

HEDIS® MY2023

Quick Reference Guide



● Medicaid

● Ambetter (Commercial)

● Wellcare



For more information, visit www.ncqa.org

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HEDIS® MY2023 Quick Reference Guide

Updated to reflect NCQA HEDIS 2023 Technical Specifications

Peach State Health Plan, Ambetter from Peach State Health Plan, and Wellcare Medicare Advantage Plan strive to provide quality healthcare to our membership as measured through HEDIS quality metrics. We created the HEDIS Quick Reference Guide to help you increase your practice's HEDIS rates and to address care opportunities for your patients. Please always follow the State and/or CMS billing guidance and ensure the HEDIS codes are covered before submission.

WHAT IS HEDIS?

HEDIS® (Healthcare Effectiveness Data and Information Set) is a set of standardized performance measures developed by the National Committee for Quality Assurance (NCQA) to objectively measure, report, and compare quality across health plans.

NCQA develops HEDIS® measures through a committee represented by purchasers, consumers, health plans, health care providers, and policymakers.

HOW ARE RATES CALCULATED?

HEDIS rates can be calculated in two ways: administrative data or hybrid data. Administrative data consists of claim or encounter data submitted to the health plan. Hybrid data consists of both administrative data and a sample of medical record data. Hybrid data requires a review of a random sample of member medical records to abstract data for services rendered that were not reported to the health plan through claims/encounter data. Accurate and timely claim/ encounter data reduces the need for medical record review. If services are not billed or not billed accurately, they are not included in the calculation.

WHAT ARE THE SCORES USED FOR?

As state and federal governments move toward a quality-driven healthcare industry, HEDIS rates are becoming more important for both health plans and individual providers. State purchasers of healthcare use aggregated HEDIS rates to evaluate health insurance companies' efforts to improve preventive health outreach for members. Physician-specific scores are also used to measure your practice's preventive care efforts. Your practice's HEDIS score determines your rates for physician incentive programs that pay you an increased premium—for example, Pay for Performance (P4P) or Quality Bonus Funds.

MEDICAL RECORDS

When administrative and hybrid data are not available, organizations may use other sources to collect data about their members on the delivery of health services to members. We review medical records to find this information. Medical records may be faxed or emailed securely to the health plan. To ease the burden on the provider and staff, and to capture these measures throughout the year, health plans may request remote access to your EMRs. Health plans can also receive information via Electronic Data Exchange (EDS). EDS also referred to as supplemental data electronically captures additional clinical information about a member, beyond administrative claims, that are received by Peach State Health Plan.

PAY FOR PERFORMANCE (P4P)

P4P is an activity-based reimbursement, with an incentive payment based on achieving defined and measurable goals related to access, continuity of care, patient satisfaction, and clinical outcomes. Based on program performance, you are eligible to earn compensation in addition to what you are paid through your Participating Provider Agreement.

HOW CAN I IMPROVE MY HEDIS SCORES?

Use real-time care gap information to manage our assigned population through Interpretata accessed through Availity

- ▶ Submit claim/encounter data for each service rendered
- ▶ Make sure that chart documentation reflects all services billed
- ▶ Bill (or report by encounter submission) for all delivered services, regardless of contract status
- ▶ Ensure that all claim/encounter data is submitted in an accurate and timely manner
- ▶ Consider including CPT® II codes to provide additional details and reduce medical record requests
 - » CPT® II codes are supplemental tracking codes that can be used for performance measurement. The use of these codes will decrease the need for some record abstraction and chart review thereby minimizing administrative burdens on providers and other healthcare staff.
 - » CPT® II codes ensure gaps in care are closed in a timelier manner
 - » Improve the accuracy of gaps-in-care reporting
 - » More effectively monitor quality and service delivery within a provider's practice.

- » They capture data that ICD-10 codes and CPT® Category I codes do not – so important information related to health outcome measures is relayed more efficiently.

HEDIS AND HIPAA

As a reminder, protected health information (PHI) that is used or disclosed for purposes of treatment, payment, or health care operations is permitted by HIPAA Privacy Rules (45 CFR 164.506) and does not require consent or authorization from the member/members. The medical record review staff and/or vendor will have a signed HIPAA-compliant Business Associate Agreement.

GLOSSARY OF TERMS

- **Numerator** – The number of members who meet compliance criteria based on NCQA technical specifications for appropriate care, treatment, or service.
- **Denominator** – The number of members who qualify for the measure criteria, based on NCQA technical specifications.
- **Measurement year** – In most cases, the 12-month timeframe between which a service was rendered; generally, January 1 through December 31.
- **Reporting year** – The timeframe when data is collected and reported. The service dates are from the measurement year, which is usually the year prior. In some cases, the service dates may go back more than one year.



Administrative: Measures reported as administrative uses the total eligible population for the denominator. Medical, pharmacy and encounter claims count toward the numerator. In some instances, health plans use approved supplemental data for the numerator.



Hybrid: Measures reported as hybrid use a random sample of 411 members from a health plan's total eligible population for the denominator. The numerator includes medical and pharmacy claims, encounters, and medical record data. In some cases, health plans use auditor approved supplemental data for the numerator.



Electronic Clinical Data Systems (ECDS): HEDIS quality measures reported using ECDS is a secure sharing of patient medical information electronically between systems. Measures that leverage clinical data captured routinely during the care delivery can reduce the burden on providers to collect data for quality reporting.



CAHPS Survey: On an annual basis, the Consumer Assessment of Health Plans Survey (CAHPS) is sent to a group of randomly-selected members.

HEDIS® MY2023 • Updates on HEDIS Measures 2023

HEDIS MEASURE CHANGES

■ Annual Dental Visit (ADV)

- Retired this measure focused on access to dental care rather than the quality of dental care.

*This measure is replaced by Oral Evaluation, Dental Services, and Topical Fluoride for Children

■ Breast Cancer Screening (BCS)*

- Only the BCS-E measure will be reported

■ Deprescribing of Benzodiazepines in Older Adults (DBO)

- **New** this is a first-year measure
- Clinical guidelines recommend deprescribing benzodiazepines slowly and safely, rather than stopping use immediately, to minimize withdrawal symptoms and improve patient outcomes.

■ Emergency Department Visits for Hypoglycemia in Older Adults with Diabetes (EDH)

- **New**, this is a first-year measure
- Identify older patients with diabetes who are at the highest risk of hypoglycemia.

■ Oral Evaluation, Dental Services (OED)

- **New** this is a first-year measure
- Identify pediatric members who are receiving dental care and work towards improving access and utilization of dental evaluations.

■ Topical Fluoride for Children (TFC)

- **New** this is a first-year measure
- Identify pediatric members receiving fluoride varnish application and promote fluoride treatments in younger members.

For additional information or questions please contact Provider Services:

Provider Services Hours: Monday – Friday, 7:00 a.m. to 7:00 p.m.

Provider Service Phone Number: 1-866-874-0633

Quality Website: www.pshpgeorgia.com/providers/quality-improvement.html



ADULT HEALTH

For more information, visit www.ncqa.org

ADULTS’ ACCESS TO PREVENTIVE/AMBULATORY HEALTH SERVICES (AAP)

Lines of Business: Commercial, Medicaid, Medicare ●●●

Members 20 years of age and older who had an ambulatory or preventive care visit. The organization reports three separate percentages for each product line.

- Medicaid and Medicare members who had an ambulatory or preventive care visit during the measurement year.
- Commercial members who had an ambulatory or preventive care visit during the measurement year or the 2 years prior to the measurement year.

DESCRIPTION	CODES
Ambulatory Visits	<p>CPT: 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411-99412, 99429 99483 92002, 92004, 92012, 92014, 99304-99310, 99315-99316, 99318, 99324-99328 99334-99337</p> <p>HCPCS: G0402, G0438-G0439, G0463, S0620-S0621, T1015</p> <p>ICD-10-CM: Z00.00, Z00.01, Z00.5, Z00.8, Z02.0, Z02.2, Z02.3, Z02.4, Z02.5, Z02.6, Z02.71, Z02.79, Z02.81-Z02.83, Z02.89, Z02.9, Z76.1</p>

Telehealth Visits	Online Assessment	CPT: 98969-98972, 99421-99444, 99457, 99458 HCPCS: G0071, G2010, G2012, G2061-G2063
	Telephone Visits	CPT: 98966-98968, 99441-99443
	Modifiers/POS	Modifiers: GT, 95 POS: 02

Codes subject to change.

CONTROLLING HIGH BLOOD PRESSURE (CBP)

Lines of Business: Commercial, Medicaid, Medicare ●●●

Members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (BP) was adequately controlled (<140/90 mm Hg) during the measurement year.

CPT-CAT II	CODES
Systolic Blood Pressure less than 130 mm Hg	3074F
Systolic Blood Pressure 130 -139 mm Hg	3075F
Systolic Blood Pressure greater than or equal to 140 mm Hg	3077F
Diastolic Blood Pressure less than 80 mm Hg	3078F
Diastolic Blood Pressure 80-89 mm Hg	3079F
Diastolic Blood Pressure greater than or equal to 90 mm Hg	3080F

DESCRIPTION	CODES
Hypertension	ICD-10-CM: I10
Remote BP Monitoring	CPT: 93784, 93788, 93790, 99091, 99453, 99454, 99457, 99473-99474
Online Assessments	CPT: 98969–98972, 99421-99423, 99444, 99457, 99458 HCPCS: G0071, G2010, G2012, G2061–G2063
Telephone Visits	CPT: 98966-98968, 99441-99443

Codes subject to change.

Helpful Documentation Tips:

- Missing BP documentation is considered non-compliant.
- Retake BP if the initial reading is high (≥ 140/90 mm hg), and document and record the lowest systolic and diastolic readings on the same day.

- Review the patient's hypertensive medication history, and patient compliance, and consider modifying treatment plans for uncontrolled blood pressure, as needed.
- Do not round up BP values if using a digital machine, record exact values.
- Telephone visits, e-visits, and virtual check-ins are now acceptable settings for BP readings.

COLORECTAL SCREENING (COL)

Lines of Business: Commercial, Medicare ●●●

Members 45- 75 years of age who had appropriate screening for colorectal cancer.

- Fecal occult blood test (FOBT) during the measurement year
- Flexible sigmoidoscopy during the measurement year or the four (4) years before the measurement year.
- Colonoscopy during the measurement year or the nine (9) years before the measurement year.
- CT colonography during the measurement year or the four (4) years before the measurement year.
- Stool DNA (sDNA) with FIT test during the measurement year for the two (2) years prior to the measurement year.

DESCRIPTION	CODES
Colonoscopy	CPT: 44388-44394, 44397, 44401-44408, 45355, 45378-45393, 45398 HCPCS: G0105, G0121
CT Colonography	CPT: 74261- 74263
sDNA FIT Test	CPT: 881528
Flexible Sigmoidoscopy	CPT: 45330-45335, 45337, 45338, 45340-45342, 45346, 45347, 45349, 45350 HCPCS: G0104
FOBT Lab Test	CPT: 82270, 82274 HCPCS: G0328
Total Colectomy	CPT: 44150-44153, 44155-44158, 44210-44212
Exclusion: Members who had colorectal cancer or a total colectomy	

Codes subject to change.

Helpful Documentation Tips:

- The medical record must include the date when colorectal cancer screening was performed, and results are reported in the medical history.
- A pathology report that indicates the type of screening (e.g., colonoscopy, flexible sigmoidoscopy) and the date when the screening was performed.
- Do Not Count digital rectal exams (DRE), FOBT tests performed in an office setting or performed on a sample collected via DRE.

CARDIAC REHABILITATION (CRE)

Lines of Business: Commercial, Medicaid, Medicare ●●●

Members 18 years and older who attended cardiac rehabilitation following a qualifying cardiac event, including myocardial infarction, percutaneous coronary intervention, coronary artery bypass grafting, heart and heart/lung transplantation, or heart valve repair/replacement.

Measurement Year: July 1, prior MY - June 30, current MY

Four rates are reported:

- **Initiation:** Members who attended 2 or more sessions of cardiac rehabilitation within 30 days after a qualifying event.
- **Engagement 1:** Members who attended 12 or more sessions of cardiac rehabilitation within 90 days after a qualifying event.
- **Engagement 2:** Members who attended 24 or more sessions of cardiac rehabilitation within 180 days after a qualifying event.
- **Achievement:** Members who attended 36 or more sessions of cardiac rehabilitation within 180 days after a qualifying event

CARDIAC REHABILITATION CODES
CPT: 93797, 93798
HCPCS: G0422, G0423, S9472

Codes subject to change.

Note: Transportation (non-emergency) may be available for rides to the member’s rehabilitation sessions.

PHARMACOTHERAPY MANAGEMENT OF COPD EXACERBATION (PCE)

Lines of Business: Commercial, Medicaid, Medicare ●●●

The percentage of COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or ED visit on or **between January 1–November 30 of the measurement year** and who were dispensed appropriate medications.

Two rates are reported:

1. **Dispensed a systemic corticosteroid** (or there was evidence of an active prescription) within 14 days of the event.
2. **Dispensed a bronchodilator** (or there was evidence of an active prescription) within 30 days of the event.

Note: The eligible population for this measure is based on acute inpatient discharges and ED visits, not on members. The denominator can include multiple events for the same individual.

Systemic Corticosteroid Medications

DESCRIPTION	PRESCRIPTION		
Glucocorticoids	■ Cortisone	■ Hydrocortisone	■ Prednisolone
	■ Dexamethasone	■ Methylprednisolone	■ Prednisone

Bronchodilator Medications

DESCRIPTION	PRESCRIPTION		
Anticholinergic agents	■ Aclidinaium bromide	■ Tiotropium ■ Umeclidinium	
	■ Ipratropium		
Beta 2-agonists	■ Albuterol	■ Indacaterol	■ Olodaterol
	■ Arformoterol	■ Levalbuterol	■ Salmeterol
	■ Formoterol	■ Metaproterenol	
Bronchodilator combinations	■ Albuterol- ipratropium	■ Formoterol- aclidinium	■ Olodaterol- tiotropium
	■ Budesonide- formoterol	■ Formoterol- glycopyrrolate	■ Umeclidinium- vilanterol
	■ Fluticasone- salmeterol	■ Formoterol- mometasone	
	■ Fluticasone- vilanterol	■ Glycopyrrolate- indacaterol	
	■ Fluticasone furoate- umeclidinium- vilanterol		

Subject to change. Please refer to www.pshpgeorgia.com for specific drug coverage.

To Improve HEDIS Measure

- Schedule a follow-up appointment within 7-14 days of discharge and ensure your patient has the appropriate medications.
- Have members demonstrate the use of inhalers to ensure medication administration is appropriately given.
- Check the Peach State Health Plan Provider Portal (provider.pshpgeorgia.com) to ensure that the member has filled medications.

STATIN THERAPY FOR PATIENTS WITH CARDIOVASCULAR DISEASE (SPC)

Lines of Business: Commercial, Medicaid, Medicare ●●●

The percentage of males 21–75 years of age and females 40–75 years of age during the measurement year, who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and met the following criteria. **The following rates are reported:**

1. **Received Statin Therapy:** Members dispensed at least one high-intensity or moderate-intensity statin medication during the measurement year.
2. **Statin Adherence 80%:** Members who remained on a high-intensity or moderate-intensity statin medication for at least 80% of the treatment period.

Note:

The treatment period is defined as the earliest prescription dispensing date in the measurement year for any statin medication of at least moderate intensity through the last day of the measurement year.

High- and Moderate-Intensity Statin Medications

DESCRIPTION	PRESCRIPTION	MEDICATION LISTS
High-intensity statin therapy	Atorvastatin 40-80 mg	Atorvastatin High Intensity Medications List
High-intensity statin therapy	Amlodipine-atorvastatin 40-80 mg	Amlodipine Atorvastatin High Intensity Medications List
High-intensity statin therapy	Rosuvastatin 20-40 mg	Rosuvastatin High Intensity Medications List
High-intensity statin therapy	Simvastatin 80 mg	Simvastatin High Intensity Medications List
High-intensity statin therapy	Ezetimibe-simvastatin 80 mg	Ezetimibe Simvastatin High Intensity Medications List

Moderate-intensity statin therapy	Atorvastatin 10-20 mg	Atorvastatin Moderate Intensity Medications List
Moderate-intensity statin therapy	Amlodipine-atorvastatin 10-20 mg	Amlodipine Atorvastatin Moderate Intensity Medications List
Moderate-intensity statin therapy	Rosuvastatin 5-10 mg	Rosuvastatin Moderate Intensity Medications List
Moderate-intensity statin therapy	Simvastatin 20-40 mg	Simvastatin Moderate Intensity Medications List
Moderate-intensity statin therapy	Ezetimibe-simvastatin 20-40 mg	Ezetimibe Simvastatin Moderate Intensity Medications List
Moderate-intensity statin therapy	Pravastatin 40-80 mg	Pravastatin Moderate Intensity Medications List
Moderate-intensity statin therapy	Lovastatin 40 mg	Lovastatin Moderate Intensity Medications List
Moderate-intensity statin therapy	Fluvastatin 40-80 mg	Fluvastatin Moderate Intensity Medications List
Moderate-intensity statin therapy	Pitavastatin 1-4 mg	Pitavastatin Moderate Intensity Medications List

Subject to change. Please refer to www.pshpgeorgia.com for specific drug coverage.

To Improve HEDIS Measure

- Encourage patients to enroll in an auto-refill program at their pharmacy.
- Avoid giving samples; only prescriptions with a pharmacy claim are utilized to measure adherence.
- Offer tips to patients such as:
 - Taking the medication at the same time each day
 - Use a pill box
 - Discuss potential side effects and encourage the member to contact the provider and not stop usage.



BEHAVIORAL HEALTH

For more information, visit www.ncqa.org

FOLLOW-UP CARE FOR CHILDREN PRESCRIBED ADHD MEDICATION (ADD)

Lines of Business: *Commercial, Medicaid* ●●

The percentage of children 6–12 years of age newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who 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:** The percentage of members 6–12 years of age with a prescription dispensed for ADHD medication, who had one follow-up visit with a practitioner with prescribing authority during the 30-day Initiation Phase
- **Continuation and Maintenance (C&M) Phase:** The percentage of members 6–12 years of age with a prescription dispensed for ADHD medication, who remained on the medication for at least 210 days, and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.

Initiation Phase <ul style="list-style-type: none">■ Dispensed ADHD medication	1st Follow Up Visit <ul style="list-style-type: none">■ Outpatient Visit with practitioner with prescribing authority■ No more than 30 days from initiation of prescription.	Continuation & Maintenance Phase <ul style="list-style-type: none">■ 2nd and 3rd follow-up outpatient visit with practitioner■ Visits must occur within 270 days after initiation phase has ended

To Improve HEDIS Measure

- Prescribe only one month of medication to ensure the member returns to the office within 30 days
- Consider scheduling all three follow-up appointments before leaving the office:
 - Within 30 days of the new prescription
 - Three months
 - Six to nine months
- Educate the child and caregiver(s) about the need to reevaluate whether the medications are working as intended after 2-3 weeks, and to regularly monitor the effects afterward
- Submit the correct CPT codes
- Utilize telehealth as one option for improving compliance

METABOLIC MONITORING FOR CHILDREN AND ADOLESCENTS ON ANTIPSYCHOTICS (APM)

Lines of Business: Commercial, Medicaid ●●

The percentage of children and adolescents 1–17 years of age who had two or more antipsychotic prescriptions and had metabolic testing. **Three rates are reported:**

1. The percentage of children and adolescents on antipsychotics who received blood glucose testing.
2. The percentage of children and adolescents on antipsychotics who received cholesterol testing.
3. The percentage of children and adolescents on antipsychotics who received blood glucose and cholesterol testing.


DESCRIPTION	CODES
HbA1C Lab Test	CPT: 83036, 83037 CPT-CAT II: 3044F, 3046F, 3051F, 3052F
Glucose Lab Test	CPT: 80047, 80048, 80050, 80053, 80069, 82947, 82950, 82951
LDL-C Lab Test	CPT: 80061, 83700, 83701, 83704, 83721 CPT-CAT II: 3048F, 3049F, 3050F
Cholesterol Lab Test	CPT: 82465, 83718, 83722, 84478

Codes subject to change.

To Improve HEDIS Measure

- Individual tests to measure cholesterol and blood glucose levels can be done on the same or different dates of service.
- The use of CPT® Category II codes and supplemental data helps identify clinical outcomes such as HbA1c level. It can also reduce the need for requesting medical chart reviews.
- Go to www.pshpgeorgia.com/providers.html for additional resources on care management for individuals with behavioral health problems.

ANTIDEPRESSANT MEDICATION MANAGEMENT (AMM)

Lines of Business: Commercial, Medicaid, Medicare 

The percentage of members 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:**

1. **Effective Acute Phase Treatment:** The percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks)
2. **Effective Continuation Phase Treatment:** The percentage of members who remained on an antidepressant medication for at least 180 days (6 months).

DESCRIPTION	CODES	
Major Depression	ICD-10-CM: F32.0–F32.4, F32.9, F33.0–F33.3, F33.41, F33.9	
BH Outpatient	CPT: 99078, 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411-99412, 99510	
Telehealth Visits	Telephone Visits	CPT: 98966-98968, 99441-99443
	Online Assessments	CPT: 98969-98972, 99421-99444, 99457 HCPCS: G0071, G2010, G2012, G2061-G2063
	Modifiers/ POS	Modifiers: GT, 95 POS: 02

Codes subject to change.

To Improve HEDIS Measure:

Educating your patients is the key to medication compliance.

- Discuss how to take antidepressants and how they work, the benefits, and how long to take them.
- Tell your patients how long they can expect to be on the antidepressants before they start to feel better.
- Stress the importance of taking the medication even if they begin feeling better.
- Talk about common side effects, how long they may last, and how to manage them.
- Let your patient know what to do if they have questions or concerns.
- Monitor with scheduled follow-up appointments.
- Consider a psychotherapy referral for your patients.

DIABETES MONITORING FOR PEOPLE WITH DIABETES AND SCHIZOPHRENIA (SMD)

Lines of Business: Medicaid ●

The percentage of members 18–64 years of age with schizophrenia or schizoaffective disorder and diabetes who had both an LDL-C test and an HbA1c test during the measurement year.

DESCRIPTION	CODES
Hemoglobin A1c (HbA1c)	CPT: 83036, 83037 CPT-CAT II: 3044F, 3046F, 3051F, 3052F
Glucose Test	CPT: 80047, 80048, 80050, 80053, 80069, 82947, 82950, 82951
LDL-C Test	CPT: 80061, 83700, 83701, 83704, 83721 CPT-CAT II: 3048F, 3049F, 3050F
Cholesterol Test	CPT: 82465, 83718, 83722, 84478

Codes subject to change.

Note: The member must have both tests to be compliant with the measure.

To Improve HEDIS Measure:

- Use appropriate documentation and correct coding.
- Teach the patient the need for follow-up appointments to empower shared decision-making between the provider and the patient.

- Ensure quality communication between behavioral and primary care providers in the coordination of care
- Schedule an annual A1c and LDL-C test.

DIABETES SCREENING FOR PEOPLE WITH SCHIZOPHRENIA OR BIPOLAR DISORDER WHO ARE USING ANTIPSYCHOTIC MEDICATIONS (SSD)

Lines of Business: Medicaid ●

The percentage of members 18–64 years of age with schizophrenia, schizoaffective disorder, or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.

DESCRIPTION	CODES
Glucose Test	CPT: 80047, 80048, 80050, 80053, 80069, 82947, 82950
Hemoglobin A1c (HbA1c) Test	CPT: 83036, 83037

CPT-CAT II: HEMOGLOBIN A1C (HBA1C) TEST	
DESCRIPTION	CODE
7%: Most recent HbA1c < 7.0% (DM)	3044F
9.0%: Most recent HbA1c > 9.0% (DM)	3046F
Most recent HbA1c ≥ 7.0% and ≤ 8.0% (DM)	3051F
Most recent HbA1c ≥ 8.0% and ≤ 9.0% (DM)	3052F

Codes subject to change.

To Improve HEDIS Measure:

- Use appropriate documentation and correct coding.
- Teach the patient the need for follow-up appointments to empower shared decision-making between the provider and the patient.
- Ensure quality communication between behavioral and primary healthcare providers in the coordination of care.
- Maintain appointment availability for patients.
- Outreach to patients who cancel appointments and reschedule as soon as possible.
- Schedule an annual glucose or A1c test.



DIABETES CARE

For more information, visit www.ncqa.org

BLOOD PRESSURE CONTROL FOR PATIENTS WITH DIABETES (BPD)

Lines of Business: Commercial, Medicaid, Medicare ●●●

The percentage of members 18–75 years of age with diabetes (type 1 and type 2) whose blood pressure was adequately controlled (< 140/90 mm Hg) during the measurement year.

Note:

- The last blood pressure reading of the measurement year is the one utilized in the measure.
- If multiple HbA1c tests were performed in the measurement year, the result from the last test is utilized.

DESCRIPTION	CPT-CAT II
Systolic Blood Pressure less than 130 mm Hg	3074F
Systolic Blood Pressure 130-139 mm Hg	3075F
Systolic Blood Pressure greater than or equal to 140 mm Hg	3077F
Diastolic Blood Pressure less than 80 mm Hg	3078F
Diastolic Blood Pressure 80-89 mm Hg	3079F
Diastolic Blood Pressure greater than or equal to 90 mm Hg	3080F
Remote Blood Pressure Monitoring	CPT: 93784, 93788, 93790, 99091, 99453, 99454, 99457, 99473, 99474

Codes subject to change.

To Improve HEDIS Measure:

- If a member’s initial BP reading is elevated at the start of a visit, you can take multiple readings during the same visit and use the lowest diastolic and lowest systolic to document the overall reading. Retake the member’s BP after they’ve had time to rest.
- The use of CPT – Category II codes helps identify clinical outcomes such as diastolic and systolic readings. It can also reduce the need for some medical chart reviews.
- Encourage your patient to monitor their BP at home using a digital BP machine. BP readings taken by the member and documented in the member’s medical record meet the criteria for this measure.

EYE EXAM FOR PATIENTS WITH DIABETES (EED)

Lines of Business: Commercial, Medicaid, Medicare ●●●

The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had a retinal eye exam.

DESCRIPTION	CODES
Diabetic Eye Exam	CPT: 92225-92229, 92230, 92235, 92240, 92250, 92260
Measure Year: Eye Exam with Evidence of Retinopathy	CPT – CATII: 2022F, 2024F, 2026F 2024F, 2026F
Measure Year: Eye Exam without Evidence of Retinopathy	CPT-CAT II: 2023F, 2025F, 2033F 2025F, 2033F
Unilateral Eye Enucleation with a Bilateral Modifier	CPT: 65091, 65093, 65101, 65103, 65105, 65110, 65112, 65114 Modifier: 50
Diabetic Retinal Screening Negative in Prior Year: *Must be a Negative result to be compliant and the reported date should be the date the provider reviewed the patient’s eye exam from the prior year	CPT: 3072F

Codes subject to change.

Helpful Documentation Tips:

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 (optometrist or ophthalmologist), the date when the procedure was performed, and the results.
- A chart or photograph indicating the date when the fundus photography was performed and evidence that an optometrist or ophthalmologist 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 or by a system that provides an artificial intelligence (AI) interpretation.
- Documentation of a negative retinal or dilated eye exam by an optometrist or ophthalmologist in the year prior to the measurement year, results indicating retinopathy was not present.
- Notate anytime in the member's history of evidence that the member had bilateral eye enucleation or acquired absence of both eyes.

To Improve HEDIS Measure:

- Work with a local ophthalmologist or optometrist to establish DRE referral contacts/relationships.
- Educate the patients about the difference between an eye exam to get new glasses and a comprehensive diabetic eye exam.
- Documentation of hypertensive retinopathy is considered positive for diabetic retinopathy. An annual comprehensive diabetic eye exam is recommended.

HEMOGLOBIN A1C CONTROL FOR PATIENTS WITH DIABETES (HBD)

Lines of Business: Commercial, Medicaid, Medicare ●●●

The percentage of members 18–75 years of age with diabetes (types 1 and 2) whose hemoglobin A1c (HbA1c) was at the following levels during the measurement year:

- HbA1c Control (<8.0%)
- HbA1c Poor Control (>9.0%)

DESCRIPTION	CPT- CAT II CODES
7%: Most recent HbA1c level less than 7.0% (DM)	3044F
9.0%: Most recent HbA1c greater than 9.0% (DM)	3046F
Most recent HbA1c level greater than or equal to 7.0% and less than or equal to 8.0% (DM)	3051F
Most recent HbA1c level greater than or equal to 8.0% and less than or equal to 9.0% (DM)	3052F

Codes subject to change.

To Improve HEDIS Measure:

- The frequency of visits should depend on the level of A1c control; members with elevated A1c levels need to be seen more frequently.
- Schedule follow-up visits and A1c testing with diabetic patients to monitor for changes.
- Document the date of the HbA1c with the results.
- Submit the CPT code for the test performed and the CPT-CAT II codes to report the A1c results.

KIDNEY HEALTH EVALUATION FOR PATIENTS WITH DIABETES (KED)

Lines of Business: Commercial, Medicaid, Medicare ●●●

The percentage of members 18–85 years of age with diabetes (type 1 and type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR), during the measurement year.

DESCRIPTION	CPT CODES
Estimated Glomerular Filtration Rate (eGFR)	80047, 80048, 80050, 80053, 80069, 82565
Quantitative Urine Albumin Lab Test	82043
Urine Creatinine Lab Test (uACR)	82570

Codes subject to change.

To Improve HEDIS Measure:

- Routinely refer members with type 1 or type 2 diabetes to a participating lab for their eGFR and uACR.
- Follow up with patients to discuss their lab results.

- Educate the patient on how diabetes can affect the kidneys and provide tips on preventing damage to their kidneys:
 - Controlling High Blood Pressure
 - Medication Adherence by taking prescribed medication that protects the kidney functionality (ACE inhibitors or ARBs)
 - Offer education on harmful medications to the kidneys (NSAIDS such as naproxen or ibuprofen)
 - Suggest a diet of lower protein and limited salt intake
- Coordinate patient care with specialists (endocrinologist or nephrologist) as needed.

STATIN THERAPY FOR PATIENTS WITH DIABETES (SPD)

Lines of Business: Commercial, Medicaid, Medicare ●●●

The percentage of members 40–75 years of age during the measurement year with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) who met the following criteria. **Two rates are reported:**

1. **Received Statin Therapy:** Members who were dispensed at least one statin medication of any intensity during the measurement year.
2. **Statin Adherence 80%:** Members who remained on a statin medication of any intensity for at least 80% of the treatment period

To Improve HEDIS Measure:

- Educate patients on the importance of statin medication adherence.
- Adherence to the SPD measure is determined by the member remaining on their prescribed high or low-intensity statin medication for 80% of their treatment period.
- Adherence is determined by pharmacy claims data (the plan will capture data each time the member fills their prescription).

Diabetes Medication

DESCRIPTION	PRESCRIPTION		
Alpha-glucosidase inhibitors	<ul style="list-style-type: none"> Acarbose 	<ul style="list-style-type: none"> Miglitol 	
Amylin analogs	<ul style="list-style-type: none"> Pramlintide 		
Antidiabetic combinations	<ul style="list-style-type: none"> Alogliptin-metformin Alogliptin-pioglitazone Canagliflozin-metformin Dapagliflozin-metformin Empagliflozin-linagliptin Empagliflozin-metformin 	<ul style="list-style-type: none"> Glimepiride-pioglitazone Glipizide-metformin Glyburide-metformin Linagliptin-metformin Metformin-pioglitazone Metformin-repaglinide 	<ul style="list-style-type: none"> Metformin-rosiglitazone Metformin-saxagliptin Metformin-sitagliptin
Insulin	<ul style="list-style-type: none"> Insulin aspart Insulin aspart-insulin aspart protamine Insulin degludec Insulin detemir Insulin glargine Insulin glulisine 	<ul style="list-style-type: none"> Insulin isophane human Insulin isophane-insulin regular Insulin lispro Insulin lispro-insulin lispro protamine Insulin regular human Insulin human inhaled 	
Meglitinides	<ul style="list-style-type: none"> Nateglinide 	<ul style="list-style-type: none"> Repaglinide 	
Glucagon-like peptide-1 (GLP1) agonists	<ul style="list-style-type: none"> Albiglutide Dulaglutide Exenatide 	<ul style="list-style-type: none"> Liraglutide (excluding Saxenda®) Semaglutide 	
Sodium-glucose cotransporter 2 (SGLT2) inhibitor	<ul style="list-style-type: none"> Canagliflozin Dapagliflozin (excluding Farxiga®) 	<ul style="list-style-type: none"> Empagliflozin 	
Sulfonylureas	<ul style="list-style-type: none"> Chlorpropamide Glimepiride 	<ul style="list-style-type: none"> Glipizide Glyburide 	<ul style="list-style-type: none"> Tolazamide Tolbutamide

Thiazolidinediones	<ul style="list-style-type: none"> ■ Pioglitazone 	<ul style="list-style-type: none"> ■ Rosiglitazone 	
Dipeptidyl peptidase-4 (DDP-4) inhibitors	<ul style="list-style-type: none"> ■ Alogliptin ■ Linagliptin 	<ul style="list-style-type: none"> ■ Saxagliptin ■ Sitagliptin 	

Subject to change. Please refer to www.pshpgeorgia.com for specific drug coverage.



WOMEN’S HEALTH

For more information, visit www.ncqa.org

CERVICAL CANCER SCREENING (CCS)

Lines of Business: Commercial, Medicaid ● ●

The percentage of women 21-64 years of age who were screened for cervical cancer using the following criteria:

- Women 21-64 years of age who had cervical cytology performed within the last 3 years
- Women 30-64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years
- Women 30-64 years of age who had cervical cytology/high-risk human papillomavirus (hrHPV) co-testing within the last 5 years

DESCRIPTION	CODES
Cytopathology, cervical, or vaginal	CPT: CPT: 88141-88143, 88147, 88148, 88150, 88152-88154, 88164-88167, 88174, 88175 HCPCS: G0123, G0124, G0141, G0143-G0145, G0147, G0148, P3000, P3001, Q0091
High-Risk HPV Co-Testing	CPT: 87624, 87625 HCPCS: G0476
EXCLUSIONS Codes	ICD-10-CM
Absence of Cervix	Q51.5, Z90.710, Z90.712

Codes subject to change.

Exclusions:

- Hysterectomy with no residual cervix, cervical agenesis, or acquired absence of cervix any time during the member's history through December 31 of the measurement year

Helpful Documentation Tips:

- Documentation in the medical record indicating the date when the cervical cytology was performed with results
- Any of the following documentation meets criteria for exclusion:
 - **“complete, “total”, or “radical” hysterectomy** (abdominal, vaginal, or unspecified)
 - **“vaginal hysterectomy”**
 - **“vaginal pap smear”** in conjunction with documentation or “hysterectomy”
 - **“hysterectomy”** in combination with documentation that the patient no longer needs pap testing/cervical cancer screening.

To Improve HEDIS Measure:

- Use ICD-10 Q51.5, Z90.710, or Z90.712 to indicate the exclusion (acquired absence of cervix/uterus).
- The medical record must have cervical cytology test results and hrHPV results documented, even if the member self-reports being previously screened by another provider.

CHLAMYDIA SCREENING IN WOMEN (CHL)

Lines of Business: Commercial, Medicaid ●●

The percentage of women 16-24 years of age who were identified as sexually active and who has at least one test for chlamydia during the measurement year.

CPT CODE FOR CHLAMYDIA SCREENING
87710, 87270, 87320, 87490-87492, 87810

Codes subject to change.

To Improve HEDIS Measure:

- Testing either a urine analysis or vaginal swab from the same Thin Prep used for the Pap smear.
- A note indicating the date the test was performed and the result or findings.
- Ensure females 16–24 years of age receive appropriate screening for chlamydia each year.

- Chlamydia infections often have no symptoms so routine screening when at risk is important. The CDC recommends a non-invasive nucleic acid amplification test or NAAT for chlamydia screening. This can be completed through a urine test. Use CPT® code 87491.
- Add chlamydia screening as a standard lab for women 16–24 years old. Use well-child exams and well-women exams for this purpose.

PRENATAL AND POSTPARTUM CARE (PPC)

Lines of Business: Commercial, Medicaid ●●

Members who delivered live births on or between **10/08/2023 – 10/-7/2024** with the following facets of prenatal and postpartum care:

- **Timeliness of Prenatal Care:** Members who received a prenatal care visit in the first trimester, on or before the enrollment start date, or within 42 days of enrollment in the organization.
- **Postpartum Care:** Members that received a postpartum visit on or between 7 and 84 days after delivery.

PRENATAL CARE	
DESCRIPTION	CODES
Stand Alone Prenatal Visits	CPT: 99500 CPT-CAT II: 0500F, 0501F, 0502F HCPCS: H1000-H1004
Prenatal Visits	CPT: 99201-99205, 99211-99215, 99241-99245, 99483 HCPCS: G0463, T1015
Prenatal Bundled Services	CPT: 59400, 59425, 59426, 59510, 59610, 59618 HCPCS: H1005 ICD-10-CM: Z03.71-Z03.75, Z03.79, Z34.00-Z34.03, Z34.80-Z34.83, Z34.90- Z34.93, Z36, Z36.0-Z36.5, Z36.81-Z36.89, Z36.8A, Z36.9
POSTPARTUM CARE	
DESCRIPTION	CODES
Stand Alone Postpartum Visits	CPT: 57170, 58300, 59430, 99501 CPT-CAT II: 0503F HCPCS: G0101
Postpartum Bundled Services	CPT: 59400, 59410,59510, 59510, 59610, 59614, 59618, 59622 ICD-10-CM: Z01.411, Z01.419, Z01.42, Z30.430, Z39.1, Z39.2

Cervical Cytology	CPT: 88141-88143, 88147, 88148, 88150, 88152-88154, 88164-88167, 88174, 88175
Online Assessments	CPT: 98969-98972, 99421-99444, 99457 HCPCS: G0071, G2010, G2012, G2061-G2063
Telephone Visits	CPT: 98966-98968, 99441-99443

Codes subject to change.

To Improve HEDIS Measure for Prenatal Care:

- Encourage the patient to attend all scheduled prenatal visits
- Documentation in the medical record must include a note indicating the date when the prenatal care visit occurred, and evidence of one of the following:
 - A basic physical OB exam with any of the following: fetal heart tone auscultation, pelvic exam with obstetric observations, and fundal height measurement. The use of a standardized prenatal flow sheet is acceptable.
 - Evidence that a prenatal care procedure was performed, such as:
 - » Obstetric panel screening test
 - » TORCH antibody panel alone, or
 - » A rubella antibody test/titer with an Rh incompatibility (ABO/Rh) blood typing, or
 - » Ultrasound of a pregnant uterus.
 - Documentation of LMP, EDD, or gestational age in conjunction with either of the following:
 - » Prenatal risk assessment and counseling education.
 - » Complete obstetrical history.

Note: *A PAP test does not meet the criteria for prenatal care

To Improve HEDIS Measure for Postpartum Care:

- Pelvic exam.
- Documentation must include a note indicating the date when a postpartum visit occurred and one of the following:
 - Evaluation of weight, BP, breasts, and abdomen – Notation of **“breastfeeding”** is acceptable for the “evaluation of breasts” component
 - Notation of postpartum care, including, but not limited to: – Notation of **“postpartum care,” “PP care,” “PP check,” “6-week check”** – A preprinted **“Postpartum Care”** form in which information was documented during the visit.

- Perineal or cesarean incision/wound check
- Screening for depression, anxiety, tobacco use, substance use disorder, or preexisting mental health disorders
- Glucose screening for women with gestational diabetes
- Documentation of any of the following topics:
 - » Infant care or breastfeeding
 - » Resumption of intercourse, birth spacing, or family planning
 - » Sleep/Fatigue
 - » Resumption of physical activity and attainment of healthy weight

Note: *A PAP test ALONE is acceptable documentation for the postpartum visit, if it is in conjunction with a visit in the acceptable timeframe with an appropriate provider type as it provides evidence of a pelvic exam

Appropriate Coding:

- There are times when providers submit the global bill for maternity service prior to the postpartum visit. In these cases when a member has a postpartum visit, please submit a claim on the date of the postpartum visit with the appropriate CPT/CPT II Code and ICD-10 Code for postpartum care.

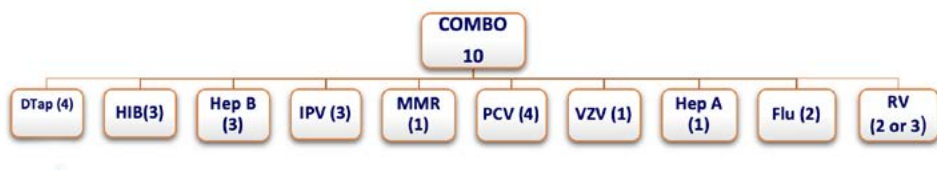
CHILD AND ADOLESCENT HEALTH

For more information, visit www.ncqa.org

CHILDHOOD IMMUNIZATION STATUS (CIS)

Lines of Business: Commercial, Medicaid ●●

The percentage of children 2 years of age who had the recommended vaccines by or before the child's second birthday:



The measure calculates a rate for each vaccine and three combination rates.

FOLLOWS THE CDC ADVISORY COMMITTEE ON IMMUNIZATION PRACTICES (ACIP) GUIDELINES FOR IMMUNIZATION FOR CHILDREN

VACCINE	CODES
DTaP	CPT: 90697, 90698, 90700, 90723
PV	CPT: 90697, 90698, 90713, 90723
MMR	CPT: 90707, 90710
Hib	CPT: 90644, 90647, 90648, 90697, 90698, 90748
Hep B	CPT: 90697, 90723, 90740, 90744, 90747, 90748
VZV	CPT: 90710, 90716
PCV	CPT: 90670

FOLLOWS THE CDC ADVISORY COMMITTEE ON IMMUNIZATION PRACTICES (ACIP) GUIDELINES FOR IMMUNIZATION FOR CHILDREN	
VACCINE	CODES
Hep A	CPT: 90633
RV – 2 doses	CPT: 90681
RV – 3 doses Schedule	CPT: 90680
FLU – 2 doses	CPT: 90655, 90657, 90661, 90673, 90685-90689

VACCINE ADMINISTRATION	HCPCS
Administration of Hepatitis B Vaccine	G0010
Administration of Influenza Virus Vaccine	G0008
Administration of Pneumococcal Vaccine	G0009

Codes subject to change.

To Improve HEDIS Measure:

- To Improve HEDIS Measure:
- Timely submission of claims and encounter data to capture gap closure.
- Notate the name of the antigen and the date of the immunization.
- Documentation the member received the immunization “at delivery” or “in the hospital” meet the criteria (e.g., Hep B).
- Overdue immunization and lead testing can be administered during a sick visit when medically appropriate.
- Anaphylaxis due to vaccine is numerator compliant for DTaP, HepB, HiB, and Rotavirus.
- Encephalitis due to vaccine is numerator complaint for DTaP only.
- Document Anaphylactic reaction due to vaccination:
 - **submit ICD-10-CM codes T80.52XA, T80.52XD, or T80.52XSZ**

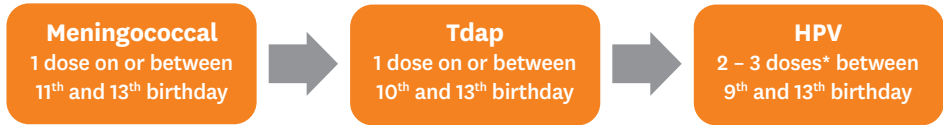
Note: If the child is 2 years and 1 day old when services are rendered the member is non-compliant for HEDIS ratings. A Parent/guardian refusal of vaccinations is not a valid exclusion for HEDIS standards.

IMMUNIZATIONS FOR ADOLESCENTS (IMA)

Lines of Business: Commercial, Medicaid ● ●

The percentage of adolescents 13 years of age who completed immunizations on or before the member's 13th birthday.

The measure calculates a rate for each vaccine and two combination rates.



***The following criteria meet HPV HEDIS standards:**

- **Two** HPV doses **146 days apart** OR **three** HPV doses with different dates of service between the member's **9th and 13th** birthday.

FOLLOWS THE CDC ADVISORY COMMITTEE ON IMMUNIZATION PRACTICES (ACIP) GUIDELINES FOR IMMUNIZATION FOR CHILDREN	
VACCINE	CODES
Meningococcal	CPT: 90619, 90733, 90734
Tdap	CPT: 90715
HPV	CPT: 90649-90651

Codes subject to change.

To Improve HEDIS Measure:

- Timely submission of claims and encounter data to capture gap closure.
- Notate the name of the antigen and the date of the immunization.
- Anaphylaxis due to vaccine is numerator compliant for any of the antigens.
- Document Anaphylaxis reaction and code appropriately ICD-10-CM codes: **T80.5XA, T80.52XD, or TX80.52XS.**

LEAD SCREENING IN CHILDREN (LSC)

Lines of Business: Commercial, Medicaid ●●

The percentage of children 2 years of age who had one or more capillary or venous lead blood tests for lead poisoning by their second birthday.

CPT CODE FOR LEAD SCREENING
83655

Codes subject to change.

To Improve HEDIS Measure:

- Lead screening must be performed on or before the child’s 2nd birthday to be compliant
- Check for compliance with immunizations and lead screening at an 18-month well-child visit before 2 years old.
- A lead risk assessment does not satisfy the venous blood lead requirement for Medicaid members, regardless of the risk score
 - **EPSDT:** Blood lead testing is required at 12 months and 24 months for all Medicaid-eligible children regardless of the responses to the questions in the lead screening assessment.
- If using a Certified Lead Analyzer, then bill with the appropriate CPT code 83655
- Timely submission of claims and encounter data

ORAL EVALUATION, DENTAL SERVICES (OED)

Lines of Business: Medicaid ●

The percentage of members under 21 years of age who received a comprehensive or periodic oral evaluation with a dental provider during the measurement year.

ADA CODES FOR ORAL EVALUATION
D0120, D0145, D0150

Codes subject to change.

To Improve HEDIS Measure:

- Educate the parent/caregiver on the importance of good oral health starts early and establish a primary dental provider (PDP) for Oral Evaluation and Dental Services.
- Refer patient to schedule with their Primary Care Dental Provider for dental services.

- Advise the parent to contact Peach State Health Plan or access to our website: www.pshp.com to “Find a Doctor” in their area with convenient office hours.
- Federally Qualified Health Centers (FHQC) and Rural Health Clinics/Centers can serve as a Primary Care Dental Home.

TOPICAL FLUORIDE FOR CHILDREN (TFC)

Lines of Business: Medicaid ●

Members 1 – 4 years of age who received at least two fluoride varnish applications during the measurement year.

CPT CODE FOR FLUORIDE VARNISH
99188

Codes subject to change.

To Improve HEDIS Measure:

- Fluoride is essential for preventing dental caries and tooth decay.
- Primary care setting can start applying fluoride varnish with the first tooth eruption and apply it every 3- 6 months.
- Perform an Oral Health Risk Assessment to determine any risk factors.
- Educate the parent/caregiver on the importance of good oral health starts early and establish a primary dental provider (PDP) for Oral Evaluation and Dental Services.
- Educate the parent on how to clean all surfaces of the teeth and gums twice a day, in the morning and before going to bed.

WELL-CHILD VISITS IN THE FIRST 30 MONTHS OF LIFE (W30)

Lines of Business: Commercial, Medicaid ●●

The percentage of members who had the following number of well-child visits with a PCP during the last 15 months. The following rates are reported:

- **Well-Child Visits in the First 15 Months:** Children who turned 15 months old during the measurement year: Six or more well-child visits.
- **Well-Child Visits for Age 15 Months–30 Months:** Children who turned 30 months old during the measurement year: Two or more well-child visits.

W30 Preventive Health Timeline



DESCRIPTION	CODES	
Preventive Medicine	CPT:	99381, 99382, 99391, 99392 Modifier: EP
	HCPCS:	G0438, G0439, S0302
	ICD-10-CM:	Z00.110, Z00.111, Z00.121, Z00.129, Z00.2, Z76.1, Z76.2

Codes subject to change.

To Improve HEDIS Measure:

- Documentation of a visit with a PCP noting the date of service to validate a well-child exam was performed.
- Member’s birth through 30 months should receive preventive visits throughout the year according to the specified timeframe.
- Perform a well-visit exam during a **follow-up visit or sick visit**; when medically appropriate
- Use proper coding to ensure accurate reporting of the HEDIS measure
- Document all appropriate screening requirements about the American Academy/Bright Futures <https://brightfutures.aap.org/Pages/default.aspx>
- EPSDT preventive medical visits that occur at 15 months and 1 day old, **will not count towards (W30) 0-15 months HEDIS scores.**

Periodicity schedule

Recommendations for Preventive Pediatric Health Care

https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf



Recommendations for Preventive Pediatric Health Care

Bright Futures/American Academy of Pediatrics



Each child and family is unique; therefore, these Recommendations for Preventive Pediatric Health Care are designed for the care of children who are receiving nurturing parenting, have no manifestations of any important health problems, and are growing and developing in a satisfactory fashion. Developmental, psychosocial, and chronic conditions may be identified during the course of the child's life. Additional visits may be necessary if circumstances suggest concern. These recommendations represent a consensus by the American Academy of Pediatrics (AAP) and Bright Futures. The AAP continues to emphasize the great importance of continuity of care in comprehensive health supervision and the need to avoid fragmentation of care.

Refer to the specific guidance by age as listed in the *Bright Futures Guidelines* (Hagan, J., Shaw, K., Duncan, P.M., eds. *Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents*, 4th ed. American Academy of Pediatrics, 2017).
The recommendations in this statement do not indicate an exclusive course of treatment or serve as a standard of care. Individual circumstances may require modification.
The Bright Futures/American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care are updated annually.

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	AGE	INFANCY					EARLY CHILDHOOD					MIDDLE CHILDHOOD					ADOLESCENCE																	
		Prenatal ¹	Newborn ²	3-5d ³	By 1 mo	2 mo	4 mo	6 mo	9 mo	12 mo	15 mo	18 mo	24 mo	30 mo	3 y	4 y	5 y	6 y	7 y	8 y	9 y	10 y	11 y	12 y	13 y	14 y	15 y	16 y	17 y	18 y	19 y	20 y	21 y	
HISTORY and MEASUREMENTS	Length/Height and Weight	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	
	Head Circumference		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	
	Weight for Length		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	
	Body Mass Index ⁴		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	
	Blood Pressure ⁵	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	
	Vision ⁶	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	
	Hearing ⁷	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	
DEVELOPMENTAL/SOCIAL/BEHAVIORAL/MENTAL HEALTH																																		
Maternal Depression Screening ⁸			●	●	●	●	●	●	●			●		●																				
Autism Spectrum Disorder Screening ⁹			●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Developmental Surveillance			●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Behavioral/Social/Emotional Assessment ¹⁰			●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Tobacco, Alcohol, or Drug Use Assessment ¹¹			●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Depression and Suicide Risk Screening ¹²			●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
PHYSICAL EXAMINATION ¹³			●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
PROCEDURES ¹⁴			●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Newborn Blood Screening ¹⁵			●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Newborn Bilirubin ¹⁶			●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Critical Congenital Heart Defect ¹⁷			●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Immunization ¹⁸			●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Anemia ¹⁹			●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Lead ²⁰			●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Tuberculosis ²¹			●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Dyslipidemia ²²			●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Sexually Transmitted Infection ²³			●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Hypertension ²⁴			●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Hepatitis B Virus Infection ²⁵			●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Hepatitis C Virus Infection ²⁶			●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Sudden Cardiac Arrest/Death ²⁷			●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Cervical Dysplasia ²⁸			●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
ORAL HEALTH ²⁹			●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Fluoride Varnish ³⁰			●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Fluoride Supplementation ³¹			●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
ANTICIPATORY GUIDANCE			●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●

1. If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished in the suggested age, the schedule is brought up to date at the earliest possible time.
2. A prenatal visit is recommended for parents who are at high risk for first-time parents, and for those who request a conference. This visit should occur before the 12th week of pregnancy. The visit should include a discussion of the benefits of prenatal care and an informed method of evaluation after birth, and breastfeeding should be encouraged (and instruction and support).
3. Newborns should have an evaluation within 3 to 5 days of birth and within 48 to 72 hours after discharge from the hospital. This visit should include an evaluation of the newborn's health, and breastfeeding should be encouraged (and instruction and support).
4. Newborns should have an evaluation within 3 to 5 days of birth and within 48 to 72 hours after discharge from the hospital. This visit should include an evaluation of the newborn's health, and breastfeeding should be encouraged (and instruction and support).
5. Screens per "Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity: Summary Report." <https://doi.org/10.1542/peds.2007.23950>
6. Screening should occur per "Clinical Practice Guideline for Screening and Management of High Blood Pressure in Children and Adolescents." <https://doi.org/10.1542/peds.2013.1542>
7. A visual acuity screen is recommended at ages 4 and 5 years, as well as in cooperative 3-year-olds. Instrument-based screening is recommended for children with risk factors for amblyopia, such as strabismic, refractive, or congenital causes. Screening should be performed at visits before age 5 years.
8. Confirmatory screen was completed, verify results, and follow up, as appropriate. Newborns should be screened.
9. Verify results as soon as possible, and follow up, as appropriate.
10. Screens with audiotape included by 6:00 and 8:00 AM high-frequency once between 11 and 14 years, once between 15 and 17 years, and once between 18 and 21 years. See "The Sensitivity of Adolescent Hearing Screens Significantly Improves by Adding High Frequencies." <https://doi.org/10.1542/peds.2013.1542>
11. Screening should occur per "Promoting Optimal Development: Identifying Infants and Young Children With Developmental Disorders Through Developmental Surveillance and Screening." <https://doi.org/10.1542/peds.2013.1542>
12. Screening should occur per "Promoting Optimal Development: Identifying Infants and Young Children With Developmental Disorders Through Developmental Surveillance and Screening." <https://doi.org/10.1542/peds.2013.1542>
13. Screening should occur per "Promoting Optimal Development: Identifying Infants and Young Children With Developmental Disorders Through Developmental Surveillance and Screening." <https://doi.org/10.1542/peds.2013.1542>



(continued)

- [illegible]

Summary of Changes Made to the Bright Futures/AAP Recommendations for Preventive Pediatric Health Care (Periodicity Schedule)

This schedule reflects changes approved in November 2021 and published in July 2022. For updates and a list of previous changes made, visit www.aap.org/periodicityschedule.

CHANGES MADE IN NOVEMBER 2021

HEPATITIS B VIRUS INFECTION
Assessing risk for HBV infection has been added to occur from newborn to 21 years (to account for the range in which the risk assessment can take place) to be consistent with recommendations of the USPTF and the 2021–2024 edition of the AAP Red Book: *Report of the Committee on Infectious Diseases*.

- Footnote 31: It should be noted to read as follows: "Perform a risk assessment for hepatitis B virus (HBV) infection according to recommendations per the USPCF (<https://www.hiv.gov/hivinfo/topic-guides/treatment/hepatitis-b-testing>) and in the 2021-2022 edition of the AAP Red Book: *Report of the Committee on Infectious Diseases*, making every effort to preserve confidentiality of the patient."

SUDDEN CARDIAC ARREST AND SUDDEN CARDIAC DEATH

Assessing risk for sudden cardiac arrest and sudden cardiac death has been added to occur from 11 to 21 years (to account for the range in which the assessment can take place) to be consistent with AAP policy ("Sudden Death in the Young: Information for the Primary Care Provider").

- Footnote 33 has been added to read as follows: "Perform a risk assessment, as appropriate, per 'Sudden Death in the Young: Information for the Primary Care Provider' (<https://doi.org/10.1542/peds.2021-052044>)."

DEPRESSION AND SUICIDE RISK

Screening for suicide risk has been added to the existing depression screening recommendation to be consistent with the GLAD-PC and AAP policy.

- Footnote 16 has been updated to read as follows: "Screen adolescents for depression and suicide risk, making every effort to preserve confidentiality of the adolescent. See Guidelines for Adolescent Depression in Primary Care (GLAD-PC), Part I: Practice Preparation, Identification, Assessment, and Initial Management (<https://doi.org/10.54286/gadp.2017.1481>), Mental Health Competencies for Pediatric Practice (<https://doi.org/10.54286/gadp.2019.21757>), and The 21st Century Cures Act & Adolescent Suicide (2016-1420) and The 21st Century Cures Act & Adolescent Confidentiality (<https://doi.org/10.54286/gadp.2019.21757>)."

BEHAVIORAL/SOCIAL/EMOTIONAL

Footnote 4: The updated Behavioral Assessment and Screening (BAS) has been updated to the Psychosocial/Social/Emotional Screening (annually from newborn to 21 years) to align with AAP policy, the American College of Obstetricians and Gynecologists (Women's Preventive Services Initiative) recommendations, and the American Academy of Child & Adolescent Psychiatry guidelines. Footnote 4 has been updated to read as follows: "Screen for behavioral and emotional problems per Promoting Optimal Development: pediatrics.aappublications.org/content/134/2/e2015021." pediatrics.aappublications.org/content/134/2/e2015021. Mental Health Competencies for Pediatric Practice: www.aap.org/clinical-resources/mental-health-competencies-for-pediatric-practice. The Assessment and Treatment of Children and Adolescents With Anxiety Disorders (www.aap.org/clinical-resources/assessment-and-treatment-of-children-and-adolescents-with-anxiety-disorders) and Screening for Anxiety in Adolescent and Adult Women: A Recommendation From the Women's Preventive Services Initiative (<http://pubmed.ncbi.nlm.nih.gov/25315596/>). The screening should be family centered and may include

determinants of health, racism, poverty, and relational health. See 'Poverty and Child Health in the United States' (<https://doi.org/10.1542/peds.2016-0339>). The Impact of Racism on Child and Adolescent Health' (<https://doi.org/10.1542/peds.2019-1765>). and 'Preventing Childhood Toxic Stress: Partnering With Families and Communities to Promote Relational Health' (<https://doi.org/10.1542/peds.2021-05288>)."

IIRIDE VARNISH

Footnote 37 has been updated to read as follows: "The USPSTF recommends that primary care clinicians apply fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption (<https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/prevention-of-dental-caries-in-children-young-child-age-5-years-screening-and-treatment>). Once teeth are present, apply fluoride varnish to all children every 3 to 6 months in the primary care or dental office based on caries risk. Indications for fluoride use are noted in "Fluoride Use in Caries Prevention in the Primary Care Setting" (<https://doi.org/10.1542/peds.2020-034637>").

UORIDE SUPPLEMENTATION

Footnote 38 has been updated to read as follows: "If primary water source is deficient in fluoride, consider oral fluoride supplementation. See 'Fluoride Use in Caries Prevention in the Primary Care Setting' (<https://doi.org/10.1542/peds.2020-034637>)."

CHANGES MADE IN NOVEMBER 2020

DEVELOPMENTAL
Footnote 12 has been updated to read as follows: "Screening should occur per Promoting Optimal Development: Identifying Infant and Young Children With Developmental Disorders Through Developmental Surveillance and Screening (<https://doi.org/10.1542/peds.2019-3449>)."

AUTISM SPECTRUM DISORDER

Footnote 13 has been updated to read as follows: "Screening should occur per 'Identification, Evaluation, and Management of Children With Autism Spectrum Disorder' (<https://doi.org/10.1542/peds.2019-3447>)."

HEPATITIS C VIRUS INFECTION

Screening for HCV infection has been added to occur at least once between the ages of 18 and 79 years to be consistent with recommendations of the USPSTF and CDC. Footnote 32 has been added to read as follows: "All individuals should be screened for hepatitis C virus (HCV) infection according to the USPSTF recommendation (<https://www.uspreventiveservicestaskforce.org/uspstf/hcv/hcv-recommendation/>) and Centers for Disease Control and Prevention (CDC) recommendations (<https://www.cdc.gov/mmwr/volumes/69/wr/mm6902a1.html>) at least once between the ages of 18 and 79. Those with a increased risk of HCV infection, including those who are persons with past or current injection drug use, should be tested for HCV infection and reassessed annually."

Immunization Schedule: Birth to 18 Years

- Range of recommended ages for all children
- Range of recommended ages for catch-up immunization
- Range of recommended ages for certain high-risk groups
- Recommended based on shared clinical decision-making or *can be used in this age group
- No recommendation/Not applicable

DEVELOPMENTAL SCREENINGS	
A Developmental Screening using a STANDARDIZED DEVELOPMENTAL SCREENING TOOL must be performed at 9 months, 18 months, and 30 months during EPSDT preventive medical visits.	
ACCEPTABLE STANDARDIZED TOOLS	
<ul style="list-style-type: none">■ Ages and Stages Questionnaire (ASQ) – 2 months to 5 years■ Ages and Stages Questionnaire – 3rd Edition (ASQ-3)■ Battelle Developmental Inventory Screening Tool (BDI-ST) Birth to 95 months■ Bayley Infant Neuro-developmental Screen (BINS) – 3 months to 2 years■ Brigance Screens-II – Birth to 90 months	<ul style="list-style-type: none">■ Child Development Inventory (CDI) - 18 months to 6 years■ Infant Development Inventory – Birth to 18 months■ Parents’ Evaluation of Developmental Status (PEDS) – Birth to 8 years■ Parent’s Evaluation of Developmental Status – Developmental Milestones (PEDS-DM)■ Survey of Well – Being in Young Children (SWYC)
*Reimbursement is delivered for performing developmental screening using a standardized tool; providers must bill CPT Code 96110 with the EP modifier and the appropriate preventive ICD-10-CM diagnosis code	

Note: The tools listed above are not specific recommendations for tools but are examples of tools cited in Bright Futures that meet the above criteria.

Tools that do NOT meet the criteria: It is important to note that standardized tools specifically focused on one domain of development (e.g. child’s socio-emotional development [ASQ-SE] or autism [M-CHAT]) are not included in the list above as this measure is anchored to recommendations related to global developmental screening using tools that identify risk for developmental, behavioral and social delays.

- *For additional information please reference The Centers for Disease Control and Prevention at www.cdc.gov/vaccines/schedules/hcp/imz/child-adolescent.html

Table 1

Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger, United States, 2022

These recommendations must be read with the notes that follow. For those who fall behind or start late, provide catch-up vaccination at the earliest opportunity as indicated by the green bars. To determine minimum intervals between doses, see the catch-up schedule (Table 2).

Vaccine	Birth	1 mo	2 mos	4 mos	6 mos	9 mos	12 mos	15 mos	18 mos	19-23 mos	2-3 yrs	4-6 yrs	7-10 yrs	11-12 yrs	13-15 yrs	16 yrs	17-18 yrs
Hepatitis B (HepB)	1 st dose	← 2 nd dose →					3 rd dose										
Rotavirus (RV): RV1 (2-dose series), RV5 (3-dose series)			1 st dose	2 nd dose	See Notes												
Diphtheria, tetanus, acellular pertussis (DTaP <7 yrs)			1 st dose	2 nd dose	3 rd dose			← 4 th dose →				5 th dose					
<i>Haemophilus influenzae</i> type b (Hib)			1 st dose	2 nd dose	See Notes		3 rd or 4 th dose See Notes										
Pneumococcal conjugate (PCV13)			1 st dose	2 nd dose	3 rd dose		← 4 th dose →										
Inactivated poliovirus (IPV <18 yrs)			1 st dose	2 nd dose			3 rd dose					4 th dose					
Influenza (IV4)																	
Influenza (LAIV4)																	
Measles, mumps, rubella (MMR)					See Notes		1 st dose					2 nd dose					
Varicella (VAR)							1 st dose					2 nd dose					
Hepatitis A (HepA)					See Notes												
Tetanus, diphtheria, acellular pertussis (Tdap ≥7 yrs)																	
Human papillomavirus (HPV)																	
Meningococcal (MenACWY-D ≥9 mos, MenACWY-CRM ≥2 mos, MenACWY-TT ≥2 years)																	
Meningococcal B (MenB-4C, MenB-PhiP)																	
Pneumococcal polysaccharide (PPSV23)																	
Dengue (DENVACYD; 9-16 yrs)																	

Range of recommended ages for all children
 Range of recommended ages for catch-up vaccination
 Range of recommended ages for certain high-risk groups
 Recommended vaccination can begin in this age group
 Recommended vaccination based on shared clinical decision-making
 No recommendation/not applicable
 Seropositive in endemic areas only (See Notes)
 See Notes
 1st dose
 2nd dose
 Annual vaccination 1 or 2 doses
 Annual vaccination 1 dose only
 Annual vaccination 1 dose only
 2nd dose
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CHILD AND ADOLESCENT WELL-CARE VISITS (WCV)

Lines of Business: Commercial, Medicaid ●●

The percentage of members 3–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.

Components of a comprehensive well-child visit include:



DESCRIPTION	CODES
Preventive Medicine	CPT: 99382-99385, 99391-9935 Modifier: EP
	HCPCS: G0438, G0439, S0302
	ICD-10-CM: Z00.00, Z00.01, Z00.121, Z00.129, Z00.2, Z00.3, Z02.5, Z76.2

Codes subject to change.

To Improve HEDIS Measure:

- Perform Well-Child visits during a Sports physical visit. Use the appropriate CPT and ICD-10 codes to ensure HEDIS gap closure
- A handout given to the parent without documentation of a discussion does not meet the criteria for health education /anticipatory guidance
- During every visit, it is important to discuss weight, BMI, nutrition patterns, and the importance of physical activity.

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

Lines of Business: Commercial, Medicaid ●●

The percentage of members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of the following during the measurement year.

- BMI percentile documentation*
- Counseling for nutrition
- Counseling for physical activity

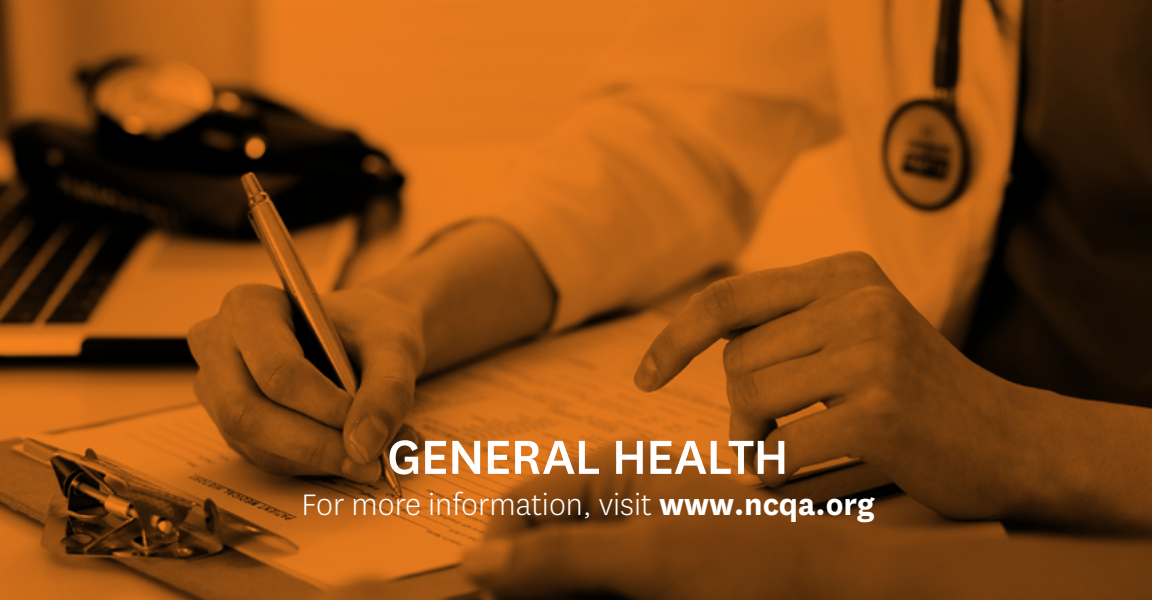
**BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed rather than an absolute BMI value.*

DESCRIPTION	CODES
Nutrition Counseling	CPT: 97802-97804
	HCPCS: G0270, G0271, G0447, S9449, S9452, S9470
	ICD-10-CM: Z71.3
Physical Activity	HCPCS: G0447, S9451
	ICD-10-CM: Z02.5, Z71.82
BMI PERCENTILE	ICD-10-CM
BMI, pediatric, less than 5th percentile for age	Z68.51
BMI, pediatric, 5th percentile to 85th percentile for age	Z68.52
BMI, pediatric, 85th percentile to 95th percentile for age	Z68.53
BMI, greater than or equal to 95th percentile for age	Z68.54

Codes subject to change.

To Improve HEDIS Measure:

- Documentation must include height, weight, and BMI percentile documented in the medical record or plotted on a BMI age growth chart.
- Take advantage of every office visit (including sick visits) to provide education on physical activity, nutrition, and BMI percentile calculations.
- Schedule the next annual exam before the patient leaves the office.
- Use the appropriate CPT/ICD-10 codes to ensure HEDIS gap closure, to reduce medical record/chart review.



GENERAL HEALTH

For more information, visit www.ncqa.org

AVOIDANCE OF ANTIBIOTIC TREATMENT FOR ACUTE BRONCHITIS/ BRONCHIOLITIS (AAB)

Lines of Business: Commercial, Medicaid, Medicare ●●●

The percentage of episodes for members ages 3 months and older with a diagnosis of acute bronchitis/ bronchiolitis that did not result in an antibiotic dispensing event.

Intake Period: July 1, prior MY2022 – June 30, current MY2023

Note: A higher rate indicates appropriate treatment (i.e., the portion for whom antibiotics were not prescribed).

*If a patient warrants a prescription for antibiotics, include the appropriate diagnosis that supports the use of antibiotics including bacterial infections and/or chronic conditions

DESCRIPTION	CODES
Chronic Obstructive Pulmonary Disease (COPD)	J44.0, J44.1, J44.9
Emphysema	J43.0-J43.2, J43.8, J43.9
Chronic Bronchitis	J41.0, J41.1, J41.8

Codes subject to change.

To Improve HEDIS Measure:

- Members treated for acute bronchitis should NOT be prescribed antibiotics unless there are co-morbid conditions or competing diagnoses that require antibiotic therapy.
- Educate patients on the difference between viral and bacterial infections.

- Suggest at-home treatments such as:
 - Over-the-Counter (OTC) cough medicine and anti-inflammatory medicine
 - Drinking extra fluids and rest
 - Using a nasal irrigation device or steamy hot shower for nasal and sinus congestion relief
- If the patient or Caregiver insists on an antibiotic:
- Explain that unnecessary antibiotics can be harmful.
- Provide a prescription for symptom relief instead of an antibiotic, if appropriate.
- Arrange an early follow-up visit, either by phone call or re-examination.

ASTHMA MEDICATION RATIO (AMR)

Lines of Business: Commercial, Medicaid ●●

Members 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year

Intake Period: July 1, prior MY2022 – June 30, current MY2023

Step 1: For each member, count the units of asthma controller medications

(Asthma Controller Medication List) dispensed during the measurement year.

Step 2: For each member, count the units of asthma reliever medications

(Asthma Reliever Medication List) dispensed during the measurement year.

- For each member, sum the units calculated in steps 1 and step 2 to determine units of total asthma medications.
- For each member, calculate the ratio using the following formula:
 - * Units of Controller Medications/Units of Total Asthma Medications

Asthma Controller Medications

DESCRIPTION	PRESCRIPTIONS	MEDICATION LISTS	ROUTE
Antibody inhibitors	Omalizumab	Omalizumab Medications List	Injection
Anti-interleukin-4	Dupilumab	Dupilumab Medications List	Injection
Anti-interleukin-5	Benralizumab	Benralizumab Medications List	Injection
Anti-interleukin-5	Mepolizumab	Mepolizumab Medications List	Injection
Anti-interleukin-5	Reslizumab	Reslizumab Medications List	Injection
Inhaled steroid combinations	Budesonide-formoterol	Budesonide Formoterol Medications List	Inhalation
Inhaled steroid combinations	Fluticasone-salmeterol	Fluticasone Salmeterol Medications List	Inhalation
Inhaled steroid combinations	Fluticasone-vilanterol	Fluticasone Vilanterol Medications List	Inhalation
Inhaled steroid combinations	Formoterol-mometasone	Formoterol Mometasone Medications List	Inhalation
Inhaled corticosteroids	Beclomethasone	Beclomethasone Medications List	Inhalation
Inhaled corticosteroids	Budesonide	Budesonide Medications List	Inhalation
Inhaled corticosteroids	Ciclesonide	Ciclesonide Medications List	Inhalation
Inhaled corticosteroids	Flunisolide	Flunisolide Medications List	Inhalation
Inhaled corticosteroids	Fluticasone	Fluticasone Medications List	Inhalation
Inhaled corticosteroids	Mometasone	Mometasone Medications List	Inhalation
Leukotriene modifiers	Montelukast	Montelukast Medications List	Oral
Leukotriene modifiers	Zafirlukast	Zafirlukast Medications List	Oral
Leukotriene modifiers	Zileuton	Zileuton Medications List	Oral

DESCRIPTION	PRESCRIPTIONS	MEDICATION LISTS	ROUTE
Methylxanthines	Theophylline	Theophylline Medications List	Oral

Asthma Reliever Medications

DESCRIPTION	PRESCRIPTIONS	MEDICATION LISTS	ROUTE
Short-acting, inhaled beta-2 agonists	Albuterol	Albuterol Medications List	Inhalation
Short-acting, inhaled beta-2 agonists	Levalbuterol	Levalbuterol Medications List	Inhalation

Subject to change. Please refer to www.pshpgeorgia.com for specific drug coverage.

APPROPRIATE TESTING FOR PHARYNGITIS (CWP)

Lines of Business: Commercial, Medicaid, Medicare ●●●

The percentage of episodes for members 3 years and older where the member was diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode.

Intake Period: July 1, prior MY – June 30, current MY2023

DESCRIPTION	CODES
Group A Strep Test Pharyngitis	CPT: 87070, 87071, 87081, 87430, 87650-87652, 87880 ICD-10-CM: J02.0, J02.8, J02.9
Tonsilitis	ICD-10-CM: J03.00, J03.01, J03.80, J03.81, J03.90, J03.91

Codes subject to change.

To Improve HEDIS Measure:

- Perform a rapid strep test or throat culture to confirm the diagnosis before prescribing Antibiotics.
- Educate patients that an antibiotic is not necessary for viral infections if a rapid strep test and/or throat culture is negative.
- Submit any co-morbid diagnosis codes that apply to claim submission.
- Clinical guidelines recommend a strep test when the only diagnosis is pharyngitis.
- Strep tests can be either a rapid strep test or a lab test.
- Strep testing must be done in conjunction with dispensing of antibiotics.

APPROPRIATE TREATMENT FOR UPPER RESPIRATORY INFECTION (URI)

Lines of Business: Commercial, Medicaid, Medicare ●●●

The percentage of episodes for members 3 months of age and older with a diagnosis of upper respiratory infection (URI) that did not result in an antibiotic dispensing event.

Intake Period: July 1, prior MY2022 – June 30, current MY2023

Note: A higher rate indicates appropriate URI treatment. It describes the episodes that did not result in an antibiotic being dispensed.

*In prescribing an antibiotic, list all competing or comorbid diagnosis codes on the claim when submitting (e.g., acute pharyngitis, acute sinusitis, otitis media, emphysema, COPD, chronic bronchitis).

ICD-10-CM CODES TO IDENTIFY URI	J00, J06.0, J06.9
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To Improve HEDIS Measure:

- Discuss facts, including:
 - A majority of URIs are caused by viruses, not bacteria.
 - Antibiotics will not help a patient get better or feel better when diagnosed with a viral infection.
 - Taking antibiotics when not indicated could cause more harm than good.

USE OF IMAGING STUDIES FOR LOW BACK PAIN (LBP)

Lines of Business: Commercial, Medicaid, Medicare ●●●

The percentage of members 18–75 years of age with a principal diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis.

Note: A higher score indicates appropriate treatment of low back pain. It describes the proportion for whom imaging studies did not occur.

CPT CODES FOR IMAGING STUDY
72020, 72052, 72100,72110, 72114, 72120, 72131-72133, 72141, 72142, 72146-72149, 72156, 72158 72200, 72202, 72220

Codes subject to change.

To Improve HEDIS Measure:

- Avoid ordering diagnostic studies in the first 6 weeks of newly diagnosed onset back pain in absence of - cancer, recent trauma, neurologic impairment, or IV drug abuse.

- Educate the patient on methods of comfort for pain relief, stretching exercises, and activity level.
- Identify the reason for visits for low back pain (e.g., depression, anxiety, narcotic dependency, psychosocial stressors).
- Submit the correct exclusion ICD-10 codes when applicable.



OPIOID USE AND TREATMENT

For more information, visit www.ncqa.org

RISK OF CONTINUED OPIOID USE (COU)

Lines of Business: Commercial, Medicaid, Medicare ●●●

Members 18 years of age and older who have a new episode of opioid use that puts them at risk for continued opioid use. **Two rates are reported:**

1. The percentage of members with at least 15 days of prescription opioids in a 30-day period.
2. The percentage of members with at least 31 days of prescription opioids in a 62-day period.

Intake period: November 1, MY2022 – October 31, MY2023

NOTE:

- A lower rate indicates a better performance.
- Data is captured with pharmacy claims submission for opioid medications filled.

To Improve HEDIS Measure:

- Prescribe the lowest effective dose of opioids for the shortest period needed.
- Schedule follow-up appointments to assess pain management.
- Develop a treatment plan with the patient who is ready to cut down on prescriptions.
- Discuss with patients alternative pain management methods to lower their risk of developing opioid dependence.

USE OF OPIOIDS AT HIGH DOSAGE (HDO)

Lines of Business: Commercial, Medicaid, Medicare ●●●

The percentage of members 18 years of age and older who received prescription opioids at a high dosage (average morphine milligram equivalent dose [MME] ≥ 90) for ≥ 15 days during the measurement year.

- MME: Morphine milligram equivalent. The dose of oral morphine is the analgesic equivalent of a given dose of another opioid analgesic.
 - A daily dose is calculated using the units per day, strength, and the MME conversion factor (different for each drug)
 - The total sum of the MME daily doses calculated and averaged for all opioids dispensed to the member

To Improve HEDIS Measure:

- A lower rate is a better performance. Member is compliant if the average daily dose of MME is < 90 .
- Assess the benefits and any potential side effects with the patient within 1-4 weeks of starting opioid therapy for chronic pain or dosage increase.
- Schedule follow-up appointments before they leave the office.
- Use the lowest dosage of opioids in the shortest length of time when possible.
- Review the members' history of controlled substance prescriptions.

PHARMACOTHERAPY FOR OPIOID USE DISORDER (POD)

Lines of Business: Commercial, Medicaid, Medicare ●●●

The percentage of opioid use disorder (OUD) pharmacotherapy events that lasted at least 180 days among members 16 years of age and older with a diagnosis of OUD and a new OUD pharmacotherapy event.

Intake Period: July 1, MY2022 – June 30, MY2023

To Improve HEDIS Measure:

- Promote compliance and encourage treatment for a minimum of 180 days:
 - Educate patients with OUD on the risks and benefits of pharmacotherapy, treatment without medication, and no treatment
 - Identify and address any barriers:
- Keeping appointments
- Timely medication refills
 - Set reminder calls to confirm appointments.

USE OF OPIOIDS FOR MULTIPLE PROVIDERS (UOP)

Lines of Business: Commercial, Medicaid, Medicare ●●●

The percentage of members 18 years and older, receiving prescription opioids for ≥15 days during the measurement year, who received opioids from multiple providers.

Three rates are reported.

1. **Multiple Prescribers:** The percentage of members receiving prescriptions for opioids from four or more different prescribers during the measurement year.
2. **Multiple Pharmacies:** The percentage of members receiving prescriptions for opioids from four or more different pharmacies during the measurement year.
3. **Multiple Prescribers and Multiple Pharmacies:** The percentage of members receiving prescriptions for opioids from four or more different prescribers and four or more different pharmacies during the measurement year (i.e., the percentage of members who are numerator compliant for both the Multiple Prescribers and Multiple Pharmacies rates).

Note: A lower rate indicates better performance for all three rates.

To Improve HEDIS Measure:

- Identify an alternative pain management method to reduce the patient's risk of developing opioid dependence.
- Stay informed on the latest opioid research and guidelines available by visiting the websites at CDC - www.cdc.gov/opioids/guideline-update/, HHS - www.hhs.gov/opioids/ or the GA Department of Public Health - <https://dph.georgia.gov/stopopioidaddiction>
- Ensure patients take medication only as directed. They should never adjust the schedule or dosage on their own.



ELDERLY CARE

For more information, visit www.ncqa.org

ADVANCE CARE PLANNING (ACP)

Lines of Business: Medicare only ●

The percentage of adults 66–80 years of age with advanced illness, an indication of frailty, or who are receiving palliative care, and adults 81 years of age and older who had advance care planning during the measurement year.

DESCRIPTION	CODES
Advance Care Planning	CPT: 99483, 99497 CPT-CAT II: 1123F, 1124F, 1157F, 1158F HCPCS: S0257 ICD-10-CM: Z66 (Do not resuscitate)

Codes are subject to change.

Helpful Documentation Tips

- Presence of an advance care plan; (e.g., living will, health care power of attorney, health care proxy, actionable medical orders, or surrogate decision maker).
- Documentation of an advance care planning discussion and date in the measurement year.
- Notation in the medical record indicating the member previously executed an advance care plan.

To Improve HEDIS Measure:

- Discuss with the patient their decision for resuscitation, life-sustaining treatment, and end-of-life care.
- If the member does not wish to put an advance directive on file, have advance care planning. Discussion with the member at least once a year and document it in the medical record.

CARE FOR OLDER ADULTS (COA)

Lines of Business: Medicare only ●

The percentage of adults 66 years and older who had each of the following during the measurement year:

- Medication Review
- Functional Status Assessment
- Pain Assessment

DESCRIPTION	CODES
Medication Review 1159F (Medication list) 1160F (Medication review) Both codes are required to meet compliance	CPT: 90863, 99483, 99605, 99606 CPT-CAT-II: 1159F, 1160F
Functional Status Assessment	CPT: 99483 CPT-CAT-II: 1170F HCPCS: G0438, G0439
Pain Assessment	CPT-CAT-II: 1125F, 1126F

Codes are subject to change.

Helpful Documentation Tips

- **Medication review** – A review of all member’s medications, including prescription medications, over-the-counter medications, and herbal or supplemental therapies.
- **Functional status assessment** – Documentation must include evidence of a complete functional status assessment to include a notation that Activities of Daily Living (ADL) were assessed, cognitive status, sensory ability, and other functional independence.

- **Pain Assessment** – Perform an annual comprehensive pain assessment to screen the patient for the presence of pain and to assess pain intensity. This can be documented using a standardized pain assessment tool or documentation that the patient was assessed for pain and the date it was performed.

DEPRESCRIBING OF BENZODIAZEPINES IN OLDER ADULTS (DBO)

Lines of Business: Medicare only ●

The percentage of members 67 years of age and older who were dispensed benzodiazepines and achieved a 20% decrease or greater in benzodiazepine dose (diazepam milligram equivalent [DME] dose) during the measurement year.

DESCRIPTION	ICD-10-CM CODES
Alcohol Withdrawal	F10.230-F10.232, F10.239
Benzodiazepine Withdrawal	F13.230-F10.232, F10.239, F13.930-F13.932, F13.939
Generalized Anxiety Disordered	F41.0, F41.3, F41.8, F41.9

Codes are subject to change.

To Improve HEDIS Measure:

- The deprescribing best practice is a multistage process, rather than introducing an act of stopping the medication.
- Use a very slow tapering method aiming for dose reduction with continued tapering resulting in drug-free.
- Create a useful tapering schedule and monitor the patient’s progress with follow-up appointments.
- Provide the member with educational materials explaining withdrawal symptoms (e.g., insomnia, anxiety, irritability, gastrointestinal symptoms) that often occur when dose reduction is implemented.
 - If the patient presents with such symptoms, reassure that they are usually mild and subside in days to several weeks
 - Maintain the current dose for one or two weeks and then resume the taper

EMERGENCY DEPARTMENT VISITS FOR HYPOGLYCEMIA IN OLDER ADULTS WITH DIABETES (EDH)

Lines of Business: Medicare only ●

For members, 67 years of age and older with diabetes (types 1 and 2), the risk-adjusted ratio of observed to expected (O/E) emergency department (ED) visits for hypoglycemia during the measurement year. **Two rates are reported:**

- For all members 67 years of age and older with diabetes (types 1 and 2) the risk-adjusted ratio of O/E ED visits for hypoglycemia during the measurement year, stratified by dual eligibility.
- For a subset of members 67 years of age and older with diabetes (types 1 and 2) who had at least one dispensing event of insulin within each 6-month treatment period from July 1 of the year prior to the measurement year through December 31 of the measurement year, the risk-adjusted ratio of O/E ED visits for hypoglycemia, stratified by dual eligibility.

DESCRIPTION	CODES
ED Visit	CPT: 99281 – 99285
Hypoglycemia	ICD-10-CM: E08.64, E08.641, E08.649, E09.64, E09.641, E09.649, E10.64, E10.641, E10.649, E11.64, E11.641, E11.649, E13.64, E13.641, E13.649, E16.0, E16.1, E16.2

Codes are subject to change.

To Improve HEDIS Measure:

- Schedule post-ED visit follow-up with 3- 5 days to review their diabetes management.
- Educate the patient on the causes and symptoms of Hypoglycemia (e.g., sweat, tremble, weakness, difficulty seeing clearly, confusion or passing out, or having a seizure).
- Confirm if the patient is monitoring blood glucose levels frequently.
- Inform the patient about Hypoglycemia prevention and how to prepare to treat it promptly at any time.

FOLLOW-UP AFTER EMERGENCY DEPARTMENT VISIT FOR PEOPLE WITH MULTIPLE HIGH-RISK CHRONIC CONDITIONS (FMC)

Lines of Business: Medicare only ●

The percentage of emergency department (ED) visits for members 18 years of age and older who have multiple high-risk chronic conditions who had a follow-up service within 7 days of the ED visit.

Patients with two or more of the following chronic conditions that were diagnosed during the measurement are included:

- COPD and Asthma
 - Alzheimer’s disease and related disorders
 - Depression
 - Chronic Kidney Disease
- Heart Failure
 - Acute Myocardial Infarction
 - Atrial Fibrillation
 - Stroke and Transient Ischemic Attack

DESCRIPTION	CODES	
ED	CPT: 99281-99285	
Outpatient	CPT: 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411-12, 99429, 99455-56, 99483	
	HCPCS: G0463, T1015	
	POS: 02	
Transitional Care Management Services	CPT: 99495, 99496	
Telehealth Visits	Telephone Visits	CPT: 98966-98968, 99441-99443
	Online Assessments	CPT: 98969-98972, 99421-99444, 99457 HCPCS: G0071, G2010, G2012, G2061-G2063
	Modifiers/ POS	Modifiers: GT, 95 POS: 02
EXCLUSIONS		
Any ED Visits that resulted in an acute or non-acute inpatient stay, occurring on the day of the ED visit or within 7 days after the ED visit Note: An ED visit billed on the same claim as an inpatient stay is considered a visit that resulted in an inpatient t stay.		

Codes are subject to change.

To Improve HEDIS Measure:

- Schedule post-ED follow-up visit within 3 – 5 days after discharge.
- Keep open appointments so patients with an ED visit can be seen within 7 days of their discharge.
- In addition to an office visit, follow-up can be provided via telehealth, telephone, e-visit, and virtual
- Check-in visits.
- Encourage members to have regular office visits with a primary care provider to monitor and manage
- Chronic disease conditions.
- Instruct patients to call your PCP's office/after-hours line when their condition changes (weight gain, medication changes, or high/low blood sugar readings).

OSTEOPOROSIS MANAGEMENT IN WOMEN WHO HAD A FRACTURE (OMW)

Lines of Business: Medicare only ●

The percentage of women 67–85 years of age who suffered a fracture 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.

Intake Period: July 1, MY2022 - June 30, MY2023

DESCRIPTION	CODES
Bone Mineral Density Tests	CPT: 76977, 77078, 77080, 77081, 77085, 77086
Long- Acting Osteoporosis Medications	HCPCS: J0897, J1740, J3489
Osteoporosis Medication Therapy	HCPCS: J0897, J1740, J3110, J3111, J3489

Codes are subject to change.

To Improve HEDIS Measure:

- Prescribe the appropriate osteoporosis medications within 180 days of their discharge for a fracture.
- Order a Bone Mineral Density Test (BMD) within six months of the fracture.
- If the fracture resulted in an inpatient stay, a BMD test performed during the stay will close the care gap.

- Schedule a follow-up office visit soon as possible after the event.
- Women at risk for osteoporosis should receive a bone density screening every 2 years.

TRANSITIONS OF CARE (TRC)

Lines of Business: Medicare only ●

The percentage of discharges for members 18 years of age and older who had each of the following.

Four rates are reported:

- Notification of Inpatient Admission: Documentation of receipt of notification of inpatient admission on the day of admission through 2 days after the admission (3 total days).
- Receipt of Discharge Information: Documentation of receipt of discharge information on the day of discharge through 2 days after the discharge (3 total days).
- Patient Engagement After Inpatient Discharge: Documentation of patient engagement (e.g., office visits, visits the home, telehealth) provided within 30 days after discharge.
- Medication Reconciliation Post-Discharge: Documentation of medication reconciliation on the date of discharge through 30 days after discharge (31 total days).

Notification of Inpatient Admission: Medical Record documentation is necessary for compliance and must include evidence of the receipt of notification of inpatient admission on the day of admission or the following day. Documentation must include evidence of the date when the documentation was received.

Receipt of Discharge Information: Medical Record documentation is necessary for compliance and must include receipt of discharge information on the day of discharge or the following day with evidence of the date when the documentation was received. At a minimum, the discharge information.

DESCRIPTION	CODES	
Patient Engagement After Inpatient Discharge	CPT: 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99429, 99455, 99456, 99483 HCPCS: G0402, G0438, G0439, G0463, T1015	
Telehealth	Telephone Visits	CPT: 98966-98968, 99441-99443
	Online Assessments	CPT: 98969-98972, 99421-99444, 99457 HCPCS: G0071, G2010, G2012, G2061-G2063
	Modifiers/ POS	Modifiers: GT, 95 POS: 02
Medication reconciliation encounter	CPT: 99483 99495, 99496	
Medication reconciliation intervention	CPT-CAT II: 1111F	

To Improve HEDIS Measure:

- Documentation includes medication reconciliation on the date of discharge through 30 days after discharge (a total of 31 days)
- To be conducted by a prescribing provider, physician assistant, clinical pharmacist, or registered nurse.
- Does not have to be completed in a face-to-face visit, Schedule telehealth, phone visits, e-visits, and virtual check-ins.



FROM



Peach State Health Plan, Wellcare, and Ambetter are affiliated products serving Medicaid, Medicare, and Health Insurance Marketplace members, respectively. The information presented here is representative of our network of products. If you have any questions, please contact Provider Relations.

Provider Services Hours: Monday – Friday, 7:00 a.m. to 7:00 p.m.

CONTACT INFORMATION FOR PROVIDER SERVICES

Peach State Health Plan

1-866-874-0633 • pshp.com

Ambetter from Peach State Health Plan

1-877-687-1180 • ambetter.pshpgeorgia.com

Wellcare Medicare Health Plans • 1-855-538-0454

<https://www.wellcare.com/Georgia/Contact-Us>

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