IMPERIAL HEALTH PLAN OF CALIFORNIA

2021 HEDIS Guide

IMPERIAL INSURANCE COMPANIES

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*The listed sample codes are not inclusive and do not represent a complete list of codes

ANNUAL WELLNESS VISIT (AWV)

DESCRIPTION	
Yearly visit to develop or update a personalized prevention plan and perform a health risk assessment.	
ICD-10 CODES	
No abnormal findings	Z00.00
With abnormal findings	Z00.01
HCPCS CODES	
Welcome	G0402
Initial	G0438
Subsequent	G0439

DOCUMENTATION

Medical record must include:

- Patient name and date of birth
- Date of service
- Height, weight, BMI, blood pressure, and other measurements deemed appropriate
- Medical and family history
- Assessment of preventable diseases with risk and treatment options
- Assessment of cognitive impairment
- Depression screening
- Updated list of prescriptions and medications
- Health Risk Assessment:
  - Demographic data (*e.g., age, gender, race, ethnicity*)
  - Self-assessment of health status, frailty, and physical function
  - Psychosocial and behavioral health risks
  - Activities of daily living
- Assessment of functional ability and level of safety (*e.g., fall risk, hearing, home safety*)
- Checklist or schedule of preventive screenings for the next 5-10 years

BEST PRACTICES

1. Remind and schedule patients for annual office visits
2. Educate and vaccinate patient for influenza yearly
3. Submit timely encounters with appropriate ICD-10 and HCPCS codes

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CARE FOR OLDER ADULTS

FUNCTIONAL STATUS ASSESSMENT
Complete functional assessment must include one of the following: • Notation that Activities of Daily Living (ADL) were assessed [or at least five of the following were assessed: bathing, dressing, eating, transferring, using toilet, walking] • Notation that Instrumental Activities of Daily Living (IADL) were assessed [or at least four of the following were assessed: shopping for groceries, driving or using public transportation, using the telephone, meal preparation, housework, home repair, laundry, taking medication, handling finances] • Result of assessment using a standardized functional status assessment tool

CPT II CODES	
Functional Status	1170F

MEDICATION REVIEW
Medication list in chart with a dated notation of medication review annually by a prescribing provider or clinical pharmacist. If not on any medications, this should be noted with a date as well.

CPT II CODES	
Medication Review	1160F
Medication List	1159F
*One of each code must be billed to demonstrate compliance	

PAIN ASSESSMENT
Notations for pain assessment must include one of the following: • Documentation that the member was assessed for pain (positive or negative finding) • Result of assessment using a standardized assessment tool **A pain management/treatment plan alone does not count. Either does screening for chest pain or positive chest pain alone or a pain assessment completed during an acute inpatient setting.*

CPT II CODES	
Pain present	1125F
No pain present	1126F

ADVANCE CARE PLANNING
Document, dated discussion and/or presence of advance directive or living will in the chart

CPT II CODES	
Advance Care Plan in Record	1157F
Advance Care Plan discussion documented	1158F

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BREAST CANCER SCREENING (BCS)

DESCRIPTION
Women 50–74 years of age who had a mammogram to screen for breast cancer between October 2019 and December 2021.

CPT CODES	
Mammography	77055-77057, 77061-77063, 77065-77067

***Exclusion codes**: Absence of Left Breast, Absence of Right Breast, Advanced Illness, Bilateral, Mastectomy, Frailty, History of Bilateral Mastectomy, Unilateral Mastectomy*

DOCUMENTATION

Medical record must include:

- Patient name and date of birth
- Copy of radiology report and documentation of historic mammogram results with date of service between 10/1/2019 – 12/31/2021

BEST PRACTICES

1. Educate patients on breast cancer prevention
2. Review findings and document history of a mammogram performed within the last 2 years
3. Refer patient to radiologist and schedule for a mammogram
    a. Schedule a follow-up visit with patient to review results
    b. Document completed mammogram in progress notes with date of service and result of the screening

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CONTROLLING HIGH BLOOD PRESSURE (CBP)

DESCRIPTION	
Patients 18–85 years of age who had a diagnosis of hypertension with their blood pressure adequately controlled (<140/90 mm Hg)	
ICD-10 CODES	
Diagnosis of Hypertension or Hypertensive Disease	I10-I16 *code to the highest specificity
CPT II CODES	
Systolic BP < 130 mm Hg	3074F
Systolic BP between 130-139 mm Hg	3075F
Diastolic BP < 80 mm Hg	3078F
Diastolic BP between 80-89 mm Hg	3079F
CPT CODES	
Outpatient	99201-99205, 99211-99215, 99241-99245, 99341-99345
HCPCS CODES	
Outpatient	G0402, G0438, G0439, G0463, T1015

***Exclusion codes**: Acute Inpatient, Advanced Illness, ESRD, ESRD Obsolete, Frailty, Inpatient Stay, Kidney, Transplant, Non-acute Inpatient Stay, Observation, Pregnancy*

DOCUMENTATION

Medical record must include:

- Patient name and date of birth
- Date of service
- Most recent systolic and diastolic blood pressure values in 2021
    - If there are multiple BPs on the same date of service, use the lowest systolic and diastolic BP on that date as the representative BP

BEST PRACTICES

1. Schedule patients for an annual office visit
2. Always re-check blood pressure if initial reading is 140/90 mm Hg or greater
3. Submit timely encounters with proper ICD-10, CPT/CPT II, and outpatient visit codes
    a. ICD-10 code for hypertension should be submitted to the highest specificity

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COMPREHENSIVE DIABETES CARE (CDC) – Eye Exam

DESCRIPTION	
Patients 18–75 years of age with diabetes (type 1 and 2) who had screening or monitoring for diabetic retinal disease within the measurement year.	
ICD-10 CODES	
Diagnosis of Diabetes	***code to the highest specificity**
CPT II CODES	
Retinal Eye Exam Reviewed (Positive)	2022F, 2024F, 2026F
Retinal Eye Exam Reviewed (Negative)	2023F, 3072F

DOCUMENTATION

Medical record must include:

- Patient name and date of birth
- Date of service
- Retinal or dilated eye exam report from an optometrist or ophthalmologist
  - Presence or absence of retinopathy must be documented

BEST PRACTICES

1. Refer patient to an optometrist or ophthalmologist for diabetic retinal exam
2. Review eye exam results with patient and document results in patient's medical record

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COMPREHENSIVE DIABETES CARE (CDC) – HbA1c Control <8

DESCRIPTION	
Patients 18–75 years of age with diabetes (type 1 and 2) whose had HbA1c testing within the measurement year and most recent HbA1c test has a value < 8.0%	
ICD-10 CODES	
Diagnosis of Diabetes	*code to the highest specificity
CPT II CODES	
HbA1c < 7.0%	3044F
HbA1c 7.0 – 7.9%	3051F
HbA1c 8.0 – 9.0%	3052F
HbA1c > 9.0%	3046F

DOCUMENTATION

Medical record must include:

- Patient name and date of birth
- Date of most recent HbA1c test
- Lab Report
  - Documentation of results/findings

BEST PRACTICES

1. Schedule regular follow-up with patients to monitor changes and adjust therapies as needed
   a. Add HbA1c & urine microalbumin testing as a standard order for patients diagnosed with diabetes
   b. Coordinate care with specialists such as an endocrinologist or nephrologist as needed
2. Submit timely encounters with proper ICD-10, CPT, and outpatient visit codes
   a. ICD-10 code for diabetes must be submitted to the highest specificity

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Kidney Health Evaluation for Patients with Diabetes (KED)

DESCRIPTION
Patients 18–85 years of age with diabetes (type 1 and type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR), during the measurement year: • At least one eGFR is required during the measurement period • At least one uACR is required during the measurement period - The uACR is identified by the member having both a quantitative urine albumin test and a urine creatinine test with service dates four or less days apart • Care must be captured administratively for the KED Measure. Medical record submission will not count.

BEST PRACTICES

1. Schedule regular follow-up with patients to monitor changes and adjust therapies as needed
    a. Routinely refer members with a diagnosis of type 1 or type 2 diabetes out to have their eGFR and uACR
2. Follow up with patients to discuss and educate on lab results
3. Educate on how diabetes can affect the kidneys and offer tips to your patients on preventing damage to their kidneys
    a. Controlling their blood pressure, blood sugars, cholesterol, and lipid levels
    b. Take medications as prescribed that can protect kidney function (ACE inhibitors or ARBs)
    c. Offer education on medications that could be harmful to the kidneys (NSAIDs such as naproxen or ibuprofen)
    d. Limit protein intake and salt in diet
4. Coordinate care with specialists such as an endocrinologist or nephrologist as needed

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COLORECTAL CANCER SCREENING (COL)

DESCRIPTION
Patients 50-75 years of age who had one of the following screenings for colorectal cancer: ▪ Colonoscopy in 2012 to 2021 ▪ Sigmoidoscopy in 2017 to 2021 ▪ Fecal occult blood test (FOBT, gFOBT, iFOBT) in 2020 to 2021 ▪ FIT DNA test in 2019 to 2021

CPT & HCPCS CODES	
FOBT	82270, 82274, G3028
Flexible Sigmoidoscopy	45330-45335, 45337-45342, 45345-45347, 45349, 45350, G0104
Colonoscopy	44388-44394, 44397, 44401-44408, 45355, 45378-45393, 45398, G0105, G0121
CT Colonography	74261-74263, G0213-G0215, G0231
FIT-DNA	81528, G0464

DOCUMENTATION

Medical record must include:

- Patient name and date of birth
- Date of service
- Lab/Pathology reports
  - Documentation of results/findings

BEST PRACTICES

1. Educate patients on the importance of colorectal cancer screening
   a. A colonoscopy every 10 years and stool testing done yearly are shown to have similar effectiveness in identifying colon cancer
2. Refer patient to a gastroenterologist for a colonoscopy
3. Alternatively, have patient complete an immunochemical fecal occult blood test (iFOBT)
   a. Have iFOBT kits readily available in the office to provide to patients during their visit

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TRANSITIONS OF CARE (TRC)
&
MEDICATION RECONCILIATION POST-DISCHARGE (MRP)

DESCRIPTION
The percentage of discharges from 1/1/2021-12/31/2021 for patients 18 years old and older who had an inpatient admission and discharge with documentation of the following four components: • Notification of Inpatient Admission • Receipt of Discharge Information • Patient Engagement After Inpatient Discharge • Medication Reconciliation Post-Discharge

CPT CODES	
Transitional care management services (within 14 days of discharge)	99495
Transitional care management services (within 7 days of discharge)	99496
CPT II CODES	
Discharge medications reconciled with the current medication list in the outpatient medical record	1111F

DOCUMENTATION

Medical record must include:

- Documentation of receipt of notification of inpatient admission on the day of admission or the following day
- Documentation of receipt of discharge information on the day of discharge or the following day
- Documentation of patient engagement (e.g., office visits, visits to the home, telehealth) provided within 30 days after discharge
- Medication Reconciliation Post-Discharge: Documentation of medication reconciliation on the date of discharge through 30 days after discharge (31 total days)

BEST PRACTICES

1. Submit timely encounters with proper coding
2. Ensure all components are documented in the medical record

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MEDICATION ADHERENCE – BLOOD PRESSURE, CHOLESTEROL, or DIABETES MEDICATIONS

DESCRIPTION
Percentage of Medicare Part D beneficiaries 18 years or older with a prescription for blood pressure, cholesterol, and/or diabetes medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication. **"Blood pressure medication"** means an ACE (angiotensin-converting enzyme) inhibitor or and ARB (angiotensin receptor blocker) drug, or a direct renin inhibitor drug. **"Cholesterol medication"** means a statin drug. **"Diabetes medication"** means a biguanide drug, a sulfonylurea drug, a thiazolidinedione drug, a DDP-IV inhibitor, an incretin mimetic or a meglitinide drug. Members who take insulin are not included.

BEST PRACTICES

1. Assess proactively whether the patient is taking medication as prescribed.
    a. Identify & resolve any patient specific adherence barriers
2. Encourage adherence by providing 90-day prescriptions for maintenance drugs.
3. Provide an updated prescription to the pharmacy if your patient's medication dose has changed since their original prescription

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STATIN USE IN PERSONS WITH DIABETES (SUPD)

DESCRIPTION
Percentage of Medicare Part D beneficiaries 40-75 years who were dispensed at least two diabetes medication fills who received a statin medication fill during the measurement period, and remained on a statin medication of *any intensity* for at least 80% of the treatment period. **"Diabetes medication"** means a biguanide drug, a sulfonylurea drug, a thiazolidinedione drug, a DDP-IV inhibitor, an incretin mimetic or a meglitinide drug. Members who take insulin are not included.

BEST PRACTICES

1. Assess proactively whether the patient is taking medication as prescribed.
    a. Identify & resolve any patient specific adherence barriers
2. Encourage adherence by providing 90-day prescriptions for maintenance drugs.
3. Provide an updated prescription to the pharmacy if your patient's medication dose has changed since their original prescription

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STATIN THERAPY FOR PATIENTS WITH CARDIOVASCULAR DISEASE (SPC)

DESCRIPTION
The percentage of males 21-75 years of age and females 40-75 years of age during the measurement year, who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and were dispensed at least one *high* or *moderate-intensity* statin medication during the measurement year. Members must have remained on a statin medication for at least 80% of the treatment period.

BEST PRACTICES

1. Assess proactively whether the patient is taking medication as prescribed.
    a. Identify & resolve any patient specific adherence barriers
2. Encourage adherence by providing 90-day prescriptions for maintenance drugs.
3. Provide an updated prescription to the pharmacy if your patient's medication dose has changed since their original prescription

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