HEDIS Benchmarks

and Coding Guidelines for Quality Care

Wellpoint ℠

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The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All enrollee 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 members. Your state/provider contract(s), Medicaid, enrollee 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 enrollees and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 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.

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.

Description	CPT®/HCPCS
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

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Description	CPT®/HCPCS
	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
	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

Description	ICD10CM
Pharyngitis	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

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

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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

Description	CPT/HCPCS
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

Description	CPT/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

Description	CPT/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

Description	ICD10CM
Reason for Ambulatory Visit	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 Z02.5: Encounter for examination for participation in sport

Description	CPT/HCPCS
	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 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.

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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 May 1 of the year prior to the measurement year to April 30 of the measurement year. 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.

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

Description	ICD10CM/CPT/ ICD10PCS/HCPCS
Major depression	ICD10CM 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 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
Behavioral health (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

Description	ICD10CM/CPT/ ICD10PCS/HCPCS
	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
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

Description	ICD10CM/CPT/ ICD10PCS/HCPCS
	(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 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:

- ahrq.gov
- ncbi.nlm.nih.gov

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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.

Description	ICD10CM/CPT/HCPCS
Asthma	ICD10CM 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

Description	ICD10CM/CPT/HCPCS
	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
	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

Description	ICD10CM/CPT/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
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
- 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?
- Offering current *Clinical Practice Guideline*s 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.

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.

Description	CPT/HCPCS/ICD10CM
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) 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

Description	CPT/HCPCS/ICD10CM
	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
	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	ICD10CM
	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
	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

Description	CPT/HCPCS/ICD10CM
	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
	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
Residential Behavioral Health Treatment	HCPCS

Description	CPT/HCPCS/ICD10CM
	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	ICD10CM 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

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

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 member 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 (digital monitor) 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 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

Description	CPT-CAT II/LOINC
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) 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)

Description	CPT-CAT II/LOINC
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
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

Notes:

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The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All enrollee 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 members. Your state/provider contract(s), Medicaid, enrollee 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 enrollees and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 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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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

Description	CPT/CPT-CAT II/LOINC/HCPCS
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

Description	CPT/CPT-CAT II/LOINC/HCPCS
	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)
	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
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)

Description	CPT/CPT-CAT II/LOINC/HCPCS
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 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

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All enrollee 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 members. Your state/provider contract(s), Medicaid, enrollee 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 enrollees and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 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.

Description	CPT/CPT-CAT II/LOINC/HCPCS
	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:

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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 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.

Description	CPT/HCPCS/LOINC
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

Description	CPT/HCPCS/LOINC
	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
	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	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

Description	CPT/HCPCS/LOINC
	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
	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 website.
- 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 uspreventiveservicestaskforce.org.

Notes:

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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)
DTaP	4
IPV	3
MMR	1
Hib	3
Hep B	3
VZV	1
PCV	4
Hep A	1
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:
- 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 a contraindication to a childhood vaccine on or before their second birthday

Codes to identify immunizations:

Immunization	CPT	CVX/HCPCS/ICD10PCS
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

Immunization	CPT	CVX/HCPCS/ICD10PCS
		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.
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

Immunization	CPT	CVX/HCPCS/ICD10PCS
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
Rotavirus (two- or three-dose)	Two-dose: 90681 Three-dose: 90680	Two-dose: 119 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

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All enrollee 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 members. Your state/provider contract(s), Medicaid, enrollee 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 enrollees and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 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.

Immunization	CPT	CVX/HCPCS/ICD10PCS
		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 800-CDC-INFO (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:

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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

Description	CPT/LOINC
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

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All enrollee 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 members. Your state/provider contract(s), Medicaid, enrollee 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 enrollees and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 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.

Description	CPT/LOINC
	14513-6: Chlamydia trachomatis Ag [Presence] in Urine sediment by Immunofluorescence
	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
	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

Description	CPT/LOINC
	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
	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/efault.htm

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.

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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 66-80 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)

Description	CPT/HCPCS
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.

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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

Description	CPT/HCPCS/ICD10CM/LOINC
Pharyngitis	ICD10CM J02.0: Streptococcal pharyngitis J02.8: Acute pharyngitis due to other specified organisms

Description	CPT/HCPCS/ICD10CM/LOINC
	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
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
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

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Description	CPT/HCPCS/ICD10CM/LOINC
	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
	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

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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

Services	CPT/HCPCS/CPT-CAT II
Unilateral eye enucleation	CPT 65091, 65093, 65101, 65103, 65105, 65110, 65112, 65114
Diabetic retinal screening	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)

Services	CPT/HCPCS/CPT-CAT II
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.

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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

Services	CPT/HCPCS/ICD10CM/POS
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, 99350, 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

Services	CPT/HCPCS/ICD10CM/POS
	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
	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

Services	CPT/HCPCS/ICD10CM/POS
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
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

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All enrollee 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 members. Your state/provider contract(s), Medicaid, enrollee 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 enrollees and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 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.

Services	CPT/HCPCS/ICD10CM/POS
	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)
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

Services	CPT/HCPCS/ICD10CM/POS
	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)
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

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All enrollee 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 members. Your state/provider contract(s), Medicaid, enrollee 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 enrollees and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 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.

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.

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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

Services	CPT/HCPCS/POS
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, 99350, 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

Services	CPT/HCPCS/POS
	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
	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

Services	CPT/HCPCS/POS
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
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
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

Services	CPT/HCPCS/POS
	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.

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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

Services	CPT/HCPCS/ICD10CM/POS
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, 99350, 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

Services	CPT/HCPCS/ICD10CM/POS
	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
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
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)

Services	CPT/HCPCS/ICD10CM/POS
	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
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

Services	CPT/HCPCS/ICD10CM/POS
	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)
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

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All enrollee 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 members. Your state/provider contract(s), Medicaid, enrollee 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 enrollees and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 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.

Services	CPT/HCPCS/ICD10CM/POS
	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 |
| 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 |

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All enrollee 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 members. Your state/provider contract(s), Medicaid, enrollee 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 enrollees and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 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.

Services	CPT/HCPCS/ICD10CM/POS
	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
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

Services	CPT/HCPCS/ICD10CM/POS
	33: Custodial Care Facility 49: Independent Clinic 50: Federally Qualified Health Center 71: Public Health Clinic 72: Rural Health Clinic
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 7 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

Services	CPT/HCPCS
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, 99350, 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

Services	CPT/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
	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
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

Services	CPT/HCPCS
	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
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

Services	CPT/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
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:

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All enrollee 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 members. Your state/provider contract(s), Medicaid, enrollee 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 enrollees and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 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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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

Description	CPT/CPT-CAT II/LOINC/HCPCS
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)
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

Description	CPT/CPT-CAT II/LOINC/HCPCS
	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.

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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:

Description	CPT/HCPCS/ICD10CM/ICD10PCS/POS
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, 99350, 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 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

Description	CPT/HCPCS/ICD10CM/ICD10PCS/POS
	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
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

Description	CPT/HCPCS/ICD10CM/ICD10PCS/POS
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
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

Description	CPT/HCPCS/ICD10CM/ICD10PCS/POS
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 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
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

Description	CPT/HCPCS/ICD10CM/ICD10PCS/POS
	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)
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,

Description	CPT/HCPCS/ICD10CM/ICD10PCS/POS
	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
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
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

Description	CPT/HCPCS/ICD10CM/ICD10PCS/POS
	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
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
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
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 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:

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All enrollee 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 members. Your state/provider contract(s), Medicaid, enrollee 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 enrollees and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 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.

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

Description	CPT	CVX
HPV Vaccine Procedure	90649, 90650, 90651	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	90619, 90733, 90734	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	90715	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.

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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

Description	CPT/LOINC
Estimated Glomerular Filtration Rate Lab Test	CPT 80047, 80048, 80050, 80053, 80069, 82565 LOINC

Description	CPT/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)
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

Description	CPT/LOINC
	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
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.

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.

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.

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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

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All enrollee 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 members. Your state/provider contract(s), Medicaid, enrollee 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 enrollees and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 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.

- o Spinal infection
- o Major organ transplant
- o Prolonged use of corticosteroids
- o Osteoporosis
- o Lumbar surgery
- o Spondylopathy
- o Fragility fracture
- o Spondylopathy

Services	CPT/ICD10CM
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 M53.86: Other specified dorsopathies, lumbar region M53.87: Other specified dorsopathies, lumbosacral region M53.88: Other specified dorsopathies, sacral and sacrococcygeal region

Services	CPT/ICD10CM
	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
	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

Services	CPT/ICD10CM
	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
	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.

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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:

Services	CPT/LOINC
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

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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 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:

Services	CDT
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 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.

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.

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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 members, 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 7 and 84 days after delivery
Documentation in the medical record must include a note indicating the date when a postpartum visit occurred and any 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 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

Services	CPT/ CPT-CAT II/HCPCS/ ICD10PCS
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

Services	CPT/ CPT-CAT II/HCPCS/ ICD10PCS
	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 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 G2252: Brief communication technology-based service, for example, virtual check-in, by a physician or other qualified health care professional who can

Services	CPT/ CPT-CAT II/HCPCS/ ICD10PCS
	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
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

Services	CPT/ CPT-CAT II/HCPCS/ ICD10PCS
	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.

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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.

Notes:

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 glulisine Insulin isophane human Insulin isophane-insulin regular Insulin lispro Insulin lispro-insulin lispro protamine	

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

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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

Services	CPT/CPT-CATII/HCPCS/LOINC
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 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

Services	CPT/CPT-CATII/HCPCS/LOINC
	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	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

Services	CPT/CPT-CATII/HCPCS/LOINC
	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 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.

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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:

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All enrollee 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 members. Your state/provider contract(s), Medicaid, enrollee 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 enrollees and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 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.

- 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 to identify lead test:

Services	CPT/CDT
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 relationship managements 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.

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Appropriate Treatment for Upper Respiratory Infection (URI)

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All enrollee 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 members. Your state/provider contract(s), Medicaid, enrollee 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 enrollees and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 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.

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

Description	CPT/HCPCS/ICD10CM
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

Description	CPT/HCPCS/ICD10CM
	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
	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

Description	CPT/HCPCS/ICD10CM
	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 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.
- 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

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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 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.

Description	CPT/HCPCS/ICD10CM
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.

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. 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.

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. Contact your provider relationship managements representative for more information.
- Members may be eligible for transportation assistance at no cost, contact Member Services for arrangement.

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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):
  o May be a BMI growth chart if utilized
- Counseling for nutrition (diet):
  o Services rendered during a telephone visit, e-visit or virtual check-in meet criteria
- Counseling for physical activity (sports participation/exercise):

- o   Services rendered for obesity or eating disorders may be used to meet criteria
- o   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

Description	CPT/HCPCS/ICD10CM/LOINC
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

Description	CPT/HCPCS/ICD10CM/LOINC
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.

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.

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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

Description	CPT/HCPCS
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.

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.

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.

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Patient care opportunities

You can find patient care opportunities within the Patient360 application located on Availity Essentials Payer Spaces. To access the Patient360 application, you must have the *Patient360* role assignment. From Availity's home page, select Payer Spaces, then choose the health plan from the menu. Choose the Patient360 tile from the Payer Space Applications menu and complete the required information on the screen. Gaps in care are located in the *Active Alerts* section of the *Member Summary*.

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