Health Net®

2021 HEDIS® Provider Pocket Guide

COMMERCIAL/MEDICARE

Coverage for every stage of life™

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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:

- Behavioral health
- Child/adolescent preventive health

(continued)

- Adult/older adult preventive health
- Chronic conditions
- Care coordination

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. Measures are derived from the NCQA HEDIS Measurement Year 2020 and 2021 Volume 2 Technical Specifications, released in July 2020.

Refer to the table below to find out if the HEDIS measure applies for commercial or Medicare product.

Areas of Focus	Measure Description		COMM	MCR
Behavioral Health	AMM[1]	Antidepressant Medication Management	✔	✔
	ADD[1]	Follow-up Care for Children Prescribed ADHD Medication	✔	
	IET	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	✔	✔
Child/ Adolescent Preventive Health	CIS-10	Childhood Immunization Status – Combo 10	✔	

Areas of Focus	Measure Description		COMM	MCR
Child/ Adolescent Preventive Health (cont.)	IMA-2	Immunizations for Adolescents – Combo 2	✓	
	WCC[1]	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents	✓	
Adult/ Older Adult Preventive Health	BCS[1]	Breast Cancer Screening	✓	✓
	CCS	Cervical Cancer Screening	✓	
	COL[1]	Colorectal Cancer Screening	✓	✓
	COA[1]	Care for Older Adults	✓	✓
Chronic Conditions	AMR[1]	Asthma Medication Ratio	✓	
	CBP[1]	Controlling Blood Pressure	✓	✓
	CDC[1]	Comprehensive Diabetes Care	✓	✓

Areas of Focus	Measure Description		COMM	MCR
Chronic Conditions (cont.)	SPC[1]	Statin Therapy for Patients with Cardiovascular Disease	✔	✔
	SPD[1]	Statin Therapy for Patients with Cardiovascular Disease	✔	✔
Care Coordination	TRC[1]	Transitions of Care		✔

[1]HEDIS measures with new telehealth accommodations.

General Tips

HEDIS Improvement Tips

Calculating HEDIS Rates

General Tips

HEDIS Improvement Tips

Use the below tips to help improve your HEDIS performance scores:

- **Submit claim/encounter data for services rendered.**
- **Ensure chart documentation reflects all services billed.**
- **Bill (or report by encounter submission) for all delivered services, regardless of contract status.**
- **Submit all claim/encounter data correctly and in a timely manner.**
- **Add CPT II codes to provide more details and reduce medical record request.**
- **Use the patient list provided by Health Net* to identify and perform outreach to patients with gaps in care.**
- **Avoid missed opportunities by taking advantage of every office visit (including sick visits) to provide preventive and chronic care.**
- **Review and evaluate appointment hours, access, scheduling process, billing and office/patient flow.**
- **Build care gap "alerts" within your electronic health record (EHR) system.**

Calculating HEDIS Rates

HEDIS rates can be calculated in two ways: administrative data or hybrid data.

- Administrative data consists of claims or encounter data submitted to the plan.
- Hybrid data consists of administrative data and sample of medical record data. It also requires review of a random sample of patient medical records to abstract data for services that were rendered, but were not reported to the plan through claims or encounter data.

Submitting accurate and timely claim and encounter data reduces the need for medical record review. If services are not billed or billed accurately, they are not included in the calculation. Providers and other health care staff should document to the highest specificity to aid with the most correct coding choice.

Questions

Contact the Quality Improvement Department by email at cqi_medicare@healthnet.com. For more information, visit www.ncqa.org.

Behavioral Health

Antidepressant Medication Management (AMM)

Follow-up Care for Children Prescribed ADHD Medication (ADD)

Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)

Behavioral Health

Antidepressant Medication Management (AMM)

Measure description

The percentage of patients ages 18 and older 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), for a total of 114 days from the earliest prescription dispense date.

Continuation phase. The percentage of patients who remained on medication for at least 180 days (6 months), for a total of 232 days from the 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

Assess patient's symptoms of depression using an age-appropriate standardized assessment, (e.g., the Patient Health Questionnaire (PHQ-9)), at baseline and various points in the patient's progression.

Encourage collaboration and communication with the patient's behavioral health provider or encourage the patient to complement medication with therapy. Assist the patient by calling their mental health benefit administrator on the back of their ID card to help connect them to a mental health provider for further treatment.

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.

Provide reassurance that depression is common and can be treated.

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.

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.

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

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.

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

Telehealth Accommodations

E-visits and virtual check-ins added to the event/diagnosis.

Follow-up Care for Children Prescribed ADHD Medication (ADD)

Measure description

The percentage of children newly prescribed an attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed.

Two rates are reported:

Initiation Phase. The percentage of patients ages 6–12 who had at least one follow-up visit with a provider with prescribing authority within 30 days of receiving a new ADHD medication.

Continuation and Maintenance Phase. The percentage of patients ages 6–12 who continued ADHD treatment for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a provider within 270 days (9 months) after the initiation phase ended.

ADHD medications

CNS stimulants: Dextroamphetamine, Dexmethylphenidate, Lisdexamfetamine, Methylphenidate, Methamphetamine

(continued)

Alpha-2 receptor agonists: Clonidine, Guanfacine

Miscellaneous ADHD medications: Atomoxetine

Provider action

Use an e-visit or virtual check-in for one of the visits after the first 30 days. Only one online assessment is allowed during the continuation and maintenance phase.

Schedule the first follow-up visit, while the patient is still in the office, to occur within the 30 days of the initial prescription to assess if the medication is working as expected and assess any adverse events.

Consider prescribing the first ADHD medication for a 21 or 30 day supply to encourage timely follow-up.

Refill the medication after the patient completes their office visit.

Schedule two more follow-up visits in the nine months after the first 30 days to continue to monitor your patient's progress. These visits must occur on different dates of service.

Refer patient for psychosocial care, if indicated. Assist the patient by calling their mental health benefit administrator on the back of their ID card to help connect them to a mental health provider for further treatment. Encourage communication and collaboration if a mental health provider is currently involved in their treatment.

Codes

Follow-up visits: *CPT* 96150–96154, 96156, 96158, 96189, 96164, 96165, 96167,96168, 96170, 96171, 98960–98962, 99078, 99201–99205, 99211–99215, 99217–99220, 99241–99245, 99341–99345, 99347–99350, 99381–99387, 99391–99397, 99401–99404, 99411, 99412, 99483, 99510;
HCPCS G0155, G0176, G0177, G0409–G0411, G0463, H0002, H0004, H0031, H0034–H0037, H0039, H0040, H2000, H2001, H2010–H2020, S0201,S9480, S9484, S9485, T1015

Telephone visits: CPT 98966–98968, 99441–99443

Telehealth modifier: 95, GT

Telehealth visits will be identified by the telehealth modifier or the presence of a telehealth point of service (POS) code

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

Note: Only one of the two continuation and maintenance phase visits may be an e-visit or virtual check-in.

Follow-up visits with POS: *CPT* 90791, 90792, 90832–90834, 90836–90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221–99223, 99231–99233, 99238, 99239, 99251–99255 **With POS:** 02 (telehealth), 03, 05, 07, 09, 11–20, 22, 33, 49, 50, 52, 53, 71, 72

Exclusions

Patients are excluded if they:

- Are in hospice. Refer to the Addendum section at the end of the guide for hospice codes.
- Filled an ADHD prescription 120 days prior to the index prescription start date (IPSD).
- Have a diagnosis of narcolepsy anytime during their history through December 31 of the measurement year (optional exclusion).
- Had an acute inpatient encounter for a mental, behavioral or neurodevelopmental disorder during the 30 days after the IPSD (initiation phase exclusion only).

- Had an acute inpatient encounter for a mental, behavioral or neurodevelopmental disorder during the 300 days after the IPSD (continuation and maintenance phase only).

Telehealth accommodations

Telehealth and telephone visits added to the initiation phase numerator.

E-visits and virtual check-ins added to the continuation and maintenance phase numerator and modified telehealth restrictions.

Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)

Measure description

The percentage of adolescent and adult patients with a new episode of alcohol or other drug (AOD) abuse or dependence who received the following:

- Initiation of AOD Treatment. The percent of patients who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth or medication treatment within 14 days of the AOD diagnosis.
- Engagement of AOD Treatment. The percent of patients who initiated treatment and who were engaged in ongoing AOD treatment within 34 days of the initiation visit. Engagement of treatment is defined as patients who either:
  1. had an opioid treatment service that bills monthly or had a visit that included medication administration within 34 days of the initiation event;

2. for patients that initiated with a medication treatment event and had two or more visits, where one was a medication treatment event;

3. for patients who did not initiate with a medication event had at least two visits, with at least one being a medication treatment event.

Provider action

- Screen patients annually using a standardized tool, such as the Alcohol Use Disorders Identification Test (AUDIT)-C or National Institute on Drug Abuse (NIDA), to identify substance use issues.
- Document identified substance abuse in the patient chart and provide the appropriate diagnosis code on all relevant claims, including associated follow-up visits and treatment services.
- Schedule a follow-up visit within 14 days of diagnosis and at least two additional visits within 30 days of the first follow-up visit. Follow-up treatment that takes place on the date of the diagnosis must be with different providers.

- Consider immediate referral to a behavioral health provider when giving a diagnosis of alcohol or other drug dependence. Assist the patient by calling their mental health benefit administrator on the back of their ID card to help connect them to a mental health provider for further treatment.
- Ask the patient who already has a mental health provider for written consent to collaborate with their existing mental health provider, to support coordination of care and treatment. Ensure the patient has written consent to have information shared between providers and the health plan.
- Educate patients on the effects of substance abuse and all treatment options, including medication treatment (please see examples for medication treatment below).

Alcohol Use Disorder Treatment Medications

Aldehyde dehydrogenase inhibitor: Disulfiram (oral)

Antagonist: Naltrexone (oral and injectable)

Other: Acamprosate (oral; delayed-release tablet)

Opioid Use Disorder Treatment Medications

Antagonist: Naltrexone (oral and injectable)

Partial agonist: Buprenorphine (sublingual tablet, injection, implant)

Buprenorphine/naloxone (sublingual tablet, buccal film, sublingual film)

Codes

Alcohol abuse and dependence:
ICD-10 F10.10, F10.120, F10.121, F10.129, F.10.14, F.10.150, F.10.151, F10.159, F10.180, F10.181, F10.182, F10.188, F10.19, F10.20, F10.220, F10.221, F10.229, F10.230, F10.231, F10.232, F10.239, F10.24, F10.250, F10.251, F10.259, F10.26, F10.27, F10.280, F10.281, F10.282, F10.288, F10.29

Opioid abuse and dependence:
ICD-10 F11.10, F11.120, F11.121, F11.122, F11.129, F11.14, F11.150, F11.151, F11.159, F11.181, F11.182, F11.188, F11.19, F11.20, F11.220–F11.222, F11.229, F11.23, F11.24, F11.250, F11.251, F11.259, F11.281, F11.282, F11.288, F11.29

Other drug abuse and dependence:
ICD-10 F12.10, F12.120–F12.122, F12.129, F12.150, F12.151, F12.159, F12.180, F12.188, F12.19, F12.20, F12.220, F12.221–F12.222, F12.229, F12.23, F12.250, F12.251, F12.259, F12.280, F12.288,

(continued)

F12.29, F13.10, F13.120, F13.121, F13.129, F13.14, F13.150, F13.151, F13.159, F13.180–F13.182, F13.188, F13.19, F13.20, F13.220, F13.221, F13.229, F13.230–F13.232, F13.239, F13.24, F13.250, F13.251, F13.259, F13.26, F13.27, F13.280–F13.282, F13.288, F13.29, F14.10, F14.120–F14.122, F14.129, F14.14, F14.150, F14.151, F14.159, F14.180–F14.182, F14.188, F14.19, 14.20, F14.220–F14.222, F14.229, F14.23, F14.24, F14.250, F14.251, F14.259, F14.280–F14.282, F14.288, F14.29, F15.10, F15.120, F15.121, F15.122, F15.129, F15.14, F15.150, F15.151, F15.159, F15.180–F15.182, F15.188, F15.19, F15.20, F15.220–F15.222, F15.229, F15.23, F15.24, F15.250, F15.251, F15.259, F15.280–F15.282, F15.288, F15.29, F16.10, F16.120–F16.122, F16.129, F16.14, F16.150, F16.151, F16.159, F16.180, F16.183, F16.188, F16.19, F16.20, F16.220, F16.221, F16.229, F16.24, F16.250, F16.251, F16.259, F16.280, F16.283, F16.288, F16.29, F18.10, F18.120, F18.121, F18.129, F18.14, F18.150, F18.151, F18.159, F18.17, F18.180, F18.188, F18.19, F18.20, F18.220, F18.221, F18.229, F18.24, F18.250, F18.251, F18.259, F18.27, F18.280, F18.288, F18.29, F18.90, F18.920, F18.921, F18.929, F18.94, F18.950, F18.951, F18.959, F18.97, F18.980, F18.988, F18.99, F19.10, F19.120–F19.122, F19.129, F19.14, F19.150, F19.151, F19.159, F19.16, F19.17, F19.180–F19.182, F19.188, F19.19, F19.20, F19.220–F19.222, F19.229, F19.230–F19.232, F19.239, F19.24,

F19.250, F19.251, F19.259, F19.26, F19.27, F19.280, F19.281, F19.282, F19.288, F19.29

Use the below visit codes along with one of the diagnosis codes above to capture initiation and engagement of AOD treatment.

IET stand alone visits: *CPT* 98960–98962, 99078, 99201–99205, 99211–99215, 99241–99245, 99341–99345, 99347–99350, 99384–99387, 99394–99397, 99401–99404, 99408, 99409, 99411, 99412, 99483, 99510; *HCPCS* G0155, G0176, G0177, G0396, G0397, G0409–G0411, G0443, G0463, H0001, H0002, H0004, H0005, H0007, H0015, H0016, H0020, H0022, H0031, H0034–H0037, H0039, H0040, H0047, H2000, H2001, H2010–H2020, H2035, H2036, S0201, S9480, S9484, S9485, T1006, T1012, T1015

Detoxification visits: *HCPCS* H0008–H0014; *ICD* HZ2ZZZZ;

ED visits: *CPT* 99281–99285;

Observation visits: *CPT* 99217–99220

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

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

OUD Weekly Non Drug Service (with opioid abuse and dependence diagnosis): *HCPCS* G2071, G2074–G2077, G2080

OUD Monthly Office Based Treatment (with opioid abuse and dependence diagnosis): *HCPCS* G2086, G2087

OUD Weekly Drug Treatment (with opioid abuse and dependence diagnosis): *HCPCS* G2067–G2070, G2072, G2073

IET Visit Group 1 and POS Group 1: *CPT* 90791, 90792, 90832–90834, 90836–90840, 90845, 90847, 90849, 90853, 90875, 90876

With POS: 02, 03, 05, 07, 09, 11–20, 22, 33, 49, 50, 52, 53, 57, 58, 71, 72 and diagnosis code (see above) for alcohol abuse and dependence, opioid abuse and dependence, other drug abuse and dependence

IET Visit Group 2 and POS Group 2: *CPT* 99221–99223, 99231–99233, 99238, 99239, 99251–99255

With POS: 02, 52, 53 and diagnosis code (see above) for alcohol abuse and dependence, opioid abuse and dependence, other drug abuse and dependence

AOD Medication Treatment: *HCPCS* H0020, H0033, J0570–J0575, J2315, Q9991, Q9992, S0109

Exclusions

Patients are excluded if they:

- Are in hospice. Refer to the Addendum section at the end of the guide for hospice codes.
- Had a claim/encounter with diagnosis of AOD abuse or dependence, AOD medication treatment or an alcohol or opioid dependency treatment medication dispensing event during the 60 days (two months) before the Index Episode Date (IESD).

Child/Adolescent Preventive Health

Childhood Immunization Status – Combination 10 (CIS-10)

Immunizations for Adolescents – Combination 2 (IMA-2)

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

Child/Adolescent Preventive Health

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

- 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 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 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

- **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 of 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 patients.
- Consider offering drop-in hours or after-hours appointments for patient 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 (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 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 of 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.[5]
- Counseling for physical activity.[5]

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.

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

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.

Note: Member-collected biometric values (height, weight, BMI percentile) are acceptable only if the information is collected by a primary care practitioner or specialist, if the specialist is providing a primary care service related to the condition being assessed, while taking a patient's history. The information must be recorded, dated and maintained in the member's legal health record.

Data files will require an outpatient visit on same date of service with NPI when submitting BMI percentiles.

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

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

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

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

Adult/Older Adults Preventive Health

Breast Cancer Screening (BCS)

Cervical Cancer Screening (CCS)

Colorectal Cancer Screening (COL)

Care for Older Adults (COA)

Adult/Older Adults Preventive Health

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 31 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.

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

Codes

Mammography: *CPT* 77055–77057, 77061–77063, 77065–77067;
HCPCS G0202, G0204, G0206

Exclusions

Patients are excluded if they:

- Have a history of bilateral mastectomy.
- Are in hospice.
- Received palliative care during the measurement year.
- Are Medicare patients ages 66 and older enrolled in an institutional special needs plans (I-SNP) or living long-term in an institution.
- Are ages 66 and older with frailty and advanced illness.

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

Bilateral mastectomy: *ICD-10* OHTV0ZZ; *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

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

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Exclusion codes

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

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, 58541–58544, 58548, 58550, 58552–58554, 58570–58573, 58575, 58951, 58953, 58954, 59856, 59135; *ICD-10* 0UTC0ZZ, 0UTC4ZZ, 0UTC7ZZ, 0UTC8ZZ, OUT90ZL, OUT90ZZ, OUT94ZL, OUT94ZZ, OUTC4ZZ, OUT97ZL, OUT97ZZ, OUT98ZL, OUTC7ZZ OUTC8ZZ, COUT9FZZ

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

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

Colorectal Cancer Screening (COL)

Measure description

The percentage of patients ages 50–75 who had appropriate screening for colorectal cancer. Any of the following meet criteria:

- Fecal occult blood test (FOBT) during the measurement year: guaiac-based (gFOBT) / immunochemical FOBT or fecal immunological test (FIT).
- Flexible sigmoidoscopy during the measurement year or the four years prior to the measurement year.
- Colonoscopy during the measurement year or the nine years prior.
- Computerized tomography (CT) colonography during the measurement year or four years prior.
- Fecal immunochemical test (FIT)-DNA (Cologuard®) test during the measurement year or two years prior.

Provider action

Need date and type of colorectal cancer screening(s) performed. A result is not required if the documentation is clearly part of the "medical history" section of the medical record. If it is not clear, results or findings need to be provided to show screening was performed and not just ordered.

Colonoscopy must be complete or evidence must show that the scope advanced beyond splenic flexure to be considered compliant within the time frame. An incomplete colonoscopy or evidence that the scope advanced into the sigmoid colon can be considered compliant as a flexible sigmoidoscopy.

Do not count digital rectal exam (DRE) or FOBT test performed in an office setting or performed on a sample collected via DRE as evidence of colorectal cancer screening.

Educate patients on the importance of colorectal cancer screening. Discuss different screening options and make a recommendation based on patients' risks and preferences.

Use standing orders and empower office staff to give FOBT or FIT kits to patients who need colorectal cancer screening or prepare referral for a colonoscopy.

Implement a FLU-FOBT program to increase access to colorectal cancer screening by offering home tests to patients at the time of their flu shots.

Codes

FOBT: *CPT* 82270, 82274; *HCPCS* G0328

Flexible sigmoidoscopy: *CPT* 45330–45335, 45337–45342, 45345–45347,45349, 45350; *HCPCS* G0104

Colonoscopy: *CPT* 44388–44394, 44397, 44401–44408, 45355, 45378–45393, 45398; *HCPCS* G0105, G0121

CT Colonography: *CPT* 74261–74263

FIT-DNA: *CPT* 81528; *HCPCS* G0464

Exclusion codes

Patients are excluded if they:

- Have a history of colorectal cancer (cancer of the small intestine does not count).
- Had a total colectomy (partial or hemicolectomies do not count).
- Are in hospice.
- Received palliative care in the measurement year.
- Are Medicare patients ages 66 and older enrolled in an institutional special needs plans (I-SNP) or living long-term in an institution.
- Are ages 66 and older with frailty and advanced illness.

Colorectal cancer: *HCPCS* G0213–G0215, G0231;
ICD-10 C18.0–C18.9, C19, C20, C21.2, C21.8, C78.5, Z85.038, Z85.048

Total colectomy: *CPT* 44150–44158, 44210–44212;
ICD-10 0DTE0ZZ, 0DTE4ZZ, 0DTE7ZZ, 0DTE8ZZ

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

Telehealth accommodations

Telephone visits, e-visits and virtual check-ins were added to the advanced illness exclusion.

Care for Older Adults (COA)

Measure description

The percentage of adults ages 66 and older, in a Special Needs Plan, who had each of the following during the measurement year:

- Advance care planning (e.g., living will, health care power of attorney, health care proxy, POLST, Five Wishes).
- Medication review by a prescribing provider or clinical pharmacist and presence of medication list.
- Functional status assessment (e.g., Activities of Daily Living [ADL] or Instrumental Activities of Daily Living [IADL], standardized functional status assessment tool).
- Pain status assessment (e.g., numeric pain scale, faces pain scale, present pain inventory).

Provider action

Provide evidence of advance care plan in the medical record or document advance care planning discussion with the provider and the date it was discussed or note that the patient previously executed an advance care plan.

Document the date of service of the medication review or notation of no medications.

A medication list signed and dated within the measurement year by the prescribing practitioner or clinical pharmacist meets criteria for medication review.

A review of side effects for a single medication at the time of prescription alone is not sufficient.

A medication review performed without the member present meets criteria.

Medication review, functional status assessment, and pain assessment conducted in an acute inpatient setting do not meet criteria.

For ADLs, note that at least five of the following were assessed: bathing, dressing, eating, transferring (e.g., getting up and down from sitting or lying position), using toilet or walking.

For IADLs, note that at least four of the following were assessed: grocery shopping, driving or using public transportation, using a phone, cooking or meal preparation, housework, home repair, laundry, taking medications, or handling finances.

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A functional status assessment limited to an acute or single condition, event or body system does not meet criteria for a comprehensive functional status assessment.

The components of the functional status assessment may take place during separate visits within the measurement year.

Document that the patient was assessed for pain (which may include positive or negative findings for pain) and the date when it was performed. Include results of assessment using a standardized pain assessment tool.

Notation of pain management plan alone or pain treatment plan alone.

Screening for chest pain alone or documentation of chest pain alone does not meet criteria.

Use a standardized template to capture COA components for patients ages 66 and older in EHR.

Codes

Advance care planning: *CPT* 99483,99497;
CPT II 1123F, 1124F, 1157F, 1158F;
HCPCS S0257;
ICD-10 Z66

Medication review: *CPT* 90863, 99483, 99605, 99606;
CPT II 1160F

Medication list: *CPT II* 1159F;
HCPCS G8427

Functional status assessment: *CPT* 99483;
CPT II 1170F;
HCPCS G0438, G0439

Pain status assessment: *CPT II* 1125F, 1126F

Transitional Care Management Services:
CPT 99495, 99496

Telehealth accommodations

Services rendered during a telephone visit, e-visit or virtual check-in meet criteria for the Advance Care Planning, Functional Status Assessment and Pain Assessment.

Chronic Conditions

Asthma Medication Ratio (AMR)

Controlling Blood Pressure (CBP)

Comprehensive Diabetes Care (CDC)

- Hemoglobin A1c (HbA1c) testing and control
- Retinal eye exam
- Medical attention for nephropathy
- Blood pressure control (< 140/90 mm Hg)

Statin Therapy for Patients with Cardiovascular Disease (SPC)

Statin Therapy for Patients with Diabetes (SPD)

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.[6]

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.

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[6]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* new codes 98969–98972, 99421–99423, 99444; 99458;
HCPCS G2010, G2012, G2061–G2063

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

Exclusions 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

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.

Remote measurements by any digital device 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 test.

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- Taken by the member using a non-digital device such as with a manual blood pressure cuff and a stethoscope.

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

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

Data files will require an outpatient visit on same date of service with NPI when submitting blood pressures.

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

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

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

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

Exclusions

Patients are excluded if they:

- Received palliative care in the measurement year.
- Are in hospice.
- Are Medicare patients ages 66 and older enrolled in an institutional special needs plans (I-SNP) or living long-term in an institution.
- Are ages 66–80 with frailty and advance illness (Refer to the Frailty and Advanced Illness section in the Addendum at the end of the guide for additional information).
- Are ages 81 and older with frailty.
- Have evidence of end-stage renal disease or had a kidney transplant or dialysis (optional exclusion).
- Have a diagnosis of pregnancy (optional exclusion).

(continued)

- Had nonacute inpatient admission during the measurement year (optional exclusion).
- Refer to the Addendum section for additional information on frailty, advanced illness exclusion criteria, hospice, and palliative care codes.

Telehealth accommodations

The restriction that only one of the two visits with a hypertension diagnosis be an outpatient telehealth, telephone visit, e-visit or virtual check-in when identifying the event/diagnosis was removed.

Telephone visits, e-visits and virtual check-ins were added to the advanced illness exclusion.

Telephone visits, e-visits and virtual check-ins were added as appropriate settings for BP readings.

The requirements for remote monitoring was removed to allow BPs taken by any digital device.

Comprehensive Diabetes Care (CDC)

Measure description

The percentage of patients ages 18–75 with diabetes who had each of the following:

- Hemoglobin A1c (HbA1c) testing and control.
- Retinal eye exam.
- Medical attention for nephropathy.[7]
- Blood pressure control (< 140/90 mm Hg).

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

Exclusions

Patients are excluded if they:

- Received palliative care in the measurement year.
- Are in hospice.
- Are Medicare patients ages 66 and older enrolled in an institutional special needs plans (I-SNP) or living long-term in an institution.
- Are ages 66 and older with frailty and advanced illness.

[7]Medical attention for nephropathy is only reported for the Medicare product line.

- 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.

Telehealth accommodations

- The restriction that only one of the two visits with a diabetes diagnosis be an outpatient telehealth, telephone visit, e-visit or virtual check-in when identifying the event/diagnosis was removed.
- Telephone visits, e-visits and virtual check-ins were added to the advanced illness exclusion.
- Telephone visits, e-visits and virtual check-ins were added as appropriate settings for blood pressure readings.
- The requirements for remote monitoring was removed to allow BPs taken by any digital device.

CDC – HbA1c testing and control

An HbA1c test performed during the measurement year with value. Depending on the test value, patients will fall into different categories of controls:

- HbA1c control < 8.0%
- HbA1c poor control > 9.0%[8]

Provider action

- Evaluate and document HbA1c every three to six months. The last HbA1c result of the year counts toward the HEDIS score.
- Must have date and most recent result during measurement year in chart – use reported value and not threshold for result. Documentation of A1c, HbA1c, HgbA1c, HB1c, Hemoglobin A1c, Glycohemoglobin A1c, Glycohemoglobin, Glycated hemoglobin and Glycosylated hemoglobin count toward the A1c testing indicator.
- If result is missing or test was not done during measurement year then member will be counted as poorly controlled.
- Re-evaluate patient's care plan and repeat testing as needed.

[8]A lower rate indicates better performance for this indicator (i.e., low rates of poor control indicate better care). For CMS Star Ratings, Diabetes Care – Blood Sugar Controlled is calculated as subtraction of the HbA1c poor control (>9.0%) rate from 100.

Codes

HbA1c test: *CPT* 83036, 83037

HbA1c test and level < 7.0%: *CPT II* 3044F

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

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

HbA1c test and level > 9.0%: *CPT II* 3046F

CDC – Retinal eye exam

Eye screening or monitoring for diabetic retinal disease. This includes diabetics who had any of the following:

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

Provider action

- Document date of service eye exam was rendered by an eye care professional and the results (specialty must be noted), **or**

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- A chart or photograph indicating the date when fundus photography was performed with evidence that the eye care professional reviewed the results. Alternatively, results may be read by a qualified reading center that operates under the direction of a medical director who is a retinal specialist or read by a system that provides an artificial intelligence (AI) interpretation, **or**
- Evidence that member had bilateral eye enucleation or acquired absence of both eyes:
  - Unilateral eye enucleation with a bilateral modifier
  - Two unilateral eye enucleations with service dates 14 days or more apart
  - Left unilateral eye enucleation and right unilateral enucleation on the same or different dates of service, **or**
- Documentation of a negative retinal or dilated eye exam must clearly note that the retinopathy was not present in the medical record.
- Review eye exam report (from an eye care professional) and place it in patient's medical record.

Codes

Diabetic Retinal Screening: *CPT* 67028, 67030, 67031, 67036, 67039, 67040–67043, 67101, 67105, 67107, 67108, 67110, 67113, 67121, 67141, 67145, 67208, 67210, 67218, 67220, 67221, 67227, 67228, 92002, 92004, 92012, 92014, 92018, 92019, 92134, 92225–92228, 92230, 92235, 92240, 92250, 92260, 99203–99205, 99213–99215, 99242–99245; *HCPCS* S0620, S0621, S3000

Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy: *CPT II* 2022F

Seven standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy: *CPT II* 2024F

Eye imaging validated to match diagnosis from seven standard field stereoscopic retinal photos results documented and reviewed; with evidence of retinopathy: *CPT II* 2026F

Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy: *CPT II* 2023F

(continued)

Seven standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy: *CPT II* 2025F

Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy: *CPT II* 2023F

Eye imaging validated to match diagnosis from seven standard field stereoscopic retinal photos results documented and reviewed; without evidence of retinopathy: *CPT II* 2033F

Diabetic retinal screening negative in prior year: *CPT II* 3072F

Unilateral eye enucleation: *CPT* 65091, 65093, 65101, 65103, 65105, 65110, 65112, 65114

Unilateral eye enucleation left: *ICD-10* 08T1XZZ

Unilateral eye enucleation right: *ICD-10* 08T0XZZ

Bilateral modifier: 50

CDC – Medical attention for nephropathy

A nephropathy screening or monitoring test or evidence of nephropathy. This includes diabetics who had any of the following:

- A nephropathy screening or monitoring test.
- Evidence of treatment for nephropathy or angiotensin converting enzyme (ACE) or angiotensin receptor blocker (ARB) therapy.
- Evidence of stage 4 chronic kidney disease (CKD), end-stage renal disease (ESRD), kidney transplant, or nephrology visit.

At least one ACE inhibitor or ARB dispensing event.

Provider action

- Document date urine protein screening was completed with result, **or**
- Provide confirmatory documentation such as proteinuria (unspecific), albuminuria (specific), BUN/creatinine ratio (urine), **or**
- Documentation of a visit to a nephrologist, kidney transplant or nephrectomy, **or**

(continued)

- Documentation of medical attention for diabetic nephropathy, ESRD, chronic renal failure (CRF), CKD, acute renal failure (ARF), renal insufficiency, renal dysfunction, dialysis, hemodialysis or peritoneal dialysis, **or**
- Clear evidence that patient received ACE/ARB therapy during the measurement year:
  - Documentation that a prescription for an ACE/ARB therapy was written, or
  - Documentation that a prescription for an ACE/ARB was filled, or
  - Documentation that patient took an ACE/ARB

Codes

Urine protein tests: *CPT* 81000–81003, 81005, 82042–82044, 84156

Positive microalbuminuria test result documented and reviewed: *CPT II* 3060F

Negative microalbuminuria test result documented and reviewed: *CPT II* 3061F

Positive macroalbuminuria test result documented and reviewed: *CPT II* 3062F

Documentation of treatment for nephropathy (eg, patient receiving dialysis, patient being treated for ESRD, CRF, ARF, or renal insufficiency, any visit to a nephrologist): *CPT II* 3066F

ACE or ARB therapy prescribed or currently being taken (CAD, CKD, HF): *CPT II* 4010F

CKD stage 4: *ICD-10* N18.4

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

Dialysis: *CPT* 90935, 90937, 90945, 90947, 90997, 90999, 99512;
HCPCS G0257, S9339;

Nephrectomy: *CPT* 50340, 50370

Kidney transplant: *CPT* 50360, 50635, 50380

ACE Inhibitor and ARB Medications

Angiotensin converting enzyme inhibitors: Benazepril, Captopril, Enalapril, Fosinopril, Lisinopril, Moexipril, Perindopril, Quinapril, Ramipril, Trandolapril

Angiotensin II inhibitors: Azilsartan, Candesartan, Eprosartan, Irbesartan, Losartan, Olmesartan, Telmisartan, Valsartan

(continued)

Anti-hypertensive combinations:
Amlodipine-benazepril, Amlodipine-hydrochlorothiazide-valsartan, Amlodipine-hydrochlorothiazide-olmesartan, Amlodipine-olmesartan, Amlodipine-perindopril, Amlodipine-telmisartan, Amlodipine-valsartan, Azilsartan-chlorthalidone, Benazepril-hydrochlorothiazide, Candesartan-hydrochlorothiazide, Captopril-hydrochlorothiazide, Enalapril-hydrochlorothiazide, Fosinopril-hydrochlorothiazide, Hydrochlorothiazide-irbesartan, Hydrochlorothiazide-lisinopril, Hydrochlorothiazide-losartan, Hydrochlorothiazide-moexipril, Hydrochlorothiazide-olmesartan, Hydrochlorothiazide-quinapril, Hydrochlorothiazide-telmisartan, Hydrochlorothiazide-valsartan, Nebivolol-valsartan, Sacubitril-valsartan, Trandolapril-verapamil

CDC – Blood pressure control (< 140/90 mm Hg)

The most recent BP reading taken during outpatient visit, telephone visit, e-visit or virtual check, non-acute inpatient encounter or remote monitoring event during the measurement year.

Provider action

- Determine the representative blood pressure (BP):
  - Identify the most recent BP reading noted during 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 is recorded during the measurement year or if the reading is incomplete, assume that the patient is "not controlled."
- Bill BP CPT II codes on each office visit claim along with a hypertensive condition.

(continued)

- 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 test.
  - Taken by the member using a non-digital device such as with a manual blood pressure cuff and a stethoscope.
- Remote measurements by any digital device are acceptable.
- Instruct staff to take a repeat reading if abnormal BP is obtained.
- Promote use of proper blood pressure monitoring technique by staff taking BP readings.

Codes

Systolic < 130 mm Hg: *CPT II* 3074F

Systolic 130–139 mm Hg: *CPT II* 33075F

Systolic ≥ 140 mm Hg: *CPT II* 3077F

Diastolic < 80 mm Hg: *CPT II* 33078F

Diastolic 80–89 mm Hg: *CPT II* 3079F

Diastolic ≥ 90 mm Hg: *CPT II* 3080F

Outpatient visits: *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

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

Online assessments: *CPT* 98969–98972, 99421–99423, 99444, 99458;
HCPCS G2010, G2012, G2061, G2062, G2063

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

Statin Therapy for Patients with Cardiovascular Disease (SPC)

Measure description

The percentage of males ages 21–75 and females ages 40–75 during the measurement year who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and met the following criteria. Two rates are reported:

- Received statin therapy. Patients who were dispensed at least one high-intensity or moderate-intensity statin medication during the measurement year.
- Statin adherence 80%. Patients who remained on a high-intensity or moderate-intensity statin medication for a least 80% of the treatment period.

Note: Index prescription start date (IPSD) is the earliest prescription dispensing date for any statin medication of at least moderate intensity during the measurement year. The treatment period begins on the IPSD through the last day of the measurement year.

Provider action

Educate patients on the benefits of statin medication to prevent cardiovascular events.

Educate and encourage patients to contact you if they think they are experiencing side effects.

If a patient has had previous intolerance to statins, consider a statin re-challenge using a different moderate- to high-intensity statin. Hydrophilic statins, such as pravastatin, fluvastatin and rosuvastatin, may have lower risk of myalgia side effects.

Document in the medical record patient conditions that exclude them from taking a statin and submit a claim with appropriate exclusion diagnosis code.

Encourage patients to obtain 90-day supplies at their pharmacy once they demonstrate they tolerate statin therapy.

Sample medications given to patients will not count for the measure.

Medications

High-intensity statin therapy:

Atorvastatin 40–80 mg
Amlodipine-atorvastatin 40–80 mg
Rosuvastatin 20–40 mg
Simvastatin 80 mg
Ezetimibe-simvastatin 80 mg

Moderate-intensity statin therapy:

Atorvastatin 10–20 mg
Amlodipine-atorvastatin 10–20 mg
Rosuvastatin 5–10 mg
Simvastatin 20–40 mg
Ezetimibe-simvastatin 20–40 mg
Pravastatin 40–80 mg
Lovastatin 40 mg
Fluvastatin 40–80 mg
Pitavastatin 2–4 mg

Exclusions

Patients are excluded if they:

- Received palliative care in the measurement year.
- Are in hospice.
- Have a pregnancy diagnosis during the measurement year or prior year.
- Have in vitro fertilization (IVF) in the measurement year or prior year
- Were dispensed at least one prescription for clomiphene during the measurement year or prior year.
- Have ESRD or dialysis during the measurement year or prior year.
- Have cirrhosis during the measurement year or the prior year.
- Have myalgia, myositis, myopathy or rhabdomyolysis during the measurement year.
- Are Medicare patients ages 66 and older enrolled in an institutional special needs plans (I-SNP) or living long-term in an institution.
- Are ages 66 and older with frailty and advanced illness.

Statin Therapy for Patients with Diabetes (SPD)

Measure description

The percentage of patients ages 40–75 during the measurement year with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) who met the following criteria. Two rates are reported:

- Received statin therapy. Patients who were dispensed at least one statin medication of any intensity during the measurement year.
- Statin adherence 80%. Patients who remained on statin medication of any intensity for a least 80% of the treatment period.

Note: Index prescription start date (IPSD) is the earliest prescription dispensing date for any statin medication of at least moderate intensity during the measurement year. The treatment period begins on the IPSD through the last day of the measurement year.

Provider action

Educate patients with diabetes of their increased risk of cardiovascular disease and the benefits of statin medication to prevent cardiovascular events.

Educate patients on the importance of statin medication adherence and address barriers as appropriate.

Educate and encourage patients to contact you if they think they are experiencing side effects.

If a patient has had previous intolerance to statins, consider a statin re-challenge to identify a tolerated statin or dose. Hydrophilic statins, such as pravastatin, fluvastatin and rosuvastatin, may have lower risk of myalgia side effects.

Document in the medical record patient conditions that exclude them from taking a statin and submit a claim with appropriate exclusion diagnosis code.

Encourage patients to obtain 90-day supplies at their pharmacy once they demonstrate they tolerate statin therapy.

Sample medications given to patients will not count for the measure.

Medications

High-intensity statin therapy:
Atorvastatin 40–80 mg,
Amlodipine-atorvastatin 40–80 mg,
Rosuvastatin 20–40 mg,
Simvastatin 80 mg,
Ezetimibe-simvastatin 80 mg

Moderate-intensity statin therapy:
Atorvastatin 10–20 mg,
Amlodipine-atorvastatin 10–20 mg,
Rosuvastatin 5–10 mg,
Simvastatin 20–40 mg,
Ezetimibe-simvastatin 20–40 mg,
Pravastatin 40–80 mg,
Lovastatin 40 mg,
Fluvastatin 40–80 mg, Pitavastatin 2–4 mg

Low-intensity statin therapy:
Simvastatin 5–10 mg,
Ezetimibe-simvastatin 10 mg,
Pravastatin 10–20 mg,
Lovastatin 10–20 mg,
Fluvastatin 20 mg, Pitavastatin 1 mg

Exclusions

Patients are excluded if they:

- Received palliative care in the measurement year.
- Are in hospice.
- Have one or more acute impatient or outpatient visits with a diagnosis of ischemic vascular disease (IVD) any time during the measurement year and year prior.
- Have a pregnancy diagnosis during the measurement year or prior year.
- Have cirrhosis in the measurement year or prior year.
- Have in vitro fertilization (IVF) in the measurement year or prior year.
- Were dispensed at least one prescription for clomiphene during the measurement year or prior year.
- Have ESRD or dialysis during the measurement year or prior year.
- Have cirrhosis during the measurement year or the prior year.
- Have myalgia, myositis, myopathy or rhabdomyolysis during the measurement year.

- Are Medicare patients ages 66 and older enrolled in an institutional special needs plans (I-SNP) or living long-term in an institution.
- Are ages 66 and older with frailty and advanced illness.
- Do not have a diagnosis of diabetes during the measurement year or year prior and had a diagnosis of polycystic ovarian syndrome, gestational or steroid-induced diabetes (optional exclusion).

Care Coordination

Transitions of Care (TRC)

Care Coordination

Transitions of Care (TRC)

Measure description

The percentage of discharges (acute or nonacute) for patients ages 18 and older who had each of the following. Four rates are reported:

- Notification of inpatient admission. Documentation of receipt of notification of inpatient admission on the day of admission through two days after the admission (three total days). This rate is collected through medical record review only; no administrative reporting is available.
- Receipt of discharge information. Documentation of receipt of discharge information on the day of discharge through two days after the discharge (three total days). This rate is collected through medical record review only; no administrative reporting is available.
- Patient engagement after inpatient discharge. Documentation of patient engagement (e.g., office visits, visits to the home, telehealth) provided within 30 days after discharge. Do not include patient engagement that occurs on the same date of discharge.

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- Medication reconciliation post-discharge. Documentation of medication reconciliation on the date of discharge through 30 days after discharge (31 total days). Medication reconciliation:
  - Is a type of review where the discharge medications are reconciled with the most recent medication list in the outpatient medical record.
  - Is conducted by a prescribing doctor, clinical pharmacist or registered nurse.
  - Does not have to be completed in a face-to-face visit.
  - Does not require the patient to be present.

Denominator

The denominator is based on discharges, not on patients. If patients have more than one discharge, all discharges on or between January 1 and December 1 of the measurement year are included in the denominator.

Only the last discharge applies if patient is readmitted within 30 days after discharge or in the case of a direct transfer to another acute or non-acute inpatient stay (such as a skilled nursing facility).

Note: Documentation in any outpatient medical record that is accessible to the PCP or ongoing care provider is eligible for use in reporting.

Provider action

- Notification of inpatient admission: Documentation in the medical record must include evidence of receipt of notification of inpatient admission with date/time stamp on the day of or through two days after the admission. Examples of this documentation include:
  - Communication between the emergency department, inpatient providers or staff and the member's PCP or ongoing care provider (e.g., phone call, email, fax).
  - Communication about the admission to the member's PCP or ongoing care provider through a health information exchange; an automated admission via discharge and transfer (ADT) alert system; or a shared electronic medical record (EMR) system.
  - Communication about admission to the member's PCP or ongoing care provider from the member's health plan.

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- Indication that a specialist admitted the member to the hospital and notified the member's PCP or ongoing care provider.
- Indication that the PCP or ongoing care provider placed orders for test and treatments during the member's inpatient stay.
- Indication that the admission was elective and the member's PCP or ongoing care provider was notified or had performed a preadmission exam.

The following notations or examples of documentation do not count as numerator compliant:

- Documentation that the member or the member's family notified the member's PCP or ongoing care provider of the admission.
- Documentation of notification that does not include a time frame or date and timestamp.

- Receipt of discharge information: Documentation in the medical record must include evidence of receipt of discharge information with date/time stamp on the day of or through two days after the discharge. Discharge information may be included in a discharge summary or summary of care record or be located in structured fields in an electronic health record (EHR). At a minimum, the discharge information must include all of the following:
  - Name of practitioner responsible for the patient's care during the inpatient stay.
  - Procedures or treatment provided.
  - Diagnoses at discharge.
  - Current medication list and allergies.
  - Test results, or documentation of pending/no pending test(s).
  - Instructions for patient-care post discharge.
- Patient engagement after inpatient discharge: Documentation must include evidence of patient engagement within 30 days after discharge. Any of the following will meet criteria:
  - An outpatient visit, including office visits and home visits.

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- A telephone visit.
- A synchronous telehealth visit where real-time interaction occurred between the member and provider using audio and video communication.
- An e-visit or virtual check-in (asynchronous telehealth where two-way interaction, which was not real-time, occurred between the member and provider).

- Medication reconciliation post-discharge: Documentation in the medical record must include evidence of medication reconciliation and the date it was performed. Any of the following meets the criteria:

	In Chart	Documentation Dated Within 30 Days of Discharge and Signed by Correct Provider Type
30-day post-discharge visit made	Current medication list in the progress notes	• Notation provider aware of admission, and • Evidence of medication reconciliation of discharge and current medications.

	In Chart	Documentation Dated Within 30 Days of Discharge and Signed by Correct Provider Type
No visit	Current medication list	• Notation of no new medications ordered on discharge, or • Notation to discontinue discharge medications, or • No changes to discharged medications, or • Notation that current and discharge medications reconciled, or • Notation that discharged medications were reviewed.
No visit	Current medication list discharge summary	• Documentation in discharge summary that the discharge medications were reconciled with the most recent outpatient medications, and • Discharge summary filed in chart within 30 days.

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Codes

Outpatient visits: *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

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

Online assessments: *CPT* 98969–98972, 99421–99423, 99444, 99458;
HCPCS G2010, G2012, G2061, G2062, G2063

Telehealth modifier: 95, GT

Transitional care management services: *CPT* 99496 (TCM 7 day) and 99495 (TCM 14 day)

Medication reconciliation encounter: *CPT* 99483, 99495, 99496

Medication reconciliation intervention: *CPT II* 1111F

Exclusions

Patients are excluded if they are in hospice.

Telehealth accommodations

E-visits and virtual check-ins were added to the patient engagement after inpatient discharge numerator.

Addendum

Frailty and Advanced Illness Exclusion Criteria

Value Sets for Event and Diagnosis Criteria

Value Sets for Patient Setting Criteria

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–L89.214, L89.216, L89.219–L89.224, L89.226, L89.229,

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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: *CPT* 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

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