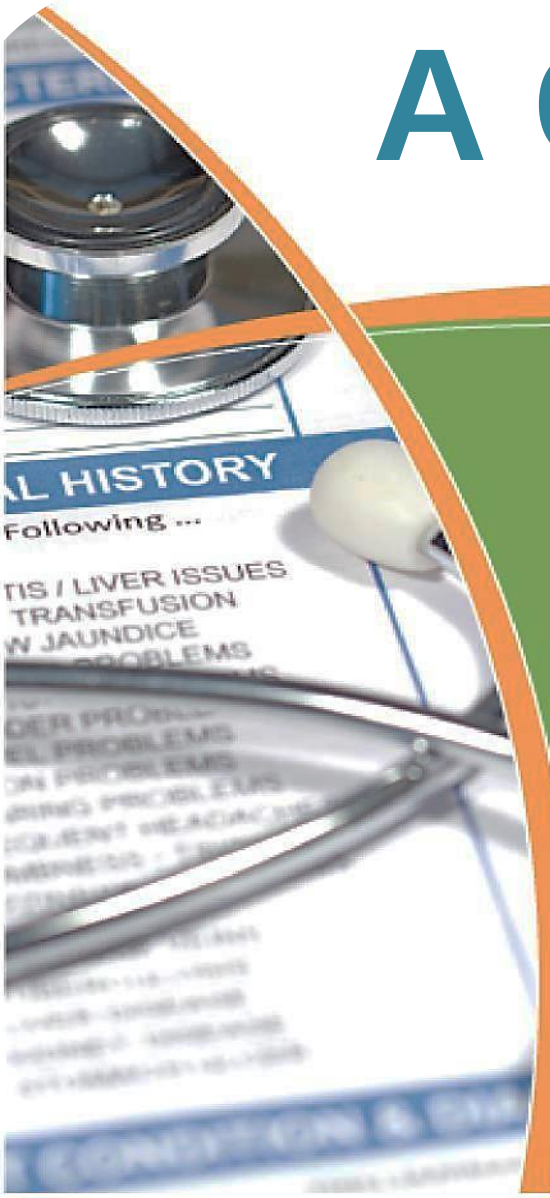
L.A. Care
HEALTH PLAN

2016 HEDIS AT A GLANCE



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*Medicare Star Program

Welcome to 2016 HEDIS-At-A-Glance

L. A. Care is an NCQA-accredited health plan. HEDIS is the gold standard for measuring quality health care performance, and is part of the NCQA accreditation process. HEDIS-At-A-Glance is a reference guide designed to help your practice provide the best quality care, in alignment with the HEDIS standards. This document is merely a tool and provides a general summary on some limited HEDIS® Program requirements. This document should not be used as legal advice or expert advice or comprehensive summary of the HEDIS ® Program. Please refer to ncqa.org for HEDIS ® Program measures and guidelines as well as relevant statutes.

The information provided is in this document is for 2016 HEDIS period and is current at the time this document was created. NCQA HEDIS ® Program requirements, applicable laws, and L.A. Care's policy change from time to time, and information and documents requested from you may also change to comply with these requirements

L.A. Care is not affiliated with NCQA or its HEDIS ®Program and does not receive any financial remuneration from it."

2016 HEDIS-At-A-Glance highlights 32 priority HEDIS measures that can potentially have significant impact on Auto-assignment and Medicare Star Program. Additionally, if you participate in and qualify for Physician Pay-for-Performance Program, the information contained in this reference guide may help you maximize the incentives you receive as part of L. A. Care's Physician Pay-for-Performance Program for Medi-Cal and L. A. Care Covered members.

L.A. Care Health Plan collects data for HEDIS reporting annually from January to May. The Reporting Year (RY) details the performance rates from the previous year or, the Measurement Year (MY). For example, HEDIS 2016 (RY) reports data collected from services rendered from January 1, 2015 to December 31, 2015 (MY).
For HEDIS related inquiries, please contact HEDIS_Ops@lacare.org.

Pay for Performance: Look for this symbol  for Measurement Year 2015 measures that are included in the L.A. Care's pay-for-performance programs.
For more details contact incentive_ops@lacare.org.

2016 Medicare Star Ratings

One of the Centers for Medicare & Medicaid Services' (CMS) most important strategic goals is to improve the quality of care and general health status for Medicare beneficiaries. : "The information provided is in this document is for 2016 period and is current at the time this document was created, CMS requirements, applicable laws, and L.A. Care's policy change from time to time, and for additional information, please refer to the CMS website for a description of the CMS requirements for the Medicare Star ratings. "

CMS publishes the Part C and D Star Ratings each year to: measure quality in Medicare Advantage (MA) and Prescription Drug Plans (PDPs or Part D plans), assist beneficiaries in finding the best plan for them, and determine MA Quality Bonus Payments. Moreover, the ratings support the efforts of CMS to improve the level of accountability for the care provided by physicians, hospitals, and other providers. CMS continues to see increases in the number of Medicare beneficiaries in high-performing Medicare Advantage (MA) plans. Star Ratings are driving improvements in Medicare quality. The information included in this Fact Sheet is evidence of such improvement and is based on the 2016 Star Ratings published on Medicare Plan Finder (MPF) on October 8, 2015.

Background

Medicare Advantage with prescription drug coverage (MA-PD) contracts are rated on up to 44 unique quality and performance measures; MA-only contracts (without prescription drug coverage) are rated on up to 32 measures; and stand-alone PDP contracts are rated on up to 15 measures. Each year, CMS conducts a comprehensive review of the measures that make up the Star Ratings, considering the reliability of the measures, clinical recommendations, feedback received from stakeholders, and data issues. All measures transitioned from the Star Ratings are included in the display measure available from this page http://go.cms.gov/partcanddstarratings. Changes to existing measures are summarized in Attachment A.

The Star Ratings measures span five broad categories:

- Outcomes
- Intermediate Outcomes
- Patient Experience
- Access
- Process

For the 2016 Star Ratings, outcomes and intermediate outcomes continue to be weighted three times as much as process measures, and patient experience and access measures are weighted 1.5 times as much as process measures. CMS assigns a weight of 1 to all new measures. The Part C and D quality improvement measures receive a weight of 5 to further reward contracts for the strides they made to improve the care provided to Medicare enrollees. CMS continues to lower the overall Star Rating for contracts with serious compliance issues, defined as the imposition of enrollment or marketing sanctions.

L.A. Care's Improvement Initiatives

L.A. Care is actively pursuing interventions to improve its star rating. Most importantly L.A. Care recognizes the need to better support the valuable and necessary care you provide to our members. We have developed incentive programs to support your efforts. As an example we introduced a provider incentive for CMC members who receive an annual exam. Additionally we have developed provider incentives for targeted measures. L.A. Care has developed a cross-departmental team that can prioritize key star measures. The team is creating and implementing a strategic plan to increase star measures performance.

Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis (AAB)

Q: Which members are included in the sample?

A: Adults 18-64 years of age who had an outpatient or ED visit with a diagnosis of acute bronchitis, and were not dispensed prescription for antibiotic medication in 2015.

Q: What codes are used?

A: Please reference attached sample codes; reference Value Set Directory for additional codes

Q: What documentation is needed in the medical record?

A: *None*. This measure requires **claim/encounter data** submission only using the appropriate Value Set Codes.

Q: What type of document is acceptable?

A: Evidence from a claim/encounter with a date of service for any outpatient or ED visit with an acute bronchitis diagnosis and no new or refill prescription for an antibiotic medication in 2015.

Q: How to improve score for this HEDIS measure?

A:

- ☑ Use of complete and accurate Value Set Codes.
- ☑ Timely submission of claims and encounter data

Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis (AAB)

SAMPLE CODES

ICD-10 codes
J20.9

CPT codes
99217-99220

Exclusion ICD-10 codes
B20, C00-D49, E84.9, J43.9, J44.9

Adult BMI Assessment (ABA)

Q: Which members are included in the sample?

A: Members 18-74 years of age who had an outpatient visit and whose body mass index (BMI) was documented in **2014** or **2015**.

Q: What codes are used?

A: Please reference attached sample codes; reference Value Set Directory for additional codes

Q: What documentation is needed in the medical record?

A: Documentation in the medical record must include: a **note** indicating an outpatient visit, **date** visit occurred, and evidence of the following:

For members 21 years and older, medical record must indicate:

☑ Weight
☑ BMI Value

For members younger than 21 years old, medical record must indicate:

☑ Height
☑ Weight
☑ BMI Percentile *(Documented as a value (e.g., 85th percentile) or plotted on an age-growth chart.)*

Q: What type of medical record is acceptable?

A: One or more of the following: (visit completed in **2014** or **2015**)

☑ PM 160/CHDP
☑ Progress notes/Office visit notes
☑ Complete Physical Examination Form
☑ Dated BMI growth chart/log and weight

Note: *Ranges and thresholds do not meet criteria for this indicator.*

Adult BMI Assessment (ABA)

Q: How to improve score for this HEDIS measure?
A: ☑ Use of complete and accurate Value Set Codes. ☑ Timely submission of claims and encounter data ☑ Ensure presence of all components in the medical record documentation *Exclusion (optional): A diagnosis of pregnancy in 2014 or 2015*

Adult BMI Assessment (ABA)

SAMPLE CODES

ICD- 10 codes
Z68.51-Z68.54, Z68.1, Z68.20-Z68.24, Z68.25, Z68.30, Z68.41

CPT codes
99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99385-99387

Exclusion ICD-10 code
Z33.1

Follow-Up Care for Children Prescribed ADHD Medication (ADD)

Q: Which members are included in the sample?

A: Children 6-12 years newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication that had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported.

- ☑ *Initiation Phase.* Children with an ambulatory prescription dispensed for ADHD medication that had one follow-up visit during the 30-day Initiation Phase.
- ☑ *Continuation and Maintenance (C&M) Phase.* Members who (a) remained on ADHD medication for at least 210 days (7 months) and (b) had at least two follow-up visits within 270 days (9 months) after the Initiation Phase ended

Q: What codes are used?

A: Please reference attached sample codes; reference Value Set Directory for additional codes

Q: What documentation is needed in the medical record?

A: *None*. This measure requires **claim/encounter data** submission only using the appropriate Value Set Codes.

Q: What type of document is acceptable?

A: Evidence from a claim/encounter

1. Children in the specified age range who were dispensed an ADHD medication

Description	Prescription		
CNS stimulants	• Amphetamine-dextroamphetamine • Dexmethylphenidate	• Dextroamphetamine • Lisdexamfetamine	• Methylphenidate • Methamphetamine
Alpha-2 receptor agonists	• Clonidine	• Guanfacine	
Miscellaneous ADHD medications	• Atomoxetine		

2. Member follow-up visit with a practitioner with prescribing authority, within 30 days of ADHD medication dispensing
    a. Of these members, in the following 9 months, who received at least 2 additional follow-up visits with any practitioner

Follow-Up Care for Children Prescribed ADHD Medication (ADD)

Q: How to improve score for this HEDIS measure?
A: ☑ Use of complete and accurate Value Set ☑ Timely submission of claims and encounter data ☑ Schedule 30-day follow-up for all children who are dispensed ADHD medication to assess how medication is working.

Follow-Up Care for Children Prescribed ADHD Medication (ADD)

SAMPLE CODES

ICD-10 codes
F90.0-F90.2, F90.8, F90.9, F91.0-F91.3, F91.8, F91.9

CPT codes
90791, 90801, 90804-90819, 90821-90824, 90826-90829, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90857, 90862, 90875, 90876, 96150-96154, 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99223, 99231-99233, 99238, 99239, 99241-99245, 99341-99345, 99347-99350, 99381-99384, 99391-99394, 99401-99404, 99411, 99412, 99510

HCPCS visit codes
G0155, G0176, G0177, G0409, G0410, G0411, G0463, H0002, H0004, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, M0064, S0201, S9480, S9484, S9485, T1015

Exclusion ICD-10 codes
G47.419

Antidepressant Medication Management (AMM)

Q: Which members are included in the sample?

A: Adults 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment. Two rates are reported.

- ☑ Effective Acute Phase Treatment. Members who remained on an antidepressant medication for at least 84 days (12 weeks).
- ☑ Effective Continuation phase Treatment. Members who remained on an antidepressant medication for at least 180 days (6 months).

Q: What codes are used?

A: Please reference attached sample codes; reference Value Set Directory for additional codes

Q: What documentation is needed in the medical record?

A: *None*. This measure requires **claim/encounter data** submission only using the appropriate Value Set Codes.

Antidepressant Medication Management (AMM)

Q: What type of document is acceptable?

A: Evidence from a claim/encounter

1. Diagnosis of major depression and date of the earliest dispensing event for an antidepressant medication

Description	Prescription		
Miscellaneous antidepressants	• Bupropion	• Vilazodone	• Vortioxetine
Monoamine oxidase inhibitors	• Isocarboxazid • Phenelzine	• Selegiline • Tranylcypromine	
Phenylpiperazine antidepressants	• Nefazodone	• Trazodone	
Psychotherapeutic combinations	• Amitriptyline-chlordiazepoxide • Amitriptyline-perphenazine		• Fluoxetine-olanzapine
SNRI antidepressants	• Desvenlafaxine • Duloxetine	• Levomilnacipran • Venlafaxine	
SSRI antidepressants	• Citalopram • Escitalopram	• Fluoxetine • Fluvoxamine	• Paroxetine • Sertraline
Tetracyclic antidepressants	• Maprotiline	• Mirtazapine	
Tricyclic antidepressants	• Amitriptyline • Amoxapine • Clomipramine	• Desipramine • Doxepin (>6 mg) • Imipramine	• Nortriptyline • Protriptyline • Trimipramine

2. Calendar days covered with prescriptions within the specified 180-day (6-month) measurement interval based on pharmacy claims

Q: How to improve score for this HEDIS measure?

A:

- ☑ Use of complete and accurate Value Set
- ☑ Timely submission of claims and encounter data
- ☑ Follow Practice Guidelines for the Treatment of Patients with Major Depressive Disorders
- ☑ Treat members with diagnosis of major depression for at least six months.
- ☑ Utilize the PHQ-9 assessment tool in management of depression.
- ☑ Educate members that it might take up to 4 weeks for therapeutic effect and of possible medication side effects.

Antidepressant Medication Management (AMM)

SAMPLE CODES

ICD-10 codes
F32.0-F32.4, F32.9, F33.0-F33.3, F33.41, F33.9

CPT codes
90791, 90801, 90804, 90806, 90808, 90810, 90812, 90814, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90862, 90867-90870, 90875, 90876, 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99223, 99231-99233, 99238, 99239, 99241-99245, 99251-99255, 99281-99285, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99411, 9912, 99510

HCPCS visit codes
G0155, G0176, G0177, G00409-11, G0463, H002, H004, H0031, H0034, H0035-37, H0039, H0040, H2000, H2001, H2010-20, M0064, S0201, S9480, S94845, T1015

Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)

Q: Which members are included in the sample?

A: Adults 18 years and older with a diagnosis of rheumatoid arthritis and who were dispensed at least one ambulatory prescription for a disease-modifying anti-rheumatic drug (DMARD) in 2015.

Q: What codes are used?

A: Please reference attached sample codes; reference Value Set Directory for additional codes

Q: What documentation is needed in the medical record?

A: *None*. This measure requires **claim/encounter data** submission only using the appropriate Value Set Codes.

Q: What documentation is needed in the medical record?

A: Evidence from claim/encounter/pharmacy data

- A date of service for any outpatient visit or a non-acute inpatient discharge with a diagnosis of rheumatoid arthritis, and a prescription for DMARD in 2015.

DMARDs:

Description	Prescription		
5-Aminosalicylates	• Sulfasalazine		
Alkylating agents	• Cyclophosphamide		
Aminoquinolines	• Hydroxychloroquine		
Anti-rheumatics	• Auranofin • Gold sodium thiomalate	• Leflunomide • Methotrexate	• Penicillamine
Immunomodulators	• Abatacept • Adalimumab • Anakinra • Certolizumab	• Certolizumab pegol • Etanercept • Golimumab • Infliximab	• Rituximab • Tocilizumab
Immunosuppressive agents	• Azathioprine	• Cyclosporine	• Mycophenolate
Janus kinase (JAK) inhibitor	• Tofacitinib		
Tetracyclines	• Minocycline		

Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)

Q: How to improve score for this HEDIS measure?
A: ☑ Use of complete and accurate Value Set ☑ Timely submission of claims and encounter data ☑ Ensure proper documentation in medical record ☑ Evidence of a diagnosis of HIV or pregnancy **-** *documentation will assist in excluding members from the HEDIS sample.*

Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)

SAMPLE CODES

ICD-10 codes
M06.9

CPT codes
99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99456

HCPCS visit codes
G0402, G0438, G0439, G0463, T1015

HCPCS injection codes
J0129, J0135, J0717, 0718, J1600, J1602, J1745, J3262, J7502, J7515-J7518, J9250, J9260, J9310

Exclusion ICD-10 codes
B20, Z33.1

Adolescent Well-Care Visits (AWC)

Q: Which members are included in the sample?

A: Members 12-21 years of age who had at least one comprehensive well-care visit with a Primary Care Practitioner or an OB/GYN practitioner in **2015**.

Q: What codes are used?

A: Please reference attached sample codes; reference Value Set Directory for additional codes

Q: What documentation is needed in the medical record?

A: Documentation in the medical record must include a note indicating a visit with a PCP or OB/GYN practitioner, the date when the well-care visit occurred and evidence of all of the following:

- ☑ ***A health/interval history***
- ☑ ***A physical developmental history***
- ☑ ***A mental developmental history***
- ☑ ***A physical exam***
- ☑ ***Health education/anticipatory guidance***

PHYSICAL EXAM	HEALTH HISTORY	PHYSICAL HEALTH DEVELOPMENT	MENTAL HEALTH DEVELOPMENT	ANTICIPATORY GUIDANCE
Weight	Interval history	Developing appropriately for age	Making good grades at school	Safety (seat belt)
Height	Active problems	Does not smoke or drink alcohol	Has good circle of friends	Nutrition (vitamins, frequency of eating, snacks, ideal weight)
Chest	Past medical history	Participates in team sports at school	Transitioning to high school well	Fitness and the importance of exercise
Heart	Surgical history	Discussions about P.E. at school	Seems detached from family/friends	Oral health (dental visits, eating habits, need for orthodontics
Lungs	Family history	Discussions on menstrual cycle	Sleeps more than usual	Sexuality (safe sex, birth control)
Tanner Stages	Social history in addition to any of the above	Has problems gaining weight	Seems depressed all the time	Substance abuse

Q: What type of medical record is acceptable?

A:

- ☑ *PM 160/CHDP*
- ☑ *Progress notes/Office visit notes with dated growth chart*
- ☑ *Complete Physical Examination Form*
- ☑ *Anticipatory Guidance/Developmental Milestone Form*

Adolescent Well-Care Visits (AWC)

Q: How to improve score for this HEDIS measure?
A: ☑ Use every office visit (including sick visits and sports physicals) to provide a well-care visit and immunizations ☑ Use standardized templates for AWC in EHRs ☑ Use the Childhood and Adolescent Wellness Flyers for Providers as a guideline of recommended health services for certain age groups (http://www.lacare.org/sites/default/files/LA1401_0815.pdf) ☑ Use of complete and accurate Value Set Codes. ☑ Timely submission of claims and encounter data ☑ Ensure proper documentation of all components in the medical record for each visit where preventative services are rendered /addressed

Adolescent Well-Care Visits (AWC)

SAMPLE CODES

ICD-10 codes
• Z00.1, Z00.129 (0-17 years) • Z00.121 (0-17 years) • Z00.00 (15-124 years) • Z00.01 (15-124 years)

CPT codes
99384, 99385

Breast Cancer Screening (BCS)

Q: Which members are included in the sample?

A: Women 50 to 74 years of age who had one or more mammograms to screen for breast cancer any time on or between **10/1/2013 – 12/31/2015.**

Q: What codes are used?

A: Please reference attached sample codes; reference Value Set Directory for additional codes

Q: What documentation is needed in the medical record?

A: *None*. This measure requires **claim/encounter data** submission only using the appropriate Value Set References.

Q: What type of document is acceptable?

A: Evidence from claim/encounter

- Screening Mammography between 10/1/2013 -12/31/2015

Q: How to improve score for this HEDIS measure?

A:

- ☑ Use of complete and accurate Value Set
- ☑ Timely submission of claims and encounter data
- ☑ Note that mammograms do not need prior authorization and share list of nearby contracted imagining/mammography centers with member.
- ☑ Educate female members about the importance of early detection, address common barriers/fears, and encourage testing.
- ☑ Proper coding or documentation of mastectomy either bilateral or unilateral – *to assist in excluding member from the HEDIS sample. See below for exclusion criteria.*

Exclusions for Breast Cancer Screening: (*Use designated Value Set for each*)

Any of the following meet criteria for bilateral mastectomy:

- Bilateral Mastectomy
- Unilateral Mastectomy with a bilateral modifier
- Two unilateral mastectomies with service dates 14 days or more apart
- Unilateral mastectomy with right-side modifier with same date of service
- Unilateral mastectomy with left-side modifier with same date of service

Breast Cancer Screening (BCS)

SAMPLE CODES

CPT codes
77055-77057

HCPCS screening and diagnostic mammography codes
G0202, G0204, G0206

Exclusion ICD-10 codes
Z90.11, Z90.12, Z90.13

Controlling High Blood Pressure (CBP)

Q: Which members are included in the sample?

A: Members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled in 2015 based on the following criteria:

- Members 18–59 years of age whose BP was <140/90 mm Hg.
- Members 60–85 years of age with a diagnosis of diabetes whose BP was <140/90 mm Hg.
- Members 60–85 years of age without a diagnosis of diabetes whose BP was <150/90 mm Hg.

Q: What codes are used?

***A*:** Please reference attached sample codes; reference Value Set Directory for additional codes

Q: What documentation is needed in the medical record?

A: Must include <u>both</u> of the following:

1. Notation of hypertension (HTN, High BP, Elevated BP, Hypertensive vascular disease, Hyperpiesis, Hyperpiesia, Borderline HTN, Intermittent HTN, History of HTN) anytime on or before **June 30, 2015**, ***<u>and</u>***

2. Notation of the lowest systolic and lowest diastolic BP reading from the most recent BP notation in the medical record in **2015.** (The BP reading must occur after the date when the diagnosis of HTN was confirmed.)

Q: What type of medical record is acceptable?

A: Notation of hypertension (HTN) in one or more of the following:

- ☑ Health maintenance form
- ☑ Encounter form
- ☑ Hospital H&P or discharge summary
- ☑ Problem list
- ☑ Progress notes (*BP reading*)
- ☑ SOAP note (*BP reading*)

Q: How to improve score for this HEDIS measure?

A:

- ☑ Use of complete and accurate Value Set Codes.
- ☑ Timely submission of claims and encounter data
- ☑ Ensure proper documentation in medical record
- ☑ Submit any documentation with ESRD, Pregnancy, Kidney transplant or non-acute inpatient admission - *documentation will assist in excluding members from the HEDIS sample*

Controlling High Blood Pressure (CBP)

SAMPLE CODES

ICD-10 codes
I10, E11.9

CPT codes
99201-99205, 99211-99215, 99217-99223, 99231-99233, 99238, 99239, 99241-99245, 99251-99255, 99281-99285, 99304-99310, 99315, 99316, 99318, 99324-99328, 99334-99337, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99420 , 99429, 99455, 99456

HCPCS visit codes
G0402, G0438, G0439, T1015

Exclusion ICD-10 code
N18.6, Z94.0, Z33.1

Cervical Cancer Screening (CCS)

Q: What documentation is needed in the medical record?

A:

- ☑ Women 21-64 years of age, and
- ☑ Had a Pap smear (cervical cytology) in **2013, 2014, or 2015**

Or

- ☑ Women 30-64 years of age, and
- ☑ Had cervical cytology/human papillomavirus (HPV) co-testing on the same date of service in **2011, 2012, 2013, 2014, or 2015**

Q: What codes are used?

A: Please reference attached sample codes; reference Value Set Directory for additional codes

Q: What documentation is needed in the medical record?

A: Documentation must include both of the following criteria:

- ☑ a note indicating the date test was performed, ***and***
- ☑ the result or finding

Q: What type of medical record is acceptable?

A: Acceptable document:

- ☑ Cervical cytology report / HPV report
- ☑ Chronic Problem List with documentation of Pap smear with or without HPV, including date and result
- ☑ Any documentation of history of hysterectomy with no residual cervix
- ☑ Progress note or consultation - notation of date and result of Pap smear
- ☑ Documentation of a "vaginal pap smear" in conjunction with documentation of hysterectomy
- ☑ Documentation of hysterectomy in combination with documentation that the patient no longer needs pap testing/cervical cancer screening

Q: How to improve score for this HEDIS measure?

A:

- ☑ Use of complete and accurate Value Set Codes.
- ☑ Timely submission of claims and encounter data
- ☑ Ensure proper documentation in medical record
- ☑ Request results of screenings be sent to you if done at OB/GYN visit
- ☑ Hysterectomy with no residual cervix - *documentation will assist in excluding member from the HEDIS sample*

Cervical Cancer Screening (CCS)

SAMPLE CODES

ICD-10 codes
Q51.5, Z90.710, Z90.712

CPT codes
87620-87622, 87624, 87625, 88141-88143, 88147, 88148, 88150, 88152-88154, 88164-88167, 88174, 88175

HCPCS screening codes
G0123, G0124, G0141, G0143-G0145, G0147, G0148, P3000, P3001, Q0091

Exclusion ICD-10 code
Q51.5

Comprehensive Diabetes Care (CDC)

Q: Which members are included in the sample?

A: Members 18-75 years of age with diabetes (Type I & 2) who had ***each*** of the following:

- ☑ Hemoglobin A1c (HbA1c) testing in 2015
- ☑ HbA1c Control (< 8.0%)
- ☑ HbA1c Poor Control (> 9.0%)
- ☑ Retinal eye exam in 2014 or 2015
- ☑ Medical attention for nephropathy in 2015
- ☑ Blood pressure (BP) control (<140/90 mmHg) in 2015

Q: What codes are used?

A: Please reference attached sample codes; reference Value Set Directory for additional codes

Q: What documentation is needed in the medical record?

A:

Hemoglobin A1c (HbA1c) Testing and Control in 2015

- Date of the most recent HbA1c test and the result

Retinal Eye Exam

- A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in 2015.
- A negative retinal or dilated eye exam (negative for retinopathy) by an eye care professional in 2014.
- A note or letter from an ophthalmologist, optometrist, PCP or other healthcare professional indicating that an ophthalmoscopic exam was completed by an eye care professional, the date when the procedure was performed and the results.
- A chart or photograph of retinal abnormalities indicating the date when the fundus photography was performed and evidence that an eye care professional reviewed the results.

Medical attention for nephropathy in 2015

- Urine microalbumin test with the date performed, and result/finding
- Evidence of nephropathy (e.g., renal transplant, ESRD, visit to nephrologist)
- Any urine protein testing or monitoring in 2015 (positive or negative result).
- Evidence of ACE inhibitor/ARB therapy.

Blood pressure (BP) control (<140/90 mmHg)

- The most recent BP reading during an outpatient visit or a nonacute inpatient encounter in 2015 (use the lowest systolic and lowest diastolic BP on the same date of service).

Comprehensive Diabetes Care (CDC)

Q: What type of document is acceptable?

A:

- ☑ Progress notes
- ☑ Health Maintenance Log
- ☑ Lab reports
- ☑ Eye exam report from eye care professional (optometrist or ophthalmologist)
- ☑ Nephrology consult report
- ☑ Medication list
- ☑ Blood Pressure Log from the medical record

Q: How to improve score for this HEDIS measure?

A:

- ☑ Use of complete and accurate Value Set Codes.
- ☑ Timely submission of claims and encounter data
- ☑ Review diabetes services needed at each office visit
- ☑ HbA1c control – schedule regular follow-up with patients to monitor changes and adjust therapies as needed.
- ☑ BP control – measure and document BP at each office visit and if elevated (>140/90), measure BP again at end of the visit.
- ☑ Ensure proper documentation in medical record. For example:
  - Coding is for *diabetic* retinal eye exam vs. general retinal eye exam
  - Date, time, and result of each BP taken
  - Gestational diabetes and steroid-induced diabetes – *documentation will assist in excluding members from the HEDIS sample*

Comprehensive Diabetes Care (CDC)

SAMPLE CODES

ICD-10 codes
E11.9, E11.21, E11.22, E11.311, E11.319, E11.351, E11.359, , Z99.2, Z94.0

CPT codes
67028, 67030, 67031, 67036, 67039-67043, 67101, 67105, 67107, 67108, 67110, 67112, 67113, 67121, 67141, 67145, 67208, 67210, 67218, 67220, 67221, 67227, 67228, 92002, 92004, 92012, 92014, 92018, 92019, 92134, 92225-92228, 92230, 92235, 92240, 92250, 92260, 99203-99205, 99213-99215, 99242-99245

CPT II codes
3072F, , 2022F, 2024F, 2026F, 3044F, 3045F, 3046F, 3075F, 3079F

HCPCS ophthalmic examination codes and diabetic indicator
S0620, S0621, S0625, S3000

Exclusion ICD-10 codes
O24.419, O24.919, , I50.9, I12.9, F03.90, ,N18.4, Z89.9

Chlamydia Screening in Women (CHL)

Q: Which members are included in the sample?

A: Women 16-24 years of age who were identified as sexually active and who had at least one test for Chlamydia in **2015.**

Q: What codes are used?

A: *Please reference attached sample codes; reference Value Set Directory for additional codes*

Q: What documentation in the medical record is acceptable?

A: *None*. This measure requires **claim/encounter data** submission only using the appropriate Value Set References.

Q: What type of document is acceptable?

A: Evidence from claim and encounter data.

- One chlamydia test in **2015**

Q: How to improve score for this HEDIS measure?

A:

- ☑ Use of complete and accurate Value Set Codes.
- ☑ Timely submission of claims and encounter data
- ☑ For all those on birth control pills, make chlamydia screening a standard lab
- ☑ Remember that chlamydia screening can be performed through a simple urine test offer this as an option for your members
- ☑ Proper coding or documentation will assist in excluding members from the HEDIS sample.
- ☑ Exclude members based on a pregnancy test alone ***and*** who meet either of the following:
  - A pregnancy test in 2015 ***and*** a prescription for isotretinoin (Retinoid) on the date of pregnancy test or the 6 days after the pregnancy test.
  - A pregnancy test in 2015 ***and*** an x-ray on the date of the pregnancy test or the 6 days after the pregnancy test.

Chlamydia Screening in Women (CHL)

SAMPLE CODES

ICD-10 codes
A74.9, , Z33.1, Z30.019

Chlamydia test CPT codes
87110, 87270, 87320, 87490-87492, 87810

Exclusion pregnancy test CPT codes
81025, 84702, 84703

Childhood Immunization Status (CIS)

Q: Which members are included in the sample?

A: Children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines **by their second birthday**.

Q: What codes are used?

A: Please reference attached sample codes; reference Value Set Directory for additional codes

Q: What documentation is needed in the medical record?

A: Documentation must include <u>any</u> of the following:

*Specific for**: MMR, HepB, VZV, and HepA***

- ☑ Evidence of the antigen or combination vaccine (include specific dates)
- ☑ Documented history of the illness
- ☑ A seropositive test result

Specific for: ***DTaP, HiB, IPV, PCV, rotavirus, and influenza***

- ☑ Evidence of the antigen or combination vaccine (include specific dates)

<u>OR</u>

- ☑ Notation indicating contraindication for a specific vaccine:
  (Use designated Value Set for each)

Any Particular Vaccine	• Anaphylactic reaction to the vaccine or its components
DTaP	• Encephalopathy ***with*** a vaccine adverse-effect code
MMR, VZV, and Influenza	• Immunodeficiency • HIV • Anaphylactic reaction to neomycin • Lymphoreticular cancer, multiple myeloma or leukemia
IPV	• Anaphylactic reaction to streptomycin, polymyxin B or neomycin
Hepatitis B	• Anaphylactic reaction to common baker's yeast

Childhood Immunization Status (CIS)

Q: What type of medical record is acceptable?

A: One or more of the following:

- ☑ Certificate of immunization including specific dates and types of vaccines
- ☑ Hospital record with notation of HepB
- ☑ Immunization Record and Health History Form
- ☑ Health Maintenance Form
- ☑ Lab report for seropositive test
- ☑ Print out of LINK/CAIR registry
- ☑ Progress/office notes with notations of vaccines given
- ☑ Medical History Form

Q: How to improve score for this HEDIS measure?

A:

- ☑ Upload immunizations on to California Immunizations Registry (http://cairweb.org)
- ☑ Use the Childhood and Adolescent Wellness Flyers for Providers as a guideline of recommended health services for certain age groups (http://www.lacare.org/sites/default/files/LA1401_0815.pdf)
- ☑ Educate parents about the importance of timely vaccinations and share the immunization schedule
- ☑ Use of complete and accurate Value Set Codes.
- ☑ Timely submission of claims and encounter data
- ☑ Ensure proper documentation of dates and types of immunizations, test results, history of illness, or contraindication for a specific vaccine.

Childhood Immunization Status (CIS)

SAMPLE CODES

CPT codes	
DTaP-HiB-IPV	90698
DTaP for younger than 7	90700
DTaP- HiB	90721
DTaP-HepB-IPV	90723
IPV	90713
MMR	90707
MMRV	90710
Measles and Rubella	90708
Measles	90705
Mumps	90704
Rubella	90706
HiB	90645-90648
HepB-HiB	90748
HepB Dialysis or immunosuppressed patient (3 dose)	90740
HepB-3 dose pediatric/adolescent	90744
HepB Dialysis/ immunosuppressed patient (4 dose)	90747
VZV	90716
PCV	90669, 90670

Exclusion ICD-10 code
T80.52XA, T80.52XD, T80.52XS

Care for Older Adults (COA)

Q: Which members are included in the sample?

A: Adults 66 years and older who had ***each*** of the following in **2015**:

- ☑ Advance care planning
- ☑ Medication review
- ☑ Functional status assessment
- ☑ Pain assessment

Q: What codes are used?

A: Please reference attached sample codes; reference Value Set Directory for additional codes

Q: What documentation is needed in the medical record?

A:

- ☑ **Advanced Care Planning** – evidence must include either the presence of advanced care plan in the medical record ***or*** documentation of advance care planning discussion with the provider and the date when it was discussed.

- ☑ **Evidence of Medication Review** – must include medication list in the medical record, and evidence of a medication review and the date when it was performed ***or*** notation that the member is not taking any medication and the date when it was noted.

- ☑ **Evidence of Functional Status Assessment** – documentation must include evidence of functional status assessment ***and*** the date when it was performed.

- ☑ **Evidence of Pain Assessment** – documentation must include evidence of a pain assessment (may include positive or negative findings for pain) and the date when it was performed.

Care for Older Adults (COA)

Q: What type of medical record is acceptable?

A:

Advanced Care Planning:

- ☑ Advance Directives
- ☑ Actionable medical orders
- ☑ Copy of Living Wills
- ☑ Copy of documentation of surrogate decision maker
- ☑ Evidence of oral statements noted in the medical record in 2015

Medication Review:

- ☑ Current medication list in 2015
- ☑ Notation of medication review in 2015
- ☑ Date and notation that the member is not taking any medication in 2015.

Functional Status Assessment:

- ☑ Progress notes, IHSS forms, HRA forms, AWE form
- ☑ Notation that Activities of Daily Living (ADL) were assessed or that at least 5 of the following were assessed: bathing, dressing, eating, transferring [e.g., getting in and out of chairs], using toilet, walking.
- ☑ Notation that Instrumental Activities of Daily Living (IADL) were assessed or at least 4 of the following were assessed: shopping for groceries, driving or using public transportation, using the telephone, meal preparation, housework, home repair, laundry, taking medications, handling finances.
- ☑ Result of assessment using a standardized functional status assessment tool
- ☑ Notation of cognitive status, ambulation status, sensory ability (hearing, vision and speech) and, other functional independence (e.g., exercise).

Pain Assessment:

- ☑ Progress notes – notation of a pain assessment (which may include positive or negative findings for pain)
- ☑ Result of assessment using a standardized pain assessment tool
- ☑ Numeric rating scales (verbal or written)
- ☑ Pain Thermometer
- ☑ Pictorial Pain Scales
- ☑ Visual analogue scale
- ☑ Brief Pain Inventory
- ☑ Chronic Pain Grade
- ☑ PROMIS Pain Intensity Scale
- ☑ Pain Assessment in Advanced Dementia (PAINAD) Scale

Care for Older Adults (COA)

Q: How to improve score for this HEDIS measure?
A: ☑ Use of complete and accurate Value Set Codes. ☑ Timely submission of claims and encounter data ☑ Ensure complete and appropriate documentation in medical record ☑ Timely submission of AWE Forms that are complete and accurate

Care for Older Adults (COA)

SAMPLE CODES

Advance Care Planning:
CPT Category II codes 1157F, 1158F S0257

Medication Review:
CPT Category II codes 1159F, 1160F **HCPCS code** G8427

Functional Status Assessment:
CPT Category II code 1170F

Pain Assessment:
CPT Category II codes 1125F, 1126F

Colorectal Cancer Screening (COL)

Q: Which members are included in the sample?

A: Members 50-75 years of age who had one or more appropriate screenings for colorectal cancer.

Q: What codes are used?

A: Please reference attached sample codes; reference Value Set Directory for additional codes

Q: What documentation is needed in the medical record?

A: Documentation in the medical record must include a note indicating the **date** the colorectal cancer screening was performed. Appropriate screenings are defined by **any** of the following:

- ☑ Fecal Occult Blood Test in **2015**; guaiac (gFOBT) or immunochemical (iFOBT)
- ☑ Flexible sigmoidoscopy performed in **2011**, **2012**, **2013**, **2014** or **2015**
- ☑ Colonoscopy in **2015** *or* ***within 9 years prior to 2015***.

Q: What type of medical record is acceptable?

A: One or more of the following:

- ☑ Health Maintenance Form
- ☑ Progress notes/Office visits notes
- ☑ Problem List
- ☑ Laboratory/Pathology Reports
- ☑ Medical History Forms
- ☑ X-ray Reports
- ☑ GI Consults/ Reports/ Flowcharts
- ☑ Complete Physical Examination Fo

Note: Do not count digital rectal exams (DRE), FOBT tests performed in an office setting or performed on a sample collected via DRE.

Colorectal Cancer Screening (COL)

Q: How to improve score for this HEDIS measure?

A:

- ☑ Use of complete and accurate Value Set Codes.
- ☑ Timely submission of claims and encounter data
- ☑ Prior to each visit for members 50 years and older, review chart to determine if COL screening has been completed, if not, discuss options with member, as colonoscopy every 10 years and stool testing done yearly are shown to have similar effectiveness in identifying colon cancer.
- ☑ Request a supply of stool screening test kits from your contracted lab(s) to have on hand to share with members when at office visits.
- ☑ If a member reports having had a colonoscopy, request that the member share a copy of the results/report or provide contact information of the rendering provider so that office staff can call to request the member's colonoscopy results/report. Remember to attach this information to the member's medical record for documentation purposes.
- ☑ Timely submission of claims and encounter data
- ☑ Ensure presence of all components in the medical record documentation
- ☑ *Exclude members with diagnosis of colorectal cancer or total colectomy (Use designated Value Set for each)*

Colorectal Cancer Screening (COL)

SAMPLE CODES

FOBT:
CPT codes 82270, 82274 **HCPCS Code** G0328

Flexible Sigmoidoscopy:
45330-45335, 45337-45342, 45345 **PCS code** G0104

Colonoscopy:
45378 **HCPCS codes** G0105, G0121

Exclusion ICD-10 Code:
C18.9, Z90.49

Appropriate Testing for Children with Pharyngitis (CWP)

Q: Which members are included in the sample?

A: Children 2-18 years of age, who were diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode (**7/1/2014 - 6/30/2015**) during any outpatient or ED visit.

Q: What codes are used?

A: Please reference Value Set Directory for codes to identify pharyngitis, visit type, and group A streptococcus (strep) test. Please reference attached sample codes.

Antibiotic Medications:

Description	Prescription	
Aminopenicillins	• Amoxicillin	• Ampicillin
Beta lactamase inhibitors	• Amoxicillin-clavulanate	
First generation cephalosporins	• Cefadroxil • Cefazolin • Cephalexin	
Folate antagonist	• Trimethoprim	
Lincomycin derivatives	• Clindamycin	
Macrolides	• Azithromycin • Clarithromycin • Erythromycin	• Erythromycin ethylsuccinate • Erythromycin lactobionate • Erythromycin stearate
Miscellaneous antibiotics	• Erythromycin-sulfisoxazole	
Natural penicillins	• Penicillin G potassium • Penicillin G sodium • Penicillin V potassium	
Penicillinase-resistant penicillins	• Dicloxacillin	
Quinolones	• Ciprofloxacin • Levofloxacin	• Moxifloxacin • Ofloxacin
Second generation cephalosporins	• Cefaclor • Cefprozil • Cefuroxime	
Sulfonamides	• Sulfamethoxazole-trimethopin	
Tetracyclines	• Doxycycline • Minocycline • Tetracycline	
Third generation cephalosporins	• Cefdinir • Cefixime • Cefpodoxime	• Ceftibuten • Cefditoren • Ceftriaxone

Appropriate Testing for Children with Pharyngitis (CWP)

Q: What documentation is needed in the medical record?

A: *None*. This measure requires **claim/encounter data** submission only using the appropriate Value Set References.

Q: What type of document is acceptable?

A: Evidence of claims/encounter data:

- ☑ Date of service for an outpatient or ED visit with a diagnosis of pharyngitis
- ☑ Throat culture lab report
- ☑ Date and result of strep test with a diagnosis of pharyngitis
- ☑ Antibiotic prescription for the episode

Q: How to improve score for this HEDIS measure?

A:

- ☑ Use of complete and accurate Value Set Codes.
- ☑ Timely submission of claims and encounter data
- ☑ Ensure proper documentation in medical record

Appropriate Testing for Children with Pharyngitis (CWP)

SAMPLE CODES

ICD-10 codes
J02.0, J02.9, J03.00, J03.90

CPT codes
87070, 87071, 87081, 87430, 87650-87652, 87880

Frequency of Ongoing Prenatal Care (FPC)

Q: Which members are included in the sample?

A: Women who delivered between ***November 6, 2014 and November 5, 2015*** and had the following number of expected prenatal visits during the first, second, and third trimesters.

- < 21 percent of expected visits
- 21 percent – 40 percent of expected visits
- 41 percent – 60 percent expected visits
- 61 percent – 80 percent of expected visits
- ≥ 81 percent of expected visits

Expected Number of Prenatal Care Visits for a Given Gestational Age and Month Member Enrolled in the Organization

Month of Pregnancy Member Enrolled in the Organization*									
Gestational Age in Weeks	**0-1st month**	**2nd month**	**3rd month**	**4th month**	**5th month**	**6th month**	**7th month**	**8th month**	**9th month**
28	6	5	4	3	1	1	—	—	—
29	6	5	4	3	1	1	—	—	—
30	7	6	5	4	2	1	1	—	—
31	7	6	5	4	2	1	1	—	—
32	8	7	6	5	3	2	1	—	—
33	8	7	6	5	3	2	1	—	—
34	9	8	7	6	4	3	2	1	—
35	9	8	7	6	4	3	2	1	—
36	10	9	8	7	5	4	3	1	—
37	11	10	9	8	6	5	4	2	—
38	12	11	10	9	7	6	5	3	—
39	13	12	11	10	8	7	6	4	1
40	14	13	12	11	9	8	7	5	1
41	15	14	13	12	10	9	8	6	2
42	16	15	14	13	11	10	9	7	3
43	17	16	15	14	12	11	10	8	4

Note: Dashes indicate that no visits are expected.

Frequency of Ongoing Prenatal Care (FPC)

Q: What codes are used?

A: Please reference attached sample codes; reference Value Set Directory for additional codes

Q: What documentation is needed in the medical record?

A:

- ☑ ACOG form
- ☑ Progress notes with basic physical OB exam that includes auscultation for fetal heart tone or pelvic exam with OB observations or measurement of fundus height.
- ☑ Lab report – OB panel (includes all labs within the panel), TORCH antibody panel, a rubella antibody test/titer with an Rh incompatibility (ABO/Rh) blood typing**,** linked with **an** office visit.
- ☑ Echography of a pregnant uterus / Pelvic ultrasound**,** linked with an office visit.
- ☑ Documentation of EDD in conjunction with either prenatal risk assessment and counseling /education or complete OB history.

Q: How to improve score for this HEDIS measure?

A:

- ☑ Use of complete and accurate Value Set Codes.
- ☑ Timely submission of claims and encounter data
- ☑ Ensure proper documentation in medical record
- ☑ Deliveries **NOT** resulting in a Live Birth – *proper coding or documentation will assist in excluding members from the HEDIS sample*.

Frequency of Ongoing Prenatal Care (FPC)

SAMPLE CODES

ICD-10 codes
Z34.00, Z33.1, Z337.0, Z37.50, 9.90, O01.90, O15.00, O16.9, O24.419, O24.919, O48.0, O48.1, , , Z33.2

CPT codes
99201-99215, 59425 or 59426

Prenatal Ultrasound CPT codes
76801, 76805, 76811, 76813, 76815-76821, 76825-76828

Obstetric Panel CPT codes
80055,86777,86644,86694

Exclusion codes
Z37.1, Z37.4, Z37.7

Human Papillomavirus Vaccine for Female Adolescents (HPV)

Q: Which members are included in the sample?

A: Female adolescents 13 years of age who had three doses of the human papillomavirus (HPV) vaccine **by their 13th birthday**.

Q: What codes are used?

A: Please reference attached sample codes; reference Value Set Directory for additional codes

Q: What documentation is needed in the medical record?

A: Must include any of the following:

- ☑ A note indicating the name of specific antigen and the date of service
- ☑ A certificate of immunization that includes specific dates and types of immunizations administered.
- ☑ Anaphylactic reaction to the vaccine or its components any time on or before the member's 13th birthday
- ☑ Anaphylactic reaction to the vaccine or its components with a date of service prior to October 1, 2011

HPV vaccine – At least 3 HPV vaccinations, with different dates of service, on or between the member's 9th and 13th birthdays.

Q: What type of document is acceptable?

A: One or more of the following:

- ☑ Certificate of immunization including specific dates and types of vaccines
- ☑ Immunization Record and health
- ☑ History Form
- ☑ Health Maintenance Form/Report
- ☑ Print out of LINK/CAIR registry
- ☑ Progress note/Office visit – with notations of vaccines given
- ☑ Notation of anaphylactic reaction to serum or vaccination

Human Papillomavirus Vaccine for Female Adolescents (HPV)

Q: How to improve score for this HEDIS measure?

A:

- ☑ Upload immunizations on to California Immunizations Registry (http://cairweb.org)
- ☑ Use the Childhood and Adolescent Wellness Flyers for Providers as a guideline of recommended health services for certain age groups (http://www.lacare.org/sites/default/files/LA1401_0815.pdf)
- ☑ Use every office visit (including sick visits) to provide immunizations and well-child visits
- ☑ Educate parents about the importance of timely vaccinations and share the immunization schedule
- ☑ Use EHR alerts to notify staff of immunizations
- ☑ Outreach to females starting from age 9 to administer the vaccine
- ☑ Use of complete and accurate Value Set Codes.
- ☑ Timely submission of claims and encounter data
- ☑ Ensure proper documentation in medical record
- ☑ Anaphylactic reaction to the vaccine or its components - *documentation will assist in excluding from the HEDIS sample*

Human Papillomavirus Vaccine for Female Adolescents (HPV)

SAMPLE CODES

CPT codes
90649, 90650

Exclusion ICD-10 codes
T80.52XA, T80.52XD, T80.52XS

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)

Q: Which members are included in the sample?

A: Adolescent and adult members (13 years and older) with a new episode of **alcohol or other drug (AOD)** dependence who received the following:

- ☑ Initiation of AOD Treatment. Members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis.
- ☑ Engagement of AOD Treatment. Members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.

Q: What codes are used?

A: Please reference attached sample codes; reference Value Set Directory for additional codes

Q: What documentation is needed in the medical record?

A: *None*. This measure requires **claim/encounter data** submission only using the appropriate Value Set References.

Q: What documentation is needed in the medical record?

A: Evidence from a claim/encounter

1. New diagnosis of alcohol or other drug (AOD) dependence and date
2. Initiation of member treatment within 14 days of the AOD diagnosis
    a. Of these members who initiated treatment, evidence of two or more additional services (inpatient admissions, outpatient visits, intensive outpatient encounters or partial hospitalizations with any AOD diagnosis) within 30 days of the initiation treatment.
        i. Note that multiple engagement visits may occur on the same day, but they must be with different providers in order to count.

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)

Q: How to improve score for this HEDIS measure?

A:

- ☑ Use of complete and accurate Value Set
- ☑ Timely submission of claims and encounter data
- ☑ Consider screening all members at office visits using a substance abuse screening tool.
- ☑ Perform SBIRT for members who answer positive for alcohol on the SHA or whom you suspect have an alcohol problem.
- ☑ Once a member is identified with AOD diagnosis, initiate brief intervention or refer for treatment within 14 days. Then complete at least two brief interventions within 30 days of diagnosis.
- ☑ When referring members out to substance abuse providers, ensure an appointments is made within 14 days of diagnosis.

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)

SAMPLE CODES

ICD-10 codes
F10.10, F10.129, F10.19, F10.20, F10.229, F10.230, F10.239, F10.29

CPT codes
90845, 90847, 90849, 90853, 90875, 90876, 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99223, 99231-99233, 99238, 99239, 99241-99245, 99251-99255, 99281-99285, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99408, 99409, 99411, 99412, 99510

HCPCS codes
G0155, G0176, G0177, G0396, G0397, G0409-G0411, H0001-H0005, H0007, H0015, H0016, H0020, H0022, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, H2035, H2036, M0064, S0201, S9480, S9484, S9485, T1006, T1012, T1015

Immunizations for Adolescents (IMA)

Q: Which members are included in the sample?

A: Adolescents who had one dose of meningococcal vaccine (MCV) **and** one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) or one tetanus, diphtheria toxoids vaccine (Td) **by their 13th birthday**.

Q: What codes are used?

A: Please reference attached sample codes; reference Value Set Directory for additional codes

Q: What documentation is needed in the medical record?

A: Must include <u>any</u> of the following:

- ☑ A note indicating the name of specific antigen and the date of the immunization
- ☑ A certificate of immunization that includes specific dates and types of immunizations administered.
- ☑ Anaphylactic reaction to the vaccine or its components any time on or before the member's 13th birthday
- ☑ Anaphylactic reaction to the vaccine or its components with a date of service prior to October 1, 2011

Meningococcal vaccine – given between member's 11th and 13th birthday

Tdap/Td vaccine – given between member's 10th and 13th birthday

Q: What type of medical record is acceptable?

A: One or more of the following:

- ☑ Certificate of immunization including specific dates and types of vaccines
- ☑ Immunization Record and health History Form
- ☑ Health Maintenance Form/Report
- ☑ Print out of LINK/CAIR registry
- ☑ Progress note/Office visit – with notations of vaccines given
- ☑ Notation of anaphylactic reaction to serum or vaccination

Immunizations for Adolescents (IMA)

Q: How to improve score for this HEDIS measure?
A: ☑ Upload immunizations on to California Immunizations Registry (http://cairweb.org) ☑ Use the Childhood and Adolescent Wellness Flyers for Providers as a guideline of recommended health services for certain age groups (http://www.lacare.org/sites/default/files/LA1401_0815.pdf) ☑ Use every office visit (including sick visits) to provide immunizations and well-child visits ☑ Educate parents about the importance of timely vaccinations and share the immunization schedule ☑ Use EHR alerts to notify staff of immunizations ☑ Use of complete and accurate Value Set Codes. ☑ Timely submission of claims and encounter forms ☑ Ensure proper documentation of dates and types of immunizations, or contraindication for a specific vaccine.

Immunizations for Adolescents (IMA)

SAMPLE CODES

CPT codes
Meningococcal 90733, 90734 **Tdap** 90715 **Td** 90714, 90718 **Tetanus** 90703 **Diphtheria** 90719

Exclusion codes
T80.52XA, T80.52XD, T80.52XS

Use of Imaging Studies for Low Back Pain (LBP)

Q: Which members are included in the sample?

A: Members 18-50 years of age with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis.

Q: What codes are used?

A: Please reference attached sample codes; reference Value Set Directory for additional codes

Q: What documentation is needed in the medical record?

A: *None*. This measure requires **claim/encounter data** submission only using the appropriate Value Set References.

Q: What type of document is acceptable?

A: Evidence from claim/encounter

- Imaging study with diagnosis of low back pain on the IESD or in the 28 days following the IESD.
  Index Episode Start Date (IESD): The earliest date of service for an outpatient or ED encounter during the Intake Period (January 1, 2015 – December 3, 2015) with a principal diagnosis of low back pain.

Q: How to improve score for this HEDIS measure?

A:

- ☑ Use of complete and accurate Value Set Codes.
- ☑ Timely submission of claims and encounter data
- ☑ Proper coding or documentation of any of the following diagnoses for which imaging is clinically appropriate – *to assist in excluding members from the HEDIS sample. See below for exclusion criteria.*

Exclusions : (*Use designated Value Set for each*)

Any of the following meet criteria:

- Cancer
- Recent Trauma
- Intravenous drug abuse
- Neurologic impairment

Use of Imaging Studies for Low Back Pain (LBP)

SAMPLE CODES

ICD-10 codes
M54.5, M54.9, M54.89, M54.30-M54.32, M54.40-M54.42

CPT codes
98925-98929, 98940-98942, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99281-99285, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99456

Imaging Studies CPT codes
72010, 72020, 72052, 72100, 72110, 72114, 72120, 72131-72133, 72141, 72142, 72146-72149, 72156, 72158, 72200, 72202, 72220

HCPCS codes
T1015

Exclusion ICD-10 codes
C00-D49

Lead Screening in Children (LSC)

Q: Which members are included in the sample?

A: Children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning **by their second birthday**.

Q: What codes are used?

A: Please reference attached sample codes; reference Value Set Directory for additional codes

Q: What documentation is needed in the medical record?

A: Documentation must include both of the following:

- ☑ A note indicating the date the test was performed
- ☑ The result or finding

Q: What type of document is acceptable?

A:

- ☑ Laboratory Report
- ☑ Chronic Problem List
- ☑ Health Maintenance Form
- ☑ Progress note with notation of the date and the result of lead screening

Q: How to improve score for this HEDIS measure?

A:

- ☑ Use of complete and accurate Value Set
- ☑ Timely submission of claims and encounter data
- ☑ Ensure proper documentation in medical record

Lead Screening in Children (LSC)

SAMPLE CODES

CPT codes
83655

Medication Management for People With Asthma (MMA)

Q: Which members are included in the sample?

A: Members 5–85 years of age, who were identified as having persistent asthma and who were dispensed appropriate medications that they remained on during the treatment period in 2015. Two rates are reported:

1. Members who remained on an asthma controller medication for at least 50% of their treatment period.
2. Members who remained on an asthma controller medication for at least 75% of their treatment period.

Q: What codes are used?

A: Please reference attached sample codes; reference Value Set Directory for additional codes

Q: What documentation is needed in the medical record?

A: *None*. This measure requires **claim/encounter data** submission only using the appropriate Value Set References.

Q: What type of document is acceptable?

A: Evidence from 2015 claims/encounter:

1. Compliant with asthma controller medication for at least 50% of treatment period.
2. Compliant with asthma controller medication for at least 75% of treatment period.

Asthma Controller Medications

Description	Prescriptions		
Antiasthmatic combinations	• Dyphylline-guaifenesin	• Guaifenesin-theophylline	
Antibody inhibitor	• Omalizumab		
Inhaled steroid combinations	• Budesonide-formoterol	• Fluticasone-salmeterol	• Mometasone-formoterol
Inhaled corticosteroids	• Beclomethasone • Budesonide	• Ciclesonide • Flunisolide	• Fluticasone CFC free • Mometasone
Leukotriene modifiers	• Montelukast	• Zafirlukast	• Zileuton
Mast cell stabilizers	• Cromolyn		
Methylxanthines	• Aminophylline	• Dyphylline	• Theophylline

Medication Management for People With Asthma (MMA)

Q: How to improve score for this HEDIS measure?

A:

- ☑ Use of complete and accurate Value Set Codes.
- ☑ Timely submission of claims and encounter data
- ☑ Ensure proper documentation in medical record
- ☑ Proper coding or documentation – *to assist in excluding members from the HEDIS sample. See below for exclusion criteria.*

Required Exclusions:

- Members who had any of the following diagnoses (documented) any time during the member's history through 12/31/2015:
  - Emphysema.
  - Other Emphysema.
  - COPD.
  - Obstructive Chronic Bronchitis.
  - Chronic Respiratory Conditions Due to Fumes/Vapors.
  - Cystic Fibrosis.
  - Acute Respiratory Failure
- Members who had no asthma controller medications dispensed in 2015

Medication Management for People With Asthma (MMA)

SAMPLE CODES

ICD-10 codes
J45.909

CPT codes
99201-99205, 99211-99223, 99231-99233, 99238, 99239, 99241-99245, 99251-99255, 99281-99287, 99391-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99456

HCPCS codes
G0402, G0438, G0439, G0463, T1015

Exclusion ICD-10 codes
J43.9, J44.9, E84.9, J96

Annual Monitoring for Patients on Persistent Medications (MPM)

Q: Which members are included in the sample?

A: Members 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent [angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB)], digoxin, diuretics in **2015**, and at least one therapeutic monitoring event for the therapeutic agent in **2015**.

Q: What codes are used?

A: Please reference attached sample codes; reference Value Set Directory for additional codes

Q: What documentation is needed in the medical record?

A: *None*. This measure requires **claim/encounter data** submission only using the appropriate Value Set codes.

Q: What type of document is acceptable?

A: Evidence from claim/encounter for **each** of the following rates in **2015**:

Rate 1: Annual Monitoring for Members on ACE Inhibitors or ARBs

- ☑ A lab panel test, **or**
- ☑ A serum potassium test **and** a serum creatinine test

Rate 2: Annual Monitoring for Members on Digoxin

- ☑ A lab panel test **and** a serum digoxin test, **or**
- ☑ A serum potassium test **and** a serum creatinine test **and** a serum digoxin test

Rate 3: Annual Monitoring for Members on Diuretics

- ☑ A lab panel test, **or**
- ☑ A serum potassium test **and** a serum creatinine test

Q: How to improve score for this HEDIS measure?

A:

- ☑ Use of complete and accurate Value Set Codes.
- ☑ Timely submission of claims and encounter data
- ☑ Exclude members who had an inpatient (acute or non-acute) claim/encounter in 2015.

Annual Monitoring for Patients on Persistent Medications (MPM)

SAMPLE CODES

CPT codes
80047, 80048, 80050, 80051, 80053, 80069, 80162, 82565, 82576, 84132

Exclusion CPT codes
99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291

Medication Reconciliation Post-Discharge (MRP)

Q: Which members are included in the sample?

A: Members 18 years and older who had an acute or non-acute inpatient discharge **on or between 01/01/2015 and 12/01/2015**, and for whom medications were reconciled the date of discharge through 30 days after discharge (31 total days).

Q: What codes are used?

***A*:** Please reference attached sample codes; reference **Value** Set Directory for additional codes

Q: What documentation is needed in the medical record?

A: Documentation in the medical record must include evidence of medication reconciliation and the date when it was performed. Any of the following meets criteria:

- ☑ Documentation that the provider reconciled the current and discharge medications.
- ☑ Documentation of the current medications with a notation that references the discharge medications (e.g., no changes in medications since discharge, same medications at discharge, discontinue all discharge medications.
- ☑ Documentation of the member's current medications with a notation that the discharge medications were reviewed.
- ☑ Documentation of a current medication list, a discharge medication list and notation that both lists were reviewed on the same date of service.
- ☑ Notation that no medications were prescribed or ordered upon discharge.

Q: What type of medical record is acceptable?

A:

- ☑ A medication list in a discharge summary that is present in the outpatient chart
- ☑ Discharge Summary
- ☑ Progress notes with the member's current medication list and a notation of reconciliation of discharge medications with the current medications

Q: How to improve score for this HEDIS measure?

A:

- ☑ Use of complete and accurate Value Set Codes.
- ☑ Timely submission of claims and encounter data
- ☑ Ensure proper documentation of medication reconciliation and the date when it was performed.

Medication Reconciliation Post-Discharge (MRP)

SAMPLE CODES

CPT II codes
1111F

Osteoporosis Management in Women Who Had a Fracture (OMW)

Q: Which members are included in the sample?

A: Women 67-85 years of age who suffered a fracture (7/1/2014 - 6/30/2015), and who had either a bone mineral density (BMD) test or prescription for a drug to treat osteoporosis in the six months after the fracture.

Q: What codes are used?

A: Please reference attached sample codes; reference **Value** Set Directory for additional codes

Q: What documentation is needed in the medical record?

A: None. This measure requires **claim/encounter data** submission only using the appropriate Value Set References.

Q: *What type of document is acceptable?*

A: Evidence of claims/encounter data

- ☑ BMD (bone mineral density) test
- ☑ Osteoporosis therapy
- ☑ Fracture
- ☑ Visit type

Note: Fractures of fingers, toes, face and skull are not included in this measure.

Osteoporosis Therapies:

Description	Prescription
Biphosphonates	• Alendronate • Alendronate-cholecalciferol • Ibandronate • Risedronate • Zoledronic acid
Other agents	• Calcitonin • Denosumab • Raloxifene • Teriparatide

Osteoporosis Management in Women Who Had a Fracture (OMW)

Q: How to improve score for this HEDIS measure?

A:

- ☑ Use of complete and accurate Value Set Codes.
- ☑ Timely submission of claims and encounter data
- ☑ Ensure proper documentation in medical record
- ☑ ***Required Exclusions:***
  - members who had a BMD test during 24 months prior to IESD*
  - members who had osteoporosis therapy during 12 months prior to IESD*
  - member who received a dispensed prescription or had an active prescription to treat osteoporosis during 12 months prior to IESD*

    *IESD: Index Episode Start Date [The earliest date of service for any encounter during the Intake Period (7/1/14 – 6/30/15) with a diagnosis of fracture].

    Note: *Fractures of finger, toe, face and skull are not included**.***

Osteoporosis Management in Women Who Had a Fracture (OMW)

SAMPLE CODES

ICD- 10 codes
M48.40XA, M84.319A, M84.350A

CPT codes
76977, 77078, 77080-77082

HCPCS codes
G0130

Pharmacotherapy Management of COPD Exacerbation (PCE)

Q: Which members are included in the sample?

A: Members 40 years of age and older with COPD exacerbations who had an acute inpatient discharge or ED visit on or between January 1, 2015 – November 30, 2015, and who were dispensed a systemic corticosteroid and/or a bronchodilator.

Q: What codes are used?

A: Please reference attached sample codes; reference Value Set Directory for additional codes

Q: What documentation is needed in the medical record?

A: *None*. This measure requires **claim/encounter data** submission only using the appropriate Value Set References.

Q: What type of document is acceptable?

A: Evidence from claim/encounter

1. Dispensed prescription for systemic corticosteroid within 14 days of the event

Systemic Corticosteroids

Description	Prescription			
Glucocorticoids	• Betamethasone • Dexamethasone	• Hydrocortisone • Methylprednisolone	• Prednisolone • Prednisone	• Triamcinolone

2. Dispensed prescription for a bronchodilator within 30 days of the event

Bronchodilators

Description	Prescription		
Anticholinergic agents	• Albuterol-ipratropium • Aclidinium-bromide	• Ipratropium • Tiotropium	• Umeclidinium
Beta 2-agonists	• Albuterol • Arformoterol • Budesonide-formoterol • Fluticasone-salmeterol • Fluticasone-vilanterol	• Formoterol • Indacaterol • Levalbuterol • Mometasone-formoterol • Metaproterenol	• Olodaterol hydrochloride • Pirbuterol • Salmeterol • Umeclidinium-vilanterol
Methylxanthines	• Aminophylline • Dyphylline-guaifenesin	• Guaifenesin-theophylline • Dyphylline • Theophylline	

Q: How to improve score for this HEDIS measure?

A:

☑ Use of complete and accurate Value Set Codes.
☑ Timely submission of claims and encounter data

Pharmacotherapy Management of COPD Exacerbation (PCE)

SAMPLE CODES

ICD- 10 codes
J44.9, J42, J43.9

CPT codes
99281-99285

Prenatal and Postpartum Care (PPC)

Q: Which members are included in the sample?

A:

☑ Women who delivered between November 6, 2014 and November 5, 2015, **and**

☑ Had a prenatal care visit in the 1st trimester or within 42 days of enrollment in the health plan, **and**

☑ Had a postpartum visit on or between 21 and 56 days after delivery.

Q: What codes are used?

A: Please reference attached sample codes; reference Value Set Directory for additional codes

Q: What documentation is acceptable?

A: **Prenatal Care Visit**
(First Trimester or within 42 days of enrollment)

- ☑ ACOG
- ☑ Progress notes with basic physical OB exam that includes auscultation for fetal heart tone or pelvic exam with OB observations or measurement of fundus height
- ☑ Lab report – OB panel (must include all labs within the panel), TORCH antibody panel with an office visit
- ☑ Echography of a pregnant uterus / Pelvic ultrasound
- ☑ Documentation of EDD in conjunction with either: prenatal risk assessment and counseling /education or complete OB history.

Post-partum Visit
(21-56 days after delivery)

Progress note with documentation of:

- ☑ Pelvic exam
- ☑ Evaluation of weight, BP, breasts and abdomen
- ☑ Any documentation of: Post-Partum Care, PP care, PP check, 6-week check, or a preprinted "postpartum Care" form in which information was documented during the visit.
- ☑ Pap smear within post-partum timeframe

Q: How to improve score for this HEDIS measure?

A:

- ☑ Use of complete and accurate Value Set Codes.
- ☑ Timely submission of claims and encounter data
- ☑ Ensure proper documentation in medical record
- ☑ Documentation of deliveries **NOT** resulting in a Live Birth – *proper coding or documentation will assist in excluding members from the HEDIS sample*

Prenatal and Postpartum Care (PPC)

SAMPLE CODES

ICD- 10 codes
Z34.00, Z37.0, Z37.50, O09.90,

Prenatal E/M Visits, CPT codes
99201-99205, 99211-99215, 99241-99245, 99500

Prenatal CPT II codes
0500F, 0501F, 0502F

Postpartum CPT II code
0503F

Prenatal HCPCS codes
G0463, T1015

Postpartum HCPCS code
G0101

OB Bundled Services CPT codes
59400,or59510, or 59610 or 59618,

Prenatal Ultrasound CPT codes
76801, 76805, 76811, 76813, 76815-76821, 76825-76828

Obstetric Panel CPT codes
80055, 86777, 86644, 86694

Prenatal and Postpartum Care (PPC)

SAMPLE CODES

Exclusion ICD-10 codes
Z37.1, Z37.4, Z37.7

Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)

Q: Which members are included in the sample?

A: Members 40 years of age and older with a new diagnosis of COPD or newly active COPD, who received appropriate spirometry testing to confirm the diagnosis.

Q: What codes are used?

A: Please reference attached sample codes; reference Value Set Directory for additional codes

Q: What documentation is needed in the medical record?

A: *None*. This measure requires **claim/encounter data** submission only using the appropriate Value Set Codes.

Q: What type of document is acceptable?

A: Evidence from claim/encounter

- One spirometry test confirming diagnosis of Chronic Obstructive Pulmonary Disease (COPD) during the 730 days (2 years) prior to the IESD through 180 days (6 months) after the IESD.

Index Episode Start Date (IESD): The earliest date of service for an outpatient, ED, or acute inpatient encounter during the Intake Period (July 1, 2014 - June 30, 2015) with any diagnosis of COPD.

Q: How to improve score for this HEDIS measure?

A:

☑ Use of complete and accurate Value Set Codes.
☑ Timely submission of claims and encounter data

Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)

SAMPLE CODES

Commercial, Medicaid, Medicare

ICD-10 codes
J44.9, J42, J43.9

CPT codes
99201-99205, 99211-99215, 99217-99223, 99231-99233, 99238, 99239, 99241-99245, 99251-99255, 99281-99285, 99291, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99456, 94010, 94014-94016, 94060, 94070, 94375, 94620

Appropriate Treatment for Children with Upper Respiratory Infection (URI)

Q: Which members are included in the sample?

A: Children 3 months -18 years of age who were given a diagnosis of upper respiratory infection (URI) and were not dispensed an antibiotic prescription in **2015.**

Q: What codes are used?

A: Please reference attached sample codes; reference Value Set Directory for additional codes

Q: What documentation in the medical record is acceptable?

A: *None.* This measure requires **claim/encounter data** submission only using the appropriate Value Set References

Q: What type of document is acceptable?

A: Evidence from a claim/encounter with a date of service for any outpatient or ED visit with **only** a URI diagnosis and no new or refill prescription for an antibiotic medication in 2015.

Q: How to improve score for this HEDIS measure?

A:

- ☑ Use of complete and accurate Value Set Codes.
- ☑ Timely submission of claims and encounter data
- ☑ Ensure proper documentation in medical record
- ☑ Exclude claims/encounters with more than one diagnosis code and ED visits that result in an inpatient admission.

Appropriate Treatment for Children with Upper Respiratory Infection (URI)

SAMPLE CODES

Commercial, Medicaid:

ICD- 10 codes
J06.9

CPT codes
99201-99205, 99211-99215, 99217-99223, 99231-99233, 99238, 99239, 99241-99245, 99251-99255, 99281-99285, 99291, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99456, 94010, 94014-94016, 94060, 94070, 94375, 94620

Well-Child Visits in the First 15 Months of Life (W15)

Q: Which members are included in the sample?

A: Members who turned 15 months old in **2015** and who had 0, 1, 2, 3, 4, 5, 6 or more well-child visits with a primary care practitioner during their first 15 months of life.

Q: What codes are used?

A: Please reference attached sample codes; reference Value Set Directory for additional codes

Q: What documentation is needed in the medical record?

A: Documentation in the medical record must include a **note** indicating a visit with a primary care practitioner, the **date** when the well-child visit occurred and evidence of **all** of the following:

- ☑ A health/interval history
- ☑ A physical developmental history
- ☑ A mental developmental history
- ☑ A physical exam
- ☑ Health education/anticipatory guidance

PHYSICAL EXAM	HEALTH HISTORY	PHYSICAL HEALTH DEVELOPMENT	MENTAL HEALTH DEVELOPMENT	ANTICIPATORY GUIDANCE
Weight	Interval history	Developing appropriately for age	Coos and babbles at parents	Safety (car seats, laying baby on back for sleep, child-proofing home, etc.)
Height	Active problems	Turns face to side when placed on stomach	Pleasurable response to familiar, enjoyable situations (bottle, bath, faces, etc.)	Nutrition (vitamins, ideal weight)
Head circumference	Past medical history	Follows parents with eyes	Cries more than normal	Independence (baby's decreased interest in breast as he/she grows older)
Chest	Surgical history	Sits unsupported for 10 minutes	Shows fear of strangers	Family (changing roles, sibling interaction, etc)
Heart	Family history	Responds appropriately to variations in sound	Quiets down when picked up	Discussions on how to recognize an ill baby
Lungs	Social history with above	Walks alone with one hand held	Looks for toy fallen out of sight	Discussions about socialization (i.e. play groups) and play

Well-Child Visits in the First 15 Months of Life (W15)

Q: What type of medical record is acceptable?

A:

- ☑ PM 160/CHDP
- ☑ Progress notes/Office visit notes with dated growth chart
- ☑ Complete Physical Examination Form
- ☑ Anticipatory Guidance/Developmental Milestone Form

Q: How to improve score for this HEDIS measure?

A:

- ☑ Use of complete and accurate Value Set Codes.
- ☑ Timely submission of claims and encounter data
- ☑ Ensure proper documentation of ALL components in the medical record for each visit where preventative services are rendered/addressed

Well-Child Visits in the First 15 Months of Life (W15)

SAMPLE CODES

Commercial, Medicaid:

ICD- 10 codes
• Z00.129 (0-17 years) • Z00.121 (0-17 years)

CPT codes
99381, 99391, 99382, 99392

Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)

Q: Which members are included in the sample?

A: Members 3-6 years of age who had one or more well-child visits with a primary care practitioner in **2015**.

Q: What codes are used?

A: Please reference attached sample codes; reference Value Set Directory for additional codes

Q: What documentation is needed in the medical record?

A: Documentation in the medical record must include a **note** indicating a visit with a primary care practitioner, the **date** when the well-child visit occurred and evidence of **all** of the following:

- ☑ A health/interval history
- ☑ A physical developmental history
- ☑ A mental developmental history
- ☑ A physical exam
- ☑ Health education/anticipatory guidance.

PHYSICAL EXAM	HEALTH HISTORY	PHYSICAL HEALTH DEVELOPMENT	MENTAL HEALTH DEVELOPMENT	ANTICIPATORY GUIDANCE
Weight	Interval history	Developing appropriately for age	Making good grades in school	Safety (car seats, swimming lessons, seat belts, helmets, knee and elbow pads, strangers, etc.)
Height	Active problems	Can skip	Understands and responds to commands	Nutrition (vitamins, frequency of eating, snacks, ideal weight)
Chest	Past medical history	Hops on one foot	Learning alphabet and numbers	Discussion on fitness and the importance of exercise
Heart	Surgical history	Runs and climbs well	Competent with fork and spoon	Oral health (Dental visits, eating habits, need for orthodontics, etc.)
Lungs	Family history	Rides a tricycle	Very imaginative play	Mental Health (confidence, self-esteem, etc.)
Tanner Stage	Social history with above	Stands on one foot for 3-5 seconds	Knows own sex	Preparing for school

Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)

Q: What type of medical record is acceptable?

A:

- ☑ PM 160/CHDP
- ☑ Progress notes/Office visit notes with dated growth chart
- ☑ Complete Physical Examination Form
- ☑ Anticipatory Guidance/Developmental Milestone Form

Q: How to improve score for this HEDIS measure?

A:

- ☑ Use every office visit (including sick visits) to provide a well-child visit and immunizations
- ☑ Use standardized templates for W34 in EHRs
- ☑ Use self-inking stamps for paper charts that capture all 5 components of the visit (order via email to quality@lacare.org)
- ☑ Use the Childhood and Adolescent Wellness Flyers for Providers as a guideline of recommended health services for certain age groups (http://www.lacare.org/sites/default/files/LA1401_0815.pdf)
- ☑ Use of complete and accurate Value Set Codes.
- ☑ Timely submission of claims and encounter data
- ☑ Ensure proper documentation of all components in the medical record for each visit where preventative services are rendered/addressed

Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)

SAMPLE CODES

ICD- 10 codes
• Z00.129 (0-17 years) • Z00.121 (0-17 years)

CPT codes
99382, 99392, 99383, 99393

Weight Assessment and Counseling for Nutrition & Physical Activity for Children/Adolescents (WCC)

Q: Which members are included in the sample?

A: Members 3-17 years of age who had an outpatient visit with a PCP or OB/GYN and had evidence of BMI percentile with height and weight documentation, counseling for nutrition, and counseling for physical activity in **2015**.

Q: What codes are used?

A: Please reference attached sample codes; reference Value Set Directory for additional codes

Q: What documentation is needed in the medical record?

A: Documentation in the medical record must include a note indicating the **date** of the office visit and evidence of the following:

- ☑ BMI percentile ***or*** BMI percentile plotted on age-growth chart
- ☑ Height and weight
- ☑ Counseling for nutrition or referral for nutrition education
- ☑ Counseling for physical activity or referral for physical activity

Q: What type of medical record is acceptable?

A: One or more of the following:

- ☑ PM 160/CHDP
- ☑ Progress notes/Office visits notes
- ☑ Anticipatory Guidance Form
- ☑ Staying Healthy Assessment Form
- ☑ Complete Physical Examination Form
- ☑ Dated growth chart/log
- ☑ Nutrition and Physical Activity Assessment Form
- ☑ What Does Your Child Eat Form

Weight Assessment and Counseling for Nutrition & Physical Activity for Children/Adolescents (WCC)

Q: How to improve score for this HEDIS measure?
A: ☑ Use of complete and accurate Value Set Codes. ☑ Timely submission of claims and encounter data ☑ Ensure presence of all components in the medical record documentation *Exclusion (optional): A diagnosis of pregnancy in 2015.*

Weight Assessment and Counseling for Nutrition & Physical Activity for Children/Adolescents (WCC)

SAMPLE CODES

ICD- 10 codes
• Z00.129 (0-17 years) • Z00.121 (0-17 years) • Z68.51-Z68.54 • Z71.3

CPT codes
99383, 99384

Exclusion ICD-10 code
Z33.1