HIGHMARK HEALTH OPTIONS

2023 Medical Record Standards
For Primary Care and Specialist Providers

1. **MEMBER ID**	Each page in the record contains member name or member ID number.
2. **SIGNED ENTRY**	All entries are signed or initialed (electronically) by the provider.
3. **DATED ENTRY**	All entries are dated.
4. **LEGIBILITY**	The record is legible to someone other than the provider or provider's staff.
5. **PROBLEM LIST (PCPs)**	Problem list is current and completed for each member, including significant illness, medical conditions, and health maintenance concerns.
6. **MEDICATION LIST**	Prescribed medications and dosages are documented on a medication list.
7. **ALLERGIES**	Presence/absence of allergies or adverse reactions to medications are prominently noted (1 year of age and older). An absence of allergies should be clearly documented in the record.
8. **MEDICAL HISTORY**	Includes serious injuries, operations and illnesses of member. For children and adolescents, this includes prenatal care, birth, and childhood illnesses.
9. **TOBACCO USE**	Use/nonuse of tobacco products is documented on members age 12 and older.
10. **ALCOHOL USE**	Use/nonuse of alcohol is documented on members 12 years of age and older.
11. **DRUG USE**	Use/nonuse of illicit drugs is documented on members 12 years of age and older.
12. **HISTORY AND PHYSICAL**	A complete history and physical exam including appropriate subjective and objective information for presenting complaints.
13. **LAB, DIAGNOSTIC TESTS AND OTHER STUDIES**	Labs and other studies must be appropriate to the presenting complaint, or diagnosis.
14. **WORKING DIAGNOSIS**	There is a clearly documented diagnostic impression by the provider that is consistent with findings for each member visit.
15. **PLAN OF ACTION, THERAPIES, TREATMENT, AND PRESCRIBED REGIMENS**	Each visit is finalized with a plan of action and/or treatment plan that are consistent with diagnosis. Treatment options (e.g., medical versus surgical, etc.) and risks of treatments are discussed as appropriate.
16. **FOLLOW-UP VISIT**	Notation concerning follow-up care included.
17. **CONTINUITY OF CARE**	Includes documentation on communication between PCP or specialist care (whichever applicable), notes from consultations, follow-up plans for significantly abnormal lab or imaging results, ER discharge summaries, and records from transferred care or SNFs/home care agencies, as applicable.
18. **DISCHARGE SUMMARY**	If the member was in the hospital, there is a discharge summary signed and dated within 30 days.
19. **CARE MEDICALLY APPROPRIATE**	Medical record describes medically appropriate and necessary care, and there is no evidence of the member being placed at inappropriate risk.
20. **CONFIDENTIALITY**	Medical records contain confidentiality statements or a copy of signed consents to release information.
21. **TELEHEALTH VISIT CONSENT**	For telehealth and virtual visits, the member's verbal consent must be documented in the member's medical record.

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