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<td>E</td>
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Welcome

Welcome to Molina's Healthcare Effectiveness Data and Information Set (HEDIS®) Provider Guide and Toolkit. Developed by the National Committee for Quality Assurance, HEDIS® is a widely used set of performance measures in the managed care industry, and an essential tool in ensuring that our members are getting the best healthcare possible. Thus, it is vitally important that our providers understand the HEDIS® specifications and guidelines.

Our mission is to provide quality health services to financially vulnerable families and individuals covered by government programs, and we want to do everything we can do to make this process as easy as possible. This guide is intended to be an easy-to-follow reference that covers all of the HEDIS® measures applicable to Medicaid (Apple Health), Medicare and Marketplace, while also providing other tips to help you focus on your work.

We understand that HEDIS® specifications can be complex, so we have designed this guide to clearly define Molina's criteria for meeting HEDIS® guidelines. We welcome your feedback and look forward to supporting all your efforts to provide quality healthcare to our members.

About Molina:

Molina Healthcare of Washington is active in 37 of the 39 Washington counties, with over 660,000 members. The National Committee for Quality Assurance (NCQA) has awarded Molina with the rating of Commendable, as an organization with well-established programs for service and clinical quality that meets rigorous requirements for consumer protection and quality improvement for our Medicaid members.

Quality is improving access, removing barriers, providing a positive customer services experience, and delivering preventative and diagnostic care.

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
How to Use This Guide

This guide is comprised of four sections:

**Section 1: Molina Healthcare Resources – The support you need to focus on your work**

This section provides a brief summary of key services offered by Molina Healthcare including links and contact information. Additional information on these valuable resources is available on MolinaHealthcare.com and in your Molina Healthcare Provider Manual.

**Section 2: Partnering with Molina to Promote and Measure Quality**

This section includes an overview on the processes of the HEDIS®, Medicare Star and Health Outcome Survey Programs, and how Molina will collaborate with you to promote and measure quality health care services.

An overview of the Molina Medicaid Incentive Programs will assist you in educating patients about the rewards associated with obtaining critical preventative and disease management care in a timely fashion. Based on key HEDIS® measures, the Incentive Program includes rewards for pediatric preventative and immunization services, breast cancer screening, prenatal and postpartum care and diabetes management.

**Section 3: Procedure and Diagnosis Coding in HEDIS®: Tips and Resources**

This section focuses on two areas of frequent provider questions; The ICD-10-CM transition and Modifier 25 usage as it applies to Preventative and Acute Care services performed at the same encounter. This information supplements the coding tips referenced in Section 4.

**Section 4: HEDIS® & Other Tips by Measure**

This section includes a description of each HEDIS® measure, the correct billing codes to support services rendered and tips to improve your HEDIS® scores.

The “Tips” section of each measure also includes specific resources and tools available to you that correspond with that measure. References include:

- Clinical Practice Guidelines (CPG) associated with the measure
- Patient education materials
- Molina Member Incentive Programs relevant to the measure
- Care and Disease Management opportunities for certain diagnoses
- HCC Pearls: Coding and documentation tips to help you accurately represent your patient’s conditions and ensure appropriate Risk Adjustment classification.
- Links to tools such as BMI Charts, Prenatal and Postpartum Calendar Calculators and the HEP (ACE) exam template
SECTION 1:
MOLINA HEALTHCARE RESOURCES

What can we do for you?
# Molina Healthcare of Washington Provider Contacts

## PROVIDER INFORMATION FOR MEDICAID/MEDICARE

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Phone Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prior Authorizations: Medical/Behavioral Health</strong></td>
<td>(800) 869-7185 Fax: (800) 767-7188</td>
</tr>
<tr>
<td><strong>24 Hour Nurse Advice Line:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>English:</strong></td>
<td>(888) 275-8750 (TTY: 1-866/735-2929)</td>
</tr>
<tr>
<td><strong>Spanish:</strong></td>
<td>(866) 648-3537 (TTY: 1-866/833-4703)</td>
</tr>
<tr>
<td><strong>Radiology, NICU, Transplant Authorizations:</strong></td>
<td>(855) 714-2415 Fax: (877) 731-7218</td>
</tr>
<tr>
<td><strong>Vision Care:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Phone:</strong></td>
<td>(888) 493-4070 Fax: (866) 772-0285</td>
</tr>
<tr>
<td><strong>Transportation:</strong></td>
<td></td>
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<tr>
<td><strong>Covered by Apple Health.</strong></td>
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<tr>
<td>A list of brokers can be found at</td>
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<tr>
<td>Click on “Regional Broker.”</td>
<td></td>
</tr>
<tr>
<td><strong>Pharmacy Authorizations:</strong></td>
<td>(800) 869-7185 Fax: (800) 869-7791</td>
</tr>
<tr>
<td><strong>Dental:</strong></td>
<td>(800) 869-7185 Fax: (866) 772-0285</td>
</tr>
<tr>
<td><strong>Provider Customer Service:</strong></td>
<td>(888) 858-5414 Fax: (877) 814-0342</td>
</tr>
<tr>
<td><strong>Covered by Apple Health.</strong></td>
<td></td>
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<tr>
<td>A list of dental providers and more information on dental benefits is available at <a href="http://www.hca.wa.gov/medicaid/dentalproviders/">http://www.hca.wa.gov/medicaid/dentalproviders/</a> Documents/AdultDentalCoverage.pdf, or you can call HCA for more information at (800) 562-3022.</td>
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## PROVIDER INFORMATION FOR MARKETPLACE

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<td>(866) 648-3537 (TTY: 1-866/833-4703)</td>
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<tr>
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<td></td>
</tr>
<tr>
<td><strong>Phone:</strong></td>
<td>(800) 869-7185 Fax: (866) 767-7188</td>
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**Available features include:**

- Electronic authorization submission and status through Clear Coverage application with potential for automatic approval at the time of submission: [https://eportal.molinahealthcare.com/Provider/Login](https://eportal.molinahealthcare.com/Provider/Login)
- Claims submission and status
- Member Eligibility
- Provider Directory
- Download Frequently used Forms
- Nurse Advice Line Report

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Providers may utilize Molina Healthcare’s ePortal at: [MolinaHealthcare.com](http://MolinaHealthcare.com)
### MEMBER INFORMATION FOR MEDICAID

<table>
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<tr>
<th><strong>Member Customer Service Benefits/Eligibility:</strong></th>
<th><strong>Transportation:</strong></th>
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</thead>
<tbody>
<tr>
<td>Phone: (800) 869-7165 TTY/TDD 711</td>
<td>Phone: (800) 869-7185 Fax: (800) 767-7188</td>
</tr>
<tr>
<td>Fax: (800) 816-3778</td>
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**24 Hour Nurse Advice Line:**

- **English:** 1 (888) 275-8750
- **Spanish:** 1 (888) 648-3537

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### MEMBER INFORMATION FOR MEDICARE

**MEDICARE SERVICE AREA:** KING, PIERCE, SKAGIT, SNOHOMISH, SPOKANE, STEVENS, WHATCOM, WHITMAN

<table>
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<tr>
<th><strong>Member Customer Service Benefits/Eligibility:</strong></th>
<th><strong>Non-Molina Medicare members can get information:</strong></th>
</tr>
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<tbody>
<tr>
<td>Phone: (800) 665-1029</td>
<td>Phone: (866) 403-8293</td>
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**24 Hour Nurse Advice Line:**

- **English:** 1 (888) 275-8750
- **Spanish:** 1 (866) 648-3537

**Transportation:**

- Reservations: (866) 475-5423
- Ride Assist: (866) 474-5331

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### MEMBER INFORMATION FOR MARKETPLACE

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<th><strong>Member Customer Service Benefits/Eligibility:</strong></th>
<th><strong>Transportation:</strong></th>
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<tr>
<td>Phone: (888) 858-3492 Fax: (800) 816-3778</td>
<td>Phone: (888) 858-3492 Fax: (800) 767-7188</td>
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</tbody>
</table>

**24 Hour Nurse Advice Line:** English: 1 (888) 275-8750 Spanish: 1 (866) 648-3537

**My Molina allows members to manage their health care online at MyMolina.com**

**Benefits of registering for My Molina**

- Check your doctor
- Check your eligibility
- View service history
- Request and print your ID Card
- Update your contact information
- Get health reminders on services you need
Case Management Program

Molina Healthcare provides a comprehensive Case Management (CM) program to all members who meet criteria for services. The CM program focuses on procuring and coordinating the care, services and resources needed by members with complex issues through a continuum of care. Molina Healthcare adheres to Case Management Society of America Standards of Practice Guidelines in its execution of urgent needs or significant findings.

The CM program is individualized to accommodate a member’s needs with collaboration and approval from the member’s PCP. The Molina Healthcare case manager will arrange individual services for members whose needs include on-going medical care, home health care, rehabilitation services and preventative services including:

- Access to eligible services
- Assistance with appointments and tests
- Transportation services through Health Care Authority
- Identifying gaps in care or health care needs
- Access resources to help members with special health care needs and/or help their caregivers deal with day-to-day stress
- Help with discharge planning
- Assessing eligibility for ongoing care services and support
- Connection with community resources
- Findings services to fill in for non-covered benefit needs (this includes community and social services programs)
- Coordinating services with a PCP, family members, caregivers, representatives and any other providers

Referral to Case Management:

Members with the following high-risk medical conditions may be referred by their PCP or specialty care provider to the CM program for evaluation:

- High risk pregnancy, including members with a history of a previous preterm delivery
- Catastrophic medical conditions (e.g. neoplasm, organ/tissue transplants)
- Chronic illness (e.g. asthma, diabetes, End Stage Renal Disease)
- Preterm births
- High-technology home care requiring more than two weeks of treatment
- Member accessing ER services inappropriately
- Children with Special Health Care Needs, including request for Autism Assessment or ABA Therapy

Referral to the CM program may be made by contacting Molina Healthcare at:

Phone: (800) 869-7165      Fax: (800) 767-7188

Online Referral Form: Refer to Molina of Washington Care Management Referral Form
Date: ____________________

Referral Source Information
Person Making Referral: ____________________ Office Name: ____________________
Phone Number: ____________________
Referring Provider: ____________________ Specialty: ____________________
Telephone Number: ____________________ Diagnoses: ____________________

Patient Information
Name: ____________________ DOB: ____________________
Address: ____________________
Telephone Number: ____________________
Patient’s Current Location If Other Than Residence: ____________________
Molina Member ID #: ____________________ OR Provider One ID #: ____________________

Reason for Referral
Member needs support with the following areas (check all that apply):

*Please attach clinical notes if available.

☐ Catastrophic- medical or trauma related ☐ Multiple Hospitalizations/ER visits/Multiple Surgeries
☐ Chronic condition or recurring medical problems ☐ OB-GYN (high risk)
☐ Functional or emotional impairment ☐ Organ Transplant/Single/Multiple Organ Failure
☐ Pediatric/Neonatal ☐ Behavioral Health/Chemical Dependency
☐ Mentally, physically handicapped or developmentally disabled

☐ Housing Assistance ☐ Transportation
☐ Assistance with obtaining food ☐ Community Resources
☐ PCP/Specialist Appointment Set up ☐ Understanding health care benefits
☐ Smoking Cessation Services

Member needs assistance managing one or more of the following chronic conditions:

☐ Asthma ☐ CVD ☐ Obesity
☐ CHF ☐ Diabetes ☐ Prediabetes
☐ COPD ☐ Depression ☐ Other
☐ Other (please specify): ____________________

TO BETTER SERVE YOUR PATIENT PLEASE LET THEM KNOW YOU WILL BE REFERRING THEM TO US FOR SERVICES.
Disease Management Program

Molina's Disease Management program currently offers support to Molina members diagnosed with prediabetes, diabetes, asthma, chronic obstructive pulmonary disease (COPD), and congestive heart failure (CHF). The goals of this program are to work directly with you and your Molina patient to prevent the onset of chronic disease and to stabilize existing disease. In practical terms our Disease Management clinical staff can help:

- Reinforce and supplement the information you provide your Molina patient
- Improve medical compliance and management efforts
- Patients make healthy lifestyle changes and stay on track with their health-related goals
- Remove barriers to care and refer Molina patients to needed services
- Partner with you in developing, implementing and updating a care plan
- Provide you with updates on your patient’s progress, areas of concern, and/or problems identified
- Offer incentives to Molina patients to support healthy behaviors

We understand resources for supporting patients in these ways may be limited. That is why we offer this voluntary program FREE OF CHARGE and welcome the opportunity to support you in caring for your Molina patient.

To refer your Molina patient to this program, please complete and fax the referral form below, or send a secure e-mail to:

MHWDiseaseManagement@MolinaHealthcare.com
Fax: (800) 767-7188

To consult with a Health Manager on your Molina patient already enrolled in Molina’s Disease Management program, please call Molina’s Member Services department at (800) 869-7165 and ask to speak with the Health Manager assigned to your patient. You may also direct your patient to call Member Services to enroll directly.

Disease Management Referral Form: Refer to Molina of Washington Care Management Referral Form

We look forward to working with you in keeping your Molina patients healthy!
Transitional Care Management Program

During episodes of illness involving multiple care settings, patients are at increased risk of poor health outcomes and avoidable re-admissions resulting from fragmented care if care transitions are not well executed. Molina designed its patient-centered Transitional Care program to improve the quality of care for members with complex physical, long-term and behavioral health needs as they transition across care settings. Transitional Care programs have been shown to reduce preventable re-admissions and Emergency Department use.

The target population for Molina’s Transitional Care program is patients at high risk of re-admission, including patients with a diagnosis of:

- Asthma
- Cellulitis
- Chronic obstructive pulmonary disease (COPD)
- Congestive heart failure (CHF)
- Diabetes
- Pneumonia
- Chronic mental illness
- Substance abuse disorder

Additional secondary criteria will be considered based on acuity and may include, but are not limited to the following:

- Patient history of re-admission and poor adherence to follow-up treatment
- Alzheimer’s disease
- Parkinson’s disease
- Multiple co-morbid conditions

Visits with the Transitional Care Coach begin with a face-to-face visit while the patient is still in the hospital, followed up by a phone call within 2 – 3 days after discharge, a face-to-face visit at the patient’s place of residence, and continues as needed for up to 6 weeks. During these visits, the Transitional Care Coach will:

- Complete and implement an individual transitional care transition plan and personal health record
- Assess the safety of the patient’s home environment
- Assess the patient’s support network and community connections
- Assist the patient with immediate psychosocial needs such as food, transportation, clothing, social support, advocacy and other community-based resources
- Review medications with the patient, ensuring that all needed medications are provided and questions answered
- As the transitional care process nears completion, the Transitional Care Coach will assess the patient’s ongoing needs and if needed, initiate a referral to the Molina Case Management Program or PCP who will work with the member to address those needs going forward.
Molina Community Connector Program

- Provides community based, in person, member interactions
- Role modeled after community health worker workforce
- An integral member of the Case Management teams; “eyes and ears”
- Highly visible role as a connector to care and services

Community Connectors have the ability to build trusting relationships with members. They are flexible, realistic, practical and culturally sensitive. They are well connected to their community and have knowledge of the resources offered within.

Key Benefits of Community Connector Engagement:
- Face-to-face visits to assess member needs and identify barriers
- Care Coordination; provide resources for caregiver
- Connect members to appropriate community resources
- System Navigation; facilitate access to health care systems
- Discuss alternatives to visiting Emergency Departments
- Health Coaching; promote health literacy
- Provide Health Education; teach self-management skills
- Cultural liaison
- Help members understand healthcare benefits
Community Outreach: What can the Molina Healthcare Team do for you?

Molina Healthcare is one of several managed care plans, for adults and children who are eligible for free or low cost government-sponsored health care programs, through the Health Care Authority (HCA).

We can assist community members by:
- Educating them about HCA programs and Molina Healthcare’s role, including Medicaid application assistance
- Enrolling them as a member of Molina Healthcare
- Helping Molina Healthcare members change providers
- Checking eligibility and escalate ongoing issues
- Connecting them with other services and resources, such as shelter, transportation and food

Volunteers
Molina Healthcare’s VTO (Volunteer Time Off) program encourages Molina Healthcare employees to volunteer in order to help promote the Molina Healthcare family spirit throughout the community!

Speakers and Presentations
Molina Healthcare staff are available to give presentations for your organization’s staff or to community members. Topics may include:
- Molina Healthcare – Managed Care and/or Medicaid
- Health Education Topics (e.g., Heart Health, Diabetes, Nutrition)

Sponsorships
Sponsorship of events or projects may be available for organizations who are interested in creating a meaningful partnership with Molina Healthcare.

Community Champions
The annual Community Champions event was established to honor the memory of Molina Healthcare’s physician founder, Dr. C. David Molina. He believed in community partners working together to create programs that would help care for society’s most vulnerable individuals. This event honors the unsung heroes who work in our communities and inspire others through their selflessness, extraordinary service and contributions that positively affect the lives of those around them.

Nominees and winners are honored at a dinner and awards ceremony in the fall. Each winner receives a $1,000 grant to “pay it forward” to an organization of their choice.

The Molina Foundation
The Molina Foundation is a 501(c)(3) nonprofit dedicated to improving lives through literacy and education. We tailor our services based on volume of requests and available resources. In general, at least 70 percent of the people you serve must be low-income in order to qualify for assistance. To learn about our programs, please visit www.MolinaFoundation.org.
SECTION 2: Partnering with Molina to Promote and Measure Quality
To our members: Make healthy choices and earn reward points you can redeem online for health related items – up to $200 in total rewards per calendar year. See below for a list of reward-earning appointments.

**Healthy 15-Month-Olds**
Take your child in for 6 well child exams by the time they are 15 months old.

**Healthy Two-Year-Olds**
Make sure your child gets all required immunizations before they turn 2.

**Well Child Check Ups, Ages 3, 4, 5 and 6**
A well child exam is a physical exam that includes vision and hearing tests. Your child will also get immunizations (shots) if they are due. Shots help them stay healthy. Take your child to a yearly well child exam.

**Breast Cancer Screening**
Women who are 50 years to 74 years of age should get a mammogram every two years. Women who have had breast cancer or other breast problems, or have a family history of breast cancer, might need to get mammograms before age 50. They may also need to get them more often. Talk to your health care provider about when to start and how often you should have a mammogram.

To receive reward points in this program, get a mammogram at least once every two years.

**Adolescent Well Care, Ages 12-21**
A check-up is a complete physical exam and may include vision and hearing tests. Your provider should check blood pressure, height, weight and body mass index (BMI). Your teen may need some shots or boosters. Take them to a yearly well care visit.

**Prenatal Care**
See your provider in the first three months of pregnancy or within 42 days of joining Molina.

**Postpartum Care**
Visit your provider for an exam 21-56 days after you’ve delivered your baby.

**Staying Healthy with Diabetes**
As a member of this program, you can team up with your health care provider to set and reach your diabetes management goals. Members who reduce their Hemoglobin A1C, and get their annual eye exams receive reward points.

*Health Incentives are subject to change without notice*
How to Submit HEDIS® Data to Molina

Claims and Encounters
Molina prefers that our providers submit all HEDIS® information on a claim (HCFA 1500), an efficient and highly automated claims process that ensures prompt and appropriate payment for your services. The “HEDIS® Tips” section of this manual contains the appropriate CPT® and ICD-9/ICD-10-CM codes needed to bill for a particular measure.

Supplemental data
Supplemental data (including medical records) may be submitted to Molina through several methods:
- Fax of Medical Records to Molina: Fax Number: (800) 338-6131
- Secure e-mail Medical Records to Molina: E-mail Address: HEDIS_SDS@MolinaHealthcare.com
- EMR or Registry data exchange

Submission Deadline for Supplemental Data: Reporting year data must be submitted by January 31st of the year after the reporting year.

Provider-reported data is subject to audit. For details regarding the audit process, please refer to the Auditing of Supplemental Data, on page 18 of this manual.
Avoid Missed Opportunities

Make Every Visit Count

Avoid missed opportunities by taking advantage of every Molina member office visit to provide a well child visit, immunizations, lead testing and BMI percentile calculations.

- A sports physical becomes a well child visit by adding anticipatory guidance (e.g. safety, nutrition, health, and social/behavior) to the sports physical history and physical exam.

- A sick visit and well child visit can be performed on the same day by adding a Modifier 25 to the sick visit, and billing for the appropriate preventative visit. Molina will reimburse for both services, in accordance with CPT® Modifier 25 guidelines. Please refer to the Modifier 25: Preventative and Acute Care Services at the Same Encounter, Tips & Best Practices section of this guide for further information.

- Molina will reimburse you for one well child visit per calendar year for children three years and older. You do not need to wait 12 months between the visits. Remember, infants up to 15 months need at LEAST six well child visits.

- BMI percentiles are a calculation based on the child's height and weight and should be calculated at every visit.
Auditing of Supplemental Data

Periodically throughout the year, Molina conducts a HEDIS® program audit of supplemental data provided by practices, selected randomly from throughout our network. As required to meet NCQA guidelines, Molina must ensure the supplemental data we receive reflects the highest degree of accuracy.

Each audited practice is given a partial list of supplemental data provided to Molina during the program year. Practices are required to return a copy of the medical record that documents the supplemental data. For example, if a mammogram screening has been supplied as supplemental data, the practice would submit a copy of the mammogram result from the radiologist as proof the service was rendered.

Procedure for the audit process:

- Audit notices are distributed at on-site office visits or by mail/fax request
- Providers are required to respond to the audit within one week of the delivery date or the specified timeframe.
- If a medical record is unavailable, audit results will be recalculated to determine a compliance score with the audit. A compliance score less than 95% accuracy will result in an additional audit of medical records.
- Sanctions against the practice may also be considered based on audit results
Glossary

Below is a list of definitions used in this manual.

**HEDIS®**
The Healthcare Effectiveness Data and Information Set (HEDIS®) is a widely used set of performance measures in the managed care industry, developed and maintained by the National Committee for Quality Assurance (NCQA). HEDIS® was designed to allow consumers to compare health plan performance to other plans and to national or regional benchmarks.

**Measure**
A quantifiable clinical service provided to patients to assess how effective the organization carries out specific quality functions or processes.

**Administrative Data**
Evidence of service taken from claims, encounters, lab or pharmacy data.

**Supplemental Data**
Evidence of service found data source other than claims, encounters, lab or pharmacy data. All supplemental data may be subject to audit.

**Denominator**
Entire Health Plan population that is eligible for the specific measure.

**Numerator**
Number of members compliant with the measure.

**Exclusion**
Member becomes in-eligible and removed from the sample based on specific criteria, e.g. incorrect gender, age, etc.

**Hybrid**
Evidence of services taken from the patient’s medical record.

**Measurement Year**
The year that the health plan gathers data.

**HEDIS® Measure Key**
The 3 letter acronym that NCQA uses to identify a specific measure.

**WAIIS**
The Washington State Immunization Information System (WAIIS) is an electronic immunization registry available to providers for the maintenance of immunization records.

**NDC**
The National Drug Code is a unique ten-digit number and serves as a product identifier for human drugs in commercial distribution. This number identifies the labeler, product, and trade package size.

**Method of Measurement**
Appropriate forms and methods of submitting data to Molina to get credit for specific measure.

**Clinical Practice Guidelines (CPG)**
Clinical Practice Guidelines are based on scientific evidence, review of the medical literature, or appropriately established authority. The recommendations for care are suggested as guides for making clinical decisions.
SECTION 3: Procedure and Diagnosis Coding in HEDIS®: Tips & Resources
ICD-10-CM

No more delays!
Effective 10/1/2015 ICD-10-CM Diagnosis coding will be in effect. Molina Healthcare will only accept transactions containing ICD-10-CM and ICD-10-PCS codes, as well as ICD-10 based DRGs. In accordance with CMS guidelines, transactions submitted with ICD-9 diagnosis and procedural coding will be rejected back to the submittor with a remittance advance.

- Dates of Service prior to October 1, 2015: Submit claims with the appropriate ICD-9 diagnosis code.
- Dates of Service on or after October 1, 2015: Submit claims with the appropriate ICD-10 diagnosis code.
- For outpatient services that span the implementation date, the claim must be split and date-appropriate coding used.

The individual pages in Section 4 provide you with the ICD-9 diagnosis and procedure codes, as well as the cross-walked ICD-10-CM diagnosis and procedure codes. The ICD-9 codes are provided as an illustration to assist you in identifying the approximate ICD-10-CM family of codes to be used. Please refer to your ICD-10-CM Manuals for further code specificity.

Resource Links:
Molina Healthcare ICD-10 Information and FAQ:
http://www.molinahealthcare.com/providers/common/medicaid/hipaa/Pages/code sets.aspx

Centers for Medicare & Medicaid Services (CMS.gov) Resources:
https://www.cms.gov/Medicare/Coding/ICD10/Index.html
**Modifier 25:**

Preventative and Acute Care Services at the Same Encounter - Tips & Best Practices

**Background:**
For both preventative and acute care services to be reimbursable, all required components of both services must be performed and documented.

According to the National Correct Coding Initiative (NCCI): “The CPT® Manual defines Modifier 25 as a ‘significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service’. Modifier 25 may be appended to an evaluation and management (E/M) CPT® code to indicate that the E/M is significant and separately identifiable from other services reported on the same date of service. The E/M service may be related to the same or different diagnosis as the other procedure(s).”

**Preventative Services (CPT® 99381-99395)**
- Select Preventative Service codes based on the age of the patient on the date of service, as well as whether the patient is new or established
- Services include an age/gender appropriate history, comprehensive examination, counseling/anticipatory guidance/risk factor interventions, and the ordering of laboratory/diagnostic procedures (Lab and diagnostic procedures are reimbursed separately.)
- Services also include care of a small problem or pre-existing condition that requires no extra work

**Acute (Sick) Care Services (CPT® 99201 – 99215)**
- If a problem or abnormality is encountered and is significant enough to require additional work to perform the key components of a problem-orientated E/M service, then the appropriate code 99201-99215 should be reported
- For New Patients: All three key components of History, Exam and Medical Decision-Making must be met or exceeded to report each particular level
- For Established Patients: Two out of three of the key components of History, Exam, and Medical Decision-Making must be met or exceeded to reach each level
- Don't double-dip! Documentation that supports elements of the Preventative Services may not contribute to the elements and level of the Acute Care Service
- Please refer to your CPT® Manual for further E/M level specifics

**Diagnosis Codes Must Match**
Be sure you report preventative care diagnoses codes with preventative care CPT® codes. Problem-focused diagnosis codes should correspond to problem-focused or “sick” visits reported with 99201 – 99215.

**Clinical Examples:**
A patient presents for a sprained ankle and the physician orders ankle x-rays. On the EMR health maintenance screen, an alert indicates the patient is due for their well visit. The well visit can be conducted with the exam of the sprained ankle as long as the documentation supports an E/M. A 99213 with Modifier 25 is reported in addition to 99392 appropriately.

A patient presents for a well child checkup/preventative visit. During the exam, it is noted the child has minor diaper rash. The physician encourages the mother to change her diaper more frequently. It would not be
appropriate to report a problem-orientated E/M visit in addition to the preventative service, as the findings of diaper rash were trivial and incidental.

**Suggestions:**

- **As a best practice, educate the member about Preventative Health Exams and Sick Exams.** Provide patients with an educational flyer about what occurs in a well exam. A notice can also be used to explain the office visit policy for preventative and sick exams and the reasons for it. It should be sent to patients along with confirmation of their preventative appointment or presented to them when they check in. The policy should also be explained in the information about the practice that you send to patients prior to their first appointment.

- **Involve your scheduling staff.** Any patient requesting to schedule a preventative service should be asked if he or she wishes to discuss any other health problems with the doctor. If the patient does not want to discuss other problems and the health problem may be considered insignificant, the scheduler can ask the patient to come in for a problem-orientated visit first and the preventative service at a later date. Encourage the patient to schedule both visits. If the patient indicates that he or she has no health problems to discuss with the doctor, the scheduler should let the patient know that if a health problem arises that another visit may be necessary.

**Resource Links:**


**References:**

SECTION 4: HEDIS® Tips
GENERAL HEDIS® TIPS TO IMPROVE SCORES

Work with Molina – we are your partners in care and would like to assist you in improving your HEDIS® scores.

Use HEDIS® specific billing codes when appropriate. This will help reduce the number of medical records we are required to review in your office. We have tip reference guides on what codes are needed for HEDIS®.

Use HEDIS® Needed Services Lists that Molina sends you to identify patients who have gaps in care. If a patient calls for a sick visit, see if there are other needed services (e.g. well care visits, preventive care services). Keep the needed services list by the receptionist’s phone so the appropriate amount of time can be scheduled for all needed services when patients call for a sick visit.

Avoid missed opportunities. Many patients may not return to the office for preventive care so make every visit count. Schedule follow-up visits before patients leave.

Improve office management processes and flow. Review and evaluate appointment hours, access, and scheduling processes, billing and office/patient flow. We can help to streamline processes.

- Review the next day’s schedule at the end of each day
- Ensure the appropriate test equipment or specific employees are available for patient screenings procedures
- Call patients 48 hours before their appointments to remind them about their appointment and anything they will need to bring. Ask them to make a commitment that they will be there. This will reduce no-show rates
- Train staff to manage routine questions from patients and to educate patients regarding tests and screenings that are due
- Use non-physicians for items that can be delegated. Also have them prepare the room for items needed
- Consider using an agenda setting tool to elicit patient’s key concerns by asking them to prioritize their goals and questions. Molina has a sample tool that you can use
- Provide an after visit summary to ensure patients understand what they need to do. This improves the patient’s perception that there is good communication with their provider

Take advantage of your EMR. If you have an EMR, try to build care gap “alerts” within the system.
HEDIS® TIPS: APPROPRIATE TESTING FOR CHILDREN WITH PHARYNGITIS

MEASURE DESCRIPTION
Children 3-18 years of age diagnosed with pharyngitis and dispensed an antibiotic should have received a Group A strep test within 3 days prior to the diagnosis date through the 3 days after the diagnosis date.

USING CORRECT BILLING CODES

Codes to Identify Pharyngitis

<table>
<thead>
<tr>
<th>Description</th>
<th>ICD-9 Code</th>
<th>ICD-10 Code*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute pharyngitis</td>
<td>462</td>
<td>J02.8, J02.9</td>
</tr>
<tr>
<td>Acute tonsillitis</td>
<td>463</td>
<td>J03.00, J03.01, J03.80, J03.81, J03.90, J03.91</td>
</tr>
<tr>
<td>Streptococcal sore throat</td>
<td>034.0</td>
<td>J02</td>
</tr>
</tbody>
</table>

Codes to Identify Strep Test

<table>
<thead>
<tr>
<th>Description</th>
<th>CPT® Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strep Test</td>
<td>87070, 87071, 87081, 87430, 87650-87652, 87880</td>
</tr>
</tbody>
</table>

*ICD-10-CM codes are to be used on or after 10/1/2015. Please refer to your ICD-10-CM Manual for further code specificity.

HOW TO IMPROVE HEDIS® SCORES

- Perform a rapid strep test or throat culture to confirm diagnosis before prescribing antibiotics. Submit this test to Molina Healthcare for payment if the State permits, or as a record that you performed the test. Use the codes above.
- Clinical findings alone do not adequately distinguish Strep vs. non-Strep pharyngitis. Most “red throats” are viral and therefore should never be treated empirically, even in children with a long history of strep. In these cases, strep may have become resistant and a culture test is needed.
- Submit any co-morbid diagnosis codes that apply on claim/encounter
- If rapid strep test and/or throat culture is negative, educate parents/caregivers that an antibiotic is not necessary for viral infections
- Additional resources for clinicians and parents/caregivers about pharyngitis can be found here: http://www.cdc.gov/getsmart/index.html
**MEASURE DESCRIPTION**

Children 3 months to 18 years of age diagnosed with Upper Respiratory Infection (URI) **should not** be dispensed an antibiotic within 3 days of the diagnosis.

Note: Claims/encounters with more than one diagnosis (e.g., competing diagnoses) are excluded from the measure.

**USING CORRECT BILLING CODES**

### Codes to Identify URI

<table>
<thead>
<tr>
<th>Description</th>
<th>ICD-9 Code</th>
<th>ICD-10* Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute nasopharyngitis (common cold)</td>
<td>460</td>
<td>J00</td>
</tr>
<tr>
<td>Acute laryngotraheobronchitis</td>
<td>465.0</td>
<td>J06.0</td>
</tr>
<tr>
<td>Acute URI</td>
<td>465.8, 465.9</td>
<td>J06.0</td>
</tr>
</tbody>
</table>

### Codes to Identify Competing Diagnoses

<table>
<thead>
<tr>
<th>Description</th>
<th>ICD-9 Code</th>
<th>ICD-10* Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Otitis media</td>
<td>382</td>
<td>H66, H67</td>
</tr>
<tr>
<td>Acute sinusitis</td>
<td>461</td>
<td>J01.80, J01.90</td>
</tr>
<tr>
<td>Chronic sinusitis</td>
<td>473</td>
<td>J32</td>
</tr>
<tr>
<td>Pharyngitis</td>
<td>462</td>
<td>J02.0, J02.8, J02.9</td>
</tr>
<tr>
<td>Streptococcal tonsillitis</td>
<td>034.0</td>
<td>J03.00, J03.01, J03.80</td>
</tr>
<tr>
<td>Acute tonsillitis</td>
<td>463</td>
<td>J03.81, J03.90, J03.91</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>418-486</td>
<td>J13-J20</td>
</tr>
</tbody>
</table>

*ICD-10-CM codes are to be used on or after 10/1/2015. Please refer to your ICD-10-CM Manual for further code specificity.
HOW TO IMPROVE HEDIS® SCORES

- Do not prescribe an antibiotic for a URI diagnosis only
- Submit any co-morbid/competing diagnosis codes that apply (examples listed in the “Codes to Identify Common Competing Diagnoses” table above)
- Code and bill for all diagnoses based on patient assessment
- Educate patient on comfort measures (e.g., acetaminophen for fever, rest, extra fluids) and advise patient to call back if symptoms worsen (antibiotic can be prescribed if necessary after 3 days of initial diagnosis)
- You are encouraged to re-submit an encounter if you missed a second diagnosis code and you see a member on the needed services report published by Molina Healthcare
- Patient educational materials on antibiotic resistance and common infections can be found here: http://www.cdc.gov/getsmart/index.html
HEDIS® TIPS: WELL CHILD VISITS FIRST 15 MONTHS OF LIFE

MEASURE DESCRIPTION
Children who turned 15 months old during the measurement year and who had at least 6 well child visits with a PCP prior to turning 15 months.

Well child visits consist of:
- A health history
- A physical developmental history
- A mental developmental history
- A physical exam
- Health education/anticipatory guidance

USING CORRECT BILLING CODES

Codes to Identify Well child Visits

<table>
<thead>
<tr>
<th>Description</th>
<th>Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well child Visits</td>
<td>CPT*: 99381, 99382, 99391, 99392</td>
</tr>
<tr>
<td></td>
<td>ICD-9: V20.2, V20.31, V20.32, V70.0, V70.3,</td>
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<tr>
<td></td>
<td>V70.5, V70.6, V70.8, V70.9</td>
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<tr>
<td></td>
<td>ICD-10-CM*: Z00.110, Z00.111, Z00.121,</td>
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<tr>
<td></td>
<td>Z00.129, Z00.5, Z00.8, Z02.79, Z02.81-Z02.83,</td>
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<tr>
<td></td>
<td>Z02.89, Z02.9</td>
</tr>
</tbody>
</table>

*ICD-10-CM codes are to be used on or after 10/1/2015. Please refer to your ICD-10-CM Manual for further code specificity.

HOW TO IMPROVE HEDIS® SCORES

- Avoid missed opportunities by taking advantage of every office visit (including sick visits) to provide a well child visit, immunizations and lead testing
- Make daycare physicals into well-care visits by performing and documenting the required elements and submitting appropriate codes
- Medical records need to include the date when a health and developmental history and physical exam was performed and what health education/anticipatory guidance was given
- Use standardized templates in charts and in EMRs that allow checkboxes for standard counseling activities
- Refer to the Clinical Practice Guideline (CPG) for Preventative Health of Children and Adolescents at http://www.molinahealthcare.com/providers/wa/medicaid/PDF/PHG-Children-Adolescents.pdf
- Molina Healthcare offers a member Health Incentive program called Healthy 15-Month-Olds. Molina Members earn reward points redeemable for health related items. For more information, please call WA Molina’s Wellness Quality Line at (800) 869-7175 Ext. 141428.
MEASURE DESCRIPTION
Children 3 to 6 years of age who had one or more well child visits with a PCP during the measurement year.
Well child visits consist of:
- A health history
- A physical developmental history
- A mental developmental history
- A physical exam
- Health education/anticipatory guidance

USING CORRECT BILLING CODES
Codes to Identify Well child Visits

<table>
<thead>
<tr>
<th>Description</th>
<th>Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well child Visits</td>
<td>CPT*: 99382, 99383, 99392, 99393</td>
</tr>
<tr>
<td></td>
<td>ICD-9: V20.2, V70.0, V70.3, V70.5, V70.6,</td>
</tr>
<tr>
<td></td>
<td>V70.8, V70.9</td>
</tr>
<tr>
<td></td>
<td>ICD-10-CM*: Z00.121, Z00.129, Z00.5, Z00.8,</td>
</tr>
<tr>
<td></td>
<td>Z02.0, Z02.2, Z02.5, Z02.6, Z02.79,</td>
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<tr>
<td></td>
<td>Z02.81-Z02.83, Z02.89, Z02.9</td>
</tr>
</tbody>
</table>

*ICD-10-CM codes are to be used on or after 10/1/2015. Please refer to your ICD-10-CM Manual for further code specificity.

HOW TO IMPROVE HEDIS® SCORES
- Avoid missed opportunities by taking advantage of every office visit (including sick visits) to provide a well child visit, immunizations and BMI percentile calculations
- Make sports/daycare physicals into well-care visits by performing and documenting the required elements and submitting appropriate codes
- Medical records need to include the date when a health and developmental history and physical exam was performed and what health education/anticipatory guidance was given
- Use standardized templates in charts and in EMRs that allow checkboxes for standard counseling activities
- Refer to the Clinical Practice Guideline (CPG) for Preventative Health of Children and Adolescents at http://www.molinahealthcare.com/providers/wa/medicaid/PDF/PHG-Children-Adolescents.pdf
- Molina Healthcare offers a member Health Incentive program Well child Check Ups, Ages 3, 4, 5 and 6. Medicaid Members earn reward points redeemable for health related items. For more information, please call WA Molina’s Wellness Quality Line at (800) 869-7175 Ext. 141428.
MEASURE DESCRIPTION
Members 12-21 years of age who had one comprehensive well-care visit with a PCP or OB/GYN during the measurement year.

Well-care visit consists of:
• A health history
• A physical developmental history
• A mental developmental history
• A physical exam
• Health education/anticipatory guidance

USING CORRECT BILLING CODES
Codes to Identify Well-Care Visits

<table>
<thead>
<tr>
<th>Description</th>
<th>Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well Care Visits</td>
<td><strong>CPT</strong>: 99384-99385, 99394-99395</td>
</tr>
<tr>
<td></td>
<td><strong>ICD-9</strong>: V20.2, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9</td>
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<tr>
<td></td>
<td><strong>ICD-10</strong>: Z00.00, Z00.01, Z00.121, Z00.129, Z00.5, Z00.8, Z02.0-Z02.6, Z02.71, Z02.79, Z02.81-Z02.83, Z02.89, Z02.9</td>
</tr>
</tbody>
</table>

*ICD-10-CM codes are to be used on or after 10/1/2015. Please refer to your ICD-10-CM Manual for further code specificity.

HOW TO IMPROVE HEDIS® SCORES

• Avoid missed opportunities by taking advantage of every office visit (including sick visits) to provide a well-care visit, immunizations and BMI value/percentile calculations
• BMI values are a calculation based on the child’s height and weight and should be calculated and documented at every visit
• A sick visit and well child visit can be performed on the same day by adding a Modifier -25 to the sick visit, and billing for the appropriate preventative visit. Molina will reimburse both services in accordance with Modifier -25 guidelines
• Make sports/day care physicals into well-care visits by performing and documenting the required services and submitting appropriate codes
• The medical record needs to include the date when a health and developmental history and physical exam were performed and health education/anticipatory guidance was given
• Use standardized templates in charts in EMRs that allow checkboxes for standard counseling activities.
• Refer to the Clinical Practice Guideline (CPG) for Preventative Health of Children and Adolescents at http://www.molinahealthcare.com/providers/wa/medicaid/PDF/PHG-Children-Adolescents.pdf
• Molina Healthcare offers a member Health Incentive program for Adolescent Well Care. Medicaid Members earn reward points redeemable for health related items. For more information, please call WA Molina’s Wellness Quality Line at (800) 869-7175 Ext. 141428.
HEDIS® TIPS: CHILDHOOD IMMUNIZATIONS

MEASURE DESCRIPTION
Children 2 years of age who had the following vaccines on or before their second birthday:

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

USING CORRECT BILLING CODES

**Codes to Identify Childhood Immunizations**

<table>
<thead>
<tr>
<th>Description</th>
<th>Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>DTaP</td>
<td>90700, 90698, 90700, 90721, 90723</td>
</tr>
<tr>
<td>IPV</td>
<td>90698, 90713, 90723</td>
</tr>
<tr>
<td>MMR</td>
<td>90707, 90710</td>
</tr>
<tr>
<td>Rubella</td>
<td>90706</td>
</tr>
<tr>
<td>HiB</td>
<td>90644-90648, 90698, 90721, 90748</td>
</tr>
<tr>
<td>Hepatitis A</td>
<td>90633</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>90740, 90744, 90747, 90748</td>
</tr>
<tr>
<td>Newborn Hepatitis B</td>
<td>ICD-9 Procedure: 99.55</td>
</tr>
<tr>
<td></td>
<td>ICD-10-PCS*: 3E0234Z</td>
</tr>
<tr>
<td>VZV</td>
<td>90716</td>
</tr>
<tr>
<td>Pneumococcal conjugate</td>
<td>90670</td>
</tr>
<tr>
<td>Rotavirus (two-dose schedule)</td>
<td>90681</td>
</tr>
<tr>
<td>Rotavirus (three-dose schedule)</td>
<td>90680 (Covered only if free from DoH for children younger than 1 year)</td>
</tr>
<tr>
<td>Influenza</td>
<td>90630, 90657, 90661, 90673, 90685</td>
</tr>
</tbody>
</table>

*ICD-10-PCS codes are to be used on or after 10/1/2015. Please refer to your ICD-10-PCS Manual for further code specificity.
HOW TO IMPROVE HEDIS® SCORES

- Use the Washington State Immunization Information System to register immunizations: www.waiis.wa.gov
- Review a child’s immunization record before every visit and administer needed vaccines
- Recommend immunizations to parents. Parents are more likely to agree with vaccinations when supported by the provider. Address common misconceptions about vaccinations, e.g., MMR causing autism. (This has been completely disproven.)
- Have a system for patient reminders
- Some vaccines may have been given before the patients were Molina Healthcare members. Include these on the members’ vaccination record even if your office did not provide the vaccine.
- Refer to the Clinical Practice Guideline (CPG) for Immunizations (within Preventative Services for Children and Adolescents) at: http://www.molinahealthcare.com/providers/wa/medicaid/PDF/PHG-Children-Adolescents.pdf
- Molina Healthcare offers a member Health Incentive program for Childhood Immunizations. Medicaid Members earn reward points redeemable for health related items. For more information, please call WA Molina’s Wellness Quality Line at (800) 869-7175 Ext. 141428
MEASURE DESCRIPTIONS

Measure Description: Immunizations for Adolescents

Children 13 years of age who received the following vaccines on or before their 13th birthday:

- One meningococcal vaccine (must be completed on or between the 11th and 13th birthdays)
- One Tdap or one Td vaccine (must be completed on or between the 11th and 13th birthdays)

Measure Description: HPV

Female adolescents 13 years of age who received the HPV vaccine series by their 13th birthday:

- Three dose human papillomavirus (HPV) vaccine series with different dates of administration
- Entire series completed between the 9th and 13th birthdays

USING CORRECT BILLING CODES

Codes to Identify Adolescent Immunizations

<table>
<thead>
<tr>
<th>Description</th>
<th>Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meningococcal</td>
<td>CPT*: 90733, 90734</td>
</tr>
<tr>
<td>Tdap</td>
<td>CPT*: 90715</td>
</tr>
<tr>
<td>Td</td>
<td>CPT*: 90714</td>
</tr>
<tr>
<td>Human Papillomavirus (HPV)</td>
<td>CPT*: 90649, 90650, 90651</td>
</tr>
</tbody>
</table>

HOW TO IMPROVE HEDIS® SCORES

- Use the Washington State Immunization Information System to register immunizations: www.waiis.wa.gov
- Review missing vaccines with parents
- Recommend immunizations to parents. Parents are more likely agree with vaccinations when supported by the provider. Address common misconceptions about vaccinations.
- Train office staff to prep the chart in advance of the visit and identify overdue immunizations
- Make every office visit count. Take advantage of sick visits for catching up on needed vaccines.
- Institute a system for patient reminders
- Some vaccines will have been given before they were Molina members. Include these on the patient’s vaccination record even if your office did not provide the vaccine.
- Refer to the Clinical Practice Guideline (CPG) for Immunizations (within Preventative Services for Children and Adolescents) at: http://www.molinahealthcare.com/providers/wa/medicaid/PDF/PHG-Children-Adolescents.pdf
- Molina Healthcare offers a member Health Incentive program for Adolescent Well Care. Medicaid Members earn reward points redeemable for health related items. For more information, please call WA Molina’s Wellness Quality Line at (800) 869-7175 Ext. 141428.
MEASURE DESCRIPTION

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

USING CORRECT BILLING CODES

<table>
<thead>
<tr>
<th>Description</th>
<th>CPT® Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead Tests</td>
<td>83655</td>
</tr>
</tbody>
</table>

HOW TO IMPROVE HEDIS® SCORES

- Avoid missed opportunities by taking advantage of every office visit (including sick visits) to perform lead testing
- Consider a standing order for in-office lead testing
- Educate parents about the dangers of lead poisoning and the importance of testing
- Bill in-office testing where permitted by the State fee schedule and Molina Healthcare policy
HEDIS® TIPS: WEIGHT ASSESSMENT AND COUNSELING

MEASURE DESCRIPTION
Children 3-17 years of age who had an outpatient visit with a primary care physician or OB/GYN and who had evidence of the following during the measurement year:
- BMI percentile documentation or BMI percentile plotted on age-growth chart (height, weight and BMI percentile must be documented)
- Counseling for nutrition or referral for nutrition education
- Counseling for physical activity or referral for physical activity

USING CORRECT BILLING CODES
Codes to Identify BMI Percentile, Counseling for Nutrition and Counseling for Physical Activity

<table>
<thead>
<tr>
<th>Description</th>
<th>Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>BMI Percentile</td>
<td>ICD-9: V85.51-V85.54</td>
</tr>
<tr>
<td></td>
<td>ICD-10*: Z68.51-Z68.54</td>
</tr>
<tr>
<td>Counseling for Nutrition</td>
<td>CPT*: 97802-97804</td>
</tr>
<tr>
<td></td>
<td>ICD-9: V65.3</td>
</tr>
<tr>
<td></td>
<td>ICD-10*: Z71.3</td>
</tr>
<tr>
<td></td>
<td>HCPCS: S9470 (WA Medicaid Maternity Support Services only)</td>
</tr>
<tr>
<td>Counseling for Physical Activity</td>
<td>ICD-9: V65.41</td>
</tr>
</tbody>
</table>

*ICD-10-CM codes are to be used on or after 10/1/2015. Please refer to your ICD-10-CM Manual for further code specificity.

HOW TO IMPROVE HEDIS® SCORES
- Use appropriate HEDIS® measure diagnosis and procedure codes to avoid medical review
- Avoid missed opportunities by taking advantage of every office visit (including sick visits and sports physicals) to capture BMI percentile and counseling on nutrition and physical activity
- Place BMI percentile charts near scales (Ask Molina for copies, or access them here http://www.cdc.gov/healthyweight/assessing/bmi/)
- When documenting BMI percentile include:
  - Height, weight and BMI percentile
- When counseling for nutrition document:
  - Current nutrition behaviors (e.g., appetite or meal patterns, eating and dieting habits)
- When counseling for physical activity document:
  - Physical activity counseling (e.g., child rides tricycle in the yard)
  - Current physical activity behaviors (e.g., exercise routine, participation in sports activities and exam for sports participation)
Merely documenting “cleared for sports” does not count towards the HEDIS® measure, but a sports physical with documentation supporting the elements of preventative medicine CPT® codes does count.

- To meet criteria, notation of anticipatory guidance related solely to safety must include specific mention of physical activity recommendations.

**Other Tips**

- Refer to the Clinical Practice Guideline (CPG) for Preventative Health of Children and Adolescents at http://www.molinahealthcare.com/providers/wa/medicaid/PDF/PHG-Children-Adolescents.pdf
- Molina Healthcare offers a member Health Incentive program for Child and Adolescent Well Care. Medicaid Members earn reward points redeemable for health related items. For more information, please call WA Molina’s Wellness Quality Line at (800) 869-7175 Ext. 141428.
HEDIS® TIPS: ADULTS WITH ACUTE BRONCHITIS

MEASURE DESCRIPTION
Adults 18-64 years of age diagnosed with acute bronchitis **should not** be dispensed an antibiotic within 3 days of the visit.

Note: Prescribing antibiotics for acute bronchitis is not indicated unless there is a comorbid diagnosis or a bacterial infection (examples listed on the right).

Only about 10% of cases of acute bronchitis are due to a bacterial infection, so in most cases antibiotics will not help.

USING CORRECT BILLING CODES

**Codes to Identify Acute Bronchitis**

<table>
<thead>
<tr>
<th>Description</th>
<th>ICD-9 Code</th>
<th>ICD-10 Code*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute bronchitis</td>
<td>466.0</td>
<td>J20.3-J20.9</td>
</tr>
</tbody>
</table>

**Codes to Identify Comorbid Conditions**

<table>
<thead>
<tr>
<th>Description</th>
<th>ICD-9 Code</th>
<th>ICD-10 Code*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic bronchitis</td>
<td>491</td>
<td>J41, J42</td>
</tr>
<tr>
<td>Emphysema</td>
<td>492</td>
<td>J43, J98.2, J98.3</td>
</tr>
<tr>
<td>COPD</td>
<td>493.2, 496</td>
<td>J44</td>
</tr>
</tbody>
</table>

**Codes to Identify Competing Diagnoses**

<table>
<thead>
<tr>
<th>Description</th>
<th>ICD-9 Code</th>
<th>ICD-10 Code*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute sinusitis</td>
<td>461.8, 461.9</td>
<td>J01.80, J01.90</td>
</tr>
<tr>
<td>Otitis media</td>
<td>382</td>
<td>H66, H67</td>
</tr>
<tr>
<td>Pharyngitis</td>
<td>462</td>
<td>J02.0, J02.8, J02.9</td>
</tr>
<tr>
<td>Streptococcal Tonsillitis</td>
<td>034.0</td>
<td>J03.00, J03.01, J03.80</td>
</tr>
<tr>
<td>Acute Tonsillitis</td>
<td>463</td>
<td>J03.81, J03.90, J03.91</td>
</tr>
</tbody>
</table>

*ICD-10-CM codes are to be used on or after 10/1/2015. Please refer to your ICD-10-CM Manual for further code specificity.

HOW TO IMPROVE HEDIS® SCORES

- Educate patients on comfort measures without antibiotics (e.g., extra fluids and rest)
- Discuss realistic expectations for recovery time (e.g., cough can last for 4 weeks without being “abnormal”)
- For patients insisting an antibiotic:
  - Give a brief explanation
  - Write a prescription for symptom relief instead of an antibiotic
  - Encourage follow-up in 3 days if symptoms do not get better
- Submit comorbid diagnosis codes if present on claim/encounter (see codes above)
- Submit competing diagnosis codes for bacterial infection if present on claim/encounter (see codes above)
MEASURE DESCRIPTION
The percentage of adults 66 years and older who had each of the following during the measurement year:

- Advance care planning (advanced directive, living will, or discussion with date).
- Medication review by a prescribing practitioner or clinical pharmacist and presence of a medication list (a medication list signed and dated during the measurement year by a prescribing practitioner or clinical pharmacist will also count.)
- Functional status assessment (e.g., ADLs or IADLs).
- Pain assessment (e.g., pain inventory, numeric scale, faces pain scale). Notation of screening or documentation of chest pain alone does not count.

USING CORRECT BILLING CODES

Codes to Identify Care of Older Adults

<table>
<thead>
<tr>
<th>Description</th>
<th>Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advance Care Planning</td>
<td>CPT® II: 1157F, 1158F</td>
</tr>
<tr>
<td></td>
<td>CPT*: 99497</td>
</tr>
<tr>
<td></td>
<td>HCPCS: S0257</td>
</tr>
<tr>
<td>Medication Review</td>
<td>CPT*: 90863, 99605, 99606</td>
</tr>
<tr>
<td></td>
<td>CPT® II: 1160F</td>
</tr>
<tr>
<td>Medication List</td>
<td>CPT® II: 1159F</td>
</tr>
<tr>
<td>Functional Status Assessment</td>
<td>CPT® II: 1170F</td>
</tr>
<tr>
<td>Pain Assessment</td>
<td>CPT® II: 1125F, 1126F</td>
</tr>
</tbody>
</table>

HOW TO IMPROVE HEDIS® SCORES

- Use the Annual Comprehensive Exam (ACE) form from Molina Healthcare to capture these assessments if the patient is eligible (insert link here)
- Use the Medicare Star Checklist Tool for reference and to place on top of chart as a reminder to complete. (insert link here)
- Remember that the medication review measure requires that the medications are listed in the chart, in addition to a notation that the review was performed.
- The pain screening cannot be for an acute pain event. Instead, the screening must be comprehensive, involving not only any current acute pain syndrome but also other systems not involved in the current pain event. (Over-all, global evaluation of pain)
- If on EMR, incorporate a standardized template to capture these measures for members 66 years and older. The Molina Healthcare HEP Annual Comprehensive Exam (ACE) form may be utilized as a guide.
- Patients with chronic conditions such as asthma, diabetes, and End Stage Renal Disease may qualify for case management and should be referred to the Molina Healthcare CM Program for evaluation: (800) 869-7165
MEASURE DESCRIPTION
Adults 18-75 years of age with diabetes (type 1 and type 2) who had each of the following:
- Hemoglobin A1c (HbA1c) testing
  - HbA1c poor control (>9.0%)*
    *a lower rate is better
  - HbA1c control
    - Medicaid (<8.0%)
    - Medicare (≤9.0%)
- Eye exam (retinal or dilated) performed
- BP control (<140/90mmHg)
- Nephropathy monitoring
  - Nephropathy screening or monitoring test
  - Treatment for nephropathy or ACE/ARB therapy
  - Stage 4 CKD
  - ESRD
  - Kidney transplant
  - Visit with a nephrologist
  - ACE/ARB dispensed

USING CORRECT BILLING CODES

<table>
<thead>
<tr>
<th>Description</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Codes to Identify Diabetes</td>
<td>ICD-9: 250.00-250.93, 357.2, 362.01-362.07, 366.41, 648.00-648.04 ICD-10*: E10, E11, E13, O24</td>
</tr>
<tr>
<td>Codes to Identify HbA1c</td>
<td>CPT*: 83036, 83037 CPT* II: 3044F (if HbA1c &lt;7%) 3045F (if HbA1c 7-9%) 3046F (if HbA1c &gt;9%)</td>
</tr>
<tr>
<td>Codes to Identify Nephropathy Screening Test</td>
<td>CPT*: 81000-81003, 81005, 82042, 82043, 82044 CPT* II: 3060F, 3061F, 3062F</td>
</tr>
<tr>
<td>Codes to Identify Eye Exam (must be performed by optometrist or ophthalmologist)</td>
<td>CPT*: 92002, 92004, 92012, 92014, 92018, 92019, 92134, 92225, 92226, 92227-92228 (Medicare only) 92230, 92235, 92240, 92250, 92260, 92903-99205, 99213-99215, 99242-99245 (WA Medicaid only)</td>
</tr>
<tr>
<td>Codes to Identify Potential Diabetic Retinopathy Procedures</td>
<td>CPT*: 67028, 67030, 67031, 67036, 67039-67043, 67101, 67105, 67107, 67108, 67110, 67112, 67113, 67121, 67141, 67145, 67208, 67210, 67218, 67220, 67221, 67227, 67228</td>
</tr>
<tr>
<td>Codes to Identify Diabetic Retinal Screening with Eye Care Professional billed by a Provider</td>
<td>CPT* II: 2022F, 20243F, 2026F, 3072F</td>
</tr>
</tbody>
</table>

*ICD-10-CM codes are to be used on or after 10/1/2015. Please refer to your ICD-10-CM Manual for further code specificity.
**HEDIS® TIPS: COMPREHENSIVE DIABETES CARE**

**HOW TO IMPROVE HEDIS® SCORES**

- Review diabetes services needed at each office visit
- Order labs prior to patient appointments
- If point-of-care HbA1c tests are completed in-office, it is helpful to bill for this. Also, ensure that the HbA1c result and date of test is documented in the chart.
- Adjust therapy to improve HbA1c and BP levels; follow-up with patients to monitor changes
- A digital eye exam, remote imaging, and fundus photography can count as long as the results are read by an eye care professional (optometrist or ophthalmologist).
- Use code 3072F if the member’s eye exam was negative or showed low risk for retinopathy in the prior year
- Prescribe statin therapy to all diabetics age 40 to 75 years

**Other Tips**

- Refer to the Clinical Practice Guideline (CPG) for Diabetes at http://www.molinahealthcare.com/providers/wa/medicaid/resource/PDF/CPG-Diabetes.pdf
- Members with chronic conditions such as diabetes may qualify for case management, and should be referred to the Molina Healthcare CM Program for evaluation: (800) 869-7165
- Molina Healthcare also offers a Health Incentive program for Medicaid members called Staying Healthy with Diabetes. Members who reduce their Hemoglobin A1c and get their annual eye exams receive reward points. For more information call WA Molina Quality Line at: (800) 869-7175 Ext. 141428.
- Please also refer to the Molina Healthcare HCC Pearl for Diabetes at http://www.molinahealthcare.com/providers/wa/medicaid/comm/PDF/Diabetes.pdf
MEASURE DESCRIPTION

• Patients 18-59 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90) during the measurement year.

• Patients 60-85 years of age who had a diagnosis of hypertension (HTN) and diabetes and whose BP was adequately controlled (<140/90) during the measurement year.

• Patients 60-85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<150/90) during the measurement year.

Note: Patients are included in the measure if there was a claim/encounter with a diagnosis of hypertension on or before June 30 of the measurement year.

The most recent BP during the measurement year is used.

USING CORRECT BILLING CODES

Codes to Identify Hypertension

<table>
<thead>
<tr>
<th>Description</th>
<th>ICD-9 Code</th>
<th>ICD-10 Code*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypertension</td>
<td>401.0, 401.1, 401.9</td>
<td>I10</td>
</tr>
</tbody>
</table>

*ICD-10-CM codes are to be used on or after 10/1/2015. Please refer to your ICD-10-CM Manual for further code specificity.

HOW TO IMPROVE HEDIS® SCORES

• Calibrate the sphygmomanometer annually

• Select the appropriately sized BP cuff

• Upgrade to an automated blood pressure machine

• If the BP is high at the office visit (140/90 or greater), take it again. HEDIS® allows us to use the lowest systolic and lowest diastolic readings in the same day, and oftentimes the second reading is lower.

• Do not round BP values up. If using an automated machine, record exact values.

• Review hypertensive medication history and patient compliance, and consider modifying treatment plans for uncontrolled blood pressure as needed. Have the patient return in 3 months.

• Current guidelines recommend two BP drugs started at first visit if the initial reading is very high and is unlikely to respond to a single drug and lifestyle modification.

• Molina Healthcare has staff available to address medication issues
Other Tips

- Refer to the Clinical Practice Guideline (CPG) for Hypertension at http://www.molinahealthcare.com/providers/wa/medicaid/resource/PDF/CPG-Hypertension.pdf

- Molina Healthcare also offers a member program called Heart Healthy Living Cardiovascular Program that assists members with their understanding and management of cardiovascular disease, including hypertension. Please contact the Molina Healthcare CM Program for further information. (800) 869-7165 Ext. 141428.

- If patient has other conditions complicating hypertension, be sure to document and code as specifically as possible to ensure accurate Risk Adjustment reporting. For example, if the patient has Stage 5 Chronic Kidney Disease or End Stage Renal Disease in addition to hypertension:
  
  o Improper and Non-Specific Documentation and Coding: I10 (Essential, primary hypertension)
  
  o Correct, Complete and Specific Documentation and Coding: I12.0 (Hypertensive chronic kidney disease with Stage 5 CKD/ESRD) An additional code to identify the stage of CKD would also be reported.

**MEASURE DESCRIPTION**

Patients 18-50 years of age with a new primary diagnosis of low back pain in an outpatient or ED visit who did not have an x-ray, CT, or MRI within 28 days of the primary diagnosis. A higher score indicates appropriate treatment of low back pain (i.e. the proportion for whom imaging studies did not occur).

**Exclusions:**
- Members with a diagnosis of low back pain during the 180 days prior to the Index Episode Start Date (IESD = earliest date of service with a principal diagnosis of low back pain).
- Cancer any time during the member’s history through 28 days after the IESD.
- Trauma any time during the 12 months prior to the IESD.
- IV drug abuse any time during the 12 months prior to the IESD through 28 days after the IESD.
- Neurologic impairment any time during the 12 months prior to the IESD through 28 days after the IESD.

**USING CORRECT BILLING CODES**

**Codes to Identify Low Back Pain**

<table>
<thead>
<tr>
<th>Description</th>
<th>ICD-9 Codes</th>
<th>ICD-10 Codes*</th>
</tr>
</thead>
</table>

**Codes to Identify Exclusions**

<table>
<thead>
<tr>
<th>Description</th>
<th>ICD-9 Codes</th>
<th>ICD-10 Codes*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer</td>
<td>140-165, 170-176, 179, 180-209, 230-239, V10</td>
<td>Z85, Z86.000, Z86.001, Z86.008, Z86.03, C00-C26, C30-C34, C37-C41, C43-C58, C4A, C60-C86, C7A, C7B, C88, C90-C96, D00-D07, D09, D37-D49</td>
</tr>
<tr>
<td>Trauma</td>
<td>800-839, 850-854, 860-869, 905-909, 926.11, 926.12, 929, 952, 958-959</td>
<td>S02.0-S03.1, S06, S12-S14, S21-S24, S26-S27, S31.0, S31.6, S32, S33.0-S33.4, S34.0-S34.1, S36-S37, S38.1, S42, S43.0-S43.3, S49.0-S49.1, S52, S53.0--S53.1, S59.0-S59.2, S62, S63.0-S63.2, S72, S73, S79.0-S79.1, S82, S83.0-S83.1, S89.0-S89.3, S92, S93.0-S93.3</td>
</tr>
<tr>
<td>IV Drug Abuse</td>
<td>304.0-304.2, 304.4, 305.4-305.7</td>
<td>F11, F13-F15</td>
</tr>
<tr>
<td>Neurologic Impairment</td>
<td>344.60, 729.2</td>
<td>G83.4, M54.16, M54.17, M54.18, M99.03, M99.04</td>
</tr>
</tbody>
</table>

*ICD-10-CM codes are to be used on or after 10/1/2015. Please refer to your ICD-10-CM Manual for further code specificity.*
HOW TO IMPROVE HEDIS® SCORES

• Avoid ordering diagnostic studies within 30 days of a diagnosis of new-onset back pain in the absence of red flags (e.g. cancer, recent trauma, neurologic impairment, or IV drug abuse)
• Provide patient education on comfort measures (e.g. pain relief, stretching exercises, and activity level)
• Use correct exclusion codes if applicable (e.g. cancer)
• Look for other reasons for visits for low back pain (e.g. depression, anxiety, narcotic dependency, psychosocial stressors, etc.)
**MEASURE DESCRIPTION**
The percentage of women 67-85 years of age who suffered a fracture and who had either a bone mineral density (BMD) test or prescription for a drug to treat or prevent osteoporosis in the six months after the fracture.

**USING CORRECT BILLING CODES**

<table>
<thead>
<tr>
<th>Description</th>
<th>Codes</th>
</tr>
</thead>
</table>
| Bone Mineral Density Test | **CPT**: 76977, 77078, 77080-77081, 77085, 77086  
**HCPCS**: G0130  
**ICD-9 Procedure**: 88.98  
**ICD-10-PCS**: BP48ZZ1, BP49ZZ1, BP4GZZ1, BP4HZZ1, BP4LZZ1, PB4MZZ1, BP4NZZ1, BP4PZZ1, BQ00ZZ1, BQ01ZZ1, BQ03ZZ1, BQ04ZZ1, BR00ZZ1, BR07ZZ1, BR09ZZ1, BR0GZZ1 |
| Osteoporosis Medications | **HCPCS**: J0630, J0897, J1740, J3489 |
| Long-Acting Osteoporosis Medications (For inpatient stays only) | **HCPCS**: J0897, J1740, J3310, J3489 |

*ICD-10-PCS codes are to be used on or after 10/1/2015. Please refer to your ICD-10-PCS Manual for further code specificity.

**Osteoporosis Therapies**

<table>
<thead>
<tr>
<th>Description</th>
<th>Brand Names</th>
<th>Generic Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Biphosphonates</td>
<td>Fosamax, Fosamax Plus D, Reclast, Boniva, Actonel, Atelvia</td>
<td>Alendronate, Alendronate-cholecalciferol, Zoledronic acid, Ibandronate, Risedronate</td>
</tr>
<tr>
<td>Other agents</td>
<td>Miacalcin, Prolia, Evista, Forteo</td>
<td>Calcitonin, Denosumab,Raloxifene, Teriparatide</td>
</tr>
</tbody>
</table>

**HOW TO IMPROVE HEDIS® SCORES**

- Order a BMD test on all women with a diagnosis of fracture within 6 months OR prescribe medication to prevent osteoporosis (e.g., bisphosphonates).
- Educate patient on safety and fall prevention
- Aggressive risk adjustment can overstate osteoporosis by confusing lower Z scores/osteopenia with osteoporosis
- Refer to the Clinical Practice Guideline (CPG) for Osteoporosis Screening (within Adult Preventative Services) at [http://www.molinahealthcare.com/providers/wa/medicaid/PDF/PHG-Adults.pdf](http://www.molinahealthcare.com/providers/wa/medicaid/PDF/PHG-Adults.pdf)
- Please also refer to the Molina Healthcare HCC Pearl on Fractures at [http://www.molinahealthcare.com/providers/wa/medicaid/comm/PDF/fractures.pdf](http://www.molinahealthcare.com/providers/wa/medicaid/comm/PDF/fractures.pdf)
MEASURE DESCRIPTION

Members 18 years of age and older who were diagnosed with rheumatoid arthritis (RA) and who were dispensed at least one DMARD prescription during the measurement year.

DMARDs:

<table>
<thead>
<tr>
<th>Description</th>
<th>Brand Name</th>
<th>Generic Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>5-Aminosalicyclates</td>
<td>Azulfidine</td>
<td>Sulfasalazine</td>
</tr>
<tr>
<td>Alkylating agents</td>
<td>Cytoxan</td>
<td>Cyclophosphamide</td>
</tr>
<tr>
<td>Aminoquinolines</td>
<td>Plaquenil</td>
<td>Hydroxychloroquine</td>
</tr>
<tr>
<td>Anti-rheumatics</td>
<td>Ridaura</td>
<td>Auranofin</td>
</tr>
<tr>
<td></td>
<td>Myochrysine</td>
<td>Gold sodium thiomalate</td>
</tr>
<tr>
<td></td>
<td>Arava</td>
<td>Leflunomide</td>
</tr>
<tr>
<td></td>
<td>Trexall</td>
<td>Methotrexate</td>
</tr>
<tr>
<td></td>
<td>Cuprimine</td>
<td>Penicillamine</td>
</tr>
<tr>
<td>Immunomodulators</td>
<td>Orencia</td>
<td>Abatacept</td>
</tr>
<tr>
<td></td>
<td>Humira</td>
<td>Adalimumab</td>
</tr>
<tr>
<td></td>
<td>Kineret</td>
<td>Anakinra</td>
</tr>
<tr>
<td></td>
<td>Cimzia</td>
<td>Certolizumab pegol</td>
</tr>
<tr>
<td></td>
<td>Enbrel</td>
<td>Etanercept</td>
</tr>
<tr>
<td></td>
<td>Simponi</td>
<td>Golimumab</td>
</tr>
<tr>
<td></td>
<td>Remicade</td>
<td>Infliximab</td>
</tr>
<tr>
<td></td>
<td>Rituxan</td>
<td>Rituximab</td>
</tr>
<tr>
<td></td>
<td>Actemra</td>
<td>Tocilizumab</td>
</tr>
<tr>
<td>Immunosuppressive agents</td>
<td>Imuran</td>
<td>Azathioprine</td>
</tr>
<tr>
<td></td>
<td>Neoral</td>
<td>Cyclosporine</td>
</tr>
<tr>
<td></td>
<td>CellCept</td>
<td>Mycophenolate</td>
</tr>
<tr>
<td>Janus kinase (JAK) inhibitor</td>
<td>Xeljanz</td>
<td>Tofacitinib</td>
</tr>
<tr>
<td>Tetracyclines</td>
<td>Minocin</td>
<td>Minocycline</td>
</tr>
</tbody>
</table>

USING CORRECT BILLING CODES

Codes to Identify Rheumatoid Arthritis

<table>
<thead>
<tr>
<th>Description</th>
<th>Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rheumatoid Arthritis</td>
<td>ICD-9: 714.0, 714.1, 714.2, 714.81</td>
</tr>
<tr>
<td></td>
<td>ICD-10-CM*: M05, M06</td>
</tr>
</tbody>
</table>

*ICD-10-CM codes are to be used on or after 10/1/2015. Please refer to your ICD-10-CM Manual for further code specificity.
HOW TO IMPROVE HEDIS® SCORES

- Confirm RA versus osteoarthritis (OA) or joint pain
  - Audit a sample of charts of members identified as having rheumatoid arthritis to assess accuracy of coding
  - The usual ratio of OA to RA diagnosing is 9:1
  - Aggressive risk adjustment can overstate RA vs. OA
- Prescribe DMARDs when diagnosing rheumatoid arthritis in your patients
- Refer to the current American College of Rheumatology standards/guidelines at: http://www.rheumatology.org/Practice-Quality/Clinical-Support/Clinical-Practice-Guidelines/Rheumatoid-Arthritis
- Refer patients to network rheumatologists as appropriate for consultation and/or co-management
- Consult the Molina Healthcare Drug Formulary regarding oral prescription medications at: http://www.molinahealthcare.com/providers/wa/medicaid/drug/Pages/formulary.aspx

USING CORRECT BILLING CODES

<table>
<thead>
<tr>
<th>Description</th>
<th>Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>DMARD</td>
<td>HCPCS: J0129, J0135, J0717, J1438, J1602, J1745, J3262, J7502, J7515-J7518, J9250, J9260, J9310</td>
</tr>
</tbody>
</table>
MEASURE DESCRIPTION
Patients 40 years of age and older with a new diagnosis of COPD or newly active COPD, who received a spirometry testing to confirm the diagnosis in the 2 years prior to the diagnosis or within 6 months of the diagnosis.

USING CORRECT BILLING CODES

Codes to Identify COPD

<table>
<thead>
<tr>
<th>Description</th>
<th>ICD-9 Code</th>
<th>ICD-10 Code*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic bronchitis</td>
<td>491.0, 491.1, 491.20-491.22, 491.8, 491.9</td>
<td>J41.0, J41.1, J41.8, J42</td>
</tr>
<tr>
<td>Emphysema</td>
<td>492.0, 492.8</td>
<td>J43.0, J43.1, J43.2, J43.8, J43.9</td>
</tr>
<tr>
<td>COPD</td>
<td>493.20, 493.21, 493.22, 496</td>
<td>J44.0, J44.1, J44.9</td>
</tr>
</tbody>
</table>

*ICD-10-CM codes are to be used on or after 10/1/2015. Please refer to your ICD-10-CM Manual for further code specificity.

Codes to Identify Spirometry Testing

<table>
<thead>
<tr>
<th>Description</th>
<th>CPT® Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spirometry</td>
<td>94010, 94014-94016, 94060, 94070, 94375, 94620</td>
</tr>
</tbody>
</table>

HOW TO IMPROVE HEDIS® SCORES
- Spirometry testing for the diagnosing of COPD is the standard of care
- Perform spirometry test on patients newly diagnosed with COPD within 180 days to confirm diagnosis of COPD, evaluate severity and assess current therapy. Note: If the patient had a spirometry performed in the previous 2 years to confirm the “new” diagnosis of COPD in the first place, they do not need a repeat.
- Ensure spirometry testing is appropriately documented
- Perform spirometry in office if equipment is available. If equipment is not available in your office, arrange for patient to get the test completed at a location with spirometry equipment, for example, a pulmonology unit.
- Differentiate acute (J20) from chronic bronchitis (J41, J42) and use correct coding to ensure patient is not inadvertently put into the HEDIS® measure
- Review problem lists and encounter forms and remove COPD/chronic bronchitis when the diagnosis was made in error
HEDIS® TIPS: SPIROMETRY TESTING IN COPD ASSESSMENT

Other Tips

- Refer to the Clinical Practice Guideline (CPG) for COPD at http://www.molinahealthcare.com/providers/wa/medicaid/resource/PDF/CPG-COPD.pdf
- For patients diagnosed with chronic bronchitis, document and code to the highest specificity of the patient’s condition for more accurate Risk Adjustment reporting, for example:
  - Non-specific documentation and coding: J40 (Bronchitis, not specified as acute or chronic)
  - Correct, complete and specific documentation coding: J41.1 (Mucopurulent chronic bronchitis)
- Molina Healthcare has a COPD Health Management Program aimed at assisting patients with their understanding of management of COPD. Please contact the Molina Healthcare CM Program for further information at (800) 869-7165 Ext. 141428.
MEASURE DESCRIPTION

Adults 18-74 years of age who had an outpatient visit and whose body mass index (BMI) or BMI percentile (for patients younger than 20 years) was documented during the measurement year or the year prior to the measurement year.

For members 20 years of age or older on the date of service, documentation in the medical record must indicate the weight and BMI value, dated during the measurement year or year prior to the measurement.

For patients younger than 20 years on the date of service, documentation in the medical record must indicate the height, weight and BMI percentile dated during the measurement year or year prior to the measurement. The following meets criteria for BMI percentile:

- BMI percentile documented as a value (e.g., 85th percentile)
- BMI percentile plotted on an age-growth chart

USING CORRECT BILLING CODES

Codes to Identify BMI

<table>
<thead>
<tr>
<th>Description</th>
<th>ICD-9 Code</th>
<th>ICD-10 Code*</th>
</tr>
</thead>
<tbody>
<tr>
<td>BMI &lt;19, adult</td>
<td>V85.0</td>
<td></td>
</tr>
<tr>
<td>BMI 19 or less, adult</td>
<td></td>
<td>Z68.1</td>
</tr>
<tr>
<td>BMI between 19-24, adult</td>
<td>V85.1</td>
<td></td>
</tr>
<tr>
<td>BMI between 20-24, adult</td>
<td></td>
<td>Z68.20-Z68.24</td>
</tr>
<tr>
<td>BMI between 25-29, adult</td>
<td>V85.21-V85.25</td>
<td>Z68.25-Z68.29</td>
</tr>
<tr>
<td>BMI between 30-39, adult</td>
<td>V85.30-V85.39</td>
<td>Z68.30-Z68.39</td>
</tr>
<tr>
<td>BMI 40 and over, adult</td>
<td>V85.41-V85.45</td>
<td>Z68.41-Z68.45</td>
</tr>
<tr>
<td>BMI, pediatric, ≤ 5th percentile for age</td>
<td>V85.51</td>
<td>Z68.51</td>
</tr>
<tr>
<td>BMI, pediatric, 5th percentile to &lt;85th percentile for age</td>
<td>V85.52</td>
<td>Z68.52</td>
</tr>
<tr>
<td>BMI, pediatric, 85th percentile to &lt;95th percentile for age</td>
<td>V85.53</td>
<td>Z68.53</td>
</tr>
<tr>
<td>BMI, pediatric, ≥ 95th percentile for age</td>
<td>V85.54</td>
<td>Z68.54</td>
</tr>
</tbody>
</table>

*ICD-10-CM codes are to be used on or after 10/1/2015. Please refer to your ICD-10-CM Manual for further code specificity.
HOW TO IMPROVE HEDIS® SCORES

- Make BMI assessment part of the vital sign documentation at each visit
- Use correct billing codes to report BMI calculations (Z68.1-Z68.54). Accurate billing will decrease need for additional records requests.
- Ensure proper documentation for BMI in the medical record with all components (i.e., date, weight, height and BMI value)
- If on an EMR, update the EMR templates to automatically calculate a BMI
- Place BMI charts near scales. (Ask Molina for copies, or access them here <insert link>)
- If not on an EMR, you can calculate the BMI here: http://www.cdc.gov/healthyweight/assessing/bmi
- Refer to the Clinical Practice Guideline (CPG) for Obesity in Adults at: http://www.molinahealthcare.com/providers/wa/medicaid/resource/PDF/CPG-Obesity.pdf
- Please also refer to the Molina Healthcare HCC Pearl on Morbid Obesity at: http://www.molinahealthcare.com/providers/wa/medicaid/comm/PDF/morbid-obesity.pdf
- Medicaid members may qualify for Weight Watchers membership if the patient’s BMI is ≥25. Please contact the Molina’s Wellness Quality Line for WA at (800) 869-7175 Ext. 141428.
MEASURE DESCRIPTION
Women 50-74 years of age who had one or more mammograms any time on or between October 1 two years prior to the measurement year and December 31 of the measurement year.
Exclusions: Bilateral mastectomy
Note: Biopsies, breast ultrasounds and MRIs do not count because HEDIS® does not consider them to be appropriate primary screening methods.

USING CORRECT BILLING CODES

Codes to Identify Mammogram

<table>
<thead>
<tr>
<th>Description</th>
<th>Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast Cancer Screening</td>
<td>CPT*: 77055--77057</td>
</tr>
<tr>
<td></td>
<td>HCPCS: G0202, G0204, G0206</td>
</tr>
<tr>
<td></td>
<td>ICD-9 Procedure: 87.36, 87.37</td>
</tr>
<tr>
<td></td>
<td>UB Revenue: 0401, 0403</td>
</tr>
</tbody>
</table>

Codes to Identify Breast Cancer Screening Exclusions

<table>
<thead>
<tr>
<th>Description</th>
<th>ICD-10-CM*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acquired absence of left breast and nipple</td>
<td>Z90.12</td>
</tr>
<tr>
<td>Acquired absence of right breast and nipple</td>
<td>Z90.11</td>
</tr>
<tr>
<td>Acquired absence of bilateral breasts and nipples</td>
<td>Z90.13</td>
</tr>
</tbody>
</table>

*ICD-10-CM codes are to be used on or after 10/1/2015. Please refer to your ICD-10-CM Manual for further code specificity.

HOW TO IMPROVE HEDIS® SCORES

- Educate female patients about the importance of early detection and encourage testing
- Use needed services list to identify patients in need of mammograms
- Schedule a mammogram for the patient or send/give patient a referral/script (if needed)
- Have a list of mammogram facilities available to share with the patient (helpful to print on colored paper for easy reference)
- Discuss possible fears the patient may have about mammograms and inform women that currently available testing methods are less uncomfortable and require less radiation
- Document in the medical record if the patient has had bilateral mastectomy, and fax Molina Healthcare the chart to (888) 336-6131
- Utilize ICD-10-CM diagnosis codes to report exclusions to the HEDIS® measure, such as absence of the breast (See codes in the above table). Correctly coding these conditions may prevent medical record requests.
• Refer to the Clinical Practice Guideline (CPG) for Breast Cancer Screening (within the Adult Preventative Services) at http://www.molinahealthcare.com/providers/wa/medicaid/PDF/PHG-Adults.pdf
• Molina Healthcare offers a member Health Incentive program for Breast Cancer Screening. Medicaid Members earn reward points redeemable for health related items. For more information, please call (800) 869-7175 Ext. 141428.
MEASURE DESCRIPTION
Women 21*-64 years of age who were screened for cervical cancer using either of the following criteria:
- Women age 24-64 who had cervical cytology during the measurement year or the two years prior to the measurement year.
- Women age 30-64 who had cervical cytology and human papillomavirus (HPV) co-testing performed during the measurement year or the four years prior to the measurement.

Exclusions: Women who had a hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix.

* Molina Healthcare has adopted guidelines recommending cervical cancer screening to begin at age 21 years.

USING CORRECT BILLING CODES

Codes to Identify Cervical Cancer Screening

<table>
<thead>
<tr>
<th>Description</th>
<th>Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cervical cytology</td>
<td>CPT*: 88141-88143,</td>
</tr>
<tr>
<td></td>
<td>88147, 88148, 88150,</td>
</tr>
<tr>
<td></td>
<td>88152-88154, 88164-</td>
</tr>
<tr>
<td></td>
<td>88167, 88174, 88175</td>
</tr>
<tr>
<td>HCPCS:</td>
<td>G0123, G0124, G0141,</td>
</tr>
<tr>
<td></td>
<td>G0143-G0145, G0147,</td>
</tr>
<tr>
<td></td>
<td>G0148, P3000, Q0091</td>
</tr>
<tr>
<td>UB Revenue:</td>
<td>0923</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Description</th>
<th>Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>HPV Test</td>
<td>CPT*: 87620-87622,</td>
</tr>
<tr>
<td></td>
<td>87624, 87625</td>
</tr>
</tbody>
</table>

Codes to Identify Cervical Cancer Screening Exclusions

<table>
<thead>
<tr>
<th>Description</th>
<th>ICD-9 Diagnosis</th>
<th>ICD-10 Diagnosis*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acquired absence of both cervix and uterus</td>
<td>V88.01</td>
<td>Z90.710</td>
</tr>
<tr>
<td>Acquired absence of cervix with remaining uterus</td>
<td>V88.03</td>
<td>Z90.712</td>
</tr>
<tr>
<td>Agenesis and aplasia of cervix</td>
<td>752.43</td>
<td>Q51.5</td>
</tr>
</tbody>
</table>

*ICD-10-CM codes are to be used on or after 10/1/2015. Please refer to your ICD-10-CM Manual for further code specificity.

HOW TO IMPROVE HEDIS® SCORES

- Use needed services lists to identify women who need a Pap test
- Use a reminder/recall system (e.g. tickler file)
- Request to have results of Pap tests sent to you if done at OB/GYN visits
- Don’t miss opportunities (e.g. completing Pap tests during regularly scheduled well woman visits, sick visits, urine pregnancy tests, or screenings for UTI or Chlamydia/STIs)
- Document in the medical record if the patient has had a hysterectomy with no residual cervix and fax us the chart. Remember synonyms – “total”, “complete”, or “radical”.

- Utilize ICD-10-CM diagnosis codes to report exclusions to the HEDIS® measure, such as absence or agenesis of cervix (See codes in the above table). Correctly coding these conditions may prevent medical record requests.

- Refer to the Clinical Practice Guideline (CPG) for Cervical Cancer Screening (within Adult Preventative Services) at http://www.molinahealthcare.com/providers/wa/medicaid/PDF/PHG-Adults.pdf
MEASURE DESCRIPTION
Women 16-24 years of age who were identified as sexually active and who had at least one Chlamydia test during the measurement year.

Exclusion: Members who were included in the measure based on pregnancy test alone and the member had a prescription for isotretinoin or an x-ray on the date of the pregnancy test or the 6 days after the pregnancy test.

USING CORRECT BILLING CODES
<table>
<thead>
<tr>
<th>Description</th>
<th>CPT® Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chlamydia Screening</td>
<td>87110, 87270, 87320, 87490-87492, 87810</td>
</tr>
</tbody>
</table>

HOW TO IMPROVE HEDIS® SCORES
- Perform Chlamydia screening every year on every 16-24 year old female identified as sexually active (use any visit opportunity)
- Add Chlamydia screening as a standard lab for women 16-24 years old. Use well child exams and well woman exams for this purpose.
- Ensure that you have an opportunity to speak with your adolescent female patients without her parent present.
- Remember that Chlamydia screening can be performed through a urine test. Offer this option for your patients.
- Place a Chlamydia swab next to Pap test or pregnancy detection materials
MEASURE DESCRIPTION

Patients 50-75 years of age who had one of the following colorectal cancer screenings:

- gFOBT or iFOBT (or FIT) with required number of samples for each test during the measurement year, or
- Flexible sigmoidoscopy during the measurement year or the four years prior to the measurement year, or
- Colonoscopy during the measurement year, or the nine years prior to the measurement year

Note: FOBT tests performed in an office or performed on a sample collected via a digital rectal exam (DRE) do not meet criteria.

Exclusions: Colorectal cancer or total colectomy

USING CORRECT BILLING CODES

**Codes to Identify Colorectal Cancer Screening**

<table>
<thead>
<tr>
<th>Description</th>
<th>Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>FOBT</td>
<td>CPT*: 82270, 82274</td>
</tr>
<tr>
<td>Flexible Sigmoidoscopy</td>
<td>CPT*: 45330-45335, 45337-45342, 45345-45347, 45349, 45350</td>
</tr>
<tr>
<td></td>
<td>HCPCS: G0104</td>
</tr>
<tr>
<td></td>
<td>ICD-9 Procedure: 45.24</td>
</tr>
<tr>
<td>Colonoscopy</td>
<td>CPT*: 44388-44394, 44397, 44401-44408, 45355, 45378-45393, 45398</td>
</tr>
<tr>
<td></td>
<td>HCPCS: G0105, G0121</td>
</tr>
<tr>
<td></td>
<td>ICD-9 Procedure: 45.22, 45.23, 45.25, 45.42, 45.43</td>
</tr>
</tbody>
</table>

**Codes to Identify Colorectal Cancer Screening Exclusions**

<table>
<thead>
<tr>
<th>Description</th>
<th>Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colorectal Cancer</td>
<td>ICD-9: 153.0-153.9, 154.0, 154.1, 197.5, V10.05, V10.06</td>
</tr>
<tr>
<td></td>
<td>ICD-10-CM*: C18.0-C18.9, C19, C20, C21.2, C21.8, C78.5, Z85.038, Z85.048</td>
</tr>
<tr>
<td>Total Colectomy</td>
<td>CPT*: 44150-44151, 44155-44158, 44210-44212</td>
</tr>
<tr>
<td></td>
<td>ICD-9 Procedure: 45.81, 45.82, 45.83</td>
</tr>
<tr>
<td></td>
<td>ICD-10-PCS*: 0DTE4ZZ, 0DTE4ZZ, 0DTE7ZZ, 0DTE8ZZ</td>
</tr>
</tbody>
</table>

*ICD-10-CM and ICD-10-PCS codes are to be used on or after 10/1/2015. Please refer to your ICD-10-CM and ICD-10-PCS Manuals for further code specificity.
HOW TO IMPROVE HEDIS® SCORES

- Update patient history annually regarding colorectal cancer screening (test done and date completed)
- Encourage patients who are resistant to having a colonoscopy to have a stool test that they can complete at home (either gFOBT or iFOBT)
- The iFOBT/FIT has fewer dietary restrictions and samples
- Use standing orders and empower office staff to distribute FOBT or FIT kits to patients who need colorectal cancer screening or prepare referral for colonoscopy. Follow-up with patients.
- Clearly document patients with ileostomies, which implies colon removal (exclusion) and patients with a history of colon cancer (See table above for the appropriate reporting codes)
- Refer to the Clinical Practice Guideline (CPG) for Colorectal Cancer Screening at http://www.molinahealthcare.com/providers/wa/medicaid/resource/PDF/Colorectal_Cancer_Screening_Practice_Guideline_2013.pdf
**HEDIS® TIPS: ANTIDEPRESSANT MEDICATION MANAGEMENT**

**MEASURE DESCRIPTION**
The percentage of adults 18 years of age and older who were diagnosed with a new episode of major depression:

- **Effective Acute Phase Treatment.**
  The percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 84 days (12 weeks).

- **Effective Continuation Phase Treatment.**
  The percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 180 days (6 months).

**USING CORRECT BILLING CODES**

**Codes to Identify Major Depression**

<table>
<thead>
<tr>
<th>Description</th>
<th>ICD-9 Code</th>
<th>ICD-10* Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major depression</td>
<td>296.20-296.25,</td>
<td>F32.0-F32.4,</td>
</tr>
<tr>
<td></td>
<td>296.30-296.35,</td>
<td>F32.9,</td>
</tr>
<tr>
<td></td>
<td>298.0, 311</td>
<td>F33.0-F33.3,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>F33.41, F33.9</td>
</tr>
</tbody>
</table>

*ICD-10-CM codes are to be used on or after 10/1/2015. Please refer to your ICD-10-CM Manual for further code specificity.

**Description** | **Generic Name** | **Brand Name**  
--- | --- | ---  
Miscellaneous antidepressants | Buproprion | Wellbutrin*  
                              | Vilazodone | Zyban*  
                              | Vortioxetine | Viibryd*  
                              |            | Brintellix*  
Phenylpiperazine antidepressants | Nefazodone | Serzone*  
                              | Trazodone | Desyrel*  
                              |            |            
Psychotherapeutic combinations | Amitriptyline- | Limbitrol*  
                              | chloridiazepoxide; | Triavl*  
                              | Amitriptyline- | Etrafon*  
                              | perphenazine; | Symbax*  
                              | Fluoxetine- |            
                              | olanzapine |            
SNRI antidepressants | Desvenlafaxine | Pristiq*  
                              | Levomilnacipran | Cymbalta*  
                              | Duloxetine | Effexor*  
                              | Venlafaxine |            
SSRI antidepressants | Citalopram | Celexa*  
                              | Escitalopram | Lexapro*  
                              | Fluoxetine | Prozac*  
                              | Fluvoxamine | Lувox*  
                              | Paroxetine | Paxil*  
                              | Sertraline | Zoloft*  
Tetracyclic antidepressants | Maprotiline | Elavil*  
                              | Mirtazapine | Asendin*  
                              |            | Anafranil*  
                              |            | Norpramin*  
                              |            | Sinequan*  
                              |            | Tofranil*  
                              |            | Pamelor*  
                              |            | Vivaftil*  
                              |            | Surmontil*  
Tricyclic antidepressants | Amitriptyline | Elavil*  
                              | Amoxapine | Asendin*  
                              | Clomipramine | Anafranil*  
                              | Desipramine | Norpramin*  
                              | Doxepin (>6mg) | Sinequan*  
                              | Imipramine | Tofranil*  
                              | Nortriptyline | Pamelor*  
                              | Protriptyline | Vivaftil*  
                              | Trimipramine | Surmontil*  
Monoamine oxidase inhibitors | Isocarboxazid | Marplan*  
                              | Phenelzine | Nardil*  
                              | Selegiline | Anipryl*  
                              |            | Emsam*  

*ICD-10-CM codes are to be used on or after 10/1/2015. Please refer to your ICD-10-CM Manual for further code specificity.
 HOW TO IMPROVE HEDIS® SCORES

- Educate patients on the following:
  - Depression is common and impacts 15.8 million adults in the United States
  - Most antidepressants take 1-6 weeks to work before the patient starts to feel better
  - In many cases, sleep and appetite improve first while improvement in mood, energy and negative thinking may take longer
  - The importance of staying on the antidepressant for a minimum of 6 months
  - Strategies for remembering to take the antidepressant on a daily basis
  - The connection between taking an antidepressant and signs and symptoms of improvement
  - Common side effects, how long the side effects may last and how to manage them
  - What to do if the patient has a crisis or has thoughts of self-harm
  - What to do if there are questions or concerns
**MEASURE DESCRIPTION**

Members 6-12 years old, with a new prescription for an attention-deficit/hyperactivity disorder (ADHD) who had:

- At least one follow-up visit with practitioner with prescribing authority during the first 30 days of when the ADHD medication was dispensed. (Initiation Phase)
- At least two follow-up visits within 270 days (9 months) after the end of the initiation phase. One of these visits may be a telephone call. (Continuation and Maintenance Phase)

**USING CORRECT BILLING CODES**

### Codes to Identify Follow-up Visits

<table>
<thead>
<tr>
<th>Description</th>
<th>Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telephone Visits</td>
<td>CPT*: 99441-99443 (Can use for one Continuation and Maintenance Phase visit.)</td>
</tr>
</tbody>
</table>

### Telephone Visits

<table>
<thead>
<tr>
<th>Description</th>
<th>Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Follow-up Visits</td>
<td>CPT*: 90785, 90791, 90792, 90832-90834, 90836-90838, 90845, 90847, 90849, 90853 WITH POS: 03, 05, 07, 09, 11, 12, 13, 14, 15, 20, 22, 33, 49, 50, 52, 53, 71, 72</td>
</tr>
<tr>
<td></td>
<td>CPT*: 99221-99223, 99231-99233, 99238, 99239, 99251-99255 WITH POS: 52, 53</td>
</tr>
</tbody>
</table>

**HOW TO IMPROVE HEDIS® SCORES**

- When prescribing a new medication to your patient, be sure to schedule a follow-up visit within 30 days to assess how the medication is working. Schedule this visit while your patient is still in the office.
- Schedule two more visits in the 9 months after the first 30 days, to continue to monitor your patient’s progress.
- Use a phone visit for one of the visits after the first 30 days. This may help you and your patients if getting to an office visit is difficult (Codes 99441-99443). Only one phone visit is allowed during the Continuation and Maintenance Phase. If a phone visit is done, at least one face-to-face visit should also be completed.
- NEVER continue these controlled substances without at least 2 visits per year to evaluate the child’s progress. If nothing else, you need to monitor the child’s growth to make sure they are on the correct dosage.
- Refer to the Clinical Practice Guideline (CPG) for the Diagnosis, Evaluation and Treatment of ADHD at [http://www.molinahealthcare.com/providers/wa/medicaid/resource/PDF/CPG-ADHD.pdf](http://www.molinahealthcare.com/providers/wa/medicaid/resource/PDF/CPG-ADHD.pdf)
HEDIS® TIPS: FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS

MEASURE DESCRIPTION
Members 6 years of age and older who were hospitalized for treatment of selected mental health diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner within 7 and 30 days of discharge.

USING CORRECT BILLING CODES
Codes to Identify Follow-up Visits (must be with a mental health practitioner)

<table>
<thead>
<tr>
<th>Description</th>
<th>Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Follow-up Visits</td>
<td>CPT®-Medicare &amp; Medicaid: 99201-99205, 99211-99215, 99217-99220, 99341-99345, 99347-99350</td>
</tr>
<tr>
<td></td>
<td>CPT®-Medicare Only: 90839-90840, G0463 (OPPS only)</td>
</tr>
<tr>
<td></td>
<td>CPT®-WA Medicaid Only: 99241-99245, 99383-99385, 99393-99395, 99078, 99401</td>
</tr>
<tr>
<td></td>
<td>Transitional Care Management Visits, Medicare Only: 99495 (only for 7-day indicator) 99496 (only for 30 day follow-up indicator)</td>
</tr>
<tr>
<td></td>
<td>HCPCS: G0409 (Medicare only)</td>
</tr>
<tr>
<td></td>
<td>UB Rev (Visit in a behavioral health setting): 0513, 0900-0905, 0907, 0911-0919</td>
</tr>
<tr>
<td></td>
<td>UB Rev (Visit in a non-behavioral health setting): 0510, 0515-0523, 0526-0529, 0982, 0983</td>
</tr>
</tbody>
</table>

Codes to Identify Exclusions

<table>
<thead>
<tr>
<th>Description</th>
<th>Codes</th>
<th>POS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Follow-up Visits</td>
<td>CPT*: 90791, 90792, 90832-90834, 90836-90838, 90839-90840 (Medicare only), 90845, 90847, 90849, 90853, 90870</td>
<td>03, 05, 07, 09, 11, 12, 13, 14, 15, 20, 22, 24, 33, 49, 50, 52, 53, 71, 72</td>
</tr>
<tr>
<td></td>
<td>CPT*:99221-99223, 99231-99233, 99238, 99239, 99251-99255 (Medicaid only)</td>
<td>52, 53</td>
</tr>
</tbody>
</table>
HOW TO IMPROVE HEDIS® SCORES

• The literature indicates that the patient is at greater risk for hospitalization within the first 7 days post-discharge, and that the risk of patient self-harm is high within the first 3 weeks post-discharge
• Ensure that the follow-up appointment is made before the patient leaves the hospital and is scheduled within 7 days of discharge
• Assist the patient with navigation of barriers, such as using their transportation benefit to get to their follow-up appointment
• Review medications with patients to ensure they understand the purpose and appropriate frequency and method of administration
• Ensure accurate discharge dates and document not just the appointments scheduled, but appointments kept. Visits must be with a mental health practitioner.
• Follow-up visits must be supported by a claim, encounter or note from the mental health practitioner’s medical chart

Other Tips

• Please refer to the Clinical Practice Guidelines (CPG) on Bipolar Disorders and Depression at:
  o http://www.molinahealthcare.com/providers/wa/medicaid/resource/PDF/CPG-ADHD.pdf
  o http://www.molinahealthcare.com/providers/wa/medicaid/resource/PDF/CPG-Depression.pdf
• Document and code to the highest specificity of the patient’s condition for more accurate Risk Adjustment reporting, for example:
  o Non-specific documentation and coding: F32.9 (Major depressive disorder, single episode, unspecified, or Depression NOS)
  o Correct, complete and specific documentation coding: F32.1 (Major depressive disorder, single episode, moderate)
• Patients with chronic mental illness who are receiving care in multiple care settings may benefit from the Molina Healthcare Transitional Care Program. The Transitional Care Coaches ensure the coordination and continuity of care from one care setting to another. Please contact the Molina Healthcare CM Program for further information: (800) 869-7165 Ext. 141428.
**MEASURE DESCRIPTION**

Prenatal care visit in the first trimester or within 42 days of enrollment, where the practitioner type is an OB/GYN or other prenatal care practitioner or PCP*, with one of these:

- Basic physical obstetrical exam that includes auscultation for fetal heart tone, or pelvic exam with obstetric observations, or measurement of fundus height (a standardized prenatal flow sheet may be used)
- Obstetric panel
- Ultrasound of pregnant uterus
- Pregnancy-related diagnosis code
- TORCH antibody panel (Toxoplasma, Rubella, Cytomegalovirus and Herpes simplex testing)
- Rubella antibody test/titer with an Rh incompatibility (ABO/RH) blood typing (e.g., a prenatal visit with rubella and ABO, a prenatal visit with rubella and Rh, or a prenatal visit with rubella and ABO/Rh)
- Documented LMP or EDD with either a completed obstetric history or prenatal risk assessment and counseling/education

*For visits to a PCP, a diagnosis of pregnancy must be present along with any of the above

**USING CORRECT BILLING CODES**

Please note that global billing or bundled codes do not provide specific date information to count towards this measure.

<table>
<thead>
<tr>
<th>Description</th>
<th>Codes</th>
</tr>
</thead>
</table>
| Prenatal Care Visits         | CPT*: 99201-99205, 99211-99215, 99241-99245  
CPT" II: 0500F, 0501F, 0502F  
UB Revenue: 0514               |
| Obstetric Panel              | CPT*: 80055                                                           |
| Prenatal Ultrasound          | CPT*: 76801, 76805, 76811, 76813, 76815-76821, 76825-76828  
ICD-9 Procedure: 88.78        
ICD-10-PCS*: BY49ZZZ, BY4BZZZ, BY4CZZZ, BY4DZZZ, BY4FZZZ, BY4GZZZ |
| ABO and Rh                   | CPT" (ABO): 86900  
CPT" (Rh): 86901            |
| TORCH                        | CPT* (Toxoplasma): 86777, 86778  
CPT* (Rubella): 86762        
CPT* (Cytomegalovirus): 86644  
CPT* (Herpes simplex): 86694, 86695, 86696 |
| Pregnancy Diagnosis (for PCP, use these codes and one of the codes above) | ICD-9 Diagnosis: 640.x3, 641.x3, 642.x3, 643.x3, 644.x3, 645.x3, 646.x3, 647.x3, 648.x3, 649.x3, 651.x3, 652.x3, 653.x3, 654.x3, 655.x3, 656.x3, 657.x3, 658.x3, 659.x3, 678.x3, 679.x3, V22-V23, V28  
ICD-10-CM*: O09-O16, O20-O26, O28-O36, O40-O48, O60.0, O71, O88, O91, O92, O98, O99, O9A, Z03.7, Z33, Z34, Z36 |

*ICD-10-CM and ICD-10-PCS codes are to be used on or after 10/1/2015. Please refer to your ICD-10-CM and ICD-10-PCS Manuals for further code specificity.
HOW TO IMPROVE HEDIS® SCORES

- Schedule prenatal care visits starting in the first trimester or within 42 days of enrollment
- Ask front office staff to prioritize new pregnant patients and ensure prompt appointments for any patient calling for a pregnancy visit to make sure the appointment is within the first trimester or within 42 days of enrollment
- Have a direct referral process to OB/GYN practitioners in place
- Use the Prenatal Calendar Tool from Molina to ensure the visit is within the correct time frame. The calendar tool is available on-line at: http://www.molinahealthcare.com/providers/wa/medicaid/forms/PDF/Prenatal-and-Postpartum-Calendars.PDF
- Please refer to the Clinical Practice Guideline (CPG) on Prenatal Care at: http://www.molinahealthcare.com/providers/wa/medicaid/PDF/PHG-Prenatal-Care-Routine.pdf
- Patients diagnosed with a high-risk pregnancy, including patients with a history of previous preterm delivery may qualify for case management and should be referred to the Molina Healthcare CM Program for evaluation: (800) 869-7165
- Molina Healthcare offers a member Health Incentive program for Prenatal Care, where Medicaid members earn reward points redeemable for health related items. For more information, please call (800) 869-7165 Ext. 141428.
MEASURE DESCRIPTION
Postpartum visit for a pelvic exam or postpartum care with an OB/GYN practitioner or midwife, family practitioner or other PCP on or between 21 and 56 days after delivery. A Pap test within 21-56 days after delivery also counts.

Documentation in the medical record must include a note with the date when the postpartum visit occurred and one of the following:

- Pelvic exam, or
- Evaluation of weight, BP, breast and abdomen, or
- Notation of “postpartum care”, PP check, PP care, 6-week check, or pre-printed “Postpartum Care” form in which information was documented during the visit

USING CORRECT BILLING CODES
Please note that global billing or bundling codes do not provide specific date information to count towards this measure.

Codes to Identify Postpartum Visits
<table>
<thead>
<tr>
<th>Description</th>
<th>Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Postpartum Visit</td>
<td>CPT*: 57170, 58300, 59430</td>
</tr>
<tr>
<td></td>
<td>CPT® II: 0503F</td>
</tr>
<tr>
<td></td>
<td>HCPCS: G0101</td>
</tr>
<tr>
<td></td>
<td>ICD-9 Diagnosis: V24.1, V24.2, V25.1, V72.3, V76.2</td>
</tr>
<tr>
<td></td>
<td>ICD-9 Procedure: 89.26</td>
</tr>
<tr>
<td></td>
<td>ICD-10* Diagnosis: Z01.411, Z01.419, Z30.430, Z39.1, Z39.2</td>
</tr>
</tbody>
</table>

*ICD-10-CM codes are to be used on or after 10/1/2015. Please refer to your ICD-10-CM Manual for further code specificity.

Codes to Identify Cervical Cytology
<table>
<thead>
<tr>
<th>Description</th>
<th>CPT*, HCPCS, UB Revenue Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cervical Cytology</td>
<td>CPT*: 88141-88143, 88147, 88148, 88150, 88152-88154, 88164-88167, 88174, 88175</td>
</tr>
<tr>
<td></td>
<td>HCPCS: P3000, P3001</td>
</tr>
<tr>
<td></td>
<td>UB Rev: 0923</td>
</tr>
</tbody>
</table>
HOW TO IMPROVE HEDIS® SCORES

- Schedule your patient for a postpartum visit within 21 to 56 days from delivery (please note that staple removal following a cesarean section does not count as a postpartum visit for HEDIS®)

- Use the Postpartum Calendar Tool from Molina to ensure the visit is within the correct time frame. The calendar tool is available on-line at: http://www.molinahealthcare.com/providers/wa/medicaid/forms/PDF/Prenatal-and-Postpartum-Calendars.PDF

- Molina Healthcare offers a member Health Incentive program for Postpartum Care. Medicaid Members earn reward points redeemable for health related items. For more information, please call (800) 869-7175 Ext. 141428.

- Please refer to the Clinical Practice Guideline (CPG) on Prenatal Care (which also addresses Postpartum Care) at: http://www.molinahealthcare.com/providers/wa/medicaid/PDF/PHG-Prenatal-Care-Routine.pdf
Q: Does Molina have another mechanism to collect HEDIS® data other than the claims system?
Answer: Yes, Molina has the capability to collect medical records using the following methods:
- Fax Medical Record to (800) 338-7976
- Email Medical Record to: HEDIS_SDS@MolinaHealthcare.com and [send secure]
- EMR or Registry data exchange
- Provider Services Portal: https://provider.molinahealthcare.com/provider/login

Q: Our practice did a well child exam on an infant. Why does this service continue to show up on my report as non-compliant?
Answer: Newborns less than 15 months old need six well child visits before they turn 15 months to be marked compliant.

Q: A member has changed their PCP and no longer sees our doctor, but still shows up on our HEDIS®/missed services report. How do we get this changed?
Answer: The member should notify the Molina Member Services Department of the change, either by phone (800) 869-7165, or online at MyMolina.com. Once notified, the member will be removed from your HEDIS® missing services report. The HEDIS® missing services report displays members who are assigned to a provider office as of the run date of the report.

Q. Can the member change their PCP on the Molina Website?
Answer: Yes. Members can change their doctor, request an ID card, and check their eligibility using the web portal on the Molina website, MolinaHealthcare.com.

Q: The Missed Service Report still lists services we performed months ago. How can we get the Missed Service Report corrected?
Answer: Give your Molina Provider Representative a specific example of the issue so the problem can be properly investigated. Factors that may influence whether a service is removed from the Missed Service Report include:

1. HEDIS® guidelines for meeting compliance for a specific measure. To mark a member compliant, a specific diagnosis or CPT® code must be billed. Even though the service was performed, if the claim does not reflect the specific diagnosis or CPT® code the member will remain non-compliant and continue to show up on your report. Refer to your Molina Healthcare HEDIS® Provider Guide and Toolkit for information regarding HEDIS® codes.
2. Lack of a secondary claim. For members who have another primary insurance, Molina must receive a secondary claim in order to mark the member compliant.
3. Timing issues. Missing Service Reports reflect a time lag between the render date and the date the member is marked compliant because Molina has to wait until the claim is billed.
4. Compliance timeframe issues. The service must be performed within the timeframes for the HEDIS® measure. If a service is performed outside the compliance timeframe, the member will continue to show up on your report.

Q: Is there a penalty for doctors who have patients who do not cooperate?
Answer: HEDIS® standards make no distinction between non-compliant and uncooperative members, and there is no provision to remove an uncooperative member from the targeted population. Plans and providers are encouraged to work with these members to render the recommended service(s).