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

GAPEC-2693-18

June 2019
Introduction

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

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

- **Georgia Families** is the statewide program designed to deliver health care services to Medicaid and PeachCare for Kids® members. Amerigroup began operations in the Atlanta service region on June 1, 2006, and on September 1, 2006, for the East, North and Southeast service regions. On February 1, 2012, operations expanded to the remainder of the state in the Central and Southwest service regions. The Georgia Families contract with the Department of Community Health (DCH) was renewed and effective July 1, 2017.

- **Georgia Families 360°** is the statewide program designed to deliver health care services to children and youth in foster care, adoption assistance and certain youth in the Department of Juvenile Justice (DJJ) system. On March 3, 2014, Amerigroup became the only care management organization in the state of Georgia responsible for the well-being and health care coordination of over 27,000 of the state’s most vulnerable children and youth through the 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.

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

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

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

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

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

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

- American Academy of Pediatrics (AAP) Bright Futures Guidelines — published 2017
- Advisory Committee on Immunization Practices (ACIP) Immunization Schedule — published 2018
- NCQA HEDIS Technical Specifications — published 2018
- CMS Technical Specifications and Resource Manual — published 2018
- Georgia DCH Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services Manual (Health Check Program) — published 2018

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.

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<tr>
<th>Medical record data, reporting and requests</th>
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<td><strong>Responsible:</strong></td>
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<td>Health plan</td>
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HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).

*Please note: The codes and tips listed do not guarantee reimbursement. The information provided is based on HEDIS 2019 technical specifications, the 2018 CMS technical specifications and the 2018 EPSDT Services Health Check Program 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.*
Remember, when providing services for our members:

- Providers contracted with Amerigroup must perform all required components of an EPSDT visit as outlined in the *DCH EPSDT Services Manual*.
- In accordance with federal regulation, a provider is not required to exhaust other health plan benefits with respect to EPSDT preventive health screenings. Even if the member has other health insurance, you may file Medicaid first for preventive health services as outlined in *Part 1 Policies and Procedures for Medicaid and PeachCare for Kids*. This will ensure accurate and timely reporting of EPSDT services.
- Providers are encouraged to see newly enrolled Georgia Families members within 90 calendar days of health plan enrollment to establish a primary medical care relationship and complete a medical assessment.
- Providers are encouraged to see members newly entering or re-entering the 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 listed in the *Bright Futures Periodicity Schedule*.
- Preventive health visits (well visits) should be completed per the *Bright Futures Periodicity Schedule*:
  - Example — John’s birthday is April 1. He had his three-year preventive health visit on November 30, 2018. John is eligible for his next health check at any time on or after April 1, 2019.
- Sick visits are missed opportunities to complete a preventive health visit. Amerigroup allows reimbursement for preventive health visits (well visits) that include sick visits. Be sure to bill modifier 25 with the applicable evaluation and management (E&M) code (CPT codes 99211-99212) for the sick visit as well as the appropriate diagnosis codes for respective visits.
- The appropriate EPSDT HIPAA referral code should be documented on the EPSDT claim when an EPSDT visit has occurred to document whether or not problems were identified during the preventive health visit and a referral is needed for further diagnostic and treatment services:
  - NU — normal, no follow-up visit needed
  - AV — available, not used: Patient refused referral.
  - SZ — under treatment: Patient is currently under treatment for health problem and has a return visit.
  - ST — new services requested: Referral to another provider for diagnostic or corrective treatment/scheduled.

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

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

<table>
<thead>
<tr>
<th>Information or questions on the following:</th>
<th>Contact:</th>
</tr>
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<tr>
<td>Georgia Families 360°SM members (foster care, adoptive assistance and DJJ)</td>
<td>Georgia Families 360°SM Intake team at 1-855-661-2021</td>
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<tr>
<td>Georgia Families and PeachCare for Kids members</td>
<td>Quality Management team at 678-587-4868</td>
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<tr>
<td>Quality performance measures</td>
<td>Quality Management team at 678-587-4868</td>
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<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 <em>Your Local Provider Relations Representative</em>.</td>
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Please note: The codes and tips listed do not guarantee reimbursement. The information provided is based on HEDIS 2019 technical specifications, the 2018 CMS technical specifications and the 2018 EPSDT Services Health Check Program 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.
References

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

- Advisory Committee on Immunization Practices immunization schedule — [https://www.cdc.gov/vaccines/schedules/hcp/child-adolescent.html](https://www.cdc.gov/vaccines/schedules/hcp/child-adolescent.html)
- Agency for Healthcare Research and Quality — [https://www.qualitymeasures.ahrq.gov](https://www.qualitymeasures.ahrq.gov)
- AAP Dentistry periodicity schedule — [http://www.aapd.org/assets/1/7/Periodicity-AAPDSchedule.pdf](http://www.aapd.org/assets/1/7/Periodicity-AAPDSchedule.pdf)
- AAP — [https://www.aap.org](https://www.aap.org)
- Amerigroup provider self-service website — [https://providers.amerigroup.com/GA](https://providers.amerigroup.com/GA)
- Bright Futures — [https://www.brightfutures.org](https://www.brightfutures.org)
- Georgia Department of Community Health (DCH) — [http://dch.georgia.gov/medicaid](http://dch.georgia.gov/medicaid)
- Georgia Department of Public Health — [https://dph.georgia.gov](https://dph.georgia.gov)
- Georgia EPSDT services (Health Check program) — [https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/tabId/54/Default.aspx](https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/tabId/54/Default.aspx)
- U.S. Preventive Services Task Force — [https://www.uspreventiveservicestaskforce.org](https://www.uspreventiveservicestaskforce.org)

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# Recommendations for Preventive Pediatric Health Care

**Bright Futures/American Academy of Pediatrics**

Each child and family is unique, therefore, these Recommendations for Preventive Pediatric Health Care are designed for the child who is receiving comprehensive preventing, home monitoring of any important health problems, and are growing and developing in a satisfactory fashion. Developmental, psychosocial, and chronic disease issues for children and adolescents may require frequent counseling and treatment visits separate from preventive care visits. Additional visits also may become necessary if circumstances suggest variations from normal.

These recommendations represent a consensus by the American Academy of Pediatrics (AAP) and the Bright Futures Recommended Preventive Services for Children. These visits emphasize the need to avoid fragmentation of care. Refer to the specific guidance for age as listed in the Bright Futures Guidelines (Haggerty JS, Shaw JS, Duross PA, ref. Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents, 5th ed. Elk Grove Village, IL: American Academy of Pediatrics, 2017).

The recommendations in this statement do not indicate an exclusive course of treatment or standard of medical care deviation, taking into account individual circumstances, may be appropriate. Copyright © 2017 by the American Academy of Pediatrics, updated February 2017. 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.

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<thead>
<tr>
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<th>HISTORICAL CHECKS</th>
<th>LATEST CHILDLHOOD</th>
<th>EARLY CHILDLHOOD</th>
<th>MIDDLE CHILDLHOOD</th>
<th>ADOLESCENCE</th>
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<td>MEASUREMENTS</td>
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1. If child comes under care for the first time at any point on the schedule, or any items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time.

2. A prenatal visit is recommended for parents who are at high risk, for their fetuses, and is for those who request a visit. The prenatal visit should include anticipatory guidance, pertinent medical history, and a discussion of benefits and alternatives. A planned method of screening, referred to as the "Prenatal PM" ([http://pediatrics.aappublications.org/content/114/5/772.full](http://pediatrics.aappublications.org/content/114/5/772.full)), is suggested.

3. Newborns should have their evaluation early after birth, and breastfeeding should be encouraged and instruction and support offered.

4. Newborns should have an evaluation within 1 to 3 days of birth and within 48 to 72 hours after discharge from the hospital in order to identify and manage any problems. A breastfeeding evaluation should occur formalized breastfeeding evaluation, and they should receive education and instruction. It is recommended that "Breastfeeding and the use of human milk" ([https://www.cdc.gov/breastfeeding/infant/infantfeeding.htm](https://www.cdc.gov/breastfeeding/infant/infantfeeding.htm)). "Newborns discharged less than 48 hours after delivery will be examined within 48 hours of discharge per "Hospital Stay for Healthy Term Newborns" ([http://pediatrics.aappublications.org/content/135/1/192.full](http://pediatrics.aappublications.org/content/135/1/192.full)).

5. Conform an initial screen was completed, verify results, and follow up as appropriate. Newborns should be screened, per "2000 Practice Guidelines and Guidelines for Early Hearing Detection and Intervention Programs" ([http://pediatrics.aappublications.org/content/106/2/262.full](http://pediatrics.aappublications.org/content/106/2/262.full)), as well as "Breastfeeding and the use of human milk" ([https://www.cdc.gov/breastfeeding/infant/infantfeeding.htm](https://www.cdc.gov/breastfeeding/infant/infantfeeding.htm)). "Newborns discharged less than 48 hours after delivery will be examined within 48 hours of discharge per "Hospital Stay for Healthy Term Newborns" ([http://pediatrics.aappublications.org/content/135/1/192.full](http://pediatrics.aappublications.org/content/135/1/192.full)).

6. Blood pressure measurement in infants and children with specific risk conditions should be performed at 6 years of age.

7. A visual acuity screen is recommended for ages 6, 11, and 14 years, as well as in cooperative 3-year-olds. Immunoassay screening may be used to screen for the age 6 and 12 years; in addition to the visual acuity at 13 through 15 years of age.


9. "Screening for the detection and management of the development of new and persistent conditions" ([http://pediatrics.aappublications.org/content/134/2/352.full](http://pediatrics.aappublications.org/content/134/2/352.full)).

10. "Screening for the detection and management of the development of new and persistent conditions" ([http://pediatrics.aappublications.org/content/134/2/352.full](http://pediatrics.aappublications.org/content/134/2/352.full)).

11. "Screening for the detection and management of the development of new and persistent conditions" ([http://pediatrics.aappublications.org/content/134/2/352.full](http://pediatrics.aappublications.org/content/134/2/352.full)).

12. Screening should occur per "Identification and Evaluation of Children With Autism Spectrum Disorders" ([http://pediatrics.aappublications.org/content/130/1/184.full](http://pediatrics.aappublications.org/content/130/1/184.full)).

13. This assessment should be implemented and may include an assessment of child emotional and behavioral health, congenital anomalies, and social determinants of health. See "The Struggling: Understanding Behavior, and Mental Health" ([http://pediatrics.aappublications.org/content/139/3/486.full](http://pediatrics.aappublications.org/content/139/3/486.full)).

14. A recommended assessment tool is available at [http://www.childwelfare.gov/tacl/c5673t5373a5373/](http://www.childwelfare.gov/tacl/c5673t5373a5373/). The recommendations in this statement do not indicate an exclusive course of treatment or standard of medical care deviation. Taking into account individual circumstances, may be appropriate. Copyright © 2017 by the American Academy of Pediatrics, updated February 2017. 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.

15. These may be modified, depending on your results and individual needs.

(continued)
19. Confirm initial screening was accomplished, verify results, and follow up, as appropriate.
   The Recommended Uniform Newborn Screening Panel (https://hrsa.gov/advisory-committees/heritable-disorders/rusp/index.html), as determined by The Secretary’s Advisory Committee on Heritable Disorders in Newborns and Children, and state newborn screening laws/regulations (http://genes-r-usUTHSCA.edu/home) establish the criteria for and coverage of newborn screening procedures and programs.

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

21. Confirm initial screening was accomplished, verify results, and follow up, as appropriate. See “Hyperbilirubinemia in the Newborn Infant ≥35 Weeks’ Gestation: An Update With Clarifications” (http://pediatrics.aappublications.org/content/124/4/1193).

22. 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 “Endorsement of Health and Human Services Recommendation for Pulse Oximetry Screening for Critical Congenital Heart Disease” (http://pediatrics.aappublications.org/content/129/1/190.full).

23. Schedules, per the AAP Committee on Infectious Diseases, are available at http://redbook.solutions.aap.org/55/immunization_Schedules.aspx. Every visit should be an opportunity to update and complete a child’s immunizations.

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

25. For children at risk of lead exposure, see “Low Level Lead Exposure Harms Children; A Renewed Call for Primary Prevention” (http://www.cdc.gov/ncceb/lead/ACCLPP_Final_Document_030712.pdf).

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

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


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

30. Adolescents should be screened for HIV according to the USPSTF recommendations (http://www.uspreventiveservicestaskforce.org/uspstf/uspsvih1v.htm) once between the ages of 15 and 18, making every effort to preserve confidentiality of the adolescent. Those at increased risk of HIV infection, including those who are sexually active, participate in injection drug use, or are being tested for other STIs should be tested for HIV and reassessed annually.

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

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


34. See USPSTF recommendations (http://www.uspreventiveservicestaskforce.org/uspsf/uspsodnh.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 varnish are noted in “Fluoride Use in Caries Prevention in the Primary Care Setting” (http://pediatrics.aappublications.org/content/134/3/826).

35. If primary water source is deficient in fluoride, consider oral fluoride supplementation. See “Fluoride Use in Caries Prevention in the Primary Care Setting” (http://pediatrics.aappublications.org/content/134/3/826).
Summary of Changes Made to the
Bright Futures/AAP Recommendations for Preventive Pediatric Health Care
(Periodicity Schedule)

This schedule reflects changes approved in February 2017 and published in April 2017.
For updates, visit www.aap.org/periodicityschedule.
For further information, see the Bright Futures Guidelines, 4th Edition, Evidence and Rationale chapter
(https://brightfutures.aap.org/Bright%20Futures%20Documents/BF4_Evidence_Rationale.pdf).

CHANGES MADE IN FEBRUARY 2017

HEARING

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

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

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

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

PSYCHOSOCIAL/BEHAVIORAL ASSESSMENT

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

TOBACCO, ALCOHOL, OR DRUG USE ASSESSMENT

• The header was updated to be consistent with recommendations.
DEPRESSION SCREENING
• Adolescent depression screening begins routinely at 12 years of age (to be consistent with recommendations of the US Preventive Services Task Force [USPSTF]).

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

NEWBORN BLOOD
• Timing and follow-up of the newborn blood screening recommendations have been delineated.
• Footnote 19 has been updated to read as follows: “Confirm initial screen was accomplished, verify results, and follow up, as appropriate. The Recommended Uniform Newborn Screening Panel (http://www.hrsa.gov/advisorycommittees/mchadvisory/heritabledisorders/recommendedpanel/uniformscreeningpanel.pdf), as determined by The Secretary’s Advisory Committee on Heritable Disorders in Newborns and Children, and state newborn screening laws/regulations (http://genes-r-us.uthscsa.edu/sites/genes-r-us/files/nbs4disorders.pdf) establish the criteria for and coverage of newborn screening procedures and programs.”
• Footnote 20 has been added to read as follows: “Verify results as soon as possible, and follow up, as appropriate.”

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

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

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

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

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

The table below shows vaccine acronyms, and brand names for vaccines routinely recommended for children and adolescents. The use of trade names in this immunization schedule is for identification purposes only and does not imply endorsement by the ACIP or CDC.

<table>
<thead>
<tr>
<th>Vaccine Type</th>
<th>Abbreviation</th>
<th>Brand(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diphtheria, tetanus, and acellular pertussis vaccine</td>
<td>DTaP</td>
<td>Daptacel Infanrix</td>
</tr>
<tr>
<td>Diphtheria, tetanus vaccine</td>
<td>DT</td>
<td>No Trade Name</td>
</tr>
<tr>
<td><em>Haemophilus influenza</em> type B vaccine</td>
<td>Hib (PRP-T)</td>
<td>ActHIB</td>
</tr>
<tr>
<td></td>
<td>Hib (PRP-O MP)</td>
<td>Hiberix</td>
</tr>
<tr>
<td></td>
<td></td>
<td>PedvaxHNIB</td>
</tr>
<tr>
<td>Hepatitis A vaccine</td>
<td>HepA</td>
<td>Havrix</td>
</tr>
<tr>
<td>Hepatitis B vaccine</td>
<td>HepB</td>
<td>Engerix-B</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Recombivax HB</td>
</tr>
<tr>
<td>Human papillomavirus vaccine</td>
<td>HPV</td>
<td>Gardasil 9</td>
</tr>
<tr>
<td>Influenza vaccine (inactivated)</td>
<td>IIV</td>
<td>Multiple</td>
</tr>
<tr>
<td>Measles, mumps, and rubella vaccine</td>
<td>MMR</td>
<td>M-M-R II</td>
</tr>
<tr>
<td>Meningococcal serogroups A, C, W, Y vaccine</td>
<td>MenACWY-D</td>
<td>Menactra</td>
</tr>
<tr>
<td></td>
<td>MenACWY-CRM</td>
<td>Menevo</td>
</tr>
<tr>
<td>Meningococcal serogroup B vaccine</td>
<td>MenB-4C</td>
<td>Bexsero</td>
</tr>
<tr>
<td></td>
<td>MenB-FHbp</td>
<td>Trumenba</td>
</tr>
<tr>
<td>Pneumococcal 13-valent conjugate vaccine</td>
<td>PCV13</td>
<td>Prevnar 13</td>
</tr>
<tr>
<td>Pneumococcal 23-valent polysaccharide vaccine</td>
<td>PPSV23</td>
<td>Pneumovax</td>
</tr>
<tr>
<td>Poliovirus vaccine (inactivated)</td>
<td>IPV</td>
<td>IPOL</td>
</tr>
<tr>
<td>Rotavirus vaccines</td>
<td>RV1, RV5</td>
<td>Rotarix</td>
</tr>
<tr>
<td></td>
<td></td>
<td>RotaTeq</td>
</tr>
<tr>
<td>Tetanus, diphtheria, and acellular pertussis vaccine</td>
<td>Tdap</td>
<td>Adacel</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Boostrix</td>
</tr>
<tr>
<td>Tetanus and diphtheria vaccine</td>
<td>Td</td>
<td>Tenivac</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No Trade Name</td>
</tr>
<tr>
<td>Varicella vaccine</td>
<td>VAR</td>
<td>Varivax</td>
</tr>
</tbody>
</table>

| Combination Vaccines                              |              |                |
| DTaP, hepatitis B and inactivated poliovirus vaccine | DTaP-HepB-IPV| Pediatrix      |
| DTaP, inactivated poliovirus and *Haemophilus influenza* type B vaccine | DTaP-IPV/Hib | Pentacel       |
| DTaP and inactivated poliovirus vaccine           | DTaP-IPV     | Kinrix          |
|                                                   |              | Quadracel      |
| Measles, mumps, rubella, and varicella vaccines   | MMRV         | ProQuad         |

Approved by the

Advisory Committee on Immunization Practices
(www.cdc.gov/vaccines/acip)

American Academy of Pediatrics
(www.aap.org)

American Academy of Family Physicians
(www.aafp.org)

American College of Obstetricians and Gynecologists
(www.acog.org)

This schedule includes recommendations in effect as of January 1, 2018.
Figure 1. Recommended Immunization Schedule for Children and Adolescents Aged 18 Years or Younger—United States, 2018.

(For those who fall behind or start late, see the Catch-up Schedule [Figure 2]).

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

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Birth</th>
<th>1 mo</th>
<th>2 mos</th>
<th>4 mos</th>
<th>6 mos</th>
<th>9 mos</th>
<th>12 mos</th>
<th>15 mos</th>
<th>18 mos</th>
<th>19-23 mos</th>
<th>2-3 yrs</th>
<th>4-6 yrs</th>
<th>7-10 yrs</th>
<th>11-12 yrs</th>
<th>13-15 yrs</th>
<th>16 yrs</th>
<th>17-18 yrs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis B (HepB)</td>
<td>1st dose</td>
<td>2nd dose</td>
<td>3rd dose</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Rotavirus (RV) RV1 (2-dose series); RV5 (3-dose series)</td>
<td>1st dose</td>
<td>2nd dose</td>
<td></td>
<td>See footnote 2</td>
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<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>
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<tr>
<td>Haemophilus influenzae type b (Hib)</td>
<td>1st dose</td>
<td>2nd dose</td>
<td></td>
<td>See footnote 4</td>
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<tr>
<td>Pneumococcal conjugate (PCV13)</td>
<td>1st dose</td>
<td>2nd dose</td>
<td>3rd dose</td>
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<tr>
<td>Inactivated poliovirus (IPV; &lt;18 yrs)</td>
<td>1st dose</td>
<td>2nd dose</td>
<td></td>
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<tr>
<td>Influenza (IV)</td>
<td></td>
<td></td>
<td></td>
<td>Annual vaccination (IV) 1 or 2 doses</td>
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<tr>
<td>Measles, mumps, rubella (MMR)</td>
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<td></td>
<td>See footnote 8</td>
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<tr>
<td>Varicella (VAR)</td>
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<td>1st dose</td>
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<tr>
<td>Hepatitis A (HepA)</td>
<td></td>
<td></td>
<td></td>
<td>1st dose</td>
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<tr>
<td>Meningococcal C (MenACWY-D ≥9 mos MenACWY-CRM ≥2 mos)</td>
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<td></td>
<td></td>
<td>See footnote 11</td>
<td></td>
</tr>
<tr>
<td>Tetanus, diphtheria, &amp; acellular pertussis (Tdap; ≥7 yrs)</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>Tdap</td>
<td></td>
</tr>
<tr>
<td>Human papillomavirus (HPV)</td>
<td></td>
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<td></td>
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<td></td>
<td></td>
<td>See footnote 14</td>
<td></td>
</tr>
<tr>
<td>Meningococcal B</td>
<td></td>
<td></td>
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<td>See footnote 12</td>
<td></td>
</tr>
<tr>
<td>Pneumococcal polysaccharide (PPSV23)</td>
<td></td>
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<td></td>
<td></td>
<td></td>
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<td>See footnote 5</td>
<td></td>
</tr>
</tbody>
</table>

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

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.

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Minimum Age for Dose 1</th>
<th>Dose 1 to Dose 2</th>
<th>Minimum Interval Between Doses</th>
<th>Dose 2 to Dose 3</th>
<th>Dose 3 to Dose 4</th>
<th>Dose 4 to Dose 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis B</td>
<td>Birth</td>
<td>4 weeks</td>
<td>8 weeks and at least 16 weeks after first dose. Minimum age for the final dose: 24 weeks.</td>
<td>6 months</td>
<td>6 months</td>
<td></td>
</tr>
<tr>
<td>Rotavirus</td>
<td>6 weeks Maximum age for first dose is 14 weeks, 6 days</td>
<td>4 weeks</td>
<td>Maximum age for final dose is 8 months, 0 days.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diphtheria, tetanus, and acellular pertussis</td>
<td>6 weeks</td>
<td>4 weeks</td>
<td>4 weeks If current age is younger than 12 months and first dose was administered before the 1st birthday. OR If current age is 12 through 59 months (as final dose) 8 weeks and</td>
<td>8 weeks as final dose</td>
<td>This dose only necessary for children aged 12 through 59 months who received 3 doses before the 1st birthday. OR If both doses were PRP-OMP (PedvaxHIB, Comvax) and were administered before the 1st birthday. No further doses needed if previous dose was administered at age 15 months or older.</td>
<td></td>
</tr>
<tr>
<td>Haemophilus influenzae Type B</td>
<td>6 weeks</td>
<td>4 weeks</td>
<td>8 weeks If first dose was administered before the 1st birthday. OR If first dose was administered at age 12 through 14 months. No further doses needed if first dose was administered at age 15 months or older.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumococcal conjugate</td>
<td>6 weeks</td>
<td>4 weeks</td>
<td>4 weeks If current age is younger than 12 months and first dose was administered before the 1st birthday. OR If first dose was administered before the 1st birthday. OR If current age is 12 through 59 months (as final dose) 8 weeks and</td>
<td>8 weeks as final dose</td>
<td>This dose only necessary for children aged 12 through 59 months who received 3 doses before the 1st birthday. OR If both doses were PRP-OMP (PedvaxHIB, Comvax) and were administered before the 1st birthday. No further doses needed if previous dose was administered at age 15 months or older.</td>
<td></td>
</tr>
<tr>
<td>Inactivated poliovirus</td>
<td>6 weeks</td>
<td>4 weeks</td>
<td>4 weeks If current age is &lt; 4 years 6 months (as final dose) if current age is 4 years or older.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measles, mumps, and rubella</td>
<td>12 months</td>
<td>4 weeks</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Varicella</td>
<td>12 months</td>
<td>3 months</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis A</td>
<td>12 months</td>
<td>6 months</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meningococcal (MenACWY) (MenACWY-CRM2)</td>
<td>6 weeks</td>
<td>8 weeks</td>
<td>See footnote 11</td>
<td>See footnote 11</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meningococcal (MenACWY-CRM2)</td>
<td>Not Applicable (N/A)</td>
<td>8 weeks</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tetanus, diphtheria, and acellular pertussis</td>
<td>7 years</td>
<td>4 weeks</td>
<td>4 weeks If first dose of DTaP/DT was administered before the 1st birthday. OR If first dose of DTaP/DT or DTaP/IP was administered after the 1st birthday.</td>
<td>6 months if first dose of DTaP/DT was administered before the 1st birthday. OR If first dose of DTaP/DT or DTaP/IP was administered after the 1st birthday.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Human papillomavirus</td>
<td>9 years</td>
<td>Routine dosing intervals are recommended.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis A</td>
<td>N/A</td>
<td>6 months</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>N/A</td>
<td>4 weeks</td>
<td>8 weeks and at least 16 weeks after first dose.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inactivated poliovirus</td>
<td>N/A</td>
<td>6 months</td>
<td>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.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measles, mumps, and rubella</td>
<td>N/A</td>
<td>4 weeks</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Varicella</td>
<td>N/A</td>
<td>3 months if younger than age 13 years. 4 weeks if age 13 years or older.</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.
Figure 3. Vaccines that might be indicated for children and adolescents aged 18 years or younger based on medical indications

<table>
<thead>
<tr>
<th>VACCINE</th>
<th>INDICATION</th>
<th>Pregnancy</th>
<th>Immunocompromised status (excluding HIV infection)</th>
<th>HIV infection CD4+ count</th>
<th>Kidney failure, end-stage renal disease, on hemodialysis</th>
<th>Heart disease, chronic lung disease</th>
<th>CSF leaks/organ implants</th>
<th>Apnea and persistent complement deficiencies</th>
<th>Chronic liver disease</th>
<th>Diabetes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis B⁴</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rotavirus⁵</td>
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<td>Measles, mumps, rubella⁹</td>
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*Severe Combined Immunodeficiency

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

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

For further guidance on the use of the vaccines mentioned below, see: www.cdc.gov/vaccines/hcp/acip-recs/index.html. For vaccine recommendations for persons 19 years of age and older, see the Adult Immunization Schedule.

Additional information

- For information on contraindications and precautions for the use of a vaccine, consult the General Best Practice Guidelines for Immunization and relevant ACIP statements, at www.cdc.gov/vaccines/hcp/acip-recs/index.html.
- For calculating intervals between doses, 4 weeks = 28 days. Intervals of ≥4 months are determined by calendar months.
- Within a number range (e.g., 12–18), a dash (–) should be read as “through.”
- Vaccine doses administered ≤4 days before the minimum age or interval are considered valid. Doses of any vaccine administered ≥5 days earlier than the minimum interval or minimum age should not be counted as valid and should be repeated as age-appropriate. The repeat dose should be spaced after the invalid dose by the recommended minimum interval. For further details, see Table 3–1, Recommended and minimum ages and intervals between vaccine doses, in General Best Practice Guidelines for Immunization at www.cdc.gov/vaccines/hcp/acip-recs/general-recs/timing.html.
- Information on travel vaccine requirements and recommendations is available at wwwnc.cdc.gov/travel.
- The National Vaccine Injury Compensation Program (VICP) is a no-fault alternative to the traditional legal system for resolving vaccine injury claims. All routine child and adolescent vaccines are covered by VICP except for pneumococcal polysaccharide vaccine (PPSV23). For more information, see www.hrsa.gov/vaccinecompensation/index.html.

1. Hepatitis B (HepB) vaccine. (minimum age: birth)
   Birth Dose (Monovalent HepB vaccine only):
   - Mother is HBSAg-Negative: 1 dose within 24 hours of birth for medically stable infants ≥2,000 grams. Infants <2,000 grams administer 1 dose at chronological age 1 month or hospital discharge.
   - Mother is HBSAg-Positive:
     - Give HepB vaccine and 0.5 mL of HBIG (at separate anatomic sites) within 12 hours of birth, regardless of birth weight.
     - Test for HBSag and anti-HBs at age 9–12 months. If HepB series is delayed, test 1–2 months after final dose.
   - Mother’s HBSag status is unknown:
     - Give HepB vaccine within 12 hours of birth, regardless of birth weight.
     - For infants <2,000 grams, give 0.5 mL of HBIG in addition to HepB vaccine within 12 hours of birth.
     - Determine mother’s HBSag status as soon as possible. If mother is HBSag-positive, give 0.5 mL of HBIG to infants ≥2,000 grams as soon as possible, but no later than 7 days of age.

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

   Infants who did not receive a birth dose should begin the series as soon as feasible (see Figure 2).
   - Administration of 4 doses is permitted when a combination vaccine containing HepB is used after the birth dose.
   - Minimum age for the final (3rd or 4th) dose: 24 weeks.
   - Minimum Intervals: Dose 1 to Dose 2 ≥4 weeks / Dose 2 to Dose 3: 8 weeks / Dose 1 to Dose 3: 16 weeks. (When 4 doses are given, substitute “Dose 4” for “Dose 3” in these calculations.)

   Catch-up vaccination:
   - Unvaccinated persons should complete a 3-dose series at 0, 1–2, and 6 months.
   - Adolescents 11–15 years of age may use an alternative 2-dose schedule, with at least 4 months between doses (adult formulation Recombivax HB only).
   - For other catch-up guidance, see Figure 2.

2. Rotavirus vaccines. (minimum age: 6 weeks)
   Routine vaccination:
   - Rotarix: 2-dose series at 2 and 4 months.
   - RotaTeq: 3-dose series at 2, 4, and 6 months.
   - If any dose in the series is either RotaTeq or unknown, default to 3-dose series.

   Catch-up vaccination:
   - The 5th dose is not necessary if the 4th dose was administered at 4 years or older.
   - For other catch-up guidance, see Figure 2.

3. Diphtheria, tetanus, and acellular pertussis (DTaP) vaccine. (minimum age: 6 weeks [4 years for Kinrix or Quadracel])
   Routine vaccination:
   - 5-dose series at 2, 4, 6, and 15–18 months, and 4–6 years:
     - Prospectively: A 4th dose may be given as early as age 12 months if at least 6 months have elapsed since the 3rd dose.
     - Retrospectively: A 4th dose that was inadvertently given as early as 12 months may be counted if at least 4 months have elapsed since the 3rd dose.

   Catch-up vaccination:
   - Do not start the series on or after age 15 weeks, 0 days.
   - The maximum age for the final dose is 8 months, 0 days.
   - For other catch-up guidance, see Figure 2.
For further guidance on the use of the vaccines mentioned below, see: www.cdc.gov/vaccines/hcp/acip-recs/index.html.

4. *Haemophilus influenzae* type b (Hib) vaccine.
   (minimum age: 6 weeks)
   
   **Routine vaccination:**
   - ActHIB, Hiberix, or Pentacel: 4-dose series at 2, 4, 6, and 12–15 months.
   - PedvaxHIB: 3-dose series at 2, 4, and 12–15 months.

   **Catch-up vaccination:**
   - 1st dose at 7–11 months: Give 2nd dose at least 4 weeks later and 3rd (final) dose at 12–15 months or 8 weeks after 2nd dose (whichever is later).
   - 1st dose at 12–14 months: Give 2nd (final) dose at least 8 weeks after 1st dose.
   - 1st dose before 12 months and 2nd dose before 15 months: Give 3rd (final) dose 8 weeks after 2nd dose.
   - 2 doses of PedvaxHIB before 12 months: Give 3rd (final) dose at 12–59 months and at least 8 weeks after 2nd dose.
   - Unvaccinated at 15–59 months: 1 dose.
   - For other catch-up guidance, see Figure 2.

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

   *Unimmunized = Less than routine series (through 14 months) OR no doses (14 months or older)

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

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

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

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

   **Age 6–18 years:**
   - Any PCV13 but no PPSV23: 2 doses of PPSV23 (1st dose of PPSV23 administered 8 weeks after PCV13 and 2nd dose of PPSV23 administered at least 5 years after the 1st dose of PPSV23).
For further guidance on the use of the vaccines mentioned below, see: www.cdc.gov/vaccines/hcp/acip-recs/index.html.

7. **Influenza vaccines. (minimum age: 6 months)**
   
   **Routine vaccination:**
   - Administer an age-appropriate formulation and dose of influenza vaccine annually.
     - **Children 6 months–8 years who did not receive at least 2 doses of influenza vaccine before July 1, 2017 should receive 2 doses separated by at least 4 weeks.**
     - **Persons 9 years and older:**
       - Live attenuated influenza vaccine (LAIV) not recommended for the 2017–18 season.
   
   (For the 2018–19 season, see the 2018–19 ACIP influenza vaccine recommendations.)

8. **Measles, mumps, and rubella (MMR) vaccine. (minimum age: 12 months for routine vaccination)**
   
   **Routine vaccination:**
   - 2-dose series at 12–15 months and 4–6 years.
   - The 2nd dose may be given as early as 4 weeks after the 1st dose.
   
   **Catch-up vaccination:**
   - Unvaccinated children and adolescents: 2 doses at least 4 weeks apart.

**International travel:**
- **Infants 6–11 months:** 1 dose before departure.
- **Children 12–15 months:** 2 doses at 12–15 months (12 months for children in high-risk areas) and 2nd dose as early as 4 weeks later.

**Unvaccinated children 12 months and older:** 2 doses at least 4 weeks apart at or before departure.

**Mumps outbreak:**
- Persons ≥12 months who previously received ≤2 doses of mumps-containing vaccine and are identified by public health authorities to be at increased risk during a mumps outbreak should receive a dose of mumps-virus containing vaccine.

9. **Varicella (VAR) vaccine. (minimum age: 12 months)**
   
   **Routine vaccination:**
   - 2-dose series: 12–15 months and 4–6 years.
   - The 2nd dose may be given as early as 3 months after the 1st dose (a dose given after a 4-week interval may be counted).

**Catch-up vaccination:**
- Age 13–15 years: 1 dose now and booster at age 16–18 years. Minimum interval 8 weeks.
- Age 16–18 years: 1 dose.

10. **Hepatitis A (HepA) vaccine. (minimum age: 12 months)**
    
    **Routine vaccination:**
    - 2 doses, separated by 6–18 months, between the 1st and 2nd birthdays. (A series begun before the 2nd birthday should be completed even if the child turns 2 before the second dose is given.)

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

    **Special populations:**
    - Previously unvaccinated persons who should be vaccinated:
      - Persons traveling to or working in countries with high or intermediate endemicity
      - Men who have sex with men
      - Users of injection and non-injection drugs
      - Persons who work with hepatitis A virus in a research laboratory or with non-human primates
      - Persons with clotting-factor disorders
      - Persons with chronic liver disease
      - Persons who anticipate dose 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 (administer the 1st dose as soon as the adoption is planned—if ideally at least 2 weeks before the adoptee’s arrival).

11. **SeroGroup A, C, W, Y meningococcal vaccines. (Minimum age: 2 months [Menveo], 9 months [Menactra]).**
    
    **Routine:**
    - 2-dose series: 11-12 years and 16 years.

    **Catch-Up:**
    - Age 13-15 years: 1 dose now and booster at age 16-18 years. Minimum interval 8 weeks.
    - Age 16-18 years: 1 dose.

**Chronic liver disease, alcoholism:**

**Age 6–18 years:**
- No history of PPSV23: 1 dose of PPSV23 (at least 8 weeks after any prior PCV13 dose).

*Incomplete schedules are any schedules where PCV13 doses have not been completed according to ACIP recommended catch-up schedules. The total number and timing of doses for complete PCV13 series are dictated by the age at first vaccination. See Tables 8 and 9 in the ACIP pneumococcal vaccine recommendations (www.cdc.gov/mmwr/pdf/rr/rr5911.pdf) for complete schedule details.

**6. Inactivated poliovirus vaccine (IPV). (minimum age: 6 weeks)**
   
   **Routine vaccination:**
   - 4-dose series at ages 2, 4, 6–18 months, and 4–6 years.
   - Administer the final dose on or after the 4th birthday and at least 6 months after the previous dose.

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

**Series Containing Oral Polio Vaccine (OPV), either mixed OPV-IPV or OPV-only series:**
- Total number of doses needed to complete the series is the same as that recommended for the U.S. IPV schedule. See www.cdc.gov/mmwr/volumes/66/ww/mm6601a8.htm?s_cid=mm6601a8_w.
- Only trivalent OPV (tOPV) counts toward the U.S. vaccination requirements. For guidance to assess doses documented as “OPV” see www.cdc.gov/mmwr/volumes/66/ww/mm6606a7.htm?s_cid=mm6606a7_w.
- For other catch-up guidance, see Figure 2.
For further guidance on the use of the vaccines mentioned below, see: [www.cdc.gov/vaccines/hcp/acip-recs/index.html](http://www.cdc.gov/vaccines/hcp/acip-recs/index.html).

**Special populations and situations:**

**Anatomic or functional asplenia, sickle cell disease, HIV infection, persistent complement component deficiency (including eculizumab use):**

- **Menveo**
  - 1st dose at 8 weeks: 4-dose series at 2, 4, 6, and 12 months.
  - 1st dose at 7–23 months: 2 doses (2nd dose at least 12 weeks after the 1st dose and after the 1st birthday).
  - 1st dose at 24 months or older: 2 doses at least 8 weeks apart.

- **Menactra**
  - Persistent complement component deficiency:
    - 9–23 months: 2 doses at least 12 weeks apart
    - 24 months or older: 2 doses at least 8 weeks apart
  - Anatomic or functional asplenia, sickle cell disease, or HIV infection:
    - 24 months or older: 2 doses at least 8 weeks apart
  - Menactra must be administered at least 4 weeks after completion of PCV13 series.

**Children who travel to or live in countries where meningococcal disease is hyperendemic or epidemic, including countries in the African meningitis belt or during the Hajj, or exposure to an outbreak attributable to a vaccine serogroup:**

- Children <24 months of age:
  - **Menveo (2–23 months):**
    - 1st dose at 8 weeks: 4-dose series at 2, 4, 6, and 17 months.
    - 1st dose at 7–23 months: 2 doses (2nd dose at least 12 weeks after the 1st dose and after the 1st birthday).
  - **Menactra (9–23 months):**
    - 2 doses (2nd dose at least 12 weeks after the 1st dose. 2nd dose may be administered as early as 8 weeks after the 1st dose in travelers).
  - Children 2 years or older: 1 dose of **Menveo** or **Menactra**.

**Note:** Menactra should be given either before or at the same time as DTaP. For MenACWY booster dose recommendations for groups listed under “Special populations and situations” above, and additional meningococcal vaccination information, see meningococcal MMWR publications at [www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/mening.html](http://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/mening.html).

12. **SERO group B meningococcal vaccines (minimum age: 10 years [Bexsero, Trumenba].**

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

**Special populations and situations:**

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

**Note:** Bexsero and Trumenba are not interchangeable.

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

13. **Tetanus, diphtheria, and acellular pertussis (Tdap) vaccine. (minimum age: 11 years for routine vaccinations, 7 years for catch-up vaccination)**

**Routine vaccination:**

- Adolescents 11–12 years of age: 1 dose.
- Pregnant adolescents: 1 dose during each pregnancy (preferably during the early part of gestational weeks 27–36).
- Tdap may be administered regardless of the interval since the last tetanus- and diphtheria-toxoid-containing vaccine.

**Catch-up vaccination:**

- Adolescents 13–18 who have not received Tdap: 1 dose, followed by a Td booster every 10 years.
- Persons aged 7–18 years not fully immunized with DTaP: 1 dose of Tdap as part of the catch-up series (preferably the first dose). If additional doses are needed, use Td.

- Children 7–10 years who receive Tdap inadvertently or as part of the catch-up series may receive the routine Tdap dose at 11–12 years.
- **DTaP inadvertently given after the 7th birthday:**
  - Child 7–10: DTaP may count as part of catch-up series. Routine Tdap dose at 11–12 may be given.
  - Adolescent 11–18: Count dose of DTaP as the adolescent Tdap booster.
  - For other catch-up guidance, see Figure 2.

14. **Human papillomavirus (HPV) vaccine (minimum age: 9 years)**

**Routine and catch-up vaccination:**

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

**Special situations:**

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

*See MMWR, December 16, 2016;65(49):1405–1408, at [www.cdc.gov/mmwr/volumes/65/wr/pdfs/mm6549a5.pdf](http://www.cdc.gov/mmwr/volumes/65/wr/pdfs/mm6549a5.pdf).
Adherence to Antipsychotic Medications for Individuals with Schizophrenia

This HEDIS measure looks at the percentage of members age 19-64 with schizophrenia or schizoaffective disorder who were dispensed an antipsychotic medication and remained on the medication for at least 80 percent of their treatment period.

**Code your services correctly**

Use the following diagnosis codes to document schizophrenia.

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**Best practices and helpful tips**

- The treatment period begins when the antipsychotic medication is dispensed.
- 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.
- 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.
- Antipsychotic medications include but are not limited to:

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</table>

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<table>
<thead>
<tr>
<th>Type</th>
<th>Description</th>
<th>Prescription</th>
</tr>
</thead>
<tbody>
<tr>
<td>Long-acting injections</td>
<td>Long-acting injections — 14-day supply</td>
<td>• Risperidone</td>
</tr>
<tr>
<td></td>
<td>Long-acting injections — 28-day supply</td>
<td>• Aripiprazole</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Fluphenazine decanoate</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Haloperidol decanoate</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Olanzapine</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Paliperidone palmitate</td>
</tr>
</tbody>
</table>

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

**How can we help?**

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

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

**Other resources**

You can find more information and tools online:

- Behavioral health case management — [https://providers.amerigroup.com/ProviderDocuments/ALL_BHCaseMgmt.pdf](https://providers.amerigroup.com/ProviderDocuments/ALL_BHCaseMgmt.pdf)
- Medication adherence in schizophrenia — [https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3805432](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3805432)
- National Institute of Mental Health — [https://www.nimh.nih.gov](https://www.nimh.nih.gov)

**Notes**

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Adolescent Well-Care Visits: 12-21 Years Old

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

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

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

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

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

If you encounter abnormalities or address a pre-existing problem during a well-child visit, and the problem/abnormality is significant enough to require additional work to perform the key components of problem-oriented E&M services, be sure to bill both the appropriate EPSDT visit code and the appropriate E&M code (see the table below) with modifiers 25 and EP and the applicable EPSDT HIPAA referral code (NU, AV, S2, ST).

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

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

Best practices and helpful tips
- Sick visits and sports physicals may be missed opportunities to complete a well visit and may count for a well visit if the appropriate documentation is included.
- Follow the AAP Bright Futures Periodicity Schedule of recommendations for preventive pediatric health care for well visits and screenings.

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• Height, weight, BMI, and counseling for nutrition and physical activity should be completed as part of the visit. For patients under 20, document their BMI percentile. For patients 20 and older, document their BMI value.
• Appropriate immunizations may be an important part of these visits. Administer immunizations in accordance to the ACIP. Check the Georgia Registry of Immunization Transactions and Services database to ensure vaccines have not been administered elsewhere.
• Use your member roster to contact patients who are due for their annual well visit or are new to your practice.
• If you use electronic medical records (EMRs), consider creating a flag to track patients who are due or past due for a visit. If you do not use EMRs, consider creating a manual tracking method.
• Consider offering evening, early morning and/or weekend office hours to accommodate working young adults or parents with children involved in after-school activities.
• Appointment reminders by text, email, postcard or phone call work well for most parents and young adults.
• Consider dedicating a night at your practice for teen well visits or teen-related health topic discussions.

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

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

Other resources
You can find more information and tools online:
• ACIP Immunization Schedule — https://www.cdc.gov/vaccines/schedules/hcp/index.html
• Being Healthy Brings Rewards program — https://providers.amerigroup.com/ProviderDocuments/GAGA_CAID_HlthBringsRewards.pdf
• Bright Futures Tools — https://brightfutures.aap.org/materials-and-tools/Pages/default.aspx
• Printable growth charts:
  o Boys — www.cdc.gov/growthcharts/data/set1clinical/cj41l023.pdf

Notes

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Adult BMI Assessment

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

Record your efforts
Make sure your medical record documentation reflects all of the following:
- Date of the visit
- Height and weight
- BMI:
  - For patients ages 20 and older, document BMI value
  - For patients under age 20, document BMI percentile (listed as a percentile or plotted on a BMI growth chart)

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

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

<table>
<thead>
<tr>
<th>Description</th>
<th>CPT</th>
<th>HCPCS</th>
<th>UBREV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient visits</td>
<td>99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99429, 99455, 99456, 99483</td>
<td>G0402, G0438, G0439, G0463, T1015</td>
<td>0510-0517, 0519-0523, 0526-0529, 0982, 0983</td>
</tr>
</tbody>
</table>

Best practices and 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; however, documentation of BMI value or percentile can be completed at any office visit.
- 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 and chronic disease conditions related to obesity or being overweight.
- Provide staff training on BMI documentation, medical assessment, brief and focused advice, and treatment. Offer your staff a continuing medical education (CME) course to enhance your treatment and prevention of obesity.
- Place posters and educational messages in treatment rooms and waiting areas to help motivate patients to initiate discussions with you about health screenings.
- Review your EMR or assessment forms to check for fields that document BMI. Offices that use EMRs should check whether their systems have the ability to auto-calculate BMI once height and weight are entered. Remember that ranges do not meet compliance.

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How can we help?

- Providing education to members on the importance of annual well visits and BMI screenings through various sources, such as phone calls, newsletters and health education fliers
- Providing individualized reports of your patients who are due or overdue for services
- Working with you to plan, implement and evaluate member events to help promote preventive health care services
- Offering current Clinical Practice Guidelines on our provider self-service website

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

Other resources

You can find more information and tools online:

- Printable growth charts:
  - Boys — [www.cdc.gov/growthcharts/data/set1clinical/cj41l023.pdf](https://www.cdc.gov/growthcharts/data/set1clinical/cj41l023.pdf)

Notes

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Antidepressant Medication Management

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

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

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

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

**Best practices and helpful tips**
- Educate your patients and their spouses, caregivers, and/or guardians about the importance of:
  - Compliance with long-term medications.
  - Not abruptly stopping medications without consulting you.
  - Contacting you immediately if they experience any unwanted/adverse reactions so their treatment can be re-evaluated.
  - Scheduling and attending follow-up appointments to review the effectiveness of their medications.
  - Calling your office if they cannot get their medications refilled.
- Discuss the benefits of participating in our behavioral health case management program.
- Ask your patients who have a behavioral health diagnosis to provide you access to their behavioral health records if you are their primary care provider.
- Be sure to contact our Pharmacy department at 1-800-454-3730 to verify required preauthorization of medications.
- Consider writing a 90-day supply of antidepressant medications.
- Antidepressant medications include but are not limited to:

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

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<table>
<thead>
<tr>
<th>Description</th>
<th>Prescription</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSRI antidepressants</td>
<td>• Citalopram</td>
</tr>
<tr>
<td></td>
<td>• Escitalopram</td>
</tr>
<tr>
<td></td>
<td>• Fluoxetine</td>
</tr>
<tr>
<td></td>
<td>• Fluvoxamine</td>
</tr>
<tr>
<td></td>
<td>• Paroxetine</td>
</tr>
<tr>
<td></td>
<td>• Sertraline</td>
</tr>
<tr>
<td>Tetracyclic antidepressants</td>
<td>• Maprotiline</td>
</tr>
<tr>
<td></td>
<td>• Mirtazapine</td>
</tr>
<tr>
<td>Tricyclic antidepressants</td>
<td>• Amitriptyline</td>
</tr>
<tr>
<td></td>
<td>• Amoxapine</td>
</tr>
<tr>
<td></td>
<td>• Clomipramine</td>
</tr>
<tr>
<td></td>
<td>• Desipramine</td>
</tr>
<tr>
<td></td>
<td>• Doxepin (&gt; 6 mg)</td>
</tr>
<tr>
<td></td>
<td>• Imipramine</td>
</tr>
<tr>
<td></td>
<td>• Nortriptyline</td>
</tr>
<tr>
<td></td>
<td>• Protriptyline</td>
</tr>
<tr>
<td></td>
<td>• Trimipramine</td>
</tr>
</tbody>
</table>

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

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

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

Other resources
You can find more information and tools online:
- American Psychiatric Association — [www.psychiatry.org/patients-families/depression/what-is-depression](http://www.psychiatry.org/patients-families/depression/what-is-depression)
- Behavioral health case management — [https://providers.amerigroup.com/ProviderDocuments/ALL_BHCaseMgmt.pdf](https://providers.amerigroup.com/ProviderDocuments/ALL_BHCaseMgmt.pdf)
- National Institute of Mental Health — [https://www.nimh.nih.gov](https://www.nimh.nih.gov)

Notes

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Appropriate Testing for Children with Pharyngitis

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

Code your services correctly

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

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

Best practices and helpful tips

- This measure looks at members who received group A 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 factor in the success of this measure.)
- Document the performance of a rapid strep test, or the parent or caregivers’ refusal of testing in medical records.
- Discuss with patients ways to treat symptoms:
  - Get extra rest.
  - Drink plenty of fluids.
  - Use over-the-counter medications.
  - Use a cool-mist vaporizer and nasal spray for congestion.
  - Eat ice chips or use throat spray or lozenges for sore throats.
- 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.
  - Keeping a child diagnosed with a sore throat out of school or day care until he or she has taken antibiotics for at least 24 hours and until symptoms improve.
- Be sure to contact our Pharmacy department at 1-800-454-3730 to verify required preauthorization of medications.
- Antibiotic medications include but are not limited to:

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

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

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

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 2019 technical specifications, the 2018 CMS technical specifications and the 2018 EPSDT Services Health Check Program and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.
Other resources
You can find more information and tools online:
- CDC bronchitis — [https://www.cdc.gov/antibiotic-use/community/for-patients/common-illnesses/bronchitis.html](https://www.cdc.gov/antibiotic-use/community/for-patients/common-illnesses/bronchitis.html)
- CDC Get Smart: Know When Antibiotics Work campaign materials and more — [https://www.cdc.gov/getsma](https://www.cdc.gov/getsma):
  - Prescription Pad for Viral Infection
  - Get Smart: Know When Antibiotics Work
  - Cold or Flu: Antibiotics Don’t Work for You

Notes

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Appropriate Treatment for Children with Upper Respiratory Infection

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

Code your services correctly
Use the following diagnosis codes to 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>

Best practices and helpful tips
- Educating patients on the difference between bacterial and viral infections is a key factor in the success of this measure. Reducing the unnecessary use of antibiotics is the goal of this measure:
  - Be equipped to teach patients about the real cause of their illness and explain how using antibiotics when they are not needed can be harmful and cause antibiotic resistance.
  - Educate patients on the effects of frequently using antibiotics for a viral infection by using educational tools that are available.
- Post educational materials in your waiting room and treatment areas for patients.
- In accordance with the ACIP, administer influenza vaccine annually to all children beginning at 6 months of age.
- Focus your discussion on things patients can do to treat the symptoms of URI and the common cold, like:
  - Getting extra rest.
  - Drinking plenty of fluids.
  - Treating the symptoms with over-the-counter medications.
  - Using a cool mist vaporizer/nasal spray for congestion.
  - Using ice chips or throat spray/lozenges for sore throats.
- Don’t let your patients pressure you into writing antibiotic prescriptions for URIs. If a parent/caregiver insists on an antibiotic:
  - Refer to the illness as a common cold; parents and caregivers tend to associate this label with a less-frequent need for antibiotics.
  - Write a prescription for symptom relief such as an over-the-counter cough medicine.

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

Please note: The codes and tips listed do not guarantee reimbursement. The information provided is based on HEDIS 2019 technical specifications, the 2018 CMS technical specifications and the 2018 EPSDT Services Health Check Program 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 2019 technical specifications, the 2018 CMS technical specifications and the 2018 EPSDT Services Health Check Program and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

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

Other resources
You can find more information and tools online:
- Get Smart: Know When Antibiotics Work campaign materials and more — https://www.cdc.gov/getsmt:
  - Prescription Pad for Viral Infection
  - Get Smart: Know When Antibiotics Work
  - Cold or Flu: Antibiotics Don’t Work for You

Notes
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis

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

Code your services correctly

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

<table>
<thead>
<tr>
<th>Description</th>
<th>ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute bronchitis</td>
<td>J20.3-J20.9</td>
</tr>
<tr>
<td>COPD</td>
<td>J44.0, J44.1, J44.9</td>
</tr>
<tr>
<td>Cystic fibrosis</td>
<td>E84.0, E84.11, E84.19, E84.8, E84.9</td>
</tr>
<tr>
<td>Emphysema</td>
<td>J43.0-J43.2, J43.8, J43.9</td>
</tr>
<tr>
<td>HIV</td>
<td>B20, Z21, B97.35</td>
</tr>
<tr>
<td>Immune system disorders</td>
<td>D80.0-D80.9, D81.0-D81.2, D81.4, D81.6, D81.7, D81.89, D81.9, D82.0-D82.4, D82.8, D82.9, D83.0-D83.2, D83.8, D83.9, D84.0, D84.1, D84.8, D84.9, D89.3, D89.810-D89.813, D89.82, D89.89, D89.9</td>
</tr>
<tr>
<td>Malignant neoplasms</td>
<td>C00.0-C96.9</td>
</tr>
<tr>
<td>Other comorbid conditions</td>
<td>A15.0-A15.9, A17.0-A19.9, B44.81, D57.01, D57.211, D57.411, D57.811, J22, J41.0-J42, J47.0-J47.9, J60-J82, J84.01-J84.9, J85.0-J86.9, J90-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>

Best practices and helpful tips

- There is considerable evidence that prescribing antibiotics for uncomplicated acute bronchitis is not necessary unless associated with a comorbid diagnosis, such as chronic obstructive pulmonary disease (COPD), emphysema, cystic fibrosis, respiratory diseases, immune system disorders and malignant neoplasms.
- Acute bronchitis should only need treatment with antibiotics due to an associated comorbid diagnosis. If prescribing an antibiotic for a bacterial infection (or comorbid condition) in patients with uncomplicated acute bronchitis, be sure to use the diagnosis code for the bacterial infection and/or comorbid condition.
- If a patient insists on an antibiotic:
  - Refer to the illness as a chest cold rather than bronchitis; patients tend to associate this label with a less-frequent need for antibiotics.
  - Write a prescription for symptom relief such as an over-the-counter cough medicine.
- Offer annual flu shots in your office or inform your patients of the importance of getting the vaccine and where they can get it.
How can we help?
- Offering current Clinical Practice Guidelines on our provider self-service website
- Providing education to members through newsletters, community events and health education materials
- Offering nonemergency transportation for our members to appointments

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

Other resources
You can find more information and tools online:
- CDC bronchitis — [https://www.cdc.gov/getsmart/community/for-patients/common-illnesses/bronchitis.html](https://www.cdc.gov/getsmart/community/for-patients/common-illnesses/bronchitis.html)
- Get Smart: Know When Antibiotics Work campaign materials and more — [https://www.cdc.gov/getsmart](https://www.cdc.gov/getsmart):
  - Prescription Pad for Viral Infection
  - Get Smart: Know When Antibiotics Work
  - 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 2019 technical specifications, the 2018 CMS technical specifications and the 2018 EPSDT Services Health Check Program 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.
Breast Cancer Screening

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

Record your efforts
Make sure your medical record documentation reflects all of the following:
- Date of the screening
- Type of screening
- Results of the screening

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

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

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

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

<table>
<thead>
<tr>
<th>Description</th>
<th>ICD-10-CM</th>
<th>CPT</th>
</tr>
</thead>
<tbody>
<tr>
<td>History of a bilateral mastectomy</td>
<td>Z90.13</td>
<td></td>
</tr>
<tr>
<td>Absence of left breast</td>
<td>Z90.12</td>
<td></td>
</tr>
<tr>
<td>Absence of right breast</td>
<td>Z90.11</td>
<td></td>
</tr>
<tr>
<td>Unilateral Mastectomy</td>
<td>19180, 19200, 19220, 19240, 19303-19307</td>
<td></td>
</tr>
</tbody>
</table>

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

Please note: The codes and tips listed do not guarantee reimbursement. The information provided is based on HEDIS 2019 technical specifications, the 2018 CMS technical specifications and the 2018 EPSDT Services Health Check Program 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.
• 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
• 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:

• Being Healthy Brings Rewards program — [https://providers.amerigroup.com/ProviderDocuments/GAGA_CAID_HlthBringsRewards.pdf](https://providers.amerigroup.com/ProviderDocuments/GAGA_CAID_HlthBringsRewards.pdf)
• CDC breast cancer screening — [https://www.cdc.gov/cancer/breast/basic_info/screening.htm](https://www.cdc.gov/cancer/breast/basic_info/screening.htm)

Notes

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Please note: The codes and tips listed do not guarantee reimbursement. The information provided is based on HEDIS 2019 technical specifications, the 2018 CMS technical specifications and the 2018 EPSDT Services Health Check Program 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.
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
- The results or findings from the test
- 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>
<th>CPT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Absence of cervix</td>
<td>51925, 56308, 57540, 57545, 57550, 57555, 57556, 58150, 58152, 58200, 58210, 58240, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290-58294, 58548, 58550, 58552-58554, 58570-58573, 58575, 58951, 58953, 58954, 58956, 59135</td>
<td></td>
</tr>
<tr>
<td>Absence of both cervix and uterus</td>
<td>Z90.710</td>
<td></td>
</tr>
<tr>
<td>Absence of cervix with remaining uterus</td>
<td>Z90.712</td>
<td></td>
</tr>
<tr>
<td>Congenital absence of cervix</td>
<td>Q51.5</td>
<td></td>
</tr>
</tbody>
</table>

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

Best practices and helpful tips

- In order to be counted for co-testing, the sample for the pap and HPV test must be collected and performed at the same time on the same date of service, regardless of the cytology result.
- Discuss the importance of well-woman exams, mammograms, Pap tests and HPV testing with all female patients between 21-64 years of age.

Please note: The codes and tips listed do not guarantee reimbursement. The information provided is based on HEDIS 2019 technical specifications, the 2018 CMS technical specifications and the 2018 EPSDT Services Health Check Program 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.
• 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
• 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:
• Being Healthy Brings Rewards program — https://providers.amerigroup.com/ProviderDocuments/GAGA_CAIID_HlthBringsRewards.pdf

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>

**Best practices and helpful tips**

- Chlamydia is the most frequently reported bacterial sexually transmitted disease in the United States. An estimated three million chlamydia infections occur annually among sexually active adolescents and young adults. Chlamydia may cause infertility if left undiagnosed or untreated.
- Screening for chlamydia is recommended at least annually for all sexually active women 24 years of age and younger.
- While screening for chlamydia in sexually active females can be done during any visit, routinely screen female patients who are sexually active in this age group for chlamydia every year as part of their annual well visit.
- Urine screening for chlamydia is acceptable for all female patients 16 years of age and older during adolescent well-care visits.
- Take a sexual history when you see adolescents. Create an environment conducive to taking a sexual history by:
  - Making sure you have an opportunity to speak with the adolescent without her parent(s) present.
  - Reinforcing confidentiality within limits.
  - Introducing sensitive issues by starting with nonthreatening topics first and moving to more sensitive ones.
- If your office does not perform chlamydia screenings, refer members to a participating OB/GYN or other appropriate provider and 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 2019 technical specifications, the 2018 CMS technical specifications and the 2018 EPSDT Services Health Check Program and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.
Other resources
You can find more information and tools online:

- CDC chlamydia facts and brochures —  
  [https://www.cdc.gov/std/chlamydia/facts-brochures.htm](https://www.cdc.gov/std/chlamydia/facts-brochures.htm)
- U.S. Preventive Services Task Force clinical summary on chlamydia screening —  

Notes
Comprehensive Diabetes Care

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

- Hemoglobin A1c (HbA1c) testing
- HbA1c poor control (< 9 percent)
- HbA1c control (< 8 percent)
- HbA1c control (< 7 percent)
- BP control (< 140/90 mm Hg)
- Medical attention for nephropathy
- Dilated retinal eye exam

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

- Date of each visit.
- All diabetes evaluation notes.
- All blood pressure (BP) 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</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HbA1c Test result</td>
<td>3044F-3046F¹</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment for nephropathy</td>
<td>3066F, 4010F</td>
<td>E08.21, E08.22, E08.29, E09.21, E09.22, E09.29, E10.21, E10.22, E10.29, E11.21, E11.22, E11.29, E13.21, E13.22, E13.29, I12.0, I12.9, I13.0, I13.10, I13.11, I13.2, I15.0, I15.1, N00.0-N07.9, N08, N14.0-N14.4, N17.0-N17.2, N17.8, N17.9, N18.1-N18.6, N18.9, N19, N25.0, N25.1, N25.81, N25.89, N25.9, N26.1, N26.2, N26.9, Q60.0-Q60.6, Q61.00-Q61.02, Q61.11, Q61.19, Q61.2-Q61.5, Q61.8, Q61.9, R80.0-R80.3, R80.8, R80.9</td>
<td></td>
</tr>
<tr>
<td>Urine protein test</td>
<td>81000-81003, 81005, 82042-82044, 84156, 3060F-3062F¹</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BP reading result</td>
<td>3074F¹, 3075F¹, 3077F-3080F¹</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 2019 technical specifications, the 2018 CMS technical specifications and the 2018 EPSDT Services Health Check Program 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>CPT</th>
<th>ICD-10-CM</th>
<th>HCPCS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retinal eye exams with an eye care professional</td>
<td>67028, 67030, 67031, 67036, 67039-67043, 67101, 67105, 67107, 67108, 67110, 67113, 67121, 67141, 67145, 67208, 67210, 67218, 67220, 67221, 67227, 67228, 92002, 92004, 92012, 92014, 92018, 92019, 92134, 92225-92228, 92230, 92235, 92240, 92250, 92260, 99203-99205, 92213-92215, 92230, 92235, 92240, 92250, 92260, 99203-99205, 92213-92215, 99242-99245</td>
<td>S0620, S0621, S3000</td>
<td></td>
</tr>
<tr>
<td>Retinal eye exams</td>
<td>3072F, 2022F, 2024F, 2026F</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1 The use of CPT Category II codes help with quality reporting and may reduce the need for medical record requests.
2 Indicates a retinal eye exam was completed with an eye care professional.

**Best practices and helpful tips**

- If your practice uses EMRs, set flags or reminders in the system to alert your staff when a patient’s screenings are due.
- If you use paper charts, consider having a template to identify the last date of necessary screening and the next time the patient should be screened.
- Send appointment reminders and call patients to remind them of upcoming appointments.
- Consider including a diabetes educator on your team or periodically bringing one in to speak with patients during office visits.
- Draw labs in your office rather than referring members to a local lab for screenings.
- Refer members to the network of eye providers for their annual diabetic eye exam.
- Eye exams from the prior year that are negative for retinopathy are counted as compliant.
- Follow up to receive copies of lab test results, eye exam results or any specialist referral and document in your chart.
- Educate your patients, their families, caregivers and guardians on diabetes care, including:
  - Taking all prescribed medications as directed.
  - Adding regular exercise to daily activities to maintain healthy weight and ideal body mass index.
  - Regularly monitoring blood sugar and BP 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

Please note: The codes and tips listed do not guarantee reimbursement. The information provided is based on HEDIS 2019 technical specifications, the 2018 CMS technical specifications and the 2018 EPSDT Services Health Check Program 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.
• 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.

Other resources
You can find more information and tools online:

• American Diabetes Association — www.diabetes.org
• Avesis Vision provider — https://www.avesis.com
• Being Healthy Brings Rewards program — https://providers.amerigroup.com/ProviderDocuments/GAGA_CAID_HlthBringsRewards.pdf
• CDC information on diabetes — https://www.cdc.gov/diabetes/home
• Disease Management Centralized Care Unit — https://providers.amerigroup.com/Pages/ga-about-dmccu.aspx

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Controlling High Blood Pressure

This HEDIS measure looks at members 18-85 years of age who had a diagnosis of hypertension and whose BP is regularly monitored and adequately controlled (< 140/90 mm Hg).

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

- Date of each visit
- All progress notes, problem history and medication reviews
- All BP readings
- Any notation of your patient using a remote blood pressure monitoring device

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 hypertension, outpatient visits and remote BP monitoring:

<table>
<thead>
<tr>
<th>Description</th>
<th>ICD-10-CM</th>
<th>CPT</th>
<th>HCPCS</th>
<th>UBREV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Essential (primary) hypertension</td>
<td>I10</td>
<td>99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99429, 99455, 99456, 99483</td>
<td>G0402, G0438, G0439, G0463, T1015</td>
<td>0510-0517, 0519-0523, 0526-0529, 0982, 0983</td>
</tr>
<tr>
<td>Outpatient visits</td>
<td></td>
<td>99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99429, 99455, 99456, 99483</td>
<td>G0402, G0438, G0439, G0463, T1015</td>
<td>0510-0517, 0519-0523, 0526-0529, 0982, 0983</td>
</tr>
<tr>
<td>Telephone visits*</td>
<td>98966-98968, 99441-99443</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Remote BP monitoring</td>
<td>93784, 93788, 93790, 99091</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Be sure to use the appropriate telehealth modifier of 95 or GT, if applicable.

Use the following CPT Category II codes to document BP readings:

<table>
<thead>
<tr>
<th>Description</th>
<th>CPT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Systolic BP readings — less than 140 mm Hg</td>
<td>3074F, 3075F</td>
</tr>
<tr>
<td>Systolic BP readings — greater than or equal to 140 mm Hg</td>
<td>3077F</td>
</tr>
<tr>
<td>Diastolic BP readings — less than 90 mm Hg</td>
<td>3079F, 3078F</td>
</tr>
<tr>
<td>Diastolic BP readings — greater than or equal to 90 mm Hg</td>
<td>3080F</td>
</tr>
</tbody>
</table>

**Note**: The use of CPT Category II codes help with quality reporting and may reduce the need for medical record requests.

Best practices and helpful tips
- Both systolic and diastolic values must be below the stated values (< 140/90 mm Hg). Only the most recent BP measurement during the year counts towards compliance.

Please note: The codes and tips listed do not guarantee reimbursement. The information provided is based on HEDIS 2019 technical specifications, the 2018 CMS technical specifications and the 2018 EPSDT Services Health Check Program 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.
• Improve the accuracy of BP measurements performed by your clinical staff by:
  o Providing training materials from the American Heart Association.
  o Conducting BP competency tests to validate the education of each clinical staff member.
  o 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.
• BP readings may be taken from a remote monitoring device that is digitally stored electronically transmitted directly to your office. While remote BP monitoring may be utilized, member self-reported BP readings do not count. Be sure to clearly document the medical record if your patient is using a BP monitor that transmits the readings to your office.
• 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:
  o Heart-healthy eating and a low-salt diet.
  o Smoking cessation and avoiding secondhand smoke.
  o Adding regular exercise to daily activities.
  o Home BP monitoring.
  o Ideal BMI.
  o The importance of taking all prescribed medications as directed.

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

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

Other resources
You can find more information and tools online:
• American Heart Association — https://www.heart.org
• Being Healthy Brings Rewards program — https://providers.amerigroup.com/ProviderDocuments/GAGA_CAID_HlthBringsRewards.pdf
• Disease Management Centralized Care Unit — https://providers.amerigroup.com/Pages/ga-about-dmccu.aspx

Please note: The codes and tips listed do not guarantee reimbursement. The information provided is based on HEDIS 2019 technical specifications, the 2018 CMS technical specifications and the 2018 EPSDT Services Health Check Program 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 2019 technical specifications, the 2018 CMS technical specifications and the 2018 EPSDT Services Health Check Program 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>

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

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

Please note: The codes and tips listed do not guarantee reimbursement. The information provided is based on HEDIS 2019 technical specifications, the 2018 CMS technical specifications and the 2018 EPSDT Services Health Check Program 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 young adults.

How can we help?
• Providing individualized reports of your patients that are due or overdue for services
• Working with you to plan, implement and evaluate member events to help promote preventive health care services
• Assisting with scheduling appointments for our members, if needed
• Offering nonemergency transportation for our members to appointments
• Encouraging preventive care through our Being Healthy Brings Rewards program

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

Other resources
You can find more information and tools online:
• AAP commonly used screening instruments and tools — https://toolkits.solutions.aap.org/selfserve/ssPage.aspx?SelfServeContentId=screening_tools
• Developmental monitoring and screening — www.cdc.gov/ncbddd/childdevelopment/screening-hcp.html

Notes

Please note: The codes and tips listed do not guarantee reimbursement. The information provided is based on HEDIS 2019 technical specifications, the 2018 CMS technical specifications and the 2018 EPSDT Services Health Check Program 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.
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>
</table>

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

* The use of CPT Category II codes help with quality reporting and may reduce the need for medical record requests.

Best practices and helpful tips

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

<table>
<thead>
<tr>
<th>Description</th>
<th>Prescriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Miscellaneous antipsychotic agents</td>
<td>Aripiprazole, Asenapine, Brexpiprazole, Cariprazine, Clozapine, Haloperidol</td>
</tr>
<tr>
<td>Phenothiazine antipsychotics</td>
<td>Chlorpromazine, Fluphenazine</td>
</tr>
<tr>
<td>Psychotherapeutic combinations</td>
<td>Amitriptyline-perphenazine</td>
</tr>
<tr>
<td>Thioxanthenes</td>
<td>Thiothixene</td>
</tr>
</tbody>
</table>

Please note: The codes and tips listed do not guarantee reimbursement. The information provided is based on HEDIS 2019 technical specifications, the 2018 CMS technical specifications and the 2018 EPSDT Services Health Check Program and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.
<table>
<thead>
<tr>
<th>Description</th>
<th>Prescriptions</th>
</tr>
</thead>
</table>
| Long-acting injections | • Aripiprazole  
                         | • Fluphenazine decanoate               |
|                     | • Haloperidol decanoate  
                         | • Paliperidone palmitate               |
|                     | • Risperidone  
                         | • Olanzapine                           |

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

**How can we help?**

- Providing individualized reports of your patients that are due or overdue for services
- Offering disease management and behavioral health case management programs to members

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

**Other resources**

You can find more information and tools online:

- Behavioral health case management — [https://providers.amerigroup.com/ProviderDocuments/ALL_BHCaseMgmt.pdf](https://providers.amerigroup.com/ProviderDocuments/ALL_BHCaseMgmt.pdf)
- *Diabetes, Psychiatric Disorders, and the Metabolic Effects of Antipsychotic Medications* — [http://clinical.diabetesjournals.org/content/24/1/18](http://clinical.diabetesjournals.org/content/24/1/18)
- Disease Management Centralized Care Unit — [https://providers.amerigroup.com/Pages/ga-about-dmccu.aspx](https://providers.amerigroup.com/Pages/ga-about-dmccu.aspx)

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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 illness or intentional self-harm diagnoses 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 follow-up care within seven days of discharge
- The percentage of discharges for which the member received follow-up care within 30 days of discharge

Code your services correctly

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

<table>
<thead>
<tr>
<th>Description</th>
<th>ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental illness</td>
<td>F20.0-F25.9, F30.10-F34.9, F39, F42-F44.89, F53-F53.1, F60.0-F60.9, F63.1-F63.9, F68.10-F68.A, F84.0-F84.9, F90-F91.9, F93.0-F94.9</td>
</tr>
<tr>
<td>Intentional self-harm</td>
<td>T14.91, T36.0-T65.92, T71.112-T71.232</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Description</th>
<th>CPT</th>
<th>HCPCS</th>
<th>UBREV</th>
<th>POS1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient visit²</td>
<td>90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221-99223, 99231-99233, 99238, 99239, 99251-99255</td>
<td></td>
<td>02, 03, 05, 07, 09, 11-20, 22, 33, 49, 50, 52, 53, 71, 72</td>
<td></td>
</tr>
<tr>
<td>Electroconvulsive therapy</td>
<td>90870</td>
<td></td>
<td>0901</td>
<td>03, 05, 07, 09, 11-20, 22, 24, 33, 49, 50, 52, 53, 71, 72</td>
</tr>
<tr>
<td>Observation visit</td>
<td>99217-99220</td>
<td></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 2019 technical specifications, the 2018 CMS technical specifications and the 2018 EPSDT Services Health Check Program 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>CPT</th>
<th>HCPCS</th>
<th>UBREV</th>
<th>POS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transitional care management</td>
<td>99496, 99495</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1 Be sure to include the appropriate POS code, if applicable.
2 Be sure to apply the modifier(s) for telehealth visits (GT, 95), if applicable.

**Best practices and helpful tips**

- Visits that occur on the date of discharge do not count as a follow-up visit for this measure.
- Educate your patients and their spouses, caregivers, or guardians about the importance of compliance with the long-term medications prescribed.
- Encourage patients to participate in our behavioral health case management program for help getting follow-up discharge appointments and other support.
- Teach patients’ families to review all discharge instructions for patients and ask for details of all follow-up discharge instructions, such as the dates and times of appointments.
- Ask patients with a mental health diagnosis to allow you access to their mental health records if you are their primary care provider.

**How can we help?**

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

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

**Other resources**

You can find more information and tools online:

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

**Notes**

Please note: The codes and tips listed do not guarantee reimbursement. The information provided is based on HEDIS 2019 technical specifications, the 2018 CMS technical specifications and the 2018 EPSDT Services Health Check Program 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:** had one 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) after the Initiation phase ended

**Code your services correctly**

Use the following diagnosis and procedure codes to identify the follow-up visits (outpatient, intensive outpatient or partial hospitalization) for children who newly prescribed an ADHD medication:

<table>
<thead>
<tr>
<th>Description</th>
<th>CPT</th>
<th>HCPCS</th>
<th>UBREV</th>
<th>POS1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partial hospitalization/intensive outpatient</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Observation visit</td>
<td>99217-99220</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health and behavior assessment/intervention</td>
<td>96150-96154</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Telephone visits²</td>
<td>98966-98968, 99441-99443</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1 Be sure to include the appropriate POS code, if applicable.
2 Only one of the two additional visits in the continuation and maintenance phase may be a telephone or telehealth visit. Be sure to apply the applicable modifier(s) for telehealth visits (GT, 95), if applicable.

Please note: The codes and tips listed do not guarantee reimbursement. The information provided is based on HEDIS 2019 technical specifications, the 2018 CMS technical specifications and the 2018 EPSDT Services Health Check Program 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.
Best practices and 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.
- Educate your patients and their parents, guardians, or caregivers about the use of and compliance with long-term ADHD medications and the disease process.
- Discuss how and when the medication will be administered (such as only during school or every day, etc.) as these factors may affect the length of the prescription given.
- Collaborate with other organizations to share information, research best practices about ADHD interventions and appropriate standards of practice, their effectiveness and safety.
- Be sure to contact our Pharmacy department at 1-800-454-3730 to verify required preauthorization of medications.
- ADHD medications include but may not be limited to:

<table>
<thead>
<tr>
<th>Description</th>
<th>Prescriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>CNS stimulants</td>
<td>Amphetamine-</td>
</tr>
<tr>
<td></td>
<td>dextroamphetamine</td>
</tr>
<tr>
<td></td>
<td>Dexamethasone</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>

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

How can we help?

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

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

Please note: The codes and tips listed do not guarantee reimbursement. The information provided is based on HEDIS 2019 technical specifications, the 2018 CMS technical specifications and the 2018 EPSDT Services Health Check Program 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:

- The National Resource on ADHD — [https://chadd.org](https://chadd.org)

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Immunizations for Children and Adolescents

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

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

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

Immunizations for adolescents
This HEDIS measure looks at adolescents 13 years of age who received the following immunizations on or before their 13th birthday:

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

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

Record your efforts
Make sure that your medical record documentation reflects all the following:
- Date of the immunization (historic and current)
- The name of the specific antigen administered
- Evidence of anaphylactic reaction to any vaccine or its components, if applicable
- Parent refusal, documented history of illness or seropositive test result
- The date of the first Hep B vaccine given at the hospital and name of the hospital, if available

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

<table>
<thead>
<tr>
<th>Description</th>
<th>Immunization</th>
<th>CPT</th>
<th>HCPCS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immunizations for children</td>
<td>DTap</td>
<td>90698, 90700, 90721, 90723</td>
<td></td>
</tr>
<tr>
<td></td>
<td>IPV</td>
<td>90698, 90713, 90723</td>
<td></td>
</tr>
<tr>
<td></td>
<td>MMR</td>
<td>90707, 90710</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Measles*</td>
<td>90705</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Measles/rubella*</td>
<td>90708</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mumps*</td>
<td>90704</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rubella*</td>
<td>90706</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hib</td>
<td>90644-90648, 90698, 90721, 90748</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hep B</td>
<td>90723, 90740, 90744, 90747, 90748</td>
<td>G0010</td>
</tr>
<tr>
<td></td>
<td>VZV*</td>
<td>90710, 90716</td>
<td></td>
</tr>
<tr>
<td></td>
<td>PCV</td>
<td>90670</td>
<td>G0009</td>
</tr>
<tr>
<td></td>
<td>Hep A*</td>
<td>90633</td>
<td></td>
</tr>
</tbody>
</table>

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Please note: The codes and tips listed do not guarantee reimbursement. The information provided is based on HEDIS 2019 technical specifications, the 2018 CMS technical specifications and the 2018 EPSDT Services Health Check Program 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>
<th>HCPCS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immunizations for children</td>
<td>Rotavirus (2 dose)</td>
<td>90681</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rotavirus (3 dose)</td>
<td>90680</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Influenza</td>
<td>90655, 90657, 90661, 90662, 90673, 90685-90688</td>
<td></td>
</tr>
</tbody>
</table>

* MMR, VZV and Hep A vaccinations must be administered on or between the child’s first and second birthdays.

<table>
<thead>
<tr>
<th>Description</th>
<th>Immuneization</th>
<th>CPT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immunizations for adolescents</td>
<td>HPV$^3$</td>
<td>90649-90651</td>
</tr>
<tr>
<td></td>
<td>Meningococcal$^1$</td>
<td>90734</td>
</tr>
<tr>
<td></td>
<td>Tdap$^2$</td>
<td>90715</td>
</tr>
</tbody>
</table>

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

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

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

**Best practices and helpful tips**

- Administer immunizations in accordance to the ACIP. Check the Georgia Registry of Immunization Transactions and Services database to ensure vaccines have not been administered elsewhere.
- Parental or patient refusal do not count as compliance for immunizations.
- 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 the Georgia Registry of Immunization Transactions and Services database.
- 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** — https://www.cdc.gov/vaccines/schedules/hcp/index.html
- **Georgia Medicaid Management Information System** — https://www.mmis.georgia.gov/portal
- **VFC program** — https://dph.georgia.gov/vaccines-children-program

Notes

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Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment

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

- **Initiation of AOD treatment** — started treatment within 14 days of the diagnosis through:
  - An inpatient AOD admission
  - An outpatient visit for AOD abuse or dependence
  - An intensive outpatient encounter or partial hospitalization
  - A telehealth or medication treatment

- **Engagement of AOD treatment** — started the above initiation treatment and had two or more additional alcohol and other drug dependence services or medication treatment sessions within 34 days of the initiation visit

**Code your services correctly**

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

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

<table>
<thead>
<tr>
<th>Description</th>
<th>CPT</th>
<th>HCPCS</th>
<th>UBREV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observation visit</td>
<td>99217-99220</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Telephone visit</td>
<td>98966-98968, 99441-99443</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medication treatment</td>
<td></td>
<td>H0020, H0033, J0571-J0575, J2315, S0109</td>
<td></td>
</tr>
<tr>
<td>Online Assessment</td>
<td>98969, 99444</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Be sure to apply the applicable telehealth modifier (GT, 95), as applicable.*

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Please note: The codes and tips listed do not guarantee reimbursement. The information provided is based on HEDIS 2019 technical specifications, the 2018 CMS technical specifications and the 2018 EPSDT Services Health Check Program 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>CPT</th>
<th>POS</th>
</tr>
</thead>
<tbody>
<tr>
<td>IET visits group 1*</td>
<td>90791, 90792, 90832-90834, 90836-90840,</td>
<td>02, 03, 05, 07, 09, 11-20, 22, 33, 49, 50, 52, 53, 57, 71, 72</td>
</tr>
<tr>
<td></td>
<td>90845, 90847, 90849, 90853, 90875, 90876</td>
<td></td>
</tr>
<tr>
<td>IET visits group 2*</td>
<td>99221-99223, 99231-99233, 99238, 99239,</td>
<td>02, 52, 53</td>
</tr>
<tr>
<td></td>
<td>99251-99255</td>
<td></td>
</tr>
</tbody>
</table>

* Be sure to apply the applicable telehealth modifier (GT, 95), if applicable.

**Best practices and 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.
- Medications treatment for AOD includes but may not be limited to:

<table>
<thead>
<tr>
<th>Treatment type</th>
<th>Description</th>
<th>Prescriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol abuse or dependence</td>
<td>Aldehyde dehydrogenase inhibitor</td>
<td>• Disulfiram (oral)</td>
</tr>
<tr>
<td></td>
<td>Antagonist</td>
<td>• Naltrexone (oral and injectable)</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>• Acamprosate (oral; delayed-release table)</td>
</tr>
<tr>
<td>Opioid abuse or dependence</td>
<td>Antagonist</td>
<td>• Naltrexone (oral and injectable)</td>
</tr>
<tr>
<td>Partial antagonist</td>
<td></td>
<td>• Buprenorphine (sublingual tablet and implant)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Buprenorphine/naloxone (sublingual table, buccal film, sublingual film)</td>
</tr>
</tbody>
</table>

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

**How can we help?**

- 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
- 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:

- Behavioral health case management — [https://providers.amerigroup.com/ProviderDocuments/ALL_BHCaseMgmt.pdf](https://providers.amerigroup.com/ProviderDocuments/ALL_BHCaseMgmt.pdf)
- National Institute of Alcohol Abuse and Alcoholism — [https://niaaa.nih.gov](https://niaaa.nih.gov)
- Substance Abuse and Mental Health Services Administration — [https://www.samhsa.gov/find-help/atod](https://www.samhsa.gov/find-help/atod)
- Disease Management Centralized Care Unit — [https://providers.amerigroup.com/Pages/ga-about-dmccu.aspx](https://providers.amerigroup.com/Pages/ga-about-dmccu.aspx)

Notes
Lead Screening in Children

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

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

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

<table>
<thead>
<tr>
<th>Description</th>
<th>CPT</th>
<th>ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead screening</td>
<td>83655¹</td>
<td>Z13.88</td>
</tr>
<tr>
<td>Capillary or venous</td>
<td>36415²</td>
<td>Z13.88</td>
</tr>
<tr>
<td></td>
<td>36416²</td>
<td></td>
</tr>
</tbody>
</table>

¹ Be sure to use modifiers 90 and/or 91, if applicable.
² 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 appropriate diagnosis code, EP modifier and POS code 99. Modifier 25 must be included when a vaccine is administered during the preventive visit.

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

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

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Sick visits may be a missed opportunity to complete a lead screening or an annual well visit.
Include a lead test reminder with lab name and address on your appointment confirmation/reminder cards.
If you obtain the specimen and analyze the test in your office, you should report results to the Georgia Healthy Homes and Lead Poisoning Prevention Program. See the link in Other Resources.
Contact our Case Management department if the results are greater than 10 micrograms/dl.

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

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

Other resources
You can find more information and tools online:
- Being Healthy Brings Rewards program — https://providers.amerigroup.com/ProviderDocuments/GAGA_CAID_HlthBringsRewards.pdf
- Georgia Medicaid Management Information System — https://www.mmis.georgia.gov/portal

Notes

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Medication Management for People with Asthma

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

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

Code your services correctly
Use the following diagnosis codes to appropriately document asthma:

<table>
<thead>
<tr>
<th>Description</th>
<th>ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma</td>
<td>J45.20-J45.22, J45.30-J45.32, J45.40-J45.42, J45.50-J45.52, J45.901, J45.902, J45.909, J45.990, J45.991, J45.998</td>
</tr>
</tbody>
</table>

Best practices and helpful tips

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

<table>
<thead>
<tr>
<th>Type</th>
<th>Description</th>
<th>Prescriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Controller</td>
<td>Antiasthmatic combinations</td>
<td>• Dyphylline-guaifenesin</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Guaifenesin-theophylline</td>
</tr>
<tr>
<td>Antibody inhibitors</td>
<td></td>
<td>• Omalizumab</td>
</tr>
<tr>
<td>Anti-interleukin-5</td>
<td></td>
<td>• Mepolizumab</td>
</tr>
<tr>
<td>Inhaled steroid</td>
<td></td>
<td>• Budesonide-formoterol</td>
</tr>
<tr>
<td>combinations</td>
<td></td>
<td>• Fluticasone-vilanterol</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Fluticasone-salmeterol</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Mometasone-formoterol</td>
</tr>
<tr>
<td>Inhaled corticosteroids</td>
<td></td>
<td>• Beclomethasone</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Budesonide</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Flunisolide</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Ciclesonide</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Mometasone</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Type</th>
<th>Description</th>
<th>Prescriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Controller</td>
<td>Leukotriene modifiers</td>
<td>• Montelukast</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Zafirlukast</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Zileuton</td>
</tr>
<tr>
<td>Methylxanthines</td>
<td></td>
<td>• Dyphylline</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Theophylline</td>
</tr>
<tr>
<td>Reliever</td>
<td>Short-acting, inhaled beta-2 agonists</td>
<td>• Albuterol</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Pirbuterol</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Levalbuterol</td>
</tr>
</tbody>
</table>

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

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

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

Other resources
You can find more information and tools online:
- CDC’s Asthma Action Plan — [https://www.cdc.gov/asthma/actionplan.html](https://www.cdc.gov/asthma/actionplan.html)
- Disease Management Centralized Care Unit — [https://providers.amerigroup.com/Pages/ga-about-dmccu.aspx](https://providers.amerigroup.com/Pages/ga-about-dmccu.aspx)

Notes

Please note: The codes and tips listed do not guarantee reimbursement. The information provided is based on HEDIS 2019 technical specifications, the 2018 CMS technical specifications and the 2018 EPSDT Services Health Check Program 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.
Metabolic Monitoring for Children and Adolescents on Antipsychotics

This HEDIS measure looks at children and adolescents 1-17 years of age who had two or more antipsychotic prescriptions dispensed and had metabolic testing.

Code your services correctly
Use the following procedure codes to identify metabolic testing:

<table>
<thead>
<tr>
<th>Description</th>
<th>CPT</th>
</tr>
</thead>
<tbody>
<tr>
<td>HbA1c Tests</td>
<td>83036, 83037, 3044F-3046F</td>
</tr>
<tr>
<td>Glucose Tests</td>
<td>80047, 80048, 80050, 80053, 80069, 82947, 82950, 82951</td>
</tr>
<tr>
<td>LDL-C Tests</td>
<td>80061, 83700, 83701, 83704, 83721, 3048F-3050F</td>
</tr>
<tr>
<td>Cholesterol Tests</td>
<td>82465, 83718, 84478</td>
</tr>
</tbody>
</table>

Best practices and helpful tips
- Antipsychotic medications include but may not be limited to:

<table>
<thead>
<tr>
<th>Type</th>
<th>Description</th>
<th>Prescription</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antipsychotics</td>
<td>Miscellaneous antipsychotic agents</td>
<td>• Aripiprazole</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Asenapine</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Brexpiprazole</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Cariprazine</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Clozapine</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Haloperidol</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Thiothixene</td>
</tr>
<tr>
<td>Thioxanthenes</td>
<td></td>
<td>• Thiothixene</td>
</tr>
<tr>
<td>Long-acting injections</td>
<td></td>
<td>• Aripiprazole</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Fluphenazine decanoate</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Haloperidol decanoate</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Olanzapine</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Paliperidone</td>
</tr>
<tr>
<td>Antipsychotic combinations</td>
<td>Psychotherapeutic combinations</td>
<td>• Fluoxetine-olanzapine</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Perphenazine-amitriptyline</td>
</tr>
</tbody>
</table>

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

How can we help?
- Offering current Clinical Practice Guidelines on our provider self-service website
- Offering our behavioral health case management program to our members
- 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 2019 technical specifications, the 2018 CMS technical specifications and the 2018 EPSDT Services Health Check Program 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:

- Behavioral health case management —
  https://providers.amerigroup.com/ProviderDocuments/ALL_BHCaseMgmt.pdf
- Medicaid Formulary —

Notes

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Pharmacotherapy Management of COPD Exacerbation

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

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

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

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

Code your services correctly
Use the following diagnosis and procedure codes to identify COPD:

<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>

Best practices and 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, including:

- Long-term versus quick relief medications.
- Smoking cessation counseling and pharmacotherapy options.
- 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.

Please note: The codes and tips listed do not guarantee reimbursement. The information provided is based on HEDIS 2019 technical specifications, the 2018 CMS technical specifications and the 2018 EPSDT Services Health Check Program 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.
• Provide staff training on proper use of inhalers and breathing techniques used in patients with COPD; offer a CME course to enhance your treatment and prevention of COPD exacerbations.
• Display posters and educational messages in treatment rooms and waiting areas to help motivate patients to initiate discussions with you about smoking cessation.
• Be sure to contact the Pharmacy department at 1-800-454-3730 to verify required preauthorization of medications.
• Systemic corticosteroids and bronchodilators include but may not be limited to:

<table>
<thead>
<tr>
<th>Type</th>
<th>Description</th>
<th>Prescriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Systemic corticosteroids</td>
<td>Glucocorticoids</td>
<td>Cortisone-acetate</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Dexamethasone</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hydrocortisone</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Methylprednisolone</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Prednisolone</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Prednisone</td>
</tr>
<tr>
<td>Bronchodilators</td>
<td>Anticholinergic agents</td>
<td>Ipratropium</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tiotropium</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Umeclidinium</td>
</tr>
<tr>
<td></td>
<td>Beta 2-agonists</td>
<td>Formoterol-glycopyrrolate</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Indacaterol-glycopyrrolate</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mometasone-formoterol</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Olodaterol</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Olodaterol-tiotropium</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Umeclidinium-vilanterol</td>
</tr>
<tr>
<td></td>
<td>Antiasthmatic combinations</td>
<td>Dyphylline-guaifenesin</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Guaifenesin-theophylline</td>
</tr>
</tbody>
</table>

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

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

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

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

Notes

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Prenatal and Postpartum Care

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

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

**Record your efforts**

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

- Documentation of when prenatal care was initiated or the date of the member’s first prenatal visit
- The date of the prenatal visit and evidence of at least one of the following:
  - A basic physical obstetrical examination that includes one of the following:
    - Auscultation for fetal heart tone
    - Pelvic exam with obstetric observations
    - Measurement of fundus height (A standardized prenatal flow sheet may be used.)
  - Prenatal care procedure, such as:
    - Screening test/obstetric panel
    - TORCH antibody panel alone
    - A rubella antibody test/titer with an Rh incompatibility (ABO/RH blood typing)
    - Ultrasound/echography of a pregnant uterus
  - Documentation of last menstrual period or estimated due date with either prenatal risk assessment and counseling/education or complete obstetrical history
- The date of postpartum visit and evidence of at least one of the following:
  - Pelvic exam
  - Evaluation of weight, blood pressure, breasts and abdomen (Notation of breastfeeding is acceptable for the evaluation of breasts component.)
  - Notation of postpartum care (e.g., postpartum care, PP care, PP check, six-week check or a preprinted postpartum care form in which information was documented during the visit)
Code your services correctly

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

<table>
<thead>
<tr>
<th>Type</th>
<th>Description</th>
<th>ICD-10-CM</th>
<th>CPT</th>
<th>HCPCS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prenatal visits</td>
<td>Antibody tests</td>
<td>86644, 86694-86696, 86762, 86777, 86778, 86794, 86795, 86796, 86797</td>
<td>86900, 86901, 86902</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Blood typing</td>
<td>86780, 86781, 86782, 86783, 86784, 86785</td>
<td>80055, 80011</td>
<td></td>
</tr>
<tr>
<td></td>
<td>OB panel</td>
<td>76801, 76805, 76811, 76813, 76815-76821, 76825-76828</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Postpartum visits</td>
<td>Cervical cytology tests</td>
<td>88141-88143, 88147, 88148, 88150, 88152-88154, 88164-88167, 88174, 88175</td>
<td>G0123, G0124,G0141, G0143-G0145, G0147, G0148, P3000, P3001, Q0091</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Postpartum visits*</td>
<td>Z01.411, Z01.419, Z01.42, Z30.430, Z39.1, Z39.2</td>
<td>59400, 59410, 59510, 59515, 59610, 59614, 59618, 59622, 57170, 58300, 59430, 99501, 0503F</td>
<td>G0101</td>
</tr>
</tbody>
</table>

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

Best practices and helpful tips

- ACOG recommends a minimum of 14 prenatal visits for a 40-week pregnancy. To ensure regular care, remind members to schedule all required visits, including:
  - One visit every four weeks until 28 weeks’ gestation (at least six visits).
  - One visit every two weeks until 36 weeks’ gestation (at least four visits).
  - One visit every week after 36 weeks until delivery (at least four visits).

- Prenatal risk assessments should be performed at the first prenatal visit or as early in pregnancy as possible. Risk assessments should include screening for:
  - Alcohol, tobacco and drug use.
  - Depression.
  - Intimate partner violence.

- It is essential to identify maternal risk factors early in pregnancy to ensure the best outcome for the member.
• If the patient comes in one-two weeks after delivery for the removal of staples, educate her on the importance of coming back for a visit 21-56 days after discharge from the hospital and schedule the visit. Explain the purpose of the postpartum visit — what you will examine, discuss and why.

• A follow-up Cesarean section postoperative visit 1-2 weeks after delivery does not count as a postpartum visit. Only a visit between 21-56 days meets compliance for this measure. (A day early or a day late does not count.)

• Call patients to schedule the postpartum visits as well as remind them of their appointment dates and times. Be sure to follow up with patients who miss appointments and reschedule.

• All services can be documented using the ACOG forms.

How can we help?
We help you get members the proper care they need for their pregnancy by:

• Offering current Clinical Practice Guidelines on our provider self-service website.
• Enrolling members into our maternal programs to help you coordinate their care.
• Distributing educational materials to members we identify as pregnant or recently given birth.
• Reaching out to members to remind them of the importance of their prenatal and postpartum care and assist them with making 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:

• American Congress of Obstetricians and Gynecologists — https://www.acog.org/About-ACOG/ACOG-Departments/Patient-Records
• Maternal Child program — https://providers.amerigroup.com/ProviderDocuments/ALL_TCOBAM_Program_Flier.pdf

Notes

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Preventive Dental Services

This measure looks at children age 0-20 years who had a preventive dental service completed.

Code your services correctly

Use the following procedure code to identify preventive dental:

<table>
<thead>
<tr>
<th>Description</th>
<th>CPT</th>
<th>CDT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Application of fluoride varnish</td>
<td>99188</td>
<td>D1206</td>
</tr>
</tbody>
</table>

If the sole purpose of the visit was to apply the fluoride varnish, providers may not bill for an E&M visit in addition to billing for the application of fluoride varnish. In this instance, the provider may bill for the fluoride varnish code only.

Best practices and helpful tips

- Once teeth are present, the application of fluoride varnish is required and may be applied every 3-6 months in the primary care or dental office for children between the ages of 6 months and 5 years.
- Fluoride varnish acts to retard, arrest and reverse the caries process. The teeth absorb the fluoride varnish, strengthening the enamel and helping prevent cavities. It is not a substitute for fluoridated water or toothpaste.
- Remember that members have a primary care dental (PCD) provider listed on their ID cards.
- Consider referring the member to a dental home, if available. If not available, perform a risk assessment at https://www.aap.org/en-us/Documents/oralhealth_RiskAssessmentTool.pdf.
- EPSDT services require a dental/oral health assessment.

How can we help?

- Providing dental providers with individualized reports of your patients that are due or overdue for services
- Assisting dental providers with scheduling appointments for our members, if needed
- Offering nonemergency transportation for our members to dental appointments
- Working with dental providers 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:

- Fluoride Use in Caries Prevention in the Primary Care Setting — http://pediatrics.aappublications.org/content/134/3/626

Notes
Use of 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-J43.2, J43.8, J43.9</td>
<td></td>
</tr>
<tr>
<td>COPD</td>
<td>J44.0, J44.1, J44.9</td>
<td>94010, 94014-94016, 94060, 94070, 94375, 94620</td>
</tr>
<tr>
<td>Spirometry testing</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Best practices and 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.
- 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 and/or quick relief medications
  - Smoking cessation counseling
  - Breathing training
  - Oxygen treatments
  - Using meter-dose inhalers
  - Avoiding elements that trigger attacks, such as dust, pollen, smoking and secondary smoke, cold air and pets

How can we help?

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

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

Please note: The codes and tips listed do not guarantee reimbursement. The information provided is based on HEDIS 2019 technical specifications, the 2018 CMS technical specifications and the 2018 EPSDT Services Health Check Program 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:

- GOLD — https://goldcopd.org
- COPD National Action Plan —

Notes
Use of Imaging Studies for Low Back Pain

This HEDIS measure looks at members 18-50 years of age with a primary diagnosis of low 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 low back pain and imaging studies:

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

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

**Best practices and helpful tips**

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

**Other resources**

You can find more information and tools online:


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

This HEDIS measure looks at members 3-17 years of age who had one or more outpatient visits with their PCP or OB/GYN during the year and documented evidence of the following:
- Height, weight and BMI percentile
- Counseling for nutrition
- Counseling for physical activity

Record your efforts
Make sure that your medical record documentation reflects all of the following:
- Date of the visit
- Both height and weight
- BMI percentile documented or plotted on an appropriate age-growth chart
- Checklist to indicate discussion of counseling for nutrition and physical activity
- Any weight or obesity counseling
- Any advice or anticipatory guidance given

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

<table>
<thead>
<tr>
<th>Description</th>
<th>ICD-10-CM</th>
<th>CPT</th>
<th>HCPCS</th>
</tr>
</thead>
<tbody>
<tr>
<td>BMI percentile</td>
<td>Z68.51-Z68.54</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Counseling for nutrition; physician assessment</td>
<td>Z71.3*</td>
<td>99401, 99402</td>
<td></td>
</tr>
<tr>
<td>assessment only</td>
<td></td>
<td></td>
<td>G0270, G0271, G0447, G0447, S9452, S9470</td>
</tr>
<tr>
<td>Counseling for nutrition; dietician assessment</td>
<td>Z71.3*</td>
<td>97802-97804</td>
<td></td>
</tr>
<tr>
<td>assessment only</td>
<td></td>
<td></td>
<td>G0447, S9451</td>
</tr>
<tr>
<td>Counseling for physical activity</td>
<td>Z02.5, Z71.82</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

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

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

Please note: The codes and tips listed do not guarantee reimbursement. The information provided is based on HEDIS 2018 technical specifications and the 2017 CMS technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.
Best practices and 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; however, these services may be completed during a visit other than a well-child visit. Services specific to an acute or chronic condition do not count for counseling for nutrition or physical activity.
- Sick visits and sports physicals may be missed opportunities to complete a well visit and may count for a well-visit if the appropriate documentation is included.
- Consider incorporating appropriate nutritional and weight management questioning and counseling into your routine clinical practice.
- 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
- 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:

- Being Healthy Brings Rewards program — https://providers.amerigroup.com/ProviderDocuments/GAGA_CAID_HlthBringsRewards.pdf
- Printable growth charts:
  - Boys — https://www.cdc.gov/growthcharts/data/set1clinical/cj41l023.pdf
Please note: The codes and tips listed do not guarantee reimbursement. The information provided is based on HEDIS 2018 technical specifications and the 2017 CMS technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.
Well-Child Visits in the First 15 Months of Life

This HEDIS measure looks at the percentage of members who turned 15 months old during the measurement year and who had six or more well-child visits with a primary care provider before turning 15 months old.

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

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

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

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

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

If you encounter abnormalities or address a pre-existing problem during a well-child visit and the problem/abnormality is significant enough to require additional work to perform the key components of problem-oriented E&M services, be sure to bill both the appropriate EPSDT visit code and the appropriate E&M code (see the table below) with modifiers 25 and EP and the applicable EPSDT HIPAA referral code (NU, AV, S2, ST).

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

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

- Follow the AAP Bright Futures Periodicity Schedule of recommendations for preventive pediatric health care for well-child visits and screenings. If Bright Futures guidelines are followed the member should have at least eight visits prior to turning 15 months old.
- Sick visits may be missed opportunities to complete a well visit and may count for a well-visit if the appropriate documentation is included.
- All visits must occur on or before the child’s 15-month birthday. Consider scheduling the 15th month visit around 14 months.
- 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 database to ensure vaccines have not been administered elsewhere.
- Use your member roster to contact patients who are due for their well visits or are new to your practice.
- Schedule the next appointment at the end of each visit.
- If you use EMRs, consider creating a flag to track patients who are due or past due for a visit. If you do not use EMRs, consider creating a manual tracking method.
- Consider offering evening, early morning and/or weekend office hours to accommodate working young adults or parents with children involved in after-school activities.
- Appointment reminders by text, email, postcard or phone call work well for most parents and young adults.

How can we help?

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

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

Other resources

You can find more information and tools online:

- ACIP Immunization Schedule — https://www.cdc.gov/vaccines/schedules/hcp/index.html
- Being Healthy Brings Rewards program — https://providers.amerigroup.com/ProviderDocuments/GAGA_CAID_HlthBringsRewards.pdf

Notes

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Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life

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
- A physical developmental history
- A mental developmental history
- 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 (EPSDT)</td>
<td>99382, 99383, 99392, 99393</td>
<td>Z00.121, Z00.129, Z00.8, Z02-Z02.89</td>
<td>G0438, G0439</td>
</tr>
</tbody>
</table>

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

If you encounter abnormalities or address a pre-existing problem during a well-child visit and the problem/abnormality is significant enough to require additional work to perform the key components of problem-oriented E&M services, be sure to bill both the appropriate EPSDT visit code and the appropriate E&M code (see the table below) with modifiers 25 and EP and the applicable EPSDT HIPAA referral code (NU, AV, S2, ST).

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

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

Please note: The codes and tips listed do not guarantee reimbursement. The information provided is based on HEDIS 2019 technical specifications and the 2018 CMS technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.
Best practices and helpful tips

- Follow the AAP Bright Futures Recommendations Periodicity Schedule of preventive pediatric health care for well-child visits and screenings.
- Sick visits may be missed opportunities to complete a well visit and may count for a well-visit if the appropriate documentation is included.
- Height, weight, BMI percentile and counseling for nutrition and physical activity should be completed as part of the visit.
- 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.
- 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:

- Being Healthy Brings Rewards program — https://providers.amerigroup.com/ProviderDocuments/GAGA_CAID_HlthBringsRewards.pdf
- Printable growth charts:
  - Boys — https://www.cdc.gov/growthcharts/data/set1clinical/cj41l023.pdf

Notes

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