Child Health and Disability Prevention Program

Medical Record Review

General Guidelines

- All sites, including mobile vans, satellite centers, and school-based clinics, must be reviewed using the Medical Record Review Tool(DHCS 4492) in conjunction with the Child Health and Disability Prevention (CHDP) Facility Review Tool (DHCS 4493) during an on-site visit to a Provider.
- Local CHDP Programs enrolling a new provider should request a pediatric chart(s) with equivalent services.
- On subsequent reviews, request current CHDP records.
- This form may not be used for more than one provider.

Directions for Scoring

- Every item is weighted.
- Total possible points = 140 (per record reviewed).
- Review a minimum of five randomly selected medical records.
- Score full weighted points for each criterion that is met. Do not score partial points for any criterion.
- Score zero points if criterion is not met.
- Critical Element (CE) areas are scored as Pass/Fail. All elements must be met for this criterion, or the provider will receive a Fail.
- Not applicable (N/A) applies to any criterion that does not apply to the medical record being reviewed. Score N/A with the full weighted points (1 or 3 as designated) for that criterion.

Score Calculation

- Add the category scores for each record reviewed to determine the total points of the review score.
- Multiply the number of records reviewed by the total possible points per record to score the total possible points (100 x number of records reviewed).
- Calculate the percent score by dividing the Review score points by the total possible points. For example:

	Review Score Points Awarded	Total Score Points Possible	Percent Score Calculation
Five Records	650	700	650 ÷ X 100 = 92.8 or 93%

- Round percentages to the next smaller percentage if < 0.5 or to the next larger percentage if 0.5 or >.. For example, if the score for five records is 74.8%, it would be reported as 75%.
- Determine the degree of successful completion by the Business Entity for the Medical Record Review using the thresholds below.

Critical Element

Items identified as Pass/Fail must be met in addition to the overall score. To pass a CE, the provider must achieve more than 50% or 50% + 1 of the total eligible charts for that item. (i.e., in Developmental screening: if total charts with 9m, 18m, and 30m ages is 4, the provider must pass 3 charts minimum). Criteria will be reassessed at a follow-up visit and Conditional Approval maybe warranted if CE components are still deficient.

FULL APPROVAL	CONDITIONAL APPROVAL	NOT APPROVED
88% through 100 With line items passd	70% through 87% With line items failed	less than 70%

Medical Record Review Scoring Summary

Instructions

- Transfer point totals from the Medical Record Review Tool (DHS 4492) for each Criteria Section into the Total Points Given column. Add up Total Points Given.
- Enter the number of Total Records Reviewed. Multiply the Total Records Reviewed by the Maximum Points Possible for Each Record Reviewed to determine the Maximum Points Possible for All Records Reviewed. Add up Maximum Points Possible for All Records Reviewed.
- To determine the percentage, calculate: (Total Points Given) ÷ (Maximum Points for All Records Reviewed) X 100. Then follow the instructions for scoring on the Medical Record Review Tool.

Line Items

- Enter the number of line items passed and/or failed for each criteria section into the line item passed/failed columns.
- The provider is placed on Conditional Approval if any lines items are failed, regardless of the total numeric score.

Medical Record Criteria	Total Points Given	Total Records Reviewed	Maximum Points Possible		CE Items	
			For Each Record Reviewed	For All Records Reviewed	# Passed	# Failed
1. Format			5		NA	NA
2. Documentation			20		NA	NA
3. Coordination and Continuity of Care			31			
4. Pediatric Preventive Care			84			
Total Score:			140		☐ Pass	☐ Fail

Total Percentage:

☐ Full approval (88% through 100%) **☐ Conditional Approval (70% through 87%)** **☐ Not approved (less than 70%)**

Child Health and Disability Prevention Program
Medical Record Review Scoring Tool

Provider Name:	Office Contact(s):
Site Address:	Reviewer name:
Clinician:	Date:
1.	3.
2.	4.

[ ] Electronic [ ] Paper [ ] Hybrid

Criteria met: Give full points **Criteria not met:** 0 points **Criteria not applicable:** N/A (Give full points)

Section 1: Format Criteria		Wt.	1	2	3	4	5	Score	Pass/Fail
	Clinician								
	Child ID								
	Age/Gender								
	Date of Service								
A. Individual medical record for child/youth.									
1) Child/youth identification is on each page.		1							
2) Client personal biographical information is documented.		1							
3) Emergency contact is identified.		1							
4) Each medical record is consistently organized and contents are secure.		1							
B. Primary language, linguistic service needs.		1							
Comments:	Points Per Chart								
Section 1 Total Possible Per Chart		**5**					**Section 1 Total:**		

Medical Record Review Scoring Guidelines **Section 2: Documentation Criteria**	Wt.	1	2	3	4	5	Score	Pass/ Fail
A. Documentation that parent/guardian of the client has received a copy of the Notice of Privacy Practices is present. Documentation that the minor has received a Notice of Privacy Practices is present. (if applicable)	2							
B. Parent/legal guardian general Consent for Treatment and CHDP Consent for Treatment (PM 211) is present. Minor general Consent for Treatment and CHDP Consent for Treatment (PM 211) is present.	2							
C. Release of Medical Information.	2							
D. Signed informed consents are present when any invasive procedure is performed.	2							
E. Errors are corrected according to legal medical documentation standards.	2							
F. All entries are signed, co-signed, if applicable, dated and legible.	2							
G. Copy of pre-enrollment application (DHCS 4073) must be in chart if using Gateway.	2							
H. Allergies and adverse reactions are prominently noted at each well-child visit.	2							
I. Chronic problems and/or significant conditions are listed.	2							
J. Current continuous medications are listed.	2							
Comments: Points Per Chart								
Section 2 Total Possible Per Chart	20				**Section 2 Total:**			

Medical Record Review Scoring Guidelines **Section 3: Coordination and Continuity of Care**	Wt.	1	2	3	4	5	Score	Pass/ Fail
A. Comprehensive Health History								
1) Past Medical History	2							
2) Social History	2							
3) Tobacco Exposure	2							
4) Review of Systems	2							
5) Family History	2							
B. Treatment plans address identified conditions found during history and physical examination.	3							Pass Fail
C. Instructions of child/youth and/or primary caregiver for follow-up care are documented.	3							Pass Fail
D. Unresolved and/or continuing problems are addressed and documented at the time of the subsequent visit.	2							Pass Fail
E. Test results, reports, and referrals								
1) Consultation, test results, diagnostic reports, and referrals have explicit notation of review in the medical record.	3							Pass Fail
2) Test results, diagnostic reports, referrals, and consultation reports are discussed with parent(s), legal guardian, and/or child/youth with explicit notation in the medical record.	3							Pass Fail
3) Age appropriate referral to WIC.	2							
F. Missed appointments and follow-up contacts/outreach efforts are documented.	2							
G. Care Coordination Referral	3							Pass Fail
Comments: Points Per Chart								
Section 3 Total Possible Per Chart	31				**Section 3 Total:**			

Medical Record Review Scoring Guidelines **Section 4: Pediatric Preventive Care**	Wt.	1	2	3	4	5	Score	Pass/Fail
A. Developmental Health								
1) Developmental Screening (i.e. ASQ, PEDS) *Screening Required at 9m, 18m and 30m and if surveillance outcome is positive or noted concern at any age.*	3							Pass Fail
2) Autism Spectrum Disorder Screening (i.e. MCHAT) *Required at 18m, 24m or as needed*	3							Pass Fail
3) Developmental Surveillance *Required at every well child visit*	3							Pass Fail
B. Behavioral Health								
1) Psychosocial/Behavioral Assessment *Required at every well child visit*	2							
2) Tobacco, Alcohol, Or Drug Use Assessment (i.e., CRAFFT) *Age appropriate risk assessment*	2							
3) Depression Screening and/or Maternal Depression Screening *Depression Screening Required: 12 years and older* *Maternal Depression Screening Required: 1m, 2m, 4m, 6m*	3							Pass Fail

Medical Record Review Scoring Guidelines Section 4: Pediatric Preventive Care	Wt.	1	2	3	4	5	Score	Pass/Fail
C. Adolescent Sexual Health *Screening should begin at age 11 years*	2							
D. Vision Screening (LEA/HOTV and Sloan/Snellen) completed and documented. *Risk Assessment required for newborn-35m; 7y, 9y, 11y, 13y,14y, 16y-21y* *Vision Screening Required: 3y, 4y, 5y, 6y, 8y, 10y, 12y, and 15y*	3							Pass Fail
E. Hearing screening is completed and documented (500hz-8000hz as applicable). *Risk Assessment required for 4m-3y, 7y, 9y* *Hearing Screening Required: NB, 3 days-2mo, 4y, 5y, 6y, 8y, 10y, 11-14y, 15-17y, 18-21y*	3							Pass Fail
F. Oral Health								
1) Assess whether the child has a dental home. If no dental home is identified, perform a risk assessment and refer to a dental home. Required at 6m, 9m Risk Assessment: 12m, each age interval from 18m-6y	2							

Medical Record Review Scoring Guidelines **Section 4: Pediatric Preventive Care**	Wt.	1	2	3	4	5	Score	Pass/Fail
2) Routine Dental Home Referral *Required every 6 months, beginning age one.*	3							Pass Fail
3) Fluoride Varnish is offered and documented at least twice a year. *Range during which a service is to be performed: 6m-5y*	2							
4) Fluoride supplementation is assessed, prescribed, and documented as applicable. *Fluoride supplementation risk assessment: 6m, 9m, 12m, 18m, 24m, 30m, each age interval from 3y-16y*	2							
G. Procedures								
1) Anemia *Required: 9-12m* *Risk assessment Required: 4m; each age interval 15m-21y*	3							Pass Fail
2) Dyslipidemia *Dyslipidemia Risk Assessment: 24m, 4y, 6y, 8y, 12y-16y* *Range during which a service is to be performed: 9y-11y, 17-21y*	2							

Medical Record Review Scoring Guidelines **Section 4: Pediatric Preventive Care**	Wt.	1	2	3	4	5	Score	Pass/Fail
3) Sexually Transmitted Infections *STI Risk Assessment: 11y-21y* *HIV Risk Assessment: 11y-14y; 19y-21y* *HIV screening range during which a service is to be performed: 15-18y*	2							
4) Other testing is completed as appropriate	2							
H. Lead anticipatory guidance, screening ordered, and results documented. *Anticipatory guidance 6 -72 months. Lead screening required 12m, 24m. 24 months to 72 months, for children not tested at 24 months or later.*	3							Pass Fail
I. TB risk assessment and/or tuberculin skin test (Mantoux) is completed. *Risk assessment: by 1m, 6m, 12m, 24m; and at each age interval 3y-21y* *TB test if risk assessment is positive*	2							
J. Childhood Immunizations (IZ)								

Medical Record Review Scoring Guidelines **Section 4: Pediatric Preventive Care**	Wt.	1	2	3	4	5	Score	Pass/Fail
1) Immunization history and record are present. Summary page is present and includes consolidation of IZs from other sources. *Every well child visit*	2							
2) IZs were given by this provider when due (at the time of the visit) unless medically contraindicated or refused by the parent. *Every well child visit*	3							Pass Fail
3) Documentation meets VFC requirements. For each vaccine, the administration site, manufacturer, and lot number are recorded in the medical record. *Every well child visit*	3							Pass Fail
4) For each vaccine, receipt of the Vaccine Information Statement (VIS) is documented including edition date. *Every well child visit*	2							
K. Age-appropriate growth measurements are taken and plotted sequentially at each visit.								
1) Head Circumference. *Required at each age interval: NB-24 months*	3							Pass Fail

Medical Record Review Scoring Guidelines **Section 4: Pediatric Preventive Care**	Wt.	1	2	3	4	5	Score	Pass/Fail
2) Body Mass Index (BMI) Percentile. *BMI percentile: 2y – 21y* *Weight for length: < 2y old*	3							Pass Fail
3) Weight. *Every well child visit*	3							Pass Fail
4) Length/Height (recumbent length/standing height) taken and plotted on appropriate growth chart. *Every well child visit*	3							Pass Fail
L. Vital Signs (TPR, BP) are measured at each visit appropriate for age. *Every well child visit*	3							Pass Fail
M. Initial and Periodic Health Assessments are completed. *Every well child visit*								
1) History and Physical Exam. *Every well child visit*	3							Pass Fail
2) Dental Assessment (inspection of the teeth, gums and mouth) *Every well child visit*	3							Pass Fail

Medical Record Review Scoring Guidelines **Section 4: Pediatric Preventive Care**	Wt.	1	2	3	4	5	Score	Pass/Fail
3) Nutritional assessment. *Every well child visit*	3							Pass Fail
4) Health education/anticipatory guidance. *Every well child visit*	3							Pass Fail
Comments: Points Per Chart								
Section 4 Total Possible Per Chart	84				**Section 4**	**Total:**		

Medical Record Review Scoring Guidelines **Section 1 : Format Criteria**	
Rationale: A well-organized medical record keeping system permits effective and confidential client care and quality review. *All criteria applies to paper and Electronic Medical Record (EMR) or Electronic Health Record (EHR) charts unless otherwise stated. For the purposes of these guidelines, EMR will be referenced.*	
A. An individual medical record is established for each child/youth.	
Providers must be able to readily identify each client treated. A medical record shall be started upon the initial visit for each child/youth. "Family Charts" are not acceptable. EMR: Reviewer needs access to all relevant/pertinent areas of the EMR to complete the medical record review. Provider office staff must be available to reviewer to assist EMR review as needed.	
1)	Child/youth identification is on each page Child/youth identification must include first and last name, and/or a unique client number established for use at the clinic site. Electronically maintained records and printed records from electronic systems must contain client identification.
2)	Client personal biographical information is documented Personal biographical information includes: date of birth, current address, home/work phone numbers, and name of parents, if client is a minor. If portions of the personal biographical information are not completed, reviewers should attempt to determine if client has refused to provide information. Do not deduct points if client has not provided all personal information requested by the provider.
3)	Emergency "contact" is identified. The name and phone number of an "emergency contact" person is identified for all clients (i.e. parent, legal

Medical Record Review Scoring Guidelines Section 1 : Format Criteria	
	guardian, or other person if parent/legal guardian not available). If a member refuses to provide an emergency contact, "refused" is noted in the record. Do not deduct points if client has not provided personal information requested by the provider.
4)	Each medical record is consistently organized and contents are securely fastened. Contents and format of medical records within the practice site are uniformly organized. Printed chart contents are securely fastened, attached or bound to prevent medical record loss. Electronic medical record information is readily available.
B. 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 (LEP) client are documented. Language documentation is not necessary "N/A," if English is the primary language. Client refusal of interpreter services is documented at least once and be accepted throughout the member's care unless otherwise specified. 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).	

Medical Record Review Scoring Guidelines

Section 2: Documentation Criteria

Rationale: Well-documented medical records facilitate communication and coordination, and promote the efficiency and effectiveness of treatment.

A. Documentation that parent/guardian of the client and/or minor has received a copy of the Notice of Privacy Practices is present.

Form signed by parent/guardian acknowledging receipt of Notice of Privacy Practices in chart. If applicable and minor is emancipated, documentation that minor received a copy of the privacy notice is needed. Provider must make good faith effort to obtain the individual's written acknowledgement of receipt of the notice. If an acknowledgment cannot be obtained, the provider must document his or her efforts to obtain the acknowledgment and the reason why it was not obtained.

The HIPAA Privacy Rule establishes national standards to protect individuals' medical records and other personal health information and applies to health plans, health care clearinghouses, and those health care providers that conduct certain health care transactions electronically. The right to inspect, review and receive a copy of the medical records is covered by the Privacy Rule.

US DHHS Notice of Privacy Practices for Protected Health Information (45 CFR 164.520)

https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/privacy-practices-for-protected-health-information/index.html

US DHHS Model Notice of Privacy Practices

https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/model-notices-privacy-practices/index.html

B. Consent

Providers must obtain voluntary written consent prior to examination and treatment, with appropriate regard to

Medical Record Review Scoring Guidelines **Section 2: Documentation Criteria**
the patient's age and following State and Federal laws. Minors (patients younger than 18 years of age) may provide their own legal consent for CHDP health assessment services, if: 1) The minor is emancipated, as determined by the court, 2) The minor is, or has been, married or 3) Parental consent for the service is not necessary under State or Federal law. Minors of any age may consent to: medical care related to pregnancy, contraception, abortion, sexual assault services, rape services, emergency medical services, skeletal x-ray to diagnose child abuse or neglect. (Cal. Family Code 6925, 6928) (Cal. Bus & Prof. Code 2397) (Cal. Penal Code 11171.2)
Minors of 12 years of age and older may consent to: outpatient mental health services/shelter services (if in the opinion of the attending professional person, the minor is mature enough to participate intelligently in the mental health treatment or counseling services; minor is not authorized to receive convulsive therapy, psychosurgery or psychotropic drugs on their own consent), drug and alcohol abuse treatment, (minor is not authorized to receive replacement narcotic abuse treatment on their own consent, minor does not have the right to refuse medical care and counseling for a drug or alcohol related problem when the minor's parent or guardian consents for that treatment), diagnosis and/or treatment for infectious, contagious communicable diseases, rape services for minors 12 and over, acquired immunodeficiency syndrome/human immunodeficiency virus (AIDS/HIV) preventive care, testing, diagnosis and treatment, preventive care, diagnosis and/or treatment for sexually transmitted diseases, care related to diagnosis or treatment of an injury as a result of intimate violence and the collection of medical evidence with regard to the alleged intimate partner violence. (Cal. Family Code 6924, 6929(b), 6929(f), 6926, 6927, 6930) (Cal. Health and Safety Code 121020, 124260). Minors of 15 years of age or older minor may consent to: general medical care. [Cal. Family Code 6922(a)] An emancipated minor may consent to medical, dental and psychiatric care. [Cal Family Code 7050(e)]. See Cal. Family Code 7002 for emancipation criteria.

Medical Record Review Scoring Guidelines

Section 2: Documentation Criteria

For more information related to minor consent laws:

http://www.publichealth.lacounty.gov/dhsp/Providers/toolkit2.pdf

http://teenhealthlaw.org/consent/

C. Release of Medical Information

Consent must be obtained prior to release of patient information if applicable.

D. Informed Consent

Signed informed consents are present when any invasive procedure is performed.

Adults, parents/legal guardians of a minor or emancipated minors may sign consent forms for operative and invasive procedures*. Persons less than 18 years of age are emancipated if they have entered into a valid marriage, are on military active duty, or have received a court declaration of emancipation under CA Family Code, Section 7122. Note: Human sterilization requires DHCS Consent Form PM330.

*An invasive procedure is a medical procedure that invades (enters) the body, usually by cutting or puncturing the skin or by inserting instruments into the body. Very minor procedures such as drawing blood testing, umbilical cord blood donations and a few other very specific tests are not considered invasive and do not require a consent. Consent is implied by entering the provider's office or lab and allowing blood to be drawn. Ref: National Institutes of Health; American Cancer Society. Note: Written consent for HIV testing is no longer required (AB 682) 2007.

Informed consent is an agreement to a proposed course of treatment based on receiving clear, understandable information about the treatment's potential benefits and risks. Client must also be informed about all treatments available for their health condition, and the risks of receiving no treatment. Informed consent can be given informally in the course of discussion with the doctor during a routine office visit or similar situation. Informed

Medical Record Review Scoring Guidelines Section 2: Documentation Criteria
consent can also be given formally, by signing a document that states the doctor has fully discussed a treatment or procedure with you and that you have acknowledged and agreed to the risks. (https://oag.ca.gov/research/consent)
E. Errors are corrected according to legal medical documentation standards.
The person that makes the documentation error corrects the error. One correction method is single line drawn through the error, with the writer's initial and date written above or near the lined-through entry. Similar variations such as single line and initial are also used. 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. Note: Reviewers must determine the method used for error corrections for EMR on a case by case basis. This should include the log-in process and whether the EMR allows for corrections to be made after entries are made.
F. Signature, Date, Eligibility
Signature: includes the first initial, last name and title of health care personnel providing care, including Medical Assistants. 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, meaning the stamped signature can be verified, validated, confirmed, and is countersigned or initialed. Note: In electronic records (EMR), methods to document signatures (and/or authenticate initials) will vary, and must be individually evaluated. Reviewers should assess the log-in process and may need to request print-outs of entries. **Date:** includes the month/day/year. Only standard abbreviations are used. Entries are in reasonably consecutive order by date. 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

Medical Record Review Scoring Guidelines Section 2: Documentation Criteria
new entry. Late entries are explained in the medical record, signed and dated. **Legibility:** means the record entry is readable by a person other than the writer. Handwritten documentation signatures and initials are entered in ink that can be readily/clearly copied.
G. Copy of pre-enrollment application (DHCS 4073) must be in chart if using Gateway.
Must be presented when requested by the State and/or local CHDP program. The DHCS 4073 and the Immediate Need Eligibility Document must be retained or scanned into the client record. It is recommended that the application summary also be retained in the record. A copy of the DHCS 4073 must be completed, signed and dated. If client has full-scope Medi-Cal document NA.
H. Allergies and adverse reactions are prominently noted at each well-child visit.
Allergies and adverse reactions are listed in a prominent, easily identified and consistent location in the medical record. If client has no allergies/adverse reactions, "No Known Allergies" (NKA) OR "No Known Drug Allergies" (NKDA) must be documented. (22 CCR Section 70527, 28 CCR Section 1300.80)
I. Chronic problems and/or significant conditions are listed.
Documentation may be on a separate "problem list" 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 problems with slow progress or little progress (e.g., hypertension, depression, diabetes). (22 CCR Section 70527, 28 CCR Section 1300.80)
J. **Current continuous medications are listed.**

Medical Record Review Scoring Guidelines **Section 2: Documentation Criteria**
Documentation may be on a separate medication list or a clearly identifiable medication list in the progress notes. The list of current, on-going medications must include medication name, strength, dosage, route, and frequency. Discontinued medications are noted on the medication list or in progress notes, if applicable. (22 CCR Section 70527, 28 CCR Section 1300.80)

Medical Record Review Scoring Guidelines **Section 3: Coordination and Continuity of Care**
Rationale: The medical record promotes "seamless" continuity-of-care by communicating the client's past and current health status and medical treatment, and future health care plans.
A. Comprehensive health history, including family history is done.
An update to the Health History is documented at each periodic visit. A comprehensive health history should include the following information for all clients: family history, including serious accidents, diseases, and surgeries. Pediatric histories should include past prenatal and birth history, results of newborn hearing screening (for infants up to 1 year of age), growth and development, social including tobacco exposure, and childhood illnesses. For clients aged 14 years and above, the history includes past and current sexual history, tobacco, alcohol, and substance use, and mental health issues. Verify that comprehensive health history is present in chart, (at least one). For reviewers, The Staying Healthy Assessment form (from Managed Care) may supplement social history documented in other parts of the chart. https://www.dhcs.ca.gov/formsandpubs/forms/pages/stayinghealthyassessmentquestionnaires.aspx
B. Treatment plans address identified conditions found during history and physical examination.
Treatment and/or action plan is documented for each diagnosis, and relates to the stated diagnosis. For example if physical exam, vital sign, and/or lab findings are **out of range**, then they should be addressed in the assessment and plan (i.e. BMI percentile is not within normal growth ranges).

Medical Record Review Scoring Guidelines Section 3: Coordination and Continuity of Care	
C. Instructions of child/youth and/or primary caregiver for follow-up care are documented.	
Specific follow-up instructions, along with a definitive time for return visit or other follow-up care is documented. Time period for return visits and/or other follow-up care is definitively stated in number of days, weeks, months, etc., or as needed.	
D. Unresolved and/or continuing problems are addressed and documented at the time of subsequent visits.	
Documentation shows that unresolved and/or chronic problems are assessed at subsequent visits. All problems need not be addressed at every visit. Reviewer should be able to determine if provider follows up with client about treatment regimens, recommendations, counseling, and referrals.	
E. Test results, reports and referrals.	
1)	Medical record contains consultation reports, diagnostic test results, and referrals. There is documented evidence of review by the examiner. Diagnostic (e.g., lab, x-ray) test reports, consultation summaries, inpatient discharge records, emergency and urgent care records must have evidence of review by a physician. Evidence of review may be the physician's initials or signature on the report/record, or a notation in the progress note by physician.
2)	A physician must review all reports with evidence in medical record of follow-up with the client. Record includes notation about client contact or attempted contacts, follow-up treatment and/or instruction provided, and return. EMR: Copy of protocol is available upon request

Medical Record Review Scoring Guidelines Section 3: Coordination and Continuity of Care	
3)	Health Assessment Only providers have documented a referral to both a medical and dental provider. Infants and children younger than 5 years of age may be eligible for the Women, Infants, and Children (WIC) Supplemental Nutrition Program and should be referred appropriately.
F. Missed appointments	
Documentation includes incidents of missed appointments and/or examinations. Attempts to contact the client and/or parent/guardian (if minor), and the results of follow-up actions are also documented in the record.	
G. Care Coordination Referral	
Use of care coordination form or alternate form is required for all Fee for Service/Gateway and Foster Care children. A copy of the CHDP referral has been scanned in to the patient's chart. See program letter 17-06. Non-applicable for FQHC.	

Medical Record Review Scoring Guidelines Section 4. Pediatric Preventive Care	
Rationale: The medical record promotes "seamless" continuity of care by communicating the client's past and current health status, medical treatment, and future health care plans.	
A. Developmental Health	
Early identification of developmental disorders is critical to the well-being of children and their families. It is an integral function of the primary care medical home and an appropriate responsibility of all pediatric health care professionals.	
1) Developmental Screening	A standardized, validated developmental screening is required at the ages recommended per AAP/Bright Futures. (9, 18, and 24-30 month visits as of 2019). In addition, for children who are not yet in kindergarten, screening should be conducted at other well visits when developmental surveillance reveals concerns. Catch-up screens should be conducted for patients not screened at the appropriate intervals, including new patients without a history of screening. Screening of children who have not yet entered kindergarten, using a standardized, validated developmental tool, is required • At ages recommended by AAP Bright Futures (9, 18, 24-30 month visits as of 2019) • When developmental surveillance reveals concerns • When the child was not screened at the appropriate age (catch-up), including new patients If needed, a follow up visit may be scheduled to complete the screening. AAP summary of developmental screening tools, AAP algorithm for developmental surveillance and screening

Medical Record Review Scoring Guidelines Section 4. Pediatric Preventive Care	
2) Autism Spectrum Disorder screening	Screening of children using a standardized, validated tool is required At ages recommended by AAP/Bright Futures (18 and 24 month visits as of 2019) • When developmental surveillance reveals concern • When the child was not screened at the appropriate age (catch-up), including new patients.(http://pediatrics.aappublications.org/content/120/5/1183.full). MCHAT as one of the possible AAP recommended ASD screening tools may be completed between 16-30 months of age. https://mchatscreen.com/, CDC Autism Handouts
3) Developmental surveillance	There is documentation of all surveillance and screening activities. There are 5 components of developmental surveillance at every well-child visit: eliciting and attending to the parents' concerns about their child's development; documenting and maintaining a developmental history; making accurate observations of the child; identifying risk and protective factors; and maintaining an accurate record of documenting the process and findings. Any concerns raised during surveillance should be promptly addressed. Assessment of older children: https://www.aap.org/en-us/professional-resources/Reaching-Teens/Documents/Private/SSHADESS_handout.pdf
B. Behavioral Screening	
1) Psychosocial, Behavioral Assessment	Required at every well child visit This assessment should be family centered and may include an assessment of child social-emotional health, caregiver depression, and social determinants of health. See "Promoting Optimal Development: Screening for Behavioral and Emotional Problems" and "Poverty and

Medical Record Review Scoring Guidelines Section 4. Pediatric Preventive Care	
	Child Health in the United States".
2) Tobacco, Alcohol or Drug Use Assessment	**Tobacco assessment** 11-21 years old Tobacco, Alcohol or Drug use assessment (i.e. CRAFFT). Age appropriate assessment tools are available: https://toolkits.solutions.aap.org/DocumentLibrary/BFTK2e_Links_Screening_Tools.pdf
3) Depression Screening	**Depression Screening**: 12 years and older Recommended screening using the Patient Health Questionnaire (PHQ)-2 or other tools available in the GLAD-PC toolkit. **Maternal Depression Screening Required**: by 1m, 2m, 4m, 6m Screening should occur per "Incorporating Recognition and Management of Perinatal and Postpartum Depression into Pediatric Practice" and AAP Tool Kit.
C. Adolescent Sexual Health	
Adolescents from age 11-21 years of age should be assess for sexual activity at every well child visit. If adolescents are identified as sexually active, the clinician shall proceed with questions 1-3 and document discussion, intervention, referral, and/or treatment where applicable. For reviewers, The Staying Healthy Assessment form (from Managed Care) may supplement social history documented in other parts of the chart.	

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https://www.dhcs.ca.gov/formsandpubs/forms/pages/stayinghealthyassessmentquestionnaires.aspx

https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/adolescent-sexual-health/Pages/default.aspx

https://pediatrics.aappublications.org/content/125/5/1094

- Intimate Partner Violence

The Centers for Disease Control and Prevention defines intimate partner violence (IPV) as a pattern of coercive behaviors that may include repeated battering and injury, psychological abuse, sexual assault, progressive social isolation, deprivation, and intimidation. "Intimate partner" includes current and former partners.

The USPSTF recommends that clinicians screen for intimate partner violence in women of reproductive age and provide or refer women who screen positive to ongoing support services.

https://www.cdc.gov/violenceprevention/intimatepartnerviolence/index.html

- Contraceptive Care

Responsibility of pediatricians includes helping teens reduce risks and negative health consequences associated with adolescent sexual behaviors, including unintended pregnancies and sexually transmitted infections. The USPSTF recommends that all women who are planning or capable of pregnancy (sexually active) take a daily supplement containing 0.4 to 0.8mg (400 to 800ug) of folic acid.

- STI Screening on Sexually Active Adolescents

All sexually active adolescents should be screened for sexually transmitted infections (STIs), Chlamydia, gonorrhea, and syphilis. High risk adolescents (15-21 years) who are pregnant, men having sex with men, or persons with HIV should be screened for syphilis.

Providers should address prevention, screening, and treatment of STIs with their sexually active adolescent and

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young adult patients as part of their regular annual health care visits.

https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/adolescent-sexual-health/Pages/STI-Screening-Guidelines.aspx

https://pediatrics.aappublications.org/content/134/1/e302

D. Vision screening

Risk Assessment required for newborn-35m; 7y, 9y, 11y, 13y,14y, 16y-21y

Vision Screening Required: 3y, 4y, 5y, 6y, 8y, 10y, 12y, and 15y

Visual acuity screening is required:

- At ages recommended by AAP/Bright Futures (cooperative 3 year olds, 4, 5, 6,8, 10, 12, and 15 years as of 2019)
- When history or examination reveals concerns
- When the child was not screened at the appropriate age (catch-up), including new patients

Instrument-based screening may be used to assess risk at ages 12 and 24 months, in addition to the well visits at 3 through 5 years of age. Once children can read an eye chart easily, optotype-based acuity should supplement instrument-based testing. Instrument-based screening at any age is suggested if unable to test visual acuity monocularly with age-appropriate optotypes.

"Visual System Assessment in Infants, Children, and Young Adults by Pediatricians" and "Procedures for the Evaluation of the Visual System by Pediatricians".

A visual acuity screen is recommended at ages 4 and 5 years, as well as in cooperative 3-year-olds. Instrument-based screening may be used to assess risk at ages 12 and 24 months, in addition to the well visits at 3 through 5

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years of age. Once children can read an eye chart easily, optotype-based acuity should supplement instrument-based testing. Instrument-based screening at any age is suggested if unable to test visual acuity monocularly with age-appropriate optotypes. See "Visual System Assessment in Infants, Children, and Young Adults by Pediatricians" and "Procedures for the Evaluation of the Visual System by Pediatricians".

E. Hearing screening

Risk Assessment required for 4m-3y, 7y, 9y

Hearing Screening Required: NB, 3 days-2mo, 4y, 5y, 6y, 8y, 10y, 11-14y, 15-17y, 18-21y

Confirm initial screen was completed, verify results, and follow up, as appropriate. Newborns should be screened, per "Year 2007 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs" (http://pediatrics.aappublications.org/content/120/4/898.full).

Hearing screening is required:

- At ages recommended by AAP/Bright Futures (4, 5, 6,8, 10, once between each of these age intervals: 11-14, 15-17, and 18-21 years, as of 2019)
- When history or examination reveals concerns
- When the child was not screened at the appropriate age (catch-up), including new patients

American Academy of Pediatrics/Bright Futures (AAP/BF) recommends screening using a pure tone air

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conduction audiometer with intensity levels of 20 or 25***** decibels (dB) depending on the noise level in the screening room at frequency levels of 500*, 1000, 2000, 4000, (3000 optional) for all ages. To include 6,000 and 8,000 Hz frequencies for ages 11 and older. *****AAP recommends. However, American Speech-Language-Hearing Association (ASHA) states is only accurate if conducted in a sound-proof booth http://pediatrics.aappublications.org/content/124/4/1252 The Sensitivity of Adolescent Hearing Screens Significantly Improves by Adding High Frequencies (http://www.jahonline.org/article/S1054-139X(16)00048-3/fulltext).	
F. Oral Health	
1) Dental Home	Required at 6m, 9m. For the 12-, 18-, 24-, 30-month, and the 3- and 6-year visits, risk assessment should continue if a dental home has not been established. Assess whether the child has a dental home. If no dental home is identified (i.e. dental visit in the last 6 months), perform a risk assessment (https://www.aap.org/RiskAssessmentTool) and refer to a dental home. Recommend brushing with fluoride toothpaste in the proper dosage for age. See "Maintaining and Improving the Oral Health of Young Children" (http://pediatrics.aappublications.org/content/134/6/1224).
2) Routine Dental Home Referral	Routine dental referral required for children age 1 and up (or at eruption of first tooth) who have not seen a dentist in the last 6 months and do not have an upcoming appointment scheduled. Referral required at all ages if a dental problem is suspected or detected.

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	Referrals to other providers for specialty care is documented in the chart.
3) Fluoride Varnish	Fluoride Varnish is offered and documented at least twice a year (up to 3 times a year) Range during which a service is to be performed: 6m-5y The USPSTF and AAP recommend that primary care clinicians apply fluoride varnish to the teeth of all infants and children through 5 years of age (up to 6th birthday). Starting when the first tooth erupts, Fluoride Varnish should be applied up to 3 times per year (but at least twice a year) and documented in child's medical record. If a medical provider/clinic does not offer the application of fluoride varnish, the child is referred to a Medi-Cal provider who does offer this benefit. Referral to another Medi-Cal provider must be documented in the child's medical record. (A referral to a dentist is not a substitute for application of fluoride varnish in the medical office). Current American Academy of Pediatric Dentistry recommendations for children at high risk of caries is that fluoride varnish be applied to their teeth every 3 to 6 months. https://brightfutures.aap.org/Bright%20Futures%20Documents/BF4_OralHealth.pdf https://brightfutures.aap.org/Bright%20Futures%20Documents/BF4_InfancyVisits.pdf Fluoride Use in Caries Prevention in the Primary Care Setting, Melinda B. Clark, Rebecca L. Slayton, SECTION ON ORAL HEALTH http://pediatrics.aappublications.org/content/134/3/626 https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/dental-caries-in-children-from-birth-through-age-5-years-screening

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4) Fluoride	It is recommended to prescribe a fluoride supplement if drinking water is not adequately fluoridated. (6mos to 16 years). Fluoride assessment and supplementation is documented in the child's medical record. Fluoride supplementation risk assessment: 6m, 9m, 12m, 18m, 24m, 30m, each age interval from 3y-16y
G. Procedures	
1) Anemia	Required: 9-12m Risk assessment Required: 4m; each age interval 15m-21y Screening for iron-deficiency anemia routine screen at 9-12 months. Risk Assessments at 4 months and all visits after 12 months; screen if risk assessment is positive. California WIC requires anemia hematocrit/hemoglobin (Hct/Hgb) screening with determination of hemoglobin concentration at 9-12 months, 24 months, 3 years, and 4 years for all WIC participants. If abnormal, repeat test every 6 months. See "Diagnosis and Prevention of Iron Deficiency and Iron-Deficiency Anemia in infants and Young Children (0–3 Years of Age)" (http://pediatrics.aappublications.org/content/126/5/1040.full). Bright Futures recommends universal screening for anemia at approximately 12 months of

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	age with determination of hemoglobin concentration and an assessment of risk factors associated with iron deficiency/iron deficiency anemia (ID/IDA). Selective screening can be performed at any age starting at 4 months when risk factors for ID/IDA have been identified, including risk of inadequate iron intake according to dietary history. (CHDP Health Assessment Guidelines)
2) Dyslipidemia	Dyslipidemia Risk Assessment: 24m, 4y, 6y, 8y, 12y-16y Range during which a service is to be performed: 9y-11y; 17-21y Screening for dyslipidemia is to occur once between 9 and 11 years of age, and once between 17 and 21 years of age (to be consistent with guidelines of the National Heart, Lung, and Blood Institute). See "Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents" https://www.nhlbi.nih.gov/health-topics/integrated-guidelines-for-cardiovascular-health-and-risk-reduction-in-children-and-adolescents/integrated-guidelines-for-cardiovascular-health-and-risk-reduction-in-children-and-adolescents-full-report
3) Sexually Transmitted Infection, HIV	STI Risk Assessment: 11y-21y HIV Risk Assessment: 11y-14y; 19y-21y HIV screening range during which a service is to be performed: 15-18y Adolescents should be screened for sexually transmitted infections (STIs) per recommendations in the current edition of the American Academy of Pediatrics (AAP) Red Book: Report of the Committee on Infectious Diseases.

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	HIV: Adolescents should be screened for HIV according to the United States Preventive Services Task Force (USPSTF) recommendations () once between the ages of 15 and 18, making every effort to preserve confidentiality of the adolescent. Those at increased risk of HIV infection, including those who are sexually active, participate in injection drug use, or are being tested for other STIs, should be tested for HIV and reassessed annually. Reference: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics
4) Other Testing	**a. Newborn blood**: Confirm initial screen was accomplished, verify results, and follow up, as appropriate. The Recommended Uniform Newborn Screening Panel (https://www.hrsa.gov/advisory-committees/heritable-disorders/rusp/index.html) as determined by The Secretary's Advisory Committee on Heritable Disorders in Newborns and Children, and state newborn screening laws/regulations the criteria for and coverage of newborn screening procedures and programs. At 3-5 days: Verify results as soon as possible, and follow up, as appropriate. **b. Newborn Bilirubin**: Confirm initial screening was accomplished, verify results, and follow up, as appropriate. See "Hyperbilirubinemia in the Newborn Infant ≥35 Weeks' Gestation: An Update With Clarifications" (http://pediatrics.aappublications.org/content/124/4/1193). **c. Critical Congenital heart defect**: Screening for critical congenital heart disease using pulse oximetry should be performed in newborns, after 24 hours of age, before discharge from the hospital, per "Endorsement of Health and Human Services Recommendation for Pulse Oximetry Screening for Critical

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	Congenital Heart Disease."
H. Lead Counseling, screening ordered, and results documented	
Risk assessment: 6m, 9m, 18m, 3y, 4y, 5y, 6y Risk assessment and/or Lead Screening Required at 12m, 24m (based on universal screening requirements) Lead screening is mandated by California in publicly supported programs, including Medical-Cal and WIC. Routine screening (Blood Lead test) at 12 months and 24 months. 24 months to 6 years, for children not tested at 24 months or later. For children at risk of lead exposure, see "Low Level Lead Exposure Harms Children: A Renewed Call for Primary Prevention". Per California's Screening regulations: At each periodic assessment from 6 months to 6 years. • Screen (blood lead test) • Children in publicly supported programs* at both 12 months and 24 months. • Children age 24 months to 6 years who were not tested at 24 months or later. Assess: If child not in publicly supported program • Ask: "Does your child live in, or spend a lot of time in, a place built before 1978 that has peeling or chipped paint or that has been recently remodeled?" Blood lead test: If the answer to the question is "yes" or "don't know." • Other indications for blood lead test	

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- Suspected lead exposure
- Parental request
- Recent immigrant from country with high levels of environmental lead
- Change in circumstance has put child at risk of lead exposure

Local provider should refer to State Childhood Lead Poisoning Prevention Branch for guidance on follow up.

I. TB risk assessment and/or tuberculin skin test is completed

Risk assessment: by 1m, 6m, 12m, 24m; and at each age interval 3y-21y

TB test if risk assessment is positive

Tuberculosis testing per recommendations of the AAP Committee on Infectious Diseases, published in the current edition of the AAP Red Book: Report of the Committee on Infectious Diseases. Testing should be performed on recognition of high-risk factors.

The TB Risk Assessment Questionnaire is administered at 1m, 6m, 12m, 24m; and at each age interval 3y-21y.

Perform the TB test if risk assessment is positive (can include Quantiferon blood test). The Tuberculin Skin Test (TST) is read by trained personnel 48-72 hours after administration and is recorded in millimeters (mm) of induration. Children with positive reactions have documentation of follow-up medical evaluation, chest x-ray, and other needed diagnostic laboratory studies, or referral to specialist as appropriate. Refer to Health Assessment Guidelines for standards.

Per the Health Assessment Guidelines, testing for tuberculosis is not a universal requirement for school entry in California. However, California law allows local health departments to require TB testing for school entry based on local epidemiology. Check with your local health department for local policy.

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J. Childhood Immunizations

1) Immunization history and record are present. Immunization summary page is present and includes consolidation of IZs from other sources.
2) IZs were given by this provider when due (at the time of the visit) unless medically contraindicated or refused by the parent.
3) Documentation meets VFC requirements. For each vaccine, the administration site, manufacturer, and lot number are recorded in the medical record.

For each vaccine, receipt of the Vaccine Information Statement (VIS) is documented including edition date.

There is a consolidated immunization record present. Immunization registry summary is acceptable. Immunization status is assessed at each health assessment visit and during each encounter. All needed vaccines are administered according to guidelines established by the Public Health Service Advisory Committee on Immunization Practices (ACIP), unless medically contraindicated or refused by the parent. For each vaccine, the manufacturer and lot number is recorded in the medical record. Documentation of receipt of VIS exists including date of VIS. Generally found on the Immunization Administrative Sheet.

(See the current edition of the "Pink Book" under the appendix related to the VIS at: Refer to EZIZ website or https://www.cdc.gov/vaccines/pubs/pinkbook/genrec.html)

A history of immunizations is received and a copy of the current immunization records should be in the paper chart or EMR. Documentation must have the elements required by the Vaccines for Children (VFC) Program.

K. Age Appropriate Growth Measurements are taken and plotted sequentially at each visit using appropriate growth charts

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Head circumference required at each age interval: NB-24 months. BMI percentile: 2y – 21y. Weight for length: < 2y old. CDC recommends that health care providers use the WHO growth charts to monitor growth for infants and children ages 0 to 2 years of age in the U.S. Use the CDC growth charts to monitor growth for children age 2 years and older in the U.S.

Age-appropriate growth measurements are taken and plotted sequentially at each visit according to the CHDP Health Assessment Guidelines.

- Infants and toddlers <24 months of age: weight, length, head circumference, and weight/length plotted using appropriate growth charts.
- Children ≥ 24 months of age and adolescents: weight, height and BMI percentile calculated and plotted using appropriate growth charts.

L. Vital signs (TPR, BP) are measured at each visit appropriate for age.

Vital signs Temperature Pulse Respiration (TPR) are measured and recorded at each visit.

Blood pressure (BP) measurement begins at three years of age. If hypertension (BP ≥ 95th percentile for age and sex) is suspected, the child's position, limb, and cuff size are documented in the medical record. The BP measurement is repeated if ≥ the 90th percentile for age and sex.

Blood Pressure measurement in infants and children with specific risk conditions should be performed at visits before age 3. http://pediatrics.aappublications.org/content/140/3/e20171904

M. Assessments and Physical Exam

Inspection of the teeth, gums and mouth. Charts of comprehensive care providers shall have evidence of episodic care. A complete physical exam – unclothed – is documented at each periodic visit. Each visit has a documented

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diagnosis or impression and is based on an age appropriate physical exam or stated chief complaint or reason for the visit based on client interview. Initial and periodic health assessments are completed according to CHDP periodicity. Initial and periodic health assessments shall have nutrition, dental, health education/anticipatory guidance, developmental and tobacco assessments and guidance. EMR: Age and content appropriate templates used for well child exam.	
1) Physical Exam	CHDP Program pediatric preventive physical examinations are completed at each health assessment visit and include: (1) review of systems and interval histories as appropriate; (2) anthropometric measurements (3) physical examination/body inspection, including screening for STI's of sexually active adolescents. Care Coordination form required for all Fee-for-Service (FFS)/Gateway patients. Follow-up care or referral is provided for identified physical health problems as appropriate.
2) Dental Assessment	Dental Assessment includes an inspection of the mouth, teeth, and gums at every health assessment visit. Children are referred to a dentist at any age if a dental problem is detected or suspected. Caries classification is specified and documented in the medical record and referral form (if applicable). In accordance with the recommendation of the AAP American Academy of Pediatric Dentistry, (AAPD) the CHDP program recommends a direct referral to a dentist beginning at one year of age and at least every six months thereafter. Code of Regulations, Title 17, Subchapter 13, 6843.
3) Nutritional Assessment	Nutritional Assessment requirement includes: (1) anthropometric measurements; (2) laboratory test to screen for anemia (hematocrit or hemoglobin); and (3) breastfeeding/infant formula intake status, food/nutrient intake, and eating habits. Based on problems/conditions identified in the nutritional assessment, reviewers should look for

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	referral of nutritionally at-risk children under five years of age to the WIC Supplemental Nutrition Program, or for medical nutrition therapy and/or other in-depth nutritional assessment as appropriate. Code of Regulations, Title 17, Subchapter 13, 6846. Use of CHDP assessment form or equivalent should address all areas https://www.dhcs.ca.gov/formsandpubs/forms/Documents/What.Does.Your.Child.Eat.ENGLISH.pdf https://www.dhcs.ca.gov/formsandpubs/forms/Documents/What.Do.You.Eat.ENGLISH.pdf https://www.dhcs.ca.gov/formsandpubs/forms/Forms/ChildMedSvcForms/dhcs4035b.pdf https://govt.westlaw.com/calregs/Document/I1274DCD0D60611DE88AEDDE29ED1DC0A?viewType=FullText&originationContext=documenttoc&transitionType=CategoryPageItem&contextData=(sc.Default)
4) Health Education, Anticipatory Guidance	Health Education/Anticipatory Guidance is provided at each health assessment visit. This includes providing or referring to counseling, and providing appropriate, specifically related educational materials. Identified problems and interventions (nutrition counseling, parenting classes, smoking cessation programs, etc.) are addressed in the progress notes. https://www.aap.org/en/practice-management/bright-futures#search=Health%20Education%2FAnticipatory%20Guidance CHDP Classification Referral Guide https://www.dhcs.ca.gov/formsandpubs/publications/Documents/Dental-Classification-Guide.pdf DHCS Periodicity Schedule.

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	https://www.dhcs.ca.gov/services/chdp/Documents/DentalPeriodicity.pdf https://govt.westlaw.com/calregs/Document/I1213AA00D60611DE88AEDDE29ED1DC0A?viewType=FullText&originationContext=documenttoc&transitionType=CategoryPageItem&contextData=(sc.Default) More info on EPSDT https://www.denti-cal.ca.gov/DC_documents/providers/provider_bulletins/archive/Volume_26_archive.zip http://www.aapd.org/media/Policies_Guidelines/G_Periodicity.pdf.