DOCUMENTATION TIPS

Measure 205: HIV/AIDS:

Sexually Transmitted Disease Screening for Chlamydia, Gonorrhea, and Syphilis

Electronic health records (EHRs) collect and organize notes, medication lists, and patient information using various formats. With providers also documenting this information in unique ways, this can potentially cause confusion and an increased timeline for measure mapping with DataDerm. This tip sheet can help you manage reporting requirements for performance measures and streamline standard documentation practices to allow seamless data pull into DataDerm.

The DataDerm team will work with you to connect DataDerm with your EHR to extract data. To make the process as smooth as possible, it helps to document key elements of patient care. DataDerm cannot read scanned images of any kind, including scanned images for labs, letters to physicians, pathology reports, follow-up plans, and dates. If you have scanned images with information needed for your measures, please add a note in your chart with the date and required patient information for this data to be accurately collected.

This tip sheet can assist paper-based practices in standardizing documentation practices. Keeping notes in the patient's paper chart of all documentation requirements will assist you when reporting for this measure.

Measure 205: HIV/AIDS: Sexually Transmitted Disease Screening for Chlamydia, Gonorrhea, and Syphilis

For all patients aged 13 and older, document the following in your notes:

- Diagnosis of HIV/AIDS
  - The ICD-10-CM code Z21, B20
- At least two medical visits during the measurement period, with at least 90 days between each visit
  - The CPT or HCPCS code for the patient encounter during the reporting period: 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, G0402
- Note in the medical record the results of the patient's STD screenings for ALL of the following at least once since the diagnosis of HIV infection:
  - Chlamydia,
  - Gonorrhea, and
  - Syphilis
- If the patient is not eligible for the STD screenings, note in the medical record if applicable:
  - Patients who use hospice services any time during the measurement period (G9725)
- If the STD screenings are not in the medical record, document reason(s) for patient not having one. If applicable, include:
  - Patient refusal

For more information, contact the American Academy of Dermatology:
WEBSITE: aad.org

AMERICAN ACADEMY of DERMATOLOGY | ASSOCIATION