

Child Health and Disability Prevention (CHDP) Program MEDICAL RECORD REVIEW TOOL SCORING INSTRUCTIONS AND REVIEWER GUIDELINES

General Guidelines for Review of a Medical Record

- All sites, including mobile vans, satellite centers, and school-based clinics, must be reviewed using the Medical Record Review Tool (DHS 4492) in conjunction with the CHDP Facility Review Tool (DHS 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 be used for more than one provider. List each provider's name and initials on page 3, and write the provider's initials under the appropriate medical record number.

Directions for Scoring

A total of eight items are scored for every record reviewed. Every item is weighted.

15 items weighted 1 = possible points = 15
 35 items weighted 2 = possible points = 70
 Total possible points = 85 (per record reviewed)

- Review a minimum of **five** randomly selected medical records.
- Score full weighted points (1 or 2 as designated) for each criterion that is met. Do not score partial points for any criterion.
- Score zero points if criterion is not met.
- 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 2 as designated) for that criterion.
- 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 (85 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
One Record	75	85	75 divided by 85 x 100 = 88%
Five Records	275	425	282 divided by 425 x 100 = 65%

- Round percentages to the next smaller percentage for .1–.5, or to the next larger percentage for .6–.9. For example, the above percentage for five records was 64.8%, would be reported as 65%.
- Determine the degree of successful completion by the Business Entity for the Medical Record Review using the following thresholds:
 FULL APPROVAL = 85% through 100% CONDITIONAL APPROVAL = 70% through 84% NOT APPROVED = less than 70%

Child Health and Disability Prevention (CHDP) Program MEDICAL RECORD REVIEW TOOL

Provider name(s): (1) _____ (2) _____ Contact name: _____
 (3) _____ (4) _____ Reviewer name: _____
 Provider address: _____ Date: _____

Criteria met: Give full points. Criteria not met: 0 points Criteria not applicable: N/A (Give full points.)		Medical Record	Medical Record	Medical Record	Medical Record	Medical Record	Score	
		Provider Initials						X
		Child/Youth ID Number						X
		Age/Gender						X
1. Format Criteria	Points							
A. An individual medical record is established for each child/youth.	2							
B. Child/youth identification is on each page.	1							
C. Individual personal biographical information is documented.	1							
D. Emergency contact is identified.	1							
E. Each medical record is consistently organized.	1							
F. Chart contents are securely fastened.	1							
G. Each child/youth has a primary care physician identified.	1							
H. A consent form is signed and in the chart.	1							
I. Each medical record has documentation that the child/youth has received a copy of the office's/clinic's notice of privacy practices.	1							

Criteria met: Give full points. Criteria not met: 0 points Criteria not applicable: N/A (Give full points.)		Medical Record	Medical Record	Medical Record	Medical Record	Medical Record	Score	
		Provider Initials						
		Child/Youth ID Number						
		Age/Gender						
2. Documentation Criteria		Points						
A. Allergies and adverse reactions are prominently noted.	2							
B. Health-related conditions are identified (e.g., problem list).	1							
C. Current continuous medications are listed.	1							
D. Signed release of medical information is present when appropriate.	1							
E. Abnormal reports are reviewed and documented.	2							
F. Immunization history and record are present.	2							
G. Errors are corrected according to medical documentation standards.	1							
H. All entries are signed, cosigned if applicable, dated, and legible.	1							

Criteria met: Give full points. Criteria not met: 0 points Criteria not applicable: N/A (Give full points.)		Medical Record	Score				
	Provider Initials						X
	Child/Youth ID Number						X
	Age/Gender						X
3. Coordination and Continuity of Care Criteria	Points						
A. Health history and initial/periodic review of systems are documented.	2						
B. Evidence of age-appropriate exams is documented.	2						
C. Treatment plans are consistent with diagnoses.	2						
D. Instructions for child/youth and/or primary caregiver for follow-up care are documented.	2						
E. Unresolved and/or continuing problems are addressed and documented at the time of the subsequent visit.	2						
F. Consultation, referral, diagnostic test results, and diagnostic reports have explicit notation in the medical record.	2						
G. Abnormal test results/diagnostic reports and discussion with parent(s), legal guardian, and/or child/youth have explicit notation in the medical record.	2						
H. Missed appointments and follow-up contacts/outreach efforts are documented.	2						

Criteria met: Give full points. Criteria not met: 0 points Criteria not applicable: N/A (Give full points.)		Medical Record	Medical Record	Medical Record	Medical Record	Medical Record	Score	
		Provider Initials						
		Child/Youth ID Number						
		Age/Gender						
4. Pediatric Preventive Criteria		Points						
According to CHDP periodicity, the following must be documented in the medical record:								
A. Initial and Periodic Health Assessments are completed.								
1. Nutritional assessment.		2						
2. Dental assessment.		2						
3. Health education/anticipatory guidance.		2						
4. Developmental assessment.		2						
5. Tobacco assessment.		2						
B. Age-appropriate history and physical exams are current.		2						
C. Vision screening (Snellen test or equivalent) is completed.		2						

Criteria met: Give full points. Criteria not met: 0 points Criteria not applicable: N/A (Give full points.)		Medical Record	Medical Record	Medical Record	Medical Record	Medical Record	Score	
		Provider Initials						
		Child/Youth ID Number						
		Age/Gender						
4. Pediatric Preventive Criteria (continued)	Points							
D. Hearing screening (nonaudiometric and/or audiometric test) is completed.	2							
E. CHDP lab work is present.								
1. Hgb/Hct.	2							
2. Urine/dipstick.	2							
3. Other.	2							
F. Lead counseling and testing are completed.	2							
G. TB risk assessment and/or tuberculin skin test (Mantoux) is completed.	2							
H. Childhood Immunizations (IZs):								
1. Immunization summary page is present and includes consolidation of IZs from other sources.	2							
2. IZs were given by this provider when due (at the time of the visit).	2							
3. For each vaccine, the administration site, manufacturer, and lot number are recorded in the medical record.	1							
4. For each vaccine, receipt of the Vaccine Information Statement (VIS) is documented.	1							

Criteria met: Give full points. Criteria not met: 0 points Criteria not applicable: N/A (Give full points.)		Medical Record	Medical Record	Medical Record	Medical Record	Medical Record	Score	
		Provider Initials						
		Child/Youth ID Number						
		Age/Gender						
4. Pediatric Preventive Criteria (continued)		Points						
I. Other testing is completed as appropriate for age, such as Pap, STD testing.	2							
J. 1. If Health Assessment Only Provider, referred child/youth to a medical and dental home. Or 2. If Comprehensive Health Provider, referred child/youth to a dental home.	2							
K. Age-appropriate growth measurements are taken and plotted at each visit.	2							
1. Head Circumference.	2							
2. Body Mass Index (BMI).	2							
3. Weight.	2							
4. Length/Height (recumbent length/standing height).	2							
L. Blood pressure is measured at each visit as appropriate for age.	2							
M. Health assessment results submitted for billing/reporting concur with documentation in the medical record.	2							

**Child Health and Disability Prevention (CHDP) Program
MEDICAL RECORD REVIEW SCORING SUMMARY SHEET**

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.

Medical Record Criteria	Total Points Given	Maximum Points Possible		
		Total Records Reviewed	For Each Record Reviewed	For All Records Reviewed
1. Format			10	
2. Documentation			11	
3. Coordination and Continuity of Care			16	
4. Pediatric Preventive Care			48	
Total Score		X	85	

Approval Status: Full approval (85% through 100%) Conditional Approval (70% through 84%) Not approved (less than 70%)