CHDP Medical Record Reviewer Guidelines

Rationale: A well-organized medical record keeping system permits effective and confidential client care and quality review.

1. Format Criteria	**Medical Record Reviewer Guidelines – Format (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.
2) Individual 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 shall be identified for all clients. If the client is a minor, the contact person must be a parent or legal guardian. Emancipated minors and adults may list anyone they so choose. Do not deduct points if client has not provided personal information requested by the provider.
4) Each medical record on site is consistently organized.	Contents and format of printed and/or electronic records within the practice site are uniformly organized.
5) Chart contents are securely fastened.	Printed chart contents must be fastened or bound to prevent medical record loss. Document NA if EMR.
6) Notice of Privacy Practices.	Signed form or sticker needs to be present in chart identifying the parent/guardian received a copy of the privacy notice.

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

2. Documentation Criteria	Medical Record Reviewer Guidelines - Documentation
A. Allergies and adverse reactions are prominently noted at each well-child visit.	Allergies and adverse reactions must be listed in a 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.
B. Health-related conditions are identified (e.g., problem list).	Chronic conditions include current long-term, on-going problems with slow progress or little progress (e.g., hypertension, depression, diabetes). Documentation can be on a separate problem list or listed in the progress notes.
C. Current continuous medications are listed.	The list of current, on-going medications must include medication name, strength, dosage. Documentation can be on a separate problem list or listed in the progress notes.
D. Appropriate consents are present in record.	Providers must obtain voluntary written consent prior to examination and treatment, with appropriate regard to the patient's age and following State and Federal laws. Consent also must be obtained prior to release of patient information. 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. For more information related to minor consent laws: http://publichealth.lacounty.gov/std/docs/Adolescent_Confidentiality_Toolkit.pdf.
E. Errors are corrected according to legal medical documentation standards.	Persons making a documentation error must correct it by drawing a single line through the error, writing "error" above/near the lined-through entry, writing the corrected information, and signing the entry. Erasing and/or use of correction fluid is not acceptable. EMR: As appropriate, errors are documented per provider protocol (copy of protocol is available).
F. All entries are signed, co-signed, if applicable, dated and legible.	Signature includes the first initial, last name, and title. Stamped signatures are acceptable, but must be authenticated. Methods used to authenticate signatures in electronic medical records are dependent upon computerized system used on site, and must be individually evaluated by reviewers. Date includes the month/day/year. Physician's assistants must have a co-signature by a physician as required by California law (copy of protocol is available). Legibility means the record entry is readable by a person other than the writer.
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.

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.

3. Coordination and Continuity of Care Criteria	**Medical Record Reviewer Guidelines – Coordination and Continuity of Care**
A. Comprehensive health history, including family history is done.	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, 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. An update to the Health History and Review of Systems is documented at each periodic visit.
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.
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.	Medical record contains consultation reports, diagnostic test results, and referrals. There is documented evidence of review by the examiner. 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. 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. EMR: Copy of protocol is available upon request. Health Assessment Only providers have documented a referral to both a medical and dental provider. Beginning at age three years, all children are referred annually to a dentist regardless of whether a dental problem is detected or suspected. If a Comprehensive Health Care Provider, the examiner has made an annual referral to a dentist regardless of whether a dental problem is detected or suspected. Dental exams are recommended at age 1 year. Referral is required at age 3 years. 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 and follow-up contacts/outreach efforts are documented.	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.

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.

4. Pediatric Preventive Criteria	**Medical Record Reviewer Guidelines – Pediatric Preventive Care**
A. Developmental Screening is completed.	Children are assessed for developmental and behavioral risks. The use of a standardized screening tool is recommended. Indicate the standardized tool the provider uses. Refer to Health Assessment Guidelines for standards.
B. Behavioral Screening is completed.	
C. Vision screening is completed and documented.	Vision screening is completed with results according to CHDP periodicity. Screening for visual problems should occur at each health assessment visit and results should be documented in the record and on the PM 160. Vision screening for infants and children from birth to three years of age consists of a red reflex examination, corneal penlight evaluation, and an external eye inspection. The Health Assessment Guidelines indicates the use of standardized charts, such as HOTV, LEA or equivalent charts, for children age three to five years; Snellen or equivalent charts, for children age six years and older may be used. The method used for visual screening varies depending on the age, maturity, and language development level of the child. CHDP recommends that any child unable to be tested after two attempts or in whom an abnormality is detected be referred for an initial eye evaluation by an optometrist/ophthalmologist experienced in the care of children. Referral to an optometrist or ophthalmologist is provided as appropriate. Refer to Health Assessment Guidelines for standards.
D. Hearing screening is completed and documented.	The American Academy of Pediatrics (AAP) recommends initial newborn hearing screening prior to discharge from the delivery hospital or by approximately one month of age. The CHDP assessment for hearing problems includes non-audiometric screening for infants and children from two months through two years of age. Non-audiometric screening may include an assessment of speech and language development, a family and medical history, parental concerns, physical examination, and use of measured noisemaker or sound generators. Audiometric screening is done on children and young adults from age 3-20 years at each health assessment visit. The screening results are documented in the medical record and on the PM 160. Failed audiometric screenings are followed up with a repeat screening. Children who fail to respond on two screenings separated by an interval of at least two weeks and no later then six weeks after the initial screening should be referred to a specialist and/or California Children's Services (CCS). Refer to Health Assessment Guidelines for standards.
E. Fluoride Use.	It is recommended to prescribe a fluoride supplement if drinking water isnot adequately fluoridated. Fluoride Varnish applications should be offered for children less than 6 years of age, up to 3 times per year, based on the caries risk of the child.
F. CHDP lab work is present. Other testing is completed as indicated. Lead counseling and testing are completed.	Each child has a hemoglobin (Hb) or hematocrit (Hct), and other lab as appropriate for age and according to the CHDP periodicity schedule. Urine dipstick and analysis, glucose and cholesterol screening, pap smears, chlamydia testing, or other sexually transmitted illnesses (STI) testing are performed as indicated. Follow the current lead protocol in the CHDP Health Assessment Guidelines. Follow-up care or referral to specialist is provided as appropriate.
G. TB risk assessment and/or tuberculin skin test is completed.	The TB Risk Assessment Questionnaire is administered at each health assessment visit. The Tuberculin Skin Test (TST) is administered as indicated. The 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.

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4. Pediatric Preventive Criteria (cont)	Medical Record Reviewer Guidelines – Pediatric Preventive Care (cont)
H. Childhood immunizations are up to date. Immunization history and record are present. Immunization log meets VFC requirements.	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: http://www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/appdx-full-e.pdf.) A history of immunizations received and a copy of the current immunization records should be in the paper chart or EMR. The Immunization Log must have the elements required by the Vaccines for Children (VFC) Program.
I. Evidence of Complete Physical Examination is documented, including age-appropriate growth measurements.	Age-appropriate growth measurements are taken and plotted sequentially at each visit according to the CHDP Health Assessment Guidelines. When appropriate for age, each child/client under the age of 2 has a head circumference taken and plotted on a growth chart. Each child/client over the age of 2 has a length/height and weight taken and plotted at each visit. For children over the age of 2, Body Mass Index (BMI) percentile is determined and plotted on the appropriate growth chart. Note: 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 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.
J. Vital signs (TPR, BP) are measured at each visit appropriate for age.	Vital signs (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. Refer to Health Assessment Guidelines for current standards.
K. Initial and periodic health assessments are completed and recorded on a PM 160.	**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. 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 of weight and length/height, and head circumference of infants up to age 24 months; (3) physical examination/body inspection, including screening for sexually transmitted infections (STI's) of sexually active adolescents. Assessments are appropriately recorded on Confidential Screening/Billing Report (PM 160) forms, with identified problems documented in the progress notes. Follow-up care or referral is provided for identified physical health problems as appropriate. **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. In accordance with the recommendation of the AAP, the CHDP program recommends a direct referral to a dentist beginning at one year of age and at least annually thereafter.

	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 referral of nutritionally at-risk children under five years of age to the Women, Infants and Children (WIC) Supplemental Nutrition Program, or for medical nutrition therapy and/or other in-depth nutritional assessment as appropriate. **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. **Developmental Assessment** – refer to Health Assessment Guidelines for standards. List screening tool if used. **Behavioral Assessment** includes an age appropriate and culturally sensitive socio-emotional/behavioral history and screening at each health assessment visit. Integrate information from the health history and physical examination to determine whether the child's development and behavior falls within a normal range according to age group and cultural background. **Tobacco Assessment** – refer to Health Assessment Guidelines for standards.
L. Health assessment results submitted for billing/reporting are consistent with documentation in the medical record.	The findings of the health assessment are recorded in the client's medical record and are reported on the statewide report form known as the Confidential Screening/Billing Report (PM 160). The findings recorded and reported are the same for the date of service. EMR: Copy of PM160 must be scanned into the record.

The following link contains information regarding Federal and State medical record retention policies and regulations:
http://www.thedoctors.com/KnowledgeCenter/PatientSafety/articles/CON_ID_001849