Quality Measures Guide

Learn about the Healthcare Effectiveness Data and Information Set (HEDIS®) measures, Pharmacy Quality Alliance (PQA) measures, and Asuris-specific quality measures that we track for various programs and annual reporting.

This guide includes the criteria and diagnosis or procedure codes required to meet compliance for measures we track for the following programs, lines of business or provider agreements:

- Annual HEDIS chart review
- Value-based agreements (VBA)
- Medicare Quality Incentive Program (QIP)
- Health insurance exchange quality rating system (QRS)

The table on the following pages indicate which measures are included in this guide.

**Large code sets**

Some of the measures include large code sets for specific types of diagnoses. If you need the extended list of codes for a specific measure, please contact your provider consultant.

**Notes:**

- The diagnosis and/or procedure codes in this guide are in compliance with the *HEDIS 2020 Volume 2 Technical Specifications*, which apply to dates of service in 2019. HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).
- Reimbursement for these services will be in accordance with the terms and conditions of your agreement with us.
<table>
<thead>
<tr>
<th>Measure name</th>
<th>HEDIS chart review</th>
<th>VBA</th>
<th>QIP</th>
<th>QRS</th>
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<td>Adult body mass index (BMI) assessment (ABA)</td>
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<td>Annual monitoring for patients on persistent medications (MPM)</td>
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<td>Anxiety and depression screening (Asuris VBA measure)</td>
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<tr>
<td>Appropriate testing for pharyngitis (CWP)</td>
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<tr>
<td>Appropriate treatment for upper respiratory infection (URI)</td>
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<td>Asthma medication ratio (AMR)</td>
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<td>Avoidance of antibiotic treatment in adults with acute bronchitis (AAB)</td>
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<td>Colorectal cancer screening (COL)</td>
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<td>Controlling blood pressure (CBP)</td>
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<td>Diabetes—A1c testing (CDC)</td>
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<tr>
<td>Diabetes—Blood pressure control (CDC)</td>
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<td>Disease modifying anti-rheumatic drug therapy for rheumatoid arthritis (ART)</td>
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<td>Follow-up after hospitalization for mental illness (FUH)</td>
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<td>Immunization for adolescents—includes human papillomavirus vaccine (IMA)</td>
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<td>Initiation and engagement of alcohol and other drug dependence treatment (IET)</td>
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<td>Medication adherence</td>
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<td>Medication management for people with asthma (MMA)</td>
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<td>Osteoporosis management in women who have had a fracture (OMW)</td>
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<td>Persistence of beta blocker treatment after a heart attack (PBH)</td>
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<td>Plan all-cause readmissions (PCR)</td>
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<td>Prenatal and postpartum care (PPC)</td>
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<td>Statin therapy for patients with cardiovascular disease (SPC)</td>
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<td>Statin use in persons with diabetes (SUPD) (PQA measure)</td>
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<td>Transitions of care (TRC)</td>
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<td>Use of high-risk medications in older adults (DAE)</td>
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<td>Use of imaging studies for low back pain (LBP)</td>
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<tr>
<td>Use of opioids at high dosage</td>
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<tr>
<td>Weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)</td>
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<td>Well-child visits in the 3rd, 4th, 5th and 6th years of life (W34)</td>
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## Adult BMI assessment (ABA)

### Ages 18-74

<table>
<thead>
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<th>Part of:</th>
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<td>商業病人</td>
<td>HEDIS 計畫审查</td>
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<tr>
<td>醫保優勢受保病人</td>
<td>QIP</td>
</tr>
<tr>
<td>VBA</td>
<td>QRS</td>
</tr>
</tbody>
</table>

### Measure description and methodology

Measure assesses the calculation of BMI in adults.

**Requires:**
- Outpatient visit during measurement year
- BMI recorded within the past two years (including measurement year)

**Notes:**
- Weight and BMI value must be in medical record and date the BMI was recorded
- Patient younger than age 20: height, weight and BMI percentile required as a value or plotted on an age growth chart

**Methodology:** Claims and encounter data

### Codes used in measure

**BMI:**
- **ICD-10:** Z68.1, Z68.20-Z68.45, Z68.51-Z68.54

**Outpatient visit:**
- **CPT®:** 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99429, 99455, 99456, 99483
- **HCPCS:** G0402, G0463, G0483, T1015

Pregnancy diagnosis (large code set)

### Exclusions

- Pregnancy during current year and/or prior year
- Members in hospice
### Annual monitoring for patients on persistent medications (MPM)

<table>
<thead>
<tr>
<th>Ages 18+</th>
<th>Applies to:</th>
<th>Part of:</th>
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<tr>
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<td>☑ Commercial patients</td>
<td>☑ HEDIS chart review</td>
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<tr>
<td></td>
<td>☑ Medicare Advantage patients</td>
<td>☑ QIP</td>
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<tr>
<td></td>
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<td>☑ VBA</td>
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<tr>
<td></td>
<td></td>
<td>☑ QRS</td>
</tr>
</tbody>
</table>

#### Measure description and methodology

Measure assesses whether routine follow-up blood tests are being used for management of specific classes of medications.

**Requires:**
- At least 180 days of treatment with ACE Inhibitors or ARBs during the measurement year
- At least one serum potassium and serum creatinine therapeutic monitoring test in the measurement year.
- At least 180 days of treatment with diuretic medications

**Methodology:** Medical and pharmacy claims, and encounter data

#### Codes used in measure

- **Serum potassium test:**
  - CPT 80051, 84132
- **Serum creatinine test:**
  - CPT 82565, 82575
- **Lab panel test:**
  - CPT 80047-80050, 80053, 80069
- **Large code sets:**
  - Diuretic medications
  - ACE inhibitor/ARB medications

#### Exclusions

- Members in hospice
- Acute inpatient stay or non-acute inpatient stay during the measurement year.
Antidepressant medication management (AMM)

**Ages 18+**

- Commercial patients
- Medicare Advantage patients

**Part of:**
- HEDIS chart review
- QIP
- VBA
- QRS

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**Measure description and methodology**

Measure assesses the prescription of antidepressants for treatment of major depression.

**Requires:**
- Major depression diagnosis
- New prescription and refill history for antidepressant medication

**Intake period:** 12-month window from May 1 of the year prior ending on April 30 of the measurement year.

**Index prescription start date (IPSD):** Earliest prescription dispensing date during the intake period for an antidepressant where the date is in the intake period and there is a negative medication history.

**Negative medication history:** A period of 105 days prior to the IPSD when the member had no pharmacy claims for either new or refill prescriptions for an antidepressant medication.

**Treatment days:** Number of calendar days covered (requires 180 days).

Two phases included in measure:
- Acute—at least 84 days of continuous treatment with antidepressant medication during the 114 days period following the IPSD
- Continuation—at least 180 days of continuous treatment during the 231 days following the IPSD

**Methodology:** Medical claims, pharmacy claims and encounter data

**Codes used in measure**

- **Stand alone outpatient visits:**

- **Visits that require POS:**
  - CPT: 90791, 90792, 90832 90834, 90836 90840, 90845, 90847, 90849, 90853, 90867 90870, 90875, 90876, 99221-99223, 99231-99233, 99238, 99239, 99251-99255
  - POS: 02, 03, 05, 07, 09, 11-20, 22, 24, 33, 49, 50, 52, 53, 71, 72

- **Telehealth visits:**
  - CPT: 98966-98968, 99441-99443
  - Modifier: 95, GT

**Major depression diagnosis:**
- ICD-10: F32.0-F32.9, F33.0-F33.3, F33.40-F33.42, F33.9, F34.1

**Large code sets:**
- Inpatient stay
- Antidepressant medications

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**Exclusions**

- No diagnosis of major depression within 60 days prior and 60 days after dispensing an antidepressant
- Prior antidepressant prescription within 105 days of the IPSD
- Members in hospice
Anxiety and depression screening (Asuris VBA measure)

<table>
<thead>
<tr>
<th>Ages 12+</th>
<th>Applies to:</th>
<th>Part of:</th>
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<td>☐ Medicare Advantage patients</td>
<td>☑ QIP</td>
</tr>
<tr>
<td></td>
<td>☑ VBA</td>
<td>☑ QRS</td>
</tr>
</tbody>
</table>

**Measure description and methodology**

Measure assesses screening for anxiety and depression.

**Requires:**
- Medical eligibility for the whole measurement year
- Office visit during the measurement year

Members with a screening for GAD-7 or PHQ-2/PHQ-9 at any point during the measurement year based on one of the following:
- **CPT** 96127 (brief emotional/behavioral assessment)
- **CPT** 96150 (health and behavior assessment)
- **HCPCS** G0444 (annual depression screening, 15 minutes)
- GAD-7 result in EHR file
- GAD-2 result in EHR file
- PHQ-2 result in EHR file
- PHQ-9 result in EHR file
- PHQ-A result in EHR file
- SCARED result in EHR file

**Methodology:** Medical claims and medical record review

**Codes used in measure**

Office visits:
- **CPT** 98966-98968, 98969, 99201-99205, 99211-99215, 99354, 99355, 99358, 99359, 99381, 99382, 99387, 99383-99386, 99391, 99397, 99392-99396, 99401-99404, 99411, 99412, 99420, 99429, 99441-99443, 99444, 99499
- **HCPCS** G0344, G0402, S0610, S0612, S0613, S0280, S0281

**Exclusions**

- Members in hospice
- Member has a diagnosis of depression during the year prior to the measurement period
- Member has a diagnosis of bipolar disorder during the measurement period or the year prior to the measurement period

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**Asuris Northwest Health**

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### Appropriate testing for pharyngitis (CWP)

**Ages 3+**

- **Commercial patients**
- **Medicare Advantage patients**

**Part of:**
- HEDIS chart review
- QIP
- VBA
- QRS

#### Measure description and methodology

Measure assesses members diagnosed with pharyngitis, who were dispensed an antibiotic and received a group A streptococcus (strep) test.

**Requires:**
- Episode date: Outpatient visit, telephone visit, online assessment, observation visit, or an ED visit during the intake period with a diagnosis of pharyngitis
- A group A streptococcus test in the seven-day period from three days prior to the episode date through three days after the episode date

**Notes:**
Intake period is a 12-month window that begins on July 1 of the year prior to the measurement year and ends on June 30 of the measurement year

**Methodology:** Claims and encounter data

#### Codes used in measure

<table>
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<th>Group A strep tests:</th>
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<td>- HCPCS G0402, G0438, G0439, G0463, T1015</td>
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<tr>
<td>Telehealth visit: CPT 98966-98968, 99441-99443</td>
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</tr>
<tr>
<td>Online assessment: CPT 98969, 99444</td>
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<tr>
<td>Observation visit: CPT 99217-99220</td>
<td></td>
</tr>
<tr>
<td>ED visit: CPT 99281-99285</td>
<td></td>
</tr>
<tr>
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<tr>
<td>Large code sets:</td>
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<tr>
<td>- Inpatient stay</td>
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<tr>
<td>- CWP antibiotic medications list</td>
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<tr>
<td>- HIV</td>
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<tr>
<td>- Malignant neoplasms</td>
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<tr>
<td>- Emphysema</td>
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<tr>
<td>- COPD</td>
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<tr>
<td>- Comorbid conditions</td>
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<tr>
<td>- Disorders of the immune system</td>
<td></td>
</tr>
<tr>
<td>- Competing diagnosis</td>
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</table>

#### Exclusions

- Members in hospice
- Outpatient, ED, or observation visits that result in an inpatient stay
- Exclude episode dates in the following circumstances:
  - If the member did not receive antibiotics on or up to three days after the episode date
  - When the member had a claim/encounter with any diagnosis for a comorbid condition during the 12 months prior to or on the episode date
  - Where a new or refill prescription for an antibiotic medication was filled 30 days prior to the episode date or was active on the episode date
  - Where the member had a claim/encounter with a competing diagnosis on or three days after the episode date
- Exclude members not continuously enrolled (without a gap in coverage) from 30 days prior to the episode date through three days after the episode date (34 total days)
Appropriate treatment for upper respiratory infection (URI)

<table>
<thead>
<tr>
<th>Ages 3 months+</th>
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<tr>
<td></td>
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<td>☑ QRS</td>
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</tbody>
</table>

Measure description and methodology

Measure assesses the percentage of episodes for members age three months and older with a diagnosis of upper respiratory infection that did not result in an antibiotic dispensing event.

Requires:
- Episode date: Outpatient visit, telephone visit, online assessment, observation visit, or an ED visit during the intake period with a diagnosis of upper respiratory infection
- A dispensed prescription for a CWP antibiotic medication on or 3 days after the episode date

Note:
The intake period is a 12-month window that begins on July 1 of the year prior to the measurement year and ends on June 30 of the measurement year.

Methodology: Medical claims, pharmacy claims and encounter data

Codes used in measure

Outpatient visit:
- **CPT** 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99429, 99455, 99456, 99483
- **HCPCS** G0402, G0438, G0439, G0463, T1015

Telehealth visit: **CPT** 98966-98968, 99441-99443

Online assessment: **CPT** 98969, 99444

Observation visit: **CPT** 99217-99220

ED visit: **CPT** 99281-99285

Upper respiratory infection: **ICD-10** J00, J06.0, J06.9

Large code sets:
- Inpatient stay
- CWP antibiotic medications list
- HIV
- Malignant neoplasms
- Emphysema
- COPD
- Comorbid conditions
- Disorders of the immune system
- Pharyngitis
- Competing diagnosis

Exclusions

- Members in hospice
- Outpatient, ED, or observation visits that result in an inpatient stay
- Exclude episode dates in the following circumstances:
  - When the member had a claim/encounter with any diagnosis for a comorbid condition during the 12 months prior to or on the episode date
  - Where a new or refill prescription for an antibiotic medication was filled 30 days prior to the episode date or was active on the episode date
  - Where the member had a claim/encounter with a competing diagnosis on or three days after the episode date
- Exclude members not continuously enrolled (without a gap in coverage) from 30 days prior to the episode date through three days after the episode date (34 total days)
Asthma medication ration (AMR)

<table>
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<th>Codes used in measure</th>
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<td>Telehealth visit:</td>
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<td>CPT 99966-99968, 99441-99443</td>
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<tr>
<td>Online assessment:</td>
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<td>CPT 99969, 99444</td>
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<tr>
<td>Observation visit:</td>
</tr>
<tr>
<td>CPT 99217-99220</td>
</tr>
<tr>
<td>ED visit:</td>
</tr>
<tr>
<td>CPT 99281-99285</td>
</tr>
<tr>
<td>Asthma: ICD-10 J45.20-J45.22, J45.30-J45.32, J45.40-J45.42, J45.50-J45.52, J45.901, J45.902, J45.909, J45.990, J45.991, J45.998</td>
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<td>- Emphysema</td>
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<tr>
<td>- COPD</td>
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<tr>
<td>- Obstructive chronic bronchitis</td>
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<tr>
<td>- Chronic respiratory conditions due to fumes or vapors</td>
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<tr>
<td>- Cystic fibrosis</td>
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<td>- Acute respiratory failure</td>
</tr>
<tr>
<td>- Asthma controller medications</td>
</tr>
<tr>
<td>- Asthma reliever medications</td>
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</tbody>
</table>

**Measure description and methodology**

Measure assesses the percentage of members age five to 64 who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.

**Requires:**
- At least one ED visit, acute inpatient encounter, or acute inpatient discharge, with a principal diagnosis of asthma, or
- At least four outpatient visits, telephone visits, or online assessments (on different dates of service) with any diagnosis of asthma and at least two asthma medication dispensing events for any controller or reliever medication, or
- At least four asthma medication dispensing events for any controller or reliever medication

**Notes:**
A member identified as having persistent asthma because of at least four asthma medication dispensing events, where leukotriene modifiers or antibody inhibitors were the sole asthma medication dispensed in that year, must also have at least one diagnosis of asthma, in any setting, in the same year as the leukotriene modifier or antibody inhibitor.

**Methodology:** Medical claims, pharmacy claims and encounter data

**Exclusions**
- Members in hospice
- Members who had a diagnosis of any of the following anytime during the member’s history through December 31 of the measurement year:
  - Emphysema
  - COPD
  - Obstructive chronic bronchitis
  - Chronic respiratory conditions due to fumes or vapors
  - Cystic fibrosis
  - Acute respiratory failure
- Members who had no asthma controller or reliever medications dispensed during the measurement year.
Avoidance of antibiotic treatment for acute bronchitis/bronchiolitis (AAB)

Ages 3 months and older  
- Commercial patients  
- Medicare Advantage patients

Part of:  
- HEDIS chart review  
- QIP  
- VBA  
- QRS

Measure description and methodology

Measures assesses bronchitis treatment unnecessary antibiotics.

Requires:
- Acute bronchitis diagnosis
- Knowledge of antibiotic prescriptions for treatment

Intake period: July 1 of the year prior to the measurement year to June 30 of the measurement year

Episode date: Service date for any outpatient, telephone, online assessment, observation or ED visit with a diagnosis of acute bronchitis or acute bronchiolitis

Index episode start date (IESD): Earliest episode date during the intake period that meets all of the following:
- Negative medication history: Must be at least 30 days after any prior treatment with antibiotics with no continuing active antibiotics.
- Negative comorbid condition history for 12 months prior to and including the episode date.
- Negative competing diagnosis from the episode date through three days after the episode date.
- Continuous enrollment from 30 days prior to the episode date through three days after the episode date (34 total days).

Methodology: Medical claims, pharmacy claims and encounter data

Codes used in measure

Outpatient visits:
- HCPCS: G0402, G0438, G0439, G0463, T1015

Telehealth visits:
- CPT: 98966-98968, 99441-99443
- Modifier: 95, GT

Online assessments:
- CPT: 98969, 99444

Acute bronchitis diagnosis:
- ICD-10: J20.0-J20.9, J40

Pharyngitis diagnosis:
- ICD-10: J02.0, J02.8, J02.9, J03.00, J03.01, J03.80, J03.81, J03.90, J03.91

Large code set:
- Antibiotic medication

Exclusions

- ED visits or observation visits that result in an inpatient stay
- Encounters where the member has a diagnosis for a comorbid condition during the 12 months prior to or on the episode date: HIV, malignant neoplasms, emphysema, COPD, comorbid conditions or disorders of the immune system
- New prescription or refill for an antibiotic medication 30 days prior to the episode date, or active on the episode date
- Members in hospice
- Encounter where the member had a diagnosis of pharyngitis or some competing diagnosis on the episode date through three days after the episode date
# Breast cancer screening (BCS)

<table>
<thead>
<tr>
<th>Ages 52-74 as of December 31 of the measurement year</th>
<th>Applies to:</th>
<th>Part of:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☑ Commercial patients</td>
<td>☑ HEDIS chart review</td>
</tr>
<tr>
<td></td>
<td>☑ Medicare Advantage patients</td>
<td>☑ QIP</td>
</tr>
<tr>
<td></td>
<td>☑</td>
<td>☑ VBA</td>
</tr>
<tr>
<td></td>
<td>☑</td>
<td>☑ QRS</td>
</tr>
</tbody>
</table>

The measure addresses the prevalence of routine breast cancer screenings.

### Requires:
- Screening mammogram

### Notes:
- **Primary screening only**: no diagnosis or treatment included
- **Date range for screening**: October 1 two years prior through December 31 of the measurement year

### Methodology:
Claims and encounter data

### Codes used in measure

<table>
<thead>
<tr>
<th>Procedure</th>
<th>CPT Codes</th>
<th>HCPCS Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mammogram</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-</td>
<td>77055-77057, 77061-77063, 77065-77067</td>
<td>G0202, G0204, G0206</td>
</tr>
<tr>
<td></td>
<td><strong>Mastectomy</strong></td>
<td></td>
</tr>
<tr>
<td>- History of bilateral mastectomy:</td>
<td>ICD-10-CM Z90.13</td>
<td></td>
</tr>
<tr>
<td>- Bilateral mastectomy:</td>
<td>ICD-10-PCS 0HTV0ZZ</td>
<td></td>
</tr>
<tr>
<td>- Unilateral mastectomy:</td>
<td>CPT 19180, 19200, 19220, 19240, 19303-19307</td>
<td></td>
</tr>
<tr>
<td>- Unilateral mastectomy right:</td>
<td>ICD-10-PCS 0HTT0ZZ</td>
<td></td>
</tr>
<tr>
<td>- Unilateral mastectomy left:</td>
<td>ICD-10-PCS 0HTU0ZZ</td>
<td></td>
</tr>
<tr>
<td><strong>Modifiers for mastectomy</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Left:</td>
<td>LT</td>
<td></td>
</tr>
<tr>
<td>- Right:</td>
<td>RT</td>
<td></td>
</tr>
<tr>
<td>- Bilateral:</td>
<td>50</td>
<td></td>
</tr>
<tr>
<td><strong>Absence of Right Breast</strong></td>
<td>ICD-10-CM Z90.11</td>
<td></td>
</tr>
<tr>
<td><strong>Absence of Left Breast</strong></td>
<td>ICD-10-CM Z90.12</td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient visit</strong></td>
<td>CPT</td>
<td></td>
</tr>
<tr>
<td>- 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99429, 99445, 99455, 99463, 99483</td>
<td>G0402, G0438, G0439, G0463, T1015</td>
<td></td>
</tr>
<tr>
<td><strong>Observation visit</strong></td>
<td>CPT 99217-99220</td>
<td></td>
</tr>
<tr>
<td><strong>Emergency department visit</strong></td>
<td>CPT 99281-99285</td>
<td></td>
</tr>
<tr>
<td><strong>Non-acute inpatient visit</strong></td>
<td>CPT 99304-99310, 99315, 99316, 99318, 99324-99328, 99334-99337</td>
<td></td>
</tr>
<tr>
<td><strong>Acute inpatient visit</strong></td>
<td>CPT 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291</td>
<td></td>
</tr>
</tbody>
</table>

| Large code sets | |
| - Frailty diagnosis code | |
| - Advanced illness diagnosis code | |
| - Dementia medications list | |

Continued on next page
Breast cancer screening (BCS) (continued)

Exclusions

Any time in history:
- Bilateral mastectomy
- Unilateral mastectomy (with bilateral modifier)
- Two separate unilateral mastectomies on different dates at least 14 days apart
- History of bilateral mastectomy
- A unilateral mastectomy without a right, left or bilateral modifier and a left mastectomy
- A unilateral mastectomy without a right, left or bilateral modifier and a right mastectomy
- Absence of right/left breast
- Members in hospice

Supplemental and medical record data may not be used for these exclusions:
- Medicare members 66 and older as of December 31 of the measurement year who meet either of the following:
  • Enrolled in an institutional SNP (I-SNP) any time during the measurement year
  • Living long-term in an institution any time during the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File
- Members 66 and older as of December 31 of the measurement year (all product lines) with frailty and advanced illness. Members must meet both of the following frailty and advanced illness criteria to be excluded:
  • At least one claim/encounter for frailty during the measurement year
  • Any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years):
    - At least two outpatient visits, observation visits, ED visits or non-acute inpatient encounters on different dates of service, with an advanced illness diagnosis (Visit type need not be the same for the two visits)
    - At least one acute inpatient encounter with an advanced illness diagnosis
    - A dispensed dementia medication
Cervical cancer screening (CCS)

<table>
<thead>
<tr>
<th>Ages 24-64 as of December 31 of the measurement year</th>
<th>Applies to:</th>
<th>Part of:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☑ Commercial patients</td>
<td>☑ HEDIS chart review</td>
</tr>
<tr>
<td></td>
<td>☐ Medicare Advantage patients</td>
<td>☐ QIP</td>
</tr>
<tr>
<td></td>
<td>☐ VBA</td>
<td>☑ QRS</td>
</tr>
</tbody>
</table>

**Measure description and methodology**

Measure assesses preventive cervical cancer screenings based on the following criteria:
- 21 to 64 year-old women cervical cytology every three years
- 30 to 64 year-old women cervical cytology and HPV co-testing every five years
- 30 to 64 year-old women who had cervical cytology and high-risk HPV cotesting within the last five years

Requires:
- Cervical cancer screening
- HPV testing (if appropriate)

**Note:** For medical record review, count any cervical cancer screening method that includes collection and microscopic analysis of cervical cells

**Methodology:** Claims, encounter data and medical record review

**Codes used in measure**

Cervical cytology (Pap tests):
- **CPT:** 88141-88143, 88147, 88148, 88150, 88152-88154, 88164-88167, 88174, 88175
- **HCPCS:** G0123, G0124, G0141, G0143-G0145, G0147, G0148, P3000, P3001, Q0091

HPV tests:
- **CPT:** 87620-87622, 87624, 87625
- **HCPCS:** G0476

**Exclusions**

Members in hospice

Any of the following any time during the member’s history through December 31 of the measurement year:
- Hysterectomy with no residual cervix, cervical agenesis, or acquired absence of cervix
- Exclude incomplete labs and labs where results indicate “no cervical cells were present”
- Exclude biopsies
- Reflex testing
## Childhood immunization status (CIS)

### Age 2 during the measurement year

<table>
<thead>
<tr>
<th>Applies to:</th>
<th>Part of:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☑ Commercial patients</td>
<td>⊗ HEDIS chart review</td>
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<tr>
<td>☐ Medicare Advantage patients</td>
<td>☑ QIP</td>
</tr>
<tr>
<td>☑ VBA</td>
<td>☑ QRS</td>
</tr>
</tbody>
</table>

### Measure description and methodology

Measure assesses the immunization history of children at two years of age based on recommended standards.

**Requires:**
- Diphtheria, tetanus and acellular pertussis (DTaP), four doses
- Polio (IPV), three doses
- Measles, mumps and rubella (MMR), one dose
- H influenza type B (HiB), three doses
- Hepatitis B (HepB), three doses
- Varicella (chicken pox) (VZV), one dose
- Pneumococcal conjugate (PCV), four doses
- Hepatitis A (HepA), one dose
- Rotavirus (RV), two or three doses dependent on vaccine
- Influenza (Flu), two doses

**Notes:**
- For MMR, Hep B, VZV and Hep A, antigen or combination vaccine, documented history of the illness, or a seropositive test will count as evidence of presence/need.
- For DTaP, IPV, HiB, pneumonia, rotavirus and influenza, count only evidence of the antigen or combination vaccine.
- Each antigen is reported separately so make sure all immunizations are reflected in claim submitted for visit.

**Methodology:** Claims, encounter data and medical record review

### Codes used in measure

<table>
<thead>
<tr>
<th>Codes used in measure</th>
<th>DTaP: CPT 90698, 90700, 90721, 90723</th>
</tr>
</thead>
<tbody>
<tr>
<td>IPV: CPT 90698, 90713, 90723</td>
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<tr>
<td>MMR:</td>
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<tr>
<td>• CPT: 90707, 90710</td>
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<tr>
<td>• ICD-10-CM: B05.0 B05.1, B05.2, B05.3, B05.4, B05.81, B05.89, B05.9, B06.00, B06.01, B06.02, B06.09, B06.81, B06.82, B06.89, B06.9, B26.0, B26.1, B26.2, B26.3, B26.81-B26.85, B26.89, B26.9</td>
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<tr>
<td>HiB: CPT 90644-90648, 90698, 90721, 90748</td>
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<tr>
<td>HepB:</td>
<td></td>
</tr>
<tr>
<td>• CPT: 90723, 90740, 90744, 90747, 90748</td>
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</tr>
<tr>
<td>• HCPCS: G0010</td>
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<tr>
<td>• ICD-10-PCS: 3E0234Z</td>
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<tr>
<td>VZV:</td>
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<td>• CPT: 90710, 90716</td>
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<tr>
<td>• 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-B02.9</td>
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</tr>
<tr>
<td>PCV:</td>
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<tr>
<td>• CPT: 90670</td>
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</tr>
<tr>
<td>• HCPCS: G0009</td>
<td></td>
</tr>
<tr>
<td>HepA:</td>
<td></td>
</tr>
<tr>
<td>• CPT: 90633</td>
<td></td>
</tr>
<tr>
<td>• ICD-10-CM: B15.0, B15.9</td>
<td></td>
</tr>
<tr>
<td>RV:</td>
<td></td>
</tr>
<tr>
<td>• CPT: 90680, 90681</td>
<td></td>
</tr>
<tr>
<td>Flu:</td>
<td></td>
</tr>
<tr>
<td>• CPT: 90655, 90657, 90660-90662, 90673, 90685-90688</td>
<td></td>
</tr>
<tr>
<td>• HCPCS: G0008</td>
<td></td>
</tr>
</tbody>
</table>

### Exclusions

- Any individuals with a contraindication for any single specific vaccine or immunization, including leukemia, anaphylaxis, multiple myeloma, lymphoreticular cancer, immunodeficiency HIV, history of intussusception or encephalopathy with a vaccine adverse effect code
- Reaction to Streptomycin, Polymyxin B, Neomycin or baker's yeast
- Members in hospice
Chlamydia screening in women (CHL)

<table>
<thead>
<tr>
<th>Ages 16-24</th>
<th>Applies to:</th>
<th>Part of:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☑ Commercial patients</td>
<td>☑ HEDIS chart review</td>
</tr>
<tr>
<td></td>
<td>☐ Medicare Advantage patients</td>
<td>☑ QIP</td>
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<tr>
<td></td>
<td>☑ VBA</td>
<td>☑ QRS</td>
</tr>
</tbody>
</table>

Measure description and methodology

Measures annual chlamydia testing for young women who are sexually active.

Requires:
- Documentation of sexual activity status (active or not)
- Chlamydia testing

Methodology: Medical or prescription claims and encounter data

<table>
<thead>
<tr>
<th>Codes used in measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnancy tests:</td>
</tr>
<tr>
<td>- CPT: 81025, 84702, 84703</td>
</tr>
<tr>
<td>Chlamydia test:</td>
</tr>
<tr>
<td>- CPT: 87110, 87270, 87320, 87490-87492, 87810</td>
</tr>
<tr>
<td>Large code sets:</td>
</tr>
<tr>
<td>- Pregnancy diagnosis</td>
</tr>
<tr>
<td>- Sexual activity codes</td>
</tr>
<tr>
<td>- Contraceptive medications</td>
</tr>
</tbody>
</table>

Exclusions

- Members who had a pregnancy test during the measurement year and a prescription for isotretinoin on the date of the pregnancy test or the six days after the pregnancy test.
- Members who had a pregnancy test during the measurement year and an X-ray on the date of the pregnancy test or the six days after the pregnancy test.
- Members in hospice
Colorectal cancer screening (COL)

Ages 50-75

Applies to:
- ✔ Commercial patients
- ✔ Medicare Advantage patients

Part of:
- ✔ HEDIS chart review
- ✔ QIP
- ✔ VBA
- ✔ QRS

Measure description and methodology

Measure addresses the prevalence of the various colon cancer screening tests.

Requires:
A colorectal cancer screening in the appropriate time (including measurement year):
- Colonoscopy—10 years
- CT colonography—5 years
- Flexible sigmoidoscopy—5 years
- FIT-DNA (Cologuard)—3 years
- FOBT—measurement year only
- FIT—measurement year only

Methodology: Claims, encounter data and medical record review

Codes used in measure

Colonoscopy:
- CPT: 44388-44394, 44397, 44401-44408, 45355, 45378-45393, 45398
- CPT II: G0105, G0121

CT colonography:
- CPT: 74261-74263

Flexible sigmoidoscopy:
- CPT: 45330-45335, 45337-45342, 45345-45347, 45349, 45350
- CPT II: G0104

FIT-DNA:
- CPT: 81528
- CPT II: G0464

FOBT:
- CPT: 82270, 82274
- CPT II: G0328

Colorectal cancer diagnosis:
- ICD-10-CM: C18.0-C19, C20, C21.2, C21.8, C78.5, Z85.038, Z85.048
- HCPCS: G0213-G0215, G0231

Total colectomy:
- CPT: 44150-44153, 44155-44158, 44210-44212
- ICD-10-PCS: 0DTE0ZZ, 0DTE4ZZ, 0DTE7ZZ, 0DTE8ZZ

Outpatient visit:
- CPT: 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99429, 99455, 99456, 99483
- HCPCS: G0402, G0438, G0439, G0463, T1015

Observation visit: CPT 99217-99220

Emergency department visit: CPT 99281-99285

Non-acute inpatient visit: CPT 99304-99310, 99315, 99316, 99324-99328, 99334-99337

Acute inpatient visit: CPT 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291

Large code sets:
- Frailty diagnosis
- Advanced illness diagnosis
- Dementia medications list

Continued on next page
Exclusions

Any time in history:
- Colorectal cancer
- Total colectomy
- Members in hospice

Supplemental and medical record data may not be used for these exclusions:
- Medicare members 66 and older as of December 31 of the measurement year who meet either of the following:
  • Enrolled in an institutional SNP (I-SNP) any time during the measurement year
  • Living long-term in an institution any time during the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File
- Members 66 and older as of December 31 of the measurement year (all product lines) with frailty and advanced illness. Members must meet **both** of the following frailty and advanced illness criteria to be excluded:
  • At least one claim/encounter for frailty during the measurement year
  • Any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years)
    - A dispensed dementia medication
    - At least one acute inpatient encounter with an advanced illness diagnosis
    - At least two outpatient visits, observation visits, ED visits or non-acute inpatient encounters on different dates of service, with an advanced illness diagnosis (may be two different visit types)

Colorectal cancer screening (COL) (continued)
# Controlling blood pressure (CBP)

<table>
<thead>
<tr>
<th>Ages 18-85</th>
<th>Applies to:</th>
<th>Part of:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>✅ Commercial patients</td>
<td>✅ HEDIS chart review</td>
</tr>
<tr>
<td></td>
<td>✅ Medicare Advantage patients</td>
<td>✅ QIP</td>
</tr>
<tr>
<td></td>
<td>✅ VBA</td>
<td>✅ QRS</td>
</tr>
</tbody>
</table>

## Measure description and methodology

Measure assesses the routine monitoring of the diagnosis of hypertension.

**Controlled blood pressure:** <140/90 during the measurement year

**Requires:**
- Two visits on different dates of service with a diagnosis of hypertension during the measurement year or the year prior to the measurement year (count services over both years). Only one of the two visits may be a telephone visit, an online assessment or a telehealth visit.
- Results of blood pressure documented as part of visit or remote monitoring event.
- Blood pressure must be under control per results of test.
- Timing of blood pressure reading must be chronologically later than the second hypertension diagnosis and must occur within the measurement year.

**Methodology:** Claims, encounter data and medical record review

## Codes used in measure

- **Diagnosis of hypertension:** [ICD-10-CM](https://icd10data.com/ICD10CM/) I10
- **Outpatient visits:**
  - **CPT:** 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99429, 99455, 99456, 99483
  - **HCPCS:** G0402, G0438, G0439, G0463, T1015
- **Non-acute inpatient visit:** **CPT** 99304-99310, 99315, 99318, 99324-99328, 99334-99337
- **Remote blood pressure monitoring:** **CPT** 93784, 93788, 93790, 99091
- **Blood pressure:** **CPT II** 3074F, 3075F, 3077F, 3078F, 3079F, 3080F
- **Acute inpatient visit:** **CPT** 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291
- **Observation visit:** **CPT** 99217-99220
- **Emergency department visit:** **CPT** 99281-99285
- **Telehealth visits:**
  - **CPT:** 98966-98968, 99441-99443
  - **Modifier:** 95, GT
- **Online assessment:** **CPT** 98969, 99444
- **End-stage renal disease:**
  - **CPT:** 36145, 36147, 36800, 36810, 36815, 36818-36821, 36831-36833, 90919-90921, 90923-90925, 90935, 90937, 90940, 90945, 90947, 90951-90970, 90989, 90993, 90997, 90999, 99512
  - **HCPCS:** G0257, G0308-G0319, G0321-G0323, G0325-G0327, G0392, G0393, S9339
  - **ICD-10-CM:** N18.5, N18.6, Z91.15, Z99.2
  - **ICD-10-PCS:** 3E1M39Z, 5A1D00Z, 5A1D60Z, 5A1D70Z, 5A1D80Z, 5A1D90Z
- **Kidney transplant:**
  - **CPT:** 50300, 50320, 50340, 50360, 50365, 50370, 50380
  - **HCPCS:** S2065
  - **ICD-10-CM:** Z94.0
  - **ICD-10-PCS:** 0TY00Z0-0TY00Z2, 0TY10Z0-0TY10Z2
- **Large code sets:**
  - Frailty diagnosis
  - Advanced illness diagnosis
  - Dementia medication
  - Pregnancy diagnosis
  - Non-acute inpatient stay

Continued on next page
**Exclusions**

- Dialysis
- Pregnancy
- End-stage renal disease
- Kidney transplant
- Non-acute inpatient stay
- Blood pressures taken during an acute inpatient stay or an ED visit, on the same day as a diagnostic test or diagnostic or therapeutic procedure requiring a change in medication or diet on or one day before the day of the test or procedure, except for fasting blood tests or reported or taken by the member
- Members in hospice

**Note:** Supplemental and medical record data may not be used for the following exclusions:

- Medicare members 66 and older as of December 31 of the measurement year who meet either of the following:
  - Enrolled in an institutional special needs plan (I-SNP) any time during the measurement year
  - Living long-term in an institution any time during the measurement year as identified in the monthly membership detail data file
- Members 66-80 as of December 31 of the measurement year with frailty and advanced illness. Members must meet both of the following frailty and advanced illness criteria to be excluded:
  1. At least one claim/encounter for frailty during the measurement year
  2. Any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years)
     - At least two outpatient, observation, emergency department visits or non-acute inpatient encounters on different dates of service with an advanced illness diagnosis (may be two different visit types)
     - At least one acute inpatient encounter with an advanced illness diagnosis
     - A dementia medication dispensed
- Members 81 and older as of December 31 of the measurement year with frailty during the measurement year
Diabetes—A1c testing (CDC)

<table>
<thead>
<tr>
<th>Ages 18-75</th>
<th>Applies to:</th>
<th>Part of:</th>
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<tr>
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<td>☑ Commercial patients</td>
<td>☑ HEDIS chart review</td>
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<td>☑ Medicare Advantage patients</td>
<td>QIP</td>
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<tr>
<td></td>
<td>☑ VBA</td>
<td>QRS</td>
</tr>
</tbody>
</table>

**Measure description and methodology**

Measure is designed to assess the routine diabetes screening and monitoring of diabetes control through the use of A1c testing.

**Requires:**
- Diagnosis of diabetes (type 1 or 2) during the measurement year or year prior by:
  - Two or more visits (non-acute inpatient) on different dates of service with diagnosis of diabetes (only include non-acute inpatient encounters without telehealth)
  - Only one of the two visits may be a telehealth visit, a telephone visit or an online assessment
  - One acute inpatient encounter with a diagnosis of diabetes without telehealth
- Prescribed hypoglycemic/antihyperglycemics or insulin on an ambulatory basis

**Notes:**
- Results from the most recent HbA1c screening test during the measurement year
- Value must be <9.0%. Any number above that value or if there is no value recorded, the record cannot be used
- Can be identified in chart notes as A1c, hemoglobin A1c, HgbA1c, HbA1c, glycohemoglobin A1c, glycohemoglobin, glycated hemoglobin or glycosylated hemoglobin

**Methodology:** Claims, encounter data and medical record review

**Codes used in measure**

HgbA1c blood test:
- **CPT:** 83036, 83037
- **CPT II:**
  - HbA1c Level <7.0% — 3044F
  - HbA1c Level 7.0-9.0% — 3045F (for dates of service before October 1, 2019)
  - HbA1c Level ≥7.0-<8.0% — 3051F (for dates of service on or after October 1, 2019)
  - HbA1c Level ≥8.0-<9.0% — 3051F (for dates of service on or after October 1, 2019)
  - HbA1c Level >9.0 — 3046F

Acute inpatient visit: **CPT** 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291

Outpatient visits:
- **CPT:** 99201-99205, 99211-99215, 99241-99245, 99249-99255, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99429, 99455, 99456, 99483
- **HCPCS:** G0402, G0438, G0439, G0463, T1015

Non-acute inpatient visit: **CPT** 99304-99310, 99315, 99316, 99318, 99324-99328, 99334-99337

Observation visit: **CPT** 99217-99220

Emergency department visit: **CPT** 99281-99285

Telehealth visits:
- **CPT:** 98966-98968, 99441-99443
- **Modifier:** 95, GT
- **POS:** 02

Online assessment: **CPT** 98969, 99444

Large code sets:
- Diabetes diagnosis
- Diabetes medication list
- Frailty diagnosis
- Advanced illness diagnosis
- Dementia medication
- Gestational or steroid-induced diabetes diagnosis

Continued on next page
Diabetes—A1c testing (CDC) (continued)

Exclusions

- Diagnosis of gestational or steroid-induced diabetes during the measurement year or the year prior and **no** diagnosis of diabetes during the same time
- Members in hospice

**Note**: Supplemental and medical record data may not be used for these exclusions:
- Medicare members 66 and older as of December 31 of the measurement year who meet either of the following:
  - Enrolled in an institutional SNP (I-SNP) any time during the measurement year
  - Living long-term in an institution any time during the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File
- Members 66 and older as of December 31 of the measurement year (all product lines) with frailty and advanced illness. Members must meet **both** of the following frailty and advanced illness criteria to be excluded:
  - At least one claim/encounter for frailty during the measurement year
  - Any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years)
    - A dispensed dementia medication
    - At least one acute inpatient encounter with an advanced illness diagnosis
    - At least two outpatient visits, observation visits, ED visits, or non-acute inpatient encounters on different dates of service, with an advanced illness diagnosis (may be two different visit types)
Diabetes—Blood pressure control (CDC)

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<td>☑ HEDIS chart review ☑ QIP ☐ VBA ☐ QRS</td>
</tr>
</tbody>
</table>

**Measure description and methodology**

Measure assesses the routine monitoring of blood pressure control for patients with diabetes

**Requires:**
- Diagnosis of diabetes (type 1 or 2) during the measurement year or year prior by:
  - Two or more visits (non-acute inpatient) on different dates of service with diagnosis of diabetes (only include non-acute inpatient encounters without telehealth)
  - Only one of the two visits may be a telehealth visit, a telephone visit or an online assessment
  - One acute inpatient encounter with a diagnosis of diabetes without telehealth
  - Prescribed hypoglycemic/antihyperglycemics or insulin on an ambulatory basis

**Notes:**
- Results from the most recent blood pressure reading during the measurement year
- Value must be <140/90 mm Hg
- Can be taken during a remote monitoring event

**Methodology:** Claims, encounter data, pharmacy data and medical record review

**Codes used in measure**

| Blood pressure: CPT II 3074F, 3075F, 3077F, 3078F, 3079F, 3080F |
| Acute inpatient visit: CPT 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291 |
| Outpatient visits: |
| - CPT: 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99429, 99455, 99456, 99483 |
| - HCPCS: G0402, G0438, G0439, G0463, T1015 |
| Non-acute inpatient visit: CPT 99304-99310, 99315, 99316, 99318, 99324-99328, 99334-99337 |
| Online assessments: CPT 98969, 99444 |
| Remote blood pressure monitoring: CPT 93784, 93788, 93790, 99091, 99453, 99454, 99457 |
| Observation visit: CPT 99217-99220 |
| Emergency department visit: CPT 99281-99285 |
| Telehealth visits: |
| - CPT: 98966-98968, 99441-99443 |
| - Modifier: 95, GT |
| - POS: 02 |

Continued on next page
Diabetes—Blood pressure control (CDC) (continued)

Exclusions

- Diagnosis of gestational or steroid-induced diabetes during the measurement year or the year prior and no diagnosis of diabetes during the same time.
- Members in hospice

Note: Supplemental and medical record data may not be used for the following exclusions:
- Medicare members 66 and older as of December 31 of the measurement year who meet either of the following:
  • Enrolled in an institutional special needs plan (I-SNP) any time during the measurement year
  • Living long-term in an institution any time during the measurement year as identified in the monthly membership detail data file
- Members 66 and older as of December 31 of the measurement year with frailty and advanced illness. Members must meet both of the following frailty and advanced illness criteria to be excluded:
  1. At least one claim/encounter for frailty during the measurement year
  2. Any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years)
    - A dementia medication dispensed
    - An acute inpatient encounter with an advanced illness diagnosis
    - At least two outpatient, observation, emergency department visits or non-acute inpatient encounters on different dates of service with an advanced illness diagnosis (may be two different visit types)
Diabetes — Eye exam (CDC)

Ages 18-75
Applies to:
☑ Commercial patients
☑ Medicare Advantage patients

Part of:
☐ HEDIS chart review
☑ QIP
☑ VBA
☑ QRS

Measure description and methodology

Measure is designed to assess the routine diabetes screening and monitoring.

Requires:
- Diagnosis of diabetes (type 1 or 2) during the measurement year or year prior by one of the following:
  - Two or more visits (not acute inpatient) on different dates of service with diagnosis of diabetes (this includes non-acute inpatient encounters without telehealth modifier or place of service)
  - One of the two visits may be a telehealth visit, a telephone visit, or an online assessment
  - One acute inpatient encounter with a diagnosis of diabetes without telehealth modifier or place of service
  - Prescribed hypoglycemic/antihyperglycemics or insulin on an ambulatory basis

Retinal exam:
- Retinal or dilated eye exam by an optometrist or ophthalmologist during the measurement year; must include results
- A chart note or photograph of retina via fundus photography reviewed by eye care professional; must include results
- Bilateral eye enucleation anytime during the member’s history through December 31 of the measurement year
- Negative retinal or dilated eye exam by an optometrist or ophthalmologist in the year prior to the measurement year; must include results

Methodology: Claims, encounter data and medical record review

Codes used in measure

- Retinal eye exam:
  - CPT: 67028, 67030, 67031, 67036, 67039-67043, 67101, 67105, 67107, 67108, 67110, 67113, 67121, 67141, 67145, 67208, 67210, 67218, 67220, 67221, 67227, 67228, 92002, 92004, 92012, 92014, 92018, 92019, 92134, 92225-92228, 92230, 92235, 92240, 92250, 92260, 99203-99205, 99213-99215, 99242-99245
  - HCPCS: S0620, S0621, S3000

- Unilateral eye enucleation with bilateral modifier: (modifier 50):
  - CPT 65091, 65093, 65101, 65103, 65105, 65110, 65112, 65114

- Unilateral eye enucleation left: ICD-10-PCS
  - 08B10ZX, 08B10ZZ, 08B13ZX, 08B13ZZ, 08B1XZX, 08B1XZZ

- Unilateral eye enucleation right: ICD-10-PCS
  - 08B00ZX, 08B00ZZ, 08B03ZX, 08B03ZZ, 08B0XZX, 08B0XZZ

- Diabetes mellitus without complications: ICD-10-CM
  - E10.9, E11.9, E13.9

- Acute inpatient visit: CPT 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291

- Outpatient visit:
  - CPT: 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99429, 99455, 99456, 99483
  - HCPCS: G0402, G0438, G0439, G0463, T1015

- Observation visit: CPT 99217-99220
- Emergency department visit: CPT 99281-99285
- Non-acute inpatient visit: CPT 99304-99310, 99315, 99316, 99318, 99324-99328, 99334-99337
- Online assessment: CPT 98969, 99444

- Telehealth visits:
  - CPT: 98966-98968, 99441-99443
  - Modifier: 95, GT
  - POS: 02

- Large code sets:
  - Diabetes diagnosis
  - Diabetes medication list
  - Frailty diagnosis
  - Advanced illness diagnosis
  - Dementia medication list
  - Gestational or steroid-induced diabetes diagnosis

Continued on next page
Exclusions

- Diagnosis of gestational or steroid induced diabetes during the measurement year or the year prior and no diagnosis of diabetes during the same time
- Members in hospice

Note: Supplemental and medical record data may not be used for the following exclusions:
- Medicare members 66 and older as of December 31 of the measurement year who meet either of the following:
  - Enrolled in an institutional special needs plan (I-SNP) any time during the measurement year
  - Living long-term in an institution any time during the measurement year as identified in the monthly membership detail data file
- Members 66 and older as of December 31 of the measurement year with frailty and advanced illness. Members must meet both of the following frailty and advanced illness criteria to be excluded:
  1. At least one claim/encounter for frailty during the measurement year
  2. Any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years)
     - A dementia medication dispensed
     - An acute inpatient encounter with an advanced illness diagnosis
     - At least two outpatient, observation, emergency department visits or non-acute inpatient encounters on different dates of service with an advanced illness diagnosis (may be two different visit types)

More information about diabetic eye examinations

Patients with diabetes need a comprehensive diabetic eye exam at least once each year to prevent eye problems that can lead to serious eye disease and even blindness.

The ADA standard
The American Diabetes Association (ADA) has published the following guidelines for retinopathy:
- An initial dilated comprehensive retinal exam should be conducted by an ophthalmologist or optometrist shortly after diagnosis of type 2 diabetes.
- Subsequent exams should be conducted annually by an ophthalmologist or optometrist.
- Less frequent exams may be considered if the patient has had at least one normal exam.

For more information on ADA guidelines for diabetes diagnosis, monitoring and screening, visit their website at diabetes.org.

Patient benefits and education
Annual diabetic eye exams are a benefit for all Asuris Medicare Advantage members, in addition to any routine vision examinations available. The member’s copay may vary depending on the services provided and whether the provider is in-network.

To support your patient education efforts about eye care for people with diabetes, we have identified the following resources:
- The National Eye Health Education Program from the National Eye Institute: nei.nih.gov/nehep/programs/diabeticeyedisease/educational.

Claim submission
When you submit claims for a diabetic eye examination, be sure to include the appropriate ICD-10 code and one of the following procedure codes for the services provided by an ophthalmologist or optometrist.

Medical record documentation
If you are the provider rendering the examination, please provide results of the screening to the patient’s primary care provider (PCP) to support care coordination efforts. The documentation should specify that a retinopathy screening was done and include the findings.
# Diabetes—Medical attention for nephropathy (CDC)

## Measure description and methodology

Measure is designed to assess the routine diabetes screening and monitoring for the presence or progress of nephropathy.

**Requires:**
- Diagnosis of diabetes (type 1 or 2) during the measurement year or year prior by one of the following:
  - Two or more visits (not acute inpatient) on different dates of service with diagnosis of diabetes (this includes non-acute inpatient encounters without telehealth modifier or place of service)
  - One of the two visits may be a telehealth visit, a telephone visit, or an online assessment
  - One acute inpatient encounter with a diagnosis of diabetes without telehealth modifier or place of service
- Prescribed hypoglycemic/antihyperglycemics or insulin on an ambulatory basis

**Nephropathy monitoring activities:**
- ACE Inhibitor/ARB ambulatory prescription
- Albumin or protein urine test
- Visit to nephrologist
- Kidney transplant
- Medical attention for diabetic nephropathy
  - ESRD (no telehealth)
  - Chronic renal failure
  - Chronic kidney disease (CKD)
  - Renal insufficiency
  - Proteinuria
  - Albuminuria
  - Renal dysfunction
  - Acute renal failure
  - Dialysis, hemodialysis or peritoneal dialysis

**Methodology:** Claims, encounter data and medical record review

### Codes used in measure

- **ESRD without telehealth:**
  - CPT: 36147, 36800, 36810, 36815, 36818-36821, 36831-36833, 90935, 90937, 90940, 90945, 90947, 90951-90970, 90989, 90993, 90997, 90999, 99512
  - CPT II: G0257, S9339
  - ICD-10-CM: N18.5, N18.6, Z91.15, Z99.2
  - ICD-10-PCS: 3E1M93Z, 5A1D00Z, 5A1D60Z, 5A1D70Z, 5A1D80Z, 5A1D90Z
- **Kidney transplant:**
  - CPT: 50360, 50365, 50380
  - CPT II: S2065
  - ICD-10-CM: Z94.0
  - ICD-10-PCS: 0TY00Z0-0TY00Z2, 0TY10Z0-0TY10Z2
  - CKD stage 4
  - ICD-10-CM: N18.4
- **Urine protein test:**
  - CPT: 81000-81003, 81005, 82042-82044, 84156
  - CPT II: 3060F, 3061F, 3062F
- **Diabetes mellitus without complications:** ICD-10-CM E10.9, E11.9, E13.9
- **Acute inpatient visit:** CPT: 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291
  - Outpatient visit: CPT: 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99429, 99455, 99456, 99483
  - HCPCS: G0402, G0438, G0439, G0463, T1015
- **Observation visit:** CPT: 99217-99220
- **Emergency department visit:** CPT: 99281-99285
- **Non-acute inpatient visit:** CPT: 99304-99310, 99315, 99316, 99318, 99324-99328, 99334-99337
- **Online assessment:** CPT: 99969, 99444
- **Telehealth visits:**
  - CPT: 98966, 98968, 99441 99443
  - Modifier: 95, GT
  - POS: 02
- **Large code sets:**
  - Nephrologist visits/nephropathy treatment
  - Diabetes diagnosis
  - Diabetes medications list
  - ACE inhibitor/ARB medications list
  - Frailty diagnosis
  - Advanced illness diagnosis
  - Dementia medication list
  - Gestational or steroid-induced diabetes diagnosis

---

**Part of:**
- HEDIS chart review
- QIP
- VBA
- QRS

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<table>
<thead>
<tr>
<th>Ages 18-75</th>
<th>Applies to:</th>
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<tr>
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<td>Commercial patients</td>
</tr>
<tr>
<td></td>
<td>Medicare Advantage patients</td>
</tr>
</tbody>
</table>
Exclusions

- Diagnosis of gestational or steroid-induced diabetes during the measurement year or the year prior and no diagnosis of diabetes during the same time
- Members in hospice

Note: Supplemental and medical record data may not be used for the following exclusions:

- Medicare members 66 and older as of December 31 of the measurement year who meet either of the following:
  - Enrolled in an institutional special needs plan (I-SNP) any time during the measurement year
  - Living long-term in an institution any time during the measurement year as identified in the monthly membership detail data file
- Members 66 and older as of December 31 of the measurement year with frailty and advanced illness. Members must meet both of the following frailty and advanced illness criteria to be excluded:
  1. At least one claim/encounter for frailty during the measurement year
  2. Any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years)
    - A dementia medication dispensed
    - An acute inpatient encounter with an advanced illness diagnosis
    - At least two outpatient, observation, emergency department visits or non-acute inpatient encounters on different dates of service with an advanced illness diagnosis (may be two different visit types)
## Disease modifying anti-rheumatic drug therapy for rheumatoid arthritis (ART)

<table>
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<td>□ QRS</td>
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</tbody>
</table>

### Measure description and methodology

Measure assesses the medical management of those with rheumatoid arthritis.

**Requires:**
- Diagnosis of rheumatoid arthritis
- Two or more of the following between January 1 and November 30 of the measurement year:
  - Outpatient visits
  - Non-acute inpatient discharge
  - A telephone visit
  - An online assessment
- Note: Only one of the two visits may be a telehealth, a telephone visit or an online assessment.
- Ambulatory prescription of disease modifying anti rheumatic drug (DMARD) during the whole measurement year (January 1 through December 31)

**Methodology:** Claims, encounter data or pharmacy data

### Codes used in measure

**Outpatient visit:**
- **CPT:** 99201-99205, 99211-99215, 99241-99245, 9931-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99429, 99455, 99456, 99463, 99483
- **HCPCS:** G0402, G0438, G0439, G0463, T1015

**Online assessment:** **CPT** 98969, 99444

**Telehealth visits:**
- **CPT:** 98966-98968, 99441-99443
- **Modifier:** 95, GT
- **POS:** 02

**DMARDs:**
- **HCPCS:** J0129, J0135, J0717, J1438, J1602, J1745, J3262, J7502, J7515, J7516, J7517, J7518, J9250, J9260, J9310, J9311, J9312, Q5102, Q5103, Q5104, Q5109

**HIV:** **ICD-10-CM** B20, B97.35, Z21

**Observation visit:** **CPT** 99217-99220

**Emergency department visit:** **CPT** 99281-99285

**Non-acute inpatient visit:** **CPT** 99304-99310, 99315, 99316, 99318, 99324-99328, 99326-99337

**Acute inpatient visit:** **CPT** 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291

**Large code sets:**
- Rheumatoid arthritis diagnosis
- Non-acute inpatient stay
- DMARD medications list
- Frailty diagnosis
- Advanced illness diagnosis
- Dementia medications list
- Pregnancy diagnosis

Continued on next page
Disease modifying anti-rheumatic drug therapy for rheumatoid arthritis (ART) (continued)

**Exclusions**

During measurement year:
- Pregnancy
- Members in hospice

Any time in history:
- HIV

**Note**: Supplemental and medical record data may not be used for the following exclusions:
- Medicare members 66 and older as of December 31 of the measurement year who meet either of the following:
  - Enrolled in an institutional special needs plan (I-SNP) any time during the measurement year
  - Living long-term in an institution any time during the measurement year as identified in the monthly membership detail data file
- Members 66-80 as of December 31 of the measurement year with frailty and advanced illness. Members must meet both of the following frailty and advanced illness criteria to be excluded:
  1. At least one claim/encounter for frailty during the measurement year
  2. Any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years)
     - At least two outpatient, observation, emergency department visits or non-acute inpatient encounters on different dates of service with an advanced illness diagnosis (may be two different visit types)
     - At least one acute inpatient encounter with an advanced illness diagnosis
     - A dementia medication dispensed
- Members 81 and older as of December 31 of the measurement year with frailty during the measurement year
Follow-up after hospitalization for mental illness (FUH)

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<td>☑ QRS</td>
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</table>

**Measure description and methodology**

Measures the percentage of discharges for members age six and older who were hospitalized for treatment of selected mental illness or intentional self-harm and who had a follow-up visit with a mental health practitioner.

Includes:
- Percentage of discharges for which member received follow-up care within 30 days after discharge
- Percentage of discharges for which member received follow-up care within seven days after discharge

**Requires:**
An acute inpatient discharge with a principal diagnosis of mental illness or intentional self-harm between January 1 and December 1 of the measurement year.

**Methodology:** Medical claims and encounter data

<table>
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<th>Codes used in measure</th>
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<td>POS: 02, 03, 05, 07, 09, 11-20, 22, 24, 33, 49, 50, 52, 53, 71, 72</td>
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<tr>
<td>Electroconvulsive therapy: CPT 90870</td>
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<td>Partial hospitalization or intensive outpatient:</td>
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<tr>
<td>Transitional care management services: CPT 99495, 99496</td>
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<tr>
<td>Visit setting unspecified: CPT 90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221-99233, 99238, 99239, 99251-99255</td>
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<td>Large code sets:</td>
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<tr>
<td>- Inpatient stay</td>
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<td>- Intentional self-harm</td>
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<tr>
<td>- Mental health diagnosis</td>
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<tr>
<td>- Mental health illness</td>
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**Exclusions**

- Members in hospice
- Members with a discharge that occurs after December 1 of the measurement year
Immunizations for adolescents (IMA)

<table>
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</table>

**Measure description and methodology**

Measure assesses the immunization status of adolescent children at 13 years of age.

**Requires:**

Before the age of 13, following immunizations:
- Meningococcal conjugate vaccine one dose
- Tdap one dose
- Human papillomavirus (HPV) vaccines two or three doses

**Notes:**

- The antigen and date it was administered must be documented.
- Two-dose HPV requires 146 days between doses

**Standard schedule:**

- Meningococcal between 11th and 13th birthday.
- Tdap between 10th and 13th birthday
- HPV between 9th and 13th birthday

**Methodology:** Claims, encounter data and medical record review

**Codes used in measure**

<table>
<thead>
<tr>
<th>Vaccines</th>
<th>CPT Code(s)</th>
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<tbody>
<tr>
<td>Meningococcal</td>
<td>90734</td>
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<tr>
<td>Tdap</td>
<td>90715</td>
</tr>
<tr>
<td>HPV</td>
<td>90649-90651</td>
</tr>
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</table>

**Exclusions**

- Anaphylactic reaction to the vaccine or its components any time on or before the member’s 13th birthday
- Anaphylactic reaction to the vaccine or its components with a date of service prior to October 2011
- Tdap: encephalopathy with vaccine adverse-effect code any time on or before the member’s 13th birthday
- Members in hospice
Initiation and engagement of alcohol and other drug dependence treatment (IET)

<table>
<thead>
<tr>
<th>Ages 13+</th>
<th>Applies to:</th>
<th>Part of:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☑ Commercial patients</td>
<td>☑ HEDIS chart review</td>
</tr>
<tr>
<td></td>
<td>☑ Medicare Advantage patients</td>
<td>☑ QIP</td>
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<td>☑ VBA</td>
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<td>☑ QRS</td>
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</tbody>
</table>

**Measure description and methodology**

Measures the percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) abuse or dependence who received the following:
- Initiation of AOD treatment is the percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth or medication treatment within 14 days of the diagnosis.
- Engagement of AOD treatment is the percentage of members who initiated treatment and who were engaged in ongoing AOD treatment within 34 days of the initiation visit.

**Requires:**
- new episode of AOD abuse or dependence during the Intake Period.

Intake period is January 1 to November 13 of the measurement year.

Index episode is the earliest eligible encounter during the Intake Period with a diagnosis of AOD abuse or dependence.

Index episode start date is the earliest date of service for an eligible encounter during the intake period with a diagnosis of AOD abuse or dependence.

**Notes:**
- For an outpatient, intensive outpatient, partial hospitalization, observation, telehealth, detox, or ED visit (not resulting in an inpatient stay), the IESD is the date of service.
- For an inpatient stay the IESD is the discharge date.
- For ED and observation that result in an inpatient stay, the IESD is the date of discharge.

**Methodology:** Medical claims, pharmacy claims and encounter data

**Codes used in measure**

- AOD medication treatment: **HCPCS** H0020, H0033, J0570-J0575, J2315, Q9991-Q9992, S0109
- Detoxification: **HCPCS** H0008-H0014
- Emergency department visit: **CPT** 99281-99285
- IET POS (Group 1): 02, 03, 05, 07, 09, 11, 12-20, 22, 33, 49, 50, 52, 53, 57
- IET POS (Group 2): 02, 52, 53
- IET stand-alone visits:
  - **CPT** 99960-99962, 99078, 99201-99205, 99212-99215, 99241-99245, 99244, 99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99411, 99412, 99483, 99510
- IET visits (Group 1): **CPT** 90791, 90792, 90832-90834, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876
- IET visits (Group 2): **CPT** 99221-99223, 99231-99233, 99238, 99239, 99251-99255
- Observation: **CPT** 99217-99220
- Online assessments: **CPT** 98969, 99444
- Telehealth visits: **CPT**: 98966-98968, 99441-99443

**Exclusions**

- Members in hospice
- Members with an inpatient stay that has a discharge date after November 27 of the measurement year

**ASURIS NORTHWEST HEALTH**

33
Medication adherence

<table>
<thead>
<tr>
<th>Applies to:</th>
<th>Part of:</th>
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<tbody>
<tr>
<td>Commercial patients</td>
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<tr>
<td>Medicare Advantage patients</td>
<td>QIP</td>
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<td></td>
<td>VBA</td>
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<tr>
<td></td>
<td>QRS</td>
</tr>
</tbody>
</table>

Medication adherence, a group of triple-weighted Medicare Star Rating measures, focuses on adherence rates in Medicare patients 18 or older who have two or more fills of a medication from the drug classes below:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Drug classes included</th>
<th>Exclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>Biguanides, sulfonylureas, thiazolidinediones, dipeptidyl peptidase IV (DPP-IV), incretin mimetics, meglitinides and sodium-glucose cotransporter-2 (SGLT2) inhibitors</td>
<td>Patients on insulin, receiving hospice care or who have end-stage renal disease (ESRD) are excluded.</td>
</tr>
<tr>
<td>Hypertension</td>
<td>Angiotensin-converting enzyme (ACE), angiotensin receptor blockers (ARBs) or direct renin inhibitors</td>
<td>Patients on Entresto (sacubitril/valsartan), receiving hospice care or who have ESRD are excluded.</td>
</tr>
<tr>
<td>Hyperlipidemia</td>
<td>Statins</td>
<td>Patients receiving hospice care or who have ESRD are excluded.</td>
</tr>
</tbody>
</table>

Gaps are identified when a patient does not adhere to their target medication as prescribed by the provider.

If the patient missed a refill or was late to refill earlier in the year, they may show up as non-adherent even if they recently filled their prescription.

Adherence rates are measured in terms of the proportion of days covered (PDC). Patients should be filling their prescription to have enough medication to cover 80% or more of the year.

Higher adherence is associated with improved outcomes. There are many reasons why a patient may not be taking their medications as prescribed, including cost, adverse events, inconvenience or lack of understanding of their regimen.

As a provider, you can empower patients to take their medications as prescribed. Effective two-way communication significantly increases the odds of your patients taking their medications properly.

**Identify the problem**

The following tips may help identify your patients who may not be adhering to their treatment plan:

- Use a medication adherence scale.
- Ask patients if they are sticking to their drug regimen. If they are not, try to help them identify and address the barriers.
- Look for underlying conditions. For example, patients who are depressed rarely take their medications, so consider treating the depression first.
**Medication adherence (continued)**

**Address the problem**

We appreciate your efforts to discuss any medication adherence gaps with your patients.

<table>
<thead>
<tr>
<th>What a patient might say</th>
<th>Possible solutions</th>
</tr>
</thead>
</table>
| I forget.                | - Simplify the drug regimen (e.g. dosing, frequency) whenever possible.  
- Encourage patients to use pillboxes or mobile apps to help them remember.  
- Suggest patients sign up for automatic refills, synchronized refills and/or a 90-day supply through their pharmacy. |
| My medication makes me feel sick. | - Change the dose.  
- Prescribe an alternative medication.  
- Suggest ways to manage or reduce side effects. |
| I feel fine.             | - Explain how the patient's disease affects the body and use teach-back to ensure your patient understands.  
- Be clear about the benefit of the medication. For example, you might say, “If you take your diabetes medications and control your blood sugar, you may not need to have your eyeglass prescription changed as often.” |
| I can’t afford my medication. I only take half a pill a day to save money. | - Determine if any medications can be safely discontinued.  
- Prescribe generics or lower-cost alternatives when possible.  
- Prescribe a 100-day supply for Medicare patients to lower their costs.  
  - Effective January 1, 2020, Medicare Advantage members can receive a 100-day supply of medications for these adherence measures.  
  - Tier 1 and Tier 2 medications: Pay two months’ supply copay for 100-day supply  
  - Tier 3 medications: Pay 2.5 months’ supply copay for 100-day supply |
| There are so many pills. I can’t keep them straight! It’s too complicated. | - Suggest pharmacist counseling.  
- Simplify the regimen if possible.  
- Determine if any medications can be safely discontinued.  
- Consider switching to once-a-day or combination therapy. |
| I can’t understand these instructions. | - Suggest pharmacist counseling.  
- Use teach-back to ensure your patient understands.  
- Use plain language. Instead of saying, “This will treat your hypertension,” say, “Let’s try this for your high blood pressure.” |
Medication management for people with asthma (MMA)

Ages 5-64 years

**Applies to:**
- ☑ Commercial patients
- ☐ Medicare Advantage patients

**Part of:**
- ☐ HEDIS chart review
- ☑ QIP
- ☐ VBA
- ☑ QRS

<table>
<thead>
<tr>
<th>Measure description and methodology</th>
<th>Codes used in measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measure assesses the prescribing and use of medications for an appropriate length of time in the treatment and control of persistent asthma.</td>
<td>ED visits:</td>
</tr>
<tr>
<td>Requires:</td>
<td>- CPT: 99281-99285</td>
</tr>
<tr>
<td>- Diagnosis of persistent asthma</td>
<td>Outpatient visits:</td>
</tr>
<tr>
<td>Persistent asthma is defined by at least one event in the measurement year and prior year (does not have to be the same):</td>
<td>- HCPCS: G0402, G0438, G0439, G0463, T1015</td>
</tr>
<tr>
<td>- One or more acute inpatient stays with asthma as the principal diagnosis</td>
<td>Asthma diagnosis:</td>
</tr>
<tr>
<td>- One or more emergency department visits with asthma as the principal diagnosis</td>
<td>- ICD-10: J45.20-J45.22, J45.30-J45.32, J45.40-J45.42, J45.50-45.52, J45.901, J45.902, J45.909, J45.990, J45.991, J45.998</td>
</tr>
<tr>
<td>- Four or more outpatient/observation visits on different service dates with asthma as a diagnosis and at least two asthma medications must be dispensed</td>
<td>Online assessment:</td>
</tr>
<tr>
<td>- At least four asthma medications dispensed</td>
<td>- CPT: 98969, 99444</td>
</tr>
<tr>
<td>Index prescription start date (IPSD) is the earliest prescription dispensing date for any asthma controller medication during the measurement year.</td>
<td>Telehealth visits:</td>
</tr>
<tr>
<td>Treatment period starts with the IPSD and continues through the end of the measurement year.</td>
<td>- CPT: 98966-98968, 99441-99443</td>
</tr>
<tr>
<td>Portion of days covered (PDC) is the number of days covered by at least one asthma controller medication prescription, divided by the number of days in the treatment period.</td>
<td>- Modifier: 95, GT</td>
</tr>
<tr>
<td>Notes:</td>
<td>- POS: 02</td>
</tr>
<tr>
<td>- Rates are based on PDC as a percentage of medication compliance at 50% and 75% of the total treatment period.</td>
<td>Large code sets:</td>
</tr>
<tr>
<td>- Each injection or intravenous infusion counts as one dispensing event.</td>
<td>- Acute inpatient stay</td>
</tr>
<tr>
<td>Methodology: Medical claims, pharmacy claims and encounter data</td>
<td>- Asthma controller medications</td>
</tr>
<tr>
<td>Exclusions</td>
<td>- Asthma reliever medications</td>
</tr>
<tr>
<td>- Any of the following anytime during the member’s history through December 31st of the measurement year:</td>
<td>- Members in hospice</td>
</tr>
<tr>
<td>emphysema, COPD, obstructive chronic bronchitis, chronic respiratory conditions due to fumes/vapors, cystic fibrosis and acute respiratory failure</td>
<td></td>
</tr>
</tbody>
</table>
Medication reconciliation post-discharge (MRP)

Ages 18+

Applies to:
- ☑ Commercial patients
- ☑ Medicare Advantage patients

Part of:
- ☑ HEDIS chart review
- ☑ QIP
- ☑ VBA
- ☑ QRS

Measure description and methodology

Measure assesses the prevalence of transitions in care upon discharge from an inpatient setting. Target is medication management. Medication reconciliation is a focused review of the medications prescribed at the time of discharge from an inpatient setting (hospital, skilled nursing facility, etc.) and reconciliation with the medication list in the outpatient record.

Requires:
- Discharge from inpatient setting
- Reconciliation of discharge medications with outpatient medications, completed within 31 days of discharge (discharge date + 30 days)
- Reconciliation must be performed by prescribing provider, clinical pharmacist or RN
- See next page for medical record documentation requirements

Notes:
- All records submitted must contain and admission and discharge date.
- The medication list must be included with the medical records.
- If other staff in the office do not have the right credentials, the results must be reviewed and signed off by a prescribing provider, pharmacist or RN.
- Chart note must reflect the outcome of the reconciliation/comparison and clearly indicate that the office visit or interaction is related to the inpatient stay.

Methodology: Claims, encounter data and medical record review

Codes used in measure

Medication reconciliation:
- CPT: 99483, 99495, 99496
- HCPCS: 1111F

Large code set: inpatient stay

Exclusions

- Member is excluded if the inpatient discharge occurs after December 1st of the measurement year.
- Members in hospice
Medication reconciliation post-discharge (MRP) (continued)

More information about medication reconciliation post-discharge

Medical record documentation
Documentation in the medical record must include evidence of medication reconciliation and the date when it was performed. Any of the following meet criteria:
- Documentation of the current medications (e.g., current medication list) with a notation that the provider reconciled the current and discharge medications
- Documentation of the current medications (e.g., current medication list) with a notation that references the discharge medications (e.g., “no changes in medication since discharge”, “same medications at discharge”, “discontinue all discharge medications”)
- Documentation of the member’s current medications (e.g., current medication list) with a notation that the discharge medications were reviewed
- Documentation of a current medication list, a discharge medication list and notation that both lists were reviewed on the same date of service
- Documentation of the current medications (e.g., current medication list) with evidence that the member was seen for post-discharge hospital follow-up with evidence of medication reconciliation or review. Evidence that the member was seen for post-discharge follow-up requires documentation that indicates that the provider was aware of the member’s hospitalization or discharge
- Documentation in the discharge summary that the discharge medications were reconciled with the most recent medication list in the outpatient medical record. There must be evidence that the discharge summary was filed in the outpatient chart on the date of discharge through 30 days after discharge (31 total days)*
- Notation that no medications were prescribed or ordered upon discharge.

* Note: A discharge summary with a list of medications the patient should start, continue or stop taking is not considered evidence that the discharge medications were reconciled with the most recent medication list in the outpatient medical record and does not meet criteria for this measure. This is because the medication instructions could be limited to the medications the patient was taking as an inpatient. If the discharge summary references the medications the “patient was taking prior to admission” (in addition to the discharge medications) or stated that “medication reconciliation” had been performed, or contained documentation that the discharge medications “were reconciled with the medications in the outpatient chart” this would meet criteria for medication reconciliation.

Transitional care management codes
Here are some guidelines for using transitional care management (TCM) codes for medication reconciliation. TCM codes can be submitted:
- When a patient is being discharged from an inpatient or outpatient hospital stay to home or to a nursing or rehabilitation facility, or
- When a patient is being discharged from a nursing or rehabilitation facility to home
These codes are eligible for reimbursement even if the patient was discharged with home health services.
TCM codes require:
- Only one provider per admission may bill for the service
- Medication reconciliation either prior to or during the visit, by a prescribing provider, clinical pharmacist or registered nurse
- Documented interactive patient communication with the provider or clinic staff, or a visit with the provider within two business days of discharge
- If patient is readmitted within 30 days of the previous hospital stay, TCM codes may not be billed after the discharge for the readmission

Use CPT 99495 for a visit of moderate complexity that is within 14 calendar days of discharge. Note: The visit must meet both requirements.

Use CPT 99496 for a visit of high complexity that is within seven calendar days of discharge. Note: The visit must meet both requirements.

CMS has published information for you to learn about these codes: cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Transitional-Care-Management-Services-Fact-Sheet-ICN908628.pdf
# Osteoporosis management in women who had a fracture (OMW)

<table>
<thead>
<tr>
<th>Ages 67-85</th>
<th>Applies to:</th>
<th>Part of:</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>☑ Commercial patients</td>
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<td>☑ VBA</td>
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<td></td>
<td></td>
<td>☑ QRS</td>
</tr>
</tbody>
</table>

## Measure description and methodology

Measure assesses whether the treatment for osteoporosis is initiated after a fracture.

**Requires:**
- A new fracture during the intake period and
- A bone mineral density (BMD) test or a medication to treat osteoporosis within six months of the fracture

**Intake period** is a 12-month window July 1 of the year prior to June 30 of the measurement year.

**Episode date** is the earliest date of service for an eligible encounter during the intake period with a diagnosis of a fracture, including:
- Date of service for an outpatient, observation or ED visit. Observation and ED visits that result in an inpatient stay are not included.
- Date of discharge for an acute or non-acute inpatient stay
- Discharge date from the last admission for a direct transfer

**Index Episode Start Date (IESD)** is the earliest episode date during the intake period that meets all eligible population criteria

**Methodology:** Claims, encounter data and pharmacy data

## Codes used in measure

BMD tests:
- **CPT:** 76977, 77078, 77080-77082, 77085, 77086
- **ICD-10:** BP48ZZ1, BP49ZZ1, BP4GZZ1, BP4HZZ1, BP4LZZ1, BP4MZZ1, BP4NZZ1, BP4PZZ1, BQ00ZZ1, BQ01ZZ1, BQ03ZZ1, BQ04ZZ1, BR00ZZ1, BR07ZZ1, BR09ZZ1, BR0GZZ1

Outpatient visit:
- **CPT:** 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99429, 99455, 99456, 99483
- **HCPCS:** G0402, G0438, G0439, G0463, T1015

Observation visit: **CPT** 99217-99220

Emergency department visit: **CPT** 99281-99285

Non-acute inpatient visit: **CPT** 99304-99310, 99315, 99316, 99318, 99324-99328, 99334-99337

Acute inpatient visit: **CPT** 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291

Telehealth:
- **CPT:** 98966-98968, 99441-99443,
- **Modifier:** 95, GT
- **POS:** 02

Large code sets:
- Fractures
- Inpatient stay
- Osteoporosis medications list
- Frailty diagnosis
- Advanced illness diagnosis
- Dementia medications list

Continued on next page
Osteoporosis management in women who had a fracture (OMW) (continued)

**Exclusions**

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

**Notes:**
- For an acute or non-acute inpatient IESD, use the IESD date of admission to determine the number of days prior to the IESD
- For direct transfers, use the first admission date to determine the number of days prior to the IESD

Members who had either of the following during the 60-day period prior to the IESD:
- An outpatient visit, with or without a telehealth modifier, a telephone visit, an online assessment, an observation visit or an ED visit for a fracture. (Do not include ED visits or observation visits that result in an inpatient stay)
- An acute or non-acute inpatient discharge for a fracture

BMD test up to 24 months prior to the episode date

Osteoporosis therapy or prescription during the 12 months prior to the episode date

Members in hospice

**Note:** Supplemental and medical record data may not be used for the following exclusions:
- Medicare members 67 and older as of December 31 of the measurement year who meet either of the following:
  - Enrolled in an institutional special needs plan (I-SNP) any time during the intake period through the end of the measurement year
  - Living long-term in an institution any time during the measurement year as identified in the monthly membership detail data file
- Members 67-80 as of December 31 of the measurement year with frailty and advanced illness. Members must meet **both** of the following frailty and advanced illness criteria to be excluded:
  1. At least one claim/encounter for frailty during the measurement year
  2. Any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years)
    - At least two outpatient, observation, emergency department visits or non-acute inpatient encounters on different dates of service with an advanced illness diagnosis (may be two different visit types)
    - At least one acute inpatient encounter with an advanced illness diagnosis
    - A dementia medication dispensed
- Members 81 and older as of December 31 of the measurement year with frailty during the measurement year
Persistence of beta blocker treatment after a heart attack (PBH)

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<th>Ages 18+</th>
<th>Applies to:</th>
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</table>

Part of:
- ☑ HEDIS chart review
- ☑ QIP
- ☑ VBA
- ☑ QRS

Measure description and methodology

Measure assesses the prevalence of treatment with beta blockers after hospitalization for acute myocardial infarction (AMI).

Requires:
- AMI diagnosis
- Hospital stay between July 1 prior year and June 30 measurement year for AMI
- Beta blocker prescription refill history 180 days starting with discharge date

Note: Hospitalization must be for the AMI diagnosis. If multiple admissions, only first one counts.

Methodology: Medical claims, pharmacy claims and encounter data

Codes used in measure

Acute myocardial infarction diagnosis:

Large code sets:
- Acute inpatient stay
- Beta blocker medications
- Frailty diagnosis
- Advanced illness diagnosis

Exclusions

- Any of the following any time in the member's history through the end of the continuous enrollment period:
  - Asthma
  - COPD
  - Obstructive chronic bronchitis
  - Chronic respiratory conditions due to fumes/vapors
  - Hypotension (heart block >1 degree or sinus bradycardia)
  - A medication dispensing event indicative of a history of asthma
  - Intolerance or allergy to beta blocker therapy
- Non-acute inpatient stay
- Members in hospice

Note: Supplemental and medical record data may not be used for the following exclusions:
- Medicare members 66 and older as of December 31 of the measurement year who meet either of the following any time on or between July 1 of the year prior to the measurement year and the end of the measurement year:
  - Enrolled in an institutional special needs plan (I-SNP)
  - Living long-term in an institution
- Members 66-80 as of December 31 of the measurement year with frailty and advanced illness. Members must meet both of the following frailty and advanced illness criteria to be excluded:
  1. At least one claim/encounter for frailty any time on or between July 1 of the year prior to the measurement year and the end of the measurement year
  2. Any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years)
     - At least two outpatient, observation, emergency department visits or non-acute inpatient encounters on different dates of service with an advanced illness diagnosis (may be two different visit types)
     - At least one acute inpatient encounter with an advanced illness diagnosis
     - A dementia medication dispensed
- Members 81 and older as of December 31 of the measurement year with frailty any time on or between July 1 of the year prior to the measurement year and the end of the measurement year
Plan all-cause readmissions (PCR)

Ages 18+

Applies to:
- Commercial patients
- Medicare Advantage patients

Part of:
- HEDIS chart review
- QIP
- VBA
- QRS

Measure description and methodology

Measure assesses the prevalence of acute inpatient and observation readmissions within a specific period of time after discharge from an inpatient setting.

Requires:
- Acute inpatient or observation stay with a discharge on or between January 1 and December 1 of the measurement year
- Unplanned acute readmission for any diagnosis within 30 days of discharge

Index hospital stay (IHS): Acute inpatient stays with a discharge during the measurement period
Index admission date: IHS admission date
Index discharge date: IHS discharge date
Index readmission stay: Acute inpatient or observation stay within 30 days of a previous index discharge date
Index readmission date: Admission date associated with the index readmission stay
Classification period: 365 days prior to and including an index discharge date

Outlier:
- Medicare members in the eligible population with four or more index hospital stays between January 1 and December 1 of the measurement year
- Commercial members in the eligible population with three or more index hospital stays between January 1 and December 1 of the measurement year

Non-outlier: Members in the plan population who are not considered outliers

Methodology: Claims and encounter data

Codes used in measure

Chemotherapy: ICD-10-CM Z51.0, Z51.11, Z51.12

Observation stay: CPT 99217-99220

Large code sets:
- Inpatient stay
- Non-acute inpatient stay
- Pregnancy diagnosis
- Perinatal conditions
- Rehabilitation
- Organ transplant
- Potentially planned procedures
- Acute condition

Follow risk adjustment determination guide on following pages for more information.

Exclusions

- Acute inpatient stay with principal diagnosis of pregnancy
- Non-acute inpatient stay
- A condition originating in the perinatal period
- Death during hospital stay
- Planned stays within 30 days of an unplanned stay with chemotherapy, rehabilitation or organ transplant
- Potentially planned procedure without a principal acute diagnosis
- Hospital stays where discharge date occurs after December 1 of the measurement year
- Hospital stays where the index admission date is the same as the index discharge date
- Members in hospice

Continued on next page
Plan all-cause readmissions (PCR) continued—Risk adjustment determination guide

For each IHS, use the following to identify risk adjustment categories based on presence of surgeries, discharge condition, comorbidity, age and gender.

### Surgeries

Determine if the member underwent surgery during the inpatient stay. (Download the list of surgery codes from the NCQA website Table HCC Surg). Consider an IHS to include a surgery if at least one procedure code in Table HCC Surg is present from any provider between the admission and discharge dates.

### Discharge condition

Assign a discharge Clinical Condition (CC) category code to the IHS based on its primary discharge diagnosis, using Table PCR DischCC (from NCQA's website). For acute to acute transfers, use the transfer's primary discharge diagnosis.

Exclude diagnoses that cannot be mapped to Table PCR-DischCC.

### Comorbidities

**Step 1**: Identify all diagnoses for encounters during the classification period. Include the following when identifying encounters

**Step 2**: Assign each diagnosis to one comorbid Clinical Condition (CC) category using Table CC Comorbid (from NCQA's website)

**Step 3**: Determine HCC's for each comorbid CC identified. Refer to table HCC Rank (from NCQA's website)

**Step 4**: Assess each ranking group separately and select only the highest ranked HCC in each ranking group using the Rank column

**Step 5**: Identify combination HCC's listed in Table HCC Comb (from NCQA's website)

### Risk adjustment weighting

Continued on next page
Plan all-cause readmissions (PCR) continued—Risk adjustment determination guide

For each IHS, use the following steps to identify risk adjustment weights based on presence of surgeries, discharge condition, comorbidity, age and gender:

Step 1: For each IHS with a surgery, link the surgery weight (Use tables from NCQA's website accordingly)
- For Medicare product lines ages 18-64: Use Table PCR MA OtherWeights Under65.
- For Medicare product lines ages 65 and older: Use Table PCR MA OtherWeights 65plus.
- For commercial product lines: Use Table PCR Comm OtherWeights

Step 2: For each IHS with a discharge CC category, link the primary discharge weight (Use tables from NCQA's website accordingly)
- For Medicare product lines ages 18-64: Use Table PCR MA DischCC Weight Under65.
- For Medicare product lines ages 65 and older: Use Table PCR MA DischCC Weight 65plus.
- For commercial product lines: Use Table PCR Comm DischCC Weight.

Step 3: For each IHS with a comorbidity HCC category, link the weights (Use tables from NCQA's website accordingly)
- For Medicare product lines ages 18-64: Use Table PCR MA ComorbHCC Weight Under65.
- For Medicare product lines ages 65 and older: Use Table PCR MA ComorbHCC Weight 65plus.
- For commercial product lines: Use Table PCR Comm ComorbHCC Weight.

Step 4: Link the age and gender weights for each IHS (Use tables from NCQA's website accordingly)
- For Medicare product lines ages 18-64: Use Table PCR MA OtherWeights Under65.
- For Medicare product lines ages 65 and older: Use Table PCR MA OtherWeights 65plus.
- For commercial product lines: Use Table PCR Comm OtherWeights.

Step 5: Identify the base risk weight (Use tables from NCQA's website accordingly)
- For Medicare product lines ages 18-64: Use Table PCR MA OtherWeights Under65.
- For Medicare product lines ages 65 and older: Use Table PCR MA OtherWeights 65plus.
- For commercial product lines: Use Table PCR Comm OtherWeights to determine the base risk weight.

Step 6: Sum all weights associated with the IHS (i.e. presence of surgery, primary discharge diagnosis, comorbidities, age, gender and base risk weight). Use the following formula to calculate:

\[
\text{Estimated Readmission Risk} = \frac{\text{exp (sum of weights for IHS)}}{1 + \text{exp (sum of weights for IHS)}}
\]

Step 7: Calculate the Count of Expected Readmissions for each age and stratification category. The Count of Expected Readmissions is the sum of the Estimated Readmission Risk calculated in step 6 for each IHS in each age and stratification category.

\[
\text{Count of Expected Readmissions} = \text{Sum (Estimated Readmission Risk)}
\]

Step 8: Use the following formula and the Estimated readmission risk calculated in Step 6 to calculate variance for each IHS.

\[
\text{Variance} = \text{Estimated Readmission Risk} \times (1 - \text{Estimated Readmission Risk})
\]
Prenatal and postpartum care (PPC)

<table>
<thead>
<tr>
<th>Applies to:</th>
<th>Part of:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☑ Commercial patients</td>
<td>☑ HEDIS chart review</td>
</tr>
<tr>
<td>☐ Medicare Advantage patients</td>
<td>☐ QIP</td>
</tr>
<tr>
<td>☐ VBA</td>
<td>☐ QRS</td>
</tr>
</tbody>
</table>

Measure description and methodology

Measure assesses the care women are being provided in their prenatal and postpartum periods.

Requires:
- Established pregnancy
- Live birth on or between October 8 of the year prior to the measurement year to October 7 of the measurement year
- Evidence of visits during the prenatal and postpartum periods:
  - Prenatal care visit during the first trimester or within 42 days of enrollment in the health plan
  - Postpartum visit between 7 and 84 days after delivery

First trimester: 176-280 days prior to delivery or estimated delivery date

Notes:
- Enrollment must have occurred at least 43 days prior to delivery through 60 days after delivery. All testing must have a corresponding visit to ensure continuity of care.

Methodology:
Claims, encounter data and/or medical record review

Codes used in measure

Delivery:
- ICD-10-PCS: 10D00Z0-10D00Z2, 10D07Z3-10D07Z8, 10E0XZZ
- CPT: 59400, 59409, 59410, 59510, 59514, 59515, 59610, 59612, 59614, 59618, 59620, 59622

Prenatal visits:
- CPT: 59400, 59425, 59426, 59510, 59610, 59618, 99201-99205, 99211-99215, 99241-99245, 99483, 99500
- CPT II: 0500F, 0501F, 0502F
- HCPCS: G0463, H1000-H1005, T1015

Obstetric panel: CPT 80055, 80081

Prenatal ultrasound:
- CPT: 76801, 76805, 76811, 76813, 76815 76821, 76825 76828
- ICD-10-PCS: BY49ZZZ, BY4BZZZ, BY4CZZZ, BY4DZZZ, BY4FZZZ, BY4GZZZ

Antibodies:
- Toxoplasma: CPT 86777, 86778
- Rubella: CPT 86762
- Cytomegalovirus: CPT 86644
- Herpes simplex: CPT 86694 86696
- ABO or Rh test: CPT 86900, 86901

Postpartum visits:
- CPT: 57170, 58300, 59400, 59410, 59430, 59510, 59515, 59610, 59614, 59618, 59622, 99501
- CPT II: 0503F
- HCPCS: G0101

Cervical cytology:
- CPT: 88141-88143, 88147, 88148, 88150, 88152-88154, 88164-88167, 88174, 88175
- HCPCS: G0123, G0124, G0141, G0143-G0145, G0147, G0148, P3000, P3001, Q0091

TORCH panel: CPT 86695

Large code set:

Exclusions
- Non-live births
- Members in hospice
Measure is designed to assess the use of statins in those at higher risk of cardiovascular events.

Requires:
- Presence of clinical atherosclerotic cardiovascular disease (ASCVD) determined by:
  - Event: MI with an inpatient stay, CABG, PCI, other revascularization during year prior to measurement year
  - Diagnosis: Ischemic vascular disease (IVD) during both the measurement year and the year prior based on outpatient visits, telephone visits, online assessments or at least one acute inpatient stays without a telehealth modifier or telehealth place of service code (only one of the two visits may be a telehealth visit, a telephone visit, or an online assessment)
- Ambulatory prescriptions for high or moderate intensity statin dose

Reported as two different rates:
- Those receiving at least one high or moderate intensity statin therapy during the measurement year
- Those remaining on high or moderate intensity statin therapy for 80% or more of the treatment period (for QIP, this rate is not included in the calculation)

Index Prescription Start Sate (IPSD): The earliest prescription dispensing date for any statin medication of at least moderate intensity during the measurement year

Note: See More information about statins for Medicare Advantage members on page 49

Methodology: Medical claim and/or encounter data and pharmacy claim

Codes used in measure

- Outpatient visit:
  - CPT: 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99429, 99455, 99456, 99483
  - HCPCS: G0402, G0438, G0439, G0463, T1015
  - Online assessment: CPT 98969, 99444
  - Telehealth visits:
    - CPT: 98966-98968, 99441-99443
    - Modifier: 95, GT
    - POS: 02
- Observation visit: CPT 99217-99220
- Emergency department visit: CPT 99281-99285
- Non-acute inpatient visit: CPT 99304-99310, 99315, 99316, 99318, 99324-99328, 99334-99337
- Acute inpatient visit: CPT 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291
  - Myocardial infarction:
  - Coronary artery bypass graft:
    - CPT: 33510-33514, 33516-33519, 33521-33523, 33533-33536
    - HCPCS: S2205-S2209
    - ICD-10-PCS: large code set
  - Percutaneous coronary intervention:
    - CPT: 92920, 92924, 92928, 92933, 92937, 92941, 92943, 92980, 92982, 92995
    - HCPCS: C9600, C9602, C9604, C9606, C9607
    - ICD-10-PCS: large code set
Statin therapy for patients with cardiovascular disease (SPC) (continued)

**Codes used in measure (continued)**

- Other revascularization: **CPT**: 37220, 37221, 37224-37229, 37230, 37231
- In Vitro Fertilization: **HCPCS**: S4015, S4016, S4018, S0420, S0421
- ESRD:
  - **CPT**: 36147, 36800, 36810, 36815, 36818-36821, 36831-36833, 90935, 90937, 90940, 90945, 90947, 90951-90970, 90989, 90993, 90997, 90999, 99512
  - **HCPCS**: G0257, S9339
  - **ICD-10-CM**: N18.5, N18.6, Z91.15, Z99.2
  - **ICD-10-PCS**: 3E1M39Z, 5A1D00Z, 5A1D60Z, 5A1D70Z, 5A1D80Z, 5A1D90Z
  - **ICD-9-CM**: 585.5, 585.6, V45.11
  - **ICD-9-PCS**: 39.95, 54.98
- Cirrhosis: **ICD-10-CM**: K70.30, K70.31, K71.7, K74.3, K74.4, K74.5, K74.60, K74.69, P78.81

**Exclusions**

- Members in hospice
- Event in measurement year or year prior:
  - Pregnancy
  - In vitro fertilization
  - Clomiphene dispensing
  - ESRD
  - Cirrhosis
- During measurement year:
  - Myalgia
  - Myositis
  - Myopathy
  - Rhabdomyolysis

**Note**: Supplemental and medical record data may not be used for these exclusions:

- Medicare members 66 and older as of December 31 of the measurement year who meet either of the following:
  - Enrolled in an institutional SNP (I-SNP) any time during the measurement year
  - Living long-term in an institution any time during the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File
- Members 66 and older as of December 31 of the measurement year (all product lines) with frailty and advanced illness. Members must meet BOTH of the following frailty and advanced illness criteria to be excluded:
  - At least one claim/encounter for frailty during the measurement year
  - Any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years)
    - A dispensed dementia medication
    - At least one acute inpatient encounter with an advanced illness diagnosis
    - At least two outpatient visits, observation visits, ED visits, or non-acute inpatient encounters on different dates of service, with an advanced illness diagnosis (may be two different visit types)
# Statin therapy in persons with diabetes (SUPD) (PQA measure)

<table>
<thead>
<tr>
<th>Ages 40-75</th>
<th>Applies to:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☑ Commercial patients</td>
</tr>
<tr>
<td></td>
<td>✓ Medicare Advantage patients</td>
</tr>
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<tr>
<td>☐ VBA</td>
</tr>
<tr>
<td>☐ QRS</td>
</tr>
</tbody>
</table>

## Measure description and methodology

The percentage of patients ages 40 to 75 years who were dispensed medications for diabetes and received a statin medication.

### Requires:
- Members are included in the measure if they have had at least two fills with unique dates of service for diabetes medications during the measurement period
- Reported as one or more prescriptions of any intensity for statin therapy (one or more dispensing during the measurement year)

**Note:** See More information about statins for Medicare Advantage members on page 49

### Methodology
Pharmacy claims

### Exclusions
- Members with ESRD
- Members in hospice
More information about statins for Medicare Advantage members

Our formulary for Medicare Advantage members includes statin medications. The following cost estimates are based on a 30-day supply. Your patient may see additional savings if they receive a 100-day supply. Actual prices may vary depending on patient benefits, the pharmacy used and the amount or strength of medication dispensed.

<table>
<thead>
<tr>
<th>Formulary tier</th>
<th>Statins</th>
<th>Average patient cost per month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1</td>
<td>Atorvastatin, Lovastatin, Pravastatin, Rosuvastatin, Simvastatin</td>
<td>$3</td>
</tr>
<tr>
<td>Tier 2</td>
<td>Fluvastatin, Simvastatin/Ezetimab</td>
<td>$8-$13</td>
</tr>
</tbody>
</table>

Helping your patients begin statin therapy

Here are some common reasons why patients may not start statin therapy, and how you can work with them to find the right solution for them.

<table>
<thead>
<tr>
<th>Reason for not starting or continuing statin therapy</th>
<th>Suggestions for discussion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient's cholesterol level is normal or good</td>
<td>Even if the patient does not have high cholesterol, there is strong evidence from studies that if a patient has diabetes and their LDL cholesterol is anywhere from 70 to 189 mg/dL, a moderate-intensity statin reduces incidence of heart attack and stroke significantly.</td>
</tr>
<tr>
<td>History of muscle pain from statin or patient cannot tolerate statins</td>
<td>Guidelines recommend restarting the same statin at the same or lower dose once the muscle pain is resolved or trying a different statin at a low dose.</td>
</tr>
<tr>
<td>Notes:</td>
<td>- Pravastatin has the lowest incidence of myalgia.</td>
</tr>
<tr>
<td></td>
<td>- Rosuvastatin is recommended for patients with cardiovascular disease and history of myalgia.</td>
</tr>
<tr>
<td>Patient is on fenofibrate, niacin, Zetia or other non-statin cholesterol medication</td>
<td>There is no supporting evidence that adding a non-statin medication reduces the incidence of heart attack and stroke. The strongest evidence supports a moderate- or high-intensity statin in patients with diabetes to reduce the risk of heart disease (ACCORD trial).</td>
</tr>
<tr>
<td>Patient has refused statin therapy in the past</td>
<td>If a statin is appropriate for the patient, discuss the benefits of statin therapy again at their next appointment.</td>
</tr>
</tbody>
</table>

More information

Here are additional resources if you have questions about statin therapy recommendations for your patients:
- American Diabetes Association Standards of Medical Care in Diabetes–2017: care.diabetesjournals.org/content/diacare/suppl/2016/12/15/40.Supplement_1.DC1/DC_40_S1_final.pdf
- The American College of Cardiology (ACC) and American Heart Association (AHA) task force report on practice guidelines, 2013 ACC/AHA Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults: circ.ahajournals.org/content/early/2013/11/11/cir.0000437738.63853.7a
## Transitions of care (TRC)

<table>
<thead>
<tr>
<th>Ages 18 and older</th>
<th>Applies to:</th>
<th>Part of:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>□ Commercial patients</td>
</tr>
<tr>
<td></td>
<td></td>
<td>☑ Medicare Advantage patients</td>
</tr>
</tbody>
</table>

### Measure description and methodology

**An acute or non-acute inpatient admission discharge on or between January 1 and December 1 of the measurement year**

**Notification of inpatient admission:** Documention of receipt of notification of inpatient admission on the day of admission or the following day in the outpatient chart

**Receipt of discharge information:** Documention of receipt of discharge information on the day of discharge or the following day, and must be in the appropriate medical record even when the primary care or ongoing care provider is the discharging provider

**Patient engagement after inpatient discharge:**
Documentation of patient engagement within 30 days of discharge provided in the outpatient chart; do not count the date of discharge

**Medication reconciliation post-discharge:**
- Documentation of medication reconciliation on the date of discharge through 30 days after discharge (31 total days)
- This is a type of review in which the discharge medications are reconciled with the most recent medication list in the outpatient medical record and needs to include the date medication reconciliation was performed

**Methodology:** Claims, encounter data and medical record review

### Codes used in measure

**Outpatient visits:**
- **CPT:** 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99429, 99455, 99456, 99483
- **HCPCS:** G0402, G0438, G0439, G0463, T1015

**Medication Reconciliation:**
- **CPT:** 99483, 99495, 9496
- **CPT II:** 1111F

**Telehealth visits:**
- **CPT:** 98966-98968, 99441-99443
- **Modifier:** 95, GT

**Transitional Care Management Services:**
- **CPT:** 99495, 99496

**Large code sets:**
- **Inpatient stay**

### Exclusions

- Members in hospice
- An acute or non-acute inpatient stay where the discharge date occurs after December 1 of the measurement year
Use of high-risk medications in older adults (DAE)

<table>
<thead>
<tr>
<th>Ages 66+</th>
<th>Applies to:</th>
<th>Part of:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Commercial patients □ Commercial patients ✓ Medicare Advantage patients</td>
<td>☑ HEDIS chart review</td>
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<td>☑ QIP</td>
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<td>□ VBA</td>
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<td></td>
<td></td>
<td>□ QRS</td>
</tr>
</tbody>
</table>

**Measure description and methodology**

Measure assesses the percentage of Medicare members age 66 and older who had at least two dispensing events for the same high-risk medication.

**Requires:**
- At least two dispensing events for the same high-risk medication during the measurement year
- Two or more dispensing events on different dates of service
- Summed days supply exceeds the days supply criteria

**Note:** The intent is to identify all patients who had multiple dispensing events where the summed days supply exceeds the days supply criteria; there is no requirement that each dispensing event exceed the days supply criteria.

**Methodology:** Pharmacy claims

**Codes used in measure**

Billing for this measure is reliant on pharmacy claims. The results are based on medication refill history for the specified medications (NDC codes).

**Large code sets:**
- High-risk medications list
- High-risk medications with days supply criteria medications list
- High-risk medications with average daily dose criteria medications list

**Exclusion**

- Members in hospice
Use of imaging studies for lower back pain (LBP)

<table>
<thead>
<tr>
<th>Ages 18-50</th>
<th>Applies to:</th>
<th>Part of:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>✓ Commercial patients</td>
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<td></td>
<td></td>
<td>□ QRS</td>
</tr>
</tbody>
</table>

**Measure description and methodology**

Measures assesses whether imaging was performed when there is a primary diagnosis of uncomplicated low back pain.

**Requires:**
- Lower back pain primary diagnosis
- Documentation of imaging study (X-ray, MRI, CT scan) if completed

**Intake period:** January 1 through December 3 of the measurement year

**Index episode start date (IESD):** Earliest date of service for an outpatient or ED encounter for lower back pain during the intake period

**Negative diagnosis history:** The period of 180 days prior to the IESD with no visits or treatment for lower back pain

**Note:** Imaging for this measure would have occurred within 28 days of the diagnosis. Inverse measure so lower rate is better.

**Methodology:** Claims and encounter data

**Codes used in measure**

Outpatient visits:
- **CPT:** 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99429, 99455, 99456, 99483
- **HCPCS:** G0402, G0438, G0439, G0463, T1015

Osteopathic and chiropractic manipulative treatment:
- **CPT:** 98925 98929, 98940 98942

Physical therapy:
- **CPT:** 97110, 97112, 97113, 97124, 97140, 97161 97164

Telehealth visits:
- **CPT:** 98966-98968, 99441- 99443
- **Modifier:** 95, GT

Online assessments:
- **CPT:** 98969, 99444

Uncomplicated low back pain imaging study:
- **CPT:** 72020, 72052, 72100, 72110, 72114, 72120, 72131-72133, 72141, 72142, 72146-72149, 72156, 72158, 72200, 72202, 72220

**Exclusions**

- Inpatient stays resulting from ER or observation visits
- Members with cancer, HIV or major organ transplant anytime during their history through 28 days after the IESD
- Members with recent trauma anytime during the three months prior to the IESD through 28 days after the IESD
- Members with intravenous drug abuse, neurologic impairment or spinal infection anytime during the 12 months prior to the IESD through 28 days after the IESD
- Members with 90 consecutive days of corticosteroid treatment anytime during the 12 months prior to and including the IESD
- Members in hospice
Use of opioids at high dose (HDO)

<table>
<thead>
<tr>
<th>Ages 18+</th>
<th>Applies to:</th>
<th>Part of:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td>☑ QRS</td>
</tr>
</tbody>
</table>

Measure description and methodology

Measures the proportion of members who received prescription opioids at high dose.

Requires:
- Two or more opioid dispensing events on different dates of service
- 15 or more days covered by opioids

Note:
- Average morphine milligram equivalent dose (MME) greater than or equal to 90

Treatment Period starts on the earliest prescription dispense date during the measurement year and ends on the last opioid prescription dispense date during the measurement year plus days supply minus one.

Methodology: Pharmacy claims

Codes used in measure

Sickle cell anemia: ICD-10 D57.00-D57.02, D57.1, D57.20, D57.211, D57.212, D57.219, D57.40, D57.411, D57.412, D57.519, D57.80, D57.811, D57.812, D57.819

Large code sets:
- Opioid medications
- Malignant neoplasms

Exclusions

- Members with cancer
- Members with sickle cell disease
- Members in hospice
Weight assessment and counseling for nutrition and physical activity for children and adolescents (WCC)

Ages 3-17
Applies to:
☑ Commercial patients
☐ Medicare Advantage patients

Part of:
☑ HEDIS chart review
☐ QIP
☑ VBA
☑ QRS

Measure description and methodology

Measure addresses the health of the child by assessment of BMI percentile, nutritional habits and physical activity level for children and adolescents.

Requires:
- Documentation of an office visit with PCP or OBGYN
- BMI percentile documentation
- Counseling for nutrition
- Counseling for physical activity

Notes:
- BMI requires height, weight and BMI percentile from the same data source. Percentile plotted on an age growth chart is accepted.
- BMI percentile documented as a value (e.g., 85th percentile)
- BMI percentile ranges or thresholds do not meet criteria
- Nutrition counseling requires a chart note discussing current nutrition behaviors, nutritional checklist, and/or counseling
- Physical activity counseling includes discussion of current physical activity, a physical activity checklist, counseling or referral for physical activity

Methodology: Claims, encounter data and medical record review.

Codes used in measure

Outpatient visits:
- CPT: 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99429, 99455, 99456, 99483
- HCPCS: G0402, G0438, G0439, G0463, T1015

BMI Percentile:
- ICD-10-CM: Z68.51-Z68.54

Nutrition counseling:
- CPT: 97802-97804
- 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

Exclusions
- Pregnancy
- Members in hospice
Well child visits in the third, fourth, fifth and sixth years of life (W34)

<table>
<thead>
<tr>
<th>Ages 3-6</th>
<th>Applies to:</th>
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</tr>
</thead>
<tbody>
<tr>
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<td></td>
<td>☑ Medicare Advantage patients</td>
<td>☑ QRS</td>
</tr>
</tbody>
</table>

### Measure description and methodology

Measure assesses the expected routine well child visit for children within the appropriate age range.

**Requires:**
- Record of well-child visit which must include
  - Health history
  - Physical developmental history
  - Mental developmental history
  - Physical exam
  - Health education and/or anticipatory guidance

**Health history:** An assessment of the patient’s history of disease or illness. It can include, but is not limited to, past illness, surgery or hospitalization and family health history.

**Physical developmental history:** An assessment of specific age-appropriate physical developmental milestones

**Mental developmental history:** An assessment of specific age-appropriate mental developmental milestones

**Health education:** Anticipatory guidance given by the healthcare provider to parents or guardians in anticipation of emerging issues that a child and family may face.

**Methodology:** Claims and encounter data

### Codes used in measure

Well child visits:
- **CPT:** 99382-99385, 99392-99394
- **HCPCS:** G0438, G0439
- **ICD-10-CM:** Z00.00, Z00.01, Z00.110, Z00.111, Z00.2, Z00.129, Z00.5, Z00.8, Z02.0-Z02.6, Z02.71, Z02.82, Z76.1, Z76.2

### Exclusions

- Services rendered in the inpatient or emergency department settings
- Outpatient visit for treatment of an acute or chronic condition
- Members in hospice

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