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

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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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ANTIDEPRESSANT MEDICATION MANAGEMENT (AMM) **ICD-10-CM Codes** Major Depressive Disorder, single episode F32.0-F32.4 Major Depressive Disorder, single episode, unspecified F32.9 Major Depressive Disorder, recurrent F33.0-F33.3 Major Depressive Disorder, single episode, in partial remission F33.9	**Members 18 years of age or older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment** **Two rates are reported:** • Effective Acute Phase Treatment: percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks) • Effective Continuation Phase Treatment: Percentage of members who remained on an antidepressant medication for at least 180 days (6 months) • For a complete list of medications and NDC codes, please visit ncqa.org **Suggestions for Improving Performance:**

Major Depressive Disorder, recurrent, unspecified F33.9 ***Administrative Measure***	• To ensure your patients complete follow-up visits, prescribe a 30-day supply of medication at the first visit and require a follow-up visit to continue the medication. Schedule the 30 day and 2 more follow up visits at the prescribing appointment. • Use the Patient Health Questionnaire (PHQ-9) to help assess the specificity of Major Depressive Disorder for your patients- mild, moderate, or severe. The Patient Health Questionnaire is available at www.phqscreeners.com. • Discuss the recommended length of medication treatment, and the risks of recurrence if medication is stopped before 6 months, even if they are feeling better. • Discuss possible side effects of the medication and ways the patient can contact your office with questions and concerns. • Ask patients if there is a barrier in filling medications and share available resources, ie drug manufacturers, suggest contacting Oscar for assistance. **Exclusions:** • Members in hospice or using hospice services during the measurement year.
APPROPRIATE TESTING FOR PHARYNGITIS (CWP) **Group A Strep Test** **CPT Codes:** 87070, 87071, 87081, 87430, 87650-87652, 87880 **SNOMED**: 122121004, 122205003, 122303007 **LOINC**: 11268-0, 17656-0, 17898-8, 18481-2, 31971-5, 49610-9, 5036-9, 60489-2, 626-2, 6557-3, 6558-1, 6559-9, 68954-7, 78012-2 **<u>Pharyngitis</u>:** **ICD 10 Codes:** J02.0, J02.8, J02.9, J03.00, J03.01, J03.80-81, J03.90-91 ***Administrative Measure***	**Members 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 - Third generation cephalosporins: Cefdinir, Cefixime, Cefpodoxime, Ceftibuten, Cefditoren, Ceftriaxone **Dicloxacillin Removed from list (NEW 2022)* **Exclusions:** ● Members in hospice or using hospice services during the measurement year. ● Negative Medication History: ○ A period of 30 days prior to the Episode Date when the member had no pharmacy claims for either new or refill prescriptions for an antibiotic. ○ No prescriptions dispensed 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 where the patient has not been diagnosed with any of the following competing conditions: HIV, malignant neoplasm, emphysema, COPD, immune system disorders and other comorbid conditions (TB, sickle cell anemia, respiratory failure, etc)
APPROPRIATE TREATMENT FOR UPPER RESPIRATORY INFECTION (URI) ***Administrative Measure***	**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
- 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 in hospice
- 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 **Obstructive chronic Bronchitis ICD-10:** 491.20 -491.22 **Chronic respiratory conditions due to fumes/vapors ICD-10:** J68.4 **Hospice: CPT:** 99377,99378 **HCPCS:** G0182 ***Administrative Measure***	**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. • 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***	**This measure is the percent episodes for 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: 77055 - 77057, 77061 - 77063, 77065 - 77067
CPT-CAT-II- 3014F
HCPCS Codes – G0202, G0204, G0206 **UBREV Codes –** 401, 403

SNOMED CT: 12389009, 24623002, 43204002, 71651007, 241055006, 241057003, 241058008, 258172002, 439324009, 450566007, 709657006, 723778004, 723779007, 723780005, 726551006, 384151000119104, 392521000119107, 392531000119105, 566571000119105, 572701000119102

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

Administrative Measure

Members 50-74 years of age who had a mammogram to screen for breast cancer every 2 years.

- **Administrative Gender of Female (AdministrativeGender code F) at any time in the member's history.**
- **Sex Assigned at Birth (LOINC code 76689-9) of Female (LOINC code LA3-6) at any time in the member's history.**
- **Sex Parameter for Clinical Use of Female (SexParameterForClinicalUse code Female-typical) during the measurement period.**

Exclusions:

- 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.
- Members in hospice
- Members 66-80 years of age as of Dec 31 of MY2023 with frailty and advanced illness
- Members 81 years of age or older as of Dec 31 of MY2023 with frailty
- Members who died during measurement year
- Members who had gender-affirming chest surgery (CPT code 19318) with a diagnosis of gender dysphoria (Gender Dysphoria Value Set) any time during the member's history through the end of the measurement period.

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 50–74. Depending on risk factors, mammograms may be done more frequently.

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 MY2022 with frailty and advanced illness ● Members 81 years of age or older as of Dec 31 of MY2022 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.
CERVICAL CANCER SCREENING (CCS) **<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,	**Members 21-64 years of age who were screened for cervical cancer using either of the following criteria:** - **Members 21-64 years of age who had cervical cytology performed within the last 3 years. (MY 2022 valid dates 2021 through 2023)** - **Members 30-64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed alone or as cotesting within the last 5 years. (MY 2022 valid dates 2019 through 2023)** - **Administrative Gender of Female (AdministrativeGender code F) at any time in the member's history.** - **Sex Assigned at Birth (LOINC code 76689-9) of Female (LOINC code LA3-6) at any time in the member's history.** - **Sex Parameter for Clinical Use of Female (SexParameterForClinicalUse code Female-typical) during the measurement period.** **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

62051000119105, 62061000119107, 98791000119102

<u>HPV Tests</u>:
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: 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

Hybrid Measure

- Members with Sex Assigned at Birth (LOINC code 76689-9) of Male (LOINC code LA2-8) at any time in the patient's history.

Suggestions to Improve Measure Performance:

- 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.
      * 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

CHLAMYDIA SCREENING IN WOMEN (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***	**Women 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 **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
COLORECTAL CANCER SCREENING (COL) **<u>Colonoscopy</u>:** **CPT Codes:** 44388-44394, 44397, 44401-44408, 45355, 45378-45393, 45398 **CPT-CAT-II- Colon Cancer Screen** 3017F **HCPCS:** G0105, G0121 **<u>CT Colonography</u>:** **CPT Codes:** 74261-74263 **<u>FIT-DNA Lab Test</u>:** **CPT Code:** 81528 **HCPCS:**G0464 **<u>Flexible Sigmoidoscopy</u>:** **CPT Codes:** 45330-45335, 45337-45342, 45345-45347, 45349-45350	**Members 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 2022 valid dates are 2014 through 2023) • **CT Colonography** within MY or 4 years prior (ie MY 2023 valid dates are 2019 through 2023) • **FIT - DNA Lab Test (Cologuard)** within MY or 2 years prior (ie MY 2023 valid dates are 2021 through 2023) • **Flexible Sigmoidoscopy** within MY or 4 years prior (ie MY 2023 valid dates are 2019 through 2023) • **FOBT Lab Test** during the MY (ie MY 2023 valid dates are 2023)

HCPCS:G0104 **<u>FOBT Lab Test</u>:** **CPT Codes:** 82270, 82274 **HCPCS:**G0328 **<u>Colorectal Cancer:</u>** **HCPCS:**G0213, G0214, G0215, G0231 **ICD 10:** C18.0-C18.9, C19, C20, C21.2, C21.8, C78.5, Z85.038, Z85.048 **<u>Total Colectomy</u>:** **CPT Codes:** 44150-44153, 44155-44158, 44210-44212 ICD-10: 0DTE0ZZ, 0DTE4ZZ, 0DTE7ZZ, 0DTE8ZZ ***Hybrid Measure***	• Must be 3 or more returned samples -OR- an unspecified number of returned samples (If only 1 sample is indicated, it DOES NOT meet the measure) • In office FOBT and or Digital rectal exams results DO NOT meet the measure **Exclusions:** • Colorectal Cancer • Total Colectomy • Members in Hospice • Members receiving palliative care Code: ICD-10 Z51.5 at least once during the measurement year. • Medicare members 66 yoa and older as of December 31 of MY2023 living long-term in an institution or enrolled in an Institutional SNP (I-SNP) • Members 66-80 years of age as of Dec 31 of MY2022 with frailty and advanced illness • Members 81 years of age or older as of Dec 31 of MY2022 with frailty • Member 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 • Member can self report and it can be documented in the chart: Only the type of test and date is needed to meet the measure, Example: 10/2022 colonoscopy -or- 03/15/2021 Cologuard • AVOID using ambiguous language like around or approximately while documenting: ex: Colonoscopy ~~around~~ 5 years ago
HEMOGLOBIN A1C CONTROL FOR PATIENTS WITH DIABETES (HBD) **<u>DM ICD-10 Codes</u>:** **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.____	***NEW 2022-Standalone DM measure* Members 18-75 years of age with diabetes (type 1 and type 2) whose hemoglobin A1c (HbA1c) was at the following levels during the measurement year:** • **Hemoglobin A1c (HbA1c) testing:** ○ HgA1C control is demonstrated by < 8% ○ Poor control as documented by > 9% for Exchange, Commercial, and Medicare Advantage Members **Exclusions:** • Polycystic Ovarian Syndrome • Steroid Induced Diabetes • Gestational Diabetes

<u>HbA1c Control:</u> **HbA1c Test CPT Codes:** 83036, 83037 **HbA1c Level 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 ***Hybrid Measure***	• 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. • Patient reported A1c values should include test result and approximate date performed. • Clearly document past medical and surgical history.
BLOOD PRESSURE CONTROL FOR PATIENTS WITH DIABETES (BPD) **<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>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***	***NEW 2022-Standalone DM measure* 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:** • Polycystic Ovarian Syndrome • Steroid Induced Diabetes • Gestational Diabetes • Members in hospice • Members receiving palliative care • Members 66-80 years of age as of Dec 31 of MY2022 with frailty and advanced illness • Members 81 years of age or older as of Dec 31 of MY2022 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.

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: 67028, 67030, 67031, 67036, 67039, 67040

Diabetic Retinal Screening with Eye Care Professional: CPT Codes: 2022F, 2023F, 2024F, 2025F, 2026F, 2033F

Low risk for retinopathy (no evidence of retinopathy in the prior year) 3072F

Hybrid Measure

***NEW 2022-Standalone DM 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:
- Polycystic Ovarian Syndrome
- Steroid Induced Diabetes
- Gestational Diabetes
- Members in hospice
- Members receiving palliative care
- Members 66-80 years of age as of Dec 31 of MY2022 with frailty and advanced illness
- Members 81 years of age or older as of Dec 31 of MY2022 with frailty

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.

APPROPRIATE TESTING FOR PHARYNGITIS (CWP)

Group A Strep Test
CPT Codes: 87070, 87071, 87081, 87430, 87650-87652, 87880

SNOMED: 122121004, 122205003, 122303007

LOINC: 11268-0, 17656-0, 17898-8, 18481-2, 31971-5, 49610-9, 5036-9, 60489-2, 626-2, 6557-3, 6558-1, 6559-9, 68954-7, 78012-2

<u>Pharyngitis</u>:

Members **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. Members can appear in the measure multiple times during the year.

Suggestions to Improve Measure Performance:
- Document group A strep tests. Compliance is met if the member 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

ICD 10 Codes: J02.0, J02.8, J02.9, J03.00, J03.01, J03.80-81, J03.90-91 *Administrative Measure*	- Lincomycin derivatives: Clindamycin - Macrolides: Azithromycin, Clarithromycin, Erythromycin, - 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 - 3rd gen cephalosporins: Cefdinir, Cefixime, Cefpodoxime, Ceftibuten, Cefditoren, Ceftriaxone **Dicloxacillin Removed from list (NEW 2022)* **Exclusions:** - Hospice - Negative Medication History: ○ A period of 30 days prior to the Episode Date when the member had no pharmacy claims for either new or refill prescriptions for an antibiotic. ○ No prescriptions dispensed 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 where the patient has not been diagnosed with any of the following competing conditions: HIV, malignant neoplasm, emphysema, COPD, immune system disorders and other comorbid conditions (TB, sickle cell anemia, respiratory failure, etc)
FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS (FUH) ***Administrative Measure***	**Discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health practitioner.** - **Two rates are reported:** - **Discharges for which the member received follow-up within 30 days after discharge** - **Discharges for which the member received follow-up within 7 days after discharge** **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) **CPT Codes:** 98960-98962, 99078, 99201-99205, 99211-99215, 99241-9945, 99341-9945, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99408-99409, 99411-99412, 99510, 90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90875-90876, 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99483, 99217-99220 **HCPCS Codes:** G0155, G0176, G0177, G0396, G0397, G0409-G0411, G0463, H0001, H0002, H0004, H0005, H0007, H0015, H0016, H002, H0034-H0037, H0039, H0040, H0047, H2000, H2010-H2020, H2035, H2036, M0064, S021, S9480, S9484, S9485, T1006, T1012, T1015 ***Administrative Measure***	**Adolescent and adult members 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. - Document substance abuse and code it on any claims submitted. Remove from claims and documentation when it is no longer a diagnosis.
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. **Eligible Population:** - 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. **The Following Will Not Be Counted in the Measure Population:** - 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	**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

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:** 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***	• 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.