Quality Reporting and Performance Measures
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GAPEC-2252-17

February 2018
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Introduction

For over 10 years, Amerigroup Community Care has focused solely on meeting the health care needs of Georgia’s most financially vulnerable Americans. Throughout this time, we have coordinated our members’ physical and behavioral health care while offering a continuum of education, access, care and outcomes that result in lower cost, improved quality and better health status for our members.

Our members are enrolled in one of two programs that provide managed care services in the state of Georgia:

- **Georgia Families** is the statewide program designed to deliver health care services to Medicaid and PeachCare for Kids® members. Amerigroup began operations in the Atlanta service region on June 1, 2006, and on September 1, 2006, for the East, North and Southeast service regions. On February 1, 2012, operations expanded to the remainder of the state in the Central and Southwest service regions. The Georgia Families contact with the Department of Community Health (DCH) was renewed and effective July 1, 2017.
- **Georgia Families 360°SM (GF360)** is the statewide program designed to deliver healthcare services to children and youth in foster care, adoption assistance and certain youth in the Department of Juvenile Justice (DJJ) system. On March 3, 2014, Amerigroup became the only care management organization in the state of Georgia responsible for the well-being and health care coordination of over 27,000 of the state’s most vulnerable children and youth through the GF360 program. Amerigroup recognizes the unique circumstances of these members, such as exposure to trauma through abuse and/or neglect, complex behavioral and physical health conditions, high utilization of psychotropic medications, and frequent placement changes.

In accordance to the Institute of Medicine (IOM) study committee, quality of care is the degree to which health services for individuals and populations increase the likelihood of desired outcomes and are consistent with current professional knowledge. (Institute of Medicine, 1990)

At Amerigroup, we are dedicated to offering real solutions that improve health care access and quality of care for our members, while proactively working to reduce the overall cost of care to taxpayers. We look to you, our providers, to render high-quality care to our members as we work together to make a difference in the lives of those we serve.
Quality reporting and performance measures

To keep ourselves accountable to the DCH, you and our members, we compare our performance against benchmarks for certain quality performance measures developed by agencies such as the National Committee for Quality Assurance (NCQA), the Agency for Healthcare Research & Quality (AHRQ), and the Centers for Medicare & Medicaid Services (CMS). The reporting of these performance measure rates is a contractual requirement with target performance levels set by DCH and is used for public reporting by the agency.

The performance measures that are reported may come from the following sources:

- Healthcare Effectiveness Data and Information Set (HEDIS®), a tool created by NCQA to measure performance in care and service
- Adult and Child Core Set — health care quality measures developed by CMS to better understand the quality of health care that Medicaid members receive

The overall intent of this booklet is to provide an overview of certain quality performance measures and the requirements, and/or recommendations of services that should be performed to meet those measures as well as provide guidance on how to apply correct coding for those services. The booklet is based on information from the following resources:

- American Academy of Pediatrics Bright Futures Guidelines — published 2017
- Advisory Committee on Immunization Practices (ACIP) Immunization Schedule — published 2017
- NCQA HEDIS Technical Specifications — published 2017
- Georgia DCH Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services Manual (Health Check Program) — published 2017

Proper coding is critical to ensuring accurate reporting of these measures, and it may also decrease the need for medical record reviews. Accurate coding not only helps us assess your performance on the quality of care that is provided to our members, but also helps to accurately report rates. In working together to meet these targets, we improve overall quality of care, which leads to better health outcomes for our members — your patients.

<table>
<thead>
<tr>
<th>Medical record data, reporting and requests</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Responsible:</strong></td>
</tr>
<tr>
<td>Health plan</td>
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<tr>
<td></td>
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<tr>
<td></td>
</tr>
<tr>
<td>Provider</td>
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</tbody>
</table>

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

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Remember when providing services for our members:

- Providers contracted with Amerigroup must perform all required components of an EPSDT visit as outlined in the *DCH EPSDT* manual.
- In accordance with federal regulation, a provider is not required to exhaust other health plan benefits with respect to EPSDT preventive health screenings. Even if the member has other health insurance, you may file Medicaid first for preventive health services as outlined in *Part 1 Policies and Procedures for Medicaid and PeachCare for Kids*. This will ensure accurate and timely reporting of EPSDT services.
- Providers are encouraged to see newly enrolled Georgia Families members within 90 calendar days of health plan enrollment to establish a primary medical care relationship and complete a medical assessment.
- Providers are encouraged to see members newly entering or re-entering the GF360 program within 10 calendar days to establish a primary medical care relationship and complete a medical assessment as outlined in DCH’s EPSDT program. Children and adolescents in the GF360 program *may require more frequent EPSDT services than what is listed in the Bright Futures Periodicity Schedule*.
- Preventive health visits (well visits) should be completed per the *Bright Futures Periodicity Schedule*:
  - Example — John’s birthday is April 1. He had his three-year preventive health visit on November 30, 2017. John is eligible for his next health check at any time on or after April 1, 2018.
- Sick visits are missed opportunities to complete a preventive health visit. Amerigroup allows reimbursement for preventive health visits (well visits) that include sick visits. Be sure to bill modifier 25 with the applicable Evaluation and Management (E&M) code (CPT codes 99211-99212) for the sick visit as well as the appropriate diagnosis codes for respective visits.
- The appropriate EPSDT HIPAA referral code should be documented on the EPSDT claim when an EPSDT visit has occurred to document whether or not problems were identified during the preventive health visit and a referral is needed for further diagnostic and treatment services:
  - NU — normal, no follow-up visit needed
  - AV — available, not used: Patient refused referral.
  - SZ — under treatment: Patient is currently under treatment for health problem and has a return visit.
  - ST — new services requested: Referral to another provider for diagnostic or corrective treatment/scheduled.

While the codes contained within this booklet align with HEDIS, CMS and EPSDT reporting, the information *does not guarantee reimbursement*; however, proper coding can lead to optimal reimbursement. Your provider contract, Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes.

*The information contained within this booklet does not dictate or control your clinical decisions regarding the appropriate care of our members. All member care and related decisions about treatment are the sole responsibility of the provider.*
We are here to help! If you have any questions or would like additional information, please contact one of the departments in the table below.

<table>
<thead>
<tr>
<th>Information or questions on the following:</th>
<th>Contact:</th>
</tr>
</thead>
<tbody>
<tr>
<td>GF360 members (Foster Care, Adoptive Assistance and Department of Juvenile Justice)</td>
<td>GF360 Intake team at 1-855-661-2021</td>
</tr>
<tr>
<td>Georgia Families members (Medicaid and PeachCare for Kids)</td>
<td>Quality Management team at 1-800-454-3730, ext. 74868 or local 678-587-4868</td>
</tr>
<tr>
<td>Quality performance measures</td>
<td>Quality Management team at 1-800-454-3730, ext. 74868 or local 678-587-4868</td>
</tr>
<tr>
<td>Any additional questions</td>
<td>Your local Provider Relations representative — Visit <a href="http://providers.amerigroup.com/GA">http://providers.amerigroup.com/GA</a>, select the Contact Us link at the top of the webpage and then open the PDF file entitled Your Local Provider Relations Representative.</td>
</tr>
</tbody>
</table>
References

In addition to the other resource sections contained within this booklet, below are additional resources and references:

- Advisory Committee on Immunization Practices immunization schedule — https://www.cdc.gov/vaccines/schedules/hcp/child-adolescent.html
- American Academy of Pediatric Dentistry periodicity schedule — http://www.aapd.org/assets/1/7/Periodicity-AAPDSchedule.pdf
- American Academy of Pediatrics — www.aap.org
- Our provider self-service website — https://providers.amerigroup.com/GA
- Bright Futures — www.brightfutures.org
- Georgia Department of Community Health (DCH) — http://dch.georgia.gov/medicaid
- Georgia Department of Public Health — https://dph.georgia.gov
- National Committee for Quality Assurance HEDIS and performance measurement — www.ncqa.org/hedis-quality-measurement
- National Quality Forum — www.qualityforum.org

Please note: The codes and tips listed do not guarantee reimbursement. The information provided is based on HEDIS 2018 technical specifications and the 2018 CMS technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.
### Recommendations for Preventive Pediatric Health Care

#### Bright Futures

#### American Academy of Pediatrics

The following recommendations are aimed at providing comprehensive health supervision for children and adolescents. They are designed to support the health and well-being of all children and families. These recommendations are intended for use by pediatricians and other health care providers in the delivery of preventive pediatric care.

#### Preventive health care

<table>
<thead>
<tr>
<th>AGE</th>
<th>Prenatal</th>
<th>Newborn</th>
<th>1 mo</th>
<th>2 mo</th>
<th>4 mo</th>
<th>6 mo</th>
<th>9 mo</th>
<th>12 mo</th>
<th>15 mo</th>
<th>18 mo</th>
<th>24 mo</th>
<th>30 mo</th>
<th>36 mo</th>
<th>42 mo</th>
</tr>
</thead>
<tbody>
<tr>
<td>19 y</td>
<td>20 y</td>
<td>21 y</td>
<td>22 y</td>
<td>23 y</td>
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<td>25 y</td>
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<td>43 y</td>
<td>44 y</td>
<td>45 y</td>
<td>46 y</td>
<td>47 y</td>
<td>48 y</td>
</tr>
</tbody>
</table>

**Notes:**

- AAP: American Academy of Pediatrics
- GLAD-PC: Healthy Child Wheel
- http://pediatrics.aappublications.org/content/137/1/e20153597
- http://pediatrics.aappublications.org/content/137/1/e20153596
- http://pediatrics.aappublications.org/content/120/5/1183.full

#### Bright Futures Guidelines

- Refers to the specific guidance by age as listed in the table above.

#### American Academy of Pediatrics

- Bright Futures Guidelines
- Refer to the specific guidance by age as listed in the table above.

#### Recommendations for Preventive Pediatric Health Care

- These recommendations represent a consensus by the American Academy of Pediatrics (AAP) for the delivery of comprehensive health supervision and the need to avoid fragmentation of care.

#### Variations

- Variations, taking into account individual circumstances, may be appropriate.

#### Copyright

- Copyright © 2017 by the American Academy of Pediatrics, updated February 2017.

#### Variations

- Variations, taking into account individual circumstances, may be appropriate.

#### Recommendations

- These recommendations may become necessary if requested by parents or are necessary for medical reasons.

#### Evaluation

- Newborns should have an evaluation within 3 to 5 days of birth and within 48 to 72 hours after discharge from the hospital.

#### Breastfeeding

- Breastfeeding should be encouraged (and instruction and support provided) for newborns and for any breastfeeding mother.

#### Tobacco, Alcohol, or Drug Use Assessment

- Risk assessment to be performed with appropriate action to follow, if positive.

#### Autism Spectrum Disorder Screening

- The risk of autism spectrum disorder is increased in families with a history of autism or Down syndrome. The risk is also increased in families with a history of intellectual disability or other developmental delays. The risk is also increased in families with a history of intellectual disability or other developmental delays.

#### Psychosocial/Behavioral Assessment

- This assessment should be performed using a standardized tool that is appropriate for the child’s age and developmental level.

#### Maternal Depression Screening

- The risk of maternal depression is increased in families with a history of depression or anxiety disorders. The risk is also increased in families with a history of cigarette smoking or alcohol use.

#### Developmental Surveillance

- Developmental surveillance should be performed using a standardized tool that is appropriate for the child’s age and developmental level.

#### Physical Examination

- Length/Height and Weight
- Head Circumference
- Newborn Bilirubin
- Newborn Blood
- Initial/Interval
- Ages

#### Health Assessment

- Health assessment should be performed using a standardized tool that is appropriate for the child’s age and developmental level.

#### Tobacco, Alcohol, or Drug Use Assessment

- Risk assessment to be performed with appropriate action to follow, if positive.

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#### Developmental Surveillance

- Developmental surveillance should be performed using a standardized tool that is appropriate for the child’s age and developmental level.
19. Confirm initial screen was accomplished, verify results, and follow up, as appropriate. 
   The Recommended Uniform Newborn Screening Panel (http://www.hrsa.gov/ 
   advisorycommittees/methodology/hospital/inter/heritabledisorders/recommendedpanel/ 
   uniformscreeningpanel.pdf), as determined by The Secretary's Advisory 
   Committee on Heritable Disorders in Newborns and Children, and state newborn screening 
   laws/regulations (http://genes-r-us.uthscsa.edu/sites/genes-r-us/files/ 
   nshdisorderspdf) establish the criteria for and coverage age of newborn screening 
   procedures and programs.

20. Verify results as soon as possible, and follow up, as appropriate.

21. Confirm initial screening was accomplished, verify results, and follow up, 
   as appropriate. See “Hypothyroidism in the Newborn Infant: A 33-Weeks’ 
   Gestation: An Update With Clarifications” (http://pediatrics.aappublications.org/ 
   content/124/4/1935). 

22. Screening for critical congenital heart disease using pulse oximetry should be 
   performed in neonates, after 24 hours of age, before discharge from the hospital, 
   per “Endorsement of Health and Human Services Recommendation for Pulse 
   Oximetry Screening for Critical Congenital Heart Disease” (http://pediatrics. 
   aappublications.org/content/129/4/1195.full).

23. Schedules, per the AAP Committee on Infectious Diseases, are available at 
   http://redbook.solutions.aap.org/SS/Immunization_Schedules.aspx. Every visit 
   should be an opportunity to update and complete a child’s immunizations.

24. See “Diagnosis and Prevention of Iron Deficiency and Iron-Deficiency Anemia 
   in Infants and Young Children: 0–3 Years of Age” (http://pediatrics.aappublications. 
   org/content/126/5/1040.full).

25. For children at risk of lead exposure, see “Low Level Lead Exposure Harms 
   Children: A Renewed Call for Primary Prevention” (http://www.cdc.gov/nceh/lead/ACCLPP/ 

26. Perform risk assessments or screenings as appropriate, based on universal screening 
   requirements for patients with Aicardi or in high prevalance areas.

27. Tuberculosis testing per recommendations of the AAP Committee on Infectious 
   Diseases, published in the current edition of the AAP Red Book: Report of the 
   Committee on Infectious Diseases. Testing should be performed on recognition 
   of high-risk factors.

28. See “Integrated Guidelines for Cardiovascular Health and Risk Reduction in 
   Children and Adolescents” (https://www.nhlbi.nih.gov/health-topics/integrated-guidelines-

29. Adolescents should be screened for sexually transmitted infections (STIs) as 
   recommended in the current edition of the AAP Red Book: Report of the 
   Committee on Infectious Diseases. 

30. Adolescents should be screened for HIV according to the USPSTF 
   recommendations (http://www.uspreventiveservicestaskforce.org/uspstf/uspservih.htm) once 
   between the ages of 15 and 18, making every effort to preserve confidentiality 
   of the adolescent. Those at increased risk of HIV infection, including those who are 
   sexually active, participate in injection drug use, or are being tested for other STIs, 
   should be tested for HIV and reassessed annually.

31. See USPSTF recommendations (http://www.uspreventiveservicestaskforce.org/ 
   uspservih.htm). Indications for pelvic examinations prior to age 21 are noted in 
   “Gynecologic Examination for Adolescents in the Pediatric Office Setting” 
   (http://pediatrics.aappublications.org/content/126/3/583.full).

32. Assess whether the child has a dental home. If no dental home is identified, perform 
   a risk assessment (https://www.aap.org/iskassessmenttool) and refer to a 
   dental home. Recommend brushing with fluoride toothpaste in the proper dosage for age. 
   See “Maintaining and Improving the Oral Health of Young Children” (http:// 
   pediatrics.aappublications.org/content/134/6/1224).

   “Maintaining and Improving the Oral Health of Young Children” (http:// 
   pediatrics.aappublications.org/content/134/6/1224).

34. See USPSTF recommendations (http://www.uspreventiveservicestaskforce.org/ 
   uspservih.htm). Once teeth are present, fluoride varnish may be applied to 
   all children every 3–6 months in the primary care or dental office. Indications 
   for fluoride use are noted in “Fluoride Use in Caries Prevention in the Primary Care 
   Setting” (http://pediatrics.aappublications.org/content/134/3/626).

35. If primary water source is deficient in fluoride, consider oral fluoride supplementation. 
   See “Fluoride Use in Caries Prevention in the Primary Care Setting” (http://pediatrics. 
   aappublications.org/content/134/3/626).

### Summary of Changes Made to the Bright Futures/AAP Recommendations for Preventive Pediatric Health Care (Periodicity Schedule)

This schedule reflects changes approved in February 2017 and published in April 2017. For updates, visit www.aap.org/periodicityschedule.

For further information, see the Bright Futures Guidelines, 4th Edition, Evidence and Rationale chapter (https://brightfutures.aap.org/Bright%20Futures%20Documents/BF4 Evidence_Rationale.pdf).

### Changes Made in February 2017

#### Hearing
- Timing and follow-up of the screening recommendations for hearing during the infancy visits have been delineated. Adolescent risk assessment has changed to screening once during each time period.

- Footnote 8 has been updated to read as follows: “Confirm initial screen was completed, verify results, and follow up, as appropriate. Newborns should be screened, per ‘Year 2007 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs’ (http://pediatrics.aappublications.org/content/120/4/898.full).”

- Footnote 9 has been added to read as follows: “Verify results as soon as possible, and follow up, as appropriate.”

- Footnote 10 has been added to read as follows: “Screen with audiometry including 6,000 and 8,000 Hz high frequencies once between 11 and 14 years, once between 15 and 17 years, and once between 18 and 21 years. See ‘The Sensitivity of Adolescent Hearing Screens Significantly Improves by Adding High Frequencies’ (http://www.jahonline.org/article/S1054-139X(16)00048-3/fulltext).”

#### Psychosocial/Behavioral Assessment
- Footnote 13 has been added to read as follows: “This assessment should be family centered and may include an assessment of child social-emotional health, caregiver depression, and social determinants of health. See ‘Promoting Optimal Development: Screening for Behavioral and Emotional Problems’ (http://pediatrics.aappublications.org/content/135/2/384) and ‘Poverty and Child Health in the United States’ (http://pediatrics.aappublications.org/content/137/4/e20160339).”

#### Tobacco, Alcohol, or Drug Use Assessment
- The header was updated to be consistent with recommendations.
DEPRESSION SCREENING
• Adolescent depression screening begins routinely at 12 years of age (to be consistent with recommendations of the US Preventive Services Task Force [USPSTF]).

MATERNAL DEPRESSION SCREENING
• Screening for maternal depression at 1-, 2-, 4-, and 6-month visits has been added.
• Footnote 16 was added to read as follows: “Screening should occur per ‘Incorporating Recognition and Management of Perinatal and Postpartum Depression Into Pediatric Practice’ (http://pediatrics.aappublications.org/content/126/5/1032).”

NEWBORN BLOOD
• Timing and follow-up of the newborn blood screening recommendations have been delineated.
• Footnote 19 has been updated to read as follows: “Confirm initial screen was accomplished, verify results, and follow up, as appropriate. The Recommended Uniform Newborn Screening Panel (http://www.hrsa.gov/advisorycommittees/mchb/advisory/heritabledisorders/recommendedpanel/uniformscreeningpanel.pdf), as determined by The Secretary’s Advisory Committee on Heritable Disorders in Newborns and Children, and state newborn screening laws/regulations (http://genes-r-us.uthscsa.edu/sites/genes-r-us/files/nbsdisorders.pdf) establish the criteria for and coverage of newborn screening procedures and programs.”
• Footnote 20 has been added to read as follows: “Verify results as soon as possible, and follow up, as appropriate.”

NEWBORN BILIRUBIN
• Screening for bilirubin concentration at the newborn visit has been added.
• Footnote 21 has been added to read as follows: “Confirm initial screening was accomplished, verify results, and follow up, as appropriate. See ‘Hyperbilirubinemia in the Newborn Infant ≥35 Weeks’ Gestation: An Update With Clarifications’ (http://pediatrics.aappublications.org/content/124/4/1193).”

DYSLIPIDEMIA
• Screening for dyslipidemia has been updated to occur once between 9 and 11 years of age, and once between 17 and 21 years of age (to be consistent with guidelines of the National Heart, Lung, and Blood Institute).

SEXUALLY TRANSMITTED INFECTIONS
• Footnote 29 has been updated to read as follows: “Adolescents should be screened for sexually transmitted infections (STIs) per recommendations in the current edition of the AAP Red Book: Report of the Committee on Infectious Diseases.”

HIV
• A subheading has been added for the HIV universal recommendation to avoid confusion with STIs selective screening recommendation.
• Screening for HIV has been updated to occur once between 15 and 18 years of age (to be consistent with recommendations of the USPSTF).
• Footnote 30 has been added to read as follows: “Adolescents should be screened for HIV according to the USPSTF recommendations (http://www.uspreventiv servicestaskforce.org/uspstf/usphivi.htm) once between the ages of 15 and 18, making every effort to preserve confidentiality of the adolescent. Those at increased risk of HIV infection, including those who are sexually active, participate in injection drug use, or are being tested for other STIs, should be tested for HIV and reassessed annually.”

ORAL HEALTH
• Assessing for a dental home has been updated to occur at the 12-month and 18-month through 6-year visits. A subheading has been added for fluoride supplementation, with a recommendation from the 6-month through 12-month and 18-month through 16-year visits.
• Footnote 32 has been updated to read as follows: “Assess whether the child has a dental home. If no dental home is identified, perform a risk assessment (https://www.aap.org/RiskAssessmentTool) and refer to a dental home. Recommend brushing with fluoride toothpaste in the proper dosage for age. See ‘Maintaining and Improving the Oral Health of Young Children’ (http://pediatrics.aappublications.org/content/134/6/1224).”
• Footnote 33 has been updated to read as follows: “Perform a risk assessment (https://www.aap.org/RiskAssessmentTool). See ‘Maintaining and Improving the Oral Health of Young Children’ (http://pediatrics.aappublications.org/content/134/6/1224).”
• Footnote 35 has been added to read as follows: “If primary water source is deficient in fluoride, consider oral fluoride supplementation. See ‘Fluoride Use in Caries Prevention in the Primary Care Setting’ (http://pediatrics.aappublications.org/content/134/3/626).”
Recommended Immunization Schedule for Children and Adolescents Aged 18 Years or Younger, UNITED STATES, 2018

Approved by the
Advisory Committee on Immunization Practices
(www.cdc.gov/vaccines/acip)
American Academy of Pediatrics
(www.aap.org)
American Academy of Family Physicians
(www.aafp.org)
American College of Obstetricians and Gynecologists
(www.acog.org)

This schedule includes recommendations in effect as of January 1, 2018.

Please note: The codes and tips listed do not guarantee reimbursement. The information provided is based on HEDIS 2018 technical specifications and the 2018 CMS technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

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<th>Vaccine type</th>
<th>Abbreviation</th>
<th>Brand(s)</th>
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</thead>
<tbody>
<tr>
<td>Diphtheria, tetanus, and acellular pertussis vaccine</td>
<td>DTaP</td>
<td>DaptacelInfanrix</td>
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<tr>
<td>Diphtheria, tetanus vaccine</td>
<td>DT</td>
<td>No Trade Name</td>
</tr>
<tr>
<td>Haemophilus influenza type B vaccine</td>
<td>Hib (PRP-T)</td>
<td>ArchibHibrixPedvaxHib</td>
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<td>Haemophilus influenza type B vaccine</td>
<td>Hib (PRP-OMP)</td>
<td>ArchibHibrixPedvaxHib</td>
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<td>HepB</td>
<td>Engerix-BRecombivax HB</td>
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<tr>
<td>Human papillomavirus vaccine</td>
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<td>Gardasil 9</td>
</tr>
<tr>
<td>Influenza vaccine (inactive)</td>
<td>IIV</td>
<td>Multiple</td>
</tr>
<tr>
<td>Measles, mumps, and rubella vaccine</td>
<td>MMR</td>
<td>M-M-R II</td>
</tr>
<tr>
<td>Meningococcal serogroups A, C, W, Y vaccine</td>
<td>MenACWY-D</td>
<td>Menactra</td>
</tr>
<tr>
<td>Meningococcal serogroup B vaccine</td>
<td>MenB-4C</td>
<td>Menveo</td>
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<tr>
<td>MenB-FHbp</td>
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</tr>
<tr>
<td>Pneumococcal 13-valent conjugate vaccine</td>
<td>PCV13</td>
<td>Prevnar 13</td>
</tr>
<tr>
<td>Pneumococcal 23-valent polysaccharide vaccine</td>
<td>PPSV23</td>
<td>Pneumovax</td>
</tr>
<tr>
<td>Poliovirus vaccine (inactive)</td>
<td>IPV</td>
<td>OPOL</td>
</tr>
<tr>
<td>Rotavirus vaccines</td>
<td>RV1</td>
<td>Rotarix</td>
</tr>
<tr>
<td>Rotarix</td>
<td>RV1</td>
<td>Rotarix</td>
</tr>
<tr>
<td>Tetanus, diphtheria, and acellular pertussis vaccine</td>
<td>Tdap</td>
<td>AcelgardBoostrix</td>
</tr>
<tr>
<td>Tetanus and diphtheria vaccine</td>
<td>Td</td>
<td>Tenvac No Trade Name</td>
</tr>
<tr>
<td>Varicella vaccine</td>
<td>VAR</td>
<td>Varivax</td>
</tr>
</tbody>
</table>

**Combination Vaccines**

<table>
<thead>
<tr>
<th>Vaccine type</th>
<th>Abbreviation</th>
<th>Brand(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>DTaP, hepatitis B and inactivated poliovirus vaccine</td>
<td>DTaP-HepB-IPV</td>
<td>Pediarix</td>
</tr>
<tr>
<td>DTaP, inactivated poliovirus and Haemophilus influenza type B vaccine</td>
<td>DTaP-IPV/Hib</td>
<td>Pentacel</td>
</tr>
<tr>
<td>DTaP and inactivated poliovirus vaccine</td>
<td>DTaP-IPV</td>
<td>Kinrix Quadracel</td>
</tr>
<tr>
<td>Measles, mumps, rubella, and varicella vaccines</td>
<td>MMRV</td>
<td>ProQuad</td>
</tr>
</tbody>
</table>

The table below shows vaccine acronyms, and brand names for vaccines routinely recommended for children and adolescents. The use of trade names in this immunization schedule is for identification purposes only and does not imply endorsement by the ACIP or CDC.
Figure 1. Recommended Immunization Schedule for Children and Adolescents Aged 18 Years or Younger—United States, 2018.

(FOR THOSE WHO FALL BEHIND OR START LATE, SEE THE CATCH-UP SCHEDULE [FIGURE 2]).

These recommendations must be read with the footnotes that follow. For those who fall behind or start late, provide catch-up vaccination at the earliest opportunity as indicated by the green bars in Figure 1. To determine minimum intervals between doses, see the catch-up schedule (Figure 2). School entry and adolescent vaccine age groups are shaded in gray.

### Vaccine Schedule

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Birth</th>
<th>1 mo</th>
<th>2 mos</th>
<th>4 mos</th>
<th>6 mos</th>
<th>9 mos</th>
<th>12 mos</th>
<th>15 mos</th>
<th>18 mos</th>
<th>19-23 mos</th>
<th>2-3 yrs</th>
<th>4-6 yrs</th>
<th>7-10 yrs</th>
<th>11-12 yrs</th>
<th>13-15 yrs</th>
<th>16 yrs</th>
<th>17-18 yrs</th>
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</thead>
<tbody>
<tr>
<td><strong>Hepatitis B (HepB)</strong></td>
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<tr>
<td><strong>Rotavirus (RV) RV1 (2-dose series); RV5 (3-dose series)</strong></td>
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<td><strong>Diphtheria, tetanus, &amp; acellular pertussis (DTaP) DTaP: &lt;7 yrs</strong></td>
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<td><strong>Pneumococcal conjugate (PCV13)</strong></td>
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<td><strong>Inactivated poliovirus (IPV: &lt;18 yrs)</strong></td>
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<td><strong>Influenza (IIV)</strong></td>
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<td>Annual vaccination (IIV) 1 or 2 doses</td>
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<td><strong>Measles, mumps, rubella (MMR)</strong></td>
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<td><strong>Varicella (VAR)</strong></td>
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<td><strong>Hepatitis A (HepA)</strong></td>
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<td><strong>Meningococcal (MenACWY-D: &gt;9 mos; MenACWY-CRM: ≥2 mos)</strong></td>
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<td><strong>Tdap</strong></td>
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<tr>
<td><strong>Human papillomavirus (HPV)</strong></td>
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<td><strong>Meningococcal B</strong></td>
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<td>See footnote 12</td>
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</table>

**NOTE:** The above recommendations must be read along with the footnotes of this schedule.
FIGURE 2. Catch-up immunization schedule for persons aged 4 months–18 years who start late or who are more than 1 month behind—United States, 2018.

Please note: The codes and tips listed do not guarantee reimbursement. The information provided is based on HEDIS 2018 technical specifications and the 2018 CMS Technical Specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate guidance.

Children age 4 months through 6 years

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Minimum Age for Dose 1</th>
<th>Minimum Interval Between Doses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis B</td>
<td>Birth</td>
<td>Dose 1 to Dose 2: 8 weeks and at least 16 weeks after first dose. Minimum age for the final dose is 24 weeks.</td>
</tr>
<tr>
<td>Rotavirus</td>
<td>6 weeks</td>
<td>Dose 2 to Dose 3: 4 weeks. Maximum age for final dose is 6 months, 0 days.</td>
</tr>
<tr>
<td>Diptheria, tetanus, and acellular pertussis</td>
<td>6 weeks</td>
<td>Dose 3 to Dose 4: 6 weeks. Dose 4 to Dose 5: 6 months.</td>
</tr>
</tbody>
</table>

Haemophilus influenzae type b

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Minimum Age for Dose 1</th>
<th>Minimum Interval Between Doses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pneumococcal conjugate</td>
<td>6 weeks</td>
<td>4 weeks if first dose was administered before the 1st birthday. No further doses needed if first dose was administered at age 15 months or older.</td>
</tr>
</tbody>
</table>

Inactivated poliovirus

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Minimum Age for Dose 1</th>
<th>Minimum Interval Between Doses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measles, mumps, rubella</td>
<td>12 months</td>
<td>4 weeks if current age is &lt; 4 years. 6 months (as final dose) if current age is 4 years or older.</td>
</tr>
<tr>
<td>Hepatitis A</td>
<td>12 months</td>
<td>4 weeks if current age is &lt; 4 years. 6 months (as final dose) if current age is 4 years or older.</td>
</tr>
</tbody>
</table>

Meningococcal (MenACWY-D ≥9 mos; MenACWY-CRM ≥2 mos)

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Minimum Age for Dose 1</th>
<th>Minimum Interval Between Doses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meninfectum</td>
<td>6 weeks</td>
<td>8 weeks if first dose was administered before the 1st birthday. No further doses needed for healthy children if first dose was administered at age 24 months or older.</td>
</tr>
</tbody>
</table>

Children and adolescents age 7 through 18 years

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Minimum Age for Dose 1</th>
<th>Minimum Interval Between Doses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tetanus, diphtheria, tetanus, diphtheria, and acellular pertussis</td>
<td>7 years</td>
<td>4 weeks if first dose of DTaP/DT was administered before the 1st birthday. 6 months (as final dose) if first dose of DTaP/DT or Tdap/Td was administered at or after the 1st birthday.</td>
</tr>
</tbody>
</table>

Human papillomavirus

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Minimum Age for Dose 1</th>
<th>Minimum Interval Between Doses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis A</td>
<td>9 years</td>
<td>Routine dosing intervals are recommended.</td>
</tr>
<tr>
<td>Rotavirus</td>
<td>9 years</td>
<td>Routine dosing intervals are recommended.</td>
</tr>
</tbody>
</table>

NOTE: The above recommendations must be read along with the footnotes of this schedule.
### Figure 3. Vaccines that might be indicated for children and adolescents aged 18 years or younger based on medical indications

<table>
<thead>
<tr>
<th>VACCINE ▼</th>
<th>INDICATION</th>
<th>Pregnancy</th>
<th>Immunocompromised status (excluding HIV infection)</th>
<th>HIV infection CD4+ count</th>
<th>Kidney failure, end-stage renal disease, on hemodialysis</th>
<th>Heart disease, chronic lung disease</th>
<th>CSF leaks/cochlear implants</th>
<th>Asplenia and persistent complement deficiencies</th>
<th>Chronic liver disease</th>
<th>Diabetes</th>
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<tbody>
<tr>
<td>Hepatitis B¹</td>
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<tr>
<td>Rotavirus²</td>
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<tr>
<td>Diphtheria, tetanus, &amp; acellular pertussis³ (DTaP)</td>
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<tr>
<td>Haemophilus influenzae type b⁴</td>
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<tr>
<td>Pneumococcal conjugate⁵</td>
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<td>Inactivated poliovirus⁶</td>
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<tr>
<td>Measles, mumps, rubella⁷</td>
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<tr>
<td>Meningococcal ACWY¹¹</td>
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<tr>
<td>Tetanus, diphtheria, &amp; acellular pertussis¹² (Td)</td>
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<td>Pneumococcal poly saccharide⁵</td>
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**NOTE:** The above recommendations must be read along with the footnotes of this schedule.

Vaccination according to the routine schedule recommended
Recommended for persons with an additional risk factor for which the vaccine would be indicated
Vaccination is recommended, and additional doses may be necessary based on medical condition. See footnotes.
No recommendation
Contraindicated
Precaution for vaccination

¹Severe Combined Immunodeficiency
²For additional information regarding HIV laboratory parameters and use of live vaccines; see the General Best Practice Guidelines for Immunization "Altered Immunocompetence" at: www.cdc.gov/vaccines/hcp/acip-recs/general-recommendations.htm, and Table 4-1 (footnote D) at: www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html.

*NOTE: The above recommendations must be read along with the footnotes of this schedule.*
Footnotes — Recommended Immunization Schedule for Children and Adolescents Aged 18 Years or Younger, UNITED STATES, 2018

For further guidance on the use of the vaccines mentioned below, see: www.cdc.gov/vaccines/hcp/acip-recs/index.html.

For vaccine recommendations for persons 19 years of age and older, see the Adult Immunization Schedule.

Additional information

- For information on contraindications and precautions for the use of a vaccine, consult the General Best Practice Guidelines for Immunization and relevant ACIP statements, at www.cdc.gov/vaccines/hcp/acip-recs/index.html.
- For calculating intervals between doses, 4 weeks = 28 days. Intervals of ≥4 months are determined by calendar months.
- Within a number range (e.g., 12–18), a dash (–) should be read as “through.”
- Vaccine doses administered ≤4 days before the minimum age or interval are considered valid. Doses of any vaccine administered ≥5 days earlier than the minimum interval or minimum age should not be counted as valid and should be repeated as age-appropriate. The repeat dose should be spaced after the invalid dose by the recommended minimum interval. For further details, see Table 3-1, Recommended and minimum ages and intervals between vaccine doses, in General Best Practice Guidelines for Immunization at www.cdc.gov/vaccines/hcp/acip-recs/general-recs/timing.html.
- Information on travel vaccine requirements and recommendations is available at wwwnc.cdc.gov/travel/.

• The National Vaccine Injury Compensation Program (VICP) is a no-fault alternative to the traditional legal system for resolving vaccine injury claims. All routine child and adolescent vaccines are covered by VICP except for pneumococcal polysaccharide vaccine (PPSV23). For more information; see www.hrsa.gov/vaccinecompensation/index.html.

1. Hepatitis B (HepB) vaccine. (minimum age: birth)

Birth Dose (Monovalent HepB vaccine only):

- Mother is HBsAg-Negative: 1 dose within 24 hours of birth for medically stable infants ≥2,000 grams. Infants <2,000 grams administer 1 dose at chronological age 1 month or hospital discharge.

- Mother is HBsAg-Positive: Give HepB vaccine and 0.5 mL of HBIG (at separate anatomic sites) within 12 hours of birth, regardless of birth weight.
  - Test for HBsAg and anti-HBs at age 9–12 months. If HepB series is delayed, test 1–2 months after final dose.

- Mother's HBsAg status is unknown:
  - Give HepB vaccine within 12 hours of birth, regardless of birth weight.
  - For infants <2,000 grams, give 0.5 mL of HBIG in addition to HepB vaccine within 12 hours of birth.
  - Determine mother's HBsAg status as soon as possible. If mother is HBsAg-positive, give 0.5 mL of HBIG to infants ≥2,000 grams as soon as possible, but no later than 7 days of age.

Routine Series:
- A complete series is 3 doses at 0, 1–2, and 6–18 months. (Monovalent HepB vaccine should be used for doses given before age 6 weeks.)

- Infants who did not receive a birth dose should begin the series as soon as feasible (see Figure 2).
- Administration of 4 doses is permitted when a combination vaccine containing HepB is used after the birth dose.
- Minimum age for the final (3rd or 4th) dose: 24 weeks.
- Minimum Intervals: Dose 1 to Dose 2: 4 weeks / Dose 2 to Dose 3: 8 weeks / Dose 1 to Dose 3: 16 weeks. (When 4 doses are given, substitute “Dose 4” for “Dose 3” in these calculations.)
- Catch-up vaccination:
  - Unvaccinated persons should complete a 3-dose series at 0, 1–2, and 6 months.
  - Adolescents 11–15 years of age may use an alternative 2-dose schedule, with at least 4 months between doses (adult formulation Recombivax HB only).
  - For other catch-up guidance, see Figure 2.

2. Rotavirus vaccines. (minimum age: 6 weeks)

Routine vaccination:
- Routine Series: 2-dose series at 2 and 4 months.
- Rotarix: 3-dose series at 2, 4, and 6 months. If any dose in the series is either Rotarix or unknown, default to 3-dose series.

Catch-up vaccination:
- Do not start the series on or after age 15 weeks, 0 days.
- The maximum age for the final dose is 8 months, 0 days.
- For other catch-up guidance, see Figure 2.

3. Diphtheria, tetanus, and a cellular pertussis (DTaP) vaccine. (minimum age: 6 weeks [4 years for Kinrix or Quadracel])

Routine vaccination:
- 5-dose series at 2, 4, 6, and 15–18 months, and 4–6 years.
  - Prospectively: A 4th dose may be given as early as age 12 months if at least 6 months have elapsed since the 3rd dose.
  - Retrospectively: A 4th dose that was inadvertently given as early as 12 months may be counted if at least 4 months have elapsed since the 3rd dose.

Catch-up vaccination:
- The 5th dose is not necessary if the 4th dose was administered at 4 years or older.
- For other catch-up guidance, see Figure 2.
For further guidance on the use of the vaccines mentioned below, see: www.cdc.gov/vaccines/hcp/acip-recs/index.html.

4. **Haemophilus influenzae type b (Hib) vaccine.**
   (minimum age: 6 weeks)
   **Routine vaccination:**
   - ActHIB, Hibercix, or Pentacel: 4-dose series at 2, 4, 6, and 12–15 months.
   - PedvaxHIB: 3-dose series at 2, 4, and 12–15 months.
   **Catch-up vaccination:**
   - 1st dose at 7–11 months: Give 2nd dose at least 4 weeks later and 3rd (final) dose at 12–15 months or 8 weeks after 2nd dose (whichever is later).
   - 1st dose at 12–14 months: Give 2nd (final) dose at least 8 weeks after 1st dose.
   - 1st dose before 12 months and 2nd dose before 15 months: Give 3rd (final) dose 8 weeks after 2nd dose.
   - 2 doses of PedvaxHIB before 12 months: Give 3rd (final) dose at 12–59 months and at least 8 weeks after 2nd dose.
   - Unvaccinated at 15–59 months: 1 dose.
   - For other catch-up guidance, see Figure 2.

   **Special Situations:**
   - Chemotherapy or radiation treatment 12–59 months:
     - Unvaccinated or only 1 dose before 12 months: Give 2 doses, 8 weeks apart
     - 2 or more doses before 12 months: Give 1 dose, at least 8 weeks after previous dose.
   - Doses given within 14 days of starting therapy or during therapy should be repeated at least 3 months after therapy completion.
   - Hematopoietic stem cell transplant (HSCT)
     - 3-dose series with doses 4 weeks apart starting 6 to 12 months after successful transplant (regardless of Hib vaccination history).
   - Anatomic or functional asplenia (including sickle cell disease)
     - 12–59 months:
       - Unvaccinated or only 1 dose before 12 months: Give 2 doses, 8 weeks apart
       - 2 or more doses before 12 months: Give 1 dose, at least 8 weeks after previous dose.
     - Unimmunized* persons 5 years or older
       - Give 1 dose
   - Elective splenectomy
     - Unimmunized* persons 15 months or older
       - Give 1 dose (preferably at least 14 days before procedure).
   - HIV infection
     - 12–59 months:
       - Unvaccinated or only 1 dose before 12 months:
         - Give 2 doses 8 weeks apart.
       - 2 or more doses before 12 months: Give 1 dose, at least 8 weeks after previous dose.
     - Unimmunized* persons 5–18 years
       - Give 1 dose
   - Immunoglobulin deficiency, early component complement deficiency
     - 12–59 months:
       - Unvaccinated or only 1 dose before 12 months:
         - Give 2 doses, 8 weeks apart.
       - 2 or more doses before 12 months: Give 1 dose, at least 8 weeks after previous dose.

5. **Pneumococcal vaccines. (minimum age: 6 weeks [PCV13], 2 years [PPSV23])**
   **Routine vaccination with PCV13:**
   - 4-dose series at 2, 4, 6, and 12–15 months.
   **Catch-up vaccination with PCV13:**
   - 1 dose for healthy children aged 24–59 months with any incomplete* PCV13 schedule
   - For other catch-up guidance, see Figure 2.

   **Special situations: High-risk conditions:**
   - Administer PCV13 doses before PPSV23 if possible.

   **Chronic heart disease (particularly cyanotic congenital heart disease and cardiac failure); chronic lung disease (including asthma treated with high-dose, oral, corticosteroids); diabetes mellitus:**

   **Age 2–5 years:**
   - Any incomplete* schedules with:
     - o 3 PCV13 doses: 1 dose of PCV13 (at least 8 weeks after any prior PCV13 dose).
     - o <3 PCV13 doses: 2 doses of PCV13, 8 weeks after the most recent dose and given 8 weeks apart.
   - No history of PPSV23: 1 dose of PPSV23 (at least 8 weeks after any prior PCV13 dose).

   **Age 6–18 years:**
   - No history of either PCV13 or PPSV23: 1 dose of PCV13, 1 dose of PPSV23 at least 8 weeks later.
   - Any PCV13 but no PPSV23: 1 dose of PPSV23 at least 8 weeks after the most recent dose of PCV13
   - PPV23 but no PCV13: 1 dose of PCV13 at least 8 weeks after the most recent dose of PPSV23.

   **Sickle cell disease and other hemoglobinopathies; anatomic or functional asplenia; congenital or acquired immunodeficiency; HIV infection; chronic renal failure; nephrotic syndrome; malignant neoplasms, lymphomas, Hodgkin disease, and other diseases associated with treatment with immunosuppressive drugs or radiation therapy; solid organ transplantation; multiple myeloma:**

   **Age 2–5 years:**
   - Any incomplete* schedules with:
     - o 3 PCV13 doses: 1 dose of PCV13 (at least 8 weeks after any prior PCV13 dose).
     - o <3 PCV13 doses: 2 doses of PCV13, 8 weeks after the most recent dose and given 8 weeks apart.
   - No history of PPSV23: 1 dose of PPSV23 (at least 8 weeks after any prior PCV13 dose).

   **Age 6–18 years:**
   - No history of either PCV13 or PPSV23: 1 dose of PCV13, 2 doses of PPV23 (1st dose of PPV23 administered 8 weeks after PCV13 and 2nd dose of PPV23 administered at least 5 years after the 1st dose of PPV23).
   - Any PCV13 but no PPSV23: 2 doses of PPV23 (1st dose of PPV23 to be given 8 weeks after the most recent dose of PCV13 and 2nd dose of PPV23 administered at least 5 years after the 1st dose of PPV23).
Catch-up vaccination:

Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS), and state recommendations. Please refer to the appropriate agency for additional guidance.

**Infectious conditions requiring vaccination:**

- Persons 7–18 years without evidence of immunity (see MMWR 2007;56[No. RR-4], at www.cdc.gov/mmwr/pdf/rr/rr5604.pdf) have 2 doses of varicella vaccine:
  - Ages 7–12: routine interval 3 months (minimum interval: 4 weeks).
  - Ages 13 and older: minimum interval 4 weeks.

**Influenza vaccines. (minimum age: 6 months)**

Routine vaccination:

- Administer an age-appropriate formulation and dose of influenza vaccine annually.
  - Children 6 months–8 years who did not receive at least 2 doses of influenza vaccine before July 1, 2017 should receive 2 doses separated by at least 4 weeks.
  - Persons 9 years and older 1 dose
  - Live attenuated influenza vaccine (LAIV) not recommended for the 2017–18 season.

**Measles, mumps, and rubella (MMR) vaccine. (minimum age: 12 months)**

Routine vaccination:

- 2-dose series at 12–15 months and 4–6 years.
  - The 2nd dose may be given as early as 4 weeks after the 1st dose.

**Pneumococcal vaccines. (minimum age: 2 months)**

Routine vaccination:

- 4-dose series at 2, 4, 6–18 months, and 4–6 years. Administer the final dose on or after the 4th birthday and at least 6 months after the previous dose.

Catch-up vaccination:

- In the first 6 months of life, use minimum ages and intervals only for travel to a polio-endemic region or during an outbreak.
  - If 4 or more doses were given before the 4th birthday, give 1 more dose at age 4–6 years and at least 6 months after the previous dose.
  - A 4th dose is not necessary if the 3rd dose was given on or after the 4th birthday and at least 6 months after the previous dose.
  - IPV is not routinely recommended for U.S. residents 18 years and older.

Series Containing Oral Polio Vaccine (OPV), either mixed OPV-IPV or OPV-only series:

- Total number of doses needed to complete the series is the same as that recommended for the U.S. IPV schedule. See www.cdc.gov/mmwr/volumes/66/wr/mm6601a6.htm?s_cid=mm6601a6_w.
  - Only trivalent OPV (TOPV) counts toward the U.S. vaccination requirements. For guidance to assess doses documented as “OPV” see www.cdc.gov/mmwr/volumes/66/wr/mm6606a7.htm?s_cid=mm6606a7_w.
  - For other catch-up guidance, see Figure 2.
  - For other catch-up guidance, see Figure 2.

**7. Influenza vaccines. (minimum age: 6 months)**

Routine vaccination:

- Administer an age-appropriate formulation and dose of influenza vaccine annually.
  - Children 6 months–8 years who did not receive at least 2 doses of influenza vaccine before July 1, 2017 should receive 2 doses separated by at least 4 weeks.
  - Persons 9 years and older 1 dose
  - Live attenuated influenza vaccine (LAIV) not recommended for the 2017–18 season.

**10. Hepatitis A (HepA) vaccine. (minimum age: 12 months)**

Routine vaccination:

- 2 doses, separated by 6-18 months, between the 1st and 2nd birthdays. (A series begun before the 2nd birthday should be completed even if the child turns 2 before the second dose is given.)

Catch-up vaccination:

- Anyone 2 years of age or older may receive HepA vaccine if desired. Minimum interval between doses is 6 months.

**Special populations:**

Previously unvaccinated persons who should be vaccinated:

- Persons traveling to or working in countries with high or intermediate endemicity
- Men who have sex with men
- Users of injection and non-injection drugs
- Persons who work with hepatitis A virus in a research laboratory or with non-human primates
- Persons with clotting-factor disorders
- Persons with chronic liver disease
- Persons who anticipate close, personal contact (e.g., household or regular babysitting) with an international adoptee during the first 60 days after arrival from a country with high or intermediate endemicity (administer the 1st dose as soon as the adoption is planned—ideally at least 2 weeks before the adoptee’s arrival).

**11. Serogroup A, C, W, Y meningococcal vaccines. (Minimum age: 2 months [Menveo], 9 months [Menactra].)**

Routine:

- 2-dose series: 11-12 years and 16 years.

Catch-Up:

- Age 13-15 years: 1 dose now and booster at age 16–18 years. Minimum interval 8 weeks.
- Age 16-18 years: 1 dose.
For further guidance on the use of the vaccines mentioned below, see: www.cdc.gov/vaccines/hcp/acip-recs/index.html.

Special populations and situations:
Anatomic or functional asplenia, sickle cell disease, HIV infection, persistent complement component deficiency (including eculizumab use):
- **Menveo**
  - 1st dose at 8 weeks: 4-dose series at 2, 4, 6, and 12 months.
  - 1st dose at 7–23 months: 2 doses (2nd dose at least 12 weeks after the 1st dose and after the 1st birthday).
  - 1st dose at 24 months or older: 2 doses at least 8 weeks apart.
- **Menactra**
  - Persistent complement component deficiency:
    - 9–23 months: 2 doses at least 12 weeks apart.
    - 24 months or older: 2 doses at least 8 weeks apart.
  - Anatomic or functional asplenia, sickle cell disease, or HIV infection:
    - 24 months or older: 2 doses at least 8 weeks apart.
  - **Menactra** must be administered at least 4 weeks after completion of PCV13 series.

Children who travel to or live in countries where meningococcal disease is hyperendemic or epidemic, including countries in the African meningitis belt or during the Hajj, or exposure to an outbreak attributable to a vaccine serogroup:
- Children <24 months of age:
  - **Menveo** (2-23 months):
    - 1st dose at 8 weeks: 4-dose series at 2, 4, 6, and 12 months.
    - 1st dose at 7-23 months: 2 doses (2nd dose at least 12 weeks after the 1st dose and after the 1st birthday).
  - **Menactra** (9-23 months):
    - 2 doses (2nd dose at least 12 weeks after the 1st dose. 2nd dose may be administered as early as 8 weeks after the 1st dose in travelers).
- Children 2 years or older: 1 dose of **Menveo** or Menactra.

12. Serogroup B meningococcal vaccines (minimum age: 10 years [Bexsero, Trumenba]).
Clinical discretion: Adolescents not at increased risk for meningococcal B infection who want MenB vaccine.
MenB vaccines may be given at clinical discretion to adolescents 16–23 years (preferred age 16–18 years) who are not at increased risk.
- Bexsero: 2 doses at least 1 month apart.
- Trumenba: 2 doses at least 6 months apart. If the 2nd dose is given earlier than 6 months, give a 3rd dose at least 4 months after the 2nd.

Special populations and situations:
Anatomic or functional asplenia, sickle cell disease, persistent complement component deficiency (including eculizumab use), serogroup B meningococcal disease outbreak
- Bexsero: 2-dose series at least 1 month apart.
- Trumenba: 3-dose series at 0, 1–2, and 6 months.

Note: Bexsero and Trumenba are not interchangeable.

For additional meningococcal vaccination information, see meningococcal MMWR publications at: www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/ mening.html.

13. Tetanus, diphtheria, and acellular pertussis (Tdap) vaccine. (minimum age: 11 years for routine vaccinations, 7 years for catch-up vaccination)
Routine vaccination:
- Adolescents 11–12 years of age: 1 dose.
- Pregnant adolescents: 1 dose during each pregnancy (preferably during the early part of gestational weeks 27–36).
- Tdap may be administered regardless of the interval since the last tetanus- and diphtheria-toxoid-containing vaccine.

Catch-up vaccination:
- Adolescents 13–18 who have not received Tdap: 1 dose, followed by a Td booster every 10 years.
- Children 7–10 years who receive Tdap inadvertently or as part of the catch-up series may receive the routine Tdap dose at 11–12 years.
- DTaP inadvertently given after the 7th birthday:
  - Child 7–10: DTaP may count as part of catch-up series. Routine Tdap dose at 11-12 may be given.
  - Adolescent 11–18: Count dose of DTaP as the adolescent Tdap booster.
- For other catch-up guidance, see Figure 2.

14. Human papillomavirus (HPV) vaccine (minimum age: 9 years)
Routine and catch-up vaccination:
- Routine vaccination for all adolescents at 11–12 years (can start at age 9) and through age 18 if not previously adequately vaccinated. Number of doses depend on age at initial vaccination:
  - Age 9–14 years at initiation: 2-dose series at 0 and 6–12 months. Minimum interval: 5 months (repeat a dose given too soon at least 12 weeks after the invalid dose and at least 5 months after the 1st dose).
  - Age 15 years or older at initiation: 3-dose series at 0, 1–2 months, and 6 months. Minimum intervals: 4 weeks between 1st and 2nd dose; 12 weeks between 2nd and 3rd dose; 5 months between 1st and 3rd dose (repeat dose(s) given too soon at or after the minimum interval since the most recent dose).
- Persons who have completed a valid series with any HPV vaccine do not need any additional doses.

Special situations:
- History of sexual abuse or assault: Begin series at age 9 years.
- Immunocompromised* (including HIV) aged 9–26 years: 3-dose series at 0, 1–2 months, and 6 months.
- Pregnancy: Vaccination not recommended, but there is no evidence the vaccine is harmful. No intervention is needed for women who inadvertently received a dose of HPV vaccine while pregnant. Delay remaining doses until after pregnancy. Pregnancy testing not needed before vaccination.

*See MMWR, December 16, 2016;65(49):1405–1408, at www.cdc.gov/mmwr/volumes/65/rr/pdfs/mm6549a5.pdf.
Adolescent Well-Care Visits: 12 to 21 Years Old

This HEDIS measure looks at members 12-21 years of age who had at least one comprehensive well-care visit with a primary care provider (PCP) or an OB/GYN during the calendar year.

Record your efforts
Make sure that your medical record documentation reflects all of the following:
- Date of the visit
- A health history
- Both physical and mental developmental histories
- A physical exam
- Health education and anticipatory guidance

Code your services correctly
Proper coding is critical to ensuring accurate reporting of these measures, and it may also decrease the need for medical record reviews. Use the following diagnosis and procedure codes to document comprehensive well-care visits:

<table>
<thead>
<tr>
<th>Description</th>
<th>CPT</th>
<th>ICD-10-CM</th>
<th>HCPCS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive well-care visit</td>
<td>99384, 99385, 99394, 99395</td>
<td>Z00.00, Z00.01, Z00.121,Z00.129, Z02-Z02.89</td>
<td>G0438, G0439</td>
</tr>
</tbody>
</table>

When billing office visits for preventive health screening services, providers must use the appropriate diagnosis code, EP modifier and place of service (POS) code 99. The 25 modifier must be included when a vaccine is administered during the preventive visit.

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 (see the table below) with modifiers 25 and EP and the applicable EPSDT HIPAA referral code (NU, AV, S2, ST).

<table>
<thead>
<tr>
<th>Description</th>
<th>CPT</th>
</tr>
</thead>
<tbody>
<tr>
<td>EPSDT visit</td>
<td>99384, 99385, 99394, 99395</td>
</tr>
<tr>
<td>E&amp;M sick visit</td>
<td>99211 or 99212</td>
</tr>
</tbody>
</table>

EPSDT preventive health screenings are exempt from third-party liability. Even if the member has other health insurance, you may file Medicaid first for preventive health services. This will ensure accurate and timely reporting of EPSDT services.

Helpful tips
- Follow the American Academy of Pediatrics Bright Futures Periodicity Schedule of recommendations for preventive pediatric health care for well visits and screenings.

Please note: The codes and tips listed do not guarantee reimbursement. The information provided is based on HEDIS 2018 technical specifications and the 2017 CMS technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.
• Appropriate immunizations are an important part of these visits. Administer immunizations in accordance to the ACIP. Check the Georgia Registry of Immunization Transactions and Services (GRITS) database to ensure vaccines have not been administered elsewhere.
• Sick visits and sports physicals may be missed opportunities to complete well visits.
• Use your member roster to contact patients who are due for their annual well visit or are new to your practice.
• If you use electronic medical records (EMRs), consider creating a flag to track patients who are due or past due for a visit. If you do not use EMRs, consider creating a manual tracking method.
• Consider offering evening, early morning and/or weekend office hours to accommodate working young adults or parents with children involved in after-school activities.
• Appointment reminders by text, email, postcard or phone call work well for most parents and young adults.
• Consider dedicating a night at your practice for teen well visits or teen-related health topic discussions.

How can we help?
• Providing individualized reports of your patients who are due or overdue for services
• Assisting with scheduling appointments for our members, if needed
• Offering nonemergency transportation for our members to appointments
• Providing education to members about the importance of annual well visits through various sources such as phone calls, newsletters and health education fliers
• Working with you to plan, implement and evaluate member events to help promote preventive health care services
• Encouraging preventive care through our Being Healthy Brings Rewards program

Contact our Quality Management team at 678-587-4868 with any questions or for additional information.

Other resources
You can find more information and tools online:
• ACIP Immunization Schedule — www.cdc.gov/vaccines/schedules/hcp/index.html
• Bright Futures Tools — https://brightfutures.aap.org/materials-and-tools/Pages/default.aspx
• Georgia Medicaid Management Information System — https://www.mmis.georgia.gov/portal

Notes

Please note: The codes and tips listed do not guarantee reimbursement. The information provided is based on HEDIS 2018 technical specifications and the 2017 CMS technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.
Adult Body Mass Index Assessment

This HEDIS measure looks at members 18-74 years of age who had an outpatient visit and whose body mass index (BMI) was documented during the measurement year or year prior to measurement year.

Record your efforts

Make sure your medical record documentation reflects all of the following:

- Date of the visit
- Height and weight
- BMI:
  - For patients ages 20 and older, document BMI value
  - For patients under age 20, document BMI percentile (listed as a percentile or plotted on a BMI growth chart)

Code your services correctly

Proper coding is critical to ensuring accurate reporting of these measures, and it may also decrease the need for medical record reviews. Use the following diagnosis and procedure codes to document BMI screenings and outpatient visits:

<table>
<thead>
<tr>
<th>Description</th>
<th>ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>BMI percentile</td>
<td>Z68.51-Z68.54</td>
</tr>
<tr>
<td>BMI value</td>
<td>Z68.1, Z68.20-Z68.45</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Description</th>
<th>CPT</th>
<th>HCPCS</th>
<th>UBREV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient visits</td>
<td>99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99385-99387, 99395-99397, 99401-99404, 99411, 99412, 99429, 99455, 99456</td>
<td>G0402, G0438, G0439, G0463, T1015</td>
<td>0510-0517, 0519-0523, 0526-0529, 0982, 0983</td>
</tr>
</tbody>
</table>

Helpful tips

- Annual well visits are a great time to assess and discuss BMI and provide counseling to patients on the importance of nutrition and physical activity.
- Encourage your staff to use tools such as handheld cards, charts, EMR flags and educational brochures within the office to promote teaching on ideal BMI as well as chronic disease conditions related to obesity or being overweight.
- Provide staff training on BMI documentation, medical assessment, brief and focused advice, and treatment. Offer your staff 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 health 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 are entered. Remember that ranges do not meet compliance.

Please note: The codes and tips listed do not guarantee reimbursement. The information provided is based on HEDIS 2018 technical specifications and the 2017 CMS technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.
How can we help?

- Distributing BMI charts during office site visits
- Providing education to members on the importance of annual well visits and BMI screenings through various sources, such as phone calls, newsletters and health education fliers
- Providing individualized reports of your patients who are due or overdue for services
- Working with you to plan, implement and evaluate member events to help promote preventive health care services

Contact our Quality Management team at 678-587-4868 with any questions or for additional information.

Other resources
You can find more information and tools online:


Notes
Antidepressant Medication Management

This HEDIS measure looks at members 18 years of age and older with a diagnosis of major depression who were treated with an antidepressant medication and remained on an antidepressant medication treatment.

Two rates are reported:
- **Effective acute phase treatment**: patients diagnosed and treated who remained on an antidepressant medication for at least 84 days (12 weeks)
- **Effective continuation phase treatment**: patients newly diagnosed and treated who remained on an antidepressant medication for at least 180 days (6 months)

**Code your services correctly**
Proper coding is critical to ensuring accurate reporting. Use the following diagnosis codes to identify major depression:

<table>
<thead>
<tr>
<th>Description</th>
<th>ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major depression</td>
<td>F32.0-F32.4, F32.9, F33.0-F33.3, F33.41, F33.9</td>
</tr>
</tbody>
</table>

**Helpful tips**
- Educate your patients and their spouses, caregivers, and/or guardians about the importance of:
  - Compliance with long-term medications.
  - Not abruptly stopping medications without consulting you.
  - Contacting you immediately if they experience any unwanted/adverse reactions so their treatment can be re-evaluated.
  - Scheduling and attending follow-up appointments to review the effectiveness of their medications.
  - Calling your office if they cannot get their medications refilled.
- Discuss the benefits of participating in our behavioral health case management program.
- Ask your patients who have a behavioral health diagnosis to provide you access to their behavioral health records if you are their primary care provider.
- Be sure to contact the Amerigroup Pharmacy department at 1-800-454-3730 to verify required preauthorization of medications.
- Antidepressant medications include, but are not limited to:

<table>
<thead>
<tr>
<th>Description</th>
<th>Prescription</th>
</tr>
</thead>
</table>
| Miscellaneous antidepressants | • Bupropion  
• Vilazodone  
• Vortioxetine                                                                 |
| Monoamine oxidase inhibitors | • Isocarboxazid  
• Phencelzine  
• Selegiline  
• Tranylcypromine                                                          |
| Phenylpiperazine antidepressants | • Nefazodone  
• Trazodone                                                                 |
| Psychotherapeutic combinations | • Amitriptyline-chlordiazepoxide  
• Amitriptyline-perphenazine  
• Fluoxetine-olanzapine                                                  |
| SNRI antidepressants       | • Desvenlafaxine  
• Duloxetine  
• Levomilnacipran  
• Venlafaxine                                                              |

Please note: The codes and tips listed do not guarantee reimbursement. The information provided is based on HEDIS 2018 technical specifications and the 2017 CMS technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.
<table>
<thead>
<tr>
<th>Description</th>
<th>Prescription</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSRI antidepressants</td>
<td>• Citalopram</td>
</tr>
<tr>
<td></td>
<td>• Escitalopram</td>
</tr>
<tr>
<td></td>
<td>• Fluoxetine</td>
</tr>
<tr>
<td></td>
<td>• Fluvoxamine</td>
</tr>
<tr>
<td></td>
<td>• Paroxetine</td>
</tr>
<tr>
<td></td>
<td>• Sertraline</td>
</tr>
<tr>
<td>Tetracyclic antidepressants</td>
<td>• Maprotiline</td>
</tr>
<tr>
<td>Tricyclic antidepressants</td>
<td>• Amitriptyline</td>
</tr>
<tr>
<td></td>
<td>• Amoxapine</td>
</tr>
<tr>
<td></td>
<td>• Clomipramine</td>
</tr>
<tr>
<td></td>
<td>• Desipramine</td>
</tr>
<tr>
<td></td>
<td>• Doxepin (&gt; 6 mg)</td>
</tr>
<tr>
<td></td>
<td>• Imipramine</td>
</tr>
<tr>
<td></td>
<td>• Nortriptyline</td>
</tr>
<tr>
<td></td>
<td>• Protriptyline</td>
</tr>
<tr>
<td></td>
<td>• Trimipramine</td>
</tr>
</tbody>
</table>

**Note:** Not all medications listed above are in our formulary. Prior authorization and/or step therapy may be required.

**How can we help?**
- Offering current Clinical Practice Guidelines on our provider self-service website
- Providing individualized reports of your patients who are due or overdue for services
- Offering nonemergency transportation for our members to appointments
- Offering our behavioral health case management program to members

Contact our Quality Management team at 678-587-4868 with any questions or for additional information.

**Other resources**
You can find more information and tools online:
- American Psychiatric Association — https://www.psychiatry.org/patients-families/depression/what-is-depression
- Behavioral health case management — https://providers.amerigroup.com/ProviderDocuments/ALL_BHCaseMgmt.pdf

**Notes**  

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Please note: The codes and tips listed do not guarantee reimbursement. The information provided is based on HEDIS 2018 technical specifications and the 2017 CMS technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.
Appropriate Testing for Children with Pharyngitis

This HEDIS measure looks at the percentage of children 3-18 years of age who were diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode.

Code your services correctly
Use the following diagnosis and procedure codes to identify pharyngitis, tonsillitis or streptococcal sore throats and strep tests:

<table>
<thead>
<tr>
<th>Description</th>
<th>ICD-10-CM</th>
<th>CPT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute pharyngitis</td>
<td>J02.8, J02.9</td>
<td></td>
</tr>
<tr>
<td>Acute tonsillitis</td>
<td>J03.80, J03.81, J03.90, J03.91</td>
<td></td>
</tr>
<tr>
<td>Streptococcal pharyngitis (sore throat)</td>
<td>J02.0</td>
<td></td>
</tr>
<tr>
<td>Streptococcal tonsillitis</td>
<td>J03.00, J03.01</td>
<td></td>
</tr>
<tr>
<td>Group A streptococcal tests</td>
<td></td>
<td>87070, 87071, 87081, 87430, 87650-87652, 87880</td>
</tr>
</tbody>
</table>

Helpful tips

- This measure looks at members who received group A streptococcus (strep) tests with a diagnosis of pharyngitis, tonsillitis or streptococcal sore throats and were appropriately dispensed antibiotics within three days of the diagnosis.
- 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.
- Due to considerable evidence that prescribing antibiotics is not the first line of treatment for colds or sore throats caused by viruses, pediatric Clinical Practice Guidelines recommend that only children with lab-confirmed group A strep or other bacteria-related ailments be treated with appropriate antibiotics.
- If a patient tests negative for group A strep but insists on an antibiotic:
  - Refer to the illness as a sore throat due to a cold; patients tend to associate the label with a less-frequent need for antibiotics.
  - Write a prescription for symptom relief, like over-the-counter medicines.
- 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 parent or caregivers’ 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.

Please note: The codes and tips listed do not guarantee reimbursement. The information provided is based on HEDIS 2018 technical specifications and the 2017 CMS technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.
• Educate patients and their parents or caregivers that they can prevent infection by:
  o Washing hands frequently.
  o Keeping an infected person’s eating utensils and drinking glasses separate from other family members.
  o Thoroughly washing an infected toddler’s toys in hot water with disinfectant soap.
  o 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.

• Be sure to contact the Pharmacy department at 1-800-454-3730 to verify required preauthorization of medications.

• Antibiotic medications include but are not limited to:

<table>
<thead>
<tr>
<th>Description</th>
<th>Prescriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aminopenicillins</td>
<td>Amoxicillin</td>
</tr>
<tr>
<td></td>
<td>Ampicillin</td>
</tr>
<tr>
<td>Beta-lactamase inhibitors</td>
<td>Amoxicillin-clavulanate</td>
</tr>
<tr>
<td>First generation cephalosporins</td>
<td>Cefadroxil</td>
</tr>
<tr>
<td></td>
<td>Cefazolin</td>
</tr>
<tr>
<td>Folate antagonist</td>
<td>Trimethoprim</td>
</tr>
<tr>
<td>Lincomycin derivatives</td>
<td>Clindamycin</td>
</tr>
<tr>
<td>Macrolides</td>
<td>Azithromycin</td>
</tr>
<tr>
<td></td>
<td>Clarithromycin</td>
</tr>
<tr>
<td></td>
<td>Erythromycin</td>
</tr>
<tr>
<td></td>
<td>Erythromycin ethylsuccinate</td>
</tr>
<tr>
<td></td>
<td>Erythromycin lactobionate</td>
</tr>
<tr>
<td></td>
<td>Erythromycin stearate</td>
</tr>
<tr>
<td>Miscellaneous antibiotics</td>
<td>Erythromycin-sulfisoxazole</td>
</tr>
<tr>
<td>Natural penicillins</td>
<td>Penicillin G potassium</td>
</tr>
<tr>
<td></td>
<td>Penicillin G sodium</td>
</tr>
<tr>
<td></td>
<td>Penicillin V potassium</td>
</tr>
<tr>
<td>Penicillinase-resistant penicillins</td>
<td>Dicloxacillin</td>
</tr>
<tr>
<td>Quinolones</td>
<td>Ciprofloxacin</td>
</tr>
<tr>
<td></td>
<td>Levofloxacin</td>
</tr>
<tr>
<td></td>
<td>Moxifloxacin</td>
</tr>
<tr>
<td></td>
<td>Ofloxacin</td>
</tr>
<tr>
<td>Second generation cephalosporins</td>
<td>Cefaclor</td>
</tr>
<tr>
<td></td>
<td>Cefprozil</td>
</tr>
<tr>
<td></td>
<td>Cefuroxime</td>
</tr>
<tr>
<td>Sulfonamides</td>
<td>Sulfamethoxazole-trimethoprim</td>
</tr>
<tr>
<td>Tetracyclines</td>
<td>Doxycycline</td>
</tr>
<tr>
<td></td>
<td>Minocycline</td>
</tr>
<tr>
<td></td>
<td>Tetracycline</td>
</tr>
<tr>
<td>Third generation cephalosporins</td>
<td>Cefdinir</td>
</tr>
<tr>
<td></td>
<td>Cefixime</td>
</tr>
<tr>
<td></td>
<td>Ceftobuten</td>
</tr>
<tr>
<td></td>
<td>Cefditoren</td>
</tr>
<tr>
<td></td>
<td>Cefpodoxime</td>
</tr>
<tr>
<td></td>
<td>Ceftriaxone</td>
</tr>
</tbody>
</table>

**Note:** Not all medications listed above are in our Formulary. Prior authorization and/or step therapy may be required.

**How can we help?**

• Offering current Clinical Practice Guidelines on our provider self-service web site
• Providing education to members through newsletters, community events and health education materials
• Providing your office with resources such as health education materials (e.g., Ameritips)

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Please note: The codes and tips listed do not guarantee reimbursement. The information provided is based on HEDIS 2018 technical specifications and the 2017 CMS technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.
Contact our Quality Management team at 678-587-4868 with any questions or for additional information.

Other resources
You can find more information and tools online:
- CDC Bronchitis — www.cdc.gov/getsma|t/community/for-patients/common-illnesses/bronchitis.html
- CDC Get Smart: Know When Antibiotics Work campaign materials and more — www.cdc.gov/getsma|t:
  - Prescription Pad for Viral Infection
  - Get Smart: Know When Antibiotics Work
  - Cold or Flu: Antibiotics Don’t Work for You

Notes

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Appropriate Treatment for Children with Upper Respiratory Infection

This HEDIS measure looks at members 3 months-18 years of age who were given a diagnosis of URI and were not dispensed an antibiotic prescription.

Code your services correctly

Use the following diagnosis codes to appropriately identify URI, pharyngitis and tonsillitis:

<table>
<thead>
<tr>
<th>Description</th>
<th>ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>URI</td>
<td>J00, J06.0, J06.9</td>
</tr>
<tr>
<td>Acute pharyngitis</td>
<td>J02.8, J02.9</td>
</tr>
<tr>
<td>Acute tonsillitis</td>
<td>J03.80, J03.81, J03.90, J03.91</td>
</tr>
<tr>
<td>Streptococcal pharyngitis</td>
<td>J02.0</td>
</tr>
<tr>
<td>Streptococcal tonsillitis</td>
<td>J03.00, J03.01</td>
</tr>
</tbody>
</table>

Helpful tips

- Educating patients on the difference between bacterial and viral infections is a key factor in the success of this measure, reducing unnecessary use of antibiotics is the goal of this measure:
  - Be equipped to teach patients about the real cause of their illness and explain how using antibiotics when they are not needed can be harmful and cause antibiotic resistance.
  - Educate patients on the effects of frequently using antibiotics for a viral infection by using educational tools that are available.
- Post educational materials in your waiting room and treatment areas for patients.
- In accordance with the ACIP, administer influenza vaccine annually to all children beginning at 6 months of age.
- 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.
- Don’t let your patients pressure you into writing antibiotic prescriptions for URIs. If a parent/caregiver insists on an antibiotic:
  - Refer to the illness as a common cold; parents and caregivers tend to associate this label with a less-frequent need for antibiotics.
  - Write a prescription for symptom relief such as an over-the-counter cough medicine.

How can we help?

- Offering current Clinical Practice Guidelines on our provider self-service website
- Providing individualized reports of your patients that are due or overdue for services

Contact our Quality Management team at 678-587-4868 with any questions or for additional information.

Please note: The codes and tips listed do not guarantee reimbursement. The information provided is based on HEDIS 2018 technical specifications and the 2017 CMS technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.
**Other resources**
You can find more information and tools online:
- Get Smart: Know When Antibiotics Work campaign materials and more —
  www.cdc.gov/getsmtart:
  - Prescription Pad for Viral Infection
  - Get Smart: Know When Antibiotics Work
  - Cold or Flu: Antibiotics Don’t Work for You

**Notes**
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis

This HEDIS measure looks at members 18-64 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription.

Code your services correctly

Use the following diagnosis codes to identify acute bronchitis and/or comorbid conditions:

<table>
<thead>
<tr>
<th>Description</th>
<th>ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute bronchitis</td>
<td>J20.3-J20.9</td>
</tr>
<tr>
<td>COPD</td>
<td>J44.0, J44.1, J44.9</td>
</tr>
<tr>
<td>Cystic fibrosis</td>
<td>E84.0, E84.11, E84.19, E84.8, E84.9</td>
</tr>
<tr>
<td>Emphysema</td>
<td>J43.0-J43.2, J43.8, J43.9</td>
</tr>
<tr>
<td>HIV</td>
<td>B20, Z21, B97.35</td>
</tr>
<tr>
<td>Immune system disorders</td>
<td>D80.0-D80.9, D81.0-D81.4, D81.6, D81.7, D81.89, D81.9, D82.0-D82.4, D82.8, D82.9, D83.0-D83.2, D83.8, D83.9, D84.0, D84.1, D84.8, D84.9, D89.3, D89.810-D89.813, D89.82, D89.89, D89.9</td>
</tr>
<tr>
<td>Malignant neoplasms</td>
<td>C00.0-C96.9</td>
</tr>
<tr>
<td>Other comorbid conditions</td>
<td>A15.0-A15.9, A17.0-A19.9, B44.81, D57.01, D57.211, D57.411, D57.811, J22, J41.0-J42, J47.0-J47.9, J60-J68.3, J68.9-J70.9, J80-J82, J84.01-J84.9, J85.0-J86.9, J90-J94.9, J95.00-J96.92, J99, M30.1, M32.13, M33.01, M33.11, M33.21, M33.91, M34.81, M35.02, O09.011-O98.013, O98.019, O98.02, O98.03</td>
</tr>
</tbody>
</table>

Helpful tips

- There is considerable evidence that prescribing antibiotics for uncomplicated acute bronchitis is not necessary unless associated with a comorbid diagnosis, such as chronic obstructive pulmonary disease (COPD), emphysema, cystic fibrosis, respiratory diseases, immune system disorders and malignant neoplasms.
- Acute bronchitis should only need treatment with antibiotics due to an associated comorbid diagnosis. 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 this label with a less-frequent need for antibiotics.
  - Write a prescription for symptom relief such as an over-the-counter cough medicine.
- Offer annual flu shots in your office or inform your patients of the importance of getting the vaccine and where they can get it.

How can we help?

- Offering current Clinical Practice Guidelines on our provider self-service website
- Providing education to members through newsletters, community events and health education materials

Contact our Quality Management team at 678-587-4868 with any questions or for additional information.

Please note: The codes and tips listed do not guarantee reimbursement. The information provided is based on HEDIS 2018 technical specifications and the 2017 CMS technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.
Other resources
You can find more information and tools online:

- CDC Bronchitis — www.cdc.gov/getsmart/community/for-patients/common-illnesses/bronchitis.html
- Get Smart: Know When Antibiotics Work campaign materials and more — www.cdc.gov/getsmart
  - Prescription Pad for Viral Infection
  - Get Smart: Know When Antibiotics Work
  - Cold or Flu: Antibiotics Don’t Work for You
- Medicaid Formulary —

Notes

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________
Breast Cancer Screening

This HEDIS measure looks at women 50-74 years of age who had at least one mammogram to screen for breast cancer. The mammogram must occur between October 1 two years prior to the measurement year and December 31 of the current year.

Record your efforts

Make sure your medical record documentation reflects all of the following:

- Date of the screening
- Type of screening
- Results of the screening

Code your services correctly

Proper coding is critical to ensuring accurate reporting of these measures, and it may also decrease the need for medical record reviews. Use the following diagnosis and procedure codes to document breast cancer screenings:

<table>
<thead>
<tr>
<th>Description</th>
<th>CPT</th>
<th>HCPCS</th>
<th>UBREV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mammography, bilateral</td>
<td>77056, 77057, 77066, 77067</td>
<td>G0202, G0204</td>
<td>0401, 0403</td>
</tr>
<tr>
<td>Mammography, unilateral</td>
<td>77055, 77065</td>
<td>G0206</td>
<td></td>
</tr>
<tr>
<td>Digital breast tomosynthesis, unilateral</td>
<td>77061</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Digital breast tomosynthesis, bilateral</td>
<td>77062, 77063</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Be sure to use the appropriate modifiers (such as 50, LT and/or RT) as applicable.

If the member previously had a bilateral mastectomy, be sure to document as part of the member’s history in the chart and use the code below:

<table>
<thead>
<tr>
<th>Description</th>
<th>ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>History of a bilateral mastectomy</td>
<td>Z90.13</td>
</tr>
</tbody>
</table>

Helpful tips

- Unilateral mastectomies or absence of one breast do not meet compliance for this measure. Women must still have a mammogram on the remaining breast.
- Discuss mammogram screening with all female patients between 50-74 years of age (or younger if the patient has a family history of breast cancer or other risk factors).
- Conduct outreach calls to patients to remind them of the importance of annual wellness visits and assist in scheduling mammograms.
- Request and retain copies of mammography results in the patient’s records or tell patients to make sure they ask the mammography centers to send a copy to your office for records.
- Use your EMR to create flags or reminders for members who need a mammogram for a referral during their annual visit.
- Arrange one-on-one patient education by a health professional or trained person to discuss the importance of breast cancer screening.
- Display posters and educational messages in treatment rooms and waiting areas to help motivate patients to initiate discussions with you about screening.

Please note: The codes and tips listed do not guarantee reimbursement. The information provided is based on HEDIS 2018 technical specifications and the 2017 CMS technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.
How can we help?

- Offering current Clinical Practice Guidelines on our provider self-service website
- Providing individualized reports of your patients that are due or overdue for services
- Providing education to members on the importance of breast cancer screenings through various sources, such as phone calls, newsletters and health education fliers
- Working with you to plan, implement and evaluate member events to help promote mammogram screenings and other preventive health care services
- Offering nonemergency transportation for our members to appointments
- Assisting with scheduling appointments for our members, if needed
- Encouraging preventive care and well-woman visits through our Being Healthy Brings Rewards program

Contact our Quality Management team at 678-587-4868 with any questions or for additional information.

Other resources

You can find more information and tools online:

- CDC Breast Cancer Screening — https://www.cdc.gov/cancer/breast/basic_info/screening.htm

Notes
Cervical Cancer Screening

This HEDIS measure looks at the percentage of women 21-64 years of age who were screened for cervical cancer using either of the following criteria:

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

Record your efforts

Make sure your medical record documentation reflects all of the following:

- Date of the screening
- Type of test that was performed
- Notation if patient has a history of hysterectomy (Add complete details if it was a complete, total or radical abdominal or vaginal hysterectomy with no residual cervix.)

Code your services correctly

Proper coding is critical to ensure accurate reporting of these measures, and it may also decrease the need for medical record reviews. Use the following procedure codes to document cervical cancer screening:

<table>
<thead>
<tr>
<th>Description</th>
<th>CPT</th>
<th>HCPCS</th>
<th>UBREV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cervical cytology tests</td>
<td>88141-88143, 88147, 88148, 88150, 88152-88154, 88164-88167, 88174, 88175</td>
<td>G0123, G0124, G0141, G0143-G0145, G0147, G0148, P3000, P3001, Q0091</td>
<td></td>
</tr>
<tr>
<td>HPV tests</td>
<td>87620-87622, 87624, 87625</td>
<td>G0476</td>
<td></td>
</tr>
</tbody>
</table>

If the member previously had a hysterectomy or an absence of the cervix, document as part of the member’s history in the chart and use one of the diagnosis codes below:

<table>
<thead>
<tr>
<th>Description</th>
<th>ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Absence of both cervix and uterus</td>
<td>Z90.710</td>
</tr>
<tr>
<td>Absence of cervix with remaining uterus</td>
<td>Z90.712</td>
</tr>
<tr>
<td>Congenital absence of cervix</td>
<td>Q51.5</td>
</tr>
</tbody>
</table>

Note: Be sure to include, at a minimum, the year the surgical procedure was performed.

Helpful tips

- Discuss the importance of well-woman exams, mammograms, Pap tests and HPV testing with all female patients between 21-64 years of age.
- Be a champion in promoting women’s health by reminding them of the importance of annual wellness visits.
- Refer members to another appropriate provider if your office does not perform Pap tests and request copies of results be sent to your office.
- Train your staff on the use of educational materials to promote cervical cancer screening.
- Use your EMR and/or a manual tracking tool to identify patients due for cervical cancer screening.
- Display posters and educational messages in treatment rooms and waiting areas to help motivate patients to initiate discussions with you about screening.

Please note: The codes and tips listed do not guarantee reimbursement. The information provided is based on HEDIS 2018 technical specifications and the 2017 CMS technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.
How can we help?
- Offering current Clinical Practice Guidelines on our provider self-service website
- Providing individualized reports of your patients that are due or overdue for services
- Working with you to plan, implement and evaluate member events to help promote cervical cancer screenings and other preventive health care services
- Offering nonemergency transportation for our members to appointments
- Providing education to members on the importance of cervical cancer screenings through various sources such as phone calls, post cards, newsletters and health education fliers
- Encouraging preventive care and well-woman visits through our Being Healthy Brings Rewards program

Contact our Quality Management team at 678-587-4868 with any questions or for additional information.

Other resources
You can find more information and tools online:

Notes
Chlamydia Screening in Women

This HEDIS measure looks at sexually active women 16-24 years of age who received at least one chlamydia test during the measurement year.

Code your services correctly

Use the following procedure codes to document screenings for chlamydia:

<table>
<thead>
<tr>
<th>Description</th>
<th>CPT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chlamydia tests</td>
<td>87110, 87270, 87320, 87490-87492, 87810</td>
</tr>
</tbody>
</table>

Helpful tips

- Chlamydia is the most frequently reported bacterial sexually transmitted disease in the United States. An estimated three million chlamydia infections occur annually among sexually active adolescents and young adults. Chlamydia may cause infertility if left undiagnosed or untreated.
- Screening for chlamydia is recommended at least annually for all sexually active women 24 years of age and younger.
- While screening for chlamydia in sexually active females can be done during any visit, routinely screen female patients who are sexually active in this age group for chlamydia every year as part of their annual well visit.
- Urine screening for chlamydia is acceptable for all female patients 16 years of age and older during adolescent well-care visits.
- 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) present.
  - Reinforcing confidentiality within limits.
  - Introducing sensitive issues by starting with nontargeting 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 ensure that you receive the results.
- Manage positive chlamydia tests and provide treatment the same way as any other test result:
  - Ensure continuity of care after a positive screening test.
  - Set aside time to discuss the test result, treatment plan and the implications of a positive test result with your patients.
  - Educate patients on the need to inform their partner(s). Reinfection is common and may cause infertility.

How can we help?

- Offering current Clinical Practice Guidelines on our provider self-service website
- Providing individualized reports of your patients that are due or overdue for services
- Providing your office with resources such as health education materials (e.g., Ameritips)
- Assisting with scheduling appointments for our members, if needed

Contact our Quality Management team at 678-587-4868 with any questions or for additional information.

Please note: The codes and tips listed do not guarantee reimbursement. The information provided is based on HEDIS 2018 technical specifications and the 2017 CMS technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.
Other resources
You can find more information and tools online:

- U.S. Preventive Services Task Force Clinical Summary on Chlamydia Screening —

Notes

Please note: The codes and tips listed do not guarantee reimbursement. The information provided is based on HEDIS 2018 technical specifications and the 2017 CMS technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.
Comprehensive Diabetes Care

This HEDIS measure looks at members 18-75 years of age with diabetes (type 1 and type 2) who had each of the following during the calendar year:

- Hemoglobin A1c (HbA1c) testing
- HbA1c poor control (< 9.0 percent)
- HbA1c control (< 8.0 percent)
- HbA1c control (< 7.0 percent)
- BP control (< 140/90 mm Hg)
- Medical attention for nephropathy
- Dilated retinal eye exam

Record your efforts
Make sure that your medical record documentation reflects:

- Date of each visit.
- All diabetes evaluation notes.
- All blood pressure readings, lab test orders with results as well as eye exams and results:
  - If services listed above were not completed as recommended, document the reasons.
- Referrals for other providers for diabetes care such as endocrinologists.

Code your services correctly
Proper coding is critical to ensure accurate reporting of these measures, and it may also decrease the need for medical record reviews. Use the following diagnosis and procedure codes to document comprehensive diabetes care:

<table>
<thead>
<tr>
<th>Description</th>
<th>CPT</th>
<th>ICD-10-CM</th>
<th>HCPCS</th>
</tr>
</thead>
<tbody>
<tr>
<td>HbA1c Test</td>
<td>83036, 83037, 3044F-3046F</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment for nephropathy</td>
<td>3066F, 4010F</td>
<td>E08.21, E08.22, E08.29, E09.21, E09.22, E09.29, E10.21, E10.22, E10.29, E11.21, E11.22, E11.29, E13.21, E13.22, E13.29, I12.0, I12.9, I13.0, I13.10, I13.11, I13.2, I15.0, I15.1, N00.0-N07.9, N08, N14.0-N14.4, N17.0-N17.2, N17.8, N17.9, N18.1-N18.6, N18.9, N19, N25.0, N25.1, N25.81, N25.89, N25.9, N26.1, N26.2, Q60.0-Q60.6, Q61.00-Q61.02, Q61.11, Q61.19, Q61.2-Q61.5, Q61.8, Q61.9, R80.0-R80.3, R80.8, R80.9</td>
<td></td>
</tr>
<tr>
<td>Urine protein test</td>
<td>81000-81003, 81005, 82042-82044, 84156, 3060F-3062F</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood pressure</td>
<td>3074F, 3075F, 3077F-3080F</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please note: The codes and tips listed do not guarantee reimbursement. The information provided is based on HEDIS 2018 technical specifications and the 2017 CMS technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.
Description | CPT | ICD-10-CM | HCPCS
---|---|---|---

* Indicates retinal eye exam with eye care professional

Helpful tips

- If your practice uses EMRs, set flags or reminders in the system to alert your staff when a patient’s screenings are due.
- If you use paper charts, consider having a template to identify the last date of necessary screening and the next time the patient should be screened.
- Send appointment reminders and call patients to remind them of upcoming appointments.
- Consider including a diabetes educator on your team or periodically bringing one in to speak with patients during office visits.
- Draw labs in your office rather than referring members to a local lab for screenings.
- Refer members to the network of eye providers for their annual diabetic eye exam.
- Eye exams from prior year that are negative for retinopathy are counted as compliant.
- Follow up on lab test results, eye exam results or any specialist referral and document on your chart.
- Educate your patients, their families, caregivers and guardians on diabetes care, including:
  - Taking all prescribed medications as directed.
  - Adding regular exercise to daily activities to maintain healthy weight and ideal body mass index.
  - Regularly monitoring blood sugar and blood pressure at home.
  - Eating heart-healthy, low-calorie and low-fat foods.
  - Stopping smoking and avoiding second-hand smoke.
  - Fasting prior to having blood sugar/lipid panels drawn to ensure accurate results.
  - Keeping all medical appointments; getting help with scheduling necessary appointments, screenings and tests to improve compliance.

How can we help?

- Offering current Clinical Practice Guidelines on our provider self-service website
- Offering disease management programs to our members
- Working with you to plan, implement and evaluate member events to help promote diabetes care management and other preventive health care services
- Providing individualized reports of your patients that are due or overdue for services
- Offering nonemergency transportation for our members to appointments
- Encouraging diabetic care management through our Being Healthy Brings Rewards program

Please note: The codes and tips listed do not guarantee reimbursement. The information provided is based on HEDIS 2018 technical specifications and the 2017 CMS technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.
Contact our Quality Management team at 678-587-4868 with any questions or for additional information.

**Other resources**

You can find more information and tools online:

- American Diabetes Association — www.diabetes.org
- Avesis Vision provider — www.avesis.com
- CDC Information on Diabetes — www.cdc.gov/diabetes/home
- Disease Management Centralized Care Unit — https://providers.amerigroup.com/Pages/ga-about-dmccu.aspx

**Notes**

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Controlling High Blood Pressure

This HEDIS measure looks at members 18-85 years of age who had a diagnosis of hypertension and whose blood pressure (BP) is regularly monitored and adequately controlled based on the following criteria:

- Members 18-59 years of age whose BP was < 140/90 mm Hg
- Members 60-85 years of age with a diagnosis of diabetes whose BP was < 140/90 mm Hg
- Members 60-85 years of age without a diagnosis of diabetes whose BP was < 150/90 mm Hg

Record your efforts

Make sure that your medical record documentation reflects all of the following:

- Date of each visit
- All progress notes, problem history and medication reviews
- All BP readings

Code your services correctly

Use the following diagnosis and procedure codes to document hypertension and outpatient visits:

<table>
<thead>
<tr>
<th>Description</th>
<th>ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Essential hypertension</td>
<td>I10</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Description</th>
<th>CPT</th>
<th>HCPCS</th>
<th>UBREV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient visits</td>
<td>99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99385-99387, 99395-99397, 99401-99404, 99411, 99412, 99429, 99455, 99456</td>
<td>G0402, G0438, G0439, G0463, T1015</td>
<td>0510-0517, 0519-0523, 0526-0529, 0982, 0983</td>
</tr>
</tbody>
</table>

Helpful tips

- Both systolic and diastolic values must be below stated values. Only the most recent BP measurement during the year counts towards compliance.
- Improve the accuracy of BP measurements performed by your clinical staff by:
  - Providing training 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.
- Instruct your office staff to recheck the BP 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 hypertension programs for additional education and support by calling 1-800-454-3730 to speak with a case manager.
- Perform chart audits and obtain one-on-one feedback by physician leaders.
- 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 BMI.

Please note: The codes and tips listed do not guarantee reimbursement. The information provided is based on HEDIS 2018 technical specifications and the 2017 CMS technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.
The importance of taking all prescribed medications as directed.

How can we help?
- Offering current Clinical Practice Guidelines on our provider self-service website
- Providing individualized reports of your hypertensive patients that are due or overdue for services
- Offering nonemergency transportation for our members to appointments
- Working with you to plan, implement and evaluate member events to help promote preventive health care services
- Providing education to members the importance of managing their high BP through various sources, such as phone calls, newsletters and health education fliers
- Providing your office with resources such as health education materials about hypertension (e.g., Ameritips)

Contact our Quality Management team at 678-587-4868 with any questions or for additional information.

Other resources
You can find more information and tools online:
- American Heart Association — www.heart.org
- Disease Management Centralized Care Unit — https://providers.amerigroup.com/Pages/ga-about-dmccu.aspx

Notes

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Developmental Screening in the First Three Years of Life

This CMS measure looks at children screened for risk of developmental, behavioral and social delays using a standardized screening tool in the 12 months preceding their first, second or third birthday.

Record your efforts
Make sure that your medical record documentation reflects all of the following:
- The date in which the screening test was performed
- The standardized tool that was used
- The result or score from the screening

Code your services correctly
Proper coding is critical to ensure accurate reporting of these measures, and it may also decrease the need for medical record reviews. Use the following procedure code to document developmental screening:

<table>
<thead>
<tr>
<th>Description</th>
<th>CPT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developmental screening with scoring and documentation, per standardized instrument</td>
<td>96110</td>
</tr>
</tbody>
</table>

When billing office visits for preventive health screening services, providers must use the appropriate diagnosis code, EP modifier and POS code 99. The 25 modifier must be included when a vaccine is administered during the preventive visit.

Helpful tips
- Follow the American Academy of Pediatrics *Bright Futures Periodicity Schedule* of recommendations for preventive pediatric health care for well visits and screenings.
- The American Academy of Pediatrics recommends that the developmental screening be completed at the 9-month, 18-month and 30-month visits. If applicable, the screening can be performed during a catch-up visit.
- Standardized tools that are only focused on one domain of development do not count for this measure (such as the ASQ-SE or M-CHAT). Appropriate developmental screening tools identify risk for developmental, behavioral and social delays.
- The following tools that meet the criteria for developmental screening include:
  - *Ages and Stages Questionnaire (ASQ)* — 2 months-5 years
  - *Ages and Stages Questionnaire — 3rd Edition (ASQ-3)*
  - *Battelle Developmental Inventory Screening Tool (BDI-ST)* — birth-95 months
  - *Bayley Infant Neuro-developmental Screen (BINS)* — 3 months-2 years
  - *Brigance Screens-II* — birth-90 months
  - *Child Development Inventory (CDI)* — 18 months-6 years
  - *Infant Development Inventory* — birth-18 months
  - *Parents’ Evaluation of Developmental Status (PEDS)* — birth-8 years
  - *Parent’s Evaluation of Developmental Status — Developmental Milestones (PEDS-DM)*
- Consider offering evening, early morning and/or weekend office hours to accommodate working parents or guardians.
- Appointment reminders by text, email, postcard or phone call work well for most parents and young adults.

Please note: The codes and tips listed do not guarantee reimbursement. The information provided is based on HEDIS 2018 technical specifications and the 2017 CMS technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.
How can we help?
- Providing individualized reports of your patients that are due or overdue for services
- Working with you to plan, implement and evaluate member events to help promote preventive health care services
- Assisting with scheduling appointments for our members, if needed
- Offering nonemergency transportation for our members to appointments
- Encouraging preventive care through our Being Healthy Brings Rewards program

Contact our Quality Management team at 678-587-4868 with any questions or for additional information.

Other resources
You can find more information and tools online:
- Developmental Monitoring and Screening — https://www.cdc.gov/ncbddd/childdevelopment/screening-hcp.html
- Georgia Medicaid Management Information System — https://www.mmis.georgia.gov/portal

Notes
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications

This HEDIS measure looks at members 18-64 years of age with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.

Code your services correctly

Use the following diagnosis and procedure codes to identify a diagnosis of schizophrenia or bipolar disorder and screening tests for diabetes:

<table>
<thead>
<tr>
<th>Description</th>
<th>ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bipolar disorder</td>
<td>F30.10-F30.13, F30.2-F30.4, F30.8, F30.9, F31.0, F31.10-F31.13, F31.2,</td>
</tr>
<tr>
<td></td>
<td>F31.30-F31.32, F31.4, F31.5, F31.60-F31.64, F31.70-F31.78, F31.81, F31.89,</td>
</tr>
<tr>
<td></td>
<td>F31.9</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Description</th>
<th>CPT,</th>
</tr>
</thead>
<tbody>
<tr>
<td>HbA1c Tests</td>
<td>83036, 83037, 3044F-3046F</td>
</tr>
<tr>
<td>Glucose Tests</td>
<td>80047, 80048, 80050, 80053, 80069, 82947, 82950, 82951</td>
</tr>
</tbody>
</table>

Helpful tips

- Per the NCQA, lack of appropriate care for diabetes and cardiovascular disease for people with schizophrenia or bipolar disorder can lead to worsening health and death. Addressing these physical health needs of people with schizophrenia or bipolar disorder is an important way to improve health.
- Be sure to contact our Pharmacy department at 1-800-454-3730 to verify required preauthorization of medications.
- Antipsychotic medications may include but are not limited to:

<table>
<thead>
<tr>
<th>Description</th>
<th>Prescriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Miscellaneous antipsychotic agents</td>
<td>Aliciprazole, Asenapine, Brexpiprazole, Cariprazine, Clozapine, Haloperidol, Iloperidone, Loxapine, Fluoxetine-olanzapine, Thiothixene, Thioridazine, Paliperidone, Pimozide, Quetiapine, Quetiapine fumarate, Risperidone, Ziprasidone, Trifluoperazine</td>
</tr>
<tr>
<td>Phenothiazine antipsychotics</td>
<td>Chlorpromazine, Fluphenazine, Perphenazine, Perphenazine-amitriptyline, Prochlorperazine, Trifluoperazine</td>
</tr>
<tr>
<td>Psychotherapeutic combinations</td>
<td>Fluoxetine-olanzapine</td>
</tr>
<tr>
<td>Thioxanthenes</td>
<td>Thiothixene</td>
</tr>
<tr>
<td>Long-acting injections</td>
<td>Fluphenazine decanoate, Paliperidone palmitate, Aripiprazole, Haloperidol decanoate, Risperidone, Olanzapine</td>
</tr>
</tbody>
</table>

Note: Not all medications listed above are in our Formulary. Prior authorization and/or step therapy may be required.

Please note: The codes and tips listed do not guarantee reimbursement. The information provided is based on HEDIS 2018 technical specifications and the 2017 CMS technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.
How can we help?
• Providing individualized reports of your patients that are due or overdue for services
• Offering disease management and behavioral health case management programs to members

Contact our Quality Management team at 678-587-4868 with any questions or for additional information.

Other resources
You can find more information and tools online:
• Behavioral health case management —
  https://providers.amerigroup.com/ProviderDocuments/ALL_BHCaseMgmt.pdf
• Diabetes, Psychiatric Disorders, and the Metabolic Effects of Antipsychotic Medications —
  http://clinical.diabetesjournals.org/content/24/1/18
• Disease Management Centralized Care Unit — https://providers.amerigroup.com/Pages/ga-about-dmccu.aspx

Notes

Please note: The codes and tips listed do not guarantee reimbursement. The information provided is based on HEDIS 2018 technical specifications and the 2017 CMS technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.
Follow-Up After Hospitalization for Mental Illness

This HEDIS measure looks at members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had a follow-up visit with a mental health practitioner.

Two rates are reported:

- The percentage of discharges for which the member received a follow-up visit (outpatient, intensive outpatient encounter or partial hospitalization) within seven days of discharge
- The percentage of discharges for which the member received a follow-up visit (outpatient, intensive outpatient encounter or partial hospitalization) within 30 days of discharge

**Code your services correctly**

Use the following diagnosis and procedure codes to identify a diagnosis of mental health or illness and follow-up visits:

<table>
<thead>
<tr>
<th>Description</th>
<th>ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental health or illness</td>
<td>F03.90, F03.91, F20.0-F53, F59-FF66, F68.10-F69, F80.0-F84.9, F88-F95.9, F98.0-F99</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Description</th>
<th>CPT</th>
<th>HCPCS</th>
<th>UBREV</th>
<th>POS*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visits group 1</td>
<td>90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90867-90870, 90875, 90876</td>
<td>0513, 0900-0905, 0907, 0911-0916, 0917, 0919</td>
<td>03, 05, 07, 09, 11-20, 22, 24, 33, 49, 50, 52, 53, 71, 72</td>
<td></td>
</tr>
<tr>
<td>Visits group 2</td>
<td>99221-99223, 99231-99233, 99238, 99239, 99251-99255</td>
<td>0510, 0515-0517, 0519-0523, 0526-0529, 0982, 0983</td>
<td>52, 53</td>
<td></td>
</tr>
<tr>
<td>Transitional care management</td>
<td>99496, 99495**</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Be sure to include the appropriate POS code, if applicable. Visits that occur on the date of discharge do not count as a follow-up visit for this measure. If applicable, be sure to apply the modifier(s) for telehealth visits (GT, 95).

** Code only meets for the 30-Day follow-up.**

Please note: The codes and tips listed do not guarantee reimbursement. The information provided is based on HEDIS 2018 technical specifications and the 2017 CMS technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.
**Helpful tips**

- Educate your patients and their spouses, caregivers, or guardians about the importance of compliance with the long-term medications prescribed.
- Encourage patients to participate in our behavioral health case management program for help getting follow-up discharge appointments and other support.
- Teach patients’ families to review all discharge instructions for patients and ask for details of all follow-up discharge instructions, such as the dates and times of appointments.
- Ask patients with a mental health diagnosis to allow you access to their mental health records if you are their primary care provider.

**How can we help?**

- Offering current Clinical Practice Guidelines on our provider self-service website
- Providing individualized reports of your patients that are due or overdue for services
- Offering our behavioral health case management program to members

Contact our Quality Management team at 678-587-4868 with any questions or for additional information.

**Other resources**

You can find more information and tools online:

- Behavioral health case management —
  https://providers.amerigroup.com/ProviderDocuments/ALL_BHCaseMgmt.pdf
- National Institute of Mental Health — www.nimh.nih.gov

**Notes**
Follow-Up Care for Children Prescribed ADHD Medication

This HEDIS measure looks at children 6-12 years of age who were newly prescribed ADHD medication and had at least three follow-up care visits within a 10-month period. The first visit should be within 30 days of the first ADHD medication dispensed.

Two rates are reported:
- **Initiation phase:** follow-up visit with prescriber within 30 days of prescription
- **Continuation and maintenance phase:** remained on the ADHD medication for at least 210 days and had two more follow-up visits within 270 days (nine months)

**Code your services correctly**

Use the following diagnosis and procedure codes to identify the follow-up visits for children utilizing an ADHD medication:

<table>
<thead>
<tr>
<th>Description</th>
<th>CPT</th>
<th>HCPCS</th>
<th>UBREV</th>
<th>POS*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visits group 1</td>
<td>90791, 90792, 90832-90840, 90845, 90847, 90849, 90853, 90875, 90876</td>
<td></td>
<td></td>
<td>03, 05, 07, 09, 11-20, 22, 33, 49, 50, 52, 53, 71, 72</td>
</tr>
<tr>
<td>Visits group 2</td>
<td>99221-99223, 99231-99233, 99238, 99239, 99251-99255</td>
<td></td>
<td></td>
<td>52, 53</td>
</tr>
<tr>
<td>Telephone visits*</td>
<td>98966-98968, 99441-99443</td>
<td></td>
<td></td>
<td>02</td>
</tr>
</tbody>
</table>

* Be sure to include the appropriate POS code, if applicable.

** Only one of the two additional visits in the continuation and maintenance phase may be a telephone or telehealth visit. If applicable, be sure to apply the applicable modifier(s) for telehealth visits (GT, 95).

**Helpful tips**
- When prescribing a new ADHD medication:
  - Be sure to schedule a follow-up visit right away (scheduling the appointment within three weeks of the medication initiation should allow time for rescheduling before the 30 days if needed).
  - Visits must be scheduled within 30 days of ADHD medication initially prescribed or restarted after a 120-day break. (Consider writing the initial prescription for only a three-week supply.)
  - Schedule follow-up visits while patients are still in the office.
  - Have your office staff call patients at least three days before appointments.

Please note: The codes and tips listed do not guarantee reimbursement. The information provided is based on HEDIS 2018 technical specifications and the 2017 CMS technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.
After the initial follow-up visit, schedule at least two more office visits in the next nine months to monitor patient’s progress.

- Be sure that follow-up visits include the diagnosis of ADHD.

- Educate your patients and their parents, guardians, or caregivers about the use of and compliance with long-term ADHD medications and the disease process.

- Discuss how and when the medication will be administered (such as only during school or every day, etc.) as these factors may affect the length of the prescription given.

- Collaborate with other organizations to share information, research best practices about ADHD interventions and appropriate standards of practice, their effectiveness and safety.

- Be sure to contact the Pharmacy department at 1-800-454-3730 to verify required preauthorization of medications.

- ADHD medications include but may not be limited to:

<table>
<thead>
<tr>
<th>Description</th>
<th>Prescriptions</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>CNS stimulants</td>
<td>• Amphetamine-dextroamphetamine</td>
<td>• Lisdexamfetamine</td>
</tr>
<tr>
<td></td>
<td>• Dextmethylphenidate</td>
<td>• Methamphetamine</td>
</tr>
<tr>
<td></td>
<td>• Dextroamphetamine</td>
<td>• Methylphenidate</td>
</tr>
<tr>
<td>Alpha-2 receptor agonists</td>
<td>• Clonidine</td>
<td>• Guanfacine</td>
</tr>
<tr>
<td>Miscellaneous ADHD medications</td>
<td>• Atomoxetine</td>
<td></td>
</tr>
</tbody>
</table>

**Note:** Not all medications listed above are in our formulary. Prior authorization and/or step therapy may be required.

**How can we help?**

- Offering current Clinical Practice Guidelines on our provider self-service website
- Assisting with scheduling appointments for our members, if needed
- Assisting with reminder calls to members for their scheduled follow-up appointments
- Providing individualized reports of your patients that are due or overdue for services
- Providing education to members on ADHD through various sources, such as newsletters and health education materials

Contact our Quality Management team at 678-587-4868 with any questions or for additional information.

**Other resources**

You can find more information and tools online:

- The National Resource on ADHD — www.chadd.org

**Notes**
Immunizations for Children and Adolescents

Immunizations for children
This HEDIS measure looks at members 2 years of age and younger who received the following immunizations on or before their 2nd birthday:

<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>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Immunization</th>
<th>Dose(s)</th>
</tr>
</thead>
<tbody>
<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>

Immunizations for adolescents
This HEDIS measure looks at adolescents 13 years of age who received the following immunizations on or before their 13th 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>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Immunization</th>
<th>Dose(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>HPV</td>
<td>2 or 3</td>
</tr>
</tbody>
</table>

Record your efforts
Make sure that your medical record documentation reflects all the following:

- Date of the immunization (historic and current)
- The name of the specific antigen administered
- Evidence of anaphylactic reaction to any vaccine or its components, if applicable
- Parent refusal, documented history of illness or seropositive test result
- The date of the first Hep B vaccine given at the hospital and name of the hospital, if available

Code your services correctly
Proper coding is critical to ensure accurate reporting of these measures, and it may also decrease the need for medical record reviews. Use the following procedure codes to document immunizations for children and adolescents:

<table>
<thead>
<tr>
<th>Description</th>
<th>Immunization</th>
<th>CPT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immunizations for children</td>
<td>DTap</td>
<td>90698, 90700, 90721, 90723</td>
</tr>
<tr>
<td></td>
<td>IPV</td>
<td>90698, 90713, 90723</td>
</tr>
<tr>
<td></td>
<td>MMR</td>
<td>90707, 90710</td>
</tr>
<tr>
<td></td>
<td>Measles</td>
<td>90705</td>
</tr>
<tr>
<td></td>
<td>Measles/rubella</td>
<td>90708</td>
</tr>
<tr>
<td></td>
<td>Mumps</td>
<td>90704</td>
</tr>
<tr>
<td></td>
<td>Rubella</td>
<td>90706</td>
</tr>
<tr>
<td></td>
<td>Hib</td>
<td>90644-90648, 90698, 90721, 90748</td>
</tr>
<tr>
<td></td>
<td>Hep B</td>
<td>90723, 90740, 90744, 90747, 90748</td>
</tr>
<tr>
<td></td>
<td>VZV</td>
<td>90710, 90716</td>
</tr>
<tr>
<td></td>
<td>PCV</td>
<td>90669, 90670</td>
</tr>
<tr>
<td></td>
<td>Hep A</td>
<td>90633</td>
</tr>
<tr>
<td></td>
<td>Rotavirus (2 dose)</td>
<td>90681</td>
</tr>
<tr>
<td></td>
<td>Rotavirus (3 dose)</td>
<td>90680</td>
</tr>
<tr>
<td></td>
<td>Influenza</td>
<td>90655, 90657, 90661, 90662, 90673, 90685, 90687</td>
</tr>
</tbody>
</table>

Please note: The codes and tips listed do not guarantee reimbursement. The information provided is based on HEDIS 2018 technical specifications and the 2017 CMS technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.
<table>
<thead>
<tr>
<th>Description</th>
<th>Immunization</th>
<th>CPT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immunizations for adolescents</td>
<td>HPV***</td>
<td>90649-90651</td>
</tr>
<tr>
<td></td>
<td>Meningococcal*</td>
<td>90644, 90734</td>
</tr>
<tr>
<td></td>
<td>Tdap**</td>
<td>90715</td>
</tr>
</tbody>
</table>

* Meningococcal — The service date must occur on or between the member’s 11th and 13th birthdays.
** Tdap orTd — The service date must occur on or between the member’s 10th and 13th birthdays.
*** HPV — The service date must occur on or between the member’s 9th and 13th birthdays. There must be at least 146 days between the first and second dose of the HPV vaccine. For example, if the service date for the first vaccine was March 1, then the service date for the second vaccine must be after July 25.

When billing office visits for preventive health screening services, providers must use the appropriate diagnosis code, EP modifier and POS code 99. The 25 modifier must be included when a vaccine is administered during the preventive visit.

EPSDT preventive health screenings are exempt from third-party liability. Even if the member has other health insurance, you may file Medicaid first for preventive health services. This will ensure accurate and timely reporting of EPSDT services.

**Helpful tips**
- Administer immunizations in accordance to the ACIP. Check the Georgia Registry of Immunization Transactions and Services (GRITS) database to ensure vaccines have not been administered elsewhere.
- An immunization assessment is a key element of preventive health services and is required for all children. Develop or implement standing orders for nurses and physician assistants in your practice to allow staff to identify opportunities to immunize. If you use an EMR, create a flag to track patients due for immunizations.
- Once you give members their needed immunizations, let us and the state know by recording the immunizations in GRITS.
- Consider offering evening, early morning and/or weekend office hours to accommodate working young adults or parents with children involved in after-school activities.
- Enroll in the Vaccines for Children (VFC) program to receive vaccines. For questions about enrollment and vaccine orders, contact the VFC program at 1-800-848-3868.

**How can we help?**
- Providing you with individual reports of your patients overdue for services if needed
- Working with you to plan, implement and evaluate member events to help promote well-child visits, immunizations and other preventive health care services
- Assisting with scheduling appointments for our members, if needed
- Providing education to members on the importance of immunizations through various sources, such as phone calls, newsletters and health education materials
- Offering nonemergency transportation for our members to appointments
- Encouraging preventive care through our Being Healthy Brings Rewards program

Contact our Quality Management team at 678-587-4868 with any questions or for additional information.

Please note: The codes and tips listed do not guarantee reimbursement. The information provided is based on HEDIS 2018 technical specifications and the 2017 CMS technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.
Other resources
You can find more information and tools online:

- **ACIP Immunization Schedule** — [www.cdc.gov/vaccines/schedules/hcp/index.html](http://www.cdc.gov/vaccines/schedules/hcp/index.html)
- Georgia Medicaid Management Information System — [https://www.mmis.georgia.gov/portal](https://www.mmis.georgia.gov/portal)
- Vaccines for Children program — [https://dph.georgia.gov/vaccines-children-program](https://dph.georgia.gov/vaccines-children-program)

Notes
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

This HEDIS measure looks at members 13 years of age and older with a new episode of alcohol or other drug (AOD) dependence treatment who received the following treatment:

- **Initiation of AOD treatment** — started treatment within 14 days of the diagnosis through:
  - An acute or nonacute inpatient AOD dependence facility
  - An outpatient visit for AOD dependence abuse or dependence
  - An intensive outpatient or partial hospitalization

- **Engagement of AOD treatment** — started the above initiation treatment and had two or more additional alcohol and other drug dependence treatment sessions within 30 days of the initiating treatment

Code your services correctly

Use the following diagnosis and procedure codes for AOD dependence and visits for the initiation and engagement of alcohol or other drug dependence treatment:

<table>
<thead>
<tr>
<th>Description</th>
<th>ICD-10-CM</th>
<th>HCPCS</th>
<th>UBREV</th>
</tr>
</thead>
<tbody>
<tr>
<td>AOD dependence</td>
<td>F10.10-F19.29</td>
<td>H0008-H0014</td>
<td>0116, 0126, 0136, 0146, 0156</td>
</tr>
<tr>
<td>Detoxification</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Description</th>
<th>CPT</th>
<th>HCPCS</th>
<th>UBREV</th>
</tr>
</thead>
<tbody>
<tr>
<td>IET visits group 1</td>
<td>90791, 90792, 90832-90840, 90845, 90847, 90849, 90853, 90875, 90876</td>
<td></td>
<td>03, 05, 07, 09, 11-20, 22, 33, 49, 50, 52, 53, 57, 71, 72</td>
</tr>
<tr>
<td>IET visits group 2</td>
<td>99221-99223, 99231-99233, 99238, 99239, 99251-99255</td>
<td></td>
<td>52, 53</td>
</tr>
</tbody>
</table>

Helpful tips

Some of the barriers to members starting and engaging in substance abuse treatment include:

- Lack of member knowledge on importance and availability of treatment services.
- Lack of coordination of care between physical and behavioral health practitioners.
- Denial of patients in addressing their alcohol or other drug dependence.
- Resistance to seeking drug and alcohol treatment due to social stigma.

Please note: The codes and tips listed do not guarantee reimbursement. The information provided is based on HEDIS 2018 technical specifications and the 2017 CMS technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.
• No support from family, friends, peer or other community groups.
• Little emphasis from providers in addressing these issues during a regular wellness visit.

How can we help?
• Outreaching to providers to be advocates and provide the resources needed to educate our members
• Guiding with the above noted services to drive member success in completing alcohol and other drug dependence treatment

Other resources
You can find more information and tools online:
• Behavioral health case management — https://providers.amerigroup.com/ProviderDocuments/ALL_BHCaseMgmt.pdf
• National Institute of Alcohol Abuse and Alcoholism — https://niaaa.nih.gov
• Substance Abuse and Mental Health Services Administration — https://www.samhsa.gov/atod
• Disease Management Centralized Care Unit — https://providers.amerigroup.com/Pages/ga-about-dmccu.aspx

Notes
Lead Screening in Children

This HEDIS measure looks at members who had one or more capillary or venous lead blood tests for lead poisoning on or before their 2nd birthday.

Record your efforts
Make sure that your medical record documentation reflects all of the following:
- Date the blood test was performed
- Results or findings

Code your services correctly
Proper coding is critical to ensure accurate reporting of these measures, and it may also decrease the need for medical record reviews. Use the following diagnosis and procedure codes to document lead screenings:

<table>
<thead>
<tr>
<th>Description</th>
<th>CPT</th>
<th>ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead screening</td>
<td>83655**</td>
<td>Z13.88</td>
</tr>
<tr>
<td>Capillary or venous</td>
<td>36415* or 36416*</td>
<td>Z13.88</td>
</tr>
</tbody>
</table>

* When billing these CPT codes, providers must bill with the diagnosis code to signify blood lead level screening.

**Be sure to use modifiers 90 and 91, if applicable.

When billing office visits for preventive health screening services, providers must use the appropriate diagnosis code, EP modifier and POS code 99. The 25 modifier must be included when a vaccine is administered during the preventive visit.

EPSDT preventive health screenings are exempt from third-party liability. Even if the member has other health insurance, you may file Medicaid first for preventive health services. This will ensure accurate and timely reporting of EPSDT services.

Helpful tips
- CMS requires universal lead screenings (blood tests) for Medicaid eligible children at 12 and 24 months of age.
- Completing a lead risk assessment questionnaire does not count as a lead screening. Completing a blood-screening test meets compliance.
- Anticipatory guidance is required as part of a routine preventive health visit. You should cover:
  - Effects of lead poisoning on children.
  - Sources of lead poisoning.
  - Pathways of exposure.
  - How to prevent childhood exposure to lead hazards.
  - Appropriate testing schedules for children.
- Draw patient’s blood while they are in your office instead of sending them to the lab. Consider performing finger stick screenings in your practice.
- Develop a process to check medical records for lab results to ensure previously ordered lead screenings have been completed and documented. Assign one staff member to follow up on results when patients are sent to a lab for screening.

Please note: The codes and tips listed do not guarantee reimbursement. The information provided is based on HEDIS 2018 technical specifications and the 2017 CMS technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.
Sick visits may be a missed opportunity to complete a lead screening or an annual well visit.
Include a lead test reminder with lab name and address on your appointment confirmation/reminder cards.
If you obtain the specimen and analyze the test in your office, you should report results to the Georgia Healthy Homes and Lead Poisoning Prevention Program. See the link in Other Resources.
Contact our Case Management department if the results are greater than 10 micrograms/dl.

How can we help?
- Offering current Clinical Practice Guidelines on our provider self-service website
- Providing individualized reports of your patients that are due or overdue for services
- Sending reminder postcards to members due for a lead screening
- Working with you to plan, implement and evaluate member events to help promote well-child visits, lead screenings and other preventive health care services
- Assisting with scheduling appointments for our members, if needed
- Offering nonemergency transportation for our members to appointments
- Encouraging preventive care through our Being Healthy Brings Rewards program

Contact our Quality Management team at 678-587-4868 with any questions or for additional information.

Other resources
You can find more information and tools online:
- Georgia Medicaid Management Information System — https://www.mmis.georgia.gov/portal

Notes

Please note: The codes and tips listed do not guarantee reimbursement. The information provided is based on HEDIS 2018 technical specifications and the 2017 CMS technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.
Medication Management for People with Asthma

This HEDIS measure looks at the percentage of members 5-64 years of age who were identified as having persistent asthma and were dispensed the appropriate asthma controller medication that they remained on during the treatment period.

Two rates are reported:
- The percentage of members who remained on an asthma controller medication for at least 50 percent of their treatment period
- The percentage of members who remained on an asthma controller medication for at least 75 percent of their treatment period

Code your services correctly

Use the following diagnosis codes to appropriately document asthma:

<table>
<thead>
<tr>
<th>Description</th>
<th>ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma</td>
<td>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</td>
</tr>
</tbody>
</table>

Helpful tips

- For members with asthma, you should:
  - Prescribe controller medication.
  - Educate members in identifying asthma triggers and taking controller medications.
  - Remind members to get their controller medication filled regularly.
  - Remind members not to stop taking the controller medications even if they are feeling better and are symptom-free.
  - Create and maintain an asthma action plan.
  - Offer annual flu shots in your office or inform your patients of the importance of getting the vaccine and where they can get it.
- Be sure to keep notes of every time you prescribe an asthma medication.
- Be sure to contact the Pharmacy department at 1-800-454-3730 to verify required preauthorization of medications.
- Appropriate medications for asthma include but are not limited to:

<table>
<thead>
<tr>
<th>Description</th>
<th>Prescriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antiasthmatic combinations</td>
<td>• Dyphylline-guaifenesin • Guaifenesin-theophylline</td>
</tr>
<tr>
<td>Antibody inhibitors</td>
<td>• Omalizumab</td>
</tr>
<tr>
<td>Inhaled steroid combinations</td>
<td>• Budesonide-formoterol • Fluticasone-salmeterol • Fluticasone-salmeterol-free</td>
</tr>
<tr>
<td>Inhaled corticosteroids</td>
<td>• Beclomethasone • Flunisolide</td>
</tr>
<tr>
<td></td>
<td>• Budesonide • Ciclesonide • Mometasone</td>
</tr>
</tbody>
</table>

Note: Not all medications listed above are in our Formulary. Prior authorization and/or step therapy may be required.

Please note: The codes and tips listed do not guarantee reimbursement. The information provided is based on HEDIS 2018 technical specifications and the 2017 CMS technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.
<table>
<thead>
<tr>
<th>Description</th>
<th>Prescriptions</th>
</tr>
</thead>
</table>
| Leukotriene modifiers               | • Montelukast  
|                                     | • Zileuton  
|                                     | • Zafirlukast               |
| Mast cell stabilizers               | • Cromolyn                  |
| Mast cell stabilizers               | • Cromolyn                  |
| Mast cell stabilizers               | • Cromolyn                  |
| Methyloxanthines                    | • Aminophylline  
|                                     | • Theophylline  
|                                     | • Dyphyllin                 |
| Short-acting, inhaled beta-2 agonists| • Albuterol  
|                                     | • Pirbuterol  
|                                     | • Levalbuterol              |

**Note:** Not all medications listed above are in our *Formulary*. Prior authorization and/or step therapy may be required.

**How can we help?**

- Offering current Clinical Practice Guidelines on our provider self-service website
- Providing individualized reports of your patients that are due or overdue for services
- Providing education to members on the importance of asthma control, medication compliance and controller medications through various sources, such as phone calls, newsletters and health education materials
- Offering disease management programs to our members
- Assisting with scheduling appointments for our members, if needed

Contact our Quality Management team at 678-587-4868 with any questions or for additional information.

**Other resources**

You can find more information and tools online:

- CDC’s Asthma Action Plan — [https://www.cdc.gov/asthma/actionplan.html](https://www.cdc.gov/asthma/actionplan.html)
- Disease Management Centralized Care Unit — [https://providers.amerigroup.com/Pages/ga-about-dmccu.aspx](https://providers.amerigroup.com/Pages/ga-about-dmccu.aspx)

**Notes**
Pharmacotherapy Management of COPD Exacerbation

This HEDIS measure looks at chronic obstructive pulmonary disease (COPD) exacerbations for members 40 years of age and older who had an acute inpatient discharge or emergency department (ED) visit on or between January 1-November 30 of the measurement year and who were dispensed appropriate medications.

Two rates are reported:
- Dispensed a systemic corticosteroid (or there was evidence of an active prescription) within 14 days of the acute inpatient discharge or ED visit
- Dispensed a bronchodilator (or there was evidence of an active prescription) within 30 days of the acute inpatient discharge or ED visit

Record your efforts
Make sure that medical record reflects all of the following:
- Your review of the discharge summary along with the discharge medications for both a systemic corticosteroid and a bronchodilator
- A schedule of regular follow-up visits to review the medication management/compliance
- Record of any new prescriptions written at follow-up visits
- All discussions about the COPD disease process — medication management along with proper use of inhalers and other medications, such as systemic corticosteroids, patient compliance and availability of smoking cessation assistance

Code your services correctly
Use the following diagnosis and procedure codes to identify COPD, inpatient stays and ED visits:

<table>
<thead>
<tr>
<th>Description</th>
<th>ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic bronchitis</td>
<td>J41.0, J41.1, J41.8, J42</td>
</tr>
<tr>
<td>COPD</td>
<td>J44.0, J44.1, J44.9</td>
</tr>
<tr>
<td>Emphysema</td>
<td>J43.0-J43.2, J43.8, J43.9</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Description</th>
<th>CPT</th>
<th>UBREV</th>
</tr>
</thead>
<tbody>
<tr>
<td>ED visit</td>
<td>99281-99285</td>
<td>0450-0452, 0456, 0459, 0981</td>
</tr>
<tr>
<td>Inpatient stay</td>
<td></td>
<td>0100, 0101, 0110-0114, 0116-0124, 0126-0134, 0136-0144, 0146-0154, 0156-0160, 0164, 0167, 0169-0174, 0179, 0190-0194, 0199, 0200-0204, 0206-0214, 0219, 1000-1002</td>
</tr>
</tbody>
</table>

Helpful tips
- Make sure you schedule an appointment with your patient upon notification of an inpatient discharge or ED visit. Have your staff call the member prior to the visit to confirm.
- Discuss the importance of smoking cessation; offer solutions to assist with quitting.
- Offer annual flu shots in your office or inform your patients of the importance of getting the vaccine and where they can get it.

Please note: The codes and tips listed do not guarantee reimbursement. The information provided is based on HEDIS 2018 technical specifications and the 2017 CMS technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.
• Educate patients about the use of and compliance with prescribed treatments, including:
  o Long-term versus quick relief medications.
  o Smoking cessation counseling and pharmacotherapy options.
  o Breathing training.
  o Oxygen treatments.
  o Using metered-dose inhalers.
  o Avoiding elements that trigger attacks, such as dust, pollen, smoking and secondary smoke, cold air and pets.
• Encourage your staff to use tools within the office to promote smoking cessation.
• Provide staff training on proper use of inhalers and breathing techniques used in patients with COPD; offer a CME course to enhance your treatment and prevention of COPD exacerbations.
• Display posters and educational messages in treatment rooms and waiting areas to help motivate patients to initiate discussions with you about smoking cessation.
• Be sure to contact the Pharmacy department at 1-800-454-3730 to verify required preauthorization of medications.
• Appropriate systemic corticosteroids and bronchodilators include but are not limited to:

<table>
<thead>
<tr>
<th>Description</th>
<th>Prescriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Glucocorticoids</td>
<td>• Betamethasone</td>
</tr>
<tr>
<td></td>
<td>• Dexamethasone</td>
</tr>
<tr>
<td></td>
<td>• Hydrocortisone</td>
</tr>
<tr>
<td></td>
<td>• Methylprednisolone</td>
</tr>
<tr>
<td></td>
<td>• Prednisolone</td>
</tr>
<tr>
<td></td>
<td>• Triamcinolone</td>
</tr>
<tr>
<td></td>
<td>• Cortisone-acetate</td>
</tr>
<tr>
<td>Anticholinergic agents</td>
<td>• Albuterol-irratropium</td>
</tr>
<tr>
<td></td>
<td>• Acldinium-bromide</td>
</tr>
<tr>
<td></td>
<td>• Ipratropium</td>
</tr>
<tr>
<td></td>
<td>• Tiotropium</td>
</tr>
<tr>
<td></td>
<td>• Umeclidinium</td>
</tr>
<tr>
<td>Beta 2-agonists</td>
<td>• Budesonide-formoterol</td>
</tr>
<tr>
<td></td>
<td>• Fluticasone-salmeterol</td>
</tr>
<tr>
<td></td>
<td>• Fluticasone-vilanterol</td>
</tr>
<tr>
<td></td>
<td>• Formoterol-glycopyrrolate</td>
</tr>
<tr>
<td></td>
<td>• Indacaterol-glycopyrrolate</td>
</tr>
<tr>
<td></td>
<td>• Mometasone-formoterol</td>
</tr>
<tr>
<td></td>
<td>• Olodaterol hydrochloride</td>
</tr>
<tr>
<td></td>
<td>• Olodaterol-tiotropium</td>
</tr>
<tr>
<td></td>
<td>• Umeclidinium-vilanterol</td>
</tr>
<tr>
<td>Methylxanthines</td>
<td>• Aminophylline</td>
</tr>
<tr>
<td></td>
<td>• Dyphylline</td>
</tr>
<tr>
<td></td>
<td>• Theophylline</td>
</tr>
<tr>
<td>Antiasthmatic combinations</td>
<td>• Dyphylline-guaifenesin</td>
</tr>
<tr>
<td></td>
<td>• Guaifenesin-theophylline</td>
</tr>
</tbody>
</table>

Note: Not all medications listed above are in our Formulary. Prior authorization and/or step therapy may be required.
How can we help?

- Offering current Clinical Practice Guidelines on our provider self-service website
- Providing education to members on COPD through various sources, such as phone calls, newsletters and health education materials
- Offering disease management programs to our members

Contact our Quality Management team at 678-587-4868 with any questions or for additional information.

Other resources

You can find more information and tools online:

- The Global Initiative for Chronic Obstructive Lung Disease (GOLD) — www.goldcopd.org
- Disease Management Centralized Care Unit — https://providers.amerigroup.com/Pages/ga-about-dmccu.aspx

Notes

Please note: The codes and tips listed do not guarantee reimbursement. The information provided is based on HEDIS 2018 technical specifications and the 2017 CMS technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.
Prenatal and Postpartum Care

This HEDIS measure looks at the percentage of deliveries of live births on or between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care:

- **Timeliness of prenatal care** — the percentage of deliveries that received a prenatal care visit as a member in the first trimester on the enrollment start date or within 42 days of enrollment as a member
- **Postpartum care** — the percentage of deliveries that had a postpartum visit on or between 21-56 days after delivery

**Record your efforts**

Make sure your medical record documentation reflects all of the following:

- Documentation of when prenatal care was initiated or the date of the member’s first prenatal visit
- The date of the prenatal visit and evidence of at least one of the following:
  - A basic physical obstetrical examination that includes one of the following:
    - Auscultation for fetal heart tone
    - Pelvic exam with obstetric observations
    - Measurement of fundus height (A standardized prenatal flow sheet may be used.)
  - Prenatal care procedure, such as:
    - Screening test/obstetric panel
    - TORCH antibody panel alone
    - A rubella antibody test/titer with an Rh incompatibility (ABO/RH blood typing)
    - Ultrasound/echography of a pregnant uterus
  - Documentation of last menstrual period or estimated due date with either prenatal risk assessment and counseling/education or complete obstetrical history
- The date of postpartum visit and evidence of at least 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**

Proper coding is critical to ensure accurate reporting of these measures, and it may also decrease the need for medical record reviews. Use the following diagnosis and procedure codes to document services for prenatal and postpartum visits:

<table>
<thead>
<tr>
<th>Description</th>
<th>ICD-10-CM</th>
<th>CPT</th>
<th>HCPCS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antibody tests</td>
<td></td>
<td>86644, 86694-86696, 86762, 86777, 86778</td>
<td></td>
</tr>
<tr>
<td>Blood typing</td>
<td></td>
<td>86900, 86901</td>
<td></td>
</tr>
</tbody>
</table>

Please note: The codes and tips listed do not guarantee reimbursement. The information provided is based on HEDIS 2018 technical specifications and the 2017 CMS technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.
Please note: The codes and tips listed do not guarantee reimbursement. The information provided is based on HEDIS 2018 technical specifications and the 2017 CMS technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

<table>
<thead>
<tr>
<th>Description</th>
<th>ICD-10-CM</th>
<th>CPT</th>
<th>HCPCS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cervical cytology tests</td>
<td></td>
<td>88141-88143, 88147, 88148, 88150, 88152-88154, 88164-88167, 88174, 88175</td>
<td>G0123, G0124, G0141, G0143-G0145, G0147, G0148, P3000, P3001, Q0091</td>
</tr>
<tr>
<td>OB panel</td>
<td></td>
<td>80055, 80011</td>
<td></td>
</tr>
<tr>
<td>Prenatal ultrasounds</td>
<td></td>
<td>76801, 76805, 76811, 76813, 76815-76821, 76825-76828</td>
<td></td>
</tr>
<tr>
<td>Prenatal visits</td>
<td></td>
<td>59400, 59425, 59426, 59510, 59610, 59618, 99201-99205, 99211-99215, 99241-99245, 99500, 0500F, 0501F, 0502F</td>
<td>G0463, H1000-H1004, T1015</td>
</tr>
<tr>
<td>Postpartum visits*</td>
<td>Z01.411, Z01.419, Z01.42, Z30.430, Z39.1, Z39.2</td>
<td>59400, 59410, 59510, 59515, 59610, 59614, 59618, 59622, 57170, 58300, 59430, 99501, 0503F</td>
<td>G0101</td>
</tr>
</tbody>
</table>

* If you use a global billing code, make sure the postpartum visit date is on the claim.

Helpful tips

- ACOG recommends a minimum of 14 prenatal visits for a 40-week pregnancy. To ensure regular care, remind members to schedule all required visits, including:
  - One visit every four weeks until 28 weeks’ gestation (at least six visits).
  - One visit every two weeks until 36 weeks’ gestation (at least four visits).
  - One visit every week after 36 weeks until delivery (at least four visits).
- Prenatal risk assessments should be performed at the first prenatal visit or as early in pregnancy as possible. Risk assessments should include screening for:
  - Alcohol, tobacco and drug use.
  - Depression.
  - Intimate partner violence.
- It is essential to identify maternal risk factors early in pregnancy to ensure the best outcome for the member.
- If the patient comes in one or two weeks after delivery for the removal of staples, educate her on the importance of coming back for a visit 21-56 days after discharge from the hospital and schedule the visit. Explain the purpose of the postpartum visit — what you will examine, discuss and why.
- A follow-up Cesarean section postoperative visit 1-2 weeks after delivery does not count as a postpartum visit. Only a visit between 21-56 days meets compliance for this measure. (A day early or a day late does not count.)
- Call patients to schedule the postpartum visits as well as remind them of their appointment dates and times. Be sure to follow up with patients who miss appointments and reschedule.
- All services can be documented using the ACOG forms.
How can we help?
We help you get members the proper care they need for their pregnancy by:
- Offering current Clinical Practice Guidelines on our provider self-service website
- Enrolling members into our maternal programs to help you coordinate their care
- Distributing educational materials to members we identify as pregnant or recently given birth
- Reaching out to members to remind them of the importance of their prenatal and postpartum care and assist them with making appointments if needed
- Offering additional benefits and incentives for pregnant members and new moms

Contact our Quality Management team at 678-587-4868 with any questions or for additional information.

Other resources
You can find more information and tools online:
- American Congress of Obstetricians and Gynecologists — www.acog.org/About-ACOG/ACOG-Departments/Patient-Records

Notes

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**Spirometry Testing in the Assessment and Diagnosis of COPD**

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

**Code your services correctly**

Use the following diagnosis and procedure codes to document COPD, chronic bronchitis, emphysema and spirometry testing:

<table>
<thead>
<tr>
<th>Description</th>
<th>ICD-10-CM</th>
<th>CPT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic bronchitis</td>
<td>J41.0, J41.1, J41.8, J42</td>
<td></td>
</tr>
<tr>
<td>Emphysema</td>
<td>J43.0, J43.1, J43.2, J43.8, J43.9</td>
<td></td>
</tr>
<tr>
<td>COPD</td>
<td>J44.0, J44.1, J44.9</td>
<td></td>
</tr>
<tr>
<td>Spirometry testing</td>
<td></td>
<td>94010, 94014-94016, 94060, 94070, 94375, 94620</td>
</tr>
</tbody>
</table>

**Helpful tips**

- A diagnosis of COPD is based on signs and symptoms, medical and family history, and test results.
- A key lung function test for COPD is spirometry testing. Spirometry testing is safe, affordable, noninvasive and accurate and can detect lung function deficits even in patients who are asymptomatic.
- Perform a spirometry test for individuals who present with dyspnea, chronic cough, increased sputum production or wheezing.
- Educate patients about the use of and compliance with prescribed treatments:
  - Long-term and/or 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

**How can we help?**

- Offering current Clinical Practice Guidelines on our provider self-service website
- Providing education to members on COPD through various sources, such as phone calls, newsletters and health education materials
- Providing individualized reports of your patients that are due or overdue for services
- Offering disease management programs to our members

Contact our Quality Management team at 678-587-4868 with any questions or for additional information.
Other resources
You can find more information and tools online:

- The Global Initiative for Chronic Obstructive Lung Disease (GOLD) — www.goldcopd.org

Notes
Use of Imaging Studies for Lower Back Pain

This HEDIS measure looks at members 18-50 years of age with a primary diagnosis of lower back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis.

Code your services correctly

Use the following diagnosis and procedure codes to identify lower back pain and imaging studies.

<table>
<thead>
<tr>
<th>Description</th>
<th>ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lower back pain</td>
<td>M47.26-M47.28, M47.816-M47.818, M47.896-M47.898, M48.06-M48.08, M51.16,</td>
</tr>
<tr>
<td></td>
<td>M51.17, M51.26, M51.27, M51.36, M51.37, M51.86, M51.87, M53.2X6-M53.2X8,</td>
</tr>
<tr>
<td></td>
<td>M53.3, M53.86-M53.88, M54.16-M54.18, M54.30-M54.32, M54.40-M54.42, M54.5,</td>
</tr>
<tr>
<td></td>
<td>M54.9, M54.89, M54.9, M99.03, M99.04, M99.23, M99.33, M99.43, M99.53, M99.63,</td>
</tr>
<tr>
<td></td>
<td>M99.73, M99.83, S33.100A, S33.100D, S33.100S, S33.110A, S33.11D, S33.110S,</td>
</tr>
<tr>
<td></td>
<td>S33.120A, S33.120D, S33.120S, S33.130A, S33.130D, S33.130S, S33.140A, S33.140D,</td>
</tr>
<tr>
<td></td>
<td>S33.140S, S33.5XXA, S33.6XXA, S33.8XXA, S33.9XXA, S39.002A, S39.002D, S39.002S,</td>
</tr>
<tr>
<td></td>
<td>S39.82XS, S39.92XA, S39.92XD, S39.92XS</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Description</th>
<th>CPT</th>
<th>UBREV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Imaging study</td>
<td>72010, 72020, 72052, 72100,</td>
<td>0320, 0329, 0350, 0352,</td>
</tr>
<tr>
<td></td>
<td>72110, 72114, 72120,</td>
<td>0359, 0610, 0612, 0614,</td>
</tr>
<tr>
<td></td>
<td>72131-72133, 72141, 72142,</td>
<td>0619, 0972</td>
</tr>
<tr>
<td></td>
<td>72146-72149, 72156,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>72158, 72200, 72202, 72220</td>
<td></td>
</tr>
</tbody>
</table>

Helpful tips

- Members who did not receive an imaging study immediately after a lower back pain diagnosis indicates appropriate treatment of lower back pain.
- Avoid ordering diagnostic studies in the first six weeks of new onset back pain if there are no red flags, such as cancer, recent trauma, neurologic impairment or intravenous (IV) drug abuse.
- When ordering an imaging study for a red flag or other reasons, use the correct primary or secondary diagnosis code for red flags, such as cancer, recent trauma, neoplasms, neurologic impairment or IV drug use.
- Recommended treatments for back pain can include some of the following:
  - Hot or cold packs
  - Activities or strengthening exercises
  - Physical therapy
  - Medications like aspirin or ibuprofen or counter-irritants like topical creams or sprays

Other resources

You can find more information and tools online:


Please note: The codes and tips listed do not guarantee reimbursement. The information provided is based on HEDIS 2018 technical specifications and the 2017 CMS technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.
Notes

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Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

This HEDIS measure looks at members 3-17 years of age who had one or more outpatient visits with their PCP or OB/GYN during the year and documented evidence of the following:

- Height, weight and BMI percentile
- Counseling for nutrition
- Counseling for physical activity

Record your efforts
Make sure that your medical record documentation reflects all of the following:

- Date of the visit
- Both height and weight
- BMI percentile documented or plotted on an appropriate age-growth chart
- Checklist to indicate discussion of counseling for nutrition and physical activity
- Any weight or obesity counseling
- Any advice or anticipatory guidance given

Code your services correctly
Proper coding is critical to ensure accurate reporting of these measures, and it may also decrease the need for medical record reviews. 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>ICD-10-CM</th>
<th>CPT</th>
<th>HCPCS</th>
</tr>
</thead>
<tbody>
<tr>
<td>BMI percentile</td>
<td>Z68.51-Z68.54</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Counseling for nutrition; physician assessment only</td>
<td>Z71.3*</td>
<td>99401, 99402</td>
<td></td>
</tr>
<tr>
<td>Counseling for nutrition; dietician assessment only</td>
<td>Z71.3*</td>
<td>97802-97804</td>
<td>G0270, G0271, G0447, S9452, S9470</td>
</tr>
<tr>
<td>Counseling for physical activity</td>
<td>Z02.5, Z71.82</td>
<td>G0447, S9451</td>
<td></td>
</tr>
</tbody>
</table>

* Counseling for nutrition (Z71.3) is reimbursable when billed with a diagnosis code for overweight (Z68.53) or obese (Z68.54) children.

When billing office visits for preventive health screening services, providers must use the appropriate diagnosis code, EP modifier and POS code 99. The 25 modifier must be included when a vaccine is administered during the preventive visit.

EPSDT preventive health screenings are exempt from third-party liability. Even if the member has other health insurance, you may file Medicaid first for preventive health services. This will ensure accurate and timely reporting of EPSDT services.

Helpful tips
- Height, weight, BMI percentile and counseling for nutrition and physical activity should be completed at least once per year as part of a well visit.
- Consider incorporating appropriate nutritional and weight management questioning and counseling into your routine clinical practice.

Please note: The codes and tips listed do not guarantee reimbursement. The information provided is based on HEDIS 2018 technical specifications and the 2017 CMS technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.
- Sick visits and sports physicals may be missed opportunities to complete well visits.
- Services may be completed during a visit other than a well-child visit; however, services specific to an acute or chronic condition do not count for counseling for nutrition or physical activity.
- When counseling for nutrition, be sure to document face-to-face discussion of current nutritional behavior, like appetite or meal patterns, eating and dieting habits, any counseling or referral to nutrition education, any nutritional educational materials that were provided during the visit, anticipatory guidance for nutrition, eating disorders, nutritional deficiencies, and underweight, obesity or overweight discussion.
- When counseling for physical activity, document face-to-face discussion of current physical activity behaviors, like exercise routines, participation in sports activities or bike riding, referrals to physical activity, educational material that was provided, anticipatory guidance on physical activity, and obesity or overweight discussion. Recommendations and counseling for physical activity should include discussion of more than topics related solely to sports or safety.
- Review your EMR or assessment forms to check for fields that document BMI percentile. Offices that use EMRs should check whether their systems have the ability to auto calculate the BMI percentile once height and weight are entered.

How can we help?
- Offering current Clinical Practice Guidelines on our provider self-service website
- Providing individualized reports of your patients that are due or overdue for services
- Providing your office with pediatric BMI wheels
- Working with you to plan, implement and evaluate member events to help promote preventive health care services
- Assisting with scheduling appointments for our members, if needed
- Encouraging preventive care through our Being Healthy Brings Rewards program

Contact our Quality Management team at 678-587-4868 with any questions or for additional information.

Other resources
You can find more information and tools online:
- Printable growth charts:
  - Boys — www.cdc.gov/growthcharts/data/set1clinical/cj41l023.pdf
- Georgia Medicaid Management Information System — https://www.mmis.georgia.gov/portal

Notes

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Well-Child Visits: 0 to 15 Months Old

This HEDIS measure looks at the percentage of members who turned 15 months old during the measurement year and who had the following number of well-child visits with a primary care provider during their first 15 months of life:

- No well-child visit
- One well-child visit
- Two well-child visits
- Three well-child visits
- Four well-child visits
- Five well-child visits
- Six or more well-child visits

Record your efforts

Make sure that your medical record documentation reflects all of the following:

- Date of each visit (a minimum of six visits completed at least two weeks apart)
- A health history
- Both physical and mental developmental histories
- A physical exam
- Health education and anticipatory guidance

Code your services correctly

Proper coding helps us meet this measure for quality reporting and may decrease the need for medical record review. Use the following diagnosis and procedure codes to document comprehensive well-child visits:

<table>
<thead>
<tr>
<th>Description</th>
<th>CPT</th>
<th>ICD-10-CM</th>
<th>HCPCS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive well-child visit</td>
<td>99381-99382, 99391-99392, 99461</td>
<td>Z00.110, Z00.111, Z00.121, Z00.129, Z02-Z02.89</td>
<td>G0438, G0439</td>
</tr>
</tbody>
</table>

When billing office visits for preventive health screening services, providers must use the appropriate diagnosis code, EP modifier and POS code 99. The 25 modifier must be included when a vaccine is administered during the preventive visit.

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 (see the table below) with modifiers 25 and EP and the applicable EPSDT HIPAA referral code (NU, AV, S2, ST).

<table>
<thead>
<tr>
<th>Description</th>
<th>CPT</th>
</tr>
</thead>
<tbody>
<tr>
<td>EPSDT visit</td>
<td>99381, 99382, 99391, 99392</td>
</tr>
<tr>
<td>E&amp;M sick visit</td>
<td>99211, 99212</td>
</tr>
</tbody>
</table>

EPSDT preventive health screenings are exempt from third-party liability. Even if the member has other health insurance, you may file Medicaid first for preventive health services. This will ensure accurate and timely reporting of EPSDT services.

Please note: The codes and tips listed do not guarantee reimbursement. The information provided is based on HEDIS 2018 technical specifications and the 2017 CMS technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.
Helpful tips

- Follow the American Academy of Pediatrics Bright Futures Periodicity Schedule of recommendations for preventive pediatric health care for well-child visits and screenings.
- Appropriate immunizations are an important part of these visits. Administer immunizations in accordance to the ACIP. Check the Georgia Registry of Immunization Transactions and Services (GRITS) database to ensure vaccines have not been administered elsewhere.
- Use your member roster to contact patients who are due for their well visits or are new to your practice.
- Schedule the next appointment at the end of each visit.
- If you use EMRs, consider creating a flag to track patients who are due or past due for a visit. If you do not use EMRs, consider creating a manual tracking method.
- Sick visits may be missed opportunities to complete well visits.
- Consider offering evening, early morning and/or weekend office hours to accommodate working young adults or parents with children involved in after-school activities.
- Appointment reminders by text, email, postcard or phone call work well for most parents and young adults.

How can we help?

- Providing individualized reports of your patients due or overdue for services
- Assisting with scheduling appointments for our members, if needed
- Offering nonemergency transportation for our members to appointments
- Working with you to plan, implement and evaluate member events to help promote preventive health care services
- Providing education to parents about the importance of well-child visits through various sources, such as phone calls, newsletters and health education fliers
- Encouraging preventive care through our Being Healthy Brings Rewards program

Contact our Quality Management team at 678-587-4868 with any questions or for additional information.

Other resources

You can find more information and tools online:

- **ACIP Immunization Schedule** — [www.cdc.gov/vaccines/schedules/hcp/index.html](http://www.cdc.gov/vaccines/schedules/hcp/index.html)
- **Bright Futures Tools** — [https://brightfutures.aap.org/materials-and-tools/Pages/default.aspx](https://brightfutures.aap.org/materials-and-tools/Pages/default.aspx)
- **Georgia Medicaid Management Information System** — [https://www.mmis.georgia.gov/portal](https://www.mmis.georgia.gov/portal)

Notes

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Well-Child Visits: 3 to 6 Years Old

This HEDIS measure looks at members 3-6 years of age who had one or more comprehensive well-child visits with a PCP during the calendar year.

Record your efforts
Make sure that your medical record documentation reflects all the following:
- Date of the visit
- A health history
- Both physical and mental developmental histories
- A physical exam
- Health education and anticipatory guidance

Code your services correctly
Proper coding is critical to ensure accurate reporting of these measures, and it may also decrease the need for medical record reviews. Use the following diagnosis and procedure codes to document comprehensive well-child visits:

<table>
<thead>
<tr>
<th>Description</th>
<th>CPT</th>
<th>ICD-10-CM</th>
<th>HCPCS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive well-child visit</td>
<td>99382, 99383, 99392, 99393</td>
<td>Z00.121, Z00.129, Z00.8, Z02-Z02.89</td>
<td>G0438, G0439</td>
</tr>
</tbody>
</table>

When billing office visits for preventive health screening services, providers must use the appropriate diagnosis code, EP modifier and POS code 99. The 25 modifier must be included when a vaccine is administered during the preventive visit.

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 (see the table below) with modifiers 25 and EP and the applicable EPSDT HIPAA referral code (NU, AV, S2, ST).

<table>
<thead>
<tr>
<th>Description</th>
<th>CPT</th>
</tr>
</thead>
<tbody>
<tr>
<td>EPSDT visit</td>
<td>99382, 99383, 99392, 99393</td>
</tr>
<tr>
<td>E&amp;M sick visit</td>
<td>99211, 99212</td>
</tr>
</tbody>
</table>

EPSDT preventive health screenings are exempt from third-party liability. Even if the member has other health insurance, you may file Medicaid first for preventive health services. This will ensure accurate and timely reporting of EPSDT services.

Helpful tips
- Follow the American Academy of Pediatrics Bright Futures Recommendations periodicity schedule of preventive pediatric health care for well-child visits and screenings.
- Sick visits may be missed opportunities to complete well visits.
- Use your member roster to contact patients who are due for their annual well visit or are new to your practice.

Please note: The codes and tips listed do not guarantee reimbursement. The information provided is based on HEDIS 2018 technical specifications and the 2017 CMS technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.
• If you use EMRs, consider creating a flag to track patients who are due or past due for preventive services. If you do not use EMRs, consider creating a manual tracking method.
• Consider offering evening, early morning and/or weekend office hours to accommodate working parents and guardians.
• Appointment reminders by text, email, postcard or phone call work well for most parents and guardians.

How can we help?
• Providing individualized reports of your patients that are due or overdue for services
• Assisting with scheduling appointments for our members, if needed
• Offering nonemergency transportation for our members to appointments
• Working with you to plan, implement and evaluate member events to help promote annual well-child exams and other preventive health care services
• Providing education to members about the importance of annual well visits through various sources such as phone calls, newsletters and health education fliers
• Encouraging preventive care through our Being Healthy Brings Rewards program

Contact our Quality Management team at 678-587-4868 with any questions or for additional information.

Other resources
You can find more information and tools online:
• Bright Futures Tools — https://brightfutures.aap.org/materials-and-tools/Pages/default.aspx
• Georgia Medicaid Management Information System — https://www.mmis.georgia.gov/portal

Notes