Humana

Healthcare Effectiveness Data and Information Set (HEDIS®)

Medicare Advantage benefit coverage

Our plan covers many preventive services at no cost when performed by an in-network provider.

Measure	Benefit/coverage	Coding guidance
Breast cancer screening (BCS)	**35-39 years old:** One baseline screening **40 and older:** One annual screening (elapsed 11 months*) **Younger than 35**: No mammography benefit **Exception:** Ordered as a diagnostic test by a physician as a result of patient signs/ symptoms, breast cancer history or family history	**Preventive:** Covered at 100% (either screening meets the requirement and is based on site availability) • 77067 Screening mammography (bilateral) • 77067 and 77063 Screening breast tomosynthesis (3D) (bilateral) (list separately in addition to code for primary procedure) **Diagnostic:** Coverage will vary by plan • 77065 Diagnostic mammography (unilateral) • 77066 Diagnostic mammography (bilateral) • 77065 and G0279 (unilateral) or 77066 (bilateral) Diagnostic breast tomosynthesis (3D) (list separately in addition to code for primary procedure)
Colorectal cancer screening (COL)	**Colonoscopy/fecal occult blood test (FOBT)/flexible sigmoidoscopy/barium enemas: 50 years old and older** at normal and/or high risk of developing colorectal cancer **Cologuard:** Must be **50-85** years old, asymptomatic and have average colorectal cancer risk **Note:** There are no age limitations for coverage of screening colonoscopies	**Preventive:** Covered at 100% • G0121 Colonoscopy once every 10 years (elapsed 119 months*) non-high risk • G0105 Colonoscopy once every two years (elapsed 23 months*) high-risk • FOBT once every year (elapsed 11 months*) o 82270 guaiac based o 82274 or G0328 Fecal immuno-chemical test • G0104 Flexible sigmoidoscopy once every five years (elapsed 59 months*) • 81528 Cologuard once every three years with specific criteria **Diagnostic:** Coverage will vary by plan; however, screenings may be covered at 100% if: • Processed as preventive • Provided by a physician, facility or anesthesiologist • Accompanied with a diagnosis code (Z12.11, Z12.12, Z80.0, Z83.71) o Primary diagnosis not required

*Designated months that must elapse for coverage listed above

†For plans filed with a plan deductible, these services may apply to the plan deductible. Any member who has this service prior to meeting the plan deductible may have out-of-pocket costs.

Disclaimer: This information should be used as a guide and is not a complete description of benefits. Contact the plan for more information. Limitations, copayments and restrictions may apply. Benefits and/or member cost-share may change on Jan. 1 of each year. To verify benefits, please call the service line at **1-866-427-7478**.

Humana

Osteoporosis treatment in women who had a fracture (OMW)	**No visit limits:** Test frequency is dependent on medical necessity, varying from **once every 24 months** to more frequently. **Coverage pertains to Medicare beneficiaries who:** • Are estrogen deficient and at risk for osteoporosis (determined by clinician) • Have vertebral abnormalities • Receive glucocorticoid therapy for more than three months • Have primary hyperparathyroidism • Receive monitoring for FDA-approved osteoporosis drug therapy	**Preventive:** Covered at 100% 76977, 77078, 77080, 77081, 77085, G0130 **Note:** An ICD-10 diagnosis code that indicates risk factors exist for osteoporosis also should be submitted. Screening diagnosis codes, such as Z13.820, may cause the claim to be denied.
Comprehensive diabetes care – blood sugar controlled (CDC-HbA1c)	**No test limits:** Test frequency is dependent on the level of diabetes control, varying from every three months to more frequently	**Preventive:** Covered at 100% 83036, 83037 hemoglobin A1c (HbA1c) screening **CPT II codes to report reading level:** • 3044F: HbA1c level less than 7.0 • 3045F: HbA1c level 7.0 – 9.0 • 3046F: HbA1c level greater than 9.0
Comprehensive diabetes care – eye exam (CDC-eye)	**Test limit:** One dilated/retinal eye exam each plan year, when administered by an in-network PCP or specialist **For negative results:** It must be clear in the record that the patient had a dilated/retinal eye exam by an eye care professional and retinopathy was not present. Report negative retinopathy results using diagnostic codes E10.9, E11.9 and E13.9.	Covered at 100%† 92002, 92004, 92012, 92014, 92134, 92225, 92226, 92227, 92228, 92230, 92235, 92240, 92250, 92260 • Cost share will apply if not billed with diabetes diagnosis codes E08 – E13 **CPT II codes for measurement closure:** • 2022F: Dilated retinal eye exam • 2024F: Seven standard field stereoscopic photos • 2026F: Eye imaging validated to match diagnosis from seven standard field stereoscopic photos • 3072F: Low risk, no evidence prior year
Comprehensive diabetes care – kidney disease monitoring (CDC-nephropathy)	**No test limits as medically necessary:** • Nephropathy screening or monitoring test • Nephropathy treatment or visit	Covered at 100% (payable as lab services): 81001, 81002, 81003, 81005, 82042, 82043, 82044, 84156 **CPT II codes for measurement closure:** Urine protein tests • 3060F: Positive microalbuminuria result • 3061F: Negative microalbuminuria result • 3062F: Positive macroalbuminuria result Nephropathy treatment • 3066F, 4010F: Documentation of treatment

*Designated months that must elapse for coverage listed above

†For plans filed with a plan deductible, these services may apply to the plan deductible. Any member who has this service prior to meeting the plan deductible may have out-of-pocket costs.

LC1792ALL0819 Y0040_GHHKNTXEN_C

Humana

Medication reconciliation post-discharge (MRP)	Medication reconciliation (face-to-face, telephone, electronic) conducted by a prescribing practitioner, clinical pharmacist or registered nurse on day of discharge through 30 days (beginning date of discharge)	**MRP:** 99496 (days one to seven post-discharge), 99495 (days eight to 14 post-discharge), 99483 (within 30 days post-discharge*) **CPT II code for measurement closure:** • 1111F (within 30 days post-discharge*, include NPI): Discharge medications reconciled with current medication list in outpatient record **Note:** Please see the transitional-care-management-services policy for use of these codes. * The 30-day limit for use of this code relates to the measure specifications and is not a time limit for when the code can be used.
Annual Wellness Visit (AWV)	**Initial AWV:** Once per lifetime, 12 months after initial Medicare enrollment **Subsequent AWV:** Once per **calendar year (Jan. 1-Dec. 31) following the initial AWV**	**Preventive:** Covered at 100% • G0438 Initial AWV • G0439 Subsequent AWV During both AWV and PPE visits, be sure to document: **ICD10 diagnosis code to report BMI range** • Z68.1-45 based on result **CPT II codes to report blood pressure (BP) reading:** • 3074F Most recent systolic BP less than 130 mmHg • 3075F Most recent systolic BP 130-139 mmHg • 3077F Most recent systolic BP greater than or equal to 140 mmHg • 3078F Most recent diastolic BP less than 80 mmHg • 3079F Most recent diastolic BP 80-89 mmHg • 3080F Most recent diastolic BP greater than or equal to 90 mmHg
Initial preventive physical exam (IPPE)	**One-time "Welcome to Medicare" preventive visit:** Health review, education/counseling (includes screenings/shots), referrals	**Preventive:** Covered at 100% • Physical exam: G0402 Note: See BMI and BP guidance in AWV section
Annual preventive physical exam (APPE)	**Humana Medicare Advantage benefit only:** Once per **calendar year (Jan. 1-Dec. 31)**	**Supplemental:** Covered at 100% **New patient:** 99381 – 99387 **Established patient:** 99391 – 99397 **Note:** Service should be submitted with appropriate initial or periodic preventive medicine codes. **Note:** See BMI and BP guidance in AWV section

*Designated months that must elapse for coverage listed above
†For plans filed with a plan deductible, these services may apply to the plan deductible. Any member who has this service prior to meeting the plan deductible may have out-of-pocket costs.
Disclaimer: This information should be used as a guide and is not a complete description of benefits. Contact the plan for more information. Limitations, copayments and restrictions may apply. Benefits and/or member cost-share may change on Jan. 1 of each year. To verify benefits, please call the service line at **1-866-427-7478**.