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 workflow with every encounter.

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

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Manager, Commercial Quality Improvement
Office Phone: (423) 535-7865
Patty_Howard@bcbst.com
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## Best Practices and Processes Behind the CAHPS Survey – 29
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

HEDIS codes can change from year to year. The codes in this document are from the HEDIS 2019 specifications.

<table>
<thead>
<tr>
<th>Measure</th>
<th>What Service Is Needed</th>
<th>What To Report (Sample Of Codes and/or Diagnoses)</th>
<th>Exclusions</th>
<th>Helpful Tips</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive Diabetes Care (has 4 parts) (CDC)</td>
<td>Type 1 and Type 2 diabetics ages 18-75 who had:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Hemoglobin A1C control &lt;8.0 (listed by HbA1C results)</td>
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<tr>
<td></td>
<td>• Retinal eye exam (interpretation to be completed by an eye care professional)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Nephropathy: nephropathy screening or evidence of nephropathy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• BP: &lt;140/90 mmHg</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hemoglobin A1C ranges:</td>
<td>Target range &lt;8 percent for the last reading charted for member for the measurement year</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eye exam:</td>
<td>The eye exam can be dilated or retinal exam</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nephropathy screening test:</td>
<td>Urine testing for microalbumin or protein</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evidence of nephropathy:</td>
<td>Administrative / claims closure: CKD stage 4, ESRD, kidney transplant, or nephrologist MD visit</td>
<td></td>
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<tr>
<td>B/P:</td>
<td>&lt;140/90 for the last B/P reading charted for member for the measurement year</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sample CPT Codes:</td>
<td>Diabetic retinal screening: 67028, 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, 92269-92270, 99213-99215, 99242-99245, S3000, S0620-S0621</td>
<td></td>
<td></td>
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<tr>
<td>Diabetic retinal screening negative:</td>
<td>3072F</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetic retinal screening with eye care professional:</td>
<td>2022F, 2024F, 2026F</td>
<td></td>
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<tr>
<td>Note:</td>
<td>Providers performing retinal imaging in office and sending results to eye care professionals to review and interpret should use CPTII codes.</td>
<td></td>
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</tr>
<tr>
<td>Two Eye Enucleations:</td>
<td>65091, 65093, 65101, 65103, 65105, 65110, 65112, 65114, 08B10ZX, 08B10ZZ, 08B13ZX, 08B13ZZ, 08B1XZX, 08B1XZZ, 08B00ZX, 08B00ZZ, 08B03ZX, 08B03ZZ, 08B0XZX, 08B0XZZ</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Diabetic blood pressure control:</td>
<td>Diastolic less than 80: 3078F</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Diastolic 80-89: 3079F</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Diastolic greater than/equal to 90: 3080F</td>
<td></td>
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<td></td>
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<tr>
<td></td>
<td>Systolic less than 140: 3074F-3075F</td>
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<tr>
<td></td>
<td>Systolic greater than/equal to 140: 3077F</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>HbA1C testing: level less than 7.0: 3044F</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>HbA1C level 7.0-9.0: 3045F</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>HbA1c level greater than 9.0: 3046F</td>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>HbA1c tests: 3044F-3046F, 83036-83037</td>
<td></td>
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</tr>
<tr>
<td>Blood Pressure:</td>
<td>Member 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.</td>
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<td></td>
<td>Patients in hospice, or using hospice services.</td>
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<tr>
<td></td>
<td>Patients with advanced illness and frailty, in hospice, or using hospice services.</td>
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<tr>
<td>Retinal Eye Exam:</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: 1st reading- 130/95; 2nd reading-156/80- the gap can be closed with the reading of 130/80.</td>
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<tr>
<td></td>
<td>The A1c and B/P gaps can open and close during the measurement year based on the most recent readings being in range.</td>
<td></td>
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<tr>
<td></td>
<td>Lab values can be obtained from inpatient records but the B/P cannot be used if from the ER or inpatient record.</td>
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<tr>
<td>HbA1c Testing:</td>
<td>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 cannot identify if patient’s level is below 8.0 based on that code.</td>
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<tr>
<td></td>
<td>Hgb A1C results must be on a specific date – we cannot use &quot;recent or last A1C&quot;- it must have a date.</td>
<td></td>
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</tr>
<tr>
<td>Measure</td>
<td>What Service Is Needed</td>
<td>What To Report (Sample Of Codes and/or Diagnoses)</td>
<td>Exclusions</td>
<td>Helpful Tips</td>
</tr>
<tr>
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<td>--------------------------------------------------</td>
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</tr>
</tbody>
</table>
| **Pharmacotherapy Management of COPD Exacerbation (PCE)** | Patients need to have been prescribed and filled two medications:  
- Corticosteroids within 14 days of discharge from an inpatient stay or ED visit  
- Bronchodilator within 30 days of discharge from an inpatient stay or ED visit | **Sample Diagnoses:**  
- Emphysema  
- Chronic Obstructive Asthma  
- Chronic Obstructive Bronchitis  
- Simple Chronic Bronchitis | Patients in hospice, or using hospice services. | Explore possible reasons for your patients’ medication non-compliance (i.e. cost, denial, depression, substance use/abuse). |
| **Use of Imaging Studies for Low Back Pain (LBP)** | Goal for this measure is for the provider to wait 29 days or more to order imaging study--an image study done when the diagnosis of uncomplicated low back pain is given will open the gap unless the member meets the exclusion criteria. | Exclusions that would warrant use of imaging studies (see examples in exclusions column)  
- Cancer  
- Trauma  
- Neurologic impairment  
- IV drug use  
- HIV  
- Spinal infection  
- Major organ transplant  
- Prolonged use of corticosteroids | Patients in hospice, or using hospice services. | 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 conducted. This will prevent an open gap. Encourage patients to try conservative treatment such as:  
- Ice of heat  
- OTC pain relief  
- Stretching or back strengthening exercises  
- Safe back habits |
### Colorectal Cancer Screening (COL)

The percentage of patients 50-75 years of age who had appropriate screening for colorectal cancer.

<table>
<thead>
<tr>
<th>Measure</th>
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</table>
| **Six types of screening tests can be done: stool testing or scope options** | | | | The length of time that this gap closes is based on the type of screening. While colonoscopy is the gold standard, the measure will close with any of the following screening types:  
• Colonoscopy (every 10 years)  
• Flexible Sigmoidoscopy (every five years)  
• CT Colonography (every five years)  
• FIT-DNA Test (every three years)  
• Fecal Occult Blood Testing (FOBT), including Fecal Immunochemical Testing (FIT), requires only one stool sample (annually)  
In-office Guiac Test and fecal occult blood testing via digital rectal exam do NOT meet the measure criteria.  
Guiac testing is acceptable if it is 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 guiac testing, three samples are required each year. |
| **Colonoscopy** during the measurement year or the nine years prior (needed every ten years) | Sample CPT® codes:  
**Colonoscopy**: 44388-44394, 44397, 44401-44408, 45355, 45378-45393, 45398 | Patients with colon cancer or history of colon cancer.  
Patients with a total colectomy.  
Patients in hospice, or using hospice services.  
Patients with advanced illness and frailty. |
<p>| <strong>Flexible sigmoidoscopy</strong> during the measurement year or the four years prior (needed every five years) | <strong>Flexible sigmoidoscopy</strong>: 45330-45335, 45337-45342, 45345-45347, 45349-45350 | | | |
| <strong>CT colonography</strong> during the measurement year or the four years prior (needed every five years) | <strong>CT colonography</strong>: 74263 | | | |
| <strong>FIT-DNA test</strong> | <strong>FIT-DNA test</strong>: 81528 | | | |
| <strong>Fecal occult blood test (FOBT)</strong>, including fecal immunochemical testing (FIT), requires only one stool sample (annually); if using guiac testing, three samples are required. | <strong>Fecal occult blood test (FOBT)</strong>: 82270, 82274 | | | |</p>
<table>
<thead>
<tr>
<th>Measure</th>
<th>What Service Is Needed</th>
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<th>Exclusions</th>
<th>Helpful Tips</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Controlling High Blood Pressure (CBP)</strong></td>
<td>A compliant blood pressure is &lt;140/90</td>
<td>Sample diagnosis:</td>
<td>End Stage Renal Disease or Kidney Transplant. Pregnancy during the measurement year.</td>
<td>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 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 based on the most recent B/P reading being in range.</td>
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<tr>
<td></td>
<td></td>
<td>Sample CPT Codes to identify high blood pressure control:</td>
<td>Patients in hospice, or using hospice services. Patients with advanced illness and frailty.</td>
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<tr>
<td></td>
<td></td>
<td>• Diastolic less than 80: 3078F</td>
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<tr>
<td></td>
<td></td>
<td>• Diastolic 80-89: 3079F</td>
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<tr>
<td></td>
<td></td>
<td>• Systolic less than 140: 3074F-3075F</td>
<td></td>
<td></td>
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<tr>
<td><strong>Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)</strong></td>
<td>Appropriate treatment for acute bronchitis is to not dispense an antibiotic (does not apply if exclusion criteria satisfied).</td>
<td>Sample diagnoses (where an antibiotic is not recommended without a comorbid condition or additional diagnosis of bacterial infection).</td>
<td>Member has documented diagnosis of comorbid condition such as:</td>
<td>Coding and documentation for noted bacterial infections along with the bronchitis are important for this measure. If an antibiotic is given for bronchitis alone, a gap will open and it cannot be closed. Documentation of certain comorbid conditions will exclude a member from this measure (a few examples are: HIV, Cancer, COPD, Cystic Fibrosis, Immune system issues, Emphysema). If a member’s condition does not improve and an antibiotic is indicated, a gap will not occur if the antibiotic is given at least three days after the encounter when AAB was diagnosed.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Acute bronchitis</td>
<td>• HIV</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• Bronchitis not specified as acute or chronic</td>
<td>• Cancer</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Chronic bronchitis with acute exacerbation</td>
<td>• COPD</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Bronchiectasis with acute exacerbation</td>
<td>• Emphysema</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Acute upper respiratory Infection (URI)</td>
<td>• Cystic fibrosis</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Pharyngitis</td>
<td>• Disorders of the immune system</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Tonsilitis</td>
<td>Patients in hospice, or using hospice services.</td>
<td></td>
</tr>
</tbody>
</table>
### General Health Measures

**Medication Management for People with Asthma (MMA)**

The percentage of patients 5-64 years of age who were identified as having persistent asthma and were dispensed appropriate medications they remained on during the treatment period.

Goal is for member to remain on asthma controller medication for at least 75 percent of the treatment period or greater. Treatment period defined as the time period starting with the date of diagnosis until the end of the calendar year.

**Sample diagnoses:**
- Asthma unspecified
- Extrinsic asthma
- Intrinsic asthma
- Chronic obstructive asthma

**Exclusions**
- Patients in hospice, or using hospice services.
- COPD
- Emphysema
- Cystic Fibrosis
- Acute respiratory failure
- Chronic respiratory conditions

**Helpful Tips**
- Explore possible reasons for your patients’ medication non-compliance (i.e. cost, denial, depression, substance use/abuse)

<table>
<thead>
<tr>
<th>Measure</th>
<th>What Service Is Needed</th>
<th>What To Report (Sample Of Codes and/or Diagnoses)</th>
<th>Exclusions</th>
<th>Helpful Tips</th>
</tr>
</thead>
</table>
| **Medication Management for People with Asthma (MMA)** | Goal is for member to remain on asthma controller medication for at least 75 percent of the treatment period or greater. Treatment period defined as the time period starting with the date of diagnosis until the end of the calendar year. | Sample diagnoses:  
- Asthma unspecified  
- Extrinsic asthma  
- Intrinsic asthma  
- Chronic obstructive asthma | Patients in hospice, or using hospice services.  
- COPD  
- Emphysema  
- Cystic Fibrosis  
- Acute respiratory failure  
- Chronic respiratory conditions | Explore possible reasons for your patients’ medication non-compliance (i.e. cost, denial, depression, substance use/abuse) |

### Adult Immunization Status (AIS)

Patients 19 years of age and older who are up to date on recommended routine vaccines for influenza, tetanus, diphtheria, acellular pertussis (Td or Tdap), zoster and pneumococcal.

- Flu Shot - every year
- Tdap/Td vaccine - every 10 years
- Herpes zoster vaccine - one or two shots at age 50 or older (one dose of the live vaccine or two doses of the recombinant vaccine at least 28 days apart)
- Pneumococcal vaccine (PCV 13 or PPSV23) - for age 66 years of age and older

**Exclusions**
- Patients:  
  - On active chemotherapy during the year  
  - Who had a bone marrow transplant during the year  
  - With history of immuno-compromised conditions, cochlear implants, sickle cell, anatomic or functional asplenia, HB-S disease, cerebrospinal fluid leak  
  - In hospice, or using hospice services

**Helpful Tips**
- Explore possible reasons for your patients’ medication non-compliance (i.e. cost, denial, depression, substance use/abuse)
<table>
<thead>
<tr>
<th>Measure</th>
<th>What Service Is Needed</th>
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<th>Exclusions</th>
<th>Helpful Tips</th>
</tr>
</thead>
</table>
| Adult BMI Assessment (ABA) | • For 20 and older — documentation in chart must indicate weight and BMI value  
• For younger than 20 — documentation in chart must include height, weight, and BMI percentile | **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 Pctl for age: Z68.51  
BMI 5th Pctl - <85th Pctl: Z68.52  
BMI 85th Pctl - <95th Pctl: Z68.53  
BMI Greater Than or Equal to 95th Pctl: Z68.54 | Patients who have a diagnosis of pregnancy during the measurement year or the year prior to the measurement year.  
Patients in hospice, or using hospice services. | For members 18 and 19 years of age, a BMI percentile must be documented rather than just the BMI value.  
This measure is for dates of service during the measurement year (2019) or the year prior (2018).  
For younger than 20 – list a BMI percentile or the medical record can show the BMI percentile plotted on a BMI for age growth chart. |
## Statin Therapy for Patients with Cardiovascular Disease (SPC)

The percentage of men 21-75 years of age, and women 40-75 years of age, who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and who were dispensed at least one high or moderate-intensity statin medication and who remained on a high or moderate-intensity statin medication for at least 80 percent of the treatment period.

**Note:** Treatment period is defined as the dispensing date of at least a moderate-intensity statin through the end of the year.

<table>
<thead>
<tr>
<th>Measure</th>
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<th>Exclusions</th>
<th>Helpful Tips</th>
</tr>
</thead>
</table>
| **Statin Therapy for Patients with Cardiovascular Disease (SPC)** | Goal is for member to:  
- Receive a moderate or high intensity statin drug  
AND  
- Remain on statin medication for at least 80 percent or greater of the treatment period for those prescribed 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 | Patients in hospice, or using hospice services.  
Pregnancy during the measurement year.  
Patients who were prescribed estrogen agonist medications.  
Patients with:  
- ESRD  
- Cirrhosis  
- Myaligia  
- Myositis  
- Myopathy  
- Rhabdomyolysis  
Patients with advanced illness and frailty. | Only high or moderate intensities of statin therapy will meet the goal of this measure.  
Encourage members to get a 90 day fill of their prescription to help save money and time.  
Explore possible reasons for your patients’ medication non-compliance (i.e. cost, denial, depression, substance use/abuse). |
<table>
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</tr>
</thead>
</table>
| Statin Therapy for Patients with Diabetes (SPD) | Goal is for patient to:  
- Receive a statin medication  
- Remain on statin medication for at least 80 percent of the treatment period | **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**  
**Patients with advanced illness and frailty** | - Clinical atherosclerotic cardiovascular disease (ASCVD)  
- Coronary artery bypass graft (CABG)  
- Myocardial infarction (MI)  
- Percutaneous coronary intervention (PCI)  
- Other revascularization  
- Patients with advanced illness and frailty | Any intensity of statin therapy will meet the goal of this measure.  
Explore possible reasons for your patients’ medication non-compliance (i.e. cost, denial, depression, substance use/abuse). |
## Plan All-Cause Readmissions (PCR)

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.

### What Service Is Needed

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 To Report (Sample Of Codes and/or Diagnoses)

Patients in hospice, or using hospice services.

**Hospital stays for the following reasons do not 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

### Exclusions

- 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.
<table>
<thead>
<tr>
<th>Measure</th>
<th>What Service Is Needed</th>
<th>What To Report (Sample Of Codes and/or Diagnoses)</th>
<th>Exclusions</th>
<th>Helpful Tips</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Use of Opioids at High Dosage (UOD)</strong></td>
<td></td>
<td></td>
<td>Patients in hospice, or using hospice services.</td>
<td>Multiple prescribers is defined as: The proportion of patients receiving prescriptions for opioids from four or more different prescribers during the measurement year. National Provider Identifier (NPI) is used to determine if the prescriber for medication dispensing events was the same or different.</td>
</tr>
<tr>
<td>Percentage of patients 18 years and older receiving prescription opioids for greater than, or equal to, 15 days during the measurement year at a high dosage (average milligram morphine dose (MME &gt;120mg)</td>
<td></td>
<td></td>
<td>Patients who had cancer during the measurement year.</td>
<td></td>
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<tr>
<td>Patients who had Sickle Cell disease during the measurement year.</td>
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<td></td>
<td>Patients who had Sickle Cell disease during the measurement year.</td>
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</tr>
<tr>
<td><strong>Use of Opioids from Multiple Providers (UOP)</strong></td>
<td></td>
<td></td>
<td>Patients in hospice or using hospice services.</td>
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</tr>
<tr>
<td>Percentage of patients 18 years and older receiving prescription opioids for greater than, or equal to, 15 days during the measurement year who received opioids from multiple providers</td>
<td></td>
<td></td>
<td>Patients who had Sickle Cell disease during the measurement year.</td>
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<tr>
<td>Measure</td>
<td>What Service Is Needed</td>
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</tbody>
</table>
| **Chlamydia Screening in Women (CHL)** | **Test for Chlamydia:** Urine test or cervical cell sample during the measurement year | **Sample CPT Codes:**  
Chlamydia Testing: 87110, 87270, 87320, 87490-87492, 87810 | Patients in hospice, or using hospice services.  
Members who had a pregnancy test and were prescribed retinoid medication 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. Members who were dispensed prescription contraceptives during the measurement year are considered sexually active. Members on contraceptives for another reason are not excluded.  
Including documentation of CHL test on the claim form is important in closing the gap for this measure.  
For patients that may be hesitant to undergo chlamydia screening, informing them that a simple urine test is all that's needed and the test is recommended for all girls ages 16-24, can help ease their concerns. |
### Cervical Cancer Screening (CCS)

The percentage of women 21-64 years of age who were screened for cervical cancer.

<table>
<thead>
<tr>
<th>Measure</th>
<th>What Service Is Needed</th>
<th>What To Report (Sample Of Codes and/or Diagnoses)</th>
<th>Exclusions</th>
<th>Helpful Tips</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Screening type based on age and MD/patient preference</strong></td>
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<tr>
<td>• Age 21-29: Pap test during the measurement year or the two years prior (needed every three years)</td>
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<tr>
<td>• Age 30-64: the measurement year or the two years prior (needed every three years) OR</td>
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<tr>
<td>• Age 30-64: Pap and HPV testing at the same time during the measurement year or the four years prior (needed every five years)</td>
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<tr>
<td><strong>Sample CPT® (and HCPCS) Codes:</strong></td>
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<tr>
<td>Cervical Cytology HCPCS: G0123, G0124, G0141, G0143, G0144, G0145, G0147, G0148, P3000, P3001, Q0091</td>
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<tr>
<td><strong>Cervical Cytology CPT®:</strong> 88141-88143, 88147-88148, 88150, 88152-88154, 88164-88167, 88174-88175</td>
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<tr>
<td>HPV Test: 87620-87622, 87624-87625, G0476 (HCPCS)</td>
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<td><strong>Patients who had a hysterectomy with:</strong></td>
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<tr>
<td>• no residual cervix</td>
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<td></td>
<td>Documentation of “hysterectomy” alone does not exclude a member from this measure. The documentation must show “total hysterectomy,” “complete hysterectomy,” etc. to show evidence that the cervix was removed and screening is not needed.</td>
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<tr>
<td>• cervical agenesis</td>
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<tr>
<td>OR</td>
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<tr>
<td>• acquired absence of cervix</td>
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<td><strong>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.</strong></td>
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<tr>
<td>Measure</td>
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<tr>
<td><strong>Prenatal and Postpartum Care (PPC)</strong></td>
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<tr>
<td>The percentage of deliveries of live births</td>
<td><strong>Prenatal Care:</strong></td>
<td><strong>Sample diagnoses:</strong> Pregnancy, high-risk pregnancy, young primigravida, elderly primigravida, elderly multigravida</td>
<td>Patients in hospice, or using hospice services.</td>
<td>Indicating specific pre-natal and post-partum visits via coding is important for the system processing for gap closure.</td>
</tr>
<tr>
<td></td>
<td>• Within the first trimester <strong>OR</strong> • Within 42 days of enrollment</td>
<td><strong>Sample CPT® (AND HCPCS) Codes</strong> to identify a prenatal care visit (Give date care started for bundled services.) <strong>Prenatal Visit:</strong> 99201-99205, 99211-99215, 99241-99245 (GO463, T1015) <strong>Prenatal Bundled Services:</strong> 59400, 59425-59426, 59510, 59610, 59618 (H1005) <strong>Standalone Prenatal Visit:</strong> 0500F-0502F, 99500 (H1000-H1004) <strong>Obstetric Panel:</strong> 80055, 80081 <strong>Pregnancy Test:</strong> 81025, 84702-84703 <strong>Sample CPT® codes</strong> to identify a postpartum care visit (Give date care started for bundled services.) <strong>Postpartum:</strong> 0503F, 57170, 58300, 59430, 99501 <strong>Postpartum Bundled Services:</strong> 59400, 59410, 59510, 59515, 59610, 59614, 59618, 59622 <strong>Cervical Cytology:</strong> 88141-88143, 88147-88148, 88150, 88152-88154, 88164-88167, 88174-88175</td>
<td></td>
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<tr>
<td></td>
<td><strong>Postpartum Care:</strong> Visit on or between 21-56 days after delivery</td>
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<tr>
<td>Measure</td>
<td>What Service Is Needed</td>
<td>What To Report (Sample Of Codes and/or Diagnoses)</td>
<td>Exclusions</td>
<td>Helpful Tips</td>
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</tr>
<tr>
<td><strong>Breast Cancer Screening (BCS)</strong></td>
<td>Mammography or 3D Tomosynthesis every two years</td>
<td><strong>Sample CPT Codes:</strong></td>
<td>Women who have had mastectomies (bilateral, two unilateral, or unilateral mastectomy with bilateral modifier.)&lt;br&gt;Patients in hospice, or using hospice services.&lt;br&gt;Patients with advanced illness and frailty.</td>
<td>Screenings are needed at least every two years to meet the measure.&lt;br&gt;The following types and methods of mammograms will meet the measure for compliance (screening, diagnostic, film, digital or digital breast tomosynthesis).&lt;br&gt;MRIs, ultrasounds, and biopsies do NOT meet the measure.</td>
</tr>
</tbody>
</table>

<p>| Women’s Health Measures                     | HEDIS codes can change from year to year. The codes in this document are from the HEDIS 2019 specifications. | 15                                                                 |</p>
<table>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Appropriate Treatment for Children with Upper Respiratory Infections (URI)</strong>&lt;br&gt;The percentage of children 3 months-18 years of age who were given a diagnosis of URI and were not dispensed an antibiotic prescription</td>
<td><strong>Goal:</strong> For the child not to be prescribed an antibiotic for a URI-only diagnosis</td>
<td><strong>Sample diagnoses (where antibiotics may be appropriate):</strong>&lt;br&gt;• Sinusitis (Acute/Chronic)&lt;br&gt;• Tonsillitis&lt;br&gt;• Bacterial Infection (unspecified)&lt;br&gt;• Pneumonia&lt;br&gt;• Otitis Media&lt;br&gt;• Whooping cough&lt;br&gt;• Pneumonia</td>
<td>Patients in hospice, or using hospice services.</td>
<td>Coding and documentation for noted bacterial infections along with the URI are important for this measure. <strong>If an antibiotic is given for a URI alone, a gap will open and it cannot be closed.</strong>&lt;br&gt;If a member’s condition does not improve and an antibiotic is indicated, a gap will not occur if the antibiotic is given greater than three days (i.e. day four or beyond) after the encounter when a URI was diagnosed.</td>
</tr>
<tr>
<td><strong>Appropriate Testing for Children with Pharyngitis (CWP)</strong>&lt;br&gt;The percentage of children 3-18 years of age who were diagnosed with pharyngitis, dispensed an antibiotic, and received a group A streptococcus (strep) test for the episode</td>
<td><strong>Goal:</strong> Patients need to have strep test done if they are diagnosed with pharyngitis only and have received an antibiotic prescription</td>
<td><strong>Sample diagnoses:</strong>&lt;br&gt;• Acute pharyngitis&lt;br&gt;• Acute tonsillitis&lt;br&gt;• Streptococcal pharyngitis&lt;br&gt;• Acute streptococcal tonsillitis&lt;br&gt;<strong>Sample CPT® Codes:</strong>&lt;br&gt;<strong>Group A strep test:</strong> 87070-87071, 87081, 87430, 87650-87652, 87880</td>
<td>Patients in hospice, or using hospice services.</td>
<td>This measure is focused on the member <strong>getting a strep test before they are given an antibiotic</strong> for a related pharyngitis dx (acute pharyngitis, acute tonsillitis, streptococcal pharyngitis, etc.). Compliance is <strong>not</strong> based on strep test result as long as the test was performed.&lt;br&gt;Including documentation of in-office strep test on the claim form is important in gap prevention for this measure.</td>
</tr>
</tbody>
</table>
## Childhood Immunization Status (CIS)

The percentage of children two years of age who had specified vaccines by their second birthday.

### Ten vaccine types or series to be completed prior to child’s second birthday:
- Must have received all doses for each vaccine.
  - Four DTaP (diphtheria, tetanus, and pertussis)
  - Three IPV (polio)
  - One MMR (measles, mumps and rubella)
  - Three HiB (haemophilus influenza type B)
  - Three hepatitis B (Hep B)
  - One hepatitis A (Hep A)
  - One varicella (chickenpox)
  - Four PCV (pneumococcal)
  - Two or three RV (rotavirus)
  - Two influenza (flu)

### Sample CPT® (and HCPCS) Codes:
- **DTap vaccine:** 90698, 90700, 90721, 90723
- **HiB vaccine:** 90644-90648, 90698, 90721, 90748
- **HepA vaccine:** 90633
- **Hep B vaccine:** 90723, 90740, 90744, 90747-90748, G0010 (HCPCS)
- **IPV vaccine:** 90698, 90713, 90723
- **Influenza vaccine:** 90655, 90657, 90661-90662, 90673, 90685, 90687, G0008 (HCPCS)
- **MMR vaccine:** 90707, 90710
- **Measles vaccine:** 90705
- **Measles/rubella vaccine:** 90708
- **Mumps vaccine:** 90704
- **Rubella vaccine:** 90706
- **Pneumococcal conjugate vaccine:** 90670, G0009 (HCPCS)
- **Rotavirus vaccine (2 dose schedule):** 90681
- **Rotavirus vaccine (3 dose schedule):** 90680
- **VZV (chickenpox) vaccine:** 90710, 90716

### Exclusions:
- Patients in hospice, or using hospice services.
- Children who had a contraindication for a specific vaccine.

### Helpful Tips:
- Schedule patients so that all immunizations are completed by 23 months of age.
- Give educational materials that reinforce your advisement on the importance of vaccinations.
- The two immunizations most often missing in the entire CIS series are: the two flu vaccines and the two or three rotavirus vaccines.

**Important note:** Since the first influenza immunization can be given at six months of age, the second vaccine for influenza can be a challenge for babies born in the fall of the year due to immunization time frames and availability of the vaccine; this may require extra visits and ordering extra vaccines.

VZV, MMR, and Hep A must be given on or between the child’s first and second birthday to be measure compliant.

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.

DTap, IPV, HIB, Pneumococcal and Rotavirus should be given at least 42 days after birth for compliance.
<table>
<thead>
<tr>
<th>Measure</th>
<th>What Service Is Needed</th>
<th>What To Report (Sample Of Codes and/or Diagnoses)</th>
<th>Exclusions</th>
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</tr>
</thead>
</table>
| **Immunizations for Adolescents (IMA)** | Must have received all doses for each vaccine on or before their 13th birthday:  
- One meningococcal - given on or between the 11th and 13th birthday  
- One Tdap (tetanus, diphtheria, and pertussis) - given on or between the 10th and 13th birthday  
- HPV: given on or between the ninth and 13th birthday | **Sample CPT Codes:**  
Meningococcal vaccine: 90644, 90734  
Tdap vaccine: 90715  
HPV vaccine: 90649-90651 | Patients in hospice, or using hospice services. Adolescents who had a contraindication to a specific vaccine. | 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 now 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.  
**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.
<table>
<thead>
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<th>Measure</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Weight Assessment/ Counseling for Nutrition and Physical for Children/ Adolescents (WCC)</td>
<td>All three components must be met for gap to close</td>
<td><strong>Nutrition Counseling and Surveillance:</strong> 97802-97804, G0270, G0271, G0447, S9449, S9452, S9470, Z71.3</td>
<td>Patients in hospice, or using hospice services. Female patients who had a diagnosis of pregnancy during the measurement year.</td>
<td>Visits that document BMI, counseling for nutrition or physical activity and are signed by an RN only are NOT acceptable.</td>
</tr>
<tr>
<td></td>
<td>• BMI percentile - Height, weight, and BMI percentile must be documented in the chart</td>
<td><strong>Physical Activity Counseling:</strong> G0447, S9451, Z02.5</td>
<td></td>
<td>For BMI:</td>
</tr>
<tr>
<td></td>
<td>• Counseling for nutrition</td>
<td><strong>BMI Percentile:</strong></td>
<td></td>
<td>A specific BMI percentile is the key here; it can be documented on an age-growth chart.</td>
</tr>
<tr>
<td></td>
<td>• Counseling for physical activity</td>
<td><strong>BMI &lt;5th Pctl for age:</strong> Z68.51</td>
<td></td>
<td>Use specific BMI percentiles that account for age and gender rather than absolute BMI.</td>
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<tr>
<td></td>
<td></td>
<td><strong>BMI 5th Pctl - &lt;85th Pctl:</strong> Z68.52</td>
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<td>Documentation that does NOT meet compliance:</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>BMI 85th Pctl - &lt;95th Pctl:</strong> Z68.53</td>
<td></td>
<td>• BMI value only</td>
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<td></td>
<td></td>
<td><strong>BMI Greater Than or Equal to 95th Pctl:</strong> Z68.54</td>
<td></td>
<td>• Height and weight only</td>
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<td><strong>Note:</strong> BMI percentile can be plotted on a BMI chart as well as documented in the record as a percentile. Either is acceptable.</td>
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<td>• A general range of percentile is not specific enough (e.g. &lt;85 percent).</td>
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<td>For Nutrition:</td>
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<td>Documentation of:</td>
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<td></td>
<td>• Discussions about current nutrition behaviors, such as “eats a well-balanced diet with fruits and vegetables”</td>
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<td>• Providing and discussing educational materials on nutrition during the face-to-face visit</td>
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<td>• Weight or obesity counseling</td>
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<td></td>
<td>• The assessment of current eating habits and dieting behaviors</td>
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<td>• Counseling on diet or eating habits, any educational resources provided, or nutrition referrals made</td>
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<td>Documentation of “picky eater” does NOT meet the intent of the measure.</td>
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<td>For Physical Activity:</td>
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<td>Documentation of:</td>
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<td>• Discussions about current physical activity behaviors, such as “exercise routines, participation in sports activities”</td>
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<td>• Sports physical exam completion during visit</td>
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<td></td>
<td>• Counseling or referral for physical activity</td>
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<td></td>
<td></td>
<td>• Weight or obesity counseling</td>
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<td></td>
<td>Documentation of “decrease screen time” or “participates in after school activity” does NOT meet the intent of the measure.</td>
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<td>Guidance should include recommendations on types and amounts of physical activity – not counseling solely related to safety during physical activity.</td>
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</tbody>
</table>

Note: BMI percentile can be plotted on a BMI chart as well as documented in the record as a percentile. Either is acceptable.
<table>
<thead>
<tr>
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<th>Exclusions</th>
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</tr>
</thead>
</table>
| Well Child Visits in The First Fifteen Months of Life (W15) | **Target:** At least five to six well-child visits  
**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 | Services specific to an acute or chronic condition do not count toward the measure, but they can be rendered during the same visit as these preventive services.  
Patients in hospice, or using hospice services. | Visits for acute or chronic conditions do NOT meet the measure intent, but they 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, physical history, mental history, physical exam, and health education/anticipatory guidance.  
Stating “Well developed, well nourished” will NOT meet the intent of the measure; it must be specific. |
| Well Child Visits in the Third, Fourth, and Sixth Years of Life (W34) | **Target:** A yearly well-child visit from ages 3-6  
**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 | Services specific to an acute or chronic condition do not count toward the measure, but they can be rendered during the same visit as these preventive services.  
Patients in hospice, or using hospice services. | Visits for acute or chronic conditions do NOT meet the measure intent, but they 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, physical history, mental history, physical exam, and health education/anticipatory guidance.  
Stating “Well developed, well nourished” will NOT meet the intent of the measure; it must be specific. |
<table>
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<th>Exclusions</th>
<th>Helpful Tips</th>
</tr>
</thead>
</table>
| Adolescent Well-Care Visits (AWC) | Target: A yearly well-care visit from ages 12-21 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 | Services specific to an acute or chronic condition do not count toward the measure, but they can be rendered during the same visit as preventive services.  
Patients in hospice, or using hospice services. | Visits for acute or chronic conditions do NOT meet the measure intent, but they can be rendered during the same visit as preventive services. 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. |
**Follow-up Care for Children Prescribed ADHD/ADD Medication (ADD)**

The percentage of children 6-12 years of age newly prescribed ADHD medication who had at least three follow-up care visits within a 10-month period

**Note:** The first visit must be within 30 days of the medication dispense date.

<table>
<thead>
<tr>
<th>Measure</th>
<th>What Service Is Needed</th>
<th>What To Report (Sample Of Codes and/or Diagnoses)</th>
<th>Exclusions</th>
<th>Helpful Tips</th>
</tr>
</thead>
</table>
| Initial follow-up visit: Within 30 days of filling medication | **Commonly Prescribed ADHD Medications:**  
  - CNS stimulants:  
    - Amphetamine  
    - Demethylphenidate  
    - Dextroamphetamine  
    - Lisdexamfetamine  
    - Methamphetamine  
    - Methylphenidate  
  - Alpha-2 receptor agonists:  
    - Clonidine  
    - Guanfacine  
  - Miscellaneous ADHD medications:  
    - Atomoxetine  
  **Sample CPT® Codes for ADD:**  
  **Telephone visit:** 98966-98968, 99441-99443 | Patients who have a diagnosis of narcolepsy, who are in hospice, or using hospice services. | A patient is considered to have a “newly prescribed” medication if this is the first time they have filled an ADD medication, or they have had no documentation of filling an ADD medication in the past 90 days (negative medical history for 120 days) (Ex: taking a summer hiatus from the ADD meds—last filled in May, new fill in Sept.). Children who take medication vacations resulting in prescription gaps of greater than 90 days (negative medical history for 120 days) will need to start the follow-up cycle again as if the prescription were new. |
### Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)

The percentage of adolescent and adult patients 13 years of age and older with a NEW episode of alcohol or other drug dependence who initiated treatment and had follow-up services

**Initiation of treatment:** Outpatient visit, intensive outpatient encounter, partial hospitalization or inpatient (alcohol or drug) admission within 14 days of the diagnosis AND

**Continued treatment:** Those who initiated treatment and had two or more additional services for (alcohol or drug) within 34 days of the initial visit

**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
- Other stimulant use

**Exclusions:**
Patients in hospice, or using hospice services.

**Helpful Tips:**
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 for the initiation phase.
<table>
<thead>
<tr>
<th>Measure</th>
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</tr>
</thead>
</table>
| **Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)** | • At least one test for blood glucose or HbA1c  
• At least one test for LDL-C or cholesterol test | | Patients who are in hospice, or using hospice services. | |
| | | | | |
| **Use of First-Line Psychosocial Care for Children and Adolescents (APP)** | Documentation of psychosocial care conducted, (can be telehealth), sometime between the 90 days prior to the patient filling medication through 30 days after the patient fills medication | | Patients who are in hospice, or using hospice services.  
Patients who were hospitalized or had two or more OP visits for diagnosis of Schizophrenia, Bipolar Disorder, other psychosocial and development disorders (Autism). | |
### Follow-up After Hospitalization for Mental Illness (FUH)

The percentage of discharges for patients six years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health practitioner.

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td><strong>Time range for follow-up:</strong> rates are measured for patients who received follow-up care within the following two time frames.</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>• Within seven days of discharge</td>
<td><strong>Sample Diagnoses:</strong></td>
<td>Patients in hospice, or using hospice services.</td>
<td>The follow-up visits for this measure MUST be with a mental health practitioner. Do not include visits that occur on the date of discharge.</td>
</tr>
<tr>
<td></td>
<td>• Within 30 days of discharge</td>
<td>• Dementia</td>
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<tr>
<td></td>
<td></td>
<td>• Schizophrenia</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• Schizoaffective disorder</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• Manic episode</td>
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<td></td>
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<tr>
<td></td>
<td></td>
<td>• Bipolar disorder</td>
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<td></td>
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<tr>
<td></td>
<td></td>
<td>• Major depressive disorder</td>
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<td></td>
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<tr>
<td></td>
<td></td>
<td>• Post-traumatic stress disorder</td>
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<td></td>
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<tr>
<td></td>
<td></td>
<td>• Attention-deficit hyperactivity disorder</td>
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<tr>
<td></td>
<td></td>
<td>• Mental illness</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Intentional self-harm</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Sample CPT® Codes for follow-up with a mental health practitioner:**

**CPT Codes:** 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99408-99409, 99411-99412, 99510


**Transitional care management 7 Day:** 99496

**Transitional care management 14 Day:** 99495

**Note:** Additional codes may apply dependent on provider type and point of service.
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</table>
| **Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)** | Time range for follow-up: rates are measured for patients who received follow-up care within the following two time frames.  
- Within seven days of ED visit  
- Within 30 days of ED visit | | Patients in hospice, or using hospice services. | This is an episodes-based measure; 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, = 3 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. |
<table>
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</tr>
</thead>
</table>
| **Follow-up After Emergency Department Visit for Mental Illness (FUM)** | Same information goes in what service is needed column as for the FUA measure above. | 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, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99408-99409, 99411-99412,99510  
Transitional care management 7 Day: 99496  
Transitional care management 14 Day: 99495  
Note: Additional codes may apply dependent on provider type and point of service. | Patients in hospice, or using hospice services. | This is an episodes based measure;  
A member could be in this measure as many times as the criteria is met. (Ex: 3 visits to ED for mental illness, each greater than 30 days apart, = 3 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. |
## Antidepressant Medication Management (AMM)

The percentage of patients 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment.

**Treatment phases:** Patient compliance is based on the two following phases:
- **Acute phase:** Remain on antidepressant for 12 weeks or more
- **Continuation phase:** Remain on antidepressant for at least six months

### 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

**Exclusions:**

- Patients in hospice, or using hospice services.

**Helpful Tips:**

- Patients who have filled their antidepressant medication enough times to have 180 days supply of medication since diagnosis/first fill of Rx 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.
- Explore possible reasons for your patients’ medication non-compliance (i.e. cost, denial, depression, substance use/abuse).
Best Practices and Processes Behind the CAHPS Survey

CAHPS is an acronym for the Consumer Assessment of Healthcare Providers and Systems. It’s a survey used to capture member perceptions of their care from their personal providers and their health plan. Each year, from February to April, we work with an NCQA certified vendor to send the survey and collect responses from randomly selected members.

Protocol Process

BlueCross BlueShield of Tennessee chose mail/telephone/Internet protocol with pre-notification postcard

1. Pre-notification postcard mailed (optional)
2. Questionnaire with cover letter and business reply envelope (BRE) mailed
3. First reminder postcard mailed
4. Replacement questionnaire with cover letter and BRE to all non-responders
5. Second reminder postcard mailed
6. Telephone interviews conducted with non-responders (minimum of three/max of six attempts)
Survey Questionnaire Examples
In the last 12 months, did you get care from a doctor or other health provider besides your personal doctor?
___Yes ___No > If No, Go to question 23

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?
___Never ___Sometimes ___Usually ___Always

Categories Included in the Survey
- Getting Care Quickly
- Shared Decision Making
- How Well Doctors Communicate
- Getting Needed Care
- Customer Service
- Plan Information on Costs
- Claims Processing
- Care Coordination
- Rating of Health Care
- Rating of Personal Doctor
- Rating of Specialist
- Rating of Health Plan

Best Practice Tips
Improved patient experiences and outcomes lead to healthier, more satisfied patients. Here are some suggestions on how you can help to improve scores:

- Ask patients at every visit if they have had any care from another doctor or health care provider, including physical therapy, home health, hospitalizations, etc.
- Explain to patients the importance of keeping you up-to-date on all of their health care episodes and medications
- Patients tend to give their doctors higher scores when they perceive that their doctor does the following:
  - Explains things in a way that was easy to understand
  - Listens to their concerns
  - Spends time with them
  - Involves them in shared-decision making about treatment options

How We Are Making a Difference
We use these communication channels to encourage members to keep you informed on all their health care updates:

- Educational tools like the member scorecard
- Live, real-time discussions on member calls
- Enhancing digital technology so members know the cost estimates for procedures, visits and medications, and helping them find providers in their areas.
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HCPCS is the Healthcare Common Procedure Coding System.

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