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Record your efforts and code your services appropriately.
Proper documentation and coding decreases the need for medical record reviews and helps us meet the HEDIS® measure for quality reporting based on the care provided.
The codes listed in this booklet are informational only; this information does not guarantee reimbursement.
Your state contract (e.g. Medicare, Medicaid, etc.) and state Medicaid and CMS guidelines determine reimbursement for the applicable codes.
PCP: A physician or non-physician (Nurse Practitioner; Physician Assistant) who offers primary care medical services.

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

www.anthem.com
Adolescent well-care visits: Children 12-21 years old

This HEDIS measure looks at the percentage of patients 12 to 21 years of age who had at least one comprehensive well-care visit with a PCP or OB-GYN during the measurement 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 per your state’s guidelines.
- Indicate in the medical record that the office visit was specifically for a well-care exam with a PCP or OB-GYN and include the visit date.
- Document each well visit in the member’s medical record.
- Make sure your medical records reflect all the following:
  - A medical history
  - Physical and mental developmental histories
  - A physical exam
  - Health education and anticipatory guidance

Code your services correctly

Use the following diagnosis and procedure codes to document comprehensive well-care visits:

<table>
<thead>
<tr>
<th>CPT</th>
<th>MOD</th>
<th>ICD-9-CM Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>99384–99385, 99394–99395</td>
<td>EP</td>
<td>V20.2, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9</td>
</tr>
</tbody>
</table>

The codes listed are informational only; this information does not guarantee reimbursement.

If you encounter abnormalities or address a pre-existing problem during a well-child visit and the problem/abnormality is significant enough to require additional work to perform the key components of problem-oriented E&M services, be sure to bill both the appropriate EPSDT visit code and the appropriate E&M code with modifier 25*.

<table>
<thead>
<tr>
<th>EPSDT visit code</th>
<th>E&amp;M sick visit code</th>
</tr>
</thead>
<tbody>
<tr>
<td>99384–99385</td>
<td>99211 25</td>
</tr>
<tr>
<td>99394–99395</td>
<td>99212 25</td>
</tr>
</tbody>
</table>

*Include modifier EP where required.

The codes listed are informational only; this information does not guarantee reimbursement.

Helpful tips

- Use your member roster to contact patients who are due for an annual exam or are new to your practice.
- Ask your Provider Relations representative about missed care opportunity reports if you aren’t already receiving them.
- If you use electronic health records (EHRs), create a flag to track patients due or past due for a preventive screening.
- If you do not use EHRs, create a manual tracking method. Sick visits may be a missed opportunity for your patient to get a health check.

Proper coding decreases the need for medical record reviews and helps us meet the HEDIS measure for quality reporting based on the care provided. The codes listed are informational only; this information does not guarantee reimbursement. Your state contract (e.g. Medicare, Medicaid, etc.) and state Medicaid and CMS guidelines determine reimbursement for the applicable codes.
• Consider extending your office hours into the evening, early morning or weekend to accommodate working parents and kids involved in after-school activities.
• Complete a well-care visit at the same time as sports physical.
• Consider having a teen night at your practice. Contact Health Promotion for help planning the event.

**How we can help**

We help you get our members in your care in for their well-child visits by:

• Keeping you up-to-date on members overdue for services
• Assisting with patient scheduling if needed
• Perhaps offering incentives and drawings for prizes to encourage members to get preventive care; contact your Provider Relations representative or Health Promotion department for details

**Notes**
Adult BMI screening

This HEDIS measure looks at the percentage of patients between the ages of 18–74 years who had outpatient visits and whose Body Mass Indices (BMIs) were documented in their medical records during the measurement year or the year prior to the measurement year.

Get your efforts on record
Make sure your medical records reflect all of the following:

- The date of the outpatient visit
- The weight and BMI value of the patient
- For patients younger than 19 years of age, include:
  - BMI percentile documented as a value (e.g., 85th percentile)
  - BMI percentile plotted on an age-growth chart

Code your services correctly!
Use the following diagnosis and procedure codes to document BMI screenings.

<table>
<thead>
<tr>
<th>CPT</th>
<th>HCPCS</th>
<th>UB Revenue</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201–99205</td>
<td>G0402</td>
<td>051X, 0520–0523, 0526–0529, 0982, 0983</td>
</tr>
<tr>
<td>99211–99215</td>
<td>G0438</td>
<td></td>
</tr>
<tr>
<td>99241–99245</td>
<td>G0439</td>
<td></td>
</tr>
<tr>
<td>99341–99345</td>
<td></td>
<td></td>
</tr>
<tr>
<td>99347–99350</td>
<td></td>
<td></td>
</tr>
<tr>
<td>99381–99384</td>
<td></td>
<td></td>
</tr>
<tr>
<td>99385–99387</td>
<td></td>
<td></td>
</tr>
<tr>
<td>99391–99394</td>
<td></td>
<td></td>
</tr>
<tr>
<td>99395–99397</td>
<td></td>
<td></td>
</tr>
<tr>
<td>99401–99404</td>
<td></td>
<td></td>
</tr>
<tr>
<td>99411, 99412</td>
<td></td>
<td></td>
</tr>
<tr>
<td>99420, 99429</td>
<td></td>
<td></td>
</tr>
<tr>
<td>99455, 99456</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The codes listed are informational only; this information does not guarantee reimbursement.

Codes to identify BMI

<table>
<thead>
<tr>
<th>ICD-9-CM Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>V85.0–V85.5</td>
</tr>
</tbody>
</table>

The codes listed are informational only; this information does not guarantee reimbursement.

Helpful tips

- Discuss ideal weight per height and age with all patients. Show the patients where their heights and weights plot on the Adult BMI Chart.
- Document all discussions about BMI in the medical record to include any patient noncompliance with nutritional counseling.
- Encourage your staff to use tools within the office to promote ideal BMI, such as handheld cards, charts, electronic medical record (EMR) flags and educational brochures.
- Provide staff training on BMI, medical assessment, brief and focused advice, and treatment. Offer a continuing medical education (CME) course to enhance your treatment and prevention of obesity.
- Place posters and educational messages in treatment rooms and waiting areas to help motivate patients to initiate discussions with you about screenings.
- Review your EMR or assessment forms to check for fields that document BMI. Offices that use EMRs should check whether their systems have the ability to auto calculate BMI once height and weight is entered.
- Talk to your local Provider Relations representative to determine if we can assist implement and evaluate events for a particular screening like annual wellness checkups that include BMI screenings or a comprehensive screening event.

Proper coding decreases the need for medical record reviews and helps us meet the HEDIS measure for quality reporting based on the care provided. The codes listed are informational only; this information does not guarantee reimbursement.
Your state contract (e.g. Medicare, Medicaid, etc.) and state Medicaid and CMS guidelines determine reimbursement for the applicable codes.
Proper coding decreases the need for medical record reviews and helps us meet the HEDIS measure for quality reporting based on the care provided. The codes listed are informational only; this information does not guarantee reimbursement. Your state contract (e.g. Medicare, Medicaid, etc.) and state Medicaid and CMS guidelines determine reimbursement for the applicable codes.

**How we can help**

We help you with BMI screening by:
- Handing out adult BMI charts during site visits and town hall meetings or mailing them to you upon request
- Educating members on the importance of BMI screening through health education; contact your local Provider Relations representative for information
- Coordinating with you to plan focused health prevention clinic days if available in your state

**Other available resources**

You can find more information and tools online at:
- ama-assn.org
- cdc.gov/healthyweight/assessing/bmi/index.html

**Notes**

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______________________________________________________________________________
Appropriate testing for children with pharyngitis

This HEDIS measure looks at the percentage of patients 2–18 years of age who were diagnosed with pharyngitis, tonsillitis or streptococcal sore throats; were dispensed antibiotics and received group A streptococcus (strep) tests during office or emergency room visits.

Pediatric clinical practice guidelines recommend only children with lab-confirmed group A strep or other bacteria-related ailments be treated with appropriate antibiotics.

Pharyngitis is the only condition among upper respiratory infections (URIs) whose diagnosis can be validated through lab results. It serves as an indicator of appropriate antibiotic use among all respiratory tract infections. A strep test (rapid assay or throat culture) is the test of group A strep pharyngitis.

Code your services correctly!

Use the following diagnosis and procedure codes.

**Codes to identify pharyngitis:**

<table>
<thead>
<tr>
<th>Description</th>
<th>ICD-9-CM Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute pharyngitis</td>
<td>462</td>
</tr>
<tr>
<td>Acute tonsillitis</td>
<td>463</td>
</tr>
<tr>
<td>Streptococcal sore throat</td>
<td>034.0</td>
</tr>
</tbody>
</table>

The codes listed are informational only; this information does not guarantee reimbursement.

**Codes to identify group A streptococcal tests:**

<table>
<thead>
<tr>
<th>CPT</th>
<th>LOINC codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>87070, 87071, 87081, 87430, 87650–87652, 87880</td>
<td>626-2, 5036-9, 6556-5, 6557-3, 6558-1, 6559-9, 11266-0, 17656-0, 18481-2, 31971-5, 49610-9, 60489-2, 68954-7</td>
</tr>
</tbody>
</table>

The codes listed are informational only; this information does not guarantee reimbursement.

**Codes to identify visit type:**

<table>
<thead>
<tr>
<th>Description</th>
<th>CPT</th>
<th>UB Revenue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency department</td>
<td>99281–99285</td>
<td>045x, 0981</td>
</tr>
</tbody>
</table>

The codes listed are informational only; this information does not guarantee reimbursement.
Helpful tips

- If a patient tests negative for pharyngitis 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
  - Write a prescription for symptom relief like over-the-counter medicines
- Use the modified Centor score to help determine which patients shouldn’t need testing, throat cultures/RADTs or empiric treatment with antibiotics.
- Educate patients on the difference between bacterial and viral infections (this is a key point in the success of this measure).
- Document the performance of a rapid strep test or the patients’, parents’ or caregiver’s refusal of testing in medical records.
- Discuss with patients ways to treat symptoms:
  - Get extra rest
  - Drink plenty of fluids
  - Use over-the-counter medications
  - Use a cool-mist vaporizer and nasal spray for congestion
  - Eat ice chips or use throat spray or lozenges for sore throats
- Let patients and their parents or caregivers know they can prevent infection by:
  - Washing hands frequently
  - Keeping an infected person’s eating utensils and drinking glasses separate from other family members
  - Thoroughly washing an infected toddler’s toys in hot water with disinfectant soap

Keeping a child diagnosed with a sore throat out of school or day care until he or she has taken antibiotics for at least 24 hours and until symptoms improve.

How can we help
We help you with appropriate testing for kids with pharyngitis by educating our members on pharyngitis through quarterly newsletters, community events and health education materials.

Other resources
Visit the Centers for Disease Control and Prevention website at www.cdc.gov/getsmart for these helpful materials and more:

- Prescription Pad for Viral Infection
- Get Smart: Know When Antibiotics Work (podcast)
- Cold or Flu. Antibiotics Don’t Work for You. (brochure)

Notes
Avoidance of antibiotic treatment for adults with acute bronchitis

This HEDIS measure looks at the percentage of adults 18 to 64 years of age with a diagnosis of uncomplicated acute bronchitis (diagnosis code 466.0) who were not dispensed an antibiotic prescription.

There is considerable evidence that prescribing antibiotics for uncomplicated acute bronchitis is not indicated unless there is a comorbid diagnosis like:
- HIV disease; asymptomatic HIV (042, V08)
- Cystic fibrosis (277.0)
- Disorders of the immune system (279.xx)
- Malignant neoplasm (140–209.9)
- Chronic bronchitis (491.x)
- Emphysema (492.x)
- Bronchiectasis (494.x)
- Extrinsic allergic alveolitis (495.x)
- Other diseases of the respiratory system (510.x–519.xx)
- Tuberculosis (010.xx–018.xx)
- Pneumoconiosis and other lung disease due to external agents (500–508.x)
- Chronic airway obstruction, chronic obstructive asthma (493.2x, 496)

Or a bacterial infection like:
- Sinusitis (461.9)
- Otitis media (382.9)

Code your services correctly!
Use the following diagnosis and procedure codes to indicate acute bronchitis:

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>ICD-9-CM Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute bronchitis</td>
<td>466.0</td>
</tr>
</tbody>
</table>

The codes listed are informational only; this information does not guarantee reimbursement.

Helpful tips
- If prescribing an antibiotic for a bacterial infection (or comorbid condition) in patients with uncomplicated acute bronchitis, be sure to use the diagnosis code for the bacterial infection and/or comorbid condition.
- If a patient insists on an antibiotic:
  - Refer to the illness as a chest cold rather than bronchitis; patients tend 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.

Other resources
You can find print and online tools on the Centers for Disease Control and Prevention website as part of the Get Smart: Know When Antibiotics Work campaign.

Proper coding decreases the need for medical record reviews and helps us meet the HEDIS measure for quality reporting based on the care provided. The codes listed are informational only; this information does not guarantee reimbursement. Your state contract (e.g. Medicare, Medicaid, etc.) and state Medicaid and CMS guidelines determine reimbursement for the applicable codes.
Proper coding decreases the need for medical record reviews and helps us meet the HEDIS measure for quality reporting based on the care provided. The codes listed are informational only; this information does not guarantee reimbursement. Your state contract (e.g. Medicare, Medicaid, etc.) and state Medicaid and CMS guidelines determine reimbursement for the applicable codes.

Go to www.cdc.gov/getsmart for these helpful materials and more:

- Prescription Pad for Viral Infection (4” x 6” handout)
- Get Smart: Know When Antibiotics Work (podcast)
- Cold or Flu. Antibiotics Don't Work for You. (brochure)

Notes
Breast cancer screening

This HEDIS measure looks at the percentage of female patient’s ages 50–74 years who had one or more mammograms to screen for breast cancer in the current measurement year and the year prior to the measurement year.

Record your efforts
To meet the requirement, documentation and/or mammogram reports must appear in the medical record to provide evidence a mammogram was performed.

Code your services correctly
Use the following diagnosis and procedure codes to document breast cancer screenings:

<table>
<thead>
<tr>
<th>CPT</th>
<th>HCPCS</th>
<th>ICD-9-CM Procedure</th>
<th>UB Revenue</th>
</tr>
</thead>
<tbody>
<tr>
<td>77055–77057</td>
<td>G0202, G0204, G0206</td>
<td>87.36, 87.37</td>
<td>0401, 0403</td>
</tr>
</tbody>
</table>

The codes listed are informational only; this information does not guarantee reimbursement.

Helpful tips
Discuss breast cancer screening with all female patients between the ages of 50–74 years (younger if the patient has a family history of breast cancer).
- Conduct outreach calls to patients to remind them of the importance of annual wellness visits and assist in scheduling mammograms.
- Follow up with patients who miss appointments.
- Request and retain copies of mammography results in patients’ records.
- Use your EMR to create flags or reminders for members needing a mammogram or a referral.
- Arrange one-on-one patient education by a health professional or trained layperson promoting breast cancer screening.

Best practices
- Document all discussions about breast cancer screening.
- Partner with us to discuss member screening and outreach events to promote preventive health care.
- Motivate your office staff to use tools within the office to promote breast cancer screening, such as member handheld reminder cards, chart or electronic medical record flags, and education brochures.
- Put up posters and educational messages in waiting areas; they help motivate patients to initiate discussions with physicians regarding screenings.
Proper coding decreases the need for medical record reviews and helps us meet the HEDIS measure for quality reporting based on the care provided. The codes listed are informational only; this information does not guarantee reimbursement. Your state contract (e.g. Medicare, Medicaid, etc.) and state Medicaid and CMS guidelines determine reimbursement for the applicable codes.

How we can help

- Educating members on breast cancer screening through our health education materials, contact your Provider Relations representative for additional information
- Reminding members thru various sources who have not yet had their mammogram to contact their physician to schedule one

We help you meet this benchmark by:
- Offering Clinical Practice Guidelines (CPGs) on our provider self-service site; these help improve health care quality and reduce unnecessary variation in care for our members; information on breast cancer screening is in the Adult Preventive Health CPG
- Working with you to schedule member screening events to help promote breast cancer screening and other preventive health care services

Notes

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________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
Cervical cancer screening

This HEDIS measure looks at the percentage of female patient's ages 21–64 years who have had one or more Pap tests for cervical cancer this year or two years prior. Or Pap test/HPV co-testing once every five years for women ages 30-64.

Get your efforts on record!
Make sure your medical records reflect:
- The date and type of the test that was performed
- The result or finding of the Pap test and/or HPV co-testing

Code your services correctly
Use the following diagnosis and procedure codes to document cervical cancer screening:

<table>
<thead>
<tr>
<th>CPT</th>
<th>HCPCS</th>
<th>ICD-9-CM Procedure</th>
<th>UB Revenue</th>
<th>LOINC</th>
</tr>
</thead>
<tbody>
<tr>
<td>88141–88143, 88147, 88148, 88150, 88152– 88155, 88164– 88167, 88174, 88175</td>
<td>G0123, G0124, G0141, G0143– G0145, G0147, G0148, P3000, P3001, Q0091</td>
<td>91.46</td>
<td>0923</td>
<td>10524-7, 18500- 9, 19762-4, 19764-0, 19765- 7, 19766-5, 19774-9, 33717- 0, 47527-7, 47528-5</td>
</tr>
</tbody>
</table>

The codes listed are informational only; this information does not guarantee reimbursement.

Helpful tips
- Discuss importance of well woman exams and cervical cancer screening with all female patients between 21 and 64 years of age.
- Conduct outreach calls to patients to remind them of the importance of annual wellness visits.
- Refer members to other appropriate provider or gynecologists if your office does not perform Pap tests in your office, and request copies of Pap test/HPV co-testing results be sent to your office.
- If patients have a history of hysterectomy, add complete details if it was a Complete, Total or Radical abdominal or vaginal hysterectomy with no residual cervix, also document history of cervical agenesis or acquired absence of cervix. Include at a minimum the year the surgical procedure was performed.
- Talk to your Provider Relations representative if scheduling a health screening clinic day in your community is a possibility and our staff may help plan, implement and evaluate events for a particular preventive screening like a cervical cancer screening or a complete comprehensive women’s health screening event.
- Encourage your staff to use tools within the office to promote cervical cancer screening such as handheld cards to teach patients, add EMR flags and/or have tracking tool of who need the screenings, use educational brochures.
- Posters and educational messages in treatment rooms and waiting areas help motivate patients to initiate discussions with you about screening. Train your staff on preventive screenings or find out if we provide training.
Proper coding decreases the need for medical record reviews and helps us meet the HEDIS measure for quality reporting based on the care provided. The codes listed are informational only; this information does not guarantee reimbursement. Your state contract (e.g. Medicare, Medicaid, etc.) and state Medicaid and CMS guidelines determine reimbursement for the applicable codes.

How we can help
We help you get our members this critical service by:

- Offering you access to our Clinical Practice Guidelines (CPGs) on our provider self-service site - reference these to help improve health care quality and reduce unnecessary variation in care for our members
- Offering you the HEDIS Measure Desktop Reference Guide
- Coordinating with you to plan and focus on improving health awareness of our members by providing health screenings, activities, materials and resources when and as available or as needed
- Educating members on the importance of cervical cancer screening through various sources such as phone calls, post cards, newsletters, health education fliers and may also help with scheduling appointments or maybe offering incentives to complete screening

Contact your Provider Relations representative for any questions or discuss during office visits.

Other available resources
You can find more information and tools online at uspreventiveservicestaskforce.org.

Notes
Childhood and adolescent immunizations

The Childhood Immunization Status HEDIS measure looks at the percentage of patients 2 years old and younger who received the following vaccinations by their second birthdays:

<table>
<thead>
<tr>
<th>Immunization</th>
<th>Dose(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>DTaP/DT</td>
<td>4</td>
</tr>
<tr>
<td>IPV</td>
<td>3</td>
</tr>
<tr>
<td>MMR</td>
<td>1</td>
</tr>
<tr>
<td>Hib</td>
<td>3</td>
</tr>
<tr>
<td>Hep B</td>
<td>3</td>
</tr>
<tr>
<td>VZV</td>
<td>1</td>
</tr>
<tr>
<td>PCV</td>
<td>4</td>
</tr>
<tr>
<td>Hep A</td>
<td>1</td>
</tr>
<tr>
<td>Rotavirus</td>
<td>3</td>
</tr>
<tr>
<td>Influenza</td>
<td>2</td>
</tr>
</tbody>
</table>

The codes listed are informational only; this information does not guarantee reimbursement.

The Immunizations for Adolescents (IMA) and Human Papillomavirus (HPV) HEDIS measures look at the percentage of adolescents who are 13 years of age and received the following immunizations by their thirteenth birthday:

<table>
<thead>
<tr>
<th>Immunization</th>
<th>Dose(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meningococcal</td>
<td>1</td>
</tr>
<tr>
<td>Tdap or Td</td>
<td>1</td>
</tr>
<tr>
<td>HPV</td>
<td>3</td>
</tr>
</tbody>
</table>

The codes listed are informational only; this information does not guarantee reimbursement.

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 registry if applicable
- Documenting the immunizations (historic and current) within medical records to include:
  - A note indicating the name of the specific antigen and the date of the immunization
  - The certificate of immunization prepared by an authorized health care provider or agency
  - Parent refusal, 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, if available
Code your services correctly!

Use these procedure codes to document immunizations for children from birth through 2 years of age:

<table>
<thead>
<tr>
<th>Immunization</th>
<th>CPT Code(s)</th>
<th>Modifier</th>
<th>Diagnosis Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>DTaP</td>
<td>90698, 90700, 90721, 90723</td>
<td>EP</td>
<td>V06.8, V06.1</td>
</tr>
<tr>
<td>IPV</td>
<td>90698, 90713, 90723</td>
<td>EP</td>
<td>V06.8, V04.0</td>
</tr>
<tr>
<td>MMR</td>
<td>90707, 90710</td>
<td>EP</td>
<td>V06.4, V06.8</td>
</tr>
<tr>
<td>Measles/Rubella</td>
<td>90708</td>
<td>EP</td>
<td>V06.8</td>
</tr>
<tr>
<td>Measles/Mumps/Rubella</td>
<td>Measles: 90705; Mumps: 90704 Rubella: 90706, 90707, 90710</td>
<td>EP</td>
<td>V04.2, V04.6, V04.3 V06.4, V06.8</td>
</tr>
<tr>
<td>Hib</td>
<td>90645, 90646, 90647, 90648, 90698, 90721, 90748</td>
<td>EP</td>
<td>V03.81, V06.8</td>
</tr>
<tr>
<td>Hep B</td>
<td>90723, 90740, 90744, 90747, 90748</td>
<td>EP</td>
<td>V06.8, V05.3</td>
</tr>
<tr>
<td>VZV</td>
<td>90710, 90716</td>
<td>EP</td>
<td>V06.8, V05.4</td>
</tr>
<tr>
<td>PCV</td>
<td>90669, 90670</td>
<td>EP</td>
<td>V03.82</td>
</tr>
<tr>
<td>Hep A</td>
<td>90633</td>
<td>EP</td>
<td>V05.3</td>
</tr>
<tr>
<td>Rotavirus (two-dose or three-dose)</td>
<td>Two-dose: 90681; three-dose: 90680</td>
<td>EP</td>
<td>V04.89</td>
</tr>
<tr>
<td>Influenza</td>
<td>90655, 90657, 90661, 90662</td>
<td>EP</td>
<td>V04.81</td>
</tr>
<tr>
<td>Meningococcal</td>
<td>90733, 90734</td>
<td>EP</td>
<td>V03.89</td>
</tr>
<tr>
<td>Tetanus</td>
<td>90703</td>
<td>EP</td>
<td>V03.7</td>
</tr>
<tr>
<td>Diphtheria</td>
<td>90719</td>
<td>EP</td>
<td>V03.5</td>
</tr>
<tr>
<td>HPV</td>
<td>90649, 90650</td>
<td>EP</td>
<td>V04.89</td>
</tr>
</tbody>
</table>

Helpful tips

- If you use electronic health records, create a flag to track patients due for immunizations.
- Extend your office hours into the evening, early morning or weekend to accommodate working parents.
- Develop or implement standing orders for nurses and physician assistants in your practice to allow staff to identify opportunities to immunize.
- Enroll in the Vaccines for Children (VFC) Program to receive vaccines. For questions about enrollment and vaccine orders, contact your state VFC coordinator. Find your coordinator when you visit www.cdc.gov/vaccines/programs/vfc/contacts-state.html or call 1-800-CDC-INFO.

How we can help

We can help you get children in for their immunizations by:

- Keeping you up-to-date on members overdue for services
- Assisting with patient scheduling if needed
- We may be offering member incentives to encourage parents to schedule appointments for their children

Call your provider representative for more information.

Proper coding decreases the need for medical record reviews and helps us meet the HEDIS measure for quality reporting based on the care provided. The codes listed are informational only; this information does not guarantee reimbursement.

Your state contract (e.g. Medicare, Medicaid, etc.) and state Medicaid and CMS guidelines determine reimbursement for the applicable codes.
Proper coding decreases the need for medical record reviews and helps us meet the HEDIS measure for quality reporting based on the care provided. The codes listed are informational only; this information does not guarantee reimbursement. Your state contract (e.g. Medicare, Medicaid, etc.) and state Medicaid and CMS guidelines determine reimbursement for the applicable codes.
Chlamydia screening in women

This HEDIS measure looks at the percentage of 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. May cause infertility if left undiagnosed or untreated.

Code your services correctly!
Use the following diagnosis and procedure codes to document chlamydia screenings:

<table>
<thead>
<tr>
<th>CPT Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>87110, 87270, 87320, 87490–87492, 87810</td>
</tr>
</tbody>
</table>

The codes listed are informational only; this information does not guarantee reimbursement.

Helpful tips

- Urine screening for chlamydia is acceptable for all female patients 16 years of age and older during adolescent well-care visits. Make this screening a routine requirement for your patients.
- Screen for chlamydia every year.
- Use any visit opportunity to screen female patients who are sexually active in this age group.
- 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)
  - Reinforcing confidentiality within limits
  - Introducing sensitive issues by starting with nonthreatening topics first and moving to more sensitive ones
- If your office does not perform chlamydia screenings, refer members to a participating OB-GYN or other appropriate provider and have the results sent to you.

Positive test results

- Manage positive chlamydia tests the same way as any other test result.
- Ensure continuity of care after a screening test.
- Leave a prescription at the reception desk for patients to collect the same day and remember to set aside time to discuss the test result and the implications of a positive test result with your patients.
- Educate patients on the need to inform their partner(s). Reinfection is common and may cause infertility.

Proper coding decreases the need for medical record reviews and helps us meet the HEDIS measure for quality reporting based on the care provided. The codes listed are informational only; this information does not guarantee reimbursement. Your state contract (e.g. Medicare, Medicaid, etc.) and state Medicaid and CMS guidelines determine reimbursement for the applicable codes.
How we can help

We help you get our members in for chlamydia screenings by:

- Keeping you up-to-date on members overdue for HEDIS-related services
- Sending you a list of your patients due for a chlamydia screening
- Providing resources on health educational materials for your practice
- Assisting with patient appointment scheduling if needed
- Contact your Provider Relations representative to find out if we are offering well-woman and adolescent incentives to encourage members to get preventive care

Notes
Comprehensive diabetes care

This HEDIS measure evaluates members age 18–75 yearly to determine if they achieved control levels for blood sugar, blood pressure, and are being monitored for long-term prevention of complications related to diabetes.

Comprehensive diabetes care includes members ages 18–75 with type 1 and type 2 diabetes who received the following exams:
- Hemoglobin A1c (HbA1c) testing
- HbA1c less than 7 percent (for patients less than 65 yrs. of age and no comorbid conditions)
- HgA1c less than 8 percent
- HbA1c greater than 9 percent
- Retinal or dilated eye exam by an eye care professional
- Kidney disease monitoring for nephropathy (either a microalbumin test or ACEI/ARB use)
- Blood pressure (BP) monitoring (<140/90 mm Hg)

Record your efforts
Document all diabetes evaluation notes, blood pressure, and lab test and eye exam results in the member’s medical record. If exams listed above were not done or recommended, document the reasons in the member’s record.

Code your services correctly!
Use the following procedure codes to document comprehensive diabetes care:

<table>
<thead>
<tr>
<th>Service</th>
<th>CPT Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>HbA1c</td>
<td>83036, 83037</td>
</tr>
<tr>
<td>Eye exams</td>
<td>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</td>
</tr>
<tr>
<td>Nephropathy screening</td>
<td>82042, 82043, 82044, 84156</td>
</tr>
<tr>
<td>Evidence of treatment for nephropathy</td>
<td>36147, 36800, 36810, 36815, 36818, 36819-36821, 36831-36833, 50300, 50320, 50340, 50360, 50365, 50370, 50380, 90935, 90937, 90940, 90945, 90947, 90957-90962, 90965, 90966, 90969, 90970, 90989, 90993, 90997, 90999, 99512</td>
</tr>
<tr>
<td>Urine microalbumin test</td>
<td>81000-81003, 81005</td>
</tr>
</tbody>
</table>

The codes listed are informational only; this information does not guarantee reimbursement.

Helpful tips
- For the recommended frequency of testing and screening, refer to the Clinical Practice Guidelines for diabetes mellitus
- If your practice uses electronic medical records (EMRs), have flags or reminders set in the system to alert your staff when a patient’s screenings are due
- If you use hard-copy charts, have a template to identify the last date of necessary screening
Proper coding decreases the need for medical record reviews and helps us meet the HEDIS measure for quality reporting based on the care provided. The codes listed are informational only; this information does not guarantee reimbursement. Your state contract (e.g. Medicare, Medicaid, etc.) and state Medicaid and CMS guidelines determine reimbursement for the applicable codes.

and the next time the patient should be screened

- Send appointment reminders and call patients to remind them of upcoming appointments and necessary screenings
- Consider including a diabetes educator on your team or periodically bringing one in to speak with patients during office visits
- Follow up on lab test results, eye exam results or any specialist referral and document on your chart

Educate your patients
Educate your patients, their families, caregivers and guardians on diabetes care, including:
- Taking all prescribed medications as directed
- Adding regular exercise to daily activities
- Regularly monitoring blood sugar and blood pressure at home
- Maintaining healthy weight and ideal body mass index
- Eating heart-healthy, low calorie and low-fat foods
- Smoking cessation and avoiding secondhand smoke
- Educating patients on the importance of fasting prior to having blood sugar & lipids panels drawn to ensure accurate results
- Emphasize the importance of keeping all medical appointments and help schedule necessary appointments, screenings and tests

How we can help
We can help you with comprehensive diabetes care by:
- Providing online Clinical Practice Guidelines (CPGs) to help improve health care quality and reduce variation in the diabetic care our members receive; you should review and ensure compliance with CPGs for clinicians
- We can reach out to our members through the programs we offer
- Call Provider Services to find out about programs that may be available to our diabetic members
- Contact your local Provider Relations representative to request copies of educational resources that may be available on Diabetes for your office
- If we have a provider representative for the region you cover we can help schedule clinic days or provide education to our members at your office; please contact your local Provider Relations representative to find out

Notes
Controlling high blood pressure

This HEDIS measure includes patients ages 18 to 85 years old who had diagnoses of hypertension in outpatient visit settings and whose blood pressures (BP) are adequately controlled. Most recent BP readings during the measurement year after the diagnosis of hypertension is tracked; if patient’s record does not have a blood pressure recorded, it would be assumed that the patient’s BP is not under control.

Record your efforts
- A diagnosis of hypertension prior to June 30 of the calendar year
- Recorded BP monitoring to an adequate control range. NCQA added age and condition specific treatment goals that align with the eighth Joint National Committee hypertension guidelines:
  - 18–59 years (<140/90 mm Hg)
  - 60–85 years with diabetes (<140/90 mm Hg)
  - 60–85 years without diabetes (<150/90 mm Hg)

Code your services correctly
The NCQA recognizes the following diagnosis and procedure codes to document hypertension and outpatient visits:

<table>
<thead>
<tr>
<th>Codes to identify hypertension</th>
<th>Description</th>
<th>ICD-9-CM Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypertension</td>
<td></td>
<td>401.0–401.9</td>
</tr>
</tbody>
</table>

The codes listed are informational only; this information does not guarantee reimbursement.

<table>
<thead>
<tr>
<th>Codes to identify outpatient visits</th>
<th>Description</th>
<th>CPT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient visits</td>
<td></td>
<td>99201–99205; 99211–99215; 99381-99383 and 99391-99393</td>
</tr>
</tbody>
</table>

The codes listed are informational only; this information does not guarantee reimbursement.

Helpful tips
- Improve the accuracy of BP measurements performed by your clinical staff by:
  - Providing training tapes 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; have your staff record the recheck in patients’ medical records.
- Refer high-risk members to our case management program for additional education and support
- Provide in-practice presentations by an internal interventional cardiologist and after-hours Continuing Medical Education (CME) courses.
- Perform chart audits and one-on-one feedback by physician leaders.

Proper coding decreases the need for medical record reviews and helps us meet the HEDIS measure for quality reporting based on the care provided. The codes listed are informational only; this information does not guarantee reimbursement.
Your state contract (e.g. Medicare, Medicaid, etc.) and state Medicaid and CMS guidelines determine reimbursement for the applicable codes.
Proper coding decreases the need for medical record reviews and helps us meet the HEDIS measure for quality reporting based on the care provided. The codes listed are informational only; this information does not guarantee reimbursement. Your state contract (e.g. Medicare, Medicaid, etc.) and state Medicaid and CMS guidelines determine reimbursement for the applicable codes.

- Educate patients and their spouses, caregivers or guardians about the elements of a healthy lifestyle such as:
  - Heart-healthy eating and a low-salt diet
  - Smoking cessation and avoiding secondhand smoke
  - Adding regular exercise to daily activities
  - Home BP monitoring
  - Ideal body mass index
  - The importance of taking all prescribed medications as directed

Other resources
You can find more information and tools online at:
- nhlbi.nih.gov/guidelines/hypertension/jnc7full.pdf
- amga.org/research/research/Hypertension/Compendiums/novant.pdf

How we can help
We support you in helping patients control high blood pressure by:
- Providing online Clinical Practice Guidelines (CPGs) to help improve health care quality and reduce unnecessary variation in care for our members; you should review and ensure compliance with CPGs for clinicians to flag elevated BP readings
- Reaching out to our hypertensive members through our programs
- Reach out to you with a list of hypertensive members and hypertension guidelines to remind you to monitor your patients who have been diagnosed with hypertension
- Find out if community Event staff are available to help you schedule, plan, implement and evaluate a health screening clinic day
- Educating our members on high blood pressure through health education materials

Notes
Lead screening in children

This HEDIS measure looks at the percentage of patients who turned 2 during the measurement year and had one or more capillary or venous lead blood tests for lead poisoning by their second birthday.

- Federal regulations require that Medicaid members receive a lead screening blood test at 12 and 24 months of age.
- Medicaid children between 36 and 72 months of age should receive a lead screening blood test if no records exist showing a previous test.
- If you obtain the specimen and analyze the test in your office, you should report results to your state’s Childhood Lead Poisoning Prevention Program.

Anticipatory guidance is required as part of a routine health check visit. You should cover:

- Effects of lead poisoning on children
- Sources of lead poisoning
- Pathways of exposure
- How to prevent child exposure to lead hazards
- Appropriate testing schedules for children

Reminder: Completing a lead risk assessment questionnaire does not count as a lead screening.

Get your efforts on record!
When documenting lead screening, include:

- Date the test was performed
- Results or findings

Code your services correctly
Use the following diagnosis and procedure codes to document lead screening:

<table>
<thead>
<tr>
<th>Description</th>
<th>CPT</th>
<th>ICD-9</th>
<th>Mod</th>
<th>Medical record documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead screening</td>
<td>83655</td>
<td>V82.5</td>
<td>EP, 90 or EP, 91</td>
<td>Results, findings and date of screening</td>
</tr>
<tr>
<td>Capillary or venous</td>
<td>36415 or 36416</td>
<td>V82.5</td>
<td>EP</td>
<td></td>
</tr>
</tbody>
</table>

The codes listed are informational only; this information does not guarantee reimbursement.

Helpful tips

- Draw patients’ blood while they are in your office instead of sending them to the lab.
- Consider performing finger stick screenings in your practice.
- Assign one staff member to follow up on results when patients are sent to a lab for screening.
- Develop a process to check medical records for lab results to ensure previously ordered lead screenings have been completed.
- Use sick and well-child visits as opportunities to encourage parents to have their child tested.
- Contact our Case Management department if the results are greater than 10 micrograms/dL.

Proper coding decreases the need for medical record reviews and helps us meet the HEDIS measure for quality reporting based on the care provided. The codes listed are informational only; this information does not guarantee reimbursement.

Your state contract (e.g. Medicare, Medicaid, etc.) and state Medicaid and CMS guidelines determine reimbursement for the applicable codes.
Proper coding decreases the need for medical record reviews and helps us meet the HEDIS measure for quality reporting based on the care provided. The codes listed are informational only; this information does not guarantee reimbursement. Your state contract (e.g. Medicare, Medicaid, etc.) and state Medicaid and CMS guidelines determine reimbursement for the applicable codes.

Notes
Medication management for people with asthma

This HEDIS measure looks at the percentage of patients 5–64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period. For members with asthma, you should:

- Prescribe a controller medication
- Assist member in identifying asthma triggers and creating an Asthma Action Plan (document in medical record)
- Remind patients to get their controller medication filled

Get your efforts on record!

Document in the member’s medical record every time you hand out an asthma medication sample by:

- Adding a note to the file
- Including a copy of the written prescription

Code your services correctly

Appropriate controller and reliever medications

<table>
<thead>
<tr>
<th>Description</th>
<th>Prescriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antiasthmatic combinations</td>
<td>Dyphylline-guaifenesin*</td>
</tr>
<tr>
<td>Antibody inhibitors</td>
<td>Omalizumab*</td>
</tr>
<tr>
<td>Inhaled steroid combinations</td>
<td>Budesonide-formoterol†</td>
</tr>
<tr>
<td></td>
<td>Fluticasone-salmeterol†</td>
</tr>
<tr>
<td></td>
<td>Mometasone-formoterol†</td>
</tr>
<tr>
<td>Inhaled corticosteroids</td>
<td>Beclomethasone</td>
</tr>
<tr>
<td></td>
<td>Budesonide</td>
</tr>
<tr>
<td></td>
<td>Ciclesonide</td>
</tr>
<tr>
<td></td>
<td>Flunisolide</td>
</tr>
<tr>
<td></td>
<td>Fluticasone CFC free</td>
</tr>
<tr>
<td></td>
<td>Mometasone</td>
</tr>
<tr>
<td></td>
<td>Triamcinolone</td>
</tr>
<tr>
<td>Leukotriene modifiers</td>
<td>Montelukast†</td>
</tr>
<tr>
<td></td>
<td>Zafirlukast</td>
</tr>
<tr>
<td></td>
<td>Zileuton*</td>
</tr>
<tr>
<td>Mast cell stabilizers</td>
<td>Cromolyn</td>
</tr>
<tr>
<td>Methylxanthines</td>
<td>Aminophylline</td>
</tr>
<tr>
<td></td>
<td>Dyphylline*</td>
</tr>
<tr>
<td></td>
<td>Theophylline</td>
</tr>
</tbody>
</table>
Proper coding decreases the need for medical record reviews and helps us meet the HEDIS measure for quality reporting based on the care provided. The codes listed are informational only; this information does not guarantee reimbursement.

Your state contract (e.g. Medicare, Medicaid, etc.) and state Medicaid and CMS guidelines determine reimbursement for the applicable codes.

The codes listed are informational only; this information does not guarantee reimbursement.

### How we can help
We can help you keep members on track with their asthma medications by:
- Providing you with quality report cards to help you track your performance
- Educating members on asthma control and offering your practice materials to hand out as well as needed
- Helping you schedule appointments for your patients if needed
- Emphasize to your patients the importance of medication compliance and controller medications

### Notes

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Postpartum checkups

This HEDIS measure looks at the percentage of patients who had a postpartum visit to an OB/GYN practitioner or midwife, family practitioner or other Primary care physician that included a pelvic exam or postpartum care on or between 21 and 56 days after delivery. Members who had an early C-section incision check must have a complete postpartum visit between 21-56 days after delivery. Code your patients’ postpartum visit even if you use global billing.

Get your efforts on record
Make sure your medical records reflect:
- The date of the postpartum visit - must be between 21-56 days after delivery
- Use of CPT Category II code 0503F, defined as postpartum care visit, will help with HEDIS data collection
- Must include evidence of one of the following:
  - Pelvic exam
  - Evaluation of weight, blood pressure, breasts and abdomen (notation of breastfeeding is acceptable for the evaluation of breasts component)
  - Notation of postpartum care, (e.g., postpartum care, PP care, PP check, six-week check) or a preprinted Postpartum Care form in which information was documented during the visit

Code your services correctly
Use the following diagnosis and procedure codes to document postpartum checkups:

<table>
<thead>
<tr>
<th>Postpartum Visit Codes</th>
<th>CPT</th>
<th>MOD</th>
<th>ICD-9-CM Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>57170, 58300, 59400*,</td>
<td>None</td>
<td>V24.1, V24.2,</td>
</tr>
<tr>
<td></td>
<td>59410*, 59430, 59510*,</td>
<td></td>
<td>V25.1, V72.3,</td>
</tr>
<tr>
<td></td>
<td>59515*, 59610*, 59614*,</td>
<td></td>
<td>V76.2</td>
</tr>
<tr>
<td></td>
<td>59618*, 59622*, 88141-</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>88143, 88147, 88148,</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>88150, 88152–88155,</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>88164–88167, 88174,</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>88175, 99501</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Generally, these codes are used on the date of delivery, not on the date of the postpartum visit, so this code may be used only if the claim form indicates when postpartum care was rendered.

The codes listed are informational only; this information does not guarantee reimbursement.

Helpful tips
- If the patient comes in one or two weeks after delivery for the removal of staples, incision check or other reasons, schedule another appointment for a complete postpartum checkup and educate patient on the importance of new moms coming back for a checkup 21–56 days after they’re discharged from the hospital after delivery and schedule the visit. Refer them to a PCP if needed
- If your office schedules newborn visits speak to the mom about infants immunization and well visits
- Help patients to schedule the postpartum visits as well as remind them of their appointment dates and times. Patients who have had multiple pregnancies and deliveries, teens, and/or high risk pregnancies need additional support, encouragement and education to be emphasized on the postpartum visit
- Call patients who missed appointments and reschedule

Proper coding decreases the need for medical record reviews and helps us meet the HEDIS measure for quality reporting based on the care provided. The codes listed are informational only; this information does not guarantee reimbursement. Your state contract (e.g. Medicare, Medicaid, etc.) and state Medicaid and CMS guidelines determine reimbursement for the applicable codes.
• Make sure the postpartum checkup date is on or between 21 and 56 days (a day early or a day late does not count)
• If your office uses a global bill, make sure the postpartum date is added on the claim, this will prevent the search for this information thru our medical record reviews which may have been a barrier in capturing the post-partum visits that occur in your office
• Document all services using the ACOG forms

**How we can help**
We help you get our members the postpartum care they need by:
• Posting postpartum care Clinical Practice Guidelines on our provider self-service website
• Calling members to remind them to schedule their postpartum visits if needed
• Enrolling members into our special maternity programs to help you coordinate their care
• Distributing education materials to members we identify as pregnant or have recently given birth
• Your patients may even be eligible for incentives thru the programs we offer for prenatal checkups and postpartum visits. Call your provider representative to find out.

**Other available resources**
You can find more information and tools online at www.acog.org/For_Patients

**Notes**
 Spirometry testing for patients with COPD

This HEDIS measure looks at the percentage of our members age 40 years and older with a new diagnosis of COPD or newly active COPD who received appropriate spirometry testing to confirm the diagnosis.

Get your efforts on record!
Make sure your medical records reflect evidence of appropriate spirometry testing for those with newly diagnosed or newly active COPD. Evidence can be taken from:
- Documentation of outpatient visits
- Documentation of acute inpatient encounters, ER or observation visit
- Documentation made for transfers or readmissions

Code your services correctly
Use the following diagnosis and procedure codes to document COPD diagnosis and spirometry testing.

**Codes to identify COPD:**

<table>
<thead>
<tr>
<th>Description</th>
<th>ICD-9-CM Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic bronchitis</td>
<td>491</td>
</tr>
<tr>
<td>Emphysema</td>
<td>492</td>
</tr>
<tr>
<td>COPD</td>
<td>493.2, 496</td>
</tr>
</tbody>
</table>

The codes listed are informational only; this information does not guarantee reimbursement.

**Codes to identify spirometry testing:**

<table>
<thead>
<tr>
<th>Description</th>
<th>CPT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spirometry testing</td>
<td>94010, 94014–94016, 94060</td>
</tr>
<tr>
<td></td>
<td>94070, 94375, 94620</td>
</tr>
</tbody>
</table>

The codes listed are informational only; this information does not guarantee reimbursement.

**Helpful tips**
- Perform a spirometry test for individuals who present with dyspnea, chronic cough, increased sputum production or wheezing.
- To support a COPD diagnosis, document in the medical record spirometry testing performed prior to the initiation of pharmacotherapy treatment.
- Educate patients about the use of and compliance with prescribed treatments:
  - Long-term medications
  - Quick-relief medications
  - Smoking cessation counseling
  - Breathing training
  - Oxygen treatments
  - Using meter-dose inhalers
  - Avoiding elements that trigger attacks, such as dust, pollen, smoking and secondary smoke, cold air, and pets
- Talk to your Provider Relations representative about if scheduling a health screening clinic day in your community is a possibility. Our staff may be able to help you plan, implement and evaluate events for a particular screening like an annual wellness check or a comprehensive spirometry screening event for patients with respiratory problems.

Proper coding decreases the need for medical record reviews and helps us meet the HEDIS measure for quality reporting based on the care provided. The codes listed are informational only; this information does not guarantee reimbursement.

Your state contract (e.g. Medicare, Medicaid, etc.) and state Medicaid and CMS guidelines determine reimbursement for the applicable codes.
How we can help
We help you meet this benchmark by:

- Offering you our HEDIS Measure Desktop Reference Guide and posting the COPD Clinical Practice Guidelines on our provider self-service website
- Coordinating with you to plan focused health prevention clinic days to improve health awareness by providing health screenings, activities, materials and resources if available in your state
- Educating members about COPD through health education material
- To find out more information, please contact your Provider Relations representative or Health Promotion department

Other available resources
You can find more information and tools online at:

- goldcopd.org
- guidelines.gov/content.aspx?id=15437

Notes
Proper coding decreases the need for medical record reviews and helps us meet the HEDIS measure for quality reporting based on the care provided. The codes listed are informational only; this information does not guarantee reimbursement. Your state contract (e.g. Medicare, Medicaid, etc.) and state Medicaid and CMS guidelines determine reimbursement for the applicable codes.

Upper respiratory infections: Children ages 3 months-18 years

This HEDIS measure looks at the percentage of our members 3 months to 18 years old who were given a diagnosis of Upper Respiratory Infection (URI) and were not dispensed an antibiotic prescription.

Educate your patients
Educating patients on the difference between bacterial and viral infections is a key point in the success of this measure.
- Be equipped to teach patients about the real cause of their illness and explain how using antibiotics when they’re not needed can be harmful and cause antibiotic resistance.
- Don’t let your patients pressure you into writing antibiotic prescriptions for URIs.
- Educate patients the effects of frequently using antibiotics for a viral infection by using educational tools that are available.

Code your services correctly
The codes listed are informational only; this information does not guarantee reimbursement.
Use the following diagnosis codes to identify URI:

<table>
<thead>
<tr>
<th>Description</th>
<th>ICD-9-CM Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute nasopharyngitis (common cold)</td>
<td>460</td>
</tr>
<tr>
<td>URI</td>
<td>465.x</td>
</tr>
</tbody>
</table>

Helpful tips
- Post educational materials in your waiting room and treatment areas for patients.
- Focus your discussion on things patients can do to treat the symptoms of URI and the common cold like:
  - Getting extra rest
  - Drinking plenty of fluids
  - Treating the symptoms with over-the-counter medications
  - Using a cool mist vaporizer/nasal spray for congestion
  - Using ice chips or throat spray/lozenges for sore throats
- If a parent/caregiver insists on an antibiotic:
  - Refer to the illness as a common cold; parents and caregivers tend 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.

Educating patients on the difference between bacterial and viral infections is a key point in the success of this measure.
- Be equipped to teach patients about the real cause of their illness and explain how using antibiotics when they’re not needed can be harmful and cause antibiotic resistance.
- Don’t let your patients pressure you into writing antibiotic prescriptions for URIs.
- Educate patients the effects of frequently using antibiotics for a viral infection by using educational tools that are available.
How we can help
We offer Clinical Practice Guidelines (CPGs) on our provider self-service site to help improve health care quality and reduce unnecessary variation in care for our members.

Other resources
You can find print and online tools on the Centers for Disease Control and Prevention website as part of the Get Smart: Know When Antibiotics Work campaign.

Go to www.cdc.gov/getsmart for these helpful materials and more:
• Prescription Pad for Viral Infection (4” x 6” handout)
• Get Smart: Know When Antibiotics Work (podcast)
• Cold or Flu. Antibiotics Don’t Work for You. (brochure)

Notes
Weight assessment and nutritional counseling: Children 3-17 years old

This HEDIS measure looks at the percentage of patients age 3-17 years of age who had one or more outpatient visits with PCPs or OB-GYNs and documented evidence of all the following during the measurement year:

- Body Mass Index (BMI) percentile
- Counseling for nutrition
- Counseling for physical activity

Remember: A nutritional evaluation and anticipatory guidance are required as part of the routine health check visit!

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

- Date of visit
- Weight and height
- BMI percentile documented or plotted on a growth chart
- Documentation of BMI expressed as kg/m² for adolescents 16-17 years of age
- Have a checklist to indicate nutrition and physical activity was addressed and document details of the same

Code your services correctly!
Use the following diagnosis and procedure codes to document weight assessment and counseling for nutrition and physical activity:

<table>
<thead>
<tr>
<th>Description</th>
<th>CPT</th>
<th>ICD-9</th>
<th>Medical Record Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>BMI percentile</td>
<td></td>
<td>V85.51–V85.54</td>
<td>Height, weight and percentile</td>
</tr>
</tbody>
</table>
| Counseling for nutrition, physician only*  | 99401, 99402 | V65.3 with V85.53 and V85.54 | 1. Engagement in discussion of behaviors  
2. Checklist indicating counseling addressed  
3. Counseling or referral  
4. Educational materials given to member |
| Counseling for nutrition, dietician only*  | 97802, 97804 | V65.3         |                                                                                             |
| Counseling for physical activity           |            | V65.41        |                                                                                             |

*Counseling for nutrition (V65.3) is only reimbursable when billed with a diagnosis code for overweight (V85.53) or obese (V85.54) children.

The codes listed are informational only; this information does not guarantee reimbursement.
Helpful tips

- Measure height and weight at least annually; for 16- and 17-year-olds only, you may either calculate BMI percentile or document the values alone.
- 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 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 was provided during the visit, anticipatory guidance for nutrition, obesity or overweight discussion that was done.
- When counseling for physical activity, document 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.

How we can help
We may help you meet this benchmark by offering¹:

- Free pediatric BMI wheels for use in your practice
- Reimbursement for you for nutritional counseling given to overweight and obese children younger than age 21
- Free Weight Watchers* vouchers to obese members (minimum 10 years of age); you must bill a diagnosis code for obesity on the claim

¹Offerings on these vary by state.
Contact your local Provider Relations representative to find out if these specific tools and programs are offered in your area.

Notes
Well-child visits: Children 0-15 months old

This HEDIS measure looks at the percentage of patients who turned 15 months old during the measurement year and had at least six well-child visits with a primary care provider (PCP) during that time.

Record your efforts

- Follow the American Academy of Pediatrics Bright Futures Recommendations for Preventive Pediatric Health Care periodicity schedule for well visits and services per your state’s guidelines.
- Document each well visit in the member’s medical record.
- Complete all six well visits by 15 months of life.
- Make sure your medical records reflect all the following:
  - Six well-child visits with a PCP completed at least two weeks apart
  - A medical history
  - Physical and mental developmental histories
  - A physical exam
  - Health education and anticipatory guidance

Code your services correctly

Use the following diagnosis and procedure codes to document comprehensive well-child visits:

<table>
<thead>
<tr>
<th>CPT</th>
<th>MOD</th>
<th>ICD-9-CM Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>99381, 99382, 99391, 99392, 99461</td>
<td>EP</td>
<td>V20.2, V20.3X, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9</td>
</tr>
</tbody>
</table>

The codes listed are informational only; this information does not guarantee reimbursement.

If you encounter abnormalities or address a pre-existing problem during a well-child visit and the problem/abnormality is significant enough to require additional work to perform the key components of problem-oriented E&M services, be sure to bill both the appropriate EPSDT visit code and the appropriate E&M code with modifier EP and 25.

Helpful tips

- Use your member roster to contact patients who are due for an exam or are new to your practice.
- Ask your Provider Relations representative about missed care opportunity reports.
- Schedule the next visit at the end of the appointment.
- If you use electronic health records (EHRs), consider creating a flag to track patients due or past due for a visit.
- If you do not use EHRs, consider creating a manual tracking method. Sick visits may be a missed opportunity for your patient to get a wellness exam.
- Consider extending your office hours into the evening, early morning or weekend to accommodate working parents.

Proper coding decreases the need for medical record reviews and helps us meet the HEDIS measure for quality reporting based on the care provided. The codes listed are informational only; this information does not guarantee reimbursement. Your state contract (e.g. Medicare, Medicaid, etc.) and state Medicaid and CMS guidelines determine reimbursement for the applicable codes.
Proper coding decreases the need for medical record reviews and helps us meet the HEDIS measure for quality reporting based on the care provided. The codes listed are informational only; this information does not guarantee reimbursement. Your state contract (e.g. Medicare, Medicaid, etc.) and state Medicaid and CMS guidelines determine reimbursement for the applicable codes.

How we can help
We help you get our members in your care in for their well-child visits by:
- Keeping you up-to-date on members overdue for services
- Assisting with patient scheduling
- Offering incentives and drawings for prizes to encourage members to get preventive care; contact your Provider Relations representative or Health Promotion department.

Notes
________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________
Well-child visits: Children 3-6 years old

This HEDIS measure looks at the percentage of patients ages 3 to 6 years of age who had one or more comprehensive well-child visits with a primary care provider (PCP) during the measurement 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 per your state’s guidelines. Sick visits may be missed opportunities for your patient to get health checks; complete an annual exam during the sick visit.
- Document each well visit in the member’s medical record.
- Make sure your medical records reflect all the following:
  - A note indicating a visit to a PCP
  - The date the well-child visit occurred
  - Physical and mental development histories
  - A physical exam
  - Health education and anticipatory guidance

Code your services correctly

Use the following diagnosis and procedure codes to document comprehensive well-child visits:

<table>
<thead>
<tr>
<th>CPT</th>
<th>Mod</th>
<th>ICD-9-CM Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>99382, 99383, 99392, 99393</td>
<td>EP</td>
<td>V20.2, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9</td>
</tr>
</tbody>
</table>

The codes listed are informational only; this information does not guarantee reimbursement.

If you encounter abnormalities or address a pre-existing problem during a well-child visit and the problem/abnormality is significant enough to require additional work to perform the key components of problem-oriented E&M services, be sure to bill both the appropriate EPSDT visit code and the appropriate E&M code with modifier 25.*

<table>
<thead>
<tr>
<th>EPSDT visit code</th>
<th>E&amp;M sick visit code</th>
</tr>
</thead>
<tbody>
<tr>
<td>99382–99383</td>
<td>99211 – 25</td>
</tr>
<tr>
<td>99392–99393</td>
<td>99212 – 25</td>
</tr>
</tbody>
</table>

*Include modifier EP where required.

The codes listed are informational only; this information does not guarantee reimbursement.

Helpful tips

How we can help

We help you get our members in your care in for their well-child visits by:
- Keeping you up-to-date on members overdue for services
- Assisting with patient scheduling
- Offering incentives and drawings for prizes to encourage members to get preventive care; contact your Provider Relations representative or Health Promotion department for details

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