

Field Name	Column Name	Description
1	Each entry is legible to the reviewer.	<p>All entries and documentation within the medical record must be legible to the reviewer. If the documentation cannot be clearly understood because it not legible or the entire entry is not legible, then the indicator is “No”. The provider must maintain legible, accurate, and complete charts and records in order to support and justify the services provided. <i>Chart</i> means a summary of essential medical information on an individual patient. <i>Record</i> means dated reports supporting claims submitted to the Division for services provided in an office, hospital, outpatient, or other place of service. Records of service shall be entered in chronological order by the practitioner who rendered the service. Records shall be legible and shall include but not be limited to: 1. Date(s) of service 2. Patient's name and date of birth 3. Name and title of person performing the service 4. Pertinent medical history 5. Pertinent findings on examination 6. Medications, equipment or supplies prescribed or provided 7. Recommendations for additional treatment, procedures, or consultations 8. Tests and results 9. Plan of treatment, care and outcome 10. The original handwritten personal signature, initial or electronic signature of the person performing the service must be on the patient's medical records. This includes but is not limited to progress notes, lab reports for each date of services billed. NOTE: Electronic signature is defined as "an electronic or digital method executed or adopted by a party with the intent to be bound by or to authenticate a record, which is unique to the person using it, is capable of verification, is under the sole control of the person using it, and is linked to the data in such a manner that if the data are changed the signature is invalidated." O.C.G.A. 10-12-3. (1) (1997) 11. All medical records must be written in Standard English Language. Records must be available to DMA or its agents and to the U.S. Department of Health and Human Services upon request. Documentation must be timely, complete, and consistent with the by-laws and medical policies of the office or facility where the service are provided. All medical records must be written in Standard English Language. Records must be available to DMA or its agents and to the U.S. Department of Health and Human Services upon request. Documentation must be timely, complete, and consistent with the by-laws and medical policies of the office or facility where the services are provided.</p>
2	H&P and Developmental History are updated	<p>The history may be obtained from the parent or guardian or through a form or checklist sent to the parent for completion. History must contain, but is not limited to: 1. Present health status and past health history of member; 2. developmental information; 3. allergies and immunization history; 4. family history; 5. dietary history; and 6. risk assessment of lead exposure. Documentation: Once the health history is recorded in the medical record, only an update is required for subsequent visits.</p>

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3	Allergies and adverse reactions to medications are prominently displayed	The patient's allergies to medications and any adverse reactions must be conspicuously (in an obvious location) listed in the ambulatory medical record or on the front or inside cover of the medical record folder I would pick one spot, inside of the cover in red ink! I wouldn't put anything on the front cover, but I would make it obvious inside the folder. Or, if the allergies and adverse reactions to medications are absent, "No known allergies" "NKA" or "NA" or "none" is documented in the ambulatory medical record inconspicuously or on the front or on the front inside cover of the medical records. You should not have to hunt for this information
4	Growth: Measured, Plotted on Graph and documented in progress notes	The <i>head circumference</i> should be measured with a metal or plastic tape measure. This measurement should be routinely taken at each visit during the first two (2) years of life. If the measurement assessment indicates a low head circumference (<10% hc/age) or a high head circumference (> 95% hc/age), further evaluation, treatment or parent counseling is necessary. The <i>weight</i> should be measured at all ages with the child nude or wearing an examination gown. The <i>height</i> for infants up to two (2) years should be measured as recumbent length using a properly constructed measuring device. Height measurements for children two (2) years and over should be accomplished using a vertical measuring board or fixed wall device, with a non-flexible headboard. Measuring devices attached to scales are not accurate and should not be used. Measurement should be taken at each visit. The Centers for Disease Control and Prevention and the National Center for Health Statistics Growth Charts and BMI for age charts are available at the following website: www.cdc.gov/growthcharts .
5	BMI documented in medical record	The BMI (<i>Body Mass Index</i>) should be calculated (2-20 years of age) using the formula: English Formula [Weight in pounds ÷ Height in inches ÷ Height in inches] x 703 Metric Formula [Weight in kilograms ÷ Height in cm ÷ Height in cm] x 10,000 If the measurement assessments indicate overweight (> 95% BMI for age), at risk for overweight (85-95% BMI for age), underweight (< 5% BMI) or low height for age (< 5% ht/age), further evaluation, treatment or parent counseling is necessary. The Centers for Disease Control and Prevention and the National Center for Health Statistics Growth Charts and BMI for age charts are available at the following website: www.cdc.gov/growthcharts . Please see Appendix O for additional information on BMI and weight.
6	Vision: Measurement and Method documented in chart (referral if applicable)	All children should have an eye exam by ophthalmoscope. In addition, all children should have additional vision testing which is age appropriate. The Vision Exam may include but not be limited to the following: Exam for ocular motility, fixation test, Hirschberg test, cover test, red reflex, light reflex, Snellen chart, broken wheel and Titmus. Documentation: Documentation of examinations performed and results (pass/fail).

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7	Hearing: Measurement and Method documented in chart (referral if applicable).	<p>Hearing testing for infants and young children up to the age of four (4) should be accomplished using Denver noise makers, speech, etc.</p> <p>Hearing measurement after the age of four (4) should be done with a screening audiometer, screening for each ear using the audiometric pure tones 500 Hz, 1000 Hz, 2000 Hz, 4000 Hz, 25 db with pass-fail results. Documentation: Documentation of examinations performed and results (Pass – Fail).</p>
8	Referral/Treatment noted between the PCP and Specialist	All suspicious or abnormal findings identified during a Health Check (EPSDT) screen must be treated or be further evaluated. For non-GBHC members, the screening provider must either treat (if qualified) or refer all members with abnormal findings. For GBHC members, all services (except immunizations, TB, lead, interperiodic Health Check (EPSDT) screen, interperiodic vision, and interperiodic hearing) must be referred by their GBHC primary care provider (PCP). Health Check (EPSDT) providers must contact the GBHC provider to discuss any clinical findings which require prompt medical attention. Other findings requiring routine follow-up must be referred back to the GBHC provider.
9	Follow-Up for Abnormal Values documented in chart	All suspicious or abnormal findings identified during a Health Check (EPSDT) screen must be treated or be further evaluated. For non-GBHC members, the screening provider must either treat (if qualified) or refer all members with abnormal findings. For GBHC members, all services (except immunizations, TB, lead, interperiodic Health Check (EPSDT) screen, interperiodic vision, and interperiodic hearing) must be referred by their GBHC primary care provider (PCP). Health Check (EPSDT) providers must contact the GBHC provider to discuss any clinical findings which require prompt medical attention. Other findings requiring routine follow-up must be referred back to the GBHC provider.
10	Developmental/Behavioral Assessment documented in the chart	Developmental/Behavioral screening should be by screen, history and appropriate physical examination. Developmental/Behavioral surveillance is performed at each Health Check (EPSDT) exam, and is not a separate service. Documentation: Screening, history and physical findings must be documented in the medical record. Include type/name of tool used for assessment.
11	Appropriate Unclothed Physical exam documented in the record	The physical examination must be performed with the child unclothed but suitable draped. A complete physical examination and inspection must be completed, including an examination of the heart with a stethoscope. Documentation: Findings must be documented in the medical record. A checklist type form with normal/abnormal may be utilized for recording. However, abnormal findings must be documented
12	Immunizations Status completed for age (4:3:1 documented in chart for 0 – 35 months old)	Immunizations (4:3:1= 4 DTaP and/or DTaP/Hep B/IPV and/or DTP and/or DT , 3 IPV and/or DtaP/Hep B/IPV and/or OPV , and 1 MMR) have been documented in the designated section (VAR: Vaccine Administration Record), in the progress notes or there is a statement that the immunizations are up-to-date. This indicator applies to pediatric members ages birth to 2 years for the Health Check (EPSDT) program
13	Tuberculin Risk Assessment completed and documented	The TB Risk Assessment Questionnaire (see Appendix A) should be completed beginning at birth (sequence 0) and at each screening thereafter, in order to determine risk. For detailed information see Core Curriculum on Tuberculosis: What the Clinician Should Know, Fourth Edition, 2000, U.S. Department of Health and Human Services, Public Health Services.

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14	Tuberculin test completed and documented	TB skin test results should be read and documented by a health professional. Any child with a positive skin test should be referred to the Health Department. LTBI (Latent Tuberculosis Infection) in children less than five years should be reported to the local health department (if no one can be reached at the local health department, then call the state TB program at 404-657-2634).
15	Hemoglobin and/or Hematocrit Test documented	A hematocrit or hemoglobin must be performed at least once during each time period. The suggested ages are 9 months, 2 years, 8 years and 18 years of age. Performances of additional tests are left to the individual practitioner. If the clinical or laboratory assessment reveals an iron deficiency anemia, further evaluation, treatment or parent counseling is necessary. Documentation: Test results as well as any further evaluation, treatment or counseling must be documented in the medical record
16	Lead Blood Screening documented at 12 and 24 months of age	Since 1989, Federal law has required that children enrolled in Medicaid must have their blood lead measured at 12 and 24 months of age . For the 12-month screening, the acceptable range of testing is from 9 - 15 months of age. For the 24-month screening, the acceptable range of testing is from 18-35 months of age. Despite the availability of these ranges, lead screenings should be done as close as possible to 12 and 24 months of age
17	Health education and counseling is noted	Anticipatory guidance and health education are an integral part of the screening and must be provided by the professional. Age appropriate topics/information must be presented during each screen. Providers may use oral and written information. Documentation: Specific topics discussed or written information distributed must be age appropriate and recorded in the medical record. It is mandatory that these services be documented
18	Required Equipment and Required Location Where Services Are to be Provided	In addition to an examination table and routine supplies, providers must have the following equipment to perform portions of the Health Check Screen: A. Scale for weighing infants; B. Scale for weighing other children; C. Measuring board or device for measuring length or height in the recumbent position for infants and children up to the age of two (2); D. Measuring board or device for measuring height in the vertical position for children who are over two (2) years old; E. Blood pressure apparatus with infant, child and adult cuffs; F. Screening audiometer; G. Centrifuge or other device for measuring hemocrit or hemoglobin; H. Eye charts appropriate for age of the child; I. Developmental/Behavioral test supplies; and J. Ophthalmoscope-otoscope.