

HEDIS® 2025

Documentation and Coding Guidelines



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EFFECTIVENESS OF CARE: PREVENTION AND SCREENING

Measure	Measure Description	Measure Information/Documentation Required	Coding
Care for Older Adults (COA)	Adults 66 years of age and older who had each of the following during the MY: - Medication review. - Functional Status Assessment (FSA). - Pain Assessment.	Medication Review: A review conducted by a prescribing practitioner or clinical pharmacist in the MY. The member does not need to be present for the medication review. Any of the following are acceptable: - The presence of a medication list in the medical record with notation of the date reviewed. - Dated notation that member is not taking any medications. - Transitional care management services documented during the MY. - Criteria is not met if review performed by an RN. Functional Status Assessment: At least one functional status assessment during the MY and the date it was performed. Functional status assessment must include one of the following: - Notation that Activities of Daily Living (ADLs) were assessed or that at least five of the following were assessed: bathing, dressing, eating, transferring (e.g., getting in and out of chairs), using toilet, walking.	Functional Status Assessment: CPT: 99483 CPT-CAT-II: 1170F HCPCS: G0438, G0439 Pain Assessment: CPT-CAT-II: 1125F, 1126F Medication Review (with Medication List): CPT: 90863, 99483, 99605, 99606 CPT-CAT-II: 1160F Medication List (with Medication Review): CPT-CAT-II: 1159F HCPCS: G8427 Transitional Care Management: CPT: 99495, 99496 <i>Note: LOINC and SNOMED codes can be captured through electronic data submissions. Please contact your Account Executive for more information.</i>

	• Notation that Instrumental Activities of Daily Living (IADLs) were assessed or at least four of the following were assessed: shopping for groceries, driving or using public transportation, using the telephone, cooking or meal preparation, housework, home repair, laundry, taking medications, handling finances. • Result of an assessment using a standardized functional status assessment tool. • Criteria is not met by a fall assessment. Pain Assessment: At least one pain assessment during the MY and the date it was performed. • Documentation that the patient was assessed for pain (which may include positive or negative findings for pain). • Result of assessment using a standardized pain assessment tool. • Criteria is not met by notation of only a pain management plan or only a pain treatment plan. • Criteria is not met by notation of only screening for chest pain or only documentation of chest pain. Note: • Telephone, e-visit, or virtual check-in visits are acceptable for FSA and pain assessment. • Exclude services provided in an acute inpatient setting. Required Exclusions: Members who meet any of the following criteria are excluded from the measure:	
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		• In hospice or using hospice services any time in the MY. • Deceased at any time in the MY. Common Chart Deficiencies: • Medication Review: Medication review completed by RN. • FSA: Documentation referencing patient living alone but not specifically that patient can perform ADLs or IADLs. • FSA: Documentation of “normal” under review of systems without specifically addressing ADLs/IADLs. • FSA: A functional status assessment limited to an acute or single condition, event, or body system. • Pain: Patient not assessed for pain at visit. • Pain: Diagnosis or medication related to pain or pain management plan but no documentation of pain assessment.	
Measure	Measure Description	Measure Information/Documentation Required	Coding
Chlamydia Screening (CHL)	Members 16 – 24 years of age who were recommended for routine chlamydia screening, were identified as sexually active and who had at least one test for chlamydia during the MY.	Perform chlamydia screening each year on every 16- to 24-year-old member recommended for routine chlamydia screening and identified as sexually active. Chlamydia screening can be performed through a urine test. Required Exclusions: Members who meet any of the following criteria are excluded from the measure: • In hospice or using hospice services any time in the MY. • Deceased at any time in the MY.	Chlamydia Tests: CPT: 87110, 87270, 87320, 87490, 87491, 87492, 87810 <i>Note: LOINC and SNOMED codes can be captured through electronic data submissions. Please contact your Account Executive for more information.</i>

		• A pregnancy test in the MY and a prescription for isotretinoin (Retinoid) on the date of the pregnancy test or 6 days after the pregnancy test. • A pregnancy test in the MY and an X-ray on the date of the pregnancy test or the 6 days after the pregnancy test. Common Chart Deficiencies: • Not collecting/testing urine sample routinely at well-visits. • Criteria is not met by notation of parental/patient refusal. • Criteria is not met by notation that patient is not sexually active.	
Measure	Measure Description	Measure Information/Documentation Required	Coding
Lead Screening Children (LSC)	Children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning at any time by their 2nd birthday.	Documentation in the medical record must include both of the following on or before the 2nd birthday: • A note indicating the date the test was performed. • The result or finding. Required Exclusions: Members who meet any of the following criteria are excluded from the measure: • In hospice or using hospice services any time in the MY. • Deceased at any time in the MY. Common Chart Deficiencies: • Lab results not documented in the record. • Documentation of result as “unknown.” • Documentation of a lead assessment versus a lead screening. • Lead screening not ordered, not completed, or result not documented. • Lead screening after the child’s 2nd birthday.	Lead Tests: CPT: 83655 <i>Note: LOINC and SNOMED codes can be captured through electronic data submissions. Please contact your Account Executive for more information.</i>

		Results of screening performed at an outside lab, health department, or WIC office not included in record.	
Measure	Measure Description	Measure Information/Documentation Required	Coding
Oral Evaluation, Dental Services (OED)	Members under 21 years of age who received a comprehensive or periodic oral evaluation with a dental provider during the measurement year (MY).	Documentation in the medical record must contain evidence of a comprehensive or periodic oral evaluation by a dental provider. Dental providers include dentist, dental hygienist, dental assistant, dental therapist, endodontist, denturist, oral medicinist, oral/maxillofacial dentist/surgeon. Required Exclusions: Members who meet any of the following criteria are excluded from the measure: - In hospice or using hospice services any time in the MY. - Deceased at any time in the MY.	CDT: D0120, D0145, D0150 Dental Provider Taxonomy: 122300000X, 1223D0001X, 1223D0004X, 1223E0200X, 1223G0001X, 1223P0106X, 1223P0221X, 1223P0300X, 1223P0700X, 1223S0112X, 1223X0008X, 1223X0400X, 1223X2210X, 122400000X, 124Q00000X, 125J00000X, 125K00000X, 125Q00000X, 126800000X, 204E00000X, 261QD0000X, 261QF0400X, 261QR1300X, 261QS0112X
Measure	Measure Description	Measure Information/Documentation Required	Coding
Topical Fluoride for Children (TFC)	Members 1 – 4 years of age who received at least two fluoride varnish applications during the measurement year (MY).	Application of fluoride varnish on two different dates of service in the MY. Required Exclusions: Members who meet any of the following criteria are excluded from the measure: - In hospice or using hospice services any time in the MY. - Deceased at any time in the MY.	CDT: 99188, D1206
Measure	Measure Description	Measure Information/Documentation Required	Coding
Weight Assessment and Counseling for Nutrition and Physical Activity for	Members 3 – 17 years of age who had an outpatient visit with a	BMI Percentile: Documentation must include height, weight, and BMI percentile during the MY.	BMI Percentile: ICD10CM: Z68.51, Z68.52, Z68.53, Z68.54

Children/Adolescents (WCC)	PCP or OB/GYN and who had evidence of each of the following during the MY: • BMI percentile documentation. • Counseling for nutrition. • Counseling for physical activity.	• The height, weight, and BMI must be from the same data source. • BMI percentile can be documented as a value or plotted on an age-growth chart. • Member-reported values (weight, height, BMI) can be captured during a telephone visit, e-visit, or virtual check-in. Counseling for Nutrition: Documentation of counseling for nutrition or referral for nutrition education during the MY. Examples include: • Discussion of current nutrition behaviors (e.g., eating habits, dieting behaviors). • Checklist indicating nutrition was addressed. • Member received educational materials on nutrition during a face-to-face visit. • Anticipatory guidance for nutrition. • Weight or obesity counseling. • Referral to the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). Counseling for Physical Activity: Documentation of counseling for physical activity or referral for physical activity during the MY. Examples include: • Checklist indicating physical activity was addressed. • Member received educational materials on physical activity during a face-to-face visit. • Anticipatory guidance for physical activity or weight/obesity counseling. • Weight or obesity counseling. • Discussion of current physical activity (e.g., sports activities, exercise routines). • Exam for sport participation/sports physical.	Nutrition Counseling: CPT: 97802, 97803, 97804 HCPCS: G0270, G0271, G0447, S9449, S9452, S9470 ICD10CM: Z71.3 Physical Activity Counseling: HCPCS: G0447, S9451 Encounter for Physical Activity Counseling: Z02.5, Z71.82 <i>Note: LOINC and SNOMED codes can be captured through electronic data submissions. Please contact your Account Executive for more information.</i>
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Notes:

- Services may be rendered during a visit other than a well-child visit; however, services specific to the assessment or treatment of an acute or chronic condition do not count toward the “Counseling for Nutrition” and “Counseling for Physical Activity” indicators.
- Services may be delivered during a telephone visit, e-visit, or virtual check-in. This includes member-reported data (e.g., height, weight, BMI) documented in the chart.

Required Exclusions:

Members who meet any of the following criteria are excluded from the measure:

- In hospice or using hospice services any time in the MY.
- Deceased at any time in the MY.
- Diagnosis of pregnancy during the MY.

Common Chart Deficiencies:

- Height, weight, and BMI percentile not documented *each* year.
- BMI documented as a value and not as a percentile.
- BMI percentile documented as a range or threshold.
- BMI documented on an appropriate age-growth chart but without name, DOB, or discernible DOS on the chart.
- BMI documented on weight or stature for age charts.
- Documentation of developmental milestones without notation of anticipatory guidance or education for physical activity.

		• Missing counseling/education on physical activity and/or nutrition. • Notation of “health education” or “anticipatory guidance” without specific mention of nutrition and/or physical activity. • Counseling on safety (e.g., “wears helmet” or “water safety”) without specific mention of physical activity recommendations. • Notation solely related to “screen time” without specific mention of physical activity recommendations. • Documentation of diet or appetite “regular” or “good” without notation of counseling. • Notation of encouragement to follow “healthy lifestyle” without specific mention of physical activity and/or nutrition. • Screening forms/checklists that are not completed or do not have specific references to nutrition and/or physical activity. • Documentation specific to the assessment or treatment of an acute or chronic condition (e.g., discussion of diet related for a child with diarrhea). • Well-child services delivered in sick visit but not coded on claim.	
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EFFECTIVENESS OF CARE: RESPIRATORY CONDITIONS

Measure	Measure Description	Measure Information/Documentation Required	Coding
Appropriate Testing for Pharyngitis (CWP) <i>This is also a measure (CWP-E) collected through claims and Electronic Clinical Data Systems.</i>	The percentage of episodes for members 3 years and older where the member was diagnosed with pharyngitis, dispensed an antibiotic, and	Outpatient, telephone, observation or ED visit, e-visit, or virtual check-in with only a diagnosis of pharyngitis and a dispensed antibiotic for that episode of care during the Intake Period (IP), which is 3 days prior and 3 days after the diagnosis.	Group A Strep Test: CPT: 87070, 87071, 87081, 87430, 87650, 87651, 87652, 87880 Pharyngitis Diagnosis: ICD10CM: J02.0, J02.8, J02.9, J03.00, J03.01, J03.80, J03.81, J03.90, J03.91

<i>Please discuss options for a direct data feed with your Account Executive. Direct data feeds can improve provider quality performance and reduce the burden of medical record requests.</i>	received a group A Streptococcus (Strep) test for the episode. This is an episode-based event, so a member may be included multiple times.	Visits that result in an inpatient stay are excluded. Telehealth visits are included in event/diagnosis criteria. Required Exclusions: Members who meet any of the following criteria are excluded from the measure: • In hospice or using hospice services any time in the MY. • Deceased at any time in the MY. Common Chart Deficiencies: • Additional/competing diagnosis requiring antibiotics not documented in visit or coded on claim.	<i>Note: LOINC and SNOMED codes can be captured through electronic data submissions. Please contact your Account Executive for more information.</i>
Measure	Measure Description	Measure Information/Documentation Required	Coding
Asthma Medication Ratio (AMR)	The percentage of members 5 – 64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 50% or greater during the MY.	Oral medication-dispensing event: Multiple prescriptions for different medications dispensed on the same day are counted as separate dispensing events. If multiple prescriptions for the same medication are dispensed on the same day, sum the day's supply and divide by 30. Use the Drug ID to determine if the prescriptions are the same or different. Inhaler-dispensing event: All inhalers (i.e., canisters) of the same medication dispensed on the same day count as one dispensing event. Medications with different drug IDs dispensed on the same day are counted as different dispensing events. Injection-dispensing events: Each injection counts as one dispensing event. Multiple	Population includes ED, IP, and/or observation visits billed with asthma diagnosis or 4 non-controller asthma medication-dispensing events during the MY and the year prior. Asthma Diagnosis: ICD10CM: J45.21, J45.22, J45.30, J45.31, J45.32, J45.40, J45.41, J45.42, J45.50, J45.51, J45.52, J45.901, J45.902, J45.909, J45.991, J45.998 Asthma Controller Medications: Antibody inhibitors: Omalizumab Anti-interleukin-4: Dupilumab Anti-interleukin-5: Benralizumab, Mepolizumab, Reslizumab Inhaled steroid combinations: Budesonide-formoterol, Fluticasone-salmeterol, Fluticasone-vilanterol, Formoterol-mometasone Inhaled corticosteroids: Beclomethasone, Budesonide, Ciclesonide, Flunisolide, Fluticasone, Mometasone Leukotriene modifiers: Montelukast, Zafirlukast, Zileuton

		dispensed injections of the same or different medications count as separate dispensing events. Units of medications: When identifying medication units for the numerator, count each individual medication, defined as an amount lasting 30 days or less, as one medication unit. One medication unit equals one inhaler canister, one injection, or a 30-day or less supply of an oral medication. Required Exclusions: Members who meet any of the following criteria are excluded from the measure: • In hospice or using hospice services any time in the MY. • Members who had no asthma medications dispensed during the MY. • Members who had a diagnosis of any of the following in the member's history through December 31 of the MY: emphysema, COPD, Obstructive Bronchitis, chronic respiratory conditions due to fumes/vapors, Cystic Fibrosis, acute respiratory failure. • Deceased at any time in the MY. Common Chart Deficiencies: • No documentation of review of medications at every visit.	Long-acting beta-2 adrenergic agonists (LABA): Fluticasone furoate-umeclidinium-vilanterol, Salmeterol Long-acting muscarinic agonists (LAMA): Tiotropium Methylxanthines: Theophylline Asthma Reliever Medications: Beta-2 adrenergic agonist-corticosteroid combination: Albuterol-budesonide Short-acting, inhaled beta-2 agonists: Albuterol, Levalbuterol <i>Note: LOINC and SNOMED codes can be captured through electronic data submissions. Please contact your Account Executive for more information.</i>
Measure	Measure Description	Measure Information/Documentation Required	Coding
Medication Management for People with Asthma (MMA) <i>Retired by NCQA in MY20 but may still apply in</i>			<i>Requires state-specific measure codes.</i>

state quality reporting. Consult with your Account Executive.			
Measure	Measure Description	Measure Information/Documentation Required	Coding
Pharmacotherapy Management of COPD Exacerbation (PCE)	Members 40 years of age and older who had an acute inpatient discharge or ED visit on or between January 1 through November 30 of MY and who had evidence of an active prescription or were dispensed the appropriate medications: - A Systemic Corticosteroid within 14 days of the event, or - A Bronchodilator within 30 days of the event. This is an episode-based event, so a member may be included multiple times.	Required Exclusions: Members who meet any of the following criteria are excluded from the measure: - In hospice or using hospice services any time in the MY. - Deceased at any time in the MY.	HEDIS rates are based on pharmacy claims. Systemic Corticosteroid Medications: Glucocorticoids: Cortisone, Dexamethasone, Hydrocortisone, Methylprednisolone, Prednisolone, Prednisone Bronchodilator Medications: Anticholinergic agents: Acclidinium bromide, Ipratropium, Tiotropium, Umeclidinium Beta-2 agonists: Albuterol, Arformoterol, Formoterol, Indacaterol, Levalbuterol, Metaproterenol, Olodaterol, Salmeterol Bronchodilator combinations: Albuterol-ipratropium, Budesonide-formoterol, Fluticasone-salmeterol, Fluticasone-vilanterol, Fluticasone furoate-umeclidinium-vilanterol, Formoterol-acclidinium, Formoterol-glycopyrrolate, Formoterol-mometasone, Glycopyrrolate-indacaterol, Olodaterol-tiotropium, Umeclidinium-vilanterol
ACCESS AND AVAILABILITY			
Measure	Measure Description	Measure Information/Documentation Required	Coding
Adults' Access to Preventive/Ambulatory Health Services (AAP)	Members 20 years and older who had an ambulatory or preventive care visit during the MY.	One or more ambulatory or preventive care visits during the MY. Telephone and e-visits are acceptable. Required Exclusions:	Ambulatory Visits: CPT: 92002, 92004, 92012, 92014, 98966, 98967, 98968, 98970, 98971, 98972, 98980, 98981, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99242, 99243, 99244, 99245, 99304, 99305, 99036, 99307, 99308, 99309, 99310, 99315, 99316, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382,

		Members who meet any of the following criteria are excluded from the measure: • In hospice or using hospice services any time in the MY. • Deceased at any time in the MY.	99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99421, 99422, 99423, 99429, 99441, 99442, 99443, 99457, 99458, 99483 HCPCS: G0071, G0402, G0438, G0439, G0463, G2010, G2012, G2250, G2251, G2252, S0620, S0621, T1015 UBREV: 0510, 0511, 0512, 0513, 0514, 0515, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0524, 0525, 0526, 0527, 0528, 0529, 0982, 0983 Reason for Ambulatory Visit: ICD10CM: Z00.00, Z00.01, Z00.121, Z00.129, Z00.3, Z00.5, Z00.8, Z02.0, Z02.1, Z02.2, Z02.3, Z02.4, Z02.5, Z02.6, Z02.71, Z02.79, Z02.81, Z02.82, Z02.83, Z02.84, Z02.89, Z02.9, Z76.1, Z76.2 <i>Note: LOINC and SNOMED codes can be captured through electronic data submissions. Please contact your Account Executive for more information.</i>
Measure	Measure Description	Measure Information/Documentation Required	Coding
Initiation and Engagement of Substance Use Disorder Treatment (IET)	Adolescent and adult members with a new episode of substance use disorder (SUD) who received Initiation of SUD Treatment or Engagement of SUD Treatment. Two rates are reported: 1. Initiation of SUD Treatment: Members who initiate treatment through an inpatient SUD admission, outpatient visit, intensive	The MY is 1/1 – 12/31. Note: • Methadone is not included in the medication lists for the measure. • Medication treatment meets criteria for members being treated for alcohol or opioid abuse or dependence. It does not meet the criteria for treatment of other drug abuse or dependence. Required Exclusions: Members who meet any of the following criteria are excluded from the measure: • In hospice or using hospice services any time in the MY. • Deceased at any time in the MY.	Visit Setting Unspecified: (With Outpatient Place of Service (POS) and with Alcohol Abuse and Dependence, Opioid Abuse and Dependence, or Other Drug Abuse and Dependence): (with Partial Hospitalization POS and with Alcohol Abuse and Dependence, Opioid Abuse and Dependence, or Other Drug Abuse and Dependence): (With Behavioral Health (BH) Outpatient Visit and with Alcohol Abuse and Dependence, Opioid Abuse and Dependence, or Other Drug Abuse and Dependence): (with Nonresidential Substance Abuse Treatment Facility POS and with Alcohol Abuse and Dependence, Opioid Abuse and Dependence, or Other Drug Abuse and Dependence): (with Community Mental Health Center POS and with Alcohol Abuse and Dependence, Opioid Abuse and Dependence, or Other Drug Abuse and Dependence):

	outpatient encounter, or partial hospitalization, telehealth, or medication treatment within 14 days of the diagnosis. 2. Engagement of SUD Treatment: The percentage of members who initiated treatment and who had two or more additional SUD services or medication treatment within 34 days of the initiation visit. Each qualifying episode between 11/15 of the year prior to the MY and 11/14 of the MY is included.	(with Telehealth POS and with Alcohol Abuse and Dependence, Opioid Abuse and Dependence, or Other Drug Abuse and Dependence): CPT: 90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99252, 99253, 99254, 99255 BH Outpatient Visit: (with Alcohol Abuse and Dependence, Opioid Abuse and Dependence, or Other Drug Abuse and Dependence): CPT: 98960, 98961, 98962, 99078, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99242, 99243, 99244, 99245, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99483, 99492, 99493, 99494, 99510 HCPCS: G0155, G0176, G0177, G0409, G0463, G0512, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, T1015 UBREV: 0510, 0513, 0515, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0526, 0527, 0528, 0529, 0900, 0902, 0903, 0904, 0911, 0914, 0915, 0916, 0917, 0919, 0982, 0983 Partial Hospitalization or Intensive Outpatient Visit: (with Alcohol Abuse & Dependence, Opioid Abuse & Dependence, or Other Drug Abuse & Dependence): HCPCS: G0410, G0411, H0035, H2001, H2012, S0201, S9480, S9484, S9485 UBREV: 0905, 0907, 0912, 0913 Substance Use Disorder Services: (With AOD (Alcohol and Other Drug) Abuse and Dependence, Opioid Abuse and Dependence, or Other Drug Abuse and Dependence): CPT: 99408, 99409 HCPCS: G0396, G0397, G0443, H0001, H0005, H0007, H0015, H0016, H0022, H0047, H0050, H2035, H2036, T1006, T1012
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		UBREV: 0906, 0944, 0945 Substance Abuse Counseling and Surveillance: ICD10CM: Z71.41, Z71.51 Telephone Visit: (with Alcohol Abuse and Dependence, Opioid Abuse and Dependence, or Other Drug Abuse and Dependence): CPT: 98966, 98967, 98968, 99441, 99442, 99443 Online Assessments: (with Alcohol Abuse and Dependence, Opioid Abuse and Dependence, or Other Drug Abuse and Dependence): CPT: 98970, 98971, 98972, 98980, 98981, 99421, 99422, 99423, 99457, 99458 HCPCS: G0071, G2010, G2012, G2250, G2251, G2252 ODD Monthly Office-Based Treatment: HCPCS: G2086, G2087 ODD Weekly Drug Treatment Service: G2067, G2068, G2069, G2070, G2072, G2073 ODD Weekly Non-Drug Service: HCPCS: G2071, G2074, G2075, G2076, G2077, G2080 Psychiatric facility-partial hospitalization POS: 52 Community Mental Health Center POS: 53 Outpatient POS: 03, 05, 07, 09, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 22, 33, 49, 50, 71, 72 Non-Residential Substance Abuse POS: 57, 58 Telehealth POS: 02, 10
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		Alcohol Abuse and Dependence: ICD10CM: F10.10, F10.120, F10.121, F10.129, F10.130, F10.131, F10.132, F10.139, F10.14, F10.150, F10.151, F10.159, F10.180, F10.181, F10.182, F10.188, F10.19, F10.20, F10.220, F10.221, F10.229, F10.230, F10.231, F10.232, F10.239, F10.24, F10.250, F10.251, F10.259, F10.26, F10.27, F10.280, F10.281, F10.282, F10.288, F10.29 Opioid Abuse and Dependence: ICD10CM: F11.10, F11.120, F11.121, F11.122, F11.129, F11.13, F11.14, F11.150, F11.151, F11.159, F11.181, F11.182, F11.188, F11.19, F11.20, F11.220, F11.221, F11.222, F11.229, F11.23, F11.24, F11.250, F11.251, F11.259, F11.281, F11.282, F11.288, F11.29 Other Drug Abuse and Dependence: ICD10CM: F12.10, F12.120, F12.121, F12.122, F12.129, F12.13, F12.150, F12.151, F12.159, F12.180, F12.188, F12.19, F12.20, F12.220, F12.221, F12.222, F12.229, F12.23, F12.250, F12.251, F12.259, F12.280, F12.288, F12.29, F13.10, F13.120, F13.121, F13.129, F13.130, F13.131, F13.132, F13.139, F13.14, F13.150, F13.151, F13.159, F13.180, F13.181, F13.182, F13.188, F13.19, F13.20, F13.220, F13.221, F13.229, F13.230, F13.231, F13.232, F13.239, F13.24, F13.250, F13.251, F13.259, F13.26, F13.27, F13.280, F13.281, F13.282, F13.288, F13.29, F14.10, F14.120, F14.121, F14.122, F14.129, F14.13, F14.14, F14.150, F14.151, F14.159, F14.180, F14.181, F14.182, F14.188, F14.19, F14.20, F14.220, F14.221, F14.222, F14.229, F14.23, F14.24, F14.250, F14.251, F14.259, F14.280, F14.281, F14.282, F14.288, F14.29, F15.10, F15.120, F15.121, F15.122, F15.129, F15.13, F15.14, F15.150, F15.151, F15.159, F15.180, F15.181, F15.182, F15.188, F15.19, F15.20, F15.220, F15.221, F15.222, F15.229, F15.23, F15.24, F15.250, F15.251, F15.259, F15.280, F15.281, F15.282, F15.288, F15.29, F16.10, F16.120, F16.121, F16.122, F16.129, F16.14, F16.150, F16.151, F16.159, F16.180, F16.183, F16.188, F16.19, F16.20, F16.220, F16.221, F16.229, F16.24, F16.250, F16.251, F16.259, F16.280, F16.283, F16.288, F16.29, F18.10, F18.120, F18.121, F18.129, F18.14, F18.150, F18.151, F18.159, F18.17, F18.180, F18.188, F18.19, F18.20, F18.220, F18.221, F18.229, F18.24, F18.250, F18.251, F18.259, F18.27, F18.280, F18.288,
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			F18.29, F19.10, F19.120, F19.121, F19.122, F19.129, F19.130, F19.131, F19.132, F19.139, F19.14, F19.150, F19.151, F19.159, F19.16, F19.17, F19.180, F19.181, F19.182, F19.188, F19.19, F19.20, F19.220, F19.221, F19.222, F19.229, F19.230, F19.231, F19.232, F19.239, F19.24, F19.250, F19.251, F19.259, F19.26, F19.27, F19.280, F19.281, F19.282, F19.288, F19.29 Alcohol Use Disorder Treatment Medications List (if diagnosis from Alcohol Abuse and Dependence): Aldehyde dehydrogenase inhibitor: Disulfiram (oral) Antagonist: Naltrexone (oral and injectable) Other: Acamprosate (oral, delayed-release tablet) Naltrexone Injection: HCPCS: G2073, J2315 Opioid Use Disorder Treatment Medications (if diagnosis from Opioid Abuse and Dependence): Antagonist: Naltrexone (oral and injectable) Partial Agonist: Buprenorphine (sublingual tablet, injection, implant), Buprenorphine/naloxone (sublingual tablet, buccal film, sublingual film) Naltrexone Injection: HCPCS: G2073, 315 <i>Note: LOINC and SNOMED codes can be captured through electronic data submissions. Please contact your Account Executive for more information.</i>
Measure	Measure Description	Measure Information/Documentation Required	Coding
Prenatal and Postpartum Care (PPC)	The percentage of deliveries of live births on or between October 8 of the year prior to the MY and October 7 of the MY. For these members, the measure assesses the following facets of prenatal and postpartum care.	Prenatal care visit to an OB/GYN or other prenatal care practitioner or PCP. For visits to a PCP, a diagnosis of pregnancy must be present. Documentation in the medical record must include a note indicating the date when the prenatal care visit occurred, and evidence of one of the following: Documentation indicating pregnancy or reference to pregnancy (use of a standardized prenatal flow sheet, documentation of LMP, EDD, GA, a positive	Prenatal Indicator: Stand Alone Prenatal Visits: CPT: 99500 CPT-CAT-II: 0500F, 0501F, 0502F HCPS: H1000, H1001, H1002, H1003, H1004 Bundled Prenatal Visits: CPT: 59400, 59425, 59426, 59510, 59610, 59618 HCPCS: H1005 <i>(Dates of service required to validate within measure time frame.)</i>

	• Timeliness of Prenatal Care. The percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date, or within 42 days of enrollment in the organization. • Postpartum Care. The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery.	pregnancy test, gravidity and parity, a complete obstetrical history, prenatal risk assessment or counseling/education). • A basic physical obstetrical examination that includes auscultation for fetal heart tone, or pelvic exam with obstetric observations, or measurement of fundus height • Evidence that a prenatal care procedure was performed (OB panel, ultrasound, etc.). Postpartum visit to an OB/GYN or other prenatal care practitioner or PCP. Documentation in the medical record must include a note indicating the date when the postpartum care visit occurred, and evidence of one of the following: • Pelvic Exam: Colposcopy is not acceptable for a postpartum visit. • Evaluation of weight, BP, breast, and abdomen: Notation of “breastfeeding” is acceptable for the “evaluation of breasts” component. • Notation of postpartum care, including, but not limited to: Notation of “postpartum care,” “PP care,” “PP Checks,” “6-week check.” • A preprinted “Postpartum Care” form in which information was documented during the visit. • Perineal or cesarean incision/wound check. • Screening for depression, anxiety, tobacco use, substance use disorder, or preexisting mental health disorders. • Glucose screening for women with gestational diabetes. • Documentation of any of the following: infant care or breastfeeding, resumption of	Prenatal Visits (with Diagnosis of Pregnancy): CPT: 98966, 98967, 98968, 98970, 98971, 98972, 98980, 98981, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99242, 99243, 99244, 99245, 99421, 99422, 99423, 99441, 99442, 99443, 99457, 99458, 99483 HCPS: G0071, G0463, G2010, G2012, G2250, G2251, G2252, T1015 Postpartum Indicator Encounter for Postpartum Care: Z01.411, Z01.419, Z01.42, Z30.430, Z39.1, Z39.2 Postpartum Care: CPT: 57170, 58300, 59430, 99501 CPT-CAT-II: 0503F HCPCS: G0101 Bundled Postpartum Visits: CPT: 59400, 59410, 59510, 59515, 59610, 59614, 59618, 59622 (Dates of service required to validate within measure time frame.) Cervical Cytology Lab Test: CPT: 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 <i>Note: LOINC and SNOMED codes can be captured through electronic data submissions. Please contact your Account Executive for more information.</i>
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intercourse, birth spacing, family planning, sleep/fatigue, resumption of physical activity, attainment of healthy weight.

Note:

- Services provided during a telephone visit, e-visit, or virtual check-in are acceptable.
- Services that occur over multiple visits count toward Timeliness of Prenatal Care if all services are within the time frame established in the measure. Ultrasound and lab results alone are not considered a visit; they must be combined with an office visit with an appropriate practitioner in order to count for this measure.

Required Exclusions:

Members who meet any of the following criteria are excluded from the measure:

- In hospice or using hospice services any time in the MY.
- Deceased at any time in the MY.
- Non-live birth.

Common Chart Deficiencies:

- Missing signature on charts so unable to determine provider type of services.
- Only initials on charts, so unable to determine provider type of services.
- Ultrasound and/or labs with no associated prenatal visit documented in measure time frame.
- Initial prenatal visit documented as intake with RN but no visit with OB/GYN or PCP.
- Diagnosis of pregnancy not documented in chart.
- Dates of service in progress notes do not align with dates on ONAF.
- ONAF not filled out completely.

		Visit in postpartum time frame does not reference pregnancy/delivery.	
Measure	Measure Description	Measure Information/Documentation Required	Coding
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	Children and adolescents 1 – 17 years of age who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment.	Documentation of psychosocial care in the 121-day period from 90 days prior to the Rx dispensing date through 30 days after the Rx dispensing date. Required Exclusions: Members who meet any of the following criteria are excluded from the measure: - In hospice or using hospice services any time in the MY. - Deceased at any time in the MY.	Psychosocial Care: CPT: 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90846, 90847, 90849, 90853, 90875, 90876, 90880 HCPCS: G0176, G0177, G0409, G0410, G0411, H0004, H0035, H0036, H0037, H0038, H0039, H0040, H2000, H2001, H2011, H2012, H2013, H2014, H2017, H2018, H2019, H2020, S0201, S9480, S9484, S9485 <i>Note: LOINC and SNOMED codes can be captured through electronic data submissions. Please contact your Account Executive for more information.</i>
EFFECTIVENESS OF CARE: CARDIOVASCULAR CONDITIONS			
Measure	Measure Description	Measure Information/Documentation Required	Coding
Controlling High Blood Pressure (CBP)	Members 18 – 85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90) during the MY.	- BP must be latest reading in the MY and must occur on or after the diagnosis of HTN. - BP readings taken on the same day as a diagnostic test or diagnostic or therapeutic procedure that requires a change in diet or change in medication on or one day before the test or procedure, with the exception of fasting blood tests, are not used. - BP readings taken during an inpatient stay or ED visit are not used. - When multiple BP measurements occur on the same date, the lowest systolic and lowest diastolic BP reading will be used. - If no BP is recorded during the MY, the member is “not controlled.” - Services provided during a telephone visit, e-visit, or virtual check-in are acceptable. - Member-reported data documented in medical record is acceptable if BP captured	Systolic and Diastolic Result: CPT-CAT-II: - Most Recent Systolic less than 130: 3074F - Most Recent Systolic 130 – 139: 3075F - Systolic greater than or equal to 140: 3077F - Most Recent Diastolic less than 80: 3078F - Most Recent Diastolic 80 – 89: 3079F - Most Recent Diastolic greater than or equal to 90: 3080F Hypertension Diagnosis: ICD10CM: I10 <i>Note: LOINC and SNOMED codes can be captured through electronic data submissions. Please contact your Account Executive for more information.</i>

with a digital device and documented in the medical record with date BP taken.

Required Exclusions:

Members who meet any of the following criteria are excluded from the measure:

- In hospice or using hospice services any time in the MY.
- Deceased at any time in the MY.
- Receiving palliative care any time in the MY.
- 66 years of age and older with frailty **and** advanced illness during the MY.
- Evidence of ESRD or kidney transplant on or prior to 12/31 of the MY.
Documentation must include a dated note indicating evidence of ESRD, kidney transplant, or dialysis.
- Diagnosis of pregnancy during the MY.
- A nonacute inpatient admission during the MY.

Common Chart Deficiencies:

- Retake of BP that is 140/90 or above not documented.
- Member-reported BP is not documented with sufficient detail.
- Claim missing CPT II codes for BP results.
- BP rounded up before documented in medical record.
- BP documented as a range.
- No documentation of follow-up appointment scheduled if BP elevated.
- Cardiology visits with no BP documented in the chart.
- Flowsheets missing member name and second identifier such as date of birth.

Measure	Measure Description	Measure Information/Documentation Required	Coding
Persistence of Beta Blocker Treatment After a Heart Attack (PBH)	Members 18 years of age and older during the MY who were hospitalized and discharged from 7/1 of the year prior to the MY to 6/30 of the MY with a diagnosis of acute myocardial infarction (AMI) and who received persistent beta-blocker treatment for six months after discharge.	Required Exclusions: Members who meet any of the following criteria are excluded from the measure: • In hospice or using hospice services any time in the MY. • Deceased at any time in the MY. • Receiving palliative care any time in the MY. • 66 years of age and older with advanced illness during the MY. • 81 years of age and older with frailty any time on or between 7/1 of the year prior to the MY and 12/31 of the MY. • Documentation of any of the following: ○ Asthma. ○ COPD. ○ Obstructive chronic bronchitis. ○ Chronic respiratory conditions due to fumes or vapors. ○ Hypotension. ○ Heart block >1 degree. ○ Sinus bradycardia. ○ A medication-dispensing event indicative of a history of asthma. ○ Intolerance or allergy to beta-blocker therapy. ○ Contraindication to beta-blocker therapy. Common Chart Deficiencies: • Medication was ordered with no evidence that it was dispensed.	HEDIS rates are based on pharmacy claims. Beta-Blocker Medications: Noncardioselective 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 AMI Diagnosis: ICD10CM: I21.01, I21.02, I21.09, I21.11, I21.19, I21.21, I21.29, I21.3, I21.4 <i>Note: LOINC and SNOMED codes can be captured through electronic data submissions. Please contact your Account Executive for more information.</i>
Measure	Measure Description	Measure Information/Documentation Required	Coding
Cardiac Rehabilitation (CRE)	The percentage of members 18 years and	The MY is 1/1 – 12/31.	Cardiac Rehabilitation: CPT: 93797, 93798

	older who attended cardiac rehabilitation following a qualifying cardiac event, including: • Myocardial infarction. • Percutaneous coronary intervention. • Coronary artery bypass grafting. • Heart and heart/lung transplantation. • Heart valve replacement. Four rates are reported as the percentage of members who attended the specified number of cardiac rehabilitation sessions within the specified time after a qualifying event: 1. Initiation: 2 or more sessions within 30 days. 2. Engagement 1: 12 or more sessions within 90 days. 3. Engagement 2: 24 or more sessions within 180 days. 4. Achievement: 36 or more sessions within 180 days.	The Intake Period (IP) is a 12-month window that begins on July 1 of the year prior to the MY and ends on June 30 of the MY. The Episode Date (EP) is the most recent cardiac event during the IP, including myocardial infarction (MI), coronary artery bypass graft (CABG), percutaneous coronary intervention (PCI), heart or heart/lung transplant, or heart valve repair/replacement. For MI, CABG, heart or heart/lung transplant or heart valve repair/replacement, the EP is the date of discharge. For PCI, the EP is the date of service. For inpatient claims, the EP is the date of discharge. Required Exclusions: Members who meet any of the following criteria are excluded from the measure: • In hospice or using hospice services any time in the MY. • Deceased at any time in the MY. • Receiving palliative care during the IP through the end of the MY. • 66 years of age and older with frailty and advanced illness during the MY. • 81 years of age and older with frailty during the IP through the end of the MY. • Discharged from an inpatient setting with the following during the 180 days after the EP: MI, CABG, heart or heart/lung transplant, heart valve repair or replacement. • PCI in any setting during the 180 days after the EP.	HCPCS: G0422, G0423, S9472 <i>Note: LOINC and SNOMED codes can be captured through electronic data submissions. Please contact your Account Executive for more information.</i>
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Measure	Measure Description	Measure Information/Documentation Required	Coding
Statin Therapy for Patients with Cardiovascular Disease (SPC)	Males 21 – 75 years of age and females 40 – 75 years of age during the measurement year (MY) who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and met the following criteria. Two rates are reported: 1. Received Statin Therapy: Members who were dispensed at least one high- or moderate-intensity statin medication during the MY. 2. Statin Adherence 80%: Members who remained on a high- or moderate-intensity statin medication for at least 80% of the treatment period.	The Index Prescription Start Date (IPSD) is the earliest dispensing date for any statin medication of at least moderate intensity during the MY. The Treatment Period (TP) is the period beginning on the IPSD through 12/31 of the MY. Required Exclusions: Members who meet any of the following criteria are excluded from the measure: • In hospice or using hospice services any time in the MY. • Deceased at any time in the MY. • Receiving palliative care any time in the MY. • 66 years of age and older with frailty and advanced illness during the MY. • Documentation of any of the following in the MY or year prior: Pregnancy, IVF treatment, dispensed prescription for Clomiphene, cirrhosis, end stage renal disease (ESRD), or dialysis. • Documentation of any of the following in the MY: Myalgia, myositis, myopathy, or rhabdomyolysis. • Documentation of myalgia or rhabdomyolysis caused by statins in the MY or at any time in the members history. Common Chart Deficiencies: • No documentation of review of medications at every visit.	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) MI Diagnosis: ICD10CM: I21.01, I21.02, I21.09, I21.11, I21.19, I21.21, I21.29, I21.3, I21.4, I21.9, I21.A1, I21.A9, I22.0, I22.1, I22.2, I22.8, I22.9, I23.0, I23.1, I23.2, I23.3, I23.4, I23.5, I23.6, I23.7, I23.8 CABG Diagnosis: CPT: 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33530, 33533, 33534, 33535, 33536 HCPCS: S2205, S2206, S2207, S2208, S2209 ICD10PCS: 0210083, 0210088, 0210089, 0210093, 0210098, 0210099, 0211083, 0211088, 0211089, 0211093, 0211098, 0211099, 0212083, 0212088, 0212089, 0212093, 0212098, 0212099, 0213083, 0213088, 0213089, 0213093, 0213098, 0213099, 021008C, 021008F, 021008W, 021009C, 021009F, 021009W, 02100A3, 02100A8, 02100A9, 02100AC, 02100AF, 02100AW, 02100J3, 02100J8, 02100J9, 02100JC, 02100JF, 02100JW, 02100K3, 02100K8, 02100K9, 02100KC, 02100KF, 02100KW, 02100Z3, 02100Z8, 02100Z9, 02100ZC, 02100ZF, 021108C, 021108F, 021108W, 021109C, 021109F, 021109W, 02110A3, 02110A8, 02110A9, 02110AC, 02110AF, 02110AW, 02110J3, 02110J8, 02110J9, 02110JC, 02110JF, 02110JW, 02110K3, 02110K8, 02110K9, 02110KC, 02110KF, 02110KW, 02110Z3, 02110Z8, 02110Z9, 02110ZC, 02110ZF, 021208C, 021208F, 021208W, 021209C, 021209F, 021209W, 02120A3, 02120A8, 02120A9, 02120AC, 02120AF, 02120AW, 02120J3, 02120J8, 02120J9, 02120JC, 02120JF, 02120JW, 02120K3, 02120K8, 02120K9,

			02120KC, 02120KF, 02120KW, 02120Z3, 02120Z8, 02120Z9, 02120ZC, 02120ZF, 021308C, 021308F, 021308W, 021309C, 021309F, 021309W, 02130A3, 02130A8, 02130A9, 02130AC, 02130AF, 02130AW, 02130J3, 02130J8, 02130J9, 02130JC, 02130JF, 02130JW, 02130K3, 02130K8, 02130K9, 02130KC, 02130KF, 02130KW, 02130Z3, 02130Z8, 02130Z9, 02130ZC, 02130ZF PCI Diagnosis: CPT: 92920, 92924, 92928, 92933, 92937, 92941, 92943 HCPCS: C9600, C9602, C9604, C9606, C9607 ICD10PCS: 0270346, 0270356, 0270366, 0270376, 0270446, 0270456, 0270466, 0270476, 0271346, 0271356, 0271366, 0271376, 0271446, 0271456, 0271466, 0271476, 0272346, 0272356, 0272366, 0272376, 0272446, 0272456, 0272466, 0272476, 0273346, 0273356, 0273366, 0273376, 0273446, 0273456, 0273466, 0273476, 02703E6, 02704E6, 02713E6, 02714E6, 02723E6, 02724E6, 02733E6, 02734E6, 027034Z, 027035Z, 027036Z, 027037Z, 02703D6, 02703DZ, 02703EZ, 02703F6, 02703FZ, 02703G6, 02703GZ, 02703T6, 02703TZ, 02703Z6, 02703ZZ, 027044Z, 027045Z, 027046Z, 027047Z, 02704D6, 02704DZ, 02704EZ, 02704F6, 02704FZ, 02704G6, 02704GZ, 02704T6, 02704TZ, 02704Z6, 02704ZZ, 027134Z, 027135Z, 027136Z, 027137Z, 02713D6, 02713DZ, 02713EZ, 02713F6, 02713FZ, 02713G6, 02713GZ, 02713T6, 02713TZ, 02713Z6, 02713ZZ, 027144Z, 027145Z, 027146Z, 027147Z, 02714D6, 02714DZ, 02714EZ, 02714F6, 02714FZ, 02714G6, 02714GZ, 02714T6, 02714TZ, 02714Z6, 02714ZZ, 027234Z, 027235Z, 027236Z, 027237Z, 02723D6, 02723DZ, 02723EZ, 02723F6, 02723FZ, 02723G6, 02723GZ, 02723T6, 02723TZ, 02723Z6, 02723ZZ, 027244Z, 027245Z, 027246Z, 027247Z, 02724D6, 02724DZ, 02724EZ, 02724F6, 02724FZ, 02724G6, 02724GZ, 02724T6, 02724TZ, 02724Z6, 02724ZZ, 027334Z, 027335Z, 027336Z, 027337Z, 02733D6, 02733DZ, 02733EZ, 02733F6, 02733FZ, 02733G6, 02733GZ, 02733T6, 02733TZ, 02733Z6, 02733ZZ, 027344Z, 027345Z, 027346Z, 027347Z, 02734D6, 02734DZ, 02734EZ, 02734F6, 02734FZ, 02734G6, 02734GZ, 02734T6, 02734TZ, 02734Z6, 02734ZZ
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		Other Revascularization Diagnosis: CPT: 37220, 37221, 37224, 37225, 37226, 37227, 37228, 37229, 37230, 37231 IVD Diagnosis: ICD10CM: I20.0, I20.2, I20.8, I20.9, I24.0, I24.8, I24.9, I25.10, I25.110, I25.111, I25.112, I25.118, I25.119, I25.5, I25.6, I25.700, I25.701, I25.702, I25.708, I25.709, I25.710, I25.711, I25.712, I25.718, I25.719, I25.720, I25.721, I25.722, I25.728, I25.729, I25.730, I25.731, I25.732, I25.738, I25.739, I25.750, I25.751, I25.752, I25.758, I25.759, I25.760, I25.761, I25.762, I25.768, I25.769, I25.790, I25.791, I25.792, I25.798, I25.799, I25.810, I25.811, I25.812, I25.82, I25.83, I25.84, I25.89, I25.9, I63.20, I63.211, I63.212, I63.213, I63.219, I63.22, I63.231, I63.232, I63.233, I63.239, I63.29, I63.50, I63.511, I63.512, I63.513, I63.519, I63.521, I63.522, I63.523, I63.529, I63.531, I63.532, I63.533, I63.539, I63.541, I63.542, I63.543, I63.549, I63.59, I65.01, I65.02, I65.03, I65.09, I65.1, I65.21, I65.22, I65.23, I65.29, I65.8, I65.9, I66.01, I66.02, I66.03, I66.09, I66.11, I66.12, I66.13, I66.19, I66.21, I66.22, I66.23, I66.29, I66.3, I66.8, I66.9, I67.2, I70.1, I70.201, I70.202, I70.203, I70.208, I70.209, I70.211, I70.212, I70.213, I70.218, I70.219, I70.221, I70.222, I70.223, I70.228, I70.229, I70.231, I70.232, I70.233, I70.234, I70.235, I70.238, I70.239, I70.241, I70.242, I70.243, I70.244, I70.245, I70.248, I70.249, I70.25, I70.261, I70.262, I70.263, I70.268, I70.269, I70.291, I70.292, I70.293, I70.298, I70.299, I70.301, I70.302, I70.303, I70.308, I70.309, I70.311, I70.312, I70.313, I70.318, I70.319, I70.321, I70.322, I70.323, I70.328, I70.329, I70.331, I70.332, I70.333, I70.334, I70.335, I70.338, I70.339, I70.341, I70.342, I70.343, I70.344, I70.345, I70.348, I70.349, I70.35, I70.361, I70.362, I70.363, I70.368, I70.369, I70.391, I70.392, I70.393, I70.398, I70.399, I70.401, I70.402, I70.403, I70.408, I70.409, I70.411, I70.412, I70.413, I70.418, I70.419, I70.421, I70.422, I70.423, I70.428, I70.429, I70.431, I70.432, I70.433, I70.434, I70.435, I70.438, I70.439, I70.441, I70.442, I70.443, I70.444, I70.445, I70.448, I70.449, I70.45, I70.461, I70.462, I70.463, I70.468, I70.469, I70.491, I70.492, I70.493, I70.498, I70.499, I70.501, I70.502, I70.503, I70.508, I70.509, I70.511, I70.512, I70.513, I70.518, I70.519, I70.521, I70.522, I70.523, I70.528, I70.529, I70.531, I70.532, I70.533,
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EFFECTIVENESS OF CARE: DIABETES			
Measure	Measure Description	Measure Information/Documentation Required	Coding
Glycemic Status Assessment for Patients With Diabetes (GSD) <i>Formerly the HBD A1c Control for Patients with Diabetes indicator.</i>	Members 18 – 75 years of age with diabetes (Type 1 or Type 2) whose most recent glucose management indicator (GMI) or hemoglobin A1c (HbA1c) was at the following levels in the MY: - Glycemic Status (<8.0%) - Glycemic Status (>9%)	At a minimum, the documentation in the medical record must include a note indicating the date when the most recent HbA1c test was performed in the MY and the result or findings. Ranges and thresholds DO NOT meet criteria — a distinct numeric result is required. Terms below, with date of service and result, can be used: A1c, Hemoglobin A1c, Glycated Hemoglobin, HbA1c, Glycohemoglobin A1c, Glycosylated Hemoglobin, HgA1c.	HbA1c Lab Test: CPT: 83036, 83037 HbA1c Test Result or Finding: CPT-CAT-II: - Less than 7.0: 3044F - Greater than or equal to 7.0 and less than 8.0: 3051F - Greater than or equal to 8.0 and less than or equal to 9.0: 3052F - Greater than 9.0: 3046F

	<i>A lower rate in Poor Control (>9%) indicates better performance.</i>	Required Exclusions: Members who meet any of the following criteria are excluded from the measure: • In hospice or using hospice services any time in the MY. • Deceased at any time in the MY. • Receiving palliative care any time in the MY. • 66 years of age or older who are living long term in an institution at any time during the measurement year. • 66 years of age and older with frailty and advanced illness during the MY. Common Chart Deficiencies: • A1c noted in the chart but without specific date. • In-house A1c noted in visit but no result documented. • A1c result documented as a range. • Diabetes diagnosis and medication documented but missing documentation of treatment, follow-up, and/or progress. • Flowsheets missing member name and second identifier such as date of birth. • Incomplete or missing information from specialists or consulting providers.	<i>Note: LOINC and SNOMED codes can be captured through electronic data submissions. Please contact your Account Executive for more information.</i>
Measure	Measure Description	Measure Information/Documentation Required	Coding
Eye Exam for Patients with Diabetes (EED) <i>Formerly the CDC Eye Exam indicator.</i>	Members 18 – 75 years of age with diabetes (Type 1 and Type 2) who had a retinal eye exam during the measurement year (MY), an exam with a negative result in the year prior to the MY, or documentation of	Documentation can include any of the following noted in the medical record: • A note or letter during the MY prepared by an ophthalmologist, optometrist, PCP, or other health care provider indicating that an ophthalmoscopic exam was completed by an eye care provider, the date when the procedure was performed and the results. • Documentation of a negative (or normal) retinal or dilated exam by an eye care	Retinal Eye Exams: CPT: 92235, 92230, 92250, 99245, 99243, 99244, 99242, 99205, 99203, 99204, 99215, 99213, 99214, 92018, 92019, 92004, 92002, 92014, 92012, 92202, 92201, 92134 HCPCS: S0621, S0620, S3000 Retinal Imaging: CPT: 92227, 92228

	bilateral eye enucleation any time prior to 12/31 of the MY.	provider in the year prior to the MY, where results indicate retinopathy was not present and the date when the exam was performed. - A chart or photograph indicating the date when the fundus photography was performed and evidence that an eye care professional (optometrist or ophthalmologist) or qualified reading center reviewed the results, or that results were read by a system that provides artificial intelligence (AI) interpretation. Hypertensive retinopathy is handled the same as diabetic retinopathy when reporting the Eye Exam indicator. - Positive for hypertensive retinopathy is counted as positive for diabetic retinopathy if diabetic retinopathy not documented. - An eye exam documented as negative for hypertensive retinopathy is counted as negative for diabetic retinopathy if diabetic retinopathy not documented. Common Abbreviations for Retinopathy: - NPDR (Non-proliferative diabetic retinopathy). - PDR (Proliferative diabetic retinopathy). - BDR (Background diabetic retinopathy). - Mild BDR or PDR. - Severe PDR. Examples of Negative Exam: - Assessment of fundus and macula were “normal.” - Diabetes mellitus without ophthalmic complication.	Diabetes Mellitus without Complications (in Year Prior to MY with Diabetic Retinal Screening): ICD10CM: E10.9, E11.9, E13.9 Low Risk for Retinopathy (none present in prior year): CPT-CAT-II: 3072F Eye Exam without Evidence of Retinopathy: CPT-CAT-II: 2023F, 2025F, 2033F Eye Exam with Evidence of Retinopathy (in the MY Only): CPT-CAT-II: 2022F, 2024F, 2026F Unilateral Eye Enucleation (with Bilateral Modifier or 2 Unilateral Enucleations More than 14 Days Apart): CPT: 65091, 65093, 65101, 65103, 65105, 65110, 65112, 65114 <i>Note: LOINC and SNOMED codes can be captured through electronic data submissions. Please contact your Account Executive for more information.</i>
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- Retinal exam documented as “normal” is considered negative for retinopathy if diabetic retinopathy not documented.

Note: Notation limited to a statement that included “Diabetes without complications” does not meet criteria.

Required Exclusions:

Members who meet any of the following criteria are excluded from the measure:

- In hospice or using hospice services any time in the MY.
- Deceased at any time in the MY.
- Receiving palliative care any time in the MY.
- 66 years of age and older with frailty **and** advanced illness during the MY.
- Bilateral eye enucleation.

Blindness is not an exclusion for a diabetic eye exam.

Common Chart Deficiencies:

- Documentation of diabetic exam without results.
- Documentation of diabetic eye exam without provider (including credentials) of the exam.
- Documentation is not clear that patient had a dilated or retinal exam.
- Documentation not specific as to presence of retinopathy.
- Incomplete or missing information from specialists or consulting providers.
- Documentation of “diabetes without complications” does **not** meet criteria.

Measure	Measure Description	Measure Information/Documentation Required	Coding
Blood Pressure Control for Patients with Diabetes (BPD) <i>Formerly the CDC BP indicator.</i>	Members 18 – 75 years of age with diabetes (Type 1 and Type 2) who had a controlled BP of <140/90 mm Hg during the MY.	- BP must be latest reading in the MY. - BP readings taken on the same day as a diagnostic test or diagnostic or therapeutic procedure that requires a change in diet or change in medication on or one day before the test or procedure, with the exception of fasting blood tests, are not used. - BP readings taken during an inpatient stay or ED visit are not used. - When multiple BP measurements occur on the same date, the lowest systolic and lowest diastolic BP reading will be used. - If no BP is recorded during the MY, the member is “not controlled.” - Member-reported data documented in medical record is acceptable if BP captured with a digital device. Required Exclusions: Members who meet any of the following criteria are excluded from the measure: - In hospice or using hospice services any time in the MY. - Deceased at any time in the MY. - Receiving palliative care any time in the MY. 66 years of age and older with frailty and advanced illness during the MY. Common Chart Deficiencies: - Retake of BP that is 140/90 or above not documented. - Member-reported BP is not documented with sufficient detail. - BP rounded up before documented in medical record. - BP documented as a range.	Systolic and Diastolic Result: CPT-CAT-II: - Most Recent Systolic less than 130: 3074F - Most Recent Systolic 130 – 139: 3075F - Systolic greater than or equal to 140: 3077F - Most Recent Diastolic less than 80: 3078F - Most Recent Diastolic 80 – 89: 3079F - Most Recent Diastolic greater than or equal to 90: 3080F <i>Note: LOINC and SNOMED codes can be captured through electronic data submissions. Please contact your Account Executive for more information.</i>

		- Claim missing CPT II codes for BP results. - Flowsheets missing member name and second identifier such as date of birth. - Incomplete or missing information from specialists or consulting providers.	
Measure	Measure Description	Measure Information/Documentation Required	Coding
Kidney Evaluation for Patients With Diabetes (KED)	The percentage of members ages 18 – 85 with diabetes (Type 1 and Type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ration (uACR), during the MY.	Documentation must include the required tests with result and date of service. Required Exclusions: Members who meet any of the following criteria are excluded from the measure: - In hospice or using hospice services any time in the MY. - Deceased at any time in the MY. - Receiving palliative care any time in the MY. - Evidence of ESRD or dialysis any time during the member’s history through 12/31 of the MY. 66 years of age and older with frailty and advanced illness during the MY. 81 years of age and older with frailty during the MY.	All three are required: Estimated Glomerular Filtration Rate Lab Test: CPT: 80047, 80048, 80050, 80053, 80069, 82565 Quantitative Urine Albumin Lab Test: CPT: 82043 Urine Creatinine Lab Test: CPT: 82570 Service dates of Quantitative Urine Albumin Lab Test and Urine Creatinine Lab Test must be four or less days apart. <i>Note: LOINC and SNOMED codes can be captured through electronic data submissions. Please contact your Account Executive for more information.</i>
Measure	Measure Description	Measure Information/Documentation Required	Coding
Statin Therapy for Patients with Diabetes (SPD)	The percentage of adults 40 – 75 years of age during the MY with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) who met the following criteria. Two rates are reported:	The Index Prescription Start Date (IPSD) is the earliest dispensing date for any statin medication of any intensity during the MY. The Treatment Period (TP) is the period beginning on the IPSD through 12/31 of the MY. Required Exclusions: Members who meet any of the following criteria are excluded from the measure:	Low-, Medium-, or High-Intensity Statin: Amlodipine-Atorvastatin, Atorvastatin, Ezetimibe-Simvastatin, Fluvastatin Lovastatin, Pitavastatin, Pravastatin, Rosuvastatin, Simvastatin

	1. Received statin therapy: Members who were dispensed at least one statin medication of any intensity during the MY. 2. Statin adherence 80%: Remained on a statin medication of any intensity for at least 80% of the treatment period.	• In hospice or using hospice services any time in the MY. • Deceased at any time in the MY. • Receiving palliative care any time in the MY. • 66 years of age and older with frailty and advanced illness during the MY. • Documentation of any of the following during the year prior to the MY: MI (myocardial infarction), CABG (coronary artery bypass graft), PCI (percutaneous coronary intervention), or other revascularization. • Documentation of any of the following during the MY or the year prior: pregnancy, IVF, dispensed prescription for Clomiphene, ESRD, dialysis, or cirrhosis. • Documentation of any of the following in the MY: myalgia, myositis, myopathy, or rhabdomyolysis. • Documentation of myalgia or rhabdomyolysis caused by statins in the MY or at any time in the members history. • Diagnosis of ischemic vascular disease during the MY or the year prior who had at least one outpatient visit, telephone visit, online assessment, virtual check-in or acute inpatient encounter with an IVD diagnosis. • No diagnosis of diabetes in any setting during the MY or the year prior and who had a diagnosis of polycystic ovarian syndrome, gestational diabetes, or steroid-induced diabetes during the MY or the year prior.	
EFFECTIVENESS OF CARE: MUSCULOSKELETAL CONDITIONS			
Measure	Measure Description	Measure Information/Documentation Required	Coding
Disease-Modifying Anti-Rheumatic Drug Therapy			<i>Requires state-specific measure codes.</i>

for Rheumatoid Arthritis (ART) <i>Retired by NCQA in MY20 but may still apply in state quality reporting. Consult with your Account Executive.</i>			
Measure	Measure Description	Measure Information/Documentation Required	Coding
Osteoporosis Management in Women Who Had a Fracture (OMW)	Women 67 – 85 years of age who suffered a fracture and who had either a bone or mineral density (BMD) test or prescription for a drug to treat osteoporosis in the six months after the fracture. Fractures of finger, toe, face, and skull are not included in this measure.	The MY is 1/1 – 12/31. The Intake Period (IP) is a 12-month window beginning 7/1 of the year prior to the MY and ending 6/30 of the MY. The IP is used to capture the first fracture. The Episode Date (EP) is an eligible encounter during the IP with a diagnosis of fracture. - For outpatient, observation, or ER visit, the EP is the date of service. - For inpatient stay, the EP is the date of discharge. Required Exclusions: Members who meet any of the following criteria are excluded from the measure: - In hospice or using hospice services any time in the MY. - Deceased at any time in the MY. - Receiving palliative care during the IP through the end of the MY. 67 – 80 years of age with frailty and advanced illness during the IP through the end of the MY. 81 years of age and older with frailty during the IP through the end of the MY. - Had a BMD test during the 730 days prior to the ED.	HEDIS rates are based on pharmacy claims/BMD testing. Bone Mineral Density Tests: CPT: 76977, 77078, 77080, 77081, 77085, 77086 ICD10PCS: BP48ZZ1, BP49ZZ1, BP4GZZ1, BP4HZZ1, BP4LZZ1, BP4MZZ1, BP4NZZ1, BP4PZZ1, BQ00ZZ1, BQ01ZZ1, BQ03ZZ1, BQ04ZZ1, BR00ZZ1, BR07ZZ1, BR09ZZ1, BR0GZZ1 Osteoporosis Medication Therapy: HCPCS: J0897, J1740, J3110, J3111, J3489 Long-Acting Osteoporosis Medications: HCPCS: J0897, J1740, J3489 Osteoporosis Medications List: Bisphosphonates: Alendronate, Alendronate-cholecalciferol, Ibandronate, Risedronate, Zoledronic acid Other Agents: Abaloparatide, Denosumab, Raloxifene, Romosozumab, Teriparatide <i>Note: LOINC and SNOMED codes can be captured through electronic data submissions. Please contact your Account Executive for more information.</i>

		- Had a claim/encounter for osteoporosis therapy prior to the ED. - Received a dispensed prescription or had an active prescription to treat osteoporosis during the 365 days prior to the ED.	
Measure	Measure Description	Measure Information/Documentation Required	Coding
Osteoporosis Screening in Older Women (OSW)	The percentage of women 65 – 75 who received osteoporosis screening.	One or more osteoporosis screening tests on or between the member's 65th birthday and 12/31 of the MY. Required Exclusions: Members who meet any of the following criteria are excluded from the measure: - In hospice or using hospice services any time in the MY. - Deceased at any time in the MY. - Receiving palliative care any time in the MY. 66 years of age and older with frailty and advanced illness during the IP through the end of the MY. - Had a claim/encounter for osteoporosis therapy any time in the member's history through 12/31 of the year prior to the MY. - Had a dispensed dementia medication in the MY or the year prior to the MY. - Had a dispensed prescription to treat osteoporosis any time from 1/1 three years prior to the MY through 12/31 of the year prior to the MY.	Osteoporosis Screening Tests: CPT: 76977, 77078, 77080, 77081, 77085
EFFECTIVENESS OF CARE: BEHAVIORAL HEALTH			
Measure	Measure Description	Measure Information/Documentation Required	Coding
Follow-Up After Hospitalization for Mental Illness (FUH)	Percentage of discharges for members 6 years of age and older	The MY is 1/1 – 12/31.	Visit Setting Unspecified: (With Outpatient POS Value Set and with a Mental Health Provider):

	who were hospitalized for treatment of selected mental illness or Intentional Self Harm diagnoses and who had a follow-up visit with a mental health provider. Two rates are reported: 1. The percentage of discharges for which the member received follow-up within 30 (calendar) days of discharge. 2. The percentage of discharges for which the member received follow-up within 7 (calendar) days of discharge.	An outpatient visit, with a mental health provider within 7 and 30 (calendar) days after discharge. Do not include visits that occur on the date of discharge. • A visit with a mental health provider in any of the following settings: ○ Outpatient. ○ Behavioral health outpatient. ○ Telehealth visit. ○ Telephone visit. ○ Observation visit. ○ Transitional care management visit. ○ Peer Support Services. • A visit in any of the following settings: ○ Intensive outpatient/partial hospitalization. ○ Community mental health center. ○ Electroconvulsive therapy visit. ○ Behavioral healthcare setting. ○ Psychiatric residential treatment center. Required Exclusions: Members who meet any of the following criteria are excluded from the measure: • In hospice or using hospice services any time in the MY. • Deceased at any time in the MY. Common Chart Deficiencies: • Follow-up visit more than 7 days or 30-days after discharge. • Criteria is not met by a follow-up on the date of discharge.	(With Partial Hospitalization POS): (With Community Mental Health Center POS): (With Psychiatric Residential Treatment Center POS): (With Telehealth POS Value Set and with a Mental Health Provider): CPT: 90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99252, 99253, 99254, 99255 BH Outpatient: (With a Mental Health Provider): (with Community Mental Health Center POS): CPT: 98960, 98961, 98962, 99078, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99242, 99243, 99244, 99245, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99483, 99492, 99493, 99494, 99510 HCPCS: G0155, G0176, G0177, G0409, G0463, G0512, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, T1015 UBREV: 0510, 0513, 0515, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0526, 0527, 0528, 0529, 0900, 0902, 0903, 0904, 0911, 0914, 0915, 0916, 0917, 0919, 0982, 0983 Partial Hospitalization or Intensive Outpatient: HCPCS: G0410, G0411, H0035, H2001, H2012, S0201, S9480, S9484, S9485 UBREV: 0905, 0907, 0912, 0913 Transitional Care Management Services: (With a Mental Health Provider): (With Community Mental Health Center POS): CPT: 99495, 99496 Electroconvulsive Therapy: (With Ambulatory Surgical Center POS): (With Community Mental Health POS):
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			(With Outpatient POS): (With Partial Hospitalization POS): CPT: 90870 ICD10PCS: GZB0ZZZ, GZB1ZZZ, GZB2ZZZ, GZB3ZZZ, GZB4ZZZ Behavioral Healthcare Setting Visit: UBREV: 0513, 0900, 0901, 0902, 0903, 0904, 0905, 0907, 0911, 0912, 0913, 0914, 0915, 0916, 0917, 0919, 1001 Residential Behavioral Health Treatment: HCPCS: T2048, H0019, H0017, H0018 Telephone Visit: (With a Mental Health Provider): CPT: 98966, 98967, 98968, 99441, 99442, 99443 Psychiatric Collaborative Care Management: CPT: 99492, 99493, 99494 HCPCS: G0512 Peer Support Services: (With any diagnosis of mental health disorder) HCPCS: T1012, H0040, H0039, H0025, H0024, T1016, H0046, S9445, G0140, H0038, H2014, H2023, G0177 Psychiatric Facility-Partial Hospitalization: 52 Non-Residential Substance Abuse POS: 57, 58 Community Mental Health POS: 53 Residential Substance Abuse Treatment Facility POS: 55 Psychiatric Residential Treatment Center: 56 Ambulatory Surgical Center POS: 24 Telehealth POS: 2 Mental Illness: ICD10CM: F20.0, F20.1, F20.2, F20.3, F20.5, F20.81, F20.89, F20.9, F21, F22, F23, F24, F25.0, F25.1, F25.8, F25.9, F28, F29, F30.10, F30.11, F30.12, F30.13, F30.2, F30.3, F30.4, F30.8, F30.9, F31.0, F31.10, F31.11, F31.12, F31.13, F31.2, F31.30, F31.31, F31.32, F31.4, F31.5, F31.60, F31.61, F31.62, F31.63, F31.64, F31.70, F31.71, F31.72, F31.73, F31.74, F31.75, F31.76, F31.77, F31.78, F31.81, F31.89, F31.9, F32.0, F32.1, F32.2, F32.3, F32.4,
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		T46.1X2D, T46.1X2S, T46.2X2A, T46.2X2D, T46.2X2S, T46.3X2A, T46.3X2D, T46.3X2S, T46.4X2A, T46.4X2D, T46.4X2S, T46.5X2A, T46.5X2D, T46.5X2S, T46.6X2A, T46.6X2D, T46.6X2S, T46.7X2A, T46.7X2D, T46.7X2S, T46.8X2A, T46.8X2D, T46.8X2S, T46.902A, T46.902D, T46.902S, T46.992A, T46.992D, T46.992S, T47.0X2A, T47.0X2D, T47.0X2S, T47.1X2A, T47.1X2D, T47.1X2S, T47.2X2A, T47.2X2D, T47.2X2S, T47.3X2A, T47.3X2D, T47.3X2S, T47.4X2A, T47.4X2D, T47.4X2S, T47.5X2A, T47.5X2D, T47.5X2S, T47.6X2A, T47.6X2D, T47.6X2S, T47.7X2A, T47.7X2D, T47.7X2S, T47.8X2A, T47.8X2D, T47.8X2S, T47.92XA, T47.92XD, T47.92XS, T48.0X2A, T48.0X2D, T48.0X2S, T48.1X2A, T48.1X2D, T48.1X2S, T48.202A, T48.202D, T48.202S, T48.292A, T48.292D, T48.292S, T48.3X2A, T48.3X2D, T48.3X2S, T48.4X2A, T48.4X2D, T48.4X2S, T48.5X2A, T48.5X2D, T48.5X2S, T48.6X2A, T48.6X2D, T48.6X2S, T48.902A, T48.902D, T48.902S, T48.992A, T48.992D, T48.992S, T49.0X2A, T49.0X2D, T49.0X2S, T49.1X2A, T49.1X2D, T49.1X2S, T49.2X2A, T49.2X2D, T49.2X2S, T49.3X2A, T49.3X2D, T49.3X2S, T49.4X2A, T49.4X2D, T49.4X2S, T49.5X2A, T49.5X2D, T49.5X2S, T49.6X2A, T49.6X2D, T49.6X2S, T49.7X2A, T49.7X2D, T49.7X2S, T49.8X2A, T49.8X2D, T49.8X2S, T49.92XA, T49.92XD, T49.92XS, T50.0X2A, T50.0X2D, T50.0X2S, T50.1X2A, T50.1X2D, T50.1X2S, T50.2X2A, T50.2X2D, T50.2X2S, T50.3X2A, T50.3X2D, T50.3X2S, T50.4X2A, T50.4X2D, T50.4X2S, T50.5X2A, T50.5X2D, T50.5X2S, T50.6X2A, T50.6X2D, T50.6X2S, T50.7X2A, T50.7X2D, T50.7X2S, T50.8X2A, T50.8X2D, T50.8X2S, T50.902A, T50.902D, T50.902S, T50.912A, T50.912D, T50.912S, T50.992A, T50.992D, T50.992S, T50.A12A, T50.A12D, T50.A12S, T50.A22A, T50.A22D, T50.A22S, T50.A92A, T50.A92D, T50.A92S, T50.B12A, T50.B12D, T50.B12S, T50.B92A, T50.B92D, T50.B92S, T50.Z12A, T50.Z12D, T50.Z12S, T50.Z92A, T50.Z92D, T50.Z92S, T51.0X2A, T51.0X2D, T51.0X2S, T51.1X2A, T51.1X2D, T51.1X2S, T51.2X2A, T51.2X2D, T51.2X2S, T51.3X2A, T51.3X2D, T51.3X2S, T51.8X2A, T51.8X2D, T51.8X2S, T51.92XA, T51.92XD, T51.92XS, T52.0X2A, T52.0X2D, T52.0X2S, T52.1X2A, T52.1X2D, T52.1X2S, T52.2X2A, T52.2X2D, T52.2X2S, T52.3X2A, T52.3X2D, T52.3X2S, T52.4X2A, T52.4X2D, T52.4X2S, T52.8X2A, T52.8X2D, T52.8X2S, T52.92XA, T52.92XD, T52.92XS, T53.0X2A, T53.0X2D, T53.0X2S, T53.1X2A, T53.1X2D, T53.1X2S, T53.2X2A, T53.2X2D, T53.2X2S, T53.3X2A, T53.3X2D, T53.3X2S, T53.4X2A, T53.4X2D, T53.4X2S, T53.5X2A, T53.5X2D, T53.5X2S, T53.6X2A,
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			X81.1XXD, X81.1XXS, X81.8XXA, X81.8XXD, X81.8XXS, X82.0XXA, X82.0XXD, X82.0XXS, X82.1XXA, X82.1XXD, X82.1XXS, X82.2XXA, X82.2XXD, X82.2XXS, X82.8XXA, X82.8XXD, X82.8XXS, X83.0XXA, X83.0XXD, X83.0XXS, X83.1XXA, X83.1XXD, X83.1XXS, X83.2XXA, X83.2XXD, X83.2XXS, X83.8XXA, X83.8XXD, X83.8XXS <i>Note: LOINC and SNOMED codes can be captured through electronic data submissions. Please contact your Account Executive for more information.</i>
Measure	Measure Description	Measure Information/Documentation Required	Coding
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications (SSD)	The percentage of members 18 – 64 years of age with schizophrenia, schizoaffective disorder, or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening test during the MY.	A glucose test or HbA1c test performed during the MY. Required Exclusions: Members who meet any of the following criteria are excluded from the measure: • In hospice or using hospice services any time in the MY. • Deceased at any time in the MY. • Diabetes.	Members are identified through administrative and pharmacy claims. Glucose Lab Test: CPT: 80047, 80048, 80050, 80053, 80069, 82947, 82950, 82951 HbA1C Lab Test: CPT: 83036, 83037 HbA1C Test Result or Finding: CPT-CAT-II: 3044F, 3046F, 3051F, 3052F Antipsychotics Medications: Miscellaneous antipsychotic agents: Aripiprazole, Asenapine, Brexpiprazole, Cariprazine, Clozapine, Haloperidol, Iloperidone, Loxapine, Lumateperone, Lurasidone, Molindone, Olanzapine, Paliperidone, Quetiapine, Risperidone, Ziprasidone Phenothiazine antipsychotics: Chlorpromazine, Fluphenazine, Perphenazine, Prochlorperazine, Thioridazine, Trifluoperazine Psychotherapeutic combinations: Amitriptyline-perphenazine Thioxanthenes: Thiothixene Long-Acting Injections: Aripiprazole, Fluphenazine decanoate, Haloperidol decanoate, Olanzapine, Paliperidone palmitate, Risperidone

			<i>Note: LOINC and SNOMED codes can be captured through electronic data submissions. Please contact your Account Executive for more information.</i>
Measure	Measure Description	Measure Information/Documentation Required	Coding
Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)	The percentage of members 18 – 64 years of age with schizophrenia or schizoaffective disorder, and diabetes who had both an LDL-C test and an HbA1c test during the MY.	An HbA1c test and an LDL-C test performed in the MY. Required Exclusions: Members who meet any of the following criteria are excluded from the measure: • In hospice or using hospice services any time in the MY. • Deceased at any time in the MY.	Members are identified through administrative and pharmacy claims. HbA1C Lab Test: CPT: 83036, 83037 HbA1C Test Result or Finding: CPT-CAT-II: 3044F, 3046F, 3051F, 3052F LDL C Lab Test: CPT: 80061, 83700, 83701, 83704, 83721 LDL C Test Result or Finding: CPT-CAT-II: 3048F, 3049F, 3050F Must have both A1c and LDL. <i>Note: LOINC and SNOMED codes can be captured through electronic data submissions. Please contact your Account Executive for more information.</i>
Measure	Measure Description	Measure Information/Documentation Required	Coding
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC)	The percentage of members 18 – 64 years of age with schizophrenia or schizoaffective disorder and cardiovascular (IVD, CABG, PCI, AMI) disease	An LDL-C test performed during the MY. Required Exclusions: Members who meet any of the following criteria are excluded from the measure: • In hospice or using hospice services any time in the MY. • Deceased at any time in the MY.	LDL C Lab Test: CPT: 80061, 83700, 83701, 83704, 83721 LDL C Test Result or Finding: CPT-CAT-II: 3048F, 3049F, 3050F

	who had an LDL-C test during the MY.		<i>Note: LOINC and SNOMED codes can be captured through electronic data submissions. Please contact your Account Executive for more information.</i>
Measure	Measure Description	Measure Information/Documentation Required	Coding
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)	The percentage of members 18 years of age and older during the MY with schizophrenia or schizoaffective disorder who were dispensed and remained on an oral or long-acting injection antipsychotic medication at least 80% of their treatment period.	The Index Prescription Start Date (IPSD) is the earliest prescription-dispensing date during the MY. The Treatment period is the IPSD through the last day of the MY. Required Exclusions: Members who meet any of the following criteria are excluded from the measure: • In hospice or using hospice services any time in the MY. • Deceased at any time in the MY. • 66 – 80 years of age with frailty and advanced illness during the MY. • 81 years of age and older with frailty. • Diagnosis of dementia in the MY.	Schizophrenia Diagnosis: ICD10CM: F20.0, F20.1, F20.2, F20.3, F20.5, F20.81, F20.89, F20.9, F25.0, F25.1, F25.8, F25.9 Long-Acting Injections 14-Day Supply: HCPCS: J2794, J2801 Long-Acting Injections 28-Day Supply: HCPCS: J0401, J1631, J1943, J1944, J2358, J2426, J2680 Long-Acting Injections 30-Day Supply: HCPCS: J2798 Oral Antipsychotic Medications: Miscellaneous antipsychotic agents: Aripiprazole, Asenapine, Brexpiprazole, Cariprazine, Clozapine, Haloperidol, Iloperidone, Loxapine, Lumateperone, Lurasidone, Molindone, Olanzapine, Paliperidone, Quetiapine, Risperidone, Ziprasidone, Phenothiazine antipsychotics: Chlorpromazine, Fluphenazine, Perphenazine, Prochlorperazine, Thioridazine, Trifluoperazine Psychotherapeutic combinations: Amitriptyline-perphenazine Thioxanthenes: Thiothixene Long-Acting Injections: 28-day supply: Aripiprazole, Fluphenazine decanoate, Haloperidol decanoate, Olanzapine, 35-day supply: Paliperidone palmitate (Invega Sustenna) 104-day supply: Paliperidone palmitate (Invega Trinza) 201-day supply: Paliperidone palmitate (Invega Hafyera) <i>Note: LOINC and SNOMED codes can be captured through electronic data submissions. Please contact your Account Executive for more information.</i>

Measure	Measure Description	Measure Information/Documentation Required	Coding
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	The percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness or Intentional Self Harm, who had a follow-up visit for mental illness. Two rates are reported: 1. The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days). 2. The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days).	A follow-up visit with any practitioner, with a principal diagnosis of a mental health disorder or with a principal diagnosis of Intentional Self Harm and any diagnosis of a mental health disorder within 7 and 30 days after ED visit. Include outpatient visits, behavioral health outpatient visits, intensive outpatient visits, partial hospitalizations, community mental health visits, electroconvulsive therapy visits, telehealth visits, psychiatric residential treatment, psychiatric collaborative care management, peer support services, and observation visits. • Includes visits that occur on the date of the ED visit • Telephone visits, e-visits, and virtual check-ins are acceptable. Required Exclusions: Members who meet any of the following criteria are excluded from the measure: • In hospice or using hospice services any time in the MY. • Deceased at any time in the MY.	Visit Setting Unspecified: (With Outpatient POS and Principal Diagnosis of Mental Health or Principal Diagnosis of Intentional Self Harm with Any Diagnosis of Mental Health): (With Partial Hospitalization POS and Principal Diagnosis of Mental Health or Principal Diagnosis of Intentional Self Harm with any Diagnosis of Mental Health): (With Community Mental Health Center POS and Principal Diagnosis of Mental Health or Principal Diagnosis of Intentional Self Harm with Any Diagnosis of Mental Health): (With Telehealth POS and Principal Diagnosis of Mental Health or Principal Diagnosis of Intentional Self Harm with Any Diagnosis of Mental Health): CPT: 90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99252, 99253, 99254, 99255 BH Outpatient: (With Principal Diagnosis of Mental Health or Principal Diagnosis of Intentional Self Harm with Any Diagnosis of Mental Health): CPT: 98960, 98961, 98962, 99078, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99242, 99243, 99244, 99245, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99483, 99492, 99493, 99494, 99510 HCPCS: G0155, G0176, G0177, G0409, G0463, G0512, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, T1015 UBREV: 0510, 0513, 0515, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0526, 0527, 0528, 0529, 0900, 0902, 0903, 0904, 0911, 0914, 0915, 0916, 0917, 0919, 0982, 0983 Behavioral Healthcare Setting:

			UBREV: 0904, 0917, 0907, 0901, 0916, 0900, 0915, 0914, 0905, 0902, 0919, 0913, 0912, 0903, 0513, 0911, 1001 Partial Hospitalization or Intensive Outpatient: (With Principal Diagnosis of Mental Health or Principal Diagnosis of Intentional Self Harm with Any Diagnosis of Mental Health): HCPCS: G0410, G0411, H0035, H2001, H2012, S0201, S9480, S9484, S9485 UBREV: 0905, 0907, 0912, 0913 Electroconvulsive Therapy: (With Ambulatory Surgical Center POS, Community Mental Health POS, Outpatient POS, or Partial Hospitalization POS with a Principal Diagnosis of Intentional Self Harm with Any Diagnosis of Mental Health): CPT: 99495, 99496, 99381, 99382, 99391, 99392 Observation: (With Principal Diagnosis of Mental Health or Principal Diagnosis of Intentional Self Harm with Any Diagnosis of Mental Health): CPT: 99217, 99218, 99219, 99220 Telephone Visits: (With Principal Diagnosis of Mental Health or Principal Diagnosis of Intentional Self Harm with Any Diagnosis of Mental Health): CPT: 98966, 98967, 98968, 99441, 99442, 99443 Online Assessments: (With Principal Diagnosis of Mental Health or Principal Diagnosis of Intentional Self Harm with Any Diagnosis of Mental Health): CPT: 98970, 98971, 98972, 98980, 98981, 99421, 99422, 99423, 99457, 99458 HCPCS: G0071, G2010, G2012, G2250, G2251, G2252 Psychiatric Collaborative Care Management: (With any diagnosis of mental health disorder) CPT: 99494, 99492, 99493 HCPCS: G0512 (Rural Health or federally qualified health center only)
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			Peer Support Services: (With any diagnosis of mental health disorder) HCPCS: T1012, H0040, H0039, H0025, H0024, T1016, H0046, S9445, G0140, H0038, H2014, H2023, G0177 Residential Behavioral Health Treatment: HCPCS: T2048, H0019, H0017, H0018 Psychiatric Facility-Partial Hospitalization POS: 52 Psychiatric Residential Treatment Center POS: 56 Community Mental Health Center POS: 53 Ambulatory Surgical Center POS: 24 Outpatient POS: 03, 05, 07, 09, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 22, 33, 49, 50, 71, 72 Telehealth POS: 2 Mental Illness: ICD10CM: F20.0, F20.1, F20.2, F20.3, F20.5, F20.81, F20.89, F20.9, F21, F22, F23, F24, F25.0, F25.1, F25.8, F25.9, F28, F29, F30.10, F30.11, F30.12, F30.13, F30.2, F30.3, F30.4, F30.8, F30.9, F31.0, F31.10, F31.11, F31.12, F31.13, F31.2, F31.30, F31.31, F31.32, F31.4, F31.5, F31.60, F31.61, F31.62, F31.63, F31.64, F31.70, F31.71, F31.72, F31.73, F31.74, F31.75, F31.76, F31.77, F31.78, F31.81, F31.89, F31.9, F32.0, F32.1, F32.2, F32.3, F32.4, F32.5, F32.81, F32.89, F32.9, F32.A, F33.0, F33.1, F33.2, F33.3, F33.40, F33.41, F33.42, F33.8, F33.9, F34.0, F34.1, F34.81, F34.89, F34.9, F39, F40.00, F40.01, F40.02, F40.10, F40.11, F40.210, F40.218, F40.220, F40.228, F40.230, F40.231, F40.232, F40.233, F40.240, F40.241, F40.242, F40.243, F40.248, F40.290, F40.291, F40.298, F40.8, F40.9, F41.0, F41.1, F41.3, F41.8, F41.9, F42.2, F42.3, F42.4, F42.8, F42.9, F43.0, F43.10, F43.11, F43.12, F43.20, F43.21, F43.22, F43.23, F43.24, F43.25, F43.29, F43.8, F43.81, F43.89, F43.9, F44.89, F53.0, F53.1, F60.0, F60.1, F60.2, F60.3, F60.4, F60.5, F60.6, F60.7, F60.81, F60.89, F60.9, F63.0, F63.1, F63.2, F63.3, F63.81, F63.89, F63.9, F63.81, F63.89, F63.9, F68.10,
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			T41.1X2S, T41.202A, T41.202D, T41.202S, T41.292A, T41.292D, T41.292S, T41.3X2A, T41.3X2D, T41.3X2S, T41.42XA, T41.42XD, T41.42XS, T41.5X2A, T41.5X2D, T41.5X2S, T42.0X2A, T42.0X2D, T42.0X2S, T42.1X2A, T42.1X2D, T42.1X2S, T42.2X2A, T42.2X2D, T42.2X2S, T42.3X2A, T42.3X2D, T42.3X2S, T42.4X2A, T42.4X2D, T42.4X2S, T42.5X2A, T42.5X2D, T42.5X2S, T42.6X2A, T42.6X2D, T42.6X2S, T42.72XA, T42.72XD, T42.72XS, T42.8X2A, T42.8X2D, T42.8X2S, T43.012A, T43.012D, T43.012S, T43.022A, T43.022D, T43.022S, T43.1X2A, T43.1X2D, T43.1X2S, T43.202A, T43.202D, T43.202S, T43.212A, T43.212D, T43.212S, T43.222A, T43.222D, T43.222S, T43.292A, T43.292D, T43.292S, T43.3X2A, T43.3X2D, T43.3X2S, T43.4X2A, T43.4X2D, T43.4X2S, T43.502A, T43.502D, T43.502S, T43.592A, T43.592D, T43.592S, T43.602A, T43.602D, T43.602S, T43.622A, T43.622D, T43.622S, T43.632A, T43.632D, T43.632S, T43.642A, T43.642D, T43.642S, T43.652A, T43.652D, T43.652S, T43.692A, T43.692D, T43.692S, T43.8X2A, T43.8X2D, T43.8X2S, T43.92XA, T43.92XD, T43.92XS, T44.0X2A, T44.0X2D, T44.0X2S, T44.1X2A, T44.1X2D, T44.1X2S, T44.2X2A, T44.2X2D, T44.2X2S, T44.3X2A, T44.3X2D, T44.3X2S, T44.4X2A, T44.4X2D, T44.4X2S, T44.5X2A, T44.5X2D, T44.5X2S, T44.6X2A, T44.6X2D, T44.6X2S, T44.7X2A, T44.7X2D, T44.7X2S, T44.8X2A, T44.8X2D, T44.8X2S, T44.902A, T44.902D, T44.902S, T44.992A, T44.992D, T44.992S, T45.0X2A, T45.0X2D, T45.0X2S, T45.1X2A, T45.1X2D, T45.1X2S, T45.2X2A, T45.2X2D, T45.2X2S, T45.3X2A, T45.3X2D, T45.3X2S, T45.4X2A, T45.4X2D, T45.4X2S, T45.512A, T45.512D, T45.512S, T45.522A, T45.522D, T45.522S, T45.602A, T45.602D, T45.602S, T45.612A, T45.612D, T45.612S, T45.622A, T45.622D, T45.622S, T45.692A, T45.692D, T45.692S, T45.7X2A, T45.7X2D, T45.7X2S, T45.8X2A, T45.8X2D, T45.8X2S, T45.92XA, T45.92XD, T45.92XS, T46.0X2A, T46.0X2D, T46.0X2S, T46.1X2A, T46.1X2D, T46.1X2S, T46.2X2A, T46.2X2D, T46.2X2S, T46.3X2A, T46.3X2D, T46.3X2S, T46.4X2A, T46.4X2D, T46.4X2S, T46.5X2A, T46.5X2D, T46.5X2S, T46.6X2A, T46.6X2D, T46.6X2S, T46.7X2A, T46.7X2D, T46.7X2S, T46.8X2A, T46.8X2D, T46.8X2S, T46.902A, T46.902D, T46.902S, T46.992A, T46.992D, T46.992S, T47.0X2A, T47.0X2D, T47.0X2S, T47.1X2A, T47.1X2D, T47.1X2S, T47.2X2A, T47.2X2D,
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			T47.2X2S, T47.3X2A, T47.3X2D, T47.3X2S, T47.4X2A, T47.4X2D, T47.4X2S, T47.5X2A, T47.5X2D, T47.5X2S, T47.6X2A, T47.6X2D, T47.6X2S, T47.7X2A, T47.7X2D, T47.7X2S, T47.8X2A, T47.8X2D, T47.8X2S, T47.92XA, T47.92XD, T47.92XS, T48.0X2A, T48.0X2D, T48.0X2S, T48.1X2A, T48.1X2D, T48.1X2S, T48.202A, T48.202D, T48.202S, T48.292A, T48.292D, T48.292S, T48.3X2A, T48.3X2D, T48.3X2S, T48.4X2A, T48.4X2D, T48.4X2S, T48.5X2A, T48.5X2D, T48.5X2S, T48.6X2A, T48.6X2D, T48.6X2S, T48.902A, T48.902D, T48.902S, T48.992A, T48.992D, T48.992S, T49.0X2A, T49.0X2D, T49.0X2S, T49.1X2A, T49.1X2D, T49.1X2S, T49.2X2A, T49.2X2D, T49.2X2S, T49.3X2A, T49.3X2D, T49.3X2S, T49.4X2A, T49.4X2D, T49.4X2S, T49.5X2A, T49.5X2D, T49.5X2S, T49.6X2A, T49.6X2D, T49.6X2S, T49.7X2A, T49.7X2D, T49.7X2S, T49.8X2A, T49.8X2D, T49.8X2S, T49.92XA, T49.92XD, T49.92XS, T50.0X2A, T50.0X2D, T50.0X2S, T50.1X2A, T50.1X2D, T50.1X2S, T50.2X2A, T50.2X2D, T50.2X2S, T50.3X2A, T50.3X2D, T50.3X2S, T50.4X2A, T50.4X2D, T50.4X2S, T50.5X2A, T50.5X2D, T50.5X2S, T50.6X2A, T50.6X2D, T50.6X2S, T50.7X2A, T50.7X2D, T50.7X2S, T50.8X2A, T50.8X2D, T50.8X2S, T50.902A, T50.902D, T50.902S, T50.912A, T50.912D, T50.912S, T50.992A, T50.992D, T50.992S, T50.A12A, T50.A12D, T50.A12S, T50.A22A, T50.A22D, T50.A22S, T50.A92A, T50.A92D, T50.A92S, T50.B12A, T50.B12D, T50.B12S, T50.B92A, T50.B92D, T50.B92S, T50.Z12A, T50.Z12D, T50.Z12S, T50.Z92A, T50.Z92D, T50.Z92S, T51.0X2A, T51.0X2D, T51.0X2S, T51.1X2A, T51.1X2D, T51.1X2S, T51.2X2A, T51.2X2D, T51.2X2S, T51.3X2A, T51.3X2D, T51.3X2S, T51.8X2A, T51.8X2D, T51.8X2S, T51.92XA, T51.92XD, T51.92XS, T52.0X2A, T52.0X2D, T52.0X2S, T52.1X2A, T52.1X2D, T52.1X2S, T52.2X2A, T52.2X2D, T52.2X2S, T52.3X2A, T52.3X2D, T52.3X2S, T52.4X2A, T52.4X2D, T52.4X2S, T52.8X2A, T52.8X2D, T52.8X2S, T52.92XA, T52.92XD, T52.92XS, T53.0X2A, T53.0X2D, T53.0X2S, T53.1X2A, T53.1X2D, T53.1X2S, T53.2X2A, T53.2X2D, T53.2X2S, T53.3X2A, T53.3X2D, T53.3X2S, T53.4X2A, T53.4X2D, T53.4X2S, T53.5X2A, T53.5X2D, T53.5X2S, T53.6X2A, T53.6X2D, T53.6X2S, T53.7X2A, T53.7X2D, T53.7X2S, T53.92XA, T53.92XD, T53.92XS, T54.0X2A, T54.0X2D, T54.0X2S, T54.1X2A, T54.1X2D, T54.1X2S, T54.2X2A, T54.2X2D, T54.2X2S, T54.3X2A, T54.3X2D,
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		T63.392S, T63.412A, T63.412D, T63.412S, T63.422A, T63.422D, T63.422S, T63.432A, T63.432D, T63.432S, T63.442A, T63.442D, T63.442S, T63.452A, T63.452D, T63.452S, T63.462A, T63.462D, T63.462S, T63.482A, T63.482D, T63.482S, T63.512A, T63.512D, T63.512S, T63.592A, T63.592D, T63.592S, T63.612A, T63.612D, T63.612S, T63.622A, T63.622D, T63.622S, T63.632A, T63.632D, T63.632S, T63.692A, T63.692D, T63.692S, T63.712A, T63.712D, T63.712S, T63.792A, T63.792D, T63.792S, T63.812A, T63.812D, T63.812S, T63.822A, T63.822D, T63.822S, T63.832A, T63.832D, T63.832S, T63.892A, T63.892D, T63.892S, T63.92XA, T63.92XD, T63.92XS, T64.02XA, T64.02XD, T64.02XS, T64.82XA, T64.82XD, T64.82XS, T65.0X2A, T65.0X2D, T65.0X2S, T65.1X2A, T65.1X2D, T65.1X2S, T65.212A, T65.212D, T65.212S, T65.222A, T65.222D, T65.222S, T65.292A, T65.292D, T65.292S, T65.3X2A, T65.3X2D, T65.3X2S, T65.4X2A, T65.4X2D, T65.4X2S, T65.5X2A, T65.5X2D, T65.5X2S, T65.6X2A, T65.6X2D, T65.6X2S, T65.812A, T65.812D, T65.812S, T65.822A, T65.822D, T65.822S, T65.832A, T65.832D, T65.832S, T65.892A, T65.892D, T65.892S, T65.92XA, T65.92XD, T65.92XS, T71.112A, T71.112D, T71.112S, T71.122A, T71.122D, T71.122S, T71.132A, T71.132D, T71.132S, T71.152A, T71.152D, T71.152S, T71.162A, T71.162D, T71.162S, T71.192A, T71.192D, T71.192S, T71.222A, T71.222D, T71.222S, T71.232A, T71.232D, T71.232S, X71.0XXA, X71.0XXD, X71.0XXS, X71.1XXA, X71.1XXD, X71.1XXS, X71.2XXA, X71.2XXD, X71.2XXS, X71.3XXA, X71.3XXD, X71.3XXS, X71.8XXA, X71.8XXD, X71.8XXS, X71.9XXA, X71.9XXD, X71.9XXS, X72.XXXA, X72.XXXD, X72.XXXS, X73.0XXA, X73.0XXD, X73.0XXS, X73.1XXA, X73.1XXD, X73.1XXS, X73.2XXA, X73.2XXD, X73.2XXS, X73.8XXA, X73.8XXD, X73.8XXS, X73.9XXA, X73.9XXD, X73.9XXS, X74.01XA, X74.01XD, X74.01XS, X74.02XA, X74.02XD, X74.02XS, X74.09XA, X74.09XD, X74.09XS, X74.8XXA, X74.8XXD, X74.8XXS, X74.9XXA, X74.9XXD, X74.9XXS, X75.XXXA, X75.XXXD, X75.XXXS, X76.XXXA, X76.XXXD, X76.XXXS, X77.0XXA, X77.0XXD, X77.0XXS, X77.1XXA, X77.1XXD, X77.1XXS, X77.2XXA, X77.2XXD, X77.2XXS, X77.3XXA, X77.3XXD, X77.3XXS, X77.8XXA, X77.8XXD, X77.8XXS, X77.9XXA, X77.9XXD, X77.9XXS, X78.0XXA, X78.0XXD, X78.0XXS, X78.1XXA, X78.1XXD, X78.1XXS, X78.2XXA, X78.2XXD,
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			X78.2XXS, X78.8XXA, X78.8XXD, X78.8XXS, X78.9XXA, X78.9XXD, X78.9XXS, X79.XXXA, X79.XXXD, X79.XXXS, X80.XXXA, X80.XXXD, X80.XXXS, X81.0XXA, X81.0XXD, X81.0XXS, X81.1XXA, X81.1XXD, X81.1XXS, X81.8XXA, X81.8XXD, X81.8XXS, X82.0XXA, X82.0XXD, X82.0XXS, X82.1XXA, X82.1XXD, X82.1XXS, X82.2XXA, X82.2XXD, X82.2XXS, X82.8XXA, X82.8XXD, X82.8XXS, X83.0XXA, X83.0XXD, X83.0XXS, X83.1XXA, X83.1XXD, X83.1XXS, X83.2XXA, X83.2XXD, X83.2XXS, X83.8XXA, X83.8XXD, X83.8XXS <i>Note: LOINC and SNOMED codes can be captured through electronic data submissions. Please contact your Account Executive for more information.</i>
Measure	Measure Description	Measure Information/Documentation Required	Coding
Follow-Up After Emergency Department Visit for Substance Use (FUA)	The percentage of emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow up. Two rates are reported: 1. The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days). 2. The percentage of ED visits for which	A follow-up visit or a pharmacotherapy dispensing event within 30 days after the ED visit (31 total days). Includes visits that occur on the date of the ED visit. A follow-up visit or pharmacotherapy dispensing event within 7 days after the ED visit (8 total days). Include visits that occur on the date of the ED visit. Required Exclusions: Members who meet any of the following criteria are excluded from the measure: • In hospice or using hospice services any time in the MY. • Deceased at any time in the MY.	Visit Setting Unspecified: (With Outpatient POS and with a Principal Diagnosis of AOD Abuse and Dependence, Substance Induced Disorders or Unintentional Drug Overdose, or with Mental Health Provider) (With Partial Hospitalization POS and with a Principal Diagnosis of AOD Abuse and Dependence, Substance Induced Disorders or Unintentional Drug Overdose, or with Mental Health Provider) (With Nonresidential Substance Abuse Treatment Facility POS and with any Diagnosis of AOD Abuse and Dependence, Substance Induced Disorders or Unintentional Drug Overdose, or with Mental Health Provider) (With Community Mental Health Center POS, and with Any Diagnosis of AOD Abuse and Dependence, Substance Induced Disorders or Unintentional Drug Overdose, or with a Mental Health Provider) (With Telehealth POS, and with Any Diagnosis of AOD Abuse and Dependence, Substance Induced Disorders or Unintentional Drug Overdose, or with Mental Health Provider): CPT: 90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221,

	the member received follow-up within 7 days of the ED visit (8 total days).	99222, 99223, 99231, 99232, 99233, 99238, 99239, 99252, 99253, 99254, 99255 BH Outpatient: (With Any Diagnosis of AOD Abuse and Dependence, Substance Induced Disorders or Unintentional Drug Overdose, or with a Mental Health Provider) CPT: 98960, 98961, 98962, 99078, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99242, 99243, 99244, 99245, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99483, 99492, 99493, 99494, 99510 HCPCS: G0155, G0176, G0177, G0409, G0463, G0512, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, T1015 UBREV: 0510, 0513, 0515, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0526, 0527, 0528, 0529, 0900, 0902, 0903, 0904, 0911, 0914, 0915, 0916, 0917, 0919, 0982, 0983 Partial Hospitalization or Intensive Outpatient Visit: (With Any Diagnosis of AOD Abuse and Dependence, Substance Induced Disorders or Unintentional Drug Overdose, or with a Mental Health Provider) HCPCS: G0410, G0411, H0035, H2001, H2012, S0201, S9480, S9484, S9485 UBREV: 0905, 0907, 0912, 0913 Peer Support Service: (With Any Diagnosis of AOD Abuse and Dependence, Substance Induced Disorders or Unintentional Drug Overdose): HCPCS: G0177, H0024, H0025, H0038, H0039, H0040, H0046, H2014, H2023, S9445, T1012, T1016 OD Weekly Non-Drug Service: (With Any Diagnosis of AOD Abuse and Dependence, Substance Induced Disorders or Unintentional Drug Overdose):
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			HCPCS: G2071, G2074, G2075, G2076, G2077, G2080 OD Monthly Office-Based Treatment: (With Any Diagnosis of AOD Abuse and Dependence, Substance Induced Disorders or Unintentional Drug Overdose, or with a Mental Health Provider): HCPCS: G2086, G2087 Telephone Visits: (With Any Diagnosis of AOD Abuse and Dependence, Substance Induced Disorders or Unintentional Drug Overdose, or with Mental Health Provider): CPT: 98966, 98967, 98968, 99441, 99442, 99443 Online Assessments: (With Any Diagnosis of AOD Abuse and Dependence, Substance Induced Disorders or Unintentional Drug Overdose, or with Mental Health Provider): CPT: 98970, 98971, 98972, 98980, 98981, 99421, 99422, 99423, 99457, 99458 HCPCS: G0071, G2010, G2012, G2250, G2251, G2252 Substance Abuse Counseling and Surveillance: ICD10CM: Z71.41, Z71.51 Substance Use Disorder Services: CPT: 99408, 99409 HCPCS: G0396, G0397, G0443, H0001, H0005, H0007, H0015, H0016, H0022, H0047, H0050, H2035, H2036, T1006, T1012 UBREV: 0906, 0944, 0945 Behavioral Health Assessment: CPT: 99408, 99409 HCPCS: G0396, G0397, G0442, G2011, H0001, H0002, H0031, H0049 Substance Use Services: HCPCS: H0006, H0028
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			Pharmacotherapy-Dispensing Event: Alcohol Use Disorder Treatment Medications: Aldehyde dehydrogenase inhibitor: Disulfiram (oral) Antagonist: Naltrexone (oral and injectable) Other: Acamprosate (oral and delayed-release tablet) Opioid Use Disorder Treatment Medications: Antagonist: Naltrexone (oral and injectable) Partial agonist: Buprenorphine (sublingual tablet, injection, implant), Buprenorphine/naloxone (sublingual tablet, buccal film, sublingual film) AOD Medication Treatment: HCPCS: H0020, H0033, J0570, J0571, J0572, J0573, J0574, J0575, J0577, J0578, J2315, Q9991, Q9992, S0109 ODD Weekly Drug Treatment Service: HCPCS: G2067, G2068, G2069, G2070, G2072, G2073 Outpatient POS: 03, 05, 07, 09, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 22, 33, 49, 50, 71, 72, 81 Psychiatric Facility-Partial Hospitalization: 52 Non-Residential Substance Abuse POS: 57, 58 Community Mental Health POS: 53 Residential Substance Abuse Treatment Facility POS: 55 Psychiatric Residential Treatment Center: 56 Telehealth POS: 02, 10 AOD Abuse and Dependence Diagnosis: ICD10CM: F10.10, F10.120, F10.121, F10.129, F10.130, F10.131, F10.132, F10.139, F10.14, F10.150, F10.151, F10.159, F10.180, F10.181, F10.182, F10.188, F10.19, F10.20, F10.220, F10.221, F10.229, F10.230, F10.231, F10.232, F10.239, F10.24, F10.250, F10.251, F10.259, F10.26, F10.27, F10.280, F10.281, F10.282, F10.288, F10.29, F11.10, F11.120, F11.121, F11.122, F11.129, F11.13, F11.14, F11.150, F11.151, F11.159, F11.181, F11.182,
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		F11.188, F11.19, F11.20, F11.220, F11.221, F11.222, F11.229, F11.23, F11.24, F11.250, F11.251, F11.259, F11.281, F11.282, F11.288, F11.29, F12.10, F12.120, F12.121, F12.122, F12.129, F12.13, F12.150, F12.151, F12.159, F12.180, F12.188, F12.19, F12.20, F12.220, F12.221, F12.222, F12.229, F12.23, F12.250, F12.251, F12.259, F12.280, F12.288, F12.29, F13.10, F13.120, F13.121, F13.129, F13.130, F13.131, F13.132, F13.139, F13.14, F13.150, F13.151, F13.159, F13.180, F13.181, F13.182, F13.188, F13.19, F13.20, F13.220, F13.221, F13.229, F13.230, F13.231, F13.232, F13.239, F13.24, F13.250, F13.251, F13.259, F13.26, F13.27, F13.280, F13.281, F13.282, F13.288, F13.29, F14.10, F14.120, F14.121, F14.122, F14.129, F14.13, F14.14, F14.150, F14.151, F14.159, F14.180, F14.181, F14.182, F14.188, F14.19, F14.20, F14.220, F14.221, F14.222, F14.229, F14.23, F14.24, F14.250, F14.251, F14.259, F14.280, F14.281, F14.282, F14.288, F14.29, F15.10, F15.120, F15.121, F15.122, F15.129, F15.13, F15.14, F15.150, F15.151, F15.159, F15.180, F15.181, F15.182, F15.188, F15.19, F15.20, F15.220, F15.221, F15.222, F15.229, F15.23, F15.24, F15.250, F15.251, F15.259, F15.280, F15.281, F15.282, F15.288, F15.29, F16.10, F16.120, F16.121, F16.122, F16.129, F16.14, F16.150, F16.151, F16.159, F16.180, F16.183, F16.188, F16.19, F16.20, F16.220, F16.221, F16.229, F16.24, F16.250, F16.251, F16.259, F16.280, F16.283, F16.288, F16.29, F18.10, F18.120, F18.121, F18.129, F18.14, F18.150, F18.151, F18.159, F18.17, F18.180, F18.188, F18.19, F18.20, F18.220, F18.221, F18.229, F18.24, F18.250, F18.251, F18.259, F18.27, F18.280, F18.288, F18.29, F19.10, F19.120, F19.121, F19.122, F19.129, F19.130, F19.131, F19.132, F19.139, F19.14, F19.150, F19.151, F19.159, F19.16, F19.17, F19.180, F19.181, F19.182, F19.188, F19.19, F19.20, F19.220, F19.221, F19.222, F19.229, F19.230, F19.231, F19.232, F19.239, F19.24, F19.250, F19.251, F19.259, F19.26, F19.27, F19.280, F19.281, F19.282, F19.288, F19.29 Substance Induced Disorders: ICD10CM: F10.90, F10.920, F10.921, F10.929, F10.930, F10.931, F10.932, F10.939, F10.94, F10.950, F10.951, F10.959, F10.96, F10.97, F10.980, F10.981, F10.982, F10.988, F10.99, F11.90, F11.920, F11.921, F11.922, F11.929, F11.93, F11.94, F11.950, F11.951, F11.959, F11.981, F11.982, F11.988, F11.99, F12.90,
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		F12.920, F12.921, F12.922, F12.929, F12.93, F12.950, F12.951, F12.959, F12.980, F12.988, F12.99, F13.90, F13.920, F13.921, F13.929, F13.930, F13.931, F13.932, F13.939, F13.94, F13.950, F13.951, F13.959, F13.96, F13.97, F13.980, F13.981, F13.982, F13.988, F13.99, F14.90, F14.920, F14.921, F14.922, F14.929, F14.93, F14.94, F14.950, F14.951, F14.959, F14.980, F14.981, F14.982, F14.988, F14.99, F15.90, F15.920, F15.921, F15.922, F15.929, F15.93, F15.94, F15.950, F15.951, F15.959, F15.980, F15.981, F15.982, F15.988, F15.99, F16.90, F16.920, F16.921, F16.929, F16.94, F16.950, F16.951, F16.959, F16.980, F16.983, F16.988, F16.99, F18.90, F18.920, F18.921, F18.929, F18.94, F18.950, F18.951, F18.959, F18.97, F18.980, F18.988, F18.99, F19.90, F19.920, F19.921, F19.922, F19.929, F19.930, F19.931, F19.932, F19.939, F19.94, F19.950, F19.951, F19.959, F19.96, F19.97, F19.980, F19.981, F19.982, F19.988, F19.99 Unintentional Drug Overdose: ICD10CM: T40.0X1A, T40.0X1D, T40.0X1S, T40.0X4A, T40.0X4D, T40.0X4S, T40.1X1A, T40.1X1D, T40.1X1S, T40.1X4A, T40.1X4D, T40.1X4S, T40.2X1A, T40.2X1D, T40.2X1S, T40.2X4A, T40.2X4D, T40.2X4S, T40.3X1A, T40.3X1D, T40.3X1S, T40.3X4A, T40.3X4D, T40.3X4S, T40.411A, T40.411D, T40.411S, T40.414A, T40.414D, T40.414S, T40.421A, T40.421D, T40.421S, T40.424A, T40.424D, T40.424S, T40.491A, T40.491D, T40.491S, T40.494A, T40.494D, T40.494S, T40.5X1A, T40.5X1D, T40.5X1S, T40.5X4A, T40.5X4D, T40.5X4S, T40.601A, T40.601D, T40.601S, T40.604A, T40.604D, T40.604S, T40.691A, T40.691D, T40.691S, T40.694A, T40.694D, T40.694S, T40.711A, T40.711D, T40.711S, T40.714A, T40.714D, T40.721A, T40.721S, T40.724A, T40.724D, T40.724S, T40.8X1A, T40.8X1D, T40.8X1S, T40.8X4A, T40.8X4D, T40.8X4S, T40.901A, T40.901D, T40.901S, T40.904A, T40.904D, T40.904S, T40.991A, T40.991D, T40.991S, T40.994A, T40.994D, T40.994S, T41.0X1A, T41.0X1D, T41.0X1S, T41.0X4A, T41.0X4D, T41.0X4S, T41.1X1A, T41.1X1D, T41.1X1S, T41.1X4A, T41.1X4D, T41.1X4S, T41.201A, T41.201D, T41.201S, T41.204A, T41.204D, T41.204S, T41.291A, T41.291D, T41.291S, T41.294A, T41.294D, T41.294S, T41.3X1A, T41.3X1D, T41.3X1S, T41.3X4A, T41.3X4D, T41.3X4S, T41.41XA, T41.41XD, T41.41XS, T41.44XA, T41.44XD, T41.44XS, T41.5X1A, T41.5X1D, T41.5X1S, T41.5X4A, T41.5X4D, T41.5X4S, T42.3X1A,
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			T42.3X1D, T42.3X1S, T42.3X4A, T42.3X4D, T42.3X4S, T42.4X1A, T42.4X1D, T42.4X1S, T42.4X4A, T42.4X4D, T42.4X4S, T43.601A, T43.601D, T43.601S, T43.604A, T43.604D, T43.604S, T43.621A, T43.621D, T43.621S, T43.624A, T43.624D, T43.624S, T43.631A, T43.631D, T43.631S, T43.634A, T43.634D, T43.634S, T43.641A, T43.641D, T43.641S, T43.644A, T43.644D, T43.644S, T43.651A, T43.651D, T43.651S, T43.654A, T43.654D, T43.654S, T43.691A, T43.691D, T43.691S, T43.694A, T43.694D, T43.694S, T51.0X1A, T51.0X1D, T51.0X1S, T51.0X4A, T51.0X4D, T51.0X4S <i>Note: LOINC and SNOMED codes can be captured through electronic data submissions. Please contact your Account Executive for more information.</i>
Measure	Measure Description	Measure Information/Documentation Required	Coding
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)	Members 13 years of age or older who had an acute inpatient hospitalization, residential treatment or detoxification visit for a diagnosis of substance use disorder that resulted in a follow-up visit or service for substance use disorder.	The percentage of acute inpatient hospitalizations, residential treatment, or withdrawal management visits for a diagnosis of substance use disorder among members 13 years of age and older that result in a follow-up visit or service for substance use disorder: 7-Day Follow-Up: A follow-up visit or event with any practitioner for a principal diagnosis of substance use disorder within the 7 days after an episode for substance use disorder. 30-Day Follow-Up: A follow-up visit or event with any practitioner for a principal diagnosis of substance use disorder within the 30 days after an episode for substance use disorder. Note: - Methadone is not included in the medication lists for the measure. - Follow-up does not include withdrawal management.	Visit Setting Unspecified: (With Outpatient POS and with a Principal Diagnosis of AOD Abuse and Dependence): (With BH Outpatient Visit and with a Principal Diagnosis of AOD Abuse and Dependence): (With Partial Hospitalization POS and with a Principal Diagnosis of AOD Abuse and Dependence): (With Nonresidential Substance Abuse Treatment Facility POS and with a Principal Diagnosis of AOD Abuse and Dependence): (With Community Mental Health Center POS and with a Principal Diagnosis of AOD Abuse and Dependence): (With Telehealth POS and with a Principal Diagnosis of AOD Abuse and Dependence): CPT: 90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99252, 99253, 99254, 99255 BH Outpatient: (With Principal Diagnosis of AOD Abuse and Dependence): CPT: 98960, 98961, 98962, 99078, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99242, 99243, 99244, 99245,

		Required Exclusions: Members who meet any of the following criteria are excluded from the measure: • In hospice or using hospice services any time in the MY. • Deceased at any time in the MY.	99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99483, 99492, 99493, 99494, 99510 HCPCS: G0155, G0176, G0177, G0409, G0463, G0512, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, T1015 UBREV: 0510, 0513, 0515, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0526, 0527, 0528, 0529, 0900, 0902, 0903, 0904, 0911, 0914, 0915, 0916, 0917, 0919, 0982, 0983 Partial Hospitalization or Intensive Outpatient Visit: (With a Principal Diagnosis of AOD Abuse and Dependence): HCPCS: G0410, G0411, H0035, H2001, H2012, S0201, S9480, S9484, S9485 UBREV: 0905, 0907, 0912, 0913 Substance Use Disorder Services: (With a Principal Diagnosis of AOD Abuse and Dependence): CPT: 99408, 99409 HCPCS: G0396, G0397, G0443, H0001, H0005, H0007, H0015, H0016, H0022, H0047, H0050, H2035, H2036, T1006, T1002 UBREV: 0906, 0944, 0945 Substance Abuse Counseling and Surveillance: ICD10CM: Z71.41, Z71.51 Residential Behavioral Health Treatment: (With a Principal Diagnosis of AOD Abuse and Dependence): HCPCS: H0017, H0018, H0019, T2048 Telephone Visit (With a Principal Diagnosis of AOD Abuse and Dependence): CPT: 98966, 98967, 98968, 99441, 99442, 99443 Online Assessments: (With a Principal Diagnosis of AOD Abuse and Dependence):
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			CPT: 98970, 98971, 98972, 98980, 98981, 99421, 99422, 99423, 99457, 99458 HCPCS: G0071, G2010, G2012, G2250, G2251, G2252 OD Monthly Office-Based Treatment: (With a Principal Diagnosis of AOD Abuse and Dependence): HCPCS: G2086, G2087 OD Weekly Non-Drug Service: (With a Principal Diagnosis of AOD Abuse and Dependence): HCPCS: G2071, G2074, G2075, G2076, G2077, G2080 Pharmacotherapy-Dispensing Event: Alcohol Use Disorder Treatment Medications: Aldehyde dehydrogenase inhibitor: Disulfiram (oral) Antagonist: Naltrexone (oral and injectable) Other: Acamprosate (oral and delayed-release tablet) Opioid Use Disorder Treatment Medications: Antagonist: Naltrexone (oral and injectable) Partial agonist: Buprenorphine (sublingual tablet, injection, implant), Buprenorphine/naloxone (sublingual tablet, buccal film, sublingual film) AOD Medication Treatment: HCPCS: H0020, H0033, J0570, J0571, J0572, J0573, J0574, J0575, J0577, J0578, J2315, Q9991, Q9992, S0109 OD Weekly Drug Treatment Service: HCPCS: G2067, G2068, G2069, G2070, G2072, G2073 Outpatient POS: 03, 05, 07, 09, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 22, 33, 49, 50, 71, 72 Psychiatric Facility-Partial Hospitalization POS: 52 Non-Residential Substance Abuse POS: 57, 58 Community Mental Health POS: 53
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			Telehealth POS: 02 AOD Abuse and Dependence Diagnosis: ICD10CM: F10.10, F10.120, F10.121, F10.129, F10.130, F10.131, F10.132, F10.139, F10.14, F10.150, F10.151, F10.159, F10.180, F10.181, F10.182, F10.188, F10.19, F10.20, F10.220, F10.221, F10.229, F10.230, F10.231, F10.232, F10.239, F10.24, F10.250, F10.251, F10.259, F10.26, F10.27, F10.280, F10.281, F10.282, F10.288, F10.29, F11.10, F11.120, F11.121, F11.122, F11.129, F11.13, F11.14, F11.150, F11.151, F11.159, F11.181, F11.182, F11.188, F11.19, F11.20, F11.220, F11.221, F11.222, F11.229, F11.23, F11.24, F11.250, F11.251, F11.259, F11.281, F11.282, F11.288, F11.29, F12.10, F12.120, F12.121, F12.122, F12.129, F12.13, F12.150, F12.151, F12.159, F12.180, F12.188, F12.19, F12.20, F12.220, F12.221, F12.222, F12.229, F12.23, F12.250, F12.251, F12.259, F12.280, F12.288, F12.29, F13.10, F13.120, F13.121, F13.129, F13.130, F13.131, F13.132, F13.139, F13.14, F13.150, F13.151, F13.159, F13.180, F13.181, F13.182, F13.188, F13.19, F13.20, F13.220, F13.221, F13.229, F13.230, F13.231, F13.232, F13.239, F13.24, F13.250, F13.251, F13.259, F13.26, F13.27, F13.280, F13.281, F13.282, F13.288, F13.29, F14.10, F14.120, F14.121, F14.122, F14.129, F14.13, F14.14, F14.150, F14.151, F14.159, F14.180, F14.181, F14.182, F14.188, F14.19, F14.20, F14.220, F14.221, F14.222, F14.229, F14.23, F14.24, F14.250, F14.251, F14.259, F14.280, F14.281, F14.282, F14.288, F14.29, F15.10, F15.120, F15.121, F15.122, F15.129, F15.13, F15.14, F15.150, F15.151, F15.159, F15.180, F15.181, F15.182, F15.188, F15.19, F15.20, F15.220, F15.221, F15.222, F15.229, F15.23, F15.24, F15.250, F15.251, F15.259, F15.280, F15.281, F15.282, F15.288, F15.29, F16.10, F16.120, F16.121, F16.122, F16.129, F16.14, F16.150, F16.151, F16.159, F16.180, F16.183, F16.188, F16.19, F16.20, F16.220, F16.221, F16.229, F16.24, F16.250, F16.251, F16.259, F16.280, F16.283, F16.288, F16.29, F18.10, F18.120, F18.121, F18.129, F18.14, F18.150, F18.151, F18.159, F18.17, F18.180, F18.188, F18.19, F18.20, F18.220, F18.221, F18.229, F18.24, F18.250, F18.251, F18.259, F18.27, F18.280, F18.288, F18.29, F19.10, F19.120, F19.121, F19.122, F19.129, F19.130, F19.131, F19.132, F19.139, F19.14, F19.150, F19.151, F19.159,
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Measure	Measure Description	Measure Information/Documentation Required	Coding
Pharmacotherapy for Opioid Use Disorder (POD)	The percentage of new opioid use disorder (OUD) pharmacotherapy events with OUD pharmacotherapy for 180 or more days among members age 16 and older with a diagnosis of OUD.	Intake period: 12-month period that begins on 7/1 of the year prior to the MY and ends on 6/30 of the MY. The Treatment Period (TP) is the date of an OUD dispensing event or OUD medication administration event during the IP. No more than an 8-day gap is allowed during the TP. Note: • Methadone is not included in the medication lists for the measure. Required Exclusions: Members who meet any of the following criteria are excluded from the measure: • In hospice or using hospice services any time in the MY. • Deceased at any time in the MY.	Members are identified through administrative and pharmacy claims. Opioid Abuse and Dependence Diagnosis: ICD10CM: F11.10, F11.120, F11.121, F11.122, F11.129, F11.13, F11.14, F11.150, F11.151, F11.159, F11.181, F11.182, F11.188, F11.19, F11.20, F11.220, F11.221, F11.222, F11.229, F11.23, F11.24, F11.250, F11.251, F11.259, F11.281, F11.282, F11.288, F11.29 Opioid Use Disorder Treatment Medications: Antagonist: Naltrexone (oral) Antagonist: Naltrexone (injectable) Partial agonist: Buprenorphine (sublingual tablet), Buprenorphine (injection), Buprenorphine (implant), Buprenorphine/naloxone (sublingual tablet, buccal film, sublingual film) Agonist: Methadone (oral) is only acceptable when billed on a medical claim. A pharmacy claim would be indicative of treatment for pain rather than OUD. Buprenorphine Implant: HCPCS: G2070, G2072, J0570 Buprenorphine Injection: HCPCS: G2069, Q9991, Q9992 Buprenorphine Naloxone: HCPCS: J0572, J0573, J0574, J0575

			Buprenorphine Oral: HCPCS: H0033, J0571 Buprenorphine Oral Weekly: HCPCS: G2068, G2079 Methadone Oral: HCPCS: H0020, S0109 Methadone Oral Weekly: HCPCS: G2067, G2078 Naltrexone Injection: HCPCS: G2073, J2315 <i>Note: LOINC and SNOMED codes can be captured through electronic data submissions. Please contact your Account Executive for more information.</i>
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EFFECTIVENESS OF CARE: CARE COORDINATION

Measure	Measure Description	Measure Information/Documentation Required	Coding
Advance Care Planning (ACP) <i>1st Year Measure (MY2022)</i>	Adults 66 – 80 years of age with advanced illness, frailty, or receiving palliative care, and adults 81 years of age or older, who had advance care planning during the MY.	Advance Care Plan or discussion of Advance Care Planning documented in the medical record on or before 12/31 of the MY. Required Exclusions: Members who meet any of the following criteria are excluded from the measure: • In hospice or using hospice services in the MY. • Deceased at any time in the MY.	CPT: 99483, 99497 CPT-CAT-II: 1123F, 1124F, 1157F, 1158F HCPCS: S0257 ICD10CM: Z66, Z51.5
Measure	Measure Description	Measure Information/Documentation Required	Coding
Transition of Care (TRC)	Members 18 years of age and older who had	Notification of Inpatient Admission (NIA):	Patient Engagement Indicator: Outpatient and Telehealth:

	an inpatient discharge for which each of the following occurred: 1. Notification of Inpatient Admission. 2. Receipt of Discharge Information. 3. Patient Engagement After Inpatient Discharge. 4. Medication Reconciliation Post-Discharge. Each qualifying discharge in the MY is measured.	Documentation must include evidence of receipt of notification of inpatient admission on the day of admission through the 2 days following admission. Admission refers to the date of inpatient admission or date of admission for an observation stay that turns into an inpatient admission. Documentation must include evidence of receipt of notification of inpatient admission that includes evidence of the date when the documentation was received. Any of the following examples meet criteria: • Communication between inpatient providers or staff and the member's PCP or ongoing care provider (e.g., phone call, email, fax). • Communication about admission between emergency department and the member's PCP or ongoing care provider (e.g., phone call, email, fax). • Communication about admission to the member's PCP or ongoing care provider through a health information exchange; an automated admission, discharge, and transfer (ADT) alert system; or a shared electronic medical record system. • Communication about admission to the member's PCP or ongoing care provider from the member's health plan. • Indication that the member's PCP or ongoing care provider admitted the member to the hospital. • Indication that a specialist admitted the member to the hospital and notified the member's PCP or ongoing care provider. • Indication that the PCP or ongoing care provider placed orders for tests and	CPT: 98966, 98967, 98968, 98970, 98971, 98972, 98980, 98981, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99242, 99243, 99244, 99245, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99421, 99422, 99423, 99429, 99441, 99442, 99443, 99455, 99456, 99457, 99458, 99483 HCPCS: G0071, G0402, G0438, G0439, G0463, G2010, G2012, G2250, G2251, G2252, T1015 Transitional Care Management Services: CPT: 99495, 99496 Online Assessments: CPT: 98970, 98971, 98972, 98980, 98981, 99421, 99422, 99423, 99457, 99458 HCPCS: G0071, G2010, G2012, G2250, G2251, G2252 Medication Reconciliation Post-Discharge Indicator: Medication Reconciliation Encounter: CPT: 99483, 99495, 99496 Medication Reconciliation Intervention: CPT-CAT-II: 1111F The Notification of Inpatient Admission and Receipt of Discharge Information has no administrative reporting option. They are based on medical record review only. <i>Note: LOINC and SNOMED codes can be captured through electronic data submissions. Please contact your Account Executive for more information.</i>
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		treatments any time during the member's inpatient stay. - Documentation that the PCP or ongoing care provider performed a preadmission exam or received communication about a planned inpatient admission. The time frame that the planned inpatient admission must be communicated is not limited to the day of admission or the 2 days following; documentation that the PCP or ongoing care provider performed a preadmission exam or received notification of a planned admission prior to the admit date also meets criteria. The planned admission documentation or preadmission exam must clearly pertain to the admission. Receipt of Discharge Information (RDI): Documentation must include evidence of receipt of discharge information on the day of discharge through the 2 days following discharge. Discharge information may be included in, but not limited to, a discharge summary or summary of care record or be located in structured fields in an Electronic Health Record (EHR). At a minimum, the discharge information must include all of the following: - The practitioner responsible for the member's care during the inpatient stay. - Procedures or treatment provided. - Diagnoses at discharge. - Current medication list. - Testing results, or documentation of pending tests or no tests pending. - Instructions for patient care post-discharge.	
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		Patient Engagement After Inpatient Discharge (PE): Documentation must include evidence of patient engagement within 30 days following discharge. Any of the following meets criteria: • An outpatient visit, including office visits and home visits. • A telephone visit. • A synchronous telehealth visit where real-time interaction occurred between the member and provider via telephone or video conferencing. Do not include patient engagement that occurs on the date of discharge. • An e-visit or virtual check-in. Medication Reconciliation Post-Discharge (Med Rec): Documentation in the outpatient medical record must include evidence of medication reconciliation and the date it was performed by a prescribing practitioner (including physician assistant), clinical pharmacist, or registered nurse, as documented on the date of discharge through 30 days after discharge (31 total days). Any of the following meet criteria: • Documentation of the current medications with a notation that the provider reconciled the current and discharge medications. • Documentation of the current medications with a notation that references the discharge medications (e.g., no changes in medications since discharge, same medications at discharge, discontinue all discharge medications). • Documentation of the member's current medications with a notation that the discharge medications were reviewed.	
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		• Documentation of a current medication list, a discharge medication list, and notation that both lists were reviewed on the same date of service. • Documentation of the current medications with evidence that the member was seen for post-discharge hospital follow-up with evidence of medication reconciliation or review. • Documentation in the discharge summary that the discharge medications were reconciled with the most recent medication list in the outpatient medical record. There must be evidence that the discharge summary was filed in the outpatient chart on the date of discharge through 30 days after discharge (31 total days). • Notation that no medications were prescribed or ordered upon discharge. • Only documentation in the outpatient chart meets the intent of the rate, but an outpatient visit is not required, and the member does not have to be present. The following notations or examples of documentation do not count as numerator compliant for Notification of Inpatient Admission and Notification of Inpatient Discharge: • Documentation that the member or the member's family notified the member's PCP or ongoing care provider of the admission or discharge. Required Exclusions: Members who meet any of the following criteria are excluded from the measure:	
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		• In hospice or using hospice services any time in the MY. • Deceased at any time in the MY. • Remained in an acute or nonacute facility from discharge through 12/1 of the MY. Common Chart Deficiencies: • Inpatient records cannot be used for TRC. • NIA: Documentation that a provider sent the member to the ED does not meet criteria. • NIA: Documentation that the member or the member's family member notified the PCP or ongoing care provider of the admission does not meet criteria. • NIA: Documentation of notification that does not include a time frame or date when the documentation was received does not meet criteria. • NIA: Documentation that communication was sent to the PCP does not meet criteria — documentation of receipt is required. • RDI: Discharge Summary not included in outpatient record or missing one or more of the 6 required elements. • RDI: Documentation on Discharge Summary that communication was sent to the PCP does not meet criteria — documentation of receipt is required. • PE: Patient engagement that occurs on the date of discharge, or more than 30 days after discharge, does not meet criteria. • Med Rec: Completed by incorrect provider type. • Med Rec: Documentation of current medications reviewed without reference to the hospitalization.	
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		Med Rec: Medication list found in both the discharge summary and outpatient record but no evidence the two were reconciled.	
Measure	Measure Description	Measure Information/Documentation Required	Coding
Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions (FMC)	Members 18 years and older who have multiple high-risk chronic conditions who had a follow-up service within 7 days of the ED visit. Each qualifying ED in the Measurement Period (MP) is measured.	The MP is 1/1 through 12/24. ED visits that result in an inpatient stay or that are followed by admission to acute or nonacute inpatient care within 7 days are excluded. Chronic conditions include: - COPD, asthma, and bronchitis. - Alzheimer's disease and related disorders (dementia, frontotemporal dementia). - Chronic kidney disease. - Major depression. - Dysthymic disorder. - Heart failure and chronic heart failure. - Acute myocardial infarction. - Atrial fibrillation. - Stroke and transient ischemic attack. Acceptable follow-up visit types include: - An outpatient visit, telephone visit, e-visit or virtual check-in. - Transitional care management services. - Case management visits. - Complex care management services. - An outpatient or telehealth behavioral health visit with outpatient POS. - An intensive outpatient encounter or partial hospitalization. - A community mental health center visit. - Outpatient Electroconvulsive therapy.	Follow-Up Service: Outpatient and Telehealth: CPT: 98966, 98967, 98968, 98970, 98971, 98972, 98980, 98981, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99242, 99243, 99244, 99245, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99421, 99422, 99423, 99429, 99441, 99442, 99443, 99455, 99456, 99457, 99458, 99483 HCPCS: G0071, G0402, G0438, G0439, G0463, G2010, G2012, G2250, G2251, G2252, T1015 Transitional Care Management: CPT: 99495, 99496 Case Management Encounter: CPT: 99366 HCPCS: T1016, T1017, T2022, T2023 Complex Care Management Services: CPT: 99487, 99489, 99490, 99491 HCPCS: G0506 Visit Setting Unspecified: (With Outpatient POS, Partial Hospitalization POS, Community Mental Health Center POS, or Telehealth POS): CPT: 90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99252, 99253, 99254, 99255 BH Outpatient:

		• A substance use disorder service or counseling. Required Exclusions: Members who meet any of the following criteria are excluded from the measure: • In hospice or using hospice services any time in the MY. • Deceased at any time in the MY.	CPT: 98960, 98961, 98962, 99078, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99242, 99243, 99244, 99245, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99483, 99492, 99493, 99494, 99510 HCPCS: G0155, G0176, G0177, G0409, G0463, G0512, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, T1015 UBREV: 0510, 0513, 0515, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0526, 0527, 0528, 0529, 0900, 0902, 0903, 0904, 0911, 0914, 0915, 0916, 0917, 0919, 0982, 0983 Partial Hospitalization or Intensive Outpatient: HCPCS: G0410, G0411, H0035, H2001, H2012, S0201, S9480, S9484, S9485 UBREV: 0905, 0907, 0912, 0913 Electroconvulsive Therapy: (With Ambulatory Surgical Center POS, Community Mental Health Center POS, Outpatient POS, or Partial Hospitalization POS): CPT: 90870 ICD10PCS: GZB0ZZZ, GZB1ZZZ, GZB2ZZZ, GZB3ZZZ, GZB4ZZZ Substance Abuse Counseling and Surveillance: ICD10CM: Z71.41, Z71.51 Substance Use Disorder Services: CPT: 99408, 99409 HCPCS: G0396, G0397, G0443, H0001, H0005, H0007, H0015, H0016, H0022, H0047, H0050, H2035, H2036, T1006, T1012 UBREV: 0906, 0944, 0945 Online Assessments: CPT: 98970, 98971, 98972, 98980, 98981, 99421, 99422, 99423, 99457, 99458 HCPCS: G0071, G2010, G2012, G2250, G2251, G2252
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			Domiciliary/Rest Home Visit: CPT: 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337 Outpatient POS: 03, 05, 07, 09, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 22, 24, 33, 49, 50, 52, 53, 71, 72, 81 Telehealth POS: 02 <i>Note: LOINC and SNOMED codes can be captured through electronic data submissions. Please contact your Account Executive for more information.</i>
EFFECTIVENESS OF CARE: OVERUSE/APPROPRIATENESS			
Measure	Measure Description	Measure Information/Documentation Required	Coding
Avoidance of Antibiotic Treatment for Acute Bronchitis (AAB) <i>This is also a measure (AAB-E) collected through claims and Electronic Clinical Data Systems. Please discuss options for a direct data feed with your Account Executive. Direct data feeds can improve provider quality performance and reduce the burden of medical record requests.</i>	The percentage of episodes for members ages 3 months and older with a diagnosis of acute bronchitis/bronchiolitis that did not result in an antibiotic dispensing event. Higher rate indicates appropriate treatment of adults with acute bronchitis (i.e., the proportion for whom antibiotics were not prescribed).	The Intake Period (IP) is the 12-month window that begins 7/1 of the year prior to the MY and ends 6/30 of the MY. The Episode Date (EP) is the date of service for any outpatient, telephone, observation, or ED visit, e-visit or virtual check-in during the IP, with a diagnosis of acute bronchitis/bronchiolitis. Dispensed prescription for an antibiotic medication (AAB Antibiotic Medications List) on or three days after the EP. Required Exclusions: Members who meet any of the following criteria are excluded from the measure: - In hospice or using hospice services any time in the MY. - Deceased at any time in the MY. Common Chart Deficiencies:	Acute Bronchitis Diagnosis: ICD10CM: J20.3, J20.4, J20.5, J20.6, J20.7, J20.8, J20.9, J21.0, J21.1, J21.8, J21.9 AAB Antibiotic Medications: Aminoglycosides: Amikacin, Gentamicin, Streptomycin, Tobramycin Aminopenicillins: Amoxicillin, Ampicillin Beta-lactamase inhibitors: Amoxicillin-clavulanate, Ampicillin-sulbactam, Piperacillin-tazobactam First-generation cephalosporins: Cefadroxil, Cefazolin, Cephalexin Fourth-generation cephalosporins: Cefepime Lincomycin derivatives: Clindamycin, Lincomycin Macrolides: Azithromycin, Clarithromycin, Erythromycin Miscellaneous antibiotics: Aztreonam, Chloramphenicol, Dalfopristin-quinupristin, Daptomycin, Linezolid, Metronidazole, Vancomycin Natural penicillins: Penicillin G benzathine-procaine, Penicillin G potassium, Penicillin G procaine, Penicillin G sodium, Penicillin V potassium, Penicillin G benzathine Penicillinase-resistant penicillins: Dicloxacillin, Nafcillin, Oxacillin Quinolones: Ciprofloxacin, Gemifloxacin, Levofloxacin, Moxifloxacin, Ofloxacin Rifamycin derivatives: Rifampin

		Additional/competing diagnosis requiring antibiotics not documented in visit or coded on claim.	Second-generation cephalosporin: Cefaclor, Cefotetan, Cefoxitin, Cefprozil, Cefuroxime Sulfonamides: Sulfadiazine, Sulfamethoxazole-trimethoprim Tetracyclines: Doxycycline, Minocycline, Tetracycline Third-generation cephalosporins: Cefdinir, Cefixime, Cefotaxime, Cefpodoxime, Ceftazidime, Ceftriaxone Urinary anti-infectives: Fosfomycin, Nitrofurantoin, Nitrofurantoin macrocrystals-monohydrate, Trimethoprim <i>Note: LOINC and SNOMED codes can be captured through electronic data submissions. Please contact your Account Executive for more information.</i>
Measure	Measure Description	Measure Information/Documentation Required	Coding
Non-Recommended PSA-Based Screening in Older Men (PSA) <i>This is also a measure (PSA-E) collected through claims and Electronic Clinical Data Systems. Please discuss options for a direct data feed with your Account Executive. Direct data feeds can improve provider quality performance and reduce the burden of medical record requests.</i>	Male members 70 years and older who were screened unnecessarily for prostate cancer using prostate-specific antigen (PSA)–based screening. A lower rate indicates better performance.	Required Exclusions: Members who meet any of the following criteria are excluded from the measure: - In hospice or using hospice services any time in the MY. - Deceased at any time in the MY. - Prostate cancer diagnosis any time during the member’s history through December 31 of the MY. - Dysplasia of the prostate during the MY or the year prior. - A PSA test during the year prior to the MY where lab data indicate an elevated result (>4.0 nanograms/milliliter) or an abnormal result. - Dispensed prescription for a 5-alpha reductase inhibitor during the MY.	PSA Lab Test: CPT: 84152, 84153, 84154 HCPCS: G0103 <i>Note: LOINC and SNOMED codes can be captured through electronic data submissions. Please contact your Account Executive for more information.</i>
Measure	Measure Description	Measure Information/Documentation Required	Coding
Appropriate Treatment for Upper Respiratory Infection (URI)	The percentage of episodes for members 3 months of age and older	The Intake Period (IP) is the 12-month window that begins July 1 of the year prior to the MY and ends on June 30 of the MY.	URI Diagnosis: ICD10CM: J00, J06.0, J06.9

<i>This is also a measure (URI-E) collected through claims and Electronic Clinical Data Systems. Please discuss options for a direct data feed with your Account Executive. Direct data feeds can improve provider quality performance and reduce the burden of medical record requests.</i>	with a diagnosis of upper respiratory infection (URI) that did not result in an antibiotic dispensing event. This is an episode-based event, so a member may be included multiple times. Higher rate indicates appropriate treatment (i.e., the proportion for whom antibiotics were NOT prescribed).	The Episode Date (EP) is the Date of Service (DOS) for any outpatient, telephone, observation or ED visit, e-visit, or virtual check-in during the IP with a diagnosis or URI. If a member has more than one EP in a 31-day period, only the first EP will be used. Members with a comorbid condition during the 12 months prior to the EP will be excluded. These include: • HIV, HIV Type 2. • Malignant neoplasm. • Emphysema. • COPD. • Disorders of the immune system. • Other comorbid conditions. Required Exclusions: Members who meet any of the following criteria are excluded from the measure: • In hospice or using hospice services any time in the MY. • Deceased at any time in the MY. Common Chart Deficiencies: • Additional/competing diagnosis requiring antibiotics not documented in visit or coded on claim.	Antibiotic Medications: Aminoglycosides: Amikacin, Gentamicin, Streptomycin, Tobramycin Aminopenicillins: Amoxicillin, Ampicillin Beta-lactamase inhibitors: Amoxicillin-clavulanate, Ampicillin-sulbactam, Piperacillin-tazobactam First-generation cephalosporins: Cefadroxil, Cefazolin, Cephalexin Fourth-generation cephalosporins: Cefepime Lincomycin derivatives: Clindamycin, Lincomycin Macrolides: Azithromycin, Clarithromycin, Erythromycin Miscellaneous antibiotics: Aztreonam, Chloramphenicol, Dalbapristin-quinupristin, Daptomycin, Linezolid, Metronidazole, Vancomycin Natural penicillins: Penicillin G benzathine, Penicillin G benzathine-procaine, Penicillin G potassium, Penicillin G procaine, Penicillin G sodium, Penicillin V potassium Penicillinase-resistant penicillins: Dicloxacillin, Nafcillin, Oxacillin Quinolones: Ciprofloxacin, Gemifloxacin, Levofloxacin, Moxifloxacin, Ofloxacin Rifamycin derivatives: Rifampin Second-generation cephalosporins: Cefaclor, Cefotetan, Cefoxitin, Cefprozil, Cefuroxime Sulfonamides: Sulfadiazine, Sulfamethoxazole-trimethoprim Tetracyclines: Doxycycline, Minocycline, Tetracycline Third-generation cephalosporins: Cefdinir, Cefixime, Cefotaxime, Cefpodoxime, Ceftazidime, Ceftriaxone Urinary anti-infectives: Fosfomycin, Nitrofurantoin, Nitrofurantoin macrocrystals-monohydrate, Trimethoprim <i>Note: LOINC and SNOMED codes can be captured through electronic data submissions. Please contact your Account Executive for more information.</i>
Measure	Measure Description	Measure Information/Documentation Required	Coding
Potentially Harmful Drug-Disease Interactions in Older Adults (DDE)	Medicare members 65 years of age and older who have evidence of an underlying disease,	Required Exclusions: Members who meet any of the following criteria are excluded from the measure:	HEDIS rates are based on Diagnosis and Medications/Pharmacy Claims. Potentially Harmful Drugs — History of Falls Medications:

	condition, or health concern and who were dispensed an ambulatory prescription for a potentially harmful medication concurrent with or after the diagnosis. Three rates are reported: 1. A history of falls and a prescription for anticonvulsants, SSRIs, antipsychotics, benzodiazepines, non-benzodiazepine hypnotics, or tricyclic antidepressants. 2. Dementia and prescription for antipsychotics, benzodiazepines, non-benzodiazepine hypnotics, tricyclic antidepressants, H2 receptor antagonists, or anticholinergic agents. 3. Chronic kidney disease and prescription for Cox-2 selective	• In hospice or using hospice services any time in the MY. • Deceased at any time in the MY. • Receiving palliative care any time in the MY. • History of falls and dementia rates only: A diagnosis of psychosis, schizophrenia, schizoaffective disorder, or bipolar disorder on or between 1/1 of the year prior to the MY and 12/1 of the MY. • History of falls rate only: A diagnosis of major depressive disorder or seizure disorder on or between 1/1 of the year prior to the MY and 12/1 of the MY.	Antiepileptics: Carbamazepine, Clobazam, Divalproex sodium, Ethosuximide, Ethotoin, Felbamate, Fosphenytoin, Gabapentin, Lacosamide, Lamotrigine, Levetiracetam, Methsuximide, Oxcarbazepine, Phenobarbital, Phenytoin, Pregabalin, Primidone, Rufinamide, Tiagabine HCL, Topiramate, Valproic acid, Vigabatrin, Zonisamide SNRIs: Desvenlafaxine, Duloxetine, Levomilnacipran, Venlafaxine, SSRIs: Citalopram, Escitalopram, Fluoxetine, Fluvoxamine, Paroxetine, Sertraline Potentially Harmful Drugs—History of Falls and Dementia Medications: Antipsychotics: Aripiprazole, Asenapine, Brexpiprazole, Cariprazine, Chlorpromazine, Clozapine, Fluphenazine, Haloperidol, Iloperidone, Loxapine, Lurasidone, Molindone, Olanzapine, Paliperidone, Perphenazine, Pimozide, Quetiapine, Risperidone, Thioridazine, Thiothixene, Trifluoperazine, Ziprasidone Benzodiazepines: Alprazolam, Chlordiazepoxide, Clonazepam, Clorazepate, Diazepam, Estazolam, Flurazepam, Lorazepam, Midazolam, Oxazepam, Quazepam, Temazepam, Triazolam Nonbenzodiazepine hypnotics: Eszopiclone, Zaleplon, Zolpidem Tricyclic antidepressants: Amitriptyline, Amoxapine, Clomipramine, Desipramine, Doxepin (>6 mg), Imipramine, Nortriptyline, Protriptyline, Trimipramine Dementia Medications: Cholinesterase inhibitors: Donepezil, Galantamine, Rivastigmine Miscellaneous central nervous system agents: Memantine Dementia combinations: Donepezil-Memantine Potentially Harmful Drugs—Dementia Medications: Anticholinergic agents, antiemetics: Prochlorperazine, Promethazine Anticholinergic agents, antihistamines: Brompheniramine, Carbinoxamine, Chlorpheniramine, Clemastine, Cyproheptadine, Dexbrompheniramine, Dexchlorpheniramine, Dimenhydrinate, Diphenhydramine, Doxylamine, Pyrilamine, Triprolidine, Hydroxyzine, Meclizine
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	NSAIDs or non-aspirin NSAIDs. Members with more than one disease or condition may appear in the measure multiple times. <i>A lower rate indicates better performance.</i>	Anticholinergic agents, antispasmodics: Atropine, Belladonna alkaloids, Clidinium-chlordiazepoxide, Dicyclomine, Homatropine, Hyoscyamine, Methscopolamine, Propantheline, Scopolamine Anticholinergic agents, antimuscarinics (oral): Darifenacin, Fesoterodine, Flavoxate, Oxybutynin, Solifenacin, Tolterodine, Trospium Anticholinergic agents, anti-Parkinson agents: Benztropine, Trihexyphenidyl Anticholinergic agents, skeletal muscle relaxants: Cyclobenzaprine, Orphenadrine Anticholinergic agents, SSRIs: Paroxetine Anticholinergic agents, antiarrhythmic: Disopyramide Cox-2 Selective NSAIDs and Nonaspirin NSAIDs: Cox-2 Selective NSAIDs: Celecoxib Nonaspirin NSAIDs: Diclofenac, Etodolac, Fenoprofen, Flurbiprofen, Ibuprofen, Indomethacin, Ketoprofen, Ketorolac, Meclofenamate, Mefenamic acid, Meloxicam, Nabumetone, Naproxen, Naproxen sodium, Oxaprozin, Piroxicam, Sulindac, Tolmetin Dementia: ICD10CM: F01.50, F01.51, F02.80, F02.81, F03.90, F03.91, F04, F10.27, F10.97, F13.27, F13.97, F18.17, F18.27, F18.97, F19.17, F19.27, F19.97, G30.0, G30.1, G30.8, G30.9, G31.83 Diagnosis of ESRD: ICD10CM: N18.5, N18.6, Z99.2 Dialysis Procedure: CPT: 90935, 90937, 90945, 90947, 90997, 90999, 99512 HCPCS: G0257, S9339 ICD10PCS: 3E1M39Z, 5A1D00Z, 5A1D60Z, 5A1D70Z, 5A1D80Z, 5A1D90Z CKD Stage 4 Diagnosis: ICD10CM: N18.4 Total Nephrectomy:
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			CPT: 50220, 50225, 50230, 50234, 50236, 50240, 50340, 50370, 50543, 50545, 50546, 50548 ICD10: 0TB00ZZ, 0TB03ZZ, 0TB04ZZ, 0TB07ZZ, 0TB08ZZ, 0TB10ZZ, 0TB13ZZ, 0TB14ZZ, 0TB17ZZ, 0TB18ZZ, 0TT00ZZ, 0TT04ZZ, 0TT10ZZ, 0TT14ZZ, 0TT20ZZ, 0TT24ZZ, 0TT04ZG, 0TT14ZG, 0TT24ZG Kidney Transplant: CPT: 50360, 50365, 50380 HCPCS: S2065 ICD10PCS: 0TY00Z0, 0TY00Z1, 0TY00Z2, 0TY10Z0, 0TY10Z1, 0TY10Z2 <i>Note: LOINC and SNOMED codes can be captured through electronic data submissions. Please contact your Account Executive for more information.</i>
Measure	Measure Description	Measure Information/Documentation Required	Coding
Risk of Continued Opioid Use (COU)	Members 18 years of age and older who have a new episode of opioid use that puts them at risk for continued opioid use. Two rates are reported: - Members whose new episode of opioid use lasts at least 15 days in a 30-day period. - Members whose new episode of opioid use lasts at least 31 days in a 62-day period.	The MY is 1/1 – 12/31. The Index Prescription Start Date (IPSD) is the earliest prescription dispensing date during the IP. 15-day: Prescriptions covering more than 15 calendar days during the 30-day period beginning on the IPSD through 29 days after the IPSD. 62-day: Prescriptions covering more than 31 calendar days during the 62-day period beginning on the IPSD through 61 days after the IPSD. Required Exclusions: Members who meet any of the following criteria are excluded from the measure: In hospice or using hospice services any time in the MY.	Opioid Medications: Benzhydrocodone, Buprenorphine (transdermal patch and buccal film), Butorphanol, Codeine, Dihydrocodeine, Fentanyl, Hydrocodone, Hydromorphone, Levorphanol, Meperidine, Methadone, Morphine, Opium, Oxycodone, Oxymorphone, Pentazocine, Tapentadol, Tramadol The Opioid Medications List excludes: - Injectables. - Opioid-containing cough and cold products. - Single-agent and combination buprenorphine products used to treat opioid use disorder for medication-assisted treatment (buprenorphine sublingual tablets, buprenorphine subcutaneous implant, and all buprenorphine/naloxone combination products). - lonsys® (fentanyl transdermal patch). - This is for inpatient use only and is available only through a restricted program under a Risk Evaluation and Mitigation Strategy (REMS).

	<i>A lower rate Indicates better performance.</i>	- Deceased at any time in the MY. - Receiving palliative care during 12 months prior to the IPSD through 61 days after the IPSD. - Cancer (Malignant Neoplasm) during 12 months prior to the IPSD through 61 days after the IPSD. - Sickle Cell Anemia or HB S Disease during 12 months prior to the IPSD through 61 days after the IPSD.	Methadone when prescribed for the treatment of opioid use disorder. <i>Note: LOINC and SNOMED codes can be captured through electronic data submissions. Please contact your Account Executive for more information.</i>
Measure	Measure Description	Measure Information/Documentation Required	Coding
Use of High-Risk Medication in Older Adults (DAE)	The percentage of Medicare members 67 years of age and older who had at least two dispensing events for high-risk medications. Two rates are reported: - At least 2 dispensing events for high-risk medications to avoid from the same drug class. - At least 2 dispensing events for high-risk medications to avoid from the same drug class, except for appropriate diagnoses.	Required Exclusions: Members who meet any of the following criteria are excluded from the measure: - In hospice or using hospice services any time in the MY. - Deceased at any time in the MY. - Receiving palliative care in the MY. Common Chart Deficiencies: - No documentation of review of medications at every visit.	HEDIS rates are based on Diagnosis + Medications/Pharmacy Claims High-Risk Medications: Anticholinergics, first-generation antihistamines: Brompheniramine, Carbinoxamine, Chlorpheniramine, Clemastine, Cyproheptadine, Dexbrompheniramine, Dexchlorpheniramine, Diphenhydramine (oral), Dimenhydrinate, Doxylamine, Hydroxyzine, Meclizine, Promethazine, Pyrilamine, Triprolidine Anticholinergics, anti-Parkinson agents: Benztropine (oral), Trihexyphenidyl Antispasmodics: Atropine (exclude ophthalmic), Belladonna alkaloids, Chlordiazepoxide-clidinium, Dicyclomine, Hyoscyamine, Methscopolamine, Propantheline, Scopolamine Antithrombotic: Dipyridamole (oral excluding extended release) Cardiovascular, alpha agonists, central: Guanfacine, Methyl dopa Cardiovascular, other: Disopyramide, Nifedipine, excluding extended release Central nervous system, antidepressants: Amitriptyline, Amoxapine, Clomipramine, Desipramine, Imipramine, Nortriptyline, Paroxetine, Protriptyline, Trimipramine Central nervous system, barbiturates: Amobarbital, Butabarbital, Butalbital, Pentobarbital, Phenobarbital, Secobarbital Central nervous system, vasodilators: Ergoloid mesylates, Isosuprine Central nervous system, other: Meprobamate

	<i>A lower rate indicates better performance.</i>	Endocrine system, estrogens with or without progestins; include only oral and topical patch products: Conjugated estrogen, Esterified estrogen, Estradiol, Estropipate Endocrine system, sulfonylureas, long-duration: Chlorpropamide, Glimepiride, Glyburide Endocrine system, other: Desiccated thyroid, Megestrol Nonbenzodiazepine hypnotics: Eszopiclone, Zaleplon, Zolpidem Pain medications, skeletal muscle relaxants: Carisoprodol, Chlorzoxazone, Cyclobenzaprine, Metaxalone, Methocarbamol, Orphenadrine Pain medications, other: Indomethacin, Ketorolac, includes parenteral, Meperidine High-Risk Medications with Days-Supply Criteria (<90 days): Anti-Infectives, other: Nitrofurantoin, Nitrofurantoin macrocrystals monohydrate High-Risk Medications with Average Daily Dose Criteria: Alpha agonists, central: Reserpine >0.1 mg/day Cardiovascular, other: Digoxin >0.125 mg/day Tertiary TCAs (as single agent or as part of combination products): Doxepin >6 mg/day High-Risk Medications Based on Prescription and Diagnosis Data: Antipsychotics, first (conventional) and second (atypical) generation: Aripiprazole, Aripiprazole lauroxil, Asenapine, Brexpiprazole, Cariprazine, Chlorpromazine, Clozapine, Fluphenazine, Haloperidol, Iloperidone, Loxapine, Lurasidone, Molindone, Olanzapine, Paliperidone, Perphenazine, Pimavanserin, Pimozide, Quetiapine, Risperidone, Thioridazine, Thiothixene, Trifluoperazine, Ziprasidone Benzodiazepines, long, short, and intermediate acting: Alprazolam, Chlordiazepoxide, Clonazepam, Clorazepate, Diazepam, Estazolam, Flurazepam, Lorazepam, Midazolam, Oxazepam, Quazepam, Temazepam, Triazolam
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			<i>Note: LOINC and SNOMED codes can be captured through electronic data submissions. Please contact your Account Executive for more information.</i>
Measure	Measure Description	Measure Information/Documentation Required	Coding
Use of Imaging Studies for Low Back Pain (LBP)	Members 18 – 75 years of age with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis.	An imaging study with a diagnosis of uncomplicated low back pain on the IESD or in the 28 days following the IESD. Do not include outpatient, ED, or observation visits that result in an inpatient stay. Required Exclusions: Members who meet any of the following criteria are excluded from the measure: • In hospice or using hospice services any time in the MY. • Deceased at any time in the MY. • Receiving palliative care any time in the MY. • 66 years of age and older with frailty and advanced illness during the MY. • Any of the following anytime in the member's history through 28 days after the IESD: ○ Cancer. ○ HIV. ○ Major organ transplant. ○ Osteoporosis. ○ Spondylopathy. ○ Osteoporosis therapy. ○ Lumbar surgery. ○ • Any of the following during 12 months (1 year) prior to the IESD through 28 days after the IESD: ○ IV drug abuse. ○ Neurologic impairment.	Imaging Study: CPT: 72020, 72052, 72100, 72110, 72114, 72120, 72131, 72132, 72133, 72141, 72142, 72146, 72147, 72148, 72149, 72156, 72158, 72200, 72202, 72220 Uncomplicated Low Back Pain: ICD10CM: M47.26, M47.27, M47.28, M47.816, M47.817, M47.818, M47.896, M47.897, M47.898, M48.061, M48.07, M48.08, M51.16, M51.17, M51.26, M51.27, M51.36, M51.37, M51.86, M51.87, M53.2X6, M53.2X7, M53.2X8, M53.3, M53.86, M53.87, M53.88, M54.16, M54.17, M54.18, M54.30, M54.31, M54.32, M54.40, M54.41, M54.42, M54.5, M54.50, M54.51, M54.59, M54.89, M54.9, M99.03, M99.04, M99.23, M99.33, M99.43, M99.53, M99.63, M99.73, M99.83, M99.84, S33.100A, S33.100D, S33.100S, S33.110A, S33.110D, S33.110S, S33.120A, S33.120D, S33.120S, S33.130A, S33.130D, S33.130S, S33.140A, S33.140D, S33.140S, S33.5XXA, S33.6XXA, S33.8XXA, S33.9XXA, S39.002A, S39.002D, S39.002S, S39.012A, S39.012D, S39.012S, S39.092A, S39.092D, S39.092S, S39.82XA, S39.82XD, S39.82XS, S39.92XA, S39.92XD, S39.92XS <i>Note: LOINC and SNOMED codes can be captured through electronic data submissions. Please contact your Account Executive for more information.</i>

		○ Spinal infection. • Any of the following during the 3 months (90 days) prior to the IESD through 28 days after the IESD: ○ Trauma. ○ Fragility fracture. • 90 consecutive days of corticosteroid treatment any time during the 366-day period that begins 365 days prior to the IESD and ends on the IESD.	
Measure	Measure Description	Measure Information/Documentation Required	Coding
Use of Opioids at High Dosage (HDO)	The proportion of members 18 years and older who received prescription opioids at a high dosage (average morphine milligram equivalent dose [MME] ≥90) for ≥15 days during the MY. <i>A lower rate indicates better performance.</i>	Required Exclusions: Members who meet any of the following criteria are excluded from the measure: • In hospice or using hospice services any time in the MY. • Deceased at any time in the MY. • Receiving palliative care any time in the MY. • Members with cancer (malignant neoplasm) in the MY. • Members with sickle cell anemia, or HB S Disease, in the MY.	Opioid Medications: Benzhydrocodone: Acetaminophen Benzhydrocodone (4.08 mg, 6.12 mg, 8.16 mg) Butorphanol: Butorphanol (10 MGPML) Codeine: Codeine Sulfate (15 mg, 30 mg, 60 mg), Acetaminophen Codeine (2.4 MGPML, 15 mg, 30 mg, 60 mg), Acetaminophen Butalbital Caffeine Codeine (30 mg), Aspirin Butalbital Caffeine Codeine (30 mg), Aspirin Carisoprodol Codeine (16 mg) Dihydrocodeine: Acetaminophen Caffeine Dihydrocodeine (16 mg), Aspirin Caffeine Dihydrocodeine (16 mg) Fentanyl buccal or sublingual tablet, transmucosal lozenge (mcg): Fentanyl (100 mcg, 200 mcg, 300 mcg, 400 mcg, 600 mcg, 800 mcg, 1200 mcg, 1600 mcg) Fentanyl oral spray (mcg): Fentanyl (100 MCGPS, 200 MCGPS, 400 MCGPS, 600 MCGPS, 800 MCGPS) Fentanyl nasal spray (mcg): Fentanyl (100 MCGPS, 300 MCGPS, 400 MCGPS) Fentanyl transdermal film/patch (mcg/hr): Fentanyl (12 MCGPH, 25 MCGPH, 37.5 MCGPH, 50 MCGPH, 62.5 MCGPH, 75 MCGPH, 87.5 MCGPH, 100 MCGPH) Hydrocodone: Hydrocodone (10 mg, 15 mg, 20 mg, 30 mg, 40 mg, 50 mg, 60 mg, 80 mg, 100 mg, 120 mg), Acetaminophen Hydrocodone (.5 MGPML, .67 MGPML, 2.5 mg, 5 mg, 7.5 MGPML, 10 mg), Hydrocodone Ibuprofen (2.5 mg, 5 mg, 7.5 mg, 10 mg)

			Hydromorphone: Hydromorphone (1 MGPML, 2 mg, 3 mg, 4 mg, 8 mg, 12 mg, 16 mg, 32 mg) Levorphanol: Levorphanol (2 mg, 3 mg) Meperidine: Meperidine (10 MGPML, 50 mg, 75mg, 100 mg, 150 mg), Methadone: Methadone (1 MGPML, 2 MGPML, 5 mg, 10 mg, 10 MGPML, 40 mg) Morphine: Morphine (2 MGPML, 4 MGPML, 5 mg, 10 mg, 15 mg, 20 MGPML, 20 mg, 30 mg, 40 mg, 45 mg, 50 mg, 60 mg, 75 mg, 80 mg, 90 mg, 100 mg, 120 mg, 200 mg) Opium: Belladonna Opium (30 mg, 60 mg) Oxycodone: Oxycodone (1 MGPML, 5 mg, 7.5 mg, 9 mg, 10 mg, 13.5 mg, 15 mg, 18 mg, 20 mg, 20 MGPML, 27 mg, 30 mg, 36 mg, 40 mg, 60 mg, 80 mg), Acetaminophen Oxycodone (1 MGPML, 2 MGPML, 2.5 mg, 5 mg, 7.5 mg, 10 mg), Aspirin Oxycodone (4.84 mg), Ibuprofen Oxycodone (5 mg) Oxymorphone: Oxymorphone (5 mg, 7.5 mg, 10 mg, 15 mg, 20 mg, 30 mg, 40 mg) Pentazocine: Naloxone Pentazocine (50 mg) Tapentadol: Tapentadol (50 mg, 75 mg, 100 mg, 150 mg, 200 mg, 250 mg) Tramadol: Tramadol (50 mg, 100 mg, 150 mg, 200 mg, 300 mg), Acetaminophen Tramadol (37.5 mg) The HDO Opioid Medications List excludes: • Injectables. • Opioid cough and cold products. • Ionsys® (fentanyl transdermal patch). ○ This is for inpatient use only and is available only through a restricted program under a Risk Evaluation and Mitigation Strategy (REMS). • Methadone for the treatment of opioid use disorder. <i>Note: LOINC and SNOMED codes can be captured through electronic data submissions. Please contact your Account Executive for more information.</i>
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Measure	Measure Description	Measure Information/Documentation Required	Coding
Use of Opioids From Multiple Providers (UOP)	The percentage of members 18 years and older receiving prescription opioids for ≥15 days during the MY who received opioids from multiple providers. Three rates are reported: Multiple Prescribers: The proportion of members receiving prescriptions for opioids from four or more different prescribers during the MY. Multiple Pharmacies: The proportion of members receiving prescriptions for opioids from four or more different pharmacies during the MY. Multiple Prescribers and Multiple Pharmacies: The proportion of members receiving prescriptions for opioids from four or	Required Exclusions: Members who meet any of the following criteria are excluded from the measure: - In hospice or using hospice services any time in the MY. - Deceased at any time in the MY.	Opioid Medications: Benzhydrocodone, Buprenorphine (transdermal patch and buccal film), Butorphanol, Codeine, Dihydrocodeine, Fentanyl, Hydrocodone, Hydromorphone, Levorphanol, Meperidine, Methadone, Morphine, Opium, Oxycodone, Oxymorphone, Pentazocine, Tapentadol, Tramadol The UOP Opioid Medications List excludes: - Injectables. - Opioid cough and cold products. - Single-agent and combination buprenorphine products used as part of medication-assisted treatment of opioid use (buprenorphine sublingual tablets, buprenorphine subcutaneous implant, and all buprenorphine/naloxone combination products). - Ionsys® (fentanyl transdermal patch), because: - It is only for inpatient use. - It is only available through a restricted program under a Risk Evaluation and Mitigation Strategy (REMS). - Methadone when prescribed for the treatment of opioid use disorder. <i>Note: LOINC and SNOMED codes can be captured through electronic data submissions. Please contact your Account Executive for more information.</i>

	more different prescribers and four or more different pharmacies during the MY (i.e., the proportion of members who are numerator compliant for both the Multiple Prescribers and Multiple Pharmacies rates). <i>A lower rate indicates better performance for all three rates.</i>		
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UTILIZATION			
Measure	Measure Description	Measure Information/Documentation Required	Coding
Well-Child Visits in the First 30 Months of Life (W30)	The percentage of members 15 months – 30 months of age who had the recommended well-child visits with a PCP. Two rates are reported: 1. 6 or more visits on or before the 15-month birthday. 2. 2 or more visits between the 15-month birthday plus 1 day and the 30-month birthday.	Documentation from the medical record must include a note indicating a well visit with a PCP and the date the well-child visit occurred. Telehealth, telephone visits, and online assessments do not meet the criteria. Well-child/EPSTD visit criteria is based on American Academy of Pediatrics Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents. https://www.aap.org/en/practice-management/bright-futures/bright-futures-materials-and-tools/ Note: Preventive services may be rendered on visits other than well-child visits. Medical records must include documentation of preventive services. Chronic or acute condition	Use age-appropriate preventive E&M. Encounter for Well Care: ICD10CM: Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.2, Z00.3, Z01.411, Z01.419, Z02.5, Z02.84, Z76.1, Z76.2 Well Care Visit: CPT: 99381, 99382, 99383, 99384, 99385, 99391, 99392, 99393, 99394, 99395, 99461 HCPCS: G0438, G0439, S0302, S0610, S0612, S0613 <i>Note: LOINC and SNOMED codes can be captured through electronic data submissions. Please contact your Account Executive for more information.</i>

		assessment and treatment are excluded from this provision. Required Exclusions: Members who meet any of the following criteria are excluded from the measure: • In hospice or using hospice services any time in the MY. • Deceased at any time in the MY. Common Chart Deficiencies: • Children being seen for sick visits only and no documentation/claims/encounter data related to well visit services provided.	
Measure	Measure Description	Measure Information/Documentation Required	Coding
Child and Adolescent Well-Care Visits (WCV)	The percentage of members 3 – 21 years of age who had at least one comprehensive well-care visit with a PCP or OB/GYN practitioner during the MY.	Documentation from the medical record must include a note indicating a visit with a PCP or OB/GYN, the date when the well-child visit occurred. Telehealth, telephone visits, and online assessments do not meet the criteria. Well-child/EPSTDT visit criteria is based on American Academy of Pediatrics Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents. https://www.aap.org/en/practice-management/bright-futures/bright-futures-materials-and-tools/ Note: Preventive services may be rendered on visits other than well-child visits. Medical records must include documentation of preventive services. Chronic or acute condition assessment and treatment are excluded from this provision. Required Exclusions:	Use age-appropriate preventive E&M. Encounter for Well Care: ICD10CM: Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.2, Z00.3, Z01.411, Z01.419, Z02.5, Z02.84, Z76.1, Z76.2 Well Care Visit: CPT: 99381, 99382, 99383, 99384, 99385, 99391, 99392, 99393, 99394, 99395, 99461 HCPCS: G0438, G0439, S0302, S0610, S0612, S0613 <i>Note: LOINC and SNOMED codes can be captured through electronic data submissions. Please contact your Account Executive for more information.</i>

		Members who meet any of the following criteria are excluded from the measure: • In hospice or using hospice services any time in the MY. • Deceased at any time in the MY. Common Chart Deficiencies: • Children or adolescents being seen for sick visits only and no documentation/claims/encounter data related to well-visit services provided.	
MEASURES COLLECTED USING ELECTRONIC CLINICAL DATA SYSTEMS			
Measure	Measure Description	Measure Information/Documentation Required	Coding
Follow-Up Care for Children Prescribed ADHD Medication (ADD-E) <i>This is a measure collected through claims and Electronic Clinical Data Systems. Please discuss options for a direct data feed with your Account Executive. Direct data feeds can improve provider quality performance and reduce the burden of medical record requests.</i>	The percentage of children 6 – 12 years of age who had a newly prescribed ADHD medication and who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported: 1. Initiation Phase: Members who had one follow-up visit with practitioner with prescribing authority during the 30 days following the IPSD.	The Intake Period (IP) is the 12-month window starting 3/1 of the year prior to the MY and ending the last calendar day of 2/MY. The Index Prescription Start Date (IPSD) is the earliest prescription dispensing date for an ADHD medication in the IP and where there is a negative medication history. Telephone, telehealth visits are acceptable in both the Initiation and Continuation Phases. Only one of the 2 Continuation Phase visits can be e-visit or virtual check-in. Required Exclusions: Members who meet any of the following criteria are excluded from the measure: • In hospice or using hospice services any time in the MY. • Deceased in the MY.	Members are identified through administrative and pharmacy claims. ADHD Medications: CNS Stimulants: Dexmethylphenidate, Dextroamphetamine, Lisdexamfetamine, Methylphenidate, Methamphetamine. Alpha-2 receptor agonists: Clonidine, Guanfacine Miscellaneous ADHD Medications: Atomoxetine Visit Setting Unspecified (with Outpatient POS, Partial Hospitalization POS, Community Mental Health Center POS, or Telehealth POS): CPT: 90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99252, 99253, 99254, 99255 Outpatient POS: 03, 05, 07, 09, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 22, 33, 49, 50, 71, 72 Telehealth POS: 02

	2. Continuation Phase: Members who remained on the medication for at least 210 days, had a visit in the Initiation Phase, and had at least two follow-up visits within 270 days after the Initiation Phase ended.	- Acute inpatient encounter or discharge with principal diagnosis of mental, behavioral, or neurodevelopmental disorder. - Diagnosis of narcolepsy. Common Chart Deficiencies: - Follow-up visit more than 30 days after initial medication dispensed date. 2 additional visits within 9 months of starting medication are not documented.	Psychiatric Facility-Partial Hospitalization POS: 52 Community Mental Health Center POS: 53 BH Outpatient: CPT: 98960, 98961, 98962, 99078, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99242, 99243, 99244, 99245, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99483, 99492, 99493, 99494, 99510 HCPCS: G0155, G0176, G0177, G0409, G0463, G0512, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, T1015 UBREV: 0510, 0513, 0515, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0526, 0527, 0528, 0529, 0900, 0902, 0903, 0904, 0911, 0914, 0915, 0916, 0917, 0919, 0982, 0983 Health and Behavior Assessment or Intervention: CPT: 96156, 96158, 96159, 96164, 96165, 96167, 96168, 96170, 96171 Partial Hospitalization or Intensive Outpatient: HCPCS: G0410, G0411, H0035, H2001, H2012, S0201, S9480, S9484, S9485 UBREV: 0905, 0907, 0912, 0913 Telephone Visit: CPT: 98966, 98967, 98968, 99441, 99442, 99443 Online Assessments: (Continuation Phase One of Two Visits): CPT: 98970, 98971, 98972, 98980, 98981, 99421, 99422, 99423, 99457, 99458 HCPCS: G0071, G2010, G2012, G2250, G2251, G2252
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			Note: LOINC and SNOMED codes can be captured through electronic data submissions. Please contact your Account Executive for more information.
Measure	Measure Description	Measure Information/Documentation Required	Coding
Adult Immunization Status (AIS-E) <i>This is a measure collected through claims and Electronic Clinical Data Systems. Please discuss options for a direct data feed with your Account Executive. Direct data feeds can improve provider quality performance and reduce the burden of medical record requests.</i>	Members 19 years of age and older who are up to date on recommended routine vaccines for influenza; tetanus and diphtheria (Td) or tetanus, diphtheria, and acellular pertussis (Tdap); zoster; and pneumococcal.	The Measurement Period (MP) is 1/1 through 12/31. Influenza: Members who received an influenza vaccine on or between 7/1 of the year prior to the MP and 6/30 of the MP, or with prior influenza virus vaccine-adverse reaction any time during or before the MP. Td/Tdap: Members who received at least one Td vaccine or one Tdap vaccine between nine years prior to the start of the MP and the end of the MP, or with history of at least one of the following contraindications any time during or before the MP: - Anaphylaxis due to Tdap vaccine, anaphylaxis due to Td vaccine or its components. - Encephalopathy due to Tdap or Td vaccination (post tetanus vaccination encephalitis, post diphtheria vaccination encephalitis, or post pertussis vaccination encephalitis). Zoster: Members who received two doses of the herpes zoster recombinant vaccine at least 28 days apart, on October 1, 2017, through the end of the MP or with anaphylaxis due to	Immunization Administered: Procedure code: ICD10PCS: 3E0234Z Adult Influenza Immunization: CVX: 88, 135, 140, 141, 144, 150, 153, 155, 158, 166, 168, 171, 185, 186, 197, 205 Influenza Virus LAIV Immunization: CVX: 111, 149 Adult Pneumococcal Immunization: CVX: 33, 109, 133, 152, 215, 216 Herpes Zoster Recombinant Immunization: CVX: 187 Td Immunization: CVX: 09, 113, 115, 138, 139 Tdap Immunization: CVX: 115 Adult Hepatitis B Immunization: CVX: 104, 220, 43, 44, 45 Hepatitis B Immunization: CVX: 146, 198, 110, 51, 44, 08, 45 Vaccine Procedure: Adult Influenza Vaccine Procedure: CPT: 90630, 90653, 90654, 90656, 90658, 90661, 90662, 90673, 90674, 90682, 90686, 90688, 90689, 90694, 90756

		herpes zoster vaccine any time during or before the MP. Pneumococcal: Members who were administered at least one dose of an adult pneumococcal vaccine on or after the member's 19th birthday, before or during the MP, or prior pneumococcal vaccine-adverse reaction any time during or before the MP. Hepatitis B: • Members who received at least three doses of the childhood hepatitis B vaccine on different dates of service on or before their 19th birthday. • Members who received a hepatitis B vaccine series on or after their 19th birthday, before or during the measurement period, including either of the following: ○ 2 doses of the recommended two-dose adult hepatitis B vaccine administered at least 28 days apart, OR ○ At least three doses of any other recommended adult hepatitis B vaccine on different days of service • Members who had a hepatitis B surface antigen, hepatitis B surface antibody or total antibody to hepatitis B core antigen test, with a positive result any time before or during the measurement period. • Members with a history of hepatitis B illness any time before or during the measurement period	Herpes Zoster Live Vaccine Procedure: CPT: 90736 Herpes Zoster Recombinant Vaccine Procedure: CPT: 90750 Influenza Virus LAIV Vaccine Procedure: CPT: 90660, 90672 Adult Pneumococcal Vaccine Procedure: CPT: 90670, 90671, 90677, 90732 HCPCS: G0009 Td Vaccine Procedure: CPT: 90714 Tdap Vaccine Procedure: CPT: 90715 Adult Hepatitis B Vaccine Procedure: CPT: 90743, 90739, 90759, 90746, 90740, 90747, 90744 Hepatitis B Vaccine Procedure: CPT: 90723, 90697, 90748, 90740, 90747, 90744 HCPCS: G0010 Hepatitis B: ICD10CM: B16.0, B16.1, B16.2, B16.9, B17.0, B18.0, B18.1, B19.10, B19.11 <i>Note: LOINC and SNOMED codes can be captured through electronic data submissions. Please contact your Account Executive for more information.</i>
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		- Members with anaphylaxis due to the hepatitis B vaccine any time before or during the measurement period. Required Exclusions: Members who meet any of the following criteria are excluded from the measure: - In hospice or using hospice services any time in the MP. - Deceased at any time in the MP.	
Measure	Measure Description	Measure Information/Documentation Required	Coding
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E) <i>This is a measure collected through claims and Electronic Clinical Data Systems. Please discuss options for a direct data feed with your Account Executive. Direct data feeds can improve provider quality performance and reduce the burden of medical record requests.</i>	Children and adolescents 1 – 17 years of age who had two or more antipsychotic prescriptions and had metabolic testing.	Both of the following during the MY. - At least one test for blood glucose or HbA1c, and - At least one test for LDL-C or cholesterol Required Exclusions: Members who meet any of the following criteria are excluded from the measure: - In hospice or using hospice services any time in the MY. - Deceased in the MY. Common Chart Deficiencies: - A1C, LDL-C ordered but not completed.	Members are identified through administrative and pharmacy claims. Glucose Lab Test: CPT: 80047, 80048, 80050, 80053, 80069, 82947, 82950, 82951 HbA1C Lab Test: CPT: 83036, 83037 HbA1C Test Result or Finding: CPT-CAT-II: 3044F, 3046F, 3051F, 3052F Cholesterol Lab Test: CPT: 82465, 83718, 83722, 84478 LDL C Lab Test: CPT: 80061, 83700, 83701, 83704, 83721 LDL C Test Result or Finding: CPT-CAT-II: 3048F, 3049F, 3050F <i>Note: LOINC and SNOMED codes can be captured through electronic data submissions. Please contact your Account Executive for more information.</i>

Measure	Measure Description	Measure Information/Documentation Required	Coding
Breast Cancer Screening (BCS-E) <i>This is a measure collected through claims and Electronic Clinical Data Systems. Please discuss options for a direct data feed with your Account Executive. Direct data feeds can improve provider quality performance and reduce the burden of medical record requests</i>	Members 50 – 74 years of age who were recommended for a routine breast cancer screening and had a mammogram to screen for breast cancer.	All types and methods of mammograms (screening, diagnostic, film, digital, or digital breast tomosynthesis) qualify for numerator compliance. Note: Biopsies, breast ultrasounds, and MRIs do not count toward this measure. Required Exclusions: Members who meet any of the following criteria are excluded from the measure: • In hospice or using hospice services in the MP. • Deceased at any time in the MP. • Receiving palliative care any time in the MP. • 66 years of age and older with frailty and advanced illness during the MY. • Had gender-affirming chest surgery (CPT code 19318) with a diagnosis of gender dysphoria (Gender Dysphoria Value Set) any time during the member's history through the end of the MP. • Bilateral mastectomy or both right and left unilateral mastectomy with bilateral modifier from same procedure any time during the member's history through the end of the MY.	Mammography: CPT: 77061, 77062, 77063, 77065, 77066, 77067 <i>Note: LOINC and SNOMED codes can be captured through electronic data submissions. Please contact your Account Executive for more information.</i>
Measure	Measure Description	Measure Information/Documentation Required	Coding
Cervical Cancer Screening (CCS-E)	Members 24 – 64 years of age in the MY who were recommended for routine cervical cancer	Documentation using either of the following criteria meet:	Cervical Cytology (Pap): CPT: 88141, 88142, 88143, 88147, 88148, 88150, 88152, 88153, 88164, 88165, 88166, 88167, 88174, 88175

<i>This is a measure collected through claims and Electronic Clinical Data Systems. Please discuss options for a direct data feed with your Account Executive. Direct data feeds can improve provider quality performance and reduce the burden of medical record requests.</i>	screening using the following criteria: • Ages 24 – 64: A cervical cytology (Pap) test within the last 3 years. • Ages 30 – 64: A cervical high-risk human papillomavirus (hrHPV) test performed within the last 5 years. • Ages 30 – 64: A cervical cytology (Pap test/high-risk human papillomavirus [hrHPV]) co-testing within the last 5 years.	• A note indicating the date when the cervical cytology was performed and the findings. • A note indicating the date when the hrHPV test was performed and the findings. Note: Evidence of hrHPV testing within the last 5 years also captures patients who had co-testing. Do NOT Count: • Lab results that indicate results “Unknown.” • Lab results that indicate the sample was inadequate or that “no cervical cells were present” is not a valid screening. • Biopsies are diagnostic and are not valid as a primary cervical cancer screening. Required Exclusions: Members who meet any of the following criteria are excluded from the measure: • In hospice or using hospice services any time in the MY. • Deceased at any time in the MY. • Receiving palliative care any time in the MY. • Evidence of a hysterectomy with no residual cervix. Must specify “complete,” “total,” “radical,” “abdominal,” or “vaginal” hysterectomy. • “Cervical agenesis” or “acquired absence of the cervix.” • Hysterectomy in combination with documentation that the patient no longer needs Pap testing/cervical cancer screening. Gender Exclusions: • Evidence that a patient was born a male.	HCPCS: G0123, G0124, G0141, G0143, G0144, G0145, G0147, G0148, P3000, P3001, Q0091 High-Risk HPV Testing: CPT: 87624, 87625 HCPCS: G0476 <i>Note: LOINC and SNOMED codes can be captured through electronic data submissions. Please contact your Account Executive for more information.</i>
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		- Members with Male sex assigned at birth. - Documentation patient is “transitioning from male to female” or has undergone sex reassignment surgery from male to female. - Documentation of “binary,” “non-binary,” “transgender,” or “transsexual” would not be considered an exclusion. Common Chart Deficiencies: - Unclear if member’s cervix is absent. - Hysterectomy is not documented in the chart sufficiently to exclude member from measure. - Member-reported data not documented with sufficient information to show the screening was completed with a result in the measure time frame. - Pap/HPV test completed but results not documented. - Missing clear documentation on transgender patients (not clear that member is appropriate for the screening or if screening ordered/completed).	
Measure	Measure Description	Measure Information/Documentation Required	Coding
Childhood Immunization Status (CIS-E) <i>This is a measure collected through claims and Electronic Clinical Data Systems. Please discuss options for a direct data feed with your Account Executive. Direct data feeds can improve provider quality</i>	Members 2 years of age in the MY who are up to date on recommended routine vaccines for diphtheria, tetanus, and acellular pertussis (DTaP); polio (IPV); measles, mumps, and rubella (MMR); Haemophilus influenza type B (HiB); hepatitis B (HepB); chicken pox	Children 2 years of age who had the following: 1 MMR on or between the 1st and 2nd birthdays or history of measles, mumps, and rubella on or before the 2nd birthday. 1 VZV on or between the 1st and 2nd birthdays, history of chicken pox, or anaphylaxis due to the VZV vaccine on or before the 2nd birthday. 1 HepA on or between the 1st and 2nd birthdays, history of hepatitis A, or anaphylaxis due to the vaccine on or before the 2nd birthday.	Use applicable vaccination code or diagnosis indicating history of disease. Procedure code: ICD10PCS: 3E0234Z Diphtheria and Tetanus Toxoids and Acellular Pertussis vaccine (DTaP): CVX: 20, 50, 106, 107, 110, 120, 146 CPT: 90697, 90698, 90700, 90723 Haemophilus Influenza Type B (HiB):

<i>performance and reduce the burden of medical record requests.</i>	(VZV); pneumococcal conjugate (PCV); hepatitis A (HepA); rotavirus (RV); and influenza (flu).	• 3 HepB with different date of service on or before the 2nd birthday or history of the illness or anaphylaxis due to the vaccine. One of the 3 can be newborn (DOB to 7 days after birth). • 3 IPV with different DOS on or before the 2nd birthday. Do not count if administered prior to 42 days after birth. • 3 Hib with different DOS on or before the 2nd birthday or anaphylaxis due to the HiB vaccine. Do not count DOS prior to 42 days after birth. • 4 PCV with different DOS or anaphylaxis due to the vaccine on or before the 2nd birthday. Do not count DOS prior to 42 days after birth. • 4 DTaP different DOS on or before the 2nd birthday or anaphylaxis or encephalitis due to any of the vaccines. Do not count DOS prior to 42 days after birth. • 2 or 3 RV on different DOS or anaphylaxis due to the vaccine on or before the 2nd birthday. Do not count DOS prior to 42 days after birth. • 2 Flu with different DOS or anaphylaxis due to the vaccine on or before 2nd birthday. Do not count DOS prior to 6 months (180 days) after birth. One of the two vaccinations can be LAIV administered ONLY on the 2nd birthday. Documentation: • A note indicating the name of the specific antigen and the date of the immunization. • A certificate of immunization prepared by an authorized health care provider or agency, including the specific dates and types of immunizations administered.	CVX: 17, 46, 47, 48, 49, 50, 51, 120, 146, 148 CPT: 90644, 90647, 90648, 90697, 90698, 90748 Hepatitis A Vaccine (HepA): CVX: 31, 83, 85 CPT: 90633 History of Hepatitis A: ICD10CM: B15.0, B15.9 Hepatitis B Vaccine (HepB): CVX: 08, 44, 45, 51, 110, 146 CPT: 90697, 90723, 90740, 90744, 90747, 90748 HCPCS: G0010 History of Hepatitis B: ICD10CM: B16.0, B16.1, B16.2, B16.9, B17.0, B18.0, B18.1, B19.10, B19.11 Inactivated Poliovirus Vaccine (IPV): CVX: 10, 89, 110, 120, 146 CPT: 90697, 90698, 90713, 90723 Influenza Vaccine: CVX: 88, 140, 141, 150, 153, 155, 158, 161, 171, 186 CPT: 90655, 90657, 90661, 90673, 90674, 90685, 90686, 90687, 90688, 90689, 90756 LAIV Immunization: CVX: 111, 149 CPT: 90660, 90672 Measles, Mumps, and Rubella Vaccine (MMR): CVX: 03, 94 CPT: 90707, 90710 History of Measles: ICD10CM: B05.0, B05.1, B05.2, B05.3, B05.4, B05.81, B05.89, B05.9
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		- Initial HepB given "at birth" or "nursery/hospital" should be documented in the medical record or indicated on the immunization record as appropriate. - Immunizations documented using a generic header (e.g., polio vaccine) or "IPV/OPV" can be counted as evidence of IPV. Required Exclusions: Members who meet any of the following criteria are excluded from the measure: - In hospice or using hospice services any time in the MY. - Deceased at any time in the MY. - Any of the following on or before the child's 2nd birthday: - Severe combined immunodeficiency. - Immunodeficiency. - HIV. - Lymphoreticular cancer, multiple myeloma, or leukemia. - Intussusception. - Organ and bone marrow transplants. Common Chart Deficiencies: - Immunizations administered after the 2nd birthday. - PCP charts do not contain immunization records if vaccine(s) received elsewhere, such as those given at health departments or those given in the hospital at birth. - Rotavirus documentation does not specify if 2-dose or 3-dose. - Flu Mist only meets criteria when administered on the 2nd birthday. - A note that "member is up to date" with all immunizations does not constitute compliance due to insufficient data.	History of Mumps: ICD10CM: B26.0, B26.1, B26.2, B26.3, B26.81, B26.82, B26.83, B26.84, B26.85, B26.89, B26.9 History of Rubella: ICD10CM: B06.00, B06.01, B06.02, B06.09, B06.81, B06.82, B06.89, B06.9 Pneumococcal Conjugate Vaccine (PCV): CVX: 109, 133, 152, 215, 216 CPT: 90670, 90671 HCPS: G0009 Rotavirus Vaccine (RV): CVX: 116, 122 (3 dose) CPT: 90680 (3 dose), 90681 (2 dose) Varicella Zoster Virus (VZV): CVX: 21, 94 CPT: 90710, 90716 Varicella Zoster: ICD10CM: 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 <i>Note: LOINC and SNOMED codes can be captured through electronic data submissions. Please contact your Account Executive for more information.</i>
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		Parental refusal does not meet compliance.	
Measure	Measure Description	Measure Information/Documentation Required	Coding
Colorectal Cancer Screening (COL-E) <i>This is a measure collected through claims and Electronic Clinical Data Systems. Please discuss options for a direct data feed with your Account Executive. Direct data feeds can improve provider quality performance and reduce the burden of medical record requests.</i>	The percentage of members 45 – 75 years of age who had appropriate screening for colorectal cancer.	The MY is 1/1 – 12/31. Documentation in the medical record must include a note indicating the date when the colorectal cancer screening was performed. A result is not required if the documentation is clearly part of the “medical history” section of the record; if this is not clear, the result or finding must also be present. (This ensures that the screening was performed and not merely ordered.) - Colonoscopy in past 10 years (the MY and 9 years prior). - Flexible Sigmoidoscopy in past 5 years (the MY and 4 years prior). - CT Colonography in past 5 years (the MY and 4 years prior). - Stool DNA (sDNA) with FIT test in past 3 years (the MY and 2 years prior). - Fecal Occult Blood Test (FOBT) in the MY. Required Exclusions: Members who meet any of the following criteria are excluded from the measure: - In hospice or using hospice services any time in the MY. - Deceased in the MY. - Receiving palliative care any time in the MY. 66 years of age and older with frailty and advanced illness during the MY. - Colorectal cancer any time in member history through 12/31 of the MY. - Total colectomy any time in member history through 12/31 of the MY.	Colonoscopy: CPT: 44388, 44389, 44390, 44391, 44392, 44394, 44401, 44402, 44403, 44404, 44405, 44406, 44407, 44408, 45378, 45379, 45380, 45381, 45382, 45384, 45385, 45386, 45388, 45389, 45390, 45391, 45392, 45393, 45398 HCPCS: G0105, G0121 Flexible Sigmoidoscopy: CPT: 45330, 45331, 45332, 45333, 45334, 45335, 45337, 45338, 45340, 45341, 45342, 45346, 45347, 45349, 45350 HCPCS: G0104 CT Colonography: CPT: 74261, 74262, 74263 Stool DNA (sDNA) with Fit Lab Test: CPT: 81528 FOBT Lab test: CPT: 82270, 82274 HCPCS: G0328 <i>Note: LOINC and SNOMED codes can be captured through electronic data submissions. Please contact your Account Executive for more information.</i>

		Common Chart Deficiencies: • Member-reported data not documented with sufficient information to show the screening was completed in the measure time frame. • Documentation not clear on type of screening (e.g., only “Col” or “Colon”). • Documentation not clear on location to which scope advanced in situations of incomplete colonoscopy (must advance to the cecum) or flexible sigmoidoscopy (must advance into the sigmoid colon). • Most recent screening dates not documented in the record/updated in patient history. • Documentation of only “up to date.” • Documentation of only “next due” dates. • FOBTs performed in an office setting. • FOBTs performed on a sample collected via Digital Rectal Exam (DRE). • Fewer than 3 samples documented for gFOBT. • Documentation not clear if Stool-DNA with FIT or FIT FOBT.	
Measure	Measure Description	Measure Information/Documentation Required	Coding
Blood Pressure Control for Patients with Hypertension (BPC-E) <i>This is a measure collected through claims and Electronic Clinical Data Systems. Please discuss options for a</i>	The percentage of members 18 – 85 years of age who had a diagnosis of hypertension (HTN) and whose most recent blood pressure (BP) was <140/90 mm Hg during the measurement period.	• BP must be latest reading in the MY and must occur on or after the diagnosis of HTN. • BP readings taken on the same day as a diagnostic test or diagnostic or therapeutic procedure that requires a change in diet or change in medication on or one day before the test or procedure, with the exception of fasting blood tests, are not used.	Systolic and Diastolic Result: CPT-CAT-II: • Most Recent Systolic less than 130: 3074F • Most Recent Systolic 130 – 139: 3075F • Systolic greater than or equal to 140: 3077F • Most Recent Diastolic less than 80: 3078F • Most Recent Diastolic 80 – 89: 3079F • Most Recent Diastolic greater than or equal to 90: 3080F Hypertension Diagnosis:

<i>direct data feed with your Account Executive. Direct data feeds can improve provider quality performance and reduce the burden of medical record requests.</i>		• BP readings taken during an inpatient stay or ED visit are not used. • When multiple BP measurements occur on the same date, the lowest systolic and lowest diastolic BP reading will be used. • If no BP is recorded during the MY, the member is “not controlled.” • Services provided during a telephone visit, e-visit, or virtual check-in are acceptable. • Member-reported data documented in medical record is acceptable if BP captured with a digital device and documented in the medical record with date BP taken. Required Exclusions: Members who meet any of the following criteria are excluded from the measure: • In hospice or using hospice services any time in the MY. • Deceased at any time in the MY. • Receiving palliative care any time in the MY. • 66 years of age and older with frailty and advanced illness during the MY. • Evidence of ESRD or kidney transplant on or prior to 12/31 of the MY. Documentation must include a dated note indicating evidence of ESRD, kidney transplant, or dialysis. • Diagnosis of pregnancy during the MY. • A nonacute inpatient admission during the MY. Common Chart Deficiencies: • Retake of BP that is 140/90 or above not documented. • Member-reported BP is not documented with sufficient detail. • Claim missing CPT II codes for BP results.	ICD10CM: I10 <i>Note: LOINC and SNOMED codes can be captured through electronic data submissions. Please contact your Account Executive for more information.</i>
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		• BP rounded up before documented in medical record. • BP documented as a range. • No documentation of follow-up appointment scheduled if BP elevated. • Cardiology visits with no BP documented in the chart. • Flowsheets missing member name and second identifier such as date of birth.	
Measure	Measure Description	Measure Information/Documentation Required	Coding
Depression Screening and Follow-Up for Adolescents and Adults (DSF-E) <i>This is a measure collected through claims and Electronic Clinical Data Systems. Please discuss options for a direct data feed with your Account Executive. Direct data feeds can improve provider quality performance and reduce the burden of medical record requests.</i>	The percentage of members 12 years of age and older who were screened for clinical depression using a standardized instrument and, if screened positive, received follow-up care. Two rates are reported: 1. Depression Screening: The percentage of members who were screened for clinical depression using a standardized instrument. 2. Follow Up on Positive Screen: The percentage of members who received follow-up care on or up to 30 days after the	The MP is 1/1 through 12/31. This measure requires the use of an age-appropriate screening instrument. The member's age is used to select the appropriate depression screening instrument. • Acceptable tools for the Adolescent 12-17 population include PHQ-9; PHQ-9M; PHQ-2; BDI-FS; CESD-R; EPDS; PROMIS Depression. • Acceptable tools for the Adult 18+ population include PHQ-9; PHQ-2; BDI-FS; BDI-II; CESD-R; DADS; GDS; EPDS; M-3; PROMIS Depression, CUDOS. Follow up which meets criteria: • Outpatient, telephone, or virtual check-in visit. • Depression case management encounter. • A behavioral health encounter. • Dispensed antidepressant medication. • Additional depression screening on a full-length instrument indicating no depression or no symptoms that require follow up on the same day as a	Encounter Performed: Behavioral Health Encounter: CPT: 90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90845, 90846, 90847, 90849, 90853, 90865, 90867, 90868, 90869, 90870, 90875, 90876, 90880, 90887, 99484, 99492, 99493 HCPCS: G0155, G0176, G0177, G0409, G0410, G0411, G0511, G0512, H0002, H0004, H0031, H0034, H0035, H0036, H0037, H0039, H0040, H2000, H2001, H2010, H2011, H2012, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, S0201, S9480, S9484, S9485 UBREV: 0900, 0901, 0902, 0903, 0904, 0905, 0907, 0911, 0912, 0913, 0914, 0915, 0916, 0917, 0919 Depression Case Management Encounter: CPT: 99366, 99492, 99493, 99494 HCPCS: G0512, T1016, T1017, T2022, T2023 Follow-Up Visit: CPT: 98960, 98961, 98962, 98966, 98967, 98968, 98970, 98971, 98972, 98980, 98981, 99078, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99242, 99243, 99244, 99245, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99421, 99422, 99423, 99441, 99442, 99443, 99457, 99458, 99483

	date of the first positive screen.	positive screen on a brief screening instrument. - A diagnosis of encounter for exercise counseling Required Exclusions: Members who meet any of the following criteria are excluded from the measure: - In hospice or using hospice services any time in the MP. - Deceased at any time in the MP. - Bipolar disorder in the year prior to the MP. - Depression that starts during the year prior to the MP.	HCPCS: G0071, G0463, G2010, G2012, G2250, G2251, G2252, T1015 UBREV: 0510, 0513, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0526, 0527, 0528, 0529, 0982, 0983 Diagnosis for encounter for exercise counseling: ICD10CM: Z71.82 Dispensed Antidepressant Medication: Miscellaneous antidepressants: Bupropion, Vilazodone, Vortioxetine Monoamine oxidase inhibitors: Isocarboxazid, Phenelzine, Selegiline, Tranylcypromine Phenylpiperazine antidepressants: Nefazodone, Trazodone Psychotherapeutic combinations: Amitriptyline-chlordiazepoxide, Amitriptyline-perphenazine, Fluoxetine-olanzapine SNRI antidepressants: Desvenlafaxine, Duloxetine, Levomilnacipran, Venlafaxine SSRI antidepressants: Citalopram, Escitalopram, Fluoxetine, Fluvoxamine, Paroxetine, Sertraline Tetracyclic antidepressants: Maprotiline, Mirtazapine Tricyclic antidepressants: Amitriptyline, Amoxapine, Clomipramine, Desipramine, Doxepin (>6mg), Imipramine, Nortriptyline, Protriptyline, Trimipramine <i>Note: LOINC and SNOMED codes can be captured through electronic data submissions. Please contact your Account Executive for more information.</i>
Measure	Measure Description	Measure Information/Documentation Required	Coding
Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS-E)	The percentage of members 12 years of age and older with a diagnosis of major depression or dysthymia who had an outpatient encounter with a PHQ-9	The Measurement Periods (MP) are: - January 1 through April 30. - May 1 through August 31. - September 1 through December 31. The PHQ-9 assessment does not need to occur during a face-to-face encounter; phone-based,	Diagnosis: Major Depression or Dysthymia: ICD10CM: F32.0, F32.1, F32.2, F32.3, F32.4, F32.5, F32.9, F33.0, F33.1, F33.2, F33.3, F33.40, F33.41, F33.42, F33.9, F34.1 Encounter Performed: Interactive Outpatient Encounter:

<i>This is a measure collected through claims and Electronic Clinical Data Systems. Please discuss options for a direct data feed with your Account Executive. Direct data feeds can improve provider quality performance and reduce the burden of medical record requests.</i>	score present in their record in the same assessment period as the encounter.	e-visit, virtual check-in, or electronic secure messaging is acceptable. Note: Standardized instruments are useful in identifying meaningful change in clinical outcomes over time. Guidelines for adults recommend that providers establish and maintain regular follow-up with patients diagnosed with depression and use a standardized tool to track symptoms. • For adolescents, guidelines recommend systematic and regular tracking of treatment goals and outcomes, including assessing depressive symptoms. • The PHQ-9 tool assesses the nine <i>DSM, Fourth Edition, Text Revision (DSM-IV-TR)</i> criterion symptoms and effects on functioning and has been shown to be highly accurate in diagnosing patients with persistent major depression, partial remission, and full remission. Required Exclusions: Members who meet any of the following criteria are excluded from the measure: • In hospice or using hospice services any time in the MP. • Deceased at any time in the MP. • Bipolar disorder in the MP. • Personality disorder in the MP. • Psychotic disorder in the MP. • Pervasive development disorder in the MP.	CPT: 90791, 90792, 90832, 90834, 90837, 98960, 98961, 98962, 98966, 98967, 98968, 98970, 98971, 98972, 98980, 98981, 99078, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99242, 99243, 99244, 99245, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99421, 99422, 99423, 99441, 99442, 99443, 99457, 99458, 99483, 99492, 99493, 99494, 99510 HCPCS: G0071, G0155, G0176, G0177, G0409, G0410, G0411, G0463, G0512, G2010, G2012, G2250, G2251, G2252, H0002, H0004, H0031, H0034, H0035, H0036, H0037, H0039, H0040, H2000, H2001, H2010, H2011, H2012, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, S0201, S9480, S9484, S9485, T1015 UBREV: 0510, 0513, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0526, 0527, 0528, 0529, 0900, 0901, 0902, 0903, 0904, 0905, 0907, 0911, 0912, 0913, 0914, 0915, 0916, 0917, 0919, 0982, 0983 <i>Note: LOINC and SNOMED codes can be captured through electronic data submissions. Please contact your Account Executive for more information.</i>
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Measure	Measure Description	Measure Information/Documentation Required	Coding
Documented Assessment After Mammogram (DBM-E) <i>This is a measure collected through claims and Electronic Clinical Data Systems. Please discuss options for a direct data feed with your Account Executive. Direct data feeds can improve provider quality performance and reduce the burden of medical record requests.</i>	The percentage of episodes of mammograms documented in the form of a BI-RADS assessment within 14 days of the mammogram for members 40 – 74 years of age.	Episodes of mammograms that receive a BI-RADS score on or within 14 days after the episode date (15 days total). Required Exclusions: Members who meet any of the following criteria are excluded from the measure: - In hospice or using hospice services any time in the MP. - Deceased at any time in the MP.	Mammography: CPT: 77062, 77061, 77066, 77065, 77063, 77067 <i>Note: LOINC and SNOMED codes can be captured through electronic data submissions. Please contact your Account Executive for more information</i>
Measure	Measure Description	Measure Information/Documentation Required	Coding
Depression Remission or Response for Adolescents and Adults (DRR-E) <i>This is a measure collected through claims and Electronic Clinical Data Systems. Please discuss options for a direct data feed with your Account Executive. Direct data feeds can improve provider quality performance and reduce</i>	The percentage of members 12 years of age and older with a diagnosis of depression and an elevated PHQ-9 score who had evidence of response or remission within 4 – 8 months of the elevated score. Three rates are reported: 1. Follow-Up PHQ-9:	The Measurement Period (MP) is 1/1 through 12/31. The Intake Period (IP) is 5/1 of the year prior to the MP through 4/30 of the MP. The Episode Intake Start Date (EISD) is the earliest date in the IP where a member has a diagnosis of major depression or dysthymia and a PHQ-9 total score >9 documented. Required Exclusions: Members who meet any of the following criteria during the IP or during the MP are excluded from the measure:	Diagnosis: Major Depression or Dysthymia: ICD10CM: F32.0, F32.1, F32.2, F32.3, F32.4, F32.5, F32.9, F33.0, F33.1, F33.2, F33.3, F33.40, F33.41, F33.42, F33.9, F34.1 Encounter Performed: Interactive Outpatient Encounter: CPT: 90791, 90792, 90832, 90834, 90837, 98960, 98961, 98962, 98966, 98967, 98968, 98970, 98971, 98972, 98980, 98981, 99078, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99242, 99243, 99244, 99245, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99421, 99422, 99423, 99441, 99442, 99443, 99457, 99458, 99483, 99492, 99493, 99494, 99510

<i>the burden of medical record requests.</i>	The percentage of members who have a follow-up PHQ-9 score documented within 4 – 8 months after the initial elevated PHQ-9 score. 2. Depression Remission: The percentage of members who achieved remission within 4 – 8 months after the initial elevated PHQ-9 score. 3. Depression Response: The percentage of members who showed response within 4 – 8 months after the initial elevated PHQ-9 score.	• In hospice or using hospice services any time in the MP. • Deceased at any time in the MP. • Bipolar disorder. • Personality disorder. • Psychotic disorder. • Pervasive development disorder.	HCPCS: G0071, G0155, G0176, G0177, G0409, G0410, G0411, G0463, G0512, G2010, G2012, G2250, G2251, G2252, H0002, H0004, H0031, H0034, H0035, H0036, H0037, H0039, H0040, H2000, H2001, H2010, H2011, H2012, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, S0201, S9480, S9484, S9485, T1015 UBREV: 0510, 0513, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0526, 0527, 0528, 0529, 0900, 0901, 0902, 0903, 0904, 0905, 0907, 0911, 0912, 0913, 0914, 0915, 0916, 0917, 0919, 0982, 0983 <i>Note: LOINC and SNOMED codes can be captured through electronic data submissions. Please contact your Account Executive for more information.</i>
Measure	Measure Description	Measure Information/Documentation Required	Coding
Immunizations for Adolescents (IMA-E) When coding E&M and vaccine administration services on the same date, you must append modifier 25 to the E&M. <i>This is measure collected through claims and Electronic Clinical Data Systems. Please discuss options for a direct data feed with your Account</i>	Adolescents 13 years of age in the MY who are up to date on recommended routine vaccines for meningococcal; tetanus, diphtheria toxoids, and acellular pertussis (Tdap); and human papillomavirus (HPV).	Adolescents 13 years of age who had the following: • Meningococcal MCV with DOS on or between the 10th and 13th birthdays or evidence of antigen or anaphylaxis due to the vaccine on or before the 13th birthday. • Tdap or TD with DOS on or between the 10th and 13th birthdays or evidence of antigen, anaphylaxis, or encephalitis due to the vaccine on or before the 13th birthday. • HPV — any of the following: ○ 3 doses with different dates of service on or between the 9th and 13th birthdays.	Meningococcal Vaccine: CVX: 32, 108, 114, 136, 147, 167, 203, 316 CPT: 90619, 90623, 90733, 90734 Tetanus, Diphtheria, & Acellular Pertussis Vaccine (Tdap): CVX: 115 CPT: 90715 HPV Vaccine: CVX: 62, 118, 137, 165 CPT: 90649, 90650, 90651

<i>Executive. Direct data feeds can improve provider quality performance and reduce the burden of medical record requests.</i>		○ 2 doses with at least 146 days between the 1st and 2nd dose on or between the 9th and 13th birthdays. ○ Anaphylaxis due to the vaccine on or before the 13th birthday. ○ Evidence of antigen. Documentation: • A note indicating the name of the specific antigen and the date of the immunization. • A certificate of immunization prepared by an authorized health care provider or agency including the specific dates and types of immunizations administered. Required Exclusions: Members who meet any of the following criteria are excluded from the measure: • In hospice or using hospice services any time in the MY. • Deceased at any time in the MY. Common Chart Deficiencies: • Immunizations administered outside of the appropriate time frames. • PCP charts do not contain records when immunizations administered elsewhere (i.e., health departments, school clinics, urgent care facilities). • HPV doses are not at least 146 days apart when only 2 doses administered. • A note that “member is up to date” with all immunizations does not constitute compliance due to insufficient data. • Parental refusal does not meet compliance. • Td (Tetanus, Diphtheria Toxoids) does not meet criteria for Tdap.	<i>Note: LOINC and SNOMED codes can be captured through electronic data submissions. Please contact your Account Executive for more information.</i>
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		• Meningococcal Recombinant (serogroup B) (MenB) does not meet criteria for the Meningococcal vaccine.	
Measure	Measure Description	Measure Information/Documentation Required	Coding
Follow-Up after Abnormal Mammogram Assessment (FMA-E) <i>This is a measure collected through claims and Electronic Clinical Data Systems. Please discuss options for a direct data feed with your Account Executive. Direct data feeds can improve provider quality performance and reduce the burden of medical record requests.</i>	The percentage of episodes for members 40 – 74 years of age with inconclusive or high-risk BI-RADS assessments that received appropriate follow-up within 90 days of the assessment.	High-risk and inconclusive BI-RADS assessment that received appropriate follow-up. Appropriate follow-up is defined as either of the following: • A high-risk BI-RADS assessment (High-Risk BI-RADS Value Set) result (Category 4: Suspicious – Category 5: Highly Suggestive of Malignancy), that received a breast biopsy (Breast Biopsy Value Set) on or within 90 days after the episode date (91 days total). • An inconclusive BI-RADS assessment (BI-RADS 0: Incomplete — Need Additional Imaging Evaluation and/or Prior Mammograms for Comparison), (Inconclusive BI-RADS Value Set) that received a mammogram (Mammography Value Set) or ultrasound (Breast Ultrasound Value Set) on or within 90 days after the episode date (91 days total). Required Exclusions: Members who meet any of the following criteria during the MP are excluded from the measure: • In hospice or using hospice services any time in the MP. • Deceased at any time in the MP.	Breast Biopsy: CPT: 19101, 19100, 19085, 19081, 19083 Breast Ultrasound: CPT: 76641, 76642 Mammography: CPT: 77062, 77061, 77066, 77065, 77063, 77067 <i>Note: LOINC and SNOMED codes can be captured through electronic data submissions. Please contact your Account Executive for more information</i>

Measure	Measure Description	Measure Information/Documentation Required	Coding
Unhealthy Alcohol Use Screening and Follow-Up (ASF-E) <i>This is a measure collected through claims and Electronic Clinical Data Systems. Please discuss options for a direct data feed with your Account Executive. Direct data feeds can improve provider quality performance and reduce the burden of medical record requests.</i>	The percentage of members 18 years of age and older who were screened for unhealthy alcohol use using a standardized instrument and, if screened positive, received appropriate follow-up care. Two rates are reported: 1. Unhealthy Alcohol Use Screening: The percentage of members who had a systematic screening for unhealthy alcohol use. 2. Alcohol Counseling or Other Follow-up Care: The percentage of members receiving brief counseling or other follow-up care within 2 months of screening positive for unhealthy alcohol use.	The Measurement Period (MP) is 1/1 through 12/31. Follow-up is an encounter on, or up to 60 days after, the date of the first positive screening that includes at least one of the following: • Feedback on alcohol use and harms. • Identification of high-risk situations for drinking and coping strategies. • Increase the motivation to reduce drinking. • Development of a personal plan to reduce drinking. • Documentation of receiving alcohol misuse treatment. Required Exclusions: Members who meet any of the following criteria during the MP are excluded from the measure: • In hospice or using hospice services any time in the MP. • Deceased at any time in the MP. • Alcohol use disorder that starts during the year prior to the MP. • History of dementia any time during the member's history through the end of the MP.	Diagnosis Alcohol Use Disorder: ICD10CM: F10.10, F10.120, F10.121, F10.129, F10.130, F10.131, F10.132, F10.139, F10.14, F10.150, F10.151, F10.159, F10.180, F10.181, F10.182, F10.188, F10.19, F10.20, F10.220, F10.221, F10.229, F10.230, F10.231, F10.232, F10.239, F10.24, F10.250, F10.251, F10.259, F10.26, F10.27, F10.280, F10.281, F10.282, F10.288, F10.29, F10.90, F10.920, F10.921, F10.929, F10.930, F10.931, F10.932, F10.939, F10.94, F10.950, F10.951, F10.959, F10.96, F10.97, F10.980, F10.981, F10.982, F10.988, F10.99, K29.20, K29.21, K70.10, K70.11 Intervention Performed: Alcohol Counseling or Other Follow-Up Care: CPT: 99408, 99409 HCPCS: G0396, G0397, G0443, G2011, H0005, H0007, H0015, H0016, H0022, H0050, H2035, H2036, T1006, T1012 ICD10CM: Z71.41 <i>Note: LOINC and SNOMED codes can be captured through electronic data submissions. Please contact your Account Executive for more information.</i>
Measure	Measure Description	Measure Information/Documentation Required	Coding
Prenatal Immunization Status (PRS-E) <i>This is a measure collected through claims and Electronic Clinical</i>	The percentage of deliveries in which the member received influenza and tetanus, diphtheria toxoids, and	The Measurement Period (MP) is 1/1 through 12/31. Influenza: • Deliveries where members received an adult influenza vaccine on or between July	Immunization Administered: Adult Influenza Immunization: CVX: 88, 135, 140, 141, 144, 150, 153, 155, 158, 166, 168, 171, 185, 186, 197, 205 Tdap Immunization:

<i>Data Systems. Please discuss options for a direct data feed with your Account Executive. Direct data feeds can improve provider quality performance and reduce the burden of medical record requests.</i>	acellular pertussis (Tdap) vaccinations.	1 of the year prior to the MP and the delivery date; or - Deliveries where members had an influenza virus vaccine-adverse reaction any time during or before the MP. Tdap: Deliveries where the members had any of the following: - At least one Tdap vaccine during the pregnancy (including the delivery date). - Anaphylactic reaction to Tdap or Td vaccine or its components any time during or before the MP. - Encephalopathy due to Td or Tdap vaccination any time during or before the MP. A note indicating the specific antigen name and the immunization date, or an immunization certificate prepared by a healthcare provider that has the dates of administration. Documented history of specific disease, anaphylactic reactions, or contraindications for a specific vaccine. Required Exclusions: Members who meet any of the following criteria are excluded from the measure: - In hospice or using hospice services any time in the MP. - Deceased at any time in the MP. - Delivered at less than 37 weeks gestation.	CVX: 115 Vaccine Procedure: Adult Influenza Vaccine Procedure: CPT: 90630, 90653, 90654, 90656, 90658, 90661, 90662, 90673, 90674, 90682, 90686, 90688, 90689, 90694, 90756 Tdap Vaccine Procedure: CPT: 90715 Deliveries: CPT: 59400, 59409, 59410, 59510, 59514, 59515, 59610, 59612, 59614, 59618, 59620, 59622 HCPCS: 10D00Z0, 10D00Z1, 10D00Z2, 10D07Z3, 10D07Z4, 10D07Z5, 10D07Z6, 10D07Z7, 10D07Z8, 10E0XZZ <i>Note: LOINC and SNOMED codes can be captured through electronic data submissions. Please contact your Account Executive for more information.</i>
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Measure	Measure Description	Measure Information/Documentation Required	Coding
Prenatal Depression Screening and Follow-Up (PND-E) <i>This is a measure collected through claims and Electronic Clinical Data Systems. Please discuss options for a direct data feed with your Account Executive. Direct data feeds can improve provider quality performance and reduce the burden of medical record requests.</i>	The percentage of deliveries in which members were screened for clinical depression while pregnant and, if screened positive, received follow-up care. Two rates are reported: 1. Depression Screening: The percentage of deliveries in which members were screened for clinical depression using a standardized instrument during the prenatal period. 2. Follow up on Positive Screen: The percentage of deliveries in which members received follow-up care within 30 days of screening positive for depression.	The Measurement Period (MP) is 1/1 – 12/31. This measure requires the use of an age-appropriate screening instrument. The member's age is used to select the appropriate depression screening instrument. - Acceptable tools for the Adolescent 12-17 population include PHQ-9; PHQ-9M; PHQ-2; BDI-FS; CESD-R; EPDS; PROMIS Depression. - Acceptable tools for the Adult 18+ population include PHQ-9; PHQ-2; BDI-FS; BDI-II; CESD-R; DADS; EPDS; M-3; PROMIS Depression, CUDOS. Follow up which meets criteria: - Outpatient, telephone, or virtual check-in visit. - Depression case management encounter. - A behavioral health encounter. - Dispensed antidepressant medication. - Additional depression screening on a full-length instrument indicating no depression or no symptoms that require follow up on the same day as a positive screen on a brief screening instrument. - Exercise counseling Required Exclusions: Members who meet any of the following criteria are excluded from the measure: - In hospice or using hospice services any time in the MP. - Deceased at any time in the MP. - Delivered at less than 37 weeks gestation.	Encounter Performed: Behavioral Health Encounter: CPT: 90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90845, 90846, 90847, 90849, 90853, 90865, 90867, 90868, 90869, 90870, 90875, 90876, 90880, 90887, 99484, 99492, 99493 HCPCS: G0155, G0176, G0177, G0409, G0410, G0411, G0511, G0512, H0002, H0004, H0031, H0034, H0035, H0036, H0037, H0039, H0040, H2000, H2001, H2010, H2011, H2012, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, S0201, S9480, S9484, S9485 UBREV: 0900, 0901, 0902, 0903, 0904, 0905, 0907, 0911, 0912, 0913, 0914, 0915, 0916, 0917, 0919 Depression Case Management Encounter: CPT: 99366, 99492, 99493, 99494 HCPCS: G0512, T1016, T1017, T2022, T2023 Follow-Up Visit: CPT: 98960, 98961, 98962, 98966, 98967, 98968, 98970, 98971, 98972, 98980, 98981, 99078, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99242, 99243, 99244, 99245, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99421, 99422, 99423, 99441, 99442, 99443, 99457, 99458, 99483 HCPCS: G0071, G0463, G2010, G2012, G2250, G2251, G2252, T1015 UBREV: 0510, 0513, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0526, 0527, 0528, 0529, 0982, 0983 Exercise Counseling: ICD10CM: Z71.82 Dispensed Antidepressant Medication: Miscellaneous antidepressants: Bupropion, Vilazodone, Vortioxetine

			Monoamine oxidase inhibitors: Isocarboxazid, Phenelzine, Selegiline, Tranylcypromine Phenylpiperazine antidepressants: Nefazodone, Trazodone Psychotherapeutic combinations: Amitriptyline-chlordiazepoxide, Amitriptyline-perphenazine, Fluoxetine-olanzapine SNRI antidepressants: Desvenlafaxine, Duloxetine, Levomilnacipran, Venlafaxine SSRI antidepressants: Citalopram, Escitalopram, Fluoxetine, Fluvoxamine, Paroxetine, Sertraline Tetracyclic antidepressants: Maprotiline, Mirtazapine Tricyclic antidepressants: Amitriptyline, Amoxapine, Clomipramine, Desipramine, Doxepin (>6mg), Imipramine, Nortriptyline, Protriptyline, Trimipramine <i>Note: LOINC and SNOMED codes can be captured through electronic data submissions. Please contact your Account Executive for more information.</i>
Measure	Measure Description	Measure Information/Documentation Required	Coding
Postpartum Depression Screening and Follow-Up (PDS-E) <i>This is a measure collected through claims and Electronic Clinical Data Systems. Please discuss options for a direct data feed with your Account Executive. Direct data feeds can improve provider quality performance and reduce the burden of medical record requests.</i>	The percentage of deliveries in which members were screened for clinical depression during the postpartum period, and if screened positive, received follow-up care. Two rates are reported. 1. Depression Screening: The percentage of deliveries in which members were screened for clinical depression using a standardized instrument	The Measurement Period (MP) is 1/1 – 12/31. This measure requires the use of an age-appropriate screening instrument. The member's age is used to select the appropriate depression screening instrument. - Acceptable tools for the Adolescent 12-17 population include PHQ-9; PHQ-9M; PHQ-2; BDI-FS; CESD-R; EPDS; PROMIS Depression. - Acceptable tools for the Adult 18+ population include PHQ-9; PHQ-2; BDI-FS; BDI-II; CESD-R; DADS; EPDS; M-3; PROMIS Depression, CUDOS. Follow up which meets criteria: - Outpatient, telephone, or virtual check-in visit.	Encounter Performed: Behavioral Health Encounter: CPT: 90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90845, 90846, 90847, 90849, 90853, 90865, 90867, 90868, 90869, 90870, 90875, 90876, 90880, 90887, 99484, 99492, 99493 HCPCS: G0155, G0176, G0177, G0409, G0410, G0411, G0511, G0512, H0002, H0004, H0031, H0034, H0035, H0036, H0037, H0039, H0040, H2000, H2001, H2010, H2011, H2012, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, S0201, S9480, S9484, S9485 UBREV: 0900, 0901, 0902, 0903, 0904, 0905, 0907, 0911, 0912, 0913, 0914, 0915, 0916, 0917, 0919 Depression Case Management Encounter: CPT: 99366, 99492, 99493, 99494 HCPCS: G0512, T1016, T1017, T2022, T2023 Exercise Counseling:

	during the postpartum period. 2. Follow up on Positive Screen: The percentage of deliveries in which members received follow-up care within 30 days of screening positive for depression.	- Depression case management encounter. - A behavioral health encounter. - Dispensed antidepressant medication. - Additional depression screening on a full-length instrument indicating no depression or no symptoms that require follow up on the same day as a positive screen on a brief screening instrument. - Exercise counseling Required Exclusions: Members who meet any of the following criteria are excluded from the measure: - In hospice or using hospice services any time in the MP. - Deceased at any time in the MP.	ICD10CM: Z71.82 Follow-Up Visit: CPT: 98960, 98961, 98962, 98966, 98967, 98968, 98970, 98971, 98972, 98980, 98981, 99078, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99242, 99243, 99244, 99245, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99421, 99422, 99423, 99441, 99442, 99443, 99457, 99458, 99483 HCPCS: G0071, G0463, G2010, G2012, G2250, G2251, G2252, T1015 UBREV: 0510, 0513, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0526, 0527, 0528, 0529, 0982, 0983 Dispensed Antidepressant Medication: Miscellaneous antidepressants: Bupropion, Vilazodone, Vortioxetine Monoamine oxidase inhibitors: Isocarboxazid, Phenelzine, Selegiline, Tranylcypromine Phenylpiperazine antidepressants: Nefazodone, Trazodone Psychotherapeutic combinations: Amitriptyline-chlordiazepoxide, Amitriptyline-perphenazine, Fluoxetine-olanzapine SNRI antidepressants: Desvenlafaxine, Duloxetine, Levomilnacipran, Venlafaxine SSRI antidepressants: Citalopram, Escitalopram, Fluoxetine, Fluvoxamine, Paroxetine, Sertraline Tetracyclic antidepressants: Maprotiline, Mirtazapine Tricyclic antidepressants: Amitriptyline, Amoxapine, Clomipramine, Desipramine, Doxepin (>6mg), Imipramine, Nortriptyline, Protriptyline, Trimipramine <i>Note: LOINC and SNOMED codes can be captured through electronic data submissions. Please contact your Account Executive for more information.</i>
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Measure	Measure Description	Measure Information/Documentation Required	Coding
Social Need Screening and Intervention (SNS-E) <i>This is a measure collected through claims and Electronic Clinical Data Systems. Please discuss options for a direct data feed with your Account Executive. Direct data feeds can improve provider quality performance and reduce the burden of medical record requests.</i>	The percentage of members who were screened, using pre-specified instruments, at least once in the measurement period (MP) for unmet food, housing, and transportation needs and received a corresponding intervention within 30 days of screening positive. The measurement period (MP) is 1/1 – 12/31.	Screenings documented on pre-specified instruments: Food Insecurity: - Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool. - American Academy of Family Physicians (AAFP) Social Needs Screening Tool. - Health Leads Screening Panel. - Hunger Vital Sign (HVS). - Protocol for Responding to and Assessing Patients' Assets, Risks & Experiences (PRAPARE). - Safe Environment for Every Kid (SEEK). - U.S. Household Food Security Survey. - U.S. Adult Food Security Survey. - U.S. Child Food Security Survey. - U.S. Household Food Security Survey – Six-Item Short Form. - We Care Survey. - WellRx Questionnaire. Housing Instability, homelessness, and housing inadequacy: - Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool. - American Academy of Family Physicians (AAFP) Social Needs Screening Tool. - Children's HealthWatch Housing Stability Vital Signs. - Health Leads Screening Panel	Food Intervention: CPT: 96156, 96160, 96161, 97802, 97803, 97804 HCPCS: S5170, S9470 Homelessness/Housing Intervention: CPT: 96156, 96160, 96161 Transportation Interventions: CPT: 96156, 96160, 96161 <i>Note: LOINC and SNOMED codes can be captured through electronic data submissions. Please contact your Account Executive for more information.</i>

		• Protocol for Responding to and Assessing Patients’ Assets, Risks & Experiences (PRAPARE). • We Care Survey. • WellRx Questionnaire. Transportation insecurity: • Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool. • American Academy of Family Physicians (AAFP) Social Needs Screening Tool. • Comprehensive Universal Behavior Screen (CUBS). • Health Leads Screening Panel. • Protocol for Responding to and Assessing Patients’ Assets, Risks & Experiences (PRAPARE). • PROMIS • WellRx Questionnaire Interventions are required for any element (food, housing, and transportation) found positive upon screening. Interventions must correspond to the positive screening and must be within 30 days of positive screen (day of screen and 30 days following for a total of 31 days). Interventions include: • Assistance. • Assessment. • Counseling. • Coordination. • Education. • Evaluation of Eligibility. • Provision. • Referral.	
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		Required Exclusions: Members who meet any of the following criteria are excluded from the measure: • In hospice or using hospice services any time in the MP. • Deceased at any time in the MP.	
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