2018 Prenatal and Postpartum Care HEDIS Tip Sheet

Billing codes support HEDIS performance. Sources of data for HEDIS vary by measure and are based on claims data from the provider and or medical record review. If a service is not billed or submitted correctly, the service may not be captured for HEDIS and this may result in a poor HEDIS performance score. ***There are two HEDIS measures for patients with live births within a year's timeframe.***

Timeliness of Prenatal Care

Measurement: The percentage of deliveries of live births on or between November 6 of the year prior to the measurement year and November 5 of the measurement year. The percentage of deliveries that received prenatal care visit in the first trimester or within 42 days of enrollment in a health plan.

Required documentation in the medical record for PRENATAL care visit:

1) A basic physical obstetrical examination that includes
   - Auscultation for fetal heart tone, ***or***
   - Pelvic exam with obstetric observations, ***or***
   - Measurement of fundus height (a standardized prenatal flow sheet may be used)
2) Prenatal Care Procedure: Could be:
   - Screening test/obstetric panel ***or***
   - TORCH antibody panel alone, ***or***
   - A rubella antibody test/titer with an Rh incompatibility (ABO/Rh) blood typing, ***or***
   - Ultrasound/Echography of a pregnant uterus
3) Documentation of LMP or EDD with *either* prenatal risk assessment & counseling/education, ***or*** complete obstetrical history

Required coding for PRENATAL care visit:

Stand Alone Prenatal Visits

CPT: 59425, 59426, 99201-99205, 99211- 99215, 99241-99245, 99500
CPT II: 0500F, 0501F, 0502F
HCPCS: H1000, H1001, H1002, H1003, H1004

Prenatal Bundled Services*

These codes must be billed with one of the CPT II codes below to satisfy the HEDIS metric.

CPT: 59400, 59510, 59610, 59618
HCPCS: H1005, T1015
CPT II: 0500F: initial pre-partum; 0501F: pre-partum flow sheet; 0502F: subsequent prenatal care (bill one of these with the bundled service code)

Postpartum Care

Measurement: Deliveries that have a postpartum visit on or between 21 and 56 days after delivery.

Required documentation in the medical record for POSTPARTUM care visit:

1) Date of delivery
2) Gestational age of infant – must be documented at or after delivery

3) Date(s) of postpartum visit(s) documented between 21 and 56 days after delivery and any one of the following:
   a. Notation of postpartum visit (PP check, PP care, 6 week check)
   b. Pelvic exam
   c. Evaluation of weight, BP, breasts and/or abdomen (Notation of breastfeeding is acceptable for evaluation of breasts.)

Required coding for POSTPARTUM care visit:

Postpartum Visits

CPT: 57170, 58300, 59430, 99501
CPT II: 0503F
HCPCS: G0101
ICD-10: Z01.411, Z01.419, Z01.42, Z30.430, Z39.1, Z39.2

Postpartum Bundled Services*

These codes must be billed with a CPT II code to satisfy the HEDIS metric.

CPT: 59400, 59410, 59510, 59515, 59610, 59614, 59618, 59622
CPT II: 0503F: post-partum care visit (bill with CPT bundled service code)

Please note that global billing or bundling codes do not provide specific date information needed for the HEDIS prenatal and postpartum care measures.

- ***Consider unbundling codes for all obstetrical services.***
- ***Use CPT II codes for each date of a prenatal and postpartum visit if you continue to utilize bundling codes such as CPT 59400.***

How can you improve HEDIS scores?

- Prioritize new pregnant patients and ensure prompt appointments for patients calling for a pregnancy visit to ensure the appointment is in the first trimester or within 42 days of enrollment.
- Schedule your patient for a postpartum visit following delivery but prior to hospital discharge within 21 to 56 days from delivery.
- Ensure that postpartum care is coded correctly; postpartum visits coded as generic follow-up care or other generic service will not apply towards completion of this measure.
- Be careful to use the appropriate code for each service and submit claims in a timely manner. Inaccurate coding on a claim, particularly when identifying date of delivery, can alter the results on this measure.
- Confirm your biller is including CPT II codes. (Some billers drop codes not associated with revenue)

Common errors in meeting requirements:

- Patients who delivered via C-section who are seen for incision check prior to 21 days after delivery and who do not return for another postpartum visit between 21 and 56 days after delivery.
- Ultrasound and lab results alone are not considered a visit; they must be linked to an office visit with an appropriate practitioner in order to count for this measure.
- A Pap test alone does not count as a prenatal care visit.
- Always bill appropriate CPT II codes with each visit.