HEDIS information guide 2023

Geisinger

Questions? Here's who to call.

Online services

NaviNet® for provider information and resources — *NaviNet.navimedix.com*

Instamed for electronic claim submission and payment transactions. 866-467-8263
Instamed.com

Claims

Call the customer care team with claims questions that cannot be resolved through NaviNet or Instamed.

Provider claims. 800-447-4000

Benefits and eligibility

Call for member benefits and eligibility unable to be found via NaviNet®.

HMO/PPO.....800-447-4000

PPO/TPA 800-504-0443

Geisinger Gold 800-498-9731

GHP Family 855-227-1302

GHP Kids (CHIP). 866-621-5235

EMHS TPA. 855-863-2429

AtlantiCare TPA. 866-379-4465

St. Luke's TPA. 866-580-3531

Exchange.....866-379-4489

Geisinger employees.....844-568-5229

Wise Foods.....844-260-8028

AON. 844-390-8332

Performance Guarantee. 844-863-6850
(Bucknell, FEDS, PA Trst, PEBTF, Walmart)

Behavioral health 888-839-7972

PA Relay 711 for hearing impaired

Quality and accreditation

Call for medical record chart review and HEDIS specification questions.

Quality and accreditation. 866-847-1216

Provider account management

Talk to your provider account manager about your contract, pay-for-quality programs and educational opportunities.

Provider account management 800-876-5357
GHPAccountMngt@Geisinger.edu

Medical management

Contact medical management to request precertification/prior authorization for things like inpatient admissions, outpatient rehabilitation, home health & hospice, SNF or DME.

Medical management. 800-544-3907

Non-emergent ambulance. 844-749-5860

Pharmacy department

Call the pharmacy department for formulary exceptions, drug authorization and prescription drug information.

Pharmacy department. 800-988-4861

GHP Family pharmacy department. 855-552-6028

Case management

Contact case management for assistance with care coordination.

Case management. 800-883-6355

GHP Family Special Needs Program
(SNP) unit. 855-214-8100

Dental services

Connect patients with dentists, oral health education from public health dental hygienists and other local resources.

Dental line..... 833-589-2194

What is HEDIS?

HEDIS®[1] (Healthcare Effectiveness Data and Information Set) is a set of standardized performance measures designed by the National Committee for Quality Assurance (NCQA) to help purchasers and consumers make reliable comparison of organization performance. NCQA is an independent, non-profit organization that accredits and certifies a wide range of health care organizations and manages the evolution of HEDIS, the performance measurement tool used by more than 90 percent of the nation's health plans. HEDIS allows for standardized measurement, standardized reporting and accurate objective side- by-side comparisons. For more information, visit **ncqa.org.**

How to be a Medicare Quality Superstar

What are the Medicare Star Ratings?

The Medicare Star Ratings were created by the Centers for Medicare & Medicaid Services (CMS). The Star Ratings system evaluates the relative quality of private health plans that offer services to Medicare beneficiaries. CMS scores health plans on a one- to five-Star Rating. Five Stars represents the highest Rating possible for a plan to achieve in a given year. Star Ratings provide Medicare consumers and their families with information about quality of care and to help them make good decisions when choosing a health plan.

Why are Medicare Star Ratings so important?

- They help members make informed decisions about health plans
- They aid members in choosing health plans with higher quality
- They promote an overall higher quality of care for members

Many of the indicators that make up the health plan's overall Star Ratings are based on the patient-physician relationship, related outcomes, and member perceptions of care and treatment.

A measure with a ★ icon in this Guide is a measure that contributes to CMS Star Ratings.

Follow these quick tips to become a Medicare quality superstar!

Schedule all important preventive care as soon as possible. For example:

- Colorectal cancer screenings
- Breast cancer screenings
- Diabetes care
- Care aimed at controlling hypertension

Make sure members are receiving appropriate and timely care.

- Perform and document pain assessments.
- Perform and document medication reconciliation (especially post-discharge from an inpatient/acute event).
- Consider a statin therapy regimen for members with cardiovascular disease and diabetes.
- Promote and encourage medication adherence.
- Providing information about bladder control, reducing the risk of falling, and monitoring physical activity.

[1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

What is CAHPS?

NCQA and CMS require health plans to administer a member satisfaction survey (Consumer Assessment of Healthcare Providers and Systems, or CAHPS®[2]). Survey results are collected annually and compared to national benchmarks. The surveys are conducted in early spring by mail and followed up by phone to non-responders. Results are available later in the summer for commercial and Medicaid health plans and later in the year for Medicare.

The CAHPS survey is a key component of the Medicare Star Ratings program, currently representing almost one-third of the health plan'soverall Star Rating. The survey asks members and consumers to report on and evaluate their experiences with healthcare.CAHPS covers topics that are important to consumers and focuses on aspects of quality consumers are most qualified to address. Each member is surveyed to gauge their satisfaction with services provided by the health plan and their perceptions of healthcare provider accessibility, the member-physician relationship and healthcare provider communication.

Multiple questions relate to member satisfaction with physicians. These pertain to the member-physician relationship and can highlight opportunities for improvement in everyday practice.

The CAHPS survey also contains questions about the health plan, the prescription drug plan, and the administration of those services.

Quick tips to help you boost your CAHPS ratings

Don't keep your members waiting too long.

- Has the member been in the waiting room for more than 15 minutes?

Get to know your members' special needs.

- Accommodate those who are frail, elderly, non-English-speaking or who have a disability.

Keep in touch with your members.

- Reach out to members who have not been seen.
- Allow extra time during appointments for questions and answers.
- Make sure each member has an annual wellness visit and completes all needed tests and screenings.
- Follow up with all test results and future appointments.

Schedule appointments appropriately.

- Urgent care – less than 24 hours
- Non-urgent care – within 1 week
- Routine/preventive care – within 1 month

[2] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

What is the Health Outcomes Survey?

The Health Outcomes Survey, or HOS, is a survey instrument that assesses members' health status and changes over time. All health plans with Medicare contracts are required to implement HOS. The survey is administered annually to a random sample of Medicare beneficiaries drawn from each health plan. A baseline survey is administered to a new cohort, or group, each year. Two years later, these same respondents are surveyedagain (i.e., follow-up measurement).

Among a variety of measures, the HOS is used to collect three HEDIS® effectiveness-of-care measures:

- Management of Urinary Incontinence in Older Adults
- Physical Activity in Older Adults
- Fall Risk Management

These measures are currently included in the Medicare Star Ratings program.

To address these measures effectively, be sure to:

- Talk to your patients about urinary incontinence. Offer them strategies to ease their concerns.
- Discuss physical activity levels with your patients. As appropriate, advise them to start, increase, or maintain their physical activity.
- Assess your patients for level of fall risk. Offer strategies to support improved balance and to avoid falls.

What is a Provider's Role in HEDIS?

Providers play an essential role in promoting the health of our members. Your office can help increase HEDIS scores by discussing the importance of preventive health screenings and exams with our members. Some HEDIS measures are included in our pay-for-performance programs, so improving care in areas measured by HEDIS may positively impact your payout for these programs. Most importantly, reinforcing preventive care compliance with our members will ultimately improve their health outcomes.

You can assist by doing the following:

- Submit complete claim/encounter data for each service rendered.
- Chart documentation must reflect all services billed.
- Accurately code all claims. Since HEDIS measures are linked to specific coding criteria, accurate coding is critical. Providing accurate information may also reduce the number of records requested.
- Consider including CPT II codes to reduce medical record requests. These codes provide details currently only found in the chart such as blood pressure and lab results.
- Avoid missed opportunities by taking advantage of sick care visits; combine the well visit components and use a modifier and proper codes to bill for both the sick and well visit.
- Routinely schedule a member's next appointment while in the office for the visit.
- Respond promptly to our requests for medical records.
- Encourage members to get preventive screenings, such as those for cervical cancer, mammography, and colorectal cancer.

What's New for 2023?

This Guide contains measures relevant to HEDIS, Medicare Star Ratings, the Pennsylvania Performance Measure (PAPM) Program, the Geisinger Pay-for-Quality (P4Q) CY 2023 Program, and the Physician Quality Summary (PQS) Program. Each year, the Guide takes into account measure additions, deletions, and revisions as measures change to best fit best practices. Below are the measure-level changes made in 2023.

New Measures

- Oral Evaluation, Dental Services (OED)
- Topical Fluoride for Children (TFC)
- Deprescribing of Benzodiazepines in Older Adults (DBO)

Additional Changes

The Guide now contains information regarding Provider Attribution. Please see the Appendices for more information.

Global Exclusions

Beginning with measurement year 2023, members are excluded from all measures if:

- They use hospice services or elect to use a hospice benefit any time during the measurement year
- Member is deceased any time during the measurement year, except for Utilization measures such as Well-Child Visits in the First 30 Months of Life and Child and Adolescent Well-Care visits.

Cross-cutting Exclusions

Regarding exclusions for hospice, deceased members, palliative care, I-SNP, LTI, advanced illness and/or frailty: The palliative care, advanced illness, frailty and long-term nursing home residence exclusions are specified in HEDIS measures where the services being captured may not be of benefit for this population or may not be in line with patients' goals of care.

Within the Guide, the measure will note the cross-cutting exclusion and will reference the appropriate Appendix.

Performance Measures

Prevention and Screenings

Children and Adolescents

Prenatal and Postpartum Screenings

Behavioral Health

Medication and Transitional Care Management

Chronic Condition Management

Overuse and Appropriateness

Appendices

Annual Wellness Visit (AWV) — Medicare, PQS

The percentage of Medicare members that had one Annual Wellness Visit (AWV) on or before December 31 of each year. Please see the CMS MLN Educational Tool for Medicare Wellness Visits for more information. http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlngeninfo

Frequently utilized provider best practices

- Allow enough time for the visit.
- For a member's initial AWV, CMS requires:
  - A Health Risk Assessment (HRA)
  - Establishment of current providers and suppliers list
  - Detection of possible cognitive impairment
  - Establishment of a patient written screening schedule
  - Risk factor review
  - Personalized health advice and referrals
  - Advanced Care Planning, at member's discretion
  - All from regular Annual Visits
- For regular Annual Visits, CMS requires the provider to, at a minimum:
  - Collect and document the member's medicaland social history, including:
    - Past medical and surgical history (illness experiences, hospital stays, operations, allergies, injuries, and treatments)
    - Current medications and supplements (including calcium and vitamins)
    - Family history (review patient's family and medical events, including hereditary conditions that place them at increased risk)
    - Diet
    - Physical activities
    - Alcohol, tobacco, and illegal drug use history
  - Review patient's potential depression risk factors, including current or past experiences with depression or other mood disorders
  - Review patient's functional ability and safety level. At a minimum, assess:
    - Ability to perform activities of daily living (ADLs)
    - Fall risk
    - Hearing impairment
    - Home safety
    - Physical exam including Height, Weight, BMI, Blood Pressure, and Visual acuity
  - End-of-life planning with patient agreement
  - Current opioid prescription use

Common codes for this measure
(Note: Codes listed are subject to plan coverage and contracted fee schedule.)

Service	Codes		Description
Medicare Annual Wellness Visit	**HCPCS:**	G0438	Annual wellness visit; includes a personalized prevention plan of service (PPS), initial visit
		G0439	Annual wellness visit includes a personalized prevention plan of service (PPS), subsequent visit
		G0468	Federally qualified health center (FQHC) visit, IPPE or AWV; a FQHC visit that includes an initial preventive physical examination (IPPE) or annual wellness visit (AWV) and includes a typical bundle of Medicare-covered services that would be furnished per diem to a member receive an IPPE or AWV. (Only valid when billed with location code 50, for our contracted FQHC providers)

Breast Cancer Screening (BCS) ★

Commercial, Exchange, Medicaid, Medicare, PQS

The percentage of women 50 – 74 years of age who had a mammogram between October 1 of the year prior to the measurement year and December 31 of the measurement year.

Frequently utilized provider best practices

- Educate members about the importance of early detection and encourage testing.
- Do not miss the opportunity to schedule a mammogram for the member during the office visit.
- Make a list of available facilities for members to choose where they would like to have themammogram.
- Discuss possible fears the member may have about mammograms and explain current testing process are less uncomfortable and require less radiation.
- Ensure transgender men are appropriately included.
- Document mastectomies in the medical record.

Common codes for this measure
(Note: Codes listed are subject to plan coverage and contracted fee schedule.)

Description	Codes	
Mammography	**CPT:**	77061, 77062, 77063, 77065, 77066, 77067

Exclusions

- Members who had a bilateral mastectomy, unilateral mastectomy with bilateral modifier, two unilateral mastectomies, or a history of bilateral mastectomy. Coding accuracy is critical to exclusion.

See Appendix 1 for frailty, advanced illness, and palliative care exclusion codes and dementia medications.

Cervical Cancer Screening (CCS)

Commercial, Exchange, Medicaid, PQS

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

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

Frequently utilized provider best practices

- Request to have the results of Pap and hrHPV tests sent to you, if they were performed at OB/GYN visits.
- Document in the medical record if the member has had a hysterectomy with no residual cervix.

Common codes for this measure
(Note: Codes listed are subject to plan coverage and contracted fee schedule.)

Description	Codes	
Cervical Cytology	**CPT:**	88141, 88142, 88143, 88147, 88148, 88150, 88152, 88153, 88164, 88165, 88166, 88167, 88174, 88175
	HCPCS:	G0123, G0124, G0141, G0143, G0144, G0145, G0147, G0148,P3000, P3001, Q0091
HPV	**CPT:**	87624, 87625
	HCPCS:	G0476

Common Chart Deficiencies

- Documentation of hysterectomy alone does not meet guidelines as an exclusion. Documentation must note either no residual cervix, cervical agenesis or acquired absence of cervix. Documentation of a Total Abdominal Hysterectomy or a Total Laparoscopic Hysterectomy is also acceptable.
- Do not use active cancer codes for screenings unless member is actively being treated for cancer.

Exclusions

- Hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix.

See Appendix 1 for palliative care exclusion codes.

Colorectal Cancer Screening (COL) ★

Commercial, Exchange, Medicaid, Medicare, PQS

The percentage of members 45 to 75 years of age who had appropriate screening for colorectal cancer:

- Colonoscopy between the measurement year and nine (9) years prior.
- Flexible sigmoidoscopy or CT colonography between the measurement year and five (5) years prior.
- FIT/DNA Cologuard between the measurement year and two (2) years prior.
- Fecal occult blood test in the measurement year.

Frequently utilized provider best practices

- Recommend FOBT/FIT-DNA as an alternative to colonoscopy when necessary.
- Use standing orders and empower office staff to distribute FOBT or FIT kits to members who need colorectal cancer screening or to prepare referral for colonoscopy.

Common codes for this measure
(Note: Codes listed are subject to plan coverage and contracted fee schedule.)

Description	Codes	
Colonoscopy	**CPT:**	44388, 44389, 44390, 44391, 44392, 44393, 44394, 44397, 44401, 44402, 44403, 44404, 44405, 44406, 44407, 44408, 45355, 45378, 45379, 45380, 45381, 45382, 45383, 45384, 45385, 45386, 45387, 45388, 45389, 45390, 45391, 45392, 45393, 45398
	HCPCS:	G0105, G0121
Flexible Sigmoidoscopy	**CPT:**	45330, 45331, 45332, 45333, 45334, 45335, 45337, 45338, 45340, 45341, 45342, 45346, 45347, 45349, 45350
	HCPCS:	G0104
CT Colonography	**CPT:**	74261, 74262, 74263
FIT - DNA (Cologuard)	**CPT:**	81528
FOBT	**CPT:**	82270, 82274
	HCPCS:	G0328

Common chart deficiencies

- Not labeling scanned colonoscopies in EMR clearly
- Not documenting and updating dates of screenings/colonoscopies in chart
- Not documenting historic colonoscopies or other services for members who changed care/ health plan

Exclusions

- Members who had colorectal cancer or a total colectomy any time prior to December 31 of the measurement year

See Appendix 1 for frailty, advanced illness, palliative care exclusion codes.

ColorectalCancer	**ICD10:**	C18.0, C18.1, C18.2, C18.3, C18.4, C18.5, C18.6, C18.7, C18.8,C18.9,C19, C20, C21.2, C21.8, C78.5, Z85.038, Z85.048
Total Colectomy	**CPT:**	44150, 44151, 44152, 44153, 4415, 44156, 44157, 44158, 44210, 44211, 44212
	ICD10:	0DTE0ZZ, 0DTE4ZZ, 0DTE7ZZ, 0DTE8ZZ

Care for Older Adults (COA) ★

Special Needs Plans (SNP): Dual-Eligible

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

- Medication review
- Functional status assessment
- Pain assessment

Frequently utilized provider best practices

- For Medication Review, document "Medication List reconciled" as a best practice.
- Services rendered during a telephone visit, e-visit or virtual check-in meet criteria for functional status and pain assessment
- Document how the patient ambulates into the office, arrives, etc.
- Review hearing, vision, etc. under review of systems.
- Incorporate the use of a standardized functional status tool
- Use CPT II codes to capture completed services and avoid chart requests.

Common codes for this measure

(Note: Codes listed are subject to plan coverage and contracted fee schedule.)

Description		Codes
**For Medication Review, one code from the Medication review list and one code from the Medication list during the same visit are required. The review must be conducted by a prescribing practitioner or a clinical pharmacist.*		
***Medication review**	**CPT:**	90863, 99483, 99605, 99606
	CPT II:	1160F
****Medication list***	**CPT II:**	1159F
	HCPCS:	G8427
Functional status assessment	**CPT:**	99483
	CPT II:	1170F
	HCPCS:	G0438, G0439
Pain assessment	**CPT II:**	1125F, 1126F

Common chart deficiencies

- Not documenting and coding for relevant conversations that take place during visits
- Documenting "normal" under eyes, nose, etc. does not count as a full assessment
- Not documenting that a member is not taking any medication and the date it is noted
- Not documenting the Activities of Daily Living (ADL) or the Instrumental Activities of Daily Living (IADL)
- Notation alone of a pain management plan or a pain treatment plan
- Documentation of chest pain alone

Exclusions

See Appendix 1 for palliative care exclusion codes.

Chlamydia Screening in Women (CHL)

Commercial, Exchange, Medicaid, PQS

The percentage of women 16 – 24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.

Members are eligible for this measure if they have claims indicating sexual activity during the measurement year, including codes for pregnancy or pregnancy testing, sexual activity, or use of contraceptive medications.

Frequently utilized provider best practices

- Perform chlamydia screening every year on every female age 16 – 24 years (use anyvisit opportunity).
- Add chlamydia screening as a standard lab for women 16 – 24 years old. Use well-child exams and well-women exams for this purpose.
- Chlamydia screening may be performed through a urine test.

Common codes for this measure
(Note: Codes listed are subject to plan coverage and contracted fee schedule.)

Description	Codes	
Chlamydia screening	**CPT:**	87110, 87270, 87320, 87490, 87491, 87492, 87810

Common medications for this measure
(Note: Medications listed are subject to plan coverage and contracted fee schedule.)

Contraceptive Medications	
Description	**Prescription**
Contraceptives	Desogestrel-ethinyl estradiol Dienogest-estradiol (multiphasic) Drospirenone-ethinyl estradiol Drospirenone-ethinyl estradiol-levomefolate (biphasic) Ethinyl estradiol-ethynodiol Ethinyl estradiol-etonogestrel Ethinyl estradiol-levonorgestrel Ethinyl estradiol-norelgestromin Ethinyl estradiol-norethindrone Ethinyl estradiol-norgestimate Ethinyl estradiol-norgestrel Etonogestrel Levonorgestrel Medroxyprogesterone Mestranol-norethindrone Norethindrone
Diaphragm	Diaphragm
Spermicide	Nonxynol 9

Exclusions

- A pregnancy test during the measurement year and a prescription for the Retinoid isotretinoin on the date of the pregnancy test or 6 days after the pregnancy test.
- A pregnancy test during the measurement year and an x-ray on the date of the pregnancy test or 6 days after the pregnancy test.

Controlling High Blood Pressure (CBP) ★

Commercial, Exchange, Medicaid, Medicare, P4Q

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

Frequently utilized provider best practices

- Do not round up a BP result.
- Use CPT II codes when billing office visits to capture blood pressure results, eliminating the need for chart review.
- Telephone visits, e-visits and virtual check-ins are appropriate settings for BP readings when member-reported BPs are taken with a digital device and recorded in the chart.
- For P4Q, ensure African American members have their BP checked before the end of each year.

Common codes for this measure
(Note: Codes listed are subject to plan coverage and contracted fee schedule.)

Description	Codes	
Essential hypertension	**ICD10:**	I10
Systolic <130	**CPT II:**	3074F
Systolic 130-139	**CPT II:**	3075F
Diastolic < 80	**CPT II:**	3078F
Diastolic 80-89	**CPT II:**	3079F

Exclusions

- Members with evidence of end-stage renal disease (ESRD), dialysis, nephrectomy, or kidney transplant any time during the member's history on or prior to December 31 of the measurement year
- Members with a diagnosis of pregnancy any time during the measurement year

See Appendix 1 for frailty, advanced illness, and palliative care exclusion codes and dementia medications.

Social Determinants of Health Screening (SDOH)

Medicaid PCMH

Social determinants of health identifies the member's needs and any deterrents to receiving quality care.

Frequently utilized provider best practices

- Complete a social determinants of health assessment annually at the member's first visit of the year with G9919 (positive) or G9920 (negative) Procedure Code claims, including ICD-10 Z-codes when relevant.
- Have the member complete a questionnaire upon check-in: www.neighborlypa.com
- Address the following with the assessment;
  - Education, literacy and language
  - Employment
  - Housing security
  - Social and mental health
  - Experience with crime and violence, including domestic violence
  - Family and social support issues
  - Economic hardship
- If screening is positive, screen again at next visit and update ICD-10 code as necessary.
- Ask member if they desire assistance with any positive findings and document member response.
- Connect member with community resources.
- Warm handoff to care coordinator or behavioral health consultant.

Social Determinants of Health Screening

Code	Description
G9919	Screening performed and positive
G9920	Screening performed and negative

Education, literacy and language

Code	Description
Z55.0	Illiteracy and low-level literacy
Z55.1	Schooling unavailable or unattainable
Z55.2	Failed school examinations
Z55.3	Underachievement in school
Z55.4	Educational maladjustment and discord with teachers and classmates
Z55.8	Other problems related to education and literacy
Z55.9	Problems related to education and literacy, unspecified

Employment

Code	Description
Z56	Problems related to employment and unemployment
Z56.0	Unemployment
Z56.1	Change of job
Z56.2	Threat of job loss
Z56.3	Stressful work schedule
Z56.4	Discord with boss and workmates
Z56.6	Other physical and mental strain related to work
Z56.82	Military deployment status
Z56.89	Other problems related to employment
Z56.9	Unspecified problems related to employment

Housing security

Code	Description

	Z59.0	Homelessness
	Z59.1	Inadequate housing
	Z59.2	Discord with neighbors, lodgers or landlord
	Z59.8	Other problems related to housing and economic circumstances
	Z59.9	Problem related to housing and economic circumstances, unspecified
Economic hardships (resources and materials)	Code	Description
	Z59	Problems related to housing and economic circumstances
	Z59.4	Lack of adequate food and safe drinking water
	Z59.5	Extreme poverty (100% FPL or below)
	Z59.6	Low income (200% FPL or below)
	Z59.7	Insufficient social insurance and welfare support
	Z91.120	Member intentionally under-dosing medication regimen due to financial hardship
Social health	Code	Description
	Z60	Problems related to social environment
	Z60.0	Problems of adjustment to life-cycle transitions
	Z60.2	Problems related to living alone
	Z60.3	Acculturation difficulty
	Z60.4	Social exclusion and rejection
	Z60.5	Target of (perceived) adverse discrimination/persecution
	Z60.8	Other problems related to social environment
Psychosocial and stress	Code	Description
	Z64	Problems related to certain psychosocial circumstances
	Z65	Problems related to other psychosocial circumstances
	Z73	Problems related to life management difficulty
	Z73.3	Stress, not elsewhere classified
Experiences with crime, violence and the judicial system	Code	Description
	Z65.0	Conviction in civil and criminal proceedings without imprisonment
	Z65.1	Imprisonment and other incarceration
	Z65.2	Problems related to release from prison
	Z65.3	Problems related to other legal circumstances
	Z65.4	Victim of crime and terrorism
	Z65.5	Exposure to disaster, war and other hostilities
Safety and domestic violence	Code	Description
	Z60.4	Social exclusion and rejection
	Z62.8	Other specified problems related to upbringing
	Z62.81	Personal history of abuse in childhood
	Z62.810	Personal history of physical and sexual abuse in childhood

	Z62.811	Personal history of psychological abuse in childhood
	Z62.812	Personal history of neglect in childhood
	Z62.819	Personal history of unspecified abuse in childhood
	Z91.41	Personal history of adult abuse
	Z91.410	Personal history of adult physical and sexual abuse

Family and social support issues

Code	Description
Z63	Other problems related to primary support group, including family circumstances
Z63.0	Problems in relationship with spouse or partner
Z63.1	Problems in relationship with in-laws
Z63.31	Absence of family member due to military deployment
Z63.32	Other absence of family member
Z63.4	Disappearance and death of family member
Z63.5	Disruption of family by separation and divorce
Z63.6	Dependent relative needing care at home
Z63.71	Stress on family due to return of family member from military deployment
Z63.72	Alcoholism and drug addiction in family
Z63.79	Other stressful life events affecting family and household
Z63.8	Other specified problems related to primary support group
Z63.9	Problem related to primary support group, unspecified

Common chart deficiencies
- Not coding with the ICD-10 for the assessment

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

Commercial, Exchange, Medicaid, P4Q, PQS

The percentage of members who had the following number of well-child visits with a PCP during the first 30 months of life. Two rates are reported:

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

Visits with a physician, nurse practitioner, or physician assistant all meet criteria.

Frequently utilized provider best practices

- Submit appropriate codes for a well-visit in person versus an e-visit (Medicaid - use EP modifier).
- Complete and code for developmental screening (Medicaid - use EP modifier).
- Complete and code for lead testing prior to 24 months (Medicaid - use EP modifier)
- A sick visit and well-visit can be performed on the same day by using modifier 25.
- Not applying fluoride or referring to a dentist at 24 months or older
- Schedule the child's next well-visit at the end of each appointment.
- For more information on well-visits, visit **BrightFutures.org**.
- See Appendix 2 for more information on EPSDT visits for Medicaid.
- For P4Q, ensure African American members have their well-visits completed based on their birthdate each year.

Common codes for this measure
(Note: Codes listed are subject to plan coverage and contracted fee schedule.)

Description	Codes	
Well-Care	**CPT:**	99381, 99382, 99383, 99384, 99385, 99391, 99392, 99393, 99394, 99395, 99461
	HCPCS:	G0438, G0439, S0302, S0610, S0612, S0613
	ICD10:	Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.2, Z00.3, Z01.411, Z01.419, Z02.5, Z76.1, Z76.2

Child and Adolescent Well-Care Visits (WCV)

Commercial, Exchange, Medicaid, P4Q, PQS

The percentage of members 3 – 21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.

Visits with a physician, nurse practitioner, or physician assistant all meet criteria.

Frequently utilized provider best practices

- Submit appropriate codes for well-visits, in person versus an e-visit. (Medicaid - use EP modifier)
- Complete and code for developmental screening (Medicaid - use EP modifier).
- Complete and code for hearing, vision, depression screenings, etc. (Medicaid - use EP modifier).
- A sick visit and well-visit can be performed on the same day by using the 25 modifier.
- Perform Tdap and Meningococcal vaccines at age 11 and second HPV at age 12.
- For more information on well-visits, visit **BrightFutures.org.**
- Schedule the child's next well-visit at the end of each appointment.
- See Appendix 2 for more information on EPSDT.

Common codes for this measure
(Note: Codes listed are subject to plan coverage and contracted fee schedule.)

Description	Codes	
Well-Care	**CPT:**	99381, 99382, 99383, 99384, 99385, 99391, 99392, 99393, 99394, 99395, 99461
	HCPCS:	G0438, G0439, S0302, S0610, S0612, S0613
	ICD10:	Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.2, Z00.3, Z01.411, Z01.419, Z02.5, Z76.1, Z76.2

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

Commercial, Exchange, Medicaid

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

- BMI percentile documentation*
- Counseling for nutrition
- Counseling for physical activity

*Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed rather than an absolute BMI value.

Frequently utilized provider best practices

- Use appropriate HEDIS codes.
- Avoid missed opportunities by taking advantage of every office visit (including sick visits and sport physicals) to capture BMI percentile, counsel on nutrition and physical activity.
- Services rendered during telephone, e-visit or virtual check-in are acceptable for physical activity and nutrition counseling. Self-reported weights and heights are acceptable.

Common codes for this measure
(Note: Codes listed are subject to plan coverage and contracted fee schedule.)

Description	Codes	
BMI percentile <5% for age	**ICD10:**	Z68.51
BMI percentile 5% to 85% for age		Z68.52
BMI percentile 85% to 95% for age		Z68.53
BMI percentile >95% for age		Z68.54
Nutrition counseling	**CPT:**	97802, 97803, 97804
	HCPCS:	G0270, G0271, G0447, S9449
	ICD10:	Z71.3
Physical activity counseling	**HCPCS:**	G0447
	ICD10:	Z02.5, Z71.82

Common chart deficiencies

- Not coding appropriately

Exclusions

- Any diagnosis of pregnancy during the measurement year

Childhood Immunization Status (CIS)

Commercial, Exchange, Medicaid, PQS

The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB); one chickenpox(VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday

The measure calculates a rate for each vaccine and three separate combination rates.

Frequently utilized provider best practices

- Review a child's immunization record before every visit and administer needed vaccines.
- Recommend immunizations to parents. Parents are more likely to agree with vaccinations when supported by the provider. Address common misconceptions about vaccinations.
- Have a system for member reminders.
- Document 2-dose or 3-dose vaccination for rotavirus.
- Ensure anaphylaxis to any vaccine is documented.
- Document history of measles, mumps, rubella, hep B, varicella and/or hepatitis A illness.

Common codes for this measure
(Note: Codes listed are subject to plan coverage andcontracted fee schedule.)

Description	Codes	
DTaP	**CPT:**	90697, 90698, 90700, 90723
Inactivated polio (IPV)	**CPT:**	90697, 90698, 90713, 90723
Measles, mumps and rubella (MMR)	**CPT:**	90707, 90710
Haemophilus influenzatype B (HiB)	**CPT:**	90644, 90647, 90648, 90697, 90698, 90748
Hepatitis B	**CPT:**	90697, 90723, 90740, 90744, 90747, 90748
	HCPCS:	G0010
Varicella (VZV)	**CPT:**	90710, 90716
Pneumococcal conjugate	**CPT:**	90670
	HCPCS:	G0009
Hepatitis A	**CPT:**	90633
Rotavirus 2-dosevaccine	**CPT:**	90681
Rotavirus 3-dosevaccine	**CPT:**	90680
Influenza vaccine	**CPT:**	90655, 90657, 90661, 90673, 90674, 90685, 90686, 90687, 90688, 90689, 90756
	HCPCS:	G0008
LAIV Live influenza intranasal vaccine (on second birthday only)	**CPT:**	90660, 90672

Common chart deficiencies

- Not giving immunizations on or before the member's second birthday
- Not documenting immunizations given elsewhere (i.e., health departments)
- Not using state registries

Exclusions

- Members who had any of the following on or before their second birthday
  - Severe combined immunodeficiency
  - Immunodeficiency HIV
  - Lymphoreticular cancer, multiple myeloma, or leukemia
  - Intussusception

Immunizations for Adolescents (IMA)

Commercial, Exchange, Medicaid, PQS

The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday

Frequently utilized provider best practices

- Use state registries
- TDaP, meningococcal and first HPV given at age 11 and second HPV before age 13
- Address that HPV causes 6 types of cancer, and the vaccine is used as cancer prevention
- Recommend immunizations to parents. Parents are more likely to agree with vaccinations when supported by the provider. Address common misconceptions about vaccinations.
- Have a system for member reminders.
- Ensure anaphylaxis to any vaccine is documented.

Common codes for this measure
(Note: Codes listed are subject to plan coverage and contracted fee schedule.)

Description	Codes	
Meningococcal vaccine	**CPT:**	90619, 90733, 90734
TDaP vaccine	**CPT:**	90715
HPV vaccine	**CPT:**	90649, 90650, 90651

Common chart deficiencies

- Immunizations given after 13th birthday
- Not documenting immunizations given elsewhere (i.e., health departments)
- Not ensuring records from previous locations are included in the chart

Exclusions

- Adolescents who had a contraindication for a specific vaccine

Lead Screening in Children (LSC) — Medicaid, P4Q

Percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday

Documentation Guidelines
- Documentation indicating the date of the lead test
- The result of the lead test

Frequently utilized provider best practices

- Take advantage of every office visit to perform lead testing when due.
- Order lead test at 1-year well visit and revisit this at the 18-month well visit.
- Consider a standing order for in-office lead testing.
- Educate parents about the dangers of lead poisoning and the importance of testing.
- If level is great than 5, **refer to GHP's Special Needs Unit (SNU) 855-214-8100** for environmental investigation and collaboration with our team to help with resources.
- Lead test is considered late if performed after the child turns 2 years of age.
- **A lead risk assessment does not satisfy the blood lead test requirement for Medicaid members** regardless of the risk score.
- Communicate options for in-office lead testing, including blood lead analyzer and MedTox filter paper testing.

Common codes for this measure
(Note: Codes listed are subject to plan coverage and contracted fee schedule.)

Description	Codes	
Lead tests	**CPT:**	83655

Common chart deficiencies
- Waiting too long to order the lead test
- Not documenting the results of the lead screening in members PCP chart

Annual Dental Visit (ADV)

Medicaid, P4Q

Percentage of members 2 – 20 years of age who had a least one dental visit during the measurement year; this measure applies only if dental care is a covered benefit in the member's Medicaid contract.

Documentation guidelines:

- One or more dental visits with dental practitioner during the measurement year.
- Any visit with a dental practitioner during the measurement year
- Visits with 1-year-olds may be counted if their second birthday occurs during the measurement year
- Visits for many 1-year-olds will be counted, because the specification includes children whose second birthday occurs during the measurement year.

Frequently utilized provider best practices	• Educate member and/or family regarding importance of dental/oral health.
	• Ask when the last dental appointment was during every well visit.
	• Educate and discuss with member and/or family the importance of topical fluoride application.
	• Educate member and/or family regarding importance of dental/oral referral.
	  • Document history of dental evaluation and/or fluoride application.
	  • Have a list of providers for referral.
	
	Healthy Teeth Healthy Children: HealthyTeethHealthyChildren.org
	This program of the Pennsylvania Chapter of the American Academy of Pediatrics is a state-wide educational program focused on improving oral healthcare for children by providing education to medical providers.
	
	Smiles for Life Program: SmilesForLifeOralHealth.org
	This is a national oral health curriculum that provides educational resources to ensure the integration of oral health and primary care.

Oral Evaluation, Dental Services (OED) — Medicaid

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

Frequently utilized provider best practices

- Educate member and/or family regarding importance of dental/oral health.
- Ask when the last dental appointment was during every well-visit.
- Educate and discuss with member and/or family the importance of topical fluoride application.
- Educate member and/or family regarding importance of dental/oral referral.
  - Document history of dental evaluation and/or fluoride application.
  - Have a list of dental providers for referral.

Healthy Teeth Healthy Children: HealthyTeethHealthyChildren.org
This program of the Pennsylvania Chapter of the American Academy of Pediatrics is a state-wide educational program focused on improving oral healthcare for children by providing education to medical providers.

Smiles for Life Program: SmilesForLifeOralHealth.org
This is a national oral health curriculum that provides educational resources to ensure the integration of oral health and primary care.

Common codes for this measure
(Note: Codes listed are subject to plan coverage and contracted fee schedule.)

All visits must be completed with a dental provider.

Description	Codes	
Oral Evaluation	CDT	D0120, D0145, D0150

Topical Fluoride for Children (TFC) — Medicaid

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

Frequently utilized provider best practices

- Educate member and/or family regarding importance of dental/oral health.
- Ask when the last dental appointment was during every well-visit.
- Educate and discuss with member and/or family the importance of topical fluoride application.
- Educate member and/or family regarding importance of dental/oral referral.
  - Document history of dental evaluation and/or fluoride application.
  - Have a list of dental providers for referral.

Healthy Teeth Healthy Children: HealthyTeethHealthyChildren.org
This program of the Pennsylvania Chapter of the American Academy of Pediatrics is a state-wide educational program focused on improving oral healthcare for children by providing education to medical providers.

Smiles for Life Program: SmilesForLifeOralHealth.org
This is a national oral health curriculum that provides educational resources to ensure the integration of oral health and primary care.

Common codes for this measure
(Note: Codes listed are subject to plan coverage and contracted fee schedule.)

Visits can be with any type of provider.

Description	Codes	
Application of Fluoride Varnish	**CPT**	99188
	CDT	D1206

Prenatal Care (PPC)

Commercial, Exchange, Medicaid, P4Q

Timeliness of prenatal care — The percentage of deliveries of live births on or between Oct. 8 of the year prior to the measurement year and Oct. 7 of themeasurement year that received a prenatal care visit during the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization.

- Prenatal care visit in which the practitioner type is and OB/GYN or other prenatal care practitioner, or a PCP (not a nurse visit and must include diagnosis of pregnancy)
- Prenatal care must be documented as one of the following three types:

1) **Documentation indicating member is pregnant** such as:

Documentation in a standardized prenatal flow sheet,	Documentation of LMP, EDD or gestational age	A positive pregnancy test result
Documentation of gravidity and parity	Documentation of complete obstetrical history	Documentation of prenatal risk assessment and counseling/education

or

2) A **basic physical obstetrical exam** including auscultation for fetal heart tone, or pelvic exam with obstetric observationsor measurement of fundus height,

or

3) Evidence that a **prenatal care procedure was performed**, such as:

An OB panel (must include hematocrit, differential WBC count, platelet count,hepB surface antigen, rubella antibody, syphilis test, RBC antibody screen, Rh and ABO blood typing)	TORCH antibody panel alone
Rubella antibody test/titer with a Rh incompatibility (ABO/Rh) blood typing	Ultrasound of a pregnant uterus

Frequently utilized provider best practices

- Schedule prenatal care visits starting in the first trimester or within 42 days of enrollment.
- Ask front office staff to prioritize a new pregnant member and ensure prompt appointments for any member calling for a pregnancy visit to make sure the appointment is in the first trimester or within 42 days of enrollment.
- Have a direct referral process to OB/GYN in place.
- Services that occur over multiple visits are appropriate as long as they are within the time frame for the measure.
- For P4Q, ensure underserved populations such as African Americans are scheduled for prenatal visits as recommended.

Common codes for this measure
(Note: Codes listed are subject to plan coverage andcontracted fee schedule.)

Description	Codes	
Prenatal bundled services	**CPT:**	59400, 59425, 59426, 59510, 59610, 59618
	HCPCS:	H1005
Prenatal visits	**CPT:**	99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99483
	HCPCS:	G0463, T1015
Stand-alone prenatalvisits	**CPT:**	99500
	CPT II:	0500F, 0501F, 0502F
	HCPCS:	H1000, H1001, H1002, H1003, H1004
Telephone visits *Requires a pregnancy Dx code*	**CPT:**	98966, 98967, 98968, 99441, 99442, 99443
Online assessments *Requires a pregnancy Dx code*	**CPT:**	98969, 98970, 98971, 98972, 99421, 99422, 99423, 99444, 99457, 99458

Prenatal Care (PPC)

Commercial, Exchange, Medicaid, P4Q

Common chart deficiencies

- Genetic counseling alone does not count as a prenatal visit.
- Maternal fetal medicine must contain appropriate components of prenatal visit to count
- Visits must be with appropriate provider; PCP, OB/GYN, nurse practitioner or midwife
- Ultrasound and lab visits by themselves are not considered a visit, they must be combined with an office visit at or near the same time as the procedure or lab

Exclusions

- Non-live births

Description	Codes	
Non-live births	**ICD10:**	O00.00, O00.01, O00.101, O00.102, O00.109, O00.111, O00.112, O00.119, O00.201, O00.202, O00.209, O00.211, O00.212, O00.219, O00.80, O00.81, O00.90, O00.91, O01.0, O01.1, O01.9, O02.0, O02.1, O02.81, O02.89, O02.9, O03.0, O03.1, O03.2, O03.30, O03.31, O03.32, O03.33, O03.34, O03.35, O03.36, O03.37, O03.38, O03.39, O03.4, O03.5, O03.6, O03.7, O03.80, O03.81, O03.82, O03.83, O03.84, O03.85, O03.86, O03.87, O03.88, O03.89, O03.9, O04.5, O04.6, O04.7, O04.80, O04.81, O04.82, O04.83, O04.84, O04.85, O04.86, O04.87, O04.88, O04.89, O07.0, O07.1, O07.2, O07.30, O07.31, O07.32, O07.33, O07.34, O07.35, O07.36, O07.37, O07.38, O07.39, O07.4, O08.0, O08.1, O08.2, O08.3, O08.4, O08.5, O08.6, O08.7, O08.81, O08.82, O08.83, O08.89, O08.9, Z37.1, Z37.4, Z37.7

Medical record documentation

Medical record dates: Oct. 8, 2022 – Oct. 7, 2023
Fax medical record information to Geisinger Health Plan Quality Department at 570-214-1380.

Postpartum Care (PPC)

Commercial, Exchange, Medicaid, P4Q

A postpartum visit for a pelvic exam or postpartum care on or between 7 and 84 days after delivery. Any of the following meet criteria when provided by an OB/GYN or other prenatal care practitioner, or PCP:

A postpartum visit	Cervical cytology	Pelvic exam
Evaluation of weight, blood pressure, breasts, **and** abdomen	Perineal or cesarean incision/wound check (not just staple removal)	Screening for depression, anxiety, tobacco use, substance use disorder, or preexisting mental health disorders
Glucose screening for women with gestational diabetes	Documentation of infant care or breastfeeding	Documentation of resumption of intercourse, birth spacing or family planning
Documentation of Sleep/fatigue	Documentation of resumption of physical activities or attainment of healthy weight	A bundled service where the organization can identify the date when postpartum care was rendered

Frequently utilized provider best practices

- Schedule your member for postpartum visit within 7 to 84 days from delivery.
- Schedule the member for postpartum care as early as possible.
- Notation of "breastfeeding" is acceptable for the "evaluation of breasts" component above.
- For the P4Q program, help underserved members such as African Americans are scheduled for timely postpartum care.

Common codes for this measure
(Note: Codes listed are subject to plan coverage and contracted fee schedule.)

Description	Codes	
Postpartum visits	**CPT:**	57170, 58300, 59430, 99501
	CPT II:	0503F
	HCPCS:	G0101
	ICD10:	Z01.411, Z01.419, Z01.42, Z30.430, Z39.1, Z39.2
Cervical cytology	**CPT:**	88141, 88142, 88143, 88147, 88148, 88150, 88152, 88153, 88164, 88165, 88166, 88167, 88174, 88175
	HCPCS:	G0123, G0124, G0141, G0143, G0144, G0145, G0147, G0148, P3000, P3001, Q0091
Postpartum bundled services *Only if DOS is clear*	**CPT:**	59400, 59410, 59510, 59515, 59610, 59614, 59618, 59622

Common chart deficiencies

- If the member had a non-live birth, document that in the medical record.

Medical record documentation

Medical record dates: October 8, 2022 – October 7, 2023
Fax medical record information to Geisinger Health Plan Quality Department at 570-214-1380.

Perinatal Depression Screening — Medicaid

The percentage of enrollees who were:

Screened for depression:	during a prenatal care visit	using a validated depression screening tool
	during a postpartum care visit	using a validated depression screening tool
Screened positive for depression:	during a prenatal care visit	with evidence of further evaluation or treatment orreferral for further treatment
	during a postpartum care visit	with evidence of further evaluation or treatment orreferral for further treatment

Additionally, depression screening during the time frame of the first two prenatal care visits is collected.

Frequently utilized provider best practices

- Perform/document depression screening and follow-up starting at the first possible perinatal visit.
- Acceptable screening tools:
  - The Edinburgh Postnatal Depression Scale (EPDS)
  - Beck Depression Inventory (BDI 1a, II)
  - Member Health Questionnaire (PHQ) – 2 and PHQ-9 Tools
  - Hamilton Rating Scale for Depression (HRSD)
  - General Health Questionnaire (GHQ-D)
  - Postpartum Depression Screening Scale (PDSS)
  - Hospital Anxiety and Depression Scale (HADS)
  - Generalized Contentment Scale
- Positive screening for depression must be referred and/or receive further follow up.
- Document evidence of current active or postpartum depression treatment including medications
- Document affirmative answers to self-harm, thoughts about death or suicidal ideation.
- Document affirmative answers on a depression assessment of suicide risk assessment checklist
- Forms such as an ACOG or an ONAF do reflect current status and are acceptable as long as they are dated within the appropriate perinatal timeframe.

Common codes for this measure
(Note: Codes listed are subject to plan coverage and contracted fee schedule.)

Description	Codes	
Prenatal bundled services	**CPT:**	59400, 59425, 59426, 59510, 59610, 59618
	HCPCS:	H1005
Prenatal visits	**CPT:**	99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99483
	HCPCS:	G0463, T1015
Stand-alone prenatal visits	**CPT:**	99500
	CPT II:	0500F, 0501F, 0502F
	HCPCS:	H1000, H1001, H1002, H1003, H1004
Telephone visits *Requires a pregnancy Dx code*	**CPT:**	98966, 98967, 98968, 99441, 99442, 99443
Online assessments *Requires a pregnancy Dx code*	**CPT:**	98969, 98970, 98971, 98972, 99421, 99422, 99423, 99444, 99457, 99458

Perinatal Depression Screening — Medicaid

	Postpartum visits	**CPT:**	57170, 58300, 59430, 99501
		CPT II:	0503F
		HCPCS:	G0101
		ICD10:	Z01.411, Z01.419, Z01.42, Z30.430, Z39.1, Z39.2
	Cervical cytology	**CPT:**	88141, 88142, 88143, 88147, 88148, 88150, 88152, 88153, 88164, 88165, 88166, 88167, 88174, 88175
		HCPCS:	G0123, G0124, G0141, G0143, G0144, G0145, G0147, G0148, P3000, P3001, Q0091
	Postpartum bundled services *Only if DOS is clear*	**CPT:**	59400, 59410, 59510, 59515, 59610, 59614, 59618, 59622

Common chart deficiencies

- Documentation of "N/A" will not count as a screening.
- Documentation of 'history of depression alone' will not count. Current status must be reflected.
- Postpartum depression screenings done prior to discharge will not be counted mental health evaluation for conditions other than depression (e.g., bipolar, ADHD)
- Documentation of member education **alone** is not acceptable as evidence of screening.

Exclusions

Description	Codes	
Non-live births	**ICD10:**	O00.00, O00.01, O00.101, O00.102, O00.109, O00.111, O00.112, O00.119, O00.201, O00.202, O00.209, O00.211, O00.212, O00.219, O00.80, O00.81, O00.90, O00.91, O01.0, O01.1, O01.9, O02.0, O02.1, O02.81, O02.89, O02.9, O03.0, O03.1, O03.2, O03.30, O03.31, O03.32, O03.33, O03.34, O03.35, O03.36, O03.37, O03.38, O03.39, O03.4, O03.5, O03.6, O03.7, O03.80, O03.81, O03.82, O03.83, O03.84, O03.85, O03.86, O03.87, O03.88, O03.89, O03.9, O04.5, O04.6, O04.7, O04.80, O04.81, O04.82, O04.83, O04.84, O04.85, O04.86, O04.87, O04.88, O04.89, O07.0, O07.1, O07.2, O07.30, O07.31, O07.32, O07.33, O07.34, O07.35, O07.36, O07.37, O07.38, O07.39, O07.4, O08.0, O08.1, O08.2, O08.3, O08.4, O08.5, O08.6, O08.7, O08.81, O08.82, O08.83, O08.89, O08.9, Z37.1, Z37.4, Z37.7

Medical record documentation	Medical record dates: October 8, 2022 – October 7, 2023 Fax medical record information to Geisinger Health Plan Quality Department at 570-214-1380.

Prenatal Screening for Smoking and Treatment Discussion During a Prenatal Visit

Medicaid

This percentage of enrollees who were:

Within first two prenatal visits	**For members who were screened and identified as smokers****
The percentage of enrollees who were screened for smoking	provide counseling/advice or a referral during the time frame of any prenatal visit during pregnancy
	Document when a member stopped smoking any time during their pregnancy
Within first two prenatal visits	**For members who were identified as exposed to smoke**
The percentage of enrollees who were screened for environmental tobacco smoke exposure	provide counseling/advice or a referral during the time frame of any prenatal visit during pregnancy

**Smokers identified as those members who smoked six months prior to or any time during the current pregnancy

Frequently utilized provider best practices

- Screening and counseling do not have to occur with the same provider or on the same DOS.
- Documentation of a discussion about the risks of smoking and exposure to ETS
- Document "smoker" or "non-smoker."
- Documentation of e-cigarette use and vaping are appropriate screenings.
- Document environmental smoke exposure, not including member's own smoking.

Common codes for this measure
(Note: Codes listed are subject to plan coverage and contracted fee schedule.)

Description	Codes	
Deliveries	**CPT:**	59400, 59409, 59410, 59510, 59514, 59515, 59610, 59612, 59614, 59618, 59620, 59622
Prenatal bundled services	**CPT:**	59400, 59425, 59426, 59510, 59610, 59618
	HCPCS:	H1005
Prenatal visits	**CPT:**	99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99483
	HCPCS:	G0463, T1015
Stand alone prenatal visits	**CPT:**	99500
	CPT II:	0500F, 0501F, 0502F
	HCPCS:	H1000, H1001, H1002, H1003, H1004

Common chart deficiencies

- Documentation of "N/A" will not count as a screening.

Prenatal Screening for Smoking and Treatment Discussion During a Prenatal Visit			Medicaid
Exclusions	Description	Codes	
	Non-live births	**ICD10:**	O00.00, O00.01, O00.101, O00.102, O00.109, O00.111, O00.112, O00.119, O00.201, O00.202, O00.209, O00.211, O00.212, O00.219, O00.80, O00.81, O00.90, O00.91, O01.0, O01.1, O01.9, O02.0, O02.1, O02.81, O02.89, O02.9, O03.0, O03.1, O03.2, O03.30, O03.31, O03.32, O03.33, O03.34, O03.35, O03.36, O03.37, O03.38, O03.39, O03.4, O03.5, O03.6, O03.7, O03.80, O03.81, O03.82, O03.83, O03.84, O03.85, O03.86, O03.87, O03.88, O03.89, O03.9, O04.5, O04.6, O04.7, O04.80, O04.81, O04.82, O04.83, O04.84, O04.85, O04.86, O04.87, O04.88, O04.89, O07.0, O07.1, O07.2, O07.30, O07.31, O07.32, O07.33, O07.34, O07.35, O07.36, O07.37, O07.38, O07.39, O07.4, O08.0, O08.1, O08.2, O08.3, O08.4, O08.5, O08.6, O08.7, O08.81, O08.82, O08.83, O08.89, O08.9, Z37.1, Z37.4, Z37.7
Medical record documentation	Medical record dates: October 8, 2022 – October 7, 2023 Fax medical record information to Geisinger Health Plan Quality Department at 570-214-1380.		

Antidepressant Medication Management (AMM)

Commercial, Exchange, Medicare, Medicaid

The percentage of members 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. Dates for this measure are May 1, 2022 – April 30, 2023.

Two rates are reported:

- **Effective acute phase treatment** — The percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks)
- **Effective continuation phase treatment** — The percentage of members who remained on an antidepressant medication for at least 180 days (6 months)

Frequently utilized provider best practices

- Review missing pharmacy refills to ensure members are getting timely refills.
- Review missing pharmacy refills to ensure members are getting timely refills.
- Discuss and educate members on the following:
  - How antidepressants work, benefits, how long they should be used
  - Antidepressant medications can take several weeks to months to show a positive change
  - The importance of staying on the antidepressant for a minimum of 6 months
  - Strategies for remembering to take the antidepressant daily
  - The connection between taking an antidepressant and signs and symptoms of improvement
  - Reiterate to never stop taking the medication without consulting the provider
- Convert member's antidepressant medication to a 90-day or 100-day supply at mail order or retail pharmacy to boost adherence.

Common codes for this measure
(Note: Codes listed are subject to plan coverage andcontracted fee schedule.)

Description	Codes	
Major depression	**ICD10:**	F32.0, F32.1, F32.2, F32.3, F32.4, F32.9, F33.0, F33.1, F33.2, F33.3, F33.41, F33.9

Common medications for this measure
(Note: Medications listed are subject to plan coverage and contracted fee schedule.)

Antidepressant Medications

Description	Prescription		
Miscellaneous antidepressants	**Bupropion**	**Vilazodone**	**Vortioxetine**
Monoamine oxidase inhibitors	**Isocarboxazid** **Phenelzine**	**Selegiline** **Tranylcypromine**	
Phenylpiperazine antidepressants	**Nefazodone**	**Trazodone**	
Psychotherapeutic combinations	**Amitriptyline-chlordiazepoxide**	**Amitriptyline-perphenazine**	**Fluoxetine-olanzapine**
SNRI antidepressants	**Desvenlafaxine** **Duloxetine**	**Levomilnacipran** **Venlafaxine**	
SSRI antidepressants	**Citalopram** **Escitalopram**	**Fluoxetine** **Fluvoxamine**	**Paroxetine** **Sertraline**
Tetracyclic antidepressants	**Maprotiline**	**Mirtazapine**	
Tricyclic antidepressants	**Amitriptyline** **Amoxapine** **Clomipramine**	**Desipramine** **Doxepin (>6 mg)** **Imipramine**	**Nortriptyline** **Protriptyline** **Trimipramine**

Antidepressant Medication Management (AMM)	Commercial, Exchange, Medicare, Medicaid
Exclusions	• Members who did not have an encounter with a diagnosis of major depression during the 121-day period from 60 days prior to the Index Prescription Start Date (IPSD), through the IPSD and the 60 days after the IPSD. The IPSD: The earliest prescription dispensing date foran antidepressant medication where the date is in the Intake Period and there is a Negative Medication History.

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

Commercial, Medicaid

The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least 3 follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed; 2 rates are reported. Dates for this measure are March 1, 2022 – February 28, 2023.

- **Initiation phase** — The percentage of members 6 – 12 years of age as of the IPSD (Index Prescription Start Date) with a prescription dispensed for ADHD medication, who had one follow-up visit with a practitioner with prescribingauthority during the 30-day Initiation Phase.
- **Continuation and maintenance (C&M) phase** — The percentage of members 6 – 12 years of age as of the IPSD with a prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9months) after the initiation phase ended.

Frequently utilized provider best practices

- When prescribing a new ADHD medication to your member, be sure to schedule a follow-up visit within 30 days. Schedule this visit while your member is still in the office.
- Can utilize telehealth.
- At the initial follow-up visit, assess and document how the medication is working, and schedule the next two follow-up visits.
- Allow no refills until the initial follow up visit is complete.
- Schedule 2 more visits in the 9 months after the first 30 days, to continue to monitor your member's progress.
- Can utilize a telehealth or telephone visit for one of the visits after the first 30 days. This may help you and your members if getting to the office is difficult.
- Only one phone visit is allowed during the continuation and maintenance phase. If a phone visit is done, at least one face-to-face visit should be completed. Make sure the visits are coded properly.

Common codes for this measure
(Note: Codes listed are subject to plan coverage and contracted fee schedule.)

Description	Codes	
Follow-up visits requiring an Outpatient Place of Service code	**CPT:**	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99251, 99252
	WITH POS:	02, 03, 05, 07, 09, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 22, 33, 49, 50, 52, 53, 71, 72
Follow-up visits ***Acceptable for either Initiation Phase or Continuation and Maintenance Phase***	**CPT:**	98960, 98961, 98962, 98966, 98967, 98968, 99078, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, 99241, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99421, 99422, 99423, 99441, 99442, 99443, 99483

Common chart deficiencies

- Using incorrect billing codes

Exclusions

- Members with a diagnosis of narcolepsy any time during their history through December 31 ofmeasurement year

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

Commercial, Medicaid

Description	Codes	
Narcolepsy	**ICD10:**	G47.411, G47.419, G47.421, G47.429

Initiation and Engagement of Substance Use Disorder Treatment (IET)

Commercial, Exchange, Medicare, Medicaid

The percentage of new substance use disorder (SUD) episodes that result in treatment initiation and engagement. Two rates are reported:

- **Initiation of SUD Treatment**. The percentage of new SUD episodes that result in treatment initiation through an inpatient SUD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth visits or medication treatment within 14 days.
- **Engagement of SUD Treatment**. The percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation.

Dates for this measure are November 15, 2022 – November 14, 2023

Documentation guidelines:
- Schedule follow-up appointment within 14 days for members with a new SUD diagnosis.
- Schedule two follow-up visits within 34 days of the initial 14-day follow-up visit.
- Include the SUD diagnosis on every claim when treating a member for issues related tothat diagnosis.
- Provide member education on available alcohol and substance use treatment services in the area.
- Follow-up visits may be with the initial provider, or a substance use treatment provider.

Frequently utilized provider best practices

- Use screening tools like AUDIT and CAGE to identify substance use issues in members.
- Document identified substance use disorder in the member chart and submit a claim with the appropriate codes.
- Schedule a follow up visit to initiate treatment within 14 days of an alcohol or substance use diagnosis.
- Schedule at least 2 additional visits within 34 days after initiation of treatment.
- Refer members to substance use disorder providers when appropriate.
- Provide members educational material and resources about alcohol and substance use treatment options.
- Work collaboratively with behavioral health case managers.
- Continue ongoing discussions with members about treatment to help increase their willingness to commit to the process, as the timeframe for initiating treatment is brief (14 days).
- Ensure progress notes are closed out with provider signature.
- Members on therapy for pain management are not classified as “dependence.”

Common codes for this measure
(Note: Codes listed are subject to plan coverage and contracted fee schedule.)

All codes generally count for both the Initiation Phase and the Engagement Phase

Description	Codes		
These codes must be matched with an appropriate Diagnosis Code (see below)	**Outpatient, Non-residential Treatment Facility, Community MH Center, Telehealth Visits**	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99251, 99252, 99253, 99254, 99255	**Requiring Place of Service (POS) Code** 02, 03, 05, 07, 09, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 22, 33, 49, 50, 52, 53, 57, 58, 71, 72

Outpatient Visits Alone Do Not Require a POS Code	98960, 98961, 98962, 99078, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99483, 99492, 99493, 99494, 99510, G0155, G0176, G0177, G0409, G0463, G0512, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, T1015
Intensive Outpatient or Partial Hospital-ization	G0410, G0411, H0035, H2001, H2012, S0201, S9480, S9484, S9485
Substance Abuse Disorder Service	99408, 99409, G0396, G0397, G0443, H0001, H0005, H0007, H0015, H0016, H0022, H0047, H0050, H2035, H2036, T1006, T1012
Observation Stay	99217, 99218, 99219, 99220
Telephone, eVisit or Virtual Check-in	98966, 98967, 98968, 98969, 98970, 98971, 98972, 99421, 99422, 99423, 99441, 99442, 99443, 99444, 99457, 99458, G0071, G2010, G2012, G2061, G2062, G2063, G2250, G2251, G2252

Diagnosis Codes

F10.10, F10.120, F10.121, F10.129, F10.130, F10.131, F10.132, F10.139, F10.14, F10.150, F10.151, F10.159, F10.180, F10.181, F10.182, F10.188, F10.19, F10.20, F10.220, F10.221, F10.229, F10.230, F10.231, F10.232, F10.239, F10.24, F10.250, F10.251, F10.259, F10.26, F10.27, F10.280, F10.281, F10.282, F10.288, F10.29, F11.10, F11.120, F11.121, F11.122, F11.129, F11.13, F11.14, F11.150, F11.151, F11.159, F11.181, F11.182, F11.188, F11.19, F11.20, F11.220, F11.221, F11.222, F11.229, F11.23, F11.24, F11.250, F11.251, F11.259, F11.281, F11.282, F11.288, F11.29, F12.10, F12.120, F12.121, F12.122, F12.129, F12.13, F12.150, F12.151, F12.159, F12.180, F12.188, F12.19, F12.20, F12.220, F12.221, F12.222, F12.229, F12.23, F12.250, F12.251, F12.259, F12.280, F12.288, F12.29, F13.10, F13.120, F13.121, F13.129, F13.130, F13.131, F13.132, F13.139, F13.14, F13.150, F13.151, F13.159, F13.180, F13.181, F13.182, F13.188, F13.19, F13.20, F13.220, F13.221, F13.229, F13.230, F13.231, F13.232, F13.239, F13.24, F13.250, F13.251, F13.259, F13.26, F13.27, F13.280, F13.281, F13.282, F13.288, F13.29, F14.10, F14.120, F14.121, F14.122, F14.129, F14.13, F14.14, F14.150, F14.151, F14.159, F14.180, F14.181, F14.182, F14.188, F14.19, F14.20, F14.220, F14.221, F14.222, F14.229, F14.23, F14.24, F14.250, F14.251, F14.259, F14.280, F14.281, F14.282, F14.288, F14.29, F15.10, F15.120, F15.121, F15.122, F15.129, F15.13, F15.14, F15.150, F15.151, F15.159, F15.180, F15.181, F15.182, F15.188, F15.19, F15.20, F15.220, F15.221, F15.222, F15.229, F15.23, F15.24, F15.250, F15.251, F15.259, F15.280, F15.281, F15.282, F15.288, F15.29, F16.10, F16.120, F16.121, F16.122, F16.129, F16.14, F16.150, F16.151, F16.159, F16.180, F16.183, F16.188, F16.19, F16.20, F16.220, F16.221, F16.229, F16.24, F16.250, F16.251, F16.259, F16.280, F16.283, F16.288, F16.29, F18.10, F18.120, F18.121, F18.129, F18.14, F18.150, F18.151, F18.159, F18.17, F18.180, F18.188, F18.19, F18.20, F18.220, F18.221, F18.229, F18.24, F18.250, F18.251, F18.259, F18.27, F18.280, F18.288, F18.29, F19.10, F19.120, F19.121, F19.122, F19.129, F19.130, F19.131,

	F19.132, F19.139, F19.14, F19.150, F19.151, F19.159, F19.16, F19.17, F19.180, F19.181, F19.182, F19.188, F19.19, F19.20, F19.220, F19.221, F19.222, F19.229, F19.230, F19.231, F19.232, F19.239, F19.24, F19.250, F19.251, F19.259, F19.26, F19.27, F19.280, F19.281, F19.282, F19.288, F19.29		
	Codes that also count for the Initiation Phase **These do not require a Diagnosis Code**	**Weekly or Monthly Opioid Treatment Service**	G2086, G2087, G2067, G2068, G2069, G2070, G2072, G2073, G2071, G2074, G2075, G2076, G2077, G2080
		Alcohol Use Disorder Medication Treatment Dispensing Event or Medication Admini-stration	G2073, J2315, Medications*: Disulfiram, acamprosate calcium, naltrexone hydrochloride or naltrexone
		Opioid Use Disorder Medication Treatment Dispensing Event or Medication Admini-stration	G2073, J2315, H0033, J0571, G2068, G2079, G2069, Q9991, Q9992, G2070, G2072, J0570, J0572, J0573, J0574, J0575, H0020, S0109, G2067, G2078 Medications*: Naltrexone Oral or Injection; Buprenorphine Oral, Injection, Implant, or Naloxone *For a complete list of medications, please contact your account manager.

Common chart deficiencies

- Use remission code if member is not actively dependent, otherwise member will be inappropriately included in the measure
- Inappropriate diagnosis codes or diagnosis codes carried forward that are no longer appropriate
- No documented follow-up appointments with appropriate codes

Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)

Commercial, Medicare, Medicaid

The percentage of members 18 years of age and older during the measurement year with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period. The measurement periodfor this measure is January 1, 2023 – December 31, 2023.

Frequently utilized provider best practices

- Schedule appropriate follow-up with the members to evaluate if medication is being taken as prescribed.
- Review missing pharmacy refills to ensure members are getting timely refills.
- Educate members on the importance of staying on the medication.
- Provide education about common side effects, how long the side effects may last and how to manage them.
- Document member diagnosis, rationale for the prescribed medication and the member's clinical response to treatment.
- Convert member's antipsychotic medication to a 90-day or 100-day supply at mail order or retail pharmacy to boost adherence.

Common codes for this measure
(Note: Codes listed are subject to plan coverage and contracted fee schedule.)

Description	Codes	
Schizophrenia	**ICD10:**	F20.0, F20.1, F20.2, F20.3, F20.5, F20.81, F20.89, F20.9, F25.0, F25.1, F25.8, F25.9
Long-acting injections	**HCPCS:**	J2794, J0401, J1631, J1943, J1944, J2358, J2426, J2680, J2798

Common medications for this measure
(Note: Medications listed are subject to plan coverage and contracted fee schedule.)

Antipsychotic Medications

Description	Prescription		
Miscellaneous antipsychotic agents (oral)	Aripiprazole Asenapine Brexpiprazole Cariprazine Clozapine Haloperidol	Iloperidone Loxapine Lumateperone Lurisadone Molindone Olanzapine	Paliperidone Quetiapine Risperidone Ziprasidone
Phenothiazine antipsychotics (oral)	Chlorpromazine Fluphenazine	Perphenazine Prochlorperazine	Thioridazine Trifluoperazine
Psychotherapeutic combinations (oral)	Amitriptyline-perphenazine		
Thioxanthenes (oral)	Thiothixene		
Long-acting injections 14 days' supply	Risperidone (excluding Perseris®)		
Long-acting injections 28 days' supply	Aripiprazole Aripiprazole lauroxil	Fluphenazine decanoate Haloperidol decanoate	Olanzapine Paliperidone palmitate
Long-acting injections 30 days' supply	Risperidone (Perseris®)		

Exclusions

- Members with a diagnosis of dementia during the measurement period
- Members who did not have two antipsychotic medication dispensing events

See Appendix 1 for frailty, advanced illness, and dementia Medication exclusion codes.

Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)

Commercial, Medicaid

The percentage of children and adolescents 1–17 years of age who had two or more antipsychotic prescriptions and had metabolic testing. Three rates are reported:

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

Dates for this measure are January 1, 2023–December 31, 2023

Frequently utilized provider best practices

- Monitor the glucose and cholesterol levels of children and adolescents on antipsychotic medication. Metabolic monitoring is recommended by The American Academy of Child and Adolescent Psychiatry to help to avoid metabolic health complications such as weight gain and diabetes.
- Document the order for glucose and cholesterol levels, lab results and any action that may be required.
- Use supplemental lab data to update medical records, when applicable.
- Establish a baseline and continuously monitor metabolic indices to ensure appropriate management of side-effects of antipsychotic medication therapy.
- Code appropriately.
- Document the member's diagnosis and clinical response to the medication
- Ensure progress note is closed out with a provider signature.

Common codes for this measure
(Note: Codes listed are subject to plan coverage and contracted fee schedule.)

Description	Codes	
Glucose tests	**CPT:**	80047, 80048, 80050, 80053, 80069, 82947, 82950, 82951
HbA1c	**CPT:**	83036, 83037
	CPT II:	3044F, 3046F, 3051F, 3052F
LDL-C	**CPT:**	80061, 83700, 83701, 83704, 83721
	CPT II:	3048F, 3049F, 3050F
Cholesterol tests	**CPT:**	82465, 83718, 83722, 84478

Common medications for this measure
(Note: Medications listed are subject to plan coverage and contracted fee schedule.)

Antipsychotic Medications

Description	Prescription	
Miscellaneous antipsychotic agents	Aripiprazole Asenapine Brexpiprazole Cariprazine Clozapine Haloperidol Iloperidone Loxapine	Lurisadone Molindone Olanzapine Paliperidone Pimozide Quetiapine Risperidone Ziprasidone
Phenothiazine antipsychotics	Chlorpromazine Fluphenazine Perphenazine	Thioridazine Trifluoperazine
Thioxanthenes	Thiothixene	

	Long-acting injections	Aripiprazole Aripiprazole lauroxil Fluphenazine decanoate Haloperidol decanoate	Olanzapine Paliperidone palmitate Risperidone
	Psychotherapeutic combinations	Fluoxetine-olanzapine	Perphenazine -amitriptyline
	Phenothiazine antipsychotics	Prochlorperazine	

Common chart deficiencies

- Not documenting order and results of required lab work

Follow-up After Hospitalization for Mental Illness (FUH)

Commercial, Exchange, Medicare, Medicaid

The percentage of discharges for members 6 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

Two rates are reported:
- The percentage of discharges for which the member received follow-up within 30 days after discharge
- The percentage of discharges for which the member received follow-up within 7 days after discharge

Discharge dates for this measure are January 1, 2023–December 1, 2023.

Frequently utilized provider best practices

- Ensure the member has a plan for follow-up visit with a mental health practitioner within 7 and 30 days after discharge. Do not include visits that occur on the date of discharge. Please keep in mind that a telehealth visit is acceptable for this measure.
- Schedule the member's aftercare appointment prior to discharge.
- Attempt to alleviate barriers to attending appointments prior to discharge.

Common codes for this measure
(Note: Codes listed are subject to plan coverage and contracted fee schedule.)

All visits must be completed with a mental health provider.

Description	Codes		
Outpatient Visit	CPT and POS:	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99251, 99252, 99253, 99254, 99255	Requiring Place of Service (POS) Code: 03, 05, 07, 09, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 22, 33, 49, 50, 52, 71, 72
Telehealth Visit			Requiring Place of Service (POS) Code: 02, 10
Intensive outpatient encounter or partial hospitalization			Requiring Place of Service (POS) Code: 52
BH outpatient	CPT:	98960, 98961, 98962, 99078, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99483, 99492, 99493, 99494, 99510	
	HCPCS:	G0155, G0176, G0177, G0409, G0463, G0512, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, T1015	
	Rev Code:	0510, 0513, 0515, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0526, 0527, 0528, 0529, 0900, 0902, 0903, 0904, 0911, 0914, 0915, 0916, 0917, 0919, 0982, 0983	
Intensive outpatient encounter or partial	HCPCS:	G0410, G0411, H0035, H2001, H2012, S0201, S9480, S9484, S9485	

	hospitalization	**Rev Code:**	0905, 0907, 0912, 0913	
		HCPCS:	G0155, G0176, G0177, G0409, G0463, G0512, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, T1015	
		Rev Code:	0510, 0513, 0515, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0526, 0527, 0528, 0529, 0900, 0902, 0903, 0904, 0911, 0914, 0915, 0916, 0917, 0919, 0982, 0983	
	Electroconvulsive Therapy	**CPT:**	90870	**Requiring Place of Service (POS) Code**
		ICD10 Procs:	GZB0ZZZ, GZB1ZZZ, GZB2ZZZ, GZB3ZZZ, GZB4ZZZ	03, 05, 0709, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 22, 24, 33, 49, 50, 52, 53, 71, 72
	Observation Visit	**CPT:**	99217, 99218, 99219, 99220	
	Transitional Care Management Services	**CPT:**	99495, 99496	
	Behavioral Healthcare Visit	**Rev Code:**	0513, 0900, 09010902, 0903, 0904, 0905, 0907, 0911, 0912, 0913, 0914, 0915, 0916, 0917, 0919	
	Telephone Visit	**CPT:**	98966, 98967, 98968, 99441, 99442, 99443	
	Psychiatric Collaborative Card Management	**CPT:**	99492, 99493, 99494	
		HCPCS:	G0512	

Asthma Medication Ratio (AMR) — Commercial, Medicaid, P4Q

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

Frequently utilized provider best practices

- Integrate review of proper inhaler usage into every encounter with an asthma member
- Review medication list to ensure member is prescribed a controller medication
- Convert member's controller medication to a 90-day or 100-day supply at mail order or retail pharmacy to boost adherence
- Review missing pharmacy refills to ensure members are getting timely refills
- Educate members on the importance taking the controller medications regularly

Common codes for this measure
(Note: Codes listed are subject to plan coverage and contracted fee schedule.)

Description	Codes	
Asthma Diagnoses	**ICD10:**	J45.21, J45.22, J45.30, J45.31, J45.32, J45.40, J45.41, J45.42, J45.50, J45.51, J45.52, J45.901, J45.902, J45.909, J45.991, J45.998

Common medications for this measure
(Note: Medications listed are subject to plan coverage and contracted fee schedule.)

Asthma Controller Medications

Description	Prescription	
Antibody inhibitors	Omalizumab	
Anti-interleukin-4	Dupilumab	
Anti-interleukin-5	Benralizumab Mepolizumab	Reslizumab
Inhaled steroid combinations	Budesonide-formoterol Fluticasone-salmeterol	Fluticasone-vilanterol Formoterol-mometasone
Inhaled corticosteroids	Beclomethasone Budesonide Ciclesonide	Flunisolide Fluticasone Mometasone
Leukotriene modifiers	Montelukast Zafirlukast	Zileuton
Methylxanthines	Theophylline	

Asthma Reliever Medications

Description	Prescription	Description
Short-acting, inhaled beta-2 agonists	Albuterol	Levalbuterol

Common chart deficiencies

- Review the exclusions sections and ensure that if the member has an excluded diagnosis that it is coded correctly

Exclusions

- Members who had a diagnosis from any of the following sets, any time during the member's history through the last day of the measurement period:

Description	Codes	
Emphysema	**ICD10:**	J43.0, J43.1, J43.2, J43.8, J43.9, J98.2, J98.3

	COPD	**ICD10:**	J44.0, J44.1, J44.9
	Obstructive chronic bronchitis	**ICD9 Only:**	491.20, 491.21,491.22
	Chronic respiratory conditions due to fumes/ vapors	**ICD10:**	J68.4
	Cystic fibrosis	**ICD10:**	E84.0, E84.11, E84.19, E84.8, E84.9
	Acute respiratoryfailure	**ICD10:**	J96.00, J96.01, J96.02, J96.20, J96.21, J96.22

Statin Therapy for Members with Cardiovascular Disease (SPC) ★

Commercial, Medicare, Medicaid, PQS

The percentage of males 21–75 years of age and females 40–75 years of age during the measurement year who wereidentified as having clinical atherosclerotic cardiovascular disease (ASCVD) and met the following criteria.

The following rates are reported:

- **Received Statin Therapy** — Members who were dispensed at least one high-intensity or moderate-intensity statinmedication during the measurement year.
- **Statin Adherence 80%** — Members who remained on a high-intensity or moderate-intensity statin medication for at least 80% of the treatment period.

Frequently utilized provider best practices

- Integrate statin therapy evaluation into every encounter with a member with cardiovascular disease.
- Review member medication list to ensure current statin therapy and to determine statin use history.
- Re-trial members on statins, when appropriate, and document true member intolerance to statins accurately.
- Dose reduction, statin medication change, and alternate-day dosing are all options for patients who may have adverse effects from a particular statin medication.
- Convert member's statin medication to a 90-day or 100-day supply at mail order or retail pharmacy to boost adherence.
- Review missing pharmacy refills to ensure members are getting timely refills and make sure prescription instructions are up to date.
- PSK9 inhibitors (i.e., Repatha, Pralulent) do not count for this measure at this time.

Common medications for this measure
(Note: Medications listed are subject to plan coverage and contracted fee schedule.)

High- and moderate-intensity statin medications

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

Common chart deficiencies

- Review exclusions section and ensure that if the member has an excluded diagnosis that it is coded correctly.

Common codes for this measure
(Note: Codes listed are subject to plan coverage and contracted fee schedule.)

Description	Codes	
Myocardial Infarction	**ICD10:**	I21.01, I21.02, I21.09, I21.11, I21.19, I21.21, I21.29, I21.3, I21.4, I21.9, I21.A1, I21.A9, I22.0, I22.1, I22.2, I22.8, I22.9, I23.0, I23.1, I23.2, I23.3, I23.4, I23.5, I23.6, I23.7, I23.8, I25.2
CABG	**CPT:**	33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33530, 33533, 33534, 33535, 33536
	HCPCS:	S2205, S2206, S2207, S2208, S2209

		ICD10PCS:	0210083, 0210088, 0210089, 0210093, 0210098, 0210099, 0211083, 0211088, 0211089, 0211093, 0211098, 0211099, 0212083, 0212088, 0212089, 0212093, 0212098, 0212099, 0213083, 0213088, 0213089, 0213093, 0213098, 0213099, 021008C, 021008F, 021008W, 021009C, 021009F, 021009W, 02100A3, 02100A8, 02100A9, 02100AC, 02100AF, 02100AW, 02100J3, 02100J8, 02100J9, 02100JC, 02100JF, 02100JW, 02100K3, 02100K8, 02100K9, 02100KC, 02100KF, 02100KW, 02100Z3, 02100Z8, 02100Z9, 02100ZC, 02100ZF, 021108C, 021108F, 021108W, 021109C, 021109F, 021109W, 02110A3, 02110A8, 02110A9, 02110AC, 02110AF, 02110AW, 02110J3, 02110J8, 02110J9, 02110JC, 02110JF, 02110JW, 02110K3, 02110K8, 02110K9, 02110KC, 02110KF, 02110KW, 02110Z3, 02110Z8, 02110Z9, 02110ZC, 02110ZF, 021208C, 021208F, 021208W, 021209C, 021209F, 021209W, 02120A3, 02120A8, 02120A9, 02120AC, 02120AF, 02120AW, 02120J3, 02120J8, 02120J9, 02120JC, 02120JF, 02120JW, 02120K3, 02120K8, 02120K9, 02120KC, 02120KF, 02120KW, 02120Z3, 02120Z8, 02120Z9, 02120ZC, 02120ZF, 021308C, 021308F, 021308W, 021309C, 021309F, 021309W, 02130A3, 02130A8, 02130A9, 02130AC, 02130AF, 02130AW, 02130J3, 02130J8, 02130J9, 02130JC, 02130JF, 02130JW, 02130K3, 02130K8, 02130K9, 02130KC, 02130KF, 02130KW, 02130Z3, 02130Z8, 02130Z9, 02130ZC, 02130ZF
	PCI	CPT:	92920, 92924, 92928, 92933, 92937, 92941, 92943
		HCPCS:	C9600, C9602, C9604, C9606, C9607

		ICD10PCS:	0270346, 0270356, 0270366, 0270376, 0270446, 0270456, 0270466, 0270476, 0271346, 0271356, 0271366, 0271376, 0271446, 0271456, 0271466, 0271476, 0272346, 0272356, 0272366, 0272376, 0272446, 0272456, 0272466, 0272476, 0273346, 0273356, 0273366, 0273376, 0273446, 0273456, 0273466, 0273476, 02703E6, 02704E6, 02713E6, 02714E6, 02723E6, 02724E6, 02733E6, 02734E6, 027034Z, 027035Z, 027036Z, 027037Z, 02703D6, 02703DZ, 02703EZ, 02703F6, 02703FZ, 02703G6, 02703GZ, 02703T6, 02703TZ, 02703Z6, 02703ZZ, 027044Z, 027045Z, 027046Z, 027047Z, 02704D6, 02704DZ, 02704EZ, 02704F6, 02704FZ, 02704G6, 02704GZ, 02704T6, 02704TZ, 02704Z6, 02704ZZ, 027134Z, 027135Z, 027136Z, 027137Z, 02713D6, 02713DZ, 02713EZ, 02713F6, 02713FZ, 02713G6, 02713GZ, 02713T6, 02713TZ, 02713Z6, 02713ZZ, 027144Z, 027145Z, 027146Z, 027147Z, 02714D6, 02714DZ, 02714EZ, 02714F6, 02714FZ, 02714G6, 02714GZ, 02714T6, 02714TZ, 02714Z6, 02714ZZ, 027234Z, 027235Z, 027236Z, 027237Z, 02723D6, 02723DZ, 02723EZ, 02723F6, 02723FZ, 02723G6, 02723GZ, 02723T6, 02723TZ, 02723Z6, 02723ZZ, 027244Z, 027245Z, 027246Z, 027247Z, 02724D6, 02724DZ, 02724EZ, 02724F6, 02724FZ, 02724G6, 02724GZ, 02724T6, 02724TZ, 02724Z6, 02724ZZ, 027334Z, 027335Z, 027336Z, 027337Z, 02733D6, 02733DZ, 02733EZ, 02733F6, 02733FZ, 02733G6, 02733GZ, 02733T6, 02733TZ, 02733Z6, 02733ZZ, 027344Z, 027345Z, 027346Z, 027347Z, 02734D6, 02734DZ, 02734EZ, 02734F6, 02734FZ, 02734G6, 02734GZ, 02734T6, 02734TZ, 02734Z6, 02734ZZ
	Other Revascular-ization	CPT:	37220, 37221, 37224, 37225, 37226, 37227, 37228, 37229, 37230, 37231
	IVD Diagnosis ICD10:	I20.0, I20.8, I20.9, I24.0, I24.8, I24.9, I25.10, I25.110, I25.111, I25.118, I25.119, I25.5, I25.6, I25.700, I25.701, I25.708, I25.709, I25.710, I25.711, I25.718, I25.719, I25.720, I25.721, I25.728, I25.729, I25.730, I25.731, I25.738, I25.739, I25.750, I25.751, I25.758, I25.759, I25.760, I25.761, I25.768, I25.769, I25.790, I25.791, I25.798, I25.799, I25.810, I25.811, I25.812, I25.82, I25.83, I25.84, I25.89, I25.9, I63.20, I63.211, I63.212, I63.213, I63.219, I63.22, I63.231, I63.232, I63.233, I63.239, I63.29, I63.50, I63.511, I63.512, I63.513, I63.519, I63.521, I63.522, I63.523, I63.529, I63.531, I63.532, I63.533, I63.539, I63.541, I63.542, I63.543, I63.549, I63.59, I65.01, I65.02, I65.03, I65.09, I65.1, I65.21, I65.22, I65.23, I65.29, I65.8, I65.9, I66.01, I66.02, I66.03, I66.09, I66.11, I66.12, I66.13, I66.19, I66.21, I66.22, I66.23, I66.29, I66.3, I66.8, I66.9, I67.2, I70.1, I70.201, I70.202, I70.203, I70.208, I70.209, I70.211, I70.212, I70.213, I70.218, I70.219, I70.221, I70.222, I70.223, I70.228, I70.229, I70.231, I70.232, I70.233, I70.234, I70.235, I70.238, I70.239, I70.241, I70.242, I70.243, I70.244, I70.245, I70.248, I70.249, I70.25, I70.261, I70.262, I70.263, I70.268, I70.269, I70.291, I70.292, I70.293, I70.298, I70.299, I70.301, I70.302, I70.303, I70.308, I70.309, I70.311, I70.312, I70.313, I70.318, I70.319, I70.321, I70.322, I70.323, I70.328, I70.329, I70.331, I70.332, I70.333, I70.334, I70.335, I70.338, I70.339, I70.341, I70.342, I70.343, I70.344, I70.345, I70.348, I70.349, I70.35,	

		I70.361, I70.362, I70.363, I70.368, I70.369, I70.391, I70.392, I70.393, I70.398, I70.399, I70.401, I70.402, I70.403, I70.408, I70.409, I70.411, I70.412, I70.413, I70.418, I70.419, I70.421, I70.422, I70.423, I70.428, I70.429, I70.431, I70.432, I70.433, I70.434, I70.435, I70.438, I70.439, I70.441, I70.442, I70.443, I70.444, I70.445, I70.448, I70.449, I70.45, I70.461, I70.462, I70.463, I70.468, I70.469, I70.491, I70.492, I70.493, I70.498, I70.499, I70.501, I70.502, I70.503, I70.508, I70.509, I70.511, I70.512, I70.513, I70.518, I70.519, I70.521, I70.522, I70.523, I70.528, I70.529, I70.531, I70.532, I70.533, I70.534, I70.535, I70.538, I70.539, I70.541, I70.542, I70.543, I70.544, I70.545, I70.548, I70.549, I70.55, I70.561, I70.562, I70.563, I70.568, I70.569, I70.591, I70.592, I70.593, I70.598, I70.599, I70.601, I70.602, I70.603, I70.608, I70.609, I70.611, I70.612, I70.613, I70.618, I70.619, I70.621, I70.622, I70.623, I70.628, I70.629, I70.631, I70.632, I70.633, I70.634, I70.635, I70.638, I70.639, I70.641, I70.642, I70.643, I70.644, I70.645, I70.648, I70.649, I70.65, I70.661, I70.662, I70.663, I70.668, I70.669, I70.691, I70.692, I70.693, I70.698, I70.699, I70.701, I70.702, I70.703, I70.708, I70.709, I70.711, I70.712, I70.713, I70.718, I70.719, I70.721, I70.722, I70.723, I70.728, I70.729, I70.731, I70.732, I70.733, I70.734, I70.735, I70.738, I70.739, I70.741, I70.742, I70.743, I70.744, I70.745, I70.748, I70.749, I70.75, I70.761, I70.762, I70.763, I70.768, I70.769, I70.791, I70.792, I70.793, I70.798, I70.799, I70.92, I75.011, I75.012, I75.013, I75.019, I75.021, I75.022, I75.023, I75.029, I75.81, I75.89, T82.855A, T82.855D, T82.855S, T82.856A, T82.856D, T82.856S
Exclusions	• Exclude members who meet any of the following criteria: • Members with a diagnosis of pregnancy during the measurement year or the year prior to the measurement year • In vitro fertilization in the measurement year or year prior to the measurement year • Dispensed at least one prescription for clomiphene during the measurement year or the year prior to the measurement year • ESRD or dialysis during the measurement year or the year prior to the measurement year • Cirrhosis during the measurement year or the year prior to the measurement year • Myalgia, myositis, myopathy or rhabdomyolysis during the measurement year See Appendix 1 for frailty, advanced illness, and palliative care exclusion codes and dementia medications.	

Statin Therapy for Members with Diabetes (SPD)

Commercial, Medicare, Medicaid, PQS

The percentage of members 40 – 75 years of age during the measurement year with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) who met the following criteria.

Two rates are reported:

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

Frequently utilized provider best practices

- Integrate statin therapy evaluation into every encounter with a diabetic member.
- Review member medication list to ensure current statin therapy and to determine statin use history
- Re-trial members on statins when appropriate and document true member intolerance to statins accurately.
- Dose reduction, statin medication change, and alternate-day dosing are all options for patients who may have adverse effects from a particular statin medication.
- Convert member's statin medication to a 90-day or 100-day supply at mail order or retail pharmacy toboost adherence.
- Review missing pharmacy refills to ensure members are getting timely refills and make sure prescription instructions are up to date.

Common medications for this measure

(Note: Medications listed are subject to plan coverage and contracted fee schedule.)

High-, moderate, and low-intensity statin medications

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

Common chart deficiencies

- Review exclusions section and ensure that if the member has an excluded diagnosis that it is coded correctly

Exclusions

- Exclude members who meet any of the following criteria:
  - Members with MI, CABG, PCI, or Other Revascularization in the year prior to the measurement year.
  - Members with an IVD diagnosis during both the measurement year and the year prior.
  - Members with a diagnosis of pregnancy during the measurement year or the year prior to the measurement year.
  - In vitro fertilization in the measurement year or year prior to the measurement year.
  - Dispensed at least one prescription for clomiphene during the measurement year or the year prior to the measurement year.
  - ESRD or dialysis during the measurement year or the year prior to the measurement year.
  - Cirrhosis during the measurement year or the year prior to the measurement year.
  - Myalgia, myositis, myopathy or rhabdomyolysis during the measurement year.

See Appendix 1 for frailty, advanced illness, and palliative care exclusion codes and dementia medications.

Statin Use in Persons with Diabetes (SUPD) ★

Medicare

- The percent of Medicare Part D beneficiaries 40-75 years old who were dispensed at least two diabetes medication fills and received a statin medication fill during the measurement period.
- This measure is a Stars measure only and is not part of HEDIS reporting.

Frequently utilized provider best practices

- Integrate statin therapy evaluation into every encounter with a diabetic member.
- Review member medication list to ensure current statin therapy and to determine statin use history.
- Re-trial members on statins when appropriate and document true member intolerance to statins accurately.
- Dose reduction, statin medication change, and alternate-day dosing are all options for patients who may have adverse effects from a particular statin medication.

Common medications for this measure

(Note: Medications listed are subject to plan coverage and contracted fee schedule.)

Description	Prescription	
Statin Medications	atorvastatin (+/- amlodipine) pitavastatin rosuvastatin (+/- ezetimibe) fluvastatin	pravastatin simvastatin (+/- ezetimibe, niacin) lovastatin (+/- niacin)

Common chart deficiencies

- Lack of statin therapy documentation and evaluation every visit.
- Review exclusions section and ensure that if the member has an excluded diagnosis that it is coded correctly.

Exclusions

- Members with these conditions are excluded from the denominator:
  - Hospice enrollment
  - ESRD diagnosis or dialysis coverage dates
  - Rhabdomyolysis and myopathy
  - Pregnancy
  - Lactation and fertility
  - Liver Disease
  - Pre-Diabetes
  - Polycystic Ovary Syndrome

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

Commercial, Medicare, Medicaid

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

Documentation guidelines:

- Identify all acute and nonacute inpatient stays
- Identify the admission and discharge dates for the stay
- Exclude all nonacute inpatient stays
- Identify the discharge date for the stay
- If member had a direct transfer to an acute inpatient care setting, use the discharge date from the transfer setting, not the initial discharge
- Direct transfer to an acute inpatient care setting
- Exclude all direct transfers to a nonacute inpatient care setting
- Direct transfers (discharge date from the first inpatient setting precedes the admission date to a second inpatient setting by one day or less) vs. two distinct inpatient stays
- If member has more than one episode of AMI during measurement year, include only the first discharge.

Frequently utilized provider best practices

- Integrate beta-blocker therapy evaluation into every encounter with a recent heart attack member
- Review member medication list to ensure current beta-blocker therapy and determine beta-blocker use history
- Document true member intolerance to beta-blockers accurately
- Convert member's beta-blocker medication to a 90-day or 100-day supply at mail order or retailpharmacy to boost adherence
- Review missing pharmacy refills to ensure members are getting timely refills

Common codes for this measure
(Note: Codes listed are subject to plan coverage and contracted fee schedule.)

Description	Codes	
AMI	**ICD10:**	I21.01, I21.02, I21.09, I21.11, I21.19, I21.21, I21.29, I21.3, I21.4

Common medications for this measure
(Note: Medications listed are subject to plan coverage and contracted fee schedule.)

Beta-Blocker Medications

Description	Prescription	
Noncardio-selective beta-blockers	Carvedilol Labetalol Nadolol Pindolol	Propranolol Timolol Sotalol
Cardioselective beta-blockers	Acebutolol Atenolol Betaxolol	Bisoprolol Metoprolol Nebivolol
Antihypertensive combinations	Atenolol-chlorthalidone Bendroflumethiazide-nadolol Bisoprolol-hydrochlorothiazide	Hydrochlorothiazide-metoprolol Hydrochlorothiazide-propranolol

Common chart deficiencies

- Review exclusions section and ensure that if the member has an excluded diagnosis that it is coded correctly

Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	Commercial, Medicare, Medicaid
Exclusions	• Members identified as having an intolerance or allergy to beta-blocker therapy. Any of the following any time during the member's history through the end of the continuous enrollment period meet criteria: • Asthma • COPD • Obstructive chronic bronchitis • Chronic respiratory conditions due to fumes and vapors • Hypotension, heart block >1st degree or sinus bradycardia • Medication dispensing event indicative of a history of asthma See Appendix 1 for frailty and advanced illness exclusion codes.

Potentially Harmful Drug-Disease Interactions in Older Adults (DDE)

Medicare

The percentage of Medicare members 65 years of age and older who have evidence of an underlying disease, condition or health concern and who were dispensed an ambulatory prescription for a potentially harmful medication, concurrent with or after the diagnosis from January 1, 2023 to December 1, 2023.

Report each of the three rates separately and as a combined rate.

- Rate 1: A history of falls and a prescription for antiepileptics, antipsychotics, benzodiazepines, nonbenzodiazepine hypnotics or antidepressants (SSRIs, tricyclic antidepressants and SNRIs)
- Rate 2: Dementia and a prescription for antipsychotics, benzodiazepines, nonbenzodiazepine hypnotics, tricyclic antidepressants, or anticholinergic agents
- Rate 3: Chronic kidney disease and Cox-2 selective NSAIDs or nonaspirin NSAIDs

Members with more than one disease or condition may appear in the measure multiple times.

***A lower rate represents better performance for all rates.**

Frequently utilized provider best practices

- Integrate a disease state review and medication review into every encounter with members aged 65 and older.
- Review member diagnoses for history of falls, dementia and chronic kidney disease andavoid respective harmful drug classes.
- Replace harmful drug classes with appropriate alternatives when one of these diagnosesare present.
- Before prescribing a new medication for an elderly member with one of these diagnoses, check first that it is not in a potentially harmful class for the member condition.
- Document reason for prescribed medication and member's age and condition.
- Code to the highest specificity using guidelines.

Common medications for this measure

(Note: Medications listed are subject to plan coverage and contracted fee schedule.)

Potentially Harmful Drugs
Rate 1: History of Falls Medications

Description	Prescription		
Antiepileptics	Carbamazepine Clobazam Divalproex sodium Ethosuximide Ethotoin Ezogabine Felbamate Fosphenytoin	Gabapentin Lacosamide Lamotrigine Levetiracetam Methsuximide Oxcarbazepine Phenobarbital Phenytoin	Pregabalin Primidone Rufinamide Tiagabine HCL Topiramate Valproic acid Vigabatrin Zonisamide
SNRIs	Desvenlafaxine Duloxetine	Levomilnacipran Venlafaxine	
SSRIs	Citalopram Escitalopram	Fluoxetine Fluvoxamine	Paroxetine Sertraline

Potentially Harmful Drugs - History of Falls and Dementia Medications

Description	Prescription		
Antipsychotics	Aripiprazole Aripiprazole lauroxil Asenapine Brexpiprazole Cariprazine Chlorpromazine Clozapine Fluphenazine	Haloperidol Iloperidone Loxapine Lurasidone Molindone Olanzapine Paliperidone Perphenazine	Pimozide Quetiapine Risperidone Thioridazine Thiothixene Trifluoperazine Ziprasidone
Benzodiazepines	Alprazolam Chlordiazepoxide Clonazepam Clorazepate Diazepam	Estazolam Flurazepam Lorazepam Midazolam	Oxazepam Quazepam Temazepam Triazolam
Nonbenzodiazepine hypnotics	Eszopiclone	Zaleplon	Zolpidem
Tricyclic antidepressants	Amitriptyline Amoxapine Clomipramine	Desipramine Doxepin (>6 mg) Imipramine	Nortriptyline Protriptyline Trimipramine

Dementia Medications - Denominator

Description	Prescription		
Cholinesterase inhibitors	Donepezil	Galantamine	Rivastigmine
Miscellaneous central nervous system agents	Memantine		
Dementia combinations	Donezepil-memantine		

Potentially Harmful Drugs - Dementia Medications

Description	Prescription		
Anticholinergic agents, antiemetics	Prochlorperazine	Promethazine	
Anticholinergic agents, antihistamines	Brompheniramine Carbinoxamine Chlorpheniramine Clemastine Cyproheptadine	Dexbrompheniramine Dexchlorpheniramine Dimenhydrinate Diphenhydramine Doxylamine	Pyrilamine Triprolidine Hydroxyzine Meclizine
Anticholinergic agents, antispasmodics	Atropine Belladonna alkaloids Clidinium-chlordiazepoxide	Dicyclomine Homatropine Hyoscyamine	Methscopolamine Propantheline Scopolamine

Anticholinergic agents, antimuscarinics (oral)	Darifenacin Fesoterodine Flavoxate	Oxybutynin Solifenacin	Tolterodine Trospium
Anticholinergic agents, anti-Parkinson agents	Benztropine	Trihexyphenidyl	
Anticholinergic agents, skeletal muscle relaxants	Cyclobenzaprine	Orphenadrine	
Anticholinergic agents, SSRIs	Paroxetine		
Anticholinergic agents, antiarrhythmic	Disopyramide		

Cox-2 Selective NSAIDs and Nonaspirin NSAIDs Medications

Description	Prescription		
Cox-2 Selective NSAIDs	Celecoxib		
Nonaspirin NSAIDs	Diclofenac Etodolac Fenoprofen Flurbiprofen Ibuprofen Indomethacin	Ketoprofen Ketorolac Meclofenamate Mefenamic acid Meloxicam Nabumetone	Naproxen Naproxen sodium Oxaprozin Piroxicam Sulindac Tolmetin

Common chart deficiencies

- Evaluate the member's current diagnoses and confirm the member's diagnoses are coded correctly
- Review exclusions section and ensure that if the member has an excluded diagnosis that it is coded correctly

Exclusions

See Appendix 1 for frailty, advanced illness, and palliative care exclusion codes.

- Members with the following diagnosis between January 1, 2022 – December 1, 2023

Exclusions for Rate 1: History of Falls; Rate 2 Exclusions as Noted

Description	Codes	
Psychosis *Also Rate 2*	**ICD10:**	F06.0, F06.1, F06.2, F06.30, F06.31, F06.32, F06.33, F06.34, F06.4, F06.8, F22, F23, F24, F28, F29, F30.2, F31.2, F31.5, F31.64, F32.3, F33.3, F44.89
Schizophrenia and Schizoaffective Disorder *Also Rate 2*	**ICD10:**	F20.0, F20.1, F20.2, F20.3, F20.5, F20.81, F20.89, F20.9, F25.0, F25.1, F25.8, F25.9

	Bipolar Disorder *Also Rate 2*	ICD10:	F30.10, F30.11, F30.12, F30.13, F30.2, F30.3, F30.4, F30.8, F30.9, F31.0, F31.10, F31.11, F31.12, F31.13, F31.2, F31.30, F31.31, F31.32, F31.4, F31.5, F31.60, F31.61, F31.62, F31.63, F31.64, F31.70, F31.71, F31.72, F31.73, F31.74, F31.75, F31.76, F31.77, F31.78, F31.81, F31.89, F31.9
	Major Depressive Disorder	ICD10:	F32.0, F32.1, F32.2, F32.3, F32.4, F32.5, F32.9, F33.0, F33.1, F33.2, F33.3, F33.40, F33.41, F33.42, F33.9, F34.1
	Seizure Disorder	ICD10:	G40.001, G40.009, G40.011, G40.019, G40.101, G40.109, G40.111, G40.119, G40.201, G40.209, G40.211, G40.219, G40.301, G40.309, G40.311, G40.319, G40.401, G40.409, G40.411, G40.419, G40.42, G40.501, G40.509, G40.801, G40.802, G40.803, G40.804, G40.811, G40.812, G40.813, G40.814, G40.821, G40.822, G40.823, G40.824, G40.833, G40.834, G40.89, G40.901, G40.909, G40.911, G40.919, G40.A01, G40.A09, G40.A11, G40.A19, G40.B01, G40.B09, G40.B11, G40.B19

Use of High-Risk Medication in Older Adults (DAE) — Medicare

The percentage of Medicare members 67 years of age and older who had at least two dispensing events for the same high-risk medication from January 2023 to December 2023.

Three rates are reported:

- Rate 1: The percentage of Medicare members 67 years of age and older who had at least two dispensing events for high-riskmedications to avoid from the same drug class.
- Rate 2: The percentage of Medicare members 67 years of age and older who had at least two dispensing events for high-riskmedications to avoid from the same drug class, except for appropriate diagnoses.
- Total Rate (the sum of the two numerators divided by the denominator, deduplicating for members in both numerators).

The measure reflects potentially inappropriate medication use in older adults, both for medications for which any use is inappropriate (Rate 1) and for medications for which use under all but specific indications is potentially inappropriate (rate 2)

***A lower rate represents better performance for all rates.**

Frequently utilized provider best practices

- Integrate a high-risk medication review into every encounter with an elderly member aged 65 and older.
- Review member medication list to ensure it does not include any high-risk medications.
- Replace high-risk medications with appropriate alternatives.
- Before prescribing a new medication for an elderly member, check first that it is not a high-risk medication.
- Document reason for prescribed medication and member's response.

Common medications for this measure
(Note: Medications listed are subject to plan coverage and contracted fee schedule.)

Description	Prescription	
Anticholinergics, first-generation antihistamines	Brompheniramine Carbinoxamine Chlorpheniramine Clemastine Cyproheptadine Dexbrompheniramine Dexchlorpheniramine	Dimenhydrinate Diphenhydramine (oral) Doxylamine Hydroxyzine Meclizine Promethazine Pyrilamine Triprolidine
Anticholinergics, anti-Parkinson agents	Benztropine (oral)	Trihexyphenidyl
Antispasmodics	Atropine (exclude ophthalmic) Belladonna alkaloids Chlordiazepoxide-clidinium Dicyclomine	Hyoscyamine Methscopolamine Propantheline Scopolamine
Antithrombotics	Dipyridamole (oral, excluding extended release)	
Cardiovascular, alpha agonists, central	Guanfacine	Methyldopa
Cardiovascular, other	Disopyramide	Nifedipine (excluding extended release)
Central nervous system, antidepressants	Amitriptyline Amoxapine Clomipramine Desipramine	Imipramine Nortriptyline Paroxetine Protriptyline Trimipramine

Central nervous system, barbiturates	Amobarbital Butabarbital Butalbital	Pentobarbital Phenobarbital Secobarbital
Central nervous system, vasodilators	Ergoloid mesylates	Isoxsuprine
Central nervous system, other	Meprobamate	
Endocrine system, estrogens with or without progestins; include only oral and topical patch products	Conjugated estrogen Esterified estrogen Estradiol Estropipate	
Endocrine system, other	Chlorpropamide Glimepiride	Glyburide
Endocrine system, sulfonylureas, long-duration	Desiccated thyroid Megestrol	
Nonbenzodiazepine hypnotics	Eszopiclone Zaleplon	Zolpidem
Pain medications, skeletal muscle relaxants	Carisoprodol Chlorzoxazone Cyclobenzaprine	Metaxalone Methocarbamol Orphenadrine
Pain medications, other	Indomethacin Ketorolac, includes parenteral	Meperidine

High-Risk Medications with Days' Supply Criteria - Rate 1

Members who meet both of the following are numerator compliant:

- *Two or more dispensing events on different dates of service.*
- *Summed days' supply exceeds the days' supply criteria.*

Description	Prescription	Days' Supply Criteria
Anti-Infectives, other	Nitrofurantoin Nitrofurantoin macrocrystals-monohydrate	>90 days

High-Risk Medications with Average Daily Dose Criteria - Rate 1

Members who meet both of the following are numerator compliant:

- *Two or more dispensing events on different dates of service.*
- *Average daily dose for two or more dispensing events (on different dates of service) exceeds the average daily dose criteria.*

Description	Prescription	Days' Supply Criteria
Alpha agonists, central	Reserpine	>0.1 mg/day
Cardiovascular, other	Digoxin	>0.125 mg/day

Tertiary TCAs (as single agent or as part of combination products)	Doxepin	>6 mg/day

High-Risk Medications Based on Prescription and Diagnosis Data – Rate 2

Members who had at least two dispensing events for high-risk medications from the same drug class except for appropriate diagnosis during the measurement year.

Antipsychotics – members who meet **both** are numerator compliant:

- Two or more dispensing events for an antipsychotic on different dates of service during the measurement year
- The member *did not* have a diagnosis of schizophrenia or schizoaffective disorder or bipolar disorder on or between January 1 of the year prior to the measurement year and the script date for antipsychotics.

Description	Prescription	
Antipsychotics, first (conventional) and second (atypical) generation	Aripiprazole Aripiprazole lauroxil Asenapine Brexpiprazole Cariprazine Chlorpromazine Clozapine Fluphenazine Haloperidol Iloperidone Loxapine Lurasidone	Molindone Olanzapine Paliperidone Perphenazine Pimavanserin Pimozide Quetiapine Risperidone Thioridazine Thiothixene Trifluoperazine Ziprasidone

High-Risk Medications Based on Prescription and Diagnosis Data – Rate 2

Members who had at least two dispensing events for high-risk medications from the same drug class except for appropriate diagnosis during the measurement year.

Benzodiazepines– members who meet **both** are numerator compliant:

- Two or more dispensing events for a benzodiazepine on different dates of service during the measurement year
- The member *did not* have a diagnosis of seizure disorders, REM sleep behavior disorder, benzodiazepine or ethanol withdrawal or severe GAD on or between January 1 of the year prior to the measurement year and the script for benzodiazepines

Description	Prescription	
Benzodiazepines, long, short and intermediate acting	Alprazolam Chlordiazepoxide Clonazepam Clorazepate Diazepam Estazolam Flurazepam	Lorazepam Midazolam Oxazepam Quazepam Temazepam Triazolam

Use of High-Risk Medication in Older Adults (DAE) — Medicare

Description	Codes	
Schizophrenia	ICD10:	F20.0, F20.1, F20.2, F20.3, F20.5, F20.81, F20.89, F20.9, F25.0, F25.1, F25.8, F25.9
Bipolar Disorder	ICD10:	F30.10, F30.11, F30.12, F30.13, F30.2, F30.3, F30.4, F30.8, F30.9, F31.0, F31.10, F31.11, F31.12, F31.13, F31.2, F31.30, F31.31, F31.32, F31.4, F31.5, F31.60, F31.61, F31.62, F31.63, F31.64, F31.70, F31.71, F31.72, F31.73, F31.74, F31.75, F31.76, F31.77, F31.78, F31.81, F31.89, F31.9
Seizure Disorders	ICD10:	G40.001, G40.009, G40.011, G40.019, G40.101, G40.109, G40.111, G40.119, G40.201, G40.209, G40.211, G40.219, G40.301, G40.309, G40.311, G40.319, G40.401, G40.409, G40.411, G40.419, G40.42, G40.501, G40.509, G40.801, G40.802, G40.803, G40.804, G40.811, G40.812, G40.813, G40.814, G40.821, G40.822, G40.823, G40.824, G40.833, G40.834, G40.89, G40.901, G40.909, G40.911, G40.919, G40.A01, G40.A09, G40.A11, G40.A19, G40.B01, G40.B09, G40.B11, G40.B19
REM Sleep BehaviorDisorder	ICD10:	G47.52
Benzodiazepine Withdrawal	ICD10:	F13.230, F13.231, F13.232, F13.239, F13.930, F13.931, F13.932, F13.939
Alcohol Withdrawal	ICD10:	F10.230, F10.231, F10.232, F10.239
General Anxiety Disorder	ICD10:	F41.0, F41.1, F41.3, F41.8, F41.9

Common chart deficiencies

- Review exclusions section and ensure that if the member has an excluded diagnosis that it is coded correctly

Exclusions	See Appendix 1 for frailty, advanced illness, and palliative care exclusion codes.

Use of Opioids at High Dosage (HDO) — Commercial, Medicare, Medicaid

The proportion of members 18 years and older, who received prescription opioids at a high dosage (MME>=90 days) for >= 15 days during the measurement year at.

***A lower rate indicates better performance.**

Frequently utilized provider best practices

- Integrate a review of the necessity and appropriateness of opioid therapy into every encounter with a member taking an opioid medication.
- Before prescribing an opioid medication, consider first line non-opioid or non-pharmacologic treatment options.
- Prior to prescribing an opioid medication, check the Prescription Drug Monitoring Program (PDMP) to avoid duplication of therapy, polypharmacy and diversion.
- Limit prescriptions to the shortest duration needed to treat condition.
- Limit dose to the lowest effective dose needed to treat condition.
- Schedule proper follow-up with the members to evaluate if dose can be decreased via taper or medication can be discontinued.
- Document reason for prescribed medication and member's response.

Common medications for this measure

(Note: Medications listed are subject to plan coverage and contracted fee schedule.)

Type of Opioid		
Benzhydrocodone	Fentanyl oral spray (mcg)	Methadone6
Butorphanol	Fentanyl nasal spray (mcg)	Morphine
Codeine	Fentanyl transdermal film/ patch (mcg/hr)	Opium
Dihydrocodeine	Hydrocodone	Oxycodone
Fentanyl buccal or sublingual tablet, transmucosal lozenge (mcg)	Hydromorphone	Oxymorphone
	Levorphanol	Pentazocine
	Meperidine	Tapentadol
		Tramadol

Common chart deficiencies

- Review exclusions section and ensure that if the member has an excluded diagnosis that it is coded correctly

Exclusions

- The following opioid medications are excluded:
  - Injectables
  - Opioid cough and cold products
  - Ionsys (fentanyl transdermal patch)
  - Methadone for the treatment of opioid use disorder
- Members with cancer.
- Members with sickle cell disease.

See Appendix 1 for frailty, advanced illness, and palliative care exclusion codes.

Use of Opioids from Multiple Providers (UOP) — Commercial, Medicare, Medicaid

The proportion of members 18 years and older, receiving prescription opioids for ≥15 days during the measurement year, who received opioids from multiple providers.

Three rates are reported:

- Multiple Prescribers - The proportion of members receiving prescriptions for opioids from four or more different *prescribers* during the measurement year.
- Multiple Pharmacies - The proportion of members receiving prescriptions for opioids from four or more different *pharmacies* during the measurement year.
- Multiple Prescribers and Multiple Pharmacies - The proportion of members receiving prescriptions for opioids from four or more different prescribers ***and*** four or more different pharmacies during the measurement year (i.e., the percentage of members who are numerator compliant for both the Multiple Prescribers and Multiple Pharmacies rates).

***A lower rate represents better performance for all three rates.**

Frequently utilized provider best practices

- Integrate a review of the necessity and appropriateness of opioid therapy into every encounter with a member taking an opioid medication
- Before prescribing an opioid medication, consider first line or non-pharmacologic treatment options
- Prior to prescribing an opioid medication, check the Prescription Drug Monitoring Program (PDMP) to avoid duplication of therapy and diversion
- When prescribing opioid medications, only ONE (1) provider per patient should be used to ensureappropriate and safe utilization throughout the course of opioid therapy. Even providers that are from the same office are classified as different providers.
- Educate patients on the importance of using one pharmacy to fill all their prescriptions
- Limit opioid prescriptions to the shortest duration needed to treat condition.
- Schedule proper follow-up with the members to evaluate if dose can be decreased via taper or medication can be discontinued
- Document reason for prescribed medication and member's response.
- Review exclusions section and ensure that if the member has an excluded diagnosis that it is coded correctly.

Common medications for this measure

(Note: Medications listed are subject to plan coverage and contracted fee schedule.)

HDO Opioid Medications

Benzhydrocodone	Meperidine
Buprenorphine (transdermal patch and buccal film)	Methadone
Butorphanol	Morphine
Codeine	Opium
Dihydrocodeine	Oxycodone
Fentanyl	Oxymorphone
Hydrocodone	Pentazocine
Hydromorphone	Tapentadol
Levorphanol	Tramadol

Exclusions

- The following opioid medications are excluded from this measure:
  - Injectables,
  - Opioid- containing cough and cold products,
  - Single-agent and combination buprenorphine products used as part of medication assisted
  - treatment of opioid use disorder (buprenorphine sublingual tablets, buprenorphine subcutaneous implant and all buprenorphine/naloxone combination products).
  - Ionsys® (fentanyl transdermal patch)
  - Methadone for the treatment of opioid use disorder.

Risk of Continued Opioid Use (COU) — Commercial, Medicare, Medicaid

The percentage of members 18 years of age and older who have a new episode of opioid use that puts them at risk for continued opioid use. Two rates are reported:

- The percentage of members with at least 15 days of prescription opioids in a 30-day period.
- The percentage of members with at least 31 days of prescription opioids in a 62-day period.

*A lower rate represents better performance.

Frequently utilized provider best practices

- Integrate a review of the necessity and appropriateness of opioid therapy into every encounterwith a member taking an opioid medication.
- Before prescribing an opioid medication, consider first line or non-pharmacologic treatment options.
- Prior to prescribing an opioid medication, check the Prescription Drug Monitoring Program (PDMP) to avoid duplication of therapy and diversion.
- Limit opioid prescriptions to the shortest duration needed to treat condition.
- Schedule proper follow-up with the members to evaluate if dose can be decreased via taper ormedication can be discontinued.
- Document reason for prescribed medication and member's response.
- Review exclusions section and ensure that if the member has an excluded diagnosis that it is coded correctly.

Common medications for this measure
(Note: Medications listed are subject to plan coverage and contracted fee schedule.)

Opioid Medications	
Benzhydrocodone	Meperidine
Buprenorphine (transdermal patch and buccal film)	Methadone
Butorphanol	Morphine
Codeine	Opium
Dihydrocodeine	Oxycodone
Fentanyl	Oxymorphone
Hydrocodone	Pentazocine
Hydromorphone	Tapentadol
Levorphanol	Tramadol

Exclusions

- Members who met at least one of these criteria during one year prior to the prescription through 61 days after:
  - Cancer
  - Sickle cell disease

See Appendix 1 for palliative care exclusion codes.

Pharmacotherapy Management of COPD (PCE) — Commercial, Medicare, Medicaid

The percentage of COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or ED visit on or between January 1 and November 30 of the measurement year and who were dispensed appropriate medications.

Two rates are reported:
- Dispensed a Systemic Corticosteroid (or there was evidence of an active prescription) within 14 days of the event.
- Dispensed a Bronchodilator (or there was evidence of an active prescription) within 30 days of the event.

NOTE: A member may be in this measure more than once in a reporting period.

Frequently utilized provider best practices

- Review medication list to ensure patient is on a bronchodilator for maintenance therapy for COPD and review refill history with the patient
- Convert member's bronchodilator medication to a 90-day or 100-day supply at mail order or retail pharmacy to boost adherence.
- Discuss therapy with a short-acting bronchodilator if appropriate for your patient
- Schedule proper follow-up soon after a COPD exacerbation to evaluate if the patient has the corticosteroid and bronchodilator medications on hand and if they are being taken as prescribed

Common codes for this measure
(Note: Codes listed are subject to plan coverage and contracted fee schedule.)

Description	Codes	
COPD	**ICD10:**	J44.0, J44.1, J44.9
Emphysema	**ICD10:**	J43.0, J43.1, J43.2, J43.8, J43.9
Chronic Bronchitis	**ICD10:**	J41.0, J41.1, J41.8, J42

Common medications for this measure
(Note: Medications listed are subject to plan coverage and contracted fee schedule.)

Systemic corticosteroid medications

Description	Prescription	
Glucocorticoids	Cortisone Dexamethasone Hydrocortisone	Methylprednisolone Prednisolone Prednisone

Bronchodilator medications

Description	Prescription	
Anticholinergic agents	Aclidinium-bromide Ipratropium	Tiotropium Umeclidinium
Beta 2-agonists	Albuterol Arformoterol Formoterol Indacaterol	Levalbuterol Metaproterenol Olodaterol Salmeterol
Bronchodilator combinations	Albuterol-ipratropium Budesonide-formoterol Fluticasone-salmerterol Fluticasone-vilanterol Fliticasone furoate-umeclidinium-vilanterol	Formoterol-aclidinium Formoterol-glycopyrrolate Formoterol-mometasone Glycopyrrolate-indacaterol Olodaterol-tiotropium Umeclidinium-vilanterol

Common chart deficiencies
- Review exclusions section and ensure that if the member has an excluded diagnosis that it is coded correctly

Transitions of Care (TRC) ★ Medicare

The percentage of discharges for members 18 years of age and older who had each of the following.

Four rates are reported:

- Notification of Inpatient Admission — Documentation of receipt of notification of inpatient admission on the day of admission through two days after the admission (3 total days).
- Receipt of Discharge Information — Documentation of receipt of discharge information on the day of discharge through 2 days after the admission (3 total days).
- Patient Engagement after Inpatient Discharge — Documentation of patient engagement (e.g., office visits, visits to the home, telehealth) provided within 30 days after discharge.
- Medication Reconciliation Post-Discharge — Documentation of medication reconciliation on the date of discharge through 30 days after discharge (31 total days).

Note: Only the Patient Engagement and Medication Reconciliation can be coded during a visit. Claim codes are not accepted for the other two numerators, which must be documented within the PCP's or ongoing care provider's chart.

Frequently utilized provider best practices

- Ensure EMR contains evidence of your member's admission within 3 total days of admit.
- EMR should also contain documentation of member's discharge within 3 total days of discharge. The discharge summary is best for this purpose.
- ADT may be used to suit this purpose if it exists within the EMR.
- Confirm members are receiving follow-up or documented contact within 30 days of discharge.
- Medication reconciliation must be conducted by a prescribing practitioner, physician assistant, clinical pharmacist or registered nurse on the date of discharge through 30 days after discharge.

Common codes for this measure
(Note: Codes listed are subject to plan coverage and contracted fee schedule.)

Description		Codes
Patient Engagement after Inpatient Discharge	**CPT:**	98966, 98967, 98968, 98969, 98970, 98971, 98972, 98980, 98981, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99421, 99422, 99423, 99429, 99441, 99442, 99443, 99444, 99455, 99456, 99457, 99458, 99483, 99495, 99496
	HCPCS:	G0071, G0402, G0438, G0439, G0463, G2010, G2012, G2061, G2062, G2063, G2250, G2251, G2252, T1015
Medication Reconciliation Post-Discharge	**CPT:**	99483, 99495, 99496
	CPTII:	1111F

Common chart deficiencies

- Discarding faxes or communications that indicate a patient is admitted.

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

Medicare

The percentage of emergency department (ED) visits for members 18 years of age and older who have multiple high-risk chronic conditions who had a follow-up service within 7 days of the ED visit.

Frequently utilized provider best practices

- Follow-up services may be counted on the date of the ED visit or 7 days after.
- Schedule follow-up services at discharge.

Common codes for this measure
(Note: Codes listed are subject to plan coverage and contracted fee schedule.)

Description		Codes	
Follow-up Services	**CPT:**	98960, 98961, 98962, 98966, 98967, 98968, 98969, 98970, 98971, 98972, 98980, 98981, 99078, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, 99241, 99242, 99243, 99244, 99245, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99366, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99408, 99409, 99411, 99412, 99421, 99422, 99423, 99429, 99439, 99441, 99442, 99443, 99444, 99455, 99456, 99457, 99458, 99483, 99487, 99489, 99490, 99491, 99492, 99493, 99494, 99495, 99496, 99510	
	HCPCS:	G0071, G0155, G0176, G0177, G0396, G0397, G0402, G0409, G0410, G0411, G0438, G0439, G0443, G0463, G0506, G0512, G2010, G2012, G2061, G2062, G2063, G2250, G2251, G2252, H0001, H0002, H0004, H0005, H0007, H0015, H0016, H0022, H0031, H0034, H0035, H0036, H0037, H0039, H0040, H0047, H0050, H2000, H2001, H2010, H2011, H2012, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, H2035, H2036, S0201, S9480, S9484, S9485, T1006, T1012, T1015, T1016, T1017, T2022, T2023	
	CPT:	90847, 90853, 99238, 99239, 90875, 90876, 99223, 99222, 99221, 99251, 99255, 99253, 99254, 99252, 90849, 90791, 90792, 90845, 90840, 90839, 90832, 90833, 90834, 90836, 90837, 90838, 99233, 99232, 99231	**Requiring Place of Service (POS) Code** 02, 03, 05, 07, 09, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 22, 33, 49, 50, 52, 53, 71, 72
	CPT or ICD10PCS:	90870, GZB0ZZZ, GZB1ZZZ, GZB2ZZZ,	**Requiring Place of Service (POS) Code**

Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions (FMC)★				Medicare
			GZB3ZZZ, GZB4ZZZ	03, 05, 07, 09, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 22, 24, 33, 49, 50, 52, 53, 71, 72

Deprescribing of Benzodiazepines in Older Adults (DBO)

Medicare

The percentage of members 67 years of age and older who were dispensed benzodiazepines and achieved a 20% decrease or greater in benzodiazepine dose (diazepam milligram equivalent [DME] dose) during the measurement year.

Frequently utilized provider best practices

- Evaluate benzodiazepine use for all patients and periodically attempt a dose reduction to ensure the lowest effective dose is prescribed.
- Before prescribing a new medication for an elderly member, check first to see if a non-benzodiazepine alternative is available.
- Avoid benzodiazepine use in the elderly due to increased risk of adverse reactions in this population, unless medically necessary.
- Query the PDMP to review controlled substance use across all providers prior to prescribing and evaluate frequency of utilization.
- Review exclusions section and ensure that if the member has an excluded diagnosis that it is coded correctly

Common medications for this measure
(Note: Medications listed are subject to plan coverage and contracted fee schedule.)

Oral Benzodiazepine Medications

Type	Medication	Strength	DME Conversion Factor
Alprazolam (oral)	Alprazolam 0.25 MG Medications List Alprazolam 0.5 MG Medications List Alprazolam 1 MG Medications List Alprazolam 1 MGPML Medications List Alprazolam 2 MG Medications List Alprazolam 3 MG Medications List	0.25 mg 0.5 mg 1 mg 1 mg 2 mg 3 mg	0.1
Chlordiazepoxide (oral)	Chlordiazepoxide 5 MG Medications List Chlordiazepoxide 10 MG Medications List Chlordiazepoxide 25 MG Medications List	5 mg 10 mg 25 mg	2.5
Clonazepam (oral)	Clonazepam 0.125 MG Medications List Clonazepam 0.25 MG Medications List Clonazepam 0.5 MG Medications List Clonazepam 1 MG Medications List Clonazepam 2 MG Medications List	0.125 mg 0.25 mg 0.5 mg 1 mg 2 mg	0.1
Clorazepate (oral)	Clorazepate 3.75 MG Medications List Clorazepate 7.5 MG Medications List Clorazepate 15 MG Medications List	3.75 mg 7.5 mg 15 mg	1.5
Diazepam (oral)	Diazepam 1 MGPML Medications List Diazepam 2 MG Medications List Diazepam 5 MG Medications List Diazepam 5 MGPML Medications List Diazepam 10 MG Medications List	1 mg 2mg 5mg 5mg 10 mg	1
Estazolam (oral)	Estazolam 1 MG Medications List Estazolam 2 MG Medications List	1 mg 2 mg	0.3
Flurazepam (oral)	Flurazepam 15 MG Medications List Flurazepam 30 MG Medications List	15 mg 30 mg	3
Lorazepam (oral)	Lorazepam 1 MG Medications List Lorazepam 2 MGPML Medications List	1 mg 2 mg	0.2
Midazolam (oral)	Midazolam 2 MGPML Medications List	2 mg	1.5
Oxazepam (oral)	Oxazepam 10 MG Medications List Oxazepam 30 MG Medications List	10 mg 30 mg	3
Quazepam (oral)	Quazepam 15 MG Medications List	15 mg	2

	Temazepam (oral)	Temazepam 7.5 MG Medications List Temazepam 15 MG Medications List Temazepam 22.5 MG Medications List Temazepam 30 MG Medications List	7.5 mg 15 mg 22.5 mg 30 mg	2
	Triazolam (oral)	Triazolam 0.125 MG Medications List Triazolam 0.25 MG Medications List	0.125 mg 0.25 mg	0.025

Exclusions	• Exclude members who meet any of the following criteria between the first day of the measurement period and the start date for the index treatment episode.
	  • Diagnosis of seizure disorder
	  • Rapid eye movement sleep behavior disorder
	  • Benzodiazepine withdrawal
	  • Ethanol withdrawal
	
	See Appendix 1 for palliative care exclusion codes.			

Medication Adherence for Diabetes Medications ★

Medicare

The percent of members with a prescription for diabetes medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.

Frequently utilized provider best practices

- Schedule proper follow-up with the members to evaluate if medication is taken as prescribed.
- Review medication cost with member at every visit and ensure prescribed therapy is still affordable.
- Make sure the pharmacy is filling the correct dose with accurate directions, and when verbally telling a patient to change a dose, send a new prescription to reflect this change.
- Convert member's diabetes medication to a 90-day or 100-day supply at mail order or retail pharmacy to boost adherence.
- Review missing pharmacy refills to ensure members are getting timely refills.
- Educate members on the importance of staying on the medication.
- Be sure to review directions and make sure accurate prescription is sent to the pharmacy.

Common medications for this measure
(Note: Medications listed are subject to plan coverage and contracted fee schedule.)

Diabetes Medications

Class	Medication(s)	
Biguanides	Metformin	
Dpp 4 Inhibitors	Alogliptin Linagliptin	Saxagliptin Sitagliptin
Glp1 Receptor Agonists	Albiglutide Dulaglutide Exenatide	Liraglutide Lixisenatide Semaglutide
Meglitinides	Nateglinide	Repaglinide
Sodium Glucose Co Transporter2 Sglt2 Inhibitors	Canagliflozin Dapagliflozin	Empagliflozin Ertugliflozin
Sulfonylureas	Chlorpropamide Glimepiride Glipizide	Glyburide Tolazamide Tolbutamide
Thiazolidinediones	Pioglitazone	Rosiglitazone

Exclusions

- ESRD diagnosis or dialysis coverage dates
- Members who take insulin are not included

Medication Adherence for Hypertension (RAS antagonists) ★

Medicare

The percent of members with a prescription for a blood pressure medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.

Frequently utilized provider best practices

- Schedule proper follow-up with the members to evaluate if medication is taken as prescribed.
- Make sure the pharmacy is filling the correct dose with accurate directions, and when verbally telling a patient to change a dose, send a new prescription to reflect this change.
- Convert member's hypertension medication to a 90-day or 100-day supply at mail order or retail pharmacy to boost adherence.
- Review missing pharmacy refills to ensure members are getting timely refills.
- Educate members on the importance of staying on the medication.

Common medications for this measure
(Note: Medications listed are subject to plan coverage and contracted fee schedule.)

RASA Medications

Class	Medication(s)	
Direct Renin Inhibitor Medications and Combinations	aliskiren (+/- hydrochlorothiazide)	
ARB Medications and Combinations	azilsartan (+/- chlorthalidone) irbesartan (+/- hydrochlorothiazide) candesartan (+/- hydrochlorothiazide) losartan (+/- hydrochlorothiazide) eprosartan (+/- hydrochlorothiazide)	olmesartan (+/- amlodipine, hydrochlorothiazide) telmisartan (+/- amlopdipine, hydrochlorothiazide) valsartan (+/- amlodipine, hydrochlorothiazide nebivolol)
ACE Inhibitor Medications and Combination Products	benazepril (+/- amlodipine, hydrochlorothiazide) captopril (+/- hydrochlorothiazide) enalapril (+/- hydrochlorothiazide) fosinopril (+/- hydrochlorothiazide) ramipril	lisinopril (+/- hydrochlorothiazide) moexipril (+/- hydrochlorothiazide) perindopril (+/- amlodipine) quinapril (+/- hydrochlorothiazide) trandolapril (+/- verapamil)

Common chart deficiencies

- No documentation of review of medications at every visit.
- No documentation of conversation about the importance of medication compliance.
- Be sure to review directions and make sure accurate prescription is sent to the pharmacy

Exclusions

- ESRD diagnosis or dialysis coverage dates
- One or more prescriptions for sacubitril/valsartan

Medication Adherence for Cholesterol ★ — Medicare

The percent of members with a prescription for a cholesterol medication (a statin drug) who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.

Frequently utilized provider best practices

- Review member medication list to ensure current statin therapy and to determine statin use history.
- Dose reduction, statin medication change, and alternate-day dosing are all options for patients who may have adverse effects from a particular statin medication.
- Schedule proper follow-up with the members to evaluate if medication is taken as prescribed.
- Make sure the pharmacy is filling the correct dose with accurate directions, and when verbally telling a patient to change a dose, send a new prescription to reflect this change.
- Convert member's statin medication to a 90-day or 100-day supply at mail order or retail pharmacy to boost adherence.
- Review missing pharmacy refills to ensure members are getting timely refills.
- Educate members on the importance of staying on the medication.

Common medications for this measure
(Note: Medications listed are subject to plan coverage and contracted fee schedule.)

Statin Medications	
Fluvastatin	pravastatin
Pitavastatin	simvastatin (+/-ezetimibe, niacin)
Rosuvastatin	lovastatin (+/- niacin)
atorvastatin (+/- amlodipine)	

Common chart deficiencies

- No documentation of review of medications at every visit.
- No documentation of conversation about the importance of medication compliance.
- Be sure to review directions and make sure accurate prescription is sent to the pharmacy (such as every other day dosing).

Exclusions

- ESRD diagnosis or dialysis coverage dates

Hemoglobin A1C Control for Patients with Diabetes (HBD) ★

Commercial, Exchange, Medicare, Medicaid, P4Q, PQS

The percentage of members 18-75 years of age with diabetes (types 1 and 2) whose hemoglobin A1c (HbA1c) was at the following levels during the measurement year.

- HbA1c Control (<8.0%)
- HbA1c Poor Control (>9.0%)

Note: A lower rate indicates better performance for this indicator (i.e., low rates of poor control indicate better care).

The last A1c of the reporting period counts for both measures.

Frequently utilized provider best practices	• Point of care testing in the office setting. • CPTII codes with POC testing or at follow-up visit after labs were completed. • Help African Americans and other underserved populations understand the importance of keeping A1cs in check and of timely A1c monitoring.

Common codes for this measure
(Note: Codes listed are subject to plan coverage and contracted fee schedule.)

Description	Codes	
HbA1c Level Less Than 7.0	**CPTII:**	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
HbA1c Level Greater Than 9.0		3046F
HbA1c Lab Test	**CPT:**	83036, 83037

Common chart deficiencies

- Doing unnecessary testing
- Not using CPTII codes at visits after labs

Exclusions	See Appendix 1 for frailty, advanced illness, and palliative care exclusion codes and dementia medications.
Medical record documentation	Medical record dates: January 1, 2023 – December 31, 2023 Submit medical records to 570-214-1380

Blood Pressure Control for Patients with Diabetes (BPD) ★

Commercial, Medicare, Medicaid

The percentage of members 18–75 years of age with diabetes (types 1 and 2) whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the measurement year.

Frequently utilized provider best practices

- Use CPTII codes for blood pressures at every visit
- When bringing a patient in for a BP recheck be sure to do a nurse visit if possible and submit CPTII code.

Common codes for this measure
(Note: Codes listed are subject to plan coverage and contracted fee schedule.)

Description	Codes	
Systolic Less Than 140	**CPTII:**	3074F, 3075F
Systolic Greater Than or Equal to 140		3077F
Diastolic Less Than 80		3078F
Diastolic 80-89		3079F
Diastolic Greater Than or Equal to 90		3080F

Common chart deficiencies

- Not using CPTII codes at visits after labs
- Not rechecking and documenting patients with elevated BP

Exclusions

See Appendix 1 for frailty, advanced illness, and palliative care exclusion codes and dementia medications.

Eye Exam for Patients with Diabetes (EED) ★

Commercial, Exchange, Medicare, Medicaid, PQS

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

Frequently utilized provider best practices

- If patient has an eye exam find out where and retrieve records
- CPTII for all eye exams when possible

Common codes for this measure
(Note: Codes listed are subject to plan coverage and contracted fee schedule.)

Description	Codes	
*Diabetic Retinal Screening in the measurement year	CPT:	67028, 67030, 67031, 67036, 67039, 67040, 67041, 67042, 67043, 67101, 67105, 67107, 67108, 67110, 67113, 67121, 67141, 67145, 67208, 67210, 67218, 67220, 67221, 67227, 67228, 92002, 92004, 92012, 92014, 92018, 92019, 92134, 92201, 92202, 92225, 92226, 92227, 92228, 92230, 92235, 92240, 92250, 92260, 99203, 99204, 99205, 99213, 99214, 99215, 99242, 99243, 99244, 99245
	HCPCS:	S0620, S0621, S3000
*Diabetic Retinal Screening in year prior to the measurement year	Any above PLUS DM Without Compli-cations (ICD10):	E10.9, E11.9, E13.9
Any Provider in the measurement year	CPT:	92229
	CPTII:	2022F, 2024F, 2026F, 2023F, 2025F, 2033F, 3072F
Any Provider in the year prior to the measurement year	CPTII:	2023F, 2025F, 2033F
Eye Enucleation (both must be coded as removed)	CPT:	Modifier 50 or 2 >14 days apart with: 65091, 65093, 65101, 65103, 65105, 65110, 65112, 65114
	ICD10PCS:	08T1XZZ and 08T0XZZ

Common chart deficiencies

- Not retrieving record of your patients' eye exams

Exclusions

See Appendix 1 for frailty, advanced illness, and palliative care exclusion codes and dementia medications.

Medical record documentation

Medical record dates: see below. Fax records to 570-214-1380

- Negative Eye exams January 1, 2023 – December 31, 2023
- Positive Eye exams January 1, 2022 – December 31, 2023

Kidney Health Evaluation for Patients with Diabetes (KED)

Commercial, Exchange, Medicare, Medicaid

The percentage of members 18 – 85 years of age with diabetes (type 1 and type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) ***and*** a urine albumin-creatinine ration (uACR) during the measurement year. The uACR may be identified by both a quantitative urine albumin test **and** a urine creatinine test <=4 days apart, **or** by a uACR.

NOTE: Rates for this measure are substantially lower than the previous measure, Diabetic Nephropathy. The measures should not be compared.

Frequently utilized provider best practices

- Collect appropriate testing in a timely manner.

Common codes for this measure
(Note: Codes listed are subject to plan coverage and contracted fee schedule.)

Description	Codes	
eGFR test	**CPT:**	80047, 80048, 80050, 80053, 80069, 82565
Quantitative urine albumin test	**CPT:**	82043
Urine creatinine test	**CPT:**	82570
uACR	**LOINC:**	13705-9, 14958-3, 14959-1, 30000-4, 32294-1, 44292-1, 59159-4, 76401-9, 77253-3, 77254-1, 89998-9, 9318-7

Common chart deficiencies

- Failure to collect testing within the measurement year

Exclusions

See Appendix 1 for frailty, advanced illness, and palliative care exclusion codes and dementia medications.

Osteoporosis Management in Women Who Had a Fracture (OMW) ★

Medicare

The percentage of women 67 – 85 years of age who suffered a fracture and who had either a bone mineral density (BMD) test or prescription for a drug to treat osteoporosis in the six months after the fracture.

- Women who suffer a fracture are at increased risk of additional fractures and more likely to have osteoporosis.
- Fractures of the finger, toe, face or skull are not included in this measure.
- Osteoporosis therapy on the index episode start date (IESD) (fracture date) or in the 180-day period after the IESD.
- Dispensed prescription to treat osteoporosis on IESD or 180-day period after IESD.

Frequently utilized provider best practices

- Order a BMD test on all women with a diagnosis of a fracture within 6 months OR prescribe medication to prevent osteoporosis.
- BMD test during inpatient stay for fracture.
- Educate member on safety and fall prevention.
- Note, aggressive risk adjustment can overstate osteoporosis by confusing lower Z scores/ osteopenia with osteoporosis.
- Encourage hospital to perform BMD tests prior to discharging member.
- If the member had more than one fracture, identify all fractures and assess eligibility.

Common codes for this measure
(Note: Codes listed are subject to plan coverage and contracted fee schedule.)

Description	Codes	
Bone mineral density test	**CPT:**	76977, 77078, 77080, 77081, 77085, 77086
	ICD10:	BP48ZZ1, BP49ZZ1, BP4GZZ1, BP4HZZ1, BP4LZZ1, BP4MZZ1, BP4NZZ1, BP4PZZ1, BQ00ZZ1, BQ01ZZ1, BQ03ZZ1, BQ04ZZ1, BR00ZZ1, BR07ZZ1, BR09ZZ1, BR0GZZ1
Osteoporosis medication therapy	**HCPCS:**	J0897, J1740, J3110, J3111, J3489
Long-acting osteoporosismedications (during inpatient stay)	**HCPCS:**	J0897, J1740, J3489

Osteoporosis medications

Description	Prescription	
Biphosphonates	Alendronate Alendronate-cholecalciferol Ibandronate	Risedronate Zoledronic acid
Other agents	Abaloparatide Denosumab Raloxifene	Romosozumab Teriparatide

Osteoporosis Management in Women Who Had a Fracture (OMW) ★

Medicare

Good examples

- Initial fractures should use the 7th character "A" for active care, which is generally diagnosed during:
  - Emergency room care
  - Surgical care
  - Evaluation/treatment by the same/different physician

*To use the 7th character A, it must be the first time the member is diagnosed for the fracture.

Example: The member was seen in the ED last week by Dr. Smith but is now seeing Dr. Jones for an orthopedic referral. Dr. Jones would not use the 7th character "A", because it is not the first time the fracture is being diagnosed.

- Subsequent fracture codes use the 7th character "D" for routine healing and recovery which can include:
  - X-rays to monitor fracture healing
  - Cast change/removal
  - Internal/external fixation device removal
  - Adjustment of medication

*Sometimes a patient with a high frailty factor can have compression fractures as an ongoing issue. Each time they are seen, this is not considered a new fracture and the 7th character "D" should be used.

Exclusions	• Members who had a BMD test during the 730 days (24 months) prior to the episode date. • Members who had a claim/encounter for osteoporosis therapy during the 365 days (12 months) prior to the episode date. • Members who received a dispensed prescription or had an active prescription to treat osteoporosis during the 365 days (12 months) prior to the episode date. See Appendix 1 for frailty, advanced illness, and palliative care exclusion codes and dementia medications.

Osteoporosis Screening in Older Women (OSW) — Medicare

The percentage of women 65 – 75 years of age who received osteoporosis screening.

Frequently utilized provider best practices	• Assist member with scheduling testing • Order testing within an appropriate time frame

Common codes for this measure
(Note: Codes listed are subject to plan coverage and contracted fee schedule.)

Description	Codes	
Osteoporosis screening test	CPT:	76977, 77078, 77080, 77081, 77085

Common chart deficiencies
• Failure to order testing for members within the age bracket

Exclusions	• Members who had a claim/encounter for osteoporosis therapy any time in the member's history through December 31 of the measurement year. • Members who had a dispensed prescription to treat osteoporosis any time on or between January 1 three years prior to the measurement year through December 31 of the measurement year. See Appendix 1 for frailty, advanced illness, and palliative care exclusion codes and dementia medications.

Appropriate Testing for Pharyngitis (CWP) — Commercial, Medicare, Medicaid

The percentage of episodes for members 3 years and older where the member was diagnosed with pharyngitis, dispensed anantibiotic and received a group A streptococcus (strep) test.

Frequently utilized provider best practices

- Document all discussions to members on the inappropriate use of antibiotics.
- Perform a rapid strep test or throat culture to confirm diagnosis before prescribing antibiotics.
- Never treat "red throats" empirically, even in children with a long history of strep.
- Submit any co-morbid diagnosis coded that apply on claim/encounter.

Common codes for this measure
(Note: Codes listed are subject to plan coverage and contracted fee schedule.)

Description	Codes	
Group A strep tests	**CPT:**	87070, 87071, 87081, 87430, 87650, 87651, 87652, 87880

Common chart deficiencies

- Prescribing an antibiotic without a positive strep test

Exclusions

See Appendix 1 for frailty and advanced illness exclusion codes.

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

Commercial, Exchange, Medicare, Medicaid

The percentage of episodes for members ages 3 months and older with a diagnosis of acute bronchitis/ bronchiolitis that did not result in an antibiotic dispensing event.

The measure is reported as an inverted rate [1–(numerator/eligible population)]. A higher rate indicates appropriate acute bronchitis/bronchiolitis treatment (i.e., the proportion for episodes that did not result in an antibiotic dispensing event).

Frequently utilized provider best practices

- If member is only diagnosed with acute bronchitis at the visit, NO antibiotic should be ordered.
- Document competing diagnoses or co-morbid condition (such as COPD) in addition to the bronchitis code.
- Provide member education materials on antibiotic resistance, comfort measures and realistic expectations for recovery time.
- If a prescription is filled after office visit, claim will be denied.

Common codes for this measure
(Note: Codes listed are subject to plan coverage and contracted fee schedule.)

Description	Codes	
Acute bronchitis	**ICD10:**	J20.3, J20.4, J20.5, J20.6, J20.7, J20.8, J20.9, J21.0, J21.1, J21.8, J21.9

Common medications for this measure
(Note: Medications listed are subject to plan coverage and contracted fee schedule.)

Antibiotic Medications

Description	Prescription		
Aminoglycosides	Amikacin Gentamicin	Streptomycin Tobramycin	
Aminopenicillins	Amoxicillin	Ampicillin	
Beta-lactamase inhibitors	Amoxicillin-clavulanate Ampicillin-sulbactam	Piperacillin-tazobactam	
First-generation cephalosporins	Cefadroxil Cefazolin	Cephalexin	
Fourth-generation cephalosporins	Cefepime		
Lincomycin derivatives	Clindamycin	Lincomycin	
Macrolides	Azithromycin Clarithromycin	Erythromycin	
Miscellaneous antibiotics	Aztreonam Chloramphenicol Dalfopristin-quinupristin	Daptomycin Linezolid Metronidazole	Vancomycin
Natural penicillins	Penicillin G benzathine-procaine Penicillin G potassium	Penicillin G procaine Penicillin G sodium	Penicillin V potassium Penicillin G benzathine
Penicillinase resistant penicillins	Dicloxacillin	Nafcillin	Oxacillin
Quinolones	Ciprofloxacin Gemifloxacin	Levofloxacin Moxifloxacin	Ofloxacin
Rifamycin derivatives	Rifampin		

	Second-generation cephalosporin	Cefaclor Cefotetan	Cefoxitin Cefprozil	Cefuroxime
	Sulfonamides	Sulfadiazine	Sulfamethoxazole-trimethoprim	
	Tetracyclines	Doxycycline	Minocycline	Tetracycline
	Third-generation cephalosporins	Cefdinir Cefixime Cefotaxime	Cefpodoxime Ceftazidime Ceftriaxone	
	Urinary anti-infectives	Fosfomycin Nitrofurantoin	Nitrofurantoin macrocrystals-monohydrate Trimethoprim	

Common chart deficiencies
- Not coding for co-morbid conditions and competing diagnosis

Appropriate Treatment for Upper Respiratory Infection (URI)

Commercial, Exchange, Medicare, Medicaid

The percentage of episodes for members 3 months of age and older with a diagnosis of upper respiratory infection (URI) thatdid not result in an antibiotic dispensing event.

The measure is reported as an inverted rate [1–(numerator/eligible population)]. A higher rate indicates appropriate acute bronchitis/bronchiolitis treatment (i.e., the proportion for episodes that did not result in an antibiotic dispensing event).

Frequently utilized provider best practices

- If member diagnosis is only URI, they should NOT have an antibiotic.
- Provide education materials on antibiotic resistance, comfort measures to parent/guardian and realistic expectations of recovery time.
- Document a second diagnosis code for any competing diagnosis (e.g., pharyngitis, otitis media, enteritis, whooping cough, etc.) in addition to the URI code.

Common codes forthis measure
(Note: Codes listed are subject to plan coverage and contracted fee schedule.)

Description	Codes	
URI	**ICD10:**	J00, J06.0, J06.9

Common medications for this measure
(Note: Medications listed are subject to plan coverage and contracted fee schedule.)

Antibiotic medications			
Description	**Prescription**		
Aminoglycosides	Amikacin Gentamicin	Streptomycin Tobramycin	
Aminopenicillins	Amoxicillin	Ampicillin	
Beta-lactamase inhibitors	Amoxicillin-clavulanate Ampicillin-sulbactam	Piperacillin-tazobactam	
First-generation cephalosporins	Cefadroxil Cefazolin	Cephalexin	
Fourth-generation cephalosporins	Cefepime		
Lincomycin derivatives	Clindamycin	Lincomycin	
Macrolides	Azithromycin Clarithromycin	Erythromycin	
Miscellaneous antibiotics	Aztreonam Chloramphenicol Dalfopristin-quinupristin	Daptomycin Linezolid Metronidazole	Vancomycin
Natural penicillins	Penicillin G benzathine-procaine Penicillin G potassium	Penicillin G procaine Penicillin G sodium	Penicillin V potassium Penicillin G benzathine
Penicillinase resistant penicillins	Dicloxacillin	Nafcillin	Oxacillin
Quinolones	Ciprofloxacin Gemifloxacin	Levofloxacin Moxifloxacin	Ofloxacin
Rifamycin derivatives	Rifampin		

Appropriate Treatment for Upper Respiratory Infection (URI)				Commercial, Exchange, Medicare, Medicaid
	Second-generation cephalosporin	Cefaclor Cefotetan	Cefoxitin Cefprozil	Cefuroxime
	Sulfonamides	Sulfadiazine	Sulfamethoxazole -trimethoprim	
	Tetracyclines	Doxycycline	Minocycline	Tetracycline
	Third-generation cephalosporins	Cefdinir Cefixime Cefotaxime	Cefpodoxime Ceftazidime Ceftriaxone	
	Urinary anti-infectives	Fosfomycin Nitrofurantoin	Nitrofurantoin macrocrystals-monohydrate Trimethoprim	

Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)

Commercial, Medicare, Medicaid

The percentage of members 40 years of age and older with a new diagnosis of COPD or newly active COPD, who received appropriate spirometry testing to confirm the diagnosis.

The earliest visit in the period between July 1 of the year prior to the measurement year through June 30 of the measurement year that meets criteria becomes the eligible population.

Members who had a diagnosis history of COPD, chronic bronchitis or emphysema within the 2 years prior to the current event are excluded from the eligible population.

Frequently utilized provider best practices	• Integrate use of spirometry testing into newly diagnosed members with COPD. • Make sure members are taking the appropriate medication and retest spirometry.		
Common codes for this measure (Note: Codes listed are subject to plan coverage and contracted fee schedule.)	Description	Codes	
	COPD	**ICD10:**	J44.0, J44.1, J44.9
	Chronic bronchitis	**ICD10:**	J41.0, J41.1, J41.8, J42
	Emphysema	**ICD10:**	J43.0, J43.1, J43.2, J43.8, J43.9
	Spirometry	**CPT:**	94010, 94014, 94015, 94016, 94060, 94070, 94375, 94620
Medical record documentation	Medical record dates: July 1, 2022 – June 30, 2023 Fax medical record information to Geisinger Health Plan Quality Department at 570-214-1380.		

Appendix

Geisinger

Appendix 1 — Frailty, Advanced Illness, Palliative Care Exclusion Codes and Dementia Medications

Description	Codes	
Palliative Care	CPT:	G9054, M1017
Frailty	CPT:	99504, 99509
	HCPCS:	E0100, E0105, E0130, E0135, E0140, E0141, E0143, E0144, E0147, E0148, E0149, E0163, E0165, E0167, E0168, E0170, E0171, E0250, E0251, E0255, E0256, E0260, E0261, E0265, E0266, E0270, E0290, E0291, E0292, E0293, E0294, E0295, E0296, E0297, E0301, E0302, E0303, E0304, E0424, E0425, E0430, E0431, E0433, E0434, E0435, E0439, E0440, E0441, E0442, E0443, E0444, E0462, E0465, E0466, E0470, E0471, E0472, E0561, E0562, E1130, E1140, E1150, E1160, E1161, E1170, E1171, E1172, E1180, E1190, E1195, E1200, E1220, E1240, E1250, E1260, E1270, E1280, E1285, E1290, E1295, E1296, E1297, E1298, G0162, G0299, G0300, G0493, G0494, S0271, S0311, S9123, S9124, T1000, T1001, T1002, T1003, T1004, T1005, T1019, T1020, T1021, T1022, T1030, T1031
	ICD10:	L89.000, L89.001, L89.002, L89.003, L89.004, L89.006, L89.009, L89.010, L89.011, L89.012, L89.013, L89.014, L89.016, L89.019, L89.020, L89.021, L89.022, L89.023, L89.024, L89.026, L89.029, L89.100, L89.101, L89.102, L89.103, L89.104, L89.106, L89.109, L89.110, L89.111, L89.112, L89.113, L89.114, L89.116, L89.119, L89.120, L89.121, L89.122, L89.123, L89.124, L89.126, L89.129, L89.130, L89.131, L89.132, L89.133, L89.134, L89.136, L89.139, L89.140, L89.141, L89.142, L89.143, L89.144, L89.146, L89.149, L89.150, L89.151, L89.152, L89.153, L89.154, L89.156, L89.159, L89.200, L89.201, L89.202, L89.203, L89.204, L89.206, L89.209, L89.210, L89.211, L89.212, L89.213, L89.214, L89.216, L89.219, L89.220, L89.221, L89.222, L89.223, L89.224, L89.226, L89.229, L89.300, L89.301, L89.302, L89.303, L89.304, L89.306, L89.309, L89.310, L89.311, L89.312, L89.313, L89.314, L89.316, L89.319, L89.320, L89.321, L89.322, L89.323, L89.324, L89.326, L89.329, L89.40, L89.41, L89.42, L89.43, L89.44, L89.45, L89.46, L89.500, L89.501, L89.502, L89.503, L89.504, L89.506, L89.509, L89.510, L89.511, L89.512, L89.513, L89.514, L89.516, L89.519, L89.520, L89.521, L89.522, L89.523, L89.524, L89.526, L89.529, L89.600, L89.601, L89.602, L89.603, L89.604, L89.606, L89.609, L89.610, L89.611, L89.612, L89.613, L89.614, L89.616, L89.619, L89.620, L89.621, L89.622, L89.623, L89.624, L89.626, L89.629, L89.810, L89.811, L89.812, L89.813, L89.814, L89.816, L89.819, L89.890, L89.891, L89.892, L89.893, L89.894, L89.896, L89.899, L89.90, L89.91, L89.92, L89.93, L89.94, L89.95, L89.96, M62.50, M62.81, M62.84, W01.0XXA, W01.0XXD, W01.0XXS, W01.10XA, W01.10XD, W01.10XS, W01.110A, W01.110D, W01.110S, W01.111A, W01.111D, W01.111S, W01.118A, W01.118D, W01.118S, W01.119A, W01.119D, W01.119S, W01.190A, W01.190D, W01.190S, W01.198A, W01.198D, W01.198S, W06.XXXA, W06.XXXD, W06.XXXS, W07.XXXA, W07.XXXD, W07.XXXS, W08.XXXA, W08.XXXD, W08.XXXS, W10.0XXA, W10.0XXD, W10.0XXS, W10.1XXA, W10.1XXD, W10.1XXS, W10.2XXA, W10.2XXD, W10.2XXS, W10.8XXA, W10.8XXD, W10.8XXS, W10.9XXA, W10.9XXD, W10.9XXS, W18.00XA, W18.00XD, W18.00XS, W18.02XA, W18.02XD, W18.02XS, W18.09XA, W18.09XD, W18.09XS, W18.11XA, W18.11XD, W18.11XS, W18.12XA, W18.12XD, W18.12XS, W18.2XXA, W18.2XXD, W18.2XXS, W18.30XA, W18.30XD, W18.30XS, W18.31XA, W18.31XD, W18.31XS, W18.39XA, W18.39XD, W18.39XS, W19.XXXA, W19.XXXD, W19.XXXS, Y92.199, Z59.3, Z73.6, Z74.01, Z74.09, Z74.1, Z74.2, Z74.3, Z74.8, Z74.9, Z91.81, Z99.11, Z99.3, Z99.81, Z99.89, R26.0, R26.1, R26.2, R26.89, R26.9, R41.81, R53.1, R53.81, R53.83, R54, R62.7, R63.4, R63.6, R64

Description	Codes	
Advanced Illness	ICD10:	A81.00, A81.01, A81.09, C25.0, C25.1, C25.2, C25.3, C25.4, C25.7, C25.8, C25.9, C71.0, C71.1, C71.2, C71.3, C71.4, C71.5, C71.6, C71.7, C71.8, C71.9, C77.0, C77.1, C77.2, C77.3, C77.4, C77.5, C77.8, C77.9, C78.00, C78.01, C78.02, C78.1, C78.2, C78.30, C78.39, C78.4, C78.5, C78.6, C78.7, C78.80, C78.89, C79.00, C79.01, C79.02, C79.10, C79.11, C79.19, C79.2, C79.31, C79.32, C79.40, C79.49, C79.51, C79.52, C79.60, C79.61, C79.62, C79.63, C79.70, C79.71, C79.72, C79.81, C79.82, C79.89, C79.9, C91.00, C91.02, C92.00, C92.02, C93.00, C93.02, C93.90, C93.92, C93.Z0, C93.Z2, C94.30, C94.32, F01.50, F01.51, F02.80, F02.81, F03.90, F03.91, F04, F10.27, F10.96, F10.97, G10, G12.21, G20, G30.0, G30.1, G30.8, G30.9, G31.01, G31.09, G31.83, G35, I09.81, I11.0, I12.0, I13.0, I13.11, I13.2, I50.1, I50.20, I50.21, I50.22, I50.23, I50.30, I50.31, I50.32, I50.33, I50.40, I50.41, I50.42, I50.43, I50.810, I50.811, I50.812, I50.813, I50.814, I50.82, I50.83, I50.84, I50.89, I50.9, J43.0, J43.1, J43.2, J43.8, J43.9, J68.4, J84.10, J84.112, J84.17, J84.170, J84.178, J96.10, J96.11, J96.12, J96.20, J96.21, J96.22, J96.90, J96.91, J96.92, J98.2, J98.3, K70.10, K70.11, K70.2, K70.30, K70.31, K70.40, K70.41, K70.9, K74.0, K74.00, K74.01, K74.02, K74.1, K74.2, K74.4, K74.5, K74.60, K74.69, N18.5, N18.6

Dementia Medications

Description	Medications
Cholinesterase inhibitors	Donepezil Galantamine Rivastigmine
Miscellaneous central nervous system agents	Memantine
Dementia combinations	Donepezil-memantine

Appendix 2 — Early Childhood Screenings

Early and periodic screening, diagnostic and treatment billing guide

Early and periodic screening, diagnostic and treatment (EPSDT) services are federally mandated services intended to provide preventive healthcare to children and young adults under the age of 21 at periodic intervals which are based on the recommendations of the American Academy of Pediatrics (AAP) and the Centers for Disease Control and Prevention (CDC). All primary care providers (PCPs) who provide services to members under the age of 21 are required to provide comprehensive healthcare, screenings, and preventive services. GHP Family requires participating PCPs to provide all EPSDT services in compliance with federal and state regulations and periodicity schedules.

EPSDT screens for any new member under the age of 21 must be scheduled within 45 days from the effective date of enrollmentunless the child is already under the care of a PCP and the child is current with screens and immunizations.

GHP Family will make quarterly lists available to each PCP that identify members who have not had an encounter during the first6 months of enrollment or members who have not complied with EPSDT periodicity and immunization schedules for children. It is the PCP's responsibility to contact all members who have not had an encounter during the previous 12 months or within the MA appointment time frames. These EPSDT member lists are also available upon request from GHP Family.

These screenings offer a unique opportunity to perform a comprehensive evaluation of a child's health and provide appropriate and timely follow-up diagnostic and treatment services. To encourage providers to perform complete EPSDT screens, support the additional time needed to perform such screens and increase the number of screens performed, EPSDT rates have been established.

To be considered a complete visit, all required components listed on the Department of Human Services (DHS) periodicity schedule must be completed. See (Exhibit A) for the complete DHS periodicity schedule.

If the visit is considered incomplete, the provider will receive the incomplete visit rate. Incomplete EPSDT screens are office visits during which the provider did not complete all the required components listed on the periodicity schedule for the child's screening period. This may include the use of applicable modifiers, diagnosis codes and required referral codes.

What services are included in an EPSDT exam?

- Comprehensive health and developmental history
- Comprehensive unclothed physical exam
- Appropriate immunizations according to age and health history
- Appropriate laboratory tests including lead toxicity screening
- Health education (anticipatory guidance including child development, healthy lifestyles, and accident and disease prevention)

After completion of a comprehensive screen, members are entitled to all services included in the approved DHS State Plan for diagnosing and treating a discovered condition. These services include:

Vision Services

At a minimum, diagnosis and treatment for defects in vision, including eyeglasses. Vision services must be provided according to a distinct periodicity schedule developed by the state and at other intervals as medically necessary. Coding is as follows:

Patient age	Procedure Codeand Description	Modifier 1	Modifier 2
Required at ages 3, 4, 5, 6, 8, 10, 12 and 15	99173 - Visual Acuity Screen	EP	52 – if service not completed
	99174 or 99177- Instrument-based screening		
Risk assessment to be done at ages 7, 9, 11 ,13, 14, 16, 17, 18, 19 and 20			

Dental services

At minimum, dental services include relief of pain and infections, restoration of teeth and maintenance of dental health. Dental services may not be limited to emergency services.

Dental risk assessment has been added to the EPSDT requirement for patients 6 – 8 months of age and again between the ages of 9 – 11 months of age.

YD referral code for dental referrals is required for all complete EPSDT screens delivered to children ages 3 through 20. Report the YD referral code in block 10d.

Hearing services

At a minimum, hearing services include diagnosis and treatment for defects in hearing, including hearing aids. Coding is as follows:

Patient age	Procedure code and description	Modifier 1	Modifier 2
Required at the following ages: Newborn Screen (If not completed as part of the newborn screen, must be done at 3–5 days, 1 month or 2–3 months)	Appropriate CPT code	EP	52 – if service not completed
Required at the following ages: Ages 4, 5, 6, 8 and 10 Once during ages 11 – 14, once during ages 15 – 17 and once during ages 18 – 20	92551 – audio screen 92552 – pure-tone air only 92553 – audiologic function test 92255 – audiologic function test 92556 – audiologic function test	EP	52 – if service not completed
Risk Assessment to be done at ages 3, 7 and 9			

Immunizations

During these visits, vaccines recommended by the **Childhood and Adolescent Immunization Schedule** are administered. The *Recommended Immunization Schedule for Persons Aged 0 Through 18 Years, The Catch-up Immunization Schedule for Persons Aged 4 Months Through 18 Years Who Start Late or Who Are More Than 1 Month Behind and The Vaccines That Might Be Indicated for Children and Adolescents Aged 18 Years Or Younger Based On Medical Indications* can be found here.

Note: Providers who see Medicaid or uninsured patients should utilize the Vaccine for Children Program (VFC) offered by the Department of Health. Providers would receive the vaccine directly from the VFC program at no cost to them. If a VFC vaccine is given during the visit, the provider is reimbursed for the administration of the vaccine. **The provider should submit a claim to GHP Family reporting the appropriate CPT code for the vaccine given.** This process effects children from birth through age 18 (until their 19th birthday) whether they have only Medicaid or Medicaid as a secondary carrier. More information regarding this program can be found on the Department of Health's website.

When reporting immunizations for members not included in the Vaccine for Kids program, as defined by DHS, providers should report both the applicable immunization and administration code **without the use of the EP modifier** and will receive separate reimbursement for both codes. **NDC codes for vaccines should be present on all EPSDT claims.**

Other necessary healthcare services

Diagnostic services

When a screening examination indicates the need for further evaluation of an individual's health, diagnostic services must be provided. Necessary referrals should be made without delay and there should be follow-up to ensure the enrollee receives a complete diagnostic evaluation.

Treatment

Necessary healthcare services must be made available for treatment of all physical and mental illnesses or conditions discovered by any screening and diagnostic procedures.

Tobacco, alcohol or drug use assessment

For patients 11 through 20 years of age, a tobacco, alcohol or drug use risk assessment is to be performed during an EPSDT screening.

Autism screening

Autism — or more precisely the autism spectrum disorders (ASDs) — represents a broad group of developmental disorders characterized by impaired social interactions, problems with verbal and nonverbal communication and repetitive behaviors or severely limited activities and interests. Coding is as follows:

Patient age	Procedure code and description	Modifier 1	Modifier 2
Required at ages 18 and 24 months	96110 – Autism screening	EP	U1**

** The U1 modifier distinguishes the autism screening from the developmental screening.

Developmental screening

Developmental delay is defined as a condition which represents a significant delay in the process of development. More precisely, children may have skills deficits including specific delays in language, perception, meta-cognition and social, emotional and/or motor development. Early identification and quality early intervention services can improve outcomes for children, families and communities.

Coding is as follows:

Patient age	Procedure code and description	Modifier
Required at 9 – 11 months, 18 months and 30 months	96110 – developmental screening	EP

Reporting developmental screening

When a child is referred to another practitioner as a result of the developmental delay screen, the YO EPSDT referral code must be populated in block 10d of the CMS-1500 form. In addition, members with suspected developmental delays under the age of 5 are required to be referred by their PCP to local Early Intervention Program services through the CONNECT Helpline at (800) 692-7288 and should be referred to the GHP Family Special Needs Unit (SNU) for additional comprehensive management.

Resources for developmental screening

Several resources are available to assist providers in educating themselves about surveillance and structured screening and in remaining up to date on validated screening tools. Providers may refer to the following resources for additional information:

- The National AAP Policy Statement: Identifying Infants and Young Children With Developmental Disorders in the Medical Home: An Algorithm for Developmental Surveillance and Screening may be found online at **http://pediatrics.aappublications.org/content/118/1/405.**
- The 2017 Bright Futures Guidelines may be found on the AAP Bright Futures web site on-line at: **https://brightfutures.aap.org/materials-and-tools/guidelines-and-pocket-guide/Pages/default.aspx**
- The Centers for Disease Control and Prevention Child Development Web site online at: **https://www.cdc.gov/ncbddd/childdevelopment/facts.html**
- The Pennsylvania Medical Assistance Bulletin (MAB) 99-09-07 Structured Screening for Developmental Delays and Autism Spectrum Disorder may be found online at: **http://www.dhs.pa.gov/publications/bulletinsearch/bulletinselected/index.htm?bn=99-09-07**

Anemia screening

Anemia is a condition that develops when your blood lacks enough healthy red blood cells or hemoglobin. Coding is as follows:

Patient age	Procedure code and description	Modifier 1	Modifier 2
Required at 9 – 11 months (If not completed at 9 – 11 months, must be done at 12 months)	85013 – Hematocrit	EP	52– if service not completed 90 – if member referred to outside lab
	85018 – Hemoglobin		
If indicated by risk assessment and/or symptoms, ages 15 months thru 20 years			

Dyslipidemia

Dyslipidemia screening is now required for children between the ages of 9 and 11 years of age. Coding is as follows:

Patient age	Procedure code and description	Modifier 1	Modifier 2
Required at age 9 years (If not completed at 9 years, must be done at next screening opportunity of 10 or 11 years) and 17 years (If not completed at 17 years, must be done at next screening opportunity of 18, 19 or 20	80061 –Dyslipidemia	EP	52 – if service not completed 90 – if member referred to outside lab
Risk assessment at 6, 8 and 12 thru 16 years			

Lead screening

Protecting children from exposure to lead is important to lifelong good health. Even low levels of lead in blood have shown to affect IQ, ability to pay attention and academic achievement. Effects of lead exposure cannot be corrected. All GHP Family children are considered at risk for lead toxicity.

Risk questions should be asked at every visit. Coding is as follows:

Patient age	Procedure code and description	Modifier 1	Modifier 2
Required at age 9 – 11 months (If not completed at 9 –11 months, must be done at next screening opportunity of 12, 15 or 18 months) and 24 months (If not completed at 24 months, must be done at next screening opportunity of 30 months, 3, 4, 5 or 6 years	83655 – Lead	EP	52 – if service not completed 90 – if member referred to outside lab

Maternal depression screening

Providers are to use a standardized health risk assessment instrument when screening for maternal depression. Providers may use a standardized screening instrument that is the most suitable tool for the provider's practice. Coding is as follows:

Patient age	Procedure code and description	Modifier 1	Modifier 2
Required by 1 month and at months 2, 4 and 6.	96161 – Maternal depression screening	EP	52 – if service not completed

Additional risk assessment testing to be done if indicated by history and/or symptoms:

Sickle cell

Sickle cell disease (SCD) is an inherited group of red blood cell disorders. Among people with SCD, "sickle" or abnormally shaped red blood cells get stuck in small blood vessels and block the flow of blood and oxygen to organs in the body. These blockages can cause repeated episodes of severe pain, organ damage, and serious infections, or even stroke.

Tuberculin (TB) test

Tuberculosis (TB) is a contagious bacterial infection that usually affects the lungs. In rare cases, it may spread to other body tissues or organs (extrapulmonary TB).

Sexually transmitted diseases (STDs)

STDs can include gonorrhea, syphilis, chlamydia, and more. Any sexually active person can be infected with an STD.

HIV screening – 15 – 18 years of age

Depression screening – 12 – 20 years of age

Reporting EPSDT services

Providers submitting for a complete EPSDT screening, including immunizations, on the CMS 1500 or UB-04 claim form or the 837-electronic format must report:

- Primary diagnosis code: Z00110, Z00111, Z00121, Z00129, Z761, Z762, Z0000 or Z0001
- Visit code 03 EPSDT
- Claim modifiers:
  - EP – Complete EPSDT exam; report EP modifier on all lines of the claim
  - 52 – Incomplete exam; service not provided
  - 90 – Referred child to an outside laboratory
  - U1 – Autism

Age-appropriate evaluation and management codes

Newborn care: 99460 Newborn care (during the admission) 99463 Newborn (same day discharge)

Patient age	New patient	Established patient	Modifier
Age < 1 year	99381	99391	EP
Age 1 – 4 years	99382	99392	EP
Age 5 – 11 years	99383	99393	EP
Age 12 – 17 years	99384	99394	EP
Age 18 – 20 years	99385	99395	EP

EP modifier

The EP modifier is required on the assessment code and this line will be the only line to receive payment. Failure to use the EP modifier on the assessment code may cause the claim to deny or to price per component instead of at the complete screening fee schedule rate. **GHP Family asks that you use the EP modifier on all lines of the claim.**

Billing example 1: A 1-month-old new patient comes into the office for an EPSDT screen. As per the periodicity schedule, the required components for a 1-month EPSDT screen are:

- New patient visit code – 99381
- Maternal depression screening – 96161
- Hearing screen (if not completed at newborn screen) – appropriate CPT code
- Modifiers: EP on all lines of the claim.

Billing example 2: A 4-year-old established patient comes into the office for an EPSDT screen. As per the periodicity schedule, the required components for a 4-year EPSDT screen are:

- Established patient visit code – 99392
- Visual acuity screen – 99173, 99174, and 99177
- Hearing screen – 92551 or 92552
- Venous lead (if not done at 24 months, 30 months or 3-year screen) – 83655
- Referral to a dental provider – Enter YD referral code in Block 10d
- Modifiers: EP on all lines of the claim

Billing example 3: A 9-month-old established patient comes into the office for an EPSDT screen. As per the periodicity schedule, the required components for a 9 –11-month EPSDT screen are:

- Established patient visit code – 99391
- Developmental screen – 96110; if a developmental delay is suspected, enter YO referral code in block 10d and contact the CONNECT Helpline at (800) 692-7288
- Anemia (hemoglobin/hematocrit) – 85018 or 85013
- Venous lead – 83655
- Dental assessment
- Modifiers: EP on all lines of the claim

Note for an incomplete EPSDT:

For providers who were unable to provide a required EPSDT service, please use the appropriate procedure code with modifier 52. Providers should make every effort possible to complete that service at the next screening opportunity. For all procedure codes reported with modifiers 52 or 90, a zero dollar ($0) billed amount must be reported.

Referrals:

When a member is referred to another practitioner as a result of an EPSDT, a two-character referral code must be populated on the claim form (block 10d). An appropriate diagnosis code must be included for each referral.

- YM – Medical referral
- YD – Dental referral (Required component for all children 3 years of age and above)
- YV – Vision referral
- YH – Hearing referral
- YB – Behavioral health referral
- YO – Other referral

Miscellaneous

Coordination of Benefits:

GHP Family will act as the primary payer (unless existing primary coverage is available and known at the time of service) for preventive pediatric care (including EPSDT services to children) and services to children having medical coverage under a Title IV-D child support order.

As mandated by DHS, GHP Family will process and pay claims for the services above, even when records indicate GHP Family is the secondary payer to an existing primary plan. GHP Family may initiate subsequent recovery efforts once the primary plan appropriately processes claims for these services. Providers must always ensure GHP Family receives encounter data for all covered services provided to members, even when third party insurance is primary and GHP Family is the payer of last resort and even when no additional payment from GHP Family is expected.

GHP Family is the payer of last resort on all other services. Providers must bill third party insurance before submitting a claim to GHP Family. GHP Family will pay the difference between the primary insurance payment and GHP Family allowable amount. Providers cannot balance bill members. If the primary insurance carrier denies the claim as a non-covered service, the claim with the denial may be submitted to GHP Family for a coverage determination under the member's program.

It is the provider's responsibility to obtain the primary insurance carrier's explanation of benefits (EOB) or the remittance advice for services rendered to members that have insurance in addition to GHP Family. The primary carrier's EOB or remittance advice should accompany any claims submitted for payment. A detailed explanation of how the claim was paid or denied should be included if not evident from the primary carrier's EOB or the remittance advice. This information is essential for GHP Family to coordinate benefits.

[1] A complete screen must include the following: a comprehensive history; relevant measurements (for assessment of growth), physical examination, anticipatory guidance/counseling/risk factor reduction interventions, all assessments/screenings as indicated on the periodicity schedule and the ordering of appropriate laboratory/diagnostic procedures as recommended by the current AAP guidelines, found at:
https://brightfutures.aap.org/materials-and- tools/guidelines-and-pocket-guide/Pages/default.aspx.

[2] Beginning at 2 years of age, weight for length measurement should be replaced by calculation of body mass index. Age-appropriate nutrition counseling should be provided regarding promotion of healthy weight, healthy nutrition and physical activity.

[3] Blood pressure should be measured as indicated by child's risk status from infant to 3 years of age, when measurement should be universal.

[4] Procedure code 99460 and modifier EP are to be used for a newborn screen performed in the hospital, but not on the same day as hospital discharge.

[5] Procedure code 99463 and modifier EP are to be used for a newborn screen performed in the hospital on the same day as hospital discharge.

[6] Pennsylvania Newborn Screening Panel should be done according to state law, prior to newborn's discharge from hospital. Confirm screen was completed, verify results and follow up as appropriate.

[7] Verify results of Pennsylvania Newborn Screening Panel as soon as possible and follow up as appropriate.

[8] Newborns should be screened for critical congenital heart disease using pulse oximetry before leaving the hospital.

[9] Developmental surveillance is required at each visit for a complete screen, except when developmental screening is required.

[10] Psychosocial/behavioral assessment should be family centered and may include an assessment of child social/emotional health, caregiver depression and social determinants of health, including both risk factors and strengths/protective factors.

[11] If testing for maternal depression and objective vision/hearing testing, anemia, lead, tuberculin or dyslipidemia is not completed, use CPT code for standard testing method plus CPT modifier 52 EPSDT (screening services/components not completed). If a screening service/ component is reported with modifier 52, the provider must complete the screening service/ component during the next screening opportunity, according to the periodicity schedule.

[12] Instrument-based screening may be completed to detect amblyopia, strabismus and/or high refractive error in children who are unable or unwilling to cooperate with traditional visual acuity screening.

[13] All newborns should receive an initial hearing screening before being discharged from hospital. If the hearing screening was not completed in hospital, the hearing screening should occur by 3 months of age.

[14] Screening must be provided at times noted, unless done previously.

[15] At 6 – 8 and 9 –11 months, an oral health risk assessment is to be administered and the need for fluoride supplementation assessed. The first dental examination is recommended at the time of the eruption of the first tooth and no later than 12 months of age. At 12, 18, 24 and 30 months, determine if child has a dental home. If not, complete assessments and refer to dental home.

[16] Beginning at 3 years of age, referral to a dental home is a required screening component and must be reported using the YD referral code.

[17] When laboratory procedures are performed by a party other than the treating or reporting physician, use CPT code plus CPT modifier 90 (reference outside lab).

[18] Initial measurement of hemoglobin or hematocrit to assess for iron-deficiency anemia is recommended between 9 and 12 months of age by the Centers for Disease Control and Prevention. Additionally, the AAP recommends risk assessment for anemia at 4 months of age, 15 months of age and then each periodicity thereafter.

[19] Capillary samples may be used for blood lead testing; however, elevated blood lead results based on capillary samples are presumptive and must be confirmed using a venous sample.

[20] All sexually active patients should be screened for sexually transmitted infections (STI).

[21] Those at increased risk of HIV infection, including those who are sexually active, participate in injection drug use, or are being tested for other STIs, should be tested for HIV and reassessed annually.

Pennsylvania's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program Periodicity Schedule andCoding Matrix – effective March 1, 2021

Services	Newborn (inpatient)	3-5 d	By 1 mo	2-3 mo	4-5 mo	6-8 mo	9-11 mo	12 mo	15 mo	18 mo	24 mo	30 mo	3 y	4 y
Complete Screen: [1,2,3]	A complete screen requires all codes indicated for each periodicity be completed and reported. Report only one CPT code if multiple CPT codes are listed per service, except for immunizations.													
New Patient	99460 EP[4]/ 99463 EP[5]	99381 EP	99381 EP	99381 EP	99381 EP	99381 EP	99381 EP	99382 EP	99382 EP	99382 EP	99382 EP	99382 EP	99382 EP	99382 EP
Established Patient		99391 EP	99391 EP	99391 EP	99391 EP	99391 EP	99391 EP	99392 EP	99392 EP	99392 EP	99392 EP	99392 EP	99392 EP	99392 EP
Pennsylvania newborn screening panel	•[6]	•[7]	—	>										
Newborn bilirubin	•													
Critical Congenital Heart Defect Screening[8]	•													
Developmental Surveillance[9]	•	•	•	•	•	•		•	•		•		•	•
Psychosocial/Behavioral Assessment[10]	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Tobacco, Alcohol or Drug Use Assessment														
Maternal Depression Screening[10,11]			96161	96161	96161	96161								
Developmental Screening							96110			96110		96110		
Autism Screening										96110 U1	96110 U1			
Vision [11]	Assessed through observation or through health history/physical													
• Visual acuity screen													99173	99173
• Instrument-based screening[12]													99174 99177	99174 99177
Hearing [11]	•	•[14]	—	>	Assessed through observation or through health history/physical									
• Audio Screen			—										★	92551
• Pure tone-air only														92552
Oral Health[15]						•	•	★		★	★	★	♦[16]	♦[16]
Anemia [11, 17]														
• Hematocrit (spun)					★[18]		85013[18]	85013[18]	If indicated by risk assessment and/or symptoms					
• Hemoglobin							85018[18]	85018[18]						
Lead [11, 17, 19]						★	83655	83655[14]	83655[14]	83655[14]	83655	83655[14]	83655[14]	83655[14]
Tuberculin Test [11]	If indicated by history and/or symptoms													
Sickle Cell														
Sexually Transmitted Infections [20]														
Dyslipidemia [11, 17]														
Immunizations	Administer immunizations according to the ACIP schedule. Every visit should be considered an opportunity to bring a child's immunizations up to date. Refer to ACIP's Recommended Childhood and Adolescent Immunization Schedules: https://www.cdc.gov/vaccines/schedules/hcp/child-adolescent.html													

Pennsylvania's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program Periodicity Schedule andCoding Matrix – March 1, 2021

Services	5 y	6 y	7 y	8 y	9 y	10 y	11 y	12 y	13 y	14 y	15 y	16 y	17 y	18 y	19 y	20 y
Complete Screen: [1,2,3]	A complete screen requires all codes indicated for each periodicity be completed and reported. Report only one CPT code if multiple CPT codes are listed per service, except for immunizations.															
New Patient	99383 EP	99383 EP	99383 EP	99383 EP	99383 EP	99383 EP	99383 EP	99384 EP	99384 EP	99384 EP	99384 EP	99384 EP	99384 EP	99385 EP	99385 EP	99385 EP
Established Patient	99383 EP	99393 EP	99393 EP	99393 EP	99393 EP	99393 EP	99393 EP	99394 EP	99394 EP	99394 EP	99394 EP	99394 EP	99384 EP	99395 EP	99395 EP	99395 EP
Developmental Surveillance [9]	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Psychosocial/Behavioral Assessment [10]	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Tobacco, Alcohol or Drug Use Assessment							96160 ★	96160 ★	96160 ★	96160 ★	96160 ★	96160 ★	96160 ★	96160 ★	96160 ★	96160 ★
Developmental Screening	If indicated by risk assessment and/or symptoms.															
Autism Screening																
Depression Screening								96127	96127	96127	96127	96127	96127	96127	96127	96127
Vision [11]																
• Visual acuity screen	99173	99173	★	99173	★	99173	★	99173	★	★	99173	★	★	★	★	★
• Instrument-based screening [12]	99174 99177	99174 99177		99174 99177		99174 99177		99174 99177			99174 99177					
Hearing [11]																
• Audio Screen	92551	92551	★	92551	★	92551	←	←	92551	→	←	92551	→	←	←	92551
• Pure tone-air only	92552	92552		92552		92552			92552			92552				92552
Oral Health	♦ [16]	♦ [16]	♦ [16]	♦ [16]	♦ [16]	♦ [16]	♦ [16]	♦ [16]	♦ [16]	♦ [16]	♦ [16]	♦ [16]	♦ [16]	♦ [16]	♦ [16]	♦ [16]
Anemia [11,17]	If indicated by risk assessment and/or symptoms.															
• Hematocrit (spun)	See Recommendations to prevent and control iron deficiency in the United States. *MMWR*. 1998;47(RR-3):1-36.															
• Hemoglobin	Beginning at 12 years of age for females, do once after onset of menses and if indicated by history and/or symptoms.															
Lead [11,17,19]	83655 [14]	83655 [14]														
Tuberculin Test [11]	If indicated by history and/or symptoms.															
Sickle Cell																
Sexually Transmitted Infections [20]											←	←		→		
HIV Screening [21]							★	★	★	★			•		★	★
Hepatitis C Virus Infection [22]														★	★	★
Dyslipidemia [11,17]		★		★	80061	80061 [14]	80061 [14]	If indicated by history and/or symptoms.					80061	80061 [14]	80061 [14]	80061 [14]
Immunizations	Administer immunizations according to the ACIP schedule. Every visit should be considered an opportunity to bring a child's immunizations up to date. Refer to ACIP's Recommended Childhood and Adolescent Immunization Schedules: **https://www.cdc.gov/vaccines/schedules/hcp/child-adolescent.html**															

Appendix 3 — Common Code Types

Visit type	Code type	Codes
Outpatient	**CPT:** **HCPCS:**	99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99429, 99455, 99456, 99483
	HCPCS:	G0402, 0438, G0439, G0463, T1015
Telehealth	**Modifier:**	95, GT
Telephone visits	**CPT:**	98966, 98967, 98968, 99441, 99442, 99443
Nonacute inpatient stay	**CPT:**	99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99318, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337
Online assessments	**CPT:**	98969, 99444
Acute inpatient	**CPT:**	99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99251, 99252, 99253, 99254, 99255, 99291
IET stand-alone visits	**CPT:**	98960, 98961, 98962, 99078, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99483, 99492, 99493, 99494, 99510
IET visits Group 1	**CPT:**	90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876
IET visits Group 2	**CPT:**	99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99251, 99252, 99253, 99254, 99255
Deliveries	**CPT:**	59400, 59409, 59410, 59510, 59514, 59515, 59610, 59612, 59614, 59618, 59620, 5962

Appendix 3 — Common Code Types (continued)

Visit type	Code type	Codes
Prenatal bundled services	**CPT:**	59400, 59425, 59426, 59510, 59610, 59618
	HCPCS:	H1005
Prenatal visits	**CPT:**	99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99483
	HCPCS:	G0463, T1015
Stand-alone prenatal visits	**CPT:**	99500
	CPTII:	0500F, 0501F, 0502F
	HCPCS:	H1000, H1001, H1002, H1003, H1004
Obstetric panel	**CPT:**	80055, 80081
Prenatal ultrasound	**CPT:**	76801, 76805, 76811, 76813, 76815, 76816, 76817, 76818, 76819, 76820, 76821, 76825, 76826, 76827, 76828

Appendix 4 — MedInsight PCP Attribution

MedInsight's standard attribution algorithm reviews 24 months of data. Each member is attributed to the PCP with the most visits and, in the case of a tie, to the PCP with the most recent visit. Note that urgent care services are excluded from consideration.

Description of MSSP attribution methodology

Medicare Shared Savings Program (MSSP) uses a two-step process to assign a member to an accountable care organization (ACO). To be assigned to an ACO, the member must receive at least one primary care service from a physician within the ACO. If the member receives primary care services from more than one ACO, the assigning process compares the proportion of primary care services (measured in terms of allowed charges) provided to a member by different ACOs and assigns the member to the ACO with the highest proportion.

1. In the first step, a member is assigned to an ACO when they receive a greater proportion of primary care services from PCPs within the ACO as compared to other ACOs.
2. PCPs are defined as those physicians with one of four specialty designations — internal medicine, general practice, family practice or geriatric medicine — or those who provide services furnished in a federally qualified health center (FQHC) or rural health clinic (RHC).
3. If a member does not receive primary care services from any PCP, either inside or outside of the ACO, then the member is assigned to an ACO when they receive a greater proportion of primary care services from specialist physicians and certain non-physician practitioners (nurse practitioners, clinical nurse specialists, and physician assistants) within the ACO as compared to other ACOs.

The following table lists the Evaluation and Management (E&M) codes (Table A) used in our standard PCP attribution algorithm. We have noted the E&M codes used in the MSSP method with an asterisk (*). The MSSP method uses E&M codes for services delivered in various inpatient facility settings. We used Milliman's Health Cost Guidelines (HCG) Grouper code sets, our review of other source documents, and clinical and actuarial judgment to develop the list of E&M codes in Table A.

Table A – Evaluation and Management (E&M) visit codes for PCP attribution (updated 2021)

Procedure code	Description	Procedure code	Description
99201*	Office/outpatient visit new	99354*	Prolonged e&m/psyctx serv o/p
99202*	Office/outpatient visit new	99355*	Prolonged e&m/psyctx serv o/p
99203*	Office/outpatient visit new	99358	Prolonged service w/o contact
99204*	Office/outpatient visit new	99359	Prolonged service w/o contact add
99205*	Office/outpatient visit new	99361	Med Conf by phy w/interd team
99211*	Office/outpatient visit est	99381	Int pm e/m new pat infant
99212*	Office/outpatient visit est	99382	Int pm e/m new pat 1-4 yrs
99213*	Office/outpatient visit est	99383	Prev visit new age 5-11
99214*	Office/outpatient visit est	99384	Prev visit new age 12-17
99215*	Office/outpatient visit est	99385	Prev visit new age 18-39
99241	Office Consultation	99386	Prev visit new age 40-64
99242	Office Consultation	99387	Init pm e/m new pat 65+ yrs
99243	Office Consultation	99392	Prev visit est age 1-4
99244	Office Consultation	99393	Prev visit est age 5-11
99245	Office Consultation	99394	Prev visit est age 12-17
99271	Conf Cons for new or est pt	99395	Prev visit est age 18-39
99272	Conf Cons for new or est pt	99396	Prev visit est age 40-64
99273	Conf Cons for new or est pt	99397	Per pm reeval est pat 65+ yr
99274	Conf Cons for new or est pt	99401	Preventive counseling indiv
99275	Conf Cons for new or est pt	99402	Preventive counseling indiv
99341*	Home visit, new patient	99403	Preventive counseling indiv
99342*	Home visit, new patient	99404	Preventive counseling indiv
99343*	Home visit, new patient	99411	Preventive counseling group
99344*	Home visit, new patient	99412	Preventive counseling group
99345*	Home visit, new patient	99420	Health risk assessment test
99347*	Home visit, est patient	99429	Unlisted preventive service
99348*	Home visit, est patient	99499	Unlisted e&m service
99349*	Home visit, est patient		
99350*	Home visit, est patient		