Baptist Health

POPULATION HEALTH SERVICES ORGANIZATION

2025 PHSO Quality Guide

HEDIS, CMS Part D Star Ratings, ECDS Measures

PHSO/BHPP Quality Team

Riley Lipschitz, MD - Chief Medical Officer, Population Health
Tonya Robertson, PharmD - Director of Pharmacy & Quality Operations
Natalie Rudolph, RN, BSN - PHSO Nurse Quality Manager
Megan McQueen Sullivan - Business Development Manager
Brittney Marshall, BSN, RN, CCM - Director of CCM and PAC

CONTACT US: BHPPQuality@baptist-health.org

2025 PHSO Quality Guide - Contents

PHSO Funds Flow Quality Measures - Quick Tips

Blood Pressure Control

Percentage of patients ages 18-85 who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled at <140/90 mmHg during the measurement year (MY).

Requirement

The most recent blood pressure reading during MY on/after the second diagnosis of hypertension (HTN)

Multiple BP values on the same day, use the lowest systolic and diastolic

Vital sign flowsheets, progress notes, or consult notes may be submitted

Patient self reported BPs are acceptable and must have been taken on a digital device and documented in their medical record.

An average BP can be used only if a distinct number of both the systolic and diastolic BP readings are available.

Exclusions: Hospice; Death; Palliative Care; ESRD; Dialysis; Nephrectomy; Kidney Transplant; Pregnancy; 80y/o + Frailty x2; 66y/o+ Advanced Illness & Frailty x2; 66y/o+ I-SNP or LT

Coding

- 9074F - Systolic BP <130
- 3075F - Systolic BP 130-139
- 3077F - Systolic BP ≥140
- 3078F - Diastolic BP <80
- 3079F - Diastolic BP 80-89
- 3080F - Diastolic BP ≥90

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Cervical Cancer Screening

Women 21–64 years of age who were screened for cervical cancer using either of the following criteria:

- Women 21–64 years of age who had cervical cytology performed within the last 3 years.
- Women 30–64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years.
- Women 30–64 years of age who had cervical cytology/high-risk human papillomavirus (hrHPV) co-testing within the last 5 years.

Documentation

Documentation of date and findings. Documentation of “complete,” “total” or “radical” hysterectomy (abdominal, vaginal, or unspecified). Documentation of “vaginal hysterectomy.” Documentation of a “vaginal pap smear” in conjunction with documentation of “hysterectomy.” Documentation of hysterectomy in combination with documentation that the patient no longer needs pap testing/cervical cancer screening. – Documentation of hysterectomy alone does not meet the criteria because it is not sufficient

Exclusions: Hospice; Death; Palliative Care; Male Sex Assigned at Birth; Hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix.

Coding

- Cervical Cytology CPT II Codes
- 87624, 87625 - High Risk HPV Lab Test

More Information

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Colorectal Cancer Screening

Percentage of patients ages 45–75 who had an appropriate screening for colorectal cancer. Rates stratified for race and ethnicity.

Requirement

FOBT or FIT - Annually, Cologuard/FIT DNA - Every 3 years, Flexible Sig - Every 5 years, CT Colonoscopy - Every 5 years, Colonoscopy - Every 10 years

FIT - requires 1 sample, gFOBT - requires 3 samples, if number of samples is not listed, it is assumed that all have been collected.

In lieu of diagnostic report/test, acceptable documentation for supplemental submission is notation of the specific test and date completed.

Specimens collected via digital exam are not accepted.

Self reported screenings documented with test type and MM/YY are acceptable.

Exclusions: Hospice; Death; Palliative Care; Total colectomy or colorectal cancer anytime in the patient's history; 80y/o + Frailty x2; 66y/o+ Advanced Illness & Frailty x2; 66y/o+ I-SNP or LT

Coding

- Exclusion codes required annually:
  - Z85.038 hx neoplasm large intestine
  - Z85.048 - hx neoplasm rectum/sigmoid junction/anus

More Information

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Eye Exam for Patients with Diabetes (EED)

The percentage of members 18 -75 years of age with diabetes (types 1 and 2) who had a retinal eye exam.

Requirement

- Retinal or dilated eye exam by an optometrist or ophthalmologist in the measurement year
- Negative retinal or dilated eye exam by an optometrist or ophthalmologist in the year prior to the measurement year
- Bilateral eye enucleations any time during their history through Dec. 31 of the measurement year

Exclusions: Hospice; Death; Palliative Care; Patients with bilateral eye enucleation; 66y/o+ I-SNP or LT; 66y/o + Frailty x2; 66y/o+ Advanced Illness & Frailty x2

Coding

- 2022F - with evidence of retinopathy
- 2023F - without evidence of retinopathy

More Information

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Statin Therapy for Patients with Diabetes

Percentage of patients ages 40–75 during the measurement year with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) who met the following criteria:

- Received statin therapy – Patients who were dispensed at least 1 statin medication of any intensity during the measurement year
- Statin adherence 80% - Patients who remained on a statin medication of any intensity for at least 80% of the treatment period

Requirement

Patients with two or more prescription claims for a diabetes medication (including insulin) during the MY.

Metformin used as a single agent is not included for denominator placement because it may be used to treat other conditions as well as diabetes.

Exclusions: Hospice; Death; Palliative Care; Dispensed at least 1 prescription of clomiphene, ESRD or dialysis, Cirrhosis, Rhabdomyolysis or Myopathy or Myositis or Myalgia, Pregnancy or Lactating, Pre-diabetes, Polycystic Ovary Syndrome (PCOS), 66y/o+ Advanced Illness & Frailty x2; 66y/o+ I-SNP or LTI.

Coding

Pharmacy claims only Exclusions:

- Myopathy - G72.0, G72.2, G72.89
- Myositis - M60.80-.9, M60.819, M60.829, M60.839, M60.849. M60.859. M60.9, M60.9,M62.82
- Myalgia - M79.10-12, M79.18
- CKD - N18.5
- ESRD - N18.6
- Dependence on Renal Dialysis - Z99.2

More Information

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Childhood Immunization Status - Combination 3 - *Pediatrician Metric*

Percentage of children age 2 who had the Combination 3 vaccines (below) on or before their second birthday.

Requirement

- 4 doses of diphtheria, tetanus, and acellular pertussis (DTaP) vaccine;
- 3 doses of polio (IPV) vaccine;
- 1 measles, mumps and rubella (MMR) vaccine;
- 3 doses of haemophilus influenza type B (HiB) vaccine;
- 3 doses of hepatitis B (Hep B) vaccine;
- 1 chicken pox (VZV) vaccine; and
- 4 doses of pneumococcal conjugate (PCV) vaccine

Exclusions: Hospice; Death; Palliative Care; Had a contraindication to a childhood vaccine

Coding

- See page 27 for a full list of codes for each type of vaccine.

More Information

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Well Child Visits in the first 0-15 Months of Life - *Pediatrician Metric*

Percentage of patients who turned 0-15 months old during the measurement year and had the recommended number of well-child visits with a primary care provider.

- Children 0-15 months old during the measurement year: 6 or more well-child visits in the first 15 months of life.

Requirement

If provider is seeing a patient for Evaluation and Management (E/M) services and all well-child visit components are completed: Attach modifier 25 or 59 to the well-child procedure code so it's reviewed as a significant, separately identifiable procedure.

Modifier 25 is used to indicate a significant and separately identifiable evaluation and management (E/M) service by the same physician on the same day another procedure or service was performed.

Modifier 59 is used to indicate that 2 or more procedures were performed at the same visit, but to different sites on the body.

Helpful resources about the components of care are available at brightfutures.aap.org.

Exclusions: Hospice; Death; Palliative Care

Coding

- See page 80 for a full list of codes for each type of vaccine.

More Information

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Appropriate Testing for Children with Pharyngitis

Definition

Percentage of episodes for patients age 3 years and older where the patient was diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test within 3 days prior to or 3 days after the diagnosis day (7 days total). A higher rate indicates appropriate testing and treatment.

Plans

- Commercial
- Exchange/Marketplace
- Medicaid
- Medicare

Quality Programs

- CMS Quality Ratings
- NCQA Health Plan Ratings

Collection & Reporting Method

- Claim / Encounter Data
- Pharmacy Data

Codes

The following codes can be used to close HEDIS gaps in care for blood pressure control.

Group A Strep Test	
CPT/CPT II	87070, 87071, 87081, 87430, 87650, 87651, 87652, 87880
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
SNOMED	122121004, 122205003, 122303007
Pharyngitis	
ICD - 10 Diagnosis	J02.0, J02.8, J02.9, J03.00, J03.01, J03.80, J03.81, J03.90, J03.91
SNOMED	140004, 652005,1532007, 2365002, 10351008, 11461005, 14465002, 17741008, 27878001, 31309002, 39271004, 40766000, 41582007, 43878008, 51209006, 55355000, 58031004, 59471009, 63866002, 72430001, 76651006, 78430008, 78911000, 82228008, 87326000, 90176007, 90979004, 95885008, 111816002, 126664009, 126665005, 164256007, 164260005, 186659004, 186963008, 95655000, 195656004, 195657008, 195658003, 195659006, 195660001, 195662009, 195663004, 195666007, 195667003, 195668008, 195669000, 195670004, 195671000, 195672007, 195673002, 195676005, 195677001, 195709006, 195779005, 195780008, 195782000, 195803003, 195804009, 195924009, 232399005, 232400003, 232401004, 232402006, 232403001, 232405008, 232406009, 232417005, 240444009, 240547000, 302911003, 312422001, 363746003, 405737000, 415724006, 703468005, 721586007, 878818001, 133171000119105, 0629231000119109, 10629271000119107

Appropriate Testing for Children with Pharyngitis - Medications

The following antibiotic medications, in conjunction with a strep test, will meet compliance for this metric:

Aminopenicillins	• Amoxicillin • Ampicillin	Natural penicillins	• Penicillin G potassium • Penicillin G sodium • Penicillin V potassium • Penicillin G benzathine
Beta-lactamase inhibitors	• Amoxicillin-clavulanate	Quinolones	• Ciprofloxacin • Levofloxacin • Moxifloxacin • Ofloxacin
First generation cephalosporins	• Cefadroxil • Cefazolin • Cephalexin	Second generation cephalosporins	• Cefaclor • Cefprozil • Cefuroxime
Folate antagonist	• Trimethoprim	Sulfonamides	• Sulfamethoxazole-trimethoprim
Lincomycin derivatives	• Clindamycin	Tetracyclines	• Doxycycline • Minocycline • Tetracycline
Macrolides	• Azithromycin • Clarithromycin • Erythromycin	Third generation cephalosporins	• Cefdinir • Cefixime • Cefpodoxime • Ceftriaxone

Exclusions

The following exclusions will be accepted during the appropriate timeframe.

Exclusion	Timeframe
• Patients in hospice or using hospice services • Patients who died	Any time in the measurement year
• HIV • Malignant Neoplasms • Malignant Neoplasms of the Skin • Emphysema • COPD • Disorders of the Immune System	12 months prior to or on the episode date

Appropriate Testing for Children with Pharyngitis - Best Practices

- The CDC's recommended actions for healthcare professionals and health care offices:
- Evaluate your prescribing habits and form a plan for antibiotic stewardship activities, such as watchful waiting or delayed prescribing
- Reference the Centers for Disease Control and Prevention cdc.gov/antibiotic-use/stewardship-report/index.html.

Important Notes

Notes

- This measure addresses appropriate diagnosis and treatment for pharyngitis with a strep test being completed three days before or three days after the primary diagnosis and prescribed antibiotics.
- A pharyngitis diagnosis can be from an outpatient, telephone, e-visit, virtual check-in, observation or emergency department visit between July 1 of the year prior to the measurement year and June 30 of the measurement year.

Medical Record (including, but not limited to)

- History and Physical
- Lab Reports
- Progress Notes

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Appropriate Testing for Children with Upper Respiratory Infection

Definition

Percentage of episodes for patients 3 months and older who were given a diagnosis of upper respiratory infection (URI) between July 1 of the year prior to the measurement year through June 30 of the measurement year and were not dispensed an antibiotic prescription on or 3 days after the diagnosis day (4 days total).

Plans

- Commercial
- Exchange/Marketplace
- Medicaid
- Medicare

Quality Programs

- CMS Quality Ratings
- NCQA Accreditation
- NCQA Health Plan Ratings

Collection & Reporting Method

- Claim / Encounter Data
- Pharmacy Data

Codes

The following codes are Upper Respiratory Infection codes that do NOT need Antibiotics.

ICD - 10 Diagnosis	J00, J06.0, J06.9
SNOMED	43692000, 54398005, 82272006

Exclusions

The following exclusions will be accepted during the appropriate timeframe.

Exclusion	Timeframe
• Patients in hospice or using hospice services • Patients who died	Any time in the measurement year
• HIV • Malignant Neoplasms • Malignant Neoplasms of the Skin • Emphysema • COPD • Disorders of the Immune System	12 months prior to or on the episode date

Appropriate Testing for Children with Upper Respiratory Infection - Best Practices

- Reference the Centers for Disease Control and Prevention “Be Antibiotics Aware: Smart Use, Best Care”: cdc.gov/patientsafety/feastures/be-antibotics-aware.html

Important Notes

Notes

- If the patient presents with a secondary bacterial infection *(ie: otitis media)*, code the bacterial infection first in order to support the prescribing of antibiotics.
- This measure addresses appropriate diagnosis and treatment for upper respiratory infections without prescribing an antibiotic.
- An upper respiratory infection diagnosis can be from an outpatient, telephone, e-visit, virtual check-in, observation or emergency department visit between July 1 of the year prior to the measurement year and June 30 of the measurement year.
- Patients who have a competing diagnosis of pharyngitis on or 3 days after the diagnosis of upper respiratory infection should be excluded.

Medical Record (including, but not limited to)

- HIstory and Physical
- Progress Notes

Asthma Medication Ratio Total

Definition

Percentage of patients ages 5–64 who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.

Plans

- Commercial
- Exchange/Marketplace
- Medicaid

Quality Programs

- CMS Quality Ratings
- NCQA Health Plan Ratings

Collection & Reporting Method

- Claim / Encounter Data
- Pharmacy Data

Medications

To comply with this measure, a patient must have the appropriate ratio of controller medications total asthma medications.

Asthma Controller Medications	
Antibody inhibitors	• Omalizumab
Anti-interleukin-4	• Dupilumab
Anti-interleukin-5	• Benralizumab • Mepolizumab • Reslizumab
Inhaled corticosteroids	• Beclomethasone • Budesonide • Ciclesonide • Flunisolide • Fluticasone • Mometasone
Inhaled steroid combinations	• Budesonide-formoterol • Fluticasone-salmeterol • Fluticasone-vilanterol • Formoterol-mometasone
Leukotriene modifiers	• Montelukast • Zafirlukast • Zileuton
Methylxanthines	• Theophylline
Asthma Reliever Medications	
Short-acting, inhaled beta-2 agonists	• Albuterol • Levalbuterol

Asthma Medication Ratio Total - Exclusions

Exclusion	Timeframe
• Patients in hospice or using hospice services • Patients who died • Patients who were NOT dispensed an asthma controller OR reliever medication	Any time in the measurement year
• Acute respiratory failure • Chronic Obstructive Pulmonary Disease (COPD) • Chronic Respiratory conditions due to fumes/vapors • Cystic fibrosis • Emphysema • Obstructive chronic bronchitis	Any time during a patient's history through December 31st of the measurement year

Best Practices

- Develop an Asthma Action Plan
- Simplify treatment regimen, when possible.
- **SMART** (single-inhaler maintenance and reliever therapy) is now the preferred therapy for patients aged 4 and up with moderate to severe asthma
  - **Symbicort (budesonide/formoterol) is the preferred SMART regimen** because of formoterol's rapid onset of action. By using Symbicort alone for both daily maintenance and quick relief, it simplifies treatment and avoids confusion about which inhaler to use.
- Use clear and simple language when providing directions on how to use inhalers.
- Help patients learn to identify and avoid asthma triggers.
- Limit or control environmental factors including: tobacco smoke, strong odors or sprays, dust mites, cockroaches, animal dander, pollen, mold.
- Educate patients on the difference between controller and reliever medications and applicable usage.
- National Institutes of Health guidelines recommend using tools such as the childhood and adult asthma control test along with an asthma action plan to help patients manage their condition.
- Reach out to patients to schedule follow-up visits for asthma.

Avoidance of Antibiotic Treatment for Acute Bronchitis

Definition

Percentage of episodes for patients ages 3 months and older with a diagnosis of acute bronchitis/bronchiolitis between July 1st of the year prior to the measurement year through June 30 of the measurement year who were not dispensed an antibiotic medication on or 3 days after the episode. A higher rate indicates appropriate treatment (not prescribed an antibiotic).

Plans

- Commercial
- Exchange/Marketplace
- Medicaid
- Medicare

Quality Programs

- CMS Quality Ratings
- NCQA Accreditation
- NCQA Health Plan Ratings

Collection & Reporting Method

- Claim / Encounter Data
- Pharmacy Data

Exclusions

The following exclusions will be accepted during the appropriate timeframe.

Exclusion	Timeframe
• Patients in hospice or using hospice services • Patients who died	Any time in the measurement year

Best Practices

- An episode for bronchitis/bronchiolitis will not count toward the measure denominator if the patient was diagnosed with one of these conditions within 12 months of the event:
  - Chronic obstructive pulmonary disease (COPD)
  - Disorders of the immune system
  - Emphysema
  - HIV
  - Malignant neoplasms
  - Other malignant neoplasms of the skin
- An episode for bronchitis/bronchiolitis will not count toward the measure denominator if the patient was diagnosed with either pharyngitis or a competing diagnosis on or 3 days after the episode date.

Blood Pressure Control

Definition

Percentage of patients ages 18-85 who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled at <140/90 mmHg during the measurement year.

Plans

- Commercial
- Exchange/Marketplace
- Medicaid
- Medicare

Quality Programs

- CMS Star Ratings
- CMS Quality Ratings
- NCQA Accreditation
- NCQA Health Plan Ratings

Collection & Reporting Method

- Claim / Encounter Data
- Medical Record Documentation
- Pharmacy Data

Codes

The following codes can be used to close HEDIS gaps in care for blood pressure control.

Systolic Blood Pressure Levels 130-139 mm Hg		Diastolic Blood Pressure Level 80-89 mmHg	
CPT/CPT II	3075F	CPT/CPT II	3079F
Systolic Blood Pressure Level <130 mmHg		Diastolic Blood Pressure Level <80 mmHg	
CPT/CPT II	3074F	CPT/CPT II	3078F
Systolic Blood Pressure Level >/=140 mmHg		Diastolic Blood Pressure Level >/=90 mmHg	
CPT/CPT II	3077F	CPT/CPT II	3080F

Blood Pressure Control - Exclusions

The following exclusions will be accepted during the appropriate timeframe.

Exclusion	Timeframe
• Patients in hospice or using hospice services • Patients receiving palliative care • Patients who died • Patients with a diagnosis of pregnancy	Any time in the measurement year
Patients ages 81 and older as of December 31 of the measurement year who had at least 2 diagnoses of frailty on different dates of service	Frailty - dx must be in the measurement year and on different dates of service
Patients ages 66–80 as of December 31 of the measurement year who had a at least 2 diagnoses of frailty on different dates of service and advanced Illness indicated by one of the following: • Two or more outpatient, observation, emergency room, telephone, e-visits, virtual check-ins or non-acute inpatient encounters or discharge(s)on separate dates of service with a diagnosis of advanced illness • One or more acute inpatient encounter(s) with a diagnosis of advanced illness • One or more acute inpatient discharge(s) with a diagnosis of advanced illness on the discharge claim • Dispensed a dementia medication: Donepezil, Donepezil-memantine,galantamine, rivastigmine or memantine	Frailty diagnoses must be in the measurement year year on different dates of service Advanced illness diagnosis must be in the measurement year or year prior to the measurement year
Medicare patients 66 and older, as of December 31st, who are either enrolled in an Institutional Special Needs Plan or living long term in an institution.	Any time in the measurement year
• Dialysis • End-stage renal disease (ESRD) • Kidney transplant • Nephrectomy	On or before Dec. 31 of the measurement year

Blood Pressure Control - Best Practices

- Document BP readings at every visit, BP readings that are 140/90 or greater should be re-taken
- Schedule follow-up visits for blood pressure control after diagnosis or medication adjustment and consider referral to cardiologist for those whose BP goal cannot be attained, or for complicated patients
- Make sure the proper cuff size is used
- Advise patients not to smoke, drink caffeinated beverages or exercise within 30 minutes of their reading and allow at least five minutes of quiet rest before BP measurement.
- Ensure patients don't cross their legs and have their feet flat on the floor during the reading. Crossing legs can raise the systolic pressure by 2-8 mmHg. Make sure the elbow is at the same level as the heart. If the patient's arm is hanging below heart level and unsupported, this position can elevate the measured blood pressure by 10-12 mmHg.
- Document blood pressure readings at each visit. If the blood pressure (BP) is high (140/90 or greater), repeat the measurement after at least a one minute wait. HEDIS allows the lowest systolic and lowest diastolic readings in the same day. Often, the second reading is lower. Do not round BP values. If using an automated machine, record exact values
- Ensure submitted claims or encounters include the appropriate CPT Category II codes for BP readings

Important Notes

Notes

- BP reading must be the latest performed within the measurement year, and on or after the second hypertension diagnosis.
- BP readings taken on the same day the patient receives a common low-intensity or preventive procedure can be used. Examples include, but aren't limited to:
  - Eye exam with dilating agents, Injections (e.g., allergy, Depo-Provera®, insulin, lidocaine, steroid, testosterone toradol, or vitamin B-12), Intrauterine device (IUD) insertion, Tuberculosis (TB) test, Vaccinations, Wart or mole removal

Test/Service/Procedure

BP reading taken during the measurement year via:
- Outpatient visits, Telephone or telehealth visits, Virtual check-ins or e-visits, and Non-acute inpatient visits
Patient-reported BP readings must be taken using a digital device in any of these visit settings and documented in patient's medical record.
Ranges and threshold will not meet the intent of the measure. A specific BP result needs to be documented.
Documentation of 'average BP' will meet the intent of the measure.
If multiple BPs were taken on the same day, the lowest systolic and the lowest diastolic should represent the BP result for the date of service.

Medical Record (including, but not limited to)

- Consultation reports
- Progress Notes
- Medical History
- SOAP Notes
- Vitals Sheet
- CPT II Codes on Claims

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Breast Cancer Screening

Definition

Percentage of female patients ages 50-74 who had a mammogram screening completed on nor by October 1st, two years prior to the measurement year, through December 31st of the measurement year.

Plans

- Commercial
- Exchange/Marketplace
- Medicaid
- Medicare

Quality Programs

- CMS Star Ratings
- CMS Quality Ratings
- NCQA Accreditation
- NCQA Health Plan Ratings

Collection & Reporting Method

- Claim / Encounter Data

Codes

The following codes can be used to close HEDIS gaps in care for mammography.

CPT/CPT II	77061, 77062, 77063, 77065, 77066, 77067
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, 6625-2, 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, 38070-9, 38071-7, 38072-5, 38090-7, 30891-5, 38807-4, 38820-7, 38854-6, 38855-3, 39150-8, 93752-4, 39153-2, 39154-0, 42168-5, 42169-3, 42174-3, 42415-0, 42416-8, 46335-6, 46336-4, 46337-2, 46338-0, 46339-8, 46342-2, 46350-5, 46351-3, 46354-7, 46355-4, 46356-2, 46380-2, 48475-8, 48492-3, 69150-1, 69251-7, 69259-0, 72137-3, 72138-1, 72139-9, 72140-7, 72141-5, 72142-3, 86462-9, 86463-7, 91517-3, 91518-1, 91519-9, 91520-7, 91521-5, 91522-3
SNOMED	12389009, 24623002, 43204002, 71651007, 24105506, 241057003, 241058008, 258172002, 439324009, 450566007, 709657006, 723778004, 723779007, 723780005, 726551006, 83331007, 866234000, 866235004, 866236003, 866237007, 384151000119104, 392521000119107, 392531000119105, 566571000119105, 572701000119102

Breast Cancer Screening - Exclusions

The following exclusions will be accepted during the appropriate timeframe.

Exclusion	Timeframe
• Patients in hospice or using hospice services • Patient is Deceased • Patient is receiving palliative care	Any time in the measurement year
Patients 66 and older, as of December 31st, who had at least two diagnoses of frailty (on different dates of service) and advanced illness. Advanced Illness is indicated by the following: • Two or more outpatient, observation, emergency room, telephone, e-visits, virtual check-ins, or non-acute inpatient encounters or discharge(s) on separate dates of services with dx of advanced illness. • One or more acute inpatient encounter(s) with a dx of advanced illness • One or more acute inpatient discharge(s) with a dx of advanced illness on the dx claim • Dispensed a dementia medication: Donepezil, Donepezil-memantine, galantamine, rivastigmine or memantine	Frailty - dx must be in the measurement year and on different dates of service Advanced Illness - dx must be in the measurement year or year prior to the measurement year
Medicare patients 66 and older, as of December 31st, who are either enrolled in an Institutional Special Needs Plan or living long term in an institution.	Any time in the measurement year

Bilateral Mastectomy
• History of bilateral mastectomy
• Unilateral mastectomy with a bilateral modifier
• Any combination of the following that indicate a mastectomy on both the left and right side
  ○ Absence of the left and right breast
  ○ Unilateral mastectomy (claims or med rec) with a left side modifier
  ○ Unilateral mastectomy (claims or med rec) with a right side modifier
  ○ Left or Right unilateral mastectomy
	Any time in the patient's history before December 31st of the measurement year

Breast Cancer Screening - Best Practices

- Educate patients about the importance of early detection and encourage screening
- Engage patients to discuss their fears about mammograms and let women know that the test is less uncomfortable and uses less radiation than it did in the past
- Establish a standing order to obtain annual mammogram for eligible population and due to the unique 27-month measurement period, physician practices may want to consider ordering a mammogram every two years for their patients beginning at 50 years old, or sooner when risk factors such as family history exist
- Document the month and year of most recent mammogram and/or mastectomy status, in the medical record

Important Notes

Notes

- This measure does not include biopsies, breast ultrasounds, or MRIs.
- If documenting a mammogram in a patient's history, please include the month and year. Results not required.

Test/Service/Procedure

Mammogram - all types and methods including screening, diagnostic, film, digital, or digital breast tomosynthesis

Medical Record (including, but not limited to)

- Consultation reports
- Diagnostic reports
- Health history and physical

Care for Older Adults: Medication Review

Definition

Percentage of adults ages 66 and older who had a medication review by a clinical pharmacist or prescribing practitioner and the presence of a medication list in the medical record or transitional care management services in the measurement year.

Plans

- Medicare

Quality Programs

- CMS Star Ratings

Collection & Reporting Method

- Claim / Encounter Data
- Medical Record Documentation

Codes

The following codes can be used to close HEDIS gaps in care.

Medication List	
CPT/CPT II	1159F *This code (medication list documented) must be submitted with 1160F (review of all medications by a prescribing practitioner or clinical pharmacist documented) on the same date of service.*
SNOMED	428191000124101, 432311000124109

Medication Review	
CPT/CPT II	99605, 99606, 90863, 99483, 1160F
SNOMED	719327002, 719328007, 719329004, 461651000124104

Care for Older Adults: Medication Review - Exclusions

The following exclusions will be accepted during the appropriate timeframe.

Exclusion	Timeframe
• Patients in hospice or using hospice services • Patient is Deceased	Any time in the measurement year

Care for Older Adults: Medication Review - Best Practices

- Always clearly document the date of service of the medication review or notation of no medications.
- A medication review conducted in an acute inpatient setting will not meet compliance.
- A medication review may be conducted with a patient over the phone if the clinician is a prescriber or clinical pharmacist. A registered nurse can collect the list of current medications from the patient during the call, but there must be evidence that the appropriate practitioner reviewed the list.
    - For example: An electronic signature with credentials on the medication list
- The medication review must include all of the patient's medications, including prescription and over-the-counter medications and herbal or supplemental therapies.
- A medication list signed and dated within the measurement year by the prescribing practitioner or clinical pharmacist meets the criteria.
    - The practitioner's signature along with a medication list in the patient's chart is considered evidence that the medications were reviewed.
    - A review of side effects for a single medication at the time of prescription alone will not meet compliance
    - The use of CPT Category II codes helps payers identify clinical outcomes such as medication reviews. It can also reduce the need for some chart review.
    - Adding CPT II modifier codes to a claim may result in the gap not closing

Important Notes

Notes

- Medication list must be included in the medical record and medication review must be completed by a prescribing provider or clinical pharmacist.
- A medication list, signed and dated during the measurement year by the appropriate practitioner type — prescribing practitioner or clinical pharmacist – meets compliance.
- A notation within the record that the medications were reviewed. If a notation is included, the signature is not needed.
- Documentation that the medications aren't tolerated isn't an exclusion for this measure.
- A review of side effects for a single medication at the time of prescription alone does not meet compliance.
- Medication review conducted in an acute inpatient setting will not meet compliance.
- Practitioner is not required to be the member's primary or ongoing care provider; any provider meeting the requirement of prescribing practitioner or clinical pharmacist can complete the medication review

Test/Service/Procedure

Medication review or dated clinician's note that says the member is not taking any medications

Medical Record (including, but not limited to)

- Health history and physical
- Medication list
- Progress notes
- SOAP notes

Care for Older Adults: Pain Assessment

Definition

Percentage of adults ages 66 and older who were assessed for pain in the measurement year.

Plans

- Medicare

Quality Programs

- CMS Star Ratings

Collection & Reporting Method

- Claim / Encounter Data
- Medical Record Documentation

Codes

The following codes can be used to close HEDIS gaps in care.

CPT/CPT II	1125F, 1126F
SNOMED	225399009, 370778008, 408952002, 408955000, 423184003, 445719003, 445790003, 445806009, 445812004, 445996003, 446009008, 446790006, 715322001, 770637008

Care for Older Adults: Pain Assessment - Exclusions

The following exclusions will be accepted during the appropriate timeframe.

Exclusion	Timeframe
• Patients in hospice or using hospice services • Patient is Deceased	Any time in the measurement year

Care for Older Adults: Pain Assessment - Best Practices

- Documentation in a patient's medical record of a pain management plan or pain treatment alone will not meet compliance.
- Documentation in a patient's medical record of screening for chest pain or documentation of chest pain alone will not meet compliance.
- A pain assessment related to a single body part, with the exception of chest, meets compliance.
- Pain scales – numbers or faces – are an acceptable form of pain assessment and meet compliance.
- A pain assessment may be conducted with the patient in various manners (phone, in person, virtually etc.) and is not limited to being completed by clinicians.

Important Notes

Notes

- Pain assessment must be completed within the measurement year.
- A pain assessment conducted in an acute inpatient setting will not meet compliance.
- Documentation of pain management alone or pain treatment alone does not meet numerator criteria.
- A pain assessment related to a single body part will meet compliance (with the exception of the chest).

Test/Service/Procedure

- Standardized pain assessment tool and results
- Date and notation of "no pain" in the medical record after the patient's pain was assessed

Medical Record (including, but not limited to)

- Health history and physical
- Home health records
- Occupational therapy notes
- Pain assessment forms
- Physical therapy notes
- Progress notes
- Skilled nursing facility minimum data set (MDS) form
- SOAP notes

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Cervical Cancer Screening

Definition

Percentage of women ages 21–64 who were screened for cervical cancer using either of the following criteria:
• Women ages 21–64 who had cervical cytology performed in the measurement year or 2 years prior
• Women ages 30–64 who had cervical cytology/high-risk human papillomavirus (hrHPV) co-testing performed in the measurement year or four years prior. The woman must have been at least age 30 on the date of the test.
• Women ages 30–64 who had cervical high-risk human papillomavirus (hrHPV) testing performed in the measurement year or four years prior

Plans

- Commercial
- Exchange/Marketplace
- Medicaid

Quality Programs

- CMS Quality Ratings
- NCQA Accreditation
- NCQA Health Plan Ratings

Collection & Reporting Method

- Administrative
  - Claim / Encounter Data
- Hybrid
  - Claim / Encounter Data
  - Medical Record Documentation

Codes

The following codes can be used to close HEDIS gaps in care for cervical cancer screening.

Cervical Cytology	
CPT/CPT II	88141, 88142, 88143, 88147, 88148, 88150, 88152, 88153, 88164, 88165, 88166, 88167, 88174, 88175
HCPCS	G0123, G0124, G0141, G0143, G0144, G0145, G0147, G0148, P3000, P3001, Q0091
LOINC	10524-7, 18500-9, 19762-4, 19764-0, 19765-7, 19766-5, 19774-9, 33717-0, 47527-7, 47528-5
SNOMED	171149006, 416107004 417036008, 440623000, 448651000124104, 168406009, 168407000, 168408005, 168410007
High Risk HPV Test	
CPT/CPT II	87624, 87625
HCPCS	G0476
LOINC	21440-3, 30167-1, 38372-9, 59263-4, 59264-2, 59420-0, 69002-4, 71431-1, 75694-0, 77379-6, 77399-4, 77400-0, 82354-2, 82456-5, 82675-0, 95539-3
SNOMED	35904009. 448651000124104, 718591004

Cervical Cancer Screening - Exclusions

The following exclusions will be accepted during the appropriate timeframe.

Exclusion	Timeframe
• Patients in hospice or using hospice services • Patient is receiving palliative care • Patient is Deceased	Any time in the measurement year
Hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix	Any time in the patient's history before December 31st of the measurement year

Best Practices

- Evidence of hrHPV testing within the last 5 years also captures patients who had cotesting. (Documentation of "HPV Test" can be counted as evidence of hrHPV Test, as long as the result is documented.)
- Documentation of a "hysterectomy" alone will not meet the intent of the exclusion.
    - The documentation must include the words "total," "complete" or "radical" abdominal or vaginal hysterectomy.
    - Documentation of a "vaginal Pap smear" with documentation of "hysterectomy"
    - Documentation of hysterectomy and documentation that a patient no longer needs Pap testing/cervical cancer screening
- Biopsies are diagnostic and therapeutic, and not valid for primary cervical cancer screening.
- Patient reported information documented in the patient's medical record is acceptable as long as there is a date and result of the test or a date of the hysterectomy and acceptable documentation of no residual cervix. The patient reported information must be logged in the patient's chart by a care provider.

Important Notes

Test/Service/Procedure

- Cervical cytology for women 21-64 (measurement year or two years prior)
- High Risk HPV test (hrHPV) with results or findings (measurement year or four years prior - test must be performed when the woman is 30 or older)

Medical Record (including, but not limited to)

- Consultation reports
- Diagnostic reports
- Health history and physical
- Lab Reports

Child and Adolescent Well-Care Visits

Definition

Percentage of patients ages ages 3-21 years who had one or more comprehensive well-care visits with a primary care provider or OB-GYN during the measurement year.

Plans

- Commercial
- Exchange/Marketplace
- Medicaid

Quality Programs

- CMS Quality Ratings
- Medicaid Select State Reporting
- NCQA Accreditation

Collection & Reporting Method

- Claim / Encounter Data

Codes

The following codes can be used to close HEDIS gaps in care for child and adolescent well-care visits.

CPT/CPT II	99381, 99382, 99383, 99384, 99385, 99391, 99392, 99393, 99394, 99395, 99461
HCPCS	G0438, G0439, S0302, S0610, S0612, S0613
ICD - 10 Diagnosis	Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.2, Z00.3, Z01.411, Z01.419, Z02.5, Z76.1, Z76.2
SNOMED	103740001, 170099002, 170107008, 170114005, 70123008, 170132005, 170141000, 170150003, 170159002, 170168000, 170250008, 170254004, 170263002, 170272005, 170281004, 170290006, 170300004, 170309003, 171387006, 171394009, 171395005, 171409007, 171410002, 171416008, 171417004, 243788004, 268563000, 270356004, 401140000, 410620009, 410621008, 410622001, 410623006, 410624000, 410625004, 410626003, 410627007, 410628002, 410629005, 410630000, 410631001, 410632008, 410633003, 410634009, 410635005, 410636006, 410637002, 410638007, 410639004, 410640002, 410641003, 410642005, 410643000, 410644006, 410645007, 410646008, 410647004, 410648009, 410649001, 410650001, 442162000, 783260l003, 444971000124105, 446301000124108, 446381000124104, 669251000168104, 669261000168102, 669271000168108, 669281000168106

Child and Adolescent Well-Care Visits - Exclusions

The following exclusions will be accepted during the appropriate timeframe.

Exclusion	Timeframe
• Patients in hospice or using hospice services • Patient is Deceased	Any time in the measurement year

Best Practices

- Take advantage of every visit, including sick visits, to capture the components of this measure
- Schedule visits within the recommended time frames
- Use standardized templates in charts and EMRs
- Set care gap “alerts” in your electronic medical record
- Encourage parents/patients to maintain the relationship with a PCP to promote consistent and coordinated health care
- Educate parents/patients on the importance of having preventive care visits
- If provider is seeing a patient for Evaluation and Management (E/M) services and all well-child visit components are completed: Attach modifier 25 or 59 to the well-child procedure code so it’s reviewed as a significant, separately identifiable procedure
    - Modifier 25 is used to indicate a significant and separately identifiable evaluation and management (E/M) service by the same physician on the same day another procedure or service was performed.
    - Modifier 59 is used to indicate that 2 or more procedures were performed at the same visit, but to different sites on the body.
- Helpful resources about the components of care are available at brightfutures.aap.org.

Important Notes

- The well-child visit must be done by a primary care provider, but it doesn’t have to be with the patient’s assigned primary care provider.
- School-based health clinic visits count for this measure if they’re for a well-care exam and the physician completing the exam is a primary care provider.

Childhood Immunization Status Combination 3

Definition

Percentage of children age 2 who had 4 doses of diphtheria, tetanus, and acellular pertussis (DTaP) vaccine; 3 doses of polio (IPV) vaccine, 1 measles, mumps and rubella (MMR) vaccine, 3 doses of haemophilus influenza type B (HiB) vaccine; 3 doses of hepatitis B (Hep B) vaccine; 1 chicken pox (VZV) vaccine; and 4 doses of pneumococcal conjugate (PCV) vaccine on or before their second birthday.

Plans

- Commercial
- Exchange/Marketplace
- Medicaid

Quality Programs

- CMS Quality Ratings (Combination 10)
- NCQA Health Plan Ratings (Combination 10)

Collection & Reporting Method

- Claim / Encounter Data
- Medical Record Documentation

Codes

The following codes can be used to close HEDIS gaps in care for childhood immunization status.

DTaP Vaccine Number of Doses: 4 Special Circumstances • Do not count dose administered from birth through 42 days. • If applicable, anaphylaxis or encephalitis due to vaccine and the date it occurred must be documented in the medical record to count toward the numerator using hybrid specifications.	
CPT/CPT II	90697, 90698, 90700, 90723
CVX COdes	20, 50, 106, 107, 110, 120, 146
SNOMED	310306005, 310307001, 310308006, 312870000, 313383003, 390846000, 390865008, 399014008, 412755006, 412756007, 412757003, 412762002, 412763007, 412764001, 414001002, 414259000, 414620004, 415507003, 415712004, 770608009, 770616000, 770617009, 770618004, 787436003, 866158005, 866159002, 866226006, 868273007, 868274001, 868276004, 868277008, 1162640003, 428251000124104, 571571000119105, 572561000119108, 6290681000119103
Anaphylaxis due to the diphtheria, tetanus or pertussis vaccine	
SNOMED	428281000124107, 428291000124105

Childhood Immunization Status - Codes (continued)

Encephalitis due to the diphtheria, tetanus or pertussis vaccine	
SNOMED	192710009, 192711008, 192712001
Hep B Vaccine, History of Hepatitis B Illness Number of Doses: 3 Special Circumstances • One of the 3 can be the newborn Hepatitis B vaccine given at hospital on date of birth or 7 days after (see code below) • If applicable, anaphylaxis due to vaccine and the date it occurred must be documented in the medical record to count toward the numerator using hybrid specifications.	
CPT/CPT II	90697, 90723, 90740, 90744, 90747, 90748
CVX Codes	08, 44, 45, 51, 110, 146
HCPCS	G0010
SNOMED	16584000, 170370000, 170371001, 170372008, 170373003, 170374009, 170375005, 170434002, 170435001, 170436000, 170437009, 312868009, 396456003, 416923003, 770608009, 770616000, 770617009, 770618004, 786846001, 1162640003, 572561000119108

Newborn Hep B Number of Doses: 1 of 3 eligible	
ICD - 10 Procedure	3E0234Z
History of Hepatitis B	
ICD- 10 Diagnosis	B16.0, B16.1, B16.2, B16.9, B17.0, B18.0, B18.1, B19.10, B19.11
SNOMED	153091000119109, 551621000124109
Anaphylaxis due to the hepatitis B vaccine	
SNOMED	1428321000124101

Childhood Immunization Status - Codes (continued)

HiB Vaccine Number of Doses: 3 Special Circumstances • Do not count dose administered from birth through 42 days. • If applicable, anaphylaxis due to vaccine and the date it occurred must be documented in the medical record to count toward the numerator using hybrid specifications.	
CPT/CPT II	90644, 90647, 90648, 90697, 90698, 90748
CVX Codes	17, 46, 47, 48, 49, 50, 51, 120, 146, 148
Anaphylaxis due to the haemophilus B vaccine	
SNOMED	433621000124101

IPV Vaccine Number of Doses: 3 Special Circumstances • Do not count dose administered from birth through 42 days. • If applicable, anaphylaxis due to vaccine and the date it occurred must be documented in the medical record to count toward the numerator using the hybrid specifications.	
CPT/CPT II	90697, 90698, 90713, 90723
CVX Codes	10, 89, 110, 120, 146
SNOMED	1310306005, 310307001, 310308006, 312869001, 312870000, 313383003, 390865008, 396456003, 412762002, 412763007, 412764001, 414001002, 414259000, 414619005, 414620004, 415507003, 415712004, 416144004, 416591003, 417211006, 417384007, 417615007, 866186002, 866227002, 868266002, 868267006, 868268001, 868273007, 868274001, 868276004, 868277008, 870670004, 572561000119108, 16290681000119103
Anaphylaxis due to the inactivated polio vaccine	
SNOMED	471321000124106

Childhood Immunization Status - Codes (continued)

MMR Vaccine or History of Measles, Mumps or Rubella Number of Doses: 1 Special Circumstances • Must be administered on or between a child's first and second birthdays. • If applicable, anaphylaxis due to vaccine and the date it occurred must be documented in the medical record to count toward the numerator using the hybrid specifications.	
CPT/CPT II	90707, 90710
CVX Codes	03, 94
SNOMED	38598009, 170431005, 170432003, 170433008, 432636005, 433733003, 871909005, 571591000119106, 572511000119105
Anaphylaxis due to the measles, mumps and rubella vaccine on or before the child's second birthday	
SNOMED	471331000124109
History of Measles	
ICD - 10 Diagnosis	B05.0, B05.1, B05.2, B05.3, B05.4, B05.81, B05.89, B05.9
SNOMED	14189004, 28463004, 38921001, 60013002, 74918002, 111873003, 161419000, 186561002, 186562009, 195900001, 240483006, 240484000, 359686005, 371111005, 406592004, 417145006, 424306000, 105841000119101
History of Mumps	
ICD - 10 Diagnosis	B26.0, B26.1, B26.2, B26.3, B26.81, B26.82, B26.83, B26.84, B26.85, B26.89, B26.9
SNOMED	10665004, 17121006, 31524007, 31646008, 36989005, 40099009, 44201003, 63462008, 72071001, 74717002, 75548002, 78580004, 89231008, 89764009, 111870000, 161420006, 235123001, 236771002, 237443002, 240526004, 240527008, 240529006, 371112003, 1163539003, 105821000119107
History of Rubella	
ICD - 10 Diagnosis	B06.00, B06.01, B06.02, B06.09, B06.81, B06.82, B06.89, B06.9
SNOMED	10082001, 13225007, 19431000, 36653000, 51490003, 64190005, 79303006, 128191000, 161421005, 165792000, 186567003, 186570004, 192689006, 231985001, 232312000, 240485004, 253227001, 406112006, 406113001, 1092361000119109, 0759761000119100

Childhood Immunization Status - Codes (continued)

PCV Vaccine Number of Doses: 4 Special Circumstances • Do not count dose administered from birth through 42 days. • If applicable, anaphylaxis due to vaccine and the date it occurred must be documented in the medical record to count toward the numerator using the hybrid specifications.	
CPT/CPT II	90670
CVX Codes	109, 133, 152
HCPCS	G0009
SNOMED	1119368005, 434751000124102
Anaphylaxis due to the pneumococcal conjugate vaccine	
SNOMED	471141000124102
VZV Vaccine or History of Varicella Zoster Number of Doses: 1 Special Circumstances • Must be administered on or between a child's first and second birthdays.	
CPT/CPT II	90710, 90716
CVX Codes	21, 94

Childhood Immunization Status - Codes (continued)

Anaphylaxis due to the varicella vaccine on or before the child's second birthday	
SNOMED	471141000124102
History of Varicella Zoster	
ICD - 10 Diagnosis	B01.0, B01.11, B01.12, B01.2, B01.81, B01.89, B01.9, B02.0, B02.1, B02.21, B02.22, B02.23, B02.24, B02.29, B02.30, B02.31, B02.32, B02.33, B02.34, B02.39, B02.7, B02.8, B02.9
SNOMED	10698009, 21954000, 23737006, 24059009, 36292003, 38907003, 42448002, 49183009, 55560002, 87513003, 111859007, 111861003, 161423008, 186524006, 186525007, 195911009, 230176008, 230198004, 230262004, 230536009, 232400003, 235059009, 240468001, 240470005, 240471009, 240472002, 240473007, 240474001, 309465005, 371113008, 397573005, 400020001, 402897003, 402898008, 402899000, 410500004, 410509003, 421029004, 422127002, 422446008, 422471006, 422666006, 423333008, 423628002, 424353002, 424435009, 424801004, 424941009, 425356002, 426570007, 428633000, 713250002, 713733003, 713964006, 715223009, 723109003, 838357005, 1163465001, 1163483009, 1179456002, 12551000132107, 12561000132105, 12571000132104, 98541000119101, 331071000119101, 681221000119108, 1087131000119102, 15678761000119105, 15678801000119102, 15678841000119100, 15680201000119106, 15680241000119108, 15680281000119103, 15685081000119102, 15685121000119100, 15685201000119100, 15685281000119108, 15936581000119108, 15936621000119108, 15989271000119107, 15989311000119107, 15989351000119108, 15991711000119108, 15991751000119109, 15991791000119104, 15992351000119104, 16000751000119105, 16000791000119100, 16000831000119106

Exclusions

The following exclusions will be accepted during the appropriate timeframe.

Exclusion	Timeframe
• Patients in hospice or using hospice services • Patient is Deceased	Any time in the measurement year
• Immunodeficiency/Severe combined immunodeficiency • HIV • Lymphoreticular cancer, multiple myeloma or leukemia • Intussusception	Any time on or before a patient's second birthday

Childhood Immunization Status - Best Practices

- When documenting the rotavirus vaccine, always include “Rotarix®” or “2-dose,” or “RotaTeq®” or “3-dose” with the date of administration.
  - If medical record documentation doesn’t indicate whether the 2-dose schedule or 3-dose schedule was used, it’s assumed that the 3-dose regimen was used but only recorded for 2 dates. The vaccinations will then not count for HEDIS®.
- Annual influenza vaccinations – 2 between ages 6 months and 2 years – are an important part of the recommended childhood vaccination series.
  - Consider using standing orders, protocols and resources from immunize.org.
- Please record HepB vaccinations given at the hospital in the child’s medical record.
- Parental refusal of vaccinations will not remove an eligible patient from the denominator.
- When possible, please review vaccine status with parents and give immunizations at visits other than only well-child appointments
  - Consider offering online appointment scheduling.
  - Help ensure safety by dedicating specific rooms for child immunizations only.
  - Offer options such as extended hours or walk-in vaccination clinics.
  - Consider setting up a drive-up immunization site.
- Schedule appointments for your patient’s next vaccination before they leave your office.
  - Remind parents of the importance of keeping immunizations on track.
  - Use phone calls, emails, texts or postcards/letters to help keep parents engaged.

Important Notes

Notes

A patient’s medical record must include:

- A note with the name of the specific antigen and the date the vaccine was administered.
- An immunization record from an authorized health care provider or agency – for example, a registry –including the name of the specific antigen and the date the vaccine was administered.

Documentation that a patient is up-to-date with all immunizations, but doesn’t include a list of the immunizations and dates they were administered, will not meet compliance.

Documentation of physician orders, CPT codes or billing charges will not meet compliance.

Medical Record (including, but not limited to)

- Health history and physical
- Immunization Record
- Lab reports
- Problem List with Illnesses Dated
- Progress Notes

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Chlamydia Screening in Women

Definition

Percentage of female patients ages 16–24 who were identified as sexually active and had at least one test to screen for chlamydia during the measurement year.

NOTE: *Sexually active is identified by a pregnancy test or diagnosis or contraceptive prescriptions being captured via claims.*

Plans

- Commercial
- Exchange/Marketplace
- Medicaid (admin only)

Quality Programs

- CMS Quality Ratings
- NCQA Accreditation
- NCQA Health Plan Ratings

Collection & Reporting Method

- Claim / Encounter Data

Codes

The following codes can be used to close HEDIS gaps in care for chlamydia screening.

Chlamydia Screening Test	
CPT/CPT II	87110, 87270, 87320, 87490, 87491, 87492, 87810
LOINC	14463-4, 14464-2, 14467-5, 14474-1,14513-6, 16600-9, 21190-4, 21191-2, 21613-5, 23838-6, 31775-0, 31777-6, 36902-5, 36903-3, 42931-6, 43304-5, 43404-3, 43405-0, 43406-8, 44806-8, 44807-6, 45068-4, 45069-2, 45075-9, 45076-7, 45084-1, 45091-6, 45095-7, 45098-1, 45100-5, 47211-8, 47212-6, 49096-1, 4993-2, 50387-0, 53925-4, 53926-2, 557-9, 560-3, 6349-5, 6354-5, 6355-2, 6356-0, 6357-8, 80360-1, 80361-9, 80362-7, 91860-7
SNOMED	104175002, 104281002, 104282009, 104290009, 117775008, 121956002, 121957006, 121958001, 121959009, 122173003, 122254005, 122321005, 122322003, 134256004, 134289004, 171120003, 285586000, 310861008, 310862001, 315087006, 315095005, 315099004, 390784004, 390785003, 395195000, 398452009, 399193003, 407707008, 442487003, 707982002

Chlamydia Screening in Women - Exclusions

The following exclusions will be accepted during the appropriate timeframe.

Exclusion	Timeframe
• Patients in hospice or using hospice services • Patient is Deceased	Any time in the measurement year

Best Practices

- Incorporate universal screening of all women in this age range.
- Screening should occur with or without symptoms.
- Screenings should also occur at any visit where oral contraceptives, sexually transmitted diseases (STD) or urinary symptoms are discussed.
- Chlamydia screening may not be captured via claims if the service is performed and billed under prenatal and postpartum global billing.
- The Centers for Disease Control and Prevention recommends self-obtained vaginal specimens for asymptomatic females. Self-obtained vaginal specimens are cleared by the U.S. Food & Drug Administration (FDA) for collection in a clinical setting.

Important Notes

Notes	Test/Service/Procedure
Test must be performed within the measurement year.	Chlamydia screening test

Medical Record (including, but not limited to)

- Consultation reports
- Health history and physical
- Lab reports

Colorectal Cancer Screening

Definition

Percentage of patients ages 45–75 who had an appropriate screening for colorectal cancer. Rates stratified for race and ethnicity.

Plans

- Commercial
- Exchange/Marketplace
- Medicaid (admin only)
- Medicare

Quality Programs

- CMS Star Ratings
- CMS Quality Ratings
- Medicaid Select State Reporting
- NCQA Accreditation
- NCQA Health Plan Ratings

Collection & Reporting Method

- Claim / Encounter Data
- Medical Record Documentation

Codes

The following codes can be used to close HEDIS gaps in care for colorectal cancer screening.

Colonoscopy	
CPT/CPT II	44388, 44389, 44390, 44391, 44392, 44393, 44394, 44397, 44401, 44402, 44403, 44404, 44405, 44406, 44407, 44408, 45355, 45378, 45379, 45380, 45381, 45382, 45383, 45384, 45385, 45386, 45387, 45388, 45389, 45390, 45391, 45392, 45393, 45398
HCPCS	G0105, G0121
History of Colonoscopy	
SNOMED	851000119109
Computed Tomography (CT) Colonoscopy	
CPT/CPT II	74261, 74262, 74263 This service isn't covered for UnitedHealthcare Medicare Advantage members.
LOINC	60515-4, 72531-7, 79069-1, 79071-7, 79101-2, 82688-3
SNOMED	418714002

Flexible Sigmoidoscopy	
CPT/CPT II	45330, 45331, 45332, 45333, 45334, 45335, 45337, 45338, 45340, 45341, 45342, 45346, 45347, 45349, 45350
HCPCS	G0104
SNOMED	44441009
History of Flexible Sigmoidoscopy	
SNOMED	841000119107
Stool DNA (sDNA) with FIT Test	
CPT/CPT II	81528 This code is specific to the Cologuard® FIT-DNA test.
LOINC	77353-1, 77354-9
SNOMED	708699002
FIT	
CPT/CPT II	82274

Colorectal Cancer Screening - Exclusions

The following exclusions will be accepted during the appropriate timeframe.

Exclusion	Timeframe
• Patients in hospice or using hospice services • Patient is Deceased • Patient is receiving palliative care	Any time in the measurement year
Patients 66 and older, as of December 31st, who had at least two diagnoses of frailty (on different dates of service) and advanced illness. Advanced Illness is indicated by the following: • Two or more outpatient, observation, emergency room, telephone, e-visits, virtual check-ins, or non-acute inpatient encounters or discharge(s) on separate dates of services with dx of advanced illness. • One or more acute inpatient encounter(s) with a dx of advanced illness • One or more acute inpatient discharge(s) with a dx of advanced illness on the dx claim • Dispensed a dementia medication: Donepezil, Donepezil-memantine, galantamine, rivastigmine or memantine	Frailty - dx must be in the measurement year and on different dates of service Advanced Illness - dx must be in the measurement year or year prior to the measurement year
Medicare patients 66 and older, as of December 31st, who are either enrolled in an Institutional Special Needs Plan or living long term in an institution.	Any time in the measurement year
Patients who had colorectal cancer or a total colectomy	Any time in the patient's history before December 31st of the measurement year

Colorectal Cancer Screening - Best Practices

- Assess existing barriers to colorectal cancer screening (i.e. access to care, cost)
- Educate the patient about the importance of early detection and encourage screening
- Request to have any colorectal cancer screening results sent to you if done at a specialty office
- Engage patients to discuss their fears
- Document the month, year and type of screening of most recent colorectal cancer screening in the medical record
- Set care gap “alerts” in your electronic medical record
- Emphasize personal choice and various modalities, especially for those who may fear having a colonoscopy
- Distribute FOBT or FIT test kits to patients who need to be screened
- Act quickly for patients who have a positive stool test result
- Clearly document administered screenings, total colectomy or colorectal cancer in patient’s medical record, including date of service.
- Ask patients if they’ve had a colorectal cancer screening, and update patient history annually

Important Notes

Notes	Test/Service/Procedure
Measurement year or 9 years prior	Colonoscopy
Measurement year or 4 years prior	• Flexible sigmoidoscopy • CT Colonography
Measurement year or 2 years prior	Stool DNA (sDNA) with FIT Test
Measurement year	iFOBT, gFOBT, FIT

Medical Record (including, but not limited to)

- Consultation reports
- Diagnostic reports
- Health history and physical
- Lab reports
- Pathology reports – For a colonoscopy, must indicate the type or screening or that the scope advanced beyond the splenic flexure. For a flexible sigmoidoscopy, must indicate the type or screening or that the scope advanced into the sigmoid colon.

Depression Screening and Follow-Up for Adolescents and Adults

Definition

Patients ages 12 and over as of January 1 of the measurement year who had:

- Depression Screening: Documented result of depression in the measurement year using a age-appropriate standardized instrument
- Follow-Up: Upon documentation of a positive depression screening, patients receive follow-up (medication or treatment) within 30 days of the positive screening

– Note: If a positive screen is followed up with a negative finding on the same day, that will count toward the numerator.

Plans

- Commercial
- Medicaid
- Medicare

Quality Programs

- Select State Reporting

Collection & Reporting Method

- Electronic Data Only

Codes

Scenario 1: Outpatient visit with diagnosis of depression or other behavioral health diagnosis

Depression Case Management Encounter	
CPT/CPT II	99366, 99492, 99493, 99494
HCPCS	G0512, T1016, T1017, T2022, T2023
SNOMED	182832007, 225333008, 385828006, 386230005, 409022004, 410216003, 410219005, 410328009, 410335001, 410346003, 410347007, 410351009, 410352002, 410353007, 410354001, 410356004, 410360001, 410363004, 410364005, 410366007, 416341003, 416584001, 424490002, 425604002, 737850002

Depression Screening and Follow-Up for Adolescents and Adults - Codes (continued)

Follow-Up Visit	
CPT/CPT II	98960, 98961, 98962, 98966, 98967, 98968, 98969, 98970,98971, 98972, 99078, 99201,99202, 99203, 99204,99205,99211, 99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, 99241, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 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, 99444, 99457, 99483
HCPCS	G0071, G0463, G2010, G2012, G2061, G2062, G2063, G2250, G2251,G2252, T1015
SNOMED	42137004, 50357006, 86013001, 90526000, 108220007, 108221006, 185317003, 85389009, 281036007, 314849005, 386472008, 386473003, 390906007, 401267002, 406547006, 870191006
UBREV	0510, 0513, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0526, 0527, 0528, 0529, 0982, 0983

Scenario 2: Dispensed an anti-depression medication

Exclusion	Timeframe
• Patients in hospice or using hospice services • History of bipolar diagnosis • Diagnosis of depression	• Any time in the measurement year • Any time during the patient's history through the measurement year • Any time during the year prior to the measurement year

Best Practices

- Mental Health is incredibly important to a patient's overall health and must be prioritized as such.
- Encourage your patient to seek counseling/therapy services or refer your patient to a behavioral health specialist.
- The PHSO offers Behavioral Health Specialists for covered patients who can assist with placement.

Eye Exam for Patients with Diabetes

Definition

Percentage of patients ages 18–75 with diabetes (Types 1 and 2) who had any one of the following:

- Retinal or dilated eye exam by an optometrist or ophthalmologist in the measurement year
- Negative retinal or dilated eye exam by an optometrist or ophthalmologist in the year prior to the measurement year
- Bilateral eye enucleations any time during their history through Dec. 31 of the measurement year

Plans

- Commercial
- Exchange/Marketplace
- Medicaid (admin only)
- Medicare

Quality Programs

- CMS Star Ratings
- CMS Quality Ratings
- NCQA Accreditation
- NCQA Health Plan Ratings

Collection & Reporting Method

- Claim / Encounter Data
- Medical Record Documentation

Codes

The following codes can be used to close HEDIS gaps in care for diabetic eye exams.

Category 1 Coding Criteria: Any Provider Eye Exam with Evidence of Retinopathy Value Set, Eye Exam Without Evidence of Retinopathy Value Set or Automated Eye Exam Value Set billed by ANY PROVIDER during MY Eye Exam without Evidence of Retinopathy Value Set billed by ANY PROVIDER during PY	
Diabetic Eye Exam without Evidence of Retinopathy in Prior Year	
CPT/CPT II	3072F
Diabetic Eye Exam without Evidence of Retinopathy	
CPT/CPT II	2023F, 2025F, 2033F
Diabetic Eye Exam with Evidence of Retinopathy	
CPT/CPT II	2022F, 2024F, 2026F
Automated Eye Exam (Imaging of retina)	
CPT/CPT II	92229

Diabetes Care: Eye Exam - Codes (continued)

Category 2 Coding Criteria: Eye Care Professional Diabetic Retinal Screening Value Set billed by an EYE CARE PROFESSIONAL during MY Diabetic Retinal Screening Value Set billed by an EYE CARE PROFESSIONAL during PY with a diagnosis of diabetes without complications (Diabetes Mellitus Without Complications Value Set)	
Diabetic Eye Exam	
CPT/CPT II	67028, 67030, 67031, 67036, 67039, 67040, 67041, 67042, 67043, 67101, 67105, 67107, 67108, 67110, 67113, 67121, 67141, 67145, 67208, 67210, 67218, 67220, 67221, 67227, 67228, 92002, 92004, 92012, 92014, 92018, 92019, 92134, 92201, 92202, 92225, 92226, 92227, 92228, 92230, 92235, 92240, 92250, 92260, 99203, 99204, 99205, 99213, 99214, 99215, 99242, 99243, 99244, 99245
HCPCS	S0620, S0621, S3000
SNOMED	274795007, 274798009, 308110009, 314971001, 314972008, 410451008, 410452001, 410453006, 410455004, 425816006, 427478009, 722161008
Diabetes Mellitus without Complications	
ICD - 10 Diagnosis	E10.9, E11.9, E13.9
SNOMED	111552007, 190412005, 313435000, 313436004, 1481000119100, 31321000119102
Unilateral Eye Enucleation	
CPT/CPT II	65091, 65093, 65101, 65103, 65105, 65110, 65112, 65114
SNOMED	59590004, 172132001, 205336009, 397800002, 397994004, 398031005
Unilateral Eye Enucleation – Left	
ICD - 10 Procedure	08T1XZZ
Unilateral Eye Enucleation – Right	
ICD - 10 Procedure	08T0XZZ
Bilateral Modifier	
CPT Modifier	50

Diabetes Care: Eye Exam - Exclusions

The following exclusions will be accepted during the appropriate timeframe.

Exclusion	Timeframe
• Patients in hospice or using hospice services • Patient is Deceased • Patient is receiving palliative care	Any time in the measurement year
Patients 66 and older, as of December 31st, who had at least two diagnoses of frailty (on different dates of service) and advanced illness. Advanced Illness is indicated by the following: • Two or more outpatient, observation, emergency room, telephone, e-visits, virtual check-ins, or non-acute inpatient encounters or discharge(s) on separate dates of services with dx of advanced illness. • One or more acute inpatient encounter(s) with a dx of advanced illness • One or more acute inpatient discharge(s) with a dx of advanced illness on the dx claim • Dispensed a dementia medication: Donepezil, Donepezil-memantine, galantamine, rivastigmine or memantine	Frailty - dx must be in the measurement year and on different dates of service Advanced Illness - dx must be in the measurement year or year prior to the measurement year
Medicare patients 66 and older, as of December 31st, who are either enrolled in an Institutional Special Needs Plan or living long term in an institution.	Any time in the measurement year

Diabetes Care: Eye Exam - Best Practices

- Always list the date of service, test, result and eye care professional's name and credentials together if you're documenting the history of a dilated eye exam in a patient's chart and don't have the eye exam report from an eye care professional.
    - For example: "Last diabetic eye exam with John Smith, OD, was June 201X with no retinopathy."
- Documentation of a diabetic eye exam by an optometrist or ophthalmologist isn't specific enough to meet the criteria. The medical record must indicate that a dilated or retinal exam was performed. If the words "dilated" or "retinal" are missing in the medical record, a notation of "dilated drops used" and findings for macula and vessels will meet the criteria for a dilated exam.
- Follow up with patients to discuss and educate on effects of diabetes
- Coordinate care with patients' other providers
- Outreach patients who have not had their eye exams and ask them to schedule one as soon as possible

Important Notes

Notes

- Patients without retinopathy should have an eye exam every 2 years.
- Patients with retinopathy should have an eye exam every year.

Test/Service/Procedure

- Dilated or retinal eye exam
- Fundus photography

Medical Record (including, but not limited to)

- Consultation reports
- Diabetic flow sheets
- Eye exam report
- Progress Notes

Glycemic Status Assessment for Patients with Diabetes

Definition

The percentage of 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]) showed their blood sugar is under control during the measurement year adequate control is < 8.0%, poor control is > 9.0%).

Plans

- Commercial
- Exchange/Marketplace
- Medicaid
- Medicare

Quality Programs

- CMS Star Ratings
- CMS Quality Ratings
- NCQA Accreditation
- NCQA Health Plan Ratings

Collection & Reporting Method

- Hybrid
  - Automated Lab Data
  - Claim/Encounter Data
  - Medical Record Documentation

Codes

The following codes can be used to close HEDIS gaps in care for HbA1c ranges.

HbA1c < 7.0%		HbA1c ≥ 8.0% and ≤ 9.0%	
CPT/CPT II	3044F	CPT/CPT II	3052F
HbA1c ≥ 7.0% and <8.0%		HbA1c > 9.0%	
CPT/CPT II	3051F	CPT/CPT II	3046F

Glycemic Status for Patients with Diabetes - Exclusions

The following exclusions will be accepted during the appropriate timeframe.

Exclusion	Timeframe
• Patients in hospice or using hospice services • Patient is Deceased • Patient is receiving palliative care	Any time in the measurement year
Patients 66 and older, as of December 31st, who had at least two diagnoses of frailty (on different dates of service) and advanced illness. Advanced Illness is indicated by the following: • Two or more outpatient, observation, emergency room, telephone, e-visits, virtual check-ins, or non-acute inpatient encounters or discharge(s) on separate dates of services with dx of advanced illness. • One or more acute inpatient encounter(s) with a dx of advanced illness • One or more acute inpatient discharge(s) with a dx of advanced illness on the dx claim • Dispensed a dementia medication: Donepezil, Donepezil-memantine, galantamine, rivastigmine or memantine	Frailty - dx must be in the measurement year and on different dates of service Advanced Illness - dx must be in the measurement year or year prior to the measurement year
Medicare patients 66 and older, as of December 31st, who are either enrolled in an Institutional Special Needs Plan or living long term in an institution.	Any time in the measurement year

Glycemic Status for Patients with Diabetes - Best Practices

- Order labs prior to patients' appointments
- Ensure documentation in the medical record includes the date when the test was performed, and the result
- Order a diabetes screening test every year and build care gap “alerts” in your electronic medical record
- Follow up with patients to discuss and educate on lab results
- Coordinate care with patients' other providers
- Outreach to patients who cancel appointments and reschedule them as soon as possible
- Follow up with patients to discuss and educate on effects of diabetes
- Coordinate care with patients' other providers
- Outreach to patients who have not had their eye exam and lab work completed and ask them to complete as soon as possible
- Discuss with patient the Importance of screening for diabetes
- Educate the patient on symptoms of new-onset diabetes
- Set care gap “alerts” in your electronic medical record
- The use of CPT II codes help payers identify clinical outcomes such as HbA1c level. It can also reduce the need for some chart review.

Important Notes

Notes

- HbA1c or glucose management indicator (GMI) test must be performed during the measurement year. If multiple tests were performed in the measurement year, the result from the last test is used.
- Ranges and thresholds do not meet compliance.

Test/Service/Procedure

- • A1c, HbA1c, HgbA1c
- • Glycohemoglobin
- • Glycohemoglobin A1c
- • Glycated hemoglobin
- • Glycosylated hemoglobin
- HB1c
- Hemoglobin A1c
- Continuous glucose monitors (CGM)

Medical Record (including, but not limited to)

- Diabetic flow sheets
- Consultation reports
- Lab reports
- Progress notes
- Vitals sheet
- Continuous glucose monitoring data

Baptist Health
POPULATION HEALTH SERVICES ORGANIZATION

Kidney Health Evaluation for Patients with Diabetes (KED)

Definition

Percentage of patients ages 18–85 with diabetes (Types 1 and 2) who had a kidney health evaluation in the measurement year. Both an eGFR and a uACR test are required on same or different dates of service.

- At least 1 estimated glomerular filtration rate (eGFR); AND
- At least 1 urine albumin-creatinine ratio (uACR) test identified by one of the following:
  - A quantitative urine albumin test AND a urine creatinine test 4 or less days apart; OR
  - A uACR

Note:

The KED quality measure was developed by the NCQA and the National Kidney Foundation (NKF) to improve kidney disease testing in people with diabetes.

In 2022, the NCQA retired the Comprehensive Diabetes Care measure – Medical Attention for Nephropathy (CDC) and replaced it with KED. The previous CPT® code 82044 was removed from the NCQA HEDIS® set and was replaced with quantitative methods using CPT 82043. Please use the NCQA updated coding to actively reflect care rendered.

Codes

The following codes can be used to close HEDIS gaps in care for diabetic kidney health evaluation.

Description	CPT2 Code	LOINC
Quantitative urine albumin lab test	**82043**	14957-5, 1754-1, 21059-1, 30003-8, 43605-5, 53530-2, 53531-0, 57369-1, 89999-7
Urine creatinine lab test	82570	20624-3, 2161-8, 35674-1, 39982-4, 57344-4, 57346-9, 58951-5
Estimated glomerular filtration rate lab test (eGFR)	80047, 80048, 80050, 80053, 80069, 82565	48642-3, 48643-1, 50044-7, 50210-4, 50384-7, 62238-1, 69405-9, 70969-1, 77147-7, 88293-6, 88294-4, 94677-2, 96591-3, 96952-1, 98979-8, 98980-6
Urine albumin creatinine ratio lab test (uACR)	N/A	13705-9, 14958-3, 14959-1, 30000-4, 32294-1, 44292-1, 59159-4, 76401-9, 77253-3, 77254-1, 89998-9, 9318-7

Kidney Health Evaluations for Patients with Diabetes - Codes (continued)

Quantitative Urine Albumin Lab Test	
CPT/CPT II	82043
LOINC	14957-5, 1754-1, 21059-1, 30003-8, 43605-5, 53530-2, 53531-0, 57369-1, 89999-7
SNOMED	104486009, 104819000
Urine Creatinine Lab Test	
CPT/CPT II	82570
LOINC	20624-3, 2161-8, 35674-1, 39982-4, 57344-4, 57346-9, 58951-5
SNOMED	8879006, 36793009, 271260009, 444322008
Urine Albumin Creatinine Ratio Test	
LOINC	13705-9,14958-3, 14959-1, 30000-4, 32294-1, 44292-1, 59159-4, 76401-9, 77253-3, 77254-1, 89998-9, 9318-7

Exclusions

The following exclusions will be accepted during the appropriate timeframe.

Exclusion	Timeframe
• Patients in hospice or using hospice services • Patient is Deceased • Patient is receiving palliative care	Any time in the measurement year
Patients 66 and older, as of December 31st, who had at least two diagnoses of frailty (on different dates of service) and advanced illness.	Frailty - dx must be in the measurement year and on different dates of service Advanced Illness - dx must be in the measurement year or year prior to the measurement year
Medicare patients 66 and older, as of December 31st, who are either enrolled in an Institutional Special Needs Plan or living long term in an institution.	Any time in the measurement year
Patients with no diagnosis of diabetes and a diagnosis of PCOS, gestational diabetes, or steroid-induced diabetes	Any time during the measurement year or the year prior

Kidney Health Evaluations for Patients with Diabetes - Best Practices

- The American Diabetes Association (ADA) and National Kidney Foundation (NKF) guidelines recommend annual kidney health evaluation for patients with diabetes.
- Advise patients that some complications from diabetes may be asymptomatic. For example, kidney disease is asymptomatic in its earliest stages and routine testing and diagnoses may help prevent/delay some life threatening complications.
- Educate and remind patients of the importance and rationale behind having these labs completed annually.
- Provide education to patients about the disease process to help increase health literacy and improve management of the health condition.
- Foster a PCP-specialist collaboration to ensure labs are completed annually and to prevent duplicate labs or noncompliance.
- Order and request labs to have patients complete prior to appointment to allow results to be available for discussion on the day of the office visit.
- Track and reach out to patients who have missed appointments.
- Order a diabetes screening test every year and build care gap “alerts” in your electronic medical record.
- Discuss with member the importance of screening for diabetes.
- Educate the member on symptoms of new-onset diabetes.

Medication Adherence for Cholesterol

Definition

Percentage of patients ages 18 and older who adhere to their cholesterol (statin) medication at least 80% of the time in the measurement period

Plans

- Medicare

Quality Programs

- CMS Star Ratings

Collection & Reporting Method

- Part D Claims
  - Pharmacy Data

Compliance

To comply with this measure, a patient must have a proportion of days covered (PDC) of 80 percent or higher for their statin medication in the measurement period.

Exclusions

The following exclusions will be accepted during the appropriate timeframe.

Exclusion	Timeframe
• Patients in hospice or using hospice services • Patient is Deceased • End Stage Renal Disease (ESRD): N18.5, N18.6, Z99.2 • Dialysis	Any time in the measurement year

Medication Adherence for Cholesterol - Best Practices

- Look for opportunities for mail-order, which may lower out -of-pocket expenses for patients.
- Improve health literacy. Talk with patients about why they're on a statin medication, and how it's important to take their medication as prescribed and get timely refills.
- Assess adherence barriers. Discuss medication adherence barriers at each visit and ask open-ended questions about concerns related to health benefits, side effects and cost.
- Discuss continued therapy. If ongoing therapy is appropriate, talk with patients about getting timely refills to prevent large gaps between fills. This is particularly important between the first and second fills to set up good habits for future fills.
    - Patients qualify for the measure with the second fill, but the measurement period starts with the date of the first fill.
    - Patients can't achieve 80% PDC when the allowable days they can miss in the year is less than zero. ADR must be zero or higher for a patient to be adherent.
- Consider extended days' supply prescriptions. When clinically appropriate, consider writing a 3-month supply of prescriptions for chronic conditions to help improve adherence and minimize frequent trips to the pharmacy – especially if getting to the pharmacy is an issue.
- Prescribe low-cost generics. When clinically appropriate, prescribe low-cost generic medications to help reduce out-of- pocket costs.
- Confirm instructions. Check that the directions on patients' prescriptions match your instructions. If the dose or frequency is changed, please void the old prescription and send a new one to the patient's pharmacy.

Medication Adherence for Diabetes Medications

Definition

Percentage of patients ages 18 or older who are adherent to their diabetes medications at least 80% of the time in the measurement period

Plans

- Medicare

Quality Programs

- CMS Star Ratings

Collection & Reporting Method

- Part D Claims
  - Pharmacy Data

Compliance

To comply with this measure, a patient must have a proportion of days covered (PDC) of 80% or higher for their diabetes medication(s) in the measurement period. These classes of diabetes medications are included in this measure:

- Biguanides
- DPP-4 inhibitors
- GLP-1 receptor agonists
- Meglitinides
- SGLT2 inhibitors
- Sulfonylureas
- Thiazolidinediones

Exclusions

The following exclusions will be accepted during the appropriate timeframe.

Exclusion	Timeframe
• Patients in hospice or using hospice services • Patient is Deceased • End Stage Renal Disease (ESRD): N18.5, N18.6, Z99.2 • Dialysis • One or more prescription claims for insulin	Any time in the measurement year

Medication Adherence for Diabetes Medications - Best Practices

- Look for opportunities for mail-order, which may lower out -of-pocket expenses for patients.
- Improve health literacy. Talk with patients about why they're on a statin medication, and how it's important to take their medication as prescribed and get timely refills.
- Assess adherence barriers. Discuss medication adherence barriers at each visit and ask open-ended questions about concerns related to health benefits, side effects and cost.
- Discuss continued therapy. If ongoing therapy is appropriate, talk with patients about getting timely refills to prevent large gaps between fills. This is particularly important between the first and second fills to set up good habits for future fills.
    - Patients qualify for the measure with the second fill, but the measurement period starts with the date of the first fill.
    - Patients can't achieve 80% PDC when the allowable days they can miss in the year is less than zero. ADR must be zero or higher for a patient to be adherent.
- Consider extended days' supply prescriptions. When clinically appropriate, consider writing a 3-month supply of prescriptions for chronic conditions to help improve adherence and minimize frequent trips to the pharmacy – especially if getting to the pharmacy is an issue.
- Prescribe low-cost generics. When clinically appropriate, prescribe low-cost generic medications to help reduce out-of- pocket costs.
- Confirm instructions. Check that the directions on patients' prescriptions match your instructions. If the dose or frequency is changed, please void the old prescription and send a new one to the patient's pharmacy.

Medication Adherence for Hypertension (RAS Antagonists)

Definition

Percentage of patients ages 18 or older who adhere to their hypertension (RAS antagonist) medication at least 80% of the time in the measurement period.

Plans

- Medicare

Quality Programs

- CMS Star Ratings

Collection & Reporting Method

- Part D Claims
  - Pharmacy Data

Compliance

To comply with this measure, a patient must have a proportion of days covered (PDC) of 80 percent or higher for their hypertension (RAS antagonist) medication in the measurement period. RAS antagonist medications include:

- Angiotensin II receptor blockers (ARBs)
- Angiotensin-converting enzyme (ACE) inhibitors
- Direct renin inhibitors

Exclusions

The following exclusions will be accepted during the appropriate timeframe.

Exclusion	Timeframe
• Patients in hospice or using hospice services • Patient is Deceased • End Stage Renal Disease (ESRD): N18.5, N18.6, Z99.2 • Dialysis • One or more prescription claim for sacubitril/valsartan (Ernesto)	Any time in the measurement year

Medication Adherence for Diabetes Medications - Best Practices

- Look for opportunities for mail-order, which may lower out -of-pocket expenses for patients.
- Improve health literacy. Talk with patients about why they're on a statin medication, and how it's important to take their medication as prescribed and get timely refills.
- Assess adherence barriers. Discuss medication adherence barriers at each visit and ask open-ended questions about concerns related to health benefits, side effects and cost.
- Discuss continued therapy. If ongoing therapy is appropriate, talk with patients about getting timely refills to prevent large gaps between fills. This is particularly important between the first and second fills to set up good habits for future fills.
    - Patients qualify for the measure with the second fill, but the measurement period starts with the date of the first fill.
    - Patients can't achieve 80% PDC when the allowable days they can miss in the year is less than zero. ADR must be zero or higher for a patient to be adherent.
- Consider extended days' supply prescriptions. When clinically appropriate, consider writing a 3-month supply of prescriptions for chronic conditions to help improve adherence and minimize frequent trips to the pharmacy – especially if getting to the pharmacy is an issue.
- Prescribe low-cost generics. When clinically appropriate, prescribe low-cost generic medications to help reduce out-of- pocket costs.
- Confirm instructions. Check that the directions on patients' prescriptions match your instructions. If the dose or frequency is changed, please void the old prescription and send a new one to the patient's pharmacy.

Osteoporosis Management in Women Who Had a Fracture

Definition

Percentage of women 67 -85 years of age who suffered a fracture and had either a bone mineral density (BMD) or received a prescription to treat osteoporosis **within six months** after the fracture.
Fractures of the fingers, toes, face or skull are not included in this measure.

Plans
- Medicare

Quality Programs
- CMS Star Ratings

Collection & Reporting Method
- Administrative
  - Claim/Encounter Data
  - Pharmacy Data

Codes

The following codes can be used to close HEDIS gaps in care for this measure.

Bone Mineral Density Tests	
CPT/CPT II	76977, 77078, 77080, 77081, 77085, 77086
ICD-10 Procedure	BP48ZZ1, BP49ZZ1, BP4GZZ1, BP4HZZ1, BP4LZZ1BP4MZZ1, BP4NZZ1, BP4PZZ1, BQ00ZZ1, BQ01ZZ1, BQ03ZZ1, BQ04ZZ1, BR00ZZ1, BR07ZZ1., BR09ZZ1, BR0GZZ1
SNOMED	22059005, 312681000, 385342005, 391057001, 391058006, 391059003, 391060008, 391061007, 391062000, 391063005, 391064004, 391065003, 391066002, 391069009, 391070005, 391071009, 391072002, 391073007, 391074001, 391076004, 391078003, 391079006, 391080009, 391071008, 391082001, 440083004, 440099005, 440100002, 449781000, 707218004, 4211000179102
Osteoporosis Medication Therapy	
HCPCS	J0897, J1740, J3110, J3111, J3489
Long-Acting Osteoporosis Medications (during inpatient stay only)	
HCPCS	J0897, J1740, J3489
Dispensed at least one of the following medications within 180 days of fracture discharge:	
Bisphosphonates	Alendronate, Alendronate-cholecalciferol, Ibandronate, Risedronate, Zoledronic acid
Other Agents	Abaloparatide, Denosumab, Raloxifene, Romosozumab, Teriparatide

Osteoporosis Management in Women Who Had a Fracture - Exclusions

The following exclusions will be accepted during the appropriate timeframe.

Exclusion	Timeframe
• Patients in hospice or using hospice services • Patient is Deceased	Any time in the measurement year
Patient is receiving palliative care	During the intake period through the end of the measurement year.
Patients ages 81 and older as of December 31st of the measurement year who had at least 2 diagnoses of frailty.	Frailty - diagnoses must be on different dates of service during the intake period through the end of the measurement year
Patients 67-80, as of December 31st, who had at least two diagnoses of fraily (on different dates of service) and advanced illness.	Frailty - dx must be in the measurement year and on different dates of service Advanced Illness - dx must be in the measurement year or year prior to the measurement year
Medicare patients 67 and older, as of December 31st, who are either enrolled in an Institutional Special Needs Plan or living long term in an institution.	Any time in the measurement year
Patients who had a BMD test	24 months prior to the fracture
Patients who had osteoporosis therapy	12 months prior to the fracture
Patients who were dispensed a medication or had an active prescription for the medication to treat osteoporosis	12 months prior to the fracture

Osteoporosis Management in Women Who Had a Fracture - Best Practices

- Provide patients who have had a fracture with a referral for BMD testing and encourage them to obtain the screening **within six months**. Follow up with the patient to ensure the test was completed.
    - Review bone mineral density results and prescribe osteoporosis treatment when appropriate.
- If patients are unable or unwilling to have the BMD testing, prescribe osteoporosis medications, if appropriate.
- Discuss fall prevention annually:
    - Ask if your patient has any problems with balance or walking. If so, evaluate if they need an assistive device such as a cane or walker.
    - Suggest an exercise or balance program.
    - Ask if your patient has fallen in the past 12 months. If so, evaluate what led to the fall.
    - Discuss trip hazards such as loose carpets, poor lighting, uneven flooring, and cluttered walkways
    - Discuss fall preventative measures such as using night lights, wearing supportive shoes with grips or no slip socks, and installing grab bars.
    - Review medications to identify possible side effects that can increase risk.
    - Encourage annual vision and hearing checks.
- Discuss osteoporosis prevention with our patients including calcium and Vitamin D supplements, weight bearing exercises, and modifying risk factors.
- Remind patients to always tell their primary care provider about a fracture, even if they have received treatment elsewhere.
- Screen female patients starting at age 65 to reduce the risk of osteoporosis.
- Consider screening women younger than 65, if they are high risk. Some risk factors include low body weight, current tobacco use, excessive alcohol consumption, history of fractures, and glucocorticoid use.

Patient Satisfaction Surveys

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

This health plan survey is a multi-year survey that evaluates consumer/patient experiences. CAHPS results are used to compare data on patients' experience of care between health plans and prescription drug plans.

The example survey questions here use the Medicare and Medicaid look-back period of 6 months.
The questions for commercial patients use a 12-month look-back.

Frequency: Annually between February and June
Target Population: Medicare Advantage, commercial and Medicaid patients
Measurement Year Look-Back: 6 months for Medicare and Medicaid, 12 months for commercial

Annual Flu Vaccine

Survey Questions

- Have you had a flu shot since July 1 (of the previous year)?

Compliance / Intent

Weight = 1
Percentage of sampled Medicare enrollees who received an influenza vaccination. No patient exclusions exist for this measure.

Care Coordination

Survey Questions

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

Compliance / Intent

Weight = 2
Assesses how well patient care is coordinated, including whether or not doctors had the records and information they needed about patients' care and how quickly patients got their test results. No patient exclusions exist for this measure.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)
Continued

Getting Appointments and Care Quickly

Survey Questions

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

Compliance / Intent

Weight = 2
Assesses how quickly the patients were able to get appointments and care No patient exclusions exist for this measure.

Getting Needed Care

Survey Questions

- In the last six months, how often did you get an appointment to see a specialist as soon as you needed?
- In the last six months, how often was it easy to get the care, tests or treatment you needed?

Compliance / Intent

Weight = 2
Assesses how easy it was for patients to get needed care and see specialists No patient exclusions exist for this measure.

Rating of Health Care

Survey Questions

- Using any number from 0 to 10, with 0 being the worst healthcare possible and 10 being the best healthcare possible, what number would you use to rate all of your healthcare in the last six months?

Compliance / Intent

Weight = 2
Assesses patients' view of the quality of the healthcare they received No patient exclusions exist for this measure.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)
Continued

Rating of Personal Doctor - Commercial and Medicaid Only

Survey Questions

- Using any number from 0 to 10, where 0 is the worst personal doctor possible and 10 is the best personal doctor possible, what number would you use to rate your personal doctor?

Compliance / Intent

This measure is used to assess the overall view members have of their personal doctor.

Rating of Specialist Seen Most Often - Commercial and Medicaid Only

Survey Questions

- We want to know your rating of the specialist you saw most often. Using any number from 0 to 10, where 0 is the worst specialist possible and 10 is the best specialist possible, what number would you use to rate that specialist?

Compliance / Intent

This measure is used to assess the overall view members have of the specialist they see most often.

Health Outcomes Survey (HOS)

This health plan patient survey is used to gather valid, reliable and clinically meaningful health status data in the Medicare Advantage program for use in quality improvement activities, pay for performance, program oversight, public reporting and improving health. All managed care organizations with Medicare Advantage contracts must participate. The survey looks at physical and mental health outcomes measures, urinary incontinence in older adults, physical activity in older adults, fall risk management, and osteoporosis testing in older women.

Frequency: Annually between July and November
Target Population: Medicare Advantage

Improving Bladder Control

Survey Questions

- Many people experience leakage of urine, also called urinary incontinence. In the past six months, have you experienced leaking of urine?
- During the past six months, how much did leaking of urine make you change your daily activities or interfere with your sleep?
- Have you ever talked with a doctor, nurse or other healthcare provider about leaking of urine?
- There are many ways to control or manage the leaking of urine, including bladder training exercises, medication and surgery. Have you ever talked with a doctor, nurse or other healthcare provider about any of these approaches?

Compliance / Intent

Weight = 1
Percentage of surveyed patients 65 years old and older who reported having any urine leakage in the past six months and who discussed treatment options for their urinary incontinence with a provider. Exclusion - patients in hospice.

Improving or Maintaining Mental Health

Survey Questions

- During the past four weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?
  - Accomplished less than you would like as a result of any emotional problems
  - Didn't do work or other activities as carefully as usual as a result of any emotional problems
- How much of the time during the past four weeks:
  - Have you felt calm and peaceful?
  - Did you have a lot of energy?
  - Have you felt downhearted and blue?
- During the past four weeks, how much of the time has your physical health or any emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?

Compliance / Intent

Weight = 1
Percentage of sampled Medicare enrollees 65 years old and older whose mental health status was the same or better than expected after two years No patient exclusions exist for this measure.

Health Outcomes Survey (HOS) *Continued*

Improving or Maintaining Physical Health

Survey Questions

- The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?
  - Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling or playing golf?
  - Climbing several flights of stairs?
- During the past four weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?
  - Accomplished less than you would like as a result of your physical health?
  - Were limited in the kind of work or other activities as a result of your physical health?
- During the past four weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

Compliance / Intent

Weight = 1
Percentage of sampled Medicare enrollees 65 years old and older whose physical health status was the same or better than expected after two years. No patient exclusions exist for this measure.

Monitoring Physical Activity

Survey Questions

- In the past 12 months, did you talk with a doctor or other health provider about your level of exercise or physical activity? For example, a doctor or other health provider may ask if you exercise regularly or take part in physical exercise.
- In the past 12 months, did a doctor or other health provider advise you to start, increase or maintain your level of exercise or physical activity? For example, in order to improve your health, your doctor or other health provider may advise you to start taking the stairs, increase walking from 10 to 20 minutes every day or to maintain your current exercise program.

Compliance / Intent

Weight = 1
Percentage of sampled Medicare patients 65 years old and older who had a doctor's visit in the past 12 months and who received advice to start, increase or maintain their level of exercise or physical activity
Exclusions - • Patients in hospice • Patients responding, "I had no visits in the past 12 months"

Health Outcomes Survey (HOS) *Continued*

Reducing the Risk of Falling

Survey Questions

- A fall is when your body goes to the ground without being pushed. In the past 12 months, did you talk with your doctor or other health provider about falling or problems with balance or walking?
- Did you fall in the past 12 months?
- In the past 12 months, have you had a problem with balance or walking?
- Has your doctor or other health provider done anything to help prevent falls or treat problems with balance or walking? Some things they might do include:
    - Suggest that you use a cane or walker
    - Suggest that you do an exercise or physical therapy program
    - Suggest a vision or hearing test

Compliance / Intent

Weight = 1
Percentage of Medicare patients 65 years old and older who had a fall or had problems with balance or walking in the past 12 months and who received a recommendation for how to prevent falls or treat problems with balance or walking from their current practitioner. Exclusion - • Patients in hospice and answering, “I had no visits in the past 12 months”

Persistence of Beta-Blocker Treatment After a Heart Attack

Definition

The percentage of patients ages 18 and older during the measurement year who were hospitalized and discharged from July 1 of the year prior to the measurement year to June 30 of the measurement year with a diagnosis of AMI and who received persistent beta-blocker treatment for 6 months after discharge. (Persistent beta-blocker treatment: at least 135 days during 180 days post discharge.)

Plans

- Commercial
- Medicaid
- Medicare

Quality Programs

- Select Medicaid State Reportng

Collection & Reporting Method

- Administrative
  - Claim/Encounter Data
  - Pharmacy Data

Medications

To comply with this measure, a patient must have completed a 135-day course of one of the following beta-blockers:

Drug Category	Medication
Non-cardioselective beta-blockers	• Carvedilol • Labetalol • Nadolol • Pindolol • Propranolol • Timolol • Sotalol
Cardioselective beta-blockers	• Acebutolol • Atenolol • Betaxolol • Bisoprolol • Metoprolol • Nebivolol
Antihypertensive combinations	• Atenolol-chlorthalidone • Bendroflumethiazide-nadolol • Bisoprolol-hydrochlorothiazide • Hydrochlorothiazide-metoprolol • Hydrochlorothiazide-propranolol

Persistence of Beta-Blocker Treatment After a Heart Attack - Exclusions

The following exclusions will be accepted during the appropriate timeframe.

Exclusion	Timeframe
• Patients in hospice or using hospice services • Patient is Deceased	Any time in the measurement year
• Asthma • Chronic obstructive pulmonary disease (COPD) • Chronic respiratory conditions due to fumes/vapors • Hypotension, heat block > 1 degree or sinus bradycardia • Intolerance or allergy to beta-blocker therapy • Medication dispensing event indicative of a history of asthma (see list below) • Obstructive chronic bronchitis	Any time in the measurement year or the year prior
Patients 66 and older, as of December 31st, who had at least two diagnoses of frailty (on different dates of service) and advanced illness. Advanced Illness is indicated by the following: • Two or more outpatient, observation, emergency room, telephone, e-visits, virtual check-ins, or non-acute inpatient encounters or discharge(s) on separate dates of services with dx of advanced illness. • One or more acute inpatient encounter(s) with a dx of advanced illness • One or more acute inpatient discharge(s) with a dx of advanced illness on the dx claim • Dispensed a dementia medication: Donepezil, Donepezil-memantine, galantamine, rivastigmine or memantine	Frailty - dx must be in the measurement year and on different dates of service Advanced Illness - dx must be in the measurement year or year prior to the measurement year
Medicare patients 66 and older, as of December 31st, who are either enrolled in an Institutional Special Needs Plan or living long term in an institution. Patients 81 and older, as of December 31st of the measurement year who had at least two diagnoses of frailty on different dates of service.	Any time on or between July 1st of the year prior to the measurement year through the end of the measurement year.

Any of the following asthma medications dispensed during the patient's history through the end of their continuous enrollment period denote a history of asthma as a required exclusion:

Drug Category	Medication
Bronchodilator combinations	• Budesonide-formoterol • Fluticasone-vilanterol • Fluticasone-salmeterol • Formoterol-mometasone
Inhaled corticosteroids	• Beclomethasone • Budesonide • Ciclesonide • Flunisolide • Fluticasone • Mometasone

Persistence of Beta-Blocker Treatment After a Heart Attack - Best Practices

- As an administrative measure, it's important to submit codes that reflect a patient's history of any exclusion noted in the preceding chart.
    - If a patient is new to your practice, you can submit the exclusion diagnoses through the initial visit claim.
    - If a patient isn't new to your practice, but their chart has documented history of 1 of the exclusion diagnoses, you can submit the diagnosis codes on any visit claim.
- At each office visit, please talk with your patients about compliance and/or barriers to taking their medications and encourage adherence.
- Please review your patients' prescription refill patterns and reinforce education and reminders. Consider:
    - Which patients don't fill prescriptions, are always late to fill or quit refilling over time?
    - Which patients are already motivated to fill and refill, but may skip an occasional dose and simply need reminders?

Statin Therapy for Patients with Cardiovascular Disease

Definition

Percentage of males ages 21–75 and females ages 40–75 during the measurement year who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and met the following criteria:

- Received statin therapy – Patients who were dispensed at least 1 high- or moderate-intensity statin education during the measurement year
- Statin adherence 80% - Patients who remained on a high- or moderate-intensity statin medication for at least 80% of the treatment period.

Note: This adherence component does NOT apply to CMS Star Ratings for Medicare patients; only the "Received statin therapy" component is required to be compliant for the SPC Star Measure.

Plans

- Commercial
- Medicaid
- Medicare

Quality Programs

- CMS Star Ratings
- NCQA Accreditation
- NCQA Health Plan Ratings

Collection & Reporting Method

- Administrative
  - Claim/Encounter Data
  - Pharmacy Data

Medications

To comply with this measure, one of the following medications must have been dispensed:.

Drug Category	Medication	
High-intensity statin therapy	• Atorvastatin 40–80 mg • Amlodipine-atorvastatin 40–80 mg • Rosuvastatin 20–40 mg • Simvastatin 80 mg • Ezetimibe-simvastatin 80 mg	
Moderate-intensity statin therapy	• Atorvastatin 10–20 mg • Amlodipine-atorvastatin 10–20 mg • Rosuvastatin 5–10 mg • Simvastatin 20–40 mg • Ezetimibe-simvastatin 20–40 mg	• Pravastatin 40–80 mg • Lovastatin 40 mg • Fluvastatin 40–80 mg • Pitavastatin 1–4 mg

Statin Therapy - Cardiovascular Disease - Exclusions

The following exclusions will be accepted during the appropriate timeframe.

Exclusion	Timeframe
• Patients in hospice or using hospice services • Patient is Deceased • Patient is receiving palliative care • Myalgia, myositis, myopathy or rhabdomyolysis diagnosis	Any time in the measurement year
• Cirrhosis • Dispensed at least one prescription for clomiphene • End Stage Renal Disease (ESDR) • Dialysis • Patients with a diagnosis of pregnancy • In vitro fertilization	Any time in the measurement year or the year prior
Patients 66 and older, as of December 31st, who had at least two diagnoses of frailty (on different dates of service) and advanced illness. Advanced Illness is indicated by the following: • Two or more outpatient, observation, emergency room, telephone, e-visits, virtual check-ins, or non-acute inpatient encounters or discharge(s) on separate dates of services with dx of advanced illness. • One or more acute inpatient encounter(s) with a dx of advanced illness • One or more acute inpatient discharge(s) with a dx of advanced illness on the dx claim • Dispensed a dementia medication: Donepezil, Donepezil-memantine, galantamine, rivastigmine or memantine	Frailty - dx must be in the measurement year and on different dates of service Advanced Illness - dx must be in the measurement year or year prior to the measurement year
Medicare patients 66 and older, as of December 31st, who are either enrolled in an Institutional Special Needs Plan or living long term in an institution.	Any time in the measurement year

Statin Therapy - Cardiovascular Disease - Best Practices

- Educate patients on the importance of complying with statin therapy during every communication
- Simplify the medication regimen by using once-daily dosing, if possible
- Listen to patients' concerns and make them an active part of shared-decision making
- Routinely arrange the next appointment for consistent follow-up and monitoring
- Consider prescribing a high- or moderate-intensity statin, as appropriate. If you determine medication is appropriate, please send a prescription to the patient's preferred pharmacy.
    - To address the SPC care opportunity, a patient must use their insurance card to fill one of the statins or statin combinations in the strengths/doses listed in the "Medications" table on the previous page by the end of the measurement year.

Statin Therapy for Patients with Diabetes

Definition

Percentage of patients ages 40–75 during the measurement year with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) who met the following criteria:

- Received statin therapy – Patients who were dispensed at least 1 statin medication of any intensity during the measurement year
- Statin adherence 80% - Patients who remained on a statin medication of any intensity for at least 80% of the treatment period

Note: The treatment period is defined as the earliest prescription dispensing date in the measurement year for any statin medication at any intensity through the last day of the measurement year.

Plans

- Commercial
- Medicaid
- Medicare

Quality Programs

- NCQA Accreditation
- NCQA Health Plan Ratings

Collection & Reporting Method

- Administrative
  - Claim/Encounter Data
  - Pharmacy Data

Medications

To comply with this measure, one of the following medications must have been dispensed:.

Drug Category	Medication	
High-intensity statin therapy	• Atorvastatin 40–80 mg • Amlodipine-atorvastatin 40–80 mg • Rosuvastatin 20–40 mg • Simvastatin 80 mg • Ezetimibe-simvastatin 80 mg	
Moderate-intensity statin therapy	• Atorvastatin 10–20 mg • Amlodipine-atorvastatin 10–20 mg • Rosuvastatin 5–10 mg • Simvastatin 20–40 mg • Ezetimibe-simvastatin 20–40 mg	• Pravastatin 40–80 mg • Lovastatin 40 mg • Fluvastatin 40–80 mg • Pitavastatin 1–4 mg
Low-intensity statin therapy	• Ezetimibe-simvastatin 10 mg • Fluvastatin 20 mg • Lovastatin 10–20 mg	• Pravastatin 10–20 mg • Simvastatin 5–10 mg

Statin Therapy - Diabetes - Exclusions

The following exclusions will be accepted during the appropriate timeframe.

Exclusion	Timeframe
• Patients in hospice or using hospice services • Patient is Deceased • Patient is receiving palliative care • Myalgia, myositis, myopathy or rhabdomyolysis diagnosis • Medicare patients ages 66 and older as of Dec. 31 of the measurement year who are either: – Enrolled in an Institutional Special Needs Plan (I-SNP) – Living long term in an institution*	Any time in the measurement year
Patients 66 and older, as of December 31st, who had at least two diagnoses of frailty (on different dates of service) and advanced illness. Advanced Illness is indicated by the following: • Two or more outpatient, observation, emergency room, telephone, e-visits, virtual check-ins, or non-acute inpatient encounters or discharge(s) on separate dates of services with dx of advanced illness. • One or more acute inpatient encounter(s) with a dx of advanced illness • One or more acute inpatient discharge(s) with a dx of advanced illness on the dx claim • Dispensed a dementia medication: Donepezil, Donepezil-memantine, galantamine, rivastigmine or memantine	Frailty - dx must be in the measurement year and on different dates of service Advanced Illness - dx must be in the measurement year or year prior to the measurement year
• Cirrhosis • Dispensed at least one prescription for clomiphene • End Stage Renal Disease (ESDR) • Dialysis • Patients with a diagnosis of pregnancy • In vitro fertilization • Patients without a diagnosis of diabetes who had a diagnosis of polycystic ovarian syndrome, gestational diabetes or steroid-induced diabetes	Any time during the measurement year or the year prior
• Coronary artery bypass grafting (CABG) • Myocardial infarction • Other revascularization procedure • Percutaneous coronary intervention (PCI)	Any time during the year prior to the measurement year
A diagnosis of ischemic vascular disease (IVD) via outpatient visit, telephone visit, e-visit or virtual check-in, acute inpatient encounter without telehealth modifier or acute inpatient discharge	Any time during the year prior to the measurement year and the measurement year (must be in both years)

Statin Therapy - Diabetes - Best Practices

- Educate patients on the importance of complying with statin therapy during every communication
- Simplify the medication regimen by using once-daily dosing, if possible
- Listen to patients' concerns and make them an active part of shared-decision making
- Routinely arrange the next appointment for consistent follow-up and monitoring
- Consider prescribing the statin, as appropriate. If you determine medication is appropriate, please send a prescription to the patient's preferred pharmacy.
    - To address the SPC care opportunity, a patient must use their insurance card to fill one of the statins or statin combinations in the strengths/doses listed in the "Medications" table on the previous page by the end of the measurement year.

Use of Imaging Studies for Low Back Pain

Definition

Percentage of patients ages 18–75 with a principal diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis.
This measure is reported as an inverted measure and a higher score indicates appropriate treatment of low back pain, where imaging studies did not occur.

Plans

- Commercial
- Medicaid
- Medicare

Quality Programs

- CMS Quality Rating System
- NCQA Accreditation
- NCQA Health Plan Ratings

Collection & Reporting Method

- Administrative
  - Claim/Encounter Data

Codes

The following codes are imaging studies that should be avoided with a diagnosis of uncomplicated low back pain.

Imaging Studies	
CPT/CPT II	72020, 72052, 72100, 72110, 72114, 72120, 72131, 72132, 72133, 72141, 72142, 72146, 72147,72148, 72149, 72156, 72158, 72200, 72202, 72220
SNOMED	2847006, 6238009, 6728003, 7812007, 21613005, 22791004, 24856003, 26537001, 35443000, 41333006,45554006, 46700000, 47987001, 48816001, 57235004, 60443006, 61368000, 66769009, 68862002, 72508000, 79760008, 86392000, 90523008, 90805008, 91333005, 91583001, 168573004, 168588009, 241092006, 241093001, 241094007, 241580002, 241592002, 241596004, 241646009, 241647000, 241648005, 276478001, 303935004, 419942003, 429860003, 429868005, 429871002, 430021001, 430507007, 431250008, 431496002, 431557005, 431613003, 431871005, 431892005, 432078003, 432244001, 432770001, 433140006, 433141005, 440450002, 443580006, 444634007, 448641007, 700319007, 700320001, 700321002, 702487007, 702488002, 702513003, 702514009, 702515005, 702516006, 702521009, 702522002, 702523007, 702607002, 702608007, 709652000, 709653005, 709698004, 711104001, 711184004, 711186002, 711224009, 711271003, 712970008, 713016000, 715290001, 715458009, 716830000, 717912001, 718542005, 718545007, 723646000, 726546000, 772220000, 783627007, 840361000, 868279006, 3721000087104, 3731000087102, 14871000087107, 17141000087101, 39445000119106, 396171000119100, 411571000119106, 411611000119102, 413001000119107, 495741000119105, 571891000119109, 572091000119106, 16328021000119109, 16384831000119100, 16554061000119109

Use of Imaging Studies for Low Back Pain - Exclusions

The following exclusions will be accepted during the appropriate timeframe.

Exclusion	Timeframe
• Patients in hospice or using hospice services • Patient is Deceased • Patient is receiving palliative care	Any time in the measurement year
Patients 66 and older, as of December 31st, who had at least two diagnoses of frailty (on different dates of service) and advanced illness. Advanced Illness is indicated by the following: • Two or more outpatient, observation, emergency room, telephone, e-visits, virtual check-ins, or non-acute inpatient encounters or discharge(s) on separate dates of services with dx of advanced illness. • One or more acute inpatient encounter(s) with a dx of advanced illness • One or more acute inpatient discharge(s) with a dx of advanced illness on the dx claim • Dispensed a dementia medication: Donepezil, Donepezil-memantine, galantamine, rivastigmine or memantine	Frailty - dx must be in the measurement year and on different dates of service Advanced Illness - dx must be in the measurement year or year prior to the measurement year
Any patient who had a diagnosis where imaging is clinically appropriate including:	
• Cancer • HIV • Major organ transplant • Osteoporosis or osteoporosis therapy • Lumbar Surgery • Spondylopathy	Any time during a patient's history through 28 days after the principal diagnosis of low back pain between Jan. 1- Dec. 3 of the measurement year.
• Recent trauma • Fragility fractures	Any time 90 days prior to or 28 days after the principal diagnosis of low back pain between Jan. 1 - Dec. 3 of the measurement year.
Prolonged use of corticosteroids - 90 consecutive days of corticosteroid treatment	Dispensed any time 12 months prior to the principal diagnosis of low back pain between Jan. 1 - Dec. 3 of the measurement year
• Intravenous drug abuse • Neurologic impairment • Spinal Infection	Any time 12 months prior to or 28 days after the principal diagnosis of low back pain between Jan. 1 – Dec. 3 of the measurement year

Use of Imaging Studies for Low Back Pain - Important Notes

Notes	Test/Service/Procedure	Medical Record (including, but not limited to)
The imaging studies listed in the column at right are not clinically appropriate for a diagnosis of uncomplicated low back pain.	• CT scan • MRI • Plain X-ray	
The principal diagnosis of uncomplicated low back pain can come from any of the services listed in the column at right for a patient to be included in this measure.		• E-visit or virtual check-in • Osteopathic or chiropractic manipulative treatment • Outpatient visit • Physical therapy visit • Telephone visit

Use of Opioids at High Dosage

Definition

Percentage of patients ages 18 and older receiving prescription opioids for ≥ 15 days during the measurement year at a high dosage (average milligram morphine equivalent [MME] dose ≥ 90 mg). A lower rate indicates a better score for this measure.

Plans

- Commercial
- Medicaid
- Medicare

Quality Programs

- NCQA Accre
- NCQA Health Plan Ratings

Collection & Reporting Method

- Administrative
  - Claim/Encounter
  - Pharmacy Data

Medications

To be included in this measure, a patient must have been prescribed one of the following opioid medications at an average MME ≥ 90 mg for ≥ 15 days:

- Benzhydrocodone
- Butorphanol
- Codeine
- Dihydrocodeine
- Fentanyl oral spray
- Fentanyl buccal or sublingual tablet, transmucosal lozenge
- Fentanyl transdermal film/patch
- Fentanyl nasal spray
- Hydrocodone
- Hydromorphone
- Levorphanol
- Meperidine
- Methadone
- Morphine
- Opium
- Oxycodone
- Oxymorphone
- Pentazocine
- Tapentadol
- Tramadol

These medications are not included as dispensing events for this measure:

- Cough and cold products with opioids
- Injectables
- Ionsys®
  - Fentanyl transdermal patch used in inpatient settings only
- Methadone for the treatment of opioid use disorder

Use of Opioids at High Dosage - Exclusions

The following exclusions will be accepted during the appropriate timeframe.

Exclusion	Timeframe
• Patients in hospice or using hospice services • Patients receiving palliative care • Patient is Deceased • Cancer • Sickle cell disease	Any time in the measurement year

Best Practices

- This measure focuses on using low dosage for opioids.
  - For treatment of acute pain using opioids, the guidelines recommend immediate-release opioids be used at a dosage as low as possible and for as few days as needed.
  - For treatment of chronic pain, guidelines recommend clinicians consider non-pharmacologic and non-opioid therapies first, and only in cases where the benefits outweigh the risks, initiation of opioid therapy.
- Information to help you stay informed about the latest opioid research and guidelines is also available at cdc.gov, hhs.gov or the Arkansas public health department website. Here are a few suggestions to get you started:
  - Prevention • Centers for Disease Control and Prevention (CDC) Guideline for Prescribing Opioids for Chronic Pain available at: cdc.gov > CDC A - Z INDEX > D > Drug Overdose (OD) > Healthcare Providers > CDC's opioid prescribing guideline for chronic pain • U.S. Department of Health & Human Services (HHS) Prevent Opioid Abuse and Addiction available at: hhs.gov/opioids > Prevention
  - Treatment • Substance Abuse and Mental Health Services Administration (SAMHSA) Medication-Assisted Treatment (MAT) available at: samhsa.gov > Programs & Campaigns > Medication-Assisted Treatment • National Institute on Drug Abuse (NIDA) Effective Treatments for Opioid Addiction available at: drugabuse.gov > Drugs of Abuse > Opioids > Effective Treatments for Opioid Addiction • HHS Treatment for Opioid Use Disorder available at: hhs.gov/opioids > Treatment • American Society of Addiction Medicine (ASAM) Educational Resources available at: asam.
  - AR Act 651 of 2021 requires naloxone to be co-prescribed in certain situations, including when the opioid dosage is 50 or more morphine milligram equivalents; when a benzodiazepine has been prescribed in the past year; or the patient has a history of opioid use disorder, substance use disorder or drug overdose..

Well Child Visits in the First 30 Months of Life

Definition

Percentage of patients who turned 15–30 months old during the measurement year and had the recommended number of well-child visits with a primary care provider.

- Children 0-15 months old during the measurement year: 6 or more well-child visits in the first 15 months of life.
- Children 15-30 months old during the measurement year: 2 or more well-child visits between 15–30 months of age.

Plans

- Commercial
- Medicaid
- Medicare

Quality Programs

- CMS Quality Rating System
- Select Medicaid State Reporting

Collection & Reporting Method

- Administrative
  - Claim/Encounter Data

Codes

The following codes can be used to close the gaps for well child visits in the first 30 months of life.

Well-Care Visits	
CPT/CPT II	99381, 99382, 99383, 99384, 99385, 99391, 99392, 99393, 99394, 99395, 99461
HCPCS	G0438, G0439, S0302, S0610, S061, S0613
ICD - 10 Diagnosis	Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.2, Z00.3, Z01.411, Z01.419, Z02.5 Z76.1, Z76.2
SNOMED	103740001, 170099002, 170107008, 170114005, 170123008, 170132005, 170141000, 170150003, 170159002, 170168000, 170250008, 170254004, 170263002, 170272005, 170281004, 170290006, 170300004, 170309003, 171387006, 171394009, 171395005, 171409007, 171410002, 171416008, 171417004, 243788004, 268563000, 270356004, 401140000, 410620009, 410621008, 410622001, 410623006, 410624000, 410625004, 410626003, 410627007, 410628002, 410629005, 410630000, 410631001, 410632008, 410633003, 410634009, 410635005, 410636006, 410637002, 410638007, 410639004, 410640002, 410641003, 410642005, 410643000, 410644006, 410645007, 410646008, 410647004, 410648009, 410649001, 410650001, 442162000, 783260003, 444971000124105, 446301000124108, 446381000124104, 669251000168104, 669261000168102, 669271000168108, 669281000168106

Well Child Visits in the First 30 Months of Life - Exclusions

The following exclusions will be accepted during the appropriate timeframe.

Exclusion	Timeframe
• Patients in hospice or using hospice services • Patient is Deceased	Any time in the measurement year

Best Practices

- If provider is seeing a patient for Evaluation and Management (E/M) services and all well-child visit components are completed: Attach modifier 25 or 59 to the well-child procedure code so it's reviewed as a significant, separately identifiable procedure.
    - Modifier 25 is used to indicate a significant and separately identifiable evaluation and management (E/M) service by the same physician on the same day another procedure or service was performed.
    - Modifier 59 is used to indicate that 2 or more procedures were performed at the same visit, but to different sites on the body.
- Helpful resources about the components of care are available at brightfutures.aap.org.