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Quick Reference Guide HEDIS® 2020

For more information, visit **www.ncqa.org**

HEDIS® Quick Reference Guide

Updated to reflect NCQA HEDIS 2020 Technical Specifications

Allwell from Peach State HealthPlan strives 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 use to address care opportunities for your patients. Please always follow the State and/or CMS billing guidance and ensure the HEDIS codes are covered prior to 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 policy makers.

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 or Quality Bonus Funds.

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 review of a random sample of member medical records to abstract data for services rendered but 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.

HOW CAN I IMPROVE MY HEDIS SCORES?

- Submit claim/encounter data for each and every 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

PAY FOR PERFORMANCE (P4P)

P4P is an activity-based reimbursement, with a bonus payment based on achieving defined and measurable goals related to access, continuity of care, patient satisfaction and clinical outcomes.

QUESTIONS?

HTTPS://ALLWELL.PSHPGEORGIA.COM/

HMO: 1-844-890-2326: (TTY: 711)
HMO SNP: 1-877-725-7748: (TTY: 711)

Providers and other health care staff should document to the highest specificity to aid with the most correct coding choice.

ANCILLARY STAFF:

Please check the tabular list for the most specific ICD-10 code choice. This guide has been updated with information from the release of the *HEDIS 2020 Volume 2 Technical Specifications* by NCQA and is subject to change

CONTENTS

ADULT HEALTH

For more information, visit **www.ncqa.org**

(AAP) Adults' Access to Preventive/Ambulatory Health Services

Measure evaluates the percentage of members 20 years and older who had an ambulatory or preventive care visit. Services that count include outpatient evaluation and management (E&M) Visits, consultations, assisted living/home care oversight, preventive medicine, and counseling.

Clinical Goal:

For patients 20 years and older, report all services for Access/Availability of Care measures, whether or not the health plan will pay for them.

Documentation:

To count services in the medical record, document in the medical record the date when the procedure was performed and the result or finding (when applicable)

Criteria to Meet the Goal:

Proper coding is critical to ensure accurate reporting of these measures, and it may also decrease the need for medical record reviews.

CPT	HCPCS	ICD-10-CM
Ambulatory Visits: 99201- 99205, 99211 -99215 99241- 99245, 99341- 99345, 99347 -99350, 99381- 99387, 99391- 99397, 99401 -99404, 99411, 99412, 99429, 92002, 92004, 92012, 92014, 99304 - 99310, 99315, 99316, 99318, 99324- 99328, 99334- 99337 98966 - 98968, 99441 - 99443, 98969, 99444, 99483	**Other Ambulatory Visits:** G0402, G0438, G0439, G0463, T1015, S0620, S0621	**Ambulatory Visits:** Z00.00, Z00.01, Z00.121, Z00.129, Z00.3, Z00.5, Z00.8, Z02.0, Z02.1, Z02.2, Z02.3, Z02.4, Z02.5, Z02.6, Z02.71, Z02.79, Z02.81, Z02.82, Z02.83, Z02.89, Z02.9, Z76.1, Z76.2

Discussion Topic:

Educate patients on the importance of having at least one ambulatory or preventive care visit during each calendar year.

How to Improve HEDIS Score

- ☐ Use appropriate billing codes as described above
- ☐ Contact your patients and schedule appointments for needed services who have not had an annual preventative visit
- ☐ Look into opportunities to expanded office hours to increase access to care for your patients
- ☐ Have staff make reminder calls to patients with upcoming appointments to reduce no show rates

(ABA) Adult BMI Assessment

This measure demonstrates the percentage of members ages 18 to 74 who had and outpatient visit and whose body mass index (BMI) was documented.

- For patients 20 and over: code the BMI value on the date of service.
- Ranges and thresholds do NOT meet criteria; a distinct BMI value or percentile is required.

Exclusions: Pregnancy

Clinical Goal:
For patients 18-74 years of age, document height, weight, and BMI at least every two years

Documentation:
BMI documented during the measurement year or the year before the measurement year

Criteria to Meet the Goal:
Proper coding is essential to ensure accurate reporting, any of the following code combinations billed by a practitioner with prescribing authority meet criteria

ICD-10-CM: BMI Value Set ages 18-74	Outpatient Visit
Z68.1, Z68.20, Z68.21, Z68.22, Z68.23, Z68.24, Z68.25, Z68.26, Z68.27, Z68.28, Z68.29, Z68.30, Z68.31, Z68.32, Z68.33, Z68.34, Z68.35, Z68.36, Z68.37, Z68.38, Z68.39, Z68.41, Z68.42, Z68.43, Z68.44, Z68.45	**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 **UB Revenue**: 0510-0517, 0519-0523, 0526-0529, 0982, 0983

Discussion Topic:

Discuss the importance of weight management and potential risk factors due to an unhealthy diet, stress, lack of sleep, and exercise. Talk with the patient to developing a plan that meets their needs and supports realistic goals to make small changes to improve their health

How to Improve HEDIS Score

- ☐ Make a BMI assessment part of the vital sign assessment of each visit.
- ☐ Use correct billing codes (decreases the need for medical records request).
- ☐ Ensure proper documentation for BMI in the medical record with all components (i.e., date, weight, height, and BMI value). Provider signature must be on the same page.
- ☐ Update the EMR templates to automatically calculate a BMI if on an EMR.
- ☐ Place BMI charts near scales.

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

Adult members 18 years of age and older who were diagnosed with rheumatoid arthritis and received at least one prescription for a disease-modifying anti-rheumatic drug (DMARD) during the measurement year.

Clinical Goal:

For patients 18 years and older, the member is dispensed at least one ambulatory prescription for a disease-modifying anti-rheumatic drug (DMARD).

Documentation:
The documentation of a prescription in the measurement year that documents the member's name, prescription name, and date dispensed in the medical record.

Criteria to Meet the Goal:
Proper coding is critical to ensure accurate reporting of these measures.

ICD-10- CM: Rheumatoid Arthritis
M05.00-M05.9, MOT.00-M06.00-M06.9

DMARD Medications

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

Discussion Topic:
Discuss the importance of taking medication as prescribed and refilling medication as directed.

How to Improve HEDIS Score

- ☐ Use appropriate billing codes as described above.
- ☐ Prescribe DMARDs when diagnosing rheumatoid arthritis with your patients.
- ☐ Refer patients to network rheumatologists as appropriate for consultation and/or co-management.

(CBP) Controlling High Blood Pressure

Measure evaluates the percentage of members 18-85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90 mm Hg).

Exclusions: Medicare excludes members 66 years of age and older living in long-term in institutional settings, advanced illness, and/or frailty from this measure.

Clinical Goal:

The percentage of members 18-85 years of age who had a diagnosis of hypertension and whose BP was adequately controlled (<140/90 mm Hg) during the measurement year.

Documentation:

Last BP reading (date & result) in the measurement year (if elevated, document all BP readings).

Criteria to Meet the Goal:

Proper coding is essential to ensure accurate reporting of the measure, and it may also decrease the need for medical records reviews.

DESCRIPTION	CODES
Hypertension	**ICD-10-CM:** I10
Systolic greater than/equal to 140	**CPT-CAT-II:** 3077F
Systolic less than 140	**CPT-CAT-II:** 3074F, 3075F
Diastolic greater than/equal to 90	**CPT-CAT-II:** 3080F
Diastolic 80-89	**CPT-CAT-II:** 3079F
Diastolic less than 80	**CPT-CAT-II:** 3078F
Remote Blood Pressure Monitoring codes	**CPT:** 93784, 93788, 93790, 99091
Outpatient codes	**CPT:** 99201 - 99205, 99211 - 99215, 99241 - 99245, 99347 -99350, 99381 - 99387, 99391 - 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99429, 99455, 99456, 99483, 99341-99345 **HCPCS:** G0402, G0438, G0439, G0463, T1015
Non-acute Inpatient codes	**CPT:** 99304 - 99310, 99315, 99316, 99318, 99324 - 99328, 99334 -99337
Telephone Visits*	**CPT:** 98966-98968, 99441-99443

Be sure to use the appropriate telehealth modifier of 95 or GT, if applicable.

Discussion of Topic:
Educate the patient and/or spouse or caregivers on:

- The importance of taking all prescribed medications as directed by the physician
- Smoking cessation and avoiding secondhand smoke
- Encourage the patient to obtain BP cuff and track BP at least three times a week
- Dietary changes on a healthy heart and eating a low sodium diet
- Regular exercise and incorporating daily activities
- Reduce alcohol intake
- Attend follow-up visits as scheduled to monitor BP

How to Improve HEDIS Score

- ☐ Select appropriate sized BP cuff.
- ☐ Retake the BP if it high at the office visit (140/90 mm Hg or greater) (HEDIS allows the lowest systolic and lowest diastolic readings in the same day) and often the second reading is lower.
- ☐ Review hypertensive medication history and patient compliance, and consider modifying treatment plan for uncontrolled blood pressure as needed.
- ☐ Have patient return in 3 months.
- ☐ Do not round BP values up. If using an automated machine, record exact values.

(CDC) Comprehensive Diabetes Care

Measure evaluates percentage of members 18-75 years of age with diabetes (type 1 and type 2) who had each of the following:

- Hemoglobin A1c (HbA1c) testing
- HgA1c poor control (>9.0%)
- HgbA1c control (<8.0%)
- HbA1c control (<7.0%)
- Eye exam (retinal) performed
- Medical attention for nephropathy
- BP control (<140/90 mm Hg)

Exclusions: Medicare excludes members 65 years of age and older living in long-term institutional settings advanced illness, and/or frailty from all of this measure.

Clinical Goals:

CDC – HbA1C	• Members will have an HbA1c test performed during the measurement year HbA1c value – poor control ≥9% (reported in PQR as inverted rate <9%) • HbA1c value good control <8%Medicare patients – goal HbA1c <9 • Non-Medicare patients
CDC – BP Control (<140/90 mm Hg)	• Members with diabetes will have blood pressure control of <140/90 mm Hg
CDC – Medical Attention for Nephropathy - Annual screening test or evidence of treatment for nephropathy with ACE/ARB therapy.	• Members will have an annual urine screen for albumin/protein done during the measurement year OR • Evidence of treatment for nephropathy OR • ACE/ARB therapy
CDC – Annual Eye Exam	• Member will have: • A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year a negative retinal or dilated eye exam (negative for retinopathy) by an eye care professional in the year prior to the measurement year a bilateral eye enucleation anytime during the member's history through December 31 of the year

Documentation:

CDC – HbA1C	Date and value of most recent HbA1c result during the measurement year.
CDC – BP Control (<140/90 mm Hg)	Date of the visit with a blood pressure reading during the measurement year. The provider interpreted any notation of a patient using a remote blood pressure monitoring device and the results.
CDC – Annual Eye Exam	Results of the most recent eye exam by an eye care professional within the measurement year or 2 years if documented low risk of retinopathy or evidence of bilateral eye enucleation/acquired absence in both eyes anytime in member's history.

CDC – Medical Attention for Nephropathy	Results of nephropathy screen during the measurement year. • A urine test for albumin or protein with documentation of the date and the results or findings; or • Documentation of visit to a nephrologist; or • Documentation of a Renal Transplant; or • Documentation of medical attention for Diabetic nephropathy, ESRD, CRF, CKD, Renal insufficiency, Proteinuria, Albuminuria, Renal Dysfunction, ARF, or Dialysis (hemodialysis or peritoneal); or • ACE/ARB Therapy prescribed during the measurement year

Criteria to Meet the Goal:

Proper coding is critical to ensure accurate reporting of these measures, and it may also decrease the need for medical record reviews.

DESCRIPTION	CODES
Outpatient Codes	**CPT:** 99201 - 99205, 99211 - 99215, 99241 - 99245, 99347 -99350, 99381 - 99387, 99391 - 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99429, 99455, 99456, 99483, 99341-99345 **HCPCS:** G0402, G0438, G0439, G0463, T1015
Non-acute Inpatient	**CPT:** 99304 - 99310, 99315, 99316, 99318, 99324 - 99328, 99334, -99337
Remote BP Monitoring	**CPT:** 93784, 93788, 93790, 99091
Diastolic 80-89	**CPT-CAT-II:** 3079F
Diastolic Greater Than/Equal To 90	**CPT-CAT-II:** 3080F
Diastolic Less Than 80	**CPT-CAT-II:** 3078F
Systolic Greater Than/Equal To 140	**CPT-CAT-II:** 3077F
Systolic Less Than 140	**CPT-CAT-II:** 3074F, 3075F
Diabetic Retinal Screening With Eye Care Professional	**CPT-CAT-II:** 2022F, 2024F, 2026F
Unilateral Eye Enucleation with a bilateral modifier	**CPT:** 65091, 65093, 65101, 65103, 65105, 65110, 65112, 65114 **CPT Modifier:** 50
HbA1C Lab Test	**CPT:** 83036, 83037 **CPT-CAT-II:** 3044F, 3045F, 3046F

HbA1c Level Greater than/equal to 7 and Less than 8	**CPT-CAT-II:** 3051F
HbA1c Level Greater than/equal to 8 and Less than/equal to 9	**CPT-CAT-II:** 3052F
HbA1C Greater than 9.0	**CPT:** 83036, 83037 **CPT-CAT-II:** 3046F

(CDC) Comprehensive Diabetes Care- Continued

Measure evaluates percentage of members 18-75 years of age with diabetes (type 1 and type 2) who had each of the following

- Hemoglobin A1c (HbA1c) testing
- HgA1c poor control (>9.0%)
- HgbA1c control (<8.0%)
- HbA1c control (<7.0%)
- Eye exam (retinal) performed
- Medical attention for nephropathy
- BP control (<140/90 mm Hg)

DESCRIPTION	CODES
Urine Protein Tests	**CPT:** 81000 - 81003, 81005, 82042 - 82044, 84156 **CPT-CAT-II:** 3060F, 3061F, 3062F
Nephropathy Treatment	**CPT-CAT-II:** 3066F, 4010F

Discussion of Topic:

Educate patient and/or caregiver on:

- Take all prescribed medication as directed by a physician
- Monitor blood sugar regularly
- Monitor blood pressure at home
- The importance of smoking cessation and second-hand smoke should be avoided
- Eating habits should consist of heart-healthy, low calorie, and low-fat foods
- Incorporating exercise and daily activities to sustain a healthy weight and BMI

The significance of keeping scheduled appointments to help control there diabetes.

How to Improve HEDIS Score

- ☐ Use EMR to set alerts in the system for when a patient's screenings are due.
- ☐ Schedule appointments and send/call patients to remind before the appointment date.
- ☐ Consider drawing labs in office and ensure HbA1c result and date are documented in the chart.
- ☐ Adjust care plan to improve HbA1c and BP levels and follow up with the patient to monitor changes.
- ☐ Refer patients to a network ophthalmologist/optometrist for an annual diabetic exam.
- ☐ Follow up and request results of lab test, eye exam and any specialty referral and document the patient's chart.

(COA) Care for Older Adults

Measure evaluates percentage of adults 66 years and older who had each of the following:

Clinical Goal:

- Advanced care planning
- Medication review
- Functional status assessment
- Pain assessment

Discussion of Topic:

- Consult with patient and/or Caregiver the importance and purpose of an Advance care plan.
- Make inquires on how the patient is taking prescribed medication, over-the-counter medication, and any other supplements as instructed by the physician
- Encourage the patient to ask questions and inform the physician about any medical issues or concerns they may have.

Documentation:

- Advance care planning – 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); or documentation of an advance care planning discussion and date; (the documentation must be noted in the measurement year); or notation in the medical record that the member previously executed an advance care plan.
- 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 – Documentation must include an assessment for pain (which may include positive or negative findings) or the result of an assessment using a standardized tool, and the date the assessment was completed.

Criteria to Meet the Goal:
Proper coding is critical to ensure accurate reporting of these measures, and it may also decrease the need for medical record reviews.

DESCRIPTION	CODES
Advanced Care Planning	**CPT:** 99483, 99497 **CPT-CAT-II:** 1123F, 1124F, 1157F, 1158F **HCPCS:** S0257 **ICD-10-CM:** Z66
Medication Review **Would need both CPT-CAT II codes to get credit. 1159F (Medication List) & 1160F (Medication Review)**	**CPT:** 90863, 99605, 99606, 99483 **CPT-CAT-II:** 1159F, 1160F **HCPCS:** G8427
Functional Status Assessment	**CPT:** 99483 **CPT-CAT-II:** 1170F **HCPCS:** G0438, G0439
Pain Assessment	**CPT-CAT-II:** 1125F, 1126F
Transitional Care Management 7 day	**CPT: 99496**
Transitional Care Management 14 day	**CPT: 99495**

How to Improve HEDIS Score

- ☐ Incorporate a standardized tool to capture these measures for members 66 years and older if using EMR.
- ☐ Remember that the medication review measure entails the medication are listed in the chart plus the review.
- ☐ Place an alert within EMR to contact the patient as a reminder of their upcoming appointment.

(COL) Colorectal Cancer Screening

Measure evaluates the percentage of members 50-75 years of age who has appropriate screening for colorectal cancer.

Clinical Goals:

- Annual FOBT or FIT
- Colonoscopy
- Flexible sigmoidoscopy
- CT Colonography

Exclusions:

- Members with a diagnosis of colorectal cancer or total colectomy are excluded.
- Medicare patients age 66 and older as of December 31 of the measurement year who enrolled in an institutional SNP live in a long-term institution any time during the measurement year.

Note: FOBT tests performed in an office or performed on a sample collected via a digital rectal exam (DRE) do not meet criteria.

Discussion of Topic:

- Explain the importance of a colorectal screening
- Provide resources information of the risk factor for colorectal cancer
- Discuss personal and family history in reference to high risk of developing colorectal cancer
- Encourage the patient on the importance of a healthy lifestyle rather a poor diet high in red meat, overweight, smoking and heavy alcohol increase the risk of colorectal cancer

Documentation:

- Colonoscopy during the measurement year or 9 years prior;
- FOBT during measurement year;
- CT Colonography during the measurement year or 4 years prior:
- FIT-DNA test during the measurement year or 2 years prior
- Flexible Sigmoidoscopy during the measurement year or 4 years prior

Criteria to Meet the Goal:

Proper coding is critical to ensure accurate reporting of these measures, and it may also decrease the need for medical record reviews.

DESCRIPTION	CODES
Colonoscopy	**CPT:** 44388 - 44394, 44397, 44401 - 44408, 45355, 45378 - 45393, 45398 **HCPCS:** G0105, G0121
CT Colonography	**CPT:** 74261 – 74263
FIT- DNA Lab Test	**CPT:** 81528 **HCPCS:** G0464
Flexible Sigmoidoscopy	**CPT:** 45330 - 45335, 45337 - 45342, 45345 - 45347, 45349 – 45350 **HCPCS:** G0104
FOBT Lab Test	**CPT:** 82270, 82274 **HCPCS:** G0328
Colorectal Cancer	**HCPCS:** G0213, G0214, G0215, G0231 ICD-10-CM: C18.0 - C18.9, C19, C20, C21.2, C21.8, C78.5, Z85.038, Z85.048
Total Colectomy	**CPT:** 44150 - 44153, 44155 - 44158, 44210 - 44212

How to Improve HEDIS Score

- ☐ Make sure to update patient chart yearly indicating colorectal cancer screening (test done and the date).
- ☐ Reassure the patient who is resistant to having a colonoscopy to perform an at-home stool test (either gFOBT or iFOBT).
- ☐ Place standing orders for office staff to dispense FOBT or FIT kits to a patient who needs colorectal screening.
- ☐ Follow-up with patients to complete the at-home kit and return the specimen for lab results.
- ☐ Document the patient ileostomies, which entails colon removal and patients with a history of colon cancer.

(MRP) Medication Reconciliation Post Discharge

Measure evaluates the percentage of discharges from January 1-December 1 for members 18 years of age or older for whom medications were reconciled the date of discharge through 30 days after discharge (31 total days).

Clinical Goals:

Members 18 years of age or older will have all medications reviewed and reconciled within 30 days of discharge from an Inpatient setting.

This measure weighs whether medication reconciliation occurred. It does not attempt to calculate the quality of the medication list documented in the medical record or the process used to document the most recent medication list in the medical record.

Note: Medication reconciliation must be conducted by a prescribing practitioner, clinical pharmacist, or registered nurse.

Discussion of Topic:

- Discuss with the patient and/or caregiver on the importance of taking medication as prescribed by a practitioner.
- Explain to the patient and/or caregiver any possible side effects of the prescribed medication.

Documentation:

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

- Documentation of the current medications with a notation that the provider reconciled the current and discharge medications.
- Documentation of the current medications with a notation that references the discharge medications.
- Documentation of the member's current medications with a notation that the discharge medications were reviewed.
- Documentation of a current medication list, a discharge medication list, and notation that both lists were reviewed on the same date of service.
- Documentation of the current medications with evidence that the member was seen for post-discharge hospital follow-up with evidence of medication reconciliation or review.
- Documentation in the discharge summary that the discharge medications were reconciled with the most recent medication list in the outpatient medical record. There must be evidence that the discharge summary was filed in the outpatient chart on the date of discharge through 30 days after discharge (31 total days).

- Notation that no medications were prescribed or ordered upon discharge.
- Only documentation in the outpatient medical record meets the intent of the measure, but an outpatient visit is not required.

Criteria to Meet the Goal:
Proper coding is critical to ensure accurate reporting of these measures, and it may also decrease the need for medical record reviews.

CPT	CPT-CAT-II
99495, 99496, 99483	1111F

How to Improve HEDIS Score

- ☐ Schedule a follow-up appointment within 7-14 days of discharge.
- ☐ Consider standing orders for those patients discharged from the hospital or emergency room.
- ☐ Remind the patient to take medication as prescribed by the practitioner.

(PBH) Persistence of Beta-Blocker Treatment after a Heart Attack

The measure demonstrates the percentage of members 18 years of age and older during the measurement year who were hospitalized and discharged from July 1 of the year prior to June 30 of the measurement year with a diagnosis of AMI and who received persistent beta-blocker treatment for six months after discharge.

Clinical Goal:
Members ≥ 18 years of age with a new diagnosis of AMI will remain on beta-blocker treatment for 6 months after the hospital discharge. Consider 90 day supply or refills times 6 if appropriate.

Criteria to Meet the Goal:
Receipt of pharmacy claims for 180 day supply for beta blocker medication

Beta-Blocker Medications

Description	Prescription		
Noncardioselective beta-blockers	· Carvedilol · Labetalol · Nadolol · Pindolol	· Propranolol · Timolol · Sotalol	
Cardioselective beta-blockers	· Acebutolol · Atenolol	· Betaxolol · Bisoprolol	· Metoprolol · Nebivolol
Antihypertensive combinations	· Atenolol-chlorthalidone · Bendroflumethiazide-nadolol · Bisoprolol-hydrochlorothiazide	· Hydrochlorothiazide-metoprolol · Hydrochlorothiazide-propranolol	

(PCE) Pharmacotherapy Management of COPD Exacerbation

Measure evaluates 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 and were dispensed appropriate medications.

Two rates are reported:

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

Dispensed a **bronchodilator** (or there was evidence of an active prescription) **within 30 days of the event**

Clinical Goal:

Assess it the patient was given appropriate medication prescribed at the time of discharge and has filled the prescription and is taking the medications as prescribed.

Criteria to Meet the Goal:

Dispense systemic corticosteroid within 14 days from date of discharge and a bronchodilator within 30 days from impatient stay or ED visit.

Systemic Corticosteroid Medications

Description	Prescription		
Glucocorticoids	· Cortisone-acetate · Dexamethasone	· Hydrocortisone · Methylprednisolone	· Prednisolone · Prednisone

*subject to change

Bronchodilator Medications

Description	Prescription		
Anticholinergic agents	· Albuterol-ipratropium · Aclidinium-bromide	· Ipratropium · Tiotropium	· Umeclidinium
Beta 2-agonists	· Albuterol · Arformoterol · Budesonide-formoterol · Fluticasone-salmeterol · Fluticasone-vilanterol · Formoterol	· Formoterol-glycopyrrolate · Indacaterol · Indacaterol-glycopyrrolate · Levalbuterol · Formoterol-mometasone · Metaproterenol	· Olodaterol hydrochloride · Olodaterol-tiotropium · Salmeterol · Umeclidinium-vilanterol
Antiasthmatic combinations	· Dyphylline-guaifenesin		

*subject to change

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

Measure evaluates the percentage of members 40 years of age and older with a new diagnosis of COPD or newly active COPD, who received appropriate spirometry testing to confirm diagnosis.

Criteria to Meet the Goal:
Submit claim with spirometry testing on the date of service using the appropriate CPT code.

CPT
94010, 94014-94016, 94060, 94070, 94375, 94620

*codes subject to change

How to Improve HEDIS Scores

- ☐ Refer members to a specialist if unable to perform test in the office (Allergist or Pulmonologist).
- ☐ Ensure results of specialist testing is documented in the patients chart.

WOMEN'S HEALTH

For more information, visit **www.ncqa.org**

(BCS) Breast Cancer Screening

Measure evaluates the percentage of women 50-74 years of age who had a mammogram to screen for breast cancer.

The measurement period is January 1 through December 31 of the current year.

Exclusions: Bilateral mastectomy any time during the member's history through December 31 of the measurement year.

Required Exclusion: Medicare patients age 66 and older as of December 31 of the measurement year who are enrolled in an institutional SNP or living long-term in an institution any time during the measurement year.

Note: This measure evaluates primary screening. Do not count biopsies, breast ultrasounds, or MRIs because they are not appropriate methods for primary breast cancer screening.

Clinical Goal:
Members between the age of 50 and 74 years will have one or more mammograms at least every two years. Educate your patients on the importance of breast cancer screening.

Documentation:
This measure is to be submitted a minimum of once per performance period for female patients seen during the performance period. There is no diagnosis associated with this measure. The patient should either be screened for breast cancer on the date of service, OR there should be documentation that the patient was screened for breast cancer at least once within 27 months prior to the end of the performance period. This measure may be submitted by eligible clinicians who perform the quality actions described in the measure based on services provided and the measure-specific denominator coding.

Criteria to Meet the Goal:
Proper coding is critical to ensure accurate reporting of these measures, and it may also decrease the need for medical record reviews.

If the member had a mastectomy, document as part of the member's history in chart

CPT	HCPCS	ICD-10-CM (mastectomy)
Breast Cancer Screening: 77055 - 77057, 77061 - 77063, 77065 – 77067 **Unilateral /Bilateral Mastectomy:** 19180, 19200, 19220, 19240, 19303-19307	G0202, G0204, G0206	Z90.13, Z90.12, Z90.11

Discussion of Topic: Discuss the importance of mammogram screening with women patients 50-74 years of age, by providing educating the patient on the benefits to screening and the potential risks factors.

How to Improve HEDIS Score

- ☐ Use EMR to create alerts or reminders for members who need mammogram for an outpatient referral during their next annual visit.
- ☐ Document bilateral mastectomy in the medical records.
- ☐ Schedule a mammogram for the patient or send the patient referral to the facility.
- ☐ Provide a list of facilities in-network to share with the patient to schedule an appointment at a convenient location.
- ☐ Discuss possible fears the patient may have about mammogram and inform the patient that currently available testing methods are less uncomfortable and require less radiation.

(CCS) Cervical Cancer Screening

This measure demonstrates the percentage of women 21-64 years of age who were screened for cervical cancer.

The measurement period is January 1 through December 31 of the current year.

Exclusion: 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.

Clinical Goal:

Women 21-64 years of age who had cervical cytology performed within 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.

Documentation:

- Screening and results from appropriate testing completed in the last 3-5 yrs.
- Document "total," "radical," "complete" abdominal or vaginal hysterectomy.

Criteria to Meet the Goal:
Proper coding is critical to ensure accurate reporting of these measures, and it may also decrease the need for medical record reviews.

DESCRIPTION	CODES
Cervical Cytology Lab Test (20-64)	**CPT:** 88141 - 88143, 88147, 88148, 88150, 88152 - 88154, 88164 - 88167, 88174, 88175 **HCPCS:** G0123, G0124, G0141, G0143, G0144, G0145, G0147, G0148, P3000, P3001, Q0091
HPV Tests (30-64)	**CPT:** 87620 - 87622, 87624, 87625 **HCPCS:** G0476
Hysterectomy with No Residual Cervix and Absence of Cervix Diagnosis	**CPT:** 51925, 56308, 57540, 57545, 57550, 57555, 57556, 58150, 58152, 58200, 58210, 58240, 58260, 58262, 58263, 58267, 58267, 58270, 58275, 58280, 58285, 58290-58294, 58548, 58550, 58552-58554, 58570-58573, 58575, 58951, 58953, 58954, 59856, 59135 **ICD-10-CM:** Q51.5, Z90.710, Z90.712

Discussion of Topic:

- Educate the patient about the importance of well-women exams, mammograms, Pap test, and HPV testing.
- Refer the patient to another provider if you do not perform pap tests and request the results be sent to your practice.
- Offer the patient educational materials on cervical cancer screening.

How to Improve HEDIS Score

- ☐ Remember to document the date when the cervical cytology was performed, along with the results and
- ☐ Findings.
- ☐ To be counted for co-testing, the sample for the pap and HPV test must be collected and performed at the same time on the same date of service, regardless of the cytology result.
- ☐ Document in the medical chart if the patient had a hysterectomy with no residual cervical.
- ☐ Avoid missed opportunities to complete PA test during regular-scheduled well-women visits, sick visits, urine pregnancy test, UTI and chlamydia/STI screenings.
- ☐ Use a reminder/recall system to schedule patients' annual well-woman visits.

(OMW) Osteoporosis Management in Women Who Had a Fracture

Measure evaluates 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. The measurement period is July 1 of the prior year to June 30 of the current year.

Clinical Goal:

- Members 67-85 years of age, who had a fracture, will have a BMD within six months of the date of fracture.
- Consider BMD every two years in this age group.

Exclusions:

- Members who have had a bone density test during the 24 months prior to the fracture.
- Members who during the 12 months prior to the fracture, received a dispensed prescription, or had an active prescription to treat osteoporosis.
- Members who had a claim/encounter for osteoporosis therapy in the 12 months prior to the fracture.
- Members 65 years of age and older living in long-term in institutional settings.

Documentation:

- Intake Period: 12-month (1 year) window that begins on July 1 of the year prior to the measurement year and ends on June 30 of the measurement year. The Intake Period is used to capture the first fracture.
- Index Episode Start Date (IESD): The earliest date of service for any encounter during the Intake Period with a diagnosis of a fracture.
  - For an outpatient or
  - ED visit, the IESD is the date of service.
  - For inpatient encounters, the IESD is the date of discharge.
- Negative DX History: A period of 60 days (2 months) prior to the IESD when the member had no diagnosis of a fracture.
- Direct Transfers: The first admission date should be used when determining the number of days prior to the IESD

Criteria to Meet the Goal:

Proper coding is critical to ensure accurate reporting of these measures, and it may also decrease the need for medical record reviews.

DESCRIPTION	CODES
Bone Mineral Density Tests	**CPT:** 76977, 77078, 77080 - 77082, 77085, 77086
Osteoporosis Medications	**HCPCS:** J0897, J1740, J3110, J3489
Long-Acting Osteoporosis Medications during Inpatient Stay	**HCPCS:** J0897, J1740, J3489

Osteoporosis Medications

Description	Prescription	
Bisphosphonates	Alendronate Alendronate-cholecalciferol Ibandronate	Risedronate Zoledronic acid
Other agents	Abaloparatide Denosumab Raloxifene	Teriparatide

How to Improve HEDIS Score

- ☐ Schedule a follow-up appointment within 7-14 days of discharge
- ☐ Consider standing orders for those patients discharged from the hospital or emergency room.
- ☐ Remind the patient to take medication as prescribed by the practitioner

GENERAL HEALTH

For more information, visit **www.ncqa.org**

(AAB) Avoidance of Antibiotic Treatment for Acute Bronchitis/ Bronchiolitis:

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

Clinical Goal:

Members treated for acute bronchitis should NOT be prescribed antibiotics unless there are co-morbid conditions or competing diagnoses that require antibiotic therapy.

Note: This measure is reported as an inverted rate. A higher rate indicates appropriate treatment of adults with acute bronchitis. It describes the proportion for whom antibiotics were not prescribed.

Exclusions:

Exclude episode dates when the member had a claim/encounter with any diagnosis for a comorbid condition during the 12 months prior to or on the episode date. A code form any of the following meet criteria for comorbid condition:

EXCLUSIONS/CO-MORBID CONDITIONS
Comorbid Conditions, Competing Diagnosis, COPD, Cystic Fibrosis, Disorders of Immune System, Emphysema, HIV, HIV Type 2, Malignant Neoplasms, Other Malignant Neoplasms of Skin, and Pharyngitis

Documentation:

Evidence from claim/encounter data with a date of service for any outpatient or ED visit with an acute bronchitis diagnosis and no new or refill prescription for an antibiotic medication in the measurement year

Criteria to Meet the Goal:

Proper coding is critical to ensure accurate reporting of these measures and it may also decrease the need for medical record reviews.

DESCRIPTION	CODES
Acute Bronchitis	**ICD-10-CM:** J20.0-J20.9
ED	**CPT:** 99281-99285
Observation	**CPT:** 99217-99220
Outpatient	**CPT:** 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347- 99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412,99483, 99429, 99455, 99456 **HCPCS:** G0402, G0438,G0439, G0463, T1015

AAB Antibiotic Medication

Description	Prescription	
Aminoglycosides	Amikacin Gentamicin	Streptomycin Tobramycin
Aminopencillins	Amoxicillin	Ampicillin
Beta-lactamase inhibitors	Amoxicillin-clavulanate Ampicillin-sulbactam	Piperacillin-tazobactam
First-generation cephalosporins	Cefadroxil Cephalexin	Cefazolin
Fourth-generation c ephalosporins	Cefepime	
Ketolides	Telithromycin	
Lincomycin derivatives	Clindamycin	Lincomycin
Macrolides	Azithromycin Clarithromycin	Erythromycin Erythromycin ethylsuccinate Erythromycin lactobionate Erythromycin stearate
Miscellaneous antibiotics	Aztreonam Chloramphenicol Dalfopristin-quinupristin	Daptomycin Linezolid Metronidazole Vanomycin
Natural penicillins	Penicillin G benzathine-procaine Penicillin G potassium	Penicillin G procaine Penicillin G sodium Penicillin V potassium Penicillin G benzathine
Penicillinase resistant penicillins	Dicioxacillin	Nafcillin Oxacillin
Quinolones	Ciprofloxacin Gemifloxacin	Levofloxacin Moxifloxacin Ofloxacin
Rifamycin derivatives	Rifampin	

Second-generation cephalosporin	Cefaclor Cefotetan	Cefoxitin Cefprozil Cefuroxime
Sulfonamides	Sulfadiazine	Sulfamethoxazole-trimethoprim
Tetracyclines	Doxycycline	Minocycline Tetracycline
Third-generation cephalosporins	Cefdinir Cefditoren Cefixime	Cefotaxime Cefpodoxime Ceftazidime Ceftibuten Ceftriaxone
Urinary anti-infectives	Fosfomysin Nitrofurantoin Nitrofurantoin macrocrystals	Nitrofurantoin macrocrystals-monohydrate Trimethoprim

Discussion of Topic:

- Educate your patients and caregivers that most URIs also known as the common cold, are caused by viruses that require no antibiotic treatment
- Remind patients that mucus that is yellow or green does not necessarily indicate a bacterial infection

How to Improve HEDIS Score

☐ **Refer to the illness as a "chest cold" or viral upper respiratory infection and suggest at home treatments such as:**

- Using over-the-counter cough medicine and anti-inflammatory medicine

- Drinking extra fluids and resting

- Using a nasal irrigation device or steamy hot shower for nasal and sinus congestion relief

☐ **If the patient or caregiver insists on an antibiotic:**

- Review the absence of bacterial infection symptoms with the patient and caregiver and educate that antibiotics will not help with viral infections

☐ - Discuss the side effects of taking antibiotics

- Arrange for an early follow-up visit, either by phone call or re-examination

(CWP) Appropriate Testing for Pharyngitis

This measure demonstrates 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.

The measurement period is July 1 of the prior year to June 30 of the current year.

Clinical Goal:
Children 3 years and older diagnosed with pharyngitis/tonsillitis must receive a strep test prior to receiving a prescription for antibiotics.

Documentation:
Document patient's medical records with date of service and lab results showing strep test was completed.

Criteria to Meet the Goal:
Proper coding is critical to ensure accurate reporting of these measures, and it may also decrease the need for medical record reviews.

CPT	ICD-10-CM
87070, 87071, 87081, 87430, 87650 - 87652, 87880	J02.0, J02.8, J02.9, J03.00, J03.01, J03.80, J03.81, J03.90, J03.91

Discussion of Topic:

- Educate on getting appropriate rest and drink plenty of fluids
- Write a prescription for the over-the-counter medications
- Wash hands frequently

How to Improve HEDIS Score

- ☐ Perform a rapid strep test or throat culture to confirm diagnosis before prescribing antibiotics.
- ☐ Educate patients that an antibiotic is not necessary for viral infections if rapid strep test and/or throat culture is negative
- ☐ Submit any co-morbid diagnosis codes that apply to claim submission

CWP Antibiotic medications

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

(FUH) Follow- Up After Hospitalization for Mental Illness

Measure evaluates percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health practitioner.

Two rates are reported:

- Discharges for which the member received follow-up within 30 days after discharge
- Discharges for which the member received follow-up within 7 days after discharge

Criteria to Meet the Goal:

Receipt of a claim for an outpatient visit, intensive outpatient visit or partial hospitalization with a mental health practitioner within 7 days after discharge and gain within 30 days of discharge

Note: Follow up with a PCP does not meet the measure. The visit must be with a mental health practitioner.

DESCRIPTION	CODES
Visit Setting Unspecified Value Set with Outpatient POS with Mental Health Practitioner	**CPT:** 90791, 90792, 90832 - 90834, 90836 - 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221 - 99223, 99231 - 99233, 99238, 99239, 99251 – 99255 **POS:** 03, 05, 07, 09, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 22, 33, 49, 50, 71, 72
BH Outpatient Visit with Mental Health Practitioner	**CPT:** 98960 - 98962, 99078, 99201 - 99205, 99211 - 99215, 99241 - 99245, 99341 - 99345, 99347 - 99350, 99381 - 99387, 99391 - 99397, 99401 - 99404, 99411, 99412, 99510, 99483 **HCPCS:** G0155, G0176, G0177, G0409, G0463, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, M0064, T1015

*codes continue on next page

(FUH) Follow-Up After Hospitalization for Mental Illness *continued*

Measure evaluates percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health practitioner.

DESCRIPTION	CODES
Visit Setting Unspecified Value Set with Partial Hospitalization POS with Mental Health Practitioner	**CPT:** 90791, 90792, 90832 - 90834, 90836 - 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221 - 99223, 99231 - 99233, 99238, 99239, 99251 – 99255 **POS:** 52
Partial Hospitalization/Intensive Outpatient	**HCPCS:** G0410, G0411, H0035, H2001, H2012, S0201, S9480, S9484, S9485
Visit Setting Unspecified Value Set with Community Mental Health Center POS	**CPT:** 90791, 90792, 90832 - 90834, 90836 - 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221 - 99223, 99231 - 99233, 99238, 99239, 99251 – 99255 **POS:** 53
Electroconvulsive Therapy with Ambulatory Surgical Center POS/ Community Mental Health Center POS/ Outpatient POS/ Partial Hospitalization POS	**CPT:** 90870 **Ambulatory POS:** 24 **Comm. POS:** 53 **Partial Hosp. POS:** 52 **Outpatient POS:** 03, 05, 07, 09, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 22, 33, 49, 50, 71, 72, 52
Telehealth Visit	**CPT:** 90791, 90792, 90832 - 90834, 90836 - 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221 - 99223, 99231 - 99233, 99238, 99239, 99251 – 99255 **POS:** 02
Observation	**CPT:** 99217-99220
Transitional Care Management	**CPT:** 99495, 99496

*codes subject to change

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

- Measure evaluates percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) abuse or dependence who received the following:
- Initiation of AOD Treatment: percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth or medication treatment within 14 days of the diagnosis
- Engagement of AOD Treatment: percentage of members who initiated treatment and who were engaged in ongoing AOD treatment within 34 days of the initiation visit

Criteria to Meet the Goal:

- Submission of claim with a visit to a behavioral health provider
- Submission of claim with a follow up visit to the provider diagnosed with AOD dependence within 14 days of the AOD diagnosis using an appropriate treatment code.
- Submission of claim for 2 additional visits for AOD treatment within 30 days following the first treatment visit.

CPT	HCPCS	POS
98960-98962, 99078, 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99408-99409, 99411-99412, 99510, 90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90875-90876, 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99483, 99217-99220	G0155, G0176, G0177, G0396, G0397, G0409-G0411, G0443, G0463, H0001, H0002, H0004, H0005, H0007, H0015, H0016, H0022, H0031, H0034-H0037, H0039, H0040, H0047, H2000, H2001, H2010-H2020, H2035, H2036, M0064, S0201, S9480, S9484, S9485, T1006, T1012, T1015	02, 03, 05, 07, 09, 11-20, 22, 33, 49-50, 52-53, 57, 71-72

*codes continue on next page

For the follow up treatments, include an ICD-10 diagnosis for Alcohol or Other Drug Dependence from the Mental, Behavioral and Neurodevelopmental Disorder Section of ICD-10 along with a procedure code for the preventive service, evaluation and management consultation or counseling service.

(URI) Appropriate Treatment for Upper Respiratory Infection

This measure is 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.

Clinical Goals:

Effectively evaluate to prevent the inappropriate prescription of antibiotics. A higher rate indicates appropriate treatment

Criteria to Meet the Goal:

Proper coding is critical to ensure accurate reporting of these measures, and it may also decrease the need for medical record reviews.

DESCRIPTION	CODES
Upper Respiratory Infection	**ICD-10-CM:** J00, J06.0, J06.9

Discussion of Topic:

- Educate your patients and caregivers that most URIs, also known as the common cold, are caused by viruses that require no antibiotic treatment.
- Write over-the-counter cough medicine and anti-inflammatory medicine
- Drinking extra fluids and resting

How to Improve HEDIS Score

- ☐ Refer to the illness as a "chest cold" or viral upper respiratory infection and suggest at-home treatments
- ☐ Remind patients that mucus that is yellow or green does not necessarily indicate a bacterial infection
- ☐ Review the absence of bacterial infection symptoms with the patient and caregiver and educate that antibiotics will not help with viral infections
- ☐ Discuss the side effects of taking antibiotics
- ☐ Arrange for an early follow-up visit, either by a phone call or re-examination

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