Pediatric HEDIS Measures
Proper Documentation to Improve HEDIS Scores

absolute total care™
Healthy Connections

Well-Child/Adolescent Visits

Ages 0-15 months, 3-6 years, 12-21 years

Each well-child/adolescent visit must have the following completed and documented:

- A health history
- A physical development history
- A mental development history
- A comprehensive physical exam
- Health education/anticipatory guidance

Absolute Total Care reimburses for sick and well visits performed on the same day. Please use **modifier 25** when billing codes 99211, 99212, or 99213 (sick visits) and the well visit codes.

Examples of Documentation

Health History	
Acceptable Documentation	**Unacceptable Documentation**
Documentation of past illnesses or surgeries (this may include birth history for infants)	No health history or previous medical conditions documented
A statement that the child is doing fine from previous visit without any new problems or interval history from previous visit	History of Present Illness (HPI) alone (e.g., "vomiting x 2 days, no diarrhea or fever")
All three are documented : allergies noted, medications list, and vaccine history	Only one or two of three (allergies, medications, vaccines) noted in the record (e.g., notation of "NKDA" alone)
Documentation of family medical history	Statement that parents are living without any documentation of family medical history
Physical Development History	
Acceptable Documentation	**Unacceptable Documentation**
Documentation of status of development (e.g., "well developed", "development: WNL", "developing normally")	Documentation of "growing appropriately" or "well nourished" **without** notation about "development"
Documentation of physical milestones met (e.g., "sits unsupported for 10 minutes", "hops on one foot", "rides bicycle", Tanner Stages/sexual maturity for adolescents) and/or any missed or delayed milestones	Documentation of "does not have special needs", "all four extremities normal", or "no gross sensory/motor deficit" and failing to address developmental milestones
Documentation that the parent indicates the child has achieved all milestones in movement and physical developmental areas	Growth charts alone without discussion of development
Checkbox next to "development appropriate for age" or "development WNL" is checked	Checkbox is not checked/left blank
Mental Development History	
Acceptable Documentation	**Unacceptable Documentation**
Documentation of status of development (e.g., "well developed", "development: WNL", "developing normally", normal milestones for age")	Documentation of "growing appropriately" or "well nourished" **without** notation about "development"
Documentation of mental milestones met (e.g., "says mama and dad randomly", "names objects", "imaginative play") and/or any missed or delayed milestones	Documentation of physical development alone and does not address mental development
Documentation of peer/family interaction or how well the child does in school (e.g., "passing or failing", "honor student")	Documentation addresses ADD/ADHD alone and does not address development in relation to age group
Checkbox next to "development appropriate for age" or "development WNL" is checked	Checkbox is not checked/left blank

Physical Exam	
Acceptable Documentation	**Unacceptable Documentation**
Documentation of a **comprehensive** physical exam (at least 3 body systems): if a sick visit, 3 body systems must be addressed in addition to those related to the chief complaint (an abdomen assessment would not count if the chief complaint was vomiting and abdominal pain)	A physical exam limited only to a condition/chief complaint (e.g., URI, knee pain, gastric issues), vital signs alone, eye exam alone
Physical assessment form with checked boxes for multiple body systems (at least 3, in addition to any areas of complaint)	Checkboxes are not checked/left blank
Health Education/Anticipatory Guidance	
Acceptable Documentation	**Unacceptable Documentation**
Documentation of general health education or anticipatory guidance that can be applied to any child in the age group (e.g., helmet safety, diet/exercise for healthy weight, discipline/limit setting, peer pressure)	Documentation of health education/anticipatory guidance related to a single condition or the chief complaint (e.g., BRAT diet, ADA diet, immunization side effects)
Checkbox next to health education/anticipatory guidance is checked	Unchecked boxes in a health education/anticipatory guidance section/left blank

Other Age-Specific Measures to Consider

During a well-child or sick visit, please consider the need for the age-specific measures mentioned below.

Childhood Immunizations and Lead

- Ages 0 and up to 2 years of age (prior to second birthday)
- At each visit, evaluate the need for immunizations and lead testing
- Children must be fully immunized and have at least one lead screening **on or before the second birthday**

Childhood Obesity/Weight Assessment and Counseling for Nutrition and Physical Activity

- Ages 3-17 years
- This measure consists of 3 components (all 3 components may occur during a well visit and/or sick visit):
  - BMI Percentile
  - Nutrition Counseling/Education
  - Physical Activity Counseling/Education
- The Adult BMI measure requires BMI percentile for ages 18-19

Adolescent Immunizations

- Before their 13th birthday, all adolescents need:
  - 1 meningococcal
  - 1 Tdap
  - 3 HPV vaccines (males and females)
- Check the status of immunizations at the 11 years old well visit (do not wait until 12 years old)

Chlamydia Screening

- Sexually active females ages 16-24 years must be tested for chlamydia **each year**. This includes those who have had:
  - A pregnancy test
  - Sexually transmitted infection (STI) testing
  - A prescription filled for contraceptives
- This can be done with a urine test: nucleic acid amplification test (NAAT) testing; use CPT code 87491