QUALITY+ PARTNERSHIPS

2024 Quality Care Measures & Comprehensive Program Information Guide

Commercial

Blue Cross Blue Shield of Tennessee

Partners in the Pursuit of Health

We value your partnership and participation in BlueCross Commercial Quality Improvement, and hope you'll find this guide helpful. The information and tips included can help you maximize your performance with each quality measure.

We know you're committed to providing quality care to your patients, so we're providing tools to help you be as successful as possible. The information in this guide is most useful when used with Electronic Medical Records (EMR). If you use EMR, ask your vendor if they can pre-populate the codes in your drop-downs. This will help you make gap closure part of your workflow with every encounter.

If you'd like additional assistance regarding this Comprehensive Commercial Quality Care Guide, please contact us using the information listed on the back of this guide.

We appreciate all you do to promote better health!

Your Commercial Quality Improvement Team

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E* indicates a HEDIS® measure that is listed under Electronic Clinical Data Systems that allows for innovative use of electronic clinical data such as Electronic Health Record (EHR), Personal Health Record (PHR) Health Information Exchange (HIE) and Case Management Systems.

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Healthcare Effectiveness Data and Information Set (HEDIS)

Developed by the National Committee for Quality Assurance (NCQA), HEDIS® is the most widely used set of performance measures in the managed care industry. It contains measures that show health plans those areas where a stronger focus could lead to improvements in member health. HEDIS® reporting is mandated by NCQA for compliance and accreditation.

Quality Program Resources

Quality Measures Quick Reference — The Bottom Line

Prevention Screening Measures	Descriptions
(BCS-E) Breast Cancer Screening	Women 50-74 years old should have a mammogram to screen for breast cancer every two years.
(CCS, CCS-E) Cervical Cancer Screening	Women 21-64 years old should be screened for cervical cancer using either of the following criteria: • Age 21-64: Cervical cytology every three years • Age 30-64: Cervical cytology and high-risk human papillomavirus infection (HPV) testing every five years OR • Age 30-64: Cervical high-risk HPV testing every five years
(CHL) Chlamydia Screening in Women	Women 16-24 years old who were identified as sexually active should have at least one chlamydia screening each year. This can be done by urine specimen.
(COL-E) Colorectal Cancer Screening	Patients 45-75 years old should have a colorectal cancer screening by one of the screening methods below as appropriate: • Colonoscopy every 10 years • Flexible sigmoidoscopy every five years • CT colonography every five years • Stool-DNA (sDNA) with FIT test every three years • Fecal occult blood testing (FOBT) yearly (if using guaiac-based testing, three samples are required)

Wellness Visits Measures	Descriptions
(W30) Well-Child Visits in the First 15 Months of Life (age: 0-15 months)	Patients should have at least six well-visits or more before turning 15 months old.
(W30) Well-Child Visits in the First 30 Months of Life (age: 15-30 months)	Patients should have at least two or more well visits between 15 and 30 months old.
(WCV) Child and Adolescent Well-Care Visits	Patients 3 to 21 years old should have one or more comprehensive well-visits with a primary care physician (PCP) or obstetrician-gynecologist (OB/GYN) every year.
(WCC-BMI) Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Body Mass Index (BMI) Percentile Documentation	Patients 3 to 17 years old should have an outpatient visit with a PCP or OB/GYN and should have chart documentation of a BMI percentile every year. This may be plotted on a BMI age-growth chart or documented in the record as a percentile. Use specific BMI percentiles that account for age and gender rather than absolute BMI.
(PPC) Prenatal Care	Patients who have a live-birth delivery should have a prenatal visit in the first trimester of that pregnancy.
(PPC) Postpartum Care	Patients who have a live-birth delivery should have a postpartum visit on or between seven and 84 days after delivery.

HEDIS codes can change from year to year. The codes in this document are from the HEDIS MY2024 specifications.

Immunization Measures	Descriptions
(CIS, CIS-E) Childhood Immunization Status Combination 10	Patients should complete the entire series of all immunizations before they turn 2 years old: • Four DTaP (diphtheria, tetanus and pertussis) • Three IPV (polio) • One MMR (measles, mumps and rubella) • Three HiB (haemophilus influenza type B) • Three Hep B (hepatitis B) • One Hep A (hepatitis A) • One VZV (varicella) • Four PCV (pneumococcal conjugate) • Two or three RV (rotavirus) • Two Flu (influenza)
(IMA, IMA-E) Immunizations for Adolescents Combination 2	Patients should complete the entire series of all immunizations before they turn 13 years old: • One meningococcal given between 11 and 13 years old • One Tdap (tetanus, diphtheria toxoids and acellular pertussis) given between 10 and 13 years old • Completed HPV series between 9 and 13 years old
(AIS) Adult Immunization Status	Patients 19 years and older should be up to date on recommended routine vaccines for influenza (flu), tetanus and diphtheria (Td) or tetanus, diphtheria and acellular pertussis (Tdap), zoster and pneumococcal.
(PRS-E) Prenatal Immunization Status	Patients who have a delivery, at 37 weeks or later, during the measurement year should have received vaccines for influenza (flu), and tetanus, diphtheria and acellular pertussis (Tdap), during that pregnancy.

Diabetes-Related Measures	Descriptions
(BPD) Blood Pressure Control for Patients with Diabetes	Patients 18-75 years old identified with diabetes (types 1 or 2) should have a controlled blood pressure of less than 140/90 as their most recent documented result during the measurement year.
(EED) Eye Exam for Patients with Diabetes	Patients 18-75 years old identified with diabetes (types 1 or 2) should have a retinal or dilated eye exam by an eye care professional, or interpreted by an eye care professional during the measurement year. Patients can also have a negative retinal eye exam in the year prior to the measurement year.
(GSD) Glycemic Status Assessment for Patients with Diabetes	Patients 18-75 years old identified with diabetes (types 1 or 2) should have a controlled HbA1c or glucose management indicator (GMI) of less than 8 as their most recent documented result during the measurement year.
(SPD) Statin Therapy for Patients with Diabetes – Received Statin Therapy	Patients 40-75 years old identified with diabetes (types 1 or 2) and don't have clinical atherosclerotic cardiovascular disease (ASCVD) should be placed on a statin medication of any intensity during the measurement year.
(SPD) Statin Therapy for Patients with Diabetes – Statin Adherence 80%	Patients 40-75 years old identified with diabetes (types 1 or 2) that don't have clinical ASCVD should remain on their statin medication for at least 80% of their treatment period during the measurement year.
(KED) Kidney Health Evaluation for Patients with Diabetes	Patients 18-85 years old identified with diabetes (types 1 or 2) should have an estimated glomerular filtration rate (eGFR) **and** a urine albumin-creatinine ratio (uACR) during the measurement year.

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Antibiotic Stewardship Measures	Descriptions
(AAB) Avoidance of Antibiotic Treatment for Acute Bronchitis/ Bronchiolitis	Patients 3 months and older with only a diagnosis of acute bronchitis/bronchiolitis shouldn't be prescribed/dispensed an antibiotic unless a competing diagnosis or an exclusion applies; or the patient continues to worsen three days after being diagnosed.
(CWP) Appropriate Testing for Pharyngitis	Patients 3 years and older diagnosed with pharyngitis should have a group A streptococcus (strep) test for the episode before being given an antibiotic.
(URI) Appropriate Treatment for Upper Respiratory Infection	Patients 3 months and older with only a diagnosis of upper respiratory infection shouldn't be prescribed/dispensed an antibiotic unless a competing diagnosis or an exclusion applies; or the patient continues to worsen three days after being diagnosed.

Behavioral Health Measures	Descriptions
(ADD-E) Follow-Up Care for Children Prescribed ADHD/ ADD Medications	Patients ages 6 to 12 who are newly prescribed ADHD/ADD medications should have at least three follow-up visits within 10 months with the first follow up with a prescriber within 30 days.
(AMM) Antidepressant Medication Management	Patients 18 years and older who have a diagnosis of major depression and were given an antidepressant medication should remain on this medication for at least 12 weeks (84 days).
	Patients 18 years and older who have a diagnosis of major depression and were given an antidepressant medication should remain on this medication for at least six months (180 days).

Behavioral Health Measures	Descriptions
(APM-E) Metabolic Monitoring for Children and Adolescents on Antipsychotics	Patients ages 1 to 17 who are on antipsychotic medication should have both blood sugar/A1C and cholesterol/LDL testing once a year.
(APP) Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	Patients ages 1 to 17 must have at least one visit with a mental health professional either 30 days before or within 90 days after filling an antipsychotic medication.
(COU) Risk of Continued Opioid Use	Patients, ages 18 and older, who haven't taken opioids in six months or more, that have a new opioid prescription for 15 days or more in a 30-day period OR 31 or more days in a 62-day period are included in this measure.
(FUA) Follow-up After Emergency Department Visit for Substance Use Disorder	Patients 3 years and older who were seen in the ED with the principal diagnosis of substance use disorder or any diagnosis of drug overdose, should have a follow-up visit for SUD within seven days of the ED visit and within 30 days of the ED visit. Telehealth visits may be used, and the visit can be with any practitioner, as long as the claim includes an SUD diagnosis.
(FUH) Follow-up After Hospitalization for Mental Illness	Patients 6 years and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnosis should have a follow-up visit with a **mental health** practitioner within seven days of discharge and 30 days of discharge.

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Behavioral Health Measures (continued)	Descriptions
(FUI) Follow-Up After High-Intensity Care for Substance Use Disorder	The percentage of acute inpatient hospitalizations, residential treatment or withdrawal management visits for a diagnosis of substance use disorder among patients 13 years and older that result in a follow-up visit or service for substance use disorder. A follow-up visit should be made within seven days after the visit or discharge and within 30 days after the visit or discharge. The follow-up visits can be with any practitioner as long as the claim includes a substance use disorder diagnosis.
(FUM) Follow-Up After Emergency Department Visit for Mental Illness	Patients 6 years and older who had an emergency department (ED) visit with a principal diagnosis of mental illness or intentional self harm should have a follow-up visit within seven days of an ED visit and within 30 days of an ED visit. Telehealth visits may be used, and the visit can be with any practitioner, as long as the claim includes an appropriate behavioral health diagnosis.
(IET) Initiation and Engagement of Substance Use Disorder Treatment	Patients 13 years and older with new substance use disorder episodes that result in treatment and engagement should have Initiation of SUD treatment within 14 days and Engagement of SUD treatment within 34 days of initiation.
(POD) Pharmacotherapy for Opioid Use Disorder	Patients, ages 16 and older, who begin a new medication assisted treatment for OUD at least 180 days with no breaks in treatment for eight or more consecutive days.
(UOP) Use of Opioids from Multiple Providers	Patients, ages 18 and older, who receive prescription opioids for 15 days or more from four or more prescribers and/or four or more pharmacies.

Other Health Measures	Descriptions
(AMR) Asthma Medication Ratio	Patients 5 to 64 years old who were identified as having persistent asthma should have a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.
(CBP) Controlling High Blood Pressure	Patients 18-85 years old with a diagnosis of hypertension should have a controlled blood pressure level of less than 140/90 as their most recent documented result during the measurement year.
(LBP) Use of Imaging for Low Back Pain	Patients 18-75 years old with a primary diagnosis of low back pain shouldn't have an imaging study within 28 days of the diagnosis by a provider unless a red flag exclusion is present.
(SPC) Statin Therapy for Patients with Cardiovascular Disease — Received Statin Therapy	Male patients 21-75 years old and female patients 40-75 years old who were identified as having clinical ASCVD should be placed on a moderate- to high-intensity statin medication during the measurement year.
(SPC) Statin Therapy for Patients with Cardiovascular Disease — Statin Adherence 80%	Male patients 21-75 years old and female patients 40-75 years old who were identified as having clinical ASCVD should be placed on a moderate- to high-intensity statin medication and should remain on the statin medication for at least 80% of their treatment period during the measurement year.

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Immunization Care

Measure	Goal of the Measure	What To Report (Sample Of Codes and/or Diagnoses)	Exclusions	Helpful Tips
Adult Immunization Status (AIS) 19 years and older	Patients should be up to date on recommended routine vaccines for influenza, tetanus, diphtheria, acellular pertussis (Td or Tdap), zoster, and pneumococcal. • Influenza (Flu) shot – every year • Tdap/Td vaccine – every 10 years • Herpes zoster vaccine – one or two shots at age 50 or older (one dose of the live vaccine or two doses of the recombinant vaccine at least 28 days apart) • Pneumococcal vaccine (PCV 13 or PPSV23) – for age 66 years and older	**Sample CPT® and HCPCS Codes:** **Td vaccine:** 90714 **Tdap vaccine:** 90715 **Herpes zoster live vaccine:** 90736 **Herpes zoster recombinant vaccine:** 90750 **Pneumococcal vaccine PCV 13:** 90670, G0009 **Pneumococcal vaccine PCCV 23:** 90732 **Influenza Vaccine:** 90630, 90653, 90661, 90662, 90673, 90686, 90689	Patients who are in hospice or using hospice services.	Inform patients about the importance of adult immunizations. Consider giving these at annual visits when appropriate. The pneumococcal vaccine can be administered after the patient's 60th birthday and before their 66th birthday. However, if given after age 66, the gap in care will still close. The measurement year is Jan. 1 - Dec. 31.

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Measure	Goal of the Measure	What To Report (Sample Of Codes and/or Diagnoses)	Exclusions	Helpful Tips
Childhood Immunization Status (CIS, CIS-E*) <2 years	Patients turning 2 during the measurement year should have all of the following immunizations **before their second birthday:** • **Four** DTaP (diphtheria, tetanus, and pertussis) • **Three** IPV (polio) • **One** MMR (measles, mumps and rubella) between the child's first and second birthday • **Three** HiB (haemophilus influenza type B) • **Three** hepatitis B (Hep B) • **One** hepatitis A (Hep A) between the child's first and second birthday • **One** varicella (chickenpox) between the child's first and second birthday • **Four** PCV (pneumococcal) • **Two** or three RV (rotavirus) • **Two** influenza (flu)	**Sample CPT® and HCPCS Codes:** **DTaP vaccine:** 90697, 90698, 90700, 90723 **HiB vaccine:** 90644, 90647, 90648, 90698, 90748 **HepA vaccine:** 90633 **Hep B vaccine:** 90697, 90723, 90740, 90744, 90747-90748, G0010 (HCPCS) **IPV vaccine:** 90698, 90713, 90723 **Influenza vaccine:** 90655, 90657, 90661, 90673, 90685, 90687, G0008 (HCPCS) **MMR vaccine:** 90707, 90710 **Pneumococcal conjugate vaccine:** 90670, G0009 (HCPCS) **Rotavirus vaccine (two dose schedule):** 90681 **Rotavirus vaccine (three dose schedule):** 90680, 90681 **VZV (chickenpox) vaccine:** 90710, 90716 **Anaphylactic reaction due to vaccine.** For a documented history of anaphylaxis, there must be a note indicating the date of the event, and which vaccine the anaphylaxis occurred with, and it must have occurred by the patient's second birthday. • An anaphylactic reaction to one vaccine only meets the criteria for that particular vaccine. All other components must still be met.	• Patients in hospice • Patients who had a contraindication for a specific vaccine before their second birthday such as an anaphylactic reaction • Patients who died during the measurement year	Schedule patients so that all immunizations are completed by 23 months. Give educational materials that reinforce your advisement on the importance of vaccinations. The two immunizations **most often missed** in the entire CIS series are: the **two flu vaccines** and the **two or three rotavirus vaccines.** Since the first influenza immunization can't be given until the child is six months old, the second vaccine for influenza can be a challenge for babies born in the fall of the year due to immunization timeframes and availability of the vaccine; this may require extra visits and ordering extra vaccines. VZV, MMR, and Hep A must be given on or between the child's first and second birthday to be measure compliant. For VZV, MMR, Hep A and Hep B, the history of the illness documented prior to two years old in the medical record with a date, or a seropositive test result would close the area of the measure for that particular vaccine. DTaP, IPV, HIB, pneumococcal and rotavirus should be given at least 42 days after birth for compliance. Typically the first Hep B is given on the date of birth (DOB) or the day after because most women and babies don't stay in the hospital longer than that. If the hospital has given the provider the patient records for the Hep B vaccine that was given at birth, they can enter the information and attest that the infant received the Hep B vaccination in the hospital – as long as the Hep B vaccination was given between the DOB and seven days after birth. For rotavirus, if documentation doesn't indicate whether the two-dose schedule or three-dose schedule was used, we have to assume a three-dose schedule was administered and must see evidence of those three doses, so documentation of the dose variation is very important. The minimum age to start the rotavirus series is six weeks (42 days). The Live Attenuated Influenza Vaccine (LAIV) can be used for CIS, but only if given on the exact day of the child's second birthday, as it's not approved for children under two.

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Measure	Goal of the Measure	What To Report (Sample Of Codes and/or Diagnoses)	Exclusions	Helpful Tips
Immunizations for Adolescents (IMA, IMA-E*) < 13 years	Patients turning 13 during the measurement year should have the following immunizations **before their 13th birthday:** • One meningococcal given on or between the 11th and 13th birthday • One Tdap (tetanus, diphtheria, and pertussis) given on or between the 10th and 13th birthday • HPV series completed between the 9th and 13th birthday	**Sample CPT® Codes:** **Meningococcal vaccine:** 90619, 90733, 90734 **Tdap vaccine:** 90715 **HPV vaccine:** 90649-90651 **Anaphylactic reaction due to vaccine.** For documented history of anaphylaxis, there must be a note indicating the date of the event and which vaccine the anaphylaxis occurred with, and must have occurred by the patient's 13th birthday. Anaphylactic reaction to one vaccine only meets criteria for that particular vaccine. All other components must still be met.	• Patients in hospice • Patients who died during the measurement year	Meningococcal vaccine must be serogroups A, C, W and Y. (Serogroup B vaccines won't close the gap in care.) Discuss the HPV vaccine from the cancer prevention standpoint. Recommend HPV the **SAME WAY-SAME DAY** as the other vaccines. CDC recommendations offer two options for the HPV vaccination: • Option 1: Series of three injections over a period of six months. **Note**: Dose two should be administered two months after the first dose, and dose three should be administered six months after the first dose • Option 2: For the two-dose HPV vaccination series, there must be at least 146 days between the first and second injections. This measure applies to **all adolescents** under the age of 13. Use educational materials that reinforce your advisement on the importance of vaccinations.
Prenatal Immunization Status (PRS-E*) Patients: no age specified	Patients who've delivered a birth in the measurement period of Jan. 1- Dec. 31 should receive the following: vaccines for influenza, tetanus, diphtheria, and acellular pertussis. • Flu shot – on or between July 1 of the year prior to the measurement period and the delivery date • Tdap vaccine – during each pregnancy	**Sample CPT® Codes:** **Tdap vaccine**: 90715 **Influenza vaccine:** 90630, 90653, 90654, 90662, 90673, 90682, 90689, 90694, 90756	**Patients who:** • Delivered earlier than 37 weeks gestation • Are in hospice or using hospice services • Die during the measurement year	The Advisory Committee on Immunization Practices (ACIP) clinical guidelines recommend that all patients who are pregnant or who might be pregnant in the upcoming influenza season receive inactivated influenza vaccines. ACIP also recommends pregnant patients receive one dose of Tdap during each pregnancy, preferably during the gestational weeks 27-36, regardless of prior history of receiving Tdap.

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Additional Resources

IMA ToolKit

- **Parents' Reminder Letter:**
  https://provider.bcbst.com/working-with-us/quality-initiatives/
- **5 Ways to Boost Your HPV Vaccination Rates:**
  https://www.cdc.gov/hpv/hcp/boosting-vacc-rates.html
- **Talking to Parents about HPV Vaccine:**
  https://www.cdc.gov/hpv/hcp/for-hcp-tipsheet-hpv.pdf
- **Vaccines for Preteens and Teens: What Parents Should Know:**
  https://www.cdc.gov/vaccines/parents/downloads/pl-dis-preteens-parents.pdf
- **Top 10 Tips for HPV Vaccination Success:**
  https://www.cdc.gov/hpv/downloads/top10-improving-practice.pdf
- **HPV Vaccine Safety and Effectiveness:**
  https://www.cdc.gov/vaccines/partners/downloads/teens/vaccine-safety.pdf

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Diabetes Care

Measure	Goal of the Measure	What To Report (Sample Of Codes and/or Diagnoses)	Exclusions	Helpful Tips
Blood Pressure Control for Patients With Diabetes (BPD) 18-75 years There are two ways to identify patients with diabetes: by claim/encounter data and by pharmacy data. **Claim/encounter data:** Patients who had at least two diagnoses of diabetes on different dates of service during the measurement year or the year prior to the measurement year. **Pharmacy data:** Patients who were dispensed insulin or hypoglycemics/antihyperglycemics during the measurement year or the year prior to the measurement year and have at least one diagnosis of diabetes during the measurement year or the year prior to the measurement year.	Patients who are identified with diabetes, (type 1 or 2), should have a controlled blood pressure of < 140/90 during the measurement year.	**Diabetic blood pressure control:** **Diastolic less than 90:** **Diastolic less than 80:** 3078F **Diastolic 80-89:** 3079F **Systolic less than 140:** 3074F, 3075F	• Patients in hospice • Patients in palliative care, Z51.5 • Patients 66 years and older with both advanced illness and frailty (at least two indications of frailty diagnoses with different dates of service during the measurement year) • Patients who died any time during the measurement year	Identify the most recent B/P reading during an outpatient visit, telephone visit, a nonacute inpatient encounter, or remote monitoring event. Don't include B/P readings: • Taken during an acute inpatient stay or an ED visit • Taken on the same day as a diagnostic test or diagnostic/therapeutic procedure that requires a change in diet or change in medication on or one day before the day of the test or procedure, with the exception of fasting blood tests Patients can now self-report B/P levels during telehealth or telephone visits if the B/P level was taken on a digital device. The date, B/P level, and the fact that it was from a patient-reported digital device must all be documented in the e-chart.

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Measure	Goal of the Measure	What To Report (Sample Of Codes and/or Diagnoses)	Exclusions	Helpful Tips (cont.)
Blood Pressure Control for Patients With Diabetes (BPD) (cont.) 18-75 years				You can retake a B/P for a patient on the same visit if the first one is out of the acceptable range. If multiple readings were recorded for the same date, same visit, use the lowest systolic and lowest diastolic B/P on that date as the representative B/P. Example: 1st reading - 130/95; 2nd reading - 156/80. The gap can be closed with the reading of 130/80. **B/P readings** The most recent value in the chart will stand for the reading for the patient for the measurement year.

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Measure	Goal of the Measure	What To Report (Sample Of Codes and/or Diagnoses)	Exclusions	Helpful Tips
Eye Exam for Patients with Diabetes (EED) 18-75 years There are two ways to identify patients with diabetes: by claim/ encounter data and by pharmacy data. **Claim/encounter data:** Patients who had at least two diagnoses of diabetes on different dates of service during the measurement year or the year prior to the measurement year. **Pharmacy data:** Patients who were dispensed insulin or hypoglycemic/ antihyperglycemics during the measurement year or the year prior to the measurement year and have at least one diagnosis of diabetes during the measurement year or the year prior to the measurement year.	Patients who are identified with diabetes, (type 1 or 2), should have a retinal or dilated eye exam by an eye care professional, or interpreted by an eye care professional during the measurement year.	**Sample CPT® Codes:** **Diabetic retinal screening:** 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, 92134,92227-92228, 92230, 92235, 92240, 92250, 92260, 99203-99205, 99213-99215, 99242-99245, S3000, S0620- S0621 **Diabetic Retinal Screening without Evidence of Retinopathy:** 2023F, 2025F, 2033F **Diabetic Retinal Screening Negative in the Prior Year:** 3072F **Diabetic Retinal Screening with Eye Care Professional:** 2022F, 2023F, 2024F, 2025F, 2026F **Note:** Providers performing retinal imaging in office and sending results to eye care professionals to review and interpret should use CPT® II codes. **Unilateral Eye Enucleations:** 65091, 65093, 65101, 65103, 65105, 65110, 65112, 65114 **Unilateral Eye Enucleation Left:** 08T1XZZ **Unilateral Eye Enucleation Right:** 08T0XZZ	• Patients in hospice • Patients in palliative care, Z51.5 • Patients 66 years and older with both advanced illness and frailty (At least two indications of frailty diagnoses with different dates of service during the measurement year) • Patients who died any time during the measurement year **Note:** Blindness isn't an exclusion for a diabetic eye exam because it's difficult to distinguish between individuals who are legally blind but require a retinal exam and those who are completely blind and therefore don't require an exam.	Bilateral eye enucleation will close the gap in care if there's documentation that the patient has had bilateral enucleation or acquired absence of both eyes. Documentation of a negative retinopathy exam can close the gap for two years, but it must be coded as such. Any retinal or dilated eye exam from an eye care provider is acceptable in the measurement year, but an exam from the previous year must be a negative result for retinopathy to be compliant. Documentation doesn't have to state specifically "no diabetic retinopathy" to be considered negative; however, it must be clear that the patient had a dilated or retinal exam by an eye care professional and evidence of retinopathy wasn't present. **Note:** The statement "diabetes without complications" does **not** meet criteria. If one eye isn't accessible, leading to an indeterminate result, this isn't considered a result/finding.

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Measure	Goal of the Measure	What To Report (Sample Of Codes and/or Diagnoses)	Exclusions	Helpful Tips (cont.)
Eye Exam for Patients with Diabetes (EED) (cont.) 18-75 years				Eye exam results read by a system that provides an artificial intelligence (AI) interpretation meet criteria for gap closure, but may not be covered. The reported purpose of digital retinal imaging with automated image interpretation, in individuals who have diabetes, is to aid in the decision of whether or not an individual should be referred to an ophthalmologist based on information provided by an automated scoring system. Retinal telescreening can only be used for a screening technique but is considered investigational and not covered for ongoing monitoring or management of the disease diabetic retinopathy.

Measure	Goal of the Measure	What To Report (Sample Of Codes and/or Diagnoses)	Exclusions	Helpful Tips
Glycemic Status Assessment for Patients with Diabetes (GSD) 18-75 years There are two ways to identify patients with diabetes: by claim/ encounter data and by pharmacy data. **Claim/encounter data:** Patients who had at least two diagnoses of diabetes, on different dates of service during the measurement year or the year prior to the measurement year. **Pharmacy data:** Patients who were dispensed insulin or hypoglycemics/ antihyperglycemics during the measurement year or the year prior to the measurement year and have at least one diagnosis of diabetes during the measurement year or the year prior to the measurement year.	Patients identified with diabetes, (type 1 or 2), should have a hemoglobin A1C (HbA1c) or glucose management indicator (GMI) less than 8 during the measurement year.	• Diabetes. **HbA1c/GMI testing:** • HbA1c/GMI level less than 7.0: 3044F • HbA1c/GMI level greater than or equal to 7.0 and less than 8.0: 3051F • HbA1c/GMI level greater than or equal to 8.0 and less than or equal to 9.0: 3052F	• Patients in hospice • Patients in palliative care, Z51.5 • Patients 66 years and older with both advanced illness and frailty diagnoses (At least two indications of frailty diagnoses with different dates of service during the measurement year) • Members who died any time during the measurement year	HbA1c/GMI results must be on a specific date. Documentation stating "recent or last A1C" doesn't meet the measure for gap closure; it must have a date. At a minimum, documentation in the medical record must include a note indicating the date when the HbA1c/GMI test was performed and the result. Lab values can be obtained from inpatient records. The most recent value in the chart will stand for the reading for the patient for the measurement year.

HEDIS codes can change from year to year. The codes in this document are from the HEDIS MY2024 specifications.

Measure	Goal of the Measure	What To Report (Sample Of Codes and/or Diagnoses)	Exclusions	Helpful Tips
Kidney Health Evaluation for Patients with Diabetes (KED) 18-85 years There are two ways to identify patients with diabetes: by claim/ encounter data and by pharmacy data.	Patients identified with diabetes, (type 1 or 2), who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) **and** a urine albumin-creatinine ratio (uACR), during the measurement year. **Kidney Health Evaluation** Patients who received **both** an eGFR and a uACR during the measurement year on the same or different dates of service: • At least one eGFR • At least one uACR identified by either of the following: **Both** a quantitative urine albumin test **and** a urine creatinine test **with** service dates four days or less apart. For example, if the service date for the quantitative urine albumin test was Dec. 1 of the measurement year, the urine creatinine test must have a service date on or between Nov. 27 and Dec. 5 of the measurement year.	**Sample Diagnosis:** • Diabetes **Members who received both an eGFR and a uACR during the measurement year on the same or different dates of service:** • At least one eGFR (Estimated Filtration Rate) - sample codes: 80047, 80048, 80050, 80053, 80069 AND • At least one uACR identified by both a quantitative urine albumin test - sample code: 82043 and a urine creatinine test - sample code: 82570	• Patients in hospice • Patients with evidence of end-stage renal disease (ESRD) • Patients 66 years and older with both advanced illness and frailty diagnoses (At least two indications of frailty diagnoses with different dates of service during the measurement year) • Patients who died any time during the measurement year • Patients that don't have diabetes	The specifications are looking for the quantitative number to provide an accurate ratio calculation. Code 82043 is for Albumin, urine (e.g., microalbumin) quantitative. There are **NOT** specific exclusions for patients being on an ACE inhibitor or ARB.

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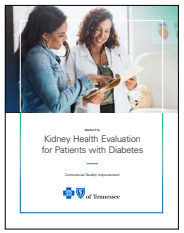
Measure	Goal of the Measure	What To Report (Sample Of Codes and/or Diagnoses)	Exclusions	Helpful Tips
Received Statin Therapy for Patients with Diabetes (SPD) 40-75 years There are two ways to identify patients with diabetes: by claim/ encounter data and by pharmacy data. **Claim/encounter data:** Patients who had at least two diagnoses of diabetes on different dates of service during the measurement year or the year prior to the measurement year. **Pharmacy data:** Patients who were dispensed insulin or hypoglycemics/ antihyperglycemics during the measurement year or the year prior to the measurement year and have at least one diagnosis of diabetes during the measurement year or the year prior to the measurement year.	Patients identified with diabetes (type 1 or 2) via claims or pharmacy data who don't have clinical atherosclerotic cardiovascular disease (ASCVD) should be dispensed at least one statin medication of any intensity during the measurement year.	**Sample Diagnosis:** • Diabetes	• Patients with at least one of the following during the year prior to the measurement year: - ASCVD - Coronary artery bypass graft (CABG) - Myocardial infarction (MI) - Percutaneous coronary intervention (PCI) - Other revascularization procedures - Ischemic Vascular Disease (IVD) • Patients with a diagnosis of pregnancy or undergoing in vitro fertilization (IVF) • Patients dispensed at least one prescription for estrogen agonists medication during the measurement year or the year prior to the measurement year • Cirrhosis • Patients 66 years and older with both advanced illness and frailty (At least two indications of frailty diagnoses with different dates of service during the measurement year) • Patients in hospice • Patients in palliative care, Z51.5 • Myopathy, myalgia, myositis, or rhabdomyolysis, G72.0, G72.2, G72.9, M60.80, M60.88, M60.89, M60.9, M62.82, M79.1, M79.10 • Patients who died any time during the measurement year	Any intensity of statin therapy will meet the goal of this measure. A telehealth visit may be helpful for checking in on your diabetic patients and discussing how well they're managing their diabetes. This would also be a good time to discuss any medication side effects and assist patients with refills. Prescribing 90-day medication fills often saves patients time and money and helps them stay on their medications. Explore possible reasons for your patients' medication non-adherence (i.e. cost, denial, depression, substance use/abuse, side effects).

HEDIS codes can change from year to year. The codes in this document are from the HEDIS MY2024 specifications.

Measure	Goal of the Measure	What To Report (Sample Of Codes and/or Diagnoses)	Exclusions	Helpful Tips
Adherence 80% Statin Therapy For Patients with Diabetes (SPD) 40-75 years There are two ways to identify patients with diabetes: by claim/encounter data and by pharmacy data. **Claim/encounter data:** Patients who had at least two diagnoses of diabetes on different dates of service during the measurement year or the year prior to the measurement year. **Pharmacy data:** Patients who were dispensed insulin or hypoglycemics/ antihyperglycemics during the measurement year or the year prior to the measurement year and have at least one diagnosis of diabetes during the measurement year or the year prior to the measurement year.	Patients identified with diabetes (type 1 or 2), who don't have clinical atherosclerotic cardiovascular disease (ASCVD) should remain on a statin medication of **any** intensity for at least 80% of their treatment period.	**Sample Diagnosis:** • Diabetes	• Patients with at least one of the following during the year prior to the measurement year. - ASCVD - Coronary artery bypass graft (CABG) - Myocardial infarction (MI) - Percutaneous coronary intervention (PCI) - Other revascularization procedures - Ischemic Vascular Disease (IVD) • Patients with a diagnosis of pregnancy or undergoing in vitro fertilization (IVF) • Patients dispensed at least one prescription for estrogen agonists medication during the measurement year or the year prior to the measurement year • End-stage renal disease • Cirrhosis • Patients 66 years and older with both advanced illness and frailty (at least two indications of frailty diagnoses with different dates of service during the measurement year) • Patients in palliative care, Z51.5 • Patients in hospice • Myopathy, myalgia, myositis, or rhabdomyolysis, G72.0, G72.2, G72.9, M60.80, M60.88, M60.89, M60.9, M62.82, M79.1, M79.10 • Patients who died any time during the measurement year	Any intensity of statin therapy will meet the goal of this measure. A telehealth visit may be helpful for checking in on your diabetic patients and discussing how well they're managing their diabetes and taking statin medications. This would also be a good time to discuss any medication side effects and assist patients with refills. Prescribing 90-day medication fills often saves patients time and money and helps them stay on their medications. Explore possible reasons for your patients' medication non-adherence (i.e. cost, denial, depression, substance use/abuse, side effects).

HEDIS codes can change from year to year. The codes in this document are from the HEDIS MY2024 specifications.

Additional Resources



Support Guide for the Kidney Evaluation Measure (KED):

Available upon request from your Quality Improvement Clinical Consultant.

Guide to Statin Measures (SPC and SPD):
https://www.bcbst.com/docs/providers/quality-initiatives/guide-statin-measure.pdf

HEDIS codes can change from year to year. The codes in this document are from the HEDIS MY2024 specifications.

Kidney Health Evaluation for Patients with Diabetes

Diagnosis Criteria: Adults with Diabetes (Type 1 and Type 2) 18-85 Years of Age

How are patients identified for the measure?

Patients are identified with diabetes by claim/encounter data and pharmacy data. They may be identified as having diabetes during the measurement year or the year prior. Any of the criteria below must be met during the measurement year or the year prior.

Claim/encounter data: Patients who had at least two diagnoses of diabetes on different dates of service during the measurement year or the year prior to the measurement year.

Pharmacy data: Patients who were dispensed insulin or hypoglycemics/antihyperglycemics during the measurement year or the year prior to the measurement year and have at least one diagnosis of diabetes during the measurement year or the year prior to the measurement year.

Other Criteria

Patients who have both BlueCross medical and pharmacy coverage.

Note: Glucophage/metformin as a solo agent isn't included because it's used to treat conditions other than diabetes. Patients with diabetes who are on these medications are identified through diagnosis codes only.

Did You Know

The following glucagon-like peptide-1 (GLP1) agonists widely used for weight control for nondiabetic patients will place them in the denominator for the KED measure.

- Albiglutide
- Dulaglutide
- Exenatide
- Liraglutide (excluding Saxenda®)
- Lixisenatide
- Semaglutide

HEDIS codes can change from year to year. The codes in this document are from the HEDIS MY2024 specifications.

Understanding the Kidney Health Evaluation for Patients with Diabetes

The National Committee for Quality Assurance (NCQA) has established specifications that impact HEDIS® measures for patients with diabetes. This measure, focused on improving kidney health, especially for those most at risk, aligns with recommendations from the American Diabetes Association and the National Kidney Foundation.

What's Needed to Meet This Measure

Patients who have been identified with diabetes, **should have both** of the following during the measurement year on the same or different dates of service:

- At least one eGFR lab test, **AND**
- At least one uACR identified by either of the following:
  - **Both a quantitative urine albumin test (Quantitative Urine Albumin Lab Test) and a urine creatinine test (Urine Creatinine Lab Test) with service dates FOUR DAYS or LESS apart.**
    - The specifications require the quantitative number to provide an accurate ratio calculation.
    - Code 82043 is for Albumin, urine (e.g., microalbumin) quantitative.
    - For example, if the service date for the quantitative urine albumin test was Dec. 1 of the measurement year, then the urine creatinine test must have a service date on or between Nov. 27 and Dec. 5 of the measurement year.
  - **A uACR lab test**

Helpful Tip

A visit to a nephrologist (nephrology monitoring) is not a numerator hit for this measure like it was for the Comprehensive Diabetes Care nephropathy measure.

There are **NOT** specific exclusions for an angiotensin-converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB).

HEDIS codes can change from year to year. The codes in this document are from the HEDIS MY2024 specifications.

Exclusions

Exclusions and Sample Exclusion Codes for KED

Patients can be excluded from the measure if they meet any of the below criteria any time during the member's history on or prior to Dec. 31 of the measurement year or the year prior to the measurement year:

- Patients with an End-Stage Renal Disease (ESRD) diagnosis (or dialysis)

  ICD-10 Codes for ESRD —

  N18.5 Chronic kidney disease, stage 5
  N18.6 End stage renal disease
  Z99.2 Dependence on renal dialysis

- Patients in hospice or using hospice services any time during the measurement year
- Patients who die any time during the measurement year

  Codes for Hospice Care

  CPT® Codes:

  99377 Supervision of a hospice patient (patient not present) requiring complex and multidisciplinary care modalities involving regular development and/or revision of care plans by that individual; review of subsequent reports of patient status; review of related laboratory and other studies; communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (e.g., legal guardian) and/or key caregiver(s) involved in patient's care; integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes.

  99378 Supervision of a hospice patient (patient not present) requiring complex and multidisciplinary care modalities involving regular development and/or revision of care plans by that individual; review of subsequent reports of patient status; review of related laboratory and other studies; communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (e.g., legal guardian) and/or key caregiver(s) involved in patient's care; integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 30 minutes or more.

  HCPCS Codes:

  G0182 Physician supervision of a patient under a Medicare-approved hospice (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans; review of subsequent reports of patient status; review of laboratory and other studies; communication (including telephone calls) with other health care professionals involved in the patient's care; integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month, of 30 minutes or more.

HEDIS codes can change from year to year. The codes in this document are from the HEDIS MY2024 specifications.

G9473 Services performed by chaplain in the hospice setting, 15 minutes each
G9474 Services performed by dietary counselor in the hospice setting, 15 minutes each
G9475 Services performed by other counselor in the hospice setting, 15 minutes each
G9476 Services performed by volunteer in the hospice setting, 15 minutes each
G9477 Services performed by care coordinator in the hospice setting, 15 minutes each
G9478 Services performed by other qualified therapist in the hospice setting, 15 minutes each
G9479 Services performed by qualified pharmacist in the hospice setting, 15 minutes each
Q5003 Hospice care provided in nursing long-term care facility or non-skilled nursing facility
Q5004 Hospice care provided in skilled nursing facility
Q5005 Hospice care provided in inpatient hospital
Q5006 Hospice care provided in inpatient hospice facility
Q5007 Hospice care provided in long-term care facility
Q5008 Hospice care provided in inpatient psychiatric facility
Q5010 Hospice home care provided in a hospice facility
S9126 Hospice care, in the home; per diem
T2042 Hospice routine home care; per diem
T2043 Hospice continuous home care; per hour
T2044 Hospice inpatient respite care; per diem
T2045 Hospice general inpatient care; per diem
T2046 Hospice long-term care, room and board only; per diem

- Palliative care anytime in the measurement year

Codes for Palliative Care

HCPCS Codes:

G9054 Oncology; primary focus of visit; supervising, coordinating or managing care of patient with terminal cancer or for whom other medical illness prevents further cancer treatment, includes symptom management, end-of-life care planning, management of palliative therapies (for use in a Medicare-approved demonstration project).
M1017 Patient admitted to palliative care services

- Patients with a diagnosis of polycystic ovarian syndrome, gestational diabetes or steroid-induced diabetes during measurement year or the year prior to measurement year, and who don't have a diagnosis of diabetes during the measurement year or the year prior to the measurement year
- Patients 66 years and older as of Dec. 31 of the current measurement year who meet both the advanced illness and frailty criteria (Refer to the Advanced Illness and Frailty guide for the criteria.)

Sample Codes for KED

Estimated Glomerular Filtration Rate Lab Test

CPT					
80047	80048	80050	80053	80069	82565

LOINC				
50044-7	62238-1	77147-7	94677-2	98979-8
50210-4	69405-9	88293-6	96591-3	98980-6
50384-7	70969-1	88294-4	96592-1	

SNOMED CT US EDITION			
12341000	241373002	444336003	706951006
18207002	444275009	446913004	763355007

Quantitative Urine Albumin Lab Test

CPT
82043

LOINC				
14957-5	21059-1	43605-5	53531-0	89999-7
1754-1	30003-8	53530-2	57369-1	

SNOMED CT US EDITION	
104486009	104819000

HEDIS codes can change from year to year. The codes in this document are from the HEDIS MY2024 specifications.

Urine Albumin Creatinine Ratio Lab Test

LOINC	
14958-3	Microalbumin/Creatinine [Mass Ratio] in 24-hour Urine
14959-1	Microalbumin/Creatinine [Mass Ratio] in Urine
30000-4	Microalbumin/Creatinine [Ratio] in Urine
44292-1	Microalbumin/Creatinine [Mass Ratio] in 12-hour Urine
59159-4	Microalbumin/Creatinine [Ratio] in 24-hour Urine
76401-9	Albumin/Creatinine [Ratio] in Urine
77253-3	Microalbumin/Creatinine [Ratio] in Urine by Detection limit<=1.0mg/L
77254-1	Microalbumin/Creatinine [Ratio] in 24-hour Urine by Detection limit<=1.0mg/L
89998-9	Microalbumin/Creatinine [Ratio] in Urine by Detection limit<=3.0mg/L
9318-7	Albumin/Creatinine [Mass Ratio] in Urine

Urine Creatinine Lab Test		
82570	CPT®	
20624-3	LOINC	Creatinine [Mass /volume] in 24-hour Urine
2161-8	LOINC	Creatinine [Mass /volume] in Urine
35674-1	LOINC	Creatinine [Mass /volume] in Urine collected for unspecified duration
39982-4	LOINC	Creatinine [Mass /volume] in Urine - baseline
57344-4	LOINC	Creatinine [Mass /volume] in 2-hour Urine
57346-9	LOINC	Creatinine [Mass /volume] in Urine in 12-hour Urine
58951-5	LOINC	Creatinine [Mass /volume] in Urine - 2nd specimen
8879006	SNOMED CT US Edition	Creatinine measurement in 24-hour (procedure)
36793009	SNOMED CT US Edition	Creatinine measurement in 12-hour (procedure)
271260009	SNOMED CT US Edition	Creatinine measurement (procedure)
444322008	SNOMED CT US Edition	Quantitative measurement of mass rate of exertion of creatinine in timed urine specimen (procedure)

HEDIS codes can change from year to year. The codes in this document are from the HEDIS MY2024 specifications.

Good-to-Know Tips

The Quality Care Rewards (QCR) system won't allow providers to select all radio buttons at the same time. You must perform multiple attestations if you choose to submit testing dates within the QCR platform.

Select the buttons one-at-a-time and enter the date for each one. All criteria listed below must be completed to submit for gap closure.

Met Goal for Measure

At least one Estimated Glomerular Filtration Rate (eGFR) test performed during the measurement year. (Note, measure requires both eGFR and uACR for compliance.)	○	Please Select Date
At least one Urine Albumin-Creatinine Ratio (uACR) test. The uACR test is identified by both a Quantitative Urine Albumin test and a Urine Creatinine test performed four or less days apart. Part 1 of 2 Quantitative Urine Albumin Test. (Note, measure requires both eGFR and uACR for compliance.)	◉	Please Select Date
At least one Urine Albumin-Creatinine Ratio (uACR) test. The uACR test is identified by both a Quantitative Urine Albumin test and a Urine Creatinine test performed four or less days apart. Part 2 of 2 Urine Creatinine test. (Note, measure requires both eGFR and uACR for compliance.)	○	Please Select Date

eGFR in Evaluating Patients with Diabetes for Kidney Disease

The two key markers for chronic kidney disease (CKD) are eGFR and urine albumin. Calculate eGFR from stable serum creatinine levels at least once a year in all patients with diabetes.

- eGFR is more accurate than serum creatinine alone. Serum creatinine is affected by muscle mass and related factors of age, sex and race.
- eGFR isn't reliable for patients with rapidly changing creatinine levels, extremes in muscle mass and body size, or altered diet patterns.

Helpful Tip

eGFR is a blood test to assess kidney function by testing for waste products (creatinine) in the blood.

HEDIS codes can change from year to year. The codes in this document are from the HEDIS MY2024 specifications.

uACR in Evaluating Patients with Diabetes for Kidney Disease

The two key markers for CKD are urine albumin and eGFR.

Assess urine albumin excretion yearly to diagnose and monitor kidney damage in patients with type 1 diabetes for five years or more, or with type 2 diabetes.

- More frequent monitoring may be indicated in patients with changing clinical status or after therapeutic interventions.
- Use a spot urine albumin-to-creatinine ratio (uACR). uACR estimates 24-hour urine albumin excretion. Twenty-four-hour collection and timed specimens aren't necessary

$$\frac{\text{Urine albumin (mg/dL)}}{\text{Urine creatinine (g/dL)}} = \text{uACR in mg/g} = \text{Albumin excretion in mg/day}$$

uACR is a ratio between two measured substances. Unlike a dipstick test for albumin, uACR is unaffected by variation in urine concentration.

Albuminuria is present when uACR is greater than 30 mg/g and is a marker for CKD.

Albuminuria is used to diagnose and monitor kidney disease. A change in albuminuria may reflect response to therapy and progression risk. A decrease in urine albumin may be associated with improved renal and cardiovascular outcomes.

Did You Know

uACR assesses kidney damage by testing urine for proteins (albumin). Use a spot urine albumin-to-creatinine ratio.

Best Practices

- Perform kidney health evaluation, eGFR and uACR, on the same or different dates of service four days or less apart for diabetic members who were dispensed insulin or hypoglycemics/ antihyperglycemics during the measurement year or year prior.
- Use complete and accurate Codes.
- Coordinate care with specialists (nephrologist and endocrinologist).
- Educate your patients about the importance of early detection and encourage annual screenings to help improve diabetes management.
- Educate patients on how diabetes can affect the kidneys and offer tips on preventing damage to their kidneys:
  - Monitor blood pressure, blood sugar, cholesterol, and lipid levels to ensure they're in control.
  - Take medications as prescribed to protect kidney function (ACE inhibitors or ARBs).
  - Offer education on medications that could be harmful to kidneys (NSAIDS such as naproxen or ibuprofen).
  - Limit protein intake and salt in diet.
- Ensure treatment decisions are timely, rely on evidence-based guidelines and include family and social community support encouraging a healthy lifestyle.

HEDIS codes can change from year to year. The codes in this document are from the HEDIS MY2024 specifications.

Guide to Statin Measures

Understanding the Statin Measures

The National Committee for Quality Assurance (NCQA) has established specifications that impact HEDIS measures for patients with cardiovascular disease and for patients identified with diabetes. These measures are focused on two of the major statin benefit populations described in the American College of Cardiology/American Heart Association guidelines and align with recommendations from the American Diabetes Association. Both statin prescribing measures recommend statin therapy for people with either cardiovascular disease or diabetes, regardless of cholesterol levels.

Statin Therapy for Patients with Cardiovascular Disease (SPC)

Patients identified as having clinical atherosclerotic cardiovascular disease (ASCVD), and who meet the criteria below, should receive at least one moderate- or high-intensity statin medication during the measurement year.

Once a patient has received this medication, they should stay on it for at least 80% of their treatment period.*

Other criteria:

- Males 21-75 with ASCVD
- Females 40-75 with ASCVD
- Patients who have both BlueCross medical and pharmacy coverage

ASCVD is identified for this measure in two ways: by an event in the previous year or by both previous and current diagnoses.

Event criteria:

- Myocardial infarction (MI) (heart attack)
- Coronary artery bypass graft surgery (CABG)
- Percutaneous coronary intervention (PCI)
- Other revascularization procedures

Diagnosis criteria:

Patients with an ischemic vascular disease (IVD) diagnosis who had at least one visit (outpatient, acute inpatient, telehealth, or acute inpatient discharge) for this diagnosis during both the measurement year and the year prior to the measurement year.

Helpful Tip

Prescribing 90-day medication fills often saves patients time and money, and helps them stay on their medications.

* Treatment period is defined as the time from when the patient initially fills their prescription to the end of the measurement year.

HEDIS codes can change from year to year. The codes in this document are from the HEDIS MY2024 specifications.

Statin Therapy for Patients with Diabetes (SPD)

Patients identified with diabetes, who meet the below criteria, should receive at least one statin medication of any intensity during the measurement year. Once a patient has received this medication, they should stay on it for at least 80% of their treatment period.*

Other criteria:

- Any patient 40-75 who has been identified with diabetes
- Patients who **don't** have ASCVD
- Patients who have both BlueCross medical and pharmacy coverage

Patients are identified for this measure through claims/encounter data or by pharmacy data during the measurement year or the year prior. Data can come from:

Claim/encounter data: Patients who had at least two diagnoses of diabetes on different dates of service during the measurement year or the year prior to the measurement year.

Pharmacy data: Patients who were dispensed insulin or hypoglycemics/antihyperglycemics during the measurement year or the year prior to the measurement year and have at least one diagnosis of diabetes during the measurement year or the year prior to the measurement

Helpful Tips

Glucophage (metformin) as a solo agent isn't included as one of the diabetes medications that qualify patients for this measure. This is because it's used to treat conditions other than diabetes.

* Treatment period is defined as the time from when the patient initially fills their prescription to the end of the measurement year.

HEDIS codes can change from year to year. The codes in this document are from the HEDIS MY2024 specifications.

Comparison Chart for SPC and SPD

Measure	Age Range	Brief Inclusion / Qualifying Criteria	Requirement to Meet the Measure	Level of Statin Required
SPC-Received Statin Therapy	Males: 21-75 Females: 40-75	Patients with clinical atherosclerotic cardiovascular disease (ASCVD)	Patients need to fill their statin medication prescription.	Moderate to high intensity
SPC-Adherence Statin Therapy	Males: 21-75 Females: 40-75	Patients with clinical ASCVD	Patients should fill enough statin medication to cover at least 80% of their treatment period.	Moderate to high intensity
SPD-Received Statin Therapy	Patients: 40-75	Patients with diabetes, who don't have ASCVD	Patients need to fill their statin medication prescription.	Any intensity
SPD-Adherence Statin Therapy	Patients: 40-75	Patients with diabetes, who don't have ASCVD	Patients should fill enough statin medication to cover at least 80% of their treatment period.	Any intensity

Exclusions

Exclusions and sample exclusion codes for SPC

- Patients with a diagnosis of pregnancy during the measurement year or the year prior to the measurement year
- In vitro fertilization in the measurement year or year prior to the measurement year
- Dispensed at least one prescription for clomiphene during the measurement year or the year prior to the measurement year
- End-stage renal disease (ESRD) diagnosis or dialysis during the measurement year or the year prior to the measurement year
  - Do not include laboratory claims (claims with POS Code 81)
- Dialysis during the measurement year or the year prior to the measurement year
- Cirrhosis during the measurement year or the year prior to the measurement year
- Myalgia, myositis, myopathy, or rhabdomyolysis during the measurement year - sample codes include: G72.0, G72.2, G72.9, M60.80, M60.88, M60.89, M60.9, M62.82, M79.1, M79.10
- Patients in hospice or using hospice services any time during the measurement year
- Patients receiving palliative care during the measurement year
- Patients who died any time during the measurement year
- Medicare members who are 66 and older and are enrolled in a special needs plan (SNP) any time during the measurement year or who are living in a long-term facility/institution during the measurement year
- Patients 66 years and older as of Dec. 31 of the current measurement year who meet both the advanced illness and frailty criteria (Refer to the Advanced Illness and Frailty guide for the criteria.)
- Patients dispensed dementia medication
  - Donepezil
  - Galantamine
  - Rivastigmine
  - Memantine
  - Donepezil-Memantine

HEDIS codes can change from year to year. The codes in this document are from the HEDIS MY2024 specifications.

Cirrhosis

Cirrhosis	[K70.30] Alcoholic cirrhosis of liver without ascites
	[K70.31] Alcoholic cirrhosis of liver with ascites
	[K71.7] Toxic liver disease with fibrosis and cirrhosis of liver
	[K74.3] Primary biliary cirrhosis
	[K74.4] Secondary biliary cirrhosis
	[K74.5] Biliary cirrhosis, unspecified
	[K74.60] Unspecified cirrhosis of liver
	[K74.69] Other cirrhosis of liver
	[P78.81] Congenital cirrhosis (of liver)

End-Stage Renal Disease

ESRD Diagnosis	[N18.5] Chronic kidney disease, stage 5
	[N18.6] End-stage renal disease
	[Z99.2] Dependence on renal dialysis

Myopathy

Muscular Pain and Disease	[G72.0] Drug-induced myopathy
	[G72.2] Myopathy due to other toxic agents
	[G72.9] Myopathy, unspecified

Myositis

Muscular Pain and Disease	[M60.80] Other myositis, unspecified site
	[M60.88] Other myositis, other site
	[M60.89] Other myositis, multiple sites
	[M60.9] Myositis, unspecified

Rhabdomyolysis

Muscular Pain and Disease	[M62.82] Rhabdomyolysis

Myalgia

Muscular Pain and Disease	[M79.1] Myalgia
	[M79.10] Myalgia, unspecified site
	[M79.11] Myalgia of mastication muscle
	[M79.12] Myalgia of auxiliary muscles, head and neck
	[M79.18] Myalgia, other site

Note: To exclude the patient, the diagnosis code for the applicable condition may be submitted on a claim or an attestation may be made in the Quality Care Rewards application located in Availity®.

HEDIS codes can change from year to year. The codes in this document are from the HEDIS MY2024 specifications.

Exclusions and Samples of Exclusion Codes for SPD

Patients can be excluded from the measure if they meet any of the below criteria:

- Patients with cardiovascular disease identified by an "event" in the previous year.
- Event criteria:
  - Myocardial Infarction (MI) (heart attack)
  - Coronary artery bypass graft surgery (CABG)
  - Percutaneous coronary intervention (PCI)
  - Other revascularization procedures
- Patients with cardiovascular disease identified by diagnosis during the measurement year and the year prior
- Patients with a diagnosis of pregnancy during the measurement year or the year prior to the measurement year
- In vitro fertilization in the measurement year or year prior to the measurement year
- Dispensed at least one prescription for clomiphene during the measurement year or the year prior to the measurement year
- ESRD diagnosis or dialysis during the measurement year or the year prior to the measurement year. Do not include laboratory claims (claims with POS code 81)
  - Do not include laboratory claims (claims with POS code 81)
- Dialysis during the measurement year or the year prior to the measurement year
- Cirrhosis during the measurement year or the year prior to the measurement year – sample codes: G72.0, G72.2, G72.9, M60.80, M60.88, M60.89, M60.9, M62.82, M79.1, M79.10
- Myalgia, myositis, myopathy, or rhabdomyolysis during the measurement year
- Patients receiving palliative care during the measurement year
- Patients in hospice or using hospice services any time during the measurement year
- Medicare patients who are 66 and older and are enrolled in an SNP any time during the measurement year or who are living in a long-term facility/institution during the measurement year
- Patients 66 and older as of Dec. 31 of the current measurement year who meet both the advanced illness and frailty criteria. (Refer to the **Advanced Illness and Frailty guide** for the criteria.)
- Dispensed dementia medication.
  - Do not include laboratory claims (claims with POS code 81)
- Patients who died any time during the measurement year

HEDIS codes can change from year to year. The codes in this document are from the HEDIS MY2024 specifications.

Cirrhosis

Cirrhosis	[K70.30] Alcoholic cirrhosis of liver without ascites
	[K70.31] Alcoholic cirrhosis of liver with ascites
	[K71.7] Toxic liver disease with fibrosis and cirrhosis of liver
	[K74.3] Primary biliary cirrhosis
	[K74.4] Secondary biliary cirrhosis
	[K74.5] Biliary cirrhosis, unspecified
	[K74.60] Unspecified cirrhosis of liver
	[K74.69] Other cirrhosis of liver
	[P78.81] Congenital cirrhosis (of liver)

End-Stage Renal Disease

ESRD Diagnosis	[N18.5] Chronic kidney disease, stage 5
	[N18.6] End-stage renal disease
	[Z99.2] Dependence on renal dialysis

Myopathy

Muscular Pain and Disease	[G72.0] Drug-induced myopathy
	[G72.2] Myopathy due to other toxic agents
	[G72.9] Myopathy, unspecified

Myositis

Muscular Pain and Disease	[M60.80] Other myositis, unspecified site
	[M60.88] Other myositis, other site
	[M60.89] Other myositis, multiple sites
	[M60.9] Myositis, unspecified

Rhabdomyolysis

Muscular Pain and Disease	[M62.82] Rhabdomyolysis

Myalgia

Muscular Pain and Disease	[M79.1] Myalgia
	[M79.10] Myalgia, unspecified site
	[M79.11] Myalgia of mastication muscle
	[M79.12] Myalgia of auxiliary muscles, head and neck
	[M79.18] Myalgia, other site

Note: To exclude the patient, the diagnosis code for the applicable condition may be submitted on a claim or an attestation may be made in the Quality Care Rewards application located in Availity®.

HEDIS codes can change from year to year. The codes in this document are from the HEDIS MY2024 specifications.

If the patient was included in the measure based on claims or encounter data, as described in the event/diagnosis criteria, the optional exclusions don't apply because the member had a diagnosis of diabetes.

Statin Medication List

Description	Prescription	Medication Lists
High-intensity statin therapy	Atorvastatin 40-80 mg	Atorvastatin High Intensity Medications List
	Amlodipine-atorvastatin 40-80 mg	Amlodipine Atorvastatin High Intensity Medications List
	Rosuvastatin 20-40 mg	Rosuvastatin High Intensity Medications List
	Simvastatin 80 mg	Simvastatin High Intensity Medications List
	Ezetimibe-simvastatin 80 mg	Ezetimibe Simvastatin High Intensity Medications List
Moderate-intensity statin therapy	Atorvastatin 10-20 mg	Atorvastatin Moderate Intensity Medications List
	Amlodipine-atorvastatin 10-20 mg	Amlodipine Atorvastatin Moderate Intensity Medications List
	Rosuvastatin 5-10 mg	Rosuvastatin Moderate Intensity Medications List
	Simvastatin 20-40 mg	Simvastatin Moderate Intensity Medications List

Description	Prescription	Medication Lists
Moderate-intensity statin therapy (continued)	Ezetimibe-simvastatin 20-40 mg	Ezetimibe Simvastatin Moderate Intensity Medications List
	Pravastatin 40-80 mg	Pravastatin Moderate Intensity Medications List
	Lovastatin 40 mg	Lovastatin Moderate Intensity Medications List
	Fluvastatin 40-80 mg	Fluvastatin Moderate Intensity Medications List
	Pitavastatin 1-4 mg	Pitavastatin Moderate Intensity Medications List
Low-intensity statin therapy	Ezetimibe-simvastatin 10 mg	Ezetimibe Simvastatin Low Intensity Medications List
	Fluvastatin 20 mg	Fluvastatin Low Intensity Medications List
	Lovastatin 10-20 mg	Lovastatin Low Intensity Medications List
	Pravastatin 10–20 mg	Pravastatin Low Intensity Medications List
	Simvastatin 5-10 mg	Simvastatin Low Intensity Medications List

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Cardiac and Respiratory Care

Measure	Goal of the Measure	What To Report (Sample Of Codes and/or Diagnoses)	Exclusions	Helpful Tips
Asthma Medication Ratio (AMR) 5-64 years	Patients 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.	**Sample diagnoses:** • Asthma unspecified – J45.901, J45.909 • Extrinsic asthma – 493.00 • Intrinsic asthma unspecified – 493.10 • Chronic obstructive asthma – 10692721000119102	Respiratory diseases with different treatment approaches than asthma: • COPD • Obstructive chronic bronchitis • Emphysema • Cystic fibrosis • Acute respiratory failure • Chronic respiratory conditions	A telehealth visit may be helpful for checking on your patients 5 to 64 years of age to determine how well they're managing their asthma. This visit could provide an opportunity to review their current medication regimen, discuss any symptoms, and assist with refills. Prescribing 90-day medication fills often saves patients time and money and helps them stay on their medications, all from the comfort and safety of their home. Appropriate asthma medication ratios of 0.50 or greater of long-term controller medications to quick-reliever medications could potentially prevent a significant proportion of asthma-related costs (hospitalizations, ER visits), while also lowering non-medication costs. Encouraging patients to remain on their controller medications to lessen and/or prevent asthma complications and flare-ups will help keep them from refilling and using their rescue inhalers more than their controller medications.

Some sample medications that are considered asthma controller medications include:

Omalizumab, Dupilumab, Benralizumab, Formoterol-mometasone, Fluticasone-vilanterol, Budesonide-formoterol, Beclomethasone, Budesonide, Ciclesonide, Fluticasone, Montelukast, and Theophylline. (This isn't an exhaustive list.)

HEDIS codes can change from year to year. The codes in this document are from the HEDIS MY2024 specifications.

Measure	Goal of the Measure	What To Report (Sample Of Codes and/or Diagnoses)	Exclusions	Helpful Tips
Controlling High Blood Pressure (CBP) 18-85 years	Patients with a diagnosis of hypertension should have a controlled blood pressure (B/P) level of <140/90 during the measurement year. Patients are entered into the measure when they've had at least two visits on different dates of service with a diagnosis of hypertension on or between Jan. 1, 2023 and June 30, 2024. The documented blood pressure would need to be in range and occur after the patient was deemed hypertensive in order for the gap in care to close. If an attestation is entered prior to the second diagnosis of hypertension that placed them into the measure, then the second diagnosis would reopen the gap.	**Sample diagnosis:** • Essential hypertension **Sample CPT® Codes** to identify high blood pressure control: **Diastolic less than 80:** 3078F **Diastolic 80-89:** 3079F **Diastolic less than 90** **Systolic less than 140:** 3074F-3075F	• Patients in hospice • Patients in palliative care, Z51.5 • Patients 66-80 years and older with both advanced illness criteria and frailty diagnosis • Patients 81 years and older with a frailty diagnosis (at least two indications of frailty diagnoses with different dates of service during the measurement year) • End-stage renal disease or kidney transplant • Patients with a diagnosis of pregnancy during the measurement year • Patients who died any time during the measurement year	Patients can now self-report B/P levels during telehealth or telephone visits if the B/P level was taken on a digital device. The date, B/P level, and the fact that it was a patient-reported digital device should be documented in the chart. B/P readings can be taken from any digital device. You can retake a B/P for a patient on the same visit if the first one is out of acceptable range. If the first check of B/P is out of range, let the patient have a few minutes to relax, take some deep breaths, and then recheck. You can use the lowest systolic and the lowest diastolic readings for a B/P level for a patient if they are taken on the **same date/same visit**. **Example:** • 1st reading is 130/95; 2nd reading is 156/80 • The gap can be closed with the reading of 130/80 The most recent value in the chart will stand for the reading for the patient for the measurement year. B/P readings that will **NOT** close the gap or meet the measure intent: • B/P readings from inpatient or ED visit • B/P taken on the same day as a diagnostic test or procedure that causes a change in diet or medication on the day of, or day before the procedure. (Examples – a colonoscopy or nebulizer treatment with bronchodilator require changes in diet or a change in medication regimen)

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Measure	Goal of the Measure	What To Report (Sample Of Codes and/or Diagnoses)	Exclusions	Helpful Tips
Pharmacotherapy Management of COPD Exacerbation (PCE) 40 years and older	Patients with a diagnosis of COPD exacerbations that were seen in an ED visit or admitted for an acute inpatient stay should have the following medications prescribed and filled: • Corticosteroids within 14 days of discharge from an acute inpatient stay or ED visit **AND** • Bronchodilator within 30 days of discharge from an acute inpatient stay or ED visit	**Sample Diagnoses:** • Emphysema • Chronic obstructive asthma • Chronic obstructive bronchitis • Simple chronic bronchitis	• Patients in hospice or using hospice services • Patients that died any time during the measurement year	Assisting patients with action plans to control exacerbations is key. Explore possible reasons for your patients' medication non-adherence (i.e. cost, denial, depression, substance use/abuse, side effects). Some sample Systemic Corticosteriod Medications include: Cortisone, Prednisolone, Prednisone, Dexamethasone; Some sample Bronchodilator Medications include: Ipratropium, Albuterol, Indacaterol, Budesonide-formoterol, Fluticasone-vilanterol (This list is only a partial list of samples and is not exhaustive.)

HEDIS codes can change from year to year. The codes in this document are from the HEDIS MY2024 specifications.

Measure	Goal of the Measure	What To Report (Sample Of Codes and/or Diagnoses)	Exclusions	Helpful Tips
Received Statin Therapy for Patients with Cardiovascular Disease (SPC) Men: 21-75 years Women: 40-75 years	Patients with a diagnosis of clinical atherosclerotic cardiovascular disease (ASCVD) should be dispensed at least one **high- or moderate-intensity statin** medication.	**Sample Diagnosis:** • Clinical atherosclerotic cardiovascular disease (ASCVD) **Sample Events:** • Coronary artery bypass graft (CABG) CPT® – 33510-33514, 33516-33519 HCPCS – S2205-S2209 • Myocardial infarction (MI) I21.4, I21.9, I22.0-I22.2, I23.7, I23.8 • Percutaneous coronary intervention (PCI) HCPCS – C9600, C9602, C9604, C9606, C9607 • Other revascularization procedures • Ischemic Vascular Disease (IVD) ICD10 – I20.0, I20.8, I20.9, I24.9, I25.10, I25.5	• Patients 66 years and older as of Dec. 31 that have both advanced illness and frailty diagnoses (At least two indications of frailty diagnoses with different dates of service during the measurement year) • Patients in hospice • Patients in palliative care, Z51.5 • Patients with a diagnosis of pregnancy or in vitro fertilization (IVF) during the measurement year or the prior year • Patients dispensed at least one prescription of an estrogen agonists medication • End-stage renal disease • Cirrhosis • Myalgia, myositis, myopathy, or rhabdomyolysis during the measurement year (sample diagnosis codes include, but not limited to: G72.0, G72.2, G72.9, M60.80, M60.88, M60.89, M60.9, M62.82, M79.1, M79.10) • Patients who died any time during the measurement year	Only high or moderate intensities of statin therapy will meet the goal of this measure. A telehealth visit may be helpful to check on patients and how they're doing with their medications and to ensure they're getting the refills they need. Encourage patients to get a 90-day fill of their prescription(s) to help save money and time. A diagnosis of IVD can be made during a telephone, telehealth, or virtual check-in visit.

HEDIS codes can change from year to year. The codes in this document are from the HEDIS MY2024 specifications.

Measure	Goal of the Measure	What To Report (Sample Of Codes and/or Diagnoses)	Exclusions	Helpful Tips
Adherence 80% Statin Therapy For Patients with Cardiovascular Disease (SPC) Men: 21-75 years Women: 40-75 years	Patients with a diagnosis of clinical atherosclerotic cardiovascular disease (ASCVD) should remain on a **high- or moderate-intensity statin** medication for at least 80% of the treatment period. **Note**: Treatment period is defined as the initial dispensing date of a moderate- or high-intensity statin through the end of the measurement year.	**Sample Diagnosis:** • Clinical atherosclerotic cardiovascular disease (ASCVD) **Sample Events:** • Coronary artery bypass graft (CABG) - CPT® - 33510-33514, 33516-33519 - HCPCS - S2205-S2209 • Myocardial infarction (MI) I21.4, I21.9, I22.0-I22.2, I23.7, I23.8 • Percutaneous coronary intervention (PCI) - HCPCS - C9600, C9602, C9604, C9606, C9607 • Other revascularization procedures - Ischemic Vascular Disease (IVD) - ICD 10 - I20.0, I20.8, I20.9, I24.9, I25.10, I25.5	• Patients age 66 years and older as of Dec. 31 that have both advanced illness and frailty diagnoses (At least two indications of frailty diagnoses with different dates of service during the measurement year) • Patients in hospice • Patients in palliative care, Z51.5 • Patients with a diagnosis of pregnancy or receiving in vitro fertilization (IVF) during the measurement year or the prior year • Patient dispensed at least one prescription of an estrogen agonists medication • End-stage renal disease • Cirrhosis • Myalgia, myositis, myopathy, or rhabdomyolysis during the measurement year - (sample diagnosis codes include, but not limited to: G72.0, G72.2, G72.9, M60.80, M60.88, M60.89, M60.9, M62.82, M79.1, M79.10) • Patients who died any time during the measurement year	Only high or moderate intensities of statin therapy will meet the goal of this measure. A telehealth visit may be helpful to check on patients and how they're doing with their medications and to ensure they're getting the refills they need. Encourage patients to get a 90-day fill of their prescription(s) to help save money and time. Explore possible reasons for your patients' medication non-adherence (i.e., cost, denial, depression, substance use/abuse, side effects).

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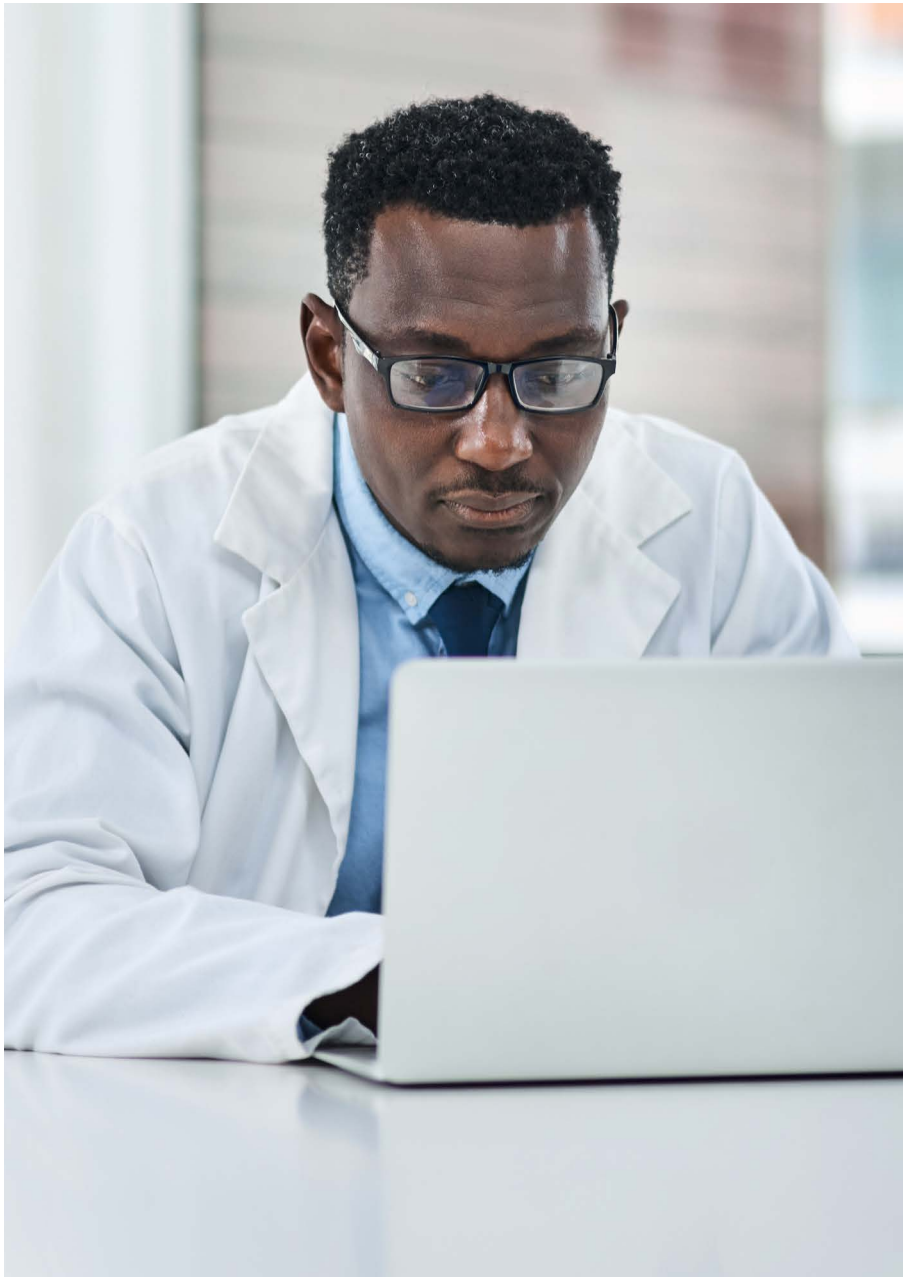
Additional Resources

Guide to Statin Measures (SPC and SPD):
https://www.bcbst.com/docs/providers/quality-initiatives/guide-statin-measure.pdf



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Guide to Statin Measures

Understanding the Statin Measures

The National Committee for Quality Assurance (NCQA) has established specifications that impact HEDIS measures for patients with cardiovascular disease and for patients identified with diabetes. These measures are focused on two of the major statin benefit populations described in the American College of Cardiology/American Heart Association guidelines and align with recommendations from the American Diabetes Association. Both statin prescribing measures recommend statin therapy for people with either cardiovascular disease or diabetes, regardless of cholesterol levels.

Statin Therapy for Patients with Cardiovascular Disease (SPC)

Patients identified as having clinical atherosclerotic cardiovascular disease (ASCVD), and who meet the criteria below, should receive at least one moderate- or high-intensity statin medication during the measurement year.

Once a patient has received this medication, they should stay on it for at least 80% of their treatment period.*

Other criteria:

- Males: 21-75 with ASCVD
- Females: 40-75 with ASCVD
- Patients who have both BlueCross medical and pharmacy coverage

ASCVD is identified for this measure in two ways: by an event in the previous year or by both previous and current diagnoses.

Event criteria:

- Myocardial infarction (MI) (heart attack)
- Coronary artery bypass graft surgery (CABG)
- Percutaneous coronary intervention (PCI)
- Other revascularization procedures

Diagnosis criteria:

Patients with an ischemic vascular disease (IVD) diagnosis who had at least one visit (outpatient, acute inpatient, telehealth, or acute inpatient discharge) for this diagnosis during both the measurement year and the year prior to the measurement year.

Helpful Tip

Prescribing 90-day medication fills often saves patients time and money, and helps them stay on their medications.

* Treatment period is defined as the time from when the patient initially fills their prescription to the end of the measurement year.

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Statin Therapy for Patients with Diabetes (SPD)

Patients identified with diabetes, who meet the below criteria, should receive at least one statin medication of any intensity during the measurement year. Once a patient has received this medication, they should stay on it for at least 80% of their treatment period.*

Other criteria:

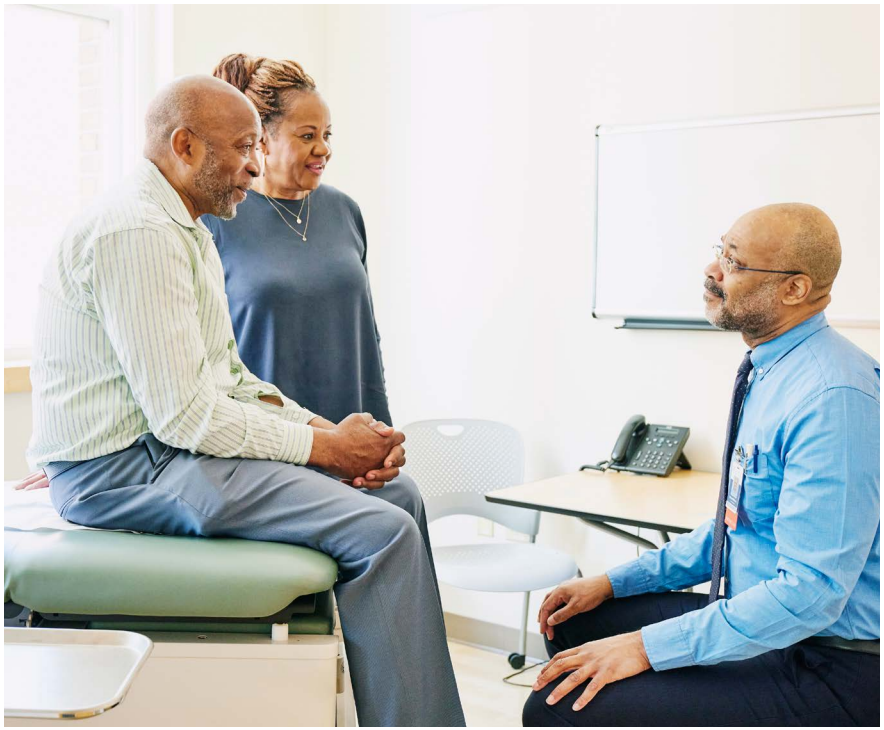
- Any patient 40-75 who has been identified with diabetes
- Patients who **don't** have ASCVD
- Patients who have both BlueCross medical and pharmacy coverage

Patients are identified for this measure through claims/encounter data or by pharmacy data during the measurement year or the year prior. Data can come from:

- Claim/encounter data: Patients who had at least two diagnoses of diabetes on different dates of service during the measurement year or the year prior to the measurement year.
- Pharmacy data: Patients who were dispensed insulin or hypoglycemics/antihyperglycemics during the measurement year or the year prior to the measurement year and have at least one diagnosis of diabetes during the measurement year or the year prior to the measurement

Helpful Tip

Glucophage (metformin) as a solo agent isn't included as one of the diabetes medications that qualify patients for this measure. This is because it's used to treat conditions other than diabetes.



* Treatment period is defined as the time from when the patient initially fills their prescription to the end of the measurement year.

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Comparison Chart for SPC and SPD

Measure	Age Range	Brief Inclusion / Qualifying Criteria	Requirement to Meet the Measure	Level of Statin Required
SPC-Received Statin Therapy	Males: 21-75 Females: 40-75	Patients with clinical atherosclerotic cardiovascular disease (ASCVD)	Patients need to fill their statin medication prescription.	Moderate to High Intensity
SPC-Adherence Statin Therapy	Males: 21-75 Females: 40-75	Patients with clinical ASCVD	Patients should fill enough statin medication to cover at least 80% of their treatment period.	Moderate to High Intensity
SPD-Received Statin Therapy	Patients: 40-75	Patients with diabetes, who don't have ASCVD	Patients need to fill their statin medication prescription.	Any intensity
SPD-Adherence Statin Therapy	Patients: 40-75	Patients with diabetes, who don't have ASCVD	Patients should fill enough statin medication to cover at least 80% of their treatment period.	Any intensity

Exclusions

Exclusions and sample exclusion codes for SPC

- Patients with a diagnosis of pregnancy during the measurement year or the year prior to the measurement year
- In vitro fertilization in the measurement year or year prior to the measurement year
- Dispensed at least one prescription for clomiphene during the measurement year or the year prior to the measurement year
- End-stage renal disease (ESRD) diagnosis (or dialysis) during the measurement year or the year prior to the measurement year
  - Do not include laboratory claims (claims with POS code 81)
- Dialysis during the measurement year or the year prior to the measurement year
- Cirrhosis during the measurement year or the year prior to the measurement year
- Myalgia, myositis, myopathy, or rhabdomyolysis during the measurement year - sample codes include: G72.0, G72.2, G72.9, M60.80, M60.88, M60.89, M60.9, M62.82, M79.1, M79.10
- Patients in hospice or using hospice services any time during the measurement year
- Patients receiving palliative care during the measurement year
- Patients who died any time during the measurement year
- Medicare members who are 66 and older and are enrolled in a special needs plan (SNP) any time during the measurement year or who are living in a long-term facility/institution during the measurement year
- Patients 66 years and older as of Dec. 31 of the current measurement year who meet both the advanced illness and frailty criteria (Refer to the Advanced Illness and Frailty guide for the criteria.)
- Patients dispensed dementia medication
  - Donepezil
  - Galantamine
  - Rivastigmine
  - Memantine
  - Donepezil-Memantine

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Cirrhosis

Cirrhosis	[K70.30] Alcoholic cirrhosis of liver without ascites
	[K70.31] Alcoholic cirrhosis of liver with ascites
	[K71.7] Toxic liver disease with fibrosis and cirrhosis of liver
	[K74.3] Primary biliary cirrhosis
	[K74.4] Secondary biliary cirrhosis
	[K74.5] Biliary cirrhosis, unspecified
	[K74.60] Unspecified cirrhosis of liver
	[K74.69] Other cirrhosis of liver
	[P78.81] Congenital cirrhosis (of liver)

End-Stage Renal Disease

ESRD Diagnosis	[N18.5] Chronic kidney disease, stage 5
	[N18.6] End-stage renal disease
	[Z99.2] Dependence on renal dialysis

Myopathy

Muscular Pain and Disease	[G72.0] Drug-induced myopathy
	[G72.2] Myopathy due to other toxic agents
	[G72.9] Myopathy, unspecified

Myositis

Muscular Pain and Disease	[M60.80] Other myositis, unspecified site
	[M60.88] Other myositis, other site
	[M60.89] Other myositis, multiple sites
	[M60.9] Myositis, unspecified

Rhabdomyolysis

Muscular Pain and Disease	[M62.82] Rhabdomyolysis

Myalgia

Muscular Pain and Disease	[M79.1] Myalgia
	[M79.10] Myalgia, unspecified site
	[M79.11] Myalgia of mastication muscle
	[M79.12] Myalgia of auxiliary muscles, head and neck
	[M79.18] Myalgia, other site

Note: To exclude the patient, the diagnosis code for the applicable condition may be submitted on a claim or an attestation may be made in the Quality Care Rewards application located in Availity®.

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Exclusions and Samples of Exclusion Codes for SPD

Patients can be excluded from the measure if they meet any of the below criteria:

- Patients with cardiovascular disease identified by an "event" in the previous year
- Event criteria:
  - Myocardial Infarction (MI) (heart attack)
  - Coronary artery bypass graft surgery (CABG)
  - Percutaneous coronary intervention (PCI)
  - Other revascularization procedures
- Patients with cardiovascular disease identified by diagnosis during the measurement year and the year prior
- Patients with a diagnosis of pregnancy during the measurement year or the year prior to the measurement year
- In vitro fertilization in the measurement year or year prior to the measurement year
- Dispensed at least one prescription for clomiphene during the measurement year or the year prior to the measurement year
- ESRD diagnosis or dialysis during the measurement year or the year prior to the measurement year.
  - Do not include laboratory claims (claims with POS code 81)
- Dialysis during the measurement year or the year prior to the measurement year
- Cirrhosis during the measurement year or the year prior to the measurement year -sample codes: G72.0, G72.2, G72.9, M60.80, M60.88, M60.89, M60.9, M62.82, M79.1, M79.10
- Myalgia, myositis, myopathy, or rhabdomyolysis during the measurement year
- Patients receiving palliative care during the measurement year
- Patients in hospice or using hospice services any time during the measurement year
- Medicare patients who are 66 and older and are enrolled in an SNP any time during the measurement year or who are living in a long-term facility/institution during the measurement year
- Patients 66 and older as of Dec. 31 of the current measurement year who meet both the advanced illness and frailty criteria (Refer to the **Advanced Illness and Frailty guide** for the criteria.)
- Dispensed dementia medication
- Patients who died any time during the measurement year

HEDIS codes can change from year to year. The codes in this document are from the HEDIS MY2024 specifications.

Cirrhosis

Cirrhosis	[K70.30] Alcoholic cirrhosis of liver without ascites
	[K70.31] Alcoholic cirrhosis of liver with ascites
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	[P78.81] Congenital cirrhosis (of liver)

End-Stage Renal Disease

ESRD Diagnosis	[N18.5] Chronic kidney disease, stage 5
	[N18.6] End-stage renal disease
	[Z99.2] Dependence on renal dialysis

Myopathy

Muscular Pain and Disease	[G72.0] Drug-induced myopathy
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	[G72.9] Myopathy, unspecified

Myositis

Muscular Pain and Disease	[M60.80] Other myositis, unspecified site
	[M60.88] Other myositis, other site
	[M60.89] Other myositis, multiple sites
	[M60.9] Myositis, unspecified

Rhabdomyolysis

Muscular Pain and Disease	[M62.82] Rhabdomyolysis

Myalgia

Muscular Pain and Disease	[M79.1] Myalgia
	[M79.10] Myalgia, unspecified site
	[M79.11] Myalgia of mastication muscle
	[M79.12] Myalgia of auxiliary muscles, head and neck
	[M79.18] Myalgia, other site

Note: To exclude the patient, the diagnosis code for the applicable condition may be submitted on a claim or an attestation may be made in the Quality Care Rewards application located in Availity®.

HEDIS codes can change from year to year. The codes in this document are from the HEDIS MY2024 specifications.

If the patient was included in the measure based on claims or encounter data, as described in the event/diagnosis criteria, the optional exclusions don't apply because the member had a diagnosis of diabetes.

Statin Medication List

Description	Prescription	Medication Lists
High-intensity statin therapy	Atorvastatin 40-80 mg	Atorvastatin High Intensity Medications List
	Amlodipine-atorvastatin 40-80 mg	Amlodipine Atorvastatin High Intensity Medications List
	Rosuvastatin 20-40 mg	Rosuvastatin High Intensity Medications List
	Simvastatin 80 mg	Simvastatin High Intensity Medications List
	Ezetimibe-simvastatin 80 mg	Ezetimibe Simvastatin High Intensity Medications List
Moderate-intensity statin therapy	Atorvastatin 10-20 mg	Atorvastatin Moderate Intensity Medications List
	Amlodipine-atorvastatin 10-20 mg	Amlodipine Atorvastatin Moderate Intensity Medications List
	Rosuvastatin 5-10 mg	Rosuvastatin Moderate Intensity Medications List
	Simvastatin 20-40 mg	Simvastatin Moderate Intensity Medications List

Description	Prescription	Medication Lists
Moderate-intensity statin therapy (continued)	Ezetimibe-simvastatin 20-40 mg	Ezetimibe Simvastatin Moderate Intensity Medications List
	Pravastatin 40-80 mg	Pravastatin Moderate Intensity Medications List
	Lovastatin 40 mg	Lovastatin Moderate Intensity Medications List
	Fluvastatin 40-80 mg	Fluvastatin Moderate Intensity Medications List
	Pitavastatin 1-4 mg	Pitavastatin Moderate Intensity Medications List
Low-intensity statin therapy	Ezetimibe-simvastatin 10 mg	Ezetimibe Simvastatin Low Intensity Medications List
	Fluvastatin 20 mg	Fluvastatin Low Intensity Medications List
	Lovastatin 10-20 mg	Lovastatin Low Intensity Medications List
	Pravastatin 10–20 mg	Pravastatin Low Intensity Medications List
	Simvastatin 5-10 mg	Simvastatin Low Intensity Medications List

HEDIS codes can change from year to year. The codes in this document are from the HEDIS MY2024 specifications.

Preventive Screening Care

Measure	Goal of the Measure	What To Report (Sample Of Codes and/or Diagnoses)	Exclusions	Helpful Tips
Breast Cancer Screening (BCS-E*) 50-74 years	Patients who were recommended in this age range should have a mammogram to screen for breast cancer at least every two years or more frequently based on provider advisement. Criteria to be included in the measure for patients in this age range includes: • Adminstrative Gender of Female (Administrative Gender code F) at any time in the patient's history. • Sex Assigned at Birth (LOINC code 76689-9) of Female (LOINC code LA3-6) at any time in the patient's history.	**Sample CPT® Codes:** **Mammography CPT®:** 77061-77063, 77065-77067 **Sample Exclusion codes:** 85.42, 85.46	• Patients in hospice • Patients who die any time during the measurement year • Patients in palliative care • Patients 66 years and older with both advanced illness criteria and two indications of a frailty diagnosis • Patients who have had mastectomies (bilateral, two unilateral, or unilateral mastectomy with bilateral modifier in the same procedure) • Patients who had gender-affirming chest surgery (CPT® code 19318) with a diagnosis of gender dysphoria any time during the patient's history through the end of the measurement period	All types and methods of mammograms qualify for meeting the measure (screening, diagnostic, film, digital, and digital breast tomosynthesis). MRIs, ultrasounds, and biopsies do **NOT** meet the measure. The measurement year is Jan. 1-Dec. 31. The measure will allow for mammograms done Oct. 1 two years prior to the measurement year through the end of the measurement year.

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Measure	Goal of the Measure	What To Report (Sample Of Codes and/or Diagnoses)	Exclusions	Helpful Tips
Cervical Cancer Screening (CCS, CCS-E*) 21-64 years	Patients who were recommended and in this age range should have a cervical cancer screening per the guidelines below or more frequently based on provider advisement according to their past history and risk: • Age 21-64: Cervical cytology during the measurement year or the two years prior • Age 30-64: Cervical cytology and high-risk HPV testing or cotesting during the measurement year or the four years prior **OR** • Age 30-64: Cervical high-risk HPV testing during the measurement year or the four years prior Criteria to be included in the measure for patients in this age range includes: • Administrative Gender of Female (Administrative Gender code F) at any time in the patient's history. • Sex Assigned at Birth (LOINC code 76689-9) of Female (LOINC code LA3-6) at any time in the patient's history.	**Sample CPT® (and HCPCS) Codes:** **Cervical Cytology HCPCS:** G0123, G0124, G0141, G0143, G0144, G0145, G0147, G0148, P3000, P3001, Q0091 **Cervical Cytology CPT®:** 88141- 88143, 88147-88148, 88150, 88152-88154, 88164-88167, 88174-88175 **High-Risk HPV Test:** 87624, 87625, (HCPCS) G0476 **Sample Exclusion Codes:** Q51.5, Z90.710, Z90.712	Patients who've had a hysterectomy with: • No residual cervix • Cervical agenesis • Acquired absence of cervix **Absence of Cervix Diagnosis (ICD-10):** Q51.5, Z90.710, Z90712 • Patients in hospice • Patients in palliative care • Patients who died during the measurement year • Patients who were assigned male gender at birth (LOINC code 76689-9) of Male (LOINC code LA2-8)	Documentation of "hysterectomy" alone does **not** exclude a member from this measure. The documentation must show "total hysterectomy," "complete hysterectomy," "vaginal hysterectomy," or that the cervix is surgically absent, to show evidence that the cervix was removed and screening isn't needed. Documentation of the pap test result and date in the chart is needed to close this gap through medical record review. However, the gap will close via claims with the correct coding for cervical cancer screenings. Biopsies don't count because they're diagnostic and not valid for primary cervical cancer screening. Sample results of "inadequate sample" or "no cervical cells" do not count. **Evidence** of high-risk hrHPV testing during the measurement year or the four years prior to the measurement year (for patients who were 30 years or older as of the date of testing) – also captures patients who had co-testing. Documentation must include both the date and the result. Generic documentation of "HPV test" and associated results can be counted as evidence of an hrHPV test. The measurement year is Jan. 1-Dec. 31.

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Measure	Goal of the Measure	What To Report (Sample Of Codes and/or Diagnoses)	Exclusions	Helpful Tips
Chlamydia Screening in Women (CHL) 16-24 years	Women identified as sexually active should have at least one chlamydia screening during the measurement year.	**Sample CPT® Codes:** **Chlamydia Testing:** 87110, 87270, 87320, 87490-87492, 87810, 0353U	• Patients in hospice • Patients who had a pregnancy test and were prescribed retinoid medication, or had an X-ray, on the date of the pregnancy test or within six days following the pregnancy test • Patients who died during the measurement year	**Note**: Sexually active status is determined from claim/encounter data and pharmacy data. Patients who receive a pregnancy test are considered sexually active. Patients who were dispensed prescription contraceptives during the measurement year are considered sexually active regardless of the diagnosis for which they were given. Patients on contraceptives for another reason aren't excluded. Therefore, a gap will show up anytime a birth control prescription is filled for a patient in this age range, regardless of the reason it's prescribed. Patients with a diagnosis of pregnancy are considered sexually active. Including documentation of CHL test on the claim form is important in closing the gap for this measure. A urine test for chlamydia screening will meet compliance with this measure and isn't as invasive. Implementing this screening into a routine workflow when contraceptives are prescribed can be helpful. The measurement year is Jan. 1-Dec. 31.

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Measure	Goal of the Measure	What To Report (Sample Of Codes and/or Diagnoses)	Exclusions	Helpful Tips
Colorectal Cancer Screening (COL-E*) 45-75 years	Patients should receive appropriate screening for colorectal cancer.	While colonoscopy is the gold standard, the measure will close with any of the following screening types and **sample CPT® codes:** • Colonoscopy during the measurement year or the nine years prior: 44388-44392, 44401-44408, 45378-45393, 45398 (every 10 years) • Flexible sigmoidoscopy during the measurement year or the four years prior: 45330-45335, 45337-45338, 45340-45347 (every five years) • CT colonography during the measurement year or the four years prior: 74261-74263 (every five years) • Stool DNA (sDNA) with FIT test during the measurement year or the two years prior: 81528 (every three years). This is different from the plain FIT testing - this testing uses DNA • Fecal occult blood testing (FOBT), including fecal immunochemical testing (FIT): 82270, 82274 requires only one stool sample (annually) • If using guaiac testing, three samples are required	• Patients in hospice • Patients in palliative care, Z51.5 • Patients with colon cancer or history of colon cancer • Patients with a total colectomy • Patients 66 years and older with both advanced illness and frailty diagnoses (at least two indications of frailty diagnoses with different dates of service during the measurement year) • Patients who died any time during the measurement year	Documentation in the medical record must include a note indicating the date when the colorectal cancer screening was performed. A result isn't required if the documentation is clearly part of the member's "medical history"; if this isn't clear, the result or finding must also be present (this ensures that the screening was performed and not merely ordered). The length of time that this gap closes is based on the type of screening performed. In-office Guaiac Test and fecal occult blood testing via digital rectal exam do NOT meet the measure criteria. Guaiac testing is acceptable if it's not collected in the office and there are at least three samples returned. It can be tested in the office when the patient returns the cards. If you use the older Guaiac testing, three samples are required each year. The U.S. Preventive Services Task Force recommends colorectal cancer screenings beginning at age 45, or earlier if patients are high risk.

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Pregnancy Health Care

Measure	Goal of the Measure	What To Report (Sample Of Codes and/or Diagnoses)	Exclusions	Helpful Tips
Postpartum Depression Screening and Follow-up (PDS-E*) Patients: no age specified	Patients who delivered a live-birth during the period of Sept. 8 of the year prior to the measurement year through Sept. 7 of the measurement year should be screened for clinical depression during the postpartum period of 7-84 days after delivery, **and, if screened positive, receive follow-up care on or within 30 days of the screening.**	Screening instruments include, but aren't limited to: PHQ-9, PHQ-2, BDI-FS, EPDS, CESD-R, CUDOS This measure requires the use of an age-appropriate screening instrument. The patient's age is used to select the appropriate depression screening instrument.	Patients who: • Are in hospice or using hospice services • Die during the measurement year	The U.S. Preventive Services Task Force recommends screening for depression among adolescents and adults, including pregnant and postpartum women. The American College of Obstetricians and Gynecologists (ACOG) recommends multiple postpartum visits no later than 12 weeks after birth, that include a full assessment of psychological well-being, including screening for postpartum depression and anxiety, with a validated instrument.
Prenatal Depression Screening and Follow-up (PND-E*) Patients: no age specified	Patients who've delivered a birth in the measurement period of Jan. 1- Dec. 31 should be screened for clinical depression using a standard instrument while pregnant **and, if screened positive, the patient should receive follow-up care within 30 days of the screening.**	Screening instruments include, but aren't limited to: PHQ-9, PHQ-2, BDI-FS, EPDS, CESD-R This measure requires the use of an age-appropriate screening instrument. The patient's age is used to select the appropriate depression screening instrument.	Patients who: • Delivered earlier than 37 weeks gestation • Are in hospice or using hospice services • Die during the measurement year	The U.S. Preventive Services Task Force recommends screening for depression among adolescents and adults, including pregnant and postpartum women. The American College of Obstetricians and Gynecologists (ACOG) recommends that clinicians screen patients at least once during pregnancy or the postpartum period for depression and the anxiety symptoms using a standardized, validated tool. Each separate pregnancy episode ending in a delivery is counted in the initial population.

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Measure	Goal of the Measure	What To Report (Sample Of Codes and/or Diagnoses)	Exclusions	Helpful Tips
Prenatal Care (PPC) Patients: no age specified	Patients who've delivered a live birth on or between Oct. 8 of the year prior to the measurement year and Oct. 7 of the measurement year should complete the following: **Prenatal Care:** Patients should have a prenatal care visit with a PCP, OB/GYN, or other prenatal care practitioner: • Within the **first trimester (which is 280-176 days prior to delivery, or the estimated delivery date [EDD])** **OR** • Within **42 days of enrollment** A diagnosis of pregnancy must be present and documented at the visit.	**Sample diagnoses:** Pregnancy, high-risk pregnancy, young primigravida, elderly primigravida, elderly multigravida **Sample CPT® (AND HCPCS) Codes to identify a prenatal care visit (Give date care started for bundled services.)** **Prenatal Visit**: 98966, 98967, 98968, 98980, 98981, 99202-99205, 99211-99215, 99241-99245, 99483 **Prenatal Bundled Services:** 59400,59425-59426, 59510, 59610, 59618 (H1005)	• Patients in hospice • Patients who died during the measurement year • Patients who have non-live births are removed from the measure	The gap can be closed through administrative claims or medical record review.

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Measure	Goal of the Measure	What To Report (Sample Of Codes and/or Diagnoses)	Exclusions	Helpful Tips
Postpartum Care (PPC) Patients: no age specified	Patients who've delivered a live birth on or between Oct. 8 of the year prior to the measurement year and Oct. 7 of the measurement year should complete the following: **Postpartum Care:** Patients should have a postpartum care visit with a PCP, OB/GYN, or other prenatal care practitioner on or between 7-84 days after delivery. Postpartum care provided in an acute care inpatient setting does not count toward the measure.	**Sample CPT®(AND HCPCS) codes to identify a postpartum care visit (Give date care started for bundled services.)** **Postpartum:** 57170, 58300, 59430, 99501 **Postpartum Bundled Services:** 59400, 59410, 59510, 59515, 59610, 59614, 59618, 59622	• Patients in hospice • Patients who died during the measurement year • Patients with non-live births are removed from the measure	For gap closure via medical record review, documentation must include the date of the postpartum visit **and** documentation of **one** of the following: • Pelvic exam • Evaluation of weight, B/P, breasts and abdomen (i.e. notation of "breastfeeding" is acceptable for the evaluation of breasts component) • Notation of postpartum care, including but not limited to: - Notation of "postpartum care," "PP Check," "6 week check" - Preprinted "postpartum care" form in which information was documented during the visit • Perineal or cesarean incision/ wound check • Screening for depression, anxiety, tobacco use, substance use disorder, or preexisting mental health disorders • Glucose screening for patients with gestational diabetes Documentation of any of the following: • Infant care or breastfeeding • Resumption of intercourse • Family planning • Sleep/fatigue • Resumption of physical activity • Attainment of healthy weight

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Measure	Goal of the Measure	What To Report (Sample Of Codes and/or Diagnoses)	Exclusions	Helpful Tips
Prenatal Immunization Status (PRS-E*) Patients: no age specified	Patients who've delivered a birth in the measurement period of Jan. 1- Dec. 31 should receive the following: vaccines for influenza, tetanus, diphtheria, and acellular pertussis. • Flu shot – on or between July 1 of the year prior to the measurement period and the delivery date • Tdap vaccine – during each pregnancy	**Sample CPT® Codes:** **Tdap vaccine**: 90715 **Influenza vaccine:** 90630, 90653, 90654, 90662, 90673, 90682, 90689, 90694, 90756	**Patients who:** • Delivered earlier than 37 weeks gestation • Are in hospice or using hospice services • Die during the measurement year	The Advisory Committee on Immunization Practices (ACIP) clinical guidelines recommend that all patients who are pregnant or who might be pregnant in the upcoming influenza season receive inactivated influenza vaccines. ACIP also recommends that pregnant patients receive one dose of Tdap during each pregnancy, preferably during the early part of gestational weeks 27-36, regardless of prior history of receiving Tdap.

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Behavioral Health Care

Behavioral Health Care Access and Coordination

Measure	Goal of the Measure	What To Report (Sample Of Codes and/or Diagnoses)	Exclusions	Helpful Tips
Unhealthy Alcohol Use Screening and Follow-up (ASF-E*) 18 years and older	Patients 18 years and older should be screened for unhealthy alcohol use during the measurement year using a standardized instrument and, **if screened positive, received appropriate follow-up care.**	**Sample screening instruments:** AUDIT, AUDIT-C **Sample CPT® codes:** 99408, 99409 **Sample HCPCS codes:** G0396, G0397, G0443, G2011, H0005, H0007 **Sample LOINC codes:** 88037-7, 75889-6	• Patients in hospice or hospice services • Patients with dementia or a history of dementia • Patients with alcohol use disorder that started the year prior to the measurement year	The U.S. Preventive Services Task Force recommends that clinicians screen adults 18 years and older for alcohol misuse and provide brief behavioral counseling interventions to those who misuse alcohol.
Risk of Continued Opioid Use (COU) 18 years and older	Patients who haven't taken opioids in six months or more, that have a new opioid prescription for 15 days or more in a 30 day period OR 31 or more days in a 62 day period.	See Exclusions	• Patients in hospice or palliative care • Patients with cancer during the measurement year • Patients with sickle cell disease during the measurement year (Sample diagnoses codes D57.00-D57.02) • Patients who died during the measurement year • Medication treatment for opioid use disorder • Injectables • Opioid cold and cough products • Patients that receive opioids while inpatient	**Opioid Medications excluded:** Opioid-containing cough and cold products, injectables, Methadone and Buprenorphine products used as a medication-assisted treatment of opioid use disorder.

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Measure	Goal of the Measure	What To Report (Sample Of Codes and/or Diagnoses)	Exclusions	Helpful Tips
Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS-E*) 12 years and older	Patients with a diagnosis of major depression or dysthymia should have an outpatient encounter with a PHQ-9 score present in their record in the same assessment period as the encounter. **Assessment periods are:** Jan. 1- April 30 May 1-Aug. 31 Sept. 1-Dec. 31	**Screening instruments include:** PHQ-9	• Patients in hospice • Patients with a diagnosis or history of - bipolar disorder - personality disorder - psychotic disorder - pervasive developmental disorder	• A PHQ-9 score must be documented in the patient's record during the appropriate assessment period. • An Interactive Outpatient encounter includes bi-directional communication that is face to face, phone-based, an e-visit, or secure electronic messaging.
Depression Remission or Response for Adolescents and Adults (DRR-E*) 12 years and older	Patients with a diagnosis of depression and an elevated PHQ-9 score should show evidence of a response or remission within four to eight months after the elevated PHQ-9 score.	**Screening instrument:** PHQ-9 **Sample codes for Major Depression include, but are not limited to:** **ICD10:** F32.0-F32.5, F32.9, F33.0-F33.3, F33.42, F33.9	• Patients in hospice or using hospice services • Patients that die during the measurement year • Patients with any of the following at any time during the patient's history: - bipolar disorder - personality disorder - psychotic disorder - pervasive developmental disorder	• A PHQ-9 score must be documented in the patient's record during the depression follow-up period. • A remission rate of depressive symptoms is demonstrated by the most recent PHQ-9 score being less than 5 during the follow-up period. • A response rate to treatment rate is demonstrated by the most recent PHQ-9 score being at least 50% lower (during the depression follow-up period), than the PHQ-9 score when the member was diagnosed with major depression and the PHQ-9 total score was >9. • The PHQ-9 assessment does not need to be completed during a face-to-face visit. The assessment can be completed by phone or through a web-based portal.

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Measure	Goal of the Measure	What To Report (Sample Of Codes and/or Diagnoses)	Exclusions	Helpful Tips
Depression Screening and Follow-Up for Adolescents and Adults (DSF-E*) 12 years and older	Patients should be screened for clinical depression, during the measurement year, using a standardized instrument **and** if screened positive, received follow-up care within 30 days of the positive depression screening.	Screening instruments include, but aren't limited to: PHQ-9, PHQ-2, BDI-FS, EPDS, CESD-R Follow-up care after a positive screening can include, but isn't limited to: • An outpatient, telephone, e-visit, or virtual check-in visit with a diagnosis of depression • A depression case management encounter that documents assessment for symptoms • A behavioral health encounter including assessment, therapy, or medication • A dispensed antidepressant medication	• Patients in hospice or using hospice services • Patients with a diagnosis of: - bipolar disorder - depression • Patients that die during the measurement year	The U.S. Preventive Services Task Force recommends screening for depression among adolescents and adults, including pregnant and postpartum women. Remember that screening instruments must be age appropriate. For example, M-3, PROMIS Depression, and CUDOS are for adults 18 years and older

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Measure	Goal of the Measure	What To Report (Sample Of Codes and/or Diagnoses)	Exclusions	Helpful Tips
Follow-up After Hospitalization for Mental Illness (FUH) Six years and older	Patients who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses should have a follow-up visit with a mental health practitioner after discharge: • **Within seven days** of discharge • **Within 30 days** of discharge To identify acute patient discharges: 1. Identify all acute and non-acute inpatient stays. 2. Exclude non-acute inpatient stays. 3. Identify the discharge date for the stay.	**Sample Diagnoses:** • Dementia • Schizophrenia • Schizoaffective disorder • Manic episode • Bipolar disorder • Major depressive disorder • Post-traumatic stress disorder • Attention-deficit hyperactivity disorder • Mental illness • Intentional self-harm **Sample CPT® Codes** for follow-up with a mental health practitioner: **CPT® Codes:** 98960-98962, 99078, 99202-99205 **HCPCS Codes:** G0155,G0176-G0177, G0409, G0463, G0512, H0002, H0004, H0031, T1015 **Transitional care management 7 day:** 99496 **Transitional care management 14 day:** 99495 **Note**: Additional codes may apply depending on provider type and point of service.	• Patients in hospice, or using hospice services • Patients who died any time during the measurement year	Telehealth visits may be used to help meet the follow-up requirements. Any of the following meet the criteria for a follow-up visit: • A telehealth or telephone visit with a principal diagnosis of a mental health disorder or intentional self-harm The follow-up visits for this measure MUST be with a **mental health practitioner.** Don't include visits that occur on the date of discharge. They won't count to close the gap. **A patient follow-up visit within seven days of discharge will automatically satisfy the 30-day requirement.** **Note:** The denominator for this measure is based on discharges, not on patients. If patients have more than one discharge, on or between Jan. 1, 2023-Dec. 1, 2023, they can have multiple gaps in care. This is an episode-based measure.

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Measure	Goal of the Measure	What To Report (Sample Of Codes and/or Diagnoses)	Exclusions	Helpful Tips
Follow-up After Emergency Department Visit for Mental Illness (FUM) Six years and older	Patients who had an emergency department (ED) visit with a principle diagnosis of mental illness or intentional self-harm, should have follow-up visits as listed below: • **Within seven days** of ED visit • **Within 30 days** of ED visit	**Sample Diagnoses:** • Dementia • Schizophrenia • Schizoaffective disorder • Manic episode • Bipolar disorder • Major depressive disorder • Post-traumatic stress disorder • Attention-deficit hyperactivity disorder • Mental illness **Sample CPT® Codes** for follow-up with a mental health practitioner: **CPT® Codes:** 98960-98962, 99078, 99201-99205, 99408-99409, 99411-99412, 99510 **HCPCS Codes:** G0155, G0176-G0177, G0409, G0463, H0002, H0031, T1015 **Transitional care management seven day:** 99496 **Transitional care management 14 day:** 99495 **Note**: Additional codes may apply depending on provider type and point of service.	• Patients in hospice, or using hospice services • Patients who died any time during the measurement year	Telehealth visits may be used to help meet the follow-up requirements. Any of the following meet the criteria for a follow-up visit: • A telehealth or telephone visit with a principal diagnosis of a mental health disorder or intentional self-harm • An e-visit or virtual check-in (online assessments) with a principal diagnosis of intentional self-harm with any diagnosis of a mental health disorder • An e-visit or virtual check-in (online assessments) with a principal diagnosis of a mental health disorder This is an episodes-based measure. A patient could be in this measure as many times as the criteria is met. (Ex: three visits to ED for mental illness, each greater than 30 days apart, equals three episodes in the measure with an addressable gap). The follow-up visits for this measure don't necessarily have to be with a mental health practitioner. They can be with any **practitioner**, as long as the claim includes the appropriate behavioral health diagnosis. Visits that occur on the same day of the ED visit will meet criteria for this measure. **A patient follow up visit within seven days of ED visit will automatically satisfy the 30-day requirement as well.**

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Measure	Goal of the Measure	What To Report (Sample Of Codes and/or Diagnoses)	Exclusions	Helpful Tips
Follow-up After Emergency Department Visit for Substance Use Disorder (FUA) (Seven days and 30 days) For ages 3 years and older	Patients who were seen in the emergency department (ED) with a principal diagnosis of substance use disorder (SUD) or any diagnosis or drug overdose, should have a follow-up visit for SUD: • **Within seven days** of ED visit • **Within 30 days** of ED visit	Sample Diagnoses for Substance Use Disorder (SUD): • Alcohol abuse • Alcohol dependence • Alcohol use • Opioid abuse • Opioid dependence • Opioid use • Cannabis abuse • Cannabis dependence • Cannabis use • Sedative, hypnotic or anxiolytic use • Cocaine abuse • Cocaine dependence • Cocaine use • Hallucinogen abuse • Hallucinogen dependence • Hallucinogen use • Inhalant abuse • Inhalant dependence • Inhalant use • Other stimulant abuse • Other stimulant dependence **Sample HCPCS codes:** G2077, G2076, G2086, G2087	• Patients in hospice, or using hospice services • Patients who died any time during the measurement year	Telehealth visits may be used by patients to meet this measure. The following will meet the criteria for a follow-up: • A telephone visit with a principal diagnosis of substance use disorder (SUD) • An e-visit or virtual check-in (online assessments) with a principal diagnosis of SUD This is an episodes-based measure; therefore, a member could be in this measure as many times as the criteria is met. (Ex: three visits to ED for SUD, each greater than 30 days apart equals three episodes in the measure with an addressable gap). The follow-up visits for this measure don't necessarily have to be with a mental health practitioner. They can be with any practitioner as long as the claim includes a substance use diagnosis. Visits that occur on the same day of the ED visit will meet criteria for this measure. **A patient follow-up visit within seven days of ED visit will automatically satisfy the 30-day requirement as well.**

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Measure	Goal of the Measure	What To Report (Sample Of Codes and/or Diagnoses)	Exclusions	Helpful Tips
Follow-up After High-Intensity Care for Substance Use Disorder (FUI) 13 years and older	Acute inpatient hospitalizations, residential treatment or withdrawal management visits for a diagnosis of substance use disorder that results in a follow-up visit or service for substance use disorder. Two rates are reported: 1. The percentage of visits or discharges where the member received follow-up for substance use disorder within the **30 days** after the visit or discharge. 2. The percentage of visits or discharges where the member received follow-up for substance use disorder within the **seven days** after the visit or discharge.	Sample Diagnoses for Substance Use Disorder (SUD): • Alcohol abuse • Alcohol dependence • Alcohol use • Opioid abuse • Opioid dependence • Opioid use • Cannabis abuse • Cannabis dependence • Cannabis use • Sedative, hypnotic or anxiolytic use • Cocaine abuse • Cocaine dependence • Cocaine use • Hallucinogen abuse • Hallucinogen dependence • Hallucinogen use • Inhalant abuse • Inhalant dependence • Inhalant use • Other stimulant abuse • Other stimulant dependence **Sample Codes:** F10.10, F10.120, F10.121, F10.129, F10.130-132, F10.139, G0396-97, GO443, H0001, H0005, H0007, H0017-19, T2048 **Sample codes for follow-up with a mental health provider:** **CPT®:**98960, 98961, 98962, 99078, 99202-99205 **HCPCS:** G0155, G0176, G0177, G0409, G0463, G0512, H0002, H0004, H0031, T1015 This measure follow-up doesn't have to be with mental health provider.	• Patients in hospice or using hospice services • Patients who died during the measurement year	Patients can use telehealth visits to meet requirements for follow-up care. Any of the following meet the criteria for a follow-up visit: • An e-visit with a mental health provider • A telephone visit with a mental health provider The follow-up visits for this measure don't have to be with a mental health practitioner. They can be with any practitioner as long as the claim includes a substance use disorder diagnosis. This is an episode-based measure. If the member is newly diagnosed and discharging from an inpatient or residential treatment, or withdrawal management visits, follow up must occur within seven days per FUI measure standards. A patient follow-up visit within seven days of discharge will automatically satisfy the 30-day requirement. **New for 2024:** Patients with withdrawal management/ detoxification-only chemical dependency benefits do not meet these criteria.

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Measure	Goal of the Measure	What To Report (Sample Of Codes and/or Diagnoses)	Exclusions	Helpful Tips
Initiation and Engagement of Substance Use Disorder Treatment (IET) 13 years and older	Patients with new substance use disorder (SUD) **episodes** that result in treatment and engagement should have: • Initiation of SUD treatment: new SUD episodes that result in treatment initiation through an inpatient SUD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth visit or mediation treatment **within 14 days** **AND** • Engagement of SUD treatment: new SUD episodes that have evidence of treatment engagement **within 34 days of initiation**	SUD Diagnosis cohort stratification: Report the following SUD Diagnosis cohort stratifications and a total: • Alcohol use disorder • Opioid use disorder • Other substance use disorder • Total **Sample Diagnoses For Substance Use Disorder (SUD):** • Alcohol abuse • Alcohol dependence • Alcohol use • Opioid abuse • Opioid dependence • Opioid use • Cannabis abuse • Cannabis dependence • Cannabis use • Sedative, hypnotic or anxiolytic use • Cocaine abuse • Cocaine dependence • Cocaine use • Hallucinogen abuse • Hallucinogen dependence • Hallucinogen use • Inhalant abuse • Inhalant dependence • Inhalant use • Other stimulant abuse • Other stimulant dependence	• Patients in hospice, or using hospice services • Patients who died any time during the measurement year.	Telehealth visits may be used to meet requirements for follow-up visits. • For initiation of SUD treatment - The patient should have at least one visit within 14 days of the initial encounter with alcohol and other drug (AOD) diagnosis. - A telephone visit - An e-visit or virtual check-in (online assessment) Please note that initiation follow-up visits that occur on the same day as the initial diagnosis must be with a different provider. • For Engagement of SUD treatment - The patient must have two or more visits following the initial visit within 34 days of the initiation visit with SUD diagnosis - A telephone visit - An e-visit or virtual check-in (online assessment) **Note**: The denominator for this measure is based on episodes. All eligible episodes count for the same patient. Therefore, patients may have multiple gaps in care if there are multiple eligible episodes. A "new episode" is considered when a patient has at least a 194-day negative history of no claims or encounters for this diagnosis.

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Behavioral Health Medication Adherence and Monitoring

Measure	Goal of the Measure	What To Report (Sample Of Codes and/or Diagnoses)	Exclusions	Helpful Tips
Follow-up Care for Children Prescribed ADHD/ADD Medications (ADD-E*) 6-12 years	Patients with newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication should have at least three follow-up care visits within a 10-month period. **Note**: The first visit must be within 30 days of the medication dispense date and can be a telehealth or telephone visit by the prescribing provider. The first visit can't be a virtual check in or e-visit.	**Commonly Prescribed ADHD Medications:** Central Nervous System (CNS) Stimulants • Demethlyphenidate • Dextroamphetamine • Lisdexamfetamine • Methamphetamine • Methylphenidate **Alpha-2 receptor agonists:** • Clonidine • Guanfacine **Miscellaneous ADHD medications:** • Atomoxetine **Sample CPT® Codes for ADHD/ADD:** 96150-96156, 96170-96171, 99252-99255 Telephone visit: 98966-98968, 99441-99443 **Note**: Other codes may apply depending on specialty and provider type.	• Patients who have a diagnosis of narcolepsy, **sample ICD-10-CM Codes** G47.419, G47.421 • Patients in hospice or using hospice services • Patients who died any time during the measurement year	A patient is considered to have a "newly prescribed" medication if this is the first time they have filled an ADD/ADHD medication or if there's no documentation (claims filed) to show a refill of the ADD/ADHD medication in the last 120 days. Children who take medication vacations resulting in prescription gaps of 120 days or more will need to start the follow-up cycle again, just as if the prescription were new.

HEDIS codes can change from year to year. The codes in this document are from the HEDIS MY2024 specifications.

Measure	Goal of the Measure	What To Report (Sample Of Codes and/or Diagnoses)	Exclusions	Helpful Tips
Antidepressant Medication Management – Effective Acute Phase Treatment (AMM) 18 years and older	Patients with a diagnosis of major depression who were prescribed an antidepressant should remain on the antidepressant medication for **at least 84 days (12 weeks)** from the time the prescription was filled.	**Sample diagnosis codes:** **Major Depression:** F32.0, F32.1, F32.2, F32.3, F32.4, F32.9, F33.0, F33.1, F33.2, F33.3, F33.41, F33.9	• Members who didn't 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 • Patients in hospice or using hospice services anytime during the measurement year • Patients who died any time during the measurement year	A telehealth visit may be helpful to check on patients and how they're doing with their medications, and to ensure they're getting the refills they need. Encouraging patients to fill a 90-day supply can be helpful. Patients who've filled their antidepressant medication enough times to have a 180-day supply of medication since diagnosis/first fill of prescription will be compliant for the measure. Appropriate coding of the type of depression is important; major depression is the diagnosis that places the member into this measure. The intake period for this measure is May 1 of the year prior to the measurement year through April 30 of the measurement year.
Antidepressant Medication Management – Effective Continuation Phase Treatment (AMM) 18 years and older	Patients with a diagnosis of major depression who were prescribed an antidepressant should remain on the antidepressant medication for **at least 180 days (six months)** from the time the prescription was filled.	**Sample diagnosis codes:** **Major Depression:** F32.0, F32.1, F32.2, F32.3, F32.4, F32.9, F33.0, F33.1, F33.2, F33.3, F33.41, F33.9	• Members who didn't 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. • Patients in hospice or using hospice services anytime during the measurement year • Patients who died any time during the measurement year	A telehealth visit may be helpful to check on patients and how they're doing with their medications, and to ensure they're getting the refills they need. Encouraging patients to fill a 90-day supply can be helpful. Patients who have filled their antidepressant medication enough times to have a 180-day supply of medication since diagnosis/first fill of prescription will be compliant for the measure. Appropriate coding of the type of depression is important; major depression is the diagnosis that places the member into this measure. The intake period for this measure is May 1 of the year prior to the measurement year through April 30 of the measurement year.

HEDIS codes can change from year to year. The codes in this document are from the HEDIS MY2024 specifications.

Measure	Goal of the Measure	What To Report (Sample Of Codes and/or Diagnoses)	Exclusions	Helpful Tips
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E*) 1-17 years	Patients who were dispensed two or more antipsychotic medications should have metabolic testing every year including **at least one** blood glucose or HbA1C test and **at least one** LDL-C or total cholesterol test.	**Sample Medications:** • Clozapine • Haloperidol • Loxapine • Olanzapine • Risperidone • Quetiapine • Chlorpromazine **Chol. Lab Test** **CPT® samples:** 82465, 83718, 83722 **Glucose Lab Test** **CPT® samples:** 80047, 80048, 80053 **LOINC code samples:** 17865-7, 1557-8, 1558-6 **HbA1c sample codes:** 83036, 83037 **LDL-C Lab Test samples:** 80061, 83700 These are sample codes only and not an exhaustive list of codes **Encounter for screening for metabolic disorder Z13.22 is required on the lab claim for proper filing.**	• Patients in hospice or using hospice services • Patients who died during the measurement year	Explaining common side effects of these medications to parents/guardians will help them understand the importance of the testing that's needed when children/adolescents are on these medications. They include: • Weight gain • High cholesterol • High blood glucose Obtain baseline labs and measurements before prescribing antipsychotic medication. Schedule a follow-up visit 12 weeks after the patient begins taking the medication to recheck baseline measurements. Perform these tests at least annually thereafter. Consider using standing orders to get labs completed. If you're a behavioral health specialist and have ordered labs, notify the primary care provider that labs have been completed and send them the results. Labs done in an inpatient setting ARE acceptable.

HEDIS codes can change from year to year. The codes in this document are from the HEDIS MY2024 specifications.

Measure	Goal of the Measure	What To Report (Sample Of Codes and/or Diagnoses)	Exclusions	Helpful Tips
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP) 1-17 years	Patients should have at least one visit with a mental health provider between 90 days prior to the patient filling an antipsychotic medication through 30 days after the patient fills the medication. The visit may be completed via synchronous telehealth, but must be by a Mental Health provider.	**Sample Medications:** • Clozapine • Haloperidol • Olanzapine • Risperidone • Quetiapine • Chlorpromazine • Fluoxetine-olanzapine • Perpenazine-amitriptyline **Mental Health Provider Sample CPT® codes:** 90832-90834, 90836-90839	• Patients in hospice or using hospice services • Patients who died during the measurement year • Patients who were hospitalized or had two or more outpatient visits for the diagnosis of Schizophrenia, Bipolar Disorder, Schizoaffective Disorder, Autism, and other developmental or psychotic disorders **Sample diagnosis codes:** F20.0-F20.3, F30.10-F30.13, F31.30 -F31.31, F22, F23, F24, F84.5, F84.0	Closing the gap requires a **mental health provider visit** claim either 90 days before the medication was dispensed or within 30 days after the medication is dispensed. Prescribe antipsychotic medication after the patient has tried therapy (within 90 days of documented psychosocial care). Follow up with patients two weeks after dispensing antipsychotic medication to remind them to complete scheduled psychosocial care (must be completed within 30 days of dispensing). **New for 2024:** Residential Behavioral Health Treatment within 90 days before filling or within 30 days after filling a prescription will close the gap.

HEDIS codes can change from year to year. The codes in this document are from the HEDIS MY2024 specifications.

Measure	Goal of the Measure	What To Report (Sample Of Codes and/or Diagnoses)	Exclusions	Helpful Tips
Pharmacotherapy for Opioid Use Disorder (POD) 16 years and older	A new treatment of opioid use disorder using pharmacotherapy treatment for at least 180 days with no gaps in treatment for eight or more consecutive days.	A new treatment event is determined by a negative medication history of opioid use disorder pharmacotherapy drug supply dispensed 31 days or more prior to treatment period start date.	• Patients in hospice, or using hospice service • Methadone prescribed as a treatment for pain and filled at a pharmacy • Patients who died during the measurement year	Discuss treatment plan with patients and evaluate treatment plans regularly. Evaluate patients for long-acting treatments as appropriate.
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA) 18 years and older	Patients with a diagnosis of schizophrenia or schizoaffective disorder should be given an antipsychotic medication and should remain on an antipsychotic medication for **at least 80% of their treatment period or longer.** A treatment period is defined as the time period starting at the earliest prescription dispensing date until the end of the measurement year.	Diagnosis of schizophrenia or schizoaffective disorder and medications given	• Patients in hospice • Patients with diagnosed dementia • Patients 66-80 years old as of Dec. 31 of the measurement year (all product lines) with frailty and advanced illness. Members must meet BOTH the Frailty and Advanced illness criteria. • Patients who died any time during the measurement year • Patients who did not have at least two antipsychotic medication dispensing events	Encourage patients to stay on medications even when they feel better. Encourage patients to talk to their pharmacy to make sure all new prescription and refill claims are being submitted to their health plan. Explore possible reasons for your patients' medication non-adherence (i.e., cost, denial, depression, substance use/abuse, side effects). Consider prescribing long-acting injectable medications instead of oral medications to enhance compliance, when appropriate.

HEDIS codes can change from year to year. The codes in this document are from the HEDIS MY2024 specifications.

Measure	Goal of the Measure	What To Report (Sample Of Codes and/or Diagnoses)	Exclusions	Helpful Tips
Use of Opioids from Multiple Providers (UOP) 18 years and older	To identify patients who receive prescription opioids for 15 days or more from multiple prescribers and/or multiple pharmacies.	N/A	• Patients in hospice or using hospice services • Patients who died during the measurement year • Medication treatment for opioid use disorder • Injectables • Opioid cold and cough products • Patients that receive opioids while inpatient	National Provider Identifier (NPI) is used to determine if the prescriber for medication dispensing events was the same or different. Multiple prescribers is defined as: The proportions of patients receiving prescriptions for opioids from four or more different prescribers during the measurement year. Multiple pharmacies is defined as: The proportion of members receiving prescriptions for opioids from four or more different pharmacies during the measurement year.

HEDIS codes can change from year to year. The codes in this document are from the HEDIS MY2024 specifications.

Over-Use and Appropriateness/Stewardship Care

Antibiotic Measures

Measure	Goal of the Measure	What To Report (Sample Of Codes and/or Diagnoses)	Exclusions	Helpful Tips
Avoidance of Antibiotic Treatment for Acute Bronchitis/ Bronchiolitis (AAB) Ages 3 months and older	Patients with acute bronchitis/ bronchiolitis should **not be** prescribed/dispensed an antibiotic unless a competing diagnosis or an exclusion applies or the patient continues to worsen.	Report and document if the patient has an exclusion or has a competing diagnosis of infection such as: Otitis Media, Sinusitis, Pneumonia, Pharyngitis. **Sample codes** for acute bronchitis that will trigger the gap to open unless there's an exclusion or competing diagnosis documented include: J20.3, J20.4, J20.5, J20.6, J20.7, J20.8, J20.9, J21.0, J21.1, J21.8, J21.9	A documented diagnosis of comorbid condition(s): • HIV • Cancer • COPD • Emphysema • Disorders of the immune system • Hospice • Patients who died any time during the measurement year	**Important Note**: Every episode counts and patient compliance will be counted for every visit where acute bronchitis/bronchiolitis is diagnosed. **Remember** to include coding and documentation for comorbid condition exclusions and for any noted bacterial infections along with the bronchitis so that a gap doesn't open. If an antibiotic is given for bronchitis alone, and there's neither a competing diagnosis nor an exclusion, a gap will open and it can't be closed. If a patient's condition doesn't improve, and an antibiotic is indicated, a gap will not occur if the antibiotic is dispensed more than three days after the encounter when the bronchitis/bronchiolitis was diagnosed. This is an off-cycle measure that runs July 1 of the previous measurement year to June 30 of the current measurement year.

HEDIS codes can change from year to year. The codes in this document are from the HEDIS MY2024 specifications.

Measure	Goal of the Measure	What To Report (Sample Of Codes and/or Diagnoses)	Exclusions	Helpful Tips
Appropriate Testing for Pharyngitis (CWP) 3 years and older	Patients need to have a strep test done if they're diagnosed with pharyngitis only and have received an antibiotic prescription.	**Sample diagnoses:** • Acute pharyngitis • Acute tonsillitis • Streptococcal pharyngitis • Acute streptococcal tonsillitis **Sample CPT® Codes:** **Group A strep test:** 87070-87071, 87081, 87430, 87650-87652, 87880	• Patients in hospice Patients with the following comorbidities: • HIV • Malignant Neoplasm • Emphysema • Chronic obstructive pulmonary disease (COPD) • Disorders of the Immune System • Patients who died any time during the measurement year	The measure is focused on the patient getting a strep test before receiving an antibiotic for a related pharyngitis diagnosis (acute pharyngitis, acute tonsillitis, streptococcal pharyngitis, etc). Compliance is not based on strep test results as long as the test was performed. Including documentation of in-office strep test on the claim form is important in gap prevention for this measure.
Appropriate Treatment for Upper Respiratory Infection (URI) 3 months and older	Patients with **ONLY** an upper respiratory infection shouldn't be prescribed/dispensed an antibiotic unless a competing diagnosis or an exclusion applies or the patient continues to worsen.	**Sample diagnoses** (where antibiotics may be appropriate). Sample codes: A15.0, J44.0, J44.1, J43.2, J43.8, J02.8, J03.00, J03.80 , H66.01-H66.07, H66.009, H66.011-H66.017, H66.019, H66.10-13, H66.20-23, H66.93 • Sinusitis (Acute/Chronic) • Tonsillitis • Bacterial Infection (unspecified) • Pneumonia • Otitis Media **Sample codes** for upper respiratory infections that will trigger the gap to open unless there's an exclusion or competing diagnosis documented include: J00, J06.0, J06.9	• Patients in hospice Patients who have: • HIV • Malignant neoplasms • COPD • Emphysema • Patients who died any time during the measurement year	**Important Note:** Every episode counts and patient compliance will be counted for every visit where upper respiratory infection is diagnosed. Coding and documentation for either a noted bacterial infection or noted exclusion comorbidity along with the URI are important for this measure. **If an antibiotic is given for a diagnosis of URI alone, a gap will open and it can't be closed.** If a patient's condition doesn't improve, and an antibiotic is indicated, a gap won't occur if the antibiotic is given at least three days after the encounter when a URI was diagnosed. This is an off-cycle measure. It runs July 1 of the previous measurement year to June 30 of the current measurement year.

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Antibiotic Stewardship Toolkit

CDC Updates for 2023-2024

Antibiotic resistance is one of the most serious public health problems in the United States. To protect patients from harm and combat antibiotic resistance, the CDC advises:

- Optimizing how you use and prescribe antibiotics
- Using educational tools to inform patients
- Practicing vigilant stewardship of antibiotic administration

Recommendations

The CDC recommends following clinical guidelines on whether to prescribe antibiotics. It's important to prescribe the right antibiotic, at the right dose, for the right duration, at the right time. Only prescribe antibiotics when needed to treat certain infections caused by bacteria – not viral illnesses.

You can do harm by prescribing antibiotics when they're not needed. Tell patients why they don't need antibiotics for a viral respiratory infection. Explain:

- What they can do to feel better
- When to seek care again if they don't feel better

A key strategy for antibiotic stewardship is to use the shortest effective duration of therapy. The goal is to optimize treatment while minimizing risks of side effects and antibiotic resistance.

Talk to patients and their families about possible harm from antibiotics, such as allergic reactions, C.difficile infection, and antibiotic resistant illnesses. Educate patients to recognize the signs and symptoms of worsening infection and sepsis, and when to seek medical care.

If sepsis is suspected, gather patient information and immediately provide it to hospital health care professionals.

For more information from the CDC, visit **https://www.cdc.gov/antibiotic-use/week/toolkit.html**

Antibiotic Stewardship and HEDIS measures AAB, URI, and CWP

Avoidance of Antibiotic Treatment for Acute Bronchitis/ Bronchiolitis (AAB)

*The percentage of episodes for patients ages **3 months and older** with a diagnosis of acute bronchitis/bronchiolitis that* **DID NOT** *result in an antibiotic-dispensing event.**

If a patient has a diagnosis of acute bronchitis/bronchiolitis, the goal of the measure is to not prescribe or dispense an antibiotic unless there's a documented (coded) competing diagnosis, exclusion or the patient's condition continues to worsen.

Document if the patient has an exclusion or competing diagnosis of infection such as: otitis media, sinusitis, pneumonia and/or pharyngitis.

Exclusions to the Measure

- Patients in hospice
- Comorbid conditions: (if the patient had a diagnosis during the 12 months prior to, or on, the episode date) HIV, cancer, emphysema, COPD, disorders of the immune system
- Competing diagnosis exclusions: the episode date and three days following the episode date when the patient had no claims/ encounters with any competing diagnosis. (This would mean they can fill the prescription on day four after the episode date.)

Documentation is key with exclusions, comorbid conditions and competing diagnoses for this measure.

The Bottom Line

If your patient has bronchitis, DO NOT order an antibiotic unless they have an additional infection, exclusion or competing diagnosis. The episode starts the day the patient comes to the office and is diagnosed. CODE any comorbidities, competing diagnosis or additional exclusionary diagnosis. If the patient continues to be sick for a longer period, postdate the prescription for four days out from their office visit with you to keep a gap in care from opening.

* Note that patients may have multiple episodes. The intake period is a 12-month window that begins on July 1 of the year prior to the measurement year and ends on June 30 of the measurement year. The intake period captures eligible episodes of treatment.

HEDIS codes can change from year to year. The codes in this document are from the HEDIS MY2024 specifications.

Appropriate Treatment for Upper Respiratory Infection (URI)

*The percentage of episodes for patients **3 months and older** with a diagnosis of upper respiratory infection (URI) that **did not** result in an antibiotic-dispensing event.**

If a patient has a diagnosis of upper respiratory infection, the goal of the measure is to not dispense an antibiotic unless there is a documented competing diagnosis, exclusion or the patient's condition continues to worsen.

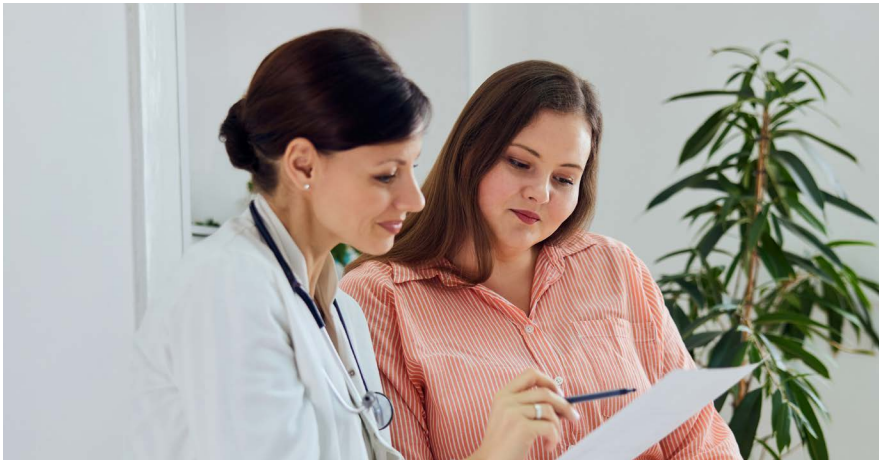
Exclusions to the Measure

- Patients in hospice
- Comorbid conditions: HIV, malignant neoplasm, COPD, emphysema
- Competing diagnosis exclusion: The episode date and three days following the episode date when the member had no claims/encounters with any competing diagnoses

Documentation is key with exclusions, comorbid conditions and competing diagnoses for this measure.

The Bottom Line

If your patient is diagnosed with upper respiratory infection, DO NOT order and antibiotic unless they have an additional infection, exclusion or competing diagnosis. The episode starts the day the patient comes to the office and is diagnosed. CODE any comorbidities, competing diagnosis or additional exclusionary diagnosis. If the patient continues to be sick for a longer period, postdating the prescription for four days out will help to keep a gap in care from opening.



* Note that patients may have multiple episodes. The intake period is a 12-month window that begins on July 1 of the year prior to the measurement year and ends on June 30 of the measurement year. The intake period captures eligible episodes of treatment.

HEDIS codes can change from year to year. The codes in this document are from the HEDIS MY2024 specifications.

Appropriate Testing for Pharyngitis (CWP)

*The percentage of episodes for patients 3 years and older where the patient was diagnosed with pharyngitis, received a group A streptococcus (strep) test for the episode, and dispensed an antibiotic.**

If a patient has a diagnosis of pharyngitis and is given an antibiotic, the goal of this measure is to ensure that appropriate testing was done. A strep test should be on file for this encounter/episode.

If doesn't matter if the strep test result was positive or negative. The measure is only focused on whether or not the test was done.

Exclusions to the Measure

- Patients in hospice
- Comorbid conditions: (If the patient had a diagnosis during the 12 months prior to, or on, the episode date) HIV, cancer, emphysema, COPD, disorders of the immune system
- Competing diagnosis exclusion: The episode date and three days following the episode date when the member had claims/encounters with any competing diagnoses

Documentation/coding for the actual strep test, the excluding comorbidity, or the competing diagnosis is extremely important for this measure.

The Bottom Line

If your patient has pharyngitis and you order an antibiotic, make sure you order a strep test.

* Note that patients may have multiple episodes. The intake period is a 12-month window that begins on July 1 of the year prior to the measurement year and ends on June 30 of the measurement year. The intake period captures eligible episodes of treatment.

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Additional Information and Resources

Using Honey as an Alternative Treatment

Patients often ask for an antibiotic to ease their symptoms. As you know, antibiotics aren't helpful for symptoms of a cold, the flu or a viral upper respiratory infection.

Recent research published in BMJ Evidence-Based Medicine found honey may be a useful alternative in treating upper respiratory tract infections. So, when offering alternative treatments, consider adding honey to your usual advice of bed rest, fluids and over-the-counter medications.

Evaluating the Effectiveness

Researchers performed a systematic review and meta-analysis of 14 previously published, randomized trials.

Studies compared honey to placebos and usual-care remedies, including diphenhydramine and dextromethorphan.

In many cases, honey outperformed other treatments and helped to improve cough severity and frequency. More study is needed, but conclusions point to honey as a cheap, widely available and effective remedy for adults and children over the age of one*.

From the CDC

The CDC offers a variety of tools for providers online. Current patient education and promotional resources, including print materials, video/audio and web images, are available at: **https://www.cdc.gov/antibiotic-use/print-materials.html**

* The American Academy of Pediatrics doesn't recommend giving honey to children younger than one because of the risk of infant botulism.

HEDIS codes can change from year to year. The codes in this document are from the HEDIS MY2024 specifications.

Radiology Related Measures

Measure	Goal of the Measure	What To Report (Sample Of Codes and/or Diagnoses)	Exclusions	Helpful Tips
Use Of Imaging Studies for Low Back Pain (LBP) 18-75 years	Patients with a diagnosis of uncomplicated low back pain should wait 28 days or more from primary diagnosis being given, before they undergo an imaging study (plain X-Ray, MRI, CT scan).	It's important to document and code for any exclusions that would warrant use of imaging studies (see exclusions column). **Sample Codes:** D00.00-49.9, Z94.1, Z94.2, Z94.3, Z94.4, G83.4, G89.11	• Cancer • Recent trauma within 90 days • Intravenous drug abuse • Neurologic impairment • HIV • Spinal infection during the year prior to visit • Major organ transplant • Prolonged use of corticosteroids (greater than or equal to 90 consecutive days within the last year) • Osteoporosis • Lumbar Surgery • Spondylopathy • Fragility Fracture (see guide) • Palliative Care, Z51.5 • Patients in hospice • Patients who died during the measurement year	Include documentation and coding, along with the diagnosis of low back pain on the claim, for "red-flag" conditions (exclusions) where an imaging study should be ordered. This will prevent an open gap that can't be closed. **CODING IS KEY!** If this gap opens, it can't be closed. Encourage patients to try conservative treatments such as: • Ice • Heat • Over-the-counter pain relief • Stretching or back strengthening exercises • Safe back habits **If LBP isn't the primary diagnosis on the claim, a gap won't open.** **A Low Back Pain Coding Guide is available upon request.**

HEDIS codes can change from year to year. The codes in this document are from the HEDIS MY2024 specifications.

Low Back Pain Toolkit / Pocket Guide

Use of Imaging Studies for Low Back Pain (LBP) (18-75 years)

Patients with a primary diagnosis of uncomplicated low back pain should wait 28 days or more from primary diagnosis being given, before they undergo an imaging study (plain X-Ray, MRI, CT scan).

- Encourage patients to try conservative treatments such as:
  - Ice
  - Heat
  - OTC Pain Relief
  - Stretching or back strengthening exercises
  - Safe back habits

Helpful Tips

- Include documentation and coding, along with the diagnosis of LBP on the claim, for "red-flag" conditions (exclusions) where an imaging study should be ordered. This will prevent an open gap that can't be closed. There's a six month review period for any primary diagnosis of LBP during that time.
- If this gap opens, it can't be closed.

Principal Diagnosis Uncomplicated back pain	No red flags (e.g. cancer, recent trauma, etc.)	Imaging Performed within 28 days of diagnosis	**Non-Compliant**
Secondary Diagnosis Uncomplicated back pain		Imaging Performed	**OK**
Secondary Diagnosis Uncomplicated back pain	Positive for red flag exclusions	Imaging Performed	**OK**

HEDIS codes can change from year to year. The codes in this document are from the HEDIS MY2024 specifications.

What to Report

It's important to document and code for any exclusions that would warrant use of imaging studies.

Below are categories and sample codes for HEDIS exclusions:

- Cancer
  - Examples: C34.10 Malignant Neoplasm of the Upper Lobe, Lung; C25.1 Malignant Neoplasm of Body of Pancreas (ICD-10 codes)
  - Cancer any time during the member's history through 28 days after the primary diagnosis of LBP.

Categories and sample codes for HEDIS exclusions:

- Recent Trauma
  - Example: G89.11 Acute Pain due to Trauma (ICD-10 code)
  - Additional examples include: S02.0XXA, S03.00XA, S06.0X0A, S06.1X0A, S06.2X0A, S06.300A, S06.310A, S06.5X6A, S12.8XXA. There are many codes in this category for use. If you have questions, please contact a Clinical Consultant for additional assistance.
  - Trauma any time during the three months (90 days) prior to the primary diagnosis of LBP through 28 days after the diagnosis of LBP.

Note: A code must be specific to be considered as an exclusion. General codes such as "falls" or "weakness" won't meet the exclusion standard. Make sure the information you're entering is as specific as possible.

- Intravenous (IV) Drug Abuse
  - Example: F11.10 Opioid abuse, uncomplicated (ICD-10 code)
  - IV drug abuse any time during the 12 months (one year) prior to the primary diagnosis of LBP through 28 days after the diagnosis of LBP.
- Neurologic Impairment
  - Example: G83.4 Cauda equina syndrome (ICD-10 code)
  - Neurologic impairment any time during the 12 months (one year) prior to the primary diagnosis of LBP through 28 days after the diagnosis of LBP.
- Human Immunodeficiency Virus (HIV)
  - Example: B20 Human Immunodeficiency Virus (HIV) disease and Z21 Asymptomatic HIV infection status (ICD-10 codes)
  - HIV any time during the patient's history through 28 days after the primary diagnosis of LBP.
- Spinal Infection
  - Example: G06.1 Intraspinal abscess and granuloma (ICD-10 code)
  - Spinal infection any time during the 12 months (one year) prior to the primary diagnosis of LBP through 28 days after the diagnosis of LBP.
- Organ Transplant (other than kidney)
  - 32850-32856 CPT® codes (CPT® is a registered trademark of the American Medical Association.)
  - Organ transplant (other than kidney) any time in the patient's history through 28 days after the primary diagnosis of LBP.
- Kidney Transplant
  - 32850-32856 CPT® codes (CPT® is a registered trademark of the American Medical Association.)
  - Example: Z94.0 Kidney Transplant Status (ICD-10 code)
  - Kidney transplant any time in the patient's history through 28 days after the primary diagnosis of LBP.

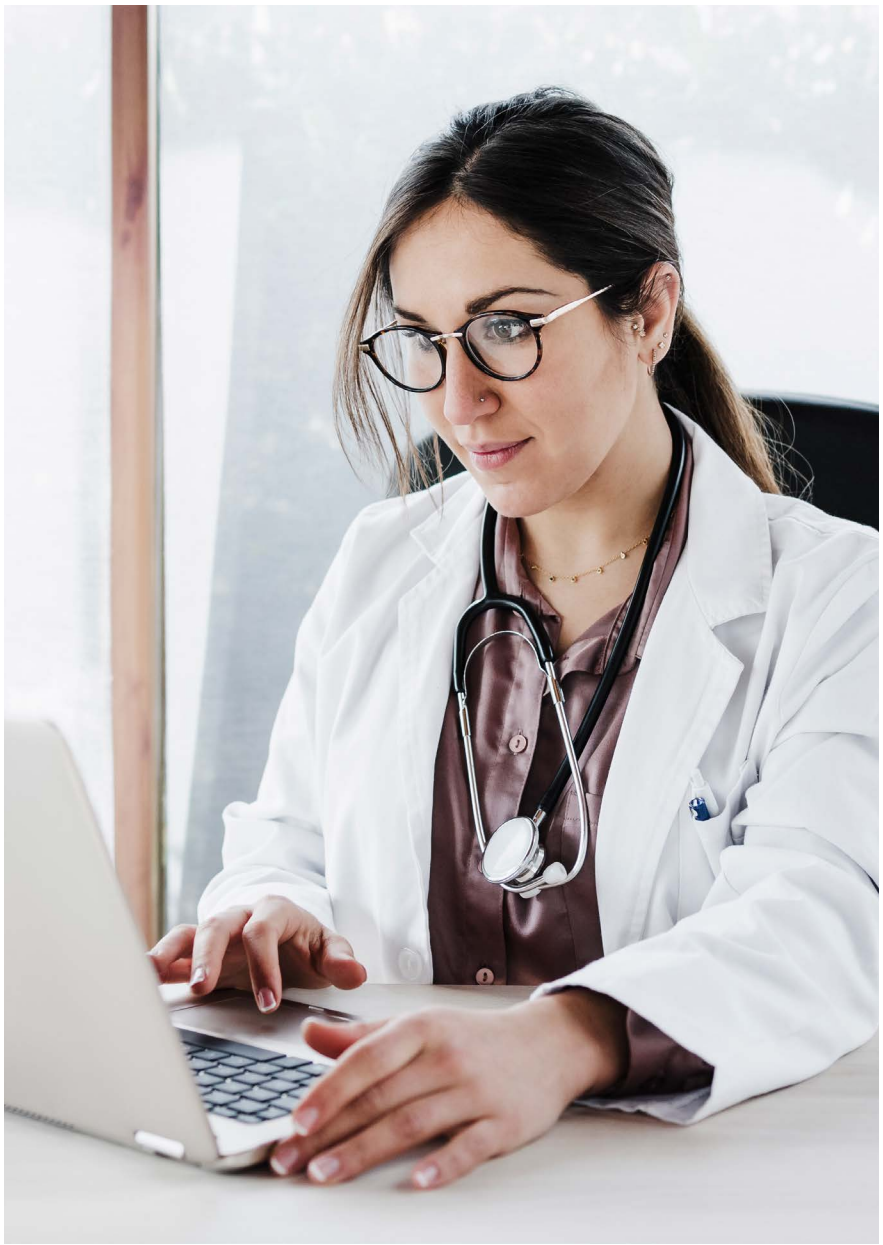
HEDIS codes can change from year to year. The codes in this document are from the HEDIS MY2024 specifications.

- Prolonged Use of Corticosteroids
  - Use Corticosteroid medication list
  - 90 consecutive days of corticosteroid treatment any time during the 365-day period prior to the primary diagnosis of LBP and ends on the day of the primary diagnosis of LBP (366 days total)
- Osteoporosis
  - Osteoporosis therapy or a dispensed prescription to treat osteoporosis
  - Any time during the patient's history through 28 days after the primary diagnosis of LBP
  - Example: CPT J0897 (CPT® is a registered trademark of the American Medical Association.); Injection, Denosumab, 1 mg
- Fragility Fracture
  - Any time during the three months (90 days) prior to the primary diagnosis of LBP through 28 days after the primary diagnosis of LBP
  - Example: M48.40XD (ICD-10 code); Fatigue fracture of vertebra, site unspecified, subsequent encounter for fracture with routine healing
- Lumbar Surgery
  - Any time during the patient's history through 28 days after the primary diagnosis of LBP
  - Example: CPT 22114
- Fragility Fracture
  - Any time during the three months (90 days) prior to the primary diagnosis of LBP through 28 days after the primary diagnosis of LBP
  - Example: M48.40XD (ICD-10 code); Fatigue fracture of vertebra, site unspecified, subsequent encounter for fracture with routine healing
- Lumbar Surgery
  - Any time during the patient's history through 28 days after the primary diagnosis of LBP
  - Example: CPT 22114
- Spondylopathy
  - Any time during the patient's history through 28 days after the primary diagnosis of LBP
  - Example: M45.0 (ICD-10 code); Ankylosing spondylitis of multiple sites in the spine
- Palliative Care
  - Patient receiving palliative care during the measurement year

HEDIS Measure: Use of Imaging Studies for LBP

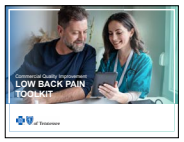
Accurate coding is key.

- The percentage of patients with a primary diagnosis of LBP who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis and does not have an exclusion code.
- **Age Group:** 18-75 years of age

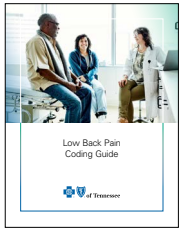


Additional Resources

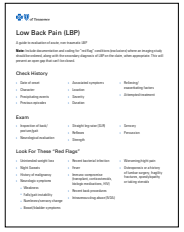
Antibiotic Stewardship Tool Kit:
https://www.bcbst.com/providers/forms/antibiotic_stewardship_toolkit.pdf



Low Back Pain Tool Kit:
https://www.bcbst.com/providers/forms/lower_back_pain_provider_toolkit.pdf



Low Back Pain Coding Guide:
https://www.bcbst.com/providers/forms/Low_Back_Pain_Coding_Guide.pdf



Low Back Pain Pocket Guide:
Available upon request from your Quality Improvement Clinical Consultant.

CDC and Choosing Wisely Information:

- **https://choosingwisely.org/#keyword=Back_pain**
- **https://www.aafp.org/family-physician/patient-care/clinical-recommendations/all-clinical-recommendations/cw-back-pain.html**

HEDIS codes can change from year to year. The codes in this document are from the HEDIS MY2024 specifications.

From the Centers of Disease Control and Prevention (CDC)

A Common Condition

Low Back Pain (LBP) is very common, causing more global disability than any other condition.

In one study, it was the most common type of pain reported by patients, with 25% of U.S. adults reporting LBP in the last three months.

LBP is frequently classified based on several clinical characteristics, including duration of symptoms.

- Acute back pain is often defined as lasting less than four weeks.
- Subacute back pain lasts four to 12 weeks.
- Chronic back pain lasts more than 12 weeks.

Many patients do not present acute symptoms for LBP, as it typically will resolve on its own without intervention.

Opioids Commonly Prescribed

Opioids continue to be prescribed for LBP, despite an overall lack of evidence to support its effectiveness.

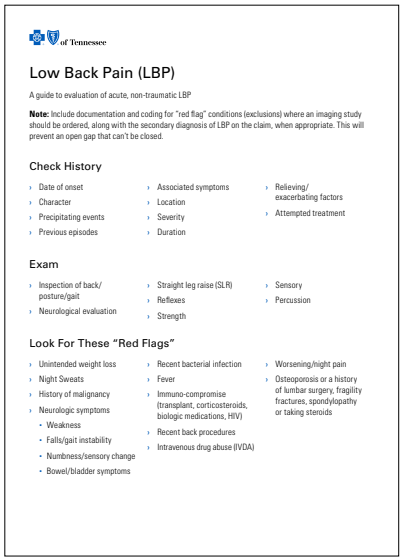
A recent study showed that 13.7% of 2017 visits for acute LBP covered by private insurance were associated with an opioid prescription. Prescriptions were for a median seven-day supply (interquartile range 4-15 days) and median daily dosage of 21.4 milligrams.

Another recent study found that in 2015, 27% of opioid-naïve patients with newly diagnosed low-back or extremity pain received an opioid prescription.

- In the last three months, 25% of U.S. adults reported having LBP, making it the most commonly reported.
- Almost 14% of insured patients who sought care for LBP were prescribed opioids.

LBP Pocket Guide

Based on recommendations from the CDC and Choosing Wisely (ABIM).



of Tennessee

Low Back Pain (LBP)

A guide to evaluation of acute, non-traumatic LBP

Note: Include documentation and coding for "red flag" conditions (exclusions) where an imaging study should be ordered, along with the secondary diagnosis of LBP on the claim, when appropriate. This will prevent an open gap that can't be closed.

Check History

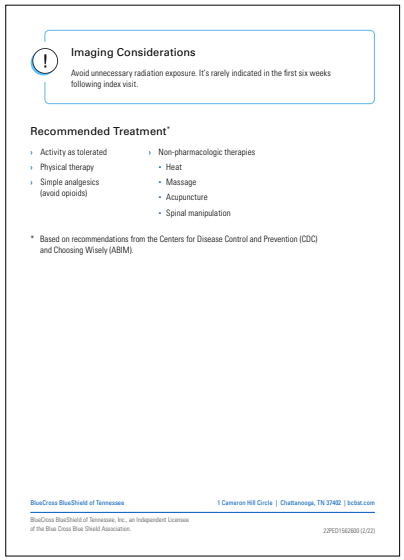
- Date of onset
- Character
- Precipitating events
- Previous episodes
- Associated symptoms
- Location
- Severity
- Duration
- Relieving/ exacerbating factors
- Attempted treatment

Exam

- Inspection of back/ posture/gait
- Neurological evaluation
- Straight leg raise (SLR)
- Reflexes
- Strength
- Sensory
- Percussion

Look For These "Red Flags"

- Unintended weight loss
- Night Sweats
- History of malignancy
- Neurologic symptoms
  - Weakness
  - Falls/gait instability
  - Numbness/sensory change
  - Bowel/bladder symptoms
- Recent bacterial infection
- Fever
- Immuno-compromise (transplant, corticosteroids, biologic medications, HIV)
- Recent back procedures
- Intravenous drug abuse (IVDA)
- Worsening/night pain
- Osteoporosis or a history of lumbar surgery, fragility fractures, spondylopathy or taking steroids



Imaging Considerations

Avoid unnecessary radiation exposure. It's rarely indicated in the first six weeks following index visit.

Recommended Treatment*

- Activity as tolerated
- Physical therapy
- Simple analgesics (avoid opioids)
- Non-pharmacologic therapies
  - Heat
  - Massage
  - Acupuncture
  - Spinal manipulation

* Based on recommendations from the Centers for Disease Control and Prevention (CDC) and Choosing Wisely (ABIM).

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23PED1562800 (2/22)

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CDC and Choosing Wisely

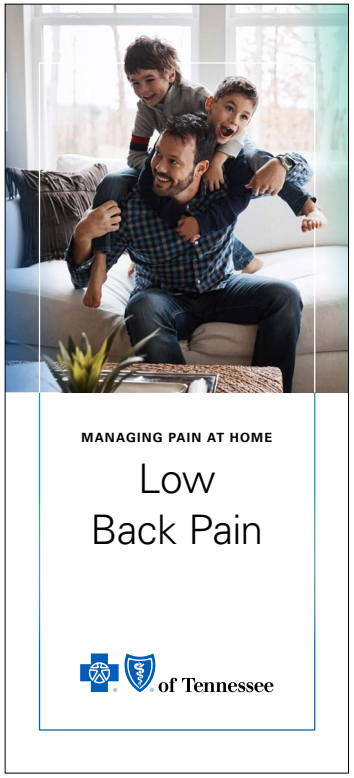
There are many external websites to assist with additional patient education related to LBP. These sites include materials for in-office use and patient visits.

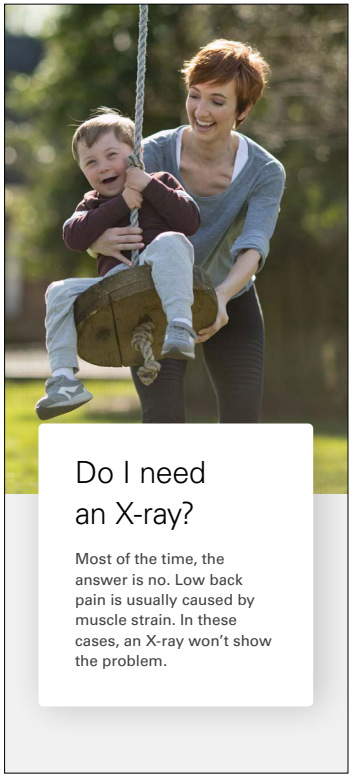
- Clinical Tools for Primary Care Providers: **https://www.cdc.gov/opioids/healthcare-professionals/index.html**
- Interactive Training Series for Healthcare Providers: **https://www.cdc.gov/opioids/providers/training/interactive.html**
- CDC Guideline for Prescribing Opioids for Chronic Pain: **https://emergency.cdc.gov/coca/calls/opioidresources.asp**

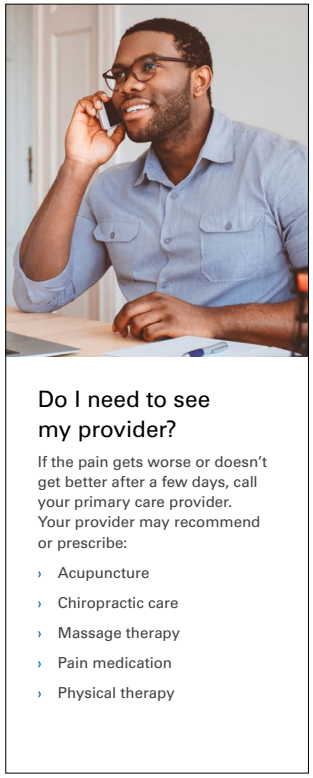
For more information, contact your BlueCross Commercial Quality Improvement team:

- Educational opportunities
- Order more Low Back Pain brochures
- Ask a question or get assistance with resources

LBP Member-Focused Brochure







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Pediatric Care (0-18)

Chronic Care

Measure	Goal of the Measure	What To Report (Sample Of Codes and/or Diagnoses)	Exclusions	Helpful Tips
Asthma Medication Ratio (AMR) 5-64 years	Patients 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.	**Sample diagnoses:** • Asthma unspecified – J45.901, J45.909 • Extrinsic asthma – 493.00 • Intrinsic asthma unspecified – 493.10 • Chronic obstructive asthma – 10692721000119102	Respiratory diseases with different treatment approaches than asthma: • COPD • Obstructive Chronic Bronchitis • Emphysema • Cystic Fibrosis • Acute respiratory failure • Chronic respiratory conditions	A telehealth visit may be helpful for checking on your patients 5 to 64 years of age to determine how well they're managing their asthma. This visit could provide an opportunity to review their current medication regimen, discuss any symptoms, and assist with refills. Prescribing 90-day medication fills often saves patients time and money and helps them stay on their medications, all from the comfort and safety of their home. Appropriate asthma medication ratios of 0.50 or greater of long-term controller medications to quick-reliever medications could potentially prevent a significant proportion of asthma-related costs (hospitalizations, emergency room visits), while also lowering non-medication costs. Encouraging patients to remain on their controller medications to lessen and/or prevent asthma complications and flare-ups will help keep them from refilling and using their rescue inhalers more than their controller medications.

Some sample medications that are considered Asthma controller medications include:

Omalizumab, Dupilumab, Benralizumab, Formoterol-mometasone, Fluticasone-vilanterol, Budesonide-formoterol, Beclomethasone, Budesonide, Ciclesonide, Fluticasone, Montelukast, and Theophylline. (This isn't an exhaustive list.)

HEDIS codes can change from year to year. The codes in this document are from the HEDIS MY2024 specifications.

Antibiotic Care

Measure	Goal of the Measure	What To Report (Sample Of Codes and/or Diagnoses)	Exclusions	Helpful Tips
Avoidance of Antibiotic Treatment for Acute Bronchitis/ Bronchiolitis (AAB) Ages three months and older	Patients with acute bronchitis/ bronchiolitis should **not be** prescribed/dispensed an antibiotic unless a competing diagnosis or an exclusion applies or the patient continues to worsen.	Report and document if the patient has an exclusion or has a competing diagnosis of infection such as: Otitis Media, Sinusitis, Pneumonia, Pharyngitis. **Sample codes** for acute bronchitis that will trigger the gap to open unless there's an exclusion or competing diagnosis documented include: J20.3, J20.4, J20.5, J20.6, J20.7, J20.8, J20.9, J21.0, J21.1, J21.8, J21.9	A documented diagnosis of comorbid condition(s): • HIV • Cancer • COPD • Emphysema • Disorders of the immune system • Hospice • Patients who died any time during the measurement year	**Important Note**: Every episode counts and patient compliance will be counted for every visit where acute bronchitis/bronchiolitis is diagnosed. **Remember** to include coding and documentation for comorbid condition exclusions and for any noted bacterial infections along with the bronchitis so that a gap doesn't open. If an antibiotic is given for bronchitis alone, and there's neither a competing diagnosis nor an exclusion, a gap will open and it can't be closed. If a patient's condition doesn't improve, and an antibiotic is indicated, a gap will not occur if the antibiotic is dispensed more than three days after the encounter when the bronchitis/bronchiolitis was diagnosed. This is an off-cycle measure that runs July 1 of the previous measurement year to June 30 of the current measurement year.

HEDIS codes can change from year to year. The codes in this document are from the HEDIS MY2024 specifications.

Measure	Goal of the Measure	What To Report (Sample Of Codes and/or Diagnoses)	Exclusions	Helpful Tips
Appropriate Testing for Pharyngitis (CWP) 3 years and older	Patients need to have a strep test done if they're diagnosed with pharyngitis only and have received an antibiotic prescription.	**Sample diagnoses:** • Acute pharyngitis • Acute tonsillitis • Streptococcal pharyngitis • Acute streptococcal tonsillitis **Sample CPT® Codes:** **Group A strep test:** 87070-87071, 87081, 87430, 87650-87652, 87880	• Patients in hospice Patients with the following comorbidities: • HIV • Malignant Neoplasm • Emphysema • Chronic obstructive pulmonary disease (COPD) • Disorders of the Immune System • Patients who died any time during the measurement year	The measure is focused on the patient getting a strep test before receiving an antibiotic for a related pharyngitis diagnosis (acute pharyngitis, acute tonsillitis, streptococcal pharyngitis, etc). Compliance is not based on strep test results as long as the test was performed. Including documentation of in-office strep test on the claim form is important in gap prevention for this measure.
Appropriate Treatment for Upper Respiratory Infection (URI) 3 months and older	Patients with **ONLY** an upper respiratory infection shouldn't be prescribed/dispensed an antibiotic unless a competing diagnosis or an exclusion applies or the patient continues to worsen.	**Sample diagnoses** (where antibiotics may be appropriate). Sample codes: A15.0, J44.0, J44.1, J43.2, J43.8, J02.8, J03.00, J03.80 , H66.01-H66.07, H66.009, H66.011-H66.017, H66.019, H66.10-13, H66.20-23, H66.93 • Sinusitis (Acute/Chronic) • Tonsillitis • Bacterial Infection (unspecified) • Pneumonia • Otitis Media **Sample codes** for upper respiratory infections that will trigger the gap to open unless there's an exclusion or competing diagnosis documented include: J00, J06.0, J06.9	• Patients in hospice Patients who have: • HIV • Malignant neoplasms • COPD • Emphysema • Patients who died any time during the measurement year	**Important Note:** Every episode counts and patient compliance will be counted for every visit where upper respiratory infection is diagnosed. Coding and documentation for either a noted bacterial infection or noted exclusion comorbidity along with the URI are important for this measure. **If an antibiotic is given for a diagnosis of URI alone, a gap will open and it can't be closed.** If a patient's condition doesn't improve, and an antibiotic is indicated, a gap won't occur if the antibiotic is given at least three days after the encounter when a URI was diagnosed. This is an off-cycle measure. It runs July 1 of the previous measurement year to June 30 of the current measurement year.

HEDIS codes can change from year to year. The codes in this document are from the HEDIS MY2024 specifications.

Measure	Goal of the Measure	What To Report (Sample Of Codes and/or Diagnoses)	Exclusions	Helpful Tips
Follow-up Care for Children Prescribed ADHD/ADD Medications (ADD-E*) 6-12 years	Patients with newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication should have at least three follow-up care visits within a 10-month period. **Note**: The first visit must be within 30 days of the medication dispense date and can be a telehealth or telephone visit by the prescribing provider. The first visit can't be a virtual check in or e-visit.	**Commonly Prescribed ADHD Medications:** Central Nervous System (CNS) Stimulants • Demethlyphenidate • Dextroamphetamine • Lisdexamfetamine • Methamphetamine • Methylphenidate **Alpha-2 receptor agonists:** • Clonidine • Guanfacine **Miscellaneous ADHD medications:** • Atomoxetine **Sample CPT® Codes for ADHD/ADD:** 96150-96156, 96170-96171, 99252-99255 Telephone visit: 98966-98968, 99441-99443 **Note**: Other codes may apply depending on specialty and provider type.	• Patients who have a diagnosis of narcolepsy, **sample ICD-10-CM Codes** G47.419, G47.421 • Patients in hospice or using hospice services • Patients who died any time during the measurement year.	A patient is considered to have a "newly prescribed" medication if this is the first time they have filled an ADD/ADHD medication or if there's no documentation (claims filed) to show a refill of the ADD/ADHD medication in the last 120 days. Children who take medication vacations resulting in prescription gaps of 120 days or more will need to start the follow-up cycle again, just as if the prescription were new.

HEDIS codes can change from year to year. The codes in this document are from the HEDIS MY2024 specifications.

Measure	Goal of the Measure	What To Report (Sample Of Codes and/or Diagnoses)	Exclusions	Helpful Tips
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E*) 1-17 years	Patients who were dispensed two or more antipsychotic medications should have metabolic testing every year including **at least one** blood glucose or HbA1C test and **at least one** LDL-C or total cholesterol test.	**Sample Medications:** • Clozapine • Haloperidol • Loxapine • Olanzapine • Risperidone • Quetiapine • Chlorpromazine **Chol. Lab Test** **CPT® samples:** 82465, 83718, 83722 **Glucose Lab Test** **CPT® samples:** 80047, 80048, 80053 **LOINC code samples:** 17865-7, 1557-8, 1558-6 **HbA1c sample codes:** 83036, 83037 **LDL-C Lab Test samples:** 80061, 83700 These are sample codes only and not an exhaustive list of codes **Encounter for screening for metabolic disorder Z13.22 is required on the lab claim for proper filing.**	• Patients in hospice or using hospice services • Patients who died during the measurement year	Explaining common side effects of these medications to parents/guardians will help them understand the importance of the testing that's needed when children/adolescents are on these medications. They include: • Weight gain • High cholesterol • High blood glucose Obtain baseline labs and measurements before prescribing antipsychotic medication. Schedule a follow-up visit 12 weeks after the patient begins taking the medication to recheck baseline measurements. Perform these tests at least annually thereafter. Consider using standing orders to get labs completed. If you're a behavioral health specialist and have ordered labs, notify the primary care provider that labs have been completed and send them the results. Labs done in an inpatient setting ARE acceptable.

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Measure	Goal of the Measure	What To Report (Sample Of Codes and/or Diagnoses)	Exclusions	Helpful Tips
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP) 1-17 years	Patients should have at least one visit with a mental health provider between 90 days prior to the patient filling an antipsychotic medication through 30 days after the patient fills the medication. The visit may be completed via synchronous telehealth, but must be by a Mental Health provider.	**Sample Medications:** • Clozapine • Haloperidol • Olanzapine • Risperidone • Quetiapine • Chlorpromazine • Fluoxetine-olanzapine • Perpenazine-amitriptyline **Mental Health Provider Sample CPT® codes:** 90832-90834, 90836-90839	• Patients in hospice or using hospice services • Patients who died during the measurement year • Patients who were hospitalized or had two or more outpatient visits for the diagnosis of Schizophrenia, Bipolar Disorder, Schizoaffective Disorder, Autism, and other developmental or psychotic disorders **Sample diagnosis codes:** F20.0-F20.3, F30.10-F30.13, F31.30 -F31.31, F22, F23, F24, F84.5, F84.0	Closing the gap requires a **mental health provider visit** claim either 90 days before the medication was dispensed or within 30 days after the medication is dispensed. Prescribe antipsychotic medication after the patient has tried therapy (within 90 days of documented psychosocial care). Follow up with patients two weeks after dispensing antipsychotic medication to remind them to complete scheduled psychosocial care (must be completed within 30 days of dispensing). **New for 2024:** Residential Behavioral Health Treatment within 90 days before filling or within 30 days after filling a prescription will close the gap.

HEDIS codes can change from year to year. The codes in this document are from the HEDIS MY2024 specifications.

Measure	Goal of the Measure	What To Report (Sample Of Codes and/or Diagnoses)	Exclusions	Helpful Tips
Follow-up After Emergency Department Visit for Substance Use Disorder (FUA) (Seven days and 30 days) For ages 3 years and older	Patients who were seen in the emergency department (ED) with a principal diagnosis of substance use disorder (SUD) or any diagnosis or drug overdose, should have a follow-up visit for SUD: • **Within seven days** of ED visit • **Within 30 days** of ED visit	Sample Diagnoses for Substance Use Disorder (SUD): • Alcohol abuse • Alcohol dependence • Alcohol use • Opioid abuse • Opioid dependence • Opioid use • Cannabis abuse • Cannabis dependence • Cannabis use • Sedative, hypnotic or anxiolytic use • Cocaine abuse • Cocaine dependence • Cocaine use • Hallucinogen abuse • Hallucinogen dependence • Hallucinogen use • Inhalant abuse • Inhalant dependence • Inhalant use • Other stimulant abuse • Other stimulant dependence **Sample HCPCS codes:** G2077, G2076, G2086, G2087	• Patients in hospice, or using hospice services • Patients who died any time during the measurement year	Telehealth visits may be used by patients to meet this measure. The following will meet the criteria for a follow up: • A telephone visit with a principal diagnosis of substance use disorder (SUD) • An e-visit or virtual check-in (online assessments) with a principal diagnosis of SUD This is an episodes-based measure; therefore, a member could be in this measure as many times as the criteria is met. (Ex: three visits to ED for SUD, each greater than 30 days apart equals three episodes in the measure with an addressable gap). The follow-up visits for this measure don't necessarily have to be with a mental health practitioner. They can be with any practitioner as long as the claim includes a substance use diagnosis. Visits that occur on the same day of the ED visit will meet criteria for this measure. **A patient follow-up visit within seven days of ED visit will automatically satisfy the 30-day requirement as well.**

Measure	Goal of the Measure	What To Report (Sample Of Codes and/or Diagnoses)	Exclusions	Helpful Tips
Follow-up After Hospitalization for Mental Illness (FUH) Six years and older	Patients who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses should have a follow-up visit with a mental health practitioner after discharge: • **Within seven days** of discharge • **Within 30 days** of discharge To identify acute patient discharges: 1. Identify all acute and non-acute inpatient stays. 2. Exclude non-acute inpatient stays. 3. Identify the discharge date for the stay.	**Sample Diagnoses:** • Dementia • Schizophrenia • Schizoaffective disorder • Manic episode • Bipolar disorder • Major depressive disorder • Post-traumatic stress disorder • Attention-deficit hyperactivity disorder • Mental illness • Intentional self-harm **Sample CPT® Codes** for follow-up with a mental health practitioner: **CPT Codes:** 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99408-99409, 99411-99412, 99510 **HCPCS Codes:** G0155,G0176-G0177, G0409-G0411, G0443, G0463, H0001-H0002, H0004-H0005, H0007, H0015-H0016, H0020, H0022, H0031, H0034-H0037, H0039-H0040, H2000-H2001, H2010-H2020, H2035-H2036, H0064, S0201, S9480, S9484-S9485, T1006, T1012, T1015 **Transitional care management 7 day:** 99496 **Transitional care management 14 day:** 99495 **Note**: Additional codes may apply depending on provider type and point of service.	• Patients in hospice, or using hospice services • Patients who died any time during the measurement year	Telehealth visits may be used to help meet the follow-up requirements. Any of the following meet the criteria for a follow-up visit: • A telehealth or telephone visit with a principal diagnosis of a mental health disorder or intentional self-harm The follow-up visits for this measure MUST be with a **mental health practitioner.** Don't include visits that occur on the date of discharge. They won't count to close the gap. **A patient follow up visit within seven days of discharge will automatically satisfy the 30-day requirement.** **Note:** The denominator for this measure is based on discharges, not on patients. If patients have more than one discharge, on or between Jan. 1, 2023-Dec. 1, 2023, they can have multiple gaps in care. This is an episode based measure.

HEDIS codes can change from year to year. The codes in this document are from the HEDIS MY2024 specifications.

Measure	Goal of the Measure	What To Report (Sample Of Codes and/or Diagnoses)	Exclusions	Helpful Tips
Follow-up After High-Intensity Care for Substance Use Disorder (FUI) 13 years and older	Acute inpatient hospitalizations, residential treatment or withdrawal management visits for a diagnosis of substance use disorder that results in a follow-up visit or service for substance use disorder. Two rates are reported: 1. The percentage of visits or discharges where the member received follow-up for substance use disorder within the **30 days** after the visit or discharge. 2. The percentage of visits or discharges where the member received follow-up for substance use disorder within the **seven days** after the visit or discharge.	Sample Diagnoses for Substance Use Disorder (SUD): • Alcohol abuse • Alcohol dependence • Alcohol use • Opioid abuse • Opioid dependence • Opioid use • Cannabis abuse • Cannabis dependence • Cannabis use • Sedative, hypnotic or anxiolytic use • Cocaine abuse • Cocaine dependence • Cocaine use • Hallucinogen abuse • Hallucinogen dependence • Hallucinogen use • Inhalant abuse • Inhalant dependence • Inhalant use • Other stimulant abuse • Other stimulant dependence **Sample Codes:** F10.10, F10.120, F10.121, F10.129, F10.130-132, F10.139, G0396-97, GO443, H0001, H0005, H0007, H0017-19, T2048	• Patients in hospice or using hospice services • Patients who died during the measurement year	Patients can use telehealth visits to meet requirements for follow-up. Any of the following meet the criteria for a follow-up visit: • An e-visit with a mental health provider • A telephone visit with a mental health provider The follow-up visits for this measure don't have to be with a mental health practitioner. They can be with any practitioner as long as the claim includes a substance use disorder diagnosis. This is an episode-based measure. If the member is newly diagnosed and discharging from an inpatient or residential treatment, or withdrawal management visits, follow up must occur within seven days per FUI measure standards. A patient follow-up visit within seven days of discharge will automatically satisfy the 30-day requirement. **New for 2024:** Patients with withdrawal management/ detoxification-only chemical dependency benefits do not meet these criteria.

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Measure	Goal of the Measure	What To Report (Sample Of Codes and/or Diagnoses)	Exclusions	Helpful Tips
Follow-up After Emergency Department Visit for Mental Illness (FUM) Six years and older	Patients who had an emergency department (ED) visit with a principal diagnosis of mental illness or intentional self-harm, should have follow up visits as listed below: • **Within seven days** of ED visit • **Within 30 days** of ED visit	**Sample Diagnoses:** • Dementia • Schizophrenia • Schizoaffective disorder • Manic episode • Bipolar disorder • Major depressive disorder • Post-traumatic stress disorder • Attention-deficit hyperactivity disorder • Mental illness **Sample CPT® Codes** for follow-up with a mental health practitioner: **CPT Codes:** 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99408-99409, 99411-99412, 99510 **HCPCS Codes:** G0155, G0176-G0177, G0409-G0411, G0443, G0463, H0001-H0002, H0004-H0005, H0007, H0015-H0016, H0020, H0022, H0031, H0034-H0037, H0039-H0040, H2000-H2001, H2010-H2020, H2035-H2036, H0064, S0201, S9480, S9484-S9485, T1006, T1012, T1015 **Transitional care management seven day:** 99496 **Transitional care management 14 day:** 99495 **Note**: Additional codes may apply depending on provider type and point of service.	• Patients in hospice, or using hospice services • Patients who died any time during the measurement year	Telehealth visits may be used to help meet the follow-up requirements. Any of the following meet the criteria for a follow-up visit: • A telehealth or telephone visit with a principal diagnosis of a mental health disorder or intentional self-harm • An e-visit or virtual check-in (online assessments) with a principal diagnosis of intentional self-harm with any diagnosis of a mental health disorder • An e-visit or virtual check-in (online assessments) with a principal diagnosis of a mental health disorder This is an episodes-based measure. A patient could be in this measure as many times as the criteria is met. (Ex: three visits to ED for mental illness, each greater than 30 days apart, equals three episodes in the measure with an addressable gap). The follow-up visits for this measure don't necessarily have to be with a mental health practitioner. They can be with any **practitioner**, as long as the claim includes the appropriate behavioral health diagnosis. Visits that occur on the same day of the ED visit will meet criteria for this measure. **A patient follow up visit within seven days of ED visit will automatically satisfy the 30-day requirement as well.**

HEDIS codes can change from year to year. The codes in this document are from the HEDIS MY2024 specifications.

Measure	Goal of the Measure	What To Report (Sample Of Codes and/or Diagnoses)	Exclusions	Helpful Tips
Initiation and Engagement of Substance Use Disorder Treatment (IET) 13 years and older	Patients with new substance use disorder (SUD) **episodes** that result in treatment and engagement should have: • Initiation of SUD treatment: new SUD episodes that result in treatment initiation through an inpatient SUD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth visit or mediation treatment **within 14 days** **AND** • Engagement of SUD treatment: new SUD episodes that have evidence of treatment engagement **within 34 days of initiation**	SUD Diagnosis cohort stratification: Report the following SUD Diagnosis cohort stratifications and a total: • Alcohol use disorder • Opioid use disorder • Other substance use disorder • Total **Sample Diagnoses For Substance Use Disorder (SUD):** • Alcohol abuse • Alcohol dependence • Alcohol use • Opioid abuse • Opioid dependence • Opioid use • Cannabis abuse • Cannabis dependence • Cannabis use • Sedative, hypnotic or anxiolytic use • Cocaine abuse • Cocaine dependence • Cocaine use • Hallucinogen abuse • Hallucinogen dependence • Hallucinogen use • Inhalant abuse • Inhalant dependence • Inhalant use • Other stimulant abuse • Other stimulant dependence	• Patients in hospice, or using hospice services • Patients who died any time during the measurement year	Telehealth visits may be used to meet requirements for follow-up visits. • For initiation of SUD treatment - The patient should have at least one visit within 14 days of the initial encounter with alcohol and other drug (AOD) diagnosis. - A telephone visit - An e-visit or virtual check-in (on-line assessment) Please note that initiation follow-up visits that occur on the same day as the initial diagnosis must be with a different provider. • For Engagement of SUD treatment - The patient must have two or more visits following the initial visit within 34 days of the initiation visit with SUD diagnosis - A telephone visit - An e-visit or virtual check-in (on-line assessment) **Note**: The denominator for this measure is based on episodes. All eligible episodes count for the same patient. Therefore, patients may have multiple gaps in care if there are multiple eligible episodes. A "new episode" is considered when a patient has at least a 194-day negative history of no claims or encounters for this diagnosis.

Measure	Goal of the Measure	What To Report (Sample Of Codes and/or Diagnoses)	Exclusions	Helpful Tips
Pharmacotherapy for Opioid Use Disorder (POD) 16 years and older	A new treatment of opioid use disorder using pharmacotherapy treatment for at least 180 days with no gaps in treatment for eight or more consecutive days.	A new treatment event is determined by a negative medication history of opioid use disorder pharmacotherapy drug supply dispensed 31 days or more prior to treatment period start date.	• Patients in hospice, or using hospice service • Methadone prescribed as a treatment for pain and filled at a pharmacy • Patients who died during the measurement year	Discuss treatment plan with patients and evaluate treatment plans regularly. Evaluate patients for long-acting treatments as appropriate.

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Well-Care Measures

Measure	Goal of the Measure	What To Report (Sample Of Codes and/or Diagnoses)	Exclusions	Helpful Tips
Chlamydia Screening in Women (CHL) 16-24 years	Women identified as sexually active should have at least one chlamydia screening during the measurement year.	**Sample CPT® Codes:** **Chlamydia Testing:** 87110, 87270, 87320, 87490-87492, 87810, 0353U	• Patients in hospice • Patients who had a pregnancy test and were prescribed retinoid medication, or had an X-ray, on the date of the pregnancy test or within six days following the pregnancy test. • Patients who died during the measurement year	**Note**: Sexually active status is determined from claim/encounter data and pharmacy data. Patients who receive a pregnancy test are considered sexually active. Patients who were dispensed prescription contraceptives during the measurement year are considered sexually active regardless of the diagnosis for which they were given. Patients on contraceptives for another reason aren't excluded. Therefore, a gap will show up anytime a birth control prescription is filled for a patient in this age range, regardless of the reason it's prescribed. Patients with a diagnosis of pregnancy are considered sexually active. Including documentation of CHL test on the claim form is important in closing the gap for this measure. A urine test for chlamydia screening will meet compliance with this measure and isn't as invasive. Implementing this screening into a routine workflow when contraceptives are prescribed can be helpful. The measurement year is Jan. 1-Dec. 31.

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Measure	Goal of the Measure	What To Report (Sample Of Codes and/or Diagnoses)	Exclusions	Helpful Tips
Childhood Immunization Status (CIS, CIS-E*) <2 years	Patients turning two during the measurement year should have all of the following immunizations **before their second birthday:** • **Four** DTaP (diphtheria, tetanus, and pertussis) • **Three** IPV (polio) • **One** MMR (measles, mumps and rubella) between the child's first and second birthday • **Three** HiB (haemophilus influenza type B) • **Three** hepatitis B (Hep B) • **One** hepatitis A (Hep A) between the child's first and second birthday • **One** varicella (chickenpox) between the child's first and second birthday • **Four** PCV (pneumococcal) • **Two** or three RV (rotavirus) • **Two** influenza (flu)	**Sample CPT® (and HCPCS) Codes:** **DTaP vaccine:** 90697, 90698, 90700, 90723 **HiB vaccine:** 90644, 90647, 90648, 90698, 90748 **HepA vaccine:** 90633 **Hep B vaccine:** 90697, 90723, 90740, 90744, 90747-90748, G0010 (HCPCS) **IPV vaccine:** 90698, 90713, 90723 **Influenza vaccine:** 90655, 90657, 90661, 90673, 90685, 90687, G0008 (HCPCS) **MMR vaccine:** 90707, 90710 **Pneumococcal conjugate vaccine:** 90670, G0009 (HCPCS) **Rotavirus vaccine (two dose schedule):** 90681 **Rotavirus vaccine (three dose schedule):** 90680, 90681 **VZV (chickenpox) vaccine:** 90710, 90716 **Anaphylactic reaction due to vaccine.** For documented history of anaphylaxis, there must be a note indicating the date of the event, which vaccine the anaphylaxis occurred with, and it must have occurred by the patient's second birthday. • Anaphylactic reaction to one vaccine only meets criteria for that particular vaccine. All other components must still be met	• Patients in hospice • Patients who had a contraindication for a specific vaccine before their second birthday such as an anaphylactic reaction • Patients who died during the measurement year	Schedule patients so that all immunizations are completed by 23 months. Give educational materials that reinforce your advisement on the importance of vaccinations. The two immunizations **most often missed** in the entire CIS series are: the two flu vaccines and the **two or three rotavirus vaccines.** Since the first influenza immunization can't be given until the child is six months old, the second vaccine for influenza can be a challenge for babies born in the fall of the year due to immunization timeframes and availability of the vaccine; this may require extra visits and ordering extra vaccines. VZV, MMR, and Hep A must be given on or between the child's first and second birthday to be measure compliant. For VZV, MMR, Hep A and Hep B, the history of the illness documented prior to two years old in the medical record with a date, or a seropositive test result would close the area of the measure for that particular vaccine. DTaP, IPV, HIB, pneumococcal and rotavirus should be given at least 42 days after birth for compliance. Typically the first Hep B is given on the date of birth (DOB) or the day after because most women and babies don't stay in the hospital longer than that. If the hospital has given the provider the patient records for the Hep B vaccine that was given at birth, then the providers can enter the information and attest that the infant received the HepB vaccination in the hospital - as long as the HepB was given between the DOB and seven days after birth. For rotavirus, if documentation doesn't indicate whether the two-dose schedule or three-dose schedule was used, we have to assume a three-dose schedule was administered and must see evidence of those three doses - therefore, documentation of the dose variation is very important. The minimum age to start the rotavirus series is six weeks (42 days). The Live Attenuated Influenza Vaccine (LAIV) CAN be used for CIS, but only if given on the exact day of the child's second birthday, as it's not approved for children under two.

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Measure	Goal of the Measure	What To Report (Sample Of Codes and/or Diagnoses)	Exclusions	Helpful Tips
Immunizations for Adolescents (IMA, IMA-E*) < 13 years	Patients turning 13 during the measurement year should have all of the following immunizations **before their 13th birthday:** • One meningococcal given on or between 11th and 13th birthday • One Tdap (tetanus, diphtheria, and pertussis) given on or between 10th and 13th birthday • HPV series completed between 9th and 13th birthday	**Sample CPT® Codes:** **Meningococcal vaccine:** 90619, 90733, 90734 **Tdap vaccine:** 90715 **HPV vaccine:** 90649-90651 **Anaphylactic reaction due to vaccine.** For documented history of anaphylaxis, there must be a note indicating the date of the event, which vaccine the anaphylaxis occurred with, and it must have occurred by the patient's 13th birthday. Anaphylactic reaction to one vaccine only meets criteria for that particular vaccine. All other components must still be met.	• Patients in hospice • Patients who died during the measurement year	Meningococcal vaccine must be serogroups A, C, W and Y. (serogroup B vaccines won't close the gap in care.) Discuss the HPV vaccine from the cancer prevention standpoint. Recommend HPV the **SAME WAY-SAME DAY** as the other vaccines. CDC recommendations offering two options for the HPV vaccination: • Option 1: Series of three injections over a period of six months. **Note**: Dose two to be administered two months after first dose, and dose three to be administered six months after first dose • Option 2: For the two-dose HPV vaccination series, there must be at least 146 days between the first and second injections. This measure applies to **BOTH** boys and girls under the age of 13. Use educational materials that reinforce your advisement on the importance of vaccinations.
Child and Adolescent Well-Care Visits (WCV) 3-21 years	Patients should have at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the year.	**Sample CPT® Codes:** **Well-care:** 99381-99385, 99391-99395, 99461 **HCPCS Codes:** G0438, G0439, S0302, S0610, S0612, S0613	• Patients in hospice • Patients who died during the measurement year	Services specific to the assessment or treatment of an acute or chronic condition don't count toward the measure. The well-child forms available on the Tennessee Chapter of American Academy of Pediatrics (TNAAP) website (if properly and fully completed) address all the components of the well-child measures. (www.tnaap.org). We highly encourage use of those forms. The measurement year is Jan. 1-Dec. 31.

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Measure	Goal of the Measure	What To Report (Sample Of Codes and/or Diagnoses)	Exclusions	Helpful Tips
Well-Child Visits in the First 30 Months (W30) 0-30 months	Patients in this age range must complete six or more visits with a PCP on different dates of service on or before the 15 month birthday. **AND** Patients must complete two or more visits, with a PCP on different dates of service, after the child turns 15 months and before they turn 30 months.	**Sample CPT® Codes:** **Well-care:** 99381-99385, 99391-99395, 99461 **HCPCS Codes:** G0438, G0439, S0302	• Patients in hospice • Patients who died during the measurement year	

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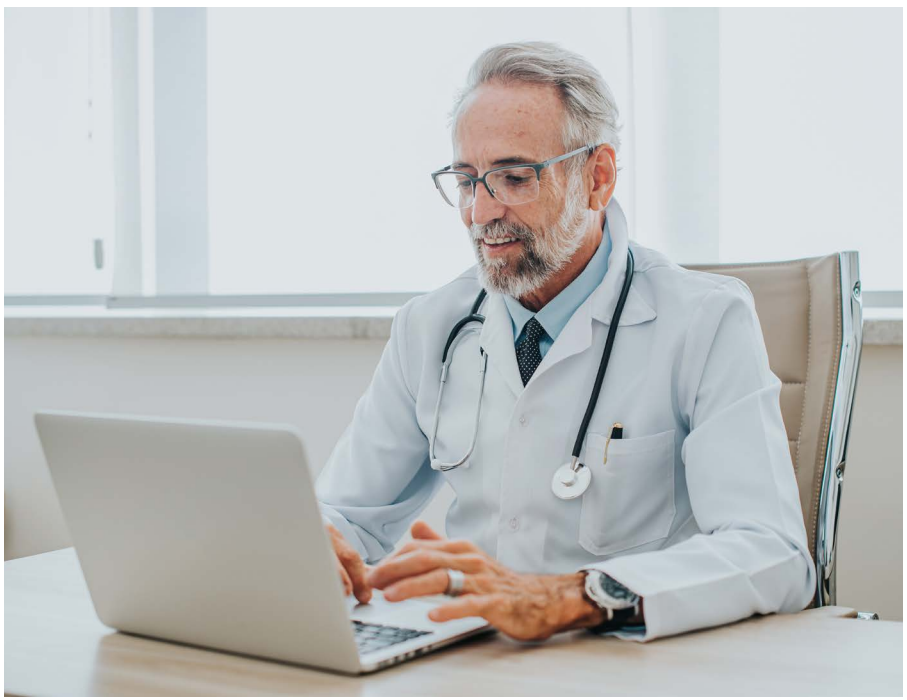
Measure	Goal of the Measure	What To Report (Sample Of Codes and/or Diagnoses)	Exclusions	Helpful Tips
Weight Assessment/ Counseling for Nutrition and Physical for Children and Adolescents (WCC BMI) 3 to 17 years	Patients must complete at least one outpatient visit with a PCP or an OB/GYN during the year and have documentation of Body Mass Index (BMI) percentile.	**Required documentation are:** • Height, weight, and BMI percentile **Note:** BMI percentile is the percentile ranking based on the CDC's BMI-for-age growth charts, which indicates the relative position of the patient's BMI number among others of the same gender and age. **LOINC Codes:** **Body Mass Index percentile:** 59574-4 **Body Mass Index percentile per age:** 59575-1 **Body Mass Index percentile per age and sex :** 59576-9 **Note**: BMI percentile can be plotted on a BMI chart or documented in the record as a percentile; either is acceptable.	• Patients in hospice • Patients who have a diagnosis of pregnancy during the measurement year • Patients who died during the measurement year	Documentation must include: height, weight, and BMI percentile during the measurement year and they must be from the same data source. Patients can now report their height, weight, and BMI during the telehealth visit, but it must be directly to the provider. The provider must still document a BMI percentile. • Patient-reported services and biometric values (height, weight, and BMI percentile) are acceptable **only** if the information is collected by a PCP, or by a specialist when providing a primary care service related to the condition being assessed while taking a patient's history. • The information must be recorded, dated and maintained in the patients' legal health record. A specific BMI percentile can be documented on an age-growth chart. Use specific BMI percentiles that account for age and gender rather than absolute BMI. Remember to document the date of service when BMI/BMI percentile is obtained. Ranges and thresholds don't meet criteria for this indicator. A distinct BMI percentile is required for numerator compliance. Documentation of >99% or <1% meets criteria because a distinct BMI percentile is evident (i.e., 100% or 0%). The measurement year is Jan. 1-Dec. 31

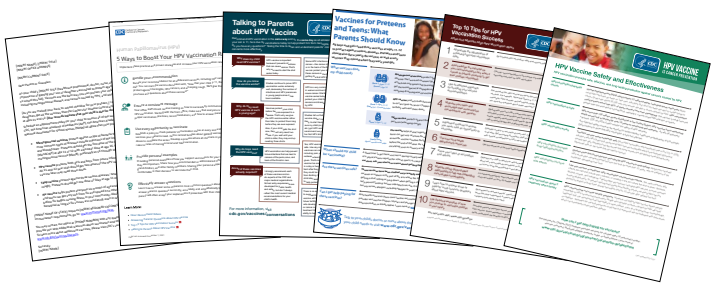
Additional Resources

Antibiotic Stewardship Tool Kit:
https://www.bcbst.com/providers/forms/antibiotic_stewardship_toolkit.pdf



IMA ToolKit

- **Parents' Reminder Letter:**
  https://provider.bcbst.com/working-with-us/quality-initiatives/
- **5 Ways to Boost Your HPV Vaccincation Rates:**
  https://www.cdc.gov/hpv/hcp/boosting-vacc-rates.html
- **Talking to Parents about HPV Vaccine:**
  https://www.cdc.gov/hpv/hcp/for-hcp-tipsheet-hpv.pdf
- **Vaccines for Preteens and Teens: What Parents Should Know:**
  https://www.cdc.gov/vaccines/parents/downloads/pl-dis-preteens-parents.pdf
- **Top 10 Tips for HPV Vaccination Success:**
  https://www.cdc.gov/hpv/downloads/top10-improving-practice.pdf
- **HPV Vaccine Safety and Effectiveness:**
  https://www.cdc.gov/vaccines/partners/downloads/teens/vaccine-safety.pdf



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Utilization and Equity Care

Measure	Goal of the Measure	What To Report (Sample Of Codes and/or Diagnoses)	Exclusions	Helpful Tips
Acute Hospital Utilization (AHU) 18 years and older	The ratio of observed to expected acute inpatient and observation stay discharges during the measurement year.	This is reported by claims.	• Patients in hospice or using hospice services Hospital stays for the following reasons do NOT meet criteria for this measure: • Principal diagnosis of mental health or chemical dependency • Psychiatry • Electroconvulsive therapy • Organ transplant • A principal diagnosis of a live-born infant, maternity-related diagnosis or maternity related stay • A potentially planned procedure without a principal acute diagnosis such as a hip replacement, heart bypass, or spinal fusion • A planned rehabilitation stay • Inpatient and observation stays that result in death	Collaborate with hospitals in order to be notified of your patients' admissions, ED visits, and discharges. Ensure a comprehensive follow-up visit, including medication reconciliation, is completed within 7-10 days post discharge. Arrange for post-hospital care as appropriate.
Emergency Department Utilization (EDU) 18 years and older	This is a ratio of observed to expected emergency department (ED) visits during the measurement year.	This is reported by claims.	Encounters for: • A principal diagnosis of mental health or chemical dependency • Psychiatry • Electroconvulsive therapy • Hospice or using hospice services	Discuss with your patients their options for care when your office is closed. If your practice offers telehealth or after hours care, educate your patients of the availability.

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Measure	Goal of the Measure	What To Report (Sample Of Codes and/or Diagnoses)	Exclusions	Helpful Tips
Plan All-Cause Readmission (PCR) 18-64 years	Percentage of members 18-64 years and older discharged from an acute hospital stay who were readmitted, whether acute or unplanned, to a hospital within 30 days, either for the same condition as their recent hospital stay or a different reason. Patients may have been readmitted back to the same hospital or to a different one.	This is reported by claims.	Patients in hospice, or using hospice services. Hospital stays for the following reasons don't meet criteria for this measure: • The patient died during the stay • Patients with the principal diagnosis of pregnancy or the principal diagnosis of a condition originating in the perinatal period • A principal diagnosis of maintenance chemotherapy • A principal diagnosis of rehabilitation • An organ transplant • A potentially planned procedure without a principal acute diagnosis	Collaborate with hospitals in order to be notified of your patients' admissions and discharges. Ensure a comprehensive follow-up visit, including medication reconciliation, is completed within 7-10 days post discharge. Arrange for post-hospital care as appropriate.

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Measure	Goal of the Measure	What To Report (Sample Of Codes and/or Diagnoses)	Exclusions	Helpful Tips
Race/Ethnicity Diversity of Membership (RDM) All Ages	An unduplicated count and percentage of patients enrolled any time during the measurement year, by race and ethnicity.	**Reporting Categories:** Race: • American Indian or Alaska Native • Asian • Black or African American • Native Hawaiian or Other Pacific Islander • White • Some Other Race • Two or More Races • Asked But No Answer • Unknown Ethnicity: • Hispanic or Latino • Not Hispanic or Latino • Asked But No Answer	None	Patient reported data is best.
Social Need Screening and Intervention (SNS-E) All Ages	The percentage of members screened, using prespecified screening tools at least once a year, for unmet food, transportation, housing, and transportation needs. For positive screening needs, patients received a corresponding intervention within 30 days of the screening.	Sample of Prespecified Screening tools: • American Academy of Family Physicians (AAFP) Social Needs Assessment OR Screening Tool **LOINC Codes:** 88122-7 and 88123-5 • Health Leads Screening Panel® **LOINC Code:** 95251-5 • Hunger Vital Sign™ **LOINC Code**: 88124-3 • Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences [PRAPARE]® **LOINC Code**: 93031-3	Members using hospice or hospice services Members who die during the measurement year Members who are both age 66 or older and living in an institution	Interventions corresponding to the positive social need may include any of the following categories: assistance, assessment, counseling, coordination, education, evaluation of eligibility, provision, or referral.

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Consumer Assessment of Healthcare Providers and Systems (CAHPS)

The CAHPS family of surveys measures topics that are important to members, such as communication skills of providers and the accessibility of services. CAHPS is considered the national standard for measuring and reporting on consumers' experiences with health plans and their services.

The CAHPS surveys ask, "Are consumers satisfied with the quality of care and customer services provided by their health plan (such as BlueCross), and their providers?"

The purpose of the surveys is to determine if consumers are satisfied with the quality of care and customer services given by their health plan and providers. They provide a measurement of how our members **perceive** the care they receive from the doctors and providers contracted with BlueCross.

Sample Survey Questions and Helpful Tips

CAHPS Survey Question	Case Management: Roles and Responsibilities
In the last 12 months, how often was it easy to get the care, tests or treatment you needed?	**Coordinating** care interventions, referrals to specialty providers and community-based support services, consults and resources **across involved health providers and care settings.**
In the last 12 months, how often did your personal doctor seem informed and up to date about the care you got from these doctors or other health providers?	**Collaborating with other health care professionals and support service providers across care settings, levels of care and professional disciplines, with special attention to safe transitions of care.** **Tip:** Be sure to ask patients if they've seen other providers recently.
When you visited your personal doctor for a scheduled appointment in the last 12 months, how often have they communicated your medical records or other information about your care?	**Communicating on an ongoing basis with the patients, patient's family or family caregiver, other involved health care professionals and support service providers, and assuring that all are well-informed and current on the case management plan of care and services.**
In the last 12 months, how often were you able to find out from your health plan how much you would have to pay for health care service or equipment?	**Educating** the patient, the family or family caregiver, and members of the inter-professional health care team about **treatment options,** community resources, **health insurance benefits,** psychosocial and financial concerns, and case management services, **in order to make timely and informed care-related decisions.**

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The Patient's Perception of Their Health Care Team

CAHPS Survey

CAHPS® is a family of surveys that measures topics important to members, such as communication skills of their providers and the accessibility of services. It's considered the national standard for measuring and reporting on consumers' experiences with health plans and their services.

The CAHPS surveys ask, "Are consumers satisfied with the quality of care and customer services provided by their health plan (such as BlueCross), and their providers?"

The survey provides a measurement of how our members (patients) perceive the care they receive from BlueCross-contracted doctors and providers.

What is CAHPS?

Consumer
Assessment of
Healthcare
Providers and
Systems

Best Practice Tip

Remember: the CAHPS survey measures the patient's perception of the health care and care coordination they've received.

Interactions with the Patient

How you interact with your patients has a direct impact on their response to the survey.

Provider ratings are based on the member's perception of the provider's ability to:

- Provide timely appointments and care
- Communicate information at the member's level
- Coordinate patient's care by using information and reports from other provider visits
- Follow up to communicate test results
- Discuss current medications and address any barriers to getting needed medication
  - Best practice tip: Coordinate patient care by using information and reports from other provider visits and:
    - Asking about care received in the ER
    - Offering assistance for needed appointments with specialists
    - Asking about any physical therapy, home health or other specialist visits
    - Reviewing current medications from all providers

Actual CAHPS Survey Questions for the Component Measure Categories

Answer options for the following questions include "Always", "Usually", "Sometimes" and "Never". Answers of "Always" and "Usually" positively impact your scores in this component measure the most.

Getting Appointments and Care Quickly

- In the last 6 months, when you needed care right away, how often did you get care as soon as you needed?
- In the last 6 months, how often did you get an appointment for a checkup or routine care as soon as you needed?
- In the last 6 months, how often did you see the person you came to see within 15 minutes of your appointment time?

Care Coordination

- In the last 6 months, when you visited your personal doctor for a scheduled appointment, how often did he or she have your medical records or other information about your care?
- In the last 6 months, when your personal doctor ordered a blood test, X-ray or other test for you, how often did someone from your personal doctor's office follow up to give you those results?
- In the last 6 months, when your personal doctor ordered a blood test, X-ray or other test for you, how often did you get those results as soon as you needed them?
- In the last 6 months, how often did you and your personal doctor talk about all the prescription medicines you were taking?
- In the last 6 months, did you get the help you needed from your personal doctor's office to manage your care among these different providers and services?
- In the last 6 months, how often did your personal doctor seem informed and up to date about the care you got from specialists?

Tips for Improving Patient Experience

Incorporating simple techniques into your daily interactions with patients will provide them with a better experience, help them achieve better health outcomes and can lead to better patient retention:

- Coordinating patient's care by using information and reports from other provider visits
- Providing timely appointments
- Discussing care received from the ER and other providers
- Ensuring follow-up to communicate test results
- Offering assistance for needed appointments with specialists
- Discussing current medications and addressing any barriers to getting needed medication
- Reviewing current medications from all providers
- Submitting claims timely and accurately

Tips for Interactions with the Patient

How you interact with your patients has a direct impact on their response to the survey.

- Communicate information at the member's level
- Coordinate patient care by
  - Asking about care received in the ER
  - Offering assistance for needed appointments with specialists
  - Asking about any physical therapy, home health or other specialist visits
  - Reviewing current medications from all providers
- Ensure patient's understanding and acceptance of plans with inquiries such as:
  - "Do you have any questions about your treatment plan?"
  - "Is there anything you would like to discuss further?"
  - "Do you feel confident with the plans discussed?"

Provider Resources

Provider Resource Guide

Why is Quality Care Important?

Educating patients to focus on their preventive care and chronic condition management empowers them to:

- Remain in control of their health care
- Stay up to date on recommendations
- Make informed decisions
- Be as healthy as they can be

We Value Your Participation in our Quality Program

We know you're already providing high-quality care for your patients, and we want to ensure your practice gets the recognition it deserves. You're helping our members get important preventive screenings, providing effective, timely treatment, and improving medication adherence so they can be as healthy as possible. This quality care is central to our mission of delivering peace of mind through better health to the members we serve.

Quality Resources for You and Your Patients

Resources for Providers

To keep you informed of changes and best practices, we provide monthly, quarterly and annual publications. We also offer a range of services and events, as well as onsite visits, to support your success in closing HEDIS measures for your patients.

Educating Our Members and Your Patients

We believe quality care involves the promotion of care management for health and wellness measures as they relate to patients' chronic conditions, age, gender and behavioral health. Our goal is to empower the patient to focus on preventive care and chronic condition management so they can make informed decisions, and have an active voice in their health.

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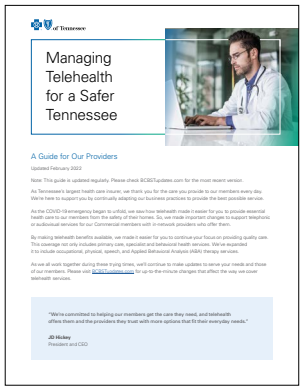
Keeping You Up to Date

Monthly BlueAlert Provider Newsletter

The BlueAlert newsletter gives you timely information on forms and process changes, coding tips, drug coverage and more. The current edition and archives are located on **provider.bcbst.com**.



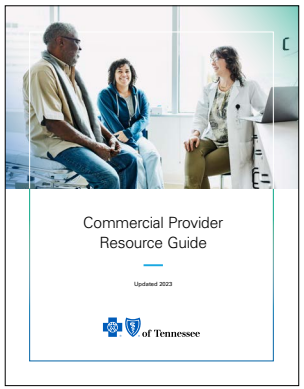
Commercial Telehealth Guide

The Telehealth Guide lists HEDIS specifications where gaps in care can be closed using telehealth. It also provides tips for coding and filing claims.

Quality Care Quarterly Newsletter

Each quarter, we send providers who participate in our quality programs a link to the quality newsletter. In it you'll find a variety of informative articles including best-practice highlights from your peers, helpful information on important HEDIS measures, tips on using the QCR tool, and upcoming events and training opportunities.

The current edition of the Quality Care Quarterly is at**provider.bcbst.com**, under **Quality Care Initiatives**. Previous editions are in the archived newsletters under **Provider News and Updates**.



Your Guide for Quality Care Measures

- New HEDIS specifications for the year
- Suggestions for incorporating the information into current workflows
- Helpful tips and best practices
- Measure-specific inclusion and exclusion criteria
- Sample diagnoses, CPT® and HCPCS codes related to gap closure
- Measure descriptions, what service is needed and what to report

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Availity® Provider Portal

Availity gives you the answers you need 24 hours a day, seven days a week. Through one convenient single sign-on, you can request claim status, view remittance advice and check benefits and eligibility status online.

In addition, the Quality Care Rewards tool located within Availity allows you to access the Quality Partnerships programs that apply to your practice. There you can identify gaps in care for your patients, attest to completed screenings, review your practice's overall progress on quality measures and much more.

For FAQs and more information about using Availity, visit Availity.com/bcbst. You'll also be able to sign up for a helpful webinar hosted by the Availity team.

Assistance with Supplemental Data Collection

You're already providing quality care to your patients, but sometimes we don't receive the data needed to document that. Our annual supplemental data collection initiative helps us capture that information.

How it Works

From early summer (June or July) through the first week of January, we provide nurses who can review your medical records to pull the data for closure of HEDIS measures that we haven't received through claims or clinical data exchange.

Reviews can be completed through remote access or onsite visits. Your practice receives credit for all the information our team locates in your records. By closing these gaps, you can increase your quality scores.

Want to Learn More?

For more information, contact a member of our team listed on the back of this guide. Participation is voluntary. This isn't an audit, it helps document the quality services you're already providing to your patients.

HEDIS codes can change from year to year. The codes in this document are from the HEDIS MY2024 specifications.

Health Education Resources Available to Patients

To help reinforce the counseling and education you offer your patients, we offer a variety of informational resources on preventive care and chronic condition management for our members. These resources are distributed at member events and mailed to members upon request. We can also supply these to your staff for distribution to your patients. Topics include, but aren't limited to:

- Living with Diabetes
- Adolescents' Preventive Health and Wellness Guide
- Men's Preventive Health and Wellness Guide
- Child Preventive Health and Wellness Guide
- Women's Preventive Health and Wellness Guide

Outreach Campaigns to Targeted Patients

Throughout the year, we identify patients who may need preventive care, screenings or education on potential health issues, and send informative clinical messages to them through mail, text messaging, email and automated phone calls. These campaigns include a focus on:

- Chronic obstructive pulmonary disease (COPD)
- Immunizations
- Flu or pneumonia
- Appropriate antibiotic use
- Coronary artery disease (CAD)
- Colorectal cancer screening
- Low back pain
- Diabetes and statin medication use

Campaigns are also sent out to patients with chronic conditions to make them aware of their disease management benefits and to encourage medication adherence and preventive screenings.

HEDIS codes can change from year to year. The codes in this document are from the HEDIS MY2024 specifications.

Patient Wellness Events

Each year we hold wellness campaigns in communities across the state to help support your efforts to deliver quality care. Our goal is to make it easy for your patients to get the preventive care they need by bringing these events to their communities.

Patient Wellness Event Campaigns include:

- Breast Cancer Screening
- Colorectal Cancer Screening
- Diabetes Care Screenings including: retinal eye exams, HbA1c, kidney function testing
- Drive-Through Flu Shot Clinics

On-Site Health Screening Events

Our quality teams often host screening events that can be held in your office, on our mobile unit, or at a local community event. We can customize these on-sites to meet your needs or preferences.

Your patients are often able to close multiple gaps in care and receive important educational material.

Customized On-Site Events can include:

- Well-Care/Screening Events
- Community Outreach
- Patient Education

Targeted Patient Education and Assistance

- Telephonic outreach offering education and assistance with appointment scheduling for needed screenings
- Preventive Screening Campaigns
- Patient Brochures

Assistance in Closing Quality Measures

Preventive care helps your patients improve their ability to lead healthy lives. But we know it's not always easy to get patients in the office for these important visits. That's why we give you other options for getting these screenings completed.

We offer customized onsite health screening events at your location tailored to best fit the needs of your office. Services we offer can include:

- Breast cancer screenings
- Colorectal cancer Screenings
- Diabetic retinal eye exams and other diabetic screenings

We identify patients who could benefit from these screenings and schedule a convenient time for them. Our onsite events can also include community outreach and member education.

HEDIS codes can change from year to year. The codes in this document are from the HEDIS MY2024 specifications.

Our team will be onsite at your event to assist our vendor partners, provide support, answer questions and help educate your patients on the importance of prevention and screening tests. There's also the opportunity for you to conduct other services during the same visit, such as:

- Annual wellness visits
- Blood pressure checks
- BMI assessments

To schedule an event, contact us at **GM_Commercial_Quality_Improvement@bcbst.com**.

Our Focus on Medication Adherence

We know you place an importance on educating patients on the benefits and risks of prescribed medication, and we're here to help. We have a dedicated team that contacts patients who aren't getting their prescriptions refilled as they should. We work with patients, their providers and pharmacies to help address the reasons the patients aren't taking their medications as prescribed. Through these efforts, we strive to impact the following HEDIS quality measures relating to medication adherence: antidepressant medications, statin medications, ADHD medications, and respiratory medications for asthma and COPD.

We've found these best practices helpful to many of our members and their providers.

1. Write prescriptions the way you instruct your patients to take their medications.
2. Encourage patients on an established maintenance medication regimen to use mail-order and 90-day supply options.
3. Talk to your patients about the purpose of their medications and how they may make them feel.
4. Coordinate all prescription refills for the same time to help prevent gaps in therapy.
5. Suggest patients use pill boxes and set reminders for refills.
6. Schedule office visits and follow-up appointments prior to prescriptions running out.
7. Refer patients to our Care Management program, at **1-800-818-8581**, for assistance with other barriers to medication adherence. We have nurse case managers, social workers, and dietitians available to help.

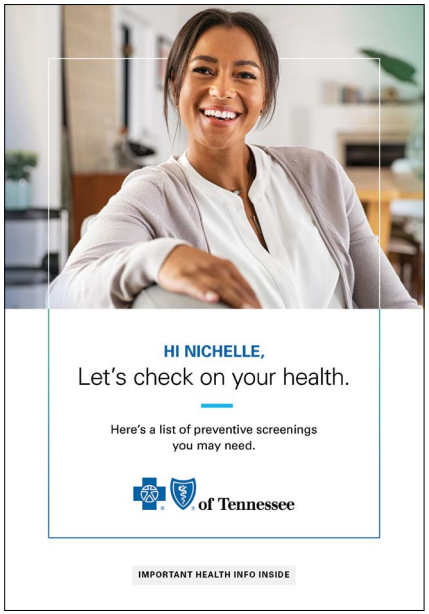
HEDIS codes can change from year to year. The codes in this document are from the HEDIS MY2024 specifications.

Individualized Patient Health Planners

Each year we mail more than 500,000 health planners to patients with at least one indicator that they may have a gap in care. The health planners are dynamically built with health indicators based on compliance status, and include health tips based on age, gender and disease condition.

These mailings usually begin in May or June. Health planners for children are sent based on their birthdays. Our intent is to encourage our members to work with their primary care doctor to be proactive in preventing conditions, and in the management of chronic conditions.

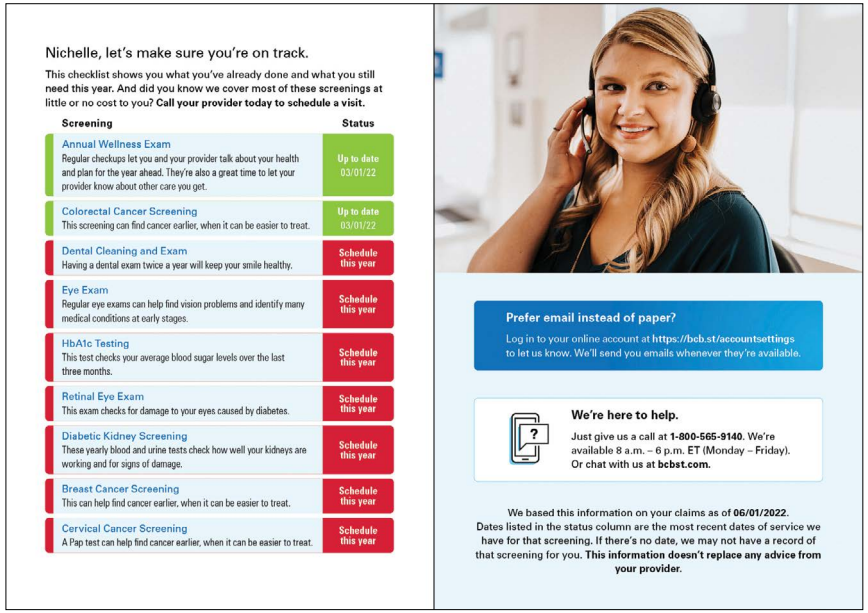
- The information provided tells patients if care is needed as soon as possible or already done for the year in accordance with the status symbol color:
  - **Red**: Screening is needed as soon as possible.
  - **Green**: Screening is up to date.
- Educational details about the screening that's needed and its purpose are also included.



2023 Health Planner Measures

Age Bands:

- Child: Ages 0-15 (addressed to parent or guardian)
- Teen: Ages 16-17 (addressed to parent or guardian)
- Adult: Ages 18+



HEDIS codes can change from year to year. The codes in this document are from the HEDIS MY2024 specifications.

Sample Health Planner with Health Indicators and Tips

These measures and care management messages reflect conditions and screenings that most often show as gaps in care.

Regular Provider Visits

Regular yearly visits with your primary care provider are important:

- To screen for diseases
- To encourage a healthy lifestyle
- To update vaccinations

Source: National Library of Medicine – nlm.nih.gov

Following Up on Mental Health

It's important to see your provider within seven days of hospitalization or residential treatment for substance use disorder. You can have an in person or virtual visit with your primary care or mental health provider. If you haven't heard from your provider, schedule an appointment within 30 days of your last visit or treatment.

Antibiotics

Antibiotics don't help with illnesses caused by viruses (like colds or the flu). If you take antibiotics too often, they may not work well when you really need them.

Source: Centers for Disease Control and Prevention – cdc.gov

From Pediatrics to Adult Care

Now that you're an adult, your health needs have changed. If you're still seeing a pediatrician, ask about switching to a provider who treats adults.

Low Back Pain

For most people, back pain eases up on its own. Staying active, applying ice, heat and using over-the-counter medications can help. Talk to your provider if your pain gets worse or doesn't improve to see what treatments would be best for you.

Source: American Board of Internal Medicine – choosingwisely.org

Asthma Medications

Knowing and avoiding your asthma triggers is key to managing your asthma. People with asthma may need short- and long-term medications to help manage their symptoms. An asthma action plan can help.

Source: American Lung Association – lung.org

Healthy in Mind & Body

Your provider is your partner in caring for your mental health and well-being. Talk to them if:

- You start taking a new medication
- You're diagnosed with depression
- Your emotions change
- You have a stay in the hospital

Source: Substance Abuse and Mental Health Services Administration – samhsa.gov

Heart Medications

Your provider may prescribe statin medication to help keep your heart healthy. Be sure to take it exactly the way your provider says to.

HEDIS codes can change from year to year. The codes in this document are from the HEDIS MY2024 specifications.

Recognizing a Heart Attack

Do you know the signs of a heart attack? They can include chest pain, shortness of breath and pain in your upper body or arms. Nausea and lightheadedness can also be signs, especially for women. If you're in doubt, don't wait – call 911.

Source: American Heart Association – heart.org

Keeping Your Lungs Healthy

- Take your medications exactly how your provider says to.
- If you smoke, make the choice to stop. Ask your provider for help.
- Avoid secondhand smoke and other triggers.

Source: American Lung Association – lung.org

Breast Self-Exam

A breast self-exam every month helps you notice small changes. If you find something, talk to your provider about it. The earlier breast cancer is found, the more likely it can be treated.

Source: National Breast Cancer Foundation – nationalbreastcancer.org

Focus for 2024 Health Planners

These measures and care management messages reflect conditions and screenings that most often show as gaps in care.

Indicator Measures

- Annual Wellness (comprised of the following)
  - Well-Child Visits in the first 30 months of life
  - Child and Adolescent Well-Child Visits ages 3-21 years
  - Adults' Access to Preventive/Ambulatory Health Services
- Childhood Immunization Status
- Immunizations for Adolescents
- Breast Cancer Screening
- Cervical Cancer Screening
- Colorectal Cancer Screening
- Diabetes Care
  - Diabetic Retinal Eye Exam
  - HbA1c control
- Kidney Health Evaluation for Patients with Diabetes
- Metabolic Testing (for children on antipsychotics)
- Dental and Vision Check-Ups

Care Management Messages and Health Tips

- Prenatal and Postpartum Care
- Use of Imaging Studies for Low Back Pain
- Pharmacotherapy Management of COPD Exacerbation
- Controlling High Blood Pressure
- Statin Therapy for Patients with Diabetes
- Statin Therapy for Patients with Cardiovascular Disease
- Medication Management for People with Asthma
- Appropriate Testing for Pharyngitis
- Appropriate Treatment for Upper Respiratory Infection
- Diabetes Blood Pressure Control
- Avoidance of Antibiotic Treatment with Acute Bronchitis
- ADHD Medication Follow Up
- Initiation and Engagement of Alcohol and Other Drug Abuse Treatment
- Medical Assistance with Smoking and Tobacco Use Cessation
- Follow-up After Hospitalization for Mental Illness
- Antidepressant Medication Management
- Transition from Pediatric to Adult Care
- Flu Vaccinations
- Well-Child Visits

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Resources Available from Commercial Quality Improvement

The Commercial Quality Improvement team can support and assist your office with educational materials for you and your patients, as well as health screenings and events. We've listed some resources below with information on how to access them. We have free patient brochures for all of the following:

Preventive Screenings

- Breast Cancer Screening
- Cervical Cancer Screening
- Chlamydia Screening
- Colorectal Cancer Screening

Wellness and Immunizations

- Adult Annual Wellness Visit
- Flu Vaccinations
- Adult Preventive Health Screening Guide
- Pregnancy
- Adolescent Preventive Health Screening Guide
- Adolescent Immunizations
- Weight Counseling for Children
- Child and Adolescent Wellness
- Childhood Immunizations
- Child Preventive Health Screening Guide

Behavioral Health and Other Measures

- Antidepressant Medication Management
- Behavioral Health Follow-up Care
- ADHD
- Opioid Education Brochure
- Antipsychotic Medications
- Behavioral Health Child APP and APM Flyer
- Smoking Cessation
- Tips for Heading Home

Chronic Diseases

- Medication Management for Asthma
- Managing COPD
- Controlling High Blood Pressure
- Statin Therapy Cardiovascular
- Diabetes
- Statin Therapy Diabetes
- Low Back Pain

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Additional Resources and Materials

- Child Immunization Magnet
- Flu Shot Flyer
- Blood Pressure Tracker Card
- Diabetes Recipe Books/Trackers
- Appropriate Antibiotic Use Cold/Flu Kits
- Hot/Cold Packs for Low Back Pain

Provider Tool Kits

Tool kits and guides are posted on **provider.bcbst.com**. You can contact the Commercial Quality Improvement Team for information on the screening events.

- Low Back Pain (LBP measure), including a **coding tool** and **an exclusion pocket guide**
- Adolescent Immunization (IMA measure resources are listed under the commercial tab)
- **Antibiotic Stewardship** – Antibiotic Treatment for Acute Bronchitis/ Bronchiolitis (AAB) and Appropriate Treatment for Upper Respiratory Infection (URI) measures
- **Provider Screening Event Toolkit**

Provider Guides

- 2024 Commercial Comprehensive Quality Information Guide
- Telehealth Guide
- Resource and Support Guide
- Bottom Line Quick Reference Guide
- Statins Guide
- Guide to Advanced Illness and Frailty Exclusions
- Support Guide for the Kidney Evaluation Measure
- Low Back Pain Coding Guide
- Cultural Competency Guide

In-Office Health Screening Event Opportunities

- Wellness
- Diabetes
- Colorectal
- Mammography

Community Screening Event Opportunities

- Wellness
- Diabetes
- Colorectal
- Mammography
- Drive-Through Flu Shot Clinics

Gap Closure Assistance with Our Vendor Partner

We're working with Retina Labs to provide specific preventive screening health tests to our Commercial members in the home and at outreach events for little to no charge to the patient. Retina Labs will perform eye exams, and A1C tests while in the patient's home. They'll leave the FIT CHEK testing kit for colorectal screening with the patient with instructions to mail the test kit in to be completed.

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Cultural Competency in Health Care

Culture shapes how people experience their world. It's a vital component of how health care services are delivered and received.

Culturally competent health care goes beyond speaking another language or recognizing people's cultural history. It's rooted in mutual respect and means being open to learning more about patients and their cultures, and acknowledging potential biases we may have. By delivering culturally competent health care, providers promote health equity and reduce health disparities.

BlueCross network providers agree not to discriminate in the quality of services and treatment provided to patients of all cultural backgrounds. They also agree to be willing and able to treat all patients.

In this guide, we share more about what it means to deliver culturally competent care and resources you may find useful. We hope you find the information helpful.

Important Definitions

Health equity is achieved when every person has the opportunity to achieve their full health potential, regardless of social position or other socially determined circumstances.[1] Some factors that may limit a person's access to health care and good health practices are:

- Racial and ethnic discrimination
- Lack of access to quality education
- Income and wealth gaps
- Inadequate housing or lack of housing
- Unsafe environments

Culture is the"... sum total of values, beliefs, standards, languages, thinking patterns, behavioral norms, communication styles, etc. of a group of people, institutions or organizations that guides decisions and actions and is transmitted from one generation to another."[2]

Cultural awareness and sensitivity involve developing an understanding of another group and knowing that cultural differences exist without assigning values (i.e., better or worse, right or wrong) to those differences.[2]

Cultural competency in health care "...describes the ability of systems to provide care to patients with diverse values, beliefs and behaviors, including the tailoring of health care delivery to meet patients' social and linguistic needs."[3]

Cultural Competency's Role in Quality Care

Sometimes, people from different cultures have different perceptions about illness and competent treatment. These beliefs may be based on religious ideas, folklore or their own common-sense explanations.[4]

People's perceptions of health care can influence clinical encounters and their willingness to take medication or have surgery. Those who've had a bad experience with the health system in the past may also feel mistrustful or hesitant. Acknowledging your patients' beliefs, perceptions about illness and self-care practices is an important part of delivering quality, culturally competent care.

1. Centers for Disease Control and Prevention
2. State of Tennessee Department of Finance and Administration Manual
3. Becoming a Culturally Competent Health Care Organization, American Hospital Association/Health Research and Educational Trust
4. Quality Care Interactions Training

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Promoting Cultural Competency

Culturally competent health care begins with an awareness of your own cultural beliefs and practices and recognizing that people from other cultures may not share them. Validating and signaling an openness to social and cultural perceptions and expectations that differ from your own helps ensure people get the care they need to prevent, identify and treat health care problems.

These factors may play a role in a patient's cultural beliefs and practices:

- Education level
- Income level
- Geographic residence
- Identification with community groups (religious, professional, community service, political, etc.)
- Individual experiences
- Length of residency in the U.S.
- Place of birth
- Language
- Age
- Race
- Ethnicity
- Sex
- Sexual orientation
- Gender identity
- Disabilities
- Veteran status

Culturally competent health care can help improve positive patient outcomes and in-office efficiency. For providers, this means a greater potential for high quality scores and financial rewards associated with our quality incentive programs.

Consider these tips to help promote culturally competent care in your practice.

Support health literacy. Ask yourself and others in your practice, "If I spoke a different language, would I feel comfortable with this treatment/facility/provider?" Then, find ways to help promote health literacy, especially among those who may have limited English proficiency (LEP), such as:

- Communicating clearly.
- Slowing down the pace of the conversation.
- Using plain language to explain information about health conditions and treatments.
- Helping patients find ways to communicate that will allow you to assess their health needs.
- Using an interpreter. Providers are required to make an interpreter available to those with LEP at no charge. **Note:** A person's family members, including their minor children, shouldn't serve as the interpreter during medical visits.

Adapt service delivery to help meet the diverse needs of patients. Moving towards culturally appropriate service delivery means being:

- Knowledgeable about cultural differences and their impact on attitudes and behaviors
- Sensitive, understanding, non-judgmental and respectful in conversations with people whose culture differs from your own
- Flexible and skillful in responding and adapting to different cultural contexts and circumstances

Make cultural knowledge a key part of your practice's policies and procedures. Ask bilingual and multicultural staff members or volunteers to help answer patients' questions and concerns.

Find ways to ask open-ended questions, when possible. Acknowledge the person's perception of illness and self-care practices. Talk with them about how the medical system works and explain that asking many questions about their health and symptoms is often necessary to get an accurate diagnosis.

Consider using the teach-back method, which involves asking people to repeat information you've shared in their own words. This can help you gauge their understanding of the discussion.

Schedule more time for appointments with those who have LEP, which may take twice as long. During these visits, talk directly to the patient (not their interpreter).

Consider involving extended family members in care planning. In many cultures, families are deeply involved in individuals' medical decisions. **Note:** Please use your clinical judgment to determine if this is appropriate. Make sure you have your patient's consent to discuss their health information with others.

Ask the Right Questions and Look for Answers

The occurrence of acute and chronic medical conditions can vary among people of different ethnicities and cultures. Your observations and questions can help improve the quality of care and remove barriers in patients' health care.

HEDIS codes can change from year to year. The codes in this document are from the HEDIS MY2024 specifications.

Where to Find More Information

Quality Care Interactions

Because we realize that the best care outcomes occur when providers and patients have developed trust, mutual respect and effective communication skills, we're excited to offer our network providers **free cultural competency training**.

The innovative, online Quality Interactions, Cultural Competency training program, provided by BlueCross BlueShield of Tennessee, can help you work more effectively with patients or peers with different cultural backgrounds.

This training uses a case-based format, and it's supported by evidence-based medicine and peer-reviewed literature. It also features pre- and post-test evaluations so you can clearly assess the effectiveness of the program. Because this program is accredited, you're eligible for 1 hour of CME, CEU or CCM credits upon completion. Additionally, we'll award you a Cultural Competency designation in our online provider directory.

If you're interested in earning this designation and continuing education through this course, please contact a member of your Commercial Quality Improvement Team to get started.

Other Online Resources

In addition to the Quality Interactions training offered at no cost to you through BlueCross, we've listed some other resources below for your reference:

- U.S. Department of Health and Human Services – Think Cultural Health **thinkculturalhealth.hhs.gov/education**
- U.S. Department of Health and Human Services – A Physician's Practical Guide to Culturally Competent Care **cccm.thinkculturalhealth.hhs.gov/**

Thank you for all you do for our members. By working together to promote this important aspect of care, we can help improve the quality of care and health equity in our state.

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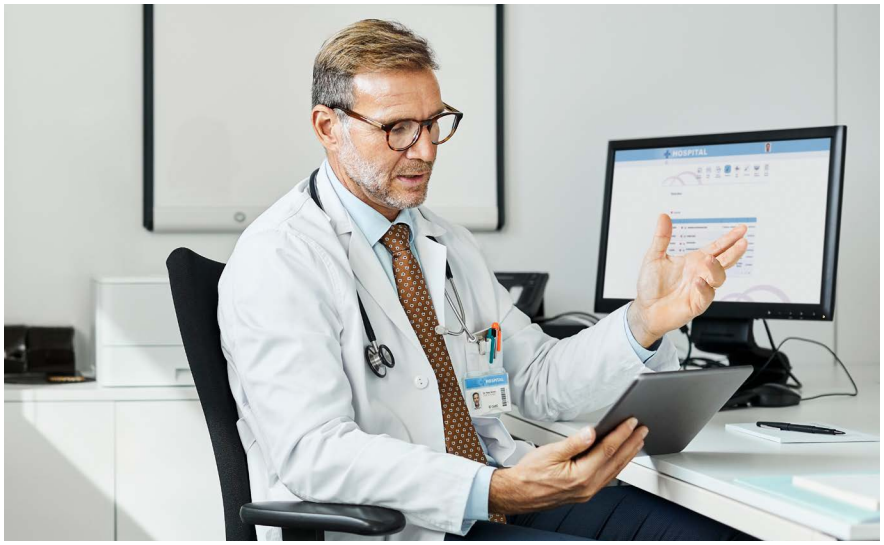
Telehealth Services for Our BlueCross Members

As the COVID-19 emergency began to unfold, we saw how telehealth made it easier for you to provide essential health care to our members from the safety of their homes. So, we made important changes to support telephonic or audiovisual services for our Commercial members with in-network providers who offer them.

Defining Current Telehealth Services

The term telehealth is used to refer to any real-time telephonic or audiovisual consultation between a patient and their in-network provider, or in some situations, an online assessment. It's also used for provider-to-provider consultations – regarding a patient's care – for certain covered services.

We allow telehealth visits through Apple® FaceTime®, Facebook Messenger, Skype, Zoom, Google Hangouts Meet™ and other office platforms. If you have questions about a different type of technology, please contact your Network Manager.



Eligible Services

Payment for most telehealth services will be consistent with your BlueCross fee schedule. To be eligible for payment, services must:

- Be covered under the patient's benefits, and eligible for payment as if it were an office visit;
- Take place through synchronous telehealth (real time, interactive audio and video), a telephone visit or asynchronous telehealth; (You can learn more about the three categories of telehealth services and which categories can be used to close specific gaps in care later in this guide.)
- Be medically appropriate and necessary, and meet the same requirements of the encounter code had it been delivered in person; and
- Include all relevant communications about the patient's medical care and follow-up in their medical record.

Any evaluation and management services (E/M) provided through telehealth must include a problem-focused history and straightforward medical decision-making, according to the Current Procedural Terminology (CPT®) manual.

HEDIS codes can change from year to year. The codes in this document are from the HEDIS MY2024 specifications.

Sample Codes for Billing Telehealth Services

Type of Service	HCPCS/CPT® Codes	Place of Service Code
Telephonic provider-to-provider or provider-to-member	99441-99443	02, 10 or normal POS code with 95 modifier
Virtual (interactive audio/visual) consultations with patients	99202-99205 and 99211-99215	02, 10 or normal POS code with 95 modifier
Behavioral health consultations with patients	90791, 90792, 90832, 90833, 90834, 90836 and 90837	02, 10 or normal POS code with 95 modifier
Diabetes education consultations with patients	97802, 97803, 97804	02, 10 or normal POS code with 95 modifier

Using Telehealth to Address Quality Measures

Tips for Closing HEDIS Gaps in Care

Proper coding is key to help document the care you're giving – and reach your quality goals. We've included some telehealth updates and sample codes that you may find helpful as you conduct your telehealth visits.

When referring to "telehealth" in this context, it's helpful to note there are three categories:

1. Synchronous telehealth – which is **real-time interactive audio and video**. We'll refer to this as **telehealth** when addressing quality measures in this section of the guide.
   - Telehealth Place of Service Codes and the 95 Modifier
   - When providing telehealth services using real-time audio and video telecommunications systems, use:
     - Place of Service (POS) 02 or 10

       or
     - Your normal POS code with a 95 modifier. Example: POS 11 with a 95 modifier

2. Telephonic – meaning telephone visits only. In this guide, we'll refer to this as **telephone visits**.
   - Telephone Visits Only
     - Sample CPT® codes include: 98966-98968, 99441-99443

HEDIS codes can change from year to year. The codes in this document are from the HEDIS MY2024 specifications.

3. Asynchronous telehealth – which is representative of e-visits or virtual check-ins, like patient portals, secure text messages or emails. In this document, we'll refer to these types of visits as **online assessments**.

   - Online Assessments (codes for e-visits and virtual check-ins)
     - Sample CPT® codes include: 98970-98972, 99421-99423
     - Sample HCPCS codes include: G0071, G2010

Specific Measures

Follow-Up Care for Children Prescribed ADHD Medication (ADD)

Children ages 6 to 12 who are starting or restarting ADD/ADHD medication should have three follow-up visits within a 10-month period. Telehealth visits are acceptable for all three follow-up visits.

- The first follow-up visit (within 30 days) must be **with a provider who has prescribing authority**, and may be performed as a telephone visit.

The subsequent two visits (within the next nine months) can be **with any provider** and may be an e-visit or telephone visits. However, only one of the two visits (during days 31-300) can be performed as a virtual check-in (online assessment).

Antidepressant Medication Management (AMM)

A telehealth visit may be helpful to check on patients and how they're doing with their antidepressant medications. This would also be a good way to discuss medication side effects and assist patients with refills. Prescribing 90-day fills often saves patients time and money while also helping them stay on their medication.

Use of First-Line Psychosocial Care for Children/Adolescents on Antipsychotics (APP)

Children who are prescribed antipsychotics without a documented major mental health diagnosis should have a visit with a mental health provider. **Synchronous telehealth visits are acceptable in this situation.** For example, a psychiatric consultation or therapy session with audio/visual interaction. The visit must occur within 30 days of the medication-filled date OR within 90 days before the medication is filled and must be completed by a **mental health provider**.

Controlling High Blood Pressure

We know that it's important to monitor the blood pressure readings of your patients with hypertension. Here are some tips that may help you monitor your patients' progress and close the gaps in care.

- You can now use member-reported B/P levels, but only if they were taken **on a digital device**.
- B/P readings can be taken from any digital device.
- B/P levels should be documented in the chart by you, the provider, and it is helpful to note that the member checked their B/P on a digital device.
- When talking to your patient about their blood pressure, documenting the name of their digital device in the chart can be helpful.
- The American Heart Association recommends that patients be encouraged to bring their digital devices to the provider office once a year to make sure the readings are accurate.
- If there are multiple B/Ps on the same date, use the lowest systolic and lowest diastolic B/P on that date as the representative B/P.
- The B/P must be a reading of less than 140/90 **to close the gap in care. This gap in care can open and close throughout, depending on whether or not the member's levels are within this range.**

Follow-Up After ED Visit for Substance Use Disorder (FUA)

Patients 13 years or older, who were seen in the emergency department (ED) with a PRINCIPAL diagnosis of substance use disorder (SUD) or any diagnosis of drug overdose, for which there was a follow-up visit, should have a follow-up visit for SUD within seven days of the ED visit. Any of the following visit types meet criteria for the follow-up visits:

- A telephone visit with any diagnosis of SUD
- An e-visit or virtual check-in (online assessments) with a diagnosis of SUD

Follow-Up After Hospitalization for Mental Illness (FUH)

Patients age 6 and older who were hospitalized for treatment of a selected mental illness or intentional self-harm diagnosis need a follow-up visit within seven days of discharge. Sample diagnoses include: dementia, schizophrenia, schizoaffective disorder, manic episode, bipolar episode, mental illness, and intentional self-harm. The following visit types meet the criteria for a follow-up visit:

- A telphone visit **with a mental health provider**
- A synchronous (audio/visual) telehealth visit **with a mental health provider**

Please note that a visit occurring on the same day as discharge won't meet the requirements for the follow-up visit for this measure.

Follow-Up After ED Visit for Mental Illness (FUM)

Patients 6 years and older who had an emergency department (ED) visit with a principal diagnosis of mental illness or intentional self-harm need a follow-up visit within seven days of the ED visit. Sample diagnoses include: dementia, schizophrenia, schizoaffective disorder, manic episode, bipolar episode, mental illness and intentional self-harm. **Any** telehealth encounter (synchronous, telephone or asynchronous) will meet the criteria for a follow-up visit, as long as one of the following two conditions apply:

- There is a principal diagnosis of mental health disorder (in this case it doesn't matter if there's a diagnosis of intentional self-harm)
- There is a principal diagnosis of self-harm, but in this case it must be accompanied by a diagnosis of mental health disorder.

Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)

Patients 13 years of age and older, who had acute inpatient hospitalizations, residential treatment or a withdrawal management visit for a diagnosis of substance use disorder (SUD) that result in a follow-up visit or service for SUD. Any of the following visit types meet the criteria for a follow-up with a practitioner:

- A telehealth visit with a principal diagnosis of SUD
- A telephone visit with a principal diagnosis of SUD
- An e-visit or virtual check-in with a principal diagnosis of SUD

Initiation and Engagement of Substance Use Disorder Treatment (IET)

For patients who are 13 years of age and older, providers may use telehealth visits to meet the requirements of the measure. If patients eligible for this measure have a new episode of alcohol or other drug abuse/dependence (AOD), they should have the following visits:

- **For Initiation of AOD Treatment:** The patient should have the following visit types within 14 days of the initial encounter with an SUD diagnosis:
  - A telephone visit with an SUD diagnosis
  - An e-visit or virtual check-in (online assessment) with an SUD diagnosis

  Please note: Initiation follow-up visits that occur on the same day as the initial diagnosis must be with a different provider.

- **For Engagement of SUD Treatment:** The patient must have two or more of the following visit types within 34 days of the initiation visit with an SUD diagnosis:
  - A telephone visit with an SUD diagnosis
  - An e-visit or virtual check-in (online assessment) with an SUD diagnosis

  Please note: Events including detoxification codes aren't considered engagement episodes.

Asthma Medication Ratio (AMR)

A telehealth visit may be helpful for checking on your patients who are 5 to 64 years of age to determine how well they're managing their asthma. The visit could provide an opportunity to review their current medication regimen, discuss any symptoms, and assist with refills. Prescribing 90-day medication fills often saves patients time and money and helps them stay on their medications, all from the comfort and safety of their home.

Appropriate asthma medication ratios of 0.50 or greater of long-term controller medications to quick-reliever medications could potentially prevent a significant proportion of asthma-related costs (hospitalizations, ER visits), while also lowering non-medication costs for patients.

Statin Therapy for Patients with Cardiovascular Disease (SPC)

A telehealth visit may be helpful to check on patients and how they're doing with their moderate- to high-intensity statin medications. This would also be a good time to discuss any medication side effects and assist patients with refills. Prescribing 90-day medication fills often saves patient time and money and helps them stay on their medications.

Statin Therapy for Patients with Diabetes (SPD - Adherence 80%)

A telehealth visit may be helpful for checking on your patients identified with diabetes and discussing how well they're managing their diabetes and taking statin medications. This would also be a good time to discuss any medication side effects assist patients with refills. Prescribing 90-day medication fills often saves patient time and money and helps them stay on their medications.

The table below lists the measures that can be met by a telehealth method, and shows the method by which a gap can be closed for that particular measure if all documentation and other specifications are met.

Measure	Telehealth (interactive audio/video)	Telephonic	Online Assessment (e-visit/virtual check-in)
ADD-E* – Initiation	C	C	—
ADD-E* – Continuation and Maintenance	C	C	C
APP	C	—	—
CBP	C	C	C
BPD	C	C	C
FUH	C	C	—
FUM	C	C	C
FUA	C	C	C
FUI	C	C	C
IET – Initiation	C	C	C
IET – Engagement	C	C	C

C=Compliance can be gained by this method.

HEDIS codes can change from year to year. The codes in this document are from the HEDIS MY2024 specifications.

Frequently Asked Questions

Can nurses perform and bill for telehealth services?

No. Only contracted and credentialed physicians, specialists, nurse practitioners, physician assistants and mental health professionals can bill for telehealth services under their own NPI. Additionally, nurse practitioners and physician assistants who provide telehealth services must be supervised by a contracted physician. Claims should be billed according to the Provider Administration Manual guidelines.

Are there telehealth services that BlueCross won't cover?

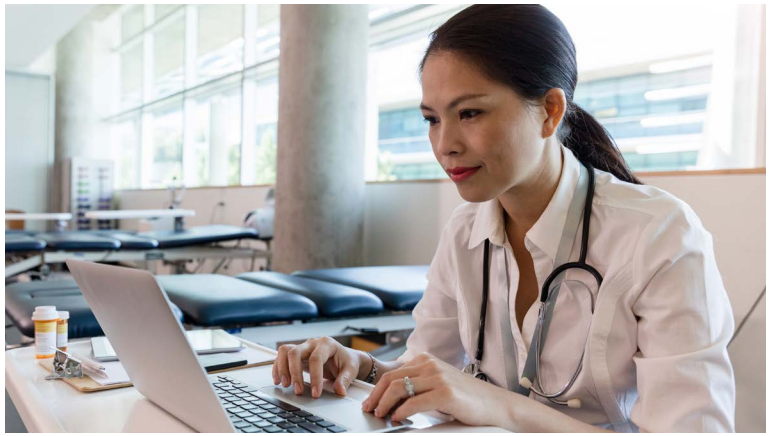
We're committed to covering the services that can be successfully administered through audio- and video-based platforms, or through online assessments. As a result, we won't cover telehealth treatment that requires specialized hands-on care, such as chiropractic services. We also won't cover telehealth treatment that requires specialized equipment, such as whirlpools or ultrasound machines. This includes:

- Athletic Training (97169-97172)
- Modalities (97010-97039) and group therapies

Patients receiving group therapy should be considered for individual therapy via telehealth. It's also important to note, we won't cover telehealth for educational or administrative services, or patient communications incidental to Evaluation and Management (E/M), counseling or medical services covered by this policy. This includes educational material.

What documentation should be included for telehealth visits?

For services provided through telehealth, you should submit the same documentation you would use for a face-to-face visit.



Resources for More Information

If you have questions about BlueCross telehealth coverage, please contact your Provider Network Manager. You can also refer to the references below:

BlueCross Provider Service

provider.bcbst.com/contact-us/

Availity® Assistance

Call the eBusiness technical support team at **1-800-924-7141** or send an email to **eBusiness_service@bcbst.com**

General Telehealth Technical Assistance

- National Consortium of Telehealth Resource Centers: **telehealthresourcecenter.org**
- U.S. Department of Health and Human Services: **telehealth.hhs.gov/providers/getting-started/**
- Behavioral Health Telehealth Assistance: **psychiatry.org/psychiatrists/practice/telepsychiatry**

HEDIS codes can change from year to year. The codes in this document are from the HEDIS MY2024 specifications.

Guide to Advanced Illness and Frailty Exclusions

The National Committee for Quality Assurance (NCQA) has established specifications that impact HEDIS measures for patients with advanced illness and frailty. Additional exclusions to these measures were made because the services recommended in the original definition may not benefit older adults with advanced illness limiting their ability to receive certain treatments.

Advanced illness and frailty codes must be submitted in the current (measurement) year to exclude the patient from the impacted HEDIS measures. Please see below for specific measures impacted by these diagnoses.

Patients age 66 and older can be excluded if they have BOTH advanced illness and frailty

- Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)
- Breast Cancer Screening (BCS)
- Blood Pressure Control for Patients With Diabetes (BPD)
  - This measure is also known as Comprehensive Diabetes Care, Blood Pressure Control (CDC_B/P)
- Cardiac Rehabilitation (CRE)
- Colorectal Cancer Screening (COL)
- Controlling Blood Pressure (CBP)
- Eye Exam for Patients With Diabetes (EED)
  - This measure is also known as Comprehensive Diabetes Care, Eye Exam (CDC_Eye)
- Glycemic Status Assessment for Patients with Diabetes (GSD)
  - This measure was also known as Hemoglobin A1C Control for Patients with Diabetes (HBD)
- Kidney Health Evaluation for Patients With Diabetes (KED)
- Use of Imaging Studies for Low Back Pain (LBP)
- Statin Therapy for Patients with Cardiovascular Disease (SPC)
- Statin Therapy For Patients with Diabetes (SPD)

Helpful Tip

It's important to note that these exclusions require BOTH the Advanced Illness codes and the Frailty codes to meet the exemption.

To qualify for advanced illness exclusion, the patient must have **at least one** of the following:

- Two claims on different dates of service with an advanced illness code during the measurement year or the year prior
- One filled prescription for a dementia medication

To qualify for frailty exclusion, the patient must have **at least two** indications of frailty with different dates of service during the current measurement year.

HEDIS codes can change from year to year. The codes in this document are from the HEDIS MY2024 specifications.

Advanced Illness

ICD-10 Code	Definition
A81.00, A81.01, A81.09	Creutzfeldt-Jakob disease
C25.0, C25.1, C25.2, C25.3, C25.4, C25.7, C25.8, C25.9	Malignant neoplasm of pancreas
C71.1, C71.2, C71.3, C71.4, C71.5, C71.6, C71.7, C71.8, C71.9	Malignant neoplasm of various sites of brain/unspecified
C77.0, C77.1, C77.2, C77.3, C77.4, C77.5, C77.8, C77.9	Secondary and unspecified malignant neoplasm of lymph nodes
C78.00	Secondary malignant neoplasm of unspecified lung
C78.01	Secondary malignant neoplasm of right lung
C78.02	Secondary malignant neoplasm of left lung
C78.1	Secondary malignant neoplasm of mediastinum
C78.2	Secondary malignant neoplasm of pleura
C78.30	Secondary malignant neoplasm of unspecified respiratory organ
C78.39	Secondary malignant neoplasm of other respiratory 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 retroperitoneum and peritoneum
C78.7	Secondary malignant neoplasm of liver and intrahepatic bile duct
C78.80	Secondary malignant neoplasm of unspecified digestive organ
C78.89	Secondary malignant neoplasm of other digestive organs
C79.00	Secondary malignant neoplasm of unspecified kidney and renal pelvis
C79.01	Secondary malignant neoplasm of right kidney and renal pelvis
C79.02	Secondary malignant neoplasm of left kidney and renal pelvis
C79.10	Secondary malignant neoplasm of unspecified urinary organs
C79.11	Secondary malignant neoplasm of bladder
C79.19	Secondary malignant neoplasm of 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

HEDIS codes can change from year to year. The codes in this document are from the HEDIS MY2024 specifications.

Advanced Illness (continued)

ICD-10 Code	Definition
C79.40	Secondary malignant neoplasm of unspecified part of nervous system
C79.49	Secondary malignant neoplasm of other parts of nervous system
C79.51, C79.52	Secondary malignant neoplasm of bone, bone marrow
C79.60, C79.61, C79.62, C79.63	Secondary malignant neoplasm of ovary
C79.70, C79.71, C79.72	Secondary malignant neoplasm of 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
F01.50, F01.51, F02.80, F02.81, F03.90, F03.91, F10.27, F10.96, F10.97	Dementia
F04	Amnestic disorder due to known physiological condition

ICD-10 Code	Definition
F10.96	Alcohol use, unspecified with alcohol-induced persisting amnestic disorder
G10	Huntington's disease
G12.21	Amyotrophic lateral sclerosis
G20	Parkinson's disease
G30.0, G30.1, G30.8, G30.9	Alzheimer's disease
G31.01	Pick's disease
G31.09	Other frontotemporal dementia
G31.83	Dementia with Lewy bodies
G35	Multiple sclerosis
I09.81, I11.0, I13.0, I13.2, I50.20, I50.21, I50.22, I50.23, I50.30, I50.31, I50.32, I50.33, I50.40, I50.41, I50.42, I50.43, I50.810, I50.811, I50.812, I50.813, I50.814, I50.82, I50.83, I50.84, I50.89, I50.9	Heart failure
I50.1	Left ventricular failure, unspecified
I12.0, I13.11, I13.2, N18.5	Hypertensive Heart Disease with Chronic Kidney Disease

HEDIS codes can change from year to year. The codes in this document are from the HEDIS MY2024 specifications.

Advanced Illness (continued)

ICD-10 Code	Definition
J43.0, J43.1, J43.2, J43.8, J43.9, J98.2, J98.3	Emphysema; Interstitial Emphysema; Compensatory Emphysema
J68.4	Chronic respiratory conditions due to chemicals, gases, fumes and vapors
J84.10, J84.112, J84.17	Pulmonary fibrosis
J84.170, J84.178	Other Interstitial Pulmonary Diseases
J96.10, J96.11, J96.12, J96.20, J96.21, J96.22, J96.90, J96.91, J96.92	Respiratory failure
K70.10, K70.11, K70.2, K70.30, K70.31, K70.40, K70.41, K70.9	Alcoholic hepatic disease
K74.0, K74.1, K74.2, K74.4, K74.5, K74.60, K74.69	Hepatic disease
K74.00, K74.01, K74.02	Hepatic fibrosis
N18.5, N18.6	Chronic kidney disease, stage 5; End stage renal disease

Frailty

Frailty Encounter

CPT® II Code	Definition
99504	Home visit for mechanical ventilation care
99509	Home visit for assistance with activities of daily living

HCPCS Code	Definition
G0162, G0299, G0300, G0493, G0494	Skilled RN services related to home health/ hospice setting
S0271	Physician management of patient home care, hospice
S0311	Comprehensive management and care coordination for advanced illness
S9123, S9124, T1000, T1001, T1002, T1003, T1004, T1005, T1019, T1020, T1021, T1022, T1030, T1031	Nursing care, respite care and personal care services

HEDIS codes can change from year to year. The codes in this document are from the HEDIS MY2024 specifications.

Frailty Device

HCPCS Code	Definition
E0100, E0105	Cane
E0130, E0135, E0140, E0141, E0143, E0144, E0147- E0149	Walker
E0163, E0165, E0167, E0168, E0170, E0171	Commode chair
E0250, E0251, E0255, E0256, E0260, E0261, E0265, E0266, E0270, E0290-E0297, E0301-E0304	Hospital bed
E0424, E0425, E0430, E0431, E0433, E0434, E0435, E0439, E0441-E0444	Oxygen
E0462	Rocking bed with or without side rails
E0465, E0466	Home ventilator
E0470-E0472	Respiratory assist device
E1130, E1140, E1150, E1160, E1161, E1170, E1171, E1172, E1180, E1190, E1195, E1200, E1220, E1240, E1250, E1260, E1270, E1280, E1285, E1290, E1295-E1298	Wheelchair

Frailty Diagnosis

ICD-10 Code	Definition
L89.000, L89.001, L89.002, L89.003, L89.004, L89.006, L89.009, L89.010, L89.011, L89.012, L89.013, L89.014, L89.016, L89.019, L89.020, L89.021, L89.022, L89.023, L89.024, L89.026, L89.029, L89.100, L89.101, L89.102, L89.103, L89.104, L89.106, L89.109, L89.110, L89.111, L89.112, L89.113, L89.114, L89.116, L89.119, L89.120, L89.121, L89.122, L89.123, L89.124, L89.126, L89.129, L89.130, L89.131, L89.132, L89.133, L89.134, L89.136, L89.139, L89.140, L89.141, L89.142, L89.143, L89.144, L89.146, L89.149, L89.150, L89.151, L89.152, L89.153, L89.154, L89.156, L89.159, L89.200, L89.201, L89.202, L89.203, L89.204, L89.206, L89.209, L89.210, L89.211, L89.212, L89.213, L89.214, L89.216, L89.219, L89.220, L89.221, L89.222, L89.223, L89.224, L89.226, L89.229, L89.300, L89.301, L89.302, L89.303, L89.304, L89.306, L89.309, L89.310, L89.311, L89.312, L89.313, L89.314, L89.316, L89.319, L89.320, L89.321, L89.322, L89.323, L89.324, L89.326, L89.329, L89.40, L89.41, L89.42, L89.43, L89.44, L89.45, L89.46, L89.500, L89.501, L89.502, L89.503, L89.504, L89.506, L89.509, L89.510, L89.511, L89.512, L89.513, L89.514, L89.516, L89.519-L89.524, L89.526, L89.529, L89.600-L89.604, L89.606, L89.609-L89.614, L89.616, L89.619-L89.624, L89.626, L89.629, L89.810-L89.814, L89.816, L89.819, L89.890, L89.891, L89.892, L89.893, L89.894, L89.896, L89.899, L89.90, L89.91, L89.92, L89.93, L89.94, L89.95, L89.96	Pressure ulcer
M62.50	Muscle wasting and atrophy, not elsewhere classified, unspecified site

HEDIS codes can change from year to year. The codes in this document are from the HEDIS MY2024 specifications.

Frailty Diagnosis (continued)

ICD-10 Code	Definition
M62.81	Muscle weakness (generalized)
M62.84	Sarcopenia
W01.0XXA , W01.0XXD, W01.0XXS, W01.10XA, W01.10XD, W01.10XS, W01.110A, W01.110D, W01.110S, W01.111A, W01.111D, W01.111S, W01.118A, W01.118D, W01.118S, W01.119A , W01.119D, W01.119S, W01.190A, W01.190D, W01.190S, W01.198A, W01.198D, W01.198S, W06.XXXA, W06.XXXD, W06.XXXS, W07.XXXA, W07.XXXD, W07. XXXS W08.XXXA , W08.XXXD, W08.XXXS W10.0XXA, W10.0XXD, W10.0XXS W10.1XXA, W10.1XXD, W10.1XXS W10.2XXA, W10.2XXD, W10.2XXS W10.8XXA, W10.8XXD, W10.8XXS W10.9XXA, W10.9XXD, W10.9XXS W18.00XA, W18.00XD, W18.00XS W18.02XA, W18.02XD, W18.02XS W18.09XA, W18.09XD, W18.09XS W18.11XA, W18.11XD, W18.11XS, W18.12XA, W18.12XD, W18.12XS, W18.2XXA, W18.2XXD,W18.2XXS, W18.30XA, W18.30XD, W18.30XS, W18.31XA, W18.31XD, W18.31XS, W18.39XA, W18.39XD, W18.39XS, W19.XXXA, W19.XXXD, 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

ICD-10 Code	Definition
Z73.6	Limitation of activities due to disability
Z74.01	Bed confinement status
Z74.09	Other reduced mobility
Z74.1	Need for assistance with personal care
Z74.2	Need for assistance at home and no other household member able to render care
Z74.3	Need for continuous supervision
Z74.8	Other problems related to care provider dependency
Z74.9	Problem related to care provider dependency, unspecified
Z91.81	History of falling
Z99.11	Dependence on respirator [ventilator] status
Z99.3	Dependence on wheelchair
Z99.81	Dependence on supplemental oxygen
Z99.89	Dependence on other enabling machines and devices

HEDIS codes can change from year to year. The codes in this document are from the HEDIS MY2024 specifications.

Frailty Symptom

ICD-10 Code	Definition
R26.2	Difficulty in walking, not elsewhere classified
R26.89	Other abnormalities of gait and mobility
R26.9	Unspecified abnormalities of gait and mobility
R53.1	Weakness
R53.83	Other fatigue
R54	Age-related physical debility
R62.7	Adult failure to thrive
R63.4	Abnormal weight loss
R63.6	Underweight
R64	Cachexia

Dementia Medications

Brand Name	Generic Product Name
Aricept	donepezil oral tablet
Aricept ODT	donepezil oral tablet, disintegrating
Razadyne	galantamine oral tablet
Razadyne ER	galantamine oral capsule, extended release
Exelon	rivastigmine oral capsule
Exelon	rivastigmine 24 hr transdermal film, extended release
Namenda	memantine oral tablet, oral solution
Namenda XR	memantine oral capsule, extended release
Namzaric	Donepezil-memantine

Best Practices for Advanced Illness and Frailty Exclusions

- Consider implementing a process to identify and add appropriate Advanced Illness and/or Frailty diagnoses for patients with upcoming appointments.
- If the documentation exists for an Advanced Illness and/or Frailty diagnosis from a previous visit, you may bill CPT® 99499 for the date of service of the previous visit and include the applicable Advanced Illness and/or Frailty code.

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E* indicates a HEDIS® measure that is listed under Electronic Clinical Data Systems that allows for innovative use of electronic clinical data such as Electronic Health Record (EHR), Personal Health Record (PHR) Health Information Exchange (HIE) and Case Management Systems.