HEDIS™

Quick Reference Guide

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HEDIS™ Quick Reference Guide

Updated to reflect NCQA HEDIS 2018 Technical Specifications

Managed Health Services (MHS) 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. 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

QUESTIONS?

MHSINDIANA.COM

1-877-647-4848

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 October 2017 release of the HEDIS® 2018 Volume 2 Technical Specifications by NCQA and is subject to change.

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

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ADULT HEALTH

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

AMBULATORY/PREVENTIVE HEALTH SERVICES

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

Ambulatory Residential/Nursing Facility E&M Visits

CPT	ICD-10	HCPCS
OUTPATIENT: 99201-99205, 99211-99215 CONSULTATIONS: NURSING FACILITY, CUSTODIAL CARE: 99341-99345, 99347-99350, 99401-99404 PREVENTIVE MEDICINE: 99381-99387, 99391-99397 COUNSELING: 99401-99404, 99411-99412 OTHER: 92002, 92004, 92012, 92014, 99304-99310, 99315-99316, 99318, 99324-99328, 99334-99337, 99429	Z00.00, Z00.01, Z00.121, Z02.6, Z00.129, Z00.5, Z00.8, Z02.0-Z02.6, Z02.71, Z02.79, Z02.81-Z02.83, Z02.89, Z02.9	G0463, T1015, S0620-S0621

ALCOHOL AND OTHER DRUG ABUSE OR DEPENDENCE TREATMENT

Measure evaluates the percentage of adolescent and adult members with a new episode of alcohol or other drug abuse or dependence (AOD) who:

· Initiated dependence treatment within 14 days of their diagnosis

· Continued treatment with 2 or more additional services within 34 days of the initiation visit

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 (see codes below).

Treatment Codes to Be Used with Diagnosis Codes

CPT	HCPCS
EDUCATION: 98960-98962 E&M: 99201-99205, 99211-99215, 99217-99220 CONSULTATION: 99241-99245 ASSISTED LIVING/HOME CARE OVERSIGHT: 99341-99345, 99347-99350, PREVENTIVE SERVICES: 99384-99387, 99394-99397 COUNSELING: 99401-99404, 99408, 99409, 99411-99412, 99510 ONLINE ASSESSMENTS: TELEHEALTH MODIFIER: 95, GT TELEPHONE VISITS: 98966-98968, 99441-99443	G0155, G0176, G0177, G0463, G0409-G0411, G0443, H0004, H0005, H0015, H0031, H0034, H0040, H2000, H2010-H2020, H2035, J0571-J0575, J2315, M0064, T1015

Treatment in Office

Use service codes below with the diagnosis code AND a place of service code:

CPT	POS
90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90875-90876	03, 05, 07, 09, 11-20, 22, 33, 49-50, 52-53, 57, 71-72

Treatment in Community Mental Health Center or Psychiatric Facility

Use the service codes below with the diagnosis code and the place of service (POS) code:

CPT	POS
99221-99223, 99231-99233, 99238, 99239	52 and 53

ASTHMA *(Medication Management)*

Measure evaluates the percentage of patients 5-64 years of age who were identified as having persistent asthma and were dispensed appropriate medications which they remained on during the treatment period within the past year.

RATES	APPROPRIATE MEDICATIONS
Medication Compliance 50%: Members who were covered by one asthma control medication at least 50% of the treatment period	Antiasthmatic combinations, Antibody inhibitors, Inhaled steroid combinations, Inhaled corticosteroids, Leukotriene modifiers, Mast cell stabilizers, Methylxanthines
Medication Compliance 75%: Members who were covered by one asthma control medication at least 75% of the treatment period	

BMI ASSESSMENT

This measure demonstrates the percentage of members ages 18 to 74 who had their BMI documented in the past two years. Recommendation is for adults to have BMI assessed at least every 2 years.

1) For patients 20 and over: Code the BMI value on the date of service.

2) For patients younger than 20, code the BMI percentile on the date of service.

3) Ranges and thresholds do NOT meet criteria; a distinct BMI value or percentile is required.

ICD-10
ICD-10 BMI Value set Z68.1, Z68.20-Z68.39, Z68.41-Z68.45; **ICD-10 BMI Percentile Value Set** Z68.51-Z68.54

CARE FOR OLDER ADULTS

Measure evaluates patients 66 years of age and older who have had each of the following during the measurement year:

1) At least one functional status assessment per year. Can be a standard assessment tool or notation of either of the following: Activities of Daily Living (ADLs); Instrumental Activities of Daily Living *(IADL); or at least three of the following: notation of cognitive status, ambulation status, sensory ability (hearing, vision, and speech), and/or other functional independence.

2) Evidence of advance care planning and the date of the discussion or the presence of a plan

3) At least annually, a review of the patient's medications by a prescribing practitioner. Includes the presence of a medication list and review of the medications. Transitional care management services also meet criteria.

4) At least annually, a pain assessment, either through a standardized pain assessment tool or documentation that pain was assessed.

DESCRIPTION	CPT	CPT CATEGORY II	HCPCS
Advance care planning	—	—	—
Medication review	—	—	—
Medication list	—	—	—
Transitional care management services	99495, 99496	—	—
Functional status assessment	—	—	—
Pain assessment	—	—	—

COLORECTAL CANCER SCREENING

Measure evaluates the percentage of members ages 50-75 who had at least one appropriate screening for Colorectal Cancer. Appropriate screening is one of the following:

1) FOBT in 2017,
2) FIT-DNA test (Cologuard) within the last 3 years,
3) Flexible sigmoidoscopy within the past five years,
4) CT colonography within the last 5 years or
5) Colonoscopy within last 10 years.

Patients who have a history of colon cancer (C18.0-18.9, C19-C20, C21.2, C21.8, C78.5,Z85.038 or Z85.048) or who have had a total colectomy are exempt from this measure.

FOBT

CPT	HCPCS
82270, 82274	

Flexible sigmoidoscopy

CPT	HCPCS
45330-45335, 45337-45342, 45345-45347, 45349-45350	

Colonoscopy

CPT	HCPCS
44388-44394, 44397, 44401-44408, 45355, 45378-45393, 45398	

COPD EXACERBATION *(Pharmacotherapy Management)*

Measure evaluates the percentage of COPD exacerbations for members age 40 and older, had an acute inpatient discharge or ED visit and who were dispensed appropriate medications.

Intent is to measure compliance with recommended pharmacotherapy management for those with COPD exacerbations.

RATES	DESCRIPTION
Systemic Corticosteroid: Dispensed prescription for systemic corticosteroid within 14 days after the episode.	Glucocorticoids
Bronchodilator: Dispensed prescription for a bronchodilator within 30 days after the episode date.	Anticholinergic agents, Beta 2-agonists, Methylxanthines, Antiasthmatic combinations

COPD *(Spirometry Testing in the Assessment and Diagnosis)*

Measure evaluates the percentage of members age 40 and older with a new diagnosis of COPD or newly active COPD, who received appropriate spirometry testing to confirm the diagnosis. Spirometry testing should be completed within 6 months of the new diagnosis or exacerbation.

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

DIABETES CARE *(Comprehensive)*

Measure demonstrates the percentage of members ages 18-75 with diabetes (types 1 & 2) who were compliant in each of the following submeasures:

HbA1c Test: is completed at least once per year (includes rapid A1c).

CPT	HCPCS
83036, 83037	—

Eye Exam: a retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) completed every year OR a negative retinal exam (no evidence of retinopathy) by an eye care professional in the year prior OR bilateral eye enucleation anytime during the member's history. Practitioners who are not eye care professionals may indicate a low risk for retinopathy due to a negative retinal exam the year prior by using CPT II code 3072F.

CPT	CPT II	HCPCS
[65091, 65093, 65101, 65103, 65105, 65110, 65112, 65114; with a bilateral modifier: 50, 09950], 67028, 67030-67031, 67036, 67039-67043, 67101, 67105, 67107-67108, 67110, 67112-67113, 67121, 67141, 67145, 67208, 67210, 67218, 67220-67221, 67227-67228, 92002, 92004, 92012, 92014, 92018-92019, 92134, 92225-92228, 92230, 92235, 92240, 92250, 92260, 99203-99205, 99213-99215, 99242-99245		

Nephropathy Screening Test: a urine protein test to screen for nephropathy performed at least once per year. A member who is being treated for nephropathy (on ACE/ARB), has evidence of ESRD, stage 4 chronic kidney disease, a history of a kidney transplant or is being seen by a nephrologist is compliant for this submeasure.

Urine Protein Tests

CPT	CPT II	HCPCS
81000-81003, 81005, 82042-82044, 84156, 50300, 50320, 50340, 50360, 50365, 50370, 50380 (Kidney Transplant)		

BP Control:

CPT	CPT II	HCPCS
99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401, 99304-99310, 99315-99316, 99318, 99324-99328, 99334-99337		G0402, G0438-G0439, G0463, T1015

MEDICATION RECONCILIATION POST-DISCHARGE

Measure evaluates the percentage of discharges from January 1-December 1 of the measurement year for members age 18 and older for whom medications at discharge were reconciled against the outpatient medical record on or within 30 days of discharge. Submit codes to identify the presence of a list of medications from the discharge summary:

CPT CATEGORY II	HCPCS
1159F	G8427

MONITORING FOR PATIENTS ON PERSISTENT MEDICATIONS *(Annual)*

ACE Inhibitors or ARBs: Members who are 18 years of age and older who received at least 180 treatment days of ACE inhibitors or ARBs within the past year should have at least one – but – they should have both:

• Serum potassium and one serum creatinine test annually

Diuretics: Members who are 18 years of age and older who have received at least 180 treatment days of a diuretic within the past year should have at least one – but – they should have both:

• One serum potassium and one serum creatinine test annually

DESCRIPTION	CPT
Lab panel	80047, 80048, 80050, 80053, 80069
Serum potassium (K+)	80051, 84132
Serum creatinine (SCr)	82565, 82575

PERSISTENCE OF BETA-BLOCKER TREATMENT AFTER A HEART ATTACK

Measure evaluates the percentage of members age 18 and older who were hospitalized and discharged with a diagnosis of AMI and who received persistent beta-blocker treatment for six months after discharge.

DESCRIPTION	MEDICATIONS
Non-cardioselective beta-blockers	Carvedilol, Labetalol, Nadolol, Penbutolol, Pindolol, Propranolol, Timolol, Sotalol
Cardioselective beta-blockers	Acebutolol, Atenolol, Betaxolol, Bisoprolol, Metoprolol, Nebivolol
Antihypertensive combinations	Atenolol-chlorthalidone, Bendroflumethiazide-nadolol, Bisoprolol-hydrochlorothiazide, Hydrochlorothizide-metoprolol, Hydrochlorothizide-propranolol

TRANSITIONS OF CARE

Measure evaluates the percentage of members 18 years of age and older who had each of the following during the measurement year. Four rates are reported.

- Notification of Inpatient Admission: Must be collected via medical record review only. Documentation of receipt of notification of inpatient admission on the day of admission or the following day.
- Receipt of Discharge Information: Must be collected via medical record review only. Documentation of receipt of discharge "information" on the day of discharge or the following day.
    - At a minimum, documentation in the medical record for discharge information should include all of the following (e.g., a discharge summary):
        - The practitioner responsible for the member's care during the inpatient stay.
        - Procedures or treatment provider.
        - Diagnoses at discharge.
        - Current medication list (including allergies).
        - Testing results, or documentation of pending tests or no tests pending.
        - Instructions for patient care.
- Patient Engagement After Inpatient Discharge: Patient engagement provided within 30 days after discharge. Do not include patient engagement that occurs on the date of discharge. The following meet criteria for patient engagement:

CPT	HCPCS	OP WITH OR WITH-OUT TELEHEALTH MODIFIER
OUTPATIENT VISITS: 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411-99412, 99429, 99455-99456 TELEPHONE VISITS: 98966-98968, TRANSITIONAL CARE MANAGEMENT SERVICES: 99495-99496	G0402, G0438-G0439, G0463, T1015	95, GT

- Medication Reconciliation Post-Discharge: Documentation of medication reconciliation on the date of discharge through 30 days after discharge (31 total days). Medication reconciliation conducted by a prescribing practitioner, clinical pharmacist or registered nurse.

Submit codes to identify the presence of a list of medications from the discharge summary:

CPT CATEGORY II	HCPCS
1159F	G8427

And submit codes to indicate the list of discharge medications were reconciled against the patient's outpatient medications:

CPT	CPT CATEGORY II
99495, 99496	1111F

NOTES

WOMEN'S HEALTH

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

BREAST CANCER SCREENING

Measure evaluates the percentage of women ages 50–74 who had a mammogram at least once in the past 27 months. Women who have had a bilateral mastectomy are exempt from this measure. Diagnostic screenings are not compliant.

Mammography Screening:

CPT	HCPCS
77055-77057, 77061-77063, 77065-77067	G0202, G0204, G0206

History of Bilateral Mastectomy

ICD10
Z90.13

CERVICAL CANCER SCREENING

Measure evaluates the percentage of women ages 21–64 who were screened for cervical cancer using either of the following criteria:

1) Cervical cytology performed every 3 years for women ages 21–64

2) Cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years (must occur within 4 days of each other) for women ages 30–64. **HPV testing in response to a positive cervical cytology test is not compliant.

3) Women who have had a hysterectomy without a residual cervix are exempt from this measure.

Cervical Cytology Codes (ages 21-64):

CPT	HCPCS
88141-88143, 88147, 88148, 88150, 88152-88154, 88164-88167, 88174, 88175	G0123, G0124, G0141, G0143, G0147, G0148, P3001

HPV code:

Ages 30-64 years old, Code from Cervical Cytology plus one

CTP	HCPCS
87620-87622, 87624, 87625	

Absence of Cervix

CPT	ICD10
51925, 56308, 57540, 57545, 57550, 57555, 57556, 58150, 58152, 58200, 58210, 58240, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290-58294, 58548, 58550, 58552-58554, 58570-58573, 58951, 58953, 58954, 58956, 59135	Q51.5, Z90.710, Z90.712

CHLAMYDIA SCREENING

Measure evaluates the percentage of women ages 16 to 24 who are sexually active who had at least one test for Chlamydia during the year. Chlamydia tests can be completed using any method, including a urine test. "Sexually active" is defined as a woman who has had a pregnancy test; testing or diagnosis of any other sexually transmitted disease; is pregnant or has been prescribed birth control.

CPT
87110, 87270, 87320, 87490-87492, 87810

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 6 months after the fracture.

Bone Density Tests

CPT	HCPCS	ICD-10PCS	PRESCRIPTION
76977, 77078, 77080-77082, 77085, 77086	G0130, J0630, J0897, J1740, J3110, J3487-J3489, Q2051	BP48ZZ1, BP49ZZ1, BP4GZZ1, BP4HZZ1, BP4LZZ1, BP4MZZ1, BP4NZZ1, BP4PZZ1, BQ00ZZ1, BQ01ZZ1, BQ3ZZ1, BQ04ZZ1, BR00ZZ1, BR07ZZ1, BR09ZZ1, BR0GZZ1	— Biphosphonates: (Alendronate, Risedronate, Ibandronate, Zoledronic acid, Alendronate-cholecalciferol), Other agents: Calcitonin, Denosumab, Raloxifene, Teriparatide

POSTPARTUM VISITS

Measure evaluates the percentage of women who delivered a baby and who had their postpartum visit on or between 21 and 56 days after delivery (3 and 8 weeks). If a bundled service code is used, submit the encounter for the postpartum service using a code below.

Any Postpartum Visit:

CPT	ICD-10	HCPCS
57170, 58300, 59430 (CPT II)	Z01.411, Z01.419, Z01.42, Z30.430, Z39.1, Z39.2	

Any Cervical Cytology Procedure:

CPT	HCPCS
88141-88143, 88147, 88148, 88150, 88152-88154, 88164-88167, 88174, 88175	G0123, G0124, G0141, G0143-G0145, G0147, G0148, P3000, P3001, Q0091

PRENATAL VISITS
TIMELINESS OF FIRST VISIT AND FREQUENCY OF VISITS

Measure evaluates the percentage of pregnant women who had their first prenatal visit in the first trimester or within 42 days of enrollment with the plan. Also, the frequency of prenatal visits is assessed.

If a bundled service code is used, submit any prenatal visits as encounters to count

- For OB or PCP provider types, choose to submit **Stand Alone Prenatal Visit** codes
- OB provider types may also submit any **Prenatal Visit** code in conjunction with any code for **Other Prenatal Services**
- PCP provider types can also submit any **Stand Alone Prenatal Visit** code and any code for **Other Prenatal Services** along with a **pregnancy diagnosis.**
- **Other Prenatal Services** (any one listed): Obstetric Panel, Prenatal Ultrasound, Cytomegalovirus and Antibody Levels for Toxoplasma, Rubella, and Herpes Simplex, Rubella antibody and ABO, Rubella and Rh, Rubella and ABO/Rh

Prenatal Visit Codes (to Use with Pregnancy Diagnosis or Other Prenatal Services)

99201-99205, 99211-99215, 99241-99245	G0463, T1015

NOTES

PEDIATRIC HEALTH

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

ACCESS TO PRIMARY CARE PRACTITIONERS

Measure evaluates the percent of children ages 12 months–19 years who had an outpatient visit within the year with a Primary Care physician.

Office or Other Outpatient Services

CPT
99201-99205, 99211-99215, 99241-99245

Home Services

CPT
99341-99345, 99347-99350

Preventive Medicine

CPT	HCPCS
99381-99387, 99391-99397, 99401-99404, 99411 99412, 99429	G0402, G0438, G0439, G0463, T1015

General Medical Examination

ICD-10
Z00.129, Z00.00, Z00.01, Z00.121, Z00.5, Z00.8, Z02.0 - Z02.6, Z02.71, Z02.79, Z02.81-Z02.83, Z02.89, Z02.9

ADHD MEDICATION FOLLOW-UP CARE

Measure demonstrates the percent of children ages 6–12 newly prescribed an ADHD medication that had at least three follow-up care visits within a 10 month period, one of which was within 30 days of when the first ADHD medication was dispensed. The intent of the measure is to assess medication impact and side effects and therefore, visits with a counselor does not count. The visit should be with a practitioner with prescribing authority. Two rates:

Initiation Phase: one face-to-face outpatient follow-up visit with a prescribing practitioner within 30 days after the date the ADHD medication was newly prescribed.

CPT	HCPCS
Health/Behavior Assessment: 96150-96154 **Education:** 99078 **Office or Outpatient Visit:** 99201-99205, 99211-99215, 99217-99220, 99241-99245 **Assisted Living/Home Care Oversight:** 99341-99345; 99347-99350 **Preventive Medicine:** 99381-99384, 99391-99394 **Counseling:** 99401-99404, 99411-99412	G0409-G0411, G0463, H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2020, M0064, S0201, S9480, S9484, S9485, T1015

CPT		POS
90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853,	WITH	03, 05, 07, 09, 11-20, 22, 33, 49, 50, 52, 53, 71, 72
99221-99223, 99231-99233, 99238, 99239, 99251-99255	WITH	52, 53

Continuation and Maintenance Phase: Two more follow-up visits from 31 to 210 days after the first ADHD medication was newly prescribed. One of the two visits may be a telephone or telehealth visit with the prescribing practitioner.

CODES TO IDENTIFY VISITS	CPT CODES TO IDENTIFY TELEPHONE VISITS / TELEHEALTH MODIFIER
Any code noted above in the initiation phase.	99441-99443/ 95, GT

ASTHMA (MEDICATION MANAGEMENT)

Measure evaluates the percentage of patients 5-64 years of age who were identified as having persistent asthma and were dispensed appropriate medications which they remained on during the treatment period within the past year.

RATES	APPROPRIATE MEDICATIONS
Medication Compliance 50%: Members who were covered by one asthma control medication at least 50% of the treatment period	Antiasthmatic combinations, Antibody inhibitor, Inhaled steroid combinations, Inhaled corticosteroids, Leukotriene modifiers, Mast cell stabilizers, Methylxanthines and Short-acting, inhaled beta-2 agonists
Medication Compliance 75%: Members who were covered by one asthma control medication at least 75% of the treatment period	

DENTAL VISIT (ANNUAL)

Measure evaluates the percentage of members ages 2–20 who had at least one dental exam with a dental practitioner in the past year.

IMMUNIZATIONS

Childhood Immunizations: Percentage of children that have had all of the required immunizations listed below by age 2.

Note: Parent refusal for any reason is not a valid exclusion.

IMMUNIZATION	DETAILS	CPT	HCPCS	CVX
DTaP	At least 4 doses < age 2	90698, 90700, 90721, 90723	—	20, 50, 106, 110, 120
IPV	At least 3 doses < age 2	90698, 90713, 90723	—	10, 89, 110, 120
MMR	At least 1 dose < age 2	90707, 90710	—	03, 94
		Measles/ Rubella-90708	—	04
		Mumps-90704, Measles-90705, Rubella-90706	—	Mumps-07, Measles-05, Rubella-06

IMMUNIZATIONS (CONTINUED)

IMMUNIZATION	DETAILS	CPT	HCPCS	CVX
HiB	At least 3 doses < age 2	90644-90648, 90698, 90721, 90748	—	17, 46-51, 120, 148
Hepatitis B	At least 3 doses < age 2	90723, 90740, 90744, 90747, 90748	—	08, 44, 45, 51, 110
VZV	At least 1 doses < age 2	90710, 90716	—	21, 94
Pneumococcal	At least 4 doses < age 2	90669, 90670	—	100, 133, 152
Hepatitis A	At least 1 doses < age 2	90633	—	31, 83, 85
Rotavirus[1]	Before age 2: 2 doses of 2-dose vaccine; 1 dose of the 2 dose vaccine and 2 doses of the 3 dose vaccine or 3 doses of the 3 dose vaccine	2 dose schedule-90681 3 dose schedule-90680	—	119 116, 122
Influenza	At least 2 doses < age 2	90655, 90657, 90661, 90662, 90673, 90685-90688	—	88, 135, 140-141, 150, 153, 155, 158, 161

1 Record must document if Rotavirus is 2 or 3 dose vaccine.

Adolescent Immunizations: percentage of adolescents turning 13 who had all the required immunizations listed below.

Meningococcal	1 on or between 11th – 13th birthdays	90734	—	108, 136, 147
Tdap	1 on or between 10th – 13th birthdays	Tdap-90715	—	115
Human Papillomavirus (HPV)	2 dose or 3 dose series on or between 9th – 13th birthdays	90649-90651	—	62, 118, 137, 165

Exclusions for Immunizations

Any vaccine	· Anaphylactic reaction
DtaP	· Encephalopathy with a vaccine adverse-effect
MMR, VZV and influenza	· Immunodeficiency · HIV · Lymphoreticular cancer, multiple myeloma or leukemia · Anaphylactic reaction to neomycin
Rotavirus	· Severe combined immunodeficiency · History of intussusception
IPV **Hepatitis B**	· Anaphylactic reaction to streptomycin, polymyxin B or neomycin · Anaphylactic reaction to common baker's yeast

LEAD SCREENING IN CHILDREN

Measure evaluates the percentage of children who had a screening test for lead poisoning at least once prior to their second birthday. A lead screening completed in the practitioner office is also allowable.

CPT
83655

PHARYNGITIS (APPROPRIATE TESTING)

Measure evaluates the percentage of children age 3-18 diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode. A higher rate represents better performance (i.e., appropriate testing). Ensure any secondary diagnoses indicating the need for an antibiotic are submitted on the claim. Rapid strep tests in the office are acceptable and should be billed.

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

UPPER RESPIRATORY INFECTION (APPROPRIATE TREATMENT)

Measure evaluates the percentage of children age 3 months–18 years who were given a diagnosis of upper respiratory infection (URI) and were not dispensed an antibiotic prescription. Ensure any secondary diagnoses indicating the need for an antibiotic are submitted on the claim.

WEIGHT ASSESSMENT AND COUNSELING FOR NUTRITION AND PHYSICAL ACTIVITY

Measure demonstrates the percentage of members ages 3–17 who had an outpatient visit with a PCP or OB/GYN and who had evidence of the following completed at least annually: 1) BMI percentile documentation1; 2) counseling for nutrition; 3) counseling for physical activity.

DESCRIPTION	CPT	ICD-10 DIAGNOSIS	HCPCS
BMI Percentile	—	Z68.51-Z68.54	—
Counseling for Nutrition	97802-97804	Z71.3	—
Counseling for Physical Activity	—	Z02.5	G0447

Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed rather than an absolute BMI value. The percentile ranking is based on the Centers for Disease Control and Prevention's (CDC) BMI-for-age growth charts.

Pregnant members excluded.

WELL CHILD AND ADOLESCENT WELL CARE VISITS

Components of a comprehensive well visit include:

1) A health history; 2) a physical developmental history; 3) a mental developmental history; 4) a physical exam; and 5) health education/anticipatory guidance.

Visits must be with a primary care practitioner (pediatrician, family practice, OB/GYN), even though the PCP does not have to be the practitioner assigned to the child. Assessment or treatment of an acute or chronic condition do not count toward the measure. Use age-appropriate codes when submitting well child visits. Do not include services rendered during an inpatient or ED visit.

Well Child Visits in the First 15 Months of Life

Measure evaluates the percentage of infants who had 6 comprehensive well care visits within the first 15 months of life.

CPT	ICD-10 DIAGNOSIS	HCPCS
99381, 99382, 99391, 99392, 99461	Z00.110, Z00.111, Z00.121, Z00.129, Z00.8, Z02.0, Z02.71, Z02.79, Z02.81, Z02.82, Z02.83, Z02.89, Z02.9, Z00.5	G0438, G0439

Well Child Visits, Ages 3–6 Years Old

Measure evaluates the percentage of children ages 3, 4, 5 or 6 years old who had at least one comprehensive well care visit per year.

CPT	ICD-10 DIAGNOSIS	HCPCS
99382, 99383, 99392, 99393	Z00.121, Z00.129, Z00.8, Z02.0, Z02.2, Z02.5, Z02.6, Z02.71, Z02.79, Z02.81, Z02.82, Z02.83, Z02.89, Z02.9	G0438, G0439

Adolescent Well Care Visits

Measure evaluates the percentage of adolescents age 12–21 years old who had at least one comprehensive well care visit per year.

CPT	ICD-10 DIAGNOSIS	HCPCS
99384, 99385, 99394, 99395	Z00.00, Z00.01, Z00.121, Z00.129, 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	G0438, G0439

NOTES