Geisinger
Health Plan

HEDIS information 2018

What is HEDIS?

- HEDIS stands for Healthcare Effectiveness Data and Information Set.
- HEDIS is a set of standardized quality measures that are used by health plans to measure the performance of important aspects of care and service.
- The National Committee for Quality Assurance (NCQA) coordinates and administers the program.
- The Centers for Medicare & Medicaid Services (CMS) uses this information to monitor the performance of managed care organizations.
- HEDIS measures focus on prevention and screening over a broad range of important health issues.
- Results are used to measure performance, identify quality initiatives and provide educational opportunities for providers and members.

What is a provider's role in HEDIS?

The medical records you provide during HEDIS reviews supply the accurate information needed to validate the quality of care provided to our members.

Providers play an essential role in promoting the health of our members. Your office can help increase HEDIS scores by discussing the importance of preventive health screenings and exams with our members. Some HEDIS measures are included in our pay-for-performance programs, so increasing scores may positively impact your payout for these programs. Most importantly, reinforcing preventive care compliance with our members will ultimately improve their health outcomes. You can assist with this by doing the following:

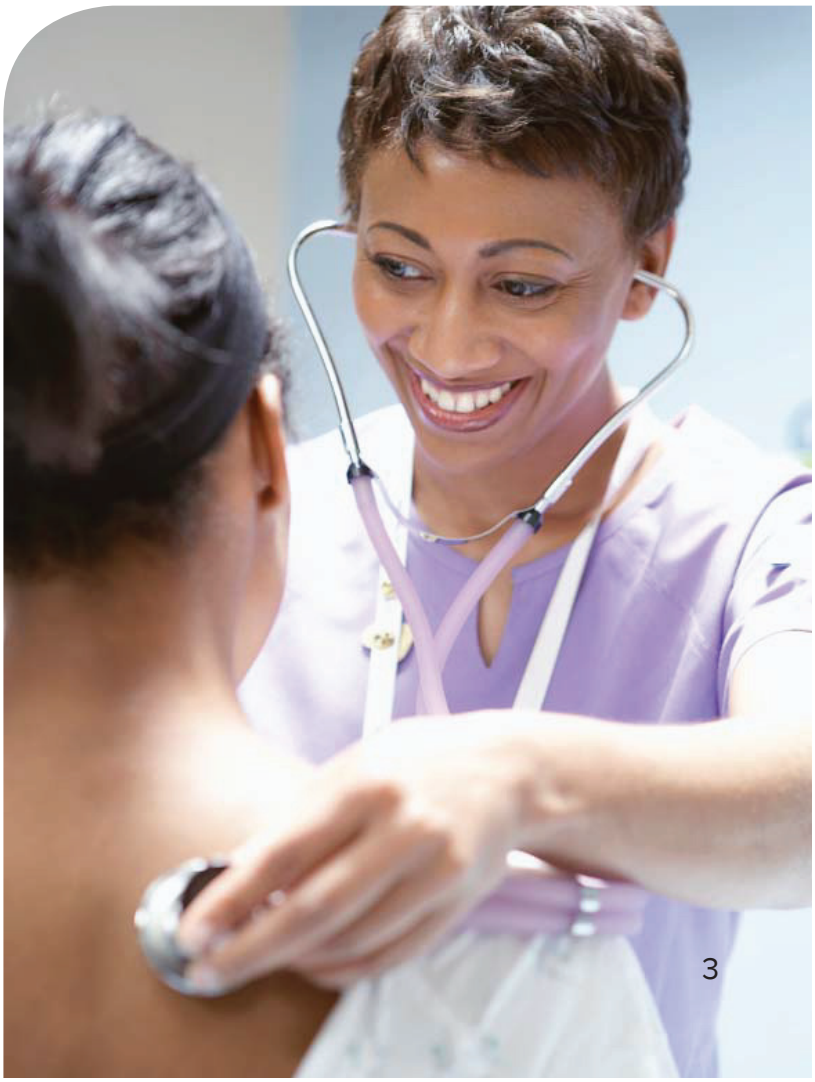
- Periodically review your Member Health Alerts report on NaviNet.net to identify any gaps in care and reach out to patients identified as noncompliant.
- Accurately code all claims. Since HEDIS measures are linked to specific coding criteria, accuracy of coding is critical. Providing accurate information may also reduce the number of records requested.
- Respond promptly to our requests for medical records.
- Document all components of care in the patient's medical record.
- Encourage our members to obtain preventive screenings, such as cervical cancer screening, mammography and colorectal cancer screening.

Geisinger Health Plan also reaches out to noncompliant members to encourage them to schedule the appropriate preventive services and screenings. Together we can help members to lead healthier lives and achieve better outcomes.

Key HEDIS 2018 measures

* *Physician Quality Summary (PQS) measure*

** *Medicaid Pay-for-Quality (P4Q) measure*



Childhood immunization status

Percentage of children who received all of the required immunizations on or before their second birthday

Diptheria, tetanus, acellular pertussis (DTaP) — Four immunizations required with different dates of service between 42 days after birth and child's second birthday

Polio (IPV) — Three immunizations required with different dates of service between 42 days after birth and child's second birthday

Measles, mumps, rubella (MMR) — One immunization required with a date of service on or before second birthday; each antigen can be given individually, but all must be given to count

Haemophilus B (HiB) — Three immunizations required with different dates of service between 42 days after birth and child's second birthday

Hepatitis B (Hep B) — Three immunizations required with different dates of service on or before the second birthday

Varicella (VZV) — One immunization required with date of service on or before child's second birthday; if only the year is reported in the medical record, use Dec. 31 of that year as the date

Pneumococcal (PCV) — Four immunizations required with different dates of service between 42 days after birth and child's second birthday

Hepatitis A (Hep A) — One immunization required with date of services on or before the second birthday

Rotavirus — Must receive required number of vaccinations on different dates of service between 42 days after birth and child's second birthday; the following combinations are compliant:

- Two doses of the two-dose vaccine
- One dose of the two-dose vaccine and two doses of the three-dose vaccine
- Three doses of the three-dose vaccine

Influenza — Two immunizations required with dates of service between six months after birth and the child's second birthday

For MMR, HepB, HepA and VZV, count any of the following:

- *Evidence of antigen or combination of vaccine*
- *Seropositive test result for each antigen*
- *Documented history of the illness*

For DTaP, IPV, HiB, PCV, rotavirus and influenza, count only evidence of the antigen or combination vaccine

Commonly used codes for childhood immunizations

90698 — Diptheria, tetanus toxoids, acellular pertussis vaccine
90700 — DTAP immunization
90721 — DTAP/HIB vaccine
90723 — Diptheria, tetanus, pertussis, hepatitis B vaccine
90633 — Hepatitis A vaccine, ped/adolescent, intramuscular use
90740 — Hepatitis B vaccine
90744 — Hepatitis B vaccine, under 11
90748 — Hepatitis B and hemophilus influenza B vaccine
90655 — Influenza virus vaccine, 6 – 35 month dose, split virus, preservative-free
90657 — Influenza virus vaccine, 6 – 35 month dose, intramuscular
90661 — Influenza virus vaccine derived from cell cultures
90662 — Influenza virus vaccine, split virus, preservative-free
90673 — Flu vaccine RIV3, no preservative
90685 — Influenza virus vaccine, quadrivalent, split virus
90687 — Influenza virus vaccine, quadrivalent, split virus
90705 — Measles immunization
90707 — MMR virus immunization
90708 — Measles-rubella immunization
90704 — Mumps immunization
90669 — Pneumococcal conjugate vaccine, 7 valent, for intramuscular use
90670 — Pneumococcal vaccine, 13 valent, for intramuscular use
90681 — Rotovirus vaccine, human, attenuated, 2-dose schedule, live, oral use
90680 — Rotavirus vaccine, tetravalent, live, oral use
90706 — Rubella immunization
90716 — Chicken pox vaccine
90645 — Hemophilus influenza B vaccine, conjugate, intramuscular use
90647 — Hemophilus influenza B vaccine, 3-dose, intramuscular use
90648 — Hemophilus influenza B vaccine, 4-dose, intramuscular use

Exclusions

K56.1 — Intussusception
T80.52XA — Anaphyllactic reaction due to vaccination, initial encounter

Immunizations for adolescents

Percentage of adolescents 13 years of age who received all of the required immunications

Meningococcal or meningococcal polysaccharide vaccine — One required on or between the 11th and 13th birthdays

Tetanus, diptheria and pertussis (Tdap) vaccine — One required on or between the 10th and 13th birthdays

Human papillomavirus vaccine (HPV) — Required between the 9th and 13th birthday (male and female); two-dose HPV (at least 146 days between the first and second dose) or three-dose HPV (different dates of service)

Codes commonly used for this measure

T80.52XA — Anaphylactic reaction due to vaccination, initial encounter
90649 — Human papilloma virus vaccine
90650 — HPV vaccine types 16 and 18, bivalent, 3-dose schedule
90644 — HIB/MEN/TT vaccine, intramuscular use
90734 — Meningococcal conjugate vaccine, serogroups A,C,Y and W-135
90715 — Tetanus, diphtheria toxoids and acellular pertussis vaccine

Weight assessment and counseling for nutrition and physical activity for children/adolescents

Percentage of children and adolescents 3 – 17 years of age who had a visit with a PCP or OB/GYN and have documentation of the following:

- BMI percentile, including height and weight, documented in the chart or plotted on an age growth chart (ranges and thresholds do not count)
- Counseling for nutrition documented in the chart, or ICD-10 code Z71.3 submitted on a claim
- Counseling for physical activity documented in the chart or ICD-10 code Z02.5 submitted on a claim

Codes commonly used for this measure

Z68.51 — Body mass index (BMI) pediatric, less than 5th percentile for age
Z68.52 — Body mass index (BMI) pediatric, 5th percentile to less than 85th percentile for age
Z68.53 — Body mass index (BMI) pediatric, 85th percentile to less than 95th percentiale for age
Z68.54 — Body mass index (BMI) pediatric, greater than or equal to 95th percentile for age
Z71.3 — Dietary counseling and surveillance
Z71.82 — Exercise counseling
Z02.5 — Encounter for examination for participation in sport
97802 — Medical nutrition therapy, initial assessment
97803 — Medical nutrition therapy, reassessment
97804 — Medical nutrition therapy, group

Adult BMI assessment

Percentage of adults 18 – 74 years of age who had an outpatient visit during the year or the prior year and have documentation of the following:

- BMI percentile documented in the chart (ranges and thresholds do not count)
- For adults younger than 20 years of age on the date of service, the BMI percentile, height, weight, or BMI plotted on a BMI graph is acceptable
- Adults 20 years and older on the date of service must have documentation of BMI value and weight in the chart.

Commonly used codes for this measure

ICD10 code	Adult BMI
Z68.1	19 or less
Z68.20	20.0 – 20.9
Z68.21	21.0 – 21.9
Z68.22	22.0 – 22.9
Z68.23	23.0 – 23.9
Z68.24	24.0 – 24.9
Z68.25	25.5 – 25.9
Z68.26	26.0 – 26.9
Z68.27	27.0 – 27.9
Z68.28	28.0 – 28.9
Z68.29	29.0 – 29.9
Z68.30	30.0 – 30.9
Z68.31	31.0 – 31.9
Z68.32	32.0 – 32.9
Z68.33	33.0 – 33.9
Z68.34	34.0 – 34.9
Z68.35	35.0 – 35.9
Z68.36	36.0 – 36.9
Z68.37	37.0 – 37.9
Z68.38	38.0 – 38.9
Z68.39	39.0 – 39.9
Z68.41	40.0 – 44.9
Z68.42	45.0 – 49.9
Z68.43	50.0 – 59.9
Z68.44	60.0 – 69.9
Z68.45	70 or greater

Appropriate treatment for children with upper respiratory infection (URI)

Percentage of children 3 months – 18 years of age diagnosed with URI only and *not* prescribed an antibiotic on or within 3 days after the episode

- Children having claims/encounters with any competing diagnosis on or within three days after the episode are excluded.
- Children on an antibiotic within 30 days before the URI episode are excluded.

Codes used to identify URI

J00 — Acute nasopharyngitis (common cold)
J06.0 — Acute laryngopharyngitis
J06.9 — Acute upper respiratorty infection, unspecified

Note: The comorbid condition and competing diagnosis code listing is very large. This list can be requested from your provider account manager.

Appropriate testing for children with pharyngitis

Percentage of children 3 – 18 years of age diagnosed with pharyngitis and prescribed an antibiotic; outpatient, observation and emergency department visits included

- Strep test completed for diagnosis of pharyngitis with antibiotic prescribed (evidence of test done three days prior to three days after the date of service)
- Children with unresolved chronic condition(s) prior to the episode are excluded.
- Children on an antibiotic within 30 days before the pharyngitis episode are excluded.

Codes used to identify pharyngitis

J02.0 — Streptococcal pharyngitis
J02.8 — Acute pharyngitis due to other specified organisms
J02.9 — Acute pharyngitis, unspecified
J03.00 — Acute streptococcal tonsillitis, unspecified
J03.01 — Acute recurrent streptococcal tonsillitis
J03.80 — Acute tonsillitis due to other specified organisms
J03.81 — Acute recurrent tonsillitis due to other specified organisms
J03.90 — Acute tonsillitis, unspecified
J03.91 — Acute recurrent tonsillitis, unspecified
J03.01 — Acute recurrent streptococcal tonsillitis

Codes billable for strep

87070 — Culture specimen, bacteria
87071 — Culture, bacterial/identification of isolates
87081 — Bacteria culture screen
87430 — Streptococcus, group A
87650 — Streptococcus, group A, direct probe technique
87651 — Streptococcus, group A, amplified probe technique
87652 — Streptococcus, group A, quantification
87880 — Streptococcus, group A

Avoidance of antibiotic treatment in adults with acute bronchitis

Percentage of adults 18 – 64 years of age diagnosed with acute bronchitis and prescribed an antibiotic on or within 3 days after the episode

- Antibiotics are not indicated in clinical guidelines for the treatment of adults with acute bronchitis who do not have a comorbidity or other infection for which antibiotics may be appropriate.
- Adults with comorbid conditions or competing diagnoses are excluded.

Codes used to identify acute bronchitis

J20.3 — Acute bronchitis due to coxsackie virus
J20.4 — Acute bronchitis due to parainfluenza virus
J20.5 — Acute bronchitis due to respiratory syncytial virus
J20.6 — Acute bronchitis due to rhinovirus
J20.7 — Acute bronchitis due to echovirus
J20.8 — Acute bronchitis due to other specified organisms
J20.9 — Acute bronchitis, unspecified

Note: The comorbid condition and competing diagnosis code listing is very large. This list can be requested from your provider account manager.

Colorectal cancer screening

Percentage of adults 50 – 75 years of age who had the appropriate screening for colorectal cancer

Acceptable screenings include:

- Fecal occult blood test (FOBT) — *Note: FOBT performed in an office setting or on a sample collected by digital rectal exam (DRE) does not meet criteria.*
- Fecal immunochemical test (FIT-DNA; e.g., Cologuard) performed during the measurement year or up to two years prior
- Flexible sigmoidoscopy performed during measurement year or up to four years prior
- CT colonography (virtual colonoscopy) performed during measurement year or up to four years prior
- Colonoscopy during the measurement year or up to nine years prior
- Members with a history of colorectal cancer or total colectomy are excluded from the measure.

Commonly used codes for this measure

45378 — Diagnostic colonoscopy
45380 — Colonoscopy and biopsy
45385 — Colonoscopy, lesion removal
74263 — CT colonography, screen
G0105 — Colorectal cancer screening; colonoscopy on individual at high risk
G0121 — Colorectal cancer screening; colonoscopy on individual not meeting high risk criteria
81528 — FIT-DNA
45332 — Sigmoidoscopy
45338 — Sigmoidoscopy
45339 — Sigmoidoscopy
81528 — Oncology (colorectal) screening quantitative real time target
82270 — Test feces for blood
82274 — Blood, occult, by fecal hemoglobin determined by immunoassay, qualitative

Breast cancer screening

Women 50 – 74 years of age who had a mammogram between October two years prior to the measurement through Dec. 31 of the measurement year

This measure evaluates primary screening. Do not count biopsies, breast ultrasounds or MRIs because they are not appropriate methods for primary breast cancer screening. Women who have had a bilateral mastectomy are excluded from this measure. Diagnostic mammograms and tomosynthesis (3D mammograms) are acceptable.

Commonly used codes for this measure

77055 — Mammogram, one breast
77056 — Mammogram, both breasts
77057 — Screening mammography, bilateral/2-view film study of each breast

Exclusions

Z90.12 — Acquired absence of left breast and nipple
Z90.11 — Acquired absence of right breast and nipple
Z90.13 — Acquired absence of bilateral breasts and nipples
19180 — Removal of breast
19200 — Removal of breast
19220 — Removal of breast
19240 — Removal of breast
19303 — Mastectomy, simple, complete
19304 — Mastectomy, subsequent
19305 — Mastectomy, radical
19306 — Mastectomy, radical, urban type
19307 — Mastectomy, modified radical

Cervical cancer screening/non-recommended cervical cancer screening in adolescent females

Women 21 – 64 years of age who had one or more cervical cytology performed every three years

- Women age 30 – 64 who had cervical cytology and HPV co-testing ordered and collected on the same date of service every 5 years
- Women who have had a total hysterectomy can be excluded

Commonly used codes for this measure

88150 — Cytopathology, pap smear
88152 — Cytopathology smears with manual cytotechnologist
87620 — Papillomavirus, human, direct probe technique
87621 — Papillomavirus, human, amplified probe technique
87622 — Papillomavirus, human, quantification
87624 — Infectious agent detection by nucleic acid (DNA or RNA); human papillomavirus (HPV), high-risk types; when both low-risk and high-risk HPV types are performed in a single assay, use only 87624
87625 — Infectious agent detection by nucleic acide (DNR or RNA); human papillomavirus (HPV), types 16 and 18 only; includes type 45, if performed
G0476 — HPV combo assay cancer screen, high-risk

Exclusions

57540 — Removal of residual cervix
58150 — Total hysterectomy
58260 — Vaginal hysterectomy
58290 — Vaginal hysterectomy, radical (Schauta type operation)
58550 — Laparoscopy hysterectomy
58954 — Bilateral salpingo-oophorectomy with omentectomy, total abdominal hysterectomy and radical dissection for debulking; with pelvic lymphadenectomy and limited para-aortic lymphadectomy
Q51.5 — Agenesis and aplasia of cervix
Z90.710 — Acquired absence of both cervix and uterus
Z90.712 — Acquired absence of cervix with remaining uterus

Chlamydia screening in women

Percentage of women 16 – 24 years of age identified as sexually active and who have had at least one test for chamydia during the measurement year

- Women who are pregnant are excluded from the measure
- Members on oral contraceptives for any reason are included in this measure

CPT codes used to identify chlamydia screening are 87110, 87270, 87320, 87490, 87491, 87492 and 87810.

Note: The list of additional commonly used codes is very large and can be requested from your provider account manager.

Osteoporosis management in women who had a fracture

Percentage of women 67 – 85 years of age who suffered a fracture and had either a bone mineral density test or prescription for a drug to prevent osteoporosis within 6 months after the date of fracture

- Women who suffer a fracture are at increased risk of additional fractures and more likely to have osteoporosis.
- Fractures of the finger, toe, face or skull are not included in this measure.
- Members living in a long-term care facility are excluded from the measure.

Note: The list of additional commonly used codes is very large and can be requested by contacting your provider account manager.

Controlling high blood pressure

Adults 18 – 85 years of age identified as hypertensive prior to June 30 of the measurement year, whose most recent blood pressure reading (after June 30) is controlled; blood pressure result must be the last reading in the measurement year

This measure is strictly reliant on medical record review.

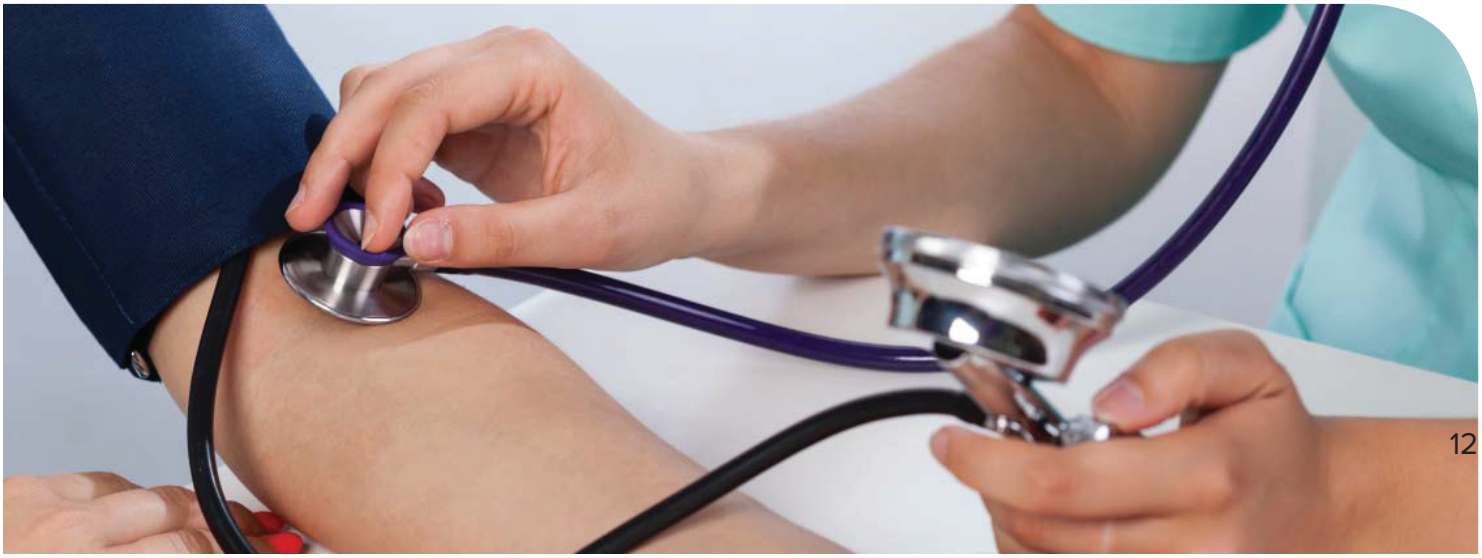
- 18 – 59 years old with a BP less than 140/90 mmHg
- 60 – 95 years old with a diagnosis of diabetes and a BP less than 140/90 mmHg
- 60 – 85 years old with no diagnosis of diabetes and a BP less than 150/90 mmHg

Members who have a slightly elevated BP during an office visit should be encouraged to have it retaken sometime during the visit.

If multiple BP readings are taken on the same day, use the lowest systolic and diastolic BP reading.

The most commonly used code for this measure is I10 — Essential (primary) hypertension.

Members living in a long-term care facility are excluded from the measure.



Comprehensive diabetes care

Adults with type 1 and type 2 diabetes 18 – 75 years of age who had each of the following in the measurement year:

- **HbA1c level** – count the most recent HbA1c test in the measurement year; may also count A1c, hemoglobin A1c, HgbA1c, glycated hemoglobin, glycosylated hemoglobin or glycohemoglobin A1c
  Level should be less than 7 percent, or less than 8 percent if the member is over age 65

  Commonly used codes for this measure

  3044F — Most recent HGB A1C level < 7.0%
  3045F — Most recent HGB A1C level 7.0 – 9.0%
  3046F — Most recent HGB A1C level < 7.0%
  83036 — Glycated hemoglobin test
  83037 — Hemoglobin, glycosylated by device cleared by FDA for home

- **Blood Pressure** – most recent BP reading noted in the measurement year
  Level should be less than 140/90 mmHg

  Commonly used codes for this measure

  3074F — Most recent systolic blood pressure < 130 mm Hg
  3075F — Most recent systolic blood pressure 130 – 139 mm Hg
  3077F — Systolic BP
  3078F — Diastolic BP < 80 mm Hg
  3079F — Diastolic BP 80 – 89 mm Hg
  3080F — Diastolic BP

- **Medical attention for diabetic nephropathy** – at least one of the following in measurement year; urine test for albumin or protein, visit to a nephrologist, renal transplant, medical attention for nephropathy or ACE/ARB therapy

  Commonly used codes for this measure

  3066F — Documentation of treatment for nephropathy
  4010F — ACE/ARB therapy prescribed or currently being taken

- **Eye exam, dilated or retinal** – every two years if negative for retinopathy; every year if postive for nephropathy

  Commonly used codes for this measure

  92002 — Eye exam, intermediate, new patient
  92004 — Eye exam, comprehensive, new patient
  92012 — Eye exam, established patient
  92225 — Special eye exam, initial
  92226 — Special eye exam, subsequent
  92230 — Eye exam with photos
  92235 — Eye exam with photos
  92250 — Eye exam with photos
  92203 — Office/outpatient visit, new
  92204 — Office/outpatient visit, new
  92205 — Office/outpatient visit, new
  92213 — Office/outpatient visit, established
  99214 — Office/outpatient visit, established
  99215 — Office/outpatient visit, established
  99242 — Office consultation
  99243 — Office consultation
  99244 — Office consultation
  99245 — Office consultation
  3072F — Retinal screening negative
  S0620 — Routine ophthalmological exam including refraction, new patient
  S0621 — Routine ophthalmological exam including refraction, established patient
  2022F — Dilated retinal exam with interpretation by ophthalmologist or optometrist
  2026F — Eye imaging validated to match diagnosis

Pharmacotherapy management of COPD exacerbation

Adults 40 years of age and older who had an acute inpatient discharge or emergency department encounter for COPD exacerbation on or between Jan. 1 and Nov. 30 of the measurement year and were:

- Dispensed a systemic corticosteroid within 14 days of the event
- Dispensed a bronchodilator within 30 days of the event

Codes used to identify members with COPD

J41.0 — Simple chronic bronchitis
J41.1 — Mucopurulent chronic bronchitis
J41.8 — Mixed simple and mucopurulent chronic bronchitis
J42 — Unspecified chronic bronchitis
J44.0 — COPD with acute lower respiratory infection
J44.1 — COPD with acute exacerbation
J44.9 — COPD, unspecified
J43.0 — Unilateral pulmonary emphysema (MacLeod's syndrome)
J43.1 — Panlobular emphysema
J43.2 — Centrilobular emphysema
J43.8 — Other emphysema
J43.9 — Emphysema, unspecified

Disease-modifying anti-rheumatic drug therapy for rheumatoid arthritis (RA)

Members diagnosed with rheumatoid arthritis and who were dispensed at least one ambulatory prescription for a disease-modifying antirheumatic drug (DMARD) during the calendar year

Evidence-based guidelines support early initiation of DMARD therapy in patients diagnosed with RA. It is important that the diagnosis is confirmed, since these drugs can be costly and damaging if RA does not exist.

GHP will deny the second claim in a calendar year submitted by a primary care provider with an RA diagnosis, if the member has not been seen by a rheumatologist within the previous two calendar years. If the RA diagnosis is an error, the claim can be submitted for payment without the RA diagnosis.

Note: The rheumatoid arthritis code list is very large and can be requested by contacting your provider account manager.

Prenatal and postpartum care

Women who deliver a live birth are assessed for the following facets of prenatal and postpartum care:

- **Prenatal care** – percentage of deliveries who have received a prenatal care visit in the first trimester, or within 42 days of enrollment. A prenatal visit must include one or a combination of the following:
    1. Basic physical or obstetrical exam including auscultation for fetal heart tone, pelvic exam with obstetric observations, or measurement of fundus height
    2. Evidence that a prenatal care procedure was performed, such as
        a. Obstetric panel
        b. TORCH antibody panel
        c. Echograph of pregnant uterus
    3. Documentation of LMP or EDD in conjunction with either a complete obstetrical history or a prenatal risk assessment and counseling/education
- **Postpartum care** – percentage of deliveries who have a postpartum visit on or between 21 days and 56 days after delivery; the visit notes must include documentation of one of the following;
    1. Pelvic exam
    2. Evaluation of weight, BP, breasts and abdomen
    3. Notation of postpartum care

Note: The prenatal and postpartum code list is very large and can be requested from your provider account manager.

Well child visits in the first 15 months of life

Percentage of children who had 6 or more well child visits with a primary care practitioner during their first 15 months of life

Documentation in the medical record must include evidence of all of the following:

- Health history
- Physical development history
- Mental development history
- Physical exam
- Health education/anticipatory guidelines

This measure does not include any visits rendered during in inpatient or emergency department visit.

Commonly used codes for this measure

99381 — Preventive visit, new infant
99382 — Preventive visit, new, age 1 – 4
99391 — Preventive visit, established, infant
99392 — Preventive visit, established, age 1 – 4
99461 — Initial newborn E&M per day, non-facility
Z00.110 — Health exam, newborn under 8 days old
Z00.111 — Health exam, newborn 8 – 28 days old
Z00.121 — Routine child health exam with abnormal findings
Z00.129 — Routine child health exam without abnormal findings
Z00.8 — Other general examination
Z02.79 — Issue of other medical certificate
Z02.81 — Paternity testing
Z02.82 — Adoption services
Z02.89 — Other administrative examinations
Z02.9 — Adminstrative examinations, unspecified

Well child visits in the third, fourth, fifth and sixth years of life

Percentage of children 3 – 6 years of age who received 1 or more well child visits with a primary care practitioner during the measurement year

Documentation in the medical record must include evidence of all of the following:

- Health history
- Physical development history
- Mental development history
- Physical exam
- Health education/anticipatory guidelines

This measure does not include visits rendered during an inpatient or emergency department visit.

Commonly used codes for this measure

99382 — Preventive visit, new, age 1 – 4
99383 — Preventive visit, new, age 5 – 11
99392 — Preventive visit, established, age 1 – 4
99393 — Preventive visit, established, age 5 – 11
Z00.121 — Routine chld health examination with abnormal findings
Z00.129 — Routine child health examination without abnormal findings
Z00.8 — Other general examination
Z02.2 — Examination for admission to residential institution
Z02.6 — Examination for insurance purposes
Z02.71 — Examination for disability determination
Z02.79 — Examination for issue of other medical certificate
Z02.81 — Paternity testing
Z02.82 — Adoption services
Z02.89 — Other administrative examinations
Z02.9 — Administrative examinations, unspecified

Adolescent well care visits

Percentage of children 12 – 21 years of age who received at least one comprehensive well care visit with a primary care practitioner or OB/GYN during the measurement year

Documentation in the medical record must include evidence of all of the following:

- Health history
- Physical development history
- Mental development history
- Physical exam
- Health education/anticipatory guidelines

This measure does not include visits rendered during an inpatient or emergency department visit.

Commonly used codes for this measure

99384 — Preventive visit, new, age 12 – 17
99385 — Preventive visit, new, age 18 – 39
99394 — Preventive visit, established, age 12 – 17
99395 — Preventive visit, established, age 18 – 39
Z00.00 — General adult medical examination without abnormal findings
Z00.01 — General adult medical examination with abnormal findings
Z00.121 — Routine chld health examination with abnormal findings
Z00.129 — Routine child health examination without abnormal findings
Z00.8 — Other general examination
Z02.0 — Examination for admission to educational institution
Z02.2 — Examination for admission to residential institution
Z02.3 — Examination for recruitment to armed forces
Z02.4 — Examination for driving license
Z02.5 — Examination for participation in sport
Z02.6 — Examination for insurance purposes
Z02.71 — Examination for disability determination
Z02.79 — Examination for issue of other medical certificate
Z02.81 — Paternity testing
Z02.82 — Adoption services
Z02.89 — Other administrative examinations
Z02.9 — Administrative examinations, unspecified

Lead screening in children (CHIP and Medicaid only)

Percentage of children 2 years of age who received one or more lead capillary or venous lead blood tests for lead poisoning by their second birthday

Providers should encourage parents to have their children tested before age two. If a high lead level is detected, children should be rescreened, and providers should recommend a home assessment to determine the source

Commonly used code for this measure

83655 — Assay for lead

Annual dental visit (CHIP and Medicaid only)

Percentage of children 2 – 20 years of age who had at least one dental visit during the measurement year

Dental caries in children are the most prevalent disease of childhood, occurring five times more frequently than asthma. Dental disease in children can lead to serious general health problems, significant pain, interference with eating, overuse of emergency department visits and lost school time.

Any visit with a dental provider counts.

Care for older adults

Adults age 66 years of age and older who had each of the following in the calendar year:

- Advance care planning or discussion documented
- Medication review
- Functional assessment that includes instrumental activities of daily living (IADLs) or activities of daily living (ADLs)
- Pain screening — assessment of current pain level or absence of pain

Commonly used codes for this measure

1125F — Pain severity quantified, pain present
1126F — Pain severity quantified, no pain present
1157F — Advanced care plan present in medical record
1158F — Advanced care plan discussion documented in medical record
1159F — Medication list documented in medical record
1160F — Review of medications by prescriber or pharmacist documented in medical record
1170F — Functional status assessed
90863 — Pharmacologic management with psychotherapy services
99497 — Advanced care planning, including the explanation and discussion of advanced directives
99605 — Medication therapy management services, new patient
99606 — Medication therapy management services, established patient

Potentially harmful medications in the elderly

Drug/disease interactions in members 65 years of age and older

- History of falls and a prescription for an anticonvulsant, nonbenzodiazepine hypnotic, SSRI, antiemetic, antipsychotic, benzodiazepine or tricyclic antidepressant
- Dementia and a prescription for an antiemetic, antipsychotic, benzodiazepine, tricyclic antidepressant, H2 receptor antagonist, nonbenzodiazepine hypnotic or anticholinergic agent
- Chronic kidney disease and a prescription for a cox-2 selective NSAID or non-aspirin NSAID

Updated medication included in this measure can be found on the 2016 Beers criteria list found on the American Geriatrics website.

Note: The list of potentially harmful drug interactions in the elderly is very large and can be requested from your provider account manager.

Medication reconciliation post discharge (SNP only)

Medicare members 18 years of age and older for whom medications were reconciled within the date of discharge through 30 days after discharge (31 days total)

- Provider reconciles current medications and discharge medications.
- The medical record includes documentation of current medications with a notation that references the discharge medications.
- The medical record includes documentation of current medications with a notation that the discharge mediations were reviewed.
- The medical record includes documentation of current medications, a discharge medication list and a notation that both lists were reviewed on the same date of service.
- The medical record includes documentation that the medications prescribed or ordered upon discharge were reconciled with the current medications by an RN, prescribing provider or clinical pharmacist.
- There is documentation of a post discharge follow up visit with medication reconciliation.
- There is documentation that no medications were prescribed or ordered upon discharge.

Commonly used codes for this measure

1111F — Discharge medications reconciled with current medication list in outpatient medical record
99495 — Transitional care management services, 14 day discharge
99496 — Transitional care management services, 7 day discharge

Emergency department utilization

Members 18 years and older who have had an emergency department visit during the measurement year

- Count an ED visit once, regardless of intensity or duration. Multiple ED visits on the same day are counted as one visit.
- Do not include ED visits that result in an inpatient stay.
- Exclude members with a principal diagnosis of mental and behavioral disorders, psychiatric patients, electroconvulsive therapy and alcohol or drug rehabilitation or detoxification.

Medication management and ratio for people with asthma

Members 5 – 64 years of age identified as having asthma and given a prescription that they remained on during 50 percent or more of the treatment period

Exclusions:

- Emphysema
- COPD
- Obstructive chronic bronchitis
- Chronic respiratory conditions due to fumes/vapors
- Cystic fibrosis
- Acute respiratory failure

Codes used to identify members with asthma

J96.00 — Acute respiratory failure, unspecified whether with hypoxia or hypercapnia
J96.01 — Acute respiratory failure with hypoxia
J96.02 — Acute respiratory failure with hypercapnia
J96.20 — Acute and chronic respiratory failure, unspecified whether with hypoxia or hypercapnia
J96.21 — Acute and chronic respiratory failure with hypoxia
J966.22 — Acute and chronic respiratory failure with hypercapnia
J45.20 — Mild intermittent asthma, uncomplicated
J45.21 — Mild intermittent asthma with (acute) exacerbation
J45.22 — Mild intermittent asthma with status asthmaticus
J45.30 — Mild persistent asthma, uncomplicated
J45.31 — Mild persistent asthma with (acute) exacerbation
J45.32 — Mild persistent asthma with status asthmaticus
J45.40 — Moderate persistent asthma, uncomplicated
J45.41 — Moderate persistent asthma with (acute) exacerbation
J45.42 — Moderate persistent asthma with status asthmaticus
J45.50 — Severe persistent asthma, uncomplicated
J45.51 — Sever persisten asthma with (acute) exacerbation
J45.52 — Severe persistent asthma with status asthmaticus
J45.901 — Unspecified asthma with (acute) exacerbation
J45.902 — Unspecified asthma with status asthmaticus
J45.909 — Unspecified asthma, uncomplicated
J45.990 — Exercise-induced bronchospasm
J45.991 — Cough variant asthma
J45.998 — Other asthma
J68.4 — Chronic respiratory conditions due to chemicals, gases, fumes and vapors
J44.0 — Chronic obstructive pulmonary disease with acute lower respiratory infection
J44.1 — Chronic obstructive pulmonary disease with (acute) exacerbation
J44.9 — Chronic obstructive pulmonary disease, unspecified
E84.0 — Cystic fibrosis with pulmonary manifestations
E84.11 — Meconium ileus in cystic fibrosis
E84.19 — Cystic fibrosis with other intestinal manifestations
E84.8 — Cystic fibrosis with other manifestations
E84.9 — Cystic fibrosis, unspecified
J43.0 — Unilateral pulmonary emphysema (MacLeod's syndrome)
J43.1 — Panlobular emphysema
J43.2 — Centrilobular emphysema
J43.8 — Other emphysema
J43.9 — Emphysema, unspecified
J98.2 — Interstitial emphysema
J98.3 — Compensatory emphysema

Pharmacy medication adherence

Members prescribed medications for diabetes or hypertension need to be monitored appropriately. Reminders by the provider for taking prescribed medications is very important in preventing complications. Discussion of healthy diet, exercise and side effects of medication can reduce the risk of diabetes and hypertension. Routine visits to the member's PCP can keep health issues under control.

Reducing potential readmissions

Percentage of Medicaid members with inpatient acute care discharges and subsequent readmissions to inpatient acute care within 30 days of the initial inpatient acute care discharge

- Exclude discharges from non-acute facilities (i.e., skilled nursing facilities, rehabilitiation, etc.)
- Do not consider transfers from and inpatient actue care facility to a non-acute inpatient facility as a readmission

Transitions of care (Medicare only)

Medicare members 18 years of age and older who had an acute or nonacute inpatient discharge between Jan. 1 and Dec. 1 of the measurement year

Documentation must include:

- Notification of inpatient admission on the day of admission or the following day to the member's PCP or ongoing care provider
- Documentation of discharge information on the day of discharge or the following day to member's PCP or ongoing care provider
- Documentation of patient engagement (i.e., office visits, visits to the home, telehealth) within 30 days after discharge to the members PCP or ongoing care provider
- Medication reconciliation post-discharge on the date of discharge through 30 days after discharge (31 total days) to the member's PCP or ongoing care provider

Commonly used codes for this measure

**1111F — ** Discharge medications reconciled with current medication list in outpatient medical record
99495 — Transitional care management services, 14 day discharge
99496 — Transitional care management services, 7 day discharge
98966, 98967, 98968, 99441, 99442, 99443 — Telephonic visits