PHMI QUALITY AND REPORTING RESOURCE 5: DOCUMENTATION AND CODING PLAYBOOK

Overview

The utility of performance measures depends upon accurate data that reflects the care and services patients receive. Through the Population Health Management Initiative (PHMI), community health centers (CHCs) will build capacity to compile and extract all internal data needed for reporting, ensuring no gaps. Accurate and timely medical coding of services provided in the CHC is essential to this process and to ensure efficient and accurate measure calculation.

This document defines the measure, assessment, documentation and coding standards aimed to meet numerator compliance with PHMI specifications for each core HEDIS measure for PHMI. In collaboration with the Data Quality and Reporting Resource 4: Standard Data Fields for HEDIS Measures, this document should be used as a starting point for improving the quality of data capture.

Measure-Specific Documentation and Coding Playbook for Core HEDIS Meaures for PHMI

For each core HEDIS measure for PHMI detailed in this playbook, the following categories and their definitions are included:

FIGURE 5.1: MEASURE-SPECIFIC DOCUMENTATION CATEGORIES WITH DESCRIPTION AND EXPLANATION

Category	Description and Explanation
Measure Definition	The high-level definition of the measure provides an understanding of the basic components needed to meet the criteria. It serves as a guide to review the medical record and understand if an assessment is being completed but not coded or captured. The definition helps CHCs understand the specific types of assessments, tests or evaluations that must be completed to meet numerator compliance.
Documentation	Shows the specific pieces of documentation that need to be within the medical record to meet the criteria. Using these documentation criteria ensures the service is documented as a precursor to or in alignment with coding. This helps CHC staff to understand how the provision of care, proper documentation in the medical record, and coding align and are used for measurement.
Standard Care Templates and Tools	A set of resource tools used to support CHCs in documenting the criteria that meets the standards for the provision of care for each measure. The standard care templates are tools that assist in ensuring accurate and complete documentation, including all critical assessments and elements necessary for compliance with the measure. Utilization of these ensures complete information for supplemental data in instances where necessary coding is missing and helps CHCs take advantage of opportunities to close care gaps and improve patient outcomes. This document references the critical elements that would be needed for a template of each measure and aligns these with and identifies where standard templates are required by the Department of Health Care Services (DHCS).
Exclusions	Some measures have exclusions or specific instances where an otherwise eligible patient would not be included in the measure. These exclusions may be documented in the medical record or coded, depending on the exclusion. Understanding the exclusions and how to properly document/code them will ensure that patients who are not intended to be within the measure are not improperly and adversely impacting measure performance.
Denominator	Defines each denominator to provide an understanding of the overall patient population that is applicable to the measure. The HEDIS Value Set Directory should be consulted for a complete list of denominator codes.
Numerator Billing Codes	Tables provide the applicable codes (e.g., CPT, CPT-II, ICD10CM) for the measure, and highlight, when relevant, the best codes to use (i.e., those that capture the most complete data). The tables provide a coding description to educate staff on the types of codes that would meet numerator compliance and ensure efficient and accurate measure calculation.

By understanding the assessments required for the measure and the documentation that aligns with them, CHCs are best positioned to understand the typical standard codes that should be used.

Best Practices for Medical Coding for Performance Measures

CHCs play a crucial role in the California safety net by providing care and services to an important and underserved patient population. To ensure performance measures are based on accurate data that reflect the care and services patients receive, coding must be completed and performed in a timely manner.

CHCs can ensure success in performance measures by:

- Knowing PHMI/HEDIS measures documentation requirements and specific parameters.
- Providing appropriate care within the designated measure time frames.
- Documenting all the care provided to patients, including dates of service clearly and accurately in the medical record.
- Accurately and consistently documenting within standard data fields where applicable (see the Data Quality and Reporting Resource 4: Standard Data Fields for HEDIS Measures tool for more information).
- Accurately and timely coding all claims/encounters, using HEDIS-specific billing codes when appropriate.

Types of Codes Indicated in this Document

Measure-specific numerator billing coding include the following code types:

FIGURE 5.2: CODING TYPES

Code System	Description
CPT	Current Procedural Terminology (CPT®) codes are an American Medical Association (AMA)-led uniform system of coding medical services, including evaluation and management services.
CPT-II	Current Procedural Terminology (CPT®) Category-II (CPT-II) codes are supplemental tracking codes that support quality and performance measurement data collection. Unlike CPT codes, CPT-II codes also indicate the result of an assessment rather than indicating only an assessment was performed.
G-Codes/ HCPCS	Healthcare Common Procedure Coding System (HCPCS) is produced by the Centers for Medicare and Medicaid Services (CMS) and is a standardized coding set for medical procedures, supplies, products, and services. G-codes are HCPCS codes used to report a patient's functional limitation being treated.
ICD10CM	International Classification of Diseases (ICD)-10-CM codes classify diagnoses and reasons for visits. ICD-10-CM is published by the United States and based on the World Health Organization (WHO)'s ICD-10 codes.
LOINC	Logical Observation Identifiers Names and Codes (LOINC®) codes are clinical codes indicating laboratory test orders and results.
SNOMED CT US Edition	Systemized Nomenclature of Medicine – Clinical Terms United States Edition (SNOMED CT US Edition) are coded terms used within electronic health records to capture, record and share clinical data; gaining use in U.S. systems to be compliant with stage two of meaningful use.
UBREV	Uniform Billing Revenue (UBREV) codes are billing codes used by institutional providers.

Coding Playbook Process Guidelines

Working with practice coaches and subject matter experts (SMEs), CHCs should follow the below steps to understand the assessment, documentation and coding that meets the measure criteria. This process is a starting point for improving data capture quality and should align with the Data Quality and Reporting Resource 4: Standard Data Fields for HEDIS Measures**.**

Step 1: Understand current coding and documentation patterns.

Feedback from the CHC team should include, but not be limited to:

- Information Technology (IT) and data team: to understand data sources and data flow to ensure all data available is being counted and calculated.
- Providers and clinicians: to identify key opportunities to understand measure specifications and documentation tools/care templates/flow sheets/progress notes used with a focus on assessment and documentation that meet measure criteria.
- Claims and coding staff: to understand the process for capturing the care and services and coding appropriately and completely.
- Medical assistants (MAs) and reception staff: MAs and other key staff who work to check in patients, take vital signs and carry out the physician's orders. The MAs are the key backbone to ensuring the details are addressed.

Step 2: Identify opportunities for improvement.

To develop a strong process for identifying gaps, defining the type of gap (data or service) and taking the effective steps to address each, CHCs should:

- Educate providers and office staff on the core HEDIS measures for PHMI:
  - Who qualifies for the measure?
  - What assessment is required?
  - What documentation counts?
  - How to code and report this data?
- Engage the providers and staff to utilize care templates and tools to ensure complete assessment and documentation is being done within the medical record, thereby improving the opportunity to have services properly coded.
- Engage the data team to assess sources of data and identify any additional sources (e.g., HIE, lab vendors, registries, ADT feeds) that can further impact rates (see Data Quality and Reporting Resource 6: External Data Acquisition for process).
- Engage the data team to develop and code a monthly internal process for tracking PHMI/HEDIS measures proactively for interventions and reporting.
- Engage the claims and coding staff to improve coding practices, including coding specificity, to further capture detailed data such as result data with CPT-II codes rather than LOINC and CPT codes.

- Engage the IT staff in understanding if any encounter clearinghouse is processing data and how to work with error/exception data to correct at the source.
- Educate medical staff on the measures so they recognize opportunities to complete services when the patient comes in for other services.
- Utilize the Data Quality and Reporting Resource 4: Standard Data Fields for HEDIS Measures tool as needed to identify opportunities to maximize use of standard data fields.

Step 3: Develop and solidify an ongoing process.

Practice coaches and SMEs should make recommendations that help coordinate/align with ongoing processes for monthly data tracking with each CHC (described in the Data Quality and Reporting Resource 4: Standard Data Fields for HEDIS Measures). This process could include:

- Actions to ensure proper medical record documentation and use of care templates. For example, building out or changing templates or implementation of additional DHCS-supported tools.
- Actions to ensure proper coding:
  - » Develop a process for capturing gaps in listing group/clinic/provider in electronic health record (EHR) data pulls that includes the utilization of this playbook and ID data; code appropriately for capture.
  - » Develop a standardized file submission process and submission tool (see population-level standard data fields).
  - » Educate IT contact for group/clinic/provider on population of file tool from EHR data to send data back.
  - » Work with staff to set reminders and check gaps listing when patients are scheduled.
- Develop policies and procedures as needed to ensure sustainability of ongoing processes. Policies and procedures for the CHC sites could include, but are not limited to, the following subjects:
  - » Data sources and capture (includes a data sources log and cadence).
  - » Coding best practices for completeness and accuracy.
  - » Identification of care gaps:
  - » Steps to address data gaps.
  - » Steps to address service gaps.
  - » Best practices in practice management:

- Outreach to patients:
  - Reminder calls, emails, text messages, mailings.
  - Educational materials.
- Episodic visit opportunities.
- Pre-appointment preparations:
  - Review gaps.
  - Prepare orders.
- Vital signs (not crossing legs, resting before taking, retaking high readings).
- Utilization of template tools to support complete documentation.
- Best practices in coding:
  - Utilization of preferred codes.
  - Utilization of services that give longer time frames.

The Seven Core Measures Specifications for PHMI are detailed below.

Hemoglobin A1c Control for Patients With Diabetes (Poor Control >9%) [HBD]

Measure Description

The percentage of patients 18–75 years of age with diabetes (types 1 and 2) whose hemoglobin A1c (HbA1c) was at the following levels during the measurement year: HbA1c poor control (> 9%).

Documentation

Documentation in medical record or lab result must include a note indicating the date when the HbA1c test was performed and result or finding during the measurement year:

- A1c.
- HbA1c.
- HgbA1c.
- Hemoglobin A1c.
- Glycohemoglobin A1c.
- Glycohemoglobin.
- Glycated hemoglobin.
- Glycosylated hemoglobin.

Exclusions

- Patients who did not have a diagnosis of diabetes in the measurement year or year prior and who had a diagnosis of polycystic ovarian syndrome, gestational diabetes or steroid-induced diabetes.
- Patients in hospice or using hospice services during the measurement year.
- Patients who died in the measurement year.
- Patients receiving palliative care in the measurement year.
- Medicare patients 66 years of age and older as of December 31 of the measurement year who meet either of the following:
  - » Enrolled in an Institutional SNP (I-SNP) any time during the measurement year.
  - » Living long-term in an institution any time during the measurement year.
- Patients 66 years of age and older as of December 31 of the measurement year with frailty and advanced illness during the measurement year. To identify patients with advanced illness, any of the following during the measurement year or the year prior to the measurement year meet criteria:
  - » At least two outpatient visits, observation visits, emergency department visits or non-acute inpatient encounters on different dates of service with an advanced illness diagnosis.
- At least one acute inpatient encounter with an advanced illness diagnosis.
- Dispensed dementia medication
  - » Cholinesterase inhibitors, including Donepezil, Galantamine, and Rivastigmine.
  - » Miscellaneous central nervous system agents, including Memantine.

Denominator

Diagnosis of diabetes in the measurement year and the year prior to the measurement year.

Numerator Billing Codes

All the codes below are used to capture the HbA1c test. The CPT-II codes are preferred because they represent the result as well as the test. The other allowable codes do not indicate the test result and could trigger the need for a medical record review.

FIGURE 5.3: HBA1C TESTS/CONTROL (CPT/CPT-II) (PREFERRED CODES IN BOLD):

Code	Service Completed Definition	Code System
Preferred Codes		
3046F	HbA1c Test with Result >9%	CPT-II
Other Allowable Codes		
83036	HbA1c test (code does not provide result).	CPT
83037	HbA1c test (code does not provide result).	CPT
17856-6	HbA1c test (Lab Code does not provide result).	LOINC
4548-4	HbA1c test (Lab Code does not provide result).	LOINC
4549-2	HbA1c test (Lab Code does not provide result).	LOINC
96595-4	HbA1c test (Lab Code does not provide result).	LOINC
43396009	HbA1c test (Lab Code does not provide result).	SNOMED
313835008	HbA1c test (Lab Code does not provide result).	SNOMED
451061000124104	Hemoglobin A1c greater than nine percent indicating poor diabetic control (finding).	SNOMED

Note: Additional HbA1c CPT-II codes identify patients who are not compliant with the measure (i.e., the codes indicate the patient's HbA1c was in good control). While these codes would not meet the measure and are not identified in the table, the codes are valuable indicators of patients who should still be monitored to ensure continued good control:

- **3044F**; HbA1c test with result <7%.
- **3045**F; HbA1c test with result 7% - 9%.

Controlling High Blood Pressure [CBP]

Measure Description

The percentage of patients 18–85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the measurement year.

Documentation

Patients who had at least two visits on different dates of service with a diagnosis of hypertension during the measurement year or the year prior to the measurement year. Only one of the two visits may be a telephone visit, an online assessment or a telehealth visit. Any of the following combinations meet criteria:

- Outpatient visit with or without a telehealth modifier, with any diagnosis of hypertension.
- A telephone visit with any diagnosis of hypertension.
- An online assessment with any diagnosis of hypertension.

Identify the most recent BP reading noted during the measurement year. The BP reading must occur on or after the date when the second diagnosis of hypertension occurred.

- BP readings from remote monitoring devices that are digitally stored and transmitted to the provider may be included. There must be documentation in the medical record that clearly states the reading was taken by an electronic device, and results were digitally stored and transmitted to the provider.
- Do not include BP readings:
  - » Taken during an acute inpatient stay or an ED visit.
  - » Taken on the same day as a diagnostic test or diagnostic/therapeutic procedure that requires a change in diet or change in medication on or one day before the day of the test or procedure, with the exception of fasting blood tests.
  - » Blood pressure taken by patient using a non-digital device such as a manual blood pressure cuff and stethoscope.

Exclusions

- Patients with evidence of ESRD, dialysis, nephrectomy or kidney transplant at any time in the patient's history or prior to the end of the measurement year.

- Patients with a diagnosis of pregnancy during the measurement year.
- Patients in hospice or using hospice services during the measurement year.
- Patients who died in the measurement year.
- Patients receiving palliative care in the measurement year.
- Medicare patients 66 years of age and older as of December 31 of the measurement year who meet either of the following:
  - » Enrolled in an Institutional SNP (I-SNP) any time during the measurement year.
  - » Living long-term in an institution any time during the measurement year.
- Patients 66 years of age and older as of December 31 of the measurement year with frailty and advanced illness during the measurement year. To identify patients with advanced illness, any of the following during the measurement year or the year prior to the measurement year meet criteria:
  - » At least two outpatient visits, observation visits, ED visits, or non-acute inpatient encounters on different dates of service with an advanced illness diagnosis.
- At least one acute inpatient encounter with an advanced illness diagnosis.
- Dispensed dementia medication
  - » Cholinesterase inhibitors, including Donepezil, Galantamine, and Rivastigmine.
  - » Miscellaneous central nervous system agents, including Memantine.

Denominator

Patients who had at least two visits on different dates of service with a diagnosis of hypertension during the first six months of the measurement year or the year prior to the measurement year.

Numerator Billing Codes

The codes below are used to capture a numerator-compliant blood pressure (BP) readings (i.e., below 140/90 mm Hg).

FIGURE 5.4: CBP NUMERATOR CLAIMS/ENCOUNTER CODES

Code	Service Completed Definition	Code System
Preferred Codes		
3074F	Systolic pressure <130 mm Hg.	CPT-II
3075F	Systolic pressure 130-139 mm Hg.	CPT-II
3078F	Diastolic pressure <80 mm Hg.	CPT-II
3079F	Diastolic pressure 80-89 mm Hg.	CPT-II
Other Allowable Codes		
75997-7	Systolic blood pressure by continuous non-invasive monitoring.	LOINC
8459-0	Systolic blood pressure - sitting.	LOINC
8460-8	Systolic blood pressure - standing.	LOINC
8461-6	Systolic blood pressure - supine.	LOINC
8480-6	Systolic blood pressure.	LOINC
8508-4	Brachial artery systolic blood pressure.	LOINC
8546-4	Brachial artery - left systolic blood pressure.	LOINC
8547-2	Brachial artery - right systolic blood pressure.	LOINC
89268-7	Systolic blood pressure - lying in L-lateral position.	LOINC
271649006	Systolic blood pressure (observable entity).	SNOMED

Note: Additional systolic/diastolic pressure CPT-II codes identify patients who are not compliant with the measure (i.e., the codes indicate the patient's blood pressure is not in good control). While these codes would not meet the measure and are not identified in the table, the codes are valuable indicators of patients who need follow-up for high blood pressure in order to achieve numerator compliance and should be tracked:

- **3077F**; Systolic pressure >140 mm Hg.
- **3080F**; Diastolic pressure >90 mm Hg.

Prenatal and Postpartum Care (Postpartum Care) [PPC]

Measure Description

The percentage of deliveries of live births that had a postpartum visit on or between seven and 84 days after delivery.

Note: HEDIS date ranges of live births are redefined for PHMI to accommodate quarterly reporting:

1. Quarter 1: live births on or between January 6 of the prior year and January 5 of the current year.
1. Quarter 2: live births on or between April 7 of the prior year and April 6 of the current year.
1. Quarter 3: live births on or between July 8 of the prior year and July 7 of the current year.
1. Quarter 4: live births on or between October 8 of the prior year and October 7 of the current year.

Documentation

Documentation of a postpartum visit to an OB/GYN practitioner or midwife, family practitioner or other PCP on or between seven and 84 days after delivery. Must include a note indicating the date when a postpartum visit occurred and one of the following:

- Pelvic exam.
- Evaluation of weight, BP, breasts and abdomen:
  - Notation of "breastfeeding" is acceptable for the "evaluation of breasts" component.
  - Notation of "abdominal wound healing" is acceptable for abdominal assessment.
- Notation of postpartum care including but not limited to:
  - Postpartum care, postpartum check, six-week check.
  - Preprinted "Postpartum Care" form in which information was documented during the visit.
  - Perineal or cesarean incision wound check.
  - Screening for depression, anxiety, tobacco use, substance use disorder or preexisting mental health disorders.
  - Glucose screening for patients with diabetes.

- » Documentation of any of the following topics:
  - ◊ Infant care or breastfeeding.
  - ◊ Resumption of intercourse, birth spacing or family planning.
  - ◊ Sleep/fatigue.
  - ◊ Resumption of physical activity and attainment of health weight.

Care Templates

Care templates that can help to capture documentation related to postpartum visits including those that comply with and include components of American College of Obstetrics and Gynecology (ACOG) recommendations[1] or the Comprehensive Perinatal Services Program (CPSP) Postpartum Assessment and Individualized Care Plan form.[2] CHCs with CPSP providers can utilize these forms to ensure proper postpartum visit information is captured.

Exclusions

- Patients in hospice or using hospice services during the measurement year.
- Patients who died in the measurement year.

Denominator

Deliveries of live births.

Note: HEDIS date ranges of live births are redefined for PHMI to accommodate quarterly reporting:

1. Quarter 1: live births on or between January 6 of the prior year and January 5 of the current year
1. Quarter 2: live births on or between April 7 of the prior year and April 6 of the current year
1. Quarter 3: live births on or between July 8 of the prior year and July 7 of the current year
1. Quarter 4: live births on or between October 8 of the prior year and October 7 of the current year

Numerator Billing Codes

All the codes below are used to identify a postpartum visit, and each would count as numerator-positive within time frames.

FIGURE 5.5: PPC NUMERATOR CLAIMS/ENCOUNTER CODES

Code	Service Completed Definition	Code System
59400	Postpartum care visit.	CPT
59410	Postpartum care visit.	CPT
59510	Postpartum care visit.	CPT
59515	Postpartum care visit.	CPT
59610	Postpartum care visit.	CPT
59614	Postpartum care visit.	CPT
59618	Postpartum care visit.	CPT
59622	Postpartum care visit.	CPT
57170	Postpartum care visit.	CPT
58300	Postpartum care visit.	CPT
59430	Postpartum care visit.	CPT
88141	Cytopathology, cervical or vaginal (any reporting system); requires interpretation by physician; used to report smears that require separate interpretation by a physician.	CPT
88142	Cytopathology screening procedures	CPT
88143	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin-layer preparation.	CPT
88147	Cytopathology screening procedures.	CPT
88148	Cytopathology screening procedures.	CPT
88150	Cytopathology screening procedures.	CPT
88152	Cytopathology, slides, cervical or vaginal; with manual screening and computer-assisted rescreening under physician supervision, describes an improved technology using optical imaging equipment to routinely evaluate negative smears.	CPT
88153	Cytopathology screening procedures.	CPT
88164	Cytopathology screening procedures.	CPT
88165	Cytopathology screening procedures.	CPT
88166	Cytopathology screening procedures.	CPT
88167	Cytopathology, slides, cervical or vaginal (the Bethesda System).	CPT
88174	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin-layer preparation.	CPT

FIGURE 5.5: PPC NUMERATOR CLAIMS/ENCOUNTER CODES (continued)

Code	Service Completed Definition	Code System
88175	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin-layer preparation.	CPT
99501	Postpartum care visit.	CPT
0503F	Postpartum care visit (prenatal).	CPT-II
G0101	Cervical or vaginal cancer screening; pelvic and clinical breast examination.	HCPCS
G0123	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin-layer preparation; screening by cytotechnologist under physician supervision.	HCPCS
G0124	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin-layer preparation requiring interpretation by physician.	HCPCS
G0141	Screening cytopathology smears, cervical or vaginal, performed by automated system with manual rescreening requiring interpretation by physician.	HCPCS
G0143	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin-layer preparation with manual screening and rescreening by cytotechnologist under physician supervision.	HCPCS
G0144	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin-layer preparation with screening by automated system under physician supervision.	HCPCS
G0145	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin-layer preparation, with screening by automated system and manual rescreening under physician supervision.	HCPCS
G0147	Screening cytopathology smears, cervical or vaginal, performed by automated system under physician supervision.	HCPCS
G0148	Screening cytopathology smears, cervical or vaginal, performed by automated system with manual rescreening.	HCPCS
P3000	Screening Papanicolaou smear, cervical or vaginal, up to three smears by technician under physician supervision.	HCPCS

FIGURE 5.5: PPC NUMERATOR CLAIMS/ENCOUNTER CODES (continued)

Code	Service Completed Definition	Code System
P3001	Screening Papanicolaou smear, cervical or vaginal, up to three smears requiring interpretation by physician.	HCPCS
Q0091	Screening Papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory.	HCPCS
Z01.411	Encounter for gynecological examination (general, routine) with abnormal findings.	ICD10CM
Z01.419	Encounter for gynecological examination (general, routine) without abnormal findings.	ICD10CM
Z01.42	Encounter for cervical smear to confirm findings of recent normal smear following initial abnormal smear.	ICD10CM
Z30.430	Encounter for insertion of intrauterine contraceptive device.	ICD10CM
Z39.1	Encounter for care and examination of lactating mother.	ICD10CM
Z39.2	Encounter for routine postpartum follow-up.	ICD10CM
10524-7	Microscopic observation (identifier) in cervix by cyto stain.	LOINC
18500-9	Microscopic observation (identifier) in cervix by cyto stain, thin prep.	LOINC
19762-4	General categories (interpretation) of cervical or vaginal smear or scraping by cyto stain.	LOINC
19764-0	Statement of adequacy [Interpretation] of Cervical or vaginal smear or scraping by cyto stain.	LOINC
19765-7	Microscopic observation (identifier) in cervical or vaginal smear or scraping by cyto stain.	LOINC
19766-5	Microscopic observation (identifier) in cervical or vaginal smear or scraping by cyto stain narrative.	LOINC
19774-9	Cytology study comment test result, cervical or vaginal smear or scraping by cyto stain.	LOINC
33717-0	Cervical and/or vaginal cytology study.	LOINC
47527-7	Cytology report of cervical or vaginal smear or scraping by cyto stain, thin prep.	LOINC
47528-5	Cytology report of cervical or vaginal smear or scraping by cyto stain.	LOINC
133906008	Postpartum care (regime/therapy).	SNOMED
133907004	Episiotomy care (regime/therapy).	SNOMED
168406009	Severe dyskaryosis on cervical smear cannot exclude invasive carcinoma (finding).	SNOMED

FIGURE 5.5: PPC NUMERATOR CLAIMS/ENCOUNTER CODES (continued)

Code	Service Completed Definition	Code System
168407000	Cannot exclude glandular neoplasia on cervical smear (finding).	SNOMED
168408005	Cervical smear - atrophic changes (finding).	SNOMED
168410007	Cervical smear - borderline changes (finding).	SNOMED
168414003	Cervical smear - inflammatory change (finding).	SNOMED
168415002	Cervical smear - no inflammation (finding).	SNOMED
168416001	Cervical smear - severe inflammation (finding).	SNOMED
168424006	Cervical smear - koilocytosis (finding).	SNOMED
169762003	Postnatal visit (regime/therapy).	SNOMED
169770008	Postnatal - eighth day visit (regime/therapy).	SNOMED
169771007	Postnatal - ninth day visit (regime/therapy).	SNOMED
169772000	Postnatal - tenth day visit (regime/therapy).	SNOMED
171149006	Screening for malignant neoplasm of cervix (procedure).	SNOMED
250538001	Dyskaryosis on cervical smear (finding).	SNOMED
268543007	Cancer cervix - screening done (finding).	SNOMED
269957009	Cervical smear result (finding).	SNOMED
269958004	Cervical smear - negative (finding).	SNOMED
269959007	Cervical smear - mild dyskaryosis (finding).	SNOMED
269960002	Cervical smear - severe dyskaryosis (finding).	SNOMED
269961003	Cervical smear - moderate dyskaryosis (finding).	SNOMED
269963000	Cervical smear - viral inflammation unspecified (finding).	SNOMED
275805003	Viral changes on cervical smear (finding).	SNOMED
281101005	Smear: no abnormality detected - no endocervical cells (finding).	SNOMED
309081009	Abnormal cervical smear (finding).	SNOMED
310841002	Cervical smear - mild inflammation (finding).	SNOMED
310842009	Cervical smear - moderate inflammation (finding).	SNOMED
384634009	Postnatal maternal examination (procedure).	SNOMED
384635005	Full postnatal examination (procedure).	SNOMED
384636006	Maternal postnatal six-week examination (procedure).	SNOMED
408883002	Breastfeeding support (regime/therapy).	SNOMED

FIGURE 5.5: PPC NUMERATOR CLAIMS/ENCOUNTER CODES (continued)

Code	Service Completed Definition	Code System
408884008	Breastfeeding support management (procedure).	SNOMED
408886005	Breastfeeding support assessment (procedure).	SNOMED
409018009	Postpartum care assessment (procedure).	SNOMED
409019001	Postpartum care management (procedure).	SNOMED
416030007	Cervicovaginal cytology - low-grade squamous intraepithelial lesion (finding)	SNOMED
416032004	Cervicovaginal cytology normal or benign (finding)	SNOMED
416033009	Cervicovaginal cytology: High grade squamous intraepithelial lesion or carcinoma (finding).	SNOMED
416107004	Cervical cytology test (procedure).	SNOMED
417036008	Liquid-based cervical cytology screening (procedure).	SNOMED
431868002	Initiation of breastfeeding (regime/therapy).	SNOMED
439074000	Dysplasia on cervical smear (finding).	SNOMED
439776006	Cervical Papanicolaou smear positive for malignant neoplasm (finding).	SNOMED
439888000	Abnormal cervical Papanicolaou smear (finding).	SNOMED
440085006	Home visit for postpartum care and assessment (procedure).	SNOMED
440623000	Microscopic examination of cervical Papanicolaou smear (procedure).	SNOMED
441087007	Atypical squamous cells of undetermined significance on cervical Papanicolaou smear (finding).	SNOMED
441088002	Atypical squamous cells on cervical Papanicolaou smear cannot exclude high-grade squamous intraepithelial lesion (finding).	SNOMED
441094005	Atypical endocervical cells on cervical Papanicolaou smear (finding).	SNOMED
441219009	Atypical glandular cells on cervical Papanicolaou smear (finding).	SNOMED
441667007	Abnormal cervical Papanicolaou smear with positive human papillomavirus deoxyribonucleic acid test (finding).	SNOMED
700399008	Cervical smear - borderline change in squamous cells (finding).	SNOMED
700400001	Cervical smear - borderline change in endocervical cells (finding).	SNOMED
717810008	Routine postpartum follow-up (regime/therapy).	SNOMED

FIGURE 5.5: PPC NUMERATOR CLAIMS/ENCOUNTER CODES (continued)

Code	Service Completed Definition	Code System
1155766001	Nuclear abnormality in cervical smear (finding).	SNOMED
448651000124104	Microscopic examination of cervical Papanicolaou smear and human papillomavirus deoxyribonucleic acid detection cotesting (procedure).	SNOMED
62051000119105	Low-grade squamous intraepithelial lesion on cervical Papanicolaou smear (finding).	SNOMED
62061000119107	High-grade squamous intraepithelial lesion on cervical Papanicolaou smear (finding).	SNOMED
98791000119102	Cytological evidence of malignancy on cervical Papanicolaou smear (finding).	SNOMED

Colorectal Cancer Screening [COL]

Measure Description

The percentage of patients 45-75 years of age who have had an appropriate screening for colorectal cancer.

Documentation

Medical records must include a note indicating the date when the colorectal cancer screening was performed.

- A result is not required if the documentation is clearly part of the medical history.
- Fecal occult blood test (FOBT/iFOBT) completed during the measurement year.
- Flexible sigmoidoscopy completed during the measurement year or four years prior to the measurement year.
- Colonoscopy completed during the measurement year or nine years prior to the measurement year.
    - » Abbreviations are not acceptable (e.g., Colo 2014, Col 2014). The documentation needs to include the full name (e.g., colonoscopy) and the date rendered.
- CT colonography during the measurement year or four years prior to the measurement year.
- FIT-DNA test during the measurement year or two years prior to the measurement year.

Exclusions

Either of the following any time during the patient's history through December 31 of the measurement year:

- Colorectal cancer.
- Total colectomy.

FIGURE 5.6: COL EXCLUSION CLAIMS/ENCOUNTER CODES

Code	Service Completed Definition	Code System
G0213-G0215, G0231	Colorectal cancer exclusion	G-Code/ HCPCS
C18.0-C18.9, C19, C20, C21.2, C21.8, C78.5, Z85.038, Z85.048	Colorectal cancer exclusion	ICD10CM
44150-44153, 44155-44158, 44210-44212	Total colectomy exclusion	CPT
0DTE0ZZ, 0DTE4ZZ		
0DTE7ZZ, 0DTE8ZZ	Total colectomy exclusion	ICD10CM

Additional exclusions:

- Patients in hospice or using hospice services during the measurement year.
- Patients who died in the measurement year.
- Patients receiving palliative care in the measurement year.
- Medicare patients 66 years of age and older as of December 31 of the measurement year who meet either of the following:
  - » Enrolled in an Institutional SNP (I-SNP) any time during the measurement year.
  - » Living long-term in an institution any time during the measurement year.
- Patients 66 years of age and older as of December 31 of the measurement year with frailty and advanced illness during the measurement year. To identify patients with advanced illness, any of the following during the measurement year or the year prior to the measurement year meet criteria:
  - » At least two outpatient visits, observation visits, ED visits or non-acute inpatient encounters on different dates of service with an advanced illness diagnosis.
  - » At least one acute inpatient encounter with an advanced illness diagnosis.

- » Dispensed dementia medication.
  - ◊ Cholinesterase inhibitors, including Donepezil, Galantamine, and Rivastigmine.
  - ◊ Miscellaneous central nervous system agents, including Memantine.

Denominator

Patients aged 45-75 years.

Numerator Billing Codes

All the codes below are used to capture a screening for colorectal cancer and would be numerator-compliant within time frames. Depending upon the type of screening used, the patient can be compliant with preventive guidelines for longer periods of time without needing a rescreening.

FIGURE 5.7: COL NUMERATOR CLAIMS/ENCOUNTER CODES

Code	Service Completed Definition	Code System
82270	FOBT (annually).	CPT
82274	FOBT (annually).	CPT
G0328	FOBT (annually).	G-Code/ HCPCS
12503-9	Hemoglobin, gastrointestinal (presence) in stool - fourth specimen.	LOINC
12504-7	Hemoglobin, gastrointestinal (presence) in stool - fifth specimen.	LOINC
14563-1	Hemoglobin, gastrointestinal (presence) in stool - first specimen.	LOINC
14564-9	Hemoglobin, gastrointestinal (presence) in stool - second specimen.	LOINC
14565-6	Hemoglobin, gastrointestinal (presence) in stool - third specimen.	LOINC
2335-8	Hemoglobin, gastrointestinal (presence) in stool.	LOINC
27396-1	Hemoglobin, gastrointestinal (mass/mass) in stool.	LOINC
27401-9	Hemoglobin, gastrointestinal (presence) in stool - sixth specimen.	LOINC
27925-7	Hemoglobin, gastrointestinal (presence) in stool - seventh specimen.	LOINC
27926-5	Hemoglobin, gastrointestinal (presence) in stool - eighth specimen.	LOINC

FIGURE 5.7: COL NUMERATOR CLAIMS/ENCOUNTER CODES (continued)

Code	Service Completed Definition	Code System
29771-3	Hemoglobin, gastrointestinal, lower (presence) in stool by immunoassay.	LOINC
56490-6	Hemoglobin, gastrointestinal, lower (presence) in stool by immunoassay - second specimen.	LOINC
56491-4	Hemoglobin, gastrointestinal, lower (presence) in stool by immunoassay - third specimen.	LOINC
57905-2	Hemoglobin, gastrointestinal,lower (presence) in stool by Immunoassay - first specimen.	LOINC
58453-2	Hemoglobin, gastrointestinal, lower (mass/volume) in stool by immunoassay.	LOINC
80372-6	Hemoglobin, gastrointestinal (presence) in stool by rapid immunoassay.	LOINC
104435004	Screening for occult blood in feces (procedure).	SNOMED
441579003	Measurement of occult blood in stool specimen using immunoassay (procedure).	SNOMED
442067009	Measurement of occult blood in two separate stool specimens (procedure).	SNOMED
442516004	Measurement of occult blood in three separate stool specimens (procedure).	SNOMED
442554004	Guaiac test for occult blood in feces specimen (procedure).	SNOMED
442563002	Measurement of occult blood in single stool specimen (procedure).	SNOMED
59614000	Occult blood in stools (finding).	SNOMED
167667006	Fecal occult blood - negative (finding).	SNOMED
389076003	Fecal occult blood - trace (finding).	SNOMED
45330-45335	Flexible sigmoidoscopy (every five years).	CPT
45337-45338	Flexible sigmoidoscopy (every five years).	CPT
45340-45342	Flexible sigmoidoscopy (every five years).	CPT
45345-45347	Flexible sigmoidoscopy (every five years).	CPT
45349	Flexible sigmoidoscopy (every five years).	CPT
45350	Flexible sigmoidoscopy (every five years).	CPT
G0104	Flexible sigmoidoscopy (every five years).	G-Code/ HCPCS
44441009	Flexible fiber-optic sigmoidoscopy (procedure).	SNOMED
396226005	Flexible fiber-optic sigmoidoscopy with biopsy (procedure).	SNOMED

FIGURE 5.7: COL NUMERATOR CLAIMS/ENCOUNTER CODES (continued)

Code	Service Completed Definition	Code System
425634007	Diagnostic endoscopic examination of lower bowel and sampling for bacterial overgrowth using fiber-optic sigmoidoscope (procedure).	SNOMED
841000119107	History of flexible sigmoidoscopy (situation).	SNOMED
44388-44394	Colonoscopy (every 10 years).	CPT
44397	Colonoscopy (every 10 years).	CPT
44401-44408	Colonoscopy (every 10 years).	CPT
45355	Colonoscopy (every 10 years).	CPT
45378-45393	Colonoscopy (every 10 years).	CPT
45398	Colonoscopy (every 10 years).	CPT
G0105	Colonoscopy (every 10 years).	G-Code/ HCPCS
G0121	Colonoscopy (every 10 years).	G-Code/ HCPCS
45.22	Endoscopy of large intestine through artificial stoma.	ICD9
45.23	Colonoscopy.	ICD9
45.25	Closed (endoscopic) biopsy of large intestine.	ICD9
45.42	Endoscopic polypectomy of large intestine.	ICD9
45.43	Endoscopic destruction of other lesion or tissue of large intestine.	ICD9
8180007	Fiberoptic colonoscopy through colostomy (procedure).	SNOMED
12350003	Colonoscopy with rigid sigmoidoscope through colotomy (procedure).	SNOMED
25732003	Fiberoptic colonoscopy with biopsy (procedure).	SNOMED
34264006	Intraoperative colonoscopy (procedure).	SNOMED
73761001	Colonoscopy (procedure).	SNOMED
174158000	Open colonoscopy (procedure).	SNOMED
174185007	Diagnostic fiber-optic endoscopic examination of colon and biopsy of lesion of colon (procedure).	SNOMED
235150006	Total colonoscopy (procedure).	SNOMED
235151005	Limited colonoscopy (procedure).	SNOMED
275251008	Diagnostic endoscopic examination of colon using fiber-optic sigmoidoscope (procedure).	SNOMED
367535003	Fiber-optic colonoscopy (procedure).	SNOMED

FIGURE 5.7: COL NUMERATOR CLAIMS/ENCOUNTER CODES (continued)

Code	Service Completed Definition	Code System
443998000	Colonoscopy through colostomy with endoscopic biopsy of colon (procedure).	SNOMED
444783004	Screening colonoscopy (procedure).	SNOMED
446521004	Colonoscopy and excision of mucosa of colon (procedure).	SNOMED
446745002	Colonoscopy and biopsy of colon (procedure).	SNOMED
447021001	Colonoscopy and tattooing (procedure).	SNOMED
709421007	Colonoscopy and dilatation of stricture of colon (procedure).	SNOMED
710293001	Colonoscopy using fluoroscopic guidance (procedure).	SNOMED
711307001	Colonoscopy using X-ray guidance (procedure).	SNOMED
789778002	Colonoscopy and fecal microbiota transplantation (procedure).	SNOMED
851000119109	History of colonoscopy (situation).	SNOMED
74261-74263	CT colonography (every five).	CPT
60515-4	CT colon and rectum with air contrast PR.	LOINC
72531-7	CT colon and rectum with contrast IV and with air contrast PR.	LOINC
79069-1	CT colon and rectum for screening without contrast IV and with air contrast PR.	LOINC
79071-7	CT colon and rectum without contrast IV and with air contrast PR.	LOINC
79101-2	CT colon and rectum for screening with air contrast PR.	LOINC
82688-3	CT colon and rectum without and with contrast IV and with air contrast PR.	LOINC
418714002	Virtual computed tomography colonoscopy (procedure).	SNOMED
81528	FIT-DNA (Every three years).	CPT
77353-1	Noninvasive colorectal cancer DNA and occult blood screening (interpretation) in stool narrative.	LOINC
77354-9	Noninvasive colorectal cancer DNA and occult blood screening (presence) in stool.	LOINC
708699002	Stool DNA-based colorectal cancer screening positive (finding).	SNOMED

Well Child Visits in the First 30 Months of Life (First 15 Months) [WC30]

Measure Description

Children who turned 15 months old during the measurement year and have at least six well child visits with a PCP during their first 15 months of life.

Documentation

The well child visit must occur with a PCP, but the PCP does not have to be the clinician assigned to the child. Documentation must include all five of the following components (examples are provided for each):

- Health history:
  - Personal medical or surgical history.
  - Social history.
  - Family history.
  - Medications, history of allergies and immunization history (all three must be combined).
  - Statement of no problems under history or no new problems from last visit is acceptable.
- Physical developmental history:
  - Documentation of physical developmental milestones appropriate for age.
  - Developing appropriately for age, normal growth and development.
  - Can throw a ball, run and play in the playground at school, etc.
  - Tanner stage.
- Mental developmental history:
  - Documentation of mental milestones appropriate for age.
  - Verbalizes well and understands instructions.
  - Competent with fork and spoon.
  - Responds appropriately to commands.
- Complete physical exam.
- Health education/anticipatory guidance:
  - Physical and oral health, healthy eating and physical activity.
  - Safety belt.
  - Nutrition.
  - Anticipatory guidance handouts given with evidence of discussion.

- » Anticipatory guidance given with evidence of discussion/
- » Anticipatory guidance with evidence of parental counseling on anticipatory guidance.
- » Counseling/education factors reviewed.

Care Templates

Care templates that can help capture documentation related to well child visits include DHCS Staying Health Assessment Questionnaires[3] or the Bright Futures/American Academy of Pediatrics periodicity schedule.[4]

Exclusions

- Patients in hospice or using hospice services during the measurement year.
- Patients who died in the measurement year.

Denominator

All patients who turned 15 months of age during the measurement year.

Numerator Billing Codes

All the codes below are used to capture well child visits. The visits PHMI is focused on must occur prior to 15 months of age. The codes below would be inclusive of all components of assessments and documentation specified above. It is critical to be sure to use the correct age specific code for the exam being done.

FIGURE 5.8: WC30 NUMERATOR CLAIMS/ENCOUNTER CODES

Code	Service Completed Definition	Code System
99381-99385	Well visit.	CPT
99391-99395	Well visit.	CPT
99461	Well visit - initial newborn exam.	CPT
G0438	Annual wellness visit; includes a personalized prevention plan of service (PPS), initial visit.	G-Code/ HCPCS
G0439	Annual wellness visit; includes a personalized prevention plan of service (PPS), subsequent visit.	G-Code/ HCPCS
S0302	Completed early periodic screening diagnosis and treatment (EPSDT) service (list in addition to code for appropriate evaluation and management service).	HCPCS
Z00.110	Health examination for newborn under eight days old.	ICD10CM
Z00.111	Health examination for newborn eight to 28 days old.	ICD10CM
Z00.121	Encounter for routine child health examination with abnormal findings.	ICD10CM
Z00.129	Encounter for routine child health examination without abnormal findings.	ICD10CM
Z00.2	Encounter for examination for a period of rapid growth in childhood.	ICD10CM
Z76.1	Encounter for health supervision and care of foundling.	ICD10CM
Z76.2	Encounter for health supervision and care of other healthy infants and children.	ICD10CM
103740001	Periodic physical examination (procedure).	SNOMED
170099002	Child examination - birth (procedure).	SNOMED
170107008	Child examination - 10 days (procedure).	SNOMED
170114005	Child examination - six weeks (procedure).	SNOMED
170123008	Child eight to nine months examination (procedure).	SNOMED
170250008	Child three months examination (procedure).	SNOMED
170254004	Child one year examination (procedure).	SNOMED
170263002	Child six months examination (procedure).	SNOMED
170272005	Child 21 months examination (procedure).	SNOMED
170300004	Child eight weeks examination (procedure).	SNOMED
170309003	Child seven months examination (procedure).	SNOMED
171417004	Preschool child health examination (procedure).	SNOMED

FIGURE 5.8: WC30 NUMERATOR CLAIMS/ENCOUNTER CODES (continued)

Code	Service Completed Definition	Code System
243788004	Child examination (procedure).	SNOMED
268563000	Child health medical examination (procedure).	SNOMED
410620009	Well child visit (procedure).	SNOMED
410621008	Well child visit - newborn (procedure).	SNOMED
410622001	Child examination - two weeks (procedure).	SNOMED
410623006	Well child visit - two weeks (procedure).	SNOMED
410624000	Well child visit - two months (procedure).	SNOMED
410625004	Child four months examination (procedure).	SNOMED
410626003	Well child visit - four months (procedure).	SNOMED
410627007	Well child visit - six months (procedure).	SNOMED
410628002	Well child visit - nine months (procedure).	SNOMED
410629005	Well child visit - 12 months (procedure).	SNOMED
410630000	Child 15 month examination (procedure).	SNOMED
410631001	Well child visit - 15 months (procedure).	SNOMED
442162000	Child six to eight weeks examination (procedure).	SNOMED
783260003	Child 15 year examination (procedure).	SNOMED
446301000124108	Well child visit - newborn less than eight days old (procedure).	SNOMED
446381000124104	Well child visit - newborn eight to 28 days old (procedure).	SNOMED

Childhood Immunization Status (Combo 10) [CIS]

Measure Description

Percentage of children who reach two years of age in the measurement year who have had all the required immunizations:

- 4 DTAP (diphtheria, tetanus, acellular pertussis).
- 3 IPV (polio).
- 1 MMR (measles, mumps, rubella).
- 3 HIB (haemophilus 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 Rotarix; 3 Rota Teq)
- 2 Influenza (flu).

Documentation

Documentation of immunization must include:

- A note indicating the name of each specific antigen and date of immunization on or before the second birthday.

Acceptable documentation includes:

- Evidence of immunizations given elsewhere (e.g., state immunization registry or hospital of birth).
- Certificate of immunization prepared by authorized health care provider or agency including the specific dates and types of immunizations administered.
- Note indicating patient received HEP B at delivery or in the hospital.
- Immunization history pulled/transcribed from the immunization registry.
- Documentation of the immunization being given in the record with the route and location of the injection site.

Care Templates

Care templates should align with the Bright Futures/American Academy of Pediatrics Immunization Schedule by Age[5] for the periodicity of immunizations, which is endorsed by DHCS for Medi-Cal and the Child Health and Disability Prevention (CHDP) program.

Exclusions

Patients who had any of the following on or before their second birthday:

- Severe combined immunodeficiency.
- Immunodeficiency.
- HIV.
- Lymphoreticular cancer, multiple myeloma or leukemia.
- Intussusception.
- Patients in hospice or using hospice services during the measurement year.
- Patients who died in the measurement year.

Specific immunizations can be excluded (but this does not exclude the need for other immunizations) due to:

- Allergic reaction to the vaccine or other contraindication.
- History of illness (for measles, mumps, rubella, chicken pox, hepatitis A, hepatitis B).

Note: Parent refusal does not meet compliance for any vaccines.

Denominator

Patients who turn two years of age during the measurement year.

Numerator Billing Codes

The codes below are used to capture the different immunizations required to meet measure compliance. Although there is no preferred code, the office can use combination antigens that benefit the patient with a smaller volume of injections. The combination codes count for all antigens within the combination. These combination codes for antigens are bolded in the table below.

FIGURE 5.9: CIS NUMERATOR CLAIMS/ENCOUNTER CODES

Code	Service Completed Definition	Code System
90698, 90700, 90721, 90723	DTaP	CPT
90698, 90713, 90723	IPV	CPT
90707, 90710	MMR	CPT
90644-90648, 90698, 90721, 90748	HIB	CPT
17, 46-51, 120, 148	HIB	CVX
3E0234Z	HEP B Newborn	ICD10CM
90723, 90740, 90744, 90747, 90748	HEP B	CPT
G0010	HEP B	G-Code/ HCPCS
90670, 90732	PCV	CPT
90710, 90716	VZV	CPT
90633	HEP A	CPT
90655, 90657, 90661, 90662, 90673, 90685, 90687, 90688	Flu	CPT
G0008	Flu	G-Code/ HCPCS
90681	Rotavirus (two dose schedule)	CPT
90680	Rotavirus (three dose schedule)	CPT
60660, 60672	LAIV	CPT

Depression Screening and Follow-Up for Adolescents and Adults [DSF-E]

Measure Description

The percentage of patients 12 years of age and older who were screened for clinical depression using a standardized instrument and, if screened positive, received follow-up care.

> **Sub-measure 1:** *Depression Screening.* The percentage of patients who were screened for clinical depression using a standardized instrument.
> **Sub-measure 2:** *Follow-Up on Positive Screen.* The percentage of patients who received follow-up care within 30 days of a positive depression screen finding.

Documentation

Documentation to identify numerator 1/denominator 2 (i.e., a patient screened for clinical depression with a positive result using a standard assessment instrument that has been normalized) and validated for the appropriate patient population (i.e., adolescents aged < 17 yrs or adults aged 18+ yrs). Eligible screening instruments with thresholds for positive findings include:

Instrument	Positive Value	Population
Patient Health Questionnaire (PHQ-9)	Total score 10	Adolescent; adult.
Patient Health Questionnaire Modified for Teens (PHQ-9M)	Total score 10	Adolescent.
Patient Health Questionnaire-2 (PHQ-2)[1]	Total score 3	Adolescent; adult
Beck Depression Inventory-Fast Screen (BDI-FS)[1]	Total score 8	Adolescent; adult
Beck Depression Inventory (BDI-II)	Total score 20	Adult.
Center for Epidemiologic Studies Depression Scale-Revised (CESD-R)	Total score 17	Adolescent; adult.
Duke Anxiety-Depression Scale (DUKE-AD)	Total score 30	Adult.
Edinburgh Postnatal Depression Scale (EPDS)	Total score 10	Adolescent; adult.
Geriatric Depression Scale Short Form (GDS)[1]	Total score 5	Adult.
Geriatric Depression Scale Long Form (GDS)	Total score 10	Adult.
My Mood Monitor (M-3)	Total score 5	Adult.
PROMIS Depression	Total score (T Score) 60	Adolescent; adult.
Clinically Useful Depression Outcome Scale (CUDOS)	Total score 31	Adult.

1 Brief screens

Documentation to identify numerator 2 (i.e., patients who received follow-up care on or up to 30 days after the date of the first positive screen (31 total days). Any of the following on or up to 30 days after the first positive screen:

- An outpatient, telephone, e-visit or virtual check-in follow-up visit with a diagnosis of depression or other behavioral health condition.
- A depression case management encounter that documents assessment for symptoms of depression or a diagnosis of depression or other behavioral health condition.
- A behavioral health encounter, including assessment, therapy, collaborative care or medication management.
- A dispensed antidepressant medication.

OR

- Documentation of additional depression screening on a full-length instrument indicating either no depression or no symptoms that require follow-up (i.e., a negative screen) on the same day as a positive screen on a brief screening instrument (e.g., brief screens include PHQ-2, BDI-FS, GDS Short Form). For example, if there is a positive screen resulting from a PHQ-2 score, documentation of a negative finding from a PHQ-9 performed on the same day qualifies as evidence of follow-up.

Care Templates

While acceptable care templates could include any of the above screening instruments, the PHQ-2 and PHQ-9 are commonly used, are available at no cost in multiple languages,[6] and allow for screening and follow-up to occur on the same day.

Exclusions

- Patients with a history of bipolar disorder at any time during the patient's history through the end of the year prior to the measurement period.
- Patients with depression that start during the year prior to the measurement period.
- Patients in hospice or using hospice services any time during the measurement period.

Denominators

Patients 12 years of age and older at the start of the measurement period (denominator 1) with a positive depression screen finding (denominator 2).

Note: HEDIS date ranges of positive depression screen findings are redefined for PHMI to accommodate quarterly reporting:

1. Quarter 1: screening between April 1 of the prior year and March 1 of the current year
1. Quarter 2: screening between July 1 of the prior year and June 1 of the current year
1. Quarter 3: screening between October 1 of the prior year and September 1 of the current year
1. Quarter 4: screening between January 1 of the prior year and December 1 of the current year

Denominator 2 Billing Codes

All of the codes below are used to identify a positive screen finding (i.e., a diagnosis of depression).

FIGURE 5.10: DSF-E DENOMINATOR 2 CLAIMS/ENCOUNTER CODES

Code	Service Completed Definition	Code System
F01.51	Vascular dementia with behavioral disturbance.	ICD10CM
F32.0	Major depressive disorder, single episode, mild.	ICD10CM
F32.1	Major depressive disorder, single episode, moderate.	ICD10CM
F32.2	Major depressive disorder, single episode, severe without psychotic features.	ICD10CM
F32.3	Major depressive disorder, single episode, severe with psychotic features.	ICD10CM
F32.4	Major depressive disorder, single episode, in partial remission.	ICD10CM
F32.5	Major depressive disorder, single episode, in full remission.	ICD10CM
F32.81	Premenstrual dysphoric disorder.	ICD10CM
F32.89	Other specified depressive episodes.	ICD10CM
F32.9	Major depressive disorder, single episode, unspecified.	ICD10CM

FIGURE 5.10: DSF-E DENOMINATOR 2 CLAIMS/ENCOUNTER CODES (continued)

Code	Service Completed Definition	Code System
F32.A	Depression, unspecified.	ICD10CM
F33.0	Major depressive disorder, recurrent, mild.	ICD10CM
F33.1	Major depressive disorder, recurrent, moderate.	ICD10CM
F33.2	Major depressive disorder, recurrent, severe, without psychotic features.	ICD10CM
F33.3	Major depressive disorder, recurrent, severe, with psychotic symptoms.	ICD10CM
F33.40	Major depressive disorder, recurrent, in remission, unspecified.	ICD10CM
F33.41	Major depressive disorder, recurrent, in partial remission.	ICD10CM
F33.42	Major depressive disorder, recurrent, in full remission.	ICD10CM
F33.8	Other recurrent depressive disorders.	ICD10CM
F33.9	Major depressive disorder, recurrent, unspecified.	ICD10CM
F34.1	Dysthymic disorder.	ICD10CM
F34.81	Disruptive mood dysregulation disorder.	ICD10CM
F34.89	Other specified persistent mood disorders.	ICD10CM
F43.21	Adjustment disorder with depressed mood.	ICD10CM
F43.23	Adjustment disorder with mixed anxiety and depressed mood.	ICD10CM
F53.0	Postpartum depression.	ICD10CM
F53.1	Puerperal psychosis.	ICD10CM
O90.6	Postpartum mood disturbance.	ICD10CM
O99.340	Other mental disorders complicating pregnancy, unspecified trimester.	ICD10CM
O99.341	Other mental disorders complicating pregnancy, first trimester.	ICD10CM
O99.342	Other mental disorders complicating pregnancy, second trimester.	ICD10CM
O99.343	Other mental disorders complicating pregnancy, third trimester.	ICD10CM
O99.344	Other mental disorders complicating childbirth.	ICD10CM
O99.345	Other mental disorders complicating the puerperium.	ICD10CM
832007	Moderate major depression (disorder).	SNOMED
2506003	Early onset dysthymia (disorder).	SNOMED

FIGURE 5.10: DSF-E DENOMINATOR 2 CLAIMS/ENCOUNTER CODES (continued)

Code	Service Completed Definition	Code System
2618002	Chronic recurrent major depressive disorder (disorder).	SNOMED
3109008	Secondary dysthymia, early onset (disorder).	SNOMED
14183003	Chronic major depressive disorder, single episode (disorder).	SNOMED
15193003	Severe recurrent major depression with psychotic features, mood-incongruent (disorder).	SNOMED
15639000	Moderate major depression, single episode (disorder).	SNOMED
18818009	Moderate recurrent major depression (disorder).	SNOMED
19527009	Single episode of major depression in full remission (disorder).	SNOMED
19694002	Late onset dysthymia (disorder).	SNOMED
20250007	Severe major depression, single episode with psychotic features, mood-incongruent (disorder).	SNOMED
25922000	Major depressive disorder, single episode with postpartum onset (disorder).	SNOMED
28475009	Severe recurrent major depression with psychotic features (disorder).	SNOMED
33078009	Severe recurrent major depression with psychotic features, mood-congruent (disorder).	SNOMED
35489007	Depressive disorder (disorder).	SNOMED
36170009	Secondary dysthymia, late onset (disorder).	SNOMED
36474008	Severe recurrent major depression without psychotic features (disorder).	SNOMED
36923009	Major depression, single episode (disorder).	SNOMED
38451003	Primary dysthymia, early onset (disorder).	SNOMED
38694004	Recurrent major depressive disorder with atypical features (disorder).	SNOMED
39809009	Recurrent major depressive disorder with catatonic features (disorder).	SNOMED
40379007	Mild recurrent major depression (disorder).	SNOMED
40568001	Recurrent brief depressive disorder (disorder).	SNOMED
42925002	Major depressive disorder, single episode with atypical features (disorder).	SNOMED
48589009	Minor depressive disorder (disorder).	SNOMED
63778009	Major depressive disorder, single episode with melancholic features (disorder).	SNOMED

FIGURE 5.10: DSF-E DENOMINATOR 2 CLAIMS/ENCOUNTER CODES (continued)

Code	Service Completed Definition	Code System
66344007	Recurrent major depression (disorder).	SNOMED
67711008	Primary dysthymia, late onset (disorder).	SNOMED
69392006	Major depressive disorder, single episode with catatonic features (disorder).	SNOMED
71336009	Recurrent major depressive disorder with postpartum onset (disorder).	SNOMED
73867007	Severe major depression with psychotic features (disorder).	SNOMED
75084000	Severe major depression without psychotic features (disorder).	SNOMED
75837004	Mood disorder with depressive features due to general medical condition (disorder).	SNOMED
76441001	Severe major depression, single episode without psychotic features (disorder).	SNOMED
77486005	Mood disorder with major depressive-like episode due to general medical condition (disorder).	SNOMED
77911002	Severe major depression, single episode with psychotic features, mood-congruent (disorder).	SNOMED
78667006	Dysthymia (disorder).	SNOMED
79298009	Mild major depression, single episode (disorder).	SNOMED
81319007	Severe bipolar II disorder, most recent episode major depressive without psychotic features (disorder).	SNOMED
83176005	Primary dysthymia (disorder).	SNOMED
84760002	Schizoaffective disorder, depressive type (disorder).	SNOMED
85080004	Secondary dysthymia (disorder).	SNOMED
87512008	Mild major depression (disorder).	SNOMED
191610000	Recurrent major depressive episodes, mild (disorder).	SNOMED
191611001	Recurrent major depressive episodes, moderate (disorder).	SNOMED
191613003	Recurrent major depressive episodes, severe with psychosis (disorder).	SNOMED
191616006	Recurrent depression (disorder).	SNOMED
191659001	Atypical depressive disorder (disorder).	SNOMED
192080009	Chronic depression (disorder).	SNOMED
231504006	Mixed anxiety and depressive disorder (disorder).	SNOMED
231542000	Depressive conduct disorder (disorder).	SNOMED

FIGURE 5.10: DSF-E DENOMINATOR 2 CLAIMS/ENCOUNTER CODES (continued)

Code	Service Completed Definition	Code System
268621008	Recurrent major depressive episodes (disorder).	SNOMED
319768000	Recurrent major depressive disorder with melancholic features (disorder).	SNOMED
320751009	Major depression, melancholic type (disorder).	SNOMED
370143000	Major depressive disorder (disorder).	SNOMED
430852001	Severe major depression, single episode with psychotic features (disorder).	SNOMED
442057004	Chronic depressive personality disorder (disorder).	SNOMED

Numerator 2 Billing Codes

All of the codes below are used to identify follow-up care to a positive screen and would be compliant for follow-up within the 30-day timeframe.

FIGURE 5.11: DSF-E NUMERATOR 2 CLAIMS/ENCOUNTER CODES

Code	Service Completed Definition	Code System
99366	Medical team conference.	CPT
99492-99494	Behavioral Health Integration (BHI).	CPT
G0512	Rural health clinic or federally qualified health center (RHC/FQHC) only, psychiatric collaborative care model (COCM), 60 minutes or more of clinical staff time for psychiatric COCM services directed by an RHC or FQHC practitioner (physician, NP, PA or CNM) and including services furnished by a behavioral health care manager and consultation with a psychiatric consultant, per calendar month.	HCPCS
T1016	Case management, each 15 minutes.	HCPCS
T1017	Targeted case management, each 15 minutes.	HCPCS
T2022	Case management, per month.	HCPCS
T2023	Targeted case management; per month.	HCPCS
182832007	Procedure related to management of drug administration (procedure).	SNOMED
225333008	Behavior management (regime/therapy).	SNOMED
385828006	Health promotion management (procedure).	SNOMED
386230005	Case management (procedure).	SNOMED

FIGURE 5.11: DSF-E NUMERATOR 2 CLAIMS/ENCOUNTER CODES (continued)

Code	Service Completed Definition	Code System
409022004	Dispensing medication management (procedure).	SNOMED
410216003	Communication care management (procedure).	SNOMED
410219005	Personal care management (procedure).	SNOMED
410328009	Coping skills case management (procedure).	SNOMED
410335001	Exercises case management (procedure).	SNOMED
410346003	Medication action/side effects case management (procedure).	SNOMED
410347007	Medication setup case management (procedure).	SNOMED
410351009	Relaxation/breathing techniques case management (procedure).	SNOMED
410352002	Rest/sleep case management (procedure).	SNOMED
410353007	Safety case management (procedure).	SNOMED
410354001	Screening case management (procedure).	SNOMED
410356004	Signs/symptoms, mental/emotional case management (procedure).	SNOMED
410360001	Spiritual care case management (procedure).	SNOMED
410363004	Support group case management (procedure).	SNOMED
410364005	Support system case management (procedure).	SNOMED
410366007	Wellness case management (procedure).	SNOMED
416341003	Case management started (situation).	SNOMED
416584001	Case management ended (situation).	SNOMED
424490002	Medication prescription case management (procedure).	SNOMED
425604002	Case management follow up (procedure).	SNOMED
737850002	Day care case management (procedure).	SNOMED
98960-98962	Education and training for patient self-management.	CPT
98966-98969	Non-face-to-face non-physician telephone services.	CPT
98970-98972	Online digital assessment and management service.	CPT
99078	Group patient education service.	CPT
99201-99205	New patient office visit for evaluation and management.	CPT
99211-99215	Established patient office visit for evaluation and management.	CPT
99217-99220	Observation care.	CPT

FIGURE 5.11: DSF-E NUMERATOR 2 CLAIMS/ENCOUNTER CODES (continued)

Code	Service Completed Definition	Code System
99241-99245	Outpatient consultation involving evaluation and management.	CPT
99341-99345	New patient home services.	CPT
99347-99350	Established patient home services.	CPT
99381-99387	New patient preventive medicine services.	CPT
99391-99397	Established patient preventive medicine services.	CPT
99401-99404	Preventive medicine, individual counseling services.	CPT
99411-99412	Preventive medicine, group counseling services.	CPT
99421-99423	Non-face-to-face online digital evaluation and management service.	CPT
99441-99444	Non-face-to-face telephone services.	CPT
99457	Remote physiologic monitoring treatment management services.	CPT
99483	Cognitive assessment and care plan services.	CPT
G0071	Payment for communication technology-based services for five minutes or more of a virtual (nonface-to-face) communication between a rural health clinic (RHC) or federally qualified health center (FQHC) practitioner and RHC or FQHC patient, or five minutes or more of remote evaluation of recorded video and/or images by an RHC or FQHC practitioner occurring in lieu of an office visit; RHC or FQHC only.	HCPCS
G0463	Hospital outpatient clinic visit for assessment and management of a patient.	HCPCS
G2010	Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related evaluation and management (E/M) service provided within the previous seven days nor leading to an e/m service or procedure within the next 24 hours or soonest available appointment.	HCPCS
G2012	Brief communication technology-based service (e.g. virtual check-in) by a physician or other qualified health care professional who can report evaluation and management services provided to an established patient not originating from a related E/M service provided within the previous seven days nor leading to an e/m service or procedure within the next 24 hours or soonest available appointment; five to 10 minutes of medical discussion.	HCPCS

FIGURE 5.11: DSF-E NUMERATOR 2 CLAIMS/ENCOUNTER CODES (continued)

Code	Service Completed Definition	Code System
G2061	Qualified non-physician healthcare professional online assessment and management service for an established patient for up to seven days; cumulative time during the seven days: five to 10 minutes.	HCPCS
G2062	Qualified non-physician healthcare professional online assessment and management service for an established patient for up to seven days' cumulative time during the seven days: 11-20 minutes.	HCPCS
G2063	Qualified non-physician healthcare professional online assessment and management service for an established patient for up to seven days; cumulative time during the seven days: 21 or more minutes.	HCPCS
G2250	Remote assessment of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment.	HCPCS
G2251	Brief communication technology-based service (e.g. virtual check-in) by a qualified healthcare professional who cannot report evaluation and management services, provided to an established patient, not originating from a related service provided within the previous seven days nor leading to a service or procedure within the next 24 hours or soonest available appointment; five to 10 minutes of clinical discussion.	HCPCS
G2252	Brief communication technology-based service (e.g. virtual check-in) by a physician or other qualified healthcare professional who can report evaluation and management services provided to an established patient, not originating from a related E/M service provided within the previous seven days nor leading to an e/m service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion.	HCPCS
T1015	Clinic visit/encounter, all-inclusive.	HCPCS
42137004	Reevaluation of established psychiatric patient (procedure).	SNOMED
50357006	Evaluation and management of patient at home (procedure).	SNOMED
86013001	Periodic reevaluation and management of healthy individual (procedure).	SNOMED

FIGURE 5.11: DSF-E NUMERATOR 2 CLAIMS/ENCOUNTER CODES (continued)

Code	Service Completed Definition	Code System
90526000	Initial evaluation and management of healthy individual (procedure).	SNOMED
108220007	Evaluation and/or management - new patient (procedure).	SNOMED
108221006	Evaluation and/or management - established patient (procedure).	SNOMED
185317003	Telephone encounter (procedure).	SNOMED
185389009	Follow-up visit (procedure).	SNOMED
281036007	Follow-up consultation (procedure).	SNOMED
314849005	Telephone contact by consultant (procedure).	SNOMED
386472008	Telephone consultation (procedure).	SNOMED
386473003	Telephone follow-up (procedure).	SNOMED
390906007	Follow-up encounter (procedure).	SNOMED
401267002	Telephone triage encounter (procedure).	SNOMED
406547006	Urgent follow-up (procedure).	SNOMED
870191006	Follow-up for depression (procedure).	SNOMED
0510	Outpatient clinic - general.	UBREV
0513	Outpatient clinic - psychiatric clinic.	UBREV
0516	Outpatient clinic - urgent care clinic.	UBREV
0517	Outpatient clinic - family practice clinic.	UBREV
0519	Outpatient clinic - other.	UBREV
0520	Freestanding clinic - general.	UBREV
0521	Freestanding clinic - RHC/FQHC.	UBREV
0522	Freestanding clinic - home visit by RHC/FQHC practitioner.	UBREV
0523	Freestanding clinic - family practice clinic.	UBREV
0526	Freestanding clinic - urgent care clinic.	UBREV
0527	Freestanding clinic - VNS to patient home in a home health shortage area.	UBREV
0528	Freestanding clinic - visit by RHC/FQHC practitioner to other nonRHC/FQHC site.	UBREV
0529	Freestanding clinic - other.	UBREV
0982	Professional fees - outpatient services.	UBREV
0983	Professional fees - clinic.	UBREV

ENDNOTES

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