Quality Performance Guide 2020

Your guide to HEDIS®, CAHPS® and Coding Accuracy

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Magellan COMPLETE CARE®

Contents

Welcome

Magellan Health, thanks you for your continued partnership and the efforts you put forth to continually improve the quality of care for our members. The Magellan quality team has created this booklet to help all provider offices achieve their best possible HEDIS®, CAHPS® and Coding Accuracy results. We hope that this resource becomes a guide and asset to you and the team within your office.

Tips to Improve CAHPS®

We strive to make the Member's experience a positive one! Each year, our members receive a survey called the Consumer Assessment of Healthcare Providers and Systems (CAHPS®). There is a survey for the Medicaid adult members and the Medicaid children. Both surveys ask your patients, our members, to rate and evaluate their experiences. The survey is comprised of several categories. This tip guide will focus on the 3 categories:

- Getting care quickly
- Getting needed care
- How well doctors communicate

The information from this survey is used to improve the quality of services we give to our members. Read on for tips to address these CAHPS® categories.

Getting care quickly

Description: Measures member perception of how quickly they received routine or urgent care within the last 6 months.

How to Improve

- Offer weekend/evening appointments to accommodate your patients' schedule
- Include clear instruction on how to access after hour care, such as accessing an urgent care center (when the office is closed) or dialing 911 in the case of an emergency.

- Consider assigning staff dedicated to preliminary work-up activities.
- Leave a few appointments available each day for urgent visits, if possible.
- Offer visits with nurse practitioners or physician's assistants.
- Understand Magellan's standards for routine and urgent visit wait time for an appointment. (Routine-within 7 days and Urgent-within 48 hours.)
- Remind patients they can call the 24-hour CareLine available 7 days a week for health-related questions.

Getting needed care

Description: Measures member perception of how easily they were able to get the care they needed from their doctor or specialist within the last 6 months, including tests, screenings, visits, and treatments.

How to Improve

- Offer an appointment agenda where patients can list concerns or questions they would like to address during their visit.
- Write down details regarding visits and referrals to a specialist for the patient.
- Leave a few appointments available each day for urgent visits, if possible.
- Review all available treatment options for the patient in their language. Avoid using medical terms that could confuse the patient.
- Schedule follow up appointments for patients while they are in the office for their visit for needed screenings, tests, treatments, and exams. Patients can also schedule appointments by contacting Magellan's Member Services.
- Use standardized order sheets for procedures or common conditions.

How well doctors communicate

Description:
Measures member perception of how well their physician communicated with them within the last 6 months. Questions in this category take into account how the physician explained things regarding the patients' health, how well the patient understood the information, if the doctor listened to the patient, if the doctor was respectful, and how much time the physician spent with the patient.

How to Improve

- If your office makes appointment reminder calls, advise the patient to list their questions or concerns and bring them to the appointment.
- Offer an appointment agenda where patients can list concerns or questions they would like to address during their visit. The agenda can also explain the purpose for the visit and what conditions are being addressed.
- Ensure there is enough time for each patients' appointment to allow time for communication between physician and patient.
- Allow the opportunity for patients to ask questions and check their understanding of the information provided during the visit.
- Listen to your patients' needs. Avoid using terms that could confuse the patient.
- Take feedback from your patients by providing short survey cards to see how the office can improve.
- Offer a visit summary to the patient that includes any treatment, goals, or action plans that were discussed during the visit.

HEDIS 2020

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

Please note: The information provided is based on HEDIS® 2020 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

The codes and tips listed are informational only; this information does not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate nor control your clinical decisions regarding the appropriate care of members. Your state/ provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes.

Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members.

Pediatric HEDIS® general helpful tips:

- Document all discussions in the medical record.
- Discuss importance of ideal weight, nutrition and exercise with all patients.
- Use the State immunization registry and transcribe into the registry the Hep B given at birth in the hospital.
- If you use electronic medical records, consider creating a flag to track patients due or past due for preventive services.
- If you do not use electronic medical records, consider creating a manual tracking method for preventive services such as immunizations and annual well-child exams.
- Make the most of the time in your office. Sick visits may be the opportunity for your patient to get annual health checks on time.

- Encourage your staff to use tools within the office to promote teaching on immunizations, asthma care, healthy living habits and importance of return visits.
- Place posters and educational messages in treatment rooms and waiting areas to help motivate patients to initiate discussions with you about health screenings.
- Consider extending your office hours into the evening, early morning or weekends to accommodate working parents.
- Contact patients to remind them of upcoming appointments and necessary screenings.
- Schedule the next visit at the end of the appointment.
- To increase patient satisfaction while waiting for service, consider offering free WiFi.

Adult HEDIS® general helpful tips:

- Document all discussions in the medical record.
- Discuss importance of medication management, chronic disease management, ideal weight, smoking cessation, preventative services, adult immunizations and importance of return visits with all patients.
- Consider including a diabetes educator on your team or periodically bringing one in to speak with patients during office visits.
- Follow up on lab results, eye exam results or any specialist visit to document on your chart.
- Refer members to the network of eye providers for their annual diabetic retinal eye exam.
- If you use electronic medical records, consider creating a flag to track patients due or past due for preventive services.
- If you do not use electronic medical records, consider creating a manual tracking method for preventive services.
- Encourage your staff to use tools within the office to promote teaching on colorectal cancer screening, cervical cancer screening and breast cancer screening.
- Provide a mammogram referral during their annual visit.
- Place posters and educational messages in treatment rooms and waiting areas to help motivate patients to initiate discussions with you about health screenings.

- Consider extending your office hours into the evening, early morning or weekends to accommodate all patients.
- Contact patients to remind them of upcoming appointments and necessary screenings.
- Schedule the next visit at the end of the appointment
- To increase patient satisfaction while waiting for service, consider offering free WiFi

Coding Accuracy: a Standard of Quality

Importance of coding accuracy

Accuracy Coding is critical in today's Health Industry. Coding is utilized for appropriate patient treatment, reimbursement, research, the basis of financial and clinical decision making and worldwide comparative trending. As a result, the accuracy of reported codes must be audited and analyzed to ensure the data is relevant and clinically validated.

Improve coding accuracy

The purpose of coding audit is to make sure the data is clinically validated and relevant, and to improve coding accuracy. During the audit process, we will make sure all levels: Diagnostic Related Group (DRG) accuracy and overall coding accuracy are established. Also the audits will reveal opportunities for training and process improvements that will ultimately result in a more efficient coding department with fewer errors, reduced denials and proper claim adjudication.

Coding responsibility

Legally, when a physician, physician assistant (PA) or nurse practitioner (NP) enroll in a Medicare, Medicaid or commercial insurance, the practitioner signs an agreement attesting that accurate claims will be submitted. The practitioner is responsible for claims submitted under his/her NPI.

Helping with filing corrected claims

Magellan will provide the ICD office guidelines for Coding along with the guidance from the Coding Clinic for the Centers for Medicare & Medicaid Services (CMS) to determine accurate code assignment.

Disclaimer

The codes and measure tips listed herein are informational only, are not all-inclusive, clinical guidelines or standards of medical care; this information does not guarantee reimbursement. All member care and related decision of treatment are the sole responsibility of the provider. This information does not dictate nor control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for a high volume of medical record review requests and/or provider audits. It is also helps us review your performance of the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).

Please note: The information provided is based on HEDIS 2020 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS), and state recommendations. Please refer to the appropriate agency for additional guidance.

Respiratory Measures

Appropriate Testing for Pharyngitis (formerly CWP)

This measure is no longer children only

This measure looks at members 3 years of age and older who received group A streptococcus (strep) tests with a diagnosis of pharyngitis, tonsillitis or streptococcal pharyngitis and were dispensed antibiotics appropriately within three days of the diagnosis.

Since there is considerable evidence that prescribing antibiotics is not the first line of treatment for a cold or sore throat caused by viruses, recommend that only lab-confirmed group A strep or other bacteria-related ailments be treated with appropriate antibiotics.

Code your services correctly

Codes to identify pharyngitis:

Description	ICD-10-CM Diagnosis
Acute pharyngitis	J02.8, J02.9
Acute tonsillitis	J03.00, J03.01, J03.80, J03.90, J03.91 J03.81
Streptococcal pharyngitis	J02.0

Codes to identify group A streptococcal tests:

Codes
CPT: 87070, 87071, 87081, 87430, 87650-87652, 87880
LOINC: 626-2, 5036-9, 6556-5, 6557-3, 6558-1, 6559-9, 11268-0, 17656-0, 18481-2, 31971-5, 49610-9, 60489-2, 68954-7, 78012-2

Codes listed are HEDIS specific. This information does not guarantee reimbursement.

Helpful tips

If a patient tests negative for group A strep, but insists on an antibiotic:

- Refer to the illness as a sore throat due to a cold; patients tend to associate the label with a less frequent need for antibiotics.

Appropriate Treatment for Upper Respiratory Infection (formerly URI)

This measure is no longer children only

This measure looks at members 3 months of age and older who were given a diagnosis of upper respiratory infection (URI) and were not dispensed an antibiotic prescription. **Educating patients on the difference between bacterial and viral infections is a key factor in the success of this measure, reducing unnecessary use of antibiotics is the goal.**

Code your services correctly

Description	ICD-10-CM Diagnosis
Acute nasopharyngitis (common cold)	J00
Acute laryngopharyngitis	J06.0
URI	J06.9
Acute pharyngitis	J02.8, J02.9
Acute tonsillitis	J03.00, J03.01, J03.80, J03.81, J03.90, J03.91
Streptococcal sore throat	J02.0

Codes listed are HEDIS specific. This information does not guarantee reimbursement.

Helpful tips

If a parent/caregiver/member insists on an antibiotic:

- Refer to the illness as a common cold; this tends to associate the label with a less-frequent need for antibiotics.
- Write a prescription for symptom relief such as an over-the-counter cough medicine.

Children and Adolescent Measures

Childhood Immunization Status (CIS)

The childhood immunization status HEDIS® measure looks at members who turned 2 years old in the measurement year and received the following vaccinations by their 2nd birthday:

Immunization	Dose(s)	Immunization	Dose(s)
DTaP	4	VZV	1
IPV	3	PCV	4
MMR	1	Hep A	1
Hib	3	Rotavirus	3
Hep B	3	Influenza	2

Get your effort on record

Once you give our members their needed immunizations, let us and the state know by:

- Recording the immunizations in your state immunization registry
- Documenting the immunizations (historic and current) within medical records and include:
  - Documented history of illness or seropositive test result
  - The date of the first hepatitis B vaccine given at the hospital and name of the hospital.

Code your immunization services correctly

Use these procedure codes to document immunizations for children from birth through 2 years of age. Add appropriate modifiers per coding guidelines when needed.

Immunization	CPT code(s)
DTaP	90698, 90700, 90721, 90723
IPV	90698, 90713, 90723
MMR	90707, 90710
Measles and Rubella	90708
Measles or mumps or rubella	measles: 90705 mumps: 90704 rubella: 90706
Hib	90644-90648, 90698, 90721, 90748
Hep B	90723, 90740, 90744, 90747, 90748
VZV	90710, 90716
PCV	90669, 90670
Hep A	90633
Rotavirus	two-dose: 90681 three-dose: 90680
Influenza	90655, 90657, 90661, 90662, 90673, 90685, 90687

Codes listed are HEDIS specific. This information does not guarantee reimbursement.

Immunizations for Adolescents (IMA)

This measure looks at children/adolescents both male and female, 9 to 13 years of age who received the following immunizations by their 13th birthday.

Immunization	Dose(s)	Age
Meningococcal	1	Ages 11–13
Tdap	1	Ages 10–13
HPV	series	Ages 9–13

HPV Series

- Either 3 vaccines with different dates of service OR
- 2 vaccines given at least 146 days apart

Get your effort on record

Once you give our members their needed immunizations, let us and the state know by:

- Recording the immunizations in your state immunization registry
- Documenting the immunizations (historic and current) within medical records to include:
  - Documented history of illness or seropositive test result

Code your services correctly

Add appropriate modifiers per coding guidelines when needed.

Immunization	CPT code(s)
Meningococcal	90644, 90734
Tdap	90715
HPV (Male and Female)	90649, 90650, 90651

Codes listed are HEDIS specific. This information does not guarantee reimbursement.

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

This HEDIS® measure looks at members 3 to 17 years of age who had one or more outpatient visits with PCPs or OB-GYNs during the year and documented evidence of weight assessment physical activity and nutritional counseling.

- Height, weight and body mass index (BMI) percentile (not BMI value)
- Counseling for nutrition
- Counseling for physical activity with recommendations

Get your efforts on record

Document BMI percentile and counseling for nutrition and physical activity annually. Make sure your records reflect:

- Weight and height
- BMI percentile documented or plotted on an age-growth chart
- Checklist to indicate counseling for nutrition and physical activity discussion
- Note Physical Activity Counseling in the Comments Section of the PM160 form

Code your services correctly

Description	ICD-10-CM Diagnosis
BMI percentile	Z68.51-Z68.54
Counseling for nutrition,	Z71.3
Counseling for physical activity-exam for sports participation	Z02.5

Codes listed are HEDIS specific. This information does not guarantee reimbursement.

Helpful tips

- Consider incorporating appropriate nutritional and weight management questioning and counseling into your routine clinical practice.
- Document any advice you give the patient.
- When counseling for nutrition, you must document face to face discussion of current nutritional behavior like appetite or meal patterns, eating and dieting habits, any counseling or referral to nutrition education, any nutritional educational materials that were provided during the visit, anticipatory guidance for nutrition, eating disorders, nutritional deficiencies, underweight, obesity or overweight discussion that was done.
- When **counseling for physical activity,** document face to face discussion of current physical activity behaviors like exercise routines, participation in sports activities or bike riding, referrals to physical activity, educational material that was provided, anticipatory guidance on physical activity, obesity or overweight discussion that was done.

Well-Child Visits: Children 3–6 Years Old (W34)

This measure looks at members 3 to 6 years of age who had one or more comprehensive well-child visits with a primary care provider (PCP) during the year.

Get your efforts on record

- Follow the American Academy of Pediatrics Bright Futures Recommendations for Preventive Pediatric Health Care periodicity schedule for well visits and services.
- Sick visits may be missed opportunities for your patient to get health checks.
- Document each well visit in the member's medical record.
- Make sure your medical records reflect all the following:
  - Physical and mental developmental histories
  - A physical exam
  - Health education and anticipatory guidance

Code your services correctly

CPT	ICD-10-CM Diagnosis	HCPCS
99381-99385, 99391-99395, 99461	Z00.110, Z00.111 Z00.121 Z00.129 Z00.5-Z00.8, Z02.0-Z02.6, Z02.71, Z02.79, Z02.81-Z02.89, Z02.9	G0438, G0439

Codes listed are HEDIS specific. This information does not guarantee reimbursement.

Adult Measures

Adult BMI Assessment (ABA)

This measure looks at members 18 to 74 years of age who had an outpatient visit with documentation of weight and body mass index (BMI) value during the year or year prior. Members under age 20 must have a height, weight and BMI percentile documented and/or plotted on a BMI chart.

Get your efforts on record

Make sure your medical records reflect all of the following:

- The weight and BMI value of the patient ages 20 to 74 years of age
- For patients younger than 20 years of age, documentation must include:
  - BMI percentile documented as a value (e.g., 85th percentile) or
  - BMI percentile plotted on an age-growth BMI chart and
  - Height and weight

Code your services correctly

Codes to identify BMI:

ICD-10-CM Diagnosis
Z68.1, Z68.20-Z68.45, Z68.51-Z68.54

Codes listed are HEDIS specific. This information does not guarantee reimbursement.

Medication Reconciliation Post-Discharge (MRP)

This HEDIS® measure looks at members 18 years of age and older for whom medications were reconciled post discharge through 30 days after discharge.

Get your efforts on record

Make sure you schedule an appointment with your patient upon notification of an acute inpatient discharge or ED visit.

Assure that medical records reflect all of the following:

- Document your review of the discharge summary, along with the discharge medications for both a systemic corticosteroid and a bronchodilator.
- Schedule regular follow-up visits to review the medication management/compliance.
  - Record any new prescription written at the follow-up visit.

Code your services correctly

Description	CPT
Medication Reconciliation	99495, 99496 and 1111F

Codes listed are HEDIS specific. This information does not guarantee reimbursement.

Diagnosis Specific Measures

Comprehensive Diabetes Care (CDC)

This measure evaluates members ages 18 to 75 with Type I or Type II diabetes.

Each year, members with Type I or Type II diabetes should have:

- HbA1c testing
- Blood pressure monitoring
- Nephropathy screening and treatment
- Dilated retinal eye exam in current year or negative exam in previous year

Diabetes control is determined by:

- HbA1c below 7% (actual goal depends on age and comorbidities).
  Code HBA1c levels by using CPT codes:
  3044F: < 7%,
  3051F (≥ 7.0 and < 8.0)
  3052F (≥ 8.0 and ≤ 9.0)
  3046F: > 9%
- Blood pressure < 140/90
  Code BP levels by using CPT codes:
  3074F: Systolic BP < 130
  3075F: Systolic BP 130-139
  3078F: Diastolic BP < 80
  3079F: Diastolic BP 80-89

Record your efforts

Though only most recent result matters document all diabetes evaluation notes, blood pressure, lab test and eye exam results in the member's medical record.

Code your services correctly

Service	CPT Codes
HbA1c	83036, 83037, 3044F-3046F
Eye exams	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, 92225-92228, 92230, 92235, 92240, 92250, 92260, 99203-99205, 92213-99215, 99242-99245
Nephropathy screening	82042, 82043, 82044, 81000-81003, 81005, 3060F, 3061F, 3062F
Evidence of treatment for nephropathy	3066F, 4010F

Codes listed are HEDIS specific. This information does not guarantee reimbursement.

Controlling High Blood Pressure (CBP)

This measure looks at members ages 18 to 85 years old who had diagnoses of hypertension and whose blood pressures (BP) are regularly monitored and controlled.

Record your efforts

- Document diagnosis of hypertension in medical record
- Members whose blood pressures (BP) are adequately controlled include:
  - Patients ages whose B/P is < 140/90
    Both systolic and diastolic values must be below stated value.

Code your services correctly

Codes to identify hypertension:

Description	ICD-10-CM Diagnosis
Hypertension	I10

Codes listed are HEDIS specific. This information does not guarantee reimbursement.

*Added blood pressure readings taken from remote patient monitoring devices that are electronically submitted directly to the provider for numerator compliance.

Helpful tips

Improve the accuracy of BP measurements performed by your clinical staff by:

- Providing training and materials from the American Heart Association
- Conducting BP competency tests to validate the education of each clinical staff member
- Making a variety of cuff sizes available
- Calibrating BP equipment through engineering protocols
- Instruct your office staff to recheck BPs for all patients with initial recorded readings greater than systolic 140 mm Hg and diastolic of 90 mm Hg during outpatient office visits.
- Warn staff against rounding results if not using digital cuffs.

Medication Management for People with Asthma (MMA)

This HEDIS® measure looks at members 5 to 64 years of age who were identified as having persistent asthma, were dispensed appropriate medications and remained on asthma controller medication during the treatment period.

For members with asthma, you should:

- Prescribe controller medication
- Educate member in identifying asthma triggers, taking controller medications
- Create an asthma action plan and document in medical record
- Remind patients to get their controller medication filled regularly
- Remind member not to stop taking the controller medications even if they are feeling better and symptom free

Code your services correctly

Appropriate controller and reliever medications—prior authorization* and step therapy may be required.

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

Asthma reliever medications	
Description	Prescriptions
Short-acting, inhaled beta-2 agonists	Albuterol Levalbuterol* Pirbuterol*

Visit the ncqa.org website for a comprehensive list of medications and NDC codes.

*Not all medications listed here maybe in the formulary, call pharmacy to verify required preauthorization of the medications.

† Inhaler combo medications

Female Specific Measures

Breast Cancer Screening (BCS)

This HEDIS® measure looks at women 50 to 74 years of age, who had a mammogram to screen for breast cancer during the current year or the year prior

Code your services correctly

Use the following diagnosis and procedure codes to document breast cancer screenings:

Codes
CPT: 77055-77057
HCPCS: G0202
UB Revenue: 0403

Codes listed are HEDIS specific. This information does not guarantee reimbursement.

Helpful tips

- If appropriate, the history code of bilateral mastectomy (OHTVOZZ) or unilateral mastectomies (right OHTTOZZ, left OHTUOZZ) may be added to exam visit.
- Discuss breast cancer screening with all female patients 50 to 74 years of age
- Conduct outreach calls to patients to remind them of the importance of annual wellness visits and assist in scheduling mammograms.
- Request and retain copies of mammography results in patients' records or tell patients to make sure they ask the mammography centers to send a copy to your office for records.
- Use your electronic medical records (EMR) to create flags or reminders for members who need a mammogram referral during their annual visit.

Cervical Cancer Screening (CCS)

This HEDIS® measure looks at women who were screened for cervical cancer using the following criteria:

- Ages 21 to 64: At least one cervical cytology (Pap) test every three years
- Ages 30 to 64: Cervical cytology (Pap) test/human papillomavirus (HPV) cotesting every five years

Get your efforts on record

Make sure your medical records reflect:

- The date and type of test that was performed. PCP may code Q0091 indicating smear obtained.
- The history code Z90.710, Z90.712 or Q51.5 may be added to an annual well-woman exam to appropriately exclude patient from this measure if the patient has an absence of the cervix.
- Document complete details of hysterectomy with mention of cervix absent or present and at a minimum the year the surgical procedure was performed

Code your services correctly

Use the following diagnosis and procedure codes to document cervical cancer screenings:

Codes
CPT: 88141-88143, 88147, 88148, 88150, 88152-4, 88164-88167, 88174, 88175
HCPCS: G0123, G0124, G0141, G0143-5 G0147,G0148, P3000, P3001, Q0091
ICD-10: Z12.4
UB Revenue: 0923

Codes listed are HEDIS specific. This information does not guarantee reimbursement.

Chlamydia Screening in Women (CHL)

CHL evaluates sexually active women ages 16 to 24 who received at least one chlamydia test during the current year.

The U.S. Preventive Services Task Force and the Centers for Disease Control and Prevention recommend screening for chlamydia at least annually for all sexually active women younger than age 25. Chlamydia is the most frequently reported bacterial sexually transmitted disease in the United States. An estimated 3 million chlamydia infections occur annually among sexually active adolescents and young adults. Chlamydia may cause infertility if left undiagnosed or untreated.

Code your services correctly

Use the following diagnosis and procedure codes to document chlamydia screenings:

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

Codes listed are HEDIS specific. This information does not guarantee reimbursement.

Helpful tips

- Urine screening for chlamydia is acceptable for all female patients 16 years of age and older who are sexually active in this age group for chlamydia every year as part of their annual well visit.
- Take a sexual history when you see adolescents. Create an environment conducive to taking a sexual history by:
  - Making sure you have an opportunity to speak with the adolescent without her parent(s)
  - Introducing sensitive issues by starting with nonthreatening topics first and moving to more sensitive ones

Positive test results

- Ensure continuity of care after a positive screening test.
- Set aside time to discuss the test result, treatment plan and the implications of a positive test result with your patients.
- Educate patients with positive tests on the need to inform their partner(s). Reinfection is common and may cause infertility.

Osteoporosis Management in Women who had a Fracture (OMW)

This HEDIS® measure looks at women 67–85 years of age who suffered a fracture and who had either a bone mineral density (BMD) test or prescription for a drug to treat osteoporosis in the **six months after the fracture.**

The National Osteoporosis Foundation (NOF) recommends performing BMD testing in appropriate patient populations, including patients who have had a fracture. The NOF also recommends initiating pharmacologic treatment in patients who have had a fracture, both clinical and asymptomatic. Pharmacotherapy for osteoporosis has been shown to reduce the risk of fractures in patients, including those with a history of fractures.[1]

Get your efforts on record

For members who have a history of a fracture:

- Order BMD
- Prescribe a drug to treat osteoporosis

Osteoporosis Medications

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

1. *National Osteoporosis Foundation. Cosman F, Tanner B, de Beur SJ, et al. Clinician's Guide to Prevention and Treatment of Osteoporosis. Osteoporosis International 2014; 25: 2359-2381*

Prenatal and Postpartum Care (PPC)

Prenatal and Postpartum Care (PPC)

This HEDIS® measure looks at members to assess the following facets of prenatal and postpartum care.

Prenatal care: The percentage of pregnant members that received at least one prenatal care visit in the first trimester on or before the enrollment start date or within 42 days of enrollment.

Postpartum care: The percentage of members that had a postpartum visit on or between 7 and 84 days after delivery.

Get your efforts on record

Make sure your medical records reflect all the following:

- **Prenatal care visit** note during the first trimester on or before the enrollment start date or within 42 days of enrollment. Document on the American Congress of Obstetricians and Gynecologists (ACOG) sheets (or similar) completely and including fundus height. For visits performed by a PCP, a diagnosis of pregnancy must be present.

  Documentation must include the visit date and evidence of one of the following:

  1. A basic physical obstetrical examination that includes:
     - Auscultation for fetal heart tone
     - Pelvic exam with obstetric observations
     - Measurement of fundus height
  2. Prenatal care procedure could be:
     - Screening test/obstetric panel
     - Ultrasound/echography of pregnant uterus
     - TORCH antibody panel alone
  3. Documentation of last menstrual period or estimated due date with *either* prenatal risk assessment and counseling/education, **or** complete obstetrical history.

- **Postpartum care visit.** The postpartum checkup date must be on or between 7 and 84 days post-delivery (a day early or a day late does not count).

  Documentation must indicate visit date and evidence of at least **one** of the following:
  - Pelvic exam
  - Evaluation of weight, blood pressure, breasts (or note of breastfeeding) and abdomen.
  - Notation of postpartum care, e.g., postpartum care, PP care, PP check, six-week check up
- Perineal or, incision check post C-section is acceptable.
- Call patients to schedule the postpartum visits as well as remind them of their appointment.
- Follow up with patients who miss appointments and reschedule.
- **Should be billed with regular evaluation & management codes, as appropriate.**

Pre and Postnatal Care	
59400	Routine obstetric care including antepartum care, vaginal delivery and postpartum care
59510	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care
59610	Routine obstetric care including antepartum care, vaginal delivery, and postpartum care; after previous cesarean delivery
59618	Routine obstetric care including antepartum care, cesarean delivery and postpartum care; following attempted vaginal delivery after previous cesarean delivery

Prenatal Care	
0500F	Initial pregnancy-related
0501F	Prenatal flowsheet documentation in medical record by first prenatal visit
0502F	Subsequent prenatal care visit
59425	Antepartum care only; 4-6 visits
59426	Antepartum care 7 or more visits
99500	Home visit for prenatal monitoring and assessment to include fetal heart rate, non-stress test, uterine monitoring, and gestational diabetes monitoring

Postpartum Care	
0503F	Postpartum care visit
59410	Vaginal delivery only; including postpartum care
59430	Postpartum care only
59614	Vaginal delivery only, after previous cesarean delivery; including postpartum care
59622	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery; including postpartum care
99501	Home visit for postnatal assessment and follow-up care

Procedures	
57170	Diaphragm or cervical cap fitting with instructions
58300	Insertion of intrauterine device (IUD)

Behavioral Health Measures

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

This HEDIS® measure looks at the percentage of children 6 to12 years of age who were newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication and had at least 3 follow-up care visits within a 10-month period, the first visit within 30 days of when the first ADHD medication was dispensed.

Two rates are reported:

- Initiation phase: follow-up visit with prescriber within 30 days of prescription
- Continuation and maintenance phase: remained on ADHD medication and had two more visits within nine months

Get your efforts on record

When prescribing a new ADHD medication:

- Be sure to schedule a follow-up visit right away to be within 30 days when ADHD medication is initially prescribed or restarted after a 120-day break.
- After the initial follow-up visits, schedule at least two more office visits in the next nine months to monitor patients' progress.
- Be sure that follow-up visits include the diagnosis of ADHD.

Code your services correctly

Use the following diagnosis and procedure codes to document children who were dispensed an ADHD medication:

Codes to identify an outpatient, intensive outpatient or partial hospitalization follow-up visit:

Codes
CPT: 96150-96154, 98960-98962, 99078, 99201-99205, 99211-99220, 99221-99223, 99231-99233, 99238, 99239, 99241-99245, 99251-99255, 99291, 99341-99350, 99381-99384, 99391-99394, 99401-99404, 99411-99412, 99510
HCPCS: G0155, G0176, G0177, G0409-G0411, G0463, H0002, H0004, H0031, H0034-H0040, H2000, H2001, H2010-H2020, M0064, S0201, S9480, S9484, S9485, T1015
UB Revenue: 0510, 0513-0529, 0900, 0902-0905, 0907, 0911-0917, 0919, 0982, 0983

Medications for monitoring The National Committee for Quality Assurance (NCQA) recognizes the following ADHD medications for monitoring and documentation of follow-up care in children:

Medications
CNS stimulants: Amphetamine-dextroamphetamine, Dexmethylphenidate, Dextroamphetamine, Lisdexamfetamine, Methamphetamine, Methylphenidate
Alpha-2 receptor agonists: Clonidine, Guanfacine
Miscellaneous ADHD medications: Atomoxetine

Follow-Up After Hospitalization for Mental Illness (FUH)

This HEDIS® measure looks at the percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health practitioner.

Two rates are reported:

1. The percentage of discharges for which the member received follow-up within 30 days after discharge.
2. The percentage of discharges for which the member received follow-up within 7 days after discharge.

Get your efforts on record

- Ensure the member has a plan for follow-up visits within 7 days of discharge and 30 days of discharge.
- Schedule the member for a follow-up visit BEFORE discharge.
- Recommend a Telehealth visit (telehealth, teleconference, Teledoc®, etc.)

Code your services correctly

Codes to identify a patient with mental illness diagnoses:

Description	ICD-10-CM Diagnosis
Mental disorders due to known physiological conditions	F03.90-F03.91
Schizophrenia, schizotypal, delusional, and other non-mood psychotic disorders	F20.0-F39
Anxiety, dissociative, stress-related, somatoform and other nonpsychotic mental disorders	F40-F48
Behavioral syndromes associated with physiological disturbances and physical factors	F50-F59
Disorders of adult personality and behavior	F60-F69
Pervasive and specific developmen disorders	F80-F89
Behavioral and emotional disorder with onset usually occuring in childhood and adolescence	F90-F98

Codes to identify an outpatient, intensive outpatient or partial hospitalization follow-up visit:

Codes
CPT: 96150-96154, 98960-98962, 99078, 99201-99205, 99211-99220, 99221-99223, 99231-99233, 99238, 99239, 99241-99245, 99251-99255, 99291, 99341-99350, 99381-99387, 99391-99397, 99401-99404, 99411-99412, 99510
HCPCS: G0155, G0176, G0177, G0409-G0411, G0463, H0002, H0004, H0031, H0034-H0040, H2000, H2001, H2010-H2020, M0064, S0201, S9480, S9484, S9485, T1015
UB Revenue: 0510, 0513-0529, 0900, 0902-0905, 0907, 0911-0917, 0919, 0982, 0983

Follow-Up After Emergency Department Visit for Mental Illness (FUM)

This HEDIS® measure looks at the percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness. Two rates are reported:

1. The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days).
2. The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days).

Get your efforts on record

- Ensure that a member with a principal diagnosis of a mental health disorder or with a principal diagnosis of intentional self-harm and any diagnosis of a mental health disorder has a follow-up visit with any practitioner, including visits on the date of the ED visit.
- Recommend a Telehealth visit (telehealth, teleconference, Teledoc®, etc.)

Code your services correctly

Codes to identify a patient with mental illness diagnoses:

Description	ICD-10-CM Diagnosis
Mental disorders due to known physiological conditions	F03.90-F03.91
Schizophrenia, schizotypal, delusional, and other non-mood psychotic disorders	F20.0-F39
Anxiety, dissociative, stress-related, somatoform and other nonpsychotic mental disorders	F40-F48
Behavioral syndromes associated with physiological disturbances and physical factors	F50-F59
Disorders of adult personality and behavior	F60-F69
Pervasive and specific developmen disorders	F80-F89
Behavioral and emotional disorder with onset usually occuring in childhood and adolescence	F90-F98

Codes to identify an outpatient, intensive outpatient or partial hospitalization follow-up visit:

Codes
CPT: 96150-96154, 98960-98962, 99078, 99201-99205, 99211-99220, 99221-99223, 99231-99233, 99238, 99239, 99241-99245, 99251-99255, 99291, 99341-99350, 99381-99387, 99391-99397, 99401-99404, 99411-99412, 99510
HCPCS: G0155, G0176, G0177, G0409-G0411, G0463, H0002, H0004, H0031, H0034-H0040, H2000, H2001, H2010-H2020, M0064, S0201, S9480, S9484, S9485, T1015
UB Revenue: 0510, 0513-0529, 0900, 0902-0905, 0907, 0911-0917, 0919, 0982, 0983

Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)

This HEDIS® measure looks at the percentage of emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow up visit for AOD. Two rates are reported:

1. The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days).
2. The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days).

Get your efforts on record

- Ensure the member has a follow-up visit with a PCP or mental health practitioner, with a principal diagnosis of alcohol, or other drug abuse or dependence, within 30 days after the ED visit; you can include visits that occur on the date of the ED visit.
- Recommend a Telehealth visit (telehealth, teleconference, Teledoc®, etc.)

Code your services correctly

Codes to identify an inpatient or observation patient:

Codes
CPT: 99217- 99220
UB Revenue: 0100-0101, 0111-0179, 0190-0219, 1000-1002

Notes

Notes

Notes

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

CAHPS® Surveys Many of the CMS patient experience surveys are in the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) family of surveys. All surveys officially designated as CAHPS surveys have been approved by the CAHPS Consortium, which is overseen by the Agency for Healthcare Research and Quality (AHRQ).

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