Blue Shield of California Promise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755

Blue Shield of California Promise Health Plan

HEDIS Toolkit

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blue california

Promise Health Plan

Contents

1 Introduction

The Blue Shield of California Promise Health Plan network comprises over 7,000 physicians, 80 hospitals, and many ancillary medical professionals. Our Provider Network Operations (PNO) department develops and manages the provider network throughout our service areas. With our information systems, Internet accessibility and experienced management support, we strive to achieve optimal provider satisfaction.

Working closely with you

Our mixed model also offers an opportunity for independent physicians and other provider types to contract directly with Blue Shield Promise, under flexible reimbursement methodologies. It is our desire to be responsive and to work closely with our providers to better understand the challenges facing them. Our objective is to help providers improve the delivery of health care services.

We put our members' care first

Blue Shield Promise's mission is to ensure that all Californians have access to high-quality health care at an affordable price. We're transforming the way health care is delivered by partnering with physicians and hospitals, so we can create a healthcare system worthy of our family and friends and sustainably affordable.

What is your role as the provider?

Our providers play a crucial role in promoting the health of our members. You and your team can assist in the HEDIS process improvement by:

- Providing appropriate care within the designated measure timeframes
- Document clearly and accurately in the medical record all the care you provide to our members
- Accurately code all claims
- Know HEDIS measures documentation requirements and specific parameters
- Respond to our requests for medical records within 5-7 days

7 Domains of Care

Quality of Clinical Care

- Ex. Controlling hypertension

Access/Availability of Care

- Member's access to basic health plan services
- Ex. prenatal & postpartum care

Experience of Care

- Member's experience with the health plan & contracted providers
- Ex. CAHPS survey questions, member ratings of providers

Utilization & Risk Adjusted Utilization

- **Measures health plan utilization**

Relative Resource Use

Health Plan Descriptive Information

- Information about health plan
- Ex. board Certification, total membership

Measures collected using Electronic Data

- Measures requiring structured electronic clinical data to be shared between clinicians and plans for automated quality reporting
- Ex. utilization of PHQ-9 to monitor depression, EMR

2 HEDIS Overview

Healthcare Effectiveness Data and Information Set (HEDIS) is a tool created by the National Committee for Quality Assurance (NCQA). Managed by NCQA to facilitate and assist in improving health care quality. It is utilized by more than 90% of America's health plans and used to measure performances on important aspects of care and service, which allows consumers to compare healthcare plans.

How our Providers can improve HEDIS scores

- Be aware of gaps in care prior to member arrival to avoid missed opportunities
- Understand HEDIS requirements and timelines for measures
- Code claims correctly and use HEDIS specific billing codes when appropriate
- Be sure documentation is clear and complete
- Be sure to include the date of service for each service in the medical record

HEDIS Record Retrieval

Our staff will contact your office to retrieve HEDIS record documentation beginning January 2020. HEDIS is a time sensitive project and it is very important that your office responds to requests for medical record documentation in a timely manner within 5 – 7 days. Documentation can be provided by fax, secure email, mail, CD/USB, or remote EMR retrieval.

Under the Health Information Portability and Accountability Act (HIPAA) privacy rule, data collection for HEDIS is permitted and does not require member consent or authorization. HEDIS data collection and release of information is permitted under HIPAA since the disclosure is part of quality assessment and improvement activities.

Submitting HEDIS Data

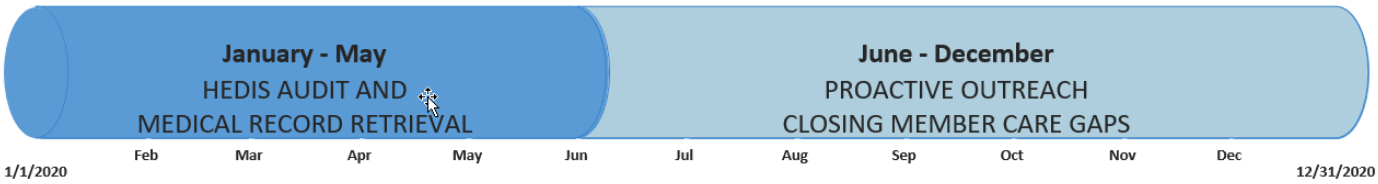
- Claims and encounters
  - HCFA 1500
- Supplemental Data
  - Standard and non-standard data
  - Fax
  - Secure email
  - EMR

2 EMR Access

How EMR Access Works and Benefits

EMR remote access uses a secure connection that allows BSC Promise Health Plan highly trained nurse reviewers access to retrieve medical record documentation remotely for HEDIS hybrid measures. HEDIS is a time-sensitive project with limited opportunity to retrieve medical records and remote EMR access significantly reduces the resources required to fulfill medical record requests. If you are interested in participating in this program, contact Mona Gonzalez (323) 827-6377.

2 HEDIS and Proactive Outreach Timeline



3 Adult BMI Assessment (ABA)

Measure Description

Members that are 18 -74 years of age who had an outpatient visit and whose body mass index (BMI) was documented during the measurement year or the year prior to the measurement year

Documentation

- Members 20 years and older:
  - Date of service
  - Weight and BMI value
  - The weight and BMI value must be from the same data source
- Members younger than 20 years on the date of service:
  - Date of service
  - Height, weight, and BMI percentile
    - For BMI percentile, either of the following meets criteria:
      - BMI percentile documented as a value
      - BMI percentile plotted on an age-growth chart
  - The height, weight, and BMI percentile must be from the same data source

Exclusions

Female members who have a diagnosis of pregnancy during the measurement year or the year prior to the measurement year

ABA Correct Billing Codes

Pediatric

ICD-10:

- < 5th percentile for age: Z68.51
- 5th percentile to < 85th percentile for age: Z68.52
- 85th percentile to < 95th percentile for age: Z68.53
- ≥ 95th percentile for age: Z68.54

Adult:

ICD-10:

- BMI 19 or below: Z68.1
- BMI 20.0 – 20.9: Z68.20
- BMI 21.0 – 21.9: Z68.21
- BMI 22.0 – 22.9: Z68.22
- BMI 23.0 – 23.9: Z68.23
- BMI 24.0 – 24.9: Z68.24
- BMI 25.0 – 25.9: Z68.25
- BMI 26.0 – 26.9: Z68.26
- BMI 27.0 – 27.9: Z68.27
- BMI 28.0 – 28.9: Z68.28
- BMI 29.0 – 29.9: Z68.29
- BMI 30.0 – 30.9: Z68.30
- BMI 31.0 – 31.9: Z68.31
- BMI 32.0 – 32.9: Z68.32
- BMI 33.0 – 33.9: Z68.33
- BMI 34.0 – 34.9: Z68.34
- BMI 35.0 – 35.9: Z68.35
- BMI 36.0 – 36.9: Z68.36
- BMI 37.0 – 37.9: Z68.37
- BMI 38.0 – 38.9: Z68.38
- BMI 39.0 – 39.9: Z 68.39
- BMI 40.0 – 44.9: Z68.41
- BMI 45.0 – 49.9: Z68.42
- BMI 50.0 – 59.9: Z68.43
- BMI 60.0 – 69.9: Z68.44
- BMI 70.0 & above: Z68.45

4 Follow-up Care for Children Prescribed ADHD Medication (ADD)

Measure Description

Children age 6-12 years of age with newly prescribed attention-deficit/hyperactivity disorder (ADHD) medicine and had at least three follow-up care visits within a 10-month period. One visit must be within the first 30 days the ADHD medication was dispensed

- Initiation Phase: Members 6-12 years of age with an ambulatory prescription dispenses for ADHD medication, who had one follow-up visit with a practitioner with prescribing authority during the 30-day initiation Phase
- Continuation and Maintenance Phase: Members 6-12 years of age with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phases ended

Guidelines

- Do not provide a refill of prescription until the initial follow-up visit has been completed complete
- Schedule follow-up visit 2-3 weeks after member starts medication therapy
- Additional visits must be scheduled within 9 months of prescribing medication at the time of the initial follow-up visit
- Reschedule cancelled appointments as soon as possible

Exclusions

Members are excluded if they had an acute inpatient encounter for a mental, behavioral or neurodevelopmental disorder during the 30 days after the earliest prescription dispensed date.

ADHD Medications	
Amphetamine-dextroamphetamine	Dexmethylphenidate
Dextroamphetamine	Lisdexamfetamine
Methamphetamine	Clonidine
Methylphenidate	Guanfacine
Auomoxetine	

ADD Correct Billing Codes:

Initiation Phase

CPT: 98960-98962, 99078, 99201-99205, 9911-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387

HCPCS: G0155, G0176, G0177, G0409, G0463, H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2010-H2011, H2013,-H2020, M0064, T1015

CPT (Observation): 99217-99220

Intensive OP Encounter/Hospital:

CPT: 90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221-99223, 99231-00233, 99238, 99239, 99251-99255

HCPCS: G040-0411, H0035, H2001, H2012, S0201, S9480, S484-9485

Follow-up Telephone Visit

CPT: 98966-98968, 99441-99443 (modifier 95, GT

Diagnosis of Narcolepsy Exclusion

ICD10: G47.411, G47.419, G47.429

5 Ambulatory Care: Emergency Department (ED) Visits (AMB)

Measure Description

Members (all ages) who utilized ambulatory care in an outpatient visit that includes telehealth or ED visit during the measurement year

- Outpatient Visits – Members who had outpatient care on an ambulatory basis including telehealth.
- ED Visits – Members who had ambulatory care services in the emergency department

Exclusions

- Do not include mental health or chemical dependency visits
- Non-acute inpatient stays
- Electroconvulsive therapy

6 Antidepressant Medication Management (AMM)

Measure Description

Members 18 years and older who were treated with antidepressant medication and had a diagnosis of major depression and who remained on an antidepressant medication treatment. Two rates are reported:

- Acute phase members remained on an antidepressant medication for at least 84 days (12 weeks).
- Continuation phase members remained on an antidepressant medication for at least 180 days (6 months).

Guidelines

- Talk to members about depression and a treatment plan and stopping the medication after the medication is started
- Ensure the member understands how long it may take before medications take effect and stress the importance of continuing the medication
- Schedule a follow-up visit before the member leaves the office and discuss the importance of the follow-up visit

AMM Correct Billing Codes

ICD10: F32.0-F32.4, F32.9, F33.0-F33.3, F33.41, F33.9

7 Asthma Medication Ratio (AMR)

Measure Description

Member 5-64 years of age who were identified as with persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater

Members with a principal diagnosis of asthma who had one prescription of an amount lasting 30 days or less

Guidelines

- Work with members to educate develop treatment goals
- Simplify treatment regimen where possible
- Discuss access to inhalers with members
- Offer education and assistance with inhalers when first prescribed
- Educate members on potential side effects of controller medications and managing side effects

Exclusions

- Members who had mental health or chemical dependency visits, non-acute patient during the measurement year
- Non-acute inpatient stays
- Emphysema, bronchitis, chronic respiratory conditions, cystic fibrosis, acute respiratory failure, or COPD

AMR Correct Billing Codes

ICD10: 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

8 Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)

Measure Description

Members that are 18 years of age and older who were diagnosed with rheumatoid arthritis and who were dispensed at least one ambulatory prescription for a disease-modifying anti-rheumatic drug during the measurement year

Documentation

Two of the following with *different dates of service* on or between January 1 and November 30 of the measurement year – visit *type* does not need to be the same for the two visits

- Outpatient visit with any diagnosis of rheumatoid arthritis
- Non-acute inpatient discharge, with any diagnosis of rheumatoid arthritis. To identify non-acute inpatient discharges:
  - Identify all acute and non-acute inpatient stays
  - Confirm the stay was for non-acute inpatient stays
  - Identify the discharge date for the stay

Exclusions

- Diagnosis of HIV any time during the member's history through December 31 of the measurement year
- Diagnosis of pregnancy any time during the measurement year
- Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following:
  - Enrolled in an Institutional SNP (I-SNP) any time during the measurement year
  - Living long-term in an institution any time during the measurement year
- Members 66 years of age and older as of December 31 of the measurement year with frailty and advance illness during the measurement year. To identify members with advance illness, any of the following during the measurement year or the year prior to the measurement year meet criteria:

- At least two outpatient visits, observation visits, ED visits, or non-acute inpatient encounters on *different dates of service*, with an advance illness diagnosis
- At least one acute inpatient encounter with an advance illness diagnosis
- A dispense dementia medication

Dementia Medications

Description	Prescription
Cholinesterase inhibitors	• Donepezil • Galantamine • Rivastigmine
Miscellaneous central nervous system agents	• Memantine

9 Adolescent Well-Care Visits (AWC)

Measure Description

Members that are 12 -21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year

Documentation

A well care visit must include on the medical record indicating that it is a well-child visit with ***all*** the following:

- Health history
  - Personal medical or surgical history
  - Social History
  - Family History
  - Medications, history of allergies, immunization history (All 3 must be combined, missing one is not valid)
  - Statement of no problems under history or no new problems from last visit is acceptable
- Physical developmental history
  - Documentation of physical developmental milestones appropriate for age
  - Developing appropriately for age, normal growth and development
  - Rides bike, can throw ball, runs and plays in playground at school, etc.
  - Tanner Stage
- Mental developmental history
  - Documentation of mental milestones appropriate for age
  - School performance
  - Verbalizes well and understands instructions
  - Competent with fork and spoon
  - Responds appropriately to commands
- Complete physical exam
- Health Education/Anticipatory Guidance
  - Physical and oral health, healthy eating, physical activity
  - Safety belt
  - Wears bicycle helmet
  - Nutrition
  - Anticipatory Guidance handouts given with evidence of discussion Anticipatory Guidance given with evidence of discussion
  - Anticipatory Guidance, with evidence of parental counseling on Anticipatory Guidance
  - Counseling/education factors reviewed

AWC Correct Billing Codes

- CPT: 99381 – 99385, 99391 – 99395, 99461
- ICD-10: Z00.00, Z00.01, Z00.110 – Z00.121, Z00.129, Z00.5, Z00.8, Z02.0 – Z02.6, Z02.71, Z02.79, Z02.81, Z02.89, Z02.9, Z76.1, Z76.2
- GCodes/HCPCS: G0438, G0439

10 Breast Cancer Screening (BCS)

Measure Description

Woman who are 50 – 74 years of age that had a mammogram to screen for breast cancer during the measurement year or the year prior to the measurement year

Exclusions

- Bilateral mastectomy or history of bilateral mastectomy
- Two unilateral mastectomies with service dates 14 days or more apart
- Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following:
    - Enrolled in an Institutional SNP (I-SNP) any time during the measurement year
    - Living long-term in an institution any time during the measurement year
- Members 66 years of age and older as of December 31 of the measurement year with frailty and advance illness during the measurement year. To identify members with advance illness, any of the following during the measurement year or the year prior to the measurement year meet criteria:
    - At least two outpatient visits, observation visits, ED visits, or non-acute inpatient encounters on *different dates of service*, with an advance illness diagnosis
    - At least one acute inpatient encounter with an advance illness diagnosis
    - A dispense dementia medication

Dementia Medications

Description	Prescription
Cholinesterase inhibitors	• Donepezil • Galantamine • Rivastigmine
Miscellaneous central nervous system agents	• Memantine

BCS Correct Billing Codes

Mammography:

- CPT: 77055 – 77057, 77061 – 77063, 77065 – 77067
- HCPCS: G0202, G0204, G0206
- UBREV: 0401, 0403

Unilateral Mastectomy:

- CPT: 19180, 19200, 19220, 19240, 19303 – 19307

Absence of Left Breast:

- ICD-10: Z90.12

Absence of Right Breast:

- ICD-10: Z90.11

Bilateral Modifier:

- CPT: 09950, 50

History of Bilateral Mastectomy:

- ICD-10: Z90.13

11 Children & Adolescents' Access to Primary Care Practitioners (CAP)

Measure Description

Members who are 12-24 months and 25 months-6 years who visited a PCP during the measurement year. Members who are 7-11 years and adolescents 12-19 years who visited a PCP during the measurement year or the year prior to the measurement year.

Guidelines

- Members must have a complete physical exam, including but not limited to height, weight, BMI percentile, vital signs, history and physical, review of systems, age-appropriate screening test, immunizations administered, all specific topics for anticipatory guidance provided.
- Include the date when a health and development history and physical exam was performed, and health education/anticipatory guidance was given in the medical records.
- Use standardized templates in charts and in EMRs that allow checkboxes for standard counseling activities

CAP Correct Billing Codes

CPT: 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411-99412, 99429
HCPSC: G0438, G0439, T1015
ICD10: 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411-99412, 99429

12 Controlling High Blood Pressure (CBP)

Measure Description

Members who are 18 -85 years of age that had a diagnosis of hypertension (HTN) and whose Blood Pressure (BP) was adequately controlled (<140/90 mm Hg)

Documentation

Members who had at least two visits on different dates of service with a diagnosis of hypertension during the measurement year or the year prior to the measurement year. Only one of the two visits may be a telephone visit, an online assessment or a telehealth visit. Any of the following combinations meet criteria:

- Outpatient visit with or without a telehealth modifier, with any diagnosis of hypertension
- A telephone visit with any diagnosis of hypertension
- An online assessment with any diagnosis of hypertension

Identify the most recent BP reading noted during the measurement year. The BP reading must occur on or after the date when the second diagnosis of hypertension occurred.

- BP readings from remote monitoring devices that are digitally stored and transmitted to the provider may be included. There must be documentation in the medical record hat clearly states the reading was taken by an electronic device, and results were digitally stored and transmitted to the provider.
- Do not include BP readings:
    - Taken during an acute inpatient stay or an ED visit
    - Taken on the same day as a diagnostic test or diagnostic/therapeutic procedure that requires a change in diet or change in medication on or one day before the day of the test or procedure, with the exception of fasting blood tests
    - Reported by or taken by the member

Exclusions

- Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following:
    - Enrolled in an Institutional SNP (I-SNP) any time during the measurement year
    - Living long-term in an institution any time during the measurement year
- Members 66 years of age and older as of December 31 of the measurement year with frailty and advance illness during the measurement year. To identify members with advance illness, any of the following during the measurement year or the year prior to the measurement year meet criteria:
    - At least two outpatient visits, observation visits, ED visits, or non-acute inpatient encounters on *different dates of service*, with an advance illness diagnosis
    - At least one acute inpatient encounter with an advance illness diagnosis
    - A dispense dementia medication

Dementia Medications

Description	Prescription
Cholinesterase inhibitors	• Donepezil • Galantamine • Rivastigmine
Miscellaneous central nervous system agents	• Memantine

CBP Correct Billing Code

- ICD-10: I10

Systolic <130 mm Hg:

- CPT:3074F

Systolic 130-139 mm Hg:

- CPT: 3075F

Systolic >140 mm Hg:

- CPT: 3077F

Diastolic pressure <80 mm Hg:

- CPT: 3078F

Diastolic Pressure 80-89 mm Hg:

- CPT: 3079F

Diastolic Pressure >90 mm Hg:

- CPT: 3080F

13 Cervical Cancer Screening (CCS)

Measure Description

Women 21 – 64 years of age who were screened for cervical cancer using either of the following criteria:

- Women 21 – 64 years of age who had cervical cytology performed within the last 3 years
- Women 30 – 64 years of age who had cervical cytology and high-risk human papillomavirus (HPV) co-testing performed within the last 5 years
- Women 30-64 years of age who had cervical cytology and high-risk human papillomavirus (hrHPV) co-testing within the last 5 years.

Documentation

Women 24 – 64 years of age, as of December 31 of the measurement year or two years prior to the measurement year, must have documentation in the medical record, or lab results:

- Date of service of when the cervical cytology was performed
- Result, or finding

Women 30 – 64 years of age, as of December 31 of the measurement year or two years prior to the measurement year, must have documentation in the medical record, or lab results:

- Date of service of when the cervical cytology and the HPV test were performed
    - Cervical cytology and HPV test must be from the same data source and same date of service
- Results, or finding

Exclusions

- Evidence of a hysterectomy with no residual cervix
    - Documentation must be: "complete", "total", "radical" abdominal or vaginal hysterectomy
    - Documentation of hysterectomy in combination with documentation that the Member no longer needs pap testing/cervical cancer screening
    - Documentation of hysterectomy alone does not meet the criteria because it is not sufficient evidence that the cervix was removed
    - A dated note with generic documentation of HPV test with results can be counted as evidence of HPV test

NOTE:

"no cervical cells were present" is not considered appropriate screening, **however** "no endocervical cells" may be used if a valid result was reported for the test

*Always check under: ADEQUACY OF SPECIMEN for SATISFACTORY FOR EVALUATION

CCS Correct Billing Codes

- CPT: 88141 – 88143, 88147, 88148, 88150, 88152 – 88154, 88164 – 88167, 88174, 88175

- GCodes/HCPCS: G0123, G0124, G0141, G0143 – G0145, G0147, G0148, P3000, P3001, Q0091
- LOINC: 10524-7, 10527-7, 18500-9, 19762-4, 19764-0, 19765-7, 19766-5, 19774-9, 33717-0, 47527-7, 47528-5

- UBREV: 0923

14 Comprehensive Diabetes Care (CDC)

Measure Description

Members that are 18 – 75 years of age with diabetes who had each of the following in the measurement year:

- Hemoglobin A1c (HbA1c) testing
  - HbA1c poor control (> 9.0%)
  - HbA1c control (< 8.0%)
  - HbA1c control (< 7.0%) for a selected population
- Retinal eye exam performed
- Medical attention for nephropathy
- BP control (< 140/90 mm Hg)

Documentation

CDC – A1c

- Documentation in medical record, or lab result, must include a note indicating the date when the HbA1c test was performed and result or finding during the measurement year:
  - A1c
  - HbA1c
  - HgbA1c
  - Hemoglobin A1c
  - Glycohemoglobin A1c
  - Glycohemoglobin
  - Glycated hemoglobin
  - Glycosylated hemoglobin

CDC – Eye Exam

- A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year
- A negative retinal or dilated eye exam (negative for retinopathy) by an eye care professional in the year prior to the measurement year
- Bilateral eye enucleation anytime during the member's history through December 31 of the measurement year

CDC – Nephropathy

- Any of the following meet the criteria for a urine test in measurement year:
  - Urine Microalbumin
  - Urine for albumin/creatinine ratio
  - 24-hour urine for total protein
- Evidence of ACE inhibitor/ARB therapy prescribed in measurement year or any of the following meet the criteria
  - Documentation of a visit to a nephrologist
  - Documentation of a renal transplant
  - Documentation of medical attention for any of the following (No restriction on provider type)
    - Diabetic nephropathy
    - ESRD
    - Chronic renal failure (CRF)
    - Chronic kidney disease (CKD)
    - Renal insufficiency
    - Proteinuria
    - Albuminuria
    - Renal dysfunction

- Acute Renal failure (ARF)
- Dialysis, hemodialysis or peritoneal dialysis

CDC – Blood Pressure

- Most recent BP reading noted during the measurement year
- Do not include BP readings that meet the following criteria
  - Taken during an acute inpatient stay or on ED visit
  - Taken on the same day as a diagnostic test or diagnostic or therapeutic procedure that requires a change in diet or change in medication on or one day before the day of the test or procedure, with the exception of fasting blood tests.
  - Reported by or taken by the member.

Exclusions

- Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following:
  - Enrolled in an Institutional SNP (I-SNP) any time during the measurement year
  - Living long-term in an institution any time during the measurement year
- Members 66 years of age and older as of December 31 of the measurement year with frailty and advance illness during the measurement year. To identify members with advance illness, any of the following during the measurement year or the year prior to the measurement year meet criteria:
  - At least two outpatient visits, observation visits, ED visits, or non-acute inpatient encounters on *different dates of service*, with an advance illness diagnosis
  - At least one acute inpatient encounter with an advance illness diagnosis
  - A dispense dementia medication

Dementia Medications

Description	Prescription
Cholinesterase inhibitors	• Donepezil • Galantamine • Rivastigmine
Miscellaneous central nervous system agents	• Memantine

CDC Correct Billing Codes

HbA1c Tests/Control (CPT/CPT II):

- HbA1c < 7%
  - CPT II: 3044F
- HbA1c 7.0%-9.0%
  - CPT II: 3045F
- HbA1c > 9%
  - CPT II: 3046F
- HbA1c Tests
  - CPT: 83036, 83037
  - CPT II: 3044F, 3045F, 3046F
  - LOINC: 17856-6, 4548-4, 4549-2

Eye Exam:

- Performed by optometrist or ophthalmologist
  - CPT: 67028, 67030, 67031, 67036, 67039-67043, 67101, 67105, 67107, 67108, 67110, 67112, 67113, 67121, 67141, 67145, 67208, 67210, 67218, 67220, 67221, 67227, 67228, 92002, 92004, 92012, 92014, 92018, 92019, 92134, 92225-92228, 92230, 92235, 92240, 92250, 92260, 99203-99205, 99213-99215,99242-99245
  - HCPCS: S0620, S0621, S3000
- Diabetic Retinal Screening Negative
  - CPT II: 3072F

Blood Pressure:

- Diastolic < 80 mm Hg
  - CPT II: 3078F
- Diastolic 80 – 89 mm Hg
  - CPT II: 3079F
- Diastolic ≥ 90 mm Hg
  - CPT II: 3080F
- Systolic < 140 mm Hg
  - CPT II: 3074F, 3075F
- Systolic ≥ 140 mm Hg
  - CPT II: 3077F

Nephropathy Test:

- Nephropathy Screening (Urine Protein Tests)
  - CPT: 81000-81003, 81005, 82042, 82043, 82044,84156
  - CPT II: 3060F, 3061F, 3062F
  - LOINC: 11218-5, 12842-1, 13705-9, 13801-6, 14956-7, 14957-5, 14958-3, 14959-1, 1753-3, 1754-1, 1755-8, 1757-4, 18373-1, 20454-5, 20621-9, 21059-1, 21482-5, 26801-1, 27298-9, 2887-8, 2888-6, 2889-4, 2890-2, 30000-4, 30001-2, 30003-8, 32209-9, 32294-1, 32551-4, 34366-5, 35663-4, 40486-3, 40662-9, 40663-7, 43605-5, 43606-3, 43607-1, 44292-1, 47558-2, 49023-5, 50561-0, 50949-7, 53121-0, 53525-2, 53530-2, 53531-0, 53532-8, 56553-1, 57369-1, 57735-3, 5804-0, 58448-2, 58992-9, 59159-4, 60678-0, 63474-1, 76401-9, 77253-3, 77254-1, 9318-7, 13986-5, 13992-3, 17819-4, 29946-1, 49002-9, 50209-6, 51190-7, 6941-9, 6942-7, 77940-5
- Nephropathy Treatment
  - CPT II: 3066F, 4010F
  - ICD-10: 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 – N00.9, N01.0 – N01.9, N02.0 – N02.9, N03.0 – N03.9, N04.0 – N04.9, N05.0 – N05.9, N06.0 – N06.9, N07.0 – N07.9, N08, N14.0 – N14.4, N17.0 – N17.2, N17.8, N17.9, N18.1 – N18.9, N19.0, 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 – Q61.9, R80.0 – R80.9

15 Chlamydia Screening in Women (CHL)

Measure Description

Women who are 16-24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year. Members are identified as being sexually active by a pregnancy test or diagnosis, sexually active, or contraceptive prescriptions being captured in claims

Guidelines

Sexual history may be captured in history and physical

Screen all sexually active women for chlamydia

Provide STD education on abstinence and for sexually active members, includes education on signs, symptoms, and treatment

Exclusions

Women who had a pregnancy test during the measurement year or who were prescribed retinoid medications on the date of the pregnancy test or six days after the pregnancy test

CHL Correct Billing Codes

CPT: 87110, 87270, 87320, 87490, 87491, 87492, 87810 (Pregnancy Test Exclusion), 81025, 84702, 84703

16 Childhood Immunization Status (CIS)

Measure Description

Children who had the following vaccines on or before their second birthday:

- 4 DTaP (diphtheria, tetanus and acellular pertussis)
- 4 PCV (pneumococcal conjugate)
- 3 Hep B (hepatitis B)
- 3 HiB (haemophilus influenza type B)
- 3 IPV (polio)
- 1 MMR (measles, mumps, rubella)
- 1 VZV (chicken pox)
- 1 Hep A (hepatitis A)
- 2/3 RV (rotavirus)
- 2 flu (influenza)

Documentation

For immunization evidence obtained from the medical record:

- Note indicated name of specific antigen and date of immunization
- Certificate of immunization prepared by authorized health care provider or agency including the specific dates and types of immunizations administered
- Note indicating member received Hep B "at delivery" or "in the hospital" meets criteria

CIS Correct Billing Codes

DTaP

- CPT: 90698, 90700, 90721, 90723

IPV

- CPT: 90698, 90713, 90723

MMR

- CPT: 90707,90710

HiB

- CPT: 90644-90648, 90698, 90721, 90748
- CVX: 17, 46 – 51, 120, 148

Hep B (newborn):

- ICD-10: 3E0234Z

Hep B

- CPT: 90723, 90740, 90744, 90747, 90748
- HCPCS: G0010

PCV

- CPT:, 90670, 90732

VZV

- CPT: 90710, 90716

Hep A

- CPT: 90633

Flu

- CPT: 90655, 90657, 90661, 90662, 90673, 90685, 90686, 90687, 90688
- HCPCS: G0008

RV (2 dose schedule)

- CPT: 90681

RV (3 dose schedule)

- CPT: 90680

LAIV

- CPT: 60660, 60672

17 Care of Older Adults (COA)

Measure Description

Members that are 66 years and older who had the following during the measurement year:

- Advance care planning
- Medication review
- Functional status assessment
- Pain assessment

Documentation

Advance care planning

- Presence of an advance care plan in the medical record
- Documentation of an advance care planning discussion with the provider and the date it was discussed. It must be noted during the measurement year
- Notation that the member previously executed an advance care plan
    - Living will
    - Surrogate decision maker/ advance directive
    - Actionable medical orders
    - POLST/MOLST

Medication review

- Medication list and at least one medication review conducted by a prescribing practitioner or clinical pharmacist during the measurement year

Functional status assessment

- At least one functional status assessment completed during the measurement year
- Notation that Activities of Daily Living (ADL) were assessed or at least five of the following were assessed:
    - Bathing
    - Dressing
    - Eating
    - Transferring (getting in and out of chairs)
    - Walking
    - Continence
- Notation that Instrumental Activities of Daily Living (IADL) were assessed or at least four of the following were assessed:
    - Shopping for groceries
    - Driving or using public transportation
    - Using the telephone
    - Meal preparation
    - Housework
    - Home repair
    - Laundry
    - Taking medications
    - Handling finances

Pain Assessment

- At least one pain assessment during the measurement year

COA Correct Billing Codes

Advance care planning:

- CPT: 99483, 99497
- CPT II: 1123F, 1124F, 1157F, 1158F
- GCodes/HCPCS: S0257

Medication review:

- CPT: 90863, 99605, 99606
- CPT II: 1159F, 1160F
- GCodes/HCPCS: G8427

Functional status assessment:

- CPT: 99483
- CPT II: 1170F

Pain assessment:

- CPT II: 1125F, 1126F

18 Colorectal Cancer Screening (COL)

Measure Description

Members that are 50 – 75 years of age who had appropriate screening for colorectal cancer

Documentation

Medical record must include a note indicating the date when the colorectal cancer screening was performed

- A result is not required if the documentation is clearly part of the medical history
- Fecal occult blood test (FOBT/iFOBT) completed during the measurement year
- Flexible sigmoidoscopy completed during the measurement year or four years prior to the measurement year
- Colonoscopy completed during the measurement year or nine years prior to the measurement year
    - Abbreviations are not acceptable i.e., Colo 2014, Col 2014 etc…need to write out Colonoscopy and the date rendered.
- CT colonography during the measurement year or four years prior to the measurement year
- FIT-DNA test during the measurement year or two years prior to the measurement year
- Abbreviations are not acceptable i.e., Colo 2014, Col 2014 etc. Must write out Colonoscopy and the date rendered

Exclusions

Exclude members who meet any of the following criteria:

- Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following:
    - Enrolled in an Institutional SNP (I-SNP) any time during the measurement year
    - Living long-term in an institution any time during the measurement year
- Members 66 years of age and older as of December 31 of the measurement year with frailty and advanced illness during the measurement year. To identify members with advanced illness, any of the following during the measurement year of the year prior to the measurement year meet criteria:
    - At least two outpatient visits, observation visits, ED visits, or non-acute inpatient encounters on *different dates* of service, with an advanced illness diagnosis
    - At least one acute inpatient encounter with an advanced illness diagnosis
    - A dispensed dementia medication

Dementia Medications

Description	Prescription
Cholinesterase inhibitors	• Donepezil • Galantamine • Rivastigmine
Miscellaneous central nervous system agents	• Memantine

Either of the following any time during the member's history through December 31 of the measurement year:

- Colorectal cancer
- Total colectomy

COL Correct Billing Codes

FOBT:

- CPT: 82270, 82274
- GCodes/HCPCS: G0328

Flexible Sigmoidoscopy:

- CPT: 45330-45335, 45337-45342, 45345-45347, 45349, 45350
- GCodes/HCPCS: G0104

Colonoscopy:

- CPT: 44388-44394, 44397, 44401-44408, 45355, 45378-45393, 45398
- GCodes/HCPCS: G0105, G0121

FIT-DNA:

- CPT: 81528
- HCPCS: G0464

CT Colonography:

- CPT: 74261 – 74263

Exclusions

Colorectal Cancer:

- GCodes/HCPCS: G0213-G0215, G0231
- ICD-10: C18.0-C18.9, C19, C20, C21.2, C21.8, C78.5, Z85.038, Z85.048

Total Colectomy:

- CPT: 44150-44153, 44155-44158, 44210-44212
- ICD-10: 0DTE0ZZ, 0DTE4ZZ, 0DTE7ZZ, 0DTE8ZZ

19 Immunizations for Adolescents (IMA)

Measure Description

Adolescents 13 years of age who had the following vaccines:

- 1 Tdap (tetanus, diphtheria toxoids and acellular pertussis)
- 2 or 3 HPV (human papillomavirus)
- 1 meningococcal (MCV4)

Documentation

For immunization evidence obtained from the medical record:

- Note indicated name of specific antigen and date of immunization
- Certificate of immunization prepared by authorized health care provider or agency including the specific dates and types of immunizations administered

The immunization must be completed within each age range:

- Tdap: on or between the member's 10th and 13th birthday
- HPV: on or between the member's 9th and 13th birthday
- MCV4: on or between the member's 11th and 13th birthday

IMA Correct Billing Codes

Tdap:

- CPT: 90715

HPV:

- CPT: 90649 – 90651

Meningococcal:

- CPT: 90734

20 Lead Screening in Children (LSC)

Measure Description

Children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday

Documentation

Medical record must include both of the following:

- A note indicating the date the test was performed
- The result or finding

LSC Correct Billing Codes

- CPT: 83655

22 Medication Reconciliation Post-Discharge (MRP)

Measure Description

Members 18 years of age (as of December 31) and older for whom medications were reconciled the date of discharge through 30 days after discharge from January 1 – December 1 of the measurement year

Documentation

- Must include evidence of medication reconciliation and the date when it was performed
    - Documentation of current medications with a notation that the provider reconciled the current and discharge medications
    - Notation of hospital follow-up with date of discharge
    - Documentation of current medications and progress notes that indicate the member was seen for post-discharge hospital follow-up with evidence of medication reconciliation or review documentation.
    - Evidence requires documentation that provider was aware of the members hospitalization or discharge.
    - Documentation of the current medication list with notation that discharge medications were reviewed OR documentation of current medication list, discharge medication list and notation that both lists were reviewed on the same date of service.
    - Documentation in the discharge summary that medications were reconciled with the most recent medication list. Discharge summary must be from the outpatient chart within 30 days of date of discharge.

MRP Correct Billing Codes

- CPT: 99483,99495, 99496F
- CPT II: 1111F

23 Osteoporosis Management in Women Who Had a Fracture (OMW)

Measure Description

Women 67 – 85 years of age who suffered a fracture and who had either a bone mineral density (BMD) test or prescription for a drug to treat osteoporosis in the six months after the fracture

Exclusions

- Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following:
  - Enrolled in an Institutional SNP (I-SNP) any time during the measurement year
  - Living long-term in an institution any time during the measurement year
- Members 66 years of age and older as of December 31 of the measurement year with frailty and advance illness during the measurement year. To identify members with advance illness, any of the following during the measurement year or the year prior to the measurement year meet criteria:
  - At least two outpatient visits, observation visits, ED visits, or non-acute inpatient encounters on *different dates of service*, with an advance illness diagnosis
  - At least one acute inpatient encounter with an advance illness diagnosis
  - A dispense dementia medication

Dementia Medications

Description	Prescription
Cholinesterase inhibitors	• Donepezil • Galantamine • Rivastigmine
Miscellaneous central nervous system agents	• Memantine

OMW Correct Billing Codes

Bone Mineral Test:

- CPT: 76977, 77078, 77080-77082, 77085, 77086
- ICD-10: BP48ZZ1, BP49ZZ1, BP4GZZ1, BP4HZZ1, BP4LZZ1, BP4MZZ1, BP4NZZ1, BP4PZZ1, BQ00ZZ1, BQ01ZZ1, BQ03ZZ1, BQ04ZZ1, BR00ZZ1, BR07ZZ1, BR09ZZ1, BR0GZZ1
- HCPCS: G0130

Osteoporosis Medications

- HCPCS: J0630, J0897, J1740, J3110, J3489,

Long-Acting Osteoporosis Medication:

- HCPCS: J0897, J1740, , J3489,

24 Plan All-Cause Readmissions (PCR)

Measure Description

The number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days for members 18 years of age or older.

Guidelines

Schedule discharge follow-up appointment within one week of discharge and during the follow-up appointment discuss the following:

- Ask the member to bring all medications to follow-up appointment
- Barriers that may have contributed to hospitalization and discuss strategies to prevent additional hospitalizations
- Assess whether prescribed outpatient work-ups or other services are scheduled (physical therapy, home health visits, durable medical equipment)
- Follow-up with members to ensure new prescriptions post-discharge are filled

Exclusions

- Acute hospitalizations for pregnant females or diagnosis/condition originating in the prenatal period
- Members in hospice during the measurement year
- Planned procedures or admissions for chemotherapy, rehabilitation, or transplant

25 Prenatal and Postpartum Care (PPC)

Measure Description

Deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year with assessments of prenatal and postpartum care

Documentation

Prenatal Care

- Must be seen during the first trimester, on or before the enrollment start date, or within 42 days of enrollment
- Must include a note indicating the date when the prenatal care visit occurred and evidence of one of the following:
    - A diagnosis of pregnancy
    - Basic physical obstetrical examination that includes auscultation for fetal heart tone, pelvic exam with obstetric observations, or measurement of fundus height
    - Evidence that a prenatal care procedure was performed, such as:
        - Screening test in the form of an obstetric panel (must include all of the following: hematocrit, differential WBC count, platelet count, hepatitis B surface antigen, rubella antibody, syphilis test, RBC antibody screen, Rh and ABO blood typing)
        - TORCH antibody panel alone
        - A rubella antibody test/titer with and Rh incompatibility (ABO/Rh) blood typing
        - Echography of a pregnant uterus
    - Documentation of LMP or EDD in conjunction with either of the following:
        - Prenatal risk assessment and counseling/education
        - Complete obstetrical history

Postpartum Care

- Postpartum visit to an OB/GN practitioner or midwife, family practitioner or other PCP on or between 7 and 84 days after delivery
- Must include a note indicating the date when a postpartum visit occurred and one of the following:
    - Pelvic exam
    - Evaluation of weight, BP, breasts and abdomen:
        - Notation of "breastfeeding" is acceptable for the "evaluation of breasts" component
        - Notation of "abdominal wound healing" is acceptable for abdominal assessment
    - Notation of postpartum care including but not limited to:
        - PP care, PP check, 6-week check
        - Preprinted "Postpartum Care" form in which information was documented during the visit
        - Perineal or cesarean incision/would check
        - Screening for depression, anxiety, tobacco use, substance use disorder, or preexisting mental health disorders
        - Glucose screening for women with diabetes
        - Documentation of any of the following topics:
        - Infant care or breastfeeding
        - Resumption of intercourse, birth spacing or family planning
        - Sleep/fatigue
        - Resumption of physical activity and attainment of health weight

Correct Billing Codes

Prenatal Care Visit:

- CPT: 99201-99205, 99211-99215, 99241-99245, 99483, 99500
- CPT II: 0500F, 0501F, 0502F
- GCodes/HCPCS: H1000-H1004, T1015, G0463

Obstetric Panel:

- CPT: 80055, 80081

Prenatal Ultrasound:

- CPT: 76801, 76805, 76811, 76813, 76815-76821, 76825-76828

ABO:

- CPT: 86900

Rh:

- CPT: 86901

TORCH (Toxoplasma):

- CPT: 86777, 86778

Rubella:

- CPT: 86762

Cytomegalovirus:

- CPT: 86644

Herpes Simplex:

- CPT: 86694, 86695, 86696

Ultrasound:

- ICD 10: BY49ZZZ, BY4BZZZ, BY4CZZZ, BY4DZZZ, BY4FZZZ, BY4GZ

Pregnancy Diagnosis:

- ICD 10: O09-O13, O28-O35, O40-O47, O98

Postpartum Visit:

- CPT: 57170, 58300, 59430, 99501
- CPT II: 0503F
- ICD-10: Z01.411, Z01.419, Z30.430, Z39.1, Z39.2
- HCPCS: G0101

26 Transitions of Care (TRC)

Measure Description

Members 18 years of age and older who had each of the following:

- Notification of inpatient admission
- Receipt of discharge information
- Member engagement after inpatient discharge
- Medication reconciliation post-discharge

Documentation

Notification of inpatient admission

- Documentation of receipt of notification of inpatient admission on the day of admission or the following day with a date/time stamp of facility to PCP

Receipt of Discharge Information

- Documentation of receipt of discharge information on the day of discharge or the following day
- Must include a discharge summary or summary of care record
    - The practitioner responsible for the member's care during the inpatient stay
    - Procedures or treatment provided
    - Diagnoses at discharge
    - Current medication list (including allergies)
    - Testing results, documentation of pending tests, or no tests pending
    - Instructions for Member care

Member Engagement After Inpatient Discharge

- Documentation of Member engagement (office visits, visits to the home, or telehealth) provided within 30 days of discharge
    - An outpatient visit, including office visits and home visits
    - Synchronous telehealth visits where real-time interaction occurred between the member and provider via telephone or video communication
    - Cannot include Member engagement that occurs on the date of discharge

Medication Reconciliation Post-Discharge

- Outpatient medical record must include evidence of medication reconciliation and the date when it was performed
    - List of current medications with a notation that the provider reconciled the current and discharge medications
- When an ED visit results in an inpatient admission, documentation must include evidence that the PCP or ongoing care provider communicated with the ED about the admission.
    - EMR documentation must include evidence that the information was filed in the EMR and is assessable to the PCP or ongoing care provider on the day of admission or the following day.

TRC Correct Billing Codes

- CPT: 98966 – 98968, 99201 – 99205, 99211 – 99215, 99241 – 99245, 99341 – 99345, 99347 – 99350, 99381 – 99387, 99391 – 99397, 99401 – 99404, 99411, 99412, 99429, 99441 – 99443, 99455, 99456, 99495, 99496
- CPT II: 1111F
- HCPCS: G0402, G0438, G0439, G0463, T1015

27 Well Child Visits in the First 15 Months of Life (W15)

Measure Description

Children who turned 15 months old during the measurement year and have at least 6 well child visits with a PCP during their first 15 months of life

Documentation

A well care visit must include on the medical record indicating that it is a well-child visit with ***all*** the following:

- Health history
  - Personal medical or surgical history
  - Social History
  - Family History
  - Medications, history of allergies, immunization history (All 3 must be combined)
  - Statement of no problems under history or no new problems from last visit is acceptable
- Physical developmental history
  - Documentation of physical developmental milestones appropriate for age,
  - Developing appropriately for age, normal growth and development
  - Can throw ball, runs and plays in playground at school, etc.
  - Tanner Stage
- Mental developmental history
  - Documentation of mental milestones appropriate for age, "
  - Verbalizes well and understands instructions
  - Competent with fork and spoon
  - Responds appropriately to commands
- Complete physical exam
- Health Education/Anticipatory Guidance
  - Physical and oral health, healthy eating, physical activity
  - Safety belt
  - Nutrition
  - Anticipatory Guidance handouts given with evidence of discussion
  - Anticipatory Guidance given with evidence of discussion
  - Anticipatory Guidance with evidence of parental counseling on Anticipatory Guidance
  - Counseling/education factors reviewed

W15 Correct Billing Codes

- CPT II: 99381 – 99385, 99391 – 99395, 99461
- ICD-10: Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.5, Z00.8, Z02.0-Z02.6, Z02.71, Z02.79, Z02.81-Z02.83, Z02.89, Z02.9, Z76.1, Z76.2
- GCodes/HCPCS: G0438, G0439

28 Well Child Visits 3 – 6 Years of Life (W34)

Measure Description

Children that are 3 – 6 years of age who had at least one well child visit with a PCP during the measurement year

Documentation

A well care visit must include on the medical record indicating that it is a well-child visit with ***all*** the following:

- Health history
  - Personal medical or surgical history
  - Social History
  - Family History
  - Medications, history of allergies, immunization history (All 3 must be combined)
  - Statement of no problems under history or no new problems from last visit is acceptable
- Physical developmental history
  - Documentation of physical developmental milestones appropriate for age
  - Developing appropriately for age, normal growth and development
  - Rides bike, can throw ball, runs and plays in playground at school, etc.
  - Tanner Stage
- Mental developmental history
  - Documentation of mental milestones appropriate for age, "
  - School performance
  - Verbalizes well and understands instructions
  - Competent with fork and spoon
  - Responds appropriately to commands
- Complete physical exam
- Health Education/Anticipatory Guidance
  - Physical and oral health, healthy eating, physical activity
  - Safety belt
  - Wears bicycle helmet
  - Nutrition
  - Anticipatory Guidance handouts given with evidence of discussion
  - Anticipatory Guidance given with evidence of discussion
  - Anticipatory Guidance with evidence of parental counseling on Anticipatory Guidance
  - Counseling/education factors reviewed

W34Correct Billing Codes

- CPT II: 99381 – 99385, 99391 – 99395, 99461
- ICD-10: Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.5, Z00.8, Z02.0-Z02.6, Z02.71, Z02.79, Z02.81-Z02.83, Z02.89, Z02.9, Z76.1, Z76.2
- GCodes/HCPCS: G0438, G043921 Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)

Measure Description

Members 3 – 17 years of age who had an outpatient visit with PCP or OB/GYN and who had evidence of the following during the measurement year:

- BMI percentile documentation
- Counseling for nutrition
- Counseling for physical activity

Documentation

BMI Percentile

- BMI percentile documented as a value
- BMI percentile plotted on an age-growth chart
- Documentation must include height and weight and BMI percentile during the measurement year. (can come from different dates of service in m/y)
- Ranges and thresholds do not meet criteria (i.e., >80% or 30-40th percentile)

Counseling for Nutrition

- Documentation of counseling for nutrition or referral for nutrition education during the measurement year
- Discussion of current nutrition behaviors
- Checklist indicating nutrition was addressed
- Member received & discussed educational materials on nutrition during a face-to-face visit
- Anticipatory guidance for nutrition
- Weight or obesity counseling
- Documentation of referral to WIC

Counseling for Physical Activity

- Documentation of counseling for physical activity or referral for physical activity during the measurement year
- Discussion of current physical activity behaviors (exercise routine, participation in sports activities, exam for sports participation)
- Checklist indicating physical activity was addressed
- Member received & discussed educational materials on physical activity during a face-to-face visit
- Anticipatory guidance specific to the child's physical activity
- Weight or obesity counseling

Note:

The following notations **do not** meet criteria:

- Nutrition
    - Notation of "health education" or "anticipatory guidance" without specific mention of nutrition
    - A physical exam finding or observation alone of being well-nourished
    - Documentation related to a member's "appetite"
- Physical Activity
    - Notation of "health education" or "anticipatory guidance" without specific mention of physical activity
    - Notation of "cleared for gym class"
    - Notation of anticipatory guidance related solely to safety (wears helmet or water safety)
    - Notation solely related to screen time

WCC Correct Billing Codes

Counseling for Nutrition:

- CPT: 97802 – 97804
- ICD 10: Z71.3
- GCodes/HCPCS: G0270, G0271, G0447, S9449, S9452, S9470

BMI Percentile:

- ICD-10: Z68.51-Z68.54

Counseling for Physical Activity:

- ICD 10: Z02.5, Z71.82
- GCodes/HCPCS: G0447, S9451