Amerigroup RealSolutions® in healthcare

Quality Reporting

and Performance Measures

GAAGP-CD-018926-23

Table of contents

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Introduction

Amerigroup Community Care is focused solely on meeting the healthcare needs of Georgia's most financially vulnerable Americans. We coordinate our members' physical and behavioral healthcare while offering a continuum of education, access, care, and outcomes that result in lower cost, improved quality, and better health status for our members.

Our members are enrolled in one of two programs that provide managed care services in the state of Georgia:

- Georgia Families is the statewide program designed to deliver healthcare services to Medicaid and PeachCare for Kids® members. Amerigroup began operations in the Atlanta service region on June 1, 2006, and on September 1, 2006, for the East, North and Southeast service regions. On February 1, 2012, operations expanded to the remainder of the state in the Central and Southwest service regions.
- Georgia Families 360°SM is the statewide program designed to deliver healthcare services to children and youth in foster care, adoption assistance and certain youth in the Department of Juvenile Justice (DJJ) system. On March 3, 2014, Amerigroup became the only care management organization in the state of Georgia responsible for the well-being and healthcare coordination of over 27,000 of the state's most vulnerable children and youth through the Georgia Families 360°SM program. Amerigroup recognizes the unique circumstances of these members, such as exposure to trauma through abuse and/or neglect, complex behavioral and physical health conditions, high utilization of psychotropic medications, and frequent placement changes.

At Amerigroup, we are dedicated to offering real solutions that improve healthcare access and quality of care for our members, while proactively working to reduce the overall cost of care to taxpayers. We look to you, our providers, to render high-quality care to our members as we work together to make a difference in the lives of those we serve.

We are here to help! If you have any questions or would like additional information, please contact one of the departments in the table below.

Information or questions on the following:	**Contact:**
Inquiries specific to **Georgia Families 360°SM** members (*foster care, adoptive assistance and DJJ*)	Georgia Families 360°SM Intake team at **855-661-2021**
Inquiries specific to **Georgia Families** and **PeachCare for Kids** members, quality reporting, performance measures or any additional questions	Your local Provider Relations representative — Visit **https://provider.amerigroup.com/georgia-provider/contact-us**
Pharmacy Department	Call **800-454-3730** or visit **https://provider.amerigroup.com/georgia-provider/resources/pharmacy-information**

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Quality Reporting

To keep ourselves accountable to the Department of Community Health (DCH), you and our members, we compare our performance against benchmarks for certain quality performance measures. These performance measures are based on technical specifications developed by agencies such as the National Committee for Quality Assurance (NCQA), the Agency for Healthcare Research & Quality (AHRQ), and the Centers for Medicare & Medicaid Services (CMS). These performance measures are a contractual requirement with the DCH and may also be utilized for public reporting by agencies, such as the DCH and NCQA.

Several of the tools utilized to assess and report our performance include, but are not limited to:

- Healthcare Effectiveness Data and Information Set (HEDIS®) — developed by NCQA to measure performance of the care and services provided to our members
- Consumer Assessment of Healthcare Providers and Systems (CAHPS®) — an annual standardized survey conducted anonymously by an NCQA-Certified third-party survey vendor to assess consumers' experiences with their health plan and health care services

We recognize that the demands on providers are greater and more complex than ever before. Yet, providing high quality care remains a principal priority. As your partner, we want to lend a hand in improving HEDIS rates, so we are committed to:

- Helping you understand HEDIS and other performance measures
- Outlining the details of key measures
- Providing the applicable codes that meet compliance
- Sharing quality performance and results
- Offering best practices and helpful tips
- Pointing you to valuable tools and resources

Providers and their staff play a central role in promoting the health of our members. To help facilitate HEDIS process improvement, you and your staff can:

- Understand HEDIS and other performance measures.
- Provide the appropriate care within the required time frame(s).
- Document all care in the patient's medical record.
- Accurately code all claims. Providing accurate information on a claim may reduce the number of records requested.
- Comply with medical records requests promptly, preferably within 5 to 7 business days.
- Utilize results and feedback to improve performance.

While the codes contained within this booklet align with HEDIS, CMS, and EPSDT reporting, the information **does not guarantee reimbursement**; however, proper coding can lead to optimal reimbursement. Your provider contract, Medicaid, member benefits, and several other guidelines determine reimbursement for the applicable codes.

The information contained within this booklet does not dictate or control your clinical decisions regarding the appropriate care of our members. All member care and related decisions about treatment are the sole responsibility of the provider.

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Supplemental data

The reporting for HEDIS and other quality performance measures requires a combination of member and provider data, administrative or claims data, and supplemental data. Supplemental data refers to additional clinical information about a member, such as historic service events, services potentially not included or partially included on a claim (*BMI percentile, blood pressure result, HbA1c result, etc.*) or even social history or demographic information never received through claims transactions. Supplemental data is utilized to support HEDIS compliance and may also be used to identify members who should be excluded from a measure.

The supplemental data efforts listed below align with your ***Participating Provider Agreement***, which requires that you comply with quality reporting and initiatives. These efforts are essential to help ensure that our members — your patients — are receiving the best health care achievable and allowing you to demonstrate your commitment to delivering quality care.

Data exchange

Amerigroup encourages electronic data submission to complement information received on claims. Submitting ongoing electronic supplemental data may provide benefits such as:

- Decrease in the number of medical records requested from Amerigroup throughout the year
- Reducing the administrative burden on your practice such as:
    - Less unnecessary contact (calls/emails) between Amerigroup and your office
    - Provider staff are not displaced from daily office tasks to fulfill requests for charts
    - Reduces onsite office visits for chart review
    - Reduces copy errors
        - Trained and proficient staff complete abstraction of HEDIS data
- More accurate reflection of performance (scorecards, gap in care reports, etc.)
- Ability to identify gaps and develop programs and/or interventions to help improve health outcomes
- Supports the collection of data for social determinants of health used throughout our organization

Your office can participate in the supplemental data exchange by:

- **EMR Flat Files** - Securely submitting flat files directly from your EMR system utilizing a standardized file layout
- **Remote Access** - Providing Amerigroup HEDIS staff remote access to abstract medical records directly from your EMR web-portal

If you choose to participate in the supplemental data exchange, contact your Provider Experience representative.

Medical record review

Proper coding of claims is critical to help us assess your performance on the quality of care that is provided to our members, but also helps to accurately report performance measure rates. When you submit claims using complete and appropriate codes for these services, we are less likely to request medical records.

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When a medical record is required to supplement HEDIS and close data gaps, you may receive requests from Amerigroup (*or one of our business partners*) to review charts for one or several of your patients. Those medical records can be sent to us via:

- HEDIS secure inbox at **ga1hphedis@amerigroup.com**
- HEDIS secure fax at **888-220-6712**

As noted above, you can also provide us with the applicable information to pull records directly from your EMR.

We know it's not an easy task to prepare charts for medical review, but we believe you are as committed to improving patient health outcomes as we are, so we are asking you to help us by complying with our requests for records timely. If there is anything we can do to make this process easier for you, please let us know. We will do all that we can to accommodate your request. We will even come to your office and collect the records if you want!

We appreciate your cooperation and timeliness in submitting the requested medical record information.

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EPSDT Services

Remember, when providing services for our members:

- Providers contracted with Amerigroup must perform all required components of an EPSDT visit as outlined in the *DCH EPSDT Services Manual*. Components of the ESPDT visit includes, but is not limited to:
    - Comprehensive health development history (inclusive both physical and mental health).
    - Comprehensive unclothed physical exam or appropriately draped
    - Health education and anticipatory guidance for both the child and caregiver
    - Dental/oral health assessments
    - Vision and heating assessments
    - Laboratory testing
    - Appropriate immunizations, in accordance with the pediatric and adult schedules for vaccines established by the Advisory Committee on Immunization Practices (ACIP)
    - Other necessary health care — diagnostic services and treatment to correct or ameliorate defects, physical and mental illnesses, and conditions discovered by the screening services
- Providers are encouraged to see members newly enrolled in Georgia Families **within 90 calendar days** to establish a primary medical care relationship and complete a medical assessment.
- Providers are required to see members newly entering or re-entering the Georgia Families 360°$_{SM}$ program **within 10 calendar days** to establish a primary medical care relationship and complete a medical assessment as outlined in DCH's EPSDT program. Children and adolescents in the Georgia Families 360°$_{SM}$ program ***may require more frequent EPSDT services than what is listed in the Bright Futures Periodicity Schedule***.
- In accordance with federal regulation, a provider is not required to exhaust other health plan benefits with respect to EPSDT preventive health screenings. **Even if the member has other health insurance, you may file Medicaid first for preventive health services** as outlined in *Part 1 Policies and Procedures for Medicaid and PeachCare for Kids*. This will ensure accurate and timely reporting of EPSDT services.
- Preventive health visits (well visits) should be completed per the *Bright Futures Periodicity Schedule*. Sick visits may be missed opportunities to complete a well visit and may count for a well-visit if the appropriate documentation is included. Amerigroup allows reimbursement for preventive health visits (well visits) that include sick visits. Be sure to bill modifier 25 with the applicable evaluation and management (E&M) code (CPT® codes 99211 to 99212) for the sick visit as well as the appropriate diagnosis codes, POS codes and/or modifiers for respective visits.
- The appropriate EPSDT *HIPAA* referral code should be documented on the EPSDT claim when an EPSDT visit has occurred to document whether or not problems were identified during the preventive health visit and a referral is needed for further diagnostic and treatment services:
    - **NU** — normal, no follow-up visit needed
    - **AV** — available, not used: Patient refused referral.
    - **S2** — under treatment: Patient is currently under treatment for health problem and has a return visit.
    - **ST** — new services requested: Referral to another provider for diagnostic or corrective treatment/scheduled.

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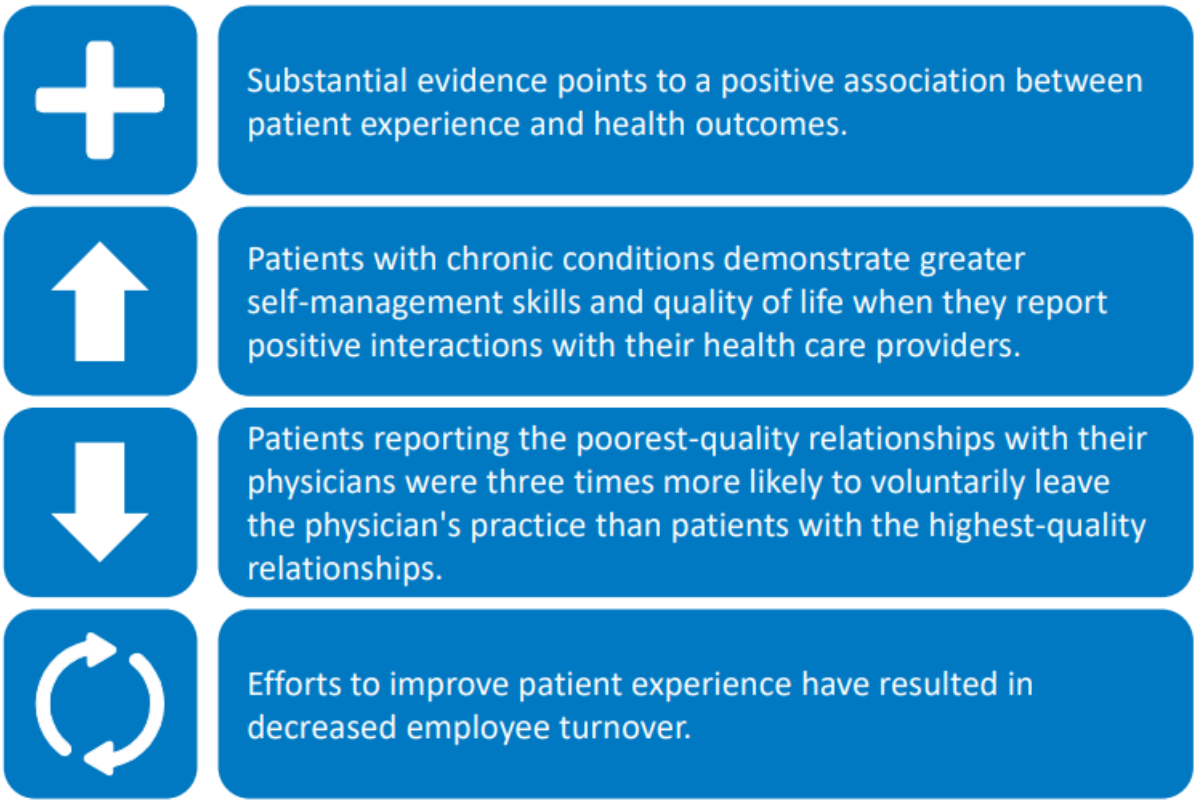
CAHPS Survey

Each year, from January to May, our members receive a survey called Consumer Assessment of Healthcare Providers and Systems (CAHPS®). CAHPS is an annual standardized tool conducted to assess consumer (member) experience with their health care services and health plan. The information from this survey is used to improve the quality of services we give to our members.

Why focus on member experience?



Tips to improve the member experience

The CAHPS survey is comprised of several categories that include questions specific to the member's experience with their provider. Since providers and their staff play a key role in the member experience, listed below are several best practices and helpful tips to improve the member's experience:

- **Getting care quickly -** This category measures the member's perception of how quickly they received routine or urgent care within the last six months. Best practices and helpful tips to help members get care quickly include but are not limited to**:**
    - Offer weekend/evening appointments to accommodate your patients' schedules.
    - Include clear instruction on how to access after-hours care such as dialing **911** in the case of an emergency.
    - Consider assigning staff dedicated to preliminary work-up activities.
    - If possible, leave a few appointments available each day for urgent visits.
    - Offer visits to members to see nurse practitioners or physician assistants.

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- Understand Amerigroup standards for routine and urgent visit wait time for an appointment. Review our standards in your provider manual at **https://provider.amerigroup.com/ga** > *Resources* > *Provider Manuals Policies & Guidelines* > ***Georgia Provider Manual***
- Remind patients they can call the 24/7 NurseLine, located on the back of their member ID card, available seven days a week for health-related questions.

- **Getting needed care** – This category measures the member's perception of how easily they were able to get the care they needed from their doctor or specialist within the last six months, including tests, screenings, visits, and treatments. Best practices and helpful tips to help members get the care they need include but are not limited to**:**
  - Offer an appointment agenda where patients can list concerns or questions they would like to address during their visit.
  - Write down details regarding visits and referrals to a specialist for the patient.
  - If possible, leave a few appointments available each day for urgent visits.
  - Review all available treatment options for the patient in their language. Amerigroup offers both telephone and face-to-face interpreter services, which you can access by calling Provider Services at **800-454-3730**. Twenty-four hours are required to schedule services.
  - Avoid using medical terms that could confuse the patient.
  - Provider offices should schedule follow-up appointments for needed screenings, tests, treatments and exams for patients while they are in the office for their visit.
  - Patients can also schedule appointments by contacting Member Services at the number located on the back of their member ID card **800-600-4441** (TTY 711).
- **Coordination of care** – This category measures the member's perception of how informed their doctor seemed regarding the care they received with other physicians or health providers within the last six months. Best practices and helpful tips to ensure coordination of care include but are not limited to**:**
  - Regularly talk to your patients about any specialists or other physicians they have seen. Ask about the care they received and if they were given any reports or notes.
  - Consider implementing a reminder in the medical record to request test results or follow-up reports. This will ensure appropriate follow-up for the patient.
  - Keep an open dialogue with your patient and discuss their previous medical history.
  - Set an expectation for the patient so they know when they will receive a follow-up call or test results. If this process is not part of the office protocol, make sure the patient is aware so they understand how they can obtain their results or follow-up.
- **How well doctors communicate –** This category measures the member's perception of how well their physician communicated with them within the last six months. Questions in this category take into account how the physician explained things regarding their health, how well they understood the information, if the doctor listened to the patient, if the doctor was respectful and how much time the physician spent with them. Best practices and helpful tips to ensure effective communication with members include but are not limited to**:**
  - Offer an appointment agenda where patients can list concerns or questions they would like to address during their visit.
  - Ensure there is enough time for each patient's appointment to allow time for communication between physician and patient. Allow the opportunity for patients to ask questions and check their understanding of the information provided during the visit.
  - Listen to your patient's needs. Avoid using terms that could confuse the patient.
  - Take feedback from your patients by providing short survey cards to see how the office can improve.

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- Offer a visit summary to the patient that includes any treatment, goals, or action plans that were discussed, prescriptions, and what the medications are for, including side effects. Include the next appointment time or recommended next appointment timeframe. If the patient is being referred to a specialist, include that information in the summary along with the option to email this information to the patient with the appropriate signatures and permissions for (*HIPAA*, compliance, etc.) during the visit.
- Allow the opportunity for patients to ask questions and check their understanding of the information provided during the visit. Use the teach-back method with patients to promote understanding.

The CAHPS survey also asks members questions about specific services that were offered and/or discussed, if applicable, such as:

- **Medical Assistance with Smoking and Tobacco Use Cessation** – These percentage of members **18 and older** who were current smokers or tobacco users and were provided the following facets of medical assistance during the measurement year:
  - **Advising Smokers and Tobacco Users to Quit** – members who received advice to quit
  - **Discussing Cessation Medications** - members who received a discussion or were recommended cessation medications
  - **Discussing Cessation Strategies** - members who received a discussion or were provided cessation methods or strategies

Additional education about the CAHPS survey, the importance of focusing on the patient experience and ways to improve the patient experience are available by visiting the Training Programs section of **https://provider.amerigroup.com/georgia-provider**.

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Performance measures

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Adults' Access to Preventive/Ambulatory Health Services (AAP)

This HEDIS measure looks at the percentage of members 20 years of age and older who had an ambulatory or preventive care visit during the measurement year.

Record your efforts

Make sure that your medical record documentation for each visit reflects all the following:

- Date of the visit(s)
- A physical exam
- Discussions regarding:
  - Routine, recommended vaccinations
  - Screenings with results (Depression, Cervical Cancer, Breast Cancer), etc.
  - Counseling on topics (as needed) such as:
    - Quitting smoking
    - Losing weight

Code your services correctly

Use the following codes to document ambulatory/preventive health visits:

Description	CPT	ICD-10-CM	HCPCS
Ambulatory Visits	92002, 92004, 92012, 92014, 99202-99205, 99211-99215, 99242-99245, 99304-99310, 99315, 99316, , , , 99341-99342, 99344-99345, 99347- 99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99429, 99483	Z00.00, Z00.01, Z00.121, Z00.129, Z00.3, Z00.5, Z00.8, Z02.0-Z02.6, Z02.71, Z02.79, Z02.81-Z02.83, Z02.89, Z02.9, Z76.1, Z76.2	G0402, G0438, G0439, G0463, T1015, S0620, S0621
Online assessments (e-visit or virtual check-in)	98971-98972, 99421-99423, , 99457, 99458		G0071, G2010, G2012, , G2250-G2252
Telephone visits	98966-98968, 99441-99443		

Best practices and helpful tips:

- Be sure to use the appropriate modifier(s) and/or POS codes, if applicable.
- Medical records to supplement HEDIS data can be sent to the HEDIS team via secure inbox at **ga1hphedis@amerigroup.com** or secure fax at **888-220-6712**.
- Sick visits may be missed opportunities to complete a well visit.
- Appropriate screenings may be an important part of these visits as well, including:
  - Breast Cancer Screenings (BCS Measure)
  - Cervical Cancer Screenings (CCS Measure)
  - Chlamydia Screenings (CHL Measure)
  - Depression screenings with a documented follow-up plan, as identified (CDF Measure)
- Use your member roster to contact patients who are due for their annual well visit or are new to your practice.
- If the patient is a smoker, be sure to offer education about the importance of smoking cessation counseling. Offer solutions to assist with quitting.

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- Encourage your staff to use tools within the office to promote smoking cessation.
- If utilizing an electronic medical record (EMR) system, consider:
    - Creating a flag to track patients who are due or past due for preventive services. If you do not use an EMR, consider creating a manual tracking method.
    - Electronic data sharing with your health plan to capture supplemental data (*additional clinical information about a member that may not have been submitted on a claim*).

How can we help?

- Providing individualized reports of your patients that are due or overdue for services
- Assisting with scheduling appointments for our members, if needed
- Offering nonemergency transportation to appointments for our members
- Providing education to members on the importance of well-visits through various sources, such as phone calls, text messages, newsletters, and/or health education materials
- Encouraging preventive care through our CHIP Rewards program

Contact your Provider Relationship Management representative for additional details and questions.

Other resources

You can find more information and tools online:

- *ACIP Immunization Schedule* — **https://www.cdc.gov/vaccines/schedules/hcp/index.html**
- Adult BMI Calculator - **https://www.cdc.gov/healthyweight/assessing/bmi/adult_bmi/english_bmi_calculator/bmi_calculator.html**
- Flu vaccinations - **https://www.ncqa.org/hedis/measures/flu-vaccinations/**
- Georgia Registry of Immunization Transactions & Services (GRITS) — **https://www.grits.state.ga.us/production/security_ui.showLogin**
- Medical Assistance with Smoking and Tobacco Use Cessation - **https://www.ncqa.org/hedis/measures/medical-assistance-with-smoking-and-tobacco-use-cessation/**

Notes

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Antidepressant Medication Management (AMM)

This HEDIS measure looks at members 18 years of age and older with a diagnosis of major depression who were treated with an antidepressant medication and remained on an antidepressant medication for the following treatment periods:

- **Effective acute phase treatment**: at least 84 days (12 weeks)
- **Effective continuation phase treatment**: at least 180 days (six months)

Code your services correctly

Use the following codes to identify major depression:

Description	ICD-10-CM
Major depression	F32.0-F32.4, F32.9, F33.0-F33.3, F33.41, F33.9

Best practices and helpful tips:

- The treatment period is the number of calendar days that the member is covered with a prescription for the antidepressant medication. Consider writing a 60-day supply of antidepressant medications.
- Educate your patients and their spouses, caregivers, and/or guardians about the importance of:
  - Compliance with long-term medications.
  - Not abruptly stopping medications without consulting you.
  - Contacting you immediately if they experience any unwanted/adverse reactions so their treatment can be re-evaluated.
  - Scheduling and attending follow-up appointments to review the effectiveness of their medications.
  - Calling your office if they cannot get their medications refilled.
- Discuss the benefits of participating in our behavioral health case management program.
- Be sure to contact our Pharmacy department at **800-454-3730** to verify required preauthorization of medications.
- Antidepressant medications include but may not be limited to:

Description	Prescription		
Miscellaneous antidepressants	• Bupropion	• Vilazodone	• Vortioxetine
Monoamine oxidase inhibitors	• Isocarboxazid • Phenelzine	• Selegiline	• Tranylcypromine
Phenylpiperazine antidepressants	• Nefazodone	• Trazodone	
Psychotherapeutic combinations	• Amitriptyline-chlordiazepoxide	• Amitriptyline-perphenazine	• Fluoxetine-olanzapine
SNRI antidepressants	• Desvenlafaxine • Duloxetine	• Levomilnacipran	• Venlafaxine
SSRI antidepressants	• Citalopram • Escitalopram	• Fluoxetine • Fluvoxamine	• Paroxetine • Sertraline
Tetracyclic antidepressants	• Maprotiline	• Mirtazapine	
Tricyclic antidepressants	• Amitriptyline • Amoxapine • Clomipramine	• Desipramine • Doxepin (> 6 mg) • Imipramine	• Nortriptyline • Protriptyline • Trimipramine

Note: *Not all medications listed above are in our formulary. Prior authorization and/or step therapy may be required.*

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How can we help?

- Offering current *Clinical Practice Guidelines* on our provider self-service website
- Providing individualized reports of your patients who are due or overdue for services
- Offering nonemergency transportation to appointments for our members
- Offering our behavioral health case management program to members

Contact your Provider Relationship Management representative for additional details and questions.

Other resources

You can find more information and tools online:

- American Psychiatric Association — **https://www.psychiatry.org/patients-families/depression/what-is-depression**
- *Medicaid Formulary* — **https://client.formularynavigator.com/Search.aspx?siteCode=7596004980**
- National Institute of Mental Health — **https://www.nimh.nih.gov**
- Pharmacy Information - **https://provider.amerigroup.com/georgia-provider/resources/pharmacy-information**

Notes

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Appropriate Testing for Pharyngitis (CWP)

This HEDIS measure looks at the percentage of episodes for members 3 years of age and older who were diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode.

Code your services correctly

Use the following codes to identify pharyngitis and strep tests:

Description	ICD-10-CM	CPT
Pharyngitis (including tonsillitis)	J02.0, J02.8, J02.9, J03.00, J03.01, J03.80, J03.81, J03.90, J03.91	
Group A streptococcal tests		87070, 87071, 87081, 87430, 87650-87652, 87880

Best practices and helpful tips:

- This measure looks at members who received group A strep tests with a diagnosis of pharyngitis, tonsillitis or streptococcal sore throats and were appropriately dispensed antibiotics within three days of the diagnosis.
- Document the performance of a rapid strep test, or the parent or caregivers' refusal of testing in medical records.
- Pharyngitis is the only condition among upper respiratory infections (URIs) whose diagnosis can be validated through lab results. It serves as an indicator of appropriate antibiotic use among all respiratory tract infections. A strep test (rapid assay or throat culture) is the test for group A strep pharyngitis.
- Due to considerable evidence that prescribing antibiotics is not the first line of treatment for colds or sore throats caused by viruses, pediatric *Clinical Practice Guidelines* recommend that only children with lab-confirmed group A strep or other bacteria-related ailments be treated with appropriate antibiotics.
- If a patient tests negative for group A strep but insists on an antibiotic:
    - Refer to the illness as a sore throat due to a cold; patients tend to associate the label with a less-frequent need for antibiotics.
    - Discuss ways to treat symptoms with patients:
        - Get extra rest.
        - Drink plenty of fluids.
        - Eat ice chips or use throat spray or lozenges for sore throats.
        - Use over-the-counter medications. Write a prescription for symptom relief, if applicable.
        - Use a cool-mist vaporizer and nasal spray for congestion.
- Educate patients on the difference between bacterial and viral infections.
- Educate patients and their parents or caregivers on how they can try prevent infection by:
    - Washing hands frequently.
    - Keeping an infected person's eating utensils and drinking glasses separate from other family members.
    - Thoroughly washing an infected toddler's toys in hot water with disinfectant soap.
    - Keeping a child diagnosed with a sore throat out of school or day care until he or she has taken antibiotics for at least 24 hours and until symptoms improve.

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- Be sure to contact our Pharmacy department at **800-454-3730** to verify required preauthorization of medications.
- Antibiotic medications include but may not be limited to:

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

Note: *Not all medications listed above are in our Formulary. Prior authorization and/or step therapy may be required.*

How can we help?

- Offering current *Clinical Practice Guidelines* on our provider self-service web site
- Offering nonemergency transportation to appointments for our members

Contact your Provider Relationship Management representative for additional details and questions.

Other resources

You can find more information and tools online:

- CDC Antibiotic Prescribing and Use — **https://www.cdc.gov/antibiotic-use/?s_cid=NCEZID-AntibioticUse-005**
- CDC bronchitis — **https://www.cdc.gov/antibiotic-use/community/for-patients/common-illnesses/bronchitis.html**
- CDC Get Smart: Know When Antibiotics Work campaign materials and more — **https://www.cdc.gov/antibiotic-use/index.html**
    - *Prescription Pad for Viral Infection*
    - *Get Smart: Know When Antibiotics Work*
    - *Cold or Flu: Antibiotics Don't Work for You*
- *Medicaid Formulary* — **https://client.formularynavigator.com/Search.aspx?siteCode=7596004980**
- Pharmacy Information - **https://provider.amerigroup.com/georgia-provider/resources/pharmacy-information**

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Asthma Medication Ratio (AMR)

This HEDIS measure looks at the percentage of members 5 to 64 years of age with persistent asthma who had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.

Code your services correctly

Use the following codes to appropriately document asthma:

Description	ICD-10-CM
Asthma	J45.21, J45.22, J45.30-J45.32, J45.40-J45.42, J45.50-J45.52, J45.901, J45.902, J45.909, J45.991, J45.998

Best practices and helpful tips:

- Be sure to keep notes of every time you prescribe an asthma medication.
- For members with asthma, you should:
  - Prescribe controller medication.
  - Educate members in identifying asthma triggers.
  - Remind members to get their controller medication filled regularly.
  - Remind members not to stop taking the controller medications even if they are feeling better and are symptom-free.
  - Create and maintain an asthma action plan.
  - Offer annual flu shots in your office or inform your patients of the importance of getting the vaccine and where they can get it.
  - Ensure members have an understanding on the importance of utilizing medications correctly (long term controller to achieve and maintain control of persistent asthma vs short-acting/quick-reliever to treat acute symptoms and exacerbations)
- Be sure to contact the Pharmacy department at **800-454-3730** to verify required preauthorization of medications.
- Medications for asthma include but may not be limited to:

Type	Description	Prescriptions
Controller	Antiasthmatic combinations	• Dyphylline-guaifenesin
	Antibody inhibitors	• Omalizumab
	Anti-interleukin-4	• Dupilumab
	Anti-interleukin-5	• Benralizumab • Mepolizumab • Reslizumab
	Inhaled steroid combinations	• Budesonide-formoterol • Fluticasone-salmetrol • Fluticasone-vilanterol • Formoterol-mometasone
	Inhaled corticosteroids	• Beclomethasone • Budesonide • Ciclesonide • Flunisolide • Fluticasone • Mometasone
	Leukotriene modifiers	• Montelukast • Zafirlukast • Zileuton
	Methylxanthines	• Theophylline

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Type	Description	Prescriptions	
Reliever	Short-acting, inhaled beta-2 agonists	• Albuterol	• Levalbuterol

Note: Not all medications listed above are in our *Formulary*. Prior authorization and/or step therapy may be required.

How can we help?

- Offering current *Clinical Practice Guidelines* on our provider self-service website
- Providing individualized reports of your patients that are due or overdue for services
- Providing education to members on the importance of asthma control, medication compliance and controller medications through various sources, such as phone calls, newsletters and health education materials
- Offering our Condition Care, formerly disease management, program to our members
- Assisting with scheduling appointments for our members, if needed

Contact your Provider Relationship Management representative for additional details and questions.

Other resources

You can find more information and tools online:

- *CDC's Asthma Action Plan* — **https://www.cdc.gov/asthma/actionplan.html**
- Disease Management/Condition Care — **https://provider.amerigroup.com/georgia-provider/patient-care/disease-management**
- *Medicaid Formulary* — **https://client.formularynavigator.com/Search.aspx?siteCode=7596004980**
- Pharmacy Information - **https://provider.amerigroup.com/georgia-provider/resources/pharmacy-information**

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Avoidance of Antibiotic Treatment for Respiratory Infections (AAB, URI)

These HEDIS measures look at the percentage of episodes for members 3 months of age and older who were diagnosed with the respiratory infections below and were **not** dispensed an antibiotic prescription. Rates are reported for the following measures:

- **Appropriate Treatment for Upper Respiratory Infection (URI)** - diagnosed with URI and were **not** dispensed an antibiotic prescription
- **Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB) -** diagnosed with acute bronchitis/bronchiolitis and were **not** dispensed an antibiotic prescription

Code your services correctly

Use the following codes to identify acute bronchitis/upper respiratory infections:

Description	ICD-10-CM
Acute bronchitis (AAB)	J20.3-J20.9, J21.0, J21.1, J21.8, J21.9
Upper Respiratory Infection (URI)	J00, J06.0, J06.9

Best practices and helpful tips:

- A higher rate indicates better performance for these measures.
- There is considerable evidence that prescribing antibiotics for uncomplicated acute bronchitis is not necessary unless associated with a comorbid diagnosis, such as chronic obstructive pulmonary disease (COPD), emphysema, cystic fibrosis, respiratory diseases, immune system disorders and malignant neoplasms. If prescribing an antibiotic for a bacterial infection (or comorbid condition) in patients with uncomplicated acute bronchitis, be sure to use the diagnosis code for the bacterial infection and/or comorbid condition.
- Educate patients on the difference between bacterial and viral infections is a key factor in the success of this measure. Reducing the unnecessary use of antibiotics is the goal of this measure.
    - Be equipped to teach patients about the real cause of their illness and explain how using antibiotics when they are not needed can be harmful and cause antibiotic resistance.
    - Educate patients on the effects of frequently using antibiotics for a viral infection by using educational tools that are available.
    - Post educational materials in your waiting room and treatment areas for patients.
- Focus your discussion on things patients can do to treat the symptoms of URI and the common cold, like:
    - Getting extra rest.
    - Drinking plenty of fluids.
    - Treating the symptoms with over-the-counter medications. Write a prescription for symptom relief, if applicable.
    - Using a cool mist vaporizer/nasal spray for congestion.
    - Using ice chips or throat spray/lozenges for sore throats.
- Don’t let patients pressure you into writing antibiotic prescriptions for URIs. If a parent/caregiver insists on an antibiotic, refer to the illness as a common cold; parents and caregivers tend to associate this label with a less-frequent need for antibiotics.
- Offer annual flu shots in your office or inform your patients on the importance of getting the vaccine and where they can get it.

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How can we help?

- Offering current *Clinical Practice Guidelines* on our provider self-service website
- Offering nonemergency transportation to appointments for our members

Contact your Provider Relationship Management representative for additional details and questions.

Other resources

You can find more information and tools online:

- CDC Antibiotic Prescribing and Use — **https://www.cdc.gov/antibiotic-use/?s_cid=NCEZID-AntibioticUse-005**
- CDC Get Smart: Know When Antibiotics Work campaign materials and more — **https://www.cdc.gov/getsmart:**
    - *Prescription Pad for Viral Infection*
    - *Get Smart: Know When Antibiotics Work*
    - *Cold or Flu: Antibiotics Don't Work for You*

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Breast Cancer Screening (BCS-E)

This HEDIS measure looks at women 50 to 74 years of age who had a mammogram to screen for breast cancer between October 1 two years prior to the current year and December 31 of the current year.

Record your efforts

Make sure your medical record documentation reflects all of the following:

- Date of the screening
- Type of screening
- Results of the screening
- If applicable, notation of a history of a mastectomy and when it was performed

Code your services correctly

Proper coding is critical to ensuring accurate reporting of this measure, and it may also decrease the need for medical record review. Use the following codes to document breast cancer screenings:

Description	CPT
Mammography, bilateral	77066, 77067
Mammography, unilateral	77065
Digital breast tomosynthesis, unilateral	77061
Digital breast tomosynthesis, bilateral	77062, 77063

Be sure to document the member's history in the chart and use the code(s) below, if applicable:

Description	ICD-10-CM
Absence of bilateral breasts	Z90.13
Absence of left breast	Z90.12
Absence of right breast	Z90.11

Best practices and helpful tips:

- Be sure to use the appropriate modifier(s) and/or POS codes, if applicable.
- Unilateral mastectomies or absence of one breast do not meet compliance for this measure. Women must still have a mammogram on the remaining breast.
- Discuss the importance of well-woman exams, mammogram screenings with all female patients between 50 to 74 years of age (or younger if the patient has a family history of breast cancer or other risk factors).
- Conduct outreach calls to patients to assist in scheduling mammograms, if necessary.
- Request and retain copies of mammography results in the patient's records or tell patients to make sure they ask the mammography centers to send a copy to your office for records.
- Display posters and educational messages in treatment rooms and waiting areas to help motivate patients to initiate discussions with you about screening.
- Medical records to supplement HEDIS data can be sent to the HEDIS team via secure inbox at **ga1hphedis@amerigroup.com** or secure fax at **888-220-6712**.
- If utilizing an electronic medical record (EMR) system, consider:
    - Creating a flag or reminder to track patients who need a mammogram of referral. If you do not use an EMR, consider creating a manual tracking method.
    - Electronic data sharing with your health plan to capture supplemental data (*additional clinical information about a member that may not have been submitted on a claim*).

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How can we help?

- Offering current *Clinical Practice Guidelines* on our provider self-service website
- Providing individualized reports of your patients that are due or overdue for services
- Providing education to members on the importance of breast cancer screening through various sources, such as phone calls, text messages, newsletters and/or health education materials
- Offering nonemergency transportation to appointments for our members
- Assisting with scheduling appointments for our members, if needed
- Encouraging preventive care and well-woman visits through our CHIP Rewards program

Contact your Provider Relationship Management representative for additional details and questions.

Other resources

You can find more information and tools online:

- American Cancer Society — **https://www.cancer.org/latest-news/special-coverage/american-cancer-society-breast-cancer-screening-guidelines.html**
- CDC breast cancer screening — **https://www.cdc.gov/cancer/breast/basic_info/screening.htm**
- U.S. Preventive Services Task Force recommendations on breast cancer screening — **https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/breast-cancer-screening**

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Care for Adults on Antipsychotic Medications (SAA, SSD)

These HEDIS measures looks at the percentage of members age 18 and older who were dispensed an antipsychotic medication. Rates are reported for the following:

- **Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)** – Members 18 years and older with schizophrenia or schizoaffective disorder who were dispensed an antipsychotic medication and remained on the medication for at least 80% of their treatment period.
- **Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)** – Members 18 to 64 years of age with schizophrenia, schizoaffective disorder, or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the current year.

Record your efforts

Make sure that medical record reflects all of the following:

- ✓ A schedule of regular follow-up visits to review the medication management/compliance
- ✓ Record of any new prescriptions written at follow-up visits
- ✓ All lab test orders with results

Code your services correctly

Use the following codes to document schizophrenia and long-acting injections:

Measure	Description	ICD-10-CM	HCPCS
Adherence to Antipsychotic Medications (SAA)	Long-acting injections (14-day supply)		J2794
	Long-acting injections (28-day supply)		J0401, J1631, J1943, J1944, J2358, J2426, J2680
	Long-acting injections (30-day supply)		C9037, J2798
Diabetes Screening (SSD)	HbA1c tests	83036, 83037,	
	HbA1c test result or finding[1]	3044F, 3046F, 3051F, 3052F	
	Glucose tests	80047, 80048, 80050, 80053, 80069, 82947, 82950, 82951	

[1] *The use of CPT Category II codes help with quality reporting and may reduce the need for medical record requests. These codes may be eligible for additional reimbursement.*

Best practices and helpful tips:

- The treatment period begins when the antipsychotic medication is dispensed.
- People being treated with antipsychotics are at increased risk of developing diabetes. Periodic screening allows for early identification and treatment of diabetes. Ensure that your patients on antipsychotics are screened for diabetes every year.
- Per the NCQA, lack of appropriate care for diabetes and cardiovascular disease for people with schizophrenia or bipolar disorder can lead to worsening health and death.
- Draw labs in your office rather than referring members to a local lab for screenings. If you do refer the member, ensure follow up to receive copies of lab test results and document/keep results in your chart.
- Educate your patients and their spouses, caregivers, and/or guardians about the importance of:

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    - Compliance with long-term medications.
    - Not abruptly stopping medications without consulting you.
    - Contacting you immediately if they experience any unwanted/adverse reactions so their treatment can be re-evaluated.
    - Scheduling and attending follow-up appointments to review the effectiveness of their medications.
    - Calling your office if they cannot get their medications refilled.
- Discuss the benefits of participating in our behavioral health case management program.
- Ask your patients who have a behavioral health diagnosis to provide you access to their behavioral health records if you are their primary care provider.
- Be sure to contact the Pharmacy department at **800-454-3730** to verify required preauthorization of medications.
- Antipsychotic medications include but may not be limited to:

Description	Prescription		
Miscellaneous antipsychotic agents (oral)	• Aripiprazole • Asenapine • Brexpiprazole • Cariprazine • Clozapine	• Haloperidol • Iloperidone • Loxapine • Lurisadone • Molindone	• Olanzapine • Paliperidone • Quetiapine • Risperidone • Ziprasidone
Phenothiazine antipsychotics (oral)	• Chlorpromazine • Fluphenazine	• Perphenazine • Prochlorperazine	• Thioridazine • Trifluoperazine
Psychotherapeutic combinations (oral)	• Amitriptyline-perphenazine		
Thioxanthenes (oral)	• Thiothixene		
Long-acting injections — 14-day supply	• Risperidone (excluding Perseris®)		
Long-acting injections — 28-day supply	• Aripiprazole • Fluphenazine decanoate • Haloperidol decanoate	• Olanzapine • Paliperidone palmitate	
Long-acting injections – 30-day supply	• Risperdone (Perseris®)		

Note: *Not all medications listed above are in our Formulary. Prior authorization and/or step therapy may be required.*

How can we help?

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- Providing individualized reports of your patients who are due or overdue for services
- Offering nonemergency transportation to appointments for our members
- Offering our behavioral health case management program to members

Contact your Provider Relationship Management representative for additional details and questions.

Other resources

You can find more information and tools online:

- *Diabetes, Psychiatric Disorders, and the Metabolic Effects of Antipsychotic Medications* — **http://clinical.diabetesjournals.org/content/24/1/18**
- Disease Management/Condition Care — **- https://provider.amerigroup.com/georgia-provider/patient-care/disease-management**

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- *Medicaid Formulary* — **https://client.formularynavigator.com/Search.aspx?siteCode=7596004980**
- Medication adherence in schizophrenia — **https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3805432**
- National Institute of Mental Health — **https://www.nimh.nih.gov**
- Pharmacy Information - **https://provider.amerigroup.com/georgia-provider/resources/pharmacy-information**

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Care for Children and Adolescents on Antipsychotic Medications (APM, APP)

These HEDIS measures look at children and adolescents 1 to 17 years of age who were dispensed antipsychotic medication. Rates are reported for the following:

- **Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)** – Members 1 to 17 years of age who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment.
- **Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)** – Members 1 to 17 years of age who had two or more antipsychotic prescriptions dispensed and had metabolic testing (blood glucose and cholesterol).

Record your efforts

Make sure that medical record reflects all of the following:

- A schedule of regular follow-up visits to review the medication management/compliance
- Record of any new prescriptions written at follow-up visits
- All lab test orders with results

Code your services correctly

Use the following codes to identify metabolic testing:

Measure	Description	CPT	HCPCS
Use of First-Line Psychosocial Care (APP)	Psychotherapy	90832-90834, 90836-90840, 90845-90847, 90849, 90853, 90875, 90876, 90880	G0176, G0177, G0409-G0411, H0004, H0035-H0040, H2000, H2001, H2011-H2014, H2017-H2020, S0201, S9480, S9484, S9485
Metabolic Monitoring (APM)	HbA1c tests	83036, 83037	
	Glucose tests	80047, 80048, 80050, 80053, 80069, 82947, 82950, 82951	
	LDL-C tests	80061, 83700, 83701, 83704, 83721, 3048F-3050F	
	Cholesterol tests	82465, 83718, 83722, 84478	

Best practices and helpful tips:

- The treatment period begins when the antipsychotic medication is dispensed.
- To be compliant for the *Use of First-Line Psychosocial Care* measure, the psychosocial care must be documented within the period of 90 days before the date the antipsychotic medication was dispensed through 30 days after.
- The American Academy of Child and Adolescent Psychiatry guidelines recommend metabolic monitoring, including monitoring of glucose and cholesterol levels, for children and adolescents on antipsychotic medications.
- Draw labs in your office rather than referring members to a local lab for screenings. If you do refer the member, ensure follow up to receive copies of lab test results and document/keep results in your chart.
- Educate your patients and their spouses, caregivers, and/or guardians about the importance of:
    - Compliance with medications.
    - Contacting you immediately if they experience any unwanted/adverse reactions so their treatment can be re-evaluated.

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    - Scheduling and attending follow-up appointments to review the effectiveness of their medications.
    - Calling your office if they cannot get their medications refilled.
- Discuss the benefits of participating in our behavioral health case management program.
- Ask your patients who have a behavioral health diagnosis to provide you access to their behavioral health records if you are their primary care provider.
- Be sure to contact our Pharmacy department at **800-454-3730** to verify required preauthorization of medications.
- Antipsychotic medications include but may not be limited to:

Description	Prescription	
Miscellaneous antipsychotic agents	• Aripiprazole • Asenapine • Brexpiprazole • Cariprazine • Clozapine • Haloperidol • Thiothixene • Iloperidone • Loxapine	• Lurisadone • Molindone • Olanzapine • Paliperidone • Pimozide • Quetiapine • Quetiapine fumarate • Risperidone • Ziprasidone
Thioxanthenes	• Thiothixene	
Long-acting injections	• Aripiprazole • Fluphenazine decanoate	• Olanzapine Paliperidone palmitate • Risperidone
Psychotherapeutic combinations	• Fluoxetine-olanzapine	• Perphenazine-amitriptyline

Note: *Not all medications listed above are in our Formulary. Prior authorization and/or step therapy may be required.*

How can we help?

- Offering current *Clinical Practice Guidelines* on our provider self-service website
- Offering our behavioral health case management program to our members
- Providing individualized reports of your patients that are due or overdue for services
- Offering nonemergency transportation to appointments for our members

Contact your Provider Relationship Management representative for additional details and questions.

Other resources

You can find more information and tools online:

- *Medicaid Formulary* — **https://client.formularynavigator.com/Search.aspx?siteCode=7596004980**
- National Institute of Mental Health — **https://www.nimh.nih.gov**
- Pharmacy Information - **https://provider.amerigroup.com/georgia-provider/resources/pharmacy-information**

Notes

Cervical Cancer Screening (CCS)

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This HEDIS measure looks at the percentage of women 21 to 64 years of age who were screened for cervical cancer using either of the following criteria:

- **Ages 21 to 64:** cervical cytology (Pap) test performed during the current year or two years prior
- **Ages 30 to 64:** cervical high risk human papillomavirus (hrHPV) test performed during the current year or four years prior
- **Ages 30 to 64:** cervical cytology (Pap) test/high-risk human papillomavirus (hrHPV) cotesting performed during the current year or four years prior

Record your efforts

Make sure your medical record documentation reflects all of the following:

- Date of the screening
- Type of test that was performed
- The results or findings from the test
- Notation if patient has a history of hysterectomy and when it was performed (*Add specific details to indicate if it was a complete, total or radical abdominal or vaginal hysterectomy with no residual cervix.*)

Code your services correctly

Proper coding is critical to ensure accurate reporting of these measures, and it may also decrease the need for medical record reviews. Use the following codes to document cervical cancer screenings:

Description	CPT	HCPCS
Cervical cytology tests	88141-88143, 88147, 88148, 88150, 88152-88153, 88164-88167, 88174, 88175	G0123, G0124, G0141, G0143-G0145, G0147, G0148, P3000, P3001, Q0091
HPV tests	, 87624, 87625	G0476

Be sure to document the member's history in the chart and use one of the codes below, if applicable:

Description	ICD-10-CM
Absence of both cervix and uterus	Z90.710
Absence of cervix with remaining uterus	Z90.712
Congenital absence of cervix	Q51.5

Note: *Be sure to include, at a minimum, the year the surgical procedure was performed.*

Best practices and helpful tips:

- Documentation of a hysterectomy alone does not meet compliance since it is not evidence that there is no cervix.
- In order to be counted for co-testing, the sample for the pap and HPV test must be collected and performed at the same time on the same date of service, regardless of the cytology result.
- Be a champion in promoting women's health by reminding them of the importance of annual wellness visits.
- Discuss the importance of well-woman exams, mammograms, Pap tests and HPV testing with all female patients between 21 to 64 years of age. Refer members to another appropriate provider if your office does not perform Pap tests and request copies of results be sent to your office.
- Train your staff on the use of educational materials to promote cervical cancer screening.
- Display posters and educational messages in treatment rooms and waiting areas to help motivate patients to initiate discussions with you about screening.

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- Medical records to supplement HEDIS data can be sent to the HEDIS team via secure inbox at **ga1hphedis@amerigroup.com** or secure fax at **888-220-6712**.
- If utilizing an electronic medical record (EMR) system, consider:
    - Creating a flag or reminder to track patients who are due for a cervical cancer screening. If you do not use an EMR, consider creating a manual tracking method.
    - Electronic data sharing with your health plan to capture supplemental data (*Additional clinical information about a member that may not have been submitted on a claim*).

How can we help?

- Offering current *Clinical Practice Guidelines* on our provider self-service website
- Providing individualized reports of your patients that are due or overdue for services
- Offering nonemergency transportation to appointments for our members
- Providing education to members on the importance of cervical cancer screening through various sources, such as phone calls, text messages, newsletters, and/or health education materials
- Encouraging preventive care and well-woman visits through our CHIP Rewards program

Contact your Provider Relationship Management representative for additional details and questions.

Other resources

You can find more information and tools online:

- American Cancer Society — **https://www.cancer.org/content/dam/cancer-org/cancer-control/en/booklets-flyers/cervical-cancer-fact-sheet.pdf**
- U.S. Preventive Services Task Force recommendations on cervical cancer screening - **https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/cervical-cancer-screening**

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Chlamydia Screening in Women (CHL)

This HEDIS measure looks at sexually active women 16 to 24 years of age who received at least one chlamydia test during the current year.

Code your services correctly

Use the following codes to document screenings for chlamydia:

Description	CPT
Chlamydia tests	87110, 87270, 87320, 87490-87492, 87810

Best practices and helpful tips:

- Chlamydia is the most commonly reported bacterial sexually transmitted disease in the United States. An estimated 1.8 million cases were reported in 2019, with young women ages 15 to 24 accounting for 43%. Chlamydia may cause infertility if left undiagnosed or untreated.
- Screening for chlamydia is recommended at least annually for all sexually active women 24 years of age and younger.
- While screening for chlamydia in sexually active females can be done during any visit, routinely screen female patients who are sexually active in this age group for chlamydia every year as part of their annual well visit.
    - Urine screening for chlamydia is acceptable for all female patients 16 years of age and older during adolescent well-care visits.
- Be a champion in promoting women's health by reminding them of the importance of annual wellness visits.
- Take a sexual history when you see adolescents. Create an environment conducive to taking a sexual history by:
    - Making sure you have an opportunity to speak with the adolescent without her parent(s) present.
    - Reinforcing confidentiality within limits.
    - Introducing sensitive issues by starting with nonthreatening topics first and moving to more sensitive ones.
- If your office does not perform chlamydia screenings, refer members to a participating OB/GYN or other appropriate provider and ensure that you receive the results.
- Manage positive chlamydia tests and provide treatment the same way as any other test result:
    - Ensure continuity of care after a positive screening test.
    - Set aside time to discuss the test result, treatment plan and the implications of a positive test result with your patients.
    - Educate patients on the need to inform their partner(s). Reinfection is common and may cause infertility.
- If utilizing an electronic medical record (EMR) system, consider electronic data sharing with your Amerigroup to capture supplemental data (additional clinical information about a member that may not have been submitted on a claim).

How can we help?

- Offering current *Clinical Practice Guidelines* on our provider self-service website
- Providing individualized reports of your patients that are due or overdue for services
- Assisting with scheduling appointments for our members, if needed
- Encouraging preventive care and well-woman visits through our CHIP Rewards program

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Contact your Provider Relationship Management representative for additional details and questions.

Other resources

You can find more information and tools online:

- CDC chlamydia facts and brochures — **https://www.cdc.gov/std/chlamydia/facts-brochures.htm**
- CDC Reported STDs in the United States, 2019 — **https://www.cdc.gov/nchhstp/newsroom/docs/factsheets/std-trends-508.pdf**
- National Chlamydia Coalition — **http://chlamydiacoalition.org/providers-patients-talk-sex**

Notes

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Controlling High Blood Pressure (CBP)

This HEDIS measure looks at members 18 to 85 years of age who had a diagnosis of hypertension and whose most recent BP was adequately controlled (<140/90 mm Hg).

Record your efforts

Make sure that your medical record documentation reflects all of the following:

- Date of each visit
- All progress notes, problem history and medication reviews
- All BP readings, including rechecks on the same day
- Any notation of your patient using a remote blood pressure monitoring device or non-digital device such as a manual blood pressure cuff and a stethoscope
- Referrals for other providers for hypertension care, such as cardiologists

Code your services correctly

Proper coding is critical to ensure accurate reporting of these measures, and it may also decrease the need for medical record reviews. Use the following codes to document hypertension and BP results:

Description	ICD-10-CM	CPT[1]
Essential (primary) hypertension	I10	
Systolic BP readings — systolic blood pressure 130-139 mm		3074F
Systolic blood pressure 130-139 mm		3075F
Systolic BP readings — greater than or equal to 140		3077F
Diastolic BP readings — less than 80		3078F
Diastolic blood pressure 80-89		3079F
Diastolic BP readings — greater than or equal to 90		3080F

[1] *The use of CPT Category II codes help with quality reporting and may reduce the need for medical record requests. These codes may be eligible for additional reimbursement.*

Best practices and helpful tips:

- A member is automatically considered **not** compliant if:
  - They did not complete an applicable BP reading in the current year.
  - The BP result is not received by Amerigroup.
  - The BP reading was taken during an acute inpatient or ED visit.
- Improve the accuracy of BP measurements performed by your clinical staff by:
  - Providing training materials from the American Heart Association.
  - Conducting BP competency tests to validate the education of each clinical staff member.
  - Making a variety of cuff sizes available.
- Instruct your office staff to recheck the BP for all patients with initial recorded readings of 140/90 mm Hg or greater during outpatient office visits; have your staff record the recheck in patients' medical records. NCQA guidance states that if there are multiple BPs on the same date of service, you can utilize the lowest systolic and lowest diastolic BP on that date as the representative BP.

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- Member self-reported BP readings are accepted as long as they are not taken by the member using a non-digital device such as a manual blood pressure cuff and a stethoscope. Be sure to clearly document the medical record the type of BP monitor that the patient is utilizing.
- Educate patients and their spouses, caregivers, or guardians about the elements of a healthy lifestyle, such as:
    - Heart-healthy eating and a low-salt diet.
    - Smoking cessation and avoiding secondhand smoke.
    - Adding regular exercise to daily activities.
    - Home BP monitoring.
    - Ideal BMI.
    - The importance of taking all prescribed medications as directed.
- Submit medical records to Amerigroup to ensure that member BP results are captured. Medical records to supplement HEDIS data can be sent to the HEDIS team via secure inbox at **ga1hphedis@amerigroup.com** or secure fax for to **888-220-6712**.
- If utilizing an electronic medical record (EMR) system, consider:
    - Creating a flag to track patients who are due or past due for preventive services. If you do not use an EMR, consider creating a manual tracking method.
    - Electronic data sharing with your health plan to capture supplemental data (*additional clinical information about a member that may not have been submitted on a claim*).

How can we help?

- Offering current *Clinical Practice Guidelines* on our provider self-service website
- Providing individualized reports of your patients that are due or overdue for services
- Offering nonemergency transportation to appointments for our members
- Providing education to members on the importance of well-visits through various sources, such as phone calls, text messages, newsletters and/or health education materials
- Encouraging annual visits and follow-up care through our CHIP Rewards program

Contact your Provider Relationship Management representative for additional details and questions.

Other resources

You can find more information and tools online:

- American Heart Association — **https://www.heart.org**
- Disease Management/Condition Care — **https://provider.amerigroup.com/georgia-provider/patient-care/disease-management**
- National Heart, Lung and Blood Institute — **https://www.nhlbi.nih.gov/files/docs/guidelines/jnc7full.pdf**

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Dental and Oral Health Services (TFC, TFL-CH)

These measures look at members who had the recommended dental services. Rates are reported for the following measures:

- **Topical Fluoride for Children (TFC) -** The percentage of members ages 1–4 who received at least two fluoride varnish applications during the measurement year.
- **Topical Fluoride for Children (TFL-CH) -** The percentage of members ages 1–20 who received at least two topical fluoride varnish applications within the measurement year. Three rates are reported:
    - dental or oral health services
    - dental services, and
    - oral health services

Code your services correctly

Use the following code(s) to identify dental and/or oral health services:

Description	CPT
Application of fluoride varnish (*TFC*)	99188
Application of fluoride varnish (*TFL-CH*)	99188

If the sole purpose of the visit was to apply the fluoride varnish, providers may not bill for an E&M visit in addition to billing for the application of fluoride varnish. In this instance, the provider may bill for the fluoride varnish code only.

Best practices and helpful tips

- Once teeth are present, the application of fluoride varnish is required and may be applied every 3 to 6 months in the primary care or dental office for children between the ages of 6 months and 5 years.
- Fluoride varnish acts to retard, arrest and reverse the caries process. The teeth absorb the fluoride varnish, strengthening the enamel and helping prevent cavities. It is not a substitute for fluoridated water or toothpaste.
- Remember that members have a primary care dental (PCD) provider listed on their ID cards.

How can we help?

- Providing individualized reports of your patients that are due or overdue for dental services
- Assisting dental providers with scheduling appointments for our members, if needed
- Offering nonemergency transportation to dental appointments
- Encouraging preventive care through our CHIP Rewards program

Contact your Provider Relationship Management representative for additional details and questions.

Other resources

You can find more information and tools online:

- AAP's oral health practice tools — **https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Oral-Health/Pages/Oral-Health-Practice-Tools.aspx**
- DentaQuest* (Dental vendor) – **https://dentaquest.com/**

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- *Fluoride Use in Caries Prevention in the Primary Care Setting* — **http://pediatrics.aappublications.org/content/134/3/626**
- U.S. Preventive Services Task Force — **https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/prevention-of-dental-caries-in-children-younger-than-age-5-years-screening-and-interventions1**

Notes

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Developmental Screening in the First Three Years of Life (DEV)

This CMS measure looks at children screened for risk of developmental, behavioral and social delays using a standardized screening tool in the 12 months before their first, second or third birthday.

Record your efforts

Make sure that your medical record documentation reflects all of the following:

- The date in which the screening test was performed
- The standardized tool that was used
- The result or score from the screening

Code your services correctly

Proper coding is critical to ensure accurate reporting of these measures, and it may also decrease the need for medical record reviews. Use the following code to document developmental screening:

Description	CPT
Developmental screening with scoring and documentation, per standardized instrument	96110

NOTE: Claims with modifier UA are excluded, as these indicate autism services.

Best practices and helpful tips:

- The AAP recommends that the developmental screening be completed at the 9-month, 18-monthand 30-month visits. If applicable, the screening can be performed during a catch-up visit.
- Standardized tools that are only focused on one domain of development do not count for this measure (such as the ASQ-SE or M-CHAT). Appropriate developmental screening tools identify risk for developmental, behavioral and social delays. Tools that meet the criteria for developmental screening include, but may not be limited to:
    - *Ages and Stages Questionnaire (ASQ)* — 2 months to 5 years
    - *Ages and Stages Questionnaire — 3rd Edition (ASQ-3)*
    - *Battelle Developmental Inventory Screening Tool (BDI-ST)* — birth-95 months
    - *Bayley Infant Neuro-developmental Screen (BINS)* — 3 months to 2 years
    - *Brigance Screens-II* — birth-90 months
    - *Child Development Inventory (CDI)* — 18 months to 6 years
    - *Infant Development Inventory* — birth-18 months
    - *Parents' Evaluation of Developmental Status (PEDS)* — birth to 8 years*)*
- When billing office visits for preventive health services, providers must:
    - Include the appropriate diagnosis code on the claim.
    - Include the applicable EPSDT Referral Code (NU, AV, S2, ST).
    - Use the applicable POS codes, if applicable. POS 99 may be applicable in certain instances.
    - Use the required modifiers:
        - Modifier EP for all preventive health visits (modifiers 90 or 91 may be applicable as well)
        - Modifier HA for catch-up visits
        - Modifier 25:
            - When a vaccine is administered during the preventive visit or

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        - To indicate that a significant, separately identifiable E&M service was provided on the same day as the preventive health visit
- Follow the *AAP Bright Futures Recommendations Periodicity Schedule* of preventive pediatric healthcare for well-child visits:
    - Appropriate screenings may be an important part of these visits as well (such as lead, developmental and/or depression screenings).
    - Appropriate immunizations are an important part of these visits. Administer immunizations in accordance with the ACIP. Utilize the Georgia Registry of Immunization Transactions & Services (GRITS) database to document administered vaccines.
    - EPSDT services require a dental/oral health assessment.
    - Height, weight, BMI **percentile**, and counseling for nutrition and physical activity should be completed at least once per year as part of a well visit; however, these services may be completed during a visit other than a well-child visit (for example, sick visit). Services specific to an acute or chronic condition do not count for counseling for nutrition or physical activity. For patients under 20 on the date of service, document their BMI percentile. For patients 20 and older, document their BMI value.
- Enroll in the Vaccines for Children (VFC) program to receive vaccines. For questions about enrollment and vaccine orders, contact the VFC program at **800-848-3868**.
- Sick visits may be missed opportunities to complete a well visit and may count for a well-visit if the appropriate documentation is included.
- Consider offering evening, early morning and/or weekend office hours to accommodate working parents or guardians.
- Appointment reminders by text, email, postcard, or phone call work well for most parents and young adults.

How can we help?

- Providing individualized reports of your patients that are due or overdue for services
- Assisting with scheduling appointments for our members, if needed
- Offering nonemergency transportation to appointments for our members
- Encouraging preventive care through our CHIP Rewards program
- Providing education to members on the importance of well-visits through various sources, such as phone calls, text messages, newsletters and/or health education materials

Contact your Provider Relationship Management representative for additional details and questions.

Other resources

You can find more information and tools online:

- *AAP Periodicity Schedule* — **https://www.aap.org/en-us/Documents/periodicity_schedule.pdf**
- VFC program — **https://dph.georgia.gov/vaccines-children-program**

Notes

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Diabetes Care (BPD, EED, HBD, KED)

These HEDIS measures look at members 18 to 75 years of age with diabetes (type 1 and type 2) who had each of the following:

- **Hemoglobin Control for Patients with Diabetes (HBD)** – HbA1c test must be performed at least once during the current year and the result must be less than 8 to be considered compliant. Only the most recent HbA1c result during the year counts towards compliance.
- **Blood Pressure Control for Patients with Diabetes (BPD)** – BP check must be performed at least once during the current year and both systolic and diastolic values must be below the stated values (<140/90 mm Hg) to be considered compliant. Only the most recent BP measurement during the year counts towards compliance.
- **Eye exam for Patients with Diabetes (EED)** – A retinal eye exam must be performed by an eye care professional (optometrist or ophthalmologist) at least once during the current year or year prior. An eye exam completed in the:
    - Current year is considered compliant (regardless of result).
    - Prior year that indicates negative for retinopathy is considered compliant.
    - Prior year that indicates positive for retinopathy is **not** considered complaint.
- **Kidney Health Evaluation for Patients with Diabetes (KED)** – A kidney health evaluation, defined by both of following:
    - an estimated glomerular filtration rate (eGFR) ***and***
    - a urine albumin-creatinine ratio (uACR) - defined by both a quantitative urine albumin test ***and*** a urine creatinine test.

Record your efforts

Make sure that your medical record documentation reflects:

- Date of each visit
- All diabetes evaluation notes
- All BP readings (only the most recent BP reading counts)
- All lab test orders with results (only the most recent A1c result counts)
- All eye exams that the member has received as well as the results
- Referrals for other providers for diabetes care, such as endocrinologists

Code your services correctly

Proper coding is critical to ensure accurate reporting of these measures, and it may also decrease the need for medical record reviews. Use the following codes to document diabetes care:

Measure	Description	CPT	HCPCS
Hemoglobin Control (HBD)	HbA1c test	83036, 83037	
	HbA1c test result – level less than 7.0	3044F[1]	
	HbA1c test result – greater than or equal to 7.0 and less than 8.0	3051F[1]	
	HbA1c test result – greater than or equal to 8.0 and less than or equal to 9.0	3052F[1]	
	HbA1c test result – greater than 9.0	3046F[1]	
Blood Pressure	Systolic BP readings — less than 130	3074F[1]	
	Systolic BP readings — 130-139	3075F[1]	

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Measure	Description	CPT	HCPCS
Control (BPD)	Systolic BP readings — greater than or equal to 140	3077F[1]	
	Diastolic BP readings — less than 80	3078F[1]	
	Diastolic BP readings — 80-89	3079F[1]	
	Diastolic BP readings — greater than or equal to 90	3080F[1]	
Eye exam (EED)	Retinal screening	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, 92227, 92228, 92230, 92235, 92240, 92250, 92260, 99203-99205, 92213-99215, 99242-99245	S0620, S0621, S3000
	Retinal Screening Negative in Prior Year	3072F[2]	
	Automated Eye Exam	92229	
	Eye exam with evidence of Retinopathy	2022F[2], 2024F[2], 2026F[2]	
	Eye exam without evidence of Retinopathy	2023F[2], 2025F[2], 2033F[2]	
Kidney evaluation (KED)	Estimated Glomerular Filtration Rate (eGFR)	80047, 80048, 80050, 80053, 80069, 82565	
	Quantitative Urine Albumin Test (uACR)	82043	
	Urine Creatinine Test (uACR)	82570	

[1] *The use of CPT Category II codes help with quality reporting and may reduce the need for medical record requests. These codes may be eligible for additional reimbursement.*

[2] *Indicates a retinal eye exam was completed with an eye care professional.*

Best practices and helpful tips:

- A member is automatically considered **not** compliant if the result/reading (Hb*A1c*, *BP*) is not received by Amerigroup.
- Members whose eye exams indicate positive for retinopathy should have a retinal eye exam completed annually. Refer your members to an eye care provider for their annual eye exam and follow-up to receive a copy of the vision exam results.
- Improve the accuracy of BP measurements performed by your clinical staff by:
    - Providing training materials from the American Heart Association.
    - Conducting BP competency tests to validate the education of each clinical staff member.
    - Making a variety of cuff sizes available.
- Instruct your office staff to recheck the BP for all patients with initial recorded readings of 140/90 mm Hg or greater during office visits; have your staff record the recheck in patients' medical records. NCQA guidance states that if there are multiple BPs on the same date of service, you can utilize the lowest systolic and lowest diastolic BP on that date as the representative BP.
- Member self-reported BP readings are accepted as long as they are not taken by the member using a non-digital device such as a manual blood pressure cuff and a stethoscope. Be sure to clearly document the medical record they type of BP monitor that the patient is utilizing.
- If you use paper charts, consider having a template to identify the last date of necessary screening and the next time the patient should be screened.
- Send appointment reminders and call patients to remind them of upcoming appointments.

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- Consider including a diabetes educator on your team or periodically bringing one in to speak with patients during office visits.
- Draw labs in your office rather than referring members to a local lab for screenings. If you do refer the member, ensure follow up to receive copies of lab test results, eye exam results, or any specialist referral and document/keep results in your chart.
- Educate your patients, their families, caregivers and guardians on diabetes care, including:
    - Taking all prescribed medications as directed.
    - Adding regular exercise to daily activities to maintain healthy weight and ideal body mass index.
    - Regularly monitoring blood sugar and BP at home.
    - Eating heart-healthy, low-calorie, and low-fat foods.
    - Stopping smoking and avoiding second-hand smoke.
    - Fasting prior to having blood sugar/lipid panels drawn to ensure accurate results.
    - Keeping all appointments; getting help with scheduling appointments, screenings, and tests to improve compliance.
- Submit medical records to Amerigroup to ensure that A1c and BP results are captured. Medical records can be sent to the HEDIS team via secure inbox at **ga1hphedis@amerigroup.com** or secure fax for to **888-220-6712**.
- If utilizing an electronic medical record (EMR) system, consider:
    - Creating a flag to track patients who are due or past due for preventive services. If you do not use an EMR, consider creating a manual tracking method.
    - Electronic data sharing with your health plan to capture supplemental data (*Additional clinical information about a member that may not have been submitted on a claim*).

How can we help?

- Offering current *Clinical Practice Guidelines* on our provider self-service website
- Offering our Condition Care, formerly disease management, programs to our members
- Providing education to members on the importance of managing their diabetes through various sources, such as phone calls, text messages, newsletters, and/or health education materials
- Providing individualized reports of your patients that are due or overdue for services
- Offering nonemergency transportation to appointments for our members
- Encouraging diabetic care management through our CHIP Rewards program

Contact your Provider Relationship Management representative for additional details and questions.

Other resources

You can find more information and tools online:

- American Diabetes Association — **https://www.diabetes.org/**
- Avesis* (Vision vendor) — **https://www.avesis.com**
- CDC information on diabetes — **https://www.cdc.gov/diabetes/home**
- Disease Management/Condition Care — **https://provider.amerigroup.com/georgia-provider/patient-care/disease-management**

Notes

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Follow-Up after Emergency Department Visit for Substance Use (FUA)

This HEDIS measure looks at the percentage of emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, who received follow up for SUD **within 7 days of the ED visit** (8 total days). The follow-up can include either a follow-up visit or a pharmacotherapy dispensing event/treatment.

Code your services correctly

Use the following codes to identify follow-up visits for substance use, substance use disorders and/or drug overdose:

Description	ICD-10-CM
Abuse and Dependence	F10.10-F10.29, F11.10-F11.29, F12.10-F12.29, F13.10-F13.29, F14.10-F14.29, F15.10-F15.29, F16.10-F16.29, F18.10-F18.29, F19.10-F19.29
Drug Overdose	T40.0X1A-T40.994S, T41.0X1A-T41.5X4S, T42.3X1A-T42.4X4S, T43.601A-T43.694S, T51.0X1A-T51.0X4S
Substance Induced Disorders	F10.920-F10.99, F11.90-F11.99, F12.90-F12.99, F13.90-F13.99, F14.90-F14.99, F15.90-F15.99, F16.90-F16.99, F18.90-F18.99, F19.90-F19.99

Description	CPT	HCPCS	POS
BH Outpatient Visits	90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90875, 90876, 98960-98962, 99078, 99202-99205, 99211-99215, 99242-99245, 99341-99342, 99344-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99483, 99492-99494, 99510	G0155, G0176, G0177, G0409, G0463, G0512, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013-H2020, T1015	02, 03, 05, 07, 09, 11-20, 22, 33, 49, 50, 52, 53, 55-58, 71, 72
Hospital inpatient and observation visits	99221-99223, 99231-99233, 99238, 99239, 99252-99255		21
Behavioral Health Assessments	99408, 99409	G0396, G0397, G0442, G2011, H0001, H0002, H0031, H0049	
Medication Treatment[1]		G2067-G2070, H0020, H0033, J0570-J0575, J2315, Q9991, Q9992, S0109	
Opioid Treatment Services (weekly or monthly)		G2071, G2074-G2077, G2080, G2086, G2087	
Partial Hospitalization / Intensive Outpatient		G0410, G0411, H0035, H2001, H2012, S0201, S9480, S9484	
Peer Support Services		G0177, H0024, H0025, H0038-H0040, H0046, H2014, H2023, S9445, T1012, T1016	

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Description	CPT	HCPCS	POS
Substance Use Disorder Services	99408, 99409	G0396, G0397, G0443, H0001, H0005-H0007, H0015, H0016, H0022, H0028, H0047, H0050, H2035, H2036, T1006, T1012	
Online assessments (e-visit or virtual check-in)	98970-98972, 99421-99423, 99457, 99458	G0071, G2010, G2012, , G2250-G2252	
Telephone visits	98966-98968, 99441-99443		

[1] *These codes count as a pharmacotherapy medication treatment.*

Best practices and helpful tips:

- When billing for these services/visits, providers must:
  - Include the appropriate diagnosis code on the claim.
  - Use the appropriate modifier(s) and/or POS codes, if applicable.
- Make sure you schedule an appointment with your patient upon notification of an inpatient discharge or ED visit. Have your staff call the member prior to the visit to confirm.
- Members may be included in this measure multiple times since this measure is based on ED visits.
- Teach patients' families to review all discharge instructions for patients and ask for details of all follow-up discharge instructions, such as the dates and times of appointments.
- Educate your patients and their spouses, caregivers, or guardians about the importance of compliance with the long-term medications prescribed.
- Encourage patients to participate in our behavioral health case management program for help getting follow-up discharge appointments and other support.
- Ask patients with a mental health diagnosis to allow you access to their mental health records if you are their primary care provider.
- Visits that occur on the date of the ED visit count towards compliance for this measure.
- Buprenorphine administered via transdermal patch or buccal film are not included because they are not FDA-approved as treatment for opioid use disorder.
- Be sure to contact our Pharmacy department at **800-454-3730** to verify required preauthorization of medications.
- Treatment medications include but may not be limited to:

Description	Prescriptions
Antagonist	• Naltrexone (oral and injectable)
Aldehyde dehydrogenase inhibitor	• Disulfiram (oral)
Partial agonist	• Buprenorphine (sublingual tablet, injection, implant) • Buprenorphine/naloxone (sublingual tablet, injection, implant)
Other	• Acamprosate (oral and delayed-release tablet)

Note: *Not all medications listed above are in our formulary. Prior authorization and/or step therapy may be required.*

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How can we help?

- Encouraging providers to be advocates and provide the resources needed to educate our members and ensure success in completing alcohol and other drug dependence treatment
- Offering current *Clinical Practice Guidelines* on our provider self-service website
- Providing individualized reports of your patients that are due or overdue for services
- Offering our behavioral health case management program to members
- Offering nonemergency transportation to appointments for our members

Contact your Provider Relationship Management representative for additional details and questions.

Other resources

You can find more information and tools online:

- National Institute of Alcohol Abuse and Alcoholism — **https://niaaa.nih.gov**
- Substance Abuse and Mental Health Services Administration — **https://www.samhsa.gov/find-help/atod**
- National Institute of Mental Health — **https://www.nimh.nih.gov**
- Pharmacy Information - **https://provider.amerigroup.com/georgia-provider/resources/pharmacy-information**

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Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)

This HEDIS measure looks at the percentage of acute inpatient hospitalizations, residential treatment or detoxification visits with a diagnosis of substance use disorder among members 13 years of age and older that result in a follow-up visit or service for substance use disorder **within the 7 days *after* the visit or discharge**.

Code your services correctly

Use the following codes to identify follow-up after high-intensity care:

Description	ICD-10-CM
Abuse and Dependence	F10.10-F10.29, F11.10-F11.29, F12.10-F12.29, F13.10-F13.29, F14.10-F14.29, F15.10-F15.29, F16.10-F16.29, F18.10-F18.29, F19.10-F19.29

Description	CPT	HCPCS	POS
BH Outpatient Visits	98960-98962, 99078, 99202-99205, 99211-99215, 99242-99245, 99341-99342, 99344-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99483, 99492-99494, 99510, 90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90875, 90876	G0155, G0176, G0177, G0409, G0463, G0512, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013-H2020, T1015	02, 03, 05, 07, 09, 11-20, 22, 33, 49, 50, 52, 53, 57, 58, 71, 72
Hospital inpatient and Observation visits	99221-99223, 99231-99233, 99238, 99239, 99252-99255		21
Partial Hospitalization / Intensive Outpatient		G0410, G0411, H0035, H2001, H2012, S0201, S9480, S9484	
Opioid Treatment Services (weekly or monthly)		G2071, G2074-G2077, G2080, G2086, G2087	
Medication Treatment[1]		G2067-G2070, H0020, H0033, J0570-J0575, J2315, Q9991, Q9992, S0109	
Residential BH Treatment		H0017-H0019, T2048	
Substance Use Disorder Services	99408, 99409	G0396, G0397, G0443, H0001, H0005-H0007, H0015, H0016, H0022, H0028, H0047, H0050, H2035, H2036, T1006, T1012	
Online assessments (e-visit or virtual check-in)	98970-98972, 99421-99423, , 99457, 99458	G0071, G2010, G2012, , G2250-G2252	
Telephone visits	98966-98968, 99441-99443		

[1] *These codes count as a pharmacotherapy medication treatment*

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Best practices and helpful tips:

- When billing for these services/visits, providers must:
    - Include the appropriate diagnosis code on the claim.
    - Use the appropriate modifier(s) and/or POS codes, if applicable.
- Make sure you schedule an appointment with your patient upon notification of an inpatient discharge. Have your staff call the member prior to the visit to confirm.
- Members may be included in this measure multiple times since this measure is based on discharges.
- Educate your patients and their spouses, caregivers, or guardians about the importance of compliance with the long-term medications prescribed.
- Encourage patients to participate in our behavioral health case management program for help getting follow-up discharge appointments and other support.
- Teach patients' families to review all discharge instructions for patients and ask for details of all follow-up discharge instructions, such as the dates and times of appointments.
- Discuss the benefits of participating in our behavioral health case management program.
- Ask your patients who have a behavioral health diagnosis to provide you access to their behavioral health records if you are their primary care provider.
- The following services/visits do **not** count as follow-up for this measure:
    - Visits that occur on the date of the visit/discharge
    - Detoxification
- Be sure to contact our Pharmacy department at **800-454-3730** to verify required preauthorization of medications.
- Treatment medications include but may not be limited to:

Description	Prescriptions
Antagonist	• Naltrexone (oral and injectable)
Aldehyde dehydrogenase inhibitor	• Disulfiram (oral)
Partial agonist	• Buprenorphine (sublingual tablet, injection, implant) • Buprenorphine/naloxone (sublingual tablet, injection, implant)
Other	• Acamprosate (oral and delayed-release tablet)

Note: *Not all medications listed above are in our formulary. Prior authorization and/or step therapy may be required.*

Note: *Buprenorphine administered via transdermal patch or buccal film are not included because they are not FDA-approved as treatment for opioid use disorder.*

How can we help?

- Offering current *Clinical Practice Guidelines* on our provider self-service website
- Providing individualized reports of your patients that are due or overdue for services
- Offering our behavioral health case management program to members
- Offering nonemergency transportation to appointments for our members

Contact your Provider Relationship Management representative for additional details and questions.

Other resources

You can find more information and tools online:

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- National Institute of Mental Health — **https://www.nimh.nih.gov**
- Pharmacy Information - **https://provider.amerigroup.com/georgia-provider/resources/pharmacy-information**

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Follow-Up after Emergency Department Visit for Mental Health (FUM)

This HEDIS measure looks at the percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness **within 7 days of the ED visit** (eight total days).

Code your services correctly

Use the following codes to identify follow-up visits for mental illness or intentional self-harm:

Description	ICD-10-CM
Mental illness	F20.0-F25.9, F28, F31.0-F31.9, F32.0-F32.9, F33.0-F33.9, F34.0-F34.9, F39, F42.0-F42.9, F43.0-F43.9, F53.0-F53.1, F60.0-F60.9, F63.0-F63.9, F68.10-F68.8, F84.0-F84.9, F90.0-F90.9, F91.0-F91.9, F93.0-F93.9, F94.0-F94.9
Intentional self-harm	T36.0X2A-T36.0X2S, T36.1X2A-T36.1X2S, T36.2X2A-T36.2X2S, T36.3X2A-T36.3X2S, T36.4X2A-T36.4X2S, T36.5X2A-T36.5X2S, T36.6X2A-T36.6X2S, T36.7X2A-T36.7X2S, T36.8X2A-T36.8X2S, T37.0X2A-T37.0X2S, T37.1X2A-T37.1X2S, T37.2X2A-T37.2X2S, T37.3X2A-T37.3X2S, T37.4X2A-T37.4X2S, T37.5X2A-T37.5X2S, T37.8X2A-T37.8X2S, T38.0X2A-T38.0X2S, T38.1X2A-T38.1X2S, T38.2X2A-T38.2X2S, T38.3X2A-T38.3X2S, T38.4X2A-T38.4X2S, T38.5X2A-T38.5X2S, T38.6X2A-T38.6X2S, T38.7X2A-T38.7X2S, T38.802A- T38.802S, T38.812A- T38.812S, T38.892A- T38.892S, T38.902A- T38.902S, T38.992A- T38.992S, T39.012A- T39.012S, T39.092A- T39.092S, T39.1X2A- T39.1X2S, T39.2X2A- T39.2X2S, T39.312A- T39.312S, T39.392A- T39.392S, T39.4X2A- T39.4X2S, T39.8X2A- T39.8X2S, T40.0X2A- T40.0X2S, T40.1X2A- T40.1X2S, T40.2X2A- T40.2X2S, T40.3X2A- T40.3X2S, T40.412A- T40.412S, T40.422A- T40.422S, T40.492A- T40.492S, T40.5X2A- T40.5X2S, T40.602A- T40.602S, T40.692A- T40.692S, T40.712A- T40.712S, T40.8X2A- T40.8X2S, T40.902A- T40.902S, T40.992A- T40.992S, T41.0X2A- T41.0X2S, T41.1X2A- T41.1X2S, T41.202A- T41.202S, T41.292A- T41.292S, T41.3X2A- T41.3X2S, T41.5X2A- T41.5X2S, T42.0X2A- T42.0X2S, T42.1X2A- T42.1X2S, T42.2X2A- T42.2X2S, T42.3X2A- T42.3X2S, T42.4X2A- T42.4X2S, T42.5X2A- T42.5X2S, T42.6X2A- T42.6X2S, T42.72XA- T42.72XD, T42.8X2A- T42.8X2S, T43.012A- T43.012S, T43.022A- T43.022S, T43.1X2A- T43.1X2S, T43.202A- T43.202S, T43.212A- T43.212S, T43.222A- T43.222S, T43.292A- T43.292S, T43.3X2A- T43.3X2S, T43.4X2A- T43.4X2S, T43.502A- T43.502S, T43.592A- T43.592S, T43.602A- T43.602S, T43.622A- T43.622S, T43.632A- T43.632S, T43.642A- T43.642S, T43.692A- T43.692S, T43.8X2A- T43.8X2S, T43.92XA- T43.92XS, T44.0X2A- T44.0X2S, T44.1X2A- T44.1X2S, T44.2X2A- T44.2X2S, T44.3X2A- T44.3X2S, T44.4X2A- T44.4X2S, T44.5X2A- T44.5X2S, T44.6X2A- T44.6X2S, T44.7X2A- T44.7X2S, T44.8X2A- T44.8X2S, T44.902A- T44.902S, T44.992A- T44.992S, T45.0X2A- T45.0X2S, T45.1X2A- T45.1X2S, T45.2X2A- T45.2X2S, T45.3X2A- T45.3X2S, T45.4X2A- T45.4X2S, T45.512A- T45.512S, T45.522A- T45.522S, T45.602A- T45.602S, T45.612A- T45.612S, T45.622A- T45.622S, T45.692A- T45.692S, T45.7X2A- T45.7X2S, T45.8X2A- T45.8X2S, T45.92XA- T45.92XS, T46.0X2A- T46.0X2S, T46.1X2A- T46.1X2S, T46.2X2A- T46.2X2S, T46.3X2A- T46.3X2S, T46.4X2A- T46.4X2S, T46.5X2A- T46.5X2S, T46.6X2A- T46.6X2S, T46.7X2A- T46.7X2S, T46.8X2A- T46.8X2S, T46.902A- T46.902S, T46.992A- T46.992S, T47.0X2A- T47.0X2S, T47.1X2A- T47.1X2S, T47.2X2A- T47.2X2S, T47.3X2A- T47.3X2S, T47.4X2A- T47.4X2S, T47.5X2A- T47.5X2S, T47.6X2A- T47.6X2S, T47.7X2A- T47.7X2S, T47.8X2A- T47.8X2S, T47.92XA- T47.92XD, T48.0X2A- T48.0X2S, T48.1X2A- T48.1X2S, T48.202A- T48.202S, T48.292A- T48.292S, T48.3X2A- T48.3X2S, T48.4X2A- T48.4X2S, T48.5X2A- T48.5X2S, T48.6X2A- T48.6X2S, T48.902A- T48.902S, T48.992A- T48.992S, T49.0X2A- T49.0X2S, T49.1X2A- T49.1X2S, T49.2X2A- T49.2X2S, T49.3X2A- T49.3X2S,

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Description	ICD-10-CM
	T49.4X2A- T49.4X2S, T49.5X2A- T49.5X2S, T49.6X2A- T49.6X2S, T49.7X2A- T49.7X2S, T49.8X2A- T49.8X2S, T50.0X2A- T50.0X2S, T50.1X2A- T50.1X2S, T50.2X2A- T50.2X2S, T50.3X2A- T50.3X2S, T50.4X2A- T50.4X2S, T50.5X2A- T50.5X2S, T50.6X2A- T50.6X2S, T50.7X2A- T50.7X2S, T50.8X2A- T50.8X2S, T50.902A- T50.902S, T50.912A- T50.912S, T50.992A- T50.992S, T50.B12A- T50.B12S, T50.B92A- T50.B92S, T50.Z12A- T50.Z12S, T50.Z92A- T50.Z92S, T51.0X2A- T51.0X2S, T51.1X2A- T51.1X2S, T51.2X2A- T51.2X2S, T51.3X2A- T51.3X2S, T51.8X2A- T51.8X2S, T51.92A- T51.92S, T52.0X2A- T52.0X2S, T52.1X2A- T52.1X2S, T52.2X2A- T52.2X2S, T52.3X2A- T52.3X2S, T52.4X2A- T52.4X2S, T52.8X2A- T52.8X2S, T52.92XA- T52.92XS, T53.0X2A- T53.0X2S, T53.1X2A- T53.1X2S, T53.2X2A- T53.2X2S, T53.3X2A- T53.3X2S, T53.4X2A- T53.4X2S, T53.5X2A- T53.5X2S, T53.6X2A- T53.6X2S, T53.7X2A- T53.7X2S, T53.92XA- T53.92XS, T54.0X2A- T54.0X2S, T54.1X2A- T54.1X2S, T54.2X2A- T54.2X2S, T54.3X2A- T54.3X2S, T54.92XA- T54.92XS, T55.0X2A- T55.0X2S, T55.1X2A- T55.1X2S, T56.0X2A- T56.0X2S, T56.1X2A- T56.1X2S, T56.2X2A- T56.2X2S, T56.3X2A- T56.3X2S, T56.4X2A- T56.4X2S, T56.5X2A- T56.5X2S, T56.6X2A- T56.6X2S, T56.7X2A- T56.7X2S, T56.812A- T56.812S, T56.892A- T56.892S, T56.92XA- T56.92XS, T57.0X2A- T57.0X2S, T57.1X2A- T57.1X2S, T57.2X2A- T57.2X2S, T57.3X2A- T57.3X2S, T57.8X2A- T57.8X2S, T58.2X2A- T58.2X2S, T58.8X2A- T58.8X2S, T58.92XA- T58.92XS, T59.0X2A- T59.0X2S, T59.1X2A- T59.1X2S, T59.2X2A- T59.2X2S, T59.3X2A- T59.3X2S, T59.4X2A- T59.4X2S, T59.5X2A- T59.5X2S, T59.6X2A- T59.6X2S, T59.7X2A- T59.7X2S, T59.812A- T59.812S, T59.892A- T59.892S, T60.0X2A- T60.0X2A, T60.1X2A- T60.1X2S, T60.2X2A- T60.2X2S, T60.3X2A- T60.3X2S, T60.4X2A- T60.4X2S, T60.8X2A- T60.8X2S, T61.772A- T61.772S, T61.782A- T61.782S, T61.8X2A- T61.8X2S, T61.92XA- T61.92XS, T62.0X2A- T62.0X2S, T62.1X2A- T62.1X2S, T62.2X2A- T62.2X2S, T62.8X2A- T62.8X2S, T62.92XA- T62.92XS, T63.002A- T63.002S, T63.012A- T63.012S, T63.022A- T63.022S, T63.032A- T63.032S, T63.042A- T63.042S, T63.062A- T63.062S, T63.072A- T63.072S, T63.082A- T63.082S, T63.092A- T63.092S, T63.112A- T63.112S, T63.122A- T63.122S, T63.192A- T63.192S, T63.2X2A- T63.2X2S, T63.302A- T63.302S, T63.312A- T63.312S, T63.322A- T63.322S, T63.332A- T63.332S, T63.392A- T63.392S, T63.412A- T63.412S, T63.422A- T63.422S, T63.432A- T63.432S, T63.442A- T63.442S, T63.452A- T63.452S, T63.462A- T63.462S, T63.482A- T63.482S, T63.512A- T63.512S, T63.592A- T63.592S, T63.612A- T63.612S, T63.622A- T63.622S, T63.632A- T63.632S, T63.692A- T63.692S, T63.712A- T63.712S, T63.792A- T63.792S, T63.812A- T63.812S, T63.822A- T63.822S, T63.832A- T63.832S, T63.892A- T63.892S, T64.02XA- T64.02XS, T65.0X2A- T65.0X2S, T65.1X2A- T65.1X2S, T65.212A- T65.212S, T65.222A- T65.222S, T65.292A- T65.292S, T65.3X2A- T65.3X2S, T65.4X2A- T65.4X2S, T65.5X2A- T65.5X2S, T65.6X2A- T65.6X2S, T65.812A- T65.812S, T65.822A- T65.822S, T65.832A- T65.832S, T65.892A- T65.892S, T71.112A- T71.112S, T71.122A- T71.122S, T71.132A- T71.132S, T71.152A- T71.152S, T71.162A- T71.162S, T71.192A- T71.192S, T71.222A- T71.222S, T71.232A- T71.232S

Description	CPT	HCPCS	POS
BH Outpatient Visits	98960-98962, 99078, 99202-99205, 99211-99215, 99242-99245, 99341-99342, 99344-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99483, 99492-99494, 99510, 90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90875, 90876	G0155, G0176, G0177, G0409, G0463, G0512, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013-H2020, T1015	02, 03, 05, 07, 09, 11-20, 22, 33, 49, 50, 52, 53, 71, 72

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Description	CPT	HCPCS	POS
Hospital inpatient and observation visits	, 99221-99223, 99231-99233, 99238, 99239, 99252-99255		21
Partial Hospitalization / Intensive Outpatient		G0410, G0411, H0035, H2001, H2012, S0201, S9480, S9484	
Electroconvulsive therapy	90870		03, 05, 07, 09, 11-20, 22, 24, 33, 49, 50, 52, 53, 71, 72
Online assessments (e-visit or virtual check-in)	98970-98972, 99421-99423, , 99457, 99458	G0071, G2010, G2012, , G2250-G2252	
Telephone visits	98966-98968, 99441-99443		

Best practices and helpful tips:

- When billing for these services/visits, providers must:
  - Include the appropriate diagnosis code on the claim.
  - Use the appropriate modifier(s) and/or POS codes, if applicable.
- Make sure you schedule an appointment with your patient upon notification of an ED visit. Have your staff call the member prior to the visit to confirm.
- Members may be included in this measure multiple times since this measure is based on ED visits.
- Educate your patients and their spouses, caregivers, or guardians about the importance of compliance with the long-term medications prescribed.
- Encourage patients to participate in our behavioral health case management program for help getting follow-up discharge appointments and other support.
- Teach patients' families to review all discharge instructions for patients and ask for details of all follow-up discharge instructions, such as the dates and times of appointments.
- Ask patients with a mental health diagnosis to allow you access to their mental health records if you are their primary care provider.
- Visits that occur on the date of the ED visit count towards compliance for this measure.

How can we help?

- Offering current *Clinical Practice Guidelines* on our provider self-service website
- Providing individualized reports of your patients that are due or overdue for services
- Offering our behavioral health case management program to members
- Offering nonemergency transportation to appointments for our members

Contact your Provider Relationship Management representative for additional details and questions.

Other resources

You can find more information and tools online:

- National Institute of Mental Health — **https://www.nimh.nih.gov**

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Follow-Up after Hospitalization for Mental Illness (FUH)

This HEDIS measure looks at members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit **with a mental health provider within 7 days after discharge.**

Code your services correctly

Use the following codes to identify follow-up visits with a mental health provider:

Description	CPT	HCPCS	POS
BH Outpatient Visits	98960-98962, 99078, 99202-99205, 99211-99215, 99242-99245, 99341-99342, 99344-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99483, 99492-99494, 99510, 90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90875, 90876	G0155, G0176, G0177, G0409, G0463, G0512, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013-H2020, T1015	53, 02, 03, 05, 07, 09, 11-20, 22, 33, 49, 50, 52, 53, 71, 72
Hospital inpatient and observation visits	99221-99223, 99231-99233, 99238, 99239, 99252-99255		21
Electroconvulsive therapy	90870		03, 05, 07, 09, 11-20, 22, 24, 33, 49, 50, 52, 53, 71, 72
			53
Partial Hospitalization / Intensive Outpatient		G0410, G0411, H0035, H2001, H2012, S0201, S9480, S9484	
Psychiatric Collaborative Care Management	99492-99494	G0512	
Transitional care management	99495, 99496		53
Telephone visits	98966-98968, 99441-99443		

Best practices and helpful tips:

- When billing for these services/visits, providers must:
  - Include the appropriate diagnosis code on the claim.
  - Use the appropriate modifier(s) and/or POS codes, if applicable.
- The following do **not** count as follow-up for this measure:
  - Visits that occur on the date of the discharge
  - Visits that do not occur with a mental health provider
- Make sure you schedule an appointment with your patient upon notification of an inpatient discharge. Have your staff call the member prior to the visit to confirm.
- Members may be included in this measure multiple times since this measure is based on discharges.

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- Educate your patients and their spouses, caregivers, or guardians about the importance of compliance with the long-term medications prescribed.
- Teach patients' families to review all discharge instructions for patients and ask for details of all follow-up discharge instructions, such as the dates and times of appointments.
- Discuss the benefits of participating in our behavioral health case management program including getting help with follow-up discharge appointments and other support.

How can we help?

- Offering current *Clinical Practice Guidelines* on our provider self-service website
- Providing individualized reports of your patients that are due or overdue for services
- Offering our behavioral health case management program to members
- Offering nonemergency transportation to appointments for our members

Contact your Provider Relationship Management representative for additional details and questions.

Other resources

You can find more information and tools online:

- National Institute of Mental Health — **https://www.nimh.nih.gov**

Notes

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

This HEDIS measure looks at children 6 to 12 years of age who were newly prescribed ADHD medication and had at least three follow-up care 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:

- **Initiation phase:** one follow-up visit within 30 days with a practitioner with prescribing authority
- **Continuation and maintenance phase:** remained on the ADHD medication for at least 210 days and had two more follow-up visits within 270 days (nine months) after the **Initiation phase** ended

Code your services correctly

Use the following codes to identify the follow-up visits for children who were newly prescribed an ADHD medication:

Description	CPT	HCPCS	POS
BH Outpatient Visits	98960-98962, 99078, 99202-99205, 99211-99215, 99242-99245, 99341-99342, 99344-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99483, 99492-99494, 99510, 90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90875, 90876	G0155, G0176, G0177, G0409, G0463, G0512, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013-H2020, T1015	02, 03, 05, 07, 09, 11-20, 22, 33, 49, 50, 52, 53, 71, 72
Hospital inpatient and observation visits	99221-99223, 99231-99233, 99238, 99239, 99252-99255		21
Health and behavior assessment/ intervention	96156, 96158, 96159, 96164, 96165, 96167, 96168, 96170, 96171		
Partial Hospitalization / Intensive Outpatient		G0410, G0411, H0035, H2001, H2012, S0201, S9480, S9484	
Online assessments (e-visit or virtual check-in)[1]	98970-98972, 99421-99423, , 99457, 99458	G0071, G2010, G2012, , G2250-G2252	
Telephone visits	98966-98968, 99441-99443		

[1] *Only one of the two additional visits in the continuation and maintenance phase (during days 31-300) may be an e-visit or virtual check-in*

Best practices and helpful tips:

- Be sure to use the appropriate modifier(s) and/or POS codes, if applicable.

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- Visits must occur within 30 days of when the ADHD medication is initially dispensed (*or restarted after a 120-day break*). Consider writing the initial prescription for only a two- or three-week supply.
- When prescribing a new ADHD medication, be sure to:
    - Schedule a follow-up visit right away while patients are still in the office (*scheduling the appointment within two or three weeks of the medication initiation should allow time for rescheduling before the 30 days if needed*).
    - Schedule at least two more office visits in the next nine months after the initial follow-up visit, to monitor patient's progress.
    - Include the diagnosis of ADHD when submitting claims for follow-up visits.
    - Discuss how and when the medication should be administered (such as only during school or every day, etc.) as these factors may affect the length of the prescription given.
    - Have your office staff call patients at least three days before appointments.
    - Educate your patients and their parents, guardians, or caregivers about the use of and compliance with long-term ADHD medications and the disease process.
- Collaborate with other organizations to share information, research best practices about ADHD interventions and appropriate standards of practice, their effectiveness and safety.
- Ask your patients who have a behavioral health diagnosis to provide you access to their behavioral health records if you are their primary care provider.
- Be sure to contact our Pharmacy department at **800-454-3730** to verify required preauthorization of medications.
- ADHD medications include but may not be limited to:

Description	Prescriptions	
CNS stimulants	• Dexmethylphenidate • Dextroamphetamine • Lisdexamfetamine	• Methamphetamine • Methylphenidate
Alpha-2 receptor agonists	• Clonidine	• Guanfacine
Miscellaneous ADHD medications	• Atomoxetine	

Note: *Not all medications listed above are in our formulary. Prior authorization and/or step therapy may be required.*

How can we help?

- Offering current *Clinical Practice Guidelines* on our provider self-service website
- Assisting with scheduling appointments for our members, if needed
- Providing individualized reports of your patients that are due or overdue for services
- Providing education to members on the importance of medication management and follow-up visits through various sources, such as phone calls, text messages, newsletters and/or health education materials
- Offering nonemergency transportation to appointments for our members

Contact your Provider Relationship Management representative for additional details and questions.

Other resources

You can find more information and tools online:

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- *Medicaid Formulary* — **https://client.formularynavigator.com/Search.aspx?siteCode=7596004980**
- The National Resource on ADHD — **https://chadd.org**
- Pharmacy Information - **https://provider.amerigroup.com/georgia-provider/resources/pharmacy-information**

Notes

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Immunizations for Children and Adolescents (CIS, IMA)

The immunization HEDIS measures look at:

- **Immunizations for children (CIS):** Children turning 2 years of age in the current year who received the following immunizations on or before their 2nd birthday.

Immunization	Minimum required dose(s)
DTaP/DT	4
IPV	3
MMR	1
Hib	3
Hep B	3

Immunization	Minimum required dose(s)
VZV	1
PCV	4
Hep A	1
Rotavirus	2 or 3
Influenza[1]	2

- **Immunizations for adolescents (IMA):** Adolescents turning 13 years of age in the current year who received the following immunizations on or before their 13th birthday.

Immunization	Minimum required dose(s)
HPV	2 or 3
Tdap or Td	1
Meningococcal	1

Record your efforts

Make sure that your medical record documentation reflects all the following:

- Date of the immunization (historic and current)
- The name of the specific antigen administered
- Evidence of anaphylactic reaction to any vaccine or its components, if applicable
- Parent refusal, documented history of illness or seropositive test result
- The date of the first Hep B vaccine given at the hospital and name of the hospital, if available

Code your services correctly

Proper coding is critical to ensure accurate reporting of these measures, and it may also decrease the need for medical record reviews. Use the following codes to document immunizations for children and adolescents:

Description	Immunization	CPT
Immunizations for children (CIS)	DTap	90697, 90698, 90700, 90723
	IPV	90697, 90698, 90713, 90723
	MMR	90707, 90710
	Hib	90644, 90697, 90698, 90721, 90748
	Hep B	90697, 90723, 90740, 90744, 90747, 90748
	VZV	90710, 90716
	PCV	90670
	Hep A	90633
	Rotavirus (2 dose)	90681
	Rotavirus (3 dose)	90680
	Influenza	90655, 90657, 90661, 90673, 90685-90689

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Description	Immunization	CPT
	Influenza LAIV	90660, 90672
Immunizations for adolescents (IMA)	HPV[4]	90649-90651
	Meningococcal	90619, 90733, 90734
	Tdap	90715
	Td	90714

Best practices and helpful tips:

- In order for several vaccines to be considered compliant, they must be administered within the applicable timeframes, as noted below:
    - MMR, VZV, and Hep A vaccinations must be administered on or between the child's first and second birthdays.
    - One of the two LAIV vaccines can be administered on the child's 2nd birthday.
    - Meningococcal must be administered on or between the member's 11th and 13th birthdays.
    - Tdap or Td must be administered on or between the member's 10th and 13th birthdays.
    - HPV must be administered on or between the member's 9th and 13th birthdays. There must be at least 146 days between the first and second dose of the HPV vaccine. For example, if the service date for the first vaccine was March 1, then the service date for the second vaccine must be after July 25.
- Follow the *AAP Bright Futures Recommendations Periodicity Schedule* of preventive pediatric healthcare for well-child visits:
    - Appropriate screenings may be an important part of these visits as well. Screenings that may be required:
        - Blood Lead Screenings (LSC Measure)
        - Developmental Screenings and referrals, if required (DEV Measure)
        - Depression screenings with a documented follow-up plan, as identified (CDF Measure)
    - EPSDT services require a dental/oral health assessment.
    - Height, weight, BMI **percentile**, and counseling for nutrition and physical activity should be completed at least once per year as part of a well visit; however, these services may be completed during a visit other than a well-child visit (for example, sick visit). Services specific to an acute or chronic condition do not count for counseling for nutrition or physical activity. For patients under 20 on the date of service, document their BMI percentile. For patients 20 and older, document their BMI value.
- When billing office visits for preventive health services, providers must:
    - Include the appropriate diagnosis code on the claim.
    - Include the applicable EPSDT Referral Code (NU, AV, S2, ST).
    - Use the applicable POS codes, if applicable. POS 99 may be applicable in certain instances.
    - Use the required modifier(s), when applicable:
        - Modifier EP for all preventive health visits (modifiers 90 or 91 may be applicable as well)
        - Modifier HA for catch-up visits
        - Modifier 25:
            - When a vaccine is administered during the preventive visit

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        - To indicate that a significant, separately identifiable E&M service was provided on the same day as the preventive health visit
- Once you give members their needed immunizations, let us and the state know by recording the immunizations in the Georgia Registry of Immunization Transactions and Services (GRITS) database.
- Parental or patient refusal does **not** count as compliance for immunizations.
- Consider offering evening, early morning and/or weekend office hours to accommodate working young adults or parents with children involved in after-school activities.
- Enroll in the Vaccines for Children (VFC) program to receive vaccines. For questions about enrollment and vaccine orders, contact the VFC program at **800-848-3868**.
- EPSDT preventive health screenings are exempt from third-party liability. Even if the member has other health insurance, you may file Medicaid first for preventive health services. This will ensure accurate and timely reporting of EPSDT services.
- Medical records to supplement HEDIS data can be sent to the HEDIS team via secure inbox at **ga1hphedis@amerigroup.com** or secure fax for to **888-220-6712**.
- If utilizing an electronic medical record (EMR) system:
    - Consider creating a flag to track patients who are due or past due for immunizations. If you do not use an EMR, consider creating a manual tracking method.
    - Consider electronic data sharing with your health plan to capture supplemental data (*additional clinical information about a member that may not have been submitted on a claim*).

How can we help?

- Providing you with individual reports of your patients overdue for services, if needed
- Assisting with scheduling appointments for our members, if needed
- Providing education to members on the importance of immunizations and well-visits through various sources, such as phone calls, text messages, newsletters and/or health education materials
- Offering nonemergency transportation to appointments for our members
- Encouraging preventive care through our CHIP Rewards program

Contact your Provider Relationship Management representative for additional details and questions.

Other resources

You can find more information and tools online:

- *ACIP Immunization Schedule* — **https://www.cdc.gov/vaccines/schedules/hcp/index.html**
- *AAP HPV Champion Toolkit* — **https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/immunizations/HPV-Champion-Toolkit/Pages/HPV-Champion-Toolkit.aspx**
- VFC program — **https://dph.georgia.gov/vaccines-children-program**

Notes

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Initiation and Engagement of Substance Use Disorder Treatment (IET)

This HEDIS measure looks at members 13 years of age and older with a new substance use disorder (SUD) episode that results in the following treatments:

- **Initiation of SUD treatment** — started treatment within 14 days of the episode date through one of the following:
  - An inpatient SUD admission
  - An outpatient visit
  - An intensive outpatient encounter or partial hospitalization
  - A telehealth visit or
  - Medication treatment
- **Engagement of SUD treatment** — started the above initiation treatment engagement within 34 days after the initiation visit

Code your services correctly

Use the following codes for the treatment of substance use disorders:

Description	ICD-10-CM
Alcohol abuse and dependence	F10.10, F10.120-F10.132, F10.139, F10.14, F10.150, F10.151, F10.159, F10.180-F10.182, F10.188, F10.19, F10.20, F10.220, F10.221, F10.229-F10.232, F10.239, F10.24, F10.250, F10.251, F10.259, F10.26, F10.27, F10.280-F10.282, F10.288, F10.29
Opioid abuse and dependence	F11.10, F11.120-F11.122, F11.129, F11.13, F11.14, F11.150, F11.151, F11.159, F11.181, F11.182, F11.188, F11.19, F11.20, F11.220-F11.222, F11.229, F11.23, F11.24, F11.250, F11.251, F11.259, F11.281, F11.282, F11.288, F11.29
Other drug use and dependence	F12.10, F12.12, F12.13, F12.15, F12.180-F12.20, F12.220-F12.229, F12.23, F12.250-F12.259, F12.280-F12.288, F12.29, F13.10, F13.120-F13.159, F13.180-F13.188, F13.19, F13.20, F13.220-F13.29, F14.10, F14.120-F14.159, F14.180, F14.19, F14.20, F14.220-F14.259, F14.280-F14.288, F14.29, F15.10, F15.120-F15.159, F15.180-F15.20, F15.220-F15.259, F15.280-F15.288, F15.29, F16.10, F16.12, F16.14, F16.150-F16.159, F16.180-F16.20, F16.220-F16.229, F16.24, F16.250-F16.259, F16.280-F16.288, F16.29, F18.10, F18.120-F18.129, F18.14, F18.150-F15.159, F18.17-F18.20, F18.220-F18.229, F18.24, F18.250-F18.259, F18.27-F18.29, F19.10, F19.120-F19.20, F19.220-F19.29

Description	CPT	HCPCS	POS
BH Outpatient Visits	98960-98962, 99078, 99202-99205, 99211-99215, 99242-99245, 99341-99342, 99344-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99483, 99492-99494, 99510, 90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90875, 90876	G0155, G0176, G0177, G0409, G0463, G0512, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013-H2020, T1015	02, 03, 05, 07, 09, 11-20, 22, 33, 49, 50, 52, 53, 57, 58, 71, 72
Hospital inpatient and Observation visits	99221-99223, 99231-99233, 99238, 99239, 99252-99255		21

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Description	CPT	HCPCS	POS
Opioid Treatment Services (weekly or monthly)		G2067-G2077, G2080, G2086, G2087	
Partial Hospitalization / Intensive Outpatient		G0410, G0411, H0035, H2001, H2012, S0201, S9480, S9484	
Substance Use Disorder Services	99408, 99409	G0396, G0397, G0443, H0001, H0005-H0007, H0015, H0016, H0022, H0028, H0047, H0050, H2035, H2036, T1006, T1012	
Online assessments (e-visit or virtual check-in)	98970-98972, 99421-99423, , 99457, 99458	G0071, G2010, G2012, , G2250-G2252	
Telephone visits	98966-98968, 99441-99443		

Best practices and helpful tips:

- When billing for these services/visits, be sure to:
  - Include the appropriate diagnosis code on the claim.
  - Use the appropriate modifier(s) and/or POS codes, if applicable.
- SUD Episodes that are not compliant for Initiation of SUD Treatment are not compliant for Engagement of SUD Treatment.
- If the SUD Episode was an inpatient discharge, the inpatient stay is considered initiation of treatment and the member is compliant for the Initiation of SUD Treatment.
- Some of the barriers to members starting and engaging in substance abuse treatment include:
  - Lack of member knowledge on importance and availability of treatment services.
  - Lack of coordination of care between physical and behavioral health practitioners.
  - Denial of patients in addressing their alcohol or other drug dependence.
  - Resistance to seeking drug and alcohol treatment due to social stigma.
  - No support from family, friends, peer or other community groups.
  - Little emphasis from providers in addressing these issues during a regular wellness visit.
- Discuss the benefits of participating in our behavioral health case management program including getting help with follow-up discharge appointments and other support.
- Ask your patients who have a behavioral health diagnosis to provide you access to their behavioral health records if you are their primary care provider.
- Be sure to contact the Pharmacy department at **800-454-3730** to verify required preauthorization of medications.
- Treatment medications for substance use disorders includes but may not be limited to:

Treatment type	Description	Prescriptions
Alcohol use disorder	Aldehyde dehydrogenase inhibitor	• Disulfiram (oral)
	Antagonist	• Naltrexone (oral and injectable)
	Other	• Acamprosate (oral; delayed-release tablet)

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Treatment type	Description	Prescriptions
Opioid use disorder	Antagonist	• Naltrexone (oral and injectable)
	Partial antagonist	• Buprenorphine (sublingual tablet, injection, implant) • Buprenorphine/naloxone (sublingual table, buccal film, sublingual film)

Note: *Not all medications listed above are in our formulary. Prior authorization and/or step therapy may be required.*

How can we help?

- Encouraging providers to be advocates and provide the resources needed to educate our members and ensure success in completing substance use treatment
- Offering current *Clinical Practice Guidelines* on our provider self-service website
- Providing individualized reports of your patients who are due or overdue for services
- Offering nonemergency transportation to appointments for our members
- Offering our behavioral health case management program to members

Contact your Provider Relationship Management representative for additional details and questions.

Other resources

You can find more information and tools online:

- Disease Management/Condition Car**https://provider.amerigroup.com/georgia-provider/patient-care/disease-management**
- National Institute of Alcohol Abuse and Alcoholism — **https://niaaa.nih.gov**
- Pharmacy Information - **https://provider.amerigroup.com/georgia-provider/resources/pharmacy-information**
- Substance Abuse and Mental Health Services Administration — **https://www.samhsa.gov/find-help/atod**

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Lead Screening in Children (LSC)

This HEDIS measure looks at members who had at least one capillary or venous lead blood tests for lead poisoning on or **before** their 2nd birthday.

Record your efforts

Make sure that your medical record documentation reflects all of the following:

- Date the blood test was performed
- Results or findings

Code your services correctly

Proper coding is critical to ensure accurate reporting of these measures, and it may also decrease the need for medical record reviews. Use the following code to document lead screening:

Description	CPT
Lead screening	83655[1]

1 When billing this code, providers must bill with the appropriate diagnosis code (Z13.88, Z00.121, Z00.129, Z77.011) to indicate blood lead level screening.

Best practices and helpful tips:

- When billing office visits for preventive health services, providers must:
    - Include the appropriate diagnosis code on the claim.
    - Include the applicable EPSDT Referral Code (NU, AV, S2, ST).
    - Use the applicable POS codes, if applicable. POS 99 may be applicable in certain instances.
    - Use the required modifier(s).
        - Modifier EP for all preventive health visits (modifiers 90 or 91 may be applicable as well)
        - Modifier HA for catch-up visits
        - Modifier 25:
            - when a vaccine is administered during the preventive visit or
            - to indicate that a significant, separately identifiable E&M service was provided on the same day as the preventive health visit
- Follow the *AAP Bright Futures Recommendations Periodicity Schedule* of preventive pediatric healthcare for well-child visits:
    - Anticipatory guidance is required as part of a preventive health visits. You can cover:
        - Effects of lead poisoning on children.
        - Sources of lead poisoning.
        - Pathways of exposure.
        - How to prevent childhood exposure to lead hazards.
        - Appropriate testing schedules for children.
- CMS requires lead screenings (blood tests) for Medicaid eligible children at 12 and 24 months of age.
- Completing a lead risk assessment questionnaire does not count as a lead screening.
- EPSDT preventive health screenings are exempt from third-party liability. Even if the member has other health insurance, you may file Medicaid first for preventive health services. This will ensure accurate and timely reporting of EPSDT services.

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- Consider performing finger stick screenings in your practice instead of sending them to the lab. If you obtain the specimen and analyze the test in your office, you should report results to the Georgia Healthy Homes and Lead Poisoning Prevention Program. See the link in *Other Resources*.
- Develop a process to check medical records for lab results to ensure previously ordered lead screenings have been completed and documented. Assign a staff member to follow up on results when patients are sent to a lab for screening.
- Sick visits may be a missed opportunity to complete an annual well visit.
- Contact our Case Management department if the results are greater than 10 micrograms/dl.
- If utilizing an electronic medical record (EMR) system, consider electronic data sharing with your Amerigroup to capture supplemental data (*additional clinical information about a member that may not have been submitted on a claim*).

How can we help?

- Offering current *Clinical Practice Guidelines* on our provider self-service website
- Providing individualized reports of your patients that are due or overdue for services
- Sending reminder postcards to members due for a lead screening
- Assisting with scheduling appointments for our members, if needed
- Offering nonemergency transportation to appointments for our members
- Encouraging preventive care through our CHIP Rewards program
- Providing education to members on the importance of lead screenings and well-visits through various sources, such as phone calls, text messages, newsletters, and/or health education materials

Contact your Provider Relationship Management representative for additional details and questions.

Other resources

You can find more information and tools online:

- CMS Medicaid lead screening and EQRO protocols — **https://www.medicaid.gov/federal-policy-guidance/downloads/cib-03-30-12.pdf**

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Pharmacotherapy Management of COPD Exacerbation (PCE)

This HEDIS measure looks at chronic obstructive pulmonary disease (COPD) exacerbations for members 40 years of age and older who had an acute inpatient discharge or emergency department (ED) visit on or between January 1 and November 30 of the current year and who were dispensed appropriate medications. Two rates are reported:

- **Dispensed a systemic corticosteroid** (or there was evidence of an active prescription) within 14 days of the acute inpatient discharge or ED visit
- **Dispensed a bronchodilator** (or there was evidence of an active prescription) within 30 days of the acute inpatient discharge or ED visit

Record your efforts

Make sure that medical record reflects all of the following:

- Your review of the discharge summary along with the discharge medications for both a systemic corticosteroid and a bronchodilator
- A schedule of regular follow-up visits to review the medication management/compliance
- Record of any new prescriptions written at follow-up visits
- All discussions about the COPD disease process — medication management along with proper use of inhalers and other medications, such as systemic corticosteroids, patient compliance and availability of smoking cessation assistance

Code your services correctly

Use the following codes to identify COPD:

Description	ICD-10-CM
Chronic bronchitis	J41.0, J41.1, J41.8, J42
COPD	J44.0, J44.1, J44.9
Emphysema	J43.0-J43.2, J43.8, J43.9

Best practices and helpful tips

- Make sure you schedule an appointment with your patient upon notification of an inpatient discharge or ED visit. Have your staff call the member prior to the visit to confirm.
- Members may be included in this measure multiple times since this measure is based on discharges and/or ED visits.
- If your patient was not given a prescription at the time of discharge, be sure to prescribe the appropriate corticosteroid within 14 days of discharge and the systemic bronchodilator within 30 days of discharge.
- Offer annual flu shots in your office or inform your patients of the importance of getting the vaccine and where they can get it.
- Educate patients about the use of and compliance with prescribed treatments, including:
    - Long-term versus quick relief medications.
    - Smoking cessation counseling. Offer solutions to assist with quitting.
    - Pharmacotherapy options.
    - Breathing training.
    - Oxygen treatments.

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    - Using metered-dose inhalers.
    - Avoiding elements that trigger attacks, such as dust, pollen, smoking and secondary smoke, cold air, and pets.
- Encourage your staff to use tools within the office to promote smoking cessation.
- Provide staff training on proper use of inhalers and breathing techniques used in patients with COPD; offer a CME course to enhance your treatment and prevention of COPD exacerbations.
- Display posters and educational messages in treatment rooms and waiting areas to help motivate patients to initiate discussions with you about smoking cessation.
- Be sure to contact the Pharmacy department at **800-454-3730** to verify required preauthorization of medications.
- Systemic corticosteroids and bronchodilators include but may not be limited to:

Type	Description	Prescriptions	
Systemic corticosteroids	Glucocorticoids	• Cortisone-acetate • Dexamethasone • Hydrocortisone	• Methylprednisolone • Prednisolone • Prednisone
Bronchodilators	Anticholinergic agents	• Aclidinium-bromide • Ipratropium	• Tiotropium • Umeclidinium
	Beta 2-agonists	• Albuterol • Arformoterol • Formoterol • Levalbuterol	• Metaproterenol • Olodaterol • Salmeterol
	Bronchodilator combinations	• Albuterol-ipratropium • Budesonide-formoterol • Dyphylline-guaifenesin • Fluticasone-salmeterol • Fluticasone-vilanterol • Fluticasone furoate-umeclidinium-vilanterol	• Formoterol-aclidinium Formoterol-glycopyrrolate • Formoterol-mometasone • Indacaterol-glycopyrrolate • Umeclidinium-vilanterol

Note: *Not all medications listed above are in our Formulary. Prior authorization and/or step therapy may be required.*

How can we help?

- Offering current *Clinical Practice Guidelines* on our provider self-service website
- Providing education to members on COPD through various sources, such as phone calls, newsletters, and/or health education materials
- Offering Condition Care, formerly disease management, programs to our members
- Providing individualized reports of your patients that are due or overdue for services
- Offering nonemergency transportation to appointments for our members

Contact your Provider Relationship Management representative for additional details and questions.

Other resources

You can find more information and tools online:

- CO*PD National Action Plan* — **https://www.nhlbi.nih.gov/news/2017/copd-national-action-plan-aims-reduce-burden-third-leading-cause-death**

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- Disease Management/Condition Care —**https://provider.amerigroup.com/georgia-provider/patient-care/disease-management**
- *Medicaid Formulary* — **https://client.formularynavigator.com/Search.aspx?siteCode=7596004980**
- Pharmacy Information - **https://provider.amerigroup.com/georgia-provider/resources/pharmacy-information**
- The Global Initiative for Chronic Obstructive Lung Disease (GOLD) — **https://goldcopd.org**

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Opioid Use in Adults (COU, HDO, UOP)

These HEDIS measures look at members 18 years of age and older who have been prescribed opioid medication. Rates are reported for the following measures:

- **Risk of Continued Opioid Use (COU) -** members who have a new episode of opioid use that puts them at risk for continued opioid use. Two rates are reported:
    - The percentage of members with at least **15 days** of prescription opioids in a 30-day period.
    - The percentage of members with at least **31 days** of prescription opioids in a 62-day period.
- **Use of Opioids at High Dosage (HDO)** - members who received prescription opioids at a high dosage (average morphine milligram equivalent dose MME ≥ 90) for ≥ 15 days during the measurement year.
- **Use of Opioids from Multiple Providers (UOP)** - members receiving prescription opioids from four or more different prescribers **and** four or more different pharmacies during the measurement year.

Best practices and helpful tips:

- A lower rate indicates better performance for these measures.
- Be sure to include the appropriate diagnosis on the claim for the treatment visits.
- Discuss the benefits of participating in our behavioral health case management program.
- Ask your patients who have a behavioral health diagnosis to provide you access to their behavioral health records if you are their primary care provider.
- Some of the barriers to members starting and engaging in substance abuse treatment include:
    - Lack of member knowledge on importance and availability of treatment services.
    - Lack of coordination of care between physical and behavioral health practitioners.
    - Denial of patients in addressing their drug dependence.
    - Resistance to seeking treatment due to social stigma.
    - No support from family, friends, peer or other community groups.
    - Little emphasis from providers in addressing these issues during a regular wellness visit.
- Be sure to contact the Pharmacy department at **800-454-3730** to verify required preauthorization of medications.
- Opioid medications may include but are not limited to:

Prescription	Medications		
Opioid medications	• Benzhydrocodone • Buprenorphine • Butorphanol • Codeine • Dihydrocodeine • Fentanyl	• Hydrocodone • Hydromorphone • Levorphanol • Meperidine • Methadone • Morphine	• Opium • Oxycodone • Oxymorphone • Pentazocine • Tapentadol • Tramadol

Note: *Not all medications listed above are in our formulary. Prior authorization and/or step therapy may be required.*

How can we help?

- Offering current *Clinical Practice Guidelines* on our provider self-service website
- Providing individualized reports of your patients who are due or overdue for services

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- Offering nonemergency transportation to appointments for our members
- Offering our behavioral health case management program to members

Contact your Provider Relationship Management representative for additional details and questions.

Other resources:

You can find more information and tools online:

- Disease Management/Condition Care — **https://provider.amerigroup.com/georgia-provider/patient-care/disease-management**
- National Institute of Alcohol Abuse and Alcoholism — **https://niaaa.nih.gov**
- Pharmacy Information - **https://provider.amerigroup.com/georgia-provider/resources/pharmacy-information**
- Substance Abuse and Mental Health Services Administration — **https://www.samhsa.gov/find-help/atod**

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Prenatal and Postpartum Care (PPC, PRS-E, LBW)

These measures assess the following facets of prenatal and postpartum care:

- **Timeliness of prenatal care (PPC)** — The percentage of deliveries of live births *(on or between October 7 of the current year and October 8 of the year prior to the current year and)* that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment as a member.
- **Postpartum care (PPC)** — The percentage of deliveries of live births *(on or between October 8 of the year prior to the current year and October 7 of the current year)* that had a postpartum visit on or between 7 to 84 days after delivery.
- **Prenatal Immunization Status (PRS-E)** - The percentage of deliveries in which women received both the influenza and tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccinations in the measurement year.
- **Live Births Weighing Less than 2,500 Grams (LBW-CH)** – The percentage of live births that weighed less than 2,500 grams at birth during the measurement year.

Record your efforts

Make sure your medical record documentation reflects all of the following:

- When prenatal care was initiated or the date of the member's first prenatal visit and evidence of at least one of the following:
    - A basic physical obstetrical examination that includes one of the following:
        - Auscultation for fetal heart tone
        - Pelvic exam with obstetric observations
        - Measurement of fundus height (A standardized prenatal flow sheet may be used.)
    - Prenatal care procedure, such as:
        - Screening test/obstetric panel
        - TORCH antibody panel alone
        - A rubella antibody test/titer with an Rh incompatibility (ABO/RH blood typing)
        - Ultrasound/echography of a pregnant uterus
    - Documentation of last menstrual period or estimated due date with either a prenatal risk assessment and counseling/education or complete obstetrical history
- The date of when the postpartum visit occurred and evidence of at least one of the following:
    - Notation of postpartum care (for example, postpartum care, PP care, PP check, six-week check, or a preprinted postpartum care form in which information was documented during the visit)
    - Pelvic exam
    - Evaluation of weight, blood pressure, breasts and abdomen (Notation of breastfeeding is acceptable for the evaluation of breasts component.)
    - Perineal or cesarean incision/wound check
    - Screening for depression, anxiety, tobacco use, substance use disorder or preexisting mental health disorders
    - Glucose screening for women with gestational diabetes
    - Infant care or breastfeeding
    - Sleep/fatigue
    - Resumption of physical activity and attainment of healthy weight
    - Resumption of intercourse, birth spacing or family planning

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Code your services correctly

Proper coding is critical to ensure accurate reporting of these measures, and it may also decrease the need for medical record reviews. Use the following codes to document visits and services for prenatal and postpartum care:

Type	Description	CPT	ICD-10-CM	HCPCS
Prenatal visits	Prenatal bundled services[2]	59400, 59425, 59426, 59510, 59610, 59618		H1005
	Prenatal visits	99202-99205, 99211-99215, 99242-99245, 99483, 99500, 0500F[1], 0501F[1], 0502F[1]		G0463, T1015, H1000-H1004
	Online assessments (e-visit or virtual check-in)	98970-98972, 99421-99423, , 99457, 99458		G0071, G2010, G2012, , G2250-G2252
	Telephone visits	98966-98968, 99441-99443		
Postpartum visits	Cervical cytology tests	88141-88143, 88147, 88148, 88150, 88152-88153, 88164-88167, 88174, 88175		G0123, G0124, G0141, G0143-G0145, G0147, G0148, P3000, P3001, Q0091
	Postpartum visits	0503F[1], 57170, 58300, 59430, 99501	Z01.411, Z01.419, Z01.42, Z30.430, Z39.1, Z39.2	G0101
	Postpartum bundled services[3]	59400, 59410, 59510, 59515, 59610, 59614, 59618, 59622		
Prenatal Immunization Status (PRS-E)	Adult Influenza Vaccine	90630, 90653, 90654, 90656, 90658, 90661, 90662, 90673, 90674, 90682, 90686, 90688, 90689, 90694, 90756		
	Tdap Vaccine	90715		

[1] The use of CPT Category II codes help with quality reporting and may reduce the need for medical record requests. These codes may be eligible for additional reimbursement.

*[2] Since bundled service codes are used on the delivery date, these codes **only** count for the prenatal visit if the claim form indicates when the prenatal care was initiated.*

*[3]Since bundled service codes are used on the delivery date, these codes **only** count for the postpartum visit if the claim form indicates when the postpartum care was rendered.*

Utilize the following codes below to close additional gaps during these visits and assist with quality reporting, if applicable:

Description	CPT	ICD-10-CM	HCPCS

Best practices and helpful tips:

- When billing for these services/visits, be sure to:
  - Include the appropriate pregnancy-related diagnosis code on the claim.
  - Use the appropriate modifier(s) and/or POS codes, if applicable.
- Ultrasound and labs must be combined with a visit to be considered compliant for prenatal care.
- All services can be documented using the ACOG forms.

* VSP is an independent company providing vision services on behalf of the health plan. DentaQuest is an independent company providing dental benefit management services on behalf of the health plan.

Please note: The codes and tips listed do not guarantee reimbursement. The information provided is based on HEDIS MY 2023 technical specifications, the 2022 CMS technical specifications and the 2022 EPSDT Services Health Check Program Manual and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and/or state recommendations. Please refer to the appropriate agency for additional guidance.

- ACOG recommends a minimum of 14 prenatal visits for a 40-week pregnancy. To ensure regular care, remind members to schedule all required visits, including:
    - One visit every four weeks until 28 weeks' gestation (at least six visits).
    - One visit every two weeks until 36 weeks' gestation (at least four visits).
    - One visit every week after 36 weeks until delivery (at least four visits).
- It is essential to identify maternal risk factors early in pregnancy to ensure the best outcome for the member. Prenatal risk assessments should be performed at the first prenatal visit or as early in pregnancy as possible. Risk assessments should include screening for:
    - Alcohol, tobacco, and drug use.
    - Depression.
    - Intimate partner violence.
- Educate expectant mothers on the importance of vaccines during pregnancy, including:
    - How influenza can result in serious illness, including a higher chance of progressing to pneumonia, when it occurs during the antepartum or postpartum period.
    - How having a fever with the flu can affect her developing baby.
    - How the flu vaccine will protect both her and her baby.
    - How passive immunity from the maternal immunization will pass on to their newborns.
    - How receiving the Tdap vaccine in the third trimester will boost the neonatal antibody levels in the baby.
    - How the Tdap vaccine will protect them and their baby from pertussis and its life-threatening complications.
- If you do not have vaccines available, refer the patient to another health care provider, pharmacy, or community vaccination center.
- Call patients to schedule the visits and/or remind them of their appointment dates and times. Be sure to follow up with patients who miss appointments and reschedule.
- Medical records to supplement HEDIS data can be sent to the HEDIS team via secure inbox at ga1hphedis@amerigroup.com or secure fax at **888-220-6712**.
- If utilizing an electronic medical record (EMR) system, consider electronic data sharing with your Amerigroup to capture supplemental data (*additional clinical information about a member that may not have been submitted on a claim*).

How can we help?

We help you get members the proper care they need for their pregnancy by:

- Offering current *Clinical Practice Guidelines* on our provider self-service website
- Enrolling members into our maternal programs to help you coordinate their care
- Offering additional benefits and incentives for pregnant members and new moms
- Providing education to members on the importance of prenatal and postpartum care through various sources, such as phone calls, text messages, newsletters, and/or health education materials
- Assisting with scheduling appointments for our members, if needed
- Offering nonemergency transportation to appointments for our members

Contact your Provider Relationship Management representative for additional details and questions.

Other resources:

You can find more information and tools online:

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Please note: The codes and tips listed do not guarantee reimbursement. The information provided is based on HEDIS MY 2023 technical specifications, the 2022 CMS technical specifications and the 2022 EPSDT Services Health Check Program Manual and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and/or state recommendations. Please refer to the appropriate agency for additional guidance.

- Amerigroup's Pregnancy and Maternal Child Services - **https://provider.amerigroup.com/georgia-provider/patient-care/pregnancy-and-maternal-child-services**

Notes

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Please note: The codes and tips listed do not guarantee reimbursement. The information provided is based on HEDIS MY 2023 technical specifications, the 2022 CMS technical specifications and the 2022 EPSDT Services Health Check Program Manual and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and/or state recommendations. Please refer to the appropriate agency for additional guidance.

Screening for Depression and Follow-up Plan (CDF)

This measure looks at the percentage of members 12 years of age and older who had an outpatient visit during the current year **and** were screened for depression using an age-appropriate standardized depression screening tool, **and** if positive, a follow-up plan is documented on the same date as the positive screen. To be considered compliant, the member must have either of the following:

- A negative screen for depression or
- A positive screen for depression **and** a follow-up plan documented on the same date of the positive screen

Code your services correctly

Use the following codes to identify screenings or active diagnoses of depression or bipolar disorder:

Description	HCPCS
Screening for depression is documented as being negative, a follow-up plan is not required	G8510
Screening for depression is documented as being positive and a follow-up plan is documented	G8431
Active diagnosis of depression or bipolar disorder, therefore screening or follow-up is not required	G9717

Best practices and helpful tips

- Members that have an active diagnosis of depression of bipolar disorder are not eligible.
- Screening tests can predict the likelihood of someone having or developing a particular disease or condition. The screening must be completed using a standardized tool that has been appropriately normalized and validated for the population in which it is being utilized.
- Common depression screening tools include but are not limited to:
    - Patient Health Questionnaire (PHQ)
    - Beck Depression Inventory (BDI)
    - Mood Feeling Questionnaire (MFQ)
    - Center for Epidemiologic Studies Depression Scales (CES-D)
    - Edinburgh Postnatal Depression Scale
    - Postpartum Depression Screening Scale
- If a positive screen is identified, a follow-up plan must be related to the positive screen and include one or more of the following
    - Additional evaluation for depression,
    - Suicide risk assessment,
    - Referral to a practitioner who is qualified to diagnose and treat depression,
    - Pharmacological interventions
    - Or other appropriate interventions or follow-up.
- Well-care visits may be missed opportunities to complete a screening for depression.
- If utilizing an electronic medical record (EMR) system, consider:
    - Creating a flag to track patients who are due or past due for preventive services. If you do not use an EMR, consider creating a manual tracking method.
    - Electronic data sharing with your health plan to capture supplemental data (*additional clinical information about a member that may not have been submitted on a claim*).

How can we help?

- Offering our behavioral health case management program to our members
- Providing individualized reports of your patients that are due or overdue for services
- Assisting with scheduling appointments for our members, if needed
- Encouraging preventive care through our CHIP Rewards program
- Offering nonemergency transportation to appointments for our members

Contact your Provider Relationship Management representative for additional details and questions.

Other resources

You can find more information and tools online:

- *Medicaid Formulary* — **https://client.formularynavigator.com/Search.aspx?siteCode=7596004980**
- National Institute of Mental Health — **https://www.nimh.nih.gov**
- Patient Health Questionnaire (PHQ) Screeners — **https://www.phqscreeners.com/select-screener**
- U.S. Preventive Services Task Force *Depression in Children and Adolescents: Screening* — **https://www.uspreventiveservicestaskforce.org/Page/Document/ClinicalSummaryFinal/depression-in-children-and-adolescents-screening**
- U.S. Preventive Services Task Force *Depression in Adults: Screening* — **https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/depression-in-adults-screening**

Notes

Statin Therapy for Patients with Cardiovascular Disease (SPC)

This HEDIS measure looks at the percentage of males 21 to 75 years of age and females 40 to 75 years of age, who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and met the following criteria:

- **Received Statin Therapy:** dispensed at least one high-intensity or moderate-intensity statin medication during the measurement year.
- **Statin Adherence 80%:** remained on a high-intensity or moderate-intensity statin medication for at least 80% of the treatment period.

Record your efforts

Make sure that your medical record documentation reflects all of the following:

- Date of each visit
- All progress notes, problem history and medication reviews
- Referrals for other providers for cardiovascular care

Code your services correctly

Use the following codes to identify atherosclerotic cardiovascular diseases and/or services.

Description	CPT	HCPCS
CABG	33510-33514, 33516-33519, 33521-33523, 33530, 33533-33536	S2205-S2209
PCI	92920, 92924, 92928, 92933, 92937, 92941, 92943	C9600, C9602, C9604, C9606, C9607
Other Revascularization	37220, 37221, 37224-37231	

Description	ICD10-CM
IVD	I20.0, I20.8, I20.9, I24.0, I24.8, I24.9, I25.10, I25.110, I25.111, I25.118, I25.119, I25.5, I25.6, I25.700, I25.701, I25.708, I25.709-I25.711, I25.718-I25.721, I25.728-I25.731, I25.738, I25.739, I25.750, I25.751, I25.758-I25.761, I25.768, I25.769, I25.790, I25.791, I25.798, I25.799, I25.810-I25.812, I25.82-I25.84, I25.89, I25.9, I63.20, I63.211-I63.213, I63.219, I63.22, I63.231-I63.233, I63.239, I63.29, I63.50, I63.511-I63.513, I63.519, I63.521, I63.522, I63.523, I63.529, I63.531-I63.533, I63.539, I63.541-I63.543, I63.549, I63.59, I65.01-I65.03, I65.09, I65.1, I65.21-I65.23, I65.29, I65.8, I65.9, I66.01-I66.03, I66.09, I66.11-I66.13, I66.19, I66.21-I66.23, I66.29, I66.3, I66.8, I66.9, I67.2, I70.1, I70.201-I70.203, I70.208, I70.209, I70.211-I70.213, I70.218, I70.219, I70.221-I70.223, I70.228, I70.229, I70.231-I70.235, I70.238, I70.239, I70.241-I70.245, I70.248, I70.249, I70.25, I70.261-I70.263, I70.268, I70.269, I70.291-I70.293, I70.298, I70.299-I70.303, I70.308, I70.309, I70.311-I70.313, I70.318, I70.319, I70.321-I70.323, I70.328, I70.329, I70.331-I70.335, I70.338, I70.339, I70.341-I70.345, I70.348, I70.349, I70.35, I70.361-I70.363, I70.368, I70.369, I70.391-I70.393, I70.398, I70.399, I70.401-I70.403, I70.408, I70.409, I70.411-I70.413, I70.418, I70.419,I70.421-I70.423, I70.428, I70.429, I70.431-I70.435, I70.438, I70.439, I70.441-I70.445, I70.448, I70.449, I70.45, I70.461-I70.463, I70.468, I70.469, I70.491-I70.493, I70.498, I70.499, I70.501-I70.503, I70.508, I70.509, I70.511-I70.513, I70.518, I70.519, I70.521-I70.523, I70.528, I70.529, I70.531-I70.535, I70.538, I70.539, I70.541-I70.545, I70.548, I70.549, I70.55, I70.561-I70.563, I70.568, I70.569, I70.591-I70.593, I70.598, I70.599, I70.601-I70.603, I70.608, I70.609, I70.611-I70.613, I70.618, I70.619, I70.621-I70.623, I70.628, I70.629, I70.631-I70.635, I70.638, I70.639, I70.641-I70.645, I70.648, I70.649, I70.65, I70.661-I70.663, I70.668, I70.669, I70.691-I70.693, I70.698, I70.699, I70.701-I70.703, I70.708, I70.709, I70.711, I70.713, I70.718, I70.719, I70.721-I70.723, I70.728, I70.729, I70.731-I70.735, I70.738, I70.739, I70.741-I70.745, I70.748, I70.749, I70.75, I70.761-I70.763, I70.768, I70.769, I70.791-I70.793, I70.798, I70.799, I70.92, I75.011-I75.013, I75.019, I75.021-I75.023, I75.029, I75.81, I75.89, T82.855, T82.856

Description	ICD10-CM
MI	I21.01, I21.02, I21.09, I21.11, I21.19, I21.21, I21.29, I21.3, I21.4, I21.9, I21.A1, I21.A9, I22.0-I22.2, I22.8, I22.9, I23.0-I23.8, I25.2

Best practices and helpful tips:

- The treatment period begins when the statin medication is dispensed.
- Be sure to use the appropriate modifier(s) and/or POS codes, if applicable.
- Ensure patients with atherosclerotic cardiovascular disease receive follow-up care to monitor medications
- Educate patients and their spouses, caregivers, or guardians about the elements of a healthy lifestyle, such as:
    - Heart-healthy eating and a low-salt diet.
    - Smoking cessation and avoiding secondhand smoke.
    - Adding regular exercise to daily activities.
    - The importance of taking all prescribed medications as directed.
- Be sure to contact our Pharmacy department at **800-454-3730** to verify required preauthorization of medications.
- The following are statin medications applicable to this measure:

Description	Prescriptions		
High-intensity statin therapy	• Atorvastatin 40-80 mg • Amlodipine-atorvastatin 40-80 mg	• Ezetimibe-simvastatin 80 mg	• Rosuvastatin 20-40 mg • Simvastatin 80 mg
Moderate-intensity statin therapy	• Atorvastatin 10-20 mg • Amlodipine-atorvastatin 10-20 mg • Rosuvastatin 5-10 mg	• Simvastatin 20-40 mg • Ezetimibe-simvastatin 20-40 mg • Pravastatin 40-80 mg	• Lovastatin 40 mg • Fluvastatin 40-80 mg • Pitavastatin 1-4 mg

Note: *Not all medications listed above are in our Formulary. Prior authorization and/or step therapy may be required.*

How can we help?

- Offering current *Clinical Practice Guidelines* on our provider self-service website
- Providing individualized reports of your patients that are due or overdue for services
- Offering nonemergency transportation to appointments for our members

Contact your Provider Relationship Management representative for additional details and questions.

Other resources

You can find more information and tools online:

- American Heart Association — **https://www.heart.org**
- Disease Management/Condition Care — **Disease Management | Georgia Provider - Amerigroup - https://provider.amerigroup.com/georgia-provider/patient-care/disease-management -**
- Pharmacy Information - **https://provider.amerigroup.com/georgia-provider/resources/pharmacy-information**

Notes

Statin Therapy for Patients with Diabetes (SPD)

This HEDIS measure looks at the percentage of members 40 to 75 years of age during the measurement year with diabetes who do **not** have clinical atherosclerotic cardiovascular disease (ASCVD) who met the following criteria. Two rates are reported:

- **Received Statin Therapy** - dispensed at least one statin medication of any intensity during the measurement year.
- **Statin Adherence 80%** - remained on a statin medication of any intensity for at least 80% of the treatment period.

Record your efforts

Make sure that your medical record documentation reflects all of the following:

- Date of each visit
- All progress notes, problem history and medication reviews
- Referrals for other providers for diabetes care such as endocrinologists

Best practices and helpful tips:

- The treatment period begins when the statin medication is dispensed.
- Be sure to use the appropriate modifier(s) and/or POS codes, if applicable.
- Educate your patients, their families, caregivers and guardians on diabetes care, including:
    - Taking all prescribed medications as directed.
    - Adding regular exercise to daily activities to maintain healthy weight and ideal body mass index.
    - Regularly monitoring blood sugar and BP at home.
    - Eating heart-healthy, low-calorie, and low-fat foods.
    - Stopping smoking and avoiding second-hand smoke.
    - Fasting prior to having blood sugar/lipid panels drawn to ensure accurate results.
    - Keeping all appointments; getting help with scheduling appointments, screenings, and tests to improve compliance.
- Be sure to contact our Pharmacy department at **800-454-3730** to verify required preauthorization of medications.
- The following are statin medications applicable to this measure:

Description	Prescriptions		
High-intensity statin therapy	• Atorvastatin 40-80 mg • Amlodipine-atorvastatin 40-80 mg	• Ezetimibe-simvastatin 80 mg	• Rosuvastatin 20-40 mg • Simvastatin 80 mg
Moderate-intensity statin therapy	• Atorvastatin 10-20 mg • Amlodipine-atorvastatin 10-20 mg • Rosuvastatin 5-10 mg	• Simvastatin 20-40 mg • Ezetimibe-simvastatin 20-40 mg • Pravastatin 40-80 mg	• Lovastatin 40 mg • Fluvastatin 40-80 mg • Pitavastatin 1-4 mg
Low-intensity statin therapy	• Ezetimibe-simvastatin 10 mg • Fluvastatin 20 mg	• Lovastatin 10-20 mg • Pravastatin 10-20 mg	• Simvastatin 5-10 mg

Note: *Not all medications listed above are in our Formulary. Prior authorization and/or step therapy may be required.*

How can we help?

- Offering current *Clinical Practice Guidelines* on our provider self-service website
- Providing individualized reports of your patients that are due or overdue for services
- Offering nonemergency transportation to appointments for our members
- Offering our Condition Care, formerly disease management, programs to our members

- Providing education to members on the importance of managing their diabetes through various sources, such as phone calls, text messages, newsletters, and/or health education materials

Contact your Provider Relationship Management representative for additional details and questions.

Other resources

You can find more information and tools online:

- American Diabetes Association — **https://www.diabetes.org/**
- CDC information on diabetes — **https://www.cdc.gov/diabetes/home**
- Disease Management/Condition Care — **https://provider.amerigroup.com/georgia-provider/patient-care/disease-management**
- National Heart, Lung and Blood Institute — **https://www.nhlbi.nih.gov/files/docs/guidelines/jnc7full.pdf**
- Pharmacy Information - **https://provider.amerigroup.com/georgia-provider/resources/pharmacy-information**

Notes

Use of Imaging Studies for Low Back Pain (LBP)

This HEDIS measure looks at members 18 to 75 years of age with a principal diagnosis of low back pain who did **not** have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis.

Code your services correctly

Use the following diagnosis and procedure codes to identify low back pain and imaging studies:

Description	ICD-10-CM	CPT
Uncomplicated low back pain	M47.26-M47.28, M47.816-M47.818, M47.896-M47.898, M48.061, M48.07, M48.08, M51.16, M51.17, M51.26, M51.27, M51.36, M51.37, M51.86, M51.87, M53.2X6-M53.2X8, M53.3, M53.86-M53.88, M54.16-M54.18, M54.30-M54.32, M54.40-M54.42, M54.5, M54.89, M54.9, M99.03, M99.04, M99.23, M99.33, M99.43, M99.53, M99.63, M99.73, M99.83, M99.84, S33.100A-S33.100S, S33.110A-S33.110S, S33.120A-S33.120S, S33.130A-S33.130S, S33.140A-S33.140S, S33.5XXA, S33.6XXA, S33.8XXA, S33.9XXA, S39.002A-S39.002S, S39.012A-S39.012S, S39.092A-S39.092S, S39.82XA, S39.92XD, S39.92XS	
Imaging study		72020, 72052, 72100, 72110, 72114, 72120, 72131-72133, 72141, 72142, 72146-72149, 72156, 72158, 72200, 72202, 72220

Best practices and helpful tips:

- Avoid ordering diagnostic studies in the first six weeks of new onset back pain if there are no red flags, such as cancer, recent trauma, neurologic impairment, or intravenous (IV) drug abuse.
- When ordering an imaging study for a red flag or other reasons, use the correct primary or secondary diagnosis code for red flags, such as cancer, recent trauma, neoplasms, neurologic impairment, HIV, spinal infection, or IV drug use.
- Recommended treatments for back pain can include some of the following:
    - Hot or cold packs
    - Activities or strengthening exercises
    - Physical therapy
    - Medications like aspirin or ibuprofen or counterirritants like topical creams or sprays

Notes

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

This HEDIS measure looks at members 3 to 17 years of age who had one or more outpatient visits with their PCP or OB/GYN during the year and documented evidence of the following:

- Height, weight, and BMI **percentile**
- Counseling for nutrition
- Counseling for physical activity

Record your efforts

Make sure that your medical record documentation reflects all of the following:

- Date of the visit
- Height and weight
- BMI **percentile** documented or plotted on an appropriate BMI-for-age growth chart (*BMI values do not count for compliance*)
- Checklist to indicate discussion of counseling for nutrition and physical activity
- Any weight or obesity counseling
- Any advice or anticipatory guidance given

Code your services correctly

Proper coding is critical to ensure accurate reporting of these measures, and it may also decrease the need for medical record reviews. Use the following codes to document weight assessment and counseling for nutrition and physical activity:

Description	ICD-10-CM	CPT	HCPCS
BMI percentile	Z68.51-Z68.54		
Nutrition counseling	Z71.3[1]	97802-97804	G0270, G0271, G0447, S9449, S9452, S9470
Physical activity counseling	Z02.5, Z71.82		G0447, S9451

[1] *Counseling for nutrition (Z71.3) may be reimbursable when billed with a diagnosis code for overweight (Z68.53) or obese (Z68.54) children.*

Best practices and helpful tips:

- When billing office visits for preventive health services, providers must:
  - Include the appropriate diagnosis code on the claim.
  - Include the applicable EPSDT Referral Code (NU, AV, S2, ST).
  - Use the applicable POS codes, if applicable. POS 99 may be applicable in certain instances.
  - Use the required modifier(s).
    - Modifier EP for all preventive health visits (modifiers 90 or 91 may be applicable as well)
    - Modifier HA for catch-up visits
    - Modifier 25:
      - when a vaccine is administered during the preventive visit or
      - to indicate that a significant, separately identifiable E&M service was provided on the same day as the preventive health visit

- Follow the *AAP Bright Futures Recommendations Periodicity Schedule* of preventive pediatric healthcare for well-child visits:
    - Appropriate screenings may be an important part of these visits as well. Screenings that may be required:
        - Blood Lead Screenings (LSC Measure)
        - Developmental Screenings and referrals, if required (DEV Measure)
        - Depression screenings with a documented follow-up plan, as identified (CDF Measure)
        - Chlamydia Screenings (CHL Measure)
    - Appropriate immunizations are an important part of these visits. Administer immunizations in accordance with the ACIP. Utilize the Georgia Registry of Immunization Transactions & Services (GRITS) database to document administered vaccines.
    - EPSDT services require a dental/oral health assessment.
    - Height, weight, BMI **percentile**, and counseling for nutrition and physical activity should be completed at least once per year as part of a well visit; however, these services may be completed during a visit other than a well-child visit (for example, sick visit). Services specific to an acute or chronic condition do not count for counseling for nutrition or physical activity. For patients under 20 on the date of service, document their BMI percentile. For patients 20 and older, document their BMI value.
- Consider incorporating appropriate nutritional and weight management questioning and counseling into your routine clinical practice.
    - When counseling for nutrition, be sure to document face-to-face discussion of current nutritional behavior, like appetite or meal patterns, eating and dieting habits, any counseling or referral to nutrition education, any nutritional educational materials that were provided during the visit, anticipatory guidance for nutrition, eating disorders, nutritional deficiencies, and underweight, obesity, or overweight discussion.
    - When counseling for physical activity, document face-to-face discussion of current physical activity behaviors, like exercise routines, participation in sports activities or bike riding, referrals to physical activity, educational material that was provided, anticipatory guidance on physical activity, and obesity or overweight discussion. Recommendations and counseling for physical activity should include discussion of more than topics related solely to sports or safety.
- Sick visits and sports physicals may be missed opportunities to complete a well visit and may count for a well-visit if the appropriate documentation is included.
- EPSDT preventive health screenings are exempt from third-party liability. Even if the member has other health insurance, you may file Medicaid first for preventive health services. This will ensure accurate and timely reporting of EPSDT services.
- Medical records to supplement HEDIS data can be sent to the HEDIS team via secure inbox at **ga1hphedis@amerigroup.com** or secure fax at **888-220-6712**.
- If utilizing an electronic medical record (EMR) system:
    - Consider creating a flag to track patients who are due or past due for preventive services. If you do not use an EMR, consider creating a manual tracking method.
    - Consider reviewing your EMR or assessment forms to check for fields that document BMI percentile
    - check to see if the system has the ability to auto calculate the BMI percentile once height and weight are entered

- Consider electronic data sharing with your health plan to capture supplemental data (*additional clinical information about a member that may not have been submitted on a claim*).

How can we help?

- Offering current *Clinical Practice Guidelines* on our provider self-service website
- Providing individualized reports of your patients that are due or overdue for services
- Assisting with scheduling appointments for our members, if needed
- Encouraging preventive care through our CHIP Rewards program
- Providing education to members on the importance of well-visits through various sources, such as phone calls, text messages, newsletters, and/or health education materials
- Offering nonemergency transportation to appointments for our members

Contact your Provider Relationship Management representative for additional details and questions.

Other resources

You can find more information and tools online:

- BMI Percentile Calculator for Child and Teen — **https://www.cdc.gov/healthyweight/bmi/calculator.html**
- Bright Futures Tools — **https://brightfutures.aap.org/materials-and-tools**
- Printable growth charts:
  - Girls — **https://www.cdc.gov/growthcharts/data/set2clinical/cj41l074.pdf**
  - Boys — **https://www.cdc.gov/growthcharts/data/set1clinical/cj41l023.pdf**
- VFC program — **https://dph.georgia.gov/vaccines-children-program**

Notes

Well-Care Visits for Children and Adolescents (W30, WCV)

These HEDIS measures look at members who had the recommended number of well visits. Rates are reported for the following measures:

- **Well-Child Visits in the First 30 Months of Life (W30):**
  - **0 to 14 months** - Six or more well-child visits with a PCP on or before turning 15 months old. Visits must be at least two weeks apart.
  - **15 to 30 months -** Two or more well-child visits with a PCP between 15 months and 30 months old. Visits must be at least two weeks apart.
- **Child and Adolescent Well-Care Visits (WCV):**
  - Members 3 to 21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN during the current year

Record your efforts

Make sure that your medical record documentation for each visit reflects all the following:

- Date of the visit(s)
- A health history
- A physical and mental development history
- A physical exam
- Height, weight, and BMI **percentile**
- Any immunizations administered
- Health education and anticipatory guidance as well as any:
  - Counseling for nutrition
  - Counseling for physical activity
- Applicable screenings with results - Lead, Developmental, Depression, STI, etc.

Code your services correctly

Proper coding is critical to ensure accurate reporting of these measures, and it may also decrease the need for medical record reviews. Use the following codes to document comprehensive well-care visits:

Description	CPT	ICD-10-CM	HCPCS
Well-care visit (*W30, WCV*)	99381-99385, 99391-99395, 99461	Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.2, Z00.3, Z01.411, Z01.419, Z02.5, Z76.1, Z76.2	G0438, G0439, S0302, S0610, S0612, S0613

Best practices and helpful tips:

- When billing office visits for preventive health services, providers must:
  - Include the appropriate diagnosis code on the claim.
  - Include the applicable EPSDT Referral Code (NU, AV, S2, ST).
  - Use the applicable POS codes, if applicable. POS 99 may be applicable in certain instances.
  - Use the required modifier(s), when applicable:
    - Modifier EP for all preventive health visits (modifiers 90 or 91 may be applicable as well)
    - Modifier HA for catch-up visits
    - Modifier 25:
      - When a vaccine is administered during the preventive visit or

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        - To indicate that a significant, separately identifiable E&M service was provided on the same day as the preventive health visit
- Follow the *AAP Bright Futures Recommendations Periodicity Schedule* of preventive pediatric healthcare for well-child visits:
    - If Bright Futures guidelines are followed, members should have at least eight visits prior to turning 15 months old. All visits must occur on or before the child turns 15 months old. Consider scheduling the 15th month visit around 14 months of age.
    - Appropriate screenings may be an important part of these visits as well. Screenings that may be required:
        - Blood Lead Screenings (LSC Measure)
        - Developmental Screenings and referrals, if required (DEV Measure)
        - Depression screenings with a documented follow-up plan, as identified (CDF Measure)
        - Chlamydia Screenings (CHL Measure)
    - Appropriate immunizations (CIS and IMA Measures) may also be an important part of these visits. Administer immunizations in accordance with the ACIP. Utilize the Georgia Registry of Immunization Transactions & Services (GRITS) database to document administered vaccines.
    - EPSDT services require a dental/oral health assessment. Remember that members have a primary care dental (PCD) provider listed on their ID cards.
    - Height, weight, BMI **percentile**, and counseling for nutrition and physical activity should be completed at least once per year as part of a well visit; however, these services may be completed during a visit other than a well-child visit (for example, sick visit). Services specific to an acute or chronic condition do not count for counseling for nutrition or physical activity. For patients under 20 on the date of service, document their BMI percentile. For patients 20 and older, document their BMI value.
- It is recommended that all Health Check providers enroll in the Vaccines For Children (VFC) program to provide immunizations to Medicaid eligible children whose ages are birth through eighteen (18) years of age.
- Use your member roster to contact patients who are due for their annual well visit or are new to your practice. Appointment reminders by text, email, postcard, or phone call work well for most parents and guardians.
- Consider offering evening, early morning and/or weekend office hours to accommodate working parents and guardians.
- Sick visits and sports physicals may be missed opportunities to complete a well visit and may count for a well-visit if the appropriate documentation is included.
- **EPSDT preventive health screenings are exempt from third-party liability. Even if the member has other health insurance, you may file Medicaid first for preventive health services. This will ensure accurate and timely reporting of EPSDT services.**
- If utilizing an electronic medical record (EMR) system, consider:
    - Creating a flag to track patients who are due or past due for preventive services. If you do not use an EMR, consider creating a manual tracking method.
    - Electronic data sharing with your health plan to capture supplemental data (*Additional clinical information about a member that may not have been submitted on a claim*).

How can we help?

- Providing individualized reports of your patients that are due or overdue for services
- Assisting with scheduling appointments for our members, if needed
- Offering nonemergency transportation to appointments for our members

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- Providing education to members on the importance of well-visits through various sources, such as phone calls, text messages, newsletters, and/or health education materials
- Encouraging preventive care through our CHIP Rewards program

Contact your Provider Relationship Management representative for additional details and questions.

Other resources

You can find more information and tools online:

- *ACIP Immunization Schedule* — **https://www.cdc.gov/vaccines/schedules/hcp/index.html**
- Bright Futures Tools — **https://brightfutures.aap.org/materials-and-tools/Pages/default.aspx**
- Georgia Registry of Immunization Transactions & Services — **https://www.grits.state.ga.us/production/security_ui.showLogin**
- Printable growth charts:
    - Girls — **https://www.cdc.gov/growthcharts/data/set2clinical/cj41l074.pdf**
    - Boys — **https://www.cdc.gov/growthcharts/data/set1clinical/cj41l023.pdf**
- VFC program — **https://dph.georgia.gov/vaccines-children-program**

Notes

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Resources

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Bright Futures Guidelines

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

Recommendations for Preventive Pediatric Health Care

Bright Futures/American Academy of Pediatrics

Bright Futures
prevention and health promotion for infants, children, adolescents, and their families[14]

Each child and family is unique; therefore, these Recommendations for Preventive Pediatric Health Care are designed for the care of children who are receiving nurturing parenting, have no manifestations of any important health problems, and are growing and developing in a satisfactory fashion. Developmental, psychosocial, and chronic disease issues for children and adolescents may require more frequent counseling and treatment visits separate from preventive care visits. Additional visits also may become necessary if circumstances suggest concerns.

These recommendations represent a consensus by the American Academy of Pediatrics (AAP) and Bright Futures. The AAP continues to emphasize the great importance of continuity of care in comprehensive health supervision and the need to avoid fragmentation of care.

Refer to the specific guidance by age as listed in the *Bright Futures Guidelines* (Hagan JF, Shaw JS, Duncan PM, eds. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*. 4th ed. American Academy of Pediatrics; 2017).

The recommendations in this statement do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

The Bright Futures/American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care are updated annually.

	INFANCY								EARLY CHILDHOOD							MIDDLE CHILDHOOD						ADOLESCENCE										
AGE[1]	Prenatal[2]	Newborn[3]	3-5 d[4]	By 1 mo	2 mo	4 mo	6 mo	9 mo	12 mo	15 mo	18 mo	24 mo	30 mo	3 y	4 y	5 y	6 y	7 y	8 y	9 y	10 y	11 y	12 y	13 y	14 y	15 y	16 y	17 y	18 y	19 y	20 y	21 y
HISTORY Initial/Interval	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
MEASUREMENTS																																
Length/Height and Weight		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Head Circumference		●	●	●	●	●	●	●	●	●	●	●																				
Weight for Length		●	●	●	●	●	●	●	●	●	●																					
Body Mass Index[5]												●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Blood Pressure[6]		★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
SENSORY SCREENING																																
Vision[7]		★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	●	★	●	★	●	★	●	★	★	●	★	★	★	★	★	★
Hearing		●[8]	●[9]	◄——►	★	★	★	★	★	★	★	★	★	★	●	●	●	★	●	★	●	◄——	——	●[10]	——►	◄——	●	——►	◄——	——	●	——►
DEVELOPMENTAL/SOCIAL/BEHAVIORAL/MENTAL HEALTH																																
Maternal Depression Screening[11]				●	●	●	●																									
Developmental Screening[12]								●			●		●																			
Autism Spectrum Disorder Screening[13]											●	●																				
Developmental Surveillance		●	●	●	●	●	●		●	●		●		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Behavioral/Social/Emotional Screening[14]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Tobacco, Alcohol, or Drug Use Assessment[15]																						★	★	★	★	★	★	★	★	★	★	★
Depression and Suicide Risk Screening[16]																							●	●	●	●	●	●	●	●	●	●
PHYSICAL EXAMINATION[17]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
PROCEDURES[18]																																
Newborn Blood		●[19]	●[20]	——►																												
Newborn Bilirubin[21]		●																														
Critical Congenital Heart Defect[22]		●																														
Immunization[23]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Anemia[24]						★			●	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Lead[25]							★	★	● or ★[26]		★	● or ★[26]		★	★	★	★															
Tuberculosis[27]				★			★		★			★		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Dyslipidemia[28]												★			★		★		★	◄——	—►●	★	★	★	★	★	◄——	——	——	●—►		
Sexually Transmitted Infections[29]																						★	★	★	★	★	★	★	★	★	★	★
HIV[30]																						★	★	★	★	◄——	——	●—►	★	★	★	★
Hepatitis B Virus Infection[31]		★	——►																													►
Hepatitis C Virus Infection[32]																													●	——►		
Sudden Cardiac Arrest/Death[33]																						★	——►									►
Cervical Dysplasia[34]																																●
ORAL HEALTH[35]							●[36]	●[36]	★			★	★	★	★	★	★															
Fluoride Varnish[37]							◄——	——	——	——	●	——	——	——	——	►——	——	——	——	——	——	——	——	——	——	——	——	——	——	——	——	——
Fluoride Supplementation[38]							★	★	★		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★					
ANTICIPATORY GUIDANCE	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●

1. If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time.
2. A prenatal visit is recommended for parents who are at high risk, for first-time parents, and for those who request a conference. The prenatal visit should include anticipatory guidance, pertinent medical history, and a discussion of benefits of breastfeeding and planned method of feeding, per "The Prenatal Visit" (https://doi.org/10.1542/peds.2018-1218).
3. Newborns should have an evaluation after birth, and breastfeeding should be encouraged (and instruction and support should be offered).
4. Newborns should have an evaluation within 3 to 5 days of birth and within 48 to 72 hours after discharge from the hospital to include evaluation for feeding and jaundice. Breastfeeding newborns should receive formal breastfeeding evaluation, and their mothers should receive encouragement and instruction, as recommended in "Breastfeeding and the Use of Human Milk" (https://doi.org/10.1542/peds.2011-3552). Newborns discharged less than 48 hours after delivery must be examined within 48 hours of discharge, per "Hospital Stay for Healthy Term Newborn Infants" (https://doi.org/10.1542/peds.2015-0699).
5. Screen, per "Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity: Summary Report" (https://doi.org/10.1542/peds.2007-2329C).
6. Screening should occur per "Clinical Practice Guideline for Screening and Management of High Blood Pressure in Children and Adolescents" (https://doi.org/10.1542/peds.2017-1904). Blood pressure measurement in infants and children with specific risk conditions should be performed at visits before age 3 years.
7. A visual acuity screen is recommended at ages 4 and 5 years, as well as in cooperative 3-year-olds. Instrument-based screening may be used to assess risk at ages 12 and 24 months, in addition to the well visits at 3 through 5 years of age. See "Visual System Assessment in Infants, Children, and Young Adults by Pediatricians" (https://doi.org/10.1542/peds.2015-3596) and "Procedures for the Evaluation of the Visual System by Pediatricians" (https://doi.org/10.1542/peds.2015-3597).
8. Confirm initial screen was completed, verify results, and follow up, as appropriate. Newborns should be screened, per "Year 2007 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs" (https://doi.org/10.1542/peds.2007-2333).
9. Verify results as soon as possible, and follow up, as appropriate.
10. Screen with audiometry including 6,000 and 8,000 Hz high frequencies once between 11 and 14 years, once between 15 and 17 years, and once between 18 and 21 years. See "The Sensitivity of Adolescent Hearing Screens Significantly Improves by Adding High Frequencies" (https://www.sciencedirect.com/science/article/abs/pii/S1054139X16000483).
11. Screening should occur per "Incorporating Recognition and Management of Perinatal Depression Into Pediatric Practice" (https://doi.org/10.1542/peds.2018-3259).
12. Screening should occur per "Promoting Optimal Development: Identifying Infants and Young Children With Developmental Disorders Through Developmental Surveillance and Screening" (https://doi.org/10.1542/peds.2019-3449).
13. Screening should occur per "Identification, Evaluation, and Management of Children With Autism Spectrum Disorder" (https://doi.org/10.1542/peds.2019-3447).

(continued)

KEY: ● = to be performed ★ = risk assessment to be performed with appropriate action to follow, if positive ◄—— ★ or ● ——► = range during which a service may be provided

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(continued)

14. Screen for behavioral and social-emotional problems per "Promoting Optimal Development: Screening for Behavioral and Emotional Problems" (https://doi.org/10.1542/peds.2014-3716), "Mental Health Competencies for Pediatric Practice" (https://doi.org/10.1542/peds.2019-2757), "Clinical Practice Guideline for the Assessment and Treatment of Children and Adolescents With Anxiety Disorders" (https://pubmed.ncbi.nlm.nih.gov/32439401), and "Screening for Anxiety in Adolescent and Adult Women: A Recommendation From the Women's Preventive Services Initiative" (https://pubmed.ncbi.nlm.nih.gov/32510990). The screening should be family centered and may include asking about caregiver emotional and mental health concerns and social determinants of health, racism, poverty, and relational health. See "Poverty and Child Health in the United States" (https://doi.org/10.1542/peds.2016-0339), "The Impact of Racism on Child and Adolescent Health" (https://doi.org/10.1542/peds.2019-1765), and "Preventing Childhood Toxic Stress: Partnering With Families and Communities to Promote Relational Health" (https://doi.org/10.1542/peds.2021-052582).
15. A recommended assessment tool is available at http://crafft.org.
16. Screen adolescents for depression and suicide risk, making every effort to preserve confidentiality of the adolescent. See "Guidelines for Adolescent Depression in Primary Care (GLAD-PC): Part I. Practice Preparation, Identification, Assessment, and Initial Management" (https://doi.org/10.1542/peds.2017-4081), "Mental Health Competencies for Pediatric Practice" (https://doi.org/10.1542/peds.2019-2757), "Suicide and Suicide Attempts in Adolescents" (https://doi.org/10.1542/peds.2016-1420), and "The 21st Century Cures Act & Adolescent Confidentiality" (https://www.adolescenthealth.org/Advocacy/Advocacy-Activities/2019-(1)/NASPAG-SAHM-Statement.aspx).
17. At each visit, age-appropriate physical examination is essential, with infant totally unclothed and older children undressed and suitably draped. See "Use of Chaperones During the Physical Examination of the Pediatric Patient" (https://doi.org/10.1542/peds.2011-0322).
18. These may be modified, depending on entry point into schedule and individual need.
19. Confirm initial screen was accomplished, verify results, and follow up, as appropriate. The Recommended Uniform Screening Panel (https://www.hrsa.gov/advisory-committees/heritable-disorders/rusp/index.html), as determined by The Secretary's Advisory Committee on Heritable Disorders in Newborns and Children, and state newborn screening laws/regulations (https://www.babysfirsttest.org/) establish the criteria for and coverage of newborn screening procedures and programs.
20. Verify results as soon as possible, and follow up, as appropriate.
21. Confirm initial screening was accomplished, verify results, and follow up, as appropriate. See "Hyperbilirubinemia in the Newborn Infant ≥35 Weeks' Gestation: An Update With Clarifications" (https://doi.org/10.1542/peds.2009-0329).
22. Screening for critical congenital heart disease using pulse oximetry should be performed in newborns, after 24 hours of age, before discharge from the hospital, per "Endorsement of Health and Human Services Recommendation for Pulse Oximetry Screening for Critical Congenital Heart Disease" (https://doi.org/10.1542/peds.2011-3211).
23. Schedules, per the AAP Committee on Infectious Diseases, are available at https://publications.aap.org/redbook/pages/immunization-schedules. Every visit should be an opportunity to update and complete a child's immunizations.
24. Perform risk assessment or screening, as appropriate, per recommendations in the current edition of the AAP *Pediatric Nutrition: Policy of the American Academy of Pediatrics* (Iron chapter).
25. For children at risk of lead exposure, see "Prevention of Childhood Lead Toxicity" (https://doi.org/10.1542/peds.2016-1493) and "Low Level Lead Exposure Harms Children: A Renewed Call for Primary Prevention" (https://www.cdc.gov/nceh/lead/docs/final_document_030712.pdf).
26. Perform risk assessments or screenings as appropriate, based on universal screening requirements for patients with Medicaid or in high prevalence areas.
27. Tuberculosis testing per recommendations of the AAP Committee on Infectious Diseases, published in the current edition of the AAP *Red Book: Report of the Committee on Infectious Diseases*. Testing should be performed on recognition of high-risk factors.
28. See "Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents" (http://www.nhlbi.nih.gov/guidelines/cvd_ped/index.htm).
29. Adolescents should be screened for sexually transmitted infections (STIs) per recommendations in the current edition of the AAP *Red Book: Report of the Committee on Infectious Diseases*.
30. Adolescents should be screened for HIV according to the US Preventive Services Task Force (USPSTF) recommendations (https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/human-immunodeficiency-virus-hiv-infection-screening) once between the ages of 15 and 18, making every effort to preserve confidentiality of the adolescent. Those at increased risk of HIV infection, including those who are sexually active, participate in injection drug use, or are being tested for other STIs, should be tested for HIV and reassessed annually.
31. Perform a risk assessment for hepatitis B virus (HBV) infection according to recommendations per the USPSTF (https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/hepatitis-b-virus-infection-screening) and in the 2021–2024 edition of the AAP *Red Book: Report of the Committee on Infectious Diseases*, making every effort to preserve confidentiality of the patient.
32. All individuals should be screened for hepatitis C virus (HCV) infection according to the USPSTF (https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/hepatitis-c-screening) and Centers for Disease Control and Prevention (CDC) recommendations (https://www.cdc.gov/mmwr/volumes/69/rr/rr6902a1.htm) at least once between the ages of 18 and 79. Those at increased risk of HCV infection, including those who are persons with past or current injection drug use, should be tested for HCV infection and reassessed annually.
33. Perform a risk assessment, as appropriate, per "Sudden Death in the Young: Information for the Primary Care Provider" (https://doi.org/10.1542/peds.2021-052044).
34. See USPSTF recommendations (https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/cervical-cancer-screening). Indications for pelvic examinations prior to age 21 are noted in "Gynecologic Examination for Adolescents in the Pediatric Office Setting" (https://doi.org/10.1542/peds.2010-1564).
35. Assess whether the child has a dental home. If no dental home is identified, perform a risk assessment (https://www.aap.org/en/patient-care/oral-health/oral-health-practice-tools/) and refer to a dental home. Recommend brushing with fluoride toothpaste in the proper dosage for age. See "Maintaining and Improving the Oral Health of Young Children" (https://doi.org/10.1542/peds.2014-2984).
36. Perform a risk assessment (https://www.aap.org/en/patient-care/oral-health/oral-health-practice-tools/). See "Maintaining and Improving the Oral Health of Young Children" (https://doi.org/10.1542/peds.2014-2984).
37. The USPSTF recommends that primary care clinicians apply fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption (https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/prevention-of-dental-caries-in-children-younger-than-age-5-years-screening-and-interventions1). Once teeth are present, apply fluoride varnish to all children every 3 to 6 months in the primary care or dental office based on caries risk. Indications for fluoride use are noted in "Fluoride Use in Caries Prevention in the Primary Care Setting" (https://doi.org/10.1542/peds.2020-034637).
38. If primary water source is deficient in fluoride, consider oral fluoride supplementation. See "Fluoride Use in Caries Prevention in the Primary Care Setting" (https://doi.org/10.1542/peds.2020-034637).

Summary of Changes Made to the Bright Futures/AAP Recommendations for Preventive Pediatric Health Care (Periodicity Schedule)

This schedule reflects changes approved in November 2021 and published in July 2022. For updates and a list of previous changes made, visit www.aap.org/periodicityschedule.

CHANGES MADE IN NOVEMBER 2021

HEPATITIS B VIRUS INFECTION

Assessing risk for HBV infection has been added to occur from newborn to 21 years (to account for the range in which the risk assessment can take place) to be consistent with recommendations of the USPSTF and the 2021–2024 edition of the AAP *Red Book: Report of the Committee on Infectious Diseases*.

- Footnote 31 has been added to read as follows: "Perform a risk assessment for hepatitis B virus (HBV) infection according to recommendations per the USPSTF (https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/hepatitis-b-virus-infection-screening) and in the 2021–2024 edition of the AAP *Red Book: Report of the Committee on Infectious Diseases*, making every effort to preserve confidentiality of the patient."

SUDDEN CARDIAC ARREST AND SUDDEN CARDIAC DEATH

Assessing risk for sudden cardiac arrest and sudden cardiac death has been added to occur from 11 to 21 years (to account for the range in which the risk assessment can take place) to be consistent with AAP policy ("Sudden Death in the Young: Information for the Primary Care Provider").

- Footnote 33 has been added to read as follows: "Perform a risk assessment, as appropriate, per 'Sudden Death in the Young: Information for the Primary Care Provider' (https://doi.org/10.1542/peds.2021-052044)."

DEPRESSION AND SUICIDE RISK

Screening for suicide risk has been added to the existing depression screening recommendation to be consistent with the GLAD-PC and AAP policy.

- Footnote 16 has been updated to read as follows: "Screen adolescents for depression and suicide risk, making every effort to preserve confidentiality of the adolescent. See 'Guidelines for Adolescent Depression in Primary Care (GLAD-PC): Part I. Practice Preparation, Identification, Assessment, and Initial Management' (https://doi.org/10.1542/peds.2017-4081), 'Mental Health Competencies for Pediatric Practice' (https://doi.org/10.1542/peds.2019-2757), 'Suicide and Suicide Attempts in Adolescents' (https://doi.org/10.1542/peds.2016-1420), and 'The 21st Century Cures Act & Adolescent Confidentiality' (https://www.adolescenthealth.org/Advocacy/Advocacy-Activities/2019-(1)/NASPAG-SAHM-Statement.aspx)."

BEHAVIORAL/SOCIAL/EMOTIONAL

The Psychosocial/Behavioral Assessment recommendation has been updated to Behavioral/Social/Emotional Screening (annually from newborn to 21 years) to align with AAP policy, the American College of Obstetricians and Gynecologists (Women's Preventive Services Initiative) recommendations, and the American Academy of Child & Adolescent Psychiatry guidelines.

- Footnote 14 has been updated to read as follows: "Screen for behavioral and social-emotional problems per 'Promoting Optimal Development: Screening for Behavioral and Emotional Problems' (https://doi.org/10.1542/peds.2014-3716), 'Mental Health Competencies for Pediatric Practice' (https://doi.org/10.1542/peds.2019-2757), 'Clinical Practice Guideline for the Assessment and Treatment of Children and Adolescents With Anxiety Disorders' (https://pubmed.ncbi.nlm.nih.gov/32439401), and 'Screening for Anxiety in Adolescent and Adult Women: A Recommendation From the Women's Preventive Services Initiative' (https://pubmed.ncbi.nlm.nih.gov/32510990/). The screening should be family centered and may include asking about caregiver emotional and mental health concerns and social determinants of health, racism, poverty, and relational health. See 'Poverty and Child Health in the United States' (https://doi.org/10.1542/peds.2016-0339), 'The Impact of Racism on Child and Adolescent Health' (https://doi.org/10.1542/peds.2019-1765), and 'Preventing Childhood Toxic Stress: Partnering With Families and Communities to Promote Relational Health' (https://doi.org/10.1542/peds.2021-052582)."

FLUORIDE VARNISH

- Footnote 37 has been updated to read as follows: "The USPSTF recommends that primary care clinicians apply fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption (https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/prevention-of-dental-caries-in-children-younger-than-age-5-years-screening-and-interventions1). Once teeth are present, apply fluoride varnish to all children every 3 to 6 months in the primary care or dental office based on caries risk. Indications for fluoride use are noted in 'Fluoride Use in Caries Prevention in the Primary Care Setting' (https://doi.org/10.1542/peds.2020-034637)."

FLUORIDE SUPPLEMENTATION

- Footnote 38 has been updated to read as follows: "If primary water source is deficient in fluoride, consider oral fluoride supplementation. See 'Fluoride Use in Caries Prevention in the Primary Care Setting' (https://doi.org/10.1542/peds.2020-034637)."

CHANGES MADE IN NOVEMBER 2020

DEVELOPMENTAL

- Footnote 12 has been updated to read as follows: "Screening should occur per 'Promoting Optimal Development: Identifying Infant and Young Children With Developmental Disorders Through Developmental Surveillance and Screening' (https://doi.org/10.1542/peds.2019-3449)."

AUTISM SPECTRUM DISORDER

- Footnote 13 has been updated to read as follows: "Screening should occur per 'Identification, Evaluation, and Management of Children With Autism Spectrum Disorder' (https://doi.org/10.1542/peds.2019-3447)."

HEPATITIS C VIRUS INFECTION

- Screening for HCV infection has been added to occur at least once between the ages of 18 and 79 years (to be consistent with recommendations of the USPSTF and CDC).
- Footnote 32 has been added to read as follows: "All individuals should be screened for hepatitis C virus (HCV) infection according to the USPSTF (https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/hepatitis-c-screening) and Centers for Disease Control and Prevention (CDC) recommendations (https://www.cdc.gov/mmwr/volumes/69/rr/rr6902a1.htm) at least once between the ages of 18 and 79. Those at increased risk of HCV infection, including those who are persons with past or current injection drug use, should be tested for HCV infection and reassessed annually."

HRSA
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CDC Immunization Schedule

Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger

UNITED STATES 2022

Vaccines in the Child and Adolescent Immunization Schedule*

Vaccine	Abbreviation(s)	Trade name(s)
Dengue vaccine	**DEN4CYD**	Dengvaxia®
Diphtheria, tetanus, and acellular pertussis vaccine	**DTaP**	Daptacel® Infanrix®
Diphtheria, tetanus vaccine	**DT**	No trade name
Haemophilus influenzae type b vaccine	**Hib (PRP-T)** **Hib (PRP-OMP)**	ActHIB® Hiberix® PedvaxHIB®
Hepatitis A vaccine	**HepA**	Havrix® Vaqta®
Hepatitis B vaccine	**HepB**	Engerix-B® Recombivax HB®
Human papillomavirus vaccine	**HPV**	Gardasil 9®
Influenza vaccine (inactivated)	**IIV4**	Multiple
Influenza vaccine (live, attenuated)	**LAIV4**	FluMist® Quadrivalent
Measles, mumps, and rubella vaccine	**MMR**	M-M-R II®
Meningococcal serogroups A, C, W, Y vaccine	**MenACWY-D**	Menactra®
	MenACWY-CRM	Menveo®
	MenACWY-TT	MenQuadfi®
Meningococcal serogroup B vaccine	**MenB-4C**	Bexsero®
	MenB-FHbp	Trumenba®
Pneumococcal 13-valent conjugate vaccine	**PCV13**	Prevnar 13®
Pneumococcal 23-valent polysaccharide vaccine	**PPSV23**	Pneumovax 23®
Poliovirus vaccine (inactivated)	**IPV**	IPOL®
Rotavirus vaccine	**RV1** **RV5**	Rotarix® RotaTeq®
Tetanus, diphtheria, and acellular pertussis vaccine	**Tdap**	Adacel® Boostrix®
Tetanus and diphtheria vaccine	**Td**	Tenivac® Tdvax™
Varicella vaccine	**VAR**	Varivax®
Combination vaccines *(use combination vaccines instead of separate injections when appropriate)*		
DTaP, hepatitis B, and inactivated poliovirus vaccine	**DTaP-HepB-IPV**	Pediarix®
DTaP, inactivated poliovirus, and *Haemophilus influenzae* type b vaccine	**DTaP-IPV/Hib**	Pentacel®
DTaP and inactivated poliovirus vaccine	**DTaP-IPV**	Kinrix® Quadracel®
DTaP, inactivated poliovirus, *Haemophilus influenzae* type b, and hepatitis B vaccine	**DTaP-IPV-Hib-HepB**	Vaxelis®
Measles, mumps, rubella, and varicella vaccine	**MMRV**	ProQuad®

*Administer recommended vaccines if immunization history is incomplete or unknown. Do not restart or add doses to vaccine series for extended intervals between doses. When a vaccine is not administered at the recommended age, administer at a subsequent visit. The use of trade names is for identification purposes only and does not imply endorsement by the ACIP or CDC.

How to use the child and adolescent immunization schedule

1. Determine recommended vaccine by age **(Table 1)**
2. Determine recommended interval for catch-up vaccination **(Table 2)**
3. Assess need for additional recommended vaccines by medical condition or other indication **(Table 3)**
4. Review vaccine types, frequencies, intervals, and considerations for special situations **(Notes)**
5. Review contraindications and precautions for vaccine types **(Appendix)**

Recommended by the Advisory Committee on Immunization Practices (www.cdc.gov/vaccines/acip) and approved by the Centers for Disease Control and Prevention (www.cdc.gov), American Academy of Pediatrics (www.aap.org), American Academy of Family Physicians (www.aafp.org), American College of Obstetricians and Gynecologists (www.acog.org), American College of Nurse-Midwives (www.midwife.org), American Academy of Physician Associates (www.aapa.org), and National Association of Pediatric Nurse Practitioners (www.napnap.org).

Report

- Suspected cases of reportable vaccine-preventable diseases or outbreaks to your state or local health department
- Clinically significant adverse events to the Vaccine Adverse Event Reporting System (VAERS) at www.vaers.hhs.gov or 800-822-7967

Questions or comments

Contact www.cdc.gov/cdc-info or 800-CDC-INFO (800-232-4636), in English or Spanish, 8 a.m.–8 p.m. ET, Monday through Friday, excluding holidays

Download the CDC Vaccine Schedules app for providers at www.cdc.gov/vaccines/schedules/hcp/schedule-app.html

Helpful information

- Complete Advisory Committee on Immunization Practices (ACIP) recommendations: www.cdc.gov/vaccines/hcp/acip-recs/index.html
- *General Best Practice Guidelines for Immunization* (including contraindications and precautions): www.cdc.gov/vaccines/hcp/acip-recs/general-recs/index.html
- Vaccine information statements: www.cdc.gov/vaccines/hcp/vis/index.html
- Manual for the Surveillance of Vaccine-Preventable Diseases (including case identification and outbreak response): www.cdc.gov/vaccines/pubs/surv-manual
- ACIP Shared Clinical Decision-Making Recommendations www.cdc.gov/vaccines/acip/acip-scdm-faqs.html

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

Scan QR code for access to online schedule

CS310020-A

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Table 1 Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger, United States, 2022

These recommendations must be read with the notes that follow. For those who fall behind or start late, provide catch-up vaccination at the earliest opportunity as indicated by the green bars.
To determine minimum intervals between doses, see the catch-up schedule (Table 2).

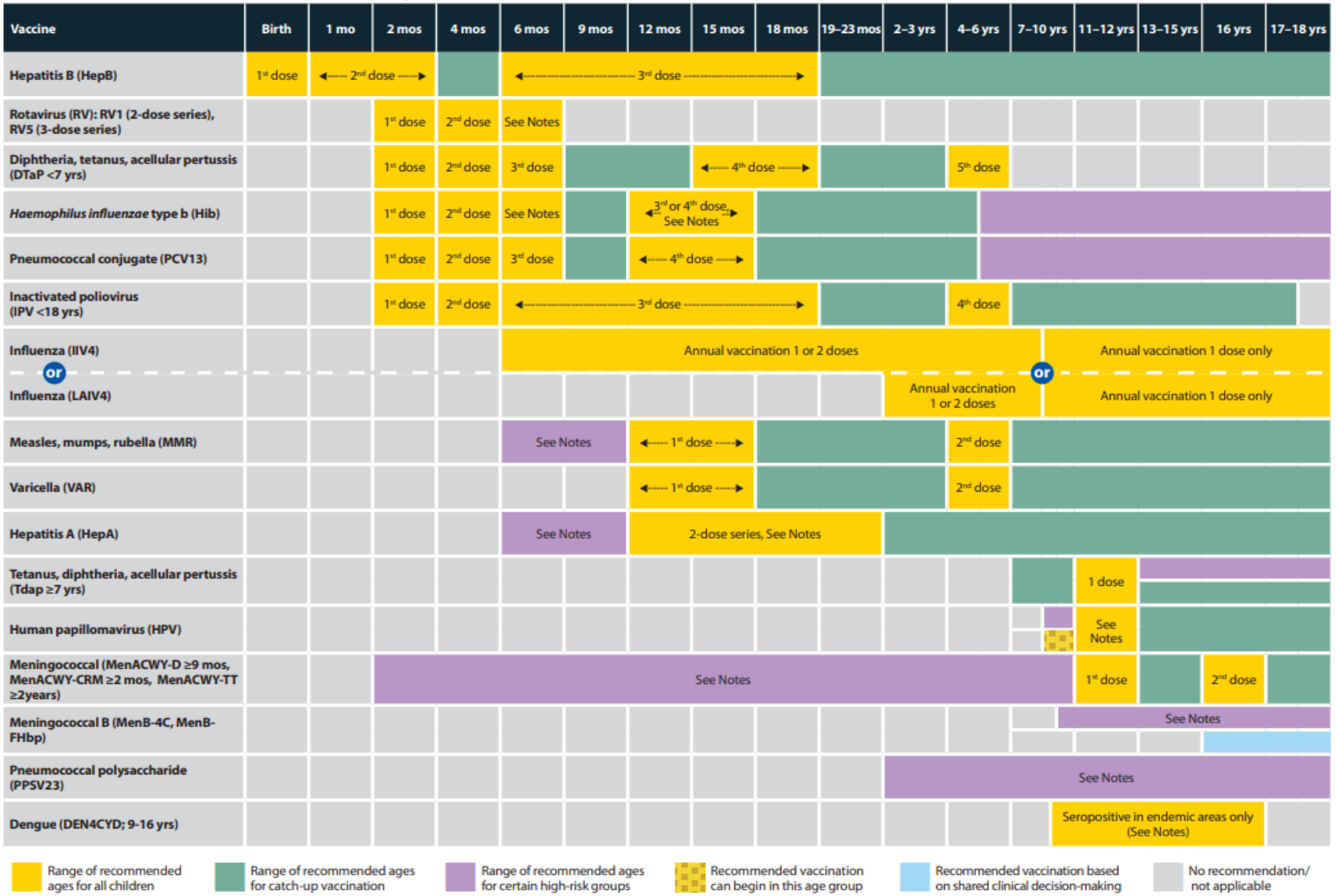

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Table 2 Recommended Catch-up Immunization Schedule for Children and Adolescents Who Start Late or Who Are More than 1 Month Behind, United States, 2022

The table below provides catch-up schedules and minimum intervals between doses for children whose vaccinations have been delayed. A vaccine series does not need to be restarted, regardless of the time that has elapsed between doses. Use the section appropriate for the child's age. **Always use this table in conjunction with Table 1 and the Notes that follow.**

Children age 4 months through 6 years					
Vaccine	**Minimum Age for Dose 1**	**Minimum Interval Between Doses**			
		Dose 1 to Dose 2	**Dose 2 to Dose 3**	**Dose 3 to Dose 4**	**Dose 4 to Dose 5**
Hepatitis B	Birth	**4 weeks**	**8 weeks *and* at least 16 weeks after first dose** minimum age for the final dose is 24 weeks		
Rotavirus	6 weeks Maximum age for first dose is 14 weeks, 6 days.	**4 weeks**	**4 weeks** maximum age for final dose is 8 months, 0 days		
Diphtheria, tetanus, and acellular pertussis	6 weeks	**4 weeks**	**4 weeks**	**6 months**	**6 months**
Haemophilus influenzae type b	6 weeks	**No further doses needed** if first dose was administered at age 15 months or older. **4 weeks** if first dose was administered before the 1st birthday. **8 weeks (as final dose)** if first dose was administered at age 12 through 14 months.	**No further doses needed** if previous dose was administered at age 15 months or older **4 weeks** if current age is younger than 12 months ***and*** first dose was administered at younger than age 7 months ***and*** at least 1 previous dose was PRP-T (ActHib®, Pentacel®, Hiberix®), Vaxelis® or unknown **8 weeks *and* age 12 through 59 months (as final dose)** if current age is younger than 12 months ***and*** first dose was administered at age 7 through 11 months; OR if current age is 12 through 59 months ***and*** first dose was administered before the 1st birthday ***and*** second dose was administered at younger than 15 months; OR if both doses were PedvaxHIB® and were administered before the 1st birthday	**8 weeks (as final dose)** This dose only necessary for children age 12 through 59 months who received 3 doses before the 1st birthday.	
Pneumococcal conjugate	6 weeks	**No further doses needed** for healthy children if first dose was administered at age 24 months or older **4 weeks** if first dose was administered before the 1st birthday **8 weeks (as final dose for healthy children)** if first dose was administered at the 1st birthday or after	**No further doses needed** for healthy children if previous dose was administered at age 24 months or older **4 weeks** if current age is younger than 12 months and previous dose was administered at <7 months old **8 weeks (as final dose for healthy children)** if previous dose was administered between 7–11 months (wait until at least 12 months old); OR if current age is 12 months or older and at least 1 dose was administered before age 12 months	**8 weeks (as final dose)** This dose only necessary for children age 12 through 59 months who received 3 doses before age 12 months or for children at high risk who received 3 doses at any age.	
Inactivated poliovirus	6 weeks	**4 weeks**	**4 weeks** if current age is <4 years **6 months (as final dose)** if current age is 4 years or older	**6 months (minimum age 4 years for final dose)**	
Measles, mumps, rubella	12 months	**4 weeks**			
Varicella	12 months	**3 months**			
Hepatitis A	12 months	**6 months**			
Meningococcal ACWY	2 months MenACWY-CRM 9 months MenACWY-D 2 years MenACWY-TT	**8 weeks**	See Notes	See Notes	
Children and adolescents age 7 through 18 years					
Meningococcal ACWY	Not applicable (N/A)	**8 weeks**			
Tetanus, diphtheria; tetanus, diphtheria, and acellular pertussis	7 years	**4 weeks**	**4 weeks** if first dose of DTaP/DT was administered before the 1st birthday **6 months (as final dose)** if first dose of DTaP/DT or Tdap/Td was administered at or after the 1st birthday	**6 months** if first dose of DTaP/DT was administered before the 1st birthday	
Human papillomavirus	9 years	**Routine dosing intervals are recommended.**			
Hepatitis A	N/A	**6 months**			
Hepatitis B	N/A	**4 weeks**	**8 weeks *and* at least 16 weeks after first dose**		
Inactivated poliovirus	N/A	**4 weeks**	**6 months** A fourth dose is not necessary if the third dose was administered at age 4 years or older and at least 6 months after the previous dose.	A fourth dose of IPV is indicated if all previous doses were administered at <4 years or if the third dose was administered <6 months after the second dose.	
Measles, mumps, rubella	N/A	**4 weeks**			
Varicella	N/A	**3 months** if younger than age 13 years. **4 weeks** if age 13 years or older			
Dengue	9 years	**6 months**	6 months		

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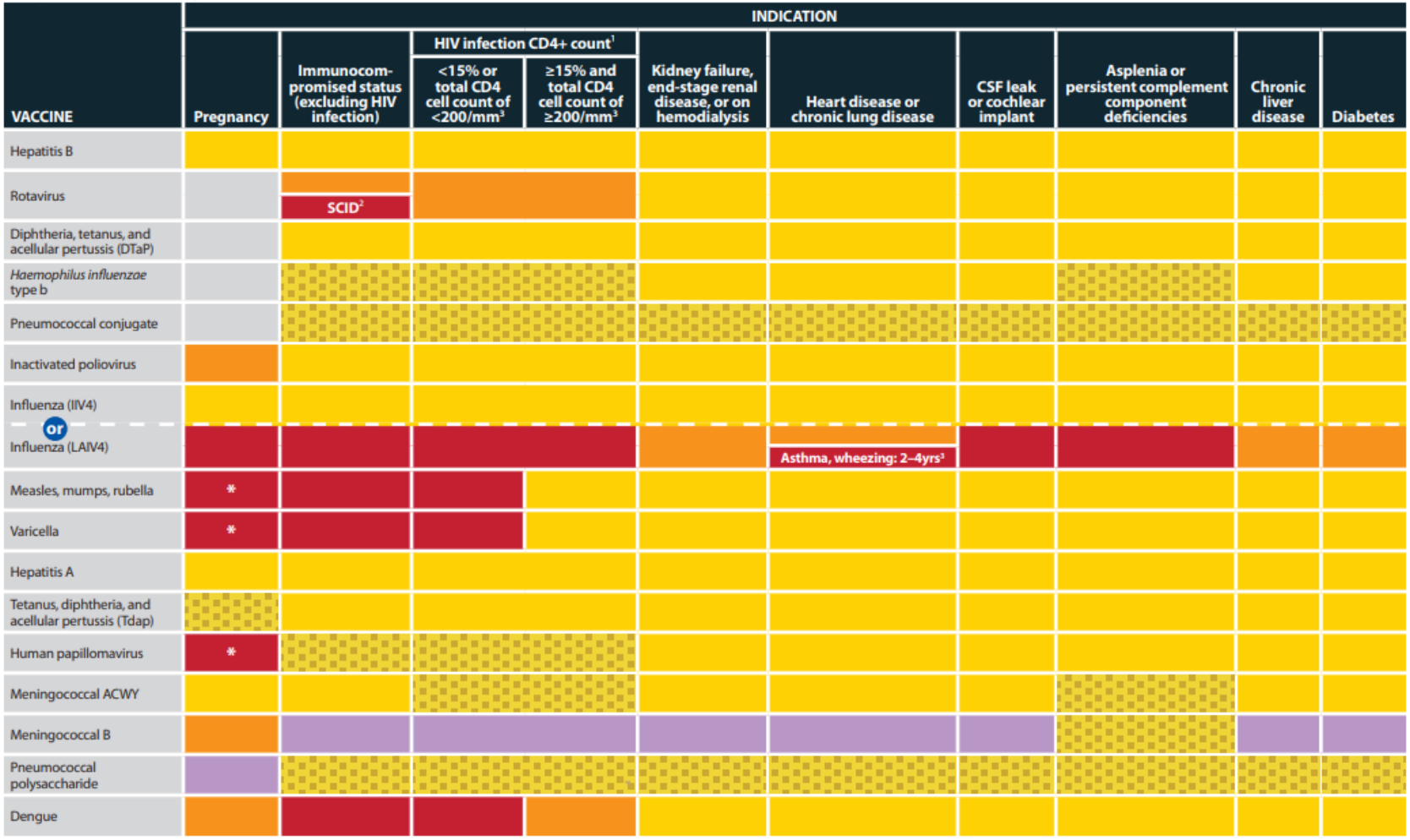
Table 3 Recommended Child and Adolescent Immunization Schedule by Medical Indication, United States, 2022

Always use this table in conjunction with Table 1 and the Notes that follow.



1 For additional information regarding HIV laboratory parameters and use of live vaccines, see the *General Best Practice Guidelines for Immunization*, "Altered Immunocompetence," at www.cdc.gov/vaccines/hcp/acip-recs/general-recs/immunocompetence.html and Table 4-1 (footnote J) at www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html.
2 Severe Combined Immunodeficiency
3 LAIV4 contraindicated for children 2–4 years of age with asthma or wheezing during the preceding 12 months

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Notes — Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger, United States, 2022

For vaccination recommendations for persons ages 19 years or older, see the Recommended Adult Immunization Schedule, 2022.

Additional information

COVID-19 Vaccination

COVID-19 vaccines are recommended for use within the scope of the Emergency Use Authorization or Biologics License Application for the particular vaccine. ACIP recommendations for the use of COVID-19 vaccines can be found at www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/covid-19.html.

CDC's interim clinical considerations for use of COVID-19 vaccines can be found at www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html.

- Consult relevant ACIP statements for detailed recommendations at www.cdc.gov/vaccines/hcp/acip-recs/index.html.
- For calculating intervals between doses, 4 weeks = 28 days. Intervals of ≥4 months are determined by calendar months.
- Within a number range (e.g., 12–18), a dash (–) should be read as "through."
- Vaccine doses administered ≤4 days before the minimum age or interval are considered valid. Doses of any vaccine administered ≥5 days earlier than the minimum age or minimum interval should not be counted as valid and should be repeated as age appropriate. **The repeat dose should be spaced after the invalid dose by the recommended minimum interval.** For further details, see Table 3-1, Recommended and minimum ages and intervals between vaccine doses, in *General Best Practice Guidelines for Immunization* at www.cdc.gov/vaccines/hcp/acip-recs/general-recs/timing.html.
- Information on travel vaccination requirements and recommendations is available at www.cdc.gov/travel/.
- For vaccination of persons with immunodeficiencies, see Table 8-1, Vaccination of persons with primary and secondary immunodeficiencies, in *General Best Practice Guidelines for Immunization* at www.cdc.gov/vaccines/hcp/acip-recs/general-recs/immunocompetence.html, and Immunization in Special Clinical Circumstances (In: Kimberlin DW, Brady MT, Jackson MA, Long SS, eds. *Red Book: 2018 Report of the Committee on Infectious Diseases*. 31st ed. Itasca, IL: American Academy of Pediatrics; 2018:67–111).
- For information about vaccination in the setting of a vaccine-preventable disease outbreak, contact your state or local health department.
- The National Vaccine Injury Compensation Program (VICP) is a no-fault alternative to the traditional legal system for resolving vaccine injury claims. All routine child and adolescent vaccines are covered by VICP except for pneumococcal polysaccharide vaccine (PPSV23). For more information, see www.hrsa.gov/vaccinecompensation/index.html.

Dengue vaccination (minimum age: 9 years)

Routine vaccination

- Age 9–16 years living in dengue endemic areas **AND** have laboratory confirmation of previous dengue infection
  - 3-dose series administered at 0, 6, and 12 months
- Endemic areas include Puerto Rico, American Samoa, US Virgin Islands, Federated States of Micronesia, Republic of Marshall Islands, and the Republic of Palau. For updated guidance on dengue endemic areas and pre-vaccination laboratory testing see www.cdc.gov/mmwr/volumes/70/rr/rr7006a1.htm?s_cid=rr7006a1_w and www.cdc.gov/dengue/vaccine/hcp/index.html

Diphtheria, tetanus, and pertussis (DTaP) vaccination (minimum age: 6 weeks [4 years for Kinrix® or Quadracel®])

Routine vaccination

- 5-dose series at age 2, 4, 6, 15–18 months, 4–6 years
  - **Prospectively:** Dose 4 may be administered as early as age 12 months if at least 6 months have elapsed since dose 3.
  - **Retrospectively:** A 4th dose that was inadvertently administered as early as age 12 months may be counted if at least 4 months have elapsed since dose 3.

Catch-up vaccination

- Dose 5 is not necessary if dose 4 was administered at age 4 years or older and at least 6 months after dose 3.
- For other catch-up guidance, see Table 2.

Special situations

- Wound management in children less than age 7 years with history of 3 or more doses of tetanus-toxoid-containing vaccine: For all wounds except clean and minor wounds, administer DTaP if more than 5 years since last dose of tetanus-toxoid-containing vaccine. For detailed information, see www.cdc.gov/mmwr/volumes/67/rr/rr6702a1.htm.

Haemophilus influenzae type b vaccination (minimum age: 6 weeks)

Routine vaccination

- **ActHIB®, Hiberix®, Pentacel®, or Vaxelis®:** 4-dose series (3 dose primary series at age 2, 4, and 6 months, followed by a booster dose* at age 12–15 months)
  - *Vaxelis® is not recommended for use as a booster dose. A different Hib-containing vaccine should be used for the booster dose.
- **PedvaxHIB®:** 3-dose series (2-dose primary series at age 2 and 4 months, followed by a booster dose at age 12–15 months)

Catch-up vaccination

- **Dose 1 at age 7–11 months:** Administer dose 2 at least 4 weeks later and dose 3 (final dose) at age 12–15 months or 8 weeks after dose 2 (whichever is later).
- **Dose 1 at age 12–14 months:** Administer dose 2 (final dose) at least 8 weeks after dose 1.
- **Dose 1 before age 12 months and dose 2 before age 15 months:** Administer dose 3 (final dose) at least 8 weeks after dose 2.
- **2 doses of PedvaxHIB® before age 12 months:** Administer dose 3 (final dose) at 12–59 months and at least 8 weeks after dose 2.
- **1 dose administered at age 15 months or older:** No further doses needed
- **Unvaccinated at age 15–59 months:** Administer 1 dose.
- **Previously unvaccinated children age 60 months or older who are not considered high risk:** Do not require catch-up vaccination

For other catch-up guidance, see Table 2. Vaxelis® can be used for catch-up vaccination in children less than age 5 years. Follow the catch-up schedule even if Vaxelis® is used for one or more doses. For detailed information on use of Vaxelis® see www.cdc.gov/mmwr/volumes/69/wr/mm6905a5.htm.

Special situations

- **Chemotherapy or radiation treatment:**
  Age 12–59 months
  - Unvaccinated or only 1 dose before age 12 months: 2 doses, 8 weeks apart
  - 2 or more doses before age 12 months: 1 dose at least 8 weeks after previous dose

  Doses administered within 14 days of starting therapy or during therapy should be repeated at least 3 months after therapy completion.
- **Hematopoietic stem cell transplant (HSCT):**
  - 3-dose series 4 weeks apart starting 6 to 12 months after successful transplant, regardless of Hib vaccination history
- **Anatomic or functional asplenia (including sickle cell disease):**
  Age 12–59 months
  - Unvaccinated or only 1 dose before age 12 months: 2 doses, 8 weeks apart
  - 2 or more doses before age 12 months: 1 dose at least 8 weeks after previous dose

  Unvaccinated persons age 5 years or older*
  - 1 dose
- **Elective splenectomy:**
  Unvaccinated persons age 15 months or older*
  - 1 dose (preferably at least 14 days before procedure)
- **HIV infection:**
  Age 12–59 months
  - Unvaccinated or only 1 dose before age 12 months: 2 doses, 8 weeks apart
  - 2 or more doses before age 12 months: 1 dose at least 8 weeks after previous dose

  Unvaccinated persons age 5–18 years*
  - 1 dose
- **Immunoglobulin deficiency, early component complement deficiency:**
  Age 12–59 months
  - Unvaccinated or only 1 dose before age 12 months: 2 doses, 8 weeks apart
  - 2 or more doses before age 12 months: 1 dose at least 8 weeks after previous dose

*Unvaccinated = Less than routine series (through age 14 months) OR no doses (age 15 months or older)

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Notes

Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger, United States, 2022

Hepatitis A vaccination
(minimum age: 12 months for routine vaccination)

Routine vaccination
- 2-dose series (minimum interval: 6 months) at age 12–23 months

Catch-up vaccination
- Unvaccinated persons through age 18 years should complete a 2-dose series (minimum interval: 6 months).
- Persons who previously received 1 dose at age 12 months or older should receive dose 2 at least 6 months after dose 1.
- Adolescents age 18 years or older may receive the combined HepA and HepB vaccine, **Twinrix®**, as a 3-dose series (0, 1, and 6 months) or 4-dose series (3 doses at 0, 7, and 21–30 days, followed by a booster dose at 12 months).

International travel
- Persons traveling to or working in countries with high or intermediate endemic hepatitis A (www.cdc.gov/travel/):
  - **Infants age 6–11 months**: 1 dose before departure; revaccinate with 2 doses, separated by at least 6 months, between age 12–23 months.
  - **Unvaccinated age 12 months or older**: Administer dose 1 as soon as travel is considered.

Hepatitis B vaccination
(minimum age: birth)

Birth dose (monovalent HepB vaccine only)
- **Mother is HBsAg-negative:**
  - **All** medically stable infants ≥2,000 grams: 1 dose within 24 hours of birth
  - Infants <2,000 grams: Administer 1 dose at chronological age 1 month or hospital discharge (whichever is earlier and even if weight is still <2,000 grams).
- **Mother is HBsAg-positive:**
  - Administer **HepB vaccine** and **hepatitis B immune globulin (HBIG)** (in separate limbs) within 12 hours of birth, regardless of birth weight. For infants <2,000 grams, administer 3 additional doses of vaccine (total of 4 doses) beginning at age 1 month.
  - Test for HBsAg and anti-HBs at age 9–12 months. If HepB series is delayed, test 1–2 months after final dose.
- **Mother's HBsAg status is unknown:**
  - Administer **HepB vaccine** within 12 hours of birth, regardless of birth weight.
  - For infants <2,000 grams, administer **HBIG** in addition to HepB vaccine (in separate limbs) within 12 hours of birth. Administer 3 additional doses of vaccine (total of 4 doses) beginning at age 1 month.
  - Determine mother's HBsAg status as soon as possible. If mother is HBsAg-positive, administer **HBIG** to infants ≥2,000 grams as soon as possible, but no later than 7 days of age.

Routine series
- 3-dose series at age 0, 1–2, 6–18 months (use monovalent HepB vaccine for doses administered before age 6 weeks)
- Infants who did not receive a birth dose should begin the series as soon as feasible (see Table 2).
- Administration of **4 doses** is permitted when a combination vaccine containing HepB is used after the birth dose.
- **Minimum age** for the final (3rd or 4th) dose: 24 weeks
- **Minimum intervals:** dose 1 to dose 2: 4 weeks / dose 2 to dose 3: 8 weeks / dose 1 to dose 3: 16 weeks (when 4 doses are administered, substitute "dose 4" for "dose 3" in these calculations)

Catch-up vaccination
- Unvaccinated persons should complete a 3-dose series at 0, 1–2, 6 months.
- Adolescents age 11–15 years may use an alternative 2-dose schedule with at least 4 months between doses (adult formulation **Recombivax HB®** only).
- Adolescents age 18 years or older may receive a 2-dose series of HepB **(Heplisav-B®)** at least 4 weeks apart.
- Adolescents age 18 years or older may receive the combined HepA and HepB vaccine, **Twinrix®**, as a 3-dose series (0, 1, and 6 months) or 4-dose series (3 doses at 0, 7, and 21–30 days, followed by a booster dose at 12 months).
- For other catch-up guidance, see Table 2.

Special situations
- Revaccination is not generally recommended for persons with a normal immune status who were vaccinated as infants, children, adolescents, or adults.
- **Post-vaccination serology testing and revaccination** (if anti-HBs < 10mIU/mL) is recommended for certain populations, including:
  - **Infants born to HBsAg-positive mothers**
  - **Hemodialysis patients**
  - **Other immunocompromised persons**

For detailed revaccination recommendations, see www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/hepb.html.

Human papillomavirus vaccination
(minimum age: 9 years)

Routine and catch-up vaccination
- HPV vaccination routinely recommended at **age 11–12 years (can start at age 9 years)** and catch-up HPV vaccination recommended for all persons through age 18 years if not adequately vaccinated
- 2- or 3-dose series depending on age at initial vaccination:
  - **Age 9–14 years at initial vaccination**: 2-dose series at 0, 6–12 months (minimum interval: 5 months; repeat dose if administered too soon)
  - **Age 15 years or older at initial vaccination**: 3-dose series at 0, 1–2 months, 6 months (minimum intervals: dose 1 to dose 2: 4 weeks / dose 2 to dose 3: 12 weeks / dose 1 to dose 3: 5 months; repeat dose if administered too soon)
- **Interrupted schedules:** If vaccination schedule is interrupted, the series does not need to be restarted.
- No additional dose recommended when any HPV vaccine series has been completed using the recommended dosing intervals.

Special situations
- **Immunocompromising conditions, including HIV infection:** 3-dose series, even for those who initiate vaccination at age 9 through 14 years.
- **History of sexual abuse or assault:** Start at age 9 years.
- **Pregnancy:** Pregnancy testing not needed before vaccination; HPV vaccination not recommended until after pregnancy; no intervention needed if vaccinated while pregnant

Influenza vaccination
(minimum age: 6 months [IIV], 2 years [LAIV4], 18 years [recombinant influenza vaccine, RIV4])

Routine vaccination
- Use any influenza vaccine appropriate for age and health status annually:
  - 2 doses, separated by at least 4 weeks, for **children age 6 months–8 years** who have received fewer than 2 influenza vaccine doses before July 1, 2021, or whose influenza vaccination history is unknown (administer dose 2 even if the child turns 9 between receipt of dose 1 and dose 2)
  - 1 dose for **children age 6 months–8 years** who have received at least 2 influenza vaccine doses before July 1, 2021
  - 1 dose for **all persons age 9 years or older**
- For the 2021-2022 season, see www.cdc.gov/mmwr/volumes/70/rr/rr7005a1.htm.
- For the 2022–23 season, see the 2022–23 ACIP influenza vaccine recommendations.

Special situations
- **Egg allergy, hives only**: Any influenza vaccine appropriate for age and health status annually
- **Egg allergy with symptoms other than hives** (e.g., angioedema, respiratory distress) or required epinephrine or another emergency medical intervention: see Appendix listing contraindications and precautions
- **Severe allergic reaction (e.g., anaphylaxis) to a vaccine component or a previous dose of any influenza vaccine:** see Appendix listing contraindications and precautions

Measles, mumps, and rubella vaccination
(minimum age: 12 months for routine vaccination)

Routine vaccination
- 2-dose series at age 12–15 months, age 4–6 years
- MMR or MMRV may be administered

Note: For dose 1 in children age 12–47 months, it is recommended to administer MMR and varicella vaccines separately. MMRV may be used if parents or caregivers express a preference.

Catch-up vaccination
- Unvaccinated children and adolescents: 2-dose series at least 4 weeks apart
- The maximum age for use of MMRV is 12 years.
- Minimum interval between MMRV doses: 3 months

Special situations
International travel
- **Infants age 6–11 months:** 1 dose before departure; revaccinate with 2-dose series at age 12–15 months (12 months for children in high-risk areas) and dose 2 as early as 4 weeks later.
- **Unvaccinated children age 12 months or older:** 2-dose series at least 4 weeks apart before departure

Notes

Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger, United States, 2022

Meningococcal serogroup A,C,W,Y vaccination (minimum age: 2 months [MenACWY-CRM, Menveo], 9 months [MenACWY-D, Menactra], 2 years [MenACWY-TT, MenQuadfi])

Routine vaccination

- 2-dose series at age 11–12 years; 16 years

Catch-up vaccination

- Age 13–15 years: 1 dose now and booster at age 16–18 years (minimum interval: 8 weeks)
- Age 16–18 years: 1 dose

Special situations

Anatomic or functional asplenia (including sickle cell disease), HIV infection, persistent complement component deficiency, complement inhibitor (e.g., eculizumab, ravulizumab) use:

- **Menveo**
  - Dose 1 at age 2 months: 4-dose series (additional 3 doses at age 4, 6 and 12 months)
  - Dose 1 at age 3–6 months: 3- or 4- dose series (dose 2 [and dose 3 if applicable] at least 8 weeks after previous dose until a dose is received at age 7 months or older, followed by an additional dose at least 12 weeks later and after age 12 months)
  - Dose 1 at age 7–23 months: 2-dose series (dose 2 at least 12 weeks after dose 1 and after age 12 months)
  - Dose 1 at age 24 months or older: 2-dose series at least 8 weeks apart
- **Menactra**
  - **Persistent complement component deficiency or complement inhibitor use:**
    - Age 9–23 months: 2-dose series at least 12 weeks apart
    - Age 24 months or older: 2-dose series at least 8 weeks apart
  - **Anatomic or functional asplenia, sickle cell disease, or HIV infection:**
    - Age 9–23 months: Not recommended
    - Age 24 months or older: 2-dose series at least 8 weeks apart
    - **Menactra®** must be administered at least 4 weeks after completion of PCV13 series.
- **MenQuadfi®**
  - Dose 1 at age 24 months or older: 2-dose series at least 8 weeks apart

Travel in countries with hyperendemic or epidemic meningococcal disease, including countries in the African meningitis belt or during the Hajj (www.cdc.gov/travel/)**:**

- Children less than age 24 months:
  - **Menveo® (age 2–23 months)**
    - Dose 1 at age 2 months: 4-dose series (additional 3 doses at age 4, 6 and 12 months)
    - Dose 1 at age 3–6 months: 3- or 4- dose series (dose 2 [and dose 3 if applicable] at least 8 weeks after previous dose until a dose is received at age 7 months or older, followed by an additional dose at least 12 weeks later and after age 12 months)
    - Dose 1 at age 7–23 months: 2-dose series (dose 2 at least 12 weeks after dose 1 and after age 12 months)
  - **Menactra® (age 9–23 months)**
    - 2-dose series (dose 2 at least 12 weeks after dose 1; dose 2 may be administered as early as 8 weeks after dose 1 in travelers)
- Children age 2 years or older: 1 dose Menveo®, Menactra®, or MenQuadfi®

First-year college students who live in residential housing (if not previously vaccinated at age 16 years or older) or military recruits:

- 1 dose **Menveo®, Menactra®,** or **MenQuadfi®**

Adolescent vaccination of children who received MenACWY prior to age 10 years:

- **Children for whom boosters are recommended** because of an ongoing increased risk of meningococcal disease (e.g., those with complement deficiency, HIV, or asplenia): Follow the booster schedule for persons at increased risk.
- **Children for whom boosters are not recommended** (e.g., a healthy child who received a single dose for travel to a country where meningococcal disease is endemic): Administer MenACWY according to the recommended adolescent schedule with dose 1 at age 11–12 years and dose 2 at age 16 years.

Note: Menactra® should be administered either before or at the same time as DTaP. MenACWY vaccines may be administered simultaneously with MenB vaccines if indicated, but at a different anatomic site, if feasible.

For MenACWY **booster dose recommendations** for groups listed under "Special situations" and in an outbreak setting and additional meningococcal vaccination information, see www.cdc.gov/mmwr/volumes/69/rr/rr6909a1.htm.

Meningococcal serogroup B vaccination (minimum age: 10 years [MenB-4C, Bexsero®; MenB-FHbp, Trumenba®])

Shared clinical decision-making

- **Adolescents not at increased risk** age 16–23 years (preferred age 16–18 years) based on shared clinical decision-making:
  - **Bexsero®:** 2-dose series at least 1 month apart
  - **Trumenba®:** 2-dose series at least 6 months apart; if dose 2 is administered earlier than 6 months, administer a 3rd dose at least 4 months after dose 2.

Special situations

Anatomic or functional asplenia (including sickle cell disease), persistent complement component deficiency, complement inhibitor (e.g., eculizumab, ravulizumab) use:

- **Bexsero®:** 2-dose series at least 1 month apart
- **Trumenba®:** 3-dose series at 0, 1–2, 6 months

Note: Bexsero® and **Trumenba®** are not interchangeable; the same product should be used for all doses in a series.

For MenB **booster dose recommendations** for groups listed under "Special situations" and in an outbreak setting and additional meningococcal vaccination information, see www.cdc.gov/mmwr/volumes/69/rr/rr6909a1.htm.

Pneumococcal vaccination (minimum age: 6 weeks [PCV13], 2 years [PPSV23])

Routine vaccination with PCV13

- 4-dose series at age 2, 4, 6, 12–15 months

Catch-up vaccination with PCV13

- 1 dose for healthy children age 24–59 months with any incomplete* PCV13 series
- For other catch-up guidance, see Table 2.

Special situations

Underlying conditions below: When both PCV13 and PPSV23 are indicated, administer PCV13 first. PCV13 and PPSV23 should not be administered during same visit.

Chronic heart disease (particularly cyanotic congenital heart disease and cardiac failure); chronic lung disease (including asthma treated with high-dose, oral corticosteroids); diabetes mellitus:

Age 2–5 years

- Any incomplete* series with:
  - 3 PCV13 doses: 1 dose PCV13 (at least 8 weeks after any prior PCV13 dose)
  - Less than 3 PCV13 doses: 2 doses PCV13 (8 weeks after the most recent dose and administered 8 weeks apart)
- No history of PPSV23: 1 dose PPSV23 (at least 8 weeks after completing all recommended PCV13 doses)

Age 6–18 years

- No history of PPSV23: 1 dose PPSV23 (at least 8 weeks after completing all recommended PCV13 doses)

Cerebrospinal fluid leak, cochlear implant:

Age 2–5 years

- Any incomplete* series with:
  - 3 PCV13 doses: 1 dose PCV13 (at least 8 weeks after any prior PCV13 dose)
  - Less than 3 PCV13 doses: 2 doses PCV13 (8 weeks after the most recent dose and administered 8 weeks apart)
- No history of PPSV23: 1 dose PPSV23 (at least 8 weeks after any prior PCV13 dose)

Age 6–18 years

- No history of either PCV13 or PPSV23: 1 dose PCV13, 1 dose PPSV23 at least 8 weeks later
- Any PCV13 but no PPSV23: 1 dose PPSV23 at least 8 weeks after the most recent dose of PCV13
- PPSV23 but no PCV13: 1 dose PCV13 at least 8 weeks after the most recent dose of PPSV23

Sickle cell disease and other hemoglobinopathies; anatomic or functional asplenia; congenital or acquired immunodeficiency; HIV infection; chronic renal failure; nephrotic syndrome; malignant neoplasms, leukemias, lymphomas, Hodgkin disease, and other diseases associated with treatment with immunosuppressive drugs or radiation therapy; solid organ transplantation; multiple myeloma:

Age 2–5 years

- Any incomplete* series with:
  - 3 PCV13 doses: 1 dose PCV13 (at least 8 weeks after any prior PCV13 dose)
  - Less than 3 PCV13 doses: 2 doses PCV13 (8 weeks after the most recent dose and administered 8 weeks apart)
- No history of PPSV23: 1 dose PPSV23 (at least 8 weeks after any prior PCV13 dose) and a dose 2 of PPSV23 5 years later

Age 6–18 years

- No history of either PCV13 or PPSV23: 1 dose PCV13, 2 doses PPSV23 (dose 1 of PPSV23 administered 8 weeks after PCV13 and dose 2 of PPSV23 administered at least 5 years after dose 1 of PPSV23)
- Any PCV13 but no PPSV23: 2 doses PPSV23 (dose 1 of PPSV23 administered 8 weeks after the most recent dose of PCV13 and dose 2 of PPSV23 administered at least 5 years after dose 1 of PPSV23)
- PPSV23 but no PCV13: 1 dose PCV13 at least 8 weeks after the most recent PPSV23 dose and a dose 2 of PPSV23 administered 5 years after dose 1 of PPSV23 and at least 8 weeks after a dose of PCV13

Notes — Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger, United States, 2022

Chronic liver disease, alcoholism:
Age 6–18 years
- No history of PPSV23: 1 dose PPSV23 (at least 8 weeks after any prior PCV13 dose)

**Incomplete series* = Not having received all doses in either the recommended series or an age-appropriate catch-up series See Tables 8, 9, and 11 in the ACIP pneumococcal vaccine recommendations (www.cdc.gov/mmwr/pdf/rr/rr5911.pdf) for complete schedule details.

Poliovirus vaccination (minimum age: 6 weeks)

Routine vaccination
- 4-dose series at ages 2, 4, 6–18 months, 4–6 years; administer the final dose on or after age 4 years and at least 6 months after the previous dose.
- 4 or more doses of IPV can be administered before age 4 years when a combination vaccine containing IPV is used. However, a dose is still recommended on or after age 4 years and at least 6 months after the previous dose.

Catch-up vaccination
- In the first 6 months of life, use minimum ages and intervals only for travel to a polio-endemic region or during an outbreak.
- IPV is not routinely recommended for U.S. residents age 18 years or older.

Series containing oral polio vaccine (OPV), either mixed OPV-IPV or OPV-only series:
- Total number of doses needed to complete the series is the same as that recommended for the U.S. IPV schedule. See www.cdc.gov/mmwr/volumes/66/wr/mm6601a6.htm?s_%20cid=mm6601a6_w.
- Only trivalent OPV (tOPV) counts toward the U.S. vaccination requirements.
  - Doses of OPV administered before April 1, 2016, should be counted (unless specifically noted as administered during a campaign).
  - Doses of OPV administered on or after April 1, 2016, should not be counted.
  - For guidance to assess doses documented as "OPV," see www.cdc.gov/mmwr/volumes/66/wr/mm6606a7.htm?s_cid=mm6606a7_w.
- For other catch-up guidance, see Table 2.

Rotavirus vaccination (minimum age: 6 weeks)

Routine vaccination
- **Rotarix®:** 2-dose series at age 2 and 4 months
- **RotaTeq®:** 3-dose series at age 2, 4, and 6 months
- If any dose in the series is either **RotaTeq®** or unknown, default to 3-dose series.

Catch-up vaccination
- Do not start the series on or after age 15 weeks, 0 days.
- The maximum age for the final dose is 8 months, 0 days.
- For other catch-up guidance, see Table 2.

Tetanus, diphtheria, and pertussis (Tdap) vaccination (minimum age: 11 years for routine vaccination, 7 years for catch-up vaccination)

Routine vaccination
- **Adolescents age 11–12 years:** 1 dose Tdap
- **Pregnancy:** 1 dose Tdap during each pregnancy, preferably in early part of gestational weeks 27–36.
- Tdap may be administered regardless of the interval since the last tetanus- and diphtheria-toxoid-containing vaccine.

Catch-up vaccination
- **Adolescents age 13–18 years who have not received Tdap:** 1 dose Tdap, then Td or Tdap booster every 10 years
- **Persons age 7–18 years not fully vaccinated* with DTaP:** 1 dose Tdap as part of the catch-up series (preferably the first dose); if additional doses are needed, use Td or Tdap.
- **Tdap administered at age 7–10 years:**
  - **Children age 7–9 years** who receive Tdap should receive the routine Tdap dose at age 11–12 years.
  - **Children age 10 years** who receive Tdap do not need the routine Tdap dose at age 11–12 years.
- **DTaP inadvertently administered on or after age 7 years**:
  - **Children age 7–9 years**: DTaP may count as part of catch-up series. Administer routine Tdap dose at age 11–12 years.
  - **Children age 10–18 years**: Count dose of DTaP as the adolescent Tdap booster.
- For other catch-up guidance, see Table 2.

Special situations
- **Wound management** in persons age 7 years or older with history of 3 or more doses of tetanus-toxoid-containing vaccine: For clean and minor wounds, administer Tdap or Td if more than 10 years since last dose of tetanus-toxoid-containing vaccine; for all other wounds, administer Tdap or Td if more than 5 years since last dose of tetanus-toxoid-containing vaccine. Tdap is preferred for persons age 11 years or older who have not previously received Tdap or whose Tdap history is unknown. If a tetanus-toxoid-containing vaccine is indicated for a pregnant adolescent, use Tdap.
- For detailed information, see www.cdc.gov/mmwr/volumes/69/wr/mm6903a5.htm.

**Fully vaccinated* = 5 valid doses of DTaP OR 4 valid doses of DTaP if dose 4 was administered at age 4 years or older

Varicella vaccination (minimum age: 12 months)

Routine vaccination
- 2-dose series at age 12–15 months, 4–6 years
- VAR or MMRV may be administered*
- Dose 2 may be administered as early as 3 months after dose 1 (a dose inadvertently administered after at least 4weeks may be counted as valid)

***Note**: For dose 1 in children age 12–47 months, it is recommended to administer MMR and varicella vaccines separately. MMRV may be used if parents or caregivers express a preference.

Catch-up vaccination
- Ensure persons age 7–18 years without evidence of immunity (see *MMWR* at www.cdc.gov/mmwr/pdf/rr/rr5604.pdf) have a 2-dose series:
  - **Age 7–12 years**: routine interval: 3 months (a dose inadvertently administered after at least 4 weeks may be counted as valid)
  - **Age 13 years and older**: routine interval: 4–8 weeks (minimum interval: 4 weeks)
  - The maximum age for use of MMRV is 12 years.

Appendix Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger, United States, 2022

Guide to Contraindications and Precautions to Commonly Used Vaccines

Adapted from Table 4-1 in Advisory Committee on Immunization Practices (ACIP) General Best Practice Guidelines for Immunization: Contraindication and Precautions available at www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html and ACIP's Recommendations for the Prevention and Control of 2021-22 seasonal influenza with Vaccines available at www.cdc.gov/mmwr/volumes/70/rr/rr7005a1.htm.

Interim clinical considerations for use of COVID-19 vaccines including contraindications and precautions can be found at
www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html

Vaccine	Contraindications[1]	Precautions[2]
Influenza, egg-based, inactivated injectable (IIV4)	• Severe allergic reaction (e.g., anaphylaxis) after previous dose of any influenza vaccine (i.e., any egg-based IIV, ccIIV, RIV, or LAIV of any valency) • Severe allergic reaction (e.g., anaphylaxis) to any vaccine component[3] (excluding egg)	• Guillain-Barré syndrome (GBS) within 6 weeks after a previous dose of any type of influenza vaccine • Persons with egg allergy with symptoms other than hives (e.g., angioedema, respiratory distress) or required epinephrine or another emergency medical intervention: Any influenza vaccine appropriate for age and health status may be administered. If using egg-based IIV4, administer in medical setting under supervision of health care provider who can recognize and manage severe allergic reactions. May consult an allergist. • Moderate or severe acute illness with or without fever
Influenza, cell culture-based inactivated injectable [(ccIIV4), Flucelvax® Quadrivalent]	• Severe allergic reaction (e.g., anaphylaxis) to any ccIIV of any valency, or to any component[3] of ccIIV4	• Guillain-Barré syndrome (GBS) within 6 weeks after a previous dose of any type of influenza vaccine • Persons with a history of severe allergic reaction (e.g., anaphylaxis) after a previous dose of any egg-based IIV, RIV, or LAIV of any valency. If using ccIV4, administer in medical setting under supervision of health care provider who can recognize and manage severe allergic reactions. May consult an allergist. • Moderate or severe acute illness with or without fever
Influenza, recombinant injectable [(RIV4), Flublok® Quadrivalent]	• Severe allergic reaction (e.g., anaphylaxis) to any RIV of any valency, or to any component[3] of RIV4	• Guillain-Barré syndrome (GBS) within 6 weeks after a previous dose of any type of influenza vaccine • Persons with a history of severe allergic reaction (e.g., anaphylaxis) after a previous dose of any egg- based IIV, ccIIV, or LAIV of any valency. If using RIV4, administer in medical setting under supervision of health care provider who can recognize and manage severe allergic reactions. May consult an allergist. • Moderate or severe acute illness with or without fever
Influenza, live attenuated [LAIV4, Flumist® Quadrivalent]	• Severe allergic reaction (e.g., anaphylaxis) after previous dose of any influenza vaccine (i.e., any egg-based IIV, ccIIV, RIV, or LAIV of any valency) • Severe allergic reaction (e.g., anaphylaxis) to any vaccine component[3] (excluding egg) • Children age 2 – 4 years with a history of asthma or wheezing • Anatomic or functional asplenia • Immunocompromised due to any cause including, but not limited to, medications and HIV infection • Close contacts or caregivers of severely immunosuppressed persons who require a protected environment • Pregnancy • Cochlear implant • Active communication between the cerebrospinal fluid (CSF) and the oropharynx, nasopharynx, nose, ear or any other cranial CSF leak • Children and adolescents receiving aspirin or salicylate-containing medications • Received influenza antiviral medications oseltamivir or zanamivir within the previous 48 hours, peramivir within the previous 5 days, or baloxavir within the previous 17 days	• Guillain-Barré syndrome (GBS) within 6 weeks after a previous dose of any type of influenza vaccine • Asthma in persons aged 5 years old or older • Persons with egg allergy with symptoms other than hives (e.g., angioedema, respiratory distress) or required epinephrine or another emergency medical intervention: Any influenza vaccine appropriate for age and health status may be administered. If using LAIV4 (which is egg based), administer in medical setting under supervision of health care provider who can recognize and manage severe allergic reactions. May consult an allergist. • Persons with underlying medical conditions (other than those listed under contraindications) that might predispose to complications after wild-type influenza virus infection [e.g., chronic pulmonary, cardiovascular (except isolated hypertension), renal, hepatic, neurologic, hematologic, or metabolic disorders (including diabetes mellitus)] • Moderate or severe acute illness with or without fever

1. When a contraindication is present, a vaccine should NOT be administered. Kroger A, Bahta L, Hunter P. ACIP General Best Practice Guidelines for Immunization. www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html
2. When a precaution is present, vaccination should generally be deferred but might be indicated if the benefit of protection from the vaccine outweighs the risk for an adverse reaction. Kroger A, Bahta L, Hunter P. ACIP General Best Practice Guidelines for Immunization. www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html
3. Vaccination providers should check FDA-approved prescribing information for the most complete and updated information, including contraindications, warnings, and precautions. Package inserts for U.S.-licensed vaccines are available at www.fda.gov/vaccines-blood-biologics/approved-products/vaccines-licensed-use-united-states

Appendix

Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger, United States, 2022

Vaccine	Contraindications[1]	Precautions[2]
Dengue (DEN4CYD)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] • Severe immunodeficiency (e.g., hematologic and solid tumors, receipt of chemotherapy, congenital immunodeficiency, long- term immunosuppressive therapy or patients with HIV infection who are severely immunocompromised)	• Pregnancy • HIV infection without evidence of severe immunosuppression • Moderate or severe acute illness with or without fever
Diphtheria, tetanus, pertussis (DTaP) Tetanus, diphtheria (DT)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] • For DTaP only: Encephalopathy (e.g., coma, decreased level of consciousness, prolonged seizures) not attributable to another identifiable cause within 7 days of administration of previous dose of DTP or DTaP	• Guillain-Barré syndrome (GBS) within 6 weeks after previous dose of tetanus-toxoid–containing vaccine • History of Arthus-type hypersensitivity reactions after a previous dose of diphtheria-toxoid— containing or tetanus-toxoid– containing vaccine; defer vaccination until at least 10 years have elapsed since the last tetanus-toxoid- containing vaccine • For DTaP only: Progressive neurologic disorder, including infantile spasms, uncontrolled epilepsy, progressive encephalopathy; defer DTaP until neurologic status clarified and stabilized • Moderate or severe acute illness with or without fever
Haemophilus influenzae type b (Hib)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] • For Hiberix, ActHib, and PedvaxHIB only: History of severe allergic reaction to dry natural latex • Less than age 6 weeks	• Moderate or severe acute illness with or without fever
Hepatitis A (HepA)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] including neomycin	• Moderate or severe acute illness with or without fever
Hepatitis B (HepB)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] including yeast • For Heplisav-B only: Pregnancy	• Moderate or severe acute illness with or without fever
Hepatitis A- Hepatitis B vaccine [HepA-HepB, (Twinrix®)]	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] including neomycin and yeast	• Moderate or severe acute illness with or without fever
Human papillomavirus (HPV)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3]	• Moderate or severe acute illness with or without fever
Measles, mumps, rubella (MMR)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] • Severe immunodeficiency (e.g., hematologic and solid tumors, receipt of chemotherapy, congenital immunodeficiency, long-term immunosuppressive therapy or patients with HIV infection who are severely immunocompromised) • Pregnancy • Family history of altered immunocompetence, unless verified clinically or by laboratory testing as immunocompetent	• Recent (≤11 months) receipt of antibody-containing blood product (specific interval depends on product) • History of thrombocytopenia or thrombocytopenic purpura • Need for tuberculin skin testing or interferon-gamma release assay (IGRA) testing • Moderate or severe acute illness with or without fever
Meningococcal ACWY (MenACWY) [MenACWY-CRM (Menveo®); MenACWY-D (Menactra®); MenACWY-TT (MenQuadfi®)]	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] • For MenACWY-D and Men ACWY-CRM only: severe allergic reaction to any diphtheria toxoid– or CRM197–containing vaccine • For MenACWY-TT only: severe allergic reaction to a tetanus toxoid-containing vaccine	• For MenACWY-CRM only: Preterm birth if less than age 9 months • Moderate or severe acute illness with or without fever
Meningococcal B (MenB) [MenB-4C (Bexsero®); MenB-FHbp (Trumenba®)]	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3]	• Pregnancy • For MenB-4C only: Latex sensitivity • Moderate or severe acute illness with or without fever
Pneumococcal conjugate (PCV13)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] • Severe allergic reaction (e.g., anaphylaxis) to any diphtheria-toxoid– containing vaccine or its component[3]	• Moderate or severe acute illness with or without fever
Pneumococcal polysaccharide (PPSV23)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3]	• Moderate or severe acute illness with or without fever
Poliovirus vaccine, inactivated (IPV)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3]	• Pregnancy • Moderate or severe acute illness with or without fever
Rotavirus (RV) [RV1 (Rotarix®), RV5 (RotaTeq®)]	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] • Severe combined immunodeficiency (SCID) • History of intussusception	• Altered immunocompetence other than SCID • Chronic gastrointestinal disease • RV1 only: Spina bifida or bladder exstrophy • Moderate or severe acute illness with or without fever
Tetanus, diphtheria, and acellular pertussis (Tdap) Tetanus, diphtheria (Td)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] • For Tdap only: Encephalopathy (e.g., coma, decreased level of consciousness, prolonged seizures) not attributable to another identifiable cause within 7 days of administration of previous dose of DTP, DTaP, or Tdap	• Guillain-Barré syndrome (GBS) within 6 weeks after a previous dose of tetanus-toxoid–containing vaccine • History of Arthus-type hypersensitivity reactions after a previous dose of diphtheria-toxoid— containing or tetanus-toxoid– containing vaccine; defer vaccination until at least 10 years have elapsed since the last tetanus-toxoid– containing vaccine • For Tdap only: Progressive or unstable neurological disorder, uncontrolled seizures, or progressive encephalopathy until a treatment regimen has been established and the condition has stabilized • Moderate or severe acute illness with or without fever
Varicella (VAR)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] • Severe immunodeficiency (e.g., hematologic and solid tumors, receipt of chemotherapy, congenital immunodeficiency, long- term immunosuppressive therapy or patients with HIV infection who are severely immunocompromised) • Pregnancy • Family history of altered immunocompetence, unless verified clinically or by laboratory testing as immunocompetent	• Recent (≤11 months) receipt of antibody-containing blood product (specific interval depends on product) • Receipt of specific antiviral drugs (acyclovir, famciclovir, or valacyclovir) 24 hours before vaccination (avoid use of these antiviral drugs for 14 days after vaccination) • Use of aspirin or aspirin-containing products • Moderate or severe acute illness with or without fever

1. When a contraindication is present, a vaccine should NOT be administered. Kroger A, Bahta L, Hunter P. ACIP General Best Practice Guidelines for Immunization. www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html
2. When a precaution is present, vaccination should generally be deferred but might be indicated if the benefit of protection from the vaccine outweighs the risk for an adverse reaction. Kroger A, Bahta L, Hunter P. ACIP General Best Practice Guidelines for Immunization. www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html
3. Vaccination providers should check FDA-approved prescribing information for the most complete and updated information, including contraindications, warnings, and precautions. Package inserts for U.S.-licensed vaccines are available at www.fda.gov/vaccines-blood-biologics/approved-products/vaccines-licensed-use-united-states.

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References

In addition to the other resource sections contained within this booklet, below are additional resources/references:

- Advisory Committee on Immunization Practices immunization schedule — **https://www.cdc.gov/vaccines/schedules/hcp/child-adolescent.html**
- Agency for Healthcare Research and Quality — **https://www.qualitymeasures.ahrq.gov**
- AAP Dentistry periodicity schedule — **http://www.aapd.org/assets/1/7/Periodicity-AAPDSchedule.pdf**
- American Academy of Pediatrics (AAP) — **https://www.aap.org**
- *Amerigroup Community Care of Georgia Formulary* — **https://client.formularynavigator.com/Search.aspx?siteCode=7596004980**
- Amerigroup provider self-service website — **https://providers.amerigroup.com/ga**
- Bright Futures — **https://www.brightfutures.org**
- *Bright Futures Guidelines* — **https://brightfutures.aap.org/materials-and-tools/guidelines-and-pocket-guide/Pages/default.aspx**
- CMS Adult Health Care Quality Measures — **https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-core-set/index.html**
- CMS Children's Health Care Quality Measures — **https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/child-core-set/index.html**
- Georgia Department of Community Health (DCH) — **https://dch.georgia.gov**
- Georgia Department of Public Health — **https://dph.georgia.gov**
- Georgia Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services (Health Check program) — **https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/tabId/54/Default.aspx**
- Georgia Medicaid Management Information System — **https://www.mmis.georgia.gov/portal**
- Georgia Part 1 Policies and Procedures for Medicaid/PeachCare for Kids — **https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/tabId/54/Default.aspx**
- National Committee for Quality Assurance HEDIS and Performance Measurement — **https://www.ncqa.org/hedis-quality-measurement**
- National Quality Forum — **http://www.qualityforum.org**
- U.S. Preventive Services Task Force — **https://www.uspreventiveservicestaskforce.org**


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