schedule for a 40-week uncomplicated pregnancy: • First visit by 6-8th week • Approximately every 4 weeks for the first 28 weeks of pregnancy • Every 2-3 weeks until 36 weeks gestation • Weekly thereafter until delivery • Postpartum visit within 4-8 weeks after delivery If the recommended ACOG schedule is not met documentation shows missed appointments, attempts to contact patient and/or outreach activities.
D. Individualized Care Plan (ICP).	ICP documentation includes specific obstetric, nutrition, psychosocial and health education risk problems/conditions, interventions, and referrals.
E. Referral to WIC and assessment of Infant Feeding status.	All potentially eligible Plan members must be referred to WIC (Public Law 103-448, Section 203(e)). Referral to WIC is documented in the medical record (Title 42, CFR 431.626(c)). Infant feeding plans are documented during the prenatal period, and infant feeding/breastfeeding status is documented during the postpartum period (MMCD Policy Letter 98-10). **Note:** Although WIC determines eligibility for program participation, nearly all Medi-Cal beneficiaries are income eligible for WIC. Federal regulations specify that pregnant and breastfeeding women are given the highest priority for WIC Program enrollment.

Rationale: Perinatal assessments are provided according to the American College of Obstetrics and Gynecologists (ACOG) standards and Comprehensive Perinatal Services Program (CPSP) Guidelines. **RN/MD Review only**

Criteria	Perinatal Preventive Reviewer Guidelines
F. HIV-related services *offered*.	The ***offering*** of prenatal HIV information, counseling and HIV antibody testing is documented (Health & Safety Code, Section 125107). Providers are ***not required*** to document that the HIV test was given or disclose (except to the patient) the results (positive or negative) of an HIV test. Offering a prenatal HIV test is not required if a positive HIV test is already documented in the patient's record or if the patient has AIDS diagnosed by a physician. **Note:** Member's participation is voluntary. Providers may provide HIV test or refer other testing program/site. DHS requires that HIV test results be maintained in a separate and distinct part of the patient's medical file, and that this separate part of the file be made accessible only to those individuals who provide direct patient care. Documentation or disclosure of HIV related information must be in accordance with confidentiality and informed consent regulations.
G. AFP/Genetic screening *offered*.	The ***offering*** of blood screening tests prior to 20 weeks gestation counting from the first day of the last normal menstrual period is documented (CCR, Title 17, Sections 6521-6532). Genetic screening documentation includes: 1) family history, 2) Triple marker screening tests: Alpha Fetoprotein (AF), unconjugated estriol (UE), human chorionic gonadotropin (HCG), 3) member's consent or refusal to participate. **Note:** Member's participation is voluntary. Testing occurs through DHS' Expanded AFP Program, and only laboratories designated by DHS may be used for testing.
H. Domestic violence abuse screening.	Provision of a Domestic Violence Screening is documented. Assessment checklists, body diagrams and/or documentation in progress notes are acceptable. Domestic violence screening includes medical screening, documentation of physical injuries or illnesses attributable to spousal/partner abuse, and referral to appropriate community service agencies (CA Health & Safety Code, Section 1233.5).
I. Family Planning evaluation.	Family Planning counseling, referral or provision of services is documented (MMCD Policy Letter 98-11).
J. Postpartum assessments.	Comprehensive postpartum reassessment includes the 4 components: medical exam, nutrition (mother and infant), psychosocial, health education are completed within 4-8 weeks postpartum (MMCD Policy Letter 96-01). If the postpartum assessment visit is not documented, medical record documents missed appointments, attempts to contact patient and/or outreach activities.