Appendix VII — Preventive Care

Appendix VII-A — Preventive Care Standards and Required Documentation

Preventive Care Service	Standard	Required Documentation
Childhood and Adolescent Immunizations	**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 **Complete immunizations on or before child's 13th birthday**: 1 – MCV4 or MPSV4 (on or between 11th and 13th birthdays) 1 – Tdap or Td (on or between 10th and 13th birthdays) **Complete immunizations on or between the female adolescent's 9th and 13th birthdays:** 3 – HPV vaccinations	When information is obtained from the patient's history, the medical record documentation must include: • Dated immunization history OR note indicating name of specific antigen and date of immunization When entries are made at the time of the immunization, documentation must include: • Name of specific antigen • Date of immunization(s) A certificate of immunization from an authorized provider or agency must include: • Specific date of immunization(s) • Type of immunization(s) given 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.**
Lead Screening	All children should have at least one lead capillary or venous blood test on or before the child's second birthday.	Any medical record documentation, including lab slips, must include all of the following: • Child's name • Child's date of birth (age is not sufficient) • Date blood test was performed • Result of test Results of erythrocyte protoporphyrin testing are unacceptable.
Well-Child Visits in the 1st 15 Months of Life	Patients who turned 15 months during the reporting year should have at least six (6) well-child visits conducted during the first 15	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

	months of life.	following: • 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 31st of the measurement year.	Documentation must include: A note by the PCP • 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 31st of measurement year.	Documentation must include: • 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: 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: • 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,

		counseling, or education about the risks of tobacco use • 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	Children 3–17 years old who had an outpatient visit with a PCP or OB/GYN should have evidence of the following: 1. BMI screening/percentile 2. Nutrition counseling 3. Physical activity counseling	Documentation in the medical record must include: • 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	Children 2-21 years of age should have at least one dental visit during the measurement year 2.	Documentation in the medical record must include: • Oral health risk assessments to identify known risk factors
Appropriate Testing for Children with Pharyngitis	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.	Documentation in the medical record must include: • 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	Antibiotics should not be prescribed for patients aged 3 months to 18 years with a diagnosis of URI.	Documentation in the medical record must include additional diagnosis (if any) during the same date of service
Follow-Up Care for Children Prescribed ADHD Medication	Children 6–12 years old who are prescribed ADHD medications should have at least 3 outpatient follow-up visits after the initial prescription: 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)	Documentation in the medical record must include the date on which the follow-up care occurred
Follow-up after Hospitalization for Mental Illness	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.	Documentation in the medical record must include: • Date of follow-up visit • Documentation that visit was with a mental health provider
Adult BMI Assessment	Patients 18–74 years old who had	Documentation in the medical

	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	Prenatal Care: initial visit must be within first trimester **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. Postpartum Care must occur between 21–56 days (3–8 wks) after delivery.	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.	Medical record documentation must include both: • Date the test was performed • Result of test
Cervical Cancer Screening	For women age 21–64 years – 1 or more cervical cytology tests at least once every 3 years. For women age 30–64 years of age – 1 or more cervical cytology and HPV co-testing at least once every five years.	Medical record documentation must include both: • 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.	Medical record documentation must include both: • Date the mammogram wasperformed • Results of procedure
Colorectal Screening	Patients age 50–75 should have 1 or more screening(s) done: 1. Fecal occult blood (FOB) in the year 2. Flexible sigmoidoscopy in the last 5 years 3. Colonoscopy in the last 10 years	Documentation in the medical record must include both: • A note indicating the date the colorectal cancer screening was performed; and • The results or finding
Comprehensive Diabetes Care	For patients age 18–75 with diabetes: 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	Medical record documentation must include all of the following: • Note that the HbA1c, nephropathy screening, dilated retinal eye exam, and BP check were performed • Date performed • Result of the test

	optometrist or ophthalmologist 3. Annual nephropathy screening a. Therapy with ACE inhibitor/ARB b. A test for microalbuminuria or documentation of existing macroalbuminuria or nephropathy 4. Blood pressure control (< 140/90 mm/Hg)	
Controlling High Blood Pressure	Document BP reading every visit for patients 18 years old and over. BP reading is considered controlled: • 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	Documentation in the medical record must include both: • Date the visit occurred • BP reading
Avoidance of Antibiotic in Acute Bronchitis	Antibiotics should not be prescribed for patients ages 18–64 years with a diagnosis of acute bronchitis.	Documentation in the medical record must include additional diagnosis or comorbidities (if any) during the same date of service
Antidepressant Medication Management	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.	Documentation in the medical record must include both: • Date of follow-up visit to a mental health provider • Name and dose of the prescribed antidepressant
Care for Older Adults	Patients 65 years old and older should receive the following: 1. Advance care planning 2. Medication review 3. Functional status assessment 4. Pain assessment	Documentation in the medical record must include evidence of: • Advance care planning • Medication list and review • Functional status assessment • Pain assessment
Medication Reconciliation	Patients 65 years old and older should have medication reconciled within 30 days of discharge.	Documentation in the medical record must include medications prescribed at discharge or a notation that no medications were prescribed.
Influenza Vaccine	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.	Medical record documentation must include both: • Date of administration • Specific antigen OR documentation of contraindication or patient refusal

Pneumococcal vaccine	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.	Medical record documentation must include both: • Date of administration • Specific antigen OR documentation of contraindication or patient refusal
HIV/AIDS Comprehensive Measures	All patients ages 2 and older with a diagnosis of HIV/AIDS should receive the following: 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	Medical record documentation must include: • Date of outpatient visits for physician services • Date the test was performed for viral load monitoring and syphilis screening • Results of tests
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	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.	Medical record documentation must include: • Date of test • Result of test
Osteoporosis Management in Women	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.	Medical record documentation must include: • Date of test and result or • Name of prescription to treat osteoporosis
DMARD for Rheumatoid Arthritis	Members who with a diagnosis of rheumatoid arthritis need to be on a disease-modifying anti-rheumatic drug (DMARD).	Medical record documentation must include: Name of prescription to treat rheumatoid arthritis.

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