Quick Reference Guide HEDIS® MY 2025

FOR MORE INFORMATION, VISIT **NCQA.ORG**

Medicaid | Medicare

'Ohana Health Plan is proud to serve Medicaid members in the state of Hawai'i. The information presented here is also representative of our affiliated and newly refreshed Wellcare brand of Medicare Advantage products serving members across the country. If you have any questions, please contact Provider Relations.

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For a complete list of codes, please visit the NCQA website at ncqa.org, or see the HEDIS value sets. Only subsets of the NCQA-approved codes are listed in this document.

HEDIS® MY 2025 Quick Reference Guide

Updated to reflect NCQA HEDIS® MY 2025 Technical Specifications

‘Ohana Health Plan strives to provide quality healthcare to our membership as measured through HEDIS® quality metrics. We created the HEDIS® MY 2025 Quick Reference Guide to help you increase your practice’s HEDIS® rates and address care opportunities for your patients. Please always follow the state and/or CMS billing guidance and ensure the HEDIS® codes are covered prior to submission. Measurement year 2025 is defined as Jan. 1, 2025 through Dec. 31, 2025.

What is HEDIS®?

HEDIS® (Healthcare Effectiveness Data and Information Set) is a set of standardized performance measures developed by the National Committee for Quality Assurance (NCQA) to objectively measure, report, and compare quality across health plans. NCQA develops HEDIS® measures through a committee represented by purchasers, consumers, health plans, healthcare providers, and policy makers.

What are the scores used for?

As state and federal governments move toward a quality-driven healthcare industry, HEDIS® rates are becoming more important for both health plans and individual providers. State purchasers of healthcare use aggregated HEDIS® rates to evaluate health insurance companies’ efforts to improve preventive health outreach for members.

Physician-specific scores are also used to measure your practice’s preventive care efforts. Your practice’s HEDIS® score determines your rates for physician incentive programs that pay you an increased premium — for example Pay For Performance or Quality Bonus Funds.

How are rates calculated?

HEDIS® rates are collected in various ways: administrative data, hybrid (medical record review data), and electronic clinical data systems (ECDS). *Administrative* data consists of claim or encounter data submitted to the health plan. *Hybrid* data consists of both administrative data and a sample of medical record data. Hybrid data requires review of a random sample of member medical records to abstract data for services rendered but that were not reported to the health plan through claims/encounter data. Accurate and timely claim/encounter data reduces the need for medical record review. If services are not billed or billed inaccurately, they are not included in the calculation.

Transition to ECDS Only Reporting

Over the last several years, NCQA has added the option to report the ECDS (Electronic Clinical Data Systems) reporting standard for several existing HEDIS measures alongside traditional HEDIS reporting. This allows health plans to assess their ECDS reporting capabilities and represents a step forward in adapting HEDIS to accommodate the expansive information available in electronic clinical datasets used for patient care and quality improvement. Based on these results, NCQA has announced the transition of several measures to ECDS-only. The major reporting change to be aware of is that traditional hybrid measures (COL, CIS, IMA, CCS) that transition to ECDS-only will no longer use the annual chart retrieval process to demonstrate compliance. All compliance from medical records must be processed through prospective supplemental data. The data sources for ECDS are Electronic Health Records, Health Information Exchanges, Case Management Systems, and Administrative Claims. For more information on ECDS and the data allowed for compliance, please visit **ncqa.org/hedis/the-future-of-hedis/hedis-electronic-clinical-data-system-ecds-reporting/**.

ECDS Measures Effective for MY 2025

- ✓ Adult Immunization Status (AIS-E) (MCR*/MCD*)**
- ✓ Blood Pressure Control for Patients With Hypertension (BPC-E) (MCR*/MCD*)**
- ✓ Breast Cancer Screening (BCS-E) (MCR*/MCD*)**
- ✓ Cervical Cancer Screening (CCS-E) (MCD)
- ✓ Childhood Immunization Status (CIS-E) (MCD)
- ✓ Colorectal Cancer Screening (COL-E) (MCR*/MCD*)**
- ✓ Depression Remission or Response for Adolescents and Adults (DRR-E) (MCR/MCD)
- ✓ Depression Screening and Follow-Up for Adolescents and Adults (DSF-E) (MCR/MCD)
- ✓ Documented Assessment After Mammogram (DBM-E) (MCR*/MCD*)**
- ✓ Follow-Up After Abnormal Mammogram Assessment (FMA-E) (MCR*/MCD*)**
- ✓ Follow-Up Care for Children Prescribed ADHD Medication (ADD-E) (MCD*)
- ✓ Immunizations for Adolescents (IMA-E) (MCD)
- ✓ Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E) (MCD*)
- ✓ Postpartum Depression Screening and Follow-Up (PDS-E) (MCD)
- ✓ Prenatal Depression Screening and Follow-Up (PND-E) (MCD)
- ✓ Prenatal Immunization Status (PRS-E) (MCD*)
- ✓ Social Need Screening and Intervention (SNS-E) (MCR/MCD)
- ✓ Unhealthy Alcohol Use Screening and Follow-Up (ASF-E) (MCR/MCD)
- ✓ Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS-E) (MCR/MCD)

*Impact to Health Plan Rating/MA Stars/QRS Stars in MY 2025

**Required to be reported for Medicare plans with Accreditation

Reference:
ncqa.org/hedis/the-future-of-hedis/hedis-electronic-clinical-data-system-ecds-reporting/

How can I improve my HEDIS® scores?

- ✓ Conduct preventive care visits annually and ensure your patients are up to date with their recommended screenings (i.e. mammograms, colonoscopies, etc.).
- ✓ Ensure that all claim/encounter data for each and every service rendered is submitted in an accurate and timely manner.
- ✓ Include CPT II codes to provide additional details and reduce medical record requests.
- ✓ Make sure that chart documentation reflects all services billed.
- ✓ Bill (or report by encounter submission) for all delivered services, regardless of contract status.
- ✓ Respond timely to medical records requests.
- ✓ Submit supplemental data throughout the measurement year.
- ✓ Early Engagement with Pharmacy Adherence is key — once a member loses days on a prescription, those days cannot be recovered.
- ✓ Speak with the members about any barriers to adherence.
- ✓ Consider utilizing RxEffect — a free online portal for our network providers that will prioritize your high-risk patients more efficiently. This will save on resources as it lists your patients at highest risk for non-adherence.
- ✓ If you have any questions regarding pharmacy and member barriers, please reach out to your local Provider Relations Representative for assistance.
- ✓ Speak with your patients about the availability of a transportation benefit (if applicable) to assist with access to care.
- ✓ Ensure that patients are aware of the option for mail-order prescription refills.
- ✓ Remember that you are now able to prescribe 100DS of medications for both retail and mail-order.

Updates to HEDIS® Measures

This guide has been updated with information from the release of the HEDIS® 2025 Volume 2 Technical Specifications by NCQA and is subject to change.

New Measures MY 2025:

- ✓ Documented Assessment After Mammogram (DBM-E)
- ✓ Follow-Up After Abnormal Mammogram Assessment (FMA-E)
- ✓ Blood Pressure Control for Patients With Hypertension (BPC-E)

Retired Measures MY 2025:

- ✓ Care for Older Adults – Pain Assessment (COA-PA)
- ✓ Childhood Immunization Status (CIS)*
- ✓ Immunizations for Adolescents (IMA)*
- ✓ Cervical Cancer Screening (CCS)*
- ✓ Antidepressant Medication Management (AMM)
- ✓ Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)
- ✓ Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)
- ✓ Ambulatory Care (AMB)
- ✓ Inpatient Utilization — General Hospital/Acute Care (IPU)

**Only the CIS-E, IMA-E and CCS-E measures will be reported.*

Transitioned Measures MY 2025:

- ✓ Colorectal Cancer Screening (COL)*
- ✓ Follow-Up Care for Children Prescribed ADHD Medication (ADD)*
- ✓ Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)*

**Only the COL-E, ADD-E and APM-E measures will be reported.*

Revised Measures:

- ✓ (HBD) Hemoglobin A1c Control for Patients with Diabetes, replaced with (GSD) Glycemic Status Assessment for Patients with Diabetes.

Availity

Clinical Quality Validation (CQV) is a time-saving application within Availity® Essentials that allows providers to quickly address and submit documentation for open Quality Care gaps and is a source of submission for P4P/P4Q programs. With an integrated workflow, pre-populated forms, document upload, status tracking, CQV is entirely digital from start to finish. Providers can electronically document their patient's care and assessments to close HEDIS® quality care gaps for Health Plan members using CQV.

- The provider's office must be registered with Availity® (**availity.com**) to receive and respond to quality care gaps electronically.
- Availity® Administrators must ensure that the roles to access CQV are assigned to the proper users. **Tip:** Locate the administrator for the organization in the Essentials menu bar. Click *[Your Name's] Account | My Account | Organization(s) | Open My Administrators*.
- Trainings and step-by-step documentation of how to navigate Availity's CQV portal can be found within Availity Essentials under the Help & Training Tab.

The Availity® CQV portal can be used in place of mailing and faxing medical records thereby relieving administrative burden on the provider's office.

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Call To Action: Please refer to the provider portal where you will find a complete list of member care gaps as applicable for the measures in this document.

(AAP) Adults' Access to Preventive/ Ambulatory Health Services

Lines of Business: Medicaid, Medicare

Measure evaluates the percentage of members 20 years of age and older who had an ambulatory or preventive care visit during the measurement year. Services that count include outpatient evaluation and management (E&M) visits, consultations, assisted living/home care oversight, preventive medicine, and counseling.

Tips:

- Synchronous telehealth visits, asynchronous telehealth visits (e-visits and virtual check-ins), or telephone visits are acceptable.
- Assist or schedule member's appointments for preventive care visits.
- Document the date and the type of visit.
- Submit the applicable codes.

CPT*	HCPCS*	ICD-10*
98966–98972, 99201–99205, 99211–99215, 99241–99245, 99341–99345, 99347–99350, 99381–99387, 99391–99397, 99401–99404, 99411, 99412, 99429, 92002, 92004, 92012, 92014, 99304–99310, 99315, 99316, 99318, 99324–99328, 99334–99337, 99421–99423, 99441–99444, 99457, 99458, 99483	G0071, G0402, G0438, G0439, G0463, G2010, G2012, G2063, G2251, G2252, S0620, S0621, S2250, T1015	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, Z02.89, Z02.9, Z76.1, Z76.2

*Codes subject to change.

(ACP) Advance Care Planning

Lines of Business: Medicare

Measure evaluates the percentage of adults:

- ✓ 66 years of age and older with advanced illness, an indication of frailty, or who are receiving palliative care and had advance care planning during the measurement year.
- ✓ 81 years of age and older who had advance care planning during the measurement year.

Tips:

- Encourage members to consider an Advance Directive, Medical Power of Attorney, Health Care Power of Attorney, or POLST (Physician Orders for Life Sustaining Treatment).
- Assist members in scheduling an Annual Preventive Visit.
- Telephone visits, e-visits, or virtual check-ins are acceptable.
- Submit the applicable codes.

Description	Codes*
Advanced Care Planning	**CPT:** 99483, 99497 **CPT II:** 1123F, 1124F, 1157F, 1158F **HCPCS:** S0257 **ICD-10:** Z66

*Codes subject to change.

(AIS-E) Adult Immunization Status

Lines of Business: Medicaid, Medicare

Measure evaluates the percentage of 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, pneumococcal, and hepatitis B.

Tips:

- Schedule appointments within immunization timeframes.
- Discuss the importance of vaccinations during member appointments.
- Include immunization history from all sources in the member's medical record.
- Use electronic medical record (EMR) system to set reminders flags.

(continued)

(AIS-E) Adult Immunization Status *(continued)*

Lines of Business: Medicaid, Medicare

Description	Codes*
Adult Hepatitis B Vaccine Procedure	**CPT:** 90740, 90744, 90746, 90747, 90759, 90739, 90743
Adult Influenza Vaccine Procedure	**CPT:** 90630, 90653, 90654, 90656, 90658, 90661, 90662, 90673, 90674, 90682, 90686, 90688, 90689, 90694, 90756
Adult Pneumoccocal Vaccine Procedure	**CPT:** 90670, 90671, 90677, 90732 **HCPCS:** G0009
Td Vaccine Procedure	**CPT:** 90714
Tdap Vaccine Procedure	**CPT:** 90715
Herpes Zoster Vaccine Procedure	**CPT:** 90750

*Codes subject to change.

(BPC-E) Blood Pressure Control for Patients with Hypertension

Lines of Business: Medicaid, Medicare

Measure evaluates the percentage of members 18 to 85 years of age during the measurement year who had a diagnosis of hypertension (HTN) and whose most recent blood pressure (BP) was <140/90 mm Hg during the measurement period.

Note: For a member to be included in measure, the member must have had at least two medical visits on two different date of services with a diagnosis of HTN, OR one medical visit with an HTN Diagnosis and a dispensed antihypertension medication.

Tips:

- Collect BP reading via any telehealth visit, and it does not require a remote monitoring device to be the source.
- Retake BP readings if the reading is = or >140/90 mm Hg.
- Help members schedule their hypertension follow-up appointments.
- Educate members on what a controlled BP means.

(continued)

(BPC-E) Blood Pressure Control for Patients with Hypertension *(continued)*

Lines of Business: Medicaid, Medicare

- Talk with members about taking their own BP via a digital device.
- If members use a digital device, and report the BP reading, capture the reading in member EMR.
- Submit applicable codes.

Description	Codes*
Diastolic Blood Pressure	**CPT:** 3078F, 3079F, 3080F
Diastolic Less Than 90	**CPT:** 3078F, 3079F
Systolic and Diastolic Result	**CPT:** 3074F, 3075F, 3077F, 3078F, 3079F, 3080F
Systolic Blood Pressure	**CPT:** 3074F, 3075F, 3077F
Systolic Less Than 140	**CPT:** 3074F, 3075F
Hypertension/Essential Hypertension	**ICD-10-CM:** I10
Exclusion: Encounter for Palliative Care	**ICD-10-CM:** Z51.5

*Codes subject to change.

*Note: Do **not** include CPT Cat II codes with a modifier (1P, 2P, 3P, 8P).*

(BPD) Blood Pressure Control for Patients with Diabetes

Lines of Business: Medicaid, Medicare

Measure evaluates the percentage of members 18 to 75 years of age with diabetes (type 1 and type 2) whose blood pressure was adequately controlled (<140/90 mm Hg) during the measurement year.

Tips:

- Member-reported BP readings can be documented in the medical record and are acceptable.
- Telehealth visits are acceptable as long as the BP reading is taken by an electronic device. (Device does not have to be remote monitoring device.) Use of a manual device does not meet criteria. Document in the note the reading is specifically from an electronic device.
- Check BP on both arms and record the lowest systolic and diastolic readings.
- Retake BP readings, after patient rests quietly for 5 minutes, if the initial BP reading is >140 systolic or >90 diastolic on first measurement. Remember to record both the initial and second BP readings.
- Never round up BP readings.
- Use correct cuff size on bare arm.
- The most recent blood pressure reading during the measurement year is used.
- Patients should rest quietly for at least five minutes before the first BP is taken.
- Submit applicable codes.

Description	Codes*
Palliative Care	**HCPCS:** G9054
Outpatient Codes (must include a diagnosis of diabetes)	**CPT:** 99202–99205, 99211–99215, 99242–99245, 99341, 99342, 99344, 99345, 99347–99350, 99381–99387, 99391–99397, 99401–99404, 99411, 99412, 99429, 99455, 99456, 99483 **HCPCS:** G0402, G0438, G0439, G0463, T1015

(continued)

(BPD) Blood Pressure Control for Patients with Diabetes *(continued)*

Lines of Business: Medicaid, Medicare

Description	Codes*
Non-Acute Inpatient (must include a diagnosis of diabetes)	**CPT:** 99304–99310, 99315–99316
Telephone Visits (must include a diagnosis of diabetes)	**CPT:** 98966–98968, 99441–99443
E-Visits or Virtual Check-ins (must include a diagnosis of diabetes)	**CPT:** 98969–98972, 99421–99423, 99457 **HCPCS:** G0071, G2010, G2012
Systolic Greater Than/ Equal to 140	**CPT II:** 3077F
Systolic 130–139	**CPT II:** 3075F
Systolic Less Than 130	**CPT II:** 3074F
Diastolic 80–89	**CPT II:** 3079F
Diastolic Greater Than/ Equal to 90	**CPT II:** 3080F
Diastolic Less Than 80	**CPT II:** 3078F
Remote BP Monitoring — Supports Telehealth	**CPT:** 93784, 93788, 93790, 99091, 99453, 99454, 99457, 99473, 99474

*Codes subject to change.

(CBP) Controlling High Blood Pressure

Lines of Business: Medicaid, Medicare

Measure evaluates the percentage of members 18 to 85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90 mm Hg) during the measurement year.

Tips:

- Exclude BP readings taken from ER or inpatient visits and visits for procedures that require a change in diet or medication regimen.
- The last blood pressure reading taken during the measurement year is used.

(continued)

(CBP) Controlling High Blood Pressure *(continued)*

Lines of Business: Medicaid, Medicare

- Blood pressure reading can be collected via any telehealth visit and it does not require a remote monitoring device to be the source.
- Retake BP readings if the reading is >140/90 mm Hg.
- Help members schedule their hypertension follow-up appointments.
- Educate members on what a controlled blood pressure means.
- Talk with members about taking their own blood pressure via a digital device.
- The patient must use a digital device to self report a blood pressure reading.
- Submit applicable codes.

Note: When submitting CPT II codes report both systolic and diastolic to complete blood pressure reading.

Description	Codes*
Essential Hypertension	**ICD-10:** I10
Systolic Greater Than/ Equal to 140	**CPT II:** 3077F
Systolic Less than 140	**CPT II:** 3074F, 3075F
Diastolic Greater Than/ Equal to 90	**CPT II:** 3080F
Diastolic 80–89	**CPT II:** 3079F
Diastolic Less Than 80	**CPT II:** 3078F
Telephone Visits	**CPT:** 98966–98968, 99441–99443
Remote BP Monitoring — Supports Telehealth	**CPT:** 93784, 93788, 93790, 99091, 99453, 99454, 99457, 99473, 99474

*Codes subject to change.

(COA) Care for Older Adults

Lines of Business: Medicare

Measure evaluates the percentage of adults 66 years of age and older who had each of the following during the measurement year:

✓ Medication review. ✓ Functional status assessment.

Tips:

- A Functional Status Assessment does not require a specific setting. Services rendered during a telephone visit, e-visit, or virtual check-in meets criteria.
- A complete medication list must be present if submitting a medical record for review (hybrid collection).
- Medication reviews must be completed by the prescribing practitioner or clinical pharmacist (reviews completed by RNs, LPNs, etc. are not acceptable for this measure).
- Medication review may be performed without the patient present.
- Complete the COA assessment form annually during an annual wellness exam.
- Submit applicable codes.

Description	Codes*
Medication Review (would require both CPT II codes of 1159F [Medication List] and 1160F [Medication Review] to be billed simultaneously to get credit)	**CPT:** 90863, 99483, 99605, 99606 **CPT II:** 1159F, 1160F **HCPCS:** G8427
Functional Status Assessment	**CPT:** 99483 **CPT II:** 1170F **HCPCS:** G0438, G0439

*Codes subject to change.

(COL-E) Colorectal Cancer Screening

The Colorectal Cancer Screening measure has transitioned to exclusive use of the Electronic Clinical Data Systems.

Summary of Changes: Only COL-E measure will be reported. COL is a retired measure and replaced with the new COL-E measure.

Lines of Business: Medicaid, Medicare

Measure evaluates the percentage of members 45 to 75 years of age who had an appropriate screening for colorectal cancer during the measurement year.

Tips:

- Educate patients on proper sample collection when distributing fecal immunochemical test (FIT) or fecal occult blood test (FOBT) testing kits.
- Complete and document all screenings for patients.
- Educate members on the importance of colorectal cancer screenings for early detection and the options available to complete their screening.
- Talk with members about using the home screenings for colorectal cancer screening.
- Help members schedule their colonoscopy screening appointments.
- Submit applicable codes.

Description	Codes*
Colonoscopy (within past 10 years)	**CPT:** 44388–44392, 44394, 44401–44408, 45378–45382, 45384-45386, 45388–45393, 45398 **HCPCS:** G0105, G0121
CT Colonography (within past five years)	**CPT:** 74261–74263
sDNA FIT Lab Test (within past three years)	**CPT:** 81528
Flexible Sigmoidoscopy (within past five years)	**CPT:** 45330–45335, 45337–45338, 45340–45342, 45346–45347, 45349, 45350 **HCPCS:** G0104

(continued)

(COL-E) Colorectal Cancer Screening *(continued)*

Lines of Business: Medicaid, Medicare

Description	Codes*
FOBT Lab Test (within measurement year)	**CPT:** 82270, 82274 **HCPCS:** G0328
Colorectal Cancer	**ICD-10:** C18.0–C18.9, C19, C20, C21.2, C21.8, C78.5, Z85.038, Z85.048
Palliative Care	**HCPCS:** G9054
Total Colectomy	**CPT:** 44150–44153, 44155–44158, 44210–44212

*Codes subject to change.

(EED) Eye Exam for Patients with Diabetes

Lines of Business: Medicaid, Medicare

Measure evaluates the percentage of members 18 to 75 years of age with diabetes (type 1 or type 2) who had a retinal eye exam during the measurement year.

Tips:

- Members need the eye exam even if they don't wear glasses.
- Refer diabetic members to an acceptable eye care professional (optometrist or ophthalmologist) annually for a dilated or retinal diabetic eye exam.
- Educate members on the eye damage that could be caused by their diabetes.
- Help members to schedule their annual diabetic eye exam appointments.
- Submit applicable codes.

(continued)

(EED) Eye Exam for Patients with Diabetes *(continued)*

Lines of Business: Medicaid, Medicare

Description	Codes*
Palliative Care	**HCPCS:** G9054
Outpatient Codes (must include a diagnosis of diabetes)	**CPT:** 99202–99205, 99211–99215, 99241–99245, 99341–99345, 99347–99350, 99381–99387, 99391–99397, 99401–99404, 99411, 99412, 99429, 99455, 99456, 99483 **HCPCS:** G0402, G0438, G0439, G0463, T1015
Non-Acute Inpatient (must include a diagnosis of diabetes)	**CPT:** 99304–99310, 99315, 99316, 99318, 99324–99328, 99334–99337
Retinal Eye Exam	**CPT:** 92002, 92004, 92012, 92014, 92018, 92019, 92134, 92201, 92202, 92230, 92235, 92250 **HCPCS:** S0620, S0621, S3000
Retinal Imaging	**CPT:** 92227, 92228
Automated Eye Exam	**CPT:** 92229
Interactive Outpatient Encounter	**CPT:** 98970–98972, 99421–99423, 99457 **HCPCS:** G0071, G2010, G2012
Unilateral Eye Enucleation With a Bilateral Modifier	**CPT:** 65091, 65093, 65101, 65103, 65105, 65110,65112, 65114 **CPT Modifier:** 50
Eye Exam With Retinopathy	**CPT II:** 2022F, 2024F
Eye Exam Without Retinopathy	**CPT II:** 2023F, 2025F, 2033F

*Codes subject to change.

(FMC) Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions

Lines of Business: Medicare

Measure evaluates the percentage of emergency department (ED) visits for members 18 years of age and older who have multiple high-risk chronic conditions who had a follow-up service within seven days of the ED visit during the measurement year.

Tips:

- Establish admission/discharge/transfer (ADT) feeds with local health systems to ensure timely notification of ED visits.
- Each ED visit requires a separate seven-day follow-up. If a patient has more than one ED visit in an eight-day period, only the first eligible visit is included.
- Maintain reserved appointments so patients with an ED visit can be seen within seven days of their discharge.
- An in-person office visit is not required. Follow-up may be provided via a telehealth, telephone, e-visit, or virtual check-in.
- Submit applicable codes.

Eligible chronic condition diagnoses:

- COPD, asthma or unspecified bronchitis
- Alzheimer's disease and related disorders
- Chronic kidney disease
- Depression
- Heart failure
- Acute myocardial infarction
- Atrial fibrillation
- Stroke and transient ischemic attack

(continued)

(FMC) Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions *(continued)*

Lines of Business: Medicare

Description	Codes*
Complex Care Management Services	**CPT:** 99439, 99487, 99489–99491 **HCPCS:** G0506
Outpatient and Telehealth	**CPT:** 98966–98968, 98970–98972, 98980, 98981, 99202–99205, 99211–99215, 99242–99245, 99341, 99342, 99344, 99345, 99347–99350, 99381–99387, 99391–99397, 99401–99404, 99411, 99412, 99421–99423, 99429, 99441–99443, 99455–99458, 99483 **HCPCS:** G0071, G0402, G0438, G0439, G0463, G2010, G2012, G2250–G2252, T1015
Case Management Encounter	**CPT:** 99366 **HCPCS:** T1016, T1017, T2022, T2023
Substance Use Disorder Services	**CPT:** 99408, 99409 **HCPCS:** G0396, G0397, G0443, H0001, H0005, H0007, H0015, H0016, H0022, H0047, H0050, H2035, H2036, T1006, T1012
Outpatient or Telehealth Behavioral Health (BH) Outpatient	**CPT:** 98960–98962, 99078, 99202–99205, 99211–99215, 99242–99245, 99341, 99342, 99344, 99345, 99347–99350, 99381–99387, 99391–99397, 99401–99404, 99411, 99412, 99483, 99492–99494, 99510 **HCPCS:** G0155, G0176–G0177, G0409, G0463, G0512, H0002, H0004, H0031, H0034, H0036–H0037, H0039–H0040, H2000, H2010–H2011, H2013–H2020, T1015
Substance Abuse Counseling and Surveillance**	**ICD-10:** Z71.41, Z71.51 **Do not include lab claims with POS code 81.
Transitional Care Management Services	**CPT:** 99495, 99496
Partial Hospitalization or Intensive Outpatient	**HCPCS:** G0410, G0411, G0035, G2001, G2012, S0201, S9480, S9484, S9485

(continued)

(FMC) Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions *(continued)*

Lines of Business: Medicare

Description	Codes*
Visit Setting Unspecified	**CPT:** 90791, 90792, 90832–90834, 90836–90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221–99223, 99231–99233, 99238, 99239, 99252–99255
An Outpatient or Telehealth Behavioral Health Visit	**Visit Setting Unspecified with Outpatient POS:** 03, 05, 07, 09, 11-20, 22, 33, 49, 50, 71, 72
An Intensive Outpatient Encounter or Partial Hospitalization	**Visit Setting Unspecified with POS:** 52
A Community Mental Health Center Visit	**Visit Setting Unspecified with POS:** 53
A Telehealth Visit	**Visit Setting Unspecified with Telehealth POS:** 02, 10
Electroconvulsive Therapy	**CPT:** 90870 **ICD-10:** GZB0ZZZ-GZB4ZZZ **With Outpatient POS:** 24, 52, 53

*Codes subject to change.

(GSD) Glycemic Status Assessment for Patients with Diabetes

Lines of Business: Medicaid, Medicare

Measure evaluates the percentage of members 18 to 75 years of age with diabetes (type 1 or type 2) whose most recent glycemic status (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) was at the following levels during the measurement year:

✓ Glycemic Status <8.0% ✓ Glycemic Status >9.0%

Tips:

- If the glycemic status is >9%, re-test after implementing appropriate treatment.
- Point of Care Testing is acceptable with appropriate coding and documentation with date of service and value.
- Member-reported A1c/GSD results are acceptable if documented in chart with test date and value.
- Conduct a diabetic visit with diabetic patients at least once per year.
- Document all A1c lab values with dates for diabetic members.
- Provide education to members regarding the need to monitor and manage their blood sugars (HgA1c).
- Assist members if needed to schedule lab visits for regular A1c testing to include transportation assistance.
- Submit applicable codes.

Note: A member who was previously compliant can become non-compliant with a more recent result.

Description	Codes*
Palliative Care	**HCPCS:** G9054
Outpatient Codes (must include a diagnosis of diabetes)	**CPT:** 99202–99205, 99211–99215, 99242–99245, 99341–99345, 99347–99350, 99381–99387, 99391–99397, 99401–99404, 99411, 99412, 99429, 99455, 99456, 99483 **HCPCS:** G0402, G0438, G0439, G0463, T1015

(continued)

(GSD) Glycemic Status Assessment for Patients with Diabetes *(continued)*

Lines of Business: Medicaid, Medicare

Description	Codes*
Non-Acute Inpatient (must include a diagnosis of diabetes)	**CPT:** 99304–99310, 99315, 99316, 99334–99337
Telephone Visits (must include a diagnosis of diabetes)	**CPT:** 98966–98968, 99441–99443
E-Visits or Virtual Check-ins (must include a diagnosis of diabetes)	**CPT:** 98970–98972, 99421–99423, 99457 **HCPCS:** G0071, G2010, G2012
HbA1c Lab Test	**CPT:** 83036, 83037
HbA1c Level Less Than 7	**CPT II:** 3044F
HbA1c Level Greater Than/ Equal to 7 and Less than 8	**CPT II:** 3051F
HbA1c Level Greater Than/ Equal to 8 and Less Than/ Equal to 9	**CPT II:** 3052F
HbA1c Greater Than 9.0	**CPT II:** 3046F

*Codes subject to change.

*Note: Do **not** include a modifier when using CPT II codes.*

(KED) Kidney Health Evaluation for Patients with Diabetes

Lines of Business: Medicaid, Medicare

Measure evalutes the percentage of members 18 to 85 years of age with diabetes (type 1 and type 2) who received a kidney health evaluation, defined by **BOTH** an estimated glomerular filtration rate (eGFR) **AND** a urine albumin-creatinine ratio (uACR), on the same or different dates of service during the measurement year.

(continued)

(KED) Kidney Health Evaluation for Patients with Diabetes *(continued)*

Lines of Business: Medicaid, Medicare

Tips:

- Conduct a diabetic visit with diabetic patients at least once per year.
- Educate members on why good kidney function is important as they work to manage their health and diabetes.
- Help members schedule their diabetes follow-up appointments and remind them of the care gaps that should be covered to include kidney function.
- Submit applicable codes.

Note the following gap closure criteria:

Members who received **BOTH** an eGFR and a uACR during the measurement year on the same or different dates of service:

✓ **uACR** — a urine lab that may appear alone on lab report.

OR

✓ **Urine creatinine and quantitative urine albumin.** These two may appear on the lab report in addition to or without a uACR result.

To close the care gap with the urine creatinine and quantitative urine albumin, test **cannot** be completed more than four days apart.

Description	Codes*
EGR: 80047, 80048, 80050, 80053, 80069, 82565	**Option 1 – Urine albumin creatinine ratio (uACR):** 13705-9, 14958-3, 14959-1, 30000-4, 32294-1, 44292-1, 59159-4, 76401-9, 77253-3, 77254-1, 89998-9, 9318-7 ***OR*** **Option 2 –** (Must be within 4 days of each other) **Quantitative Urine Albumin:** 82043 **Urine Creatinine:** 82570
Palliative Care	**HCPCS:** G9054

*Codes subject to change.

Note: As a best practice, perform both urine tests on the same day.

(PBH) Persistence of Beta-Blocker Treatment After a Heart Attack

Lines of Business: Medicaid, Medicare

Measure evaluates the percentage of members 18 years of age and older during the measurement year who were hospitalized and discharged from July 1 of the year prior to June 30 of the measurement year with a diagnosis of acute myocardial infarction (AMI), and who received persistent beta-blocker treatment for 180 days (six months) after discharge.

Note: The 180-day period that includes the discharge date and the 179 days after discharge.

Tips:

- Unless contraindicated, opt for cardioselective beta-blockers, which are less likely to affect bladder and prostate health.
- Encourage patients to report changes in urinary function.
- Proactively discuss the side effect profile(s) of beta-blockers with members to decrease the likelihood of them discontinuing treatment when experiencing mild side effects.
- Work with members to develop a dosing schedule and cadence that fits their routine.
- Recommend use of medication reminders/alarms, apps, and/or pill organizers.
- When possible, simplify medication regimens by reviewing medications lists and prescribing fewer pills or using combination drugs.
- Schedule more frequent follow-ups during the early states of treatment to address concerns and make necessary dose adjustments.
- Promote heart-healthy lifestyle modifications (i.e., diet, exercise, tension control).
- Address mental and emotional health concerns to identify and support members who may be overwhelmed by their health situation(s).
- Educate patients about the life-saving benefits of beta-blocker therapy, stressing the importance of medication adherence.

(continued)

(PBH) Persistence of Beta-Blocker Treatment After a Heart Attack *(continued)*

Lines of Business: Medicaid, Medicare

- Counsel patients that suddenly stopping medication can lead to complications such as heart attack, increased hypertension (high blood pressure) or increased anxiety.
- To prevent a risk of hypotension (low blood pressure), dose adjust medications gradually for members who are are also taking alpha-blocker(s).

Beta-Blocker Medications				
Description	**Prescription**			
Noncardioselective Beta-blockers	· Carvedilol · Propranolol	· Labetalol · Timolol	· Nadolol · Sotalol	· Pindolol
Cardioselective Beta-blockers	· Acebutolol · Atenolol	· Betaxolol · Bisoprolol	· Metoprolol · Nebivolol	
Antihypertensive Combinations	· Atenolol-chlorthalidone · Bendroflumethiazide-nadolol · Bisoprolol-hydrochlorothiazide · Hydrochlorothiazide-metoprolol · Hydrochlorothiazide-propranolol			

Required Exclusions:

- ✓ Members who use hospice services or elect to use a hospice benefit during the measurement year.
- ✓ Members who die during the measurement year.
- ✓ Members with an intolerance or allergy to beta-blocker therapy.
- ✓ Members with a diagnosis or medication dispensing event that indicates a contraindication to beta-blocker therapy and/or indicative of a history of:
  - Asthma • COPD • Obstructive chronic bronchitis
  - Chronic respiratory conditions due to fumes and vapors.
  - Hypotension (low blood pressure), heart block > 1st degree or sinus bradycardia.
  - Dispensed a medication indicative of a history of asthma (table on the following page).

(continued)

(PBH) Persistence of Beta-Blocker Treatment After a Heart Attack *(continued)*

Lines of Business: Medicaid, Medicare

- ✓ Medicare members 66 years of age and older as of Dec. 31 of the measurement year who meet either of the following:
  - Enrolled in a SNP.
  - Live long-term in an institution.
- ✓ Members 66 to 80 years of age as of Dec. 31 of the measurement year (all product lines) with frailty and advanced illness. Members must meet both frailty and advanced illness criteria to be excluded.
- ✓ Members 81 years of age and older as of Dec. 31 of the measurement year (all product lines) with at least two indications of frailty.
- ✓ Dispensed dementia medication (table below).

Asthma Exclusion Medications		
Description	**Prescription**	
Bronchodilator combinations	· Budesonide-formoterol · Fluticasone-vilanterol · Fluticasone-salmeterol · Formoterol-mometasone	
Inhaled corticosteroids	· Beclomethasone · Ciclesonide · Fluticasone	· Budesonide · Flunisolide · Mometasone

Dementia Exclusion Medications		
Description	**Prescription**	
Cholinesterase inhibitors	· Donepezil · Rivastigmine	· Galantamine
Miscellaneous Central Nervous System Agents	· Memantine	
Dementia combinations	· Donepezil-memantine	

(PCE) Pharmacotherapy Management of COPD Exacerbation

Lines of Business: Medicaid, Medicare

Measure evaluates the percentage of COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or ED visit on or between Jan. 1 to Nov. 30 during the measurement year and who were dispensed appropriate medications.

Two rates are reported:

1. Dispensed a systemic **corticosteroid** (or there was evidence of an active prescription) **within 14 days of the event**.
2. Dispensed a **bronchodilator** (or there was evidence of an active prescription) within **30 days of the event**.

Note: The eligible population for this measure is based on acute inpatient discharges and ED visits, not on members. It is possible for there to be multiple events for the same individual.

Tips:

- Educate patients on recognizing the early signs of a COPD exacerbation and the importance of seeking care early to prevent complications.
- Educate patients on the importance of adhering to prescribed medications, especially systemic corticosteroids and bronchodilators. Encourage use of pillboxes, reminder applications, and/or enrolling in automatic refill programs to support adherence.
- A prescription is considered active if the "days' supply" indicated on the date when the member was dispensed the prescription is the number of days or more between that date and the relevant date.
  - For acute inpatient stay, the relevant date is the date of admission.
  - For an ED visit, the relevant date is the date of service.

(continued)

(PCE) Pharmacotherapy Management of COPD Exacerbation *(continued)*

Lines of Business: Medicaid, Medicare

Systemic Corticosteroid Medications			
Description	**Prescription**		
Glucocorticoids	· Cortisone · Prednisolone · Methylprednisolone	· Hydrocortisone · Dexamethasone · Prednisone	
Bronchodilator Medications			
Description	**Prescription**		
Anticholinergic Agents	· Aclidinium-bromide · Ipratropium	· Umeclidinium · Tiotropium	
Beta 2-agonists	· Albuterol · Metaproterenol · Indacaterol	· Levalbuterol · Formoterol · Oledaterol	· Arformoterol · Salmeterol
Bronchodilator Combinations	· Albuterol-ipratropium · Budesonide-formoterol · Formoterol-mometasone · Glycopyrrolate-indacaterol · Umeclidinium-Vilanterol · Olodaterol-tiotropium	· Formoterol-aclidinium · Formoterol-glycopyrrolate · Fluticasone-salmeterol · Fluticasone-vilanterol · Fluticasone furoate-umeclidinium-vilarterol	

(PCR) Plan All-Cause Readmissions

Lines of Business: Medicaid, Medicare

Measure evaluates the members 18 years of age and older, the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days, and the predicted probability of an acute readmission.

Note: Medicaid: Patients 18 to 64 years of age.
Medicare: Patients 18 years of age and older.

Tips:

- Maintain reserved appointment availability for patients to follow-up within seven days after discharge to help avoid readmissions.
- Educate patients on the importance of following discharge instructions, receiving adequate follow-up care, medication adherence, and improving health literacy.
- Address Social Determinants of Health (SDoH) to ensure patients can afford their medications, have sustainable housing, their nutrition and transportation needs are met, etc.
- Submit applicable codes.

Description	Codes*
Inpatient Stay	**UBREV:** 0100, 0101, 0110–0114, 0116–0124, 0126–0134, 0136–0144, 0146–0154, 0156–0160, 0164, 0167, 0169–0174, 0179, 0190–0194, 0199–0204, 0206–0214, 0219, 1000–1002
Observation Stay	**UBREV:** 0760, 0762, 0769

*Codes subject to change.

(SPC) Statin Therapy for Patients with Cardiovascular Disease

Lines of Business: Medicaid, Medicare

Measure evaluates the percentage of males 21 to 75 years of age and females 40 to 75 years of age during the measurement year who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and met the criteria listed below.

The following rates are reported:

1. **Received Statin Therapy:** Members who were dispensed at least one high-intensity or moderate-intensity statin medication during the measurement year.

2. **Statin Adherence 80%:** Members who remained on a high-intensity or moderate intensity statin medication for at least 80% of the treatment period.

Note: Document patient muscular reactions to statins.

Tips:

- Encourage patients to enroll in an auto-refill program at their pharmacy.
- Avoid giving samples; only prescriptions with a pharmacy claim are utilized to measure adherence.
- Offer tips to patients such as:
  - Taking the medication at the same time each day.
  - Use a pill box.
  - Discuss potential side effects and encourage the member to contact the provider and not stop usage.
- Review medication list during each visit with the patient.
- Discuss the importance of medication adherence with the patient.
- When appropriate, recommend providers prescribe 90+ days supply.

(continued)

(SPC) Statin Therapy for Patients with Cardiovascular Disease *(continued)*

Lines of Business: Medicaid, Medicare

High- and Moderate-Intensity Statin Medications		
Description	**Prescription**	**Medication Lists**
High-intensity Statin Therapy	· Atorvastatin 40–80 mg	Atorvastatin High Intensity Medications List
High-intensity Statin Therapy	· Amlodipine-atorvastatin 40–80 mg	Amlodipine Atorvastatin High Intensity Medications List
High-intensity Statin Therapy	· Rosuvastatin 20–40 mg	Rosuvastatin High Intensity Medications List
High-intensity Statin Therapy	· Simvastatin 80 mg	Simvastatin High Intensity Medications List
High-intensity Statin Therapy	· Ezetimibe-simvastatin 80 mg	Ezetimibe Simvastatin High Intensity Medications List
Moderate-intensity Statin Therapy	· Atorvastatin 10–20 mg	Atorvastatin Moderate Intensity Medications List
Moderate-intensity Statin Therapy	· Amlodipine-atorvastatin 10–20 mg	Amlodipine Atorvastatin Moderate Intensity Medications List
Moderate-intensity Statin Therapy	· Rosuvastatin 5–10 mg	Rosuvastatin Moderate Intensity Medications List
Moderate-intensity Statin Therapy	· Simvastatin 20–40 mg	Simvastatin Moderate Intensity Medications List
Moderate-intensity Statin Therapy	· Ezetimibe-simvastatin 20–40 mg	Ezetimibe Simvastatin Moderate Intensity Medication List
Moderate-intensity Statin Therapy	· Pravastatin 40–80 mg	Pravastatin Moderate Intensity Medications List
Moderate-intensity Statin Therapy	· Lovastatin 40 mg	Lovastatin Moderate Intensity Medications List
Moderate-intensity Statin Therapy	· Fluvastatin 40–80 mg	Fluvastatin Moderate Intensity Medications List
Moderate-intensity Statin Therapy	· Pitavastatin 1–4 mg	Pitavastatin Moderate Intensity Medications List

(TRC) Transitions of Care

Lines of Business: Medicare

Measure evaluates the percentage of discharges for members 18 years of age and older who had ***each*** of the four reported rates listed below during the measurement year.

Four rates are reported:

1. **Notification of Inpatient Admission.**
   Documentation of receipt of notification of inpatient admission on the day of admission through two days after the admission (three total days).

2. **Receipt of Discharge Information.**
   Documentation of receipt of discharge information on the day of discharge through two days after the discharge (three total days).

3. **Patient Engagement After Inpatient Discharge.**
   Documentation of patient engagement (e.g., office visits, visits to the home, telehealth) provided within 30 days after discharge.

4. **Medication Reconciliation Post-Discharge.**
   Documentation of medication reconciliation on the date of discharge through 30 days after discharge (31 total days).

Tips:

- For this measure, medication reconciliation may be conducted by a prescribing practitioner, clinical pharmacist, physician assistant, or registered nurse.
- A medication reconciliation performed without the member present meets criteria.
- Ensure follow-up appointments are scheduled within 30 days after discharge.
- For hybrid medical record review, a comprehensive medication list must be included.
- Document medication reconciliation including a reference to the patient's hospitalization, admission or inpatient stay.
- Services may be performed during a telephone visit, e-visit, or virtual check-in.
- Submit applicable codes.

(continued)

(TRC) Transitions of Care *(continued)*

Lines of Business: Medicare

Best Documentation Practices

✓ Document evidence of receipt of **notification of inpatient admission** in the outpatient medical record. Any of the examples meet criteria:

- Communication between inpatient providers or staff and the patient's primary care physician (PCP) or ongoing care provider (e.g., phone call, email, fax).
- Communication about admission between emergency department and the patient's PCP or ongoing care provider (e.g., phone call, email, fax).
- Communication about admission to the patient's PCP or ongoing care provider through a health information exchange; an automated admission, or discharge and transfer (ADT) alert system.
- Communication about admission with the patient's PCP or ongoing care provider through a shared electronic medical record (EMR) system. When using a shared EMR system, documentation of a "received date" is not required to meet criteria. Evidence that the information was filed in the EMR and is accessible to the PCP or ongoing care provider on the day of admission through two days after the admission (three total days) meets criteria.
- Communication about admission to the patient's PCP or ongoing care provider from the patient's health plan.
- Indication that the patient's PCP or ongoing care provider admitted the patient to the hospital.
- Indication that a specialist admitted the patient to the hospital and notified the patient's PCP or ongoing care provider.
- Indication that the PCP or ongoing care provider placed orders for tests and treatments any time during the patient's inpatient stay.
- Documentation that the PCP or ongoing care provider performed a preadmission exam or received communication about a planned inpatient admission.

(continued)

(TRC) Transitions of Care *(continued)*

Lines of Business: Medicare

Note: When an ED visit results in an inpatient admission, notification that a provider sent the patient to the ED does not meet criteria. Evidence that the PCP or ongoing care provider communicated with the ED about the admission meets criteria.

✓ Document evidence of **receipt of notification of discharge information** in the outpatient medical record. At a minimum, the discharge information must include ***all*** of the following: and keep the bullets that follow:

- The practitioner responsible for the patient'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.

Note: If the PCP or ongoing care provider is the discharging provider, the discharge information must be documented in the medical record on the day of discharge through two days after the discharge (three total days).

✓ Document evidence of **patient engagement after inpatient discharge** (office visits, home visits, telehealth that does not include the date of discharge). Any of the following meet criteria:

- An outpatient visit, including office visits and home visits.
- A telephone visit.
- A synchronous telehealth visit where real-time interaction occurred between the patient and provider using audio and video communication.
- An e-visit or virtual check-in (asynchronous telehealth where two-way interaction, which was not in real-time, occurred between the patient and provider).

Note: If the patient is unable to communicate with the provider, interaction between the patient's caregiver and the provider meets criteria.

(continued)

(TRC) Transitions of Care *(continued)*

Lines of Business: Medicare

✓ Document evidence of **medication reconciliation post-discharge** and the date it was performed in the outpatient medical record. 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 patient's current medications with a notation that the discharge medications were reviewed.
- 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 patient was seen for post-discharge hospital follow-up with evidence of medication reconciliation or review. Evidence that the patient was seen for post-discharge hospital follow-up requires documentation that indicates the provider was aware of the patient's hospitalization or discharge.
- 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.

Note: A medication reconciliation performed without the member present meets criteria.

(continued)

(TRC) Transitions of Care *(continued)*

Lines of Business: Medicare

Description	Codes*
Medication Reconciliation Intervention	**CPT II:** 1111F
Medication Reconciliation	**CPT:** 99483, 99495–99496
Outpatient and Telehealth	**CPT:** 98966–98968, 98970–98972, 98980–98981, 99202–99205, 99211–99215, 99242–99245, 99341–99342, 99344–99345, 99347–99350, 99381–99387, 99391–99397, 99401–99404, 99411–99412, 99421–99423, 99429, 99441–99443, 99455–99458, 99483 **HCPCS:** G0071, G0402, G0438–G0439, G0463, G2010, G2012, G2250–G2252, T1015 **UBREV:** 0510, 0511, 0513, 0514, 0515, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0526, 0527, 0528, 0529, 0982, 0983
Transitional Care Management Services	**CPT:** 99495, 99496

*Codes subject to change.

Pharmacy Measures

(PDC) Proportion of Days Covered

Lines of Business: Medicare

Measure evaluates the percentage of members 18 years of age and older who met the PDC threshold of 80% during the measurement year.

Three rates are reported:

- ✓ Renin Angiotensin System Antagonists (PDC-RASA).
- ✓ Diabetes All Class (PDC-DR).
- ✓ Statins (PDC-STA).

1 (RASA) Adherence to Hypertensive Medications — Measure Overview

Measure evaluates the percentage of members 18 years of age and older with a RASA medication with a PDC ≥ 80% during the measurement year.

- ✓ Higher rate indicates better performance.
- ✓ Two fills needed to index into the measure.
- ✓ Targeted early in the year.

Gap Closure Requirements

PDC ≥ 80% per member

- **PDC calculated utilizing:** total days supplied of RASA pharmacy claims/date of first RASA fill to the end of the reporting interval.
- Each medication claim must be submitted through the health plan insurance. Cash payment, samples, or medications filled at out-of-network pharmacies do not count towards the measure.
- Final plan star score based upon the percentage of members with a PDC ≥ 80%.

(continued)

(PDC) Proportion of Days Covered *(continued)*

Lines of Business: Medicare

Other Criteria

- **Medication Inclusions:** RASA Medications — i.e., Lisinopril, Losartan, Enalapril, Valsartan.
- **Exclusions:** Members with a Sacubutril/valsartan claim; Hospice enrollees, ESRD.

2 (DIAB) Adherence to Diabetes Medications — Measure Overview

Measure evaluates the percentage of members 18 years of age and older with a diabetes medication with a PDC ≥ 80%.

- ✓ Higher rate indicates better performance.
- ✓ Two fills needed to index into the measure.
- ✓ Targeted early in the year.

Gap Closure Requirements

PDC ≥ 80% per member

- **PDC calculated utilizing:** total days supplied of diabetes pharmacy claims/date of first diabetes fill to the end of the reporting interval.
- Each medication claim must be submitted through the health plan insurance. Cash payment, samples or medications filled at out-of-network pharmacies do not count towards the measure.
- Final plan star score based upon the percentage of members with a PDC ≥ 80%.

Other Criteria

- **Medication Inclusions:** Diabetes Medications — i.e., Metformin, Glipizide, Glimepiride, Januvia.
- **Exclusions:** Members with an insulin claim; Hospice enrollees, ESRD.

(continued)

3 (STAT) Adherence to Cholesterol Medications — Measure Overview

Measure evaluates the percentage of members 18 years of age and older with a CHOL medication with a PDC ≥ 80%.

- ✓ Higher rate indicates better performance.
- ✓ Two fills needed to index into the measure.
- ✓ Targeted early in the year.

Gap Closure Requirements

PDC ≥ 80% per member

- **PDC calculated utilizing:** total days supplied of CHOL pharmacy claims/date of first CHOL fill to the end of the reporting interval.
- Each medication claim must be submitted through the health plan insurance. Cash payment, samples or medications filled at out-of-network pharmacies do not count towards the measure.
- Final plan star score based upon the percentage of members with a PDC ≥ 80%.

Other Criteria

- **Medication Inclusions:** CHOL Medications — i.e., Atorvastatin, Simvastatin, Rosuvastatin, Pravastatin.
- **Exclusions:** Hospice enrollees, ESRD.

(SPD) Statin Therapy for Patients with Diabetes

Lines of Business: Medicare

Measure evaluates the percentage of members 40 to 75 years of age during the measurement year with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) who met the criteria listed below.

Two rates are reported:

1. **Received Statin Therapy.** Members who were dispensed at least one statin medication of any intensity during the measurement year.
2. **Statin Adherence 80%.** Members who remained on a statin medication of any intensity for at least 80% of the treatment period.

Note: Document patient muscular reactions to statins.

(SUPD) Statin Use in Persons with Diabetes

Lines of Business: Medicare

Measure evaluates the percentage of members 40 to 75 years of age with diabetes who have a single fill of a statin during the measurement year.

- ✓ Higher rate indicates better performance.
- ✓ Only one fill needed to index in the measure.
- ✓ Targeted later in the year vs. other measures (starting in late July or August).

Gap Closure Requirements

Member received a statin therapy:

- The number of members who had at least one dispensing event for a statin medication during the measurement year.

Other Criteria

- **Medication Inclusions:** Statin Medications — i.e., Atorvastatin, Simvastatin, Rosuvastatin, Pravastatin.
- **Exclusions:** Include documentation for ERSD, Rhabdomyolysis, Pregnancy, Cirrhosis, Pre-Diabetes, Polycystic Ovary Syndrome.

(BCS-E) Breast Cancer Screening

Lines of Business: Medicaid, Medicare

Measure evaluates the percentage of members 50 to 74 years of age who were recommended for routine breast cancer screening and had a mammogram to screen for breast cancer during the measurement year. One or more mammograms any time on or between October 1 two years prior to the measurement period and the end of the measurement period.

Tips:

- Schedule member's mammogram screening annually.
- Document the date and the specific procedure completed when reviewing the patient's history.
- Submit applicable codes.
- Submit the appropriate ICD-10 diagnosis code for a member's history of bilateral mastectomy annually, Z90.13.

Description	Codes*
Mammogram	**CPT:** 77061–77063, 77065–77067 **ICD-10 (bilateral mastectomy):** Z90.13
Palliative Care	**HCPCS:** G9054

*Codes subject to change.

(CCS-E) Cervical Cancer Screening

Lines of Business: Medicaid

Measure evaluates the percentage of members 21 to 64 years of age who were screened for cervical cancer during the measurement year using ***any*** of the following criteria:

- ✓ Members 21 to 64 years of age who had cervical cytology performed within last three years.
- ✓ Members 30 to 64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last five years.
- ✓ Members 30 to 64 years of age who had cervical cytology/high risk human papillomavirus (hrHPV) co-testing within the last five years.

Tips:

- Document and code if member has had a hysterectomy with no residual cervix or absence of cervix. Document the type of hysterectomy (e.g., full, partial, vaginal, laproscopic).
- Help members schedule their routine cervical cancer screening.
- Document the date and the specific procedure completed when reviewing the patient's history.
- Submit the applicable codes.

Description	Codes*
Cervical Cytology Lab Test (Age 21 to 64)	**CPT:** 88141–88143, 88147, 88148, 88150, 88152, 88153, 88164–88167, 88174, 88175 **HCPCS:** G0123, G0124, G0141, G0143–G0145, G0147, G0148, P3000, P3001, Q0091
hrHPV Test (Age 30 to 64, every five years)	**CPT:** 87624, 87625 **HCPCS:** G0476
Palliative Care	**HCPCS:** G9054

*Codes subject to change.

(CHL) Chlamydia Screening

Lines of Business: Medicaid

Measure evaluates the percentage of members 16 to 24 years of age who were recommended for routine chlamydia screening, were identified as sexually active, and had at least one test for chlamydia during the measurement year.

Tips:

- Providers should order an annual chlamydia screening for patients (who will turn 16 years old by Dec. 31 of the measurement year).
- Perform chlamydia screening every year.
- Inform patient that chlamydia screening can be performed through a urine test. Offer this as an option for patients.
- Add chlamydia screening as a standard lab for patients 16 to 24 years of age. Use well-child exams and well-women exams for this purpose.
- Place chlamydia swab next to Pap test or pregnancy detection materials.
- Meet with teens and young adults separately from their parents to allow open conversation.
- Advise members during wellness visits or when they are seen for birth control to get screened for chlamydia.
- Submit applicable codes.

CPT*
87110, 87270, 87320, 87490–87492, 87810

*Codes subject to change.

(DBM-E) Documented Assessment After Mammogram

This is a first-year measure.

Lines of Business: Medicaid, Medicare

Measure evaluates the percentage of episodes of mammograms during the measurement year documented in the form of a BI-RADS assessment within 14 days of the mammogram for members 40 to 74 years of age.

A higher rate indicates better performance.

Definitions:

- **Participation period**
  - The episode date through 14 days after the episode date (15 days total).
- **Intake period**
  - Dec. 18 of the prior measurement period to Dec. 17 of the measurement period. The intake period is used to capture the episode date.
- **Episode date**
  - The date of service for an eligible encounter during the intake period with a mammogram procedure.
- **BI-RADS assessment**
  - Clinically documented BI-RADS score. BI-RADS is a standardized classification system proposed by the American College of Radiology, used for imaging of mammography, ultrasound, and MRI of the breast.

Tips:

- Document BI-RADS score in patient's health record on or within 14 days (15 days total) after mammogram.
  - Document breast density if it is missing from the mammogram report.
- After mammography, ensure patients receive clear communication about their breast density, including its implications for cancer risk and screening follow-up.
  - Educate patients with higher breast density about the need for additional screening, such as ultrasound or MRI, as recommended by clinical guidelines.

(continued)

(DBM-E) Documented Assessment After Mammogram *(continued)*

Lines of Business: Medicaid, Medicare

- Involve radiologists, primary care providers, and specialists to ensure that patients receive appropriate care based on their mammogram results. Ensure smooth transitions between departments for diagnostic follow-up.
- Submit applicable codes.

Description	Codes*
BIRADS Assessment	**RadLex:** RID36028–RID36036, RID36041
Mammography	**CPT:** 77061–77063, 77065–77067

*Codes subject to change.

(FMA-E) Follow-Up After Abnormal Mammogram Assessment

This is a first-year measure.

Lines of Business: Medicaid, Medicare

Measure evaluates the percentage of episodes during the measurement year for members 40 to 74 years of age with inconclusive or high-risk BI-RADS assessments that received appropriate follow-up within 90 days of the assessment.

A higher rate indicates better performance.

Definitions:

- **Participation**
  - The identifiers and descriptors for each organization's coverage used to define members' eligibility for measure reporting. Allocation for HEDIS® reporting is based on eligibility during the participation period.
- **Participation period**
  - The episode date through 90 days after the episode date (91 days total).

(continued)

(FMA-E) Follow-Up After Abnormal Mammogram Assessment *(continued)*

Lines of Business: Medicaid, Medicare

- **Intake period**
  - Oct. 3 of the year prior to the measurement period to Oct. 2 of the measurement period. The intake period is used to capture the episode date.
- **Episode date**
  - The dates of service during the intake period when a high-risk or inconclusive BI-RADS score was documented.
- **BI-RADS assessment**
  - Clinically documented BI-RADS score. BI-RADS is a standardized classification system proposed by the American College of Radiology, used for the imaging of mammography, ultrasound, and MRI of the breast.

Tips:

- Document BI-RADS score and appropriate follow-up within 90 days of assessment in patient's health record.
  - Document inconclusive or high-risk breast density if it is missing from the mammogram report.
  - Follow recommended follow-up guidelines ensuring patients:
    - Receive a **breast biopsy** on or within 90 days (91 days total) for a Category 4 (Suspicious) – Category 5 (Highly Suggestive of Malignancy) BI-RADS score.
    - Receive a **mammogram** or **ultrasound** on or within 90 days (91 days total) for a BI-RADS score or 0 (Incomplete – Need Additional Imaging Evaluation and/or Prior Mammograms for Comparison).
- Foster coordination between radiology, primary care, and oncology to ensure breast density is included in the follow-up plans for patients with higher risk factors.
- Submit applicable codes.

(continued)

(FMA-E) Follow-Up After Abnormal Mammogram Assessment *(continued)*

Lines of Business: Medicaid, Medicare

Description	Codes*
Breast Biopsy	**CPT:** 19081, 19083, 19085, 19100, 19101
Breast Ultrasound	**CPT:** 76641, 76642
High Risk BIRADS	**RadLex:** RID36030-RID36034
Inconclusive BIRADS	**RadLex:** RID36036
Mammography	**CPT:** 77061–77063, 77065-77067

*Codes subject to change.

(OMW) Osteoporosis Management in Women Who Had a Fracture

Lines of Business: Medicare

Measure evaluates the percentage of women 65 to 85 years of age during the measurement year who suffered a fracture and who had either a bone mineral density (BMD) test or prescription for a drug to treat osteoporosis in the six months after the fracture.

**Fractures of fingers, toes, face, and skull are not included in this measure.*

Tips:

- Provide patients who had a fracture with a referral for bone mineral density testing and encourage them to obtain the screening.
- When appropriate, prescribe medication to treat osteoporosis (bisphosphates).
- Check that fracture codes are used appropriately.
- Consider offering onsite bone density screening for patients at risk.
- Women at risk for osteoporosis should receive a bone density screening every two years.
- Submit applicable codes.

(continued)

(OMW) Osteoporosis Management in Women Who Had a Fracture *(continued)*

Lines of Business: Medicare

Description	Codes*
Palliative Care	**HCPCS:** G9054
Bone Mineral Density Tests	**CPT:** 76977, 77078, 77080, 77081, 77085, 77086
Osteoporosis Medications	**HCPCS:** J0897, J1740, J3110, J3111, J3489
Long-Acting Osteoporosis Medications during Inpatient Stay	**HCPCS:** J0897, J1740, J3489

*Codes subject to change.

Osteoporosis Medications			
Description	**Prescription**		
Bisphosphonates	· Alendronate · Ibandronate	· Alendronate-cholecalciferol · Risedronate	· Zoledronic acid
Other agents	· Abaloparatide · Teriparatide	· Romosozumab · Raloxifene	· Denosumab

(OSW) Osteoporosis Screening in Older Women

Lines of Business: Medicare

Measure evaluates the percentage of women 65 to 75 years of age who received an osteoporosis screening on or between the member's 65th birthday and Dec. 31 of the measurement year.

Tips:

- Provide a bone mineral density test for members without a diagnosis and have not previously been treated for osteoporosis.
- Educate members on bone health and how to adopt healthy practices.

Description	Codes*
Osteoporosis Screening Tests	**CPT:** 76977, 77078, 77080, 77081, 77085
Palliative Care	**HCPCS:** G9054

*Codes subject to change.

(PPC) Prenatal and Postpartum Care

Lines of Business: Medicaid

Measure evaluates percentage of deliveries of live births on or between Oct. 8 of the year prior to the measurement year and Oct. 7 of the measurement year. For these members, the measure assesses the following facets of prenatal and postpartum care.

- ✓ **Timeliness of Prenatal Care:** percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date, or within 42 days of enrollment in the organization.
- ✓ **Postpartum Care:** percentage of deliveries that had a postpartum visit on or between seven and 84 days after delivery.

(continued)

(PPC) Prenatal and Postpartum Care *(continued)*

Lines of Business: Medicaid

Tips:

- Schedule an initial prenatal visit within the first 12 weeks of pregnancy with an OB/GYN, PCP, or nurse midwife.
- Educate members on the importance of prenatal care throughout their pregnancy to include the postpartum visit.
- Ensure prenatal flow sheets and/or American College of Obstetricians and Gynecologists patient forms (ACOGs) are fully completed, with dates of services and provider initials (if applicable).
- Schedule postpartum visits prior to discharge after delivery.
- Submit applicable codes.

Description	Codes*
Online Assessments	**CPT:** 98970–98972, 99421–99423, 99457 **HCPCS:** G0071, G2010, G2012
Prenatal Visits	**CPT:** 99201–99205, 99211–99215, 99242–99245, 99483 **HCPCS:** G0463, T1015
Stand-Alone Prenatal Visits	**CPT:** 99500 **CPT II:** 0500F, 0501F, 0502F **HCPCS:** H1000, H1001, H1002, H1003, H1004
Cervical Cytology Lab Test	**CPT:** 88141–88143, 88147, 88148, 88150, 88152–88153, 88164–88167, 88174, 88175 **HCPCS:** G0123, G0124, G0141, G0143, G0144, G0145, G0147, G0148, P3000, P3001, Q0091
Postpartum Visits	**CPT:** 57170, 58300, 59430, 99501 **CPT II:** 0503F **HCPCS:** G0101 **ICD-10:** Z01.411, Z01.419, Z01.42, Z30.430, Z39.1, Z39.2
Telephone Visits	**CPT:** 98966–98968, 99441–99443

*Codes subject to change.

Note: When using the Online Assessment, Telephone Visit, or Prenatal Visit codes, remember to also include a Pregnancy Diagnosis code.

(PRS-E) Prenatal Immunization Status

Lines of Business: Medicaid

Measure evaluates the percentage of deliveries in the measurement period in which members had received influenza and tetanus, diphtheria toxoids, and acellular pertussis (Tdap) vaccinations during the measurement year.

Measurement Period:

- ✓ **Flu** — on or between July 1 of the year prior to the measurement year and the delivery date.
- ✓ **Tdap** — vaccine received during the pregnancy (including the delivery date).

Tips:

- Identify patients with open care gap and flag in electronic health record (EHR) system if possible. Offer needed vaccines during prenatal visits and check-ups, or when patient is admitted for delivery.
- Educate patient on the importance of vaccinations and how they protect both patient and baby, and address any fear or anxiety associated with vaccinations during pregnancy.
- Submit applicable codes and document all vaccinations in the patient electronic medical record.

Description	Codes*
Adult Influenza Immunization	**CVX:** 88, 135, 140, 141, 144, 150, 153, 155, 158, 166, 168, 171, 185, 186, 197, 205
Adult Influenza Vaccine Procedure	**CPT:** 90630, 90653, 90654, 90656, 90658, 90661, 90662, 90673, 90674, 90682, 90686, 90688, 90689, 90694, 90756
Tdap Immunization	**CVX:** 115
Tdap Vaccine Procedure	**CPT:** 90715
Anaphylaxis	**SNOMED:** 428291000124105, 428281000124107

*Codes subject to change.

(CIS-E) Childhood Immunization Status

Lines of Business: Medicaid

Measure evaluates the percentage of children two years of age during the measurement year who had four diphtheria, tetanus, and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (Hep B), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and three combination rates.

Tips:

- Document both the name of the vaccine and the date it was administered in the medical record.
- Submit applicable codes.

Description	Codes*
DTaP (4 doses)**	**CPT:** 90697, 90698, 90700, 90723 **CVX:** 20, 50, 106, 107, 110, 120, 146, 198
HiB (3 doses)**	**CPT:** 90644, 90647, 90648, 90697, 90698, 90748 **CVX:** 17, 46, 47, 48, 49, 50, 51, 120, 146, 148, 198
Hep B (3 doses) May include a newborn vaccination.	**CPT:** 90697, 90723, 90740, 90744, 90747, 90748 **CVX:** 08, 44, 45, 51, 110, 146, 198 **HCPCS:** G0010 **ICD-10:** B16.0, B16.1, B16.2, B16.9, B17.0, B18.0, B18.1, B19.10, B19.11
IPV (3 doses)**	**CPT:** 90697, 90698, 90713, 90723 **CVX:** 10, 89, 110, 120, 146

(continued)

(CIS-E) Childhood Immunization Status *(continued)*

Lines of Business: Medicaid

Description	Codes*
MMR (1 dose) If using history of illness to close MMR gap, there must be evidence of illness with all three measles, mumps, and rubella.	**CPT:** 90707, 90710 **CVX:** 03, 94 **ICD-10:** B05.0, B05.1, B05.2, B05.3, B05.4, B05.81, B05.89, B05.9, B26.0, B26.1, B26.2, B26.3, B26.81, B26.82. B26.83, B26.84, B26.85, B26.89, B26.9, B06.00, B06.01, B06.02, B06.09, B06.81, B06.82, B06.89, B06.9
Pneumococcal Conjugate PCV (4 doses)**	**CPT:** 90670, 90671, 90677 **CVX:** 109, 133, 152, 215, 216 **HCPCS:** G0009
Varicella VZV (1 dose)	**CPT:** 90710, 90716 **CVX:** 21, 94 **ICD-10:** 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
Hep A (1 dose)	**CPT:** 90633 **CVX:** 31, 83, 85 **ICD-10:** B15.0, B15.9
Influenza (2 doses)*** LAIV meets criteria for one of the two required vaccinations if administered on the 2nd birthday.	**CPT:** 90655, 90657, 90660, 90661, 90672, 90673, 90674, 90685–90689, 90756 **CVX:** 88, 111, 140, 141, 149, 150, 153, 155, 158, 161, 171, 186
Rotavirus (2 doses)**	**CPT:** 90681
Rotavirus (3 doses)**	**CPT:** 90680 **CVX:** 116, 122
Anaphylaxis	Use applicable SNOMED as indicated per vaccine (428291000124105, 428281000124107)

*Codes subject to change.

***Do not count a vaccination administered prior to 42 days after birth.*

****Do not count a vaccination administered prior to 180 days after birth.*

*Note: Rotavirus is either 2 dose **OR** 3 dose for compliancy.*

(IMA-E) Immunizations for Adolescents

Lines of Business: Medicaid

Measure evaluates the percentage of adolescents 13 years of age during the measurement year who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday. The measure calculates a rate for each vaccine and two combination rates.

Tips:

- Document both the name of the vaccine and the date it was administered in the medical record.
- Submit applicable codes.

Description	Codes*
Meningococcal (serogroups A, C, W, Y or A, C, W, Y, B) (1 dose) — must be administered between 10th and 13th birthday	**CPT:** 90619, 90623, 90733, 90734 **CVX:** 32, 108, 114, 136, 147, 167, 203, 316
Tdap (1 dose) — must be administered between the 10th and 13th birthday	**CPT:** 90715
HPV (2 or 3 dose series) — must be administered between 9th and 13th birthday	**CPT:** 90649–90651 **CVX:** 62, 118, 137, 165
Anaphylaxis	Use applicable SNOMED as indicated per vaccine. (428291000124105, 428281000124107)

*Codes subject to change.

(LSC) Lead Screening in Children

Lines of Business: Medicaid

Measure evaluates the percentage of children two years of age during the measurement year who had one or more capillary or venous lead blood test for lead poisoning on or prior to their second birthday. Only one test is required.

Tips:

- LSC testing must be performed on or prior to child's second birthday.
- Document both the date and results of the LSC screening.
- Results of 'unknown' are not acceptable.
- Submit applicable codes.

CPT*
83655

*Codes subject to change.

(OED) Oral Evaluation, Dental Services

Lines of Business: Medicaid

Measure evaluates the percentage of members under 21 years of age who received a comprehensive or periodic oral evaluation with a dental provider during the measurement year.

Tips:

- Remind patients or their responsible party of their dental benefits.
- Encourage regular check-up visits with a dentist for routine exams, cleanings, and oral x-rays.
- Help patients schedule an appointment to see a dentist.
- Federally Qualified Health Centers and Rural Health Clinics/ Centers can serve as a Primary Care Dental Home provider.

(continued)

(OED) Oral Evaluation, Dental Services *(continued)*

Lines of Business: Medicaid

Description	Codes*
Dental Provider	**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
Oral Evaluation	**CDT:** D0120, D0145, D0150

*Codes subject to change.

(TFC) Topical Fluoride for Children

Lines of Business: Medicaid

Measure evaluates the percentage of members 1 to 4 years of age who received at least two fluoride varnish applications during the measurement year.

Tips:

- Children must receive two fluoride varnish applications on different dates of services.
- During visits, educate parents about the importance of having children receive fluoride varnish applications.
- Primary care provider can start applying fluoride varnish with the first tooth eruption and apply it every three to six months.
- Perform an Oral Health Risk Assessment to determine any risk factors.
- Fluoride is essential for preventing dental carriers and tooth decay.

Description	Codes*
Topical application of fluoride varnish	**CPT:** 99188 **CDT:** D1206
Application of dental fluoride varnish (procedure)	**SNOMED CT US Edition:** 313042009

*Codes subject to change.

(W30) Well-Child Visits in the First 30 Months of Life

Lines of Business: Medicaid

Measure evaluates the percentage of children who had the following number of well-child visits with primary care physician (PCP) during the last 15 months during the measurement year.

The following rates are reported:

1. **Well-Child Visits in the First 15 Months.**
   Children who turned 15 months old during the measurement year: Six or more well-child visits.

2. **Well-Child Visits for Age 15 Months-30 Months.**
   Children who turned 30 months old during the measurement year: Two or more well-child visits.

Tips:

- Remind caregivers of appointments by texts or phone calls.
- Educate the caregiver about the importance of preventive care visits.
- Consider using templates with checkboxes to ensure required information is documented.
- Submit applicable codes.

Note: Telehealth well visits are no longer acceptable.

CPT*	HCPCS*	ICD-10*
99381, 99382, 99391, 99392, 99461	G0438, G0439, S0302	Z00.110, Z00.111, Z00.121, Z00.129, Z00.2, Z76.1, Z76.2

*Codes subject to change.

(WCC) Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

Lines of Business: Medicaid

Measure evaluates the percentage of members 3 to 17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of the following during the measurement year:

- ✓ Body mass index (BMI) percentile.
- ✓ Counseling for nutrition.
- ✓ Counseling for physical activity.

Tips:

- Be sure to document all components of the WCC measure on every visit.
- Nutrition pertains to eating habits, behaviors (not appetite).
- BMI values are not acceptable; only percentiles. Ranges are not acceptable. If plotted on chart, BMI chart must be used (not age-growth chart).
- Call members/caregivers to reschedule cancelled appointments.
- Include documentation if child/adolescent is counseled for weight or obesity.
- Submit applicable codes.

Description	Codes*
BMI Percentile	**ICD-10:** Z68.51, Z68.52, Z68.53, Z68.54
Nutrition Counseling	**CPT:** 97802–97804 **HCPCS:** G0270, G0271, G0447, S9449, S9452, S9470
Physical Activity	**HCPCS:** G0447, S9451 **ICD-10:** Z02.5, Z71.82

*Codes subject to change.

(WCV) Child and Adolescent Well-Care Visits

Lines of Business: Medicaid

Measure evaluates the percentage of members 3 to 21 years of age who had a least one comprehensive well-care visits with a PCP or OB/GYN within the measurement year. Visits occurring anytime in the measurement year, including prior to or after the patient's birthday, closes the gap.

Tips:

- Remind caregivers of appointments by texts or phone calls.
- Educate the caregiver about the importance of preventive care visits to assess growth and development and to provide immunizations and anticipatory guidance on nutrition, physical activity, and safety.
- Components of a WCV should include a health history, physical development history, and mental development history along with:
  - A physical exam (including height, weight, and BMI percentile).
  - Health education and anticipatory guidance.

Note: Telehealth well visits are no longer acceptable.

CPT*	HCPCS*	ICD-10*
99382–99385, 99391–99395	G0438, G0439, S0302, S0610, S0612, S0613	Z00.00, Z00.01, Z00.121, Z00.129, Z00.2, Z00.3, Z01.411, Z01.419, Z02.5, Z76.2

*Codes subject to change.

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

Lines of Business: Medicaid, Medicare

Measure evaluates the percentage of episodes for members ages three months and older with a diagnosis of acute bronchitis/bronchiolitis that did not result in an antibiotic dispensing event on or three days after the episode during the intake period between July 1 of the year prior to the measurement year to June 30 of the measurement year.

Tips:

- A higher rate indicates appropriate acute bronchitis/bronchiolitis treatment (i.e., the proportion for episodes that ***did not*** result in an antibiotic dispensing event).
- When clinically appropriate, suggest alternative treatments to manage symptoms, such as over-the-counter medications, humidifiers and other non-pharmacologic therapies, and getting adequate fluids and rest.
- If red flags are present warranting antibiotic therapy, document appropriate diagnosis to support use of the antibiotic prescribed.
- Submit applicable codes.

Description	Codes*
Acute Bronchitis	**ICD-10:** J20.3-J20.9, J21.0, J21.1, J21.8, J21.9

*Codes subject to change.

(AMR) Asthma Medication Ratio

Lines of Business: Medicaid

Measure evaluates the percentage of members 5 to 64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medication of 0.50 or greater during the measurement year.

Step 1: For each member, count the units of asthma controller medications (Asthma Controller Medications List) dispensed during the measurement year.

Step 2: For each member, count the units of asthma reliever medications (Asthma Reliever Medications List) dispensed during the measurement year.

- ✓ For each member, sum the units calculated in step 1 and step 2 to determine units of total asthma medications.
- ✓ For each member, calculate ratio using the below:
  - Units of Controller Medications/Units of Total Asthma Medications.

Asthma Controller Medications			
Description	**Prescriptions**	**Medication Lists**	**Route**
Antibody Inhibitors	· Omalizumab	Omalizumab Medications List	Injection
Anti-interleukin-4	· Dupilumab	Dupilumab Medications List	Injection
Anti-interleukin-5	· Benralizumab	Benralizumab Medications List	Injection
Anti-interleukin-5	· Mepolizumab	Mepolizumab Medications List	Injection
Anti-interleukin-5	· Reslizumab	Reslizumab Medications List	Injection
Inhaled Steroid Combinations	· Budesonide-formoterol	Budesonide Formoterol Medications List	Inhalation

(continued)

(AMR) Asthma Medication Ratio *(continued)*

Lines of Business: Medicaid

Asthma Controller Medications			
Description	**Prescriptions**	**Medication Lists**	**Route**
Inhaled Steroid Combinations	· Fluticasone-salmeterol	Fluticasone Salmeterol Medications List	Inhalation
Inhaled Steroid Combinations	· Fluticasone-vilanterol	Fluticasone Vilanterol Medications List	Inhalation
Inhaled Steroid Combinations	· Formoterol-mometasone	Formoterol Mometasone Medications List	Inhalation
Inhaled Corticosteroids	· Beclomethasone	Beclomethasone Medications List	Inhalation
Inhaled Corticosteroids	· Budesonide	Budesonide Medications List	Inhalation
Inhaled Corticosteroids	· Ciclesonide	Ciclesonide Medications List	Inhalation
Inhaled Corticosteroids	· Flunisolide	Flunisolide Medications List	Inhalation
Inhaled Corticosteroids	· Fluticasone	Fluticasone Medications List	Inhalation
Inhaled Corticosteroids	· Mometasone	Mometasone Medications List	Inhalation
Leukotriene Modifiers	· Montelukast	Montelukast Medications List	Oral
Leukotriene Modifiers	· Zafirlukast	Zafirlukast Medications List	Oral
Leukotriene Modifiers	· Zileuton	Zileuton Medications List	Oral
Methylxanthines	· Theophylline	Theophylline Medications List	Oral

(continued)

(AMR) Asthma Medication Ratio *(continued)*

Lines of Business: Medicaid

Asthma Reliever Medications			
Description	**Prescriptions**	**Medication Lists**	**Route**
Short-acting, Inhaled Beta-2 Agonists	· Albuterol	Albuterol Medications List	Inhalation
	· Albuterol-budesonide	Albuterol Medications List	Inhalation
Short-acting, Inhaled Beta-2 Agonists	· Levalbuterol	Levalbuterol Medications List	Inhalation

Tips:

- Nasal sprays cannot be defined as inhalation medications.

Other Criteria

- **Inclusion:** four dispenses of asthma medications per year or a hospitalization for asthma.
- **Exclusion:** member exclusion diagnoses include emphysema, COPD, and other respiratory disorders.

(CWP) Appropriate Testing for Pharyngitis

Lines of Business: Medicaid, Medicare

Measures the percentage of episodes for members three years and older where the member was diagnosed with pharyngitis, dispensed an antibiotic, and received a group A streptococcus (strep) test in the seven-day period: from three days *prior* to the episode date through three days *after* the episode during the intake period, between July 1 of the year prior to the measurement year to June 30 of the measurement year.

Tips:

- Perform a rapid strep test or a throat culture in patients who present with symptoms suggestive of strep throat before prescribing antibiotics.
- For patients with viral pharyngitis, recommend supportive treatments such as analgesics, throat lozenges, oral rinses, hydration, and rest when clinically indicated.
- Review and document the group A streptococcus (strep) test in the patient's health record.
- Provide tips for managing viral infections and their symptoms such as over-the-counter medications.
- Submit applicable codes.

Description	Codes*
Group A Strep Test	**CPT:** 87070, 87071, 87081, 87430, 87650-87652, 87880
Pharyngitis	**ICD-10-CM:** J02.0, J02.8, J02.9, J03.00, J03.01, J03.80, J03.81, J03.90, J03.91
Outpatient, Emergency Department, and Telehealth	**CPT:** 98966–98968, 98970–98972, 98980–98981, 99202–99205, 99211–99215, 99242–99245, 99281–99285, 99341–99345, 99347–99350, 99381–99387, 99391–99397, 99401–99404, 99411–99412, 99421–99423, 99429, 99441–99443, 99455-99458, 99483 **HCPCS:** G0071, G0402, G0438-G0439, G0463, G2010, G2012, G2250-G2252, T1015

*Codes subject to change.

(continued)

(CWP) Appropriate Testing for Pharyngitis *(continued)*

Lines of Business: Medicaid, Medicare

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

(LBP) Use of Imaging Studies for Low Back Pain

Lines of Business: Medicaid, Medicare

Measure evaluates the percentage of members 18 to 75 years of age with a principal diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis.

A higher score indicates appropriate treatment of low back pain (i.e., the proportion for whom imaging studies did not occur).

Tips:

- If not medically required, avoid ordering diagnostic studies (X-rays, CT, MRI) for the diagnosis of uncomplicated low back pain in the absence of red flags (e.g., cancer, recent trauma, neurologic impairment, or IV drug abuse).
- Use of complete and accurate Value Set Codes.
- Provide patient education on cautious measures for pain relief such as stretching exercises, activity level, and use of ice and/or heat when clinically indicated.
- If medically appropriate, provide a physical therapy referral, including massage, stretching, strengthening exercises, and manipulation.
- Look for other reasons for visits for low back pain (e.g., depression, anxiety, narcotic dependency, psychosocial stressors), and address appropriately.
- Document and submit claims and encounter data in a timely manner.
- Submit applicable codes.

Description	Codes*
Imaging Study	**CPT:** 72020, 72040, 72050, 72052, 72070, 72072, 72074, 72080–72084, 72100, 72110, 72114, 72120, 72125–72133, 72141–72142, 72146–72149, 72156–72158, 72200, 72202, 72220

(continued)

(LBP) Use of Imaging Studies for Low Back Pain *(continued)*

Lines of Business: Medicaid, Medicare

Description	Codes*
Uncomplicated Low Back Pain	**ICD-10:** M47.26–M47.28, M47.816–M47.818, M47.896–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–M53.2X8, M53.3, M53.86–M53.88, M54.16–M54.18, M54.30–M54.32, M54.40–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

*Codes subject to change.

(SNS-E) Social Needs Screening and Intervention

Lines of Business: Medicaid, Medicare

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

Six rates are reported:

- ✓ **Food Screening.** The percentage of members who were screened for food insecurity.
- ✓ **Food Intervention.** The percentage of members who received a corresponding intervention within 30 days (one month) of screening positive for food insecurity.
- ✓ **Housing Screening.** The percentage of members who were screened for housing instability, homelessness, or housing inadequacy.
- ✓ **Housing Intervention.** The percentage of members who received a corresponding intervention within 30 days (one month) of screening positive for housing instability, homelessness, or housing inadequacy.
- ✓ **Transportation Screening.** The percentage of members who were screened for transportation insecurity.
- ✓ **Transportation Intervention.** The percentage of members who received a corresponding intervention within 30 days (one month) of screening positive for transportation insecurity.

The SNS-E screening numerator counts only screenings that use instruments in the measure specification as identified by the associated LOINC code(s).

The SNS-E measure specification does not prohibit cultural adaptations or linguistic translations from being counted toward the measure's screening numerators.

Only screenings documented using the Logical Observation Identifiers Names and Codes (LOINC®) codes specified in the SNS-E measure count toward the measure's screening numerators.

Some screening tools are proprietary and may require licensing agreements or costs.

(continued)

(SNS-E) Social Needs Screening and Intervention *(continued)*

Lines of Business: Medicaid, Medicare

Food Insecurity Instruments	Screening Item LOINC Codes	Positive Finding LOINC Codes
Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool	88122-7 88123-5	LA28397-0 LA6729-3
American Academy of Family Physicians (AAFP) Social Needs Screening Tool	88122-7 88123-5	LA28397-0 LA6729-3
American Academy of Family Physicians (AAFP) Social Needs Screening Tool — Short Form	88122-7 88123-5	LA28397-0 LA6729-3
Health Leads Screening Panel®[1]	95251-5	LA33-6
Hunger Vital Sign™[1] (HVS)	88124-3	LA19952-3
Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences (PRAPARE)®[1]	93031-3	LA30125-1
Safe Environment for Every Kid (SEEK)®[1]	95400-8 95399-2	LA33-6
U.S. Household Food Security Survey (U.S. FSS)	95264-8	LA30985-8 LA30986-6
U.S. Adult Food Security Survey (U.S. FSS)	95264-8	LA30985-8 LA30986-6
U.S. Child Food Security Survey (U.S. FSS)	95264-8	LA30985-8 LA30986-6
U.S. Household Food Security Survey — Six-Item Short Form (U.S. FSS)	95264-8	LA30985-8 LA30986-6
We Care Survey	96434-6	LA32-8
WellRx Questionnaire	93668-2	LA33-6

[1]*Proprietary; may be cost or licensing requirement associated with use.*

(continued)

(SNS-E) Social Needs Screening and Intervention *(continued)*

Lines of Business: Medicaid, Medicare

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

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

[1]*Proprietary; may be cost or licensing requirement associated with use.*

(continued)

(SNS-E) Social Needs Screening and Intervention *(continued)*

Lines of Business: Medicaid, Medicare

Housing Inadequacy Instruments	Screening Item LOINC Codes	Positive Finding LOINC Codes
American Academy of Family Physicians (AAFP) Social Needs Screening Tool	96778-6	LA32691-0 LA28580-1 LA32693-6 LA32694-4 LA32695-1 LA32696-9 LA32001-2
American Academy of Family Physicians (AAFP) Social Needs Screening Tool — Short Form	96778-6	LA31996-4 LA28580-1 LA31997-2 LA31998-0 LA31999-8 LA32000-4 LA32001-2
Norwalk Community Health Center Screening Tool (NCHC)	99134-9 99135-6	LA31996-4 LA28580-1 LA31997-2 LA31998-0 LA31999-8 LA32000-4 LA32001-2
Transportation Insecurity Instruments	**Screening Item LOINC Codes**	**Positive Finding LOINC Codes**
Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool	93030-5	LA33-6
American Academy of Family Physicians (AAFP) Social Needs Screening Tool	99594-4	LA33-6
American Academy of Family Physicians (AAFP) Social Needs Screening Tool — Short Form	99594-4	LA33093-8 LA30134-3

(continued)

(SNS-E) Social Needs Screening and Intervention *(continued)*

Lines of Business: Medicaid, Medicare

Transportation Insecurity Instruments	Screening Item LOINC Codes	Positive Finding LOINC Codes
Comprehensive Universal Behavior Screen (CUBS)	89569-8	LA29232-8 LA29233-6 LA29234-4
Health Leads Screening Panel®[1]	99553-0	LA33-6
Inpatient Rehabilitation Facility — Patient Assessment Instrument (IRF-PAI) — version 4.0 (CMS Assessment)	101351-5	LA30133-5 LA30134-3
Outcome and assessment information set (OASIS) form — version E — Discharge from Agency (CMS Assessment)	101351-5	LA30133-5 LA30134-3
Outcome and assessment information set (OASIS) form — version E — Resumption of Care (CMS Assessment)	101351-5	LA30133-5 LA30134-3
Outcome and assessment information set (OASIS) form — version E — Start of Care (CMS Assessment)	101351-5	LA30133-5 LA30134-3
Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences (PRAPARE)®[1]	93030-5	LA30133-5 LA30134-3
PROMIS®[1]	92358-1	LA30024-6 LA30026-1 LA30027-9
WellRx Questionnaire	93671-6	LA33-6

[1]*Proprietary; may be cost or licensing requirement associated with use.*

(continued)

(SNS-E) Social Needs Screening and Intervention *(continued)*

Lines of Business: Medicaid, Medicare

✓ Identify members with positive screening and conduct an intervention corresponding to the type of need identified on or up to 30 days after the date of the first positive screening during the measurement year.

Tips:

- Interventions may include any of the following categories: adjustment, assistance, coordination, counseling, education, evaluation of eligibility, evaluation/assessment, provision, or referral.

Description	Codes*
Food Insecurity Procedures	**CPT:** 96156, 96160–96161, 97802–97804 **HCPCS:** S5170 (Home delivered meals, including preparation; per meal) **HCPCS:** S9470 (Nutritional counseling, dietitian visit)
Homelessness Procedures	**CPT:** 96156, 96160, 96161
Housing Instability Procedures	**CPT:** 96156, 96160, 96161
Inadequate Housing Procedures	**CPT:** 96156, 96160, 96161
Transportation Insecurity Procedures	**CPT:** 96156, 96160, 96161

*Codes subject to change.

(URI) Appropriate Treatment for Upper Respiratory Infection

Lines of Business: Medicaid, Medicare

Measures the percentage of episodes for members three months of age and older with a diagnosis of upper respiratory infection (URI) that did not result in an antibiotic dispensing event on or three days after the episode during the intake period between July 1 of the year *prior* to the measurement year to June 30 of the measurement year.

A higher rate indicates appropriate URI treatment (i.e., the proportion of episodes that ***did not*** result in an antibiotic dispensing event).

Tips:

- Unless clinically indicated, discourage the use of antibiotics for routine treatment of uncomplicated vial infections, such as common colds, which are typically self-limiting and often do not require antibiotic therapy.
- Provide patients with clear instructions on supportive care and managing their symptoms.
- When appropriate, recommend alternative treatments for symptom relief, such as over-the-counter medications, fluids, and rest.
- Submit applicable codes.

Description	Codes*
Acute Nasopharyngitis (common cold)	**ICD-10:** J00
Acute Laryngopharyngitis	**ICD-10:** J06.0
Acute Upper Respiratory Infection, unspecified	**ICD-10:** J06.9

*Codes subject to change.

Social Determinants of Health

(SDOH) Social Determinants of Health

Description	Codes*
Occupational Exposure to Risk Factors	**ICD-10:** Z57.0–Z57.9
Problems Related to Education and Literacy	**ICD-10:** Z55.0–Z55.9
Problems Related to Employment and Unemployment	**ICD-10:** Z56.0–Z56.9
Problems Related to Physical Environment	**ICD-10:** Z58.0–Z58.9
Problems Related to Housing and Economic Circumstances	**ICD-10:** Z59.0–Z59.9
Problems Related to Social Environment	**ICD-10:** Z60.0–Z60.9
Problems Related to Upbringing	**ICD-10:** Z62.0–Z62.9
Problems Related to Primary Support Group, Including Family Circumstances	**ICD-10:** Z63.0–Z63.9
Problems Related to Certain Psychosocial Circumstances	**ICD-10:** Z64.0–Z64.4
Problems Related to Other Psychosocial Circumstances	**ICD-10:** Z65.0–Z65.9
Problems Related to Substance Use	**ICD-10:** Z71.41, Z71.42, Z71.51, Z71.52
Problems Related to Sleep/Sleep Hygiene	**ICD-10:** Z72.820, Z72.821
Other Risk Factors	**ICD-10:** Z91.89
Patient/Caregiver Noncompliance with Dietary Regimen or Medical Treatment Due to Financial Hardship	**ICD-10:** Z911.10, Z911.90, Z91A.10, Z91A.20

(continued)

(SDOH) Social Determinants of Health *(continued)*

Description	Codes*
Transportation Insecurity Procedures	**CPT:** 96156
CPT/HCPCS Screening Codes Applicable to SDOH	**CPT:** 96156–96161, 97802–97804, 99377–99378 **HCPCS**: S5170, S9470, G0182, G9473–G9479, Q5003–Q5008, Q5010, S9126, T2042–T2046

*Codes subject to change.

Best Practices:

Include supplemental codes in the patient's diagnosis section on a claim form. Assign as many SDOH codes necessary to describe all the social problems, conditions, or risk factors documented during the current episode of care.

(ADD-E) Follow-up Care for Children Prescribed ADHD Medication

Lines of Business: Medicaid

Time frame is measurement year.

Measure evaluates the percentage of children newly prescribed attention deficit hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 300-day (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:** percentage of members 6 to 12 years of age with a prescription dispensed for ADHD medication, who had one follow-up visit with a practitioner with prescribing authority during the 30-day Initiation Phase.

2. **Continuation and Maintenance (C&M) Phase:** percentage of members 6 to 12 years of age with a prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (nine months) after the Initiation Phase ended.

Tips:

- Complete a comprehensive medical and psychiatric exam, including rating scales from parents and teachers, before diagnosing and prescribing.
- Limit the first prescription of ADHD medication to a 28- to 30-day supply and schedule follow up before the family leaves the office.
- Re-evaluate medication effectiveness no more than 30 days after initiation via telehealth when available, and regularly monitor medication effects thereafter.

(continued)

(ADD-E) Follow-up Care for Children Prescribed ADHD Medication *(continued)*

Lines of Business: Medicaid

- Periodically review the ongoing need for continued medication therapy.
- Reschedule any canceled appointments right away.
- Schedule telehealth visits if office visits are not acceptable.
- Submit applicable codes.

Description	Codes*
An Outpatient Visit	**CPT:** 90791, 90792, 90832–90834, 90836–90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221–99223, 99231–99233, 99238, 99239, 99252–99255 **POS:** 03, 05, 07, 09, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 22, 33, 49, 50, 71, 72
BH Outpatient Visit	**CPT:** 98960–98962, 99078, 99202–99205, 99211–99215, 99242–99245, 99341–99345, 99347–99350, 99381–99387, 99391–99397, 99401–99404, 99411, 99412, 99483, 99492–99494, 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
Health and Behavior Assessment/ Intervention	**CPT:** 96156, 96158, 96159, 96164, 96165, 96167, 96168, 96170, 96171
Visit Setting Unspecified Value Set with Partial Hospitalization POS	**CPT:** 90791, 90792, 90832–90834, 90836–90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221–99223, 99231–99233, 99238, 99239, 99252–99255 **POS:** 52
Partial Hospitalization/ Intensive Outpatient	**HCPCS:** G0410, G0411, H0035, H2001, H2012, S0201, S9480, S9484, S9485

(continued)

(ADD-E) Follow-up Care for Children Prescribed ADHD Medication *(continued)*

Lines of Business: Medicaid

Description	Codes*
Telehealth Visit	**CPT:** 90791, 90792, 90832–90834, 90836–90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221–99223, 99231–99233, 99238, 99239, 99252–99255 **POS:** 02, 10
Telephone Visits	**CPT:** 98966–98968, 99441–99443
E-visit/Virtual Check-in	**CPT:** 98970–98972, 98980, 98981, 99421–99423, 99457, 99458 **HCPCS:** G0071, G2010, G2012, G2250–G2252
Visit Setting Unspecified Value Set with Community Mental Health Center POS	**CPT:** 90791, 90792, 90832–90834, 90836–90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221–99223, 99231–99233, 99238, 99239, 99252–99255 **POS:** 53

*Codes subject to change.

(APM-E) Metabolic Monitoring for Children and Adolescents on Antipsychotics

Applicable Foster Care Measure

Lines of Business: Medicaid

Measure evaluates the percentage of children and adolescents 1 to 17 years of age who had two or more antipsychotic prescriptions and had metabolic testing during the measurement year.

Three rates reported:

1. Percentage of children and adolescents on antipsychotics who received blood glucose testing.
2. Percentage of children and adolescents on antipsychotics who received cholesterol testing.
3. Percentage of children and adolescents on antipsychotics who received blood glucose and cholesterol testing.

(continued)

(APM-E) Metabolic Monitoring for Children and Adolescents on Antipsychotics *(continued)*

Lines of Business: Medicaid

Tips:

- Provide members/caregivers with lab orders for HbA1c or glucose and cholesterol or LDL-C to be completed yearly.
- Coordinate care between behavioral and physical health providers.
- Educate the member and caregiver about the risks associated with taking antipsychotic medications and the importance of regular follow-up care.
- Submit applicable codes.

Description (Need either A1c or Glucose and LCL-C or Cholesterol)	Codes*
HbA1c Lab Tests	**CPT:** 83036, 83037 **CPT II:** 3044F, 3046F, 3051F, 3052F
Glucose Lab Tests	**CPT:** 80047, 80048, 80050, 80053, 80069, 82947, 82950, 82951
LDL-C Lab Tests	**CPT:** 80061, 83700, 83701, 83704, 83721 **CPT II:** 3048F, 3049F, 3050F
Cholesterol Lab Tests	**CPT:** 82465, 83718, 83722, 84478

*Codes subject to change.

*Note: Do **not** include a modifier when using CPT II codes.*

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

Lines of Business: Medicaid

Measure evaluates the percentage of children and adolescents 1 to 17 years of age who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment.

Identify members eligible for antipsychotic medications and provide psychosocial care prior to beginning a medication.

Tips:

- Before prescribing antipsychotic medication, complete or refer for a trial of first-line psychosocial care.
- Antipsychotic medications should be part of a comprehensive, multi-modal plan for coordinated treatment that includes psychosocial care.
- Periodically the ongoing need for continued therapy with antipsychotic medications should be reviewed.

Description	Codes*
Psychosocial Care	**CPT:** 90832–90834, 90836–90840, 90845–90849, 90853, 90875, 90876, 90880 **HCPCS:** G0176, G0177, G0409–G0411, H0004, H0035–H0039, H0040, H2000, H2001, H2011–H2014, H2017–H2020, S0201, S9480, S9484, S9485
Residential Behavioral Health Treatment	**HCPCS:** H0017–H0019, T2048

*Codes subject to change.

(DSF-E) Depression Screening and Follow-Up for Adolescents and Adults

Lines of Business: Medicaid, Medicare

Measure evaluates the percentage of members 12 years of age and older who were screened for clinical depression during the measurement year 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 within 30 days of a positive depression screen finding.

Depression Screening instrument: A standard assessment instrument that has been normalized and validated for the appropriate patient population. Eligible screening instruments with thresholds for positive findings are included on the following pages.

Instruments for Adolescents (≤17 years)	Total Score LOINC Codes	Positive Finding
Patient Health Questionnaire (PHQ-9)®	44261-6	Total score ≥10
Patient Health Questionnaire Modified for Teens (PHQ-9M)®	89204-2	Total score ≥10
Patient Health Questionnaire-2 (PHQ-2)®	55758-7	Total score ≥3
Beck Depression Inventory-Fast Screen (BDI-FS)®	89208-3	Total score ≥8
Center for Epidemiologic Studies Depression Scale — Revised (CESD-R)	89205-9	Total score ≥17
Edinburgh Postnatal Depression Scale (EPDS)	99046-5	Total score ≥10
PROMIS Depression	71965-8	Total score (T Score) ≥60

(continued)

(DSF-E) Depression Screening and Follow-Up for Adolescents and Adults *(continued)*

Lines of Business: Medicaid, Medicare

Instruments for Adults (18+ years)	Total Score LOINC Codes	Positive Finding
Patient Health Questionnaire (PHQ-9)®	44261-6	Total score ≥10
Patient Health Questionnaire-2 (PHQ-2)®	55758-7	Total score ≥3
Beck Depression Inventory-Fast Screen (BDI-FS)®	89208-3	Total score ≥8
Beck Depression Inventory (BDI-II)	89209-1	Total score ≥20
Center for Epidemiologic Studies Depression Scale — Revised (CESD-R)	89205-9	Total score ≥17
Duke Anxiety — Depression Scale (DUKE-AD)®	90853-3	Total score ≥30
Geriatric Depression Scale Short Form (GDS)	48545-8	Total score ≥5
Geriatric Depression Scale Long Form (GDS)	48544-1	Total score ≥10
Edinburgh Postnatal Depression Scale (EPDS)	99046-5	Total score ≥10
My Mood Monitor (M-3)®	71777-7	Total score ≥5
PROMIS Depression	71965-8	Total score (T Score) ≥60
Clinically Useful Depression Outcome Scale (CUDOS)	90221-3	Total score ≥31

Tips:

- Use age-appropriate screening instruments.
- Train staff on the importance of depression screenings and to recognize the risk factors for depression.
- Work with a care team to coordinate follow-up care for members with a positive screening.
- Ensure all services conducted during the visit are coded appropriately, including the depression screening LOINC codes.
- Coordinate file submissions to the health plan that include EHR data.

(continued)

(DSF-E) Depression Screening and Follow-Up for Adolescents and Adults *(continued)*

Lines of Business: Medicaid, Medicare

Description	Codes*
Behavioral Health Encounter	**CPT:** 90791, 90792, 90832–90839, 90845–90849, 90853, 90865–90869, 90870, 90875, 90876, 90880, 90887, 99484, 99492, 99493
Bipolar Disorder	**ICD-10:** F30.10–F30.13, F30.2–F30.9, F31.0, F31.10–F31.13, F31.2, F31.30–F31.32, F31.4, F31.5, F31.60–F31.64, F31.70–F31.78
Depression	**ICD-10:** F01.51, F01.511, F01.518, F32.0–F32.5, F32.81, F32.89, F32.9, F32.A, F33.0–F33.3, F33.40–F33.42, F33.8, F33.9, F34.1, F34.81, F34.89, F43.21, F43.23, F53.0, F53.1, O90.6, O99.340–O99.345
Depression Case Management Encounter	**CPT:** 99366, 99492–99494 **HCPCS:** G0512, T1016, T1017, T2022, T2023
Follow Up Visit	**CPT:** 98960–98962, 98966–98968, 98970–98972, 98980, 98981, 99078, 99202–99205, 99211–99215, 99242–99245, 99341–99349, 99350, 99381–99387, 99391–99397, 99401–99404, 99411, 99412, 99421–99423, 99441–99443, 99457, 99458, 99483 **HCPCS:** G0071, G0463, G2010, G2012, G2250–G2252, T1015
Hospice Encounter	**HCPCS:** G9473–G9479, Q5003–Q5010, S9126, T2042–T2046
Hospice Intervention	**CPT:** 99377, 99378 **HCPCS:** G0182
Exercise Counseling	**ICD-10:** Z71.82

*Codes subject to change.

(FUA) Follow-Up After Emergency Department Visit with Substance Use Disorder (SUD)

Applicable Foster Care Measure

Lines of Business: Medicare, Medicaid

Measure evaluates the percentage of emergency department (ED) visits among members age 13 years and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose for which there was a follow up.

The measure is based on ED visits; members may appear in a measure sample more than once. Each ED visit requires separate follow up.

Two rates are reported:

1. **Discharges for which the member received follow-up within 30 days of discharge.** A follow-up visit or a pharmacotherapy dispensing event within 30 days after the ED visit (31 total days). Include visits and pharmacotherapy events that occur on the date of the ED visit.
2. **Discharges for which the member received follow-up within seven days of discharge.** A follow-up visit or a pharmacotherapy dispensing event within seven days after the ED visit (eight total days). Include visits and pharmacotherapy events that occur on the date of the ED visit.

Tips:

- Offer virtual, telehealth, and phone visits.
- Maintain appointment availability in your practice for patients and schedule follow-up appointments before the patient leaves the office.
- Discuss the benefits of seeing a primary or specialty provider.
- Offer mutual help options like case management, peer recovery support, harm reduction, 12-step fellowships, e.g., Alcoholics Anonymous (AA), Narcotics Anonymous (NA), etc., or other community support groups.
- Reach out proactively within 24 hours if the patient does not keep scheduled appointment to schedule another.

(continued)

(FUA) Follow-Up After Emergency Department Visit with Substance Use Disorder (SUD) *(continued)*

Applicable Foster Care Measure

Lines of Business: Medicare, Medicaid

The visit can be with any practitioner if the claim includes a diagnosis of SUD (e.g., F10.xx–F19.xx) or drug overdose (e.g., T40–T43, T51). If the visit occurs with a mental health provider, the claim does not have to include the SUD or drug overdose diagnosis.

Description	Codes*
Outpatient Visit with any Diagnosis of SUD or Drug Overdose	**CPT:** 90791, 90792, 90832, 90833, 90834, 90836–90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221–99223, 99231–99233, 99238, 99239, 99252–99255, 98960–98962, 99078, 99202–99205, 99211–99215, 99242–99245, 99341, 99342, 99344, 99345, 99347–99350, 99381–99387, 99391–99397, 99401–99404, 99411, 99412, 99483, 99492–99494, 99510 **HCPCS:** G0155, G0176, G0177, G0409, G0463, G0512, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2013, H2015, H2013–H2020, T1015 **POS:** 03, 05, 07, 09, 11–20, 22, 33, 49, 50, 71–72
Intensive Outpatient Encounter or Partial Hospitalization with any Diagnosis of SUD or Drug Overdose	**CPT:** 90791, 90792, 90832–90834, 90836–90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221–99223, 99231–99233, 99238, 99239, 99252–99255 **HCPCS:** G0410, G0411, H0035, H2001, H2012, S0201, S9480, S9484, S9485
Non-residential Substance Abuse Treatment Facility with any Diagnosis of SUD or Drug Overdose	**CPT:** 90791, 90792, 90832, 90833, 90834, 90836–90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221–99223, 99231–99233, 99238, 99239, 99252–99255 **POS:** 57, 58
Community Mental Health Center Visit with any Diagnosis of SUD or Drug Overdose	**CPT:** 90791, 90792, 90832, 90833, 90834, 90836–90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221–99223, 99231–99233, 99238, 99239, 99252–99255 **POS:** 53

(continued)

(FUA) Follow-Up After Emergency Department Visit with Substance Use Disorder (SUD) *(continued)*

Applicable Foster Care Measure

Lines of Business: Medicare, Medicaid

Description	Codes*
Peer Support Service with any Diagnosis of SUD or Drug Overdose	**HCPCS:** G0140, G0177, H0024, H0025, H0038–H0040, H0046, H2014, H2023, S9445, T1012, T1016
Opioid Treatment Service That Bills Monthly or Weekly with any Diagnosis of SUD or Drug Overdose	**HCPCS:** G2086, G2087, G2071, G8074–G2077, G2080
Telehealth Visit with any Diagnosis of SUD or Drug Overdose	**CPT:** 90791, 90792, 90832, 90833, 90834, 90836–90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221–99223, 99231–99233, 99238, 99239, 99252–99255 **POS:** 02, 10
Telephone Visit with any Diagnosis of SUD or Drug Overdose	**CPT:** 98966–98968, 99441–99443
E-Visit or Virtual Check In with any Diagnosis of SUD or Drug Overdose	**CPT:** 98970–98972, 98980, 98981, 99422–99444, 99457, 99458 **HCPCS:** G0071, G2010, G2012, G2250–G2252
Substance Use Disorder Services	**CPT:** 99408, 99409 **HCPCS:** G0396, G0397, H0001, H0005, H0015, H0016, H0022, H0047, H0050, H2035, H2036, H0006, H0028, T1006, T1012
Behavioral Health Screening or Assessment for SUD or Mental Health Disorders	**CPT:** 99408, 99409 **HCPCS:** G0396, G0397, G0442, G2011, H0001, H0002, H0031, H0049
Pharmacotherapy Dispensing Event or Medication Treatment Event	**Medications:** Disulfiram (oral), Naltrexone (oral and injectable), Acamprosate (oral; delayed-release tablet), Buprenorphine (implant, injection, or sublingual tablet), Buprenorphine/naloxone (sublingual tablet, buccal film, sublingual film) **HCPCS:** G2069, G2070, G2072, G2073, H0020, H0033, J0570–J0575, J0577, J0578, J2315, Q9991, Q9992, S0109

*Codes subject to change.

(FUH) Follow-Up After Hospitalization for Mental Illness

Applicable Foster Care Measure

Lines of Business: Medicaid, Medicare

Measure evaluates the percentage of discharges for members six years of age and older who were hospitalized for a principal diagnosis of mental illness, or any diagnosis of intentional self-harm, and had a mental health follow-up service.

Two rates are reported:

1. Discharges for which the member received **follow-up within 30 days after discharge**.
2. Discharges for which the member received **follow-up within seven days after discharge**.

Tips:

- Schedule follow up appointments prior to discharge and include the date and time on discharge instructions.
- Submit applicable codes.
- Offer telehealth and phone visits.
- Reach out proactively to assist in (re)scheduling appointments within the required timeframes.
- Partner with the health plan to address social determinants, health equity, and quality care.
- Address co-morbidities and integrate care with peer support and psychiatric collaborative care models.

(continued)

(FUH) Follow-Up After Hospitalization for Mental Illness *(continued)*

Applicable Foster Care Measure

Lines of Business: Medicaid, Medicare

Description	Codes*
Outpatient Visit with a Mental Health Provider	**CPT:** 90791, 90792, 90832–90834, 90836–90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221–99223, 99231–99233, 99238, 99239, 99252–99255, 98960–98962, 99078, 99202–99205, 99211–99215, 99242–99245, 99341, 99342, 99344, 99345, 99347–99350, 99381–99387, 99391–99397, 99401–99404, 99411, 99412, 99483, 99492–99494, 99510 **POS:** 03, 05, 07, 09, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 22, 33, 49, 50, 71, 72 **HCPCS:** G0155, G0176, G0177, G0409, G0463, G0512, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013–H2020, T1015
Visit Setting Unspecified for Intensive Outpatient Encounter or Partial Hospitalization	**CPT:** 90791, 90792, 90832–90834, 90836–90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221–99223, 99231–99233, 99238, 99239, 99252–99255 **POS:** 52
Partial Hospitalization/ Intensive Outpatient	**HCPCS:** G0410, G0411, H0035, H2001, H2012, S0201, S9480, S9484, S9485
Community Mental Health Center Visit	**CPT:** 90791, 90792, 90832–90834, 90836–90840, 90845, 90847, 90849, 90853, 90875, 90876, 98960–98962, 99078, 99202–99205, 99211–99215, 99221–99223, 99231–99233, 99238, 99239, 99242–99245, 99252–99255, 99341, 99342, 99344, 99345, 99347–99350, 99381–99387, 99391–99397, 99401–99404, 99411, 99412, 99483, 99494, 99510 **HCPCS:** G0155, G0176, G0177, G0409, G0463, G0512, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013–H2020, T1015 **POS:** 53

(continued)

(FUH) Follow-Up After Hospitalization for Mental Illness *(continued)*

Applicable Foster Care Measure

Lines of Business: Medicaid, Medicare

Description	Codes*
Electroconvulsive Therapy	**CPT:** 90870 **POS:** 24, 52, 53
Peer Support Services	**HCPCS:** G0140, G0177, H0024, H0025, H0038–H0040, H0046, H2014, H2023, S9445, T1012, T1013
Psychiatric Residential	**CPT:** 90791, 90792, 90832–90834, 90836–90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221–99223, 99231–99233, 99238, 99239, 99252–99255 **POS:** 56
Telehealth Visit	**CPT:** 90791, 90792, 90832–90834, 90836–90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221–99223, 99231–99233, 99238, 99239, 99252–99255 **POS:** 02, 10
Transitional Care Management	**CPT:** 99495, 99496
Telephone Visit	**CPT:** 98966–98968, 99441–99443
Psychiatric Collaborative Care Management	**CPT:** 99492–99494 **HCPCS:** G0512

*Codes subject to change.

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

Lines of Business: Medicare, Medicaid

Measure evaluates 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 during the measurement year.

- ✓ For an acute inpatient discharge or residential treatment discharge or for withdrawal management that occurred during an acute inpatient stay or residential treatment stay, the episode date is the date of discharge.
- ✓ For direct transfers, the episode date is the discharge date from the transfer admission.
- ✓ For withdrawal management (other than withdrawal management that occurred during an acute inpatient stay or residential treatment stay), the episode date is the date of service.

Two rates are reported:

1. The percentage of visits or discharges for which the member received follow-up for substance use disorder **within the 30 days after the visit or discharge**.
2. The percentage of visits or discharges for which the member received follow-up for substance use disorder **within the seven days after the visit or discharge**.

Note: Follow up does not include withdrawal management.

Tips:

- Offer virtual, telehealth and phone visits.
- Maintain appointment availability in your practice for patients and schedule follow-up appointments before the patient leaves the office.
- Offer mutual help options like case management, peer recovery support, harm reduction, 12-step fellowships, e.g., Alcoholics Anonymous (AA) or Narcotics Anonymous (NA), etc., or other community support groups.
- Reach out proactively within 24 hours if the patient does not keep scheduled appointment to schedule another.

(continued)

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

Lines of Business: Medicare, Medicaid

The claim should include a principal diagnosis of substance use disorder (e.g., applicable code F10.10–F19.29)

Description	Codes*
Outpatient Visit with a Principal Diagnosis of SUD	**CPT:** 90791, 90792, 90832, 90833, 90834, 90836–90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221–99223, 99231–99233, 99238, 99239, 99252–99255, 98960–98962, 99078, 99202–99205, 99211–99215, 99242–99245, 99341–99345, 99347–99350, 99381–99387, 99391–99397, 99401–99404, 99411, 99412, 99483, 99492, 99494, 99510 **HCPCS:** G0155, G0176, G0177, G0409, G0463, G0512, H0002, H0004, H0031, H0034, H0036, H0037, H2000, H2010, H2011, H2013–H2020, H0039, H0040, T1015 **POS:** 03, 05, 07, 09, 11–20, 22, 33, 49, 50, 71–72
Intensive Outpatient Encounter or Partial Hospitalization with a Principal Diagnosis of SUD	**CPT:** 90791, 90792, 90832, 90833, 90834, 90836–90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221–99223, 99231–99233, 99238, 99239, 99252–99255 **HCPCS:** G0410, G0411, H0035, H2001, H2012, S0201, S9480, S9484, S9485 **POS:** 52
Non-residential Substance Abuse Treatment Facility with a Principal Diagnosis of SUD	**CPT:** 90791, 90792, 90832, 90833, 90834, 90836–90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221–99223, 99231–99233, 99238, 99239, 99252–99255 **POS:** 57, 58

(continued)

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

Lines of Business: Medicare, Medicaid

Description	Codes*
Community Mental Health Center Visit with a Principal Diagnosis of SUD	**CPT:** 90791, 90792, 90832, 90833, 90834, 90836–90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221–99223, 99231–99233, 99238, 99239, 99252–99255 **POS:** 53
Telehealth Visit with a Principal Diagnosis of SUD	**CPT:** 90791, 90792, 90832, 90833, 90834, 90836–90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221–99223, 99231–99233, 99238, 99239, 99252–99255 **POS:** 02, 10
Substance Use Disorder Services with a Principal Diagnosis of SUD	**CPT:** 99408, 99409 **HCPCS:** : G0396, G0397, G0443, H0001, H0005, H0007, H0015, H0016, H0022, H0047, H0050, H2035, H2036, T1006, T1012
Opioid Treatment Service that Bills Monthly or Weekly with a Principal Diagnosis of SUD	**HCPCS:** G2071, G2074–G2077, G2080, G2086, G2087
Residential Behavioral Health Treatment with a Principal Diagnosis of SUD	**HCPCS:** H0017, H0018, H0019, T2048
Substance use Disorder Counseling and Surveillance	**ICD-10:** Z71.41, Z71.51
Telephone Visit with a Principal Diagnosis of SUD	**CPT:** 98966–98968, 99441–99443 **ICD-10:** F10.xx–F19.xx
E-Visit or Virtual Check in with a Principal Diagnosis of SUD	**CPT:** 98970–98972, 98980, 98981, 99421–99423, 99457, 99458 **HCPCS:** G0071, G2010, G2012, G2250–G2252

(continued)

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

Lines of Business: Medicare, Medicaid

Description	Codes*
Pharmacotherapy Dispensing Event or Medication Treatment Event	**Medications:** Disulfiram (oral), Naltrexone (oral and injectable), Acamprosate (oral; delayed-release tablet), Buprenorphine (implant, injection, or sublingual tablet), Buprenorphine/naloxone (sublingual tablet, buccal film, sublingual film) **HCPCS:** G2069, G2070, G2072, G2073, H0020, H0033, J0570–J0575, J0577, J0578, J2315, Q9991, Q9992, S0109

*Codes subject to change.

(FUM) Follow-Up After Emergency Department Visit for Mental Illness

Applicable Foster Care Measure

Lines of Business: Medicare, Medicaid

Measure evaluates the percentage of ED visits for members six years of age and older with a principal diagnosis of mental illness, or any diagnosis of intentional self-harm, and had a mental health follow-up service during the measurement year.

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 seven days of the ED visit (eight total days)**.

Tips:

- Offer virtual, telehealth and phone visits.
- Maintain appointment availability in your practice for patients and schedule follow-up appointments before the patient leaves the office.

(continued)

(FUM) Follow-Up After Emergency Department Visit for Mental Illness *(continued)*

Applicable Foster Care Measure

Lines of Business: Medicare, Medicaid

- Discuss the benefits of seeing a primary or specialty provider and appropriate ED utilization.
- Partner with the health plan to address social determinants, health equity, and quality care.

The claim should include a diagnosis of mental health disorder.

Description	Codes*
Outpatient Visit with any Diagnosis of a Mental Health Disorder	**CPT:** 90791, 90792, 90832–90834, 90836–90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221–99223, 99231–99233, 99238, 99239, 99252–99255, 98960–98962, 99078, 99202–99205, 99211–99215, 99242–99245, 99341–99345, 99347–99350, 99381–99387, 99391–99397, 99401–99404, 99411, 99412, 99483, 99492–99494, 99510 **HCPCS:** G0155, G0176, G0177, G0409, G0463, G0512, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013–H2020, T1015 **POS:** 03, 05, 07, 09, 11–20, 22, 33, 49, 50, 71–72
Intensive Outpatient Encounter or Partial Hospitalization with any Diagnosis of a Mental Health Disorder	**CPT:** 90791, 90792, 90832, 90833, 90834, 90836–90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221–99223, 99231–99233, 99238, 99239, 99252–99255 **HCPCS:** G0410, G0411, H0035, H2001, H2012, S0201, S9480, S9484, S9485 **POS:** 52

(continued)

(FUM) Follow-Up After Emergency Department Visit for Mental Illness *(continued)*

Applicable Foster Care Measure

Lines of Business: Medicare, Medicaid

Description	Codes*
Community Mental Health Center Visit	**CPT:** 90791, 90792, 90832, 90833, 90834, 90836–90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221–99223, 99231–99233, 99238, 99239, 99252–99255 **POS:** 53
Electroconvulsive Therapy	**CPT:** 90780 **POS:** 24, 52, 53
Telehealth Visit with any Diagnosis of a Mental Health Disorder	**CPT:** 90791, 90792, 90832, 90833, 90834, 90836–90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221–99223, 99231–99233, 99238, 99239, 99252–99255 **POS:** 02, 10
Telephone Visit with any Diagnosis of a Mental Health Disorder	**CPT:** 98966–98968, 99441–99443
E-Visit or Virtual Check in with any Diagnosis of a Mental Health Disorder	**CPT:** 98970–98972, 98980, 98981, 99421–99423, 99457, 99458 **HCPCS:** G0071, G2010, G2012, G2250–G2252
Peer Support Services with any Diagnosis of a Mental Health Disorder	**CPT:** G014, G0177, H0024, H0025, H0038–H0040, H0046, H2014, H2023, S9445, T1012, T1016
Psychiatric Collaborative Care Management	**CPT:** 99492–99494, G0512
Psychiatric Residential Treatment	**CPT:** 90791, 90792, 90832–90834, 90836–90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221–99223, 99231–99233, 99238, 99239, 99252–99255 **POS:** 56

*Codes subject to change.

(IET) Initiation and Engagement of Substance Use Disorder (SUD) Treatment

Applicable Foster Care Measure

Lines of Business: Medicaid, Medicare

Time frame for measure: (to capture episodes) Nov. 15 of the year prior to the measurement year through Nov. 14 of the measurement year.

Measure evaluates the percentage of adolescent and adult members with a new episode of substance use disorder (SUD) episodes during the measurement year that result in treatment initiation and engagement.

Two rates are reported:

1. **Initiation of SUD Treatment:** percentage of new SUD episodes that result in treatment initiation through an inpatient SUD admission, outpatient visit, intensive outpatient encounter, or partial hospitalization, telehealth, or medication treatment **within 14 days**.

2. **Engagement of SUD Treatment:** percentage of new SUD episodes that have evidence of treatment engagement **within 34 days of initiation**.

Tips:

- Complete a comprehensive exam before diagnosing, co-existing disorders are not uncommon and can undermine effectiveness and adherence to treatment.
- Develop working alliances with specialists in substance use disorders for patients who would benefit from specialty care.
- Explain the importance of a follow-up to your patients.
- Schedule an initial follow-up appointment within 14 days.
- Reschedule patients as soon as possible who do not keep initial appointments.
- Use telehealth where appropriate.
- Offer mutual help options like case management, peer recovery support, harm reduction, 12-step fellowships, e.g., Alcoholics Anonymous (AA), Narcotics Anonymous (NA), etc., or other community support groups.

(continued)

(IET) Initiation and Engagement of Substance Use Disorder (SUD) Treatments *(continued)*

Applicable Foster Care Measure

Lines of Business: Medicaid, Medicare

- Maintain appointment availability in your practice for patients and schedule follow-up appointments before the patient leaves the office.
- Submit applicable codes.

Principal diagnosis: F10.10–F10.29 (excludes remission codes) with one of the following:

Description	Codes*
Acute or Nonacute Inpatient Admission	**UBREV:** 0100–101, 0110–114, 0116–124, 0126–134, 0136–144, 0146–154, 0156–160, 0164, 0167, 0169–174, 0179, 0190–194, 0199–204, 0206–214, 0219, 1000–1002
Outpatient Visit	**CPT:** 90791, 90792, 90832–90834, 90836–90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221–99223, 99231–99233, 99238, 99239, 98960–98962, 99078, 99211–99215, 99347–99350, 99381–99387, 99391–99397, 99401–99404, 99411–99413, 99492–99494, 99510 with POS 03, 05, 07, 09, 11–20, 22, 33, 49, 50, 71, 72
Behavioral Health Outpatient Visit with a Mental Health Provider	**CPT:** 98960–98962, 99078, 99202–99205, 99211–99215, 99242–99245, 99341, 99342, 99344, 99345, 99347, 99348, 99350, 99381–99387, 99391–99397, 99401–99404, 99411–99412, 99483, 99492–99494 **HCPCS:** G0155, G0176, G0177, G0409, G0463, G0512, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013–H2020, T1015
Intensive Outpatient Encounter or Partial Hospitalization	**CPT:** 90791–90792, 90832–90834, 90836–90840, 90845, 90847, 90849, 90853, 90875–90876, 99221–99223, 99231–99233, 99238–99239, 99251–99255 with POS 52 or G0410, G0411, H0035, H2001, H2012, S0201, S9480, S9484, S9485
Non-residential Substance Abuse Treatment Facility	**CPT:** 90791, 90792, 90832–90834, 90836–90840, 90845, 90847, 90849, 90853, 90875–90876, 99221–99223, 99231–99233, 99238–99239, 99251–99255 with POS 57, 58

(continued)

(IET) Initiation and Engagement of Substance Use Disorder (SUD) Treatments *(continued)*

Applicable Foster Care Measure

Lines of Business: Medicaid, Medicare

Description	Codes*
An Outpatient Visit at a Community Mental Health Center	**CPT:** 90791, 90792, 90832–90834, 90836–90840, 90845, 90847, 90849, 90853, 90875–90876, 99221–99223, 99231–99233, 99238–99239, 99251–99255 with POS 53
Telehealth Visit	**CPT:** 90791, 90792, 90832–90834, 90836–90840, 90845, 90847, 90849, 90853, 90875–90876, 99221–99223, 99231–99233, 99238–99239, 99251–99255 with POS 02, 10
A Substance Use Disorder Service	**CPT:** 99408, 99409 **HCPCS**: G0396, G0397, G0443, H0001, H0005, H0007, H0015, H0016, H0022, H0047, H0050, H2035, H2036, T1006, T1012
A Substance Use Disorder Counseling and Surveillance	**ICD-10:** Z71.41, Z71.51
Telephone Visit	**CPT:** 98966–98968, 99441–99443
An E-Visit or Virtual Check-In Visit	**CPT:** 98969–98972, 98980, 98981, 99421–99444, 99457, 99458 **HCPCS:** G0071, G2010, G2012, G2061–G2063, G2250–H2252
Opioid treatment service that bills monthly or weekly	**HCPCS:** G2071, G2074–G2077, G2080, G2086, G2087
An alcohol use disorder medication dispensing event (for alcohol cohort)	Disulfiram (oral), Naltrexone (oral and injectable), Acamprosate (oral and delayed-release tablet)
An Opioid Use Disorder Medication Dispensing Event (For Opioid Use Cohort)	Naltrexone (oral and injectable), Buprenorphine (sublingual tablet, injection, implant), Buprenorphine/naloxone (sublingual tablet, buccal film, sublingual film) **HCPCS:** G2069, G2070, G2072, G2073, H0020, H0033, J0570–J0575, J2315, Q9991, Q9992, S0109, G2067–G2070, G2072, G2073

*Codes subject to change.

(continued)

(IET) Initiation and Engagement of Substance Use Disorder (SUD) Treatments *(continued)*

Applicable Foster Care Measure

Lines of Business: Medicaid, Medicare

Medication Treatment Events:

- ✓ **Alcohol Use Disorder Treatment Medications:** Disulfiram (oral), Naltrexone (oral and injectable), Acamprosate (oral; delayed-release tablet).
- ✓ **Opioid Use Disorder Treatment Medications:** Naltrexone (oral and injectable), Buprenorphine (sublingual tablet, injection, and implant), Buprenorphine/naloxone (sublingual tablet, buccal film, sublingual film).
- ✓ Methadone is not included on the medication lists for this measure. Methadone for opioid use disorder (OUD) administered or dispensed by federally certified opioid treatment programs (OTP) is billed on a medical claim. A pharmacy claim for methadone would be indicative of treatment for pain rather than OUD.

(PND-E) Prenatal Depression Screening

Lines of Business: Medicaid

Measure evaluates the percentage of deliveries with at least 37 weeks of gestation in which members were screened for clinical depression while pregnant and, if screened positive, received follow-up care during the measurement year.

Two rates are reported:

1. **Depression Screening.** The percentage of deliveries in which members were screened for clinical depression during pregnancy using a standardized instrument.
2. **Follow-Up on Positive Screen.** The percentage of deliveries in which members received follow-up care within 30 days of a positive depression screen finding.

Note: Applicable LOINC codes are required for numerator 1 (Depression Screening).

(continued)

(PND-E) Prenatal Depression Screening *(continued)*

Lines of Business: Medicaid

Depression Screening instrument: A standard assessment instrument that has been normalized and validated for the appropriate patient population. Eligible screening instruments with thresholds for positive findings include:

Instruments for Adolescents (≤17 years)	Positive Finding	LOINC Code (Required for numerator 1)
Patient Health Questionnaire (PHQ-9)®	Total score ≥10	44261-6
Patient Health Questionnaire Modified for Teens (PHQ-9M)®	Total score ≥10	89204-2
Patient Health Questionnaire-2 (PHQ-2)®[1]	Total score ≥3	55758-7
Beck Depression Inventory-Fast Screen (BDI-FS)®[1,2]	Total score ≥8	89208-3
Center for Epidemiologic Studies Depression Scale — Revised (CESD-R)	Total score ≥17	89205-9
Edinburgh Postnatal Depression Scale (EPDS)	Total score ≥10	99046-5
PROMIS Depression	Total score (T Score) ≥60	71965-8
Instruments for Adults (18+ years)	**Positive Finding**	**LOINC Code (Required for numerator 1)**
Patient Health Questionnaire (PHQ-9)®	Total score ≥10	44261-6
Patient Health Questionnaire-2 (PHQ-2)®[1]	Total score ≥3	55758-7
Beck Depression Inventory-Fast Screen (BDI-FS)®[1,2]	Total score ≥8	89208-3
Beck Depression Inventory (BDI-II)	Total score ≥20	89209-1
Center for Epidemiologic Studies Depression Scale — Revised (CESD-R)	Total score ≥17	89205-9
Duke Anxiety-Depression Scale (DUKE-AD)®[2]	Total score ≥30	90853-3

[1]*Brief screening instrument. All other instruments are full-length.*

[2]*Proprietary; may be cost or licensing requirement associated with use.*

(continued)

(PND-E) Prenatal Depression Screening *(continued)*

Lines of Business: Medicaid

Instruments for Adults (18+ years)	Positive Finding	LOINC Code (Required for numerator 1)
Edinburgh Postnatal Depression Scale (EPDS)	Total score ≥10	99046-5
My Mood Monitor (M-3)®	Total score ≥5	71777-7
PROMIS Depression	Total score (T Score) ≥60	71965-8
Clinically Useful Depression Outcome Scale (CUDOS)	Total score ≥31	90221-3

Tips:

- Use age-appropriate screening instruments.
- If there is a positive screen resulting from a PHQ-2 score, documentation of a negative finding from a PHQ-9 performed on the same day qualifies as evidence of follow-up.
- Train staff on the importance of depression screenings and to recognize the risk factors for depression in pregnancy.
- Develop a workflow that includes utilizing a standardized instrument for depression screenings at every visit.
- Ask your provider relations representative about ways to submit data to the health plan directly from your Electronic Health Record/Electronic Medical Record (EHR/EMR).

(continued)

(PND-E) Prenatal Depression Screening *(continued)*

Lines of Business: Medicaid

Description	Codes*
Behavioral Health Encounter	**CPT:** 90791, 90792, 90832–90839, 90845–90849, 90853, 90865–90869, 90870, 90875, 90876, 90880, 90887, 99484, 99492, 99493 **HCPCS:** G0155, G0176, G0177, G0409–G0411, G0511, G0512, H0002, H0004, H0031, H0034–H0037, H0039, H0040, H2000, H2001, H2010–H2020, S0201, S9480, S9484, S9485
Depression Case Management Encounter	**CPT:** 99366, 99492–99494 **HCPCS:** G0512, T1016, T1017, T2022, T2023
Outpatient, Telephone, E-Visit, or Virtual Check-In with a Diagnosis of Depression or other Behavioral Health Condition	**CPT:** 98960–98962, 98966–98968, 98970–98972, 98980, 98981, 99078, 99202–99205, 99211–99215, 99242–99245, 99341, 99342, 99344, 99345, 99347–99350, 99381–99387, 99391–99397, 99401–99404, 99411, 99412, 99421–99423, 99441–99443, 99457, 99458, 99483, G0071, G0463, G2010, G2012, G2250, G2252, T1015 **ICD-10:** Applicable code between F01.511–F94.7, O90.6, O99.340–O99.345
Exercise Counseling	**ICD-10:** Z71.82
Dispensed Antidepressant Medication	

Documentation of additional depression screening on a full-length instrument indicating either no depression or no symptoms that require follow-up (i.e., a negative screen) on the same day as a positive screen on a brief screening instrument.

*Codes subject to change.

(POD) Pharmacotherapy for Opioid Use Disorder

Lines of Business: Medicare, Medicaid

Measure evaluates the percentage of opioid use disorder (OUD) pharmacotherapy events that lasted at least 180 days among members 16 years of age and older with a diagnosis of OUD and a new OUD pharmacotherapy event during the measurement year.

Measure must meet the following requirements:

- ✓ Member ages 16 years and older.
- ✓ OUD dispensing event is captured between a 12-month period that begins on July 1 of the year prior to the measurement year and ends on June 30 of the measurement year (intake period).
- ✓ Members must have a negative medication history (no OUD pharmacotherapy medications) as of 31 days prior to the new OUD pharmacotherapy.

Care Gap Closure: The measure is event-based, and it is met when the member adheres to OUD pharmacotherapy for 180 days or more without a gap in treatment of more than eight days.

Tips:

- Closely monitor medication prescriptions and do not allow any gap in treatment of eight or more consecutive days.
- Offer mutual help like peer recovery support, harm reduction, 12-step fellowships, e.g., Alcoholics Anonymous (AA) or Narcotics Anonymous (NA), etc.
- Provide timely submission of claims with correct medication name, dosage, frequency, and days covered.
- Reach out proactively within 24 hours if the patient does not keep scheduled appointment to schedule another.
- Inform of the risks and benefits of pharmacotherapy, treatment without medication, and no treatment.

Note: Members can have multiple treatment period start dates and treatment periods during the measurement year. Treatment periods can overlap.

(continued)

(POD) Pharmacotherapy for Opioid Use Disorder *(continued)*

Lines of Business: Medicare, Medicaid

Description	Codes*
Buprenorphine/naloxone (sublingual tablet, buccal film, sublingual film)	**HCPCS:** J0572-J0575
Buprenorphine Oral, Implant, and Injectable	**HCPCS:** H0033, J0570, J0571, Q9991, Q9992
Methadone	**HCPCS:** G2067, G2078, H0020, S0109
Naltrexone Injection	**HCPCS:** G2073, J2315

*Codes subject to change.

Medications List

- ✓ Naltrexone (oral and injectable), Buprenorphine (sublingual tablet, injection, or implant), Buprenorphine/naloxone (sublingual tablet, buccal film, sublingual film), Methadone (oral).
- ✓ Methadone is not included on the medication lists for this measure. Methadone for opioid use disorder (OUD) administered or dispensed by federally certified opioid treatment programs (OTP) is billed on a medical claim. A pharmacy claim for methadone would be indicative of treatment for pain rather than OUD.

(SAA) Adherence to Antipsychotic Medications for Individuals with Schizophrenia

Lines of Business: Medicare, Medicaid

The index prescription start date (IPSD) is the earliest prescription dispensing data for any antipsychoctic medication during the measurement year.

The treatment period is defined as the time beginning on the IPSD through the last day of the measurement year.

Measure evaluates the percentage of members 18 years of age and older during the measurement year with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.

If an oral medication and a long-acting injection are dispensed on the same day, calculate number of days covered by an antipsychotic medication using the prescription with the longest days supply.

Tips:

- Consider the use of long-acting injectable antipsychotic medications to increase adherence.
- Provide education on how to take the medication, expected side effects, and talking to the prescriber before stopping the medication.

Oral Antipsychotics		
· Aripiprazole	· Lumateperone	· Chlorpromazine
· Asenapine	· Lurasidone	· Fluphenazine
· Brexpiprazole	· Molindone	· Perphenazine
· Cariprazine	· Olanzapine	· Prochlorperazine
· Clozapine	· Paliperidone	· Thioridazine
· Haloperidol	· Quetiapine	· Trifluoperazine
· Iloperidone	· Risperidone	· Amitriptyline-perphenazine
· Loxapine	· Ziprasidone	· Thiothixene

(continued)

(SAA) Adherence to Antipsychotic Medications for Individuals with Schizophrenia *(continued)*

Lines of Business: Medicare, Medicaid

Long-Acting Injections	
Description	**Prescription**
Long-acting Injections 14-Day Supply	· Risperidone (excluding Perseris®)
Long-acting Injections 28-Day Supply	· Aripiprazole · Aripiprwazole lauroxil · Fluphenazine decanoate · Haloperidol decanoate · Olanzapine
Long-acting Injections 30-Day Supply	· Risperidone (Perseris®)
Long-acting Injections 35-Day supply	· Paliperidone palmitate (Invega Sustenna)
Long-acting Injections 104-Day supply	· Paliperidone palmitate (Invega Trinza)
Long-acting Injections 201-Day Supply	· Paliperidone palmitate (Invega Hafyera)

(SSD) Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications

Lines of Business: Medicaid

Measure evaluate the percentage of members 18 to 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 measurement year.

Identify members with diagnosis of schizophrenia, schizoaffective disorder, or bipolar disorder, and conduct a glucose or HbA1c lab test.

Tips:

- Provide members/caregivers with lab orders for HbA1c or glucose and cholesterol or LDL-C to be completed yearly.
- Educate the member and caregiver about the risks associated with taking antipsychotic medications and the importance of regular follow up care.
- Submit applicable codes.
- Consider using standing orders to get lab tests.
- Educate patients and their caregivers on the importance of completing annual visits and blood work.
- Discuss weight management options and encourage members to increase physical activity, improve sleep, and maintain a well-balanced diet.

Description	Codes*
Glucose Lab Test	**CPT:** 80047, 80048, 80050, 80053, 80069, 82947, 82950, 82951
HbA1c Lab Test	**CPT:** 83036, 83037
HbA1c Test Result or Finding	**CPT II:** 3044F, 3046F, 3051F, 3052F

*Codes subject to change.

*Note: Do **not** include a modifier when using CPT II codes.*


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