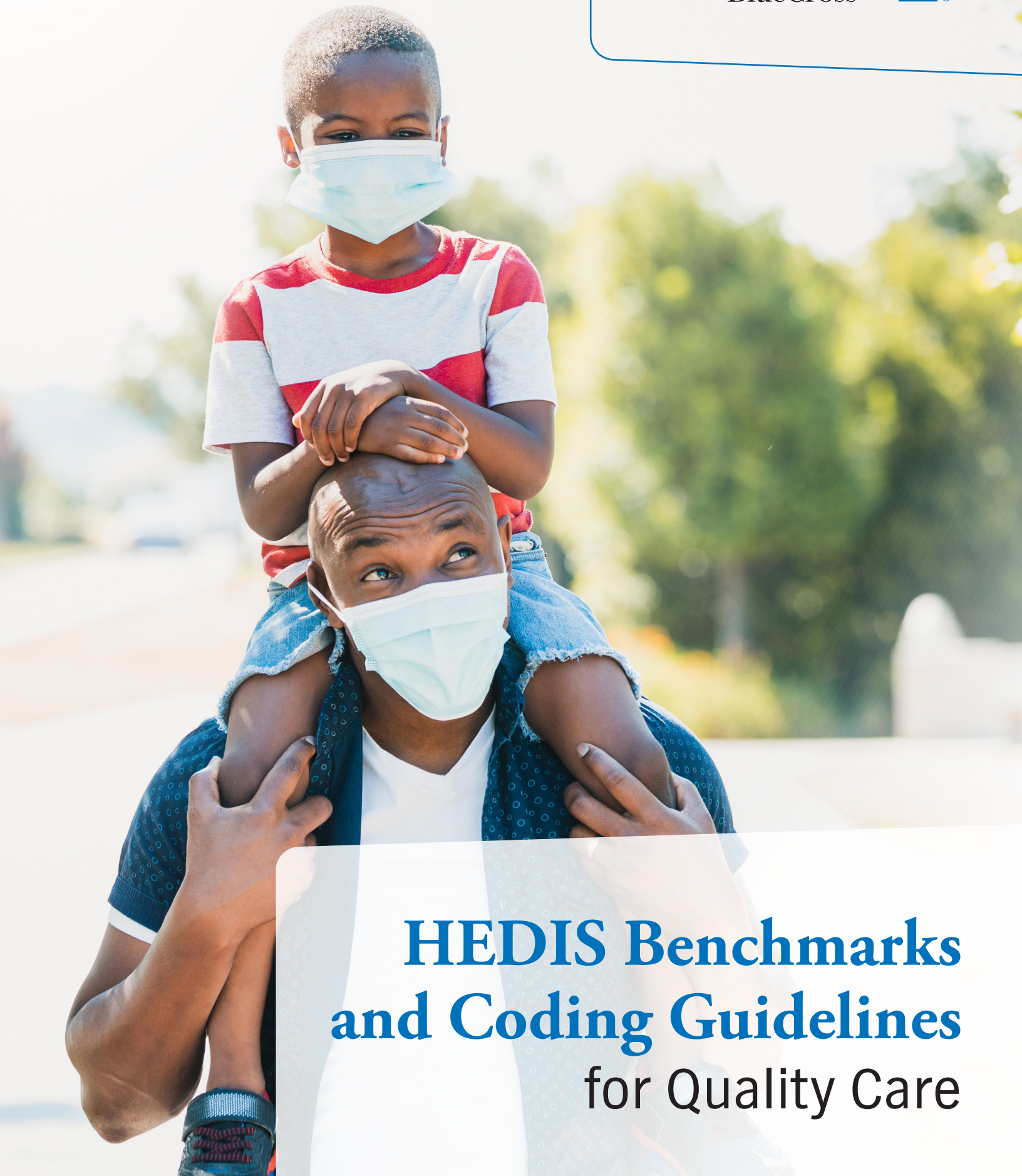
Medi-Cal Managed Care

Anthem BlueCross



HEDIS Benchmarks and Coding Guidelines for Quality Care

Contents

* Availity, LLC is an independent company providing administrative support services on behalf of Anthem Blue Cross.

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Welcome

Anthem Blue Cross (Anthem) thanks you for your continued partnership and efforts to improve the quality of care for our members. Anthem believes quality of care is a collaborative effort with our providers, members, and community. Anthem would like to commit our full efforts to supporting all work geared toward improved quality, member outreach, and healthy outcomes. As you know, we measure quality with administrative data and medical record chart review. The ever-changing quality measures, billing codes, and documentation requirements make it exceedingly difficult to capture the great care we know you are delivering. To assist, the Anthem Quality team created this reference guide to serve as a comprehensive support tool for your practice.

The good news is that Anthem is here to help.

How to use this guide:

This guide is comprised of two sections:

- **CAHPS® tips** provide information on four CAHPS composites and additional information on improving office wait time and customer satisfaction through customer service.
- **HEDIS® measure guide** offers general tips for adult and child measures, descriptions for each unique HEDIS measure, tips on proper coding/medical record documentation, and tips for your office to improve the rate for that measure.

We hope that this guide becomes a resource for you and the team within your office.

*Please note: The HEDIS definition of a **PCP** used throughout this guide is a physician or nonphysician (nurse practitioner, physician assistant or nurse midwife) who offers primary care medical services.*

Tips to improve CAHPS survey

We strive to make the member's experience a positive one

Each year, our members get a survey called the Consumer Assessment of Healthcare Providers and Systems (CAHPS). There is a survey for adult Medi-Cal Managed Care (Medi-Cal) members and a survey for children enrolled in Medi-Cal. Both surveys ask your patients (our members) to rate and evaluate their experiences. The survey also asks if member has had a flu vaccination in the past year. Additionally, the member will be asked about tobacco status and if positive for tobacco use, the level of tobacco cessation strategies offered by the provider.

The survey is comprised of several categories. This tip guide will focus on five of those categories:

- Getting care quickly
- Getting needed care
- How well doctors communicate
- Coordination of care
- Improving customer service

The information from this survey is used to improve the quality of services we give to our members. Anthem suggests the following tips to address the above mentioned CAHPS categories.

Getting care quickly

This category measures the member's perception of how quickly they received routine or urgent care within the last six months.

How to improve:

- Offer weekend/evening appointments to accommodate your patients' schedules.
- Include clear instruction on how to access after-hours care such as dialing **911** in the case of an emergency.
- Consider assigning staff dedicated to preliminary work-up activities.
- If possible, leave a few appointments available each day for urgent visits.
- Offer visits to members to see nurse practitioners or physician assistants.
- Understand Anthem's standards for routine and urgent visit wait time for an appointment. Review our standards in your provider manual at **https://providers.anthem.com/ca** under *Resources > Provider Manuals, Policies, & Guidelines > Provider Manuals.*
- Remind patients they can call the 24/7 NurseLine, available seven days a week for health-related questions: **800-224-0336**.

Getting needed care

This category measures the member's perception of how easily they were able to get the care they needed from their doctor or specialist within the last six months, including tests, screenings, visits, and treatments.

How to improve:

- Offer an appointment agenda where patients can list concerns or questions they would like to address during their visit.
- Write down details regarding visits and referrals to a specialist for the patient.
- If possible, leave a few appointments available each day for urgent visits.
- Review all available treatment options for the patient in their language. Anthem offers interpreter services, which you can access by calling the Customer Care Center at **800-407-4627**.
  For after-hours interpreter services, call **800-407-4627**.
- Avoid using medical terms that could confuse the patient.
- Provider offices should schedule follow-up appointments for needed screenings, tests, treatments, and exams for patients while members are in the office for their visit.
- Patients can also schedule appointments by contacting the Customer Care Center at **800-407-4627** Monday through Friday from 7 a.m. to 7 p.m. PT.

How well doctors communicate

This category measures the member's perception of how well their physician communicated with them within the last six months. Questions in this category take into account how the physician explained things regarding the patient's health, how well the patient understood the information, if the doctor listened to the patient, if the doctor was respectful and how much time the physician spent with the patient.

How to improve:

- Offer an appointment agenda where patients can list concerns or questions they would like to address during their visit.
- Ensure there is enough time for each patient's appointment to allow time for communication between physician and patient. Allow the opportunity for patients to ask questions and check their understanding of the information provided during the visit.
- Listen to your patient's needs. Avoid using terms that could confuse the patient.
- Take feedback from your patients by providing short survey cards to see how the office can improve.
- Offer a visit summary to the patient that includes any treatment, goals or action plans that were discussed, prescriptions and what the medications are for, including side effects. Include the next appointment time or recommended next appointment. If the patient is referred to a specialist, include that information in the summary along with the option to email this information to the patient with the appropriate signatures and permissions (*HIPAA*, compliance, etc.) during the visit.
- Allow the opportunity for patients to ask questions and check their understanding of the information provided during the visit. Use the teach-back method with patients to promote understanding.
- Greet patients courteously, demonstrate familiarity with the patient's history, resolve issues quickly, ensure representatives have the information and the training to answer questions and resolve issues, minimize transfers, spend enough time with patients, and encourage a dialogue with the patient.
- Provider can request an in-person interpreter in advance if they know the member needs it.

Coordination of care

This category measures the member's perception of how informed their doctor seemed regarding the care they received with other physicians or health providers within the last six months.

How to improve:

- Regularly talk to your patients about any specialists or other physicians they have seen. Ask about the care they received and if they were given any reports or notes.
- Consider implementing a reminder in the medical record to request test results or follow-up reports. This will ensure appropriate follow-up for the patient.
- Keep an open dialogue with your patient and discuss their previous medical history.
- Set an expectation for the patient so they know when they will receive a follow-up call or test results. If this process is not part of the office protocol, make sure the patient is aware so they understand how they can obtain their results or follow-up.

Improving customer service

Patient-centered care is continuously receiving more focus and attention, as standards for exceptional patient experience become more valued by health care regulators. A patient's experience relies on interactions between physician and office staff. Positive patient experiences begin with genuine, open communication.

How to improve:

- Understand the patient's needs from the moment they step into the office. Often, the receptionist sets the tone for the rest of the appointment based on how they give the patient undivided attention, make eye contact, smile, communicate clearly, understand and anticipate needs, and relay those needs to the care provider.
- Seek out interactions with your patients. Not only will this make the patient feel valued, but you can increase the chance of a return visit.
- Reset with every patient. Do not allow a negative experience with one patient to carry on to the next patient. Consider taking a small break if needed to reset.
- Consider implementing a recognition system for staff in the provider office with rewards for exceptional customer service. Rewards systems like this drive motivation to provide great customer service.

Pediatric HEDIS general tips

- Document all discussions in the medical record.
- Discuss the importance of ideal weight, nutrition, and exercise with all patients. Record BMI percentile.
- Use the *California State Immunization Registry (CAIR)* and transcribe into the registry the hepatitis B (Hep B) immunization given at birth in the hospital.
- If you use EMR, consider creating a flag to track patients due or past due for preventive services.
- If you do not use EMR, consider creating a manual tracking method for preventive services such as immunizations and annual well-child exams.
- Make the most of the time in your office. Sick visits may be the opportunity for your patient to also complete a preventive care component and immunizations.
- Encourage your staff to use tools within the office to promote teaching on immunizations, asthma care, healthy living habits and importance of return visits.
- Place posters and educational messages in treatment rooms and waiting areas to help motivate patients to initiate discussions with you about health screenings.
- Expand your office hours into the evening, early morning, or weekends to accommodate all patients.
- Contact patients to remind them of upcoming appointments and necessary screenings.
- Schedule the next visit at the end of the appointment.
- Take advantage of the Telehealth Allowances available for various measures.

Adult HEDIS general tips

- Document all discussions in the medical record.
- Discuss the importance of medication management, chronic disease management, ideal weight, smoking cessation, preventive services, adult immunizations, and importance of return visits with all patients.
- Consider including a diabetes educator on your team to speak with patients during office visits.
- Follow up on lab results, eye exam results, or any specialist visit to document in the member's chart.
- Refer members to the network of eye providers for their annual diabetic retinal eye exam.
- If you use EMR, consider creating a flag to track patients due or past due for preventive services.
- If you do not use EMR, consider creating a manual tracking method for preventive services.
- Encourage your staff to use tools within the office to promote teaching on colorectal cancer screening, cervical cancer screening, and breast cancer screening.
- Provide a mammogram referral during their annual visit.
- Place posters and educational messages in treatment rooms and waiting areas to help motivate patients to initiate discussions with you about health screenings.
- Expand your office hours into the evening, early morning, or weekends to accommodate all patients.
- Contact patients to remind them of upcoming appointments and necessary screenings.
- Schedule the next visit at the end of the appointment.
- Take advantage of the Telehealth Allowances available for various measures.

AAB: Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis

Since there is considerable evidence that prescribing antibiotics for uncomplicated acute bronchitis is **not** indicated unless they have an associated comorbid diagnosis, this HEDIS measure looks at the percentage of episodes for members 3 months and older with a diagnosis of acute bronchitis/bronchiolitis who were **not** dispensed an antibiotic prescription.

Code your services correctly

Use the following diagnosis and procedure codes to indicate acute bronchitis:

Diagnosis	ICD-10
Acute bronchitis	J20.3-J20.9, J21.0, J21.1, J21.8, J21.9

The codes listed are HEDIS-specific; this information does not guarantee reimbursement.

Helpful tips:

- Educate patients on the difference between bacterial and viral infections. (This is a key point in the success of this measure.) Let patients and their parents or caregivers know how they can treat and prevent infection.
- 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.

Acute bronchitis that may need treatment with antibiotics due to associated comorbid diagnosis like:

- HIV disease; asymptomatic HIV.
- Disorders of the immune system.
- Chronic bronchitis.
- Bronchiectasis.
- Other diseases of the respiratory system.
- Pneumoconiosis and other lung disease due to external agents.
- Chronic airway obstruction, chronic obstructive asthma.
- Cystic fibrosis.
- Malignant neoplasm.
- Emphysema.
- Extrinsic allergic alveolitis.
- Tuberculosis.
- Bacterial infections like:
  - Sinusitis.
  - Otitis media.

Other resources

Go to **https://cdc.gov/antibiotic-use/week/toolkit.html** for these free helpful materials and more.

Notes

AAP: Adults' Access to Preventive/Ambulartory Health Services

This HEDIS measure looks at the percentage of members 20 years of age and older who had an ambulatory or preventive care visit. The organization reports percentages for members who had an ambulatory or preventive care visit during the measurement year.

Exclusions:

- Members in hospice or using hospice services anytime during the measurement year
- Members who died during the measurement year

Description	CPT	ICD-10
Ambulatory Visits	99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402,	Z00.00, Z00.01, Z00.121, Z00.129, Z00.3, Z00.5, Z00.8, Z02.0, Z02.1, Z02.2, Z02.3, Z02.4, Z02.5, Z02.6, Z02.71, Z02.79, Z02.81, Z02.82, Z02.83, Z02.89, Z02.9, Z76.1, Z76.2

Note: The codes listed are informational only; this information does not guarantee reimbursement.

Helpful tips:

- If utilizing an EMR system, consider electronic data sharing with your health plan to capture all coded elements. Contact your Anthem Blue Cross representative for additional details and questions.

How can we help?

- Members may be eligible for transportation assistance at no cost, contact Member Services for arrangement.

Notes

ADD: Follow-Up Care for Children Prescribed ADHD Medication

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

Two rates are reported:

1. **Initiation Phase:** had prescription dispensed for ADHD medication, who had one follow-up visit with practitioner with prescribing authority during the 30-day Initiation Phase.
2. **Continuation and maintenance phase:** remained on ADHD medication for at least 210 days and had two more visits within nine months after the Initiation phase.

Record your efforts

When prescribing a new ADHD medication:

- Schedule a follow-up visit within 30 days when ADHD medication is initially prescribed or restarted after a 120-daybreak.
- After the initial follow-up visits, schedule at least two more office visits in the next nine months to monitor patients' progress.
- Be sure 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.

Telehealth allowance

Telehealth and telephone visits allowed for Initiation phase, e-visits, and virtual check-ins allowed for Continuation and Maintenance phases.

Notes

AMM: Antidepressant Medication Management

This HEDIS measure looks at the percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment. Two rates are reported:

1. **Effective Acute Phase Treatment:** The percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks).
2. **Effective Continuation Phase Treatment:** The percentage of members who remained on an antidepressant medication for at least 180 days (six months).

Telehealth allowance

E-visits and virtual check-ins allowed for diagnosis.

Notes

AMR: Asthma Medication Ratio

This HEDIS measure looks at patients 5 to 64 years of age who were identified as having persistent asthma and have a ratio of controller medications to total asthma medications of .50 or greater in measurement year.

For patients with asthma, you should:

- Prescribe controller medication and advise patients to get their controller medication filled regularly.
- Educate patients on identifying asthma triggers and taking controller medications.
- Create an asthma action plan and document it in the medical record.
- Remind patients not to stop taking the controller medications even if they are symptom-free.

The following diagnosis codes are used to identify asthma for AMR

Diagnosis	ICD-10
Asthma	J45.21, J45.22, J45.30-J45.32, J45.40-J45.42, J45.50-J45.52, J45.901, J45.902, J45.909, J45.991, J45.998

Therapeutic agents included for AMR:

Asthma controller medications

Description	Prescriptions		
Antibody inhibitors	• Omalizumab		
Anti-interleukin-4	• Dupilumab		
Anti-interleukin-5	• Mepolizumab	• Reslizumab	• Benralizumab
Inhaled steroid combinations	• Budesonide-formoterol • Fluticasone-salmeterol	• Fluticasone-vilanterol • Formoterol-mometasone	
Inhaled corticosteroids	• Beclomethasone • Budesonide	• Ciclesonide • Flunisolide	• Fluticasone • Mometasone
Leukotriene modifiers	• Montelukast	• Zafirlukast	• Zileuton
Methylxanthines	• Theophylline		

Asthma reliever medications

Description	Prescriptions	
Short-acting, inhaled beta-2 agonists	• Albuterol	• Levalbuterol

Appropriate controller and reliever medications — prior authorization** and step therapy may be required.

Individuals with a diagnosis such as emphysema, COPD, obstructive chronic bronchitis, chronic respiratory conditions due to fumes or vapors, cystic fibrosis, or acute respiratory failure are an exclusion based on NCQA technical specification for this measure. The chronic condition codes should be submitted every three years if condition persists.

Telehealth allowance

E-visits and virtual check-ins allowed for diagnosis.

APM: Metabolic Monitoring for Children and Adolescents on Antipsychotics

The percentage of children and adolescents 1 to 17 years of age who had two or more antipsychotic prescriptions and had metabolic testing. Three rates are reported:

1. The percentage who received blood glucose testing.
2. The percentage who received cholesterol (or LDL-C) testing.
3. The percentage who received blood glucose and cholesterol (or LDL-C) testing.

The metabolic testing due annually is:

- A glucose test and Cholesterol (LDL-C or cholesterol) test performed during the measurement year.

Notes

APP: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics

The percentage of children and adolescents 1 to 17 years of age who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment.

Background

Antipsychotic medications are associated with a number of potential adverse impacts, including weight gain and diabetes, which can have serious implications for future health outcomes. Children without primary indication for an antipsychotic and who are not given the benefit of a trial of psychosocial treatment first, may unnecessarily incur the risks associated with antipsychotic medications. Mental health conditions in youth are associated with a number of potential adverse effects, including increased risk for substance use. To the extent that psychosocial interventions are associated with better outcomes, underuse of these therapies may lead to poorer mental and physical health outcomes.

Telehealth allowance

Services provided during telephone visits, e-visits, and virtual check-ins are allowed for event/diagnosis.

Notes

BLL/LSC: Blood Lead Screening of Young Children

Federal law requires states to screen children, age 12 months and 24 months, enrolled in Medi-Cal (in California) for elevated blood lead levels (BLLs) as part of required prevention services offered through the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program. The BLL Screening is a federal and state requirement and includes all Anthem children between the ages of 6 months to 6 years. The LSC HEDIS measure captures the rate of children that have had at least one BLL Test by the age of 24 months.

According to the CDC, protecting children from lead exposure is important to lifelong good health. Even low levels of lead in the blood have shown to affect IQ, the ability to pay attention, and academic achievement. The most important step to take is to prevent lead exposure before it occurs. Children can be exposed to lead from sources such as paint, lead smelters, leaded pipes, solder, plumbing fixtures, and consumer products. Lead can also be present in air, food, water, dust, and soil.

Screening may be either conducted using the capillary (finger stick) or venous blood sampling methods. DHCS currently utilizes encounter data for tracking the administration of blood lead screenings. Providers must ensure point-of-care blood lead screening tests are documented in claims and encounters by appropriate coding. If the results are elevated, 3.5 mcg/dL or higher, a confirmatory venous BLL test should be ordered. The information must be reported to the Local Public Health Department, Childhood Lead Poisoning Prevention Program (CLPPP). All point-of-care testing results must also be reported to the California Department of Public Health (CDPH) Childhood Lead Poisoning Prevention Branch (CLPPB). Children with BLL above 10 mcg/dL should be referred to Anthem's Case Management. DHCS requires Anthem to inform all providers of their child members for which Anthem has no evidence of the BLL tests at 12 and 24 months or in the catch-up period up to age 72 months (6 years). This separate report is sent quarterly to providers and groups to alert providers that these children need to be tested for lead exposure.

Use the following diagnosis and procedure codes to document blood lead screening:

Blood Lead Testing CPT
83655

Requirements for providers:

- Providers must provide oral or written anticipatory guidance to the parent or guardian of a child. It must be performed and documented at EACH periodic health assessment from 6 months until 72 months of age.
- Providers must perform BLL testing on all children:
  - At 12 months and at 24 months of age, or;
  - If between 12 and 24 months of age and there is no documented BLL at 12 months, or;
  - If between 24 months and 72 months of age and there is no documented evidence of BLL testing at 24 months, or;
  - If the health care provider becomes aware of a change in circumstances has placed the child at increased risk of lead poisoning or prior testing was omitted, or;
  - When requested by the parent or guardian.
- The health care provider is not required to perform BLL testing if:
  - A parent or guardian of the child refuses to consent to the screening.
  - If risk of screening poses a greater risk to the child's health than the risk of lead poisoning.

- Providers must document the reasons for not screening in the child's medical record.

Other resources

CLPPB and CDC guidance for health care providers can be accessed at the following sites:
www.cdph.ca.gov/Programs/CCDPHP/DEODC/CLPPB/Pages/prov.aspx
www.cdc.gov/nceh/lead/advisory/acclpp/actions-blls.htm

Notes

BCS: Breast Cancer Screening

This HEDIS measure looks at women 50 to 74 years of age who had a mammogram to screen for breast cancer during the current year or the year prior.

PCP helpful tips

Compliance primarily comes from imaging coding, however, be sure your medical records reflect:

- Discuss and prescribe a breast cancer screening with all female patients 50 to 74 years of age (younger if the patient has a family history of breast cancer) every two years.
- Conduct outreach calls to patients to remind them of the importance of annual wellness visits and assist in scheduling mammograms. Since this measure evaluates primary breast cancer screening; biopsies, breast ultrasounds, and MRIs will not count as a primary breast cancer screening.
- Request and retain copies of mammography results in patients' records or ask 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 patients who need a mammogram referral during their annual visit.
- Put up posters and educational messages in waiting areas; they help motivate patients to initiate discussions with physicians regarding screenings.
- To exclude member from measure due to bilateral mastectomy: Add the history code to the exam visit.

Acquired absence of bilateral breasts and nipples
Z90.13

Code your services correctly

Imaging centers use the following procedure codes to document breast cancer imaging:

CPT
77061, 77062, 77063, 77065, 77066, 77067

The codes listed are HEDIS-specific; this information does not guarantee reimbursement.

Telehealth allowance

Telephone visits, e-visits and virtual check-ins only allowed to exclude members due to advanced illness.

Other resources

You can find more information at **www.uspreventiveservicestaskforce.org**.

Notes

CBP: Controlling High Blood Pressure

This HEDIS measure looks at patients 18 to 85 years of age who had a diagnosis of hypertension and whose blood pressure is adequately controlled (< 140/90 mm Hg).

Record your efforts:

- Blood pressure monitoring with a desired result goal of <140/90 mm Hg for HEDIS compliance:
  - Both systolic and diastolic values must be below 140/90 mm Hg to be considered compliant.
- Document diagnosis of hypertension in medical record; Code using ICD-10 code I10.
- Document treatment for the hypertension.

Code the blood pressure results

Code blood pressure results by using CPT II codes:

Systolic result	**3074F**: < 130	**3075F**: = 130-139	**3077F**: ≥ 140
Diastolic result	**3078F**: < 80	**3079F**: = 80-89	**3080F**: ≥ 90

The codes listed are HEDIS-specific; this information does not guarantee reimbursement.

Telehealth allowance

Telephone visits, e-visits, and virtual check-ins allowed for member reported blood pressures taken on a digital device and recorded by provider in medical record. Diagnosis of hypertension and advanced illness are also allowed by telehealth.

Helpful tips

Improve the accuracy of blood pressure measurements performed by your clinical staff by:

- Providing training and materials from the American Heart Association.
- Make a variety of cuff sizes available.
- Calibrating blood pressure equipment through engineering protocols.
- Instruct the staff to recheck blood pressure at the end of the visit for all patients with initial recorded readings ≥140/90 mm Hg; Record the retake results.
- Warn staff against rounding results when using manual cuffs.
- Educate patients about the elements of a healthy lifestyle, such as:
  - Heart-healthy eating, low-salt diet, adding regular exercise and smoking cessation.
  - The importance of taking all prescribed medications as directed.

Other resources

You can find more information at **www.heart.org/en/health-topics/high-blood-pressure**.

Notes

CCS: Cervical Cancer Screening

This HEDIS measure for cervical cancer screening using the following criteria:

- **Ages 21 to 64:** at least one cervical cytology (Pap) test every three years
- **Ages 30 to 64:** cervical high-risk human papillomavirus (hrHPV) testing performed in the last five years
- **Ages 30 to 64:** cervical cytology/high-risk human papillomavirus (hrHPV) co-testing in the last five years

Record your efforts

Compliance primarily comes from lab coding, however, be sure your medical records reflect:

- When performing the Pap: record the date and type of test that was performed:
  - Provider may code **Q0091**, indicating smear obtained.
- If reviewing the Pap results report or the member is self-reporting: The provider office should document the date and result of exam in the medical record.
- If the patient's cervix is absent: A history code may be added to an annual well-woman exam to appropriately exclude patient from this measure. Member reported data is acceptable if documented.

Acquired absence of cervix and uterus	Acquired absence of cervix with remaining uterus	Agenesis and aplasia of cervix
Z90.710	Z90.712	Q51.5

- Document complete details for hysterectomy: complete, total or radical abdominal or vaginal hysterectomy with no residual cervix; a note of hysterectomy alone does not exclude the member because the status of the cervix is unknown; include approximate year; this may be member-reported.
- If the member should be excluded as male-to-female transgender, please submit code **Q51.5.**

Code your services correctly

Laboratories to use procedure codes to document cervical cancer screening:

CPT	HCPCS	LOINC
87624-87625, 88141-88143, 88147, 88148, 88150, 88152, 88153 88164-88167, 88174, 88175	G0123, G0124, G0141, G0143-5, G0147, G0148, G0476, P3000, P3001, Q0091	10524-7, 18500-9, 19762-4, 19764-0, 19765-7, 19766-5, 19774-9, 21440-3, 30167-1, 38372-9, 33717-0, 47527-7, 47528-5, 59263-4, 59264-2, 59420-0, 69002-4, 71431-1, 75694-0, 77379-6, 77399-4, 77400-0, 82354-2, 82456-5, 82675-0

The codes listed are HEDIS-specific; this information does not guarantee reimbursement.

Helpful tips:

- Discuss the importance of well-woman exams, mammograms, Pap tests, and HPV testing.
- Refer patients to another appropriate provider if your office does not perform Pap tests and request copies of Pap test/HPV co-testing results be sent to your office.
- Train your staff on the use of educational materials to promote cervical cancer screening.
- Use a tracking mechanism (for example, EMR flags and/or manual tracking tool to identify patients due for cervical cancer screening).

CCP: Contraceptive Care Postpartum Women

The Centers for Medicare & Medicaid Services (CMS) measure women ages 15 to 44 who had a live birth, the percentage that:

- Were provided a most effective or moderately effective method of contraception within 3 and 60 days of delivery:
  - **Contraceptive types included:** sterilization, IUD/IUS, hormonal implant, injectable oral contraception pills, patch, or vaginal ring
- Were provided a long-acting reversible method of contraception (LARC) within 3 and 60 days of delivery:
  - **Contraceptive types included:** IUD/IUS or hormonal implant

These rates are reported at two points in time: contraceptive provision within three days of delivery is used to monitor the provision of contraception in the immediate postpartum period, while contraceptive provision within 60 days of delivery is used to monitor the provision of contraception throughout the postpartum period.

Women are stratified into two age groups: ages 15 to 20 and ages 21 to 44. Rates will be reported for the measure by age stratification within two points in time: contraceptive provision within three days of delivery and contraceptive provision within 60 days of delivery and type further to the contraceptive type provided.

Notes

CCW: Contraceptive Care-All Women

The CMS measure women ages 15 to 44 at risk of unintended pregnancy, the percentage that:

- Were provided a most effective or moderately effective method of contraception:
  - **Contraceptive types included:** sterilization, IUD/IUS, hormonal implant, injectable oral contraception pills, patch, or vaginal ring
- Were provided a long-acting reversible method of contraception (LARC):
  - **Contraceptive types included:** IUD/IUS or hormonal implant

All women are stratified into two age groups: ages 15 to 20 and ages 21 to 44.
Two rates will be reported for the measure — one for the provision of most or moderately effective methods and one for provision of LARC.

The first rate is an intermediate outcome measure, and it is desirable to have a high percentage of women who are provided the most effective or moderately effective contraceptive methods.

Notes

Comprehensive Diabetes Care

This HEDIS measure evaluates patients 18 to 75 years of age with type 1 or type 2 diabetes.

Each year, patients with type 1 or type 2 diabetes should meet three measures:

- **HBD: Hemoglobin A1c for Patients with Diabetes:**
  - **HbA1c testing** with a desired result goal of < 8% for HEDIS.
- **BPD: Blood Pressure Control for Patients with Diabetes:**
  - **Blood pressure monitoring** with a desired result goal of < 140/90 mm Hg for HEDIS compliance.
- **EED: Eye Exam for Patients with Diabetes:**
  - **Diabetic retinal eye exam** in current year or negative retinal exam in previous year.

Record your efforts

Document all diabetes evaluation notes, blood pressure, lab tests, and eye exam results in the patient's medical record.

Code your services correctly

Use the following procedure codes to document comprehensive diabetes care:

Service	CPT
HbA1c	83036, 83037, 3044F, 3046F, 3051F, 3052F
Eye exams	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, 92201, 92202, 92225, 92226, 92230, 92235, 92240, 92250, 92260, 99203- 99205, 99213-99215, 99242-99245, 3072F, 2022F, 2023F, 2024F, 2025F, 2026F, 2033F

The codes listed are HEDIS-specific; this information does not guarantee reimbursement.

Telehealth allowance

Telephone visits, e-visits, and virtual check-ins allowed for member reported blood pressures taken on a digital device along and a specific result recorded by provider in medical record. Diagnosis of hypertension and advanced illness are also allowed by telehealth.

Helpful tips:

- Have reminders set in your system to alert your staff when a patient's screenings are due.
- Contact patients to remind them of upcoming appointments and necessary screenings.
- Record lab test results, eye exam results, or any specialist referral in the patient's chart.
- Continue diabetes education and importance of monitoring and maintenance on every visit.
- Refer patients to the network of eye providers for their annual diabetic retinal eye exam.
- **Refer patients to** Centers for Disease Control and Prevention (CDC) Diabetes Prevention Program (DPP). **(Information about program after EED codes)**

Easy codes that a PCP can use to make your patient compliant for CDC no matter where service took place!

HBD: HbA1c results

Code HbA1c levels by using CPT II codes:

HbA1c result	**3044F**: < 7%	**3046F**: > 9%	**3051F:** > 7 - < 8%	**3052F:** > 8 - ≤ 9%

BPD: Blood pressure results

Code blood pressure levels by using CPT II codes:

Systolic result	**3074F**: < 130	**3075F**: = 130-139	**3077F**: ≥ 140
Diastolic result	**3078F**: < 80	**3079F**: = 80-89	**3080F**: ≥ 90

EED: Retinal screening results

Code your review of retinal screening results by using CPT II codes:

Low risk for retinopathy due to no evidence of retinopathy in the prior year	**3072F**
Reviewed dilated retinal eye exam results by ophthalmologist or optometrist, with evidence of retinopathy	**2022F**
Review of seven field photos with results by ophthalmologist or optometrist, with evidence of retinopathy	**2024F**
Review of eye imaging validated to match seven field photos with results by ophthalmologist or optometrist with evidence of retinopathy	**2026F**
Reviewed dilated retinal eye exam results by ophthalmologist or optometrist, without evidence of retinopathy	**2023F**
Review of seven field photos with results by ophthalmologist or optometrist, without evidence of retinopathy	**2025F**
Review of eye imaging validated to match seven field photos with results by ophthalmologist or optometrist, without evidence of retinopathy	**2033F**

Diabetes Prevention Program

Medi-Cal Managed Care (Medi-Cal) members at risk for type 2 diabetes now have access to the Centers for Disease Control and Prevention (CDC) Diabetes Prevention Program (DPP).

The DPP is a year-long program that consists of weekly sessions with a lifestyle coach for the first six months and monthly maintenance sessions for the latter six months. Sessions can be held in a group classroom setting or online. Participants will learn realistic lifestyle changes emphasizing weight loss through exercise, healthy-eating, and behavior modification.

Members can determine their eligibility for DPP and enroll through our program administrator, Solera Health,* by visiting **www.solera4me.com/AnthemBC_MediCal** to take the online assessment or by calling 844-612-2949 (TTY 711), Monday through Friday from 6 a.m. to 6 p.m. PT.

Criteria for eligibility include:At least 18 years of age:

- BMI of 25 or greater
    - If member is of Asian descent, a BMI of 23 or greater is required.

- Blood screening (optional, if available):
    - Hemoglobin A1C: 5.7% to 6.4%
        - Fasting plasma glucose: 100 to 125 mg/dL
        - Oral Glucose Tolerance Test: 140 to 199 mg/dL
- Exclusions include no previous diagnosis of end-stage renal disease or type 1 or type 2 diabetes; not pregnant (previous gestational diabetes is not an exclusion)

Notes

CDF: Depression Screening and Follow-up for Adolescents and Adults

This CMS measure looks at patients 12 years of age and older who were screened for depression using a standardized instrument and, who if positive, a follow-up plan is documented on the date of the positive screen.

Record your efforts

The name of the age-appropriate standardized depression screening tool utilized must be documented in the medical record. Also, for those who are screened positive for depression, follow-up care plan must be documented on the date of the positive screen.

Standardized depression screening tools for ages 12 to 17:

- *Patient Health Questionnaire for Adolescents (PHQ-A), Beck Depression Inventory-Primary Care Version (BDI-PC), Mood Feeling Questionnaire (MFQ), Center for Epidemiologic Studies Depression Scale (CES-D), Patient Health Questionnaire (PHQ-9), Pediatric Symptom Checklist (PSC-17), and PRIME MD-PHQ2*

Perinatal screening tools for ages 12 to 17:

- *Edinburgh Postnatal Depression Scale, Postpartum Depression Screening Scale, Patient Health Questionnaire 9 (PHQ-9), Beck Depression Inventory, Beck Depression Inventory–II, Center for Epidemiologic Studies Depression Scale, and Zung Self-Rating Depression Scale*

Standardized depression screening tools for ages 18 and older:

- *Patient Health Questionnaire (PHQ-9), Beck Depression Inventory (BDI or BDI-II), Center for Epidemiologic Studies Depression Scale (CES-D), Depression Scale (DEPS), Duke Anxiety- Depression Scale Measure CDF-AD: Screening for Depression and Follow-Up Plan: Age 18 and Older 50 Version of Specification: Quality ID: 134 Claims and Registry Version 2.0 for 2018 Reporting (DADS), Geriatric Depression Scale (GDS), Cornell Scale for Depression in Dementia (CSDD), PRIME MD-PHQ2, Hamilton Rating Scale for Depression (HAM-D), and Quick Inventory of Depressive Symptomatology Self-Report (QID-SR)*

Perinatal screening tools for ages 18 and older:

- *Edinburgh Postnatal Depression Scale, Postpartum Depression Screening Scale, Patient Health Questionnaire 9 (PHQ-9), Beck Depression Inventory, Beck Depression Inventory–II, Center for Epidemiologic Studies Depression Scale, and Zung Self-Rating Depression Scale*

Follow-up care plan must be documented on the date of the positive screen. The follow-up care plan must include one or more of the following (for ages 12 and older):

- Additional evaluation for depression
- Suicide risk assessment
- Referral to a practitioner who is qualified to diagnose and treat depression
- Pharmacological interventions
- Other interventions or follow-up for diagnosis or treatment of depression

CHL: Chlamydia Screening in Women

This HEDIS measure evaluates sexually active women ages 16 to 24 years of age who received at least one chlamydia test during the current year.

The U.S. Preventive Services Task Force and the Centers for Disease Control and Prevention recommend screening for chlamydia at least annually for all sexually active women younger than age 25. 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.

Code your services correctly

Use the following diagnosis and procedure codes to document chlamydia screenings:

CPT	LOINC
87110, 87270, 87320, 87490, 87491, 87492, 87810	14463-4, 14464-2, 14467-5, 14474-1, 14513-6, 16600-9, 21190-4, 21191-2, 21613-5, 23838-6, 31775-0, 31777-6, 36902-5, 36903-3, 42931-6, 43304-5, 43404-3, 43405-0, 43406-8, 44806-8, 44807-6, 45068-4, 45069-2, 45075-9, 45076-7, 45084-1, 45091-6, 45095-7, 45098-1, 45100-5, 47211-8, 47212-6, 49096-1, 4993-2, 50387-0, 53925-4, 53926-2, 557-9, 560-3, 6349-5, 6354-5, 6355-2, 6356-0, 6357-8, 80360-1, 80361-9, 80362-7, 91860-7

The codes listed are HEDIS-specific; this information does not guarantee reimbursement.

Helpful tips:

- Consider adding chlamydia screening to the annual preventative services list for females aged 16 to 24.
- Urine screening for chlamydia is acceptable for all female patients 16 years of age and older who are sexually active in this age group for chlamydia every year as part of their annual well visit.
- Take a sexual history when you see adolescents. Create an environment conducive to taking a sexual history by starting with nonthreatening topics and moving to more sensitive ones:
    - Making sure you have an opportunity to speak with the adolescent without her parent(s).
- For positive test results:
    - 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 with positive tests on the need to inform their partner(s); Reinfection is common and may cause infertility.

Notes

CIS: Childhood Immunization Status

This HEDIS measure looks at patients who turn 2 years old in the measurement year and received the following vaccinations by their 2nd birthday.

Record your efforts

Once you give patients their needed immunizations, let us and the state know by:

- Recording the immunizations in your state immunization registry including the birth hepatitis B:
  - Enroll in *California Immunization Registry — CAIR* at **http://enroll.cairweb.org**.
- Documenting the immunizations (historic and current) within medical records and include:
  - 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.

Helpful tip for Flu

For children aged 6 months to 8 years who are receiving the flu vaccine for the first time, the CDC recommends 2 doses at least 4 weeks apart to provide the best protection from the flu.

Code your services correctly

Use these procedure codes to document immunizations for children from birth to 2 years of age. Add appropriate modifiers per coding guidelines when needed. Combo vaccines are ok.

Required by age 2	Immunization — individual vaccines listed but combo vaccines are okay	CPT— indicates administration	CVX— indicates manufacturer formulation
Four	DTaP - diphtheria, tetanus and acellular pertussis	90697, 90698, 90700, 90723	20, 50, 106, 107 **Combos:** 110, 120, 146
Three	IPV - polio	90697, 90698, 90713, 90723	10, 89 **Combos:** 110, 120, 146
One	MMR - measles, mumps and rubella	90707, 90710	03, 94
Three	Hib - haemophilus influenza type B	90644, 90647, 90648, 90697, 90698, 90748	17, 46, 47, 48, 49 **Combos:** 50, 51, 120, 146, 148
Three	Hep B - hepatitis B	90697, 90723, 90740, 90744, 90747, 90748	08, 44, 45 **Combos:** 51, 110, 146
One	VZV - varicella zoster (chicken pox)	90710, 90716	21 **Combo:** 94
Four	PCV - pneumococcal conjugate	90670	109, 133, 152
One	Hep A - hepatitis A	90633	31, 83, 85
Two or Three	Rotavirus (two-dose or three-dose)	**Two-dose:** 90681 **Three-dose:** 90680	**Two-dose:** 119 **Three-dose:** 116, 122

Two	Influenza - flu	90655, 90657, 90661, 90673, 90674, 90685, 90686, 90687, 90688, 90689, 90756	88, 140, 141, 150, 153, 155, 158, 161

The codes listed are HEDIS-specific; this information does not guarantee reimbursement.

Notes

COL: Colorectal Cancer Screening

The HEDIS measure looks at the percentage of members 45 to 75 years of age who had appropriate screening for colorectal cancer.

Documentation of any one of the following are acceptable to make the member compliant:

- Fecal occult blood test (FOBT) in the measurement year.
- FIT_DNA testing (Cologuard) in the measurement year or the two years prior.
- Flexible sigmoidoscopy in measurement year or the four years prior.
- Computed Tomography (CT) colonography in the measurement year or the four years prior.
- Colonoscopy in the measurement year or nine years prior.

Code your services correctly

Use the following diagnosis and procedure codes to document screenings for colorectal cancer.

Service	CPT	HCPCS	LOINC
Fecal Occult Blood Test	82270, 82274	G0328	12503-9, 12504-7, 14563-1, 14564-9, 12565-6, 2335-8, 27396-1, 27401-9, 27925-7, 27926-5, 29771-3, 56490-6, 56490-6, 56491-4, 57905-2, 58453-2, 80372-6
FIT-DNA Test	81528		77353-1, 77354-9
Flexible Sigmoidoscopy	45330-45335, 45337, 45338, 45340-45342, 45346, 45347, 45349, 45350	G0104	
CT Colonography	74261-74263		60515-4, 72531-7, 79069-1, 79071-7, 79101-2, 82688-3
Colonoscopy	44388-44394, 44397, 44401-44408, 45355, 45378-45393, 45398	G0105, G0121	

The codes listed are HEDIS-specific; this information does not guarantee reimbursement.

Helpful tips:

- Have reminders set in your system to alert your staff when a patient's screenings are due.
- Contact patients to remind them of upcoming appointments and necessary screenings.

Notes

CWP: Appropriate Testing for Pharyngitis

This HEDIS measure looks at the percentage of episodes for members 3 years and older where the member was diagnosed with pharyngitis, dispensed an antibiotic, and received a group A streptococcus (strep) test for the episode.

Background

Pharyngitis is the only condition among upper respiratory infections (URI) where diagnosis is validated easily and objectively through administrative and laboratory data, and it can serve as an important indicator of appropriate antibiotic use among all respiratory tract infections. Overuse of antibiotics has been directly linked to the prevalence of antibiotic resistance; Promoting judicious use of antibiotics is important to reducing levels of antibiotic resistance. Clinical practice guidelines recommend group A strep should be tested by a rapid antigen detection test and/or throat culture, and that patients who test positive should be treated with an appropriate antibiotic at an appropriate dose. Antibiotic overuse and inappropriate use has been observed in children with pharyngitis in the United States.

Telehealth allowance

Services provided during telephone visits, e-visits, and virtual check-ins are allowed for diagnosis of pharyngitis.

Notes

DEV: Developmental Screening in the First Three Years of Life

This CMS measure looks at the percentage of children screened for risk of developmental, behavioral and social delays using a standardized screening tool in the 12 months preceding or on their 1st, 2nd, or 3rd birthday.

Record your efforts

Documentation in the medical record must include all of the following:

- A note indicating the date on which the test was preformed.
- The standardized tool used (see tools that meet criteria below).
- Evidence of a screening result or screening score.

Developmental screening code
96110

Tools must meet the following criteria:

- Developmental domains: The following domains must be included in the standardized developmental screening tool: motor, language, cognitive, and social-emotional.
- Established Reliability: Reliability scores of approximately 0.70 or above.
- Established Findings Regarding the Validity: Validity scores for the tool must be approximately 0.70 or above. Measures of validity must be conducted on a significant number of children and using an appropriate standardized developmental or social-emotional assessment instrument(s).
- Established Sensitivity/Specificity: Sensitivity and specificity scores of approximately 0.70 or above.

The following tools are cited by Bright Futures (and the American Academy of Pediatrics statement on developmental screening) and meet the above criteria:

- *Ages and Stages Questionnaire (ASQ) — 2 months to age 5*
- *Ages and Stages Questionnaire — 3rd edition (ASQ-3)*
- *Battelle Developmental Inventory Screening Tool (BDI-ST) — birth to 95 months*
- *Bayley Infant Neuro-developmental Screen (BINS) — 3 months to age 2*
- *Brigance Screens-II — birth to 90 months*
- *Child Development Inventory (CDI) — 18 months to age 6*
- *Infant Development Inventory — birth to 18 months*
- *Parents' Evaluation of Developmental Status (PEDS) — birth to age 8*
- *Parent's Evaluation of Developmental Status — Developmental Milestones (PEDS-DM)*

The tools listed above are not specific recommendations for tools but are examples of tools cited in Bright Futures that have met the above criteria. In addition, new tools meeting these criteria may be developed and may be included in future versions of Bright Futures.

Notes

FUA: Follow-Up after ED Visit for Substance Abuse

The percentage of emergency department (ED) visits among members age 13 years and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow-up. The following rates are reported:

1. The percentage of ED visits for which the member received follow-up within 30 days of the ED visit
2. The percentage of ED visits for which the member received follow-up within 7 days of the ED visit

FUH: Follow-Up after Hospitalization for Mental Illness

The percentage of discharges for 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 provider. Two rates are reported:

1. The percentage of discharges for which the member received follow-up within 30 days after discharge.
2. The percentage of discharges for which the member received follow-up within 7 days after discharge.

FUI: Follow-Up after High-Intensity Care for Substance Use Disorder

The percentage of acute inpatient hospitalizations, residential treatment or withdrawal management visits for a diagnosis of substance use disorder among members 13 years of age and older that result in a follow-up visit or service for substance use disorder. Two rates are reported:

1. The percentage of visits or discharges for which the member received follow-up for substance use disorder within the 30 days after the visit or discharge.
2. The percentage of visits or discharges for which the member received follow-up for substance use disorder within the 7 days after the visit or discharge.

FUM: Follow-Up after Emergency Visit for Mental Illness

The percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness. Two rates are reported:

1. The percentage of ED visits for which the member received follow-up within 30 days of the ED visit
2. The percentage of ED visits for which the member received follow-up within 7 days of the ED visit

Helpful tips for FUA, FUH, FUI and FUM:

- Reach out to patients as soon as you are notified of their hospital visit to schedule a follow-up visit.
- Receiving timely information from hospitals can assist in faster follow-up. Consider utilizing your health information exchange (HIE) to gain information on discharges or by working collaboratively with hospitals to obtain data exchange reports on your patients seen in the hospital for better care coordination.

Background

The specifications for these measures are consistent with guidelines of the National Institute of Mental Health and the Centers for Mental Health Services. Many individuals are affected by a serious mental illness (SMI).

It is important to provide regular follow-up therapy to patients after they have been hospitalized for mental illness. An outpatient visit with a mental health practitioner after discharge is recommended to make sure that the patient's transition to the home or work environment is supported and that gains made during hospitalization are not lost. It also helps health care providers detect early post-hospitalization reactions or medication problems and provide continuing care.

Notes

IHA: Initial Health Appointment

All Anthem members enrolled in Medi-Cal are required to have an initial health appointment (IHA) within 120 days of Plan enrollment. The IHA for members under age 21 conform to the most recent American Academy of Pediatricians (AAP) periodicity schedule and Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services. The IHA promotes member health by establishing a medical home and leveraging culturally and linguistically appropriate primary care to improve health care disparities. The IHA is a complete medical history, head-to-toe physical examination and assessment of health behaviors.

Record your efforts

The IHA should include, but is not limited to the following specific screenings:

- A comprehensive history
- Comprehensive physical exam
- Past medical history
- Developmental screening
- Dental Screening/oral health assessment
- Preventive services
- Diagnosis and plan of care

Individual Health Education Behavior Assessment (IHEBA) and Staying Healthy Assessment (SHA): The IHEBA/SHA were retired on January 1, 2023. As a result, all screenings and assessments addressed by completing a SHA are to be completed by the PCP using standardized assessment tools, in a culturally and linguistically appropriate manner that seek to define the member's risk factors and problems; determine a member's needs, preferences, health goals and priorities; and aid in the development of treatment recommendations, referrals and follow-up as documented in the medical record.

PCPs are required to review their monthly eligibility list available on Availity* or provided by their primary medical group/independent practice association and proactively contact their assigned members to make an appointment for an IHA within the following time:

- All members must have an IHA within 120 days of enrollment.
- The PCP's office is responsible for documenting all attempts to contact assigned members. Members medical records must reflect the reason for any delays in performing the IHA including any refusals by the member to have the exam or member's failure to attend a scheduled appointment.

An IHA is **not** necessary under the following conditions:

- If the new member is an existing patient of the PCP with an established medical record showing baseline health status. The records must include a documented IHA within the past 12 months prior to the member's enrollment and sufficient information for the PCP to provider treatment.
- If the new member is not an existing patient, transferred medical records can also meet the requirements for an IHA if a completed health history is included.
- If the new member refuses an IHA. The refusal must be documented in the member's medical record.

Code your services correctly

The list of codes may be found on the Anthem Provider Portal at:
https://providers.anthem.com/california-provider/home

The codes listed in the Anthem Provider Portal are informational only; this information does not guarantee reimbursement.

Telehealth Allowance

Components of well visits that may be offered through telehealth include:

Visual Physical Exam	Mental Development	Anticipatory Guidance
Health History	BMI Assessment	
Physical Development	Nutrition Counseling	ACEs Screening
Developmental Screening	Exercise Counseling	

*A follow up in-person visit should be scheduled when appropriate to finish additional well visit components.

IMA: Immunizations for Adolescents

This HEDIS measure looks at children/adolescents both male and female 9 to 12 years of age who received the following immunizations by their 13th birthday.

Immunization
Meningococcal serogroups A, C, W or Y
Tdap
HPV

Record your efforts

Once you give patients their needed immunizations, let us and the state know by:

- Recording the immunizations in your state immunization registry.
  - Enroll in *California Immunization Registry — CAIR* at **http://enroll.cairweb.org**.
- Documenting the immunizations (historic and current) within medical records and include documented history of illness or seropositive test result.
- Ensuring there are at least 146 days between the first and second dose if administering two-dose HPV vaccine.
- Paying special attention to age ranges for immunizations.

Code your services correctly

Use these procedure codes to document immunizations for children/adolescents 9 to 12 years of age who received the following immunizations by their 13th birthday. Add appropriate modifiers per coding guidelines when needed.

Immunization	CPT	CVX	Dose	Age
Meningococcal	90619, 90733, 90734	32, 108, 114, 136, 147, 167, 203	1	Ages 11 to 12
Tdap	90715	115	1	Ages 10 to 12
HPV (male and female adolescents)	90649, 90650, 90651	62, 118, 137, 165	2 or 3	Ages 9 to 12

The codes listed are HEDIS-specific; this information does not guarantee reimbursement.

Helpful tips:

- If you use EMR, create a flag to track patients due for immunizations.
- Develop or implement standing orders for nurses and physician assistants in your practice to allow staff to identify opportunities to immunize.
- Check all of your 11 year olds to make sure they are on track to complete the series.

Notes

KED: Kidney Health Evaluation for Patients with Diabetes

This measure evaluates members 18 to 85 years of age with diabetes (type 1 and type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) ***and*** a urine albumin-creatinine ratio (uACR), during the measurement year.

Exclusions:

- Members with evidence of ESRD
- Dialysis
- Member who did not have a diagnosis of diabetes in any setting during the measurement year or the year prior to the measurement year and had a diagnosis of polycystic ovarian syndrome, gestational diabetes or steroid induced diabetes in any setting during the measurement year
- Members receiving palliative care
- Members 66 years of age and with frailty and advanced illness. Members must meet BOTH of the following frailty and advanced illness criteria to be excluded:
    - At least two indications of frailty
    - At least two outpatient visits with an advanced illness diagnosis
- Members in hospice or using hospice services anytime during the measurement year
- Members who died during the measurement year

Service	CPT	Logical Observation Identifiers Names and Codes (LOINC)
Estimated Glomerular Filtration Rate Lab Tes	80047, 80048, 80050, 80053, 80069, 82565	48642-3, 48643-1, 50044-7, 50210-4, 50384-7, 62238-1, 69405-9, 70969-1, 77147-7, 88293-6, 88294-4, 94677-2, 96591-3, 96592-1
Urine Albumin Creatinine Ration Lab Test		13705-9, 14958-3, 14959-1, 30000-4, 32294-1, 44292-1, 59159-4, 76401-9, 77253-3, 77254-1, 89998-9, 9318-7
Urine Creatinine Lab Test	82570	20624-3, 2161-8, 35674-1, 39982-4, 57344-4, 57346-9, 58951-5
Quantitative Urine Albumin Lab Test	82043	14957-5, 1754-1, 21059-1,30003-8, 43605-5, 53530-2, 53531-0, 57369-1, 8999-7

Note: The Logical Observation Identifiers Names and Codes (LOINC) are for reporting clinical observations and laboratory testing. The codes listed are informational only; this information does not guarantee reimbursement.

Helpful tip:

- If utilizing an EMR system, consider electronic data sharing with your health plan to capture all coded elements. Contact your Anthem representative for additional details and questions.

How can we help?

We help you meet this benchmark by:

- Offering current *Clinical Practice Guidelines* on our provider self-service website.
- Helping identify community resources, such as health education classes that may be available in your area.
- Members may be eligible for transportation assistance at no cost, contact Member Services for arrangement.

Notes

LBP: Use of Imaging Studies for Low Back Pain

The percentage of members 18 to 75 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.

Background

This measure assesses whether imaging studies (plain x-ray, MRI, CT scan) are overused to evaluate members with low back pain.

Clinical guidelines for treating patients with acute low back pain strongly recommend against the use of imaging in the absence of *red flags* (for example, indications of a serious underlying pathology such as a fracture or tumor). Unnecessary or routine imaging is problematic because it is not associated with improved outcomes and exposes patients to unnecessary harms such as radiation exposure and further unnecessary treatment.
There is no compelling evidence to justify substantial deviation from the diagnostic strategy published in clinical guidelines, which indicate that for most patients with low back pain, diagnostic imaging is usually unnecessary. Although patients may have a perceived need for imaging studies, efforts to educate patients on appropriate indications for imaging are within a provider's capacity. Organizations can provide information, best-care practice models, and other support to providers, imaging centers, and members to increase knowledge and ensure that imaging studies are used appropriately for evaluation of lower back pain patients, based on the duration of symptoms and the presence of red flags.

Notes

Opioid Use Measure Management

The morbidity and mortality associated with opioid use has reached epidemic proportions, and is recognized by the Centers for Disease Control and Prevention, the Surgeon General and the White House as a significant public health problem in the U.S. Prescription opioid pain relievers cause nearly three out of four prescription drug overdoses. The age-adjusted prescription opioid mortality rate has nearly quadrupled from 1999 to 2011. Although prescription opioids are appropriate components of a pain management treatment plan for certain conditions there is limited evidence demonstrating the long-term beneficial effects of opioid use for chronic pain management for nonterminal conditions. In addition, long-term daily use of opioids can lead to increased tolerance, addiction or dependence.

Five Opiod Management Measures reported: (**Note:** A lower rate indicates better performance for all measures)

COU: Risk of Continued Opioid Use

The percentage of members 18 years of age and older who have a new episode of opioid use that puts them at risk for continued opioid use. Two rates are reported:

1. The percentage of members with at least 15 days of prescription opioids in a 30-day period.
2. The percentage of members with at least 31 days of prescription opioids in a 62-day period.

HDO: Use of Opioids at High Dosage

The proportion of members 18 years and older who received prescription opioids at a high dosage (average morphine milligram equivalent dose ≥ 90) for ≥ 15 days during the measurement year.

POD: Pharmacotheraphy for Opioid Use Disorder

The percentage of opioid use disorder (OUD) pharmacotherapy events that lasted at least 180 days among members 16 years of age and older with a diagnosis of OUD and a new OUD pharmacotherapy event.

UOP: Use of Opioids From Multiple Providers

The proportion of members 18 years and older, receiving prescription opioids for ≥15 days during the measurement year who received opioids from multiple providers. Three rates are reported:

1. *Multiple Prescribers*: Receiving prescriptions for opioids from four or more different prescribers
2. *Multiple Pharmacies*: Receiving prescriptions for opioids from four or more different pharmacies
3. *Multiple Prescribers and Multiple Pharmacies*: Receiving prescriptions for opioids from four or more prescribers **and** four or more pharmacies during the measurement year.

Notes

PCE: Pharmacotherapy Management of COPD Exacerbation

This HEDIS measure looks at the percentage of COPD exacerbations for members 40 years of age and older who had an acute impatient discharge or ED visit on or between January 1 to November 30 of the measurement year and who were dispensed appropriate medications. There are two rates that are reported:

1. Dispensed a systemic corticosteroid (or there was evidence of an active prescription) within 14 days of the event.
2. Dispensed a bronchodilator (or there was evidence of an active prescription) within 30 days of the event.

Background

Exacerbations may be the most significant drivers of negative impacts on a COPD patient. Patients experiencing exacerbations are at higher risk for repeat exacerbations, more rapid decline in lung function, and reduced exercise capacity and these effects are more pronounced for patients with severe COPD. In addition to physical effects, COPD exacerbations result in reduced quality of life and ability to conduct activities of daily living independently. Proper therapy following an exacerbation, including pharmacotherapy, can slow disease progression and reduce the risk of future exacerbations.

Notes

PCR: Plan All-Cause Readmissions

This HEDIS measure looks at 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 and the predicted probability of an acute readmission in members 18 years of age and older.

Helpful tips:

- Schedule an appointment with your patient immediately upon notification of an acute inpatient discharge or ED visit.
- Assure that medical records reflect documentation of your review of the discharge summary along with the discharge medications.
- Schedule regular follow-up visits with the patient:
    - Have your office staff call the patient prior to the visit to confirm.

Notes

PPC: Prenatal and Postpartum Care

This HEDIS measure looks at the percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year. The measure then assesses the following facets of prenatal and postpartum care:

- **Prenatal care:** the percentage of pregnant patients who received at least one prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment
- **Postpartum care:** the percentage of patients who had a postpartum visit on or between 7 and 84 days after delivery

Record your efforts

Make sure your medical records and care reflects the following:

Prenatal care visit during the first trimester:

Prenatal care visit must be on or before the enrollment start date or within 42 days of enrollment. Documentation must include the visit date by OB/GYN or PCP with diagnosis of pregnancy and evidence of **one** of the following:

- Documentation indicating the woman is pregnant or references to the pregnancy, for example:
  - Documentation in a standardized prenatal flow sheet, or;
  - Documentation of LMP, EDD or gestational age, or;
  - A positive pregnancy test result, or;
  - Documentation of gravidity or parity, or;
  - Documentation of complete obstetrical history, or;
  - Documentation of prenatal risk assessment and counseling/education.
- A basic physical obstetrical examination by OB/GYN or PCP, including one of the following:
  - Auscultation for fetal heart tone.
  - Measurement of fundus height.
  - Pelvic exam with obstetric observations.
- Prenatal care procedure, such as any of the following:
  - Screening test/obstetric panel.
  - TORCH antibody panel alone.
  - A rubella antibody test/titer with an Rh incompatibility (ABO/Rh) blood typing.
  - Ultrasound/echography of pregnant uterus.

Postpartum care visit

The postpartum checkup date must be on or between 7 and 84 day post-delivery. Documentation must indicate visit date and evidence of at least **one** of the following:

- Pelvic exam.
- Evaluation of weight, blood pressure, breasts (or note of breastfeeding), and abdomen.
- Notation of postpartum care (for example, postpartum care, six-week check-up).
- Perineal or cesarean incision/wound check.
- Screening for depression, anxiety, tobacco use, substance use disorder, or mental health disorders.
- Glucose screening for women with gestational 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.
  - Attainment of healthy weight.

Notes

PPC: Prenatal and Postpartum Care Con't

Please remember:

- Call patients to schedule the postpartum visits as well as remind them of their appointment.
- Follow up with patients who miss appointments and reschedule.
- Document completely on the ACOG sheets (or similar) and include fundal height.

Code your services correctly

Local Codes	Service definition	Billing rules
Z1032	Initial pregnancy-related office visit	One time only
Z1032 with the ZL modifier	Use if initial pregnancy-related office visit is within the first 16 weeks of gestation	One time only
Z1034	Antepartum follow-up visit (nonglobal), subsequent to the initial pregnancy-related office visit, per visit billing	2nd to 13th visit (Bill each visit separately)
Z1038	Postpartum: one follow-up office visit (nonglobal)	One time only

Most common codes for a PCP or OB/GYN to meet compliance

Bill with regular evaluation and management codes as appropriate.

	ICD-10-CM	CPT	Local codes
Prenatal	Z32.01, Z34.0 to Z34.93 pregnancy code along with a CPT office visit code	99202-99205, 99211-99215, 99241-99245, 99483, 99500	Z1032, Z1034
Postpartum	Z01.411, Z01.419, Z01.42, Z30.430, Z39.1, Z39.2	57170, 58300, 59430, 99501	Z1038

Telehealth allowance

Services provided during telephone visits, e-visits, and virtual check-ins are allowed.

Notes

SDOH: Social Drivers of Health Data Collection

Population Health Management (PHM) is an initiative of CalAIM that identifies and manages member risk and need through whole person care approaches while focusing on and addressing Social Drivers of Health (SDOH). DHCS recognizes that consistent and reliable collection of SDOH data is vital to the success of CalAIM's PHM initiative. While the DHCS encounter data system accepts and allows for MCPs to use all ICD-10-CM Z55-Z65 SDOH codes, DHCS seeks to prioritize the use of a set of pertinent SDOH codes to maximize the capture of actionable SDOH data. To advance improvements, DHCS is providing guidance on collecting SDOH data to support PHM and overcome the challenges of collecting SDOH data.

DHCS is issuing the list of 24 DHCS Priority SDOH Codes and expects providers to incorporate these codes into required applicable medical coding in a manner consistent with federal and state requirements and guidance. Encounter data must be submitted through the existing encounter data reporting mechanisms.

DHCS priority SDOH codes

Code	Description
Z55.0	Illiteracy and low-level literacy
Z59.0	Homelessness
Z59.1	Inadequate housing (lack of heating/space, unsatisfactory surroundings)
Z59.3	Problems related to living in residential institution
Z59.4	Lack of adequate food and safe drinking water
Z59.7	Insufficient social insurance and welfare support
Z59.8	Other problems related to housing and economic circumstances (foreclosure, isolated dwelling, problems with creditors)
Z60.2	Problems related to living alone
Z60.3	Acculturation difficulty (migration, social transplantation)
Z60.4	Social exclusion and rejection (physical appearance, illness or behavior)
Z62.21	Child in welfare custody (non-parental family member, foster care)
Z62.810	Personal history of physical and sexual abuse in childhood
Z62.811	Personal history of psychological abuse in childhood
Z62.812	Personal history of neglect in childhood
Z62.819	Personal history of unspecified abuse in childhood
Z62.820	Parent-biological child conflict
Z63.0	Problems in relationship with spouse or partner
Z63.4	Disappearance & death of family member (assumed death, bereavement)
Z63.5	Disruption of family by separation and divorce (marital estrangement)
Z63.6	Dependent relative needing care at home
Z63.72	Alcoholism and drug addiction in family
Z65.1	Imprisonment and other incarceration
Z65.2	Problems related to release from prison
Z65.8	Other specified problems related to psychosocial circumstances (religious or spiritual problem)

SPC: Statin Therapy for Patients with Cardiovascular Disease

This HEDIS measure looks at the percentage of males 21 to 75 years of age and females 40 to 75 years of age during the measurement year, who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and met the following criteria. The following rates are reported:

1. Received Statin Therapy – Members who were dispensed at least one high-intensity or moderate-intensity statin medication during the measurement year.
2. Statin Adherence 80% – Members who remained on a high-intensity or moderate-intensity statin medication for at least 80% of the treatment period.

Background

Cardiovascular disease is the leading cause of death in the United States. More than 121 million American adults have one or more types of cardiovascular disease. Statins are among the most commonly prescribed medications in the United States. According to recent blood cholesterol treatment guidelines from the American College of Cardiology and American Heart Association (ACC/AHA), statins of moderate or high intensity are recommended for adults with established clinical ASCVD. Many studies support the use of statins to reduce ASCVD events in primary and secondary prevention.

Telehealth allowance

Services provided during telephone visits, e-visits, and virtual check-ins are allowed for identifying the event/diagnosis.

Notes

SPD: Statin Therapy for Patients with Diabetes

This HEDIS measure looks at the percentage of members 40 to 75 years of age during the measurement year with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) who met the following criteria. The following rates are reported:

1. Received Statin Therapy – Members who were dispensed at least one statin medication of any intensity during the measurement year.
2. Statin Adherence 80% – Members who remained on a statin medication of any intensity for at least 80% of the treatment period.

Background

Patients with diabetes have elevated cardiovascular risk due in part to elevations in unhealthy cholesterol levels. Primary prevention for cardiovascular disease is an important aspect of diabetes management. The risk of an adult with diabetes developing cardiovascular disease is two to four times higher than that of an adult without diabetes. In addition to being at a higher risk for developing cardiovascular disease, patients with diabetes tend to have worse survival after the onset of cardiovascular disease.

The use of statins for primary prevention of cardiovascular disease in patients with diabetes, based on their age and other risk factors, is recommended by guidelines from the American Diabetes Association (ADA) and the American College of Cardiology/American Heart Association (ACC/AHA).

Telehealth allowance

Services provided during telephone visits, e-visits, and virtual check-ins are allowed for identifying the event/diagnosis.

Notes

SAA: Adherence to Antipsychotic Medications for Schizophrenia

This HEDIS measure looks at the percentage of members 18 years of age and older during the measurement year with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.

Background

For people with schizophrenia, nonadherence to treatment with antipsychotics is common, and medication nonadherence is a significant cause of relapse. Measuring antipsychotic medication adherence may lead to less relapse and fewer hospitalizations. Additionally, there is potential to lead to interventions to improve adherence and help close the gap in care between people with schizophrenia and the general population.

Telehealth allowance

Services provided during telephone visits, e-visits, and virtual check-ins are allowed for event/diagnosis.

Notes

SSD: Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are using Antipsychotic Medications

The percentage of members 18 to 64 years of age with schizophrenia, schizoaffective disorder, or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year. Members that already have a diagnosis of diabetes will be excluded from this measure.

The diabetes screening tests due annually are:

- A glucose test or an HbA1c test performed during the measurement year.

Background

People with schizophrenia are at greater risk of metabolic syndrome due to their serious mental illness. Diabetes screening is important for anyone with schizophrenia or bipolar disorder, and the added risk associated with antipsychotic medications contributes to the need to screen people with schizophrenia for diabetes. Diabetes screening for individuals with schizophrenia or bipolar disorder who are prescribed an antipsychotic medication may lead to earlier identification and treatment of diabetes.

Telehealth allowance

Telephone visits, e-visits, and virtual check-ins to identify members with schizophrenia or bipolar disorder are allowed. Diabetes diagnosis may be from a telephone visit, e-visit, or virtual check-in which will exclude the member from the measure.

Notes

TFL-CH: Topical Fluoride for Children

This HEDIS measure looks at the percentage of members 1 to 4 years of age who received at least two fluoride varnish applications during the measurement year.

Record your efforts:

- Two or more fluoride varnish applications on different dates of services

Exclusions:

- Members in hospice or using hospice services anytime during the measurement year
- Members who died during the measurement year

Codes to identify lead test:

Services	CPT	CDT
Application of Fluoride Varnish	99188	D1206

*The codes listed are informational only; this information does not guarantee reimbursement.

Helpful tips:

- If utilizing an EMR system, consider electronic data sharing with your health plan to capture all coded elements.

How can we help?

- Offering current Clinical Practice Guidelines on our provider self-service website
- Members may be eligible for transportation assistance at no cost, contact Member Services for arrangement.

Notes

URI: Appropriate Treatment for Upper Respiratory Infection

The percentage of episodes for members 3 months of age and older with a diagnosis of upper respiratory infection (URI) that did not result in an antibiotic dispensing event.

Background

The common cold (or URI) is a frequent reason for patients visiting the doctor's office. Though existing clinical guidelines do not support the use of antibiotics for the common cold, physicians often prescribe them for this ailment. This measure calculates the percentage of episodes among members 3 months of age and older with a diagnosis of upper respiratory infection (URI) that did not result in an antibiotic dispensing event.

Clinical practice guidelines do not recommend antibiotics for majority of upper respiratory tract infections because of the viral etiology of these infections, including the common cold. A performance measure of antibiotic use for URI sheds light on the prevalence of inappropriate antibiotic prescribing in clinical practice and raises awareness of the importance of reducing inappropriate antibiotic use to combat antibiotic resistance in the community.

Notes

W30: Well-Child Visits in the First 30 Months of Life

This HEDIS measure looks at two different age ranges: patients who turned 15 months old during the measurement year and who had at least six well-child visits with a PCP during their first 15 months of life and patients who turned 30 months old during the measurement year and who had at least two well-child visits with a PCP between 15 and 30 months of age.

Documentation of PCP visit must include all five of the following:

1. **A health history:** Health history can include but is not limited to, past illness (or lack of illness), surgery, or hospitalization and family health history.
2. **A physical developmental history:** Physical developmental history assesses specific age-appropriate physical growth developmental milestones.
3. **A mental developmental history:** Mental developmental history assesses specific age-appropriate mental growth developmental milestones.
4. **A physical exam:** evaluation of two or more body systems.
5. **Health education/anticipatory guidance:** The health care provider gives health education/ anticipatory guidance to parents or guardians in anticipation of emerging issues.

Record your efforts:

- Follow the American Academy of Pediatrics recommendations for preventive pediatric health care periodicity schedule for well visits and services (**http://www.aap.org**) and Bright Futures guidelines for health supervision (**www.brightfutures.org**).
- Complete a full exam with all five components listed above during intermediate visits if member has not had one of their six well-child visits; This may be the opportunity for your patient to get the required number of health checks before 15 months of age.
- Document each well visit in the patient's medical record. Be sure to document any advice given.

Code your services correctly

Use the following diagnosis and procedure codes to document comprehensive well-child visits:

CPT	ICD-10	HCPCS
99381, 99382, 99391, 99392, 99461	Z00.110, Z00.111, Z00.121, Z00.129, Z00.2, Z76.1, Z76.2	G0438, G0439, S0302

The codes listed are HEDIS-specific; this information does not guarantee reimbursement.

Telehealth allowance

Components of well-child visits that may be offered through telehealth include:

Visual Physical Exam	Mental Development	Anticipatory Guidance
Health History	BMI Assessment	Age-appropriate SHA/IHEBA
Physical Development	Nutrition Counseling	ACEs Screening
Developmental Screening	Exercise Counseling	

*A follow up in-person visit should be scheduled when appropriate to finish well-child visit components.

WCV: Child and Adolescent Well-Care Visits

This HEDIS measure looks at patients 3 to 21 years of age who had one or more comprehensive well child visits with a PCP or an OB/GYN during the year.

Documentation of PCP or OB/GYN visit must include all five of the following:

1. **A health history:** Health history can include but is not limited to, past illness (or lack of illness), surgery or hospitalization and family health history.
2. **A physical developmental history:** Physical developmental history assesses specific age-appropriate physical growth developmental milestones.
3. **A mental developmental history:** Mental developmental history assesses specific age-appropriate mental growth developmental milestones.
4. **A physical exam:** evaluation of two or more body systems.
5. **Health education/anticipatory guidance:** The health care provider gives health education/ anticipatory guidance to parents or guardians in anticipation of emerging issues.

Record your efforts:

- Follow the American Academy of Pediatrics recommendations for preventive pediatric health care periodicity schedule for well visits and services (**http://www.aap.org**) and Bright Futures guidelines for health supervision (**www.brightfutures.org**).
- Complete a full exam with all five components listed above during intermediate visits if member has not had their well-child visit yet in the calendar year.
- Document each well visit in the patient's medical record. Be sure to document any advice given.

Code your services correctly

Use the following diagnosis and procedure codes to document comprehensive well-child visits:

CPT	ICD-10	HCPCS
99382, 99383, 99384, 99385, 99392, 99393, 99394, 99395	Z00.00, Z00.01, Z00.121, Z00.129, Z00.2, Z00.3, Z01.411, Z01.419, Z02.5, Z76.1, Z76.2	G0438, G0439, S0302, S0610, S0612, S0613

The codes listed are HEDIS-specific; this information does not guarantee reimbursement.

Telehealth allowance

Components of well-child visits that may be offered through telehealth include:

Visual Physical Exam	Mental Development	Anticipatory Guidance
Health History	BMI Assessment	Age-appropriate SHA/IHEBA
Physical Development	Nutrition Counseling	ACEs Screening
Developmental Screening	Exercise Counseling	

*A follow up in-person visit should be scheduled when appropriate to finish well-child visit components.

Notes

WCC: Weight Assessment and Counseling for Children/Adolescents

This HEDIS measure looks at patients 3 to 17 years of age who had one or more outpatient visit with PCPs or OB/GYNs during the year and documented evidence of weight assessment including:

- Height, weight and BMI percentile (not BMI value).

Record your efforts

Document BMI percentile. Reflect the following in your records:

- Height and weight.
- BMI percentile documented or plotted on an appropriate CDC BMI-for-age-growth chart.

Code your services correctly

The BMI codes below may only be billed with a clinically associated diagnosis per ICD coding guidelines.

Use the following diagnosis and procedure codes to document weight assessment:

Description	ICD-10
BMI percentile	Z68.51, Z68.52, Z68.53, Z68.54

The codes listed are HEDIS-specific; this information does not guarantee reimbursement.

Telehealth allowance

Member-collected biometric values (height, weight, BMI percentile) are allowed if the information is collected by a primary care practitioner. The information must be recorded, dated and maintained in the member's legal health record.

Helpful tips

Consider updating the Electonic Health Records to calculate BMI Percentile every time height and weight is measured.

Notes

Thank you for your partnership with Anthem to uphold our commitment to quality care.


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