Health Net®
COMMUNITY SOLUTIONS

2020-2021 HEDIS® Provider Pocket Guide

Coverage for every stage of life™

Table of Contents

(continued)

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 2021, the California Department of Health Care Services (DHCS) All Plan Letter (APL) requirements and the NCQA HEDIS Measurement Year 2020 and 2021 Volume 2 Technical Specifications, released on July 2020.

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 visit/well-care:

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, preventative 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 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.

Codes

Doses	Name of antigen	Codes
4	**DTaP**[1]	*CPT* 90698*, 90700, 90723*
4	**PCV**[1]	*CPT* 90670; *HCPCS* G0009
3	**IPV**[1]	*CPT* 90698*, 90713, 90723*
3	**HiB**[1]	*CPT* 90644, 90647, 90698*, 90748*
3	**Hep B**[2]	*CPT* 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:** *CPT* 90705; *ICD-10* B05.0–B05.4, B05.81, B05.89, B05.9 • **Rubella:** *CPT* 90706; *ICD-10* B06.00–B06.02, B06.09, B06.81, B06.82, B06.89, B06.9 • **Mumps:** *CPT* 90704; *ICD-10* B26.0–B26.3, B26.81–B26.85, B26.89, B26.9

(continued)

Doses	Name of antigen	Codes
1	**MMR**[2,4] (cont.)	*CPT* 90707, 90710* or combination of vaccines with all three antigens (cont.): • **Measles/rubella:** *CPT* 90708 • **Mumps:** *CPT* 90704; *ICD-10* B26.0–B26.3, B26.81–B26.85, B26.89, B26.9
2	**Flu**[3]	*CPT* 90655, 90657, 90660, 90661, 90672, 90685–90689; *HCPCS* G0008
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 two.**

[4]Vaccine must be administered on or between the child's first and second birthday

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

Exclusion codes

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

For any vaccine:

- **Anaphylactic reaction due to vaccine:** *ICD-10* T80.52XA, T8052XD, T80.52XS

For DTaP:

- **Encephalopathy due to vaccine** (with vaccine causing adverse effect code): *ICD-10* G04.32
- **Vaccine causing adverse effect:** *ICD-10* T50.A15A, T50.A15D, T50.A15S

For MMR, VZV and influenza:

- **Disorder of the immune system:** *ICD-10* D80.0–D81.2, D81.4, D81.6, D81.7, D81.89, D81.9–D82.4, D82.8–D83.2, D83.8–D84.1, D84.8, D84.9, D89.3, D89.810–D89.813, D89.82, D89.89, D89.9
- **HIV:** B20, B97.35, Z21

(continued)

- **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
- **History of intussusception:** *ICD-10* K56.1

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.

Refer to the Addendum section at the end for the guide for hospice 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.

- 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 (2 doses with dates of services at least 146 days apart on or between child's 9th and 13th birthdays; or 3 doses on or between child's 9th and 13th birthdays if interval between doses is less than 146 days): *CPT* 90649–90651

Exclusion codes:
Patients who are in hospice or have the following vaccine contraindications are excluded:

For any vaccine:

- **Anaphylactic reaction to vaccine:** *ICD-10* T80.52XA, T8052XD, T80.52XS

For Tdap:

- **Encephalopathy due to vaccine** (with vaccine causing adverse effect code): *ICD-10* G04.32
- **Vaccine causing adverse effect:** *ICD-10* T50.A15A, T50.A15D, T50.A15S

Refer to the Addendum section at the end for the guide for hospice codes.

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 ages 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 codes

Patients who are in hospice are excluded. Refer to the Addendum section at the end for the guide for hospice codes.

[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 listed on pages 2–3 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

NEW! **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.

NEW! **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 2020 and 2021. 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, Z02.5, Z76.1, Z76.2

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

Exclusion codes

Patients who are in hospice are excluded. Refer to the Addendum section at the end for the guide for hospice codes.

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)

NEW! **Telephone visit:** *CPT* 98966–98968, 99441–99443

NEW! **Online assessment** (e-visits or virtual check-ins): *CPT* 98969–98972, 99421–99423, 99444, 99458;
ICD-10 G2010, G2012, G2062, G2063

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

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 codes

Patients who are in hospice are excluded from the measure. Refer to the Addendum section at the end of guide for hospice codes.

[6]Services rendered during a telephone 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 < 140/90 mm Hg (CBP)

Comprehensive Diabetes Care (CDC)

- HbA1c Testing
- HbA1c Poor Control (> 9.0%)

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, telephone visits (only three telephone 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

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

Online Assessments (e-visits or virtual check-ins): *CPT* 98969–98972, 99421–99423, 99444; 99458;
HCPCS G2010, G2012, G2061–G2063

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

Exclusion codes

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

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

Other emphysema: *ICD-10* J98.2–J98.3

COPD: *ICD-10* J44.0, J44.1, J44.9

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.

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; *HCPCS* G0202, G0204, G0206

Exclusion codes

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.

Bilateral mastectomy: *ICD-10* 0HTV0ZZ; *Modifier:* 50

Unilateral mastectomy with bilateral modifier: *ICD-10* 0HTU0ZZ, 0HTT0ZZ; *CPT* 19180, 19200, 19220, 19240, 19303–19307; *Modifier:* RT, LT

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

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

Refer to the Addendum section for additional information on frailty and advance illness exclusion criteria, and for hospice and palliative care codes.

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

HPV: *CPT* 87620–87622, 87624, 87625;
HCPCS G0476

Exclusion codes

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

(continued)

Hysterectomy with no residual cervix:
CPT 51925, 56308, 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

Refer to the Addendum section at the end for the guide for hospice and palliative care codes.

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.

Codes

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

Exclusion codes

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

Pregnancy test: *CPT* 81025, 84702, 84703

Refer to the Addendum section at the end of the guide for hospice and palliative care codes.

Controlling High Blood Pressure < 140/90 mm Hg (CBP)

Measure description

The percentage of patients ages 18–85 with hypertension whose blood pressure (BP) was adequately controlled 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

Determine the representative BP:

- Identify the most recent BP reading recorded during January 1 to June 30 of the measurement year on or after the second diagnosis of hypertension.

- If multiple BP readings were recorded on a single date, use the lowest systolic and lowest diastolic BP on that date as the representative BP. The systolic and diastolic results do not need to be from the same reading.

If no BP was recorded during the measurement year or if the reading is incomplete, assume that the patient is "not controlled."

Bill BP CPT Cat II codes on each office visit claim along with a hypertensive condition.

BP readings from a remote monitoring device that are digitally stored and transmitted to the provider are acceptable, but reading methodology must be documented in the medical record and interpreted by the provider.

Instruct staff to take a repeat reading if abnormal BP is obtained.

Promote use of proper BP monitoring technique by staff taking BP readings.

Codes

Hypertension: *ICD-10* I10

Systolic: *CPT Cat. II* 3074F, 3075F, 3077F

Diastolic: *CPT Cat. II* 3078F, 3079F, 3080F

Remote blood pressure monitoring: *CPT* 93784, 93788, 93790, 99091, 99453, 99454, 99457, 99473, 99474

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

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

NEW! **Telephone visit:** *CPT* 98966–98968, 99441–99443

NEW! **Online assessment** (e-visit or virtual check-in): *CPT* 98969–98972, 99421–99423, 99444, 99458;
HCPCS G2010, G2012, G2061, G2062, G2063

Exclusions

The following patients are excluded from the measure:

- Patients in hospice, pregnant or receiving palliative care during the measurement year.
- Patients who had a nonacute inpatient admission during the measurement year.
- Patients with evidence of end-stage renal disease (ESRD), dialysis, nephrectomy or kidney transplant.
- Patients ages 66–80 with both frailty and advanced illness during the measurement year. (Refer to the Frailty and Advanced Illness section in the Addendum at the end of the guide for additional information)
- Patients ages 81 and older as of December 31 with frailty during the measurement year.

Refer to the Addendum section at the end of guide for exclusion codes.

Comprehensive Diabetes Care (CDC)

Measure Description

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

- HbA1c testing.
- 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).

Diabetic patients are identified through the following:

- Patient was dispensed insulin or hypoglycemics/ antihyperglycemics during the current or prior measurement year.
- Patient a had diagnosis of diabetes with either:
  - At least one acute inpatient visit without telehealth, or
  - At least two of any of the following visit types on different dates of service: non-acute inpatient visit without telehealth, outpatient visit, observation visit, telephone visit, e-visits or virtual check-ins, or ED visit.

If result is missing or test was not done during measurement year then member will be counted as poorly controlled.

Provider Action

Schedule appointments and complete services for patients ages 18–75 with diagnosis of diabetes on an annual basis to assist with health maintenance of the disease processes.

The following services are required:

- Order at least one HbA1c screening annually. Repeat test if A1c is greater than 7.9%.
- Collect A1c data completed during inpatient visits or elsewhere in order to evaluate if a repeat test is required.

Bill CPT II codes for negative screenings from prior year's screenings within the measurement year.

Codes

Diabetes: Refer to the Addendum section at the end for the guide for diabetes codes.

HbA1c Lab Test: *CPT* 83036, 83037

HbA1c Test Result or Finding:
CPT Cat. II 3044F, 3046F, 3051F, 3052F

Exclusions

Patients are excluded if they:

- Received palliative care in the measurement year.
- Are in hospice.
- Are ages 66 and older with both frailty and advanced illness during the measurement year.
- Do not have a diagnosis of diabetes during the current or prior measurement year and had a diagnosis of polycystic ovarian syndrome, gestational or steroid-induced diabetes (optional exclusion).

Refer to the Addendum section for additional information on frailty and advance illness exclusion criteria, and for hospice and palliative care codes.

Maternal Health Care

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

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

Maternal Health Care

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.

(continued)

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

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

NEW! **Telephone 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. Refer to the Addendum section at the end of this guide for hospice codes.

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.

(continued)

- 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, 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.

Refer to the Addendum section at the end of this guide for hospice or acute inpatient visit codes.

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)

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.

Continuation phase. The percentage of patients who remained on medication for at least 180 days (6 months) within 232 days from earliest prescription dispense date.

Antidepressant medications

Miscellaneous antidepressants: Bupropion, Vilazodone and Vortioxetine

Monoamine oxidase inhibitors: Isocarboxazid, Phenelzine, Selegiline and Tranylcypromine

Phenylpiperazine antidepressants: Nefazodone and Trazodone

(continued)

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 treated.

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 1 refill) via phone calls, medication prompts, or case management.

Codes

Major depression: *ICD-10* F32.0–F32.4, F32.9, F33.0–F33.3, F33.41, F33.9

Follow the listed guidelines when coding for specific behavioral health (BH) visit types with a major depression diagnosis code. Refer to the Addendum section at the end of the guide for value set codes.

- **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.
- **Telephone visit:** Use the Telephone 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 medication.

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.

(continued)

- Have routine lab tests scheduled to be 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

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. Refer to the Addendum section at the end of the guide for hospice codes.

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. 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. Refer to the Addendum section at the end of the guide for value set codes.

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.

(continued)

- **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.
- **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.
- ***NEW!*** **Telehealth visit:** Use the visiting setting unspecific value set, with telehealth POS value set.
- **Telephone visit:** Use the telephone visits value set.
- ***NEW!*** **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, telephone 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.

Refer to the Addendum section at the end for the guide for diabetes diagnosis codes.

Addendum

Frailty and Advanced Illness Exclusion Criteria

Value Sets for Event and Diagnosis Criteria

Value Sets for Patient Setting Criteria

Addendum

Frailty and Advanced Illness Exclusion Criteria

Patients ages 66 and older as of December 31 of the measurement year with both frailty and advanced illness. To meet exclusion criteria, there must be a frailty claim or encounter during the measurement year and either one of the following during the measurement year or the year prior:

- At least two of any of the following on different dates of service: outpatient, observation, ED, telephone, online assessment, or nonacute inpatient visits (encounter or discharge) with a diagnosis of advanced illness on the discharge claim.
- An acute inpatient visit (encounter or discharge) with diagnosis of advanced illness on the discharge claim.
- A dispensed dementia medication.

Value Sets for Event and Diagnosis Criteria

ESRD: *ICD-10* N18.5, N18.6, Z99.2

Diabetes: *ICD-10* E10.10, E10.11, E10.21, E10.22, E10.29, E10.311, E10.319, E10.321, E10.3211–E10.3213, E10.3219, E10.329, E10.3291–E10.3293, E10.3299, E10.331, E10.3311–E10.3313, E10.3319, E10.339, E10.3391–E10.3393, E10.3399, E10.341, E10.3411–E10.3413, E10.3419, E10.349, E10.3491–E10.3493, E10.3499, E10.351, E10.3511–E10.3513, E10.3519, E10.3521– E10.3523, E10.3529, E10.3531–E10.3533, E10.3539, E10.3541–E10.3543, E10.3549, E10.3551–E10.3553, E10.3559, E10.359, E10.3591–E10.3593, E10.3599, E10.36, E10.37X1–E10.37X3, E10.37X9, E10.39–E10.44, E10.49, E10.51, E10.52, E10.59, E10.610, E10.618, E10.620–E10.622, E10.628, E10.630, E10.638, E10.641, E10.649, E10.65, E10.69, E10.8, E10.9, E11.00, E11.01, E11.10, E11.11, E11.21, E11.22, E11.29, E11.311, E11.319, E11.321, E11.3211–E11.3213, E11.3219, E11.329, E11.3291–E11.3293, E11.3299, E11.331, E11.3311–E11.3313, E11.3319, E11.339, E11.3391–E11.3393, E11.3399, E11.341, E11.3411–E11.3413, E11.3419, E11.349, E11.3491–E11.3493, E11.3499, E11.351, E11.3511–E11.3513, E11.3519, E11.3521–E11.3523, E11.3529, E11.3531–E11.3533, E11.3539, E11.3541–E11.3543, E11.3549, E11.3551–E11.3553, E11.3559, E11.359, E11.3591–E11.3593, E11.3599, E11.36, E11.37X1–E11.37X3, E11.37X9, E11.39–E11.44. E11.49, E11.51, E11.52, E11.59, E11.610, E11.618, E11.620–E11.622, E11.628, E11.630, E11.638, E11.641, E11.649, E11.65, E11.69, E11.8, E11.9, E13.00, E13.01, E13.10, E13.11, E13.21, E13.22, E13.29, E13.311, E13.319,

E13.321, E13.3211–E13.3213, E13.3219, E13.329, E13.3291–E13.3293, E13.3299, E13.331, E13.3311–E13.3313, E13.3319, E13.339, E13.3391–E13.3393, E13.3399, E13.341, E13.3411–E13.3413, E13.3419, E13.349, E13.3491–E13.3493, E13.3499, E13.351, E13.3511–E13.3513, E13.3519, E13.3521–E13.3523, E13.3529, E13.3531–E13.3533, E13.3539, E13.3541–E13.3543, E13.3549, E13.3551–E13.3553, E13.3559, E13.359, E13.3591–E13.3593, E13.3599, E13.36, E13.37X1–E13.37X3, E13.37X9, E13.39–E13.44, E13.49, E13.51, E13.52, E13.59, E13.610, E13.618, E13.620–E13.622, E13.628, E13.630, E13.638, E13.641, E13.649, E13.65, E13.69, E13.8, E13.9, O24.011, O24.011–O24.013, O24.019, O24.02, O24.03, O24.111–O24.113, O24.119, O24.12, O24.13, O24.311–O24.313, O24.319, O24.32, O24.33, O24.811–O24.813, O24.819, O24.82–O24.83

Nephrectomy: *CPT* 50340, 50370;
ICD-10 0TB00ZX, 0TB00ZZ, 0TB03ZX, 0TB03ZZ, 0TB04ZX, 0TB04ZZ, 0TB07ZX, 0TB07ZZ, 0TB08ZX, 0TB08ZZ, 0TB10ZX, 0TB10ZZ, 0TB13ZX, 0TB13ZZ, 0TB14ZX, 0TB14ZZ, 0TB17ZX, 0TB17ZZ, 0TB18ZX, 0TB18ZZ

Kidney transplant: *CPT* 50360, 50365, 50380;
HCPCS S2065;
ICD-10 0TY00Z0–0TY00Z2, 0TY10Z0– 0TY10Z2

Frailty diagnosis: *ICD-10* L89.000–L89.004, L89.006, L89.009–L89.014, L89.016, L89.019–L89.024, L89.026, L89.029, L89.100– L89.104, L89.106, L89.109–L89.114, L89.116, L89.119–L89.124, L89.126, L89.129–L89.134, L89.136, L89.139–L89.144, L89.146, L89.149–L89.154, L89.156, L89.159, L89.200–L89.204, L89.206, L89.209–

(continued)

L89.214, L89.216, L89.219–L89.224, L89.226, L89.229, L89.300–L89.304, L89.306, L89.309–L89.314, L89.316, L89.319–L89.324, L89.326, L89.329, L89.40–L89.46, L89.500–L89.504, L89.506, L89.509–L89.514, L89.516, L89.519–L89.524, L89.526, L89.529, L89.600–L89.604, L89.606, L89.609–L89.614, L89.616, L89.619–L89.624, L89.626, L89.629, L89.810–L89.814, L89.816, L89.819, L89.890–L89.894, L89.896, L89.899, L89.90–L89.96, M62.50, M62.81, M62.84, W01.0XXA, W01.0XXD, W01.0XXS, W01.10XA, W01.10XD, W01.10XS, W01.110A, W01.110D, W01.110S, W01.111A, W01.111D, W01.111S, W01.118A, W01.118D, W01.118S, W01.119A, W01.119D, W01.119S, W01.190A, W01.190D, W01.190S, W01.198A, W01.198D, W01.198S, W06.XXXA, W06.XXXD, W06.XXXS, W07.XXXA, W07.XXXD, W07.XXXS, W08.XXXA, W08.XXXD, W08.XXXS, W10.0XXA, W10.0XXD, W10.0XXS, W10.1XXA, W10.1XXD, W10.1XXS, W10.2XXA, W10.2XXD, W10.2XXS, W10.8XXA, W10.8XXD, W10.8XXS, W10.9XXA, W10.9XXD, W10.9XXS, W18.00XA, W18.00XD, W18.00XS, W18.02XA, W18.02XD, W18.02XS, W18.09XA, W18.09XD, W18.09XS, W18.11XA, W18.11XD, W18.11XS, W18.12XA, W18.12XD, W18.12XS, W18.2XXA, W18.2XXD, W18.2XXS, W18.30XA, W18.30XD, W18.30XS, W18.31XA, W18.31XD, W18.31XS, W18.39XA, W18.39XD, W18.39XS, W19.XXXA, W19.XXXD, W19.XXXS, Y92.199, Z59.3, Z73.6, Z74.01, Z74.09, Z74.1–Z74.3, Z74.8, Z74.9, Z91.81, Z99.11, Z99.3, Z99.81, Z99.89

Frailty encounter: *CPT* 99504, 99509; *HCPCS* G0162, G0299, G0300, G0493, G0494, S0271, S0311, S9123, S9124, T1000–T1005, T1019–T1022, T1030, T1031

Frailty symptom: *ICD-10* R26.0–R26.2, R26.89, R26.9, R41.81, R53.1, R53.81, R53.83, R54, R62.7, R63.4, R63.6, R64

Frailty device: *HCPCS* E0100, E0105, E0130, E0135, E0140, E0141, E0143, E0144, E0147–E0149, E0163, E0165, E0167, E0168, E0170, E0171, E0250, E0251, E0255, E0256, E0260, E0261, E0265, E0266, E0270, E0290–E0297, E0301–E0304, E0424, E0425, E0430, E0431, E0433–E0435, E0439–E0444, E0462, E0465, E0466, E0470–E0472, E0561, E0562, E1130, E1140, E1150, E1160, E1161, E1240, E1250, E1260, E1270, E1280, E1285, E1290, E1295–E1298

Advanced illness: *ICD-10* A81.00, A81.01, A81.09, C25.0–C25.4, C25.7–C25.9, C71.0–C71.9, C77.0–C77.5, C77.8, C77.9, C78.00–C78.02, C78.1, C78.2, C78.30, C78.39, C78.4–C78.7, C78.80, C78.89, C79.00–C79.02, C79.10, C79.11, C79.19, C79.2, C79.31, C79.32, C79.40, C79.49, C79.51, C79.52, C79.60–C79.62, C79.70–C79.72, C79.81, C79.82, C79.89, C79.9, C91.00, C91.02, C92.00, C92.02, C93.00, C93.02, C93.90, C93.92, C93.Z0, C93.Z2, C94.30, C94.32, F01.50, F01.51, F02.80, F02.81, F03.90, F03.91, F04, F10.27, F10.96, F10.97, G10, G12.21, G20, G30.0, G30.1, G30.8, G30.9, G31.01, G31.09, G31.83, I09.81, I11.0, I12.0, I13.0, I13.11, I13.2, I50.1, I50.20–I50.23, I50.30–I50.33, I50.40–I50.43, I50.810–I50.814, I50.82–I50.84, I50.89, I50.9, J43.0–J43.2, J43.8, J43.9, J68.4, J84.10, J84.112, J84.17, J96.10–J96.12, J96.20–J96.22, J96.90–J96.92, J98.2, J98.3, K70.10, K70.11, K70.2, K70.30, K70.31, K70.40, K70.41, K70.9, K74.0–K74.2, K74.4, K74.5, K74.60, K74.69, N18.5, N18.6

Hospice encounter: *HCPCS* G9473–G9479, Q5003–Q5008, Q5010, S9126, T2042– T2046

Hospice intervention: *CPT* 99377, 99378; *HCPCS* G0182

Palliative care: *CPT Cat. II* G9054, M1017; *ICD-10* Z51.5

Dialysis: *CPT* 90935, 90937, 90945, 90947, 90997, 90999, 99512; *HCPCS* G0257, S9339; *ICD-10* 3E1M39Z, 5A1D00Z, 5A1D60Z, 5A1D70Z, 5A1D80Z, 5A1D90Z

Value Sets for Patient Setting Criteria

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

Acute inpatient POS: *POS* 21, 51

BH outpatient: *CPT* 98960–98962, 99078, 99201–99205, 99211–99215, 99241–99245, 99341–99345, 99347–99350, 99381–99387, 99391–99397, 99401–99404, 99411, 99412, 99483, 99510;
HCPCS G0155, G0176, G0177, G0409, G0463, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013–H2020, M0064, T1015

BH stand alone acute inpatient: *UBREV* 0100, 0101, 0110, 0111, 0112, 0113, 0114, 0119, 0120, 0121, 0122, 0123, 0124, 0129, 0130, 0131, 0132, 0133, 0134, 0139, 0140, 0141, 0142, 0143, 0144, 0149, 0150, 0151, 0152, 0153, 0154, 0159, 0160, 0164, 0167, 0169, 0200, 0201, 0202, 0203, 0204, 0206, 0207, 0208, 0209, 0210, 0211, 0212, 0213, 0214, 0219, 0720, 0721, 0722, 0723, 0724, 0729, 0987

BH stand alone nonacute inpatient: *CPT* 99325–99328, 99334–99337;
HCPCS H0017-H0019, T2048

Community mental health POS: *POS* 53

ED: *CPT* 99281–99285

ED POS: *POS* 23

Electroconvulsive therapy: *CPT* 90870

Inpatient stay: *UBREV* 0100, 0101, 0110, 0111, 0112, 0113, 0114, 0116, 0117, 0118, 0119, 0120, 0121, 0122, 0123, 0124, 0126, 0127, 0128, 0129, 0130, 0131, 0132, 0133, 0134, 0136, 0137, 0138, 0139, 0140, 0141, 0142, 0143, 0144, 0146, 0147, 0148, 0149, 0150, 0151, 0152, 0153, 0154, 0156, 0157, 0158, 0159, 0160, 0164, 0167, 0169, 0170, 0171, 0172, 0173, 0174, 0179, 0190, 0191, 0192, 0193, 0194, 0199, 0200, 0201, 0202, 0203, 0204, 0206, 0207, 0208, 0209, 0210, 0211, 0212, 0213, 0214, 0219, 1000, 1001, 1002

Nonacute inpatient: *CPT* 99304-99310, 99315, 99316, 99318, 99324-99328, 99334-99337

Nonacute inpatient POS: *POS* 21, 51

Nonacute inpatient stay: *UBREV* 0022, 0024, 0118, 0128, 0138, 0148, 0158, 0190, 0191, 0192, 0193, 0194, 0199, 0524, 0525, 0550, 0551, 0552, 0559, 0660, 0661, 0662, 0663, 0669, 1000, 1001, 1002

Observation: 99217-99220

Outpatient: *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

Outpatient POS: *CPT* 03, 05, 07, 09, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 22, 33, 49, 50, 71, 72

Online assessments (e-visits or virtual check-ins): 98969–98972, 99421–99423, 99444; 99458;
HCPCS G2010, G2012, G2061–G2063

Partial hospitalization or intensive outpatient: *HCPCS* G0410, G0411, H0035, H2001, H2012, S0201, S9480, S9484, S9485

Partial hospitalization POS: *POS* 52

Telehealth POS (outpatient): *POS* 02

Telehealth modifier: *Modifier* 95, GT

Telephone visits: *CPT* 98966–98968, 99441–99443

Transcranial magnetic stimulation: *CPT* 90867-90869

Visit setting unspecified: *CPT* 90791, 90792, 90832–90834, 90836–90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221–99223, 99231–99233, 99238, 99239, 99251–99255

20-939/BKT049568EH00 (12/20)