california health & wellness™

HEDIS® 2018–2019 Provider Pocket Guide

MEDI-CAL

Measure	Childhood Immunization Status (CIS) – Combo 3	Well-Child Visit in the Third, Fourth, Fifth, and Sixth Years of Life (W34)	Immunizations for Adolescents (IMA) – Combo 2	Breast Cancer Screening (BCS)	Cervical Cancer Screening (CCS)
Provider Action	All vaccinations need to be on or before a child's second birthday: Combo 3 vaccines: DTaP (4), IPV (3), HiB (3), Hep B (3), MMR (1),* VZV (1),* PCV (4) *Vaccines need to be administered on or between the child's first and second birthdays. Medical record must include: • Member name • Date of birth • Date of service immunization was administered (not ordered) and one of the following: – a note indicating the name of the specific antigen or immunization – a certificate of immunization prepared by an authorized health care provider or agency, including types of immunizations administered – documented history of illness or a seropositive test result; there must be a note indicating the date of event, which must have occurred by the member's second birthday – notes in the medical record indicating that the member received the immunization "at delivery" or "in the hospital" (applies to Hep B only) **Note:** Submit all immunizations to the immunization registry to ensure continuity of care. Makeup immunizations that occur after the member's second birthday will not count. Members who do not complete their 4th DTaP or 4th PCV due to being on a makeup schedule will also not count.	Children ages 3, 4, 5, and 6 who had one or more well-child visits with a PCP during the measurement year. Well-child visits must include the following: • Make sure to document and submit both the correct CPT code and ICD-10 code to indicate the well-child visit was provided. • A PCP must perform the well-child visit but does not have to be the assigned PCP. • Documentation must include evidence of all the following: – a health history – a physical developmental history – a mental developmental history – a physical exam – health education/anticipatory guidance This measure applies to patients who were ages 3–6 as of December 31 of the measurement year.	• Administer 1 Tdap vaccine on or between the member's 10th and 13th birthdays. • Administer 1 meningococcal serogroups A, C, W, Y vaccine on or between the member's 11th and 13th birthdays. • Administer at least 2 human papillomavirus vaccines on or between the member's 9th and 13th birthdays. **Note:** There must be at least 146 days between the 1st and 2nd dose for the two-dose series. • Ask about vaccination status when patients come in for sick visits and sports physicals. • Document the name of the specific antigen and date of immunization.	Women ages 50–74 who have had one or more mammograms any time on or between October 1 two years prior to the measurement year and December 1 of the measurement year. 	Schedule and complete a cervical cancer screening when a member is due based on the following guidelines: • Ages 21–64: cervical cytology every 3 years. • Ages 30–64: cervical cytology and human papillomavirus co-testing every 5 years. (Use 5-year time frame only if HPV co-testing was completed on the same day and includes results. Reflex testing will not count.) • Documentation should always include date of service, test name and results. • Record information in the medical record for services completed in the office or done elsewhere on an annual basis. • Document for history of total hysterectomy (TAH or TVH), or radical abdominal or vaginal hysterectomy and bill ICD-10 codes for any of the following: Acquired absence of: both cervix and uterus, cervix with remaining uterus, or agenesis and aplasia of cervix. **Note:** Documentation of a "hysterectomy" alone does not count.
Coding	All vaccines in the Combo 3 series need to be completed in order to count for HEDIS. Any services completed after the second birthday are noncompliant. • **DTap:** CPT 90698, 90700, 90721, 90723 • **IPV:** CPT 90698, 90713, 90723 • **Hib:** CPT 90644–90648, 90698, 90721, 90748 • **Hep B:** CPT 90723, 90740, 90744, 90747, 90748 • **MMR:** CPT 90707, 90710 or Measles/Rubella 90708, Measles 90705, Rubella 90706, Mumps 90704 • **VZV:** CPT 90710, 90716 • **PCV:** CPT 90669, 90670; HCPCS G0009 **Exclusions:** • **Anaphylactic reaction:** T80.52XA, T8052XD, T80.52XS Provide the appropriate diagnosis for disorders of the immune system, encephalopathy, malignant neoplasm of lymphatic tissue, intussusception, vaccine causing adverse effects, or HIV.	**CPT codes/ICD-10-CM codes:** • **Well-child visit:** 99382, 99383, 99392, 99393/Z00.121, Z00.129, Z00.5, Z00.8, Z02.0, Z02.1–Z02.6, Z02.71, Z02.79, Z02.81–Z02.83, Z02.89, Z02.9 	**CPT codes/ICD-10-CM codes:** • **Meningococcal vaccine:** 90734 • **Tdap vaccine:** 90715 • **HPV vaccine:** 90649–90651 **Exclusions:** • **Anaphylactic reaction:** T80.52XA, T8052XD, T80.52XS	**CPT/ICD-10-PCS codes:** • **Mammography for 2018:** 77061–77063, 77065–77067 **Exclusions:** • **Bilateral mastectomy open approach:** OHTV0ZZ • **History of bilateral mastectomy:** Z90.13	**CPT codes:** **Codes for ordering labs:** • **Cervical cytology:** 88141–88143, 88147, 88148, 88150, 88152–88154, 88164–88167, 88174, 88175 • **HPV:** 87620–87622 **Surgical codes:** • **Absence of cervix:** 51925, 56308, 57540, 57545, 57550, 57555, 57556, 58150, 58152, 58200, 58210, 58240, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290–58294, 58548, 58550–58554, 58570–58573, 58951, 58953, 58954, 58956, 59135 • **ICD-10 codes:** Q5105, Z90.710, Z90.712 **Exclusion codes:** • **Abdominal hysterctomy:** 0UT90ZL, UT90ZZ, UT94ZL, 0UT94ZZ, 0UTC0ZZ, 0UTC4ZZ • **Vaginal hysterectomy:** 0UT97ZL, 0UT98ZL, 0UT9FZL

18-540
BRO024723EO00 (9/18)

Measure	Prenatal and Postpartum Care (PPC) (Prenatal Care)	Prenatal and Postpartum Care (PPC) (Postpartum Care)	Annual Monitoring for Patients on Persistent Medications (MPM)	Asthma Medication Ratio (AMR)	Controlling Blood Pressure (CBP)	Comprehensive Diabetes Care (CDC)
Provider Action	Schedule patients for their first prenatal visit in their first trimester or within 42 days of becoming a California Health & Wellness Plan member. • **PCP:** Visits must include documentation of a diagnosis of pregnancy, the prenatal care visit date and evidence of one of the following: – evidence that a prenatal procedure was performed, such as a screening test/obstetric panel, TORCH antibody panel alone, rubella antibody test/titer with an Rh incompatibility (ABO/Rh) blood typing, or ultrasound/echography of a pregnant uterus – documentation of last menstrual period (LMP) or estimated date of delivery (EDD) in conjunction with either a prenatal risk assessment and counseling/education or a complete obstetrical history (gravida, para, abortions (GPA)) and a primary diagnosis of pregnancy • **OB/GYN:** Visit must be billed with one of the following: – a pregnancy diagnosis – TORCH panel – obstetrical panel (hematocrit, WBC count, platelet count, hepatitis B, surface antigen, rubella antibody, syphilis test, RBC antibody screen, Rh and ABO blood typing) – prenatal ultrasound – rubella/Rh or rubella/ABO – a prenatal visit billed with all of the following completed on the same date of service: toxoplasma antibody, rubella, cytomegalovirus, and herpes simplex – in addition to fetal heart tone, pelvic exam with obstetrical observations and fundus height, documentation in medical record must include tests, outcomes and completed dates of service vs. ordered dates. **Note:** Members who switch health plans need to follow up with the provider within 42 days of switching, regardless of whether they have seen the same provider for care. The provider must document, at the very least, the LMP/EDD with obstetrical history (GPA) on the date of service with a primary diagnosis of pregnancy at the visit. The visit can be with a PCP or an OB/GYN.	Documentation of a postpartum care visit with an OB/GYN practitioner, midwife, family practitioner, or other PCP on or between 21–56 days after delivery. Documentation must include notation of postpartum visit, and assessment of breast, abdomen, blood pressure, and pelvic. **Note:** A Pap exam within 21–56 days after delivery also can be used. • Must also include the following: – Pelvic exam, or – Evaluation of weight, BP, breasts, and abdomen, or – Notation of "postpartum care," PP check, PP care, 6-week check, etc. 	Members ages 18 and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent and at least one therapeutic monitoring event for the therapeutic agent in the measurement year. • Monitor your patients on the following medications to ensure their safety: – angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARBs) – diuretics – antihypertensive combination drugs • Annually order the appropriate lab tests (serum potassium and serum creatinine).	Patients ages 5–64 who have a medication ratio of 0.50 or greater of controller medications to total asthma medications during the measurement year. • Ensure members are accurately diagnosed with persistent asthma. • Ensure that asthma medication, especially controller medication, is being dispensed to the patient in accordance with the proper medication schedule or need. • Submit claims correctly and in a timely manner. Correct encounters/claims with erroneous diagnosis.	Patients ages 18–85 who had at least two diagnoses of hypertension in measurement year or prior and whose blood pressure was adequately controlled during the measurement year based on the following criteria: • Most recent blood pressure reading occurring on or after the second diagnosis of hypertension was <140/90mm Hg (139/89 or less). 	Schedule and complete services for members ages 18–75 with diagnosis of diabetes on an annual basis to assist with health maintenance of the disease processes. The following services are required: • Order at least 1 HbA1c screening annually. Repeat test if A1c is greater than 7.9%. • Collect A1c data completed during inpatient visits or elsewhere in order to evaluate if a repeat test is required. • Ensure retinal screenings are completed annually. • Review, document and bill CPT II codes for retinal screenings completed by an eye care professional. • Bill CPT II codes for negative screenings from prior year screenings within the measurement year. • Bill retinal screenings completed by the PCP and sent off site for review with a professional and technical component. Bill the professional component with ophthalmologist/optometrist National Provider Identifier (NPI) and technical component with PCP NPI. • Documentation of eye exams completed need to have date of service completed, outcome, name of service completed, and name of eye care provider who performed the service. • Kidney disease monitoring (any one of the following will count): – Urine protein tests (microalbumin/macroalbumin, random, spot, 24-hour, urine dipstick (protein)) – Dispensed ACE/ARB medication – Consultation with nephrologist (if appropriate) – Document all services in the medical record – Bill CPT II codes for dipsticks completed in office – Adequate control of blood pressure <140/90mm Hg (139/89 or less) is preferred. Measure accepts last BP of the measurement year.
Coding	**CPT codes/ICD-10-PCS codes:** • **Standalone prenatal visits:** 99500 and 0500F–0502F procedure codes meet the requirements when billed by an OB/GYN or a PCP (must include primary diagnosis of pregnancy). Global billing codes billed at time of delivery will not count. • **Prenatal visit during first trimester:** 99201–99205, 99211–99215 and 99241–99245 visits require a primary diagnosis of pregnancy along with the noted tests as referenced under best practices. PCPs can begin the orders for the appropriate tests noted above before referring to an OB/GYN: – **OB panel:** 80055 – **Prenatal ultrasound:** 76801, 76805, 76811, 76813, 76815–76821, 76825–76828/BY49ZZZ, BY4BZZZ, BY4CZZZ, BY4DZZZ, BY4FZZZ, BY4GZZZ – **Toxoplasma antibody:** 86777, 86778 – **Rubella antibody:** 86762 – **Cytomegalovirus antibody:** 86644 – **Herpes simplex antibody:** 86694–86696 – **ABO:** 86900 – **Rh:** 86901 **ICD-10-CM codes:** Please refer to the 2018 ICD-10-CM code book from The American Academy of Professional Coders for additional codes.	**CPT codes:** • **Postpartum visit:** 57170, 58300, 59430, 99501/0503F • **Cervical cytology:** 88141–88143, 88147, 88148, 88150–88154, 88164–88167, 88174, 88175 **ICD-10-CM codes:** • **Postpartum visit:** Z01.411, Z01.419, Z01.42, Z30.430, Z39.1–Z39.2	**CPT codes:** • **Lab panel:** 80047, 80048, 80050, 80053, 80069 or • **Serum creatinine:** 82565, 82575 • **Serum potassium:** 80051, 84132	Prescription claims data is evaluated. **ICD-10-CM codes:** • **Asthma:** J45.20–J45.22, J45.30–J45.32, J45.40–J45.42, J45.50–J45.52, J45.901–J45.902, J45.909, J45.990–J45.991, J45.998 **Exclusions:** • **Emphysema:** J43.0, J43.1, J43.2, J43.8, J43.9 • **Other emphysema:** J98.2–J98.3 • **COPD:** J44.0, J44.1, J44.9 • **Chronic respiratory conditions due to fumes/vapors:** J68.4 • **Cystic fibrosis:** E84.0, E84.11, E84.19, E84.8–E84.9 • **Acute respiratory failure:** J96.00–J96.02, J96.20–J96.22	**CPT/CPT Cat. II codes:** • **Systolic:** 3074F, 3075F, 3077F • **Diastolic:** 3078F, 3079F, 3080F **ICD-10-CM codes:** • **Hypertension:** I10, I11.9, I12.9, I13.10	**CPT/CPT Cat. II codes:** • **HbA1c:** 83036 • **HbA1c fingerstick in office:** 83037 • **A1c value:** 3044F, 3045F, 3046F • **Eye exam (NPI of ophthalmologist/optometrist is required for the following codes to count):** 67028, 67030, 67031, 67036, 67039–67043, 67101, 67105, 67107, 67108, 67110–67113, 67121, 67141, 67145, 67208, 67210, 67218, 67220, 67221, 67227, 67228, 92002, 92004, 92012, 92014, 92018, 92019, 92134, 92225–92228, 92230, 92235, 92240, 92250, 92260, 99203–99205, 99213–99215, 99242–99245 • **Include modifiers for technical and professional components when billing 92227 and 92228 for digital imaging systems and remote interpretation.** • **92250 should be billed with the ophthalmologist's NPI in order to count.** • **Eye care providers can bill the following as no evidence of retinopathy:** E10.9, E11.9, E13.9 • **PCP can bill the following eye exam codes when service is completed by an eye care professional:** 2022F, 2024F, 2026F • **Diabetic retinal screening negative in prior year (PCP):** 3072F • **Nephropathy screening (protein urine test):** 81000–81003, 81005, 82042–82044, 84156/3060F, 3061F, 3062F • **Nephropathy treatment:** 3066F, 4010F