### 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.

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<th>Measure</th>
<th>Benefit/coverage</th>
<th>Coding guidance</th>
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| **Breast cancer screening (BCS)** | **35-39 years old:** One baseline screening  
**40 and older:** One annual screening  
(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*)  
  - 82270 guaiac based  
  - 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)  
  - Primary diagnosis not required |

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LC1792ALL0819 Y0040_GHKNTXEN_C
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<tr>
<th>Service Description</th>
<th>Frequency Details</th>
<th>Preventive Coverage</th>
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| **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  
  **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:**  
  - 3060F: Positive microalbuminuria result  
  - 3061F: Negative microalbuminuria result  
  - 3062F: Positive macroalbuminuria result  
  Nephropathy treatment  
  - 3066F, 4010F: Documentation of treatment |

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<th><strong>Medication reconciliation post-discharge (MRP)</strong></th>
<th><strong>MRP:</strong> 99496 (days one to seven post-discharge), 99495 (days eight to 14 post-discharge), 99483 (within 30 days post-discharge*)&lt;br&gt;<strong>CPT II code for measurement closure:</strong>&lt;br&gt;• 1111F (within 30 days post-discharge*, include NPI): Discharge medications reconciled with current medication list in outpatient record&lt;br&gt;<strong>Note:</strong> Please see the transitional-care-management-services policy for use of these codes.&lt;br&gt;* 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.</th>
<th><strong>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)</strong></th>
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<tr>
<td><strong>Annual Wellness Visit (AWV)</strong></td>
<td><strong>Preventive:</strong> Covered at 100%&lt;br&gt;• G0438 Initial AWV&lt;br&gt;• G0439 Subsequent AWV&lt;br&gt;During both AWV and PPE visits, be sure to document:&lt;br&gt;<strong>ICD10 diagnosis code to report BMI range</strong>&lt;br&gt;• Z68.1-45 based on result&lt;br&gt;<strong>CPT II codes to report blood pressure (BP) reading:</strong>&lt;br&gt;• 3074F Most recent systolic BP less than 130 mmHg&lt;br&gt;• 3075F Most recent systolic BP 130-139 mmHg&lt;br&gt;• 3077F Most recent systolic BP greater than or equal to 140 mmHg&lt;br&gt;• 3078F Most recent diastolic BP less than 80 mmHg&lt;br&gt;• 3079F Most recent diastolic BP 80-89 mmHg&lt;br&gt;• 3080F Most recent diastolic BP greater than or equal to 90 mmHg</td>
<td><strong>Initial AWV:</strong> Once per lifetime, 12 months after initial Medicare enrollment&lt;br&gt;<strong>Subsequent AWV:</strong> Once per calendar year (Jan. 1-Dec. 31) following the initial AWV&lt;br&gt;<strong>Preventive:</strong> Covered at 100%&lt;br&gt;• Physical exam: G0402&lt;br&gt;Note: See BMI and BP guidance in AWV section</td>
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<td><strong>Initial preventive physical exam (IPPE)</strong></td>
<td><strong>Supplemental:</strong> Covered at 100%&lt;br&gt;<strong>New patient:</strong> 99381 – 99387&lt;br&gt;<strong>Established patient:</strong> 99391 – 99397&lt;br&gt;Note: Service should be submitted with appropriate initial or periodic preventive medicine codes.&lt;br&gt;Note: See BMI and BP guidance in AWV section</td>
<td>One-time “Welcome to Medicare” preventive visit: Health review, education/counseling (includes screenings/shots), referrals</td>
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| **Annual preventive physical exam (APPE)** | | **Humana Medicare Advantage benefit only:** Once per calendar year (Jan. 1-Dec. 31)**

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