Quality Care Measures

COMMERCIAL 2020
We value your partnership and participation in BlueCross Commercial Quality Improvement, and hope you’ll find this guide helpful. The information and tips included can help you maximize your performance with each quality measure.

We know you’re committed to providing quality care to your patients, so we’re providing tools to help you be as successful as possible. The information in this guide is most useful when used with Electronic Medical Records (EMR). If you use EMR, ask your vendor if they can pre-populate the codes in your drop-downs. This will help you make gap closure part of your work flow with every encounter.

If you would like additional assistance regarding the quality care measure guidelines, please contact:

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Healthcare Effectiveness Data and Information Set (HEDIS)

Developed by the National Committee for Quality Assurance (NCQA), HEDIS® is the most widely used set of performance measures in the managed care industry. It contains measures that show health plans those areas where a stronger focus could lead to improvements in member health. HEDIS® reporting is mandated by NCQA for compliance and accreditation.

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA). See www.ncqa.org.
### General Health Measures

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

**Ages 3 months and older**

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| Patients with acute bronchitis/bronchiolitis shouldn’t be prescribed/dispensed an antibiotic unless a competing diagnosis or an exclusion applies or the patient continues to worsen. | Report and document if the patient has an exclusion or has a competing diagnosis of infection such as: Otitis Media, Sinusitis, Pneumonia, Pharyngitis. **Sample codes** for acute bronchitis that will trigger the gap to open unless there is an exclusion or competing diagnosis documented include: J20.1, J20.2, J20.3, J20.4, J20.5, J20.6, J20.7, J20.8, J20.9, J21.0, J21.1, J21.8, J21.9, J40 | A documented diagnosis of comorbid condition:  
- HIV  
- Cancer  
- COPD  
- Emphysema  
- Disorders of the immune system  
- Hospice | **Important Note**: Every episode counts and patient compliance will be counted for every visit where acute bronchitis/bronchiolitis is diagnosed.  
**NEW**: The age range for this measure has changed and is now for ages 3 months and older. **Be as specific as possible when coding diagnoses present** and remember to include coding and documentation for comorbid condition exclusions and for any noted bacterial infections along with the bronchitis so that a gap does not open. If an antibiotic is given for bronchitis alone, and there is neither a competing diagnosis nor an exclusion, a gap will open and it cannot be closed. If a patient’s condition does not improve, and an antibiotic is indicated, a gap will not occur if the antibiotic is dispensed more than three days after the encounter (i.e. day 4 or later) when the bronchitis/bronchiolitis was diagnosed. Written directions for the pharmacy on the antibiotic prescription not to be filled until _<insert date of day #4 >__ can help keep patients compliant if a prescription is written and no co-morbid or competing diagnosis is present. |
### Adult BMI Assessment (ABA)

- **Goal of the Measure:** Patients should have an outpatient visit with a documented BMI or BMI percentile depending on age during the year or year prior.

- **What To Report:**
  - **Sample diagnoses codes:**
    - **Adult BMI**
      - BMI 19 or less: Z68.1
      - BMI 20.0-23.9: Z68.20-Z68.23
      - BMI 24.0-29.9: Z68.24-Z68.29
      - BMI 30.0-39.9: Z68.30-Z68.39
      - BMI 40.0-49.9: Z68.41-Z68.42
      - BMI 50-59.9: Z68.43
      - BMI 60.0-69.9: Z68.44
      - BMI 70 or greater: Z68.45
  - **Pediatric - BMI Percentile**
    - BMI <5th Pcntl for age: Z68.51
    - BMI 5th Pcntl - <85th Pcntl: Z68.52
    - BMI 85th Pcntl - <95th Pcntl: Z68.53
    - BMI Greater Than or Equal to 95th Pcntl: Z68.54

- **Exclusions:**
  - Patients who have a diagnosis of pregnancy during the measurement year or the year prior
  - Patients in hospice

- **Helpful Tips:**
  - Remember to document the date of service when BMI/BMI percentile is obtained.
  - This measure is for dates of service during the measurement year (2020) or the year prior (2019).
  - For patients 18 and 19 years of age, a height, weight, and BMI percentile must be documented rather than just the BMI value. BMI percentile can be:
    - Documented as a value (example: 85th percentile)
    - Plotted on an age-growth chart
  - For patients 20 and older, documentation in chart must indicate weight and BMI value.

### Adult Immunization Status (AIS)

- **Goal of the Measure:** Patients should be up-to-date on recommended routine vaccines for influenza, tetanus, diphtheria, acellular pertussis (Td or Tdap), zoster, and pneumococcal.

- **What To Report:**
  - **Sample CPT® and HCPCS Codes:**
    - Td vaccine: 90714, 90718
    - Tdap vaccine: 90715
    - Herpes zoster live vaccine: 90736
    - Herpes zoster recombinant vaccine: 90750
    - Pneumococcal vaccine PCV 13: 90670, G0009
    - Pneumococcal vaccine PCCV 23: 90732
    - Influenza Vaccine: 90655, 90657, 90661, 90662, 90673, 90685-90689, G0008

- **Patients:**
  - on active chemotherapy during the year
  - who had a bone marrow transplant during the year
  - Hx of immunocompromised conditions, cochlear implants, sickle cell, anatomic or functional asplenia, HB-S disease, cerebrospinal fluid leak in hospice, or using hospice services
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| **Asthma Medication Ratio (AMR)** | Patients who were identified as having persistent asthma should have a ratio of 0.50 or greater for controller medications to total asthma medications. | **Sample diagnoses:**  
- Asthma unspecified  
- Extrinsic asthma  
- Intrinsic asthma  
- Chronic obstructive asthma | • Patients in hospice  
• COPD  
• Obstructive Chronic Bronchitis  
• Emphysema  
• Cystic Fibrosis  
• Acute respiratory failure  
• Chronic respiratory conditions | Encouraging patients to remain on their controller medications to lessen and/or prevent asthma complications and flare-ups will help keep them from refilling and using their rescue inhalers more than their controller medications. |
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| Controlling High Blood Pressure (CBP) | Patients with a diagnosis of hypertension should have a controlled blood pressure level of <140/90 during the measurement year. | **Sample diagnosis:**  
- Essential hypertension  
**Sample CPT Codes** to identify high blood pressure control:  
Diastolic less than 80: 3078F  
Diastolic 80-89: 3079F  
Systolic less than 140: 3074F-3075F | **Exclusions**  
- Patients in hospice  
- Patients 66-80 yrs. and older with both advanced illness criteria and frailty diagnosis  
- Patients 81 yrs. and older with a frailty diagnosis  
- End Stage Renal Disease or Kidney Transplant  
- Female patients with a diagnosis of pregnancy during the measurement year | You can retake a B/P for a patient on the same visit if the first one is out of acceptable range.  
If the first check of B/P is out of range, let the patient have a few minutes to relax, take some deep breaths, and then recheck; white-coat syndrome and anxiety can sometimes raise a person's B/P for a brief time.  
You can use the lowest systolic and the lowest diastolic readings for a B/P level for a patient if they are taken on the same date/same visit - Example: 1st reading- 130/95; 2nd reading-156/80- the gap can be closed with the reading of 130/80  
This gap can open and close during the measurement year depending on the range of the readings.  
**Gap closure is based on the most recent B/P reading being in range**  
B/P readings that will NOT close the gap or meet the measure intent:  
- B/P readings from inpatient or ED visit  
- B/P that is self-reported by the member  
- B/P taken on the same day as a diagnostic test or procedure that causes a change in diet or medication on the day of, or day before the procedure. (Examples – a colonoscopy or nebulizer treatment with bronchodilator require changes in diet or a change in medication regimen) |
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<td><strong>Comprehensive Diabetes Care-Blood Pressure Control (CDC)</strong> 18-75 years</td>
<td>Patients diagnosed with diabetes should have a controlled blood pressure of &lt;140/90 during the measurement year.</td>
<td><strong>Diabetic blood pressure control:</strong> Diastolic less than 80: 3078F Diastolic 80-89: 3079F Systolic less than 140: 3074F-3075F</td>
<td>• Patients with a diagnosis of gestational diabetes or steroid-induced diabetes who had NO other diagnosis of diabetes during the current year or the year prior • Patients in hospice • Patients 66 years of age and older with both advanced illness and frailty</td>
<td>You can use the lowest systolic and the lowest diastolic readings for a B/P level for a patient if they are taken on the same date/same visit. Example: first reading- 130/95; second reading-156/80. The gap can be closed with the reading of 130/80. The B/P gap can open and close during the measurement year based on the most recent reading being in range. B/P readings that will NOT close the gap or meet the measure intent: • B/P readings from inpatient or ED visit • B/P that is self-reported by the member • B/P taken on the same day as a diagnostic test or procedure that causes a change in diet or medication on the day of, or day before the procedure. (Examples – a colonoscopy or nebulizer treatment with bronchodilator require changes in diet or a change in medication regimen)</td>
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<td><strong>Comprehensive Diabetes Care-Eye Exam (CDC)</strong>&lt;br&gt;18-75 years</td>
<td>Patients diagnosed with diabetes should have a retinal or dilated eye exam by an eye care professional, or interpreted by an eye care professional during the measurement year.</td>
<td><strong>Sample CPT® Codes:</strong>&lt;br&gt;- Diabetic retinal screening: 67023, 67030-67031, 67036, 67039-67043, 67101, 67105, 67107-67108, 67110, 67113, 67121, 67141, 67145, 67208, 67210, 67218, 67220-67221, 67227-67228, 92002, 92004, 92012, 92014, 92018-92019, 92134, 92225-92228, 92230, 92235, 92240, 92250, 92260, 99203-99205, 99213-99215, 99242-99245, S3000, S0620-S0621&lt;br&gt;- Diabetic retinal screening negative: 3072F&lt;br&gt;- Diabetic retinal screening with eye care professional: 2022F, 2024F, 2026F&lt;br&gt;- Two Eye Enucleations: 65091, 65093, 65101, 65103, 65105, 65110, 65112, 65114&lt;br&gt;- Left Eye Enucleations: 08B1XZZ 08B10ZX 08B10ZZ 08B13ZX 08B1XZX 08B13ZZ&lt;br&gt;- Right Eye Enucleations: 08B0XZX 08B0XZZ 08B00ZX 08B00ZZ 08B03ZX 08B03ZZ</td>
<td>• Bilateral eye enucleation&lt;br&gt;• Patients with a diagnosis of gestational diabetes or steroid-induced diabetes who had NO other diagnosis of diabetes during the current year or the year prior&lt;br&gt;• Patients in hospice&lt;br&gt;• Patients 66 years of age and older with both advanced illness and frailty</td>
<td>Providers performing retinal imaging in office and sending results to eye care professionals to review and interpret can use CPTII codes such as 2022F, 2024F, 2026F.&lt;br&gt;Documentation of a negative retinopathy exam can close the gap for two years, but it must be coded as such. Any retinal or dilated eye exam from an eye care provider is acceptable in the measurement year, but an exam from the previous year must be a negative result for retinopathy to be compliant. Documentation does not have to state specifically no diabetic retinopathy to be considered negative; however it must be clear that the member had a dilated or retinal exam by an eye care professional and evidence of retinopathy was not present. The statement diabetes without complications does NOT meet criteria. <strong>Note:</strong> Providers performing retinal imaging in office and sending results to eye care professionals to review and interpret should use CPTII codes on the claim to indicate this.</td>
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### Comprehensive Diabetes Care - HbA1c Control (CDC)

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|         | Patients diagnosed with diabetes should have a controlled HbA1c of <8 during the measurement year. | **Sample CPT II codes:**<br>• HbA1c Level less than 7.0: 3044F  
• HbA1c Level greater than or equal to 7.0 and less than 8.0: 3051F  
• HbA1c Level greater than or equal to 8.0 and less than or equal to 9.0: 3052F. | • Patients with a diagnosis of gestational diabetes or steroid-induced diabetes who had NO other diagnosis of diabetes during the current year or the year prior  
• Patients in hospice  
• Patients 66 years of age and older with both advanced illness and frailty | **NEW : CPT II code 3051F represents HbA1c level greater than or equal to 7.0 and less than 8.0**<br>The CPT II code (3045F) that represents an HbA1c Level of 7.0 - 9.0 will not close the gap in care because the system can’t identify if patient’s level is below 8.0 based on that code.  
HcA1c results must be on a specific date. Documentation stating recent or last A1c does not meet the measure for gap closure; it must have a date.  
Lab values can be obtained from inpatient records.  
The most recent value in the chart will be the value that determines if the gap is open or closed. |
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<td>Colorectal Cancer Screening (COL) 50-75 years</td>
<td>Patients should receive appropriate screening for colorectal cancer.</td>
<td>While colonoscopy is the gold standard, the measure will close with any of the following screening types and <strong>sample CPT® codes:</strong>  - Colonoscopy during the measurement year or the nine years prior: 44388-44394, 44397, 44401-44408, 45355, 45378-45393, 45398 (every 10 years)  - Flexible sigmoidoscopy during the measurement year or the four years prior: 45330-45335, 45337-45342, 45345-45347, 45349-45350 (every five years)  - CT colonography during the measurement year or the four years prior: 74263 (every five years)  - FIT-DNA Test during the measurement year or the two years prior 81528 (every three years). This is different from the plain FIT testing - this testing uses DNA  - Fecal occult blood testing (FOBT), including fecal immunochemical testing (FIT): 82270, 82274 requires only one stool sample (annually)  - If using guaiac testing, three samples are required</td>
<td>- Patients in hospice  - Patients with colon cancer or history of colon cancer, <strong>sample CPT® code:</strong> C18.0-C18.19, C19, C20  - Patients with a total colectomy, <strong>sample CPT® codes:</strong> 44150-44153, 44155-44158  - Patients 66 years and older that have both advanced illness and frailty, <strong>sample CPT® codes:</strong> R62.7, R54</td>
<td>The length of time that this gap closes is based on the type of screening performed.  In-office Guaiac Test and fecal occult blood testing via digital rectal exam do NOT meet the measure criteria.  Guaiac testing is acceptable if it’s not collected in the office and there are at least three samples returned. It can be tested in the office when the patient returns the cards.  If you use the older Guaiac testing, three samples are required each year.</td>
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<td>Appropriate Testing for Pharyngitis (CWP) 3 years and older</td>
<td>Patients need to have a strep test done if they’re diagnosed with pharyngitis only and have received an antibiotic prescription.</td>
<td><strong>Sample diagnoses:</strong>  - Acute pharyngitis  - Acute tonsillitis  - Streptococcal pharyngitis  - Acute streptococcal tonsillitis  <strong>Sample CPT® Codes:</strong>  Group A strep test: 87070-87071, 87081, 87430, 87650-87652, 87880  LOINC Codes: 11268-0, 17656-0, 17898-8, 18481-2, 31971-5, 49610-9, 5036-9, 60489-2, 626-2, 6557-3, 6558-1, 6559-9, 68954-7, 78012-2</td>
<td>- Patients in hospice  - Patients with the following comorbidities:  - HIV  - Malignant Neoplasm  - Emphysema  - COPD  - Disorders of the Immune System</td>
<td>NEW: The age range was expanded in this measure to include both children and adults ages 3 and up.  The measure is focused on the patient getting a strep test before receiving an antibiotic for a related pharyngitis diagnosis (acute pharyngitis, acute tonsillitis, streptococcal pharyngitis, etc).  Compliance is not based on step test results as long the test was performed.  Including documentation of in-office strep test on the claim form is important in gap prevention for this measure.</td>
</tr>
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<td><strong>Flu Vaccinations for Adults (FVA)</strong>&lt;br&gt;18-64 years</td>
<td>Patients should have a flu vaccine every year.</td>
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| **Use Of Imaging Studies For Low Back Pain (LBP)**<br>18-50 years | Patients with a diagnosis of uncomplicated low back pain should wait 28 days or more from primary diagnosis being given, before they undergo an imaging study (plain X-Ray, MRI, CT scan). | Sample CPT® Codes: M47.26 -M47.28 M54.5 M99.73 | It’s important to document and code for any exclusions, such as the following, that would warrant use of imaging studies:  
- Cancer  
- Recent trauma within 90 days  
- Intravenous drug abuse  
- Neurologic impairment  
- HIV  
- Spinal infection during the year prior to visit  
- Major organ transplant  
- Prolonged use of corticosteroids (≥ 90 consecutive days within the last year)  
- Patients in hospice | Include documentation and coding along with the diagnosis of low back pain on the claim, for “red-flag” conditions (exclusions) where an imaging study should be ordered. This will prevent an open gap that can’t be closed.  
If this gap opens, it can’t be closed.  
Encourage patients to try conservative treatments such as:  
- Ice  
- Heat  
- OTC pain relief  
- Stretching or back straightening exercises  
- Safe back habits |
| **Medication Management For People with Asthma (MMA)**<br>5-64 years | Patients with asthma should remain on asthma controller medication for at least 75% of the treatment period or greater. Treatment period is defined as the time period starting at the earliest prescription dispensing date until the end of the measurement year. | Sample diagnoses/CPT Codes:  
- Asthma unspecified: 493.9  
- Extrinsic asthma: 493  
- Intrinsic asthma: 493.1  
- Chronic obstructive asthma: 1.0627E |  | Explore possible reasons for your patients’ medication non-adherence (i.e. cost, denial, depression, substance use/abuse, side effects).  
Helping patients with an asthma action plan to avoid triggers and control flare-ups is an important part of patients understanding why they need to remain on their medications. |
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| **Pharmacotherapy Management of COPD Exacerbation (PCE)** | 40 years and older                                                                                                                                                                                                                                                                  | Patients with a diagnosis of COPD exacerbations that were seen in an ED visit or admitted for an acute inpatient stay should have the following medications prescribed and filled:  
  - Corticosteroids within 14 days of discharge from acute inpatient stay or ED visit  
  - Bronchodilator within 30 days of discharge from an acute inpatient stay or ED visit  
  \textbf{AND}  
  - Bronchodilator within 30 days of discharge from an acute inpatient stay or ED visit | **Sample Diagnoses:**  
  - Emphysema  
  - Chronic Obstructive Asthma  
  - Chronic Obstructive Bronchitis  
  - Simple Chronic Bronchitis | • Patients in hospice | Assisting patients with action plans to control exacerbations is key.  
Explore possible reasons for your patients’ medication non-adherence (i.e. cost, denial, depression, substance use/abuse, side effects). |
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| ADHERENCE 80% Statin Therapy For Patients With Cardiovascular Disease (SPC) | Patients with a diagnosis of clinical atherosclerotic cardiovascular disease (ASCVD) should remain on a high or moderate-intensity statin medication for at least 80 percent of the treatment period. **Note:** Treatment period is defined as the time period starting at the earliest prescription dispensing date of at least a moderate-intensity statin through the end of the year. | **Sample Diagnoses:**  
- Clinical atherosclerotic cardiovascular disease (ASCVD)  
**Sample Events:**  
- Coronary artery bypass graft (CABG)  
- Myocardial infarction (MI)  
- Percutaneous coronary intervention (PCI)  
- Other revascularization procedures  
- Ischemic Vascular Disease (IVD) | Patients > 65 years of age that have both advanced illness and frailty  
- Patients in hospice  
- Pregnancy during the measurement year or the prior year  
- In vitro fertilization  
- Dispensed at least one prescription of an Estrogen Agonists medication  
- ESRD  
- Cirrhosis  
- Myalgia, myositis, myopathy, or rhabdomyolysis during the measurement year, **sample CPT codes:** G72.0, G72.2, G72.9, M60.80, M60.88, M60.89, M60.9, M62.82, M79.10, M79.18 | Only high or moderate intensities of statin therapy will meet the goal of this measure.  
Encourage patients to get a 90-day fill of their Rx to help save money and time.  
Explore possible reasons for your patients’ medication non-adherence (i.e. cost, denial, depression, substance use/abuse, side effects). |
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</tr>
</thead>
</table>
| RECEIVED Statin Therapy For Patients With Cardiovascular Disease (SPC) | Patients with a diagnosis of clinical atherosclerotic cardiovascular disease (ASCVD) should be dispensed at least one high or moderate intensity statin medication. | **Sample Diagnoses:**  
- Clinical atherosclerotic cardiovascular disease (ASCVD)  
- Sample Events:  
  - Coronary artery bypass graft (CABG)  
  - Myocardial infarction (MI)  
  - Percutaneous coronary intervention (PCI)  
  - Other revascularization procedures  
  - Ischemic Vascular Disease (IVD)  
- **Sample CPT codes:** G72.0, G72.2, G72.9, M60.80, M60.88, M60.89, M60.9, M62.82, M79.10, M79.18 | - Patients > 65 years of age that have both advanced illness and frailty  
- Patients in hospice  
- Pregnancy during the measurement year or the prior year  
- In vitro fertilization  
- Dispensed at least one prescription of an Estrogen Agonists medication  
- ESRD  
- Cirrhosis  
- Myalgia, myositis, myopathy, or rhabdomyolysis during the measurement year.  
- Only high or moderate intensities of statin therapy will meet the goal of this measure.  
- Encourage patients to get a 90-day fill of their Rx to help save money and time. |
### ADHERENCE 80% Statin Therapy For Patients With Diabetes (SPD) 40-75 years

**Measure Goal of the Measure**

Patients with diabetes who don’t have atherosclerotic cardiovascular disease (ASCVD) should remain on a statin medication of any intensity for 80% of the treatment period.

**Note:** Treatment period is defined as the time period starting at the earliest prescription dispensing date of at least a low-intensity statin through the end of the year.

**What To Report (Sample Of Codes and/or Diagnoses)**

- **Sample Diagnoses:**
  - Diabetes

- **Sample Events:**
  - At least two outpatient visits, observation visits, ED visits, or nonacute inpatient encounters on different dates of service, with a diagnosis of diabetes.
  - At least one acute inpatient encounter with a diagnosis of diabetes.
  - Patients dispensed insulin or hypoglycemics/anti-hyperglycemics on an ambulatory basis during the measurement year or the year prior.

**Exclusions**

- Patients in hospice
- Clinical atherosclerotic cardiovascular disease (ASCVD)
- Coronary artery bypass graft (CABG)
- Myocardial infarction (MI)
- Percutaneous coronary intervention (PCI)
- Other revascularization procedures
- Ischemic Vascular Disease (IVD)
- Patients with a diagnosis of pregnancy or undergoing in vitro fertilization
- Dispensed as least one prescription for Estrogen Agonists medication during the measurement year or the year prior to the measurement year
- ERSD
- Cirrhosis
- Patients with advanced illness and frailty
- Myopathy, Myalgia, Myositis, or Rhabdomyolysis,
  **sample CPT® codes:**
  - G72.0, G72.2, G72.9,
  - M60.80, M60.88,
  - M60.89, M60.9,
  - M62.82, M79.10,
  - M79.18

**Helpful Tips**

Any intensity of statin therapy will meet the goal of this measure.

Encourage patients to get a 90-day fill of their prescription to help save time and money.

Explore possible reasons for your patients’ medication non-adherence (i.e. cost, denial, depression, substance use/abuse, side effects).
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</table>
| RECEIVED Statin Therapy For Patients With Diabetes (SPD) 40-75 years | Patients with diabetes who don’t have atherosclerotic cardiovascular disease (ASCVD) should receive at least one statin medication during the measurement year. | **Sample Diagnoses:**  
- Diabetes  
**Sample Events:**  
- At least two outpatient visits, observation visits, ED visits, or nonacute inpatient encounters on different dates of service, with a diagnosis of diabetes.  
- At least one acute inpatient encounter with a diagnosis of diabetes.  
- Patients dispensed insulin or hypoglycemics/anti-hyperglycemics on an ambulatory basis during the measurement year or the year prior. |  
- Clinical atherosclerotic cardiovascular disease (ASCVD)  
- Coronary artery bypass graft (CABG)  
- Myocardial infarction (MI)  
- Percutaneous coronary intervention (PCI)  
- Other revascularization procedures  
- Ischemic Vascular Disease (IVD)  
- Patients with a diagnosis of pregnancy or undergoing in vitro fertilization  
- Dispensed as least one prescription for Estrogen Agonists Medication during the measurement year or the year prior to the measurement year  
- ERSD  
- Cirrhosis  
- Patients with advanced illness and frailty  
- Myopathy, Myalgia, Myositis, or Rhabdomyolysis | Any intensity of statin therapy will meet the goal of this measure.  
Encourage patients to get a 90-day fill of their prescription to help save time and money.  
Explore possible reasons for your patients’ medication non-adherence (i.e. cost, denial, depression, substance use/abuse, side effects). |
**Appropriate Treatment for Upper Respiratory Infection (URI)**

3 months and older

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</table>
| **Patients with only an upper respiratory infection shouldn’t be prescribed/dispensed an antibiotic unless a competing diagnosis or an exclusion applies or the patient continues to worsen.** | **Sample diagnoses** (where antibiotics may be appropriate):  
- Sinusitis (Acute/Chronic)  
- Tonsillitis  
- Bacterial Infection (unspecified)  
- Pneumonia  
- Otitis Media  
- Whooping cough  
- Pneumonia | **Patients in hospice**  
Comorbidities excluded:  
- HIV  
- Malignant neoplasms  
- Malignant neoplasms of skin  
- COPD  
- Emphysema  
- Outpatient visits that result in an inpatient stay | **NEW:** Age range is now 3 months and older; this measure now includes adults.  
**Important Note:** Every episode counts and patient compliance will be counted for every visit where upper respiratory infection is diagnosed.  
Be as specific as possible when coding diagnoses present and remember to include coding and documentation for comorbid condition exclusions and for any noted bacterial infections along with the upper respiratory infection so that a gap doesn’t open.  
If an antibiotic is given for upper respiratory infection alone, and there’s neither a competing diagnosis nor an exclusion, a gap will open and it can’t be closed.  
If a patient’s condition doesn’t improve, and an antibiotic is indicated, a gap won’t occur if the antibiotic is dispensed more than three days after the encounter (i.e. day four or later) when the upper respiratory infection was diagnosed.  
Written directions for the pharmacy on the antibiotic prescription not to be filled until _<insert date of day #4 >__ can help keep patients compliant if a prescription is written and no co-morbid or competing diagnosis is present. |  |
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</table>
| Breast Cancer Screening (BCS) | Female patients in this age range should have a mammogram to screen for breast cancer at least every two years or more frequently based on MD advisement. | Sample diagnoses and procedures:  
- Acquired absence of breast and nipple  
- Breast resection  
Sample CPT® Codes:  
Mammography CPT: 77055-77057, 77061-77063  
Mammography HCPCS: G0202, G0204, G0206 | Patients in hospice  
Patients 66 years and older with both advanced illness criteria and frailty diagnosis  
Women who have had mastectomies (bilateral, 2 unilateral, or unilateral mastectomy with bilateral modifier) | All types and methods of mammograms qualify for meeting the measure (screening, diagnostic, film, digital, and digital breast tomosynthesis).  
MRIs, ultrasounds, and biopsies do NOT meet the measure. |
| Measure                          | Goal of the Measure                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | What To Report (Sample Of Codes and/or Diagnoses)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Exclusions                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Helpful Tips                                                                                                                                                                                                                                                                                                                                                     |
|---------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Cervical Cancer Screening (CCS) | Female patients in this age range should at least have a cervical cancer screening per the guidelines below or more frequent based on MD advisement:  
  - Age 21-64: Cervical cytology during the measurement year or the two years prior  
  - Age 30-64: Cervical cytology and high-risk HPV testing cotesting during the measurement year or the four years prior  
  OR  
  - Age 30-64: Cervical high-risk HPV testing during the measurement year or the four years prior | **Sample CPT® and HCPCS Codes:**  
  - Cervical Cytology HCPCS: G0123, G0124, G0141, G0143, G0144, G0145, G0147, G0148, P3000, P3001, Q0091  
  - Cervical Cytology CPT®: 88141-88143, 88147-88148, 88150, 88152-88154, 88164-88167, 88174-88175  
  **HPV Test:** 87620-87622, 87624-87625, G0476 (HCPCS)  
  **Sample CPT® codes:** Q51.5, Z90.710, Z90.712  
  Patients who had a hysterectomy with:  
  - No residual cervix  
  - Cervical agenesis  
  - Acquired absence of cervix  
  - Patients in hospice  
  **Documentation of “hysterectomy” alone does not exclude a member from this measure.**  
  The documentation must show “total hysterectomy, complete hysterectomy,” or that the cervix is surgically absent, etc. to show evidence that the cervix was removed and screening is not needed.  
  Documentation of the pap test result and date in the chart is needed to close this gap through medical record review. However, the gap will close via claims with the correct coding for cervical cancer screenings.  
  Biopsies don’t count because they’re diagnostic and not valid for primary cervical cancer screening.  
  **New for 2020** – evidence of high-risk human papillomavirus (hrHPV) testing during the measurement year or the four years prior to the measurement year (for patients who were 30 years or older as of the date of testing) – counts as evidence of co-testing.  
  Documentation must include both the date and the result. Generic documentation of HPV test can be counted as evidence of hrHPV test. |
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</table>
| Chlamydia Screening In Women (CHL) 16-24 years | Female patients identified as sexually active should have at least one chlamydia screening during the measurement year. | **Sample CPT® Codes:**  
Chlamydia Testing: 87110, 87270, 87320, 87490-87492, 87810 | - Patients in hospice  
- Members who had a pregnancy test and were prescribed retinoid medication, or had an X-ray, on the date of the pregnancy test or within six days following the pregnancy test.  
- This gap will show up anytime birth control is prescribed for a woman in this age range, regardless of the reason it is prescribed.  
**Note:** Sexually-active status is determined from claim/encounter data and pharmacy data. Patients who were dispensed prescription contraceptives during the measurement year are considered sexually active. Patients on contraceptives for another reason are not excluded. Patients who have a pregnancy test are considered sexually active. Patients with a diagnosis of pregnancy are considered sexually active. Including documentation of CHL test on the claim form is important in closing the gap for this measure.  
A urine test for chlamydia screening will meet compliance with this measure and is not as invasive.  
Implementing this screening into a routine workflow when contraceptives are prescribed can be helpful. |
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</table>
| Prenatal and Postpartum Care (PPC)           | Women who have delivered a live birth on or between Oct. 8 of the year prior to the measurement year and Oct. 7 of the measurement year should complete the following: | **Sample diagnoses:** Pregnancy, high-risk pregnancy, young primigravida, elderly primigravida, elderly multigravida  
**Sample CPT® (AND HCPCS) Codes to identify a prenatal care visit** (Give date care started for bundled services.)  
- Prenatal Visit: 99201-99205, 99211-99215, 99241-99245, 99483, (GO463, T1015)  
- Prenatal Bundled Services: 59400,59425-59426, 59510, 59610, 59618 (H1005)  
- Standalone Prenatal Visit: 0500F-0502F, 99500 (H1000-H1004)  
**Sample CPT® (AND HCPCS) codes to identify a postpartum care visit** (Give date care started for bundled services.)  
- Postpartum: 57170, 58300, 59430, 99501 (G0101)  
- Postpartum Bundled Services: 59400, 59410, 59510, 59515, 59610, 59614, 59618, 59622 | **Patients in hospice**                                                                 | Can be closed via administrative claims or via medical record review.  
Indicating specific pre-natal and post-partum visits via coding is important for the system processing for gap closure.  
For gap closure via medical record review, documentation must include date of postpartum visit AND documentation of **ONE** of the following:  
- Pelvic Exam  
- Evaluation of weight, BP, breasts and abdomen (i.e. notation of breastfeeding is acceptable for the evaluation of breasts component)  
- Notation of postpartum care, including but not limited to:  
  - Notation of postpartum care, PP Check, 6 week check  
  - Preprinted postpartum care form in which information was documented during the visit  
- Perineal or cesarean incision/wound check  
- Screening for depression, anxiety, tobacco use, substance use disorder, or preexisting mental health disorders  
- Glucose screening for women with Gestational Diabetes  

**Prenatal Care:**  
- Within the **first trimester**  
- Within **42 days of enrollment**  

**Postpartum Care:**  
Patients should have a postpartum care visit on or between **7-84 days after delivery** |
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</table>
| **Adolescent Well-Care Visits (AWC)**       | Patients should have at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the year. | For gap closure, chart must include:  
- A health history  
- A physical development history  
- A mental development history  
- A physical exam  
- Health education/anticipatory guidance  
**Sample CPT® (and HCPCS) Codes:**  
Well-care: 99384, 99385, 99394, 99395, G0438, G0439 | Patients in hospice | Telehealth, inpatient, and ER visits don’t count for the measure.  
Services specific to the assessment or treatment of an acute or chronic condition don’t count toward the measure.  
Stating “Well developed, well nourished” will **NOT** meet the intent of the measure; it must be specific.  
The well child forms available on the TNAAP website (if properly and fully completed) address all the components of the well child measures. ([www.tnaap.org](http://www.tnaap.org)) We highly encourage use of those forms.
### Childhood Immunization Status (CIS) - <2 years

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<tr>
<td><strong>Sample CPT® (and HCPCS) Codes:</strong></td>
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<td>Schedule patients so that all immunizations are completed by 23 months of age.</td>
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<tr>
<td>DTap vaccine: 90698, 90700, 90721, 90723</td>
<td></td>
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<td>Give educational materials that reinforce your advisement on the importance of vaccinations.</td>
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<tr>
<td>HiB vaccine: 90644-90648, 90698, 90721, 90748</td>
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<td>The two immunizations most often missed in the entire CIS series are: the two flu vaccines and the two or three rotavirus vaccines.</td>
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<tr>
<td>HepA vaccine: 90633</td>
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<td>Since the first influenza immunization can be given at 6 months of age, the second vaccine for influenza can be a challenge for babies born in the fall of the year due to immunization timeframes and availability of the vaccine; this may require extra visits and ordering extra vaccines.</td>
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<tr>
<td>Hep B vaccine: 90723, 90740, 90744, 90747-90748, G0010 (HCPCS)</td>
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<td>DTAP, IPV, HiB, Pneumococcal and Rotavirus should be given at least 42 days after birth for compliance.</td>
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<tr>
<td>IPV vaccine: 90698, 90713, 90723</td>
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<td>In order for patients to be compliant for the Rotavirus vaccine, administration must begin at four months of age and all doses must be complete by eight months of age.</td>
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<td>Influenza vaccine: 90655, 90657, 90661-90662, 90673, 90685-90689, 90660, 90672, G0008 (HCPCS)</td>
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<td>VZV, MMR, and Hep A must be given on or between the child’s first and second birthday to be measure compliant.</td>
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<td>MMR vaccine: 90707, 90710</td>
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<td>For VZV, MMR and Hep A and Hep B, the history of the illness documented prior to two years of age in the medical record with a date, or a seropositive test result would close the area of the measure for that particular vaccine.</td>
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<tr>
<td>Measles vaccine: 90705</td>
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<td>Typically the first Hep B is given on the DOB or the day after because most women and babies don’t stay in the hospital longer than that. If the hospital has given the provider the patient records for the Hep B vaccine that was given at birth, then the providers can enter the information and attest that the infant received the HepB vaccination in the hospital - as long as the HepB was given between the DOB and seven days after birth.</td>
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<tr>
<td>Measles/rubella vaccine: 90708</td>
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<td>Mumps vaccine: 90704</td>
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<td>Rubella vaccine: 90706</td>
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<td>Pneumococcal conjugate vaccine: 90670, G0009 (HCPCS)</td>
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<td>Rotavirus vaccine (two dose schedule): 90681</td>
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<td>Rotavirus vaccine (three dose schedule): 90680</td>
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<td>VZV (chickenpox) vaccine: 90710, 90716</td>
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<tr>
<td>Immunizations for Adolescents (IMA) &lt; 13 years</td>
<td>Patients turning 13 during the measurement year should have all of the following immunizations before their 13th birthday: • One meningococcal given on or between 11th and 13th birthday • One Tdap (tetanus, diphtheria, and pertussis) given on or between 10th and 13th birthday • HPV series completed between 9th and 13th birthday</td>
<td>Sample CPT® Codes: Meningococcal vaccine: 90734 Tdap vaccine: 90715 HPV vaccine: 90649-90651</td>
<td>• Patients in hospice • Patients who had a contraindication for a specific vaccine such as an anaphylactic reaction</td>
<td>Meningococcal vaccine must be serogroups A, C, W and Y. (There are some serogroup B and polysaccharide vaccines currently being heavily advertised that will not close the gap in care.) Discuss the HPV vaccine from the cancer prevention standpoint. Recommend HPV the SAME WAY-SAME DAY as the other vaccines. CDC recommendations offer two options for the HPV vaccination: • Option 1: Series of three injections over a period of six months. Note: Dose two to be administered two months after first dose, and dose three to be administered six months after first dose • Option 2: Two injections six months apart (Note: For the two-dose vaccine series, there must be at least 146 days between the first and second dose) This measure applies to BOTH boys and girls under the age of 13. Use educational materials that reinforce your advisement on the importance of vaccinations.</td>
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</table>
| **Well Child Visits in the First Fifteen Months Of Life (W15)**  
< 15 months of age | Patients should have at least five to six well-child visits before age 15 months.                                                                                                                                                                                                 | **For gap closure, chart must include:**  
- A health history  
- A physical development history  
- A mental development history  
- A physical exam  
- Health education/anticipatory guidance  

**Sample CPT® (and HCPCS) Codes:**  
Well-care: 99381, 99382, 99391, 99392, 99461, G0438, G0439 | **Patients in Hospice** | Telehealth visits will **NOT** meet the measure.  
Visits for acute or chronic conditions do **NOT** meet the measure intent, but can be rendered during the same visit as preventive service. Correct coding is key.  
Including documentation of well-visit on the claim form is important in gap prevention for this measure.  
Documentation in the medical record for each visit should show:  
A health history, a physical history, a mental history, a physical exam, and health education/anticipatory guidance.  
Stating “Well developed, well nourished” will **NOT** meet the intent of the measure; it must be specific.  
The well child forms available on the TNAAP website (if properly and fully completed) address all the components of the well child measures. ([www.tnaap.org]) We highly encourage use of those forms. |
### Well Child Visits In The Third, Fourth, And Sixth Years Of Life (W34)

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| 3-6 years | Patients should have a yearly well-child visit with a PCP. | **For gap closure, chart must include:**  
- A health history  
- A physical development history  
- A mental development history  
- A physical exam  
- Health education/ anticipatory guidance  
**Sample CPT® (and HCPCS) Codes:**  
Well-care: 99382, 99383, 99392, 99393, G0438, G0439 | Patients in Hospice | Telehealth visits will **NOT** meet the measure.  
Visits for acute or chronic conditions do **NOT** meet the measure intent, but can be rendered during the same visit as preventive service. Correct coding is key.  
Including documentation of well-visit on the claim form is important in gap prevention for this measure.  
Documentation in the medical record for each visit should show:  
A health history, a physical history, a mental history, a physical exam, and health education/ anticipatory guidance  
Stating “Well developed, well nourished” will **NOT** meet the intent of the measure; it must be specific.  
The well child forms available on the TNAAP website (if properly and fully completed) address all the components of the well child measures. ([www.tnaap.org](http://www.tnaap.org)) We highly encourage use of those forms. |
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<td><strong>Weight Assessment/ Counseling For Nutrition and Physical For Children and Adolescents - BMI (WCC)</strong>&lt;br&gt;3-17 years</td>
<td>Patients should have an outpatient visit with a documented height, weight, and BMI percentile.</td>
<td><strong>Pediatric BMI Percentile:</strong>&lt;br&gt;BMI &lt;5th Pcntl for age: Z68.51&lt;br&gt;BMI 5th Pcntl - &lt;85th Pcntl: Z68.52&lt;br&gt;BMI 85th Pcntl - &lt;95th Pcntl: Z68.53&lt;br&gt;BMI Greater Than or Equal to 95th Pcntl: Z68.54&lt;br&gt;Note: BMI percentile can be plotted on a BMI chart or documented in the record as a percentile; either is acceptable.</td>
<td>• Patients in hospice</td>
<td>Remember to document the date of service when BMI percentile is obtained. <strong>For BMI:</strong>&lt;br&gt;A specific BMI percentile is the key here; it can be documented on an age-growth chart. Use specific BMI percentiles that account for age and gender rather than absolute BMI. Documentation that does <strong>NOT</strong> meet compliance:&lt;br&gt;• BMI value only&lt;br&gt;• Height and weight only&lt;br&gt;• A general range of percentile is not specific enough (e.g. &lt;85 percent)&lt;br&gt;• A general range such as 50-75% is not acceptable&lt;br&gt;The only ranges that can be used are &gt;99% and &lt;1% of percentile.</td>
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<td><strong>Follow-Up Care for Children Prescribed ADHD/ADD Medications (ADD)</strong>&lt;br&gt;6-12 years</td>
<td>Patients with newly prescribed ADHD medication should have at least three follow-up care visits within a 10-month period.&lt;br&gt;&lt;br&gt;Note: The first visit must be within 30 days of the medication dispense date.</td>
<td><strong>Commonly Prescribed ADHD Medications:</strong>&lt;br&gt;CNS Stimulants&lt;br&gt;• Amphetamine&lt;br&gt;• Demethylphenidate&lt;br&gt;• Dextroamphetamine&lt;br&gt;• Lisdexamfetamine&lt;br&gt;• Methamphetamine&lt;br&gt;• Methylphenidate&lt;br&gt;&lt;br&gt;<strong>Apha-2 receptor agonists:</strong>&lt;br&gt;• Clonidine&lt;br&gt;• Guanfacine&lt;br&gt;&lt;br&gt;<strong>Miscellaneous ADHD medications:</strong>&lt;br&gt;• Atomoxetine</td>
<td>• Patients who have a diagnosis of narcolepsy, sample ICD10CM® Codes G47.111, G47.419&lt;br&gt;• Patients in hospice</td>
<td>A patient is considered to have a &quot;newly prescribed&quot; medication if this is the first time they have filled an ADD/ADHD medication or if there is no documentation (claims filled) to show a refill of the ADD/ADHD medication in the last 120 days. Children who take medication vacations resulting in prescription gaps of 120 days or more will need to start the follow-up cycle again, just as if the prescription were new.</td>
</tr>
</tbody>
</table>

**Sample CPT® Codes for ADHD/ADD:**<br>90791-90797, 90801-90802, 90816-90819, 90821-90824, 90826-90829, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90857, 90862, 90875-90876, 96150-96154, 98960-98962, 99078, 99089, 99201-99205, 99211-99215, 99217-99223, 99231-99233, 99233, 99238-99239, 99241-99245, 99251-99255, 99341-99345, 99347-99350, 99381-99384, 99391-99394, 99401-99404, 99411-99412, 99483, 99510<br>Telephone visit: 98966-98968, 99441-99443<br><br>Note: Other codes may apply depending on specialty and provider type.
<table>
<thead>
<tr>
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<tr>
<td><strong>Antidepressant Medication Management - Effective Acute Phase Treatment (AMM)</strong> 18 years and older</td>
<td>Patients with a diagnosis of major depression, who were prescribed an antidepressant should remain on the antidepressant medication for at least 84 days (12 weeks) from the time the prescription was filled.</td>
</tr>
<tr>
<td><strong>Antidepressant Medication Management - Effective Continuation Phase Treatment (AMM)</strong> 18 years and older</td>
<td>Patients with a diagnosis of major depression, who were prescribed an antidepressant should remain on the antidepressant medication for at least 180 days (6 months) from the time the prescription was filled.</td>
</tr>
</tbody>
</table>

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</table>
| **Sample diagnosis codes:**  
Major Depression:  
F32.0, F32.1, F32.2, F32.3, F32.4, F32.9, F33.0, F33.1, F33.2, F33.3, F33.41, F33.9 |  
• Patients in hospice |  
Encouraging patients to fill a 90-day supply can be helpful. Patients who have filled their antidepressant medication enough times to have a 180-days supply of medication since diagnosis/first fill of prescription will be compliant for the measure.  
Appropriate coding of the type of depression is important; major depression is the diagnosis that places the member into this measure.  
Educate members about the impact of medication adherence on chronic illnesses.  
Consider adding telehealth options for those without transportation or who live in rural areas. |
| **Sample diagnosis codes:**  
Major Depression:  
F32.0, F32.1, F32.2, F32.3, F32.4, F32.9, F33.0, F33.1, F33.2, F33.3, F33.41, F33.9 |  
• Patients in hospice |  
Encouraging patients to fill a 90-day supply can be helpful. Patients who have filled their antidepressant medication enough times to have a 180-days supply of medication since diagnosis/first fill of prescription will be compliant for the measure.  
Appropriate coding of the type of depression is important; major depression is the diagnosis that places the member into this measure.  
Educate members about the impact of medication adherence on chronic illnesses.  
Consider adding telehealth options for those without transportation or who live in rural areas. |
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| Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) 1-17 years | Patients who were dispensed two or more antipsychotic medications should have metabolic testing every year: **at least one** blood glucose or HbA1C test and **at least one** LDL-C or cholesterol test. | **Sample Medications:**  
• Clozapine  
• Haloperidol  
• Loxapine  
• Olanzapine  
• Risperidone  
• Quetiapine  
• Chlorpromazine  
**Sample CPT® codes:** 80047, 800048, 80050, 80053, 82465, 83718, 83722, 84478, 80061, 83700, 83701 | • Patients in hospice | Explaining common side-effects of these medications to parents/guardians will help them understand the importance of the testing that is needed when children/adolescents are on these medications. They include:  
• Weight gain  
• High cholesterol  
• High blood glucose  
Obtain baseline labs and measurements before prescribing antipsychotic medication.  
Schedule a follow-up visit 12 weeks after the patient begins taking the medication to recheck baseline measurements. Perform these tests at least annually thereafter.  
Consider using standing orders to get labs completed.  
If you’re a behavioral health specialist and have ordered labs, notify the primary care provider that labs have been completed and send them the results. |
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<tr>
<td><strong>Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)</strong>&lt;br&gt;1-17 years</td>
<td>Patients should have at least one visit with a mental health provider sometime between 90 days prior to the patient filling an antipsychotic medication though 30 days after the patient fills medication.</td>
<td><strong>Sample Medications:</strong>&lt;br&gt;- Clozapine&lt;br&gt;- Haloperidol&lt;br&gt;- Olanzapine&lt;br&gt;- Risperidone&lt;br&gt;- Quetiapine&lt;br&gt;- Chlorpromazine&lt;br&gt;- Fluoxetine-olanzapine&lt;br&gt;- Perpenazine-amitriptyline&lt;br&gt;<strong>Mental Health Provider Sample CPT® codes:</strong>&lt;br&gt;98960, 98961, 99212, 90870</td>
<td>• Patients in hospice&lt;br&gt;• Patients who were hospitalized or had two or more OP visits for the diagnosis of Schizophrenia, Bipolar Disorder, Schizoaffective Disorder, Autism, and other developmental or psychotic disorders</td>
<td>Closing the gap requires a mental health provider visit claim either 90 days before the medication was dispensed or within 30 days after the medication is dispensed. Prescribe antipsychotic medication after the patient has tried therapy (within 90 days of documented psychosocial care). Follow-up with members two weeks after dispensing antipsychotic medication to remind them to complete scheduled psychosocial care (must be completed within 30 days of dispensing).&lt;br&gt;<strong>Sample diagnosis codes:</strong>&lt;br&gt;F20.0-F20.3, F30.10-F30.13, F31.30-F31.31, F22, F23, F24, F84.5, F84.0</td>
</tr>
<tr>
<td><strong>Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence</strong>&lt;br&gt;(7 days and 30 days) (FUA)&lt;br&gt;13 years and older</td>
<td>Patients who were seen in the emergency department (ED) with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, should have a follow up visit for AOD as follows:&lt;br&gt;- Within seven days of ED visit&lt;br&gt;- Within 30 days of ED visit</td>
<td>• Patients in hospice, or using hospice services.</td>
<td>This is an episodes-based measure; Therefore, a member could be in this measure as many times as the criteria is met. (Ex: 3 visits to ED for AOD, each greater than 30 days apart equals three episodes in the measure with an addressable gap). The follow-up visits for this measure do not necessarily have to be with a mental health practitioner. They can be with any practitioner. Visits that occur on the same day of the ED visit will meet criteria for this measure. <strong>A patient follow-up visit within seven days of ED visit will automatically satisfy the 30-day requirement as well.</strong></td>
<td></td>
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| Follow-up After Hospitalization for Mental Illness (FUH) 6 years and older | Patients who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses should have a follow-up visit with a mental health practitioner after discharge as follows:  
  - **Within seven days** of discharge  
  - **Within 30 days** of discharge | **Sample Diagnoses:**  
  - Dementia  
  - Schizophrenia  
  - Schizoaffective disorder  
  - Manic episode  
  - Bipolar disorder  
  - Major depressive disorder  
  - Post-traumatic stress disorder  
  - Attention-deficit hyperactivity disorder  
  - Mental illness  
  - Intentional Self-Harm  
  - Sample CPT® Codes for follow-up with a mental health practitioner:  
    - Transitional care management 7 day: 99496  
    - Transitional care management 14 day: 99495  
  - **Note:** Additional codes may apply depending on provider type and point of service. | • Patients in hospice, or using hospice services. | The follow-up visits for this measure MUST be with a mental health practitioner.  
  Don’t include visits that occur on the date of discharge. They won’t count to close the gap.  
  A patient follow up visit within seven days of discharge will automatically satisfy the 30-day requirement as well. |
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</table>
| **Follow-up After Emergency Department Visit for Mental Illness (FUM)** 6 years and older | Patients who had an emergency department (ED) visit with a principle diagnosis of mental illness or intentional self-harm, should have follow up visits as listed below:  
• **Within seven days** of ED visit  
• **Within 30 days** of ED visit | **Sample Diagnoses:**  
• Dementia  
• Schizophrenia  
• Schizoaffective disorder  
• Manic episode  
• Bipolar disorder  
• Major depressive disorder  
• Post-traumatic stress disorder  
• Attention-deficit hyperactivity disorder  
• Mental illness  
**Sample CPT® Codes** for follow-up with a mental health practitioner:  
CPT Codes: 98960-98962, 99078, 99201-99205, 99211-99215, 9921799220, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 9939499397, 99401-99404, 99408-99409, 99411-99412, 99510  
**Transitional care management seven day:** 99496  
**Transitional care management 14 day:** 99495 | • Patients in hospice, or using hospice services.  
**Note:** Additional codes may apply depending on provider type and point of service. |
|  |  |  |  |  | This is an episodes-based measure. A member could be in this measure as many times as the criteria is met. (Ex: three visits to ED for mental illness, each greater than 30 days apart, equals three episodes in the measure with an addressable gap).  
The follow-up visits for this measure don’t necessarily have to be with a mental health practitioner. **They can be with any practitioner.**  
Visits that occur on the same day of the ED visit will meet criteria for this measure.  
**A patient follow up visit within seven days of ED visit will automatically satisfy the 30-day requirement as well.** |
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| **Use of Opioids at High Dosage (HDO)**       | To identify patients who receive prescription opioids for ≥ 15 days during the measurement year at a high dosage (average milligram morphine dose (MME) ≥90 mg). | It’s important to document and code for any exclusions that would warrant use of continued opioid medications (see exclusions column). | • Patients in hospice  
• Patients with cancer during the measurement year  
• Patients with sickle cell disease during the measurement year | Measure acronym changed from UOD to HDO for 2020. 
MME decreased from ≥120 mg to ≥90mg. |

**Sample diagnoses codes:**

D57.00-D57.02, D57.1, C34.01, C48.0-C48.00
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</table>
| **Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)**<br>13 years and older | Patients with a new episode of alcohol or other drug (AOD) abuse or dependence should have:  
  • Initiation of AOD treatment: through outpatient visit, intensive outpatient encounter, telehealth, medication treatment, partial hospitalization or inpatient AOD admission **within 14 days of the diagnosis**  
  AND  
  • Engagement (Continuation) of AOD treatment: Those who initiated treatment and had two or more additional services (for alcohol or drug) or medication treatment **within 34 days of the initial visit**<br>Note: Events including detoxification codes are not considered engagement episodes. | **Important Note:** AOD diagnosis is required for compliance achievement.  
**Sample Diagnoses For Alcohol Or Other Drug Dependence (AOD):**  
  • Alcohol abuse  
  • Alcohol dependence  
  • Alcohol use  
  • Opioid abuse  
  • Opioid dependence  
  • Opioid use  
  • Cannabis abuse  
  • Cannabis dependence  
  • Cannabis use  
  • Sedative, hypnotic or anxiolytic use  
  • Cocaine abuse  
  • Cocaine dependence  
  • Cocaine use  
  • Hallucinogen abuse  
  • Hallucinogen dependence  
  • Hallucinogen use  
  • Inhalant abuse  
  • Inhalant dependence  
  • Inhalant use  
  • Other stimulant abuse  
  • Other stimulant dependence | • Patients in hospice, or using hospice services.                                                                                                                                                                                                                           | **Note:** If the Index Episode was an inpatient discharge (or an ED/observation visit that resulted in an inpatient stay), the inpatient stay is considered initiation of treatment and the member is compliant.  
A “new episode” is considered when a patient has at least a 60-day negative history of no claims or encounters for this diagnosis.
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| **Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)** 18 years and older | Patients with a diagnosis of schizophrenia or schizoaffective disorder should be given an antipsychotic medication and should remain on an antipsychotic medication for at least 80% of their treatment period or greater. Treatment period is defined as the time period starting at the earliest prescription dispensing date until the end of the measurement year. | Diagnosis of schizophrenia or schizoaffective disorder and medications given                                    | • Patients in hospice  
• Patients with diagnosed dementia                         | Encourage patients to stay on medications even when they feel better.  
Encourage patients to talk to their pharmacy to make sure all new prescription and refill claims are being submitted to their health plan.  
Explore possible reasons for your patients’ medication non-adherence (i.e. cost, denial, depression, substance use/abuse, side effects).  
Consider prescribing long-acting injectable medications instead of oral medications to enhance compliance, when appropriate. |
| **Use of Opioids from Multiple Providers (UOP)** 18 years and older    | To identify patients who receive prescription opioids for ≥ 15 days from multiple prescribers or/and multiple pharmacies.                                                                                                                                                                                                                             | N/A                                                                                                           | • Patients in hospice                                                                                 | National Provider Identifier (NPI) is used to determine if the prescriber for medication dispensing events was the same or different.  
Multiple prescribers is defined as: The proportions of patients receiving prescriptions for opioids from four or more different prescribers during the measurement year.  
Multiple pharmacies is defined as: The proportion of members receiving prescriptions for opioids from four or more different pharmacies during the measurement year. |
<table>
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</table>
| Acute Hospital Utilization (AHU)              | This is a ratio of observed to expected acute inpatient and observation stay discharges during the measurement year. | This is reported by claims.                      | Encounters for:  
  • A principal diagnosis of live-born infant, maternity-related diagnosis, or a maternity-related stay  
  • A principal diagnosis of mental health or chemical dependency  
  • Inpatient and observation stays with a diagnosis of death  
  • Hospice                                                                 |              |
| Emergency Department Utilization (EDU)        | This is a ratio of observed to expected emergency department (ED) visits during the measurement year. | This is reported by claims.                      | Encounters for:  
  • A principal diagnosis of mental health or chemical dependency  
  • Psychiatry  
  • Electroconvulsive therapy  
  • Hospice                                                                 |              |
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| Plan All-Cause Readmission (PCR) 18-64 years | Percentage of members 18-64 years and older discharged from an acute hospital stay who were readmitted, whether acute or unplanned, to a hospital within 30 days, either for the same condition as their recent hospital stay or a different reason. Patients may have been readmitted back to the same hospital or to a different one.                                                                 | Patients in hospice, or using hospice services. Hospital stays for the following reasons don’t meet criteria for this measure:  
• The member died during the stay  
• Female members with the principal diagnosis of pregnancy  
• The principal diagnosis of a condition originating in the perinatal period  
• A principal diagnosis of maintenance chemotherapy  
• A principal diagnosis of rehabilitation  
• An organ transplant  
• A potentially planned procedure without a principal acute diagnosis.                                                                                                                                                                                                 | Collaborate with hospitals in order to be notified of your patients’ admissions and discharges.  
Ensure comprehensive follow-up visit, including medication reconciliation is completed within 7-10 days post discharge.  
Arrange for post-hospital care as appropriate.                                                                                                                                                                                                                                                                                           |
What is CAHPS?

- **CAHPS®** - family of surveys that measures topics that are important to members, such as communication skills of providers and the accessibility of services
- **CAHPS®** is considered the national standard for measuring and reporting on consumers’ experiences with health plans and their services
- The CAHPS® surveys ask “Are consumers satisfied with the quality of care and customer services given by their health plan and providers?”
- **CAHPS®** provides a measurement of how our members perceive the care they receive from BlueCross BlueShield of Tennessee contracted doctors and providers.

What is the impact of CAHPS® interactions

*Remember:* the CAHPS® survey measures the patients’ *perception* of the care they have received. It reflects on the services we offer them.

Sample Survey Questions and Helpful Tips

<table>
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<tr>
<th>CAHPS® Survey Question</th>
<th>How You Can Help</th>
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</thead>
<tbody>
<tr>
<td>In the last 12 months, how often was it easy to get the care, tests or treatment you needed?</td>
<td>Coordinating care interventions, referrals to specialty providers and community-based support services, consults and resources across involved health providers and care settings.</td>
</tr>
<tr>
<td>In the last 12 months, how often did your personal doctor seem informed and up-to-date about the care you got from these doctors or other health providers?</td>
<td>Collaborating with other health care professional and support service providers across care settings, levels of care and professional disciplines, with special attention to safe transitions of care.</td>
</tr>
</tbody>
</table>

**Tip:** Be sure to ask patients if they have seen other providers recently.
General Health Measures

HEDIS codes can change from year to year. The codes in this document are from the HEDIS 2020 specifications.
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BlueCross BlueShield of Tennessee

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