Quality Reporting and Performance Measures
Table of contents

Performance measures
Introduction .................................................................................................................................................. 3
Quality reporting and performance measures ................................................................................................ 4

Resources
References .................................................................................................................................................... 6
Bright Futures periodicity schedule .............................................................................................................. 8
Recommended Immunization Schedule (CDC/ACIP) .................................................................................. 10
Adolescent Well-Care Visits: 12 to 21 Years Old ..................................................................................... 16
Adult Body Mass Index Screening .............................................................................................................. 18
Antidepressant Medication Management .................................................................................................. 20
Appropriate Testing for Children with Pharyngitis .................................................................................. 22
Appropriate Treatment for Children with Upper Respiratory Infections ................................................. 25
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis ....................................................... 27
Breast Cancer Screening .......................................................................................................................... 29
Cervical Cancer Screening ....................................................................................................................... 31
Chlamydia Screening in Women ............................................................................................................... 33
Comprehensive Diabetes Care ................................................................................................................... 35
Controlling High Blood Pressure ............................................................................................................. 38
Developmental Screening in the First Three Years of Life ...................................................................... 40
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications ................................................................................................................... 42
Follow-Up after Hospitalization for Mental Illness .................................................................................. 44
Follow-Up Care for Children Prescribed ADHD Medication ................................................................ 46
Immunizations for Children and Adolescents .......................................................................................... 48
Lead Screening in Children ...................................................................................................................... 50
Medication Management for People with Asthma ..................................................................................... 52
Monitoring Initiation and Engagement of Alcohol and Other Drug Dependence Treatment ................. 54
Pharmacotherapy Management of COPD Exacerbation ......................................................................... 56
Prenatal and Postpartum Care ................................................................................................................... 59
Spirometry Testing in the Assessment and Diagnosis of COPD ................................................................. 62
Use of Imaging Studies for Lower Back Pain ............................................................................................ 63
Weight Assessment, Nutritional Counseling and Physical Activity .......................................................... 64
Well-Child Visits: 0 to 15-Months Old ...................................................................................................... 66
Well-Child Visits: 3 to 6 Years Old ........................................................................................................... 68

Please note: The codes and tips listed do not guarantee reimbursement. The information provided is based on HEDIS 2017 technical specifications and the 2016 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.

GAPEC-1706-16
May 2017
Please note: The codes and tips listed do not guarantee reimbursement. The information provided is based on HEDIS 2017 technical specifications and the 2016 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.
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.

- **Georgia Families 360℠** 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 (CMO) 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 Georgia Families 360℠ 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.

We are dedicated to offering real solutions that improve health care access and quality for our members while proactively working to reduce the overall cost of care to taxpayers. At Amerigroup, 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 Georgia Department of Community Health (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.

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/recommendations of services that should be performed to meet those measures as well as provide guidance on how to correct coding for those services. The booklet is based on information from the following resources:

- American Academy of Pediatrics Bright Futures guidelines — published 2016
- Advisory Committee on Immunization Practices (ACIP) immunization schedule — published 2016
- NCQA HEDIS technical specifications — published 2016
- Georgia DCH Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services manual — 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.

Remember when providing services for Amerigroup members:

- Contracted Amerigroup providers must perform all required components of an EPSDT visit as outlined in the DCH EPSDT manual.
- EPSDT preventive 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.
- 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 Georgia Families 360℠ 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 Georgia Families 360℠ program may require more frequent EPSDT services than what is identified in the Bright Futures periodicity schedule.

Please note: The codes and tips listed do not guarantee reimbursement. The information provided is based on HEDIS 2017 technical specifications and the 2016 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.
• Preventive health visits (well visits) should be completed per the Bright Futures periodicity schedule.
  o Example — John’s birthday is April 1. He had his three-year preventive health visit on November 30, 2016. John is eligible for his next health check at any time on or after April 1, 2017.
• 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.
• Be sure to include the applicable EPSDT HIPAA referral code to document whether or not problems were identified during the preventive health visit and a referral is needed for further diagnostic and treatment services:
  o NU — normal, no follow-up visit needed
  o AV — available, not used: Patient refused referral.
  o S2 — under treatment: Patient is currently under treatment for health problem and has a return visit.
  o 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; 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>Georgia Families 360℠ members (foster care, adoptive assistance and Department of Juvenile Justice)</td>
<td>Georgia Families 360℠ Intake team at 1-855-621-2021</td>
</tr>
<tr>
<td>Georgia Families members (Medicaid and PeachCare for Kids®)</td>
<td>Quality Management team at 1-800-454-3730, extension 74868</td>
</tr>
<tr>
<td>Quality performance measures</td>
<td>Quality Management team at 1-800-454-3730, extension 74868</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.

- Amerigroup provider self-service website — https://providers.amerigroup.com/GA
- ACIP — immunization schedules — https://www.cdc.gov/vaccines/schedules/hcp/child-adolescent.html
- American Academy of Pediatrics — www.aap.org
- American Academy of Pediatric Dentistry periodicity schedule — http://www.aapd.org/assets/1/7/Periodicity-AAPDSchedule.pdf
- Georgia Department of Community Health (DCH) — http://dch.georgia.gov/medicaid
- Georgia Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services — https://www.mmis.georgia.gov
- Georgia Medicaid Management Information System — https://www.mmis.georgia.gov/portal
Each child and family is unique; therefore, these Recommendations for Preventive Pediatric Health Care are designed for the care of children who are receiving competent parenting, have no manifestations of any important health problems, and are growing and developing in satisfactory fashion. Additional visits may become necessary if circumstances suggest variations from normal. Developmental, psychosocial, and chronic disease issues for children and adolescents may require frequent counseling and treatment visits separate from preventive care visits.

**Recommendations for Preventive Pediatric Health Care**

Bright Futures/American Academy of Pediatrics

These guidelines represent a consensus by the American Academy of Pediatrics (AAP) and Bright Futures. The AAP continues to emphasize the great importance of continuity of care in controlling and preventing the spread of infectious diseases and to avoid fragmentation of care.

Refer to the specific guidance by age as listed in Bright Futures guidelines (Hagan JF, Shaw JS, Duncan PM, eds. Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents: 3rd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2006).

The recommendations in this statement do not indicate an exclusive course of treatment or standard of medical care. Variations, taking into account individual circumstances, may be appropriate.


No part of this statement may be reproduced in any form or by any means without prior written permission from the American Academy of Pediatrics. Except for one copy for personal use.

---

### Infant Feeding

- Breastfeeding should be encouraged (and instruction and support should be offered).
- A written plan for exclusive breastfeeding through 4 to 6 months should be created to reduce the risk for formula supplementation.
- Early breastfeeding is associated with better outcomes for mother and infant.

### Developmental Behavioral Assessment

- **Initial visit** is recommended to receive anticipatory guidance.
  - **Evaluation of Developmental Milestones**
  - **Developmental Screenings**
    - Autism Screening
    - Developmental Surveillance
    - Psychosocial/Behavioral Assessment
  - **Sensory Screenings**
    - Vision
    - Hearing

### Physical Exam

- **Head Circumference**
- **Weight for Length**
- **Body Mass Index (BMI)**
- **BMI Percentiles**
- **Referral for OB/Peds Follow-Up**

### Infant Immunizations

- **An important component of the newborn evaluation after birth**:
  - **Vaccinations**
  - **Vaccine Dosing**
  - **Schedules, per the AAP Committee on Infectious Diseases, are available at**:
    - [http://pediatrics.aappublications.org/content/126/5/1040.full](http://pediatrics.aappublications.org/content/126/5/1040.full)
  - **Schedules, per the 2011 AAP statement “Endorsement of Health and Human Services Recommendation for Pulse Oximetry Screening at Hospital Discharge”**
  - **Schedules, per the 2011 AAP statement “Use of Chaperones During the Physical Examination of the Pediatric Patient”**

### Psychosocial/Behavioral Assessment

- **Autism Screening**
- **Developmental Surveillance**
- **Psychosocial/Behavioral Assessment**

### Anticipatory Guidance

- **ADOLESCENCE**
  - **Hearing and Vision screening**
  - **Psychosocial/Behavioral Assessment**
  - **DIABETES SCREENING**
  - **Dyslipidemia Screening**

### Key

- 
  - Several guidelines may be appropriate, based on available screening requirements for patients with Medicaid or high prevalence areas.

### Table

<table>
<thead>
<tr>
<th>Age</th>
<th>Preventive Health Care Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-2</td>
<td>Recommendations for Preventive Pediatric Health Care</td>
</tr>
</tbody>
</table>
Summary of changes made to the Bright Futures/AAP Recommendations for Preventive Pediatric Health Care (Periodicity Schedule)

This Schedule reflects changes approved in October 2015 and published in January 2016. For updates, visit www.aap.org/periodicityschedule.

Changes made October 2015

- **Vision Screening**: The routine screening at age 18 has been changed to a risk assessment.
- Footnote 7 has been updated to read, "A visual acuity screen is recommended at ages 4 and 5 years, as well as in cooperative 3 year olds. Instrument based screening may be used to assess risk at ages 12 and 24 months, in addition to the well visits at 3 through 5 years of age. See 2016 AAP statement, “Visual System Assessment in Infants, Children, and Young Adults by Pediatricians” (http://pediatrics.aappublications.org/content/137/1/1.51) and “Procedures for Evaluation of the Visual System by Pediatricians” (http://pediatrics.aappublications.org/content/137/1/1.52).

Changes made May 2015

- **Oral Health**: A subheading has been added for fluoride varnish, with a recommendation from 6 months through 5 years.
- Footnote 25 wording has been edited and also includes reference to the 2014 clinical report, “Fluoride Use in Caries Prevention in the Primary Care Setting” (http://pediatrics.aappublications.org/content/134/3/626) and 2014 policy statement, “Maintaining and Improving the Oral Health of Young Children” (http://pediatrics.aappublications.org/content/134/6/1224.full).
- Footnote 26 has been added to the new fluoride varnish subheading: See USPSTF recommendations (http://www.uspreventiveservicestaskforce.org/uspstf/uspsdnch.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 the 2014 AAP clinical report “Fluoride Use in Caries Prevention in the Primary Care Setting” (http://pediatrics.aappublications.org/content/134/3/626).

Changes made March 2014

- **Alcohol and Drug Use Assessment**: Information regarding a recommended screening tool (CRAFFT) was added.
- **Depression**: Screening for depression at ages 11 through 21 has been added, along with suggested screening tools.

Changes to Procedures

- **Dyslipidemia screening**: An additional screening between 9 and 11 years of age has been added. The reference has been updated to the AAP-endorsed National Heart Blood and Lung Institute policy (http://www.nhlbi.nih.gov/guidelines/cvd_ped/index.htm).
- **Hematocrit or hemoglobin**: A risk assessment has been added at 15 and 30 months. The reference has been updated to the current AAP policy (http://pediatrics.aappublications.org/content/126/5/1040.full).
- **STI/HIV screening**: A screen for HIV has been added between 16 and 18 years. Information on screening adolescents for HIV has been added in the footnotes. STI screening now references recommendations made in the AAP Red Book. This category was previously titled “STI Screening.”
- **Cervical dysplasia**: Adolescents should no longer be routinely screened for cervical dysplasia until age 21. Indications for pelvic exams prior to age 21 are noted in the 2010 AAP statement “Gynecologic Examination for Adolescents in the Pediatric Office Setting” (http://pediatrics.aappublications.org/content/126/3/583.full).
- **Critical Congenital Heart Disease**: Screening for critical congenital heart disease using pulse oximetry should be performed in newborns, after 24 hours of age, before discharge from the hospital, per the 2011 AAP statement, “Endorsement of Health and Human Services Recommendation for Pulse Oximetry Screening for Critical Congenital Heart Disease” (http://pediatrics.aappublications.org/content/128/1/190.full).

See www.aap.org/periodicityschedule for additional updates made to footnotes and references in March 2014.
This schedule includes recommendations in effect as of January 1, 2016. Any dose not administered at the recommended age should be administered at a subsequent visit, when indicated and feasible. The use of a combination vaccine generally is preferred over separate injections of its equivalent component vaccines. Vaccination providers should consult the relevant Advisory Committee on Immunization Practices (ACIP) statement for detailed recommendations, available online at http://www.cdc.gov/vaccines/hcp/acip-recs/index.html. Clinically significant adverse events that follow vaccination should be reported to the Vaccine Adverse Event Reporting System (VAERS) online (http://www.vaers.hhs.gov) or by telephone (800-822-7967).
Table 1. Recommended immunization schedule for persons aged 0 through 18 years – United States, 2016.

<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>16–18 yrs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis B (HepB)</td>
<td>1st dose</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rotavirus (RV)</td>
<td>1st dose</td>
<td>2nd dose</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diphtheria, tetanus, &amp; acellular pertussis (DTaP; &lt;7 yrs)</td>
<td>1st dose</td>
<td>2nd dose</td>
<td>3rd dose</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Haemophilus influenzae type b (Hib)</td>
<td>1st dose</td>
<td>2nd dose</td>
<td>3rd dose</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumococcal conjugate (PCV13)</td>
<td>1st dose</td>
<td>2nd dose</td>
<td>3rd dose</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inactivated poliovirus (IPV; &lt;18 yrs)</td>
<td>1st dose</td>
<td>2nd dose</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Influenza (IIV; LAIV)</td>
<td>Annual vaccination (IIV only) 1 or 2 doses</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measles, mumps, rubella (MMR)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Varicella (VAR)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis A (HepA)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meningococcal (Hib-MenCY ≥ 6 weeks; MenACWY-D ≥ 9 mos; MenACWY-CRM ≥ 2 mos)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tetanus, diphtheria, &amp; acellular pertussis (Tdap; ≥7 yrs)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Human papillomavirus (2vHPV: females only; 4vHPV, 9vHPV: males and females)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meningococcal B</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumococcal polysaccharide (PPSV23)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**NOTE:** The above recommendations must be read along with the footnotes of this schedule.
The figure below provides catch-up schedules and minimum intervals between doses for children whose vaccinations have been delayed. A vaccine series does not need to be restarted, regardless of the time that has elapsed between doses. Use the section appropriate for the child’s age. Always use this table in conjunction with Figure 1 and the footnotes that follow.

**FIGURE 2. Catch-up immunization schedule for persons aged 4 months through 18 years who start late or who are more than 1 month behind — United States, 2016.**

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&lt;sup&gt;1&lt;/sup&gt;</td>
<td>Birth</td>
<td>4 weeks</td>
</tr>
<tr>
<td>Rotavirus&lt;sup&gt;1&lt;/sup&gt;</td>
<td>6 weeks</td>
<td>4 weeks</td>
</tr>
<tr>
<td>Diphtheria, tetanus, and acellular pertussis&lt;sup&gt;1&lt;/sup&gt;</td>
<td>6 weeks</td>
<td>4 weeks</td>
</tr>
<tr>
<td>Haemophilus influenza type B&lt;sup&gt;1&lt;/sup&gt;</td>
<td>6 weeks</td>
<td>4 weeks if first dose was administered before the 1&lt;sup&gt;st&lt;/sup&gt; birthday.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>8 weeks (as final dose) if first dose was administered at age 12 through 14 months.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No further doses needed if first dose was administered at age 15 months or older.</td>
</tr>
<tr>
<td>Pneumococcal&lt;sup&gt;1&lt;/sup&gt;</td>
<td>6 weeks</td>
<td>4 weeks if current age is younger than 12 months and first dose was administered at younger than age 7 months, and at least 1 previous dose was PRP-T (ActHib, Pentacel) or unknown.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>8 weeks and age 12 through 59 months (as final dose) if current age is younger than 12 months and first dose was administered at age 7 through 11 months (wait until at least 12 months old); OR if Current age is 12 through 59 months and first dose was administered before the 1&lt;sup&gt;st&lt;/sup&gt; birthday, and second dose administered at younger than 15 months; OR if both doses were PRP-DMP (PedvaxHIB; Comvax) and were administered before the 1&lt;sup&gt;st&lt;/sup&gt; birthday (wait until at least 12 months old).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No further doses needed if previous dose was administered at age 15 months or older.</td>
</tr>
<tr>
<td>Inactivated poliovirus&lt;sup&gt;1&lt;/sup&gt;</td>
<td>6 weeks</td>
<td>4 weeks^5^ if current age is younger than 12 months and first dose was administered at younger than age 7 months, and at least 1 previous dose was PRP-T (ActHib, Pentacel) or unknown.</td>
</tr>
<tr>
<td>Measles, mumps, rubella&lt;sup&gt;1&lt;/sup&gt;</td>
<td>12 months</td>
<td>4 weeks</td>
</tr>
<tr>
<td>Varicella&lt;sup&gt;1&lt;/sup&gt;</td>
<td>12 months</td>
<td>3 months</td>
</tr>
<tr>
<td>Hepatitis A&lt;sup&gt;1&lt;/sup&gt;</td>
<td>12 months</td>
<td>6 months</td>
</tr>
<tr>
<td>Meningococcal&lt;sup&gt;27&lt;/sup&gt; (Hib-MenCY ≥ 6 weeks; MenACWY-D ≥ 9 mos; MenACWY-CRM ≥ 2 mos)</td>
<td>6 weeks</td>
<td>8 weeks&lt;sup&gt;11&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>See footnote 11</td>
</tr>
<tr>
<td>Meningococcal&lt;sup&gt;27&lt;/sup&gt; (Hib-MenCY ≥ 6 weeks; MenACWY-D ≥ 9 mos; MenACWY-CRM ≥ 2 mos)</td>
<td>Not Applicable (N/A)</td>
<td>8 weeks&lt;sup&gt;11&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>See footnote 11</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&lt;sup&gt;1&lt;/sup&gt;</td>
<td>7 years&lt;sup&gt;12&lt;/sup&gt;</td>
<td>4 weeks if first dose of DTaP/DT was administered before the 1&lt;sup&gt;st&lt;/sup&gt; birthday.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>6 months (as final dose) if first dose of DTaP/DT or Tdap/Td was administered at or after the 1&lt;sup&gt;st&lt;/sup&gt; birthday.</td>
</tr>
<tr>
<td>Human papillomavirus&lt;sup&gt;13&lt;/sup&gt;</td>
<td>9 years</td>
<td>Routine dosing intervals are recommended.&lt;sup&gt;17&lt;/sup&gt;</td>
</tr>
<tr>
<td>Hepatitis A&lt;sup&gt;1&lt;/sup&gt;</td>
<td>N/A</td>
<td>6 months</td>
</tr>
<tr>
<td>Hepatitis B&lt;sup&gt;1&lt;/sup&gt;</td>
<td>N/A</td>
<td>4 weeks</td>
</tr>
<tr>
<td>Inactivated poliovirus&lt;sup&gt;1&lt;/sup&gt;</td>
<td>N/A</td>
<td>4 weeks</td>
</tr>
<tr>
<td>Measles, mumps, rubella&lt;sup&gt;1&lt;/sup&gt;</td>
<td>N/A</td>
<td>4 weeks</td>
</tr>
<tr>
<td>Varicella&lt;sup&gt;1&lt;/sup&gt;</td>
<td>N/A</td>
<td>3 months if younger than age 13 years.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4 weeks if age 13 years or older.</td>
</tr>
</tbody>
</table>

NOTE: The above recommendations must be read along with the footnotes of this schedule.
Footnotes — Recommended immunization schedule for persons aged 0 through 18 years—United States, 2016
For further guidance on the use of the vaccines mentioned below, see: http://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 contraindications and precautions to use of a vaccine and for additional information regarding that vaccine, vaccination providers should consult the relevant ACIP statement available online at http://www.cdc.gov/vaccines/hcp/acip-recs/index.html.
• For purposes of calculating intervals between doses, 4 weeks = 28 days. Intervals of 4 months or greater are determined by calendar months.
• Vaccine doses administered 4 days or less before the minimum interval are considered valid. Doses of any vaccine administered ≥ 2 days earlier than the minimum interval or minimum age should not be counted as valid doses 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 MMWR, General Recommendations on Immunization and Reports / Vol. 60 / No. 2; Table 1. Recommended and minimum ages and intervals between vaccine doses available online at http://www.cdc.gov/mmwr/pdf/rr/rr6602.pdf.
• Information on travel vaccine requirements and recommendations is available at http://wwwnc.cdc.gov/travel/destinations/list.

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

Routine vaccination: 
• At birth; administer monovalent HepB vaccine to all newborns before hospital discharge.
• For infants born to hepatitis B surface antigen (HBsAg)-positive mothers, administer HepB vaccine and 0.5 ml of hepatitis B immune globulin (HBIG) within 12 hours of birth. These infants should be tested for HBsAg and antibody to HBsAg (anti-HBs) at age 9 through 18 months (preferably at the next well-child visit) or 1 to 2 months after completion of the HepB series if the series was delayed; CDC recently recommended testing occur at age 9 through 12 months; see http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6439a6.htm.
• If mother’s HBsAg status is unknown, within 12 hours of birth administer HepB vaccine regardless of birth weight. For infants weighing less than 2,000 grams, administer HBIG in addition to HepB vaccine within 12 hours of birth. Determine mother’s HBsAg status as soon as possible and, if mother is HBsAg-positive, also administer HBIG for infants weighing 2,000 grams or more as soon as possible, but no later than age 7 days.

Doses following the birth dose:
• The second dose should be administered at age 1 or 2 months. Monovalent HepB vaccine should be used for doses administered before age 6 weeks.
• Infants who did not receive a birth dose should receive 3 doses of a HepB-containing vaccine on a schedule of 0, 1 to 2 months, and 6 months starting as soon as feasible. See Figure 2.

Catch-up vaccination:
• Unvaccinated persons should complete a 3-dose series.
• A 2-dose series (doses separated by at least 4 months) of adult formulation Recombivax HB is licensed for use in children aged 11 through 15 years.
• For other catch-up guidance, see Figure 2.

2. Rotavirus (RV) vaccines. (Minimum age: 6 weeks for both RV1 [Rotarix] and RV5 [RotaTeq])

Routine vaccination: 
Administer a series of RV vaccine to all infants as follows: 
• If Rotarix is used, administer a 2-dose series at 2 and 4 months of age.
• If RotaTeq is used, administer a 3-dose series at ages 2, 4, and 6 months.
• If any dose in the series was RotaTeq or vaccine product is unknown for any dose in the series, a total of 3 doses of RV vaccine should be administered.

Catch-up vaccination: 
• The maximum age for the first dose in the series is 14 weeks, 6 days; vaccination should not be initiated for infants aged 15 weeks, 0 days or older.
• The maximum age for the final dose in the series is 8 months, 0 days.
• For other catch-up guidance, see Figure 2.

3. Diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine. (Minimum age: 6 weeks.

Exception: DTaP-IPV [Kinrix, Quadracel]: 4 years)

Routine vaccination: 
Administer a 5-dose series of DTaP vaccine at ages 2, 4, 6, 15 through 18 months, and 4 through 6 years. The fourth dose may be administered as early as age 12 months, provided at least 6 months have elapsed since the third dose.
• Inadvertent administration of 4th DTaP dose early: If the fourth dose of DTaP was administered at least 4 months, but less than 6 months, after the third dose of DTaP, it need not be repeated.

Catch-up vaccination: 
• The fifth dose of DTaP vaccine is not necessary if the fourth dose was administered at age 4 years or older.

4. Haemophilus influenzae type b (Hib) conjugate vaccine. (Minimum age: 6 weeks for PRP-T [AC-THIB, DTaP-IPV/Hib (Pentacel) and Hib-MenCY (MenHibrix)], PRP-OMP [PedvaxHIB or COMVAX], 12 months for PRP-T [Hiberix])

Routine vaccination: 
• Administer a 2- or 3-dose Hib primary series and a booster dose (dose 3 or 4 depending on vaccine used in primary series) at age 12 through 15 months to complete a full Hib vaccine series.
• The primary series with ActHIB, MenHibrix, or Pentacel consists of 3 doses and should be administered at 2, 4, and 6 months of age. The primary series with PedvaxHIB or COMVAX consists of 2 doses and should be administered at 2 and 4 months of age; a dose at age 6 months is not indicated.
• One booster dose (dose 3 or 4 depending on vaccine used in primary series) of any Hib vaccine should be administered at age 12 through 15 months. An exception is Hibercex vaccine. Hibercex should only be used for the booster (final) dose in children aged 12 months through 4 years who have received at least 1 prior dose of Hib-containing vaccine.
• For recommendations on the use of MenHibrix in patients at increased risk for meningococcal disease, please refer to the meningococcal vaccine footnotes and also to MMWR February 28, 2014 / 63(RR01):1-13, available at http://www.cdc.gov/mmwr/PDF/rr/rr6301.pdf.

Catch-up vaccination: 
• If dose 1 was administered at ages 12 through 14 months, administer a second (final) dose at least 8 weeks after dose 1, regardless of Hib vaccine used in the primary series.
• If both doses were PRP-OMP (PedvaxHIB or COMVAX), and were administered before the first birthday, the third (and final) dose should be administered at age 12 through 59 months and at least 8 weeks after the second dose.
• If the first dose was administered at age 7 through 11 months, administer the second dose at least 4 weeks later and a third (and final) dose at age 12 through 15 months or 8 weeks after second dose, whichever is later.
• If first dose is administered before the first birthday and second dose administered at younger than 15 months, a third (and final) dose should be administered 8 weeks later.
• For unvaccinated children aged 15 months or older, administer only 1 dose.
• For other catch-up guidance, see Figure 2. For catch-up guidance related to MenHibrix, please see the meningococcal vaccine footnotes and also MMWR February 28, 2014 / 63(RR01):1-13, available at http://www.cdc.gov/mmwr/PDF/rr/rr6301.pdf.

Vaccination of persons with high-risk conditions:
Children aged 12 through 59 months who are at increased risk for Hib disease, including chemotherapy recipients and those with anatomic or functional asplenia (including sickle cell disease), human immunodeficiency virus (HIV) infection, immunoglobulin deficiency, or early component deficiency; or who have received either no doses or only 1 dose of Hib vaccine before 12 months of age, should receive 2 additional doses of Hib vaccine 8 weeks apart; children who received 2 or more doses of Hib vaccine before 12 months of age should receive 1 additional dose.
• For patients younger than 5 years of age undergoing chemotherapy or radiation treatment who received a Hib vaccine dose(s) within 14 days of starting therapy or during therapy, repeat the dose(s) at least 3 months following therapy completion.
• Recipients of hematopoietic stem cell transplant (HSCT) should be revaccinated with a 3-dose regimen of Hib vaccine starting 6 to 12 months after successful transplant, regardless of vaccination history; doses should be administered at least 4 weeks apart.
• A single dose of any Hib-containing vaccine should be administered to unimmunized* children and adolescents 15 months of age and older undergoing an elective splenectomy; if possible, vaccine should be administered at least 14 days before procedure.
4. **Haemophilus influenzae** type b (Hib) conjugate vaccine (cont’d)

- Hib vaccine is not routinely recommended for patients 5 years or older. However, 1 dose of Hib vaccine should be administered to unimmunized* persons aged 5 years or older who have anatomic or functional asplenia (including sickle cell disease) and unvaccinated persons 5 through 18 years of age with HIV infection.

* Patients who have not received a primary series and booster dose or at least 1 dose of Hib vaccine after 14 months of age are considered unimmunized.

5. Pneumococcal vaccines. (Minimum age: 6 weeks for PCV13, 2 years for PPSV23)

Routine vaccination with PCV13:

- Administer a 4-dose series of PCV13 vaccine at ages 2, 4, and 6 months and at age 12 through 15 months.

- For children aged 14 through 19 months who have received an age-appropriate series of 7-valent PCV (PCV7), administer a single supplemental dose of 13-valent PCV (PCV13).

Catch-up vaccination with PCV13:

- Administer 1 dose of PCV13 to all healthy children aged 24 through 59 months who are not completely vaccinated for their age.

- For other catch-up guidance, see Figure 2.

For children 2 through 5 years of age with high-risk conditions with PCV13 and PPSV23:

- All recommended PCV13 doses should be administered prior to PPSV23 vaccination if possible.

- For children 2 through 5 years of age with any of the following conditions: chronic heart disease (particularly cyanotic congenital heart disease and cardiac failure); chronic lung disease (including asthma if treated with high-dose oral corticosteroid therapy); diabetes mellitus; cerebrospinal fluid leak; cochlear implant; sickle cell disease and other hemoglobinopathies; anatomic or functional asplenia; HIV infection; chronic renal failure; nephrotic syndrome; diseases associated with treatment with immunosuppressive drugs or radiation therapy, including malignant neoplasms, leukemias, lymphomas, and Hodgkin disease; solid organ transplantation; or congenital immunodeficiency:
  1. Administer 1 dose of PCV13 if any incomplete schedule of 3 doses of PCV (PCV7 and/or PCV13) were received previously.
  2. Administer 1 supplemental dose of PCV13 at least 8 weeks apart if unvaccinated or any incomplete schedule of fewer than 3 doses of PCV (PCV7 and/or PCV13) were received previously.
  3. Administer 1 supplemental dose of PCV13 if 4 doses of PCV or other age-appropriate complete PCV7 series was received previously.

- The minimum interval between doses of PCV (PCV7 or PCV13) is 8 weeks.

- For children with no history of PPSV23 vaccination, administer PPSV23 at least 8 weeks after the most recent dose of PCV13.

- For children aged 6 through 18 years who have cerebrospinal fluid leak; cochlear implant; sickle cell disease and other hemoglobinopathies; anatomic or functional asplenia; congenital or acquired immunodeficiencies; HIV infection; chronic renal failure; nephrotic syndrome; diseases associated with treatment with immunosuppressive drugs or radiation therapy, including malignant neoplasms, leukemias, lymphomas, and Hodgkin disease; generalized malignancy; solid organ transplantation; or multiple myeloma:
  1. If neither PCV13 nor PPSV23 has been received previously, administer 1 dose of PCV13 now and 1 dose of PPSV23 at least 8 weeks later.
  2. If PCV13 has been received previously but PPSV23 has not, administer 1 dose of PPSV23 at least 8 weeks after the most recent dose of PCV13.
  3. If PPSV23 has been received but PCV13 has not, administer 1 dose of PCV13 at least 8 weeks after the most recent dose of PCV23.
  4. If PCV23 has been received but PCV13 has not, administer 1 dose of PCV13 at least 8 weeks after the most recent dose of PCV23.

- For children aged 6 through 18 years with chronic heart disease (particularly cyanotic congenital heart disease and cardiac failure), chronic lung disease (including asthma if treated with high-dose oral corticosteroid therapy), diabetes mellitus, alcoholism, or chronic liver disease, who have not received PPSV23, administer 1 dose of PPSV23. If PCV13 has been received previously, then PPSV23 should be administered at least 8 weeks after any prior PCV13 dose.

- A single revaccination with PPSV23 should be administered 5 years after the first dose to children with sickle cell disease or other hemoglobinopathies; anatomic or functional asplenia; congenital or acquired immunodeficiencies; HIV infection; chronic renal failure; nephrotic syndrome; diseases associated with treatment with immunosuppressive drugs or radiation therapy, including malignant neoplasms, leukemias, lymphomas, and Hodgkin disease; generalized malignancy; solid organ transplantation; or multiple myeloma.

6. Inactivated poliovirus vaccine (IPV). (Minimum age: 6 weeks)

Routine vaccination:

- Administer a 4-dose series of IPV at ages 2, 4, 6 through 18 months, and 4 through 6 years. The final dose in the series should be administered on or after the fourth birthday and at least 6 months after the previous dose.

Catch-up vaccination:

- In the first 6 months of life, minimum age and minimum intervals are only recommended if the person is at risk of imminent exposure to circulating poliovirus (i.e., travel to a polio-endemic region or during an outbreak).

- If 4 or more doses are administered before age 4 years, an additional dose should be administered at age 4 years 6 months and at least 6 months after the previous dose.

- A fourth dose is not necessary if the third dose was administered at age 4 years or older and at least 6 months after the previous dose.

7. Influenza vaccines. (Minimum age: 6 months for inactivated influenza vaccine [IIV], 2 years for live, attenuated influenza vaccine [LAIV])

Routine vaccination:

- Administer a 2-dose series of IIV annually to all children beginning at age 6 months. For most healthy, nonpregnant persons aged 2 through 49 years, either LAIV or IIV may be used. However, LAIV should NOT be administered to some persons, including 1) persons who have experienced severe allergic reactions to LAIV, any of its components, or to a previous dose of any other influenza vaccine; 2) children 2 through 17 years receiving aspirin or aspirin-containing products; 3) persons who are allergic to eggs; 4) pregnant women; 5) immunosuppressed persons; 6) children 2 through 4 years of age with asthma or who had wheezing in the past 12 months; or 7) persons who have taken influenza antiviral medications in the previous 48 hours. For all other contraindications and precautions to use of LAIV, see MMWR August 7, 2015 / 64(30):818-25 available at http://www.cdc.gov/mmwr/pdf/rr/rr5604.pdf.

For children aged 6 through 8 years:

- For the 2015-16 season, administer 2 doses (separated by at least 4 weeks) to children who are receiving influenza vaccine for the first time. Some children in this age group who have been vaccinated previously will also need 2 doses. For additional guidance, follow dosing guidelines in the 2015-16 ACIP influenza vaccine recommendations, MMWR August 7, 2015 / 64(30):818-25, available at http://www.cdc.gov/mmwr/pdf/rr/rr5604.pdf.

- For the 2016-17 season, follow dosing guidelines in the 2016 ACIP influenza vaccine recommendations.

For persons aged 9 years and older:

- Administer 1 dose.

8. Measles, mumps, and rubella (MMR) vaccine. (Minimum age: 12 months for routine vaccination)

Routine vaccination:

- Administer 2 doses of MMR vaccine at ages 12 through 15 months and 4 through 6 years. The second dose may be administered before age 4 years, provided at least 4 weeks have elapsed since the first dose.

- Administer 1 dose of MMR vaccine to infants aged 6 through 11 months before departure from the United States for international travel. These children should be revaccinated with 2 doses of MMR vaccine, the first at age 12 through 15 months (12 months if the child remains in an area where disease risk is high), and the second dose at least 4 weeks later.

- Administer 2 doses of MMR vaccine to children aged 12 months and older before departure from the United States for international travel. The first dose should be administered on or after age 12 months and the second dose at least 4 weeks later.

Catch-up vaccination:

- Ensure that all school-aged children and adolescents have had 2 doses of MMR vaccine; the minimum interval between the 2 doses is 4 weeks.

9. Varicella (VAR) vaccine. (Minimum age: 12 months)

Routine vaccination:

- Administer a 2-dose series of VAR vaccine at ages 12 through 15 months and 4 through 6 years. The second dose may be administered before age 4 years, provided at least 4 months have elapsed since the first dose.

- If the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid.

Catch-up vaccination:

- Ensure that children aged 7 through 18 years without evidence of immunity (see MMWR 2007 / 56 [No. RR-4], available at http://www.cdc.gov/mmwr/pdf/rr/rr5604.pdf) have 2 doses of varicella vaccine. For children aged 7 through 12 years, the minimum interval between doses is 3 months if the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid; for persons aged 13 years and older, the minimum interval between doses is 4 weeks.

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

Routine vaccination:

- Initiate the 2-dose HepA vaccine series at 12 through 23 months; separate the 2 doses by 6 to 18 months.

- Children who have received 1 dose of HepA vaccine before age 24 months should receive a second dose 6 to 18 months after the first dose.

- For any person aged 2 years and older who has not already received the HepA vaccine, 2 doses of HepA vaccine separated by 6 to 18 months may be administered if immunity against hepatitis A virus infection is desired.

Catch-up vaccination:

- The minimum interval between the 2 doses is 6 months.

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

10. Hepatitis A (HepA) vaccine (cont’d)

Special populations:
- Administer 2 doses of HepA vaccine at least 6 months apart to previously unvaccinated persons who live in areas where vaccination programs target older children, or who are at increased risk for infection. This includes persons traveling to or working in countries that have high or intermediate endemicity of infection; men having sex with men; users of injection and non-injection illicit drugs; persons who work with HAV-infected primates or with HAV in a research laboratory; persons with clotting-factor disorders; persons with chronic liver disease; and persons who anticipate close personal contact (e.g., household or regular babysitting) with an international adoptee during the first 60 days after arrival in the United States from a country with high or intermediate endemicity. The first dose should be administered as soon as the adoption is planned, ideally 2 or more weeks before the arrival of the adoptee.

11. Meningococcal vaccines. (Minimum age: 6 weeks for Hib-MenCY [MenHibrix], 9 months for MenACWY-D [Menactra], 2 months for MenACWY-CRM [Menveo], 10 years for serogroup B meningococcal [MenB] vaccines: MenB-4C [Bexsero] and MenB-HPB [Trumenba])

Routine vaccination:
- Administer a single dose of Menactra or Menveo vaccine at age 11 through 12 years, with a booster dose at age 16 years.
- Adolescents aged 11 through 18 years with human immunodeficiency virus (HIV) infection should receive a 2-dose primary series of Menactra or Menveo with at least 8 weeks between doses.
- For children aged 2 months through 18 years with high-risk conditions, see below.

Catch-up vaccination:
- Administer Menactra or Menveo vaccine at age 13 through 18 years if not previously vaccinated.
- If the first dose is administered at age 13 through 15 years, a booster dose should be administered at age 16 through 18 years with a minimum interval of at least 8 weeks between doses.
- If the first dose is administered at age 16 years or older, a booster dose is not needed.
- For other catch-up guidance, see Figure 2.

Clinical discretion:
- Young adults aged 16 through 23 years (preferred age range is age 16 through 18 years) may be vaccinated with either a 2-dose series of Bexsero or a 3-dose series of Trumenba vaccine to provide short-term protection against most strains of serogroup B meningococcal disease. The two MenB vaccines are not interchangeable; the same vaccine product must be used for all doses.

Vaccination of persons with high-risk conditions and other persons at increased risk of disease: Children with anatomic or functional asplenia (including sickle cell disease):

Meningococcal conjugate ACWY vaccines:
1. Menveo
   - Children who initiate vaccination at 8 weeks: Administer doses at 2, 4, 6, and 12 months of age.
   - Unvaccinated children who initiate vaccination at 7 through 23 months: Administer 2 doses, with the second dose at least 12 weeks after the first dose AND after the first birthday.
   - Children 24 months and older who have not received a complete series: Administer 2 primary doses at least 8 weeks apart.
2. MenHibrix
   - Children who initiate vaccination at 6 weeks: Administer doses at 2, 4, 6, and 12 through 15 months of age.
   - If the first dose of MenHibrix is given at or after 12 months of age, a total of 2 doses should be given at least 8 weeks apart to ensure protection against serogroups C and Y meningococcal disease.
3. Menactra
   - Children 24 months and older who have not received a complete series: Administer 2 primary doses at least 8 weeks apart.
4. Menveo
   - Children who initiate vaccination at 8 weeks: Administer doses at 2, 4, 6, and 12 months of age.
   - Unvaccinated children who initiate vaccination at 7 through 23 months: Administer 2 doses, with the second dose at least 12 weeks after the first dose AND after the first birthday.
   - Children 24 months and older who have not received a complete series: Administer 2 primary doses at least 8 weeks apart.

Meningococcal B vaccines:
1. Bexsero or Trumenba
   - Persons 10 years or older who have not received a complete series. Administer a 2-dose series of Bexsero, at least 1 month apart. Or a 3-dose series of Trumenba, with the second dose at least 2 months after the first and the third dose at least 6 months after the first. The two MenB vaccines are not interchangeable; the same vaccine product must be used for all doses.

Children with persistent complement component deficiency (includes persons with inherited or chronic deficiencies in C3, C5-9, properdin, factor D, factor H, or taking eculizumab [Soliris]):

Meningococcal conjugate ACWY vaccines:
1. Menveo
   - Children who initiate vaccination at 8 weeks: Administer doses at 2, 4, 6, and 12 months of age.
   - Unvaccinated children who initiate vaccination at 7 through 23 months: Administer 2 doses, with the second dose at least 12 weeks after the first dose AND after the first birthday.
   - Children 24 months and older who have not received a complete series: Administer 2 primary doses at least 8 weeks apart.
2. MenHibrix
   - Children who initiate vaccination 6 weeks: Administer doses at 2, 4, 6, and 12 through 15 months of age.
   - If the first dose of MenHibrix is given at or after 12 months of age, a total of 2 doses should be given at least 8 weeks apart to ensure protection against serogroups C and Y meningococcal disease.

11. Meningococcal vaccines (cont’d)

3. Menactra
   - Children 9 through 23 months: Administer 2 primary doses at least 12 weeks apart.
   - Children 24 months and older who have not received a complete series: Administer 2 primary doses at least 8 weeks apart.

Meningococcal B vaccines:
1. Bexsero or Trumenba
   - Persons 10 years or older who have not received a complete series. Administer a 2-dose series of Bexsero, at least 1 month apart. Or a 3-dose series of Trumenba, with the second dose at least 2 months after the first and the third dose at least 6 months after the first. The two MenB vaccines are not interchangeable; the same vaccine product must be used for all doses.

For children who travel to or reside in countries in which meningococcal disease is hyperendemic or epidemic, including countries in the African meningitis belt or the Hajj:
- Administer an age-appropriate formulation and series of Menactra or Menveo for protection against serogroups A and W meningococcal disease. Persons with receipt of MenHibrix is not sufficient for children traveling to the meningitis belt or the Hajj because it does not contain serogroups A or W.

For children at risk during a community outbreak attributable to a vaccine serogroup:
- Administer or complete an age- and formulation-appropriate series of MenHibrix, Menactra, or Menveo, Bexsero or Trumenba.


For other catch-recommendations for these persons, and complete information on use of meningococcal vaccines, including guidance related to vaccination of persons at increased risk of infection, see MMWR March 22, 2013 / 62(RR02):1-22, and MMWR October 23, 2015 / 64(41):1171-1176 available at http://www.cdc.gov/mmwr/pdf/rr/rr6202.pdf, and http://www.cdc.gov/mmwr/pdf/ww/mm6441.pdf.

12. Tetanus and diphtheria toxoids and acellular pertussis (Tdap) vaccine. (Minimum age: 10 years for both Boostrix and Adacel)

Routine vaccination:
- Administer 1 dose of Tdap vaccine to all adolescents aged 11 through 12 years.
- Tdap may be administered regardless of the interval since the last tetanus and diphtheria toxoid-containing vaccine.
- Administer 1 dose of Tdap vaccine to pregnant adolescents during each pregnancy (preferred during 27 through 36 weeks gestation) regardless of time since prior Td or Tdap vaccination.

Catch-up vaccination:
- Persons aged 7 years and older who are not fully immunized with DTaP vaccine should receive Tdap vaccine as 1 (preferably the first) dose in the catch-up series; if additional doses are needed, use Td vaccine. For children through 10 years who receive a dose of Tdap as part of the catch-up series, an adolescent Tdap vaccine dose at age 11 through 12 years should NOT be administered. Td should be administered instead 10 years after the Tdap dose.
- Persons aged 11 through 18 years who have not received Tdap vaccine should receive a dose followed by tetanus and diphtheria toxoids (Td) booster doses every 10 years thereafter.
- Inadvertent doses of DTaP vaccine:
  - If administered inadvertently to a child aged 7 through 10 years may count as part of the catch-up series. This dose may count as the adolescent Tdap dose, or the child can later receive a Tdap booster dose at age 11 through 12 years.
  - If administered inadvertently to an adolescent aged 11 through 18 years, the dose should be counted as the adolescent Tdap booster.
- For other catch-up guidance, see Figure 2.

13. Human papillomavirus (HPV) vaccines. (Minimum age: 9 years for 2vHPV [Cervarix], 4vHPV [Gardasil] and 9vHPV [Gardasil 9])

Routine vaccination:
- Administer 3-dose series of HPV vaccine on a schedule of 0, 1-2, and 6 months to all adolescents aged 11 through 12 years. 9vHPV, 4vHPV or 2vHPV may be used for females, and only 9vHPV or 4vHPV may be used for males.
- The vaccine series may be started at age 9 years.
- Administer the second dose 1 to 2 months after the first dose (minimum interval of 4 weeks); administer the third dose 16 weeks after the second dose (minimum interval of 12 weeks) and 24 weeks after the first dose.
- Administer HPV vaccine beginning at age 9 years to children and youth with any history of sexual abuse or assault who have not initiated or completed the 3-dose series.

Catch-up vaccination:
- Administer the vaccine series to females (2vHPV or 4vHPV or 9vHPV) and males (4vHPV or 9vHPV) at age 13 through 18 years if not previously vaccinated.
- Use recommended routine dosing intervals (see Routine vaccination above) for vaccine series catch-up.
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 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</td>
<td>99384</td>
<td>Z00.00, Z00.01, Z00.121,</td>
<td>G0438</td>
</tr>
<tr>
<td>visit</td>
<td>99385, 99394, 99395</td>
<td>Z00.129, Z02-Z02.89, G0439</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: When billing office visits for preventive health screening services, providers must use the EP modifier. 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 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>

Note: When billing office visits for EPSDT preventive health screening services, providers must use place of service (POS) code 99.

EPSDT preventive 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.
- 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.

Please note: The codes and tips listed do not guarantee reimbursement. The information provided is based on HEDIS 2017 technical specifications and the 2016 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.
• 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:
• www.aap.org/periodicitieschedule
• ACIP immunization schedule — www.cdc.gov/vaccines/schedules/hcp/index.html
• www.mmis.georgia.gov/portal

Notes
Adult Body Mass Index Screening

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, 99420, 99429, 99455, 99456</td>
<td>G0402, G0438, G0439, 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 autocalculate BMI once height and weight are entered. Remember that ranges do not meet compliance.

How can we help?
- Distributing adult 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

Please note: The codes and tips listed do not guarantee reimbursement. The information provided is based on HEDIS 2017 technical specifications and the 2016 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.
• 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:
• www.cdc.gov/healthyweight/assessing/bmi/index.html

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 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 (six months)

**Code your services correctly**

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.
- Antidepressant medications include but are not limited to:

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

Please note: The codes and tips listed do not guarantee reimbursement. The information provided is based on HEDIS 2017 technical specifications and the 2016 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>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>

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:
- A comprehensive list of medications and national drug codes (NDC) — www.ncqa.org

Notes
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>J03.00, J03.01, J03.80, J03.81, J03.90, J03.91</td>
<td>87070, 87071, 87081, 87430, 87650-87652, 87880</td>
</tr>
<tr>
<td>Streptococcal sore throat</td>
<td>J02.0</td>
<td></td>
</tr>
<tr>
<td>Group A streptococcal tests</td>
<td></td>
<td></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’s 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.
- Educate patients and their parents or caregivers that they can prevent infection by:
  - Washing hands frequently.
  - Keeping an infected person’s eating utensils and drinking glasses separate from other family members.
  - Thoroughly washing an infected toddler’s toys in hot water with disinfectant soap.

Please note: The codes and tips listed do not guarantee reimbursement. The information provided is based on HEDIS 2017 technical specifications and the 2016 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.
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.

- 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 • Ampicillin</td>
</tr>
<tr>
<td>Beta-lactamase inhibitors</td>
<td>• Amoxicillin-clavulanate</td>
</tr>
<tr>
<td>First generation cephalosporins</td>
<td>• Cefadroxil • Cefazolin • Cephalexin</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 • Erythromycin</td>
</tr>
<tr>
<td></td>
<td>• Clarithromycin • 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 • Penicillin V potassium</td>
</tr>
<tr>
<td>Penicillinase-resistant penicillins</td>
<td>• Dicloxacillin</td>
</tr>
<tr>
<td>Quinolones</td>
<td>• Ciprofloxacin • Moxifloxacin</td>
</tr>
<tr>
<td></td>
<td>• Levofloxacin • Ofloxacin</td>
</tr>
<tr>
<td>Second generation cephalosporins</td>
<td>• Cefaclor • Cefuroxime</td>
</tr>
<tr>
<td></td>
<td>• Cefprozil</td>
</tr>
<tr>
<td>Sulfonamides</td>
<td>• Sulfamethoxazole-trimethprim</td>
</tr>
<tr>
<td>Tetracyclines</td>
<td>• Doxycycline • Tetracycline</td>
</tr>
<tr>
<td></td>
<td>• Minocycline</td>
</tr>
<tr>
<td>Third generation cephalosporins</td>
<td>• Cefdinir • Ceftibuten</td>
</tr>
<tr>
<td></td>
<td>• Cefixime • Cefitoren</td>
</tr>
<tr>
<td></td>
<td>• Cefpodoxime • Ceftriaxone</td>
</tr>
</tbody>
</table>

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)

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:
- www.cdc.gov/getsmart/community/for-patients/common-illnesses/bronchitis.html
- Medicaid formulary —

Please note: The codes and tips listed do not guarantee reimbursement. The information provided is based on HEDIS 2017 technical specifications and the 2016 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.
• Get Smart: Know When Antibiotics Work campaign materials and more —
  www.cdc.gov/getsmart
  o Prescription Pad for Viral Infection
  o Get Smart: Know When Antibiotics Work
  o Cold or Flu: Antibiotics Don’t Work for You

Notes


Please note: The codes and tips listed do not guarantee reimbursement. The information provided is based on HEDIS 2017 technical specifications and the 2016 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 Treatment for Children with Upper Respiratory Infections

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’re 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 2017 technical specifications and the 2016 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/getsma
  o Prescription Pad for Viral Infection
  o Get Smart: Know When Antibiotics Work
  o Cold or Flu: Antibiotics Don’t Work for You

Notes
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis

This HEDIS measure looks at adults 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, E84.9, 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, D89.810-D89.813, D89.82, D89.98, 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, A15.4-A17.1, A17.81-A17.83, A17.89-A18.03, A18.09-A18.18, A18.2, A18.31, A18.39, A18.39, A18.4, A18.50-A18.54, A18.59-A18.7, A18.81-A18.85, A18.89-A19.2, A19.8, A19.9, B44.81, D57.01, D57.211, D57.411, D57.811, J22, J41.041.1, J41.8, J42, J47.0, J47.1, J47.9, J60, J61, J62.0, J62.8, J63.0-J63.6, J64, J65, J66.0-J66.6, J66.8, J67.0-J67.9, J68.0-J68.3, J68.9, J70.0-J70.5, J70.8, J70.9, J80, J81.0, J81.1, J82, J84.01-J84.03, J84.09, J84.10, J84.11-J84.117, J84.17, J84.2, J84.81-J84.83, J84.841-J84.843, J84.848, J84.89, J84.89, J84.9, J85.0-J85.3, J86.0, J86.9, J90, J91.0, J91.8, J92.0, J92.9, J93.0, J93.11, J93.12, J93.81-J93.83, J93.9, J94.0-J94.2, J94.8, J94.9, J95.00-J94.04, J95.09, J95.1-J95.5, J95.61, J95.71, J95.72, J95.811, J95.812, J95.821, J95.822, J95.830, J95.831, J95.84, J95.850, J95.851, J95.859, J95.88, J95.89, J96.00-J96.02, J96.10- J96.12, J96.20- J96.22, J96.90- 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 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.

Please note: The codes and tips listed do not guarantee reimbursement. The information provided is based on HEDIS 2017 technical specifications and the 2016 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 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.

Other resources
You can find more information and tools online:

- www.cdc.gov/getsmart/community/for-patients/common-illnesses/bronchitis.html
- A comprehensive list of medications and NDC — www.ncqa.org
- Get Smart: Know When Antibiotics Work campaign materials and more — www.cdc.gov/getsmart
  o Prescription Pad for Viral Infection
  o Get Smart: Know When Antibiotics Work
  o Cold or Flu: Antibiotics Don’t Work for You

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 to 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>77057</td>
<td>G0202, G0204</td>
<td>0401, 0403</td>
</tr>
<tr>
<td>Mammography, unilateral</td>
<td>77055, 77056</td>
<td>G0206</td>
<td>0401, 0403</td>
</tr>
</tbody>
</table>

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

If the member has previously had a bilateral mastectomy, 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 (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.

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

Please note: The codes and tips listed do not guarantee reimbursement. The information provided is based on HEDIS 2017 technical specifications and the 2016 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.
• 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:

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>0923</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>

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.

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

Please note: The codes and tips listed do not guarantee reimbursement. The information provided is based on HEDIS 2017 technical specifications and the 2016 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.
• 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.
- The U.S. Preventive Services Task Force and the Centers for Disease Control and Prevention recommend screening for chlamydia at least annually for all sexually active women 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 2017 technical specifications and the 2016 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 —
  www.uspreventiveservicestaskforce.org/Page/Document/ClinicalSummaryFinal/chlamydia-and-
gonorrhea-screening

Notes
Comprehensive Diabetes Care

This HEDIS measure looks at members 18-75 years of age with Type 1 or Type 2 diabetes 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 all of the following:

- 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>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, E13.11, 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>Treatment for nephropathy</td>
<td>3066F, 4010F</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urine microalbumin 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 2017 technical specifications and the 2016 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 2017 technical specifications and the 2016 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.


*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.
- 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.
- 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.
- 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

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 2017 technical specifications and the 2016 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:
  - www.diabetes.org
  - www.cdc.gov/diabetes/home
  - www.avesis.com

Notes
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

Please note: The codes and tips listed do not guarantee reimbursement. The information provided is based on HEDIS 2017 technical specifications and the 2016 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.
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 — < 140/90 mm Hg
- Members 60-85 years of age with diabetes — < 140/90 mm Hg
- Members 60-85 years of age without diabetes — < 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 blood pressure 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>Hypertension</td>
<td>I10</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Description</th>
<th>CPT</th>
<th>HCPCS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Visits</td>
<td>99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99401-99404, 99411, 99412, 99420, 99455, 99456, 99456</td>
<td>G0402, G0438, G0439, G0463, T1015</td>
</tr>
</tbody>
</table>

Helpful tips

- Both systolic and diastolic values must be below stated values. Only the most recent blood pressure measurement during the year counts towards compliance. The BP reading must occur on or after July 1 of the measurement year.
- 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 2017 technical specifications and the 2016 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 blood pressure 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:

- www.amga.org/research/research/Hypertension/Compendiums/novant.pdf

Notes

Please note: The codes and tips listed do not guarantee reimbursement. The information provided is based on HEDIS 2017 technical specifications and the 2016 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.
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>

Note: When billing office visits for preventive health screening services, providers must use the EP modifier and the appropriate ICD-10 code (Z00.121 or Z00.129, Z02-Z02.89).

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 is 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.

How can we help?

- Providing individualized reports of your patients that are due or overdue for services

Please note: The codes and tips listed do not guarantee reimbursement. The information provided is based on HEDIS 2017 technical specifications and the 2016 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.
• 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

Other resources
You can find more information and tools online:
• www.mmis.georgia.gov

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>Schizophrenia</td>
<td>F20.0-F20.3, F20.5, F20.81, F20.9, F25.0, F25.1, F25.8, F25.9</td>
</tr>
</tbody>
</table>

HbA1c Tests

<table>
<thead>
<tr>
<th>Description</th>
<th>CPT</th>
</tr>
</thead>
<tbody>
<tr>
<td>HbA1c Tests</td>
<td>83036, 83037, 3044F-3046F</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.

- Antipsychotic medications include but are not limited to:

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

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
Other resources
You can find more information and tools online:

- Medicaid formulary —
- A comprehensive list of medications and NDC — www.ncqa.org

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

Notes

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
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-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></td>
<td>0513, 0900-0905, 0907, 0911-0916, 0917, 0919, 03, 05, 07, 09, 11-20, 22, 24, 33, 49, 50, 52, 53, 71, 72</td>
<td>52, 53</td>
</tr>
<tr>
<td>Visits group 2</td>
<td>99221-99223, 99231-99233, 99238, 99239, 99251-99255</td>
<td></td>
<td>0510, 0515-0517, 0519-0523, 0526-0529, 0982, 0983</td>
<td>52, 53</td>
</tr>
</tbody>
</table>

Be sure to include the appropriate place of service (POS) code if applicable.

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.

Please note: The codes and tips listed do not guarantee reimbursement. The information provided is based on HEDIS 2017 technical specifications and the 2016 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
- 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:
- www.mhpa.org
- www.qualityforum.org

Notes

Please note: The codes and tips listed do not guarantee reimbursement. The information provided is based on HEDIS 2017 technical specifications and the 2016 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 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>Stand-alone visits</td>
<td>96150-96154, 98960-98962,</td>
<td>G0155, G0176,</td>
<td>0510, 0513,</td>
<td>03,</td>
</tr>
<tr>
<td></td>
<td>99078, 99201-99205, 99211-99215,</td>
<td>G0177, G0409-G0411, G0463,</td>
<td>0515, 0516, 0517,</td>
<td>07,</td>
</tr>
<tr>
<td></td>
<td>99217-99220, 99241-99245, 99341-99345,</td>
<td>H0002, H0004,</td>
<td>0519, 0520-0523,</td>
<td>09,</td>
</tr>
<tr>
<td>Visits group 1</td>
<td>90791, 90792, 90832-90840,</td>
<td>03, 05, 07, 09,</td>
<td>52, 53</td>
<td></td>
</tr>
<tr>
<td></td>
<td>90845, 90847, 90849, 90853, 90875, 90876</td>
<td>11-20, 22, 33, 49, 50, 52, 53, 71, 72</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Visits group 2</td>
<td>99221-99223, 99231-99233,</td>
<td>52, 53</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>99238, 99239, 99251-99255</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Telephone visits</td>
<td>98966-98968, 99441-99443</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Be sure to include the appropriate place of service (POS) code if applicable.

**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.
  - 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.

Please note: The codes and tips listed do not guarantee reimbursement. The information provided is based on HEDIS 2017 technical specifications and the 2016 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 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.
- ADHD medications include but may not be limited to:

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

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:
- A comprehensive list of medications and NDC — www.ncqa.org
- www.brightfutures.org
- www.chadd.org
- www.healthychildren.org

Notes

Please note: The codes and tips listed do not guarantee reimbursement. The information provided is based on HEDIS 2017 technical specifications and the 2016 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.
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>
<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 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>
<tr>
<td>HPV</td>
<td>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 0-2 years</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, 90667, 90668, 90685, 90687</td>
</tr>
</tbody>
</table>

Please note: The codes and tips listed do not guarantee reimbursement. The information provided is based on HEDIS 2017 technical specifications and the 2016 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 2017 technical specifications and the 2016 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 9-13 years old</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>

Note: When billing office visits for preventive health screening services, providers must use the EP modifier. The 25 modifier must be included when a vaccine is administered during the preventive visit.

EPSDT preventive 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.

Other resources

You can find more information and tools online:

- ACIP immunization schedule — www.cdc.gov/vaccines/schedules/hcp/index.html
- Vaccines for Children program — https://dph.georgia.gov/vaccines-children-program
- www.mmis.georgia.gov

Please note: The codes and tips listed do not guarantee reimbursement. The information provided is based on HEDIS 2017 technical specifications and the 2016 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.
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>

Note: *When billing these CPT codes, providers must bill with the diagnosis code to signify blood lead level screening. When billing office visits for preventive health screening services, providers must use the EP modifier. The 25 modifier must be included when a vaccine is administered during the preventive visit. **Be sure to use modifiers 90 and 91 if applicable.

If billing office visits for EPSDT preventive health screening services, providers must use place of service (POS) code 99.

EPSDT preventive 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 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.
- Sick visits may be a missed opportunity to complete a lead screening or an annual well visit.

Please note: The codes and tips listed do not guarantee reimbursement. The information provided is based on HEDIS 2017 technical specifications and the 2016 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.
• 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:
• Lead Screening, Case Management, Lab Submissions, Reporting Guidelines —
• www.mmis.georgia.gov

Notes
Medication Management for People with Asthma

This HEDIS measure looks at the percentage of members 5-85 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.

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

- Be sure to contact the Amerigroup Pharmacy department at 1-800-454-3730 to verify required preauthorization of medications.
- 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.
- 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</td>
</tr>
<tr>
<td></td>
<td>• Guaifenesin-theophylline</td>
</tr>
<tr>
<td>Antibody inhibitors</td>
<td>• Omalizumab</td>
</tr>
<tr>
<td>Inhaled steroid combinations</td>
<td>• Budesonide-formoterol</td>
</tr>
<tr>
<td></td>
<td>• Mometasone-formoterol</td>
</tr>
<tr>
<td></td>
<td>• Fluticasone-salmeter</td>
</tr>
<tr>
<td>Inhaled corticosteroids</td>
<td>• Beclomethasone</td>
</tr>
<tr>
<td></td>
<td>• Fluticasone CFC free</td>
</tr>
<tr>
<td></td>
<td>• Mometasone</td>
</tr>
<tr>
<td>Leukotriene modifiers</td>
<td>• Montelukast</td>
</tr>
<tr>
<td></td>
<td>• Zafirlukast</td>
</tr>
<tr>
<td>Mast cell stabilizers</td>
<td>• Cromolyn</td>
</tr>
<tr>
<td>Methylxanthines</td>
<td>• Aminophylline</td>
</tr>
<tr>
<td></td>
<td>• Dyphyllin</td>
</tr>
<tr>
<td>Short-acting, inhaled beta-2 agonists</td>
<td>• Albuterol</td>
</tr>
<tr>
<td></td>
<td>• Levalbuter</td>
</tr>
<tr>
<td></td>
<td>• Pirbuter</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 2017 technical specifications and the 2016 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 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:

- A comprehensive list of medications and NDC — www.ncqa.org

Notes

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
Monitoring 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/engagement (IET) 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></td>
<td></td>
</tr>
<tr>
<td>AOD procedures</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Detoxification</td>
<td></td>
<td>H0008-H0014</td>
<td>0116, 0126, 0136, 0146, 0156</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></td>
</tr>
<tr>
<td>IET visits group 2</td>
<td>99221-99223, 99231-99233, 99238, 99239, 99251-99255</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency department</td>
<td>99281-99285</td>
<td>0450-0459, 0981</td>
<td></td>
</tr>
<tr>
<td>Inpatient stay</td>
<td>0100, 0101, 0110-0114, 0116-0124, 0126-0134, 0136-0144, 0146-0154, 0156-0160, 0164, 0167, 0169, 0170-0174, 0179, 0190-0194, 0199-0204, 0206-0214, 0219, 1000, 1001, 1002</td>
<td></td>
<td></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.
- 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:

- www.qualitymeasures.ahrq.gov
- https://niaaa.nih.gov

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:
- Dispensing of a systemic corticosteroid (or there was evidence of an active prescription) within 14 days of the acute inpatient discharge or ED visit
- Dispensing of 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>Emergency department visit</td>
<td>99281-99285</td>
<td>0450-0452, 0456, 0459, 0981</td>
</tr>
<tr>
<td>Inpatient stay</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>
<td></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.
- Educate patients about the use of, and compliance with, prescribed treatments.
  - Long-term versus quick relief medications
  - Smoking cessation counseling and pharmacotherapy options

Please note: The codes and tips listed do not guarantee reimbursement. The information provided is based on HEDIS 2017 technical specifications and the 2016 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.
• Breathing training
• Oxygen treatments
• Using metered-dose inhalers
• 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 continuing medical education (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.
• 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>• Prednisone</td>
</tr>
<tr>
<td></td>
<td>• Triamcinolone</td>
</tr>
<tr>
<td>Anticholinergic agents</td>
<td>• Albuterol-ipratropium</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>• Albuterol</td>
</tr>
<tr>
<td></td>
<td>• Arformoterol</td>
</tr>
<tr>
<td></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</td>
</tr>
<tr>
<td></td>
<td>• Indacaterol</td>
</tr>
<tr>
<td></td>
<td>• Levalbuterol</td>
</tr>
<tr>
<td></td>
<td>• Mometasone-formoterol</td>
</tr>
<tr>
<td></td>
<td>• Metaproterenol</td>
</tr>
<tr>
<td></td>
<td>• Olodaterol hydrochloride</td>
</tr>
<tr>
<td></td>
<td>• Olodaterol-tiotropium</td>
</tr>
<tr>
<td></td>
<td>• Pirbuterol</td>
</tr>
<tr>
<td></td>
<td>• Salmeterol</td>
</tr>
<tr>
<td></td>
<td>• Umeclidinium-vilanterol</td>
</tr>
<tr>
<td>Methylxanthines</td>
<td>• Aminophylline</td>
</tr>
<tr>
<td></td>
<td>• Dyphylline-guaifenesin</td>
</tr>
<tr>
<td></td>
<td>• Guaifenesin-theophylline</td>
</tr>
<tr>
<td></td>
<td>• Dyphylline</td>
</tr>
<tr>
<td></td>
<td>• Theophylline</td>
</tr>
</tbody>
</table>

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
• A comprehensive list of medications and NDC — www.ncqa.org

Please note: The codes and tips listed do not guarantee reimbursement. The information provided is based on HEDIS 2017 technical specifications and the 2016 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.
• Medicaid formulary —

Notes

Please note: The codes and tips listed do not guarantee reimbursement. The information provided is based on HEDIS 2017 technical specifications and the 2016 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 an Amerigroup member in the first trimester, on the enrollment start date or within 42 days of enrollment as an Amerigroup member.
- **Frequency of ongoing prenatal care** — the percentage of deliveries that had the following number of expected prenatal visits:
  - < 21 percent of expected visits
  - 21 percent-40 percent of expected visits
  - 41 percent-60 percent of expected visits
  - 61 percent-80 percent of expected visits
  - ≥ 81 percent of expected visits.
- **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>86644, 86694-86696, 86762, 86777, 86778, 86782</td>
<td>86690, 86691</td>
<td></td>
</tr>
<tr>
<td>Blood typing</td>
<td></td>
<td>86900, 86901</td>
<td></td>
</tr>
<tr>
<td>Cervical cytology tests</td>
<td>88141-88143, 88147, 88148, 88150, 88152, 88154, 88164-88167, 88174, 88175</td>
<td>86900, 86901</td>
<td>G0123, G0124, G0141, G0143, G0144, G0145, G0147, G0148, P3000, P3001, Q0091</td>
</tr>
<tr>
<td>OB panel</td>
<td>80055, 80011</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prenatal ultrasounds</td>
<td>76801, 76805, 76811, 76813, 76815-76821, 76825-76828</td>
<td>76801, 76805, 76811, 76813, 76815-76821, 76825-76828</td>
<td>H1005, H1000-H1004</td>
</tr>
<tr>
<td>Prenatal visits</td>
<td>59400, 59425, 59426, 59510, 59610, 59618, 99500, 5000F, 5001F, 5002F</td>
<td>59400, 59425, 59426, 59510, 59610, 59618, 99500, 5000F, 5001F, 5002F</td>
<td>H1005, H1000-H1004</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, 5003F</td>
<td></td>
</tr>
</tbody>
</table>

Note: 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:
  - 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 in 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.)

Please note: The codes and tips listed do not guarantee reimbursement. The information provided is based on HEDIS 2017 technical specifications and the 2016 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.
• 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 an 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:
• www.acog.org/About-ACOG/ACOG-Departments/Patient-Records

Notes
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>94010, 94014-94016, 94375, 94620</td>
</tr>
<tr>
<td>Spirometry testing</td>
<td></td>
<td></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 medications
  - Quick-relief medications
  - Smoking cessation counseling
  - Breathing training
  - Oxygen treatments
  - Using meter-dose inhalers
  - Avoiding elements that trigger attacks, such as dust, pollen, smoking and secondary smoke, cold air and pets

**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
- www.guideline.gov/content.aspx?id=23801

Please note: The codes and tips listed do not guarantee reimbursement. The information provided is based on HEDIS 2017 technical specifications and the 2016 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.
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,</td>
</tr>
<tr>
<td></td>
<td>M99.63, M99.73, M99.83, S33.100A, S33.100D, S33.100S, S33.110A, S33.11D,</td>
</tr>
<tr>
<td></td>
<td>S33.110S, S33.120A, S33.120D, S33.120S, S33.130A, S33.130D, S33.130S, S33.140A,</td>
</tr>
<tr>
<td></td>
<td>S33.140D, S33.140S, S33.5XXA, S33.6XXA, S33.8XXA, S33.9XXA, S39.002A,</td>
</tr>
<tr>
<td></td>
<td>S39.82XA, S39.82XD, 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, 0359,</td>
</tr>
<tr>
<td></td>
<td>72110, 72114, 72120, 72131-</td>
<td>0610, 0612, 0614, 0619, 0972</td>
</tr>
<tr>
<td></td>
<td>72133, 72141, 72142, 72146-</td>
<td></td>
</tr>
<tr>
<td></td>
<td>72149, 72156, 72158, 72200,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>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:

Notes

Please note: The codes and tips listed do not guarantee reimbursement. The information provided is based on HEDIS 2017 technical specifications and the 2016 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.
Weight Assessment, Nutritional Counseling and Physical Activity

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>Z68.51-68.54</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</td>
<td>G0447, S9451</td>
<td></td>
</tr>
</tbody>
</table>

Note: *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 EP modifier. The 25 modifier must be included when a vaccine is administered during the preventive visit.

When billing office visits for EPSDT preventive health screening services, providers must use place of service (POS) code 99.

EPSDT preventive 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.
- 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.

Please note: The codes and tips listed do not guarantee reimbursement. The information provided is based on HEDIS 2017 technical specifications and the 2016 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.
• 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:
- www.aap.org/periodicityschedule
- Printable growth charts
  - Boys — www.cdc.gov/growthcharts/data/set1clinical/cj41l023.pdf
- www.mmis.georgia.gov

**Notes**

---

Please note: The codes and tips listed do not guarantee reimbursement. The information provided is based on HEDIS 2017 technical specifications and the 2016 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.
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 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>

Note: When billing office visits for preventive health screening services, providers must use the EP modifier. 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 with modifiers 25 and EP and the applicable 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>

Note: When billing office visits for EPSDT preventive health screening services, providers must use place of service (POS) code 99.

EPSDT preventive 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-child visits and screenings. Immunizations may be an important part of these visits.
- Use your member roster to contact patients who are due for their well-visits or are new to your practice.

Please note: The codes and tips listed do not guarantee reimbursement. The information provided is based on HEDIS 2017 technical specifications and the 2016 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.
- 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:
- [www.aap.org/periodicityschedule](http://www.aap.org/periodicityschedule)
- [www.mmis.georgia.gov](http://www.mmis.georgia.gov)

Notes
**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>

Note: When billing office visits for preventive health screening services, providers must use the EP modifier. 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 with modifiers 25 and EP and the applicable 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>

Note: When billing office visits for EPSDT preventive health screening services, providers must use place of service (POS) code 99.

EPSDT preventive 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.
- 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.

Please note: The codes and tips listed do not guarantee reimbursement. The information provided is based on HEDIS 2017 technical specifications and the 2016 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.
• 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:
• www.aap.org/periodicityschedule
• www.mmis.georgia.gov

Notes
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________