HEDIS[1] Resource Guide Adult Population

The Healthcare Effectiveness Data and Information Set (HEDIS[1]) is governed by the National Committee for Quality Assurance (NCQA). State and federal reporting agencies rely on data gathered through HEDIS measures for accreditation and quality reporting. This data allows us to compare our health plans and providers with similar health plans in the area of Quality of Care, Access to Care Member Satisfaction.

Value to our members:
HEDIS data offers patients the ability to review and compare different health plan ratings, in turn, helping to make informed healthcare choices.

Value to the provider:
Proactively managing care allows for identification and prevention of complications, documentation of wellness status and identification of other issues that may arise with the patient's care.

Per NCQA specifications, only certain measures allow for review of medical record documentation. Certain measures allow actual procedure or testing reports and others only allow claims data to meet compliance.

What is expected of the provider?

- Continue to educate on the importance of annual prevention, screenings, and immunizations
- Encourage your patients to schedule wellness visits and completion of required metabolic testing
- Remind your patients to follow-up with ordered tests and limit prescriptions without lab results as indicated per medication type
- Complete outreach calls to noncompliant members

How can my office improve HEDIS[1] scores?

- Claim/encounter data is the most clean and efficient way to report HEDIS[1]
- Submit claim/encounter data for each and every service rendered
- Chart documentation must reflect services billed
- All providers must bill (or report by encounter submission) for services delivered, regardless of contract status
- Consider including CPT II codes to reduce medical record requests. These codes provide details currently only found in the chart

General Documentation requirements from EMR:

- Documentation from the medical record must include patient name and date of birth
- Immunizations require date administered and product name **(A note that says "Immunizations are up to date" does not meet compliance)**

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Measures	Guidance
Advance Care Planning (ACP) **CPT-** 99483, 99497 **CPT-CAT-II-** 1123F-Discussion documented in medical record and Advocate provided and documented 1124F-Discussion documented in medical record and advocate not provided 1157F- Advanced Care Planning document is present in the medical record 1158F- Advanced Care Planning discussion documented in the medical record **HCPCS-** S0257 **ICD10CM-** Z66 Charted discussion or documentation for resuscitation, life-sustaining treatment, and end of life care preferences. SNOMED: 310305009, 425392003, 425396000, 425397009, 425393008, 3041000175100, 425394002, 3021000175108, 3011000175104, 425395001, 4921000175109, 713603004, 715016002, 310302007, 310303002, 3061000175101, 3031000175106, 310301000, 713600001, 87691000119105, 713662007, 714361002, 713665009, 713602009, 713058002, 423606002, 699388000, 714748000, 719239007, 719238004, 719240009, 713580008 ***Administrative Measure***	Members ages 66-80 years old with advanced illness, frailty or palliative care, and adults 81 years of age and older, who had advanced care planning during the measurement year. Any of the following during the measurement year: ● At least two outpatient visits, observation visits, ED visits, telephone visits, e-visits, or virtual check-ins, nonacute inpatient encounters, or non-acute inpatient discharges with an advanced illness diagnosis. ● At least one acute inpatient encounter with an advanced illness diagnosis ● At least one acute inpatient discharge with an advanced illness diagnosis on the discharge claim ● A dispensed dementia medication **Documents that may be completed as a result of the Advance Care Planning conversation can include:** **-** Durable Power of Attorney for Health Care (DPAHC) - Living Will - Combined Directives - Physician Orders for Life-Sustaining Treatment (POLST) - Identification of a Surrogate Decision maker **Suggestions for Improving Performance** ● Discuss Advance Care Planning with all patients and their caregivers especially those age 66 and older. ● Ensure that they have the opportunity to complete one of the accepted documents, or ensure a copy of their current Advance Care Plan is on file. ● Advance care planning is intended to engage patients in proactive conversations and documentation about their care preferences in the event they cannot independently express them. ● Successful advance care planning ensures that documentation is easily accessible as patients move throughout the care continuum, allowing more coordinated, goal concordant care. **Exclusions: Members in hospice or using hospice services during the measurement year.**

Adult Access To Preventative And Ambulatory Health Services (AAP) **Ambulatory Visits:** **CPT Codes:** 99483,99345,99342,99344,99341,99350,99348,99349,99347,99385,99386,99387,99384,99382,99381,99383,99306,99305,99304,99315,99316,99245,99243,99244,99242,99205,99203,99204,99202,99211,99215,99213,99214,99212,99422,99423,99421,92004,92002,92014,92012,99395,99396,99397,99394,99392,99391,99393,99401,99402,99403,99404,99411,99412,98971,98972,98970,99458,99457,98981,98980,99310,99308,99309,99307,98967,98968,98966,99442,99443,99441,99429 **ICD-10 Codes:** Z00.0x, Z00.1x Z00.3, Z00.5, Z00.8, Z02.x, Z76.1, Z76.2 **HCPCS:** G0439,G0438,G2252,G2012,G2251,T1015,G0463,G0402,G0071,G2250,G2010,S0621,S0620 **SNOMED:** 268565007, 699134002, 1269517007, 170254004, 170168000, 410630000, 783260003, 170132005, 401140000, 170141000, 170272005, 170250008, 170281004, 170150003, 170290006, 410625004, 410635005, 170159002, 1269518002, 170263002, 442162000, 170309003, 170300004, 170123008, 170107008, 410622001, 170114005, 243788004, 268563000, 713020001, 210098006, 712791009, 162655003, 207195004, 209099002, 19681004, 162651007, 18170008, 386472008, 314849005, 185317003, 386473003, 401267002, 410620009, 410642005, 410643000, 410629005, 410644006, 410645007, 410646008, 410631001, 410647004, 410648009, 410649001, 410632008, 410650001, 410624000, 410623006, 410633003, 410634009, 410626003, 410636006, 410637002, 410627007, 410638007, 410639004, 410640002, 410628002, 410641003, 281029006, 281031002 ***Administrative Measure***	Members 20 years and older who had an ambulatory or preventative care visit**.** **Exclusions:** ● Members in hospice or using hospice services during the ● measurement year. **Suggestions for Improving Performance:** ● Schedule preventive care visits. Always have one scheduled. ● Provide reminders - email, text, phone. ● Be sure to code for ambulatory and preventive care visits.

Adult Immunization Status (AIS-E) **CPT CODES:** *INFLUENZA:* 90653, 90662, 90694, 90756, 90674, 90689, 90688, 90686, 90630, 90682, 90661, 90658, 90656, 90654, 90673 TETANUS: TD 90714, Tdap 90715 ZOSTER: 90750 PNEUMOCOCCAL: 90670, 90671, 90677, 90732 Hepatitis B: 90743, 90739, 90759, 90746, 90740, 90747, 90744 ***ECDS Measure***	Persons 19 years of age and older who are up to date on recommended routine vaccines for 1. Influenza: 19-64 years of age (yoa) and 65 years and older 2. Tetanus and diphtheria (Td) or tetanus, diphtheria acellular pertussis (Tdap): 19-64 yoa and 65 years and older 3. Zoster: 50-64 yoa and 65 years and older 4. Pneumococcal: 65 years and older 5. Hepatitis B: 19-59 yoa 6. COVID-19: 65 years and older **Exclusions:** ● Members in hospice during the measurement year ● Member Death within the measurement year ● History of: ○ Anaphylaxis due to specific immunization component ○ Encephalitis due to specific immunization component
Antibiotic Utilization for Respiratory Conditions (AXR) ***Administrative Measure***	Members 3 months of age and older with a diagnosis of a respiratory condition that resulted in an antibiotic dispensing event. The goal is to decrease the overuse of antibiotics. This is an inverted measure, compliance is met if the patient DID NOT receive antibiotic medication on the date of diagnosis to 3 days after. Members can appear in the measure multiple times during the year. **Suggestions to Improve Measure Performance:** ● Do not prescribe an antibiotic for a URI diagnosis only. Code and bill for all diagnoses based on patient assessment. ● Educate patients and caregivers that most URIs are caused by viruses that require no antibiotic treatment. Refer to illness as “viral” and suggest home treatments. ● Remind patients that mucus that is yellow or green does not necessarily indicate a bacterial infection. ● Schedule a follow-up visit, either by a phone call or re-examination. ● Document members who had an outpatient visit, a telephone visit, an e-visit or virtual check-in, an observation visit or ED visit with a diagnosis of a respiratory condition. **Exclusions:** - Visits that result in an inpatient stay - Comorbidities like: human immunodeficiency virus, malignant neoplasm, emphysema, chronic obstructive pulmonary disease, immune system disorders, tuberculosis, sickle cell anemia, respiratory failure, and others - Competing Diagnosis like: pharyngitis, sinusitis, cholera, typhoid, salmonella, whooping cough and others - Members in hospice **Antibiotic Medication List:**

	- Absorbable sulfonamides: Sulfadiazine, Sulfamethoxazole-trimethoprim; - Aminoglycoside: Amikacin, Streptomycin, Gentamicin, Tobramycin; - Amoxicillin/clavulanate: Amoxicillin-clavulanate; - Azithromycin: Azithromycin, Clarithromycin - Cephalosporin (First Generation): Cefadroxil, Cephalexin, Cefazolin; - Cephalosporin (second, third, fourth generation): Cefaclor, Cefoxitin, Cefdinir, Cefpodoxime, Cefditoren, Cefprozil, Cefepime, Ceftriaxone, Cefixime, Cefuroxime, Cefotaxime, Ceftazidime, Cefotetan, Ceftibuten; - Clindamycin - Ketolide:Telithromycin; - Lincosamide: Lincomycin; - Macrolide: Erythromycin; - Penicillin: Ampicillin, Ampicillin-sulbactam, Amoxicillin, Penicillin G benzathine-procaine, Penicillin G potassium, Penicillin G Procaine, Penicillin G Sodium, Penicillin V Potassium, Piperacillin-tazobactam, Penicillin G benzathine, Dicloxacillin, Nafcillin, Oxacillin; - Tetracyclines: Doxycycline, Tetracycline, Minocycline; - Quinolones-Ciprofloxacin, Moxifloxacin, Gemifloxacin, Ofloxacin, Levofloxacin; - Miscellaneous Antibiotics: Aztreonam, Nitrofurantoin, Nitrofurantoin macrocrystals-monohydrate, Chloramphenicol, Dalfopristin-quinupristin, Rifampin, Fosfomycin, Telavancin, Linezolid, Trimethoprim, Metronidazole, Vancomycin
Appropriate Testing For Pharyngitis (CWP) **Group A Strep Test** **CPT Codes:** 87070, 87071, 87081, 87430, 87650-87652, 87880 **SNOMED**: 122121004, 122205003, 122303007 **LOINC Codes:** 17898-8, 626-2, 17656-0, 11268-0, 31971-5, 6558-1, 6559-9, 18481-2, 6557-3, 78012-2, 49610-9, 103627-6, 101300-2, 60489-2, 5036-9, 68954-7 **<u>Pharyngitis</u>:** **ICD 10 Codes:** J02.0, J02.8, J02.9, J03.00, J03.01, J03.80-81, J03.90-91 **SNOMED:** 195658003, 195671000, 195669000, 195666007, 195667003, 195655000, 195670004, 232399005, 232400003, 1296672005, 55355000, 302911003, 363746003, 195656004, 195659006, 195672007, 195660001, 195673002, 17741008,	Persons 3 years and older where the member was diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode. **Suggestions to Improve Measure Performance:** ● Document group A strep tests. Compliance is met if members received a strep test the day of, 3 days prior to or 3 days after the episode. **Antibiotic Medications List:** - Aminopenicillins: Amoxicillin, Ampicillin - Beta-lactamase inhibitors: Amoxicillin-clavulanate - First generation cephalosporins: Cefadroxil, Cefazolin, Cephalexin - Folate antagonist: Trimethoprim - Lincomycin derivatives: Clindamycin - Macrolides: Azithromycin, Clarithromycin, Erythromycin, Erythromycin ethylsuccinate, Erythromycin lactobionate, Erythromycin stearate - Natural penicillins: Penicillin G potassium, Penicillin G sodium, Penicillin V potassium, Penicillin G benzathine - Quinolones: Ciprofloxacin, Levofloxacin, Moxifloxacin, Ofloxacin - Second generation cephalosporins: Cefaclor, Cefprozil, Cefuroxime - Sulfonamides: Sulfamethoxazole-trimethoprim - Tetracyclines: Doxycycline, Minocycline, Tetracycline

10629271000119107, 195657008, 195668008, 195662009, 195676005, 78430008, 195663004, 63866002, 703468005, 195803003, 232403001, 195782000, 2365002, 232406009, 140004, 133171000119105, 90979004, 232405008, 40766000, 126664009, 27878001, 240444009, 72430001, 652005, 232401004, 186659004, 87326000, 312422001, 195924009, 195804009, 240547000, 232402006, 95885008, 126665005, 78911000, 405737000, 195779005, 195780008, 195709006, 878818001, 721586007, 59471009, 76651006, 111816002, 10629231000119109, 195677001, 31309002, 82228008, 11461005, 43878008, 186357007, 41582007, 58031004, 10351008, 90176007, 415724006, 39271004, 14465002, 186963008, 232417005, 1532007, 51209006 ***Administrative Measure***	- Third generation cephalosporins: Cefdinir, Cefixime, Cefpodoxime, Ceftibuten, Cefditoren, Ceftriaxone **Exclusions:** ● Death ● Hospice during measurement year
Appropriate Treatment For Upper Respiratory Infection (URI) **URI:** **ICD 10 Codes:** J00, J06.0, J06.9 **SNOMED:** 54398005, 82272006, 43692000 **Pharyngitis:** **ICD 10 Codes:** J02.0, J02.8, J02.9, J03.00, J03.01, J03.80-81, J03.90-91 **SNOMED:** 195658003, 195671000, 195669000, 195666007, 195667003, 195655000, 195670004, 232399005, 232400003, 1296672005, 55355000, 302911003, 363746003, 195656004, 195659006, 195672007, 195660001, 195673002, 17741008, 10629271000119107, 195657008, 195668008, 195662009, 195676005, 78430008, 195663004, 63866002, 703468005, 195803003, 232403001, 195782000, 2365002, 232406009, 140004, 133171000119105, 90979004, 232405008, 40766000, 126664009, 27878001, 240444009,	Members 3 years and older where the member was diagnosed with an upper respiratory infection that did not result in an antibiotic prescription. Compliance is met if the patient DID NOT receive antibiotic medication on the date of diagnosis to 3 days after. The goal is to decrease the overuse of antibiotics. Members can appear in the measure multiple times during the year. The measure is reported as an inverted rate. **Antibiotic Medications List** - Aminoglycosides: Amikacin, Gentamicin, Streptomycin, Tobramycin - Aminopenicillins: Amoxicillin, Ampicillin - Beta-lactamase inhibitors: Amoxicillin-clavulanate, Ampicillin-sulbactam, Piperacillin-tazobactam - First generation cephalosporins: Cefadroxil, Cefazolin, Cephalexin - Fourth-generation cephalosporins: Telithromycin - Lincomycin derivatives: Clindamycin, Lincomycin - Macrolides: Azithromycin, Clarithromycin, Erythromycin, - Natural penicillins: Penicillin G potassium, Penicillin G sodium, Penicillin V potassium, Penicillin G benzathine, Penicillin G benzathine-procaine, Penicillin G procaine - Penicillinase-resistant penicillins: Dicloxacillin, Nafcillin, Oxacillin - Quinolones: Ciprofloxacin, Gemifloxacin, Levofloxacin, Moxifloxacin, Ofloxacin - Second generation cephalosporins: Cefaclor, Cefprozil, Cefuroxime, Cefoxitin, Cefotetan - Sulfonamides: Sulfadiazine, Sulfamethoxazole-trimethoprim - Tetracyclines: Doxycycline, Minocycline, Tetracycline

72430001, 652005, 232401004, 186659004, 87326000, 312422001, 195924009, 195804009, 240547000, 232402006, 95885008, 126665005, 78911000, 405737000, 195779005, 195780008, 195709006, 878818001, 721586007, 59471009, 76651006, 111816002, 10629231000119109, 195677001, 31309002, 82228008, 11461005, 43878008, 186357007, 41582007, 58031004, 10351008, 90176007, 415724006, 39271004, 14465002, 186963008, 232417005, 1532007, 51209006 ***Administrative Measure***	- Third generation cephalosporins: Cefdinir, Cefditoren, Cefixime, Cefotaxime, Cefpodoxime, Ceftazidime, Ceftibuten,Ceftriaxone - Urinary anti-infectives: Fosfomycin, Nitrofurantoin, Nitrofurantoin macrocrystals-monohydrate - Misc. antibiotics: Aztreonam, Chloramphenicol, Dalfopristin-quinupristin, Daptomycin, Linezolid, Metronidazole, Vancomycin **Suggestions to Improve Measure Performance:** ● Do not prescribe an antibiotic for a URI diagnosis only. Code and bill for all diagnoses based on patient assessment. Diagnosis of pharyngitis or sinusitis excludes members from this measure for this episode. ● Educate patients and caregivers that most URIs are caused by viruses that require no antibiotic treatment. Refer to illness as "viral" and suggest home treatments. ● Remind patients that mucus that is yellow or green does not necessarily indicate a bacterial infection. ● Schedule a follow-up visit, either by a phone call or re-examination. **Exclusions:** ● Negative Medication History: A period of 30 days prior to an episode whereby the patient has not had any antibiotic medications dispensed AND No prescriptions filled more than 30 days prior to the Episode Date that are active on the Episode Date. ● Negative Condition History: A period of 12 months prior to the episode whereby the patient has not been diagnosed with any of the following competing conditions: human immunodeficiency virus, malignant neoplasm, emphysema, chronic obstructive pulmonary disease, immune system disorders and other comorbid conditions (tuberculosis, sickle cell anemia, respiratory failure, and others) ● Competing Diagnosis: If a patient has had a competing diagnosis during the episode period including: cholera, typhoid, salmonella, whooping cough and others ● Members who died during measurement year
Asthma Medication Ratio (AMR) **COPD ICD-10:** J44.0, J44.1, J44.9 **Cystic fibrosis ICD-10:** E84.0, E84.11, E84.19, E84.8, E84.9 **Acute respiratory failure ICD-10:** J96.0-J96.02, J96.20-J96.22 **Emphysema ICD-10:** J43.0-J43.2, J43.8, J43.9, J98.2-J98.3 **Hospice: CPT Codes:** 99377,99378	Members 5-64 years of age who are identified from claims as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater. **Exclusions:** ● COPD ● Cystic fibrosis ● Acute Respiratory Failure ● Emphysema ● Obstructive chronic bronchitis ● Chronic respiratory conditions due to fumes/vapors ● Members in hospice.

Administrative Measure	• Members who died during measurement year **Suggestions to Improve Measure Performance:** • Review and code past medical history • Ask patients if there is a barrier in filling medications and share available resources, ie drug manufacturers, suggest contacting Oscar for assistance. • Schedule follow up visits to promote compliance.
Avoidance Of Antibiotic Treatment For Acute Bronchitis/Bronchiolitis (AAB) **Exclusions:** **ICD-10:** H66.xxx, J32.xxx, H67.xxx, J35.xxx, H70.xxx, L01.xxx, J01.xxx, L03.xxx, J02.xxx, N39, J03.xxx, N76.xxx, J13.xx - J18.xx ***Administrative Measure***	Members 3 years and older with a diagnosis of acute bronchitis/bronchiolitis that **did not** result in an antibiotic prescribing event. **Exclusions:** • Members in hospice • Members who died during measurement year **Suggestions to Improve Measure Performance:** • Review and code past medical history, especially comorbid conditions, such as HIV, HIV type 2, malignant neoplasms, malignant neoplasms of skin, emphysema, COPD and disorders of the immune system weigh in the decision of prescribing an antibiotic. • Document differential diagnosis like pharyngitis, tonsillitis, otitis media, mastoiditis, sinusitis, pneumonia and urinary tract infection (UTI).These diagnoses remove a member from the measure. • Educate members on the difference between viral and bacterial infections and their recommended treatment.

Breast Cancer Screening (BCS-E)

Mammography:
CPT Codes: 77062,77061,77066, 77065,77063,77067

SNOMED CT:
833310007,726551006,723780005,450566007,723779007,723778004,241055006,241057003,439324009,241058008,71651007,866235004,432040002,866234000,572701000119102,866236003,566571000119105,866237007,24623002,384151000119104,392531000119105,392521000119107,258172002,12389009

LOINC Codes:
86463-7,72139-9,91519-9,91522-3,72142-3,72138-1,91518-1,91521-5,72141-5,72137-3,91517-3,91520-7,72140-7,86462-9,103892-6,38090-7,26346-7,48475-8,26349-1,46351-3,26287-3,37554-3,37543-6,37006-4,37016-3,26175-0,48492-3,46335-6,37552-7,37029-6,37038-7,36626-0,38071-7,42415-0,
37052-8,36642-7,38091-5,26347-5,69150-1,26350-9,26289-9,37005-6,38854-6,37017-1,26176-8,103885-0,46336-4,37553-5,37030-4,38855-3,36627-8,
38072-5,42416-8,37053-6,37768-9,26348-3,69259-0,26351-7,26291-5,37773-9,37769-7,37775-4,26177-6,103886-8,46337-2,38807-4,37770-5,37771-3
37774-7,38820-7,37772-1,46350-5,46356-2,46338-0,46339-8,46380-2,36319-2,36962-9,24605-8,103894-2,24604-1,37539-4,24610-8,37542-8,24606-6,103893-4,37551-9,37028-8,37037-9,36625-2,38070-9,69251-7

ECDS Measure

Persons ***40-74 years*** of age who have a mammogram to screen for breast cancer every 2 years.

Exclusions:
- Death
- Hospice of Palliative Care during the measurement year
- Bilateral mastectomy or history
- Unilateral mastectomy with a bilateral modifier
- Two unilateral mastectomies with service dates 14 days or more apart. For example, if the service date for the first unilateral mastectomy was February 1 of the measurement year, the service date for the second unilateral mastectomy must be on or after February 15.
- Medicare enrollees, 66 years of age and older in an Institutional SNP during the measurement year
- 66 years of age and older with Frailty **and** Advanced Illness during the measurement year
- Gender-affirming chest surgery WITH a diagnosis of gender dysphoria any time during their history

Suggestions to Improve Measure Performance:
- Review and clearly document past medical and surgical history as well as diagnostic procedures including dates and results. For example, document “bilateral mastectomy” or specify laterality. If a member had a unilateral mastectomy a contra unilateral mammogram is needed.
- Consider a standing order to mail patients for mammography 1-2 months prior to their wellness visit or next visit if doesn’t schedule wellness visits
- Educate patients on the importance of BCS, and the recommended frequency of routine mammograms is at least once every 24 months for all women ages 40–74. Depending on risk factors, mammograms may be done more frequently.

Documented Assessment After Mammogram (DBM-E) **SNOMED CT US Edition:** 397138000, 397140005, 397141009, 397143007, 397144001, 6121000179106, 6131000179108, 6141000179100, 397145000, 6111000179101 **RadLex Radiology Lexicon:** BI-RADS 0: RID36036 BI-RADS 1: RID36028 BI-RADS 2**:** RID36029 BI-RADS 3: RID36041 BI-RADS 4: RID36030 BI-RADS 4A: RID36031 BI-RADS 4B: RID36032 BI-RADS 4C: RID36033 BI-RADS 5: RID36034 BI-RADS 6: RID36035 ***ECDS Measure***	Mammograms are documented in the form of a BI-RADS assessment **within 14 days** of the mammogram for members *40-74 years of age*. **Exclusions:** • Members Death during the measurement year • Members in Hospice during the measurement year **BI-RADS categorization:** • Category 0 - Need additional imaging evaluation • Category 1 - Negative • Category 2 - Benign finding • Category 3 - Probably benign finding, short interval follow-up • Category 4 - Suspicious abnormality, biopsy should be considered • Category 4A - Suspicious abnormality, biopsy should be considered, low suspicion of malignancy • Category 4B - Suspicious abnormality, biopsy should be considered, moderate suspicion of malignancy • Category 4C - Suspicious abnormality, biopsy should be considered, high suspicion of malignancy • Category 5 - Highly suggestive of malignancy • Category 6 - known biopsy, proven malignancy
Follow-Up After Abnormal Breast Cancer Assessment (FMA-E) **Category 4 or 5 Follow up:** **Breast Biopsy:** **CPT Codes:** 19101, 19100, 19085, 19081,19083 **SNOMED:**770570005, 2841000087108,785800009,5181000087103,12131000087109,771086002,709628007,1220572004,723990008,770569009,2131000087106,1220570007,4541000087104,770568001,2141000087100,1220571006,4551000087101,237375003,172086006,373103009,373101006,309061008,309058007,44578009,1264555004,433008009,445171002,445437001,305011000000108,432550005,866232001237372000,42125001,116219004,116220005,10940003,1268996004,1179705005,1179707002,1179708007,433685008,433805008,432109009,1268323005,432337008,387736007,237378001,28768007,237379009,287553003,736615002,265253005,116334007,237377006,711508007,307298009,237376002,442963006,306381000000106,307971000000105,725936	Members 40-74 years of age with inconclusive or high-risk BI-RADS assessments that received appropriate follow-up **within 90 days** of the assessment. **Exclusions:** • Members Death during the measurement year • Members in Hospice during the measurement year **BI-RADS Categorization:** • Category 0 - Need additional imaging evaluation • Category 4 - Suspicious abnormality, biopsy should be considered • Category 4A - Suspicious abnormality, biopsy should be considered, low suspicion of malignancy • Category 4B - Suspicious abnormality, biopsy should be considered, moderate suspicion of malignancy • Category 4C - Suspicious abnormality, biopsy should be considered, high suspicion of malignancy • Category 5 - Highly suggestive of malignancy • Category 6 - known biopsy, proven malignancy

002,448689003,448336005,122601001,122737001,373102004,122739003,122738006,16214971000119103,16214691000119105,274331003,303689004,306641000000107,307981000000107,786883001,1264556003432157003,771625002 **Category 0 Follow up:** **Breast Ultrasound:** **CPT Codes:** 76641,76642 **LOINC Codes:** 24601-7, 26215-4, 26288-1, 26216-2, 26290-7, 24599-3,42132-1 **<u>Mammography:</u>** See coding detail under BCS-E ***ECDS Measure***	
Controlling High Blood Pressure (CBP) **Hypertensive ICD 10 Codes:** I10, I11.9, I11.0, I13.0, I13.9 **<u>BP Control:</u>** **CPT-2 Codes:** **Most recent:** SBP <130 mm Hg: 3074F SBP 130 to 139 mm Hg: 3075F SBP >=140 mm Hg: 3077F DBP <80 mm Hg: 3078F DBP 80-89 mm Hg: 3079F DBP >=90 mm Hg: 3080F ***Hybrid Measure***	Members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90 mm Hg) during the measurement year. **Exclusions:** ● Members in hospice, SNP or LTI flag (ages 66 or older) ● Members receiving palliative care ● Members 66-80 years of age as of Dec 31 of MY with frailty and advanced illness ● Members 81 years of age or older as of Dec 31 of MY with frailty ● ESRD ● Pregnancy ● Nonacute Inpatient admission (SNF) **Suggestions to Improve Measure Performance:** ● If SBP >139 or DBP >89, repeat BP and document all readings. ● Patient reported blood pressures must be actual readings, not ranges.

Blood Pressure Control for Patients With Hypertension (BPC-E) **Hypertensive ICD 10 Codes:** I10, I11.9, I11.0, I13.0, I13.9 **CPT Codes: 99473 and 99474** **3074F CPT II:** less than 130 mm Hg **3075F CPT II :** 130 – 139 mm Hg **3077F CPT II:** greater than or equal to 140 mm Hg **3078F CPT II:** diastolic blood pressure less than 80 mm Hg **3079F CPT II:** diastolic blood pressure 80-89 mm Hg **3080F CPT II:** diastolic blood pressure greater than or equal to 90 mm Hg ***ECDS Measure***	Members 18–85 years of age who had a diagnosis of hypertension and whose most recent blood pressure was <140/90 mm Hg during the measurement period. **Exclusions:** ● Members who use hospice services ● Members who die any time during the measurement period. ● Members receiving palliative care ● Members with a diagnosis that indicates end-stage renal disease (ESRD), nephrectomy, kidney transplant ● Members with a diagnosis of pregnancy ● Frailty and advanced illness. **Suggestions to Improve Measure Performance:** ● If SBP >139 or DBP >89, repeat BP and document all readings. ● Patient reported blood pressures must be actual readings, not ranges.
Cervical Cancer Screening (CCS-E) **<u>Cervical Cytology CPT Codes:</u>** 88141–88143, 88147, 88148, 88150, 88152–88154, 88164–88167, 88174, 88175 HCPCS Codes – G0123, G0124, G0141, G0143, G0144, G0145, G0147, G0148, P3000, P3001, Q0091 **CPT-CAT-II- 3015F** **SNOMED:** 168406009, 168407000, 168408005, 168410007, 168414003, 168415002, 168416001, 168424006, 250538001, 268543007, 269957009, 269958004, 269959007, 269960002, 269961003, 269963000, 275805003, 281101005, 309081009, 310841002, 310842009, 416030007, 416032004, 416033009, 439074000, 439776006, 439888000, 441087007, 441088002, 441094005, 441219009, 441667007, 700399008, 700400001, 62051000119105, 62061000119107, 98791000119102 **<u>HPV Tests</u>:**	Persons 21-64 years of age who were screened for cervical cancer using either of the following criteria: - Persons 21-64 years of age who had cervical cytology performed within the last 3 years. - Persons 30-64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed alone or as cotesting within the last 5 years. **Exclusions:** ● Hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix. Documenting “complete,” “total”, “abdominal”, “vaginal” or “radical” hysterectomy meet exclusion criteria. (Document this, even if there’s a current pap/HPV test available) ● Hysterectomy alone or partial will not exclude members. ● Members in hospice or palliative care: Code ICD-10 Z51.5, in the measurement year ● Member death ● Members with Sex Assigned at Birth of Male at any time during the patient’s history. **Suggestions to Improve Measure Performance:** ● When possible, obtain copy of test results ● Documentation of screening must include type, date performed AND results. ○ EXAMPLE: 10/01/2022 Pap only, negative -or- 03/01/2022 hrHPV and pap, negative.

Cervical Cytology~ CPT Codes: 87620 - 87622, 87624, 87625, 88148, 88150, 88152, 88153, 88154, 88164,-88167, 88174, 88175 **HCPCS:** G0476 G0123, G0124, G0141, G0143, G0144, G0144, G0145, G0147, G0148, P3000, P3001, Q0091 **HPV~ CPT Codes:** 87620-87622, 87624, 87625 **HCPCS:** G0476 **SNOMED:** 35904009, 48651000124104,718591004 **<u>Absence of Cervix</u>:** **CPT Codes:** 59125, 56308, 57540, 57545 **ICD-10 Codes:** Q51.5, Z90.710, Z90.712 **<u>Hysterectomy with No Residual Cervix:</u>** **CPT Codes:** 51925, 56308, 57540, 57545, 57550, 57555, 57556, 58150, 58152, 58200, 58210, 58240, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290, 58291, 58292, 58293, 58294, 58548, 58550, 58552, 58553, 58554, 58570 - 58573, 58951, 58953, 58954, 58956, 59135 **ICD-10 Codes:** OUT 0ZZ, OUTC4ZZ, OUTC7ZZ, OUTC8ZZ ***ECDS Measure***	• At Home HPV swab testing can be used to attain sample and results and will lead to measure closure * If the type of test isn't specified, it's assumed to be Pap Only, which meets the measure for 3 years not 5 years. • Clearly document past medical and surgical history as well as diagnostic procedures including dates and results. • Women 21-29 yoa HPV testing does not meet numerator compliance • In-home HPV kits will close this gap for women 30 yoa and older.

Chlamydia Screening (CHL) **<u>Chlamydia Tests CPT Codes</u>:** 87110, 87270, 87320, 87490, 87491, 87492, 87810 **<u>Pregnancy tests in conjunction with retinoid prescription CPT Codes:</u>** 81025, 84702, 84703 with isotretinoin **<u>Pregnancy test in conjunction with X-ray on the date of the pregnancy test or the six days after the pregnancy test:</u> CPT Codes:** 81025, 84702, 84703 with 700xx-705xx, 710xx-712xx, 7155x, 720xx-722xx, 730xx-732xx, 735xx-737xx, 740xx-744xx, 755xx-761xx, 763xx-764xx ***Administrative Measure***	Members 16-24 years of age who were identified as sexually active and who had at least one test for chlamydia. **Exclusions:** ● A pregnancy test during the measurement year followed within seven days (inclusive) by a prescription for isotretinoin ● A pregnancy test during the measurement year followed within seven days (inclusive) by an x-ray ● Members in hospice ● Member death ● Members who were assigned male at birth **Suggestions to Improve Performance** ● Urine analysis or vaginal ThinPrep Pap smear must be sent to a lab vendor for analysis ● Order screenings prior to preventive visits so they can be reviewed and confirmed during the visit. ● Upon birth control refill requests, double check if the patient has had testing within the measurement year. ● Clearly document past medical and surgical history as well as diagnostic procedures including dates and results. ● Encounter/office visit notes are not acceptable
Care Of Older Adults (COA) **CPT II Codes:** 1160F: Medication Review 1159F: Medication List 1170F: Functional Status Assessment **CPT Codes:** Medication Review: 90863, 99483, 99605, 99606 Functional Status Assessment: 99483 Transitional Care Management Services: 99495, 99496 **HCPCS:** Medication List: G8427 Functional Status Assessment: G0438, G0439 **SNOMED CT:** 719327002, 719328007, 719329004, 461651000124104, 304492001, 385880002	Persons 66 years of age and older who had both of the following during the measurement year. ● Medication Review ○ A Medication list in medical record AND reviewed by prescribing practitioner or clinical pharmacist AND the date it was performed. ○ Notation the patient is not taking any medications AND the date when it was noted ● Functional Status Assessment **Must include 1 of the following:* ○ Notation of Activities of Daily Life (ADL) were assessed (at least 5): bathing, dressing, eating, transferring (getting in and out of chairs), using the toilet, walking. ○ Notation that Instrumental Activities fo Dail Living (IADL) were assessed: shopping for groceries, driving or using public transportation, using the telephone, cooking or meal prep, housework, home repair, laundry, taking medications, handling finances ○ Result of assessment: ■ SF-36 ■ Assessment of Living Skills and Resources ■ Barthel ADL Index Physical Self-Maintenance (ADLS) Scale©. ■ Bayer ADL (B-ADL) Scale. ■ Barthel Index©. ■ Edmonton Frail Scale©.

	■ Extended ADL (EADL) Scale. ■ Groningen Frailty Index. ■ Independent Living Scale (ILS). ■ Katz Index of Independence in ADL©. ■ Kenny Self-Care Evaluation. ■ Klein-Bell ADL Scale. ■ Kohlman Evaluation of Living Skills (KELS). ■ Lawton & Brody's IADL scales©. ■ Patient Reported Outcome Measurement Information System ■ (PROMIS) Global or Physical Function Scales©. **Exclusions:** ● Death ● Hospice during measurement year **Suggestions to Improve Measure Performance:** ●
Utilization Of The PHQ-9 To Monitor Depression Symptoms For Adolescents And Adults (DMS-E) **Numerator Codes:** **LOINC Codes: Patient Health Questionnaire 9:** 44261-6 **LOINC Codes: Patient Health Questionnaire-9: Modified for Teens:** 89204-2 **Outpatient Encounter:** **CPT Codes:** 99201-99205, 99311-99215, 99241-99245 ***ECDS Measure***	This measure captures the percentage of members 12 years of age and older with a diagnosis of major depression or dysthymia, who had an outpatient encounter with a PHQ-9 score present in their record in the same assessment period as the encounter. This measure looks at care occurring from January 1st through December 31st of the measurement year (period). The Measurement Period is divided into three assessment periods with specific dates of service: - Assessment Period 1: January 1–April 30. - Assessment Period 2: May 1–August 31. - Assessment Period 3: September 1–December 31. *Members may have an eligible encounter in any or all three assessment periods and may be included in the measure up to three times during the Measurement Period. *The PHQ-9 assessment does not need to occur during a face-to-face encounter; it may be completed over the telephone or through a web-based portal. <u>Screening Recommendations</u>: - For adults recommend that providers establish and maintain regular follow-up with patients diagnosed with depression and use a standardized tool to track symptoms. - For adolescents, guidelines recommend systematic and regular tracking of treatment goals and outcomes, including assessing depressive symptoms.

Eligible Screening Tools Selection of the appropriate PHQ-9 assessment should be based on the member's age.

- PHQ-9: 12 years of age and older.
- PHQ-9 Modified for Teens: 12–17 years of age.

Eligible Population Ages:
Members 12 years of age and older during the measurement period.

***Members with a diagnosis of Bipolar disorder, Personality disorder, Psychotic disorder, or Pervasive developmental disorder during the measurement period will not be counted in the eligible population.**

Strategies For Improvement:

Diagnosing, treatment, and follow-up for depression will lead to significant improvement in the patient's condition. Here are some of the best practices for using the PHQ 9 screening for depression in a primary care setting.

- Members of the care team understand the importance of depression screening.
- All clinic staff receive training on the PHQ- 9 depression screening.
- Staff will be versed in strategies to engage patients on completing and understanding the tool.
- Offer assistance to patients with low health literacy on completing the questionnaire.
- We want to ensure they are answering accurately and not misunderstanding the questions.
- Whenever possible, depression screening and treatment are culturally appropriate and offered in the patient's first language.
- Screen patients at new visits, on an annual basis at well care visits, or when clinically indicated.
- The PHQ-9 is a tool the patient fills out either via paper or online portals. Have the patient take the assessment in the waiting room while they await the start of their appointment.
- Discuss the results during their appointment. Address any questions or concerns that they may have.
- Your organization will need to identify the PHQ-9 score that requires intervention in your setting. Interpretation of the screening results are as follows:

PHQ-9 Score	Depression Severity	Proposed Treatment Actions
0 – 4	None-minimal	None
5 – 9	Mild	Watchful waiting; repeat PHQ-9 at follow-up
10 – 14	Moderate	Treatment plan, considering counseling, follow-up and/or pharmacotherapy
15 – 19	Moderately Severe	Active treatment with pharmacotherapy and/or psychotherapy
20 – 27	Severe	Immediate initiation of pharmacotherapy and, if severe impairment or poor response to therapy, expedited referral to a mental health specialist for psychotherapy and/or collaborative management

	- Question nine on the screening tool needs special consideration as it is a screening for suicidal symptoms. - Have a standard workflow in place for patients answering yes regarding suicidal ideation. Have staff and treatment plans in place for these patients. - Ensure routine follow up for members testing positive on the PHQ-9 and test the member at each follow up encounter to track improvements or declines in their PHQ-9 score. Alter treatment based on scores.
Depression Screening And Follow-Up For Adolescents And Adults (DSF-E) **<u>Behavioral Health Encounter:</u>** **CPT Codes:** 90791, 90792, 90832-90834, 90836-90839 **<u>Depression Case Management Encounter:</u>** **CPT Codes:** 99366 ***ECDS Measure***	Ages: Members 12 years of age and older during the measurement period. **<u>Members that Will Not Be Counted in the Eligible Population:</u>** • Members with a diagnosis of bipolar disorder in the year prior to the Measurement Period. • Members with depression that starts during the year prior to the Measurement Period. • Members in hospice or using hospice services during the Measurement Period. **<u>Strategies for Improvement</u>** Diagnosing, treatment, and follow-up for depression will lead to significant improvement in the patient's condition. Here are some of the best practices for using the PHQ 9 screening for depression in a primary care setting. - Members of the care team understand the importance of depression screening. - All clinic staff receive training on depression screening and care. - Staff will be versed in strategies to engage patients on completing and understanding the tool. - Patients are screened at new visits, on an annual basis at well care visits, or when clinically indicated. - Collaborative depression care is performed in a primary care setting to improve outcomes. - Primary care setting includes BH services. - A care manager or team member coordinates care and follow-up. Depression Screening and Follow-Up for Adolescents and Adults (DSF-E) - Whenever possible, depression screening and treatment are culturally appropriate and offered in the patient's first language. - Options for community counselors and psychiatry are available for patients interested in that option if screened positive. - If screened positive, ensure that appropriate follow-up is established for the patient.
Colorectal Cancer Screening (COL-E) **<u>Colonoscopy</u>:**	Persons 45-75 years of age who had an appropriate screening for colorectal cancer. Screenings Included in Measure: ● **Colonoscopy** within Measurement Year (MY) or 9 years prior (ie MY 2026 valid dates are 2017 through 2026)

CPT Codes: 44388-44394, 44397, 44401-44408, 45355, 45378-45393, 45398 CPT-CAT-II- Colon Cancer Screen 3017F HCPCS: G0105, G0121 SNOMED: 8180007, 12350003, 25732003, 34264006,73761001, 174158000, 174185007, 235150006, 235151005, 275251008, 302052009, 367535003, 443998000, 444783004, 446521004, 446745002, 447021001, 709421007, 710293001, 711307001, 789778002, 1209098000 **CT Colonography:** CPT Codes: 74261-74263 LOINC Codes: 60515-4, 72531-7, 79069-1, 79071-7, 79101-2, 82688-3 SNOMED: 418714002 **FIT-DNA Lab Test:** CPT Code: 81528 LOINC Codes: 77353-1, 77354-9 **Flexible Sigmoidoscopy:** CPT Codes: 45330-45335, 45337,45338,45341,45342, 45346,45347, 45349-45350 HCPCS:G0104 SNOMED: 44441009, 396226005, 425634007 **FOBT Lab Test:** CPT Codes: 82270, 82274 HCPCS:G0328 LOINC Codes: 12503-9,12504-7, 14563-1, 14564-9, 14565-6, 2335-8, 27396-1, 27401-9, 27925-7, 27926-5, 29771-3 , 56490-6, 56491-4, 57905-2, 58453-2, 80372-6 SNOMED: 104435004, 441579003, 442067009, 442516004, 442554004, 442563002, 59614000, 167667006, 389076003 **Colorectal Cancer:** HCPCS:G0213, G0214, G0215, G0231 ICD 10: C18.0-C18.9, C19, C20, C21.2, C21.8, C78.5, Z85.038, Z85.048 **Total Colectomy:** CPT Codes: 44150-44153, 44155-44158, 44210-44212 ICD-10: 0DTE0ZZ, 0DTE4ZZ, 0DTE7ZZ, 0DTE8ZZ ***ECDS Measure***	• **CT Colonography** within MY or 4 years prior (ie MY 2026 valid dates are 2022 through 2026) • **FIT - DNA Lab Test (Cologuard)** within MY or 2 years prior (ie MY 2026 valid dates are 2024 through 2026) • **Flexible Sigmoidoscopy** within MY or 4 years prior (ie MY 2026 valid dates are 2022 through 2026) • **FOBT Lab Test** during the MY (ie MY 2026 valid dates are 2026) • In office FOBT and or Digital rectal exams results DO NOT meet the measure **Exclusions:** • Colorectal Cancer • Total Colectomy • Persons in Hospice • Persons receiving palliative care Code: ICD-10 Z51.5 at least once during the measurement year. • Medicare enrollees 66 yoa and older as of December 31 of MY living long-term in an institution or enrolled in an Institutional SNP (I-SNP) • Persons 66 years of age or older as of Dec 31 of MY with Frailty **and** Advanced Illness • Persons 81 years of age or older as of Dec 31 of MY with frailty • Death **Suggestions to Improve Measure Performance:** • Educate patients on the importance of COL screening and the screening options available. • Clearly document past medical and surgical history as well as diagnostic procedures including dates and results • Code procedures and results • CODE: 3017F upon completion of screening
Glycemic Status Assessment for Patients With Diabetes (GSD)	Members 18–75 years of age with diabetes (types 1 and 2) whose most recent glycemic status (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) was at the following levels during the measurement year: • Glycemic Status <8.0%.

DM ICD-10 Codes: Type 1 diabetes mellitus w/o complications: E10.9 Type 2 diabetes mellitus w/o complications: E11.9 Type 1 DM w/ a complication E10.___ Type 2 DM w/ complication E11.___ **CPT Codes:** HbA1c Test: 83036, 83037 **CPT-2 Codes:** Level less than 7.0: 3044F Level between: 7 and 8: 3051F 8 and 9: 3052F Level greater than 9.0: 3046F **LOINC Codes:** 17855-8,17856-6, 4548-4, 4549-2, 96595-4 **Glycemic Management Indicator:** 97506-0 **SNOMED:** 165679005, 451061000124104 ***Hybrid Measure***	• Glycemic Status >9.0%. Exclusions: • Members in hospice • Members receiving palliative care Suggestions for Improving Performance: • Pre-order HgbA1c labs so they can be reviewed during visits. Order a repeat HgBA1c if >8.0% for later in the year. • The last value in the year is used, have members repeat elevated tests prior to the end of the year. • Documentation in the medical record must include a note indicating the date when the HbA1c test or GMI was performed and the result. • Clearly document past medical and surgical history. • Continuous glucose monitoring (CGM) data is acceptable • GMI values must include documentation of the continuous glucose monitoring (CGM) data date range used to derive the value. The terminal date in the range should be used to assign the assessment date. • Member collected GMI results from their CGM documented in the member's medical record are eligible for use in reporting
Blood Pressure Control for Patients with Diabetes (BPD) **DM ICD-10 Codes:** Type 1 diabetes mellitus without complications: E10.9 Type 2 diabetes mellitus without complications: E11.9 Type 1 DM w/ a complication E10.__ Type 2 DM w/ complication E11.___ **BP Control:** **CPT-2 Codes:** **Most recent:** SBP <130 mm Hg 3074F SBP 130 to 139 mm Hg 3075F SBP >=140 mm Hg 3077F DBP <80 mm Hg 3078F DBP 80-89 mm Hg 3079F	Members 18-75 years of age with diabetes (types 1 and 2) whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the measure year. • BP Control (<140/90 mm Hg) Compliant Systolic is less than or equal to 139, and diastolic is less than or equal to 89. The lowest systolic and diastolic readings from a visit can be combined for a compliant reading. **Exclusions:** • Members in hospice • Members receiving palliative care • Members 66-80 years of age as of Dec 31 of MY with frailty and advanced illness • Members 81 years of age or older as of Dec 31 of MY with frailty **Suggestions for Improving Performance:** • If SBP >139 or DBP >89, repeat BP and document all readings. • Patient reported blood pressures must be actual readings, not ranges.

DBP >=90 mm Hg 3080F ***Hybrid Measure***	
Eye Exam for Patients with Diabetes (EED) **<u>DM ICD-10 Codes</u>:** Type 1 diabetes mellitus without complications: E10.9 Type 2 diabetes mellitus without complications: E11.9 **Type 1 DM w/ a complication:** E10.____ **Type 2 DM w/ complication:** E11.____ **<u>Retinal Screening</u>:** **CPT Codes:** 92235, 92230, 92250, 99245, 99243, 99244, 99242, 99205, 99203, 99204, 99215, 99213, 99214, 92018, 92019, 92004, 92002, 92014, 92012, 92202, 92201, 92134 **Diabetic Retinal Screening with Eye Care Professional: CPTII Codes:** 2022F, 2023F, 2024F, 2026F, 2026F, 2033F **Low risk for retinopathy (no evidence of retinopathy in the prior year)** 3072F ***Administrative Measure***	Members 18-75 years of age with diabetes (types 1 and 2) who had a retinal eye exam. ● Dilated Retinal eye exam during the measurement year or a negative result from the prior year **Exclusions:** ● Bilateral eye enucleation ● Members in hospice ● Members receiving palliative care ● Members 66-80 years of age as of Dec 31 of MY with frailty and advanced illness ● Members 81 years of age or older as of Dec 31 of MY with frailty * Note: Blindness is not an exclusion for a diabetic eye exam. **Suggestions for Improving Performance:** ● Retinal Eye Exam documentation must include the provider, date, type and results of the exam or a copy of the exam. ● Clearly document past medical and surgical history.
Cardiac Rehabilitation (CRE) **CPT Codes:** 93798 and 93797 **HCPCS:** S9472, G0422 and G0423 **DX:** 410.00-410.92	**The percentage of members 18 years and older who attended cardiac rehabilitation following a qualifying cardiac event, including myocardial infarction, percutaneous coronary intervention, coronary artery bypass grafting, heart and heart/lung transplantation or heart valve repair/replacement.** **<u>Four rates are reported</u>**: - Initiation: the percentage of members who attended 2 or more sessions of cardiac rehabilitation within 30 days after a qualifying event. - Engagement: the percentage of members who attended 12 or more sessions of cardiac rehabilitation within 90 days after a qualifying event. - Engagement 2: the percentage of members who attended 24 or more sessions of cardiac rehabilitation within 180 days after a qualifying event. - Achievement: the percentage of members who attended 36 or more sessions of cardiac rehabilitation within 180 days after a qualifying event.

	Required Exclusions: • Discharged from an inpatient setting with any of the following on the discharge claim during the 180 days after the episode date: – MI (MI Value Set). – CABG (CABG Value Set; Percutaneous CABG Value Set). – Heart or heart/lung transplant (Heart Transplant Value Set). – Heart valve repair or replacement (Heart Valve Repair or Replacement Value Set). To identify discharges: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the discharge date for the stay. - PCI. Members who had PCI (PCI Value Set; Other PCI Value Set), in any setting, during the 180 days after the episode date. - Members in hospice or using hospice services any time during the measurement period. Refer to General Guideline 15: Members in Hospice. - Members who died any time during the measurement year. Refer to General Guideline 16: Deceased Members. - Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set; ICD-10-CM code Z51.5) any time during the intake period through the end of the measurement year.
Kidney Health Evaluation (KED) **Estimated glomerular filtration rate (eGFR):** CPT Codes: 80047, 80048, 80050, 80053, 80069, 82565 LOINC Codes:69405-9, 98980-6, 94677-2, 102097-3, 98979-8, 62238-1, 77147-7, 50384-7, 50210-4, 50044-7, 70969-1 **Quantitative Urine Albumin Lab Test:** CPT Codes: 82043 LOINC Codes: 21059-1, 1754-1, 57369-1, 30003-8, 53530-2, 43605-5, 14957-5, 53531-0, 89999-7, 100158-5 **Urine Creatinine Lab Test:** CPT Codes: 82570 LOINC Codes:57346-9, 57344-4, 20624-3, 2161-8, 58951-5, 39982-4, 35674-1 **Urine albumin-creatinine ratio (uACR):** LOINC Codes: 13705-9, 9318-7, 76401-9, 44292-1, 14958-3, 14959-1, 59159-4, 77254-1, 30000-4, 77253-3, 89998-9	Persons 18–85 years of age with diabetes (type 1 and type 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. Persons who received both an eGFR and a uACR the measurement year on the same or different dates of service: • At least one estimated glomerular filtration rate (eGFR) • At least one urine albumin-creatinine (uACR): o Both a quantitative urine albumin test and a urine creatinine test. The urine tests must have service dates four or less days apart. **Exclusions:** ● Death ● Hospice or Palliative Care during the measurement year ● Medicare enrollees, 66 years of age or older in an Institutional SNP during the measurement year ● 66-80 years of age with BOTH Frailty AND Advanced Illness during the measurement year ● 81 years of age and older with Frailty during the measurement year ● End Stage Renal Disease

Administrative Measure	
Diabetes Monitoring For People With Diabetes And Schizophrenia (SMD) **<u>HBA1C Lab Test</u>:** CPT Codes: 83036, 83037 CPTII: 3044F, 3045F, 3046F LOINC Codes: 4548-4, 17855-8, 4549-2, 17856-6, 96595-4 **<u>LDL-C Test</u>:** **CPT Codes: 8**0061, 83700, 83701, 83704, 83721 CPTII: 3048F, 3049F, 3050F LOINC Codes: 2089-1, 96259-7, 13457-7, 18262-6, 49132-4, 18261-8, 12773-8, 55440-2 ***Administrative Measure***	Members 18-64 years of age with schizophrenia or schizoaffective disorder and diabetes who had both an LDL-C test and an HbA1c test. **Suggestions to Improve Measure Performance:** ● Routinely refer diabetic patients for HbA1c and cholesterol labs drawn at least annually. ● Follow up with patients to discuss and educate on lab results.
Diabetes Screening For People With Schizophrenia Or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD, SMC) **<u>HbA1c Lab Test</u>:** CPT Codes: 83036, 83037 CPT-CAT-II: 3044F, 3045F, 3046F LOINC Codes: 4548-4, 17855-8, 4549-2, 17856-6, 96595-4 **<u>Glucose Lab Tests</u>:** CPT Codes: 80047, 80048, 80050, 80053, 80069, 82947, 82950, 82951 LOINC Codes: 1514-9, 41024-1, 1518-0, 20436-2, 9375-7, 6749-6, 26554-6, 1530-5, 1533-9, 20437-0, 17865-7 ***Administrative Measure***	Members 18-64 years of age with schizophrenia, schizoaffective disorder or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test. - For a complete list of medications and NDC codes, please visit ncqa.org **Suggestions to Improve Measure Performance:** ● For members on antipsychotic medications, order glucose testing at least annually. ● Coordinate care with a member's behavioral health provider.
Follow-Up after Emergency Department Visit for People with Multiple High-Risk Chronic Conditions (FMC)	Emergency department (ED) visits for members 18 years of age and older who have multiple high-risk chronic conditions who had a follow-up service within 7 days of the ED visit. **Suggestions to Improve Measure Performance:** ● Ensure you are receiving and reviewing discharge notifications from local facilities. ● Develop a daily process to schedule members that have been discharged from the ED or an inpatient stay. Scheduling post ED follow-up visit within 3–5 days after discharge.

Administrative Measure	• Within 7 days of the discharge perform:
	  ○ An outpatient visit
	  ○ A telephone visit
	  ○ A transitional care management services
	  ○ Case management visits
	• Submit claims timely and include the appropriate codes for diagnosis, health conditions and the services provided

Follow-Up After Hospitalization For Mental Illness (FUH)
 	
Administrative Measure
	Discharges for members 6 years of age and older who were hospitalized for a principal diagnosis of mental illness (including phobia, anxiety, etc), or any diagnosis of intentional self-harm, and who had a mental health follow-up service.
	
	• **Two rates are reported:**
	  ○ Discharges for which the member received follow-up within 30 days after discharge
	  ○ Discharges for which the member received follow-up within 7 days after discharge
	Exclusions:
	• Members in hospice during the measurement year
	• Member death
	
	Suggestions to Improve Measure Performance:
	- Prior to discharge or upon receiving discharge notification, schedule a follow up appointment with a mental health practitioner, for between 7 to 30 days post discharge.
	- It is important to note that the follow up is with a mental health practitioner not just with the members PCP.

Follow-Up After Emergency Room Visit For Mental Illness (FUM) ***Administrative Measure***	Follow up on Emergency room visits for members 6 years of age and older who were seen in the emergency room for a principal diagnosis of mental illness (including phobia, anxiety, etc), or any diagnosis of intentional self-harm, and who had a mental health follow-up service. ● **Two rates are reported:** ○ Discharges for which the member received follow-up within 30 days after discharge ○ Discharges for which the member received follow-up within 7 days after discharge **Exclusions:** ● Members in hospice during the measurement year ● Member death **Suggestions to Improve Measure Performance:** - Prior to discharge or upon receiving discharge notification, schedule a follow up appointment with a mental health practitioner, for between 7 to 30 days post discharge. - It is important to note that the follow up is with a mental health practitioner not just with the members PCP.
Initiation And Engagement Of Substance Use Disorder Treatment (IET) ***Administrative Measure***	13 years of age and older with a new episode of alcohol or other drug SUD abuse or dependence who received the following: ● **Initiation of SUD Treatment:** percentage of members who initiate treatment through an inpatient SUD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth or medication treatment within 14 days of the diagnosis ● **Engagement of SUD Treatment:** percentage of members who initiated treatment and who were engaged in ongoing SUD treatment within 34 days of the initiation visit **Exclusions:** ● Members in hospice during the measurement year ● Member Death **Suggestions to Improve Measure Performance:** - Incorporate substance use questions or tools in intake and review during yearly treatment plan. - Schedule 3 follow up appointments within 34 days of initial diagnosis. Make sure the member has an appointment scheduled within 14 days and two engagement visits or medication treatment events within 34 days of the SUD diagnosis. - Document substance abuse and code it on any claims submitted. Remove from claims and documentation when it is no longer a diagnosis. - Engage the member support system and/or significant others in the treatment plan. Educate on the importance of treatment and attending appointments

Persistence Of Beta Blocker Treatment After A Heart Attack (PBH)
 	
Administrative Measure
	Members 18 years of age and older during the measurement year who were hospitalized and discharged from July 1 of the year prior to June 30 of the measurement year with a diagnosis of Acute Myocardial Infarction (AMI) and who received persistent beta-blocker treatment for six months after discharge.
	
	Beta Blocker Medications (subject to change)
	- Non Cardioselective beta-blockers
	  - Ie Carvedilol, Labetalol, Nadolol, Pindolol, Propranolol, Timolol, Sotalol
	- Cardioselective beta-blockers
	  - ie Acebutolol, Atenolol, Betaxolol, Bisoprolol, Metoprolol, Nebivolol
	- Antihypertensive combinations
	  - Ie Atenolol-chlorthalidone, Bendroflumethiazide-nadolol, Bisoprolol-hydrochlorothiazide, Hydrochlorothiazide-metoprolol, Hydrochlorothiazide-propranolol
	- For a complete list of medications and NDC codes, please visit ncqa.org
	
	Exclusions:
	● Members who have died during the measurement year
	● Members in hospice or using hospice services during measurement year
	● Members receiving palliative care
	● Members 66-80 years of age as of Dec 31 of MY with frailty and advanced illness
	● Members 81 years of age or older as of Dec 31 of MY with frailty
	● Asthma
	● Chronic Obstructive Pulmonary Disease (COPD)
	● Chronic Bronchitis
	● Chronic Respiratory issues due to fumes/vapors
	● Hypotension
	● Contraindiction to beta-blocker therapy
	
	Suggestions to Improve Measure Performance:
	● Stress the purpose and importance of medication compliance with your patient.
	● Ask patients if there is a barrier in filling medications and share available resources, ie drug manufacturers, suggest contacting Oscar for assistance.
	● Code diagnosis to ensure exclusions are captured.

Pharmacotherapy Management Of Copd Exacerbation (PCE) *Administrative Measure*	COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or ED visit on or between January 1-November 30 and who were dispensed appropriate medications. ● Two rates are reported: ○ Dispensed a systemic corticosteroid (or there was evidence of an active prescription) within 14 days of the event ○ Dispensed a bronchodilator (or there was evidence of an active prescription) within 30 days of the event **Suggestions to Improve Measure Performance:** ● Ask patients if there is a barrier in filling medications and share available resources, ie drug manufacturers, suggest contacting Oscar for assistance. ● Schedule follow up appointments before the patient is discharged.
Plan All-Cause Readmissions (PCR)	Measure Description: For members 18 years of age and older, the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. **<u>Data is reported in the following categories:</u>** - Count of Index Hospital Stay Discharges (IHS) (denominator). - An acute inpatient or observational stay with a discharge on or between January 1 and December 1 of the measurement year. - For discharges with one or more direct transfers, use the last discharge. A direct transfer is when the discharge date from the first stay precedes the admission date to a subsequent stay by one calendar day or less. - Count of Observed 30-Day Readmissions (numerator). - Count of Expected 30-Day Readmissions. **<u>Eligible Population:</u>** - Members age 18-64 years as of the date of discharge. - 18 and older as of January 1 of the measurement year. - Continuously enrolled for at least 395 days, with no more than one gap in enrollment of up to 45 days during the 395-day period, between January 1 of the year prior to the measurement year and December 1 of the measurement year. **<u>The Following Will Not Be Counted in the Measure Population:</u>** - Members who have an Index Admission Date the same as the Index Discharge Date - The member died during the stay - Female members with a principal diagnosis of pregnancy - A principal diagnosis of a condition originating in the perinatal period

	- Planned admissions for: chemotherapy; rehabilitation; organ transplant; or a potentially planned procedure
Prenatal And Postpartum Care (PPC) **Standalone prenatal visit codes:** **CPT Codes:** 99500, 0500F, 0501F, 0502F **HCPCS Codes:** H1000–H1004 **Combination of prenatal code ACCOMPANIED BY a pregnancy related diagnosis: CPT Codes:** 59400, 59510, 59425, 59426, 59610, 59618, 99201–99205, 99211–99215, 99241–99245, 99483 **HCPCS Codes:** H1005, G0463, T1015 **UBREV Code:** 514 **Cervical Cytology:** **CPT Codes:** 88141–88143, 88147, 88148, 88150, 88152– 88154, 88164–88167, 88174, 88175**, HCPCS Codes:** G0123–G0124, G0141, G0143–G0145, G0147– G0148 **LOINC Codes:** 10524–7, 18500–9, 19762–4, 19764–0, 19765–7, 19766–5, 19774–9 **UBREV Code:** 923 **Postpartum Visit:** **CPT Codes:** 57170, 58300, 59430, 59400, 59410, 59510, 59515, 59610, 59614, 59618, 59622, 99501, 0503F **ICD-10 Codes:** Z01.411, Z01.419, Z01.42, Z30.430, Z39.1–Z39.2 **HCPCS:** G0101 *Hybrid Measure*	This measure evaluates the percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care. - **Timeliness of Prenatal Care:** percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date, or within 42 days of enrollment in the organization - **Postpartum Care:** percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery **Prenatal Care Documentation in the medical record must include evidence of ONE of the following:** ● Diagnosis of pregnancy ● Fetal heart tones ● A pelvic exam with obstetric observations ● Fundal height ● Obstetric lab panel ● TORCH antibody panel alone ● Rubella antibody test with an Rh incompatibility (ABO/Rh) blood typing ● Ultrasound of a pregnant uterus ● Documentation of LMP or EDD AND a Prenatal risk assessment ● Documentation of LMP or EDD AND Complete obstetrical history **Postpartum visit:** ● Visit must be with an OB/GYN practitioner or midwife, family practitioner or other PCP. ● Cervical Cytology performed postpartum satisfies the requirement. ● Documentation in the medical record must ONE of the following: ○ Pelvic exam or evaluation of weight, BP, breasts and abdomen. Notation of “breastfeeding” is acceptable for the “evaluation of breasts” or notation of PPC, including, but not limited to: ○ Notation of “postpartum care, ” “PP care, ” “PP check, ” “6-week check.” ○ A preprinted “Postpartum Care” form in which information was documented during the visit. **Exclusions:** - Non-live births - Members in hospice **Suggestions to Improve Measure Performance:** ● Schedule an initial pregnancy visit as soon as possible. Include pregnancy diagnosis, LMP or EDD and document prenatal care in the visit note. ● Prior to discharge, schedule a postpartum visit between 7 and 84 days after delivery. Include postpartum care in the documentation,

	i.e. title the note PP Care.
Prenatal Immunization Status (PRS-E) **CPT Codes (Adult Influenza):** 90630; 90653; 90654; 90656; 90658; 90661; 90673; 90674; 90882; 90686; 90688; 90689; 90756 **CVX:** 88; 140; 141; 144; 150; 153; 155; 158; 166; 168; 171; 185; 186 **CPT Codes (Tdap Vaccine procedure):** 90715 **CVX:** 115 *ECDS Measure*	This measure captures the percentage of deliveries in which women had received influenza and tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccinations **Administration Timeline:** **Influenza:** - Deliveries where members received an adult influenza vaccine on or between July 1 of the year prior to the Measurement Period and the delivery date - Deliveries where members had an influenza virus vaccine adverse reaction any time during or before the Measurement Period. **Td/Tdap:** - Deliveries where members received at least one Tdap vaccine during the pregnancy (including on the delivery date) - Deliveries where members had any of the following: Anaphylactic reaction to Tdap or Td vaccine or its components any time during or before the Measurement Period. • Encephalopathy due to Td or Tdap vaccination (post-tetanus vaccination encephalitis, post-diphtheria vaccination encephalitis, post-pertussis vaccination encephalitis) any time during or before the Measurement Period. **Strategies for Improvement:** Educate expectant mothers on the importance of vaccines during pregnancy. - If you do not have flu vaccines available, refer the patient to another health care provider, pharmacy, or community vaccination center. - Educate expectant mothers that influenza can result in serious illness, including a higher chance of progressing to pneumonia, when it occurs during the antepartum or postpartum period. - Educate mother on how having a fever with the flu can affect her developing baby. - Educate mother on how the flu vaccine will protect both her and her baby. - Educate mothers on passive immunity the maternal immunization will pass on to their newborns. - - The Tdap vaccine is recommended in the third trimester as this will boost the neonatal antibody levels in the baby. Babies whose mothers had the TDAP vaccine during pregnancy are better protected against whooping cough during the first two months of life. - Explain to expectant mothers that the Tdap vaccine will protect them and their baby from pertussis and its life threatening complications. - Pneumonia

	- Slowed breathing or the baby stops breathing - Feeding difficulties that can lead to weight loss or dehydration - Seizures - Brain damage
Postpartum Depression Screening And Follow-Up (PDS-E) **CPT Codes** **Behavioral Health Encounter:** 90791; 90792; 90832-90834; 90836-90839 **Depression Case Management Encounter:** 99366, 99492, 99493, 99494 **Follow Up Visit w/ DX of Depression** 98960, 98961, 98962, 98966, 98967, 98968, 98970, 98971, 98972, 98980, 98981, 99078, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99242, 99243, 99244, 99245, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99421, 99422, 99423, 99441, 99442, 99443, 99457, 99458, 99483 ***ECDS Measure***	The percentage of deliveries in which members were screened for clinical depression during the postpartum period, and if screened positive, received follow-up care. • **Depression Screening.** The percentage of deliveries in which members were screened for clinical depression using a standardized instrument during the postpartum period. • **Follow-Up on a Positive Screen.** The percentage of deliveries in which members received follow-up care within 30 days of a positive depression screen finding. **Screening Tools:** Patient Health Questionnaire (PHQ-9)® ○ LOINC: 44261-6 ○ Positive Score: Total: ≥10 Patient Health questionnaire-2 (PHQ-2)®[1] ○ LOINC: 55758-7 ○ Positive Score: Total: ≥3 Beck Depression Inventory-Fast Screen (BDI-FS)®[12] ○ LOINC: 89208-3 ○ Positive Score: Total: ≥8 Beck Depression Inventory (BDI-II) ○ LOINC: 89209-1 ○ Positive Score: Total: ≥20 Center for Epidemiologic Studies Depression Scale - Revised (CESD-R) ○ LOINC: 89205-9 ○ PositiveScore: Total: ≥17 Duke Anxiety-Depression Scale (DUKE-AD)®[2] ○ LOINC: 90853-3 ○ PositiveScore: Total: ≥30 Edinburgh postnatal Depression Scale (EPDS) ○ LOINC: 71354-5 ○ PositiveScore: Total: ≥10 My Mood Monitor (M-3)® ○ LOINC: 71777-7 ○ PositiveScore: Total: ≥5 PROMIS Depression ○ LOINC 71965-8 ○ PositiveScore: Total: (T Score) ≥60 Clinically Useful Depression Outcome Scale (CUDOS) ○ LOINC: 90221-3 ○ PositiveScore: Total: ≥31 **Strategies for Improvement:**

	• Educate the patient about the importance of follow-up visits and adherence to treatment recommendations. • Schedule follow-up appointments at the time of discharge or as soon as possible. • Coordinate care with behavioral health practitioners • Outreach patients who cancel appointments and assist them with rescheduling as soon as possible offer virtual appointments as needed. • Develop outreach internal team and/or assign care/case managers to members to ensure members keep follow-up appointments or reschedule missed appointments • Use EHR flags or other tracking method for patients who may need screenings and follow-up visits
Prenatal Depression Screening And Follow-Up (PND-E) See above PDS-E for coding details	Reviews the percentage of deliveries in which members were screened for clinical depression while pregnant and, if screened positive, received follow-up care. **Two rates are reported:** • **Depression screening**: the percentage of deliveries in which members were screened for clinical depression during pregnancy using a standardized instrument with recorded result. • **Follow-up on positive screen**: the percentage of deliveries in which members received any of the following follow-up care on or up to 30 days of a positive depression screen finding: ○ An outpatient, telephone, e-visit, or virtual check-in follow-up visit with a diagnosis of depression or other behavioral health condition. ○ A depression case management encounter that documents assessment for symptoms of depression or a diagnosis of depression or other behavioral health condition. ○ A behavioral health encounter, including assessment, therapy, collaborative care, or medication management. ○ A dispensed antidepressant medication. **Screening Tools:** Patient Health Questionnaire (PHQ-9)® ○ LOINC: 44261-6 ○ Positive Score: Total: ≥10 Patient Health questionnaire-2 (PHQ-2)®[1] ○ LOINC: 55758-7 ○ Positive Score: Total: ≥3 Beck Depression Inventory-Fast Screen (BDI-FS)®[12] ○ LOINC: 89208-3 ○ Positive Score: Total: ≥8 Beck Depression Inventory (BDI-II) ○ LOINC: 89209-1 ○ Positive Score: Total: ≥20 Center for Epidemiologic Studies Depression Scale - Revised (CESD-R) ○ LOINC: 89205-9

ECDS Measure	○ PositiveScore: Total: ≥17 Duke Anxiety-Depression Scale (DUKE-AD)®² ○ LOINC: 90853-3 ○ PositiveScore: Total: ≥30 Edinburgh postnatal Depression Scale (EPDS) ○ LOINC: 71354-5 ○ PositiveScore: Total: ≥10 My Mood Monitor (M-3)® ○ LOINC: 71777-7 ○ PositiveScore: Total: ≥5 PROMIS Depression ○ LOINC 71965-8 ○ PositiveScore: Total: (T Score) ≥60 Clinically Useful Depression Outcome Scale (CUDOS) ○ LOINC: 90221-3 ○ PositiveScore: Total: ≥31 **Strategies for Improvement:** ● Educate the patient about the importance of follow-up visits and adherence to treatment recommendations. ● Schedule follow-up appointments at the time of visit or discharge. ● Coordinate care with behavioral health practitioners ● Outreach patients who cancel appointments and assist them with rescheduling as soon as possible offer virtual appointments as needed. ● Develop outreach internal team and/or assign care/case managers to members to ensure members keep follow-up appointments or reschedule missed appointments ● Use EHR flags or other tracking method for patients who may need screenings and follow-up visits **Exclusions:** ● Deliveries that occurred at less than 37 weeks gestation ● Deliveries in which members were in hospice or using hospice services ● Members who died during the measurement period.

Social Need Screening and Intervention (SNS-E)

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

- Food Screening. The percentage of members who were screened for food insecurity.
- Food Intervention. The percentage of members who received a corresponding intervention within 1 month of screening positive for food insecurity.
- Housing Screening. The percentage of members who were screened for housing instability, homelessness or housing inadequacy.
- Housing Intervention. The percentage of members who received a corresponding intervention within 1 month of screening positive for housing instability, homelessness or housing inadequacy.
- Transportation Screening. The percentage of members who were screened for transportation insecurity.
- Transportation Intervention. The percentage of members who received a corresponding intervention within 1 month of screening positive for transportation insecurity.

Interventions:

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

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

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

Eligible Screening Instruments with thresholds for positive findings include:

ECDS Measure

Food Insecurity Instruments	Screening Item LOINC Codes	Positive Finding LOINC Codes
Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool	88122-7	LA28397-0 LA6729-3
	88123-5	LA28397-0 LA6729-3
American Academy of Family Physicians (AAFP) Social Needs Screening Tool	88122-7	LA28397-0 LA6729-3

	88123-5	LA28397-0 LA6729-3
Health Leads Screening Panel®[1]	95251-5	LA33-6
Hunger Vital Sign™[1] (HVS)	88124-3	LA19952-3
Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences [PRAPARE]®[1]	93031-3	LA30125-1
Safe Environment for Every Kid (SEEK)®[1]	95400-8	LA33-6
	95399-2	LA33-6

Food Insecurity Instruments	Screening Item LOINC Codes	Positive Finding LOINC Codes
U.S. Household Food Security Survey [U.S. FSS]	95264-8	LA30985-8 LA30986-6
U.S. Adult Food Security Survey [U.S. FSS]	95264-8	LA30985-8 LA30986-6
U.S. Child Food Security Survey [U.S. FSS]	95264-8	LA30985-8 LA30986-6
U.S. Household Food Security Survey–Six-Item Short Form [U.S. FSS]	95264-8	LA30985-8 LA30986-6
We Care Survey	96434-6	LA32-8
WellRx Questionnaire	93668-2	LA33-6

Housing Instability and Homelessness Instruments	Screening Item LOINC Codes	Positive Finding LOINC Codes
Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool	71802-3	LA31994-9 LA31995-6
American Academy of Family Physicians (AAFP) Social Needs Screening Tool	99550-6	LA33-6
Children's Health Watch Housing Stability Vital Signs™1	98976-4	LA33-6
	98977-2	≥3
	98978-0	LA33-6
Health Leads Screening Panel®1	99550-6	LA33-6
Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences [PRAPARE]®1	93033-9	LA33-6
	71802-3	LA30190-5
We Care Survey	96441-1	LA33-6
WellRx Questionnaire	93669-0	LA33-6

Housing Inadequacy Instruments	Screening Item LOINC Codes	Positive Finding LOINC Codes
Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool	96778-6	LA31996-4 LA28580-1 LA31997-2 LA31998-0 LA31999-8 LA32000-4 LA32001-2
American Academy of Family Physicians (AAFP) Social Needs	96778-6	LA32691-0 LA28580-1 LA32693-6

		LA32695-1 LA32696-9 LA32001-2

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

Exclusions:

- Members in hospice or using hospice services any time during the measurement period.
- Medicare members 66 years of age and older by the end of the measurement period who meet either of the following:
  – Enrolled in an Institutional SNP (I-SNP) any time during the measurement period.
  – Living long-term in an institution any time during the measurement period

Suggestions to Improve Measure Performance:

- Incorporate one of the screening tools listed into the AWV.
- Documentation of a refusal to answer questionnaire counts as complaint

Tobacco Use Screening and Cessation Intervention (TSC_E)

ICD-10 CODES:
Z71.6: Tobacco Use Cessation Counseling OR Dispensed pharmacotherapy intervention

CPT CODES:
Tobacco Use Cessation Counseling:
3-10mins: 99406,
Greater than 10mins: 99407

LOINC CODE:
Positive Tobacco Use Status:
Current Everyday smoker: LA 18976-3
Current some day smoker: LA 18977-1
Heavy Tobacco smoker: LA18981-3
Light Tobacco smoker: LA 18982-1
Negative Tobacco Use Status:
Never Smoker: LA 18978-9
LA 15920-4
Tobacco Use Screening:
39240-7, 68535-4, 68536-2

SNOMED CODES:
Non-smoker: 8392000
Ex-smoker: 8517006
Ex-pipe smoker: 160620009
Ex-cigar smoker: 160621008
Cigar smoker: 59978006
Cigarette smoker: 65568007
Smoker: 77176002
Chews Tobacco: 81703003
Pipe Smoker: 82302008

Persons 12 years of age and older who were screened for commercial tobacco product use at least once during the measurement years and who received tobacco cessation intervention if identified as a tobacco user.
***Includes, cigarettes, e-cigarettes and smokeless tobacco products that are chewed, sucked or sniffed*

Exclusions:
- Death
- Hospice or Palliative Care during measurement year

Suggestions to Improve Measure Performance:
- Inquire of persons tobacco use at least once a year, at Wellness visit, 6 month check-up, etc.
    - Questionnaire received at check-in
    - Medical Assistant or Clinical staff inquire during intake and vitals.
        - If positive, alert the provider to initiate Counseling during the visit, if possible.
- Encourage the use of EHR's structured fields to indicate if person has had Tobacco Screening done and/or Counseling and when, instead of free text within the progress note for quick reference