Updated HEDIS® Reference Guide Now Available

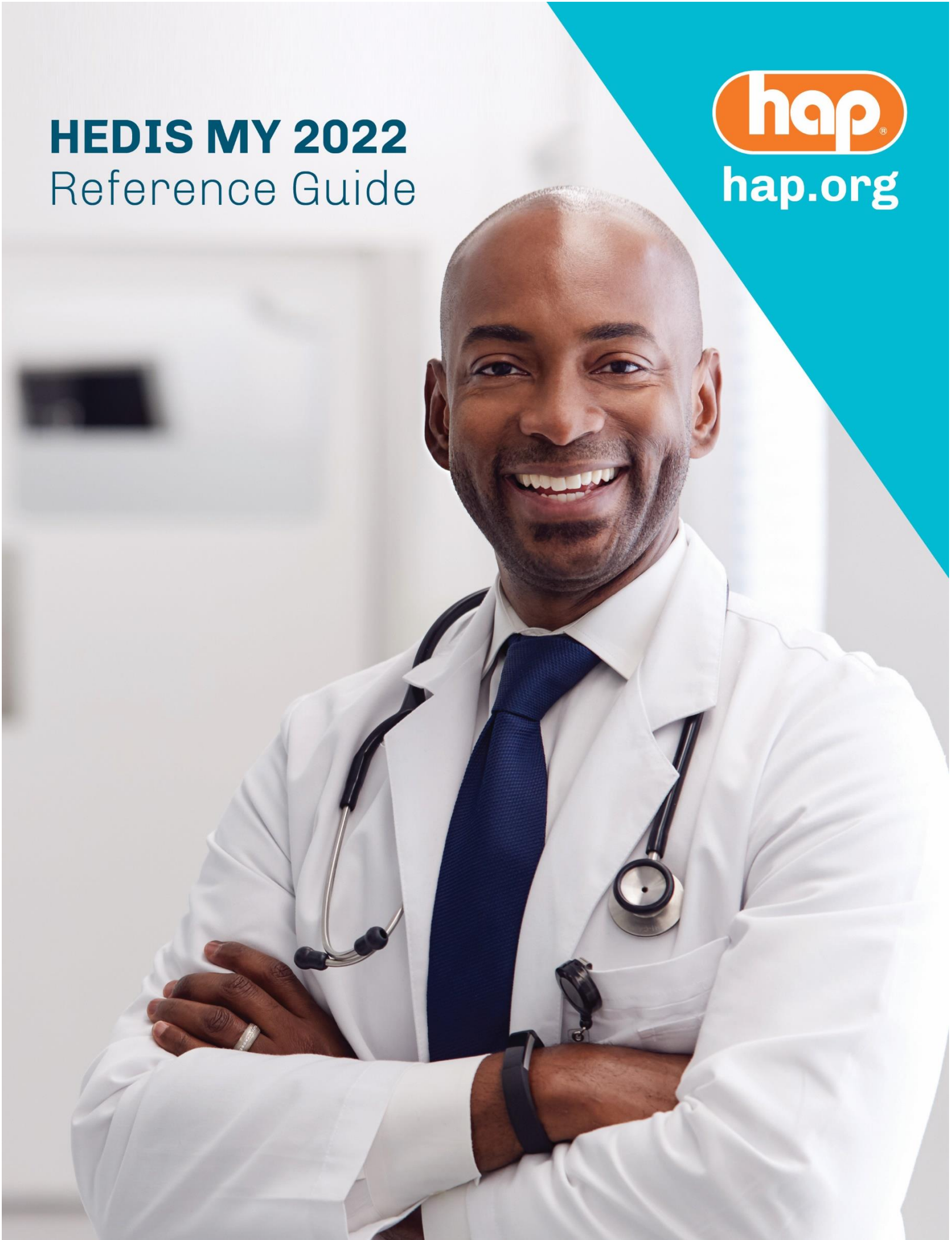
Healthcare Effectiveness Data and Information Set (HEDIS) is a set of standardized performance measures designed to ensure that purchasers and consumers have the information they need to reliably compare the health care quality.

Our updated HEDIS Reference Guide is now available. It's attached for your convenience. It can also be found online.

- Log in at **hap.org**
- Select *Resources*
- Select *Working with HAP*
- Select *HEDIS Resources*

HEDIS MY 2022
Reference Guide

hap.org



Introduction

What is HEDIS®?

Healthcare Effectiveness Data and Information Set (HEDIS) is a set of standardized performance measures, developed by the National Committee for Quality Assurance (NCQA), which allows direct, objective comparison of quality across health plans. NCQA develops the HEDIS measures through a committee represented by purchasers, consumers, health plans, health care providers and policy makers. HEDIS allows for standardized measurement, standardized reporting, and accurate objective side-by-side comparisons. For more information, visit **www.ncqa.org**.

How are the rates calculated?

HEDIS rates can be calculated in two ways:

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. • Requires review of a random sample of member medical records to abstract data for services rendered, but not reported to the health plan through claims/encounter data

Accurate and timely claim/encounter data reduces the necessity of medical record review. HAP contracts with Change Healthcare to conduct the medical record reviews on its behalf who will then:

- Contact the provider office directly to schedule an onsite or electronic review
- Scan or copy records for data validation
- Provide all medical record data collected to HAP

Annual HEDIS® timeline

Jan. 1– Dec. 31, 2022	Providers render services to HAP members and bill the appropriate claim to HAP to confirm services provided.
Feb.– May 2022	HAP's medical record vendor of choice collects and reviews HEDIS data through on-site provider office chart abstraction for services performed during the previous calendar year.
June 2022	HEDIS results for previous calendar year are certified and reported to NCQA.
Sept./Oct. 2022	NCQA releases results nationwide.

Hybrid measures that require chart abstraction

Care for older adults	Immunizations for adolescents
Cervical cancer screening	Lead screening in children
Childhood immunizations	Prenatal and postpartum care
Colorectal cancer screening	Transitions of care
Comprehensive diabetes care ***(Note:*** Comprehensive Diabetes Care (being replaced by the following new measures) • Blood Pressure Control (BPD) • Retinal Eye Exam (EED) • HbA1c Control (HBD)	Weight assessment and counseling for nutrition and physical activity for children and adolescents
Controlling high blood pressure	

This Guide

The codes in this guide are references for HEDIS:

- G codes are Medicare only
- F codes are informational
- Highlighted codes may not be covered benefits for HAP members

Your HEDIS results are not only important to HAP for data accuracy, but to your patients as well. HAP uses HEDIS data to determine which members need screenings and to provide educational programs and materials. Your participation in transmitting HEDIS data is vital to our mission of enhancing the health and well-being of the lives we touch.

Contact information

For	Contact	
HEDIS measures and this guide	HEDIS Team – Performance Measurement & Improvement	Hedis_team@hap.org

Reminders for 2022

- **Vendor for medical chart review**
  - HAP works with a vendor for medical record reviews. They contact offices directly to schedule and conduct reviews.
- **Provider portal**
  - Data can be submitted year-round to help you close gaps for measures. HAP accepts the following measures: Colorectal cancer screening, cervical cancer screening, breast cancer screening, and diabetes eye exam. Keep in mind that we work with provider groups to request charts when needed for auditing purpose throughout the year.
- **Advanced illness and/or frailty criteria**
  - In 2018 NCQA allowed additional exclusions for select HEDIS measures for patients with advanced illness and frailty. The change was made because quality measures originally meant for the adult population may not be appropriate for people with frailty and/or advanced illness.
    - Advanced illness codes include conditions listed below. These codes must be billed in the measurement year or the year prior to exclude patients from the measure

Metastatic cancer	Late stage kidney disease
Heart failure	Dementia including medication for dementia
Respiratory failure	Liver disease – cirrhosis, hepatitis

    - Frailty codes include equipment that are typically submitted via claims for things such as hospital beds, wheelchairs, and oxygen. Other conditions or situations that indicate frailty but are not always included on claims include weakness, falls, bed confinement, pressure ulcers etc.
      - Patients 66 – 80 years old must have both advanced illness and frailty to be excluded from a measure. Patients 81 and older will qualify with frailty alone. The table below lists the star measures impacted by advanced illness and frailty.
      - In 2020 Telehealth, telephone visits, e-visits and virtual check-ins are acceptable when used to exclude a patient using the advanced illness and frailty category when documented and the exclusion code is bill properly. See measures designated below*.

Measure	66 and older with advanced illness and frailty	81 and older with frailty
Breast cancer screening (BCS)* Ages 50 - 74	X	
Colorectal cancer screening (COL)* Ages 50 - 75	X	
Controlling blood pressure (CBP)* Ages 18 - 85	X	X
Osteoporosis management in women who had a fracture (OMW) Ages 67 – 85	X	X
Comprehensive diabetes care (CDC)* Ages 18 - 75	X	
Disease-modifying anti-rheumatic drug therapy for rheumatoid arthritis (ART) Ages 18 and older	X	X
Statin therapy for patients with cardiovascular disease (SPC)* • Men ages 21 – 75 • Women ages 40 - 75	X	

New Measures for 2022

Cardiac Rehabilitation (CRE)

For members 18 years and older, who attended cardiac rehabilitation following a qualifying cardiac event, including Myocardial Infarction, percutaneous coronary intervention, coronary artery bypass graft, heart ns heart/lung Transplantation or heart valve 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 member who attended 12 or more sessions of cardiac rehabilitation within 90 days of 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 member who attended 36 or more sessions of cardiac rehabilitation within 90 days of a qualifying event

Codes to identify cardiac rehabilitation

CPT/HCPCS
99797, 93738, G0422, G0423, S9472

Kidney Health Evaluation for Patients with Diabetes (KED)

For 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.

Codes to identify estimated glomerular filtration rate (eGFR) lab test

CPT
80047, 80048, 80050, 80053, 80069, 82542

Codes to identify urine creatinine lab test

CPT
82570

Osteoporosis Screening in Older Women (OSW)

For members 66 – 75 years of age who received one or more osteoporosis screening tests between the patient's 65th birthday and December 31 of the measurement year.

Codes to identify osteoporosis screening

CPT
76977, 77078, 77080, 77081, 77085

Key Measures

Adult preventive care

Advanced Care Planning (ACP)

Members 66 and older during the measurement year who had an advance care planning discussion about preferences for resuscitation, life sustaining treatment and end of life during the measurement year.

Codes to identify advance care planning

CPT
99483, 99497, 1123F, 1124F, 1157F, 1158F, S0257

Care for older adults (COA)

Members 66 years and older who had each of the following during the measurement year:

- Medication review
- Functional status assessment
- Pain assessment

Codes to identify care for older adults

Measure	CPT/HCPCS
Medication Review	90863, 99483, 99605, 99606, 1160F
Functional Status	99483, 1170F, G0438, G0439
Pain Assessment	1125F, 1126F

Dated documentation of the following is required on chart:

- Medication review includes at least one medication review with one of the following:
  - Presence of a medication list and date the review was performed
  - Dated notation that the member is not taking any medication
- Functional status assessment must include one of the following:
  - Notation that activities of daily living were assessed, or at least five of the following were assessed: bathing, dressing, eating, transferring, using toilet or walking
  - Notation that instrumental activities of daily living were assessed, or at least four of the following were assessed: shopping for groceries, driving or using public transportation, using the telephone, meal preparation, housework, home repair, laundry, taking medications or handling finances
  - Results of assessment using a standardized functional assessment tool such as SF-36, Bayer ADL Scale or Barthel Index, Edmonton Frail Scale, Independent Living Scale etc.
- Pain assessment must include one of the following:
  - Notation that patient was assessed for pain(may include positive or negative findings)
  - Results of assessment using a standardized pain assessment tool such as numeric rating scales, FLACC scale, verbal descriptor scales or pain thermometer
- NOTE – Services can be rendered during a telephone visit, e-visit or virtual check-in meet criteria for Functional Status Assessment and Pain Assessment

Tips:

- Medication review must be by a prescribing practitioner or pharmacist,
- Reviewing side effects for a single medication at time of prescription does not meet criteria.
- Functional status assessment limited to an acute or single condition, event or body system does not meet criteria.
- Notation of pain management plan alone does not meet criteria.
- Notation of pain treatment plan alone does not meet criteria.
- Notation of screening of chest pain alone or documentation of chest pain does not meet criteria.

Pediatric preventive care

Weight assessment and counseling for nutrition and physical activity for children and adolescents (WCC)

For members ages 3 to 17 years old who had an outpatient visit with a primary care physician or OB-GYN and who had annual evidence of:

- Body mass index percentile plotted on an age growth chart
- Counseling for nutrition*
- Counseling for physical activity*

*Note: Only these services can be rendered during a telephone visit, e-visit, or a virtual check-in

Codes to identify BMI assessment and counseling type:

Description	CPT/HCPCS	ICD-10-CM
BMI percentile		Z68.51-Z68 .54
Counseling for nutrition	97802-97804, G0270, G0271, G0447, S9449, S9452, S8470	Z71.3
Counseling for physical activity	S9451, G0447	Z02.5, Z71.82

Weight assessment for children and adolescents

Annual dated documentation of height, weight and BMI percentile is required on chart. Either of these meets criteria for BMI percentile:

- Weight and BMI as a percentile (no approximations)
- BMI percentile plotted on an age growth chart

Common chart deficiencies:

- BMI documented as number, not as percentile
- BMI growth charts not submitted

Documentation of counseling for nutrition for children and adolescents

Annual dated documentation of any of these is required on chart:

- Current nutrition behaviors, including:
  - Fruit and vegetable consumption
  - Portion sizes, appetite, or meal patterns
  - Breakfast habits, example: drinks two percent milk
- Checklist indicating that nutrition education was addressed
- Counseling or referral for nutrition education
- Handouts on nutrition given to patient during a face-to-face visit
- Anticipatory guidance for nutrition
- Weight or obesity counseling

Common chart deficiencies:

- Anticipatory guidance does not always address nutrition and physical activity
- Developmental milestones are not acceptable

Documentation of counseling for physical activity for children and adolescents

Annual dated documentation of any of these is required on chart:

- Current physical activity behaviors, including:
  - Exercise routine
  - Exam for sports activity
  - Participation in sports, such as playing on baseball team
- Checklist indicating that physical activity was addressed
- Counseling or referral for physical activity
- Handouts on physical activity given to patient during a face-to-face visit
- Anticipatory guidance for physical activity
- Weight or obesity counseling

Common chart deficiencies: Anticipatory guidance does not always address nutrition & physical activity.

Well-child visits in the first 30 months of life (W30)

Well-child visits are measured across two different age groups:

- Six or more visits within first 15 months
- Two or more visits between 15 and 30 months of age

A well-child visit includes a health and developmental history (physical and mental), a physical exam and health education and anticipatory guidance.

Note: Telehealth visits meet criteria for this measure

Codes to identify child well-care visits

CPT/HCPCS	ICD-10-CM
99381-99385, 99391-99395, 99461, G0438, G0439	Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.5, Z00.8, Z02.0, Z02.1-Z02.6, Z02.71, Z02.82, Z76.1, Z76.2

Well-child visits in the first 30 months of life

Dated documentation of well-care visits is required in charts, including:

- Health history
- Physical developmental history
- Mental developmental history
- Physical exam
- Health education and anticipatory guidance

Common chart deficiencies:

- Lack of documentation of required elements
- Children being seen for sick visits and the required elements are not addressed

Tips:

- Preventive services may be rendered on visits other than well-care visits.
- Use standardized templates in charts and EMRs that allow checkboxes for standard counseling activities

Child and adolescent well-care visits (WCV)

Members ages 3 to 21 years old should receive at least one annual well-child visit with a primary care physician or an OB-GYN annually. A well-care visit includes a health and developmental history (physical and mental), a physical exam and health education and anticipatory guidance.

Note: This measure replaces the former Well-child visits in the third, fourth, fifth and sixth years of age and the adolescent well-care visits HEDIS measures.

Codes to identify adolescent well-child visits

CPT/HCPCS	ICD-10-CM
99381-99385, 99391-99395, 99461, G0438, G0439	Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.5, Z00.8, Z02.0, Z02.01, Z02.1-Z02.6, Z02.9, Z02.71, Z02.82, Z76.1, Z76.2

Child and adolescent well-care visits

Dated documentation of well-care visits is required in charts, including:

- Health history
- Physical developmental history
- Mental developmental history
- Physical exam
- Health education and anticipatory guidance

Common chart deficiencies:

- Lack of documentation of required elements. Medical record needs to include the date when health and developmental history and physical exam were performed, and health education and guidance was given.
- Adolescents being seen for sick visits and the required elements are not addressed.

Tips:

- Preventive services may be rendered on visits other than well-care visits.
- Well-care visits should be done annually.

Lead screening in children (LSC)

Children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning on or before their second birthday.

Codes to identify lead screening in children

CPT
83655

Documentation in the medical record must include both of the following:

- A note indicating the date the test was performed.
- The result or finding.

Common chart deficiencies:

- Tests ordered but not done
- Lab results not found

Tips: Lead assessment does not constitute a lead screening. Be sure to order the blood test.

Adult cancer screening

Breast cancer screening (BCS)

Women ages 50 to 74 years old should receive a mammogram at least once every two years. Patients will be excluded with proof of either of these at any time during their history:

- Bilateral mastectomy
- Unilateral mastectomy with a bilateral modifier, codes must be on same claim
- Two unilateral mastectomies on different dates of service
- Any member age 66 years or older:
  - In a long-term care facility
  - With advanced illness and frailty diagnosis

Note: Biopsies, breast ultrasounds and MRIs do not count because HEDIS does not consider them to be appropriate primary screening methods.

Note

- Telehealth, telephone visits, e-visits, and virtual check-ins can be used to document event/exclusion
- Exclusions for this measure are eligible for record submission through the provider portal

Tips

- Educate female patients about the importance of early detection and encourage screening.
- Schedule the mammogram for the patient, follow-up to determine if screening is complete and obtain results
- Have a list of mammogram facilities available.

Codes to identify breast cancer screening

CPT/HCPCS
77061-77063, 77065-77067, G0202, G0204, G0206

Codes to identify breast cancer screening exclusions

CPT	ICD10PCS	ICD10CM
• Bilateral modifier: 50 • Left Modifier: LT • Right Modifier: RT • Unilateral mastectomy: 19180, 19200, 19220, 19240, 19303 -19307	• Bilateral mastectomy: OHTVOZZ • Unilateral mastectomy left: OHTUOZZ • Unilateral mastectomy right: OHTTOZZ	• History of bilateral mastectomy_Z90.13 • Absence of left breast: Z90.12 • Absence of right breast: Z90.11

Cervical cancer screening (CCS)

Women ages 21 to 64 years of age should be 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) cotesting within the last 5 years.

Note:

- Telehealth, telephone visits, e-visits, and virtual check-ins can be used to document event/exclusion
- Exclusions for this measure are eligible for record submission through the provider portal
- **Patients will be excluded with proof of hysterectomy with no residual cervix during their history**

Codes to identify cervical cancer screening

CPT/HCPCS	ICD-10-CM
88141-88143, 88147, 88148, 88150, 88152-88154, 88164-88167, 88174, 88175	G0123, G0124, G0141, G0143-G0145, G0147, G0148, P3000, P3001, Q0091

Dated documentation of cervical cancer screening with result is required in charts, including either:

- Cervical cytology (every 3 years)
- Cervical cytology and HPV test on same date of service (every 5 years)

Common chart deficiencies:

- Pap smear test results not found in PCP charts
- Pap and HPV testing not done on same day (waiting until positive Pap)
- Incomplete documentation related to hysterectomy

Tips:

- Specify if cervix was removed
- Test Pap and HPV on the same day
- Use a reminder or recall system
- When documenting an exclusion in the medical record include words Total hysterectomy, complete, radical, full, surgical removal of cervix and year of procedure

Colorectal cancer screening (COL)

Members ages 50 to 75 years old should be screened for colorectal cancer via one or more of these methods:

- Annual fecal occult blood test (FOBT)
- Flexible sigmoidoscopy every five years
- Colonoscopy every ten years
- CT colonography (virtual colonoscopy) during the measurement year or the four years prior to the measurement year
- FIT-DNA test (Cologuard) during the measurement year or the two years prior to the measurement year Patients will be excluded with proof of either of these at any time during their history:
  - Colorectal cancer
  - Total colectomy
  - Any member age 66 years or older:
    - In a long-term care facility
    - With advanced illness and frailty diagnosis

Note:

- Telehealth, telephone visits, e-visits, and virtual check-ins can be used to document event/exclusion
- Exclusions for this measure are eligible for record submission through the provider portal

Codes to identify colorectal cancer screening

Description	CPT/HCPCS
FOBT	82270, 82274, G0328
Flexible sigmoidoscopy	45330-45335, 45337-45342, 45346-45350,G0104
Colonoscopy	44388-44394, 44397, 44401-44408, 45355, 45378-45393, 45398, G0105, G0121
CT colonography	74261-74263
FIT-DNA	81528, G0464

Dated documentation of colorectal screening with results is required in charts, including one of the following:

- Colonoscopy every 10 years
- Sigmoidoscopy every 5 years
- CT colonography – virtual colonoscopy every 5 years
- FIT-DNA – Cologuard every 3 years
- Annual fecal blood testing in a lab (gFOBT) (iFOBT)(FIT)
- Personal history of colorectal cancer or evidence of total colectomy with date of occurrence

Common chart deficiencies:

- Not documenting colorectal screenings in the health history
- Not documenting history of colorectal cancer or total colectomy
- Not providing the health history with the note and/or test results
- FOBT test performed in an office setting or during a digital rectal exam does not meet criteria

Tips:

- Encourage patients who are resistant to having a colonoscopy to have stool test they can complete at home. Recommend a FIT-DNA/FOBT screening as an alternative.
- Use standing orders and empower staff to distribute FOBT kits to patients who need screenings or prepare referral for colonoscopy.

Adult diabetes care

Patients will be excluded with proof of either of these at any time during their history:

- Patients with frailty diagnosis
- Any member age 66 years or older;
  - In a long-term care facility
  - With advanced illness and frailty diagnosis

Note: Telehealth, telephone visits, e-visits, and virtual check-ins can be used to document event/exclusion

Codes to identify diabetes

Description	ICD-10-CM
Diabetes	E10, E11, E13,024

Hemoglobin A1c Control for Patients with Diabetes (HBD)

Diabetic members age 18 to 75 years old whose who's latest HbA1c results are at the following levels during the measurement year.

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

Codes to identify HbA1c control

Description	CPT
HbA1c <7%	3044F
HbA1c > 9 .0%	3046F
HbA1c >= to 7.0% and <8.0%	3051F
HbA1c >= to 8.0% and <9.0%	3052F

Blood Pressure Control for Patients with Diabetes (BPD)

Diabetic members age 18 to 75 years old with diabetes (types 1 and 2) whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the measurement year

Codes to identify blood pressure control
Diabetic members whose latest BP values were <140/90

Description	CPT
Diastolic < 80	3078F
Diastolic 80-89	3079F
Diastolic >= 90	3080F
Systolic < 130	3074F
Systolic 130-139	3075F
Systolic >= 140	3077F

Eye Exam for Patients with Diabetes (EED)

Diabetic members age 18 to 75 years old with diabetes (types 1 and 2) who had a retinal eye exam. The following codes can be submitted by a PCP, if the images are read by an eye care professional:

Note: Exclusions for the diabetes eye exam are eligible for record submission through the provider portal

Codes to identify eye exams

CPT/HCPCS
2022F, 2024F, 2026F, 3072F*

*CPT Category II code 3072F can only be used if the claim or encounter was during the measurement year because it indicates the member had "no evidence of retinopathy in the prior year." Additionally, because the code definition itself indicates results were negative, an automated result is not required.

Kidney Health Evaluation for Patients with Diabetes (KED)

Diabetic members age 18 – 85 years old with diabetes (type 1 and 2) who received both an estimated glomerular filtration rate (eGFR) and a urine albumin ratio (uACR) during the measurement year on the same or different dates of service.

- At least one eGFR
- At least one uACR identified by the following
  - The uACR is identified by the member having **both** a quantitative urine albumin test **and** a urine creatinine test with service dates four days or less apart.

Codes to identify kidney health lab tests

Description	CPT
eGFR tests	80047, 80048, 80050, 80053, 80069, 82565
Urine Albumin lab test	82043
Urine Creatinine lab test	82570

Tips:

- Follow-up with patients to discuss lab results
- Educate on how diabetes can affect the kidneys
- Review diabetic services at each visit

Common chart deficiencies:

- Tests ordered but not done
- Lab results not found
- Consult reports not found
- Repeat BP reading not documented in chart

Statin therapy for patients with Diabetes (SPD)

Diabetic members 40-75 years old who do not have clinical atherosclerotic cardiovascular disease and met the following criteria:

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

Note: Telehealth, telephone visits, e-visits and virtual check-ins can identify the diagnosis of Diabetes
Patients will be excluded with proof of either of these at any time during their history:

- Any member age 66 years or older;
  - Enrolled in an Institutional SNP
  - In a long-term care facility
  - With advanced illness and frailty diagnosis

Table to identify statin medications

Description	Prescription	
High-intensity statin therapy	Atorvastatin 40-80mg Amlodipine-atorvastatin 40-80mg	Rosuvastatin 20-40mg Simvastatin 80mg Ezetimibe-simvastatin 80mg
Moderate-intensity statin therapy	Atorvastatin 10-20mg Amlodipine-atorvastatin 10-20mg Rosuvastatin 5-10mg Simvastatin 20-40mg Ezetimibe-simvastatin 20-40 mg	Pravastatin 40-80mg Lovastatin 40mg Fluvastatin 40-80mg Pitavastatin 1-4mg
Low-intensity statin therapy	Ezetimibe-simvastatin 10mg Fluvastatin 20mg Lovastatin 10 - 20mg	Pravastatin 10-20mg Simvastatin 5-10mg

Cardiovascular conditions

Statin therapy for patients with cardiovascular disease (SPC)

The percentage of males 21-75 and females 40-75 years old who were identified as having clinical atherosclerotic cardiovascular disease and met the following criteria:

- Patients were dispensed at least one high-intensity or moderate-intensity statin medication during the measurement year
- Patients who remained on a high-intensity or moderate-intensity statin medication for at least 80 percent of the treatment period

Patients will be excluded with proof of either of these at any time during their history:

- Patients in hospice
- Any member age 66 years or older:
  - In a long-term care facility
  - With advanced illness and frailty diagnosis

Note: A telephone, e-visit or virtual check-in with diagnosis of hypertension is allowed for this measure.

Table to identify high- and moderate-intensity statin medications

Description	Prescription	
High-intensity statin therapy	Atorvastatin 40-80mg Amlodipine-atorvastatin 40-80mg	Rosuvastatin 20-40mg Simvastatin 80mg Ezetimibe-simvastatin 80mg
Moderate-intensity statin therapy	Atorvastatin 10-20mg Amlodipine-atorvastatin 10-20mg Rosuvastatin 5-10mg Simvastatin 20-40mg Ezetimibe-simvastatin 20-40mg	Pravastatin 40-80mg Lovastatin 40mg Fluvastatin 40-80mg bid Pitavastatin 2-4mg

Tip: Review medication list at every visit

Codes to identify cardiovascular disease and type

Description	CPT/HCPCS	UB Revenue	ICD-10-CM
IVD-ischemic vascular disease			I20.0, I20.8, I20.9, I24.0, I24.8, I24.9, I25.10, I25.110, I25.111, I25.118, I25.119, I25.5, I25.6, I25.700, I25.701, I25.708, I25.709, I25.710, I25.711, I25.718-I25.721, I25.728-I25.731, I25.738, I25.739, I25.750, I25.751, I25.758-I25.761, I25.768, I25.769, I25.790, I25.791, I25.798, I25.799, I25.810-I25.812, I25.82-125.84, I25.89, I25.9, I63.2, I63.5, I65.01-I65.09, I65.1, I65.2, I65.8, I65.9, I66.01-I66.03, I66.11-, I66.19,166.23, I66.29, I66.3, I66.8, I66.9, I67.2, I70.1, I70.2, I70.3, 170.4, I70.5, I70.6, I70.7, I70.92, I75.011-I75.013, I75.019-I75.023, I75.029, I75.81, I75.89, T82.855A, T82.855D, T82.855S, T82.856A, T82.856D, T82.856S
Outpatient visit codes	99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99429, 99455, 99456, 99483	0510-0517, 0519-0523, 0526-0529, 0982-0983	
Acute inpatient	99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291		

Tips:

- Prescribe medication electronically to pharmacy of patient's choice.
- Suggest a 90-day supply, mail-order or auto-refill, especially for patients stable on therapy.
- Educate the patient on how the medication may help them and possible side effects

Controlling high blood pressure (CBP)

The percentage of patients 18-85 years old who had a diagnosis of hypertension and whose blood pressure was adequately controlled during the measurement year based on the following criteria:

- Patients 18-85 years old who had a diagnosis of hypertension and whose blood pressure was adequately controlled <140/90 mm Hg
- The most recent blood pressure during the measurement year is used

The hypertension diagnosis must be captured twice during the measurement year or the year prior. The BP reading must occur on or after the second diagnosis occurs.

Note: A telephone, e-visit or virtual check-in with diagnosis of hypertension is allowed for this measure.

Patients will be excluded with proof of either of these at any time during their history:

- Patients in hospice
- Any member age 66 years or older:
  - In a long-term care facility
  - With advanced illness and frailty diagnosis

Codes to identify hypertension diagnosis

Description	ICD-10-CM
Hypertension diagnosis visit	I10

Tips:

- Document diagnosis of hypertension on at least two outpatient visits on different dates of service during the measurement year or the year prior.
- Take two blood pressure readings, one at the start of the exam and one at the end of the exam (HEDIS allows us to use the lowest systolic and diastolic readings in the same day).
- Document the exact value of the blood pressure readings and don't round up or down.
- Review and document hypertensive medication history and patient compliance.
- Suggest a 90-day supply, mail order or auto-refill, especially for patients stable on therapy
- Code appropriately for hypertension and use CPT codes for BP.
- Select the appropriate cuff size.
- Calibrate the sphygmomanometer annually.

Blood pressure

Codes to identify blood pressure under control

Description	CPT
Diastolic < 80	3078F
Diastolic 80-89	3079F
Diastolic >= 90	3080F
Systolic < 130	3074F
Systolic 130-139	3075F
Systolic >= 140	3077F

Pediatric immunizations

Immunizations for Adolescents (IMA)

Children should receive the following immunizations prior to turning 13 years old:

- One dose of meningococcal vaccine
- One tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) or one tetanus
- Two or three doses of human papillomavirus (HPV) (Number of doses depends on age at initial vaccination)

Codes to identify adolescent immunizations

Immunization	CPT Code
Meningococcal	90734
Tdap	90715
HPV	90649, 90650, 90651

Documentation of these immunizations that must be given by age 13 is required in charts:

- One Meningococcal
- One Tdap/Td
- HPV

Common chart deficiencies:

- Immunizations received after specified time frames or after turning 13 years old
- PCP charts do not contain immunization records if received at health department or school
- No documentation of allergies or contraindications
- No documentation of parental refusal

Tips:

- Document parental refusal.
- Document contraindications or allergies.
- If vaccines are obtained at a different location, please include a copy in the chart.
- HPV vaccination should be discussed as early as 9 years of age. For two-dose vaccines, there must be at least 146 days between the first and second dose of the HPV vaccine.
- Review missing immunizations with parents and recommend them. Parents are more likely to agree with vaccinations supported by the provider

Childhood immunization status (CIS)

By their second birthday, children should receive the following vaccines:

- Four diphtheria, tetanus, and acellular pertussis (DTaP)
- Three polio (IPV)
- One measles, mumps, and rubella (MMR)
- Three H influenza type B (HiB)
- Three hepatitis B (HepB)
- One varicella zoster (VZV)
- Four pneumococcal conjugate (PCV)
- One hepatitis A (HepA)
- Two or three rotavirus (RV)
- Two influenza (flu)

Note: LAIV (influenza) vaccination <**must** occur on the child's second birthday**. Note**: *(will not count if administered prior to the child's 2nd birthdate)*

Codes to identify childhood immunization status

Description	CPT
DTaP	90698, 90700, 90721, 90723
HiB	90644, 90645, 90646, 90647, 90648, 90698
Hepatitis A	90633
Hepatitis B	90688, 90723, 90740, 90744, 90747, 90748, 90723, G0010
Polio (IPV)	90698, 90713, 90723
Influenza	90655, 90657, 90660, 90661, 90662, 90672, 90673, 90685, 90686, 90687, 90688, G0008
Measles	90705
Measles, Mumps and Rubella (MMR)	90707, 90710
Measles/Rubella	90708
Mumps	90704
Pneumococcal Conjugate	90670, G0009
Rotavirus Vaccine (2 dose schedule) administered	90681
Rotavirus Vaccine (3 dose schedule) administered	90680
Rubella	90706
Varicella Zoster (VZV)	90710, 90716

Documentation of the following immunizations that must be given by age 2 is required in charts:

- Four diptheria, tetanus and acellular pertussis (DTaP)"
- Three polio (IPV)*
- One measles, mumps and rubella (MMR)
- Three H influenza type B (HiB)*
- Three hepatitis B (HepB)
- One varicella zoster (VZV)
- Four pneumococcal conjugate (PCV)*
- One hepatitis A (HepA)
- Two or three rotavirus (RV)*
- Two influenza (Flu)**

Common chart deficiencies

- Immunizations received after child turns 2 years old
- PCP charts do not contain immunization records if received at health department or school
- PCP charts do not contain immunization records
- Immunizations given in the hospital at baby's birth
- No documentation of allergies or contraindications

Tips: If missing any immunization, please include:

- Documentation of parental refusal
- Documentation of request for delayed immunization schedules
- Immunizations given at health departments
- If vaccines are obtained at a different location, please include a copy in the chart.

*These vaccinations cannot be administered prior to 42 days after birth
**Influenza must be administered at least 180 days after birth.

Adult musculoskeletal

Osteoporosis management in women who had a fracture (OMW)

For women ages 67-85 years old who suffered a fracture and who had either a bone mineral density test or a prescription for a drug to treat or prevent osteoporosis in the six months after the fracture.

Special attention should be taken <u>not</u> to submit claims with acute fracture diagnoses for old fractures that are healed. This will ensure that the appropriate population is selected, and the reported rate is accurate.

CD-10-CM provides specific codes to capture a history of a fracture that is now healed. They're located in the ICD-10 - CM Official Guidelines for Coding and Reporting in the alphabetic index under:

- Personal history (of)
- Fracture (healed)

For current, acute fractures that are receiving active treatment or are still in the healing stages and receiving subsequent treatment, ICD-10 provides specific codes to capture details of the fracture including the type and location of the injury, encounter, stage of healing and any complications. All codes assigned must be supported by the provider's documentation in the medical record. Please refer to the ICD-10-CM Official Guidelines for Coding and Reporting for further instructions.

Patients will be excluded with proof of either of these at any time during their history:

- Patients in hospice
- Any member age 67 years of age or older:
  - In a long-term care facility
  - With advanced illness and frailty diagnosis

Osteoporosis medications

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

Codes to identify bone mineral density test

CPT/HCPCS	ICD-10-PCS
76977, 77078, 77080-77081, 77085, 77086	BP48ZZ1, BP49ZZ1, BP4GZZ1, BP4HZZ1, BP4LZZ1, BP4MZZ1, BP4NZZ1, BP4PZZ1, BQ00ZZ1, BQ01ZZ1, BQ03ZZ1, BQ04ZZ1, BR00ZZ1, BR07ZZ1, BR09ZZ1, BR0GZZ1

Codes to identify fracture*

CPT/HCPCS	ICD-10-PCS
21811-21813, 21820, 21825, 22310, 23500, 23505, 23515, 23570, 23575, 23585, 23600, 23605, 23615, 23616, 23620, 23625, 23630, 24500, 24505, 24515, 24516, 24530, 24535, 24538, 24545, 24546, 24560, 24565, 24566, 24575-24577, 24579, 24582, 24650, 24655, 24665, 24666, 24670, 24675, 24685, 25500, 25505, 25515, 25520, 25525, 25526, 25530, 25535, 25545, 25560, 25565, 25574, 25575, 25622, 25624, 25628, 25630, 25635, 25645, 25650-25652, 25680, 25685, 26600, 26605, 26607, 26608, 26615, 27200, 27202, 27215, 27220, 27222, 27226-27228, 27230, 27232, 27235, 27236, 27238, 27240, 27244, 27245, 27246, 27248, 27254, 27267-27269, 27500-27503, 27506-27511, 27513, 27514, 27520, 27524, 27530, 27532, 27535, 27536, 27538, 27540, 27750, 27752, 27756, 27758-27760, 27762, 27766-27769, 27780, 27781, 27784, 27786, 27788, 27792, 27808, 27810, 27814, 27816, 27818, 27822-27828, 28400, 28405, 28406, 28415, 28420, 28430, 28435, 28436, 28445, 28450, 28455, 28456, 28465, 28470, 28475, 28476, 28485, 29850, 29851, 29855, 29856, S2360	M48.4, M80.0-M84.3, M97.0-97.42, S12, S22, S32, S42, S52, S62, S72, S82, S92,

*Fractures of finger, toe, face, and skull are not included in this measure.

Codes to identify osteoporosis visit type

Description	CPT/HCPCS	UB Revenue
Outpatient	99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99429, 99455, 99456, 99483, G0402, G0438, G0439, G0463, T1015	0510-0517, 0519-0523, 0526-0529, 0982-0983
Nonacute inpatient	99304-99310, 99315, 99316, 99318, 99324-99328, 99334-99337	0022, 0024, 0118, 0128, 0138, 0148, 0158, 0190-0199,0524, 0525, 0550-0552, 0559-0669, , 1000, 1001, 1002,
Acute inpatient	99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291	
ED	99281-99285	0450-0452, 0456, 0459, 0981
Observation	99217-99220	0760, 0762, 0769

Osteoporosis Screening in Older Women (OSW)

For women 65 – 75 years of age who received an osteoporosis screening during the measurement year or the year prior.

Patients will be excluded with proof of either of these at any time during their history:

- Patients in hospice
- Any member age 66 years or older:
  - In a long-term care facility
  - With advanced illness and frailty diagnosis

Codes to identify osteoporosis screening tests

CPT
76977, 77078, 77080, 77081, 77085

Adult and pediatric behavioral health

Antidepressant medication management (AMM)

For members 18 years and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment. Two rates are reported:

1. Effective acute phase treatment: The percentage of treated members who remained on an antidepressant medication for at least 84 days (12 weeks).

2. Effective continuation phase treatment: The percentage of treated members who remained on an antidepressant medication for at least 180 days (6 months).

Note: A telephone, e-visit or virtual check-in with event/diagnosis

Codes to identify major depression

Description	ICD-10-CM
Major depression	F32.0-32 .4, F32.9, F33.0-F33.3, F33.41, F33.9

Qualifying AMM Medications

Description	ICD-10-CM	
Miscellaneous antidepressants	Bupropion Vilazodone Vortioxetine	
Phenylpiperazine antidepressants	Nefazodone Trazodone	
Psychotherapeutic combinations	Amitriptyline-chlordiazepoxide Amitriptyline-perphenazine Fluoxetine-olanzapine	
SNRI antidepressants	Desvenlafaxine Duloxetine	Venlafaxine Levomilnacipran
SSRI antidepressants	Citalopram Escitalopram Fluoxetine	Fluvoxamine Paroxetine Sertraline
Tetracyclic antidepressants	Amitriptyline Amoxapine Clomipramine Desipramine Doxepin (>6mg)	Imipramine Nortriptyline Protriptyline Trimipramine
Monoamine oxidase inhibitors	Isocarboxazid Phenelzine	Selegiline Tranylcypromine

Follow-up care for children prescribed attention deficit hyperactivity disorder medication (ADD)

Children between 6 and 12 years old who receive a new prescription for ADHD medication should complete a follow- up visit with their doctor within 30 days of filling the prescription. Children who remain on the medications for at least 6 months should complete two additional follow-up visits within 9 months after prescription is filled. A diagnosis of ADHD is not required for inclusion in this measure.

Qualifying ADHD medications

Description	Prescription
CNS stimulants	Dexmethylphenidate Dextroamphetamine Lisdexamfetamine Methamphetamine Methylphenidate
Alpha-2 receptor agonists	Clonidine Guanfacine
Miscellaneous ADHD medications	Atomoxetine

Codes to identify follow-up care for children prescribed ADHD medication

CPT	HCPCS	POS
96150-96154, 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99381-99384, 99391-99394, 99401-99404, 99411, 99412, 99483, 99510, 99441, 99442, 99443	G0155, G0176, G0177, G0409, G0463, H0002, H0004, H0031, H0034, H0035, H0036, H0037, H0039-H0040, H2000, H2010-H2015, H2016-H2019, H2020, M0064, S0201, S9480, S9484, S9484, S9485	03, 05, 07, 09, 11-20, 22, 33, 49, 50, 71, 72

Reproductive care

Chlamydia screening in women (CHL)

Women ages 16 to 24 years old who are sexually active should have an annual chlamydia screening.

Codes to identify chlamydia tests

CPT/HCPCS
87110, 87270, 87320, 87490-87492, 87810

Prenatal and postpartum care (PPC)

The percentage of deliveries that received a prenatal care visit in the first trimester.
Note: Telephone visits, e-visits and virtual check-ins are eligible for use in reporting both rates.

Documentation in the medical chart must include a note indicating the date when the prenatal care visit occurred and evidence of at least one of these:

A basic physical obstetrical exam that includes:

- Auscultation for fetal heart tone
- Pelvic exam with obstetric observations
- Measurement of fundal height (a standardized prenatal flow sheet may be used)

Evidence that a prenatal care procedure was performed, such as:

- Screening test in the form of an obstetric panel
- TORCH antibody panel alone
- A rubella antibody test or titer with an Rh incompatibility (ABO/Rh) blood typing
- Ultrasound of pregnant uterus

Documentation of last menstrual period or estimated date of delivery in conjunction with either of the following:

- Prenatal risk assessment and counseling and education
- Complete obstetrical history

Common chart deficiencies:

- Prenatal care not done within timeframe
- A note that testing was completed but no results in chart

Tip: More information is found on the ACOG form.

Postpartum care

The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery.
Prenatal and postpartum codes can be submitted as a part of a bundle of care including delivery.

Codes to identify prenatal and postpartum visits

Description	CPT/HCPCS	ICD-10-CM
Prenatal and postpartum	59510, 59610, 59618, 59400, 59425, 59426, 59410, 59515, 59614, 59618, 59622	
Postpartum care	57170, 58300, 59430, 99501, 0503F, G0101	Z01.411, Z01.419, Z01.42, Z30.430, Z39.1, Z39.2
Prenatal care	99201-99205, 99211-99215, 99241-99245, G0463, T1015, 99483	

Postpartum visit must be documented in the medical chart on or between 7 and 84 days after delivery. The documentation must include a note indicating the date when a postpartum visit occurred and at least one of these:

- Pelvic exam
- Evaluation of weight, blood pressure, breasts, and abdomen
- Notation of "breastfeeding" is acceptable for the "evaluation of breasts" component
- Notation of postpartum care, including, but not limited to:
  - Notation of "postpartum care," "PP care," "PP check," "six-week check"
  - A preprinted postpartum care form in which information was documented during the visit.

Common chart deficiencies: No postpartum care visit was performed

Tip: Incision check post C-section does not constitute a postpartum visit.

Prenatal and postpartum codes can be submitted as a part of a bundle of care including delivery

Description	CPT/HCPCS
Stand-alone prenatal visits	0500F, 0501F, 0502F, 99500, H1000, H1001, H1002, H1003, H1004
Other prenatal visits must also include pregnancy diagnosis or one of the following:	99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241-99245, G0463, T1015, 99483
Rubella antibody, with either: • ABO • Rh	 86900 86901

Postpartum care, if performed outside of bundled reimbursement

Description	CPT/HCPCS	ICD-10-CM
Postpartum visits	0503F, 57170, 58300, 59430, 99501, G0101	Z01.411, Z01.419, Z01.42, Z30.430, Z39.1, Z39.2
Cervical cytology	88141, 88142, 88143, 88147, 88148, 88150, 88152, 88153, 88154, 88164, 88165, 88166, 88167, 88174, 88175, G0123, G0124, G0141, G0143, G0144, G0145, G0147, G0148, P3000, P3001, Q0091	

Pediatric and adult respiratory

Pharmacotherapy management for Chronic Obstructive Pulmonary Disease exacerbation (PCE)

For members ages 40 years and older who have been diagnosed with COPD exacerbations, have been discharged from acute inpatient or emergency department visit on or between Jan. 1 and Nov. 30 and were dispensed the appropriate medications. Two rates are reported:

Dispensed systemic corticosteroid within 14 days of discharge:

Description	Prescription	
Glucocorticoids	Cortisone-acetate Dexamethasone Hydrocortisone	Methylprednisolone Prednisolone Prednisone

Dispensed a bronchodilator within 30 days of discharge:

Description	Prescription	
Anticholinergic agents	Albuterol-ipratropium Aclidinium-bromide Ipratropium	Tiotropium Umeclidinium
Beta 2-agonists	Albuterol Arformoterol Budesonide-formoterol Fluticasone-salmeterol Fluticasone-vilanterol Formoterol Formoterol-glycopyrrolate Formoterol-mometasone	Indacaterol Indacaterol-glycopyrrolate Levalbuterol Metaproterenol Olodaterol hydrochloride Olodaterol-tiotropium Salmeterol Umeclidinium-vilanterol
Antiasthmatic combinations	Dyphylline-guaifenesin	

Use of spirometry testing in the assessment and diagnosis of COPD (SPR)

Members 40 and older with a new diagnosis or a newly active COPD should receive appropriate spirometry testing to confirm the diagnosis. Spirometry testing must occur between two years prior to diagnosis date and six months after diagnosis date.

Codes to identify COPD

Description	ICD-10-CM
Chronic bronchitis	J41, J42
Emphysema	J43
COPD	J44

Codes to identify spirometry testing

Description	ICD-10-CM
Spirometry	94010, 94014-94016, 94060, 94070, 94375, 94620

Avoidance of antibiotic treatment for acute bronchitis/bronchiolitis (AAB)

Members 3 months and older with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription.

Codes to identify acute bronchitis

Description	ICD-10-CM
Acute bronchitis	J2.0-J20.9, J40

Tips

- Educate patients on comfort measures, such as extra fluids and rest.
- Discuss expectations for recovery time, such as explaining cough can last for four or more days.

Codes to identify visit type

Description	CPT/HCPCS	UB Revenue
Outpatient	99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99429, 99455, 99456, G0402, G0438, G0439, G0463, T1015, 99483	0510-0517, 0519-0523, 0526-0529, 0982-0983
ED	99281-99285	0450-0452, 0456, 0459, 0981
Observation	99217-99220	

Appropriate testing for pharyngitis (CWP)

Members age 3 years and older who are diagnosed with pharyngitis should be dispensed an antibiotic and a group A streptococcus (strep) test.

Codes to identify pharyngitis

Description	ICD-10-CM
Acute pharyngitis	J02.8, J02.9
Acute tonsillitis	J03.90, J03.00, J03.80, J03
Strep sore throat	J02.0

Codes to identify group A strep tests

CPT codes
87070, 87071, 87081, 87430, 87650-87652, 87880

Appropriate treatment for children with upper respiratory infection (URI)

Children ages 3 months to 18 years old who are diagnosed with an upper respiratory infection should not be dispensed an antibiotic prescription within 3 days of diagnosis.

Codes to identify appropriate treatment for children with upper respiratory infection

Description	ICD-10-CM
Acute nasopharyngitis (common cold)	J00
URI	J06.0, J06.9

Do not include emergency room visits that result in an inpatient admission.

Tips

- Educate patient on comfort measures, such as something for fever, rest, extra fluids
- Advise patient to call back if symptoms worsen.

Medication management and care coordination

Transitions of care (TRC)

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).

Codes to identify medication reconciliation post discharge

CPT codes
1111F, 99495, 99496, 99483

Tips
Documentation for all four sub-measures needs to be present and collected from one record; the record of the PCP or ongoing care provider. To help meet compliance:

- Ensure clear evidence of date of receipt of admission and discharge information
- Document provider awareness or acknowledgement of the inpatient stay at the time of the post discharge patient engagement and medication reconciliation
- Ensure presence of current list of medications in the record for reconciliation with discharge medications
- Ensure medication reconciliation is completed and signed by either a prescribing practitioner, clinical pharmacist, or registered nurse

Codes to identify visit type

Description	CPT/HCPCS	UB Revenue
Outpatient	99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99429, 99455, 99456, G0402, G0438, G0439, T1015, 99483	0510-0517, 0519-0523, 0526-0529, 0982-0983
Telephone	98966-98968, 99441-99443	
Online assessments	98969-98972, 99421-99423, 99444, 99457	
Transitional care management	99495, 99496	

Access and availability of care

Adults' access to preventive or ambulatory health services (AAP)

The percentage of members 20 years and older who had an ambulatory or preventive care visit per year

- For Medicaid and Medicare members: One or more visits should occur in the measurement year.
- For commercial members: One or more visits should occur in the measurement year or the two years prior to the measurement year.

Codes to identify cardiovascular disease and type

Description	CPT/HCPCS	UB Revenue	ICD-10-CM
Ambulatory visit	99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99347-99350, 99381-99387, 99391-99397, 99401-99391-99397, 99401-99404, 99411, 99412, 99429, 99483, G0402, G0438, G0439, T1015	0510-0517, 0519-0523, 0526-0529, 0982-0983	Z00.00, Z00.01, Z00.121, Z00.129, Z00.3, Z00.5, Z00.8, Z02.0-Z02.6, Z02.71, Z02.79, Z02.81-Z02.83, Z02.89, Z02.9, Z76.1, Z76.2
Online assessments	98969-98972, 99421-99423, 99444, 99458, G2010, G2012		
Other ambulatory visits	92002, 92004, 92012, 92014, 99304-99310, 99315, 99316, 99318, 99324–99328, 99334-99337	0524, 0525	
Telephone visits	98966-98968, 99441-99443		

Tips

- Ensure proper documentation using correct diagnosis and procedure codes
- Submit claims and encounter date in a timely manner
- Provide services for ambulatory or preventive services at every office visit
- Provide patient reminders and materials to assist in upcoming care visits

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