Quality Measures
HEDIS® Toolkit
Measurement Year 2023

Developed by: QI HEDIS® Team

Contents

Quality Measure Toolkit

What is HEDIS®[1]?

- HEDIS stands for **Healthcare Effectiveness Data and Information Set**.
- NCQA Specifications standardize performance to evaluate and compare health plan performance and quality.
- Required for ongoing NCQA Health Plan accreditation.

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
- Survey Method.
- Electronic Clinical Data Systems (ECDS).
- Measure specifications outline measure description, exclusions and how the data may be collected.

[1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

HEDIS®: General Guidelines and Measure Descriptions

HEDIS MY2023 Highlights

New measures

- Topical Fluoride for Children (TFC).
- Oral Evaluation, Dental Services (OED).
- De-prescribing of Benzodiazepines in Older Adults (DBO).
- Emergency Department Visits for Hypoglycemia in Older Adults with Diabetes (EDH).
- Cervical Cancer Screening (CCS-E).
- Social Need Screening and Intervention (SNS-E).

Retired measures

- Breast Cancer Screening (BCS)*
- Annual Dental Visits (ADV).
- Frequency of Selected Procedures (FSP).
- Flu Vaccinations for Adults Ages 18-64 (FVA).
- Pneumococcal Vaccinations Status for Older Adults (PNU).

*Only the Breast Cancer Screening-E (BCS-E) measure will be reported.

Overall Changes

- Moved all optional exclusions to required exclusions.
- Measure Specifications and Measure Codes are subject to change by NCQA until the measures and codes are frozen by NCQA on March 31, 2023. NCQA will release an update noting any measure or code changes at that time.

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

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

New RES Measures for 2023:

- Immunization for Adolescents (including IMA-E).
- Asthma Medication Ratio.
- Colorectal Cancer Screening (COL-E).
- Follow-Up After Emergency Department Visit for Substance Use.
- Pharmacotherapy for Opioid Use Disorder.

- Initiation and Engagement of Substance Use Disorder Treatment.
- Well-Child Visits in the First 30 Months of Life.
- Breast Cancer Screening
- Adult Immunization Status.

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)
    - Note: 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.
- Document any upcoming scheduled screening and name of provider who will be performing.
- Incomplete information will not close gaps.

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.

Required Enrollment

- To ensure there is enough time for member to receive services, each measure has criteria for:
    - Continuous enrollment: Specifies the minimum amount of time that a member must be enrolled with an organization before becoming eligible for a measure
    - A gap is the time when a member is not covered by the organization. An allowable gap can occur any time during continuous enrollment.
    - Anchor date: If a measure requires a member to be enrolled and to have a benefit on a specific date, the allowable gap must not include that date; the member must also have the benefit on that date.

Measure Exclusions

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

- **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 66 years of age and older as of December 31 of the measurement year (all product lines) with frailty and

advanced illness. Members must meet **BOTH** of the following frailty and advanced illness criteria to be excluded:

- **Frailty:** At least two indications with different dates of service during the measurement year.
- **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, Memantine or Donepezil-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[2] 98966-98968, 99441-99443.
  - E-visit or virtual check-in (Online Assessments Value Set):

    - CPT: 98970-98972, 99421- 99423, 99444, 99457, 99458
    - NOTE: Effective January 1, 2020, CPT code 98969 was deleted from the AMA CPT Code list.
    - HCPCS: G0071, G2010, G2012, G2061-G2063, G2250- G2252

  - Telephone Visits Modifiers Value Set: GT, 95:
    - GT: Via interactive audio and video telecommunication system.

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        - 95: Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System.
    - Telehealth Place of Service (POS) (Telehealth POS Value Set): 02, 10:
        - 02: Telehealth Provided Other than in Patient's Home
        - 10: Telehealth Provided in Patient's Home
- Outpatient Visit (Outpatient Value Set):
    - CPT: 99202-99205, 99211-99215, 99241-99245, 99341- 99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99429, 99455, 99456, 99483
        - NOTE: Effective January 1, 2020, CPT code 99201 was deleted from the AMA CPT Code list. However, CPT code 99201 will be used for claim data reporting prior to code deletion.
    - HCPCS: G0402, G0438, G0439, G0463, T1015**.
    - UBREV: 0510, 0511, 0512, 0513, 0514, 0515, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0526, 0527, 0528, 0529, 0982, 0983
    - Outpatient Place of Service (POS):

Code	Location
03	School
05	Indian Health Service Free-standing Facility
07	Tribal 638 Free-standing Facility
09	Prison/Correctional Facility
11	Office
12	Home
13	Assisted Living Facility
14	Group Home
15	Mobile Unit
16	Temporary Lodging
17	Walk-in Retail Health Clinic
18	Place of Employment-Worksite
19	Off Campus-Outpatient Hospital
20	Urgent Care Facility
22	On Campus-Outpatient Hospital
33	Custodial Care Facility
49	Independent Clinic
50	Federally Qualified Health Center
71	Public Health Clinic
72	Rural Health Clinic

- Ambulatory Outpatient Visit Value Set:
    - CPT: 92002, 92004, 92012, 92014, 99202-99205, 99211-99215, 99241-99245, 99304-99310, 99315, 99316, 99318, 99324-99328, 99334-99337, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99429, 99461, 99483

        - NOTE: Effective January 1, 2020, CPT code 99201 was deleted from the AMA CPT Code list. However, CPT code 99201 will be used for claim data reporting prior to code deletion.
    - HCPCS: G0463, T1015**.
        - **NOTE:** **T1015 HCPCS code which identifies an all-inclusive clinic visit for services rendered at a Federally Qualified Health Center (FQHC)
    - UBREV: 0510, 0511, 0512, 0513, 0514, 0515, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0524, 0525, 0526, 0527, 0528, 0529, 0982, 0983
- Hospice Encounter Value Set:
    - HCPCS: G9473, G9474, G9475, G9476, G9477, G9478, G9479, Q5003, Q5004, Q5005, Q5006, Q5007, Q5008, Q5010, S9126, T2042, T2043, T2044, T2045, T2046
    - UBREV: 0115, 0125, 0135, 0145, 0155, 0235, 0650, 0651, 0652, 0655, 0656, 0657, 0658, 0659
- 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
        - Direct Reference Code for the following measure: ACP, BPD, CBP, CCS, COL, COU, CRE, DAE, DDE, EED, HBD, HDO, KED, LBP, OMW, OSW, SPC, SPC, SPD
- 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
        - Additional codes apply
- Advanced Illness:
    - ICD-10-CM: A81.00, A81.01, A81.09, C25.0, C25.1, C25.2, C25.3, C25.4, C25.7, C25.8, C25.9, C71.0, C71.1, C71.2, C71.3, C71.4, C71.5, C71.6, C71.7, C71.8, C71.9, C77.0, C77.1, C77.2, C77.3, C77.4, C77.5, C77.8, C77.9, C78.00, C78.01, C78.02, C78.1, C78.2, C78.30, C78.39, C78.4, C78.5, C78.6, C78.7, C78.80, C78.89, C79.00, C79.01, C79.02, C79.10, C79.11, C79.19, C79.2, C79.31, C79.32, C79.40, C79.49, C79.51, C79.52, C79.60, C79.61, C79.62, C79.63 C79.70, C79.71, C79.72, C79.81, C79.82, C79.89, C79.9, C91.00, C91.02, C92.00, C92.02, C93.00, C93.02, C93.90, C93.92, C93.Z0, C93.Z2, C94.30, C94.32, F01.50, F01.51, F02.80, F02.81, F03.90, F03.91, F04, F10.27, F10.96, F10.97, G10, G12.21, G20, G30.0, G30.1, G30.8, G30.9, G31.01, G31.09, G31.83, G35, I09.81, I11.0, I12.0, I13.0, I13.11, I13.2, I50.1, I50.20, I50.21, I50.22, I50.23, I50.30, I50.31, I50.32, I50.33, I50.40, I50.41, I50.42, I50.43, I50.810, I50.811, I50.812, I50.813, I50.814, I50.82, I50.83, I50.84, I50.89, I50.9, J43.0, J43.1, J43.2, J43.8, J43.9, J68.4, J84.10, J84.112, J84.17, J84.170, J84.178, J96.10, J96.11, J96.12, J96.20, J96.21, J96.22, J96.90, J96.91, J96.92, J98.2, J98.3, K70.10, K70.11, K70.2, K70.30, K70.31, K70.40, K70.41, K70.9, K74.0, K74.00, K74.01, K74.02, K74.1, K74.2, K74.4, K74.5, K74.60, K74.69, N18.5, N18.6.

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 from 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 (EHP, USFHP), 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.
- **Prior Year (PY)** – Year prior to measurement year.
- **Primary Source Validation (PSV)** – Steps in the data validation process required by NCQA.
- **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.)

AAB Avoidance of Antibiotic Treatment for Acute Bronchitis Bronchiolitis

Advantage MD, 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 for any outpatient, telephone, observation or ED visit, e-visit or virtual check-in during the intake period with a diagnosis of acute bronchitis/bronchiolitis, 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).

Report three age stratifications and a total rate:

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

Best Practice and Measure Tips

- 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.
    - Examples: HIV, Malignant Neoplasm, Emphysema, COPD
- An episode will not count toward the measure denominator if the member was diagnosed with pharyngitis or a competing diagnosis, if the visit resulted in and inpatient stay 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.
- This measure is based on episodes; members may have multiple episodes.
- 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.
- Telehealth visits are allowed for this measure.

Measure Exclusions

Required Exclusions:

- Members in hospice or using hospice services anytime during the measurement year.
- Members who died any time during the measurement year.

Measure Codes

Diagnosis of acute bronchitis/bronchiolitis (Acute Bronchitis Value Set): J20.3-J20.9, J21.0, J21.1, J21.8, J21.9

Measure Medications

To comply with this measure, episode dates will not count where a new or refill prescription for an antibiotic medication (AAB Antibiotic Medications List) was dispensed 30 days prior to the episode date or was active on the episode date. Otherwise, a dispensed prescription for any of below medication on or 3 days after the episode date, will count

Description	Prescription		
Aminoglycosides	• Amikacin • Gentamicin	• Streptomycin • Tobramycin	
Aminopenicillins	• Amoxicillin	• Ampicillin	
Beta-lactamase inhibitors	• Amoxicillin-clavulanate • Ampicillin-sulbactam	• Piperacillin-tazobactam	
First-generation cephalosporins	• Cefadroxil	• Cefazolin	• Cephalexin
Fourth-generation cephalosporins	• Cefepime		
Lincomycin derivatives	• Clindamycin	• Lincomycin	
Macrolides	• Azithromycin • Clarithromycin	• Erythromycin	
Miscellaneous antibiotics	• Aztreonam • Chloramphenicol • Dalfopristin-quinupristin	• Daptomycin • Linezolid • Metronidazol	• Vancomycin
Natural penicillins	• Penicillin G benzathine-procaine • Penicillin G potassium	• Penicillin G procaine • Penicillin G sodium	• Penicillin V potassium • Penicillin G benzathine

Description	Prescription		
Penicillinase resistant penicillins	• Dicloxacillin	• Nafcillin	• Oxacillin
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 • Cefixime	• Cefotaxime • Cefpodoxime • Ceftazidime	• Ceftriaxone
Urinary anti-infectives	• Fosfomycin • Nitrofurantoin	• Nitrofurantoin macrocrystals-monohydrate • Trimethoprim	

AAP Adults' Access to Preventive/Ambulatory Health Services

Advantage MD, EHP, Priority Partners, and USFHP. Members age 20 years of age and older.

The percentage of members 20 years of age and older who had an ambulatory or preventive care visit. The organization reports three separate percentages for each product line.

- Medicaid and Medicare members who had an ambulatory or preventive care visit during the measurement year.
- Commercial members who had an ambulatory or preventive care visit during the measurement year or the 2 years prior to the measurement year.

Report three age stratifications and a total rate:

- 20-44 years.
- 45-64 years.
- 65 years and older.
- Total. The total is the sum of the age stratifications.

Best Practice and Measure Tips

- Ensure members are seen within specified timeframes for each line of business.

Measure Exclusions

Required Exclusions:

- Members in hospice or using hospice services anytime during the measurement year.
- Members who died any time during the measurement year.

Measure Codes

Use the following code to identify ambulatory or preventive care visits:

- Ambulatory Visits
    - CPT: 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 99344, 99345, 99347, 99348,

99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99429, 99483
    - HCPCS: G0402, G0438, G0439, G0463, T1015
    - ICD-10-CM: Z00.00, Z00.01, Z00.121, Z00.129, Z00.3, Z00.5, Z00.8, Z02.0, Z02.1, Z02.2, Z02.3, Z02.4, Z02.5, Z02.6, Z02.71, Z02.79, Z02.81, Z02.82, Z02.83, Z02.89, Z02.9, Z76.1, Z76.2
    - UBREV: 0510, 0511, 0512, 0513, 0514, 0515, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0526, 0527, 0528, 0529, 0982, 0983
- Other Ambulatory Visits
    - CPT: 92002, 92004, 92012, 92014, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99318, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337
    - HCPCS: S0620, S0621, 0524, 0525
- Telephone Visits CPT: 98966, 98967, 98968, 99441, 99442, 99443
- Online Assessments
    - CPT: 98969, 98970, 98971, 98972, 99421, 99422, 99423, 99444, 99457, 99458
    - HCPCS: G0071, G2010, G2012, G2061, G2062, G2063, G2250, G2251, G2252

ACP Advance Care Planning (ACP)

Advantage MD, Special Needs Plan (SNP). Members age 66 years of age and older by December 31 of the measurement year.

The percentage of adults 66–80 years of age with advanced illness, an indication of frailty or who are receiving palliative care, and adults 81 years of age and older who had advance care planning during the measurement year.

Best Practice and Measure Tips

- Have a discussion or documentation about preferences for resuscitation, life-sustaining treatment and end of life care.

Measure Exclusions

Required Exclusions:

- Members in hospice or using hospice services anytime during the measurement year.
- Members who died any time during the measurement year.

Measure Codes

Evidence of advance care planning during the measurement year.

Advance Care Planning

- CPT: 99483, 99497
- HCPCS: S0257
- ICD-10-CM: Z66 Do not resuscitate

ADD Follow-Up Care for Children Prescribed ADHD Medication

EHP, Priority Partners, 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 check-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:

- Members in hospice or using hospice services anytime during the measurement year.
- Members who died any time during the measurement year.
- 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 or admission for a mental, behavioral or neurodevelopmental disorder during the 30 days after the IPSD.
- Members with a diagnosis of narcolepsy any time during their history through December 31 or the measurement year.

Exclusion Codes:

Narcolepsy ICD-10-CM:

- [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:

- Visit Setting Unspecified
    - CPT: 90791, 90792, 90832–90834, 90836–90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221–99223, 99231–99233, 99238, 99239, 99251–99255
    - Visit Setting Unspecified Value Set with any of the following POS
        - Outpatient POS: 03, 05, 07, 09, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 22, 33, 49, 50, 71, 72
        - Partial Hospitalization POS: 52
        - Community Mental Health Center POS: 53
        - Telehealth POS: 02, 10

- BH Outpatient visit
  - CPT: 98960–98962, 99078, 99202–99205, 99211–99215, 99241–99245, 99341–99345, 99347–99350, 99381–99387, 99391–99397, 99401–99404, 99411, 99412, 99483, 99492-99494, 99510
    - NOTE: Effective January 1, 2020, CPT code 99201 was deleted from the AMA CPT Code list. However, CPT code 99201 will be used for claim data reporting prior to code deletion.
  - HCPCS: G0155, G0176, G0177, G0409, G0463, G0512, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013-H2020, T1015**.
    - **NOTE:** **T1015 HCPCS code which identifies an all-inclusive clinic visit for services rendered at a Federally Qualified Health Center (FQHC)
  - UBREV: 0510, 0513, 0515, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0526, 0527, 0528, 0529, 0900, 0902, 0903, 0904, 0911, 0914, 0915, 0916, 0917, 0919, 0982, 0983
- Observation Visit
  - CPT: 99217–99220.
- A health and behavior assessment/intervention
  - CPT: 96150- 96154, 96156, 96158, 96159, 96164, 96165, 96167, 96168, 96170, 96171
- Intensive outpatient encounter or partial hospitalization
  - HCPCS: G0410, G0411, H0035, H2001, H2012, S0201, S9480, S9484, S9485
  - UBREV: 0905, 0907, 0912, 0913
- Telehealth visit
  - CPT: 98966–98968, 99441–99443.
- E-visit or virtual check-in (Online Assessments)
  - CPT: 98970, 98971, 98972, 99421, 99422, 99423, 99444, 99457, 99458
    - Note: Effective January 1, 2020, CPT code 98969 was deleted from the AMA CPT Code list.
  - HCPCS: G0071, G2010, G2012, G2061, G2062, G2063, G2250- G2252

AMM Antidepressant Medication Management

Advantage MD, Special Needs Plan (SNP), EHP, Priority Partners and USFHP. Members 18 years of age and older.

Measure evaluates percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment.

Two rates are reported:

- Effective Acute Phase Treatment: percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks)
- Effective Continuation Phase Treatment: percentage of members who remained on an antidepressant medication for at least 180 days (6 months)

Best Practice and Measure Tips

- The American Psychiatric Association and The Substance Abuse and Mental Health Services Administration recommend patients complete the Patient Health Questionnaire (PHQ)-9 screening tool as needed. Consider the following if you diagnose the patient with depression and prescribe medication
    - Encourage them to attend psychotherapy.
    - Let them know it can take several months for antidepressant medication to be effective.
    - Remind them to continue their medication for at least six months.
    - For patients with complex conditions, consider referring them to a psychiatrist.

Measure Exclusions

Required Exclusions:

- Members in hospice or using hospice services anytime during the measurement year.
- Members who died any time during the measurement year.
- Members who did not have an encounter with a diagnosis of major depression during the 121-day period from 60 days prior to the Index prescription start date (IPSD), through the IPSD and the 60 days after the IPSD.

Measure Medications

Antidepressant Medications

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

AMR Asthma Medication Ratio

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

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

New for Measure: Stratification by race and ethnicity.

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:

- 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
- Members who died any time during the measurement year.

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

Exclusion Codes:

- Acute respiratory failure
  - ICD-10-CM: J96.00-J96.02, J96.20-J96.22
- Chronic obstructive pulmonary disease (COPD)
  - ICD-10-CM: J44.0, J44.1, J44.9
- Chronic Respiratory Conditions Due To Fumes or Vapors
  - ICD-10-CM: J68.4
- Cystic fibrosis
  - ICD-10-CM: E84.0, E84.11, E84.19, E84.8, E84.9
- Emphysema
  - ICD-10-CM: J43.0-J43.2, J43.8, J43.9
- Obstructive chronic bronchitis
  - ICD-9-CM: 491.20 -491.22
- Other Emphysema
  - ICD-10-CM: J98.2-J98.3

Measure Codes

Examples of persistent asthma codes include:

- ICD-10-CM: J45.21, J45.22, J45.30 - J45.32, J45.40 - J45.42, J45.50 - J45.52, J45.901, J45.902, J45.909, J45.991, J45.998

Measure Medications

Asthma Controller Medications

Description	Prescriptions	Route
Antibody inhibitors	Omalizumab	Injection
Anti-interleukin-4	Dupilumab	Injection
Anti-interleukin-5	Benralizumab	Injection
Anti-interleukin-5	Mepolizumab	Injection
Anti-interleukin-5	Reslizumab	Injection
Inhaled steroid combinations	Budesonide-formoterol	Inhalation
Inhaled steroid combinations	Fluticasone-salmeterol	Inhalation
Inhaled steroid combinations	Fluticasone-vilanterol	Inhalation
Inhaled steroid combinations	Formoterol-mometasone	Inhalation
Inhaled corticosteroids	Beclomethasone	Inhalation

Description	Prescriptions	Route
Inhaled corticosteroids	Budesonide	Inhalation
Inhaled corticosteroids	Ciclesonide	Inhalation
Inhaled corticosteroids	Flunisolide	Inhalation
Inhaled corticosteroids	Fluticasone	Inhalation
Inhaled corticosteroids	Mometasone	Inhalation
Leukotriene modifiers	Montelukast	Oral
Leukotriene modifiers	Zafirlukast	Oral
Leukotriene modifiers	Zileuton	Oral
Methylxanthines	Theophylline	Oral

Asthma Reliever Medications

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

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):

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

Best Practice and Measure Tips

- Members who received both of the following during the measurement year on the same or different dates of service:
    - 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:

- Members in hospice or using hospice services anytime during the measurement year.
- Members who died any time during the measurement year.

Measure Codes

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

- Blood Glucose
  - 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
- Cholesterol
  - 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	Prescription		
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 • Paliperidone palmitate • Risperidone

Antipsychotic Combination Medications

Description	Prescription	
Psychotherapeutic combinations	• Fluoxetine-olanzapine	• Perphenazine-amitriptyline

Prochlorperazine Medications

Description	Prescription
Phenothiazine antipsychotics	• Prochlorperazine

APP Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics

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

The percentage of children and adolescents 1–17 years of age who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment.

Report two age stratifications and a total rate:

- 1–11 years.
- 12–17 years.
- Total. The total is the sum of the age stratifications.

Best Practice and Measure Tips

- Ensure coordinated care such as behavioral interventions, psychological therapies and skills training.
- Assess members for alcohol and drug abuse dependence and refer if necessary.
- Periodically review the ongoing need for continued therapy with antipsychotic medication.
- Assess the need for Case Management and refer if necessary.
- Medication regiment adherence is essential for the patient's treatment.

Measure Exclusions

Required Exclusion:

- Members in hospice or using hospice services anytime during the measurement year.
- Members who died any time during the measurement year.
- Members for whom first-line antipsychotic medications may be clinically appropriate:
    - At least one acute inpatient encounter with a diagnosis of schizophrenia, schizoaffective disorder, bipolar disorder, other psychotic disorder, autism or other developmental disorder during the measurement year.
    - At least two visits in an outpatient, intensive outpatient or partial hospitalization setting, on different dates of service, with a diagnosis of schizophrenia, schizoaffective disorder, bipolar disorder, other psychotic disorder, autism or other developmental disorder during the measurement year.

Measure Codes

- Psychosocial Care
    - CPT: 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90846, 90847, 90849, 90853, 90875, 90876, 90880
    - HCPCS: G0176, G0177, G0409, G0410, G0411, H0004, H0035, H0036, H0037, H0038, H0039, H0040, H2000, H2001, H2011, H2012, H2013, H2014, H2017, H2018, H2019, H2020, S0201, S9480, S9484, S9485

Measure Medications

Antipsychotic Medications

Description	Prescription		
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 • Paliperidone palmitate	• Risperidone

Antipsychotic Combination Medications

Description	Prescription	
Psychotherapeutic combinations	• Fluoxetine-olanzapine	• Perphenazine-amitriptyline

BCS-E Breast Cancer Screening

Advantage MD, EHP, Priority Partners and USFHP. Female 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.

New for Measure: Stratification by race and ethnicity.

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
- Members in hospice or using hospice services anytime during the measurement year.
- Frailty and Advanced Illness
- Living in Long Term Care
- 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

Exclusion Codes:

- Bilateral mastectomy:
    - ICD10PCS: 0HTV0ZZ
- Mastectomy (History of Bilateral Mastectomy Value Set):
        - ICD-10-CM: [Z90.13] Acquired absence of bilateral breasts and nipples
- Unilateral mastectomy
    - CPT: 19180, 19200, 19220, 19240, 19303, 19304, 19305, 19306, 19307
    - Modifiers: 50, LT, RT
    - ICD-10-CM:
        - [Z90.12] Acquired absence of left breast and nipple
        - [Z90.11] Acquired absence of right breast and nipple
    - ICD-10-PCS:
        - [0HTU0ZZ] Resection of Left Breast, Open Approach
        - [0HTT0ZZ] Resection of Right Breast, Open Approach

Measure Codes

Mammography (Mammography Value Set)

- CPT: 77061-77063, 77065-77067

BPD Blood Pressure Control for Patients with Diabetes

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

Percentage of members 18-75 years of age 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

BP reading must be the last BP result performed within the measurement year.

See **CBP** Measure for tips.

Measure Exclusions

Required Exclusions:

- Palliative Care
- Members in hospice or using hospice services anytime during the measurement year.
- Members who died any time during the measurement year.
- 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

- 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 130-139
  - CPT-CAT-II: 3075F
- Systolic Greater than/Equal to 140

- CPT-CAT-II: 3077F

Medication List: Diabetes Medications

Description	Prescription		
Alpha-glucosidase inhibitors	• Acarbose • Miglitol		
Amylin analogs	• Pramlintide		
Antidiabetic combinations	• Alogliptin-metformin • Alogliptin-pioglitazone • Canagliflozin-metformin • Dapagliflozin-metformin • Dapagliflozin-saxagliptin • Empagliflozin-linagliptin • Empagliflozin-metformin	• Empagliflozin-linagliptin-metformin • Ertugliflozin-metformin • Ertugliflozin-sitagliptin • Glimepiride-pioglitazone • Glipizide-metformin • Glyburide-metformin	• Linagliptin-metformin • Metformin-pioglitazone • Metformin-repaglinide • Metformin-rosiglitazone • Metformin-saxagliptin • Metformin-sitagliptin
Insulin	• Insulin aspart • Insulin aspart-insulin aspart protamine • Insulin degludec • Insulin degludec-liraglutide • Insulin detemir • Insulin glargine	• Insulin glargine-lixisenatide • Insulin glulisine • Insulin 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®) • Lixisenatide • Semaglutide	
Sodium glucose cotransporter 2 (SGLT2) inhibitor	• Canagliflozin	• Dapagliflozin (excluding Farxiga®)	• Empagliflozin • Ertugliflozin
Sulfonylureas	• Chlorpropamide • Glimepiride	• Glipizide • Glyburide	• Tolazamide • Tolbutamide
Thiazolidinediones	• Pioglitazone	• Rosiglitazone	
Dipeptidyl peptidase-4 (DDP-4) inhibitors	• Alogliptin • Linagliptin	• Saxagliptin • Sitagliptin	

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

CBP Controlling High BP

Advantage MD, SNP, EHP, 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 hypertension (system calculates).

If multiple BP readings are noted in the chart on the same date, the lowest systolic and lowest diastolic BP result will be used.

Report 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 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
- Members in hospice or using hospice services anytime during the measurement year.
- Members who died any time during the measurement year.
- Frailty
- Frailty and Advanced Illness
- Living in Long Term Care
- Dialysis End-stage renal disease (ESRD)
- Kidney transplant Nephrectomy
- Members with a diagnosis of pregnancy
- Non-acute inpatient admission

Measure Codes

- Hypertension
  - ICD-10: I10
- 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 130-139
    - 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.

CCS Cervical Cancer Screening

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

Female members age 21-64 who were screened 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
- Members in hospice or using hospice services anytime during the measurement year.
- Hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix any time during the member's history through December 31 of the measurement year.
- Members who died any time during the measurement year.

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.

Exclusion Codes:

- Absence of Cervix Diagnosis
    - ICD-10: Q51.5, Z90.710, Z90.712
- Hysterectomy with No Residual Cervix
    - CPT: 57530, 57531, 57540, 57545, 57550, 57555, 57556, 58150, 58152, 58200, 58210, 58240, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290-58294, 58548, 58550, 58552-58554, 58570-58573, 58575, 58951, 58953, 58954, 59856, 59135
    - ICD-10:
        - [0UTC0ZZ] Resection of Cervix, Open Approach
        - [0UTC4ZZ] Resection of Cervix, Percutaneous Endoscopic Approach
        - [0UTC7ZZ] Resection of Cervix, Via Natural or Artificial Opening
        - [0UTC8ZZ] Resection of Cervix, Via Natural or Artificial Opening Endoscopic

Measure Codes

- Cervical Cytology Lab Test
    - CPT: 88141-88143, 88147-88148, 88150, 88152, 88153, 88164-88167, 88174-88175
    - HCPCS: G0123, G0124, G0141, G0143, G0144, G0145, G0147, G0148, P3000, P3001, Q0091
- HPV Tests
    - CPT: 87624, 87625
    - HCPCS: G0476

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:

- Members in hospice or using hospice services anytime during the measurement year.
- Members who died 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 any time during the measurement year:
    - A prescription for isotretinoin (Retinoid medications)
    - An X-ray

Measure Codes

- Chlamydia Screening Test
    - CPT 87110, 87270, 87320, 87490-87492, 87810

CIS Childhood Immunizations

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

The percent of children 2 years old during the measurement year 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-TlV)
- 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. This does not exclude member from measure.
- The below count towards compliance for the vaccine. Document with event date:
    - For DTaP: Encephalitis due to the vaccine.
    - For ALL vaccines:
        - Anaphylaxis due to the vaccine.
        - Evidence of the antigen or combination vaccine.
    - For hepatitis B, MMR, VZV and hepatitis A, count any of the following:
        - Documented history of the illness.
- Must be done by 2nd birthday: when scheduling check calendar and schedule prior to 2nd birthday.
- For rotavirus, if documentation does not indicate whether the two-dose schedule or three-dose schedule was used, assume a three-dose schedule

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 date.

- 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:

- Members in hospice or using hospice services anytime during the measurement year.
- Members who died any time during the measurement year.
- Members who had any of the following on or before their second birthday:
    - Severe combined immunodeficiency
    - Immunodeficiency
    - HIV
    - Lymphoreticular cancer, multiple myeloma or leukemia
    - Intussusception

Exclusion Codes:

- Severe Combined Immunodeficiency
    - ICD-10-CM: D81.0, D81.1, D81.2, D81.9
- Disorders of the Immune System (Immunodeficiency)
    - ICD-10-CM: D80.0- D80.9, D81.0- D81.2, D81.4, D81.6, D81.7, D81.89, D81.9, D82.0- D82.4, D82.8, D82.9, D83.0-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-D89.813, D89.82, D89.831-D89.835, D89.839, D89.89, D89.9
- HIV
    - ICD-10-CM: B20, Z21
- HIV Type 2
    - ICD-10-CM: B97.35
- Malignant Neoplasm of Lymphatic Tissue
    - Lymphoreticular cancer ICD-10-CM: C81.00- C81.49,C81.70- C81.79, C81.90- C81.99, C82.00- C82.69, C82.80- C82.99, C83.00- C83.39, C83.50- C83.59,

C83.70- C83.99, C84.40- C84.49, C84.60- C84.79, C84.7A, C84.90- C84.99, C84.A0- C84.A9, C84.Z0- C84.Z9, C85.10- C85.29, C85.80- C85.99, C86.0- C86.5, C88.4, C96.9, C96.Z
    - Multiple Myeloma ICD-10-CM: C90.00, C90.01, C90.02
    - Leukemia ICD-10-CM: C90.10- C90.12, C91.00- C91.02, C91.10- C91.12, C91.30- C91.32, C91.40- C91.42, C91.50- C91.52, C91.60- C91.62, C91.90- C91.92, C91.A0- C91.A2, C91.Z0- C91.Z2, C92.00- C92.02, C92.10- C92.12, C92.20- C92.22, C92.40- C92.42, C92.50- C92.52, C92.60- C92.62, C92.90- C92.92, C92.A0- C92.A2, C92.Z0- C92.Z2, C93.00- C93.02, C93.10- C93.12, C93.30- C93.32, C93.90- C93.92, C93.Z0- C93.Z2, C94.00- C94.02, C94.20- C94.22, C94.30- C94.32, C94.80- C94.82, C95.00- C95.02, C95.10- C95.12, C95.90- C95.92
- Intussusception
    - ICD-10-CM: K56.1

Measure Codes

- DTAP
    - CPT: 90697, 90698, 90700, 90723
    - CVX: 20, 50, 106, 107, 110, 120, 146
    - Anaphylaxis Due to Diphtheria, Tetanus or Pertussis Vaccine SNOMED CT code: 428281000124107,428291000124105
    - Encephalitis Due to Diphtheria, Tetanus or Pertussis Vaccine SNOMED CT code: 192710009, 192711008, 192712001
- IPV
    - CPT: 90697, 90698, 90713, 90723
    - CVX: 10, 89, 110, 120, 146
    - Anaphylaxis due to the IPV vaccine SNOMED CT code: 471321000124106
- MMR
    - CPT: 90707, 90710
    - CVX: 03, 94
    - ICD-10-CM:
        - History of measles illness: B05.0- B05.4, B05.81, B05.89, B05.9
        - History of mumps illness: B26.0- B26.3, B26.81- B26.85, B26.89, B26.9
        - History of rubella illness: B06.00- B06.02, B06.09, B06.81, B06.82, B06.89, B06.9
    - Anaphylaxis due to the MMR vaccine SNOMED CT code: 471331000124109
- HIB
    - CPT: 90644,90647, 90648, 90697, 90698, 90748
    - CVX: 17, 46, 47, 48, 49, 50, 51, 120, 146, 148
    - Anaphylaxis due to the HiB vaccine SNOMED CT code: 433621000124101
- Hep B
    - CPT: 90697,90723, 90740, 90744, 90747, 90748
    - CVX: 08, 44, 45, 51, 110, 146
    - HCPCS: G0010

    - History of hepatitis B illness ICD-10-CM: 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
    - Anaphylaxis due to the hepatitis B vaccine SNOMED CT code: 428321000124101
- Varicella VZV
    - CPT: 90710, 90716
    - CVX: 21, 94
    - History of varicella zoster ICD-10-CM: 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
    - Anaphylaxis due to the VZV vaccine SNOMED CT code: 471341000124104
- Pneumococcal Conjugate PCV
    - CPT: 90670
    - CVX: 109,133, 152
    - HCPCS: G0009
    - Anaphylaxis due to the pneumococcal conjugate vaccine SNOMED CT code: 471141000124102
- Hep A
    - CPT: 90633
    - CVX: 31, 83, 85
    - History of hepatitis A illness ICD-10-CM: B15.0, B15.9
    - Anaphylaxis due to the hepatitis A vaccine SNOMED CT code 471311000124103
- Rotavirus
    - Rotavirus (2 Dose)
        - CPT: 90681
        - CVX: 119
    - Rotavirus (3 Dose)
        - CPT: 90680
        - CVX: 116, 122
    - Anaphylaxis due to the rotavirus vaccine SNOMED CT code: 428331000124103
- Influenza
    - CPT: 90655, 90657, 90661, 90673, 90674, 90756, 90685- 90689
    - CVX: 88,140, 141, 150, 153, 155, 158, 161, 171, 186
    - HCPCS: G0008
    - Anaphylaxis due to the influenza vaccine SNOMED CT code: 471361000124100
- Influenza LAIV
    - CPT: 90660, 90672
    - CVX: 111, 149
    - Anaphylaxis due to the influenza vaccine SNOMED CT code: 471361000124100

COA Care for Older Adults

Advantage MD, Special Needs Plan (SNP). 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 medication review performed without the member present meets criteria.

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.
- 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.
- **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:

- Members in hospice or using hospice services anytime during the measurement year.
- Exclude services provided in an acute inpatient setting.
- Members who died any time during the measurement year.

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, 99496
- **Functional status assessment**
  - CPT: 99483
  - CPT II: 1170F
  - HCPCS: G0438, G0439
- **Pain assessment**
  - CPT II: 1125F, 1126F

COL Colorectal Cancer Screening

Advantage MD, SNP, EHP, Priority Partners* and USFHP. Members 45-75 years of age.

Members age 45-75 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.
- Stool DNA (sDNA) with FIT test (Cologuard) during the MY or two (2) years prior.
- Fecal occult blood test (FOBT) during the MY. gFOBT (guaiac), FIT/iFOBT (immunochemical).

Members 46–75 years as of December 31 of the measurement year. Report two age stratifications and a total rate:

- 46–49 years.
- 50–75 years.
- Total. *** The total is the sum of the age stratifications.

Report Stratification by race and ethnicity.

***Note: Only the administrative data collection method may be used when reporting this measure for Priority Partners (Medicaid product line). There will be no medical records review.**

Best Practice and Measure Tips

- 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 stool DNA (sDNA) with FIT test is 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.
- Documentation in the medical record of "Colon Cancer Screening Done in 2022" 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:

- Palliative Care
- Members in hospice or using hospice services anytime during the measurement year.
- Frailty and Advanced Illness
- Living in Long Term Care.
- Members who had colorectal cancer or a total colectomy any time during the member's history through December 31 of the measurement year.
- Members who died any time during the measurement year.

Exclusion Codes:

- Colorectal Cancer
    - ICD-10-CM: C18.0-C18.9, C19, C20, C21.2, C21.8, C78.5, Z85.038, Z85.048
- Total Colectomy
    - CPT: 44150-44153, 44155-44158, 44210-44212
    - ICD-10-PCS:
        - [0DTE0ZZ] Resection of Large Intestine, Open Approach
        - [0DTE4ZZ] Resection of Large Intestine, Percutaneous Endoscopic Approach
        - [0DTE7ZZ] Resection of Large Intestine, Via Natural or Artificial Opening

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
- Stool DNA (sDNA) with FIT Test
  - CPT 81528 This code is specific to the Cologuard® sDNA with FIT test.

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. 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). A lower rate indicates better performance.

- **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.

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 prevent member from 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.
- Stay inform about the latest opioid research and guidelines by visiting:
  - Centers of Disease Control and Prevention
    - CDC offers a number of materials and tools about opioid prescribing guidelines.
    - Permission is not needed to print, copy, or distribute any materials. Visit the CDC website. https://www.cdc.gov/opioids/providers/prescribing/index.html

- U. S. Department of Health and Human Services
  - HHS (hhs.org) offers a number of materials and tools about opioid prescribing guidelines:
    - Prevention
    - Treatment
    - Recovery
  - The Substance Abuse and Mental Health Services Administration (SAMHSA) guidance and resources for opioid-related treatment programs
- Maryland Opioid Operational Command Center
  - Provides free resources regarding prevention, treatment and recovery. Visit the website: https://beforeitstoolate.maryland.gov/resources/

- 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:

- Members in hospice or using hospice services anytime during the measurement year.
- Members who died any time during the measurement year.
- **Any of the following during the 12 months prior to the earliest prescription dispensing date:**
  - Palliative Care
  - Cancer
  - Sickle Cell Disease

Exclusion Codes:

- Cancer
  - Malignant Neoplasms ICD-10-CM: 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, C06.9, C07, C08.0, C08.1, C08.9, C09.0, C09.1, C09.8, C09.9, C10.0, C10.1-C10.4, C10.8, C10.9, C11.0-C11.3, C11.8, C11.9, C12, C13.0, C13.1, C13.2, C13.8, C13.9,

C14.0, C14.2, C14.8, C15.3, C15.4, C15.5, C15.8, C15.9, C16.0- C16.6, C16.8, C16.9, C17.0- C17.3, C17.8, C17.9, C18.0- C18.9, C19, C20, C21.0; C92.60, C93.92, C93.Z0, C93.Z1, C93.Z2, C94.00, C94.01, C94.02, C94.20, C94.21, C94.22, C94.30, C94.31, C94.32, C94.40, C94.41, C94.42, C94.6, C94.80, C94.81, C94.82, C95.00, C95.01, C95.02, C95.10, C95.11, C95.12, C95.90, C95.91, C95.92, C96.0, C96.2, C96.20, C96.21, C96.22, C96.29, C96.4, C96.5, C96.6, C96.9, C96.A, C96.Z;

    - Additional codes apply.

- Sickle Cell Diseases
    - ICD-10-CM: 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 Medications List
Buprenorphine (transdermal patch and buccal film)	Buprenorphine Medications List
Butorphanol	Butorphanol Medications List
Codeine	Acetaminophen Butalbital Caffeine Codeine Medications List Acetaminophen Codeine Medications List Aspirin Butalbital Caffeine Codeine Medications List Aspirin Carisoprodol Codeine Medications List Codeine Sulfate Medications List
Dihydrocodeine	Acetaminophen Caffeine Dihydrocodeine Medications List Aspirin Caffeine Dihydrocodeine Medications List
Fentanyl	Fentanyl Medications List
Hydrocodone	Acetaminophen Hydrocodone Medications List Hydrocodone Medications List Hydrocodone Ibuprofen Medications List
Hydromorphone	Hydromorphone Medications List
Levorphanol	Levorphanol Medications List
Meperidine	Meperidine Medications List Meperidine Promethazine Medications List
Methadone	Methadone Medications List

Prescription	Medication Lists
Morphine	Morphine Medications List Morphine Naltrexone Medications List
Opium	Belladonna Opium Medications List Opium Medications List
Oxycodone	Acetaminophen Oxycodone Medications List Aspirin Oxycodone Medications List Ibuprofen Oxycodone Medications List Oxycodone Medications List
Oxymorphone	Oxymorphone Medications List
Pentazocine	Naloxone Pentazocine Medications List
Tapentadol	Tapentadol Medications List
Tramadol	Acetaminophen Tramadol Medications List Tramadol Medications List

CWP Appropriate Testing for Pharyngitis

Advantage MD, 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 a 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 that did not result in an inpatient stay.

Measure Exclusions

Required Exclusion:

- Members in hospice or using hospice services anytime during the measurement year.
- Members who died any time during the measurement year.

12 months prior to or on the episode date diagnosis of one of the below:

- HIV
- HIV Type 2
- Malignant Neoplasms
- Other Malignant Neoplasms of the Skin
- Emphysema
- COPD
- Comorbid Conditions
- Disorders of the Immune System

Exclusion Codes

- COPD
  - ICD-10-CM: J44.0, J44.1, J44.9
- Comorbid Conditions
  - ICD-10-CM: A15.0, A17.0, A18.01, A19.0, B44.81, D57.01, D61.810, D70.0, D71, D72.0, D75.81, D76.1, D86.0, E84.0, J22, J41.0, J42, J47.0, J60, J61, J62.0, J63.0, J64, J65, J66.0, J67.0, J68.0, J69.0, J70.0, J80, J81.0, J82, J84.01, J85.0, J86.0, J90, J91.0, J92.0, J93.0, J94.0, J95.00, J95.01, J96.00, J98.51, J99, M05.10, M30.1, M32.13, M33.01, M34.81, M35.02, O98.011, P27.0, Q25.45, Q30.0, Q31.0, Q32.0, Q33.0, Q34.0, Q34.1, Q39.0, Q89.01
    - Additional codes apply.

- Emphysema
  - ICD-10-CM: J43.0, J43.1, J43.2, J43.8, J43.9
- Disorders of the immune system
  - ICD-10-CM: 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
- Malignant neoplasms
  - ICD-10-CM: 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

- Other malignant neoplasms of the skin:
  - ICD-10-CM: C44.00-C44.02, C44.90-C44.92, C44.99 , C44.09, C44.101, C44.102, C44.1021, C44.1022, C44.109, C44.1091, C44.1092, C44.111, C44.112, C44.1121, C44.1122, C44.119, C44.1191, C44.1192, C44.121, C44.122, C44.1221, C44.1222, C44.129, C44.1291, C44.1292, C44.131, C44.1321, C44.1322, C44.1391, C44.1392, C44.191, C44.192, C44.1921, C44.1922, C44.199, C44.1991, C44.1992, C44.201, C44.202, C44.209, C44.211, C44.212, C44.219, C44.221, C44.222, C44.229, C44.291, C44.292, C44.299, C44.300, C44.301, C44.309, C44.310, C44.311, C44.319, C44.320, C44.321, C44.329, C44.390, C44.391, C44.399, C44.40, C44.41, C44.42, C44.49, C44.500, C44.501, C44.509, C44.510, C44.511, C44.519, C44.520, C44.521, C44.529, C44.590, C44.591, C44.599, C44.601, C44.602, C44.609, C44.611, C44.612, C44.619, C44.621, C44.622, C44.629, C44.691, C44.692, C44.699, C44.701, C44.702, C44.709, C44.711, C44.712, C44.719, C44.721, C44.722, C44.729, C44.791, C44.792, C44.799, C44.80, C44.81, C44.82, C44.89
    - Additional codes apply.

Measure Codes

- Group A Strep Test
  - CPT: 87070, 87071, 87081, 87430, 87650-87652, 87880
- Pharyngitis
  - ICD-10-CM: J02.0, J02.8, J02.9, J03.00, J03.01, J03.80, J03.81, J03.90, J03.91

Measure Medications

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

CWP Antibiotic Medications

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

EED Eye Exam for Patients with Diabetes

Advantage MD, EHP, Priority Partners, and USFHP. 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

- 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 fundoscopic exam without examination of macula, vessels and periphery.

- Documentation of "diabetes without complications."

Measure Exclusions

Required Exclusions:

- Palliative Care
- Members in hospice or using hospice services anytime during the measurement year.
- Members who died any time during the measurement year.
- 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

- Diabetes Mellitus Without Complications
  - ICD-10-CM: E10.9, E11.9, E13.9
- 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
  - Automated Eye Exam:
    - CPT: 92229
- Diabetic Eye Exam
  - CPT: 67028, 67030, 67031, 67036, 67039-67043, 67101, 67105, 67107, 67108, 67110, 67113, 67121, 67141, 67145, 67208, 67210, 67218, 67220, 67221, 67227, 67228, 92002, 92004, 92012, 92014, 92018, 92019, 92134, 92201, 92202, 92225-92228, 92230, 92235, 92240, 92250, 92260, 99203-99205, 99213-99215, 99242-99245
  - HCPCS: S0620, S0621, S3000
- Unilateral Eye Enucleation
  - CPT: 65091, 65093, 65101, 65103, 65105, 65110, 65112, 65114
- Unilateral Eye Enucleation – Left
  - ICD10PCS: Diagnosis 08T1XZZ
- Unilateral Eye Enucleation – Right
  - ICD10PCS: Diagnosis 08T0XZZ
- Bilateral Modifier
  - CPT Modifier 50

Medication List: Diabetes Medications

Description	Prescription		
Alpha-glucosidase inhibitors	• Acarbose • Miglitol		
Amylin analogs	• Pramlintide		
Antidiabetic combinations	• Alogliptin-metformin • Alogliptin-pioglitazone • Canagliflozin-metformin • Dapagliflozin-metformin • Dapagliflozin-saxagliptin • Empagliflozin-linagliptin • Empagliflozin-metformin	• Empagliflozin-linagliptin-metformin • Ertugliflozin-metformin • Ertugliflozin-sitagliptin • Glimepiride-pioglitazone • Glipizide-metformin • Glyburide-metformin	• Linagliptin-metformin • Metformin-pioglitazone • Metformin-repaglinide • Metformin-rosiglitazone • Metformin-saxagliptin • Metformin-sitagliptin
Insulin	• Insulin aspart • Insulin aspart-insulin aspart protamine • Insulin degludec • Insulin degludec-liraglutide • Insulin detemir • Insulin glargine	• Insulin glargine-lixisenatide • Insulin glulisine • Insulin 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®) • Lixisenatide • Semaglutide	
Sodium glucose cotransporter 2 (SGLT2) inhibitor	• Canagliflozin	• Dapagliflozin (excluding Farxiga®)	• Empagliflozin • Ertugliflozin
Sulfonylureas	• Chlorpropamide • Glimepiride	• Glipizide • Glyburide	• Tolazamide • Tolbutamide
Thiazolidinediones	• Pioglitazone	• Rosiglitazone	
Dipeptidyl peptidase-4 (DDP-4) inhibitors	• Alogliptin • Linagliptin	• Saxagliptin • Sitagliptin	

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

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

Advantage MD. Members 18 years of age and older.

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

Report two age stratifications and a total rate:

- 18–64 years.
- 65 years and older.
- Total.

Best Practice and Measure Tips

- The denominator is based on ED visits, not members.
- ED visits count between January 1 and December 24 of the measurement year where member was 18 years of age or older on the date of the visit.
- ED visits that result in an inpatient stay, either acute or non-acute, within 7 days after the inpatient stay are excluded.
- The following are eligible chronic condition diagnoses. Each bullet indicates an eligible chronic condition (for example, COPD and asthma are considered the same chronic condition):
    - COPD, asthma, unspecified bronchitis
    - Alzheimer's disease and related disorders
    - Chronic kidney disease
    - Depression
    - Heart failure (Chronic Heart Failure; Heart Failure Diagnosis).
    - Acute myocardial infarction (MI Value Set; Old Myocardial Infarction).
    - Atrial fibrillation
    - Stroke and transient ischemic attack (visit with a principal diagnosis of encounter for other specified aftercare not included).
- ED visits are counted for members with two or more different chronic conditions prior to the ED visit
- Eligible chronic condition diagnoses are identified on the discharge claim, on different dates of service, during the measurement year or year prior. (Visit type need not be the same for the two visits, but the visits must be for the same eligible chronic condition.)

    - At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set), telephone visits (Telephone Visits Value Set), e-visits or virtual check-ins (Online Assessments Value Set), nonacute inpatient encounters (Nonacute Inpatient Value Set) or nonacute inpatient discharges.
- Visits are identified chronologically. Only one visit per 8-day period. If a member has more than one ED visit in an 8-day period, only the first eligible ED visit is included.
- Ensure member has follow-up services within 7 days after the ED visit. Eight days totals to include visits that occurred on the day of the ED visit.

Measure Exclusions

Required Exclusions:

- Members in hospice or using hospice services anytime during the measurement year.
- Members who died any time during the measurement year.

Measure Codes

- Outpatient visit
    - CPT: 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99429, 99455, 99456, 99483
    - HCPCS: G0402, G0438, G0439, G0463, T1015
    - UBREV: 0510, 0511, 0512, 0513, 0514, 0515, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0526, 0527, 0528, 0529, 0982, 0983
- Telephone Visits CPT: 98966, 98967, 98968, 99441, 99442, 99443
- Transitional Care Management Services CPT: 99495, 99496
- Case Management Encounter
    - CPT: 99366
    - HCPCS: T1016, T1017, T2022, T2023
- Complex Care Management Services
    - CPT: 99439, 99487, 99489, 99490, 99491
    - HCPCS: G0506
- Visit Setting Unspecified
    - CPT: 90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99251, 99252, 99253, 99254, 99255
    - An outpatient or telehealth behavioral health visit (Visit Setting Unspecified CPT) with Outpatient Place of Service (POS):

Code	Location
03	School
05	Indian Health Service Free-standing Facility
07	Tribal 638 Free-standing Facility
09	Prison/Correctional Facility
11	Office
12	Home
13	Assisted Living Facility
14	Group Home
15	Mobile Unit
16	Temporary Lodging
17	Walk-in Retail Health Clinic
18	Place of Employment-Worksite
19	Off Campus-Outpatient Hospital
20	Urgent Care Facility
22	On Campus-Outpatient Hospital
33	Custodial Care Facility
49	Independent Clinic
50	Federally Qualified Health Center
71	Public Health Clinic
72	Rural Health Clinic

- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified CPT) with Partial Hospitalization Place of Service (POS):

Code	Location
52	Psychiatric Facility-Partial Hospitalization

- A community mental health center visit (Visit Setting Unspecified CPT) with Community Mental Health Center Place of Service (POS):

Code	Location
53	Community Mental Health Center

- A telehealth visit (Visit Setting Unspecified CPT with Telehealth Place of Service (POS):

Code	Location
02	Telehealth Provided Other than in Patient's Home
10	Telehealth Provided in Patient's Home

- An outpatient or telehealth behavioral health visit: BH Outpatient
  - CPT: 98960, 98961, 98962, 99078, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99341, 99342,

99343, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 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
    - UBREV: 0510, 0513, 0515, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0526, 0527, 0528, 0529, 0900, 0902, 0903, 0904, 0911, 0914, 0915, 0916, 0917, 0919, 0982, 0983
- Partial Hospitalization or Intensive Outpatient
    - HCPS: G0410, G0411, H0035, H2001, H2012, S0201, S9480, S9484, S9485
    - UBREV: 0905, 0907, 0912, 0913
- Electroconvulsive Therapy
    - CPT: 90870
    - ICD-10-PCS: GZB0ZZZ, GZB1ZZZ, GZB2ZZZ, GZB3ZZZ, GZB4ZZZ
    - Electroconvulsive Therapy with any of the following Place of Service (POS):
        - Ambulatory Surgical Center POS: 24
        - Community Mental Health Center POS: 53
        - Partial Hospitalization POS: 52
        - Outpatient POS:

Code	Location
03	School
05	Indian Health Service Free-standing Facility
07	Tribal 638 Free-standing Facility
09	Prison/Correctional Facility
11	Office
12	Home
13	Assisted Living Facility
14	Group Home
15	Mobile Unit
16	Temporary Lodging
17	Walk-in Retail Health Clinic
18	Place of Employment-Worksite
19	Off Campus-Outpatient Hospital
20	Urgent Care Facility
22	On Campus-Outpatient Hospital
33	Custodial Care Facility
49	Independent Clinic
50	Federally Qualified Health Center
71	Public Health Clinic
72	Rural Health Clinic

- Observation CPT: 99217, 99218, 99219, 99220
- Substance Use Disorder Services

    - CPT: 99408, 99409
    - HCPCS: G0396, G0397, G0443, H0001, H0005, H0007, H0015, H0016, H0022, H0047, H0050, H2035, H2036, T1006, T1012
    - UBREV: 0906, 0944, 0945
- E-visit or virtual check-in (Online Assessments)
    - CPT: 98969, 98970, 98971, 98972, 99421, 99422, 99423, 99444, 99457, 99458
    - HCPCS: G0071, G2010, G2012, G2061, G2062, G2063, G2250, G2251, G2252
- Domiciliary or Rest Home Visit CPT: 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337

FUH Follow-Up After Hospitalization for Mental Illness

Advantage MD, SNP, EHP, Priority Partners 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.

Report three age stratifications and a total rate:

- 6–17 years.
- 18–64 years.
- 65 years and older.
- Total. The total is the sum of the age stratifications.

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.
    - To refer your patient to a behavioral health specialist or to request coordination of care, please call the number on the back of the patient's health plan ID card or search jhhc.com.

- 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.
- Psychiatric collaborative care management count toward compliance.

Measure Exclusions

Required Exclusions:

- Members in hospice or using hospice services anytime during the measurement year.
- Members who died any time during the measurement year.

Measure Codes

- Behavioral Healthcare Setting
  - UBREV: 0513, 0900, 0901, 0902, 0903, 0904, 0905, 0907, 0911, 0912, 0913, 0914, 0915, 0916, 0917, 0919
- Electroconvulsive Therapy
  - CPT: 90870
  - ICD-10-PCS: GZB0ZZZ, GZB1ZZZ, GZB2ZZZ, GZB3ZZZ, GZB4ZZZ
  - Electroconvulsive Therapy Value Set with any of the following place of service (POS):
    - Ambulatory Surgical Center POS: 24
    - Community Mental Health Center POS: 53
    - Partial Hospitalization POS: 52
    - Outpatient POS:

Code	Location
03	School
05	Indian Health Service Free-standing Facility
07	Tribal 638 Free-standing Facility
09	Prison/Correctional Facility
11	Office
12	Home
13	Assisted Living Facility
14	Group Home
15	Mobile Unit
16	Temporary Lodging
17	Walk-in Retail Health Clinic
18	Place of Employment-Worksite
19	Off Campus-Outpatient Hospital
20	Urgent Care Facility

22	On Campus-Outpatient Hospital
33	Custodial Care Facility
49	Independent Clinic
50	Federally Qualified Health Center
71	Public Health Clinic
72	Rural Health Clinic

- BH Outpatient Visit with a **Mental Health Provider**
  - CPT: 98960-98962, 99078, 99202-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99483, 99492, 99493, 99494, 99510
    - Note: Effective January 1, 2020, CPT code 99201 was deleted from the AMA CPT Code list. However, CPT code 99201 will be used for claim data reporting prior to code deletion.
  - HCPCS: G0155, G0176, G0177, G0409, G0463, G0512, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013-H2020, T1015**
    - NOTE: **T1015 HCPCS code which identifies an all-inclusive clinic visit for services rendered at a Federally Qualified Health Center (FQHC)
  - UBREV: 0510, 0513, 0515, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0526, 0527, 0528, 0529, 0900, 0902, 0903, 0904, 0911, 0914, 0915, 0916, 0917, 0919, 0982, 0983
- Outpatient Visit (Visit Setting Unspecified)
  - CPT: 90791, 90792, 90832–90834, 90836–90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221–99223, 99231–99233, 99238, 99239, 99251–99255
  - Visit Setting Unspecified Value Set with any of the following Place of Service (POS):
    - Community Mental Health Center POS: 53
    - Partial Hospitalization POS: 52
    - Telehealth POS with **a Mental Health Provider**:

Code	**Definition**
02	Telehealth Provided Other than in Patient's Home
10	Telehealth Provided in Patient's Home

    - Outpatient POS with **a Mental Health Provider**:

Code	**Location**
03	School
05	Indian Health Service Free-standing Facility
07	Tribal 638 Free-standing Facility
09	Prison/Correctional Facility
11	Office
12	Home
13	Assisted Living Facility
14	Group Home
15	Mobile Unit

16	Temporary Lodging
17	Walk-in Retail Health Clinic
18	Place of Employment-Worksite
19	Off Campus-Outpatient Hospital
20	Urgent Care Facility
22	On Campus-Outpatient Hospital
33	Custodial Care Facility
49	Independent Clinic
50	Federally Qualified Health Center
71	Public Health Clinic
72	Rural Health Clinic

- Observation with a **Mental Health Provider**
  - CPT: 99217-99220
- Partial Hospitalization or Intensive Outpatient
  - HCPCS: G0410, G0411, H0035, H2001, H2012, S0201, S9480, S9484, S9485
  - UBREV: 0905, 0907, 0912, 0913
- Psychiatric Collaborative Care Management
  - CPT: 99492, 99493, 99494
  - HCPCS: G0512
- Telephone Visits with a **Mental Health Provider**
  - CPT: 98966, 98967, 98968, 99441, 99442, 99443
- Transitional Care Management with a **Mental Health Provider**
  - CPT: 99495, 99496
- Community mental health center visit with place of service (POS) 53 with any of the previously listed codes above:
  - Visit Setting Unspecified
  - BH Outpatient
  - Observation
  - Transitional Care Management Services

HBD Hemoglobin A1c Control for Patients With Diabetes

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 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 most recent = closest to December 31 of measurement year.

  - The member is only compliant if the most recent HbA1c result is < 8.0 for EHP, Priority Partners/VBP and USFHP.

Report Stratification by race and ethnicity.

Best Practice and Measure Tips

- 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.
- **Acceptable terminology:**

  - A1c, HbA1c, HgbA1c
  - Glycohemoglobin
  - Glycohemoglobin A1c
  - Glycated hemoglobin
  - Glycosylated hemoglobin
  - Hemoglobin A1c

- 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
- Members in hospice or using hospice services anytime during the measurement year.
- Members who died any time during the measurement year.
- 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

- 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

Description	Prescription		
Alpha-glucosidase inhibitors	• Acarbose • Miglitol		
Amylin analogs	• Pramlintide		
Antidiabetic combinations	• Alogliptin-metformin • Alogliptin-pioglitazone • Canagliflozin-metformin • Dapagliflozin-metformin • Dapagliflozin-saxagliptin • Empagliflozin-linagliptin • Empagliflozin-metformin	• Empagliflozin-linagliptin-metformin • Ertugliflozin-metformin • Ertugliflozin-sitagliptin • Glimepiride-pioglitazone • Glipizide-metformin • Glyburide-metformin	• Linagliptin-metformin • Metformin-pioglitazone • Metformin-repaglinide • Metformin-rosiglitazone • Metformin-saxagliptin • Metformin-sitagliptin
Insulin	• Insulin aspart	• Insulin glargine-lixisenatide	

Description	Prescription		
	• Insulin aspart-insulin aspart protamine • Insulin degludec • Insulin degludec-liraglutide • 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®) • Lixisenatide • Semaglutide	
Sodium glucose cotransporter 2 (SGLT2) inhibitor	• Canagliflozin	• Dapagliflozin (excluding Farxiga®)	• Empagliflozin • Ertugliflozin
Sulfonylureas	• Chlorpropamide • Glimepiride	• Glipizide • Glyburide	• Tolazamide • Tolbutamide
Thiazolidinediones	• Pioglitazone	• Rosiglitazone	
Dipeptidyl peptidase-4 (DDP-4) inhibitors	• Alogliptin • Linagliptin	• Saxagliptin • Sitagliptin	

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

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 member's 11th and 13th birthdays.
- 1 dose – Tetanus, diphtheria toxoids vaccine, and acellular pertussis vaccine (Tdap) on or between the member's 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.

New for Measure: Stratification by race and ethnicity.

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.** 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 Exclusion:

- Members in hospice or using hospice services anytime during the measurement year.
- Members who died any time during the measurement year.

Measure Codes

- Meningococcal-serogroup A,C,W, and Y(1 dose)
    - CPT: 90619, 90733, 90734
    - CVX: 32, 108, 114, 136, 147, 167, 203
    - Anaphylaxis due to the meningococcal vaccine SNOMED CT code: 428301000124106
- Tdap (1 dose)
    - CPT: 90715
    - CVX: 115
    - Anaphylaxis Due to Diphtheria, Tetanus or Pertussis Vaccine SNOMED CT code: 428281000124107, 428291000124105
    - Encephalitis Due to Diphtheria, Tetanus or Pertussis Vaccine SNOMED CT code: 192710009, 192711008, 192712001
- HPV (2 or 3 dose series)
    - CPT: 90649 – 90651
    - CVX: 62, 118, 137, 165
    - Anaphylaxis due to the HPV vaccine SNOMED CT code: 428241000124101

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:

- 18-64
- 65-74
- 75-85
- Total. The total is the sum of the age stratifications.

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

- Members in hospice or using hospice services anytime during the measurement year.
- Members who died any time during the measurement year.
- Frailty
- Frailty and Advanced Illness
- Living in Long Term Care
- 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

Description	Prescription		
Alpha-glucosidase inhibitors	• Acarbose • Miglitol		
Amylin analogs	• Pramlintide		
Antidiabetic combinations	• Alogliptin-metformin • Alogliptin-pioglitazone • Canagliflozin-metformin • Dapagliflozin-metformin • Dapagliflozin-saxagliptin • Empagliflozin-linagliptin • Empagliflozin-metformin	• Empagliflozin-linagliptin-metformin • Ertugliflozin-metformin • Ertugliflozin-sitagliptin • Glimepiride-pioglitazone • Glipizide-metformin • Glyburide-metformin	• Linagliptin-metformin • Metformin-pioglitazone • Metformin-repaglinide • Metformin-rosiglitazone • Metformin-saxagliptin • Metformin-sitagliptin
Insulin	• Insulin aspart • Insulin aspart-insulin aspart protamine • Insulin degludec • Insulin degludec-liraglutide • Insulin detemir • Insulin glargine	• Insulin glargine-lixisenatide • Insulin glulisine • Insulin isophane human • Insulin isophane-insulin regular • Insulin lispro • Insulin lispro-insulin lispro protamine • Insulin regular human • Insulin human inhaled	
Meglitinides	• Nateglinide	• Repaglinide	

Description	Prescription		
Glucagon-like peptide-1 (GLP1) agonists	• Albiglutide • Dulaglutide • Exenatide	• Liraglutide (excluding Saxenda®) • Lixisenatide • Semaglutide	
Sodium glucose cotransporter 2 (SGLT2) inhibitor	• Canagliflozin	• Dapagliflozin (excluding Farxiga®)	• Empagliflozin • Ertugliflozin
Sulfonylureas	• Chlorpropamide • Glimepiride	• Glipizide • Glyburide	• Tolazamide • Tolbutamide
Thiazolidinediones	• Pioglitazone	• Rosiglitazone	
Dipeptidyl peptidase-4 (DDP-4) inhibitors	• Alogliptin • Linagliptin	• Saxagliptin • Sitagliptin	

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

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.**

Report two age stratifications and a total rate:

- 18–64
- 65–75
- Total * The total is the sum of the age stratifications

Best Practice and Measure Tips

- **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).
- **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:

- Members in hospice or using hospice services anytime during the measurement year.
- Palliative Care
- Frailty and Advanced Illness
- Members who died any time during the measurement year.
- 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.

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

- **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)- Examples include:
        - Malignant Neoplasms ICD-10-CM: 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, C06.9, C07, C08.0, C08.1, C08.9, C09.0, C09.1, C09.8, C09.9, C10.0- C10.4, C10.8, C10.9, C11.0-C11.3, C11.8, C11.9, C12, C13.0, C13.1, C13.2, C13.8, C13.9, C14.0, C14.2, C14.8, C15.3, C15.4, C15.5, C15.8, C15.9, C16.0-C16.6, C16.8, C16.9, C17.0-C17.3, C17.8, C17.9, C18.0-C18.9, C19, C20, C21.0; C92.60, C93.92, C93.Z0, C93.Z1, C93.Z2, C94.00, C94.01, C94.02, C94.20, C94.21, C94.22, C94.30, C94.31, C94.32, C94.40, C94.41, C94.42, C94.6, C94.80, C94.81, C94.82, C95.00, C95.01, C95.02, C95.10, C95.11, C95.12, C95.90, C95.91, C95.92 C96.0, C96.2, C96.20, C96.21, C96.22, C96.29, C96.4, C96.5, C96.6, C96.9, C96.A, C96.Z;
        - Other Neoplasms ICD-10-CM: D00.00- D00.08, D00.1, D00.2, D01.0- D01.3, D01.40, D01.49, D01.5, D01.7, D01.9, D02.0, D02.1, D02.20-D02.22, D02.3, D02.4, D03.0, D03.10, D03.11, D03.111, D03.112, D03.121, D03.122, D03.20, D03.21, D03.22, D03.30, D03.39, D03.4, D03.51, D03.52, D03.59, D03.60, D03.61, D03.62, D03.70, D03.71, D03.72, D03.8, D03.9, D04.0, D04.10, D04.11, D04.111, D04.112, D04.12, D04.121, D04.122, D04.20, D04.21, D04.22, D04.30, D04.39, D04.4, D04.5, D04.60, D04.61, D04.62, D04.70,

D04.71, D04.72, D04.8, D04.9, D05.00, D05.01, D05.02, D05.10, D05.11, D05.12, D05.80, D05.81, D05.82, D05.90, D05.91, D05.92, D06.0, D06.1, D06.7, D06.9, D07.0, D07.1, D07.2, D07.30, D07.39, D07.4, D07.5, D07.60, D07.61, D07.69, D09.0, D09.10, D09.19, D09.20, D09.21, D09.22, D09.3, D09.8, D09.9, D37.01, D37.02, D37.030, D37.031, D37.032, D37.039, D37.04, D37.05, D37.09, D37.1- D37.6, D37.8, D37.9, D38.0-D38.6, D39.0, D39.10, D39.11, D39.12, D39.2, D39.8, D39.9, D40.0, D40.10, D40.11, D40.12, D40.8, D40.9, D41.00, D41.01, D41.02, D41.10, D41.11, D41.12, D41.20, D41.21, D41.22, D41.3, D41.4, D41.8, D41.9, D42.0, D42.1, D42.9, D43.0-D43.4, D43.8, D43.9, D44.0, D44.10, D44.11, D44.12, D44.2-D44.7, D44.9, D45, D46.0, D46.1, D46.20, D46.21, D46.22, D46.4, D46.9, D46.A, D46.B, D46.C, D46.Z, D47.0, D47.01, D47.02, D47.09-D47.4, D47.9, D47.Z1, D47.Z2, D47.Z9, D48.0-D48.5, D48.60, D48.61, D48.62, D48.7, D48.9, D49.0, D49.1, D49.2, D49.3, D49.4, D49.5, D49.511, D49.512, D49.519, D49.59, D49.6, D49.7, D49.81, D49.89, D49.9

- History of Malignant Neoplasm ICD-10-CM: Z85.00, Z85.01, Z85.020,
- Other Malignant Neoplasm of Skin ICD-10-CM: C44.00-C44.02

- HIV ICD-10-CM: B20, Z21
- Kidney / Major organ transplant
  - History of Kidney Transplant ICD-10-CM: Z94.0
  - Kidney Transplant:
    - CPT: 50360, 50365, 50380,
    - HCPCS: S2065
    - ICD-10-PCS: 0TY00Z0, 0TY00Z1, 0TY00Z2, 0TY10Z0, 0TY10Z1, 0TY10Z2
  - Organ Transplant Other Than Kidney:
    - CPT: 32850, 32851, 32852, 32853, 32854, 32855, 32856
- Osteoporosis
  - Osteoporosis therapy or a dispensed prescription to treat osteoporosis
    - HCPCS:
      - J0897 Injection, denosumab, 1 mg
      - J1740 Injection, ibandronate sodium, 1 mg
      - J3110 Injection, teriparatide, 10 mcg
      - J3111 Injection, romosozumab-aqqg, 1 mg
      - J3489 Injection, zoledronic acid, 1 mg

Osteoporosis Medications

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

	Raloxifene

- Lumbar surgery
  - CPT: 22114, 22207, 22214, 22224, 22511, 22512, 22514, 22515, 22533, 22534, 22558, 22612, 22630, 22632, 22633, 22634, 22857, 22862, 22865, 22867, 22868, 22869, 22870, 62287, 62380, 63005, 63012, 63017, 63030, 63035, 63042, 63044, 63047, 63048, 63052, 63053, 63056, 63057, 63087, 63088, 63090, 63091, 63102, 63103, 63170, 63200, 63252, 63267, 63272, 63277, 63282, 63287
  - HCPCS: S2348, S2350
  - ICD-10-PCS Examples:
    - [005Y0ZZ] Destruction of Lumbar Spinal Cord, Open Approach
    - [008Y0ZZ] Division of Lumbar Spinal Cord, Open Approach
    - [009Y00Z] Drainage of Lumbar Spinal Cord with Drainage Device, Open Approach
    - [00BY0ZX] Excision of Lumbar Spinal Cord, Open Approach, Diagnostic
    - [00CY0ZZ] Extirpation of Matter from Lumbar Spinal Cord, Open Approach
    - [00NY0ZZ] Release Lumbar Spinal Cord, Open Approach
    - [00QY0ZZ] Repair Lumbar Spinal Cord, Open Approach
    - [00SY0ZZ] Reposition Lumbar Spinal Cord, Open Approach
    - Open Approach
    - [0Q500ZZ] Destruction of Lumbar Vertebra, Open Approach
    - [0Q800ZZ] Division of Lumbar Vertebra, Open Approach
    - [0QH004Z] Insertion of Internal Fixation Device into Lumbar Vertebra, Open Approach
    - [0QR03KZ] Replacement of Lumbar Vertebra with Nonautologous Tissue Substitute, Percutaneous Approach
    - [0SG037J] Fusion of Lumbar Vertebral Joint with Autologous Tissue Substitute, Posterior Approach, Anterior Column, Percutaneous Approach
    - [0SW4XKZ] Revision of Nonautologous Tissue Substitute in Lumbosacral Disc, External Approach
- Spondylopathy ICD-10-CM: M45.0, M45.3, M45.4, M45.5, M45.6, M45.7, M45.8, M45.9, M48.10, M48.13, M48.14, M48.15, M48.16, M48.17, M48.18, M48.19

- **Any time during the 12 months (1 year) prior to the IESD through 28 days after the IESD:**
  - Neurologic impairment ICD-10-CM: G83.4, K59.2, M48.062, R26.2, R29.2
  - Spinal infection ICD-10-CM: A17.81, G06.1, M46.25-M46.28, M46.35-M46.38, M46.46-M46.48
  - Intravenous drug abuse ICD-10-CM: F11.10, F11.11, F11.120- F11.122, F11.129, F11.13, F11.14, F11.150, F11.151, F11.159, F11.181, F11.182, F11.188, F11.19, F11.20, F11.21, F11.220, F11.221, F11.222, F11.229, F11.23, F11.24, F11.250,

F11.251, F11.259, F11.281, F11.282, F11.288, F11.29, F13.10, F13.11, F13.120, F13.121, F13.129, F13.130, F13.131, F13.132, F13.139, F13.14, F13.150, F13.151, F13.159, F13.180, F13.181, F13.182, F13.188, F13.19, F13.20, F13.21, F13.220, F13.221, F13.229, F13.230, F13.231, F13.232, F13.239, F13.24, F13.250, F13.251, F13.259, F13.26, F13.27, F13.280, F13.281, F13.282, F13.288, F13.29, F14.10, F14.11, F14.120, F14.121, F14.122, F14.129, F14.13, F14.14, F14.150, F14.151, F14.159, F14.180, F14.181, F14.182, F14.188, F14.19, F14.20, F14.21, F14.220, F14.221, F14.222, F14.229, F14.23, F14.24, F14.250, F14.251, F14.259, F14.280, F14.281, F14.282, F14.288, F14.29, F15.10, F15.11, F15.120, F15.121, F15.122, F15.129, F15.13, F15.14, F15.150, F15.151, F15.159, F15.180, F15.181, F15.182, F15.188, F15.19, F15.20, F15.21, F15.220, F15.221, F15.222, F15.229, F15.23, F15.24, F15.250, F15.251, F15.259, F15.280, F15.281, F15.282, F15.288, F15.29

- Any time during the 3 months (90 days) prior to the IESD through 28 days after the IESD:
  - Recent trauma ICD-10-CM: G89.11 and S codes for trauma/fractures
  - Fragility fracture ICD-10-CM: M48.40XA, M48.40XD, M48.40XG, M48.40XS, M48.41XA, M48.41XD, M48.41XG, M48.41XS, M48.42XA, M48.42XD, M48.42XG, M48.42XS, M48.43XA, M48.43XD, M48.43XG, M48.43XS, M48.44XA, M48.44XD, M48.44XG, M48.44XS, M48.45XA, M48.45XD, M48.45XG, M48.45XS, M48.46XA, M48.46XD, M48.46XG, M48.46XS, M48.47XA, M48.47XD, M48.47XG, M48.47XS, M48.48XA, M48.48XD, M48.48XG, M48.48XS, M80.08XA, M80.08XD, M80.08XG, M80.08XK, M80.08XP, M80.08XS, M80.88XA, M80.88XD, M80.88XG, M80.88XK, M80.88XP, M80.88XS, M84.359A, M84.359D, M84.359G, M84.359K, M84.359P, M84.359S, M97.01XA, M97.01XD, M97.01XS, M97.02XA, M97.02XD, M97.02XS
- **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).

Corticosteroid Medications

Description	Prescription	
Corticosteroid	• Hydrocortisone • Cortisone • Prednisone • Prednisolone	• Methylprednisolone • Triamcinolone • Dexamethasone • Betamethasone/Betamethasone acetate

Measure Codes

- Principal diagnosis of uncomplicated low back pain in an outpatient setting.
    - Uncomplicated Low Back Pain ICD-10-CM: 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, M54.50, M54.51, M54.59, 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 (Outpatient Value Set)
        - CPT: 99202-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381- 99387, 99391-99397, 99401-99404, 99411, 99412, 99429, 99455, 99456, 99483
            - Note: Effective January 1, 2020, CPT code 99201 was deleted from the AMA CPT Code list. However, CPT code 99201 will be used for claim data reporting prior to code deletion.
        - HCPCS: G0402, G0438, G0439, G0463, T1015**.
            - **NOTE:** **T1015 HCPCS code which identifies an all-inclusive clinic visit for services rendered at a Federally Qualified Health Center (FQHC)
        - UBREV: 0510, 0511, 0512, 0513, 0514, 0515, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0526, 0527, 0528, 0529, 0982, 0983
    - Telephone visit (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, 10
        - 02: Telehealth Provided Other than in Patient's Home
        - 10: Telehealth Provided in Patient's Home
    - Online Assessments E-visit or virtual check-in (Online Assessments Value Set):
        - CPT: 98970-98972, 99421-99423, 99444, 99457, 99458
            - Note: Effective January 1, 2020, CPT code 98969 was deleted from the AMA CPT Code list.
        - HCPCS: G0071, G2010, G2012, G2061-G2063, G2250- G2252
    - ED visit (ED Value Set)
        - CPT: 99281-99285

        - 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

Avoid the below Imaging Study Codes during the first 30 days of a diagnosis of uncomplicated back pain.

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

LSC Lead Screening in Children – HEDIS

Priority Partners / VBP. Members age 0-2 years

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

Eligibility criteria:

- Enrolled on the child's second birthday:
  - Continuously enrolled 12 months prior to 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 is 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 / caregivers:
  - https://health.maryland.gov/phpa/OEhfp/eh/Pages/Lead.aspx
  - https://health.maryland.gov/phpa/OEHFP/EH/Shared%20Documents/Lead/HB1233_ClinicianLetter_03022021.pdf

Measure Exclusions

Required Exclusion:

- Members in hospice or using hospice services anytime during the measurement year.
- Members who died any time during the measurement year.

Measure Codes

Lead Test

- CPT Code: 83655

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 age12-23 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 is 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 / caregivers:
    - https://health.maryland.gov/phpa/OEhfp/eh/Pages/Lead.aspx
    - https://health.maryland.gov/phpa/OEHFP/EH/Shared Documents/Lead/HB1233_ClinicianLetter_03022021.pdf

Documentation via claims

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

Measure Exclusions

Required Exclusion:

- Members in hospice or using hospice services anytime during the measurement year.
- Members who died any time during the measurement year.

Measure Codes

Lead Test

- CPT Codes: 83655 and 83645 (CPT Code 83645 was discontinued but is included in the lead value-based purchasing program).

MAC Medication Adherence for Cholesterol (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:

- Members in hospice or using hospice services anytime during the measurement year.
- End-stage renal disease (ESRD) or dialysis coverage dates.

Measure Medications

Statins / Statin Combinations:

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

MAD Medication Adherence for Diabetes Medications

Advantage MD Part D. Members 18 years or older.

Percentage of members ages 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.
- One or more prescriptions for insulin

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®).

OMW Osteoporosis Management in Women Who Had a Fracture

Advantage MD, SNP. 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.

Best Practice and Measure Tips

- 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 occurs.
- 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:

- Members in hospice or using hospice services anytime during the measurement year.
- Members who died any time during the measurement year
- 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

Osteoporosis Medications

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

Measure Codes

- Bone Mineral Density Tests Value Set
  - CPT: 76977, 77078, 77080, 77081, 77085, 77086
  - ICD-10-PCS: BP48ZZ1, BP49ZZ1, BP4GZZ1, BP4HZZ1, BP4LZZ1, BP4MZZ1, BP4NZZ1, BP4PZZ1, BQ00ZZ1, BQ01ZZ1, BQ03ZZ1, BQ04ZZ1, BR00ZZ1, BR07ZZ1, BR09ZZ1, BR0GZZ1
- Osteoporosis Medication Therapy Value Set
  - HCPCS: J0897, J1740, J3110, J3111, J3489
- Long-Acting Osteoporosis Medications Value Set
  - HCPCS: J0897, J1740, J3489

OSW Osteoporosis Screening in Older Women

Advantage MD. Women 65-75 years of age as of December 31 of the Measurement Year.

The percentage of women 65–75 years of age who received osteoporosis screening tests on or between the member's 65th birthday and December 31 of the measurement year.

Best Practice and Measure Tips

- Ensure members without a diagnosis and who have not been treated for osteoporosis receive bone mineral testing.

Measure Exclusions

Required Exclusions:

- Members in hospice or using hospice services anytime during the measurement year.
- Members who died any time during the measurement year
- Palliative Care
- Frailty and Advanced Illness
- Living in Long Term Care
- Members who had a dispensed prescription to treat osteoporosis (Osteoporosis Medications List) any time on or between January 1 three years prior to the measurement year through December 31 of the year prior to the measurement year.
- Members who had a claim/encounter for osteoporosis therapy (Osteoporosis Medication Therapy Value Set; Long-Acting Osteoporosis Medications Value Set) any time in the member's history through December 31 of the year prior to the measurement year.

Osteoporosis Medications

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

Measure Codes

- Osteoporosis Screening Tests
  - CPT: 76977, 77078, 77080, 77081, 77085

PCE Pharmacotherapy Management of COPD Exacerbation

Advantage MD, SNP, 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 systemic 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.

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

Best Practice and Measure Tips

- Members with active prescriptions for these medications are administratively compliant with the measure.
- 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:

- Members in hospice or using hospice services anytime during the measurement year.
- Members who died any time during the measurement year

Measure Medications

- Systemic Corticosteroid Medications on or 14 days after the Episode Date.

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

- Bronchodilator Medications on or 30 days after the Episode Date.

Description	Prescription		
Anticholinergic agents	• Aclidinium bromide • Ipratropium	• Tiotropium • Umeclidinium	
Beta 2-agonists	• Albuterol • Arformoterol • Formoterol	• Indacaterol • Levalbuterol • Metaproterenol	• Olodaterol • Salmeterol
Bronchodilator combinations	• Albuterol-ipratropium • Budesonide-formoterol • Fluticasone-salmeterol • Fluticasone-vilanterol • Fluticasone furoate-umeclidinium-vilanterol	• Formoterol-aclidinium • Formoterol-glycopyrrolate • Formoterol-mometasone • Glycopyrrolate-indacaterol	• Olodaterol-tiotropium • Umeclidinium-vilanterol

PCR Plan All-Cause Readmissions

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

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

For commercial (EHP & USFHP) and Medicaid (Priority Partners), 18–64 years as of the Index Discharge Date.

For Medicare (Advantage MD), 18 years and older as of the Index Discharge Date.

Best Practice and Measure Tips

- The denominator for this measure is based on discharges and not members specifically.
- An acute discharge can be from any type of facility, including behavioral health facilities.
- Discharges are excluded if a direct transfer takes place after Dec. 1 of the measurement year.
- Please help members avoid readmission by:
    - Implementing a robust, safe discharge plan that includes a post-discharge phone call within 3 days of discharge to perform medication reconciliation and follows with PCP/OCP as appropriate. During call discuss these questions:
        - Do you completely understand all the instructions you were given at discharge?
        - Do you completely understand the medications and your medication instructions? Have you filled all new prescriptions?
        - Have you made your follow-up appointments? Do you need help scheduling them?
        - Do you have transportation to the appointment and/or do you need help arranging transportation?
        - Do you have any questions?
- A lower readmission rate and comprehensive diagnosis documentation will drive better scores for this measure.
- Patients with multiple comorbidities are expected to return post inpatient or observation discharge at a higher rate. Ensure all suspect conditions are appropriately identified in the patient's medical record and claims.
- Discuss palliative care or hospice programs and assist with referral as appropriate.

Measure Exclusions

- Members in hospice or using hospice services anytime during the measurement year.

Exclude acute hospitalizations for the following reasons:

- Member died during the inpatient stay
- Member with a principal diagnosis of pregnancy on the discharge claim
- Principal diagnosis of a condition originating in the perinatal period on the discharge claim
- Planned admissions for:
    - Chemotherapy maintenance
    - Principle diagnosis of rehabilitation
    - Organ transplant
    - Potentially planned procedure without a principal acute diagnosis

PPC Prenatal and Postpartum Care

EHP, Priority Partners/VBP, and USFHP. Women who had a live birth(s) on or between 10/8 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 assesses 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 twin and one was stillborn.
- Can appear twice in the measure if two separate pregnancies during time frame.

New for Measure: Stratification by race and ethnicity

Best Practice and Measure Tips

- The system uses the delivery date to calculate the prenatal timeframe and assumes a full term pregnancy. Members who deliver early may not be compliant and may require the EDD to be updated based on an EDD in an ultrasound report. LMP cannot be used to adjust the EDD.
- Provide education to members on importance of prenatal and postpartum care for them and their baby.
- Follow members closely who have or had a substance abuse or mental health diagnosis. Initiate appropriate referrals.
- Identify potential barriers to receiving care when pregnancy is confirmed. Discuss with members ways barriers can be overcome.
- Ensure members are aware of available resources to overcome barriers and any incentives for care.
- Identify members seen in ER with a diagnosis of pregnancy and initiate follow-up.
- For members who do not show or schedule appointments, attempt to engage in a telephone or video visit to close gap. Offer at time of discharge from delivery if member seems reluctant to schedule an appointment or you suspect they will not show or schedule.
- Use appropriate and accurate codes on claims.
- Use appropriate CPT Category II codes for pregnancy diagnosis office visits and postpartum visits when submitting claims for bundle maternity services.

- CPT Category II helps identify clinical outcomes
- Reduce the need for some chart review

Prenatal Care with visit date and one of the following:

- A diagnosis of pregnancy (this must be included for PCP visits).
- Documentation indicating the member 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, of 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:
  - Screening test in the form of an obstetric panel (must include all of the following: hematocrit, differential WBC count, platelet count, hepatitis B surface antigen, rubella antibody, syphilis test, RBC antibody screen, Rh and ABO blood typing), ***or***
  - Obstetric panel or TORCH antibody panel alone or rubella antibody test/titer with RH incompatibility (ABO/Rh) blood typing***, or***
  - 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 breasts 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 member with gestational diabetes.
- Documentation of discussion any of the following topics:
  - Infant care / breastfeeding.
  - Resumption of intercourse, birth spacing or family planning.
  - Sleep or fatigue.
  - Resumption of physical activity
  - Attainment of healthy weight.

Not Acceptable:

- Colposcopy alone.
- Care in an acute inpatient setting.

Use appropriate and accurate codes on claims

Measure Exclusions

Required Exclusions:

- Members in hospice or using hospice services anytime during the measurement year.
- Members who died any time during the measurement year.
- Pregnancy did not result in a live birth
- Member not pregnant
- Delivery outside of measure date parameters

Measure Codes

- Telephone Visit with a pregnancy or postpartum related diagnosis code
    - CPT: 98966, 98967, 98968, 99441, 99442, 99443
- E-visit or virtual check-in (Online Assessments) with a pregnancy or postpartum related diagnosis code
    - CPT: 98970, 98971, 98972, 99421, 99422, 99423, 99444, 99457, 99458
        - Note: Effective January 1, 2020, CPT code 98969 was deleted from the AMA CPT Code list.
    - HCPCS; G0071, G2010, G2012, G2061, G2062, G2063, G2250- G2252
- Prenatal Visit
    - Stand Alone Prenatal Visits
        - CPT/CPT II: 99500, 0500F - 05002F
        - HCPCS: H1000 - H1004
    - Office Visit with a pregnancy related diagnosis code
        - CPT: 99202-99205, 99211-99215, 99241-99245, 99483
            - Note: Effective January 1, 2020, CPT code 99201 was deleted from the AMA CPT Code list. However, CPT code 99201 will be used for claim data reporting prior to code deletion.
        - HCPCS: G0463, T1015**
            - **NOTE:** **T1015 HCPCS code which identifies an all-inclusive clinic visit for services rendered at a Federally Qualified Health Center (FQHC)
    - Prenatal bundled service - codes may be used only if the claim indicates when prenatal care was initiated.
        - CPT: 59400, 59425, 59426, 59510, 59610, 59618,
        - HCPCS: H1005

- Postpartum Visits
    - CPT/CPT II: 57170, 58300, 59430, 99501, 0503F
    - HCPCS: G0101
    - ICD-10-CM: Z01.411, Z01.419, Z01.42, Z30.430, Z39.1, Z39.2
    - Postpartum bundled services - codes may be used only if the claim indicates when PP care was rendered.
        - CPT: 59400, 59410, 59510, 59515, 59610, 59614, 59618, 59622
- Cervical Cytology
    - CPT: 88141-88143, 88147, 88148, 88150, 88152, 88153, 88164-88167, 88174-88175
    - HCPCS: G0123-24, G0141, G0143-45, G0147-48, P3000, P3001, Q0091

PRS-E Prenatal Immunization Status

EHP, Priority Partners, and USFHP. Pregnant members who deliver at >37 weeks during the measurement year.

The percentage of deliveries in the measurement period in which members had received influenza and tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccinations.

The denominator for this measure is based on deliveries, not on members.

Numerator 1—Immunization Status: Influenza

- Deliveries where members received an adult influenza vaccine on or between July 1 of the year prior to the measurement period and the delivery date, or
- Deliveries where members had anaphylaxis due to the influenza vaccine on or before the delivery date.

Numerator 2—Immunization Status: Tdap

- Deliveries where members received at least one Tdap vaccine during the pregnancy (including on the delivery date), or
- Deliveries where members had any of the following:
    - Anaphylaxis due to the diphtheria, tetanus or pertussis vaccine on or before the delivery date.
    - Encephalitis due to the diphtheria, tetanus or pertussis vaccine on or before the delivery date.

Numerator 3—Immunization Status: Combination

- Deliveries that met criteria for both numerator 1 and numerator 2.

Best Practice and Measure Tips

- Identify members with gap. Offer to members during prenatal visits or when admitted for delivery.
- Use appropriate and accurate codes on claims
- Centers for Disease Control and Prevention recommend that pregnant member receive the following immunizations:
    - A flu shot during any trimester of their pregnancy to protect themselves and their newborn babies from flu
    - 1 dose of Tdap every pregnancy, preferably during early part of gestational weeks 27–36
    - – Visit www.cdc.gov/vaccines/pregnancy for patient and provider resources

Measure Exclusions

Required Exclusions:

- Deliveries that occurred at less than 37 weeks gestation.
- Deliveries in which members were in hospice or using hospice services any time during the measurement period.

Measure Codes

- Immunizations
    - Adult Influenza:
        - CPT: 90630, 90653, 90654, 90656, 90658, 90661, 90662, 90673, 90674, 90682, 90686, 90688, 90689, 90694, 90756
        - CVX: 88, 135, 140, 141, 144, 150, 153, 155, 158, 166, 168, 171, 185, 186, 197, 205
    - Tdap:
        - CPT: 90715
        - CVX: 115
        - Anaphylaxis Due to Diphtheria, Tetanus or Pertussis Vaccine:
            - SNOMED: 428281000124107, 428291000124105
        - Encephalitis Due to Diphtheria, Tetanus or Pertussis Vaccine
            - SNOMED: 192710009, 192711008, 192712001
- Perinatal
    - ICD-10-CM:
        - [Z3A.37] 37 weeks gestation of pregnancy
        - [Z3A.38] 38 weeks gestation of pregnancy
        - [Z3A.39] 39 weeks gestation of pregnancy
        - [Z3A.40] 40 weeks gestation of pregnancy
        - [Z3A.41] 41 weeks gestation of pregnancy
        - [Z3A.42] 42 weeks gestation of pregnancy
        - [Z3A.49] Greater than 42 weeks gestation of pregnancy
        - Weeks of Gestation Less Than 37: Z3A.42, Z3A.49, Z3A.01, Z3A.08, Z3A.09, Z3A.10, Z3A.11, Z3A.12, Z3A.13, Z3A.14, Z3A.15, Z3A.16, Z3A.17, Z3A.18, Z3A.19, Z3A.20, Z3A.21, Z3A.22, Z3A.23, Z3A.24, Z3A.25, Z3A.26, Z3A.27, Z3A.28, Z3A.29, Z3A.30, Z3A.31, Z3A.32, Z3A.33, Z3A.34, Z3A.35, Z3A.36
    - Deliveries
        - CPT: 59400, 59409, 59410, 59510, 59514, 59515, 59610, 59612, 59614, 59618, 59620, 59622
        - ICD-10-CM: 10D00Z0, 10D00Z1, 10D00Z2, 10D07Z3, 10D07Z4, 10D07Z5, 10D07Z6, 10D07Z7, 10D07Z8, 10E0XZZ

SPC Statin Therapy for Patients with Cardiovascular Disease

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

The percentage of males 21-75 years of age and females 40-75 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:

- Received Statin Therapy. Dispensed at least one medication during the measurement year.
- Statin Adherence 80%. Remained on medication for at least 80% of the treatment period.

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 Value Set) and/or old myocardial infraction (Old Myocardial Infarction Value Set) 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:

- Frailty and Advanced Illness

Any time during the measurement year or the prior year:

- 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
- Palliative Care
- Living in Long Term Care
- Members in hospice or using hospice services anytime during the measurement year.
- Members who died any time during the measurement year.

Exclusion Codes

Common diagnosis codes for exclusion:

- Muscular Pain
  - Myopathy ICD-10-CM: G72.0, G72.2, G72.9
  - Myositis ICD-10-CM: M60.80, M60.811, M60.812, M60.819, M60.821, M60.822, M60.829, M60.831, M60.832, M60.839, M60.841, M60.842, M60.849, M60.851, M60.852, M60.859, M60.861, M60.862, M60.869, M60.871, M60.872, M60.879, M60.88, M60.89, M60.9
  - Rhabdomyolysis ICD-10-CM: M62.82
  - Myalgia ICD-10-CM: M79.10, M79.11, M79.12, M79.18
- Cirrhosis
  - ICD-10-CM: K70.30, K70.31, K71.7, K74.3, K74.4, K74.5, K74.60, K74.69, P78.81
- ESRD
  - ICD-10-CM: 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 40-80 mg Amlodipine-atorvastatin 40-80 mg Rosuvastatin 20-40 mg Simvastatin 80 mg Ezetimibe-simvastatin 80 mg
Moderate-intensity statin therapy	Atorvastatin 10-20 mg Amlodipine-atorvastatin 10-20 mg Rosuvastatin 5-10 mg Simvastatin 20-40 mg Ezetimibe-simvastatin 20-40 mg Pravastatin 40-80 mg Lovastatin 40 mg Fluvastatin 40-80 mg Pitavastatin 1-4 mg

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 Statins 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
- Members in hospice or using hospice services anytime during the measurement year.
- Members who died any time during the measurement year.
- Frailty
- Frailty and Advanced Illness
- Living in Long Term Care
- 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.

Any time during the measurement year or the prior year:

- 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
- Old Myocardial Infraction
- 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

Exclusion Codes

Common diagnosis **codes for exclusion:**

- Muscular Pain
    - Myopathy ICD-10-CM: G72.0, G72.2, G72.9
    - Myositis ICD-10-CM: M60.80, M60.811, M60.812, M60.819, M60.821, M60.822, M60.829, M60.831, M60.832, M60.839, M60.841, M60.842, M60.849, M60.851, M60.852, M60.859, M60.861, M60.862, M60.869, M60.871, M60.872, M60.879, M60.88, M60.89, M60.9
    - Rhabdomyolysis ICD-10-CM: M62.82
    - Myalgia ICD-10-CM: M79.10, M79.11, M79.12, M79.18
- Cirrhosis
    - ICD-10-CM: K70.30, K70.31, K71.7, K74.3, K74.4, K74.5, K74.60, K74.69, P78.81
- ESRD
    - ICD-10-CM: N18.5, N18.6, Z99.2

Measure Medications

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

High, Moderate and Low-Intensity Statin Medications

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

Diabetes Medications

Description	Prescription		
Alpha-glucosidase inhibitors	• Acarbose	• Miglitol	
Amylin analogs	• Pramlintide		
Antidiabetic combinations	• Alogliptin-metformin • Alogliptin-pioglitazone • Canagliflozin-metformin • Dapagliflozin-metformin • Dapagliflozin-saxagliptin • Empagliflozin-linagliptin • Empagliflozin-metformin	• Empagliflozin-linagliptin-metformin • Ertugliflozin-metformin • Ertugliflozin-sitagliptin • Glimepiride-pioglitazone • Glipizide-metformin • Glyburide-metformin	• Linagliptin-metformin • Metformin-pioglitazone • Metformin-repaglinide • Metformin-rosiglitazone • Metformin-saxagliptin • Metformin-sitagliptin
Insulin	• Insulin aspart	• Insulin glargine-lixisenatide	

Description	Prescription		
	• Insulin aspart-insulin aspart protamine • Insulin degludec • Insulin degludec-liraglutide • 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®) • Lixisenatide • Semaglutide	
Sodium glucose cotransporter 2 (SGLT2) inhibitor	• Canagliflozin	• Dapagliflozin (excluding Farxiga®)	• Empagliflozin • Ertugliflozin
Sulfonylureas	• Chlorpropamide • Glimepiride	• Glipizide • Glyburide	• Tolazamide • Tolbutamide
Thiazolidinediones	• Pioglitazone	• Rosiglitazone	
Dipeptidyl peptidase-4 (DDP-4) inhibitors	• Alogliptin • Linagliptin	• Saxagliptin • Sitagliptin	

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

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

Advantage MD, SNP, 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 (outpatient, 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 a repeat.
- Ensure appropriate documentation of spirometry testing.
- Differentiate acute from chronic bronchitis and use correct code so that patient is not inadvertently put into the measure.
- Review 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 Exclusion:

- Members in hospice or using hospice services anytime during the measurement year.
- Members who died any time during the measurement year.

Measure Codes

- Spirometry CPT: 94010, 94014-94016, 94060, 94070, 94375, 94620
- COPD ICD-10-CM:
  - 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

SSIA SSI Adult Ambulatory Care Visit - MDH

Priority Partners/VBP. Adults enrolled in a disabled coverage group (SSI) aged 21-64 years old.

Adults enrolled in a disabled coverage group (SSI) 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:

- S01: Public Assistance to Adults
- S02: 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.
- Members in hospice or using hospice services any time during the measurement year.

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 a virtual visit, or any PCP outpatient visit. Preventative well visits preferred.

Documentation via claims

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

Measure Codes

- Urgent care center visit
  - HCPCS: S9083, S9088
- 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, 10
  - 02: Telehealth Provided Other than in Patient's Home
  - 10: Telehealth Provided in Patient's Home
- E-visit or Virtual Check-in (Online Assessments Value Set):
  - CPT: 98970-98972, 99421-99423, 99444, 99457, 99458
    - Note: Effective January 1, 2020, CPT code 98969 was deleted from the AMA CPT Code list.
  - HCPCS: G0071, G2010, G2012, G2061-G2063, G2250- G2252
- Ambulatory Outpatient Visit:
  - CPT: 92002, 92004, 92012, 92014, 99202*-99205, 99211-99215, 99241-99245, 99304-99310, 99315, 99316, 99318, 99324-99328, 99334-99337, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99429, 99461, 99483
    - NOTE: *Effective January 1, 2020, CPT code 99201 was deleted from the AMA CPT Code list. However, CPT code 99201 will be used for claim data reporting prior to code deletion
  - HCPCS: G0463, T1015**
    - NOTE: **T1015 HCPCS code which identifies an all-inclusive clinic visit for services rendered at a Federally Qualified Health Center (FQHC)
  - UBREV: 0510, 0511, 0512, 0513, 0514, 0515, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0524, 0525, 0526, 0527, 0528, 0529, 0982, 0983

SSIC SSI Child Ambulatory Care Visit - MDH

Priority Partners/VBP. Children enrolled in a disabled coverage group (SSI) aged 0-20 years old.

Children enrolled in a disabled coverage group (SSI) aged 0-20 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

Best Practice and Measure Tips

This measure excludes

- Inpatient admissions and emergency department services.
- Members in hospice or using hospice services any time during the measurement year.

This measure includes

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

Documentation via claims

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

Measure Codes

- Urgent care center visit
  - HCPCS: S9083, S9088
- 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, 10

    - 02: Telehealth Provided Other than in Patient's Home
    - 10: Telehealth Provided in Patient's Home
- E-visit or Virtual Check-in (Online Assessments Value Set):
    - CPT: 98970-98972, 99421-99423, 99444, 99457, 99458
        - Note: Effective January 1, 2020, CPT code 98969 was deleted from the AMA CPT Code list.
    - HCPCS: G0071, G2010, G2012, G2061-G2063, G2250- G2252
- Ambulatory Outpatient Visit:
    - CPT: 92002, 92004, 92012, 92014, 99202-99205, 99211-99215, 99241-99245, 99304-99310, 99315, 99316, 99318, 99324-99328, 99334-99337, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99429, 99461, 99483,
        - Note: Effective January 1, 2020, CPT code 99201 was deleted from the AMA CPT Code list. However, CPT code 99201 will be used for claim data reporting prior to code deletion.
    - HCPCS: G0463, T1015**.
        - NOTE: **T1015 HCPCS code which identifies an all-inclusive clinic visit for services rendered at a Federally Qualified Health Center (FQHC).
    - UBREV: 0510, 0511, 0512, 0513, 0514, 0515, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0524, 0525, 0526, 0527, 0528, 0529, 0982, 0983

SUPD Statin Use in Persons with Diabetes

Advantage MD, Part D. 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 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 or frequency.

Measure Exclusions

Required Exclusions:

- Any individuals in hospice care at any time during the measurement year.
- Any individuals with ESRD at any time during the measurement year
- Any individuals with rhabdomyolysis or myopathy at any time during the measurement year
- Any individuals with pregnancy or lactation at any time during the measurement year or ≥1 prescription claim for a medication indicated for fertility during the measurement year.
- Any individuals with diagnosis of cirrhosis at any time during the measurement year.
- Any individuals with pre-diabetes at any time during the measurement year.
- Any individuals with a diagnosis of polycystic ovary syndrome (PCOS) at any time during 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
- Amlodipine-atorvastatin
- Ezetimibe-simvastatin
- Fluvastatin
- Livalo®
- Lovastatin
- Pitavastatin
- Pravastatin
- Rosuvastatin
- Simvastatin

TRC Transitions of Care Patient

Advantage MD, SNP. Members 18 years and older as of December 31 of the measurement year (MY).

Continuous Enrollment: The date of discharge through 30 days after discharge (31 days total). Member must be discharged to home on or by December 1st of the MY to remain in the measure.

Exclusions: Ensure documentation of exclusionary evidence is documented in chart or faxed to QI Department.

Required Exclusions: Hospice or using hospice services in the measurement year.

Optional Exclusion: Deceased in measurement year

Definition: The percentage of acute and non-acute discharges, on or between January 1st and December 1st of the MY, for members 18 years of age and older who had each of the four elements: Notification of Inpatient Admission, Receipt of Discharge Information, Patient Engagement after Inpatient Discharge, and Medication Reconciliation Post-Discharge.

Requirements: Only EMR systems and medical records accessible to the PCP/OCP (ongoing care provider) are eligible for use in reporting.

- Ensure all admission / discharge notifications are received and saved in the member's outpatient chart. Be sure to **include any admission / discharge notifications** from Skilled Nursing Facilities.
- Ensure appropriate engagement and medication reconciliation occur for all discharges including when discharged to home from Skilled Nursing Facilities.

<u>Members may be in the measure more than once in the measurement year</u>. Each episode is determined based on the below:

- **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.

Notification of Inpatient Admission. Documentation sent to the member's PCP or OCP must include dated evidence of receipt of notification of inpatient admission on the day of admission through 2 days after the admission (3 days total).

- **Compliance** through Medical Record Review only. **Ensure admission / discharge notifications are in member's outpatient chart.**
- If member has an observation stay and then admitted as an inpatient, the date of the admission stay is used for compliance. Observation stays are considered outpatient.

Receipt of Discharge Information. 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 the discharge (3 days total).

Note: Patients transferring from a hospital to a skilled nursing facility or other inpatient setting require notification of discharge from the skilled nursing facility or other inpatient setting. This dated notification is required in the outpatient chart along with the below **information in order to close** the HEDIS gap.

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

- **Discharge information must include ALL of the following:**
    - The practitioner responsible for the member's care during the inpatient stay.
    - Procedures or treatment provided.
    - Diagnoses at discharge.
    - Current medication list.
    - Testing results, or documentation of pending tests or no tests are pending.
    - Instructions for patient care post-discharge.
- Compliance through Medical Record Review only. **Ensure admission / discharge notifications are saved in the member's outpatient chart.**

Patient Engagement After Inpatient Discharge. Documentation of patient engagement (e.g., office visits, visits to the home, telehealth) provided within 30 days after discharge. If the member is unable to communicate with the provider, interaction between the member's caregiver and the provider meets criteria. (HYBRID: Compliance via claims or Medical Record Review.)

Note: Patients transferring from a hospital to a skilled nursing facility or other inpatient setting require engagement after discharge from the skilled nursing facility or other inpatient setting.

Easy Compliance with acceptable visit codes: (Add appropriate Medication Reconciliation Post-Discharge Code to Patient Engagement visit claim to meet medication reconciliation compliance.)

- Outpatient Visits:
  - CPT: 99202-99205, 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**
    - **NOTE:** **T1015 HCPCS code which identifies an all-inclusive clinic visit for services rendered at a Federally Qualified Health Center (FQHC)
- Telephone Visits: 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, 10
  - 02: Telehealth Provided Other than in Patient's Home
  - 10: Telehealth Provided in Patient's Home
- E-visit or virtual check-in:
  - CPT: 98970-98972, 99421-99423, 99444, 99457
  - HCPCS: G0071, G2010, G2012, G2061-G2063
- Transitional care management: CPT:99495, 99496

Medication Reconciliation Post-Discharge. Evidence discharge medications were reconciled with the most recent medication list in the PCP /OCP outpatient medical record on the date of discharge through 30 days after discharge (31 days total). (HYBRID: Compliance via claims or Medical Record Review).

Note: Patients transferring from a hospital to a skilled nursing facility or other inpatient setting DO NOT require medication reconciliation until they are discharged from the inpatient setting.

Documentation in the PCP / OCP's outpatient medical record must include:

- **Evidence of medication reconciliation and the date when it was performed by either:**
  - prescribing practitioner
  - clinical pharmacist
  - physician's assistant
  - registered nurse
- **Evidence the provider was aware of the hospitalization. It is best practice to have both of the below in note:**
  - Mention of "hospitalization," "admission" or "inpatient stay" in the note.
  - Reference to reconciliation of current and discharge medications in the note.

Easy Compliance with acceptable codes: (Add appropriate Medication Reconciliation Post-Discharge Code to Patient Engagement visit to meet MRP compliance.)

- Medication Reconciliation Encounter: CPT: 99483, 99495, 99496
- Medication Reconciliation Intervention: CPT-CAT-II: 1111F; SNOMED CT US Edition: 430193006, 428701000124107 by pharmacist

Notification of Inpatient Admission: Acceptable Criteria:

- Communication between inpatient providers/staff and the member's PCP/OCP via phone call/e-mail/fax.
- Communication about admission between emergency department and the member's PCP or OCP via phone call/e-mail/fax.
- Communication about admission to the member's PCP/OCP through HIE/ADT alert system/ shared EMR system.
- Communication about admission with the member's PCP or ongoing care provider through a shared electronic medical record (EMR) system.
    - NOTE: Received date is not required in a shared EMR system. We can utilize file date, date "in basket," or date information was accessible (generated date) to PCP/OCP.
- Communication about admission to the member's PCP or ongoing care provider from the member's health plan.
- Member's PCP/OCP admitted the member to the hospital.
- Specialist admitted the member to the hospital and notified the member's PCP/OCP.
- PCP/OCP placed orders for tests and treatments during the member's inpatient stay.
- PCP/OCP performed a preadmission exam or received communication about a planned inpatient admission up to 30 days prior to surgery/admission date.
    - The planned admission documentation or preadmission exam must clearly pertain to the denominator event.

Notification of Inpatient Admission: Not Acceptable:

- Documentation that the member or the member's family notified the member's PCP or OCP of admission.
- Documentation of notification that does not include a date when documentation was received or accessible to PCP or OCP.
- Documentation which only references Provider sending the member to the ED.

Receipt of Discharge Information Acceptable:

- 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 within timeframe.
- "Received date" is not required in a shared EMR system. We can utilize "file date", date "in the basket,'' or date information was accessible (generated date) to PCP or OCP.

Receipt of Discharge Information Not Acceptable:

- Documentation the member or the member's family notified the member's PCP or OCP of discharge.
- Documentation of notification that does not include a time frame or date when documentation received.

Medication Reconciliation Post-Discharge (MRP) Acceptable:

Best Practice for Compliance: Add appropriate Code to Patient Engagement visit to meet medication reconciliation compliance.

Examples of evidence the provider was aware of the hospitalization and medication reconciliation occurred:

- Only documentation in the outpatient chart meets the intent of the measure, but an outpatient visit is not required. Examples:
  - Provider or OCP speaks to member or caregiver via telephone and documents reference to hospitalization and medication reconciliation which is documented in outpatient chart.
    - Example: "Conversation with patient after recent hospitalization (include date of admission / discharge). Reviewed discharge medications and reconciled with current medication list. Patient is aware of medication list."
  - Care managers complete the MRP.
  - Be sure to **include** in documentation:
    - Reference to hospitalization with the dates of admission and D/C in case there are multiple admissions/ discharges.
    - Reference discharge medications reviewed and reconciled with current medication list. Patient aware of medication list.
    - Always include PCP/OCP name, EMR system, location, phone and fax.
    - Include where MRP was routed to (doctor/EMR).
    - Include any supporting documentation which confirms PCP/OCP received and entered into member's chart.
    - If documentation is faxed to PCP / OCP, request fax is shared with PCP / OCP and is added to member chart.
      - Example: "Transition of Care Medication Reconciliation Completed on (DATE) by (name). Conversation with (patient name / DOB) after recent hospitalization (include date of admission / discharge and facility discharged from if available). Reviewed discharge medications and reconciled with current medication list. Patient is aware of medication list. THIS COMMUNICATION MUST BE ADDED TO THE MEMBER'S OUTPATIENT CHART / EMR SYSTEM AS EVIDENCE OF MEDICATION RECONCILIATION POST DISCHARGE. Please save fax in member's outpatient chart and have (provider name) review.
- The act of documenting the medication list during an acceptable follow-up visit which mentions hospitalization / discharge is considered evidence the provider reviewed the medications.

- Current medication list available and provider reconciled the current and discharge medications.
- 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).
- Current medications list available and discharge medications were reviewed.
- Current medication list, discharge medication list are available and both lists were reviewed on the same date of service.
- Current medications list available, member had post-discharge hospital follow-up and medications were reconciled/reviewed.
- Discharge summary reads discharge medications were reconciled with the most recent medication list and it was filed in the PCP/OCP's outpatient chart within timeframe.
- Notation no medications were prescribed or ordered upon discharge.

Medication Reconciliation Post-Discharge (MRP) Not Acceptable:

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

Ongoing care provider (OCP) - The practitioner who assumes responsibility for the member's care.

- A provider/specialist may be considered an ongoing care provider if they provide care to the member in and out of the hospital.
- If the provider/specialist only provides care to the member in the hospital, then they are NOT considered an ongoing care provider.
- A provider/specialist who only sees the member outside the hospital MAY still be considered an ongoing care provider (e.g., if the member sees the provider before admission and then again after discharge; or if the member sees the provider regularly before admission but has no other visits for the rest of the measurement year after discharge).
- The provider/specialist is not required to perform the engagement visit in order to be considered an ongoing care provider.
    - If the cardiologist or other specialist meets the criteria described above, then they may be considered an ongoing care provider and the outpatient medical record that is accessible to the cardiologist or other specialist may be used for all the TRC measure indicators.
    - If the surgeon also sees the member outside of the hospital (i.e. they performed the pre-op exam and/or follow-up visit), then they may be considered to be the ongoing care provider. If the member only saw the surgeon while in the hospital then they may not be considered to be an OCP.

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

EHP, Priority Partners and USFHP. Member 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

New for Measure: Stratification by race and ethnicity.

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.
- This measure is based on the American Academy of Pediatrics Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents (published by the National

Center for Education in Maternal and Child Health). Visit the Bright Futures website for more information about well-child visits (https://brightfutures.aap.org/materials-and-tools/guidelines-and-pocket-guide/).

Measure Exclusions

Required Exclusion:

- Members in hospice or using hospice services anytime during the measurement year.
- Members who died any time during the measurement year.

Measure Codes

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

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.

Report two age stratifications and a total for each of the three indicators:

- 3–11 years.
- 12–17 years.
- Total. *The total is the sum of the age stratifications.

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.
- 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.

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.

BMI Percentile Not Acceptable Documentation:

- BMI percentile ranges are not acceptable.
- No BMI percentile documented in medical record or plotted on age-growth chart.
- Notation of BMI value only.
- Notation of height and weight only.

Counseling Acceptable:

- Discussion of current nutrition or physical activity behaviors (e.g., eating habits, dieting behaviors, “Patient has an adequate or well-balanced diet”, exercise routine, participation in sports activities, exam for sports participation, “Patient gets an adequate amount of exercise.”, “Lack of physical activity” (if not related to acute or chronic condition).
- Checklist indicating nutrition or physical activity was addressed.
- Counseling or referral for nutrition or physical activity.
- Member received educational materials for nutrition and physical activity 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:

- Members in hospice or using hospice services anytime during the measurement year.
- Members who have a diagnosis of pregnancy any time during the measurement year.
- Members who died any time during the measurement year.

Exclusion Codes:

- Pregnancy Exclusion
    - ICD-10-CM: Z34.00-Z34.03, Z34.80-Z34.83, Z34.90-Z34.93
      Note: Not all Pregnancy Value Set codes are listed.

Measure Codes

- BMI Percentile
  - ICD-10-CM: Z68.51, Z68.52, Z68.53, Z58.54
- Nutrition Counseling
  - CPT: 97802, 97803, 97804
  - HCPCS: G0270, G0271, G0447, S9449, S9452, S9470
  - ICD-10-CM: Z71.3
- Physical Activity Counseling
  - HCPCS: G0447, S9451
  - ICD-10-CM: Z02.5, Z71.82
- Outpatient Visits with a PCP or an OBGYN during measurement year
  - CPT: 99202-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99429, 99455, 99456, 99483
    - Note: Effective January 1, 2020, CPT code 99201 was deleted from the AMA CPT Code list. However, CPT code 99201 will be used for claim data reporting prior to code deletion.
  - HCPCS: G0402, G0438, G0439, G0463, T1015**

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

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.

Report 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.
- This measure is based on the American Academy of Pediatrics Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents (published by the National Center for Education in Maternal and Child Health). Visit the Bright Futures website for more information about well-child visits (https://brightfutures.aap.org/materials-and-tools/guidelines-and-pocket-guide/).

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:

- Members in hospice or using hospice services anytime during the measurement year.
- Members who died any time during the measurement year.

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-CM: 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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