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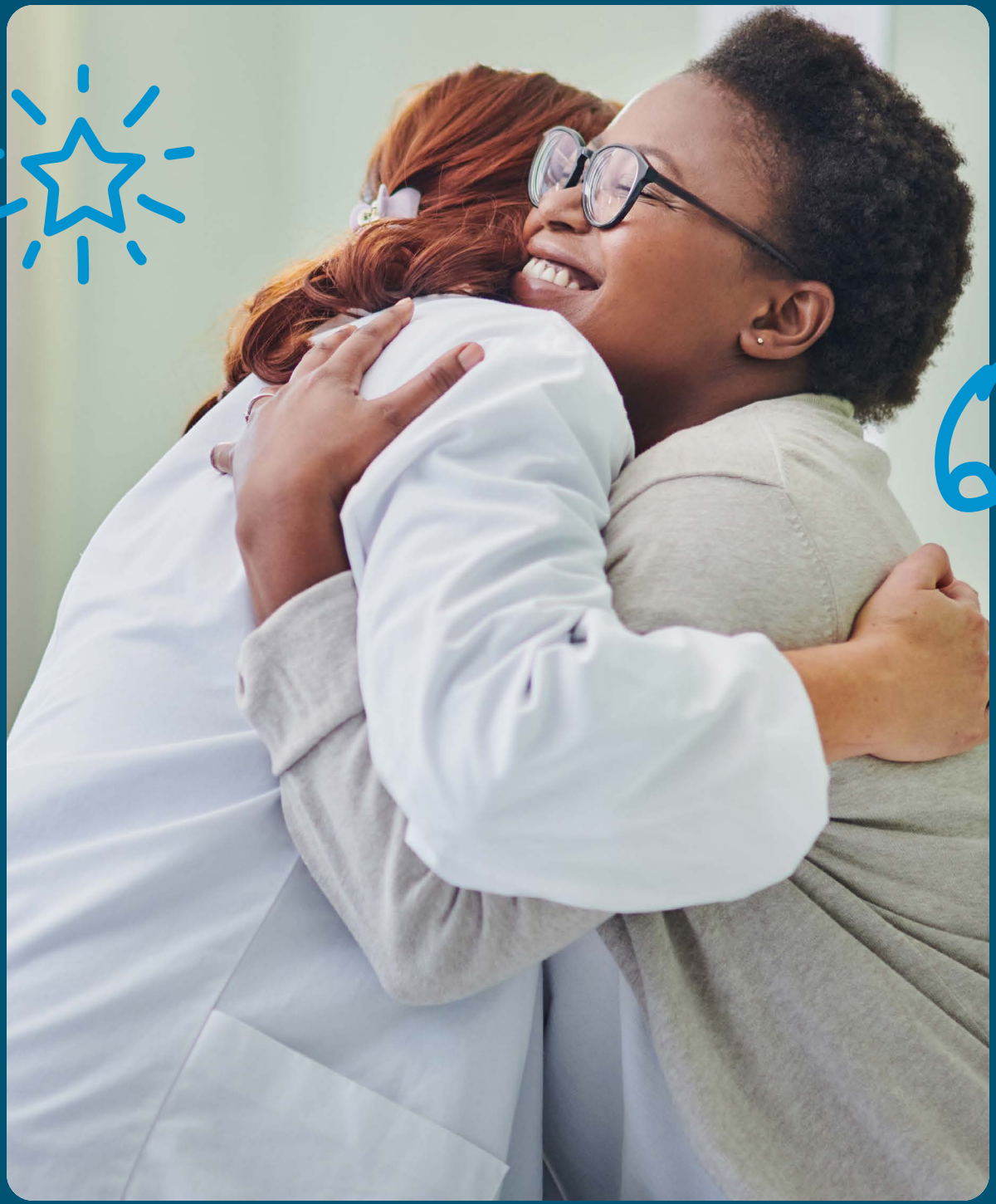

Quality TOOLKIT

MEASUREMENT YEAR (MY) 2024

Developed by: HEDIS® Team

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*** Measure of Interest—Measure is included in various provider scorecards**

How to Use This Guide

This guide is designed to help you improve your quality measures, compliance and more accurately document the high quality of care that you provide for your members. Quality measures are indicators of the health outcomes, clinical processes, patient safety, and patient satisfaction that reflect the quality of care you deliver. By following the best practices and recommendations in this guide, you can enhance your credited performance on these measures and achieve optimal scores on various programs and incentives offered by CareFirst.

This reference guide is not intended to be a complete guide for all Quality measures and requirements. For additional details and specifications for HEDIS® measures, please go to **https://www.ncqa.org/hedis/measures** or contact CareFirst.

The guide is organized by measure categories, such as preventive care, chronic care, behavioral health, and medication adherence. Each category contains a list of measures relevant to that topic, along with the definitions, criteria, exclusions, and data sources for each measure. The guide also provides tips and strategies for improving each measure, such as patient education, screening tools, care coordination, and follow-up. Additionally, the guide includes links to external resources and evidence-based guidelines that can support you in implementing these best practices.

To use this guide effectively, you should:

- Review the measures that apply to your practice and identify the areas where you need improvement.
- Select measures to focus on and set specific and measurable goals for improvement.
- Implement the recommended strategies and interventions for each measure and monitor your progress regularly.
- Use the data sources and reports available from CareFirst and other sources to track your performance and identity gaps in care.
- Engage your staff and members in the quality improvement process and solicit their feedback and suggestions.
- Celebrate your successes and share your best practices with your colleagues and peers.

By following these steps, you can improve your quality measures and provide better care for your members. Remember, you are not alone in this journey. CareFirst BlueCross BlueShield (CareFirst) is here to support you and provide the tools and resources you need to succeed. If you have any questions or concerns, please contact your Provider Network Manager (PNM) or your Regional Practice Consultant (RPC). We look forward to working with you to achieve our shared goal of improving the health of our members and communities.
For more information on how to improve medication adherence and other quality measures, including helpful videos and guides to assist you in providing optimal care for your members, please visit the CareFirst Learning and Engagement Center (Self-Paced Modules).

Looking for support?

Contact us by selecting the link here to find the correct Department.

Introduction

What is HEDIS®?

HEDIS 101 for Healthcare Delivery Partners (Self-Paced Module)

- HEDIS stands for Healthcare Effectiveness Data and Information Set.
- It was developed by the National Committee for Quality Assurance (NCQA) in the 1980s.
- NCQA specifications standardize performance to evaluate and compare health plan performance and quality under standardized definitions.
- HEDIS is required for ongoing NCQA health plan accreditation and includes more than 90 measures across six domains of care:
  - Access/availability to care
  - Effectiveness of care
  - Experience of care
  - Health plan descriptive information
  - Measures reported using electronic clinical data systems
  - Utilization and risk-adjusted utilization

How is HEDIS Data Collected?

Measure specifications outline the measure description, any exclusions, and how the data may be collected. Depending on the measure, data may be collected through:

- **Administrative/claims data**: Medical, pharmacy, vision, and behavioral health claims.
- **Supplemental data**: Files sent in by the provider or via data repositories throughout the year.
- **Medical record reviews**: Staff review the actual medical record to collect data.

We try as much as we can to collect data from sources other than medical records to reduce the burden on providers.

NCQA defines how data can be collected for a measure

Administrative measures

The total eligible population is used for the denominator. Only data considered “administrative” is allowed. Medical, pharmacy, supplemental data, and/or encounter claims count toward the numerator. Medical record review is not allowed for these measures during the hybrid HEDIS season. For some measures data can be collected via medical record review before the hybrid HEDIS season starts.

Hybrid measures

Data is collected during the hybrid HEDIS season through medical record reviews but can also be captured through administrative data collection throughout the year. For the annual HEDIS audit season, the denominator is a random sample of 411 members. Following NCQA requirements, the HEDIS software generates a random sample population of 411 eligible members. The numerator includes data from claims, encounters, medical record review data, and supplemental data.

Electronic Clinical Data Systems (ECDS)

ECDS measures were created in 2015 by NCQA to digitalize measures and move away from medical record collection in order to reduce the burden on payers and providers.

These measures are similar to administrative and hybrid measures but are collected differently.

- Several measures have been converted to ECDS versions (they end with '-E').
- Data sources include:
  - Electronic health record (EHR)/personal health record (PHR)
  - Health information exchange (HIE)/clinical registry
  - Case management system
  - Administrative
- As NCQA converts more measures to digital versions, more measures will be converted to ECDS.
- As the rates for ECDS measure align with the non-ECDS counterpart, the non-ECDS measures will be retired.
  - The following non-ECDS measures have already been retired: ADD, APM, BCS, and COL.
  - The following non-ECDS measures have not yet been retired: CIS, IMA and CCS.
  - Expect to see more hybrid measures converted and retired in the coming years.

HEDIS MY2024 Highlights

NCQA reviews the entire suite of quality measures each year and adds, revises, or retires measures as indicated by their review.

New measures

No new measures

Retired measures

- Ambulatory Care (AMB)
- Inpatient Utilization—General Hospital/Acute Care (IPU)
- Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)
- Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)
- The following measures were retired and replaced by the ECDS version of the measures:
  - Follow-Up Care for Children Prescribed ADHD Medication (ADD)
  - Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)
  - Colorectal Cancer Screening (COL)

Revised measures

- Hemoglobin A1c Control for Members with Diabetes (HBD)—Expanded to include Glucose Management Indicator (GMI) and renamed Glycemic Status Assessment for Members with Diabetes (GSD)

What About CMS and Star Ratings?

The Centers for Medicare and Medicaid (CMS) set standards that are employed for assessing healthcare quality and efficiency in federal programs such as Medicare and Medicaid. These HEDIS Measures apply to HealthChoice, the managed Medicaid program in Maryland.

- Some measures are different from HEDIS:
  - The Star quality measures typically refer to the evaluation criteria used in the Star Rating system, specifically used by CMS to evaluate the quality of Medicare Advantage (MA) and prescription drug plans (PDPs). They assess the overall quality of care provided by health plans. These measures include clinical care, patient satisfaction, and plan efficiency, and they have an impact on consumer choice and plan reimbursement.
- Measures that are unique to Star Ratings are referred to as Star Measures.

What About the Maryland Department of Health (MDH)?

MDH oversees public health policy and services in Maryland. It manages programs addressing various health issues, regulatory compliance for healthcare providers, mental health and substance abuse services, and Medicaid coverage. MDH conducts health surveillance, promotes health equity, and collaborates with local and state entities to improve health outcomes and prepare for emergencies.

- Some measures are different from HEDIS, such as an expanded timeframe for lead screening in children, SSIAJH and SSICJH.
- These measures are utilized by states to monitor and improve the overall health and well-being of their populations. They address local health disparities and ensure compliance with state-specific healthcare regulations, performance, and policies in various healthcare settings.
- Measures that are unique to MDH have been identified in this toolkit as “MDH Measure”.

Required Exclusions

An exclusion will remove a patient from the measure denominator based on information captured in claims, encounter, pharmacy, and/or enrollment data.

Exclusions must be applied as part of identifying the denominator. Exclusions for hospice, palliative care, advanced illness, frailty, and long-term nursing home residence exclusions are specified in HEDIS measures where the services being captured may not be of benefit for this population or may not be in line with members’ goals of care.

The below exclusions are calculated by the software based on administrative data.

Supplemental or medical record data may not be used for these exclusions.

- **Frailty**: Members aged 81 and older as of December 31 of the measurement year who had a diagnosis of frailty in the measurement year (see Frailty Diagnosis Value Set).
- **Frailty and Advanced Illness**: Members aged 66–80 as of December 31 of the measurement year who had a diagnosis of frailty and advanced illness.

- **Advanced Illness** is indicated by one of the following:
  - Two or more outpatient, observation, emergency (ER) or non-acute inpatient encounters or discharges on separate dates of service with a diagnosis of advanced illness.
  - One or more acute inpatient encounter(s) with a diagnosis of advanced illness.
  - One or more acute inpatient discharge(s) with a diagnosis of advanced illness on the discharge claim.
- **NOTE**: Advanced Illness diagnosis must occur in the measurement year or year prior.

- **Dispensed a Dementia Medication**: Donepezil, galantamine, rivastigmine or memantine.
- **Long-Term Care**: Medicare members aged 66 and older as of December 31 of the measurement year who are either enrolled in an Institutional Special Needs Plan (I-SNP) or living long-term in an institution.

Improving HEDIS Scores

- **Maximize use of codes**: Only codes will close gaps for administrative measures.
  - Submit claim/encounter data for every service in an accurate and timely manner.
  - Some measures collect more than one data element—submit codes required for all elements.
  - Document medical and detailed surgical history with dates and use of appropriate coding.
    - (Example: Documentation of Hysterectomy without reference to Total, Radical, etc. will not exclude patient from CCS Measure).
- Information from the medical record must validate all required measure or exclusion components.
- **Each medical record/office note MUST contain the patient name, date of birth (DOB) and date of service (DOS). Additionally**:
  - Information on a fax cover sheet cannot be used.
  - Only completed events count toward HEDIS compliance.
  - A date must be specific enough to determine a test or service was performed within the time frame specified, not merely ordered.
  - An undated event on a problem list or history sheet can be used if it is specific enough to determine that the event occurred during the timeframe specified in the measure.
- **To improve quality compliance**:
  - Educate schedulers to review for needed screenings, tests and referrals.
  - Assist members with scheduling tests and follow-up to ensure they complete ordered screenings.
  - Provide patient education on disease process and rationale for tests.
  - Ask open-ended questions to determine any barriers to care or treatment.
  - Collaborate with other providers patient receives services from to help ensure care is comprehensive, safe, and effective.
  - Refer members to a behavioral health professional as indicated.

- **Not acceptable**
  - Documenting terms such as “recent,” “most recent,” “at a prior visit,” or “colonoscopy up to date.” These are not specific enough to know when an event occurred.

Improving Medication Adherence

- Is treatment appropriate? Should therapy continue? Follow-up to assess how the medication is working.
- Encourage prescription benefit use at the pharmacy. Only prescription fills processed with a patient’s health plan ID card can be used to measure a patient’s adherence.
- **Talk with members about**:
  - Why they’re on a medication, the importance of taking medication as prescribed, and refilling the medication in a timely manner. Please confirm instructions with the patient to ensure the patient understands the instructions.
  - Any barriers or concerns related to their health benefits, the side effects or the costs.
  - Any problems they have getting medications from pharmacy.
  - Developing a medication routine if they are on multiple medications that require them to be taken at different times.
    - Encourage them to utilize pillboxes or organizers.
    - Advise them to set up reminders or alarms for when medications are due.
    - Adjust the timing, frequency, amount and/or dosage when possible to simplify the regimen.

HEDIS Terminology

- **Anchor dates**: A measure may require a patient to be enrolled and have a benefit on a specific date.
- **Continuous enrollment**: Specifies the minimum amount of time that a patient must be enrolled in an organization before becoming eligible for a measure.
  It ensures that the organization has enough time to render services. The continuous enrollment period and allowable gaps in coverage are specific to each measure.
- **Compliance**:
  - Evidence in claims or supplemental data that member received appropriate service and will be included in numerator.
  - Elements which require the last result in the MY may impact patient compliance throughout the year.
    - Example: A1c in March 6.0 = compliant. June A1c test no result reported. System will default to >9 until the result is received, as non-compliance is presumed until compliance is proven.
- **Denominator**: Number of members who qualify for measure criteria based on NCQA technical specifications.
- **Element**: Measurable way a HEDIS measure is broken down and defined.

- **Eligible population**: All members who satisfy all specified criteria, including age, continuous enrollment, benefit, event and the anchor date enrollment requirement for the measure.
  - Patient ages for each measure are based on different criteria. This may impact the age range to include additional ages.
    - Example: 18 years of age by December 31 of the measurement year. Consider when patient turns 18 and include service performed during the measurement year when patient was 17. The files must have auditor approval. **HEDIS measure**: Term for how each domain of care is further broken down. Specifications outline measure definition and details, which outline the specifications required to evaluate the recommended standards of quality for the element(s) in the measure (example: COL, BCS measures).
- **HEDIS project:** Timeframe during the year when data is collected. There are two projects:
  - **Annual project**: Also referred to as hybrid HEDIS season. The annual project is required by NCQA as part of accreditation. For hybrid measures, the patient population is based on a sample of members from each LOB. Administrative measures look at the total patient population. The audit timeframe is January to May for data collection, retrospectively evaluating performance achieved in the prior year.
  - **Prospective project:** Involves data collection for all LOBs for all members for the upcoming annual HEDIS project. The QI HEDIS team data collection timeframe is June to January. However, throughout the year CareFirst prepares for the annual HEDIS project in various ways to optimize audit results. Review of NCQA specifications and updates to training and educational materials are also performed during this time.
- **Line of business (LOB)**: Identifies the reporting population including Commercial, Medicaid, and Medicare.
- **Measurement year (MY)**: Refers to the calendar year during which the services being measured were provided. it sets the timeframe for which data is collected and analyzed to assess performance.
- **Numerator**: The number of members who meet compliance criteria based on NCQA technical specifications for appropriate care, treatment, or service.
- **Reporting year**: Calendar year after the end of the MY during which the annual HEDIS audit occurs (example: Data for MY2022 is reported in 2023).
- **Supplemental data (non-standard)**: Data collected prospectively which are not in a standard file layout. Medical record reviews are an example.
- **Supplemental data (standard)**: Standardized file process to collect data from sites to close gaps.
- **Sub-measure**: A measure can be broken down into more specific data elements of care.
- **Telehealth**: Telehealth is billed using standard CPT and HCPCS codes for professional services in conjunction with a telehealth modifier and/or a telehealth POS code.
  - CPT or HCPCS code in the value set will meet criteria (regardless of whether a telehealth modifier or POS code is present).
  - Asynchronous telehealth is sometimes referred to as an e-visit or virtual check-in, is not “real-time” but still requires two-way interaction between the patient and provider.
    - Asynchronous telehealth can occur using a patient portal, secure text messaging or email.
  - Synchronous telehealth requires real-time interactive audio and video telecommunications.

Risk Adjustment

(Self-Paced Modules)

What is risk adjustment?

Risk adjustment is a statistical process that adjusts payments to health plans based on the health status of their enrollees. It ensures equitable payment to plans that cover individuals with varying health conditions. Risk adjustment (RA) models were developed to predict and manage healthcare costs for an individual based on their reported health status and clinical complexity. These models are based strictly on the diagnoses reported. The diagnosis codes inform the total cost associated with managing the members care, which in turn impacts the accuracy of the payments provided by CMS to meet those health management costs.

Why is it done?

Risk adjustment is important for physicians to understand as accurate payments determine the funds available to support patient care models as they apply to care coordination, care management, complex care programs, transition of care programs, member benefits, and other services related to increasing the quality of care and the member experience.

How can providers help?

Providers play a crucial role by:

- Documenting diagnoses accurately and comprehensively
- Coding patient encounters with precision
- Staying informed on coding standards and risk adjustment methodologies through ongoing training
- Completing a comprehensive visit at least once a year for each member to assess current diagnosis or any progression/regressions of chronic diseases being manged

Medical record requests for risk adjustment:

- Medical record requests for risk adjustment are often handled by a vendor.
- Providers are contractually obligated to comply with these requests in a timely manner to support the risk adjustment process.
- Medical record access is CRITICAL in assessing if the clinical diagnosis documentation meets CMS coding guidelines, supporting the submission of diagnosis codes not submitted on a claim and identifying opportunities for coding and documentation improvement.

Chart retrieval timeline

Regulatory Program	Line of Business	Retrieval Period	CareFirst Retrieval deadline
ACA Risk Adjustment retrospective chart retrieval	Commercial/ACA	January–March	March 15th
ACA RADV Risk Adjustment retrospective chart retrieval	Commercial/ACA	July–November	November 25th
Commercial & Government Programs HEDIS Quality Chart retrieval	Commercial/Medicare Advantage/Medicaid	January–March	April 1st
DSNP & Group PPO Risk Adjustment Chart retrieval	Medicare Advantage	July–January of the following year	January 15th

AAB*—Avoidance of Antibiotic Treatment for Acute Bronchitis

Population: Commercial, Medicaid, Medicare

Administrative Measure

Description

Percentage of episodes for members ages 3 months and older with a diagnosis of acute bronchitis/bronchiolitis, who were not dispensed an antibiotic medication on or three days after the episode. Looks at episodes between July 1 of the year prior to the MY through June 30 of the MY. The measure is reported as an inverted rate, so a higher rate indicates appropriate treatment (not prescribed an antibiotic).

Best practice and measure tips

- Avoid prescribing an antibiotic unless there is a bacterial etiology.
- Denied claims are not included when assessing the numerator—all claims (paid, suspended, pending and denied) must be included when identifying the eligible population.
- When antibiotics are needed for a patient with acute bronchitis/bronchiolitis with comorbid conditions, submit codes on the same claim to remove patient from measure.
- An episode will not count toward the measure denominator if the patient was diagnosed with pharyngitis or a competing diagnosis on or three days after the episode date.
- Not exclusions for this HEDIS measure: asthma and diabetes diagnosis; symptoms such as fever, cough and wheezing; tobacco use.
- CDC offers several materials and tools about antibiotic resistance, appropriate prescribing and use for common infections.
  - Permission is not needed to print, copy, or distribute any materials. Visit the **CDC website**.

Required exclusions

- Hospice
- Members who died during the MY

Measure Removal codes:

An episode for bronchitis/bronchiolitis will not count toward the measure denominator if the patient was diagnosed with a differential diagnosis during the 12 months prior to or on the event date. The following common differential diagnoses will remove members from the measure as they support the use of antibiotics:

- Acute sinusitis: J01.xxx
- Acute vaginitis: N76.xxx
- Acute suppurative otitis media: H66.xxx
- Cellulitis and lymphangitis: L03.xxx
- Chronic sinusitis: J32.xxx
- Impetigo: L01.xxx
- Mastoiditis (acute and chronic): H70.xxx
- Otitis media: H67.xxx
- Pneumonia: J13.xx–J18.xx
- Tonsillitis (chronic and hypertrophy): J35.xxx
- Urinary tract infection: N39

Measure medications

Description	Prescriptions			
Aminoglycosides	■ Amikacin	■ Gentamicin	■ Streptomycin	■ Tobramycin
Aminopenicillins	■ Amoxicillin	■ Ampicillin		
Beta-lactamase inhibitors	■ Amoxicillin-clavulanate	■ Ampicillin-sulbactam	■ Piperacillin-tazobactam	
First-generation cephalosporins	■ Cefadroxil	■ Cefazolin	■ Cephalexin	
Fourth-generation cephalosporins	■ Cefepime			
Lincomycin derivatives	■ Clindamycin	■ Lincomycin		
Macrolides	■ Azithromycin	■ Clarithromycin	■ Erythromycin	
Miscellaneous antibiotics	■ Aztreonam ■ Chloramphenicol	■ Dalfopristin-quinupristin ■ Daptomycin	■ Linezolid ■ Metronidazole	■ Vancomycin
Natural penicillins	■ Penicillin G benzathine ■ Penicillin G benzathine-procaine	■ Penicillin G potassium ■ Penicillin G procaine	■ Penicillin V potassium ■ Penicillin G sodium	
Penicillinase resistant penicillins	■ Dicloxacillin	■ Nafcillin	■ Oxacillin	
Quinolones	■ Ciprofloxacin ■ Gemifloxacin	■ Levofloxacin ■ Moxifloxacin	■ Ofloxacin	
Rifamycin derivatives	■ Rifampin			
Second-generation cephalosporin	■ Cefaclor ■ Cefotetan	■ Cefoxitin ■ Cefuroxime	■ Cefprozil	
Sulfonamides	■ Sulfadiazine	■ Sulfamethoxazole-trimethoprim		
Tetracyclines	■ Doxycycline	■ Minocycline	■ Tetracycline	
Third-generation cephalosporins	■ Cefdinir ■ Cefixime	■ Cefotaxime ■ Cefpodoxime	■ Ceftazidime ■ Ceftriaxone	
Urinary anti-infectives	■ Fosfomycin ■ Nitrofurantoin	■ Nitrofurantoin macrocrystals-monohydrate	■ Trimethoprim	

AAP*—Adults' Access to Preventive/Ambulatory Health Services

Population: Commercial, Medicaid, Medicare

Administrative Measure

Description

The percentage of members 20 years of age and older who had an ambulatory or preventive care visit during the MY (Medicare and Medicaid), or during the MY or the two years prior to the measurement year (Commercial).

Best practice and measure tips

- Ambulatory or preventive care visits
- Telephone and e-visits acceptable

Required exclusions

- Hospice
- Members who entered hospice or died during the MY

Measure codes

Refer to **Appendix B** for code combinations to identify ambulatory or preventive visits: Ambulatory Visits value set; Telephone Visits value set; and Online Assessments value set.

ADD-E—Follow-Up Care for Children Prescribed ADHD Medications

Population: Commercial, Medicaid

ECDS Measure

Description

Measure evaluates the percentage of members 6–12 years of age receiving attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow up care visits within a 10-month period. One visit is required within 30 days of when the first ADHD medication was dispensed.

Two rates are reported.

- **Initiation phase**: Percentage of members receiving an ADHD medication, who had one follow-up visit with practitioner during the 30-day Initiation Phase.
- **Continuation Phase**: percentage of members who had at least two follow-up visits with a practitioner within 270 days after the Initiation phase

Best practice and measure tips

- When prescribing a new ADHD medication for a patient:
  - Schedule follow-up visits to occur before the refill is given, such as a 30-day, 60-day, and 180-day follow-up visits following the initial visit.
  - Consider scheduling follow-up visit within 14–21 days of each prescription.
  - Consider prescribing an initial two-week supply and follow-up prescriptions to a 30-day supply to ensure members follow up.
  - Only one of the two visits (during days 31–300) may be an e-visit or virtual check-in.
- **Age clarification**: Six years as of March 1 of the year prior to the MY to 12 years as of the last calendar day of February of the MY.
- Time scheduled visits on the prescription day supply to evaluate medication effectiveness, any adverse effects and to monitor patient progress.

Required exclusions

- Hospice; Members who died during the MY
- Members who filled an ADHD prescription 120 days (4 months) prior to the IPSD (applies to only Rate 1—Initiation phase)
- Members with a diagnosis of narcolepsy any time during their history through December 31 of the MY Measure medications

Measure codes

Refer to **Appendix B** for code combinations to identify follow-up visits: outpatient visits, observation visits, health and behavior assessment/intervention visits and telehealth visits.

ADHD medications

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

AIS-E*—Adult Immunization Status

Population: Commercial, Medicaid, Medicare

ECDS Measure

Description

The percentage of adults who receive the following recommended routine vaccines.

Vaccine	Eligible Age	Measurement
Influenza	Age 19+	Members who receive the influenza vaccine on or between 7/1 of the year prior to the measurement period and 6/30 of the measurement period
Td/Tdap	Age 19+	Members who receive at least one Td or one Tdap vaccine between nine years prior to the start of the measurement period and the end of the measurement period (12/31)
Zoster	Age 50+	Members who received at least one dose of the zoster live vaccine or two doses of the zoster recombinant vaccine (at least 28 days apart) anytime on or after their 50th birthday
Pneumococcal	Age 66+	Members who received pneumococcal vaccine on or after their 66th birthday

Best practice and measure tips

Document compliant vaccine administration or SNOMED code documenting adverse reaction to vaccine.

Required exclusions

- Hospice
- Members who received hospice services or died during the MY Measure codes

	CPT code	CVX code	HCPCS code
Influenza	90630, 90653, 90654, 90656, 90658, 90661, 90662, 90673, 90674, 90682, 90686, 90688, 90689, 90694, 90756 LAIV: 90660, 90672	88, 135, 140, 141, 144, 150, 153, 155, 158, 166, 168, 171, 185, 186, 197, 205 LAIV: 111, 149	
Td/Tdap	Td: 90714 Tdap: 90715	Td: 09, 113, 115, 138, 139	
Zoster	90736, 90750		
Pneumococcal	90670, 90671, 90677, 90732	33, 109, 133, 152, 215, 216	G0009

AMR—Asthma Medication Ratio

Population: Commercial, Medicaid

Administrative Measure

Description

The percentage of members 5-64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 50% or greater during the MY.

Best practice and measure tips

- Schedule follow-up appointments:
  - Report the appropriate diagnosis codes for the patient's condition, including those that may exclude the patient from this measure.
  - Use the most specific coding* possible.
  - Avoid coding asthma if the diagnosis is for an asthma-like symptom (e.g., wheezing during viral upper respiratory infection and acute bronchitis is not "asthma").
  - Ensure the patient is not using more rescue medications than preventive medication to control their asthma (i.e., rescue meds have 50% less usage than preventive meds).
  - Ensure at least half of the medications dispensed to treat their asthma are controller medications throughout the treatment/measurement period.
- Patient is considered to have persistent asthma if they have any of the following:
  - At least one ER visit with a principal diagnosis of asthma.
  - At least one acute inpatient encounter with a principal diagnosis of asthma.
  - At least one inpatient discharge with a principal diagnosis of asthma on the discharge claim.
  - At least four outpatient visits, observation visits, telephone/e-visits/virtual check-ins, on different dates of service with any diagnosis of asthma and at least two asthma medication dispensing events for any controller or reliever medication.
  - At least four asthma medication dispensing events for any controller or reliever medications.

Required exclusions

- Hospice
- Members who died during the MY
- Members who weren't prescribed an asthma medication any time during the MY

The following differential diagnoses will remove members from the measure:

- Acute respiratory failure
- Chronic obstructive pulmonary disease (COPD)
- Chronic respiratory conditions due to fumes/vapors
- Cystic fibrosis
- Emphysema
- Obstructive chronic bronchitis
- Other emphysema

Measure medications

Asthma controller medications

Description	Prescriptions			
Antibody inhibitors	■ Omalizumab			
Anti-interleukin-4	■ Dupilmab			
Anti-interleukin-5	■ Benralizumab	■ Mepolizumab	■ Rezlizumab	
Inhaled steroid combinations	■ Budesonide-formoterol	■ Fluticasone-salmetrol	■ Fluticasone-vilanterol	■ Formoterol-mometasone
Inhaled corticosteroids	■ Beclomethasone ■ Budesonide	■ Ciclensonide ■ Flunisolide	■ Fluticasone ■ Mometasone	
Leukotriene modifiers	■ Montelukast	■ Zafirlukast	■ Zileuton	
Long-acting beta2-adrenergic agonist (LABA)	■ Fluticasone furoate-umeclidinium-vilanterol	■ Salmeterol		
Long-acting muscarinic antagonists (LAMA)	■ Tiotropium			
Methylxanthines	■ Theophylline			

Asthma reliever medications

Description	Prescriptions	
Short-acting, inhaled beta-2 agonists	■ Albuterol	■ Levalbuterol

Measure codes

*Persistent asthma:

J45.21: Mild intermittent asthma with (acute) exacerbation
J45.22: Mild intermittent asthma with status asthmaticus
J45.30: Mild persistent asthma, uncomplicated
J45.31: Mild persistent asthma with (acute) exacerbation
J45.32: Mild persistent asthma with status asthmaticus
J45.40: Moderate persistent asthma, uncomplicated
J45.41: Moderate persistent asthma with (acute) exacerbation
J45.42: Moderate persistent asthma with status asthmaticus
J45.50: Severe persistent asthma, uncomplicated
J45.51: Severe persistent asthma with (acute) exacerbation
J45.52: Severe persistent asthma with status asthmaticus
J45.901: Unspecified asthma with (acute) exacerbation
J45.902: Unspecified asthma with status asthmaticus
J45.909: Unspecified asthma, uncomplicated
J45.991: Cough variant asthma
J45.998: Other asthma

APM-E—Metabolic Monitoring for Children and Adolescents on Antipsychotics

Population: Commercial, Medicaid

ECDS Measure

Description

The percentage of members 1–17 years of age who had two or more antipsychotic prescriptions and had metabolic testing.

Three rates are reported:

- Percentage of children and adolescents on antipsychotics who received blood glucose testing
- Percentage of children and adolescents on antipsychotics who received cholesterol testing
- Percentage of children and adolescents on antipsychotics who received blood glucose and cholesterol testing

Best practice and measure tips

- Order a blood glucose and cholesterol test every year and build care gap alerts in the electronic medical record.
- Measure baseline lipid profiles, fasting blood glucose level and body mass index.
- Test blood glucose and cholesterol at annual checkups or school physicals to reduce additional visits.
- If the medications are dispensed on different dates, even if it is the same medication, test both blood glucose with either a glucose or HbA1c test, and cholesterol with either a cholesterol or an LDL-C test.
- Educate members and caregivers about the:
  - Increased risk of metabolic health complications from antipsychotic medications.
  - Importance of screening blood glucose and cholesterol levels.
- Behavioral health providers:
  - Order blood glucose and cholesterol screening tests for members who do not have regular contact with their PCP and within one month of changing a patient's medication.

Required exclusion

- Members who died during the MY

Measure medications

Common antipsychotic medications

Description	Prescriptions
Miscellaneous antipsychotic agents	■ Aripiprazole ■ Asenapine ■ Brexpiprazole ■ Cariprazine ■ Clozapine ■ Haloperidol ■ Iloperidone ■ Loxapine ■ Lurasidone Hydrochloride ■ Molindone Hydrochloride ■ Olanzapine ■ Pimozide ■ Paliperidone ■ Quetiapine ■ Risperidone ■ Ziprasidone
Phenothiazine antipsychotics	■ Chlorpromazine Hydrochloride ■ Fluphenazine Hydrochloride ■ Perphenazine ■ Thioridazine ■ Trifluoperazine
Thioxanthenes	■ Thiothixene
Long-acting injections	■ Aripiprazole ■ Aripiprazole lauroxil ■ Fluphenazine decanoate ■ Haloperidol decanoate ■ Olanzapine ■ Paliperiodone palmitate ■ Risperiodone

Antipsychotic combination medications

Description	Prescriptions
Psychotherapeutic combinations	■ Fluoxetine/Olanzapine ■ Perphenazine/Amitriptyline Hydrochloride

Prochlorperazine medications

Description	Prescriptions
Phenothiazine antipsychotics	■ Prochlorperazine

Measure codes

Need both an A1C or GLUCOSE and an LDL-C or CHOLESTEROL

Test	CPT code	CPT Category II code
HbA1C lab tests	83036, 83037	3044F, 3046F, 3051F, 3052F
Glucose lab tests	80047, 80048, 80050, 80053, 80069, 82947, 82950, 82951	
LDL-C lab tests	80061, 83700, 83701, 83704, 83721	3048F, 3049F, 3050F
Cholesterol lab test	82465, 83718, 83722, 84478	

BCS-E—Breast Cancer Screening

Population: Commercial, Medicaid, Medicare

ECDS Measure

Description

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

- Dates acceptable from October 1 two years prior to the MY through December 31 of the MY.
- Patient Age is 52–74 years of age by the end of the MY.
- Members 50 years of age reflects look back age of 50 or older on test date.

Best practice and measure tips

- This measure evaluates preventive screening only.
  - Bilateral or unilateral screening mammograms are acceptable.
  - Biopsies, breast ultrasounds or MRIs are not acceptable.
- Educate members on importance of screening mammogram for early detection of breast cancer when there are usually no symptoms.
- Results can be submitted for medical record review throughout year, but medical record review cannot be performed during HEDIS annual audit.
- If documenting a mammogram in a patient's history, specify mammogram and date of service. If unilateral mammogram, you must include documentation of unilateral mastectomy. If the date is unknown, year only is acceptable. The result is not required.
- Submit the appropriate ICD-10 diagnosis code that reflects a patient's history of bilateral mastectomy (Z90.13).
- Attempt to obtain reports for patient-reported screening. Note place of service if unable to obtain report.

Required exclusions

- Hospice; Palliative care; Members who died in MY
- Frailty and advanced illness
- Living in long-term care
- (History of) bilateral mastectomy
- Unilateral mastectomy with a bilateral modifier
- Any combination of codes that indicate a mastectomy on both the left and right sides on the same or different dates of service
- Any combination of the following that indicate a mastectomy on both the left and right side:
  - absence of the left or right breast
  - unilateral mastectomy with a left-side modifier
  - unilateral mastectomy with a right-side modifier
  - left unilateral mastectomy

Measure codes

	CPT codes	ICD10CM codes	ICD10PCS (ICD9PCS) codes
Mammography	77061–63, 77065–67		
Mastectomy	19180, 19200, 19220, 19240, 19303, 19304, 19305, 19306, 19307	Z90.13 Acquired absence of bilateral breasts and nipples	0HTV0ZZ, 0HTU0ZZ, 0HTT0ZZ (85.42, 85.44, 85.46, 85.48)

BPD*—Blood Pressure Control for Members with Diabetes

Population: Commercial, Medicaid, Medicare

Hybrid Measure

Description

Percentage of members aged 18–75 with Diabetes (type 1 or type 2) whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the MY.

- Representative BP: The most recent reading during the MY (last BP of the year).

Best practice and measure tips

See CBP Measure for tips.

Required exclusions

- Hospice
- Palliative careMembers who died during the MY
- Frailty and advanced illness
- Frailty (81 years of age and older)
- Living in long-term care

Medication list

See Appendix C.

Measure codes

Refer to Appendix B for code combinations to identify follow-up visits: Outpatient visits and non-acute inpatient visits.

	CPT Category II
Diastolic less than 80	3078F
Diastolic 80–89	3079F
Diastolic greater than/equal to 90	3080F
Systolic less than 130	3074F
Systolic 130–139	3075F
Systolic greater than/equal to 140	3077F

CBP*—Controlling High Blood Pressure

Population: Commercial, Medicaid, Medicare

Hybrid Measure

Description

Members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (systolic and diastolic both LESS THAN 140/90 mm HG) during the MY.

- Representative BP: The most recent reading (last BP of the year) during the MY on or after the second diagnosis of HTN (system calculates).

Best practice and measure tips

- If initial BP is >/= 140/90, retake the patient's BP after they've had time to rest. If remains elevated, ensure patient follows up for BP check.
  - Since the last BP in the year is used, have patient follow up for elevated BPs prior to the end of the year or follow Guidelines for Patient-Reported BP Readings if a visit is not possible.
- Allow patient to rest for at least five minutes before taking the BP. Select appropriately sized BP cuff and place cuff on bare arm.
- Ensure patient is seated with feet on the floor, back supported and arm supported at heart level.
- If office uses manual blood pressure cuffs, do not round up the BP reading.

Multiple BPs on same date of service

- It is preferred to not average BP since the lowest systolic and lowest diastolic are to be used.
- If multiple BP readings are noted in the chart on the same date, the lowest systolic and lowest diastolic BP result will be used.
- If the only BP is an average BP, if it is documented "average BP today: 139/70," it is eligible for use.

Guidelines for patient-reported BP readings documented in the medical record

- Must indicate date BP was taken.
- May obtain BP during telephone visits, e-visits or virtual check-ins. Have members take BP prior to visit to report during visit.
- MyChart communications with BPs reported must indicate date taken.
- There is no requirement there be evidence that the BP was collected by a PCP or specialist.

BP readings taken the same day patient receives a common low-intensity or preventive procedure can be used

Examples include:

- Eye exam with dilating agents
- Injections (allergy, Depo Provera®, insulin, lidocaine, steroid, testosterone toradol, or vitamin B-12)
- Intrauterine device (IUD) insertion
- Tuberculosis (TB) test
- Vaccinations
- Wart or mole removal
- Fasting blood tests

Do not include BP readings:

- Taken during an acute inpatient stay or an ED visit.
- Taken on the same day as a diagnostic test or procedure that requires a medication regimen, change in diet or medication on or one day before the day of the test or procedure, with the exception of fasting blood tests.
  - Examples include, but are not limited to: colonoscopy, dialysis, infusions, chemotherapy, nebulizer treatment with albuterol.
- Taken by the patient using a non-digital device such as with a manual blood pressure cuff and a stethoscope.

Required exclusions

- Hospice
- Palliative care
- Members who died during the MY
- Frailty and advanced illness
- Frailty (81 years of age and older)
- Living in long-term care
- Dialysis
- End-stage renal disease (ESRD)
- Kidney transplant
- Members with a diagnosis of pregnancy
- Nephrectomy
- Non-acute inpatient admission

Measure codes

	CPT Cat II code
Diastolic less than 80	3078F
Diastolic 80–89	3079F
Diastolic greater than/equal to 90	3080F
Systolic less than 130	3074F
Systolic 131–140	3075F
Systolic greater than/equal to 140	3077F

CCS—Cervical Cancer Screening

Population: Commercial, Medicaid

Hybrid Measure

Description

Members 21–64 years of age who were recommended for routine cervical cancer screening and were screened for cervical cancer using any of the following criteria:

- Age 21–64 who had cervical cytology performed within the last three years*
- Age 30–64 who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last five years**
- Age 30–64 who had cervical cytology/hrHPV co-testing performed within the last five years**
- Patient Age: 24–64 years of age by the end of the MY
  - 21 years of age reflects look back age of 21 or older on test date

* Three-year look back requires 21 years or older on test date.

** Five-year look back requires 30 or older on test date.

Best practice and measure tips

- Complete test during well-woman OB/GYN visit or screening for STDs.
- Use correct diagnosis and procedure codes.
- Include date and results on all tests.
- Request results for tests performed by another provider.
- Review and document your patient's surgical and preventive screenings history with results.

Acceptable

- Patient-reported information documented in the patient's medical record is acceptable if there is a date and result of the test or a date of the hysterectomy and acceptable documentation of no residual cervix—it must be logged in the patient's chart by a care provider.
- Generic documentation of "HPV test" can count as evidence of hrHPV test.
- Lab results that indicate sample contained "no endocervical cells" may be used if a valid result was reported for test.

Not acceptable

- Biopsies or lab results that indicate inadequate sample or no cervical cells.
- Biopsies are considered diagnostic and do not meet the measure requirement.
- Referral to OB/GYN alone does not meet the measure.
- hrHPV test: DNA reflex test ordered; test not performed.
- Reflex tests are only completed when the initial Pap test is abnormal.

Required exclusions

- Hospice
- Palliative care
- Members who died during the MY
- Members with sex assigned at birth of male
- Hysterectomy: documentation must include the words “total,” “complete,” “radical” or “vaginal”
- Hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix
- Partial hysterectomy can only be used if absence of cervix is documented

Measure codes

	CPT code	HCPCS code	ICD10 code
Cervical cytology lab test	88141–43, 88147–48, 88150, 88152–53, 88164–67, 88174–75	G0123, G0124, G0141, G0143, G0144, G0145, G0147, G0148, P3000, P3001, Q0091	
HPV tests	87624, 87625	G0476	
Hysterectomy with no residual cervix	57530, 57531, 57540, 57545, 57550, 57555, 57556, 58150, 58152, 58200, 58210, 58240, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290–58294, 58548, 58550, 58552–58554, 58570–58573, 58575, 58951, 58953, 58954, 59856, 59135		0UTC0ZZ, 0UTC4ZZ, 0UTC7ZZ, 0UTC8ZZ
Absence of cervix diagnosis			Q51.5, Z90.710, Z90.712

CHL—Chlamydia Screening in Women

Population: Commercial, Medicaid

Administrative Measure

Description

Women 16–24 years of age who were identified as sexually active and had at least one test for chlamydia during the MY.

Best practice and measure tips

- Chlamydia screening may not be captured via claims if the service is performed and billed under prenatal and postpartum global billing.
- May be either urine analysis or vaginal swab from the same ThinPrep used for the Pap smear. Samples must be sent to the lab vendor for analysis.
- Note should indicate the date the test was performed and the result or finding.

Required exclusions

- Hospice
- Members who died during the MY
- If a patient qualified for the measure from a pregnancy test alone, they'll be excluded if they have one of the following on the date of the pregnancy test or six days after the pregnancy test:
  - a prescription for isotretinoin (retinoid medications)
  - an X-ray

Measure codes

	CPT code
Chlamydia screening test	87110, 87270, 87320, 87490–92, 87810, 0353U

CIS*—Childhood Immunization Status

Population: Commercial, Medicaid

Hybrid Measure

Description

The percent of children who receive the immunizations in the chart on the next page by their second birthday.

Best practice and measure tips

- Must be done by second birthday—when scheduling, check calendar and schedule prior to second birthday.
- Document the first Hep B vaccine given at the hospital or at birth when applicable (one can be newborn between date of birth and 7 days). If unavailable, provide the name of hospital where child was born.
- The below count towards compliance for the vaccine.
  - Document with event date:
    - For DTaP: encephalitis due to the vaccine
    - Anaphylactic reactions due to any vaccine
    - For hepatitis B, MMR, VZV and hepatitis A: documented history of the illness
- **Document any parent refusal for immunizations, as well as anaphylactic reactions.**

Acceptable documentation

- A certificate of immunization prepared by an authorized healthcare provider or agency including the specific dates and types of immunizations administered.
- A note indicating the name of the specific antigen and immunization.
- A note in the medical record indicating the patient received the immunization “at delivery” or “in the hospital”—use the date of birth as the date administered.
- For combination vaccinations that require more than one antigen (DTaP, MMR), evidence of all antigens must be documented. LAIV only counts if administered ON the second birthday.

Not acceptable

- A note the “patient is up to date” with all immunizations but does not list the dates and names of all immunizations.
- Vaccines documented as adult.

Required exclusions

- Hospice
- Members who died during the MY
- HIV
- Immunodeficiency
- Intussusception
- Lymphoreticular cancer, multiple myeloma or leukemia
- Severe combined immunodeficiency

Immunizations

Vaccine	Doses	Measurement Period
DTaP	4	42 days–2nd birthday
Pneumococcal Conjugate (PCV)	4	
HiB	3	
IPV	3	
Rotavirus	2 or 3	
VZV	1	On or between 1st and 2nd birthdays
MMR	1	
Hepatitis A	1	
Hepatitis B	3	On or before 2nd birthday
Influenza	2	6 months–2nd birthday

Measure codes

	CPT code	CVX code	HCPCS code	ICD10 code
DTAP	90697, 90698, 90700, 90723	20, 50, 106, 107, 110, 120, 146		
HIB	90644, 90647, 90648, 90697, 90698, 90748	17, 46, 47, 48, 49, 50, 51, 120, 146, 148		
Hep B	90697,90723, 90740, 90744, 90747, 90748	08, 44, 45, 51, 110, 146	G0010	B16.0, B16.1, B16.2, B16.9, B17.0, B18.0, B18.1, B19.10, B19.11 3E0234Z (ICD10PCS)
IPV	90697, 90698, 90713, 90723	10, 89, 110, 120, 146		
MMR	90707, 90710	03, 94		B06.00 B06.02, B06.09, B06.81, B06.82, B06.89, B06.9, B26.0–B26.3, B26.81–B26.85, B26.89, B26.9
Pneumococcal Conjugate PCV	90670, 90671	109,133, 152, 215	G0009	
Varicella VZV	90710, 90716	21, 94		B01.0, B01.11, B01.12, B01.2, B01.81, B01.89, B01.9, B02.0, B02.1, B02.21– B02.24, B02.29–B02.34, B02.39, B02.7, B02.8, B02.9
Hep A	90633	31, 83, 85		B15.0, B15.9
Influenza	90655, 90657, 90661, 90673, 90674, 90685– 90689, 90756 (LAIV—90660, 90672)	88, 140, 141, 150, 153, 155, 158, 161, 171, 186 (LAIV—111, 149)	G0008	
Rotavirus 2-dose 3-dose	 90681 90680	 -- 116, 122		

COA—Care for Older Adults

Population: Medicare Special Needs Plan only

Hybrid Measure

Description

The percentage of adults 66 years of age and older who had each of the following during the MY:

- Medication review (provider type must be a prescribing practitioner or clinical pharmacist)
- Functional status assessment*
- Pain assessment*

* The Functional Status Assessment and Pain Assessment indicators do not require a specific setting, therefore services rendered during a telephone visit, e-visit or virtual check-in meet criteria.

Best practice and measure tips

Medication review

Needs **both** a medication list and a medication review during the same visit with the appropriate provider.

- Review and list patient medications in the medical record: May include medication names only or may include medication names, dosages and frequency, over-the-counter (OTC) medications and herbal or supplemental therapies.
- Include a signed and dated medication list for the MY in the medical record—the practitioner's signature is considered evidence that the medications were reviewed.
- Complete at least one medication review.
- Include medication list in the medical record.
- Include transitional care management services during the MY.
- A medication review performed without the patient present meets criteria.

Not acceptable for medication review

- Review of side effects for a single medication at time of prescription.
- Medication lists or reviews performed in an acute inpatient setting.

Functional status assessment

A set of structured questions that elicit patient information may be helpful and may include person-reported outcome measures, screening or assessment tools or standardized questionnaires.

- A complete functional status assessment must include one of the following:
  - Note that activities of daily living (ADL) or instrumental activities of daily living (IADL) were assessed.
  - Note that at least five of the following were assessed: bathing, dressing, eating, transferring (getting in and out of chairs), using toilet, walking.
  - Note that 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:
  - 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)
  - 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
  - SF-36®
  - Patient-reported outcome measurement information system (PROMIS) global or physical function scales
- Document a complete functional status assessment in the medical record, as well as the date when it was performed.
- The components of the functional status assessment may take place during separate visits within the MY.

Not acceptable for functional status assessment

- A functional status assessment limited to an acute or single condition, event, or body system (lower back, leg) does not meet criteria for a comprehensive functional status assessment.
- Do not include comprehensive functional status assessments performed in an acute inpatient setting.

Pain assessment

- 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

Not acceptable for pain assessment

- Do not include pain assessments performed in an acute inpatient setting.
- Notation alone of a pain management plan does not meet criteria.
- Notation alone of a pain treatment plan does not meet criteria.
- Notation alone of screening for chest pain or documentation alone of chest pain does not meet criteria.

Required exclusions

- Hospice
- Members who died during the MY

Measure codes

Measure	CPT Code	CPT II Code	HCPCS Code
Medication review	90863, 99483, 99605, 99606	1160F	
Medication list		1159F	G8427
Transitional care management services	99495, 99496		
Functional status assessment	99483	1170F	G0438, G0439
Pain assessment		1125F, 1126F	

COL-E*—Colorectal Cancer Screening

Population: Commercial, Medicaid, Medicare

ECDS Measure

Description

Members aged 45–75 who received appropriate screening for colorectal cancer. Any of the following meet criteria:

- Fecal occult blood test (FOBT) during the MY
- gFOBT (guaiac) or FIT/iFOBT (immunochemical)
- Stool DNA Test (sDNA) with FIT test (Cologuard) during the MY or two years prior
- Flexible sigmoidoscopy during the MY or the four years prior
- CT Colonography (virtual colonoscopy) during the MY or the four years prior
- Colonoscopy (also known as lower endoscopy) during the MY or the years prior

Best practice and measure tips

- Document the screening test and result.
  - **NOTE**: Result is not required if documentation is part of the medical record and clearly indicates type of screening that was completed. If screening test was merely ordered and not completed the documentation will be insufficient.
- Recommend a different screening if a patient refuses or can't tolerate a colonoscopy.
- Always include a date of service and place of service if known.
- Patient refusal will not make them ineligible for this measure.

NOTE: A Stool DNA with FIT test is a Cologuard. A FIT test is the FOBT immunochemical test. They are not the same.

Acceptable

- Fecal occult blood test during the measurement period. This may include guaiac and immunochemical tests
- Stool DNA (sDNA) with FIT test during the measurement period or the 2 years prior to the measurement period.
- Flexible sigmoidoscopy during the measurement period or the 4 years prior to the measurement period.
- CT colonography during the measurement period or the 4 years prior to the measurement period.
- Colonoscopy during the measurement period or the 9 years prior to the measurement period.

Not acceptable

- Tests performed in an office setting or from any specimen collected during a digital rectal exam (DRE)
- CT scan of the abdomen and pelvis
- Unclear documentation in medical record as "COL" or "COLON 20XX" by provider without mention of the actual screening test completed

Required exclusions

- Hospice
- Palliative care
- Members who died during the MY
- Frailty and advanced illness
- Living in long-term care

Exclusion codes

Any time in a patient's history through December 31 of the MY, submit ICD-10 diagnosis code on any visit claim:

Exclusion	CPT	ICD-10
Total colectomy	44150–44153, 44155–44158, 44210–44212	0DTE0ZZ, 0DTE4ZZ, 0DTE7ZZ, 0DTE8ZZ
Colorectal cancer		C18.0–C18.9, C19, C20, C21.2, C21.8, C78.5, Z85.038, Z85.048

Measure codes

Test	CPT	HCPCS
Colonoscopy	44388–44394, 44401–44408, 45378–45392, 45384-45386, 45388-45393, 45398	G0105, G0121
Flexible sigmoidoscopy	45330–45335, 45337, 45338, 45340–45342, 45346, 45347, 45349, 45350	G0104
FOBT lab test **Guaiac Test (gFOBT)** **FIT Test Immunochemical (iFOBT/FIT)**	 82270 82274	 G0328
Computed tomography (CT) colonography	74261–74263	
Stool DNA with FIT Test	81528 This code is specific to the Cologuard® FIT-DNA test.	G0464 This code was retired and replaced with CPT code 81528

COU—Risk of Continued Opioid Use

Population: Commercial, Medicaid, Medicare

Administrative Measure

Description

The percentage of members 18 years of age and older who have a new episode of opioid use that puts them at risk for continued opioid use. Two rates are reported:

- The percentage of members with at least 15 days of prescription opioids in a 30-day period
- The percentage of members with at least 31 days of prescription opioids in a 62-day period

NOTE: A lower rate indicates better performance.

* New episodes of opioid use are captured from November 1 of the year prior to the MY through October 31 of the MY (Intake Period).

Best practice and measure tips

- Since measure is an inverse measure, a lower rate is desirable. The measure can assist in identifying members with potential opioid use disorder.
- Review patient records and outreach to members as appropriate.
- If members are in the numerator for continued opioid use at 30 days, please take steps to conclude their use of opioids by 62 days.
- The measure utilizes pharmacy claims data for opioid medications filled.
- Members are included in measure once a dispensing event for an opioid medication occurs during the Intake Period.
- All of the medications listed in the Opioid Medications Table are used to identify opioid medication dispensing events to identify same or different drugs. Use the medication lists specified for the measure in the table.
- Drugs in different medication lists are considered different drugs. For example, a dispensing event from the Acetaminophen Codeine Medications List is considered a different drug than a dispensing event from the Codeine Sulfate Medications List.

The following opioid medications are excluded from this measure:

- Injectables
- Opioid-containing cough and cold products
- Single-agent and combination buprenorphine products used as part of medication-assisted treatment of opioid use disorder (buprenorphine sublingual tablets, buprenorphine subcutaneous implant and all buprenorphine/naloxone combination products)
- Methadone for the treatment of opioid use disorder
- Ionsys (fentanyl transdermal patch)
  - For inpatient use only and only through a restricted program under a Risk Evaluation and Mitigation Strategy (REMS)

Required exclusions

Any of the following during the 12 months prior to the earliest prescription dispensing date:

- Hospice
- Palliative care
- Members who died during the MY
- Cancer
- Sickle cell disease

Exclusion codes

Exclusion	ICD-10 code
Cancer	C codes range from C00.0–C96.Z, Z85.xxx, Z86.xxx *(Note: not all diagnosis codes are included)*
Sickle Cell Diseases	D57.00– D57.03, D57.09, D57.1, D57.20, D57.211–D57.213, D57.218, D57.219, D57.40, D57.411–D57.413, D57.418, D57.419, D57.42, D57.431–D57.433, D57.438, D57.439, D57.44, D57.451–D57.453, D57.458, D57.459, D57.80, D57.811–D57.813, D57.818, D57.819

Measure medications

Prescription	Medication lists
Benzhydrocodone	■ Acetaminophen Benzhydrocodone
Buprenorphine (transdermal patch and buccal film)	■ Buprenorphine
Butorphanol	■ Butorphanol
Codeine	■ Acetaminophen Butalbital Caffeine Codeine ■ Aspirin Butalbital Caffeine Codeine ■ Codeine Sulfate ■ Acetaminophen Codeine ■ Aspirin Carisoprodol Codeine
Dihydrocodeine	■ Acetaminophen Caffeine Dihydrocodeine
Fentanyl	■ Fentanyl
Hydrocodone	■ Acetaminophen Hydrocodone ■ Hydrocodone ■ Hydrocodone Ibuprofen
Hydromorphone	■ Hydromorphone
Levorphanol	■ Levorphanol
Meperidine	■ Meperidine
Methadone	■ Methadone
Morphine	■ Morphine
Opium	■ Belladonna Opium ■ Opium
Oxycodone	■ Acetaminophen Oxycodone ■ Aspirin Oxycodone ■ Ibuprofen Oxycodone ■ Oxycodone
Oxymorphone	■ Oxymorphone
Pentazocine	■ Naloxone Pentazocine
Tapentadol	■ Tapentadol
Tramadol	■ Acetaminophen Tramadol ■ Tramadol

CWP—Appropriate Testing for Pharyngitis

Population: Commercial, Medicaid, Medicare

Administrative Measure

Description

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

- A higher rate indicates appropriate testing and treatment.

Best practice and measure tips

- This measure addresses appropriate treatment for pharyngitis with a strep test and, if appropriate, prescription of an antibiotic within three days of the test.
- A pharyngitis diagnosis can be from an outpatient visit, online assessment, telehealth visit, emergency department or observation visit between July 1 of the year prior to the MY and June 30 of the MY.

Required exclusions

- Hospice
- Members who died during the MY
- 12 months prior to or on the episode date diagnosis of one of the below:
  - COPD
  - Emphysema
  - Disorders of the immune system
  - HIV
  - Malignant neoplasms
  - Other malignant neoplasms of the skin

Measure codes

	CPT code	ICD-10 code
Group A strep test	87070–71, 87081, 87430, 87650–52, 87880	
Pharyngitis		J02.0, J02.8, J02.9, J03.00, J03.01, J03.80–81, J03.90–91

Measure medications

The following antibiotic medications, in conjunction with a strep test, will meet compliance for this measure:

Description	Prescriptions			
Aminopenicillins	■ Amoxicillin	■ Ampicillin		
Beta-lactamase inhibitors	■ Amoxicillin-clavulanate			
First generation cephalosporins	■ Cefadroxil	■ Cefazolin	■ Cephalexin	
Folate antagonist	■ Trimethoprim			
Lincomycin derivatives	■ Clindamycin			
Macrolides	■ Azithromycin	■ Clarithromycin	■ Erthromycin	
Natural penicillins	■ Penicillin G Benzathine	■ Penicillin G Potassium	■ Penicillin G Sodium	■ Penicillin V Potassium
Quinolones	■ Ciprofloxacin	■ Levofloxacin	■ Moxifloxacin	■ Ofloxacin
Second generation cephalosporins	■ Cefaclor	■ Cefprozil	■ Cefuroxime	
Sulfonamides	■ Sulfamethoxazole-trimethoprim			
Tetracyclines	■ Doxycycline	■ Minocycline	■ Tetracycline	
Third generation cephalosporins	■ Cefdinir	■ Cefixime	■ Cefpodoxime	■ Ceftriaxone

DSF-E*—Depression Screening and Follow-Up

Population: Commercial, Medicaid, Medicare

ECDS Measure

Description

The percentage of members 12 years of age and older who were screened for clinical depression using a standardized instrument and, if screened positive, received follow-up care within 30 days of the first positive screening.

Best practice and measure tips

Screening tools:

- Acceptable screening tools for members aged 12–17 include: PHQ-9, PHQ-9M, PHQ-2, BDI-FS, CESD-R, EPDS, PROMIS Depression
- Acceptable screening tools for members aged 18+ include: PHQ-9, PHQ-2, BDI-FS, BDI-II, CESD-R, DADS, GDS, EPDS, M-3, PROMIS Depression, CUDOS

Acceptable follow-up visits:

- Outpatient, telephone or virtual check-up
- Depression case management encounter
- Behavioral health encounter

Required exclusions

- Hospice
- Members who received hospice service or died during the MY
- Bipolar disorder
- Members with a history of bipolar disorder
- Depression
- Members with depression

Measure codes

Initial screening:

Screening Test	Screening Code (LOINC)	Positive Finding
PHQ-9	44261-6	>=10
PHQ-9M	89204-2	>=10
PHQ-2	55758-7	>=3
BDI-FS	89208-3	>=8
CESD-R	89205-9	>=17
DUKE-AD	90853-3	>=30
EPDS	99046-5 (aged 12–17) 48544-1 (aged 18+)	>=10 >=10
PROMIS Depression	71965-8	>=60
BDI-II	89209-1	>=20
GDS—Short	48545-8	>=5
GDS—Long	48544-1	>=10
M-3	71777-7	>=5
CUDOS	90221-3	>=31

Compliant Follow-up:

Follow-Up Visit	CPT	HCPCS
Follow-up visit	98960–2, 98966–8, 98970–2, 98980–1, 99078, 99202–5, 99211–5, 99242–5, 99341–2, 99344–5, 99347–50, 99381–7, 99391–7, 99401–4, 99411–2, 99421–3, 99441–3, 99457–8, 99483	G0071, G0463, G2010, G2012, G2250, G2251, G2252, T1015
Depression case management encounter	99366, 99492, 99493, 99494	G0512, T1016, T1017, T2022, T2023
Behavioral health encounter	90791–2, 90832–4, 90836–9, 90845–7, 90849, 90853, 90865, 90867–70, 90875–6, 90880, 90887, 99484, 99492–3	G0155, G0176–7, G0409–11, G0511–2, H0002, H0004, H0031, H0034–7, H0039–40, H2000–1, H2010–20, S0201, S9480, S9484–5

EED*—Eye Exam for Members with Diabetes

Population: Commercial, Medicaid, Medicare

Hybrid Measure

Description

Percentage of diabetic members 18–75 years of age with diabetes (type 1 or type 2) who had a retinal or dilated eye exam.

Provider specialty: ophthalmologist or optometrist

Best practice and measure tips

- Provide patient education on risks of diabetic eye disease and encourage scheduling annual exam.
- Exam must be performed by optometrist or ophthalmologist.
- Prior year exam results must indicate retinopathy was not present.
  - Hypertensive and diabetic retinopathy are managed the same—both require annual exams.
  - Even if there is no evidence of diabetic retinopathy, if there is hypertensive retinopathy the patient needs an annual exam to be compliant.
- A diagnosis of retinopathy or an eye exam with an unknown retinal status requires an annual exam.
- If negative for retinopathy, a bi-annual exam meets criteria.
- Members with bilateral eye enucleation are considered compliant.
- Obtain eye exam reports. Note eye care provider name and demographics in chart if report not available.
- For the dilated or retinal exam, it is best practice to have a bilateral retinal exam unless there is history of a unilateral eye enucleation. In some instances, a unilateral retinal/dilated exam may be used if it meets guidelines for acceptable documentation.
- Examination of macula, vessels and periphery without eye dilation meets criteria for a “retinal exam.”
- A slit-lamp examination must have documentation of dilation or evidence that the retina was examined to be considered compliant.
- Documentation can be in the form of a note or letter prepared by an ophthalmologist, optometrist, PCP or other healthcare professional. It should include: date of service, the test (indicate a dilated or retinal exam) or result, and the provider’s credentials.
  - Documentation example: Last diabetic retinal eye exam with John Smith, OD, was June 2020 with no retinopathy.
- A chart or photograph with date of fundus photography or retinal imaging and one of the following is acceptable:
  - Results read by a qualified reading center or by a system that provides an artificial intelligence (AI) interpretation.
  - Results reviewed by an eye care professional.

Not acceptable

- Routine funduscopic exam without examination of macula, vessels, and periphery
- Documentation of "diabetes without complications"

Required exclusions

- Hospice
- Members who died during the MY
- Living in long-term care
- Palliative care
- Frailty and advanced illness

Measure codes

	CPT/CPT II	HCPCS	ICD-10
Current year dilated retinal screening with evidence of retinopathy	2022F, 2024F, 2026F		
Current year dilated retinal screening without evidence of retinopathy	2023F, 2025F, 2033F		
Prior year dilated negative retinal screening	3072F		
Diabetic eye exam	67028, 67030–31, 67036, 67039–43, 67101, 67105, 67107–08, 67110, 67113, 67121, 67141, 67145, 67208, 67210, 67218, 67220–21, 67227–28, 92002, 92004, 92012, 92014, 92018–19, 92134, 92201–02, 92227–28, 92230, 92235, 92240, 92250, 92260, 99203–05, 99213–15, 99242–45	S0620, S0621, S3000	
Unilateral eye enucleation	65091, 65093, 65101, 65103, 65105, 65110, 65112, 65114		
Unilateral eye enucleation—left			08T1XZZ
Unilateral eye enucleation—right			08T0XZZ
Bilateral modifier	50		

Medication list

Diabetes medications (see BPD Measure) and **Appendix C**.

FUA—Follow-Up After Emergency Department Visit with Substance Use Disorder

Population: Commercial, Medicaid, Medicare

Administrative Measure

Description

The percentage of emergency department (ED) visits among members aged 13 years and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose for which there was a follow-up.

Two rates are reported:

- The percentage of ED visits for which the patient received a follow-up within 30 days of the ED visit (31 total days)
- The percentage of ED visits for which the patient received a follow-up within seven days of the ED visit (eight total days)

Provider specialty: any practitioner

Best practice and measure tips

- Assist members with scheduling an in-person or telehealth visit within seven days.
- Ensure the patient follows up with a behavioral health provider specifically, as primary care visits do not count.
- Educate members on the importance of following up with treatment and the available resources to them.
- The denominator for this measure is based on discharges, not on members. Members may show up in the denominator more than once.
- Time frame for discharges is January 1 through December 1 of the MY.
- Visits that occur on the date of discharge will not count toward compliance.
- This measure focuses on follow-up treatment, which must have a principal diagnosis of mental health disorder or intentional self-harm.
- Visits can occur by outpatient, community mental health center, e-visit or by telehealth.
- Use the same diagnosis for SUD at each follow-up (a non-mental illness diagnosis code will not fulfill this measure).

Required exclusions

- Hospice
- Members who died during the MY

Measure codes—patient included in denominator

Patient is included in denominator with an ED visit (see **Appendix B**) and principal diagnosis of SUD or any diagnosis of drug overdose.

Measure codes—compliant numerator

Generalized Categories	CPT/CPT II code	POS	HCPCS code
BH outpatient visit*	98960–62, 99078, 99202–05, 99211–15, 99242–45, 99341–42, 99344–45, 99347–50, 99381–87, 99391–97, 99401–04, 99411–12, 99483, 99492–94, 99510	52, 53	G0155, G0176–77, G0409, G0463, G0512, H0002, H0004, H0031, H0034, H0036–37, H0039–40, H2000, H2010–11, H2013–20, T1015
Outpatient (visit setting unspecified, outpatient place of service)*	90791–92, 90832–4, 90836–40, 90845, 90847, 90849, 90853, 90875–76, 99221–23, 99231–33, 99238–39, 99252–55	03, 05, 07, 09, 11–20, 22, 33, 49–50, 71–72	
Peer support services			G0177, H0024–25, H0038–40, H0046, H2014, H2023, S9445, T1012, T1016
Opioid treatment services			G2067–77, G2080, G2086–87
Telehealth, telephone or e-visit*	98966–68, 99441–43 98970–72, 98980–81, 99421–23, 99457–58	02, 10	 G0071, G2010, G2012, G2250–52
Substance use disorder or substance use service	99408–09		G0396–97, G0443, H0001, H0005, H0007, H0015–16, H0022, H0047, H0050, H2035–36, T1006, T1012 H0006, H0028
Behavioral health screening or assessment	99408–09		G0396–97, G0442, G2011, H0001–02, H0031, H0049

* Requires either any diagnosis of SUD, Substance Use or Drug Overdose or requires a visit with a qualified mental health provider.

NOTE: ***T1015 HCPCS code which identifies an all-inclusive clinic visit for services rendered at a Federally Qualified Health Center (FQHC).

Medication list

Description	Prescriptions			
Alcohol use disorder	■ Acamprosate Calcium	■ Disulfiram	■ Naltrexone	■ Naltrexone Hydrochloride
Opioid use disorder	■ Buprenorphine	■ Buprenorphine/Naloxone	■ Naltrexone	■ Naltrexone Hydrochloride

FUH—Follow-Up After Hospitalization for Mental Illness

Population: Commercial, Medicaid, Medicare

Administrative Measure

Description

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

Two rates are reported:

- The percentage of discharges for which the patient received follow-up within seven days after discharge.
- The percentage of discharges for which the patient received follow-up within 30 days after discharge.

Provider specialty: mental health practitioner

Best practice and measure tips

- Refer patient to a mental health provider to be seen within seven days of discharge.
- This measure focuses on follow-up treatment, which must be with a mental health provider.
- Mental health practitioner definition was changed to mental health provider and now includes certified community mental health center (CMHC) and certified physician assistant.
- Visits that occur on the date of discharge will not count toward compliance.
- The denominator for this measure is based on discharges, not on members. Members may show up in the denominator more than once.
- Time frame for discharges is January 1 through December 1 of the MY.
- The following visit types do not have to be with a mental health provider to count for numerator compliance: intensive outpatient encounters, partial hospitalizations, community mental health centers and electroconvulsive therapy settings.
- Even members receiving medication from their primary care provider still need post-discharge supportive therapy with a licensed mental health clinician such as a therapist or social worker.
- Telehealth visits with a behavioral health provider are acceptable.
- Behavioral health visits count toward compliance.

Required exclusions

- Hospice
- Members who died during the MY

Measure codes

Generalized categories	CPT code	POS code	HCPCS code
Common visit codes	90791, 90792, 90832–90834, 90836–90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221–99223, 99231–99233, 99238, 99239, 99251–99255	52	
Observation	99217–99220		
Transitional care management	99495, 99496		
BH outpatient visit with mental health practitioner	98960–98962, 99078, 99201–99205, 99211–99215, 99241–99245, 99341–99345, 99347–99350, 99381–99387, 99391–99397, 99401–99404, 99411, 99412, 99483, 99492, 99493, 99494, 99510	52, 53	G0155, G0176, G0177, G0409, G0463, G0512, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, T1015**

NOTE: **T1015 HCPCS code which identifies an all-inclusive clinic visit for services rendered at a Federally Qualified Health Center (FQHC).

FUM—Follow-Up After Emergency Department Visit for Mental Illness

Population: Commercial, Medicaid, Medicare

Administrative Measure

Description

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

Two rates are reported:

- The percentage of ED visits for which the patient received follow-up within 30 days of the ED visit (31 total days)
- The percentage of ED visits for which the patient received follow-up within seven days of the ED visit (eight total days)

Provider specialty: any practitioner

Best practice and measure tips

- Schedule follow-up appointments as soon as possible, especially for members recently discharged from the ED.
- Use the same diagnosis for mental illness at each follow-up (a non-mental illness diagnosis code will not fulfill this measure).
- This measure focuses on follow-up treatment, which must have a principal diagnosis of mental health disorder or intentional self-harm.
- The denominator for this measure is based on discharges, not on members. Members may show up in the denominator more than once.
- Visits that occur on the date of discharge will not count toward compliance.
- Visits can occur by outpatient, community mental health center, e-visit, or by telehealth.
- Electroconvulsive therapy with a principal diagnosis of a mental health disorder meets criteria for a follow-up visit.
- Time frame for discharges is January 1 through December 1 of the MY.

Required exclusions

- Hospice
- Members who died during the MY
- Acute or non-acute inpatient stays that occur on the date of the ED visit or within 30 days after

Measure codes

Generalized Categories	CPT code	POS code	HCPCS code
Common visit codes	90791, 90792, 90832–90834, 90836–90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221–99223, 99231–99233, 99238, 99239, 99251–99255	52	
Observation	99217–99220		
Transitional care management	99495, 99496		
BH outpatient visit with mental health practitioner	98960–98962, 99078, 99201–99205, 99211–99215, 99241–99245, 99341–99345, 99347–99350, 99381–99387, 99391–99397, 99401–99404, 99411, 99412, 99483, 99492, 99493, 99494, 99510	52, 53	G0155, G0176, G0177, G0409, G0463, G0512, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, T1015**

NOTE: **T1015 HCPCS code which identifies an all-inclusive clinic visit for services rendered at a Federally Qualified Health Center (FQHC).

GSD*—Glycemic Status Assessment for Members with Diabetes

(Measure formerly known as HBD)

Population: Commercial, Medicaid, Medicare

Hybrid Measure

Description

Percentage of members 18–75 years of age with diabetes (type 1 or type 2) whose glycemic status (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) was at the following levels during the MY:

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

GSD Poor Control is an inverse measure. A lower rate indicates better performance for this indicator (low rates of poor control indicate better care). For Medicare members a result 9.0 or below is acceptable.

* The most recent = closest to December 31 of MY.

Best practice and measure tips

- Medical record documentation must include a note indicating the date when the assessment/test was performed and the result.
- Always list the date of service and result of the test together.
- Document date of blood draw and results in the vitals section of your progress notes, if applicable. The date of the progress notes will not count.
- If multiple glycemic status assessments were performed in the MY, the last result is required.
- If multiple glycemic status assessment were recorded for a single date, use the lowest result.
- Since the last value in the year is used, have patient repeat an elevated test prior to the end of the year.
- Schedule labs prior to patient appointments to assist with compliance.
- Adjust therapy as indicated to improve glycemic status.

Not acceptable

- Self-tested or not processed by a lab
- Documentation of ranges and thresholds do not meet criteria (example: <9.0%)

Acceptable terminology

- A1c, HbA1c, HgbA1c
- Glycohemoglobin
- Glycohemoglobin A1c
- Glycated hemoglobin
- Glycosylated hemoglobin
- Hemoglobin A1c
- Glucose management indicator (GMI)
- Continuous glucose monitoring (must include the data date range used to derive the value, the terminal date in the range should be used to assign assessment date)

Required exclusions

- Hospice
- Palliative careMembers who died during the MY
- Frailty and advanced illness
- Living in long-term care

Measure codes

	CPT code	CPT Cat II code	LOINC Code (Requires Value)
HbA1c lab test	83036, 83037		17855-8, 17856-6, 4548-4, 4549-2, 96595-4
HbA1c level <7.0		3044F	
HbA1c level >/= 7 and <8		3051F	
HbA1c level >/= 8 and </= 9		3052F	
HbA1c >9.0		3046F	
GMI			97506-0

Medication list

Diabetes medications (see BPD Measure) and Appendix C.

IMA*—Immunizations for Adolescents

Population: Commercial, Medicaid

Hybrid Measure

Description

The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday.

Vaccine	Doses	Measurement Period
Meningococcal conjugate or meningococcal polysaccharide	1	On or between the patient's 11th–13th birthdays
Tetanus, diphtheria toxoids and acellular pertussis	1	On or between the patient's 10th–13th birthdays
Human papilloma virus series	2	On or between the patient's 9th–13th birthdays ***and*** at least 146 days between doses
	3	On or between the patient's 9th–13th birthdays

Best practice and measure tips

- Immunization must occur on or prior to the patient's 13th birthday.
- For the two-dose HPV vaccination series, there must be at least 146 days (five months) between the first and second dose of the HPV vaccine.
- The below count towards compliance—there must be a note indicating the date of the event occurring by the patient's 13th birthday.
  - All vaccines: anaphylaxis; Tdap: encephalitis
- Document any parental refusal for immunizations (this will not exclude the member from this measure)
- Document any anaphylactic reactions

Acceptable documentation

- A note indicating the name of the specific antigen and the date of the immunization
- A certificate of immunization prepared by an authorized healthcare provider or agency including the specific dates and types of immunizations administered

Not acceptable

- A note that the "patient is up to date" with all immunizations, but does not list the dates and names of all immunizations
- Meningococcal recombinant (serogroup B) (MenB) vaccines

Required exclusions

- Hospice; Members who died during the MY

Measure codes

Immunization	CPT	CVX
Meningococcal-serogroup A, C, W and Y	90619, 90733, 90734	32,108, 114, 136, 147, 167, 203
Tdap	90715	115
HPV	90649–90651	62, 118, 137, 165

KED*—Kidney Health Evaluation for Members with Diabetes

Population: Commercial, Medicaid, Medicare

Administrative Measure

Description

Percentage of members 18–85 years of age (as of December 31 of the MY) 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 MY.

Best practice and measure tips

- Educate on how diabetes can affect the kidneys and offer tips to your members 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).
- Requires both an eGFR and a uACR during the MY on the same or different dates of service:
  - Routinely refer members with a diagnosis of diabetes for both eGFR and uACR.
  - A quantitative urine albumin test and a urine creatinine test require service dates four or less days apart.
- Coordinate care with specialists such as an endocrinologist or nephrologist as needed.
- Follow up with members to discuss and educate on lab results.
- Offer education on medications that could be harmful to the kidneys (NSAIDs such as naproxen or ibuprofen).
- Limit protein intake and salt in diet.

Required exclusions

- Hospice
- Palliative care
- Members who died during the MY
- Frailty and advanced illness
- Frailty (81 years of age and older)
- Living in long-term care
- Dialysis
- End-stage renal disease (ESRD)

Measure codes

There is a large list of approved NCQA codes used to identify the services included in the KED measure. The following are a few of the approved codes.

Test	CPT code	LOINC
Estimated glomerular filtration rate lab test	80047, 80048, 80050, 80053, 80069, 82565	102097-3, 50044-7, 50210-4, 50384-7, 62238-1, 69405-9, 70969-1, 77147-7, 94677-2, 98979-8, 98980-6
Quantitative urine albumin lab tests	82043	100158-5, 14957-5, 1754-1, 21059-1, 30003-8, 43605-5, 53530-2, 53531-0, 57369-1, 89999-7
Urine creatinine lab test	82570	20624-3, 2161-8, 35674-1, 39982-4, 57344-4, 57346-9, 58951-5
Urine albumin creatinine ratio (uACR)		13705-9, 14958-3, 14959-1, 30000-4, 44292-1, 59159-4, 76401-9, 77253-3, 77254-1, 89998-9, 9318-7

Medication list

Diabetes medications (see BPD Measure) and **Appendix C**.

LBP*—Use of Imaging Studies for Low Back Pain

Population: Commercial, Medicaid, Medicare

Administrative Measure

Description

Percentage of members 18–75 years of age with a principal diagnosis of uncomplicated low back pain who did not have an imaging study (plain X-ray, MRI or CT scan) within the first four weeks (28 days) of the primary diagnosis.

This measure is reported as an inverted measure.

- A higher score indicates appropriate treatment of low back pain (the proportion for whom imaging studies did not occur).
- Measure exclusions identify members for whom imaging may be clinically appropriate within the first four weeks.
- Visits that resulted in an inpatient visit are not included.

Definitions

- Intake period: Identifies the first eligible encounter with a primary diagnosis of low back pain between January 1–December 3 of the MY.
- Eligible encounter settings include outpatient visits, ED visits, telephone visits, e-visits, virtual check-in visits, physical therapy appointments and osteopathic or chiropractic manipulative treatments.
- Index episode start date (IESD): Used to determine the earliest episode of low back pain.
- Negative diagnosis history: A period of 180 days (six months) prior to the IESD when the patient had no claims/encounters with any diagnosis of low back pain.

NOTE: Members are excluded who have a positive diagnosis history during this timeframe.

****NOTE**: Do not include supplemental data when identifying the eligible population or assessing the numerator. Supplemental data can only be used for required exclusions for this measure.

Best practice and measure tips

- Avoid ordering diagnostic studies within 30 days of a diagnosis of new-onset back pain in the absence of measure exclusions.
- First-line treatment should emphasize conservative measures.
- Provide patient education on cautious and responsible pain relief, activity level, stretching exercises, and use of heat.
- Provide physical therapy referrals, including massage, stretching, strengthening exercises, and manipulation.
- Use correct exclusion codes as applicable.
- Comorbid conditions such as sleep disorders, anxiety or depression should be treated, and psychosocial issues should be addressed.

Required exclusions

- Hospice; Members who died during the MY
- Frailty and advanced illness
- Palliative care

Members with a diagnosis where imaging is clinically appropriate will be excluded. Timeframes for each are noted. Additional codes apply.

Exclusion Category	Medical Condition
Any time during the patient's history through 28 days after the IESD:	■ Cancer ■ HIV ■ Kidney/major organ transplant ■ History of kidney transplant ■ Organ transplant other than kidney ■ Osteoporosis/osteoporosis therapy ■ Fragility fracture ■ Lumbar surgery ■ Spondylopathy
Any time during the 12 months (one year) prior to the IESD through 28 days after the IESD:	■ Neurologic impairment diagnosis ■ Spinal infection diagnosis ■ Members who died during the MY ■ Intravenous drug abuse
Any time during the three months (90 days) prior to the IESD through 28 days after the IESD:	■ Recent trauma diagnosis
Any time during the 366-day period that begins 365 days prior to the IESD and ends on the IESD, where there is 90 consecutive days of corticosteroid treatment:	■ Prolonged use of corticosteroids *When identifying consecutive treatment days, do not count days' supply that extend beyond the IESD. For example, if a patient had a 90-day prescription dispensed on the IESD, there is one covered calendar day (the IESD). (See Measure Medications).*

Measure code categories

Principal diagnosis of uncomplicated low back pain in an outpatient setting:

- Outpatient visit, telephone visit, via interactive audio and video telecommunication system, online assessments, e-visit, or virtual check-in
- Observation visit
- ED visit
- Osteopathic or chiropractic manipulative treatment
- Physical therapy visit

Measure medications

Description	Prescriptions
Corticosteriod	■ Betamethasone/ Betamethasone acetate ■ Cortisone ■ Dexamethasone ■ Hydrocortisone ■ Methylprednisolone ■ Prednisolone ■ Prednisone ■ Triamcinolone
Bisphosphonates	■ Alendronate ■ Alendronate-cholecalciferol ■ Ibandronate ■ Risedronate ■ Zoledronic acid
Other agents	■ Abaloparatide ■ Denosumab ■ Raloxifene ■ Romosozumab ■ Teriparatide

LSC*—Lead Screening in Children

Population: Medicaid

Hybrid Measure

Description

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

Best practice and measure tips

- Educate parents on the importance of screening for lead poisoning. While the child may not be exposed at home, other environments may present a new risk.
- A lead screening questionnaire alone does not meet criteria for this measure. Be sure to order the blood test and make sure it's completed.
- Visit the MD Department of Health website for additional information for providers and parents/caregivers:
  - **https://health.maryland.gov/phpa/OEHFP/EH/Pages/LeadTesting.aspx**

Required exclusions

- Hospice
- Members who died during the MY

Measure codes

Test	CPT code	LOINC
Lead	83655	10368-9, 10912-4, 14807-2, 17052-2, 25459-9, 27129-6, 32325-3, 5671-3, 5674-7, 77307-7

LSC—Lead Screening in Children

Population: Medicaid

MDH Measure

Description

This is a Maryland Department of Health (MDH) lead measure for children aged 12–23 months as of December 31 of the MY (children who turned one during the MY) who meet the following criteria:

- Continuously enrolled 90 or more days in a single HealthChoice MCO during the MY
- Did not unenroll from a HealthChoice MCO before their first birthday
- Assigned to the last HealthChoice MCO in which the child was enrolled for at least 90 days in the MY

Best practice and measure tips

- Educate parents on the importance of screening for lead poisoning. While the child may not be exposed at home, other environments may present a new risk.
- Assessment alone does not meet criteria for this measure. Be sure to order the blood test and be sure it's completed.
- Visit the MD Department of Health website for additional information for providers and parents/caregivers:
  - **https://health.maryland.gov/phpa/OEHFP/EH/Pages/LeadTesting.aspx**

Required exclusions

- Hospice
- Members who died during the MY

Measure codes

Test	CPT code
Lead	83645*, 83655 * Discontinued but is included in the lead value-based purchasing program

MAC*—Medication Adherence for Cholesterol Medication (Statins)

Population: Medicare

Star Measure

Description

Percentage of members aged 18 and older with a prescription for a cholesterol medication (a statin drug) who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.

Best practice and measure tips

Members qualify for the measure with the second fill, but the measurement period starts with the date of the first fill. To be included in the measure, the first fill of medication must occur at least 91 days before the end of the enrollment period. The proportion of days covered (PDC) is the percent of days in the measurement period covered by prescription claims for the same medication or another in its therapeutic category.

Required exclusions

- Hospice
- Members who died during the MY
- Dialysis
- End-stage renal disease (ESRD)

Measure medications

This is a general statin medication list and should not replace the advice or care you provide your members regarding what is optimal to meet their healthcare needs.

Medications			
Amlodipine-Atorvastatin	Ezetimibe-Simvastatin	Lovastatin-Niacin	Pravastatin
Atorvastatin	Fluvastatin	Niacin-Simvastatin	Rosuvastatin
Atorvastatin-Ezetimibe	Lovastatin	Pitavastatin	Simvastatin
Ezetimibe-Rosuvastatin			

MAD*—Medication Adherence for Diabetes Medications

Population: Medicare

Star Measure

Description

Percent of members 18 years of age or older with a prescription for diabetes medications who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.

Best practice and measure tips

Members qualify for the measure with the second fill, but the measurement period starts with the date of the first fill. To be included in the measure, the first fill of medication must occur at least 91 days before the end of the enrollment period.

Measure medications

These classes of diabetes medications are included in this measure:

- Biguanides
- DPP-4 inhibitors
- GLP-1 receptor agonists
- Meglitinides
- SGLT2 inhibitors
- Sulfonylureas
- Thiazolidinediones

Required exclusions

- Hospice
- End-stage renal disease (ESRD)
- Dialysis
- One or more prescriptions for insulin

MAH*—Medication Adherence for Hypertension Medications (RAS Antagonists)

Population: Medicare

Star Measure

Description

Percent of members 18 years of age or older with a prescription for a blood pressure medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.

Best practice and measure tips

Members qualify for the measure with the second fill, but the measurement period starts with the date of the first fill.

Required exclusions

- Hospice
- End-Stage Renal Disease (ESRD)
- Dialysis
- One or more prescription claim for sacubitril/valsartan (Entresto®)

Measure medications

Renin angiotensin system (RAS) antagonist medications include:

- Angiotensin receptor blockers (ARBs)
- Angiotensin-converting enzyme (ACE) inhibitors
- Direct renin inhibitors

To be included in the measure, the first fill of medication must occur at least 91 days before the end of the enrollment period.

OMW—Osteoporosis Management in Women Who Had a Fracture

Population: Medicare

Administrative Measure

Description

The percentage of women 67–85 years of age who suffered a fracture and who had either of the following in the 180 days (six months) after the fracture:

- A bone mineral density (BMD) test
- A prescription for a drug to treat osteoporosis

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

Appropriate testing or treatment for osteoporosis after the fracture is defined by any of the following criteria:

- A BMD test in any setting on the IESD or in the 180-day (six-month) period after the IESD
- A BMD test during the inpatient stay (if the IESD was an inpatient stay)
- Osteoporosis therapy on the IESD or in the 180-day (six-month) period after the IESD
- Long-acting osteoporosis therapy during the inpatient stay (if the IESD was an inpatient stay)
- A dispensed prescription to treat osteoporosis on the IESD or in the 180-day (six-month) period after the IESD

Best practice and measure tips

- Women at risk for osteoporosis should receive a bone density screening every two years.
- Osteoporosis medication must be filled using a patient's Part D prescription drug benefit.
- BMD test must take place within six months of the fracture.
- A referral for a BMD will not make the patient compliant.
- If the fracture resulted in an inpatient stay:
  - A BMD test administered during the stay will make the patient compliant.
  - Long-acting osteoporosis therapy administered during the stay will make the patient compliant.
- Documentation that the medications aren't tolerated is not an exclusion for this measure.
- See members for an office visit as soon as possible after an event.
- To help prevent women from being included in this measure incorrectly, please check that fracture codes are not used before a fracture has been verified through imaging.
- Submit a corrected claim to fix fracture codes submitted in error to remove the patient from measure.

Required exclusions

- Hospice
- Palliative care
- Members who died during the MY
- Frailty and advanced illness
- Frailty (81 years of age and older)
- Living in long-term care

The following will also exclude a patient from the measure:

	Timeframe
BMD test	730 days (two years) prior to the fracture
Osteoporosis therapy	365 days (12 months) prior to the fracture
New or active prescription for medication to treat osteoporosis	365 days (12 months) prior to the fracture

Measure codes

	HCPCS	CPT/CPT II	ICD–10 procedure
Osteoporosis medication therapy	J0987, J1740, J3110, J3111, J3489		
Long-acting osteoporosis medications	J0897, J1740, J3489		
BMD tests		76977, 77078, 77080, 77081, 77085, 77086	BP48ZZ1, BP49ZZ1, BP4GZZ1, BP4HZZ1, BP4LZZ1, BP4MZZ1, BP4NZZ1, BP4PZZ1, BQ00ZZ1, BQ01ZZ1, BQ03ZZ1, BQ04ZZ1, BR00ZZ1, BR07ZZ1, BR09ZZ1, BR0GZZ1

Measure medications

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

PCE—Pharmacotherapy Management of COPD Exacerbation

Population: Commercial, Medicaid, Medicare

Administrative Measure

Description

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

Two rates are reported:

- Dispensed a systematic corticosteroid (or there was evidence of an active prescription) within 14 days of the event
- Dispensed a bronchodilator (or there was evidence of an active prescription) within 30 days of the event

Note: The eligible population is based on acute inpatient discharges and ED visits, not on members. It is possible for the denominator to include multiple events for the same individual.

Best practice and measure tips

- Members with active prescriptions for these medications are administratively compliant with the measure.
  - Active prescription is defined as the "days supply" indicated on the date dispensed is the number of days or more between that date and the episode.
- Follow up with members to make sure any new prescriptions are filled post-discharge.
- The "episode date" for an acute inpatient stay is the admission date.
- The "episode date" for the emergency department visit is the date of service.

Required exclusions

- Hospice
- Members who died during the MY

Measure medications

Systemic corticosteroid medications on or 14 days after the episode date

Description	Prescriptions	
Glucocorticoids	■ Cortisone ■ Dexamethasone ■ Hydrocortisone	■ Methylprednisolone ■ Prednisolone ■ Prednisone

Bronchodilator medications on or 30 days after the episode date

Description	Prescriptions			
Anticholinergic agents	■ Aclidinium bromide ■ Ipratropium	■ Tiotropium ■ Umeclidinium		
Beta-2-agonists	■ Albuterol ■ Arfomoterol ■ Formoterol	■ Indacaterol ■ Levalbuterol ■ Metaproterenol	■ Olodaterol ■ Salmetrol	
Bronchodilator combinations	■ Albuterol-ipratropium ■ Budesonide-formoterol ■ Fluticasone furoate-umeclidinium-vilanterol	■ Fluticasone-salmetrol ■ Fluticasone-vilanterol ■ Formoterol-aclidinium	■ Formoterol-glycopyrrolate ■ Formoterol-mometasone ■ Glycopyrrolate-indacetrol	■ Olodaterol-tiotropium ■ Umeclidinium-vilaneterol

PCR—Plan All-Cause Readmission

Population: Commercial, Medicaid, Medicare

Administrative Measure

Description

For patient 18 years of age and older, the number of acute inpatient and observation stays during the MY that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission.

Note: For commercial and Medicaid, the measure only applies to members 18–64 years of age. The measure is based on acute inpatient and observation stays—a patient may appear in the denominator more than once.

Best practice and measure tips

- Keep open appointments so members who are discharged from the hospital can be seen within seven days of their discharge.
- Obtain and review the patient's discharge summary.
- Obtain any test results that were not available when members were discharged and track tests that are still pending.
- Perform medication reconciliation.
- Ask about barriers or issues that might have contributed to the patient's hospitalization and discuss how to prevent them in the future.
- Schedule an appointment within seven days of discharge or sooner as needed.
- Connect with your state's automated electronic admission, discharge, and transfer (ADT) system to receive admission, discharge, and transfer notifications for your members.
- Consider implementing:
  - A post-discharge process to track, monitor and follow up with members.
- Perform transitional care management for recently discharged members.
- Unplanned readmissions are associated with increased mortality and higher healthcare costs.
- Readmissions can be prevented by standardizing and improving coordination of care after discharge and increasing support for patient self-management.

Required exclusions

- Hospice

Additional exclusionary conditions

Hospital stays where:

- Admission and discharge days are the same
- Patient died during the stay
- Principal diagnosis of perinatal conditions
- Principal diagnosis of pregnancy

Planned hospital stays with any of the following:

- Chemotherapy maintenance
- Rehabilitation
- Potentially planned procedure without a principal acute diagnosis
- Organ transplant

Measure codes

- TCM codes can be billed as early as the date of the face-to-face visit and do not need to be held until the end of the service period to be submitted on a claim.
- Submit an 1111F claim as soon as the reconciliation is complete. It is not necessary to wait for all components of TCM or care-planning services to be met.
- Ensure proper HCC coding on all members. Having members coded to the highest specificity will help capture the complexity of a patient.

PPC—Prenatal and Postpartum Care

Population: Commercial, Medicaid

Hybrid Measure

Description

The percentage of live birth deliveries on or between October 8 of the year prior to the MY and October 7 of the MY. For these members, the measure assesses the following facets of prenatal and postpartum care:

- **Timeliness of prenatal care**: The percentage of deliveries that received a prenatal care visit in the first trimester on or before the enrollment start date or within 42 days of enrollment in the health plan.
- **Postpartum care**: The percentage of deliveries that had a postpartum visit on or between 7–84 days after delivery.

Provider specialty: PCP, OB/GYN, prenatal care provider

Best practice and measure tips

- Services provided during a telephone visit, e-visit or virtual check-in are acceptable for prenatal and postpartum care.
- Birth is still considered a live birth if delivering twins and one was stillborn.
- Members can appear twice in the measure if two separate pregnancies occur during the time frame.
- Services that occur over multiple visits count towards this measure if all services are within the time frame.

Prenatal care visit must have date and one of the following

- A diagnosis of pregnancy (this must be included for PCP visits)
- Documentation indicating the patient is pregnant or references to the pregnancy, for example:
  - Standardized prenatal flow sheet
  - Documentation of LMP, EDD, or gestational age
  - A positive pregnancy test result
  - Documentation of gravidity and parity, complete OB history, or prenatal risk assessment and counseling
- Basic physical obstetrical examination that includes:
  - Auscultation for fetal heart tone
  - Pelvic exam with obstetric observations
  - Measurement of fundus height
- Evidence that a prenatal care procedure was performed, such as:
  - Obstetric panel
  - TORCH antibody panel
  - Rubella antibody test/titer with RH incompatibility (ABO/Rh) blood typing
  - Ultrasound of a pregnant uterus

Not acceptable

- Ultrasound and lab result alone—they must be combined with an office visit with an appropriate provider
- A visit or documentation with a RN alone—it must be associated with appropriate provider's note

Postpartum visit must have date and one of the following

- Notation of postpartum care (including, but not limited to: “postpartum care,” “PP care,” “PP check,” “6-week check” or a preprinted postpartum care form)
- Assessment of weight, BP, abdomen and breasts (breastfeeding is acceptable for evaluation of breasts)
- Perineal or cesarean incision/wound check
- Screening for depression, anxiety, tobacco use, substance use disorder or preexisting mental health disorders
- Pelvic exam (a pap test counts toward PP care as a pelvic exam)
- Glucose screening for women with gestational diabetes
- Documentation of discussion of any of the following topics:
  - Infant care/breastfeeding
  - Resumption of physical activity, intercourse, birth spacing or family planning
  - Sleep or fatigue
  - Attainment of healthy weight

Not acceptable

- Colposcopy alone
- Care in an acute inpatient setting

Required exclusions

- Hospice
- Members who died during the MY

Measure codes

Bundled services

- **Prenatal**: Because bundled service codes are used on the date of delivery, these codes may be used only if the claim form indicates when prenatal care was initiated.
- **Postpartum**: Because bundled service codes are used on the date of delivery, not on the date of the postpartum visit, these codes may be used only if the claim form indicates when postpartum care was rendered.

	CPT/CPT II	HCPCS	ICD-10
Standalone visit for prenatal care	99500, 0500F–0502F	H1000–04	
Prenatal visits	98966–68, 98970–72, 98980–81, 99202–05, 99211–15, 99241–45, 99421–23, 99441–43, 99457–58, 99483	G0071, G0463, G2010, G2012, G2250-52, T1015	
Prenatal bundled services	59400, 59425, 59426, 59510, 59610, 59618	H1005	
Encounter for postpartum care	59400, 59410, 59425, 59426, 59510, 59610, 59614, 59618, 59622	H1005	
Postpartum visits	57170, 58300, 59430, 99501, 0503F	G0101	Z01.411, Z01.419, Z01.42, Z30.430, Z39.1, Z39.2
Postpartum bundled visits	59400, 59410, 59510, 59515, 59610, 59614, 59618, 59622		
Cervical cytology	88141–43, 88147–48, 88150, 88152–53, 88164–67, 88174–75	G0123–24, G0141, G0143–45, G0147–48, P3000, P3001, Q0091	

SNS-E*—Social Need Screening and Intervention

Population: Commercial, Medicaid, Medicare

ECDS Measure

Description

The percentage of members who were screened at least once during the measurement period for unmet food, housing, and/or transportation needs, and received a corresponding intervention within 30 days if they screened positive.

Best practice and measure tips

This is a new measure. Providers should familiarize themselves with measure specifications and applicable screening tools to utilize the compliant screening tool that works best for your organization.

Required exclusions

- Hospice; Members who utilized hospice services or died during the MY

Measure codes

Food insecurity screening tools:

Screening Tool	Screening Tool LOINC Code	Positive Finding LOINC Code
Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool	88122-7, 88123-5	LA28937-0, LA6729-3
American Academy of Family Physicians (AAFP) Social Needs Screening Tool	88122-7, 88123-5	LA28937-0, LA6729-3
American Academy of Family Physicians (AAFP) Social Needs Screening Tool—Short Form	88122-7, 88123-5	LA28937-0, LA6729-3
Health Leads Screening Panel	95251-5	LA33-6
Hunger Vital Sign (HVS)	88124-3	LA19952-3
Protocol for Responding to and Assessing Members' Assets, Risks, and Experiences (PRAPARE)	93031-3	LA30125-1
Safe Environment for Every Kid (SEEK)	95400-8, 95399-2	LA33-6
US Household Food Security Survey (US FFS) US Food Security Survey (US FFS) Household, Adult, and Child; US Child Food Security Survey (US FSS) US Household Food Security Survey—Six-Item Short Form (US FSS)	95264-8	LA30985-8, LA30986-6
We Care Survey	96434-6	LA32-8
WellRx Questionnaire	93668-2	LA33-6

Housing instability and homelessness screening tools:

Screening Tool	Screening Tool LOINC Code	Positive Finding LOINC Code
Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool	71802-3	LA-31994-9, LA-31995-6
American Academy of Family Physicians (AAFP) Social Needs Screening Tool	99550-6	LA33-6
American Academy of Family Physicians (AAFP) Social Needs Screening Tool—Short Form	71802-3	LA-31994-9, LA-31995-6
Children's Health Watch Housing Stability Vital Sign	98976-4,	LA33-6
	98977-2	>=3
	98978-0	LA33-6
Health Leads Screening Panel	99550-6	LA33-6
Protocol for Responding to and Assessing Members' Assets, Risks, and Experiences (PRAPARE)	93033-9	LA33-6
	71802-3	LA30190-5
We Care Survey	96441-1	LA33-6
WellRx Questionnaire	93669-0	LA33-6

Housing inadequacy screening tools:

Screening Tool	Screening Tool LOINC Code	Positive Finding LOINC Code
Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool	96778-6	LA31996-4, LA28580-1, LA31997-2, LA31998-0, LA31999-8, LA32000-4, LA32001-2
American Academy of Family Physicians (AAFP) Social Needs Screening Tool	96778-6	LA32691-0, LA28580-1, LA32693-6, LA32694-4, LA32695-1, LA32696-9, LA32001-2
American Academy of Family Physicians (AAFP) Social Needs Screening Tool—Short Form	96778-6	LA31996-4, LA28580-1, LA31997-2, LA31998-0, LA31999-8, LA32000-4, LA32001-2
Norwalk Community Health Center Screening Tool (NCHC)	99134-9, 99135-6	LA33-6, LA31996-4, LA28580-1, LA31997-2, LA31998-0, LA31999-8, LA32000-4, LA32001-2

Transportation insecurity screening tools:

Screening Tool	Screening Tool LOINC Code	Positive Finding LOINC Code
Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool	93030-5	LA33-6
American Academy of Family Physicians (AAFP) Social Needs Screening Tool	99594-4	LA33-6
American Academy of Family Physicians (AAFP) Social Needs Screening Tool—Short Form	99594-4	LA33093-8, LA30134-3
Comprehensive Universal Behavior Screen (CUBS)	89569-8	LA29232-8, LA29233-6, LA29234-4
Health Leads Screening Panel 1	99553-0	LA33-6
Inpatient Rehabilitation Facility—Patient Assessment Instrument (IRF-PAI) (version 4.0 [CMS Assessment])	93030-5	LA30133-5, LA30134-3
Outcome and Assessment Information set (OASIS) Form (Version E—Discharge from Agency [CMS Assessment]) OASIS Version E—Resumption of Care OASIS Version E—Start of Care	93030-5	LA30133-5, LA30134-3
Protocol for Responding to and Assessing Members' Assets, Risks and Experiences (PRAPARE)	93030-5	LA30133-5, LA30134-3
PROMIS	92358-1	LA30024-6, LA30026-1, LA30027-9
WellRx Questionnaire	93671-6	LA33-6

Acceptable interventions (within 30 days of positive screening):

Social Need Type	CPT	HCPCS
Food insecurity procedures	96156, 96160-1, 97802-4	S5170, S9470
Housing instability procedures	96156, 96160-1	
Homelessness procedures	96156, 96160-1	
Inadequate housing procedures	96156, 96160-1	
Transportation insecurity procedures	96156, 96160-1	

SPC*—Statin Therapy for Members with Cardiovascular Disease

Population: Commercial, Medicaid, Medicare

Administrative Measure

Description

The percentage of males 21–75 years of age and females 40–75 years of age during the MY who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and met the criteria.

The following rates are reported:

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

Best practice and measure tips

The treatment period is defined as the earliest prescription dispensing date in the MY for any statin medication of at least moderate intensity through the last day of the MY.

- Consider prescribing a high- or moderate-intensity statin, as appropriate.
- Patient must use their insurance card to fill one of the statins or statin combination medications through the last day of the MY.
- Educate members: Statin use should always be accompanied by lifestyle modifications focused on diet and weight loss to improve their lipid panel.

Members are identified by event or diagnosis

- **Event**: Any of the following during the year prior to the MY:
  - Discharged from an inpatient setting with a myocardial infarction (MI) on the discharge claim
  - CABG, PCI, or any other revascularization in any setting the year prior to the MY
- **Diagnosis**: Identify members as having ischemic vascular disease (IVD) who met at least one of the following criteria during both the MY and the year prior to the MY:
  - At least one outpatient visit, telephone visit, e-visit or virtual check in with an IVD diagnosis
  - At least one acute inpatient encounter with an IVD diagnosis without telehealth
  - At least one acute inpatient discharge with an IVD diagnosis on the discharge claim

Required exclusions

- Hospice
- Palliative care
- Members who died during the MY
- Frailty and advanced illness
- Living in long-term care

Timeframe	Additional Exclusion criteria
Anytime during the MY or year prior	■ Cirrhosis ■ ESRD ■ Dialysis ■ Dispensed at least one prescription for clomiphene ■ In vitro fertilization ■ Members with a diagnosis of pregnancy
During the MY	■ Myalgia ■ Myositis ■ Myopathy ■ Rhabdomyolysis

Measure medications

To comply with this measure, one of the following medications must have been dispensed:

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

SPD*—Statin Therapy for Members with Diabetes

Population: Commercial, Medicaid, Medicare

Administrative Measure

Description

Percentage of members 40–75 years of age during the MY with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) who met the criteria for the two rates.

- **Received statin therapy**: members who were dispensed at least one statin medication of any intensity during the MY
- **Statin adherence 80%**: members who remained on a statin medication of any intensity for at least 80% of the treatment period

Best practice and measure tips

- Educate members on the importance of statin medication adherence.
- Help members with diabetes understand that the condition increases one's risk of developing heart disease or stroke—and that a statin can help reduce their chance of developing these conditions.
- The treatment period is defined as the earliest prescription dispensing date in the MY for any statin medication of any intensity through the last day of the MY.
- Adherence for the SPD measure is determined by the patient remaining on their prescribed statin medication for 80% of their treatment period.
- Adherence is determined by pharmacy claims data (the plan will capture data each time the patient fills their prescription).

Required exclusions

- Hospice
- Palliative care
- Members who died during the MY
- Frailty and advanced illness
- Living in long-term care

Timeframe	Additional Exclusion criteria
Anytime during the MY or year prior	■ Cirrhosis ■ Dialysis ■ Dispensed at least one prescription for clomiphene ■ ESRD ■ In vitro fertilization ■ Members with a diagnosis of pregnancy
During the year prior to the MY	■ Coronary artery bypass grafting (CABG) ■ Myocardial infarction ■ Other revascularization procedure ■ Percutaneous coronary intervention (PCI)
During the MY	■ Myalgia ■ Myositis ■ Myopathy ■ Rhabdomyolysis
During both the MY and the year prior	■ At least one encounter with a diagnosis of ischemic vascular disease (IVD)

Measure medications

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

SSIAJH*—SSI Adults with Ambulatory Care

Population: Medicaid

MDH Measure

Description

- Disabled (SSI) Adults aged 21–64 years as of December 31 of the MY who meet all of the following criteria during the calendar year:
- Enrolled in a disabled coverage group for 320 or more days
- Enrolled in a single HealthChoice MCO for 320 or more days
- Enrolled in the HealthChoice MCO as of December 31 of the MY
- Had no more than one gap in enrollment of up to 45 days during the MY
- Enrolled in a disabled coverage group on December 31 of the MY
- The disabled coverage groups include the following eligibility categories:
  - SOl: Public assistance to adults
  - SO2: SSI recipients
  - S98: ABD—medically needy
  - H01: HCBS waiver and PACE participants
  - A04: Disabled adults, no Medicare, up to 77% FPL

Best practice and measure tips

This measure excludes:

- Inpatient admissions and emergency department services
- Ambulatory care visits with a behavioral health diagnosis code (mental or chemical dependency); if those visits were covered by the MCO
- Any ambulatory care office visit or any PCP outpatient visit (preventative well visits preferred)

Documentation via claims

This is a Maryland Department of Health (MDH) custom measure and reporting is captured by billing and encounter codes only.

Measure codes

Refer to **Appendix B** for code combinations to identify follow-up visits: urgent care center visits, ambulatory outpatient visits, telephone visits, e-visit/virtual check-ins, outpatient visits, and preferred preventative codes.

SSICJH*—SSI Children with Ambulatory Care

Population: Medicaid

MDH Measure

Description

Disabled (SSI) children from 0–20 years of age as of December 31 of the MY who meet all the following criteria during the calendar year:

- Enrolled in a disabled coverage group for 320 or more days
- Enrolled in a single HealthChoice MCO for 320 or more days
- Enrolled in the HealthChoice MCO as of December 31 of the MY
- Had no more than one gap in enrollment of up to 45 days during the MY

Best practice and measure tips

This measure excludes:

- Inpatient admissions and emergency department services
- Ambulatory care visits with a behavioral health diagnosis code (mental or chemical dependency) if those visits were covered by the MCO
- Any ambulatory care office visit or any PCP outpatient visit (preventative well visits preferred)

Documentation via claims

This is a Maryland Department of Health (MDH) custom measure and reporting is captured by billing and encounter codes only.

Measure codes

Refer to **Appendix B** for code combinations to identify follow-up visits: urgent care center visits, ambulatory outpatient visits, telephone visits, e-visit/virtual check-ins, outpatient visits, and preferred preventative codes.

SUPD—Statin Use in Persons with Diabetes

Population: Medicare

Star Measure

Description

Percentage of members with diabetes from 40–75 years of age who take the most effective cholesterol-lowering drug and received at least one fill of a statin medication in the measurement period.

Members with diabetes definition: Those who have at least two fills of diabetes medications during the MY. To comply with this measure, a patient with diabetes must have a fill for at least one statin or statin combination medication in any strength or dose using their Part D benefit during the MY.

Best practice and measure tips

- Educate members on the importance of statin medications for diabetic members over the age of 40 regardless of LDL levels.
- Prescribe at least one statin medication during the MY to members diagnosed with diabetes.
- Remind members to contact you if they think they are experiencing adverse effects, such as myalgia. Consider trying a different statin that is more hydrophilic or reducing the dose of frequency.
- Medication samples, when given, could interfere with pharmacy claims and produce false non-adherence results.
- This measure overlaps with the **Statin Therapy for Members with Cardiovascular Disease measure.** Members with the ASCVD should be prescribed a moderate- or high-intensity statin.
- This measure overlaps with the **Medication Adherence for Cholesterol (Statins) measure**.

Required exclusions

- Hospice
- Cirrhosis
- Dialysis
- End-stage renal disease (ESRD)
- Lactation and fertility
- Pregnancy
- Pre-diabetes
- Polycystic ovary syndrome
- Rhabdomyolysis and myopathy

Measure medications

This is a general statin medication list and should not replace the advice or care you provide your members regarding what is optimal to meet their healthcare needs.

Medications			
Amlodipine-atorvastatin	Ezetimibe-Simvastatin	Lovastatin-Niacin	Pravastatin
Atorvastatin	Fluvastatin	Niacin-Simvastatin	Rosuvastatin
Atorvastatin-Ezetimibe	Lovastatin	Pitavastatin	Simvastatin
Ezetimibe-Rosuvastatin			

TRC*—Transitions of Care

Population: Medicare

Hybrid Measure (Star Measure)

Description

The percentage of acute and non-acute discharges on or between January 1 and December 1 of MY for members 18 years of age and older.

Four rates are reported:

- ***Notification of inpatient admission**: Documentation of receipt of notification of inpatient admission on the day of admission through two days after the admission (three days total).
- ***Receipt of discharge information**: Documentation of receipt of discharge information on the day of discharge through two days after the discharge (three days total).
- **Patient engagement after inpatient discharge**: Documentation of patient engagement (office visits, visits to the home, telehealth) provided within 30 days after discharge.
- **Medication reconciliation post-discharge**: Documentation of medication reconciliation documented on the date of discharge through 30 days after the discharge (31 days total).

* Administrative reporting is not available for these two indicators.

Best practice and measure tips

Patient must be discharged to home on or by December 1 of the MY to remain in the measure for the episode.

- Members may appear more than once in the MY based on below criteria:
  - An episode ends if the patient remains discharged to home for 31 days. Any admission after this would create a new Admission episode.
  - An episode continues when the first discharge is followed by a readmission or direct transfer to an acute or non-acute inpatient care setting on the date of discharge through 30 days after discharge (31 days total).
  - **Admit date is the date of the first admission.**
  - **Discharge date is the date of the discharge where there are no readmissions or direct transfers within the 31 days total.**
    - Example: Inpatient acute care admits 9/3/MY to 9/10/MY with a transfer to SNF on 9/10/MY and discharged to home 9/20/MY. Admit date = 9/3/MY and discharge = 9/20/MY.
- The medical record must be accessible to the PCP or ongoing care provider to be eligible for use in reporting.
- Only documentation in the outpatient chart meets the intent of the measure, but an outpatient visit is not required.

Inpatient Notification

Documentation sent to the patient's PCP or OCP must include dated evidence of receipt of notification of inpatient admission of the day of admission through two days after admission from one of the following sources:

- Communication between inpatient providers or staff and the patient's PCP or ongoing care provider (phone call, email, fax)
- Communication about admission between ED and the patient's PCP or ongoing care provider (phone call, email, fax)
- Communication about admission to the patient's PCP or ongoing care provider through a health information exchange, an automated admission, or discharge and transfer (ADT) alert system
- Communication about admission with the patient's PCP or ongoing care provider through a shared electronic medical record (EMR) system
  - Received date is not required in a shared EMR system
  - File date, date "in basket" or date information was accessible to PCP/OCP can be used
- Communication about admission to the patient's PCP or ongoing care provider from the patient's health plan
- Indication that the patient's PCP or ongoing care provider admitted the patient to the hospital
- Indication that a specialist admitted the patient to the hospital and notified the patient's PCP or ongoing care provider
- Indication that the PCP or ongoing care provider placed orders for tests and treatments any time during the patient's inpatient stay
- Documentation that the PCP or ongoing care provider performed a preadmission exam or received communication about a planned inpatient admission
  - May be performed/received prior to admission and must be clearly related to the inpatient admission stay

Not acceptable

- Provider sending the patient to the ED
- Documentation that the patient or patient's family notified the patient's PCP or OCP of admission
- Documentation that does not indicate a time frame or date when the documentation was received

NOTE: Admission is defined as the date of the inpatient admission or the date of admission when an observation stay turns into an inpatient admission.

Receipt of discharge information

- Documentation must include all the following:
  - Provider responsible for the patient's care during the inpatient stay
  - Procedures or treatments provided during the inpatient stay
  - Diagnoses at discharge

- Test results or documentation that either test results are pending or no tests pending
- Current medication list
- Instructions for patient care post-discharge

- Discharge information may be included in, but not limited to, a discharge summary, summary of care record or located in structured fields in an EHR

Acceptable documentation

- Instructions for patient care post-discharge given to the PCP, OCP, patient, or family/caregiver
- Discharge instructions that direct the patient to follow up with the PCP
- Even when the PCP or OCP is the discharging provider, required discharge information must be documented in the appropriate medical record on the date of discharge through two days after discharge (received date is not required in a shared EMR system)
- We can utilize file date, date "in basket" or date information was accessible to PCP or OCP
- Documentation that the patient or the patient's family notified the PCP or OCP of discharge
- Documentation that does not indicate a time frame or date when the documentation was received

Patient engagement after inpatient discharge

Documentation in the outpatient medical record must include evidence of patient engagement within 30 days after discharge not including the discharge date. Any of the following meets criteria:

- Outpatient visit, including office visits and home visits
- A telephone visit
- A synchronous telehealth visit with real-time patient-provider interaction using audio and video communication
- E-visit or virtual check-in (asynchronous telehealth with two-way interaction that was not real-time between the patient and provider)
- If patient is unable to communicate with the provider, interaction between the patient's caregiver and the provider meets criteria
- Documentation can come from any outpatient record that the primary care provider (PCP) or ongoing care provider can access

Not acceptable documentation

- Patient engagement on the date of the discharge

Medication reconciliation

Documentation in the outpatient medical record must include evidence of medication reconciliation and the date when it was performed. This indicator assesses whether medication reconciliation occurred and does not attempt to assess the quality of the med list documented, or the process used to document the most recent med list in the chart.

Acceptable documentation

- Documentation of the current medications with a notation the provider reconciled the current and discharge medications
- Documentation of the current medications with a notation that references the discharge medications (no changes in medications since discharge, same medications at discharge, discontinue all discharge medications)
- Documentation of a current medication list, a discharge medication list, and notation that both lists were reviewed on the same date of service
- Documentation of the current medications with evidence that the patient was seen for post-discharge hospital follow-up with evidence of medication reconciliation or review
  - Evidence that the patient was seen for post-discharge hospital follow-up requires documentation that indicates the provider was aware of the patient's hospitalization or discharge
- 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)
- Notation that no medications were prescribed or ordered upon discharge
- The medication list may include medication names only or may include medication names, dosages and frequency

Not acceptable documentation

Documentation of "post-op/surgery follow-up" without a reference to "hospitalization," "admission" or "inpatient stay" does not imply a hospitalization and is not considered evidence that the provider was aware of a hospitalization

Required exclusions

- Hospice
- Members who died during the MY

Measure codes

The following meet criteria for patient engagement

- Outpatient visits
- Telephone visits
- E-visit or virtual check in
- Transitional care management

Refer to **Appendix B** for codes.

The following meet criteria for medication reconciliation:

	CPT	CPT-CAT-II
Medication reconciliation encounter	99483, 99495, 99496	
Medication reconciliation intervention		1111F

UOP—Use of Opioids from Multiple Providers

Population: Commercial, Medicaid, Medicare

Administrative Measure

Description

The percentage of members 18 years of age and older receiving prescription opioids for at least 15 days during the MY who received opioids from multiple providers.

Three rates are reported:

- **Multiple prescribers**: The percentage of members receiving prescriptions for opioids from four or more different prescribers during the MY.
- **Multiple pharmacies**: The percentage of members receiving prescriptions for opioids from four or more different pharmacies during the MY.
- **Multiple prescribers and multiple pharmacies**: The percentage of members receiving prescriptions for opioids from four or more different prescribers and four or more different pharmacies during the MY.

Note: A lower rate indicates better performance for all three rates.

Best practice and measure tips

- Educate members about having opioids prescribed by only one prescriber and receiving them from just one pharmacy.
- Discuss risks with patient of using multiple prescribers.
- Reinforce the treatment plan and evaluate the medication regimen considering presence/absence of side effects, potential costs, clear written instructions for medication schedule, etc.
- Assess medication compliance and inform members regarding the safe use and risks of opioids.
- Encourage the use of a pain management agreement.
- Coordinate care with the patient's other providers.
- Utilize prescription monitoring program before prescribing an opioid.
- Use the lowest dosage of opioids for the shortest length of time possible.
- Identify and address any barriers to patient keeping appointment.
- Understand community resources and educate staff on what is available.
- Provide timely submission of claims.

The following opioid medications are excluded from this measure:

- Injectables
- Opioid-containing cough and cold products
- Single-agent and combination buprenorphine products used as part of medication-assisted treatment of opioid use disorder (buprenorphine sublingual tablets, buprenorphine subcutaneous implant and all buprenorphine/naloxone combination products)
- Methadone for the treatment of opioid use disorder
- Ionsys (fentanyl transdermal patch)
  - This is for inpatient use only and is available only through a restricted program under a Risk Evaluation and Mitigation Strategy (REMS)

Required exclusions

- Hospice
- Members who died during the MY

Measure medications

Prescription	Medication lists
Benzhydrocodone	■ Acetaminophen Benzhydrocodone
Buprenorphine (transdermal patch and buccal film)	■ Buprenorphine
Butorphanol	■ Butorphanol
Codeine	■ Acetaminophen Butalbital Caffeine Codeine ■ Aspirin Butalbital Caffeine Codeine ■ Aspirin Carisoprodol Codeine ■ Codeine Sulfate ■ Acetaminophen Codeine
Dihydrocodeine	■ Acetaminophen Caffeine Dihydrocodeine
Fentanyl	■ Fentanyl
Hydrocodone	■ Acetaminophen Hydrocodone ■ Hydrocodone ■ Hydrocodone Ibuprofen
Hydromorphone	■ Hydromorphone
Levorphanol	■ Levorphanol
Meperidine	■ Meperidine
Methadone	■ Methadone
Morphine	■ Morphine
Opium	■ Belladonna Opium ■ Opium
Oxycodone	■ Acetaminophen Oxycodone ■ Aspirin Oxycodone ■ Ibuprofen Oxycodone ■ Oxycodone
Oxymorphone	■ Oxymorphone
Pentazocine	■ Naloxone Pentazocine
Tapentadol	■ Tapentadol
Tramadol	■ Acetaminophen Tramadol ■ Tramadol

URI—Appropriate Treatment for Upper Respiratory Infection

Population: Commercial, Medicaid, Medicare

Administrative Measure

Description

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

The measure is reported as an inverted rate [1-(numerator/eligible population)]. A higher rate indicates appropriate URI treatment (i.e., the proportion of episodes that did not result in an antibiotic dispensing event.

Best practice and measure tips

- **Do not prescribe an antibiotic for a URI diagnosis only.**
- Educate members on the appropriate use of antibiotics with URI.
- Educate members and their caregivers, that most URIs are caused by viruses that do NOT require antibiotics.
- Educate patient on comfort measures (acetaminophen for fever, rest, extra fluids) and advise patient to call back if symptoms worsen (antibiotic can be prescribed, if necessary, after three days of initial diagnosis).
- Discuss the side effects of taking antibiotics.
- Assess and document the diagnosis with the patient and inform them of appropriate treatment for URI.
- Encourage members to not seek antibiotics for URI diagnosis.
- Prescribe medication to relieve symptoms as applies.
- Arrange for an early follow-up visit, either by a phone call or re-examination.
- If the patient or caregiver insists on an antibiotic, review the absence of bacterial infection symptoms with the patient and educate that antibiotics will not help with viral infections.

Required exclusions

- Hospice
- Members who died during the MY

Measure Codes

- This measure uses administrative claims information to identify members who were diagnosed with uncomplicated URI (without diagnosis codes for bacterial infection and/or co-morbidity) and who were prescribed an antibiotic.
- Submit a claim for all additional competing diagnoses requiring antibiotic therapy on or within three days after the date of claim for URI, using the appropriate code(s).
- Include the date of service for an outpatient or ED visit with only a URI diagnosis and no new or refill antibiotic prescriptions.

	Description	Codes
URI	Acute nasopharyngitis (common cold) Acute laryngopharyngitis Acute URI	J00 J06.0 J06.9
Common Competing Diagnoses	Otitis media Acute sinusitis Pharyngitis Streptococcal tonsillitis, or acute tonsillitis Chronic sinusitis Pneumonia Whooping cough	H66, H67 J01.80, J01.90 A50.03, A54.5 J02.0, J02.8, J02.9, J03.00, J03.01, J03.80, J03.81, J03.90, J03.91 J32, J32.8, J32.9, J35.01, J35.03 J13-J18, J20 A37.00, A37.01, A37.10, A37.11, A37.80, A37.81, A37.90, A37.91

Measure medications

Description	Prescriptions			
Aminoglycosides	■ Amikacin	■ Gentamicin	■ Streptomycin	■ Tobramycin
Aminopenicillins	■ Amoxicillin	■ Ampicillin		
Beta-lactamase inhibitors	■ Amoxicillin-clavulanate	■ Ampicillin-sulbactam	■ Piperacillin-tazobactam	
First-generation cephalosporins	■ Cefadroxil	■ Cefazolin	■ Cephalexin	
Fourth-generation cephalosporins	■ Cefepime			
Lincomycin derivatives	■ Clindamycin	■ Lincomycin		
Macrolides	■ Azithromycin	■ Clarithromycin	■ Erythromycin	
Miscellaneous antibiotics	■ Aztreonam ■ Chloramphenicol	■ Dalfopristin-quinupristin ■ Daptomycin	■ Linezolid ■ Metronidazole	■ Vancomycin
Natural penicillins	■ Penicillin G benzathine ■ Penicillin G benzathine-procaine	■ Penicillin G potassium ■ Penicillin G procaine	■ Penicillin G sodium ■ Penicillin V potassium	
Penicillinase resistant penicillins	■ Dicloxacillin	■ Nafcillin	■ Oxacillin	
Quinolones	■ Ciprofloxacin ■ Gemifloxacin	■ Levofloxacin ■ Moxifloxacin	■ Ofloxacin	
Rifamycin derivatives	■ Rifampin			

Description	Prescriptions		
Second-generation cephalosporin	■ Cefaclor ■ Cefotetan	■ Cefoxitin ■ Cefprozil	■ Cefuroxime
Sulfonamides	■ Sulfadiazine	■ Sulfamethoxazole-trimethoprim	
Tetracyclines	■ Doxycycline	■ Minocycline	■ Tetracycline
Third-generation cephalosporins	■ Cefdinir ■ Cefixime	■ Cefotaxime ■ Cefpodoxime	■ Ceftazidime ■ Ceftriaxone
Urinary anti-infectives	■ Fosfomycin ■ Nitrofurantoin	■ Nitrofurantoin macrocrystals-monohydrate	■ Trimethoprim

W30*—Well-Child Visits in the First 30 Months of Life

Population: Commercial, Medicaid

Administrative Measure

Description

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

The following rates are reported:

- **Well-Child visits in the first 15 months**: Children who turned 15 months old during the MY: six or more well-child visits
- **Well-child visits for age 15–30 months**: Children who turned 30 months old during the MY: two or more well-child visits

Provider specialty: PCP

Best practice and measure tips

- At the new patient visit and every future visit, schedule the next well-child visit appointment.
- Visits must be with a PCP. The PCP does not have to be the practitioner assigned to the child.
- There must be at least two weeks between each well-child visit.
- Assessment or treatment of an acute or chronic condition does not count towards the measure.
- To meet administrative measure requirements, any well-care visit can be done in conjunction with a sick visit, if they are billed appropriately.
- Well-care visits can be performed anytime in the measurement/calendar year.
- For members who are off-track, schedule a catch-up well-child visit appointment for each required evaluation.

How can a provider turn a sick visit into a well visit?

- If provider is seeing a patient for evaluation and management services and all well-child visit components are completed, use one of the following:
  - Modifier 25 is used to indicate a significant and separately identifiable evaluation and management service by the same physician on the same day another procedure or service was performed.
  - Modifier 59 is used to indicate that 2 or more procedures were performed at the same visit, but to different sites on the body.
- Be sure to give additional guidance that is not related to the sick visit.

This measure is based on the American Academy of Pediatrics Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents (published by the National Center for Education in Maternal and Child Health). Visit the **Bright Futures website** for more information about well-child visits.

Required exclusions

- Hospice
- Members who died during the MY

Measure codes

Refer to **Appendix B** for code combinations to identify follow-up visits: Well-Care Visits.

WCC*—Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents

Population: Commercial, Medicaid

Hybrid Measure

Description

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

- BMI percentile documentation (can be BMI percentile plotted on a BMI-for-age growth chart)
- Counseling for nutrition
- Counseling for physical activity

Best practice and measure tips

- BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed rather than an absolute BMI value.
- Services rendered during a telephone visit, e-visit or virtual check-in meet criteria for the Counseling for physical activity or Counseling for nutrition.
- Services count if the specified documentation is present, regardless of the intent of the visit, provider type or place of service.

BMI percentile acceptable documentation

- BMI percentile plotted on an age-growth chart or documented as a value (50th percentile)
- Patient-collected height, weight and BMI percentile if entered into medical record
- Documentation of >99% or <1% meet criteria because a distinct BMI percentile is evident (i.e., 100% or 0%)

BMI percentile unacceptable documentation

- BMI value
- BMI percentile ranges and thresholds

Counseling acceptable documentation

- Discuss current nutrition or physical activity behaviors (eating habits, dieting behaviors, exercise routine, participation in sports activities, exam for sports participation).
- Indicate nutrition or physical activity was addressed.
- Counsel or refer for nutrition or physical activity.
- Provide educational materials during a face-to-face visit.
- Offer advice on nutrition or specifics related to the child's physical activity.
- Provide weight or obesity counseling, including eating disorders. (meets criteria for both counseling).
- Refer to WIC (meets criteria for nutrition only).

Counseling not acceptable documentation

- Physical Exam finding or observation alone (well-nourished) or developmental milestones alone (does not throw a ball)
- Counseling discussion without specific mention of nutrition or physical activity (appetite, healthy lifestyle habits, limits TV, computer time, cleared for gym class)
- Recommendations related solely to screen time, safety (wears helmet or water safety) without specific mention of activity recommendations
- Assessment of an acute or chronic condition (presents with chronic foot pain—unable to run, presents with diarrhea, received instructions for BRAT diet)

Required exclusions

- Hospice
- Members who died during the MY
- Members with a diagnosis of pregnancy during the MY

Measure codes

	ICD-10	CPT	HCPCS
BMI percentile	Z68.51–Z58.54		
Nutrition counseling	Z71.3	97802, 97803, 97804	G0270, G0271, G0447, S9449, S9452, S9470
Physical activity counseling	Z02.5, Z71.82		G0447, S9451

WCV—Child and Adolescent Well-Care Visits

Population: Commercial, Medicaid

Administrative Measure

Description

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

Provider specialty: PCP, OB/GYN

Best practice and measure tips

- Visits must be with a PCP. The PCP does not have to be the practitioner assigned to the child.
- Assessment or treatment of an acute or chronic condition does not count towards the measure.
- Well-care visits can be performed anytime in the measurement/calendar year.
- To meet administrative measure requirements, any well-care visit can be done in conjunction with a sick visit, if they are billed appropriately.

How can a provider turn a sick visit into a well visit?

- If provider is seeing a patient for evaluation and management services and all well-child visit components are completed, use one of the following:
  - Modifier 25 is used to indicate a significant and separately identifiable evaluation and management service by the same physician on the same day another procedure or service was performed.
  - Modifier 59 is used to indicate that 2 or more procedures were performed at the same visit, but to different sites on the body.
- Be sure to give additional guidance that is not related to the sick visit.

Examples:

- Is the child wearing their seatbelt
- Discussion of oral health
- Document home or school life
- Are they participating in a team sport
- Are they adjusting to a new school
- Visit the Bright Futures website for more information about well-child visits
  - https://www.aap.org/en/practice-management/bright-futures

Required exclusions

- Hospice
- Members who died during the MY

Measure codes

Refer to **Appendix B** for code combinations to identify follow-up visits: Well-Care Visits.

Appendix A: Race, Ethnicity and Language Diversity

Race and Ethnicity Diversity for Members (RDM)

Assesses the diversity of race and ethnicity within a specific group or organization. It helps to understand the representation of different racial and ethnic groups within a particular membership (company, institution, or community). This measure is important for evaluating and promoting diversity and inclusivity, which are essential for fostering a more equitable and representative environment. Tracking RDM can highlight areas for improvement and guide initiatives aimed at promoting diversity and inclusion.

Race and Ethnicity Stratification (RES)

New stratifications required for MY24

- Childhood Immunization Status—CIS-E
- Cervical Cancer Screening—CCS-E
- Eye Exams for Diabetic Members—EED
- Follow-Up After Hospitalization for Mental Illness—FUH
- Follow-Up After Emergency Department Visit for Mental Illness—FUM
- Kidney Health Evaluation for Members with Diabetes—KED
- Postpartum Depression Screening and Follow-Up—PDS-E
- Prenatal Depression Screening and Follow-Up—PND-E
- Prenatal Immunization Status—PRS-E

Continued stratifications required from prior years

- Child and Adolescent Well-Care Visits
- Colorectal Cancer Screening
- Controlling High Blood Pressure
- Hemoglobin A1c Control For Members With Diabetes
- Prenatal and Postpartum Care

Report only one of the nine categories for race

- Asian
- American Indian and Alaska Native
- Black or African American
- Native Hawaiian and Other Pacific Islander
- White
- Some other race
- Two or more races
- Asked but no answer
- Unknown

Report only one of the four categories for ethnicity

- Hispanic/Latino
- Not Hispanic/Latino
- Asked but no answer
- Unknown

Language diversity for members (LDM)

Evaluates the diversity of languages spoken within a specific group, organization, or community. It provides insight into the variety of languages represented among the membership, helping to assess inclusivity and representation of linguistic diversity. Tracking LDM can inform initiatives aimed at promoting language accessibility, multicultural understanding, and inclusivity, contributing to a more linguistically diverse and enriched environment.

Spoken language preferred for healthcare: data collection guidance

This information can be gathered through questions such as:

- What language do you feel most comfortable speaking with your clinician or healthcare provider?
- What language do you feel most comfortable speaking with your doctor or nurse?
- In what language do you prefer to receive your medical care?
- In what language do you want us to speak to you?
- What language do you prefer to speak when you come to the medical center?
- What language do you feel most comfortable speaking?

Preferred language for written materials: data collection guidance

This information can be gathered through questions such as:

- In which language would you feel most comfortable reading healthcare information?
- In which language would you feel most comfortable reading medical or healthcare instructions?
- What language should we write [to] you in?
- What is your preferred written language?
- In what language do you prefer to read health-related materials?
- What language do you prefer for written materials?

Other language needs: data collection guidance

This category captures data collected from questions that cannot be mapped to any of the categories above, such as:

- What is the primary language spoken at home?

Appendix B: Measure Codes

The National Committee for Quality Assurance (NCQA) uses a "Value Set Directory" to organize associated codes for each measure. Measure codes listed for each measure are not all inclusive and subject to change based on the current NCQA specifications for each measure. Below are common value sets for quick reference.

Visit type	ICD-10 codes	CPT codes	HCPCS codes
Advanced Illness (most common)	A81.00, A81.01, A81.09, C25.0, C25.1, C25.2, C25.3, C25.4		
Ambulatory Visits		92002, 92004, 92012, 92014, 98966–8, 98970–2, 98980–1, 99202–5, 99211–5, 99241–5, 99304–10, 99315–6, 99318, 99324–8, 99334–7, 99341–5, 99347–50, 99381–7, 99391–7, 99401–4, 99411–2, 99421–3, 99429, 99441–3, 99457–8, 99483	G0071, G0402, G0438–9, G0463, G2010, G2012, G2250–2, S0620–1, T1015
ED visit	[UBREV] 0450–52, 0456, 0459, 0981	99281–85	
Frailty diagnosis or encounter	L89.xxx, M62.50, M62.81, M62.84, W01.xxx, W06–W08.XXX (A,D,S), W10.xxx, W18.xxx, W19.XXX (A,D,S), Y92.199, Z59.3, Z73.6, Z74.01, Z74.09, Z74.1, Z74.2, Z74.3, Z74.8, Z74.9, Z91.81, Z99.11, Z99.3, Z99.81, Z99.89	99504, 99509	G0162, G0299, G0300, G0493, G0494, S0271, S0311, S9123, S9124, T1000–T1005, T1019–T1022, T1030–T1031
Hospice Encounter			G9473–79, Q5003–08, Q5010, S9126, T2042–46
Hospice intervention		99377–99378	G0182
Non-acute inpatient		99304–99310, 99315, 99316	
Online Assessments		98970–2, 98980–1, 99421–3, 99457–8	G0071, G2010, G2012,G2250–2
Outpatient visit		99202–99205, 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**
Palliative care encounter	Z51.5		G9054, M1017

Visit type	ICD-10 codes	CPT codes	HCPCS codes
***Preferred codes– preventative medicine**		99385, 99386, 99395, 99396	
E-visit or virtual check-in		98970–98972, 99421–99423, 99444, 99457	G0071, G2010, G2012, G2061– G2063
Telephone visits		98966– 98968, 99441–99443	
***Urgent care center visits**			S9083, S9088 *(HCPCS "S" code was discontinued but is included in the SSI value-based purchasing program)*
Well-care visits	Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.2, Z00.3, Z01.411, Z01.419, Z02.5, Z76.1, Z76.2	99381–85, 99391–95, 99461	G0438, G0439, S0302, S0610, S0612, S0613

NOTE: *These codes only apply to the SSI measures

NOTE: **T1015 HCPCS code which identifies an all-inclusive clinic visit for services rendered at a Federally Qualified Health Center (FQHC)

Telephone visits modifiers:

- GT: Via interactive audio and video telecommunication system
- 95: Synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system

Appendix C: Diabetes Medication List

Description	Prescriptions			
Alpha-glucosidase inhibitors	■ Acarbose	■ Miglitol		
Amylin analogs	■ Pramlintide			
Antidiabetic combinations	■ Alogliptin-metformin ■ Alogliptin-pioglitazone ■ Canagliflozin-metformin ■ Dapagliflozin-metformin ■ Dapagliflozin-saxagliptin ■ Empagliflozin-linagliptin	■ Empagliflozin-linagliptin-metformin ■ Empagliflozin-metformin ■ Ertugliflozin-sitagliptin ■ Ertugliflozin-metformin ■ Glyburide-metformin	■ Glimepiride-pioglitazone ■ Glipidide-metformin ■ Linagliptin-metformin ■ Metformin-pioglitazone ■ Metformin-repaglinide ■ Metformin-rosiglitazone	■ Metformin-saxagliptin ■ Metformin-sitagliptin
Insulin	■ Insulin aspart ■ Insulin aspart-insulin aspart protamine ■ Insulin degludec ■ Insulin degludec-liraglutide	■ Insulin detemir ■ Insulin glargine ■ Insulin glargine-lixisenatide ■ Insulin glulisine	■ Insulin human inhaled ■ Insulin lispro ■ Insulin lispro-insulin lispro protamine	■ Insulin isophane-human ■ Insulin isophane-insulin regular ■ Insulin regular human
Biguanides	■ Metformin			
Meglitinides	■ Nateglinide	■ Repaglinide		
Glucagon-like peptide-1 (GLP1) agonists	■ Albiglutide ■ Dulaglutide	■ Exenatide ■ Liraglutide	■ Lixisenatide ■ Semaglutide	■ Tirzepatide
Sodium glucose contransporter 2 (SGLT2) inhibitors	■ Canagliflozin	■ Dapagliflozin	■ Empagliflozin	■ Ertugliflozin
Sulfonylureas	■ Chlorpropamide ■ Glimepiride	■ Glipizide ■ Glyburide	■ Tolazamide ■ Tolbutamide	
Thiazolidinediones	■ Pioglitazone	■ Rosiglitazone		
Dipeptidyl peptidase-4 (DDP- 4) inhibitors	■ Alogliptin	■ Linagliptin	■ Saxagliptin	■ Sitagliptin

Appendix D: Quick References

For more information regarding best practices to optimize for HEDIS compliance, please reference the following additional resources, available at our website. Thank you for working together to improve documentation of quality performance.

Quick Reference Guides

- https://provider.carefirst.com/providers/resources/quick-reference-guides.page

6 Easy Online Tools for You

- https://provider.carefirst.com/carefirst-resources/provider/pdf/6-easy-tools-for-you-fast-efficient-online.pdf

Provider Link List

- https://provider.carefirst.com/carefirst-resources/provider/pdf/provider-link-list-cut0345.pdf

Provider Billing Self-Service Guide

- https://provider.carefirst.com/carefirst-resources/provider/pdf/provider-billing-self-service-guide-prd1165.pdf

Provider Product Quick Reference Guide

- https://provider.carefirst.com/carefirst-resources/provider/pdf/provider-quick-reference-guide-cut6010.pdf

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