I.	**General Medical Record Documentation**		
1	Name	Name documented? Look to demographic form if info not present use the progress note. If no demographic sheet then utilize other parts of the record	YES/NO Policy 940 Pg 2 A 2 a i
2	Address	Address documented? None or Homeless == YES Look to demographic form if info not present use the progress note. If no demographic sheet then utilize other parts of the record	YES/NO Policy 940 Pg 2 A 2 ii
3	Telephone #		YES/NO Policy 940 Pg 2 A 2 iii Policy 940 pg 14 1 a iii
4	Date of birth	DOB documented? Look to demographic form if info not present use the progress note. If no demographic sheet then utilize other parts of the record	YES/NO Policy 940 Pg 2 A 2 vi
5	Gender	Gender documented? Look to demographic form is info not present use the progress note. If no demographic sheet then utilize other parts of the record	YES/NO Policy 940 pg 2 A 2 v
6	AHCCCS ID#/Insurance Information	AHCCCS ID# or insurance info documented? Scanned insurance card, medical record number, account number, office identifier, etc==YES If information is not present==NO	YES/NO Policy 940 Pg 2 A 2 iv
7	There is documentation of HIPAA Notice of Privacy Practices	Documentation that a HIPAA Notice of Privacy Practices is signed by the mbr or representative? Maybe a separate form, might be part of administrative part of record, may be found outside of the audit review period. Typically is provided to member upon their 1st visit or general consent form Use NA if an established pt. Only look for HIPAA for new pt during review period--does not need to be done annually unless there is a change	YES/NO/NA 45 CFR 160 and subparts A and E of Part 164
8	There is documentation that a Release of information is signed by the member?	Documentation that a Release of information is signed by the mbr or representative? Maybe a separate form, might be part of administrative part of record, may be found outside of the audit review period. Typically is provided to member upon their 1st visit or general consent form Use NA if an established pt. Only look for Release of information for new pt during review period--does not need to be done annually unless there is a change	YES/NO/NA 45 CFR 160 and subparts A and E of Part 164 Policy 940 pg 3 A 2 K I
9	Documentation of discussion related to Advanced Directives and/or Advance Directive in record (18 yrs. & older)	Documentation of discussion related to Advanced Directives and/or Advance Directive in record (18 yrs & older)? May be anywhere throughout the record, may be outside of audit period. Typically discussed with mbr on 1st visit. Surgical consents are NOT acceptable. A provider discussion of Advance Directives with the member in the last year counts. If conversation took place--YES	YES/NO Policy 940 pg 4 A 2 K iii Policy 640
10	Documentation of a Health Care Power of Attorney or documentation authorizing a Health Care Decision Maker	Any documentation that indicates a discussion or identification of a Power of Attorney or a Health Care Decision Maker. May be a separate form, might be part of the administrative part of record, may be found outside of the audit review period. Typically discussed with mbr on 1st visit. Required only if there is a reason, mentally challenged--otherwise is NA	YES/NO/NA Policy 940 pg 4 A 2 k ii
II.	**Chart Structure/Record Maintained**		
11	DOS reviewed had patient name, AHCCCS ID# or Mbr DOB	DOS reviewed had pt name and AHCCCS # or DOB (first pg) or AHCCCS # or DOB on subsequent pages? Progress notes/well visits look for pt identifier in most recent 2 DOS. (Just one Pt identifier is necessary: Name, DOB, AHCCCS#)	YES/NO Policy 940 pg 2 A 2 b
12	DOS reviewed is dated and initialed/signed--dated and initialed but not necessarily signed	DOS reviewed is dated and initialed/signed?	YES/NO Policy 940 pg 3 A 2 g i
13	Supervision is documented, whenever health care assistants or para professionals provide services if applicable (i.e. MA or non collaborative PA)	Supervision is documented, whenever health care assistants or para professionals provide services (NA)? Review notes entered by MA for co-signature of MD or DO==YES If a MA did not provide services ==NA State of Az requires physician to sign supervision of non collaborative PA or MA If provider signs date of service it indicates the intent of the question	YES/NO/NA Policy 940
14	Evidence that diagnostic tests are reviewed, dated or initialed by PCP	If applicable, are diagnostic tests reviewed, dated orC20:D22 initialed by PCP? Look for diagnostic tests (x-rays/procedures) to be initialed==YES If test/procedure not initialed, review the notes from DOS following the date of the report for indication of reviewed==YES If no diagnostic tests in the record=NA If there is evidence that it is an EMR record =YES Tests --need to see a note added about the tests	YES/NO/NA Policy 940 pg 4 #3 iv

15	Evidence that labs are reviewed, dated or initialed by PCP	If applicable, are lab tests reviewed, dated or initialed by PCP? Look for lab tests to be initialed==YES If lab test not initialed, review the notes from DOS following the date of the report for indication of reviewed==YES If no lab tests in the record=NA Labs--need to see a note added about the labs	YES/NO/NA Policy 940 pg 4 #3 iv 1
16	Evidence that consults reports are reviewed, dated or initialed by PCP	Are applicable consults reports reviewed, dated or initialed by PCP? Check for evidence of a review--phone log, note in progress note, etc May be electronically reviewed but should be noted. Review evidenced by initialing/signing the report or by documenting in following progress note==YES If there are no consultations/letters in the record=NA May need to look for additional notes concerning the report. Initials might not be evident on the EMR.	YES/NO/NA Policy 940 pg 4 #3 iv,
17	In the event of a procedure, a signed consent is present.	There is a signed consent present for a procedure that is performed in the PCPs office specific to the procedure Procedures include removal of warts/moles, biopsies, implants, vaccines	YES/NO/NA Policy 320 Q Policy 940 pg 4 A #2 K iii 2
III.	**Medical/Social History/Medical Management** **Review the following for the DOS selected for sample**		
18	Telemedicine visits are clearly identified as such	Any telemedicine visits are clearly identified in the record--YES No telemedicine visits occurred==NA Validate the visit has been identified as visual or audio. If not idenified--NO	YES/NO/NA Policy 940 pg 3 #2 j Policy 320
19	Allergies documented	Allergies documented? If found in any of the examples: Summary page, 1 of the 2 most recent DOS or Well visit==YES Entry of NKDA or allergies-none==YES	YES/NO Policy 940 pg 2 #2 d v
20	Adverse reactions to medication documented?	Adverse reactions medication documented?	YES/NO Policy 940 pg 2 #2 d vi
21	Evidence of an current medication list	There is an current medication list? If found in any of the examples: Summary page, 1 of the 2 most recent DOS or Well visit==YES Statements of "No ongoing meds" or Meds-none"==YES	YES/NO Policy 940 pg 4 #3 a iv 4
22	Family medical history is documented	Family medical history is documented? If found in any of the examples: Summary page, 1 of the 2 most recent DOS or Well visit==YES Documentation of adoption, foster child with unknown family history==YES If under 21 yrs, should also include prenatal care and birth history of the mbr's mother while pregnant with the mbr (if known)	YES/NO Policy 940 pg 4 #3 a i
23	Documentation of Past Medical History	Past medical history is documented? If found in any of the examples: Summary page, 1 of the 2 most recent DOS or Well visit==YES Past surgical history may also be used==YES Includes previous illness or injuries Emergent/Urgent Care received	YES/NO Policy 940 pg 2 A 2 d Policy 430 430 Attachment A 430 Attachment E
24	Documentation of Dental History beginning at 1yr of age	Documentation of dental hx (beginning at 1 yr of age) Any documentation pertaining to dental visits, appts scheduled, dental concerns expressed by parent or guardian==YES Documentation pertaining to dental home (place of treatment) or name of dentist==YES Present in Well child visits for criteria or in one of the most recent 2 DOS in the record==YES If under 1 yr of age==NA If there is no information documented about dental hx==NO	YES/NO/NA Policy 431 430 Attachment E 431 Attachment A
25	Social history is documented	Social history is documented? If found in any of the examples: Summary page, 1 of the 2 most recent DOS or Well visit==YES If there are only sick visits available in record==NA Documentation of past and current activities that are age appropriate and may include: Living arrangement--(does mbr live alone, with spouse or significant other), Type of dwelling (own home, group home, nursing home, assisted living facility), neighborhood safety, access to transportation of medical appts, education level, nutrition and eating habits, sexual history, current and typical daily activities, financial situation, other relevant social factors, employment and/or occupation history, interpersonal and Domestic Violence assessment/screening	YES/NO/NA 430 Attachment E Policy 940 pg4 A #3 a i

26	Smoking/alcohol/drug use history - 11 years & older is documented in DOS reviewed	Smoking/alcohol/drug use history is documented? Documented==YES Negative statements such as Nonsmoker/Alcohol-none/Drugs-none ==YES Not addressed--NO Under the age of 11yrs--NA No credit if only noted in Anticipatory guidance since that is education and not obtaining a hx Use of Adolescent Substance Use Disorder Screening is required for mbrs 12 yrs and older--such as GAP (after age 10) or HEADDSS (starting at age 13)	YES/NO/NA 430 Attachment E Found on Attachment E for the following ages: 9-12yr old, 13-17yr old and 18-21yr old
27	Subjective description—chief complaint is documented in DOS reviewed--reason for visit	Subjective description-chief complaint is documented in DOS reviewed Progress notes within review period include documentation of a hx pertinent to chief complaint at each visit==YES Present in Well visits for criteria or one of the most recent 2 DOS in the record==YES	YES/NO 430 Attachment E
28	Objective description—pertinent exam is documented in DOS reviewed	Objective description -pertinent exam is documented in DOS reviewed? Progress notes within review period include documentation of a hx pertinent to chief complaint at each visit==YES Present in Well visits for criteria or one of the most recent 2 DOS in the record==YES	YES/NO 430 Attachment E
29	Assessment/Diagnosis description is documented in DOS reviewed	Assessment/Diagnosis description is documented in DOS reviewed? Diagnosis is documented for each visit==YES Present in Well visits for criteria or one of the most recent 2 DOS in the record==YES	YES/NO 430 Attachment E
30	Plan of treatment documented in DOS reviewed	Plan of treatment documented in DOS reviewed? May be combined with the assessment as assessment and plan (A&P)==YES Treatment includes tests ordered or referrals==YES If found in any of these examples: 1 of the 2 most recent DOS or Well visit==YES	YES/NO 430 Attachment E
31	There is documentation of follow-up visit time in DOS reviewed	There is documentation of follow up visit time in DOS reviewed? Follow up return visit plan is routinely documented in each visit note or progress note==YES Follow up may be prn or as needed but should be specified==YES If found in any of these examples: 1 of the 2 most recent DOS or Well visit==YES May also include if plan documents follow up for therapy, specialist etc ==YES	YES/NO 430 Attachment E
32	Coordination of care between PCP/specialist/BH in DOS reviewed, if applicable	Care coordination of care between PCP/specialist/BH if applicable? If a consultation was requested, there is a note from consultant or behavioral health provider in the chart or other evidence of communication between the PCP and the specialist or BH ==YES Should be an order and return communication back to PCP. Could be phone call or letter Mbr refused==YES Mbr did not require specialty/BH care==NA Excludes hospital consults and dental referrals. Includes Integrated services Providers of integrated care shall operate as a team that functions as a single-point of whole health treatment and care. Co-location or making referrals without coordinating care through a team approach does not equate to integrated care Make a note if it is an integrated care clinic (record would be in one system) A note from spec or BH should be in the PCP record to indicate communication between them. Should be a note within next 3 visits or so if there is a note the mbr was compliant	YES/NO/NA 430 Attachment E Policy 510 pg1 A, pg 2 D
33	Pt. informed of abnormal results, in DOS reviewed, if applicable includes imaging, screenings, labs,	Pt informed of abnormal imaging results, abnormal screenings or lab results in DOS reviewed, if applicable? Any attempts at communicating abnormal results are acceptable ==YES There were no abnormal diagnostic test results==NA Pt informed of any other abnormal screening on DOS reviewed, if applicable? May be found in telephone calls or notation on the report itself of any contact==YES Attempts at communicating abnormal results are acceptable==YES There are no abnormal screening results==NA Pt informed of abnormal lab results in DOS reviewed, if applicable? Any attempts at communicating abnormal results are acceptable ==YES There were no abnormal diagnostic test results==NA Look first to lab results, if abnormal, look to next DOS to see if documentation of review with patient. May also be found in telephone calls or notation on the report itself of contact.	YES/NO/NA Policy 940 Pg 4 --not specifically listed

34	Documented discussion of availability of family planning services—age 13-20 years for both males & females in DOS reviewed	Documentation of discussion with mbr about the availability of family planning services -ages 13-20 years of age for both males and females? If discussion takes place with mbr or guardian==YES Birth control or IUD==YES Family planning counseling==YES Documentation of a sterilization or refusal ==YES Mbr has had a hysterectomy or vasectomy==YES If discussion about contraceptives takes place with Mbr or guardian==YES The mbr is not of reproductive age-under 13 ==NA No Well Visit has occurred==NA Evidence of preconception counseling performed? Includes discussion regarding healthy lifestyle between pregnancies==YES Mbr refused==YES No mention in record==NO If just noted not sexually active--NO (doesn't cover fp services availability) On EPSDT form under Anticipatory Guidance beginning on the 13-17 year old form and 18-21 yr old form	YES/NO/NA Policy 420 pg 3 #3 430 Attachment E
IV.	**Health Maintenance**		
35	Immunization record is maintained	Immunization record in record? An immunization record is maintained==YES Imm record within the pt chart==YES If imm record is present in record but blank and the parent/guardian has refused immunizations==YES If there is no imm record in the chart==NO	YES/NO Policy 430 pg 5 #8 430 Attachment E 430 Attachment A
36	EPSDT Clinical Sample Templates and complete as of the DOS reviewed (Most recent effective templates) may also be part of an undated EMR)	EPSDT Clinical Sample Template is used and completed on DOS==YES EPSDT visit must be done in the appropriate yr EPSDT form corresponds with mbrs age at the time of the well visit; i.e. 9mth form is used until mbr turns 12mths. Etc. EPSDT may be in a form of a EMR record	YES/NO Policy 430 pg 2 III
37	Evidence of Objective and Subjective Hearing is assessed documented as of DOS reviewed	Documentation may be found in a dated EPSDT form, progress note or consultation report (excluded tympanometry)? Objective/Subjective Hearing is monitored and documented as of DOS reviewed==YES Objective results of actual screening present==YES Documentation evidence of hearing assessment/hearing ability (Subjective)==YES Mbr/parent/guardian refuses service==YES There is documentation in the record that required testing/screening was conducted at the specified ages during the review period==YES Objective screening at (by a standard testing method): At ages NB, 2-6wks(--all newborns should be screened for hearing loss at birth and again 2 to 6 wks. afterward) 4,5,6,8,10,12,15, and 18 yrs Subjective screening at (by history): Look for evidence that provider acknowledges hearing ability (i.e.; not all inclusive: hearing normal, responds to voices, sounds) At ages 3-5 days, 2,4,6,9,12,15,18,24,30mths, 3,7,9,11,13,14,16,17, 19,20yrs	YES/NO/NA Policy 430 pg 7 #13 430 Attachment E 430 Attachment A
38	Evidence of Objective and Subjective Vision is assessed documented as of DOS reviewed	Documentation may be found in a dated EPSDT form, progress note or consultation report? Objective/Subjective Vision is monitored and documented as of DOS reviewed==YES Objective results of actual screening present==YES Documentation of evidence that provider acknowledges vision ability (Subjective)==YES Mbr/parent/guardian refuses services==YES There is documentation in the record that required testing/screening was conducted at the specified ages during the review period==YES Note: 3yr Objective screening--if uncooperative rescreen in 6mths Objective screening (by a standard testing method): At Ages 3,4,5,6,8,10,12, 15,18yrs Subjective screening (by history): At Ages NB, 3-5 days, 1,2,4,6,9,12,15,18,24,30mths, 7,9,11,13,14,16,17,19,20yrs	YES/NO/NA Policy 430 Pg 6 #12 430 Attachment E 430 Attachment E

39	Evidence of Objective and Subjective Speech assessment and documented as of DOS reviewed	Objective/Subjective speech is monitored and documented as of DOS? There is documentation in the record that required testing was conducted at the specified ages during the review period==YES There is documentation that provider acknowledges speech ability (Subjective)==YES Mbr/parent/guardian refuses services==YES Objective screening (by a standard testing method): At ages NB, 2wks, by 1mth, 6wks, 4,5,6,8,10,12,15, and 18 yrs Subjective screening at (by history): At ages 3-5 days, 2,4,6,9,12,15,18,24,30mths, 3,7,9,11,13,14,16,17, 19,20yrs	YES/NO/NA 430 Attachment E 430 Attachment A
40	Vital signs documented -- Includes Temp, heart and resp rate	At each in person visit Vital signs documented? Vital signs other than BP documented==YES Need all of the elements to be counted, otherwise a NO	YES/NO Policy 940 pg 14 I #1 c i, vii 430 Attachment E
41	Blood pressure documented for those age 30 months & older	BP documented? BP is documented for those age 30mth and older==YES At each in person visit Mbr is under age 30 mths==NA	YES/NO/NA Policy 940 pg 14 I #1 c ii 430 Attachment E 430 Attachment A
42	Growth screening is documented in record NB-18 months	Growth screening is documented in record ? A height, weight, and head circumference is recorded==YES Mbr/parent/guardian refuses services==YES Mbr is not appropriate age ==NA includes head occipital-frontal circumference percentile	YES/NO/NA 430 Attachment E 430 Attachment A
43	BMI or Percentile is documented in record ages 2-21 years	BMI value or Percentile is documented in record? BMI or Percentile is documented ==YES Mbr is under age 2==NA	YES/NO/NA Policy 940 pg 14 I #1 c 430 Attachment E 430 Attachment A
44	Appropriate follow up is documented for abnormal BMI	Appropriate follow up is documented for abnormal BMI? Appropriate follow up is documented==YES Use of the appropriate BMI growth chart shared (separate document) to determine if BMI is valid==YES BMI is within normal range==NA Nutritional Guidance handouts, Return appt for weight check, discussion regarding changing lifestyle--limiting screen time, moderate activity for 30 mins/day	YES/NO/NA Policy 430 pg 4 #3 430 Attachment E
45	Nutritional screening is documented on DOS	Nutritional screening is documented? Nutritional screening is documented in record==YES Present in Well child visits for criteria or in one of the most recent 2 DOS in the record==YES	YES/NO Policy 430 pg 4 #3 430 Attachment E 430 Attachment A
46	Pulse Oximetry	At every visit if applicable	YES/NO/NA Policy 940 pg 14 I #1 c viii
47	Inhaled O2	If receiving O2 amount must be recorded	YES/NO/NA Policy 940 pg 14 I #1 c ix
48	Unique Identifier for Implantable Devices (if applicable)		YES/NO/NA Policy 940 pg 14 I #1 c x
49	Oral health screen == A screening is intended to identify gross dental or oral lesions but is not a thorough clinical examination and does not involve making a clinical diagnosis resulting in a treatment plan.	Oral health screen documented? Documented evidence of dental screening beginning at 6mths of age==YES Education on flossing, dental visits, referral to dentist, white spots, cavities==YES Visual exam of oral cavity (Mucous membranes)==YES Documentation of any of the elements found on the EPSDT tracking form under oral health ==YES Documentation of any type of education regarding oral health is provided==YES No documentation regarding any type of oral cavity screening or dental education during well visit or EPSDT visit==NO Mbr/parent/guardian refuses services==YES	YES/NO Policy 430 pg 6 #11 Policy 430 Pg 17 #7 430 Attachment E 430 Attachment A 431 Attachment A Policy 431 pg 1 III
50	Is Dental fluoride varnish applied to those ages 6 months with at least one tooth erupted up to 5 years. May be applied every 3 mths	Dental fluoride varnish applied to those ages 6mths - 5 yrs of age? Dental fluoride varnish applied to those ages 6mths to 5yrs of age or with first teeth==YES Recurrent applications up to 5 yrs of age==YES Mbr/parent/guardian refuses services==YES Pt outside of age range==NA Child within range but has no teeth--NA	YES/NO/NA Policy 430 pg 6 #11 b 430 Attachment E 430 Attachment A 431 Attachment A Policy 431 pg 4 B 2 d i

51	Is there a developmental surveillance documented in the DOS	Documentation of developmental surveillance? Developmental surveillance documented in the DOS reviewed==YES Present in Well child visits for criteria or in one of the most recent 2 DOS in the record==YES On the EPSDT form, well visits, or progress notes	YES/NO 430 Attachment E 430 Attachment A
52	Is there documentation of developmental screening at 9, 18, 30 months as appropriate in DOS reviewed visit Dev screening does not include physical nutritional and BH	Documentation of developmental screening Using a screening tool==YES Mbr/parent/guardian refuses services==YES Pt outside of age range==NA Suggested standardized screening tools can be found in CMS Core Measures Developmental Screening in the first Three Years of Life These include: ASQ-3, PEDS, Battelle Developmental Inventory Screening Tool, Bayley Infant Neuro-Developmental Screen, Brigance Screens II, Child Development Inventory, Infant Development Inventory These are not specific recommendations but were cited in Bright Futures	YES/NO/NA Policy 430 Pg 5 #6 430 Attachment E 430 Attachment A
53	Is there documentation that Autism Spectrum Disorder (ASD) specific developmental screening was done at 18 months and 24 months using the Modified Checklist for Autism in Toddlers (MCHAT-R) or a tool listed in Column C	Documentation that the MCHAT tool was used to screen for Autism if 18mths and 24 mths? MCHAT-R tool used --YES Mbr/parent/guardian refuses services==YES Pt outside of age range==NA Suggested standardized screening tools can be found in CMS Core Measures Developmental Screening in the first Three Years of Life These include: ASQ-3, PEDS, Battelle Developmental Inventory Screening Tool, Bayley Infant Neuro-Developmental Screen, Brigance Screens II, Child Development Inventory, Infant Development Inventory These are not specific recommendations but were cited in Bright Futures	Policy 430 pg 5 #6 f 430 Attachment E 430 Attachment A
54	Is anticipatory guidance documented in DOS reviewed	Anticipatory guidance documented? Anticipatory guidance documented in DOS reviewed==YES Health education/anticipatory guidance documented in a progress note during EPSDT visit==YES Documented in the well visit or one of the most recent 2 DOS in the record==YES Should have more than 1 element covered in the anticipatory guidance.	430 Attachment E Policy 430 Pg 6 #10
55	Is behavioral health screening on DOS reviewed	Behavioral health screening on DOS? BH screening on DOS documented==YES BH screening documented in a progress note during EPSDT visit==YES Present in the well visit or one of the most recent 2 DOS in the record==YES	YES/NO Policy 430 Pg 4 #4 430 Attachment E 430 Attachment A
56	Is blood lead testing completed/ordered at the 12 & 24 month visit documented in the DOS reviewed	Blood lead testing completed or ordered by provider==YES Documentation is present for blood lead testing at any age==YES Mbr/parent/guardian refuses services==YES Pt outside of age range==NA Blood lead testing required at 12 and 24 mths or at any time a risk is identified from 6mths to 6yrs	YES/NO/NA Policy 430 pg 6 #9 b Policy 430 pg 14 E #3 430 Attachment E 430 Attachment A
57	Is verbal lead screening documented in the DOS reviewed.(6mths through 6yrs) per EPSDT Periodicity Schedule	Documentation of a verbal lead screening on DOS from 6mths to 6yrs==YES Documentation is present for verbal screening (age of home, lead paint, etc)==YES Mbr/parent/guardian refuses services==YES Pt outside of age range==NA Mbr at 12 and 24 mths do not require a verbal lead screening==NA	YES/NO/NA Policy 14 E #3 430 Attachment E 430 Attachment A
58	If verbal lead screening indicated a child to be at risk--blood lead level was ordered	A verbal lead screening identifies a child at risk? A verbal lead screening identifies a child to be at risk and a blood lead level was ordered==YES Documentation indicates a blood lead level was ordered ==YES Child over the age of 6yrs==NA Verbal screening was negative--NA Mbr/parent/guardian refuses services==YES	YES/NO/NA Policy 14 E #3 430 Attachment E 430 Attachment A
59	Is HGB/HCT - 12 months or at risk documented in DOS reviewed	An HGB/HCT at 12 mths or at risk--removed all ages Documentation found that a HGB/HCT was ordered or completed==YES Results of either Hgb or HCT documented in record==YES Documentation of order==YES Mbr/parent/guardian refuses services==YES Mbr is not 12mths of age==YES No indication of risk==NA	YES/NO/NA Policy 430 pg 6 #9 A 430 Attachment E
60	Yearly syphilis testing beginning at 15 years of age and older	A test for syphilis is done on all mbrs 15 years of age and older Documentation found that a test for syphilis was ordered=YES Results of syphilis is found in record=YES Mbr/parent/guardian refuses testing=YES Mbr is under the age of 15yrs=NA	YES/NO/NA Policy 430--pg20 9. c

61	Newborn Blood Spot--Initial there evidence that an INITIAL Newborn Bloodspot test was done between 24 hours and 72 hours of birth? If child is more than 12 mos. N/A	Is there evidence that an INITIAL newborn bloodspot test was done between 24hrs and 72 hrs of birth==YES Evidence of initial newborn bloodspot test completed==YES No evidence of test completed==NO Child is more than 12mths of age==NA There should be a lab result, hospital record, phone call of result, documentation in record of result	YES/NO/NA Policy 430 pg 8 #7 430 Attachment E 430 Attachment A
62	Newborn Blood Spot--2nd test--done/ordered within 1st 10 days of life if required. If child is more than 12 mos. N/A	There is evidence of a 2nd newborn bloodspot test was done/ordered within the first 10 days of life, if required? Evidence of 2nd bloodspot test was completed==YES Evidence of INITIAL bloodspot test was normal==YES No results available for INITIAL bloodspot and no evidence of a 2nd test==NO Child is more than 12mths of age==NA 2nd test is required ONLY if the 1st test was abnormal or not known May be found on the EPSDT forms for ages 3-5 days, 1 and 2 mths of age May be found under labs ordered in the record	YES/NO/NA Policy 430 pg 8 #7 430 Attachment E 430 Attachment A
63	Is a TB Test - ages 12 months to 21 years documented in DOS reviewed [if at risk]	A TB test --ages 12mths to 21 yrs documented if at risk== YES Documentation that mbr is not at risk or parent/guardian refuse==YES TB test ordered or performed acceptable==YES Mbr is under 12 mths of age==NA A TB test required for the following risk factors: Confirmed or suspected as having TB, In jail or prison during the last 5yrs, Living in a household with an HIV-infected person or the child is infected with HIV, Traveling or immigrating from or having significant contact with persons indigenous to endemic countries	YES/NO/NA Policy 430 pg 7 #14 430 Attachment E 430 Attachment A
64	CSPMP or PDMP Check on DOS if mbr is prescribed a controlled substance by the PCP	Documentation/evidence that the CSPMP or PDMP has been checked for mbrs that were prescribed a controlled substance? Mbr is prescribed a controlled substance and provider has documented having checked the CSPMP or PDMP or has placed a copy of the CSPMP or PDMP report in the chart==YES Mbr has not been prescribed a controlled substance==NA	YES/NO/NA Policy 940 pg3 A 2 h
65	CSPMP or PDMP Medication adverse interaction-- The PCP is to check the CSPMP or PDMP if the PCP prescribes another medication that is known to adversely interact with controlled substances such as antidepressant, particularly SSRIs and MAOI--	If mbr is receiving controlled substances, documentation/evidence that the CSPMP or PDMP has been checked prior to prescribing a medication that is known to adversely interact with controlled substances Are they being prescribed other sedating medications such as anxiolytics, sedative hypnotics. See list. The CSPMP or PDMP must be check whether the PCP is aware that the member is receiving a controlled substance or not	YES/NO/NA Policy 940 pg 3 A 2 h
V.	**Behavioral Health If applicable**		
66	Routine Requests--Is there documentation that Provider responds to BH providers requests within 10 business days, if applicable, on DOS reviewed	Documentation that Provider responds to BH providers requests within 10 business days, if applicable on DOS==YES Documentation evidence of request and response to BH provider within 10 business days==YES Mbr doesn't not have a BH diagnosis==NA There are no requests for information from BH provider==NA	YES/NO/NA Policy 940 pg 7 #4 d i
67	Urgent Requests--Is there documentation that Provider responds to BH providers requests within 24 hrs	Documentation that Provider responds to BH providers requests within 24hrs, if applicable on DOS==YES Documentation evidence of request and response to BH provider within 24hrs==YES Mbr doesn't not have a BH diagnosis==NA There are no requests for information from BH provider==NA	YES/NO/NA Policy 940 pg 7--can't find it specifically listed
68	PCP within their scope of practice, evaluates and/or treats,patient for ADHD, as appropriate, on DOS reviewed using a standardized tool	PCP evaluates and/or treats, pt for ADHD ==YES Mbr does not have ADHD diagnosis==NA Example of standardized tool: NICHI Vanderbilt Assessment Scales	YES/NO/NA Policy 910 pg 6 bb iv Policy 430 Pg 18 #10 430 Attachment E
69	PCP within their scope of practice evaluates and/or treats, patient for depression, as appropriate, on DOS reviewed using a standardized tool	PCP evaluates and/or treats pt for depression ==YES Mbr does not have depression diagnosis==NA Example of standardized tool: PHQ-9	YES/NO/NA Policy 910 pg 6 bb iv Policy 430 Pg 18 #10 Policy 430 pg 4 #4 430 Attachment E
70	PCP within their scope of practice evaluates and/or treats patient for anxiety, as appropriate, on DOS reviewed using a standardized tool	PCP evaluates and/or treats pt for Anxiety ==YES Mbr does not have anxiety diagnosis==NA Example of standardized tool: GAD	YES/NO/NA Policy 910 pg 6 bb iv Policy 430 Pg 4 #4 430 Attachment E

71	PCP updates BH provider when changes to medication and/or diagnosis occur, on DOS reviewed	PCP updates BH provider when changes to meds and/or diagnosis occur==YES BH provided with an update on conditions and/or medications==YES Mbr does not have BH diagnosis==NA No indication in record that BH provider is part of care ==NA	YES/NO/NA Policy 940 pg 3 #2 i Policy 430 Pg 12 #28
72	Documentation of BH referrals for conditions including ADHD, depression or anxiety, as appropriate, on DOS reviewed	Documentation of BH referrals for conditions including ADHD, depression, or anxiety as appropriate==YES If applicable BH referrals and services provided are present==YES Mbr does not have BH diagnosis==NA No indication in record that BH provider is part of care ==NA	YES/NO/NA 430 Attachment E
73	If PCP is treating member with medications for (ADHD, Depression or anxiety); there is a completed annual assessment of members health condition and treatment plan, as appropriate, on DOS reviewed	PCP is treating mbr with medications for ADHD, depression or anxiety; there is a completed annual assessment of mbrs health condition and treatment plan as appropriate==YES Annual assessment completed==YES PCP is using a screening tool for the annual assessment =YES Plan of treatment is present in progress notes==YES PCP is not treating mbr for any of these conditions==NA	YES/NO/NA Policy 320
74	For PCPs prescribing medication to treat Opioid Use Disorder (OUD) there is evidence of a BH referral	The PCP refers the mbr to BH provider for psychological and/or behavioral therapy component of the Medication Assisted Treatment (MAT) model==YES Mbr is not receiving treatment for OUD==NA	YES/NO/NA Policy 910 pg 6 bb v
75	During the 1, 2, 4 and 6 mth EPSDT visit a Postpartum depression screening consisting of a standard norm-criterion referenced screening tool is performed for screening the birthing parent for signs and symptoms of postpartum depression	Positive screening results require referrals to appropriate case managers and services at the health plan YES==screening completed and referrals made if necessary NO== +Screening completed and referrals were not made NA==An EPSDT visits that is not the 1, 2, 4 or 6mth visit or birthing parent refused to answer	YES/NO/NA Policy 430 pg 4 #4 c i
76	Beginning at 10 years of age, an Adolescent Suicide screening consisting of a standardized, norm-referenced screening tool specific for suicide and depression shall be performed during the EPSDT visit	A Positive screening result will require appropriate BH referral for further evaluation and service provisions YES--screening completed and referrals made if necessary NO--+ screening but referrals were not made NA--EPSDT visits prior to 10 years of age or parent/guardian refused	YES/NO/NA Policy 430 pg 5 c ii
77	Adolescent Drug/Substance Use Disorder Screening	Screening should consist of a standard, criterion-reference screening tool specific for substance use. Positive screening results require appropriate and timely referral to BH for further evaluation and service provision Screening beginning at age 12 If under age 12 ==NA Use of Adolescent Substance Use Disorder Screening is required for mbrs 12 yrs and older--such as GAP (after age 10) or HEADDSS (starting at age 13)	YES/NO/NA 430 Attachment A
78	If clinically indicated (based on severity of behavioral health needs or other significant medical needs) the PCP ensures transfer of care	There is evidence/documentation in the record that indicates prior to first scheduled appt, all relevant member medical information including the reason for transfer and current medications, were provided to the BH or specialist providers. PCP has ensured member has adequate prescribed medication to get to their initial BH or specialist provider appointment	YES/NO/NA Policy 510 pg 3 #6
79	There is documentation of a consent for coordination of care with patient's substance abuse disorder (SUD) treatment provider is in place	For patients with SUD, evidence of member consent for Coordination of Care with patient's SUD treatment provider is in place. Documentation that a SUD coord of care specific, Release of information document I signed by the mbr or representative? May be a separate form, might be part of administrative part of record, ma be found outside of the audit review period. Typically is provided to mbr upon their 1st visit or general consent form	YES/NO/NA 45 CFR 160 and subparts A and E of Part 164
80	If member has SUD/MAT treatment provider, there is evidence in the documentation of the PCP coordinating care with identified provider(s)	Evidence the PCP is/has coordinated care with the SUD/MAT treatment provider(s)	YES/NO/NA
81	Evidence/documentation that the PCP is utilizing a	If there is an identified need in regard to trauma, behavioral health or social determination, look	YES/NO/NA