Health Plan of San Joaquin

# HEDIS 2021-2022

## Gaps in Care Documentation & Billing Guide for Providers

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Community Partnership Wellness

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## Administrative Quality Measures

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# DISCLAIMER

This material serves as a tool to assist providers, their clinical team, and billing staff with information to improve HEDIS performance. This tip sheet is just a tool to use as a reference and is not a guarantee for payment or reimbursement.

HEDIS 2020-2021 Volume 1 Technical Specifications for Health Plans was used to generate this Provider Billing Guide.

HEDIS indicators have been designed by NCQA to standardize performance measurement and do not necessarily represent the ideal standard of care.

Information contained in this report is based on claims data only.

This tip sheet was developed by Health Plan of San Joaquin's Quality Management team as a resource tool to support provider initiatives to increase outcome rates for measures reported for HEDIS/MCAS. The billing tips provided are recommendations only and focus on increasing outcome rates for administratively reported data (i.e. claims and encounter submissions) and hybrid reported data (i.e. medical record review). The list is not all inclusive and additional codes may be available. If you have a question about a specific value set (codes) please contact HPSJ's HEDIS and Accreditation team or your Provider Services Representative.This tip sheet also includes the NCQA requirements related to provider specialty types.

Clinical record documentation to support patient compliance with HEDIS/MCAS measures can be faxed to the attention of the HEDIS team at 209.762.4730.

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# WHAT IS HEDIS?

HEDIS is a registered trademark of the National Quality Committee for Quality Assurance (NCQA)

**Healthcare Effectiveness Data and Information Set (HEDIS)**
NCQA defines HEDIS as "a set of standardized performance measures designed to ensure that purchasers and consumers have the information they need to reliably compare the performance of health care plans."

HEDIS is a performance measurement tool that is coordinated and administered by NCQA and used by the Centers for Medicare & Medicaid Services (CMS) for monitoring the performance of managed care organizations. Results from HEDIS data collection serve as measurements for quality improvement processes, educational initiatives, and preventive care programs. All managed care companies who are NCQA accredited perform HEDIS reviews the same time each year.

There are two types of HEDIS data referred to in this guide:
**Administrative data** – comes from submitted claims and encounters
**Hybrid data** – comes from chart collection/review

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# ANNUAL HEDIS TIMELINE

## February - May

HPSJ Quality Department Staff Collect and Review HEDIS data from the previous calendar year

## June

HEDIS results are certified and reported to NCQA

## October

NCQA releases Quality Compass results nationwide for Medicaid

# HEDIS Medical Record Retrieval Process:

- Medical Records requested for HEDIS review are required and HPSJ does not reimburse copy services or copying fees for records requested for this purpose.
- Collection methods include: fax, mail, remote access to Electronic Medical Records (EMR), record pick ups and onsite scanning (if available)
- Turn around time for record retrieval is 10 business days for non-urgent requests.
- Turn around time for urgent requests is 24 hours
- **We strongly encourage those offices with EMR systems to reach out to our HEDIS Department at HEDIS@HPSJ.com**

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# HIPAA

Under the Health Information Portability and Accountability Act (HIPAA) Privacy Rule, data collection for HEDIS is permitted, and the release of this information requires no special patient consent or authorization. Please be assured our members' personal health information is maintained in accordance with all federal and state laws. HEDIS results are reported collectively without individual identifiers or outcomes. All of the health plans' contracted providers' records are protected by these laws.

1. HEDIS data collection and release of information is permitted under HIPAA since the disclosure is part of quality assessment and improvement activities
2. The records you provide us during this process helps us to validate the quality of care our members received

# Tips and Best Practices

- Use your Care Gap Finder (CGF) roster to contact patients who are due for exams, labs or referrals
- Document all services and referrals in your medical record for the patient.
- Use this guide to ensure all services are captured through your claims and encounter data by coding appropriately to lessen the need for medical record requests from your office.
- Schedule your patients next well or follow up visit at the end of the current appointment.
- Set standing orders for patients ongoing labs and preventative exams such as:
  - HbA1c quarterly blood draws
  - Diabetic retinal exams
  - Mammograms
- If your office has an EMR system contact HPSJ's HEDIS and Accreditation Manager - Vanessa Lagemann at vlagemann@hpsj.com to set up remote access and ongoing electronic data feeds.

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# Claims Corner

## Coding for Telehealth Visits

1. E/M codes should be billed with **POS 02** and **modifier 95** for telehealth office visits.
   - Definition from DHCS: Medi-Cal providers may bill their managed care plan as appropriate for any covered Medi-Cal benefits or services using the appropriate procedure codes (CPT/HCPCS) that are appropriate to be provided via a telehealth modality.
   - The benefits or service delivered via telehealth must meet the procedural definitions and components of the CPT/HCPCS billed
2. E-Consults (**CPT 99451**) in conjunction with **modifier GQ**: Interprofessional telephone/internet/electronic health record assessment and management services provided by consultative physician, including written report of the patients treatment of 5 or more minutes.
3. Other Virtual/Telephonic Communications (not to be billed in conjunction with E/M or other procedure codes)
   - **HCPCS code G2010**: Remote evaluation of recorded video and/or image submitted by an established patient, including interpretation with follow-up with the patient within 24 hours, not originating from a related evaluation ad management (E/M) service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment.
   - **HCPCS code G2012**: Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion. G2012 can be billed when the virtual communication occurred via a telephone call.
4. Additional Telehealth Codes
   - **CPT 98966, 98967 and 98968**: Non-Face-to-Face Nonphysician Telephone Services
   - **CPT 99441, 99442 and 99443**: Non-Face-to-Face Telephone Services

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# **CBP -** Controlling High Blood Pressure

## Measure Definition

Patients 18-85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90mmHg) during the measurement year.

## Medical Record Documentation Best Practices

- Document Patients Blood Pressure during every visit
- BP may be taken multiple times during a visit - all readings should be clearly documented in the medical record
- **DO NOT** round up or down.
- BP readings from remote monitoring devices that are digitally stored and transmitted to the provider may be used. There must be documentation in the medical record that clearly states the reading was taken by an electronic device, and results were digitally stored, transmitted to and interpreted by the provider.

## Telehealth Tips

- Blood pressures taken by the patient during a telehealth visit can be used for the CBP measure so long as the patient is using a digital blood pressure monitor.
- It should be clearly stated in the medical record that the blood pressure was taken by the patient and documented during the telehealth visit

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# CBP - Controlling High Blood Pressure

## Coding your claims and Encounters

CBP is a hybrid measure and data can be collected through medical record review. The best way to reduce the burden of medical record review during HEDIS season is to ensure you have coded all of your claims and encounters for your patients visit to the highest level of specificity.

| Code Type | Code | Defenition |
|---|---|---|
| ICD-10 | I10 | Essential Hypertension |
| CPT II | 3074F | Systolic BP <130 |
| CPT II | 3075F | Systolic BP 130 - 139 |
| CPT II | 3077F | Systolic BP ≥140 |
| CPT II | 3078F | Diastolic BP <80 |
| CPT II | 3079F | Diastolic BP 80 - 89 |
| CPT II | 3080F | Diastolic BP ≥90 |

# CCS - Cervical Cancer Screening

## Measure Definition

Female patients 21-64 years of age who were screened for cervical cancer using either of the following criteria:

- Women age 21-64 who had cervical cytology performed within the last 3 years
- Women age 30-64 who had cervical cytology with human papillomavirus (HPV) co-testing performed within the last 5 years

## Medical Record Documentation Best Practices

- Referrals for service do not close out this measure.
- Documentation of the service within the medical record should include
  - Collection Date
  - HPV co-testing when applicable
  - Results of the screening
- Patients may be exempt if they have had a complete, total or radical hysterectomy. This must be clearly documented in the patients medical record.
- Documentation stating 'history of hysterectomy' without the term 'Complete', 'Total' or 'Radical' included does not qualify for exclusion from this measure.

## Telehealth Tips

- These services should not be rendered via telehealth.

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# CCS - Cervical Cancer Screening

## Coding your Claims and Encounters

CCS is a hybrid measure and data can be collected through medical record review. The best way to reduce the burden of medical record review during HEDIS season is to ensure you have coded all of your claims and encounters for your patients visit to the highest level of specificity.

| Code Type | Code | Defenition |
|---|---|---|
| CPT | 88141-88143, 88147, 88148, 88150, 88152, 88153, 88164-88167, 88174, 88175 | Cervical Cancer Screening |
| CPT | 87624, 87625 | HPV Testing |

## Coding for Exclusions

For patients who have had 'Total', 'Complete' or 'Radical' Hysterectomies it is important to code this information on your claims and encounter form. This helps ensure that the patient is excluded automatically in the future and should no longer show up on your CGF lists.

| Code Type | Code | Definition |
|---|---|---|
| ICD - 10 | Q51.5, Z90.710, Z90.712 | Absence of Cervix |
| CPT | 51925, 57540, 57545, 57550, 57555, 57556, 58150, 58152, 58200, 58210, 58240, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290-58294, 58550, 58552-58554, 58570-58573, 58575, 58951, 58953, 58954, 58956, 59135 | |

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# CDC - Comprehensive Diabetes Care - BP

## Measure Definition

Patients ages 18-75 years of age with a diagnosis of diabetes (types 1 and 2) whose last blood pressure in the measurement year was less than 140/90mmHg.

## Medical Record Documentation Best Practices

- Document Patients Blood Pressure during every visit
- BP may be taken multiple times during a visit - all readings should be clearly documented in the medical record
- DO NOT round up or down.
- BP readings from remote monitoring devices that are digitally stored and transmitted to the provider may be used. There must be documentation in the medical record that clearly states the reading was taken by an electronic device, and results were digitally stored, transmitted to and interpreted by the provider.

## Telehealth Tips

- Blood pressures taken by the patient during a telehealth visit can be used for the CBP measure so long as the patient is using a digital blood pressure monitor.
- It should be clearly stated in the medical record that the blood pressure was taken by the patient and documented during the telehealth visit

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# CDC - Comprehensive Diabetes Care - BP

## Coding your Claims and Encounters

CDC is a hybrid measure and data can be collected through medical record review. The best way to reduce the burden of medical record review during HEDIS season is to ensure you have coded all of your claims and encounters for your patients visit to the highest level of specificity.

| Code Type | Code | Definition |
|---|---|---|
| ICD-10 | E10.10-E13.9, O24.011-O24.33,O24.811-O24.83 | Diabetes |
| ICD-10 | I10 | Essential Hypertension |
| CPT II | 3074F | Systolic BP <130 |
| CPT II | 3075F | Systolic BP 130 - 139 |
| CPT II | 3077F | Systolic BP ≥ 140 |
| CPT II | 3078F | Diastolic BP <80 |
| CPT II | 3079F | Diastolic BP 80 - 89 |
| CPT II | 3080F | Diastolic BP ≥ 90 |

## Coding for Exclusions

Patients with a diagnosis of gestational diabetes or steroid-induced diabetes, in any setting, during the measurement year or the year prior, with no encounters in any setting with a diagnosis of diabetes.

| Code Type | Code | Definition |
|---|---|---|
| ICD 10 | E08.00-E08.9, E09.00-E09.9, E28.2, O24.410, O24.414, O24.415, O24.419, O24.420, O24.424, O24.425, O24.429, O24.430, O24.434, O24.435, O24.439, O24.911-O24.913, O24.919, O24.92, O24.93 | Diabetes Exclusions |

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# CDC - Comprehensive Diabetes Care - Eye

## Measure Definition

Patients ages 18-75 years of age with a diagnosis of diabetes (types 1 and 2) without retinopathy who had a retinal or dilated eye exam in the past 2 years or with retinopathy who had a retinal or dilated eye exam in the past year.

## Medical Record Documentation Best Practices

Documentation in the medical record must include one of the following:

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

## Telehealth Tips

- These services should not be rendered via telehealth.

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# CDC - Comprehensive Diabetes Care - Eye

## Coding your Claims and Encounters

CDC is a hybrid measure and data can be collected through medical record review. The best way to reduce the burden of medical record review during HEDIS season is to ensure you have coded all of your claims and encounters for your patients visit to the highest level of specificity.

| Code Type | Code | Definition |
|---|---|---|
| ICD-10 | E10.10-E13.9, O24.011- | Diabetes |
| ICD-10 | 08T1XZZ | Resection of Left Eye, External Approach |
| ICD-10 | 08T0XZZ | Resection of Right Eye, External Approach |
| CPT | 65091, 65093, 65101, 65103, | Unilateral Eye Enucleation |
| CPT | 67028, 67030, 67031, 67036, 67039-67043, 67101, 67105, 67107, 67108, 67110, 67113, 67121, 67141, 67145, 67208, 67210, 67218, 67220, 67221, 67227, 67228, 92002, 92004, 92012, 92014, 92018, 92019, 92134, 92201, 92202, 92225-92228, 92230, 92235, 92240, 92250, 92260, 99203-99205, 99213-99215, 99242-99245 | Diabetic Retinal Screening |
| CPT II | 2022F | Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy |
| CPT II | 2023F | Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy |
| CPT II | 2024F | Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy |
| CPT II | 2025F | 7 standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy |
| CPT II | 2026F | Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed; with evidence of retinopathy |
| CPT II | 2033F | Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed; without evidence of retinopathy |
| CPT II | 3072F | Low risk for retinopathy (no evidence of retinopathy in the prior year) (DM) |

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# **CDC -** Comprehensive Diabetes Care - Eye

## Coding your Claims and Encounters

| Code Type | Code | Definition |
|---|---|---|
| HCPCS | S0620 | Routine ophthalmological examination including refraction; new patient |
| HCPCS | S0621 | Routine ophthalmological examination including refraction; established patient |
| HCPCS | S3000 | Diabetic indicator; retinal eye exam, dilated, bilateral |

## Coding for Exclusions

Patients with a diagnosis of gestational diabetes or steroid-induced diabetes, in any setting, during the measurement year or the year prior, with no encounters in any setting with a diagnosis of diabetes.

| Code Type | Code | Definition |
|---|---|---|
| ICD 10 | E08.00-E08.9, E09.00-E09.9, E28.2, O24.410, O24.414, O24.415, O24.419, O24.420, O24.424, O24.425, O24.429, O24.430, O24.434, O24.435, O24.439, O24.911-O24.913, O24.919, O24.92, O24.93 | Diabetes Exclusions |

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# CDC - Comprehensive Diabetes Care - HbA1c Testing

## Measure Definition

Patients ages 18-75 years of age with diabetes (types 1 and 2) who had HbA1c Testing during the measurement year.

## Medical Record Documentation Best Practices

Documentation of HbA1c date of service and results.

- Control is identified as HbA1c levels under 8.0
- Poor control is identified as HbA1c levels at 9.0 or higher or not found

## Telehealth Tips

- These services should not be rendered via telehealth.

## Coding your Claims and Encounters

CDC is a hybrid measure and data can be collected through medical record review. The best way to reduce the burden of medical record review during HEDIS season is to ensure you have coded all of your claims and encounters for your patients visit to the highest level of specificity.

| Code Type | Code | Definition |
|---|---|---|
| ICD-10 | E10.10-E13.9, O24.011-O24.33,O24.811-O24.83 | Diabetes |
| CPT | 83036, 83037 | HbA1c Lab Test |
| LOINC | 17856-6, 4548-4, 4549-2 | HbA1c Lab Test |
| CPT II | 3044F, 3046F, 3051F, 3052F | HbA1c Lab results |

## Coding for Exclusions

Patients with a diagnosis of gestational diabetes or steroid-induced diabetes, in any setting, during the measurement year or the year prior, with no encounters in any setting with a diagnosis of diabetes.

| Code Type | Code | Definition |
|---|---|---|
| ICD 10 | E08.00-E08.9, E09.00-E09.9, E28.2, O24.410, O24.414, O24.415, O24.419, O24.420, O24.424, O24.425, O24.429, O24.430, O24.434, O24.435, O24.439, O24.911-O24.913, O24.919, O24.92, O24.93 | Diabetes Exclusions |

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# **CIS -** Childhood Immunization Status

## Measure Definition

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

## Medical Record Documentation Best Practices

- Review and document all of patients historical vaccines, dates of service and dose information in the patients medical record.
- Update patients medical records with all vaccine information done in your office
- Update patients immunization status and history in state registries (RIDE and/or CAIR)
- Document patients date of first Hepatitis B vaccination if given at the hospital and note the hospital.
- Document history of illness in chart if child has had an anaphylactic reaction

## Telehealth Tips

- These services should not be rendered via telehealth.

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# CIS - Childhood Immunization Status

## Coding your Claims and Encounters

CIS is a hybrid measure and data can be collected through medical record review. The best way to reduce the burden of medical record review during HEDIS season is to ensure you have coded all of your claims and encounters for your patients visit to the highest level of specificity.

| Code Type | Code | Definition | CVX |
|---|---|---|---|
| ICD-10 | B05.0, B05.1 – B05.4, B05.81, B05.89, B05.9 | Measles Vaccine | |
| ICD-10 | B06.00, B06.01, B06.02, B06.09, B06.81, B06.89, B06.9 | Rubella Vaccine | |
| CPT II | 90698, 90700, 90723 | Dtap Vaccine | 20, 50, 106, 107, 110, 120 |
| CPT II | 90633 | Hep A Vaccine | 31, 83, 85 |
| CPT II | 90723, 90740, 90744, 90747, 90748 | Heb B Vaccine | 8, 44, 45, 51, 110 |
| CPT II | 90644 - 90648, 90698, 90748 | HiB - Haemophilus Influenza Type B Vaccine | 17, 46 – 51, 120, 148 |
| CPT II | 90698, 90713, 90723 | IPV - Inactivated Polio Vaccine | 10, 89, 110, 120 |
| CPT II | 90707, 90710 | MMR - Measles, Mumps and Rubella Vaccine | 03, 94 |
| CPT II | 90670 | Pneumococcal Conjugate Vaccine | 133, 152 |

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# **CIS -** Childhood Immunization Status

## Coding your Claims and Encounters

| Code Type | Code | Definition | CVX |
|---|---|---|---|
| CPT II | 90681 | Rotavirus 2 dose vaccine | 119 |
| CPT II | 90680 | Rotavirus 3 dose vaccine | 116, 122 |
| CPT II | 90710, 90716 | Varicella Zoster Vaccine | 21, 94 |
| CPT II | 90655, 90657, 90662, 90673, 90685, 90686, 90688, 90689 | Influenza Vaccine | 88, 135, 140, 141, 150, 153, 155, 158, 161 |

## Coding for Exclusions

Patients with a contraindication for a specific vaccine.

| Code Type | Code | Definition |
|---|---|---|
| ICD-10 | T80.52XA, T80.52XD, T80.52XS | Any particular vaccine Anaphylactic Reaction |

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# **LSC -** Lead Screening in Children

## Measure Definition

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

## Medical Record Documentation Best Practices

- Document date test was performed and the result and finding
- Document any patient referrals clearly in the medical record
- Document any patient refusals clearly in the medical record
- Documentation should include evidence of written of oral anticipatory guidance to a parent or guardian - including at a minimum - the information that children can be harmed by exposure to lead, especially deteriorating or disturbed lead-based paint and dust from it and are particularly at risk of lead poisoning.
- Completion of a Risk Assessment Questionnaire does not meet the Medicaid requirement for anticipatory guidance.

## Telehealth Tips

- These services should not be rendered via telehealth.

# LSC - Lead Screening in Children

## Coding your Claims and Encounters

LSC is a hybrid measure and data can be collected through medical record review. The best way to reduce the burden of medical record review during HEDIS season is to ensure you have coded all of your claims and encounters for your patients visit to the highest level of specificity.

| Code Type | Code | Definition |
|---|---|---|
| CPT | 83655 | Lead Screening |

## Coding for Exclusions

No exclusions available for this measure

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# IMA - Immunizations for Adolescents

## Measure Definition

Children 13 years of age who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday.

## Medical Record Documentation Best Practices

- Review and document all of patients historical vaccines, dates of service and dose information in the patients medical record.
- Update patients medical records with all vaccine information done in your office
- Update patients immunization status and history in state registries (RIDE and/or CAIR)
- Document history of illness in chart if child has had an anaphylactic reaction
- Meningococcal recombinant serogroup B does NOT count

## Telehealth Tips

- These services should not be rendered via telehealth.

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# IMA - Immunizations for Adolescents

## Coding your Claims and Encounters

IMA is a hybrid measure and data can be collected through medical record review. The best way to reduce the burden of medical record review during HEDIS season is to ensure you have coded all of your claims and encounters for your patients visit to the highest level of specificity.

| Code Type | Code | Definition | CVX |
|---|---|---|---|
| CPT | 90715 | Tdap Vaccine | 115 |
| CPT | 90734 | Meningococcal Vaccine | 108, 114, 136, 147, 167 |
| CPT | 90649, 90650, 90651 | HPV - Human Papilomavirus | 62, 118, 137, 165 |

## Coding for Exclusions

Patients with a contraindication for a specific vaccine.

| Code Type | Code | Definition |
|---|---|---|
| ICD-10 | T80.52XA, T80.52XD, T80.52XS | Any particular vaccine Anaphylactic Reaction |

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# PPC - Prenatal & Postpartum Care - Prenatal

## Measure Definition

Pregnant female patients who received a prenatal care visit in their first trimester, on or before the enrollment start date or within 42 days of enrollment with the health plan.

## Medical Record Documentation Best Practices

- Document any referrals for OB care clearly
- Documentation indicating the woman is pregnant or references to the pregnancy:
  - Documentation in a standardized prenatal flow sheet, **or**
  - Documentation of LMP, EDD or gestational age, **or**
  - A positive pregnancy test results, **or**
  - Documentation of gravidity and parity, **or**
  - Documentation of complete obstetrical history, **or**
  - Documentation of prenatal risk assessment and counseling/education
- A basic physical obstetrical examination that includes
  - Auscultation for fetal heart tone, **or**
  - Pelvic exam with obstetric observations, **or**
  - Measurement of fundus height (a standardized prenatal flow sheet may be used)
- Documentation of evidence that a prenatal care procedure was performed, such as:
  - Screening test in the form of an obstetric panel (must include all of the following: hematocrit, differential WBC count, platelet count, hepatitis B surface antigen, rubella antibody, syphilis test, RBC antibody screen, Rh and ABO blood typing), **or**
  - TORCH antibody panel alone, **or**
  - A rubella antibody test/titer with an Rd incompatibility (ABO/Rh) blood typing, **or**
  - Ultrasound of pregnant uterus

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# **PPC -** Prenatal & Postpartum Care - Prenatal

## Coding your Claims and Encounters

PPC is a hybrid measure and data can be collected through medical record review. The best way to reduce the burden of medical record review during HEDIS season is to ensure you have coded all of your claims and encounters for your patients visit to the highest level of specificity.

| Code Type | Code | Definition |
|---|---|---|
| CPT | 59400, 59510, 59610, 59618 | Prenatal Bundled Services |
| CPT II | 0500F | Initial comprehensive pregnancy-related office visit (1 in 6 months) |
| CPT II | 0501F | Prenatal flow sheet documented |
| CPT II | 0502F | Subsequent prenatal visit for continuing to care |

# PPC - Prenatal & Postpartum Care - Postpartum

## Measure Definition

Female patients who delivered a live birth who had a postpartum visit on or between 7 and 84 days after delivery.

## Medical Record Documentation Best Practices

- Documentation should clearly state:
  - Postpartum care, PP check, PP Care, 6 week PP check etc
  - Pelvic exam
  - Evaluation of weight, BP, breasts and abdomen
  - Perineal or cesarean incision/wound check
- Documentation of infant care, breastfeeding, family planning, sleep/fatigue and/or resumption of physical activity
- Documentation of any screenings ordered including
  - glucose tests for patients with gestational diabetes
  - behavioral or mental health screenings
  - tobacco or substance use
- Documentation of any completed cervical cancer screenings including results

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# **PPC -** Prenatal & Postpartum Care - Postpartum

## Coding your Claims and Encounters

PPC is a hybrid measure and data can be collected through medical record review. The best way to reduce the burden of medical record review during HEDIS season is to ensure you have coded all of your claims and encounters for your patients visit to the highest level of specificity.

| Code Type | Code | Definition |
|---|---|---|
| CPT | 59400, 59410, 59510, 59515, 59610, 59614, 59618, 59622 | Postpartum Bundled Services |
| CPT | 57170, 58300, 59430, 99501 | Postpartum Care Visit |
| CPT II | 0503F | Postpartum Care Visit |
| ICD-10 | Z01.411 | abnormal findings |
| ICD-10 | Z01.419 | Encounter for gynecological Examination (general) (routine) w/o abnormal findings |
| ICD-10 | Z01.42 | Encounter for cervical smear to confirm findings of recent normal smear following initial abnormal smear |
| ICD-10 | Z30.430 | Encounter for insertion of intrauterine contraceptive device |
| ICD-10 | Z39.1 | Encounter for care and examination of lactating mother |
| ICD-10 | Z39.2 | Encounter for routine postpartum follow-up |

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# WCC - Weight Assessment, Counseling for Nutrition & Physical Activity for Children

## Measure Definition

Children ages 3 - 17 years of age who had a visit with evidence of the following:

- BMI Percentile Documentation
- Counseling for nutrition
- Counseling for Physical Activity

## Medical Record Documentation Best Practices

- BMI Percentile documentation should always include documentation of patients height, weight and BMI Percentile. BMI percentile may be documented as a value or plotted on an age-growth chart. BMI ranges and thresholds do not meet criteria for this indicator.
- Counseling for Nutrition documentation should include notation of at least one of the following :
  - Discussion of current nutrition behaviors (e.g., eating habits, dieting behaviors)
  - Checklist indicating nutrition was addressed
  - Counseling or referral for nutrition was addressed
  - Member received educational materials on nutrition
  - Weight and/or obesity counseling
- Counseling for Physical activity documentation should include notation of at least one of the following:
  - Discussion of current physical activity behaviors (e.g., exercise routine, participation in sports activities, exam for sports participation)
  - Checklist indicating physical activity was addressed
  - Counseling or referral for physical activity
  - Member received educational materials on physical activity
  - Anticipatory guidance specific to the child's physical activity
  - Weight and/or obesity counseling

Health Plan of San Joaquin

# WCC - Weight Assessment, Counseling for Nutrition & Physical Activity for Children

## Coding your Claims and Encounters

WCC is a hybrid measure and data can be collected through medical record review. The best way to reduce the burden of medical record review during HEDIS season is to ensure you have coded all of your claims and encounters for your patients visit to the highest level of specificity.

| Code Type | Code | Definition |
|---|---|---|
| CPT | 97802-97804 | Nutrition Counseling |
| HCPCS | S9449 | Weight management classes, Non-physician provider, per session |
| HCPCS | S9452 | Nutrition classes, non-physician provider, per session |
| HCPCS | S9470 | Nutritional counseling, dietitian visit |
| ICD-10 | Z02.5 | Encounter for examination for participation in sport |
| ICD-10 | Z68.51-Z68.54 | BMI Percentiles |
| ICD-10 | Z71.3 | Dietary Counseling and surveillance |
| ICD-10 | Z71.82 | Exercise Counseling |

## Coding for Exclusions

Female members who have a diagnosis of pregnancy during the measurement year.

| Code Type | Code | Definition |
|---|---|---|
| ICD-10 | O00.0-O99.893 | Pregnancy |
| ICD-10 | O9A.111-O9A.53 | Abuse complicating pregnancy |
| ICD-10 | Z03.71-Z03.79, Z33.1-Z33.3, Z34.00-Z34.03, Z34.80-Z34.80-Z34.83 Z34.90-Z34.93, Z36-Z36.9 | Pregnancy |

# AAB - Avoidance of Antibiotic Treatment with Acute Bronchitis

## Measure Definition

Patients 3 months and older with a diagnosis of acute bronchitis/bronchiolitis that did not result in an antibiotic dispensing event.

## Coding your Claims and Encounters

AAB is an admin measure and data can only be collected through claims and encounter data. It is important you ensure you have coded all of your claims and encounters for your patients visit to the highest level of specificity.

| Code Type | Code | Definition |
|---|---|---|
| ICD-10 | J20.3-J20.9, J21.0, J21.1, J21.8, J21.9 | Acute Bronchitis |

## Coding for Exclusions

Members in hospice are excluded from this measure.

| Code Type | Code | Definition |
|---|---|---|
| HCPCS | Q5003-Q5008, Q5010, S9126, T2042-T2046 | Hospice |

Health Plan of San Joaquin

# AAP - Adults Access to Preventative/ Ambulatory Health Services

## Measure Definition

Patients 20 years and older who had an ambulatory or preventative care visit.

## Coding your Claims and Encounters

AAP is an admin measure and data can only be collected through claims and encounter data. It is important you ensure you have coded all of your claims and encounters for your patients visit to the highest level of specificity.

| Code Type | Code | Definition |
|---|---|---|
| CPT | 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381, 99391-99395, 99401-99403, 99411, 99412, 99429, 99455, 99456, 99483 | Office visit |
| ICD-10 | 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 | Office visit |

Health Plan of San Joaquin

# ADD - Follow-Up care for Children Prescribed ADHD Medication

## Measure Definition

Patients 6-12 years of age, newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication or a change in dosage for the same 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.

## Measure Best Practices

- No medication refills until initial follow-up visit is complete
- Conduct initial follow-up visit 2-3 weeks after member starts medication therapy
- Schedule additional 2 visits within 9 months of medication at the time of initial follow-up visit
- If member cancels an appointment, reschedule right away

## Coding your Claims and Encounters

ADD is an admin measure and data can only be collected through claims and encounter data. It is important you ensure you have coded all of your claims and encounters for your patients visit to the highest level of specificity.

| Code Type | Code | Definition |
|---|---|---|
| CPT | 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99385, 99391-99395, 99401 | Office visit |
| CPT | 98966-98968, 99441-99443 | Telehealth Visit |
| HCPCS | H2000, T1015 | Office visit |

# ADD - Follow-Up care for Children Prescribed ADHD Medication

## Coding for Exclusions

Members in hospice are excluded from this measure.

| Code Type | Code | Definition |
|---|---|---|
| HCPCS | Q5003-Q5008, Q5010, S9126, T2042-T2046 | Hospice |

Health Plan of San Joaquin

# AMM - Antidepressant Medication Management

## Measure Definition

Patients 18 years of age and older with a diagnosis of major depression who were treated with antidepressant medication and remained on an antidepressant medication treatment. Measure is reported two ways:

- **Acute Phase** - Patients who remained on an antidepressant medication for at least 84 days (12 weeks)
- **Continuation Phase** - Patients who remained on an antidepressant medication for at least 180 days (6 months)

## Measure Best Practices

- Discuss medication treatment plan with patient including how long it may take before they feel effects of the medication.
- Discuss importance of staying on medication. Make sure they know to call if any problems or side effects before discontinuing medication.
- Schedule follow-up visits at the end of each visit.
- If patient cancels appointment, reschedule right away.

## Coding your Claims and Encounters

AMM is an admin measure and data can only be collected through claims and encounter data. It is important you ensure you have coded all of your claims and encounters for your patients visit to the highest level of specificity.

| Code Type | Code | Definition |
|---|---|---|
| CPT | 98960-98962, 99078, 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411-99412, 99483, 99510 | Office visit |
| CPT | 98966-98968, 99441-99443 | Telehealth Visit |
| HCPCS | H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013-H2020, T1015 | Office visit |
| ICD-10 | F32.0-F32.4, F32.9, F33.0-F33.3, F33.41, F33.9 | Major Depression |

Health Plan of San Joaquin

# AMR - Asthma Medication Ratio

## Measure Definition

Patients 5-64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of .50 or greater.

All inhalers (i.e., canisters) of the same medication dispensed on the same day count as one dispensing event. Different inhaler medications dispensed on the same day are counted as different dispensing events.

## Measure Best Practices

- Review patient medications at every visit
- Provide patient education including medication compliance

## Coding your Claims and Encounters

AMR is an admin measure and data can only be collected through claims and encounter data. It is important you ensure you have coded all of your claims and encounters for your patients visit to the highest level of specificity.

| Code Type | Code | Definition |
|---|---|---|
| ICD-10 | J45.21-J45.22, J45.30-J45.32, J45.40-J45.42, J45.50-J45.52, J45.901-J45.902, J45.909, J45.991, J45.998 | Asthma |

Health Plan of San Joaquin

# APM - Metabolic Monitoring for Children and Adolescents on Antipsychotics

## Measure Definition

Patients 1-17 years of age who had two or more antipsychotic prescriptions and had metabolic testing.

## Coding your Claims and Encounters

APM is an admin measure and data can only be collected through claims and encounter data. It is important you ensure you have coded all of your claims and encounters for your patients visit to the highest level of specificity.

| Code Type | Code | Definition |
|---|---|---|
| CPT | 82465, 83718, 83722, 84478 | Cholesterol Lab test |
| CPT | 80047, 80048, 80050, 80053, 80069, 82947, 82950, 82951 | Glucose lab test |
| CPT | 83036, 83037 | HbA1c Lab test |
| CPT II | 3044F, 3045F, 3046F, 3051F, 3052F | HbA1c Results |
| CPT | 80061, 83700, 83701, 83704, 83721 | LDL-C Lab Test |
| CPT II | 3048F, 3049F, 3050F | LDL-C Lab Test |

Health Plan of San Joaquin

# BCS - Breast Cancer Screening

## Measure Definition

Patients 50 - 74 years of age who had a mammogram to screen for breast cancer.

## Measure Best Practices

- Provide patient education during office visits
- Assist with scheduling mammogram or refer to HPSJ member services for assistance with scheduling

## Coding your Claims and Encounters

BCS is an admin measure and data can only be collected through claims and encounter data. It is important you ensure you have coded all of your claims and encounters for your patients visit to the highest level of specificity.

| Code Type | Code | Definition |
|---|---|---|
| CPT | 77055, 77057, 77061-77063, 77065-77067 | Breast Cancer Screening |

## Coding for Exclusions

Patients in hospice, those who received palliative care, meet the frailty and advanced illness criteria or those who had a bilateral mastectomy are excluded from the measure.

| Code Type | Code | Definition |
|---|---|---|
| CPT | 19180, 19200, 19220, 19240, 19303-19307 | Unilateral Mastectomy |
| ICD - 10 | Z90.11 | Absence of RIGHT breast |
| ICD - 10 | Z90.12 | Absence of LEFT breast |
| ICD - 10 | Z90.13 | Hx. Bilateral Mastectomy |
| HCPCS | Q5003-Q5008, Q5010, S9126, T2042-T2046 | Hospice |

Health Plan of San Joaquin

# CCP - Contraceptive Care - Postprtum Women

## Measure Definition

Patients 15- 44 years of age who were provided the most effective or moderatly effective contraceptive methods during the postpartum period (3 days to 60 days after delivery.

## Coding your Claims and Encounters

CCP is an admin measure and data can only be collected through claims and encounter data. It is important you ensure you have coded all of your claims and encounters for your patients visit to the highest level of specificity.

| Code Type | Code | Definition |
|---|---|---|
| CPT | 11981, 11983, 57170, 58300, 58565, 58600, 58605, 58611, 58615, 58670, 58671 | Contraceptive Care |
| HCPCS | J7296-J7298, J7300, J7307 | Long-Acting Reversible Contraception (LAR-C) |
| ICD 10 | Z30.011, Z30.013, Z30.014, Z30.015, Z30.016, Z30.017, Z30.41, Z30.42, Z30.44 - Z30.46 Z30.430, Z30.431, Z30.433, T83.39XA, T83.39AD, T83.39XS, T83.31XA, T83.31XD, T83.31XS, T83.32XA, T83.32XD, T83.32XS | Contraceptive Care |

Health Plan of San Joaquin

# CCW - Contraceptive Care for Women

## Measure Definition

Patients 15- 44 years of age who were provided the most effective or moderatly effective contraceptive.

## Coding your Claims and Encounters

CCW is an admin measure and data can only be collected through claims and encounter data. It is important you ensure you have coded all of your claims and encounters for your patients visit to the highest level of specificity.

| Code Type | Code | Definition |
|---|---|---|
| CPT | 11981, 11983, 57170, 58300, 58565, 58600, 58605, 58611, 58615, 58670, 58671 | Contraceptive Care |
| HCPCS | J7296-J7298, J7300, J7307 | Long-Acting Reversible Contraception (LAR-C) |
| ICD 10 | Z30.011, Z30.013, Z30.014, Z30.015, Z30.016, Z30.017, Z30.41, Z30.42, Z30.44 - Z30.46 Z30.430, Z30.431, Z30.433, T83.39XA, T83.39AD, T83.39XS, T83.31XA, T83.31XD, T83.31XS, T83.32XA, T83.32XD, T83.32XS | Contraceptive Care |

Health Plan of San Joaquin

# CDF - Screening for Depression and Follow-up Plan

## Measure Definition

Patients 12 and older who were screened for depression on the date of an encounter using an age appropriate standardized depression screening tool (i.e. PHQ9) and if positive, a follow-up plan is documented on the date of the positive screen.

## Coding your Claims and Encounters

CDF is an admin measure and data can only be collected through claims and encounter data. It is important you ensure you have coded all of your claims and encounters for your patients visit to the highest level of specificity.

| Code Type | Code | Definition |
|---|---|---|
| CPT | 90791, 90792, 90832, 90834, 90837, 92625, 96116, 96118, 96150, 95151, 97165, 97166, 97167, 99201, 99202-99205, 99212-99215 | Outpatient Visit |
| HCPCS | G0101, G0402, G0438, G0439, G0444, G0502-G0505, G0507 | Outpatient Visit |
| HCPCS | G8431, G8510 | Depression Screening |

## Coding for Exclusions

Patients with an active diagnosis of depression or bipolar disorder are excluded from the measure.

| Code Type | Code | Definition |
|---|---|---|
| ICD 10 | F01.51, F32.0-F32.5, F32.89, F32.9, F33.0-F33.4, F33.41, F33.42, F33.8, F33.9, F34.1, F34.1, F34.81, F34.89, F43.21, F43.23, F53.0, F53.0, O90.6, O99.340-O99.343, O99.345 | Depression and other mental disorders |

Health Plan of San Joaquin

# CHL - Chlamydia Screening

## Measure Definition

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

## Coding your Claims and Encounters

CHL is an admin measure and data can only be collected through claims and encounter data. It is important you ensure you have coded all of your claims and encounters for your patients visit to the highest level of specificity.

| Code Type | Code | Definition |
|---|---|---|
| CPT | 87110, 87270, 87320, 87490-87492, 87810 | Chlamydia Screening |
| LOINC | 14463-4, 14464-2, 14467-5, 14474-1, 14513-6, 16600-9, 21190-4, 21191-2, 21613-5, 23838-6, 31775-0, 31777-6, 36902-5, 36903-3, 42931-6, 43304-5, 43404-3, 43405-0, 43406-8, 44806-8, 44807-6, 45068-4, 45069-2, 45075-9, 45076-7, 45084-1, 45091-6, 45095-7, 45098-1, 45100-5, 47211-8, 47212-6, 49096-1, 4993-2, 50387-0, 53925-4, 53926-2, 557-9, 560-3, 6349-5, 6354-5, 6355-2, 6356-0, 6357-8, 80360-1, 80361-, 80362 7, 91860-7 | Chlamydia Screening |
| CPT | 11976, 57170, 58300, 58301, 58600, 58605, 58615, 59000, 59001, 59012, 59015, 59020, 59025, 59030, 59050, 59051, 59070, 59072, 59074, 59076, 59100, 59120, 59121, 59130, 59135, 59136, 59140, 59150, 59151, 59160, 59300, 59320, 59325, 59350, 59400, 59409, 59414, 59510, 59525, 59610, 59612, 59618, 59620, 59812, 59830, 59840, 59841, 59850, 59851, 59852, 59855, 59856, 59857, 59870, 59871, 59897, 59898, 59899, 76801, 76805, 76811, 76813, 76815-76821, 76825-76828, 76941, 76946, 80055, 80081, 82105, 82106, 82143, 82731, 83632, 83661-83664, 84163, 84704, 86592, 86593, 86631, 86632, 87110, 87164, 87166, 87270, 87320, 87490-87492, 87590-87592, 87624, 87625, 87660, 87661, 87808, 87810, 87850, 88141, 88142, 88143, 88147, 88148, 88150, 88152, 88153, 88164, 88165, 88166, 88167, 88174, 88175, 88235, 88267, 88269 | Sexual Activity |

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# CHL - Chlamydia Screening

## Coding your Claims and Encounters

CHL is an admin measure and data can only be collected through claims and encounter data. It is important you ensure you have coded all of your claims and encounters for your patients visit to the highest level of specificity.

| Code Type | Code | Definition |
|---|---|---|
| ICD 10 | A34, A51.2, A51.31, A51.32, A51.39, A51.41 - A51.45, A51.46, A51.49, A51.5, A51.9, A52.00 -A52.06, A52.09-A52.17, A52.19, A52.2, A52.3, A52.71 - A52.79, A52.8, A52.9, A53.0, A53.9, A54.00 - A54.03, A54.09, A54.1, A54.21, A54.24, A54.29 - A54.33, A54.39 - A54.43, A54.49, A54.5, A54.6, A54.81 - A54.86, A54.89, A54.9, A55, A56.00, A56.01, A56.02, A56.09, A56.11, A56.19, A56.2-A56.4, A56.8, A57, A58, A59.00, A59.01, A59.03, A59.09, A59.8, A59.9, A60.00, A60.03, A60.04, A60.09, A60.1, A60.9, A63.0, A63.8, A64, B20, B97.33, B97.34, B97.35, B97.7, F52.6, F53, F53.0, F53.1, G44.82, N70.01, N70.02, N70.03, N70.11, N70.12, N70.13, N70.91-N70.93, N71.0, N71.1, N71.9, N93.0, N94.1, N94.10, N94.11, N94.12, N94.19, N96, N97.0, N97.1, N97.2, N97.8, N97.9, O94, T38.4X1A, T38.4X1D, T38.4X1S, T38.4X2A, T38.4X2D, T38.4X2S, T38.4X3A, T38.4X3D, T38.4X3S, T38.4X4A, T38.4X4D, T38.4X4S, T38.4X5A, T38.4X5D, T38.4X5S, T38.4X6A, T38.4X6D, T38.4X6S, T83.31XA, T83.31XD, T83.31XS, T83.32XA, T83.32XD, T83.32XS, T83.39XA, T83.39XD, T83.39XS, Z20.2, Z21, Z22.4, Z30.011-Z30.019, Z30.02, Z30.09, Z30.2, Z30.40 - Z30.430 - Z30.433, Z30.44 - Z30.46, Z30.49, Z30.8, Z30.9, Z31.0, Z31.41, Z31.42, Z31.430, Z31.438, Z31.440, Z31.441, Z31.448, Z31.49, Z31.5, Z31.61, Z31.62, Z31.69, Z31.7, Z31.81-Z31.84, Z31.89, Z31.9, Z32.00-Z32.3, Z33.1-Z33.3, 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, Z37.0, Z37.1-Z37.50, Z37.51, Z37.52, Z37.53, Z37.54, Z37.59, Z37.60-Z37.64, Z37.69, Z37.7, Z37.9, Z39.0, Z39.1, Z39.2, Z64.0, Z64.1, Z72.51-Z72.53, Z79.3, Z92.0, Z97.5, Z98.51 | Sexual Activity |

# CHL - Chlamydia Screening

## Coding for Exclusions

Patients who qualified for the measure based on a pregnancy test and meet either of the following should be excluded from the measure:

- A pregnancy test followed by a prescription for isotretinoin within seven days.
- A pregnancy test followed by an xray within 7 days.

| Code Type | Code | Definition |
|---|---|---|
| CPT | 81025, 84702, 84703 | Pregnancy Test |
| CPT | 70010-76499 | Diagnostic Radiology |

# COB - Concurrent use of Opiods & Benzodiazepines

## Measure Definition

Patients 18 and older with concurrent use of prescription opiods and benzodiazapines.

- Patients with 2 or more prescription claims for any benzodiazepine with different dates of service.
- Concurrent use of opiod and benzodiazepines for 30 or more cumulative days

## Coding for Exclusions

Patients with a diagnosis of cancer or are in hospice are excluded from this measure.

| Code Type | Code | Definition |
|---|---|---|
| HCPCS | Q5003-Q5008, Q5010, S9126, T2042-T2046 | Hospice |
| ICD 10 | C00-D49 | Cancer |

Health Plan of San Joaquin

# CWP - Appropriate Testing for Children With Pharyngitis

## Measure Definition

Patients 3 and older who were diagnosed with phayngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode.

## Coding your Claims and Encounters

CWP is an admin measure and data can only be collected through claims and encounter data. It is important you ensure you have coded all of your claims and encounters for your patients visit to the highest level of specificity.

| Code Type | Code | Definition |
|---|---|---|
| ICD 10 | J02.0, J02.8, J02.9, J03.00, J03.01, J03.80, J03.81, J03.90, J03.91 | Pharyngitis |
| CPT | 87070, 87071, 87081, 87430, 87650-87652, 87880 | Group A Strep Test |
| LOINC | 11268-0, 17656-0, 17898-8, 18481-2, 31971-5, 49610-9, 5036-9, 60489-2, 626-2, 6557-3, 6558-1, 6559-9, 68954-7, 78012-2 | Strep Test Results |

Health Plan of San Joaquin

# CWP - Appropriate Testing for Children With Pharyngitis

## Coding for Exclusions

Patients with a diagnosis of cancer, HIV, HIV type 2, Emphysema, COPD or other comorbid conditions during the 12 months prior to the episode date or are in hospice are excluded from this measure.

| Code Type | Code | Definition |
|---|---|---|
| HCPCS | Q5003-Q5008, Q5010, S9126, T2042-T2046 | Hospice |
| ICD 10 | C00-D49 | Cancer |
| ICD 10 | J44.0, 444.1, J44.9 | COPD |
| ICD 10 | D80.0-D81.2, D81.4, D81.6, D81.7, D81.89, D81.9, D82.0-D82.4, D82.8, D82.9, D83.0-D83.2, D83.8-D84.1, D84.8, D84.81, D84.821, D84.822, D84.89, D84.9, D89.3, D89.810-D89.813, D89.82, D89.831-D89.835, D89.839, D89.89, D89.9 | Disorders of the Immune System |
| ICD 10 | J43.0-J43.2, J43.8, J43.9 | Emphysema |
| ICD 10 | B20, Z21 | HIV |
| ICD 10 | B97.35 | HIV Type 2 |

# DEV - Developmental Screening in the First Three Years of Life

## Measure Definition

Patients screened for risk of developmental, behavioral and social delays using a standardized screening tool in the 12 months preceding or on their first, second or third birthdays.

## Medical Record Documentation Best Practices

- Documentation in the medical record should include all o the following:
  - A note indicating the date the test was performed
  - A standardized tool recognized by Bright Futures & the American Academy of Pediatrics
  - Evidence of a screening result or screening score

## Coding your Claims and Encounters

DEV is an admin measure and data can only be collected through claims and encounter data. It is important you ensure you have coded all of your claims and encounters for your patients visit to the highest level of specificity.

| Code Type | Code | Definition |
|---|---|---|
| CPT | 96110 | Developmental Screening |

Health Plan of San Joaquin

# HVL - HIV Viral Load Suppression

## Measure Definition

Patients 18 and older with a diagnosis of Human Immunodeficiency Virus (HIV) who had a HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year.

## Coding your Claims and Encounters

HVL is an admin measure and data can only be collected through claims and encounter data. It is important you ensure you have coded all of your claims and encounters for your patients visit to the highest level of specificity.

| Code Type | Code | Definition |
|---|---|---|
| ICD 10 | B20, Z21 | HIV |
| CPT | 99201, 99381, 99202, 99382, 99203, 99383, 99204, 99384, 99205, 99385, 99212, 99386, 99213, 99387, 99214, 99391, 99215, 99392, 99241, 99393, 99242, 99394, 99243, 99395, 99244, 99396, 99245, 99397 | Office Visits |
| LOINC | 20447-9, 21333-0, 23876-6, 41515-8, 48511-0, 59419-2, 70241-5 | HIV Viral load <200 copies/ml |

# IHA - Initial Health Assessment

## Measure Definition

Patients newly enrolled who had an Initial Health Assessment (IHA) completed within their first 120 days of enrollment.

## Medical Record Documentation Best Practices

- Be sure to complete an annual Staying Healthy Assessment (SHA) with every new patient and annually with all patients.
- Visit the DHCS website for age and language specific SHA tools for use in your office

## Coding your Claims and Encounters

IHA is an admin measure and data can only be collected through claims and encounter data. It is important you ensure you have coded all of your claims and encounters for your patients visit to the highest level of specificity.

| Code Type | Code | Definition |
|---|---|---|
| ICD 10 | B20, Z21 | Encounter for routine exam |
| CPT | 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381, 99391-99395, 99401-99403, 99411, 99412, 99429, 99455, 99456, 99483 | Evaluation and examination |
| HCPCS | G0402, T1015 | Evaluation and examination |

Health Plan of San Joaquin

# KED - Kidney Health Evaluation for Patients With Diabetes

## Measure Definition

Patients 18-85 years of age with diabetes (type 1 and 2) who received a kidney health evaluation defined by an estimated glomerular filtration rate (eGFR) and a urine albumin-cratinine ratio (uACR) must be a quantitative urine albumin test and a urine creatinine test with service dates four or less days apart through one of the following:

- One acute inpatient face to face encounter with a diagnosis of diabetes
- One acute inpatient discharge with a diagnosis of diabetes on the discharge claim
- At least two outpatient visits, observation visits, telephone visits, e-visits of virtual check-ins, ED visits, nonacute inpatient encounters or nonacute inpatient, on different dates of service with a diagnosis of diabetes.

## Coding your Claims and Encounters

KED is an admin measure and data can only be collected through claims and encounter data. It is important you ensure you have coded all of your claims and encounters for your patients visit to the highest level of specificity.

| Code Type | Code | Definition |
|---|---|---|
| CPT | 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291 | Acute Inpatient Visit |
| CPT | 99304-99310, 99315, 99316, 99318, 99324-99328, 99334-99337 | Non-acute Inpatient Visit |
| CPT | 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99429, 99455, 99456, 99483 | Outpatient Visit |
| HCPCS | G0402, G0438, G0439, G0463, T1015 | Outpaitient Visit |
| CPT | 99217-99220 | Observation |
| CPT | 99281-99285 | ED Visit |
| CPT | 98969-98972, 99421-99423, 99444, 99458 | Online Assessment |
| HCPCS | G2010, G2012, G2061-G2063 | Online Assessment |

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# LBP - Use of Imaging Studies for Low Back

## Measure Definition

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

## Coding your Claims and Encounters

LBP is an admin measure and data can only be collected through claims and encounter data. It is important you ensure you have coded all of your claims and encounters for your patients visit to the highest level of specificity.

| Code Type | Code | Definition |
|---|---|---|
| ICD 10 | M47.26-M47.28, M47.816-M47.818, M47.896-M47.898, M48.06, M48.061, M48.062, M48.07, M48.08, M51.16, M51.17, M51.26, M51.27, M51.36, M51.37, M51.86, M51.87, M53.2X6, M53.2X7, M53.2X8, M53.3, M53.86-M53.88, M54.16-M54.18, M54.30-M54.32, M54.40-M54.42, M54.5, M54.89, M54.9, M99.03, M99.04, M99.23, M99.33, M99.43, M99.53, M99.63, M99.73, M99.83, M99.84, S33.100A, S33.100D, S33.100S, S33.110A, S33.110D, S33.110S, S33.120A, S33.120D, S33.120S, S33.130A, S33.130D, S33.130S, S33.140A, S33.140D, S33.140S, S33.5XXA, S33.6XXA, S33.8XXA, S33.9XXA, S39.002A, S39.002D, S39.002S, S39.012A, S39.012D, S39.012S, S39.092A, S39.092D, S39.092S, S39.82XA, S39.82XD, S39.82XS, S39.92XA, S39.92XD, S39.92XS | Uncomplicated Low Back Pain |
| CPT | 72020, 72052, 72100, 72110, 72114, 72120, 72131-72133, 72141, 72142, 72146-72149, 72156, 72158, 72200, 72202, 72220 | Imaging Studies |

# OHD - Use of Opiods at High Dosage in Persons Without Cancer

## Measure Definition

Patients 18 and older who received prescriptions for opiods with an acerage daily dosage greater than or equal to 90 morphine miligram equivalents (MME) over a period of 90 days of more.

## Coding for Exclusions

Patients with a diagnosis of cancer or are in hospice are excluded from this measure.

| Code Type | Code | Definition |
|---|---|---|
| HCPCS | Q5003-Q5008, Q5010, S9126, T2042-T2046 | Hospice |
| ICD 10 | C00-D49 | Cancer |

# PCR - Plan All-Cause Readmissions

## Measure Definition

Patients 18-64 years who had an acute inpatient or observation stay that were followed by an unplanned acute readmission for any diagnosis within 30 days.

## Measure Best Practices

- A lower score is better
- Follow up with patients recently discharged from the hospital within 30 days to review discharge instructions

## Coding your Claims and Encounters

PCR is an admin measure and data can only be collected through claims and encounter data. It is important you ensure you have coded all of your claims and encounters for your patients visit to the highest level of specificity.

| Code Type | Code | Definition |
|---|---|---|
| CPT | 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291 | Acute Inpatient Visit |
| CPT | 99328, 99334-99337 | Non-acute Inpatient Visit |

# SSD - Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications

## Measure Definition

Patients 18-64 years f age with schizophrenia, schizoaffective disorder or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening.

## Coding your Claims and Encounters

SSD is an admin measure and data can only be collected through claims and encounter data. It is important you ensure you have coded all of your claims and encounters for your patients visit to the highest level of specificity.

| Code Type | Code | Definition |
|---|---|---|
| CPT | 90791, 90792, 90832, 90833, 90834, 90836-90839, 90840, 90847, 90853, 99221, 99222, 99223, 99231-99233, 99238, 99239, 99251-99255 | Office Visit |
| CPT | 98966-98968, 99441-99443 | Telehealth Visit |
| ICD 10 | F30.10-F30.13, F30.2-F30.4, F30.8, F30.9, F31.0, F31.10-F31.13, F31.2, F31.30-F31.32, F31.4, F31.5, F31.60-F31.64, F31.70-F31.78 | Bipolar Disorder |
| ICD 10 | f31.81, F31.89, F31.9 | Other Bipolar |
| ICD 10 | F20.0-F20.3, F20.5, F20.81, F20.89, F20.9, F25.0, F25.1, F25.8, F25.9 | Schizophrenia |

# SSD - Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications

## Coding for Exclusions

Patients with a diagnosis of diabetes are excluded from this measure.

| Code Type | Code | Definition |
|---|---|---|
| ICD-10 | E10.10-E13.9, O24.011-O24.33,O24.811-O24.83 | Diabetes |

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# URI - Treatment for Children With Upper Respiratory Infection

## Measure Definition

Patients 3 months and older who were diagnosed with upper respiratory infection (URI) and **WERE NOT** dispensed an antibiotic prescription.

## Coding your Claims and Encounters

URI is an admin measure and data can only be collected through claims and encounter data. It is important you ensure you have coded all of your claims and encounters for your patients visit to the highest level of specificity.

| Code Type | Code | Definition |
|---|---|---|
| ICD-10 | J00, J06.0, J06.9 | Acute Upper Respiratory Infection |
| ICD 10 | J02.0, J02.8, J02.9, J03.00, J03.01, J03.80, J03.81, J03.90, J03.91 | Pharyngitis |

# **W30 -** Well-Child Visits in the first 30 Months of Life - 0 - 15 months & 15 - 30 Month

## Measure Definition

Children ages 0-15 months who had 6 or more well visits on different dates of service on or before their 15 month birthday.
Children 15 - 30 months who had 2 or more well visits on different dates of service on or before their 30 month birthday.

## Medical Record Documentation Best Practices

- Documentation should include date of service with PCP and all of the following:
  - Patient health history
  - Physical developmental history
  - Mental developmental history
  - Physical exam
  - Health Education
  - Anticipatory Guidance
- Sick visits can be turned into well visits as long as all of the above services are performed and documented in the patients medical record for the visit

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# W30 - Well-Child Visits in the first 30 Months of Life - 0 - 15 months & 15 - 30 Month

## Coding your Claims and Encounters

W30 is an admin measure and data can only be collected through claims and encounter data. It is important you ensure you have coded all of your claims and encounters for your patients visit to the highest level of specificity.

| Code Type | Code | Definition |
|---|---|---|
| CPT | 99381-99385, 99391-99395, 99461 | Well Visit |
| HCPCS | S0302 | Completed early periodic screening diagnosis and treatment (epsdt) service (list in addition to code for appropriate evaluation and management service) |
| ICD-10 | Z00.00 | Encounter for general adult medical examination without abnormal findings |
| ICD-10 | Z00.01 | Encounter for general adult medical examination with abnormal findings |
| ICD-10 | Z00.110 | Health examination for newborn under 8 days old |
| ICD-10 | Z00.111 | Health examination for newborn 8 to 28 days old |
| ICD-10 | Z00.121 | Encounter for routine child health examination with abnormal findings |
| ICD-10 | Z00.129 | Encounter for routine child health examination without abnormal findings |
| ICD-10 | Z00.2 | Encounter for examination for period of rapid growth in childhood |
| ICD-10 | Z00.3 | Encounter for examination for adolescent development state |
| ICD-10 | Z02.5 | Encounter for examination for participation in sport |
| ICD-10 | Z76.1 | Encounter for health supervision and care of foundling |
| ICD-10 | Z76.2 | Encounter for health supervision and care of other healthy infant and child |

# WCV - Child & Adolescent Well-Care Visits

## Measure Definition

Patients 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.

## Medical Record Documentation Best Practices

- Documentation should include date of service with PCP and all of the following:
  - Patient health history
  - Physical developmental history
  - Mental developmental history
  - Physical exam
  - Health Education
  - Anticipatory Guidance
- Sick visits can be turned into well visits as long as all of the above services are performed and documented in the patients medical record for the visit

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# WCV - Child & Adolescent Well-Care Visits

## Coding your Claims and Encounters

W30 is an admin measure and data can only be collected through claims and encounter data. It is important you ensure you have coded all of your claims and encounters for your patients visit to the highest level of specificity.

| Code Type | Code | Definition |
|---|---|---|
| CPT | 99381-99385, 99391-99395, 99461 | Well Visit |
| HCPCS | S0302 | Completed early periodic screening diagnosis and treatment (epsdt) service (list in addition to code for appropriate evaluation and management service) |
| ICD-10 | Z00.00 | Encounter for general adult medical examination without abnormal findings |
| ICD-10 | Z00.01 | Encounter for general adult medical examination with abnormal findings |
| ICD-10 | Z00.110 | Health examination for newborn under 8 days old |
| ICD-10 | Z00.111 | Health examination for newborn 8 to 28 days old |
| ICD-10 | Z00.121 | Encounter for routine child health examination with abnormal findings |
| ICD-10 | Z00.129 | Encounter for routine child health examination without abnormal findings |
| ICD-10 | Z00.2 | Encounter for examination for period of rapid growth in childhood |
| ICD-10 | Z00.3 | Encounter for examination for adolescent development state |
| ICD-10 | Z02.5 | Encounter for examination for participation in sport |
| ICD-10 | Z76.1 | Encounter for health supervision and care of foundling |
| ICD-10 | Z76.2 | Encounter for health supervision and care of other healthy infant and child |