

Appendix VII — Preventive Care

Appendix VII-A — Preventive Care Standards and Required Documentation

Preventive Care Service	Standard	Required Documentation
<p>Childhood and Adolescent Immunizations</p>	<p>Complete immunizations on or before the child's 2nd birthday: 4 – DTaP/DTP 3 – IPV 3 – Hib 3 – Hep B 4 – PCV 1 – MMR 1 – VZV 2 or 3 – Rotavirus 1 – Hep A 2 – Influenza</p> <p>Complete immunizations on or before child's 13th birthday: 1 – MCV4 or MPSV4 (on or between 11th and 13th birthdays)</p> <p>1 – Tdap or Td (on or between 10th and 13th birthdays)</p> <p>Complete immunizations on or between the female adolescent's 9th and 13th birthdays: 3 – HPV vaccinations</p>	<p>When information is obtained from the patient's history, the medical record documentation must include:</p> <ul style="list-style-type: none"> • Dated immunization history OR note indicating name of specific antigen and date of immunization <p>When entries are made at the time of the immunization, documentation must include:</p> <ul style="list-style-type: none"> • Name of specific antigen • Date of immunization(s) <p>A certificate of immunization from an authorized provider or agency must include:</p> <ul style="list-style-type: none"> • Specific date of immunization(s) • Type of immunization(s) given <p>All entries must be dated by the child's 2nd birthday. A note that the patient is up-to-date with all immunizations is not sufficient documentation.</p>
<p>Lead Screening</p>	<p>All children should have at least one lead capillary or venous blood test on or before the child's second birthday.</p>	<p>Any medical record documentation, including lab slips, must include all of the following:</p> <ul style="list-style-type: none"> • Child's name • Child's date of birth (age is not sufficient) • Date blood test was performed • Result of test <p>Results of erythrocyte protoporphyrin testing are unacceptable.</p>
<p>Well-Child Visits in the 1st 15 Months of Life</p>	<p>Patients who turned 15 months during the reporting year should have at least six (6) well-child visits conducted during the first 15</p>	<p>Documentation must include a note indicating a visit with a PCP, the date on which the well-child visit occurred, and evidence of all the</p>

	months of life.	following: <ul style="list-style-type: none"> • A health history • A physical developmental history • A mental developmental history • A physical exam • Health education/anticipatory guidance
Well-Child Visits in the 3rd, 4th, 5th, and 6th Year of Life	At least one (1) well-child visit with a PCP during the measurement year for all patients who were 3–6 years of age as of December 31 st of the measurement year.	Documentation must include: A note by the PCP <ul style="list-style-type: none"> • Date of the well-child visit • Health history • A physical developmental history • A mental developmental history • A physical exam • Health education/anticipatory guidance

Adolescent Well-Care Visits	At least one (1) comprehensive well-care visit with a PCP or OB/GYN for all patients 12–21 years old by December 31 st of measurement year.	Documentation must include: <ul style="list-style-type: none"> • A note by the PCP or OB/GYN • Date of the well-care visit • A health history • A physical developmental history • A mental developmental history • A physical exam • Health education/anticipatory guidance
Adolescent Screening & Counseling	Adolescents 12–17 years old who receive comprehensive well-care visit with a PCP or OB/GYN should have the following seven components of preventive care during the measurement year: <ol style="list-style-type: none"> 1. BMI screening/percentile 2. Nutrition 3. Physical activity/exercise 4. Sexual activity & preventive actions 5. Depression 6. Risks of tobacco usage 7. Risks of substance abuse (including alcohol and drugs) 	Documentation in the medical record must include: <ul style="list-style-type: none"> • BMI calculation/percentile or graph (BMI percentile is required for 3–15 years old; BMI value is acceptable for 16–17 years old) • Notation of assessment, counseling, or education on both nutrition & exercise • Notation of assessment, counseling, or education on physical activity/exercise • Notation of assessment, counseling, or education on preventive actions and risk behaviors associated with sexual activity • Notation of an assessment for depression • Notation of assessment,

		<p>counseling, or education about the risks of tobacco use</p> <ul style="list-style-type: none"> • Notation of assessment, counseling, or education about the risks of substance abuse (including alcohol and drugs)
Weight Assessment and Counseling for Nutrition & Physical Activity for Children and Adolescents	<p>Children 3–17 years old who had an outpatient visit with a PCP or OB/GYN should have evidence of the following:</p> <ol style="list-style-type: none"> 1. BMI screening/percentile 2. Nutrition counseling 3. Physical activity counseling 	<p>Documentation in the medical record must include:</p> <ul style="list-style-type: none"> • BMI percentile documentation (BMI percentile is required for 3–15 years old; BMI value is acceptable for 16–17 years old) • Notation of counseling on nutrition • Notation of counseling on physical activity
Annual Dental Visit	<p>Children 2-21 years of age should have at least one dental visit during the measurement year 2.</p>	<p>Documentation in the medical record must include:</p> <ul style="list-style-type: none"> • Oral health risk assessments to identify known risk factors
Appropriate Testing for Children with Pharyngitis	<p>For children 2–18 years of age, a strep test/throat culture should be performed when a diagnosis of pharyngitis is made and antibiotics are prescribed.</p>	<p>Documentation in the medical record must include:</p> <ul style="list-style-type: none"> • Date the strep test/throat culture was performed and the result • Additional diagnosis (if any) during the same date of service
Appropriate Treatment for URI	<p>Antibiotics should not be prescribed for patients aged 3 months to 18 years with a diagnosis of URI.</p>	<p>Documentation in the medical record must include additional diagnosis (if any) during the same date of service</p>
Follow-Up Care for Children Prescribed ADHD Medication	<p>Children 6–12 years old who are prescribed ADHD medications should have at least 3 outpatient follow-up visits after the initial prescription:</p> <ol style="list-style-type: none"> 1. 1 follow-up visit within 30 days 2. 2 follow-up visits within 2 to 9 months after the initial prescription (one can be a telephone visit) 	<p>Documentation in the medical record must include the date on which the follow-up care occurred</p>
Follow-up after Hospitalization for Mental Illness	<p>Patients 6 years of age and older who were hospitalized during the year for mental health disorders should have follow-up visits by a mental health provider within 7 and 30 days of hospital discharge.</p>	<p>Documentation in the medical record must include:</p> <ul style="list-style-type: none"> • Date of follow-up visit • Documentation that visit was with a mental health provider
Adult BMI Assessment	<p>Patients 18–74 years old who had</p>	<p>Documentation in the medical</p>

	an outpatient visit should have evidence of BMI screening performed	record must include the BMI value and weight for members 18 years and older
Prenatal and Postpartum Care	<p>Prenatal Care: initial visit must be within first trimester</p> <p>Frequency of Prenatal Care: Every 4 wks during first 28 wks of pregnancy, every 2–3 wks until 36th wk of pregnancy, then every wk until birth. ACOG guidelines recommend 14 prenatal visits for a 40-wk gestation.</p> <p>Postpartum Care must occur between 21–56 days (3–8 wks) after delivery.</p>	Documentation in the medical record must include a note indicating the date on which the prenatal or postpartum visit occurred
Chlamydia Screening in Women	Sexually active women age 16–24 years old should be screened for chlamydia once a year.	<p>Medical record documentation must include both:</p> <ul style="list-style-type: none"> • Date the test was performed • Result of test
Cervical Cancer Screening	<p>For women age 21–64 years – 1 or more cervical cytology tests at least once every 3 years.</p> <p>For women age 30–64 years of age – 1 or more cervical cytology and HPV co-testing at least once every five years.</p>	<p>Medical record documentation must include both:</p> <ul style="list-style-type: none"> • Date cervical cytology and HPV test were performed • Result of test(s)
Breast Cancer Screening	Women age 50–74 should have a mammogram at least once every two years.	<p>Medical record documentation must include both:</p> <ul style="list-style-type: none"> • Date the mammogram was performed • Results of procedure
Colorectal Screening	<p>Patients age 50–75 should have 1 or more screening(s) done:</p> <ol style="list-style-type: none"> 1. Fecal occult blood (FOB) in the year 2. Flexible sigmoidoscopy in the last 5 years 3. Colonoscopy in the last 10 years 	<p>Documentation in the medical record must include both:</p> <ul style="list-style-type: none"> • A note indicating the date the colorectal cancer screening was performed; and • The results or finding
Comprehensive Diabetes Care	<p>For patients age 18–75 with diabetes:</p> <ol style="list-style-type: none"> 1. 1 or more HbA1c test(s) in the year. Result should be < 7 % 2. A screening for diabetic retinal disease in the year for members with diabetic retinopathy and every 2 years for members without diabetic retinopathy by an 	<p>Medical record documentation must include all of the following:</p> <ul style="list-style-type: none"> • Note that the HbA1c, nephropathy screening, dilated retinal eye exam, and BP check were performed • Date performed • Result of the test

	<p>optometrist or ophthalmologist</p> <p>3. Annual nephropathy screening</p> <p>a. Therapy with ACE inhibitor/ARB</p> <p>b. A test for microalbuminuria or documentation of existing macroalbuminuria or nephropathy</p> <p>4. Blood pressure control (< 140/90 mm/Hg)</p>	
Controlling High Blood Pressure	<p>Document BP reading every visit for patients 18 years old and over. BP reading is considered controlled:</p> <ul style="list-style-type: none"> • 18-59 years old whose BP was <140/90 mm Hg. • 60-85 years of age with a diagnosis of diabetes whose BP was <140/90 mm Hg. • 60-85 years of age without a diagnosis of diabetes whose BP <150/90 	<p>Documentation in the medical record must include both:</p> <ul style="list-style-type: none"> • Date the visit occurred • BP reading
Avoidance of Antibiotic in Acute Bronchitis	<p>Antibiotics should not be prescribed for patients ages 18–64 years with a diagnosis of acute bronchitis.</p>	<p>Documentation in the medical record must include additional diagnosis or comorbidities (if any) during the same date of service</p>
Antidepressant Medication Management	<p>Patients 18 years of age and older with a diagnosis of major depression must remain on medication for a minimum of 84 days and optimally at least 180 days.</p>	<p>Documentation in the medical record must include both:</p> <ul style="list-style-type: none"> • Date of follow-up visit to a mental health provider • Name and dose of the prescribed antidepressant
Care for Older Adults	<p>Patients 65 years old and older should receive the following:</p> <ol style="list-style-type: none"> 1. Advance care planning 2. Medication review 3. Functional status assessment 4. Pain assessment 	<p>Documentation in the medical record must include evidence of:</p> <ul style="list-style-type: none"> • Advance care planning • Medication list and review • Functional status assessment • Pain assessment
Medication Reconciliation	<p>Patients 65 years old and older should have medication reconciled within 30 days of discharge.</p>	<p>Documentation in the medical record must include medications prescribed at discharge or a notation that no medications were prescribed.</p>
Influenza Vaccine	<p>Patients 18 years of age and over or those with chronic illnesses or weak immune systems should receive an annual flu vaccine during the months of July to December.</p>	<p>Medical record documentation must include both:</p> <ul style="list-style-type: none"> • Date of administration • Specific antigen OR documentation of contraindication or patient refusal

<p>Pneumococcal vaccine</p>	<p>Patients 65 years of age and over or those with chronic illnesses or weak immune systems should receive a pneumococcal vaccine at least once in their lifetime.</p>	<p>Medical record documentation must include both:</p> <ul style="list-style-type: none"> • Date of administration • Specific antigen OR documentation of contraindication or patient refusal
<p>HIV/AIDS Comprehensive Measures</p>	<p>All patients ages 2 and older with a diagnosis of HIV/AIDS should receive the following:</p> <ol style="list-style-type: none"> 1. Engaged in Care – 2 outpatient visits for physician services of primary care or HIV-related care, on 2 different dates of service occurring at least 182 days (6 months) apart within the measurement year 2. Viral Load Monitoring – 2 viral load tests conducted on different dates of service at least 6 months apart within the measurement year 3. Syphilis Screening Rate – 1 syphilis screening test performed within the measurement year for members 19 years or older 	<p>Medical record documentation must include:</p> <ul style="list-style-type: none"> • Date of outpatient visits for physician services • Date the test was performed for viral load monitoring and syphilis screening • Results of tests
<p>Use of Spirometry Testing in the Assessment and Diagnosis of COPD</p>	<p>Members 40 years of age and older with a new diagnosis of COPD or newly active COPD who received spirometry testing to confirm the diagnosis.</p>	<p>Medical record documentation must include:</p> <ul style="list-style-type: none"> • Date of test • Result of test
<p>Osteoporosis Management in Women</p>	<p>Women 67-85 years of age who suffered a fracture and who had to either a bone mineral density test or prescription for a drug to treat osteoporosis in the six months after the fracture.</p>	<p>Medical record documentation must include:</p> <ul style="list-style-type: none"> • Date of test and result or • Name of prescription to treat osteoporosis
<p>DMARD for Rheumatoid Arthritis</p>	<p>Members who with a diagnosis of rheumatoid arthritis need to be on a disease-modifying anti-rheumatic drug (DMARD).</p>	<p>Medical record documentation must include:</p> <p>Name of prescription to treat rheumatoid arthritis.</p>

**Please refer to NYSDOH website for further info/additional requirements.*