Quick Reference Guide

HEDIS® MY2021

For more information, visit www.ncqa.org

Note: Please always follow the State and/or CMS billing guidance and ensure the HEDIS codes are covered prior to submission. The codes and tips listed do not guarantee reimbursement.

Contents

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INTRODUCTION

HEDIS® MY 2021 Quick Reference Guide

Updated to reflect NCQA HEDIS 2021 Technical Specifications

Peach State Health Plan, Ambetter from Peach State Health Plan and Allwell from Peach State Health Plan strive to provide quality healthcare to our membership as measured through HEDIS quality metrics. We created the HEDIS Quick Reference Guide to help you increase your practice's HEDIS rates and to use to address care opportunities for your patients. Please always follow the State and/or CMS billing guidance and ensure the HEDIS codes are covered prior to submission.

WHAT IS HEDIS?

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

NCQA develops HEDIS® measures through a committee represented by purchasers, consumers, health plans, health care providers, and policy makers.

WHAT ARE THE SCORES USED FOR?

As state and federal governments move toward a quality-driven healthcare industry, HEDIS rates are becoming more important for both health plans and individual providers. State purchasers of healthcare use aggregated HEDIS rates to evaluate health insurance companies' efforts to improve preventive health outreach for members. Physician-specific scores are also used to measure your practice's preventive care efforts. Your practice's HEDIS score determines your rates for physician incentive programs that pay you an increased premium—for example Pay for Performance or Quality Bonus Funds.

HOW ARE RATES CALCULATED?

HEDIS rates can be calculated in two ways: administrative data or hybrid data. Administrative data consists of claim or encounter data submitted to the health plan. Hybrid data consists of both administrative data and a sample of medical record data. Hybrid data requires review of a random sample of member medical records to abstract data for services rendered but that were not reported to the health plan through claims/encounter data. Accurate and timely claim/encounter data reduces the need for medical record review. If services are not billed or not billed accurately, they are not included in the calculation.

How can I improve my HEDIS scores?

- Use real-time care gap information to manage our assigned population through Interpreta accessed through Availity
- Submit claim/encounter data for each and every service rendered
- Make sure that chart Documentation: reflects all services billed
- Bill (or report by encounter submission) for all delivered services, regardless of contract status
- Ensure that all claim/encounter data is sub-mitted in an accurate and timely manner
- Consider including CPT II codes to provide additional details and reduce medical record requests

PAY FOR PERFORMANCE (P4P)

P4P is an activity-based reimbursement, with a bonus payment based on achieving defined and measurable goals related to access, continuity of care, patient satisfaction and clinical outcomes.

Contact Information

Peach State Health Plan
1-866-874-0633 • pshp.com

Ambetter from Peach State Health Plan
1-877-687-1180 • ambetter.pshpgeorgia.com

Allwell from Peach State Health Plan
https://allwell.pshpgeorgia.com
HMO: 1-844-890-2326: (TTY: 711)
HMO SNP: 1-877-725-7748: (TTY: 711)

Providers and other health care staff should document to the highest specificity to aid with the most correct coding choice.

ANCILLARY STAFF:

Please check the tabular list for the most specific ICD-10-CM code choice.
This guide has been updated with information from the release of the HEDIS MY2021

Volume 2 Technical Specifications by NCQA and is subject to change.

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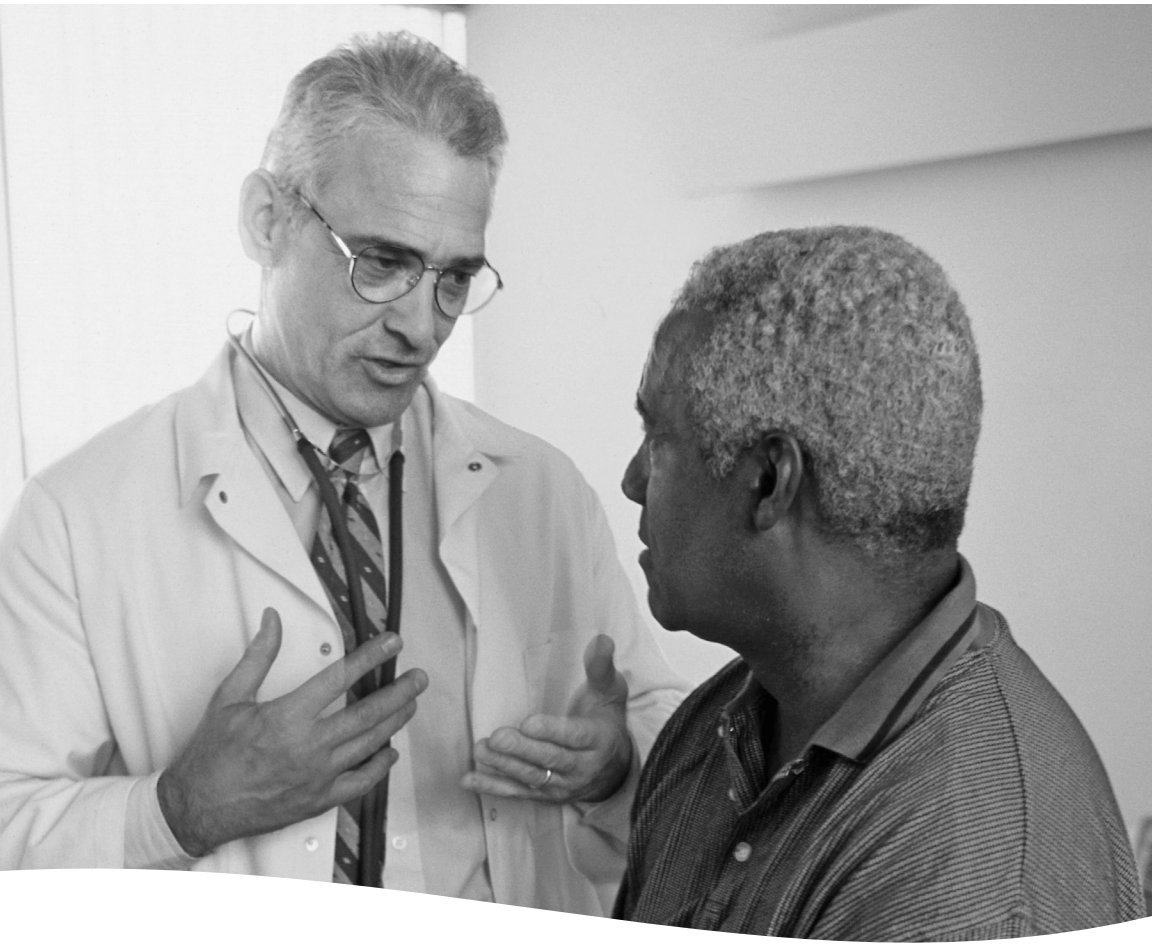
ADULT HEALTH



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

Line of Business: Commercial, Medicaid, Medicare

The percentage of members 20 years and older who had an ambulatory or preventive care visit. The organization reports three separate percentages for each product line.

- Medicaid and Medicare members who had an ambulatory or preventive care visit during the measurement year.
- Commercial members who had an ambulatory or preventive care visit during the measurement year or the two years prior to the measurement year.

Proper coding is critical to ensure accurate reporting of the measure, and it may decrease the need for medical record reviews.

Description	Codes
Ambulatory Visits	**CPT:** 99201 -99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99429, 99483, 92002, 92004, 92012, 92014, 99304-99310, 99315, 99316, 99318, 99324-99328, 99334-99337 **ICD-10-CM:** Z00.00, Z00.01, Z00.121, Z00.129, Z00.3, Z00.5, Z00.8, Z02.0, Z02.2, Z02.3, Z02.4, Z02.5, Z02.6, Z02.71, Z02.79, Z02.81-Z02.83, Z02.89, Z02.9, Z76.1 **HCPCS:** G0402, G0438, G0439, G0463, T1015, S0620, S0621

**Codes subject to change*

Best Practices:

- Appropriate coding will ensure the preventative visit is captured through claims submission
- Contact patients to schedule appointments who have not completed annual preventative visit during the calendar year

(COA) Care for Older Adults

Line of Business: Medicare Only

The percentage of adults 66 years and older who had each of the following during the measurement year:

- Advance care planning
- Medication review
- Functional status assessment
- Pain assessment

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Documentation:

- **Advance care planning** – Presence of an advance care plan; (e.g., living will, healthcare power of attorney, health care proxy, actionable medical orders, or surrogate decision-maker); or Documentation: of an advance care planning discussion and date; (the Documentation: must be noted in the measurement year); or notation in the medical record that the member previously executed an advance care plan.
- **Medication review** – A review of all member's medications, including prescription medications, over-the-counter medications, and herbal or supplemental therapies.
- **Functional status assessment** – Documentation: must include evidence of a complete functional status assessment to include a notation that Activities of Daily Living (ADL) were assessed, cognitive status, sensory ability, and other functional independence.
- **Pain assessment** – Documentation: must include an assessment for pain (which may include positive or negative findings) or the result of an assessment using a standardized tool, and the date the assessment was completed.

Proper coding is critical to ensure accurate reporting of these measures, and it may also decrease the need for medical record reviews.

Description	Codes
Advanced Care Planning	**CPT:** 99483, 99497 **CPT-CAT-II:** 1123F, 1124F, 1157F, 1158F **HCPCS:** S0257 **ICD-10-CM:** Z66
Medication Review *CPT-CAT-II 1159F (Medication list) & 1160F (Medication review) both are needed to meet compliancy	**CPT:** 90863, 99483, 99605, 99606 **CPT-CAT-II:** 1160F
Functional Status Assessment	**CPT:** 99483 **CPT-CAT-II:** 1170F **HCPCS:** G0438, G0439
Pain Assessment	**CPT-CAT-II:** 1125F, 1126F
Transitional Care Management 7 day & **Transitional Care Management 14 day**	**CPT:** 99495 **CPT:** 99496

**Codes subject to change*

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Best Practice:

- Ensure the medical record is documented appropriately to report the measures
- The Medication Review measures requires the medications are listed in the chart plus the review
- Place an alert within EMR to contact patient's as a reminder for upcoming appointment

(COL) Colorectal Screening

Line of Business: Commercial, Medicare

The percentage of members 50–75 years of age who had appropriate screening for colorectal cancer.

Clinical Goal:

- Annual FOBT or FIT
- Flexible Sigmoidoscopy
- Colonoscopy
- CT Colonography

Documentation:

- Fecal occult blood test (FOBT) during the measurement year
- Flexible sigmoidoscopy during the measurement year or the four years before the measurement year.
- Colonoscopy during the measurement year or the nine years before the measurement year.
- CT colonography during the measurement year or the four years before the measurement year.
- FIT-DNA test during the measurement year or the two years before the measurement year.

Exclusions:

- Members with a diagnosis of colorectal cancer or total colectomy are excluded
- Medicare patients age 66 and older as of December 31 of the MY who enrolled in an institutional SNP live in a long-term institution any time during the MY.

Proper coding is critical to ensure accurate reporting of these measures, and it may also decrease the need for medical record reviews.

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Description	Codes
Colonoscopy	**CPT:** 44388-44394, 44397, 44401-44408, 45355, 45378-45393, 45398 **HCPCS:** G0105, G0121
CT Colonography	**CPT:** 74261, 74262, 74263
FIT-DNA Lab Test	**CPT:** 81528 **HCPCS:** G0464
Flexible Sigmoidoscopy	**CPT:** 45330-45335, 45338-45342, 45345-45350 **HCPCS:** G0104
FOBT Lab Test	**CPT:** 81170, 81173 **HCPCS:** G0328
Colorectal Cancer	**HCPCS:** G0213- G0215, G0231
Total Colectomy	**CPT:** 44150-44153, 44155-44158, 44210-44212

**Codes subject to change*

Note: *FOBT tests performed in an office or performed on a sample collected via a digital rectal exam (DRE) do not meet criteria.*

Best Practice:

- Place standing orders for office staff to dispense FOBT or FIT kits to patients needing colorectal screening
- Reassure the patient who is resistant to having a colonoscopy to perform an at-home stool test (either GFOBT or IFOBT)
- Follow-up with patients to complete the at-home kit and return the specimen for lab results
- Update the patient chart yearly indicating colorectal cancer screening (indicate test performed and the date of lab results)
- Document the patient ileostomies, which entails colon removal and patients with a history of colon cancer

(TRC) Transitions of Care

Line of Business: Medicare Only

The percentage of discharges for members 18 years of age 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 2 days after the admission (3 total days).
- **Receipt of Discharge Information**: Documentation: of receipt of discharge information on the day of discharge through 2 days after the discharge (3 total days).
- **Patient Engagement After Inpatient Discharge:** Documentation: of patient engagement (e.g., office visits, visits to the home, telehealth) provided within 30 days after discharge.
- **Medication Reconciliation Post-Discharge:** Documentation: of medication reconciliation on the date of discharge through 30 days after discharge (31 total days).

Proper Documentation: of patient engagement provided within 30 days after discharge is required to meet compliance.

Description	Codes
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
Medication Reconciliation Encounter	**CPT:** 99483, 99495, 99456
Medication Reconciliation Intervention	**CPT-CAT II:** 1111F
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:** G0438, G0439, G0463, T1015

**Codes subject to change*

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BEHAVIORAL HEALTH

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

Line of Business: Commercial, Medicaid

The percentage of children and adolescents 1–17 years of age who had a new prescription for an antipsychotic medication and had Documentation: of psychosocial care as first-line treatment.

Clinical Goal:

The underutilization of first-line psychosocial interventions children and adolescents can be medicated unnecessarily and may inadvertently incur the risks associated with antipsychotic medications. The goal is for member's prescribed antipsychotic medication to have psychosocial interventions documented as the first line of treatment.

Proper coding is essential to ensure accurate reporting and exclusions for members with a diagnosis of bipolar, other psychotic disorder, or schizophrenia.

Description	Codes
Psychosocial Care	**CPT:** 90832-90834, 90836-90840, 90845-90847, 90849, 90853, 90875, 90876, 90880 **HCPCS:** G0176, G0177, G0409, G0140, G0411, H0004, H0035, H0036, H0037-H0040, H2000, H2001, H2011-H2014, H2017-H2020, S0201, S9480, S9484, S9485
Bipolar	**ICD-10-CM:** 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 Psychotic and Developmental Disorders	**ICD-10-CM:** F22-F24, F28-F29, F32.3, F33.3, F84.0, F84.2-F84.3, F84.5, F84.8-F84.9, F95.0-F95.2, F95.8-F95.9
Schizophrenia	**ICD-10-CM:** F20.0-F20.3, F20.5, F20.81, F20.89, F20.9, F25.0-F25.1, F25.8-F25.9

**Codes subject to change*

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Antipsychotic Medications

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

Antipsychotic Combination Medications

Description	Prescription	
Psychotherapeutic combinations	Fluoxetine-olanzapine	Perphenazine-amitriptyline

**Subject to change. Please refer to www.pshp.ga.com for specific drug coverage*

(FUA) Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence

Line of Business: Commercial, Medicaid, Medicare

The percentage of emergency department (ED)visits for members thirteen years of age and older with a principal diagnosis of alcohol or other drug abuse or dependence who had a follow-up visit with any practitioner for AOD.

Two rates are reported:

1. Follow-Up care within 30 days - The percentage of members who received follow-up within 30 days of the Emergency Department visit. (31 days)
2. Follow-Up care within seven days - The percentage of members who received follow-up within seven days of the Emergency Department visit. (8 days)

Note: This measure includes follow up visits that occur on the date of the Emergency Department visit.

Clinical Goal:

- Members seen in the Emergency Department for alcohol or other drug abuse or dependence (AOD) diagnosis are at increased risk for inpatient admission if follow-up is not addressed timely. Appropriate follow-up care decreases the risk before they reach a crisis point or harm to the self or others.
- The goal is for member's that had an emergency department visit for principal alcohol or other drug abuse, or dependence diagnosis will be seen by any practitioner within seven days of discharge.
- The goal is for member's that had an emergency department visit for principal alcohol or other drug abuse or dependence diagnosis, or self-harm will be seen by any practitioner within **30 days of discharge.**

Proper coding is essential to ensure accurate reporting of alcohol or other drug abuse or dependence and follow–up visits occurred.

Description	Codes
Emergency Department Visit	**CPT:** 99281-99285
Abuse and Dependence	**ICD-10-CM:** F10.10, F10.120, F10.121, F10.14, F10.150, F.10.151, F10.159, F10.180-F10.182, F10.188, F10.19, F10.20, F10.220, F10.221, F10.229-F10.232, F10.239, F10.24, F10.250, F10.251, F10.259, F10.26, F10.27, F10.280-F10.282, F10.288, F10.29, F11.10, F11.120-F11.122, F11.129,

**Codes subject to change*

Best Practice:

- Train your patients and staff on the **"Teach Back Method"** to ensure patients and caregivers review and understand discharge instructions and the next steps in their care for follow-up.
- Maintain appointment availability in your practice for recent hospital discharges.
- Make sure member has two appointments before discharge: one within seven days and one within 30 days.
- Provide education to patients and caregivers on the importance of follow-up to reduce the risk of readmission.
- Reach out to patients that do not keep initial follow-up appointments and set flags if available in EHR or develop tracking method for members due or past due for follow-up after discharge visits and require staff to follow up with patients that miss or cancel their appointment.

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(FUH) Follow-Up after Hospitalization for Mental Illness

Line of Business: Commercial, Medicaid, Medicare

The percentage of members six years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health practitioner.

Two rates are reported:

1. Discharges for which the member received **follow-up care within 30 days after discharge**
2. Discharges for which the member received **follow-up care within 7 days after discharge**

Intake Period: January 1, through December 31 of the MY

Clinical Goal:

- Members hospitalized for a mental health diagnosis are at risk for readmission after discharge if follow-up is not addressed. Appropriate follow-up care decreases the risk of readmissions and provides an opportunity to identify patients in need or further hospitalization before they reach a crisis point or cause harm to their self or others.
- The goal is for member's that had an inpatient hospitalization for mental health diagnosis will be seen by a mental health practitioner within 7 days of discharge.
- The goal is for member's that had an inpatient hospitalization for mental health diagnosis will be seen by a mental health practitioner within 30 days of discharge.

Note: Follow-up with a PCP does not meet the measure.

Proper coding is essential to ensure accurate reporting of mental illness and follow-up visit.

Description	ICD-10 CM Codes
Mental Health Diagnosis Codes	F03.90, F03.91, F20.0-F53, F59-FF66, F68.10-F69, F80.0-F84.9. F88-F95.9,F98.0-F99
Intentional Self Harm	T14.91**, T36.0**- T65.92**, T71.112** - T71.232**

**Codes subject to change ** The appropriate 7th character is to be added to indicate: A - Initial encounter; D - subsequent encounter; or S – Sequela*

Description	Codes
Visit Setting Unspecified Value Set with Outpatient POS with Mental Health Practitioner	**CPT:** 90791, 90792, 90832 - 90834, 90836 - 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221 - 99223, 99231 - 99233, 99238, 99239, 99251 – 99255 **POS:** 03, 05, 07, 09, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 22, 33, 49, 50, 71, 72
BH Outpatient Visit with Mental Health Practitioner	**CPT:** 98960 - 98962, 99078, 99201 - 99205, 99211 - 99215, 99241 - 99245, 99341 - 99345, 99347 - 99350, 99381 - 99387, 99391 - 99397, 99401 - 99404, 99411, 99412, 99510, 99483 **HCPCS:** G0155, G0176, G0177, G0409, G0463, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013 - H2020, T1015
Visit Setting Unspecified Value Set with Partial Hospitalization POS with Mental Health Practitioner	**CPT:** 90791, 90792, 90832 - 90834, 90836 - 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221 - 99223, 99231 - 99233, 99238, 99239, 99251 – 99255 **POS:** 52
Partial Hospitalization/ Intensive Outpatient	**HCPCS:** G0410, G0411, H0035, H2001, H2012, S0201, S9480, S9484, S9485
Visit Setting Unspecified Value Set with Community Mental Health Center POS	**CPT:** 90791, 90792, 90832 - 90834, 90836 - 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221 - 99223, 99231 - 99233, 99238, 99239, 99251 – 99255 **POS:** 53
Electroconvulsive Therapy with Ambulatory Surgical Center POS/ Community Mental Health Center POS/ Outpatient POS/ Partial Hospitalization POS	**CPT:** 90870 **Ambulatory POS:** 24 **Comm. POS:** 53 **Partial Hosp. POS:** 52 **Outpatient POS:** 03, 05, 07, 09, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 22, 33, 49, 50, 71, 72
Observation	**CPT:** 99217-99220
Transitional Care Management	**CPT:** 99495, 99496

**Codes subject to change*

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Best Practice:

- Train your patients and staff on the **"Teach Back Method"** to ensure patients and caregivers review and understand discharge instructions and the next steps in their care for follow-up.
- Maintain appointment availability in your practice for recent hospital discharges.
- Make sure member has two appointments before discharge: one within 7 days and one within 30 days.
- Provide education to the patient and caregivers on the importance of follow-up to reduce the risk of readmission.

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

Line of Business: Commercial, Medicaid, Medicare

The percentage of acute inpatient hospitalizations, residential treatment, or detoxification visits for a diagnosis of substance use disorder among members 13 years of age and older that result in a follow-up visit or service for substance use disorder.

Two rates are reported:

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

Clinical Goal:

- Members receiving substance use disorder care are susceptible to losing contact with the health care system after discharge resulting in untimely follow up and negative outcomes.
- Assess timely follow up and continued contact with the health care system following a high intensity visit for a principal diagnosis of substance use and disorder.

Proper coding is essential to ensure accurate reporting.

Description	Codes
AOD Abuse and Dependence	**ICD-10 CM:** F10.10, F10.120, F10.121, F10.129, F10.14, F10.150, F10.151, F10.159, F10.180 – F10.182, F10.188. F10.19, F10.20, F10.220, F10.221, F10.229 – F10.232, F10.239, F10.24, F10.250, F10.251, F10.259, F10.26, F10.27, F10.280 – F10.282, F10.288, F10.29, F11.10, F11.120 – F11.122, F11.129, F11.14, F11.150, F11.151, F11.159, F11.181, F11.182, F11.188, F11.19, F11.20, F11.220, F11.221, F11.222, F11.29, F12.10, F12.120, F12.121, F12.122, F12.129, F12.150, F12.151, F12.159, F12.180, F12.188, F12.19, F12.20, F12.220 – F12.222, F12.229, F12.23, F12.250, F12.251, F12.259, F12.280, F12.288, F12.29, F13.10, F13.120, F13.121, F13.129, F13.14, F13.150, F13.14, F13.150, F13.151, F13.159, F13.180 – F13.182, F13.188, F13.19, F13.20, F13.220, F13.221, F13.229 - F13.232, F13.239, F13.24, F13.250, F13.251, F13.26, F13.27, F13.280, F13.282, F13.288, F13.29, F14.10, F14.210 – F14.122, F14.129, F14.14, F14.150, F14.151, F14.159, F14.180 - F14.182, F14.188, F14.19, F14.20, F14.220, F14.221, F14.222, F14.229, F14.23, F14.24, F14.250, F14.251, F14.259, F14.280, F14.281, 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 – F15.252, 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, F18.18, F18.20, F18.220, F18.221, F18.229, F18.24, F18.250, F18.251, F18.259, F18.27, F18.280, F18.288, F18.29, F19.10, F19.120, F19.121, F19.122, F19.129, F19.14, F19.150, F19.151, F19.159, F19.16, F19.17, F19.180, F19.181, F19.182, F19.188, F19.19, F19.20, F19.220, F19.221, F19.222, F19.229, F19.230, F19.231, 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
Detoxification	**HCPCS:** H0008, H0009, H0010, H0011, H0012, H0013, H0014

**Codes subject to change*

(FUM) Follow-Up after Emergency Department Visit for Mental

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Illness

Line of Business: Commercial, Medicaid, Medicare

The percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness.

Two rates are reported:

1. Follow up care within 30 days - The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days).
2. Follow up care within seven days - The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days).

Clinical Goal:

- Members seen in the Emergency Department for mental health diagnosis are at increased risk for inpatient admission if follow-up is not addressed timely. Appropriate follow-up care decreases the risk before they reach a crisis point or harm to the self or others.
- The goal is for members that had an emergency department visit for a principal mental health diagnosis or self-harm will be seen by any practitioner within 7 days (total 8 days) and 30 days (total 31 days) of discharge.

Proper coding is essential to ensure accurate reporting of mental health disorder or intentional self-harm and follow-up visits occurred:

Description	ICD-10- CM Codes
Mental Health Diagnosis	F03.90, F03.91, F20.0-F53.1, F59-F66, F68.10-F69, F80.0-F84.9. F88-F95.9, F98.0-F99
Intentional Self Harm	T14.91**, T36.0**- T65.92**, T71.112** - T71.232**

**Codes subject to change ** The appropriate 7th character is to be added to indicate: A - Initial encounter, D - subsequent encounter, or S - Sequela*

Note: When submitting claims for follow-up treatment include the appropriate mental health diagnosis or intentional self-harm diagnosis along with the procedure codes as indicated below.

Best Practice:

- Train your patients and staff on the **"Teach Back Method"** to ensure patients and caregivers review and understand discharge instructions and the next steps in their care for follow-up.
- Maintain appointment availability in your practice for recent hospital discharges.

- Make sure member has two appointments before discharge: one within seven days and one within 30 days.
- Provide education to patients and caregivers on the importance of follow-up to reduce the risk of readmission.
- Reach out to patients that do not keep initial follow-up appointments and set flags if available in EHR or develop tracking method for members due or past due for follow-up after discharge visits and require staff to follow up with patients that miss or cancel their appointment.

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

Line of Business: Commercial, Medicaid, Medicare

- **Initiation of AOD Treatment** - The percentage of members 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 diagnosis.
- **Engagement of AOD Treatment**- The percentage of members who initiated treatment and who were engaged in ongoing AOD treatment within 34 days of the initiation visit.

***Intake Period:* January 1 *through* November 14 *of the* MY**

Clinical Goal:

- Increasing initiation and engagement of members who have an alcohol and other drug dependence (AOD) can help to minimize drug use related illnesses and deaths, unburdening overused health services and alleviating other socio-economic hardships associated with substance use disorders.

Proper coding is essential to ensure accurate reporting. When treating patients for issues related to alcohol or other drug dependence diagnosis, code for the diagnosis on every claim.

Description	Codes
Alcohol Abuse or dependence	**ICD-10-CM:** F10.10-F19.29
Opioid Abuse or dependence	**ICD-10-CM:** F11.10 - F11.29

Note: Please always follow the State and/or CMS billing guidance and ensure the HEDIS codes are covered prior to submission. The codes and tips listed do not guarantee reimbursement.

Other Drug Abuse or Dependence	**ICD-10-CM:** F12.10 - F16.29, F18.10, F18.120 - F18.129, F 18.14, F18.150, F18.151, F18.159, F18.17, F18.180, F18.188, F18.19, F18.20 - F18.29, F19.10, F19.120 - F19.229, F19.230 -F19.29
OUD Monthly Office Based Treatment	**HCPCS:** G2086, G2087
OUD Weekly Non-Drug Service	**HCPCS:** G2071, G2074, G2075
OUD Weekly Drug Treatment Service	**HCPCS:** G2067, G2068, G2069, G2070

**Codes subject to change*

Best Practice:

- Incorporate substance use questions or tools upon intake and upon yearly treatment plan review at a minimum.
- Schedule an appropriate follow-up treatment. For newly diagnosed patients, in particular, schedule **3 follow-up appointments within the first 34 days (1 visit within 14 days, 2 or more visits within 34 days)**. Increased intensity of contact in early stages of treatment will help to address the concerns as timely as possible and help to keep the patient connected and motivated for treatment.
- Be sure to document in the medical records and use appropriate codes for claims submission.
- Educate patients on the effects of substance abuse. Substance abuse often coincides with other behavioral health problems, like major depression or anxiety disorders, which can make treating substance abuse or diagnosing a behavioral health disorder more difficult. In instances like these, referral to a behavioral health provider is prudent.

CARDIOVASCULAR

For more information, visit **www.ncqa.org**

Note: Please always follow the State and/or CMS billing guidance and ensure the HEDIS codes are covered prior to submission. The codes and tips listed do not guarantee reimbursement.

(CBP) Controlling High Blood Pressure

Line of Business: Commercial, Medicaid, Medicare

The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90 mm Hg) during the measurement year.

Exclusions:

Members 66–80 years of age as of December 31 of the measurement year (all product lines) with frailty and advanced illness.

Clinical Goal:

Members 18-85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled **(<140/90 mm Hg).**

Documentation:

The last BP reading (date & result) in the measurement year (if elevated, document all BP readings).

Proper coding is essential to ensure accurate reporting of the measure, and it may also decrease the need for medical records reviews.

Description	Codes
Hypertension	**ICD-10-CM:** I10
Systolic greater than or equal to 140	**CPT-CAT-II:** 3077F
Systolic less than 140	**CPT-CAT-II:** 3074F, 3075F
Diastolic greater than or equal to 90	**CPT-CAT-II:** 3080F
Diastolic 80-89	**CPT-CAT-II:** 3079F
Diastolic less than 80	**CPT-CAT-II:** 3078F
Remote Blood Pressure Monitoring	**CPT:** 93784, 93788, 93790, 99091, 99453, 99454, 99457, 99473, 99474
Outpatient	**CPT:** 99384-99387, 99391-99397, 99401-99404, 99411, 99412, 99455, 99456, 99483 **HCPCS:** G0438, G0439, G0463, T1015
Non-acute Inpatient	**CPT:** 99304-99310, 99315, 99316, 99318, 99324-99328, 99334-99337

**Codes are subject to change*

Note: Please always follow the State and/or CMS billing guidance and ensure the HEDIS codes are covered prior to submission. The codes and tips listed do not guarantee reimbursement.

Best Practice:

- Have patient return in 3 months for continuous monitoring of BP
- The importance of taking all prescribed medications as directed by the physician
- Select appropriate sized BP cuff.
- Retake the BP if it high at the office visit (140/90 mm Hg or greater) HEDIS allows the lowest systolic and lowest diastolic readings in the same day and often the second reading is lower.
- Do not round BP values up. If using an automated machine, record exact values.
- Review hypertensive medication history and patient compliance, and consider modifying treatment plan for uncontrolled blood pressure as needed.

(CRE) Cardiac Rehabilitation

Line of Business: Commercial, Medicaid, Medicare

The percentage of members 18 years and older, who attended cardiac rehabilitation following a qualifying cardiac event, including myocardial infarction, percutaneous coronary intervention, coronary artery bypass grafting, heart and heart/lung transplantation or heart valve repair/replacement.

Four rates are reported:

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

The measurement period begins on July 1 of the year prior to the measurement year and ends on June 30 of the measurement year

Clinical Goal:

- Member's attending Cardiac Rehabilitation with at least 2 or more sessions from initiation within 30 days through achievement of 36 or more sessions within 180 days after the qualifying event.

Proper coding is essential to ensure accurate reporting of the measure, and it may also decrease the need for medical records reviews.

Note: Please always follow the State and/or CMS billing guidance and ensure the HEDIS codes are covered prior to submission. The codes and tips listed do not guarantee reimbursement.

Description	Codes
Cardiac Rehabilitation	**CPT:** 93797, 93798 **HCPCS:** G0422, G0423, S9472

**Codes are subject to change*

Best Practice:

Medical Records/Chart should include Documentation of:

- Physician-prescribed exercise each day cardiac rehabilitation items and services are furnished
- Cardiac risk factor modification, including education, counseling and behavioral intervention tailored to the patient's individual needs
- Psychosocial assessment Documentation: should be present
- Outcomes assessment
- Educate your patient and/or caregivers on the importance of scheduling and attending follow-up session for cardiac rehabilitation.
- To provide Cardiac Rehabilitation program that includes exercise training, healthy lifestyle education and stress counseling
- Send appointment reminders and/or call your patients to remind them of upcoming appointments.

DIABETES

For more information, visit **www.ncqa.org**

Note: Please always follow the State and/or CMS billing guidance and ensure the HEDIS codes are covered prior to submission. The codes and tips listed do not guarantee reimbursement.

(CDC) Comprehensive Diabetes Care

Line of Business: Commercial, Medicaid, Medicare

The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had each of the following:

- Hemoglobin A1c (HbA1c) testing
- HbA1c poor control (>9.0%)
- HbA1c control (<8.0%)
- Eye exam (retinal) performed
- Medical attention for nephropathy**
- BP control (<140/90 mm Hg)
-

****This indicator only reported for the Medicare product line.**

Clinical Goals:

CDC- HbA1c >9.0% Poor Control	▪ Members will have a HbA1c test performed during the measurement year HbA1c value – poor control ≥9% (reported in PQR as inverted rate <9%) ▪ HbA1c value good control <8%Medicare patients – goal HbA1c <9 ▪ Non-Medicare patients
CDC – BP Control (<140/90 mm Hg)	▪ Members will have an annual urine screen for albumin/protein done during the measurement year ▪ -OR ▪ Evidence of treatment for nephropathy ▪ -OR ▪ ACE/ARB therapy
CDC – Annual Eye Exam	Member will have: ▪ A retinal or dilated eye exam by an eye care professional (optometrist/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 a bilateral eye enucleation anytime during the member's history through December 31 of the year

Documentation:

CDC – HbA1c	▪ Date and value of most recent HbA1c result during the measurement year.
CDC – BP Control (<140/90 mm Hg)	▪ Date of the visit with a blood pressure reading during the measurement year. ▪ The provider interpreted any notation of a patient using a remote blood pressure monitoring device and the results.
CDC – Annual Eye Exam	▪ Results of the most recent eye exam by an eye care professional within the measurement year or 2 years if documented low risk of retinopathy or evidence of bilateral eye enucleation/acquired absence in both eyes anytime in member's history
CDC – Medical Attention for Nephropathy (Medicare Only)	Results of nephropathy screen during the measurement year: ▪ A urine test for albumin or protein with Documentation: of the date and the results or findings; or ▪ Documentation: of visit to a nephrologist; or ▪ Documentation: of a Renal Transplant; or ▪ Documentation: of medical attention for Diabetic nephropathy, ESRD, CRF, CKD, Renal insufficiency, Proteinuria, Albuminuria, Renal Dysfunction, ARF, or Dialysis (hemodialysis or peritoneal); or ▪ ACE/ARB Therapy prescribed during the measurement year

Proper coding is critical to ensure accurate reporting of these measures, and it may decrease the need for medical record reviews.

Description	Codes
Outpatient	**CPT:** 99201 - 99205, 99211 - 99215, 99241- 99245, 99341-99345, 99347 -99350, 99381 - 99387, 99391 - 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99429, 99455, 99456, 99483 **HCPCS:** G0402, G0438, G0439, G0463, G9054, M1017, T1015 **ICD-10 CM:** Z51.5
Non-acute Inpatient	**CPT:** 99304 - 99310, 99315, 99316, 99318, 99324 - 99328, 99334, -99337

Note: Please always follow the State and/or CMS billing guidance and ensure the HEDIS codes are covered prior to submission. The codes and tips listed do not guarantee reimbursement.

Remote BP monitoring	**CPT:** 93784, 93788, 93790, 99091, 99453, 99454, 99457, 99473, 99474
Diastolic 80-89	**CPT-CAT II:** 3079F
Diastolic greater than or equal to 90	**CPT-CAT II:** 3080F
Diastolic less than 80	**CPT-CAT II:** 3078F
Systolic greater than or equal to 140	**CPT-CAT II:** 3077F
Systolic less than 140	**CPT-CAT II:** 3074F, 3075F
Diabetic Retinal Screening with Eye Care Professional	**CPT-CAT-II:** 2022F, 2023F, 2024F, 2025F, 2026F, 2033F and 3072F
Unilateral Eye Enucleation with a bilateral modifier	**CPT:** 65091, 65093, 65101, 65103, 65105, 65110, 65112, 65114 **CPT Modifier:** 50
HbA1c Lab Test	**CPT:** 83036, 83037 **CPT-CAT II:** 3044F, 3046F
HbA1c Level Greater than/equal to 7 and Less than 8	**CPT-CAT II:** 3051F
HbA1c Level Greater than/equal to 8 and Less than/equal to 9	**CPT-CAT II:** 3052F
HbA1C Greater than 9.0	**CPT-CAT-II:** 3052F
Urine Protein Tests	**CPT:** 81000 - 81003, 81005, 82042 - 82044, 84156 **CPT-CAT-II:** 3060F, 3061F, 3062F
Nephropathy Treatment ****Medicare Only**	**CPT-CAT-II:** 3066F, 4010F

**Codes are subject to change*

Best Practice:

- Schedule follow-up appointments and/or **BP and A1C re-checks** if the BP or A1C is not controlled.
- Schedule all appropriate screenings for members identified as diabetic.
- Include CPT coding identified above as appropriate when submitting claims.

Note: Please always follow the State and/or CMS billing guidance and ensure the HEDIS codes are covered prior to submission. The codes and tips listed do not guarantee reimbursement.

- The HEDIS rules state that the last **A1C** taken during the year is the only one that counts towards meeting the measure

(KED) Kidney Health Evaluation for Patients with Diabetes

Line of Business: Commercial, Medicaid, Medicare

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

Proper coding is critical to ensure accurate reporting of these measures, and it may decrease the need for medical record reviews.

Description	Codes
Estimated Glomerular Filtration Rate Lab Test	**CPT:** 80047, 80048, 80050, 80053, 80069, 82565
Quantitative Urine Albumin Lab Test	**CPT:** 82043
Urine Creatinine Lab Test	**CPT:** 82570

**Codes are subject to change*

Best Practice:

Medical Records/Chart should include Documentation:

- Perform an annual Kidney Health Evaluation that include screening for kidney disease and include both lab testing consisting of eGFR and uACR in patients 18-85 years of age with diabetes
- Billing with the appropriate lab codes for claims submission
- Document in the chart the lab test and the results of the test

(SMD) Diabetes Monitoring for People with Diabetes and Schizophrenia

Line of Business: Medicaid

The percentage of members 18–64 years of age with schizophrenia or schizoaffective disorder and diabetes who had both an LDL-C test and an HbA1c test during the measurement year.

Note: Please always follow the State and/or CMS billing guidance and ensure the HEDIS codes are covered prior to submission. The codes and tips listed do not guarantee reimbursement.

Clinical Goal:

- Persons with serious mental illness who use antipsychotics are at increased risk of cardiovascular diseases and diabetes. Lack of appropriate care for diabetes and cardiovascular disease for people with schizophrenia, schizo-affective or bipolar disorder who use antipsychotic medications can lead to worsening health and death. Screening and monitoring of physical health needs is an important way to improve health, quality of life and economic outcomes downstream.
- The goal is for members with schizophrenia and Diabetes receive annual assessment and screenings HbA1c and LDL - C test. Documentation: of the date of tests and lab results should be in the medical record.

Proper coding is essential to ensure accurate reporting. When treating a patient for schizophrenia and Diabetes, code for the diagnosis on every claim.

Description	Codes
Schizophrenia	**ICD-10 CM:** F20.0-F20.3, F20.5, F20.81, F20.89, F20.9, F25.0, F25.8, F25.9
HbA1C Lab Tests	**CPT:** 83036, 83037 **CPT-CAT-II:** 3044F, 3046F, 3051F, 3052F
LDL-C Lab Tests	**CPT:** 80061, 83700, 83701, 83704, 83721 **CPT-CAT-II:** 3048F, 3049F, 3050F, 3051F, 3052F

**Codes subject to change*

Best Practice:

- Increase patient's compliance by generating standing orders for lab testing
- Educate patients and their caregivers on the importance of completing annual visits and blood work annually.
- Maintain appointment availability in your practice for patients and schedule follow-up appointments with the patient before departing from the appointment when it is applicable for lab work and diabetes management.
- Contact patients who do not keep follow-up appointments and set flags in EHR or develop tracking method for patients due/past due for lab work and assessments. Require staff to follow up with patients that miss or cancel their appointments.

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

Line of Business: Medicaid

The percentage of members 18–64 years of age with schizophrenia, schizo-affective or bipolar disorder, who have dispensed an antipsychotic medication and had a diabetes screening during the measurement year.

Clinical Goal:

- Persons with serious mental illness who use antipsychotics are at increased risk of cardiovascular diseases and diabetes. Lack of appropriate care for diabetes and cardiovascular disease for people with schizophrenia, schizo-affective or bipolar disorder who use antipsychotic medications can lead to worsening health and death.
- Screening and monitoring of physical health needs is an important way to improve health, quality of life and economic outcomes downstream.
- The goal is for members with schizophrenia or Bipolar Disorder who were dispensed antipsychotic medication receive annual assessment and screenings for Diabetes.
- Documentation of the date of the glucose test or HbA1c lab results should be in the medical record.

Proper coding is essential to ensure accurate reporting

Description	Codes
Schizophrenia	**ICD-10-CM:** F20.0 - F20.9, F25.0 - F25.9
Bipolar Disorder	**ICD-10-CM:** F30.10 - F31.78
Other Bipolar Disorder	**ICD-10-CM:** F31.81, F31.89, F31.9
HbA1C Lab Tests	**CPT:** 83036, 83037 **CPT-CAT-II:** 3044F, 3046F, 3051F, 3052F
Glucose Lab Tests	**CPT:** 80047, 80048, 80050, 80053, 80069, 82947, 82950, 82951

**Codes subject to change*

Note: Please always follow the State and/or CMS billing guidance and ensure the HEDIS codes are covered prior to submission. The codes and tips listed do not guarantee reimbursement.

Best Practice:

- Increase patient's compliance by generating a standing order for lab testing
- Educate patients and their caregivers on the importance of completing annual visits and blood work annually.
- Maintain appointment availability in your practice for patients and schedule follow-up appointments with the patient before departing from the appointment when it is applicable for lab work and diabetes management.
- Contact patients who do not keep follow-up appointments and set flags in EHR or develop tracking method for patients due/past due for lab work and assessments. Require staff to follow up with patients that miss or cancel their appointments.

CHILDREN AND ADOLESCENTS

For more information, visit **www.ncqa.org**

Note: Please always follow the State and/or CMS billing guidance and ensure the HEDIS codes are covered prior to submission. The codes and tips listed do not guarantee reimbursement.

(CIS) Childhood Immunization Status

Line of Business: Commercial, Medicaid

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

Proper coding is essential to ensure accurate reporting

Description	Codes
DTAP (4 dose)	**CPT:** 90698, 90700, 90721, 90723 **CVX:** 20, 50, 106, 107, 110, 120
HIB (3 dose)	**CPT:** 90644, 90645, 90646, 90647, 90648, 90698, 90721, 90748 **CVX:** 17, 46, 47, 48, 49, 50, 51, 120, 148
Newborn HepB (3 dose)	**CPT:** 90723, 90740, 90744, 90747, 90748 **CVX:** 08, 44, 45, 51, 110 **HCPCS:** G0010 **ICD-10-CM:** B16.0, B16.1, B16.2, B16.9, B17.0, B18.0, B18.1, B19.10, B19.11, Z22.51
IPV (3 dose)	**CPT:** 90698, 90713, 90723 **CVX:** 10, 89, 110, 120
MMR (1 dose)	**CPT:** 90705, 90707, 90710, 90708, 90704, 90706 **CVX:** 05, 03, 94, 04, 07, 06 **ICD-10-CM:** B05.0, B05.1, B05.2, B05.3, B05.4, B05.81, B05.89, B05.9, B26.0, B26.1, B26.2, B26.3, B26.81, B26.82. B26.83, B26.84, B26.85, B26.89, B26.9, B06.00, B06.01, B06.02, B06.09, B06.81, B06.82, B06.89, B06.9
Pneumococcal Conjugate PCV (4 dose)	**CPT:** 90670 **CVX:** 133, 152 **HCPCS:** G0009

Note: Please always follow the State and/or CMS billing guidance and ensure the HEDIS codes are covered prior to submission. The codes and tips listed do not guarantee reimbursement.

Varicella VZV (1 dose)	**CPT:** 90710, 90716 **CVX:** 21, 94 **ICD-10-CM:** B01.0, B01.11, B01.12, B01.2, B01.81, B01.89, B01.9, B02.0, B02.1, B02.21, B02.22, B02.23, B02.24, B02.29, B02.30, B02.31, B02.32, B02.33, B02.34, B02.39, B02.7, B02.8, B02.9
HepA (1 dose)	**CPT:** 90633 **CVX:** 31, 83, 85 **ICD-10-CM:** B15.0, B15.9
Influenza Flu (2 dose)	**CPT:** 90655, 90657, 90661, 90662, 90673, 90685, 90686, 90687, 90688, 90689, 90660, 90672 **CVX:** 88, 135, 140, 141, 150, 153, 155, 158, 161, 111, 149 **HCPCS:** G0008
Rotavirus (2 Dose)	**CPT:** 90681 **CVX:** 119
Rotavirus (3 Dose)	**CPT:** 90680 **CVX:** 116, 122

**Codes subject to change*

Best Practice:

- Check compliance with immunizations and lead screening at 18-month well-child visit (not at 2 years old)
- Schedule a visit to "catch up" on immunizations and lead screenings
- If using Certified Lead Analyzer, submit CPT code 83655
- Encourage and offer flu shots during the months of September through May
- Members with Medicaid coverage are considered at risk for lead poisoning and should be screened by age 1 and 2 years
- Overdue immunizations and lead testing can be administered at sick visits as medically appropriate
- Anaphylactic reaction due to vaccination: submit ICD-10-CM codes T80.52XA, T80.52XD, or T80.52XS

Note: Please always follow the State and/or CMS billing guidance and ensure the HEDIS codes are covered prior to submission. The codes and tips listed do not guarantee reimbursement.

(IMA) Immunizations for Adolescents

Line of Business: Commercial, Medicaid

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

Proper coding is essential to ensure accurate reporting

Description	Codes
Meningococcal -serogroup A,C,W, and Y: (1 dose)	**CPT:** 90734 **CVX:** 108, 114, 136, 147, 167
Tdap (1 dose)	**CPT:** 90715 **CVX:** 115
HPV (2 or 3 dose series)	**CPT:** 90649-90651 **CVX:** 62, 118, 137, 165

**Codes subject to change*

Best Practice:

- Check the status of immunizations at 11-year-old well visit (not 12-year-old well visit)
- Schedule a visit to "catch up" on immunizations and lead screenings
- Encourage and explain benefits of HPV immunizations to members
- Overdue immunizations can be administered at sick visits (as medically appropriate)
- Anaphylactic reaction can happen and should be documented with ICD-10-CM codes: T80.52XA, T80.52XD or T80.52XS

(LSC) Lead Screening in Children

Line of Business: Medicaid

The percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.

Proper coding is essential to ensure accurate reporting

Description	Codes
Lead Screening-Lab Test	83655

**Codes subject to change*

Note: Please always follow the State and/or CMS billing guidance and ensure the HEDIS codes are covered prior to submission. The codes and tips listed do not guarantee reimbursement.

Best Practice:

- Check compliance with immunizations and lead screening at 18-month well-child visit (not 2 years old)
- If using Certified Lead Analyzer, submit CPT code 83655
- Members with Medicaid coverage are considered at risk for lead poisoning and should be screened by age 1 and 2 years

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

Line of Business: Commercial, Medicaid

The percentage of members 3–17 years of age, who had an outpatient visit with a PCP or OB/GYN and who had evidence of the following during the measurement year.

- BMI percentile Documentation:*
- Counseling for nutrition
- Counseling for physical activity

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

Proper coding is essential to ensure accurate reporting

Description	Codes
BMI Percentile	**ICD-10-CM:** Z68.51, Z68.52, Z68.53, Z58.54
Nutrition Counseling	**CPT:** 97802, 97803, 97804 **HCPCS:** G0270, G0271, G0447, S9449, S9452, S9470 **ICD-10-CM:** Z71.3
Physical Activity	**HCPCS:** G0447, S9451 **ICD-10-CM:** Z02.5, Z71.82

**Codes subject to change*

All children ages 13-17 years old must have Documentation: of BMI Percentile, Nutritional Counseling and Physical Activity Counseling in the Medical Record.

Best Practice:

- BMI Percentile: Always add informational ICD-10-CM code Z68.51-Z68.54 to the claim
- Nutritional counseling: add informational diagnosis code Z71.3 to claim, Medical Nutrition Therapy CPT codes: 97802-97804; Medical Nutrition HCPCS codes: G0270, G0271, G0447, S9449, S9452, S9470; ICD-10-CM code Z71.3

Note: Please always follow the State and/or CMS billing guidance and ensure the HEDIS codes are covered prior to submission. The codes and tips listed do not guarantee reimbursement.

- Physical activity counseling: add HCPCS codes G0447 and S9451; ICD-10-CM code Z02.5 and Z71.82

(WCV) Child and Adolescent Well-Care Visits

Line of Business: Commercial, Medicaid

The percentage of members 3-21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.

Clinical Goal:

Components of a comprehensive well care visit include: A health history, a physical development assessment, mental development assessment, a physical exam and discussion of health education/anticipatory guidance. Visit must be with a PCP or OB/GYN and assessment or treatment of an acute or chronic condition do not count towards the measure. Be sure to use age appropriate codes.

Best Practice:

- Well-care visit may be completed anytime in the calendar year
- When medically appropriate, conduct a well-visit exam during a follow-up visit or sick visit
- Adopt current Bright Futures guidelines for all age groups
- Outreach members who were not seen in the prior year.
- Call new members to schedule their annual visit

CPT	HCPCS	ICD-10-CM
99382 - 99385, 99392 – 99395 With HIPAA Modifier: EP	G0438, G0439, S0302	Z00.00, Z00.01, Z00.121, Z00.129, Z00.2, Z00.3, Z02.5, Z76.2

**Codes subject to change*

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

Line of Business: Commercial, Medicaid

The percentage of members who had the following number of well-child visits with a PCP during the last 15 months.

Two rates are reported:

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

Note: Please always follow the State and/or CMS billing guidance and ensure the HEDIS codes are covered prior to submission. The codes and tips listed do not guarantee reimbursement.

Clinical Goal:

Ensure members birth through 30 months receive appropriate preventive visits during the calendar year during the appropriate timeframes.

Proper coding is essential to ensure accurate reporting of the measure, and it may decrease the need for medical records reviews.

CPT	HCPCS	ICD-10-CM
99381, 99382, 99391, 99392, 99461 With HIPAA Modifier: EP	G0438, G0439, S0302	Z00.110, Z00.111, Z00.121, Z00.129, Z00.2, Z02.5, Z76.1, Z76.2

**Codes subject to change*

Best Practice:

- Well-child exams must be performed by a primary care provider
- Well exams may be completed anytime in the calendar year
- Adopt current Bright Futures guidelines for all age groups
- Schedule more than six visits to assure completions of the six visits prior to 15 months of age
- Schedule more than two visits to assure completion of 15 months to 30 months of age
- Consider performing lead testing at 12 months or with other lab tests before the 2nd birthday
- When medically appropriate, conduct a well-visit exam during a follow-up visit or sick visit.
- Notate EPSDT when billing

Note: Please always follow the State and/or CMS billing guidance and ensure the HEDIS codes are covered prior to submission. The codes and tips listed do not guarantee reimbursement.

Immunization Schedule: Birth to 15 Months

- Range of recommended ages for all children
- Range of recommended ages for catch-up immunization
- Range of recommended ages for certain high-risk groups
- Recommended based on shared clinical decision-making or *can be used in this age group
- No recommendation/Not applicable

Vaccine	Birth	1 mo	2 mos	4 mos	6 mos	9 mos	12 mos	15 mos
Hepatitis B (HepB)	1st dose	2nd dose			←3rd dose→			
Rotavirus: (RV) RV1 (2-dose series); RV5 (3-dose series)			1st dose	2nd dose	See notes*			
Diphtheria, tetanus, & acellular pertussis (DTaP: <7 yrs)			1st dose	2nd dose	3rd dose			←4th dose→
Haemophilus influenzae type b (Hib)			1st dose	2nd dose	See notes*		←3rd or 4th dose, See notes*→	
Pneumococcal conjugate (PCV13)			1st dose	2nd dose	3rd dose		←4th dose→	
Inactivated poliovirus (IPV: <18 yrs)			1st dose	2nd dose	←3rd dose→			
Influenza (IIV)					Annual vaccination 1 or 2 doses			
or Influenza (LAIV4)								
Measles, mumps, rubella (MMR)					See notes*		←1st dose→	
Varicella (VAR)							←1st dose→	
Hepatitis A (HepA)					See notes*		←2-dose series, See notes*→	
Tetanus, diphtheria, & acellular pertussis (Tdap: ≥7 yrs)								
Human papillomavirus (HPV)								
Meningococcal (MenACWY-D ≥9 mos, MenACWY-CRM ≥2 mos, MenACWY-TT ≥2years)			See notes*					
Meningococcal B (MenB)								
Pneumococcal polysaccharid (PPSV23)								

*For additional information please reference The Centers for Disease Control and Prevention at https://www.cdc.gov/vaccines/schedules/hcp/imz/child-adolescent.html

Note: Please always follow the State and/or CMS billing guidance and ensure the HEDIS codes are covered prior to submission. The codes and tips listed do not guarantee reimbursement.

Immunization Schedule: 18 Months to 18 Years

- Range of recommended ages for all children
- Range of recommended ages for catch-up immunization
- Range of recommended ages for certain high-risk groups
- Recommended based on shared clinical decision-making or *can be used in this age group
- No recommendation/Not applicable

Vaccine	18 mos	19-23 mo	2-3 yrs	4-6 yrs	7-10 yrs	11-12 yrs	13-15 yrs	16 yrs	17-18 yrs
Hepatitis B (HepB)	←3rd dose→								
Rotavirus: (RV) RV1 (2-dose series); RV5 (3-dose series)									
Diphtheria, tetanus, & acellular pertussis (DTaP: <7 yrs)	←4th dose→			5th dose					
Haemophilus influenzae type b (Hib)									
Pneumococcal conjugate (PCV13)									
Inactivated poliovirus (IPV: <18 yrs)	←3rd dose→			4th dose					
Influenza (IIV)	Annual vaccination 1 or 2 doses					Annual vaccination 1 dose only			
or Influenza (LAIV4)			Annual vaccination 1 or 2 doses or			Annual vaccination 1 dose only			
Measles, mumps, rubella (MMR)				2nd dose					
Varicella (VAR)				2nd dose					
Hepatitis A (HepA)	← 2-dose series, See notes*→								
Tetanus, diphtheria, & acellular pertussis (Tdap: ≥7 yrs)						Tdap			
Human papillomavirus (HPV)					*	See notes*			
Meningococcal (MenACWY-D ≥9 mos, MenACWY-CRM ≥2 mos, MenACWY-TT ≥2years)						1st dose		2nd dose	
Meningococcal B (MenB)						See notes*			
Pneumococcal polysaccharid (PPSV23)			See notes*						

*For additional information please reference The Centers for Disease Control and Prevention at https://www.cdc.gov/vaccines/schedules/hcp/imz/child-adolescent.html

Note: Please always follow the State and/or CMS billing guidance and ensure the HEDIS codes are covered prior to submission. The codes and tips listed do not guarantee reimbursement.

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

Recommendations for Preventive Pediatric Health Care

Bright Futures/American Academy of Pediatrics

Bright Futures
prevention and health promotion for infants, children, adolescents, and their families™

Each child and family is unique; therefore, these Recommendations for Preventive Pediatric Health Care are designed for the care of children who are receiving competent parenting, have no manifestations of any important health problems, and are growing and developing in a satisfactory fashion. Developmental, psychosocial, and chronic disease issues for children and adolescents may require frequent counseling and treatment visits separate from preventive care visits. Additional visits also may become necessary if circumstances suggest variations from normal.

These recommendations represent a consensus by the American Academy of Pediatrics (AAP) and Bright Futures. The AAP continues to emphasize the great importance of continuity of care in comprehensive health supervision and the need to avoid fragmentation of care.

Refer to the specific guidance by age as listed in the *Bright Futures Guidelines* (Hagan JF, Shaw JS, Duncan PM, eds. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*. 4th ed. American Academy of Pediatrics; 2017).

The recommendations in this statement do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

The Bright Futures/American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care are updated annually.

	INFANCY							EARLY CHILDHOOD							MIDDLE CHILDHOOD						ADOLESCENCE									
AGE[1]	**Prenatal**[2]	**Newborn**[3]	**3-5 d**[4]	**By 1 mo**	**2 mo**	**4 mo**	**6 mo**	**9 mo**	**12 mo**	**15 mo**	**18 mo**	**24 mo**	**30 mo**	**3 y**	**4 y**	**5 y**	**6 y**	**7 y**	**8 y**	**9 y**	**10 y**	**11 y**	**12 y**	**13 y**	**14 y**	**15 y**	**16 y**	**17 y**	**18 y**	**19 y**	**20 y**	**21 y**
HISTORY Initial/Interval	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
MEASUREMENTS																															
Length/Height and Weight		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Head Circumference		●	●	●	●	●	●	●	●	●	●	●																			
Weight for Length		●	●	●	●	●	●	●	●	●	●																				
Body Mass Index[4]												●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Blood Pressure[5]		★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
SENSORY SCREENING																															
Vision[7]		★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	●	★	●	★	●	★	●	★	★	●	★	★	●	★	★	★
Hearing		●[8]	●[9]	⟶	★	★	★	★	★	★	★	★	★	★	●	●	●	★	●	★	●	★	●	●[9]	⟵	●	⟶	⟵	●	⟶	⟵	●	⟶
DEVELOPMENTAL/BEHAVIORAL HEALTH																															
Developmental Screening[11]								●				●		●																	
Autism Spectrum Disorder Screening[12]												●	●																		
Developmental Surveillance		●	●	●	●	●	●		●	●		●		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Psychosocial/Behavioral Assessment[13]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Tobacco, Alcohol, or Drug Use Assessment[14]																						★	★	★	★	★	★	★	★	★	★
Depression Screening[15]																							●	●	●	●	●	●	●	●	●
Maternal Depression Screening[16]					●	●	●	●																							
PHYSICAL EXAMINATION[17]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
PROCEDURES[18]																															
Newborn Blood		●[19]	●[20]	⟶																											
Newborn Bilirubin[21]		●																													
Critical Congenital Heart Defect[22]		●																													
Immunization[23]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Anemia[24]						★			●	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Lead[25]							★	★	● or ★[26]		★	● or ★[26]		★	★	★	★															
Tuberculosis[27]				★			★		★			★		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Dyslipidemia[28]												★			★		★		★	⟵	●	⟶	★	★	★	★	★	⟵			●	⟶
Sexually Transmitted Infections[29]																						★	★	★	★	★	★	★	★	★	★
HIV[30]																						★	★	★	★	⟵		●	⟶	★	★	★
Hepatitis C Virus Infection[31]																													●	⟶		
Cervical Dyslasia[32]																															●
ORAL HEALTH[33]							●[34]	●[35]	★		★	★	★	★	★	★	★														
Fluoride Varnish[35]				⟵				●	⟶																						
Fluoride Supplementation[36]							★	★	★		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★					
ANTICIPATORY GUIDANCE	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●

1. If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time.
2. A prenatal visit is recommended for parents who are at high risk, for first-time parents, and for those who request a conference. The prenatal visit should include anticipatory guidance, pertinent medical history, and a discussion of benefits of breastfeeding and planned method of feeding, per "The Prenatal Visit" (http://pediatrics.aappublications.org/content/124/4/1227.full).
3. Newborns should have an evaluation after birth, and breastfeeding should be encouraged (and instruction and support should be offered).
4. Newborns should have an evaluation within 3 to 5 days of birth and within 48 to 72 hours after discharge from the hospital to include evaluation for feeding and jaundice. Breastfeeding newborns should receive formal breastfeeding evaluation, and their mothers should receive encouragement and instruction, as recommended in "Breastfeeding and the Use of Human Milk" (http://pediatrics.aappublications.org/content/129/3/e827.full). Newborns discharged less than 48 hours after delivery must be examined within 48 hours of discharge, per "Hospital Stay for Healthy Term Newborns" (http://pediatrics.aappublications.org/content/125/2/405.full).
5. Screen, per "Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity: Summary Report" (http://pediatrics.aappublications.org/content/120/Supplement_4/S164.full)
6. Screening should occur per "Clinical Practice Guideline for Screening and Management of High Blood Pressure in Children and Adolescents" (http://pediatrics.aappublications.org/content/140/3/e20171904). Blood pressure measurement in infants and children with specific risk conditions should be performed at visits before age 3 years.
7. A visual acuity screen is recommended at ages 4 and 5 years, as well as in cooperative 3-year-olds. Instrument-based screening may be used to assess risk at ages 12 and 24 months, in addition to the well visits at 3 through 5 years of age. See "Visual System Assessment in Infants, Children, and Young Adults by Pediatricians" (http://pediatrics.aappublications.org/content/137/1/e20153596) and "Procedures for the Evaluation of the Visual System by Pediatricians" (http://pediatrics.aappublications.org/content/137/1/e20153597).
8. Confirm initial screen was completed, verify results, and follow up, as appropriate. Newborns should be screened, per "Year 2007 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs" (http://pediatrics.aappublications.org/content/120/4/898.full).
9. Verify results as soon as possible, and follow up, as appropriate.
10. Screen with audiometry including 6,000 and 8,000 Hz high frequencies once between 11 and 14 years, once between 15 and 17 years, and once between 18 and 21 years. See "The Sensitivity of Adolescent Hearing Screens Significantly Improves by Adding High Frequencies" (https://www.sciencedirect.com/science/article/abs/pii/S1054139X16000483).
11. Screening should occur per "Promoting Optimal Development: Identifying Infants and Young Children With Developmental Disorders Through Developmental Surveillance and Screening" (https://pediatrics.aappublications.org/content/145/1/e20193449).
12. Screening should occur per "Identification, Evaluation, and Management of Children With Autism Spectrum Disorder" (https://pediatrics.aappublications.org/content/145/1/e20193447).
13. This assessment should be family centered and may include an assessment of child social-emotional health, caregiver depression, and social determinants of health. See "Promoting Optimal Development: Screening for Behavioral and Emotional Problems" (http://pediatrics.aappublications.org/content/135/2/384) and "Poverty and Child Health in the United States" (http://pediatrics.aappublications.org/content/137/4/e20160339).
14. A recommended assessment tool is available at http://crafft.org.
15. Recommended screening using the Patient Health Questionnaire (PHQ)-2 or other tools available in the GLAD-PC toolkit and at https://downloads.aap.org/AAP/PDF/Mental_Health_Tools_for_Pediatrics.pdf.
16. Screening should occur per "Incorporating Recognition and Management of Perinatal Depression Into Pediatric Practice" (https://pediatrics.aappublications.org/content/143/1/e20183259).
17. At each visit, age-appropriate physical examination is essential, with infant totally undclothed and older children undressed and suitably draped. See "Use of Chaperones During the Physical Examination of the Pediatric Patient" (http://pediatrics.aappublications.org/content/127/5/991.full).
18. Those may be modified, depending on entry point into schedule and individual need.
19. Confirm initial screen was accomplished, verify results, and follow up, as appropriate. The Recommended Uniform Screening Panel (https://www.hrsa.gov/advisory-committees/heritable-disorders/rusp/index.html), as determined by The Secretary's Advisory Committee on Heritable Disorders in Newborns and Children, and state newborn screening laws/regulations (https://www.babysfirsttest.org/newborn-screening/states) establish the criteria for and coverage of newborn screening procedures and programs.

(continued)

KEY: ● = to be performed ★ = risk assessment to be performed with appropriate action to follow, if positive ⟵●⟶ = range during which a service may be provided

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Periodicity schedule: Recommendations for Preventive Pediatric Health Care

https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf

(continued)

20. Verify results as soon as possible, and follow up, as appropriate.
21. Confirm initial screening was accomplished, verify results, and follow up, as appropriate. See "Hyperbilirubinemia in the Newborn Infant ≥35 Weeks' Gestation: An Update With Clarifications" (http://pediatrics.aappublications.org/content/124/4/1193).
22. Screening for critical congenital heart disease using pulse oximetry should be performed in newborns, after 24 hours of age, before discharge from the hospital, per "Endorsement of Health and Human Services Recommendation for Pulse Oximetry Screening for Critical Congenital Heart Disease" (http://pediatrics.aappublications.org/content/129/1/190.full).
23. Schedules, per the AAP Committee on Infectious Diseases, are available at https://redbook.solutions.aap.org/SS/immunization_Schedules.aspx. Every visit should be an opportunity to update and complete a child's immunizations.
24. Perform risk assessment or screening, as appropriate, per recommendations in the current edition of the AAP *Pediatric Nutrition: Policy of the American Academy of Pediatrics* (Iron chapter).
25. For children at risk of lead exposure, see "Prevention of Childhood Lead Toxicity" (http://pediatrics.aappublications.org/content/138/1/e20161493) and "Low Level Lead Exposure Harms Children: A Renewed Call for Primary Prevention" (http://www.cdc.gov/nceh/lead/ACCLPP/Final_Document_030712.pdf).
26. Perform risk assessments or screenings as appropriate, based on universal screening requirements for patients with Medicaid or in high prevalence areas.
27. Tuberculosis testing per recommendations of the AAP Committee on Infectious Diseases, published in the current edition of the AAP *Red Book: Report of the Committee on Infectious Diseases*. Testing should be performed on recognition of high-risk factors.
28. See "Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents" (http://www.nhlbi.nih.gov/guidelines/cvd_ped/index.htm).
29. Adolescents should be screened for sexually transmitted infections (STIs) per recommendations in the current edition of the AAP *Red Book: Report of the Committee on Infectious Diseases*.
30. Adolescents should be screened for HIV according to the US Preventive Services Task Force (USPSTF) recommendations (https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/human-immunodeficiency-virus-hiv-infection-screening) once between the ages of 15 and 18, making every effort to preserve confidentiality of the adolescent. Those at increased risk of HIV infection, including those who are sexually active, participate in injection drug use, or are being tested for other STIs, should be tested for HIV and reassessed annually.
31. All individuals should be screened for hepatitis C virus (HCV) infection according to the USPSTF (https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/hepatitis-c-screening) and Centers for Disease Control and Prevention (CDC) recommendations (https://www.cdc.gov/mmwr/volumes/69/rr/rr6902a1.htm) at least once between the ages of 18 and 79. Those at increased risk of HCV infection, including those who are persons with past or current injection drug use, should be tested for HCV infection and reassessed annually.
32. See USPSTF recommendations (https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/cervical-cancer-screening). Indications for pelvic examinations prior to age 21 are noted in "Gynecologic Examination for Adolescents in the Pediatric Office Setting" (http://pediatrics.aappublications.org/content/126/3/583.full).
33. Assess whether the child has a dental home. If no dental home is identified, perform a risk assessment (https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Oral-Health/Pages/Oral-Health-Practice-Tools.aspx) and refer to a dental home. Recommend brushing with fluoride toothpaste in the proper dosage for age. See "Maintaining and Improving the Oral Health of Young Children" (http://pediatrics.aappublications.org/content/134/6/1224).
34. Perform a risk assessment (https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Oral-Health/Pages/Oral-Health-Practice-Tools.aspx). See "Maintaining and Improving the Oral Health of Young Children" (http://pediatrics.aappublications.org/content/134/6/1224).
35. See USPSTF recommendations (https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/dental-caries-in-children-from-birth-through-age-5-years-screening). Once teeth are present, fluoride varnish may be applied to all children every 3 to 6 months in the primary care or dental office. Indications for fluoride use are noted in "Fluoride Use in Caries Prevention in the Primary Care Setting" (http://pediatrics.aappublications.org/content/134/3/626).
36. If primary water source is deficient in fluoride, consider oral fluoride supplementation. See "Fluoride Use in Caries Prevention in the Primary Care Setting" (http://pediatrics.aappublications.org/content/134/3/626).

Summary of Changes Made to the Bright Futures/AAP Recommendations for Preventive Pediatric Health Care (Periodicity Schedule)

This schedule reflects changes approved in November 2020 and published in March 2021. For updates and a list of previous changes made, visit www.aap.org/periodicityschedule.

CHANGES MADE IN NOVEMBER 2020

DEVELOPMENTAL

- Footnote 11 has been updated to read as follows: "Screening should occur per 'Promoting Optimal Development: Identifying Infant and Young Children With Developmental Disorders Through Developmental Surveillance and Screening' (https://pediatrics.aappublications.org/content/145/1/e20193449)."

AUTISM SPECTRUM DISORDER

- Footnote 12 has been updated to read as follows: "Screening should occur per 'Identification, Evaluation, and Management of Children With Autism Spectrum Disorder' (https://pediatrics.aappublications.org/content/145/1/e20193447)."

HEPATITIS C VIRUS INFECTION

- Screening for hepatitis C virus infection has been added to occur at least once between the ages of 18 and 79 years (to be consistent with recommendations of the USPSTF and CDC).
- Footnote 31 has been added to read as follows: "All individuals should be screened for hepatitis C virus (HCV) infection according to the USPSTF (https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/hepatitis-c-screening) and Centers for Disease Control and Prevention (CDC) recommendations (https://www.cdc.gov/mmwr/volumes/69/rr/rr6902a1.htm) at least once between the ages of 18 and 79. Those at increased risk of HCV infection, including those who are persons with past or current injection drug use, should be tested for HCV infection and reassessed annually."
- Footnotes 31 through 35 have been renumbered as footnotes 32 through 36.

CHANGES MADE IN OCTOBER 2019

MATERNAL DEPRESSION

- Footnote 16 has been updated to read as follows: "Screening should occur per 'Incorporating Recognition and Management of Perinatal Depression Into Pediatric Practice' (https://pediatrics.aappublications.org/content/143/1/e20183259)."

CHANGES MADE IN DECEMBER 2018

BLOOD PRESSURE

- Footnote 6 has been updated to read as follows: "Screening should occur per 'Clinical Practice Guideline for Screening and Management of High Blood Pressure in Children and Adolescents' (http://pediatrics.aappublications.org/content/140/3/e20171904). Blood pressure measurement in infants and children with specific risk conditions should be performed at visits before age 3 years."

ANEMIA

- Footnote 24 has been updated to read as follows: "Perform risk assessment or screening, as appropriate, per recommendations in the current edition of the AAP *Pediatric Nutrition: Policy of the American Academy of Pediatrics* (Iron chapter)."

LEAD

- Footnote 25 has been updated to read as follows: "For children at risk of lead exposure, see 'Prevention of Childhood Lead Toxicity' (http://pediatrics.aappublications.org/content /138/1/e20161493) and 'Low Level Lead Exposure Harms Children: A Renewed Call for Primary Prevention' (https://www.cdc.gov/nceh/lead/ACCLPP/Final_Document_030712.pdf)."

Note: Please always follow the State and/or CMS billing guidance and ensure the HEDIS codes are covered prior to submission. The codes and tips listed do not guarantee reimbursement.

Early and Periodic Screening, Diagnostic And Treatment (EPSDT) Quick Reference Guide

INFANCY AND EARLY CHILDHOOD EPSDT PREVENTIVE MEDICAL VISITS			
Children should have 11 EPSDT visits before 3 years old. Complete Eight (8) visits within 15 months. Three (3) additional EPSDT preventive medical visits should occur before age 3 years:			
3-5 day	By 1 month	2 months	4 months
6 months	9 months	12 months	15 months
18 months	24 months	30 months	3 years old/annually

HEDIS Requirements

HEDIS requires at least 6 visits by 15 months and 2 or more visits by 30 months.

Note: EPSDT preventive medical visits that occur at 15 months and 1 day old, will not count towards HEDIS scores.

Tips

- If the Provider is compliant with the Bright Futures guideline, they will be compliant with the HEDIS requirements.
- Schedule a visit for members who may need to catch up with the BFG periodicity schedule.
- Document type of anticipatory guidance.
- Assess for a dental home and first dental exam no later than 12 months. According to American Academy of Pediatrics (AAP) 2020 Bright Futures, "Promoting Oral Health."

DEVELOPMENTAL SCREENINGS

A Developmental Screening using a STANDARDIZED DEVELOPMENTAL SCREENING TOOL must be performed at the 9 months, 18 months and 30 months during EPSDT preventive medical visits.

Acceptable Standardized Tools

- Ages and Stages Questionnaire (ASQ) – 2 months to 5 years
- Ages and Stages Questionnaire – 3rd Edition (ASQ-3)
- Battelle Developmental Inventory Screening Tool (BDI-ST) Birth to 95 months
- Bayley Infant Neuro-developmental Screen (BINS) – 3 months to 2 years
- Brigance Screens-II – Birth to 90 months
- Child Development Inventory (CDI) - 18 months to 6 years
- Infant Development Inventory – Birth to 18 months
- Parents' Evaluation of Developmental Status (PEDS) – Birth to 8 years
- Parent's Evaluation of Developmental Status – Developmental Milestones
- (PEDS-DM)

*Reimbursement is delivered for performing developmental screening using a standardized tool; providers must bill CPT Code 96110 with the EP modifier and the appropriate preventive ICD-10-CM diagnosis code

Note: Please always follow the State and/or CMS billing guidance and ensure the HEDIS codes are covered prior to submission. The codes and tips listed do not guarantee reimbursement.

GENERAL HEALTH
Medication Management

For more information, visit **www.ncqa.org**

Note: Please always follow the State and/or CMS billing guidance and ensure the HEDIS codes are covered prior to submission. The codes and tips listed do not guarantee reimbursement.

(ADD) Follow-Up Care for Children prescribed ADHD Medication

Line of Business: Commercial, Medicaid

The percentage of members 6-12 years of age newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least 3 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:

1. **Initiation Phase:** The percentage of members who had one follow-up visit with a practitioner with prescribing authority during the 30-day initiation phase.
2. **Continuation and Maintenance Phase:** The percentage of members who remained on the medication for at least 210 days and who had at least three follow-up visits which with a practitioner with prescribing authority within 270 days (9 months) after the initiation phase.

Intake period: March 1, 2020 - February 28, 2021

Clinical Goal:

When managed appropriately, medication for ADHD can control symptoms of hyperactivity, impulsiveness, and sustain concentration. To ensure that medication is prescribed and managed correctly, it is important that a pediatrician with prescribing authority monitor's children.

Proper coding is essential to ensure accurate reporting; any of the following code combinations billed by a practitioner with prescribing authority meets criteria.

Description	Codes
Outpatient visit with Outpatient POS	**CPT:** 90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221-99223, 99231-99233, 99238, 99239, 99251-99255 **POS:** 03, 05, 07, 09, 11-20, 22, 33, 49, 50, 71, 72

Note: Please always follow the State and/or CMS billing guidance and ensure the HEDIS codes are covered prior to submission. The codes and tips listed do not guarantee reimbursement.

BH Outpatient visit	**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, T1015 **UBREV:** 0510, 0513, 0515, 0516-0529, 0900, 0902, 0903 0904, 0911, 0914 - 0917, 0919, 0982, 0983
Observation Visit	**CPT:** 99217-99220
Health and Behavior Assessment/ Intervention	**CPT:** 96150 - 96154, 96156, 96158, 96164, 96165, 96167, 96168, 96170, 96171
Visit Setting Unspecified Value Set with Partial Hospitalization POS	**CPT:** 90791, 90792, 90832 - 90834, 90836 - 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221 - 99223, 99231 - 99233, 99238, 99239, 99251 – 99255 **POS:** 52
Partial Hospitalization/ Intensive Outpatient	**HCPCS:** G0410, G0411, H0035, H2001, H2012, S0201, S9480, S9484, S9485
Visit Setting Unspecified Value Set with Community Mental Health Center POS	**CPT:** 90791, 90792, 90832 - 90834, 90836 - 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221 - 99223, 99231 - 99233, 99238, 99239, 99251 – 99255 **POS:** 53

**Codes subject to change*

Best Practice:

- Discuss the importance of taking medication as prescribed and remaining on medication.
- Educate members on possible side effects and length of time for the medication to have the desired effect.
- Schedule a two weeks to follow up an appointment before the patient leaves your office and send appointment reminder to ensure patient returns within 30 days.
- Schedule a six weeks, three months and six months follow up appointments before the patient leaves your office. Send an appointment reminder to ensure patient returns and has at least two visits in nine months.

Note: Please always follow the State and/or CMS billing guidance and ensure the HEDIS codes are covered prior to submission. The codes and tips listed do not guarantee reimbursement.

- Set a flag if available in EHR or develop tracking method for members prescribed or restarted ADHD medication and require staff to follow up with patients that miss or cancel their appointment.

(AMM) Antidepressant Medication Management

Line of Business: Commercial, Medicaid, Medicare

The percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on antidepressant medication treatment.

Two rates are reported:

1. **Effective Acute Phase Treatment** - The percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks).
2. **Effective Continuation Phase Treatment** - The percentage of members who remained on an antidepressant medication for at least 180 days (6 months).

Clinical Goal:

The goal is for members with a diagnosis of major depression to remain on medication therapy during the acute phase for at least 12 weeks and continue for at least six months; reducing regression and re-hospitalization.

Proper coding is essential to ensure accurate reporting

Description	Codes
Major Depression	F32.0, F32.1, F32.2, F32.3. F32.4, F32.9, F33.0, F33.1, F33.2, F33.3, F33.41, F33.9

**Codes subject to change*

Best Practice:

Educate the patient and/or caregiver on:

- The importance of taking medication as prescribed and remaining on medication even when the member starts to feel better for a minimum of six months.
- What are the risks of abruptly stopping medication or before the six months treatment phase; the patient should first schedule a follow-up and consult with the physician.
- Talk over the possible side effects and length of time for the medication to have the desired effect.
- Schedule follow up an appointment before the patient leaves your office and send appointment reminders.

Note: Please always follow the State and/or CMS billing guidance and ensure the HEDIS codes are covered prior to submission. The codes and tips listed do not guarantee reimbursement.

- Set flags if available in EHR or develop tracking method for members prescribed antidepressants and require staff to follow up with patients that miss or cancel their appointment.

Antidepressant Medications

Description	Prescription		
Miscellaneous antidepressants	Bupropion	Vilazodone	Vortioxetine
Monoamine oxidase inhibitors	Isocarboxazid Phenelzine	Selegiline Tranylcypromine	
Phenylpiperazine antidepressants	Nefazodone	Trazodone	
Psychotherapeutic combinations	Amitriptyline-chlordiazepoxide Amitriptyline-perphenazine		Fluoxetine-olanzapine
SNRI antidepressants	Desvenlafaxine Duloxetine	Levomilnacipran Venlafaxine	
SSRI antidepressants	Citalopram Escitalopram	Fluoxetine Fluvoxamine	Paroxetine Sertraline
Tetracyclic antidepressants	Maprotiline	Mirtazapine	
Tricyclic antidepressants	Amitriptyline Amoxapine Clomipramine	Desipramine Doxepin (>6 mg) Imipramine	Nortriptyline Protriptyline Trimipramine

**Subject to change. Please refer to www.pshp.ga.com for specific drug coverage.*

(APM) Metabolic Monitoring for Children and Adolescents on Antipsychotics

Line of Business: Commercial, Medicaid

The percentage of children and adolescents 1-17 years of age who had two or more antipsychotic prescriptions and had metabolic testing.

Three rates are reported:

1. The percentage of children and adolescents on antipsychotics who received blood glucose testing.

2. The percentage of children and adolescents on antipsychotics who received cholesterol testing.

3. The percentage of children and adolescents on antipsychotics who received blood glucose and cholesterol testing.

Clinical Goal:

Medication Management for member's prescribed two or more antipsychotic medication with ongoing monitoring and metabolic testing by performing an HbA1c and LDL-C test annually.

Proper coding is essential to ensure accurate reporting

Description	Codes
HBA1c Tests	**CPT:** 83036, 83037 **CPT-CAT-II:** 3044F, 3046F, 3051F, 3052F
Glucose Lab Tests	**CPT:** 80047, 80048, 80050, 80053, 80069, 82947, 82950, 82951
LDL - C Tests	**CPT:** 80061, 83700, 83701, 83704, 83721 **CPT-CAT-II:** 3048F, 3049F, 3050F
Cholesterol Lab Tests	**CPT:** 82465, 83718, 83722, 84478

**Codes subject to change*

Best Practice:

- Increase patient's compliance by generating a standing order for lab testing
- Educate members and their caregivers on the importance of completing annual visits and blood work annually for metabolic testing.
- Maintain appointment availability in your practice for patients and schedule follow-up appointments before a member leaving appointment as applicable for lab work.
- Contact patients that do not keep follow-up appointments and set flags if available in EHR or develop tracking method for members due or past due for lab work and assessments. Require staff to follow up with patients that miss or cancel their appointment.

(PBH) Persistence of Beta-Blocker Treatment after a Heart Attack

Line of Business: Commercial, Medicaid, Medicare

The percentage of members 18 years of age and older during the measurement year who were hospitalized and discharged from July 1 of the year prior to the

Note: Please always follow the State and/or CMS billing guidance and ensure the HEDIS codes are covered prior to submission. The codes and tips listed do not guarantee reimbursement.

measurement year to June 30 of the measurement year with a diagnosis of AMI and who received persistent beta-blocker treatment for six months after discharge.

Clinical Goal:

Members >18yrs of age and older with a new diagnosis of AMI will remain on beta-blocker treatment for 6 months after the hospital discharge. Consider 90 day supply or refills times 6 if appropriate.

Receipt of pharmacy claims for 180 day supply of beta blocker medication

Best Practice:

- Provide education on the importance of adhering to the prescribed medications.
- Review potential side effects and adjust medications as needed.
- Monitor adherence and discuss potential barriers with the patient.
- Prescribe a 90-day supply to encourage adherence:
- Refer to www.pshp.ga.com for 90 day supply benefits
- Consider patient's co-morbidities

Description	ICD-10-CM
AMI	I21.01, I21.02, I21.09, I21.11, I21.19, I21.21, I21.29, I21.3, I21.4

**Codes Subject to Change*

Beta-Blocker Medications

Description	Prescription		
Noncardioselective beta-blockers	Carvedilol Labetalol Nadolol Pindolol	Propranolol Timolol Sotalol	
Cardioselective beta-blockers	Acebutolol Atenolol	Betaxolol Bisoprolol	Metoprolol Nebivolol
Antihypertensive combinations	Atenolol-chlorthalidone Bendroflumethiazide-nadolol Bisoprolol-hydrochlorothiazide	Hydrochlorothiazide-metoprolol Hydrochlorothiazide-propranolol	

**Subject to change. Please refer to www.pshp.ga.com for specific drug coverage.*

Note: Please always follow the State and/or CMS billing guidance and ensure the HEDIS codes are covered prior to submission. The codes and tips listed do not guarantee reimbursement.

(POD) Pharmacotherapy for Opioid Use Disorder

Line of Business: Commercial, Medicaid, Medicare

The percentage of new opioid use disorder (OUD) pharmacotherapy events with OUD pharmacotherapy for 180 or more days among members age 16 and older with a diagnosis of OUD.

Clinical Goal:

Continuity of pharmacotherapy is vital to the prevention of member relapse and overdose, as well as improve the outcomes of those with OUD.

Proper coding is essential to ensure accurate reporting.

Description	ICD-10 CM
Opioid Abuse and Dependence	F11.10, F11.120-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

**Codes subject to change*

Opioid Use Disorder Treatment Medication

Description	Prescription	Medication Lists	Value Sets and Days' Supply
Antagonist	Naltrexone (oral)	Naltrexone Oral Medications List	NA—Codes do not exist
Antagonist	Naltrexone (injectable)	Naltrexone Injection Medications List	Naltrexone Injection Value Set (31 days' supply)
Partial agonist	Buprenorphine (sublingual tablet)	Buprenorphine Oral Medications List	Buprenorphine Oral Value Set (1 day supply) Buprenorphine Oral Weekly Value Set (7 days' supply)
Partial agonist	Buprenorphine (injection)	Buprenorphine Injection Medications List	Buprenorphine Injection Value Set (31 days' supply)
Partial agonist	Buprenorphine (implant)	Buprenorphine Implant Medications List	Buprenorphine Implant Value Set (180 days' supply)

Note: Please always follow the State and/or CMS billing guidance and ensure the HEDIS codes are covered prior to submission. The codes and tips listed do not guarantee reimbursement.

Partial agonist	Buprenorphine/ naloxone (sublingual tablet, buccal film, sublingual film)	Buprenorphine Naloxone Medications List	Buprenorphine Naloxone Value Set (1 day supply)
Agonist	▪ Methadone (oral)	▪ NA (refer to Note below)	▪ Methadone Oral Value Set (1 day supply) ▪ Methadone Oral Weekly Value Set (7 days' supply)

**Subject to change. Please refer to www.pshp.ga.com for specific drug coverage.*

(SAA) Adherence to Antipsychotic Medications for Individuals with Schizophrenia

Line of Business: Commercial, Medicaid, Medicare

The percentage of members 18 years of age and older during the measurement year with schizophrenia or schizoaffective disorder who were dispensed and remained on antipsychotic medication for at least 80% of their treatment period.

Clinical Goal:

Member's prescribed antipsychotic medication to continue on their medication.

Proper coding is essential to ensure accurate reporting. When treating a patient for schizophrenia diagnosis, code for the diagnosis on the claim.

Description	ICD-10- CM
Schizophrenia	F20.0-F20.3, F20.5, F20.81, F20.89, F20.9, F25.0, F25.1, F25.8, F25.9

Note: Please always follow the State and/or CMS billing guidance and ensure the HEDIS codes are covered prior to submission. The codes and tips listed do not guarantee reimbursement.

Oral Antipsychotic Medications

Description	Prescription	Medication Lists
Miscellaneous antipsychotic agents (oral)	Aripiprazole	Aripiprazole Oral Medications List
	Asenapine	Asenapine Oral Medications List
	Brexpiprazole	Brexpiprazole Oral Medications List
	Cariprazine	Cariprazine Oral Medications List
	Clozapine	Clozapine Oral Medications List
	Haloperidol	Haloperidol Oral Medications List
	Iloperidone	Iloperidone Oral Medications List
	Loxapine	Loxapine Oral Medications List
	Lurasidone	Lurasidone Oral Medications List
	Molindone	Molindone Oral Medications List
	Olanzapine	Olanzapine Oral Medications List
	Paliperidone	Paliperidone Oral Medications List
	Quetiapine	Quetiapine Oral Medications List
	Risperidone	Risperidone Oral Medications List
	Ziprasidone	Ziprasidone Oral Medications List
Phenothiazine antipsychotics (oral)	Chlorpromazine	Chlorpromazine Oral Medications List
	Fluphenazine	Fluphenazine Oral Medications List
	Perphenazine	Perphenazine Oral Medications List
	Prochlorperazine	Prochlorperazine Oral Medications List
	Thioridazine	Thioridazine Oral Medications List
	Trifluoperazine	Trifluoperazine Oral Medications List
Psychotherapeutic combinations (oral)	Amitriptyline-perphenazine	Amitriptyline Perphenazine Oral Medications List
Thioxanthenes (oral)	Thiothixene	Thiothixene Oral Medications List

**Subject to change. Please refer to www.pshp.ga.com for specific drug coverage.*

Note: Please always follow the State and/or CMS billing guidance and ensure the HEDIS codes are covered prior to submission. The codes and tips listed do not guarantee reimbursement.

(SMC) Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia

Line of Business: Medicaid

The percentage of members 18–64 years of age with schizophrenia or schizo-affective disorder and cardiovascular disease, who had an LDL-C test during the measurement year.

Clinical Goal:

Members with schizophrenia, and cardiovascular disease will receive an annual LDL – C lab testing.

Proper coding is vital to ensure accurate reporting. When treating a patient for schizophrenia and cardiovascular diagnosis, code with the appropriate diagnosis for claim submission.

Description	Codes
Schizophrenia	**ICD-10 CM:** F20.0 - F20.9, F25.0 - F25.9
Ischemic Vascular Disease	**Diagnoses ICD-10-CM:** Codes in Categories I70-I75.89, plus T82.855A, T82.855D, T82.855S, T82.856A, T82.856D, T82.856S
LDL- C Tests	**CPT:** 80061, 83700, 83701, 83704, 83721
LDL - C Test Results	**CPT-CAT- II:** 3048F, 3049F, 3050F

**Codes subject to change*

(SPC) Statin Therapy for Patients with Cardiovascular Disease

Line of Business: Commercial, Medicaid, Medicare

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

1. **Received Statin Therapy:** Members who were dispensed at least one high-intensity or moderate-intensity statin medication during the measurement year.

2. **Statin Adherence 80%:** Members who remained on a high-intensity or moderate-intensity statin medication for at least 80% of the treatment period.

Clinical Goal:

Prescribe at least one high-intensity or moderate-intensity statin medication during the measurement year.

Note: Please always follow the State and/or CMS billing guidance and ensure the HEDIS codes are covered prior to submission. The codes and tips listed do not guarantee reimbursement.

Exclusion from the HEDIS Measure:

Patients are excluded if they: Are a patient in hospice or living in a long-term institutional setting any time in the measurement year.

- Female members with a diagnosis of pregnancy, dispensed clomiphene or underwent in-vitro fertilization in the measurement year or the year prior to the measurement year.
- Member diagnosis with ESRD during the measurement year or the year prior to the measurement year.
- Diagnosis of cirrhosis during the measurement year or the year prior to the measurement year.
- Have myalgia, myositis, myopathy or rhabdomyolysis during the measurement year.
- Have an advanced illness and frailty:
  - » Medicare members ages 66 and older with advanced illness in the measurement year or the year prior to the measurement year and frailty in the measurement year are excluded when claims are received with advanced illness (includes dispensed dementia medication) and frailty codes. See the Advanced illness and frailty guide for more information.

When a patient is unable to tolerate statin medication, they are excluded from the measure. Document the condition in their medical record and submit a claim using the appropriate code:

Description	ICD-10-CM Code
Myalgia	M79.1, M79.10-M79.12, M79.18
Myositis	M60.80, M60.811, M60.812, M60.819, M60.821, M60.822, M60.829, M60.831, M60.832, M60.839 , M60.841, M60.842, M60.849, M60.51, M60.852, M60.859, M60.861, M60.862, M60.869, M60.871, M60.872, M60.879, M60.88, M60.89, M60.9
Myopathy	G72.0, G72.2, G72.9
Rhabdomyolysis	M62.82

**Codes subject to change*

High- and Moderate-Intensity Statin Medications

Description	Prescription	Medication Lists
High-intensity statin therapy	Atorvastatin 40-80 mg	Atorvastatin High Intensity Medications List

Note: Please always follow the State and/or CMS billing guidance and ensure the HEDIS codes are covered prior to submission. The codes and tips listed do not guarantee reimbursement.

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

**Subject to change. Please refer to www.pshp.ga.com for specific drug coverage.*

(SPD) Statin Therapy for Patients with Diabetes

Line of Business: Commercial, Medicaid, Medicare

The percentage of members 40–75 years of age during the measurement year with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) who met the following criteria.

Two rates are reported:

1. **Received Statin Therapy:** Members who were dispensed at least one statin medication of any intensity during the measurement year.
2. **Statin Adherence 80%:** Members who remained on a statin medication of any intensity for at least 80% of the treatment period

Clinical Goal:

Member dispensed at least one statin medication or remained on statin medication 80% of treatment period for any intensity meets compliance

Exclusion from the HEDIS Measure:

Patients are excluded if they:

- Diagnosis identifying members who had of MI, CABG, PCI and other revascularization procedures
- Female members with a diagnosis of Pregnancy, IVF, dispensed at least one Clomiphene, ESRD or Cirrhosis
- Have myalgia, myositis, myopathy or rhabdomyolysis during the measurement year.
- Have an advanced illness and frailty:
  - » Medicare members ages 66 and older with advanced illness in the measurement year or the year prior to the measurement year and frailty in the measurement year are excluded when claims are received with advanced illness (includes dispensed dementia medication) and frailty codes. See the Advanced illness and frailty guide for more information.

Best Practice:

- Review the patients medication list at every visit
- Educate the patients about the importance of medication compliance.

High, Moderate and Low-Intensity Statin Medications

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

Low-intensity statin therapy	Ezetimibe-simvastatin 10 mg	Ezetimibe Simvastatin Low Intensity Medications List
Low-intensity statin therapy	Fluvastatin 20 mg	Fluvastatin Low Intensity Medications List
Low-intensity statin therapy	Lovastatin 10-20 mg	Lovastatin Low Intensity Medications List
Low-intensity statin therapy	Pravastatin 10–20 mg	Pravastatin Low Intensity Medications List
Low-intensity statin therapy	Simvastatin 5-10 mg	Simvastatin Low Intensity Medications List

**Subject to change. Please refer to www.pshp.ga.com for specific drug coverage.*

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

Line of Business: Medicaid

The percentage of members 18–64 years of age with schizophrenia, schizoaffective disorder or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.

Clinical Goal:

- Persons with serious mental illness who use antipsychotics are at increased risk of cardiovascular diseases and diabetes. Lack of appropriate care for diabetes and cardiovascular disease for people with schizophrenia, schizoaffective or bipolar disorder who use antipsychotic medications can lead to worsening health and death.
- Screening and monitoring of physical health needs is an important way to improve health, quality of life and economic outcomes downstream.
- The goal is for members with schizophrenia or Bipolar Disorder who were dispensed antipsychotic medication receive annual assessment and screenings for Diabetes.
- Documentation of the date of the glucose test or HbA1c lab results should be in the medical record.

Proper coding is essential to ensure accurate reporting.

Note: Please always follow the State and/or CMS billing guidance and ensure the HEDIS codes are covered prior to submission. The codes and tips listed do not guarantee reimbursement.

Description	Codes
Schizophrenia	**ICD-10-CM:** F20.0 - F20.9, F25.0 - F25.9
Bipolar Disorder	**ICD-10-CM:** F30.10 - F31.78
Other Bipolar Disorder	**ICD-10-CM:** F31.81, F31.89, F31.9
HbA1C Lab Tests	**CPT:** 83036, 83037 **CPT-CAT-II:** 3044F, 3046F, 3051F, 3052F
Glucose Lab Tests	**CPT:** 80047, 80048, 80050, 80053, 80069, 82947, 82950, 82951

Best Practice:

- To increase compliance, consider using standing orders to get lab tests.
- Educate members and their caregivers on the importance of completing annual visits and blood work annually.
- Maintain appointment availability in your practice for patients and schedule follow-up appointments before a member leaves appointment as applicable for lab work and diabetes management.
- Reach out to patients that do not keep follow-up appointments and set flags if available in EHR or develop tracking method for members due or past due for lab work and assessments. Require staff to follow up with patients that miss or cancel their appointment.

Note: Please always follow the State and/or CMS billing guidance and ensure the HEDIS codes are covered prior to submission. The codes and tips listed do not guarantee reimbursement.

TREATMENT

For more information, visit **www.ncqa.org**

Note: Please always follow the State and/or CMS billing guidance and ensure the HEDIS codes are covered prior to submission. The codes and tips listed do not guarantee reimbursement.

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

Line of Business: Commercial, Medicaid, Medicare

The percentage of episodes for members ages 3 months and older with a diagnosis of acute bronchitis/ bronchiolitis that did not result in an antibiotic dispensing event.

The measurement period begins on July 1 of the year prior to the measurement year and ends on June 30 of the measurement year.

Clinical Goal:

Members treated for acute bronchitis should NOT be prescribed antibiotics unless there are co-morbid conditions or competing diagnoses that require antibiotic therapy.

***Note:** This measure is reported as an inverted rate. A higher rate indicates appropriate treatment of adults with acute bronchitis. It describes the proportion for who were not prescribed an antibiotic

Exclusions:

Exclude episode dates when the member had a claim/encounter with any diagnosis for a comorbid condition during the 12 months prior to or on the episode date. A code from any of the following meet criteria for comorbid conditions:

Exclusions/Co-Morbid
Comorbid Conditions, COPD, Disorders of the Immune System, Emphysema, HIV Type 2, HIV, Malignant Neoplasms, Other Malignant Neoplasm of Skin

Documentation:

Evidence from claim/encounter data with a date of service for any outpatient or ED visit with an acute bronchitis diagnosis and no new or refill prescription for an antibiotic medication in the measurement year.

Proper coding is critical to ensure accurate reporting of these measures and it may also decrease the need for medical record reviews.

Description	Codes
Acute Bronchitis	**ICD-10-CM:** J20.3-J20.9, J21.1, J21.8, J21.9
ED	**CPT:** 99281-99285 **UBREV:** 0450-0452, 0456, 0459, 0981
Observation	**CPT:** 99217-99220

Outpatient	**CPT:** 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99401-99404, 99411, 99412, 99455, 99456,99483 **HCPCS:** G0438, G0439, G0463, T1015

**Codes subject to change*

AAB Antibiotic Medications

Description	Prescription		
Aminoglycosides	Amikacin Gentamicin	Streptomycin Tobramycin	
Aminopenicillins	Amoxicillin	Ampicillin	
Beta-lactamase inhibitors	Amoxicillin-clavulanate Ampicillin-sulbactam	Piperacillin-tazobactam	
First-generation cephalosporins	Cefadroxil	Cefazolin	Cephalexin
Fourth-generation cephalosporins	Cefepime		
Ketolides	Telithromycin		
Lincomycin derivatives	Clindamycin	Lincomycin	
Macrolides	Azithromycin Clarithromycin	Erythromycin Erythromycin ethylsuccinate	Erythromycin lactobionate Erythromycin stearate
Miscellaneous antibiotics	Aztreonam Chloramphenicol Dalfopristin-quinupristin	Daptomycin Linezolid Metronidazole	Vancomycin
Natural penicillins	Penicillin G benzathine-procaine Penicillin G potassium	Penicillin G procaine Penicillin G sodium	Penicillin V potassium Penicillin G benzathine

Note: Please always follow the State and/or CMS billing guidance and ensure the HEDIS codes are covered prior to submission. The codes and tips listed do not guarantee reimbursement.

Penicillinase resistant penicillins	Dicloxacillin	Nafcillin	Oxacillin
Quinolones	Ciprofloxacin Gemifloxacin	Levofloxacin Moxifloxacin	Ofloxacin
Rifamycin derivatives	Rifampin		
Second-generation cephalosporin	Cefaclor Cefotetan	Cefoxitin Cefprozil	Cefuroxime
Sulfonamides	Sulfadiazine	Sulfamethoxazole-trimethoprim	
Tetracyclines	Doxycycline	Minocycline	Tetracycline
Third-generation cephalosporins	Cefdinir Cefditoren Cefixime	Cefotaxime Cefpodoxime Ceftazidime	Ceftibuten Ceftriaxone
Urinary anti-infective	Fosfomycin Nitrofurantoin Nitrofurantoin macrocrystals	Nitrofurantoin macrocrystals-monohydrate Trimethoprim	

**Subject to change. Please refer to www.pshp.ga.com for specific drug coverage.*

Best Practice:

- Refer to the illness as a "chest cold" or viral upper respiratory infection and suggest at home treatments such as:
  - » Over-the-Counter (OTC) cough medicine and anti-inflammatory medicine
  - » Drinking extra fluids and resting
  - » Using a nasal irrigation device or steamy hot shower for nasal and sinus congestion relief
- If the patient or Caregiver insists on an antibiotic:
  - » Review the absence of bacterial infection symptoms with the patient/caregiver and educate that antibiotics will not help with viral infections
  - » Discuss the side effects of taking antibiotics
  - » Arrange an early follow-up visit, either by phone call or re-examination

Note: Please always follow the State and/or CMS billing guidance and ensure the HEDIS codes are covered prior to submission. The codes and tips listed do not guarantee reimbursement.

(AMR) Asthma Medication Ratio

Line of Business: Commercial, Medicaid

The percentage of members 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.

- **Step 1:** For each member, count the units of asthma controller medications dispensed during the measurement year. ***Refer to Asthma Controller Medication List***
- **Step 2:** For each member, count the units of asthma reliever medications dispensed during the measurement year. ***Refer to Asthma Reliever Medication List***
- **Step 3:** For each member, sum the units calculated in step 1 and step 2 to determine units of total asthma medications.
- **Step 4:** For each member, calculate the ratio of controller medications to total asthma medications using the following formula. Round (using the .5 rule) to the nearest whole number.

  Calculation: Units of Controller Medication (step 1)
  Units of Reliever Medication (step 3)

Best Practice:

- Develop an asthma action plan with patient and education on reduction of asthma triggers
- Ensure proper coding to avoid coding asthma if not formally diagnosed asthma and only asthma-like symptoms were present **(ex. Wheezing during viral URI or acute bronchitis is not "asthma.")**
- Educate on potential side effects of controller medications and how to manage side effects
- Teach patients on use of asthma medications and the importance of using asthma controller medications daily
- Prescribe a long-term controller medication and provide reminders to your patients to fill controller medications

Asthma Controller Medication

Description	Prescriptions	Medication Lists	Route
Antiasthmatic combinations	Dyphylline-guaifenesin	Dyphylline Guaifenesin Medications List	Oral
Antibody inhibitors	Omalizumab	Omalizumab Medications List	Injection

Note: Please always follow the State and/or CMS billing guidance and ensure the HEDIS codes are covered prior to submission. The codes and tips listed do not guarantee reimbursement.

Anti-interleukin-4	Dupilumab	Dupilumab Medications List	Injection
Anti-interleukin-5	Benralizumab	Benralizumab Medications List	Injection
Anti-interleukin-5	Mepolizumab	Mepolizumab Medications List	Injection
Anti-interleukin-5	Reslizumab	Reslizumab Medications List	Injection
Inhaled steroid combinations	Budesonide-formoterol	Budesonide Formoterol Medications List	Inhalation
Inhaled steroid combinations	Fluticasone-salmeterol	Fluticasone Salmeterol Medications List	Inhalation
Inhaled steroid combinations	Fluticasone-vilanterol	Fluticasone Vilanterol Medications List	Inhalation
Inhaled steroid combinations	Formoterol-mometasone	Formoterol Mometasone Medications List	Inhalation
Inhaled corticosteroids	Beclomethasone	Beclomethasone Medications List	Inhalation
Inhaled corticosteroids	Budesonide	Budesonide Medications List	Inhalation
Inhaled corticosteroids	Ciclesonide	Ciclesonide Medications List	Inhalation
Inhaled corticosteroids	Flunisolide	Flunisolide Medications List	Inhalation
Inhaled corticosteroids	Fluticasone	Fluticasone Medications List	Inhalation
Inhaled corticosteroids	Mometasone	Mometasone Medications List	Inhalation
Leukotriene modifiers	Montelukast	Montelukast Medications List	Oral
Leukotriene modifiers	Zafirlukast	Zafirlukast Medications List	Oral

Leukotriene modifiers	Zileuton	Zileuton Medications List	Oral
Methylxanthines	Theophylline	Theophylline Medications List	Oral

Asthma Reliever Medication

Description	Prescriptions	Medication Lists	Route
Short-acting, inhaled beta-2 agonists	Albuterol	Albuterol Medications List	Inhalation
Short-acting, inhaled beta-2 agonists	Levalbuterol	Levalbuterol Medications List	Inhalation

**Subject to change. Please refer to www.pshp.ga.com for specific drug coverage.*

(CWP) Appropriate Testing for Pharyngitis

Line of Business: Commercial, Medicaid, Medicare

The percentage of episodes for members 3 years and older where the member was diagnosed with pharyngitis, dispensed an antibiotic, and received a group A streptococcus (strep) test for the episode.

The measurement period begins on July 1 of the year prior to the measurement year and ends on June 30 of the measurement year.

CPT	ICD-10-CM
87070, 87071, 87081, 87430, 87650, 87651, 87652, 87880	J02.0, J02.8, J02.9, J03.00, J03.01, J03.80, J03.81, J03.90, J03.91

**Codes subject to change*

Best Practice:

- Perform a rapid strep test or throat culture to confirm diagnosis before prescribing Antibiotics
- Educate patients that an antibiotic is not necessary for viral infections if rapid strep test and/or throat culture is negative
- Submit any co-morbid diagnosis codes that apply to claim submission

Note: Please always follow the State and/or CMS billing guidance and ensure the HEDIS codes are covered prior to submission. The codes and tips listed do not guarantee reimbursement.

CWP Antibiotic Medications

Description	Prescription	
Aminopenicillins	Amoxicillin	Ampicillin
Beta-lactamase inhibitors	Amoxicillin-clavulanate	
First generation cephalosporins	Cefadroxil Cefazolin	Cephalexin
Folate antagonist	Trimethoprim	
Lincomycin derivatives	Clindamycin	
Macrolides	Azithromycin Clarithromycin Erythromycin	Erythromycin ethylsuccinate Erythromycin lactobionate Erythromycin stearate
Natural penicillins	Penicillin G benzathine Penicillin G potassium	Penicillin G sodium Penicillin V potassium
Penicillinase-resistant penicillins	Dicloxacillin	
Quinolones	Ciprofloxacin Levofloxacin	Moxifloxacin Ofloxacin
Second generation cephalosporins	Cefaclor Cefprozil	Cefuroxime
Sulfonamides	Sulfamethoxazole-trimethoprim	
Tetracyclines	Doxycycline Minocycline	Tetracycline
Third generation cephalosporins	Cefdinir Cefixime Cefpodoxime	Ceftibuten Cefditoren Ceftriaxone

**Subject to change. Please refer to www.pshp.ga.com for specific drug coverage.*

(PCE) Pharmacotherapy Management of COPD Exacerbation

Line of Business: Commercial, Medicaid, Medicare

The percentage of COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or ED visit on or between January 1–November 30 of the measurement year and who were dispensed appropriate medications.

Two rates are reported:

1. Dispensed a systemic corticosteroid (or there was evidence of an active prescription) **within 14 days of the event.**
2. Dispensed a bronchodilator (or there was evidence of an active prescription) **within 30 days of the event.**

Clinical Goals:

Assess if the patient was given appropriate medication prescribed at the time of discharge and has filled the prescription and is taking the medications as prescribed.

Dispense systemic corticosteroid **within 14 days from date of discharge** and a bronchodilator **within 30 days from impatient stay or ED visit.**

Best Practice:

- Schedule a follow-up appointment within 7-14 days of discharge
- Consider standing orders for patient discharged from the hospital or ED
- Remind patients to fill their corticosteroid and bronchodilator prescriptions
- Refer to Peach State's adopted clinical practice guidelines on COPD located on Peach State website: www.pshpgeorgia.com

Systemic Corticosteroid Medications

Description	Prescription		
Glucocorticoids	Cortisone-acetate Dexamethasone	Hydrocortisone Methylprednisolone	Prednisolone Prednisone

Bronchodilator Medications

Description	Prescription	
Anticholinergic agents	Aclidinium bromide Ipratropium	Tiotropium Umeclidinium

Note: Please always follow the State and/or CMS billing guidance and ensure the HEDIS codes are covered prior to submission. The codes and tips listed do not guarantee reimbursement.

Beta 2-agonists	Albuterol Arformoterol Formoterol Indacaterol	Levalbuterol Metaproterenol Salmeterol
Bronchodilator combinations	Albuterol-ipratropium Budesonide-formoterol Dyphylline-guaifenesin Fluticasone-salmeterol Fluticasone-vilanterol Fluticasone furoate-umeclidinium-vilanterol Formoterol-aclidinium	Formoterol-glycopyrrolate Formoterol-mometasone Indacaterol-glycopyrrolate Olodaterol hydrochloride Olodaterol-tiotropium Umeclidinium-vilanterol

**Subject to Change*

(SPR) Use of Spirometry Testing in the Assessment and Diagnosis of COPD

Line of Business: Commercial, Medicaid, Medicare

The percentage of members 40 years of age and older with a new diagnosis of COPD or newly active COPD, who received appropriate spirometry testing to confirm the diagnosis.

Clinical Goal:

Required to submit a claim with spirometry testing on the date of service using the appropriate CPT code.

Codes
CPT: 94010, 94014, 94015, 94016, 94060, 94070, 94375, 94620

**Codes subject to change*

Best Practice:

- Refer members to a specialist if unable to perform test in the office (Allergist or Pulmonologist)
- Ensure results of specialist testing is documented in the patients chart

(URI) Appropriate Treatment for Upper Respiratory Infection

Line of Business: Commercial, Medicaid, Medicare

The percentage of episodes for members 3 months of age and older with a diagnosis of upper respiratory infection (URI) that did not result in an antibiotic dispensing event.

The measurement period begins on **July 1** of the year prior to the measurement year and ends on **June 30** of the measurement year.

Clinical Goals:

Effectively evaluate to prevent the inappropriate prescription of antibiotics. A higher rate indicates appropriate treatment.

Proper coding is critical to ensure accurate reporting of the measure and it may decrease the need for medical record review

Description	Code
Upper Respiratory Infection diagnosis	**ICD-10-CM:** J00, J06.0, J06.9

Note: Please always follow the State and/or CMS billing guidance and ensure the HEDIS codes are covered prior to submission. The codes and tips listed do not guarantee reimbursement.

WOMEN'S HEALTH

For more information, visit **www.ncqa.org**

Note: Please always follow the State and/or CMS billing guidance and ensure the HEDIS codes are covered prior to submission. The codes and tips listed do not guarantee reimbursement.

(BCS) Breast Cancer Screening

Line of Business: Commercial, Medicaid, Medicare

The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer.

Measurement year is January 1 through December 31 of the current year.

Clinical Goal:

Patients between the age of 50 and 74 years will have one or more mammograms at least every two years. Educate your patients on the importance of Breast Cancer Screening.

Documentation:

- This measure is to be submitted a minimum of once per performance for female patients during the performance period.
- Patient should be screened for breast cancer on the date of service or there should be Documentation: that the patient was screened for breast cancer 27 months prior to the end of the performance period.
- The measure may be submitted by eligible clinicians who perform the quality actions described in the measure based on services provided and the measure specific denominator coding

Proper coding is critical to ensure accurate reporting of these measures, and it may also decrease the need for medical record reviews

Description	Codes
Breast Cancer Screening	**CPT:** 77055-77057, 77061-77063, 77065-77067 **HCPCS:** G020, G0204, G0206
Unilateral / Bilateral Mastectomy	**CPT:** 19180, 19200, 19220, 19240, 19303, 19304 -19307,
History of Mastectomy (RT, LT & Bilateral Breast)	**ICD-10-CM:** Z90.11, Z90.12, Z90.13,

**Codes subject to change*

Note: This measure evaluates primary screening. Do not count biopsies, breast ultrasounds, or MRIs because they are not appropriate methods for primary breast cancer screening.

Exclusions:

- Bilateral mastectomy any time during the member's history through December 31 of the measurement year.

Medicare patients age 66 and older as of December 31 of the measurement year who are enrolled in an institutional SNP or living long-term in an institution any time during the measurement year.

Best Practice:

- Use EMR to create alerts or reminders for members who need mammogram for an outpatient referral during their next annual visit.
- Discuss possible fears the patient may have about mammogram and inform the patient that currently available testing methods are less uncomfortable and require less radiation
- Provide a list of facilities in-network to share with the patient to schedule an appointment at a convenient location.
- Schedule a mammogram for the patient or send the patient referral to the facility
- Document bilateral mastectomy in the medical records.

(CCS) Cervical Cancer Screening

Line of Business: Commercial, Medicaid

The percentage of women 21–64 years of age who were screened for cervical cancer using either of the following criteria:

- Women 21–64 years of age who had cervical cytology performed within the last 3 years.
- Women 30–64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years.
- Women 30–64 years of age who had cervical cytology/high-risk human papillomavirus (hrHPV) co-testing within the last 5 years.

Documentation:

- Screening and results from appropriate testing completed in the last 3-5 years
- Document "total", "radical", "complete" abdominal or vaginal hysterectomy.

Proper coding is critical to ensure accurate reporting of these measures, and it may also decrease the need for medical record reviews.

Description	Codes
Cervical Cytology Lab Test	**CPT:** 88164-88167, 88174, 88175 **HCPCS:** G0123, G0124, G0141, G0143-G0145, G0147, G0148, P3000, P3001, Q0091
HPV Test	**CPT:** 87620-87622 87624, 87625 HPCS: G0476

Note: Please always follow the State and/or CMS billing guidance and ensure the HEDIS codes are covered prior to submission. The codes and tips listed do not guarantee reimbursement.

Hysterectomy with No Residual Cervix and Absence of Cervix Diagnosis	**CPT:** 51925, 56308, 57540, 57545, 57550, 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, 58956, 59135 **ICD-10-CM:** Q51.5, Z90.710, Z90.12

**Codes subject to change*

Exclusions:

- Hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix any time during the member's history through December 31 of the measurement year.

Best Practice:

- Use a reminder/recall system to schedule patients' annual well-women visits.
- Avoid missed opportunities to complete a PA testing during regular-scheduled well-women visits, sick visits, urine pregnancy test, UTI and chlamydia/STI screenings.
- Co-testing is counted only if the sample for the Pap and HPV test is collected and performed at the same timer for the same date of service, regardless of the cytology result.
- Remember to document the date when the cervical cytology was performed, along with the results and findings.
- Document in the medical records if the patient had a hysterectomy with no residual cervix.

(CHL) Chlamydia Screening in Women

Line of Business: Commercial, Medicaid

The percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.

Sexual activity is determined by:

- Pregnancy test or diagnosis
- Prescription filled for Contraceptive
- History of any other STD testing performed

Clinical Goal:

Chlamydia screening is essential because most women who have the condition do not experience symptoms. The main objective of chlamydia screening is to prevent pelvic inflammatory disease (PID), infertility and ectopic pregnancy, in which very high rates of occurrence are among women with untreated chlamydia infection.

Note: Please always follow the State and/or CMS billing guidance and ensure the HEDIS codes are covered prior to submission. The codes and tips listed do not guarantee reimbursement.

Proper coding is critical to ensure accurate reporting of these measures, and it may also decrease the need for medical record reviews.

Codes
CPT: 87110, 87270, 87320, 87490-87492, 87810

**Codes subject to change*

Best Practice:

- Perform Chlamydia Screening if patient is sexually active
- CDC recommends non-invasive nucleic acid amplification test (NAAT) for chlamydia screening
- Using appropriate codes will ensure the service is captured through claims submission

(OMW) Osteoporosis Management in Women Who Had a Fracture

Line of Business: Medicare Only

The percentage of women 67–85 years of age who suffered a fracture and who had either a bone mineral density (BMD) test or prescription for a drug to treat osteoporosis in the six months after the fracture.

Exclusion from the HEDIS Measure:

- Members who had a bone density test during the 24 months prior to the fracture.
- Members who during the 12 months prior to the fracture, received a dispensed prescription, or had an active prescription to treat osteoporosis
- Members who had a claim/encounter for osteoporosis therapy during the 12 months prior to the fracture
- Members 67 years of age and older living in long-term institutional settings

Proper coding is critical to ensure accurate reporting of the measure, and it may also decrease the need for medical record review.

Description	Codes
Bone Mineral Density Test (BMD)	**CPT:** 76977, 77078, 77080, 77081,77085, 77086
Osteoporosis Medication Therapy	**HCPCS:** J0897, J1740, J3110, J3489
Long-Acting Osteoporosis Medications	**HCPCS:** J0897, J1740, J3489

**Codes subject to change*

Note: Please always follow the State and/or CMS billing guidance and ensure the HEDIS codes are covered prior to submission. The codes and tips listed do not guarantee reimbursement.

Osteoporosis Medications

Description	Prescription	
Bisphosphonates	Alendronate Alendronate-cholecalciferol Ibandronate	Risedronate Zoledronic acid
Other agents	Abaloparatide Denosumab Raloxifene	Romosozumab Teriparatide

Best Practice:

- Schedule a follow-up appointment within 7-14 days of discharge
- Consider standing orders for those patients discharged from the hospital or emergency room
- Remind the patient to take medication as prescribed by the practitioner

(OSW) Osteoporosis Screening in Older Women

Line of Business: Medicare

The percentage of women 65–75 years of age who received osteoporosis screening.

Exclusion from the HEDIS Measure:

- Members who had a claim/encounter for osteoporosis therapy during 12 months prior to the measurement year (MY)
- Members who had a dispensed prescription to treat osteoporosis anytime on or between January 1 three years prior to the MY through December 31 of year prior to MY
- Members 66 years of age and older living in long-term institutional settings

Proper coding is critical to ensure accurate reporting of the measure, and it may also decrease the need for medical record review

Description	Codes
Osteoporosis Screening Tests	**CPT:** 76977, 77078, 77080, 77081, 77085

**Codes subject to change*

Osteoporosis Medications

Description	Prescription	
Bisphosphonates	Alendronate Alendronate-cholecalciferol Ibandronate	Risedronate Zoledronic acid

Note: Please always follow the State and/or CMS billing guidance and ensure the HEDIS codes are covered prior to submission. The codes and tips listed do not guarantee reimbursement.

Other agents	Abaloparatide Denosumab Raloxifene	Romosozumab Teriparatide

(PPC) Prenatal and Postpartum Care

Line of Business: Commercial, Medicaid

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

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

Proper coding is critical to ensure accurate reporting of the measure, and it may also decrease the need for medical record review

Description	Codes
Stand Alone	**HCPCS:** H1000-H1004
Pregnancy Visit Codes	**CPT:** 99201-99205, 99211-99215, 99241-99245, 99483 **HCPCS:** G0463, T1015
Postpartum Visits	**CPT:** 57170, 58300, 59430, 99501 **CPT-CAT II:** 0503F **HCPCS:** G0101 **ICD-10-CM:** Z01.411, Z01.419, Z01.42, Z30.430, Z39.1, Z39.2

**Codes subject to change*

Best Practice:

- Check compliance with immunizations and lead screening at 18-month well-child visit (not 2 years old)
- If using Certified Lead Analyzer, submit CPT code 83655
- Members with Medicaid coverage are considered at risk for lead poisoning and should be screened by age 1 and 2 years

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1-877-687-1180 • ambetter.pshpgeorgia.com

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Note: Please always follow the State and/or CMS billing guidance and ensure the HEDIS codes are covered prior to submission. The codes and tips listed do not guarantee reimbursement.

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Telehealth & HEDIS®

Using Technology to Deliver Quality Care

Telehealth for Medicare Advantage Risk Adjustment and Quality

1. Telehealth Services & Risk Adjustment

Telehealth refers to a broad collection of electronic and telecommunications technologies that support delivery of health care services from distant locations. Forms of telehealth include Telemedicine, Virtual Check-Ins, E-Visits, and Telephone visits, among others.

Risk Adjustment, meanwhile, requires that reported diagnoses stem from face-to-face visits between patients and providers. Telehealth services that employ synchronous audio and video technology that permits communication between patients and providers in real time meet risk adjustment's face-to-face requirement.

A. Telemedicine

Telemedicine is the practice of medicine using technology to deliver care at a distance. A practitioner in one location (distant site) uses telecommunications to deliver care to a patient at another location (originating site).

These visits are considered the same as in-person visits and are paid at the same rate as regular, in-person visits.

***Services** that can be provided via telemedicine include, among others, office/outpa-tient visits, annual wellness visits, emergency department or initial inpatient consultations, ESRD-related services, individual and group diabetes self-management training, and individual psychotherapy.Established Patient Office/Outpatient Visit.*

Practitioners who can furnish and get payment for covered telehealth services (subject to state law) can include physicians, nurse practitioners, physician assistants, nurse midwives, clinical psychologists, clinical social workers, and registered dietitians.

Telemedicine Requirements

Established patient/provider relationship

Originating Site *(patient's location)*

II. A rural setting that is:

- In a county outside a Metropolitan Statistical Area (MSA), or
- A rural Health Professional Shortage Area (HPSA) in a rural census tract

**Originating site geographic conditions do not apply to: hospital-based and CAH-based renal dialysis centers, renal dialysis facilities, and patient homes when practitioners furnish either monthly home dialysis ESRD-related medical evaluations or treatment of a substance use disorder or a co-occurring mental health disorder.*

III. Patient Location

- A medical facility, such as physician office, Hospital, Critical Access Hospital (CAH), Rural Health Clinic, Federally Qualified Health Center, Hospital-based or CAH-based Renal Dialysis Center, Skilled Nursing Facility (SNF), Community Mental Health Center, Renal Dialysis Facility, Mobile Stroke Unit, or
- Homes of beneficiaries with either End-Stage Renal Disease (ESRD) getting home dialysis, or substance use disorders receiving treatment for same (or a co-occurring mental health disorder)

Technology: The provider must use an interactive audio and video telecommunications system that permits real-time communication between the distant site and the patient

**Transmitting medical information to a practitioner who reviews it later, an asynchronous telecommunications system, is permitted in Alaska and Hawaii.*

Risk Adjustment

The utilization of synchronous audio and video technology permitting real-time interaction makes Telemedicine visits acceptable for risk adjustment.

Telemedicine Coding and Billing

Telemedicine does not require a distinct set of CPT/HCPCS codes. Any services furnished via telemedicine are reported utilizing the same codes that are employed when an in-person visit takes place.

Distant Site Billing *(location of servicing provider)*

1. CPT/HCPCS Codes

New Patient Office/Outpatient Visit:

	History	Exam	MDM
99201	Problem focused	Problem focused	Straightforward
99202	Expanded problem focused	Expanded problem focused	Straightforward
99203	Detailed	Detailed	Low
99204	Comprehensive	Comprehensive	Moderate
99205	Comprehensive	Comprehensive	High

**Requires all 3 Components: History, Exam, and Medical Decision Making (MDM)*

Established Patient Office/Outpatient Visit:

	History	Exam	MDM
99212	Problem focused	Problem focused	Straightforward
99213	Expanded problem focused	Expanded problem focused	Low
99214	Detailed	Detailed	Moderate
99215	Comprehensive	Comprehensive	High

**Requires 2 of 3 Components: History, Exam, and Medical Decision Making (MDM)*

1. Place of Service (POS) Code
   - 02 – Telehealth
2. Modifiers
   - 95 – Synchronous telemedicine service rendered via real-time interactive audio/video system
   - *GT – via interactive audio/video system
   - GQ – via asynchronous system (for use in Alaska and Hawaii)

**CAHs billing for telehealth services under CAH Optional Payment Method II should submit institutional claims using modifier GT*

Originating Site Billing

- Q3014 – Originating site facility fee

**Applicable when patient presents to a medical facility as originating site. This fee does not apply when the home serves as the originating site.*

Telemedicine Documentation Tips

- When >50% of the total visit time is spent counseling, document the total visit time + topics discussed to meet CPT requirements.
- All chronic, active, or status (amputations, dialysis status, etc.) conditions that impact the current date of service should be clearly documented.
- Specify a condition's acuity or severity
- Do not use broad terms when a more specific diagnosis is available
- Avoid the phrase "history of" when documenting active conditions that impact the member's current encounter
- All records should have a valid signature including an authentication statement and the rendering provider's credentials.

B. Virtual Check-Ins

Virtual check-ins are short (5-10 minutes), patient-initiated communication with a practitioner for patients to check in with their doctor to determine whether an office visit or other service is needed, or remote evaluation of recorded video and/or images submitted by patient.

**The communication should not be related to a medical visit within the previous 7 days and should not lead to a medical visit within the next 24 hours (or soonest appointment available), otherwise it's bundled into the E/M service.*

Practitioners who can furnish the service are physicians, nurse practitioners, physician assistants, certified nurse midwives, clinical psychologists, and clinical social workers.

Documentation: Verbal consent should be noted in the medical record for the service, five to 10 minutes of medical discussion should be documented, along with a statement that the patient does not require a visit unless there is a problem.

Virtual Check-In Requirements

Established patient/provider relationship

Originating Site

1. Geographic area – All areas
2. Patient Location – All locations, including patient's home

Technology: Communication may take place via a number of modalities including synchronous discussion over a telephone or exchange of information through video or image. The practitioner may respond to the patient's concern by telephone, audio/video, secure text messaging, email, or use of a patient portal.

Risk Adjustment

Virtual Check-Ins are not acceptable for CMS-operated risk adjustment programs.

Virtual Check-Ins - Coding and Billing

G2010	Remote evaluation of pre-recorded info
G2012	Virtual check-in
G0071	RHC/FQHC communications services

C. E-Visits

E-visits are patient-initiated communications through an online patient portal. Once a patient generates the initial inquiry communications can occur over a 7-day period

Practitioners who can furnish the service include physicians, nurse practitioners (NPs), physician assistants (PAs), and other clinicians who are able to bill for E/M services independently, as well as physical therapists (PTs), occupational therapists (OTs), speech language pathologists, clinical psychologists, and other health care professionals not able to bill E/M services independently.

E-Visit Requirements

Established patient/provider relationship

Originating Site

Geographic area – All areas

Patient Location – All locations, including patient's home

Technology: Patient Portal

Risk Adjustment

E-visits are not acceptable for CMS-operated risk adjustment programs.

E-Visits - Coding and Billing

Physicians, NPs, and PAs:

99421	Non face-to-face online digital E/M service, established patient, up to 7 days, 5-10 minutes
99422	Non face-to-face online digital E/M service, established patient, up to 7 days, 11-20 min.
99423	Non face-to-face online digital E/M service, established patient, up to 7 days, 21+ minutes

Physical or Occupational Therapy, SLP, clinical Psych

G2061	Non face-to-face online digital E/M service, established patient, up to 7 days, 5-10 minutes
G2062	Non face-to-face online digital E/M service, established patient, up to 7 days, 11-20 min.
G2063	Non face-to-face online digital E/M service, established patient, up to 7 days, 21+ minutes
98970	Non face-to-face online digital E/M service, established patient, up to 7 days, 5-10 minutes
98971	Non face-to-face online digital E/M service, established patient, up to 7 days, 11-20 min.
98972	Non face-to-face online digital E/M service, established patient, up to 7 days, 21+ minutes

**Medicare does not accept CPT codes 98970-98972. E-visit services furnished by clinicians unable to report E/M services independently to Medicare beneficiaries must be reported utilizing a code from the G2061-G2063 code series.*

D. Telephone Visits

Telephone Visits are non-face-to-face, patient-initiated services over the telephone.

**The communication should not be related to a medical visit within the previous 7 days and should not lead to a medical visit within the next 24 hours (or soonest appointment available).*

Practitioners who can furnish telephone visits include physicians, NPs, PAs and other clinicians who are able to bill for E/M services independently, plus PTs, OTs, clinical psychologists, registered dietitians and other health care professionals not able to bill E/M services independently.

Telephone Visit Requirements

Established patient/provider relationship

Risk Adjustment

Telephone visits are not acceptable for CMS-operated risk adjustment programs.

Telephone Visits - Coding and Billing

Physicians, NPs, and PAs:

99441	Telephone E/M service provided to an established patient, parent, or guardian; 5-10 minutes
99442	Telephone E/M service provided to an established patient, parent, or guardian; 11-20 minutes
99443	Telephone E/M service provided to an established patient, parent, or guardian; 21-30 minutes

Phys. or Occup., Therapy, SLP, Clinical Psych:

98966	Telephone assessment and management service provided to an established patient, parent, or guardian; 5-10 minutes
98967	Telephone assessment and management service provided to an established patient, parent, or guardian; 11-20 minutes
98968	Telephone assessment and management service provided to an established patient, parent, or guardian; 21-30 minutes

Resources

https://www.pshpgeorgia.com/providers/coronavirus-information.html

https://ambetter.pshpgeorgia.com/provider-resources/manuals-and-forms/coronavirus-guidelines.html

HEDIS	Measure Description	Telehealth Enhancement	Product Lines	HEDIS Value Set Code
AMR	**Asthma Medication Ratio:** The percentage of members 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.	The measure includes telephone visits, e-visits and virtual check-ins	***Commercial, Medicaid***	**Telephone Visits** **CPT:** 98966, 98967, 98967, 99441, 99442, 99443 **Online Assessment (e-visits and virtual check-ins)** **CPT:** 98969, 98970, 98971, 98972, 99421, 99422, 99423, 99444, 99458 **HCPCS:** G2010, G2012, G2061, G2062, G2063 **Telehealth Modifier:** GT, 95 **Telehealth POS:** 02
APP	**Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics:** The percentage of children and adolescents 1–17 years of age who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment.	The measure includes telephone visits e-visits and virtual check-ins	***Commercial, Medicaid***	**Telephone Visits** **CPT:** 98966, 98967, 98968, 99441, 99442, 99443 **Online Assessment (e-visits and virtual check-ins)** **CPT:** 98969, 98970, 98971, 98972, 99421, 99422, 99423, 99444, 99458 **HCPCS:** G2010, G2012, G2061, G2062, G2063 **Telehealth POS:** 02
ART	**Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis- Scheduled for Retirement:** The percentage of members 18 years of age and older who were diagnosed with rheumatoid arthritis and who were dispensed at least one ambulatory prescription for a disease-modifying anti-rheumatic drug **(DMARD)**.	The measure includes telephone visits, e-visits and virtual check-ins to the advanced illness exclusion. ***At least one DMARD dispense is required to meet compliance**	***Medicare***	**Telephone Visits** **CPT:** 98966, 98967, 98968, 99441, 99442, 99443 **Online Assessment (e-visits and virtual check-ins)** **CPT:** 98969, 98970, 98971, 98972, 99421, 99422, 99423, 99444, 99458 **HCPCS:** G2010, G2012, G2061, G2062, G2063
BCS	**Breast Cancer Screening:** The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer	The measure includes telephone visits, e-visits and virtual check-ins to the advanced illness exclusion. ***Mammogram required for member compliance**	***Commercial, Medicaid, Medicare***	**Telephone Visits** **CPT:** 98966, 98967, 98968, 99441, 99442, 99443 **Online Assessment (e-visits and virtual check-ins)** **CPT:** 98969, 98970, 98971, 98972, 99421, 99422, 99423, 99444, 99458 **HCPCS:** G2010, G2012, G2061, G2062, G2063

HEDIS	Measure Description	Telehealth Enhancement	Product Lines	HEDIS Value Set Code
CBP	**Controlling High Blood Pressure:** The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90 mm Hg) during the measurement year	The measure includes telephone visits, e-visits and virtual check-ins to the advanced illness exclusion ***BP adequately controlled (<140/90mm Hg) meets compliance for measure**	***Commercial, Medicaid, Medicare***	**Telephone Visits** **CPT:** 98966, 98967, 98968, 99441, 99442, 99443 **Online Assessment (e-visits and virtual check-ins)** **CPT:** 98969, 98970, 98971, 98972, 99421, 99422, 99423, 99444, 99458 **HCPCS:** G2010, G2012, G2061, G2062, G2063
CDC	**Comprehensive Diabetes Care:** The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had each of the following: Hemoglobin A1c (HbA1c) testing.* ▪ HbA1c poor control (>9.0%).* ▪ HbA1c control (<8.0%).* ▪ Eye exam (retinal) performed. ▪ Medical attention for nephropathy. ** (**Medicare only) ▪ BP control (<140/90 mm Hg).	The measure includes telephone visits, e-visits and virtual check-ins to the advanced illness exclusion. ***Lab HbA1c, Urine and Eye exam and adequately Controlled BP are required to meet compliance.**	***Commercial, Medicaid, Medicare***	**Telephone Visits** **CPT:** 98966, 98967, 98968, 99441, 99442, 99443 **Online Assessment (e-visits and virtual check-ins)** **CPT:** 98969, 98970, 98971, 98972, 99421, 99422, 99423, 99444, 99458 **Telehealth Modifier:** GT, 95 **Telehealth POS:** 02
COA	**Care for Older Adults:** The percentage of adults 66 years and older who had each of the following during the measurement year: ▪ Advance care planning ▪ Medication review ▪ Functional status assessment ▪ Pain assessment	The measure includes telephone visits, e-visits and virtual check-ins for Advance Care Planning, Functional status assessment and Pain Assessment indicators. ***Telehealth not applicable for Medication Review.**	***Medicare***	**Telephone Visits** **CPT:** 98966, 98967, 98968, 99441, 99442, 99443 **Online Assessment (e-visits and virtual check-ins)** **CPT:** 98969, 98970, 98971, 98972, 99421, 99422, 99423, 99444, 99458 **HCPCS:** G2010, G2012, G2061, G2062, G2063
COL	**Colorectal Cancer Screening:** The percentage of members 50–75 years of age who had appropriate screening for colorectal cancer.	The measure includes telephone visits, e-visits and virtual check-ins	***Commercial, Medicare***	**Telephone Visits** **CPT:** 98966, 98967, 98968, 99441, 99442, 99443 **Online Assessment (e-visits and virtual check-ins)** **CPT:** 98969, 98970, 98971, 98972, 99421, 99422, 99423, 99444, 99458 **HCPCS:** G2010, G2012, G2061, G2062, G2063

HEDIS	Measure Description	Telehealth Enhancement	Product Lines	HEDIS Value Set Code
CRE	****NEW*** **Cardiac Rehabilitation:** The percentage of members 18 years and older, who attended cardiac rehabilitation following a qualifying cardiac event, including myocardial infarction, percutaneous coronary intervention, coronary artery bypass grafting, heart and heart/lung transplantation or heart valve repair/replacement. Four rates are reported: ***Initiation.*** The percentage of members who attended 2 or more sessions of cardiac rehabilitation within 30 days after a qualifying event ***Engagement 1.*** The percentage of members who attended 12 or more sessions of cardiac rehabilitation within 90 days after a qualifying event. ***Engagement 2.*** The percentage of members who attended 24 or more sessions of cardiac rehabilitation within 180 days after a qualifying event. ***Achievement***. The percentage of members who attended 36 or more sessions of cardiac rehabilitation within 180 days after a qualifying event.	The measure includes telephone visits, e-visits and virtual check-ins to the advanced illness exclusion	***Commercial, Medicaid, Medicare***	**Telephone Visits** **CPT:** 98966, 98967, 98968, 99441, 99442, 99443 **Online Assessment (e-visits and virtual check-ins)** **CPT:** 98969, 98970, 98971, 98972, 99421, 99422, 99423, 99444, 99458 **HCPCS:** G2010, G2012, G2061, G2062, G2063
FMC	**Follow-up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions:** The percentage of emergency department (ED) visits for members 18 years and older who have multiple high-risk chronic conditions who had a follow-up service within 7 days of the ED visit.	The measure includes telephone visits, e-visits and virtual check-ins	***Medicare***	**Telephone Visits** **CPT:** 98966, 98967, 98968, 99441, 99442, 99443 **Online Assessment (e-visits and virtual check-ins)** **CPT:** 98969, 98970, 98971, 98972, 99421, 99422, 99423, 99444, 99458 **HCPCS:** G2010, G2012, G2061, G2062, G2063 **Telehealth POS:** 02

HEDIS	Measure Description	Telehealth Enhancement	Product Lines	HEDIS Value Set Code
KED	***NEW** **Kidney Health Evaluation for Patients With Diabetes (KED):** The percentage of members 18–85 years of age with diabetes (type 1 and type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR), during the measurement year.	The measure includes telephone visits, e-visits and virtual check-ins of the event diagnosis. ***eGFR and uACR are required for member compliant with measure**	***Commercial, Medicaid, Medicare***	**Telephone Visits** **CPT:** 98966, 98967, 98968, 99441, 99442, 99443 **Online Assessment (e-visits and virtual check-ins)** **CPT:** 98969, 98970, 98971, 98972, 99421, 99422, 99423, 99444, 99458 **HCPCS:** G2010, G2012, G2061, G2062, G2063 **Telehealth Modifier:** GT, 95 **Telehealth POS:** 02
OMW	**Osteoporosis Management in Women Who Had a Fracture:** The percentage of women 67–85 years of age who suffered a fracture and who had either a bone mineral density (BMD) test or prescription for a drug to treat osteoporosis in the six months after the fracture	The measure includes telephone visits, e-visits and virtual check-ins to the advanced illness exclusion. ***BMD test or RX for drug to treat osteoporosis is required to meet compliance**	***Medicare***	**Telephone Visits** **CPT:** 98966, 98967, 98968, 99441, 99442, 99443 **Online Assessment (e-visits and virtual check-ins)** **CPT:** 98969, 98970, 98971, 98972, 99421, 99422, 99423, 99444, 99458 **HCPCS:** G2010, G2012, G2061, G2062, G2063 **Telehealth Modifier:** GT, 95 **Telehealth POS:** 02
OSW	***NEW** **Osteoporosis Screening in Older Women:** The percentage of women 65–75 years of age who received osteoporosis screening.	The measure includes telephone visits, e-visits, and virtual check-ins to the advanced illness exclusion. ***Osteoporosis screening is required to meet compliance**	***Medicare***	**Telephone Visits** **CPT:** 98966, 98967, 98968, 99441, 99442, 99443 **Online Assessment (e-visits and virtual check-ins)** **CPT:** 98969, 98970, 98971, 98972, 99421, 99422, 99423, 99444, 99458 **HCPCS:** G2010, G2012, G2061, G2062, G2063
PBH	**Persistence of Beta-Blocker Treatment After a Heart Attack:** The percentage of members 18 years of age and older during the measurement year who were hospitalized and discharged from July 1 of the year prior to the measurement year to June 30 of the measurement year with a diagnosis of AMI and who received persistent beta-blocker treatment for six months after discharge.	The measure includes telephone visits, e-visits and virtual check-ins to the advanced illness exclusion. ***Persistent beta-blocker treatment is required to meet compliance.**	***Commercial, Medicaid, Medicare***	**Telephone Visits** **CPT:** 98966, 98967,98968, 99441, 99442, 99443 **Online Assessment (e-visits and virtual check-ins)** **CPT:** 98969, 98970, 98971, 98972, 99421, 99422, 99423, 99444, 99458 **HCPCS:** G2010, G2012, G2061, G2062, G2063

HEDIS	Measure Description	Telehealth Enhancement	Product Lines	HEDIS Value Set Code
PPC	**Prenatal and Postpartum Care:** The percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care. ***Timeliness of Prenatal Care.*** The percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization. ***Postpartum Care.*** The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery. The percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care.	The measure includes telephone visits, e-visits and virtual check-ins to the Timeliness of Prenatal Care ***Not applicable to postpartum care.**	***Commercial, Medicaid***	**Telephone Visits** **CPT:** 98966, 98967, 98968, 99441, 99442, 99443 **Online Assessment (e-visits and virtual check-ins)** **CPT:** 98969, 98970, 98971, 98972, 99421, 99422, 99423, 99444, 99458 **HCPCS:** G2010, G2012, G2061, G2062, G2063
SPC	**Statin Therapy for Patients with Cardiovascular Disease:** The percentage of males 21–75 years of age and females 40–75 years of age during the measurement year, who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and met the following criteria. The following rates are reported: ***Received Statin Therapy.*** Members who were dispensed at least one high-intensity or moderate-intensity statin medication during the measurement year. ***Statin Adherence 80%.*** Members who remained on a high-intensity or moderate-intensity statin medication for at least 80% of the treatment period.	The measure includes telephone visits, e-visits and virtual check-ins to the advanced illness exclusion. ***Rx dispensed at least one high or moderated intensity statin medication or a member remaining on statin medication 80% of treatment period meets compliance**	***Commercial, Medicaid, Medicare***	**Telephone Visits** **CPT:** 98966, 98967, 98968, 99441, 99442, 99443 **Online Assessment (e-visits and virtual check-ins)** **CPT:** 98969, 98970, 98971, 98972, 99421, 99422, 99423, 99444, 99458 **HCPCS:** G2010, G2012, G2061, G2062, G2063 **Telehealth Modifier:** GT, 95 **Telehealth POS:** 02

HEDIS	Measure Description	Telehealth Enhancement	Product Lines	HEDIS Value Set Code
SPD	**Statin Therapy for Patients With Diabetes:** The percentage of members 40–75 years of age during the measurement year with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) who met the following criteria. Two rates are reported: 1. ***Received Statin Therapy:*** Members who were dispensed at least one statin medication of any intensity during the measurement year. 2. ***Statin Adherence 80%:*** Members who remained on a statin medication of any intensity for at least 80% of the treatment period.	The measure includes telephone visits, e-visits and virtual check-ins to the advanced illness exclusion. ***Member dispensed at least one statin medication or remained on statin medication at 80% of treatment period for any intensity meets compliance**	***Commercial, Medicaid, Medicare***	**Telephone Visits** **CPT:** 98966, 98967, 98968, 99441, 99442, 99443 **Online Assessment (e-visits and virtual check-ins)** **CPT:** 98969, 98970, 98971, 98972, 99421, 99422, 99423, 99444, 99458 **HCPCS:** G2010, G2012, G2061, G2062, G2063 **Telehealth Modifier:** GT, 95 **Telehealth POS:** 02
SPR	**Use of Spirometry Testing in the Assessment and Diagnosis of COPD:** The percentage of members 40 years of age and older with a new diagnosis of COPD or newly active COPD, who received appropriate spirometry testing to confirm the diagnosis	The measure includes telephone visits, e-visits and virtual check-ins to step 1 of the event/diagnosis and removed the requirement to exclude telehealth. ***Documentation of spirometry testing required to meet compliance**	***Commercial, Medicaid, Medicare***	**Telephone Visits** **CPT:** 98966, 98967,98968, 99441, 99442, 99443 **Online Assessment (e-visits and virtual check-ins)** **CPT:** 98969, 98970, 98971, 98972, 99421, 99422, 99423, 99444, 99458 **HCPCS:** G2010, G2012, G2061, G2062, G2063
TRC	**Transition Care:** **The percentage of discharges for members 18 years of age and older who had each of the following.** **Four rates are reported:** 1. **Notification of Inpatient Admission:** Documentation of receipt of notification of inpatient admission on the day of admission through 2 days after the admission (3 total days). 2. **Receipt of Discharge Information:** Documentation of receipt of discharge information on the day of discharge through 2 days after the discharge (3 total days). 3. **Patient Engagement After Inpatient Discharge:** Documentation of patient engagement (e.g., office visits, visits to the home, telehealth) provided within 30 days after discharge. 4. **Medication Reconciliation Post-Discharge:** Documentation of medication reconciliation on the date of discharge through 30 days after discharge (31 total days).	The measure includes e-visits and virtual check-ins for the Patient Engagement After Inpatient Discharge metrics. ***Documentation of patient engagement provided within 30 days after discharge is required to meet compliance metric.**	***Medicare***	**Telephone Visits** **CPT:** 98966, 98967,98968, 99441, 99442, 99443 **Online Assessment (e-visits and virtual check-ins)** **CPT:** 98969, 98970, 98971, 98972, 99421, 99422, 99423, 99444, 99458 **HCPCS:** G2010, G2012, G2061, G2062, G2063

HEDIS	Measure Description	Telehealth Enhancement	Product Lines	HEDIS Value Set Code
WCV	**Child and Adolescent Well Care Visits:** The percentage of members 3–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year. ***NOTE:** ***This measure is a combination measure that replaces the former "Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life" and "Adolescent Well-Care Visits" HEDIS measures.***	Remove the Telehealth exclusions for well care visits.	***Commercial, Medicaid***	**CPT:** 99381, 99382, 99383,99384,99385,99391, 99392,99393,99394,99395, 99461 **HCPCS:** G0438,60439,20302 **ICD10-CM:** Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.2, Z00.3, Z00.5, Z76.1, Z76.2 **Telehealth Modifier:** GT, 95 **Telehealth POS:** 02
W30	**Well-Child Visits in the First 30 Months of Life:** The percentage of members who had the following number of well-child visits with a PCP during the last 15 months. The following rates are reported: ***Well-Child Visits in the First 15 Months:*** Children who turned 15 months old during the measurement year: Six or more well-child visits. ***Well-Child Visits for Age 15 Months–30 Months:*** Children who turned 30 months old during the measurement year: Two or more well-child visits.	Remove the Telehealth exclusions for well care visits.	***Commercial, Medicaid***	**CPT:** 99381, 99382, 99383,99384,99385,99391, 99392,99393,99394,99395, 99461 **HCPCS:** G0438,60439,20302 **ICD10-CM:** Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.2, Z00.3, Z00.5, Z76.1, Z76.2 **Telehealth Modifier:** GT, 95 **Telehealth POS:** 02

Measure Description		Telehealth Enhancement	Product Lines	HEDIS Value Set Code
ADD	**Follow-up Care for Children Prescribed ADHD Medication (ADD):** The percentage of children newly prescribed 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 Reported:** 1. ***Initiation Phase:*** The percentage of members 6–12 years of age with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with a practitioner with prescribing authority during the 30-day Initiation Phase. 2. ***Continuation and Maintenance (C&M) Phase:*** The percentage of members 6–12 years of age with an ambulatory prescription dispensed for ADHD medication, who remained on the medication 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 practitioner within 270 days (9 months) after the Initiation Phase ended.	The measure includes telehealth and telephone visits to the ***Initiation Phase*** The measure includes e-visits and virtual check-ins to the ***Continuation and Maintenance Phase*** numerator and modified the telehealth restrictions	***Commercial, Medicaid***	**Telephone Visits** **CPT:** 98966, 98967,98968, 99441, 99442, 99443 **Online Assessment (e-visits and virtual check-ins)** **CPT:** 98969, 98970, 98971, 98972, 99421, 99422, 99423, 99444, 99458 **HCPCS:** G2010, G2012, G2061, G2062, G2063 **Telehealth POS:** 02

Measure Description		Telehealth Enhancement	Product Lines	HEDIS Value Set Code
AMM	**Antidepressant Medication Management:** The percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment. **Two Rates Reported** 1. ***Effective Acute Phase Treatment:*** The percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks). 2. ***Effective Continuation Phase Treatment:*** The percentage of members who remained on an antidepressant medication for at least 180 days (6 months).	The measure includes e-visits and virtual check-ins to the event/diagnosis required exclusion. ***Member who remain on antidepressant medication during the treatment period meet compliance.**	***Commercial, Medicaid, Medicare***	**Telephone Visits** **CPT:** 98966, 98967,98968, 99441, 99442, 99443 **Online Assessment (e-visits and virtual check-ins)** **CPT:** 98969, 98970, 98971, 98972, 99421, 99422, 99423, 99444, 99458 **HCPCS:** G2010, G2012, G2061, G2062, G2063 **Telehealth POS:** 02
FUH	**Follow-up After Hospitalization for Mental Illness:** The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider. **Two rates are reported:** 1. The percentage of members discharged and had a follow-up visit within 30 days after discharge 2. The percentage of members discharged and had a follow-up visit within seven days	The measure includes telephone visits ***Member had follow-up visit with mental health provider within 30 days after discharge or 7 days after discharge meets compliance.**	***Commercial, Medicaid, Medicare***	**Telephone Visits** **CPT:** 98966, 98967,98968, 99441, 99442, 99443

Measure Description		Telehealth Enhancement	Product Lines	HEDIS Value Set Code
FUM	**Follow-up After Emergency Department Visit for Mental Illness:** The percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness. **Two rates are reported:** 1. The percentage of members who received follow-up within 30 days of the ED visit (31 total days). 2. The percentage of member received follow-up within 7 days of the ED visit (8 total days).	The measure includes telephone visits, e-visits and virtual check-ins	***Commercial, Medicaid, Medicare***	**Telephone Visits** **CPT:** 98966, 98967,98968, 99441, 99442, 99443 **Online Assessment (e-visits and virtual check-ins)** **CPT:** 98969, 98970, 98971, 98972, 99421, 99422, 99423, 99444, 99458 **HCPCS:** G2010, G2012, G2061, G2062, G2063 **Telehealth POS:** 02
SAA	**Adherence to Antipsychotic Medications for Individuals with Schizophrenia:** The percentage of members 18 years of age and older during the measurement year with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.	The measure includes telephone visits, e-visits and virtual check-ins to the event/diagnosis and to the advanced illness exclusion ***Member who remain on antipsychotic medications at 80% of the treatment period meets compliance.**	***Commercial, Medicaid, Medicare***	**Telephone Visits** **CPT:** 98966, 98967,98968, 99441, 99442, 99443 **Online Assessment (e-visits and virtual check-ins)** **CPT:** 98969, 98970, 98971, 98972, 99421, 99422, 99423, 99444, 99458 **HCPCS:** G2010, G2012, G2061, G2062, G2063 **Telehealth POS:** 02
SMD	**Diabetes Monitoring for People with Diabetes and Schizophrenia:** The percentage of members 18–64 years of age with schizophrenia or schizoaffective disorder and diabetes who had both an **LDL-C test** and an **HbA1c test** during the measurement year.	The measure includes telephone visits, e-visits and virtual check-ins of the event diagnosis. ****Lab required for member compliant with measure***	***Medicaid***	**Telephone Visits** **CPT:** 98966, 98967,98968, 99441, 99442, 99443 **Online Assessment (e-visits and virtual check-ins)** **CPT:** 98969, 98970, 98971, 98972, 99421, 99422, 99423, 99444, 99458 **HCPCS:** G2010, G2012, G2061, G2062, G2063 **Telehealth POS:** 02

Measure Description		Telehealth Enhancement	Product Lines	HEDIS Value Set Code
SSD	**Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication:** The percentage of members 18–64 years of age with schizophrenia, schizoaffective disorder or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening **(glucose lab test or HbA1c test)** test during the measurement year.	The measure includes telephone visits, e-visits and virtual check-ins of the event diagnosis ***Lab required for member compliant with measure**	***Medicaid***	**Telephone Visits** **CPT:** 98966, 98967,98968, 99441, 99442, 99443 **Online Assessment (e-visits and virtual check-ins)** **CPT:** 98969, 98970, 98971, 98972, 99421, 99422, 99423, 99444, 99458 **HCPCS:** G2010, G2012, G2061, G2062, G2063 **Telehealth POS:** 02

Resources

https://www.pshpgeorgia.com/providers/coronavirus-information.html

https://ambetter.pshpgeorgia.com/provider-resources/manuals-and-forms/coronavirus-guidelines.html