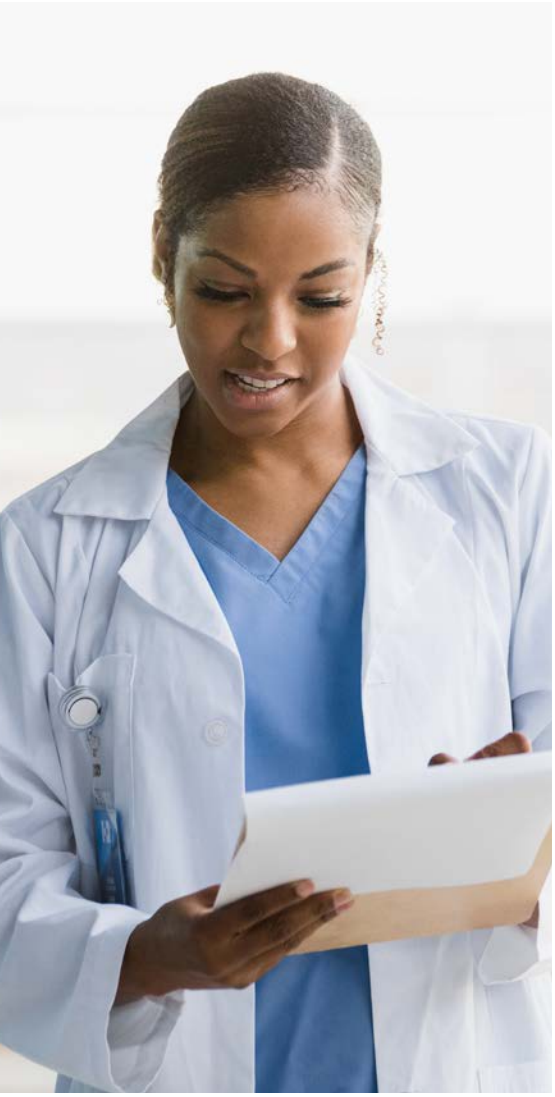
HEDIS Benchmarks and Coding Guidelines

for Quality Care



BlueCross BlueShield of North Carolina | HealthyBlue®

NCHB-CD-042177-23

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Note: The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All patient care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of patients. Your state/provider contract(s), Medicaid, patient benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our patients and meet the HEDIS measure for quality reporting based on the care you provide our patients. Please note: The information provided is based on HEDIS My 2020 & My 2021 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

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Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)

This HEDIS® measure looks at the percentage of episodes for members ages 3 months and older with a diagnosis of acute bronchitis/bronchiolitis that did not result in an antibiotic dispensing event July 1 of the year prior to the measurement year to June 30 of the measurement year.

Exclusions:

- Members who use hospice services or elect to use a hospice benefit anytime during the measurement year
- Members who die any time during the measurement year.

	Codes
Outpatient, ED and Telehealth	**CPT:** 98966, 98967, 98968, 98970, 98971, 98972, 98980, 98981, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99242, 99243, 99244, 99245, 99281, 99282, 99283, 99284, 99285, 99341,99342, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99421, 99422, 99423, 99429, 99441, 99442, 99443, 99455,99456, 99457, 99458, 99483 **HCPCS:** **G0071**: Payment for communication technology-based services for 5 minutes or more of a virtual (non-face-to-face) communication between a rural health clinic (RHC) or federally qualified health center (FQHC) practitioner and RHC or FQHC patient, or 5 minutes or more of remote evaluation of recorded video and/or images by an RHC or FQHC practitioner, occurring in lieu of an office visit; RHC or FQHC only

	Codes
Outpatient, ED and Telehealth (cont.)	**HCPCS:** **G0402:** Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment **G0438:** Annual wellness visit; includes a personalized prevention plan of service (PPS), initial visit **G0439:** Annual wellness visit, includes a personalized prevention plan of service (PPS), subsequent visit **G0463:** Hospital outpatient clinic visit for assessment and management of a patient **G2010:** Remote evaluation of recorded video and/or images submitted by an established patient (for example, store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment **G2012:** Brief communication technology-based service, for example, virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion **G2250:** Remote assessment of recorded video and/or images submitted by an established patient (for example, store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment

	Codes
Outpatient, ED and Telehealth (cont.)	**HCPCS:** **G2251:** Brief communication technology-based service, for example, virtual check-in, by a qualified health care professional who cannot report evaluation and management services, provided to an established patient, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of clinical discussion **G2252:** Brief communication technology-based service, for example, virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion **T1015:** Clinic visit/encounter, all-inclusive
Pharyngitis	**ICD10CM:** **J02.0:** Streptococcal pharyngitis **J02.8:** Acute pharyngitis due to other specified organisms **J02.9:** Acute pharyngitis, unspecified **J03.00:** Acute streptococcal tonsillitis, unspecified **J03.01:** Acute recurrent streptococcal tonsillitis **J03.80:** Acute tonsillitis due to other specified organisms **J03.81:** Acute recurrent tonsillitis due to other specified organisms **J03.90:** Acute tonsillitis, unspecified **J03.91:** Acute recurrent tonsillitis, unspecified

	Codes
Acute Bronchitis	**J20.3:** Acute bronchitis due to coxsackievirus
	J20.4: Acute bronchitis due to parainfluenza virus
	J20.5: Acute bronchitis due to respiratory syncytial virus
	J20.6: Acute bronchitis due to rhinovirus
	J20.7: Acute bronchitis due to echovirus
	J20.8: Acute bronchitis due to other specified organisms
	J20.9: Acute bronchitis, unspecified
	J21.0: Acute bronchiolitis due to respiratory syncytial virus
	J21.1: Acute bronchiolitis due to human metapneumovirus
	J21.8: Acute bronchiolitis due to other specified organisms
	J21.9: Acute bronchiolitis, unspecified

Note: The codes listed are informational only; this information does not guarantee reimbursement.

Helpful tips:

- If a member insists on an antibiotic:
  - Refer to the illness as a chest cold rather than bronchitis; members tend to associate the label with a less-frequent need for antibiotics.
  - Write a prescription for symptom relief, such as an over-the-counter cough medicine.
  - Treat with antibiotics if associated comorbid diagnosis.
- If utilizing an electronic medical record (EMR) system, consider electronic data sharing with your health plan to capture all coded elements. Contact your provider relationship managements representative for additional details and questions.

How can we help?

We help you with avoidance of antibiotic treatment for members with acute bronchitis / bronchiolitis by:

- Offering current *Clinical Practice Guidelines* on our provider self-service website.
- Members may be eligible for transportation assistance at no cost, contact Member Services for arrangement.

Other available resources

Go to **cdc.gov/antibiotic-use/index.html**

Adults' Access to Preventive/Ambulatory Health Services (AAP)

This HEDIS measure looks at the percentage of members 20 years of age and older who had an ambulatory or preventive care visit. The organization reports percentages for members who had an ambulatory or preventive care visit during the measurement year.

Exclusions:

- Members who use hospice services or elect to use a hospice benefit anytime during the measurement year
- Members who died during the measurement year

	Codes:
Ambulatory Visits	**CPT:** 92002, 92004, 92012, 92014, 98966, 98967, 98968, 98970, 98971, 98972, 98980, 98981, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99242, 99243, 99244, 99245, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396,99397, 99401, 99402, 99403, 99404, 99411, 99412, 99421, 99422, 99423, 99429, 99441, 99442, 99443, 99457, 99458, 99483 **HCPCS:** **G0071:** Payment for communication technology-based services for 5 minutes or more of a virtual (non-face-to-face) communication between a rural health clinic (RHC) or federally qualified health center (FQHC) practitioner and RHC or FQHC patient, or 5 minutes or more of remote evaluation of recorded video and/or images by an RHC or FQHC practitioner, occurring in lieu of an office visit; RHC or FQHC only **G0402:** Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment **G0438:** Annual wellness visit; includes a personalized prevention plan of service (PPS), initial visit

Ambulatory Visits (cont.)	**HCPCS:** **G0439:** Annual wellness visit, includes a personalized prevention plan of service (PPS), subsequent visit **G0463:** Hospital outpatient clinic visit for assessment and management of a patient **G2010:** Remote evaluation of recorded video and/or images submitted by an established patient (for example, store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment **G2012:** Brief communication technology-based service, for example, virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion **G2250:** Remote assessment of recorded video and/or images submitted by an established patient (for example, store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment **G2251:** Brief communication technology-based service, for example, virtual check-in, by a qualified health care professional who cannot report evaluation and management services, provided to an established patient, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of clinical discussion

Ambulatory Visits (cont.)	**HCPCS:** **G2252:** Brief communication technology-based service, for example, virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion **S0620:** Routine ophthalmological examination including refraction; new patient **S0621:** Routine ophthalmological examination including refraction; established patient **T1015:** Clinic visit/encounter, all-inclusive
Reason for Ambulatory Visit	**ICD10CM:** **Z00.00:** Encounter for general adult medical examination without abnormal findings **Z00.01:** Encounter for general adult medical examination with abnormal findings **Z00.121:** Encounter for routine child health examination with abnormal findings **Z00.129:** Encounter for routine child health examination without abnormal findings **Z00.3:** Encounter for examination for adolescent development state **Z00.5:** Encounter for examination of potential donor of organ and tissue **Z00.8:** Encounter for other general examination **Z02.0:** Encounter for examination for admission to educational institution **Z02.1:** Encounter for pre-employment examination **Z02.2:** Encounter for examination for admission to residential institution **Z02.3:** Encounter for examination for recruitment to armed forces **Z02.4:** Encounter for examination for driving license

Reason for Ambulatory Visit (cont.)	**ICD10CM:** **Z02.5:** Encounter for examination for participation in sport **Z02.6:** Encounter for examination for insurance purposes **Z02.71:** Encounter for disability determination **Z02.79:** Encounter for issue of other medical certificate **Z02.81:** Encounter for paternity testing **Z02.82:** Encounter for adoption services **Z02.83:** Encounter for blood-alcohol and blood-drug test **Z02.89:** Encounter for other administrative examinations **Z02.9:** Encounter for administrative examinations, unspecified **Z76.1:** Encounter for health supervision and care of foundling **Z76.2:** Encounter for health supervision and care of other healthy infant and child

Note: The codes listed are informational only; this information does not guarantee reimbursement.

Helpful tips:

- If utilizing an EMR system, consider electronic data sharing with your health plan to capture all coded elements. Contact your Provider Solutions representative for additional details and questions.

How can we help?

- Members may be eligible for transportation assistance at no cost, contact Member Services for arrangement.

Notes:

Antidepressant Medication Management (AMM)

This measure looks at the percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment. Two rates are reported:

- **Effective acute phase treatment**: the percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks).
- **Effective continuation phase treatment**: the percentage of members who remained on an antidepressant medication for at least 180 days (six months).

Record your efforts:

- Identify all acute and nonacute inpatient stays
- Identify the admission and discharge dates for the stay. Either an admission or discharge during the required time frame meets criteria

Exclusions:

- Members who did not have an encounter with a diagnosis of major depression during the 121-day period from 60 days prior to the index prescription start date (IPSD), through the IPSD and the 60 days after the IPSD
- Members in hospice or using hospice services anytime during the measurement year
- Members who died during the measurement year

	Codes:
Major Depression	**ICD-10-CM:** **F32.0:** Major depressive disorder, single episode, mild **F32.1:** Major depressive disorder, single episode, moderate **F32.2:** Major depressive disorder, single episode, severe without psychotic features **F32.3:** Major depressive disorder, single episode, severe with psychotic features **F32.4:** Major depressive disorder, single episode, in partial remission **F32.9:** Major depressive disorder, single episode, unspecified **F33.0:** Major depressive disorder, recurrent, mild **F33.1:** Major depressive disorder, recurrent, moderate

	Codes:
Major Depression (cont.)	**ICD-10-CM:** **F33.2:** Major depressive disorder, recurrent severe without psychotic features **F33.3:** Major depressive disorder, recurrent, severe with psychotic symptoms **F33.41:** Major depressive disorder, recurrent, in partial remission **F33.9:** Major depressive disorder, recurrent, unspecified
BH Outpatient	**CPT:** 98960-98962, 99078, 99202-99205, 99211-99215, 99242-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99483, 99492-99494, 99510 **HCPCS:** **G0155:** Services of clinical social worker in home health or hospice settings, each 15 minutes **G0176:** Activity therapy, such as music, dance, art or play therapies not for recreation, related to the care and treatment of patient's disabling mental health problems, per session (45 minutes or more) **G0177:** Training and educational services related to the care and treatment of patient's disabling mental health problems per session (45 minutes or more) **G0409:** Social work and psychological services, directly relating to and/or furthering the patient's rehabilitation goals, each 15 minutes, face-to-face; individual (services provided by a CORF-qualified social worker or psychologist in a CORF) **G0463:** Hospital outpatient clinic visit for assessment and management of a patient **G0512:** Rural health clinic or federally qualified health center (RHC/FQHC) only, psychiatric collaborative care model (psychiatric COCM), 60 minutes or more of clinical staff time for psychiatric COCM services directed by an RHC or FQHC practitioner (physician, NP, PA, or CNM) and including services furnished by a behavioral health care manager and consultation with a psychiatric consultant, per calendar month

	Codes:
BH Outpatient (cont.)	**HCPCS:** **H0002:** Behavioral health screening to determine eligibility for admission to treatment program **H0004:** Behavioral health counseling and therapy, per 15 minutes **H0031:** Mental health assessment, by non-physician **H0034:** Medication training and support, per 15 minutes **H0036:** Community psychiatric supportive treatment, face-to-face, per 15 minutes **H0037:** Community psychiatric supportive treatment program, per diem **H0039:** Assertive community treatment, face-to-face, per 15 minutes **H0040:** Assertive community treatment program, per diem **H2000:** Comprehensive multidisciplinary evaluation **H2010:** Comprehensive medication services, per 15 minutes **H2011:** Crisis intervention service, per 15 minutes **H2013:** Psychiatric health facility service, per diem **H2014:** Skills training and development, per 15 minutes **H2015:** Comprehensive community support services, per 15 minutes **H2016:** Comprehensive community support services, per diem **H2017:** Psychosocial rehabilitation services, per 15 minutes **H2018:** Psychosocial rehabilitation services, per diem **H2019:** Therapeutic behavioral services, per 15 minutes **H2020:** Therapeutic behavioral services, per diem **T1015:** Clinic visit/encounter, all-inclusive

	Codes:
Electroconvulsive Therapy	**CPT:** 90870 **ICD10PCS:** **GZB0ZZZ:** Electroconvulsive Therapy, Unilateral-Single Seizure **GZB1ZZZ:** Electroconvulsive Therapy, Unilateral-Multiple Seizure **GZB2ZZZ:** Electroconvulsive Therapy, Bilateral-Single Seizure **GZB3ZZZ**: Electroconvulsive Therapy, Bilateral-Multiple Seizure **GZB4ZZZ:** Other Electroconvulsive Therapy
Transcranial Magnetic Stimulation	**CPT:** 90867, 90868, 90869
Online Assessments	**CPT:** 98970, 98971, 98972, 98980, 98981, 99421, 99422, 99423, 99457, 99458 **HCPCS:** **G0071**: Payment for communication technology-based services for 5 minutes or more of a virtual (non-face-to-face) communication between a rural health clinic (RHC) or federally qualified health center (FQHC) practitioner and RHC or FQHC patient, or 5 minutes or more of remote evaluation of recorded video and/or images by an RHC or FQHC practitioner, occurring in lieu of an office visit; RHC or FQHC only **G2010**: Remote evaluation of recorded video and/or images submitted by an established patient (for example, store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment

	Codes:
Online Assessments (cont.)	**HCPCS:** **G2012:** Brief communication technology-based service, for example, virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion **G2250**: Remote assessment of recorded video and/or images submitted by an established patient (for example, store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment **G2251**: Brief communication technology-based service, for example, virtual check-in, by a qualified health care professional who cannot report evaluation and management services, provided to an established patient, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of clinical discussion **G2252**: Brief communication technology-based service, for example, virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion
Telephone Visits	**CPT:** 98966, 98967, 98968, 99441, 99442, 99443
Visit Setting Unspecified	**CPT:** 90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99252, 99253, 99254, 99255

Note: The codes listed are informational only; this information does not guarantee reimbursement.

Helpful tips:

Educate your members and their spouses, caregivers, and/or guardians about the importance of:

- Complying with long-term medications.
- Not abruptly stopping medications without consulting you.
- Contacting you immediately if they experience any unwanted/adverse reactions so that their treatment can be re-evaluated.
- Scheduling and attending follow-up appointments to review the effectiveness of their medications.
- Calling your office if they cannot get their medications refilled.
- Discuss the benefits of participating in a behavioral health case management program.
- Ask your members who have a behavioral health diagnosis to provide you access to their behavioral health records if you are their primary care provider.
- If utilizing an EMR system, consider electronic data sharing with your health plan to capture all coded elements. Contact your provider relationship managements representative for additional details and questions.

How can we help?

- Members may be eligible for transportation assistance at no cost; contact Member Services for arrangement.

We help you with antidepressant medication management by:

- Offering current *Clinical Practice Guidelines* on our provider self-service website.

Other available resources:

You can find more information and tools online at:

- **www.ahrq.gov**
- **www.ncbi.nlm.nih.gov**

Asthma Medication Ratio (AMR)

This HEDIS measure looks at the percentage of members 5 to 64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.5 or greater during the measurement year.

Record your efforts:

- **Oral medication dispensing event**: Multiple prescriptions for different medications dispensed on the same day are counted as separate dispensing events — If multiple prescriptions for the same medication are dispensed on the same day, sum up the days' supply and divide by 30. Use the drug ID to determine if the prescriptions are the same or different.
- **Inhaler dispensing event**: All inhalers (for example, canisters) of the same medication dispensed on the same day count as one dispensing event — Medications with different drug IDs dispensed on the same day are counted as different dispensing events.
- **Injection dispensing events**: Each injection counts as one dispensing event. Multiple dispensed injections of the same or different medications count as separate dispensing events.
- **Units of medications**: When identifying medication units for the numerator, count each individual medication, defined as an amount lasting 30 days or less, as one medication unit. One medication unit equals one inhaler canister, one injection, or a 30-day or less supply of an oral medication.

Exclusions:

- Members who use hospice services or elect to use a hospice benefit any time during the measurement year
- Members who die any time during the measurement year
- Members who had no asthma controller or reliever medications dispensed during the measurement year.
- Members who had a diagnosis that requires a different treatment approach than members with asthma any time during the member's history through December 31 of the measurement year.

	Codes:
Asthma	**ICD-10-CM:** **J45.21:** Mild intermittent asthma with (acute) exacerbation **J45.22:** Mild intermittent asthma with status asthmaticus **J45.30:** Mild persistent asthma, uncomplicated **J45.31:** Mild persistent asthma with (acute) exacerbation **J45.32:** Mild persistent asthma with status asthmaticus **J45.40:** Moderate persistent asthma, uncomplicated **J45.41:** Moderate persistent asthma with (acute) exacerbation **J45.42:** Moderate persistent asthma with status asthmaticus **J45.50:** Severe persistent asthma, uncomplicated **J45.51:** Severe persistent asthma with (acute) exacerbation **J45.52:** Severe persistent asthma with status asthmaticus **J45.901:** Unspecified asthma with (acute) exacerbation **J45.902:** Unspecified asthma with status asthmaticus **J45.909:** Unspecified asthma, uncomplicated **J45.991:** Cough variant asthma **J45.998:** Other asthma
Outpatient and Telehealth	**CPT:** 98966, 98967, 98968, 98970, 98971, 98972, 98980, 98981, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99242, 99243, 99244, 99245, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99421, 99422, 99423, 99429, 99441, 99442, 99443, 99455, 99456, 99457, 99458, 99483
	HCPCS: **G0071:** Payment for communication technology-based services for 5 minutes or more of a virtual (non-face-to-face) communication between a rural health clinic (RHC) or federally qualified health center (FQHC) practitioner and RHC or FQHC patient, or 5 minutes or more of remote evaluation of recorded video and/or images by an RHC or FQHC practitioner, occurring in lieu of an office visit; RHC or FQHC only

	Codes:
Outpatient and Telehealth (cont.)	**HCPCS:** **G0402:** Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment **G0438:** Annual wellness visit; includes a personalized prevention plan of service (PPS), initial visit **G0439:** Annual wellness visit, includes a personalized prevention plan of service (PPS), subsequent visit **G0463:** Hospital outpatient clinic visit for assessment and management of a patient **G2010:** Remote evaluation of recorded video and/or images submitted by an established patient (for example, store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment **G2012:** Brief communication technology-based service, for example, virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion **G2250:** Remote assessment of recorded video and/or images submitted by an established patient (for example, store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment **G2251:** Brief communication technology-based service, for example, virtual check-in, by a qualified health care professional who cannot report evaluation and management services, provided to an established patient, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of clinical discussion

	Codes:
Outpatient and Telehealth (cont.)	**G2252:** Brief communication technology-based service, for example, virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion **T1015:** Clinic visit/encounter, all-inclusive
CDC Race and Ethnicity	**1002-5:** American Indian or Alaska Native **2028-9:** Asian **2054-5:** Black or African American **2076-8:** Native Hawaiian or Other Pacific Islander **2106-3:** White **2135-2:** Hispanic or Latino **2186-5:** Not Hispanic or Latino

Helpful tip:

- If utilizing an EMR system, consider electronic data sharing with your health plan to capture all coded elements. Contact your Provider Solutions representative for additional details and questions.

How can we help?

- Offering current *Clinical Practice Guidelines* on our provider self-service website.
- Providing you with individual reports of your members overdue for services if needed.
- Assisting with patient scheduling if needed.
- Members may be eligible for transportation assistance at no cost; contact Member Services for arrangement.

Notes:

Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)

This HEDIS measure looks at the percentage of children and adolescents 1 to 17 years of age who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment January 1 through December 1 of the measurement year.

Record your efforts:

Documentation of psychosocial care in the 121-day period from 90 days prior to the IPSD through 30 days after the IPSD.

Exclusions:

- Members who use hospice services or elect to use a hospice benefit any time during the measurement year.
- Members who die any time during the measurement year.
- Members for whom first-line antipsychotic medications may be clinically appropriate: members with a diagnosis of schizophrenia, schizoaffective disorder, bipolar disorder, other psychotic disorder, autism, or other developmental disorder on at least two different dates of service during the measurement year.

	Codes:
Psychosocial Care	**CPT:** 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90846, 90847, 90849, 90853, 90875, 90876, 90880
	HCPCS: **G0176:** Activity therapy, such as music, dance, art or play therapies not for recreation, related to the care and treatment of patient's disabling mental health problems, per session (45 minutes or more) **G0177:** Training and educational services related to the care and treatment of patient's disabling mental health problems per session (45 minutes or more) **G0409:** Social work and psychological services, directly relating to and/or furthering the patient's rehabilitation goals, each 15 minutes, face-to-face; individual (services provided by a CORF-qualified social worker or psychologist in a CORF)

	Codes:
Psychosocial Care (cont.)	**HCPCS:** **G0410:** Group psychotherapy other than of a multiple-family group, in a partial hospitalization setting, approximately 45 to 50 minutes **G0411:** Interactive group psychotherapy, in a partial hospitalization setting, approximately 45 to 50 minutes **H0004:** Behavioral health counseling and therapy, per 15 minutes **H0035:** Mental health partial hospitalization, treatment, less than 24 hours **H0036:** Community psychiatric supportive treatment, face-to-face, per 15 minutes **H0037:** Community psychiatric supportive treatment program, per diem **H0038:** Self-help/peer services, per 15 minutes **H0039:** Assertive community treatment, face-to-face, per 15 minutes

	Codes:
Psychosocial Care (cont.)	**HCPCS:** **H0040:** Assertive community treatment program, per diem **H2000:** Comprehensive multidisciplinary evaluation **H2001:** Rehabilitation program, per 1/2 day **H2011:** Crisis intervention service, per 15 minutes **H2012:** Behavioral health day treatment, per hour **H2013:** Psychiatric health facility service, per diem **H2014:** Skills training and development, per 15 minutes **H2017:** Psychosocial rehabilitation services, per 15 minutes **H2018:** Psychosocial rehabilitation services, per diem **H2019:** Therapeutic behavioral services, per 15 minutes **H2020:** Therapeutic behavioral services, per diem **S0201:** Partial hospitalization services, less than 24 hours, per diem **S9480:** Intensive outpatient psychiatric services, per diem **S9484:** Crisis intervention mental health services, per hour **S9485:** Crisis intervention mental health services, per diem
Bipolar Disorder	**ICD-10-CM:** **F30.10:** Manic episode without psychotic symptoms, unspecified **F30.11:** Manic episode without psychotic symptoms, mild **F30.12:** Manic episode without psychotic symptoms, moderate **F30.13:** Manic episode, severe, without psychotic symptoms **F30.2:** Manic episode, severe with psychotic symptoms **F30.3:** Manic episode in partial remission **F30.4:** Manic episode in full remission **F30.8**: Other manic episodes **F30.9:** Manic episode, unspecified **F31.0:** Bipolar disorder, current episode hypomanic

	Codes:
Bipolar Disorder (cont.)	**ICD-10-CM:** **F31.10:** Bipolar disorder, current episode manic without psychotic features, unspecified **F31.11:** Bipolar disorder, current episode manic without psychotic features, mild **F31.12:** Bipolar disorder, current episode manic without psychotic features, moderate **F31.13:** Bipolar disorder, current episode manic without psychotic features, severe **F31.2:** Bipolar disorder, current episode manic severe with psychotic features **F31.30:** Bipolar disorder, current episode depressed, mild or moderate severity, unspecified **F31.31:** Bipolar disorder, current episode depressed, mild **F31.32:** Bipolar disorder, current episode depressed, moderate **F31.4:** Bipolar disorder, current episode depressed, severe, without psychotic features **F31.5:** Bipolar disorder, current episode depressed, severe, with psychotic features **F31.60:** Bipolar disorder, current episode mixed, unspecified **F31.61:** Bipolar disorder, current episode mixed, mild **F31.62:** Bipolar disorder, current episode mixed, moderate **F31.63:** Bipolar disorder, current episode mixed, severe, without psychotic features **F31.64:** Bipolar disorder, current episode mixed, severe, with psychotic features **F31.70:** Bipolar disorder, currently in remission, most recent episode unspecified **F31.71:** Bipolar disorder, in partial remission, most recent episode hypomanic **F31.72:** Bipolar disorder, in full remission, most recent episode hypomanic **F31.73:** Bipolar disorder, in partial remission, most recent episode manic

	Codes:
Bipolar Disorder (cont.)	**F31.74:** Bipolar disorder, in full remission, most recent episode manic **F31.75:** Bipolar disorder, in partial remission, most recent episode depressed **F31.76:** Bipolar disorder, in full remission, most recent episode depressed **F31.77:** Bipolar disorder, in partial remission, most recent episode mixed **F31.78:** Bipolar disorder, in full remission, most recent episode mixed
Other Psychotic and Developmental Disorders	**ICD10CM:** **F22:** Delusional disorders **F23:** Brief psychotic disorder **F24:** Shared psychotic disorder **F28:** Other psychotic disorder not due to a substance or known physiological condition **F29:** Unspecified psychosis not due to a substance or known physiological condition **F32.3:** Major depressive disorder, single episode, severe with psychotic features **F33.3:** Major depressive disorder, recurrent, severe with psychotic symptoms **F84.0:** Autistic disorder **F84.2:** Rett's syndrome **F84.3:** Other childhood disintegrative disorder **F84.5:** Asperger's syndrome **F84.8:** Other pervasive developmental disorders **F84.9:** Pervasive developmental disorder, unspecified **F95.0:** Transient tic disorder **F95.1:** Chronic motor or vocal tic disorder **F95.2:** Tourette's disorder **F95.8:** Other tic disorders **F95.9:** Tic disorder, unspecified

	Codes:
Residential Behavioral Health Treatment	**HCPCS:** **H0017:** Behavioral health; residential (hospital residential treatment program), without room and board, per diem **H0018:** Behavioral health; short-term residential (non-hospital residential treatment program), without room and board, per diem **H0019:** Behavioral health; long-term residential (non-medical, non-acute care in a residential treatment program where stay is typically longer than 30 days), without room and board, per diem **T2048**: Behavioral health; long-term care residential (non-acute care in a residential treatment program where stay is typically longer than 30 days), with room and board, per diem
Schizophrenia	**CPT:** **F20.0:** Paranoid schizophrenia **F20.1:** Disorganized schizophrenia **F20.2:** Catatonic schizophrenia **F20.3:** Undifferentiated schizophrenia **F20.5:** Residual schizophrenia **F20.81:** Schizophreniform disorder **F20.89:** Other schizophrenia **F20.9:** Schizophrenia, unspecified **F25.0:** Schizoaffective disorder, bipolar type **F25.1:** Schizoaffective disorder, depressive type **F25.8:** Other schizoaffective disorders **F25.9:** Schizoaffective disorder, unspecified

Helpful tip:

- If using an EMR system, consider electronic data sharing with your health plan to capture all coded elements. Contact your provider relationship managements representative for additional details and questions.

How can we help?

- Offering current *Clinical Practice Guidelines* on our provider self-service website.
- Providing you with individual reports of your members overdue for services if needed.
- Assisting with patient scheduling if needed.
- Members may be eligible for transportation assistance at no cost; contact Member Services for arrangement.

Notes:

Blood Pressure Control for Patients with Diabetes (BPD)

This HEDIS measure looks at the percentage of members 18 to 75 years of age with diabetes (type 1 and 2) whose blood pressure (BP) was adequately controlled (< 140/90 mm Hg) during the measurement year.

Record your efforts:

- Members 18 to 75 years of age whose BP is < 140/90 mm Hg
- If there are multiple BPs on the same date of service, use the lowest systolic and lowest diastolic BP on that date as the representative BP
- BP readings taken by the member using a digital device and documented in the member's medical record are eligible for use in reporting (provided the BP does not meet any exclusion criteria).

What does not count?

Do not include BP readings:

- Taken during an acute inpatient stay or an ED visit.
- Taken on the same day as a diagnostic test or diagnostic or therapeutic procedure that requires a change in diet or change in medication on or one day before the day of the test or procedure, with the exception of fasting blood tests.
- Taken by the member using a non-digital device such as with a manual blood pressure cuff and a stethoscope.

Exclusions:

- Members who use hospice services or elect to use a hospice benefit any time during the measurement year
- Members who die any time during the measurement year
- Members receiving palliative care any time during the measurement year
- Members who had an encounter with palliative anytime during the measurement year
- Members 66 years of age and older as of December 31 of the measurement year (all product lines) with frailty and advanced illness. Members must meet both frailty and advanced illness criteria to be excluded

	Codes:
Diastolic Blood Pressure	**CPT-CAT II:** **3078F:** Most recent diastolic blood pressure less than 80 mm Hg (HTN, CKD, CAD) (DM) **3079F:** Most recent diastolic blood pressure 80-89 mm Hg (HTN, CKD, CAD) (DM) **3080F:** Most recent diastolic blood pressure greater than or equal to 90 mm Hg (HTN, CKD, CAD) (DM)
	LOINC: **75995-1:** Diastolic blood pressure by Continuous non-invasive monitoring **8453-3:** Diastolic blood pressure--sitting **8454-1:** Diastolic blood pressure--standing **8455-8:** Diastolic blood pressure--supine **8462-4:** Diastolic blood pressure **8496-2:** Brachial artery Diastolic blood pressure **8514-2:** Brachial artery - left Diastolic blood pressure **8515-9:** Brachial artery - right Diastolic blood pressure **89267-9:** Diastolic blood pressure--lying in L-lateral position
Diastolic Less Than 90	**CPT-CAT II:** **3078F:** Most recent diastolic blood pressure less than 80 mm Hg (HTN, CKD, CAD) (DM) **3079F:** Most recent diastolic blood pressure 80-89 mm Hg (HTN, CKD, CAD) (DM)
Systolic and Diastolic Result	**CPT-CAT: II** **3074F:** Most recent systolic blood pressure less than 130 mm Hg (DM) (HTN, CKD, CAD) **3075F:** Most recent systolic blood pressure 130-139 mm Hg (DM) (HTN, CKD, CAD) **3077F:** Most recent systolic blood pressure greater than or equal to 140 mm Hg (HTN, CKD, CAD) (DM) **3078F:** Most recent diastolic blood pressure less than 80 mm Hg (HTN, CKD, CAD) (DM)

	Codes:
Systolic and Diastolic Result (cont.)	**CPT-CAT II:** **3079F:** Most recent diastolic blood pressure 80-89 mm Hg (HTN, CKD, CAD) (DM) **3080F:** Most recent diastolic blood pressure greater than or equal to 90 mm Hg (HTN, CKD, CAD) (DM)
Systolic Blood Pressure	**CPT-CAT II:** **3074F:** Most recent systolic blood pressure less than 130 mm Hg (DM) (HTN, CKD, CAD) **3075F:** Most recent systolic blood pressure 130-139 mm Hg (DM) (HTN, CKD, CAD) **3077F:** Most recent systolic blood pressure greater than or equal to 140 mm Hg (HTN, CKD, CAD) (DM) **LOINC:** **75997-7:** Systolic blood pressure by Continuous non-invasive monitoring **8459-0:** Systolic blood pressure—sitting **8460-8:** Systolic blood pressure—standing **8461-6:** Systolic blood pressure—supine **8480-6:** Systolic blood pressure **8508-4:** Brachial artery Systolic blood pressure **8546-4:** Brachial artery - left Systolic blood pressure **8547-2:** Brachial artery - right Systolic blood pressure **89268-7:** Systolic blood pressure--lying in L-lateral position

	Codes:
Systolic less than 140	**CPT-CAT II:** **3074F:** Most recent systolic blood pressure less than 130 mm Hg (DM) (HTN, CKD, CAD) **3075F:** Most recent systolic blood pressure 130-139 mm Hg (DM) (HTN, CKD, CAD)

Note: The Logical Observation Identifiers Names and Codes (LOINC) are for reporting clinical observations and laboratory testing. The codes listed are informational only; this information does not guarantee reimbursement.

Helpful tips:

- Improve the accuracy of BP measurements performed by your clinical staff by:
  - Providing training materials from the American Heart Association.
  - Conducting BP competency tests to validate the education of each clinical staff member.
  - Making a variety of cuff sizes available.
- Instruct your office staff to recheck BPs for all members with initial recorded readings greater than systolic 140 mm Hg and diastolic of 90 mm Hg during outpatient office visits; have your staff record the recheck in member's medical records.
- Refer high-risk members to our hypertension programs for additional education and support.
- Educate members and their spouses, caregivers, or guardians about the elements of a healthy lifestyle such as:
  - Heart-healthy eating and a low-salt diet.
  - Smoking cessation and avoiding secondhand smoke.
  - Adding regular exercise to daily activities.
  - Home BP monitoring.
  - Ideal body mass index (BMI).
  - The importance of taking all prescribed medications as directed.
- Remember to include the applicable Category II reporting code above on the claim form to help reduce the burden of HEDIS medical record review!
- If utilizing an EMR system, consider electronic data sharing with your health plan to capture all coded elements. Contact your provider relationship account representative for additional details and questions.

How can we help?

We support you in helping members control high blood pressure by:

- Providing online *Clinical Practice Guidelines* on our provider self-service website.
- Reaching out to our hypertensive members through our programs.
- Helping identify your hypertensive members.
- Helping you schedule, plan, implement and evaluate a health screening Clinic Day; call your provider relationship managements representative to find out more.
- Educating our members on high blood pressure through health education materials if available.
- Supplying copies of healthy tips for your office.
- Members may be eligible for transportation assistance at no cost, contact Services for arrangement.

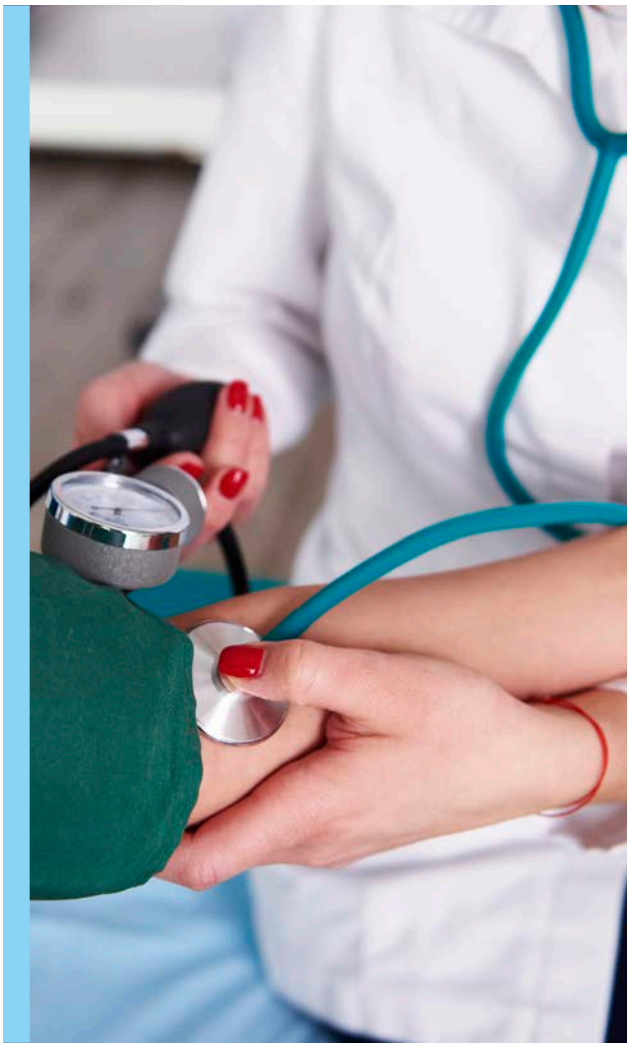
Other available resources:

You can find more information and tools online at:

- **nhlbi.nih.gov**
- **cdc.gov/bloodpressure/index.htm**

Controlling High Blood Pressure (CBP)

This HEDIS measure looks at the percentage of members ages 18 to 85 years who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (< 140/90 mm Hg) during the measurement year.



Record your efforts:

Document blood pressure and diagnosis of HTN. Members whose BP is adequately controlled include:

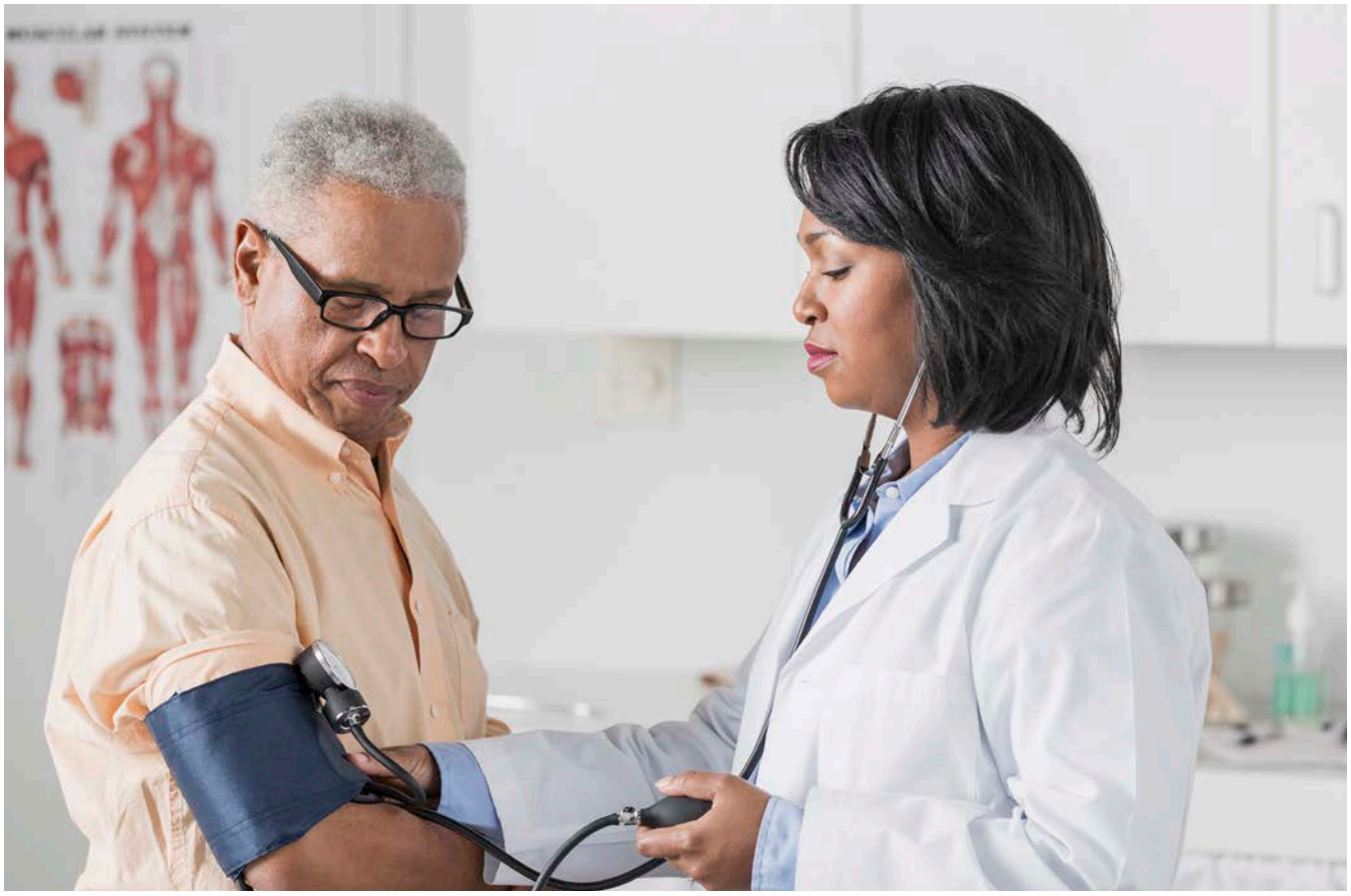
- Members 18 to 85 years of age who had a diagnosis of HTN and whose BP was adequately controlled (< 140/90 mm Hg) during the measurement year.
- The most recent BP reading during the measurement year on or after the second diagnosis of hypertension:
  - If multiple BP measurements occur on the same date or are noted in the chart on the same date, use the lowest systolic and lowest diastolic BP reading.
  - If no BP is recorded during the measurement year, assume that the member is not controlled.

What does not count?

- If taken on the same day as a diagnostic test or procedure that requires a change in diet or medication regimen
- On or one day before the day of the test or procedure with the exception of fasting blood tests
- Taken during an acute inpatient stay or an ED visit
- Taken by the member using a non-digital device such as with a manual blood pressure cuff and a stethoscope.

Exclusions:

- Members who use hospice services or elect to use a hospice benefit any time during the measurement year
- Members who die any time during the measurement year
- Members receiving palliative care any time during the measurement year
- Members who had an encounter for palliative care anytime during the measurement year
- Members with a diagnosis that indicates end-stage renal disease (ESRD) any time during the member's history on or prior to December 31 of the measurement year
- Members with a procedure that indicates ESRD: dialysis any time during the member's history on or prior to December 31 of the measurement year
- Members with a diagnosis of pregnancy any time during the measurement year
- Members 66 to 80 years of age as of December 31 of the measurement year (all product lines) with frailty and advanced illness. Members must meet BOTH frailty and advanced illness criteria to be excluded
- Members 81 years of age and older as of December 31 of the measurement year (all product lines) with at least two indications of frailty with different dates of service during the measurement year



	Codes:
Diastolic Blood Pressure	**CPT-CAT II:** **3078F:** Most recent diastolic blood pressure less than 80 mm Hg (HTN, CKD, CAD) (DM) **3079F:** Most recent diastolic blood pressure 80-89 mm Hg (HTN, CKD, CAD) (DM) **3080F:** Most recent diastolic blood pressure greater than or equal to 90 mm Hg (HTN, CKD, CAD) (DM) **LOINC:** **75995-1:** Diastolic blood pressure by Continuous non-invasive monitoring **8453-3:** Diastolic blood pressure--sitting **8454-1:** Diastolic blood pressure--standing **8455-8:** Diastolic blood pressure--supine **8462-4:** Diastolic blood pressure **8496-2:** Brachial artery Diastolic blood pressure **8514-2:** Brachial artery - left Diastolic blood pressure **8515-9:** Brachial artery - right Diastolic blood pressure **89267-9:** Diastolic blood pressure--lying in L-lateral position
Diastolic Less Than 90	**CPT-CAT II:** **3078F:** Most recent diastolic blood pressure less than 80 mm Hg (HTN, CKD, CAD) (DM) **3079F:** Most recent diastolic blood pressure 80-89 mm Hg (HTN, CKD, CAD) (DM)

	Codes:
Systolic and Diastolic Result	**CPT-CAT II:** **3074F:** Most recent systolic blood pressure less than 130 mm Hg (DM) (HTN, CKD, CAD) **3075F:** Most recent systolic blood pressure 130-139 mm Hg (DM) (HTN, CKD, CAD) **3077F:** Most recent systolic blood pressure greater than or equal to 140 mm Hg (HTN, CKD, CAD) (DM) **3078F:** Most recent diastolic blood pressure less than 80 mm Hg (HTN, CKD, CAD) (DM) **3079F:** Most recent diastolic blood pressure 80-89 mm Hg (HTN, CKD, CAD) (DM) **3080F:** Most recent diastolic blood pressure greater than or equal to 90 mm Hg (HTN, CKD, CAD) (DM)
Systolic Blood Pressure	**CPT-CAT II:** **3074F:** Most recent systolic blood pressure less than 130 mm Hg (DM) (HTN, CKD, CAD) **3075F:** Most recent systolic blood pressure 130-139 mm Hg (DM) (HTN, CKD, CAD) **3077F:** Most recent systolic blood pressure greater than or equal to 140 mm Hg (HTN, CKD, CAD) (DM) **LOINC:** **75997-7:** Systolic blood pressure by Continuous non-invasive monitoring **8459-0:** Systolic blood pressure—sitting **8460-8:** Systolic blood pressure--standing **8461-6:** Systolic blood pressure—supine **8480-6:** Systolic blood pressure **8508-4:** Brachial artery Systolic blood pressure **8546-4:** Brachial artery - left Systolic blood pressure **8547-2:** Brachial artery - right Systolic blood pressure **89268-7:** Systolic blood pressure--lying in L-lateral position

	Codes:
Systolic less than 140	**CPT-CAT II:** **3074F:** Most recent systolic blood pressure less than 130 mm Hg (DM) (HTN, CKD, CAD) **3075F:** Most recent systolic blood pressure 130-139 mm Hg (DM) (HTN, CKD, CAD)
Outpatient and Telehealth Without UBREV	**CPT:** 98966, 98967, 98968, 98970, 98971, 98972, 98980, 98981, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99242, 99243, 99244, 99245, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99421, 99422, 99423, 99429, 99441, 99442, 99443, 99455, 99456, 99457, 99458, 99483
	HCPCS: **G0071:** Payment for communication technology-based services for 5 minutes or more of a virtual (non-face-to-face) communication between a rural health clinic (RHC) or federally qualified health center (FQHC) practitioner and RHC or FQHC patient, or 5 minutes or more of remote evaluation of recorded video and/or images by an RHC or FQHC practitioner, occurring in lieu of an office visit; RHC or FQHC only **G0402:** Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment **G0438:** Annual wellness visit; includes a personalized prevention plan of service (PPS), initial visit **G0439:** Annual wellness visit, includes a personalized prevention plan of service (PPS), subsequent visit **G0463:** Hospital outpatient clinic visit for assessment and management of a patient **G2010:** Remote evaluation of recorded video and/or images submitted by an established patient (for example, store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment

	Codes:
Outpatient and Telehealth Without UBREV (cont.)	**G2012:** Brief communication technology-based service, for example, virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion **G2250:** Remote assessment of recorded video and/or images submitted by an established patient (for example, store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment **G2251:** Brief communication technology-based service, for example, virtual check-in, by a qualified health care professional who cannot report evaluation and management services, provided to an established patient, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of clinical discussion **G2252:** Brief communication technology-based service, for example, virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion **T1015:** Clinic visit/encounter, all-inclusive
CDC Race and Ethnicity	**1002-5:** American Indian or Alaska Native **2028-9:** Asian **2054-5:** Black or African American **2076-8:** Native Hawaiian or Other Pacific Islander **2106-3**: White **2135-2:** Hispanic or Latino **2186-5:** Not Hispanic or Latino

Note: The Logical Observation Identifiers Names and Codes (LOINC) are for reporting clinical observations and laboratory testing. The codes listed are informational only; this information does not guarantee reimbursement.

Helpful tips:

- Improve the accuracy of BP measurements performed by your clinical staff by:
  - Providing training materials from the American Heart Association.
  - Conducting BP competency tests to validate the education of each clinical staff member.
  - Making a variety of cuff sizes available.
- Instruct your office staff to recheck BPs for all members with initial recorded readings greater than systolic 140 mm Hg and diastolic of 90 mm Hg during outpatient office visits; have your staff record the recheck in member's medical records.
- Refer high-risk members to our hypertension programs for additional education and support.
- Educate members and their spouses, caregivers, or guardians about the elements of a healthy lifestyle such as:
  - Heart-healthy eating and a low-salt diet.
  - Smoking cessation and avoiding secondhand smoke.
  - Adding regular exercise to daily activities.
  - Home BP monitoring.
  - Ideal body mass index (BMI).
  - The importance of taking all prescribed medications as directed.
- Remember to include the applicable Category II reporting code above on the claim form to help reduce the burden of HEDIS medical record review!

If utilizing an EMR system, consider electronic data sharing with your health plan to capture all coded elements. Contact your provider relationship managements representative for additional details and questions.

How can we help?

We support you in helping members control high blood pressure by:

- Providing online *Clinical Practice Guidelines* on our provider self-service website
- Reaching out to our hypertensive members through our programs.
- Helping identify your hypertensive members.
- Helping you schedule, plan, implement and evaluate a health screening Clinic Day; call your provider relationship managements representative to find out more.
- Educating our members on high blood pressure through health education materials if available.
- Supplying copies of healthy tips for your office.
- Members may be eligible for transportation assistance at no cost, contact Member Services for arrangement.

Other available resources

You can find more information and tools online at:

- **www.nhlbi.nih.gov**
- **https://www.cdc.gov/bloodpressure/index.htm**

Notes:

Cervical Cancer Screening (CCS)

This HEDIS measure looks at the percentage of members 21 to 64 years of age who were recommended for routine cervical cancer screening and were screened for cervical cancer using any of the following criteria:

- **Members 21 to 64 years of age** who were recommended for routine cervical cancer screening and had cervical cytology performed within the last three years.
- **Members 30 to 64 years of age** who were recommended for routine cervical cancer screening and had cervical high-risk human papillomavirus (hrHPV) testing performed within the last five years.
- **Members 30 to 64 years of age** who were recommended for routine cervical cancer screening and had cervical cytology/high-risk human papillomavirus (hrHPV) cotesting within the last five years.

Record your efforts:

Make sure your medical records reflect:

- The date when the cervical cytology was performed.
- The results or findings
  - "Unknown" is not considered a result/finding
- Notes in member's chart if member has a history of hysterectomy.
  - Complete details if it was a complete, total, or radical abdominal, vaginal, or unspecified hysterectomy with no residual cervix; also, document history of cervical agenesis or acquired absence of cervix. (Include, at a minimum, the year the surgical procedure was performed.)

Exclusions:

Members who have one of the following in their history can be excluded:

- Members who use hospice services or elect to use a hospice benefit any time during the measurement year
- Members who die any time during the measurement year
- Hysterectomy with no residual cervix
- Cervical agenesis or acquired absence of cervix
- Members receiving palliative care
- Member who had an encounter for palliative care
- Members with sex assigned at birth of male at any time in the patient's history.

	Codes:
Cervical Cytology Lab Test	**CPT:** 88141, 88142, 88143, 88147, 88148, 88150, 88152, 88153, 88164, 88165, 88166, 88167, 88174, 88175 **HCPCS:** **G0123:** Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, screening by cytotechnologist under physician supervision **G0124:** Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, requiring interpretation by physician **G0141:** Screening cytopathology smears, cervical or vaginal, performed by automated system, with manual rescreening, requiring interpretation by physician **G0143:** Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with manual screening and rescreening by cytotechnologist under physician supervision **G0144:** Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with screening by automated system, under physician supervision

	Codes:
Cervical Cytology Lab Test (cont.)	**HCPCS:** **G0145:** Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with screening by automated system and manual rescreening under physician supervision **G0147:** Screening cytopathology smears, cervical or vaginal, performed by automated system under physician supervision **G0148:** Screening cytopathology smears, cervical or vaginal, performed by automated system with manual rescreening **P3000:** Screening papanicolaou smear, cervical or vaginal, up to three smears, by technician under physician supervision **P3001:** Screening papanicolaou smear, cervical or vaginal, up to three smears, requiring interpretation by physician **Q0091:** Screening papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory
	LOINC: **10524-7:** Microscopic observation [Identifier] in Cervix by Cyto stain **18500-9:** Microscopic observation [Identifier] in Cervix by Cyto stain.Thin prep **19762-4:** General categories [Interpretation] of Cervical or vaginal smear or scraping by Cyto stain **19764-0**: Statement of adequacy [Interpretation] of Cervical or vaginal smear or scraping by Cyto stain **19765-7:** Microscopic observation [Identifier] in Cervical or vaginal smear or scraping by Cyto stain **19766-5:** Microscopic observation [Identifier] in Cervical or vaginal smear or scraping by Cyto stain Narrative **19774-9:** Cytology study comment Cervical or vaginal smear or scraping Cyto stain **33717-0:** Cervical AndOr vaginal cytology study **47527-7:** Cytology report of Cervical or vaginal smear or scraping Cyto stain.Thin prep **47528-5**: Cytology report of Cervical or vaginal smear or scraping Cyto stain

High Risk HPV Lab Test

Codes:

CPT:
87624, 87625

HCPCS:
G0476: Infectious agent detection by nucleic acid (DNA or RNA); human papillomavirus (HPV), high-risk types (for example, 16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 68) for cervical cancer screening, must be performed in addition to PAP test

LOINC:
21440-3: Human papilloma virus 16+18+31+33+35+45+51+52+56 DNA [Presence] in Cervix by Probe

30167-1: Human papilloma virus 16+18+31+33+35+39+45+51+52+56+58+59+68 DNA [Presence] in Cervix by Probe with signal amplification

38372-9: Human papilloma virus 6+11+16+18+31+33+35+39+42+43+44+45+51+52+56+58+59+68 DNA [Presence] in Cervix by Probe with signal amplification

59263-4: Human papilloma virus 16 DNA [Presence] in Cervix by Probe with signal amplification

59264-2: Human papilloma virus 18 DNA [Presence] in Cervix by Probe with signal amplification

59420-0: Human papilloma virus 16+18+31+33+35+39+45+51+52+56+58+59+66+68 DNA [Presence] in Cervix by Probe with signal amplification

69002-4: Human papilloma virus E6+E7 mRNA [Presence] in Cervix by NAA with probe detection

71431-1: Human papilloma virus 31+33+35+39+45+51+52+56+58+59+66+68 DNA [Presence] in Cervix by NAA with probe detection

75694-0: Human papilloma virus 18+45 E6+E7 mRNA [Presence] in Cervix by NAA with probe detection

77379-6: Human papilloma virus 16 and 18 and 31+33+35+39+45+51+52+56+58+59+66+68 DNA [Interpretation] in Cervix

77399-4: Human papilloma virus 16 DNA [Presence] in Cervix by NAA with probe detection

	Codes:
High Risk HPV Lab Test (cont.)	**LOINC:** **77400-0:** Human papilloma virus 18 DNA [Presence] in Cervix by NAA with probe detection **82354-2:** Human papilloma virus 16 and 18+45 E6+E7 mRNA [Identifier] in Cervix by NAA with probe detection **82456-5:** Human papilloma virus 16 E6+E7 mRNA [Presence] in Cervix by NAA with probe detection **82675-0:** Human papilloma virus 16+18+31+33+35+39+45+51 +52+56+58+59+66+68 DNA [Presence] in Cervix by NAA with probe detection **95539-3:** Human papilloma virus 31 DNA [Presence] in Cervix by NAA with probe detection

Note: The Logical Observation Identifiers Names and Codes (LOINC) are for reporting clinical observations and laboratory testing. The codes listed are informational only; this information does not guarantee reimbursement.

Helpful tips:

- Discuss the importance of well-woman exams, mammograms, Pap tests and HPV testing with all female members between ages 21 to 64 years.
- Be a champion in promoting women's health by reminding them of the importance of annual wellness visits.
- Refer members to another appropriate provider if your office does not perform Pap tests and request copies of Pap test/HPV co-testing results be sent to your office.
- Talk to your provider relationship managements representative to determine if a health screening Clinic Day has been scheduled in your community. Our staff may be able to help plan, implement and evaluate events for a particular preventive screening, like a cervical cancer screening or a complete comprehensive women's health screening event (only if this is offered in your practice area).
- Train your staff on the use of educational materials to promote cervical cancer screening.
- Use a tracking mechanism, (for example, EMR flags and/or manual tracking tool) to identify members due for cervical cancer screening.
- Display posters and educational messages in treatment rooms and waiting areas to help motivate members to initiate discussions with you about screening.
- Train your staff on preventive screenings or find out if we provide training.
- If utilizing an EMR system, consider electronic data sharing with your health plan to capture all coded elements. Contact your provider relationship managements representative for additional details and questions.

How can we help?

We help you get our members this critical service by:

- Offering you access to our *Clinical Practice Guidelines* on our provider self-service bsite.
- Coordinating with you to plan and focus on improving health awareness for our members by providing health screenings, activities, materials, and resources if available or as needed.
- Educating members on the importance of cervical cancer screening through various sources, such as phone calls, post cards, newsletters, and health education fliers if available.
- Members may be eligible for transportation assistance at no cost, contact Member Services for arrangement.

Other available resources:

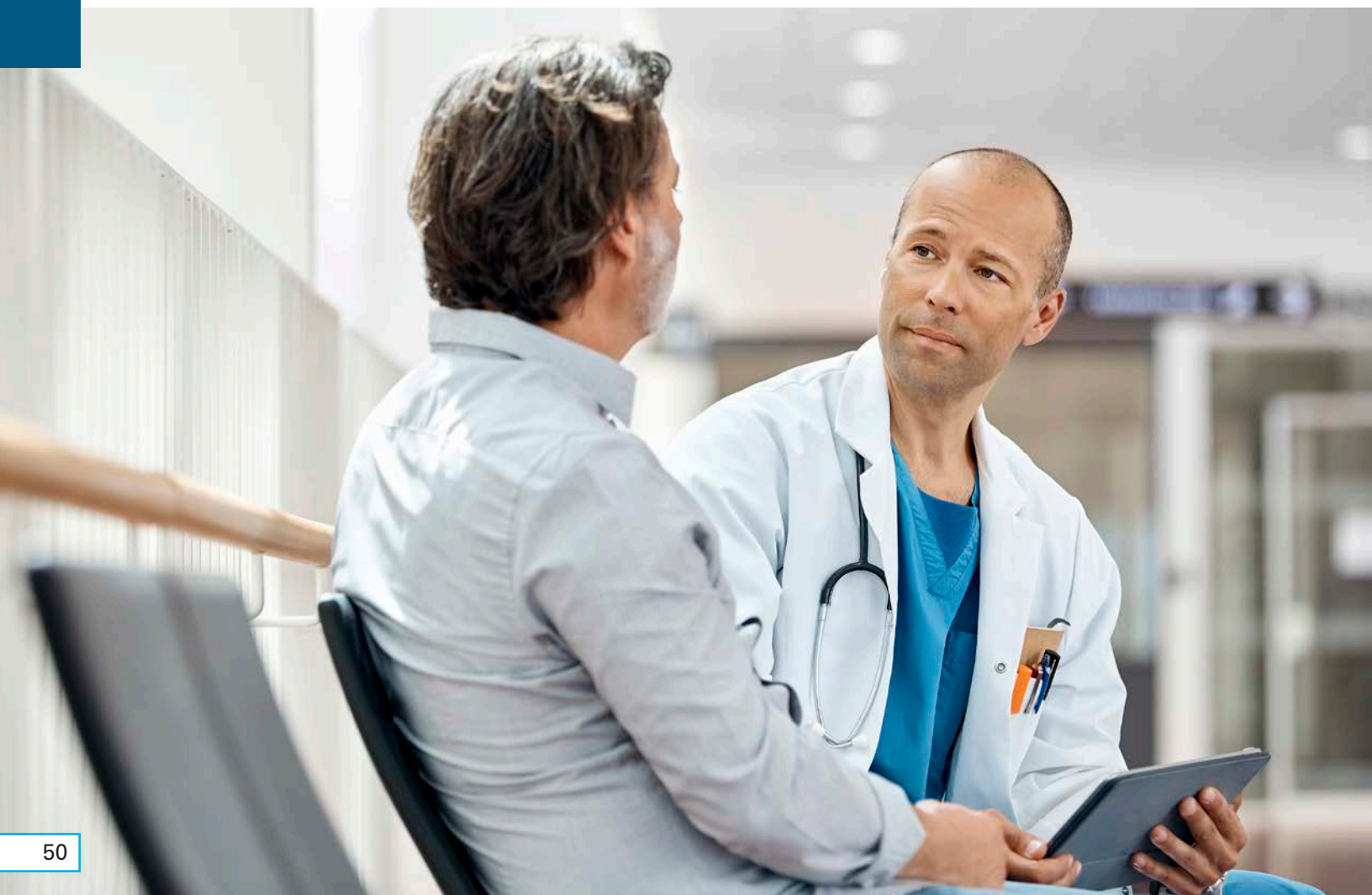
You can find more information and tools online at **www.uspreventiveservicestaskforce.org.**

Screening for Depression and Follow-Up Plan (CDF)

The percentage of members 12 years of age who were screened for clinical depression using a standardized instrument and, if screened positive, received follow-up care on the same of encounter as the positive screen (measure steward: CMS).

Record your efforts:

- This measure requires the use of an age-appropriate screening instrument. The member's age is used to select the appropriate depression screening instrument.
- Depression screening captured in health risk assessments or other types of health assessments are allowed if the questions align with a specific instrument that is validated for depression screening. For example, if a health risk assessment includes questions from the PHQ-2, it counts as screening if the member answered the questions, and a total score is calculated.



Codes to identify outpatient encounter:

	Codes
Screening for Depression and Follow-Up Plan (CDF)	**CPT:** 59400, 59510, 59610, 59618, 90791, 90792, 90832, 90834, 90837, 92625, 96116, 96121, 96130, 96131, 96132, 96133, 96136, 96137, 96138, 96139, 96146, 96150, 96151, 97165, 97166, 97167, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99318, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99339, 99340, 99483, 99484, 99492, 99493, 99384, 99385, 99386, 99387, 99394, 99395, 99396, 99397 **HCPCS:** G0101, G0402, G0438, G0439, G0444

Codes to identify depression screening and results:

	Codes
Screening for Depression and Follow-Up Plan (CDF)	**HCPCS:** **G8431:** Screening for depression is documented as being positive and a follow-up plan is documented. **G8510:** Screening for depression is documented as negative, a follow-up plan is not required.

Helpful tips:

- Use your member roster to contact members who are due for an exam or are new to your practice.
- Schedule the next visit at the end of the appointment.
- If you use EMRs, consider creating a flag to track members due or past due for a visit. If you do not use EMRs, consider creating a manual tracking method. Consider extending your office hours into the evening, early morning, or weekend to accommodate working parents.
- Remember to include the applicable ICD-10-CM code above on the claim form to help reduce the burden of HEDIS medical record review.

How can we help?

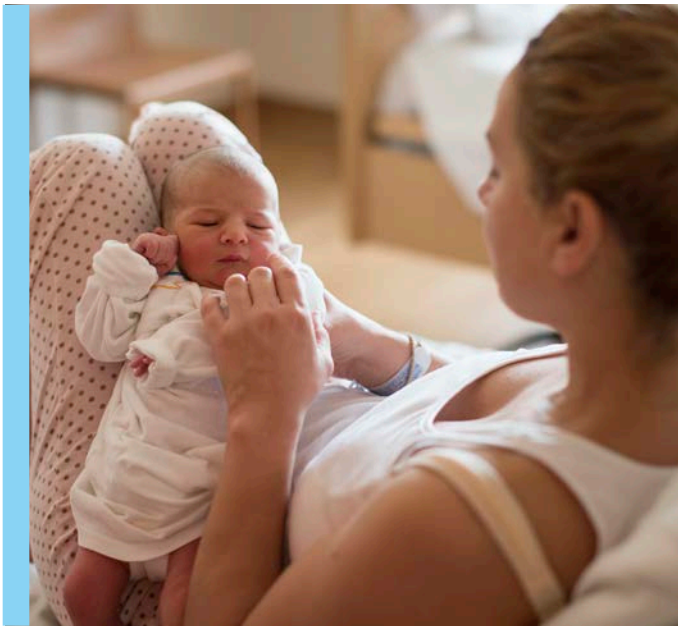
We help you meet this benchmark by:

- Offering current Clinical Practice Guidelines on our provider website at **provider.healthybluenc.com**.
- Providing individualized reports of your members overdue for services.
- Encouraging members to get preventive care through our programs. Contact your Advanced Medical Home Provider Clinical Liaison for more information.

Notes:

Childhood Immunization Status (CIS)

This measure looks at the percentage of children turning 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (Hep B), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and three combination rates:



- **DTap (Diphtheria, Tetanus, Pertussis):** At least four vaccinations with different dates of service. Do not count a vaccination administered prior to 42 days after birth.
- **IPV (Inactivated Polio Vaccine):** At least three vaccinations with different dates of service. Do not count a vaccination administered prior to 42 days after birth.
- **MMR (Measles, Mumps and Rubella:** Can only be given on or between the child's first and second birthdays.
- **HiB (Haemophilus influenza type b):** At least three vaccinations with different dates of service. Do not count a vaccination administered prior to 42 days after birth.
- **Hep B (Hepatitis B):** At least three vaccinations with different dates of service. One of the three vaccinations can be a newborn hepatitis B vaccination during the 8-day period that begins on the date of birth and ends 7 days after the date of birth.
- **VZV (Herpes Zoster Zostavax):** At least one vaccination with a date of service on or between the child's first and second birthdays.
- **PCV (Pneumococcal conjugate vaccine):** At least four vaccinations with different dates of service. Do not count a vaccination administered prior to 42 days after birth.
- **Hep A (Hepatitis A):** At least one vaccination with a date of service on or between the child's first and second birthdays.
- **RV (Rotavirus):** At least two doses of the two-dose rotavirus vaccine on different dates of service:
  - **or** at least three doses of the three-dose rotavirus vaccine different dates of service
  - **or** at least one dose of the two-dose rotavirus vaccine and at least two doses of the three-dose rotavirus vaccine all on different dates of service.
  - Do not count a vaccination administered prior to 42 days after birth.

- **Flu (Influenza):** At least two influenza vaccinations with different dates of service on or before the child's second birthday. Do not count a vaccination administered prior to 180 days after birth:
  - An influenza vaccination recommended for children 2 years and older administered on the child's second birthday meets criteria for one of the two required vaccinations.

Immunization:	Dose(s):	Immunization:	Dose(s):
DTaP	4	Hep B	3
IPV	3	VZV	1
MMR	1	PCV	4
Hib	3	Hep A	1

Immunization:	Dose(s):
Rotavirus	• Two-dose (Rotarix®) • Three-dose (Rotateq®) vaccine
Influenza	2 — Second dose may be LAIV given on 2nd birthday

Record your efforts:

Once you give our members their needed immunizations, let us and the state know by:

- Recording the immunizations in your state registry.
- Documenting the immunizations (historic and current) within medical records to include:
  - A note indicating the name of the specific antigen and the date of the immunization.
  - The certificate of immunization prepared by an authorized health care provider or agency.
  - For documented history of illness or anaphylaxis, there must be a note indicating the date of the event, which must have occurred by the member's second birthday.
  - The date of the first hepatitis B vaccine given at the hospital and name of the hospital if available.
  - A note that the *Member is up to date* with all immunizations, but which does not list the dates of all immunizations and the names of the immunization agents does not constitute sufficient evidence of immunization for HEDIS reporting.

Exclusions:

- A note indicating the name of the specific antigen and the date of the immunization.
- The certificate of immunization prepared by an authorized health care provider or agency.
- For documented history of illness or anaphylaxis, there must be a note indicating the date of the event, which must have occurred by the member's second birthday.

Codes to identify immunizations:

	Codes:	
DTaP	**CPT:** 90697, 90698, 90700, 90723	**20:** diphtheria, tetanus toxoids and acellular pertussis vaccine **50:** DTaP-Haemophilus influenzae type b conjugate vaccine **106:** diphtheria, tetanus toxoids and acellular pertussis vaccine, 5 pertussis antigens **107:** diphtheria, tetanus toxoids and acellular pertussis vaccine, unspecified formulation **110:** DTaP-hepatitis B and poliovirus vaccine **120:** diphtheria, tetanus toxoids and acellular pertussis vaccine, Haemophilus influenzae type b conjugate, and poliovirus vaccine, inactivated (DTaP-Hib-IPV) **146:** Diphtheria and Tetanus Toxoids and Acellular Pertussis Adsorbed, Inactivated Poliovirus, Haemophilus b Conjugate (Meningococcal Protein Conjugate), and Hepatitis B (Recombinant) Vaccine.
IPV	**CPT:** 90697, 90698, 90713, 90723	**10:** poliovirus vaccine, inactivated **89:** poliovirus vaccine, unspecified formulation **110:** DTaP-hepatitis B and poliovirus vaccine **120:** diphtheria, tetanus toxoids and acellular pertussis vaccine, Haemophilus influenzae type b conjugate, and poliovirus vaccine, inactivated (DTaP-Hib-IPV) **146:** Diphtheria and Tetanus Toxoids and Acellular Pertussis Adsorbed, Inactivated Poliovirus, Haemophilus b Conjugate (Meningococcal Protein Conjugate), and Hepatitis B (Recombinant) Vaccine.

	Codes:	
MMR	**CPT:** 90707, 90710	**03:** measles, mumps, and rubella virus vaccine **94:** measles, mumps, rubella, and varicella virus vaccine
Hib	**CPT:** 90644, 90647, 90648, 90697, 90698, 90748	**17:** Haemophilus influenzae type b vaccine, conjugate unspecified formulation **46:** Haemophilus influenzae type b vaccine, PRP-D conjugate **47:** Haemophilus influenzae type b vaccine, HbOC conjugate **48:** Haemophilus influenzae type b vaccine, PRP-T conjugate **49:** Haemophilus influenzae type b vaccine, PRP-OMP conjugate **50:** DTaP-Haemophilus influenzae type b conjugate vaccine **51:** Haemophilus influenzae type b conjugate and Hepatitis B vaccine **120:** diphtheria, tetanus toxoids and acellular pertussis vaccine, Haemophilus influenzae type b conjugate, and poliovirus vaccine, inactivated (DTaP-Hib-IPV) **146:** Diphtheria and Tetanus Toxoids and Acellular Pertussis Adsorbed, Inactivated Poliovirus, Haemophilus b Conjugate (Meningococcal Protein Conjugate), and Hepatitis B (Recombinant) Vaccine. **148:** Meningococcal Groups C and Y and Haemophilus b Tetanus Toxoid Conjugate Vaccine

	Codes:	
Hep B	**CPT:** 90697, 90723, 90740, 90744, 90747, 90748	**08:** hepatitis B vaccine, pediatric or pediatric/adolescent dosage **44:** hepatitis B vaccine, dialysis patient dosage **45:** hepatitis B vaccine, unspecified formulation 51: Haemophilus influenzae type b conjugate and Hepatitis B vaccine **110:** DTaP-hepatitis B and poliovirus vaccine **146:** Diphtheria and Tetanus Toxoids and Acellular Pertussis Adsorbed, Inactivated Poliovirus, Haemophilus b Conjugate (Meningococcal Protein Conjugate), and Hepatitis B (Recombinant) Vaccine
		HCPCS **G0010:** Administration of hepatitis b vaccine
Newborn Hepatitis B Vaccine Administered		**ICD10PCS** **3E0234Z:** Introduction of Serum, Toxoid and Vaccine into Muscle, Percutaneous Approach
VZV	**CPT:** 90710, 90716	**21:** varicella virus vaccine **94:** measles, mumps, rubella, and varicella virus vaccine
PCV	**CPT:** 90670, 90671	**109:** pneumococcal vaccine, unspecified formulation **133:** pneumococcal conjugate vaccine, 13 valent **152:** Pneumococcal Conjugate, unspecified formulation **215:** Pneumococcal conjugate vaccine 15-valent (PCV15), polysaccharide CRM197 conjugate, adjuvant, preservative free
Hep A	**CPT:** 90633	**31:** hepatitis A vaccine, pediatric dosage, unspecified formulation **83:** hepatitis A vaccine, pediatric/adolescent dosage, 2 dose schedule **85:** hepatitis A vaccine, unspecified formulation

	Codes:	
Rotavirus (two- or three-dose)	**Two-dose:** 90681	**Two-dose:** 119
	Three-dose: 90680	**Three-dose:** **116:** rotavirus, live, pentavalent vaccine **122:** rotavirus vaccine, unspecified formulation
Influenza	**CPT:** 90655, 90657, 90661, 90673, 90674, 90685, 90686, 90687, 90688, 90689	**88:** influenza virus vaccine, unspecified formulation **140:** Influenza, seasonal, injectable, preservative free **141:** Influenza, seasonal, injectable **150:** Influenza, injectable, quadrivalent, preservative free **153:** Influenza, injectable, Madin Darby Canine Kidney, preservative free **155:** Seasonal, trivalent, recombinant, injectable influenza vaccine, preservative free **158:** influenza, injectable, quadrivalent, contains preservative **161:** Influenza, injectable, quadrivalent, preservative free, pediatric **171:** Influenza, injectable, Madin Darby Canine Kidney, preservative free, quadrivalent **186:** Influenza, injectable, Madin Darby Canine Kidney, quadrivalent with preservative **HCPCS:** **G0008:** Administration of influenza virus vaccine
Influenza: live attenuated for intranasal use	**CPT:** 90660, 90672	**111:** Influenza virus vaccine, live attenuated, for intranasal **149:** Influenza, live, intranasal, quadrivalent

Note: The codes listed are informational only; this information does not guarantee reimbursement.

Helpful tips:

- If you use an EMR, create a flag to track members due for immunizations.
- Extend your office hours into the evening, early morning, or weekends to accommodate working parents.
- Develop or implement standing orders for nurses and physician assistants in your practice to allow staff to identify opportunities to immunize.
- Enroll in the Vaccines for Children (VFC) program to receive vaccines. If you have questions about enrollment and vaccine orders, contact your state VFC coordinator. Find your coordinator when you visit **cdc.gov/vaccines/programs/vfc/contacts-state.html** or call **800CDCINFO (800-232-4636)**.
- If utilizing an EMR system, consider electronic data sharing with your health plan to capture all coded elements. Contact your provider relationship managements representative for additional details and questions.

How can we help?

We can help you get children in for their immunizations by:

- Offering current *Clinical Practice Guidelines* on our provider self-service website.
- Providing you with individual reports of your members overdue for services if needed.
- Assisting with member scheduling if needed.
- Members may be eligible for transportation assistance at no cost, contact Member Services for arrangement.

Notes:

Chlamydia Screening in Women (CHL)

This HEDIS measure looks at the percentage of women 16 to 24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.

Record your efforts:

- Indicate the date the test was performed and the results

Exclusions:

- Members in hospice or elect to use a hospice benefit any time during the measurement year.
- Members who died during the measurement year

Based on a pregnancy test alone and who meet either of the following:

- A pregnancy test and a prescription for isotretinoin on the date of the pregnancy test or the six days after
- A pregnancy test and an x-ray on the date of the pregnancy test or the six days after

	Codes:
Chlamydia Testing	**CPT:** 87110, 87270, 87320, 87490, 87491, 87492, 87492, 87810, 0353U **LOINC:** **14463-4:** Chlamydia trachomatis [Presence] in Cervix by Organism specific culture **14464-2:** Chlamydia trachomatis [Presence] in Vaginal fluid by Organism specific culture **14465-9:** Chlamydia trachomatis [Presence] in Urethra by Organism specific culture **14467-5:** Chlamydia trachomatis [Presence] in Urine sediment by Organism specific culture **14474-1:** Chlamydia trachomatis Ag [Presence] in Urine sediment by Immunoassay **14513-6:** Chlamydia trachomatis Ag [Presence] in Urine sediment by Immunofluorescence

	Codes:
Chlamydia Testing (cont.)	**LOINC:** **16600-9:** Chlamydia trachomatis rRNA [Presence] in Genital specimen by Probe **21190-4:** Chlamydia trachomatis DNA [Presence] in Cervix by NAA with probe detection **21191-2:** Chlamydia trachomatis DNA [Presence] in Urethra by NAA with probe detection **23838-6:** Chlamydia trachomatis rRNA [Presence] in Genital fluid by Probe **31775-0:** Chlamydia trachomatis Ag [Presence] in Urine sediment **34710-4:** Chlamydia trachomatis Ag [Presence] in Anal **42931-6:** Chlamydia trachomatis rRNA [Presence] in Urine by NAA with probe detection **44806-8:** Chlamydia trachomatis+Neisseria gonorrhoeae DNA [Presence] in Urine by NAA with probe detection **44807-6:** Chlamydia trachomatis+Neisseria gonorrhoeae DNA [Presence] in Genital specimen by NAA with probe detection **45068-4:** Chlamydia trachomatis+Neisseria gonorrhoeae DNA [Presence] in Cervix by NAA with probe detection **45069-2:** Chlamydia trachomatis+Neisseria gonorrhoeae rRNA [Presence] in Genital specimen by Probe **45072-6:** Chlamydia trachomatis+Neisseria gonorrhoeae rRNA [Presence] in Anal by Probe **45073-4:** Chlamydia trachomatis+Neisseria gonorrhoeae rRNA [Presence] in Tissue by Probe **45075-9:** Chlamydia trachomatis+Neisseria gonorrhoeae rRNA [Presence] in Urethra by Probe **45084-1:** Chlamydia trachomatis DNA [Presence] in Vaginal fluid by NAA with probe detection **45089-0:** Chlamydia trachomatis rRNA [Presence] in Anal by Probe **45090-8:** Chlamydia trachomatis DNA [Presence] in Anal by NAA with probe detection

	Codes:
Chlamydia Testing (cont.)	**LOINC:** **45091-6:** Chlamydia trachomatis Ag [Presence] in Genital specimen **45093-2:** Chlamydia trachomatis [Presence] in Anal by Organism specific culture **45095-7:** Chlamydia trachomatis [Presence] in Genital specimen by Organism specific culture **50387-0:** Chlamydia trachomatis rRNA [Presence] in Cervix by NAA with probe detection **53925-4:** Chlamydia trachomatis rRNA [Presence] in Urethra by NAA with probe detection **53926-2:** Chlamydia trachomatis rRNA [Presence] in Vaginal fluid by NAA with probe detection **57287-5:** Chlamydia trachomatis rRNA [Presence] in Anal by NAA with probe detection **6353-7:** Chlamydia trachomatis Ag [Presence] in Tissue by Immunofluorescence **6356-0:** Chlamydia trachomatis DNA [Presence] in Genital specimen by NAA with probe detection **6357-8:** Chlamydia trachomatis DNA [Presence] in Urine by NAA with probe detection **80360-1:** Chlamydia trachomatis+Neisseria gonorrhoeae rRNA [Presence] in Urine by NAA with probe detection **80361-9:** Chlamydia trachomatis+Neisseria gonorrhoeae rRNA [Presence] in Cervix by NAA with probe detection **80362-7:** Chlamydia trachomatis+Neisseria gonorrhoeae rRNA [Presence] in Vaginal fluid by NAA with probe detection **80363-5:** Chlamydia trachomatis DNA [Presence] in Anorectal by NAA with probe detection **80364-3:** Chlamydia trachomatis rRNA [Presence] in Anorectal by NAA with probe detection **80365-0:** Chlamydia trachomatis+Neisseria gonorrhoeae rRNA [Presence] in Anorectal by NAA with probe detection **80367-6:** Chlamydia trachomatis [Presence] in Anorectal by Organism specific culture

	Codes:
Chlamydia Testing (cont.)	**LOINC:** **82306-2:** Chlamydia trachomatis rRNA [Presence] in Throat by NAA with probe detection **87949-4:** Chlamydia trachomatis DNA [Presence] in Tissue by NAA with probe detection **87950-2:** Chlamydia trachomatis [Presence] in Tissue by Organism specific culture **88221-7:** Chlamydia trachomatis DNA [Presence] in Throat by NAA with probe detection **89648-0:** Chlamydia trachomatis [Presence] in Throat by Organism specific culture **91860-7:** Chlamydia trachomatis Ag [Presence] in Genital specimen by Immunofluorescence **91873-0:** Chlamydia trachomatis Ag [Presence] in Throat by Immunofluorescence

Note: The Logical Observation Identifiers Names and Codes (LOINC) are for reporting clinical observations and laboratory testing. The codes listed are informational only; this information does not guarantee reimbursement.

How can we help?

- Members may be eligible for transportation assistance at no cost; contact Member Services for arrangement.

Helpful resource:

- **cdc.gov/std/chlamydia/default.htm**

Helpful tips:

- If utilizing an EMR system, consider electronic data sharing with your health plan to capture all coded elements. Contact your provider relationship managements representative for additional details and questions.

Cardiac Rehabilitation (CRE)

This HEDIS measure evaluates the percentage of members 18 years and older who attended cardiac rehabilitation following a qualifying cardiac event, including myocardial infarction, percutaneous coronary intervention, coronary artery bypass grafting, heart and heart/lung transplantation or heart valve repair/replacement on or between July 1 of the year prior to the measurement year to June 30 of the measurement year. Four rates are reported:

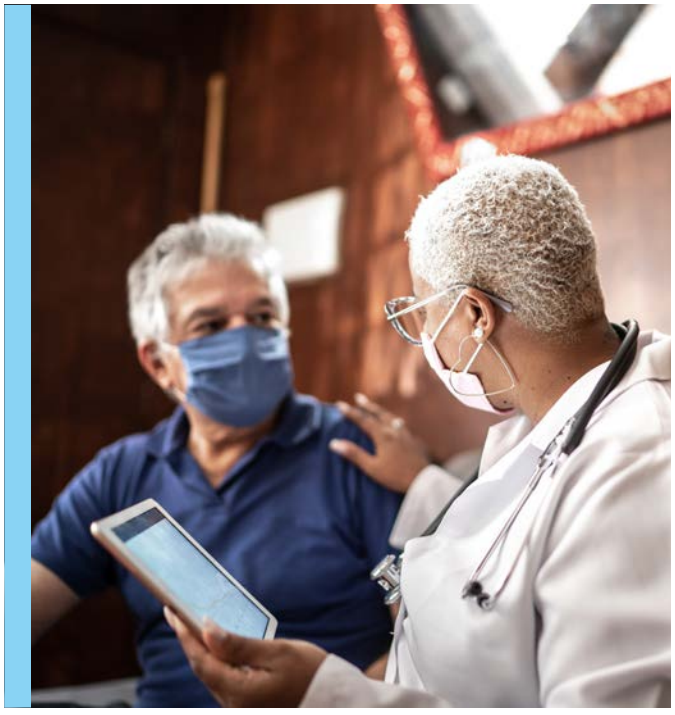
- **Initiation:** The percentage of members who attended 2 or more sessions of cardiac rehabilitation within 30 days after a qualifying event.
- **Engagement 1:** The percentage of members who attended 12 or more sessions of cardiac rehabilitation within 90 days after a qualifying event.
- **Engagement 2:** The percentage of members who attended 24 or more sessions of cardiac rehabilitation within 180 days after a qualifying event.
- **Achievement:** The percentage of members who attended 36 or more sessions of cardiac rehabilitation within 180 days after a qualifying event.

Record your efforts

Count multiple cardiac rehabilitation sessions on the same date of service as multiple sessions. For example, if a member has two different codes for cardiac rehabilitation on the same date of service (or one code billed as two units), count this as two sessions of cardiac rehabilitation.

Exclusions:

- Members who use hospice services or elect to use a hospice benefit any time during the measurement year
- Members who die any time during the measurement year
- Members receiving palliative care any time during the measurement year
- Members who had an encounter for palliative anytime during the measurement year
- Members 66 to 80 years of age and older as of December 31 of the measurement year (all product lines) with frailty **and** advanced illness. Members must meet **both** frailty and advanced illness criteria to be excluded



- Members 81 years of age and older as of December 31 of the measurement year (all product lines) with at least two indications of frailty with different dates of service during the measurement year
- Discharged from an inpatient setting with any of the following on the discharge claim during the 180 days after the episode date:
  - Myocardial Infarction (MI)
  - Coronary artery bypass graft (CABG)
  - Heart or heart/lung transplant
  - Heart valve repair or replacement
  - Percutaneous Coronary Intervention (PCI)

	Codes
Cardiac Rehabilitation	**CPT:** 93797, 93798 **HCPCS:** **G0422:** Intensive cardiac rehabilitation; with or without continuous ECG monitoring with exercise, per session **G0423:** Intensive cardiac rehabilitation; with or without continuous ECG monitoring; without exercise, per session **S9472:** Cardiac rehabilitation program, non-physician provider, per diem

How can we help?

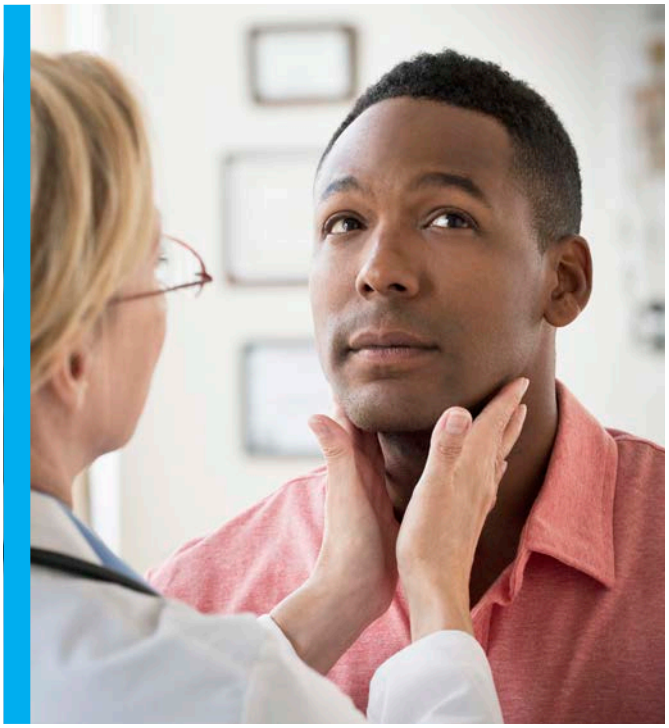
- Members may be eligible for transportation assistance at no cost, contact Member Services for arrangement.

Helpful tips:

- If utilizing an EMR system, consider electronic data sharing with your health plan to capture all coded elements. Contact your provider relationship managements representative for additional details and questions.

Appropriate Testing for Pharyngitis (CWP)

This HEDIS measure evaluates the percentage of episodes for members 3 years of age and older where the member was diagnosed with pharyngitis, dispensed an antibiotic, and received a group A streptococcus (strep) test for the episode on or between July 1 of the year prior to the measurement year to June 30 of the measurement year.



Record your efforts:

- Document results of all strep tests or refusal for testing in medical record.
- If antibiotics are prescribed for another condition, ensure accurate coding and documentation will associate the antibiotic with the appropriate diagnosis.

Exclusions:

- Members who use hospice services or elect to use a hospice benefit any time during the measurement year
- Members who die any time during the measurement year

	Codes:
Pharyngitis	**ICD-10-CM:** **J02.0:** Streptococcal pharyngitis **J02.8:** Acute pharyngitis due to other specified organisms **J02.9:** Acute pharyngitis, unspecified **J03.00:** Acute streptococcal tonsillitis, unspecified **J03.01:** Acute recurrent streptococcal tonsillitis **J03.80:** Acute tonsillitis due to other specified organisms **J03.81:** Acute recurrent tonsillitis due to other specified organisms **J03.90:** Acute tonsillitis, unspecified **J03.91:** Acute recurrent tonsillitis, unspecified

	Codes:
Group A Strep Tests	**CPT:** 87070, 87071, 87081, 87430, 87650, 87651, 87652, 87880
	LOINC: **101300-2:** Streptococcus pyogenes DNA [Presence] in Throat by NAA with non-probe detection **11268-0:** Streptococcus pyogenes [Presence] in Throat by Organism specific culture **17656-0:** Streptococcus pyogenes [Presence] in Specimen by Organism specific culture **17898-8:** Bacteria identified in Throat by Aerobe culture **18481-2:** Streptococcus pyogenes Ag [Presence] in Throat **31971-5:** Streptococcus pyogenes Ag [Presence] in Specimen **49610-9:** Streptococcus pyogenes DNA [Identifier] in Specimen by NAA with probe detection **5036-9:** Streptococcus pyogenes rRNA [Presence] in Specimen by Probe **60489-2:** Streptococcus pyogenes DNA [Presence] in Throat by NAA with probe detection **626-2:** Bacteria identified in Throat by Culture **6557-3:** Streptococcus pyogenes Ag [Presence] in Throat by Immunofluorescence **6558-1:** Streptococcus pyogenes Ag [Presence] in Specimen by Immunoassay **6559-9:** Streptococcus pyogenes Ag [Presence] in Specimen by Immunofluorescence **68954-7:** Streptococcus pyogenes rRNA [Presence] in Throat by Probe **78012-2:** Streptococcus pyogenes Ag [Presence] in Throat by Rapid immunoassay

	Codes:
Outpatient, ED and Telehealth	**CPT:** 98966, 98967, 98968, 98970, 98971, 98972, 98980, 98981, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99242, 99243, 99244, 99245, 99281, 99282, 99283, 99284, 99285, 99341,99342, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99421, 99422, 99423, 99429, 99441, 99442, 99443, 99455,99456, 99457, 99458, 99483 **HCPCS:** **G0071:** Payment for communication technology-based services for 5 minutes or more of a virtual (non-face-to-face) communication between a rural health clinic (RHC) or federally qualified health center (FQHC) practitioner and RHC or FQHC patient, or 5 minutes or more of remote evaluation of recorded video and/or images by an RHC or FQHC practitioner, occurring in lieu of an office visit; RHC or FQHC only **G0402:** Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment **G0438:** Annual wellness visit; includes a personalized prevention plan of service (PPS), initial visit **G0439:** Annual wellness visit, includes a personalized prevention plan of service (PPS), subsequent visit **G0463:** Hospital outpatient clinic visit for assessment and management of a patient **G2010:** Remote evaluation of recorded video and/or images submitted by an established patient (for example, store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment

	Codes:
Outpatient, ED and Telehealth (cont.)	**HCPCS:** **G2012:** Brief communication technology-based service, for example, virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion **G2250:** Remote assessment of recorded video and/or images submitted by an established patient (for example, store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment **G2251:** Brief communication technology-based service, for example, virtual check-in, by a qualified health care professional who cannot report evaluation and management services, provided to an established patient, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of clinical discussion **G2252:** Brief communication technology-based service, for example, virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion **T1015:** Clinic visit/encounter, all-inclusive

Note: The Logical Observation Identifiers Names and Codes (LOINC) are for reporting clinical observations and laboratory testing. The codes listed are informational only; this information does not guarantee reimbursement.

Helpful tips:

- If a member tests negative for group A strep but insists on an antibiotic:
  - Refer to the illness as a sore throat due to a cold; members tend to associate the label with a less-frequent need for antibiotics.
  - Write a prescription for symptom relief, like over-the-counter medications.
- Educate members on the difference between bacterial and viral infections. This is the key point in the success of this measure. Use CDC handouts or education tools as needed.
- Discuss with members ways to treat symptoms:
  - Get extra rest.
  - Drink plenty of fluids.
  - Use over-the-counter medications.
  - Use the cool-mist vaporizer and nasal spray for congestion.
  - Eat ice chips or use throat spray/lozenges for sore throats.
- Educate members and their parents or caregivers that they can prevent infection by:
  - Washing hands frequently.
  - Disinfecting toys.
  - Keeping the child out of school or day care for at least 24 hours until antibiotics have been taken and symptoms have improved.
- If utilizing an EMR system, consider electronic data sharing with your health plan to capture all coded elements. Contact your provider relationship managements representative for additional details and questions.

How can we help?

- Members may be eligible for transportation assistance at no cost, contact Member Services for arrangement.

Helpful resources

cdc.gov/antibiotic-use/index.html

Eye Exam for Patients With Diabetes (EED)

This HEDIS measure looks at the percentage of members 18 to 75 years of age with diabetes (types 1 and 2) who had a retinal eye exam.

Record your efforts:

- A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year.
- A negative retinal or dilated eye exam (negative for retinopathy) by an eye care professional in the year prior to the measurement year.
- Bilateral eye enucleation any time during the member's history through December 31 of the measurement year.

Exclusions:

- Members who use hospice services or elect to use a hospice benefit any time during the measurement year
- Members who die any time during the measurement year
- Members receiving palliative care any time during the measurement year.
- Members who had an encounter for palliative anytime during the measurement year
- Members 66 years of age and older as of December 31 of the measurement year (all product lines) with frailty and advanced illness. Members must meet both frailty and advanced illness criteria to be excluded

	Codes:
Unilateral Eye Enucleation	**CPT:** 65091, 65093, 65101, 65103, 65105, 65110, 65112, 65114
Diabetic Retinal Screenings	**CPT:** 67028, 67030, 67031, 67036, 67039, 67041, 67042, 67043, 67101, 67105, 67107, 67108, 67110, 67113, 67121, 67141, 67145, 67208, 67210, 67218, 67220, 67221, 67227, 67228, 92002, 92004, 92012, 92014, 92018, 92019, 92134, 92201, 92202, 92227, 92228, 92230, 92235, 92240, 92250, 92260, 99203, 99204, 99205, 99213, 99214, 99215, 99242, 99243, 99244, 99245 **HCPCS:** **S0620:** Routine ophthalmological examination including refraction; new patient **S0621:** Routine ophthalmological examination including refraction; established patient **S3000:** Diabetic indicator; retinal eye exam, dilated, bilateral
Eye Exam with Evidence of Retinopathy	**CPT-CAT II:** **2022F:** Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy (DM) **2024F:** 7 standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy (DM) **2026F:** Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed; with evidence of retinopathy (DM)

	Codes:
Eye Exam without Evidence of Retinopathy	**CPT-CAT II:** **2023F:** Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy (DM) **2025F:** 7 standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy (DM) **2033F:** Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed; without evidence of retinopathy (DM)
Unilateral Eye Enucleation	**CPT:** 65091, 65093, 65101, 65103, 65105, 65110, 65112, 65114
CDC Race and Ethnicity	**1002-5:** American Indian or Alaska Native **2028-9:** Asian **2054-5:** Black or African American **2076-8:** Native Hawaiian or Other Pacific Islander **2106-3:** White **2135-2:** Hispanic or Latino **2186-5:** Not Hispanic or Latino

Note: The codes listed are informational only; this information does not guarantee reimbursement.

Helpful tips:

- For the recommended frequency of testing and screening, refer to the *Clinical Practice Guidelines* for diabetes mellitus.
- If your practice uses EMRs, have flags or reminders set in the system to alert your staff when a member's screenings are due.
- Send appointment reminders and call members to remind them of upcoming appointments and necessary screenings.
- Follow up on lab test results, eye exam results or any specialist referral and document on your chart.
- Refer members to the network of eye providers for their annual diabetic eye exam.
- Educate your members and their families, caregivers, and guardians on diabetes care, including:
  - Taking all prescribed medications as directed.
  - Adding regular exercise to daily activities.
  - Having a diabetic eye exam each year with an eye care provider.
  - Regularly monitoring blood sugar and blood pressure at home.
  - Maintaining healthy weight and ideal body mass index.
  - Eating heart-healthy, low-calorie, and low-fat foods.
  - Stopping smoking and avoiding second-hand smoke.
  - Keeping all medical appointments; getting help with scheduling necessary appointments, screenings, and tests to improve compliance.

- Remember to include the applicable Category II reporting code above on the claim form to help reduce the burden of HEDIS medical record review.
- If utilizing an electronic medical record (EMR) system, consider electronic data sharing with your health plan to capture all coded elements. Contact your provider relationship managements representative for additional details and questions.

How can we help?

- We can help you with comprehensive diabetes care by:
- Providing online *Clinical Practice Guidelines* on our provider self-service website.
- Providing programs that may be available to our diabetic members.
- Supplying copies of educational resources on diabetes that may be available for your office.
- Providing education at your office if available in your area.
- Members may be eligible for transportation assistance at no cost, contact Member Services for arrangement.

EED

Notes:

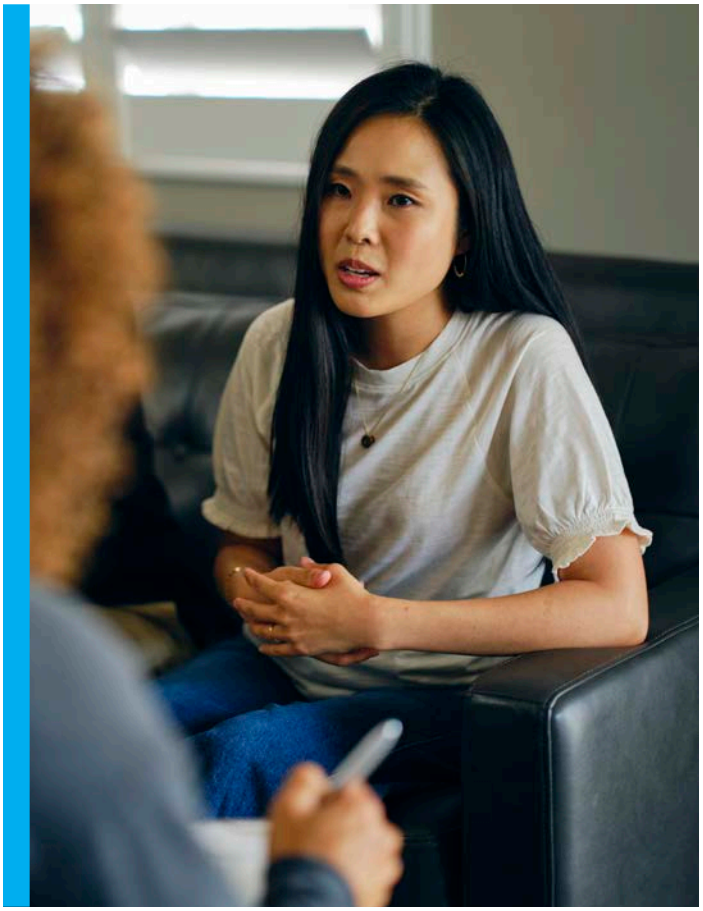
Follow-up After Emergency Department Visit for Substance Use (FUA)

This HEDIS measure evaluates the percentage of emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, who had a follow up visit for SUD during the measurement year. Two rates are reported:

- The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days)
- The percentage of ED visits for which the member received follow-up within seven days of the ED visit (eight total days)

Record your efforts:

- *30 Day Follow-Up*: A member has a follow-up visit or a pharmacotherapy dispensing event 30 days after the ED visit (31 total days). Include events and visits that occur on the date of the ED visit.
- *7 Day Follow-Up*: A member has a follow-up visit or a pharmacotherapy dispensing event 7 days after the ED visit (8 total days). Include events and visits that occur on the date of the ED visit.



Exclusions:

- ED visits that result in an inpatient stay
- Members who use hospice services or elect to use a hospice benefit anytime during the measurement year
- Members who died during the measurement year

	Codes:
BH outpatient	**CPT:** 98960, 98961, 98962, 99078, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99242, 99243, 99244, 99245, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99483, 99492, 99493, 99494, 99510
	HCPCS: **G0155:** Services of clinical social worker in home health or hospice settings, each 15 minutes **G0176:** Activity therapy, such as music, dance, art or play therapies not for recreation, related to the care and treatment of patient's disabling mental health problems, per session (45 minutes or more) **G0177:** Training and educational services related to the care and treatment of patient's disabling mental health problems per session (45 minutes or more) **G0409:** Social work and psychological services, directly relating to and/or furthering the patient's rehabilitation goals, each 15 minutes, face-to-face; individual (services provided by a CORF-qualified social worker or psychologist in a CORF) **G0463:** Hospital outpatient clinic visit for assessment and management of a patient **G0512:** Rural health clinic or federally qualified health center (RHC/FQHC) only, psychiatric collaborative care model (psychiatric COCM), 60 minutes or more of clinical staff time for psychiatric COCM services directed by an RHC or FQHC practitioner (physician, NP, PA, or CNM) and including services furnished by a behavioral health care manager and consultation with a psychiatric consultant, per calendar month **H0002:** Behavioral health screening to determine eligibility for admission to treatment program **H0004:** Behavioral health counseling and therapy, per 15 minutes **H0031:** Mental health assessment, by non-physician **H0034:** Medication training and support, per 15 minutes **H0036:** Community psychiatric supportive treatment, face-to-face, per 15 minutes

	Codes:
BH outpatient (cont.)	**HCPCS:** **H0037:** Community psychiatric supportive treatment program, per diem **H0039:** Assertive community treatment, face-to-face, per 15 minutes **H0040:** Assertive community treatment program, per diem **H2000:** Comprehensive multidisciplinary evaluation **H2010:** Comprehensive medication services, per 15 minutes **H2011:** Crisis intervention service, per 15 minutes **H2013:** Psychiatric health facility service, per diem **H2014:** Skills training and development, per 15 minutes **H2015:** Comprehensive community support services, per 15 minutes **H2016:** Comprehensive community support services, per diem **H2017:** Psychosocial rehabilitation services, per 15 minutes **H2018:** Psychosocial rehabilitation services, per diem **H2019:** Therapeutic behavioral services, per 15 minutes **H2020:** Therapeutic behavioral services, per diem **T1015:** Clinic visit/encounter, all-inclusive
Abuse Counseling and Surveillance	**ICD10CM:** **Z71.41:** Alcohol abuse counseling and surveillance of alcoholic **Z71.51:** Drug abuse counseling and surveillance of drug abuser
Substance Use Disorder Services	**CPT:** 99408, 99409 **HCPCS:** **G0396:** Alcohol and/or substance (other than tobacco) misuse structured assessment (for example, audit, DAST), and brief intervention 15 to 30 minutes **G0397:** Alcohol and/or substance (other than tobacco) misuse structured assessment (for example, audit, DAST), and intervention, greater than 30 minutes

	Codes:
Substance Use Disorder Services (cont.)	**HCPCS:** **G0443:** Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes **H0001:** Alcohol and/or drug assessment **H0005:** Alcohol and/or drug services; group counseling by a clinician **H0007:** Alcohol and/or drug services; crisis intervention (outpatient) **H0015:** Alcohol and/or drug services; intensive outpatient (treatment program that operates at least 3 hours/day and at least 3 days/ week and is based on an individualized treatment plan), including assessment, counseling; crisis intervention, and activity therapies or education **H0016:** Alcohol and/or drug services; medical/somatic (medical intervention in ambulatory setting) **H0022:** Alcohol and/or drug intervention service (planned facilitation) **H0047:** Alcohol and/or other drug abuse services, not otherwise specified **H0050:** Alcohol and/or drug services, brief intervention, per 15 minutes **H2035:** Alcohol and/or other drug treatment program, per hour **H2036** Alcohol and/or other drug treatment program, per diem **T1006:** Alcohol and/or substance abuse services, family/couple counseling **T1012:** Alcohol and/or substance abuse services, skills development
Substance Use Services	**HCPCS:** **H0006:** Alcohol and/or drug services; case management **H0028:** Alcohol and/or drug prevention problem identification and referral service (for example, student assistance and employee assistance programs), does not include assessment

	Codes:
OUD monthly office-based treatment	**HCPCS:** **G2086:** Office-based treatment for opioid use disorder, including development of the treatment plan, care coordination, individual therapy and group therapy and counseling; at least 70 minutes in the first calendar month **G2087:** Office-based treatment for opioid use disorder, including care coordination, individual therapy and group therapy and counseling; at least 60 minutes in a subsequent calendar month
OUD weekly drug treatment service	**HCPCS:** **G2067:** Medication assisted treatment, methadone; weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing, if performed (provision of the services by a Medicare-enrolled opioid treatment program) **G2068:** Medication assisted treatment, buprenorphine (oral); weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a Medicare-enrolled opioid treatment program) **G2069:** Medication assisted treatment, buprenorphine (injectable); weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a Medicare-enrolled opioid treatment program) **G2070:** Medication assisted treatment, buprenorphine (implant insertion); weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a Medicare-enrolled opioid treatment program) **G2072:** Medication assisted treatment, buprenorphine (implant insertion and removal); weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a Medicare-enrolled opioid treatment program) **G2073:** Medication assisted treatment, naltrexone; weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a Medicare-enrolled opioid treatment program)

	Codes:
OUD weekly Nondrug service	**HCPCS:** **G2071:** Medication assisted treatment, buprenorphine (implant removal); weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a Medicare-enrolled opioid treatment program) **G2074:** Medication assisted treatment, weekly bundle not including the drug, including substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a Medicare-enrolled opioid treatment program) **G2075:** Medication assisted treatment, medication not otherwise specified; weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing, if performed (provision of the services by a Medicare-enrolled opioid treatment program) **G2076:** Intake activities, including initial medical examination that is a complete, fully documented physical evaluation and initial assessment by a program physician or a primary care physician, or an authorized healthcare professional under the supervision of a program physician qualified personnel that includes preparation of a treatment plan that includes the patient's short-term goals and the tasks the patient must perform to complete the short-term goals; the patient's requirements for education, vocational rehabilitation, and employment; and the medical, psycho- social, economic, legal, or other supportive services that a patient needs, conducted by qualified personnel (provision of the services by a Medicare-enrolled opioid **G2077:** Periodic assessment; assessing periodically by qualified personnel to determine the most appropriate combination of services and treatment (provision of the services by a Medicare-enrolled opioid treatment program); list separately in addition to code for primary procedure **G2080:** Each additional 30 minutes of counseling in a week of medication assisted treatment, (provision of the services by a Medicare-enrolled opioid treatment program); list separately in addition to code for primary procedure
Residential Program Detoxification	**HCPCS:** **H0010:** Alcohol and/or drug services; sub-acute detoxification (residential addiction program inpatient) **H0011**: Alcohol and/or drug services; acute detoxification (residential addiction program inpatient)

	Codes:
Telehealth POS	**POS:** 02: Telehealth Provided Other than in Patient's Home 10: Telehealth Provided in Patient's Home
Telephone visits	**CPT:** 98966, 98967, 98968, 99441, 99442, 99443
CDC Race and Ethnicity	**1002-5:** American Indian or Alaska Native **2028-9:** Asian **2054-5:** Black or African American **2076-8**: Native Hawaiian or Other Pacific Islander **2106-3:** White **2135-2:** Hispanic or Latino **2186-5:** Not Hispanic or Latino

Note: The codes listed are informational only; this information does not guarantee reimbursement.

How can we help?

- Offer current *Clinical Practice Guidelines* on our provider self-service website.
- Members may be eligible for transportation assistance at no cost, contact Member Services for arrangement.

Other available resources

You can find more information and tools online at **qualityforum.org.**

Helpful tip

If utilizing an EMR system, consider electronic data sharing with your health plan to capture all coded elements. Contact your provider relationship managements representative for additional details and questions.

Follow-Up After Hospitalization for Mental Illness (FUH)

This HEDIS measure evaluates the percentage of discharges for members ages 6 years and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider during the measurement year. Two rates are reported:

- The percentage of discharges for which the member received follow-up within 30 days after discharge
- The percentage of discharges for which the member received follow-up within 7 days after discharge

Exclusions:

- Exclude discharges followed by readmission or direct transfer to a nonacute inpatient care setting within the 30-day follow-up period, regardless of principal diagnosis for the readmission
- Members who use hospice or elect to use a hospice benefit any time during the measurement year
- Members who died during the measurement year

	Codes:
BH outpatient	**CPT:** 98960, 98961, 98962, 99078, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99242, 99243, 99244, 99245, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99483, 99492, 99493, 99494, 99510
	HCPCS: **G0155:** Services of clinical social worker in home health or hospice settings, each 15 minutes **G0176:** Activity therapy, such as music, dance, art or play therapies not for recreation, related to the care and treatment of patient's disabling mental health problems, per session (45 minutes or more) **G0177:** Training and educational services related to the care and treatment of patient's disabling mental health problems per session (45 minutes or more) **G0409:** Social work and psychological services, directly relating to and/or furthering the patient's rehabilitation goals, each 15 minutes, face-to-face; individual (services provided by a CORF-qualified social worker or psychologist in a CORF) **G0463:** Hospital outpatient clinic visit for assessment and management of a patient **G0512:** Rural health clinic or federally qualified health center (RHC/FQHC) only, psychiatric collaborative care model (psychiatric COCM), 60 minutes or more of clinical staff time for psychiatric COCM services directed by an RHC or FQHC practitioner (physician, NP, PA, or CNM) and including services furnished by a behavioral health care manager and consultation with a psychiatric consultant, per calendar month **H0002:** Behavioral health screening to determine eligibility for admission to treatment program **H0004:** Behavioral health counseling and therapy, per 15 minutes **H0031**: Mental health assessment, by non-physician **H0034:** Medication training and support, per 15 minutes **H0036:** Community psychiatric supportive treatment, face-to-face, per 15 minutes

	Codes:
BH outpatient (cont.)	**HCPCS:** **H0037:** Community psychiatric supportive treatment program, per diem **H0039:** Assertive community treatment, face-to-face, per 15 minutes **H0040:** Assertive community treatment program, per diem **H2000:** Comprehensive multidisciplinary evaluation **H2010:** Comprehensive medication services, per 15 minutes **H2011:** Crisis intervention service, per 15 minutes **H2013:** Psychiatric health facility service, per diem **H2014:** Skills training and development, per 15 minutes **H2015:** Comprehensive community support services, per 15 minutes **H2016:** Comprehensive community support services, per diem **H2017:** Psychosocial rehabilitation services, per 15 minutes **H2018:** Psychosocial rehabilitation services, per diem **H2019:** Therapeutic behavioral services, per 15 minutes **H2020:** Therapeutic behavioral services, per diem **T1015:** Clinic visit/encounter, all-inclusive
Psychiatric Collaborative Care Management	**CPT:** 99492, 99493, 99494 **HCPCS:** **G0512:** Rural health clinic or federally qualified health center (RHC/FQHC) only, psychiatric collaborative care model (psychiatric COCM), 60 minutes or more of clinical staff time for psychiatric COCM services directed by an RHC or FQHC practitioner (physician, NP, PA, or CNM) and including services furnished by a behavioral health care manager and consultation with a psychiatric consultant, per calendar month
Transitional care management services	**CPT:** 99495, 99496

	Codes:
Telephone visits	**CPT:** 98966, 98967, 98968, 99441, 99442, 99443
Telehealth POS	**POS:** 02 10
Visit setting unspecified	**CPT:** 90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99252, 99253, 99254, 99255

	Codes:
Outpatient POS	**POS:** 03: School 05: Indian Health Service Free-standing Facility 07: Facility 09: Tribal 638 Free-standing Facility 11: Office 12: Home 13: Assisted Living Facility 14: Group Home 15: Mobile Unit 16: Temporary Lodging 17: Walk-in Retail Clinic 18: Place of Employment-Worksite 19: Off Campus-Outpatient Hospital 20: Urgent Care Facility 22: On-Campus Outpatient Hospital 33: Custodial Care Facility 49: Independent Clinic 50: Federally Qualified Health Center 71: Public Health Clinic 72: Rural Health Clinic
CDC Race and Ethnicity	**1002-5:** American Indian or Alaska Native **2028-9:** Asian **2054-5:** Black or African American **2076-8**: Native Hawaiian or Other Pacific Islander **2106-3:** White **2135-2:** Hispanic or Latino **2186-5:** Not Hispanic or Latino

Note: The codes listed are informational only; this information does not guarantee reimbursement.

Helpful tips:

- Educate your members and their spouses, caregivers, or guardians about the importance of compliance with long-term medications, if prescribed.
- Encourage members to participate in our behavioral health case management program for help getting a follow-up discharge appointment within seven days and other support.
- Teach member's families to review all discharge instructions for members and ask for details of all follow-up discharge instructions, such as the dates and times of appointments. The post discharge follow up should optimally be within seven days of discharge.
- Ask members with a mental health diagnosis to allow you access to their mental health records if you are their primary care provider.
- Telehealth services that are completed by a qualified mental health provider can be used for this measure.
- If utilizing an EMR system, consider electronic data sharing with your health plan to capture all coded elements. Contact your provider relationship managements representative for additional details and questions.

How can we help?

We help you with follow-up after hospitalization for mental illness by:

- Offer current *Clinical Practice Guidelines* on our provider self-service website.
- Members may be eligible for transportation assistance at no cost, contact Member Services for arrangement.

Notes:

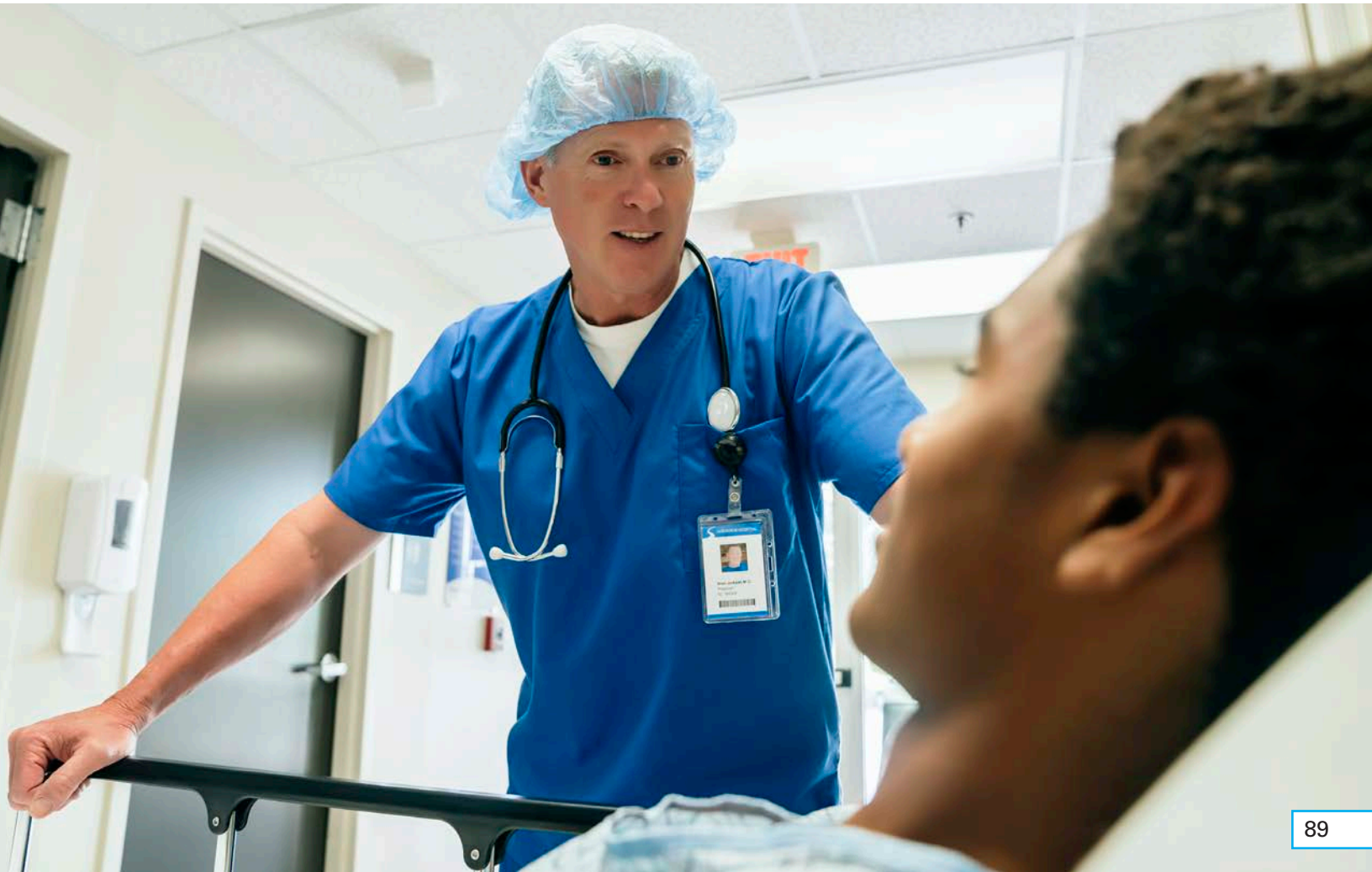
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)

This HEDIS measure evaluates the percentage of acute inpatient hospitalizations, residential treatment, or withdrawal management visits for a diagnosis of substance use disorder among members 13 years of age and older that result in a follow-up visit or service for substance use disorder during the measurement year. Two rates are reported:

- The percentage of visits or discharges for which the member received follow-up for substance use disorder within the 30 days after the visit or discharge.
- The percentage of visits or discharges for which the member received follow-up for substance use disorder within the 7 days after the visit or discharge.

Exclusions:

- Members who use hospice services or elect to use a hospice benefit any time during the measurement year
- Members who die any time during the measurement year



	Codes:
BH outpatient	**CPT:** 98960, 98961, 98962, 99078, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99242, 99243, 99244, 99245, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99483, 99492, 99493, 99494, 99510
	HCPCS: **G0155:** Services of clinical social worker in home health or hospice settings, each 15 minutes **G0176:** Activity therapy, such as music, dance, art or play therapies not for recreation, related to the care and treatment of patient's disabling mental health problems, per session (45 minutes or more) **G0177:** Training and educational services related to the care and treatment of patient's disabling mental health problems per session (45 minutes or more) **G0409:** Social work and psychological services, directly relating to and/or furthering the patient's rehabilitation goals, each 15 minutes, face-to-face; individual (services provided by a CORF-qualified social worker or psychologist in a CORF) **G0463:** Hospital outpatient clinic visit for assessment and management of a patient **G0512:** Rural health clinic or federally qualified health center (RHC/FQHC) only, psychiatric collaborative care model (psychiatric COCM), 60 minutes or more of clinical staff time for psychiatric COCM services directed by an RHC or FQHC practitioner (physician, NP, PA, or CNM) and including services furnished by a behavioral health care manager and consultation with a psychiatric consultant, per calendar month **H0002:** Behavioral health screening to determine eligibility for admission to treatment program **H0004:** Behavioral health counseling and therapy, per 15 minutes **H0031:** Mental health assessment, by non-physician **H0034:** Medication training and support, per 15 minutes **H0036:** Community psychiatric supportive treatment, face-to-face, per 15 minutes

	Codes:
BH outpatient (cont.)	**HCPCS:** **H0037:** Community psychiatric supportive treatment program, per diem **H0039:** Assertive community treatment, face-to-face, per 15 minutes **H0040:** Assertive community treatment program, per diem **H2000:** Comprehensive multidisciplinary evaluation **H2010:** Comprehensive medication services, per 15 minutes **H2011:** Crisis intervention service, per 15 minutes **H2013:** Psychiatric health facility service, per diem **H2014:** Skills training and development, per 15 minutes **H2015:** Comprehensive community support services, per 15 minutes **H2016:** Comprehensive community support services, per diem **H2017:** Psychosocial rehabilitation services, per 15 minutes **H2018:** Psychosocial rehabilitation services, per diem **H2019:** Therapeutic behavioral services, per 15 minutes **H2020:** Therapeutic behavioral services, per diem **T1015:** Clinic visit/encounter, all-inclusive
Substance Abuse Counseling and Surveillance	**ICD10CM:** **Z71.41:** Alcohol abuse counseling and surveillance of alcoholic **Z71.51:** Drug abuse counseling and surveillance of drug abuser

	Codes:
Substance Use Disorder Services	**CPT:** 99408, 99409 **HCPCS:** **G0396:** Alcohol and/or substance (other than tobacco) misuse structured assessment (for example, audit, DAST), and brief intervention 15 to 30 minutes **G0397:** Alcohol and/or substance (other than tobacco) misuse structured assessment (for example, audit, DAST), and intervention, greater than 30 minutes **G0443:** Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes **H0001:** Alcohol and/or drug assessment **H0005:** Alcohol and/or drug services; group counseling by a clinician **H0007:** Alcohol and/or drug services; crisis intervention (outpatient) **H0015:** Alcohol and/or drug services; intensive outpatient (treatment program that operates at least 3 hours/day and at least 3 days/ week and is based on an individualized treatment plan), including assessment, counseling; crisis intervention, and activity therapies or education **H0016:** Alcohol and/or drug services; medical/somatic (medical intervention in ambulatory setting) **H0022:** Alcohol and/or drug intervention service (planned facilitation) **H0047:** Alcohol and/or other drug abuse services, not otherwise specified **H0050:** Alcohol and/or drug services, brief intervention, per 15 minutes **H2035:** Alcohol and/or other drug treatment program, per hour **H2036:** Alcohol and/or other drug treatment program, per diem **T1006:** Alcohol and/or substance abuse services, family/couple counseling **T1012:** Alcohol and/or substance abuse services, skills development

	Codes:
Substance Use Services	**HCPCS:** **H0006:** Alcohol and/or drug services; case management **H0028:** Alcohol and/or drug prevention problem identification and referral service (for example, student assistance and employee assistance programs), does not include assessment
OUD monthly office-based treatment	**HCPCS:** **G2086:** Office-based treatment for opioid use disorder, including development of the treatment plan, care coordination, individual therapy and group therapy and counseling; at least 70 minutes in the first calendar month **G2087:** Office-based treatment for opioid use disorder, including care coordination, individual therapy and group therapy and counseling; at least 60 minutes in a subsequent calendar month
OUD weekly drug treatment service	**HCPCS:** **G2067:** Medication assisted treatment, methadone; weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing, if performed (provision of the services by a Medicare-enrolled opioid treatment program) **G2068:** Medication assisted treatment, buprenorphine (oral); weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a Medicare-enrolled opioid treatment program) **G2069:** Medication assisted treatment, buprenorphine (injectable); weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a Medicare-enrolled opioid treatment program) **G2070:** Medication assisted treatment, buprenorphine (implant insertion); weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a Medicare-enrolled opioid treatment program)

	Codes:
OUD weekly drug treatment service (cont.)	**HCPCS:** **G2072:** Medication assisted treatment, buprenorphine (implant insertion and removal); weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a Medicare-enrolled opioid treatment program) **G2073:** Medication assisted treatment, naltrexone; weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a Medicare-enrolled opioid treatment program)
OUD weekly Nondrug service	**G2071:** Medication assisted treatment, buprenorphine (implant removal); weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a Medicare-enrolled opioid treatment program) **G2074:** Medication assisted treatment, weekly bundle not including the drug, including substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a Medicare-enrolled opioid treatment program) **G2075:** Medication assisted treatment, medication not otherwise specified; weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing, if performed (provision of the services by a Medicare-enrolled opioid treatment program) **G2076:** Intake activities, including initial medical examination that is a complete, fully documented physical evaluation and initial assessment by a program physician or a primary care physician, or an authorized healthcare professional under the supervision of a program physician qualified personnel that includes preparation of a treatment plan that includes the patient's short-term goals and the tasks the patient must perform to complete the short-term goals; the patient's requirements for education, vocational rehabilitation, and employment; and the medical, psycho- social, economic, legal, or other supportive services that a patient needs, conducted by qualified personnel (provision of the services by a Medicare-enrolled opioid

	Codes:
OUD weekly Nondrug service (cont.)	**G2077:** Periodic assessment; assessing periodically by qualified personnel to determine the most appropriate combination of services and treatment (provision of the services by a Medicare-enrolled opioid treatment program); list separately in addition to code for primary procedure **G2080:** Each additional 30 minutes of counseling in a week of medication assisted treatment, (provision of the services by a Medicare-enrolled opioid treatment program); list separately in addition to code for primary procedure
Online Assessments	**CPT** 98970, 98971, 98972, 98980, 98981, 99421, 99422, 99423, 99457, 99458 **HCPCS** **G0071:** Payment for communication technology-based services for 5 minutes or more of a virtual (non-face-to-face) communication between a rural health clinic (RHC) or federally qualified health center (FQHC) practitioner and RHC or FQHC patient, or 5 minutes or more of remote evaluation of recorded video and/or images by an RHC or FQHC practitioner, occurring in lieu of an office visit; RHC or FQHC only **G2010:** Remote evaluation of recorded video and/or images submitted by an established patient (for example, store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment **G2012:** Brief communication technology-based service, for example, virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion **G2250:** Remote assessment of recorded video and/or images submitted by an established patient (for example, store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment

	Codes:
Online Assessments (cont.)	**G2251:** Brief communication technology-based service, for example, virtual check-in, by a qualified health care professional who cannot report evaluation and management services, provided to an established patient, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of clinical discussion **G2252:** Brief communication technology-based service, for example, virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion
Outpatient POS	**POS** 03: School 05: Indian Health Service Free-standing Facility 07: Facility 09: Tribal 638 Free-standing Facility 11: Office 12: Home 13: Assisted Living Facility 14: Group Home 15: Mobile Unit 16: Temporary Lodging 17: Walk-in Retail Clinic 18: Place of Employment-Worksite 19: Off Campus-Outpatient Hospital 20: Urgent Care Facility 22: On-Campus Outpatient Hospital 33: Custodial Care Facility 49: Independent Clinic 50: Federally Qualified Health Center 71: Public Health Clinic 72: Rural Health Clinic

	Codes:
Telephone visits	**CPT** 98966, 98967, 98968, 99441, 99442, 99443
Telehealth POS	**POS** 02 10
Visit setting unspecified	**CPT** 90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99252, 99253, 99254, 99255

How can we help?

We help you with follow-up after hospitalization for mental illness by:

- Offer current *Clinical Practice Guidelines* on our provider self-service website.
- Members may be eligible for transportation assistance at no cost, contact Member Services for arrangement.

Other available resources

You can find more information and tools online at:

- **qualityforum.org**

Helpful tip:

- If utilizing an EMR system, consider electronic data sharing with your health plan to capture all coded elements. Contact your provider relationship managements representative for additional details and questions.

Notes:

Follow-Up After Emergency Department Visit for Mental Illness (FUM)

This HEDIS measure evaluates the percentage of emergency department (ED) visits for members ages 6 years and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness during the measurement year. Two rates are reported:

1. The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days)
2. The percentage of ED visits for which the member received follow-up within seven days of the ED visit (8 total days)

Exclusions:

- ED visits that result in an inpatient stay
- ED visits followed by admission to an acute or nonacute inpatient care setting on the date of the ED visit or within the 30 days after the ED visit (31 total days)
- Members in hospice or using hospice services anytime during the measurement year
- Members who died during the measurement year

	Codes:
BH Outpatient	**CPT:** 98960, 98961, 98962, 99078, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99242, 99243, 99244, 99245, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99483, 99492, 99493, 99494, 99510
	HCPCS: **G0155:** Services of clinical social worker in home health or hospice settings, each 15 minutes **G0176:** Activity therapy, such as music, dance, art or play therapies not for recreation, related to the care and treatment of patient's disabling mental health problems, per session (45 minutes or more) **G0177:** Training and educational services related to the care and treatment of patient's disabling mental health problems per session (45 minutes or more)

	Codes:
BH Outpatient (cont.)	**HCPCS:** **G0409:** Social work and psychological services, directly relating to and/or furthering the patient's rehabilitation goals, each 15 minutes, face-to-face; individual (services provided by a CORF-qualified social worker or psychologist in a CORF) **G0463:** Hospital outpatient clinic visit for assessment and management of a patient **G0512:** Rural health clinic or federally qualified health center (RHC/FQHC) only, psychiatric collaborative care model (psychiatric COCM), 60 minutes or more of clinical staff time for psychiatric COCM services directed by an RHC or FQHC practitioner (physician, NP, PA, or CNM) and including services furnished by a behavioral health care manager and consultation with a psychiatric consultant, per calendar month **H0002:** Behavioral health screening to determine eligibility for admission to treatment program **H0004:** Behavioral health counseling and therapy, per 15 minutes **H0031:** Mental health assessment, by non-physician **H0034:** Medication training and support, per 15 minutes **H0036:** Community psychiatric supportive treatment, face-to-face, per 15 minutes **H0037:** Community psychiatric supportive treatment program, per diem **H0039:** Assertive community treatment, face-to-face, per 15 minutes **H0040:** Assertive community treatment program, per diem **H2000:** Comprehensive multidisciplinary evaluation **H2010**: Comprehensive medication services, per 15 minutes **H2011:** Crisis intervention service, per 15 minutes **H2013:** Psychiatric health facility service, per diem **H2014**: Skills training and development, per 15 minutes **H2015:** Comprehensive community support services, per 15 minutes **H2016:** Comprehensive community support services, per diem **H2017:** Psychosocial rehabilitation services, per 15 minutes **H2018:** Psychosocial rehabilitation services, per diem **H2019:** Therapeutic behavioral services, per 15 minutes **H2020:** Therapeutic behavioral services, per diem **T1015:** Clinic visit/encounter, all-inclusive

	Codes:
Telehealth POS	**POS** 02 10
Outpatient POS	**POS** 03: School 05: Indian Health Service Free-standing Facility 07: Facility 09: Tribal 638 Free-standing Facility 11: Office 12: Home 13: Assisted Living Facility 14: Group Home 15: Mobile Unit 16: Temporary Lodging 17: Walk-in Retail Clinic 18: Place of Employment-Worksite 19: Off Campus-Outpatient Hospital 20: Urgent Care Facility 22: On-Campus Outpatient Hospital 33: Custodial Care Facility 49: Independent Clinic 50: Federally Qualified Health Center 71: Public Health Clinic 72: Rural Health Clinic
Visit setting unspecified	**CPT** 90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99252, 99253, 99254, 99255

	Codes:
Online Assessments	**CPT** 98970, 98971, 98972, 98980, 98981, 99421, 99422, 99423, 99457, 99458
	HCPCS **G0071:** Payment for communication technology-based services for 5 minutes or more of a virtual (non-face-to-face) communication between a rural health clinic (RHC) or federally qualified health center (FQHC) practitioner and RHC or FQHC patient, or 5 minutes or more of remote evaluation of recorded video and/or images by an RHC or FQHC practitioner, occurring in lieu of an office visit; RHC or FQHC only **G2010:** Remote evaluation of recorded video and/or images submitted by an established patient (for example, store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment **G2012:** Brief communication technology-based service, for example, virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion

	Codes:
Online Assessments (cont.)	**HCPCS** **G2250:** Remote assessment of recorded video and/or images submitted by an established patient (for example, store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment **G2251:** Brief communication technology-based service, for example, virtual check-in, by a qualified health care professional who cannot report evaluation and management services, provided to an established patient, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of clinical discussion **G2252:** Brief communication technology-based service, for example, virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion
Telephone visits	**CPT** 98966, 98967, 98968, 99441, 99442, 99443
CDC Race and Ethnicity	**1002-5:** American Indian or Alaska Native **2028-9:** Asian **2054-5:** Black or African American **2076-8**: Native Hawaiian or Other Pacific Islander **2106-3:** White **2135-2:** Hispanic or Latino **2186-5:** Not Hispanic or Latino

Note: The codes listed are informational only; this information does not guarantee reimbursement.

How can we help?

- We help you with follow-up after hospitalization for mental illness by:
- Offer current *Clinical Practice Guidelines* on our provider self-service website.
- Members may be eligible for transportation assistance at no cost, contact Member Services for arrangement.

Other available resources

You can find more information and tools online at:

- **www.qualityforum.org**

Helpful tip:

- If utilizing an EMR system, consider electronic data sharing with your health plan to capture all coded elements. Contact your provider relationship managements representative for additional details and questions.

Notes:

Glycemic Status Assessment for Patients With Diabetes (GSD)

This measure looks at the percentage of members 18 to 75 years of age with diabetes (types 1 and 2) whose most recent glycemic status (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) was at the following levels during the measurement year:

- Glycemic Status < 8.0%.
- Glycemic Status > 9.0%.

Note: A lower rate indicates better performance for this indicator (such as, low rates of Glycemic Status > 9% indicate better care).

Record your efforts:

- Document the result of the most recent glycemic status assessment (HbA1c or GMI) performed during the measurement year
- When identifying the most recent glycemic status assessment (HbA1c or GMI), GMI values must include documentation of the continuous glucose monitoring data date range used to derive the value. The terminal date in the range should be used to assign assessment date.

Exclusions:

- Members who use hospice services or elect to use a hospice benefit any time during the measurement year
- Members who die any time during the measurement year
- Members receiving palliative care any time during the measurement year
- Members who had an encounter for palliative anytime during the measurement year
- Members 66 years of age and older as of December 31 of the measurement year (all product lines) with frailty and advanced illness. Members must meet both frailty and advanced illness criteria to be excluded

	Codes:
HbA1c Level Greater Than or Equal to 8.0	**CPT-CAT II** **3046F:** Most recent hemoglobin A1c level greater than 9.0% (DM) **3052F:** Most recent hemoglobin A1c (HbA1c) level greater than or equal to 8.0% and less than or equal to 9.0% (DM)
HbA1c Level Less Than 8.0	**CPT-CAT II** **3044F:** Most recent hemoglobin A1c (HbA1c) level less than 7.0% (DM) **3051F:** Most recent hemoglobin A1c (HbA1c) level greater than or equal to 7.0% and less than 8.0% (DM)
Hb1c Level Less Than or Equal to 9.0	**CPT-CAT II** **3044F:** Most recent hemoglobin A1c (HbA1c) level less than 7.0% (DM) **3051F:** Most recent hemoglobin A1c (HbA1c) level greater than or equal to 7.0% and less than 8.0% (DM) **3052F:** Most recent hemoglobin A1c (HbA1c) level greater than or equal to 8.0% and less than or equal to 9.0% (DM)

	Codes:
HbA1c Tests Results or Findings:	**CPT-CAT II** **3044F:** Most recent hemoglobin A1c (HbA1c) level less than 7.0% (DM) **3046F:** Most recent hemoglobin A1c level greater than 9.0% (DM) **3051F:** Most recent hemoglobin A1c (HbA1c) level greater than or equal to 7.0% and less than 8.0% (DM) **3052F:** Most recent hemoglobin A1c (HbA1c) level greater than or equal to 8.0% and less than or equal to 9.0% (DM)
HbA1c Lab Test	**CPT** 83036, 83037 **LOINC** **17855-8:** Hemoglobin A1c/Hemoglobin. Total in Blood by calculation **17856-6:** Hemoglobin A1c/Hemoglobin. Total in Blood by HPLC **4548-4:** Hemoglobin A1c/Hemoglobin. Total in Blood **4549-2:** Hemoglobin A1c/Hemoglobin. Total in Blood by Electrophoresis **96595-4:** Hemoglobin A1c/Hemoglobin. Total in DBS
CDC Race and Ethnicity	**1002-5:** American Indian or Alaska Native **2028-9:** Asian **2054-5:** Black or African American **2076-8**: Native Hawaiian or Other Pacific Islander **2106-3:** White **2135-2:** Hispanic or Latino **2186-5:** Not Hispanic or Latino

Note: The Logical Observation Identifiers Names and Codes (LOINC) are for reporting clinical observations and laboratory testing. The codes listed are informational only; this information does not guarantee reimbursement.

Helpful tips:

- For the recommended frequency of testing and screening, refer to the *Clinical Practice Guidelines* for diabetes mellitus.
- If your practice uses EMRs, have flags or reminders set in the system to alert your staff when a member's screenings are due.
- Send appointment reminders and call members to remind them of upcoming appointments and necessary screenings.
- Follow up on lab test results and document on your chart.
- Draw labs in your office if accessible or refer members to a local lab for screenings.
- Educate your members and their families, caregivers, and guardians on diabetes care, including:
  - Taking all prescribed medications as directed.
  - Adding regular exercise to daily activities.
  - Regularly monitoring blood sugar and blood pressure at home.
  - Maintaining healthy weight and ideal body mass index.
  - Eating heart-healthy, low-calorie, and low-fat foods.
  - Stopping smoking and avoiding second-hand smoke.
  - Fasting prior to having blood sugar and lipid panels drawn to ensure accurate results.
  - Keeping all medical appointments; getting help with scheduling necessary appointments, screenings, and tests to improve compliance.
- Remember to include the applicable Category II reporting code above on the claim form to help reduce the burden of HEDIS medical record review.
- If utilizing an electronic medical record (EMR) system, consider electronic data sharing with your health plan to capture all coded elements. Contact your provider relationship managements representative for additional details and questions.

How can we help?

We can help you with comprehensive diabetes care by:

- Providing online *Clinical Practice Guidelines* on our provider self-service website.
- Providing programs that may be available to our diabetic members.
- Supplying copies of educational resources on diabetes that may be available for your office.
- Scheduling Clinic Days or providing education at your office if available in your area.
- Members may be eligible for transportation assistance at no cost, contact Member Services for arrangement.

Initiation and Engagement of Substance Use Disorder Treatment (IET)

This measure looks at the percentage of new substance use disorder (SUD) episodes that result in treatment initiation and engagement. Two rates are reported:

- **Initiation of SUD treatment:** The percentage of new SUD episodes that result in treatment initiation through an inpatient SUD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth visit, or medication treatment within 14 days. November 15 of the year prior to the measurement year to November 14 of the measurement year.
- **Engagement of SUD treatment:** The percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation.

Exclusions:

- Members who use hospice services or elect to use a hospice benefit any time during the measurement year
- Members who died during the measurement year

Initiation and engagement of alcohol and other drug dependence treatment (IET) codes:

	Codes:
BH outpatient	**CPT** 98960, 98961, 98962, 99078, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99242, 99243, 99244, 99245, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99483, 99492, 99493, 99494, 99510 **HCPCS** **G0155:** Services of clinical social worker in home health or hospice settings, each 15 minutes **G0176:** Activity therapy, such as music, dance, art or play therapies not for recreation, related to the care and treatment of patient's disabling mental health problems, per session (45 minutes or more) **G0177:** Training and educational services related to the care and treatment of patient's disabling mental health problems per session (45 minutes or more) **G0409:** Social work and psychological services, directly relating to and/or furthering the patient's rehabilitation goals, each 15 minutes, face-to-face; individual (services provided by a CORF-qualified social worker or psychologist in a CORF) **G0463:** Hospital outpatient clinic visit for assessment and management of a patient **G0512:** Rural health clinic or federally qualified health center (RHC/FQHC) only, psychiatric collaborative care model (psychiatric COCM), 60 minutes or more of clinical staff time for psychiatric COCM services directed by an RHC or FQHC practitioner (physician, NP, PA, or CNM) and including services furnished by a behavioral health care manager and consultation with a psychiatric consultant, per calendar month **H0002:** Behavioral health screening to determine eligibility for admission to treatment program **H0004:** Behavioral health counseling and therapy, per 15 minutes **H0031:** Mental health assessment, by non-physician **H0034:** Medication training and support, per 15 minutes **H0036:** Community psychiatric supportive treatment, face-to-face, per 15 minutes

	Codes:
BH outpatient (cont.)	**HCPCS** **H0037:** Community psychiatric supportive treatment program, per diem **H0039:** Assertive community treatment, face-to-face, per 15 minutes **H0040:** Assertive community treatment program, per diem **H2000:** Comprehensive multidisciplinary evaluation **H2010:** Comprehensive medication services, per 15 minutes **H2011:** Crisis intervention service, per 15 minutes **H2013:** Psychiatric health facility service, per diem **H2014:** Skills training and development, per 15 minutes **H2015:** Comprehensive community support services, per 15 minutes **H2016:** Comprehensive community support services, per diem **H2017:** Psychosocial rehabilitation services, per 15 minutes **H2018:** Psychosocial rehabilitation services, per diem **H2019:** Therapeutic behavioral services, per 15 minutes **H2020:** Therapeutic behavioral services, per diem **T1015:** Clinic visit/encounter, all-inclusive
Buprenorphine Implant	**HCPCS** **G2070:** Medication assisted treatment, buprenorphine (implant insertion); weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a Medicare-enrolled opioid treatment program) **G2072:** Medication assisted treatment, buprenorphine (implant insertion and removal); weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a Medicare-enrolled opioid treatment program) **J0570:** Buprenorphine implant, 74.2 mg
Buprenorphine Injection	**HCPCS** **G2069:** Medication assisted treatment, buprenorphine (injectable); weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a Medicare-enrolled opioid treatment program) **Q9991:** Injection, buprenorphine extended-release (sublocade), less than or equal to 100 mg **Q9992:** Injection, buprenorphine extended-release (sublocade), greater than 100 mg

	Codes:
Buprenorphine Naloxone	**HCPCS** **J0572:** Buprenorphine/naloxone, oral, less than or equal to 3 mg buprenorphine **J0573:** Buprenorphine/naloxone, oral, greater than 3 mg, but less than or equal to 6 mg buprenorphine **J0574:** Buprenorphine/naloxone, oral, greater than 6 mg, but less than or equal to 10 mg buprenorphine **J0575:** Buprenorphine/naloxone, oral, greater than 10 mg buprenorphine
Buprenorphine Oral	**HCPCS** **H0033:** Oral medication administration, direct observation **J0571:** Buprenorphine, oral, 1 mg
Buprenorphine Oral Weekly	**HCPCS** **G2068:** Medication assisted treatment, buprenorphine (oral); weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a Medicare-enrolled opioid treatment program) **G2079:** Take-home supply of buprenorphine (oral); up to 7 additional day supply (provision of the services by a Medicare-enrolled opioid treatment program); list separately in addition to code for primary procedure
Detoxification	**HCPCS** **H0008:** Alcohol and/or drug services; sub-acute detoxification (hospital inpatient) **H0009:** Alcohol and/or drug services; acute detoxification (hospital inpatient) **H0010:** Alcohol and/or drug services; sub-acute detoxification (residential addiction program inpatient) **H0011:** Alcohol and/or drug services; acute detoxification (residential addiction program inpatient) **H0012:** Alcohol and/or drug services; sub-acute detoxification (residential addiction program outpatient) **H0013:** Alcohol and/or drug services; acute detoxification (residential addiction program outpatient) **H0014:** Alcohol and/or drug services; ambulatory detoxification **ICD10PCS:** **HZ2ZZZZ:** Detoxification Services for Substance Abuse Treatment

	Codes:
Methadone Oral	**HCPCS** **H0020:** Alcohol and/or drug services; methadone administration and/or service (provision of the drug by a licensed program) **S0109:** Methadone, oral, 5 mg
Methadone Oral Weekly	**HCPCS** **G2067:** Medication assisted treatment, methadone; weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing, if performed (provision of the services by a Medicare-enrolled opioid treatment program) **G2078:** Take-home supply of methadone; up to 7 additional day supply (provision of the services by a Medicare-enrolled opioid treatment program); list separately in addition to code for primary procedure
Naltrexone Injection	**HCPCS** **G2073:** Medication assisted treatment, naltrexone; weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a Medicare-enrolled opioid treatment program) **J2315:** Injection, naltrexone, depot form, 1 mg

Note: The codes listed are informational only; this information does not guarantee reimbursement.

How can we help?

We can help you with monitoring initiation and engagement of alcohol and other drug dependence treatment by:

- Reaching out to providers to be advocates and providing the resources to educate our members.
- Calling our behavioral health Provider Service for additional information.
- Guiding with the above noted services to drive member success in completing alcohol and other drug dependence treatment.
- Members may be eligible for transportation assistance at no cost, contact Member Services for arrangement.

Helpful tip:

- If utilizing an electronic medical record (EMR) system, consider electronic data sharing with your health plan to capture all coded elements. Contact your provider relationship managements representative for additional details and questions.

Notes:

Immunizations for Adolescents (IMA)

This measure reviews the percentage of adolescents 13 years of age who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday. The measure calculates a rate for each vaccine and two combination rates.

Vaccines administered on or before their 13th birthday:

- One MCV/meningococcal vaccine on or between 11th and 13th birthdays, and one Tdap or one Td vaccine on or between their 10th and 13th birthdays
- At least two doses of HPV vaccine with DOS at 146 days apart on or between the 9th and 13th birthdays:
  - Or at least three HPV vaccines with different dates of service on or between the ninth and 13th birthdays

Record your efforts

Immunization information obtained from the medical record:

- A note indicating the name of the specific antigen and the date of the immunization.
- A certificate of immunization prepared by an authorized health care provider or agency, including the specific dates and types of immunizations administered.
- Document in the medical record parent or guardian refusal.

Two-dose HPV vaccination series:

- There must be at least 146 days between the first and second dose of the HPV vaccine.

Meningococcal:

- *Do not count* meningococcal recombinant (serogroup B) (MenB) vaccines.

Exclusions:

- Members who use hospice services or elect to use a hospice benefit any time during the measurement year
- Members who died during the measurement year

	Codes:
HPV Vaccine Procedure	**CPT:** 90649, 90650, 90651 **CVX:** **62:** human papilloma virus vaccine, quadrivalent **118:** human papilloma virus vaccine, bivalent **137:** HPV, unspecified formulation **165:** Human Papillomavirus 9-valent vaccine
Meningococcal Vaccine Procedure	**CPT:** 90619, 90733, 90734 **CVX:** **32:** meningococcal polysaccharide vaccine (MPSV4) **108:** meningococcal ACWY vaccine, unspecified formulation **114:** meningococcal polysaccharide (groups A, C, Y and W-135) diphtheria toxoid conjugate vaccine (MCV4P) **136:** meningococcal oligosaccharide (groups A, C, Y and W-135) diphtheria toxoid conjugate vaccine (MCV4O) **147:** Meningococcal, MCV4, unspecified conjugate formulation (groups A, C, Y and W-135) **167:** meningococcal vaccine of unknown formulation and unknown serogroups **203:** meningococcal polysaccharide (groups A, C, Y, W-135) tetanus toxoid conjugate vaccine 0.5mL dose, preservative free
Tdap Vaccine Procedure	**CPT:** 90715 **CVX:**115
CDC Race and Ethnicity	**1002-5:** American Indian or Alaska Native **2028-9:** Asian **2054-5:** Black or African American **2076-8**: Native Hawaiian or Other Pacific Islander **2106-3:** White **2135-2:** Hispanic or Latino **2186-5:** Not Hispanic or Latino

Note: The codes listed are informational only; this information does not guarantee reimbursement.

How can we help?

We help you meet this benchmark by:

- Offering current *Clinical Practice Guidelines* on our provider self-service website.
- Members may be eligible for transportation assistance at no cost, contact Member Services for arrangement.

Helpful tip:

- If utilizing an EMR system, consider electronic data sharing with your health plan to capture all coded elements. Contact your provider relationship managements representative for additional details and questions.

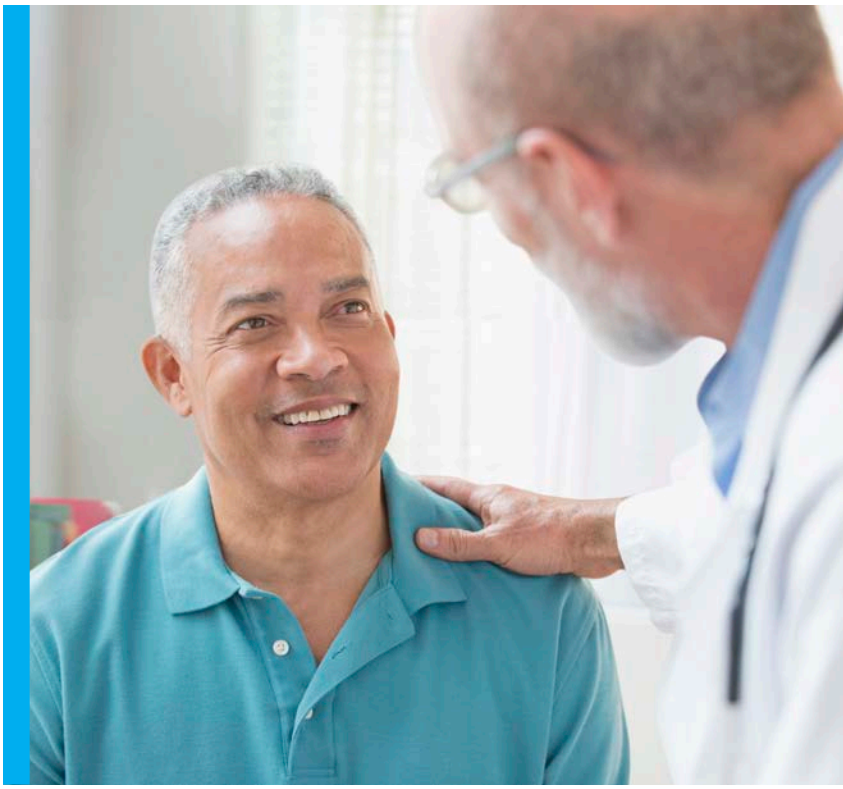
Notes:

Kidney Health Evaluation for Patients with Diabetes (KED)

This measure evaluates the percentage of members 18 to 85 years of age with diabetes (type 1 and type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) ***and*** a urine albumin-creatinine ratio (uACR), during the measurement year.

Exclusions:

- Members who use hospice services or elect to use a hospice benefit any time during the measurement year
- Members who die any time during the measurement year
- Members receiving palliative care any time during the measurement year
- Members who had an encounter for palliative care anytime during the measurement year
- Members with a diagnosis of end-stage renal disease (ESRD) any time during the member's history on or prior to December 31 of the measurement year
- Members who had dialysis any time during the member's history on or prior to December 31 of the measurement year
- Members 66 to 80 years of age as of December 31 of the measurement year (all product lines) with frailty and advanced illness. Members must meet BOTH frailty and advanced illness criteria to be excluded
- Members 81 years of age and older as of December 31 of the measurement year (all product lines) with at least two indications of frailty with different dates of service during the measurement year
- Advanced illness on at least two different dates of service
- Dispensed dementia medication



Estimated Glomerular Filtration Rate Lab Test

Codes:

CPT

80047, 80048, 80050, 80053, 80069, 82565

LOINC

50044-7: Glomerular filtration rate/1.73 sq M. Predicted among females [Volume Rate/Area] in Serum, Plasma or Blood by Creatinine-based formula (MDRD)

50210-4: Glomerular filtration rate/1.73 sq M. Predicted [Volume Rate/Area] in Serum, Plasma or Blood by Cystatin C-based formula

50384-7: Glomerular filtration rate/1.73 sq M. Predicted [Volume Rate/Area] in Serum, Plasma or Blood by Creatinine-based formula (Schwartz)

62238-1: Glomerular filtration rate/1.73 sq M. Predicted [Volume Rate/Area] in Serum, Plasma or Blood by Creatinine-based formula (CKD-EPI)

69405-9: Glomerular filtration rate/1.73 sq M. Predicted [Volume Rate/Area] in Serum, Plasma or Blood

70969-1: Glomerular filtration rate/1.73 sq M. Predicted among males [Volume Rate/Area] in Serum, Plasma or Blood by Creatinine-based formula (MDRD)

77147-7: Glomerular filtration rate/1.73 sq M. Predicted [Volume Rate/Area] in Serum, Plasma or Blood by Creatinine-based formula (MDRD)

94677-2: Glomerular filtration rate/1.73 sq M. Predicted [Volume Rate/Area] in Serum, Plasma or Blood by Creatinine and Cystatin C-based formula (CKD-EPI)

98979-8: Glomerular filtration rate/1.73 sq M. Predicted [Volume Rate/Area] in Serum, Plasma or Blood by Creatinine-based formula (CKD-EPI 2021)

98980-6: Glomerular filtration rate/1.73 sq M. Predicted [Volume Rate/Area] in Serum, Plasma or Blood by Creatinine and Cystatin C-based formula (CKD-EPI 2021)

	Codes:
Quantitative Urine Albumin Lab Test	**CPT** 82043 **LOINC** **100158-5:** Microalbumin [Mass/volume] in Urine collected for unspecified duration **14957-5:** Microalbumin [Mass/volume] in Urine **1754-1:** Albumin [Mass/volume] in Urine **21059-1:** Albumin [Mass/volume] in 24-hour Urine **30003-8:** Microalbumin [Mass/volume] in 24-hour Urine **43605-5:** Microalbumin [Mass/volume] in 4-hour Urine **53530-2:** Microalbumin [Mass/volume] in 24-hour Urine by Detection limit <= 1.0 mg/L **53531-0:** Microalbumin [Mass/volume] in Urine by Detection limit <= 1.0 mg/L **57369-1:** Microalbumin [Mass/volume] in 12-hour Urine **89999-7:** Microalbumin [Mass/volume] in Urine by Detection limit <= 3.0 mg/L
Urine Albumin Creatinine Ratio Lab Test	**LOINC** **13705-9:** Albumin/Creatinine [Mass Ratio] in 24-hour Urine **14958-3:** Microalbumin/Creatinine [Mass Ratio] in 24-hour Urine **14959-1**: Microalbumin/Creatinine [Mass Ratio] in Urine **30000-4:** Microalbumin/Creatinine [Ratio] in Urine **44292-1:** Microalbumin/Creatinine [Mass Ratio] in 12-hour Urine **59159-4:** Microalbumin/Creatinine [Ratio] in 24-hour Urine **76401-9:** Albumin/Creatinine [Ratio] in 24-hour Urine **77253-3:** Microalbumin/Creatinine [Ratio] in Urine by Detection limit <= 1.0 mg/L **77254-1:** Microalbumin/Creatinine [Ratio] in 24-hour Urine by Detection limit <= 1.0 mg/L **89998-9:** Microalbumin/Creatinine [Ratio] in Urine by Detection limit <= 3.0 mg/L **9318-7:** Albumin/Creatinine [Mass Ratio] in Urine

	Codes:
Urine Creatinine Lab Test	**CPT** 82570 **LOINC** **20624-3:** Creatinine [Mass/volume] in 24-hour Urine **2161-8:** Creatinine [Mass/volume] in Urine **35674-1:** Creatinine [Mass/volume] in Urine collected for unspecified duration **39982-4:** Creatinine [Mass/volume] in Urine –baseline **57344-4:** Creatinine [Mass/volume] in 2-hour Urine **57346-9:** Creatinine [Mass/volume] in 12-hour Urine **58951-5:** Creatinine [Mass/volume] in Urine –2nd specimen
CDC Race and Ethnicity	**1002-5:** American Indian or Alaska Native **2028-9:** Asian **2054-5:** Black or African American **2076-8**: Native Hawaiian or Other Pacific Islander **2106-3:** White **2135-2:** Hispanic or Latino **2186-5:** Not Hispanic or Latino

Note: The Logical Observation Identifiers Names and Codes (LOINC) are for reporting clinical observations and laboratory testing. The codes listed are informational only; this information does not guarantee reimbursement.

How can we help?

We help you meet this benchmark by:

- Offering current *Clinical Practice Guidelines* on our provider self-service website.
- Helping identify community resources, such as health education classes that may be available in your area.
- Members may be eligible for transportation assistance at no cost, contact Member Services for arrangement.

Helpful tip:

- If utilizing an EMR system, consider electronic data sharing with your health plan to capture all coded elements. Contact your provider relationship managements representative for additional details and questions.

Notes:

Use of Imaging Studies for Low Back Pain (LBP)

This HEDIS measure looks at the percentage of members 18 to 75 years of age with a principal diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis January 1 to December 3 of the measurement year.

The measure is reported as an inverted rate. A higher score indicates appropriate treatment of low back pain (for example, the proportion for whom imaging studies did not occur).

Exclusions:

- Members who use hospice services or elect to use a hospice benefit any time during the measurement year.
- Members who die any time during the measurement year.
- Members 66 years of age or older as of December 31 of the measurement year (all product lines) with frailty and advanced illness. Members must meet BOTH frailty and advanced illness criteria to be excluded.
- Members meet any of the following criteria:
  - Cancer
  - Recent trauma
  - Intravenous drug abuse
  - Neurological impairment
  - HIV
  - Spinal infection
  - Major organ transplant
  - Prolonged use of corticosteroids
  - Osteoporosis
  - Lumbar surgery
  - Spondylopathy
  - Fragility fracture
  - Spondylopathy

	Codes:
Uncomplicated Low Back Pain	**ICD10CM** **M47.26:** Other spondylosis with radiculopathy, lumbar region **M47.27:** Other spondylosis with radiculopathy, lumbosacral region **M47.28:** Other spondylosis with radiculopathy, sacral and sacrococcygeal region **M47.816:** Spondylosis without myelopathy or radiculopathy, lumbar region **M47.817:** Spondylosis without myelopathy or radiculopathy, lumbosacral region **M47.818:** Spondylosis without myelopathy or radiculopathy, sacral and sacrococcygeal region **M47.896:** Other spondylosis, lumbar region **M47.897:** Other spondylosis, lumbosacral region **M47.898:** Other spondylosis, sacral and sacrococcygeal region **M48.061:** Spinal stenosis, lumbar region without neurogenic claudication **M48.07:** Spinal stenosis, lumbosacral region **M48.08:** Spinal stenosis, sacral and sacrococcygeal region **M51.16:** Intervertebral disc disorders with radiculopathy, lumbar region **M51.17:** Intervertebral disc disorders with radiculopathy, lumbosacral region **M51.26:** Other intervertebral disc displacement, lumbar region **M51.27:** Other intervertebral disc displacement, lumbosacral region **M51.36:** Other intervertebral disc degeneration, lumbar region **M51.37:** Other intervertebral disc degeneration, lumbosacral region **M51.86:** Other intervertebral disc disorders, lumbar region **M51.87:** Other intervertebral disc disorders, lumbosacral region **M53.2X6:** Spinal instabilities, lumbar region **M53.2X7:** Spinal instabilities, lumbosacral region **M53.2X8:** Spinal instabilities, sacral and sacrococcygeal region **M53.3:** Sacrococcygeal disorders, not elsewhere classified

	Codes:
Uncomplicated Low Back Pain (cont.)	**M53.86:** Other specified dorsopathies, lumbar region **M53.87:** Other specified dorsopathies, lumbosacral region **M53.88:** Other specified dorsopathies, sacral and sacrococcygeal region **M54.16:** Radiculopathy, lumbar region **M54.17:** Radiculopathy, lumbosacral region **M54.18:** Radiculopathy, sacral and sacrococcygeal region **M54.30:** Sciatica, unspecified side **M54.31:** Sciatica, right side **M54.32:** Sciatica, left side **M54.40:** Lumbago with sciatica, unspecified side **M54.41:** Lumbago with sciatica, right side **M54.42:** Lumbago with sciatica, left side **M54.50:** Low back pain, unspecified **M54.51:** Vertebrogenic low back pain **M54.59:** Other low back pain **M54.89:** Other dorsalgia **M54.9:** Dorsalgia, unspecified **M99.03:** Segmental and somatic dysfunction of lumbar region **M99.04:** Segmental and somatic dysfunction of sacral region **M99.23:** Subluxation stenosis of neural canal of lumbar region **M99.33:** Osseous stenosis of neural canal of lumbar region **M99.43:** Connective tissue stenosis of neural canal of lumbar region **M99.53:** Intervertebral disc stenosis of neural canal of lumbar region **M99.63:** Osseous and subluxation stenosis of intervertebral foramina of lumbar region **M99.73:** Connective tissue and disc stenosis of intervertebral foramina of lumbar region **M99.83:** Other biomechanical lesions of lumbar region **M99.84**: Other biomechanical lesions of sacral region

	Codes:
Uncomplicated Low Back Pain (cont.)	**S33.100A:** Subluxation of unspecified lumbar vertebra, initial encounter **S33.100D:** Subluxation of unspecified lumbar vertebra, subsequent encounter **S33.100S:** Subluxation of unspecified lumbar vertebra, sequela **S33.110A:** Subluxation of L1/L2 lumbar vertebra, initial encounter **S33.110D:** Subluxation of L1/L2 lumbar vertebra, subsequent encounter **S33.110S:** Subluxation of L1/L2 lumbar vertebra, sequela **S33.120A:** Subluxation of L2/L3 lumbar vertebra, initial encounter **S33.120D:** Subluxation of L2/L3 lumbar vertebra, subsequent encounter **S33.120S:** Subluxation of L2/L3 lumbar vertebra, sequela **S33.130A:** Subluxation of L3/L4 lumbar vertebra, initial encounter **S33.130D:** Subluxation of L3/L4 lumbar vertebra, subsequent encounter **S33.130S:** Subluxation of L3/L4 lumbar vertebra, sequela **S33.140A:** Subluxation of L4/L5 lumbar vertebra, initial encounter **S33.140D:** Subluxation of L4/L5 lumbar vertebra, subsequent encounter **S33.140S:** Subluxation of L4/L5 lumbar vertebra, sequela **S33.5XXA:** Sprain of ligaments of lumbar spine, initial encounter **S33.6XXA:** Sprain of sacroiliac joint, initial encounter **S33.8XXA:** Sprain of other parts of lumbar spine and pelvis, initial encounter **S33.9XXA:** Sprain of unspecified parts of lumbar spine and pelvis, initial encounter **S39.002A:** Unspecified injury of muscle, fascia and tendon of lower back, initial encounter **S39.002D:** Unspecified injury of muscle, fascia and tendon of lower back, subsequent encounter **S39.002S:** Unspecified injury of muscle, fascia and tendon of lower back, sequela

	Codes:
Uncomplicated Low Back Pain (cont.)	**S39.012A:** Strain of muscle, fascia and tendon of lower back, initial encounter **S39.012D:** Strain of muscle, fascia and tendon of lower back, subsequent encounter **S39.012S:** Strain of muscle, fascia and tendon of lower back, sequela **S39.092A:** Other injury of muscle, fascia and tendon of lower back, initial encounter **S39.092D:** Other injury of muscle, fascia and tendon of lower back, subsequent encounter **S39.092S:** Other injury of muscle, fascia and tendon of lower back, sequela **S39.82XA:** Other specified injuries of lower back, initial encounter **S39.82XD:** Other specified injuries of lower back, subsequent encounter **S39.82XS:** Other specified injuries of lower back, sequela **S39.92XA:** Unspecified injury of lower back, initial encounter **S39.92XD:** Unspecified injury of lower back, subsequent encounter **S39.92XS:** Unspecified injury of lower back, sequela
Imaging study	**CPT** 72020, 72040, 72050, 72052, 72070, 72072, 72074, 72080, 72081, 72082, 72083, 72084, 72100, 72110, 72114, 72120, 72125, 72126, 72127, 72128, 72129, 72130, 72131, 72132, 72133, 72141, 72142, 72146, 72147, 72148, 72149, 72156, 72157, 72158, 72200, 72202, 72220

Note: The codes listed are informational only; this information does not guarantee reimbursement.

How can we help?

We help you meet this benchmark by:

- Offering current *Clinical Practice Guidelines* on our provider self-service website.
- Helping identify community resources, such as health education classes that may be available in your area.
- Members may be eligible for transportation assistance at no cost, contact Member Services for arrangement.

Helpful tip:

- If utilizing an EMR system, consider electronic data sharing with your health plan to capture all coded elements. Contact your provider relationship managements representative for additional details and questions.

Notes:

Lead Screening in Children (LSC)

This HEDIS measure looks at the percentage of children 2 years of age who had one or more capillary or venous lead blood tests for lead poisoning by their second birthday.

Record your efforts:

When documenting lead screening, include:

- Date the test was reported
- Results or findings

Note: *Unknown* is not considered a result/finding for medical record reporting.

Exclusions:

- Members who use hospice services or elect to use a hospice benefit any time during the measurement year
- Members who die any time during the measurement year

Codes to identify lead test:

	Codes:
Lead tests	**CPT:** 83655 **LOINC:** **10368-9:** Lead [Mass/volume] in Capillary blood **10912-4:** Lead [Mass/volume] in Serum or Plasma **14807-2:** Lead [Moles/volume] in Blood **17052-2:** Lead [Presence] in Blood **25459-9:** Lead [Moles/volume] in Serum or Plasma **27129-6:** Lead [Mass/mass] in Red Blood Cells **32325-3:** Lead [Moles/volume] in Red Blood Cells **5671-3:** Lead [Mass/volume] in Blood **5674-7:** Lead [Mass/volume] in Red Blood Cells **77307-7:** Lead [Mass/volume] in Venous blood

Note: The Logical Observation Identifiers Names and Codes (LOINC) are for reporting clinical observations and laboratory testing. The codes listed are informational only; this information does not guarantee reimbursement.

Helpful tips:

- Draw member's blood while they are in your office instead of sending them to the lab.
- Consider performing finger stick screenings in your practice.
- Assign one staff member to follow up on results when members are sent to a lab for screening.
- Develop a process to check medical records for lab results to ensure previously ordered lead screenings have been completed and documented.
- Use sick and well-child visits as opportunities to encourage parents to have their child tested.
- Include a lead test reminder with lab name and address on your appointment confirmation/reminder cards.
- If utilizing an EMR system, consider electronic data sharing with your health plan to capture all coded elements. Contact your provider relationship managements representative for additional details and questions.

How can we help?

We help you with lead screening in children by:

- Offering current *Clinical Practice Guidelines* on our provider self-service website
- Members may be eligible for transportation assistance at no cost; contact Member Services for arrangement.

Other available resources

- **cdc.gov/nceh/lead/audience/healthcare-providers.html**

Notes:

Oral Evaluation, Dental Services (OED)

This HEDIS measure looks at the percentage of members under 21 of age who received a comprehensive oral evaluation with a dental provider during the measurement year.

Record your efforts:

- Date of evaluation

Exclusions:

- Members in hospice or using hospice services anytime during the measurement year
- Members who died during the measurement year

	Codes:
Oral Evaluation	**CDT** **D0120:** Periodic oral evaluation - established patient **D0145:** Oral evaluation for a patient under three years of age and counseling with primary caregiver **D0150:** Comprehensive oral evaluation - new or established patient

Note: The codes listed are informational only; this information does not guarantee reimbursement.

Helpful tip:

- If utilizing an EMR system, consider electronic data sharing with your health plan to capture all coded elements. Contact your Provider Solutions representative for additional details and questions.

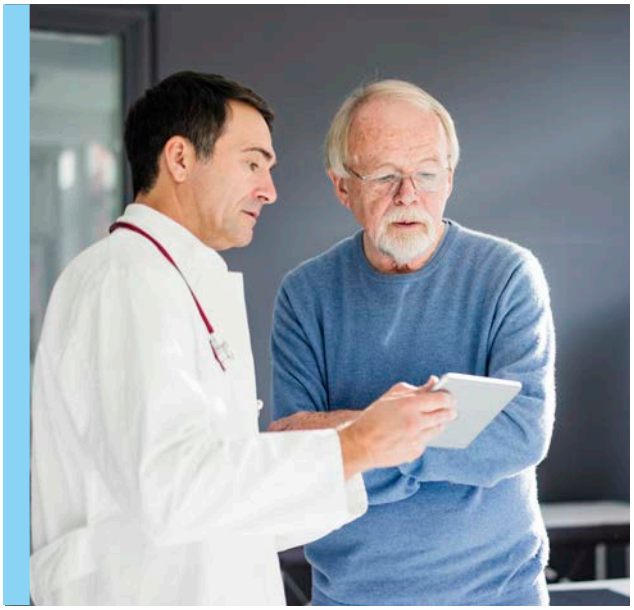
How can we help?

- Offering current *Clinical Practice Guidelines* on our provider self-service website
- Members may be eligible for transportation assistance at no cost; contact Member Services for arrangement.

Notes:

Plan All Cause Readmission (PCR)

This HEDIS measure looks at the number of patients ages 18 and older with acute inpatient or observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and a predicted probability of an acute readmission.



Data is reported in the following categories:

- Count of Index Hospital Stays (IHS) (denominator).
- An acute inpatient or observational stay with a discharge on or between January 1 and December 1 of the measurement year.
- For discharges with one or more direct transfers, use the last discharge. A direct transfer is when the discharge date from the first stay precedes the admission date to a subsequent stay by one calendar day or less.
- Count of observed 30-day readmissions (numerator).
- Count of expected 30-day readmissions.

Record your efforts:

- Monitor admission, discharge, and emergency department visit reports.
- Obtain hospital discharge summary and use to schedule post-discharge appointments within three to seven days.
- Document any conditions found during hospital admission within office visit notes and perform a medication reconciliation soon after discharge to prevent medication related readmissions.
- Consider telehealth or home health visits for discharged patients, when appropriate.
- Complete patient risk assessments to manage potential admissions (congestive heart failure, diabetes, COPD).
- Give clear instructions on changes that need immediate attention: to call office when condition changes (weight gain, medication changes, and high/low blood sugar readings).
- Develop a coordinated transition of care process (include multi-faceted treatment team).
- Provide extensive ongoing member outreach to manage potential admissions.

Strategies for decreasing readmissions:

- Identify high hospital utilizers. Partner with the health plan if you need assistance in obtaining this data.
- Identify the underlying problem for readmission to the hospital
- Know which populations might be at risk for readmissions:
- Postop complications
- Patients that have not presented to their PCP in follow up.
- Medication non-adherence.
- Recurrence of chronic conditions:
  - Heart disease/heart failure
  - COPD
  - Pneumonia
- Include as part of the health care team patient advocates or family members to support the patients' health goals and advise practices. This extra support could decrease exacerbations in conditions leading to admissions and readmissions.
- For end-of-life care: Involve hospice or home health providers to ensure patients don't go to the hospital for non-emergent end-of-life care issues.
- Provide patients and their family members with informed choices, opportunities for advance directives, and counseling may prevent painful and unnecessary admissions.
- Use translators for patients with limited English proficiency.
- Use interpreters/sign language for deaf or hard of hearing patients.
- Have various ways to communicate instructions to patients based on health literacy levels.
- Use videos.
- Use pictures.
- Ensure written materials are no higher than a 5th grade reading level.
- Partner with hospital to improve care coordination at discharge.
- Schedule a follow up with the patient within seven days of discharge
- Perform medication reconciliation.
- Use home healthcare or tele-monitoring for chronically ill patients.

Exclusions included in measure programming and system reporting

Use correct exclusion codes (list is not all inclusive):

- Female members with a principal diagnosis of pregnancy on the discharge claim
- Principal diagnosis of a condition originating in the perinatal period on the discharge claim

Planned admission using any of the following:

- Principal diagnosis of maintenance chemotherapy
- Principal diagnosis of rehabilitation
- An organ transplants
- Potentially planned procedure without a principal acute diagnosis
- The member expired during the stay
- Hospice care

Note: For hospital stays that include an acute-to-acute direct transfer, use both the original stay and the direct transfer stay to identify exclusions in this step.

How can we help?

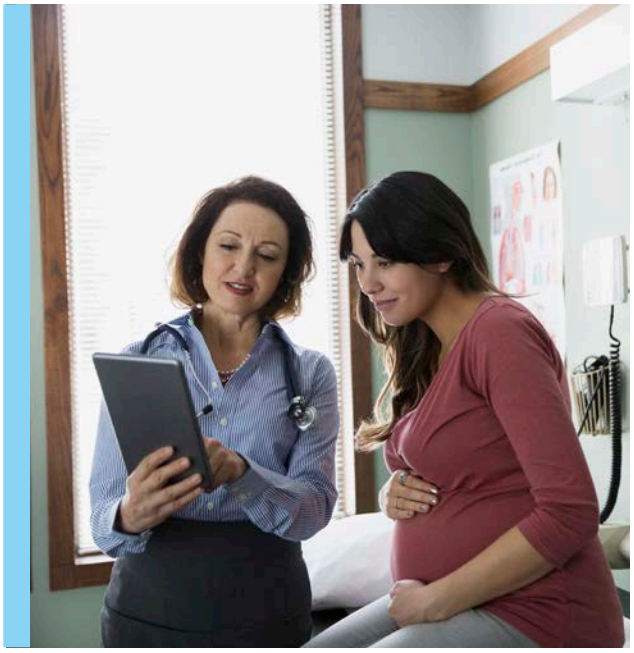
- Contact your Advanced Medical Home Provider Clinical Liaison for more information.

Notes:

Prenatal and Postpartum Care (PPC)

This HEDIS measure looks at the percentage deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care:

- **Timeliness of prenatal care:** The percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization.
- **Postpartum care:** The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery.



Record your efforts:

Prenatal care visit must include one of the following:

- Diagnosis of pregnancy
- A physical examination that includes one of the following:
  - Auscultation for fetal heart tone
  - Pelvic exam with obstetric observations
  - Measurement of fundus height
- Evidence that a prenatal care procedure was performed such as one of the following:
  - Obstetric panel including hematocrit, differential WBC count, platelet count, hepatitis B surface antigen, rubella antibody, syphilis test, RBC antibody screen, Rh and ABO blood typing)
  - TORCH antibody panel alone
  - A rubella antibody test/titer with an Rh incompatibility (ABO/Rh) blood typing
  - Ultrasound of a pregnant uterus
- Documentation of LMP, EDD or gestational age in conjunction with either of the following:
  - Prenatal risk assessment and counseling/education
  - Complete obstetrical history

Postpartum care visit on or between seven and 84 days after delivery

Documentation in the medical record must include a note indicating the date when a postpartum visit occurred and one of the following:

- Pelvic exam
- Evaluation of weight, BP, breasts, and abdomen
- Notation of breastfeeding is acceptable for the *evaluation of breasts* component
- Notation of postpartum care, including, but not limited to:
  - Notation of *postpartum care, PP care, PP check, 6-week check*
  - A preprinted *Postpartum Care* form in which information was documented during the visit
- Perineal or cesarean incision/wound check
- Screening for depression, anxiety, tobacco use, substance use disorder or preexisting mental health disorders
- Glucose screening for women with gestational diabetes
- Documentation of any of the following topics:
  - Infant care or breastfeeding
  - Resumption of intercourse, birth spacing or family planning.
  - Sleep/fatigue
  - Resumption of physical activity and attainment of healthy weight

Exclusions:

- Non-live births
- Members in hospice or using hospice services anytime during the measurement year
- Members who died during the measurement year

	Codes:
Deliveries	**CPT** 59400, 59409, 59410, 59510, 59514, 59515, 59610, 59612, 59614, 59618, 59620, 59622 **ICD10PCS** **10D00Z0:** Extraction of Products of Conception, High, Open Approach **10D00Z1:** Extraction of Products of Conception, Low, Open Approach **10D00Z2:** Extraction of Products of Conception, Extraperitoneal, Open Approach **10D07Z3:** Extraction of Products of Conception, Low Forceps, Via Natural or Artificial Opening **10D07Z4:** Extraction of Products of Conception, Mid Forceps, Via Natural or Artificial Opening **10D07Z5:** Extraction of Products of Conception, High Forceps, Via Natural or Artificial Opening **10D07Z6:** Extraction of Products of Conception, Vacuum, Via Natural or Artificial Opening **10D07Z7:** Extraction of Products of Conception, Internal Version, Via Natural or Artificial Opening **10D07Z8:** Extraction of Products of Conception, Other, Via Natural or Artificial Opening **10E0XZZ:** Delivery of Products of Conception, External Approach
Prenatal Bundled Services	**CPT** 59400, 59425, 59426, 59510, 59610, 59618 **HCPCS** **H1005:** Prenatal care, at-risk enhanced service package (includes h1001-h1004)
Prenatal Visits	**CPT** 98966, 98967, 98968, 98970, 98971, 98972, 98980, 98981, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99242, 99243, 99244, 99245, 99421, 99422, 99423, 99441, 99442, 99443, 99457, 99458, 99483

	Codes:
Prenatal Visits (cont.)	**HCPCS** **G0071:** Payment for communication technology-based services for 5 minutes or more of a virtual (non-face-to-face) communication between a rural health clinic (RHC) or federally qualified health center (FQHC) practitioner and RHC or FQHC patient, or 5 minutes or more of remote evaluation of recorded video and/or images by an RHC or FQHC practitioner, occurring in lieu of an office visit; RHC or FQHC only **G0463:** Hospital outpatient clinic visit for assessment and management of a patient **G2010:** Remote evaluation of recorded video and/or images submitted by an established patient (for example, store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment **G2012:** Brief communication technology-based service, for example, virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion **G2250:** Remote assessment of recorded video and/or images submitted by an established patient (for example, store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment **G2251:** Brief communication technology-based service, for example, virtual check-in, by a qualified health care professional who cannot report evaluation and management services, provided to an established patient, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of clinical discussion

	Codes:
Prenatal Visits (cont.)	**G2252:** Brief communication technology-based service, for example, virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion **T1015:** Clinic visit/encounter, all-inclusive
Stand Alone Prenatal Visits	**CPT** 99500 **CPT-CAT II** **0500F:** Initial prenatal care visit (report at first prenatal encounter with health care professional providing obstetrical care. Report also date of visit and, in a separate field, the date of the last menstrual period [LMP]) (Prenatal) **0501F:** Prenatal flow sheet documented in medical record by first prenatal visit (documentation includes at minimum blood pressure, weight, urine protein, uterine size, fetal heart tones, and estimated date of delivery). Report also: date of visit and, in a separate field, the date of the last menstrual period [LMP] (Note: If reporting 0501F Prenatal flow sheet, it is not necessary to report 0500F Initial prenatal care visit) (Prenatal) **0502F:** Subsequent prenatal care visit (Prenatal) [Excludes: patients who are seen for a condition unrelated to pregnancy or prenatal care (for example, an upper respiratory infection; patients seen for consultation only, not for continuing care)] **HCPCS** **H1000:** Prenatal care, at-risk assessment **H1001:** Prenatal care, at-risk enhanced service; antepartum management **H1002:** Prenatal care, at risk enhanced service; care coordination **H1003:** Prenatal care, at-risk enhanced service; education **H1004:** Prenatal care, at-risk enhanced service; follow-up home visit

	Codes:
Postpartum Bundles Services	**CPT** 59400, 59410, 59510, 59515, 59610, 59614, 59618, 59622
Postpartum Care	**CPT** 57170, 58300, 59430, 99501
	CPT-CAT II Postpartum care visit (Prenatal)
	HCPCS Cervical or vaginal cancer screening; pelvic and clinical breast examination
CDC Race and Ethnicity	**1002-5:** American Indian or Alaska Native **2028-9:** Asian **2054-5:** Black or African American **2076-8**: Native Hawaiian or Other Pacific Islander **2106-3:** White **2135-2:** Hispanic or Latino **2186-5:** Not Hispanic or Latino

Note: These codes are used to capture encounter data for individual prenatal and postpartum visits. Category II codes do not generate payment but help with more accurate reporting. The designated CPT Category II codes should be used in conjunction with the date of the prenatal or postpartum visit.

How can we help?

We help you meet this benchmark by:

- Offering current *Clinical Practice Guidelines* on our provider self-service website.
- Helping identify community resources, such as health education classes that may be available in your area.
- Members may be eligible for transportation assistance at no cost, contact Member Services for arrangement.

Helpful tip:

- If utilizing an EMR system, consider electronic data sharing with your health plan to capture all coded elements. Contact your provider relationship managements representative for additional details and questions.

Notes:

Statin Therapy for Patients with Cardiovascular Disease (SPC)

This HEDIS measure looks at the percentage of males 21 to 75 years of age and females 40 to 75 years of age during the measurement year, who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and met the following criteria. The following rates are reported:

- **Received statin therapy:** Members who were dispensed at least one high-intensity or moderate-intensity statin medication during the measurement year
- **Statin adherence 80%:** Members who remained on a high-intensity or moderate-intensity statin medication for at least 80% of the treatment period (treatment period begins with the earliest dispensing event for any high-intensity or moderate-intensity statin medication during the measurement year).

Exclusions:

- Members who use hospice services or elect to use a hospice benefit any time during the measurement year
- Members who die any time during the measurement year
- Members with a diagnosis of pregnancy during the measurement year or the year prior to the measurement year.
- In vitro fertilization in the measurement year or the year prior to the measurement year.
- Dispensed at least one prescription for clomiphene during the measurement year or the year prior to the measurement year.
- End stage renal disease (ESRD) during the measurement year or the year prior to the measurement year.
- Dialysis during the measurement year or the year prior to the measurement year.
- Cirrhosis during the measurement year or the year prior to the measurement year.
- Myalgia, myositis, myopathy, or rhabdomyolysis during the measurement year.
- Members receiving palliative care any time during the measurement year.
- Members who had an encounter for palliative anytime during the measurement year.
- Members 66 years of age and older as of December 31 of the measurement year (all product lines) with frailty and advanced illness. Members must meet both frailty and advanced illness criteria to be excluded

High- and Moderate-Intensity Statin Medications

Description	Prescription
High-intensity statin therapy	Atorvastatin 40-80 mg
High-intensity statin therapy	Amlodipine-atorvastatin 40-80 mg
High-intensity statin therapy	Rosuvastatin 20-40 mg
High-intensity statin therapy	Simvastatin 80 mg
High-intensity statin therapy	Ezetimibe-simvastatin 80 mg
Moderate-intensity statin therapy	Atorvastatin 10-20 mg
Moderate-intensity statin therapy	Amlodipine-atorvastatin 10-20 mg
Moderate-intensity statin therapy	Rosuvastatin 5-10 mg
Moderate-intensity statin therapy	Simvastatin 20-40 mg
Moderate-intensity statin therapy	Ezetimibe-simvastatin 20-40 mg
Moderate-intensity statin therapy	Pravastatin 40-80 mg
Moderate-intensity statin therapy	Lovastatin 40 mg
Moderate-intensity statin therapy	Fluvastatin 40-80 mg
Moderate-intensity statin therapy	Pitavastatin 1-4 mg

How can we help?

We help you meet this benchmark by:

- Offering current *Clinical Practice Guidelines* on our provider self-service website.
- Helping identify community resources, such as health education classes that may be available in your area.
- Members may be eligible for transportation assistance at no cost, contact Member Services for arrangement.

Helpful tip:

- If utilizing an EMR system, consider electronic data sharing with your health plan to capture all coded elements. Contact your provider relationship managements representative for additional details and questions.

Statin Therapy for Patients with Diabetes (SPD)

This HEDIS measures looks at the percentage of members 40 to 75 years of age during the measurement year with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) who met the following criteria.

Two rates are reported:

- **Received statin therapy:** members who were dispensed at least one statin medication of any intensity during the measurement year
- **Statin adherence 80%:** members who remained on a statin medication of any intensity for at least 80% of the treatment period (treatment period begins with the earliest dispensing event for any statin medication during the measurement year).

Record your efforts:

- Document review of continued use of prescribed medications during member visits.
- Document evidence of exclusion criteria.

Exclusions:

- Members with at least one of the following during the year prior to the measurement year in any setting:
  - Myocardial Infarction (MI)
  - Coronary artery bypass graft (CABG)
  - Percutaneous Coronary Intervention (PCI)
  - Other revascularization procedure
- Members who had at least one encounter with a diagnosis of IVD during both the measurement year and the year prior to the measurement year
- Members with a diagnosis of pregnancy during the measurement year or year prior to the measurement year
- In vitro fertilization in the measurement year or year prior to the measurement year
- Dispensed at least one prescription for clomiphene during the measurement year or the year prior to the measurement year
- End stage renal disease (ESRD) during the measurement year or the year prior to the measurement year
- Dialysis during the measurement year or the year prior to the measurement year
- Cirrhosis during the measurement year or the year prior to the measurement year
- Myalgia, myositis, myopathy, or rhabdomyolysis during the measurement year
- Members who use hospice services or elect to use a hospice benefit any time during the measurement year
- Members who die any time during the measurement year
- Members receiving palliative care any time during the measurement year
- Members who had an encounter for palliative care any time during the measurement year
- Members 66 years of age and older as of December 31 of the measurement year (all product lines) with frailty **and** advanced illness. Members must meet **both** frailty and advanced illness criteria to be excluded

Diabetes Medications

Description	Prescription
Alpha-glucosidase inhibitors	Acarbose Miglitol
Amylin analogs	Pramlintide
Antidiabetic combinations	Alogliptin-metformin Alogliptin-pioglitazone Canagliflozin-metformin Dapagliflozin-metformin Dapagliflozin-saxagliptin Empagliflozin-linagliptin Empagliflozin-linagliptin-metformin Empagliflozin-metformin Ertugliflozin-metformin Ertugliflozin-sitagliptin Glimepiride-pioglitazone Glipizide-metformin Glyburide-metformin Linagliptin-metformin Metformin-pioglitazone Metformin-repaglinide Metformin-rosiglitazone Metformin-saxagliptin Metformin-sitagliptin
Insulin	Insulin aspart Insulin aspart-insulin aspart protamine Insulin degludec Insulin degludec-liraglutide Insulin detemir Insulin glargine Insulin glargine-lixisenatide Insulin glulisine Insulin isophane human Insulin isophane-insulin regular Insulin lispro Insulin lispro-insulin lispro protamine Insulin regular human Insulin human inhaled

Description	Prescription
Meglitinides	Nateglinide Repaglinide
Biguanides	Metformin
Glucagon-like peptide-1 (GLP1) agonists	Albiglutide Dulaglutide Exenatide Liraglutide Lixisenatide Semaglutide
Sodium glucose cotransporter 2 (SGLT2) inhibitor	Canagliflozin Dapagliflozin Empagliflozin Ertugliflozin
Sulfonylureas	Chlorpropamide Glimepiride Glipizide Glyburide Tolazamide Tolbutamide
Thiazolidinediones	Pioglitazone Rosiglitazone
Dipeptidyl peptidase-4 (DDP-4) inhibitors	Alogliptin Linagliptin Saxagliptin Sitaglipin

How can we help?

We help you meet this benchmark by:

- Offering current *Clinical Practice Guidelines* on our provider self-service website.
- Helping identify community resources, such as health education classes that may be available in your area.
- Members may be eligible for transportation assistance at no cost, contact Member Services for arrangement.

Helpful tip:

- If utilizing an EMR system, consider electronic data sharing with your health plan to capture all coded elements. Contact your provider relationship managements representative for additional details and questions.

Notes:

Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

This HEDIS measure looks at the percentage of members 18 to 64 with schizophrenia, schizoaffective disorder, or bipolar disorder and who were dispensed an antipsychotic medication and had a diabetic screening test during the measurement year.

Record your efforts:

- Document review of continued use of prescribed medications during member visits.
- Document evidence of exclusion criteria.

An antipsychotic medication dispensed event during the measurement year identified by claim/encounter data or pharmacy data **and** a glucose test or an HbA1c test performed during the measurement year, as identified by claim/encounter or automated laboratory data.

Exclusions:

- Members who use hospice services or elect to use a hospice benefit any time during the measurement year
- Members who die any time during the measurement year
- Members with diabetes
- Members who had no antipsychotic medications dispensed during the measurement year

	Codes:
Glucose Lab Test	**CPT** 80047, 80048, 80050, 80053, 80069, 82947, 82950, 82951 **LOINC** **10450-5:** Glucose [Mass/volume] in Serum or Plasma --10 hours fasting **1492-8:** Glucose [Mass/volume] in Serum or Plasma --1.5 hours post 0.5 g/kg glucose IV **1494-4:** Glucose [Mass/volume] in Serum or Plasma --1.5 hours post 100 g glucose PO **1496-9:** Glucose [Mass/volume] in Serum or Plasma --1.5 hours post 75 g glucose PO **1499-3:** Glucose [Mass/volume] in Serum or Plasma --1 hour post 0.5 g/kg glucose IV **1501-6:** Glucose [Mass/volume] in Serum or Plasma --1 hour post 100 g glucose PO **1504-0:** Glucose [Mass/volume] in Serum or Plasma --1 hour post 50 g glucose PO **1507-3:** Glucose [Mass/volume] in Serum or Plasma --1 hour post 75 g glucose PO **1514-9** Glucose [Mass/volume] in Serum or Plasma --2 hours post 100 g glucose PO **1518-0:** Glucose [Mass/volume] in Serum or Plasma --2 hours post 75 g glucose PO **1530-5:** Glucose [Mass/volume] in Serum or Plasma --3 hours post 100 g glucose PO **1533-9:** Glucose [Mass/volume] in Serum or Plasma --3 hours post 75 g glucose PO **1554-5:** Glucose [Mass/volume] in Serum or Plasma --12 hours fasting **1557-8** Fasting glucose [Mass/volume] in Venous blood **1558-6:** Fasting glucose [Mass/volume] in Serum or Plasma **17865-7:** Glucose [Mass/volume] in Serum or Plasma --8 hours fasting **20436-2:** Glucose [Mass/volume] in Serum or Plasma --2 hours post dose glucose

	Codes:
Glucose Lab Test (cont.)	**20437-0:** Glucose [Mass/volume] in Serum or Plasma --3 hours post dose glucose **20438-8:** Glucose [Mass/volume] in Serum or Plasma --1 hour post dose glucose **20440-4:** Glucose [Mass/volume] in Serum or Plasma --1.5 hours post dose glucose **2345-7:** Glucose [Mass/volume] in Serum or Plasma **26554-6:** Glucose [Mass/volume] in Serum or Plasma --2.5 hours post dose glucose **41024-1:** Glucose [Mass/volume] in Serum or Plasma --2 hours post 50 g glucose PO **49134-0:** Glucose [Mass/volume] in Blood --2 hours post dose glucose **6749-6:** Glucose [Mass/volume] in Serum or Plasma --2.5 hours post 75 g glucose PO **9375-7:** Glucose [Mass/volume] in Serum or Plasma --2.5 hours post 100 g glucose PO
HbA1c Tests Results or Findings:	**CPT-CAT II** **3044F:** Most recent hemoglobin A1c (HbA1c) level less than 7.0% (DM) **3046F:** Most recent hemoglobin A1c level greater than 9.0% (DM) **3051F:** Most recent hemoglobin A1c (HbA1c) level greater than or equal to 7.0% and less than 8.0% (DM) **3052F:** Most recent hemoglobin A1c (HbA1c) level greater than or equal to 8.0% and less than or equal to 9.0% (DM)
HbA1c Lab Test	**CPT** 83036, 83037 **LOINC** **17855-8:** Hemoglobin A1c/Hemoglobin. Total in Blood by calculation **17856-6:** Hemoglobin A1c/Hemoglobin. Total in Blood by HPLC **4548-4:** Hemoglobin A1c/Hemoglobin. Total in Blood **4549-2:** Hemoglobin A1c/Hemoglobin. Total in Blood by Electrophoresis **96595-4:** Hemoglobin A1c/Hemoglobin. Total in DBS

Online assessments

Codes:

CPT

98970, 98971, 98972, 98980, 98981, 99421, 99422, 99423, 99457, 99458

HCPCS

G0071: Payment for communication technology-based services for 5 minutes or more of a virtual (non-face-to-face) communication between a rural health clinic (RHC) or federally qualified health center (FQHC) practitioner and RHC or FQHC patient, or 5 minutes or more of remote evaluation of recorded video and/or images by an RHC or FQHC practitioner, occurring in lieu of an office visit; RHC or FQHC only

G2010: Remote evaluation of recorded video and/or images submitted by an established patient (for example, store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment

G2012: Brief communication technology-based service, for example, virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion

G2250: Remote assessment of recorded video and/or images submitted by an established patient (for example, store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment

G2251: Brief communication technology-based service, for example, virtual check-in, by a qualified health care professional who cannot report evaluation and management services, provided to an established patient, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of clinical discussion

	Codes:
Online assessments (cont.)	**G2252:** Brief communication technology-based service, for example, virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion
Telephone visits	**CPT** 98966, 98967, 98968, 99441, 99442, 99443
Visit Setting Unspecified	**CPT** 90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99252, 99253, 99254, 99255

Note: The Logical Observation Identifiers Names and Codes (LOINC) are for reporting clinical observations and laboratory testing. The codes listed are informational only; this information does not guarantee reimbursement.

How can we help?

We help you meet this benchmark by:

- Offering current *Clinical Practice Guidelines* on our provider self-service website.
- Helping identify community resources, such as health education classes that may be available in your area.
- Members may be eligible for transportation assistance at no cost, contact Member Services for arrangement.

Helpful tip:

- If utilizing an EMR system, consider electronic data sharing with your health plan to capture all coded elements. Contact your provider relationship managements representative for additional details and questions.

Topical Fluoride for Children (TFC)

This HEDIS measure looks at the percentage of members 1 to 4 years of age who received at least two fluoride varnish applications during the measurement year.

Record your efforts:

- Two or more fluoride varnish applications on different dates of services

Exclusions:

- Members in hospice or using hospice services anytime during the measurement year
- Members who died during the measurement year

Codes to identify lead test:

	Codes:	
Application of Fluoride Varnish	**CPT:**	99188
	CDT:	D1206: Topical application of fluoride varnish

* The codes listed are informational only; this information does not guarantee reimbursement.

Helpful tip:

- If utilizing an EMR system, consider electronic data sharing with your health plan to capture all coded elements. Contact your Provider Solutions representative for additional details and questions.

How can we help?

- Offering current *Clinical Practice Guidelines* on our provider self-service website
- Members may be eligible for transportation assistance at no cost; contact Member Services for arrangement.

Notes:

Appropriate Treatment for Upper Respiratory Infection (URI)

This HEDIS measure looks at the percentage of episodes for members 3 months of age and older with a diagnosis of upper respiratory infection (URI) that did not result in a dispensed antibiotic dispensing event.

A higher rate indicates appropriate URI treatment (such as, the proportion of episodes that did not result in an antibiotic dispensing event July 1 of the year prior to the measurement year to June 30 of the measurement year.

Record your efforts:

- Document results of all strep tests or refusal for testing in medical records.
- If antibiotics are prescribed for another condition, ensure accurate coding and documentation will associate the antibiotic with the appropriate diagnosis.

Exclusions:

- Members who use hospice services or elect to use a hospice benefit any time during the measurement year
- Members who die any time during the measurement year

	Codes:
Pharyngitis	**ICD10CM** **J02.0:** Streptococcal pharyngitis **J02.8:** Acute pharyngitis due to other specified organisms **J02.9:** Acute pharyngitis, unspecified **J03.00**: Acute streptococcal tonsillitis, unspecified **J03.01:** Acute recurrent streptococcal tonsillitis **J03.80:** Acute tonsillitis due to other specified organisms **J03.81:** Acute recurrent tonsillitis due to other specified organisms **J03.90:** Acute tonsillitis, unspecified **J03.91:** Acute recurrent tonsillitis, unspecified
URI	**ICD10CM** **J00:** Acute nasopharyngitis [common cold] **J06.0:** Acute laryngopharyngitis **J06.9:** Acute upper respiratory infection, unspecified

Outpatient, ED, and Telehealth

CPT

98966, 98967, 98968, 98970, 98971, 98972, 98980, 98981, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99242, 99243, 99244, 99245, 99281, 99282, 99283, 99284, 99285, 99341,99342, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99421, 99422, 99423, 99429, 99441, 99442, 99443, 99455,99456, 99457, 99458, 99483

HCPCS

G0071: Payment for communication technology-based services for 5 minutes or more of a virtual (non-face-to-face) communication between a rural health clinic (RHC) or federally qualified health center (FQHC) practitioner and RHC or FQHC patient, or 5 minutes or more of remote evaluation of recorded video and/or images by an RHC or FQHC practitioner, occurring in lieu of an office visit; RHC or FQHC only

G0402: Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment

G0438: Annual wellness visit; includes a personalized prevention plan of service (PPS), initial visit

G0439: Annual wellness visit, includes a personalized prevention plan of service (PPS), subsequent visit

G0463: Hospital outpatient clinic visit for assessment and management of a patient

G2010: Remote evaluation of recorded video and/or images submitted by an established patient (for example, store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment

G2012: Brief communication technology-based service, for example, virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion

Outpatient, ED, and Telehealth (cont.)	**G2250:** Remote assessment of recorded video and/or images submitted by an established patient (for example, store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment **G2251:** Brief communication technology-based service, for example, virtual check-in, by a qualified health care professional who cannot report evaluation and management services, provided to an established patient, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of clinical discussion **G2252:** Brief communication technology-based service, for example, virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion **T1015:** Clinic visit/encounter, all-inclusive

* The codes listed are informational only; this information does not guarantee reimbursement.

How can we help?

- Members may be eligible for transportation assistance at no cost; contact Member Services for arrangement

Helpful resources:

- **www.CDC.gov/antibiotic-use**

Helpful tips:

- If a member tests negative for group A strep but insists on an antibiotic:
  - Refer to the illness as a sore throat due to a cold; members tend to associate the label with a less-frequent need for antibiotics.
  - Write a prescription for symptom relief, like over-the-counter medications.
- Educate members on the difference between bacterial and viral infections. This is the key point in the success of this measure.
  - Discuss with members ways to treat symptoms:
  - Get extra rest.
  - Drink plenty of fluids.
  - Use over-the-counter medications.
  - Use the cool-mist vaporizer and nasal spray for congestion.
  - Eat ice chips or use throat spray/lozenges for sore throats.
- Educate members and their parents or caregivers that they can prevent infection by:
  - Washing hands frequently.
  - Disinfecting toys.
  - Keeping the child out of school or day care for at least 24 hours until antibiotics have been taken and symptoms have improved.
- If utilizing an EMR system, consider electronic data sharing with your health plan to capture all coded elements. Contact your provider relationship managements representative for additional details and questions.

Notes:

Well-Child Visits in the First 30 Months of Life (W30)

This HEDIS measure looks at the percentage of members who had the following number of well-child visits with a PCP during the last 15 months. The following rates are reported:

- **Well-Child Visits in the First 15 Months:** children who turned 15 months old during the measurement year: Six or more well-child visits.
- **Well-Child Visits for Age 15 Months to 30 Months:** children who turned 30 months old during the measurement year: Two or more well-child visits.

Record your efforts:

Documentation from the medical record must include a note indicating a visit with a PCP, the date when the well-child visit occurred and evidence of all of the following:

- **A health history:** Health history is an assessment of the member's history of disease or illness. Health history can include, but is not limited to, past illness (or lack of illness), surgery or hospitalization (or lack of surgery or hospitalization) and family health history.
- **A physical developmental history:** Physical developmental history assesses specific age-appropriate physical developmental milestones, which are physical skills seen in children as they grow and develop.
- **A mental developmental history:** Mental developmental history assesses specific age-appropriate mental developmental milestones, which are behaviors seen in children as they grow and develop.
- **A physical exam** (for example, height, weight, BMI, heart, lungs, abdomen, more than one system assessed).
- **Health education/anticipatory guidance:** Health education/anticipatory guidance is given by the health care provider to parents or guardians in anticipation of emerging issues that a child and family may face.

Exclusions:

- Members in hospice or using hospice services anytime during the measurement year
- Members who died during the measurement year

	Codes:
Well Care Visit	**CPT** 99381, 99382, 99383, 99384, 99385, 99391, 99392, 99393, 99394, 99395, 99461 **HCPCS** **G0438:** Annual wellness visit; includes a personalized prevention plan of service (PPS), initial visit **G0439:** Annual wellness visit, includes a personalized prevention plan of service (PPS), subsequent visit **S0302:** Completed early periodic screening diagnosis and treatment (EPSDT) service (list in addition to code for appropriate evaluation and management service)
CDC Race and Ethnicity	**1002-5:** American Indian or Alaska Native **2028-9:** Asian **2054-5:** Black or African American **2076-8**: Native Hawaiian or Other Pacific Islander **2106-3:** White **2135-2:** Hispanic or Latino **2186-5:** Not Hispanic or Latino

How can we help?

Members may be eligible for transportation assistance at no cost; contact Member Services We help you meet this benchmark by:

- Offering current *Clinical Practice Guidelines* on our provider self-service website.
- Providing individualized reports of your members overdue for services.
- Encouraging members to get preventive care through our programs. Contact your Provider Solutions representative for more information.
- Members may be eligible for transportation assistance at no cost; contact Member Services for arrangement.

Helpful tip:

- Use your member roster to contact members who are due for an exam or are new to your practice.
- Schedule the next visit at the end of the appointment.
- If you use EMRs, consider creating a flag to track members due or past due for a visit. If you do not use EMRs, consider creating a manual tracking method. Sick visits may be a missed opportunity for your member to get a wellness exam.
- Consider extending your office hours into the evening, early morning, or weekend to accommodate working parents.
- Remember to include the applicable ICD-10 code above on the claim form to help reduce the burden of HEDIS medical record review!
- If utilizing an EMR system, consider electronic data sharing with your health plan to capture all coded elements. Contact your provider relationship managements representative for additional details and questions.

Notes:

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents (WCC)

This HEDIS measure looks at the percentage of members ages 3 to 17 years who had an outpatient visit with a PCPs or OB/GYN and who had evidence of the following during the measurement year:

- BMI percentile documentation*
- Counseling for Nutrition
- Counseling for Physical Activity

* Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed rather than an absolute BMI value.

Record your efforts:

Three separate rates are reported:

- Height, weight, and BMI percentile (not BMI value):
  - May be a BMI growth chart if utilized
- Counseling for nutrition (diet):
  - Services rendered during a telephone visit, e-visit or virtual check-in meet criteria
- Counseling for physical activity (sports participation/exercise):
  - Services rendered for obesity or eating disorders may be used to meet criteria
  - Services rendered during a telephone visit, e-visit or virtual check-in meet criteria

Exclusions:

- Members with a diagnosis of pregnancy
- Members who use hospice services or elect to use a hospice benefit any time during the measurement year
- Members who die any time during the measurement year

How can we help?

We help you meet this benchmark by:

- Offering current *Clinical Practice Guidelines* on our provider self-service website.
- Helping identify community resources, such as health education classes that may be available in your area.
- Members may be eligible for transportation assistance at no cost; contact Member Services for arrangement.

	Codes:
BMI Percentile	**ICD10CM** **Z68.51**: Body mass index [BMI] pediatric, less than 5th percentile for age **Z68.52:** Body mass index [BMI] pediatric, 5th percentile to less than 85th percentile for age **Z68.53:** Body mass index [BMI] pediatric, 85th percentile to less than 95th percentile for age **Z68.54:** Body mass index [BMI] pediatric, greater than or equal to 95th percentile for age
	LOINC **59574-4:** Body mass index (BMI) [Percentile] **59575-1:** Body mass index (BMI) [Percentile] Per age **59576-9:** Body mass index (BMI) [Percentile] Per age and sex
Nutrition Counseling	**CPT** 97802, 97803, 97804
	HCPCS **G0270:** Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), individual, face to face with the patient, each 15 minutes **G0271:** Medical nutrition therapy, reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), group (2 or more individuals), each 30 minutes **G0447:** Face-to-face behavioral counseling for obesity, 15 minutes **S9449:** Weight management classes, non-physician provider, per session **S9452:** Nutrition classes, non-physician provider, per session **S9470:** Nutritional counseling, dietitian visit
Physical Activity Counseling	**HCPCS** **G0447:** Face-to-face behavioral counseling for obesity, 15 minutes **S9451:** Exercise classes, non-physician provider, per session

Encounter for Physical Activity Counseling	ICD10CM
	Z02.5: Encounter for examination for participation in sport
	Z71.82: Exercise counseling

Note: The Logical Observation Identifiers Names and Codes (LOINC) are for reporting clinical observations and laboratory testing. The codes listed are informational only; this information does not guarantee reimbursement.

Helpful tips:

- Measure height and weight at least annually and document the BMI percentile for age in the medical record.
- Consider incorporating appropriate nutritional and weight management questioning and counseling into your routine clinical practice.
- Document any advice you give the member.
- Document face-to-face discussion of current nutritional behavior, like appetite or meal patterns, eating and dieting habits, any counselling or referral to nutrition education, any nutritional educational materials that were provided during the visit, anticipatory guidance for nutrition, eating disorders, nutritional deficiencies, underweight, and obesity or overweight discussion.
- Document face-to-face discussion of current physical activity behaviors, like exercise routines, participation in sports activities or bike riding, referrals to physical activity, educational material that was provided, anticipatory guidance on physical activity, and obesity or overweight discussion.
- If utilizing an EMR system, consider electronic data sharing with your health plan to capture all coded elements. Contact your provider relationship managements representative for additional details and questions.

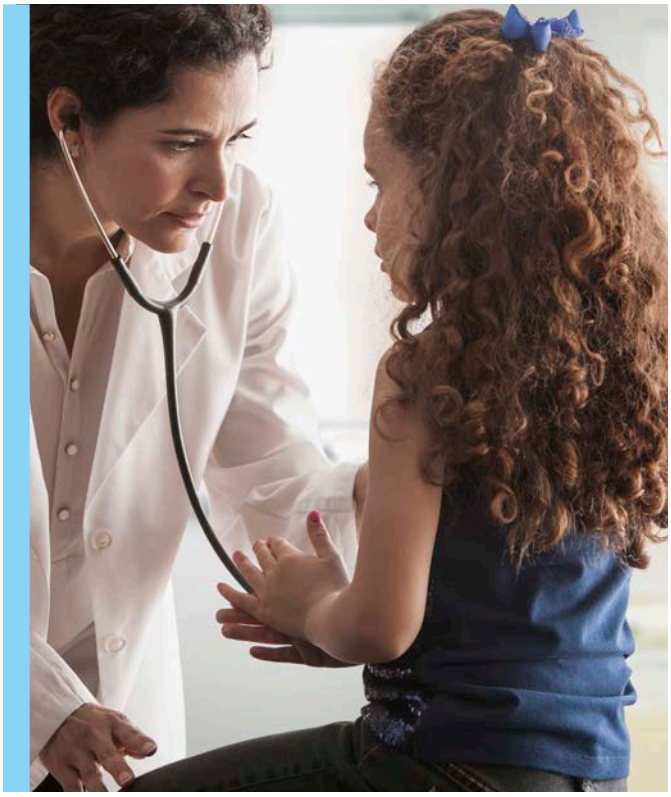
Notes:

Child and Adolescent Well-Care Visits (WCV)

This HEDIS measure looks at the percentage of members ages 3 to 21 years who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.

Record your efforts:

Documentation must include a note indicating a visit to a PCP, the date when the well-child visit occurred and evidence of *all* of the following:



- **A health history:** Health history is an assessment of the member's history of disease or illness. Health history can include, but is not limited to, past illness (or lack of illness), surgery or hospitalization (or lack of surgery or hospitalization) and family health history.
- **A physical developmental history:** Physical developmental history assesses specific age-appropriate physical developmental milestones, which are physical skills seen in children as they grow and develop.
- **A mental developmental history:** Mental developmental history assesses specific age-appropriate mental developmental milestones, which are behaviors seen in children as they grow and develop.
- **A physical exam** (for example, height, weight, BMI, heart, lungs, abdomen, more than one system assessed)
- **Health education/anticipatory guidance:** Health education/anticipatory guidance is given by the health care provider to parents or guardians in anticipation of emerging issues that a child and family may face.

Exclusions:

- Members who use hospice services or elect to use a hospice benefit any time during the measurement year
- Members who die any time during the measurement year

	Codes:
Well Care Visit	**CPT** 99381, 99382, 99383, 99384, 99385, 99391, 99392, 99393, 99394, 99395, 99461 **HCPCS** **G0438:** Annual wellness visit; includes a personalized prevention plan of service (PPS), initial visit **G0439:** Annual wellness visit, includes a personalized prevention plan of service (PPS), subsequent visit **S0302:** Completed early periodic screening diagnosis and treatment (EPSDT) service (list in addition to code for appropriate evaluation and management service)
CDC Race and Ethnicity	**1002-5:** American Indian or Alaska Native **2028-9:** Asian **2054-5:** Black or African American **2076-8**: Native Hawaiian or Other Pacific Islander **2106-3:** White **2135-2:** Hispanic or Latino **2186-5:** Not Hispanic or Latino

Note: The codes listed are informational only; this information does not guarantee reimbursement.

How can we help?

- We help you meet this benchmark by:
- Offering current *Clinical Practice Guidelines* on our provider self-service website.
- Providing individualized reports of your members overdue for services.
- Encouraging members to get preventive care through our programs.
- Members may be eligible for transportation assistance at no cost, contact Member Services for arrangement.

Helpful tips:

- Use your member roster to contact members who are due for an annual exam.
- Schedule the next visit at the end of the appointment.
- If you use EMRs, consider creating a flag to track members due or past due for preventive services. If you do not use EMRs, consider creating a manual tracking method for well checks. Sick visits may be missed opportunities for your member to get health checks.
- Consider extending your office hours into the evening, early morning, or weekend to accommodate working parents.
- Remember to include the applicable ICD-10 code above on the claim form to help reduce the burden of HEDIS medical record review!
- If utilizing an EMR system, consider electronic data sharing with your health plan to capture all coded elements. Contact your provider relationship managements representative for additional details and questions.

Notes:

https://provider.healthybluenc.com