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HEDIS Quick Reference Guide

What we have provided in this guide is the most recent, up-to-date information available at print time. HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA). This tool is meant to be used as a quick-glance reference. All codes are subject to change; there may be revisions, deletions or additions to this information that occur from one measurement period to another. Please contact Buckeye Health Plan regarding any questions you may have with the information provided. Thank you for your efforts in the continuous improvement of quality for our members/your patients.

What is HEDIS?

HEDIS® (Healthcare Effectiveness Data and Information Set) is a set of standardized performance measures developed by the National Committee for Quality Assurance (NCQA) which allows direct, objective comparison of ***quality*** across health plans. NCQA develops the HEDIS® measures through a committee represented by purchasers, consumers, health plans, health care providers and policy makers. HEDIS® allows for standardized measurement, standardized reporting and accurate, objective side-by-side comparisons. Consult NCQA's website for more information: **ncqa.org**.

What are the scores used for?

As both State and Federal governments move toward a healthcare industry that is driven by quality, HEDIS® rates are becoming more and more important, not only to the health plan, but to the individual provider as well. State purchasers of healthcare use the aggregated HEDIS® rates to evaluate the effectiveness of a health insurance company's ability to demonstrate an improvement in preventive health outreach to its members. Physician-specific scores are being used as evidence of preventive care from primary care office practices. These rates then serve as a basis for physician incentive programs such as 'pay for performance' and 'quality bonus funds'. These programs pay providers an increased premium based on their individual scoring of quality indicators such as those used in HEDIS®.

How are the rates calculated?

HEDIS® rates can be calculated in two ways: administrative data or hybrid data. Administrative data consists of claim or encounter data submitted to the health plan. Hybrid data consists of both administrative data and a sample of medical record data. Hybrid data requires review of a random sample of member medical records to abstract data for services rendered but that were not reported to the health plan through claims/encounter data. Accurate and timely claim/encounter data reduces the necessity of medical record review.

How can I improve my HEDIS scores?

- Submit claim/encounter data for each and every service rendered.
- Chart documentation must reflect services billed.
- All providers must bill (or report by encounter submission) for services delivered, regardless of contract status.
- Claim/encounter data is the most clean and efficient way to report HEDIS.®
- If services are not billed or not billed accurately, they are not included in the calculation.
- Accurate and timely submission of claim/encounter data will positively reduce the number of medical record reviews required for HEDIS® rate calculation.
- Consider including CPT II codes to reduce medical record requests. These codes provide details currently only found in the chart such as lab results.
- Avoid missed opportunities by taking advantage of sick-care visits; combine the well visit components and use a modifier and proper codes to bill for both the sick and well visit.
- Use the member list provided by Buckeye to contact patients who are in need of a visit.
- Routinely schedule a member's next appointment while in the office for the visit.

What is CAHPS?

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) is an annual survey sent to members/patients to measure satisfaction with their providers and healthcare systems. The goal of CAHPS is to capture accurate and complete information about the member reported experiences with health care. This information measures how well the member's expectations and goals were met. CAHPS helps determine the areas of service that have the greatest impact on overall satisfaction and opportunities for improvement which aid in increasing the quality of provided care. The CAHPS survey results are shared with the consumers, which provides them information they can use to choose physicians and health systems.

Important topics that are surveyed include, but are not limited to:

- How well Providers communicate with patients
- Providers use of information to coordinate patient care
- Helpful, courteous and respectful office staff
- Patients rating of the Provider

Transportation

Transportation is available to all Buckeye members to covered healthcare/dental appointments, WIC appointments, and redetermination appointments with CDJFS caseworker and trips to your patient's pharmacy following a doctor's appointment (limited area). To refer a patient or for any further questions, please call our Member Services at **1-866-246-4358 (TDD/TTY: 1-800-750-0750).**

Care Management

Care management, care coordination and disease coaching are part of Buckeye's benefits and available to all Buckeye members. We provide services for many conditions, such as asthma, diabetes, COPD, high-risk pregnancy, mental health/substance use disorders and many other conditions. Our care management staff are highly knowledgeable and experienced to help address your patient's care management needs and assist with removing barriers to care. To refer a patient or for any further questions, please call our Member Services at **1-866-246-4358 (TDD/TTY: 1-800-750-0750).**

AAB: Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis

Members 18–64 years of age diagnosis of acute bronchitis who were not dispensed an antibiotic prescription.

Important Codes*			
Outpatient	**CPT:** 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99429, 99455, 99456	**with or without**	**Telehealth Modifier:** **CPT:** 95, GT
Outpatient	**HCPCS:** G0402, G0438, G0439, G0463, T1015		
Outpatient	**UB Rev:** 0510, 0511, 0512, 0513, 0514, 0515, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0526, 0527, 0528, 0529, 0982, 0983		
Telephone Visit	**CPT:** 98966, 98967, 98968, 99441, 99442, 99443		
Online Assessment	**CPT:** 98969, 99444		
Acute Bronchitis	**ICD 10:** J20.3, J20.4, J20.5, J20.6, J20.7, J20.8,J20.9		

*codes subject to change

HEDIS® Improvement Tips:

- **Educate member:**
  - Antibiotics are not needed for viral infections
  - On importance calling/returning to the office if symptoms worsen or if no improvement
  - Regarding good hand washing to prevent spread of infection
- **Include appropriate documentation, date of episode and submit claims for all diagnoses that are established at the visit.**

AAP: Adults' Access to Preventive/Ambulatory Health Services

Members 20 years and older who had an ambulatory or preventive care visit during the measurement year.

<table>
<tr><th colspan="4">Important Codes*</th></tr>
<tr><td rowspan="4">Ambulatory Visits</td><td colspan="3">CPT: 99201-99205, 99211-99215, 99381-99387, 99391-99397, 99401-99404</td></tr>
<tr><td colspan="3">HCPCS: G0402, G0438, G0439, G0463, T1015</td></tr>
<tr><td colspan="3">UB Rev: 0510-0517, 0519-0523, 0526-0529, 0982-0983</td></tr>
<tr><td colspan="3">ICD 10: Z00.00, Z00.01, Z00.121, Z00.129, Z00.5, Z00.8, Z02.0-Z02.6, Z02.71, Z02.79, Z02.81, Z02.82, Z02.83, Z02.89, Z02.9</td></tr>
<tr><td rowspan="3">Other Ambulatory Visits with or without Telehealth</td><td>CPT: 92002, 92004, 92012, 92014, 99304-99310, 99315, 99316, 99318, 99324-99328, 99334-99337</td><td rowspan="3">with or without</td><td rowspan="3">Telehealth Modifier:
CPT: 95, GT</td></tr>
<tr><td>HCPCS: S0620, S0621</td></tr>
<tr><td>UB Rev: 0524, 0525</td></tr>
<tr><td>Telephone visit</td><td colspan="3">CPT: 98966-98968, 99441-99443</td></tr>
<tr><td>Online Assessment</td><td colspan="3">CPT: 98969, 99444</td></tr>
</table>

*codes subject to change

HEDIS® Improvement Tips:

- **Outreach to newly assigned member to schedule appointment.**
- **Educate the member on the importance of preventive screenings.**
- **Reminder calls, text messages or mailings can assist with ensuring members do not miss scheduled appointments.**
- **Schedule annual visit or follow-up visit before member leaves the office.**

ABA: Adult BMI Assessment

Members 18–74 years of age who had an outpatient visit and whose body mass index was documented during the measurement year or the previous year.

Important Codes*					
Adult BMI (age 20+)					
19 or less	Z68.1	**28.0-28.9**	Z68.28	**37.0-37.9**	Z68.37
20.0-20.9	Z68.20	**29.0-29.9**	Z68.29	**38.0-38.9**	Z68.38
21.0-21.9	Z68.21	**30.0-30.9**	Z68.30	**39.0-39.9**	Z68.39
22.0-22.9	Z68.22	**31.0-31.9**	Z68.31	**40.0-44.9**	Z68.41
23.0-23.9	Z68.23	**32.0-32.9**	Z68.32	**45.0-49.9**	Z68.42
24.0-24.9	Z68.24	**33.0-33.9**	Z68.33	**50-59.9**	Z68.43
25.0-25.9	Z68.25	**34.0-34.9**	Z68.34	**60.0-69.9**	Z68.44
26.0-26.9	Z68.26	**35.0-35.9**	Z68.35	**70 or greater**	Z68.45
27.0-27.9	Z68.27	**36.0-36.9**	Z68.36		
Pediatric BMI (age younger than 20)					
BMI <5th percentile for age				**ICD-10:** Z68.51	
BMI 5th percentile to <85th percentile for age				**ICD-10:** Z68.52	
BMI 85th percentile to <95th percentile for age				**ICD-10:** Z68.53	
BMI >95th percentile for age				**ICD-10:** Z68.54	

*codes subject to change

HEDIS® Improvement Tips:

- <u>Exclusion:</u>
  - Members with diagnosis of pregnancy during the measurement year or year prior.
- **Documentation must include height, weight, BMI value and date of completion and members younger than 20 years BMI value must be documented in a percentile.**
- **BMI percentile must be documented either as a value (i.e. 85 percentile) or plotted on an age-growth chart.**
- **BMI ranges and thresholds do not meet the criteria.**
- **Obtain height and weight at each visit, document and calculate BMI.**
  - Formulas:
  - BMI = weight (lb.)/ [height (inches)]^2 x 703
  - BMI = weight (kg) / [height (meters)]^2
- **Ensure electronic medical record automatically calculates BMI**

ADD: Follow-up Care for Children Prescribed ADHD Medication

Children, ages 6-12, with a newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10 month period. The two rates reported for this measure are:

Initiation Phase: Member had one outpatient (**OP**), intensive outpatient (**IOP**) or partial hospitalization (**PHP**) follow-up visit **within 30 days** of ADHD medication dispensed with a practitioner with prescribing authority.

Continuation and Maintenance (C&M) Phase: Member remained on the medication for at least 210 days and had at least 2 follow-up visits with a practitioner **within the next 270 days (9 months)** after the Initiation Phase.

<table>
<tr><th colspan="5">Use Appropriate Billing Codes*</th></tr>
<tr><th colspan="5">Initiation and C&M Phase Codes</th></tr>
<tr><td>Visit Setting Unspecified</td><td>CPT: 90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221-99223, 99231-99233, 99238, 99239, 99251-99255</td><td>With either</td><td>OP</td><td>POS: 03, 05, 07, 09, 11-20, 22, 33, 49, 50, 71, 72</td></tr>
<tr><td></td><td></td><td></td><td>PHP</td><td>POS: 52</td></tr>
<tr><td></td><td></td><td></td><td>Community Mental Health Center (CMHC)</td><td>POS: 53</td></tr>
<tr><td>Behavioral Health Outpatient (BH OP)</td><td colspan="4">CPT: 98960-98962, 99078, 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99483, 99510
HCPCS: G0155, G0176, G0177, G0409, G0463, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013-H2020, M0064, T1015
UBREV: 0510, 0513, 0515-0517, 0519-0523, 0526-0529, 0900, 0902-0904, 0911, 0914-0917, 0919, 0982, 0983</td></tr>
<tr><td>Observation</td><td colspan="4">CPT: 99217-99220</td></tr>
<tr><td>Health and Behavior Assessment/ Intervention</td><td colspan="4">CPT: 96150-96154</td></tr>
</table>

ADD: Follow-up Care for Children Prescribed ADHD Medication

Initiation and C&M Phase Codes	
PHP/IOP	**HCPCS:** G0410, G0411, H0035, H2001., H2012, S0201, S9480, S9484, S9485 **UBREV:** 0905, 0907, 0912, 0913

C&M Only Codes			
Visit Setting Unspecified CPT Codes (see above)	**With**	**Telehealth**	**POS:** 02

Important Codes*:	
Telephone Visits	**CPT:** 98966-98968, 99441-99443

*codes subject to change

HEDIS® Improvement Tips:

- Exclusion:
  - Apply for members who have experienced an acute inpatient encounter for mental health or alcohol or other drug (AOD) abuse or dependence, and members diagnosed with narcolepsy.
- **The initial visit when medication was prescribed does not count as the initiation phase visit.**
- **Prescribe 30 day supply and require members attend a 30-day follow-up appointment in order to continue medication.**
- **Educate caregiver(s) on importance of dispensing the correct amount of prescribed medication and keeping follow-up appointments.**
- **HEDIS® has provided a Medication Table for this measure. See the medication section at the back of the booklet.**

ADV: Annual Dental Visit

- Members 2–20 years of age who had at least one dental visit during the calendar year with a Dental Practitioner.

Definition of Dental Practitioner
Dental Practitioners hold a DMD (Doctor of Dental Medicine) or a DDS (Doctor of Dental Surgery) from an accredited school and is licensed to practice dentistry by a state board of dental examiners. Certified and licensed dental hygienists are considered dental practitioners.

HEDIS® Improvement Tips:

- **Educate parent(s)/guardian(s) and member of the importance of good oral hygiene, especially in starting at an early age. Schedule dental visits as young as 2 years of age.**
- **Buckeye Health Plan covers (2) periodic oral exams and cleaning per year.**
- **Reminder calls, text messages or mailings can assist with ensuring members do not miss scheduled appointments.**
- **Schedule annual visit or follow-up visit before member leaves the office.**
- **Transportation to and from dental appointments available for all Buckeye members, contact member service for more details.**

Adherence for Cholesterol (Statins)/Hypertension (Renin angiotensin system (RAS) Antagonists)/ Oral Diabetes Medications

Members 18 years of age and older with either:

- Coronary artery disease (CAD) who were prescribed a statin ***or***
- Hypertension who were prescribed a RAS antagonists or a angiotensin converting enzyme inhibitors (ACEI), or a angiotensin receptor blockers (ARB), or a direct renin inhibitor medication ***or***
- Diabetes who were prescribed any of the following medications: biguanide, sulfonylurea, thiazolidinedione, DPP-IV Inhibitor, incretin mimetic or meglitinide (Please note: Insulin is NOT Included) ***and***
- Who has filled and is taking their medication at least 80% of the time during the measurement year.

HEDIS® Improvement Tips:

- **During each visit with the member review medication list and ask if there are any issues with filling or taking medications. If there are any problems with filling or taking medications, ask why?**
- **Educate the member on the purpose of the medication including how often to take the medication and possible side effects.**
- **Encourage member to take medications as prescribed and to notify provider with any issues regarding the medication.**
- **Check online formulary for covered medications (buckeyehealthplan.com)**
- **Offer 90-day supply of medication to member, if stable.**
- **Encourage member to sign up for auto fill with their pharmacy or mail order.**
- **Schedule annual visit or follow-up visit before member leaves the office.**

ART: Disease Modifying Anti-Rheumatic Drug Therapy

Members 18 years of age and older who were diagnosed with rheumatoid arthritis and who were dispensed at least one ambulatory prescription for a disease-modifying anti-rheumatic drug (DMARD).

Use Appropriate Billing Codes*	
Description	**Codes**
Rheumatoid Arthritis	**ICD 10:** M05.861, M05.862, M05.869, M05.871, M05.872, M05.879, M05.89, M05.9, M06.00, M06.011, M06.012, M06.019, M06.021, M06.022, M06.029, M06.031, M06.032, M06.039, M06.041, M06.042, M06.049, M06.051, M06.052, M06.059, M06.061, M06.062, M06.069, M06.071, M06.072, M06.079, M06.08, M06.09, M06.1, M06.20, M06.211, M06.212, M06.219, M06.221, M06.222, M06.229, M06.231, M06.232, M06.239, M06.241, M06.242, M06.249, M06.251, M06.252, M06.259, M06.261, M06.262, M06.269, M06.271, M06.272, M06.279, M06.28, M06.29, M06.30, M06.311, M06.312, M06.319, M06.321, M06.322, M06.329, M06.331, M06.332, M06.339, M06.341, M06.342, M06.349, M06.351, M06.352, M06.359, M06.361, M06.362, M06.369, M06.371, M06.372, M06.379, M06.38, M06.39, M06.80, M06.811, M06.812, M06.819, M06.821, M06.822, M06.829, M06.831, M06.832, M06.839, M06.841, M06.842, M06.849, M06.851, M06.852, M06.859, M06.861, M06.862, M06.869, M06.871, M06.872, M06.879, M06.88, M06.89, M06.9
DMARD	**HCPCS:** J0129, J0135, J0717, J1438, J1600, J1602, J1745, J3262, J7502, J7515- J7518, J9250,J9260, J9310, Q5102-Q5104

*codes subject to change

HEDIS® Improvement Tips:

- **Current practice guidelines from the American College of Rheumatology can be found at: rheumatology.org/Practice-Quality/Clinical-Support/Clinical-Practice-Guidelines/Rheumatoid-Arthritis**
- **During each visit with the member: review medication list and if any issues with filling or taking medications, ask why?**
- **Educate the member on the purpose of the medication including how often to take the medication, possible side effects and to notify provider with any issues regarding the medication.**
- **Encourage member to sign up for auto fill with their pharmacy or mail order.**
- **HEDIS® has provided a Medication Table for this measure. See the medication section at the back of the booklet.**

AWC: Adolescent Well-Care Visit

Members 12–21 years of age who had at least one comprehensive well-care visit with a PCP or OB/GYN during the measurement year.

Well-care visits consists of all of the following:

- A health history
- A physical development history
- Health education/anticipatory guidance
- A mental developmental history
- A physical exam

Use Appropriate Billing Codes*	
Description	**Codes**
Well-Care Visits	**CPT:** 99381-99385, 99391-99395
	HCPCS: G0438, G0439
	ICD-10-CM: Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.5, Z00.8, Z02.0-Z02.6, Z02.71, Z02.79. Z02.81-Z02.83, Z02.89, Z02.9, Z76.1, Z76.2

*codes subject to change

HEDIS® Improvement Tips:

- **Prevent missed opportunities! Use Modifier 25 to pair with sick or sports/day care physicals to well-care visits on a claim.**
- **Include appropriate documentation of well-care visit must include a note indicating a visit to a PCP or OB/GYN that includes date of service and each of the following evidence:**
  - Health history (history of illness, disease, surgery, allergies, medications, immunizations and family health history)
  - Physical developmental history (milestones)
  - Mental developmental history (milestones)
  - Physical exam
  - Health education/anticipatory guidance
- **Additional information regarding well-care please visit the American Academy of Pediatric Guidelines for Health Supervision at aap.org and/or Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents at Brightfutures.org.**
- **Outreach to newly assigned member to schedule appointment.**
- **Reminder calls, text messages or mailings can assist with ensuring patients do not miss scheduled appointments.**

BCS: Breast Cancer Screening

Women 50–74 years of age who had one or more mammograms between October 1, 2 years prior (starting at age 50) to the measurement year and December 31 of the measurement year.

Use Appropriate Billing Codes*	
Description	**Codes**
Breast Cancer Screening	**CPT:** 77055-77057, 77061-77067
	HCPCS: G0202, G0204, G0206
	UBREV: 0401, 0403
History of Bilateral Mastectomy	**ICD-10:** Z290.13

*codes subject to change

HEDIS® Improvement Tips:

- **Exclusions:**
  - Two unilateral mastectomies with service dates 14 or more days apart
  - History of bilateral mastectomy
  - Member 66 years and older who are enrolled in a long-term institution or SNP.
- **Provide education and benefits regarding early detection of breast cancer through routine mammograms.**
- **Encourage all women ages 50–74 to get a mammogram because early detection of breast cancer is key to survival.**
- **Submit the appropriate mastectomy code to exclude the patient from this measure if this diagnosis has occurred in their health history.**
- **MRI's, breast ultrasounds or biopsies DO NOT meet standards for this measure**

CAP: Children's and Adolescents Access to Primary Care Practitioners

Members 12 months–19 years of age who had one or more visit with a PCP.

Members are banded into the following age ranges:

- 12–24 and 25 months–6 years
- 7–11 years and Adolescents 12–19 years

Use Appropriate Billing Codes*	
Description	**Codes**
Ambulatory Visits	**CPT:** 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99429, 99483
	HCPCS: G0438, G0439, G0463, T1015
	UB Rev: 0510-0517, 0519-0523, 0526-0529, 0982, 0983
	ICD-10: Z00.121, Z00.129, Z00.3, Z00.5, Z00.8, Z02.0-Z02.6, Z02.71, Z02.79, Z02.81, Z02.82, Z02.83, Z02.89, Z02.9, Z76.2, V20.2,

*codes subject to change

HEDIS® Improvement Tips:

- **Exclusion:**
  - Any visit to specialist provider.
- **Include appropriate documentation of well-care visit must include a note indicating a visit to a PCP or OB/GYN that includes date of service and each of the following evidence:**
  - Health history
  - Physical developmental history
  - Mental developmental history
  - Physical exam
  - Health education/anticipatory guidance
- **Additional information regarding well-care please visit: American Academy of Pediatric Guidelines for Health Supervision at aap.org and/or Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents at Brightfutures.org.**
- **Outreach to newly assigned member to schedule appointment.**
- **Reminder calls, text messages or mailings can assist with ensuring patients do not miss scheduled appointments.**

CBP: Controlling High Blood Pressure

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

Use Appropriate Billing Codes*	
Description	**Codes**
Hypertension	**ICD-10:** I10
Systolic Greater Than/Equal to 140	**CPT II:** 3077F
Systolic Less Than 130	**CPT II:** 3074F
Systolic 130-139	**CPT II:** 3075F
Diastolic Greater Than/Equal to 90	**CPT II:** 3080F
Diastolic Less Than 80	**CPT II:** 3078F
Diastolic 80-89	**CPT II:** 3079F
Remote Blood Pressure Monitoring	**CPT:** 93784, 93788, 93790, 99091
Telephone Visits	**CPT:** 98966-98968, 99441-99443
Telehealth Modifier	**CPT Modifier:** 95, GT

*codes subject to change

HEDIS® Improvement Tips:

- Exclusion:
  - Member age 66 and older as of January 1 and who are enrolled in an Institutional SNP or living long-term in an institution any time during the measurement year.
- **The blood pressure reading must be most recent and occur on or after the date the member was diagnosed with hypertension for the second time.**
- **Blood pressures taken during an emergency room, an acute inpatient stay, diagnostic test/procedure and/or member reported DO NOT meet standards for this measure.**
- **If the member initial blood pressure is high, repeat the blood pressure later in the visit. You may use the lowest systolic and diastolic blood pressure results from the visit to represent that day's visit BP results.**
- **Ensure when taking the member's BP, the member is sitting with legs uncrossed and arms relaxed.**
- **Ensure right placement and size of the blood pressure cuff for the member.**

CCS: Cervical Cancer Screening

Women 21–64 years of age who were screened for cervical cancer using either of the following criteria:

- Women age 21–64 who had cervical cytology performed during the measurement year or the two years prior (every 3 years).
- Women age 30–64 who had cervical cytology/human papillomavirus (HPV) co-testing performed during the measurement year or the four years prior (every 5 years).

Use Appropriate Billing Codes*	
Description	**Codes**
Cervical Cytology	**CPT:** 88141-88143, 88147, 88148, 88150, 88152-88154, 88164-88167, 88174, 88175
	HCPCS: G0123, G0124, G0141, G0143-G0145, G0147, G0148, P3000, P3001, Q0091
HPV Tests	**CPT:** 87620-87622, 87624, 87625
	HCPCS: G0476
Absence of Cervix	**CPT:** 58575

*codes subject to change

HEDIS® Improvement Tips:

- **Exclusions:**
  - Documentation in the member's health history of a hysterectomy (total, complete or radical) with no residual cervix by either:
    - "Vaginal pap smear" in conjunction with documented hysterectomy **or**
    - Documentation of hysterectomy and patient no longer in need of pap testing/cervical cancer screening.
- **The following do not qualify:**
  - Lab results that state the sample was inadequate or that "no cervical cells were present"
  - Biopsies (these are diagnostic and not valid for primary cervical cancer screening)
- **The human papillomavirus test should be completed <4 days apart to qualify for the five year testing.**
- **Documentation in the medical record must include note indicating:**
  - Date of service and the for cervical cytology was performed (21–64 years).
  - Date of service and the result for cervical cytology and HPV test was performed (30–64 years).