



CCHRI 2009 MEDICAL RECORD RETRIEVAL, ASSESSMENT, AND PURSUIT MANUAL

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Instructions for Submitting HEDIS® Documentation

The California Cooperative Healthcare Reporting Initiative (CCHRI) has prepared these guidelines for provider organizations who have chosen to become a Collector during the 2009 HEDIS Data Collection Project.

This document describes measure-specific medical record assessment and photocopying requirements. In addition, the beginning of the document provides summary/reference information regarding measure characteristics and data submission requirements. More detailed process instructions are included in the CCHRI 2009 HEDIS Data Collection Project Collector Workshop materials.

For further information, please contact Marlise Goodwin at marlise.goodwin@thomsonreuters.com, 805-681-5839. In addition, CCHRI training materials can be downloaded from the CCHRI website: www.cchri.org.

DESCRIPTION OF MEASURE SECTIONS

The following describes the contents of each section of the measure-specific instructions.

DENOMINATOR	Describes the criteria that qualify a member for inclusion in the measure / denominator. Denominator inclusion is determined by the health plan. A member will only appear on your pull list if the health plan has determined that the member meets the denominator criteria.
NUMERATORS	Describes required numerator services and numerator timeframe. The <u>numerator service</u> must be delivered during the <u>numerator timeframe</u> to count as a <u>numerator positive</u> . If a measure has more than one numerator (i.e., more than one required numerator service and/or numerator timeframe), a description of each numerator is included.
CONTRAINDICATIONS	Lists valid contraindications for the measure.
PHOTOCOPY INSTRUCTIONS	If you find a numerator positive (i.e., required numerator service delivered within the numerator timeframe), you are only required to submit the documentation indicating the numerator positive. The numerator service is most likely to be found in the documents listed in the Photocopy Instructions section. If you do not find a numerator positive (i.e., member is numerator negative), this section identifies the types of medical record documentation you are required to submit, <u>at a minimum</u> . Note, however, that you are strongly encouraged to submit other potentially useful documents as well. The Photocopy Instructions for Numerator Negative section identifies the timeframe over which these documents are required.
PHOTOCOPY INSTRUCTIONS FOR NUMERATOR NEGATIVES	If the member is numerator negative, the Photocopy Instructions section identifies the medical record documentation you are required to submit. This section also identifies the numerator timeframe (i.e., date range) across which you must submit the documentation identified in the Photocopy Instructions.
MEASURE-SPECIFIC INFORMATION	Provides a description of any unique, measure-specific requirements or considerations.
POSSIBLE PRACTITIONER TYPE(S)	Lists physician specialties that are most likely to have the medical record information required by the measure.

SUBMISSION INSTRUCTIONS/NOTES

The following are notes regarding some specific data submission issues. Description and clarification of the submission process was covered in the WebEx Sessions and will also be covered during the on-site Workshops.

1. Submitting Out-of-Timeframe Services

- In some cases, you may find a qualifying numerator service, however, it is delivered outside the numerator timeframe
 - For Childhood Immunization, an IPV rendered after the child's second birthday
 - This information is useful to health plans to focus their pursuit activities (i.e., further pursuit of an "in timeframe" IPV is unlikely to be fruitful)
- Out-of-timeframe services may also provide referral clues
 - For Cervical Cancer Screening, a pap smear in 2009 may provide clues to a provider who rendered an "in timeframe" pap smear
- If you have information on relevant out-of-timeframe services, please submit them to the health plan – highlight the services and make a relevant note on the medical record document (e.g., "out of timeframe pap smear")

2. Copying the Numerator Timeframe for Numerator Negatives

If you search the medical record(s) but cannot find evidence of a numerator positive (i.e., the required numerator service delivered during the numerator timeframe), you must photocopy all required chart documentation covering a measure-specific timeframe.

In the description of each measure, the "PHOTOCOPY INSTRUCTIONS FOR NUMERATOR NEGATIVES" section identifies the measure-specific timeframe.

The "PHOTOCOPY INSTRUCTIONS" section describes the minimum documentation you are required to submit for numerator negatives (i.e., the chart information considered "required"). For example, for Childhood Immunization, the required documentation you must submit includes:

- Demographic/Face Sheet(s)
- Immunization Records
- Health Maintenance Form/Report
- Progress Notes
- Problem Lists
- Medical History Form
- Laboratory Reports
- Growth Chart

However, in addition to this list, please submit any documentation you feel might help the health plan in locating providers, determining what related services the patient received, etc.

If you do not wish to separate out the documentation identified as "required" from the rest of the medical record, you can simply copy all documentation spanning the timeframe identified in "PHOTOCOPY INSTRUCTIONS FOR NUMERATOR NEGATIVES".

3. “If In Doubt, Send It Out”

This Manual describes the documentation you are required to provide as a Collector. However, you may run across information that falls outside these requirements but may be very useful for the health plan. Health plans are especially interested in any information that will help them identify a provider who may have rendered the numerator service (e.g., referral information). As noted earlier, they are also interested in numerator services that were not delivered during the HEDIS timeframe (e.g., immunizations rendered after the second birthday).

If you have any doubts about the usefulness of a piece of medical record documentation, send it to the health plan. Health plans would prefer more, rather than less, documentation.

4. Submitting Administrative Data

Collectors have the option of searching their administrative data systems and submitting evidence of numerator positive services to the health plans. This process and caveats were discussed during the Level I and Level II Collector WebEx training sessions.

- Work with your contracted Health Plans
 - Administrative Data is acceptable from claims, encounter, and transaction databases
 - Supplemental Data files (“non-standard” files) road-maps are required for auditing purposes
 - Electronic files from EMRs
 - Electronic files from disease management (DM) or case management systems
 - Electronic files from measure-exclusion databases
 - If you are planning on submitting any of the above, contact your Health Plan representative as soon as possible to avoid any problems during the Data Collection Project

MEASURE REFERENCE INFORMATION

1. Measures Requiring Specialty/PCP Identification

The following measures require specialty/PCP identification:

- Comprehensive Diabetes Care, Numerator 5
 - Exam by optometrist or ophthalmologist
- Comprehensive Diabetes Care, Numerator 8
 - Office visit with a nephrologist
- Prenatal and Postpartum Care
 - OB/GYN practitioner or midwife
- Well-Child Visits in the First 15 Months of Life
 - Primary care practitioner, physician assistants, nurse practitioners
- Well-Child Visits in the 3rd- 6th Years of Life
 - Primary care practitioner, physician assistants, nurse practitioners
- Adolescent Well-Care Visits
 - Primary care practitioner, physician assistants, nurse practitioners, OB/GYN

You must submit evidence of the rendering physician’s specialty for these measures.

2. Measures with Contraindications

The following measures have contraindications. The contraindications are described in the measure-specific sections of this Manual. Please search the medical record for evidence of these contraindications and forward to the health plan.

CCS	Cervical Cancer Screening
CDC	Comprehensive Diabetes Care
CIS	Childhood Immunization Status
COL	Colorectal Cancer Screening

Note: contraindications can occur anytime on or before the end of the numerator timeframe. For example, a hysterectomy in 1965 would count as a valid contraindication for the Cervical Cancer Screening measure.

Note: if you find a contraindication, you must still search for numerator service. If you find evidence of both a contraindication and the numerator service, submit both to the health plan. The health plan may be able to remove the member from the denominator. The health plan makes the final decision.

3. Measures with Patient-Specific Numerator Timeframes

The numerator start and end dates are included in the Electronic Pull List for all measures where the numerator timeframe is patient-specific (see list below). The Medical Record Submission Cover Sheet will show numerator start and end dates for PPC. For example, for the Postpartum Care measure, the numerator timeframe is between 21 and 56 days (inclusive) following delivery. Therefore, the numerator timeframe varies for each patient, depending on date of childbirth. The Medical Record Submission Cover Sheet will contain the delivery date, the timeframe for Numerator 1 (trimester), and the timeframe for Numerator 2 (21 and 56 days after delivery).

The measures with patient-specific numerator timeframes are:

CIS	Childhood Immunization Status
MRP	Medication Reconciliation Post-Discharge
PPC	Prenatal and Postpartum Care
W15	Well-Child Visits in the First 15 Months of Life

Summary of Measure Characteristics

Measure	Product		Rotation Measure?	Type of Numerator Timeframe		Contraindication	Specialty
	Commercial	Medicare	Commercial	Same for all Patients	Patient-Specific		
Adult BMI Assessment	√	√	No	√			
Care for Older Adults		SNP	No	√			
Cervical Cancer Screening	√		No	√		√	
Childhood Immunization Status	√		Yes		√	√	
Cholesterol Management for Patients With Cardiovascular Conditions	√	√	Yes	√			
Colorectal Cancer Screening	√	√	Yes	√		√	
Comprehensive Diabetes Care	√	√	Yes**	√		√	Num 5: Optometrist or Ophthalmologist Num 8: Nephrologist
Controlling High Blood Pressure*	√	√	No	√			
Medication Reconciliation Post-Discharge		SNP	No		√		
Prenatal and Postpartum Care	√		No		√		OB/GYN, FP, PCP, MW
Weight Assessment and Counseling for Nutrition and Physical Activity	√		No	√			
Adolescent Well-Care Visits	√		Yes	√			PCP, PA, NP, OB/GYN
Well Child Visits in the First 15 Months of Life	√		Yes		√		PCP, PA, NP
Well Child Visits in Years 3 - 6	√		Yes	√			PCP, PA, NP

Summary of Changes to HEDIS Technical Specifications for 2009
Updated with October 1st “Frozen” Tech Spec Changes

The following table summarizes 2009 HEDIS medical record requirement specifications changes.

Measure	Changes to Numerator Specifications
Adult BMI Assessment	<ul style="list-style-type: none"> • First year measure
Care for Older Adults	<ul style="list-style-type: none"> • First year measure, Medicare SNP only
Cervical Cancer Screening	<ul style="list-style-type: none"> • No changes to this measure
Childhood Immunization	<ul style="list-style-type: none"> • Revised number of HiB doses, deferring the third booster during vaccine shortage • Clarified generic header of “DTaP/DTP/DT.”
Cholesterol Management for Patients With Cardiovascular Conditions	<ul style="list-style-type: none"> • No changes to this measure
Colorectal Cancer Screening	<ul style="list-style-type: none"> • Clarified when “result” is required in the medical record documentation
Comprehensive Diabetes Care	<ul style="list-style-type: none"> • Added new numerators HbA1c control (<7% and <8.0%) (Note: <7.0% collected for HEDIS 2008 but not reported)
Controlling High Blood Pressure	<ul style="list-style-type: none"> • Clarified that BP readings taken during an acute inpatient stay or ED visit should not be included
Medication Reconciliation Post-Discharge	<ul style="list-style-type: none"> • First year measure, Medicare SNP only
Prenatal and Postpartum Care	<ul style="list-style-type: none"> • Added examples of medical record documentation that meet criteria for notation of postpartum care
Weight Assessment/ Counseling for Nutrition and Physical Activity in Children/Adolescents	<ul style="list-style-type: none"> • First year measure
Adolescent Well-Care Visits	<ul style="list-style-type: none"> • No changes to this measure
Well-Child Visits in the First 15 Months of Life	<ul style="list-style-type: none"> • No changes to this measure
Well-Child Visits in the 3 rd – 6 th Years of Life	<ul style="list-style-type: none"> • No changes to this measure

ADULT BMI ASSESSMENT (ABA)	
DENOMINATOR	Members 18 – 74 in the measurement year who have had an outpatient visit and had their body mass index (BMI) documented or the year prior (2007, 2008)
NUMERATOR	Outpatient visit with Body Mass Index documented in the measurement year or year prior (2007, 2008)
CONTRAINDICATIONS	None Exclusion: Pregnancy during measurement year or year prior
PHOTOCOPY INSTRUCTIONS	Copy: <ul style="list-style-type: none"> • Demographic/Face Sheet(s) • Progress Notes • Problem Lists • Height/Weight Grid • All Anticipatory Guidance Grids • Documentation showing periodic well visits • Exam for sports activities/participation forms • Development Grids Also include any other documentation you feel may be relevant.
PHOTOCOPY INSTRUCTIONS FOR NUMERATOR NEGATIVES	If the member is <u>not</u> numerator positive, at a <u>minimum</u> copy the documents identified in the Photocopy Instructions for the following period: January 1, 2007 through December 31, 2008
MEASURE-SPECIFIC INFORMATION	Documentation in the medical record must indicate the date of the BMI and the BMI value. For members younger than 19 years, on the date of service, documentation of BMI percentile also meets criteria: <ul style="list-style-type: none"> • BMI percentile documented as a value (e.g., 85th percentile) • BMI percentile plotted on an age-growth chart <p><i>Note: The following notations or examples of documentation are considered “negative findings” and do not count as numerator compliant.</i></p> <ul style="list-style-type: none"> – No BMI or BMI percentile documented in medical record or plotted on age-growth chart – Notation of height and weight only – BMI or BMI percentile noted prior to look-back period or after the measurement year
POSSIBLE PRACTITIONER TYPE(s)	PCP OB/GYN Cardiologist Geriatric Physician Nutritionist Bariatric

CARE FOR OLDER ADULTS (COA)	
DENOMINATOR	Adults 65 years or older and who had the numerator services in the measurement year (2008):
NUMERATORS	<p>Numerator 1: Advanced care planning</p> <p>Numerator 2: Medication review</p> <p>Numerator 3: Functional status assessment</p> <p>Numerator 4: Pain screening</p> <p>Note: For HEDIS 2009, organizations should report this indicator using the hybrid method only.</p>
CONTRAINDICATIONS	None
PHOTOCOPY INSTRUCTIONS	<p>Copy:</p> <ul style="list-style-type: none"> • Demographic/Face Sheet(s) • Progress Notes • Problem Lists • Health Maintenance Form/Report • History and Physical Notes • Medication List/Record • Advance Directives, living wills (any form with surrogate decision maker or court appointed representative) • Geriatric Assessment tool/form • Functional Assessment Tool (activities of Daily Living form (ADL) or ILS tool) • Pain Management Forms • Education Forms
PHOTOCOPY INSTRUCTIONS FOR NUMERATOR NEGATIVES	<p>If the member is <u>not</u> numerator positive, at a <u>minimum</u> copy the documents identified in the Photocopy Instructions for the following period:</p> <p style="text-align: center;">January 1 through December 31, 2008</p>
MEASURE-SPECIFIC INFORMATION	<p>Advance Care Planning:</p> <p>Evidence of advance care planning including a discussion about preferences for resuscitation, life-sustaining treatment and end of life care. Evidence of advance care planning must include either:</p> <ul style="list-style-type: none"> • The presence of an advanced care plan in the medical record, or • Documentation of an advance care planning discussion with the provider <i>and</i> the date on which it was discussed. The documentation of discussion must be notated in the measurement year. <p>Examples of advance care plans include:</p> <ul style="list-style-type: none"> • Advance directives. Directives pertaining to treatment preferences and the designation of a surrogate decision-maker in the event that a person should become unable to make medical decisions on their own behalf. Advance directives generally may be a living will, power of attorney or health care proxy

CARE FOR OLDER ADULTS (COA)

- **Actionable medical orders.** Written instructions regarding initiation, continuation, withholding or withdrawal of particular forms of life-sustaining treatment.
- **Living wills.** Legal documents denoting preferences for life-sustaining treatment and end of life care
- **Surrogate decision maker.** A written document designating someone else to make future medical treatment choices

Examples of an advance care planning discussion include either:

- Notation in the medical record of a discussion with a provider or the initiation of a discussion by a provider during the measurement year, **or**

Oral statements. Conversations with relatives or friends about life-sustaining treatment and end of life care documented in the medical record. Patient designation of an individual who can make decisions on their behalf. Evidence of oral statements must be notated in the medical record during the measurement year.

Medication Review:

At least one medication review conducted by a prescribing practitioner or clinical pharmacist during the measurement year and the presence of a medication list in the medical record, as documented through either administrative data or medical record review.

A medication review is a review of a member's medications including prescription medications, over the counter medications (OTC) or herbal therapies. A medication list is a list of member's medications in the medical record which may include prescriptions, over the counter medications and herbal therapies or supplements. Documentation must come from the same medical record and must include the following.

- A medication list in the medical record, **and** Evidence of a medication review and the date on which it was performed

At a minimum, **medication review** is documentation that a practitioner has reviewed all medications that the member is taking (including prescriptions, OTCs and herbal or supplemental therapies). A review of side effects for a single medication at the time of prescription alone is not sufficient. If the member is not taking any medications, notation of this fact and the date on which it was noted is also considered numerator compliant.

Functional Status Assessment:

Documentation in the medical record must include evidence of functional status assessment and the date on which it was performed.

Notations for functional status assessment may include the following.

- Functional independence
- Loss of independent performance, Activities of Daily Living (ADL), social activities, or Instrumental Activities of Daily Living (IADL)
- The level of assistance needed to accomplish daily activities
- Result of assessment using a standardized functional status assessment tool, not limited to:

CARE FOR OLDER ADULTS (COA)	
	<ul style="list-style-type: none"> – SF-36® – ADL list – Assessment of Living Skills and Resources (ALSAR) – Barthel ADL Index Physical Self-Maintenance Scale (ADLS) – Bayer Activities of Daily Living Scale (B-ADL) – Barthel Index – Extended Activities of Daily Living Scale (EADL) – Independent Living Scale (ILS) – Katz Index of Independence in Activities of Daily Living – Kenny Self-Care Evaluation – Klein-Bell Activities of Daily Living Scale – Kohlman Evaluation of Living Skills (KELS) – Lawton & Brody’s IADL scales <p>Pain Screening:</p> <p>Documentation in the medical record must include evidence of pain screening or a pain management plan and the date on which it was performed. Evidence of pain screening may include the following.</p> <ul style="list-style-type: none"> – Notation of the presence or absence of pain – Results of a screening using a standardized pain screening tool for example but not limited to: <ul style="list-style-type: none"> – Multidimensional Pain Inventory – Faces Pain Scale – 0–10 Numeric Rating Scales verbal or visual – Verbal Descriptor Scale – Brief Pain Inventory (Short Form) <p>Evidence of a pain management plan may include the following.</p> <ul style="list-style-type: none"> – Notation of no pain intervention and the rationale – Notation of plan for treatment of pain, which may include use of pain medications, psychological support, and patient/family education – Notation of plan for reassessment of pain including reassessment time interval <p><i>Note: Clinical pharmacists may conduct a medication review with the patient either in person or by phone, and the information is documented in the medical record, it counts as a numerator hit.</i></p>
POSSIBLE PRACTITIONER TYPE(s)	PCP Geriatric Physician Cardiologist Rheumatologist

CERVICAL CANCER SCREENING (CCS)	
DENOMINATOR	Women age 24 through 64 in the measurement year (2008)
NUMERATOR	Pap smear on or between January 1, 2006 and December 31, 2008
CONTRAINDICATIONS	<p>Submit evidence of any of the following contraindications occurring anytime on or before December 31, 2008.</p> <ul style="list-style-type: none"> • Hysterectomy with no residual cervix <p>Copy any available information regarding hysterectomy (i.e., whether it indicates “no residual cervix” or not).</p>
PHOTOCOPY INSTRUCTIONS	<p>Copy:</p> <ul style="list-style-type: none"> • Demographic/Face Sheet(s) • Health Maintenance Form/Report • Progress Notes • Problem Lists • Medical History Forms • Medication List • Cytology Reports • Pathology Reports • Ultrasound Surgery or Procedure Reports • Flow Charts <p>Also include any other documentation you feel may be relevant.</p>
PHOTOCOPY INSTRUCTIONS FOR NUMERATOR NEGATIVES	<p>If the member is <u>not</u> numerator positive, at a <u>minimum</u> copy the documents identified in the Photocopy Instructions for the following period:</p> <p style="text-align: center;">January 1, 2006 through December 31, 2008</p>
MEASURE-SPECIFIC INFORMATION	<p>The contraindication (hysterectomy with no residual cervix) may have occurred a long time in the past. Search as far back as you can for this contraindication.</p> <p>Documentation of “complete hysterectomy,” “total hysterectomy,” “total abdominal or vaginal hysterectomy” or “radical hysterectomy” meets the criteria for hysterectomy with no residual cervix. Documentation of a “vaginal pap smear” in conjunction with documentation of “hysterectomy” meets the criteria for hysterectomy with no residual cervix. However, documentation of “hysterectomy” alone does not meet the criteria because it does not indicate the cervix has been removed. The hysterectomy must have occurred by December 31 of the measurement year.</p>
POSSIBLE PRACTITIONER TYPE(s)	<p>Primary Care Physician (Family Practice, Internist)</p> <p>Obstetrician/Gynecologist</p>

CHILDHOOD IMMUNIZATION STATUS (CIS)	
DENOMINATOR	Children who turned 2 years old in measurement year (2008).
NUMERATORS	<p>Numerator 1: Four DtaP vaccinations with different dates of service on or before 2nd birthday. DTaP vaccines administered before age 42 days <u>do not count</u>.</p> <p>Numerator 2: Three IPV vaccinations with different dates of service on or before 2nd birthday. IPV vaccines administered before age 42 days <u>do not count</u>.</p> <p>Numerator 3: At least two HiB vaccinations with different dates of service on or before 2nd birthday. HiB vaccines administered before age 42 days <u>do not count</u>.</p> <p>Note: Due to the HiB shortage, only two of the three doses are required for HEDIS 2009.</p> <p>Numerator 4: Three hepatitis B immunizations with different dates of service on or before 2nd birthday.</p> <p>Numerator 5: One MMR vaccination on or before 2nd birthday.</p> <p>Numerator 6: At least one Varicella (VZV) on or before 2nd birthday.</p> <p>Numerator 7: At least four Pneumococcal conjugate vaccinations on or before 2nd birthday.</p>
CONTRAINDICATIONS	<p>Submit evidence of any of the following contraindications occurring on or before the child's 2nd birthday.</p> <ul style="list-style-type: none"> • Anaphylactic reaction to any vaccine or its components • Encephalopathy (DTaP) • HIV disease or asymptomatic HIV (MMR, VZV) • Immunodeficiency, including genetic (congenital) immunodeficiency syndromes (MMR, VZV) • Cancer of lymph reticular or histiocytic tissue (MMR, VZV) • Multiple myeloma (MMR, VZV) • Leukemia (MMR, VZV) • Anaphylactic reaction Neomycin (MMR, VZV) • Anaphylactic reaction to common baker's yeast (Hep B)
PHOTOCOPY INSTRUCTIONS	<p>Copy:</p> <ul style="list-style-type: none"> • Demographic/Face Sheet(s) • Immunization Records • Health Maintenance Form/Report • Progress Notes • Problem Lists • Medical History Forms • Laboratory Reports • Growth Chart
PHOTOCOPY INSTRUCTIONS FOR NUMERATOR NEGATIVES	<p>If the member is <u>not</u> numerator positive, at a <u>minimum</u> copy the documents identified in the Photocopy Instructions for the following period:</p> <p style="text-align: center;">Birth through December 31, 2008</p>

CHILDHOOD IMMUNIZATION STATUS (CIS)

NUMERATOR-SPECIFIC INFORMATION

Member's date of birth is included on the Medical Record Submission Cover Sheet and in the Electronic Pull List. The Electronic Pull List will also include the date 42 days after birth, and the 1st and 2nd birth dates.

NOTE: Acceptable alternatives for Numerator 4, 5, and 6 (hepatitis B, MMR, and VZV) include a documented **history of the disease** or a **seropositive test result**. For Numerator 1, 2, 3, and 7 (DtaP, HiB, IPV, and Pneumococcal conjugate, count only the following: evidence of the antigen or combination vaccine.

For immunization evidence obtained from the medical record, the organization may count members where there is evidence that the antigen was rendered from one of the following.

- A note indicating the name of the specific antigen and the date of the immunization, **or**
- A certificate of immunization prepared by an authorized health care provider or agency including the specific dates and types of immunizations administered.

For documented history of illness or a seropositive test result, the organization must find a note indicating the date of the event. The event must have occurred by the member's second birthday.

Notes in the medical record indicating that the member received the immunization "at delivery" or "in the hospital" may be counted toward the numerator. This applies only to immunizations that do not have minimum age restrictions (e.g., prior to 42 days after birth). A note that the "member is up to date" with all immunizations but which does not list the dates of all immunizations and the names of the immunization agents does not constitute sufficient evidence of immunization for HEDIS reporting.

Note: *Immunizations documented using a generic header of "DTaP/DTP/DT" can be counted as evidence of DTaP.*

POSSIBLE PRACTITIONER TYPE(s)

Pediatrician
Other Primary Care Physician (Family Practice, Internist)

CHILDHOOD IMMUNIZATION STATUS (CIS)

VACCINES APPLICABLE TO THIS MEASURE

(including commonly used abbreviations)

(note: this list is not comprehensive and is provided for your reference)

Common Name	Includes:
ActHIB	HIB
Attenuvax	Measles
Biavax II	Rubella and Mumps
Comvax	HIB and Hepatitis B
Engerix-B	Hepatitis B
HbOC	HIB conjugate vaccine
HbPV	HIB
HBV	Hepatitis B vaccine
HibTITER	HIB conjugate vaccine
Infanrix	DTaP
IPOLE	Inactivated poliovirus vaccine
Meruvax	Rubella
MMR	Measles, Mumps, and Rubella
M-R-vax	Measles and Rubella
Mumpsvax	Mumps
OmniHIB	HIB
PedvaxHIB	HIB
Praxis	HIB
ProHIBiT	HIB and Diphtheria
PRP-D	HIB conjugate vaccine
PRP-OMP	HIB conjugate vaccine
PRP-T	HIB conjugate vaccine
Recombivax HB	Hepatitis B
TriHIBit	HIB and DTP/DTaP
Varivax	Varicella

CHOLESTEROL MANAGEMENT FOR PATIENTS WITH CARDIOVASCULAR CONDITIONS (CMC)	
DENOMINATOR	Members age 18 through 75 who were hospitalized and discharged alive between January 1 and November 1 of the year prior to the measurement year for an acute myocardial infarction (AMI), coronary artery bypass graft (CABG), or percutaneous transluminal coronary angioplasty (PTCA) or who had a diagnosis of Ischemic Vascular Disease (IVD) in 2007 and 2008.
NUMERATORS	Numerator 1: An LDL-C screening performed during the measurement year. Numerator 2: The most recent LDL-C level less than 100 mg/dL.
CONTRAINDICATIONS	None
PHOTOCOPY INSTRUCTIONS	Copy: <ul style="list-style-type: none"> • Demographic/Face Sheet(s) • Health Maintenance Form/Report • Progress Notes • Problem Lists • Hospital Documents • History and Physical Notes • Discharge Summary • Consultation Notes • Medication List • LDL Cholesterol Lab Reports (include all lipid panel reports, LDL and total cholesterol) • Laboratory Reports <p>Also include any other documentation you feel may be relevant.</p>
PHOTOCOPY INSTRUCTIONS FOR NUMERATOR NEGATIVES	If the member is <u>not</u> numerator positive, at a <u>minimum</u> copy the documents identified in the Photocopy Instructions for the following period: January 1, 2007 through December 31, 2008
MEASURE-SPECIFIC INFORMATION	Documentation must include, at a <u>minimum</u> , the date of the screening and the results. Some of the various terms for low-density lipoprotein (LDL-C), or names of tests that may include LDL-C, are Lipid profile, Coronary heart disease risk index, Lipoprotein electrophoresis, and Beta lipoproteins.
POSSIBLE PRACTITIONER TYPE(s)	Primary Care Physician (Family Practice, Internist) Cardiologist

COLORECTAL CANCER SCREENING (COL)	
DENOMINATOR	Adults age 51 through 80 as of December 31 of the measurement year (2008)
NUMERATORS	<p>One or more appropriate screenings documented by:</p> <ul style="list-style-type: none"> • Fecal occult blood test (FOBT) during the measurement year <p>OR</p> <ul style="list-style-type: none"> • Flexible sigmoidoscopy during 2004, 2005, 2006, 2007, or 2008 <p>OR</p> <ul style="list-style-type: none"> • Double contrast barium enema (DCBE) including clinical synonym “air contrast enema” during 2004, 2005, 2006, 2007, or 2008 <p>OR</p> <ul style="list-style-type: none"> • Colonoscopy during 2008 or nine years prior (1999-2007) <p>If you have archived records covering the 10 year timeframe, you <u>must</u> retrieve and assess them for evidence of service.</p>
CONTRAINDICATIONS	<p>Submit evidence of any of the following contraindications occurring anytime on or before December 31 of the measurement year.</p> <ul style="list-style-type: none"> • Diagnosis of colorectal cancer • Total colectomy <p>The contraindication (diagnosis of colorectal cancer and total colectomy) may have occurred a long time in the past. Search as far back as you can for this contraindication.</p>
PHOTOCOPY INSTRUCTIONS	<p>Copy:</p> <ul style="list-style-type: none"> • Demographic/Face Sheet(s) • Health Maintenance Form/Report • Progress Notes • Problem Lists • Laboratory Reports • Medical History Forms • Pathology Reports • X-ray Reports • Most Recent Patient Health Questionnaire • Medication Lists • GI Consults • Flow Charts <p>Also include any other documentation you feel may be relevant.</p> <p>Documentation in the medical record must include both of the following:</p> <ul style="list-style-type: none"> • Note indicating the date of the colorectal cancer screening <p>AND</p> <ul style="list-style-type: none"> • Result or finding <p>Note: medical histories indicating the name and date of the test count as numerator positives even if no result or finding is present.</p>

COLORECTAL CANCER SCREENING (COL)	
PHOTOCOPY INSTRUCTIONS FOR NUMERATOR NEGATIVES	<p>If the member is <u>not</u> numerator positive, at a <u>minimum</u>, copy the documents identified in the Photocopy Instructions for the following period:</p> <p style="text-align: center;">January 1, 2004 through December 31, 2008</p> <p>Note that this is the only measure for which you do not have to copy the entire numerator timeframe if a member is negative.</p>
MEASURE-SPECIFIC INFORMATION	<p>You must search for numerator evidence for the entire 10-year numerator timeframe. Copy the five-year timeframe only if you did not find one or more screenings.</p> <p>Documentation in the medical record must include a note indicating the date the colorectal cancer screening was performed. A result is not required if the documentation is clearly part of the “medical history” section of the record. If it is unclear whether the documentation is part of the medical history, then the result or finding must also be present (this ensures that the screening was performed and not merely ordered).</p> <p>There are two types of FOBT tests: guaiac (gFOBT) and immunochemical (iFOBT). Depending on the type of FOBT test, a certain number of samples are required for numerator compliance. Follow the instructions below to determine member compliance.</p> <ul style="list-style-type: none"> • If the medical record indicates that fewer than three samples were returned but does not indicate the type of test, the member does not meet the criteria. • If the medical record indicates the type of test but does not indicate how many samples were returned, assume that the required number of samples was returned. • Immunochemical (iFOBT) tests may require fewer than three samples. If the medical record indicates that fewer than three samples were returned and an iFOBT was done, the member meets the screening criteria for inclusion in the numerator. <p><i>Do not count the following as evidence of a colorectal screening.</i></p> <ul style="list-style-type: none"> • <i>Digital rectal exam</i> because it is not specific or comprehensive enough to screen for colorectal cancer • <i>Single contrast barium enema or notation of barium enema</i> because they are not as specific or as comprehensive as the double contrast or air contrast barium enema <p>In many cases, you may not have medical record information covering the entire 10-year numerator timeframe. Therefore, the Cover Sheet contains the following questions intended to provide health plans with useful pursuit strategy information. Please be sure to answer these questions for all numerator negative members:</p> <ol style="list-style-type: none"> 1. Date this person first became your patient. _____ 2. If you could not complete a medical record search for the ten-year numerator timeframe, please explain why in the comments section below.
POSSIBLE PRACTITIONER TYPE(s)	<p>Primary Care Physician (Family Practice, Internist)</p> <p>OB/GYN</p> <p>Gastroenterologist</p>

COMPREHENSIVE DIABETES CARE (CDC)	
DENOMINATOR	Members age 18 through 75 who health plan has identified as having (type 1 and type 2) diabetes
NUMERATORS	Numerator 1: HbA1c testing Numerator 2: HbA1c poor control (>9.0%) Numerator 3: HbA1c good control (<7.0%) Numerator 4: HbA1c good control (<8.0%) Numerator 5: Eye exam (retinal) performed Numerator 6: LDL-C screening performed Numerator 7: LDL controlled (<100 mg/dL) Numerator 8: Medical attention for nephropathy Numerator 9: Blood pressure control (<130/80 mm Hg) Numerator 10: Blood pressure control (<140/90 mm Hg)
CONTRAINDICATIONS	Submit evidence of any of the following contraindications occurring on or before December 31 of the measurement year (2008). <ul style="list-style-type: none"> • Steroid induced • Gestational Diabetes • Polycystic ovary disease
PHOTOCOPY INSTRUCTIONS	The following identifies the documentation you must copy to cover all ten numerators: <ul style="list-style-type: none"> • Demographic/Face Sheet(s) • Health Maintenance Form/Record • Medical History Form • Diabetic Flow Sheets (Charts) • Notes from Diabetes Educator • Notes or referrals to/from diabetic Teaching Centers • Laboratory Reports • Progress Notes • Problem Lists • Retinal Photograph(s) • Fluorescein Angiography Report(s) • Report(s) of Consultation • Provider notes • Hospital Reports • Medication List
PHOTOCOPYING INSTRUCTIONS — NUMERATOR-SPECIFIC INSTRUCTIONS	The following identifies the numerator positive criteria for each of the ten numerators: Numerator 1: HbA1c Testing An HbA1c laboratory test performed 2008. Documentation must include, at a <u>minimum</u> , the date of the test and the results. Notations of the following meet the measure requirements: A1c, HbA1c, Hemoglobin A1c, glycohemoglobin A1c, and HgbA1c.

COMPREHENSIVE DIABETES CARE (CDC)

Numerator 2: Poor HbA1c Control

The most recent HbA1c level during the measurement year. To be numerator positive, the most recent HbA1c in 2008 must be **greater** than 9.0%. Note: this is the only numerator where being numerator positive indicates poor quality. In any case, you must submit the most recent 2008 HbA1c. For example, if you identify an HbA1c level in April 2008 and a subsequent level in October 2008, the appropriate level to submit is the one from October 2008.

Numerators 3 and 4: Good HbA1c Control

The value of the last HbA1c test performed in 2008 must be documented. To be numerator positive, the **most recent** HbA1c in 2008 must be less than either 7.0% or 8.0%. You must submit the most recent 2008 HbA1c test result. For example, if you identify an HbA1c level in April 2008 and a subsequent level in October 2008, submit the level from October 2008. In this manner, the plan may make the appropriate numerator determination. See special section below with exclusions for the less than 7% indicator.

Numerator 5: Eye Exam

- A retinal or dilated eye exam performed by an ophthalmologist or optometrist in the measurement year

OR

- A negative retinal exam (no evidence of retinopathy) by an ophthalmologist or optometrist in the year prior to the measurement year

At a minimum, documentation in the medical record must include one of the following.

- A note or letter prepared by an ophthalmologist, optometrist, PCP or other health care professional indicating that an ophthalmoscopic exam was completed by an eye care professional, the date on which the procedure was performed and the results, **or**
- A chart or photograph of retinal abnormalities indicating the date on which the fundus photography was performed and evidence that an eye care professional reviewed the results. Alternatively, results may be read by a qualified reading center that operates under the direction of a medical director who is a retinal specialist.

NOTE: Blindness is not a contraindication for diabetic eye exam

Numerator 6: LDL-C Screening

An LDL-C laboratory test 2008. Documentation must include, at a minimum, the date of the test and the results. Some of the various terms for low-density lipoprotein (LDL-C), or names of tests that may include LDL-C, are Lipid profile, Coronary heart disease risk index, Lipoprotein electrophoresis, and Beta lipoproteins.

Numerator 7: LDL-C Level <100 mg/dL

The value of the **most recent** LDL-C test performed in 2008. To count toward this numerator, result must be documented and must be less than 100 mg/dL.

COMPREHENSIVE DIABETES CARE (CDC)

Numerator 8: Medical Attention for Diabetic Nephropathy

This numerator measures the percentage of members who had evidence of monitoring for diabetic nephropathy. There are several criteria that will qualify as a numerator positive. Each item listed below counts as evidence of nephropathy monitoring.

Urine microalbumin test. A note indicating the date test was performed and the result. Any of the following meet the criteria for a urine microalbumin test

- 24-hour urine for microalbumin
- Timed urine for microalbumin
- Spot urine for microalbumin
- Urine for microalbumin/creatinine ratio
- 24-hour urine for total protein
- Random urine for protein/creatinine ratio.

Evidence of nephropathy. Any of the following meet criteria for evidence of nephropathy.

- Documentation of a visit to a nephrologist
- Documentation of medical attention for any of the following (no restriction on provider type)
 - Diabetic nephropathy
 - End-stage renal disease (ESRD)
 - Chronic renal failure (CRF)
 - Chronic kidney disease (CKD)
 - Renal insufficiency
 - Proteinuria
 - Albuminuria
 - Renal dysfunction
 - Acute renal failure (ARF)
 - Dialysis, hemodialysis or peritoneal dialysis
- A positive urine macroalbumin test during the measurement year. At a minimum, documentation in medical record must include a note indicating the date on which the test was performed, and a positive result. Any of the following notations in the medical record indicate a positive urine macroalbumin test
 - Positive urinalysis (random, spot or timed) for protein
 - Positive urine (random, spot or timed) for protein
 - Positive urine dipstick for protein
 - Positive tablet reagent for urine protein
 - Positive result for albuminuria
 - Positive result for macroalbuminuria
 - Positive result for proteinuria
 - Positive result for gross proteinuria

Note: "Trace" urine macroalbumin test results are not considered numerator compliant.

Evidence of ACE Inhibitor/ARB therapy. Documentation in medical record must include, at minimum, a note indicating that the member received an ambulatory prescription for ACE inhibitors/ARBs within the measurement year.

COMPREHENSIVE DIABETES CARE (CDC)

Numerators 9 and Numerator 10: Blood pressure level <130/80 and <140/90

These numerators measure the **most recent** representative blood pressure measurement in 2008.

To be considered “representative,” the BP must have been obtained during a visit to the practitioner’s office or other non-emergency outpatient facility, such as a clinic.

- The representative BP is the most recent BP taken during 2008. The lowest BP is used as the representative BP regardless of posture. Contrary to the CBP measure, you do not need to confirm a diagnosis of hypertension for these numerators.
- The lowest systolic and lowest diastolic values can be utilized to fulfill the numerator criteria for the representative BP.
- The systolic and diastolic results do not need to be from the same reading but the reading does need to occur on the same day.

Readings taken under the following circumstances are not eligible:

- BP readings from an acute inpatient stay or ED visit
- Outpatient visits for the sole purpose of having a diagnostic or surgical procedure performed (e.g., colonoscopy, removal of wart)
- BP measurements obtained on the same day as a major diagnostic or surgical procedure (e.g., stress test, IV contrast for radiology)
- BP readings obtained at an emergency room visit
- BP reading that are self-reported by patient (e.g., those taken at home or at a health fair)

An exception to the last item is that a home visit BP reading taken by a licensed medical professional and documented in the medical record by the deadline for service may be counted.

COMPREHENSIVE DIABETES CARE (CDC)

PHOTOCOPY INSTRUCTIONS FOR NUMERATOR NEGATIVES

If the member is not numerator positive for Numerators 1, 3, 4, 5, 6, 7, 8, 9 or 10 and numerator negative for Numerator 2 (i.e., HbA1c \leq 9.0%), at a minimum, copy each of the documents identified below for any numerators that are negative.

- **Diabetic Flow Sheet and all notes from Diabetes Educator**
- All Hemoglobin A1c **Laboratory Reports** for 2008 ***OR*** dated **Progress Notes** indicating date of service and results of most recent Hemoglobin A1c done in 2008.
- All dated **Report(s)**, **Retinal Photograph(s)**, **Fluorescein Angiography Report(s)** or **Report(s) of Consultation** summarizing results of eye exams performed by an **Eye Care Specialist** (Ophthalmologist or Optometrist) in 2007 *and* 2008, ***OR***, lacking any of the above,
All **Provider notes** (including PCP), dated and with results, indicating eye exam(s) completed by an **Eye Care Specialist** (Ophthalmologist or Optometrist) in 2007 *and* 2008.
- All LDL cholesterol **Laboratory Reports** 2008 (including lipid panel reports w/o LDL), ***OR*** dated **Progress Notes** indicating date of service and results of most recent LDL done in 2008
- Dated **Progress Notes** or **Reports of Consultation** or **Laboratory Reports** or **Hospital Reports** documenting one or more of the following:
 - All microalbumin tests from 2008
 - All total urine protein tests from 2008
 - All *positive* macroalbumin (urinalysis protein) tests from 2008
 - Evidence of diagnosis of or treatment for nephropathy in 2008, documented as one of the following:
 - ✓ Dialysis or preparation for dialysis
 - ✓ Renal transplant
 - ✓ Diagnosis of renal failure
 - ✓ Diagnosis of congenital kidney disease (renal hypoplasia or cystic kidney disease)
 - ✓ Visit to nephrologists

Additionally, for each patient submit any available documentation that explicitly notes the diabetic medication status for that patient (e.g., NIDDM or Type II diabetes, IDDM or Type I diabetes, Insulin-requiring diabetes, etc.) and whether or not the patient used insulin in 2008 (e.g., as evidenced through “insulin” missing from a medication list). Submit patient’s medication list.

MEASURE-SPECIFIC INFORMATION

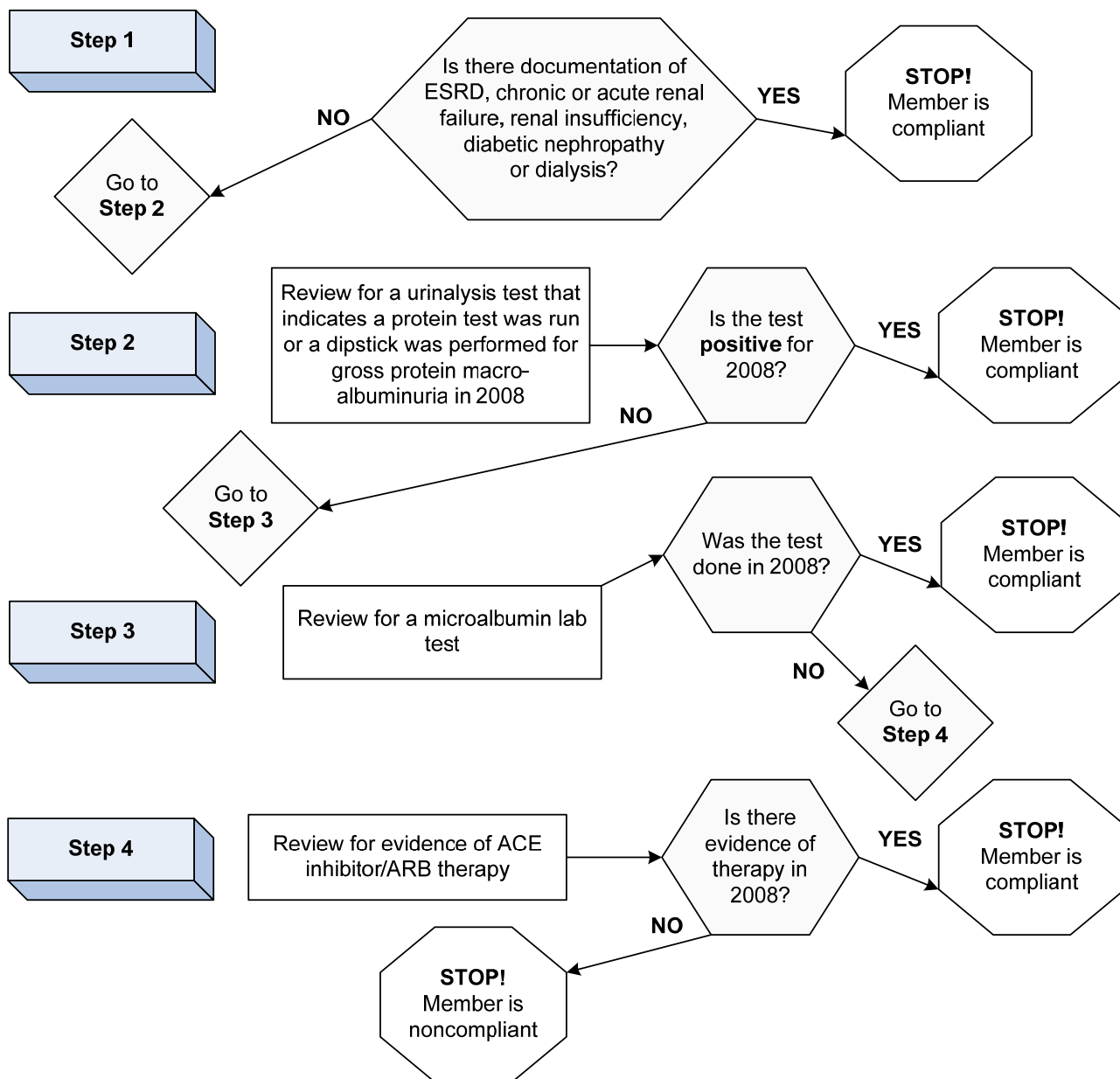
See Numerator Negative Photocopy Instructions

POSSIBLE PRACTITIONER TYPE(s)

- Primary Care Physician (Family Practice, Internist)
- Endocrinologist
- Ophthalmologist
- Optometrist
- Nephrologist
- Cardiologist

Comprehensive Diabetes, Numerator 8 –

Monitoring for Diabetic Nephropathy



CONTROLLING HIGH BLOOD PRESSURE (CBP)	
DENOMINATOR	Members age 18 through 85 with a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90) during the measurement year
NUMERATOR	Most recent, representative blood pressure measurement in 2008, after the diagnosis of hypertension, was <140 systolic and <90 diastolic
CONTRAINDICATIONS	<p>End-stage renal disease anytime prior to December 31, 2008. Documentation in the medical record must include a dated note indicating evidence of ESRD. Documentation of dialysis or renal transplant also meets the criteria for evidence of end-stage renal disease.</p> <p>Pregnancy during the measurement year.</p>
PHOTOCOPY INSTRUCTIONS	<p>Copy:</p> <ul style="list-style-type: none"> • Demographic/Face Sheet(s) • Health Maintenance Form/Report • Progress Reports • Problem Lists • Medical History Form • Medication Lists • Cardiology Consult Reports • Vital Sign Flow Sheet (Chart) <p>Also include any other documentation you feel may be relevant.</p> <p>To be considered "representative," the BP must have been obtained during a visit to the practitioner's office or other non-emergency outpatient facility, such as a clinic.</p> <ul style="list-style-type: none"> • The representative BP is the most recent BP taken during 2008. This reading must occur after the diagnosis of hypertension. The lowest BP is used as the representative BP regardless of posture. • The lowest systolic and lowest diastolic values can be utilized to fulfill the numerator criteria for the representative BP. • The systolic and diastolic results do not need to be from the same reading. <p>Readings taken under the following circumstances are <u>not</u> eligible:</p> <ul style="list-style-type: none"> • Outpatient visits for the sole purpose of having a diagnostic or surgical procedure performed (e.g., colonoscopy, removal of wart) • BP measurements obtained on the same day as a major diagnostic or surgical procedure (e.g., stress test, IV contrast for radiology) • BP readings obtained at an emergency room visit • BP reading that are self-reported by patient (e.g., those taken at home or at a health fair) <p>An exception to the last item is that a home visit BP reading taken by a licensed medical professional and documented in the medical record by the deadline for service may be counted.</p>

CONTROLLING HIGH BLOOD PRESSURE (CBP)	
DENOMINATOR CONFIRMATION	<p>The Blood Pressure measure is unique in that it is the only measure for which the plan <u>must confirm the diagnosis</u> that placed the member in the denominator (i.e., the hypertension diagnosis occurring on or before 6/30/2008).</p> <p>Note that the diagnosis of hypertension can occur prior to June 30, 2008. You must search as far back in the medical record as you can to identify the diagnosis of hypertension. Any of the following notations confirms the diagnosis of HTN: HTN, High BP (HBP), Elevated BP (↑BP), Borderline HTN, Intermittent HTN, History of HTN, Hypertensive vascular disease (HVD), Hyperpiesia, Hyperpiesis).</p> <p>If you cannot confirm the diagnosis of hypertension, you must copy the patient's medical record for the following:</p> <ul style="list-style-type: none"> • January 1, 2007 through December 31, 2008 <p>If the diagnosis is found on a problem list, the date of the diagnosis does not have to be noted.</p> <p>Documentation of hypertension diagnosis can generally be found in progress notes, problem lists, office note, subjective, objective, assessment, plan (SOAP) note, encounter form, telephone call record, diagnostic report, or hospital discharge summary.</p> <p>Statements such as "rule out hypertension," "possible hypertension," "white-coat hypertension," "questionable hypertension," and "consistent with hypertension" are not sufficient to confirm diagnosis of hypertension if such statement are the ONLY notations of hypertension in the medical record.</p>
PHOTOCOPY INSTRUCTIONS FOR NUMERATOR NEGATIVES	<p>If you are able to confirm the diagnosis of hypertension (the denominator), but the member is <u>not</u> numerator positive, at a <u>minimum</u> copy the documents identified in Photocopy Instructions for the following timeframe:</p> <p style="text-align: center;">January 1, 2008 through December 31, 2008</p> <p>Note: If you are not able to confirm the diagnosis of hypertension see the Denominator Confirmation section above for photocopying instructions.</p>
MEASURE-SPECIFIC INFORMATION	<p>The blood pressure reading can usually be found in a progress note or on a flow sheet used to record BP readings. Note that the most recent BP reading may be found in a consult note, not only the PCP note.</p>
POSSIBLE PRACTITIONER TYPE(s)	<p>Primary Care Physician (Family Practice, Internist)</p> <p>Any specialist who would routinely monitor blood pressure</p>

LEAD SCREENING IN CHILDREN (LSC)	
DENOMINATOR	Children two years of age in the measurement year.
NUMERATOR	At least one capillary or venous lead blood tests for lead poisoning by their second birthday.
CONTRAINDICATIONS	Same as the Childhood Immunization Status measure:
PHOTOCOPY INSTRUCTIONS	<p>Copy:</p> <ul style="list-style-type: none"> • Demographic/Face Sheet(s) • Progress Notes • Problem Lists • Laboratory Reports • Height/Weight Grid • All Anticipatory Guidance Grids • Documentation showing periodic well visits • Exam for sports activities/participation forms • Development Grids
PHOTOCOPY INSTRUCTIONS FOR NUMERATOR NEGATIVES	<p>If the member is <u>not</u> numerator positive, at a <u>minimum</u> copy the documents identified in the Photocopy Instructions for the following period:</p> <p style="text-align: center;">Birth through December 31, 2008</p>
MEASURE-SPECIFIC INFORMATION	<p>Documentation in the medical record must include the following:</p> <ul style="list-style-type: none"> • A note indicating the date the test was performed, and • The result or finding (i.e., the actual blood lead level)
POSSIBLE PRACTITIONER TYPE(s)	<p>Pediatrician Other Primary Care Physician (Family Practice, Internist)</p>

MEDICATION RECONCILIATION POST-DISCHARGE (MRP)	
DENOMINATOR	Members 65 years or older in the measurement year (2008) for whom medications were reconciled on or within 30 days of discharge (January 1 – December 1, 2008)
NUMERATOR	Medication reconciliation on or within 30 days of discharge in the measurement year
CONTRAINDICATIONS	None
PHOTOCOPY INSTRUCTIONS	Copy: <ul style="list-style-type: none"> • Demographic/Face Sheet(s) • Progress Notes • Problem Lists • Height/Weight Grid • Discharge Documentation • Medication Lists • Health Maintenance Form/Record • Medical History Form • Hospital Records – Discharge Summary; Transfer Evaluation – (Admission/Discharge)
PHOTOCOPY INSTRUCTIONS FOR NUMERATOR NEGATIVES	If the member is <u>not</u> numerator positive, at a <u>minimum</u> copy the documents identified in the Photocopy Instructions for the following period: January 1, 2008 through December 31, 2008
MEASURE-SPECIFIC INFORMATION	Documentation in the medical record must include evidence of medication reconciliation, and the date on which it was performed. The following evidence meets criteria. <ul style="list-style-type: none"> • A list of medications that were prescribed or ordered upon discharge, or • Notation that no medications were prescribed or ordered upon discharge <p><i>Note: The denominator is based on the discharge date found in administrative/claims data. This date must be used regardless of any subsequent data errors or corrections found during medical record review.</i></p> <p><i>Only documentation in the outpatient chart meets the intent of the measure. A medication list in a discharge summary obtained from the hospital or inpatient chart should not be used as evidence of medication reconciliation, but if this discharge summary is in the outpatient chart, this meets the intent of the measure.</i></p>
POSSIBLE PRACTITIONER TYPE(s)	PCP Surgeon Hospitalist Attending Physician Resident Medication Reconciliation Nurse

PRENATAL and POSTPARTUM CARE (PPC)	
DENOMINATOR	Women with a live birth between November 6, 2007 and November 5, 2008
NUMERATORS	<p>Numerator 1: Timeliness of Prenatal Care Prenatal care between 176-260 days prior to delivery, OR within 42 days of enrolling in health plan</p> <p>Numerator 2: Postpartum Care One postpartum visit on or between 21 – 56 days after delivery</p>
CONTRAINDICATIONS	None
PHOTOCOPY INSTRUCTIONS	<p>Copy:</p> <ul style="list-style-type: none"> • Demographic/Face Sheet(s) • Progress Notes • Problem Lists • Prenatal Care Records • Prenatal Lab Reports • Delivery Record/Discharge Summaries • Postpartum Visit Note(s) • Standardized ACOG Forms <p>PRENATAL VISIT CRITERIA: The numerator requires that a member have a timely prenatal care visit with an OB/GYN practitioner or midwife, family practitioner or other PCP. Each member will be assigned one of three possible timeframes for the visit:</p> <ol style="list-style-type: none"> 1. The entire first trimester of pregnancy 2. From enrollment date until the end of the first trimester 3. The period from the day of enrollment through the 42nd day after enrollment <p>The cover sheet will display the Prenatal Numerator Timeframe.</p> <p>To count as numerator positive, documentation in the medical record must include a dated note with evidence of one of the following:</p> <p><i>Prenatal care visit to an OB/GYN practitioner or midwife, family practitioner or other PCP.</i> Documentation in medical record must include a note indicating the date on which the prenatal visit occurred and evidence of the visit. For visits to a <i>family practitioner or PCP</i>, a diagnosis of pregnancy must also be present. Evidence of a prenatal care visit must include <i>one</i> of the following.</p> <ul style="list-style-type: none"> • A basic physical obstetrical examination that includes auscultation for fetal heart tone, or pelvic exam with obstetric observations, or measurement of fundus height (a standardized prenatal flow sheet may be used) • Evidence that a prenatal care procedure was performed, such as: <ul style="list-style-type: none"> – Screening test in the form of an obstetric panel (e.g., hematocrit, differential WBC count, platelet count, hepatitis B surface antigen, rubella antibody, syphilis test, RBC antibody screen, Rh[D] and ABO blood typing), or – TORCH antibody panel alone or a rubella antibody test/titer with an Rh incompatibility (ABO/Rh) blood typing, or – Echography of a pregnant uterus

PRENATAL and POSTPARTUM CARE (PPC)	
	<ul style="list-style-type: none"> • Documentation of LMP or EDD in conjunction with <i>either</i> of the following. <ul style="list-style-type: none"> – Prenatal risk assessment and counseling/education, or – Complete obstetrical history <p>When counting prenatal visits, include visits with physician assistants, nurse practitioners, midwives and registered nurses, provided that a co-signature by a physician is present, if required by state law.</p> <p>POSTPARTUM VISIT CRITERIA: Documentation in the medical record must include a note indicating the date on which a postpartum visit occurred and <i>one</i> of the following.</p> <ul style="list-style-type: none"> • Pelvic exam, or • Evaluation of weight, BP, breasts and abdomen, or • Notation of postpartum care, including but not limited to the following: <ul style="list-style-type: none"> – Notation of “postpartum care,” “PP care,” “PP check,” “6-week check.” A preprinted “Postpartum Care” form in which information was documented during the visit <p>Services that occur over multiple visits count toward this measure as long as all services are within the timeframe established in the measure.</p> <p>Send any medical record information you have showing a premature delivery, or if the medical record delivery date is different than the delivery date provided by the health plan.</p> <p><i>Note: A Pap test alone does not count as a prenatal care visit for timeliness indicator as it does not constitute a “pelvic exam with obstetric observations.” For the postpartum care indicator, the Pap test does count as numerator compliant. A colposcopy alone is not considered numerator compliant for either indicator in this measure.</i></p>
PHOTOCOPY INSTRUCTIONS FOR NUMERATOR NEGATIVES	<p>If the member is not numerator positive for both numerators, at a <u>minimum</u> copy the documents identified in Photocopy Instructions for the entire numerator timeframe:</p> <p style="text-align: center;">Prenatal Timeframe Start Date (i.e., start of pregnancy or enrollment date) to Postpartum End Date (i.e., 56 days after delivery)</p> <p>Consult the Cover Sheet or Electronic Pull List to identify the above dates.</p>
MEASURE-SPECIFIC INFORMATION	<p>The Delivery Date and the Start and End Dates of both the Prenatal and Postpartum Numerator Timeframes appear on the Cover Sheet and are available in the Electronic Pull List.</p> <p>For this measure, the member often receives the prenatal or postpartum visit; however, it doesn’t meet the timeframe requirements. This information is very valuable to health plans (i.e., further pursuit/follow up is unlikely to be fruitful). Please submit all out-of-timeframe prenatal and postpartum visits.</p>

PRENATAL and POSTPARTUM CARE (PPC)

**POSSIBLE PRACTITIONER
TYPE(s)**

Obstetrician/Gynecologist
Midwife
Family Practitioner
PCP

WEIGHT ASSESSMENT AND COUNSELING FOR NUTRITION AND PHYSICAL ACTIVITY FOR CHILDREN/ADOLESCENTS (WCC)	
DENOMINATOR	Members 3 – 17 of age who had an outpatient visit with a PCP or OB/GYN during the measurement year (2008) and who received the numerator services listed below
NUMERATOR	Numerator 1: BMI Percentile Numerator 2: Counseling for Nutrition Numerator 3: Counseling for Physical Activity
CONTRAINDICATIONS	None Exclusion: Pregnancy during measurement year
PHOTOCOPY INSTRUCTIONS	<ul style="list-style-type: none"> • Demographic/Face Sheet(s) • Progress Notes • Problem Lists • Height/Weight Grid • All Anticipatory Guidance Grids • Any separate documents showing periodic well-child/ adolescent visits, such as CHDP PM-160 forms or proprietary well-child forms • Exam for sports activities / participation forms • Development Grids • Education Forms
PHOTOCOPY INSTRUCTIONS FOR NUMERATOR NEGATIVES	If the member is <u>not</u> numerator positive, at a <u>minimum</u> copy the documents identified in the Photocopy Instructions for the following period: <p style="text-align: center;">January 1, 2008 to December 31, 2008</p>
MEASURE-SPECIFIC INFORMATION	<p>Numerator 1: BMI Percentile:</p> <p>Documentation must include a note indicating the date on which the BMI percentile was documented and evidence of either of the following.</p> <ul style="list-style-type: none"> • BMI percentile, <i>or</i> • BMI percentile plotted on age-growth chart <p>For adolescents 16–17 years, on the date of service, documentation of a BMI value expressed as kg/m² is acceptable.</p> <p>Numerator 2: Counseling for Nutrition:</p> <p>Documentation must include a note indicating the date and at least one of the following.</p> <ul style="list-style-type: none"> • Engagement in discussion of current nutrition behaviors (e.g., eating habits, dieting behaviors) • Checklist indicating nutrition was addressed • Counseling or referral for nutrition education • Member received educational materials on nutrition • Anticipatory guidance for nutrition

WEIGHT ASSESSMENT AND COUNSELING FOR NUTRITION AND PHYSICAL ACTIVITY FOR CHILDREN/ADOLESCENTS (WCC)

Numerator 3: Counseling for Physical Activity:

Documentation must include a note indicating the date and at least one of the following.

- Engagement in discussion of current physical activity behaviors (e.g. exercise routine, participation in sports activities, exam for sports participation)
- Checklist indicating physical activity was addressed
- Counseling or referral for physical activity
- Member received educational materials on physical activity
- Anticipatory guidance for physical activity

The following notations or examples of documentation are considered “negative findings” and do not count as numerator compliant.

- **BMI**
 - No BMI or BMI percentile documented in medical record or plotted on age-growth chart
 - Notation of height and weight only
 - BMI or BMI percentile noted prior to or after the measurement year
- **Nutrition and Diet**
 - No counseling/education on nutrition and diet
 - Counseling/education prior to or after the measurement year
 - Notation of “health education” or “anticipatory guidance” without any specific mention of nutrition
- **Physical Activity**
 - No counseling/education on physical activity
 - Notation of “cleared for gym class” alone without any of the aforementioned documentation
 - Counseling/education prior to or after the measurement year
 - Notation of “health education” or “anticipatory guidance” without any specific mention of physical activity

Note: Services may be rendered on the occasion of visits other than well-child visits. These services count if the specified documentation is present, regardless of the primary intent of the visit.

Member-reported BMI may be used if the disease management system is related to wellness, prevention, or obesity; the member-reported BMI or height and weight were measured by a licensed professional; and the disease management system information is either in the patient’s medical record or the physician can access the information during a visit.

POSSIBLE PRACTITIONER TYPE(s)

- Pediatrician
- Other Primary Care Physician (Family Practice, Internist)
- Obstetrician/Gynecologist

ADOLESCENT WELL-CARE VISITS (AWC)	
DENOMINATOR	Members age 12 – 21 in the measurement year (2008)
NUMERATOR	One comprehensive well-care visit with a primary care provider and/or OB/GYN in the measurement year (2008).
CONTRAINDICATIONS	None
PHOTOCOPY INSTRUCTIONS	<p>Copy:</p> <ul style="list-style-type: none"> • Demographic/Face Sheet(s) • Progress Notes • Problem Lists • Any separate documents showing periodic well-child visits, such as CHDP PM-160 forms or proprietary well-child forms • Height/Weight Grid • Anticipatory Guidance Grid • Development Grid <p>Also include any other documentation you feel may be relevant.</p> <p>At a minimum, documentation for this visit must be a dated note indicating the following:</p> <ul style="list-style-type: none"> • Notation of health and developmental history (both physical and mental), • A physical examination, and • Health education/anticipatory guidance. <p>Generally the intent of the visit should be stated to be for well-adolescent care. However, if an adolescent is brought in for illness or injury and all components of a well-care visit are documented, the visit may be counted. A well-care examination performed by a Registered Nurse Practitioner or Physician Assistant working for the primary care physician counts as a qualifying well-child visit if all visit components are present. Note that comprehensive well-care visits with OB/GYN practitioners may also count towards this measure, as long as all visit components are present.</p> <p>Submit evidence of physician specialty or PCP status.</p> <p>Please note that cumulative documentation is acceptable for this measure, as long as all service dates from which visit components are taken occur within the measurement year. For example, the following pieces of documentation can be aggregated and counted as a well care visit, using the latest service date for the numerator date:</p> <ul style="list-style-type: none"> – Health and developmental history documented on May 17 – Physical exam performed on July 8 – Anticipatory guidance documented at a visit on October 22 <p>In the example above, the HEDIS service date would be 10/22/2008.</p> <p>Documentation of well-child visits can generally be found in the History and Physical, Progress Notes, or EPSDT (CHDP) forms.</p> <p>The following types of visits do NOT count:</p> <ul style="list-style-type: none"> • Inpatient • ER • Specialist (unless it is an OB/GYN)

ADOLESCENT WELL-CARE VISITS (AWC)	
	School-based clinics may count if documentation from the visit was entered into the record before 12/31/2008.
PHOTOCOPY INSTRUCTIONS FOR NUMERATOR NEGATIVES	<p>If the member is <u>not</u> numerator positive, at a <u>minimum</u> copy the documents identified in the Photocopy Instructions for the following period:</p> <p style="text-align: center;">January 1, 2008 to December 31, 2008</p>
MEASURE-SPECIFIC INFORMATION	None
POSSIBLE PRACTITIONER TYPE(s)	Pediatrician Other Primary Care Physician (Family Practice, Internist) Obstetrician/Gynecologist

WELL-CHILD VISITS IN THE FIRST 15 MONTHS OF LIFE (W15)	
DENOMINATOR	Members who turned 15 months in the measurement year (2008)
NUMERATOR	Six or more comprehensive well-child visits during the first 15 months of life
CONTRAINDICTIONS	None
PHOTOCOPY INSTRUCTIONS	<p>Copy:</p> <ul style="list-style-type: none"> • Demographic/Face Sheet(s) • Progress Notes • Problem Lists • Any separate documents showing periodic well-child visits, such as CHDP PM-160 forms or proprietary well-child forms • Height/Weight Grid • Anticipatory Guidance Grid • Development Grid <p>Also include any other documentation you feel may be relevant.</p> <p>Remember, visits may occur in 2007 and/or 2008, depending on the child's date of birth.</p> <p>At a minimum, the documentation for this visit must be a dated note indicating the following:</p> <ul style="list-style-type: none"> • Notation of health and developmental history (both physical and mental), • A physical examination, and • Health education/anticipatory guidance. <p>Generally, the intent of the visit should be stated to be for well-child care. However, if a child is brought in for illness or injury and all components of a well-care visit are documented, the visit may be counted as a well-child visit. A well-child examination performed by a Registered Nurse Practitioner or Physician Assistant working for the PCP counts as a qualifying well-child visit if all visit components are present.</p> <p>Submit evidence of PCP status.</p> <p>Please note that cumulative documentation is acceptable for this measure, as long as all service dates from which visit components are taken occur within the measurement year. For example, the following pieces of documentation can be aggregated and counted as <u>one</u> well care visit, using the latest service date for the numerator date:</p> <ul style="list-style-type: none"> – Health and developmental history documented on May 17 – Physical exam performed on July 8 – Anticipatory guidance documented at a visit on October 22 <p>In the example above, the HEDIS service date would be 10/22/2008</p> <p>Documentation of well-child visits can generally be found in the History and Physical, Progress Notes, or EPSDT (CHDP) forms.</p> <p>The following types of visits do NOT count:</p> <ul style="list-style-type: none"> • Inpatient • ER • Specialist <p>School-based clinics may count if documentation from the visit was entered into the record before 12/31/2008.</p>

WELL-CHILD VISITS IN THE FIRST 15 MONTHS OF LIFE (W15)	
PHOTOCOPY INSTRUCTIONS FOR NUMERATOR NEGATIVES	<p>If the member is <u>not</u> numerator positive, at a <u>minimum</u> copy the documents identified in the Photocopy Instructions for the following period:</p> <p style="text-align: center;">Birth to 15-months</p>
MEASURE-SPECIFIC INFORMATION	<p>Birth date and date when member turned 15 months will be included in the Electronic Pull List.</p> <p>Member must have at least six visits within the first 15 months of life to be considered numerator positive. Please continue to search all available medical record information if you have found fewer than six visits.</p>
POSSIBLE PRACTITIONER TYPE(s)	<p>Pediatrician</p> <p>Other Primary Care Physician (Family Practice, Internist)</p>

WELL-CHILD VISITS IN THE 3RD, 4TH, 5TH, AND 6TH YEARS OF LIFE (W34)	
DENOMINATOR	Children who turned 3, 4, 5, or 6 in the measurement year (2008)
NUMERATORS	One well-child visit with a primary care provider in 2008
CONTRAINDICATIONS	None
PHOTOCOPY INSTRUCTIONS	<p>Copy:</p> <ul style="list-style-type: none"> • Demographic/Face Sheet(s) • Progress Notes • Problem Lists • Any separate documents showing periodic well-child visits, such as CHDP PM-160 forms or proprietary well-child forms • Height/Weight Grid • Anticipatory Guidance Grid • Development Grid <p>Also include any other documentation you feel may be relevant. At a minimum, the documentation for this visit must be a dated note indicating the following:</p> <ul style="list-style-type: none"> • notation of health and developmental history (both physical and mental), • a physical examination, and • health education/anticipatory guidance. <p>Generally the intent of the visit should be stated to be for well-child care. However, if a child is brought in for illness or injury and all components of a well-care visit are documented, the visit may be counted as a well-child visit. A well-child examination performed by a Registered Nurse Practitioner or Physician Assistant working for the primary care physician counts as a qualifying well-child visit if all visit components are present.</p> <p>Submit evidence of PCP status.</p> <p>Please note that cumulative documentation is acceptable for this measure, as long as all service dates from which visit components are taken occur within the measurement year. For example, the following pieces of documentation can be aggregated and counted as <u>one</u> well care visit, using the latest service date for the numerator date:</p> <p style="padding-left: 40px;">Health and developmental history documented on May 17</p> <p style="padding-left: 40px;">Physical exam performed on July 8</p> <p style="padding-left: 40px;">Anticipatory guidance documented at a visit on October 22</p> <p style="padding-left: 40px;">In the example above, the HEDIS service date would be 10/22/2008.</p> <p>Documentation of well-child visits can generally be found in the History and Physical, Progress Notes, or EPSDT (CHDP) forms.</p> <p>The following types of visits do NOT count:</p> <ul style="list-style-type: none"> • Inpatient • ER • Specialist <p>School-based clinics may count if documentation from the visit was entered into the record before 12/31/2007..</p>

WELL-CHILD VISITS IN THE 3RD, 4TH, 5TH, AND 6TH YEARS OF LIFE (W34)	
PHOTOCOPY INSTRUCTIONS FOR NUMERATOR NEGATIVES	<p>If the member is <u>not</u> numerator positive, at a <u>minimum</u> copy the documents identified in the Photocopy Instructions for the following period:</p> <p style="text-align: center;">January 1, 2008 to December 31, 2008</p>
MEASURE-SPECIFIC INFORMATION	None
POSSIBLE PRACTITIONER TYPE(s)	Pediatrician Other Primary Care Physician (Family Practice, Internist)

CCHRI 2009
MEDICAL RECORD PHOTOCOPYING REQUIREMENTS FOR NUMERATOR NEGATIVES

MEASURE	TIMEFRAME	REQUIRED DOCUMENTATION
Adult BMI Assessment (ABA)	January 1, 2007 – December 31, 2008	<ol style="list-style-type: none"> 1. Demographic/Face Sheet(s) 2. Progress Notes 3. Problem Lists 4. Height/Weight Grid 5. All Anticipatory Guidance Grids 6. Any separate documents showing periodic well visits (annual exams???) 7. Exam for sports activities / participation forms Development Grids
Care for Older Adults (COA)	January 1, 2008 – December 31, 2008	<ol style="list-style-type: none"> 1. Demographic/Face Sheet(s) 2. Progress Notes 3. Problem Lists 4. Health Maintenance Form/Report 5. History and Physical Notes 6. Medication List/Record 7. Advance Directives, living wills (any form with surrogate decision maker or court appointed representative) 8. Geriatric Assessment tool/form 9. Functional Assessment Tool (activities of Daily Living form (ADL) or ILS tool) 10. Pain Management Forms 11. Education Forms
Cervical Cancer Screening (CCS)	January 1, 2006 - December 31, 2008	<ol style="list-style-type: none"> 1. Demographic/Face Sheet(s) 2. Health Maintenance Form/Record 3. Problem Lists 4. Progress Notes 5. Medical History Forms 6. Cytology Reports 7. Pathology Reports 8. Ultrasound Surgery or Procedure Reports 9. Flow Chart

MEASURE	TIMEFRAME	REQUIRED DOCUMENTATION
Childhood Immunization Status (CIS)	Birth through December 31, 2008	<ol style="list-style-type: none"> 1. Demographic/Face Sheet(s) 2. Health Maintenance Form/Record 3. Problem Lists 4. Progress Notes 5. Medical History Form 6. Immunization Records 7. Laboratory Reports
Cholesterol Management For Patients With Cardiovascular Conditions (CMC)	January 1,2007 -December 31, 2008	<ol style="list-style-type: none"> 1. Demographic/Face Sheet(s) 2. Health Maintenance Form/Report 3. Progress Notes 4. Problem Lists 5. Hospital Documents 6. History and Physical Notes 7. Discharge Summary 8. Consultation Notes (Cardiology) 9. Medication List 10. LDL Cholesterol Lab Reports (include all lipid panel reports, LDL, and total cholesterol)
Colorectal Cancer Screening (COL)	<p><u>Collector must look back the entire 10 year numerator timeframe</u>, January 1, 1999 – December 31, 2008 to find evidence of service. If no evidence of service is found, copy the “required documentation” for the five year period January 1, 2004 through December 31, 2008.</p> <p>(If record is extremely large >75pages – contact Health Plan representative)</p>	<ol style="list-style-type: none"> 1. Demographic/Face Sheet(s) 2. Health Maintenance Form/Record 3. Medical History Forms 4. Progress Notes 5. Problem Lists 6. Laboratory Reports 7. Pathology Reports 8. X-ray Reports 9. Most Recent Patient Health Questionnaire 10. Medication Lists 11. GI Consults 12. Flow Charts

MEASURE	TIMEFRAME	REQUIRED DOCUMENTATION
Comprehensive Diabetes Care (CDC)	January 1, 2007 -December 31, 2008	<ol style="list-style-type: none"> 1. Demographic/Face Sheet(s) 2. Health Maintenance Form/Record 3. Medical History Form 4. Diabetic Flow Sheets (Charts) 5. Notes from Diabetes Educator 6. Notes or referrals to/from diabetic Teaching Centers 7. Laboratory Reports 8. Progress Notes 9. Problem Lists 10. Retinal Photograph(s) 11. Fluorescein Angiography Report(s) 12. Report(s) of Consultation 13. Provider notes 14. Hospital Reports 15. Medication List
Controlling High Blood Pressure (CBP)	January 1, 2007 - December 31, 2008	<ol style="list-style-type: none"> 1. Demographic/Face Sheet(s) 2. Health Maintenance Form/Report 3. Medical History Form 4. Progress Notes 5. Problem Lists 6. Medication Lists 7. Cardiology Consult Reports 8. Vital Sign Flow Sheet (Charts)
Medication Reconciliation During Post-Discharge (MRP)	January 1, 2008 – December 1, 2008	<ol style="list-style-type: none"> 1. Demographic/Face Sheet(s) 2. Progress Notes 3. Problem Lists 4. Height/Weight Grid 5. Discharge Documentation 6. Medication Lists 7. Health Maintenance Form/Record 8. Medical History Form 9. Hospital Records – Discharge Summary; Transfer Evaluation – (Admission/Discharge)

MEASURE	TIMEFRAME	REQUIRED DOCUMENTATION
Prenatal And Postpartum Care (PPC)	The Delivery Date and the Start and End Dates of both the Prenatal and Postpartum Numerator Timeframes appear on the Medical Record Submission Cover Sheet	<ol style="list-style-type: none"> 1. Demographic/Face Sheet(s) 2. Prenatal Care Records 3. Prenatal Lab Reports 4. Progress Notes 5. Problem Lists 6. Delivery Record/Discharge Summaries 7. Postpartum Visit Note(s) (to extend 3 months beyond the birth date) 8. Standardized ACOG Forms
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)	January 1, 2008 – December 31, 2008	<ol style="list-style-type: none"> 1. Demographic/Face Sheet(s) 2. Progress Notes 3. Problem Lists 4. Height/Weight Grid 5. All Anticipatory Guidance Grids 6. Any separate documents showing periodic well-child/ adolescent visits, such as CHDP PM-160 forms or proprietary well-child forms 7. Exam for sports activities / participation forms 8. Development Grids 9. Education Forms
Adolescent Well-Care Visits (AWC)	January 1, 2008 - December 31, 2008	<ol style="list-style-type: none"> 1. Demographic/Face Sheet(s) 2. Progress Notes 3. Problem Lists 4. Any separate documents showing periodic well-child visits, such as CHDP PM-160 forms or proprietary well-child forms 5. Height/Weight Grid 6. Anticipatory Guidance Grid 7. Development Grid

MEASURE	TIMEFRAME	REQUIRED DOCUMENTATION
Well-Child Visits In The First 15 Months Of Life (W15)	Birth to 15-months. Dates will appear on the Medical Record Submission Cover Sheet	<ol style="list-style-type: none"> 1. Demographic/Face Sheet(s) 2. Progress Notes 3. Problem Lists 4. Any separate documents showing periodic well-child visits, such as CHDP PM-160 forms or proprietary well-child forms 5. Height/Weight Grid 6. Anticipatory Guidance Grid 7. Development Grid
Well-Child Visits In The 3 rd , 4 th , 5 th , And 6 th Years Of Life (W34)	January 1, 2008 - December 31, 2008	<ol style="list-style-type: none"> 1. Demographic/Face Sheet(s) 2. Progress Notes 3. Problem Lists 4. Any separate documents showing periodic well-child visits, such as CHDP PM-160 forms or proprietary well-child forms 5. Height/Weight Grid 6. Anticipatory Guidance Grid 7. Development Grid