Telehealth for Medicare Advantage

Risk Adjustment & Quality

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Telehealth Services & Risk Adjustment

Telehealth refers to a broad collection of electronic and telecommunications technologies that support delivery of healthcare 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.

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 office/outpatient visits, annual wellness visits, emergency department or initial inpatient consultations, end-stage renal disease (ESRD)-related services, individual and group diabetes self-management training, and individual psychotherapy.

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)[1]

- A rural location that is:
  - In a county outside a metropolitan statistical area (MSA), or
  - In a rural health professional shortage area (HPSA) in a rural census tract

Patient location

- A medical facility, such as physician office, 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 ESRD getting home dialysis, or substance use disorders receiving treatment for the 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.[2]

Risk Adjustment

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

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

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

Due to the COVID-19 emergency, Medicare has expanded telehealth coverage and eased current rules, such as the telemedicine originating site requirements. Patient homes can now serve as originating sites, regardless of diagnosis, for the duration of the COVID-19 crisis. See CMS's general provider telehealth and telemedicine toolkit (PDF) for details. *This document provides a broad overview of common telehealth services and is for informational purposes only. Please refer to the resources for the most up-to-date information.*

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Telemedicine Coding & Billing

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

Distant site billing (location of servicing provider):

CPT®/HCPCS codes: New patient office/outpatient visit[3]			
	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

CPT®/HCPCS codes: Established patient office/outpatient visit[4]			
	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

Place of service (POS) code

- **02:** Telehealth

Modifiers

- **95:** Synchronous telemedicine service rendered via real-time interactive audio/video system
- **GT:**[5] Via interactive audio/video system
- **GQ:** Via asynchronous system (for use in Alaska and Hawaii)

Originating site billing

- **Q3014:**[6] Originating site facility fee

Virtual Check-Ins

Virtual check-ins are short (5–10 minutes), patient-initiated communications with a practitioner to check in and determine whether an office visit or other service is needed, or if remote evaluation of recorded video and/or images submitted by the patient is needed.[7]

Practitioners who can furnish the service include 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, and 5–10 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

- **Geographic area:** All areas
- **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 a patient portal.

Risk Adjustment

Virtual check-ins are not acceptable for CMS-operated risk adjustment programs.

3 Requires all three components: history, exam and medical decision-making (MDM)
4 Requires two of three components: history, exam and medical decision-making (MDM)
5 CAHs billing for telehealth services under CAH optional payment method II should submit institutional claims using modifier GT
6 Applicable when patient presents to a medical facility as originating site. This fee does not apply when the home serves as the originating site.
7 The communication should not be related to a medical visit within the past seven days and should not lead to a medical visit within the next 24 hours (or soonest available appointment). Otherwise, it is bundled into the evaluation and management (E/M) service.

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Virtual Check-In Coding & Billing

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

E-Visits

E-visits are patient-initiated communications that take place via an online patient portal. Once a patient generates the initial inquiry, communications can occur over a seven-day period.

Practitioners who can furnish the service include physicians, nurse practitioners, physician assistants and other clinicians who are able to bill for evaluation and management (E/M) services independently, as well as physical therapists, occupational therapists, speech language pathologists, clinical psychologists and other healthcare professionals who are 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 & Billing

Physicians, nurse practitioners and physician assistants	
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 minutes
99423	Non-face-to-face online digital E/M service, established patient, up to 7 days, 21+ minutes

Physical/occupational therapists, speech language pathologists and clinical psychologists[8]	
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 minutes
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 minutes
98972	Non-face-to-face online digital E/M service, established patient, up to 7 days, 21+ minutes

8 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 using a code from the G2061–G2063 code series.

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Telephone Visits

Telephone visits are non-face-to-face, patient-initiated services over the telephone.[9]

Practitioners who can furnish telephone visits include physicians, nurse practitioners, physician assistants and other clinicians who are able to bill for E/M services independently, as well as physical therapists, occupational therapists, clinical psychologists, registered dietitians and other healthcare professionals who are 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 & Billing

Physicians, nurse practitioners and physician assistants	
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

Physical/occupational therapists, speech language pathologists and clinical psychologists	
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

Center for Connected Health Policy: State Telehealth Laws and Reimbursement Policies

CMS: Applicability of diagnoses from telehealth services for risk adjustment (PDF)

CMS: General Provider Telemedicine and Telehealth Toolkit (PDF)

Medicare Learning Network (MLN) Booklet: Telehealth Services (PDF)

Medicare Telehealth Frequently Asked Questions (PDF)

Medicare Telemedicine Healthcare Provider Fact Sheet

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

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COVID-19 Public Health Emergency (PHE) & Telehealth Expansion

Telemedicine During PHE

Beginning March 1, 2020, the Centers for Medicare and Medicaid Services (CMS) will make payments for Medicare telehealth services furnished to patients in broader circumstances so that beneficiaries can receive healthcare without having to travel to a healthcare facility during the COVID-19 PHE.

These benefits are being expanded on a **temporary and emergency basis** under 1135 waiver authority and Coronavirus Preparedness and Response Supplemental Appropriations Act.

Temporary Changes to Telemedicine Requirements

New patient/provider relationship will be allowed.

- Even though an established relationship is still required, the Department of Health and Human Services (HHS) has announced that they will not conduct audits to ensure that such a prior relationship existed for claims submitted during the PHE.

Originating site (patient's location)

- **Geographic area:** Telemedicine will be allowed in all areas of the country and in all settings.
- **Patient location:** Telemedicine restrictions on a patient's location during a visit have been waived. Any healthcare facility or the patient's home will be accepted.

Technology: A provider can use **any non-public-facing remote communication product** that is available to communicate with patients as long as the technology has audio/video capabilities that are used for two-way, real-time interactive communication. HHS will exercise enforcement discretion and waive penalties for HIPAA violations against healthcare providers that serve patients in good faith through technologies such as FaceTime® or Skype.

NOTE: Audio-only consults are still prohibited for telemedicine. See **Telephone Visits** in the right-hand column.

Prescribing Controlled Substances

Prescriptions for all schedule II-V controlled substances may be issued without an in-person medical evaluation if all of the following requirements are met: The prescription is for a legitimate medical purpose by a practitioner acting in the useful course of their professional practice; the telemedicine communication is conducted using an audio-visual, real-time, two-way interactive communication system; and the practitioner is acting in accordance with applicable federal and state laws.

Risk adjustment note: Due to the expansion of virtual care, organization that submit diagnoses for **CMS-operated risk-adjusted payment are able to submit diagnoses for risk adjustment that are from telehealth visits when those visits meet all criteria for risk adjustment eligibility**, which include being from an allowable inpatient, outpatient or professional service, and from a face-to-face encounter. Telephone visits are not acceptable for risk adjustment.

Telephone Visits

In ordinary circumstances, telephone E/M visits (CPT codes **98966–98968** and **99441–99443**) are recognized as non-covered services for Medicare beneficiaries. If the needs of the patient are significant enough to require the amount of time and attention from the provider specified in the codes for higher-level telephone E/M services, either an in-person visit or telemedicine visit would be required.

Temporary Changes to Telephone Visit Requirements

CMS has recognized that in the context of trying to reduce exposure risks associated with the PHE for the COVID-19 pandemic, two-way audio and video technology may not be available to all beneficiaries. During the PHE, separate payments will be made for CPT codes **98966–98968** and **99441–99443**.

Due to the COVID-19 emergency, Medicare has expanded telehealth coverage and eased current rules, such as the telemedicine originating site requirements. Patient homes can now serve as originating sites, regardless of diagnosis, for the duration of the COVID-19 crisis. See CMS's general provider telehealth and telemedicine toolkit (PDF) for details. ***This document provides a broad overview of common telehealth services and is for informational purposes only. Please refer to the resources for the most up-to-date information.***

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Evaluation & Management (E/M) Visits

The current E/M coding guidelines preclude the billing practitioner from selecting the office/outpatient E/M code level based on time in circumstances where the practitioner is not engaged in counseling and/or care coordination.

Temporary Changes to E/M Visit Requirements

The E/M level selection furnished via telehealth can be based on MDM or time, with time defined as all of the time associated with the E/M on the day of the encounter. The requirement to document the history and/or physical exam in the medical record has been removed temporarily.

Telehealth Coding & Billing

With the expansion of services due to the PHE, all telehealth services should be billed with place of service **02**, and modifier **95** should be appended when appropriate.

Resources

CMS: Medicare Telemedicine Healthcare Provider Fact Sheet

CMS: Applicability of diagnoses from telehealth services for risk adjustment (PDF)

Department of Health & Human Services CCIIO: Risk Adjustment FAQ on COVID-19 (PDF)

Federal Register: Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency

U.S. Department of Health & Human Services: Notification of Enforcement Discretion for Telehealth Remote Communications During the COVID-19 Nationwide Public Health Emergency

U.S. Department of Justice Drug Enforcement Administration: Telemedicine

Telehealth & HEDIS®: Using Technology to Deliver Quality Care

Just as technology can be used to deliver care remotely, certain quality measures can be completed via telehealth.

Prevention & Screening

Care for Older Adults

The percentage of adults 66 and older who had each of the following during the measurement year. Report each of the four rate separately:

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

HEDIS Value Set:

Advance care planning: 99483, 99497, 1123F, 1124F, 1157F, 1158F, S0257
Medication review: 90863, 99605, 99606, 1159F, 1160F, G8427
Functional status assessment: 99483, 1170F, G0438, G0349
Pain screening: 1125F, 1126F
Transition of care (seven days): 99496
Transition of care (14 days): 99495

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Weight Assessment and Counseling for Nutrition & Physical Activity (WCC)

Assesses children and adolescents 3–17 years of age who had an outpatient visit with a primary care practitioner (PCP) or OB/GYN during the measurement year and had evidence of:

- Body mass index (BMI) percentile documentation[10]
- Counseling for nutrition
- Counseling for physical activity

HEDIS Value Set:

ICD-10: Z68.51–Z68.54

Counseling for nutrition

Nutrition counseling: 97802–97804, G0270, G0271, G0447, S9449, S9452, S9470

ICD-10-CM: Z71.3 (dietary counseling and surveillance)

Counseling for physical activity

Non-physical exercise class: S9451

ICD-10-CM: Z02.5 (encounter for sports physical), Z71.82 (encounter for exercise counseling)

Medication Management & Care Coordination

Medication Reconciliation Post-Discharge (MRP)

Assesses whether adults 18 years and older who were discharged from an inpatient facility had their medications reconciled within 30 days

HEDIS Value Set:

CPT/HCPCS: 99483, 99495, 99496

CPT II: 1111F

Telephone visits: 98966–98968, 99441–99443

Transitions of Care (TRC)

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:**[11] Documentation of receipt of notification of inpatient admission on the day of admission or the day following
- **Receipt of discharge information:** Documentation of receipt of discharge information on the day of discharge or the day following
- **Patient engagement after inpatient discharge:** Documentation of patient engagement (e.g., office visits, visits to the home, telehealth) provided within 30 days of discharge
- **Medication reconciliation post-discharge:**[12] Documentation of medication reconciliation on the date of discharge through 30 days after discharge (31 total days)

HEDIS Value Set:

CPT/HCPCS: 99483, 99495, 99496

CPT II: 1111F

Telephone visits: 98966–98968, 99441–99443

10 The weight assessment and documentation of BMI is not applicable for telehealth, as self-reported biometrics do not close WCC measure.

11 Notification of admission and discharge must be found in provider medical record.

12 Follow-up visit and medication reconciliation may be completed via telehealth visit.

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Access/Availability of Care

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

Assesses members 20 years of age and older who had an ambulatory or preventive care visit during the measurement year

HEDIS Value Set:

ICD-10

General medical exam: Z00.00, Z00.01

CPT

18–39 years old: 99385, 99395

40–64 years old: 99386, 99396

65+ years old: 99387, 99397

HCPCS

Initial preventive physical examination: G0402[13]

Annual wellness visit: G0438, G0439

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

Assesses whether children/adolescents 1–17 years of age who had a new prescription for an antipsychotic medication had documentation of psychosocial care as first-line treatment before being prescribed an antipsychotic

HEDIS Value Set:

ICD-10-CM: F20.0–F20.3, F20.5, F20.81, F20.89, F20.9, F25.0, F25.1, F25.8, F28.9, F22–F24, F28, F29, F30.10–F30.13, F30.2–F30.4, F30.8, F30.9, F31.10–F31.13, F31.2, F31.30–F31.32, F31.4, F31.5, F31.60–F31.64, F31.70–F31.78, F32.3, F33.3, F84.0, F84.2, F84.3, F84.5, F84.8, F84.9, F95.0–F95.2, F95.8, F95.9

Psychosocial care: 90832-90834, 90836-90840, 90845-90847, 90849, 90853, 90875, 90876, 90880

HCPCS psychosocial care: G0176, G0177, G0409–G0411, H0004, H0035–H0040, H2000, H2001, H2011–H2014, H2017–H2020, S0201, S9480, S9484, S9485

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

Assesses adults and adolescents 13 years of age and older with a new episode of alcohol or drug (AOD) abuse or dependence who received the following:

- **Initiation of AOD treatment:** Adolescents and adults who initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication-assisted treatment (MAT) within 14 days of the diagnosis
- **Engagement of AOD treatment:** Adolescents and adults who initiated treatment and haw two or more additional AOD services or MAT within 34 days of the initiation visit

HEDIS Value Set:

CPT/HCPCS: 98962, 99078, 99201–99205, 99211–99215, 99217–99220, 99241–99245, 99341–99345, 99347–99350, 99381–99387, 99391–99397, 99401–99404, 99408, 99409, 99411, 99412, 99510, 98966–98968, 99441–99443, 98970–98972, 99421–99423, H0033, J0570–J0575, J2315, S0109, Q9991, Q9992, G0155, G0176, G0177, G0396, G0397, G0409–G0411, G0443, G0463, H0001, H0002, H0004, H0005, H0007, H0015, H0016, H0022, H0031, H0034–H0037, H0039, H0040, H0047, H2000, H2001, H2010–H2020, H2035, H2036, M0064, S0201, S9480, S9484, S9485, T1006, T1012, T1015, 90791, 90792, 90832–90834, 90836–90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221–99223, 99231–99233, 99238, 99239, 99251–99255

13 Medicare has not approved the use of telemedicine to furnish the initial preventive physical examination (IPPE), HCPCS G0402

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Prenatal & Postpartum Care (PPC)

Assesses important facets of prenatal and postpartum care:[14]

- **Timeliness of prenatal care:** The percentage of deliveries that received a prenatal care visits as a member of the organization in the first trimester, on the enrollment start date or within 42 days of enrollment into the organization
- **Postpartum care:** The percentage of deliveries that had a postpartum visit between 21 and 56 days after delivery

HEDIS Value Set:

Prenatal care

ICD-10-CM (use appropriate code family: O): Z03.71–Z03.75, Z03.79, Z34.00–Z34.03, Z34.80–Z34.83, Z34.90–Z34.93, Z36, Z36.0–Z36.5, Z36.81–Z36.89, Z36.8A, Z36.9

E/M service: 99201-99205, 99211-99215, 99241-99245, 99500

Prenatal bundled codes: 59400, 59425, 59426, 59510, 59610, 59618

Postpartum care

ICD-10-CM: Z01.411, Z01.419, Z01.42, Z30.430, Z39.1, Z39.2

E/M service: 99501

Postpartum bundled codes: 59400, 59410, 59430, 59510, 59515, 59610, 59614, 59618, 59622

Cervical cytology: 88141-88143, 88147, 88148, 88150, 88152–88154, 88164-88167, 88174, 88175

CPT: 57170, 58300

CPT II: 0503F

Overuse/Appropriateness

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

Assesses the percentage of members ages 3 months and older with a diagnosis of acute bronchitis/bronchiolitis and who were not dispensed an antibiotic prescription (a higher rate is better)

HEDIS Value Set:

ICD-10-CM: J20.3–K20.9, J21.0, J21.1, J21.8, J21.9

Telephone visits: 98966–98968, 99441–99443

Use of Imaging Studies for Lower Back Pain (LBP)

Assesses members 18–50 years old with a primary diagnosis of lower back pain who did not have an imaging study (plain X-ray, MRI or CT scan) within 28 days of the diagnosis (a higher score indicates better performance)

HEDIS Value Set:

ICD-10-CM: M47.26–M47.28, M47.816–M47.818, M47.896–M47.898, M48.06, M48.061, M48.062, M48.07, M48.08, M51.16, M51.17, M51.26, M51.27, M51.36, M51.37, M51.86, M51.87, M53.2X6–M53.2X8, M53.3, M53.86–M53.88, M54.16–M54.18, M54.30–M54.32, M54.40–M54.42, M54.5, M54.89, M54.9, M99.03, M99.04, M99.23, M99.33, M99.43, M99.53, M99.63, M99.73, M99.83, M99.84, S33.100A, S33.100D, S33.100S, S33.110A, S33.110D, S33.110S, S33.120A, S33.120D, S33.120S, S33.130A, S33.130D, S33.130S, S33.140A, S33.140D, S33.140S, S33.5XXA, S33.6XXA, S33.8XXA, S33.9XXA, S39.002A, S39.002D, S39.002S, S39.012A, S39.012D, S39.092A. S39.092D, S39.092S, S39.82XA, S39.82XD, S39.82XS, S39.92XS

CPT: 98970–98972, 99421–99423, 98966–98968, 99441–99443, 72020, 72052, 72100, 72110, 72114, 72120, 72131-72133, 72141, 72142, 72146–72149, 72156, 72158, 72200, 72202, 72220

14 Follow-up appointments will be required for both facets.

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Use of Opioids from Multiple Providers (UOP)

The proportion of members 18 years and older, receiving prescription opioids for more than 15 days during the measurement year, who received opioids from multiple providers. Three rates are reported:

- **Multiple prescribers:** The proportion of members receiving prescriptions for opioids from four or more different prescribers during the measurement year
- **Multiple pharmacies:** The proportion of members receiving prescriptions for opioids from four or more different pharmacies during the measurement year
- **Multiple prescribers and multiple pharmacies:** The proportion of members receiving prescriptions for opioids from four or more different prescribers and four or more different pharmacies during the measurement year (i.e., the proportion of members who are numerator-compliant for both the multiple prescribers and multiple pharmacies rates).

HEDIS Value Set:

ONLY exclusion codes on the HEDIS value set

Respiratory Conditions

Asthma Medications Ratio (AMR)

Assesses the percentage of adults and children 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

HEDIS Value Set:

ICD-10-CM: E84.0, E84.11, E84.19, E84.8, E84.9, J43.0, J43.1, J43.2, J43.8, J43.9, J44.0, J44.1, J44.9, J45.20–J45.22, J45.30–J45.32, J45.40–J45.42, J45.50–J45.52, J45.901, J45.902, J45.909, J45.990, J45.991, J45.998, J68.4, J96.00–J96.02, J96.20–J96.22

Telephone visits: 98966–98968, 99441–99443

Appropriate Treatment for Upper Respiratory Infection (URI)

Assesses children between 3 months and 18 years of age who were given a diagnosis of upper respiratory infection and were not dispensed an antibiotic prescription. A higher rate indicates appropriate treatment of children with URI (i.e., the proportion for whom antibiotics were not prescribed).

HEDIS Value Set:

ICD-10-CM: J00, J06.0, J06.9

CPT: 98966–98968, 99441–99443, 99345, 99347–99350, 99381–99387, 99391–99397, 99401–99404, 99411, 99412, 99429, 99455, 99456, G0402, G0438, G0439, G0463, T1015

CPT II: 3074F, 3075F, 3077F, 3078F, 3079F, 3080F

Remote blood pressure monitoring: 93784, 93788, 93790, 99091, 99453, 99454, 99457

Online assessments: 98970–98972, 99421–99423

Telephone visits: 98966–98968, 99441–99443

Cardiovascular Conditions

Controlling High Blood Pressure (CBP)[15]

Assesses adults 18–85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (< 140/90 mm Hg)

HEDIS Value Set:

E/M service: 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

CPT II: 3074F, 3075F, 3077F, 3078F, 3079F, 3080F

Remote blood pressure monitoring: 93784, 93788, 93790, 99091, 99453, 99454, 99457

Online assessments: 98970–98972, 99421–99423

Telephone visits: 98966–98968, 99441–99443

15 A follow-up visit will be required. This measure may be closed via telehealth only when blood pressure readings are submitted by remote blood pressure monitoring. Self-reported blood pressure readings cannot be used to close the CBP measure.

Statin Use in Persons with Cardiovascular Disease (SPC)

Assesses males 21–75 years of age and females 40–75 years of age who have clinical atherosclerotic cardiovascular disease (ASCVD) and who meet the following criteria:

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

HEDIS Value Set:

ICD-10-CM: I21.01, I21.02, I21.09, I21.11, I21.19, I21.21, I21.29, I21.3, I21.4, I21.9, I21.A1, I21.A9, I22.0, I22.1, I22.2, I22.8, I22.9, I23.0–I23.8, I25.2

CPT: 33510–33514, 33516–33519, 33521–33523, 33533–33536, 92920, 92924, 92928, 92933, 92937, 92941, 92943, 92980, 92982, 92995, 99201–99205, 99211–99215, 99241–99245, 99341–99345, 99347–99350, 99381–99387, 99391–99397, 99401–99404, 99411, 99412, 99429, 99455, 99456, 99483, 99221–99223, 99231–99233, 99238, 99239, 99251–99255, 99291

Diabetes

Comprehensive Diabetes Care (CDC)[16]

Assesses adults 18–75 years of age with diabetes (type 1 or type 2) who had each of the following:

- Hemoglobin A1c (HbA1c) testing, HbA1c poor control (> 9.0%), HbA1c control (< 8.0 %), HbA1c control (< 7.0%) for a selected population
- Eye exam (retinal) performed
- Medical attention for nephropathy
- Blood pressure control (< 140/90 mm Hg)

HEDIS Value Set:

HbA1c

CPT: 83036, 83037

CPT II: 3044F, 3045F, 3046F, 3051F, 3052F

Eye exam (retinal) performed

Diabetic retinal screening with eye care professional performed, results documented and reviewed: 2022F, 2023F, 2024F, 2025F, 2026F, 2033F

No evidence of retinopathy in prior year: 3072F

Kidney disease monitoring

Labs: 81000–81003, 81005, 82042–82044, 84156

CPT II: 3060F, 3061F, 3062F, 3066F, 4010F

Control of Blood Pressure

CPT II: 3074F, 3075F, 3077F, 3078F, 3079F, 3080F

Remote blood pressure monitoring: 93784, 93788, 93790, 99091, 99453, 99454, 99457

Online assessments: 98970–98972, 99421–99423

Telephone visits: 98966–98968, 99441–99443

Statin Therapy for Patients with Diabetes (SPD)

Assesses adults 40–75 years of age who have diabetes and do not have clinical ASCVD, who meet 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 statin medication of any intensity for at least 80% of the treatment period

HEDIS Value Set:

ICD-10-CM: I21.01, I21.02, I21.09, I21.11, I21.19, I21.21, I21.29, I21.3, I21.4, I21.9, I21.A1, I21.A9, I22.0, I22.1, I22.2, I22.8, I22.9, I23.0-I23.8, I25.2

CPT: 33510–33514, 33516–33519, 33521–33523, 33533–33536, 92920, 92924, 92928, 92933, 92937, 92941, 92943, 92980, 92982, 92995, 99201–99205, 99211–99215, 99241–99245, 99341–99345, 99347–99350, 99381–99387, 99391–99397, 99401–99404, 99411, 99412, 99429, 99455, 99456, 99483, 99221–99223, 99231-99233, 99238, 99239, 99251–99255, 99291

16 Additional exclusion criteria are required for this indicator, which will result in a different eligible population from all other indicators. Telehealth will not close HbA1c, nephropathy, eye exam or blood pressure gaps unless submitted via remote blood pressure monitoring or in=home testing kits. A follow-up appointment will be required.

Due to the COVID-19 emergency, Medicare has expanded telehealth coverage and eased current rules, such as the telemedicine originating site requirements. Patient homes can now serve as originating sites, regardless of diagnosis, for the duration of the COVID-19 crisis. See CMS's general provider telehealth and telemedicine toolkit (PDF) for details. *This document provides a broad overview of common telehealth services and is for informational purposes only. Please refer to the resources for the most up-to-date information.*

Telehealth for Medicare Advantage

Risk Adjustment & Quality

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Musculoskeletal Conditions

Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)

Assesses 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)

HEDIS Value Set:

HCPCS

DMARDs: J0129, J0135, J0717, J1438, J1602, J1745, J3262, J7502, J7515-J7518, J9250, J9260, J9310, Q5102-Q5204

New: J9311, J9312, Q5109

Telephone visits: 98966–98968, 99441–99443

Osteoporosis Management in Women Who Had a Fracture (OMW)

Assesses 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 or prevent osteoporosis in the six months following the fracture

HEDIS Value Set:

Bone mineral density tests

CPT: 76977, 77078, 77080–77082, 77085, 77086

HCPCS

Osteoporosis therapy (after fracture): J0897, J1740, J3110, J3489

Telephone visits: 98966–98968, 99441–99443

Behavioral Health

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

The two rates of this measure assess follow-up care for children prescribed an ADHD medication:

- **Initiation phase:** Assesses children 6–12 years of age who were diagnosed with ADHD and had one follow-up visit with a practitioner with prescribing authority within 30 days of their first prescription of ADHD medication
- **Continuation and maintenance phase:** Assesses children 6–12 years of age who had a prescription for ADHD medication and remained on the medication for at least 210 days, and had at least two follow-up visits with a practitioner in the nine months following the initiation phase

HEDIS Value Set:

CPT/HCPCS: 96150–96154, 98960–98962, 99078, 99201–99205, 99211–99215, 99217–99220, 99241–99245, 99341–99345, 99347–99350, 99381–99387, 99391–99397, 99401–99404, 99411, 99412, 99510, G0155, G0176, G0177, G0409–G0411, G0463, H0002, H0004, H0031, H0034–H0037, H0039, H0040, H2000, H2001, H2010–H2010, M0064, S0201, S9480, S9484, S9485, T1015

Telephone visits: 98966–98968, 99441–99443

Initiation phase: 90791, 90792, 90832–90834, 90836-90840, 90845, 90847, 90849, 90853, 90875, 90876

C&M phase: 99221–99223, 99231–99233, 99238, 99239, 99251–99255, 99291

Antidepressant Medication Management (AMM)

Assesses adults 18 years of age and older with a diagnosis of major depression who were newly treated with antidepressant medication and remained on their antidepressant medications. Two rates are reported:

- **Effective acute phase treatment:** Adults who remained on an antidepressant medication for at least 84 days (12 weeks)
- **Effective continuation phase treatment:** Adults who remained on an antidepressant medication for at least 180 days (6 months)

HEDIS Value Set:

ICD-10-CM: F32.0–F32.4, F32.9, F33.0–F33.3, F33.41, F33.9

CPT: 98966–98968, 99441–99443

Telehealth for Medicare Advantage

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

Assesses emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence who had a follow-up visit for AOD. Two rates are reported:

- ED visits for which the member received follow-up within 30 days of the ED visit (31 total days)
- ED visits for which the member received follow-up within 7 days of the ED visit (8 total days)

HEDIS Value Set:

CPT/HCPCS: 98960–98962, 99078, 99201–99205, 99211–99215, 99217–99220, 99241–99245, 99341–99345, 99347–99350, 99381–99387, 99391–99397, 99401–99404, 99411, 99412, 99510, 98970–98972, 99421–99423, 98966–98968, 99441–99443, G0155, G0176, G0177, G0396, G0397, G0409–G0411, G0443, G0463, H0001, H0002, H0004, H0005, H0007, H0015, H0016, H0022, H0031, H0034–H0037, H0039, H0040, H0047, H2000, H2001, H2010–H2020, H2035, H2036, M0064, S0201, S9480, S9484, S9485, T1006, T1012, T1015, 90791, 90792, 90832–90834, 90836–90840, 90845, 90847, 90849, 90853, 90870, 90875, 90876, 99221–99223, 99231–99233, 99238, 99239, 99251–99255

Follow-Up After Hospitalization for Mental Illness (FUH)

Assesses adults and children 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm and had a follow-up visit with a mental health practitioner. Two rate are reported:

- The percentage of members with a follow-up within 7 days of discharge
- The percentage of members with a follow-up within 30 days of discharge

HEDIS Value Set:

CPT/HCPCS: 98960–98962, 99078, 99201–99205, 99211–99215, 99217–99220, 99241–99245, 99341–99345, 99347–99350, 99381–99387, 99391–99397, 99401–99404, 99411, 99412, 99510, G0155, G0176, G0177, G0409, G0463, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010–H2020, M0064, T1015, 90791, 90792, 90832–90834, 90836–90840, 90845, 90847, 90849, 90853, 90870, 90875, 90876, 99221–99223, 99231–99233, 99238, 99239, 99251–99255

Follow-Up After Emergency Department Visit for Mental Illness (FUM)

Assesses ED visits for adults and children 6 years of age and older with a principal diagnosis of mental illness, or intentional self-harm, and who received a follow-up visit for mental illness. Two rates are reported:

- ED visits for which the member received follow-up within 30 days of the ED visit (31 total days)
- ED visits for which the member received follow-up within 7 days of the ED visit (8 total days)

HEDIS Value Set:

CPT/HCPCS: 98960–98962, 99078, 99201–99205, 99211–99215, 99217–99220, 99241–99245, 99341–99345, 99347–99350, 99381–99387, 99391–99397, 99401–99404, 99411, 99412, 99510, G0155, G0176, G0177, G0409, G0463, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010–H2020, M0064, T1015, 90791, 90792, 90832–90834, 90836–90840, 90845, 90847, 90849, 90853, 90870, 90875, 90876, 99221–99223, 99231–99233, 99238, 99239, 99251–99255

Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)

Assesses adults 19–64 years of age who have schizophrenia and were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period

HEDIS Value Set:

HCPCS: J2794, J0401, J1631, J2358, J2426, J2680, C9035, C9037

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