2020 Reviewer's Guide for Medical Record Review

The standards developed for medical record documentation reflect a set of commonly accepted standards, *Clinical Practice Guidelines* and Early and Periodic Screening, Diagnostic and Treatment (EPSDT) visits. The standards include demographic information, health history, details of ongoing clinical issues and preventive health care. Records kept in accordance with these standards facilitate effective medical care, coordination and continuity of care among practitioners. Ten charts.

Standard		Rationale	Auditor guide
1.	Cultural and linguistic needs are being met, including documentation of interpretation service provided.	To address the relationship between culture, language and health care outcomes.	Does the medical record document an assessment of cultural and linguistic needs (for example, notation of language spoken, if other than English)? If necessary, are interpretation services available/utilized? The medical record can be supplemented by the verbal report of the provider or their office staff regarding office practices related to interpretation services. Score N/A if the member speaks and understands English.
2.	Legibility — The record is legible to someone other than the writer.	To ensure that the record can be read by someone other than the writer.	The record is legible to someone other than the writer. Any record judged illegible by one clinical reviewer should be evaluated by a second reviewer. One should make a copy of the chart and bring it back to the office to have a second reviewer look to see if it is legible.
3.	Member name or an ID number noted.	To maintain the integrity of the medical record and ensure that all documents belong to the patient.	Patient name or an identification number is found on each page in the record. May need to print out from the EMR to see if it appears on each page. **NOTE:** Be aware of different access to data within the same provider's office to ensure you get the most complete record.
4.	Personal biographical data noted.	To provide biographical and identifiable data pertinent to the patient's care and treatment planning. To provide emergency information should an incident occur within the physician's office. Many names are not gender specific.	Personal/demographic information may be located in different areas of the chart. If not located in the actual record, all demographics may be contained in a computer system and an example sheet from one of the records must be provided to

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		Recording the sex of a patient helps differentiate males from females.	confirm everything is present. Check to see if the physician is using more than one type of system for documenting demographics. The following data should be present on a demographic form: • Date of birth/age* • Sex* • Address* • Employer • Marital status • Phone number home or work* * At a minimum, these data fields should be present. Where the name is located on the individual page is not important, but it must be there. Ideally, the name is present along with an ID number and/or date of birth. For double-sided pages of the medical record, both sides must have the member ID. For EMR systems, provider must print a 2-3 page sample of a medical record for review of page identification. At a minimum, each page must have printed: • Patient name and medical record number, or • Patient name and date of birth, or • Patient name and an ID number
5.	Documentation of an allergy or absence of allergies and adverse reactions noted.	To prevent the prescribing of any medication to which the member is allergic.	Documentation of an allergy or NKA/NKDA must be present for all members. Prominent location is interpreted as a place on or within chart that stands out visually when holding or upon opening chart. Examples: on front of chart in red or on a red sticker, first page of inside chart or listed on each and every visit notation.
6.	All entries must be signed.	To maintain the integrity of the medical record.	Every progress note should be signed by provider to attest to its correctness. This may be an actual signature, initials, stamped or electronic.
7.	All entries must be dated.	To maintain the integrity of the medical record.	All entries must be dated with month, day and year. This may be hand written, stamped or electronic.

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8.	Current problem list maintained. (Should include one of the following: symptoms and complaints, affect, behavior, focus topics, significant incidents or historical events).	Maintaining a current problem list that includes significant illnesses, medical conditions and psychological conditions enhances information from which a provider can effectively develop a treatment plan. Enhances the ability of the physician and other health care professionals to evaluate and plan the patient's immediate treatment and to monitor his or her health care over time.	Review for current chronic problems. Current problems are defined as any health or mental issue adversely affecting the patient that requires treatment and/or monitoring of its condition over a period of three or more months. Short-term and resolved problems need not be listed. It is acceptable if the physician or office staff documents all current problems at the beginning or end of each office visit notation; however, the problems must be recorded consistently. The problem list should include one of the following: symptoms and complaints, affect, behavior, focus topics, significant incidents or historical events.
9	Medication list maintained.	A centrally located listing of a member's medications assists the provider and support staff with an overview of prescribed medications. The provider can easily assess medications for possible drug interactions, over medication, drug treatment history and management of potential habit forming medications. Medications, when clearly identified, prevent duplication of prescriptions.	Current medications need to be clearly identified in a list in each patient's record. The dosage and date initially prescribed or refilled for each medication listed must be present for best practice. Look for maintenance drugs listed on medication list, even if frequency is PRN. It is acceptable if the physician or office staff person documents all current medications at the beginning of each office visit notation or on an annual physical form. Brand name or generic names are appropriate.
10	Past medical history is noted. (Include pertinent family and social history.)	All patients need to have documentation of medical histories in their record base, from which a planned course of treatment can be developed.	Past, family, interval and developmental history have to be addressed in the patient record. For children, developmental milestones/assessment behavior screening must be present. For patients seen three or more times, examples of accepted history are: a formal questionnaire completed by patient, parent, office staff, physician or a narrative by the physician; past medical history that includes serious accidents, operations and illnesses; social history that refers to family history (maternal/paternal, siblings) as well as pertinent family and social history.
11	Diagnosis	All providers must analyze the member's cause or nature of a condition from its signs and symptoms to determine the member's diagnosis.	Documentation of a member's diagnosis is required in the member's chart.
12	Smoking, ETOH	More deaths, illnesses and disabilities are a result of smoking, ETOH and substance abuse. The impact of	Documentation may be found in the initial history. At each preventive office visit, there should be documentation regarding

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	substance abuse noted.	dependence and drug abuse affect almost every organ in the human body. Tobacco abuse as well as substance abuse is an important factor when planning a course of treatment. A person with history of tobacco/substance abuse would need to avoid, whenever possible, any potential environments where encounters with tobacco smoke or substance use would affect him or her during a course of treatment.	smoking, ETOH and substance abuse. All medical records should have documentation of screenings and plan of treatment/education and/or referrals for treatment at another facility. A notation that the patient is or is not using tobacco, alcohol or drugs must also be noted in order to obtain credit and re-addressed as indicated and/or as needed. If smoking, alcohol or drugs was noted, was member advised to quit? No documentation of smoking, alcohol or drug cessation counseling is an opportunity for provider education.
13	History and physical examination noted.	To ensure appropriate review of all systems that relate to the problem currently being assessed for treatment.	Appropriate subjective and objective information is obtained for the presenting complaints. Physical examination must consist of more than one body system.

14	Functional or cognitive deficits noted. Documentation must include an assessment of member's ability to perform ADL and IADL.	To ensure one annual functional assessment.	Documentation in the medical record must include evidence of a complete functional status assessment and the date when it was performed.
			Notations for a complete functional status assessment must include one of the following:
			• Notation that Activities of Daily Living (ADL) were assessed (at a minimum, the assessment must include bathing, dressing, eating, transferring [for example, getting in and out of chairs], using toilet, walking).
			• Notation that Instrumental Activities of Daily Living (IADL) were assessed (at a minimum, the assessment must include shopping for groceries, driving or using public transportation, using the telephone, meal preparation, housework, home repair, laundry, taking medications, handling finances).
			• Result of assessment using a standardized functional status assessment tool.
			• Notation that at least three of the following four components were assessed:
			  ○ Cognitive status
			  ○ Ambulation status

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			○ Sensory ability (including hearing, vision and speech) ○ Other functional independence (for example, exercise, ability to perform job)
15	Plan of treatment noted. (Should include notations of progress, impediments, or treatment complications).	To ensure appropriate treatment planning.	Documentation for each visit supports presenting complaints, clinical findings, evaluation, treatment plan and follow-up recommendations. Should also include notations of progress, impediments, or treatment complications.
16	Consultations, referrals, and specialist reports noted. (Includes social service assistance and, if requested, a referral to county welfare agency.)	To ensure appropriate treatment planning.	Consultations, lab results, X-rays and other studies must be noted in the record and indicate primary care physician review when appropriate. Social service assistance and, if requested, a referral to county welfare agency must also be noted.
17	Plan for abnormal findings noted.	To ensure appropriate treatment planning.	There is recognition in the chart of an adequate follow-up of all significantly abnormal results by either the PCP or consultant. Results of specialist consultations must be noted in the record and indicate primary care physician review.
18	Emergency care: Copies of emergency treatment documentation such as ER summary sheet.	To ensure appropriate treatment planning.	Copies of emergency treatment and hospital admissions should be present in the chart. Look for ER summary sheet. **NOTE:** Inquire if provider has access to hospital records and ER care. Provider may view this information online from a different location, and this is acceptable. Progress notes may reflect the ER visit.
19	Hospital discharge summaries: Copies of in-	To ensure appropriate treatment planning.	Copies of hospital discharge summaries in the medical record if noted. **NOTE:** Inquire if provider has access to hospital discharge summaries. Provider may view this information online from a

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	patient hospital discharge summaries noted in the medical record.		different location and this is acceptable. Progress notes may reflect the hospital/discharge information.
20	Diagnostic tests	To ensure appropriate treatment planning.	Diagnostic tests/information: The data and information used to analyze and translate into knowledge for planning, decision-making or management reporting. Examples of such tests include: EKG, MRI, CT scan, labs, etc.
21	Documentation of therapies and other prescribed regimens (PT, OT, E-Stim, etc.) noted. (Include modalities such as individual, group or family therapy and date/duration for BH.)	To ensure appropriate treatment planning.	Therapies and other prescribed regimens: such as PT, OT, E-Stim, etc. For behavioral health (BH), modalities such as individual, group or family therapy and the date/duration should be noted in the charts documentation.
22	Notations about follow-up care, calls or visits, specific time of return noted in days, weeks or months documented.	To ensure appropriate treatment planning.	Follow-up is defined as a documented statement that expressed when the physician recommended the patient should return for continued care. Follow-up encounter forms or notes have a notation, when indicated, concerning follow-up care, call or visit. Specific time to return is noted in weeks, months or PRN.
23	Process in place for the exchange of confidential information from specialists or post-	To ensure continuity of care.	A provider making a referral transmits necessary information to the provider receiving the referral. A provider furnishing a referral service reports appropriate information to the referring provider.

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	hospitalization referral/care in a timely manner.		A provider will request information from other treating providers as necessary to provide care. If the organization offers a point-of-service benefit or other benefit providing coverage of services by non-network providers, the organization transmits information about services used by an enrollee under the benefit to the enrollee's primary care provider. When an enrollee chooses a new primary care or MLTSS provider within the network, the enrollee's records are transferred to the new provider in a timely manner that ensures continuity of care.
24	Advance directives age 21 and older: Documentation of an advanced care planning discussion between the provider and member with the date when it was discussed noted.	To ensure that the health care choices of the member are followed when the member is unable to make the decisions for themself.	For adult enrollees (age 21 and older), evidence of advance care planning must include either: • The presence of a dated advance care plan in the medical record, or • Documentation of an advance care planning discussion between the provider and member with the date when it was discussed. The documentation of discussion must be notated in the measurement year. Advance care planning may take place during any type of visit, but at a minimum, it must take place during a preventive health or annual exam visit. Document Yes if the advance directive was discussed with the member. Document No if the advance directive was not discussed with the member. Document N/A if the member is younger than 21.
25	Documentation that unresolved problems from previous visits	To prevent injury and unnecessary treatment that may jeopardize the patient's health.	A statement of resolution of previous problems or stability of problem should be recorded if the patient returns for a follow-up to the issue. Problems from previous visits must be addressed if the problem has not been resolved. If the physician recommends

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	are addressed in subsequent visits.		return PRN or the patient does not return, no previous visit notation is required. The issue is assumed resolved by both patient and physician.
26	Vision screening documented.	Preventive medicine. To ensure appropriate treatment planning. Since screening may find disease at an early stage, there may be a better chance of curing the disease.	Vision screening by the PCP in the context means, at a minimum. When a patient comes in for their annual physical, a vision test should be performed using a vision chart (ex: Snellen Chart). A referral to an ophthalmologist should follow the following schedule: 6-12 months of age: Initial exam 3-5 years of age: At least one exam during this time frame 6-17 years of age: Before 1st grade and annually thereafter 18 years of age +: Yearly eye exams. If it is determined that a member is at high risk for certain vision problems (ex: diabetics), they may need to be seen more frequently.
27	Hearing screening documented.	Preventive medicine. To ensure appropriate treatment planning. Since screening is vital for early identification and management of hearing loss. Failure to detect congenital or acquired hearing loss may result in deficits in speech and language acquisition, poor academic performance, personal social maladjustments and emotional difficulties. Screenings at an early stage may provide a better chance of limiting hearing loss.	Hearing (auditory) screening by the PCP in the context means, at a minimum, when a patient comes in for their annual physical, a vision test should be performed using a vision chart (ex: Snellen Chart). A referral to an audiologist should follow the following schedule: 0-3 months of age: Initial exam 4, 5, 6, 8 and 10 year olds: During well-child visit Hearing should then be checked at least once every 10 years up to the age of 50. Then, hearing should be screened every three years.
28	Dental screening documented.	Preventive medicine. To ensure appropriate treatment planning. Since screening may find disease at an early stage, there may be a better chance of curing the disease.	Dental services may not be limited to emergency services. Dental screening by the PCP in the context means, at a minimum, observation of tooth eruption, occlusion pattern, presence of caries or oral infection. A referral to a dentist by age 1 or soon after the eruption of the first primary tooth is mandatory and at a minimum, a dental visit twice a year with follow-up during well-child visits to ensure that all needed dental preventive and treatment services are provided, thereafter, through age 20.

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29	Dental referral documented.	Preventive medicine.	A referral to a dentist by age 1 or soon after the eruption of the first primary tooth is mandatory and at a minimum, a dental visit twice a year with follow-up during well-child visits to ensure that all needed dental preventive and treatment services are provided, thereafter, through age 20.
30	Coordination and continuity of care between behavioral health and physical/medical	To ensure continuity of care. Comorbid conditions can complicate treatment of and recovery from both physical and behavioral health issues. Continuity of care is the plan of care that should ensure progress without unreasonable interruption.	Documentation in the medical record must include evidence that when a behavioral health issue is identified, that the PCP works together with the BH provider to ensure continuity of care. This includes and is not limited to the exchange of medications that may be prescribed by the collaborating disciplines. PCPs and behavioral health providers are required to communicate directly to ensure continuity of care. A physical and behavioral health provider should exchange health information at the following junctures: • When the member first accesses a physical or behavioral health service. • When a change in the member's health or treatment plan requires an alteration of the other provider's treatment plan (for example, when a member who has been taking lithium becomes pregnant). • When the member is admitted to or discharged from the hospital. • When the member discontinues care. • When a member is admitted and a consultation is warranted. • Once a quarter if not otherwise required. Information should contain at a minimum: • Provider's name and contact information. • Member's name, date of birth, gender, ID number and contact information. • Reason for referral (initial contact only).

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			• Current diagnosis. • History of the presenting illness and other relevant medical and social histories (initial contact only). • Level of suicide, homicide, physical harm or threat. • Current treatment plan. • Special instructions (for example, diagnostic questions to be answered, treatment recommendations). The provider will maintain a copy of the release of information form and document care coordination in the member's medical record. *Reference: Amerigroup Community Care Provider Manual 2019*
31	Completed immunization record for ages 12 and under or a notation that immunizations are up-to-date.	State requirement to monitor and access provider compliance to provision of screenings important to the quality of health care of the Medicaid population.	Vaccinations for children should be present in medical record or a signed waiver by parents if refused. A reason for refusal should be present, but not the decisive factor for scoring if a signed waiver is present. **Immunizations:** • 4 DTaP (Diphtheria, Tetanus and Acellular Pertussis) • 3 IPV (Polio) • 1 MMR (Measles, Mumps and Rubella) • 3 HiB (Haemophilus Influenza type B) • 3 Hep B (Hepatitis B) • 1 VZV (Varicella/Chicken Pox) • 4 PCV (Pneumococcal Conjugate) • 1 Hep A (Hepatitis A) • 2 or 3 RV (Rotavirus) • 2 flu (Influenza) If practitioner states that the child received immunizations from the Health Department and there is no documentation in the record of immunizations being up to date, apply a positive score only if provider does not administer vaccinations at his or her clinic.

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			If provider does supply and administer vaccinations and states "vaccinations are up-to-date" or "vaccinations provided through another practitioner" and there is no documentation in the record of immunization, documentation must be present that provider requested a copy of missing vaccinations from either patient, parent, legal guardian or clinic where vaccinations were administered. Reference: **http://www.cdc.gov/vaccines/acip/index.html**
32	Lead risk assessment completed and lead screening by 12 months and 24 months of age; or by 72 months of age, if not previously tested.	Lead poisoning in childhood primarily affects the central nervous system, the kidneys and the blood-forming organs. Adverse effects in young children have been noted at levels as low as 10 µg/dL and include impairment in cognitive function and initiation of various behavioral disorders. *Reference:* **http://www.qualitymeasures.ahrq.gov/content.aspx?id=48599&search=lead+screening**	Lead risk assessment and screening: documentation of children age 2 who had one or more capillary or venous lead blood test for lead poisoning by their 2nd birthday. *Reference: HEDIS® Technical Specification* HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA). Lead screening: the contractor shall provide a screening program for the presence of lead toxicity in children, which shall consist of two components: verbal risk assessment and blood lead testing. Verbal risk assessment: the provider shall perform a verbal risk assessment for lead toxicity at every periodic visit between the ages of 6 and 72 months as indicated on the schedule. The verbal risk assessment includes, at a minimum, the following types of questions: • Does your child live in or regularly visit a house built before 1978? Does the house have chipping or peeling paint? • Was your child's daycare center/preschool/babysitter's home built before 1978? Does the house have chipping or peeling paint?

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			• Does your child live in or regularly visit a house built before 1978 with recent, ongoing or planned renovation or remodeling? • Have any of your children or their playmates had lead poisoning? • Does your child frequently come in contact with an adult who works with lead? Examples include construction, welding, pottery or other trades practiced in your community. • Do you give your child home or folk remedies that may contain lead? Lead screening using blood lead level determinations must be done for every Medicaid-eligible and NJ FamilyCare child: • Between 9 months and 18 months, preferably at 12 months of age • At 18-26 months, preferably at 24 months of age • Test any child between 27 to 72 months of age not previously tested *Reference: NJ Medicaid Contract.*
Adults — HEDIS measure for adults 21 and older			
1	Documentation of BMI value is noted in medical record.	To improve the quality of life and help prevent short- and long-term complications of obesity.	BMI value is calculated within past two years for adults ages 21-74. Documentation in the medical record must indicate the weight and BMI value, dated during the measurement year or year prior to the measurement year.
2	Documentation of referral for breast cancer screening annually for women ages 50-74 and ABD population for	State requirement to monitor and assess provider compliance to provision of screenings important to the quality of health care and education of the Medicaid population.	Documentation of referral for breast cancer screening. Annual mammogram screening for women ages 50-74. ABD and MLTSS population: annually for ages 65-75.

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	ages 65-75 noted.		
3	Documentation of the last HgbA1c test result is noted in the medical record for adults identified as having diabetes.	To ensure appropriate treatment planning.	HgbA1c test result is documented in the medical record for adults 21 and older identified as having diabetes. At a minimum, an HgbA1c should be present in the medical record once within a given measurement year with documented recommendations for any adjustments to medication based on results. If HgbA1c is greater than 7, follow-up testing should be recommended.
4	If yes, is the HgbA1c < 8% for adults identified as having diabetes?	To ensure appropriate treatment planning.	Documentation of HgbA1c < 8 for adults 21 and over identified as having diabetes.
5	Documentation of blood pressure screening < 140/90 from last office visit is noted in the medical record for adults identified as having diabetes.	For prevention and control of hypertension, blood pressure should be measured at every routine visit.	Blood pressure is measured and documented annually. Documented BP of < 140/90 from last office visit.
6	Documentation of annual dilated or retinal eye exam is noted in medical record for adults identified as having diabetes.	Preventive medicine. To evaluate for the presence of disease of the retina that results in impairment or loss of vision due to diabetes.	Biennial eye examination: percentage of enrollees receiving dilated retinal exam in the past two years. *Reference: NJ Medicaid Contract*
7	Documentation of annual	Preventive medicine. To evaluate urine for the presence of a protein for the prevention of kidney damage.	A yearly urine microalbumin test should be documented in the medical record unless member had a nephrologist visit during the

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	nephropathy screening test is noted in the medical record for adults identified as having diabetes.		measurement year or member has been prescribed an ACE inhibitor/ARB therapy during the measurement year. Evidence of a positive urine macroalbumin test, treatment for nephropathy, Stage 4 chronic kidney disease, ESRD or kidney transplant also meet for nephropathy screening. **ACE therapy** *Accupril (Quinapril)* *Aceon (Perindopril)* *Altace (Ramipril)* *Capoten (Captopril)* *Epaned (Enalapril)* *Lotensin (Benazepril)* *Mavik (Trandolopril)* *Monopril (Fosinopril)* *Prinivil (Lisinopril)* *Univasc (Moexipril)* *Vasotec (Enalapril)* *Zestril (Lisinopril)* **ARB therapy** *Atacand (Candesartan)* *Diovan (Valsartan)* *Avapro (Irbesartan)* *Edarbi (Azilsartan)* *Benicar (Olmesartan)* *Micardis (Telmisartan)* *Cozaar (Losartan)* *Teveten (Eprosartan)*
8	Documentation of adults 21 to 64 years of age who were identified as having	To monitor patient's effectiveness of pharmacotherapy and the severity of the illness.	If a diagnosis of asthma is seen in the chart, look for asthma care plan (in other words, documentation in provider notes or copy of an asthma action plan form) and documentation that the member was appropriately prescribed medication during the measurement year for their asthma.

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	persistent asthma and who were appropriately prescribed medication.		
9	Documentation of annual influenza vaccine.	To ensure appropriate services for the prevention of communicable disease is accessible to the member and offered. Prevent risk of complications that could arise from exposure and contraction of a communicable disease.	Documentation on a collective data record or in an office note is acceptable. Immunization records from a previous provider are acceptable. If vaccination was offered but declined or not obtained, credit is given to provider so long as documentation is present reflecting discussion. Routine annual influenza vaccination is recommended for all persons aged ≥ 6 months who do not have contraindications. Vaccination optimally should occur before onset of influenza activity in the community. *Reference:* **http://www.cdc.gov/flu/index.htm**
10	Documentation of pneumonia vaccine for adults age 65 and older, earlier if high risk.	To ensure appropriate services for the prevention of communicable disease is accessible to the member and offered. Prevent risk of complications that could arise from exposure and contraction of a communicable disease.	CDC recommends pneumococcal conjugate vaccination PCV13 for: • All babies and children younger than 2 years old. • All adults 65 years or older. • People 2 through 64 years old with certain medical conditions. CDC recommends pneumococcal polysaccharide vaccination PPSV23 for: • All adults 65 years or older. • People 2 through 64 years old with certain medical conditions. • Adults 19 through 64 years old who smoke cigarettes. Documentation on a collective data record or in an office note is acceptable. Immunization records from a previous provider are acceptable. If vaccination was offered but declined or not

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			obtained, credit is given to provider, so long as documentation is present reflecting discussion. Adults with specified immunocompromising conditions who are eligible for pneumococcal vaccine should be vaccinated with PCV13 during their next pneumococcal vaccination opportunity. Reference: **http://www.cdc.gov/pneumonia**
11	Documentation of adults who were hospitalized for treatment of selected mental illness (BH provider).	To ensure the importance of compliance.	Documentation that an adult member was hospitalized for the treatment of selected mental illness.
12	Documentation of a follow-up visit within seven days of discharge for adults who were hospitalized for treatment of selected mental illness (BH provider).	To ensure the importance of compliance.	Documentation that a follow-up visit or encounter occurred within seven days of discharge for adults who were hospitalized for treatment of selected mental health illnesses (BH provider).
13	Documentation of a follow-up visit within 30 days of discharge for adults who were hospitalized for treatment of selected mental	To ensure the importance of compliance.	Documentation that a follow-up visit occurred within the 30-day follow-up period after an adult member was hospitalized for the treatment of selected mental illnesses (BH provider). If there was a readmission or direct transfer to an acute facility for a principal diagnosis of mental health within the 30-day follow-up period, count only the readmission or the discharge from the facility to which the member was transferred. Exclude both the initial discharge and the readmission/direct transfer discharge if the

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	illness (BH provider).		readmission/direct transfer discharge occurs after December 1 of the measurement year.
14	Prostate cancer screening ages 65-75 at least every two years.	Preventive. Since screening may find diseases at an early stage, there may be a better chance of curing the disease.	Prostate cancer screening may include prostate specific antigen (PSA), digital rectal exam (DRE) or ultrasound. ABD population: Screen for prostate cancer scheduled for enrollees ages 65-75 at least every two years and documentation on medical records of all tests given, positive findings and actions taken to provide appropriate follow-up care.
EPSDT visit guidelines — from birth through age 20 State requirement to monitor and assess provider compliance to provision of screenings important to the quality of health care of the Medicaid population.			
1	Documentation of height, weight and BMI percentile for children ages 3-20 is noted.	To improve the quality of life and help prevent short- and long-term complications of obesity.	**BMI calculated annually for members ages 3-20.** Documentation must include height, weight and BMI percentile. The height, weight and BMI must be from the same data source. Either of the following meets criteria for BMI percentile: • BMI percentile • BMI percentile plotted on age-growth chart Please bring a copy of the BMI graph back to the office.
2	Documentation of counseling for nutrition or referral for nutrition education for children ages 3-20 is noted.	One of the most important developments in pediatrics in the past two decades has been the emergence of a new chronic disease: obesity in childhood and adolescence. The CDC states that overweight children and adolescents are more likely to become obese as adults. Reference: **http://www.qualitymeasures.ahrq.gov/content.aspx?id=48584&search=wcc**	Nutritional assessment (recommended beginning at age 3). Documentation must include a note indicating the date and at least one of the following: • Discussion of current nutrition behaviors (for example, eating habits, dieting behaviors). • Checklist indicating nutrition was addressed. • Counseling or referral for nutrition education. • Member received educational materials on nutrition. • Anticipatory guidance for nutrition; EPSDT requirement.

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3	Documentation of counseling for physical activity or referral for physical activity for children ages 3-20 is noted.	One of the most important developments in pediatrics in the past two decades has been the emergence of a new chronic disease: obesity in childhood and adolescence. The CDC states that overweight children and adolescents are more likely to become obese as adults. Reference: **http://www.qualitymeasures.ahrq.gov/content.aspx?id=48584&search=wcc**	Documentation must include a note indicating the date and at least one of the following: • Discussion of current physical activity behaviors (for example, exercise routine, participation in sports activities, exam for sports participation) • Checklist indicating physical activity was addressed • Counseling or referral for physical activity
4	Documentation of female adolescents who had three doses of HPV vaccine on or between their 9th and 13th birthday noted.	State requirement to monitor and assess provider compliance to provision of screenings important to the quality of health care of the Medicaid population.	Documentation on a collective data record or in an office note is acceptable. Immunization records from a previous provider are acceptable. Vaccinations for children should be present in medical record or a signed waiver by parents if refused. A reason for refusal should be present, but not the decisive factor for scoring if a signed waiver is present. Human papillomavirus (HPV): 3 doses at 11-12 yrs., 2nd dose 2 mos. after 1st, 3rd dose 6 mos. after 1st; at 13-20 yrs. if not previously vaccinated. Reference: **https://www.cdc.gov/mmwr/volumes/65/wr/mm6549a5.htm** If practitioner states that the child received immunizations from the Health Department and there is no documentation in the record of immunizations being up to date, apply a positive score only if provider does not administer vaccinations at his or her clinic. If provider does supply and administer vaccinations and states "vaccinations are up-to-date" or "vaccinations provided through another practitioner" and there is no documentation in the record of immunization, documentation must be present that provider

<table>
<tr><th></th><th>Standard</th><th>Rationale</th><th>Auditor guide</th></tr>
<tr><td></td><td></td><td></td><td>requested a copy of missing vaccinations from either patient, parent, legal guardian or clinic where vaccinations were administered.</td></tr>
<tr><td>5</td><td>Documentation of children ages 6-12 newly prescribed ADHD medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed.</td><td>To provide accurate and appropriate assessment of a member's problem and appropriate treatment planning.</td><td>Index prescription start date: the earliest prescription dispensing date for an ADHD medication where the date is in the intake period and there is a negative medication history.

Identify all children ages 6-12 who were dispensed an ADHD medication (Table ADD-A) during the 12-month intake period.

Table ADD-A: ADHD medications
<table>
<tr><th>Description</th><th>Prescription</th><th></th><th></th></tr>
<tr><td>CNS stimulants</td><td>Amphetamine-dextroamphetamine

Dexmethylphenidate</td><td>Dextroamphe-tamine
Lisdexamfetamine
Methamphetamine</td><td>Methylphe-nidate</td></tr>
<tr><td>Alpha-2 receptor agonists</td><td>Clonidine</td><td>Guanfacine</td><td></td></tr>
<tr><td>Miscellaneous ADHD medications</td><td>Atomoxetine</td><td></td><td></td></tr>
</table></td></tr>
<tr><td>6</td><td>Documentation of children 5-20 years of age who were identified as having persistent asthma and who were appropriately prescribed medication.</td><td>To provide accurate and appropriate assessment of a member's problem and appropriate treatment planning.</td><td>The percentage of members ages 5-20 during the measurement year who were identified as having persistent asthma and who were appropriately prescribed medication during the measurement year.</td></tr>
<tr><td>7</td><td>Health education/ anticipatory guidance was given as appropriate for age.</td><td>Preventive care.</td><td>Anticipatory guidance: the education provided to parents or authorized individuals during routine prenatal or pediatric visits to prevent or reduce the risk to their fetuses or children developing a particular health problem.</td></tr>
</table>

	Standard	Rationale	Auditor guide
			Documentation is present for health education as appropriate for age.
8	Documentation of children ages 6 and older who were hospitalized for treatment of selected mental illness (BH provider).	To ensure the importance of compliance.	Members age 6 and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit. To ensure the importance of compliance. The percentage of discharges for which members age 6 and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intense outpatient encounter or partial hospitalization with a mental health practitioner and received follow-up within seven days of discharge. If the discharge is followed by readmission or direct transfer to an acute facility for a principal diagnosis of mental health within the 30-day follow-up period, count only the readmission discharge or the discharge from the facility to which the member was transferred. Exclude both the initial discharge and the readmission/direct transfer discharge if the readmission/direct transfer discharge occurs after December 1 of the measurement year.
9	Documentation of a follow-up visit within seven days of discharge for children ages 6 and older who were hospitalized for treatment of selected mental illness (BH provider).	To ensure the importance of compliance.	Documentation that a follow-up visit or encounter occurred within seven days of discharge for children ages 6 and older who were hospitalized for treatment of selected mental health illnesses (BH provider).

	Standard	Rationale	Auditor guide
10	Documentation of a follow-up visit within 30 days of discharge for children ages 6 and older who were hospitalized for treatment of selected mental illness (BH provider).	To ensure the importance of compliance.	Documentation that a follow-up visit occurred within the 30-day follow-up period after a child ages 6 and older was hospitalized for the treatment of selected mental illnesses (BH provider). If there was a readmission or direct transfer to an acute facility for a principal diagnosis of mental health within the 30-day follow-up period, count only the readmission discharge or the discharge from the facility to which the member was transferred. Exclude both the initial discharge and the readmission/direct transfer discharge if the readmission/direct transfer discharge occurs after June 1 of the measurement year.
11	Documentation of a developmental screening performed.	To ensure compliance and access to early intervention services if necessary.	Documentation that a developmental screening was performed before a child turns 1 year old, between 1 and 2 years old and/or between 2 and 3 years old. The screening can be a formal tool, a hard copy note by the doctor regarding the child's development (should include cognitive as well as physical) or a developmental screening in the EMR.
12	If documentation of a developmental screening performed, specify what type.	To ensure the importance of compliance.	Documentation of what type of screening tool used. This can be a formal tool, a hard copy note by the doctor regarding the child's development (should include cognitive as well as physical) or a developmental screening in the EMR.
13	If documentation of screening for risk behaviors (listed below) is found in the medical record during the adolescent AWC for	To ensure the importance of compliance. Risk behavior screenings include: • Tobacco • Alcohol • Drugs • Sexual behavior	Documentation of screening for the five risk behaviors (tobacco, alcohol, drugs, sexual behavior and depression) found in the adolescent (12 through 20 year olds) member's chart during their AWC. A positive depression screening will only be for PHQ-A, PHQ-2, PHQ-9 or Becks Depression Tool. The other four risk behaviors can be screened by asking open-ended questions; no formal tool is required.

	Standard	Rationale	Auditor guide
	12- through 20-year-old members (check off all that were screened).	• Depression	
14	If screening for risk behaviors (listed below) was positive during the adolescent AWC for 12- through 20-year-old members, was there a clinical response present in the documentation.	To ensure the importance of compliance. Risk behavior screenings include: • Tobacco • Alcohol • Drugs • Sexual behavior • Depression	Documentation of a clinical response (physician action taken to address any identified risks) by the provider when a member screens positive for any of the five risk behaviors (tobacco, alcohol, drugs, sexual behavior and depression) found in the adolescent (12 through 20 year olds) member's chart during their AWC.
15	Comments		List any additional comments the reviewer feels are pertinent to the chart review.