Quality Measures Guide

Learn about the quality measures that we track for various programs and annual reporting. This guide includes specifications for measures from the following sources:

- Healthcare Effectiveness Data and Information Set (HEDIS®)
- Pharmacy Quality Alliance (PQA)

One source supports multiple quality programs

Each measure in this guide includes the criteria, definitions, denominators, numerators, exclusions and relevant diagnosis or procedure codes required to meet compliance for measures we track for the following quality programs, lines of business or provider agreements:

- Annual HEDIS chart review
- Total Care Shared Savings/Accountable Health Networks (AHN)
- 2024 Quality Incentive Program (QIP)

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 relations executive.

Notes:

- The diagnosis and/or procedure codes in this guide are in compliance with the *HEDIS Measure Year (MY) 2023 Volume 2 Technical Specifications*. HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA). Visit ncqa.org for more information.
- This guide is intended to help you understand the information we use to report quality data; it is not clinical advice, nor does it include recommendations.
- Reimbursement for services represented in these measures will be in accordance with the terms and conditions of your agreement with us.

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Measure name	QIP	HEDIS chart review	Total Care/ AHN
Antidepressant medication management—acute and continuation (AMM)	✓		
Appropriate Treatment for Upper Respiratory Infection (URI)			✓
Asthma medication ratio (AMR)	✓		✓
Blood pressure control for patients with diabetes (BPD)		✓	
Breast cancer screening (BCS-E)	✓		✓
Cervical cancer screening (CCS)	✓	✓	
Child and adolescent well-care visits (WCV)	✓		✓
Childhood immunization status (CIS)	✓	✓	✓
Chlamydia screening in women (CHL)	✓		
Colorectal cancer screening (COL-E)	✓		✓
Controlling blood pressure (CBP)	✓	✓	✓
Eye exam for patients with diabetes (EED)	✓	✓	✓
Follow-up after hospitalization for mental illness (FUH)	✓		
Hemoglobin A1c control for patients with diabetes (HBD)		✓	✓
Immunization for adolescents (IMA)	✓	✓	✓
Medication adherence: proportion of days covered for diabetes, renin angiotensin system antagonists and statins	✓		
Plan all-cause readmissions (PCR)			✓
Prenatal and postpartum care (PPC)		✓	
Social needs screening and intervention (SNS-E)		✓	
Statin therapy for patients with diabetes (SPD)			✓
Transitions of care (TRC)		✓	
Weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)	✓	✓	✓
Well-child visits in the first 30 months of life (6 or more visits) (W30)	✓		✓

Appendix

Advanced illness and frailty exclusions

Antidepressant medication management–acute and continuation (AMM)
Ages 18+ as of the IPSD

Measure description

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

METHODOLOGY
Medical claims, pharmacy claims and encounter data

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

REQUIRES
- Major depression diagnosis
- New prescription and refill history for antidepressant medication

Two phases included in measure:
- **Acute**–at least 84 days of continuous treatment with antidepressant medication beginning on the IPSD through 114 days after the IPSD
- **Continuation**–at least 180 days of continuous treatment with an antidepressant medication beginning on the IPSD through 231 days after the IPSD

REQUIRED EXCLUSIONS
- Members who did not have an encounter with a diagnosis of major depression during the 121-day period from 60 days prior to the IPSD, through the IPSD, and the 60 days after the IPSD
- Members who were dispensed a prescription for an antidepressant medication 105 days prior to the IPSD
- Members in hospice
- Members who died anytime during the measurement year

Codes used in measure

NUMERATOR CODES
Large code set:
- Antidepressant medications list

DENOMINATOR CODES
Standalone outpatient visits:
- **CPT** 90867-90870, 98960-98962, 98966-98972, 99078, 99205, 99211-99215, 99241-99245, 99281-99285, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99421-99423, 99441-99444, 99457, 99458, 99483, 99492-99494, 99510

- **HCPCS** G0071, G0155, G0176, G0177, G0409-G0411, G0463, G0512, G2010, G2012, G2061-G2063, G2250-G2252 H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010, H2011-H2020, S0201, S9480, S9484, S9485, T1015
- **ICD-10-PCS** GZB0ZZZ-GZB4ZZZ

Visits that require place of service (POS)
- **CPT** 90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221-99223, 99231-99233, 99238, 99239, 99252-99255
- **POS** 02, 03, 05, 07, 09, 11-20, 22, 23, 33, 49, 50, 52, 53, 71, 72

Acute inpatient:
- **CPT** 99221-99223, 99231-99236, 99238, 99239, 99251-99255, 99291

Non-acute inpatient:
- **CPT** 99304-99310, 99315, 99316

Major depression diagnosis:
- **ICD-10-CM** F32.0-F32.4, F32.9-F33.3, F33.41, F33.9

Hospice:
- **CPT** 99377, 99378
- **HCPCS** G0182, G9473-G9479, Q5003-Q5008, Q5010, S9126, T2042-T2046

Large code sets:
- Antidepressant medications list
- Inpatient stay

Appropriate treatment for upper respiratory infection (URI)

Ages 3 months or older on the episode date

Measure description

Measure assesses the percentage of episodes for members 3 months of age or older with a diagnosis of upper respiratory infection (URI) that did not result in an antibiotic dispensing event.

METHODOLOGY

Medical claims, pharmacy claims and encounter data

Definitions

Intake period	July 1 of the year prior to the measurement year to June 30 of the measurement year. The intake period captures eligible episodes of treatment.
Episode date	The date of service for any outpatient, telephone or ED visit, e-visit or virtual check-in during the intake period with a diagnosis of URI.
Negative medication history	To qualify for negative medication history, the following criteria must be met: - A period of 30 days prior to the episode date when the member had no pharmacy claims for either new or refill prescriptions for a listed antibiotic drug. - No prescriptions dispensed more than 30 days prior to the episode date that are active on the episode date. A prescription is considered active if the “days supply” indicated on the date when the member was dispensed the prescription is the number of days or more between that date and the relevant service date. The 30-day look-back period for pharmacy data includes the 30 days prior to the intake period.
Negative comorbid condition history	A period of 365 days prior to and including the episode date when the member had no claims/encounters with any diagnosis for a comorbid condition (366 days total).
Negative competing diagnosis	The episode date and 3 days following the episode date when the member had no claims/encounters with a competing diagnosis.

REQUIRES
Dispensed prescription for an antibiotic medication from the AAB Antibiotic Medications List on or 3 days after the episode date.

REQUIRED EXCLUSIONS
- Members in Hospice
- Members who died anytime during the measurement year

Remove episode dates where the member had a claim/encounter with any diagnosis for a comorbid condition (Comorbid Conditions Value Set) during the 12 months prior to or on the episode date. **Note**: Do not include laboratory claims (claims with POS code 81).

Remove episode dates where a new or refill prescription for an antibiotic medication (AAB Antibiotic Medications List) was dispensed 30 days prior to the episode date or was active on the episode date.

Remove episode dates where the member had a claim/encounter with a competing diagnosis on or three days after the episode date. Either of the following meets criteria for a competing diagnosis. Do not include laboratory claims (claims with POS code 81).

- Pharyngitis Value Set.
- Competing Diagnosis Value Set.

Codes used in measure

DENOMINATOR CODES
Outpatient, ED and Telehealth

- **CPT** 99396, 99397,99401-99404, 99411,99412,99421-99423, 99429, 99441-99443,099455-99458, 99438,HCPCS G0071, G0402, G0438, G0439,G0463, G2010, G0212, G2250- G2252, T1015

Pharyngitis

- J02.0, J02.8, J02.9, J03.00, J03.01, J03.80, J03.81, J03.90, J03.91
- URI – J00, J06.0, J06.9

NUMERATOR CODES

Hospice Encounter

- **HCPCS** G9473-G9479, Q5003- G5008, Q5010, S9126, Q5010, T2042-T2046

Hospice Intervention

- **CPT** 99377,99378
- **HCPCS** G0182

LARGE CODE SETS
- Comorbid conditions
- Competing Diagnosis
- Inpatient Stay

Asthma medication ratio (AMR)
Ages 5-64

Measure description

Measure assesses the percentage of members ages 5 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.

METHODOLOGY
Medical claims, pharmacy claims and encounter data

REQUIRES
- At least one emergency department (ED) visit, acute inpatient encounter or acute inpatient discharge, with a principal diagnosis of asthma
- At least four outpatient visits, telephone visits, e-visits or virtual check-ins, (on different dates of service) with any diagnosis of asthma and at least two asthma medication-dispensing events for any controller or reliever medication, **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.

REQUIRED 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
  - Chronic obstructive pulmonary disease (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
- Members who died anytime during the measurement year

Codes used in measure

Denominator codes
Outpatient and telehealth visit:
- **CPT** 98966-98668, 98970-98972, 98980, 98981, 99202-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99421-99423, 99429,99441-99443 99455-99458, 99483
- **HCPCS** G0071, G0402, G0438, G0439, G0463, G2010, G2012, G2250-G2252, T1015

ED and acute inpatient:
- **CPT** 99221-99223, 99231-99236, 99238, 99239, 99251-99255, 99281-99285, 99291

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

Hospice:

- **CPT** 99377, 99378
- **HCPCS** G0182, G9473 – G9479, Q5003 – Q5008, Q5010, S9126, T2042 – T2046

Respiratory diseases with different treatment approaches than asthma:

- **ICD-10** E84.0, E84.11, E84.19, E84.8, E84.9, J43.0-J43.2, J43.8-J44.1, J44.9, J68.4, J96.00-J96.02, J96.20-J96.22, J98.2, J98.3

Large code sets:
- Asthma controller medications and reliever medications
- Inpatient stay
- Nonacute inpatient stay

Blood pressure control for patients with diabetes (BPD)

Ages 18-75

Measure description

The percentage of members 18-75 years of age with diabetes (Type 1 or Type 2) whose blood pressure was adequately controlled (<140/90 mm Hg) during the measurement year

METHODOLOGY:

Claims, encounter data, pharmacy data and medical record review

REQUIRES:

- Members who had at least two diagnoses of diabetes on different dates of service during the measurement year, or year prior to the measurement year.
- Members who were dispensed insulin or hypoglycemics/antihyperglycemic during the measurement year of the year prior to the measurement year.

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 telephone visit, e-visit, virtual check-in or reported by the member

REQUIRED EXCLUSIONS

- Members in hospice
- Members receiving palliative care during the measurement year
    - **Note**: Do not include laboratory claims with POS 81
- Members who died anytime during the measurement year

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) anytime during the measurement year
    - Living long-term in an institution anytime 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 two indications of frailty (with different dates of service) 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
    - Advanced illness on at least two different dates of service

Codes used in measure

NUMERATOR CODES

Blood pressure:

- **CPT II** 3074F, 3075F, 3077F, 3078F, 3079F, 3080F
- **CPT CAT II** Modifier 1P, 2P, 3P, 8P

DENOMINATOR CODES

Acute inpatient visit:

- **CPT** 99221-99223, 99231-99236, 99238, 99239, 99251-99255, 99291
- **POS** 21,51

Online assessment:

- **CPT** 98969-98972, 98980, 98981, 99421-99423, 99444, 99457, 99458
- **HCPCS** G0071, G2010, G2012, G2061-G2063, G2250-G2252

Observation visit:

- **CPT** 99217-99220

ED visit:

- **CPT** 99281-99285
- **POS** 23

Large code sets:

- Diabetes value
- Diabetes medications list
- Frailty
- Advanced illness diagnosis
- Dementia medications list

REQUIRED EXCLUSION CODES

Hospice:

- **CPT** 99377, 99378
- **HCPCS** G0182, G9473-G9479, Q5003-Q5008, Q5010, S9126, T2042-T2046

Palliative care:

- **HCPCS** M1017
- **ICD-10** Z51.5

Breast cancer screening (BCS)

Ages 52-74 as of December 31 of the measurement year

Measure description

Measure addresses the prevalence of routine breast cancer screenings.

METHODOLOGY

Claims and encounter data

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
- Sex assigned at birth of female
- Administrative gender of female at any time in the members history

REQUIRED EXCLUSIONS

Any time in history:

- Bilateral mastectomy
- Unilateral mastectomy (with bilateral modifier)
- History of bilateral mastectomy
- A unilateral mastectomy with a left-side modifier
- A unilateral mastectomy with a right-side modifier
- Absence of right/left breast
- Members in hospice
- Members receiving palliative care during the measurement period
- Members who had gender affirming chest surgery with a diagnoses of gender dysphoria anytime during the members history through the end of the measurement period

Members receiving palliative care during the measurement year

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) anytime during the measurement year
  - Living long-term in an institution anytime 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 two indications of frailty, (with different dates of service), 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
  - Advanced illness on at least two different dates of service.

Codes used in measure

NUMERATOR CODES
Mammogram:
- **CPT** 77061-77063, 77065-77067

DENOMINATOR CODES

Administrative gender of female: **Administrative gender code** F

Sex assigned at birth of female: **LOINC** 76689-9, LA3-6

REQUIRED EXCLUSION CODES
Mastectomy:
- History of bilateral mastectomy: **ICD-10-CM** Z90.13
- Bilateral mastectomy: **ICD-10-PCS** 0HTV0ZZ
- Unilateral mastectomy: **CPT** 19180, 19200, 19220, 19240, 19303-19307
- Unilateral mastectomy right: **ICD-10-PCS** 0HTT0ZZ
- Unilateral mastectomy left: **ICD-10-PCS** 0HTU0ZZ
- Members who had gender affirming chest surgery with a diagnosis of gender dysphoria any time during the members history through the end of the measurement period. CPT 19318

Modifiers for mastectomy:
- **Left**: LT
- **Right**: RT
- **Bilateral**: 50

Absence of right breast:
- **ICD-10-CM** Z90.11

Absence of left breast:
- **ICD-10-CM** Z90.12

Palliative care:
- **HCPCS** G9054, M1017
- **ICD-10-CM** Z51.5

Gender dysphoria:
- **ICD-10-CM** F64.1, F64.2, F64.8, F64.9

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

Cervical cancer screening (CCS)

Ages 24-64 as of December 31 of the measurement year

Measure description

Measure assesses preventive cervical cancer screenings based on the following criteria:

- 21 to 64 year-old members recommended cervical cytology every three years
- 30 to 64 year-old members who had cervical cytology and high-risk HPV co-testing within the last five years
- 30 to 64 year-old members who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last five years

METHODOLOGY

Claims, encounter data and medical record review

REQUIRES

- Cervical cancer screening
- HPV testing (if appropriate)
- Administrative gender of female,
- Sex assigned at birth of female
- Sex parameter for clinical use of female during the measurement year

Note:

- For medical record review, count any cervical cancer screening method that includes collection and microscopic analysis of cervical cells
- Unknown is not considered a result/finding for medical record reporting

REQUIRED EXCLUSIONS

- Members in hospice
- Members receiving palliative care during the measurement year
- Any of the following anytime during the member's history through December 31 of the measurement year:
  - Hysterectomy with no residual cervix, cervical agenesis, or acquired absence of cervix
  - Documentation of "complete," "total" or "radical" hysterectomy
  - Documentation of "vaginal hysterectomy"
  - Exclude incomplete labs and labs where results indicate "no cervical cells were present"
  - Exclude biopsies
  - Reflex testing
  - Members who died anytime during the measurement year
  - Members who use hospice services or elect to use a hospice benefit during the measurement year
  - Members receiving palliative care or had an encounter for palliative care during the measurement year.
  - Members who died anytime during the measurement year
  - Members assigned as male at birth

Note:
- Documentation of hysterectomy alone does not meet the criteria, because it is not sufficient evidence that the cervix was removed.
- Unknown is not considered a result/finding for medical record reporting

Codes used in measure

NUMERATOR CODES

Cervical cytology (Pap tests):
- **CPT** 88141-88143, 88147, 88148, 88150, 88152-88153, 88164-88167, 88174, 88175
- **HCPCS** G0123, G0124, G0141, G0143-G0145, G0147, G0148, P3000, P3001, Q0091

HPV tests:
- **CPT** 87624, 87625
- **HCPCS** G0476
- **SNOMED** 718591004

DENOMINATOR CODES
- **Administrative gender code** F
- Sex assigned at birth of female: **LOINC** 76689-9, LA3-6
- Sex parameter for clinical use of female during the measurement year

REQUIRED EXCLUSION CODES

Sex assigned at birth of male: **LOINC** 76689-9, LA2-8

Absence of cervix:
- **ICD-10**: Q51.5, Z90.710, Z90.712

Hysterectomy with no residual cervix:
- **CPT** 57530, 57531, 57540, 57545, 57550, 57555, 57556, 58150, 58152, 58200, 58210, 58240, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290-58294, 58548, 58550, 58552-58554, 58570-58573, 58575, 58951, 58953, 58954, 58956, 59135
- **ICD-10** 0UTC0ZZ, 0UTC4ZZ, 0UTC7ZZ, 0UTC8ZZ

Palliative care:
- **HCPCS** M1017

Hospice:
- **CPT** 99377, 99378
- **HCPCS** G0182, G9473-G9479, Q5003-Q5008, Q5010, S9126, T2042-T2046

Child and adolescent well-care visits (WCV)
Ages 3-21

Measure description
Measure assesses the percentage of members who had at least one comprehensive well-care visit with a PCP or OB/GYN during the measurement year

METHODOLOGY
Claims and encounter data

REQUIRES
One or more well-care visits during the measurement year that occurred with a PCP or an OB/GYN

REQUIRED EXCLUSIONS
- Members in hospice
- Members who died anytime during the measurement year
- **Note**: Do not include laboratory claims with POS code 81

Codes used in measure
NUMERATOR CODES

Well-care visits:
- **CPT** 99381-99385, 99391-99395, 99461
- **HCPCS** G0438, G0439, S0302, S0610, S0612, S0613
- **ICD-10-CM** Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.2, Z00.3, Z01.411, Z01.419, Z02.5, Z76.1, Z76.2

REQUIRED EXCLUSION CODES:

Hospice:
- **CPT** 99377, 99378
- **HCPCS** G0182, G9473-G9479, Q5003-Q5008, Q5010, S9126, T2042-T2046

Childhood immunization status (CIS)

Age 2 during the measurement year

Measure description

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

METHODOLOGY

Claims, encounter data and medical record review

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 DTaP count any of the following:
  - Evidence of the antigen or combination vaccine
  - Anaphylaxis due to the vaccine
  - Encephalitis due to the vaccine
- For MMR, VZV, hepatitis A,, and hepatitis B count any of the following:
  - Evidence of the antigen or combination vaccine
  - Documented history of the illness
  - Anaphylaxis due to the vaccine
- For IPV, Pneumococcal conjugate, influenza, HiB, and rotavirus, count either:
  - Evidence of the antigen or combination vaccine
  - Anaphylaxis due to the vaccine
- For influenza, the LAIV vaccination must occur on the child's second birthday
- Each antigen is reported separately so make sure all immunizations are reflected in the claim submitted for visit.

REQUIRED EXCLUSIONS

- Members in hospice
- Members who died anytime during the measurement year
- Members who had any of the following on or before their second birthday:
  - Severe combined immunodeficiency
  - Immunodeficiency
  - HIV/HIV Type 2
  - Lymphoreticular cancer, multiple myeloma or leukemia
  - Intussusception
  - **Note:** Do not include laboratory claims with POS 81

Codes used in measure

NUMERATOR CODES

DTaP:

- **CPT 90697,** 90698, 90700, 90723

Anaphylaxis due to Diphtheria, Tetanus or Pertussis Vaccine:

- **SNOMED** 428281000124107, 428291000124105

Encephalitis due to Diphtheria, Tetanus or Pertussis Vaccine:

- **SNOMED** 192710009, 192711008, 192712001

IPV

- **CPT** 90697**,** 90698, 90713, 90723

Anaphylaxis due to the IPV vaccine:

- **SNOMED** 471321000124106

MMR:

- **CPT** 90707, 90710

Measles:

- **ICD-10-CM** B05.0 B05.1, B05.2, B05.3, B05.4, B05.81, B05.89, B05.9

Mumps:

- **ICD-10-CM** B26.0, B26.1, B26.2. B26.3, B26.81-B26.85, B26.89, B26.9

Rubella:

- **ICD-10-CM** B06.00, B06.01, B06.02, B06.09, B06.81, B06.82, B06.89, B06.9,

Anaphylaxis due to the MMR vaccine:

- **SNOMED** 471331000124109

HiB:

- **CPT** 90644, 90647, 90648, 90697, 90698, 90748

Anaphylaxis due to HiB Vaccine:

- **SNOMED** 433621000124101

HepB:

- **CPT 90697,** 90723, 90740, 90744, 90747, 90748
- **HCPCS** G0010
- **ICD-10-CM** B16.0, B16.1, B16.2, B16.9, B17.0, B18.0, B18.1, B19.10, B19.11
- **ICD-10-PCS** 3E0234Z

Anaphylaxis due to Hepatitis B Vaccine:

- **SNOMED** 428321000124101

VZV:

- **CPT** 90710, 90716
- **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

Anaphylaxis due to Varicella Zoster Vaccine:

- **SNOMED** 471341000124104

PCV:

- **CPT** 90670, 90671
- **HCPCS** G0009

Anaphylaxis due to Pneumococcal Conjugate Vaccine:
- **SNOMED** 471141000124102

HepA:
- **CPT** 90633
- **ICD-10-CM** B15.0, B15.9

Anaphylaxis due to Hepatitis A Vaccine:
- **SNOMED** 471311000124103

RV:
- **CPT** 90680, 90681

Anaphylaxis due to Rotavirus Vaccine:
- **SNOMED** 428331000124103

Flu:
- **CPT** 90655, 90657, 90660, 90661, 90672, 90673, 90674, 90685-90689, 90756
- **HCPCS** G0008

Anaphylaxis due to Influnezae Vaccine:
- **SNOMED** 471361000124100

REQUIRED EXCLUSION CODES
- Members who die during the measurement year

Hospice:
- **CPT** 99377, 99378
- **HCPCS** G0182, G9473-G9479, Q5003-Q5008, Q5010, S9126, T2042-T2046

Large code sets:
- Contraindications to Childhood Vaccines

Chlamydia screening in women (CHL)
Ages 16-24

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

METHODOLOGY
Medical or prescription claims and encounter data

REQUIRES
- Documentation of sexual activity status
- Chlamydia testing

REQUIRED 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
- Members who died anytime during the measurement year

Codes used in measure
NUMERATOR CODES
Chlamydia test:
- **CPT** 0353U**,** 87110, 87270, 87320, 87490-87492, 87810

DENOMINATOR CODES
Pregnancy tests:
- **CPT** 81025, 84702, 84703

Large code sets:
- Sexual activity codes
- Contraceptive medications list
- Retinoid medications list
- Diagnostic radiology codes

REQUIRED EXCLUSION CODES
Members who died during the measurement year

Hospice:
- **CPT** 99377, 99378
- **HCPCS** G0182, G9473-G9479, Q5003-Q5008, Q5010, S9126, T2042-T2046

Colorectal cancer screening (COL)

Ages 46–75 years as of December 31 of the measurement year

Measure description

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

METHODOLOGY

Claims and encounter data

REQUIRES

A colorectal cancer screening in the appropriate time (including measurement year):

- Colonoscopy—10 years
- CT colonography—5 years
- Flexible sigmoidoscopy—5 years
- sDNA FIT (Cologuard)—3 years
- FOBT/FIT—measurement year only

EXCLUSIONS

Any time in history:

- Colorectal cancer
- Total colectomy
- **Note**: Do not include laboratory claims with POS 81

Any time during the measurement year:

- Members in hospice
- Members receiving palliative care
- Members who died

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 (SNP) anytime during the measurement year
  - Living long-term in an institution anytime during the measurement year as identified in the monthly membership detail data file
- Members 66 years of age 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 two indications of frailty with different dates of service 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 dispensed dementia medication
     - Advanced illness on at least two different dates of service

Codes used in measure

NUMERATOR CODES

FOBT:
- **CPT** 82270, 82274
- **HCPCS** G0328

Flexible sigmoidoscopy:
- **CPT** 45330-45335, 45337, 45338, 45340-45342, 45346, 45347, 45349, 45350
- **HCPCS** G0104
- **SNOMED** 841000119107

Colonoscopy:
- **CPT** 44388-44394, 44397, 44401-44408, 45355, 45378-45393, 45398
- **HCPCS** G0105, G0121
- **SNOMED** 851000119109

CT colonography:
- **CPT** 74261-74263

sDNA FIT test:
- **CPT** 81528
- **SNOMED** 708699002

REQUIRED EXCLUSION CODES

Colorectal cancer:
- **ICD-10-CM** C18.0-C19, C20, C21.2, C21.8, C78.5, Z85.038, Z85.048

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

Palliative care:
- **HCPCS** M1017
- **ICD-10- CM** CODE Z51.5

Colorectal cancer:
- **ICD-10-CM** C18.0-C19, C20, C21.2, C21.8, C78.5, Z85.038, Z85.048

Total colectomy:
- **CPT** 44150-44153, 44155-44158, 44210-44212
- **ICD-10-PCS** 0DTE0ZZ, 0DTE4ZZ, 0DTE7ZZ, 0DTE8ZZ
- **SNOMED** 119771000119101

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

Controlling blood pressure (CBP)

Ages 18-85

Measure description

Measure assesses the routine monitoring of the diagnosis of hypertension. Controlled blood pressure: <140/90 during the measurement year

METHODOLOGY

Claims, encounter data and medical record review

REQUIRES

- Two visits on different dates of service with a diagnosis of hypertension on or between January 1 of the year prior to the measurement year and June 30 of the measurement year.
- 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 on the same day as or later than the second hypertension diagnosis and must occur within the measurement year.

Note: Member reported blood pressure readings that meet the current blood pressure reporting criteria can be used when captured via audio or video or electronically.

REQUIRED EXCLUSIONS

- Dialysis
- Pregnancy
- End-stage renal disease
- Nephrectomy
- 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
- Taken by the member using a non-digital device such as a manual blood pressure cuff and a stethoscope
- Members in hospice
- Members receiving palliative care during the measurement year
- Members who died anytime during the measurement year

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 (SNP) anytime during the measurement year
    - Living long-term in an institution anytime 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 two indications of frailty with different dates of service 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 dispensed dementia medication

- Members 81 and older as of December 31 of the measurement year with at least two indications of frailty with different dates of service during the measurement year

Codes used in measure

NUMERATOR CODES
Blood pressure:
- **CPT II** 3074F, 3075F, 3077F, 3078F, 3079F, 3080F
- **Note:** Do not include any of these CPT II codes if they have one of the following modifiers: 1P,2P, 3P, 8P

DENOMINATOR CODES
Diagnosis of hypertension:
- ICD-10-CM I10

Outpatient and telehealth visit:
– **CPT** 98966 – 98668, 98970-98972, 98980,98981**,** 99202 -99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99421-99423, 99429,99441-99443 99455-99458, 99483
– **HCPCS**, **HCPCS** G0071**,** G0402, G0438, G0439, G0463**,** G2010, G2012, G2250-G2252, T1015

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

REQUIRED EXCLUSION CODES
Dialysis:
- **CPT** 90935, 90937, 90945, 90947, 90997, 90999, 99512
- **HCPCS** G0257, S9339
- **ICD-10-PCS** 3E1M39Z, 5A1D00Z, 5A1D60Z, 5A1D70Z, 5A1D80Z, 5A1D90Z

End stage renal disease:
- **ICD-10-CM** N18.5, N18.6, Z99.2

Nephrectomy:
- **CPT** 50220, 50225, 50230, 50234, 50236, 50240, 50340, 50370, 50543, 50545, 50546, 50548
- **ICD-10-PCS** 0TB00ZZ, 0TB03ZZ, 0TB04ZZ, 0TB07ZZ, 0TB08ZZ, 0TB10ZZ, 0TB13ZZ, 0TB14ZZ, 0TB17ZZ, 0TB18ZZ, 0TT00ZZ, 0TT04ZZ, 0TT10ZZ, 0TT14ZZ, 0TT20ZZ, 0TT24ZZ

Kidney transplant:
- **CPT** 50360, 50365, 50380
- **HCPCS** S2065
- **ICD-10-CM** Z94.0
- **ICD-10-PCS** 0TY00Z0-0TY00Z2, 0TY10Z0-0TY10Z2

Palliative Care:
- **HCPCS** M1017
- **ICD-10-CM** Z51.5
- **Note:** Do not include laboratory claims with POS 81

Acute inpatient visit:
- **CPT** 99221-99223, 99231-99236, 99238, 99239, 99251-99255, 99291 POS 21, 51

ED visit:
- **CPT** 99281-99285
- **POS** 23

Large code sets:
- Frailty diagnosis
- Advanced illness diagnosis
- Dementia medication list
- Pregnancy diagnosis
- Inpatient Stay
- Non-acute inpatient stay

Eye exam for patients with diabetes (EED)
Ages 18-75

Measure description
The percentage of members 18-75 years of age with diabetes (Type 1 or Type 2) who had a retinal eye exam

METHODOLOGY
Claims, encounter data, pharmacy data and medical record review

REQUIRES
Members who had at least two diagnoses of diabetes on different dates of service during the measurement year, or year prior to the measurement year.

- Members who were dispensed insulin or hypoglycemics/antihyperglycemic during the measurement year of the year prior to the measurement year Retinal exam
- Retinal or dilated eye exam by an optometrist or ophthalmologist during the measurement year; 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
- A chart note or photograph indicating the date when the fundus photography was performed and one of the following:
  - Evidence that an eye care professional reviewed the results
  - Evidence that the results were read by a qualified reading center that operates under the direction of a medical director who is a retinal specialist
  - Evidence that results were read by a system that provides artificial intelligence (AI) interpretation

REQUIRED EXCLUSIONS
- Members in hospice
- Members receiving palliative care during the measurement year or having an encounter using ICD-10 CM Z51.5
- Members who died anytime during the measurement year

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) anytime during the measurement year
  - Living long-term in an institution anytime 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 two indications of frailty (with different dates of service) during the measurement year. Do not include laboratory claims with POS 81.
  2. Either of the following during the measurement year or the year prior to the measurement year (count services that occur over both years):

- A diagnosis of advanced illness on at least two different dates of service
- A dementia medication dispensed

Notes:

- Blindness is not an exclusion for a diabetic eye exam because it is difficult to distinguish between individuals who are legally blind but require a retinal exam and those who are completely blind and do not require an exam.
- Hypertensive retinopathy is not handled differently from diabetic retinopathy: for example, an eye exam documented as positive for hypertensive retinopathy would count as positive.
- If one eye is not accessible, leading to an indeterminate result, this is not considered a result/finding
- An eye exam result documented as "unknown" does not meet criteria

Codes used in measure

NUMERATOR CODES

Diabetic retinal screening:

- **CPT** 67028, 67030, 67031, 67036, 67039-67043, 67101, 67105, 67107, 67108, 67110, 67113, 67121, 67141, 67145, 67208, 67210, 67218, 67220, 67221, 67227, 67228, 92002, 92004, 92012, 92014, 92018, 92019, 92134, 92201, 92202, 92227, 92228, 92230, 92235, 92240, 92250, 92260, 99203-99205, 99213-99215, 99242-99245
- **HCPCS** S0620, S0621, S3000

Diabetic retinal screening negative in prior year:

- **CPT II** 3072F

Eye exam with retinopathy:

- **CPT II** 2022F, 2024F, 2026F
- **Note:** Do not include these codes with a CPT II modifier 1P, 2P, 3P, 8P

Eye exam without retinopathy:

- **CPT II** 2023F, 2025F, 2033F
- **Note:** Do not include these codes with a CPT II modifier 1P, 2P, 3P, 8P

Automated eye exam:

- **CPT** 92229

Unilateral eye enucleation:

- **CPT** 65091, 65093, 65101, 65103, 65105, 65110, 65112, 65114
- Left**: ICD-10-PCS** 08T1XZZ
- Right: **ICD-10-PCS** 08T0XZZ
- Bilateral: **Modifier** 50

Diabetes without complications:

- **ICD-10-CM** E10.9, E11.9, E13.9

Large code sets:

- Diabetes diagnosis
- Diabetes medications list

REQUIRED EXCLUSION CODES

Palliative care:

- **HCPCS** G9054, M1017
- **ICD-10-CM** Z51.5
- **Note**: Do not include lab claims with POS code 81

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

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

The member's coverage for diabetic eye exams 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/learn-about-eye-health**.
- The Centers for Disease Control and Prevention (CDC) resources for diabetes prevention and management: **cdc.gov/diabetes/professional-info**.

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.

Follow-up after hospitalization for mental illness (FUH)

Ages 6+ as of the date of discharge

Measure description

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

Includes:

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

METHODOLOGY
Medical claims and encounter data

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

Notes: The following meet criteria for a follow-up visit:

- An outpatient visit with a mental health provider
- An intensive outpatient encounter or partial hospitalization
- A community mental health center visit
- Electroconvulsive therapy
- A telehealth visit with a mental health provider
- An observation visit with a mental health provider
- Transitional care management services with a mental health provider
- A visit in a behavioral healthcare setting
- A telephone visit with a mental health provider
- Psychiatric collaborative care management

REQUIRED EXCLUSIONS
- Members in hospice
- Members who died anytime during the measurement year
- Exclusions: Members with a discharge that occurs after December 1 of the measurement year
- Members with discharges or direct transfers to a nonacute inpatient care setting within the 30-day follow-up period

Codes used in measure

NUMERATOR CODES

Behavioral health outpatient:

- **CPT** 98960-98962, 99078, 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99483, 99492-99494, 99510
- **HCPCS** G0155, G0176, G0177, G0409, G0463, G0512, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013-H2020, T1015

Behavioral healthcare setting:

- **UBREV** 0513, 0515-0517, 0519-0523, 0526-0529, 0900-0905, 0907, 0911-0917, 0919, 0982, 0983

Electroconvulsive therapy:

- **CPT** 90870
- **ICD-10-PCS** GZB0ZZZ, GZB1ZZZ, GZB2ZZZ, GZB3ZZZ, GZB4ZZZ
- **POS** 24,52, 53

Partial hospitalization or intensive outpatient:

- **HCPCS** G0410, G0411, H0035, H2001, H2012, S0201, S9480, S9484, S9485
- **POS** 52

Psychiatric collaborative care management:

- **CPT** 99492-99494
- **HCPCS** G0512

Telephone visits:

- **CPT** 98966-98968, 99441-99443
- **POS** 02,10

Transitional care management services:

- **CPT** 99495, 99496

Visit setting unspecified:

- **CPT** 90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221-99223, 99231-99233, 99238, 99239, 99252 -99255
- **POS** Code 52
- **Outpatient POS** 03, 05, 07, 09, 11-20, 22, 33, 49, 50, 71, 72
- **Community mental health center POS** 53
- **Ambulatory surgical center POS** 24

REQUIRED EXCLUSION CODES:

Hospice intervention:

- **CPT** 99377, 99378
- **HCPCS** G0182

Hospice encounter:

- **HCPCS** G9473-G9479, Q5003- G0182, Q5003- Q5008, Q5010, T2042-T2046

DENOMINATOR CODES

Large code sets:

- Mental illness and intentional self-harm
- Inpatient stay
- Intentional self-harm (for readmit only, in with mental conjunctional health diagnosis)
- Non-acute inpatient stay
- Mental health diagnosis
- Mental health practitioner

Hemoglobin A1c control for patients with diabetes (HBD)

Ages 18-75

Notes:

- This measure will change to Glycemic Status Assessment for patients with Diabetes (GSD) for HEDIS MY2024
- For the 2024 MA QIP, we will accept glucose management indicator (GMI) reporting and updated the denominator in addition to the criteria listed below.

Measure description

The percentage of members 18-75 years of age with diabetes (types 1 and 2) whose most recent glycemic status (hemoglobinA1c [HbA1C] or GMI was the following levels during the measurement year:

- Glycemic status <8.0%
- Glycemic status >9.0%

METHODOLOGY

Claims, encounter data, pharmacy data, and medical record review

REQUIRES

Diagnosis of diabetes (type 1 or 2) during the measurement year or year prior by:

- Claims / encounter data, members need to have two diagnoses of diabetes on different dates of service during the measurement year or the year prior. Members were dispensed hypoglycemic/antihyperglycemics or insulin on an ambulatory basis during the measurement year or the year prior

Notes:

- Results must be 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, HB1c, glycohemoglobin, glycated hemoglobin or glycosylated hemoglobin

REQUIRED EXCLUSIONS

- Members in hospice during the measurement year
- Members receiving palliative care during the measurement year
    - Members who have a palliative care visit Z51.5
- Members who died anytime during the measurement year

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) anytime during the measurement year
    - Living long-term in an institution anytime 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 two indications of frailty with different dates of service 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
    - Advanced illness on at least two different dates of service

Codes used in measure

NUMERATOR CODES

HgbA1c blood test:
- **CPT** 83036, 83037
- **CPT II** (**Note:** Do not include modifiers)
    - HbA1c Level <7.0%—3044F
    - HbA1c Level ≥7.0-<8.0%—3051F
    - HbA1c Level ≥8.0-≤9.0%—3052F
    - HbA1c Level >9.0—3046F

DENOMINATOR CODES

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

REQUIRED EXCLUSION CODES

Palliative care encounter:
- **HCPCS** M1017
- **ICD10** CM Z51.5
- **Note**: Do not include laboratory claims with POS 81

Hospice intervention:
- **CPT** 99377,99378
- **HCPCS** G0182

Hospice encounter:
- **HCPCS** G9473-G9479, Q5003-Q5008, Q5010, S9126, T2042-T20

Immunizations for adolescents (IMA)
Age 13 during the measurement year

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

METHODOLOGY
Claims, encounter data and medical record review

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

Notes:
- The antigen and the date it was administered must be documented.
- Two-dose HPV requires 146 days between doses
- For Tdap count any of the following:
  - Evidence of the antigen or combination vaccine
  - Anaphylaxis due to the vaccine
  - Encephalitis due to the vaccine
- For meningococcal and HPV count either:
  - Evidence of the antigen or combination vaccine
  - Anaphylaxis due to the vaccine

Standard schedule:
- Meningococcal serogroups A, C, W, Y on or between 11th and 13th birthday.
- Tdap on or between 10th and 13th birthday
- HPV on or between 9th and 13th birthday

REQUIRED EXCLUSIONS
- Members in hospice
- Members who died anytime during the measurement year

Codes used in measure
NUMERATOR CODES
Meningococcal:
- **CPT** 90619, 90733, 90734

Anaphylaxis due to Meningococcal vaccine:
- **SNOMED** 428301000124106

Tdap vaccine procedure
- **CPT** 90715

Anaphylaxis due to Tdap vaccine:
- **SNOMED** 428281000124107, 428291000124105

Encephalitis due to Tdap vaccine:
- **SNOMED** 192710009, 192711008, 192712001

HPV:
- **CPT** 90649-90651

Anaphylaxis due to HPV vaccine:
- **SNOMED** 428241000124101

REQUIRED EXCLUSIONS:
Hospice intervention and encounter:
- **HCPCS** G9473-G9479, Q5003- G0182, Q5003- Q5008, Q5010, T2042-T2046

Medication adherence

Applies to Medicare Star Ratings and Quality Rating System (QRS)/Marketplace
18 years and older

Measure description

The percentage of members 18 years and older who have two or more fills of a qualifying medication on unique dates of service who fill their prescription often enough to cover 80% or more of the time during the measurement period.

METHODOLOGY
Pharmacy claims

Measure	Drug classes included	Exclusions (Any time during measurement year)
Medication adherence for diabetes	Biguanides, sulfonylureas, thiazolidinediones, dipeptidyl peptidase IV (DPP-IV) inhibitors, GIP/GLP-1 receptor agonists , meglitinides, and sodium-glucose cotransporter-2 (SGLT2) inhibitors	• ESRD or dialysis • Hospice or using hospice services • One or more prescription claim for insulin
Medication adherence for hypertension (RAS antagonists)	Angiotensin-converting enzyme (ACE) inhibitors, angiotensin receptor blockers (ARBs) and direct renin inhibitors	• ESRD or dialysis • Hospice or using hospice services • One or more prescription claim for Entresto (sacubitril/valsartan)
Medication adherence for cholesterol (statins)	Statins	• ESRD or dialysis • Hospice or using hospice services

Gaps are identified when a patient does not adhere to their target medication(s) as prescribed by the provider. Adherence rates are measured in terms of Proportion of Days Covered (PDC) defined as percent days in the measurement period "covered" by prescription claims for at least one drug in the target drug classes. The number of days covered is based on the prescription fill date and days' supply and calculated by dividing the number of covered days by number of days in the measurement period.

Patients should be filling their prescription to have enough medication to cover 80% or more of the time during the measurement period.

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.

- Help the patient refill their medication by the "Must Fill By" date to help them become adherent.
- Switch the prescription to a 90- or 100-day supply to help the patient save money and time

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:

- 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 are more nonadherent to their medications, so consider treating the depression first.
- Look for and address social determinants of health (SDoH) barriers such as transportation, financial, housing, food insecurity, etc.

Address the problem

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

Scenario	Possible solutions
Forgetfulness	- 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 switch to a 90- or 100-day supply through their pharmacy.
Side effects	- Ask. Some patients may not admit to side effects without being prompted. - Change the dose. - Prescribe an alternative medication. - Suggest ways to manage or reduce side effects.
Poor understanding/ Health literacy	- Explain how the patient's disease affects the body and use teach-back to ensure your patient understands. - Suggest pharmacy counseling - Use plain language. Instead of saying, "This will treat your hypertension," say, "Let's try this for your high blood pressure." - 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." - Highlight importance of controlling the medical condition being treated, even if symptoms are not present

Cost	- Determine if any medications can be safely discontinued. - Prescribe generics or lower-cost alternatives when possible. - Prescribe up to a 90-day supply. - Encourage patients to use a preferred pharmacy.
Polypharmacy	- 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.
SDoH	- Have the member call Customer Service at the number on their member ID card to learn of benefits that may help, including: • **211.org** • **needymeds.org** • **findhelp.org** • **fullcart.org**

Plan all-cause readmissions (PCR)

Ages 18+ as of the index discharge date

Measure description

Measure assesses the prevalence of acute inpatient and observation stays during the measurement
year that were followed by an unplanned acute readmission for any diagnosis within 30 days of discharge and the predicted probability of an acute readmission.

METHODOLOGY
Claims and encounter data

DEFINITIONS
- Index hospital stay (IHS): Acute inpatient or observation stay with a discharge on or between January 1 and December 1 of the measurement year
- Index admission date: IHS admission date
- Index discharge date: IHS discharge date (must occur on or between January 1 and December 1 of the measurement year)
- Index readmissions stay: Acute inpatient or observation stay for any diagnosis with an admission date 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 eligible population who are not considered outliers

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

REQUIRED EXCLUSIONS
Members in hospice

Exclusions:
- Non-acute inpatient stay
- A principal diagnosis of a condition originating in the perinatal period
- Death during hospital stay
- Members with a principal diagnosis of pregnancy on the discharge claim
- A planned acute hospital stay with any of the following on the discharge claim:
  - Principal diagnosis of maintenance chemotherapy
  - Principal diagnosis of rehabilitation
  - An 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
- **Note**: Supplemental data can be used for required exclusions

Codes used in measure

DENOMINATOR CODES

Observation Stay:

- **UBREV**: 0760, 0762, 0769

Large code sets:

- Inpatient stay
- Non-acute inpatient stay
- Surgery procedure

NUMERATOR CODES

Observation stay (above)

Large code sets:

Outpatient, ED, telephone, acute inpatient and nonacute inpatient

EXCLUSION CODES

Chemotherapy:

- **ICD-10-CM** Z51.0, Z51.11, Z51.12

Rehabilitation:

- **ICD-10-CM** Z44.001, Z44.002, Z44.009, Z44.011, Z44.012, Z44.019, Z44.021, Z44.022, Z44.029, Z44.101, Z44.102, Z44.109, Z44.111, Z44.112, Z44.119, Z44.121, Z44.122, Z44.129, Z44.30-Z44.32, Z44.8, Z44.9, Z45.1, Z45.31, Z45.320, Z45.321, Z45.328, Z45.41, Z45.42, Z45.49, Z45.811, Z45.812, Z45.819, Z46.82, Z46.89, Z46.9

Kidney transplant:

- **CPT** 50360, 50365, 50380
- **HCPCS** S2065
- **ICD-10-PCS** 0TY00Z0-0TY00Z2, 0TY10Z0- 0TY10Z2

Introduction of autologous pancreatic cells:

- **ICD- 10-PCS** 3E030U0, 3E030U1, 3E033U0, 3E033U1, 3E0J3U0, 3E0J3U1, 3E0J7U0, 3E0J7U1, 3E0J8U1

Large code sets:

- Pregnancy diagnosis
- Perinatal conditions
- Bone marrow transplant
- Organ transplant other than kidney
- Potentially planned procedures
- Acute condition

Hospice:

- Hospice intervention:
  - **CPT** 99377, 99378
  - **HCPCS** G0182
- Hospice encounter:
  - **HCPCS** G9473-G9479, Q5003-Q5008, Q5010, S9126, T2042-T2046

Risk adjustment determination guide

For each IHS among nonoutlier members, use the following to identify risk adjustment categories based on presence of observation stay status at discharge, surgeries, discharge condition, comorbidity, age and gender.

Observation stay

Determine if the IHS at discharge was an observation stay (Observation stay code set). For direct transfers, determine the hospitalization status using the last discharge.

Surgeries

Determine if the member underwent surgery during the inpatient stay. (Surgery procedure code set). Consider an IHS to include a surgery if at least one procedure code is present from any provider between the admission and discharge dates.

Discharge condition

Assign a discharge clinical condition (CC) category code or codes to the IHS based on its primary discharge diagnosis, using Table CC Mapping (from NCQA's website). For direct transfers, use the primary discharge diagnosis from the last discharge.

Exclude diagnoses that cannot be mapped to Table CC Mapping.

Comorbidities

- **Step 1**: Identify all diagnoses for encounters during the classification period for each denominator unit of measure (I.e.. Denominator event or member). Include the following when identifying encounters: outpatient visits, telephone visits, observation visits, ED visits, acute and non-acute inpatient encounters
- **Step 2**: Assign each diagnosis to one comorbid CC category using Table CC Mapping (from NCQA's website)
- **Step 3**: Determine hierarchical condition categories (HCCs) 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 HCCs listed in Table HCC Comb (from NCQA's website)

Risk adjustment weighting

For each IHS among nonoutliers, use the following steps to identify risk adjustment weights based on observation stays status at discharge, surgeries, discharge condition, comorbidity, age and gender:

- **Step 1**: For each IHS discharge that is an observation stay, link the observation stay IHS weight.
- **Step 2**: For each IHS with a surgery, link the surgery weight.
- **Step 3**: For each IHS with a discharge CC Category, link the primary discharge weights.
- **Step 4**: For each IHS with a comorbidity HCC Category, link the comorbidity weights.
- **Step 5**: Link the age and gender weights for each IHS.
- **Step 6**: Sum all weights associated with the IHS (i.e., observation stay, presence of surgery, primary discharge diagnosis, comorbidities, age and gender) and use the formula below to calculate the Estimated Readmission Risk for each IHS:

Estimated Readmission Risk = [exp (sum of weights for IHS)] / [1 + exp (sum of weights for IHS)] Note: “Exp” refers to the exponential or antilog function.

- **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.

Count of Expected Readmissions = ∑(Estimated Readmission Risk)

- **Step 8**: Use the formula below and the Estimated Readmission Risk calculated in step 6 to calculate the variance for each IHS.

Variance = Estimated Readmission Risk x (1 – Estimated Readmission Risk)

Example: If the Estimated Readmission Risk is 0.1518450741 for an IHS, then the variance for this IHS is 0.1518450741 x 0.8481549259 = 0.1287881476.

Note: When calculating variance at the IHS level, do not round. Organizations must sum the variances for each stratification and age when populating the Variance cells in the reporting tables. When reporting, round the variance to 4 decimal places using the .5 rule.

Prenatal and postpartum care (PPC)

Measure description

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

METHODOLOGY
Claims, encounter data and/or medical record review

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

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:
    - For members who were continuously enrolled, a prenatal care visit during the first trimester. For members who were not continuously enrolled, a prenatal care visit during the period that begins 280 days prior to delivery and ends 42 days after their enrollment start date
    - Postpartum visit between 7 and 84 days after delivery

REQUIRED EXCLUSIONS
- Members in hospice
- Members who died anytime during the measurement year

Codes used in measure

NUMERATOR CODES
Prenatal Bundled Services:
- **CPT** 59400, 59425, 59426, 59510, 59610, 59618
- **HCPCS** H1005

Stand-alone prenatal visits:
- **CPT** 99500
- **CPT II** 0500F, 0501F, 0502F
- **HCPCS** H1000-H1004

Prenatal visits:
- **CPT** 99201-99205, 99211-99215, 99241-99245, 99483
- **HCPCS** G0463, T1015
- **Note**: Do not include CPT CAT II modifiers

Telephone visits:
- **CPT** 98966-98968, 99441-99443
- **ICD-10-CM** Z01.411, Z01.419, Z01.42, Z30.430, Z39.1, Z39.2
- **Note**: Do not include laboratory claims with POS 81

Postpartum Bundled Services:
- **CPT** 59400, 59410, 59510, 59515, 59610, 59614, 59618, 59622

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

Large code sets:
- Pregnancy diagnosis

DENOMINATOR CODES

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

EXCLUSION CODES

Acute inpatient:
- **CPT** 99221-99223, 99231,99236, 99238, 99239, 99251-99255, 99291
- **POS** 21, 51
- Non-live births

Hospice:
- Hospice Intervention:
  - **CPT** 99377, 99378 **HCPCS** G0182
- Hospice encounter:
  - **HCPCS** G9473-G9479, Q5003-Q5008, Q5010, S9126, T2042, T2046

Social Need Screening and Intervention (SNS-E)

<u>Measure description</u>

The percentage of members who were screened, using prespecified instruments, at least once during the measurement period for unmet food, housing and transportation needs, and received a corresponding intervention if they screened positive.

- **Food screening**: The percentage of members who were screened for food insecurity.
- **Food intervention**: The percentage of members who received a corresponding intervention within one month of screening positive for food insecurity.
- **Housing screening:** The percentage of members who were screened for housing instability, homelessness or housing inadequacy.
- **Housing intervention**: The percentage of members who received a corresponding intervention within one month of screening positive for housing instability, homelessness or housing inadequacy.
- **Transportation screening**: The percentage of members who were screened for transportation insecurity.
- **Transportation intervention**: The percentage of members who received a corresponding intervention within one month of screening positive for transportation insecurity.

METHODOLOGY

Claims and encounter data

DEFINITIONS

- **Participation**: The identifiers and descriptors we use to define members' eligibility during the participation period.
- **Participation period**: The measurement period.
- **Food insecurity**: Uncertain, limited or unstable access to food that is: adequate in quantity and in nutritional quality; culturally acceptable; safe and acquired in socially acceptable ways.
- **Housing instability**: Currently consistently housed but experiencing any of the following circumstances in the past 12 months: being behind on rent or mortgage, multiple moves, cost burden or risk of eviction.
- **Homelessness**: Currently living in an environment that is not meant for permanent human habitation (e.g., cars, parks, sidewalks, abandoned buildings, on the street), not having a consistent place to sleep at night, or because of economic difficulties, currently living in a shelter, motel, temporary or transitional living situation.
- **Housing inadequacy**: Housing does not meet habitability standards.
- **Transportation insecurity**: Uncertain, limited or no access to safe, reliable, accessible, affordable and socially acceptable transportation infrastructure and modalities necessary for maintaining one's health, well-being or livelihood.

REQUIRES

Provide screenings, using prespecified instruments, at least once during the measurement period for unmet food, housing and transportation needs, and provide intervention for positive screenings.

Provide an intervention corresponding to the type of need identified on or up to 30 days after the date of the first positive screening during the measurement period.

- A positive food insecurity screen finding must be met by a food insecurity intervention.
- A positive housing instability or homelessness screen finding must be met by a housing instability or homelessness intervention.

- A positive housing inadequacy screen finding must be met by a housing inadequacy intervention.
- A positive transportation insecurity screen finding must be met by a transportation insecurity intervention.

Intervention may include any of the following intervention categories: assistance, assessment, counseling, coordination, education, evaluation of eligibility, provision or referral.

REQUIRED EXCLUSIONS

- Members in hospice or using hospice services any time during the measurement period.
- Medicare members 66 years of age and older by the end of the measurement period who meet either of the following:
  - Enrolled in an Institutional SNP (I-SNP) any time during the measurement period.
  - Living long-term in an institution any time during the measurement period, as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the measurement period.

Codes used in measure

NUMERATOR CODES

Food insecurity instruments	Screening item LOINC codes	Positive finding LOINC codes
Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool	88122-7 88123-5	LA28397-0, LA6729-3 LA28397-0, LA6729-3
American Academy of Family Physicians (AAFP) Social Needs Screening Tool	88122-7 88123-5	LA28397-0, LA6729-3 LA28397-0, LA6729-3
Health Leads Screening Panel®[1]	95251-5	LA33-6
Hunger Vital Sign™ (HVS)[1]	88124-3	LA19952-3
Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences [PRAPARE]®[1]	93031-3	LA30125-1
Safe Environment for Every Kid (SEEK)®[1]	95400-8 95399-2	LA33-6 LA33-6
U.S. Household Food Security Survey [U.S. FSS]	95264-8	LA30985-8, LA30986-6
U.S. Adult Food Security Survey [U.S. FSS]	95264-8	LA30985-8, LA30986-6
U.S. Child Food Security Survey [U.S. FSS]	95264-8	LA30985-8, LA30986-6
U.S. Household Food Security Survey–Six-Item Short Form [U.S. FSS]	95264-8	LA30985-8, LA30986-6
We Care Survey	96434-6	LA32-8
WellRx Questionnaire	93668-2	LA33-6

[1]Proprietary; may be cost or licensing requirement associated with use.

Housing instability, homelessness and housing inadequacy instruments	Screening Item LOINC Codes	Positive Finding LOINC Codes
Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool	71802-3	LA31994-9, LA31995-6
American Academy of Family Physicians (AAFP) Social Needs Screening Tool	99550-6	LA33-6
Children's Health Watch Housing Stability Vital Signs™1	98976-4 98977-2 98978-0	LA33-6 ≥3 LA33-6
Health Leads Screening Panel®1	99550-6	LA33-6
Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences [PRAPARE]®1	93033-9 71802-3	LA33-6 LA30190-5
We Care Survey	96441-1	LA33-6
WellRx Questionnaire	93669-0	LA33-6
Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool	96778-6	LA31996-4, LA28580-1, LA31997-2, LA31998-0, LA31999-8, LA32000-4, LA32001-2
American Academy of Family Physicians (AAFP) Social Needs Screening Tool	96778-6	LA32691-0, LA28580-1, LA32693-6, LA32694-4, LA32695-1, LA32696-9, LA32001-2

[1]Proprietary; may be cost or licensing requirement associated with use.

Transportation Insecurity Instruments	Screening Item LOINC Codes	Positive Finding LOINC Codes
Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool	93030-5	LA33-6
American Academy of Family Physicians (AAFP) Social Needs Screening Tool	99594-4	LA33-6
Comprehensive Universal Behavior Screen (CUBS)	89569-8	LA29232-8, LA29233-6, LA29234-4
Health Leads Screening Panel®[1]	99553-0	LA33-6
Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences [PRAPARE]®[1]	93030-5	LA30133-5, LA30134-3
PROMIS®[1]	92358-1	LA30024-6, LA30026-1, LA30027-9
WellRx Questionnaire	93671-6	LA33-6

[1]Proprietary; may be cost or licensing requirement associated with use.

DENOMINATOR CODES

The initial population (members of any age enrolled at the start of the measurement period who also meet criteria for participation), minus exclusions.

Statin therapy for patients with diabetes (SPD)

Members 40-75 years of age

Measure description

Measure is designed to assess the use of statins in patients with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD).

METHODOLOGY

Medical claim and/or encounter data and pharmacy claim

DEFINITIONS

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

REQUIRES

Presence of diabetes determined by claim/encounter data or by pharmacy data:

- Claim/encounter data: Any of the following during the measurement year or the year prior
  - Diabetes diagnosis in acute inpatient encounter or discharge.
  - Diabetes diagnosis in two outpatient visits, observation visits telephone visits, e-visits/virtual check-ins, and/or nonacute inpatient encounters/discharges on different dates of service.
- Pharmacy data: At least one dispensing event for insulin or hypoglycemics/antihyperglycemics during the measurement year or the year prior.

Reported as two different rates:

- Those receiving at least one statin medication during the measurement year.
- Those remaining on the statin medication for 80% or more of the treatment period.

REQUIRED EXCLUSIONS

- Members in hospice
- Members who received palliative care
  - **ICD-10-CM** code Z51.5
  - **Note**: Do not include laboratory claims with POS 81
- Members who died
- Event in measurement year or year prior:
  - Members who did not have a diagnosis of diabetes and had a diagnosis of polycystic ovarian syndrome, gestational diabetes, or steroid-induced diabetes.
  - MI, CABG, PCI, or other revascularization
  - Intravascular disease
  - Pregnancy
  - In vitro fertilization
  - Dispensed clomiphene medication
  - ESRD or dialysis
  - Cirrhosis
- During measurement year, and must be documented every 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

- 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 two indications of frailty with different dates of service during the measurement year
    - **Note**: Do not include laboratory claims with POS code 81
  - 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, telephone visits, e-visits/virtual check-ins, non-acute inpatient encounters, or nonacute inpatient discharges 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
    - At least one acute inpatient discharge with an advanced illness diagnosis
    - A dispensed dementia medication

Codes used in measure

DENOMINATOR CODES

Large code sets:

- Diabetes
- Diabetes medications list
- Inpatient stay
- Nonacute inpatient stay

Outpatient, telehealth and acute inpatient

- **CPT** 98966-98968, 98970-98972, 98980-98981, 99202-99205, 99211-99215, 99221-99223, 99231-99236, 99238, 99239,99241-99245, 99251- 99255, 99291,99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404,99411-99412,99412-99423, 99429,99441-99443, 99429, 99441-99443, 99455-99458, 99483
- **HCPCS** G0071, G0402, G0438, G0439, G0463, G0210, G2012, G2250-G2252, T1015

NUMERATOR CODES:

Large code sets:

- Statin medications lists

REQUIRED EXCLUSION CODES:

Large code sets:

- CABG
- PCI
- IVD
- Pregnancy
- IVF
- Estrogen agonists medications list
- Muscular pain and disease
- Advanced illness diagnosis
- Frailty diagnosis
- Dementia medication list

Myocardial infarction:
- **ICD-10-CM** I21.01, I21.02, I21.09, I21.11, I21.19, I21.21, I21.29, I21.3, I21.4, I21.9, I21.A1, I21.A9, I21.B I22.0-I22.2, I22.8-I23.8, I25.6

Old myocardial infarction:
- **ICD-10-CM** I25.2

Other revascularization:
- **CPT** 37220, 37221, 37224-37231

ESRD:
- **ICD-10** N18.5, N18.6, Z99.2

Dialysis:
- **CPT** 90935, 90937, 90945, 90947, 90997, 90999, 99512
- **HCPCS** G0257, S9339
- **ICD-10-PCS** 3E1M39Z, 5A1D00Z, 5A1D60Z, 5A1D70Z, 5A1D80Z, 5A1D90Z

Cirrhosis:
- **ICD-10** K70.30, K70.31, K71.7, K74.3-K74.5, K74.60, K74.69, P78.81

Hospice intervention and encounter:
- **HCPCS** G9473-G9479, Q5003- G0182, Q5003- Q5008, Q5010, T2042-T2046

Palliative care:
- **HCPCS** G9054, M1017

Transitions of care (TRC)

Ages 18 and older

Measure description

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

METHODOLOGY

Claims, encounter data and medical record review

Communication about admission to the member

Documentation of receipt of notification of inpatient admission on the day of admission through two days after admission in the outpatient chart (this indicator is reported based solely on medical record documentation); criteria can be met by any of the following:

- Communication between inpatient providers or staff and the member's PCP or ongoing care provider (e.g. phone call, e-mail, fax)
  - **Note**: If the notification comes from a fax, the date and time of transmission on the fax meets criteria for evidence that the provider was notified of the admission; no further signature or date stamp is needed
- Communication about admission between emergency department (ED) and the member's PCP or ongoing care provider (e.g. phone call, email, fax)
  - **Note**: If a PCP sends a patient to the ED, and the patient is subsequently admitted, it is **not** considered a notification of inpatient admission unless there is documentation indicating that the PCP was notified of the patient's admission
- Communication about admission to the member's PCP or ongoing care provider through a health information exchange, or an automated admission, discharge, and transfer (ADT) alert system, or a shared electronic medical record (EMR) system
  - **Note**: When a shared EMR is identified as the appropriate medical record, documentation of a "received date" is **not** required to meet criteria; evidence that the information was filed in the EMR and is accessible to the PCP or ongoing care provider on the day of admission through two days after admission meets criteria
- Communication about admission to the member's PCP or ongoing care provider from the member's health plan
- Documentation that the PCP or ongoing care provider admitted the member to the hospital
- Documentation that a specialist admitted the member to the hospital **and** notified the member's PCP or ongoing care provider.
- Indication that the PCP or ongoing care provider placed orders for tests and treatments during the member's inpatient stay.
- Documentation that the PCP or ongoing care provider performed a preadmission exam or received communication about a planned inpatient admission

Notes:

- The timeframe that the planned inpatient admission must be communicated is not limited to the day of admission through two days after the admission; documentation that the PCP or ongoing care provider performed a preadmission exam or received notification of a planned admission prior to the admit date also meets criteria
- The planned admission documentation or preadmission exam must clearly pertain to the denominator event

IDENTIFYING THE APPROPRIATE MEDICAL RECORD

Documentation **must** be in the outpatient medical record and include evidence of receipt of inpatient admission that includes the date when the documentation was received. (The only exception is for bullet #3 above).

Receipt of discharge information: Documentation of receipt of discharge information on the day of discharge through two days after discharge and must be in the appropriate medical record even when the primary care or ongoing provider is the discharging provider (this indicator is reported based solely on medical record documentation)

At minimum, the discharge information must include all the following:

- The practitioner responsible for the member's care during the inpatient stay
- Procedures or treatment provided
- Diagnosis at discharge
- Current medication list
- Testing results, or documentation of pending tests or no tests pending
- Instructions for patient care post-discharge

IDENTIFYING THE APPROPRIATE MEDICAL RECORD

Documentation must come from the outpatient medical record and include evidence of receipt of discharge information with the date when the documentation was received. (The only exception is for shared EMR systems, see note below).

Note: When a shared EMR is identified as the appropriate medical record, documentation of a "received date" is **not** required to meet criteria. Evidence that the information was filed in the EMR and is accessible to the PCP or ongoing care provider on the day of discharge through two days after discharge meets criteria.

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

An outpatient visit, including office visits and home visits

- A telephone visit
- A synchronous telehealth visit where real-time interaction occurred between the member and provider using audio and video communication
- An e-visit or virtual check-in (asynchronous telehealth where two-way interaction, which was not real-time, occurred between the member and provider)

Notes:

- If the member is unable to communicate with the provider, interaction between the member's caregiver and the provider meets criteria
- Do not count patient engagement that occurs on 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
- Documentation in the outpatient medical record must include evidence of medication reconciliation conducted by a prescribing practitioner, clinical pharmacist, or registered

nurse, and the date when it was performed. Any of the following evidence meets criteria:

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

- All records submitted should contain the admission and discharge date or otherwise identify that it is related to that hospitalization. Documentation of "post-op/surgery follow-up" without a reference to "hospitalization", "admission", or "inpatient stay" does not imply a hospitalization and is not considered evidence that the provider was aware of a hospitalization.
- 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.
- The 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.

REQUIRED EXCLUSIONS

- Members in hospice
- Members who died anytime during the measurement year

Codes used in measure

NUMERATOR CODES

Outpatient and telehealth visits:

- **CPT** 98966-98968,98970-98972,98980, 98981, 99202, 99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412,99421-99423, 99429, 99441-99458, 99483
- **HCPCS** G0071, G0402, G0438, G0439, G0463, G2010, G2012, G2250, G2251, G2252, T1015

Medication reconciliation encounter:

- **CPT** 99483, 99495, 99496

Medication reconciliation:

- **CPT II** 1111F (Post-hospitalization reconciliation)

Transitional care management services:

- **CPT** 99495, 99496

DENOMINATOR CODES

Large code sets:

- Inpatient stay
- Non-acute inpatient stay
-

REQUIRED EXCLUSIONS

- Hospice encounter:
    - **HCPCS** G9473, G9497, Q5003, Q5008, Q5010, S9126, T2042-T2046
- Hospice:
    - **CPT** 99377,99378, **HCPCS** G0182

More information about medication reconciliation post-discharge (MRP)

Medical record documentation

Documentation in the outpatient medical record must include evidence of medication reconciliation and the date 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 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 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 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.

Notes:

- 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 because the medication instructions could be limited to the medications the patient was taking as an inpatient. If the discharge summary lists the medications the “patient was taking prior to admission” in addition to the discharge medications or states that “medication reconciliation” was performed or contains documentation that the discharge medications “were reconciled with the medications in the outpatient chart” this would meet criteria for medication reconciliation.
- Documentation of a procedure alone is not sufficient evidence to qualify for provider awareness of an inpatient stay, even if the procedure is typically performed in an inpatient setting or the provider is who performed the procedure.
- Providers should be using the words such as “hospitalization”, “hospital follow-up”, “admitted”, “inpatient”, “discharged”, “went home”,or the date the member was admitted and discharged

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/files/document/mln908628-transitional-care-management-services.pdf

Weight assessment and counseling for nutrition and physical activity for children and adolescents (WCC)

Ages 3-17

Measure description

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

METHODOLOGY

Claims, encounter data and medical record review

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 is accepted)
- 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
- Member-reported biometric values (height, weight, BMI percentile) that were collected by the provider and documented in the medical record meet criteria
- The Counseling for Nutrition and Counseling for Physical Activity indicators do not require a specific setting. Therefore, services rendered during a telephone visit, e-visit or virtual check-in meet criteria.

REQUIRED EXCLUSIONS

- Members who had a diagnosis of pregnancy
- Members in hospice
- Members who died anytime during the measurement year

Codes used in measure

NUMERATOR CODES

BMI percentile:

- **ICD-10-CM** Z68.51-Z68.54

Note: Do not include laboratory claims with POS 81

Nutrition counseling:

- **CPT** 97802-97804
- **HCPCS** G0270, G0271, G0447, S9449 S9452, S9470
- **ICD-10-CM** Z71.3

Note: Do not include laboratory claims with POS 81

Physical activity counseling:
- **HCPCS** G0447, S9451

Encounter for Physical Activity Counseling:
- **ICD-10-CM** Z02.5, Z71.82

Note: Do not include laboratory claims with POS 81

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

Online assessment: (E-visit or virtual check-in)
- **CPT** 98970-98972, 98980, 98981, 99421-99423, 99457, 99458
- **HCPCS** G0071, G2010, G2012, G2250-G2252

DENOMINATOR CODES

Outpatient visits:
- **CPT** 99202-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99429, 99455, 99456, 99483
- **HCPCS** G0402, G0438, G0439, G0463, T1015

REQUIRED EXCLUSION CODES

Large code set:
- Pregnancy value set

Note: Do not include laboratory claims with POS 81

- Hospice Intervention:
    - **CPT** 99377, 99378
    - **HCPCS** G0182
- Hospice Encounter:
    - **HCPCS** G9473-G9479, Q5003-Q5008, Q5010, S9126, T2042-T2046
- Members who die during the measurement year

Well child visits in the first 30 months of life (W30)

Ages 15-30 months during the measurement year

Measure description

Measure assesses the number of expected routine well child visits with a PCP during the last 15 months

- Children 0-15 months (who turned 15 months old during the measurement year) = Six or more well-child visits on or before the 15-month birthday
- Children 15-30 months (who turned 30 months old during the measurement year) = Two or more well-child visits between the child's 15-month birthday plus one day and the 30-month birthday

Note: The well-child visit must occur with a PCP, but does not have to be assigned to the child

METHODOLOGY

Claims and encounter data

REQUIRED EXCLUSIONS

- Members in hospice
- Members who died anytime during the measurement year

Codes used in measure

NUMERATOR CODES:

Encounter for well-care:

- **ICD-10-CM** Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.2, Z00.3, Z01.411, Z01.419, Z02.5, Z76.1, Z76.2

Well care visits:

- **CPT** 99381-99385, 99391-99395, 99461
- **HCPCS** G0438, G0439, S0302, S0610, S0612, S0613

Note: Do not include laboratory claims with POS 81

REQUIRED EXCLUSIONS

Hospice encounter:

- **HCPCS** G9473-G9479, Q5003-Q5008, Q5010, S9126, T2042-T2046

Hospice intervention:

- **CPT** 99377, 99378, HCPCS G01

Appendix: Advanced illness and frailty exclusions

NCQA allows exclusions from select measures (listed below) when the member has advanced illness and frailty. Codes from the NCQA Advanced Illness Value Set and/or Frailty Value Sets for devices, diagnoses, encounters and symptoms are used to identify patients who can be removed from the impacted measures' eligible populations.

Notes:

- Appropriate and applicable coding using HEDIS-approved ICD-10-CM, CPT, and HCPCS codes on submitted claims is required to exclude patients for advanced illness and frailty.
- Medical records and other proof of service documents **cannot** be used to identify patients with advanced illness and frailty; however, they can be used for palliative care exclusions.

Measures and exclusions

The table below lists the patient criteria for exclusion and the measures affected.

If the Patient is:	They can be excluded from:
Age 66 and older with both advanced illness and frailty	– Breast cancer screening (BCS-E) – Colorectal cancer screening (COL-E) – Hemoglobin A1c control for patients with diabetes (HBD) – Eye exam for patients with diabetes (EED) – Blood pressure control for patients with diabetes (BPD) – Statin therapy for patients with diabetes (SPD) – Statin therapy for patients with cardiovascular disease (SPC)
Age 66-80 with both advanced illness and frailty	– Controlling blood pressure (CBP) – Kidney health evaluation for patients with diabetes (KED)
Age 67-80 with both advanced illness and frailty	– Osteoporosis management in women who have had a fracture (OMW)
Age 81 and older with frailty alone	– Controlling blood pressure (CBP) – Kidney health evaluation for patients with diabetes (KED) – Osteoporosis management in women who have had a fracture (OMW)

Exclusion criteria

Members must meet both of the following frailty and advanced illness criteria to be excluded:

Frailty is indicated by the following:

- At least two frailty diagnoses on different dates of service during the measurement year (See Frailty code list below)

Advanced illness is indicated by one of the following:

– At least two diagnoses of advanced illness on different dates of service during the measurement year or year prior. Do not include claims where the advanced illness diagnosis was from an independent lab (POS 81).

– Dispensed dementia medication donepezil, donepezil-memantine, galantamine, rivastigmine or memantine.

Advanced illness

DEMENTIA MEDICATIONS

A dementia medication dispensed during the measurement year or the year prior to the measurement year serves as an advanced illness identifier.

Medication type	Name
Cholinesterase inhibitors	Donepezil, Galantamine, Rivastigmine
Miscellaneous central nervous system agents	Memantine
Dementia combinations	Donepezil-memantine

ADVANCED ILLNESS CODES

Advanced Illness diagnosis codes must be billed on at least two different dates of service during the measurement year or the year prior to the measurement year.

Advanced illness ICD-10 code	Definition
A81.00-01, A81.09	Creutzfeldt-Jakob disease
C25.0-4, 7-9	Malignant neoplasm of pancreas
C71.0-9	Malignant neoplasm of brain
C77.0-5, 8-9	Secondary and unspecified malignant neoplasm of lymph nodes
C78.00-2	Secondary malignant neoplasm of lung
C78.1	Secondary malignant neoplasm of mediastinum
C78.2	Secondary malignant neoplasm of pleura
C78.30, C78.39	Secondary malignant neoplasm of other respiratory or other organs
C78.4	Secondary malignant neoplasm of small intestine
C78.5	Secondary malignant neoplasm of large intestine and rectum
C78.6	Secondary malignant neoplasm of

Advanced illness ICD-10 code	Definition
	retroperitoneum and peritoneum
C78.7	Secondary malignant neoplasm of liver and intrahepatic bile duct
C78.80, C78.89	Secondary malignant neoplasm of unspecified or other digestive organs
C79.00-02	Secondary malignant neoplasm of kidney and renal pelvis
C79.10-11, C79.19	Secondary malignant neoplasm of bladder and other urinary organs
C79.2	Secondary malignant neoplasm of skin
C79.31	Secondary malignant neoplasm of brain
C79.32	Secondary malignant neoplasm of cerebral meninges
C79.40, C79.49	Secondary malignant neoplasm of unspecified or other parts of nervous system
C79.51	Secondary malignant neoplasm of bone
C79.52	Secondary malignant neoplasm of bone marrow
C79.60	Secondary malignant neoplasm of unspecified ovary
C79.61	Secondary malignant neoplasm of right ovary
C79.62	Secondary malignant neoplasm of left ovary
C79.63	Secondary malignant neoplasm of bilateral ovaries
C79.70	Secondary malignant neoplasm of unspecified adrenal gland
C79.71	Secondary malignant neoplasm of right adrenal gland
C79.72	Secondary malignant neoplasm of left adrenal gland
C79.81	Secondary malignant neoplasm of breast
C79.82	Secondary malignant neoplasm of genital organs
C79.89	Secondary malignant neoplasm of other specified sites
C79.9	Secondary malignant neoplasm of unspecified site
C91.00, C92.00, C93.00, C93.90, C93.Z0, C94.30	Leukemia not having achieved remission
C91.02, C92.02, C93.02, C93.92, C93.Z2, C94.32	Leukemia in relapse

Advanced illness ICD-10 code	Definition
F01.50, F01.51, F01.511, F01.518, F01.52-54, F01.A0, F01.A11, F01.A18, F01.A2-4, F01.B0, F01.B11, F01.B18, F01.B2-4, F01.C0, F01.C11, F01.C18, F01.C2-4, F02.80, F02.81, F02.811, F02.818, F02.82-84, F02.A0, F02.A11, F02.A18, F02.A2-4, F02.B11, F02.B18, F02.B2-4, F02.C0, F02.C11, F02.C18, F02.C2-4, F03.90, F03.91, F03.911, F03.918, F03.92- 94, F03.A0, F03.A11, F03.A18, F03.A2-4, F03.B0, F03.B11, F03.B18, F03.B2-4, F03.C0, F03.C11, F03.C18, F03.C2-4, G31.09, G31.83	Dementia
F04	Amnestic disorder due to known physiological condition
F10.27, 96-97	Alcohol-induced persisting amnestic disorder or dementia
G30.0, G30.1, G30.8, G30.9	Alzheimer's disease
G10	Huntington's disease
G12.21	Amyotrophic lateral sclerosis
G20	Parkinson's disease
G31.01	Pick's disease
G35	Multiple sclerosis
I09.81, I11.0, I13.0, I13.2, I50.20- 23, I50.30-33, I50.40-43, I50.810-814	Heart failure
I12.0, I13.11, I13.2, N18.5	Chronic kidney disease, stage 5
I50.1	Left ventricular failure, unspecified
J43.0-2, J43.8-9, J98.2-3	Emphysema
J68.4	Chronic respiratory conditions due to chemicals, gases, fumes and vapors
J84.10, J84.112, J84.17, J84.170 J84.178	Pulmonary fibrosis
J96.10-12, J96.20-22, J96.90-.92	Respiratory failure
K70.10-K70.9, K70.41, K70.9	Alcoholic hepatic disease
K74.0-K74.2, K74.4-K74.69,	Hepatic disease, cirrhosis
N18.5, N18.6	End stage renal disease

Frailty
Frailty codes must be billed in the measurement year and include two indications of frailty with different dates of service.

Frailty CPT code	Definition
99504	Home visit for mechanical ventilation care
99509	Home visit for assistance with activities of daily living and personal care
Frailty HCPCS code	**Definition**
E0100, E0105	Cane
E0130-E0149	Walker
E0163 -E0171	Commode chair
E0250-E0270, E0290-E0297, E0301-E0304	Hospital bed
E0424-E0444	Oxygen
E0462	Rocking bed with or without side rails
E0465, E0466	Home ventilator
E0470-2	Respiratory assist device
E1130, E1140, E1150, E1160, E1161, E1170, E1171, E1172, E1180, E1190, E1195, E1200, E1220, E1240, E1250, E1260, E1270, E1280, E1285, E1290, E1295, E1296, E1297, E1298	Wheelchair
G0162, G0299, G0300, G0493-4	Skilled RN services related to home health/hospice setting
S0271	Physician management of patient home care, hospice
S0311	Management and coordination for advanced illness
S9123, S9124, T1000-5, T1019-T1022, T1030, T1031	Nursing, respite care, and personal care services

Frailty ICD-10 code	Definition
L89.000-L89.96	Pressure ulcer
M62.50	Muscle wasting and atrophy, not elsewhere classified, unspecified
M62.81	Muscle weakness (generalized)
M62.84	Sarcopenia
R26.2	Difficulty in walking, not elsewhere classified
R26.89	Other abnormalities of gait and mobility
R26.9	Unspecified abnormalities of gait and mobility
R53.1	Weakness

Frailty ICD-10 code	Definition
R53.81	Other malaise
R54	Age-related physical debility
R62.7	Adult failure to thrive
R63.4	Abnormal weight loss
R63.6	Underweight
R64	Cachexia
W01.0XXA-W01.198S, W06.XXXA-W10.9XXS, W18.00XA-W19.XXXS	Fall
Y92.199	Unspecified place in other specified residential institution as the place of occurrence of the external cause
Z59.3	Problems related to living in residential institution
Z73.6	Limitation of activities due to disability
Z74.01	Bed confinement status
Z74.09	Other reduced mobility
Z74.1	Need for assistance with personal care
Z74.2	Need for assistance at home and no other household member able
Z74.3	Need for continuous supervision
Z74.8-9	Problems related to care provider dependency
Z91.81	History of falling
Z99.11	Dependence on respirator [ventilator] status
Z99.3	Dependence on wheelchair
Z99.81	Dependence on supplemental oxygen
Z99.89	Dependence on other enabling machines and devices

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