Date of Review:	Name of Reviewer:	Location:
Name of Provider:	Clinic/Practice Name:	

	Electronic Use Legend 1 = Standard Met 0 = Standard Not Met ■= Standard Not Applicable	1 Texas Health Steps Clinical Record Review Tool	Paper Use Legend ✓ = Standard Met X = Standard Not Met N/A = Standard Not Applicable	

		Record Review Score										
	Gender											Percent Met
	Unique Identifier											
	Patient Age											
	Record Number	#1	#2	#3	#4	#5	#6	#7	#8	#9	#10	
1	**Comprehensive Health and Developmental History**											
1A	Initial and Interval History as Appropriate											
1B	Mental Health Screening											
1C	Tuberculosis Screening											
1D	Developmental Surveillance/Screening											
1E	Autism Screening											
1F	Nutrition Screening											
2	**Age Appropriate Screening and Administration of Immunizations**											
3	**Laboratory Screening**											
3A	Newborn Screening Panel											
3B	Blood Lead Level											
3C	Anemia (Hgb/HCT)											
3D	Dyslipidemia Screening											
3E	HIV Screening											
3F	Risk-based Tests											
4	**Comprehensive Physical Examination**											
4A	Complete Physical Examination											
4B	Length/Height											
4C	Weight											
4D	BMI											

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		Record Review Score										
	Gender											Percent Met
	Unique Identifier											
	Patient Age											
	Record Number	**#1**	**#2**	**#3**	**#4**	**#5**	**#6**	**#7**	**#8**	**#9**	**#10**	
4E	Fronto-Occipital Circumference											
4F	Blood Pressure											
4G	Vision											
4H	Hearing											
5	**Age Appropriate Health Education and Anticipatory Guidance**											
6	**Dental Referral**											
7	**Follow-up Instructions to Return for Next Preventive Visit**											
	Total Standards Components Met	0	0	0	0	0	0	0	0	0	0	

Comments:

Texas Health Steps Clinical Record Review Tool Instructions

Record Review Criteria	Instructions For Review
General Instructions	Electronic Format ● The total will self populate with numerical values. ● This will require input of numerical result in each cell to allow this feature. ● Values: 1=Component was completed 0=Component was not completed ■=Component not applicable for the age or gender of the record. Format cell to highlight in black. Paper Format ●Complete the fields as indicated below. ●Values: ✓=Component was completed X=Component was not completed N/A= Component not applicable for the age or gender of the record. ●This form will accommodate up to 10 records per specific paid claims date. ●Review all information in the record for the specific date of the selected paid claim only. **●When reviewing the record, flow sheets, laboratory slips, stand alone immunization records or other forms are acceptable documentation methods for purposes of this review even if such documentation is not noted on the clinical record form or narrative sheet.** Record Identifier Methods: ●Gender: as noted on the record, ●Unique Identifier: create a unique number or other confidential means of identifying the specific record under review. ●Patient age: notate the age of the patient as recorded on the date of the checkup under review, ●Record Number: the order of the record 1-10 under review. All federal and state required components of the Texas Health Steps checkup must be reviewed and scored using the Texas Health Steps Periodicity Schedule in effect at the time of the paid claims. The current schedule date is located online at http://www.dshs.state.tx.us/thsteps/providers.shtm. ●Provider banner messages are available on the TMHP website at: http://www.tmhp.com/Pages/Medicaid/medicaid_pubs_banners.aspx ●For further information, the Texas Medicaid Provider Procedures Manuals may also be found on the TMHP website at http://www.tmhp.com/Pages/Medicaid/Medicaid_Publications_Provider_manual.aspx
Comprehensive Health and Developmental History	Documentation must contain an initial health history and each subsequent checkup up must contain information on an interim history. ● The comprehensive health and developmental history must address the following areas: physical, mental, developmental, nutritional and tuberculosis. ●The interim history may state "No Change" and will be considered complete if an initial history is completed as described and in the record. ●If the checkup form under review is the initial visit and the THSteps child health record is being used, a "See new patient history form" box, may be completed and no interim history is required. ●A separate interim history form is an acceptable method of documentation. ●If the checkup form under review is for a subsequent checkup, an interim history must be documented.

Texas Health Steps Clinical Record Review Tool Instructions

Record Review Criteria	Instructions For Review
Developmental Surveillance/ Screening	Documentation must include age appropriate developmental surveillance or screening in accordance with the THSteps Periodicity Schedule in effect at the time of the visit, including: ●Required component 6 months to 6 years ●Developmental Screening required at 9, 18, 24 months, 3 and 4 years ●**Effective 4/1/2015 autism screening required at 18 months and again at 24 months.** Approved tools include the M-CHAT and M-CHAT R/F ●Approved Developmental Screening tools include Parents' Evaluation of Development Status (PEDS) and Ages and Stages Questionnaire (ASQ) or Ages and Stages Questionnaire: Social-Emotional (ASQ:SE) ●Developmental surveillance is required at all other checkups
Mental Health Screening	Documentation must include age appropriate mental health screening in accordance with the THSteps Periodicity Schedule in effect at the time of the visit, including: ●Required component birth to 20 years ●Required screening using one of the THSteps approved screening tools once per lifetime for every adolescent between the ages of 12 through 18 years. ●Approved mental health screening tools include: Pediatric Symptom Checklist (PSC-35), Pediatric Symptom Checklist (Y-PSC), Personal Health Questionnaire (PHQ-9) and Car, Relax, Alone, Friends, Forget, Trouble (CRAFFT). ●Documentation must include screening tool used, screening results and any referrals made.
Tuberculosis Screening	Documentation must include age appropriate tuberculosis screening in accordance with the THSteps Periodicity Schedule in effect at the time of the visit, including: ●Annually beginning at 12 months of age ● Use of the Tuberculosis Questionnaire tool which can be found at http://www.dshs.state.tx.us/thsteps/forms.shtm. ●Administration of a Tuberculin Skin Test (TST) when screening tool indicates a risk for possible exposure.
Age Appropriate Screening and Administration of Immunizations	●Documentation must include age appropriate assessment and administration of immunizations according to Texas Health Steps Policy and the Advisory Committee on Immunization Practices (ACIP) guidelines in effect at the time of the visit. ●Providers must not refer clients to another health care provider for immunizations. Current recommendations as well as previous recommendations may be found at http://www.cdc.gov/vaccines/pubs/ACIP-list.htm. ●A separate immunization record within the medical record is acceptable documentation in place of documentation on the patient record.
Laboratory Screening	Documentation must include age appropriate laboratory tests in accordance with the THSteps Periodicity Schedule in effect at the time of the visit, including: ●Screening for lead toxicity through blood lead levels at 12 and 24 months of age, through 6 years if unable to locate documentation of a previous test. ●Anemia screening through a hemoglobin or hematocrit, NOTE: Effective November 1, 2015 anemia screenings are only required at 12 months of age and are no longer required between 18 and 24 months of age, or 12 and 16 years of age for females. ●Dyslipidemia screening (provider choice of test): NOTE: Effective November 1, 2015 documentation must include dyslipidemia screening once at 9 through 11 years of age and once again at 18 through 20 years of age, regardless of risk. ●HIV screening: NOTE: Effective November 1, 2015 documentation must include HIV screening once at 16 through 18 years of age, regardless of risk. ●Risk based test(s) or decision not to complete specific test(s) supported by clinical documentation, including history and physical findings.

Texas Health Steps Clinical Record Review Tool Instructions

Record Review Criteria	Instructions For Review
Physical Examination	Documentation of a complete physical examination is required at each checkup. A comprehensive physical examination includes measurements and percentiles documented according to the THSteps Periodicity Schedule for: ●Fronto-occipital circumference, ●Length or height, ●Weight and BMI, and ●Blood pressure **The use of the World Health Organization (WHO) growth charts is recommended for infants and children birth to 2 years of age. The use of the Centers for Disease Control (CDC) growth charts is recommended for children who are 2 years of age or older.** Results of sensory screening for vision and hearing screening documented according to the THSteps Periodicity Schedule.
Health Education	Documentation must include age appropriate health education and anticipatory guidance given. It is not necessary to document the specific topics covered.
Dental Referral	Documentation must include a dental referral given beginning at 6 months of age and at all other appropriate ages as noted on the THSteps Periodicity Schedule until a dental home has been established.
Follow-up Instructions to Return for Next Preventive Visit	Documentation must include the time frame for the next preventive visit.