Quality Measures
HEDIS® Toolkit
Measurement Year 2022

Developed by: QI HEDIS® Team

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE

Contents

What is HEDIS®?

- HEDIS stands for **Healthcare Effectiveness Data and Information Set.**
- 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.
- Required for ongoing NCQA Health Plan accreditation.

HEDIS MY 2022 includes 96 measures across 6 domains of care:

- Effectiveness of Care
- Access/Availability of Care
- Experience of Care
- Utilization and Risk Adjusted Utilization
- Health Plan Descriptive Information
- Measures Reported Using Electronic Clinical Data Systems

How is HEDIS Data Collected?

Depending on the measure, data may be collected through:

- Administrative/claims data
- Supplemental files sent in by the provider during the year
- Medical record reviews
- Measure specifications outline measure description, exclusions and how the data may be collected.

HEDIS MY2022 Highlights

New measures

- Advance Care Planning (ACP)
- Deprescribing of Benzodiazepines in Older Adults (DBO)
- Antibiotic Utilization for Respiratory Conditions (AXR)
- Childhood Immunization Status (CIS-E)
- Immunizations for Adolescents (IMA-E)
- Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E)

Retired measures

- Comprehensive Diabetes Care (CDC)—Medical Attention for Nephropathy and HbA1c Testing indicators
- Antibiotic Utilization (ABX)

Revised measures

- The former Comprehensive Diabetes Care (CDC) measure has been separated into three standalone measures:
  - » Hemoglobin A1c Control for Patients With Diabetes (HBD)
  - » Blood Pressure Control for Patients With Diabetes (BPD)
  - » Eye Exam for Patients With Diabetes (EED)
- The former Mental Health Utilization (MPT) measure was revised to Diagnosed Mental Health Disorders (DMH) and has moved to the Behavioral Health subdomain.
- The former Identification of Alcohol and Other Drug Services (IAD) measure was revised to Diagnosed Substance Use Disorders (DSU) and has moved to the Behavioral Health subdomain.

Language Diversity and Race and Ethnicity (RES) Stratification is now required for the following measures:

- Child and Adolescent Well-Care Visits
- Colorectal Cancer Screening
- Controlling High Blood Pressure
- Hemoglobin A1c Control for Patients With Diabetes
- Prenatal and Postpartum Care
- ***Report only one of the 9 categories for race:***
  - White
  - Black or African American
  - American Indian and Alaska Native
  - Asian
  - Native Hawaiian and Other Pacific Islander
  - Some Other Race
  - Two or More Races
  - Asked but No Answer
  - Unknown
- ***Report only one of the 4 categories for ethnicity:***
  - Hispanic/Latino.
  - Not Hispanic/Latino.
  - Asked but No Answer.
  - Unknown

Language Diversity for Members:

- Spoken language preferred for health care. Data collection guidance. This information can be gathered through questions such as:
  - » What language do you feel most comfortable speaking with your clinician or health care 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 health care information?
  - » In which language would you feel most comfortable reading medical or health care 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?*

Best Practice and Measure Tips: How can I improve 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 member from CCS Measure).
- Information from the medical record must validate all required measure or exclusion components.
- **Each medical record/office note MUST contain:**
  - » Member Name
  - » Date of Birth (DOB)
  - » Date of Service (DOS)
  - » Information on a fax cover sheet cannot be used.
  - » Only completed events count toward HEDIS compliance.
  - » Documentation in a medical record of a diagnosis or procedure code alone does not comply with the numerator criteria.
  - » 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 as long as it is specific enough to determine that the event occurred during the timeframe specified in the measure.
  - » Educate schedulers to review for needed screenings, tests and referrals.
  - » Assist member with scheduling tests. Follow-up to ensure completes ordered screening.
  - » Provide member education on disease process and rationale for tests.
  - » Ask open-ended questions to determine any barriers to care or treatment.
  - » Collaborate with other providers member 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.

Improve Medication Adherence:

- Is treatment appropriate? Should therapy continue? Follow-up to assess how the medication is working.
- Use prescription benefit at the pharmacy. Only prescription fills processed with a member's health plan ID card can be used to measure a member's adherence.
- **Talk with members about:**
  - » Why they are on a medication, the importance of taking medication as prescribed and timely refills. Confirm instructions.
  - » Any barriers? Are there concerns related to health benefits, side effects or cost? Any problems getting medications from pharmacy?
  - » Develop a medication routine with each patient if they are on multiple medications that require them to be taken at different times.
  - » Encourage members to utilize pillboxes or organizers.
  - » Advise members 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.

Measure Exclusions

Exclusions are either Optional or Required. An exclusion will remove a member from the measure denominator based on information captured in claims, encounter, pharmacy, and/or enrollment data.

Optional exclusions: Some measures allow using an exclusion based on measure compliance. If the member is not compliant, the optional exclusion can be used.

Required 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 patients' 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 ages 81 and older as of Dec. 31 of the measurement year who had a diagnosis of frailty in the measurement year (See Frailty Diagnosis Value Set).
- **FRAILITY AND ADVANCED ILLNESS:** Members ages 66–80 as of Dec. 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 ages 66 and older as of Dec. 31 of the measurement year who are either:
  - Enrolled in an Institutional Special Needs Plan (I-SNP).
  - Living long term in an institution

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:

- Telephone visits: Eligible measures will reference the Telephone Visits Value Set and or the Online Assessments Value Set.
  - Telephone Visits Value Set: CPT[1] 98966-98968, 99441-99443
- Telephone Visits Modifiers: GT, 95:
  - GT: Via interactive audio and video telecommunication system
  - 95: Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System
- Telehealth Place of Service (POS) 02:
  - E-visit or virtual check-in (Online Assessments Value Set):
  - CPT: 98970-98972, 99421- 99423, 99444, 99457
  - HCPCS: G0071, G2010, G2012, G2061-G2063
- Outpatient visit (Outpatient Value Set)
  - CPT: 99201-99205, 99211-99215, 99241-99245, 99341- 99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99429, 99455, 99456, 99483
  - HCPCS: G0402, G0438, G0439, G0463, T1015**

- Ambulatory outpatient visit
  - CPT: 92002, 92004, 92012, 92014, 99201-99205, 99211-99215, 99241-99245, 99304-99310, 99315, 99316, 99318, 99324-99328, 99334-99337, 99341-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99429, 99461, 99483
  - HCPCS: G0463, T1015**

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

- Hospice Intervention
  - CPT: 99377-99378
  - HCPCS: G0182
- Palliative Care Encounter
  - G9054 Oncology
  - M1017 Patient admitted to palliative care services
  - Z51.5 Encounter for palliative care
- Frailty Encounter
  - CPT: 99504, 99509
  - HCPCS: G0162, G0299, G0300, G0493, G0494, S0271, S0311, S9123, S9124, T1000, T1001, T1002, T1003, T1004, T1005, T1019, T1020, T1021, T1022, T1030, T1031
- Frailty Diagnosis Value Set
  - [L89.xxx] Pressure ulcer
  - [M62.50] Muscle wasting and atrophy, not elsewhere classified, unspecified site
  - [M62.81] Muscle weakness (generalized)
  - [M62.84] Sarcopenia
  - [W01.0XXA] Fall
  - [W19.XXXA] Unspecified fall, initial encounter
  - [W19.XXXD] Unspecified fall, subsequent encounter
  - [W19.XXXS] Unspecified fall, sequela
  - [Y92.199] Unspecified place in other specified residential institution as the place of occurrence of the external cause
  - [Z59.3] Problems related to living in residential institution
  - [Z73.6] Limitation of activities due to disability
  - [Z74.01] Bed confinement status
  - [Z74.09] Other reduced mobility

  - » [Z74.1] Need for assistance with personal care
  - » [Z74.2] Need for assistance at home and no other household member able to render care.
  - » [Z74.3] Need for continuous supervision
  - » [Z74.8] Other problems related to care provider dependency
  - » [Z74.9] Problem related to care provider dependency, unspecified
  - » [Z91.81] History of falling
  - » [Z99.11] Dependence on respirator [ventilator] status
  - » [Z99.3] Dependence on wheelchair
  - » [Z99.81] Dependence on supplemental oxygen
  - » [Z99.89] Dependence on other enabling machines and devices
- Advanced Illness: there are multiple codes, a few examples:
  - » ICD-10: A81.00, A81.01, A81.09, C25.0, C25.1, C25.2, C25.3, C25.4

HEDIS Terminology

- **Anchor dates:** A measure may require a member to be enrolled and to have a benefit on a specific date.
- **Continuous enrollment:** Specifies the minimum amount of time that a member 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.
- **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. Also referred to as a sub-measure.
- **Eligible Population:** All members who satisfy all specified criteria, including age, continuous enrollment, benefit, event and the anchor date enrollment requirement for the measure.
- **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).

- **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 Annual Project.
  - » **Hybrid Measures:** Data is collected during the Annual Project through medical record reviews, but can also be collected prospectively. Most allow administrative data to be included. For the Annual HEDIS Audit Season, the denominator is a random sample of 411 members. This is created from a health plan's total eligible population by the software following NCQA requirements. The numerator includes data medical and pharmacy claims, encounters, medical record review data and supplemental data.
- **HEDIS Project:** Timeframe during the year when data is collected. There are two Projects:
  - » **Annual Project:** Also referred to as Retrospective. This is required by NCQA as part of Accreditation. For HYBRID Measures, the member population is based on a sample of members from each LOB. Administrative Measures look at the total member population. The Audit timeframe is January to May for data collection.
- **Prospective Project:** Involves data collection for all LOB, for all members for the next Annual Project. The QI HEDIS Team data collection timeframe is June to January. However, throughout the year JHHC prepares for the Annual 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: Commercial, Medicaid (Priority Partners) Medicare (Advantage MD)
- **Measurement Year (MY):** Refers to the year prior to the Reporting Year. NCQA Specifications reference in measure requirements and anchor dates.
- **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. (e.g., For MY2022, the Report Year is 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.
  - » Synchronous telehealth requires real-time interactive audio and video telecommunications.
  - » 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** sometimes referred to as an e-visit or virtual check-in, is not "real-time" but still requires two-way interaction between the member and provider.
  - » Asynchronous telehealth can occur using a patient portal, secure text messaging or email.

Compliance

- Elements which require the last result in the Measurement Year may impact member 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.)
- Member 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 member turns 18 and include service performed during the measurement year when member was 17.) The files must have Auditor approval.

AVOIDANCE OF ANTIBIOTIC TREATMENT FOR ACUTE BRONCHITIS

(AAB) Avoidance of Antibiotic Treatment for Acute Bronchitis

EHP, Priority Partners, and USFHP. Members age 3 months and older.

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 3 days after the episode. Looks at episodes between July 1 of the year prior to the measurement year through June 30 of the measurement year. The measure is reported as an inverted rate: A higher rate indicates appropriate treatment (not prescribed an antibiotic).

Best Practice and Measure Tips

- Denied claims are not included when assessing the numerator, all claims (paid, suspended, pending and denied) must be included when identifying the eligible population.
- Avoid prescribing an antibiotic unless there is a bacterial etiology.
- When antibiotics are needed for a patient with acute bronchitis / bronchiolitis with comorbid conditions: submit codes on the same claim to remove member from measure.
- An episode will not count toward the measure denominator if the member was diagnosed with pharyngitis or a competing diagnosis on or 3 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 a number of 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.

Measure Exclusions

Required Exclusions: Hospice.

An episode for bronchitis/bronchiolitis will not count toward the measure denominator if the member was diagnosed with one of the following conditions during the 12 months prior to or on the event date.

Exclusion Codes Value Set:

- COPD
  - » J44.0, J44.1, J44.9
- Emphysema
  - » J43.0, J43.1, J43.2, J43.8, J43.9
- Disorders of the immune system
  - » D80.0-D81.2, D81.4 , D81.6, D81.7, D81.89, D81.9, D82.0-D82.4, D82.8, D82.9, D83.0, D83.1, D83.2, D83.8, D83.9, D84.0, D84.1, D84.8, D84.81, D84.821, D84.822, D84.89, D84.9, D89.3, D89.810, D89.811, D89.812, D89.813, D89.82, D89.831, D89.832, D89.833, D89.834, D89.835, D89.839, D89.89, D89.9
- HIV B20, Z21
- Malignant neoplasms
  - » C00.0-C00.6, C00.8, C00.9, C01, C02.0-C02.4, C02.8, C02.9, C03.0, C03.1, C03.9, C04.0, C04.1, C04.8, C04.9, C05.0, C05.1, C05.2, C05.8, C05.9, C06.0, C06.1, C06.2, C06.80, C06.89
- Other malignant neoplasms of the skin
  - » *Additional codes apply.*

Measure Codes

- Common differential diagnosis that remove members from measure due to presentation:
  - » Acute suppurative otitis media: H66.xxx
  - » Chronic sinusitis: J32.xxx
  - » Otitis media: H67.xxx
  - » Tonsillitis (chronic and hypertrophy): J35.xxx
  - » Mastoiditis (acute and chronic): H70.xxx
  - » Impetigo: L01.xxx
  - » Acute sinusitis: J01.xxx
  - » Cellulitis and lymphangitis: L03.xxx
  - » Pharyngitis: J02.xxx
  - » Urinary tract infection: N39
  - » Acute tonsillitis: J03.xxx
  - » Acute vaginitis: N76.xxx
  - » Pneumonia: J13.xx-J18.xx

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		
Ketolides	• Telithromycin		
Lincomycin derivatives	• Clindamycin	• Lincomycin	
Macrolides	• Azithromycin • Clarithromycin	• Erythromycin	
Miscellaneous antibiotics	• Aztreonam • Chloramphenicol • Dalfopristin-quinupristin	• Daptomycin • Linezolid • Metronidazole	• Vancomycin
Natural penicillins	• Penicillin G benzathine-procaine • Penicillin G potassium	• Penicillin G procaine • Penicillin G sodium	• Penicillin V potassium • Penicillin G benzathine
Penicillinase resistant penicillins	• Dicloxacillin	• Nafcillin	• Oxacillin
Description	**Prescriptions**		
Quinolones	• Ciprofloxacin • Gemifloxacin	• Levofloxacin • Moxifloxacin	• Ofloxacin
Rifamycin derivatives	• Rifampin		
Second-generation cephalosporin	• Cefaclor • Cefotetan	• Cefoxitin • Cefprozil	• Cefuroxime
Sulfonamides	• Sulfadiazine	• Sulfamethoxazole-trimethoprim	
Tetracyclines	• Doxycycline	• Minocycline	• Tetracycline
Third-generation cephalosporins	• Cefdinir • Cefditoren • Cefixime	• Cefotaxime • Cefpodoxime • Ceftazidime	• Ceftibuten • Ceftriaxone
Urinary anti-infectives	• Fosfomycin • Nitrofurantoin	• Nitrofurantoin macrocrystals-monohydrate • Trimethoprim	

FOLLOW UP CARE FOR CHILDREN PRESCRIBED ADHD MEDICATIONS

(ADD) Follow up Care for Children Prescribed ADHD Medications

EHP, Priority Partners/VBP, and USFHP. Members between 6 and 12 years of age.

Measure evaluates the percentage of members 6-12 years of age with newly prescribed 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 6-12 years of age as of the IPSD (Index Prescription Start Date) with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with practitioner with prescribing authority during the 30-day Initiation Phase.
- **Continuation and Maintenance (C&M) Phase:** percentage of members 6-12 years of age with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase.

Best Practice and Measure Tips

- **Age Clarification:** 6 years as of March 1 of the year prior to the measurement year to 12 years as of the last calendar day of February of the measurement year.
- Timing of scheduled visits is key based on the prescription day supply to evaluate medication effectiveness, any adverse effects and to monitor the patient's progress.
- When prescribing a new ADHD medication for a patient:
  - » Schedule follow-up visits to occur before the refill is given.
  - » Schedule a 30-day, 60-day and 180-day follow-up visit from the initial visit before member leaves office.
  - » Consider scheduling follow-up visit within 14 to 21 days of each prescription.
  - » Consider prescribing an initial two-week supply and follow-up prescriptions to a 30-day supply to ensure patient follow-up.
  - » Only one of the two visits (during days 31–300) may be an e-visit or virtual re-in.

Measure Medications

ADHD Medications

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

Measure Exclusions

Required Exclusions:

- Hospice
- Patients who filled an ADHD prescription 120 days (4 months) prior to the IPSD (Index Prescription Start Date). Applies to only Rate 1 – Initiation phase.
- Patients who had an acute inpatient encounter for a mental, behavioral or neurodevelopmental disorder during the 30 days after the IPSD.

Optional Exclusions: Members with a diagnosis of narcolepsy any time during their history through December 31 or the measurement year.

- Narcolepsy Value Set:
  - [G47.411] Narcolepsy with cataplexy;
  - [G47.419] Narcolepsy without cataplexy;
  - [G47.421] Narcolepsy in conditions classified elsewhere with cataplexy;
  - [G47.429] Narcolepsy in conditions classified elsewhere without cataplexy

Measure Codes

The following code combinations identify follow-up visits:

- Outpatient visit
  - » CPT: 90791, 90792, 90832–90834, 90836–90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221–99223, 99231–99233, 99238, 99239, 99251–99255, 98960–98962, 99078, 99201–99205, 99211–99215, 99241–99245, 99341–99345, 99347–99350, 99381–99387, 99391–99397, 99401–99404, 99411, 99412, 99429, 99455, 99456, 99483, 99510
  - » HCPCS: G0155, G0176, G0177, G0409, G0463, G0512, H0002,H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013, H2020, M0064, T1015**

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

  - » An observation visit (observation value set) CPT: 99217–99220
  - » A health and behavior assessment/intervention CPT: 96156, 96158, 96159, 96164, 96165, 96167, 96168, 96170, 96171
  - » Telehealth visit CPT: 98966–98968, 99441–99443

ASTHMA MEDICATION RATIO

(AMR) Asthma Medication Ratio

EHP, Priority Partners/VBP, and USFHP. Members age 5-64 years of age.

The percentage of members who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 50% or greater during the measurement year.

Best Practice and Measure Tips

- Schedule follow-up appointments:
  - » Ensure the patient is not using more rescue medications than preventive medication to control their asthma (i.e., rescue meds have 50 percent less usage than preventive meds).
  - » Report the appropriate diagnosis codes for the member's condition. Include the appropriate codes for diagnosed conditions that may exclude the member from this measure.
  - » 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 1 ER visit with a principal diagnosis of asthma;
  - » At least 1 acute inpatient encounter with a principal diagnosis of asthma;
  - » At least 1 inpatient discharge with a principal diagnosis of asthma on the discharge claim;
  - » At least 4 outpatient visits, observation visits, telephone visits or e-visits or virtual check-ins, on different dates of service, with any diagnosis of asthma and at least 2 asthma medication dispensing events for any controller or reliever medication;
  - » At least 4 asthma medication dispensing events for any controller or reliever medications.

Measure Exclusions

Required Exclusions: Any of the below anytime during a member's history through Dec. 31 of the measurement year:

- Acute respiratory failure
- Chronic obstructive pulmonary disease (COPD)
- Chronic respiratory conditions due to fumes/vapors
- Cystic fibrosis
- Emphysema
- Obstructive chronic bronchitis
- Other emphysema
- Members who weren't prescribed an asthma medication any time during the measurement year.
- Members in hospice or using hospice services anytime during the measurement year

Measure Codes

Examples of persistent asthma codes include *J45.30-32, J45.40-42, J45.50-52*

Exclusion Codes:

- COPD: ICD-10: J44.0, J44.1, J44.9
- Cystic fibrosis: ICD-10: E84.0, E84.11, E84.19, E84.8, E84.9
- Acute respiratory failure: ICD-10: J96.00-J96.02, J96.20-J96.22
- Emphysema: ICD-10: J43.0-J43.2, J43.8, J43.9, J98.2-J98.3
- Obstructive chronic bronchitis: ICD-9: 491.20 -491.22
- Chronic respiratory conditions: ICD-10: J68.4

Measure Medications

Asthma Controller Medications

Description	Prescriptions
Anthiasthmatic combinations	• Dyphyline-guaifenesin
Antibody inhibitors	• Omalizumab
Anti-interleukin-4	• Dupilmab
Anti-interleukin-5	• Benralizumab
Anti-interleukin-5	• Mepolizumab
Anti-interleukin-5	• Rezlizumab
Inhaled steroid combinations	• Budesonide-formoterol
Inhaled steroid combinations	• Fluticasone-salmetrol
Inhaled steroid combinations	• Fluticasone-vilanterol
Inhaled steroid combinations	• Formoterol-mometasone
Inhaled corticosteroids	• Beclomethasone
Inhaled corticosteroids	• Budesonide
Inhaled corticosteroids	• Ciclensonide
Inhaled corticosteroids	• Flunisolide
Inhaled corticosteroids	• Budesonide
Inhaled corticosteroids	• Fluticasone
Inhaled corticosteroids	• Mometasone
Leukotriene modifiers	• Montelukast
Leukotriene modifiers	• Zafirlukast
Leukotriene modifiers	• Zileuton
Methylxanthines	• Theophylline

Asthma Reliever Medications

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

METABOLIC MONITORING FOR CHILDREN AND ADOLESCENTS ON ANTIPSYCHOTICS

(APM) Metabolic Monitoring for Children and Adolescents on Antipsychotics

EHP, Priority Partners, and USFHP. Members 1-17 years of age.

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

Three rates are reported (#3 is Accreditation for Commercial and Medicaid):

1. Percentage of children and adolescents on antipsychotics who received blood glucose testing.
2. Percentage of children and adolescents on antipsychotics who received cholesterol testing.
3. Percentage of children and adolescents on antipsychotics who received blood glucose and cholesterol testing.

Best Practice and Measure Tips

Members who received both of the following: At least one test for blood glucose or HbA1c and at least one test for LDL-C or cholesterol.

- 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.
- Measure baseline lipid profiles, fasting blood glucose level and body mass index.
- Ordering a blood glucose and cholesterol test every year and building care gap alerts in the electronic medical record.
- Testing blood glucose and cholesterol at a member's annual checkup or school physical to reduce additional visits.
- 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:
  - » Ordering blood glucose and cholesterol screening tests for members who do not have regular contact with their PCP and within 1 month of changing a member's medication.

Measure Exclusions

Required Exclusion:

Measure Codes: *Need both an A1C or GLUCOSE and LDL C CODES or CHOLESTEROL*

- HbA1C Lab Tests
  - » CPT: 83036, 83037
  - » CPT-CAT-II: 3044F, 3046F, 3051F, 3052F
- Glucose Lab Tests
  - » CPT: 80047, 80048, 80050, 80053, 80069, 82947, 82950, 82951
- LDL-C Lab Tests
  - » CPT: 80061, 83700, 83701, 83704, 83721
  - » CPT-CAT-II: 3048F, 3049F, 3050F
- Cholesterol Lab Test
  - » CPT: 82465, 83718, 83722, 84478

Measure Medications

Antipsychotic Medications

Description	Prescriptions		
Miscellaneous antipsychotic agents	• Aripiprazole • Asenapine • Brexpiprazole • Cariprazine • Clozapine • Haloperidol	• Iloperidone • Loxapine • Lurasidone • Molindone • Olanzapine • Paliperidone	• Pimozide • Quetiapine • Risperidone • Ziprasidone
Phenothiazine antipsychotics	• Chlorpromazine • Fluphenazine • 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

Prochlorperazine Medications

Description	Prescription	
Phenothiazine antipsychotics	• Prochlorperazine	

BREAST CANCER SCREENING

(BCS) Breast Cancer Screening

Advantage MD, EHP, and Priority Partners, and USFHP. Members 50-74 years of age.

- Female members 50-74 years of age who had at least one mammograms to screen for breast cancer
- Dates acceptable from October 1 two years prior to the measurement year through December 31 of the measurement year
- Member Age is 52 years of age during measurement year
- Age 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.
- 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 member's history specify mammogram and date of service. If unilateral mammogram, 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 member's history of bilateral mastectomy, Z90.13.
- Attempt to obtain reports for member reported screening. Notate place of service if unable to obtain report.
- Educate members on importance of screening mammogram for early detection of breast cancer when there are usually no symptoms.
- The advanced illness exclusion can be identified from a telephone visit, e-visit or virtual check in.

Measure Exclusions

Required Exclusions:

- Palliative Care
- Hospice
- Frailty
- Frailty and Advanced Illness
- Living in Long Term Care

Optional Exclusions:

Bilateral mastectomy or two unilateral mastectomies 14 or more days apart. Any time in a member's history through December 31 of the measurement year:

- Any combination of codes that indicate a mastectomy on both the left and right sides on the same or different dates of service:
- Bilateral mastectomy
- History of bilateral mastectomy
- Unilateral mastectomy with a bilateral modifier
- 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

Mammography (Mammography Value Set)

- CPT: 77061-63, 77065-67
- HCPCS: G0202, G0204, G0206

Exclusion Codes:

- Mastectomy (History of Bilateral Mastectomy Value Set): ICD10CM
- Z90.11 Acquired absence of right breast and nipple
- Z90.12 Acquired absence of left breast and nipple
- Z90.13 Acquired absence of bilateral breasts and nipples

BLOOD PRESSURE CONTROL FOR PATIENTS WITH DIABETES

(BDP) Blood Pressure Control for Patients with Diabetes

NEW – Replaced Comprehensive Diabetes Care: Controlling High BP

Advantage MD, EHP, and Priority Partners, and USFHP. Members 18-75 years of age.

Percentage of members with Diabetes (Type 1 and Type 2) who had the following:

- BP was adequately controlled (systolic and diastolic both <140/90 mm HG) during the measurement year*

* Uses last BP of the year.

Best Practice and Measure Tips

This is a new measure, which resulted from the separation of the former Comprehensive Diabetes Care measure indicators into individual measures. BP reading must be the last BP result performed within the measurement year.

See CBP Measure for tips.

Measure Exclusions

Required Exclusions:

- Palliative Care
- Hospice
- Frailty
- Frailty and Advanced Illness
- Living in Long Term Care

Required Exclusion: Members without a diagnosis of diabetes and a diagnosis of polycystic ovarian syndrome, gestational diabetes or steroid-induced diabetes during the measurement year or the year prior.

Measure Codes

- Outpatient Codes
  - » CPT: 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347 -99350, 99381-99387, 99391-99397, 99401- 99404, 99411, 99412, 99429, 99455, 99456, 99483, 99341-99345
  - » HCPCS: G0402, G0438, G0439, G0463, T1015
- Non-Acute Inpatient
  - » CPT: 99304-99310, 99315, 99316, 99318, 99324-99328, 99334-99337
- Diastolic Less than 80
  - » CPT-CAT-II: 3078F
- Diastolic 80-89
  - » CPT-CAT-II: 3079F
- Diastolic Greater than/Equal to 90
  - » CPT-CAT-II: 3080F
- Systolic Less than 130
  - » CPT-CAT-II: 3074F
- Systolic 131-140
  - » CPT-CAT-II: 3075F
- Systolic Greater than/Equal to 140
  - » CPT-CAT-II: 3077F

Medication List

Diabetes Medications

Note: Glucophage/metformin as a solo agent is not included because it is used to treat conditions other than diabetes; members with diabetes on these medications are identified through diagnosis codes only.

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

CONTROLLING HIGH BLOOD PRESSURE

(CBP) Controlling High Blood Pressure

Advantage MD, EHP, and Priority Partners and USFHP. Members 18-85 years of age.

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

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

New for Measure: Stratification by race and ethnicity.

Best Practice and Measure Tips

- Allow patient to rest for at least 5 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.
- If initial BP is > 140/90, retake the member's BP after they've had time to rest. If remains elevated, ensure member follows up for BP check.
  - » Since the last BP in the year is used, have member follow up for elevated BPs prior to the end of the year or follow Guidelines for Member Reported BP Readings if a visit is not possible.

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 Member 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
- My Chart communications with BPs reported must indicate date taken.
- There is no requirement there be evidence the BP was collected by a PCP or specialist

BP readings taken the same day member receives a common low-intensity or preventive procedure can be used. Examples include, but aren't limited to:

- Eye exam with dilating agents
- Injections (e.g., 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 visits.
- 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.
- Member taken manual BPs reported are not acceptable at this time.

Measure Exclusions

Required Exclusions:

- Palliative Care
- Hospice
- Frailty
- Frailty and Advanced Illness
- Living in Long Term Care

Optional Exclusions during measurement year:

- Dialysis End-stage renal disease (ESRD) Kidney transplant Nephrectomy
- Female members with a diagnosis of pregnancy
- Non-acute inpatient admission

Measure Codes

- Hypertension
  - » ICD-10: I10
- Outpatient Codes
  - » CPT: 99201-99205, 99211-99215, 99241-99245, 99347-99350, 99381-99387, 99391-99397, 99401, 99402, 99403, 99404, 99411, 99412, 99429, 99455, 99456, 99483, 99341-99345
  - » HCPCS: G0402, G0438, G0439, G0463, T1015
- Diastolic Less than 80
  - » CPT-CAT-II: 3078F
- Diastolic 80-89
  - » CPT-CAT-II: 3079F
- Diastolic Greater than/Equal to 90
  - » CPT-CAT-II: 3080F
- Systolic Less than 130
  - » CPT-CAT-II: 3074F
- Systolic 130-140
  - » CPT-CAT-II: 3075F
- Systolic Greater than/Equal to 140
  - » CPT-CAT-II: 3077F

Organizations that use CPT Category II codes to identify numerator compliance must use coding consistently throughout measurement year.

CERVICAL CANCER SCREENING

(CCS) Cervical Cancer Screening

EHP, Priority Partners, and USFHP. Female members 21 to 64 years of age.

Female members age 21-64 who were screening for cervical cancer using the following criteria:

- Age 24-64 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**

*Three year look back requires 21 years or older on test date.
**Five year look back requires age 30 or older on test date.

Best Practice and Measure Tips

- All tests require date and result.
- Request results for tests performed by another provider
- Complete test during well woman OB/GYN visit, sick visits, urine pregnancy tests, UTI or screening for STDs
- Review and document your patient's surgical and preventive screenings history with results
- Use correct diagnosis and procedure codes

Acceptable:

- Member reported information documented in the patient's medical record is acceptable as long as there is a date and result of the test or a date of the hysterectomy and acceptable documentation of no residual cervix. The member reported information 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.

Exclusion Acceptable:

- Documentation of a "vaginal Pap smear" with documentation of hysterectomy.
- Documentation of hysterectomy and documentation that a member no longer needs Pap testing/cervical cancer screening.

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.

Measure Exclusions

Required Exclusions: Palliative Care, Hospice

Optional Exclusions:

- Hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix
- Acquired absence of both cervix and uterus
- Partial hysterectomy can only be used if absence of cervix is documented
  - » Documentation of a "hysterectomy" alone will not meet the intent of the exclusion. The documentation must include the words "total," "complete" or "radical" abdominal or vaginal hysterectomy.

Optional Exclusion Timeframe: Any time in a member's history through December 31 of the measurement year.

Measure Codes

- Cervical Cytology Lab Test
  - » CPT: 88141-43, 88147-48, 88150, 88152-54, 88164-67, 88174-75
  - » HCPCS: G0123, G0124, G0141, G0143, G0144, G0145, G0147, G0148, P3000, P3001, Q0091
- HPV Tests
  - » CPT: 87624, 87625
  - » HCPCS: G0476
- Hysterectomy with No Residual Cervix
  - » CPT: 51925, 56308, 57530, 57531, 57540, 57545, 57550, 57555,57556, 58150, 58152, 58200, 58210, 58240, 58260, 58262, 58263, 58267, 58267, 58270, 58275, 58280, 58285, 58290-58294, 58548, 58550, 58552-58554, 58570-58573, 58575, 58951, 58953, 58954, 59856, 59135
- ICD-10: OUTC0ZZ, OUTC4ZZ, OUTC7ZZ, OUTC8ZZ
- Absence of Cervix Diagnosis
  - » ICD-10: Q51.5, Z90.710, Z90.712

CHLAMYDIA SCREENING IN WOMEN

(CHL) Chlamydia Screening in Women

EHP, Priority Partners, and USFHP. Female members 16-24 years of age.

Women who were identified as sexually active and had at least one chlamydia test in the measurement year. Report two age stratifications and a total rate:

- 16–20 years (Women)
- 21–24 years (Women)
- Total (Women)

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 a 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.

Measure Exclusions

Required Exclusions: Hospice

Optional Exclusions: Any time during the measurement year:

If a member 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

- Chlamydia Screening Test
  - » CPT 87110, 87270, 87320, 87490-92, 87810

CHILDHOOD IMMUNIZATIONS

(CIS) Childhood Immunizations

EHP, Priority Partners, and USFHP. Children who turned 2 years old during the measurement year.

The percent of children who receive the following immunizations by their 2nd birthday.

- Combo 3:
  - 4 doses – DTaP, PCV
  - 3 doses – Hib, IPV, Hep B
  - 1 dose – MMR, VZV (On or between child's 1st and 2nd birthday)
- Combo 10 (includes all Combo 3 immunizations above plus the following):
  - 1 dose – Hep A (On or between child's 1st and 2nd birthday)
  - 2 doses – Rotavirus Monovalent (Rotarix-RVl) OR 3 doses – Rotavirus Pentavalent (RotaTeq-TIV)
  - 2 doses – Influenza

Best Practice and Measure Tips

- Hep B (One can be newborn between date of birth and 7 days). Document the first Hep B vaccine given at the hospital or at birth when applicable (if unavailable – name of hospital where child was born).
- **DOCUMENT ANY PARENT REFUSAL FOR IMMUNIZATIONS, AS WELL AS ANAPHYLACTIC REACTIONS.** This does not exclude member from measure.
- Anaphylactic Reactions count toward numerator compliance. Include event date. The below count towards compliance for the vaccine.
- Document with event date:
  - For DTaP: Encephalitis due to the vaccine.
  - For DTaP, hepatitis B, HiB and rotavirus: Anaphylaxis due to the vaccine.
  - For hepatitis B, MMR, VZV and hepatitis A, count any of the following:
  - Documented history of the illness.
  - A seropositive test result.
- Must be done by 2nd birthday: when scheduling check calendar and schedule prior to 2nd birthday.

Acceptable documentation:

- A certificate of immunization prepared by an authorized health care 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 member 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 "member is up to date" with all immunizations but does not list the dates and names of all immunizations.
- Vaccines documented as Adult.
- **Influenza:** Do not count a vaccination administered prior to 6 months (180 days after birth.)
- **DTaP, IPV, HiB, Pneumococcal conjugate, Rotavirus**: Do not count a vaccination administered prior to 42 days after birth.

Measure Exclusions

Required Exclusions: Hospice

- Members who had any of the following on or before their second birthday:
  - » Severe combined immunodeficiency (Severe Combined Immunodeficiency Value Set)
  - » Immunodeficiency (Disorders of the Immune System Value Set)
  - » HIV (HIV Value Set; HIV Type 2 Value Set)
- Lymphoreticular cancer, multiple myeloma or leukemia (Malignant Neoplasm of Lymphatic Tissue Value Set)
- Intussusception (Intussusception Value Set)

Exclusion Codes:

- Severe Combined Immunodeficiency: ICD-10: D81.0, D81.1, D81.2, D81.9
- Disorders of the Immune System (Immunodeficiency): ICD-10: D80.0, D80.1, D80.2, D80.3, D80.4, D80.5, D80.6, D80.7, D80.8, D80.9, D81.0, D81.1, D81.2, D81.4, D81.6, D81.7, D81.89, D81.9, D82.0, D82.1, D82.2, D82.3, D82.4, D82.8, D82.9, D83.0, D83.1, D83.2, D83.8, D83.9, D84.0, D84.1, D84.8, D84.81, D84.821, D84.822, D84.89, D84.9, D89.3, D89.810, D89.811, D89.812, D89.813, D89.82, D89.831, 89.832, D89.833, D89.834, D89.835, D89.839, D89.89, D89.9

- HIV: ICD-10: B20, Z21
- HIV Type 2: ICD-10: B97.35
- Malignant Neoplasm of Lymphatic Tissue
  - » Lymphoreticular cancer ICD-10: C81.xx, C82.xx, C83.xx, C84.xx, C85.xx, C86.xx, C91.xx, C96.9, C96.Z
  - » Multiple Myeloma ICD-10: C90.00, C90.01, C90.02
  - » Leukemia ICD-10: C90.10, C90.11, C90.12, C91.xx, C92.xx, C93.xx, C94.xx, C95.xx
- Intussusception: ICD-10: K56.1

Measure Codes

- DTAP
  - » CPT: 90697, 90698, 90700, 90723
  - » CVX: 20, 50, 106, 107, 110, 120, 146
- HIB
  - » CPT: 90644, 90647, 90648, 90697, 90698, 90748
  - » CVX: 17, 46, 47, 48, 49, 50, 51, 120, 146, 148
- Hep B
  - » CPT: 90697,90723, 90740, 90744, 90747-8
  - » CVX: 08, 44, 45, 51, 110, 146
  - » HCPCS: G0010
  - » ICD-10: B16.0, B16.1, B16.2, B16.9, B17.0, B18.0, B18.1, B19.10, B19.11
  - » Newborn Hepatitis B Vaccine Administered
  - » ICD10PCS: [3E0234Z] Introduction of Serum, Toxoid and Vaccine into Muscle
- Percutaneous Approach
- IPV CPT: 90697, 90698, 90713, 90723
- CVX: 10, 89, 110, 120, 146
- MMR
- CPT: 90707, 90710
- CVX: 03, 94
- ICD-10: B05.0- B05.4, B05.81, B05.89, B05.9, B26.0- B26.3, B26.81- B26.85, B26.89, B26.9, B06.00- B06.02, B06.09, B06.81, B06.82, B06.89, B06.9

- Pneumococcal Conjugate PCV
  - » CPT: 90670
  - » CVX: 109,133, 152
  - » HCPCS: G0009
- Varicella VZV
  - » CPT: 90710, 90716
  - » CVX: 21, 94
  - » ICD-10: 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
  - » CPT: 90633
  - » CVX: 31, 83, 85
  - » ICD-10: B15.0, B15.9
- Influenza
  - » CPT: 90655, 90657, 90660, 90661, 90673, 90685- 90689, 90672
  - » CVX: 88,140, 141, 150, 153, 155, 158, 161, 111, 149
  - » HCPCS: G0008
- Rotavirus
  - » Rotavirus (2 Dose): CPT: 90681, CVX: 119
  - » Rotavirus (3 Dose): CPT: 90680, CVX: 116, 122

CARE FOR OLDER ADULTS

(COA) Care for Older Adults

Advantage MD Special Needs Plan Members 66 years of age and older.

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

Medication review:

Provider type must be a prescribing practitioner or clinical pharmacist:

- Functional status assessment*
- Pain assessment*

NOTE: Above can be documented through Admin Data or Medical record review:

**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:

Either of the following meets criteria:

- Both of the following during the same visit with the appropriate provider:
  - » At least one medication review ***(Medication Review Value Set).***
  - » The presence of a medication list in the medical record ***(Medication List Value Set).***

    or
  - » Transitional care management services during the measurement year.
  - » A medication list, signed and dated during the measurement year meets criteria: The practitioner's signature is considered evidence that the medications were reviewed.
  - » Review and List of the member's 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.
  - » A set of structured questions that elicit member information may be helpful. May include person-reported outcome measures, screening or assessment tools or standardized questionnaires.

Functional status assessment

A complete functional status assessment must include one of the following:

- **Notation that Activities of Daily Living (ADL) were assessed**

  or

- **Notation that at least five of the following were assessed:**
  - Bathing, dressing, eating, transferring [e.g., getting in and out of chairs], using toilet, walking.
- **Notation that Instrumental Activities of Daily Living (IADL) were** assessed

  or

- **Notation 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.
- Documentation in the medical record must include evidence of a complete functional status assessment and the date when it was performed.
- A functional status assessment limited to an acute or single condition, event or body system (e.g., lower back, leg) does not meet criteria for a comprehensive functional status assessment.
- The components of the functional status assessment numerator may take place during separate visits within the measurement year.
- Do not include comprehensive functional status assessments performed in an acute inpatient setting.
- **Result of assessment using a standardized functional status assessment tool, not limited to:**
  - SF-36®.
  - Assessment of Living Skills and Resources (ALSAR).
  - Barthel ADL Index Physical Self-Maintenance (ADLS) Scale.
  - Bayer ADL (B-ADL) Scale.
  - Barthel Index.
  - Edmonton Frail Scale.
  - Extended ADL (EADL) Scale.
  - Groningen Frailty Index.
  - Independent Living Scale (ILS).
  - 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
- » Patient Reported Outcome Measurement Information System (PROMIS) Global or Physical Function Scales

Pain Assessment:

- Documentation in the medical record must include evidence of a pain assessment and the date when it was performed.
  - » A medication review performed without the member present meets criteria.
- **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.

Measure Exclusions

Required Exclusions: Hospice.

Measure Codes

- Medication Review:
  - » CPT: 90863, 99483, 99605, 99606
  - » CPT II: 1160F
- Medication List:
  - » CPT II: 1159F
  - » HCPCS: G8427
- Transitional Care Management Services: CPT: 99495
- Functional status assessment
  - » CPT : 99483
  - » CPT II: 1170F
  - » HCPCS: G0438, G0439
- Pain assessment
  - » CPT II: 1125F, 1126F

COLORECTAL CANCER SCREENING

(COL) Colorectal Cancer Screening

Advantage MD, EHP, and USFHP. Members 50-75 years of age.

Members age 50-75 who received one or more of the following screenings for colorectal cancer:

- Colonoscopy (also known as lower endoscopy) during the MY or the (9) years prior
- Flexible sigmoidoscopy during the MY or the four (4) years prior
- CT Colonography (Virtual Colonoscopy) during the MY or the four (4) years prior
- FIT DNA Test (Cologuard) during the MY or two (2) years prior
- Fecal occult blood test (FOBT) during the MY. gFOBT (guaiac), FIT/iFOBT (immunochemical)

New for Measure: Stratification by race and ethnicity.

Best Practice and Measure Tip

- Best practice to have the actual screening test and result. However, result is not required as long as documentation is part of the medical record and clearly indicates screening was completed and not merely ordered.
- Always include a date of service and place of service if known.
- Member refusal will not make them ineligible for this measure.
- Recommend a different screening if a member refuses or can't tolerate a colonoscopy.

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

Acceptable:

- Colonoscopy indicating "poor bowel prep" or "incomplete exam" with documentation of scope advancing past splenic flexure for a colonoscopy or advancing into sigmoid colon for flexible sigmoidoscopy.
- Two types of FOBT tests: guaiac (gFOBT) and immunochemical (iFOBT/FIT). Depending on the type of FOBT test, a certain number of samples are required for numerator compliance.
- For FIT test: as long as the medical record indicates that a FIT was done, the member meets criteria regardless of how many samples were returned

- For gFOBT and unspecified type of test:
  - If the medical record does not indicate the number of samples (assume correct number returned) OR indicates three or more samples were returned, the member meets criteria.
- The FOBT test must be processed and results reported by a lab.
- The advanced illness exclusion can be identified from a telephone visit, e-visit or virtual check-in.
- Documentation in the medical record of "Colon Cancer Screening Done in 2021" without notation of type of screening can only be used as evidence of FOBT.

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.

Measure Exclusions

Required Exclusions: Hospice.

- Palliative Care
- Hospice
- Frailty
- Frailty and Advanced Illness
- Living in Long Term Care.

Optional Exclusions (Any time in a member's history through Dec. 31 of the measurement year, submit ICD-10 diagnosis code on any visit claim):

- Total colectomy CPT: 44150-44153, 44155-44158, 44210-44212
- Colorectal cancer
  - HCPCS: G0213, G0214, G0215, G0231
  - ICD-10: C18.0-C18.9, C19, C20, C21.2, C21.8, C78.5, Z85.038, Z85.048

Measure Codes

- Colonoscopy
  - » CPT: 44388-44394, 44397, 44401-44408, 45355, 45378-45393, 45398
  - » HCPCS: G0105, G0121
- Flexible Sigmoidoscopy
  - » CPT: 45330-45335, 45337, 45338, 45340-45342, 45346,45347, 45349, 45350
  - » HCPCS: G0104
- FOBT Lab Test
  - » Guaiac Test (gFOBT): CPT: 82270
  - » FIT Test Immunochemical (iFOBT/FIT):
    - – CPT: 82274
    - – HCPCS: G0328
- Computed Tomography (CT) Colonography
  - » CPT:74261-74263 FIT-DNA Test
  - » CPT 81528 This code is specific to the Cologuard® FIT-DNA test.
  - » HCPCS: G0464 This code was retired and replaced with CPT code 81528

RISK OF CONTINUED OPIOID USE

(COU) Risk of Continued Opioid Use

Advantage MD, EHP, Priority Partners/VBP, and USFHP. Members 18 years of age and older.

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:

- 15 days of prescription opioids in a 30-day period
- 31 days of prescription opioids in a 62-day period

Report two age stratifications and a total rate:

- 18–64 years
- 65 years and older
- Total: The total is the sum of the age stratifications

***Note**: A lower rate indicates better performance.*

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

Best Practice and Measure Tips

- Refer to JH opioid prescribing guidelines.
- The measure utilizes pharmacy claims data for opioid medications filled.
- Since measure is an inverse measure, a lower rate is desirable. The measure can assist in identifying members with potential opioid use disorder.
- Members are included in measure once a dispensing event for an opioid medication occurs during the Intake Period.
- Review member records and outreach to members as appropriate.
- Once members are compliant for 30 days rate, take steps to deter member becoming compliant for the 62 days rate.
- All of the medications lists 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 Opioid Medications 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). This is for inpatient use only and is available only through a restricted program under a Risk Evaluation and Mitigation Strategy (REMS).

Measure Exclusions

Required Exclusions:

Any of the following during the 12 months prior to the earliest prescription dispensing date: Hospice, Palliative Care, Cancer, Sickle Cell Disease.

Measure Exclusion Codes:

- Hospice
  - HCPCS: G9473, G9474, G9475, G9476, G9477, G9478, G9479, Q5003, Q5004, Q5005, Q5006, Q5007, Q5008. Q5010, S9126, T2042, T2043, T2044, T2045, T2046, G0182
- Palliative Care
  - HCPCS: G9054, M1017
  - ICD 10: Z51.5
- Cancer
  - IDC 10: C codes range from C00.0- C96.Z *(Note: not all diagnosis codes are included)*
- Sickle Cell Diseases
  - ICD 10: 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 • Acetaminophen Codeine • Aspirin Butalbital Caffeine Codeine • Aspirin Carisoprodol Codeine • Aspirin Codeine • Codeine Phosphate • Codeine Sulfate
Dihydrocodeine	• Acetaminophen Caffeine Dihydrocodeine • Aspirin Caffeine Dihydrocodeine
Fentanyl	• Fentanyl
Hydrocodone	• Acetaminophen • Hydrocodone • Hydrocodone • Hydrocodone • Ibuprofen
Hydromorphone	• Hydromorphone
Levorphanol	• Levorphanol
Meperidine	• Meperidine • Meperidine Promethazine
Methadone	• Methadone
Prescription	
Morphine	• Morphine • Morphine Naltrexone
Opium	• Belladonna Opium • Opium

Prescription	Medication Lists
Oxycodone	• Acetaminophen Oxycodone • Ibuprofen Oxycodone • Oxycodone
Oxymorphone	• Oxymorphone
Pentazocine	• Naloxone Pentazocine
Tapentadol	• Tapentadol
Tramadol	• Acetaminophen • Tramadol

APPROPRIATE TESTING FOR PHARYNGITIS

(CWP) Appropriate Testing for Pharyngitis

EHP, Priority Partners, and USFHP. Members 3 years of age and older.

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

- A higher rate indicates appropriate testing and treatment.

Report three age stratifications and total rate:

- 3-17 years
- 18-64 years
- 65 years and older
- Total. The total is the sum of the age stratifications

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 measurement year and June 30 of the measurement year.

Measure Exclusions

Required Exclusions: Hospice.

- 12 months prior to or on the episode date diagnosis of one of the below:
  - COPD J44.0, J44.1, J44.9
  - Emphysema J43.0, J43.1, J43.2, J43.8, J43.9
  - Disorders of the immune system
  - HIV B20, Z21
  - Malignant neoplasms
  - Other malignant neoplasms of the skin
  - Additional codes apply.

Measure Codes

- Group A Strep Test
  - » CPT: 87070-71, 87081, 87430, 87650-52, 87880
- Pharyngitis ICD-10 Diagnosis
  - » 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	
Macrolides	• Azithromycin • Clarithromycin	• Erthromycin
Natural Penicillin's	• 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 • Micocycline	• Tetracycline
Third generation cephalosporins	• Cefdinir • Cefixime • Cefpodoxime	• Ceftibuten • Cefditoren • Ceftriaxone

EYE EXAM FOR PATIENT WITH DIABETES

(EED) Eye Exam for Patient with Diabetes

NEW - Replaced Comprehensive Diabetes Care: Diabetic Eye Exam

Advantage MD, EHP, Priority Partners, and USHFP. Members 18-75 years of age.

Percentage of diabetic members who had the following: Eye Exam-A retinal or dilated eye exam to detect retinopathy performed by an ophthalmologist or optometrist. 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

Provider Specialty: Ophthalmologist or Optometrist.

Best Practice and Measure Tips

- This measure resulted from the separation of indicators that replaces the former Comprehensive Diabetes Care Eye Exam.
- Provide member education on risks of Diabetic Eye Disease, and encourage scheduling annual exam.
- Obtain eye exam reports. Notate eye care provider name and demographics in chart if report not available.
- 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.
- Documentation can be in the form of a note or letter prepared by an ophthalmologist, optometrist, PCP or other health care professional. Include: date of service, the test (indicate a dilated or retinal exam) or result, and the care provider's credentials.
  - » Documentation example: "Last diabetic retinal eye exam with John Smith, OD, was June 201X with no retinopathy."
- Must indicate performed by Optometrist or Ophthalmologist.
- A slit-lamp examination must have documentation of dilation or evidence that the retina was examined to be considered compliant.
- Examination of macula, vessels and periphery without eye dilation meets criteria for a "retinal exam."

- 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.
- Prior year exam results must indicate retinopathy was not present.

Not Acceptable:

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

Measure Exclusions

Required Exclusions:

- Palliative Care
- Hospice
- Frailty
- Frailty and Advanced Illness
- Living in Long Term Care
- Members without a diagnosis of diabetes and a diagnosis of polycystic ovarian syndrome, gestational diabetes or steroid-induced diabetes during the measurement year or the year prior.

Measure Codes

Diabetic Retinal Screening with Eye Care Professional:

- Current year dilated retinal screening with evidence of retinopathy:
  - » CPT II: 2022F, 2024F, 2026F
- Current year dilated retinal screening without evidence of retinopathy:
  - » CPT II: 2023F, 2025F, 2033F
- Prior year dilated negative retinal screening: CPT II: 3072F
- Diabetic Eye Exam
  - » CPT/CPT II: 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, 92225-28, 92230, 92235, 92240, 92250, 92260, 99203-05, 99213-15, 99242-45

- HCPCS: S0620, S0621, S3000
- Unilateral Eye Enucleation
  - » CPT/CPT II: 65091, 65093, 65101, 65103, 65105, 65110, 65112, 65114
- Unilateral Eye Enucleation – Left
  - » ICD-10: Diagnosis 08T1XZZ
- Unilateral Eye Enucleation – Right
  - » ICD-10: Diagnosis 08T0XZZ
- Bilateral Modifier
  - » CPT Modifier 50

Medication List: Diabetes Medications (See BDP Measure)

FOLLOW UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS

(FUH) Follow Up After Hospitalization for Mental Illness

Advantage MD, EHP, and USFHP. Members 6 years of age and older.

The percent of discharges for members age 6 and older who were hospitalized for treatment of selected mental illness diagnoses or intentional self-harm diagnoses and who had a follow-up visit with a mental health practitioner.

Two rates are reported:

- Discharges for which the member received follow-up within 7 days after discharge
- Discharges for which the member received follow-up within 30 days after discharge

Provider Specialty: Mental Health Practitioner

Best Practice and Measure Tips

- The denominator for this measure is based on discharges, not on members. If members have more than one discharge, include all discharges on or between January 1 and December 1 of the measurement year.
- Visits that occur on the date of discharge will not count toward compliance.
- This measure focuses on follow-up treatment, which must be with a mental health provider.
- Mental Health Practitioner definition changed to Mental Health Provider and includes certified Community Mental Health Center (CMHC) and certified Physician Assistant.
- 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.
- Refer patient to a mental health provider to be seen within seven days of discharge.
- Even patients 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.

Measure Exclusions

Required Exclusions: Hospice

Measure Codes

- Common Visit Codes:
  - » 90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221-99223, 99231-99233, 99238, 99239, 99251–99255
  - » POS: 02
- Observation
  - » CPT: 99217-99220
- Transitional Care Management
  - » CPT: 99495, 99496
- BH Outpatient Visit with Mental Health Practitioner
  - » CPT: 98960-98962, 99078, 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, --99483, 99492, 99493, 99494, 99510
  - » HCPCS: 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)

HEMOGLOBIN A1C CONTROL FOR PATIENTS WITH DIABETES

(HBD) Hemoglobin A1c Control for Patients With Diabetes

NEW - Replaced Comprehensive Diabetes Care: Diabetic HbA1c Test with Controlled Result

Advantage MD, EHP, Priority Partners/VBP, and USFHP. Members 18-75 years of age.

Percentage of members 18-75 years of age with Diabetes (Types 1 and Type 2) whose hemoglobin A1c (HbA1c) was at the following levels during the measurement year:

- HbA1c control (<8.0%).
- HbA1c poor control (>9.0%). *This is an inverse measure. A lower rate indicates better performance for this indicator (i.e., low rates of poor control indicate better care). *For Advantage MD members a result 9.0 or below is acceptable.
- The member is only compliant if the most recent HbA1c result is < 8.0 for EHP, Priority Partners/VBP and USFHP.

**The most recent = closest to December 31 of measurement year.*

New for Measure: Stratification by race and ethnicity.

Best Practice and Measure Tips

- This measure resulted from the separation of indicators that replaces the former Comprehensive Diabetes Care measure for A1C.
  - » Removed the Hemoglobin A1c (HbA1c) Testing indicator.
- If multiple tests were performed in the measurement year, the result from the last test is required.
- Since the last value in the year is used, have member repeat elevated test prior to the end of the year.
- Documentation in the medical record must include a note indicating the date when the HbA1c test was performed and the result.
- Always list the date of service, result and test together.
- If test result(s) are documented in the vitals section of your progress notes, please include the date of the blood draw with the result. The date of the progress notes will not count.
- Schedule labs prior to patient appointments to assist with compliance.
- Adjust therapy as indicated to improve A1c levels.

- Not Acceptable: Self tested when 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
- Always list the date of service, result and test together.
- If test result(s) are documented in the vitals section of your progress notes, please include the date of the blood draw with the result. The date of the progress notes will not count.
- Schedule labs prior to patient appointments to assist with compliance.
- Adjust therapy as indicated to improve A1c levels.

Not Acceptable:

- Self-tested when not processed by a lab
- Documentation of ranges and thresholds do not meet criteria. Example: < 9.0%

Measure Exclusions

Required Exclusions:

- Palliative Care
- Hospice
- Frailty
- Frailty and Advanced Illness
- Living in Long Term Care

Required Exclusion: Members without a diagnosis of diabetes and a diagnosis of polycystic ovarian syndrome, gestational diabetes or steroid-induced diabetes during the measurement year or the year prior.

Measure Codes

- HbA1C Lab Test
  - » CPT: 83036, 83037
- HbA1c Level Less than 7.0
  - » CPT-CAT-II: 3044F
- HbA1c Level Greater than/Equal to 7 and Less than 8
  - » CPT-CAT-II: 3051F
- HbA1c Level Greater than/Equal to 8 and Less than/Equal to 9
  - » CPT-CAT-II: 3052F
- HbA1C Greater than 9.0
  - » CPT-CAT-II: 3046F

Medication List: Diabetes Medications (See BDP Measure)

IMMUNIZATIONS FOR ADOLESCENTS

(IMA) Immunizations for Adolescents

EHP, Priority Partners, and USFHP. Adolescents 13 years of age during the Measurement Year.

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

Combo 1:

- 1 dose – Meningococcal conjugate or meningococcal polysaccharide vaccine on or between the members' 11th and 13th birthdays
- 1 dose – Tetanus, diphtheria toxoids vaccine, and acellular pertussis vaccine (Tdap) on or between the members' 10th and 13th birthdays

Combo 2 (includes above combo 1 immunizations plus the following):

- 2 dose series or 3 dose series of the HPV (human papilloma virus) vaccine with different dates of service between the member's 9th and 13th birthdays

Best Practice and Measure Tips

- Immunization must occur on or prior to the member's 13th birthday.
- **Document any parent refusal for immunizations, as well as anaphylactic reactions.** There must be a note indicating the date of the event occurring by the member's 13th birthday. This will not exclude the member from this measure.
- The below count towards compliance. There must be a note indicating the date of the event occurring by the member's 13th birthday.
  - » All vaccines: Anaphylaxis
  - » Tdap: Encephalopathy
- For the two-dose HPV vaccination series, there must be at least 146 days (5 months) between the first and second dose of the HPV vaccine.

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 health care provider or agency including the specific dates and types of immunizations administered.

Not acceptable:

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

Measure Exclusions

Required Exclusions: Hospice

Measure Codes

- Meningococcal-serogroup A,C,W, and Y(1 dose)
  - » CPT: 90619, 90733, 90734
  - » CVX: 32,108, 114, 136, 147, 167, 203
- Tdap (1 dose)
  - » CPT: 90715
  - » CVX: 115
- HPV (2 or 3 dose series)
  - » CPT: 90649 – 90651
  - » CVX: 62, 118, 137, 165

KIDNEY HEALTH EVALUATION FOR PATIENTS WITH DIABETES

(KED) Kidney Health Evaluation for Patients with Diabetes

Advantage MD, EHP, Priority Partners, and USFHP. Members 18-85 years of age.

Percentage of members 18-85 years of age with Diabetes (Type 1 and Type 2) as of December 31 of the measurement year who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR), during the measurement year.

Reports three age stratifications and a total rate.

Best Practice and Measure Tips

- Requires both an eGFR and a uACR during the measurement year 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.
- Follow up with patients to discuss and educate on lab results
- Educate on how diabetes can affect the kidneys and offer tips to your patients on preventing damage to their kidneys
- Controlling their blood pressure, blood sugars, cholesterol, and lipid levels
- Take medications as prescribed that can protect kidney function (ACE inhibitors or ARBs)
- Offer education on medications that could be harmful to the kidneys (NSAIDs such as naproxen or ibuprofen)
- Limit protein intake and salt in diet
- Coordinate care with specialists such as an endocrinologist or nephrologist as needed.

Measure Exclusions

Required Exclusions:

- ESRD
- Dialysis
- Palliative Care
- Hospice
- Frailty
- Frailty and Advanced Illness
- Living in Long Term Care

Required Exclusion: Members without a diagnosis of diabetes in any setting and a diagnosis of polycystic ovarian syndrome, gestational diabetes or steroid-induced diabetes during the measurement year or the year prior

Measure Codes

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

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

Medication List: Diabetes Medications (See BDP Measure)

USE OF IMAGING STUDIES FOR LOW BACK PAIN

(LBP) Use of Imaging Studies for Low Back Pain

Advantage MD, EHP, Priority Partners, and USFHP. Members 18-75 years of age.

Percentage of members with a new primary diagnosis of uncomplicated low back pain in an outpatient setting who **did not** have an imaging study (plain X-ray, MRI, or CT scan) within the first 4 weeks (28 days) of the primary diagnosis.

Age clarification: 18 years as of January 1 of the measurement year to 75 years as of December 31 of the measurement year.

Best Practice and Measure Tips

NOTE: *Added to Advantage MD for MY2022*

This measure is reported as an inverted measure.

- A higher score indicates appropriate treatment of low back pain (i.e., the proportion for whom imaging studies did not occur).
- Measure exclusions identify members for whom imaging may be clinically appropriate within the first 4 weeks.
- Visits that result in an inpatient visit are not included.

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

Definitions

- **Intake Period:** Identifies the first eligible encounter with a primary diagnosis of low back pain between January 1–December 3 of the measurement year.

Eligible encounter settings include:

- Office visits, outpatient evaluations, emergency department visits, observation level of care, telephone visits, e-visits or virtual check-in visits
- Osteopathic and/or chiropractic manipulative treatment or physical therapy.
- **IESD:** Index Episode Start Date. Earliest date of service for an eligible encounter during the Intake Period with a principal diagnosis of low back pain.
  - » **Negative Diagnosis History:** A period of 180 days (6 months) prior to the IESD when the member had no claims/encounters with any diagnosis of low back pain.

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

Avoid ordering diagnostic studies within 30 days of a diagnosis of new-onset back pain in the absence of measure exclusions.

- Use correct exclusion codes as applicable.
- First-line treatment should emphasize conservative measures.
- Provide patient education on cautious and responsible pain relief, activity level, stretching exercises, use of heat.
- Physical Therapy referral, including massage, stretching, strengthening exercises and manipulation.
- Comorbid conditions such as sleep disorders, anxiety or depression should be treated, and psychosocial issues should be addressed.

Measure Exclusions

Required Exclusion: Hospice

- CPT:72020, 72052, 72100, 72110, 72114, 72120, 72131-72133, 72141-72142, 72146- 72149, 72156, 72158, 72200, 72202, 72220

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

Any time during the member's history through 28 days after the IESD:

- Cancer: ICD-10 C and D Codes (active) / Z Codes (history of)
- HIV: B20, Z21
- Kidney / Major organ transplant
- History of Kidney Transplant: Z94.0

Kidney Transplant:

- CPT: 50360, 50365, 50380,
- HCPCs: S2065
- ICD10PCS: 0TY00Z0, 0TY00Z1, 0TY00Z2, 0TY10Z0, 0TY10Z1, 0TY10Z2
- Organ Transplant Other Than Kidney
  - » CPT: 32850, 32851, 32852, 32853, 32854, 32855, 32856, 33927, 33928, 33929, 33930, 33933, 33935, 33940, 33944, 33945, 44132, 44133, 44135, 44136, 44137, 44715, 44720, 44721, 47133, 47135, 47136, 47140, 47141, 47142, 47143, 47144, 47145, 47146, 47147, 48160, 48550, 48551, 48552, 48554, 48556
- HCPCS: S2053, S2054m S2055, S2060, S2061, S2152
- ICD 10-PCS: 02YA0Z0 - 02YA0Z2, 07YM0Z0 -07YM0Z2, 07YP0Z0 - 07YP0Z2, 0BYC0Z0 - 0BYC0Z2, 0BYD0Z0 - 0BYD0Z2, 0BYF0Z0 - 0BYF0Z2, 0BYG0Z0 - 0BYG0Z2, 0BYH0Z0 - 0BYH0Z2, 0BYJ0Z0 - 0BYJ0Z2, 0BYK0Z0 - 0BYK0Z2, 0BYL0Z0 - 0BYL0Z2, 0BYM0Z0 - 0BYM0Z2, 0DY50Z0 - 0DY50Z2, 0DY60Z0 - 0DY60Z2, 0DY80Z0 - 0DY80Z2, 0DYE0Z0 - 0DYE0Z2, 0FY00Z0 - 0FY00Z2

- 0FYG0Z0 - 0FYG0Z2, 0UY00Z0 - 0UY00Z2, 0UY10Z0 - 0UY10Z2, 0UY90Z0 - 0UY90Z2, 0WY20Z0, 0WY20Z1, 0XYJ0Z0, 0XYJ0Z1, 0XYK0Z0, 0XYK0Z1, 3E030U1, 3E033U1, 3E0J3U1, 3E0J7U1, 3E0J8U1

Any time during the 12 months (1 year) prior to the IESD through 28 days after the IESD:

- Neurologic impairment Diagnosis: G83.4, K59.2, M48.062, R26.2, R29.2
- Spinal infection Diagnosis: A17.81, G06.1, M46.25-M46.28, M46.35-M46.38, M46.46-M46.48
- Intravenous drug abuse F Diagnosis Codes including: F11.10, F11.11, F11.20-22, F11.129, F11.13, F11.14, F11.150, F11.151, F11,181, F11.182, F11.188, F11.19, F11.20, F11.21, F11.220, F11.221, F11.222, F11.229, F11.23, F11.24
- Any time during the 3 months (90 days) prior to the IESD through 28 days after the IESD:
  - » Recent trauma Diagnosis: G89.11, ICD-10 S codes for trauma/fractures

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 member had a 90-day prescription dispensed on the IESD, there is one covered calendar day (the IESD). (See Measure Medications).

Measure Codes

Principal diagnosis of uncomplicated low back pain (Uncomplicated Low Back Pain Value Set) in an outpatient setting.

- Uncomplicated Low Back Pain Diagnosis: M47.26, M47.27, M47.28, M47.816, M47.817, M47.818, M47.896, M47.897, M47.898, M48.061, M48.07, M48.08, M51.16, M51.17, M51.26, M51.27, M51.36, M51.37, M51.86, M51.87, M53.2X6, M53.2X7, M53.2X8, M53.3, M53.86, M53.87, M53.88, M54.16, M54.17, M54.18, M54.30, M54.31, M54.32, M54.40, M54.41, M54.42, M54.5, M54.89, M54.9, M99.03, M99.04, M99.23, M99.33, M99.43, M99.53, M99.63, M99.73, M99.83, M99.84, S33.100A, S33.100D, S33.100S, S33.110A, S33.110D, S33.110S, S33.120A, S33.120D, S33.120S, S33.130A, S33.130D, S33.130S, S33.140A, S33.140D, S33.140S, S33.5XXA, S33.6XXA, S33.8XXA, S33.9XXA, S39.002A, S39.002D, S39.002S, S39.012A, S39.012D, S39.012S, S39.092A, S39.092D, S39.092S, S39.82XA, S39.82XD, S39.82XS, S39.92XA, S39.92XD, S39.92XS
- Outpatient visit, Telephone visit, Via interactive audio and video telecommunication system, Online Assessments E-visit or virtual check-in
- Observation visit (Observation Value Set)
  - » CPT: 99217 – 99220

- ED visit (ED Value Set)
  - » CPT: 99281-99285, SNOMED: 4525004, UBREV: 0450-0452, 0456, 0459, 0981
- Osteopathic or chiropractic manipulative treatment (Osteopathic and Chiropractic Manipulative Treatment Value Set)
  - » CPT: 98925 – 98929, 98940 - 98942
- Physical therapy visit (Physical Therapy Value Set)
  - » CPT: 97110, 97112, 97113, 97124, 97140, 97161 – 97164

Measure Medications

Corticosteroid Medications

Description	Prescriptions	
Corticosteriod	• Hydrocortisone • Cortisone • Prednisone • Prednisolone	• Methylprednisolone • Triamcinolone • Dexamethasone • Betamethasone

LEAD SCREENING IN CHILDREN - HEDIS

(LSC) Lead Screening in Children - HEDIS

Priority Partners/EHP/USFHP. Members age 0-2 years.

Children must have a least one capillary or venous blood tests on or before their second birthday.

- Eligibility criteria:
  - » Continuously 12 months prior to the child's second birthday
- Enrolled on the child's second birthday:
  - » Continuously 12 months prior to the child's second birthday
  - » Enrolled on the child's second birthday

Best Practice and Measure Tips

- Assessment alone does not meet criteria for this measure – be sure to order the blood test and be sure it's completed.
- 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.
- Visit the MD Department of Health website for additional information for providers and parents/care givers:
  - » https://health.maryland.gov/phpa/OEhfp/eh/Pages/Lead.aspx
  - » https://health.maryland.gov/phpa/OEHFP/EH/Shared%20Documents/Lead/B1233_ClinicianLetter_03022021.pdf

Measure Exclusions

Required Exclusions: Hospice

Measure Codes

- Lead test is defined by the following:
  - » CPT Codes: 83655

LEAD SCREENING IN CHILDREN - MDH

(LSC) Lead Screening in Children - MDH

Priority Partners/VBP. Members age 12-23 months.

This is a Maryland Department of Health (MDH) Lead Measure for children age 12-23 months as of December 31 of the measurement year (i.e., children who turned one year of age during the measurement year) who meet the following criteria:

- Continuously enrolled 90 or more days in a single HealthChoice MCO during the measurement year.
- The child did not dis-enroll from a HealthChoice MCO before their first birthday.
- The child is assigned to the last HealthChoice MCO in which the child was enrolled for at least 90 days in the measurement year.

Best Practice and Measure Tips

- Assessment alone does not meet criteria for this measure – be sure to order the blood test and be sure it's completed.
- 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.
- Visit the MD Department of Health website for additional information for providers and parents/care givers:
  - » https://health.maryland.gov/phpa/OEhfp/eh/Pages/Lead.aspx
  - » https://health.maryland.gov/phpa/OEHFP/EH/Shared%20Documents/Lead/B1233_ClinicianLetter_03022021.pdf

Measure Exclusions

Required Exclusions: Hospice

Measure Codes

- Lead test is defined by the following:
  - » CPT Codes: 83655 and 83645 (CPT Code 83645 was discontinued but is included in the lead value-based purchasing program).

MEDICATION ADHERENCE FOR CHOLESTEROL MEDICATION (STATINS)

(MAC) Medication Adherence for Cholesterol Medication (Statins)

Advantage MD Part D. Members 18 years or older.

Percentage of members ages 18 and older who adhere to their cholesterol (statin) medication at least 80 percent of the time in the measurement period.

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 PDC is the percent of days in the measurement period covered by prescription claims for the same medication or another in its therapeutic category.

Measure Exclusions

Required Exclusions: Anytime in the Measurement Year:

- Hospice
- End-stage renal disease (ESRD) or dialysis coverage dates.

Measure Medications:

Statins / Statin Combinations

Description	Prescription		
Statins/Statin Combinations	• Advicor	• Ezetimibe/Simvastatin	• Mevacor
	• Altoprey ER	• Flolipid	• Pravachol
	• Altoprey	• Fluvastatin	• Prevastatin
	• Amlodipine/Atrovastatin	• Lescol	• Rosuvastatin
	• Atorvastatin/COQ10	• Lesxol XL	• Simcor
	• Atorvastatin	• Lipitor	• Simvastatin
	• Caduet	• Livalo	• Vytorin
	• Crestor	• Lovastatin	• Zocor

MEDICATION ADHERENCE FOR DIABETES MEDICATIONS

(MAD) Medication Adherence for Diabetes Medications

Advantage MD Part D. Members 18 years or older.

Percent of members 18 or older who are adherent to their diabetes medications at least 80% or more of the time they are supposed to be taking the medication in the measurement period.

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
  - Incretin mimetics
  - Meglitinides
  - SGLT2 inhibitors
  - Sulfonylureas
  - Thiazolidinediones

Measure Exclusions

Required Exclusions: Anytime in the Measurement Year:

- Hospice
- End-stage renal disease (ESRD) or dialysis covered days.

MEDICATION ADHERENCE FOR HYPERTENSION (RAS ANTAGONISTS)

(MAH) Medication Adherence for Hypertension (RAS antagonists)

Advantage MD Part D. Members 18 years or older.

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

Best Practice and Measure Tips

- RAS antagonist medications include:
  - » Angiotensin II receptor blockers (ARBs)
  - » Angiotensin-converting enzyme (ACE) inhibitors
  - » Direct renin inhibitors
  - » 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 Exclusions

Required Exclusions: Anytime in the Measurement Year:

- Hospice
- End-stage renal disease (ESRD)
- One or more prescription claim for sacubitril/valsartan (Entresto®)

OSTEOPOROSIS MANAGEMENT IN WOMEN WHO HAD A FRACTURE

(OMW) Osteoporosis Management in Women Who Had a Fracture

Advantage MD. Women 67-85 years of age as of December 31 of the Measurement Year.

The percentage of women 67-85 years of age as of December 31 of the Measurement Year who suffered a fracture and who had either of the following in the 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 defined by any of the following criteria:

- A BMD test in any setting, on the IESD or in the 180-day (6-month) period after the IESD.
  - » If the IESD was an inpatient stay, a BMD test during the inpatient stay.
- Osteoporosis therapy on the IESD or in the 180-day (6 month) period after the IESD.
  - » If the IESD was an inpatient stay, long-acting osteoporosis therapy during the inpatient stay.
- A dispensed prescription to treat osteoporosis on the IESD or in the 180-day (6 month) period after the IESD.
- A BMD test in any setting, on the IESD or in the 180-day (6-month) period after the IESD.
  - » If the IESD was an inpatient stay, a BMD test during the inpatient stay.
- Osteoporosis therapy on the IESD or in the 180-day (6-month) period after the IESD.
  - » If the IESD was an inpatient stay, long-acting osteoporosis therapy during the inpatient stay
- A dispensed prescription to treat osteoporosis on the IESD or in the 180-day (6-month) period after the IESD

Best Practice and Measure Tips

- One of the following osteoporosis medications within 180 days of their discharge for a fracture:
  - » Bisphosphonates
  - » Alendronate
  - » Alendronate-cholecalciferol
  - » Ibandronate
  - » Risedronate
  - » Zoledronic acid
  - » Other agents
  - » Abaloparatide
  - » Denosumab
  - » Raloxifene
  - » Teriparatide
- Osteoporosis medication must be filled using a member's Part D prescription drug benefit.
- BMD test must take place within six months of the fracture.
- If the fracture resulted in an inpatient stay, a BMD test administered during the stay will close the care opportunity.
- Documentation that the medications aren't tolerated is not an exclusion for this measure.
- If the fracture resulted in an inpatient stay, long-acting osteoporosis therapy administered during the stay will close the care opportunity.
- See members for an office visit as soon as possible after an event.
- Osteoporosis medication must be filled using a member's Part D prescription drug benefit.
- 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 member from measure.
- A referral for a BMD will not close this care opportunity.
- Women at risk for osteoporosis should receive a bone density screening every two years.

Measure Exclusions

Required Exclusions:

- Hospice
- Palliative Care
- Frailty, Frailty and Advanced Illness, Living in Long Term Care
- Members who had a BMD test during the 24 months prior to the fracture
- Members who had osteoporosis therapy during the 12 months prior to the fracture
- Members who were dispensed a medication or had an active prescription for medication to treat osteoporosis during the12 months prior to the fracture

Measure Exclusions

Required Exclusion: Hospice

- Osteoporosis Medication Therapy Value Set
  - » HCPCS: J0987, J1740, J3110, J3111, J3489
- Long-Acting Osteoporosis Medications Value Set
  - » HCPCS: J0897, J1740, J3489
- Bone Mineral Density Tests Value Set
  - » CPT/CPT II: 76977, 77079, 77080, 77801, 77085, 77086
  - » ICD-10 Procedure: BP48ZZ1, BP49ZZ1, BP4GZZ1, BP4HZZ1, BP4LZZ1, BP4MZZ1, BP4NZZ1, BP4PZZ1, BQ00ZZ1, BQ01ZZ1, BQ03ZZ1, BQ04ZZ1, BR00ZZ1, BR09ZZ1, BR0GZZ1

PHARMACOTHERAPY MANAGEMENT OF COPD EXACERBATION

(PCE) Pharmacotherapy Management of COPD Exacerbation

Advantage MD, EHP, Priority Partners, and USFHP. Members 40 years of age and older.

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 and were dispensed appropriate medications.

Two rates are reported:

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

Best Practice and Measure Tips

- Members with active prescriptions for these medications are administratively compliant with the measure.
- An active prescription is one that's noted as having available medication left in the "days" supply through the episode date or further.
- 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.
- Follow up with members to make sure any new prescriptions are filled post-discharge.

Measure Exclusions

Required Exclusion: Hospice

Measure Medications

Systemic Corticosteroid Medications on or 14 days after the Episode Date

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

Bronchodilator Medications on or 30 days after the Episode Date

Description	Prescriptions		
Anticholinergic Agents	• Cortisone	• Hydrocortisone	• Prednisolone
	• Dexamethasone	• Methylprednisolone	• Prednisone
Beta-2-Agonists	• Albuterol • Arfomoterol • Formoterol	• Indacaterol • Levalbuterol • Metaproterenol	• Olodaterol • Salmetrol
Bronchodilator Combinations	• Albuterol-ipratropium • Budesonide-formoterol • Fluticasone-salmetrol • Fluticasone-vilanterol • Fluticasone furoate-umeclidinium-vilanterol	• Formoterol-aclidinium • Formoterol-glycopyrrolate • Formoterol-mometasone • Glycopyrrolate-indacetrol	• Olodaterol-tiotropium • Umeclidinium-vilaneterol

PRENATAL AND POSTPARTUM CARE

(PPC) Prenatal and Postpartum Care

EHP, Priority Partners/VBP, and USFHP. Women who had a live birth (s) on or between 10/5 year prior to the MY and 10/7 of the MY.

The percentage of live birth deliveries on or between October 8 of the year prior to the measurement year and October 7 of the measurement year. For these women, the measure assess the following.

- Timeliness of Prenatal Care: A prenatal care visit in the first trimester or within 42 days of enrollment in the health plan.
- Postpartum Care: A postpartum visit on or between 7 and 84 days after delivery

Provider Specialty: PCP, OB/GYN, Prenatal Care Provider

- Services provided during a telephone visit, e-visit or virtual check-in are acceptable for prenatal and postpartum care.
- Birth is considered a live birth if delivered twice and one was stillborn.
- Can appear twice in the measure if two separate pregnancies during time frame.

Best Practice and Measure Tips

Prenatal Care with visit date and one of the following:

- A diagnosis of pregnancy (this must be included for PCP visits).
- Documentation indicating the women is pregnant or references to the pregnancy; for example.
- Standardized prenatal flow sheet, LMP, EDD, gestational age, gravidity and parity, notation of positive pregnancy test result, OB history, or prenatal risk assessment and counseling.
- PE with auscultation for fetal heart tone, obstetric observations, or prenatal risk assessment and counseling.
- PE with auscultation for fetal heart tone, obstetric observations, or measurement of fundus height.
- Evidence that a prenatal care procedure was performed, such as:
  - » Obstetric panel or TORCH antibody panel alone or rubella antibody test/titer with RH incompatibility (ABO/Rh) blood typing
  - » Ultrasound of a pregnant uterus

Not acceptable:

- Ultrasound and lab results not combined with an office visit
- A visit or documentation with a RN alone. It must be associated with appropriate provider's note.

Postpartum with visit date and one of the following:

- Notation of PP care (including, but not limited to: "postpartum care", "PP care", "PP check", "6-week check" (Alone will make member compliant).
- Assessment of breast or breast feeding, weight, BP check and abdomen (breast feeding 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 will count 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

Measure Exclusions

Required Exclusions:

- Hospice
- Pregnancy did not result in a live birth
- Member not pregnant
- Delivery outside of measure date parameters

Measure Codes

Bundled service - codes may be used only if the claim indicates when prenatal care was initiated.

- Visit for prenatal care
  - » CPT/CPT II: 99500, 0500F-05002F
  - » HCPCS: H1000-04

- Prenatal Visit
  - » CPT/CPT II: 99201-05, 99211-15, 99241-45, 99483
  - » HCPCS: G0463, T1015
- Bundled Service – codes may be used only if the claim indicates when PP care was rendered
  - » CPT/CPT II: 59400, 59410, 59425, 59426, 59510, 59610, 59614, 59618, 59622
  - » HCPCS: H1005
- Postpartum Visits
  - » CPT/CPT: 57170, 58300, 59430, 99501, 0503F
  - » HCPCS: G0101
  - » ICD-10 Diagnosis: Z01.411, Z01.419, Z01.42, Z30.430, Z39.1, Z39.2
- Cervical Cytology
  - » CPT/CPT II: 88141-43, 88147-48, 88150, 88152-54, 88164-67, 88174-75
  - » HCPCS: G0123-24, G0141, G0143-45, G0147-48, P3000, P3001, Q0091

STATIN THERAPY FOR PATIENTS WITH CARDIOVASCULAR DISEASE

(SPC) Statin Therapy for Patients with Cardiovascular Disease

Advantage MD, EHP, Priority Partners, and USFHP. Males 21-75 years of age and Females 40-75 years of age.

The percentage of males 21-75 years of age and females 407-75 years of age as of December 31 of the measurement year, diagnosed with clinical atherosclerotic cardiovascular disease (ASCVD) and were dispensed at least one high or moderate-intensity statin medication during the measurement year.

The following rates are reported:

1. Received Statin Therapy. Dispensed at least one medication during the measurement year.
2. Statin Adherence 80%. Remained on medication for at least 80% of the treatment period.
3. **Total Rate:** Report two age/gender stratifications and a total rate.

*__NOTE:__ *All numerator compliant for Rate 1 must be used as the eligible population for Rate 2 (regardless of the data source used to capture the Rate 1 numerator).*

Best Practice and Measure Tips

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

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

Members are identified by event or diagnosis

- **Event:** 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 measurement year.
- **Diagnosis:** Identify members as having ischemic vascular disease (IVD) who met at least one of the following criteria during both the measurement year and the year prior to the measurement year:
  - » 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.

Measure Exclusions

Required Exclusions:

- Palliative Care
- Hospice
- Frailty
- Frailty and Advanced Illness
- Living in Long Term Care

Anytime during the measurement year or the prior year:

- Female members with a diagnosis of pregnancy
- In vitro fertilization
- Dispensed at least one prescription for clomiphene
- ESRD or dialysis
- Cirrhosis

During the Measurement Year:

- Myalgia
- Myositis
- Myopathy
- Rhabdomyolysis

Measure Codes

Common Codes for Exclusion:

- Muscular Pain
- Myopathy: G72.0, G72.2, G72.9
- Myositis: M60.80, M60.811, M60.812, M60.819, M60.821, M60.822, M60.829, M60.831, M60.832, M60.839, M60.841, M60.842, M60.869, M60.871, M60.872, M60.879, M60.88, M60.89, M60.9
- Rhabdomyolysis: M62.82
- Cirrhosis: K70.30, K70.31, K71.7, K74.3, K74.4, K74.5, K74.60, K74.69, P78.81
- ESRD: N18.5, N18.6, Z99.2

Measure Medications

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

High and Moderate-Intensity Statin Medications

Description	Prescription	
High-Intensity Statin Therapy	• Atorvastatin 40-80mg • Amlodipine-Atorvastatin 40-50mg • Rosuvastatin 20-40mg	• Simvastatin 80mg • Ezetimibe-Simvastatin 80mg • Atorvastatin 10-20mg
Moderate-Intensity Statin Therapy	• Atorvastatin 10-20mg • Amlodipine-Atorvastatin 10-20mg • Rosuvastatin 5-10mg • Simvastatin 20-40mg • Ezetimibe-Simvastatin 20-40mg	• Pravastatin 40-80mg • Lovastatin 40mg • Fluvastatin 40-80mg • Pitavastatin 1-4mg

Measure Codes

Common Codes for Exclusion:

- Muscular Pain
  - » Myopathy: G72.0, G72.2, G72.9
  - » Myositis: M60.80, M60.811, M60.812, M60.819, M60.821, M60.822, M60.829, M60.831, M60.832, M60.839, M60.841, M60.842, M60.869, M60.871, M60.872, M60.879, M60.88, M60.89, M60.9
  - » Rhabdomyolysis: M62.82
  - » Cirrhosis: K70.30, K70.31, K71.7, K74.3, K74.4, K74.5, K74.60, K74.69, P78.81
  - » ESRD: N18.5, N18.6, Z99.2

STATIN THERAPY FOR PATIENTS WITH DIABETES

(SPD) Statin Therapy for Patients with Diabetes

Advantage MD, EHP, Priority Partners, and USFHP. Members 40-75 years of age.

Percentage of members ages 40-75 during the measurement year with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) who met the following criteria for the two rates.

- Received Statin Therapy. Members who were dispensed at least one statin medication of any intensity during the measurement year.
- Statin Adherence 80%. Members who remained on a statin medication of any intensity 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 measurement year for any statin medication of at least moderate intensity through the last day of the measurement year. Help patients with diabetes understand they are more likely to develop heart disease or stroke, and Statin can help reduce their chance of developing these conditions.
- Educate patients on the importance of statin medication adherence.
- Adherence for the SPD measure is determined by the member remaining on their prescribed high or low intensity statin medication for 80% of their treatment period.
- Adherence is determined by pharmacy claims data (the plan will capture data each time the member fills their prescription).

Measure Exclusions

Required Exclusions:

- Palliative Care
- Hospice
- Frailty
- Frailty and Advanced Illness
- Living in Long Term Care

- **Any time during the measurement year or the prior year:**
  - » Female members with a diagnosis of pregnancy
  - » In vitro fertilization
  - » Dispensed at least one prescription for clomiphene
  - » ESRD or dialysis
  - » Cirrhosis
- **During the year prior to the Measurement Year:**
  - » Coronary artery bypass grafting (CABG)
  - » Myocardial infarction
  - » Other revascularization procedure
  - » Percutaneous coronary intervention (PCI)
- During the Measurement Year:
  - » Myalgia
  - » Myositis
  - » Myopathy
  - » Rhabdomyolysis
- **During both the Measurement Year and the year prior to the Measurement Year:**
  - » A diagnosis of ischemic vascular disease IVD

Measure Exclusions

Common codes for exclusion:

- Muscular Pain
  - » Myopathy: G72.0, G72.2, G72.9
  - » Myositis: M60.80, M60.811, M60.812, M60.819, M60.821, M60.822, M60.829, M60.831, M60.832, M60.839, M60.841, M60.842, M60.869, M60.871, M60.872, M60.879, M60.88, M60.89, M60.9
  - » Rhabdomyolysis: M62.82
  - » Cirrhosis: K70.30, K70.31, K71.7, K74.3, K74.4, K74.5, K74.60, K74.69, P78.81
  - » ESRD: N18.5, N18.6, Z99.2

Measure Medications (See SPC Measure)

USE OF SPIROMETRY TESTING IN THE ASSESSMENT AND DIAGNOSIS OF COPD

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

Advantage MD, EHP, Priority Partners, and USFHP.

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

Best Practice and Measure Tips

- At least one claim/encounter for spirometry during the 730 days (2 years) prior to the IESD through 180 days (6 months) after the IESD.
- Members must have Negative Diagnosis History (no COPD diagnosis codes captured on claims) of 730 days (2 years) prior to the IESD to be included in the measure population.
- Index Episode Start Date (IESD): The earliest date of service for an eligible visit (outpatients, ED, or acute inpatient) encounter during the Intake Period with any diagnosis of COPD.
- Perform spirometry test on patients newly diagnosed with COPD within 180 days to confirm diagnosis of COPD, evaluate severity, and assess current therapy. If the patient had a spirometry performed in the previous 2 years to confirm the "new" diagnosis of COPD in the first place, they do not need to repeat.
- Ensure appropriate documentation of spirometry testing.
- Differentiate acute from chronic bronchitis and use correct code so that the patient is not inadvertently put into the measure.
- Review the problem lists and encounter forms and remove COPD/Chronic Bronchitis when the diagnosis was made in error.
- Do not bill the COPD diagnosis code when screening to rule out the condition; instead, use code Z13.83 (encounter for screening for respiratory disorder NEC).

Measure Exclusions

Required Exclusions: Hospice

Measure Codes

- Spirometry: 94010, 94014-94016, 94060, 94070, 94375, 94620
- ED: 99281-99285
- Observation: 99217-99220
- Codes for COPD
  - » Chronic Bronchitis: J41.0, J41.1, J41.8, J42
  - » Emphysema: J43.0, J43.1, J43.2, J43.8, J43.9
  - » COPD: J44.0, J44.1, J44.9

SSI ADULTS WITH AMBULATORY CARE

(SSIAJH) SSI Adults with Ambulatory Care

VBP. Disabled (SSI) Adults aged 21-64 years old.

Disabled (SSI) Adults aged 21-64 years as of December 31 of the measurement year 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 measurement year
- Had no more than one gap in enrollment of up to 45 days during the measurement year
- Enrolled in a disabled coverage group on December 31 of the measurement year

The disabled coverage groups include the following eligibility categories:

- SOI: 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.

This measure includes

- Ambulatory care visits with a behavioral health diagnosis code (mental or chemical dependency); if those visits were covered by the MCO.
- At least one ambulatory care visit in an office 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

- Urgent Care Center Visit
  - » S9083, S9088 (HCPCS "S" Code was discontinued but is included in the SSI value-based purchasing program).
- **Preferred Codes –** preventative medicine CPT codes associated with this are contained in the following value sets:
  - » CPT 99385, 99386, 99395, 99396
- Telephone Visits Value Set:
  - » CPT 98966-98968, 99441-99443
- Telephone Visits Modifiers: GT 95
  - » GT: Via interactive audio and video telecommunication system.
  - » 95: Synchronous Telemedicine Service Rendered via a Real-time Interactive Audio and Video Telecommunications System.

Telehealth Place of Service (POS) 02:

- E-visit or virtual check-in (Online Assessments Value Set):
  - » CPT: 98970-98972, 99421-99423, 99444, 99457
  - » HCPCS: G0071, G2010, G2012, G2061-G2063
- Outpatient Visit (Outpatient Value Set): CPT: 99201-99205, 99211-99215, 99241-99245, 99341-99350, 99381-99386, 99391-99396, 99401-99404, 99411, 99412, 99429, 99455, 99456, 99483, G0402, G0438, G0439, G0463, T1015**
- Ambulatory Outpatient Visit: 92002, 92004, 92012, 92014, 99201-99205, 99211-99215, 99241-99245, 99304-99310, 99315, 99316, 99318, 99324-99328, 99334-99337, 99341-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99429, 99461, 99483, G0463, T1015**

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

SSI CHILDREN WITH AMBULATORY CARE

(SSICJH) SSI Children with Ambulatory Care

VBP Disabled (SSI) Child: Children aged 0-20 years old.

Disabled (SSI) Children aged 0-20 years old as of December 31 of the measurement year who meet all of the following criteria during the calendar year.

1. Enrolled in a disabled coverage group for 320 or more days
2. Enrolled in a single HealthChoice MCO for 320 or more days
3. Enrolled in the HealthChoice MCO as of December 31 of the measurement year
4. Had no more than one gap in enrollment of up to 45 days during the measurement year.

Best Practice and Measure Tips

This measure excludes

- Inpatient admissions and emergency department services.

This measure includes

- Ambulatory care visits with a behavioral health diagnosis code (mental or chemical dependency), if those visits were covered by the MCO.
- At least one ambulatory care visit in an office or any PCP outpatient visits. 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

- Urgent Care Center Visit
  - » S9083, S9088 (HCPCS "S" Code was discontinued but is included in the SSI value-based purchasing program).
- **Preferred Codes** – preventative medicine CPT codes associated with this measure are contained in the following value sets: 99382-99385, 99392-99395
- Telephone Visits Value Set: CPT 98966-98698, 99441-9943
- Telephone Visits Modifiers: GT 95
  - » GT: Via interactive audio and video telecommunication system
  - » 95: Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System
- Telehealth Place of Service (POS) 02:

  - » E-visits or virtual check-in (Online Assessment Value Set):
  - » CPT: 98970-98972, 99421-99423, 99444, 99457
  - » HCPCS: G0071, G2010, G2012, G2061-G2063
- Outpatient Visit (Outpatient Value Set): CPT: 99201-99205, 99211-99215, 99241-99245, 99341-99350, 99381-99385, 99391-99395, 99401-99404, 99411, 99412, 99429, 99455, 99456, 99483, G0402, G0438, G0439, G0463, T1015**
- Ambulatory Outpatient Visit: 92002, 92004, 92014, 99201-99205, 99211-99215, 99241-99245, 99304-99310, 99315, 99316, 99318, 99324-99328, 99334-99337, 99341-99350, 99381-99385, 99391-99395, 99401-99404, 99411, 99412, 99429, 99461, 99483, G0463, T1015**

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

STATIN USE IN PERSONS WITH DIABETES

(SUPD) Statin Use in Persons with Diabetes

Advantage MD. Members with diabetes ages 40-75.

Percentage of members with diabetes ages 40-75 who receive at least one fill of a statin medication in the measurement year.

Members with Diabetes definition: Those who have at least two fills of diabetes medications during the measurement year. To comply with this measure, a member 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 measurement year.

Best Practice and Measure Tips

- Prescribe at least one statin medication during the measurement year to patients diagnosed with diabetes.
- Medication samples, when given, could interfere with pharmacy claims and produce false non-adherence results.
- This measure overlaps with the Statin Therapy for Patients with Cardiovascular Disease measure. Patients with the ASCVD should be prescribed a moderate-intensity or high-intensity statin.
- This measure overlaps with the Medication Adherence for Cholesterol (Statins) measure.
- Educate patients on the importance of statin medications for diabetic patients over the age of 40, regardless of LDL levels.
- Remind patients 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.

Measure Exclusions

Required Exclusions:

- Hospice
- End-stage renal disease (ESRD) anytime in the Measurement year.

Measure Medications

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

• Atorvastatin	• Pitavastatin	• Lovastatin	• Pravastatin
• Amlodipine-atrovastatin	• Fluvastatin	• Ezetimibe-Simvastatin	• Rosuvastatin
• Simvastatin	• Livalo®		

TRANSITIONS OF CARE: PATIENT ENGAGEMENT AFTER INPATIENT DISCHARGE

(TRC) Transitions of Care: Patient Engagement after Inpatient Discharge

Advantage MD, Provider Specialty: PCP, OCP. Members age 18 years and older.

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. Patient Engagement and Inpatient Discharge is one of the four rates reported for the TRC measure. Requires documentation of patient engagement (office visits, visits to the home, telehealth) provided within 30 days after discharge.

Best Practice and Measure Tips

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. Asynchronous telehealth visit with real-time member-provider interaction suing audio and video communication.
- E-visit or virtual check-in (asynchronous telehealth with two-way interaction, which was not real-time, between the member and provider).
- If member is unable to communicate with the provider, interaction between the member's caregiver and the provider meets criteria.
- Member engagement on the date of the discharge will not be compliant.
- Documentation can come from any outpatient record that the primary care provider (PCP) or ongoing care provider can access.

Measure Exclusions

Required Exclusion: Hospice

Measure Codes

The following meet criteria for patient engagement:

- Outpatient Visits
- Telephone Visits
- E-Visit or Virtual Check In
- Transitional Care Management

TRANSITIONS OF CARE: RECEIPT OF DISCHARGE INFORMATION

(TRC) Transitions of Care: Receipt of Discharge Information

Advantage MD, Provider Specialty: PCP, OCP. Members age 18 years and older.

The percentage of acute and non-acute discharges, on or between January 1st and Dec. 1st of the MY, for members 18 years of age and older. Receipt of Discharge Information is one of the four rates reported for the TRC Measure. Requires documentation of receipt of discharge information on the day of discharge through 2 days after the discharge (3 days total).

Best Practice and Measure Tips

Documentation sent to the member's PCP or OCP must include dated evidence of receipt of discharge information on the day of discharge through 2 days after discharge. Discharge information must include all of the following:

- The name of the care provider responsible for the member's care during the inpatient stay
- Services or treatments provided during the inpatient stay
- Diagnoses at discharge
- Test results or documentation that either test results are pending or no test results are pending
- Current medication list
- 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, Member, or Family/Caregiver
- Discharge instructions that direct the member 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 2 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.

Not Acceptable Documentation

- Documentation that the member or the member's family notified the PCP or OCP of discharge

TRANSITIONS OF CARE: INPATIENT NOTIFICATION

(TRC) Transitions of Care: Inpatient Notification

Advantage MD Provider Specialty: PCP, OCP. Members age 18 years and older.

The percentage of acute and non-acute discharges, on or between January 1 and December 1 of the Measurement Year, for members 18 years of age and older. Inpatient Notification is one of the four rates reported for the TRC Measure. Requires documentation of receipt of notification of inpatient admission on the day of admission through 2 days after the admission (3 days total).

- Administrative reporting is not available for this indicator.

Best Practice and Measure Tips

Documentation sent to the member's PCP or OCP must include dated evidence of receipt of notification of inpatient admission of the day of admission through 2 days after admission from one of the following sources:

- Communication between inpatient providers or staff and the member's PCP or ongoing care provider (e.g., phone call, email, fax)
- Communication about admission between emergency department and the member's PCP or ongoing care provider (e.g., phone call, email, fax)
- Communication about admission to the member'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 member'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 member's PCP or ongoing care provider from the member's health plan. The member's PCP or ongoing care provider admitted the member to the hospital. Specialist admitted the member to the hospital and notified the member's PCP or ongoing care provider.
- The PCP or ongoing care provider placed orders for tests and treatments any time during the member'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 member to the ED
- Documentation that the member or member's family notified the member's PCP or OCP of admission

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.*

Measure Exclusions

Required Exclusion: Hospice

TRANSITIONS OF CARE: MEDICATION RECONCILIATION POST-DISCHARGE

(TRC) Transitions of Care: Medication Reconciliation Post-Discharge

Advantage MD. Members age 18 years and older.

The percentage of acute and non-acute discharges, on or between January 1 and December 1 of the Measurement Year, for members 18 years of age and older. Medication Reconciliation Inpatient Notification is one of the four rates reported for the TRC Measure. Requires documentation of medication reconciliation documented on the date of discharge through 30 days after the discharge (31 days total).

Provider Specialty: Prescribing Practitioner, Clinical Pharmacist, Registered Nurse.

Best Practice and Measure Tips

- Member must be discharged to home on or by December 1st of the MY to remain in the measure for the episode.
  - » Members may be in the measure more than once in the measurement year based on below criteria:
  - – **An episode ends** if the member 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 = date of the first admission**
  - – **Discharge date = date of the discharge where there are no readmissions or direct transfers within the 31 days total.**

  Example: *Inpatient acute care admit 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.*

Documentation in outpatient medical record:

- Must include evidence of medication reconciliation with most recent list and the date when it was performed.
- 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.

Any of the following meets criteria:

- Current medications list with a notation the provider reconciled the current and discharge medications.
- The current medications with a notation that references the discharge medications (e.g., no changes in medications since discharge, same medications at discharge, discontinue all discharge medications).
- Documentation of the current medications with evidence that the member was seen for post-discharge hospital follow-up with evidence of medication reconciliation or review.
- Evidence that the member was seen for post-discharge hospital follow-up requires documentation that indicates the provider was aware of the member'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.

Measure Exclusions

Required Exclusion: Hospice

Measure Codes

Medication Reconciliation

- Medication Reconciliation Encounter:
  - » CPT: 99483, 99495, 99496
- Medication Reconciliation Intervention:
  - » CPT II:1111F

WELL-CHILD VISITS IN THE FIRST 30 MONTHS OF LIFE

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

Priority Partners. Members ages 15 months-30 months during measurement year.

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

The following rates are reported:

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

Provider Specialty: PCP

Best Practice and Measure Tips

- 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, JHHC reminds all LOB well-care visits can be done in conjunction with sick visits, as long as they are billed appropriately.
- Well-care visits can be performed anytime in the measurement/calendar year.
- If provider is seeing a patient for Evaluation and Management services and all well-child visit components are completed: Attach modifier 25 or 59 to the well-child procedure code so it's reviewed as a significant, separately identifiable procedure.
- 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.
- For members who are off-track, schedule a catch-up well-child visit appointment for each required evaluation.
- At the new patient visit and every future visit, schedule the next well-child visit appointment.

Measure Exclusions

Required Exclusion: Hospice

Measure Codes

- Well-Care Codes
  - » CPT: 99381, 99382, 99391, 99392, 99461
  - » HCPCS: G0438, G0439 , S0302
  - » ICD-10: Z00.110, Z00.111, Z00.121, Z00.129, Z00.2, Z00.3 Z00.5, Z76.1, Z76.2

WEIGHT ASSESSMENT AND COUNSELING FOR NUTRITION AND PHYSICAL ACTIVITY FOR CHILDREN/ ADOLESCENTS

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

EHP, Priority Partners, and USFHP. Members age 3-17 years.

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

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

Best Practice and Measure Tips

- Services count if the specified documentation is present, regardless of the intent of the visit, provider type or place of service.
- BMI percentile ranges are not acceptable.
- Services rendered during a telephone visit, e-visit or virtual check-in meet criteria for the Counseling for physical activity or Counseling for nutrition.
- BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed rather than an absolute BMI value.
- A BMI value is not acceptable for this age range

BMI percentile Acceptable Documentation:

- BMI percentile plotted on an age-growth chart or documented as a value (50th percentile).
- Member-collected height, weight, and BMI percentile if entered into medical record.

Counseling Acceptable:

- Discussion of current nutrition or physical activity behaviors (e.g., eating habits, dieting behaviors, exercise routine, participation in sports activities, exam for sports participation)
- Checklist indicating nutrition or physical activity was addressed
- Counseling or referral for nutrition or physical activity

- Member received educational materials during a face-to-face visit
- Anticipatory guidance for nutrition or specific to physical activity
- Weight or obesity counseling (eating disorders) *meets criteria for both counseling.
- Referral to WIC

Counseling: Not Acceptable:

- Physical Exam finding or observation alone (e.g., well-nourished) or developmental milestones alone (e.g., Does not throw a ball)
- Notation of a discussion without specific mention of nutrition or physical activity (e.g., "appetite", "healthy lifestyle habits", "Limits T.V, computer time", "Cleared for gym class")
- Notation of AG related solely to screen time, safety (e.g. wears helmet or water safety) without specific mention of activity recommendations
- Assessment of an acute or chronic condition (e.g., presents with chronic foot pain - unable to run, presents with diarrhea, received instructions for BRAT diet)

Measure Exclusions

Required Exclusion: Hospice

Optional Exclusions: Diagnosis of pregnancy during the measurement year.

Exclusion Codes:

- Pregnancy Exclusion
  - » ICD-10: Z34.00-Z34.03, Z34.80-Z34.83, Z34.90-Z34.93

Measure Codes

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

CHILD AND ADOLESCENT WELL-CARE VISITS

(WCV) Child and Adolescent Well-Care Visits

EHP, Priority Partners, and USFHP. Members age 3-21 years.

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

- 3-11 years.
- 12-17 years.
- 18-21 years.
- Total - the total is the sum of the age stratifications for each product line.

New for Measure: Stratification by race and ethnicity.

Provider Specialty: PCP, OB/GYN

Measure is through Administrative Data. Medical record review is not performed.

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, JHHC reminds all LOB well-care visits can be done in conjunction with sick visits, as long as 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 (E/M) services and all well-child visit components are completed: Attach modifier 25 or 59 to the well-child procedure code so it's reviewed as a significant, separately identifiable procedure.
  - » Modifier 25 is used to indicate a significant and separately identifiable evaluation and management (E/M) 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 addition 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://brightfutures.aap.org/materials-and-tools/guidelines-and-pocket-guide/).

Measure Exclusions

Required Exclusion: Hospice

Measure Codes

Be sure to use age-appropriate codes.

- Well-Care
  - » CPT: 99382-99385, 99392- 99395
  - » HCPCS: G0438, G0439, S0302, S0610, S0612, S0613
  - » ICD-10: Z00.00, Z00.01, Z00.121, Z00.129, Z00.2, Z00.3, Z01.411, Z01.419, Z02.5, Z76.1, Z76.2

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