HEDIS® Measurement Year 2024

Guidelines for
HealthCare Providers

Introduction

Centers Plan for Healthy Living (CPHL) would like to thank our providers for the ongoing quality care you provide to our Members.

CPHL works collaboratively with our providers to promote preventative care and to improve the quality of care for our members. The Healthcare Effectiveness Data and Information Set (HEDIS) is a report card of the success of our joint efforts.

HEDIS is a process developed and maintained by NCQA and used by regulatory agencies and health plans to measure annual performance in nationally recognized quality metrics. HEDIS measure results are submitted annually to the Centers for Medicare & Medicaid Services (CMS) and are specifically designed to allow consumers to compare health plan performance for the purposes of ensuring access to quality services through a Plan's network of contracted Providers.
Each year our goal is to improve our process for requesting and obtaining medical records for our HEDIS project, and to demonstrate the exceptional care that you have provided to our members.

In an effort to improve our scores and in preparation for the upcoming 2024 HEDIS audit, CPHL created the "HEDIS® Measurement Year 2024 Guidelines for HealthCare Providers", as a guide to help you understand the requirements for each measure, how to use the correct billing codes on the claim form, and how to improve HEDIS® scores.

We strongly encourage you to review this guide with your office staff including your billing/coding team.

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

MEASURE DESCRIPTION

Patients 20 years and older who had an ambulatory or preventive care visit during the measurement year.

CORRECT BILLING CODES

Description	Codes
Ambulatory visits	**CPT:** 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404,99411,99412, 99429,99461**,** 92002, 92004, 92012, 92014, 99304-99310, 99315, 99316, 99318, 99324-99328, 99334-99337
	HCPCS: G0402**,** G0438, G0439, G0463, T1015**,** S0620, S0621
	ICD-10: Z00.00, Z00.01, Z00.121, Z00.129, Z00.5, Z00.8, Z02.0-Z02.6, Z02.71, Z02.79, Z02.81, Z02.82, Z02.83, Z02.89, Z02.9 **,** Z00.3, Z76.1, Z76.2
	UB Rev: 0510-0517, 0519-0529, 0982-0983
Telephone Visits	**CPT:**98966 - 98968,99441- 99443

HOW TO IMPROVE HEDIS® SCORES

1. Use appropriate billing codes as described above.
2. Educate patients on the importance of having at least one ambulatory or preventive care visit during each calendar year.
3. Contact patients on the needed services list who have not had a preventive or ambulatory health visit.
4. Look into offering expanded office hours to increase access to care.
5. Make reminder calls to patients who have appointments to decrease no-show rates.

Diabetes

Glycemic Status Assessment for Patients with Diabetes (GSD)

MEASURE DESCRIPTION

Patients 18-75 years of age with diabetes (type1 or type 2) whose most recent glycemic status (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) was at the following levels during the measurement year:

- Glycemic Status <8.0%.
- Glycemic Status >9.0%.

Note: At a minimum, documentation in the medical record must include a note indicating the date when the glycemic status assessment was performed and the result.

Blood Pressure Control for Patients with Diabetes (BPD)

MEASURE DESCRIPTION

Patients 18-75 years of age with diabetes (type1 or type 2) whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the measurement year.

Note: Medical record documentation must include the most recent BP reading during the measurement year.

Eye Exam for Patients with Diabetes (EED)

MEASURE DESCRIPTION

Patients 18-75 years of age with diabetes (type1 or type 2) who had a retinal eye exam performed by an eye care professional (optometrist or ophthalmologist).

At a minimum, documentation in the medical record must include one of the following:

- A note or letter prepared by an ophthalmologist, optometrist, PCP or other health care professional indicating that an ophthalmoscopic exam was completed by an eye care professional (optometrist or ophthalmologist), the date when the procedure was performed and the results.
- A chart or photograph indicating the date when the fundus photography was performed and one of the following:
  - Evidence that an eye care professional (optometrist or ophthalmologist) reviewed the results.
  - Evidence results were read by a qualified reading center that operates under the direction of a medical director who is a retinal specialist.

Evidence results were read by a system that provides an artificial intelligence (AI) interpretation.

- Evidence that the member had bilateral eye enucleation or acquired absence of both eyes. Look as far back as possible in the member's history through December 31 of the measurement year.
- Documentation of a negative retinal or dilated exam by an eye care professional (optometrist or ophthalmologist) in the year prior to the measurement year, where results indicate retinopathy was not present (e.g., documentation of normal findings).

Documentation does not have to state specifically "no diabetic retinopathy" to be considered negative for retinopathy; however, it must be clear that the patient had a dilated or retinal eye exam by an eye care professional (optometrist or ophthalmologist) and that retinopathy was not present. Notation limited to a statement that indicates "diabetes without complications" does not meet criteria.

CORRECT BILLING CODES

Description	Codes
Codes to Identify Diabetes	**ICD-10:** E10, E11, E11.10 , E11.11 ,E13
Codes to Identify HbA1c Tests	**CPT:** 83036, 83037 **CPT II:** 3044F (if HbA1c <7%), 3051F (if HbA1c 7% - 8%), 3052 F (if HbA1c 8% - 9%), 3046F (if HbA1c >9%)
Codes to Identify Blood Pressure Control	**CPT II:** 3074F (systolic < 130), 3075F (systolic 130-139) 3077F (if systolic ≥ 140) 3078F (if diastolic < 80) 3079F (if diastolic 80-89) 3080F (if diastolic ≥ 90)
Dialysis	**HCPCS**: G0257, S9339
Codes to Identify Eye exam (must be performed by optometrist or ophthalmologist)	**CPT:** 67028, 67030, 67031, 67036, 67039-67043, 67101, 67105, 67107, 67108, 67110, 67112, 67113, 67121, 67141, 67145, 67208, 67210, 67218, 67220, 67221, 67227, 67228, 92002, 92004, 92012, 92014, 92018, 92019, 92134, 92225-92228, 92230, 92235, 92240, 92250, 92260, 99203-99205, 99213-99215, 99242-99245 **HCPCS:** S0620, S0621, S3000
Codes to Identify Diabetic Retinal Screening with Eye Care Professional	Positive for Diabetic Retinopathy **CPT II:** 2022F, 2024F, 2026F, Negative for Diabetic Retinopathy: **CPT II:**2023F ,2025F, 2033F

HOW TO IMPROVE HEDIS® SCORES

1. Review diabetes services needed at each office visit.
2. Order labs prior to patient appointments.
3. Bill for point of care testing if completed in office and Ensure HbA1c result and date are documented in the chart.
4. Labs indicating “poor” control are often not repeated again later in the calendar year. Bring the member back in for testing!
5. Adjust therapy to improve HbA1c and BP levels; follow-up with patients to monitor changes.
6. Make sure a digital eye exam, remote imaging, and fundus photography are read by an eye care professional (optometrist or ophthalmologist) so the results count.
7. Use code **3072F** if member’s eye exam was negative or showed low risk for retinopathy in the prior year.

Kidney Health Evaluation for Patients with Diabetes (KED)*

***This measure was developed by NCQA with input from the National Kidney Foundation.**

Patients 18–85 years of age with diabetes (type 1 or 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.

Estimated glomerular filtration rate(eGFR) tests: CPT: 80047, 80048, 80050, 80053, 80069,82565

Urine albumin-creatinine ratio(uACR)tests: LOINC: 76401-9, 9318-7

HOW TO IMPROVE HEDIS® SCORES

1. Routinely refer members with a diagnosis of type 1 or type 2 diabetes out to have their eGFR and uACR
2. Follow up with patients to discuss and educate on lab results
3. Educate on how diabetes can affect the kidneys and offer tips to your patients on preventing damage to their kidneys:
   - Controlling their blood pressure, blood sugars, cholesterol, and lipid levels
   - Take medications as prescribed that can protect kidney function (ACE inhibitors or ARBs)
   - Offer education on medications that could be harmful to the kidneys (NSAIDs such as naproxen or ibuprofen)
   - Limit protein intake and salt in diet
4. Coordinate care with specialists such as an endocrinologist or nephrologist as needed.
5. Use of complete and accurate Value Set Codes
6. Timely submission of claims and encounter data

Controlling High Blood Pressure (CBP)

MEASURE DESCRIPTION

Patients 18-85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the measurement year.

Adequate control	Both a representative systolic BP <140 mm Hg and a representative diastolic BP of <90 mm Hg.
Representative BP	The most recent BP reading during the measurement year on or after the second diagnosis of hypertension. If multiple BP measurements occur on the same date, or are noted in the chart on the same date, use the lowest systolic and lowest diastolic BP reading. If no BP is recorded during the measurement year, assume that the member is “not controlled.”

CORRECT BILLING CODES

Description	Codes
Hypertension	**ICD-10:** I10
Systolic Less Than 130	**CPT – CAT – II:** 3074F
Systolic 130-139	**CPT – CAT – II:** 3075F
Systolic Greater Than/Equal To 140	**CPT – CAT – II:** 3077F
Diastolic Less Than 80	**CPT – CAT – II:** 3078F
Diastolic 80–89	**CPT – CAT – II:** 3079F
Diastolic Greater Than/Equal To 90	**CPT – CAT – II:** 3080F

HOW TO IMPROVE HEDIS® SCORES

1. Upgrade to an automated blood pressure machine.
2. Select appropriately sized BP cuff.
3. Retake the BP if it is high at the office visit (140/90 mm Hg or greater) and oftentimes the second reading is lower.
4. Do not round BP values up. If using an automated machine, record exact values.
5. Review hypertensive medication history and patient compliance, and consider modifying treatment plans for uncontrolled blood pressure, as needed. Have the patient return in 3 months.
6. Start two BP drugs at first visit if initial reading is very high and is unlikely to respond to a single drug and lifestyle modification.

Note: The BP reading may be from a telephone visit, e-visit, or other virtual visit. The BP reading may be patient reported if taken by the patient using a digital device and documented as such in the record.

Breast Cancer Screening (BCS)

MEASURE DESCRIPTION

Women 50-74 years of age who were recommended for routine breast cancer screening and had a mammogram to screen for breast cancer.

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.

CORRECT BILLING CODES

Description	Codes
Breast Cancer Screening	**CPT**: 77061-77067
Measure Exclusion Codes:	
Bilateral Mastectomy	**ICD-10**: 0HTV0ZZ

Unilateral Mastectomy **with** a Bilateral Modifier **or** Two Unilateral Mastectomy Codes 14 days or more apart	**Unilateral Mastectomy:** **CPT**: 19303-19307
History of Bilateral Mastectomy	**ICD-10**: Z90.13

HOW TO IMPROVE HEDIS® SCORES

1. Educate female patients about the importance of early detection and encourage testing.
2. Use needed services list to identify patients in need of mammograms.
3. Document a bilateral mastectomy in the medical record and fax us the chart.
4. Schedule a mammogram for patient or send/give patient a referral/script (if needed).
5. Have a list of mammogram facilities available to share with the patient (helpful to print on colored paper for easy reference).
6. Discuss possible fears the patient may have about mammograms and inform women that currently available testing methods are less uncomfortable and require less radiation

Tips for Success:

- Document date mammogram completed and Provider name or location if available.
- Request a copy of the Mammogram results and maintain in the patient record.

Colorectal Cancer Screening (COL)

MEASURE DESCRIPTION

Patients 45-75 years of age who had one of the following screenings for colorectal cancer screening:

1. gFOBT or iFOBT (or FIT) with required number of samples for each test during the measurement year (MY), or
2. Flexible sigmoidoscopy during the measurement year or the four (**4**) years prior to the (MY), or flexible sigmoidoscopy every 10 years, with FIT every year. or
3. Colonoscopy during the measurement year or the nine (**9**) years prior to the MY.
4. CT colonography during the measurement year or the four (**4**) years prior to MY
5. FIT-DNA test (ex: Cologuard®) during the measurement year or the two (**2**) years prior to the measurement year.

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

CORRECT BILLING CODES

Codes to Identify Colorectal Cancer Screening

Description	Codes
FIT- DNA (Cologuard®)	**CPT:** 81528
FOBT	**CPT:** 82270, 82274 HCPCS: G0328
Flexible Sigmoidoscopy	**CPT:** 45330-45335,45337-45342, 45346-45347,45349-45350 **HCPCS:** G0104
Colonoscopy	**CPT:** 44388-44394, 44401-44408, 45378-45393, 45398 **HCPCS:** G0105, G0121
CT Colonography	**CPT:** 74261-74263

Codes to Identify Optional Exclusions

Description	Codes
Colorectal Cancer	**ICD-10 CM:** C18.0-C18.9, C19, C20, C21.2, C21.8, C78.5, Z85.038, Z85.048
Total Colectomy	**CPT:** 44150 - 44153, 44155-44158, 44210-44212 **ICD-10 PCS**: 0DTE0ZZ, 0DTE4ZZ, 0DTE7ZZ, 0DTE8ZZ

HOW TO IMPROVE HEDIS® SCORES

1. Providers should review/confirm all preventive health screenings at each visit.
2. Dates and results need to be consistently documented.
3. Patient reported data noted on a medical record is sufficient evidence with date.
4. For Colonoscopy or Sigmoidoscopy document the year of the test at a minimum. Example: Colonoscopy 2013. Result not required when documented in patient's history.
5. When colorectal screening is reported, obtain report from specialist to ensure medical record is complete.
6. If patient declines colonoscopy, then explain benefits of Cologuard® testing if appropriate and provide referral for Cologuard on-line if patient agrees.
7. Cologuard® will provide follow-up with the patient once referral received! Cologuard® is an FDA- approved, noninvasive multi-target stool DNA test for colorectal cancer screening.

Use the EPICCARE LINK PROVIDER PORTAL Web portal link below that allows Providers to order, track patient orders, monitor test compliance, and access reports online. You can register for a free account with three easy steps:

1. Go on https://www.exactlabs.com/
2. Click on link in upper right-hand corner where it says 'EpicCare Link Provider Portal'
3. Click on "Request New Account"

Visit https://www.cologuardtest.com/hcp/resources/how-to-order for additional resources.

Transitions of Care (TRC)

MEASURE DESCRIPTION

Patients 18 years of age and older with discharges (acute and non-acute inpatient) who had documentation by the Provider of each of the following during the measurement year:

1. **Notification of Inpatient Admission**
   - Documentation of receipt of notification of inpatient admission on the day of admission or on the day of admission through 2 days after the admission (**3 total days**). Documentation in your outpatient record of any tests and treatments ordered during the member's inpatient stay.
   - Documentation that the admission was elective and you had performed a preadmission exam or were notified of pre-admission testing results.
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 (does not include the date of discharge).
4. **Medication Reconciliation Post-Discharge**
   - Documentation of medication reconciliation on the date of discharge through 30 days after discharge (**31 total days**).

Intent: *This measure aims to improve care coordination during care transitions for at-risk populations including older adults and other individuals with complex health needs.*

CORRECT BILLING CODES

Definition	Code System	Code
Transitional Care Management Services	CPT	99495; 99496
Outpatient	CPT	99202-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99429, 99455, 99456
Outpatient	HCPCS	G0402, G0438, G0439, G0463, T1015
Outpatient	UBREV	510-523; 526-529; 982;983
Telephone Visits	CPT	98966-98968, 99441-99443
Medication Reconciliation	CPT	99483,99495, 99496
Medication Reconciliation	CPT – CAT - II	1111F

HOW TO IMPROVE HEDIS® SCORES

Always ask your patient about any recent hospitalizations and document!

1. Include evidence of receipt of notification of inpatient admission with a date stamp in the patient chart.
    a. Communication between **inpatient / emergency department providers or staff** and the member's PCP or ongoing care provider (e.g., phone call, e-mail, fax).
    b. Communication about admission to the member's PCP or ongoing care provider through a **health information exchange; an automated admission, discharge and transfer (ADT) alert system; or a shared electronic medical record system**
    c. Communication about admission to the member's PCP or ongoing care provider from the member's **health plan**.
    d. Indication that the member's **PCP or ongoing care provider** admitted the member to the hospital.
    e. Indication that a **specialist** admitted the member to the hospital and notified the member's PCP or ongoing care provider.
    f. Documentation that the PCP or ongoing care provider performed a **preadmission exam** or received communication about a **planned inpatient admission**.
    g. Communication about admission with the member's PCP or ongoing care provider through a shared electronic medical record (EMR) system. When using a shared EMR system, documentation of a "received date" is not required to meet criteria. Evidence that the information was filed in the EMR and is accessible to the PCP or ongoing care provider on the day of admission through 2 days after the admission (3 total days) meets criteria.
2. Include evidence of receipt of discharge information on the day of discharge or the following day in the patient chart. At a minimum, the information should include:
    a. The practitioner responsible for the member's care during the inpatient stay.
    b. Procedures or treatment provided.
    c. Diagnoses at discharge.
    d. Current medication list (including allergies).
    e. Testing results, or documentation of pending tests or no tests pending.
    f. Instructions for patient care post-discharge.
3. Documentation must include evidence of patient **engagement** within **30** days after discharge.
    a. Engagement can either be an **actual outpatient visit** (including office and home visits) **OR**
    b. A synchronous **telehealth visits** where real-time interaction occurred between the member and provider via telephone or video-conferencing.
    c. A telephone visits.
    d. An e-visit or virtual check-in (asynchronous telehealth where two-way interaction, which was not real-time, occurred between the member and provider).
4. Documentation in the outpatient medical record must include **evidence of medication reconciliation** (by a prescribing practitioner**,** Clinical pharmacist or a Registered nurse).**and** the **date** when it was performed.
    a. Documentation of the current medications with a **notation** that the provider **reconciled** the current and discharge medications.

b. Documentation of the current medications with a **notation** that references the **discharge medications** (e.g., no changes in medications since discharge, same medications at discharge, discontinue all discharge medications).
c. Documentation of the member's current medications with a notation that the **discharge medications** were **reviewed**.
d. Documentation of a current medication list, a discharge medication list and notation that both lists were **reviewed** on the **same date of service**.
e. Documentation of the **current medications** with evidence that the member was seen for post-discharge hospital follow-up with **evidence of medication reconciliation or review**.
f. Documentation in the **discharge summary** that the discharge medications were **reconciled** with the most recent medication list in the outpatient medical record. There must be evidence that the discharge summary was **filed in the outpatient chart** on the date of discharge through 30 days after discharge (31 total days).
g. Notation that **no medications** were **prescribed or ordered** upon discharge.

Care for Older Adults (COA)

MEASURE DESCRIPTION

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

1) **Medication review:**

At least one medication review conducted by a prescribing practitioner or clinical pharmacist during the measurement year ***and*** the presence of a medication list in the medical record, as documented through either administrative data or medical record review.
A medication list, signed and dated during the measurement year by the appropriate practitioner type (prescribing practitioner or clinical pharmacist), meets criteria (the practitioner's signature is considered evidence that the medications were reviewed).

2) **Functional status assessment**

Documentation in the medical record must include evidence of a complete functional status assessment and the date when it was performed.
Notations for a complete functional status assessment must include one of the following:

- Notation that Activities of Daily Living (ADL) were assessed or that at least five of the following were assessed: bathing, dressing, eating, transferring [e.g., getting in and out of chairs], using toilet, walking.
- Notation that Instrumental Activities of Daily Living (IADL) were assessed or at least four of the following were assessed: shopping for groceries, driving or using public transportation, using the telephone, cooking or meal preparation, housework, home repair, laundry, taking medications, handling finances.
- Result of assessment using a standardized functional status assessment tool, not limited to:

  – SF-36®.
  – Assessment of Living Skills and Resources (ALSAR).
  – Barthel ADL Index Physical Self-Maintenance (ADLS) Scale.

- Bayer ADL (B-ADL) Scale.
- Barthel Index.
- Edmonton Frail Scale.
- Extended ADL (EADL) Scale.
- Groningen Frailty Index.
- Independent Living Scale (ILS).
- Patient Reported Outcome Measurement Information System (PROMIS) Global or Physical Function Scales
- Katz Index of Independence in ADL.
- Kenny Self-Care Evaluation.
- Klein-Bell ADL Scale.
- Kohlman Evaluation of Living Skills (KELS).
- Lawton & Brody's IADL scales.

A functional status assessment limited to an acute or single condition, event or body system (e.g., lower back, leg) does not meet criteria for a comprehensive functional status assessment. The components of the functional status assessment numerator may take place during separate visits within the measurement year. Do not include comprehensive functional status assessments performed in an acute inpatient setting.

3) Pain assessment:

At least one pain assessment during the measurement year.

Documentation in the medical record must include evidence of a pain assessment and the date when it was performed.

Notations for a pain assessment must include one of the following:

- Documentation that the patient was assessed for pain (which may include positive or negative findings for pain).
- Result of assessment using a standardized pain assessment tool, not limited to:
  - Numeric rating scales (verbal or written).
  - Face, Legs, Activity, Cry Consolability (FLACC) scale.
  - Verbal descriptor scales (5–7 Word Scales, Present Pain Inventory).
  - Pain Thermometer.
  - Pictorial Pain Scales (Faces Pain Scale, Wong-Baker Pain Scale).
  - Visual analogue scale.
  - Brief Pain Inventory.
  - Chronic Pain Grade.
  - PROMIS Pain Intensity Scale.
  - Pain Assessment in Advanced Dementia (PAINAD) Scale.

Do not include pain assessments performed in an acute inpatient setting

CORRECT BILLING CODES

Description	Codes
Medication Review	**CPT:** 90863, 99483,99605, 99606 **CPT II:** 1160F
Medication List	**CPT II:** 1159F **HCPCS:** G8427
Transitional care management services Codes:	**CPT:** 99495, 99496
Functional Status Assessment	**CPT II:** 1170F **CPT:**99483
Pain Assessment	**CPT II:** 1125F, 1126F

HOW TO IMPROVE HEDIS® SCORES

1. Use the Care for Older Adults (COA) form from Centers Plan for Healthy Living (CPHL) to capture these assessments and keep a copy in the medical record.
2. Be sure to include evidence of a complete functional status assessment.
3. Documentation that the patient was assessed for pain (which may include positive or negative findings for pain) and document result of assessment using a standardized pain assessment tool.
4. Remember that the medication review measure requires that the medications are listed in the chart, plus the review (conducted by a prescribing practitioner or Clinical pharmacist).
5. Incorporate a standardized template to capture these measures for Members 66 years and older if on EMR. Use CPHL's COA form as a guide.

Advance Care Planning (ACP)

MEASURE DESCRIPTION

Patients 66–80 years of age with advanced illness, an indication of frailty or who are receiving palliative care, and adults 81 years of age and older who had advance care planning (A discussion or documentation about preferences for resuscitation, life-sustaining treatment and end of life care) during the measurement year. Examples include:

- Advance Directives
- Actionable Medical Orders
- Living Will
- Surrogate decision maker

Tips for Success:

- Explain purpose of HCP to patient and question whether they have designated someone to make decisions for them if unable. Have they executed an AD?
- Document "discussed HCP and member refused to execute" as opposed to documenting "member refused"

CORRECT BILLING CODES

Description	Codes
Advance Care Planning	**CPT:**99483,99497 **CPT II:** 1123F, 1124F, 1157F, 1158F **HCPCS:** S0257 **ICD10CM:** Z66

Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions (FMC)

MEASURE DESCRIPTION

The percentage of emergency department (ED) visits for patients 18 years of age and older who have multiple high-risk chronic conditions who **had a follow-up service within 7 days of the ED visit**.

Medical Record: A follow-up service **within 7 days** after the ED visit Include visits that occur on the date of the ED visit (**8 total days**). The following meet criteria for follow-up:

- An outpatient visit.
- A telephone visit.
- An outpatient or telehealth behavioral health visit.
- An intensive outpatient encounter or partial hospitalization.
- A community mental health center visit.
- A telehealth visits.
- An observation visits.
- A substance use disorder service.
- An e-visit or virtual check-in.

Tips for Success

- Educate the patient about the importance of follow-up and adherence to treatment recommendations
- Discuss the importance of timely, recommended follow-up visits
- Schedule follow-up appointments as soon as possible, particularly those patients recently discharged
- Coordinate care with behavioral health practitioners by sharing progress notes and updates
- Outreach patients who cancel appointments and assist them with rescheduling as soon as possible
- Consider telemedicine visit when in-person visits are not available
- Discuss the importance of seeking follow-up with a mental health provider
- Develop outreach internal team and/or assign care/case managers to members to ensure members keep follow-up appointments or reschedule missed appointments
- Set flags if available in EHR or develop tracking method for patients who may need screenings and follow-up visits

CORRECT BILLING CODES

Description	Codes
Outpatient visits	**CPT:** 99202- 99205, 99211- 99215, 99217-99220,99241- 99245, 99341- 99345, 99347- 99350, 99381- 99387, 99391- 99397, 99401- 99404, 99411,99412,99429,99455,99456,99483 **HCPCS:** G0402, G0438, G0439, G0463, T1015
Telephone visits	**CPT:** 98966,98967,98968,99441,99442,99443
An intensive outpatient encounter or partial hospitalization	**HCPCS:** G0410, G0411, H0035, H2001, H2012, S0201, S9480, S9484, S9485

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