HEDIS® Provider Pocket Guide

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CPT codes were taken from the American Medical Association (AMA) CPT Code Handbook.

Introduction

The Healthcare Effectiveness Data and Information Set (HEDIS®) is a set of standardized measures developed by the National Committee for Quality Assurance (NCQA) to measure, report and compare performance across health plans.

Providers have a direct impact on affiliated health plans and provider organization performance ratings based on patient experience and the care provided.

Use this HEDIS provider pocket guide to help increase HEDIS scores by knowing what actions to take and how to code correctly for the below services:

- Pediatric care
- Preventive/chronic care

(continued)

- Maternal health care
- Behavioral health care

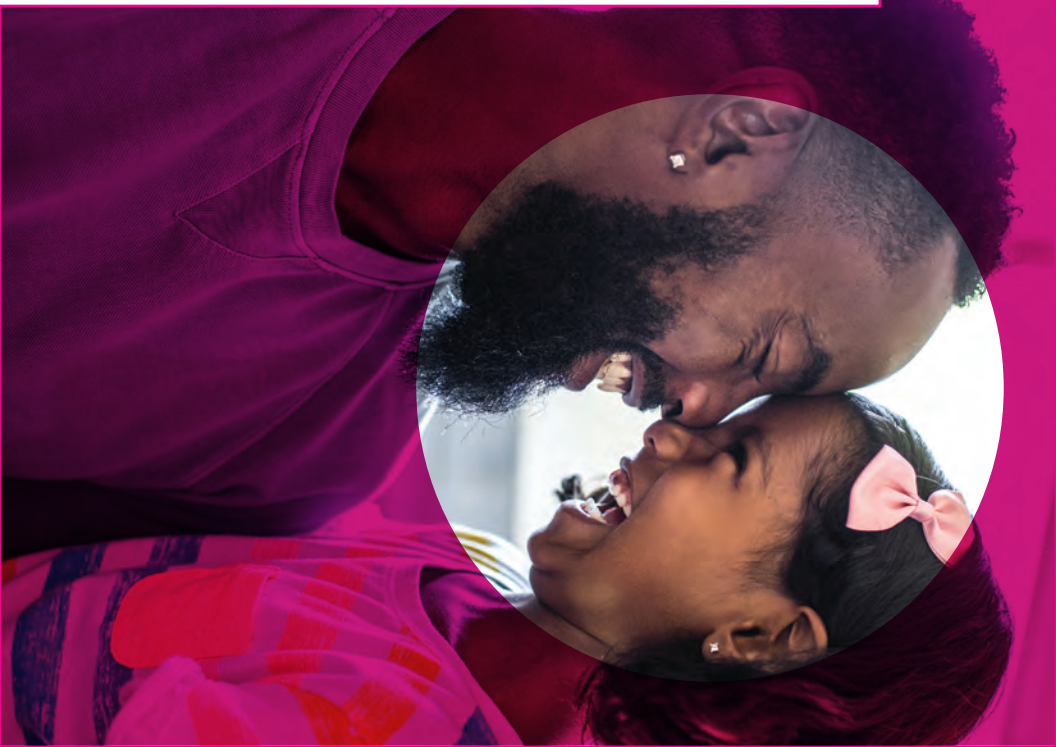
This guide serves as a helpful reference tool and is not intended to replace professional coding standards or billing practices. Measures and codes in this guide are not all inclusive and can be changed, deleted or removed at any time.

The improvement measures are derived from the Managed Care Accountability Set (MCAS) for reporting year 2022, the California Department of Health Care Services (DHCS) All Plan Letter (APL) requirements and the NCQA HEDIS Measurement Year 2021 and 2022 Volume 2 Technical Specifications, released on March 31, 2022.

General Tips

HEDIS Improvement Tips

Medical Record Documentation Standards



General Tips

HEDIS Improvement Tips. HEDIS rates are scored based on administrative billing data and medical record review. Use the below tips to help improve your HEDIS performance scores:

- Ensure patients are accurately diagnosed and services are rendered appropriately based on medical necessity and clinical practice guidelines.
- Follow the American Academy of Pediatrics/Bright Futures Periodicity Schedule and U.S. Preventive Services Task Force preventive and clinical practice guidelines for rendering health services to patients during wellness visits.
- Ensure accurate action, follow-up, documentation, and billing of services.
- Submit claims correctly and in a timely manner.
- Correct encounters/claims with erroneous diagnoses.
- Schedule appointments and review patient charts prior to patient visits to close care gaps.

Medical Record Documentation Standards. Medical record notations of health history and exams need to be specific, clear, have detailed assessments, and show evidence of patient-provider discussions and patient advisories.

For any well-child/well-care visit:

Documentation of wellness visits must include ALL elements:

Health history

Health history is an assessment of the patient's history of disease or illness. It 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.

Physical development history (infants, children and adolescents)

Physical developmental history assesses specific age-appropriate physical developmental milestones, which are physical skills in children as they grow and develop.

e.g., motor development for infants and children; Tanner Stages, puberty, or smoking, illicit drug use, or alcohol use for adolescents.

Mental development/health history

Mental developmental history assesses specific age-appropriate mental development milestones, which are behaviors seen in children as they grow and develop.

e.g., appropriate communication/mental milestones for age, reads for enjoyment, does well in school, caring supportive relation with family or sexual identity.

Physical exam

Documentation of at least two body systems, not related to the reason for the visit if the visit is relative to an acute or chronic condition.

i.e., notation of "physical exam WNL" is acceptable.

Health education/anticipatory guidance

Health education/anticipatory guidance is given by the health care provider to parents/guardians in anticipation of emerging issues that a child or family may face. e.g., notation of tobacco screening/use or exposure, physical abuse/neglect, preventive teaching in anticipation of child's development. Documentation must be age specific.

Pediatric Care

Childhood Immunization Status – Combination 10 (CIS-10)

Immunizations for Adolescents – Combination 2 (IMA-2)

Lead Screening in Children (LSC)

Well-Care Visits (W30, WCV)

- Well-Child Visits in the First 30 Months of Life (W30)
- Child and Adolescent Well-Care Visits (WCV)

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

- BMI percentile documentation (WCC-BMI)
- Counseling for nutrition (WCC-N)
- Counseling for physical activity (WCC-PA)

Pediatric Care

Childhood Immunization Status – Combination 10 (CIS-10)

Measure description

The percentage of children who turned age 2 during the measurement year who had the required CIS-10 immunizations.

Provider action

Schedule a series of wellness visits with patient and follow up as needed.

Review the child's immunization status (i.e., immunization record, registry) prior to each visit.

Update immunization records with shots given at birth, in the hospital or by other providers (if available) and administer needed vaccines.

Advise the child's parent which vaccines will be given at the visit. If needed, address vaccine concerns and misconceptions.

Ensure medical record documentation includes:

- Patient name
- Date of birth

(continued)

- Date of service immunization was administered (not ordered) and one of the following:
  - name of vaccine
  - immunization certificate of vaccine administration by an authorized health care provider or agency
  - documented history of illness, adverse reactions or a seropositive test result
- Parent refusal

Vaccines requiring more than one dose should be administered at different dates of service.

Indicate in the immunization record which dose was given.

Submit all immunizations to the immunization registry at cairweb.org to ensure continuity of care. Include all immunizations, including immunizations given at another facility (i.e., the Hepatitis B vaccine given at birth in the hospital).

Codes

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Doses	Name of antigen	Codes
4	**DTaP**[1]	*CPT* 90697, 90698*, 90700, 90723*
4	**PCV**[1]	*CPT* 90670; *HCPCS* G0009
3	**IPV**[1]	*CPT* 90697, 90698*, 90713, 90723*
3	**HiB**[1]	*CPT* 90644, 90647, 90648, 90697, 90698*, 90748*
3	**Hep B**[2]	*CPT* 90697, 90723*, 90740, 90744, 90747, 90748*; *ICD-10* 3E0234Z, B16.0, B16.1, B16.2, B16.9, B17.0, B18.0, B18.1, B19.10, B19.11; *HCPCS* G0010
1	**Hep A**[2,4]	*CPT* 90633
1	**MMR**[2,4]	*CPT* 90707, 90710* or combination of vaccines with all three antigens: • **Measles:** *ICD-10* B05.0–B05.4, B05.81, B05.89, B05.9 • **Rubella:** *ICD-10* B06.00, B06.01, B06.02, B06.09, B06.81, B06.82, B06.89, B06.9 • **Mumps:** *ICD-10* B26.0, B26.1, B26.2, B26.3, B26.81, B26.82, B26.83, B26.84, B26.85, B26.89, B26.9

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Doses	Name of antigen	Codes
1	**VZV**[2,4]	*CPT* 90710*, 90716; *ICD-10* B01.0, B01.11, B01.12, B01.2, B01.81, B01.89, B01.9, B02.0, B02.1, B02.21–B02.24, B02.29, B02.30–B02.34, B02.39, B02.7–B02.9
2 or 3	**Rotavirus**[1]	Any of the following: • **2 dose vaccine:** *CPT* 90681 • **3 dose vaccine:** *CPT* 90680 **or** • **1 of the 2 dose vaccines and 1 of the 3 dose vaccines listed above:** *CPT* 90680, 90681

[1]Do not count a vaccination administered prior to 42 days after birth.

[2]Count seropositive test results or history of illness.

[3]Do not count a vaccination administered prior to 180 days after birth. One of the two flu vaccines can be a live, attenuated influenza vaccine (LAIV) administered to the child at the age of 2.

[4]Vaccine must be administered on or between the child's 1st and 2nd birthdays.

*The CPT codes are combination vaccines with multiple antigens: 90698, 90710, 90723, 90748.

Exclusion

Patients who are in hospice or have the following vaccine contraindications are excluded.

For MMR, VZV and influenza:

- **HIV:** B20, Z21
- **Malignant neoplasm of lymphatic tissue:** *ICD-10* C81.00–C81.49, C81.70–C81.79, C81.90–C82.69, C82.80–C83.19, C83.30–C83.39, C83.50–C83.59, C83.70–C84.19, C84.40–C84.49, C84.60–C84.79, C84.90–C84.99, C84.A0–C84.A9, C84.Z0–C84.Z9, C85.10–C85.29, C85.80–C85.99, C86.0–C86.6, C88.2–C88.9, C90.00–C90.02, C90.10–C90.12, C90.20–C90.22, C90.30–C90.32, C91.00–C91.02, C91.10–C91.12, C91.30–C91.32, C91.40–C91.42, C91.50–C91.52, C91.60–C91.62, C91.90–C91.92, C91.A0–C91.A2, C91.Z0–C91.Z2, C92.00–C92.02, C92.10–C92.12, C92.20–C92.22, C92.30–C92.32, C92.40–C92.42, C92.50–C92.52, C92.60–C92.62, C92.90–C92.92, C92.A0–C92.A2, C92.Z0–C92.Z2, C93.00–C93.02, C93.10–C93.12, C93.30–C93.32, C93.90–C93.92, C93.Z0–C93.Z2, C94.00–C94.02, C94.20–C94.22, C94.30–C94.32, C94.80–C94.82, C95.00–C95.02, C95.10–C95.12, C95.90–C95.92, C96.0, C96.2, C96.20–C96.22, C96.29, C96.4, C96.9, C96.A, C96.Z

- **Anaphylactic reaction to neomycin:** No applicable codes.

For Rotavirus:

- **Severe combined immunodeficiency:** ICD-10 D81.0–D81.2, D81.9

For IPV:

- **Anaphylactic reaction streptomycin, polymyxin B or neomycin:** No applicable codes.

For Hepatitis B:

- **Anaphylactic reaction due to common baker's yeast:** No applicable codes.

Immunizations for Adolescents – Combination 2 (IMA-2)

Measure description

The percentage of adolescents who turn age 13 during the measurement year who had the required IMA-2 vaccinations.

Provider action

Missing HPV vaccines are the primary reason for noncompliance:

- Promote consistent provider/clinic recommendation of HPV vaccines to members.
- Consider offering drop-in hours or after-hours appointments for member convenience.
- Create alerts within your electronic health record (EHR) to indicate when the immunizations are due.
- Give call reminders for series vaccines.
- Reduce over-immunization and ensure timely data submission by providing all completed vaccinations to the immunization registries (CAIR2, RIDE, PHIMS, SDIR, etc.).
- Implement standing orders for all males and females starting at age 9.

- Be sure your immunization claims and records are clear about which meningococcal was given.

HPV rates are reported for both females and males.

Ensure medical record documentation includes patient name, date of birth, dates of service, names of vaccines and the dates given (not dates ordered).

Codes

Meningococcal serogroups A,C,W,Y vaccine (with dates of service on or between the child's 11th and 13th birthdays): *CPT* 90734

Tdap (with dates of service on or between the child's 10th and 13th birthdays): *CPT* 90715

HPV (Two doses with dates of services at least 146 days apart on or between child's 9th and 13th birthdays; or three doses on or between child's 9th and 13th birthdays if interval between doses is less than 146 days): *CPT* 90649–90651

Exclusion

Patients who are in hospice are excluded.

Lead Screening in Children (LSC)

Measure description

The percentage of children who turned age 2 during the measurement year who had at least one lead blood testing for lead poisoning by their 2nd birthday.

Provider action

Provide the child's parents or guardian oral or written anticipatory guidance on harmful effects of lead exposure starting at age 6 months to 72 months.

Provide lead testing to children at age 12 months and at 24 months during their periodic health assessments.

Provide lead blood testing:

- If there is no documented evidence of lead blood testing for children up to age 72 months.
- If requested by a parent or guardian.
- Whenever there is a change in circumstance which increases child to exposure or increased risk of lead poisoning.

(continued)

Document in the medical record the date the test was completed, the test result or reasons for not performing the lead test including:

- Provider's professional judgment that the testing posed a greater risk to child's health or safety.
- Child's parent or guardian refused the lead testing with a signed statement of voluntary refusal.[5]

Labs and health care providers should report all blood-lead level test results electronically to the California Childhood Lead Poisoning Prevention Branch (CLPPB) of the CA Department of Public Health.
Visit www.cdph.ca.gov/Programs/CCDPHP/DEODC/CLPPB/Pages/report_results.aspx for more information.

Codes

Lead tests: *CPT* 83655

Exclusion

Patients who are in hospice are excluded.

[5]Reasons for not obtaining a signed statement due to member declining or unable to do so, should also be documented.

Well-care visits with a PCP for children and adolescents. (W30, WCV)

Follow medical record documentation requirements of wellness visits as required by the DHCS Plan Letter 14-004. Ensure complete documentation for all five components.

Create a template with a checklist for well-child visits to ensure measure compliance. Utilize standardized templates in electronic health records (EHRs) as available.

Establish standardized clinical and administrative processes to ensure proper delivery and documentation of services.

The following measures for well-child/well-care visits are administrative measures according to NCQA HEDIS technical specifications.

Measure description

Well-Child Visits in the First 30 Months of Life (W30). The percentage of infants with the minimum number of well-child visits completed before age 30 months.

- For children in their their first 15 months of life: six well-child visits.
- For children in their 15–30 months of life: two well-child visits.

Visits should occur on different dates of service.

Child and Adolescent Well-Care Visits (WCV). The percentage of children and adolescents ages 3–21 with at least one well-care visit with a PCP or OB/GYN completed annually.

Provider action

Schedule the required number of visits ahead of time, taking into account make-up visits and rescheduling.

Actively pursue missed appointments with letters and reminder calls.

Turn a sick visit into a well-child visit.

Sports physicals that include a physical exam (including body mass index (BMI)), developmental assessment, and anticipatory guidance can be billed as well-visits as long as all three components are clearly documented on the same date. ICD-10 code for sport examination: Z02.5.

Outreach and schedule appointments during convenient times for parents and their children. Take advantage of school breaks and holidays (such as summer and winter breaks), and offer extended/weekend hours.

Use telehealth to complete well-child visits for measurement years 2021 and 2022. Use appropriate telehealth codes or modifiers.

Ensure that electronic health records (EHRs) are being submitted with correct codes and that provider information is current.

Codes

Well-care visit: *CPT* 99381–99385, 99391–99395, 99461;
HCPCS G0438, G0439, S0302;
ICD-10 Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.2, Z00.3, Z01.411, Z01.419, Z02.5, Z76.1, Z76.2

Exclusion

Patients who are in hospice are excluded.

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

Measure description

The percentage of patients ages 3–17 who had an outpatient visit with a PCP or OB/GYN during the measurement year with evidence of the following:

- BMI percentile documentation.
- Counseling for nutrition.[6]
- Counseling for physical activity.[6]

For BMI component, medical records should show the following:

- BMI percentile as a distinct % value, or
- BMI percentile plotted on an age-growth chart

Percentile ranges will not meet criteria; however, a distinct value such as > 99% or < 1% value is acceptable.

Patient-reported biometric values should be collected by a PCP or specialist providing the weight assessment, and must be recorded, and dated in the legal health record.

Exclusion: Patients who are pregnant or in hospice.

Provider action

Take advantage of well-child visits and sick visits to complete this measure.

Measure and record patient's current height and weight along with BMI percentile for age results (plotted on growth chart or reported percentile).

When counseling for nutrition, discuss appropriate food intake, healthy eating habits, issues including body image and eating disorders, etc.

When counseling for physical activity, discuss organized sports activities or after school programs and document age-appropriate activity, such as "rides bike for 30 minutes a day."

Document evidence of counseling or referral for nutrition education or physical activity in the medical record. May use a checklist to note topics discussed.

Codes

Outpatient visit: *CPT* 99201–99205, 99211–99215, 99241–99245, 99341–99345, 99347–99350, 99381–99387, 99391–99397, 99401–99404, 99411–99412, 99429, 99455–99456, 99483;
HCPCS G0402, G0438, G0439, G0463, T1015

(continued)

BMI percentile: *ICD-10* Z68.51–Z68.54

Counseling for nutrition: *CPT* 97802–97804;
HCPCS G0270, G0271, G0447, S9449, S9452, S9470;
ICD-10 Z71.3

Counseling for physical activity:
HCPCS G0447, S9451;
ICD-10 Z02.5, Z71.82

Exclusion

Patients who are in hospice are excluded from the measure.

[6]Services rendered during a phone visit, e-visit or virtual check-in meet criteria for these indicators.

Preventive/Chronic Care

Asthma Medication Ratio (AMR)

Breast Cancer Screening (BCS)

Cervical Cancer Screening (CCS)

Chlamydia Screening in Women Ages 16–24 (CHL)

Controlling High Blood Pressure (CBP)

Preventive/
Chronic Care

Asthma Medication Ratio (AMR)

Measure description

The percentage of patients ages 5–64 with persistent asthma, who have a medication ratio of 0.50 or greater of controller medications to total asthma medications during the measurement year.

Calculation of medication ratio = units of asthma controller medications/units of total asthma medications.[7]

To meet persistent asthma eligible criteria, there must be at least one of the following criteria met with a diagnosis of asthma during both the measurement year and the year prior:

- At least one emergency department (ED) visit.
- At least one acute inpatient encounter or discharge.
- At least four outpatient visits, observation visits, phone visits (only three phone visits allowed), or online assessments on different dates of service and with two asthma medication dispensing events for any controller or reliever medication.

(continued)

[7]Units of total asthma medications = units of asthma controller medications + units of asthma reliever medications

- At least four asthma dispensing events for any controller or reliever medication.

Where leukotriene modifiers or antibody inhibiters were the sole asthma medication dispensed for the patient, the diagnosis of asthma must have occurred during the same year.

Provider action

Ensure patients are accurately diagnosed with persistent asthma.

Educate patients about the difference between controller and reliever medications.

Ensure that asthma medication, especially controller medication, is being dispensed to the patient in accordance with the proper medication schedule or need.

Create an asthma action plan. Train patients on inhaler techniques and ensure use of asthma spacers and peak flow meters.

Assess asthma symptoms and the patient's asthma action plan at every visit to determine if medication adjustment or medication adherence reinforcement is needed.

Asthma Medications

Asthma Controller Medications:

- Antiasthmatic combinations: Dyphylline-guaifenesin
- Antibody inhibitors: Omalizumab
- Anti-interleukin-4: Dupilumab
- Anti-interleukin-5: Benralizumab, Mepolizumab, and Reslizumab
- Inhaled steroid combinations: Budesonide-formoterol, Fluticasone-salmeterol, Fluticasone-vilanterol, and Formoterol-mometasone
- Inhaled corticosteroids: Beclomethasone, Budesonide, Ciclesonide, Flunisolide, Fluticasone, and Mometasone
- Leukotriene modifiers: Montelukast, Zafirlukast, and Zileuton
- Methylxanthines: Theophylline

Asthma Reliever Medications:

- Short-acting, inhaled beta-2 agonists: Albuterol, Levalbuterol

Codes

Asthma: *ICD-10* J45.21–J45.22, J45.30–J45.32, J45.40–J45.42, J45.50–J45.52, J45.901, J45.902, J45.909, J45.991, J45.998

ED visit: *CPT* 99281–99285

Acute inpatient visit: *CPT* 99221–99223, 99231–99233, 99238, 99239, 99251–99255, 99291

Outpatient visit: *CPT* 99201–99205, 99211–99215, 99241–99245, 99341–99345, 99347–99350, 99381–99387, 99391–99397, 99401–99404, 99411, 99412, 99429, 99455, 99456, 99483;
HCPCS G0402, G0438, G0439, G0463, T1015

Observation visit: *CPT* 99217–99220

Phone visit: *CPT* 98966–98968, 99441–99443

Online Assessments (e-visits or virtual check-ins): *CPT* 98969–98972, 99421–99423, 99444, 99457;
HCPCS G0071, G2010, G2012, G2061–G2063

Outpatient telehealth visit: *POS* 02;
Modifier 95, GT

Exclusion

Patients who had no asthma controller or reliever medications dispensed or have any of the following diagnoses:

Emphysema: *ICD-10* J43.0, J43.1. J43.2 J43.8, J43.9

Other emphysema: *ICD-10* J98.2–J98.3

Chronic respiratory conditions due to fumes/vapors: *ICD-10* J68.4

Cystic fibrosis: *ICD-10* E84.0, E84.11, E84.19, E84.8, E84.9

Acute respiratory failure:
ICD-10 J96.00–J96.02, J96.20–J96.22

Breast Cancer Screening (BCS)

Measure description

The percentage of patients who need screening, ages 50–74, who have had one or more mammograms any time on or between October 1, two years prior to the measurement year and December 1 of the measurement year.

Note: All types and methods of mammograms (screening, diagnostic, film, digital, or digital breast tomosynthesis) meet the numerator compliance. Biopsies, breast ultrasounds or MRIs are not counted.

Provider action

Document date of mammogram along with proof of completion:

- Providing results or findings will indicate screening was ordered and completed.

Develop standing orders along with automated referrals (if applicable) for patients ages 50–74, who need screening.

Refer patients to local mammography imaging centers. Follow up to verify completion.

Providers and clinics should hold mobile mammography events to meet members in their communities. The Plan Provider Engagement team can help clinics organize the events.

Encourage members to attend mobile mammography events offered by the Plan or their provider.

Providers should educate patients about the importance of routine screening.

Discuss possible concerns or fear patients may have about the screening.

Conduct telehealth visits with patients to reduce access to care barriers.

Codes

Mammography: *CPT* 77055–77057, 77061–77063, 77065–77067

Exclusion

Patients in hospice, those who received palliative care during the measurement year, those who had a bilateral mastectomy or who meet the frailty and advance illness exclusion criteria are excluded.

History of bilateral mastectomy: *ICD-10* Z90.13

Unilateral mastectomy with bilateral modifier: *CPT* 19180, 19200, 19220, 19240, 19303–19307; *Modifier:* RT, LT

Absence of both right and left breasts: *ICD-10* Z90.11, Z90.12

Cervical Cancer Screening (CCS)

Measure description

The percentage of patients who need screening, ages 21–64 who had the following age-appropriate cervical cancer screenings:

- For ages 21–64: a cervical cytology is performed every three years.
- For ages 30–64: a cervical cytology and human papillomavirus co-testing is performed every five years, (use five-year time frame only if HPV co-testing was completed on the same day and includes results. Reflex testing will not count), or
- For ages 30–64: a cervical high-risk human papillomavirus (hrHPV) testing is performed every five years.

Provider action

Schedule and complete a cervical cancer screening when a patient is due.

Always include dates of service, specific test names and results in the medical record.

Document for history of total hysterectomy (TAH or TVH), or radical abdominal or vaginal hysterectomy and bill ICD-10 codes for any of the following:

- Acquired absence of: both cervix and uterus, cervix with remaining uterus, or agenesis and aplasia of cervix.

Note: Documentation of a "hysterectomy" alone does not count.

Discuss possible concerns or fear patients may have about the screening.

Codes

Cervical cytology: *CPT* 88141–88143, 88147, 88148, 88150, 88152–88154, 88164–88167, 88174, 88175;
HCPCS G0123, G0124, G0141, G0143–G0145, G0147, G0148, P3000, P3001, Q0091

Exclusion

Patients who received palliative care during the measurement, in hospice or do not have a cervix are excluded.

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Hysterectomy with no residual cervix: *CPT* 51925, 56308, 57530, 57531 57540, 57545, 57550, 57555, 57556, 58150, 58152, 58200, 58210, 58240, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290–58294, 58548, 58550, 58552–58554, 58570–58573, 58575, 58951, 58953, 58954, 59856, 59135; *ICD-10* 0UTC0ZZ, 0UTC4ZZ, 0UTC7ZZ, 0UTC8ZZ

Absence of cervix diagnosis: *ICD-10* Q51.5, Z90.710, Z90.712

Chlamydia Screening in Women (CHL)

Measure description

The percentage of patients who need screening, ages 16–24, identified as sexually active and who tested for chlamydia during the measurement year.

Provider action

Order a chlamydia screening and provide follow-up for patients who are pregnant, taking contraceptives or identified themselves as sexually active.

Chlamydia screening can be performed through a simple urine test; offer this as an option for your patients.

The best practice for chlamydia screening is to have standing orders for urine screening for all teens and women ages 16 to 24.

Codes

Chlamydia test: *CPT* 87110, 87270, 87320, 87490–87492, 87810

Exclusion

Patients who are pregnant, in hospice, or received palliative care during the measurement year.

Pregnancy test: *CPT* 81025, 84702, 84703

Controlling High Blood Pressure (CBP)

Measure description

The percentage of patients ages 18–85 who had diagnosis of hypertension and whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the measurement year based on the following criteria:

- Patients had at least two visits on different dates of service, both with a diagnosis of hypertension on or between January 1 of the year prior to the measurement year and June 30 of the measurement year.
- The most recent BP reading taken during the measurement year on or after the second diagnosis of hypertension was <140/90mm Hg.

Provider action

- Identify the most recent BP reading noted during the measurement year. Always list the date of service and BP reading together.
- Services provided during a phone visit, e-visit or virtual check-in are acceptable.
- 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.

- Identify the lowest systolic and lowest diastolic BP reading from the most recent BP notation in the medical record. If a patient's initial BP reading is elevated at the start of a visit, you can take multiple readings during the same visit and use the lowest diastolic and lowest systolic to document the overall reading.

- BP readings taken by the patient using a digital device, and documented in the patient's medical record are eligible for use in reporting (provided the BP does not meet any exclusion criteria). There is no requirement that there be evidence the BP was collected by a PCP or specialist.

- Review with office staff the proper way to take a blood pressure, ensure patient is seated in a chair with back supported, feet flat on the ground, and their legs are uncrossed.

- Instruct office staff to recheck patient's blood pressure if initial recorded reading is greater than systolic 140 mm Hg and diastolic of 90 mm Hg during outpatient office visit; have staff record the recheck in patient's medical records.
- Patient's BP is "not controlled" if the BP reading is ≥140/90 mm Hg or is missing, or if there is no BP reading during the measurement year or if the reading is incomplete (e.g., the systolic or diastolic level is missing).
- Ranges and thresholds do not meet criteria for this measure. A distinct numeric result for both the systolic and diastolic BP reading is required. A BP documented as an "average BP" (e.g., "average BP: 139/70") is eligible for use.

Codes

Description	CPT II Codes
Diastolic BP less than 80	3078F
Diastolic BP 80-89	3079F
Diastolic BP greater than or equal to 90	3080F
Systolic BP less than 130 mm Hg	3074F
Systolic BP 130-139 mm	3075F
Systolic BP greater than or equal to 140	3077F

Exclusion

The following patients are excluded from the measure:

- In hospice or using hospice services during the measurement year.
- Receiving palliative care.
- Ages 66-80 as of December 31 of the measurement year with frailty and advanced illness during the measurement year.
- Evidence of end-stage renal disease (ESRD) or kidney transplant on or prior to December 31 of the measurement year. Documentation must include a dated note indicating evidence of ESRD, kidney transplant or dialysis.
- Ages 81 and older as of December 31 of the measurement year with frailty.
- Pregnancy diagnosis during the measurement year.
- A nonacute inpatient admission during the measurement year.

Diabetes Care

Hemoglobin A1c Control for Patients with Diabetes (HBD)

Blood Pressure Control for Patients with Diabetes (BPD)

Eye Exam for Patients with Diabetes (EED)

Kidney Health Evaluation for Patients with Diabetes (KED)


T W T F S

Hemoglobin A1c Control for Patients With Diabetes (HBD)

Measure description

The percentage of patients ages 18–75 with diabetes (type 1 and 2) who had the following levels during the measurement year:

- HbA1c control (< 8.0%).
- HbA1c poor control (> 9.0%).

Note for HbA1c poor control > 9%: A lower rate indicates better performance for this indicator (i.e., low rates of poor control indicate better care).

Provider action

- Documentation in the medical record must include a note indicating the date when the most recent HbA1c test was performed in the measurement year along with result or findings. Always list the date of service, result and test together.

- HbA1c should be completed two to four times each year with result date and distinct numeric result. A1c result documented as a range and/or threshold does not meet criteria. The last HbA1c result of the year must be less than or equal to nine to show evidence of diabetes control.
- Order labs to be completed prior to patient appointments and review diabetic services needed at each office visit.
- Educate patients about the importance of routine screening and medication compliance.

Codes

HbA1c Level < 7.0%: *CPT II* 3044F

HbA1c ≥ 7.0% and <8.0%: *CPT II* 3051F

HbA1c ≥ 8.0% and ≤ 9.0%: *CPT II* 3052F

HbA1c > 9.0%: *CPT II* 3046F

HbA1c Screening: *CPT* 83036, 83037

Exclusions

Patients are excluded if they:

- In hospice or using hospice services any time in the measurement year.
- Receiving palliative care any time in the measurement year.
- Ages 66 and older with frailty and advanced illness during the measurement year.
- Did not have a diagnosis of diabetes in the measurement year or the year prior and who had a diagnosis of polycystic ovarian syndrome, gestational diabetes, or steroid-induced diabetes during the measurement year or the year prior.
- Ages 66 and older as of December 31 of the measurement year who are either enrolled in an Institutional SNP (I-SNP) or living long-term in an institution during the measurement year.

Blood Pressure Control for Patients With Diabetes (BPD)

Measure description

The percentage of patients ages 18–75 with diabetes (types 1 and 2) whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the measurement year.

Provider action

- Document BP readings at every visit; do not use ranges or thresholds. BP readings that are 140/90 or greater should be re-taken - if the patient has a high blood pressure reading at the beginning of the visit, retake and record it at the end of the visit.
- Make sure the proper cuff size is used, and appropriate technique utilized while taking BP reading (i.e., patients don't cross their legs and have their feet flat on the floor during the reading, and elbow is at the same level as the heart)
- Do not include BP readings:
  - Taken during an acute inpatient stay or an ED visit.

(continued)

  - 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 a patient using a non-digital device such as with a manual blood pressure cuff and stethoscope.

- Encourage patients to use a digital device to track and report their BP during every visit. Patient reported data documented in medical record is acceptable if BP captured with a digital device.
- Educate patients about the risks of uncontrolled blood pressure and reinforce the importance of medication adherence.
- Ranges and thresholds do not meet criteria for this measure. A distinct numeric result for both the systolic and diastolic BP reading is required.

Codes

Description	CPT II Codes
Diastolic BP less than 80	3078F
Diastolic BP 80-89	3079F
Diastolic BP greater than or equal to 90	3080F
Systolic BP less than 130 mm Hg	3074F
Systolic BP 130-139 mm	3075F
Systolic BP greater than or equal to 140	3077F

Exclusions

Patients who meet any of the following criteria are excluded from the measure:

- In hospice or using hospice services any time in the measurement year.
- Receiving palliative care any time in the measurement year.
- Ages 66 and older with frailty and advanced illness during the measurement year.
- Did not have a diagnosis of diabetes in the measurement year or the year prior and who had a diagnosis of polycystic ovarian syndrome, gestational diabetes, or steroid-induced diabetes during the measurement year or the year prior.
- Ages 66 and older as of December 31 of the measurement year who are either enrolled in an Institutional SNP (I-SNP) or living long-term in an institution during the measurement year.

Eye Exam for Patients With Diabetes (EED)

Measure description

The percentage of patients ages 18-75 with a diagnosis of diabetes (Type 1 and Type 2) who had a retinal eye exam.

Diabetic Retinal Exam

Screening or monitoring for diabetic retinal disease as identified by one of the following exams performed in the measurement year or the year prior to the measurement year.

- Retinal or dilated eye exam must be performed 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.

Provider action

- Documentation can be in the form of a note or letter prepared by an ophthalmologist, optometrist, PCP, or other health care provider indicating that an ophthalmoscopic exam was completed by an eye care provider, the date when the procedure was performed and the results.
- Documentation of a negative retinal or dilated exam by an eye care professional (optometrist or ophthalmologist) in the year prior to the measurement year, where results indicate retinopathy was not present (e.g., documentation of normal findings).
- A chart or photograph indicating the date when the fundus photography was performed and evidence that an eye care professional (optometrist or ophthalmologist) or qualified reading center reviewed the results, or that results were read by a system that provides artificial intelligence (AI) interpretation.
- Obtain eye exam reports. Note eye care provider name and demographics in chart if report not available.
- Provide patient education on risks of diabetic eye disease and encourage scheduling annual exam.

Codes

Diabetic Eye Exam: CPT 67028, 67030, 67031, 67036, 67039, 67040, 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, 92225, 92226, 92227, 92228, 92230, 92235, 92240, 92250, 92260, 99203, 99204, 99205, 99213, 99214, 99215, 99242, 99243, 99244, 99245;HCPCS S0620, S0621, S3000

Automated Eye Exam: *CPT* 92229

Diabetic Eye Exam without Evidence of Retinopathy in Prior Year: *CPT II* 3072F

Diabetic Eye Exam without Evidence of Retinopathy: *CPT II* 2023F, 2025F, 2033F

Diabetic Eye Exam with Evidence of Retinopathy (in the Measurement Year only): *CPT II* 2022F, 2024F, 2026F

Unilateral Eye Enucleation: *CPT* 65091, 65093, 65101, 65103, 65105, 65110, 65112, 65114

Unilateral Eye Enucleation – Left: *ICD-10-PCS* 08T1XZZ

Unilateral Eye Enucleation – Right: *ICD-10-PCS* 08T0XZZ

Bilateral Modifier: *CPT Modifier* 50

Exclusions

Patients who meet any of the following criteria are excluded from the measure:

- In hospice or using hospice services any time in the measurement year.
- Receiving palliative care any time in the measurement year.
- Ages 66 and older with frailty and advanced illness during the measurement year.
- Did not have a diagnosis of diabetes in the measurement year or the year prior and who had a diagnosis of polycystic ovarian syndrome, gestational diabetes, or steroid-induced diabetes during the measurement year or the year prior.
- Ages 66 and older as of December 31 of the measurement year who are either enrolled in an Institutional SNP (I-SNP) or living long-term in an institution during the measurement year.

Kidney Health Evaluation for Patients With Diabetes (KED)

Measure description

The percentage of patients ages 18–85 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.

- At least 1 estimated glomerular filtration rate (eGFR); AND
- At least 1 urine albumin-creatinine ratio (uACR) test identified by one of the following:
  - A quantitative urine albumin test AND a urine creatinine test 4 or less days apart; OR
  - A uACR

Provider action

- Advise patients that some complications from diabetes may be asymptomatic. For example, kidney disease is asymptomatic in its earliest stages and routine testing and diagnoses may help prevent/delay some life-threatening complications.
- Routinely refer patients with a diagnosis of type 1 or type 2 diabetes out to have their eGFR and uACR
- Order labs to have patients complete prior to appointment to allow results to be available for discussion on the day of the office visit.
- Educate patients on how diabetes can affect the kidneys and offer tips on preventing damage to their kidneys

Codes

Estimated Glomerular Filtration Rate Lab Test: *CPT* 80047, 80048, 80050, 80053, 80069, 82565

LOINC: 48642-3, 48643-1, 50044-7, 50210-4, 50384-7, 62238-1, 69405-9, 70969-1, 77147-7, 88293-6, 88294-4, 94677-2, 96591-3, 96592-1

Quantitative Urine Albumin Lab Test: *CPT* 82043

LOINC: 14957-5, 1754-1, 21059-1, 30003-8, 43605-5, 53530-2, 53531-0, 57369-1, 89999-7

Urine Creatinine Lab Test: *CPT* 82570

LOINC: 20624-3, 2161-8, 35674-1, 39982-4, 57344-4, 57346-9, 58951-5

Urine Albumin Creatinine Ratio Test: LOINC: 13705-9,14958-3, 14959-1, 30000-4, 32294-1, 44292-1, 59159-4, 76401-9, 77253-3, 77254-1, 89998-9, 9318-7

Exclusions

Patients who meet any of the following criteria are excluded from the measure:

- Are in hospice or using hospice services in the measurement year.
- Receiving palliative care in the measurement year.
- Ages 66 and older with frailty and advanced illness during the measurement year.
- Ages 81 and older with frailty during the measurement year.
- Evidence of ESRD (end-stage renal disease) any time during the patient's history through December 31 of the measurement year.
  - Ages 66 and older as of December 31 of the measurement year who are either: enrolled in an Institutional SNP (I-SNP) or living long-term in an institution during the measurement year.
  - Did not have a diagnosis of diabetes in the measurement year or the year prior and who had a diagnosis of polycystic ovarian syndrome, gestational diabetes, or steroid-induced diabetes during the measurement year or the year prior.

Maternal Health Care

Prenatal and Postpartum Care – Timeliness of Prenatal Care (PPC-Pre)

Prenatal and Postpartum Care – Postpartum Care (PPC-Pst)

Prenatal and Postpartum Care – Timeliness of Prenatal Care (PPC-Pre)

Measure Description

The percentage of deliveries of live births that received a prenatal care visit in the first trimester or within 42 days of enrollment.

The measure assesses prenatal care visits with a PCP or OB/GYN for deliveries that occurred on or between October 8 of the year prior to the measurement year and October 7 of the measurement year.

Note: The first trimester falls within 280–176 days prior to delivery, so prenatal visits must occur any time from 280 days prior to delivery to 42 days after enrollment start date. Visits prior to the plan enrollment start date meet criteria.

Provider action

Schedule patients for their first prenatal visit in their first trimester or within 42 days of becoming a plan member.

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Document date of prenatal care visit with evidence of one of the following:

- Diagnosis or references of pregnancy as either of the following:
  - standardized prenatal flow sheet
  - last menstrual period, estimated due date, or gestational age
  - positive pregnancy test result
  - gravidity and parity
  - complete obstetrical history, or
  - risk assessment, education, or counseling of pregnancy.
- Physical obstetrical exam that includes:
  - fetal heart tone auscultation
  - pelvic exam with obstetrical observations, or
  - fundus height documentation.
- Evidence of prenatal care procedures performed:
  - obstetrical panel screening test with all of the following: hematocrit, WBC count, platelet count, hepatitis B, surface antigen, rubella antibody, syphilis test, RBC antibody screen, Rh and ABO blood typing, or
  - torch panel, or

- rubella/Rh or rubella/ABO blood typing, or
- prenatal ultrasound.

Codes

Prenatal visit during first trimester with a pregnancy diagnosis code: *CPT* 99201–99205, 99211–99215, 99241–99245, 99483; *HCPCS* G0463, T1015

Online assessments (e-visits or virtual check-ins) **with pregnancy diagnosis code:** *CPT* 98969–98972, 99421–99423, 99444, 99457, 99458; *HCPCS* G2010, G2012, G2061–G2063

Phone visit with pregnancy diagnosis code: *CPT* 98966–98968, 99441–99443

Standalone prenatal visits: *CPT* 99500; *CPT Cat. II* 0500F, 0501F, 0502F; *HCPCS* H1000–H1004

Prenatal bundled services: *CPT* 59400, 59425, 59426, 59510, 59610, 59618; *HCPCS* H1005

Exclusions

Deliveries of non-live births are excluded. Patients who are in hospice are also excluded.

Prenatal and Postpartum Care – Postpartum Care (PPC-Pst)

Measure description

The percentage of deliveries of live births that had a postpartum visit on or between 7 and 84 days after delivery.

Provider action

Schedule patient's postpartum care visit with an OB/GYN practitioner, midwife, family practitioner, or other PCP on or between 7–84 days after delivery.

Document date of postpartum visit with evidence of one of the following:

- Notation of "postpartum care," PP check, PP care, 6-week check, etc.
- Pelvic exam.
- Evaluation of weight, blood pressure, breasts and abdomen.
- Perineal or cesarean incision/wound check.
- Documentation of infant care, breastfeeding, family planning, sleep/fatigue and/or resumption of physical activity.
- Screening for glucose for patients with gestational diabetes.

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- Screening for behavioral or mental health disorders including depression, anxiety, tobacco or substance use.

Note: Can also use a Pap test completed within 7–84 days after delivery.

Codes

Postpartum visit: *CPT* 57170, 58300, 59430, 99501;
CPT Cat. II 0503F;
HCPCS G0101;
ICD-10 Z01.411, Z01.419, Z01.42, Z30.430, Z39.1, Z39.2

Cervical cytology: *CPT* 88141–88143, 88147, 88148, 88150, 88152–88154, 88164–88167, 88174, 88175;
HCPCS G0123, G0124, G0141, G0143–G0145, G0147, G0148, P3000, P3001, Q0091

Postpartum bundled services: *CPT* 59400, 59410, 59425, 59426, 59510, 59515, 59610, 59614, 59618, 59622

Exclusions

The following are excluded from the measure:

- Patients in hospice care.
- Postpartum services that were provided in an acute inpatient setting.
- Deliveries with non-live births.

Behavioral Health Care

Antidepressant Medication Management (AMM)

- Acute Phase
- Continuation Phase

Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)

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

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

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

Behavioral Health Care

Antidepressant Medication Management (AMM)

Measure description

The percentage of patients ages 18+ with a diagnosis of major depression who were treated with antidepressant medication, and who remained on their medication treatment.

Two rates are reported:

Acute phase. The percentage of patients who remained on the medication for at least 84 days (12 weeks) within 114 days from earliest prescription dispense date during the 12-month window starting on May 1 of the prior year, through April 30 of the current year.

Continuation phase. The percentage of patients who remained on medication for at least 180 days (six months) within 232 days from earliest prescription dispense date during the 12-month window starting on May 1 of the prior year, through April 30 of the current year.

Antidepressant medications

Miscellaneous antidepressants: Bupropion, Vilazodone and Vortioxetine

Monoamine oxidase inhibitors: Isocarboxazid, Phenelzine, Selegiline and Tranylcypromine

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Phenylpiperazine antidepressants: Nefazodone and Trazodone

Psychotherapeutic combinations: Amitriptyline-chlordiazepoxide, Amitriptyline-perphenazine, and Fluoxetine-olanzapine

SNRI antidepressants: Desvenlafaxine, Duloxetine, Levomilnacipran, and Venlafaxine

SSRI antidepressants: Citalopram, Escitalopram, Fluoxetine, Fluvoxamine, Paroxetine, and Sertraline

Tetracyclic antidepressants: Maprotiline and Mirtazapine

Tricyclic antidepressants: Amitriptyline, Amoxapine, Clomipramine, Desipramine, Doxepin (> 6 mg), Imipramine, Nortriptyline, Protriptyline, and Trimipramine

Provider action

Screen patients with an age-appropriate standardized assessment (e.g., the Patient Health Questionnaire (PHQ-9)), at baseline and various points in the patient's progression.

Provide reassurance that depression is common and can be managed.

Schedule a follow-up appointment within four weeks after starting a new prescription to reassess symptoms, side effects, and adjust the type/dose of medication, if needed.

Educate patients on medication options, benefits and side effects, and come to a joint agreement on treatment plan.

Discuss the importance of continuing medication as prescribed and the risks of stopping medication before six months.

Encourage collaboration and communication with the patient's behavioral health provider or encourage the patient to complement medication with therapy.

If the patient already has a behavioral health provider, ask the patient for consent to collaborate with their existing behavioral health provider, to further support medication adherence.

Outreach to patients at risk of noncompliance (missing at least one refill) via phone calls, medication prompts, or case management.

Codes

Follow the listed guidelines when coding for specific behavioral health (BH) visit types with a major depression diagnosis code.

- **An acute or nonacute inpatient stay with diagnosis of major depression on the discharge claim:** Use the Inpatient Stay value set.
- **An acute or nonacute inpatient encounter:** Use the Acute Inpatient value set or Nonacute Inpatient value set.
- **An outpatient visit:** Use the Visit Setting Unspecified value set with Outpatient POS value set.
- **A BH outpatient visit:** Use the BH Outpatient value set.
- **An intensive outpatient encounter or partial hospitalization:** Use either one of the following:
  - Partial Hospitalization or Intensive Outpatient value set.
  - Visit Setting Unspecified value set with Partial Hospitalization POS value set.
- **A community mental health center visit:** Use the Visit Setting Unspecified value set with Community Mental Health Center POS value set.

- **Electroconvulsive therapy:** Use the Electroconvulsive Therapy value set.
- **Transcranial magnetic stimulation visit:** Use the Transcranial Magnetic Stimulation value set.
- **Telehealth visit:** Use the Visit Setting Unspecified value set with Telehealth POS value set.
- **Observation visit:** Use the Observation value set
- **Emergency department (ED) visit:** Use ether one of the following:
  - ED value set.
  - Visit Setting Unspecified value set with ED POS value set.
- **Phone visit:** Use the Phone Visits value set
- **Online Assessment (e-visits and virtual check-ins):** Use the Online Assessments value set.

Exclusions

Patients are excluded if they:

- 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 60 days after.
- Filled a prescription for antidepressant medication 105 days before the IPSD.
- Are in hospice.

Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)

Measure description

The percentage of children and adolescents ages 1–17 prescribed with two or more antipsychotic medications that were dispensed on different dates of services during the measurement year and had metabolic testing.

Three rates are reported for this measure:

- Percentage of patients who received blood glucose testing.
- Percentage of patients who received cholesterol testing.
- Percentage of patients who received both blood glucose and cholesterol testing.

The two prescribed medications can be the same or different type of antipsychotic medications on different dates of the calendar year.

Provider action

- Perform these tests annually:
  - Blood glucose or HbA1c lab test.
  - LDL-C or cholesterol lab test.
- Follow up with patient's parents to discuss and educate on lab results.
- Have routine lab tests scheduled to be

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done in the office during a patient's visit or schedule lab testing before the patient and parent/guardian leave the office.

- If the patient reports having had previous lab work, providers must obtain the official results. Patient reporting is not valid for medical record entry.
- Educate parents on the side effects of antipsychotics and risk of weight gain and diabetes. Inform them of the appropriate health screening for certain medication therapies.
- Make sure the medical record contains the contact information of all of the patient's current providers for care coordination. Coordinate with the patient's behavioral health plan and treating behavioral health specialists.
- Utilize the coding tips to document what was done accurately and be specific in the patient's medical record.

Antipsychotic Medications:

- Miscellaneous antipsychotic agents: Aripiprazole, Asenapine, Brexpiprazole, Cariprazine, Clozapine, Haloperidol, Iloperidone, Loxapine, Lurasidone, Molindone, Olanzapine, Paliperidone, Pimozide, Quetiapine, Risperidone, and Ziprasidone
- Phenothiazine antipsychotics: Chlorpromazine, Fluphenazine, Perphenazine, Thioridazine, and Trifluoperazine
- Thioxanthenes: Thiothixene
- Long-acting injections: Aripiprazole, Fluphenazine decanoate, Haloperidol decanoate, Olanzapine, Paliperidone palmitate, and Risperidone

Antipsychotic Combination Medications:

- Psychotherapeutic combinations: Fluoxetine-olanzapine and Perphenazine-amitriptyline

Prochlorperazine Medications:

- Phenothiazine antipsychotics: Prochlorperazine

Codes

Glucose lab testing: *CPT* 80047, 80048, 80050, 80053, 80069, 82947, 82950, 82951

HbA1c lab testing: *CPT* 83036, 83037

HbA1c test result or finding: *CPT Cat. II* 3044F, 3046F, 3051F, 3052F

LDL-C testing: *CPT* 80061, 83700, 83701, 83704, 83721

LDL-C test result or finding: *CPT Cat. II* 3048F–3050F

Cholesterol lab testing: *CPT* 82465, 83718, 83722, 84478

Exclusion

Patients in hospice are excluded.

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

Measure description

The percentage of patients ages 18–64 diagnosed with schizophrenia, schizoaffective disorder or bipolar disorder, who were dispensed antipsychotic medications and had diabetes screening during the measurement year.

Provider action

- Check at each visit for the completed diabetes test (glucose or HbA1c lab test). Reorder every year if not done.
- Encourage shared decision-making by educating patients and caregivers about:
  - Increased risk of diabetes with taking antipsychotic medications.
  - Importance of screening for diabetes for those taking this type of medicine.
  - Symptoms of new-onset diabetes.
- Communicate and coordinate care between behavioral health and primary care physicians (PCPs) by requesting test results, communicating test results or scheduling an appointment for testing.

Codes

Glucose lab testing: *CPT* 80047, 80048, 80050, 80053, 80069, 82947, 82950, 82951

HbA1c lab testing: *CPT* 83036, 83037

HbA1c test result or finding: *CPT Cat. II* 3044F, 3046F, 3051F, 3052F

Schizophrenia: *ICD-10* F20.0–F20.3, F20.5, F20.81, F20.89, F20.9, F25.0, F25.1, F25.8, F25.9

Bipolar disorder: *ICD-10* F30.10–F30.13, F30.2–F30.4, F30.8, F30.9, F31.0, F31.10–F31.13, F31.2, F31.30–F31.32, F31.4, F31.5, F31.60–F31.64, F31.70–F31.78

Other bipolar disorder: *ICD-10* F31.81, F31.89, F31.9

Patient Settings:

Follow the listed guidelines when coding for specific behavioral health (BH) visits with a schizophrenia, schizoaffective disorder or bipolar disorder diagnosis code.

Patient had at least one of the following visits:

- **Acute inpatient encounter:** Use either one of the following:
  - BH standalone acute inpatient value set.
  - Visit setting unspecified value set with acute inpatient POS value set.

Or at least two of the following on different dates of service:

- **Nonacute inpatient encounter:** Use either one of the following:
  - BH standalone nonacute inpatient value set.
  - Visit setting unspecified value set with nonacute inpatient POS value set.
- **Outpatient visit:** Use either one of the following:
  - BH outpatient value set.
  - Visit setting unspecified value set with outpatient POS value set.
- **Intensive outpatient encounter or partial hospitalization:** Use either one of the following:
  - Partial hospitalization or intensive outpatient value set.
  - Visit setting unspecified value set with partial hospitalization POS value set.
- **A community mental health center visit:** Use the visit setting unspecified value set with community mental health center POS value set.

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- **Electroconvulsive therapy:** Use the electroconvulsive therapy value set.
- **Observation visit:** Use the observation value set.
- **Emergency department (ED) visit:** Use ether one of the following:
  - ED value set.
  - Visit setting unspecified value set with ED POS value set.
- **Telehealth visit:** Use the visiting setting unspecific value set, with telehealth POS value set.
- **Phone visit:** Use the phone visits value set.
- **Online Assessment** (e-visits and virtual check-ins): Use the online assessments value set.

Exclusions

Patients with diabetes during the measurement year are excluded from this measure with any of the following criteria:

- At least one acute inpatient encounter without telehealth.
- At least one acute inpatient discharge with a diagnosis of diabetes.
- At least two outpatient visits, observation visits, phone visits, e-visits, virtual check-ins, ED visits, nonacute inpatient encounters discharges (without telehealth) or nonacute inpatient and with a diagnosis of diabetes.
- Members dispensed insulin or oral hypoglycemic/antihyperglycemics during the current or prior calendar year are also excluded.

Follow-Up After ED Visit for Substance Abuse – 30 days (FUA)

Measure description

The percentage of emergency department (ED) visits among members ages 13 and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which the member received follow-up within 30 days of the ED visit (31 total days).

Provider action

- To prevent ED visits for substance use disorders, consider routinely screening patients for mental health concerns, including depression, anxiety, unhealthy alcohol use, or other substance use conditions. Act on positive screens by partnering with the patient and connecting the patient to a behavioral health provider for treatment.
- Providers or staff notified of a patient's recent ED visit should the patient within 24 to 48 hours via phone to assess the patient's health status, medications, needed appointments, and what to do if a health or medical problem arises.
- Telehealth, phone visits, e-visits or virtual check-ins with a principal diagnosis of a mental health support follow-up requirements. Visits that occur on the date of the ED visit are also compliant.

- Consider a prompt referral to a behavioral health provider to start treatment within seven days of the ED visit.

Codes

Substance Use Disorder Diagnosis codes: Refer to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) at www.psychiatry.org/psychiatrists/practice/dsm for diagnosis codes.

Outpatient Visit: *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, 99251, 99252, 99253, 99254, 99255

Behavioral Health Outpatient Visit: *CPT* 98960, 98961, 98962, 99078, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 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;

(continued)

HCPCS G0155, G0176, G0177, G0409, G0463, G0512, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, T1015

Telehealth visits: *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, 99251, 99252, 99253, 99254, 99255 With Point of Service (POS) Code 02

Phone Visits: *CPT* 98966–98968; 99441–99443

E-visit or virtual check in: *CPT* 98969–98972, 99421–99444, 99457; *HCPCS* G0071, G2010, G2012, G2061, G2062, G2063

Substance use disorder service: *CPT* 99408, 99409; *HCPCS* G0396, G0397, G0443, H0001, H0005, H0007, H0015, H0016, H0022, H0047, H0050, H2035, H2036, T1006, T1012

Substance use service: *HCPCS* H0006, H0028

Behavioral health screening or assessment for SUD or mental health disorders: *CPT* 99408, 99409; *HCPCS* G0396, G0397, G0442, G2011, H0001, H0002, H0031, H0049

Pharmacotherapy dispensing event for Alcohol or other drug medication treatment: *HCPCS* H0020, H0033, J0570, J0571, J0572, J0573, J0574, J0575, J2315, Q9991, Q9992, S0109

Pharmacotherapy dispensing event for Opioid use disorder weekly drug treatment service: *HCPCS* G2067, G2068, G2069, G2070, G2072, G2073

Weekly or monthly opioid drug treatment service: *HCPCS* G2086, G2087, G2067, G2068, G2069, G2070, G2072, G2073, G2071, G2074, G2075, G2076, G2077, G2080

Exclusions

If a member has more than one ED visit in a 31-day period, include only the first eligible ED visit. Exclude the subsequent ED visits during the 31-day period. Include only the first applicable ED visit per 31-day period. For example, if a member has an ED visit on January 1, include the January 1 visit and do not include ED visits that occur on or between January 2 and January 31; then, if applicable, include the next ED visit that occurs on or after February 1.

Exclude ED visits that result in an inpatient stay and ED visits followed by an 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, regardless of the principal diagnosis for the admission.

Exclude patients in hospice or using hospice services anytime during the calendar year.

Follow-Up After ED Visit for Mental Illness – 30 days (FUM)

Measure description

The percentage of emergency department (ED) visits among members ages 6 and older with a principal diagnosis of mental illness or intentional self-harm, for which the member received follow-up within 30 days of the ED visit (31 total days).

Provider action

- To prevent ED visits for mental illness, consider routinely screening patients for mental health concerns, including depression, anxiety, unhealthy alcohol use or other substance use conditions. Act on positive screens by partnering with the patient and connecting the patient to a behavioral health provider for treatment.
- Providers or staff notified of a patient's recent ED visit should the patient within 24 to 48 hours via phone to assess the patient's health status, medications, needed appointments, and what to do if a health or medical problem arises.
- Telehealth, phone visits, e-visits or virtual check-ins with a principal diagnosis of a mental health support follow-up

requirements. Visit that occur on the date of the ED visit are also compliant.

- Consider a prompt referral to a behavioral health provider to start treatment within seven days of the ED visit.
- If providing follow-up care, please document the follow-up visit appropriately, using the below criteria:
  - The type of follow-up visit with a principal diagnosis of a mental health disorder, or
  - The type of follow-up visit with a principal diagnosis of intentional self-harm and any diagnosis of a mental health disorder.

Codes

(A follow-up visit must be paired with a principal diagnosis of a mental health disorder, or principal diagnosis of intentional self-harm with any diagnosis of a mental health disorder)

Mental Health or Intentional Self-Harm Diagnosis codes: Refer to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) at www.psychiatry.org/psychiatrists/practice/dsm for diagnosis codes.

Outpatient Visit: *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, 99251, 99252, 99253, 99254, 99255 with outpatient place of service (POS) 03, 05, 07, 09, 11-20, 22, 33, 49, 50, 71, 72

Behavioral Health Outpatient Visit: *CPT* 98960, 98961, 98962, 99078, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 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, G0176, G0177, G0409, G0463, G0512, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, T1015

Telehealth visits: *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, 99251, 99252, 99253, 99254, 99255 with point of service (POS) Code 02

Phone Visits: *CPT* 98966–98968; 99441–99443

E-visit or virtual check in: *CPT* 98969–98972, 99421–99444, 99457; *HCPCS* G0071, G2010, G2012, G2061, G2062, G2063

Community Mental Health Center:
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, 99251, 99252, 99253, 99254, 99255 with community mental health center POS 53

Observation visit: *CPT* 99217-99220

Exclusions

If a member has more than one ED visit in a 31-day period, include only the first eligible ED visit. Exclude the subsequent ED visits during the 31-day period. Include only the first applicable ED visit per 31-day period. For example, if a member has an ED visit on January 1, include the January 1 visit and do not include ED visits that occur on or between January 2 and January 31; then, if applicable, include the next ED visit that occurs on or after February 1.

Exclude ED visits that result in an inpatient stay and ED visits followed by an 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, regardless of the principal diagnosis for the admission.

Exclude patients in hospice or using hospice services anytime during the calendar year.

Community Health Plan of Imperial Valley (“CHPIV”) is the Local Health Authority (LHA) in Imperial County, providing services to Medi-Cal enrollees in Imperial County. CHPIV contracts with Health Net Community Solutions, Inc. to arrange health care services to CHPIV members. *Health Net Community Solutions, Inc. is a subsidiary of Health Net, LLC and Centene Corporation. Health Net is a registered service mark of Health Net, LLC. All other identified trademarks/service marks remain the property of their respective companies. All rights reserved.

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