HEDIS® Measurement Year 2024

Quality Measure Toolkit

JOHNS HOPKINS HEALTH PLANS

Contents

HEDIS®[1] Quality Measure Toolkit

What is HEDIS?

- HEDIS stands for **Healthcare Effectiveness Data and Information Set**.
- Developed by the National Committee for Quality Assurance (NCQA) in the 1980s.
- NCQA Specifications standardize performance to evaluate and compare health plan performance and quality.
- Contains 6 domains of care which are further divided into measures/sub-measures which include preventative care and condition specific care.
- 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.

HEDIS: General Guidelines and Measure Descriptions

HEDIS MY 2024 Highlights

New Measures

- There are no new measures for HEDIS MY 2024.

Retired Measures

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

*Only the COL-E, ADD-E and APM-E measures will be reported.

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

Revised Measure

- The former Hemoglobin A1c (HbA1c) Control for Patients With Diabetes (HBD) measure was revised to Glycemic Status Assessment for Patients With Diabetes (GSD).

Overall Changes

- Moved all optional exclusions to required exclusions.
- Multiple value sets were combined into single value sets to improve performance efficiency in digital measures.
- Removed the Observation Value Set (and references to observation) from measures, because codes in this value set were retired and replaced with codes that combine observation and hospital inpatient care.
- Removed the Guidelines for Utilization Measures due to the retirement of the AMB and IPU measures.
- Measure Specifications and Measure Codes are subject to change by NCQA until the measures and codes are frozen by NCQA on April 1, 2024. NCQA will release an update noting any measure or code changes at that time.

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

- Controlling High Blood Pressure.
- Glycemic Status Assessment for Patients With Diabetes (GSD).
- Prenatal and Postpartum Care.
- Child and Adolescent Well-Care Visits.
- 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 (BCS-E).
- Adult Immunization Status.

New RES Measures for 2024:

- Eye Exam for Patients With Diabetes (EED).
- Kidney Health Evaluation for Patients With Diabetes (KED).
- Follow-Up After Hospitalization for Mental Illness (FUH).
- Follow-Up After Emergency Department Visit for Mental Illness (FUM).
- Childhood Immunization Status (CIS-E).
- Cervical Cancer Screening (CCS-E).
- Prenatal Immunization Status (PRS-E).
- Prenatal Depression Screening and Follow-Up (PND-E).
- Postpartum Depression Screening and Follow-Up (PDS-E).

Report only one of the nine 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 four 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).
    - **Frailty and advanced illness:** Members 66 years of age and older as of Dec. 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 98966-98968, 99441-99443.
  - E-visit or virtual check-in (Online Assessments Value Set):
    - » CPT: 98970-98972, 98980, 98981, 99421- 99423, 99457, 99458
    - » HCPCS: G0071, G2010, G2012, G2250- G2252
  - 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, 99421-99423, 99429, 99455, 99456, 99457, 99458, 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
  - 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, 98980, 98981, 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, 99421-99423, 99429, 99461, 99483
  - HCPCS: G0463, G0071, G0402, G0438, G0439, G0463, G2010, G2012, G2250, G2251, G2252, S0620, S0621, 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

Measure Exclusion Code

- Hospice Encounter:
  - 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, 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:
    - » [R26.2] Difficulty in walking, not elsewhere classified
    - » [R26.89] Other abnormalities of gait and mobility
    - » [R26.9] Unspecified abnormalities of gait and mobility
    - » [R53.1] Weakness
    - » [R53.81] Other malaise
    - » [R54] Age-related physical debility
    - » [R62.7] Adult failure to thrive
    - » [R63.4] Abnormal weight loss
    - » [R63.6] Underweight
    - » [R64] Cachexia
    - » [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, F01.511, F01.518, F01.52, F01.53, F01.54, F01.A0, F01.A11, F01.A18, F01.A2, F01.A3, F01.A4, F01.B0, F01.B11, F01.B18, F01.B2, F01.B3, F01.B4, F01.C0, F01.C11, F01.C18, F01.C2, F01.C3, F01.C4, F02.80, F02.81, F02.811, F02.818, F02.82, F02.83, F02.84, F02.A0, F02.A11, F02.A18, F02.A2, F02.A3, F02.A4, F02.B0, F02.B11, F02.B18, F02.B2, F02.B3, F02.B4, F02.C0, F02.C11, F02.C18, F02.C2, F02.C3, F02.C4, F03.90, F03.91, F03.911, F03.918, F03.92, F03.93, F03.94, F03.A0, F03.A11, F03.A18, F03.A2, F03.A3, F03.A4, F03.B0, F03.B11, F03.B18, F03.B2, F03.B3, F03.B4, F03.C0, F03.C11, F03.C18, F03.C2, F03.C3, F03.C4, 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.
    - **Electronic clinical data systems (ECDS) measures:** Data systems that may be eligible for ECDS reporting include, but are not limited to, administrative claims, clinical registries, health information exchanges, immunization information systems, disease/case management systems and electronic health records. Medical records request (MRR) for these measures is not allowed 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 Johns Hopkins Health Plans 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.
- **Ongoing care provider (OCP)** – The practitioner who assumes responsibility for the member's care. You will see this term in the TRC measure.
- **Primary care practitioner (PCP)** – A physician or non-physician (e.g., nurse practitioner, physician assistant, certified nurse midwife) who offers primary care medical services.
- **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 MY 2022, 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 Dec. 31 of the measurement year — Consider when member turns 18 and include service performed during the measurement year when member was 17.)

HEDIS Measures

Measure Name	Health Plan/Program	Eligibility
Adults' Access to Preventative / Ambulatory Health Services (AAP)	Advantage MD, EHP, Priority Partners, USFHP	Members 20 years of age and older
Advance Care Planning (ACP)	Advantage MD, Dual Eligible Special Needs Plans (D-SNP)	Members 66 years of age and older
Antidepressant Medication Management (AMM)	Advantage MD, D-SNP, EHP, Priority Partners, USFHP	Members 18 years of age and older
Appropriate Testing for Pharyngitis (CWP)	Advantage MD, EHP, Priority Partners, USFHP	Members 3 years of age and older
Asthma Medication Ratio (AMR)	EHP, Priority Partners/ VBP, USFHP	Members 5–64 years of age
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)	Advantage MD, EHP, Priority Partners, USFHP	Members 3 months of age and older
Blood Pressure Control for Patients With Diabetes (BPD)	Advantage MD, EHP, Priority Partners/VBP, USFHP	Members 18–75 years of age
Breast Cancer Screening - E (BCS-E)	Advantage MD, EHP, Priority Partners, USFHP	Female Members 50–74 years of age
Care for Older Adults (COA)	Advantage MD, D-SNP,	Members 66 years of age and older
Cervical Cancer Screening (CCS) and (CCS-E)	EHP, Priority Partners, USFHP	Female members 21–64 years of age
Child and Adolescent Well-Care Visits (WCV)	EHP, Priority Partners, USFHP	Member 3–21 years of age

Childhood Immunizations (CIS) and (CIS-E)	EHP, Priority Partners, USFHP	Children turning 2 years old in Measurement Year
Chlamydia Screening in Women (CHL)	EHP, Priority Partners, USFHP	Female members 16–24 years of age
Colorectal Cancer Screening (COL-E)	Advantage MD, D-SNP, EHP, Priority Partners, USFHP	Members 45–75 years of age
Controlling High BP (CBP)	Advantage MD, D-SNP, EHP, Priority Partners, USFHP	Members 18–85 years of age
Eye Exam for Patients With Diabetes (EED)	Advantage MD, EHP, Priority Partners, USFHP	Members 18–75 years of age
Follow-up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions (FMC)	Advantage MD	Members 18 years of age and older
Follow-Up After Hospitalization for Mental Illness (FUH)	Advantage MD, D-SNP, EHP, Priority Partners, USFHP	Members 6 years of age and older
Follow-Up Care for Children Prescribed ADHD Medication (ADD-E)	EHP, Priority Partners, USFHP	Members 6–12 years of age
Glycemic Status Assessment for Patients With Diabetes (GSD)	Advantage MD, EHP, Priority Partners/VBP, USFHP	Members 18–75 years of age
Immunizations for Adolescents (IMA) and (IMA-E)	EHP, Priority Partners, USFHP	Adolescents 13 years of age during the measurement year
Kidney Health Evaluation for Patients With Diabetes (KED)	Advantage MD, EHP, Priority Partners, USFHP	Members 18–75 years of age
Lead Screening in Children-HEDIS (LSC)	Priority Partners/VBP	Members 0–2 years of age
Lead Screening in Children-MDH (LSC)	Priority Partners/VBP	Members 12–23 months of age
Medication Adherence for Cholesterol (Statins) (MAC)	Advantage MD	Members 18 years of age or older
Medication Adherence for Diabetes Medications (MAD)	Advantage MD	Members 18 years of age or older

Medication Adherence for Hypertension (RAS antagonists) (MAH)	Advantage MD	Members 18 years of age or older
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E)	EHP, Priority Partners, USFHP	Members 1–17 years of age
Osteoporosis Management in Women Who Had a Fracture (OMW)	Advantage MD, D-SNP	Women 67–85 years of age as of Dec. 31 of the measurement year.
Osteoporosis Screening in Older Women (OSW)	Advantage MD	Women 65–75 years of age as of Dec. 31 of the measurement year.
Pharmacotherapy Management of COPD Exacerbation (PCE)	Advantage MD, D-SNP, EHP, Priority Partners, USFHP	Members 40 years of age and older
Plan All-Cause Readmission (PCR)	Advantage MD, D-SNP, EHP, Priority Partners, USFHP	Members 18 years of age and older
Prenatal and Postpartum Care (PPC)	EHP, Priority Partners/VBP, USFHP	Women who had a live birth(s) on or between 10/8 year prior to the measurement year and 10/7 of the measurement year.
Prenatal Immunization Status (PRS-E)	EHP, Priority Partners, USFHP	Pregnant members who deliver at >37 weeks during the measurement year
Risk of Continued Opioid Use (COU)	Advantage MD, EHP, Priority Partners/VBP, USFHP	Members 18 years of age or older
SSI Adults Ambulatory Care Visit (SSIA)	Priority Partners/VBP	Adults enrolled in a disabled coverage group (SSI) aged 21–64 years old
SSI Child Ambulatory Care Visit (SSIC)	Priority Partners/VBP	Children enrolled in a disabled coverage group (SSI) aged 0–20 years old
Statin Therapy for Patients with Cardiovascular Disease (SPC)	Advantage MD, EHP, Priority Partners, USFHP	Males 21–75 years of age. Females 40–75 years of age
Statin Therapy for Patients With Diabetes (SPD)	Advantage MD, EHP, Priority Partners, USFHP	Members 40–75 years of age
Statin Use in Persons With Diabetes (SUPD)	Advantage MD	Members with diabetes 40–75 years of age
Transitions of Care (TRC)	Advantage MD, D-SNP	Members 18 years of age and older

Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	EHP, Priority Partners, USFHP	Members 1–17 years of age
Use of Imaging Studies for Low Back Pain (LBP)	Advantage MD, EHP, Priority Partners, USFHP	Members 18–75 years of age
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)	EHP, Priority Partners, USFHP	Members 3–17 years of age
Well-Child Visits in the First 30 Months of Life (W30)	EHP, Priority Partners, USFHP	Member 15–30 months of age during measurement year

AAP — Adults' Access to Preventive/Ambulatory Health Services

Product Lines: Advantage MD, EHP, Priority Partners and USFHP

Eligible Population:

Members 20 years of age and older as of Dec. 31 of the measurement year.

Definition:

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 stratification

Continuous Enrollment:

- Medicaid and Medicare: The measurement year.
- Commercial: The measurement year and the 730 days prior to the measurement year.

Best Practice and Measure Tips

- Ensure members are seen within specified timeframes for each line of business.
- Report all services provided and utilize appropriate billing codes.
- Educate patients on the importance of having at least one ambulatory or preventive care visit during each calendar year.
- Consider offering expanded office hours to increase access to care.
- Keep a few open appointment slots each day to see patients the day they call.
- Contact patients who have not had a preventive or ambulatory health visit.
- Make reminder calls to patients who have appointments to decrease no-show rates.

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

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

- Ambulatory Visits
    - CPT: 92002, 92004, 92012, 92014, 98966, 98967, 98968, 98970, 98971, 98972, 98980, 98981, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99318, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 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, 99421, 99422, 99423, 99429, 99441, 99442, 99443, 99457, 99458, 99483
    - HCPCS: G0071, G0402, G0438, G0439, G0463, G2010, G2012, G2250, G2251, G2252, S0620, S0621, T1015
    - UBREV: 0510, 0511, 0512, 0513, 0514, 0515, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0524, 0525, 0526, 0527, 0528, 0529, 0982, 0983
- Reason for Ambulatory Visit
    - 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

ACP — Advance Care Planning

Product Lines: Advantage MD, Dual Eligible Special Needs Plans (D-SNP)

Eligible Population:

Members 66 years of age and older by Dec. 31 of the measurement year.

Definition:

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.

Continuous Enrollment:

- 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 Exclusion:

- 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
  - CPT- CAT- II: 1123F, 1124F, 1157F,1158F
  - HCPCS: S0257
  - ICD-10-CM: Z66 Do not resuscitate

AMM — Antidepressant Medication Management

Product Lines: Advantage MD, D-SNP, EHP, Priority Partners and USFHP

Eligible Population:

Members 18 years of age and older by Dec. 31 of the measurement year.

Definition:

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)

Continuous Enrollment:

- 105 days prior to the IPSD* through 231 days after the IPSD.

*IPSD: Index prescription start date. The earliest prescription dispensing date for an antidepressant medication where the date is in the intake period and there is a Negative medication history.

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.
- Give members written instructions to reinforce teaching about the proper use of medication and what to do if they experience side effects.
- Discuss other factors that may improve symptoms, such as aerobic exercise and counseling or therapy.
- Follow up within 30 days from when prescribed medication is filled for any side effects and their response to treatment.
- For patients with complex conditions, consider referring them to a psychiatrist.
- Coordinate care by sharing progress notes and updates with behavioral health provider.
- For members who cancel or missed appointments, reach out to them and reschedule as soon as possible.

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 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

CWP — Appropriate Testing for Pharyngitis

Product Lines: Advantage MD, EHP, Priority Partners and USFHP

Eligible Population:

Members 3 years of age and older by Dec. 31 of the measurement year.

Definition:

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.

Continuous Enrollment:

- 30 days prior to the episode date through 3 days after the episode date (34 total days).

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 comorbid conditions.
- Episode dates where the member had a claim/encounter with a competing diagnosis on or 3 days after the episode date.

Exclusion Codes:

- 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.
- Competing Diagnosis
  - ICD-10-CM: A00.0, A02.0, A03.0, A04.0, A05.0, A06.0, A07.0, A08.0, A09, A37.00, A44.0, A50.01, A54.00, A55, A56.00, A57, A58, A59.00, A59.9, A63.0, A64, A69.0, A69.9, B60.0, B64, B78.1, B96.89, E83.2, H66.001, H67.1, H70.001, H95.00, J01.00, J04.10, J05.0, J13, J14, J15.0, J16.0, J17, J18.0, J20.0, J32.0, J35.01, J38.7, J39.0, K05.20, K12.2, L01.00, L03.011, L04.0, L08.1, L92.8, L98.0, M46.20, M89.00, M90.80, N10, N12, N13.0, N15.1, N16, N30.00, N39.0, N41.0, N70.01, N71.0, N72, N73.0, N74, N75.0, N76.0, N77.0, Z20.2, Z22.4.
    - » 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

AMR — Asthma Medication Ratio

Product Lines: EHP, Priority Partners and USFHP

Eligible Population:

Members 5–64 years of age and older by Dec. 31 of the measurement year. This includes Value Based Purchasing (VBP) for Priority Partners.

Definition:

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.

Report stratification by race and ethnicity.

Continuous Enrollment:

- The measurement year and the year prior to the measurement year.

Best Practice and Measure Tips

Schedule follow-up appointments:

- Ensure the patient is not using more rescue medications than preventive medication to control their asthma (i.e., rescue meds have 50% 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, 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 had a diagnosis that requires a different treatment approach than members with asthma any time during the member's history through Dec. 31 of the measurement year.
- 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.

Exclusion Codes:

- Respiratory Diseases With Different Treatment Approaches Than Asthma
  - ICD-10-CM: E84.0, E84.11, E84.19, E84.8, E84.9, J43.0, J43.1, J43.2, J43.8, J43.9, J44.0, J44.1, J44.9, J68.4, J96.00, J96.01, J96.02, J96.20, J96.21, J96.22, J98.2, J98.3, 277.00, 277.01, 277.02, 277.03, 277.09, 492.0, 492.8, 493.20, 493.21, 493.22, 496, 506.4, 518.1, 518.2, 518.81.

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	Prescription	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	Fluticasone-mometasone	Inhalation
Inhaled corticosteroids	Beclomethasone	Inhalation
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	Prescription	Route
Short-acting, inhaled beta-2 agonists	Albuterol	Inhalation
Short-acting, inhaled beta-2 agonists	Levalbuterol	Inhalation

AAB — Avoidance of Antibiotic Treatment for Acute Bronchitis/ Bronchiolitis

Product Lines: Advantage MD, EHP, Priority Partners and USFHP

Eligible Population:

Members 3 months and older by Dec. 31 of the measurement year.

Definition:

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.

Continuous Enrollment:

- 30 days prior to the episode date through 3 days after the episode date (34 total days).

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 an 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

- 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	• Penicillin G benzathine-procaine • Penicillin G potassium • Penicillin G procaine • Penicillin G sodium • Penicillin V potassium • Penicillin G benzathine
Penicillinase resistant penicillins	• Dicloxacillin • Nafcillin • Oxacillin
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

BDP — Blood Pressure Control for Patients with Diabetes

Product Lines: Advantage MD, EHP, Priority Partners and USFHP

Eligible Population:

Members 18–75 years old as of Dec. 31of the measurement year.

Definition:

Members 18–75 years of age with diabetes (type 1 and type 2) whose blood pressure (BP) was adequately controlled (< 140/90) during the measurement year.

Note: Uses last BP of the year**.**

Continuous Enrollment:

- The measurement 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

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
Biguanides	• Metformin

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

BCS-E — Breast Cancer Screening

Product Lines: Advantage MD, EHP, Priority Partners and USFHP

Eligible Population:

Women 52–74 years of age as of Dec. 31 of the measurement year.

Definition:

Women 50-74 years of age who had a mammogram to screen for breast cancer on or between Oct. 1, two (2) years prior to the measurement year, and Dec. 31 of the measurement year. (Age range notes 50 years of age: this reflects look back age of 50 or older on test date.)

NOTE: A unilateral or bilateral mammogram is acceptable; however, a bilateral mammogram is preferred for compliance.

Report stratification by race and ethnicity.

Continuous Enrollment:

- Oct. 1, two (2) years prior to the measurement year, through Dec. 31 of the measurement year.

Best Practice and Measure Tips

- This measure evaluates preventive screening only.
- **Acceptable:**
  - **Bilateral or Unilateral** mammogram performed during the measurement period.
    - » Results can be submitted for medical record review throughout the year, but medical record review cannot be performed during HEDIS annual audit.
  - Documentation "mammogram completed" and date.
    - » 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.
  - Types of mammograms: Screening, Diagnostic, Film, Digital or Digital Breast Tomosynthesis (3D Mammogram)

NOTE: CAD (Computer-Aided Detection) is only designed to help improve Results for Mammography, MRI, CTs and X-rays, but this term alone does not make the member compliant. The appropriate screening type needs to be completed.

- **Not Acceptable:**
  - Biopsies, Breast Ultrasounds or MRIs.
- The advanced illness exclusion can be identified from a telephone visit, e-visit or virtual check-in.

Measure Exclusions

Required Exclusions:

- Must occur during the measurement year:
  - Hospice or using hospice services
  - Palliative care
  - Deceased
  - Living in long term care
  - Frailty and Advanced Illness
- Documentation of bilateral mastectomy anytime in member's history through Dec. 31 of the measurement year.
  - **Documentation must indicate a mastectomy on both the left and right side on the same or different dates of service.**
    - » Any of the following meet criteria for bilateral mastectomy:
      - **A bilateral** mastectomy.
      - A unilateral mastectomy on both the left and right side on the same or different dates of service.

- Two unilateral mastectomies, which do not specify left and right, must be performed 14 days or more apart.

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

COA — Care for Older Adults

Product Lines: Advantage MD, D-SNP

Eligible Population:

Members 66 years of age and older as of Dec. 31 of the measurement year.

Description:

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.

Continuous Enrollment:

- The measurement year.

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 Exclusion:

- 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

CCS/CCS-E — Cervical Cancer Screening

Product Lines: EHP, Priority Partners and USFHP

Eligible Population:

Female members 21 to 64 years of age as of Dec. 31 of the measurement year.

Definition:

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

- Age 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.

New for CCS-E Measure: **Stratification by race and ethnicity**

Continuous Enrollment:

- Commercial: The measurement year and the 730 days prior to the measurement year.
- Medicaid: The measurement year.

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.
- Lab test wording Ecto/Endo/Vaginal Pool: liquid based.
- Any cervical cancer screening method that includes collection and microscopic analysis of cervical cells.
- The doctor may document date test done and the result. If date of test stated is "last month," "last year," etc.
    - Pap Smear/ hrHPV done Jan. 20XX-negative – document 1/31/XX
- HM (Health Maintenance) section of chart if test date and result noted.

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 Dec. 31 of the measurement year.
- Members who died any time during the measurement year.

Acceptable Exclusion:

- Documentation of a "vaginal Pap smear" with documentation of hysterectomy.
- Documentation of "vaginal hysterectomy" without further specification.
- Documentation of hysterectomy and documentation that a member no longer needs Pap testing/cervical cancer screening.
    - Documentation must be from the same provider.
- Documentation of "complete," "total" or "radical" hysterectomy (abdominal, vaginal or unspecified) — implies no residual cervix.
- Documentation of cervical agenesis.

Not Acceptable Exclusions:

- Documentation of hysterectomy alone does NOT meet the criteria, because it does not indicate the cervix has been removed.
- Supracervical hysterectomy is not acceptable, because the cervix remains intact.
- Check surgical history and physical exam notes. (Documentation of no cervix may be mentioned in the physical portion of the exam).

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
    - LOINC: 10524-7, 18500-9, 19762-4, 19764-0, 19765-7, 19766-5, 19774-9, 33717-0, 47527-7, 47528-5
- HPV Tests
    - CPT: 87624, 87625
    - HCPCS: G0476
    - LOINC: 21440-3, 30167-1, 38372-9, 59263-4, 59264-2, 59420-0, 69002-4, 71431-1, 75694-0, 77379-6, 77399-4, 77400-0, 82354-2, 82456-5, 82675-0, 95539-3

WCV — Child and Adolescent Well-Care Visits

Product Lines: EHP, Priority Partners and USFHP

Eligible Population:

Members 3–21 years of age as of Dec. 31 of the measurement year.

Definition:

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.

Continuous Enrollment:

- The measurement year.

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, Johns Hopkins Health Plans 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-care visits 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

CIS/CIS-E — Childhood Immunizations

Product Lines: EHP, Priority Partners and USFHP

Eligible Population: Children who turned 2 years old during the measurement year.

Definition:

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-RVI) OR 3 doses – Rotavirus Pentavalent (RotaTeq-TIV)
- 2 doses – Influenza

Continuous Enrollment:

- 365 days prior to the child's second birthday.

Best Practice and Measure Tips

- Advise parents on the importance of completing each vaccine series.
    - Provide handouts.
    - Educate parents on vaccination and side effects.
    - Review immunization records at each visit and catch up on any missing immunizations.
- Office improvement opportunity
    - Place guidelines to schedule visits within the CDC guidelines timeframe. (https://www.cdc.gov/vaccines/schedules/hcp/imz/catchup.html)
    - Contact parents to reschedule any missed appointment for their child's vaccination.
    - Use measure codes and exclusion code listed below when submitting claims to make member compliant by administrative data.
- 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.
- For combination vaccinations that require more than one antigen (DTaP, MMR), evidence of all antigens must be documented.
- LAIV (live attenuated influenza vaccine) only counts if administered ON the second birthday.

Acceptable Documentation:

- A certificate of immunization prepared by an authorized health care provider or agency including the specific dates and types of immunizations administered.
- A note indicating the name of the specific antigen and immunization date.
    - Immunizations documented using a generic header (e.g., polio vaccine) or "IPV/OPV" can be counted as evidence of IPV.
    - Immunizations documented using a generic header or "DTaP/DTP/DT" can be counted as evidence of DTaP.
- 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.

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 a contraindication to a childhood vaccine 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, 90671
  - CVX: 109, 133, 152, 215
  - 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, 90685- 90689, 90756
  - 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

CHL — Chlamydia Screening in Women

Product Lines: EHP, Priority Partners and USFHP

Eligible Population:

Women 16–24 years as of Dec. 31 of the measurement year.

Definition:

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) The total is the sum of the age stratifications.

Continuous Enrollment:

- The measurement year.

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.
- Document in the medical record the date the test was performed and the result or finding, including any follow-ups.
- Incorporate a sexual history into the History and Physical documentation in your EMR.
- Have patient come in for their routine yearly visit and incorporate universal screening for all women in the age range.
- A chlamydia screening should occur with or without symptoms.
- Educate member about sexually transmitted diseases (STD), include signs, symptoms, and treatment.
- For any visit where oral contraceptive, sexually transmitted diseases (STD) or urinary symptoms are discussed, a Chlamydia screening should occur.
- Educate members about safe sex and abstinence.

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
  - LOINC: 14463-4, 14464-2, 14465-9, 14467-5, 14474-1, 14513-6, 16600-9, 21190-4, 21191-2, 21613-5, 23838-6, 31775-0, 34710-4, 42931-6, 43304-5 , 43404-3 , 44806-8, 44807-6, 45068-4, 45069-2, 45072-6, 45073-4, 45075-9, 45084-1, 45089-0, 45090-8, 45091-6, 45093-2, 45095-7, 4993-2 , 50387-0, 53925-4, 53926-2, 57287-5, 6353-7, 6356-0, 6357-8, 80360-1, 80361-9, 80362-7, 80363-5, 80364-3, 80365-0, 80367-6, 82306-2, 87949-4, 87950-2, 88221-7, 89648-0, 91860-7, 91873-0

COL-E — Colorectal Cancer Screening

Colorectal Cancer Screening (COL) is retired, only COL-E measure will be reported.

Product Lines: Advantage MD, D-SNP, EHP, Priority Partners and USFHP

Eligible Population:

Members age 45–75 years as of Dec. 31 of the measurement year.

Definition:

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 **or** flexible sigmoidoscopy every 10 years, with FIT every year.
- 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 Dec. 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.**

Continuous Enrollment:

- The measurement period and the year prior to the measurement period.

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. If this is not clear, the result or finding must also be present.
    - The member's "medical history" can be located within any section of the member's medical record in order to count, including the treatment/plan, problem list, progress note, health maintenance summary, HPI, etc.
    - If the colonoscopy is documented in the "medical history" section of the medical record, then a result/finding is not required regardless of the setting (i.e., inpatient, outpatient or member reported).
        - » Examples of notation in member's medical history:
            - "Colonoscopy 6/2021"
            - "Last colonoscopy 2015"
            - "H/O colonoscopy 2021"
            - "Had last colonoscopy in 2016 per pt."
            - Provider documentation states "colonoscopy done earlier this year"
- Always include a date of service and place of service if known.
- Member refusal will not make them ineligible for this measure.
- Educate member about the importance of early detection and recommend a different screening if a member refuses or can't tolerate a colonoscopy.**
- Have FIT kits available to give members during the visit with instructions to return them to the office or mail to the lab.
- Update and document the member's history annually, including type and date of colon cancer screening tests, history of total colectomy or history of colon cancer.

****Note: A stool DNA (sDNA) with FIT test is Cologuard®. A FIT test is the FOBT immunochemical test. They are not the same.**

Acceptable:

- 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.

- The **fecal immunochemical test (FIT) (iFOBT)** uses antibodies to detect blood in the stool. Foods do not alter test results.
    - » Regardless of how many samples were returned and as long as the medical record indicates that a FIT was done, the member meets criteria.
- The **guaiac-based fecal occult blood test (gFOBT)** uses the chemical guaiac to detect blood in the stool. Certain foods can alter test results.
    - » 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.
- Inpatient or outpatient procedures.
- Member reported services recorded, dated and maintained in the member's legal health record.
    - A result is not required if documentation includes:
        - » Type of screening (colonoscopy, flexible sigmoidoscopy, etc.)
        - » Date the test was performed, this is considered part of the member's medical history and a result is not required.
    - Collected while taking a patient's history by a primary care practitioner or a specialist who is providing a primary care service related to the condition being assessed
- Colonoscopy or flexible sigmoidoscopy procedure reports with documentation that indicates a complete exam.
- **Documentation requirements: Using pathology reports, incomplete or poor prep exams**
    - **If a pathology report does not indicate the type of screening**, or if the procedure report indicates an **incomplete exam** or **poor prep,** Look for evidence of where scope advanced to:
        - » **To the cecum = colonoscopy.**
        - » To the sigmoid colon = flexible sigmoidoscopy.
            - **From a procedure report**: Refer to the report documentation for evidence.
            - **From a pathology report**: Look for location in colon where specimen(s) was removed from to identify how far the scope advanced.
                - Example: "Polyp removed from ascending colon." This member would be compliant for flexible sigmoidoscopy only. Attempt to locate procedure report to verify if member had a colonoscopy.
    - **To determine date of procedure from a pathology report:**
        - » If report indicates the type of screening, the date the screening was performed (collected date) and resulted date, use collected date since this is the procedure date.
        - » If collected date is not available, the resulted date can be used.

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. (It is not the same as a CT colonography and is not acceptable.)
- Unclear documentation in medical record as "COL" or "COLON 20XX" by provider without mention of the actual screening test completed.
- Colonoscopy indicating "**poor bowel prep**" or "**incomplete exam**" **without** documentation scope advanced to cecum for a colonoscopy or into the sigmoid colon for flexible sigmoidoscopy.

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 Dec. 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
  - SNOMED CT code: 119771000119101

Measure Codes

- Colonoscopy
  - CPT: 44388, 44389, 44390, 44391, 44392, 44394, 44401-44408, 45378, 45379, 45380, 45381, 45382, 45384, 45385, 45386, 45388, 45389, 45390, 45391, 45392, 45393, 45398
  - HCPCS: G0105, G0121
  - SNOMED CT: 851000119109, 8180007, 12350003, 25732003, 34264006, 73761001, 174158000, 174185007, 235150006, 235151005, 275251008, 302052009, 367535003, 443998000, 444783004, 446521004, 446745002, 447021001, 709421007, 710293001, 711307001, 789778002, 1209098000

- Flexible Sigmoidoscopy
  - CPT: 45330-45335, 45337, 45338, 45340-45342, 45346,45347, 45349, 45350
  - HCPCS: G0104
  - SNOMED CT: 841000119107, 44441009, 396226005, 425634007
- FOBT Lab Test
  - Guaiac Test (gFOBT): CPT: 82270
  - FIT Test Immunochemical (iFOBT/FIT):
    - » CPT: 82274
    - » HCPCS: G0328
  - LOINC: 12503-9, 12504-7, 14563-1, 14564-9, 14565-6, 2335-8, 27396-1, 27401-9, 27925-7, 27926-5, 29771-3, 56490-6, 56491-4, 57905-2, 58453-2, 80372-6
  - SNOMED CT: 104435004, 441579003, 442067009, 442516004, 442554004, 442563002
  - FOBT Test Result or Finding SNOMED CT: 59614000, 167667006, 389076003
- Computed Tomography (CT) Colonography
  - CPT: 74261-74263
  - LOINC: 60515-4, 72531-7, 79069-1, 79071-7, 79101-2, 82688-3
  - SNOMED CT: 418714002
- Stool DNA (sDNA) with FIT Test
  - CPT: 81528 This code is specific to the Cologuard® sDNA with FIT test.
  - LOINC: 77353-1, 77354-9
  - SNOMED CT: 708699002

CBP — Controlling High BP

Product Lines: Advantage MD, D-SNP, EHP, Priority Partners and USFHP

Eligible Population:

Members 18–85 years old as of Dec. 31 of the measurement year.

Definition:

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 BP reading (last BP of the year) 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.

Continuous Enrollment:

- The measurement year

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.
- Implement process and procedures for staff to follow to accurately take BP reading. See American Medical Association (AMA) Control High BP best practices for recommendations and opportunities for improvement (https://www.ama-assn.org/system/files/2019-01/measure-accurately-best-practices.pdf).
- Educate member of the important of managing blood pressure. Provide resource such as flayer and tracking log.
    - AMA self-measured blood pressure (SMBP) quick guide (https://www.ama-assn.org/system/files/2020-06/7-step-smbp-quick-guide.pdf)
    - AMA Self-measured blood pressure log (https://targetbp.org/wp-content/uploads/2017/10/SMBP-Recording-Log_TBP_Update.pdf)
- BP reading taken during an urgent care visit is acceptable.

Multiple BPs on Same Date of Service:

- All eligible BP readings in the appropriate medical record or EMR should be considered, regardless of practitioner type and setting (Excluding Acute Inpatient and ED visit settings).
- 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.
- If the "Average BP" is noncompliant or if there is no average BP, the lowest systolic and lowest diastolic from all eligible BPs, will be use.
    - In this calculation all BPs from all provider notes on the same DOS in the same EMR and any acceptable member reported BPs would be included.
    - The noncompliant average blood pressure will not be included in the calculation. (However if this is the only BP available regardless of compliance per Representative BP guidelines will be reported.)
        - (Example: 150/80, 130/86, ~~Average BP 160/76~~, it will be reported as 130/80)

Guidelines for Member Reported BP Readings Documented in the Medical Record:

- Must indicate date BP was taken.
- Only a digital device for member reporting BP reading is acceptable. **If the documentation does not specify how the member reported BP was taken, then it can be assumed to have been a digital device.**
- May obtain BP during telephone visits, e-visits or virtual check-ins. Have members take BP prior to visit to report during visit.
- MyChart communications with BPs reported must indicate date taken.
- There is no requirement there be evidence the BP was collected by a PCP or specialist.
- Provider — during a face-to-face visit.
    - The date the BP was taken by the member must be documented. If the date is not documented, the member reported BP cannot be used. This only applies to the face-to-face visit.

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.
- Documented as a range or threshold.
- An incomplete BP reading (systolic or diastolic only).
- An aortic systolic/diastolic noninvasive central blood pressure measurement.

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
- End-stage renal disease (ESRD): dialysis, nephrectomy or kidney transplant
- Members with a diagnosis of pregnancy
- Non-acute inpatient admission
    - This includes rehabilitation, nursing home, inpatient mental health, etc.

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

EED — Eye Exam for Patient with Diabetes

Product Lines: Advantage MD, EHP, Priority Partners and USFHP

Eligible Population:

Members 18—75 years old as of Dec. 31 of the measurement year.

Definition:

Percentage of diabetic (types 1 and 2) 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.

New for Measure: Stratification by race and ethnicity.

Continuous Enrollment:

- The measurement year.

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's 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 (Example: Computerized Ophthalmic Imaging such as Optical Coherence Tomography, OCT) 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.
    - Results read by a qualified reading center operating under the direction of a medical director who is a retinal specialist.
- Prior year exam results must indicate retinopathy was not present.
- AI reports:
    - Acceptable: "Negative for more than mild diabetic retinopathy": This is only considered a negative result when it is a result of an exam read by AI (IDx-DR imaging system).
    - Documentation of provider type for AI reports:
        - » If it is noted that an optometrist or ophthalmologist reviewed the AI results, then choose the appropriate provider type in the drop-down.
        - » Some of the reports state they were read by AI and do not list a provider. If so, choose the provider drop-down option, "Results read by a system that provides an artificial intelligence (AI) interpretation.

Not Acceptable:

- Routine fundoscopic exam without examination of macula, vessels and periphery.
- Documentation of "diabetes without complications."
- Exams performed by PCP or non-eye care professionals (optician)
- Refractive only exams
- Exams in which only the anterior (A) chamber of the eye is examined
- Glaucoma pressure checks
- Unilateral post-operative eye exams which do not meet guidelines for acceptable documentation

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

NOTE: Blindness is not an exclusion for a diabetic eye exam, because it is difficult to distinguish between individuals who are legally blind but require a retinal exam and those who are completely blind and, therefore, do not require an exam.

Measure Codes

- Diabetes Mellitus Without Complications
  - ICD-10-CM: E10.9, E11.9, E13.9
- Diabetic Eye Exam by any provider type
  - Current year dilated retinal screening with evidence of retinopathy:
    - » CPT II: 2022F, 2024F, 2026F
  - Current year or prior 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 Retinal Screening with Eye Care Professional
  - 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, 92227, 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
  - ICD-10-PCS: Diagnosis 08T1XZZ
- Unilateral Eye Enucleation – Right
  - ICD-10-PCS: Diagnosis 08T0XZZ
- Bilateral Modifier
  - CPT Modifier 50

Medication List: Diabetes Medication

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

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

Product Lines: Advantage MD

Eligible Population:

Members 18 years and older as of Dec. 31 of the measurement year.

Definition:

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.

Continuous Enrollment:

- 365 days prior to the ED visit through 7 days after the ED visit.

Best Practice and Measure Tips

- The denominator is based on ED visits, not members.
- ED visits count between Jan. 1 and Dec. 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 nonacute, 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, ED visits, telephone visits, e-visits or virtual check-ins, nonacute inpatient encounters 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, telephone visit, e-visit or virtual check-in
    - CPT: 98966, 98967, 98968, 98970, 98971, 98972, 98980, 98981, 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, 99421, 99422, 99423, 99429, 99441, 99442, 99443, 99455, 99456, 99457, 99458, 99483
    - HCPCS: G0071, G0402, G0438, G0439, G0463, G2010, G2012, G2250, G2251, G2252, 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
- 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, 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, 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

- Substance Abuse Counseling and Surveillance
  - ICD-10-CM: Z71.41, Z71.51
- 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

FUH — Follow-Up After Hospitalization for Mental Illness

Product Lines: Advantage MD, D-SNP, EHP, Priority Partners and USFHP

Eligible Population:

Members 6 years and older as of Dec. 31 of the measurement year

Definition:

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.

New for Measure: **Stratification by race and ethnicity.**

Continuous Enrollment:

- Date of discharge through 30 days after discharge.

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 Jan. 1 and Dec. 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.
- 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 hopkinshealthplans.org/johns-hopkins-health-plans.
- While patient is in inpatient care, help them coordinate care with a mental health provider by:
    - Helping them schedule an appointment.
    - Verify if the mental health provider is a good fit by considering location, transportation and time.
    - Identify and address any barriers that may prevent member keeping the appointment.
    - Making sure member has a good support system by engaging parents/ guardian or significant others in the treatment plan, stressing the importance of treatment and attending to their appointment.
    - Ensure member received an appointment with 7 days of discharge.
    - Share all transition of care with the member's PCP to ensure members follows up with the treatment plan. Ensure member has a PCP.
- Educate member on:
    - Importance of consistency and adherence to the medication regiment.
    - Medication side effect, what to do if the side effect are severe and can potentially result in lack of adherence to the medication regiment and treatment plan.
    - Crisis intervention options.

- 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.
- Maintain appointment availability for members with recent inpatient discharge.
- Provider should provide reminder calls to confirm appointment within 24 hours.
- If member is unable to keep scheduled appointment, reschedule it or offer telehealth visit.
- Telehealth visits with a behavioral health provider are acceptable.
- Behavioral health visits count toward compliance.
- Psychiatric collaborative care management count toward compliance.
- Submit all claims with correct service coding and principal diagnosis timely.

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 Health Care 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, 99242-99245, 99341, 99342, 99344, 99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99483, 99492, 99493, 99494, 99510
  - HCPCS: G0155, G0176, G0177, G0409, G0463, G0512, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013-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, 99252–99255
  - 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:
      - Telehealth Provided Other than in Patient's Home: 02
      - Telehealth Provided in Patient's Home:10
    - » 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

- 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
  - Transitional Care Management Services

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

Follow-Up Care for Children Prescribed ADHD Medication (ADD) is retired, only ADD-E measure will be reported.

Product Lines: EHP, Priority Partners and USFHP

Eligible Population:

Members between 6–12 years of age as of Dec. 31 of the measurement year.

Definition:

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 a prescription dispensed for ADHD medication, who had one follow-up visit with a 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 a 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.

Continuous Enrollment:

- Initiation Phase: The member was enrolled with a medical and pharmacy benefit and had no gaps in enrollment between 120 days prior to the IPSD through 30 days after the IPSD.
- C&M phase: The member was enrolled with a medical and pharmacy benefit between 120 days prior to the IPSD through 300 days after the IPSD.
    - Commercial: No more than one 45-day gap in enrollment is allowed between 31 days after the IPSD through 300 days after the IPSD.
    - Medicaid: Monthly verified enrollment with only one gap in coverage is allowed.

Best Practice and Measure Tips

- 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.
- Review treatment plan regularly and make any modifications if the patient's symptoms do not respond.
- Treatment should continue as long as symptoms remain present and cause impairment.
- Monitor treatment-emergent side effects.
- Assess periodically to determine whether there is a continue need for treatment or if symptoms have remitted.

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 Dec. 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:

- Outpatient Visit (Visit Setting Unspecified)
    - CPT: 90791, 90792, 90832–90834, 90836–90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221–99223, 99231–99233, 99238, 99239, 99252–99255
    - Visit Setting Unspecified Value Set with any of the following place of service (POS)
        - » Partial Hospitalization POS: 52
        - » Community Mental Health Center POS: 53
        - » Telehealth POS:

- Telehealth Provided Other than in Patient's Home: 02
- Telehealth Provided in Patient's Home:10

» 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
  - CPT: 98960–98962, 99078, 99202–99205, 99211–99215, 99242–99245, 99341, 99342, 99344, 99345, 99347–99350, 99381–99387, 99391–99397, 99401–99404, 99411, 99412, 99483, 99492-99494, 99510
  - 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
- A health and behavior assessment/intervention
  - CPT: 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, 98980, 98981, 99421- 99423, 99421, 99422, 99423, 99444, 99457, 99458
  - HCPCS: G0071, G2010, G2012, G2250- G2252

GSD - Glycemic Status Assessment for Patients With Diabetes*

***The former Hemoglobin A1c (HbA1c) Control for Patients With Diabetes (HBD) measure was revised to Glycemic Status Assessment for Patients With Diabetes (GSD).**

Product Lines: Advantage MD, EHP, Priority Partners and USFHP

Eligible Population:

Members 18–75 years of age as of Dec. 31 of the measurement year. This includes Value Based Purchasing (VBP) for Priority Partners.

Definition:

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

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

*The most recent = closest to Dec. 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.

Continuous Enrollment:

- The measurement year.

Report stratification by race and ethnicity.

Best Practice and Measure Tips

- New for measure:
  - Glucose management indicator (GMI) was added as an option to meet numerator criteria.
  - Continuous glucose monitoring (CGM) data is acceptable.
- 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 or GMI was performed and the result.
- GMI values must include documentation of the CGM data date range used to derive the value. The terminal date in the range should be used to assign assessment date.
- GMI results collected by the member from their CGM and documented in the member's medical record are eligible for use in reporting (provided the GMI does not meet any exclusion criteria).
- If multiple glycemic status assessments were recorded for a single date, use the lowest 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.
- Educate member on the A1c target and the CGM goals.
- Refer member to case management to help members manage chronic health conditions. (https://www.hopkinsmedicine.org/johns-hopkins-health-plans/providers-physicians/division-of-health-services#care)

Acceptable Terminology:

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

Not Acceptable:

- HbA1c self-tested when not processed by a lab.
- Documentation of ranges and thresholds do not meet criteria. Example: < 9.0%.
- "Unknown" is not considered a result/finding.

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

Measure Codes

- HbA1C Lab Test
  - CPT: 83036, 83037
  - LOINC: 97506-0

- 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

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

IMA/IMA-E — Immunizations for Adolescents

Product Lines: EHP, Priority Partners and USFHP

Eligible Population:

Adolescents 13 years of age during the measurement year.

Definition:

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 members 9th and 13th birthdays.

Report stratification by race and ethnicity.

Continuous Enrollment:

- 12 months prior to the member's 13th birthday.

Best Practice and Measure Tips

- Immunization must occur on or prior to the member's 13th birthday.
- **Document any parent refusal for immunizations, as well as anaphylactic reactions.** There must be a note indicating the date of the event occurring by the member's 13th birthday. This will not exclude the member from this measure.
- The below count towards compliance. There must be a note indicating the date of the event occurring by the member's 13th birthday.
    - For ALL vaccines:
        - » Anaphylaxis due to the vaccine
        - » Evidence of the antigen or combination vaccine.
    - 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

Product Lines: Advantage MD, EHP, Priority Partners and USFHP

Eligible Population:

Members 18—85 years of age as of Dec. 31 of the measurement year.

Definition:

Percentage of members 18–85 years of age with diabetes (type 1 and type 2) as of Dec. 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
- 65–75
- 76–85
- Total. The total is the sum of the age stratifications.

New for measure: Stratification by race and ethnicity.

Continuous Enrollment:

- The measurement year.

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.
- Control 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

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 (eGFR) Lab Test
  - CPT: 80047, 80048, 80050, 80053, 80069, 82565
  - LOINC: 50044-7, 50210-4, 50384-7, 62238-1, 69405-9, 70969-1, 77147-7, 94677-2, 98979-8, 98980-6
- Quantitative Urine Albumin Lab Test
  - CPT: 82043
  - LOINC: 100158-5, 14957-5, 1754-1, 21059-1, 30003-8, 43605-5, 53530-2, 53531-0, 57369-1, 89999-7
- Urine Albumin Creatinine Ratio (uACR) Lab Test
  - LOINC: 13705-9, 14958-3, 14959-1, 30000-4, 44292-1, 59159-4, 76401-9, 77253-3, 77254-1, 89998-9, 9318-7
- Urine Creatinine Lab Test
  - CPT: 82570
  - LOINC: 20624-3, 2161-8, 35674-1, 39982-4, 57344-4, 57346-9, 58951-5

Medication List: Diabetes Medications

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

LSC — Lead Screening in Children - HEDIS

Product Lines: Priority Partners

Eligible Population:

Members 2 years of age as of Dec. 31 of the measurement year. This includes Value Based Purchasing (VBP) for Priority Partners.

Definition:

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.
- Document in the medical record the date the test was performed and the result or findings. "Unknown" is not considered a result/finding.
- 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 and the Centers for Disease Control and Prevention (CDC) 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
  - https://www.cdc.gov/nceh/lead/default.htm

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
- LOINC Codes: 10368-9, 10912-4, 14807-2, 17052-2, 25459-9, 27129-6, 32325-3, 5671-3, 5674-7, 77307-7

LSC — Lead Screening in Children - MDH

Product Lines: Priority Partners

Eligible Population:

Members 12–23 months as of Dec. 31 of the measurement year. This includes Value Based Purchasing (VBP) for Priority Partners.

Definition:

This is a Maryland Department of Health (MDH) Lead Measure for Children age 12–23 months as of Dec. 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 disenroll 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 MDH and CDC websites 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
  - https://www.cdc.gov/nceh/lead/default.htm

Documentation Via Claims

This is an 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)

Product Lines: Advantage MD, Part D

Eligible Population:

Members 18 years or older as of Dec. 31 of the measurement year.

Definition:

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

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.

Best Practice and Measure Tips

- 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.
  - For members who are noncompliant, provide ongoing patient outreach and identify reason for noncompliance and attempt to resolve.
  - To help member commit to taking their medication, use motivational interviewing and set goals for taking their medications.
  - Implement practice processes that can identify opportunity to close gaps every time the patient is seen.
  - Encourage member to join refill reminder program at their pharmacy, if available.
  - Encourage mail order pharmacy program.

- 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.
  - Discuss other factors that may improve symptoms, such as aerobic exercise and healthy diet or lifestyle changes.
  - Give members written instructions to reinforce teaching about the proper use of medication and what to do if they experience side effects.
- Mail Order Pharmacy Program
  - Mail Order Best Practices
  - One of the most important ways to improve the health of our members is to make sure they receive and take their medications as you prescribe. Our mail order pharmacy, CVS Caremark, can help. CVS Caremark sends a three-month supply of maintenance medications in one fill, making it easier for the patient only having to fill four times a year. In addition, a three-month supply of maintenance medication on Tier 1 through 4 is available through CVS Caremark mail order at a reduced copay. This means your patient can fill a 100-day supply of Tier 1 medication and a 90-day supply of Tier 2 through 4 medication for only two times the retail copay — saving them an equivalent of four retail copays per year. Talk to your patients today about mail order pharmacy with CVS Caremark for better health and health care spending. Doctors and staff can contact CVS Caremark by calling the number below, 24 hours a day, seven days a week.
- PPO members: 877-293-5325
- HMO members: 877-293-4998

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

Product Lines: Advantage MD, Part D

Eligible Population:

Members 18 years or older as of Dec. 31 of the measurement year.

Definition:

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.

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 higher the rate is better.

Best Practice and Measure Tips

- 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.
  - For members who are noncompliant, provide ongoing patient outreach and identify reason for noncompliance and attempt to resolve.
  - To help member commit to taking their medication, use motivational interviewing and set goals for taking their medications.
  - Implement practice processes that can identify opportunities to close gaps every time the patient is seen.
  - Encourage member to join refill reminder program at their pharmacy, if available.
  - Encourage mail order pharmacy program.
- 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.
  - Discuss other factors that may improve symptoms, such as aerobic exercise and healthy diet or lifestyle changes.
  - Give members written instructions to reinforce teaching about the proper use of medication and what to do if they experience side effects.
- Mail Order Pharmacy Program
  - Mail Order Best Practices
  - One of the most important ways to improve the health of our members is to make sure they receive and take their medications as you prescribe.

Our mail order pharmacy, CVS Caremark, can help. CVS Caremark sends a three-month supply of maintenance medications in one fill, making it easier for the patient only having to fill four times a year. In addition, a three-month supply of maintenance medication on Tier 1 through 4 is available through CVS Caremark mail order at a reduced copay. This means your patient can fill a 100-day supply of Tier 1 medication and a 90-day supply of Tier 2 through 4 medication for only two times the retail copay — saving them an equivalent of four retail copays per year. Talk to your patients today about mail order pharmacy with CVS Caremark for better health and health care spending. Doctors and staff can contact CVS Caremark by calling the number below, 24 hours a day, seven days a week.

- PPO members: 877-293-5325
- HMO members: 877-293-4998

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

Product Lines: Advantage MD, Part D

Eligible Population:

Members 18 years or older as of Dec. 31 of the measurement year.

Definition:

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.

RAS antagonist medications include:

- Angiotensin II receptor blockers (ARB)
- Angiotensin-converting enzyme inhibitors (ACEI)
- 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.

Best Practice and Measure Tips

- 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.
  - For members who are noncompliant, provide ongoing patient outreach and identify reason for noncompliance and attempt to resolve.
  - To help member commit to taking their medication, use motivational interviewing and set goals for taking their medications.
  - Implement practice processes that can identify opportunity to close gaps every time the patient is seen.
  - Encourage member to join refill reminder program at their pharmacy, if available.
  - Encourage mail order pharmacy program.
- 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.
  - Discuss other factors that may improve symptoms, such as aerobic exercise and healthy diet or lifestyle changes.
  - Give members written instructions to reinforce teaching about the proper use of medication and what to do if they experience side effects.
- Mail Order Pharmacy Program
  - Mail Order Best Practices
  - One of the most important ways to improve the health of our members is to make sure they receive and take their medications as you prescribe. Our mail order pharmacy, CVS Caremark, can help. CVS Caremark sends a

three-month supply of maintenance medications in one fill, making it easier for the patient only having to fill four times a year. In addition, a three-month supply of maintenance medication on Tier 1 through 4 is available through CVS/caremark mail order at a reduced copay. This means your patient can fill a 100-day supply of Tier 1 medication and a 90-day supply of Tier 2 through 4 medication for only two times the retail copay — saving them an equivalent of four retail copays per year. Talk to your patients today about mail order pharmacy with CVS Caremark for better health and health care spending. Doctors and staff can contact CVS Caremark by calling the number below, 24 hours a day, seven days a week.

- PPO members: 877-293-5325
- HMO members: 877-293-4998

Measure Exclusions

Required Exclusions:

Anytime in the Measurement year:

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

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

Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) is retired, only APM-E measure will be reported.

Product Lines: EHP, Priority Partners and USFHP

Eligible Population:

Members between 1–17 years of age as of Dec. 31 of the measurement year.

Definition:

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

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

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

Continuous Enrollment:

- The measurement year.

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
    - » LOINC: 17855-8, 17856-6, 4548-4, 4549-2, 96595-4
  - Glucose Lab Tests
    - » CPT: 80047, 80048, 80050, 80053, 80069, 82947, 82950, 82951
    - » LOINC: 10450-5, 1492-8, 1494-4, 1496-9, 1499-3, 1501-6, 1504-0, 1507-3, 1514-9, 1518-0, 1530-5, 1533-9, 1554-5, 1557-8, 1558-6, 17865-7, 20436-2, 20437-0, 20438-8, 20440-4, 2345-7, 26554-6, 41024-1, 49134-0, 6749-6, 9375-7
- Cholesterol

- LDL-C Lab Tests
  - » CPT: 80061, 83700, 83701, 83704, 83721
  - » CPT-CAT-II: 3048F, 3049F, 3050F
  - » LOINC: 12773-8, 13457-7, 18261-8, 18262-6, 2089-1, 49132-4, 55440-2, 96259-7
- Cholesterol Lab Test
  - » CPT: 82465, 83718, 83722, 84478
  - » LOINC: 2085-9, 2093-3, 2571-8, 3043-7, 9830-1

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

OMW — Osteoporosis Management in Women Who Had a Fracture

Product Lines: Advantage MD, D-SNP

Eligible Population:

Women 67–85 years of age as of Dec. 31 of the measurement year.

Definition:

The percentage of women 67–85 years of age as of Dec. 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.

Continuous Enrollment:

- 12 months before the episode date through 6 months after the episode date.

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

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

Measure Medications

One of the following osteoporosis medications within 180 days of their discharge for a fracture:

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

OSW — Osteoporosis Screening in Older Women

Product Lines: Advantage MD

Eligible Population:

Women 66–75 years of age as of Dec. 31 of the measurement year.

Definition:

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

Continuous Enrollment:

- The measurement year and the year prior to 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.
- Educate member about bone health and adopting healthy practices:
  - Maintain a balance diet
  - Engage in weight-bearing exercises
  - Adequate calcium and vitamin D intake
  - Preventing and avoiding falls
  - Review medications that may cause bone loss
  - Review diseases, conditions and medical procedures that may cause bone loss
  - Avoiding smoking and limiting alcohol

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 Jan. 1 three years prior to the measurement year through Dec. 31 of the year prior to the measurement year.
- Members who had a claim/encounter for osteoporosis therapy (Osteoporosis Medication Therapy; Long-Acting Osteoporosis Medications) any time in the member's history through Dec. 31 of the year prior to the measurement year.

Medication Exclusions:

Osteoporosis Medications

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

Exclusion Codes:

- Osteoporosis Medication Therapy Value Set
  - HCPCS: J0897, J1740, J3110, J3111, J3489
- Long-Acting Osteoporosis Medications Value Set
  - HCPCS: J0897, J1740, J3489

Measure Codes

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

PCE — Pharmacotherapy Management of COPD Exacerbation

Product Lines: Advantage MD, D-SNP, EHP, Priority Partners and USFHP

Eligible Population:

Members 40 years of age and older as of Dec. 31 of the measurement year**.**

Definition:

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 Jan. 1 and Nov. 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.

Continuous Enrollment:

- The measurement year and the year prior to the measurement year.

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

Product Lines: Advantage MD, D-SNP, EHP, Priority Partners and USFHP

Eligible Population:

Members 18 years of age and older as of Dec. 31 of the measurement year.

Definition:

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 and 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.

IHS: Index hospital stay. An acute inpatient or observation stay with a discharge on or between Jan. 1 and Dec. 1 of the measurement year, as identified in the denominator.

Index Discharge Date: The IHS discharge date. The Index Discharge Date must occur on or between Jan. 1 and Dec. 1 of the measurement year.

Index Readmission Stay: An acute inpatient or observation stay for any diagnosis with an admission date within 30 days of a previous Index Discharge Date.

Index Readmission Date: The admission date associated with the Index Readmission Stay.

Note: Per General Guideline Members With Dual Enrollment, members with dual commercial and Medicaid enrollment may only be reported in the commercial product line. Members with dual Medicaid/Medicare enrollment "dual eligible" and with Medicare-Medicaid (MMP) enrollment may only be reported in the Medicare product line.

Continuous Enrollment:

- 365 days prior to the Index Discharge Date through 30 days after 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
    - Exclude the hospital stay if the direct transfer's discharge date occurs after Dec. 1 of the measurement year.
    - Exclude hospital stays where the Index Admission Date is the same as the Index Discharge Date.

PPC — Prenatal and Postpartum Care

Product Lines: EHP, Priority Partners, and USFHP.

Eligible Population:

Women who had a live birth(s) on or between 10/8 year prior to the MY and 10/7 of the MY (10/8/2023 to 10/7/2024). This includes Value Based Purchasing (VBP) for Priority Partners.

Definition:

The percentage of live birth deliveries on or between Oct. 8 of the year prior to the measurement year and Oct. 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 timeframe.

Report stratification by race and ethnicity

Continuous Enrollment:

- 43 days prior to delivery through 60 days after delivery.

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.
- Before discharging member from the hospital stay, look at the member's schedule history for no-show or reschedule appointment and, if member seems reluctant to schedule an appointment or you suspect they will not show, schedule a telephone or video visit.
- Maintain available appointments for member to be seen during their first trimester or postpartum period.
- When scheduling postpartum visit, use the discharge day and schedule the member after the 6th day from discharge which begins the postpartum period for the measure (within 7–84 days postpartum).
- 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). Such as visit to confirm pregnancy or pregnancy was diagnosed.
- 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, complete OB history, of prenatal risk assessment and counseling
  - A basic physical obstetrical examination with auscultation for fetal heart tone, pelvic exam 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
  - TORCH antibody panel alone, OR
  - Rubella antibody test/titer with RH incompatibility (ABO/Rh) blood typing, OR
  - Ultrasound of a pregnant uterus
- Services, such as an obstetrical history, prenatal risk assessment and counseling/ education may be provided by an RN if signed off by an acceptable practitioner. Physician co-signature indicates the physician is "accountable for care."

Acceptable:

- May utilize ACOG sheet or a standardized prenatal flow sheet.
- Services provided during a telephone visit, e-visit or virtual check-in

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.
- A Pap test does not count as a prenatal care visit.

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
  - "Physical Exam: Psychiatric: Normal mood and affect. Behavior, Judgement and thought content are normal" meets criteria.
- 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.
        - » Member seen for rash and the documentation of "breastfeeding" makes the visit compliant based on the "Infant care or breastfeeding" component
    - Resumption of intercourse, birth spacing or family planning.
        - » Sexual activity documented as being discussed, doesn't need to say "resumption".
    - Sleep or fatigue.
    - Resumption of physical activity.
    - Attainment of healthy weight.

Not Acceptable:

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

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

- Prenatal Visit
    - Stand-alone Prenatal Visits
        - » CPT/CPT II: 99500, 0500F - 05002F
        - » HCPCS: H1000 - H1004
    - Office Visit, Telephone Visit or an E-visit/virtual check-in (Online Assessment) with a pregnancy related diagnosis code
        - » CPT: 98966, 98967, 98968, 98970, 98971, 98972, 98980, 98981, 99202-99205, 99211-99215, 99241-99245, 99421-99423, 99457, 99458, 99483
        - » HCPCS: G0071, G0463, G2010, G2012, G2250, G2251, G2252, 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, G0124, G0141, G0143-G0145, G0147-48, G0148, P3000, P3001, Q0091

PRS-E — Prenatal Immunization Status

Product Lines: EHP, Priority Partners and USFHP

Eligible Population:

Pregnant members who deliver at >37 weeks during the measurement year.

Definition:

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.

New for measure: Stratification by race and ethnicity.

Continuous Enrollment:

- 28 days prior to the delivery date through the delivery date.

Best Practice and Measure Tips

- Identify members with gap. Offer immunization to members during prenatal visits or when admitted for delivery.
- Use appropriate and accurate codes on claims.
- CDC recommends 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
  - For patient and provider resources, visit: www.cdc.gov/vaccines/pregnancy

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
    - » Anaphylaxis due to the influenza vaccine SNOMED: 471361000124100
  - 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

COU — Risk of Continued Opioid Use

Product Lines: Advantage MD, EHP, Priority Partners and USFHP

Eligible Population:

Members 18 years and older as of Nov. 1 of the year prior to the measurement year. This includes Value Based Purchasing (VBP) for Priority Partners.

Definition:

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 Nov. 1 of the year prior to the measurement year through Oct. 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.

Continuous Enrollment:

- 180 days prior to the IPSD through 61 days after the IPSD.

Best Practice and Measure Tips

- Refer to Johns Hopkins 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)
    - » 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).

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.
- Palliative care
- **Any of the following during the 12 months prior to the earliest prescription dispensing date through 61 days after the IPSD:**
  - 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
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
Methadone	Methadone Medications List
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

SSIA — SSI Adult Ambulatory Care Visit - MDH

Product Lines: Priority Partners

Eligible Population:

Adults enrolled in a disabled coverage group (SSI) aged 21–64 years old as of Dec. 31 of the measurement. This includes Value Based Purchasing (VBP) for Priority Partners.

Definition:

Adults enrolled in a disabled coverage group (SSI) aged 21–64 years as of Dec. 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 Dec. 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 Dec. 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 Jan. 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 Jan. 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

Product Lines: Priority Partners

Eligible Population:

Children enrolled in a disabled coverage group (SSI) aged 0–20 years old years as of Dec. 31 of the measurement. This includes Value Based Purchasing (VBP) for Priority Partners.

Definition:

Children enrolled in a disabled coverage group (SSI) aged 0–20 years as of Dec. 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 Dec. 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

- 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 Jan. 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

SPC — Statin Therapy for Patients with Cardiovascular Disease

Product Lines: Advantage MD, EHP, Priority Partners and USFHP

Eligible Population:

Males 21–75 years of age and females 40–75 years of age as of Dec. 31 of the measurement year.

Definition:

The percentage of males 21–75 years of age and females 40-75 years of age as of Dec. 31 of the measurement year, diagnosed with clinical atherosclerotic cardiovascular disease (ASCVD) and were dispensed at least one high or moderate-intensity statin medication during the measurement year.

The following rates are reported:

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

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).

Continuous Enrollment:

- 180 days prior to the IPSD through 61 days after the IPSD.

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
- Members who died

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

Product Lines: Advantage MD, EHP, Priority Partners, and USFHP

Eligible Population:

Members ages 40–75 during the measurement year.

Definition:

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.

Continuous Enrollment:

- The measurement year and the year prior to the measurement year.

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 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
Biguanides	• Metformin

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

SUPD — Statin Use in Persons with Diabetes

Product Lines: Advantage MD, Part D

Eligible Population:

Members with diabetes ages 40–75 during the measurement year.

Definition:

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:

- Hospice enrollment
- ESRD diagnosis or dialysis coverage dates
- Rhabdomyolysis and myopathy
- Pregnancy
- Lactation and fertility
- Cirrhosis
- Prediabetes
- Polycystic ovary syndrome

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

Product Lines: Advantage MD, D-SNP

Eligible Population:

Members 18 years and older as of Dec. 31 of the measurement year (MY).

Definition:

The percentage of acute and non-acute discharges, on or between Jan. 1 and Dec. 1 of the MY, for members 18 years of age and older who had each of the four elements: -

- **Notification on Inpatient Admission.** Documentation of receipt of notification of inpatient admission on the day of admission through two days after the admission (three days total). (MRR only)
- **Receipt of Discharge Information.** Documentation of receipt of discharge information on the day of discharge through two days after the discharge (three days total). (MRR only)
- **Patient Engagement After Inpatient Discharge.** Documentation of patient engagement (e.g., office visits, visits to the home, telehealth) provided within 30 days after discharge. (HYBRID)
- **Medication Reconciliation Post-Discharge.** Documentation of medication reconciliation on the date of discharge through 30 days after discharge (31 days total). (HYBRID)

Acronyms:

- OCP — Ongoing care provider
- HIE — Health information exchange
- ADT — Automated admission, discharge and transfer alert system

Continuous Enrollment:

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

Best Practice and Measure Tips

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.

***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-operative exam and/or follow-up visit), then they may be considered to be the OCP. If the member only saw the surgeon while in the hospital then they may not be considered to be an OCP.

How Admission and Discharge Dates Are Determined:

Members may be in the measure more than once in the measurement year. 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 two days after the admission (three 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.

Acceptable Criteria:

- Communication between inpatient providers/staff and the member's PCP/OCP via phone call/email/fax.
- Communication about admission between emergency department and the member's PCP or OCP via phone call/email/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 OCP through a shared 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 OCP 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.

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:

Documentation sent to the member's PCP or OCP must include dated evidence of receipt of discharge information on the day of discharge through two days after the discharge (three 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.**

Acceptable Criteria:

- 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.

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 timeframe or date when documentation received.

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.)

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.
- **Only documentation in the outpatient chart meets the intent of the measure:**
  - 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.

Acceptable Criteria:

- Current medication list available and provider reconciled the current and discharge medications.
  - Mention of "hospitalization," "admission" or "inpatient stay" in note is not required.
- 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).
  - Mention of "hospitalization," "admission" or "inpatient stay" in note is not required.
- Current medications list available and discharge medications were reviewed.
  - Mention of "hospitalization," "admission" or "inpatient stay" in note is not required.
- Current medication list, discharge medication list are available and both lists were reviewed on the same date of service.
  - Mention of "hospitalization," "admission" or "inpatient stay" in note is not required.
  - The act of documenting the medication list is considered evidence the provider reviewed the medications.
- Current medications list available, member had post-discharge hospital follow-up and medications were reconciled/reviewed.

    - Documentation must indicate the provider was aware of the member's hospitalization/discharge.
    - The act of documenting the medication list during a follow-up visit is considered evidence the provider reviewed the medications.
- Discharge summary reads discharge medications were reconciled with the most recent medication list and it was filed (in the PCP/OCP's outpatient chart) on the date of discharge through 30 days after discharge (31 total days).
    - There must be evidence that the discharge summary was filed in the PCP/OCP's outpatient chart on the date of discharge through 30 days after discharge (31 total days).
    - Utilizing this discharge summary is the last resort, attempt to find documentation of an office visit, home visit (possibly RN), e-visit etc.
- Notation that no medications were prescribed or ordered upon discharge.

Notes:

- A medication list may include medication names only or may include medication names, dosages and frequency, over-the-counter (OCT) medications and herbal or supplemental therapies.
- The Medication Reconciliation Post-Discharge sub-measure assesses whether medication reconciliation occurred, not the quality of the med list or the process used to reconcile the medications.

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.
- Documentation indicating only that the provider was aware of the surgery (even if the procedure/surgery is typically performed inpatient) or if the provider performed the surgery is not sufficient to show that the provider was aware of the "hospitalization" at the time of the follow-up visit. (NCQA Response 4/2023)
- The presence of a discharge notification or discharge summary in the medical record alone does not count as evidence that the provider was aware of the hospitalization at the time of the follow-up visit (even if the provider was the discharging provider). (NCQA response 4/2023)

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

Patient Engagement After Inpatient Discharge

- An outpatient visit, telephone visit, e-visit or virtual check-in:

    - CPT: 98966, 98967, 98968, 98970, 98971, 98972, 98980, 98981, 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, 99421, 99422, 99423, 99429, 99441, 99442, 99443, 99455, 99456, 99457, 99458, 99483
    - HCPCS: G0071, G0402, G0438, G0439, G0463, G2010, G2012, G2250, G2251, G2252, 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
- Transitional care management: CPT: 99495, 99496

Medication Reconciliation Post-Discharge

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

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

Product Lines: EHP, Priority Partners, and USFHP

Eligible Population:

Members 1–17 years of age as of Dec. 31 of the measurement year.

Definition:

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.

Intake period: Jan. 1 through Dec. 1 of the measurement year.

IPSD: Index prescription start date. The earliest prescription dispensing date for an antipsychotic medication where the date is in the intake period and there is a negative medication history.

Negative medication history: A period of 120 days prior to the IPSD when the member had no antipsychotic medications dispensed for either new or refill prescriptions.

Continuous Enrollment:

- 120 days prior to the IPSD through 30 days after the IPSD.

Best Practice and Measure Tips

- New for measure, residential behavioral health treatment is acceptable.
- 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:
- Members with a diagnosis of schizophrenia, schizoaffective disorder, bipolar disorder, other psychotic disorder, autism or other developmental disorder on at least two different dates of service 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
- Residential Behavioral Health Treatment
  - HCPCS: H0017, H0018, H0019, T2048

Measure Medications

Antipsychotic Medications

Description	Prescription
Miscellaneous antipsychotic agents	• 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

LBP — Use of Imaging Studies for Low Back Pain

Product Lines: Advantage MD, EHP, Priority Partners and USFHP

Eligible Population:

Members 18–75 years as of Dec. 31 of the measurement year.

Definition:

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: 18–75 years as of Dec. 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

Intake Period: Identifies the first eligible encounter with a primary diagnosis of low back pain between Jan. 1 and Dec. 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.

Continuous Enrollment:

- 180 days prior to the IESD through 28 days after the IESD.

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).
- 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;
      - Additional codes apply.
    - 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, J1740, J3110, J3111, J3489

Osteoporosis Medications

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

- Lumbar surgery
  - CPT: 22114, 22207, 22214, 22224, 22511, 22512, 22514, 22515, 22533, 22534, 22558, 22612, 22630, 22632, 22633, 22634, 22857, 22860, 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
    - [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
    - [0QU007Z] Supplement Lumbar Vertebra with Autologous Tissue Substitute, Open 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
    - Additional codes apply.
- 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

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
- Avoid the below Imaging Study Codes during the first 30 days of a diagnosis of uncomplicated back pain.
  - CPT: 72020, 72040, 72050, 72052, 72070, 72072, 72074, 72080, 72081, 72082, 72083, 72084, 72100, 72110, 72114, 72120, 72125, 72126, 72127, 72128, 72129, 72130, 72131, 72132, 72133, 72141, 72142, 72146, 72147, 72148, 72149, 72156, 72157, 72158, 72200, 72202, 72220

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

Product Lines: EHP, Priority Partners and USFHP

Eligible Population:

Member 3–17 years as of Dec. 31 of the measurement year.

Definition:

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.

Continuous Enrollment:

- The measurement year.

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). Services rendered for obesity or 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 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").
- 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, Z68.54
- 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

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

Product Lines: EHP, Priority Partners and USFHP

Eligible Population:

Member ages 15–30 months during measurement year.

Definition:

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 15–30 Months. Children who turned 30 months old during the measurement year: Two or more well-child visits.

Provider Specialty: PCP

Report stratification by race and ethnicity.

Continuous Enrollment:

- Well-Child Visits in the First 15 Months: 31 days to 15 months of age. Calculate 31 days of age by adding 31 days to the date of birth.
- Well-Child Visits for Age 15–30 Months: 15 months plus 1 day to 30 months of age. Calculate the 15-month birthday plus 1 day as the first birthday plus 91 days.

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, Johns Hopkins Health Plans 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.

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

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