2022 MEDICAID CARE GAP DOCUMENTATION GUIDE

OptimaHealth®

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Table of Contents

Introduction

Preventive and chronic care management are critical steps along the pathway to helping your patients, our members, achieve optimal health. To that end, Optima Health is proud to partner with you to accomplish this very achievable goal. Electronic medical records may provide a means to track gaps in care and reminders of needed services. The Care Gap Documentation Guide is designed to help providers easily document the closure of care gaps.

This resource is organized for ease of use as follows:

- measure definition
- identification of applicable quality program(s)
- helpful tips to achieve performance measure
- codes recommended to document gap closure

For additional information or assistance, you may contact your network management trainer.

CHILD AND ADOLESCENT WELL-CARE VISITS

Definition: Members ages 3-21 as of December 31.

Applicable Quality Program(s):
HEDIS

Helpful Tips To Achieve Performance Measure:

- at least one (1) comprehensive well-care visit with a PCP or OB/GYN practitioner during the measurement year

Codes:

CPT Codes: 99381, 99382, 99383, 99384, 99385, 99391, 99392, 99393, 99394, 99395, 99461

ICD-10 Codes: Z00.0, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.2, Z00.3, Z00.5, Z76.1, Z76.2

Telehealth Visit Codes:
Telehealth requires real-time interactive audio and video telecommunications. Telehealth is billed using standard CPT and HCPCS codes for professional services along with a telehealth modifier (GT or GQ).

A telephone visit is real-time interactive audio communication. CPT codes for telephone visits are: 98966-98968 and 99441-99443.

An e-visit or virtual check-in is not real-time, but still requires two-way interaction between the member and provider. For example, a patient portal, secure text messaging or email (such as MyChart). CPT codes for these online assessments are: 98969-98972, 99421-99423, 99444, and 99458.

CHILDHOOD IMMUNIZATION STATUS (CIS)

Definition: Members who turn 2 years old during the measurement year with the following vaccines completed on or before the second birthday:

- 4 DTaP (do not count any before 42 days of age)
- 3 IPV (do not count any before 42 days of age)
- 1 MMR
- 3 HiB (do not count any before 42 days of age)
- 3 hepatitis B
- 1 VZV, positive serology, or documented chicken pox disease•4 pneumococcal conjugate (do not count any before 42 days of age)
- 1 hepatitis A
- 2 or 3 rotavirus vaccines - depends on the vaccine administered (do not count any before 42 days of age)
- 2 influenza with different dates of service - one of the two vaccinations can be a live attenuated influenza vaccine (LAIV) if administered on the child's second birthday (do not count any given prior to 6 months of age)

Applicable Quality Program(s):
HEDIS

Helpful Tips To Achieve Performance Measure:

- Documentation of "immunizations are up-to-date" is not acceptable.
- Documentation of an immunization (such as the first Hep B) received "at delivery" or "in the hospital" may be counted.

Exclusion Criteria: Contraindication for a specific vaccine (e.g., anaphylactic reaction to the vaccine or its components). Parental refusal is not an exclusion.

CHILDHOOD IMMUNIZATION STATUS (CIS) CONTINUED

Codes:

42 Days of Age Through Second Birthday:
(4) DTaP - Recommended Codes - CPT: 90697, 90698, 90700, 90723
(3) IPV - Recommended Codes - CPT: 90697, 90698, 90713, 90723
(3) HiB - Recommended Codes - CPT: 90644, 90647, 90648, 90697, 90698, 90748
(4) Pneumococcal Conjugate - Recommended Code - CPT: 90670
(2 or 3) Rotavirus - Recommended Codes - (2 Dose) CPT: 90681 or (3 Dose) CPT: 90680

On or Between First and Second Birthdays:
(1) VZV - Recommended Codes - CPT: 90710, 90716
(1) MMR - Recommended Codes - CPT: 90707; MMRV - 90710
(1) Hepatitis A - Recommended Code - CPT: 90633

On or Before Second Birthday:
(3) Hepatitis B - Recommended Codes - CPT: 90697, 90723, 90740, 90744, 90747, 90748

6 Months of Age Through Second Birthday:
(2) Influenza - Recommended Codes - CPT: 90655, 90657, 90661, 90673, 90685, 90686, 90687, 90688, 90689

On or Between 9th and 13th Birthdays:
LAIV - Recommended Codes - 90660, 90672

COMPREHENSIVE DIABETES CARE (CDC)

Definition: Adults ages 18 and older.

- eye exam - diagnosis of diabetes (type 1 or type 2) who had an eye exam (retinal) performed during the measurement year
- blood pressure control - with BP of ‹140/90•HbA1c Control (‹8) - with HbA1c ‹8.0% control within the measurement year
- HbA1c Control (›9) - HbA1c level is greater than 9%, or not tested during the measurement year

Applicable Quality Program(s):
HEDIS

Helpful Tips To Achieve Performance Measure:

- retinal/dilated eye exam (**most recent** date within the measurement year or year preceding the measurement year) or bilateral eye enucleation any time through measurement year
- blood pressure (most recent date within measurement year)
  BP of ‹ 140/90 = control
- HbA1c testing (most recent date within the measurement year)

  - HbA1c ‹ 8.0 % = control

  - HbA1c › 9.0 % = poor control

Exclusion Criteria: Members without a diagnosis of diabetes in any setting, but did have (during the measurement year or year preceding the measurement year):

- gestational diabetes
- steroid-induced diabetes
- polycystic ovarian syndrome

COMPREHENSIVE DIABETES CARE (CDC) CONTINUED

Codes:
Retinal or Dilated Eye Exam Recommended Codes:
67028, 67030, 67031, 67036, 67039-67043, 67101, 67105, 67107, 67108, 67110, 67113, 67121, 67141, 67145, 67208, 67210, 67218, 67220, 67221, 67227, 67228, 92002, 92004, 92012, 92014, 92018, 92019, 92134, 92225-92228, 92230, 92235, 92240, 92250, 92260, 99203-99205, 99213-99215, 99242-99245. CPTII - 3072F, 2022F-2026F, 2033F

Blood Pressure Control (BPD)

BP Control (<140/90 mmHg) Recommended Codes

(Systolic >/= 140) CPT-CAT-II: 3077F
(Systolic < 140) CPT-CAT-II: 3074F, 3075F
(Diastolic >/= to 90) CPT-CAT-II: 3080F
(Diastolic 80-89) CPT-CAT-II: 3079F
(Diastolic < 80) CPT-CAT-II: 3078F

(Remote Blood Pressure Monitoring Codes)
CPT: 93784, 93788, 93790, 99091, 99453, 99454, 99457, 99473

Latest HbA1C Screening Recommended Codes

CPT-CAT-II: 3046F (HbA1c >9%)
CPT-CAT-II: 3051F (HbA1c >/= 7% & <8%)
CPT-CAT-II: 3052F (HbA1c >/= 8% & <9%)
CPT-CAT-II: 3044F (HbA1c <7%)
Codes: 83036, 83037

Telehealth Visit Codes:

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An e-visit or virtual check-in is not real-time, but still requires two-way interaction between the member and provider. For example, a patient portal, secure text messaging or email (such as MyChart). CPT codes for these online assessments are: 98969-98972, 99421-99423, 99444, and 99458.

FOLLOW-UP AFTER EMERGENCY DEPARTMENT VISIT FOR ALCOHOL AND OTHER DRUG DEPENDENCE (FUA)

Definition: Ages 13 and older. ED visit with principal diagnosis of Alcohol or Other Drug (AOD) Abuse/Dependence who had a follow-up visit for AOD.

Applicable Quality Program(s):
HEDIS

Helpful Tips To Achieve Performance Measure:

- follow-up visit with any practitioner with a principal diagnosis of AOD within seven days of discharge (eight total days)
- follow-up visit with any practitioner with a principal diagnosis of AOD within 30 days of discharge (31 total days)

Exclusion Criteria: ED visits that result in an inpatient stay and ED visits followed by an admission to an acute or nonacute inpatient care setting on the date of the ED visit or within the 30 days after the ED visit, regardless of the principal diagnosis for the admission.

Codes:

ICD-10: F10.10, F10.120, F10.121, F10.129-F10.132, F10.139, F10.14, F10.150, F10.151, F10.159, F10.180-F10.182, F10.188, F10.19

CPT: 98960-98962, 99201-99205, 99211-99215

Telehealth Visit Codes:
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An e-visit or virtual check-in is not real-time, but still requires two-way interaction between the member and provider. For example, a patient portal, secure text messaging or email (such as MyChart). CPT codes for these online assessments are: 98969-98972, 99421-99423, 99444, and 99458.

FOLLOW-UP AFTER EMERGENCY DEPARTMENT VISIT FOR MENTAL ILLNESS (FUM)

Definition: Members 6 years and older with an ED visit and a principal diagnosis of mental illness or intentional self-harm on or between January 1 and December 1 of the measurement year where member was 6 years or older on the date of the visit compared to the number of days in the time period (denominator).

Applicable Quality Program(s):
HEDIS

Helpful Tips To Achieve Performance Measure:

- follow-up visit within seven days after the ED visit (eight total days) - includes visits that occur on the date of the ED visit
- follow-up visit within 30 days after the ED visit (31 total days) - includes visits that occur on the date of the ED visit

Exclusion Criteria: ED visits that result in an inpatient stay, and ED visits followed by an admission to an acute or nonacute inpatient care setting on the date of the ED visit or within the 30 days after the ED visit (31 total days), regardless of the principal diagnosis for the admission.

Codes:
Observation
CPT 99217-99220
Behavioral Health Outpatient Visit
CPT 98960-98962; 99078; 99201-99205 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99483, 99492-99494, 99510

Telehealth Visit Codes:
Telehealth requires real-time interactive audio and video telecommunications. Telehealth is billed using standard CPT and HCPCS codes for professional services along with a telehealth modifier (GT or GQ).

A telephone visit is real-time interactive audio communication. CPT codes for telephone visits are: 98966-98968 and 99441-99443.

An e-visit or virtual check-in is not real-time, but still requires two-way interaction between the member and provider. For example, a patient portal, secure text messaging or email (such as MyChart). CPT codes for these online assessments are: 98969-98972, 99421-99423, 99444, and 99458.

INITIATION AND ENGAGEMENT OF ALCOHOL AND OTHER DEPENDENCE TREATMENT (AOD)

Definition: Ages 13 and older with diagnosed AOD. New episode (60 days negative diagnosis history) of alcohol or other drug (AOD) abuse or dependence.

Applicable Quality Program(s):
HEDIS

Helpful Tips To Achieve Performance Measure:

- Initiate treatment within 14 days of the diagnosis through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication-assisted treatment (MAT).
- Receive at least two additional AOD services or MAT within 34 days of the initiation visit.

Codes:

Codes to identify AOD visits: 98960- 98962, 99078, 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99408-99409, 99411-99412, 99483, 99510

Telehealth Visit Codes:
Telehealth requires real-time interactive audio and video telecommunications. Telehealth is billed using standard CPT and HCPCS codes for professional services along with a telehealth modifier (GT or GQ).

A telephone visit is real-time interactive audio communication. CPT codes for telephone visits are: 98966-98968 and 99441-99443.

An e-visit or virtual check-in is not real-time, but still requires two-way interaction between the member and provider. For example, a patient portal, secure text messaging or email (such as MyChart). CPT codes for these online assessments are: 98969-98972, 99421-99423, 99444, and 99458.

PEDIATRIC QUALITY INDICATOR 14: ASTHMA ADMISSION RATE (PDI)

Definition: Members ages 2 through 17 years with a principal ICD-10-CM diagnosis code for asthma (ACSASTD).

Applicable Quality Program(s):
AHRQ

Helpful Tips To Achieve Performance Measure:

- development of a written asthma action plan in partnership with patient/family
- monitor medication compliance

Exclusion Criteria: Excludes cases with a diagnosis code for cystic fibrosis and anomalies of the respiratory system, obstetric admissions, and transfers from other institutions.

Codes:

Asthma Diagnosis Codes
J4521, J4552, J4522, J45901, J4531, J45902, J4532, J45990, J4541, J45991, J4542, J45998, J4551

PRENATAL AND POSTPARTUM CARE

Definition: Pregnant members who delivered a live infant during the time period specified by NCQA HEDIS® for the measurement year (as adopted by DMAS) who received a prenatal visit within the first trimester (on or before the enrollment start date or within 42 days of enrollment).

Pregnant members who delivered a live infant during the time period specified by NCQA HEDIS® for the measurement year (as adopted by DMAS) who had a postpartum visit on or between 7 and 84 days after delivery.

Applicable Quality Program(s):
HEDIS

Helpful Tips To Achieve Performance Measure:

Documentation of a prenatal visit within first trimester (on or before the enrollment start date or within 42 days of enrollment) and evidence of one of the following:

- documentation indicating the woman is pregnant or references to the pregnancy; for example:
  - documentation in standardized prenatal flowsheet, or
  - documentation of LMP, EDD, or gestational age, or
  - a positive pregnancy test result, or
  - documentation of gravidity and parity, or
  - documentation of a complete obstetrical history, or
  - documentation of prenatal risk assessment and counseling/education
- a basic physical obstetrical examination that includes auscultation for fetal heart tone, or pelvic exam with obstetric observations or measurement of fundus height (a standard prenatal flow sheet may be used)
- documentation of a postpartum visit on or between 7 and 84 days after delivery

PRENATAL AND POSTPARTUM CARE CONTINUED

Helpful Tips To Achieve Performance Measure:

- evidence that a prenatal care procedure was performed, such as:
  - screening test in the form of an obstetric panel (must include all of the following: hematocrit, differential WBC count, platelet count, hepatitis B surface antigen, rubella antibody, syphilis test, RBC antibody screen, RH and ABO blood typing)

  or

  - a rubella antibody test/titer with an Rh incompatibility (ABO/Rh) blood typing

  or

  - TORCH antibody panel alone

  or

  - ultrasound of a pregnant uterus

Ultrasound and lab results alone are not considered a visit; they must be combined with an office visit with an appropriate practitioner.

Codes:

Timeliness of Prenatal Care Recommended Codes - CPT: 99201-99205, 99211-99215, 99241-99245, 99483
Postpartum Care Recommended Codes - CPT: 57170, 58300, 59430, 99501

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PREVENTION QUALITY INDICATOR 05 (AS CALCULATED BY DMAS): COPD OR ASTHMA IN OLDER ADULTS ADMISSION RATE (PQI)

Definition: Admissions with a principal diagnosis of chronic obstructive pulmonary disease (COPD) or asthma per 100,000 population, ages 40 years and older.

Applicable Quality Program(s):
AHRQ

Helpful Tips To Achieve Performance Measure:

Discharges, for patients ages 40 years and older, with either

- principal ICD-10-CM diagnosis code for COPD (ACCOPDD*) (excluding acute bronchitis) or
- principal ICD-10-CM diagnosis code for asthma (ACSASTD*)

Exclusion Criteria: Excludes obstetric admissions and transfers from other institutions.

Codes:

Primary Diagnosis Codes for COPD and Asthma:
J41.0, J41.1, J41.8, J42., J43.0, J43.1, J43.2, J43.8, J43.9, J44.0, J44.1, J44.9, J47.0, J47.1, J47.9, J45.21, J45.22 ,J45.31, J45.32, J45.41, J45.42, J45.51, J45.52, J45.901, J45.902, J45.990, J45.991, J45.998

PREVENTION QUALITY INDICATOR 08 (AS CALCULATED BY DMAS): HEART FAILURE ADMISSION RATE (PQI)

Definition: Admissions with a principal diagnosis of heart failure per 100,000 population, ages 18 years and older.

Applicable Quality Program(s):
AHRQ

Helpful Tips To Achieve Performance Measure:

Discharges, for patients ages 18 years and older, with a principal ICD-10-CM diagnosis code for heart failure

Exclusion Criteria: Discharges, for patients ages 18 years and older, with a principal ICD-10-CM diagnosis code for heart failure

Codes:

Primary Diagnosis Codes for Heart Failure:

I09.81, I11.0, I13.0, I13.2, I50.1, I50.20, I50.21, I50.22, I50.23, I50.30, I50.31, I50.32, I50.33, I50.4, I50.41, I50.42, I50.43, I50.9, I50.810, I50.811, I50.812, I50.813, I50.814, I50.82, I50.83, I50.84, I50.89

Glossary

TABLE OF CONTENTS

Attributed Member: Member for whom the provider is held accountable in regards to care.

CPT Category II Code: Tracking codes, ending with an "F," which facilitate data collection related to quality and performance measurement.

CPT Code: Medical code set used to report medical, surgical, diagnostic procedures, and other services by physicians/providers/facilities to health insurance companies and accreditation organizations.

Denominator: The number of members who qualify for the measure criteria.

Drug Tiers: A way for insurance providers to determine medicine costs. The higher the tier, the higher the cost of the medicine for the member in general.

HCPCS Code: Healthcare Common Procedure Coding System (often pronounced hick picks) – a set of codes beginning with a letter used to report supplies, materials, drugs, procedures, and other services.

HEDIS: Health Care Effectiveness Data and Information Set – standardized performance measures developed by NCQA (National Committee for Quality Assurance).

ICD-10-CM (Diagnosis Code): A code system used by physicians and other healthcare providers to classify and code all diagnoses, signs, and symptoms.

ICD-10 (Procedure Code): A code system used to report procedures performed by physicians and other healthcare providers in a facility/hospital setting.

Numerator: The number of members who meet compliance criteria.

PMPM: Per member per month – usual unit of measure that payers remit to providers.

Glossary

TABLE OF CONTENTS

Measurement Year: January 1 through December 31.

Stars: CMS rating system used to measure how well Medicare Advantage and Part D plans perform in several areas, including quality of care and customer satisfaction. Stars ratings range from one to five, with one being the lowest score and five being the highest.

Step Therapy: Trying less expensive options before “stepping up” to drugs that cost more.

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Provider Customer Service

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