buckeye health plan

HEDIS™ Quick Reference Guide

Updated to reflect NCQA HEDIS 2016 Technical Specifications

Buckeye Health Plan strives to provide quality healthcare to our membership as measured through HEDIS quality metrics. We created the HEDIS Quick Reference Guide to help you increase your practice's HEDIS rates. Please always follow the State and/or CMS billing guidance and ensure the HEDIS codes are covered prior to submission.

What is HEDIS?

HEDIS (Healthcare Effectiveness Data and Information Set) is a set of standardized performance measures developed by the National Committee for Quality Assurance (NCQA) to objectively measure, report, and compare quality across health plans. NCQA develops HEDIS measures through a committee represented by purchasers, consumers, health plans, health care providers, and policy makers.

WHAT ARE THE SCORES USED FOR?

As state and federal governments move toward a quality-driven healthcare industry, HEDIS rates are becoming more important for both health plans and individual providers. State purchasers of healthcare use aggregated HEDIS rates to evaluate health insurance companies' efforts to improve preventive health outreach for members.

Physician-specific scores are also used to measure your practice's preventive care efforts. Your practice's HEDIS score determines your rates for physician incentive programs that pay you an increased premium — for example Pay For Performance or Quality Bonus Funds.

HOW ARE RATES CALCULATED?

HEDIS rates can be calculated in two ways: administrative data or hybrid data. Administrative data consists of claim or encounter data submitted to the health plan. Hybrid data consists of both administrative data and a sample of medical record data. Hybrid data requires review of a random sample of member medical records to abstract data for services rendered but that were not reported to the health plan through claims/encounter data. Accurate and timely claim/encounter data reduces the need for medical record review. If services are not billed or not billed accurately, they are not included in the calculation.

HOW CAN I IMPROVE MY HEDIS SCORES?

- Submit claim/encounter data for each and every service rendered
- Make sure that chart documentation reflects all services billed
- Bill (or report by encounter submission) for all delivered services, regardless of contract status
- Ensure that all claim/encounter data is submitted in an accurate and timely manner
- Consider including CPT II codes to provide additional details and reduce medical record requests

QUESTIONS?

BuckeyeHealthPlan.com

1-866-296-8731

Starting October 1, 2015 ICD-10 diagnosis and procedure codes should be used exclusively over ICD-9 codes.

Providers and other health care staff should document to the highest specificity to aid with the most correct coding choice.

Ancillary staff: Please check the tabular list for the most specific ICD-10 code choice.

For more information, visit **www.ncqa.org**

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ADULT HEALTH

AMBULATORY/PREVENTIVE HEALTH SERVICES

Measure evaluates the percentage of members age 20 years and older who had at least one ambulatory or preventive care visit per year.

Ambulatory Residential/Nursing Facility E&M Visits

CPT	ICD-10	HCPCS
99201-99205, 99211-99215, 99241-99245, 99401-99404, 99411-99412, 99420, 99429, 99304-99310, 99315-99316, 99318, 99324-99328, 99334-99337, 99341-99345, 99347-99350	Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.5-Z02.9, Z00.8	G0402, G0438, G0439, G0463

ALCOHOL AND OTHER DRUG DEPENDENCE TREATMENT

Measure evaluates the percentage of adolescent and adult members with a new episode of alcohol or other drug dependence (AOD) who:

· Initiated dependence treatment within 14 days of their diagnosis

· Continued treatment with 2 or more additional services within 30 days of the initiation visit

For the follow up treatments, include an ICD-10 diagnosis for Alcohol or Other Drug Dependence from the Mental, Behavioral and Neurodevelopmental Disorder Section of ICD-10.

Treatment Codes to Be Used with Diagnosis Codes

CPT	HCPCS
98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99411-99412, 99510	H0007, H0015-H0016, H0020, H0022, H0031, H0034-H0037, H0039-H0040, H2000-H2001, H2010-H2020, H2035-H2036, M0064, S0201, S9480, S9484-S9485, T1006, T1012, H0002, H0004, G0155, G0176, G0177, G0463, G0409, G0411, G0443, T1015

Treatment in Office

Use service codes below with the diagnosis code AND a place of service code:

90791-90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90857, 90862, 90875-90876	03, 05, 07, 09, 11-15, 20, 22, 33, 49, 50, 52-53, 57, 71-72

Treatment in Community Mental Health Center or Psychiatric Facility

Use the service codes below with the diagnosis code and the place of service (POS) code:

CPT	POS
90832, 90834, 90837, 99221-99223, 99231-99233, 99238-99239, 99251-99255	52 and 53

ASTHMA *(Medication Management)*

Measure evaluates the percentage of members age 5–64 who were identified as having persistent asthma and were dispensed appropriate medications which they remained on during the treatment period within the past year.

RATES	APPROPRIATE MEDICATIONS
Medication Compliance 50%: Members who were covered by one asthma control medication at least 50% of the treatment period	Antiasthmatic combinations, Antibody inhibitor, Inhaled steroid combinations, Inhaled corticosteroids, Leukotriene modifiers, Mast cell stabilizers, Methylxanthines
Medication Compliance 75%: Members who were covered by one asthma control medication at least 75% of the treatment period	

BMI ASSESSMENT

This measure demonstrates the percentage of members ages 18 to 74 who had their BMI documented during any outpatient visit in the past two years. Recommendation is for adults to have BMI assessed at least every 2 years.

1) For patients 21 and over: Code the BMI value on the date of service.

2) For patients younger than 21, code the BMI percentile value set on the date of service.

Ranges and thresholds do NOT meet criteria; a distinct BMI value or percentile is required.

ICD-10
ICD-10 BMI Value set Z68.1-Z68.45; **ICD-10 BMI Percentile Value Set** Z68.51-Z85.54

CARE FOR OLDER ADULTS

Measure evaluates four components:

1) At least one functional status assessment per year. Can be a standard assessment tool or notation of either of the following: Activities of Daily Living (ADLs), Instrumental Activities of Daily Living *(IADL), or notation of cognitive status, ambulation status, hearing, vision and speech, and/or other functional independence.

2) Evidence of advance care planning discussion or the presence of a plan

3) At least annually a review of the patient's medications by a prescribing practitioner. Includes the presence of a medication list and review of the medications. Transitional care management services also meet criteria.

4) Pain assessment, either through a standardized pain assessment tool or documentation that pain was assessed.

DESCRIPTION	CPT	CPT CATEGORY II	HCPCS
Advance care planning	—	1157F, 1158F	S0257
Medication review	90863, 99605, 99606	1160F	—
Medication list	—	1159F	G8427
Transitional care management services	99495, 99496	—	—
Functional status assessment	—	1170F	—
Pain assessment	—	1125F, 1126F	—

COLORECTAL CANCER SCREENING

Measure evaluates the percentage of members ages 50-75 who had at least one appropriate screening for Colorectal Cancer in the past year. Appropriate screening is FOBT in 2015, sigmoidoscopy in the last 5 years or colonoscopy in last 10 years. Patients who have a history of colon cancer or who have had a total colectomy are exempt from this measure.

FOBT

CPT	HCPCS
82270, 82274	G0328

Flexible sigmoidoscopy

CPT	HCPCS
45330-45335, 45337-45342, 45345	G0104

Colonoscopy

CPT	HCPCS
44388-44394, 44397, 45355, 45378-45387, 45391, 45392	G0105, G0121

COPD EXACERBATION *(Pharmacotherapy Management)*

Measure evaluates the percentage of COPD exacerbations for members age 40 and older and were dispensed appropriate medications.

Intent is to measure compliance with recommended pharmacotherapy management for those with COPD exacerbations.

RATES	DESCRIPTION
Systemic Corticosteroid: Dispensed prescription for systemic corticosteroid within 14 days after the episode.	Glucocorticoids
Bronchodilator: Dispensed prescription for a bronchodilator within 30 days after the episode date.	Anticholinergic agents, Beta 2-agonists, Methylxanthines

COPD *(Spirometry Testing in the Assessment and Diagnosis)*

Measure evaluates the percentage of members age 40 and older with a new diagnosis of COPD or newly active COPD, who received appropriate spirometry testing to confirm the diagnosis. Spirometry testing should be completed within 6 months of the new diagnosis or exacerbation.

CPT
94010, 94014-94016, 94060, 94070, 94375, 94620

DIABETES CARE *(Comprehensive)*

Measure demonstrates the percentage of members ages 18-75 with diabetes (types 1 & 2) who were compliant in the following submeasures:

HbA1c Test: is completed at least once per year (includes rapid A1c).

CPT	CPT II	HCPCS
83036, 83037	3044F, 3045F, 3046F	—

Eye Exam: a retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) is completed every year OR a negative retinal exam (no evidence of retinopathy) by an eye care professional in the year prior. CPT II code 3072F reflects a dilated retinal exam negative for retinopathy.

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	2022F, 2024F, 2026F, 3072F	S0620, S0621, S0625, S3000

Nephropathy Screening Test: is performed at least once per year. A member who is on ACE/ARBs or has nephropathy is compliant for this submeasure.

82042, 82043, 82044, 84156, 81000, 81001, 81002, 81003, 81005	3060F, 3061F, 3062F	—

MEDICATION RECONCILIATION POST-DISCHARGE

Measure evaluates the percentage of discharges for members age 18 and older for whom medications at discharge were reconciled against the outpatient medical record on or within 30 days of discharge.

CPT	CPT CATEGORY II
99495, 99496	1111F

MONITORING FOR PATIENTS ON PERSISTENT MEDICATIONS *(Annual)*

ACE Inhibitors or ARBs: Members who received at least 180 treatment days of ACE inhibitors or ARBs within the past year should have at least one of the following:

- A lab panel test OR a serum potassium test and a serum creatinine test

Digoxin: Members who received at least 180 treatment days of digoxin within the past year should have at least one of the following:

- A lab panel test and a serum digoxin test OR a serum potassium test and a serum creatinine test and a serum digoxin test

Diuretics: Members who have received at least 180 treatment days of a diuretic within the past year should have at least one therapeutic monitoring event annually.

- A lab panel test OR a serum potassium test and a serum creatinine test

DESCRIPTION	CPT
Lab panel	80047, 80048, 80050, 80053, 80069
Serum potassium (K+)	80051, 84132
Serum creatinine (SCr)	82565, 82575
Digoxin level	80162

PERSISTENCE OF BETA-BLOCKER TREATMENT AFTER A HEART ATTACK

Measure evaluates the percentage of members age 18 and older who were hospitalized and discharged with a diagnosis of AMI and who received persistent beta-blocker treatment for six months after discharge.

DESCRIPTION	PRESCRIPTION
Non-cardioselective beta-blockers	Carvedilol, Labetalol, Nadolol, Penbutolol, Pindolol, Propranolol, Timolol, Sotalol
Cardioselective beta-blockers	Acebutolol, Atenolol, Betaxolol, Bisoprolol, Metoprolol, Nebivolol
Antihypertensive combinations	Atenolol-chlorthalidone, Bendroflumethiazide-nadolol, Bisoprolol-hydrochlorothiazide, Hydrochlorothizide-metoprolol, Hydrochlorothizide-propranolol

WOMEN'S HEALTH

BREAST CANCER SCREENING

Measure evaluates the percentage of women ages 50–74 who had a mammogram at least once in the past two years. Women who have had a bilateral mastectomy are exempt from this measure.

CPT	HCPCS
77055-77057	G0202, G0204, G0206

CERVICAL CANCER SCREENING

Measure evaluates the percentage of women ages 21–64 who were screened for cervical cancer using either of the following criteria:

1) Cervical cytology performed every 3 years for women ages 21–64

2) Cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years (must occur within 4 days of each other) for women ages 30–64.

Women who have had a hysterectomy without a residual cervix are exempt from this measure.

Cervical Cytology Codes (ages 21-64):

CPT	HCPCS
88141-88143, 88147, 88148, 88150, 88152-88154, 88164-88167, 88174, 88175	G0123, G0124, G0141, G0143-G0145, G0147, G0148, P3000, P3001, Q0091

Ages 30-64 years old, Code from Cervical Cytology plus one HPV code:

CPT
87623, 87624, 87625

CHLAMYDIA SCREENING

Measure evaluates the percentage of women ages 16 to 24 who are sexually active who had at least one test for Chlamydia per year. Chlamydia tests can be completed using any method, including a urine test. "Sexually active" is defined as a woman who has had a pregnancy test or testing for any other sexually transmitted disease or has been prescribed birth control.

CPT
87110, 87270, 87320, 87490-87492, 87810

OSTEOPOROSIS MANAGEMENT *in Women Who Had a Fracture*

Measure evaluates the percentage of women age 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 6 months after the fracture.

Bone Density Tests

CPT	HCPCS	ICD-10	PRESCRIPTION
76977, 77078, 77080	G0130	BP48ZZ1, BP489ZZ1, BP4GZZ1, BP4HZZ1, BPFLZZ1, BP4MZZ1, BP4NZZ1, BP4PZZ1, BQ01ZZ1, BQ3ZZ1, BQ04ZZ1, BR00ZZ1, BR07ZZ1, BR09ZZ1, BR0GZZ1	Biphosphonates, Estrogens, Other agents, Sex hormone combinations

POSTPARTUM VISITS

Measure evaluates the percentage of women who delivered a baby and who had their postpartum visit on or between 21 and 56 days after delivery (3 and 8 weeks).

Any Postpartum Visit:

CPT	ICD-10	HCPCS
57170, 58300, 59430, 99501, 0503F	Z01.411, Z01.419, Z01.42, Z30.430, Z39.2	G0101

Any Cervical Cytology Procedure:

CPT	HCPS
88141-88143, 88147-88148, 88150, 88152-88154, 88164-88167, 88174-88175	G0123-G0124, G0141, G0143-G0145, G0147-G0148, P3000-P3001, Q0091, G0463

Any Postpartum Bundled Services:

CPT
59400, 59410, 59510, 59515, 59610, 59614, 59618, 59622

PRENATAL VISITS *Timeliness of First Visit and Frequency of Visits*

Measure evaluates the percentage of pregnant women who had their first prenatal visit in the first trimester or within 42 days of enrollment with the plan. Also, the frequency of prenatal visits is assessed.

- For OB or PCP provider types, choose to submit Stand Alone Prenatal Visit Codes or Bundled Services Codes
- OB provider types may also submit any OB Prenatal Visit code in conjunction with any code for Other Prenatal Services
- PCP provider types can also submit any Prenatal Visit code and any code for Other Prenatal Services Code along with a pregnancy diagnosis.
- Other Prenatal Services (any one listed): Obstetric Panel, Prenatal Ultrasound, Cytomegalovirus and Antibody Levels for Toxoplasma, Rubella, and Herpes Simplex, Rubella antibody and ABO, Rubella and Rh, Rubella and ABO/Rh

Stand Alone Prenatal Visit Codes

CPT	HCPCS
99500, 0500F, 0501F, 0502F	H1000-H1004

Bundled Services Codes

59400, 59425, 59426, 59510, 59610, 59618	H1005

OB Prenatal Visit Codes

99201-99205, 99211-99215, 99241-99245	G0463

PEDIATRIC HEALTH

ACCESS TO PRIMARY CARE PRACTITIONERS

Measure evaluates the percent of members age 12 months–19 years who had an outpatient visit.

Office or Other Outpatient Services

CPT
99201-99205, 99211-99215, 99241-99245

Home Services

CPT
99341-99345, 99347-99350

Preventive Medicine

CPT	HCPCS	ICD-10
99381-99383, 99391-99393, 99401-99429	G0402, G0438, G0439, G0463	Z00.110-Z00.129 Z00.00- Z02.9

General Medical Examination

ICD-10
Z00.110-Z00.129 Z00.00- Z02.9

ADHD MEDICATION *Follow-Up Care*

Measure demonstrates the percent of members ages 6–12 newly prescribed an ADHD medication that had at least three follow-up care visits within a 10 month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates:

Initiation Phase: one face-to-face outpatient follow-up visit with a practitioner with prescribing authority within 30 days after the date the ADHD medication was newly prescribed.

CPT		HCPCS
99349, 99350, 99383, 99384, 99393, 99394, 99401, 99402, 99403, 99404, 99411, 99412, 99510		G0155, G0176, G0177, G0409, G0410, G0411, G0463, H0002, H0004, H0031, H0034, H0035, H0036, H0037, H0039, H0040, H2000, H2001, H2010, H2011, H2012, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, M0064, S0201, S9480, S9484, S9485
CPT		**POS**
90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90857, 90862, 90875, 90876	WITH	3, 5, 7, 9, 11, 12, 13, 14, 15, 20, 22, 33, 49, 50, 52, 53, 71, 72
99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99251, 99252, 99253, 99254, 99255	WITH	52, 53

Continuation and Maintenance Phase: Two more follow-up visits from 31 to 300 days after the first ADHD medication was newly prescribed. One of the two visits may be a telephone visit with a practitioner.

CODES TO IDENTIFY VISITS	CPT CODES TO IDENTIFY TELEPHONE VISITS
Any code noted above in the initiation phase.	98966, 98967, 98968, 99441, 99442, 99443

ASTHMA *(Medication Management)*

Measure evaluates the percentage of members age 5–64 who were identified as having persistent asthma and were dispensed appropriate medications which they remained on during the treatment period within the past year.

RATES	APPROPRIATE MEDICATIONS
Medication Compliance 50%: Members who were covered by one asthma control medication at least 50% of the treatment period	Antiasthmatic combinations, Antibody inhibitor, Inhaled steroid combinations, Inhaled corticosteroids, Leukotriene modifiers, Mast cell stabilizers, Methylxanthines
Medication Compliance 75%: Members who were covered by one asthma control medication at least 75% of the treatment period	

DENTAL VISIT *(Annual)*

Measure evaluates the percentage of members ages 2–21 who had at least one dental exam with a dental practitioner in the past year.

IMMUNIZATIONS

Childhood Immunizations: percentage of 2 year olds that have all of the required immunizations listed below by age 2.

IMMUNIZATION	DETAILS	CPT	HCPCS
DTaP	At least 4 doses < age 2	90698, 90700, 90721, 90723	—
IPV	At least 3 doses < age 2	90698, 90713, 90723	—
MMR	At least 1 dose < age 2	90707, 90710	—
		Measles/Rubella-90708	—
		Measles-90705, Rubella-90706	—
Hib	At least 3 doses < age 2	90645-90648, 90698, 90721, 90748	—
Hepatitis B	At least 3 doses < age 2	90723, 90740, 90744, 90747, 90748	G0010
VZV	At least 1 doses < age 2	90710, 90716	—
Pneumococcal	At least 4 doses < age 2	90669, 90670	G0009
Hepatitis A	At least 1 doses < age 2	90633	—
Rotavirus[1]	Before age 2: 2 doses of 2-dose vaccine; 1 dose of the 2 dose vaccine and 2 doses of the 3 dose vaccine or 3 doses of the 3 dose vaccine	2 dose schedule-90681	—
		3 dose schedule-90680	
Influenza	At least 2 doses < age 2	90655, 90657, 90661, 90662, 90673, 90685	G0008

1 Record must document if Rotavirus is 2 or 3 dose vaccine. Parent refusal for any reason is not a reason for exclusion.

Adolescent Immunizations: percentage of adolescents turning 13 who had all the required immunizations listed below.

Meningococcal	1 on or between 11th – 13th birthdays	90733, 90734	—
Tdap/Td	1 on or between 10th – 13th birthdays	Tdap-90715	—
		Td-90714 or 90718	—
		Tetanus-90703	—
		Diphtheria-90719	—
Human Papillomavirus (HPV)	Three doses by 13th birthday	90649, 90650	—

LEAD SCREENING IN CHILDREN

Measure evaluates the percentage of children who had a screening test for lead poisoning at least once prior to their second birthday. *A lead screening completed in the practitioner office is also allowable.*

CPT
83655

PHARYNGITIS *(Appropriate Testing)*

Measure evaluates the percentage of children age 2-18 diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode. A higher rate represents better performance (i.e., appropriate testing). Rapid strep tests in the office are acceptable and should be billed.

CPT
87070, 87071, 87081, 87430, 87650-87652, 87880

UPPER RESPIRATORY INFECTION *(Appropriate Treatment)*

Measure evaluates the percentage of children age 3 months–18 years who were given a diagnosis of upper respiratory infection (URI) and were not dispensed an antibiotic prescription. *Ensure any secondary diagnoses indicating the need for an antibiotic are submitted on the claim*.

WEIGHT ASSESSMENT AND COUNSELING FOR NUTRITION AND PHYSICAL ACTIVITY

Measure demonstrates the percentage of members ages 3–17 who had an outpatient visit with a PCP or OB/GYN and who had evidence of the following completed at least annually: 1) BMI percentile documentation[1]; 2) counseling for nutrition; 3) counseling for physical activity

DESCRIPTION	CPT	ICD-10 DIAGNOSIS	HCPCS
BMI Percentile	—	Z68.51-Z68.54	—
Counseling for Nutrition	97802-97804	Z71.3	G0270, G0271, G0447, S9449, S9452, S9470
Counseling for Physical Activity	—	—	G0447, S9451

Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed rather than an absolute BMI value.
The percentile ranking is based on the Centers for Disease Control and Prevention's (CDC) BMI-for-age growth charts.

Pregnant members excluded.

WELL CHILD AND ADOLESCENT WELL CARE VISITS

Components of a comprehensive well visit include:
1) a health history; 2) a physical developmental history; 3) a mental developmental history; 4) a physical exam; and 5) health education/anticipatory guidance.

Visits must be with a primary care practitioner (pediatrician, family practice, OB/GYN), even though the PCP does not have to be the practitioner assigned to the child. *Use age-appropriate codes when submitting well child visits.*

Well Child Visits in the First 15 Months of Life

Measure evaluates the percentage of infants who had 6 comprehensive well care visits (EPSDT) within the first 15 months of life.

CPT	ICD-10 DIAGNOSIS
99381-99382, 99391-99392	Z00.110, Z00.111, Z00.121, Z00.129

Well Child Visits, Ages 3–6 Years Old

Measure evaluates the percentage of children ages 3, 4, 5 or 6 years old who had at least one comprehensive well care visit (EPSDT) per year.

CPT	ICD-10 DIAGNOSIS
99382, 99383, 99392 , 99393	Z00.110, Z00.111, Z00.121, Z00.129

Adolescent Well Care Visits

Measure evaluates the percentage of adolescents age 12–21 years old who had at least one comprehensive well care visit (EPSDT) per year.

CPT	ICD-10 DIAGNOSIS	HCPCS
99384-99385, 99394-99395	Z00.121, Z00.129, Z00.5, Z00.8, Z02.0	G0438, G0439

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