Provider Tip Sheets for

Using Outpatient Measures in Value-based Programs

CHILDREN'S HOSPITAL ASSOCIATION

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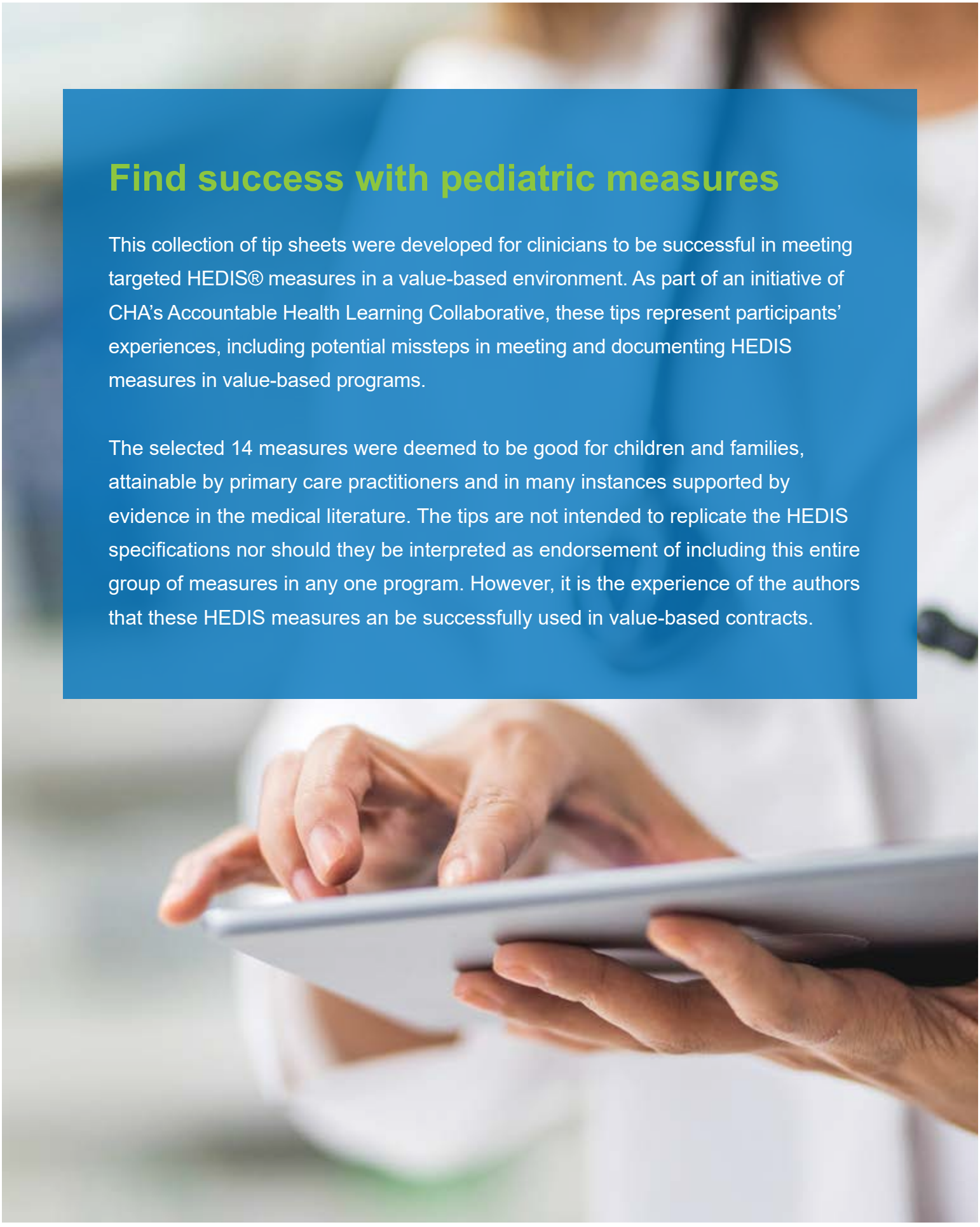
Tip sheets address the HEDIS® MY2020 and MY2021 measure specifications | September 2020



Find success with pediatric measures

This collection of tip sheets were developed for clinicians to be successful in meeting targeted HEDIS® measures in a value-based environment. As part of an initiative of CHA's Accountable Health Learning Collaborative, these tips represent participants' experiences, including potential missteps in meeting and documenting HEDIS measures in value-based programs.

The selected 14 measures were deemed to be good for children and families, attainable by primary care practitioners and in many instances supported by evidence in the medical literature. The tips are not intended to replicate the HEDIS specifications nor should they be interpreted as endorsement of including this entire group of measures in any one program. However, it is the experience of the authors that these HEDIS measures an be successfully used in value-based contracts.

User guide

Two big changes have been made to HEDIS® specifications publications:
1. The naming convention for all HEDIS volumes:
Going forward the name will refer to the measurement year. This is an improvement that should reduce confusion between the measurement year and the reporting year. These updated tip sheets reflect the specifications from HEDIS Measurement Year 2020 and Measurement Year 2021 Volume 2 “Technical Specifications for Health Plans” (shortened to HEDIS MY2020 and MY2021).

2. NCQA has traditionally released HEDIS measure specifications in July of the measurement year. For example, measure specifications for measurement year 2020 were released July 1, 2020. However, for HEDIS measurement year 2021, measure specifications were also published July 1, 2020, giving users six months to prepare. After this transition year, measure specifications will be released 5-months prior to the measurement year on Aug. 1.

Each tip sheet includes the following categories and information:

What is being measured?	A summary of the HEDIS specification description.
Type of measure	**Administrative measure**, meaning only claims information is used to calculate a rate. Hybrid chart review does not apply. **Administrative and hybrid measure**, meaning data is collected through claims data and chart review.
Which children?	Who is included and excluded from the denominator and numerator. Some measures are based on demographic and enrollment criteria, while others require a clinical event or diagnosis.
Tips	Experienced clinicians have shared common barriers to success, along with tips for improving care, measurement, patient compliance and documentation.
Common codes	A reference for documentation.
Helpful resources	Vetted sources of clinical and administrative information.

Selected measures

Notes:

- Bold indicates updated telehealth guidance
- * indicates behavioral health measure

ADMINISTRATIVE MEASURE

Appropriate Testing for Pharyngitis (CWP)*

**Required for NCQA health plan accreditation*

What is being measured?

- Percentage of episodes for members 3 years and older with a diagnosis of pharyngitis, who were dispensed an antibiotic and received a group A streptococcus (strep) test for the episode.
- This measure considers all eligible episodes so a patient can count more than once toward performance for a measurement year.
- A higher rate represents better performance (i.e., appropriate testing).

Which children?

Denominator

- Members who were 3 years or older as of the episode date with diagnosis of pharyngitis.
- Report three age stratifications and total rate: 3-17; 18-64; 65 and older.
- Continuously enrolled (no gaps) from 30 days prior through three days after the episode (34 total days).
- The denominator for this measure is based on episodes, not on members.
- Exclusions:
  - Children in hospice.
  - Episodes that result in an inpatient stay.
  - During the 12 months prior any diagnosis of HIV, malignant neoplasms, emphysema, COPD, immune system disorders and other comorbid conditions (tuberculosis, sickle cell anemia, respiratory failure and others).
  - New or refill Rx for an antibiotic 30 days prior or active on the date of service.
  - Competing diagnosis on or three days after date of service including cholera, typhoid, salmonella, whooping cough and others.

Numerator

A Group A strep test in the seven-day period from three days prior to three days after the date of service.

CWP Antibiotic Medications (in conjunction with a strep test)

Drug category	Medications	
Aminopenicillins	• Amoxicillin	• Ampicillin
Beta-lactamase inhibitors	• Amoxicillin-clavulanate	
First generation cephalosporins	• Cefadroxil • Cefazolin	• Cephalexin
Folate antagonist	• Trimethoprim	
Lincomycin derivatives	• Clindamycin	
Macrolides	• Azithromycin • Clarithromycin • Erythromycin	• Erythromycin ethylsuccinate • Erythromycin lactobionate • Erythromycin stearate
Natural penicillins	• Penicillin G Benzathine • Penicillin G potassium • Penicillin G sodium	• Penicillin V potassium
Penicillinase-resistant penicillins	• Dicloxacillin	
Quinolones	• Ciprofloxacin • Levofloxacin	• Moxifloxacin • Ofloxacin
Second generation cephalosporins	• Cefaclor • Cefprozil	• Cefuroxime
Sulfonamides	• Sulfamethoxazole-trimethoprim	
Tetracyclines	• Doxycycline • Minocycline	• Tetracycline
Third generation cephalosporins	• Cefdinir • Cefditoren • Cefixime	• Cefpodoxime • Ceftibuten • Ceftriaxone

Tips

- To qualify for denominator patients must not have had any antibiotic (from CWP antibiotic list) dispensed in the past 30 days. Patients on long-standing prophylactic antibiotics might be excluded from this measure.
- The intake period window of July 1 to June 30 is non-standard.
- The measure is only looking for evidence of a strep test, not for a positive test.
- Episodes may qualify for the denominator based on care from by outside providers (urgent care, ED, etc.). Provide patients and families with a list of preferred high-quality, after hours facilities.

Common codes

Group A strep test	
CPT	87070-71, 87081, 87430, 87650-52, 87880
LOINC	11268-0, 17656-0, 17898-8, 18481-2, 31971-5, 49610-9, 5036-9, 60489-2, 626-2, 6557-3, 6558-1, 6559-9, 68954-7, 78012-2

Tip: Always bill using the LOINC codes previously listed with your strep test submission – not local codes.

Pharyngitis	
ICD-10 diagnosis	J02.0, J02.8, J02.9, J03.00, J03.01, J03.80-81, J03.90-91

Helpful resources

- Infectious Diseases Society of America: Clinical Practice Guideline for the Diagnosis and Management of a Group A Streptococcal Pharyngitis
- CDC: Pediatric Treatment Recommendations

ADMINISTRATIVE MEASURE

Appropriate Treatment for Upper Respiratory Infection (URI)*

**Required for NCQA health plan accreditation*

What is being measured?

- Percentage of episodes for members three months and older with a diagnosis of upper respiratory infection (URI) that did **not** result in an antibiotic being dispensed.
- This measure considers all eligible episodes so a patient can count more than once toward performance for a measurement year.
- Reported as an inverted rate [1 – (numerator/eligible population)]. A higher rate indicates appropriate URI treatment (i.e. the proportion of episodes that did not result in an antibiotic being dispensed).

Which children?

Denominator

- Members who were 3 months or older as of the episode date with a diagnosis of URI.
- Report 3 age stratifications and total rate: 3-17; 18-64; 65 and older.
- Continuously enrolled (no gaps) from 30 days prior through three days after the episode (34 total days).
- The denominator for this measure is based on episodes, not on members. If a member has more than one eligible episode in a 31-day period, include only the first eligible episode.
- Exclusions:
  - Children in hospice.
  - Episodes that result in an inpatient stay.
  - During the 12 months prior any diagnosis of HIV, malignant neoplasms, emphysema, COPD, immune system disorders and other comorbid conditions (tuberculosis, sickle cell anemia, respiratory failure and others).
  - New or refill Rx for an antibiotic 30 days prior or active on the date of service.
  - Competing diagnosis on or three days after date of service including cholera, typhoid, salmonella, whooping cough and others.

Numerator

Dispensed prescription for antibiotic medication (from CWP antibiotic list) on or three days after the episode.

Medications

Drug category	Medications
Aminopenicillins	• Amoxicillin • Ampicillin
Beta-lactamase inhibitors	• Amoxicillin-clavulanate

Drug category	Medications	
First generation cephalosporins	• Cefadroxil • Cefazolin	• Cephalexin
Folate antagonist	• Trimethoprim	
Lincomycin derivatives	• Clindamycin	
Macrolides	• Azithromycin • Clarithromycin • Erythromycin	• Erythromycin ethylsuccinate • Erythromycin lactobionate • Erythromycin stearate
Natural penicillins	• Penicillin G potassium	• Penicillin G sodium • Penicillin V potassium
Penicillinase-resistant penicillins	• Dicloxacillin	
Quinolones	• Ciprofloxacin • Levofloxacin	• Moxifloxacin • Ofloxacin
Second generation cephalosporins	• Cefaclor • Cefprozil	• Cefuroxime
Sulfonamides	• Sulfamethoxazole-trimethoprim	
Tetracyclines	• Doxycycline • Minocycline	• Tetracycline
Third generation cephalosporins	• Cefdinir • Cefditoren • Cefixime	• Cefpodoxime • Ceftibuten • Ceftriaxone

Tips

- To qualify for denominator patients must not have had any antibiotic (from CWP antibiotic list) dispensed in the past 30 days. Patients on long-standing prophylactic antibiotics might be excluded from this measure.
- The intake period window of July 1 to June 30 is non-standard.
- Document a second diagnosis code for any competing diagnosis (e.g. pharyngitis, otitis media, enteritis, whooping cough, etc.) in addition to the URI code.
- Episodes may qualify for the denominator based on care from by outside providers (urgent care, ED, etc.). Provide patients and families a list of preferred high-quality, after hours facilities.

Common codes

Upper respiratory infection codes that do not need antibiotics	
ICD-10 diagnosis	J00, J06.0, J06.9

Helpful resources

- Infectious Diseases Society of America: Clinical Practice Guideline for Acute Bacterial Rhinosinusitis in Children and Adults
- *Pediatrics* article: Upper Respiratory Tract Infections
- *Pediatrics* article: Principles of Judicious Antibiotic Prescribing for Upper Respiratory Tract Infections in Pediatrics
- *Pediatrics* article: The Diagnosis and Management of Acute Otitis Media
- CDC: Pediatric Treatment Recommendations

ADMINISTRATIVE MEASURE

Asthma Medication Ratio (AMR)*

**Required for NCQA health plan accreditation*

This measure includes updated telehealth guidance:
The restriction that only 3 of the 4 visits with an asthma diagnosis be an outpatient telehealth, telephone, e-visit or virtual check-in has been removed.

What is being measured?

Percentage of members 5 -64 who were identified with persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.

Which children?

Denominator

- Ages 5-64 as of Dec. 31 of the measurement year with persistent asthma.
- Report four age ranges and total rate: 5-11; 12-18; 19-50; 51-64.
- Continuously enrolled (measurement year and the year prior) with no more than one gap of up to 45 days during each year.
- Those who met at least one of the following during both the measurement year and the year prior. (Qualifying criteria can be different in each year).
  - At least one ED visit, with a principal diagnosis of asthma.
  - At least one acute inpatient encounter with a principal diagnosis of asthma (without telehealth).
  - At least one acute patient discharge with a principal diagnosis of asthma on the discharge claim.
  - At least four visits on different dates with any diagnosis of asthma plus at least 2 dispensing events for any asthma controller or reliever medication. (Visit types can be different: outpatient, observation telephone or e-visits/virtual check-ins).
  - At least four dispensing events for any asthma controller or reliever medications (where leukotriene modifiers or antibody inhibitors were the sole asthma medication dispensed, must have at least one diagnosis of asthma in any setting in the same year they were dispensed (measurement year or year prior).
- Dispensing events:
  - Amount lasting 30 days or less. For prescriptions longer than 30 days, divide days' supply by 30 and round down.
  - Multiple prescriptions for different medications dispensed on same day are counted separately.
  - Multiple inhalers of the same medicine dispensed on same day only count as one dispensing event.
  - Each injection is counted separately.

- Exclusions:
  - Children in hospice.
  - Children with any of the following diagnoses: acute respiratory failure; chronic obstructive pulmonary disease (COPD); chronic respiratory conditions due to fumes/vapors; cystic fibrosis, emphysema, obstructive chronic bronchitis.
  - Children who weren't dispensed an asthma medication.

Numerator

Those who have a medication ratio of 0.50 or greater during the measurement year.

Calculation

Total controller medications dispensed ÷ total controller and reliever medications dispensed.

Example:	January	1 albuterol canister
	February	1 albuterol canister, 1 QVAR canister
	March	1 albuterol canister, 1 QVAR canister

2 controller medication units dispensed ÷ 5 total asthma medication units dispensed = .40, does not count toward numerator

Tips

- Clinical practice guidelines and field research have both illustrated the significance of adherence to medication regimens in controlling asthma. The evidence suggests that asthma patients who are adherent to their prescribed controllers and reliever medication regimens experience fewer exacerbations and thus fewer visits to the ED.
  - Review proper inhaler usage during every encounter with an asthma patient.
  - Review medication list to ensure member has prescriptions for both controller and reliever medications.
  - Document reason for prescribed medication and member's response.
  - Schedule follow-up to evaluate whether medications are taken as prescribed.
  - Convert controller medication to a 90-day supply to increase adherence.
  - Focus on members who have not filled prescriptions for their controller medications.
- Patients that receive 'PRN' inhaled steroid prescriptions will qualify for the denominator but will likely not qualify for the numerator.
- Report codes for diagnosed conditions that may exclude member from this measure.
- Patients may qualify based on care provided outside your network or hospital (urgent care, ED, etc.). Provide patients and families a list of preferred high-quality, after hours facilities.
- Engage community partners such as schools. For example, develop a school-based administration program for controllers instead of just rescue inhalers.
- Consider writing a single albuterol prescription with instructions to dispense two inhalers—one for home and one for school.
- Four or more albuterol fills on separate dispensing dates in one year is the most common qualifying inclusion criteria for this measure. Consider writing albuterol prescription with no more than three refills to encourage the patient or family to contact clinic prior to receiving more albuterol.

Medications

To comply with this measure, the child must have a ratio of controller medications to total (controller + reliever) asthma medications of 50% or more.

Asthma controller medications

Drug category	Medications	
Antiasthmatic combinations	– Dyphylline-guaifenesin	
Antibody inhibitors	– Omalizumab	
Anti-interleukin-4	– Dupilumab	
Anti-interleukin-5	– Benralizumab – Mepolizumab	– Reslizumab
Inhaled corticosteroids	– Beclomethasone – Budesonide – Ciclesonide	– Flunisolide – Fluticasone – Mometasone
Inhaled steroid combinations	– Budesonide-formoterol – Fluticasone-salmeterol	– Fluticasone-vilanterol – Formoterol-mometasone
Leukotriene modifiers	– Montelukast – Zafirlukast	– Zileuton
Methylxanthines	– Theophylline	

Asthma reliever medications

Drug category	Medications
Short-acting, inhaled beta-2 agonists	– Albuterol – Levalbuterol

Common codes

Asthma	
Outpatient CPT	99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401- 99404, 99411-99412, 99429, 99455-99456, 99483 UB Revenue: 051x, 0510-0517, 0519-0523, 0526-0529, 0982-0983
Acute inpatient CPT	99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291 UB Revenue: 0100-0101, 0116-0124, 0126-0134, 0136-0144 0146-0154, 0156-0160, 0167, 0169-0174, 0179, 0190-0194, 0199-0204, 0206-0214, 0219, 1000-1002
Emergency department CPT	99281-99285 UB Revenue: 0450-0452, 0456, 0459, 0981
ICD-10 diagnosis	J45.20-J45.22, J45.30-J45.32, J45.40-J45.42, J45.50-J45.52, J45.901-J45.902, J45.909, J45.990, J45.991, J45.998

Helpful resources

- National Institutes of Health: Asthma Care Quick Reference, Diagnosing and Managing Asthma
- American Academy of Allergy Asthma & Immunology: School-based Asthma Management Program
- Washington State Department of Health: Asthma Resources for Medical Professionals
- King County: Asthma Program Resources for Health Care Providers
- Tacoma-Pierce County Health Department: Asthma Resources

ADMINISTRATIVE MEASURE

Child and Adolescent Well-Care Visits (WCV)

REVISED

New for MY 2020 and MY 2021

- Replaces the former "Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)" AND "Adolescent Well-Care Visits (AWC)"
- Added members age 7-11 years
- Added age stratifications
- Removed telehealth exclusion
- Removed the hybrid data collection method

This measure includes updated telehealth guidance:
The telehealth exclusion has been removed.

What is being measured?

Percentage of members ages 3 to 21 who had at least one comprehensive well-care visit with a primary care provider or an OB/GYN during the measurement year.

Which children and adolescents?

Denominator

- Ages 3 to 21 as of Dec. 31 of the measurement year. Report three age stratifications and total rate: 3-11; 12-17; 18-21.
- Continuously enrolled with no more than one gap of up to 45 days.
- Exclude those in hospice.

Numerator

Those who had one or more well visits with a PCP or OB/GYN during the measurement year. (Practitioner does not have to be assigned to the member.)

Tips

- Well-care visit consists of all of the following. Include the dates of each component was performed or given in the medical record.
  - A health history
  - A physical developmental history
  - A mental developmental history
  - A physical exam
  - Health education/anticipatory guidance
- Ability exists to improve this measure in the short term since it is dependent on a patient receiving an annual preventive visit any time during the measurement year.

- The components of care can be completed at any appointment—not just a well visit— and on different dates of service. However, services specific to an acute or chronic condition are not compliant.
- Whenever possible (and indicated) convert sports pre-participation physical exams or dental clearance exams into well visits. Train staff to identify families who call for sports physicals and dental clearance exams who need well visits.
- Use gaps in care process and reports.
- Schedule next visit at the end of each appointment. Institute a reminder system to make sure well visits are scheduled.
- Have a reminder or call-back system to increase the number of appointments that are kept.
- Recruit office staff to help with reminders for well visits.

Medicaid

- Confirm the PCP and ensure the assignment is accurate. Examples of common issues are:
  - If the parent doesn't elect a PCP, Medicaid assigns a PCP by default.
  - Never seen the child before.
  - Child moved, but not yet terminated by Medicaid.
- For patients with Medicaid as secondary insurance, check that the well visit is billed to Medicaid instead of the primary insurance, so the child is not overlooked as counting toward the measure. This is not very common, but possible, especially with children with medical complexity.

Common codes

Well visits	
CPT	99381-85, 99391-95, 99461
HCPCS	G0438, G0439
ICD-10 diagnosis	Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.5, Z00.8, Z02.0, Z02.1, Z02.2, Z02.3, Z02.4, Z02.5, Z02.6, Z02.71, Z02.82, Z76.1, Z76.2

Helpful resources

- This measure is based on the American Academy of Pediatrics Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents
- AAP: Recommendations for Preventive Pediatric Health Care (Periodicity Schedule)
- AAP: Coding for Pediatric Preventive Care, 2020

ADMINISTRATIVE AND HYBRID MEASURE

Childhood Immunization Status Combination 10 (CIS)*

**Required for NCQA health plan accreditation*

What is being measured?

Percentage of two-year old children who had the following on or before their second birthday:

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

Which children?

Denominator

- Children who turn 2 years of age during the measurement year.
- Continuously enrolled with no more than one gap of up to 45 days during 12 months prior to the child's second birthday.
- Exclusions:
  - Children in hospice.
  - Optionally exclude children who had contraindication or anaphylactic reaction to a specific vaccine.
  - To exclude patient from denominator for vaccine contraindication secondary to immunodeficiency use D89.9 not Z28.0-Z28.09.
  - Patients who refuse any or all vaccines are included in the denominator even if with documentation of refusal (using Z28.01-Z28.89) or preventive counseling (using 99401-99404).

Numerator

Those who received the immunizations described.

Tips

Common chart deficiencies

- Immunizations received after the second birthday.
- PCP charts do not contain immunization records if received elsewhere, such as health departments.
- Immunizations given in the hospital at birth. Suggested solution: confirm with the payer(s) the process for newborn claims processing. Is the data accessible?
- No documentation of contraindications or allergies.
- No second influenza vaccination. Suggested solution: develop standard process to recall patients for second influenza vaccination.
- Documentation of physician orders, CPT codes or billing charges will not meet compliance.

Medical record requirements

- Medical record must include one of the following:
  - A note with the name of the specific antigen and the date of the immunization.
  - An immunization record from an authorized health care provider or agency. For example, a registry including the name of the specific antigen and the date of the immunization.
- For documented history of illness or a seropositive test result, there must be a note indicating the date of the event, which must have occurred by the patient's second birthday.
- Notes in the medical record indicating that the child received the immunization at delivery or in the hospital may be counted toward the numerator *only* for immunizations that do not have minimum age restrictions.
- Documentation that a child is up to date with all immunizations but doesn't include a list of the immunizations and dates is not compliant.
- Patients receiving immunizations before the appropriate window do not count in the numerator (e.g. DTaP, IPV, HiB, PCV, Rotovirus should not be given prior to 42 days after birth and influenza not prior to 6 months or 180 days after birth). See "Common Codes" below for special circumstances by type of immunization.

Improve compliance

- Leverage state immunization records to capture the patient's complete immunization record. Inquire whether the payer(s) receives records from state immunization registries as standard part of their HEDIS reporting. If applicable, consider participating in the state's immunization registry.
- Whenever possible (and appropriate), forecast, review status with parents and give vaccines at all visit types (beyond just well visits).
- Recommend immunizations to parents and address common misconceptions. They are more likely to agree with vaccinations when supported by the provider.
- Schedule appointments for your patient's next vaccination before they leave your office.

Vaccine schedules

- CDC/ACIP vaccination catch-up schedules do not necessarily line-up with HEDIS CIS specifications—in particular, be careful of getting off track with Rotovirus, HiB and DTaP (e.g. third DTaP given at 18 months makes it almost impossible to give fourth DTaP by 24 months as required in the measure).
- If patient is on an alternate vaccine schedule, pay attention to the order in which active versus inactive vaccines are given.
- Accelerate the periodicity schedule so that the two-year immunization is scheduled at 18-19 months, which is the lower end of the range from Bright Futures™.

Common codes

DTaP	
Number of doses	4
Notes	Do not count dose administered from birth through 42 days. Optionally exclude encephalopathy with a vaccine adverse-effect code. Immunizations documented using a generic header or “DTaP/DTP/DT” can be counted as evidence of DTaP.
CPT	90698, 90700, 90721, 90723
CVX codes	20, 50, 106, 107, 110, 120

Hep A	
Number of doses	1
Notes	Must be administered on or between a child’s first and second birthdays. Evidence of diagnosis for the disease and/or a positive titer recorded in supplemental electronic medical record information counts as compliance with that part of the measure.
CPT	90633
CVX codes	31, 83, 85

Hep B	
Number of doses	3
Notes	First dose can be during the first 8 days of life. Evidence of diagnosis for the disease and/or a positive titer recorded in supplemental electronic medical record information counts as compliance with that part of the measure. Initial Hepatitis B given at birth or nursery/hospital should be documented in the medical record or indicated on the immunization record, as appropriate. In the first 30 days of life, patient’s vaccination claim might be processed as parent’s claim instead of newborn’s claim. Confirm newborn claims processing with payers. Optionally exclude anaphylactic reaction to common baker’s yeast.
CPT	90723, 90740, 90744, 90747-48

Hep B	
CVX codes	08, 44, 45, 51, 110
HCPCS	G0010

HiB	
Number of doses	3
Notes	Do not count dose administered from birth through 42 days.
CPT	90644-48, 90698, 90721, 90748
CVX codes	17, 46-51, 120, 148

Influenza	
Number of doses	2
Notes	Do not count dose administered prior to age 6 months. One of the two can be an LAIV vaccination administered on the child's second birthday (do not count an LAIV vaccination before the children's second birthday). Optionally exclude for immunodeficiency, HIV, lymphoreticular cancer, multiple myeloma or leukemia, anaphylactic reaction to neomycin.
CPT	90655, 90657, 90661-62, 90673, 90685-88 (LAIV: 90660, 90672)
CVX codes	88, 135, 140, 141, 150, 153, 155, 158, 161 (LAIV: 111, 149)
HCPCS	G0008

IPV	
Number of doses	3
Notes	Do not count dose administered from birth through 42 days. Immunizations documented using a generic header (e.g. polio vaccine) or "IPV/OPV" can be counted as evidence of IPV. Optionally exclude anaphylactic reaction to streptomycin, polymyxin B or neomycin
CPT	90698, 90713, 90723
CVX codes	10, 89, 110, 120

MMR	
Number of doses	1
Notes	Any combination of measles, mumps and rubella vaccines must be administered on or between a child's first and second birthdays. Evidence of diagnosis for the disease and/or a positive titer recorded in supplemental electronic medical record information counts as compliance with that part of the measure. Optionally exclude for immunodeficiency, HIV, lymphoreticular cancer, multiple myeloma or leukemia, anaphylactic reaction to neomycin.
CPT	90707, 90710
CVX codes	03, 94

Measles/Rubella	
Number of doses	1
CPT	90708
CVX codes	04

Measles	
Number of doses	1
CPT	90705
CVX codes	05

Mumps	
Number of doses	1
CPT	90704
CVX codes	07

Rubella	
Number of doses	1
CPT	90706
CVX codes	06

PCV	
Number of doses	4
Notes	Do not count dose administered from birth through 42 days.
CPT	90670
CVX codes	133, 152
HCPCS	G0009

Rotavirus	
Number of doses	2 or 3 (depending on vaccine manufacturer)
Notes	Do not count dose administered from birth through 42 days. Optionally exclude history of intussusception; severe combined immunodeficiency. When documenting the rotavirus vaccine, always include Rotarix® or two-dose, or RotaTeq® or three-dose with the date of administration. – If medical record documentation doesn't indicate whether the two-dose schedule or three-dose schedule was used, it is assumed that the three-dose regimen was used but only recorded for two dates. The vaccinations will then not count.
CPT	Rotovirus two dose: 90681 Rotovirus three dose: 90680
CVX codes	Rotavirus two dose: 119, Rotavirus three dose: 116, 122

VZV	
Number of doses	1
Notes:	Must be administered on or between a child's first and second birthdays. Evidence of diagnosis for the disease and/or a positive titer recorded in supplemental electronic medical record information counts as compliance with that part of the measure. Optionally exclude for immunodeficiency; HIV; lymphoreticular cancer, multiple myeloma or leukemia; anaphylactic reaction to neomycin.
CPT	90710, 90716
CVX codes	21, 94

Helpful resources

- Information to help parents choose to immunize is available at from CDC Why Vaccinate or your state's public health department website.
- Current immunization schedule from the CDC, AAP, AAFP, and ACOG: Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger, United States, 2020
- AAP: Commonly Administered Pediatric Vaccines Table
- AAP: Immunizations webpage
- Children's Hospital of Philadelphia: Vaccine Education Center

ADMINISTRATIVE MEASURE

Follow-Up After Emergency Department Visit for Mental Illness (FUM)

This measure includes updated telehealth guidance:
Telephone visits, e-visits and virtual check-ins have been added to the numerator.

What is being measured?

- The percentage of ED visits for children 6 years and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness.
- Two rates are reported:
    1. The percentage of ED visits for which the child received follow-up within 30 days of the ED visit (31 total days).
    2. The percentage of ED visits for which the child received follow-up within 7 days of the ED visit (8 total days).

Which children?

Denominator

- Children who have an ED visit with a principal diagnosis of mental illness or intentional self-harm on or between Jan. 1 and Dec. 1 of the measurement year who are 6 years or older on the date of the visit.
- Report three age ranges and total rate: 6-17; 18-64, 65 and older.
- Continuously enrolled (no gaps) from date of the ED visit through 30 days after the ED visit (31 total days).
- The denominator is based on ED visits, not on members. If a member has more than one ED visit in a 31-day period include only the first eligible ED visit for that period.
- Exclusions:
    - Children in hospice.
    - ED visits that result in an admission on the same day or within 30 days of ED visit regardless of principal diagnosis for the admission (because admission may prevent an outpatient follow-up visit).

Numerators

- Follow-up visits with any practitioner, with a principal diagnosis of a mental health disorder or intentional self-harm plus any diagnosis of a mental health disorder:
    1. Within 30 days after the ED visit (31 total days).
    2. Within 7 days after the ED visit (8 total days).
- Include visits that occur on the date of the ED visit.
- Types of visits: outpatient, intensive outpatient or partial hospitalization, community mental health center, electroconvulsive therapy, telehealth, observation, telephone, e-visit or virtual check-in.

Tips

- This measure uses medical and behavioral health claims. The provider may not have access to behavioral health claims if carved out by the state.
- This measure was new in 2017 so there is not yet significant experience with it. Develop experience with it before requiring it to achieve incentive payments in a value-based contract.
- Schedule the seven-day follow-up visit within five days after the ED visit to allow flexibility in rescheduling, if necessary.
- Schedule the seven-day follow-up visit with a mental health practitioner before the patient leaves the ED.
- Call the patient and/or parent/guardian 24 to 72 hours after discharge to verify appointments are scheduled and address additional needs.
- Review medications with patient and/or caregiver and educate on the importance of taking them with appropriate frequency.
- Provide information on the importance of monitoring emotional well-being and following up with their mental health practitioner.

Common codes

Mental Illness Diagnosis Codes	
ICD-10 diagnosis	F03.xx, F20-F53, F59-F69, F80-F99, Diagnosis of intentional self-harm (multiple possible codes) With any of the following CPT:
Follow-up Visits	
CPT	98960-98962, 99078, 99201-99205, 99211-99215, 99217- 99220, 99241-99245, 99341-99345, 99347-99350, 99381- 99387, 99391-99397, 99401-99404, 99411, 99412, 99483, 99510
HCPCS	G0155, G0176, G0177, G0409-G0411, G0463, H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, M0064, S0201, S9480, S9484, S9485, T1015
UB Revenue	0510, 0513, 0515-0517, 0519-0523, 0526- 0529, 0900-0905, 0907, 0911-0917, 0919, 0982, 0983

Helpful resources

- AAP Guidelines for Adolescent Depression in Primary Care (GLAD-PC): Part 1. Practice Prep, Identification, Assessment and Initial Management
- AAP Guidelines for Adolescent Depression in Primary Care (GLAD-PC): Part 2. Treatment and Ongoing Management
- The REACH Institute: AAP Guidelines for Adolescent Depression in Primary Care (GLAD-PC) Toolkit
- Seattle Children's: Partnership Access Line Care Guides and Resources

ADMINISTRATIVE MEASURE

Follow-Up After Hospitalization for Mental Illness (FUH)*

**Required for NCQA health plan accreditation*

This measure includes updated telehealth guidance:
Telephone visits have been added to the numerator.

What is being measured?

- Percentage of discharges for members 6 years and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and had a follow-up visit with a **mental health provider**.

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

Which children?

Denominator

- Children with an acute inpatient discharge with a principal diagnosis of mental illness or intentional self-harm on the discharge claim on or between Jan. 1 and Dec. 1 of the measurement year who are 6 years or older as of the date of discharge.
- Report three age ranges and total rate: 6-17; 18-64; 65 and older.
- Continuously enrolled (no gaps) from date of discharge through 30 days after discharge.
- If more than one discharge, include all discharges between Jan. 1 and Dec. 1.
- The denominator is based on discharges, not on members. If members have more than one discharge, include all discharges on or between Jan. 1 and Dec. 1 of the measurement year.
- Exclusions:
    - Children in hospice.
    - Discharges followed by readmission or direct transfer to a nonacute inpatient setting within the 30 day follow-up period (regardless of readmission principal diagnosis) (because rehospitalization or direct transfer may prevent an outpatient follow-up visit).
    - Both the initial discharge and the readmission/direct transfer discharge, if the last discharge occurs after Dec. 1 of the measurement year.

Numerators

1. A follow-up visit with a mental health provider within 30 days of discharge.

2. A follow-up visit with a mental health provider within 7 days of discharge.

- For both, do NOT Include visits that occur on the date of discharge.
- Types of follow-up visits: outpatient, telehealth, observation, transitional care management, behavioral healthcare setting, telephone, intensive outpatient or partial hospitalization, community mental health center or electroconvulsive therapy.

Tips

- For both reported rates, visits that occur on the date of discharge will not count toward compliance.
- This measure uses medical and behavioral health claims. Providers may not have access to behavioral health claims if carved out by the state.
- Follow-up visits that are disconnected from the treatment plan may meet the measure, but not provide optimal quality care.
- A visit with a PCP does not meet compliance. The follow-up visit must be with a mental health provider.
- Improve connections between inpatient and outpatient healthcare or community providers. Mental health coordination lags behind physical medicine coordination. Developing a relationship between providers can improve transitions.
- For some patients the 7-day follow-up may provide a bridge from the discharge to the 30-day follow-up.
- Patients attending multiple appointments in quick succession may feel burdened with having to repeatedly tell their story. This can lead to increased no-shows and cancellations.
- Target care coordination to assist patients with barriers to care.
- Ensure follow-up visit is scheduled prior to discharge.
- Call the patient and/or parent/guardian 24 to 72 hours after discharge to verify appointments are scheduled and address additional needs.
- Review medications with patient and/or caregiver and educate on the importance of taking them with appropriate frequency.
- Provide information on the importance of monitoring emotional well-being and following up with their mental health practitioner.

Common codes

Mental Illness Diagnosis Codes	
ICD-10 diagnosis	F03.xx, F20-F53, F59-F69, F80-F99, Diagnosis of intentional self-harm (multiple possible codes) With any of the following CPT:
Follow-up Visits	
CPT	98960-98962, 99078, 99201-99205, 99211-99215, 99217- 99220, 99241-99245, 99341-99345, 99347-99350, 99381- 99387, 99391-99397, 99401-99404, 99411, 99412, 99483, 99510
HCPCS	G0155, G0176, G0177, G0409-G0411, G0463, H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, M0064, S0201, S9480, S9484, S9485, T1015
UB Revenue	0510, 0513, 0515-0517, 0519-0523, 0526- 0529, 0900-0905, 0907, 0911-0917, 0919, 0982, 0983

ADMINISTRATIVE MEASURE

Follow-Up Care for Children Prescribed ADHD Medication (ADD)*

**Required for NCQA health plan accreditation*

This measure includes updated telehealth guidance:
Telehealth and telephone visits have been added to the Rate 1 numerator.
E-visits and virtual check-ins have been added to the Rate 2 numerator and telehealth restrictions have been modified.

What is being measured?

- Percentage of children newly prescribed ADHD medication who had at least three follow-up visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed.
- Two rates are reported:
    1. Initiation phase: Percentage of children 6–12 years old with an ambulatory prescription dispensed for ADHD medication who had one follow-up visit with a practitioner with prescribing authority during the 30-day initiation phase.
    2. Continuation and maintenance phase: Percentage of children ages 6–12 years old with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the initiation phase, had at least two follow-up visits with a practitioner on different dates within 270 days (nine months) after the initiation phase ended.
- Many children should qualify for this measure, both for initiation, and continuation and maintenance, which typically accounts for 5% of practice volume.

Which children?

RATE 1 | Initiation Phase

Denominator

- Children 6 years as of March 1 of the year prior to the measurement year to 12 years as of the last calendar day of February for the measurement year, who were dispensed an ADHD medication during the same period.
- Assure negative medication history for each ADHD prescription: a period of 120 days prior to index prescription start date (IPSD) when the child had no ADHD medications (new or refill) dispensed.
- Continuously enrolled (no gaps) for 120 days (four months) prior to the IPSD through 30 days after.
- Exclusions
    - Children in hospice.
    - Children who had an acute inpatient encounter for a mental, behavioral or neurodevelopmental disorder during the 300 days after IPSD.
    - Optionally exclude children with a diagnosis of narcolepsy.

Drug category	Medications	
CNS stimulants	• Methylphenidate • Dexmethylphenidate • Lisdexamfetamine	• Dextroamphetamine • Methamphetamine
Alpha-2 receptor agonists	• Clonidine • Guanfacine	
Miscellaneous ADHD medications	• Atomoxetine	

Numerator

- A follow-up visit with a practitioner with prescribing authority, within 30 days after the IPSD.
- Types of follow-up visits: outpatient, observation, health and behavior assessment or intervention, intensive outpatient encounter or partial hospitalization, community mental health center, telehealth, telephone.

RATE 2 | Continuation and Maintenance Phase

Denominator

- Children 6 years as of March 1 of the year prior to the measurement year to 12 years as of the last calendar day of February for the measurement year, who were dispensed an ADHD medication during the same period, who filled a sufficient number of prescriptions to provide continuous treatment for at least 210 days out of the 300 days after the IPSD with no more than 90 gap days (regardless of number of gaps).
- Continuously enrolled for 120 days (four months) prior to the IPSD and 300 days (10 months) after the IPSD. One 45-day gap in enrollment between 31 days and 300 days after the IPSD is allowed.
- Exclusions
  - Children in hospice.
  - Children who had an acute inpatient encounter for a mental, behavioral or neurodevelopmental disorder during the 300 days after IPSD.
  - Optionally exclude children with a diagnosis of narcolepsy.

Numerator

- Those who are compliant for Rate 1 initiation phase **and** had at least two follow-up visits on different dates with any practitioner, from 31-300 days after the IPSD.
- Types of follow-up visits: outpatient, observation, health and behavior assessment or intervention, intensive outpatient encounter or partial hospitalization, community mental health center, telehealth, telephone, e-visit or virtual check-in (only one of the two visits may be this type.)

Tips

Initiation Phase

- Do not count a visit on the IPSD as the initiation phase follow-up visit.
- Use screening tools such as the Vanderbilt Assessment Scale to assist with diagnosing ADHD.
- When prescribing ADHD medication for the first time, write the initial prescription for the number of days until the follow-up appointment to increase the likelihood that a patient will come to the visit.

Follow-up visit:

- Schedule the child's follow-up appointment 21–28 days after they receive their initial prescription to assess effectiveness and address any side effects.
- Provide enough time to discuss important adherence information like taking medication as prescribed, refills, missed appointments and lost prescriptions and answer all questions.
- Discuss the importance of follow-up visits and what they involve. Schedule at least three follow-up visits at the time a patient is diagnosed and gets their prescription.
- Consider a phone call follow-up before the face-to-face follow-up visit to check on the patient.

Continuation and Maintenance Phase

- Schedule at least two more follow-up appointments within the next nine months to help ensure the child is stabilized on an appropriate dose.
- Only one of the two visits may be an e-visit or virtual check-in.

General

- Sometimes the initiator is not the PCP, but the PCP still owns the measure. It still counts because it is claims-based.
- Patients should have in-person visits at least twice a year to check vitals and growth.
- When changing doses, frequent visits are preferable.
- Review the patient's history of prescription refill patterns and reinforce education and reminders to take their medication as prescribed.
- Always schedule the next visit before the patient leaves.
- Send reminders for appointments.
- Contact those who miss appointments.

Common codes

Visit setting unspecified (must be billed with place of service code)	
CPT	90791-92, 90832-34, 90836-40, 90845, 90847, 90849, 90853, 90875-76, 99221-23, 99231-33, 99238-39, 99251-55
POS	02 (telehealth), 03, 05, 07, 09, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 22, 33, 49, 50, 52, 53, 71, 72

Behavioral health outpatient	
CPT	98960-98962, 99078, 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411-99412, 99510
HCPCS	G0155, G0176-G0177, G0409, G0463, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010-H2011, H2013-H2020, M0064, T1015
UB Rev	0510, 0513, 0515-0517, 0519-0523, 0526-0529, 0900, 0902-0904, 0911, 0914-0917, 0919, 0982-0983
Health and Behavior Assessment/Intervention	
CPT	96150-96154
Observation	
CPT	99217-99220
Telephone visits	
CPT	98966-68, 99441-43

Helpful resources

- AAP Policy: ADHD: Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents
- NICHQ Resource: Care for Children with ADHD: A Resource Toolkit for Clinicians

ADMINISTRATIVE AND HYBRID MEASURE

Immunizations for Adolescents (IMA)*

**Required for NCQA health plan accreditation*

What is being measured?

- Percentage of adolescents age 13 who had the following immunizations on or prior to their 13th birthday. The measure calculates a rate for each vaccine and two combination rates.
  - One (1) meningococcal conjugate vaccine
  - One (1) tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine
  - Two (2) human papillomavirus (HPV) at least 146 apart OR three (3) human papillomavirus (HPV) between the 9th and 13th birthdays.

Which children?

Denominator

- Adolescents who turn 13 years of age during the measurement year.
- Continuously enrolled 12 months prior to the member's 13th birthday with no more than one gap in enrollment up to 45 days during 12 months prior to the 13th birthday.
- Exclusions:
  - Adolescents in hospice.
  - Adolescents with a contraindication for a specific vaccine.
  - Optionally exclude adolescents who had anaphylactic reaction to specific vaccine on or before their 13t birthday and/or with a date of service prior to Oct. 1, 2011.
- Patients who refuse any or all vaccines are included in the denominator even if with documentation of refusal (using Z28.01-Z28.89) or preventive counseling (using 99401-99404).

Numerators

- Numerator 1: Those who received meningococcal and Tdap.
- Numerator 2: Those who receive meningococcal and Tdap and HPV.

Tips

Common chart deficiencies

- Vaccines are not administered during the appropriate time frames. Refer to the "notes" in the immunization table below.
- Documentation that a child is up to date with all immunizations, but does not include a list of the immunizations and dates, is not compliant.
- Documentation of physician orders, CPT codes or billing charges are not compliant.

Medical record requirements

- Medical record must include one of the following:
  - A note with the name of the specific antigen and the date of the immunization.
  - An immunization record from an authorized health care provider or agency. For example, a registry including the name of the specific antigen and the date of the immunization.

Improve compliance

- Leverage state immunization records to ensure you capture patient's complete immunization record. Inquire whether your payer(s) receives records from state immunization registries as standard part of their HEDIS reporting. If applicable, consider participating in your state's immunization registry.
- Whenever possible and appropriate, forecast, review status with parents and give vaccines at all visit types (beyond just well visits).
- Recommend immunizations to parents and address common misconceptions. They are more likely to agree with vaccinations when supported by the provider.
- Schedule appointments for your patient's next vaccination before they leave your office.
- Consider targeting patients past due for adolescent immunizations who are 12-12.75 years old. Specifically address non-compliant patients who have time to receive the necessary immunization and be included in the measure for the current measurement year.
- Use gaps in care process and reports.
- Schedule next visit at the end of each appointment. Institute a reminder system to make sure well visits are scheduled.
- Have a reminder or call-back system to increase the number of appointments that are kept.
- Recruit office staff to help with reminders for well visits.

Vaccine schedule

- Improvement takes a significant amount of time because the measure examines immunization completion rates for adolescents on their 13th birthday. Immunizations of interest are given at age 9 and 10 years through 12 years of age.
- Catch-up immunizations can be challenging for a series, which also require space between doses. Example: Two HPV immunizations are needed over six months and patients are only included in the measure after turning 13 years old.

Vaccine hesitancy

- Behavioral psychology literature supports listing HPV in between other vaccines being received as a pre-teen bundle. For example, Tdap, HPV then MCV.
- Giving first HPV at 9-10 years old instead of later can increase compliance.
- Hardwire scheduling of second HPV appointment and reminders.

Common codes

HPV	
Number of doses	2 or 3
Notes	• Dose must be administered on or between the 9th and 13th birthdays. • There must be at least 146 days between the first and second dose of HPV vaccine or at least three HPV vaccines with different dates of service. • May be given at the same time as other vaccines.
CPT	90649-51
CVX codes	62, 118, 137, 165

Meningococcal conjugate	
Number of doses	1
Notes	• Dose must be administered on or between the 11th and 13th birthdays. • Only quadrivalent meningococcal vaccines (serogroups A, C, W, Y) are included in the measure. *Do not count* meningococcal recombinant (serogroup B) (MenB) vaccines.
CPT	90734
CVX codes	108, 114, 136, 147, 167

Tdap	
Number of doses	1
Notes	• Dose must be administered on or between the 10th and 13th birthdays. • Optionally exclude encephalopathy with a vaccine adverse-effect code • Immunizations documented using a generic header or Tdap/Td can be counted as evidence of Tdap.
CPT	90715
CVX codes	115

Helpful resources

- Information to help parents choose to immunize is available at from CDC Why Vaccinate or your state's public health department website.
- Current immunization schedule from the CDC, AAP, AAFP, and ACOG: Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger, United States, 2020
- AAP: HPV Champion Toolkit
- American Cancer Society: What Parents Should Know About the HPV Vaccines

ADMINISTRATIVE AND HYBRID MEASURE

Lead Screening in Children (LSC)

What is being measured?

Percentage of two-year old children who had one or more capillary or venous lead blood test for lead poisoning on or before their second birthday.

Which children?

Denominator

- Children who turn 2 years old during the measurement year.
- Continuously enrolled with no more than one gap in enrollment of up to 45 days during the 12 months prior to child's second birthday.
- Exclude children in hospice.

Numerator

At least one lead capillary or venous blood test on or before the second birthday.

Tips

- All children should be screened for history of lead exposure at well visits, per Bright Futures/AAP Periodicity Schedule. Screening or risk assessment questionnaires are readily available online and can be incorporated into routine well visit workflow.
- Take advantage of every office visit (including sick visits) to perform lead testing.
- Both the date of the test and the test result must be documented with the notation of the lead screening test.
- Obtaining a lead screen sample in the practice setting (by venipuncture or CLIA-waived point-of-care (POC) screening) is associated with higher screening rates. This is more successful than sending the child/family to an external lab for a lead test.
- Consider a standing order for in-office testing.
- See technique for testing in Performing Preventive Services: A Bright Futures Handbook (pgs. 138-140) for best practice to reduce false positives.

Minimum federal and state requirements

- All children enrolled in Medicaid (in all states) are required to receive blood lead screening tests at ages 12 months and 24 months.
- Any Medicaid-enrolled child (in all states) between 24 and 72 months with no record of a previous blood lead screening test must receive one.
- Completion of a risk assessment questionnaire does not meet the Medicaid requirement.
- The Medicaid requirement is met only when the two blood lead screening tests identified in the description (or a catch-up blood lead screening test) are conducted.
- Specific state requirements for lead screening vary and can be universal or targeted policies. Know your state and payer requirements.

Common codes

Lead test	
CPT	83655
LOINC	10368-9, 10912-4, 14807-2, 17052-2, 25459-9, 27129-6, 32325-3, 5671-3, 5674-7, 77307-7

Helpful resources

- Medicaid: Lead Screening Webpage
- AAP: Detection of Lead Poisoning
- Safer Chemical Health Families Report: Gaps in State Lead Screening Policies
- See technique for testing in Performing Preventive Services: A Bright Futures Handbook (pgs. 138-140) for best practice to reduce false positives.

Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS-E)

DMS-E is reported using Electronic Clinical Data Systems (ECDS)

This measure includes updated telehealth guidance:
Added telephone visits and online assessment codes to the Interactive Outpatient Encounter Value Set.

What is being measured?

Percentage of members 12 and older with a diagnosis of major depression or dysthymia, who had an outpatient encounter with a PHQ-9 score present in their record in the same assessment period as the encounter.

There are three assessment periods during the measurement year:

- Jan. 1-April 30
- May 1-Aug. 31
- Sept. 1-Dec. 31

Which children?

Denominator

- Children 12 and older with at least one interactive outpatient encounter (bi-directional communication that is face-to-face, phone based, an e-visit or virtual check-in or via secure electronic messaging) during one of the three the assessment periods with a diagnosis of major depression or dysthymia.
- Exclusions:
  - Children in hospice.
  - Members with: bipolar disorder, personality disorder, psychotic disorder, pervasive developmental disorder.

Numerator

A PHQ-9 score in the member's record during the corresponding assessment period.

Tips

- Child must have diagnosis of major depression or dysthymia. Must have documentation of use of PHQ-9 in each assessment period where the diagnosis is used.
- Ability to improve in short-term since measure simply dependent on patient receiving PHQ-9 assessment during any assessment period in which major depression/dysthymia is diagnosed during the measurement year.
- Educate providers/care staff on PHQ-9 screening processes.
- Update EMR template to integrate screening into clinic workflow.
- Use care staff to facilitate responses while providers interpret results.

PHQ-9 Assessment

- Use PHQ-9 assessments based on the child's age:
  - PHQ-9: 12 years of age and older.
  - PHQ-9 Modified for Teens: For teenagers 12–18 years of age, the PHQ-9 assessment does not need to be face-to-face. It can be completed over the telephone or through a web-based portal.

Special implementation notes

- To implement this measure an organization must use the Electronic Clinical Data System (ECDS).
- Compliance is determined by ECDS not by documentation. However, at least one accountable care organization (ACO) has implemented this measure using chart audits by insurers to verify compliance.
- This measure was new in 2018 so there is not yet significant experience with it. Since there is limited data for this measure, first develop experience with it before requiring it to achieve incentive payments in a value-based contract.

Common codes

Diagnosis of major depression and dysthymia	
CPT	Appropriate level evaluation and management (E&M) Code 96127 Brief educational/behavioral assessment (e.g. Depression inventory, attention-deficit/hyperactivity disorder [ADHD] scale), with scoring and documentation, per standardized instrument.
ICD-10 diagnosis	F32.1-F32.5, F32.9, F33.0-F33.3, F33.40-F33.42, F33.9, F34.1

Helpful resources

- AAP Guidelines for Adolescent Depression in Primary Care (GLAD-PC): Part 1. Practice Prep, Identification, Assessment and Initial Management
- AAP Guidelines for Adolescent Depression in Primary Care (GLAD-PC): Part 2. Treatment and Ongoing Management
- The REACH Institute: AAP Guidelines for Adolescent Depression in Primary Care (GLAD-PC) Toolkit
- Seattle Children's: Partnership Access Line Care Guides and Resources

ADMINISTRATIVE AND HYBRID MEASURE

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)*

**Required for NCQA health accreditation*

This measure includes updated telehealth guidance:
Clarified that services performed during a telephone visit, e-visit or virtual check-in meet Counseling for Nutrition and Counseling for Physical Activity requirements.

What is being measured?

Percentage of children ages 3 through 17 who had an outpatient visit with a PCP or OB/GYN and had evidence of the following during the measurement year:

- Body mass index (BMI) percentile documentation.*
- Counseling for nutrition.
- Counseling for physical activity.

*Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed rather than an absolute BMI value.

Which children?

Denominator

- Children 3 to 17 as of Dec. 31 of the measurement year who had at least one outpatient visit with a primary care provider or OB/GYN.
- Report the following age ranges and total rate: 3-11; 12-17.
- Continuously enrolled with no more than one gap of up to 45 days during the measurement year.
- Exclusions:
  - Children in hospice.
  - Optionally exclude for pregnancy.

Numerators

Those with BMI percentile, counseling for nutrition and counseling for physical activity during the measurement year.

Tips

- BMI and counseling services may be performed during a visit other than a well-child visit (e.g. sick visits, sport physicals).
- Services performed during a telephone visit, e-visit or virtual check-in are compliant.
- Medical record must include height, weight and BMI percentile (must be from same data source) during the measurement year. Including a checklist in the medical record is a good way to make sure that all components of this measure are completed.

Requirements	Compliant	Not compliant
BMI percentile documentation	Either of 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. • Documentation of >99% or <1% meet criteria because a distinct BMI percentile is evident (i.e., 100% or 0%). • **NEW:** Member-collected biometric values (height, weight, BMI percentile) are eligible for use in reporting	• An absolute BMI value only. • Height and weight only. • Ranges and thresholds. This is true even for narrow or single ranges. For example, 15%-16%.
Counseling for nutrition	Must include a note of the date and at least one of the following: • Discussion of current nutrition behaviors (e.g. eating habits, dieting). • Checklist indicating nutrition was addressed. • Counseling or referral for nutrition education. • Receipt of educational materials on nutrition during a face-to-face visit. • Anticipatory guidance for nutrition. • Weight or obesity counseling. • Obesity or eating disorder related services may be used to meet criteria for Counseling for Nutrition and Physical Activity if the specified documentation is present. • Referral to Special Supplemental Nutrition for Women, Infants and Children (WIC).	• Documentation related to child's appetite. • Notation of "health education" or "anticipatory guidance" without specific mention of nutrition. • A notation of "well nourished" during a physical exam.

Requirements	Compliant	Not compliant
Counseling for physical activity	Must include a note of the date and at least one of the following: • Discussion of current physical activity behaviors (e.g. exercise, sports, exam for sports participation). • Checklist indicating physical activity was addressed. • Counseling or referral for physical activity. • Receipt of educational materials on physical activity during a face-to-face visit. • Anticipatory guidance specific to the child's physical activity. • Weight or obesity counseling. • Obesity or eating disorder related services may be used to meet criteria for Counseling for Nutrition and Physical Activity if the specified documentation is present. • Evidence of a sports physical.	• Notation of "health education" or "anticipatory guidance" without specific mention of physical activity. • Notation of anticipatory guidance related solely to safety (e.g. "wears helmet") without physical activity recommendations. • Notation solely related to screen time without mention of physical activity. • A notation of "cleared for gym class" without documentation of discussion.

Codes

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

Counseling for nutrition	
CPT	97802, 98703, 98704 (generally used by dietitians)
HCPCS	G0270, G0271, G0447, S9449, S9452, S9470
ICD-10 diagnosis	Z71.3

Counseling for physical activity	
HCPCS	G0447, S9451
ICD-10 diagnosis	Z02.5, Z71.82

Helpful resources

AAP Institute for Healthy Childhood Weight has resources for professional education, clinical support, policy tools and parents and patients. Two examples are:

- Obesity Prevention, Assessment and Treatment Algorithm
- HALF (Healthy Active Living for Families) Implementation Guide

ADMINISTRATIVE MEASURE

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

REVISED

New for MY 2020 and MY 2021

- Revised the measure name to reflect the first 30 months of life.
- Retired the 0, 1, 2, 3, 4, and 5 well-child visit rates.
- Added Rate 2 for children who turned 30 months during the measurement year and had two or more well-child visits in the last 15 months.
- Removed the hybrid data collection method.
- Removed the telehealth exclusion.

This measure includes updated telehealth guidance:
The telehealth exclusion has been removed.

What is being measured?

Percentage of members who had the following number of well-child visits with a PCP during the last 15 months. The following rates are reported:

1. *Well-Child Visits in the First 15 Months.* Children who turned 15 months old during the measurement year: Six or more well-child visits.
2. *Well-Child Visits for Age 15 Months-30 Months.* Children who turned 30 months old during the measurement year: Two or more well-child visits.

Which children?

RATE 1 | Well-Child Visits in the First 15 Months

Denominator

- Children who turn 15 months during the measurement year (calculate the 15-month birthday as the child's first birthday plus 90 days).
- Continuously enrolled with no more than one gap in enrollment of up to 45 days from 31 days through 15 months of age (calculate 31 days of age by adding 31 days to the date of birth).
- Exclude children in hospice.

Numerator

Those who had six or more well visits on different dates of service on or before the 15th month birthday. Visit must occur with a PCP but the PCP does not have to be assigned to the child.

RATE 2 | Well-Child Visits in First 15 Months

Denominator

- Children who turn 30 months during the measurement year (calculate the 30-month birthday as the second birthday plus 180 days).

- Continuously enrolled with no more than one gap in enrollment of up to 45 days from 15 months plus 1 day through 30 months (calculate the 15-month birthday plus 1 day as the first birthday plus 91 days).
- Exclude children in hospice.

Numerator

Those who had two or more well visits on different dates of service between the 15-month birthday plus 1 day and the 30-month birthday. Visit must occur with a PCP but PCP does not have to be assigned to the child.

Tips

- A well-care visit consists of all of the following. Include the dates of each component was performed or given in the medical record.
  - A health history
  - A physical developmental history
  - A mental developmental history
  - A physical exam
  - Health education/anticipatory guidance
- The components of care can be completed at any appointment—not just a well visit— and on different dates of service. However, services specific to an acute or chronic condition are not compliant.
- Often the first, second or third visit is on the mother's claim. Confirm with the payer(s) the process for the first 30 days of newborn claims processing. Is the data accessible?
- Improvement on this measure takes significant amount of time since performance is evaluated based on six visits over 15 months, then 2 visits from 15-30 months and patients are only included after turning 30 months.
- Whenever possible (and indicated) convert simple acute visits into preventive visits.
- Use gaps in care process and reports.
- Schedule next visit at the end of each appointment.
- Institute a reminder system to make sure well visits are scheduled.
- Have a reminder/call back system to increase the number of appointments that are kept.
- Recruit office staff to help with reminders for well visits.

Medicaid

- Confirm the PCP and ensure the assignment is accurate. Examples of common issues are:
  - If the parent doesn't elect a PCP, Medicaid assigns a PCP by default.
  - Never seen the child before.
  - Child moved, but not yet terminated by Medicaid.
- For patients with Medicaid as secondary insurance, check that the well visit is billed to Medicaid instead of the primary insurance so that the child is not overlooked as counting toward the measure. This is not very common but possible among children with medical complexity.

Common codes

Well-child visits	
CPT	99381-85, 99391-95, 99461
HCPCS	G0438, G0439
ICD-10 diagnosis	Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.5, Z00.8, Z02.0, Z02.1, Z02.2, Z02.3, Z02.4, Z02.5, Z02.6, Z02.71, Z02.82, Z76.1, Z76.2

Helpful resources

- This measure is based on the American Academy of Pediatrics Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents
- AAP: Recommendations for Preventive Pediatric Health Care (Periodicity Schedule)
- AAP: Coding for Pediatric Preventive Care, 2020

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The "Provider Tip Sheets for Outpatient Measures in Value-based Programs" were created from the experience and thought leadership of Children's Hospital Association's Accountable Health Learning Collaborative (AHLC). The AHLC is an interdisciplinary group of peers from 21 children's hospitals who are leaders in the delivery transformation and payment innovation necessary for a move to accountable care.

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Contact Us

Your feedback is welcome regarding what is useful and any clarifications to the guidance.
Contact Nancy Hanson with your comments at nancy.hanson@childrenshospitals.org or 202-753-5391.

The tip sheets are based on the HEDIS MY2020 and MY2021 specifications. Users can expect that they will be reviewed and updated in parallel to the National Committee for Quality Assurance (NCQA) annual review.

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