2024 HEDIS® PROVIDER REFERENCE GUIDE

Plus CMS Stars, CAHPS® and HOS tips, helping you address your patients' care opportunities and increase your practice's performance this year

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How to use this guide

This is a comprehensive guide to help you better understand HEDIS® and its impact on your patients, your practice and our health plan. In the pages to follow, you'll find a breakdown of each HEDIS measure, which includes:

- ✓ A description of the measure
- ✓ Correct billing codes for claims submissions
- ✓ Tips and best practices to help close care opportunities and improve your HEDIS rates

Use the Table of Contents to jump to the section or measure you want to learn more about.

What is HEDIS?

The National Committee for Quality Assurance (NCQA) developed and maintains the Healthcare Effectiveness Data and Information Set (HEDIS). It's one of the most widely used performance measure sets in managed care.

NCQA and the Centers of Medicare and Medicaid Services (CMS) require health plans to conduct HEDIS reporting. They use this reporting for health plan accreditation, Star Ratings and regulatory compliance.

We collect HEDIS information through a combination of claims data, medical record audits, EDCS and member surveys. This data provides information on customer satisfaction, specific health care measures and structural components that ensure quality of care.

It's important to understand HEDIS requirements to improve measure performance and quality of care. As physicians, pharmacists, office staff, medical staff and health plan employees, you have a direct impact on each measure. You can create positive HEDIS outcomes when you emphasize and focus your efforts on patient care.

Why is HEDIS important?

HEDIS ratings are very important to health plans. The scores we receive help us understand the quality of care our members receive in preventive care and those with common chronic and acute illnesses.

HEDIS ratings also help employers and consumers make reliable health plan comparisons based on care of quality and outcomes.

Annual HEDIS Timeline

January to early May	➜	Quality Improvement staff collect and review HEDIS data through on-site provider office chart abstraction and fax requests
June	➜	HEDIS results are certified and reported to NCQA
September / October	➜	NCQA releases Quality Compass® results

How are HEDIS rates calculated?

HEDIS rates are calculated with administrative data or hybrid data. Administrative data includes claim data which providers submit to the health plan and supplemental data. Hybrid data includes both administrative data and a sample of medical record data. Hybrid measures require review of a random sample of medical records to abstract data for services rendered but not reported to the health plan through claims or encounter data. **Accurate and timely claims and encounter data may reduce the need for medical record review.**

HEDIS includes more than 80 measures across six domains:

- ✓ Effectiveness of care (includes prevention and screening, respiratory and cardiovascular conditions, diabetes, musculoskeletal conditions, behavioral health, medication management and care coordination, overuse / appropriateness and more)
- ✓ Access / availability of care
- ✓ Utilization and risk adjusted utilization
- ✓ Experience of care
- ✓ Measures reported using electronic clinical data systems
- ✓ Health plan descriptive information

Find more information from NCQA.

What is a provider's role in HEDIS?

Providers play an essential role in promoting the health of your patients, our members. Your practice can help increase HEDIS scores by discussing the importance of preventive health screenings and exams and managing chronic disease with your patients.

Some HEDIS measures are included in our **provider incentive programs** (login required) and increasing scores may positively impact your payout for these programs.

Most importantly, reinforcing preventive care compliance and managing chronic illnesses with your patients will ultimately improve their health outcomes.

You can assist by doing the following:

- ✓ Submitting complete, correct and timely claims
- ✓ Making sure chart documentation reflects services billed
- ✓ Accurately coding all claims with appropriate CPT, CPT II and/or HCPCS codes*
- ✓ Avoiding missed opportunities by taking advantage of sick care visits, combining well visit components and using a modifier and proper codes to bill for both the sick and well visits
- ✓ Routinely scheduling a patient's next appointment while they're in the office for the visit
- ✓ Submitting supplemental data to close open care opportunities
- ✓ Responding promptly to our requests for medical records
- ✓ Encouraging your patients to get preventive screenings, such as cervical cancer screenings, mammography and colorectal cancer screenings

HEDIS measures are linked to specific coding criteria and so accurate coding is critical. Including appropriate CPT II codes on claims will improve efficiencies in closing gaps in care since CPT II codes provide more detail. And finally, providing accurate information could also reduce medical record review requests.

Medical Record Documentation

Document all current and past:

- Screenings (e.g., mammograms, colonoscopy)
- Immunizations (e.g., flu, HPV, MMR, Hep A)
- Test results (e.g., A1c, nephrology, FOBT kits)
- Surgical history
- Treatments
- Health education
- Prescriptions

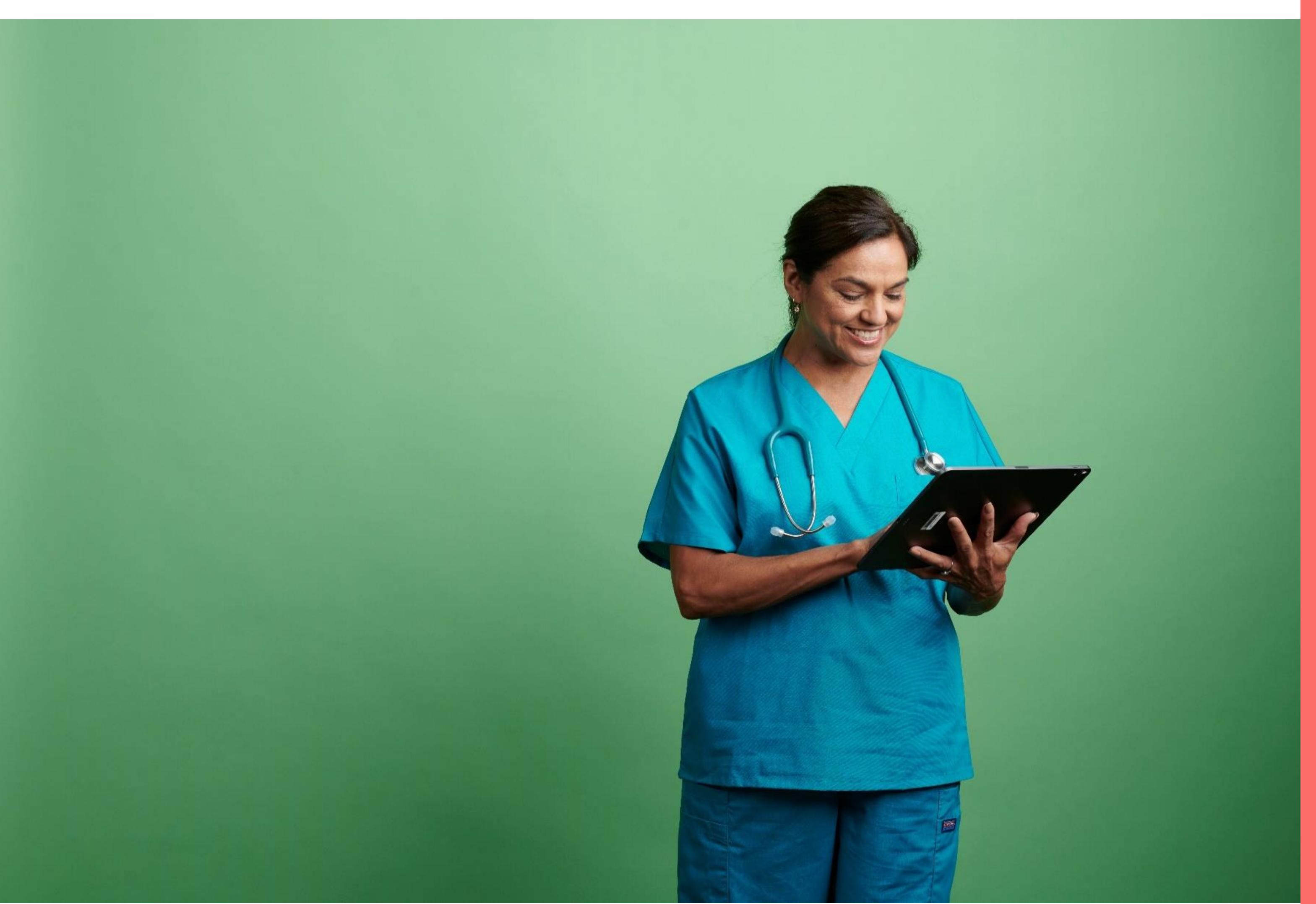
Ensure that…

✓ The patient's name and date of birth are **on every page** of the progress notes and lab results

✓ The physician, physician assistant or nurse practitioner has **signed the progress notes** after each visit

If you have the needed documentation to close care gaps, submit it to our HEDIS department by:

- ✓ **Electronically** uploading medical records – please contact ***HEDIS@priorityhealth.com*** to get a file set up or for more information
- ✓ **Email**: ***HEDIS@priorityhealth.com***
- ✓ **Fax**: 616.975.8897
- ✓ **Mail**: HEDIS at 1231 E Beltline, NE Mail Stop 1280, Grand Rapids, MI, 49525



What is the CMS Medicare Star Rating Program?

The Centers for Medicare & Medicaid Services (CMS) uses a five-star quality rating system to measure the experiences Medicare beneficiaries have with their health plan and health care system. This is the Star Rating Program. Health plans are rated on a scale of 1 to 5 stars, with 5 being the highest. These ratings are then published for consumers to gauge a plan's quality rating, ease of access to care, provider and health plan experience and satisfaction.

The Star Rating Program is intended to:

- Raise the quality of care for Medicare beneficiaries
- Strengthen beneficiary protections
- Help consumers compare health plans more easily

CMS Star Ratings Categories:

- **Staying Healthy:** Plans are rated on whether patients had access to preventive services to keep them healthy. This includes physical examinations, vaccinations like flu shots, preventive screenings and reported improvements in their physical and mental health.

- **Managing Chronic Conditions:** Plans are rated for care coordination and how frequently patients received services for long-term health conditions.

- **Member Experience with the Health Plan:** Plans are rated on member satisfaction with the plan and providers, including access to care based on the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Survey and Health Outcomes Survey (HOS).

- **Member Complaints:** Plans are rated on how frequently patients submitted complaints or left the plan, whether patients had issues getting needed services and whether plan performance improved from one year to the next.

- **Health Plan Customer Service:** Plans are rated for quality of call center services (including TTY and interpreter services) and processing appeals and new enrollments in a timely manner.

The Medicare star rating system important because it:

- Helps members make informed decisions about health plans
- Promotes a higher quality of care for members
- Provides richer benefits for members

What are the CAHPS and HOS surveys?

The Centers for Medicare & Medicaid Services (CMS) develop, implement and administer different patient experience surveys. These surveys ask patients (or in some cases their family members or caregiver) about their experiences with, and ratings of, their health care providers and plans.

CAHPS Survey

Experience ≠ satisfaction

Patient experience surveys are sometimes mistaken for customer satisfaction surveys. However, they're very different.

Patient experience surveys do:

- Ask patients whether or how often they experienced critical aspects of health care, including communication with their doctors, understanding their medication instructions and the coordination of their health care needs
- Focus on how patients' experiences are perceived as key aspects of their care

Patient experience surveys don't:

- Ask patients how satisfied they were with their care
- Focus on amenities

The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey assesses patients' experiences and satisfaction with health care. Each year, a random sample of health plan patients across commercial, Medicaid and Medicare product lines are selected to participate in the CAHPS survey. The CAHPS survey results also have an impact on the CMS Star ratings.

The CAHPS survey is administered between March and June and focuses on matters that patients themselves say are important to them based on the patient doctor relationship, such as:

- Getting care quickly
- Getting needed care/access
- Care coordination between PCP and specialists
- Communication
- Annual flu vaccine
- Rating of health care

HOS Survey

The Medicare Health Outcomes Survey (HOS) is a patient survey that also impacts CMS Star ratings. The HOS assesses the ability of a Medicare organization to maintain or improve the physical and mental health of its Medicare patients over time.
A random sample of health plan patients is selected to participate in the HOS program each year. Two years later, the same patients receive a follow-up survey. The survey results are compared, and the overall health of the patients is rated as better than, the same as or worse than expected. The surveys are administered between August and November and measure the following:

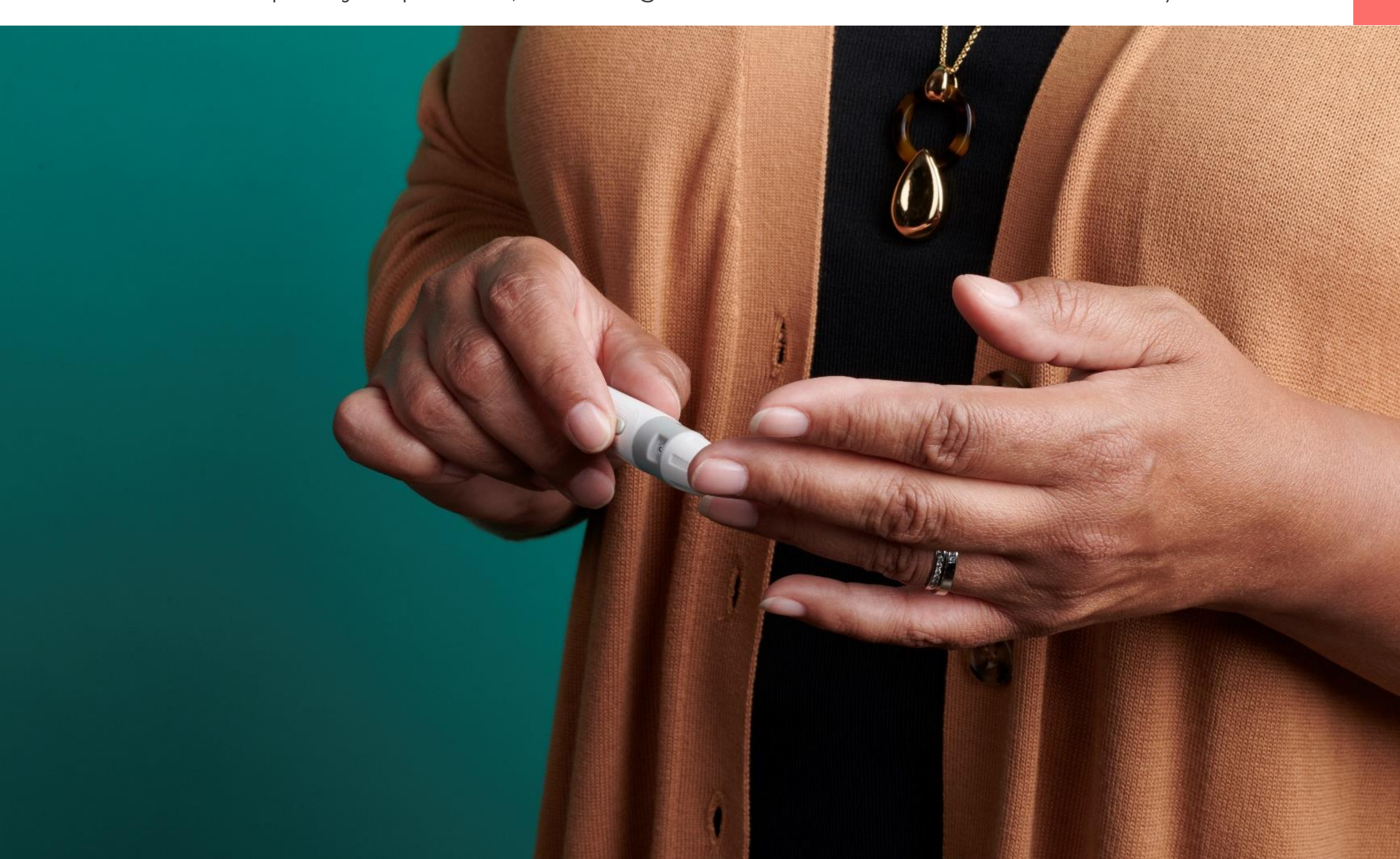
- Improved or maintained mental health
- Improved or maintained physical health
- Monitored physical activity
- Improved bladder control
- Monitored physical activity
- Reduced risk of falling

For more information about CAHPS and HOS, **download this information guide**.

Achieve excellence in CAHPS and HOS

As a provider, you can impact all aspects of the program (especially quality of care, access to care and beneficiary experience) by:

- Addressing patient concerns regarding the test/procedure
- Creating a workflow to identify non-compliant patients at appointments and their care gaps
- Getting to your patients as quickly as possible when they're in your office
- Encouraging your patients to get preventive screenings
- Getting to know your patients' needs and special needs
- Identifying barriers to care
- Keeping in touch with your patients:
    - Allowing extra time during appointments for questions and answers
    - Following up with all test results and future appointments
    - Making sure each patient has an annual well check and completes all needed tests and screenings
    - Reaching out to patients who haven't been seen
- Incorporating HOS questions into each visit by talking to patients about physical activity, physical and mental health, bladder control and falls prevention
- Reviewing the CAHPS survey to determine opportunities for you or your office to have an impact (e.g., getting your patients in for appointments as quickly as possible, reviewing tests results and coordination of care)



HEDIS measure guide

This section details every HEDIS measure, including the name of the measure, abbreviation, the services needed to close the care opportunity as well as:

Billing codes

Billing codes identified in the HEDIS specification which make your patient compliant for the measure. Billing these codes doesn't supersede CMS billing guidelines and/or your provider contract with us and doesn't guarantee payment.

Frequency

The timeframe during which the service should be provided for your patient.

Exclusions

Required exclusions identify members who must be excluded from the measure, regardless of numerator compliance. They're listed as part of the eligible population criteria because members who meet the required exclusion criteria are removed when identifying the measure's denominator.

Optional exclusions should only be used to remove members that didn't meet the measure's numerator criteria. Organizations may choose whether to apply optional exclusions.

Test, Service, or Procedure to Close Care Opportunity

This lists information needed by the health plan to show the member is compliant and gives information on where to send it.

Medical Record Documentation

This is what we look for in the documentation for the measure. These items are based on compliant patients and provider best practices.

Common Chart Deficiencies

This section lists the most common areas for improvement in chart documentation.

Symbols

Indicates the measure is a CMS Medicare Star Ratings measure

Indicates that consultation reports, progress notes, health history, labs, pathology and diagnostic reports can be emailed or faxed to our HEDIS department to close your patient's care gap. Contact information is available on page 13 of this guide.

Indicates the measure can be satisfied virtually

Indicates that the measure is an Electronic Clinical Data Systems reported measure

Test, service or procedure to close HEDIS care opportunity

Document all current and past:

- Preventive screenings and/or positive history of the screening (mammograms, colonoscopy
- Immunizations (e.g., flu, MMR, VZV, Hep A) – Ensure that all immunizations are reported in the Michigan Immunization Care Registry (MCIR)
- Test results (e.g., A1c, nephrology, FOBT kits)
- Treatments
- Health education
- Assessments
- Prescriptions, OTC and herbal supplements

5 W's of good documentation for gap closure (EHR/EMR and paper)

Who received the care?	Patient name and date of birth should be on all pages of the medical record (front and back if applicable)
Who provided the care?	• Provider should always sign and date with professional designation on every entry • Document who provided the care for test, cancer screenings etc.
What care or service was provided?	• Be specific and document what services were provided and what was discussed • Avoid subjective descriptions (e.g., well, better) • Never leave blank spaces or lines, to help prevent any altering of the notes • Use appropriate ICD-10, CPT and/or HCPCS codes • Bill CPT II codes when test results, BP readings etc. are recorded or reviewed
When was the care provided to the patient?	Give the date and time of all treatments, screenings and care
Why is good medical documentation so important?	• Defines the purpose for each encounter and the clinical circumstances • Creates consistent ongoing communication among health care providers • Helps support and improve quality of patient care • Improves medical chart reviews for HEDIS clinical care gap closures
Where should you send documentation to close care gaps?	Send medical record documentation to our HEDIS department: ✓ **Electronically** uploading medical records – please contact ***HEDIS@priorityhealth.com*** to get a file set up or for more information ✓ **Email**: ***HEDIS@priorityhealth.com*** ✓ **Fax**: 616.975.8897 ✓ **Mail**: HEDIS at 1231 E Beltline, NE Mail Stop 1280, Grand Rapids, MI, 49525

HEDIS Electronic Clinical Data Systems (ECDS) Reporting

NCQA's newest reporting method helps clinical data create insight for managing the health of individuals and groups. The HEDIS® ECDS Reporting Standard provides health plans with a method to collect and report structured electronic clinical data for HEDIS quality measurement and quality improvement.

HEDIS quality measures reported using ECDS inspire innovative use of electronic clinical data to document high-quality patient care that demonstrates commitment to evidence-based practices. These measures use digital clinical data sources containing member information and allows this information to be used to close gaps in care. Organizations that report HEDIS using ECDS encourage exchange of the information needed to provide high-quality services, ensuring that the information reaches the right people at the right time.

Why is ECDS Important?
The National Committee for Quality Assurance (NCQA) implemented ECDS to help move measures towards a more digital future. ECDS reporting is NCQA's larger strategy to enable a Digital Quality System and is aligned with the industry's move to digital measures. There is potential for traditional reporting to transition to ECDS reporting.

The HEDIS® Electronic Clinical Data Systems (ECDS) reporting methodology encourages the exchange of the information needed to provide high-quality health-care services.

The goal is to promote the integration of clinical information by automatically transferring needed data for gap closure. ECDS measures allow for plans to view quality care prospectively as opposed to reviewing quality care retrospectively.

The ECDS Reporting Standard provides a method to collect, and report structured electronic clinical data for HEDIS quality measurement and improvement.

Benefits to providers:

- Reduced burden of medical record review for quality reporting
- Improved health outcomes and care quality due to greater insights for more specific patient-centered care

Types of ECDS Data
Organizations may use several data sources to provide complete information about the quality of health services delivered to their members. Data systems that may be eligible for HEDIS® ECDS reporting include, but are not limited to, member eligibility files, EHRs, clinical registries, HIEs, administrative claims systems, electronic laboratory reports (ELR), electronic pharmacy systems, immunization information systems (IIS) and disease/case management registries.

The data within these systems come in a variety of formats. The format type determines how the source is audited. Data sources used for HEDIS ECDS reporting are categorized as follows:

EHR/PHR	EHRs and PHRs are transactional systems that store clinically relevant information collected directly from or managed by a patient. An EHR contains the medical and treatment histories of patients; a PHR includes both the standard clinical data collected in a provider's office or another care setting, in addition to information

	curated directly in the PHR by the patient though an application programming interface (API). This data category includes biometric information and clinical samples obtained directly from a patient as well as clinical findings generated as a result of samples collected from a patient (e.g., pathology, laboratory and pharmacy records generated from entities not directly connected to the patient's EHR).
HIE/clinical registry	Health Information Exchange (HIE) and clinical registries eligible for this reporting category include state HIEs, IIS, public health agency systems, regional HIEs (RHIO), Patient-Centered Data Homes™ or other registries developed for research or to support quality improvement and patient safety initiatives. Doctors, nurses, pharmacists, other health care providers and patients can use HIEs to access and share vital medical information, with the goal of creating a complete patient record. HIEs used for ECDS reporting must use standard protocols to ensure security, privacy, data integrity, sender and receiver authentication and confirmation of delivery. Clinical registries collect information about people with a specific disease or condition, or patients who may be willing to participate in research about a disease. Registries can be sponsored by a government agency, nonprofit organization, health care facility or private company, and decisions regarding use of the data in the registry are the responsibility of the registry's governing committee.
Case management system	A shared database of member information collected through a collaborative process of member assessment, care planning, care coordination or monitoring of a member's functional status and care experience. Case management systems eligible for this category of ECDS reporting include any system developed to support the organization's case/disease management activities, including activities performed by delegates.
Administrative	Includes data from administrative claims processing systems for all services incurred (paid, suspended, pending and denied) during the period defined by each measure's participation as well as member management files, member eligibility and enrollment files, electronic member rosters, internal audit files, and member call service databases.

How many ECDS measures are there?
There are currently 13 ECDS measures. NCQA has stated they will increase ECDS reported measures by transitioning traditional measures.

Traditional HEDIS® Measures

- Childhood Immunization Status (CIS-E)
- Immunizations for Adolescents (IMA-E)
- Breast Cancer Screening (BCS-E)
- Cervical Cancer Screening (CCS-E)
- Colorectal Cancer Screening (COL-E)
- Follow-Up Care for Children Prescribed ADHD Medication (ADD-E)

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

ECDS Measures

- Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)
- Unhealthy Alcohol Use Screening and Follow-Up (ASF-E)
- Adult Immunization Status (AIS-E)
- Prenatal Immunization Status (PRS-E)
- Prenatal Depression Screening and Follow-Up (PND-E)
- Postpartum Depression Screening and Follow-Up (PDS-E)
- Social Need Screening and Intervention (SNS-E)

Summary of Changes to HEDIS MY 2024

New measures	• There are no new measures for HEDIS MY 2024
Retired measures	• Colorectal Cancer Screening (COL) • Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR) • Follow-Up Care for Children Prescribed ADHD Medication (ADD)* • Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)* • Non-Recmmended Cervican Cancer Screening in Adolescent Females (NCS) ***Only the COL-E, ADD-E and APM-E measure will be reported.*
Revised measures	• The former Hemoglobin A1c (HbA1c) Control for Patients With Diabetes (HBD) measure was revised to Glycemic Status Assessment for Patients With Diabetes (GSD).

Cervical Cancer Screening (CCS/CCS-E)

The Cervical Cancer Screening measure evaluates women 21-64 years of age who had a cervical cancer screening using either of the following criteria:

- Women 21-64 years of age who had a cervical cytology performed in the measurement year or two years prior
- Women 30-64 years of age who had a cervical cytology/high risk papillomavirus (hrHPV) co-testing performed in the measurement year or four years prior
- Women 30-64 years of age who had a cervical high-risk human papillomavirus (hrHPV) testing performed in the measurement year or four years prior

Product lines	Quality programs affected	Collection and reporting method
• **Commercial** • **Medicaid**	• NCQA Health Plan Ratings	Administrative • Claim data • ECDS Hybrid • Claim data • Medical record review

Numerator compliance	Women who were screened for cervical cancer		
Billing codes	**Description**	**Code type**	**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
		LOINC	10524-7, 18500-9, 19762-4, 19764-0, 19765-7, 19766-5, 19774-9, 33717-0, 47527-7, 47528-5
		SNOMED	171149006, 416107004, 417036008, 440623000, 448651000124104
	Cervical cytology result or finding	**SNOMED**	168406009, 168407000, 168408005, 168410007, 168414003, 168415002, 168416001, 168424006, 250538001, 268543007, 269957009,269958004, 269959007, 269960002, 269961003, 269963000, 275805003, 281101005, 309081009, 310841002, 310842009, 416030007, 416032004, 416033009,439074000,439776006,439888000, 441087007,441088002,441094005,441219009, 441667007, 700399008, 700400001, 1155766001, 62051000119105, 62061000119107, 98791000119102
	High risk HPV test	**CPT**	87624, 87625
		HCPCS	G0476
		LOINC	21440-3, 30167-1, 38372-9, 59263-4, 59264-2, 59420-0, 69002-4, 71431-1, 75694-0, 77379-6, 77399-4, 77400-0, 82354-2, 82456-5, 82675-0, 95539-3
		SNOMED	35904009, 448651000124104
	Cytology examination positive for high-risk human papilomavirus (finding)	**SNOMED**	718591004
		ICD-10 Diagnosis	Q51.5, Z90.710, Z90.712
	Absence of cervix diagnosis	**SNOMED**	37687000, 248911005, 428078001, 429290001, 429763009, 473171009, 723171001, 10738891000119107

	Hysterectomy with no residual cervix	**CPT**	57530, 57531, 57540, 57545, 57550, 57555, 57556, 58150, 58152, 58200, 58210, 58240, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290, 58291, 58292, 58293, 58294, 58548, 58550, 58552, 58553, 58554, 58570, 58571, 58572, 58573, 58575, 58951, 58953, 58954, 58956, 59135
		ICD-10 PCS	0UTC0ZZ, 0UTC4ZZ, 0UTC7ZZ, 0UTC8ZZ
		SNOMED	24293001, 27950001, 31545000, 35955002, 41566006, 46226009, 59750000, 82418001, 86477000, 88144003, 116140006, 116142003, 116143008, 116144002, 176697007, 236888001, 236891001, 287924009, 307771009, 361222003, 361223008, 387626007, 414575003, 440383008, 446446002, 446679008, 708877008, 708878003, 739671004, 739672006, 739673001, 739674007, 740514001, 740515000, 767610009, 767611008, 767612001, 1163275000
Frequency/occurrence		• Cervical cytology – every three years • hrHPV – every five years • Cervical cytology and hrHPV co-testing – every five years	
Required exclusions		• History of hysterectomy with no residual cervix • History of acquired absence of cervix any time in a patient's history • History of cervical agenesis	
Test, service or procedure to close care opportunity		• Cervical pap and results or finding for women 21–64 years of age • HPV testing for women 30–64 years of age • Provide documentation of history of hysterectomy with no residual cervix (complete hysterectomy, radical hysterectomy, total hysterectomy, vaginal hysterectomy)	

Medical record documentation (including but not limited to	Medical record dates: 01/01/2022 – 12/31/2024 for pap 01/01/2020 – 12/31/2024 for HPV • Consultation reports with results • Diagnostic reports with results • Lab reports with results • Health history and physical Submit medical record documentation to Priority Health HEDIS department • Electronically uploading medical records – contact ***HEDIS@PriorityHealth.com*** to get a file set up or for more information • Email: ***HEDIS@PriorityHealth.com*** • Fax: 616.975.8897 Mail: HEDIS at 1231 E Beltline, NE Mail Stop 1280, Grand Rapids, MI 49525
Common chart deficiencies	Documentation of hysterectomy alone does not meet criteria for exclusion. • Documentation must include the words “total”, “complete” or “radical” abdominal or vaginal hysterectomy • Documentation of a “vaginal pap smear” with documentation of “hysterectomy”

Tips and best practices

- Check your Gaps in Care Report to identify your patients with open care opportunities
- Educate patients about the importance of screenings and early detection and encourage screening during preventive and sick visits
- Discuss existing barriers to regular cervical cancer screening
- Request to have results of pap tests sent to you if screening was performed by an OB/GYN or another provider
- Patient-reported information documented in the patient’s medical record is acceptable if there is a date and result of the test or a date of the hysterectomy and acceptable documentation of no residual cervix. The patient reported information must be documented in the patient’s chart by a care provider.
- Use EHR/EMR alerts for patients due for a cervical cancer screening
- Follow up with patients who have overdue cervical cancer screenings
- Help resolve patient barriers to getting screened
- Timely submission of claim data
- Lab results for cervical cancer screening or procedure codes for hysterectomy can be accepted as supplemental data

Prenatal and Postpartum Care (PPC)
Prenatal Care Sub Measure

The Prenatal Care measure evaluates patients who received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the health plan.

Definition
First trimester: 280-176 days prior to delivery (or estimated delivery date [EDD]).

Product lines	Quality programs affected	Collection and reporting method
• **Commercial** • **Medicaid**	• NCQA Health Plan Ratings • State Performance Measure	Hybrid • Claim data • Medical record documentation

Numerator compliance	A prenatal visit in the first trimester or within 42 days of enrollment		
Billing codes	**Description**	**Code type**	**Codes**
	Prenatal bundled services	**CPT**	59400, 59425, 59426, 59510, 59610, 59618
		HCPCS	H1005
	Prenatal visits Bill prenatal visits with diagnosis of pregnancy office visit	**CPT**	99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99483
		HCPCS	G0463, T1015
		ICD-10 Diagnosis	Z34.90, Z34.91, Z34.93
	Stand-alone prenatal visits	**CPT**	99500
		CPT II	0500F, 0501F, 0502F
		HCPCS	H1000, H1001, H1002, H1003, H1004
		SNOWMED	17629007, 18114009, 58932009, 66961001, 134435003, 135892000, 169712008, 169713003, 169714009, 169715005, 169716006, 169717002, 169718007, 169719004, 169720005, 169721009, 169722002, 169723007, 169724001, 169725000, 169726004, 169727008, 171054004, 171055003, 171056002, 171057006, 171058001, 171059009, 171060004, 171061000, 171062007, 171063002, 171064008, 386235000, 386322007, 397931005, 406145006, 409010002, 422808006, 424441002, 424525001, 424619006, 439165004, 439733009, 439816006, 439908001, 440047008, 440227005 440309009, 440536005, 40638004, 440669000, 440670004, 40671000, 441839001, 700256000, 702396006,

			702736005, 702737001, 702738006, 702739003, 702740001, 702741002, 702742009, 702743004, 702744005, 710970004, 713076009, 713233004, 713234005, 713235006, 713237003, 713238008, 713239000, 713240003, 713241004, 713242006, 713386003, 713387007, 717794008, 717795009,
	Online assessments	**CPT**	98969, 98970, 98971, 98972, 99421, 99422, 99423, 99444, 99457, 99458
		HCPCS	G0071, G2010, G2012, G2061, G2062, G2063, G2250, G2251, G2252
	Telephone visits	**CPT**	98966, 98967, 98968, 99441, 99442, 99443
Frequency/occurrence	Every new diagnosis of pregnancy		
Test, service or procedure to close care opportunity	**Prenatal visits:** • Prenatal care visit with an OB/GYN or prenatal care provider, which must indicate documentation and evidence of one of the following: ❖ Diagnosis of pregnancy ❖ Documentation of last menstrual period (LMP), estimated date of delivery (EDD) or gestational age with a prenatal risk assessment and counseling/education or a complete obstetrical history ❖ Obstetric panel ❖ Pelvic exam with obstetric observations ❖ (TORCH) prenatal lab results ❖ A rubella antibody test/titer with an Rh incompatibility (ABO/Rh) blood typing ❖ Ultrasound of pregnant uterus		

Medical record documentation (including but not limited to)	• Consultation reports • Diagnostic reports • Medical history • Prenatal flow sheets/ACOG form • Progress notes • SOAP notes **Prenatal care visit** with an OB/GYN, PCP, or prenatal care provider, which must include one of the following: • A diagnosis of pregnancy <u>and</u>: ❖ Documentation in a standardized prenatal flow sheet **or** ❖ Documentation of LMP, EDD, or gestational age **or** ❖ A positive pregnancy test result **or** ❖ Documentation of gravidity and parity **or** ❖ Documentation of complete obstetrical history **or** ❖ Documentation of prenatal risk assessment and counseling/education • A basic physical obstetrical examination that includes auscultation for fetal heart tone, **or** pelvic exam with obstetric observations, **or**

	measurement of fundus height (a standardized prenatal flow sheet may be used). • Evidence that a prenatal care procedure was performed, such as: ❖ Screening test in the form of an obstetric panel (must include all the following: hematocrit, differential WBC count, platelet count, hepatitis B surface antigen, rubella antibody, syphilis test, RBC antibody screen, Rh and ABO blood typing) **or** ❖ TORCH antibody panel alone **or** ❖ A rubella antibody test/titer with an Rh incompatibility (ABO/Rh) blood typing **or** ❖ Ultrasound of pregnant uterus Submit medical record documentation to Priority Health HEDIS department • Electronically uploading medical records – contact ***HEDIS@PriorityHealth.com*** to get a file set up or for more information • Email: ***HEDIS@PriorityHealth.com*** • Fax: 616.975.8897 • Mail: HEDIS at 1231 E Beltline, NE Mail Stop 1280, Grand Rapids, MI, 49525
Common chart deficiencies	• No documentation of prenatal visit in the first trimester • Scheduling initial prenatal visit after the first trimester

Tips and best practices:

- ✓ Schedule prenatal care visits starting in the first trimester or within 42 days of enrollment
- ✓ Stress and educate patients on the importance of timely initial prenatal visit
- ✓ Encourage and educate patients on the importance of keeping each prenatal visit
- ✓ When the prenatal care visit is with a PCP, the claim must include the prenatal visit, and a diagnosis of pregnancy
- ✓ Submit CPT II codes to help identify clinical outcomes such as prenatal care
- ✓ When submitting a claim for bundled maternity services, it is important to also submit separate claims for the pregnancy diagnosis office visit and postpartum visit with appropriate CPT II codes
  - ❖ Prenatal care: When submitting the claim for initial pregnancy diagnosis visit (e.g., urine test, ultrasound), always include CPT-II code 0500F as a no charge line item
  - ❖ Postpartum care: When submitting the claim for the first office postpartum visit, always include CPT-II code 0503F as a no charge line item
- ✓ Telehealth or telephone visit with a pregnancy-related diagnosis code
- ✓ Virtual check-in or e-visit with a pregnancy-related diagnosis code
- ✓ Timely for submission of claim data
- ✓ **Prenatal visit medical record documentation can be accepted as supplemental data**

Important notes

Prenatal care visit must take place in the first trimester, on or before the enrollment start date or within 42 days of enrollment with the health plan for compliance

Acceptable provider types to render prenatal care services: • OB/GYN • Physician Any of the following providers who deliver prenatal care services under the direction of an OB/GYN or certified provider: • Certified Nurse Midwife (CNM) • Nurse Practitioner (NP) • Physician's Assistant (PA)

Supplemental Data Accepted

Prenatal and Postpartum Care (PPC) Postpartum Care Sub Measure

The Postpartum Care measure evaluates patients who had a live birth that had a postpartum care visit on or between 7 and 84 days after delivery.

Product lines	Quality programs affected	Collection and reporting method
• **Commercial** • **Medicaid**	• NCQA Health Plan Ratings • State Performance Measure	Hybrid • Claim data • Medical record documentation

Numerator compliance	A postpartum visit on or between 7 and 84 days after delivery		
Billing codes	**Description**	**Code type**	**Codes**
	Postpartum bundled services	**CPT**	59400, 59410, 59510, 59515, 59610, 59614, 59618, 59622
	Postpartum care	**CPT**	57170, 58300, 59430, 99501
		CPT II	0503F
		HCPCS	G0101
		SNOWMED	133906008, 133907004, 169762003, 169770008, 169771007, 169772000, 384634009, 384635005, 384636006, 408883002, 408884008, 408886005, 409018009, 409019001, 431868002, 440085006, 717810008
	Cervical cytology lab test Cervical cytology lab test Cervical cytology result or finding	**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

	Cervical cytology lab test	**LOINC**	10524-7, 18500-9, 19762-4, 19764-0, 19765-7, 19766-5, 19774-9, 33717-0, 47527-7, 47528-5
	Cervical cytology lab test	**SNOWMED**	171149006, 416107004, 417036008, 440623000, 448651000124104
	Cervical cytology result or finding Every newborn delivery A postpartum visit for a pelvic exam or postpartum care on or between 7 and 84 days after delivery	**SNOWMED**	168406009, 168407000, 168408005, 168410007, 168414003, 168415002, 168416001, 168424006, 250538001, 269957009, 269958004, 269959007, 269960002, 269961003, 269963000, 275805003, 281101005, 309081009, 310841002, 310842009, 416030007, 416032004, 416033009, 439074000, 439776006, 439888000, 441087007, 441088002, 441094005, 441219009, 441667007, 700399008, 700400001, 1155766001, 62051000119105, 62061000119107, 98791000119102
	• Consultation reports • Medical history • Progress notes • SOAP notes **Postpartum care visit** with an OB/GYN, PCP or prenatal care provider which must include one of the following: • Notation of postpartum care • Evaluation of weight, blood pressure, breasts and abdomen • Notation of “breastfeeding” is acceptable for the “evaluation of breasts” component Pelvic exam		

Frequency/occurrence	• Perineal or cesarean incision/wound check (doesn't count if performed before seven days after delivery) • Screening for depression, anxiety, tobacco use, substance use disorder or preexisting mental health disorders • Submit medical record documentation to Priority Health HEDIS department • Electronically uploading medical records – please contact ***HEDIS@PriorityHealth.com*** to get a file set up or for more information. • Email: ***HEDIS@PriorityHealth.com*** • Fax: 616-975-8897 Mail: HEDIS at 1231 E Beltline, NE Mail Stop 1280, Grand Rapids, MI, 49525
Test, service or procedure to close care opportunity	• Documentation of postpartum care before 7 days No documentation of postpartum care
Medical record documentation (including but not limited to)	• Documentation of postpartum care before 7 days • No documentation of postpartum care
Medical record documentation (including but not limited to) continued)	• Documentation of postpartum care before 7 days • No documentation of postpartum care
Common chart deficiencies	• Documentation of postpartum care before 7 days • No documentation of postpartum care

Supplemental Data Accepted

Chlamydia Screening in Women (CHL)

The Chlamydia Screening in Women measure evaluates women 16-24 years of age who were identified as sexually active and had at least one test to screen for chlamydia in the measurement year.

Product lines	Quality programs affected	Collection and reporting method
• **Commercial** • **Medicaid**	• NCQA Health Plan Ratings • State Performance Measure	Administrative • Claim data

Numerator compliance	**At least one chlamydia test during the measurement year**		
Billing codes	**Description**	**Code type**	**Codes**
	Chlamydia screening	**CPT**	87110, 87270, 87320, 87490, 87491, 87492, 87810
		LOINC	14463-4, 14464-2, 14465-9, 14467-5, 14474-1, 14513-6, 16600-9, 21190-4, 21191-2, 23838-6, 31775-0, 34710-4, 42931-6, 44806-8, 44807-6, 45068-4, 45069-2, 45072-6, 45073-4, 45075-9, 45084-1, 45089-0, 45090-8, 45091-6, 45093-2, 45095-7, 50387-0, 53925-4, 53926-2, 57287-5, 6353-7, 6356-0, 6357-8, 80360-1, 80361-9, 80362-7, 80363-5, 80364-3. 80365-0, 80367-6, 82306-2, 87949-4, 87950-2, 88221-7, 89648-0, 91860-7, 91873-0
Frequency/occurrence	Every year		
Exclusions	• Pregnancy test and a prescription for Isotretinoin • An x-ray on the date of the pregnancy test or the 6 days after the pregnancy test during the measurement year		
Test, service or procedure to close care opportunity	• Chlamydia test		
Medical record documentation (including but not limited to)	Medical record dates: 01/01/2024 - 12/31/2024 • Consultation reports • Health history and physical • Laboratory reports with results Submit medical record documentation to Priority Health HEDIS department • Electronically uploading medical records – contact ***HEDIS@PriorityHealth.com*** to get a file set up or for more information. • Email: ***HEDIS@PriorityHealth.com***		

	• Fax: 616.975.8897 • Mail: HEDIS at 1231 E Beltline, NE Mail Stop 1280, Grand Rapids, M, 49525
Common chart deficiencies	• Not obtaining a urine sample routinely during preventive or sick visits

Tips and best practices:

- ✓ **Check your Gaps in Care Report to identify your patients with open care opportunities**
- ✓ Educate patients about the importance of screening and encourage testing during preventive and/or sick visits
- ✓ Utilize preventive health flowsheets or progress notes to document chlamydia test dates, test results and when patients are due for their next screening
- ✓ **Lab results for chlamydia screening can be accepted as supplemental data**

Supplemental Data Accepted

Glycemic Status Assessment for Patients with Diabetes (GSD)

The Hemoglobin A1c Control for Patients with Diabetes measure evaluates patients 18-75 years of age with diabetes (types 1 and 2) whose most recent hemoglobin A1c (HbA1c) with the following levels:

- Glycemic status < 8.0%
- Glycemic status > 9.0%* (inverted measure)

***Inverted measure:** Because the GSD measure rate indicates the percentage of members with an uncontrolled glycemic status, a lower rate in this measure indicates high performance. For example, if the overall rate shows that 4% of our members are uncontrolled, this means that 96% of our members have a controlled glycemic status.

Definitions:

- HbA1c control <8.0% - The patient is compliant if the result for the most recent HbA1c test is less than 8.0%
- HbA1c poor control >9.0% - The patient is considered poor control if the HbA1c results is greater than 9.0%

Product lines	Quality programs affected	Collection and reporting method
• **Commercial** • **Medicaid** • **Medicare**	• CMS Star Ratings • NCQA Health Plan Ratings • State Performance Measure	Hybrid • Claim data • Medical record

Numerator compliance	The most recent glycemic status assessment of the measurement year. The result must be ≤ 9% to show evidence of control. Documentation of either of the following are acceptable: • Hemoglobin A1c (HbA1c) • Glucose Management Indicator (GMI) ***Note:*** *Documentation must include the result and date performed*		
Billing codes	**Description**	**Code type**	**Codes**
	HbA1c lab test	**CPT**	83036, 83037
		LOINC	17855-8, 17856-6, 4548-4, 4549-2, 96595-4
		SNOWMED	43396009, 313835008
	HbA1c less than 7.0%	**CPT II**	3044F
		SNOWMED	165679005
	HbA1c greater than/equal to 7.0% and less than 8.0%	**CPT II**	3051F
	HbA1c greater than/equal to 8.0% and less than 9.0%	**CPT II**	3052F
	HbA1c greater than/equal to 9.0%	**CPT II**	3046F
		SNOWMED	451061000124104
Frequency/occurrence	Every year at minimum; every three months if uncontrolled		
Required exclusions			

<table>
<tr><td>Test, service or procedure to close care opportunity</td><td>• The most recent glycemic status assessment (HbA1c or GMI) test <u>and</u> results</td></tr>
<tr><td>Medical record documentation (including but not limited to)</td><td>Medical record dates: 01/01/2024 - 12/31/2024
At a minimum, documentation in the medical record must include a note indicating the date when the glycemic status assessment (HbA1c or GMI) was performed, and the result.

GMI results collected by the member and documented in the member's medical record are eligible for use in reporting. GMI values must include documentation of the continuous glucose monitoring data date range used to derive the value.

• Consultation reports
• Diabetic flow sheets
• Lab reports
• Progress notes

Submit medical record documentation to Priority Health HEDIS department
• Electronically uploading medical records – contact HEDIS@PriorityHealth.com to get a file set up or for more information
• Email: HEDIS@PriorityHealth.com
• Fax: 616.975.8897
• Mail: HEDIS at 1231 E Beltline, NE Mail Stop 1280, Grand Rapids, MI, 49525</td></tr>
<tr><td>Common chart deficiencies</td><td>• No HbA1c or GMI test for measurement year</td></tr>
<tr><td>Claim submission deficiencies</td><td>• Not submitting CPT II codes to report A1c test results</td></tr>
<tr><td colspan="2">Tips and best practices:
✓ Check your Gaps in Care Report to identify your patients with open care opportunities
✓ Order HbA1c test for diabetic patients at least once a year and record the date of service and value together
✓ If possible, provide point-of-care testing in your office to reduce missed laboratory opportunities
✓ If the HbA1c is performed in the office, bill the appropriate CPT II code to report the A1c results or at follow-up visit after labs were completed
✓ Ensure documentation in the medical record includes the date when the HbA1c was performed and the result
✓ Use EHR/EMR alerts for patients due for a HbA1c test or if the previous test was greater than or equal to 8.0% (≥ 9.0% for Medicare patients)
✓ Follow up with patients to discuss and educate on effects of diabetes
✓ Discuss with the patient the importance of screening for diabetes
✓ Coordinate care with patients' other providers
✓ HbA1c test results can be accepted as supplemental data</td></tr>
</table>

Supplemental Data Accepted

Blood Pressure Control for Patients with Diabetes (BPD)

The Blood Pressure Control for Patients with Diabetes measure evaluates patients 18-75 years of age with diabetes (types 1 and 2) and whose blood pressure (BP) is adequately controlled (<140/90 mmHg) during the measurement year.

Product lines	Quality programs affected	Collection and reporting method
• **Commercial** • **Medicaid** • **Medicare**	• CMS Star Ratings • NCQA Health Plan Ratings • State Performance Measure	Hybrid • Claim data • Medical record documentation

Numerator compliance	The last blood pressure reading taken during an outpatient visit in the measurement year is < 140/90 mmHg		
Billing codes	**Description**	**Code type**	**Codes**
	Diastolic less than 80	**CPT II**	3078F
	Diastolic between 80-89	**CPT II**	3079F
	Diastolic greater than/equal to 90	**CPT II**	3080F
	Systolic less than 130	**CPT II**	3074F
	Systolic between 130-139	**CPT II**	3075F
	Systolic greater than/equal to 140	**CPT II**	3077F
Frequency/occurrence	Every visit (office and telehealth)		
Test, service or procedure to close care opportunity	• Blood pressure reading taken during an outpatient visit • Patient reported blood pressure reading using a digital device and documented/recorded in the patient's medical record		
Medical record documentation (including but not limited to)	Medical record dates: 01/01/2024 - 12/31/2024 • Consultation reports • Diabetic flow sheets • Progress notes • Vitals sheet Submit medical record documentation to Priority Health HEDIS department • Electronically uploading medical records – contact ***HEDIS@PriorityHealth.com*** to get a file set up or for more information • Email: ***HEDIS@PriorityHealth.com*** • Fax: 616.975.8897 • Mail: HEDIS at 1231 E Beltline, NE Mail Stop 1280, Grand Rapids, MI, 49525		
Common chart deficiencies	• No blood pressure documented during office visit		

	• Not retaking blood pressure if greater than 140/90 during office visit
Claim submission deficiencies	Not submitting CPT II codes on claims submissions for all office and virtual visits to close care gap
Tips and best practices: ✓ **Document all BP readings at every visit** ✓ BP readings can be patient-reported during a telehealth visit, telephonic visit, e-visit or virtual check-in if the BP is taken on a digital device and must be recorded, dated and maintained in the patient's medical record ✓ If the patient's BP is 140/90 or higher at the start of the visit, recheck the BP at the end of the visit ✓ If the recheck BP reading is still 140/90 or greater, schedule a follow-up appointment. When multiple readings during the same visit are taken, record all BP readings taken during appointment. ✓ Use CPT II codes when billing office/telephone/virtual visits to capture blood pressure result ✓ Timely submission of claim data ✓ **Blood pressure service date and values can be accepted as supplemental data**	
Important notes: The last BP result of the year is the result that will determine if your patient is compliant for this measure	

Eye Exam for Patients with Diabetes (EED)

The Eye Exam for Patients with Diabetes measure evaluates patients 18-75 years of age with diabetes (types 1 and 2) who had a retinal or dilated eye exam by an ophthalmologist or optometrist in the measurement year.

Product lines	Quality programs affected	Collection and reporting method
• **Commercial** • **Medicaid** • **Medicare**	• CMS Star Ratings • NCQA Health Plan Ratings • State Performance Measure	• Hybrid • Claim data • Medical record documentation

Numerator compliance	Screening or monitoring for diabetic retinal disease by an eye care professional. This includes: • A retinal or dilated eye exam in the measurement year. • A negative retinal or dilated eye exam (negative for retinopathy) in the year prior to the measurement year. • Bilateral eye enucleation any time during the patient's history.		
Billing codes	**Description**	**Code type**	**Codes**
	Diabetic retinal screening	**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, 99202, 92225, 92226, 92227, 92228, 92230, 92235, 92240, 92250, 92260, 99203, 99204, 99205, 99213, 99214, 99215, 99242, 99243, 99244, 99245
		HCPCS	S0620, S0621, S3000
		SNOWMED	274795007, 274798009, 308110009, 314971001, 314972008 410451008, 410452001, 410453006, 410455004, 425816006, 27478009, 722161008
	Diabetic eye exam with evidence of retinopathy	**CPT II**	2022F, 2024F, 2026F
	Diabetic eye exam without evidence of retinopathy	**CPT II**	2023F, 2025F, 2033F
	Low risk for retinopathy (no evidence of	**CPT II**	3072F

<table>
<tr><td rowspan="6"></td><td>retinopathy in the prior year) (DM)</td><td></td><td></td></tr>
<tr><td rowspan="3">Unilateral eye enucleation</td><td>CPT</td><td>65091, 65093, 65101, 65103, 65105, 65110, 65112, 65114</td></tr>
<tr><td>Modifier</td><td>50 (use with bilateral procedure)</td></tr>
<tr><td>SNOWMED</td><td>59590004, 172132001, 205336009, 397800002, 397994004, 398031005</td></tr>
<tr><td>Imaging of retina for detection or monitoring of disease; point-of-care autonomous</td><td>CPT</td><td>92229</td></tr>
<tr><td colspan="3" style="display:none"></td></tr>
<tr><td>Frequency/occurrence</td><td colspan="3">Every year</td></tr>
<tr><td>Test, service or procedure to close care opportunity</td><td colspan="3">• Dilated or retinal eye exam
• Fundus photography
• Negative retinal or dilated eye exam from prior year
• Bilateral eye enucleation or acquired absence of both eyes anytime during their history</td></tr>
<tr><td>Medical record documentation (including but not limited to)</td><td colspan="3">Medical record dates
• 01/01/2024 - 12/31/2024 for retinal or dilated eye exam
• 01/01/2023 – 12/31/2023 for negative retinal or dilated eye exam

• Consultation reports
• Diabetic flow sheets
• Eye exam report
• Progress notes

Submit medical record documentation to Priority Health HEDIS department
• Electronically uploading medical records – contact HEDIS@PriorityHealth.com to get a file set up or for more information
• Email: HEDIS@PriorityHealth.com
• Fax: 616.975.8897
• Mail: HEDIS at 1231 E Beltline, NE Mail Stop 1280, Grand Rapids, M, 49525</td></tr>
<tr><td>Common chart deficiencies</td><td colspan="3">No referral to an ophthalmologist or optometrist</td></tr>
<tr><td>Claim submission deficiencies</td><td colspan="3">Not submitting CPT II codes on claims submissions</td></tr>
<tr><td colspan="4">Tips and best practices:
✓ Check your Gaps in Care Report to identify your patients with open care opportunities
✓ Always list the date of service, test, result and eye care professional's name and credentials together if you're documenting the history of a dilated eye exam in a patient's chart and you don't have the eye exam report from the eye care professional. The care provider must be an optometrist or ophthalmologist.</td></tr>
</table>

- ✓ A chart or photograph of retinal abnormalities indicating the date when the fundus photography was performed and evidence that an ophthalmologist or optometrist reviewed the results will be compliant. The fundus photography must include the result, date and signature of the reading eye care professional for compliance.
- ✓ Create a process to follow-up with patients within 60 days of referral if eye exam isn't completed
- ✓ Use EHR/EMR alerts for patients due for a retinal eye exam
- ✓ The use of CPT II codes helps identify clinical outcomes such as diabetic retinal screening with an eye care professional. It can also reduce the need for chart review.
- ✓ Timely submission of claim data

Dilated retinal eye exams with results can be accepted as supplemental data

Important notes

- Blindness is not an exclusion for a diabetic eye exam because it is difficult to distinguish between individuals who are legally blind but require a retinal exam and those who are completely blind and therefore do not require an exam.
- Hypertensive retinopathy is not handled differently from diabetic retinopathy when reporting this measure; for example, an eye exam documented as positive for hypertensive retinopathy is counted as positive for diabetic retinopathy and an eye exam documented as negative for hypertensive retinopathy is counted as negative for diabetic retinopathy. The intent of this measure is to ensure that patients with evidence of any type of retinopathy have an eye exam annually, while patients who remain free of retinopathy (i.e., the retinal exam was negative for retinopathy) are screened every other year.
- An eye exam result documented as "unknown" does not meet criteria.

Kidney Health Evaluation for Patients with Diabetes (KED)

The Kidney Health Evaluation for Patients with Diabetes measure evaluates patients 18-85 years of age with diabetes (types 1 and 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) **and** a urine albumin-creatinine ratio (uACR) during the measurement year.

Product lines	Quality programs affected	Collection and reporting method
• **Commercial** • **Medicaid** • **Medicare**	• CMS Star Ratings • NCQA Health Plan Ratings • State Performance Measure	Administrative • Claim data

<table>
<tr><td>Numerator compliance</td><td colspan="3">Patients who received both an eGFR and a uACR during the measurement year on the same or different dates of service
At least one eGFR
At least one uACR identified by either of the following:
Both a quantitative urine albumin test and a urine creatinine test with service dates four days or less apart. For example: If the service date for the quantitative urine albumin test was December 1 of the measurement year, then the urine creatinine test must have a service date on or between November 27 and December 5 of the measurement year
A uACR</td></tr>
<tr><td rowspan="10">Billing codes</td><td>Description</td><td>Code type</td><td>Codes</td></tr>
<tr><td rowspan="3">Estimated Glomerular Filtration Rate (eGFR) lab test</td><td>CPT</td><td>80047, 80048, 80050, 80053, 80069, 82565</td></tr>
<tr><td>LOINC</td><td>50044-7, 50210-4, 50384-7, 62238-1, 69405-9, 70969-1, 77147-7, 94677-2, 98979-8, 98980-6</td></tr>
<tr><td>SNOWMED</td><td>12341000, 18207002, 241373003, 444275009, 444336003, 446913004, 706951006, 763355007</td></tr>
<tr><td rowspan="3">Quantitative urine albumin lab test</td><td>CPT</td><td>82043</td></tr>
<tr><td>LOINC</td><td>100158-5, 14957-5, 1754-1, 21059-1, 30003-8, 43605-5, 53530-2, 53531-0, 57369-1, 89999-7</td></tr>
<tr><td>SNOWMED</td><td>104486009, 104819000</td></tr>
<tr><td rowspan="3">Urine creatinine lab test</td><td>CPT</td><td>82570</td></tr>
<tr><td>LOINC</td><td>20624-3, 2161-8, 35674-1, 39982-4, 57344-4, 57346-9, 58951-5</td></tr>
<tr><td>SNOWMED</td><td>8879006, 36793009, 271260009, 444322008</td></tr>
</table>

	Urine albumin creatinine ratio lab test	**LOINC**	13705-9, 14958-3, 14959-1, 30000-4, 44292-1, 59159-4, 76401-9, 77253-3, 77254-1, 89998-9, 9318-7
Frequency/occurrence	Every year		
Required exclusions	• End-stage renal disease (ESRD) diagnosis any time during the patient's history • Patients who had dialysis any time during the patient's history • Dispensed dementia medication		
Test, service or procedure to close care opportunity	• Estimated glomerular filtration rate (eGFR) test **and** • Urine albumin-creatinine ratio (uACR) test identified by one of the following: - A uACR **or** - A quantitative urine albumin test **and** a urine creatinine test 4 days or less apart		
Medical record documentation (including but not limited to)	Medical record dates: 01/01/2024 - 12/31/2024 • Consultation reports • Lab reports • Progress notes Submit medical record documentation to Priority Health HEDIS department • Electronically uploading medical records – please contact ***HEDIS@PriorityHealth.com*** to get a file set up or for more information • Email: ***HEDIS@PriorityHealth.com*** • Fax: 616.975.8897 • Mail: HEDIS at 1231 E Beltline, NE Mail Stop 1280, Grand Rapids, MI, 49525		
Common chart deficiencies	No eGFR and uACR test in medical record for the measurement year		

Tips and best practices:

- ✓ **Check your Gaps in Care Report to identify your patients with open care opportunities**
- ✓ Use EHR/EMR alerts for patients due for an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR)
- ✓ Coordinate care with specialists such as an endocrinologist or nephrologist as needed
- ✓ Visit **Kidney Health Toolkit – NCQA** to learn more about best practices in promoting kidney health
- ✓ **eGFR and uACR lab reports can be accepted as supplemental data**

Statin Therapy for Patients with Diabetes (SPD)

The Statin Therapy for Patients with Diabetes measure evaluates patients 40-75 years of age who do not have clinical atherosclerotic cardiovascular disease (ASCVD) and met the following criteria:

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

Adherence for the SPD measure is determined by the patient remaining on their prescribed statin therapy medication for at least 80% of the treatment period. This is determined by pharmacy claims data (the plan will capture data each time the patient fills their prescription).

The medications the NCQA lists in the HEDIS specifications are below. This is a general list and shouldn't replace the advice or care you provide your patients regarding what is optimal to meet their healthcare needs.

NOTE: PIP is based on the CMS Star Ratings specifications for the Medicare population and differs from the HEDIS specifications.

Product lines	Quality programs affected	Collection and reporting method
• **Commercial** • **Medicaid** • **Medicare**	• NCQA Health Plan Ratings	Administrative • Claim data • Pharmacy data

Numerator compliance	The number of patients who had at least one dispensing event for a high-intensity, moderate intensity, or low-intensity statin medication and who achieved a PDC of at least 80% during the measurement year	
To comply with this measure, one of the following medications must have been dispensed:		
Description	**Prescription**	
High-intensity statin therapy	• Atorvastatin 40-80 mg • Amlodipine-atorvastatin 40-80 mg • Ezetimibe-simvastatin 80 mg	• Rosuvastatin 20-40 mg • Simvastatin 80 mg
Moderate-intensity statin therapy	• Amlodipine-atorvastatin 10-20 mg • Atorvastatin 10-20 mg • Ezetimibe-simvastatin 20-40 mg • Fluvastatin 40-80 mg • Lovastatin 40 mg	• Pitavastatin 1–4 mg • Pravastatin 40-80 mg • Rosuvastatin 5-10 mg • Simvastatin 20-40 mg
Low-intensity statin therapy	• Ezetimibe-simvastatin 10 mg • Fluvastatin 20 mg • Lovastatin 10-20 mg	• Pravastatin 10–20 mg • Simvastatin 5-10 mg

Required exclusions	• Pregnancy or in vitro fertilization during the measurement year or year prior to the measurement year • ESRD diagnosis during the measurement year or the year prior to the measurement year • Dialysis diagnosis during the measurement year or the year prior to the measurement year • Cirrhosis diagnosis during the measurement year or the year prior to the measurement year • Myalgia, myositis, myopathy, or rhabdomyolysis during the measurement year
Test, service or procedure to close care opportunity	A filled prescription of one of the statins or statin combinations in the strengths/doses listed above
Common chart deficiencies	• No documentation of review of medications at every visit • No documentation of conversation about the importance of medication compliance

Tips and best practices:

- ✓ **Check your Gaps in Care Report to identify your patients with open care opportunities**
- ✓ Prescribe statin medication during the measurement year
- ✓ Compliance can only be achieved through prescription drug event (PDE) data
- ✓ Follow up to ensure patients fill their statin prescriptions and are taking them as directed
- ✓ Educate patients on the benefits of statin medication to prevent cardiovascular events
- ✓ Educate and encourage patients to contact you if they think they're experiencing side effects
- ✓ Encourage patients to obtain 90-day supplies at their retail or mail-in pharmacy once they demonstrate they tolerate statin therapy
- ✓ Sample medications won't count for the measure
- ✓ Schedule proper follow-up with the patients to evaluate if medications are taken as prescribed
- ✓ Develop a medication routine with each patient if they're on multiple medications that require them to be taken at different times
- ✓ Utilize pill boxes or organizers
- ✓ **Care must be captured administratively for the SPD Measure. Medical record submission won't count.**

Supplemental Data Accepted

Controlling High Blood Pressure (CBP)

The Controlling High Blood Pressure measure evaluates patients 18-85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure is adequately controlled (<140/90 mmHg) during the measurement year.

Product lines	Quality programs affected	Collection and reporting method
• **Commercial** • **Medicaid** • **Medicare**	• CMS Star Ratings • NCQA Health Plan Ratings • State Performance Measure	Hybrid • Claim data • Medical record documentation

Numerator compliance	The most recent BP reading <140/90 mm Hg taken during the measurement year		
Billing codes	**Description**	**Code type**	**Codes**
	Diastolic less than 80	**CPT II**	3078F
	Diastolic between 80-89	**CPT II**	3079F
	Diastolic greater than or equal to 90	**CPT II**	3080F
	Systolic less than 130	**CPT II**	3074F
	Systolic between 130-139	**CPT II**	3075F
	Systolic greater than or equal to 140	**CPT II**	3077F
	History of kidney transplant	**ICD-10 diagnosis**	Z94.0
Frequency/occurrence	Every visit		
Required exclusions	History of: • Dialysis • End-stage renal disease (ESRD) • Kidney transplant • Nephrectomy • Patients with a diagnosis of pregnancy during the measurement year		
Test, service or procedure to close care opportunity	• The most recent blood pressure reading taken during an outpatient office visit • Patient reported blood pressure reading using a digital device during telehealth visits and recorded in the patient's medical record		
Medical record documentation (including but not limited to)	Medical record dates: 01/01/2024 - 12/31/2024 • Consultation reports • Medical history • Progress notes • SOAP notes • Vitals sheet Submit medical record documentation to Priority Health HEDIS department		

<table>
<tr><td></td><td>• Electronically uploading medical records – contact HEDIS@PriorityHealth.com to get a file set up or for more information
• Email: HEDIS@PriorityHealth.com
• Fax: 616.975.8897
• Mail: HEDIS at 1231 E Beltline, NE Mail Stop 1280, Grand Rapids, MI, 49525</td></tr>
<tr><td>Common chart deficiencies</td><td>• No blood pressure documented during office visit
• Not performing a BP recheck if the initial BP reading is equal to or greater than 140/90</td></tr>
<tr><td>Claim submission deficiencies</td><td>• Not submitting CPT II codes on claim submissions</td></tr>
<tr><td colspan="2">Tips and best practices
✓ Check your Gaps in Care Report to identify your patients with open care opportunities
✓ If the patient’s BP is 140/90 or higher at the start of the visit, recheck the BP at the end of the visit
✓ If the recheck BP reading is still 140/90 or greater, schedule a follow-up appointment before the end of the measurement year
✓ Record all BP readings taken during appointment
✓ Telephone visits, e-visits and virtual visits are appropriate settings for BP readings and allow patient reported BP’s taken with a digital device
✓ BP readings can be patient-reported during a telehealth visit, telephonic visit, e-visit or virtual check-in, if the BP is taken on a digital device, it must be recorded, dated and maintained in the patient’s medical record
✓ Use CPT II codes when billing office/telephone/virtual visits to capture blood pressure result
✓ Timely submission of claim data
✓ Blood pressure service date and values can be accepted as supplemental data</td></tr>
<tr><td colspan="2">Important Notes
The last BP result of the year is the result that will determine if your patient is compliant for this measure</td></tr>
</table>

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

The Persistence of Beta-Blocker Treatment After a Heart Attack measure evaluates patients 18 years of age and older during the measurement year who were hospitalized and discharged with a diagnosis of acute myocardial infarction (AMI), and who received a beta blocker treatment for six months after discharge.

Product lines	Quality programs affected	Collection and reporting method
• **Commercial** • **Medicaid** • **Medicare**		Administrative • Claim data

Numerator compliance	At least 135 days of treatment with beta-blockers during the 180-day measurement interval	
To comply with this measure, a patient must receive beta blocker treatment for six months after discharge:		
Drug Category	**Medications**	
Noncardioselective beta-blockers	• Carvedilol • Labetalol • Nadolol • Pindolol	• Propranolol • Sotalol • Timolol
Cardioselective beta-blockers	• Acebutolol • Atenolol • Betaxolol	• Bisoprolol • Metoprolol • Nebivolol
Antihypertensive combinations	• Atenolol-chlorthalidone • Bendroflumethiazide-nadolol • Bisoprolol-hydrochlorothiazide	• Hydrochlorothiazide-metoprolol • Hydrochlorothiazide-propranolol
Required exclusions	Any of the below diagnosis anytime during the patient's history: • Asthma • Chronic respiratory conditions due to fumes and vapors • COPD • Hypotension, heart block > 1 degree or sinus bradycardia	• Intolerance or allergy to beta-blocker therapy • Medication dispensing event indicative of a history of asthma (see list below) • Obstructive chronic bronchitis
	Any of the following asthma medications dispensed during the patient's history denote a history of asthma: *Bronchodilator combinations* • Budesonide-formoterol • Fluticasone-salmeterol *Inhaled corticosteroids* • Beclomethasone • Budesonide	 • Fluticasone-vilanterol • Formoterol-mometasone • Flunisolide • Fluticasone

	• Ciclesonide • Mometasone
Numerator compliance	This measure requires at least 135 days of treatment with beta-blockers during the 180-day measurement period
Test, service or procedure to close care opportunity	This measure requires a filled beta blocker prescription
Common chart deficiencies	• No documentation of review of medications at every visit • No documentation of conversation about the importance of medication compliance

Tips and best practices:

✓ As an administrative measure, it's important to submit codes that reflect a patient's history of any exclusion noted in the preceding chart

- If a patient is new to your practice, you can submit the exclusion diagnoses through the initial visit claim
- If a patient isn't new to your practice, but their chart has documented history of 1 of the exclusion diagnoses, you can submit the diagnosis codes on any visit claim.

✓ At each office visit, talk with your patients about compliance and/or barriers to taking their medications and encourage adherence

✓ Review your patients' prescription refill patterns and reinforce education and reminders. Consider:

- Which patients don't fill prescriptions, are always late to fill or quit refilling over time?
- Which patients are already medicated to fill and refill but may skip an occasional dose and simply need reminders?

Statin Therapy for Patients with Cardiovascular Disease (SPC)

The Statin Therapy for Patients with Cardiovascular Disease measure evaluates males 21-75 years of age and females 40-75 years of age who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and met the following criteria:

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

Product lines	Quality programs affected	Collection and reporting method
• **Commercial** • **Medicaid** • **Medicare**	• CMS Star Ratings • NCQA Health Plan Ratings	Administrative • Pharmacy data

Numerator compliance	Males 21–75 years of age and females 40–75 years of age during the measurement year who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and were dispensed at least one high-intensity or moderate-intensity statin medication and who remained on the statin medication for at least 80% of the treatment period	
To comply with this measure, one of the following medications must have been dispensed:		
Description	**Prescription**	
High-intensity statin therapy	• Amlodipine-atorvastatin 40-80 mg • Atorvastatin 40-80 mg • Ezetimibe-simvastatin 80 mg	• Rosuvastatin 20-40 mg • Simvastatin 80 mg
Moderate-intensity statin therapy	• Amlodipine-atorvastatin 10-20 mg • Atorvastatin 10-20 mg • Ezetimibe-simvastatin 20-40 mg • Fluvastatin 40-80 mg • Lovastatin 40 mg	• Pitavastatin 1-4 mg • Pravastatin 40-80 mg • Rosuvastatin 5-10 mg • Simvastatin 20-40 mg
Numerator compliance	Patients who had at least one dispensing event for a high-intensity or moderate-intensity statin medication	
Test, service or procedure to close care opportunity	Patients with a filled prescription for these medications are administratively compliant with the measure	
Required exclusions	• Cirrhosis during the measurement year or the 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 • In vitro fertilization (IVF) in the measurement year or the year prior to the measurement year • Myalgia, myositis, myopathy or rhabdomyolysis diagnosis during the measurement year • Patients with a diagnosis of pregnancy during the measurement year or the year prior to the measurement year
Common chart deficiencies	• No documentation of review of medications at every visit • No documentation of conversation about the importance of medication adherence

Tips and best practices:

- ✓ **Check your Gaps in Care Report to identify your patients with open care opportunities**
- ✓ Prescribe a high-intensity or moderate-intensity statin medication to patients with ASCVD when clinically appropriate
- ✓ Integrate statin therapy evaluation into every encounter with a cardiovascular patient
- ✓ Follow up to ensure they fill their statin prescriptions and are taking them as directed
- ✓ Educate patients on the benefits of statin medication to prevent cardiovascular events
- ✓ Educate and encourage patients to contact you if they think they're experiencing side effects
- ✓ If a patient has had previous intolerance to statins, consider a statin re-challenge using a different moderate to high-intensity statin. Hydrophilic statins, such as pravastatin, Fluvastatin and rosuvastatin, may have lower risk of myalgia side effects.
- ✓ Document in the medical record patient conditions that exclude them from taking a statin and submit a claim with appropriate exclusion diagnosis code
- ✓ Encourage patients to obtain 90-day supplies at their pharmacy once they demonstrate they tolerate statin therapy
- ✓ Ask patient to enroll in notifications and automatic refills with their pharmacy
- ✓ Sample medications won't count for the measure

Care must be captured administratively for the SPC Measure. Medical record submission will not count.

Important Note

The "treatment period" is defined as the earliest prescription dispensing date in the measurement year for any statin medication of at least moderate intensity through the last day of the measurement year

Cardiac Rehabilitation (CRE)

The Cardiac Rehabilitation measure evaluates patients 18 years and older who attended cardiac rehabilitation following a qualifying cardiac event that had up to 36 cardiac rehabilitation sessions within the first 180 days from the cardiac event.

Four rates are reported for the CRE measure:

- **Initiation** – The percentage of patients who attended 2 or more sessions of cardiac rehabilitation within 30 days after a qualifying event.
- **Engagement 1** – The percentage of patients who attended 12 or more sessions of cardiac rehabilitation within 90 days after a qualifying event
- **Engagement 2** – The percentage of patients who attended 24 or more sessions of cardiac rehabilitation within 180 days after a qualifying event
- **Achievement** – The percentage of patients who attended 36 or more sessions of cardiac rehabilitation within 180 days after a qualifying event

Product lines	Quality programs affected	Collection and reporting method
• **Commercial** • **Medicaid** • **Medicare**		Administrative • Claim data

Numerator compliance	• At least 2 sessions of cardiac rehabilitation on the episode date through 30 days after the episode date (31 total days) (on the same or different dates of service). • At least 12 sessions of cardiac rehabilitation on the episode date through 90 days after the episode date (91 total days) (on the same or different dates of service) • At least 24 sessions of cardiac rehabilitation on the episode date through 180 days after the episode date (181 total days) (on the same or different dates of service) • At least 36 sessions of cardiac rehabilitation on the episode date through 180 days after the episode date (181 total days) (on the same or different dates of service).		
Billing codes	**Description**	**Code type**	**Codes**
	Cardiac rehabilitation	**CPT**	93797, 93798
		HCPCS	G0422, G0423, S9472
		SNOWMED	24050008, 229822009, 313395003, 385979001, 385980003, 395696000, 395697009, 395698004, 395699007
Frequency/occurrence	Every cardiac rehabilitation event		
Qualifying cardiac event	• Coronary artery bypass grafting (CABG) • Heart and heart/lung transplantation		

	• Heart valve repair/replacement • Myocardial infarction (MI) • Percutaneous coronary intervention (PCI)
Test, service or procedure to close care opportunity	• Initiation ~ at least 2 cardiac rehabilitation sessions within 31 days of the episode date • Engagement 1 ~ at least 12 cardiac rehabilitation sessions within 91 days of the episode date • Engagement 2 ~ at least 24 cardiac rehabilitation sessions within 181 days of the episode date • Achievement ~ at least 36 cardiac rehabilitation sessions within 181 days of the episode date
Medical record documentation (including but not limited to)	• Consultation notes • Progress notes Submit medical record documentation to Priority Health HEDIS department • Electronically uploading medical records – contact ***HEDIS@PriorityHealth.com*** to get a file set up or for more information • Email: ***HEDIS@PriorityHealth.com*** • Fax: 616.975.8897 • Mail: HEDIS at 1231 E Beltline, NE Mail Stop 1280, Grand Rapids, MI, 49525
Common chart deficiencies	• Sessions not scheduled in a timely manner after cardiac event. Code correctly for rehabilitation sessions

Tips and best practices:

- ✓ **Check your Gaps in Care Report to identify your patients with open care opportunities**
- ✓ Schedule cardiac rehabilitation for up to 36 sessions within the first 180 days from the cardiac event
- ✓ Assist patients in scheduling follow-up appointments, if applicable
- ✓ Encourage patients to utilize supports listed below to help them cope and succeed with rehabilitation:
  - Healthcare team
  - Counseling for stress, anxiety or depression
  - Family and friends
- ✓ Encourage physical activity when the patient is well enough to exercise
- ✓ Discuss care plan and/or barriers with the patient's Priority Health Care Manager, if applicable
- ✓ Timely submission of claim data
- ✓ **Cardiac rehabilitation progress notes can be accepted as supplemental data**

Appropriate Testing for Pharyngitis (CWP)

The Appropriate Testing for Pharyngitis measure evaluates patients ages 3 years and older where the patient was diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test.

Product lines	Quality programs affected	Collection and reporting method
• **Commercial** • **Medicaid** • **Medicare**	• NCQA Health Plan Ratings	Administrative • Claim data • Pharmacy data

Numerator compliance	A group A streptococcus test in the 7-day period from 3 days prior to the episode date through 3 days after the episode date.		
Billing codes	**Description**	**Code type**	**Codes**
	Group A streptococcus test	**CPT**	87070, 87071, 87081, 87430, 87650, 87651, 87652, 87880
		LOINC	101300-2, 11268-0, 17656-0, 17898-8, 18481-2, 31971-5, 49610-9, 5036-9, 60489-2, 626-2, 6557-3, 6558-1, 6559-9, 68954-7, 78012-2
		SNOWMED	122121004, 122205003, 122303007
	Pharyngitis diagnosis	**ICD-10 diagnosis**	J02.0, J02.8, J02.9, J03.00, J03.01, J03.80, J03.81, J03.90, J03.91
		SNOWMED	140004, 652005, 1532007, 2365002, 10351008, 11461005, 14465002, 17741008, 27878001, 31309002, 39271004, 40766000, 41582007, 43878008, 51209006, 55355000, 58031004, 59471009, 63866002, 72430001, 76651006, 78430008, 78911000, 82228008, 87326000, 90176007, 90979004, 95885008, 111816002, 126664009, 126665005, 186357007, 186659004, 186963008, 195655000, 195656004, 195657008, 195658003, 195659006, 195660001, 195662009, 195663004, 195666007, 195667003, 195668008, 195669000, 195670004, 195671000, 195672007, 195673002, 195676005, 195677001, 195709006, 195779005, 195780008, 195782000, 195803003, 195804009, 195924009, 232399005, 232400003, 232401004, 232402006, 232403001, 232405008, 232406009, 232417005, 240444009, 240547000, 302911003, 312422001,

			363746003, 405737000, 415724006, 703468005, 721586007, 878818001, 133171000119105, 10629231000119109, 10629271000119107

The following antibiotic medications, in conjunction with a strep test, will meet compliance for this measure:

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

Event / diagnosis	Every pharyngitis diagnosis
Test, service or procedure to close care opportunity	Perform a rapid strep test or throat culture to confirm diagnosis before prescribing antibiotics
Medical record documentation (including but not limited to)	• History and physical • Lab reports • Progress notes Submit medical record documentation to Priority Health HEDIS department • Electronically uploading medical records – contact ***HEDIS@PriorityHealth.com*** to get a file set up or for more information • Email: ***HEDIS@PriorityHealth.com*** • Fax: 616.975.8897 • Mail: HEDIS at 1231 E Beltline, NE Mail Stop 1280, Grand Rapids, MI, 49525
Common chart deficiencies	• No lab results or documentation of group A strep test and results • Documentation of a discussion on the proper use of antibiotics

Tips and best practices:

- ✓ Perform a rapid strep test or throat culture to confirm diagnosis before prescribing antibiotics
- ✓ Do not prescribe antibiotics until results of Group A Strep test are received
- ✓ Never treat “red throats” empirically, even in children with a long history of strep
- ✓ **Lab results can be accepted as supplemental data**

Pharmacotherapy Management of COPD Exacerbation (PCE)

The Pharmacotherapy Management of COPD Exacerbation measure evaluates patients 40 years of age and older who had an acute inpatient discharge or emergency department (ED) discharge and were dispensed appropriate medications for COPD exacerbations.

Product lines	Quality programs affected	Collection and reporting method
• **Commercial** • **Medicaid** • **Medicare**	• NCQA Health Plan Ratings	Administrative • Claim data • Pharmacy data

Numerator compliance	Dispensed prescription for systemic corticosteroid on or 14 days after the episode date		
To comply with this measure, a patient must have been dispensed a prescription for one of the following systemic corticosteroids on or 14 days of the COPD exacerbation episode:			
Systemic corticosteroid medications			
Drug category	**Medications**		
Glucocorticoids	• Cortisone • Dexamethasone	• Hydrocortisone • Methylprednisolone	• Prednisolone • Prednisone
To comply with this measure, a patient must have been dispensed or have an active prescription for one of the following bronchodilators on or within 30 days of the COPD exacerbation:			
Bronchodilator medications			
Drug category	**Medications**		
Anticholinergic agents	• Aclidnium bromide • Ipratropium	• Tiotropium	• Umeclidinium
Beta 2-agonists	• Albuterol • Arformoterol • Formoterol	• Indacaterol • Levalbuterol • Metaproterenol	• Olodaterol • Salmeterol
Bronchodilator combinations	• Albuterol-ipratropium • Budesonide-formoterol • Fluticasone-salmeterol • Fluticasone-vilanterol • Fluticasone furoate-umeclidinium-vilanterol	• Formoterol-aclidinium • Formoterol-glycopyrrolate • Formoterol-mometasone	• Glycopyrrolate-indacaterol • Olodaterol-tiotropium • Umeclidinium-vilanterol
Numerator compliance	This measure requires an active prescription of a systemic corticosteroid and bronchodilator		
Test, service or procedure to close care opportunity	Patients with active prescriptions for these medications are administratively compliant with the measure		

Tips and best practices: ✓ **Check your Gaps in Care Report to identify your patients with open care opportunities** ✓ Always follow-up with patients after an inpatient or emergency room event to make sure any new prescriptions are filled post-discharge ✓ Confirm diagnosis of COPD for patients with spirometry testing ✓ If medically appropriate, consider modifying treatment to include system corticosteroid and bronchodilator if prescription was not given Review medication list to ensure patient has prescriptions for both a systemic corticosteroid and a bronchodilator
Important note: **Active prescription is considered active if the "days of supply" indicated on the date when the patient was dispensed the prescription is the number of days or more between that date and the inpatient date of admission or ED visit date of service.**

Asthma Medication Ratio (AMR)

The Asthma Medication Ratio measure evaluates patients 5-64 years of age who were identified as having persistent asthma and had a ratio of controller medications of 0.50 or greater.

Product lines	Quality programs affected	Collection and reporting method
• **Commercial** • **Medicaid**	• NCQA Health Plan Ratings • State Performance Measure	Administrative • Claim data • Pharmacy data

Numerator compliance	Patients who have a medication ratio of ≥0.50 during the measurement year		
To comply with this measure, a patient must have the appropriate ratio of controller medication to total asthma medications.			
Asthma controller medications:			
Drug category	**Medications**		
Antibody inhibitors	• Omalizumab		
Anti-interleuken-4	• Dupilumab		
Anti-interleuken-5	• Benralizumab	• Mepolizumab	• Reslizumab
Inhaled corticosteroids	• Beclomethasone • Budesonide	• Ciclesonide • Flunisolide	• Fluticasone • Mometasone
Inhaled steroid combinations	• Budesonide-formoterol • Fluticasone-salmeterol	• Fluticasone-vilanterol	• Formoterol-mometasone
Leukotriene modifiers	• Montelukast	• Zafirlukast	• Zileuton
Methylxanthines	• Theophylline		
Asthma reliever medications:			
Short-acting, inhaled beta-2 agonists	• Albuterol	• Levalbuterol	
Required exclusions	• Acute respiratory failure • Chronic obstructive pulmonary disease (COPD) • Chronic respiratory conditions due to fumes/vapors	• Cystic fibrosis • Emphysema • Obstructive chronic bronchitis	

Tips and best practices:

- ✓ **Check your Gaps in Care Report to identify your patients with open care opportunities**
- ✓ Ensure proper coding of asthma diagnosis
- ✓ It's important to code for any diagnoses on exclusion list on an annual basis
    - o This includes COPD, emphysema, chronic respiratory conditions, acute respiratory failure, cystic fibrosis and obstructive chronic bronchitis
- ✓ Simplify treatment regimen when possible, by using clear and simple language when instructing patients on how to use inhaler

- ✓ Schedule quarterly follow-up visits or calls to ensure the patient’s asthma is in control and medications are taken as prescribed and that the medication ratio is appropriate
- ✓ Educate patients on the importance taking the controller medications regularly and refilling prescriptions in a timely manner

Supplemental Data Accepted

Osteoporosis Management in Women Who Had a Fracture (OMW)

Women who suffer a fracture are at increased risk of additional fractures and more likely to have osteoporosis. The Osteoporosis Management in Women Who Had a Fracture measure evaluates women 67-85 years of age who had a fracture and had either a bone mineral density (BMD) test or received a prescription to treat osteoporosis within six months after the fracture of an ER or inpatient discharge date.

Note: Fractures of finger, toe, face and skull are not included in this measure.

Product lines	Quality programs affected	Collection and reporting method
• **Medicare**	• CMS Star Ratings • NCQA Health Plan Ratings	Administrative • Claim data • Pharmacy data

Numerator compliance	Appropriate BMD testing or medication treatment for osteoporosis 180 days after the fracture		
To comply with this measure, a patient must have a BMD test or be prescribed at least one of the following osteoporosis medications within 180 days of their discharge for a fracture:			
Drug category	**Medications**		
Bisphosphonates	• Alendronate • Alendronate-cholecalciferol	• Ibandronate • Risedronate	• Zoledronic acid
Other Agents	• Abaloparatide • Denosumab	• Raloxifene • Romosozumab	• Teriparatide

Billing codes	**Description**	**Code type**	**Codes**
	Bone Mineral Density tests	**CPT**	76977, 77078, 77080, 77081, 77085, 77086
		ICD10PCS	BP48ZZ1, BP49ZZ1, BP4GZZ1, BP4HZZ1, BP4LZZ1, BP4MZZ1, BP4NZZ1, BP4PZZ1, BQ00ZZ1, BQ01ZZ1, BQ03ZZ1, BQ04ZZ1, BR00ZZ1, BR07ZZ1, BR09ZZ1, BR0GZZ1
		SNOWMED	22059005, 312681000, 385342005, 391057001, 391058006, 391059003, 391060008, 391061007, 391062000, 391063005, 391064004, 391065003, 391066002, 391069009, 391070005, 391071009, 391072002, 391073007, 391074001, 391076004, 391078003, 391079006, 391080009, 391081008,

<table>
<tr><td rowspan="3"></td><td></td><td></td><td>391082001, 440083004, 440099005, 440100002, 449781000, 707218004, 4211000179102</td></tr>
<tr><td>Long lasting osteoporosis medications</td><td>HCPCS</td><td>J0897, J1740, J3489</td></tr>
<tr><td>Osteoporosis medication therapy</td><td>HCPCS</td><td></td></tr>
<tr><td>Test, service or procedure to close care opportunity</td><td colspan="3">• BMD test in any setting on the Index Episode Start Date (IESD) or in the 180-day period after the IESD
• If the IESD was an inpatient stay, a BMD test during the inpatient stay
• Osteoporosis therapy on the IESD or in the 180-day period after the IESD
• If the IESD was an inpatient stay, long-acting osteoporosis therapy during the inpatient stay
• Osteoporosis medication therapy on the IESD or in the 180-day period after the IESD
• A dispensed prescription to treat osteoporosis on the IESD or in the 180-day period after the IESD</td></tr>
<tr><td>Medical record documentation (including but not limited to)</td><td colspan="3">• Bone density reports, dated with results
• Medication list
• Progress notes

Submit medical record documentation to Priority Health HEDIS department:
• Electronically uploading medical records – contact HEDIS@PriorityHealth.com to get a file set up or for more information
• Email: HEDIS@PriorityHealth.com
• Fax: 616.975.8897
• Mail: HEDIS at 1231 E Beltline, NE Mail Stop 1280, Grand Rapids, MI, 49525</td></tr>
<tr><td colspan="4">Tips and best practices:
✓ Review the DXA Bone Density Scan report that’s faxed to your office, which identifies your patients that have had a recent fracture
✓ Have your patient complete a BMD test within six months of a fracture
✓ Prescribe osteoporosis medications within six months of fracture when clinically appropriate if patient is unable or unwilling to have the BMD test
✓ Follow up with patients who have overdue BMD orders and help resolve barriers to getting tested
✓ If inpatient, request the hospital to perform BMD test prior to discharging the patient
✓ Educate patient on safety and fall prevention
✓ BMD documentation can be accepted as supplemental data</td></tr>
</table>

Supplemental Data Accepted

Osteoporosis Screening in Older Women (OSW)

Osteoporosis Screening in Women measure evaluates women 65-75 years of age who received osteoporosis screening during the measurement year.

Product lines	Quality programs affected	Collection and reporting method
• **Medicare**	NCQA Health Plan Ratings	Administrative • Claim data

<table>
<tr><td>Numerator compliance</td><td colspan="3">One or more osteoporosis screening tests on or between the member's 65th birthday and December 31 of the measurement year.</td></tr>
<tr><td rowspan="2">Billing codes</td><td>Description</td><td>Code type</td><td>Codes</td></tr>
<tr><td>Osteoporosis screening tests</td><td>CPT</td><td>76977, 77078, 77080, 77081, 77085</td></tr>
<tr><td>Frequency/occurrence</td><td colspan="3">Every year</td></tr>
<tr><td>Required exclusions</td><td colspan="3">• Patients who had a dispensed prescription to treat osteoporosis anytime on or between January 1 three years prior to the measurement year through December 31 of the year prior to the measurement year
• Patients who had a claim for osteoporosis therapy any time in the patient's history</td></tr>
<tr><td>Test, service or procedure to close care opportunity</td><td colspan="3">• Bone mineral density (BMD) test

Submit medical record documentation to Priority Health HEDIS department:
• Electronically uploading medical records – contact HEDIS@PriorityHealth.com to get a file set up or for more information
• Email: HEDIS@PriorityHealth.com
• Fax: 616.975.8897
• Mail: HEDIS at 1231 E Beltline, NE Mail Stop 1280, Grand Rapids, MI, 49525</td></tr>
<tr><td>Medical record documentation (including but not limited to)</td><td colspan="3">Medical record dates: 01/01/2024 - 12/31/2024
• Osteoporosis screening tests on or between the patient's 65th birthday and December 31 of the measurement year</td></tr>
<tr><td colspan="4">Tips and best practices:
✓ Check your Gaps in Care Report to identify your patients with open care opportunities
✓ Ask patients if they've had any recent falls or fractures
✓ Evaluate women for risk factors that would increase the risk of osteoporosis
✓ Set up a process for bone mineral density (BMD) testing:
- Refer women to obtain osteoporosis screening annually
- Create a standing order to in-network facilities for patients that meet criteria
- Make sure the screening site notifies you with results in a timely manner
- Set up a follow-up visit to discuss the results</td></tr>
</table>

- Follow up with patients who have overdue osteoporosis screening orders and help resolve their barriers to getting screened

- ✓ Discuss osteoporosis prevention methods with your patients, such as calcium, vitamin D supplements, weight-bearing exercises
- ✓ Educate patient on safety and fall prevention
- ✓ Timely submission of claim data
- ✓ **BMD reports can be submitted as supplemental data**

Care for Older Adults (COA)

The Care for Older Adults Sub Measures evaluates adults 66 years of age and older who had each of the following during the measurement year:

- **Medication review** – Documentation of a complete medication review
- **Functional status assessment** – Documentation of a complete functional status assessment using a standardized functional status assessment tool and the date when the assessment was performed
- **Pain assessment** – Documentation of a complete pain assessment using a standardized pain assessment tool and the date when it was performed

Product lines	Quality programs affected	Collection and reporting method
• **Medicare (DSN-P Medicare-Medicaid Plan only)**	• CMS Star Rating	Hybrid • Claim data • Medical record review

Numerator compliance	Medication review, functional status assessment, and pain assessment during the measurement year
Frequency/occurrence	Every year
Medical record documentation (including but not limited to)	Medical record dates: 01/01/2024 - 12/31/2024 • Documentation in the medical record must include evidence of medication review • Documentation in the medical record must include evidence of functional status assessment • Documentation in the medical record must include evidence of a pain assessment Submit medical record documentation to Priority Health HEDIS department • Electronically uploading medical records – contact ***HEDIS@PriorityHealth.com*** to get a file set up or for more information • Email: ***HEDIS@PriorityHealth.com*** • Fax: 616.975.8897 • Mail: HEDIS at 1231 E Beltline, NE Mail Stop 1280, Grand Rapids, MI, 49525
Common chart deficiencies	• No documentation of functional status assessment utilizing a standardized assessment tool • No documentation of medication list and medication review • No documentation of pain assessment utilizing a standardized assessment tool
Tips and best practices: ✓ **Check your Gaps in Care Report to identify your patients with open care opportunities**	

Care for Older Adults (COA) Functional Status Assessment

The Care for Older Adults – Functional Status Assessment measure evaluates older adults 66 years of age and older who had at least one documented functional status assessment (e.g., Activities of Daily Living (ADL), Instrumental Activities of Daily Living (IADLs) in the medical record in the measurement year that measures a patient's ability to perform activities of daily living and establishes a baseline in physical capacity. This assessment should be completed utilizing a standardized functional assessment tool.

Functional status assessment that takes place during a telephone visit, e-visit or virtual check-in meets compliance. Please submit the appropriate CPT, CPT II or HCPCS code for the type of visit.

Product lines	Quality programs affected	Collection and reporting method
• **Medicare**		Hybrid • Claim data • Medical record review

<table>
<tr><td>Numerator compliance</td><td colspan="3">Functional status assessment during the measurement year</td></tr>
<tr><td rowspan="5">Billing codes</td><td>Description</td><td>Code type</td><td>Code</td></tr>
<tr><td rowspan="4">Functional status assessment</td><td>CPT</td><td>99483</td></tr>
<tr><td>CPT II</td><td>1170F</td></tr>
<tr><td>HCPCS</td><td>G0438, G0439</td></tr>
<tr><td>SNOWMED</td><td>304492001, 385880002</td></tr>
<tr><td>Frequency/occurrence</td><td colspan="3">Every year</td></tr>
<tr><td>Test, service, or procedure to close care opportunity</td><td colspan="3">• Completed standardized functional status assessment tool with results
❖ Assessment of at least five Activities of Daily Living (ADLs): bathing, dressing, eating/meals, chores, walking, using the restroom, etc.
❖ Assessment of at least four Instrumental Activities of Daily Living (IADLs): driving, grocery shopping, housework, cooking, cooking, taking prescribed medications, etc.</td></tr>
<tr><td>Medical record documentation (including but not limited to)</td><td colspan="3">Medical record dates: 01/01/2024 - 12/31/2024
• Functional Status Assessment form(s)
• Health history and physical
• Home health records
• Occupational and/or physical therapy notes
• Progress notes
• SOAP notes

Submit completed assessment to Priority Health HEDIS department
• Electronically uploading medical records – contact HEDIS@PriorityHealth.com to get a file set up or for more information
• Email: HEDIS@PriorityHealth.com
• Fax: 616.975.8897
• Mail: HEDIS at 1231 E Beltline, NE Mail Stop 1280, Grand Rapids, MI, 49525</td></tr>
</table>

<table>
<tr><td>Claim deficiencies</td><td>Not submitting CPT II codes on claims submissions</td></tr>
<tr><td colspan="2">Tips and best practices:
✓ Check your Gaps in Care Report to identify your patients with open care opportunities
✓ A functional status assessment can be conducted in the office, telephone, e-visit or virtual check-in by a practitioner, registered nurses (RNs), licensed practical nurses (LPNs) and medical assistants for both preventive and sick visits
❖ If a practitioner or other health plan staff contacts a patient by phone to just gather information for HEDIS data collection, a service isn't being rendered and won't meet criteria
✓ A functional status assessment done in an acute inpatient setting won't meet compliance
✓ A functional status assessment limited to an acute or single condition, event or body system such as lower leg or back won't meet compliance
✓ Preformatted templates containing a check box that ADLs and/or IADLs is acceptable
✓ Use EHR/EMR alerts for patients due for a functional status assessment. Incorporate as a standardized template within your EHR/EMR if applicable.
✓ The use of CPT II codes helps identify clinical outcomes such as advance care planning, reducing the need for some chart review
✓ Timely submission of claim data
✓ Functional status assessment documentation can be accepted as supplemental data, reducing the need for some chart review</td></tr>
<tr><td colspan="2">Documentation types:</td></tr>
<tr><td colspan="2">1. Notation of ADL at least five areas were assessed, and results documented in the patient's medical record during the measurement year:</td></tr>
<tr><td>• Dressing and undressing
• Eating
• Personal hygiene</td><td>• Transferring (getting in and out of bed or chair)
• Using toilet
• Walking (ambulatory or functional mobility)</td></tr>
<tr><td colspan="2">2. Notation of IADL assessed for at least four areas with results documented in the medical record during the measurement year:</td></tr>
<tr><td>• Cooking or meal preparation
• Driving or using public transportation
• Grocery shopping
• Handling finances
• Home repair</td><td>• Laundry
• Taking medications
• Using the telephone</td></tr>
<tr><td colspan="2">3. Functional Status Assessment using a standardized functional status assessment tool to assess patient's ADLs with results documented in the patient's medical record during the measurement year, not limited to:</td></tr>
<tr><td>• Assessment of Living Skills and Resources (ALSAR)
• Barthel ADL Index Physical Self-Maintenance (ADLS) Scale
• Bayer ADL (B-ADL) Scale
• Barthel Index
• Extended ADL (EADL) Scale
• Independent Living Scale (ILS)
• Katz Index of Independence in ADL.</td><td>• Kenny Self-Care Evaluation
• Klein-Bell ADL Scale
• Kohlman Evaluation of Living Skills (KELS)
• Lawton & Brody's IADL scales
• Patient Reported Outcome Measurement Information System (PROMIS) Global or Physical Function Scales
• SF-36®</td></tr>
</table>

Care for Older Adults (COA) Medication Review

The Care for Older Adults – Medication List and Medication Review measure evaluates older adults 66 years of age and older who had a medication review by a clinical pharmacist or prescribing practitioner and the presence of a medication list in the medical record or transitional care management services in the measurement year.

Product lines	Quality programs affected	Collection and reporting method
• **Medicare**	• CMS Star Rating	Hybrid • Claim data • Medical record review

Numerator compliance	Medication review by a prescribing practitioner or clinical pharmacist during the measurement year		
Billing codes	**Description**	**Code type**	**Code**
	Medication list	**CPT II**	1159F* (must be billed with 1160F)
		HCPCS	G8427
		SNOWMED	428191000124101, 432311000124109
	Medication review	**CPT**	90863, 99483, 99605, 99606
		CPT II	1160F
		SNOWMED	719327002, 719328007, 719329004 461651000124104
	Transitional care management	**CPT**	99495, 99496
	*CPT II code 1159F (medication list documented) must be submitted with 1160F (review of all medications by a prescribing practitioner or clinical pharmacist documented) on the same date of service		
Frequency/occurrence	Every year		

Test, service or procedure to close care opportunity	Either of the following meets criteria:
	• Both of the following during the same visit during the measurement year where the provider is a prescribing practitioner or clinical pharmacist:
	  o At least one medication review and
	  o The presence of a medication list in the medical record
	• Transitional care management services during the measurement year		

Medical record documentation (including but not limited to)	Medical record dates: 01/01/2024 - 12/31/2024 • Signed and dated medication list Submit medical record documentation to Priority Health HEDIS department • Electronically uploading medical records – contact ***HEDIS@PriorityHealth.com*** to get a file set up or for more information • Email: ***HEDIS@PriorityHealth.com*** • Fax: 616.975.8897		

	• Mail: HEDIS at 1231 E Beltline, NE Mail Stop 1280, Grand Rapids, MI, 49525
Claim deficiencies	Not submitting CPT II codes on claims submissions

Tips and best practices:

- ✓ **Check your Gaps in Care Report to identify your patients with open care opportunities**
- ✓ Medication list must be included in the medical record and medication review must be completed by a prescribing provider or clinical pharmacist
- ✓ The medication list should include the medication names, dosages and frequency/occurrence, OTC medications and herbal and supplemental therapies
- ✓ A medication review can be conducted during office, telephone and e-visits if the clinician is a prescribing provider; a registered nurse can collect the list of current medications, however there must be evidence that the appropriate practitioner reviewed the list
- ✓ The use of CPT II codes help identifies clinical outcomes such as advance care planning, reducing the need for some chart review
- ✓ **Medication review and medication list can be accepted as supplemental data**

Care for Older Adults (COA) Pain Assessment

The Care for Older Adults – Pain Assessment measure evaluates older adults 66 years of age and older who had who had a documented pain assessment in the medical record in the measurement year that measures a patient's experience of pain.

Product lines	Quality programs affected	Collection and reporting method
• **Medicare**	• CMS Star Rating	Hybrid • Claim data • Medical record documentation

Numerator compliance	Pain assessment during the measurement year		
Billing codes	**Description**	**Code type**	**Code**
	Pain assessment	**CPT II:**	1125F, 1126F
		SNOWMED	225399009, 370778008, 408952002, 408955000, 423184003, 445719003, 445790003, 445806009, 445812004, 445996003, 446009008, 446790006, 715322001, 770637008
Frequency/occurrence	Every year		
Test, service or procedure to close care opportunity	• Standardized pain assessment tool and results • Date and notation of "no pain" in the medical record after the patient's pain was assessed		
Medical record documentation (including but not limited to)	Medical record dates: 01/01/2024 - 12/31/2024 • Pain assessment forms • Health history and physical • Progress notes Submit completed assessment to Priority Health HEDIS department • Electronically uploading medical records – contact ***HEDIS@PriorityHealth.com*** to get a file set up or for more information • Email: ***HEDIS@PriorityHealth.com*** • Fax: 616.975.8897 • Mail: HEDIS at 1231 E Beltline, NE Mail Stop 1280, Grand Rapids, MI, 49525		
Claim deficiencies	Not submitting CPT II codes on claims submissions		

Tips and best practices:
- ✓ **Check your Gaps in Care Report to identify your patients with open care opportunities**
- ✓ Include documentation on the completion of a standardized pain assessment tool (such as 1–10 scale or faces scale) and/or documentation that the patient was assessed for pain
- ✓ As part of a service, a pain assessment can be performed telephonically by multidisciplinary care team patients such as registered nurses (RNs), licensed practical nurses (LPNs), medical assistants, etc.
- ✓ Incorporate pain assessment as part of the standardized vital sign process

<table>
<tr><td colspan="2">✓ Incorporate pain assessment as a standardized template within your EHR/EMR if applicable
✓ Use EHR/EMR alerts for patients due for a pain assessment
✓ Pain assessment that takes place during a telephone visit, e-visit or virtual check-in meets compliance. Please submit the appropriate CPT or HCPCS code for the type of visit.
✓ The use of CPT II codes help identifies clinical outcomes such as advance care planning, reducing the need for some chart review
✓ Pain assessment documentation can be accepted as supplemental data</td></tr>
<tr><td colspan="2">Standardized Pain Assessment Tool result of an assessment using a standardized pain assessment tool performed in an outpatient setting during the measurement year:</td></tr>
<tr><td>• Brief pain inventory
• Chronic pain grade
• Face, Legs, Activity, Cry and Consolability (FLACC) scale
• Numeric rating scales (verbal or written)
• Pain Assessment in Advanced Dementia (PAINAD) scale</td><td>• Pain thermometer
• Pictorial pain scales
• PROMIS pain intensity scale
• Verbal descriptor scales (5–7-word scales, present pain inventory)
• Visual analogue scale</td></tr>
</table>

Advance Care Planning (ACP)

The Advance Care Planning measure evaluates older adults 66 - 80 years of age and older with advanced illness, an indication of frailty or who are receiving palliative care, and adults 81 years of age and older who had a discussion with their physician about preferences for resuscitation, life-sustaining treatment and end of life care in the measurement year.

Product lines	Quality programs affected	Collection and reporting method
• **Medicare**		Hybrid • Claim data • Medical record review

Numerator compliance	Evidence of advance care planning during the measurement year		
Billing codes	**Description**	**Code type**	**Code**
	Advance care planning	**CPT**	99483, 99497
		CPT II	1123F, 1124F, 1157F, 1158F
		HCPCS	S0257
		ICD10CM	Z66
		SNOWMED	310301000, 310302007, 310303002, 310305009, 423606002, 425392003, 425393008, 425394002, 425395001 425396000, 425397009, 699388000, 713058002, 713580008, 713600001, 713602009, 713603004, 713662007, 713665009, 714361002, 714748000, 715016002, 719238004, 719239007, 719240009, 3011000175104, 3021000175108, 3031000175106, 3041000175100, 3061000175101, 4921000175109, 87691000119105,
Frequency/occurrence	Every year		
Test, service or procedure to close care opportunity	• A discussion or documentation about preferences for resuscitation, life-sustaining treatment and end of life care ❖ Advanced directive, actionable medical orders, living will, surrogate decision maker are all examples of advance care planning		

<table>
<tr><td>Medical record documentation (including but not limited to)</td><td>Medical record dates: 01/01/2024 - 12/31/2024
• Advance care plan
• Documented discussion or evidence of an advance care plan in the medical record or advanced care planning discussion with a physician and the date it was discussed

Submit medical record documentation to Priority Health HEDIS department
• Electronically uploading medical records – contact HEDIS@PriorityHealth.com to get a file set up or for more information
• Email: HEDIS@PriorityHealth.com
• Fax: 616.975.8897
• Mail: HEDIS at 1231 E Beltline, NE Mail Stop 1280, Grand Rapids, MI, 49525</td></tr>
<tr><td>Claim deficiencies</td><td>Not submitting CPT II codes on claims submissions</td></tr>
<tr><td colspan="2">Tips and best practices:
✓ Check your Gaps in Care Report to identify your patients with open care opportunities
✓ Document advance care planning during preventive and sick visits
✓ Advance care planning may be conducted over the phone by any care provider type including registered nurses and medical assistants when rendered with a medical visit
✓ Use EHR/EMR alerts for patients due for an advance care planning review
✓ Use CPT II codes which help identify clinical outcomes such as advance care planning
✓ A note stating the member declined to discuss advance care planning is considered evidence that the provider initiated a discussion and meets criteria
✓ Advance care plans can be accepted as supplemental data</td></tr>
</table>

Transitions of Care (TRC)

The Transitions of Care measure evaluates patients 18 years of age and older with an acute and nonacute inpatient hospital discharge in the measurement year, who had each of the following:

- **Notification of inpatient admission** – Documentation of receipt of notification of inpatient admission on the day of admission through two days after the admission (three total days)
- **Receipt of discharge information** – Documentation of receipt of discharge information on the day of discharge through two days after the discharge (three total days)
- **Patient engagement after inpatient discharge** – Documentation of patient engagement (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)

Product lines	Quality programs affected	Collection and reporting method
• **Medicare**	CMS Star Ratings	Hybrid • Claim data • Medical record review

Numerator iance	• Evidence of notification of inpatient admission three days after the admission • Evidence of receipt of discharge information three days after the discharge • Patient engagement within 30 days after discharge • Medication reconciliation conducted by a prescribing practitioner, clinical pharmacist, physician assistant, or registered nurse on the date of discharge through 30 days after discharge (31 days total)
Frequency/occurrence	Every acute and nonacute inpatient admission and discharge
Medical record documentation (including but not limited to)	Medical record dates: 01/01/2024 - 12/31/2024 • Documentation in the medical record must include evidence of receipt of notification of inpatient admission to the patient's PCP or ongoing care provider • Documentation in the medical record must include evidence of receipt of notification of discharge information to the patient's PCP or ongoing care provider • Documentation of patient follow up or patient engagement within 30 days of discharge (e.g., office visits, home visits, telehealth) by the patient's PCP or ongoing care provider • Medication reconciliation within 30 days of discharge to the patient's PCP or ongoing care provider Submit medical record documentation to Priority Health HEDIS tment

	• Electronically uploading medical records – contact ***HEDIS@PriorityHealth.com*** to get a file set up or for more information • Email: ***HEDIS@PriorityHealth.com*** • Fax: 616.975.8897 • Mail: HEDIS at 1231 E Beltline, NE Mail Stop 1280, Grand Rapids, MI, 49525
Common chart deficiencies	• No documentation of notification of inpatient admission and/or discharge • No documentation of patient engagement after discharge • No documentation of medication reconciliation
Tips and best practices: ✓ **Review the MiHIN admission, discharge or transfer service report** to identify all acute and nonacute inpatient admissions ✓ Review the Daily Inpatient/Discharge Report from the hospitals, request a copy of the discharge summary and have staff schedule office follow-up visits or telehealth visits within one week to check progress and address any barriers to the discharge plan (i.e., prescriptions filled, DME delivered, etc.)	

Transitions of Care (TRC) Notification of Inpatient Admission

The Transitions of Care Inpatient Notification measure evaluates patients 18 years of age and older with an acute and nonacute inpatient hospital discharge in the measurement year with a notification of inpatient admission documented the day of or 2 days after the admission (3 days total).

Product lines	Quality programs affected	Collection and reporting method
• **Medicare**	CMS Star Ratings	Medical record • Medical record review only

Administrative reporting is not available for this indicator	
Numerator compliance	• Evidence of notification of inpatient admission three days after the admission
Frequency/occurrence	Every acute and nonacute inpatient admission
Exclusions	Patients who use hospice services or elect to use a hospice benefit
Test, service or procedure to close care opportunity	Medical record documentation must be about the admission and can include record of a discussion or information transfer via phone call, email, fax, EHR/EMR, email or health information exchange. Examples of this documentation include: • Communication between inpatient providers or staff and the member's PCP or ongoing care provider (e.g., phone call, email, fax). • Communication about admission between emergency department and the member's PCP or ongoing care provider (e.g., phone call, email, fax). • Communication about admission to the member's PCP or ongoing care provider through a health information exchange; an automated admission, or discharge and transfer (ADT) alert system. • Communication about admission with the member's PCP or ongoing care provider through a shared electronic medical record (EMR) system. When using a shared EMR system, documentation of a "received date" is not required to meet criteria. Evidence that the information was filed in the EMR and is accessible to the PCP or ongoing care provider on the day of admission through 2 days after the admission (3 total days) meets criteria. • Communication about admission to the member's PCP or ongoing care provider from the member's health plan. • Indication that the member's PCP or ongoing care provider admitted the member to the hospital. • Indication that a specialist admitted the member to the hospital and notified the member's PCP or ongoing care provider. • Indication that the PCP or ongoing care provider placed orders for tests and treatments any time during the member's inpatient stay.

	• Documentation that the PCP or ongoing care provider performed a preadmission exam or received communication about a planned inpatient admission. The time frame that the planned inpatient admission must be communicated is not limited to the day of admission through 2 days after the admission (3 total days); documentation that the PCP or ongoing care provider performed a preadmission exam or received notification of a planned admission prior to the admit date also meets criteria. The planned admission documentation or preadmission exam must clearly pertain to the denominator event.
Medical record documentation (including but not limited to)	Inpatient admission dates: 01/01/2024 - 12/31/2024 • Health history and physical • Home health records • Progress notes • SOAP notes Submit medical record documentation to Priority Health HEDIS department • Electronically uploading medical records – contact ***HEDIS@PriorityHealth.com*** to get a file set up or for more information • Email: ***HEDIS@PriorityHealth.com*** • Fax: 616.975.8897 • Mail: HEDIS at 1231 E Beltline, NE Mail Stop 1280, Grand Rapids, MI, 49525
Common chart deficiencies	No documentation of notification of inpatient admission

Tips and best practices:
- ✓ **Review the MiHIN admission, discharge or transfer service report** to identify all acute and nonacute inpatient admissions
- ✓ **Hospital inpatient admission notification can be accepted as supplemental data.**

Transitions of Care (TRC) Receipt of Discharge Information

The Transitions of Care Receipt of Discharge Notification measure evaluates patients 18 years of age and older with an acute and nonacute inpatient hospital discharge in the measurement year with a notification of inpatient admission documented the day of or 2 days after the admission (3 days total).

Product lines	Quality programs affected	Collection and reporting method
• **Medicare**	CMS Star Ratings	Medical record • Medical record review only

Administrative reporting is not available for this indicator	
Numerator compliance	Evidence of receipt of discharge information three days after the discharge
Frequency/occurrence	Every acute and nonacute inpatient discharge
Exclusions	Patients who use hospice services or elect to use a hospice benefit
Test, service or procedure to close care opportunity	Documentation in the medical record must include evidence of receipt of notification of inpatient discharge with date/time stamp on the day of or through two days after the discharge. Discharge information must include all the following: • The name of the care provider responsible for the patient's care during the inpatient stay • Services or treatments provided during the inpatient stay • Diagnoses at discharge • Current medication list • Test results or documentation that either test results are pending, or no test results are pending • Instructions for patient-care post-discharge to the PCP or ongoing care provider
Medical record documentation (including but not limited to)	Inpatient admission and discharge dates: 01/01/2024 - 12/31/2024 Documentation in the outpatient medical record must include evidence of receipt of discharge information on the day of discharge through 2 days after the discharge (3 total days) with evidence of the date when the documentation was received. Discharge information may be included in, but not limited to, a discharge summary or summary of care record or be located in structured fields in an EHR. At a minimum, the discharge information must include all of the following: • The practitioner responsible for the member's care during the inpatient stay. • Procedures or treatment provided. • Diagnoses at discharge.

	• Testing results, or documentation of pending tests or no tests pending. • Instructions for patient care post-discharge. Submit medical record documentation to Priority Health HEDIS department • Electronically uploading medical records – contact ***HEDIS@PriorityHealth.com*** to get a file set up or for more information • Email: ***HEDIS@PriorityHealth.com*** • Fax: 616.975.8897 • Mail: HEDIS at 1231 E Beltline, NE Mail Stop 1280, Grand Rapids, MI, 49525
Common chart deficiencies	No documentation of inpatient discharge care plan/summary with all the above requirements to close care opportunity

Tips and best practices:

- ✓ **Review the MiHIN admission, discharge or transfer service report** to identify all acute and nonacute inpatient discharges

Important Notes

When using a shared EHR/EMR system, documentation of a "received date" in the EHR/EMR isn't required to meet criteria. Evidence that the information was filed in the EHR/EMR and is accessible to the PCP or ongoing care provider on the day of discharge through 2 days after the discharge (3 total days) meets criteria.

Transitions of Care (TRC) Patient Engagement After Inpatient Discharge

The Transitions of Care Patient Engagement After Inpatient Discharge measure evaluates patients 18 years of age and older with an acute and nonacute inpatient hospital discharge in the measurement year with documentation of patient engagement completed within 30 days of the inpatient discharge.

Product lines	Quality programs affected	Collection and reporting method
• **Medicare**	CMS Star Ratings	Hybrid • Claim data • Medical record review

Numerator compliance	Patient engagement within 30 days after discharge		
Billing codes	**Description**	**Code type**	**Code**
	Outpatient	**CPT**	99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99385, 99386, 99387, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99429, 99455, 99456, 99483
		HCPCS	G0402, G0438, G0439, G0463, T1015
		SNOWMED	77406008, 84251009, 185317003, 185463005, 185464004, 185465003, 281036007, 314849005, 386472008, 386473003, 401267002, 439740005, 3391000175108, 444971000124105
		UBREV	0510, 0511, 0512, 0513, 0514, 0515, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0526, 0527, 0528, 0529, 0982, 0983
	E-visit or virtual check-in	**CPT**	98969, 98970, 98971, 98972, 99421, 99422, 99423, 99444, 99457, 99458
		HCPCS	G0071, G2010, G2012, G2061, G2062, G2063, G2250, G2251, G2252
	Telephone visits	**CPT**	98966, 98967, 98968, 99441, 99442, 99443
	Transitional care management	**CPT**	99495, 99496
Frequency/occurrence	Every acute and nonacute inpatient discharge		
Test, service or procedure to close care opportunity	Patient engagement the day after inpatient discharge through 30 days after can include: • An outpatient visit, including office visits and home visits • E-visit or virtual check-in		

	• Virtual visit – must include real time interaction with the care provider
Medical record documentation (including but not limited to)	Medical record dates: 01/01/2024 - 12/31/2024 • Health history and physical • Home health records • Progress notes • SOAP notes Documentation in the outpatient medical record must include evidence of patient engagement within 30 days after discharge. Any of the following meet criteria: • An outpatient visit, including office visits and home visits. • A telephone visit • A synchronous telehealth visit where real-time interaction occurred between the member and provider using audio and video communication. • An e-visit or virtual check-in (asynchronous telehealth where two-way interaction, which was not in real-time, occurred between the member and provider). **Note**: If the member is unable to communicate with the provider, interaction between the member's caregiver and the provider meets criteria. Submit medical record documentation to Priority Health HEDIS department • Electronically uploading medical records – contact ***HEDIS@PriorityHealth.com*** to get a file set up or for more information • Email: ***HEDIS@PriorityHealth.com*** • Fax: 616.975.8897 • Mail: HEDIS at 1231 E Beltline, NE Mail Stop 1280, Grand Rapids, MI, 49525
Common chart deficiencies	No documentation of post-discharge patient engagement

Tips and best practices:

- ✓ **Review the MiHIN admission, discharge or transfer service report** to identify inpatient discharges
- ✓ Use EHR/EMR alert reminders for follow-up appointments post-discharge
- ✓ Patient Engagement After Inpatient Discharge services provided during a telehealth visit meet the criteria

Progress notes for office visits within 30 days of an inpatient discharge can be accepted as supplemental data

Supplemental Data Accepted

Transitions of Care (TRC) Medication Reconciliation Post-Discharge

The Transitions of Care Inpatient Notification measure evaluates patients 18 years of age and older with an acute and nonacute inpatient hospital discharge in the measurement year with a medication reconciliation conducted by a prescribing practitioner, clinical pharmacist, physician assistant, or registered nurse on the date of discharge through 30 days after discharge (31 total days).

Product lines	Quality programs affected	Collection and reporting method
• **Medicare**	CMS Star Ratings	Medical record • Medical record review only

Billing codes	**Description**	**Code type**	**Code**
	Medication reconciliation encounter	**CPT**	99483, 99495, 99496
	Medication reconciliation intervention	**CPT II**	1111F
		SNOWMED	430193006, 428701000124107
Frequency/occurrence	Every visit		
Exclusions	Patients who use hospice services or elect to use a hospice benefit		
Test, service or procedure to close care opportunity	Documentation in the outpatient medical record must include evidence of medication reconciliation and the date when it was performed. Any of the following meet criteria: • Documentation of the current medications with a notation that the provider reconciled the current and discharge medications. • Documentation of the current medications with a notation that references the discharge medications (e.g., no changes in medications since discharge, same medications at discharge, discontinue all discharge medications). • Documentation of the member's current medications with a notation that the discharge medications were reviewed. • Documentation of a current medication list, a discharge medication list and notation that both lists were reviewed on the same date of service. • Documentation of the current medications with evidence that the member was seen for post-discharge hospital follow-up with evidence of medication reconciliation or review. Evidence that the member was seen for post-discharge hospital follow-up requires documentation that indicates the provider was aware of the member's hospitalization or discharge. • Documentation in the discharge summary that the discharge medications were reconciled with the most recent medication list in the outpatient medical record. There must be evidence that the discharge summary was filed in the outpatient chart on		

	the date of discharge through 30 days after discharge (31 total days). • Notation that no medications were prescribed or ordered upon discharge.
Medical record documentation (including but not limited to)	Medical record dates: 01/01/2024 - 12/31/2024 • Health history and physical • Home health records • Progress notes • SOAP notes Submit medical record documentation to Priority Health HEDIS department • Electronically uploading medical records – contact ***HEDIS@PriorityHealth.com*** to get a file set up or for more information • Email: ***HEDIS@PriorityHealth.com*** • Fax: 616.975.8897 Mail: HEDIS at 1239 E Beltline, NE Mail Stop 1280, Grand Rapids, MI, 49525
Common chart deficiencies	No documentation of post-discharge medication reconciliation
Claim deficiencies	Not submitting CPT II codes on claims submissions

Tips and best practices:

- ✓ Document evidence of medication reconciliation of discharge and current medications
- ✓ Discharge medication post-discharge doesn't require the patient to be present
- ✓ Medication reconciliation can be conducted by a prescribing practitioner, clinical pharmacist, physician assistant or registered nurse
- ✓ Medication reconciliation must be completed within 30 days of discharge
- ✓ A medication list must be present in the medical record to fully comply with this measure
- ✓ Submit the appropriate CPT II codes for post-discharge medication reconciliation
- ✓ Medication reconciliation does not require the member to be present
- ✓ **Progress notes for medication reconciliation can be accepted as supplemental data**

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

The Follow-up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions measure evaluates patients 18 years and older who have multiple high-risk chronic conditions who had a follow-up service with a care provider within seven (7) days of the ED visit.

Product lines	Quality programs affected	Collection and reporting method
• **Medicare**	CMS Star Ratings	Administrative • Claim data

Numerator compliance	A follow-up service within 7 days after the ED visit (8 total days)		
Eligible chronic condition diagnoses	• Acute myocardial infarction • Atrial fibrillation • Alzheimer's disease and related disorders • Chronic kidney disease	• COPD and Asthma • Depression • Heart failure • Stroke and transient ischemic attack	
Billing codes	**Description**	**Code type**	**Code**
	Outpatient and telehealth visit		
	Outpatient	**CPT**	98966, 98967, 98968, 98970, 98971, 98972, 98980, 98981, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99385, 99386, 99387, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99421, 99422, 99423, 99455, 99456, 99457, 99458, 99483
		HCPCS	G0402, G0438, G0439, G0463, G2010, G2012, G2250, G2251, G2252, T1015
		SNOWMED	77406008, 84251009, 185317003, 185463005, 185464004, 185465003, 281036007, 314849005, 386472008, 386473003, 401267002, 439740005, 3391000175108, 444971000124105
		UBREV	0510, 0511, 0512, 0513, 0514, 0515, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0526, 0527, 0528, 0529, 0982, 0983
	Transitional care management services		

	Transitional care management	**CPT**	99495, 99496
	Case management visits		
	Case management	**CPT**	99366
	Complex care management visits		
	Complex care management services	**CPT**	99439, 99487, 99489. 99490, 99491
	Outpatient or telehealth behavioral health visit with outpatient place of service		
	Visit setting unspecified	**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, 99253, 99254, 99255
	Outpatient POS	**POS**	03, 05, 07, 09, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 22, 33, 49, 50, 71, 72
	Outpatient or telehealth behavioral health visit		
	Behavioral health 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, 99385, 99386, 99387, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99483, 99492, 99493, 9949, 99510
		HCPCS	G0155, G0176, G0177, G0409, G0463, G0512, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013, H2014, H2016, H2017, H2018, H2019, H2020, T1015
		UBREV	0510, 0513, 0515, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0526, 0527, 0528, 0529, 0900, 0902, 0903, 0904, 0911, 0914, 0915, 0916, 0917, 0919, 0982, 0983
	Outpatient or telehealth behavioral health visit with appropriate place of service		
	Visit setting unspecified	**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, 99253, 99254, 99255

	Outpatient POS	**POS**	03, 05, 07, 09, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 22, 33, 49, 50, 71, 72
	Intensive outpatient encounter or partial hospitalization		
	Partial hospitalization or intensive outpatient visit	**HCPCS**	G0410, G0411, H0035, H2001, H2012, S0201, S9480, S9484, S9485
	Intensive outpatient encounter or partial hospitalization with appropriate place of service		
	Visit setting unspecified	**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, 99253, 99254, 99255
	Partial hospitalization POS	**POS**	52
	Community mental health center visit with appropriate place of service		
	Visit setting unspecified	**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, 99253, 99254, 99255
	Community mental health center POS	**POS**	53
	Electroconvulsive therapy with appropriate place of service		
	Electroconvulsive therapy	**CPT**	90870
	Ambulatory surgical center POS	**POS**	24
	Community mental health center POS	**POS**	53
	Outpatient POS	**POS**	03, 05, 07, 09, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 22, 33, 49, 50, 71, 72
	Partial hospitalization POS	**POS**	52
	Telehealth visit with telehealth place of service		
	Visit setting unspecified	**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, 99253, 99254, 99255
	Telehealth POS	**POS**	02, 10
	Substance use disorder or substance use counseling and surveillance		
	Substance use disorder services	**CPT**	99408, 99409
		HCPCS	G0396, G0397, G0443, H0001, H0005, H0007, H0015, H0016, H0022, H0047, H0050, H2035, H2036, T1006, T1012
		SNOWMED	20093000, 23915005, 56876005, 61480009, 64297001, 67516001, 87106005, 182969009, 266707007, 310653000, 370776007, 370854007, 385989002, 386449006, 386450006, 386451005, 414054004, 414056002, 414283008, 414501008, 415662004, 445628007, 445662007, 450760003, 704182008, 707166002, 711008001, 713106006, 713107002, 713127001, 720174008, 720175009, 720176005, 720177001, 763104007, 763233002, 763302001, 772813001, 774090004, 774091000, 792901003, 792902005, 827094004, 865964007, 428211000124100
		UBREV	0906m 0944, 0945
Frequency/occurrence	After every emergency department discharge for people with multiple high-risk chronic conditions		
Exclusions	Patients who use hospice services or elect to use a hospice benefit		
Test, service or procedure to close care opportunity	Outpatient follow-up appointment after every emergency department discharge between January 1 and December 24 of the measurement year		
Medical record documentation (including but not limited to)	Medical record dates: 01/01/2024 – 12/31/2024 Administrative and supplemental data submissions only • Consultation reports • Diagnostic reports • Health history and physical Submit medical record documentation to Priority Health HEDIS department • Electronically uploading medical records – contact ***HEDIS@PriorityHealth.com*** to get a file set up or for more information • Email: ***HEDIS@PriorityHealth.com*** • Fax: 616.975.8897		

	Mail: HEDIS at 1231 E Beltline, NE Mail Stop 1280, Grand Rapids, MI, 49525
Common chart deficiencies	• No discussion of scheduling a mammogram • No documentation of mammogram date

Tips and best practices:

- ✓ **Check your Gaps in Care Report to identify your patients with open care opportunities**
- ✓ Schedule follow-up appointment within seven (7) days of discharge:
  - ❖ Same day visit in hospital clinic/provider care office
  - ❖ Primary care physician
  - ❖ Mobile mental health team
  - ❖ Telehealth visit
  - ❖ Have the hospital to send the discharge plan for review during follow-up appointment
- ✓ Send claims to Priority Health for visits that meet the criteria
- ✓ Timely submission of claims
- ✓ **Progress notes for ED follow-up for patients with multiple high risk chronic conditions can be accepted as supplemental data**

Supplemental Data Accepted

Plan All-Cause Readmissions (PCR)

The Plan All-Cause Readmissions measure evaluates patients 18 years of age and older who had an acute inpatient and observation stay that were followed by an unplanned acute readmission for any diagnosis within 30 days of the initial discharge.

PCR focuses on better care coordination aimed at avoiding unnecessary readmissions. Seeing patients within seven days of discharge is one of the best interventions you can provide to reduce readmissions.

A lower calculated performance rate for this measure indicates better clinical care.

Product lines	Quality programs affected	Collection and reporting method
• **Commercial** • **Medicaid** • **Medicare**	• CMS Star Ratings • NCQA Health Plan Ratings	Administrative • Claim data

Numerator	At least one acute readmission for any diagnosis within 30 days of the Index Discharge Date.

Tips and best practices:

- ✓ Coordinating care from the hospital to home and ensuring a follow-up visit with the primary care physician can help your patients avoid a readmission
- ✓ You can help your patients avoid readmission by:
  - ➢ Following up with them within 1 week of their discharge
  - ➢ Schedule same-day appointments when possible
  - ➢ Request discharge summaries from the hospital prior to the follow-up call or office visit
  - ➢ Implement a safe discharge plan that includes a post-discharge telephone or telehealth visit to review discharge instructions, care plan, and medication instructions, and to answer any questions
  - ➢ Review discharge instructions and medications with patients and/or caregivers
  - ➢ Let patients know when to call their physician, when and how to take medications
  - ➢ Discuss any challenges the patient may have (need additional help at home, transportation, DME services, etc.)
- ✓ Discuss any challenges the patient may have (need additional help at home, transportation concerns, DME services, etc.) and assist them as needed. According to Journal of Family Practice, common contribution factors of readmissions are:
- ✓ Feeling unprepared for discharge
- ✓ Difficulty assessing discharge medications
- ✓ Trouble adhering to discharge medications
- ✓ Difficulty performing daily activities
- ✓ Lack of social support[1]

[1] Institute for Healthcare Improvement. (n.d.). Ask Me 3: Good Questions for Your Good Health. Retrieved from http://www.ihi.org/resources/Pages/Tools/Ask-Me-3-Good-Questions-for-Your-Good-Health.aspx

Hospitalization Following Discharge From A Skilled Nursing Facility (HFS)

The Hospitalization Following Discharge From a Skilled Nursing Facility measure evaluates patients 65 years of age and older who was discharged from a skilled nursing facility followed by an unplanned acute hospitalization for any diagnosis wiling 30 and 60 days.

Product lines	Quality programs affected	Collection and reporting method
• **Medicare**		Administrative • Claim data

Numerator	At least one acute admission for any diagnosis within 30 to 60 days of the Skilled Nursing Facility discharge date

Tips and best practices:
Coordinating care from the skilled nursing facility to home and ensuring a follow-up visit with the primary care physician can help your patients avoid an unplanned admission. You can help your patients avoid an unplanned admission by:

- ✓ Following up with them within 1 week of their discharge
- ✓ Schedule same-day appointments when possible
- ✓ Request discharge summaries from the hospital prior to the follow-up call or office visit
- ✓ Implement a safe discharge plan that includes a post-discharge telephone or telehealth visit to review discharge instructions, care plan, and medication instructions, and to answer any questions
- ✓ Review discharge instructions and medications with patients and/or caregivers
- ✓ Let patients know when to call their physician, when and how to take medications
- ✓ Discuss any challenges the patient may have (need additional help at home, transportation, DME services, etc.)
- ✓ Discuss any challenges the patient may have (need additional help at home, transportation concerns, DME services, etc.) and assist them as needed

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

The Adults' Access to Preventive/Ambulatory Health Services measure evaluates patients 20 years of age and older who had an ambulatory or preventive care visit during the measurement year.

Product lines	Quality programs affected	Collection and reporting method
• **Commercial** • **Medicaid** • **Medicare**	• State Performance Measure	Administrative • Claim data

Numerator compliance	Medicaid and Medicare: One or more ambulatory or preventive care visits during the measurement year Commercial: One or more ambulatory or preventive care visits during the measurement year or the 2 years prior to the measurement year		
Billing codes	**Description**	**Code type**	**Codes**
	Ambulatory visits	**CPT**	92002, 92004, 92012, 92014, 98969, 98970, 98971, 9897299201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99304, 99305, 99306, 99307,99308, 99309,99310, 99315, 99316, 99318, 99324,99325, 99326, 99327, 99328, 99334,99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99385, 99386, 99387, 99395, 99396, 99397,99401, 99402, 99403, 99404, 99411, 99412, 99429, 99483
		HCPCS	G0071, G0402, G0438, G0439, G0463, G2010, G2012, G2250, G2251, G2252, S0620, S0621, T1015
		SNOWMED	18170008, 19681004, 162651007, 162655003, 170107008, 170114005, 170123008, 170132005, 170141000, 170150003, 170159002, 170168000, 170250008, 170254004, 170263002, 170272005, 170281004, 170290006, 170300004, 170309003, 185317003, 207195004, 209099002, 210098006, 243788004, 268563000, 268565007, 281029006, 281031002, 314849005,

			386472008, 386473003, 01140000, 401267002, 410620009, 410622001, 410623006, 410624000, 410625004, 410626003, 410627007, 410628002, 410629005, 410630000, 410631001, 410632008, 410633003, 410634009, 410635005, 410636006, 410637002, 410638007, 410639004, 410640002, 410641003, 410642005, 410643000, 410644006, 410645007, 410646008, 410647004, 410648009, 410649001, 410650001, 442162000, 699134002, 712791009, 713020001 783260003
		UBREV	0510, 0511, 0512, 0513, 0514, 0515, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0524, 0525, 0526, 0527, 0528, 0529, 0982, 0983
	Reason for ambulatory visit	**ICD-10 diagnosis**	Z00.00, Z00.01, Z00.121, Z00.129, Z00.3, Z00.5, Z00.8, Z02.0, Z02.1, Z02.2, Z02.3, Z02.4, Z02.5, Z02.6, Z02.71, Z02.79, Z02.81, Z02.82, Z02.83, Z02.89, Z02.9, Z76.1, Z76.2
Frequency/occurrence	• Medicaid and Medicare patients every year • Commercial patients at least every two years		
Test, service or procedure to close care opportunity	• Ambulatory visit Preventative care visit		
Medical record documentation (including but not limited to)	Medical record dates: 01/01/2024 – 12/31/2024 ✓ Health history and physical ✓ Home health records ✓ Progress notes ✓ SOAP notes Submit medical record documentation to Priority Health HEDIS department • Electronically uploading medical records – please contact • HEDIS@PriorityHealth.com to get a file set up or for more information • Email: HEDIS@PriorityHealth.com • Fax: 616.975.8897 • Mail: HEDIS at 1231 E Beltline, NE Mail Stop 1280, Grand Rapids, MI, 49525		
Tips and best practices: ✓ **Check your Gaps in Care Report to identify your patients with open care opportunities** ✓ Have patients complete an annual preventative care visit / wellness check			

- ✓ **Progress reports and/or consultation reports can be accepted as supplemental data**
- ✓ Outreach to patients who have not had a preventive or ambulatory health visit to schedule a check-up
- ✓ Report all services provided and submit appropriate billing codes

Supplemental Data Accepted

Childhood Immunization Status (CIS/CIS-E)

The Childhood Immunization Status measure evaluates children turning two years during the measurement year who had received the following immunizations on or before their second birthday:

Four diphtheria, tetanus, and acellular pertussis (DTaP)	Three polio (IPV)
One measles, mumps, and rubella (MMR)	Three hepatitis B (HepB)
Three haemophilus influenza type B (HiB)	One varicella zoster (VZV)
Four pneumococcal conjugate (PCV)	One hepatitis A (HepA)
Two or three rotavirus (RV)	Two influenza (flu)

CIS assesses receipt of these ACIP-recommended vaccines by the second birthday and includes a rate for each type of vaccine and the following combination rates:

CIS Combination	DTaP	IPV	MMR	HiB	HepB	VZV	PCV	HepA	RV	Influenza
Combination 3	✓	✓	✓	✓	✓	✓	✓			
Combination 7	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Combination 10	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Product lines	Quality programs affected	Collection and reporting method
• **Commercial** • **Medicaid**	• State Performance Measure (combination 3 only)	Hybrid • Claim data • Medical record review

Immunization billing codes

DTaP **Number of Doses: 4** **Special Circumstances:** Don't count dose administered from birth through 42 days	
CPT	90697, 90698, 90700, 90723
CVX	20, 50, 106, 107, 110, 120, 146
SNOWMED	310306005, 310307001, 310308006, 312870000, 313383003, 390846000, 390865008, 399014008, 412755006, 412756007, 412757003, 412762002, 412763007, 412764001, 414001002, 414259000, 414620004, 415507003, 415712004, 770608009, 770616000, 770617009, 770618004, 787436003, 866158005, 866159002, 866226006, 868273007, 868274001, 868276004, 868277008, 1162640003, 428251000124104, 571571000119105, 572561000119108, 16290681000119103

Polio **Number of Doses: 3** **Special Circumstances:** Don't count dose administered from birth through 42 days	
CPT	90697, 90698, 90713, 90723

CVX	10, 89, 110, 120, 146
SNOWMED	310306005, 310307001, 310308006, 312869001, 312870000, 313383003, 390865008, 396456003, 412762002, 412763007, 412764001, 414001002, 414259000, 414619005, 414620004, 415507003, 415712004, 416144004, 416591003, 417211006, 417384007, 417615007, 866186002, 866227002, 868266002, 868267006, 868268001, 868273007, 868274001, 868276004, 868277008, 870670004, 572561000119108, 16290681000119103

MMR **Number of Doses: 1** **Special Circumstances:** Vaccine must be administered on or between a child's first and second birthdays	
CPT	90707, 90710
CVX	03, 94
SNOWMED	38598009, 170431005, 170432003, 170433008, 432636005, 433733003, 871909005, 571591000119106, 572511000119105
History of Measles	
ICD-10 Diagnosis	B05.0, B05.1, B05.2, B05.3, B05.4, B05.81, B05.89, B05.9
SNOWMED	14189004, 28463004, 38921001, 60013002, 74918002, 111873003, 161419000, 186561002, 186562009, 195900001, 240483006, 240484000, 359686005, 371111005, 406592004, 417145006, 424306000, 105841000119101
History of Mumps	
ICD-10 Diagnosis	B26.0, B26.1, B26.2, B26.3, B26.81, B26.82, B26.83, B26.84, B26.85, B26.89, B26.9
SNOWMED	10665004, 17121006, 31524007, 31646008, 36989005, 40099009, 44201003, 63462008, 72071001, 74717002, 75548002, 78580004, 89231008, 89764009, 111870000, 161420006, 235123001, 236771002, 237443002, 240526004, 240527008, 240529006, 371112003. 1163539003, 105821000119107
History of Rubella	
ICD-10 Diagnosis	B06.00, B06.01, B06.02, B06.09, B06.81, B06.82, B06.89, B06.9
SNOWMED	10082001, 13225007, 19431000, 36653000, 51490003, 64190005, 79303006, 128191000, 161421005, 165792000, 186567003, 186570004, 192689006, 231985001, 232312000, 240485004, 253227001, 406112006, 406113001, 1092361000119109, 10759761000119100

Hep B **Number of Doses: 3**	
CPT	90697, 90723, 90740, 90744, 90747, 90748
HCPCS	G0010
CVX	08, 44, 45, 51, 110, 146
SNOWMED	16584000, 170370000, 170371001, 170372008, 170373003, 170374009, 170375005, 170434002, 170435001, 170436000, 170437009, 312868009, 396456003, 416923003, 770608009, 770616000, 770617009, 770618004, 786846001, 1162640003, 572561000119108
History of Hepatitis B	
ICD-10 Diagnosis	B16.0, B16.1, B16.2, B16.9, B17.0, B18.0, B18.1, B19.10, B19.11
SNOWMED	1116000, 13265006, 26206000, 38662009, 50167007, 53425008, 60498001,

	61977001, 66071002, 76795007, 111891008, 165806002, 186624004, 186626002, 186639003, 235864009, 235865005, 235869004, 235871004, 271511000, 313234004, 406117000, 424099008, 424340000, 442134007, 442374005, 446698005, 838380002, 153091000119109, 551621000124109

Hib **Number of Doses: 3** **Special Circumstances:** Don't count dose administered from birth through 42 days	
CPT	90644, 90647, 90648, 90697, 90698, 90748
CVX	17, 46, 47, 48, 49, 50, 51, 120, 146, 148
SNOWMED	127787002, 170343007, 170344001, 170345000, 170346004, 310306005, 310307001, 310308006, 312869001, 312870000, 313383003, 414001002, 414259000, 415507003, 415712004, 428975001, 712833000, 712834006, 770608009, 770616000, 770617009, 770618004, 786846001, 787436003, 1119364007, 1162640003, 16292241000119109

Varicella (VZV) **Number of Doses: 1** **Special Circumstances:** Vaccine must be administered on or between a child's first and second birthdays	
CPT	90710, 90716
CVX	21, 94
SNOWMED	425897001, 428502009, 432636005, 433733003, 737081007, 871898007, 871899004, 871909005, 572511000119105
History of Varicella Zoster	
ICD-10 Diagnosis	B01.0, B01.11, B01.12, B01.2, B01.81, B01.89, B01.9, B02.0, B02.1, B02.21, B02.22, B02.23, B02.24, B02.29, B02.30, B02.31, B02.32, B02.33, B02.34, B02.39, B02.7, B02.7, B02.9
SNOWMED	4740000, 10698009, 21954000, 23737006, 24059009, 36292003, 38907003, 42448002, 49183009, 55560002, 87513003, 111859007, 111861003, 161423008, 186524006, 186525007, 195911009, 230176008, 230198004, 230262004, 230536009, 232400003, 235059009, 240468001, 240470005, 240471009, 240472002, 240473007, 240474001, 309465005, 371113008, 397573005, 400020001, 402897003, 402898008, 402899000, 410500004, 410509003, 421029004, 422127002, 422446008, 422471006, 422666006, 423333008, 423628002, 424353002, 424435009, 424801004, 424941009, 425356002, 426570007, 428633000, 713250002, 713733003, 713964006, 715223009, 723109003, 838357005, 1163465001, 1163483009, 1179456002, 12551000132107, 12561000132105, 12571000132104, 98541000119101, 331071000119101, 681221000119108, 1087131000119102, 15678761000119105, 15678801000119102, 15678841000119100, 15680201000119106, 15680241000119108, 15680281000119103, 15685081000119102, 15685121000119100, 15685201000119100, 15685281000119108, 15936581000119108, 15936621000119108, 15989271000119107, 15989311000119107, 15989351000119108, 15991711000119108, 15991751000119109, 15991791000119104, 15992351000119104, 16000751000119105, 16000791000119100, 16000831000119106

Pneumococcal Conjugate (PCV) **Number of Doses: 4** **Special Circumstances:** Don't count dose administered from birth through 42 days	
CPT	90670
HCPCS	G0009
CVX	109, 133, 152
SNOWMED	1119368005, 434751000124102

Hep A **Number of Doses: 1** **Special Circumstances:** Vaccine must be administered on or between a child's first and second birthdays	
CPT	90633
CVX	31, 83, 85
SNOWMED	170378007, 170379004, 170380001, 170381002, 170434002, 170435001, 170436000, 170437009, 243789007, 312868009, 314177003, 314178008, 314179000, 394691002, 871752004, 871753009, 871754003, 571511000119102
History of Hepatitis A	
ICD-10 Diagnosis	B15.0, B15.9
SNOWMED	16060001, 18917003, 25102003, 40468003, 43634002, 79031007, 111879004, 165997004, 206373002, 278971009, 310875001, 424758008, 428030001, 105801000119103

Rotavirus **Number of Doses: 2 or 3** **Special Circumstances:** Vaccine must be administered on or between a child's first and second birthdays	
2 Dose Vaccine	
CPT	90681
CVX	119
SNOWMED	434741000124104
3 Dose Vaccine	
CPT	90680
CVX	116, 122
SNOWMED	434731000124109

Influenza **Number of Doses: 2** **Special Circumstances:** Don't count dose administered prior to age 6 months	
CPT	90655, 90657, 90661, 90673, 90674, 90685, 90686, 90687, 90688, 90689, 90756
HCPCS	G0008
CVX	88, 140, 141, 150, 153, 155, 158, 161, 171, 186
SNOWMED	86198006

Live Addenuated Influenza Virus (LAIV) **Number of Doses: 2** **Special Circumstances:** • Must be administered on the second birthday • Only 1 of the 2 required vaccinations can be LAIV	
CPT	90660, 90672
CVX	111, 149
SNOWMED	78706008

Anaphylaxis billing codes	**Description**	**Code type**	**Code**
	Anaphylaxis due to Hepatitis B vaccine (disorder)	SNOWMED	428321000124101
	Anaphylaxis due to rotavirus vaccine (disorder)	SNOWMED	428331000124103
	Anaphylaxis due to Haemophilus influenzae type b vaccine (disorder)	SNOWMED	
	Anaphylaxis caused by vaccine product containing Streptococcus pneumoniae antigen (disorder)	SNOWMED	471141000124102
	Anaphylaxis caused by vaccine product containing Hepatitis A virus antigen (disorder)	SNOWMED	471311000124103
	Anaphylaxis caused by vaccine product containing human poliovirus antigen (disorder)	SNOWMED	471321000124106
	Anaphylaxis caused by vaccine product containing Measles morbillivirus and Mumps orthobulavirus and Rubella virus antigens (disorder)	SNOWMED	471331000124109
	Anaphylaxis caused by vaccine containing Human alphaherpesvirus 3 antigen (disorder)	SNOWMED	471341000124104
	Anaphylaxis caused by vaccine product containing Influenza virus antigen (disorder)	SNOWMED	471361000124100

Required exclusions	Any vaccine	Anaphylactic reaction to the vaccine or its components
	DTaP	Encephalopathy <u>with</u> a vaccine adverse-effect code
	Hepatitis B	Anaphylactic reaction to common baker's yeast
	IPV	Anaphylactic reaction to streptomycin, polymyxin B or neomycin
	MMR, VZV and Influenza	• Immunodeficiency • HIV

		• Lymphoreticular cancer, multiple myeloma, or leukemia • Anaphylactic reaction to neomycin
	Rotavirus	• History of intussusception • Severe combined immunodeficiency
	History of	• Hepatitis A • Hepatitis B • Measles • Mumps • Rubella • Varicella Zoster
Test, service or procedure to close care opportunity	• An immunization record or document that includes the **name of the specific antigen <u>and</u> the date** the vaccine was administered • For Hep A, Hep B, MMR and VZV, documented history of the illness counts as a numerator event and must occur on or before the child's second birthday • Provide documentation of contraindication to immunization or parental refusal if applicable ❖ Parental refusal of vaccinations doesn't remove an eligible patient from the denominator	
Medical record documentation (including but not limited to)	Medical record dates: 01/01/2022 – 12/31/2024 • Immunization record • Progress notes with documented immunizations given • Problem list with illnesses dated Submit medical record documentation to Priority Health HEDIS department • Electronically uploading medical records – please contact • HEDIS@PriorityHealth.com to get a file set up or for more information • Email: HEDIS@PriorityHealth.com • Fax: 616.975.8897 • Mail: HEDIS at 1231 E Beltline, NE Mail Stop 1280, Grand Rapids, MI, 49525	
Common chart deficiencies	Immunization records not obtained from previous primary care providers	
Tips and best practices: ✓ **Check your Gaps in Care Report to identify your patients with open care opportunities** ✓ Review immunization record before every visit (preventive and sick) and administer needed vaccines ✓ If applicable, give immunizations during a sick visit if the child's immunizations are behind ✓ Recommend immunizations to parents. Parents are more likely to agree with vaccinations when supported by the provider. Address common misconceptions and concerns about vaccinations. ✓ Annual influenza vaccinations two between 6 months and 2 years of age are an important part of the recommended childhood vaccination series ✓ Schedule appointments for your patient's next vaccination before they leave your office ✓ Remind parents the importance of keeping immunizations on track ✓ Use phone calls, emails, text messages and/or postcards/letters to help keep parents engaged		

- ✓ Offer options such as nurse visits for immunizations only, extended hours, walk-in or drive-up vaccination clinics
- ✓ Make sure all immunizations are recorded in the Michigan Care Improvement Registry (MCIR)
- ✓ For Hep A, Hep B, MMR or VZV, documented history of the illness counts as numerator compliance events – but they must occur on or before a child's second birthday
- ✓ For Rotavirus, Hep A, Hep B, HIB and DTAP, documented history of anaphylaxis due to the vaccine count as numerators compliance
- ✓ Documentation that a member is up to date with all immunizations but doesn't include a list of the immunizations and dates they were administered, will not meet compliance.
- ✓ **Immunization records can be accepted as supplemental data**

Supplemental Data Accepted

Lead Screening in Children (LSC)

The Lead Screening in Children measure evaluates children turning two years during the measurement year who had received one or more capillary or venous lead blood test for lead poisoning on or before their second birthday.

Product lines	Quality programs affected	Collection and reporting method
• **Medicaid**	• State Performance Measure	Hybrid • Claim data • Medical record review

Numerator compliance	**A lead test with results on or before the patient's 2nd birthday**		
Billing codes	**Description**	**Code type**	**Code**
	Lead test	**CPT**	83655
		LOINC	10368-9, 10912-4, 14807-2, 17052-2, 25459-9, 27129-6, 32325-3, 5671-3, 5674-7, 77307-7
		SNOWMED	8655006, 35833009
Test, service or procedure to close care opportunity	The result of the lead test		
Medical record documentation (including but not limited to)	Medical record dates: 01/01/2022 – 12/31/2024 • History and physical • Lab Results • Michigan Care Immunization Registry (MCIR) • Progress notes Submit medical record documentation to Priority Health HEDIS department • Electronically uploading medical records – please contact ***HEDIS@PriorityHealth.com*** to get a file set up or for more information • Email: ***HEDIS@PriorityHealth.com*** • Fax: 616.975.8897 • Mail: HEDIS at 1231 E Beltline, NE Mail Stop 1280, Grand Rapids, MI, 49525		

Tips and best practices:

- ✓ **Check your Gaps in Care Report to identify your patients with open care opportunities**
- ✓ Avoid missed opportunities by taking advantage of every office visit to perform lead testing
- ✓ Order lead test at one year well visit or earlier and revisit at 18-month visit
- ✓ Consider a standing order for in-office lead testing
- ✓ Educate parents about the dangers of lead poisoning and the importance of testing
- ✓ If patient is referred to a laboratory, implement a process for follow-up if order is outstanding after 30 days (sooner if the child's second birthday is approaching within 30 days)
- ✓ Date of service and result must be documented with the notation of the lead screening test

- ✓ Lead test is considered late if performed after the child turns 2 years of age
- ✓ **A lead risk assessment doesn't satisfy the blood lead test requirement for Medicaid patients**.
- ✓ **All Medicaid beneficiaries should be tested regardless of the risk score or household zip code.**
- ✓ **Lead tests can be accepted as supplemental data, reducing the need for some chart review**

Supplemental Data Accepted

Immunizations for Adolescents (IMA/IMA-E)

The Immunizations for Adolescents measure evaluates children turning thirteen years of age during the measurement year who had received the following immunizations on or before their thirteenth birthday:

- One diphtheria, toxoids, and acellular pertussis (Tdap)
- One meningococcal vaccine
- Twp human papillomavirus (HPV)

Product lines	Quality programs affected	Collection and reporting method
• **Commercial** • **Medicaid**	• NCQA Health Plan Ratings	Hybrid • Claim data • Medical record review

Immunization billing codes

Tdap **Number of Doses: 1** **Special Circumstances:** Vaccine must be administered between on or between the 10th and 13th birthday	
CPT	90715
CVX	115
SNOWMED	390846000, 412755006, 412756007, 412757003, 428251000124104, 571571000119105

Meningococcal **Number of Doses: 1** **Special Circumstances:** Vaccine must be administered between on or between the 11th and 13th birthday	
CPT	90619, 90733, 90734
CVX	32, 108, 114, 136, 147, 167, 203
SNOWMED	871874000, 428271000124109, 16298691000119102

HPV **Number of Doses: 2** **Special Circumstances:** Vaccine must be administered between on or between the 9th and 13th birthday	
CPT	90649, 90650, 90651
CVX	62, 118, 137, 165
SNOWMED	428741008, 428931000, 429396009, 717953009, 724332002, 734152003, 761841000

Exclusions	• Anaphylactic reaction to the vaccine or its components • Anaphylactic reaction to vaccine serum • Encephalopathy <u>with</u> a vaccine adverse-effect code

Test, service or procedure to close care opportunity	• An immunization record or document that includes the **name of the specific antigen <u>and</u> the date** the vaccine was administered • Provide documentation of contraindication to immunization or parental refusal if applicable
Medical record documentation (including but not limited to)	Medical record dates: 1/01/2020 – 12/31/2024 • Health history and physical • Immunization record • Progress notes with documented immunizations given • If applicable, provide documentation of contraindication to immunization • Documentation of parental refusal ➢ Parental refusal of vaccinations does not remove an eligible patient from the denominator Submit medical record documentation to Priority Health HEDIS department • Electronically uploading medical records – contact ***HEDIS@PriorityHealth.com*** to get a file set up or for more information • Email: ***HEDIS@PriorityHealth.com*** • Fax: 616.975.8897 • Mail: HEDIS at 1231 E Beltline, NE Mail Stop 1280, Grand Rapids, MI, 49525
Common chart deficiencies	Immunization records not obtained from previous primary care providers

Tips and best practices:

- ✓ **Check your Gaps in Care Report to identify your patients with open care opportunities**
- ✓ Review immunization record before every visit (preventive and sick) and administer needed vaccines
- ✓ Recommend immunizations to parents. Parents are more likely to agree with vaccinations when supported by the provider. Address common misconceptions and concerns about vaccinations.
- ✓ If applicable, give immunizations during a sick visit if the patient's immunizations are behind
- ✓ Schedule appointments for your patient's next vaccination before they leave your office
- ✓ Remind parents the importance of keeping immunizations on track
- ✓ Use phone calls, emails, text messages and/or postcards/letters to help keep parents engaged
- ✓ Offer options such as nurse visits for immunizations only, extended hours, walk-in vaccination clinics or drive-up immunization sites
- ✓ Make sure all immunizations are recorded in the Michigan Care Improvement Registry (MCIR)
- ✓ **Immunization records can be accepted as supplemental data**

Supplemental Data Accepted

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

The Well-Child Visits in the First 30 Months of Life measure evaluates children 15-30 months of age that had the recommended well-child visits:

- Children who turned 15 months old during the measurement year with six or more will-child visits from 0-15 months of age
- Children who turned 30 months old during the measurement year with two or more well-child visits from 15 – 30 months of age

Product Lines	Quality programs affected	Collection and reporting method
• **Commercial** • **Medicaid**	• State Performance Measure (first 15 months rate only)	Administrative • Claim data

Numerator compliance	• Six or more well-child visits with a PCP on different dates of service on or before the 15-month birthday • Two or more well-child visits with a PCP on different dates of service between the child's 15-month birthday plus 1 day and the 30-month birthday		
Billing codes	**Description**	**Code type**	**Codes**
	Well-child visits	**CPT**	99381, 99382, 99391, 99392, 99461
		HCPCS	G0438, G0439, S0302
		SNOWMED	103740001, 170099002, 170107008, 170114005, 170123008, 170132005, 170141000, 170150003, 170159002, 170168000, 170250008, 170254004, 170263002, 170272005, 170281004, 170290006, 170300004, 170309003, 171387006, 171394009, 171395005, 171409007, 171410002, 171416008, 171417004, 243788004, 268563000, 270356004, 401140000, 410620009, 410621008, 410622001, 410623006, 410624000, 410625004, 410626003, 410627007, 410628002, 410629005, 410630000, 410631001, 410632008, 410633003, 410634009, 410635005, 410636006, 410637002, 410638007, 410639004, 410640002, 410641003, 410642005, 410643000, 41064400,6 410645007,

			410646008, 410647004, 410648009, 410649001, 410650001, 442162000, 783260003, 444971000124105, 446301000124108, 446381000124104, 669251000168104, 669261000168102, 669271000168108, 669281000168106
	Encounter for well care	**ICD-10 diagnosis**	Z00.110, Z00.111, Z00.121, Z00.129, Z00.2, Z02.5, Z76.1, Z76.2
Frequency/occurrence	• 6+ visits in first 15 months of life • 2+ visits 15-30 months		
Test, service or procedure to close care opportunity	Documentation **MUST** include ALL the following: ✓ Physical exam ✓ Health history – assessment of patient's history of disease or illness and family health history ✓ Physical development – assessment of specific age-appropriate physical development milestones ✓ Mental development – assessment of specific age-appropriate mental developmental milestones ✓ Anticipatory guidance/health education – age-appropriate anticipatory guidance and health education topics on healthy lifestyles and practices, as well as safety and disease prevention		
Medical record documentation (including but not limited to)	• Well child forms • Health history and physical • Progress notes • Growth charts • Mental developmental history • Physical developmental history Submit medical record documentation to Priority Health HEDIS department • Electronically uploading medical records – contact ***HEDIS@PriorityHealth.com*** *to* get a file set up or for more information • Email: ***HEDIS@PriorityHealth.com*** • Fax: 616.975.8897 • Mail: HEDIS at 1231 E Beltline, NE Mail Stop 1280, Grand Rapids, MI, 49525		
Common chart deficiencies	All components of a well-child visit are not documented in the medical record ✓ Physical exam ✓ Health history ✓ Physical development ✓ Mental development ✓ Anticipatory guidance		

Tips and best practices:

- ✓ **Check your Gaps in Care Report to identify your patients with open care opportunities**
- ✓ Take advantage of every office visit (including sick visits and sports physicals) to provide an ambulatory or preventive care visit and submit the appropriate codes by documenting the components of care for a well-child visit can be completed at any time during the measurement year at any appointment – not just a well-child visits – and on different dates of service
- ✓ Create a template with a checklist for well-child visits to ensure compliance or utilize standardized templates in electronic health records (EHR/EMRs)
- ✓ If provider is seeing a patient for Evaluation and Management (E/M) service and all well-child visit components are completed, attach modifier 25 to the well-child CPT code so it is reviewed as a significant, separately identifiable procedure
- ✓ **All office and telehealth visits can be accepted as supplemental data**

Important Notes

Always include a date of service and document these components of care:

- ✓ Physical exam
  - ❖ Vital signs alone are not enough to meet compliance
- ✓ Health history
  -- Assessment of history of disease or illness
  - ❖ Notation of allergies, medication, or immunizations alone won't meet compliance; documenting all three will meet compliance
- ✓ Physical developmental history
  -- Assessment of physical developmental milestones and progress toward developing the skills needed to become a healthy child
  - ❖ Notation of Tanner stage or scale won't meet compliance
  - ❖ "Appropriate for age" without a specific reference to development won't meet compliance
- ✓ Mental developmental history
  -- Assessment of mental developmental milestone and progress toward developing the skills needed to become a healthy child
  - ❖ Notation of "appropriately responsive for age" or "well developed" alone will not meet compliance
- ✓ Anticipatory guidance/health education
  -- Given to parents or guardians to educate them on emerging issues, expectations, and things to watch for at the child's age
  - ❖ Information about medications or immunization or their side effects won't meet compliance

The following table offers examples of evaluations to help complete each component of care:

Physical exam	**Health history**	**Physical development**	**Mental development**	**Anticipatory guidance**
Assessment of multiple body systems	Birth history	Follow parents with eyes	Coos, babbles	Safety (water, child proofing, fire/gun)
Auscultation of heart and lung sounds	Medical, surgical history	Sits, crawls, walks	Easily consoled	Nutrition, weaning from bottle or breast
Measurements of weight and length	History or absence of illness	Standing up	Fears strangers, experiences separation anxiety	Development milestones
Vital signs	Immunization History +	Turns face to side when on stomach	Looks for toys that fall out of sight	Sleep patterns
	Medications +	Holding up head	Waving hello/bye	Car seats
	Frequency/Occurrence of feeding +	Drinking from cup	Counting	Exposure to secondhand smoke
	Allergies +	Building with blocks	Joins sentences	Oral health

+ Three or more of these components are required to constitute a comprehensive health history.

Child and Adolescent Well-Care Visits (WCV)

The Child and Adolescent Well-Care Visits measure evaluates children and adolescents 3-21 years of age who had one or more comprehensive well-care visits with a PCP or OB/GYN during the measurement year.

Product lines	Quality programs affected	Collection and reporting method
• **Commercial** • **Medicaid**		Administrative • Claim data

Numerator compliance	One or more well-care visits with a PCP or an OB/GYN during the measurement year		
Billing codes	**Description**	**Code type**	**Codes**
	Well-care visits	**CPT**	99382, 99383, 99384, 99385, 99392, 99393, 99394, 99395
		HCPCS	G0438, G0439, S0302, S0610, S0612, S0613
		SNOWMED	103740001, 170099002, 170107008, 170114005, 170123008, 170132005, 170141000, 170150003, 170159002, 170168000, 170250008, 170254004, 170263002, 170272005, 170281004, 170290006, 170300004, 170309003, 171387006, 171394009, 171395005, 171409007, 171410002, 171416008, 171417004, 243788004, 268563000, 270356004, 401140000, 410620009, 410621008, 410622001, 410623006, 410624000, 410625004, 410626003, 410627007, 410628002, 410629005, 410630000, 410631001, 410632008, 410633003, 410634009, 410635005, 410636006, 410637002, 410638007, 410639004, 410640002, 410641003, 410642005, 410643000, 410644006, 410645007, 410646008, 410647004, 410648009, 410649001, 410650001, 442162000, 783260003, 444971000124105, 446301000124108, 446381000124104, 669251000168104, 669261000168102, 669271000168108, 669281000168106
	Encounter for well care	**ICD-10 diagnosis**	Z00.00, Z00.01, Z00.121, Z00.129, Z00.2, Z00.3, Z02.5, Z76.2
Frequency/occurrence	Every year		

Test, service or procedure to close care opportunity	Well-care visits: ✓ Physical exam ✓ Health history ✓ Physical development ✓ Mental development ✓ Anticipatory guidance
Medical record documentation (including but not limited to)	• Well child/adolescent forms • Health history and physical • Progress notes • Growth charts • Mental developmental history • Physical developmental history Submit medical record documentation to Priority Health HEDIS department • Electronically uploading medical records – contact ***HEDIS@PriorityHealth.com*** to get a file set up or for more information • Email: ***HEDIS@PriorityHealth.com*** • Fax: 616.975.8897 • Mail: HEDIS at 1231 E Beltline, NE Mail Stop 1280, Grand Rapids, MI, 49525
Common chart deficiencies	All components of a well-child/adolescent visit are not documented in the medical record: ✓ Physical exam ✓ Health history ✓ Physical development ✓ Mental development ✓ Anticipatory guidance

Tips and best practices:

✓ **Check your Gaps in Care Report to identify your patients with open care opportunities**

✓ Documentation of the components of care for a well-care visit can be done at any time during the measurement year and on separate visits

✓ Create a template with a checklist for well-care/adolescent visits to ensure compliance or utilize standardized templates in electronic health records (EHR/EMRs)

✓ If provider is seeing a patient for Evaluation and Management (E/M) service and all well-care visit components are completed, attach modifier 25 to the well-care CPT code so it is reviewed as a significant, separately identifiable procedure

✓ **All office and telehealth visits during the year can be accepted as supplemental data**

Important Notes

Always include a date of service and document these components of care:

✓ Physical exam
  - ❖ Vital signs alone are not enough to meet compliance

✓ Health history
  - -- Assessment of history of disease or illness
  - ❖ Notation of allergies, medication, or immunizations alone won't meet compliance; documenting all three will meet compliance

✓ Physical developmental history
-- Assessment of physical developmental milestones and progress toward developing the skills needed to become a healthy child/adolescent
❖ Notation of Tanner stage or scale won’t meet compliance
❖ “Appropriate for age” without a specific reference to development won’t meet compliance
✓ Mental developmental history
-- Assessment of mental developmental milestone and progress toward developing the skills needed to become a health child
-- Notation of “appropriately responsive for age” or “well developed” alone will not meet compliance
✓ Anticipatory guidance/health education
❖ Given to parents or guardians to educate them on emerging issues, expectations and things to watch for at the child’s age
✓ Information about medications or immunization or their side effects will not meet compliance
The components of care can be completed at any appointment – not just a well-care visits – and on different dates of service

The following table offers examples of evaluations to help complete each component of care:

Physical exam	Health history	Physical development	Mental development	Anticipatory guidance
Assessment of multiple body systems	Birth history	Throws, kicks a ball	Knows full name	Safety, poison control
Auscultation of heart and lung sounds	Medical, surgical history	Hops, skips, runs	Colors, writes, reading, counting	Nutrition and exercise
Measurements of weight and length	History or absence of past illness	Rides a tricycle or bike	Uses imagination, shares with others	Interacts with others
Vital signs	Family illness/disease history	Puberty	Smoking, alcohol, drug use	Limit TV/screen time
Hearing and vision	History/absence of allergies +	Start of menses	Depression	Safe sex
Reflexes	Immunization history +	Acne	Grades	Self-exams – breast or testicular
Extremities	Medications +	Growth spurts	Personal hygiene	Oral health/dental

+ Three or more of these components are required to constitute a comprehensive health history.

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

The Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents measure evaluates children and adolescents 3-17 years of age who had an outpatient visit with a primary care provider or OB/GYN and had the following services during the measurement year:

- Body Mass Index (BMI) percentile (height, weight, and BMI percentile)
- Counseling for nutrition
- Counseling for physical activity

Product lines	Quality programs affected	Collection and reporting method
• **Commercial** • **Medicaid**	• NCQA Health Plan Ratings	Hybrid • Claim data • Medical record review

Numerator compliance	BMI percentile, counseling for nutrition and counseling for physical activity		
Billing codes	**Description**	**Code type**	**Codes**
	BMI percentile	**ICD-10 diagnosis**	Z68.51 BMI percentile <5% for age Z68.52 BMI percentile 5% to < 85% for age Z68.53 BMI percentile 85% to 95% for age Z68.54 BMI percentile >95% for age
		LOINC	59574-4, 59575-1, 59576-9
	Nutrition counseling	**CPT**	97802, 97803, 97804
		HCPCS	G0270, G0271, G0447. S9449, S9452, S9470

		SNOWMED	11816003, 61310001, 183059007, 183060002, 183061003, 183062005, 183063000, 183065007, 183066008, 183067004, 183070000, 183071001, 226067002, 266724001, 275919002,281085002, 284352003, 305849009, 305850009, 305851008, 306163007, 306164001, 306165000, 306626002, 306627006, 306628001, 313210009 370847001, 386464006, 404923009, 408910007, 410171007,410177006, 410200000, 429095004, 431482008, 443288003, 609104008, 698471002, 699827002, 699829004, 699830009, 699849008, 700154005, 700258004, 705060005, 710881000, 1230141004, 14051000175103, 428461000124101, 428691000124107, 441041000124100, 441201000124108, 441231000124100, 441241000124105, 441251000124107, 441261000124109, 441271000124102, 441281000124104, 441291000124101, 441301000124100, 441311000124102, 441321000124105, 441331000124108, 441341000124103, 441351000124101, 445291000124103 445301000124102, 445331000124105, 445641000124105
	Physical activity counseling	**HCPCS**	G0447, S9451
		SNOWMED	103736005, 183073003, 281090004, 304507003, 304549008, 304558001, 310882002, 386291006

			386292004, 386463000, 390864007, 390893007, 398636004, 398752005, 408289007, 410200000, 410289001, 410335001, 429778002, 710849009, 435551000124105
	Encounter for physical activity counseling	**ICD-10 diagnosis**	Z02.5, Z71.82
Frequency/occurrence	Every year		
Required exclusions	Any diagnosis of pregnancy during the measurement year		
Test, service or procedure to close care opportunity	• Growth charts – plotted height, weight, BMI percent • Nutrition counseling documentation of discussion or anticipatory guidance on nutrition or a referral for nutritional counseling • Physical activity counseling documentation of discussion or anticipatory guidance on physical activity or a referral for physical activity • Vitals – documented height, weight, BMI percent		
Medical record documentation (including but not limited to)	Medical record dates: 01/01/2024 - 12/31/2024: • Progress notes • Health history and physical • Growth chart Submit medical record documentation to Priority Health HEDIS department • Electronically uploading medical records – contact ***HEDIS@PriorityHealth.com*** to get a file set up or for more information • Email: ***HEDIS@PriorityHealth.com*** • Fax: 616.975.8897 • Mail: HEDIS at 1231 E Beltline, NE Mail Stop 1280, Grand Rapids, MI, 49525		
Common chart deficiencies	• Not documenting height, weight and BMI percentile at well and sick visits • Using the term “active” (doesn’t state physically active) • Using the term “good appetite” (doesn’t state what the patient is eating)		

Tips and best practices:

- ✓ **Check your Gaps in Care Report to identify your patients with open care opportunities**
- ✓ Weight assessment and counseling for nutrition and physical activity can be completed at any appointment – not just a well-care visit. However, services specific to an acute or chronic condition won't meet compliance for counseling for nutrition or physical activity.
  - ➢ For example: Patient has exercise-induced asthma or decreased appetite because of flu symptoms
- ✓ Always record height and weight and nutrition and physical activity counseling in medical record for every visit
- ✓ Services rendered during telephone, e-visit or virtual check-in. BMI Percentile calculation (height, weight and/or BMI reported by parents) or counseling for physical activity and/or nutrition that takes place during a telephone visit, e-visit or virtual check-in meets numerator compliance.
- ✓ Height, weight or BMI percentile reported by the parents and documented into the patient's official medical record by a provider is acceptable patient reported data.
- ✓ For ages 3-17, a BMI percentile or BMI percentile plotted on an age growth chart meets compliance. A BMI value won't meet compliance for this age group.
- ✓ BMI percentile ranges or thresholds won't meet compliance
- ✓ Use appropriate CPT, HCPCS and ICD-10 diagnosis: codes to report rendered services and reduce medial record review
- ✓ **All office and telehealth visits during the year can be accepted as supplemental data**

Supplemental Data Accepted

Oral Evaluation, Dental Services (OED)

The Oral Evaluation, Dental Services measure evaluates patients under 21 years of age and under who received a comprehensive or periodic oral evaluation with a dental provider during the measurement year.

Product lines	Quality programs affected	Collection and reporting method
• **Medicaid**		Administrative • Claim data

Numerator compliance	**A comprehensive or periodic oral evaluation with a dental provider during the measurement year**		
Billing codes	**Description**	**Code type**	**Codes**
	Oral Evaluation (billed by dental providers only)	**CDT**	D0120, D0145, D0150
Frequency/occurrence	Every year		
Test, service or procedure to close care opportunity	One or more dental visits with a dental practitioner (Doctor of Dental Surgery (DDS), Doctor of Dental Medicine (DMD), Certified & Licensed Dental Hygienist)		
Medical record documentation (including but not limited to)	Medical record dates: 01/01/2024 - 12/31/2024 • One or more dental visits with dental practitioner Submit medical record documentation to Priority Health HEDIS department • Electronically uploading medical records – contact ***HEDIS@PriorityHealth.com*** to get a file set up or for more information • Email: ***HEDIS@PriorityHealth.com*** • Fax: 616.975.8897 • Mail: HEDIS at 1231 E Beltline, NE Mail Stop 1280, Grand Rapids, MI, 49525		
Common chart deficiencies	• No discussion of importance of oral health • No documentation of dental visit • No referral to dental provider		

Tips and best practices:

- ✓ **Check your Gaps in Care Report to identify your patients with open care opportunities**
- ✓ Document history of dental evaluation
- ✓ Encourage new patients to establish a dental home to ensure good routine oral healthcare and follow ups

PCP engagement opportunities:

- ✓ PCPs can educate patient and/or family regarding the importance of dental/oral health
- ✓ PCPs should ask when the last dental appointment was during every well visit
- ✓ Educate patient and/or family regarding importance of dental/oral referral

Topical Fluoride for Children (TFC)

The Topical Fluoride for Children measure evaluates patients 1 – 4 years of age who received at least two fluoride varnish applications during the measurement year.

Product lines	Quality programs affected	Collection and reporting method
• Medicaid		Administrative • Claim data

<table>
<tr><td>Numerator compliance</td><td colspan="3">Two or more fluoride varnish applications during the measurement year, on different dates of service.</td></tr>
<tr><td rowspan="3">Billing codes</td><td>Description</td><td>Code type</td><td>Codes</td></tr>
<tr><td rowspan="2">Application of Fluoride Varnish</td><td>CPT</td><td>99188</td></tr>
<tr><td>CDT</td><td>D1206</td></tr>
<tr><td>Frequency/occurrence</td><td colspan="3">Every 3 - 6 months</td></tr>
<tr><td>Test, service or procedure to close care opportunity</td><td colspan="3">Primary care clinicians or dental practitioners apply fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption.</td></tr>
<tr><td>Medical record documentation (including but not limited to)</td><td colspan="3">Medical record dates: 01/01/2024 - 12/31/2024

Submit medical record documentation to Priority Health HEDIS department
• Electronically uploading medical records – contact HEDIS@PriorityHealth.com to get a file set up or for more information
• Email: HEDIS@PriorityHealth.com
• Fax: 616.975.8897
• Mail: HEDIS at 1231 E Beltline, NE Mail Stop 1280, Grand Rapids, MI, 49525</td></tr>
<tr><td>Common chart deficiencies</td><td colspan="3">• No discussion of importance of oral health
• Documentation and billing of topical fluoride varnish application
• No referral to dental provider</td></tr>
</table>

Tips and best practices:

- ✓ **Check your Gaps in Care Report to identify your patients with open care opportunities**
- ✓ American Academy of Pediatrics (AAP) recommends application of fluoride varnish at least once every 6 months, and preferably every 3 months, starting at tooth eruption
- ✓ Educate parents/caregivers on the care and cleaning of teeth and mouth and how to prevent dental and gum disease
- ✓ Provide caregiver instructions about varnish application after care
- ✓ Offer anticipatory guidance on obtaining periodic dental care from dental providers

PCP engagement opportunities:

- ✓ PCPs can educate parents or caregiver regarding the importance of dental/oral health
- ✓ PCPs should ask when the last dental appointment was during every well visit
- ✓ Educate patient and/or family regarding importance of dental/oral referral

Supplemental Data Accepted

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

The Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics measure evaluates children and adolescents 1-17 years of age who had a new prescription for an antipsychotic medication and had a psychosocial care as first line treatment during the measurement year.

Although antipsychotic medications may serve as effective treatment for a narrowly defined set of psychiatric disorders in children, they are often being prescribed for nonpsychotic conditions such as attention-deficit hyperactivity disorder and disruptive behaviors, conditions for which psychosocial interventions are considered first-line treatment. There is increased research supporting the use of psychosocial interventions as first line defense when patients present with symptoms.

Product lines	Quality programs affected	Collection and reporting method
• **Commercial** • **Medicaid**	• NCQA Health Plan Ratings	Administrative • Claim data • Pharmacy data

Numerator compliance	Documentation of psychosocial care (Psychosocial Care Value Set) in the 121-day period from 90 days prior to the IPSD through 30 days after the IPSD		
Antipsychotic medications			
Description	**Prescription**		
Miscellaneous antipsychotic agents	• Aripiprazole • Asenapine • Brexpiprazole • Cariprazine • Clozapine • Haloperidol	• Iloperidone • Loxapine • Lurasidone • 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
Antipsychotic combination medications			
Description	**Prescription**		

Psychotherapeutic combinations	• Fluoxetine-olanzapine • Perphenazine-amitriptyline		
Billing codes	**Description**	**Code type**	**Codes**
	Psychosocial care	**CPT**	90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90846, 90847, 90849, 90853, 90875, 90876, 90880
		HCPCS	G0176, G0177, G0409, G0410, G0411, H0004, H0035, H0036, H0037, H0038, H0039, H0040, H2000, H2001, H2011, H2012, H2013, H2014, H2017, H2018, H2019, H2020, S0201, S9480, S9484, S9485
		SNOWMED	166001, 1555005, 2619005, 3518004, 5694008, 6227009, 7133001, 8411005, 9591001, 15142007, 15558000, 15711005, 17447008, 17914007, 18512000, 19997007, 21055002, 22900004, 24172008, 24621000, 25621005, 26693005, 26829003, 26890005, 27482005, 27591006, 28868002, 28988002, 30808008, 31408009, 31594000, 32051004, 33661004, 35358007, 36230009, 38592005, 38678006, 39697002, 41035007, 41653002, 41838008, 45565001, 46618005, 47805006, 50160009, 51484002, 51790004, 53508008, 53769000, 57070007, 57847003, 58771002, 59364003, 59585002, 59694001, 61436009, 62474003, 63386006, 65201004, 66060003, 73139001, 75516001, 76168009, 76740001, 77170008, 78493007, 79441000, 82309004, 83474000, 84892007, 85614001, 85925008, 88848003, 89909007, 90102008, 91172002, 91425008, 91481002, 108313002, 113141001, 113143003, 113144009, 171423009, 171424003, 171425002, 171426001, 183339004, 183381005, 183382003, 183383008, 183385001, 183387009 183388004, 183389007, 183391004, 183393001, 183395008, 183396009, 183398005, 183399002, 183401008, 183402001, 183403006,

			183405004, 183406003, 183408002, 183411001, 183413003, 183422002, 225160006, 225224008, 225225009, 225226005, 225227001, 225333008, 228546003, 228548002, 228549005, 228550005, 228551009, 228553007, 228554001, 228555000, 228557008, 228575009, 229216005, 229217001, 229218006, 229219003, 229220009, 229221008, 229306004, 266744007, 299695005, 302230009, 302234000, 302235004, 302236003, 302238002, 302239005, 302240007, 302242004, 302243009, 302244003, 302245002, 302247005, 302248000, 302255003, 302259009, 302260004, 302262007, 304637004, 304638009, 304702006, 304814008, 304815009, 304816005, 304817001, 304818006, 304819003, 304820009, 304821008, 304822001, 304824000, 304825004, 304826003, 304851002, 304888004, 304889007, 304893001, 304894007, 311460008, 311461007, 311462000, 311510000, 311511001, 311522002, 311523007, 311884008, 312043006, 312044000, 313105004,314034001, 361229007, 361230002, 385768000,385769008, 385770009, 385771008, 385772001, 385773006, 385774000, 385893007, 385992003, 386255004, 386256003, 386257007, 386316003, 386367000, 386429002, 386522008, 386523003, 386524009, 386525005, 390773006, 391892008,

			397074006, ,401157001, 401162000, 405780009, 405792009, 405793004, 406165004, 406183007, 406184001, 406185000, 410112008, 410115005, 410118007, 410121009, 410124001, 410127008, 410130001, 425680009, 427954006, 429048003, 429159005, 429329005, 439330009, 439436002, 439741009, 439795004, 439805004, 439820005, 439916005, 440274001, 440582002, 440646003, 443119008, 443730003, 444175001, 449030000, 700445002, 700446001, 702471009, 702780005, 711078000, 711283001, 712558003, 718023002, 718026005, 720444008, 723528003, 723619005, 734278000, 736861004, 866252000, 868185009, 1163366004, 1236920000, 1256107005, 1259023009, 460891000124103, 460901000124104, 461561000124103
	Residential Behavioral Health Treatment	**HCPCS**	H0017, H0018, H0019, T2048
Frequency/occurrence	Every new prescription for an antipsychotic medication		
Exclusions	• Patients for whom first-line antipsychotic medications may be clinically appropriate; patients with a diagnosis of schizophrenia, schizoaffective disorder, bipolar disorder, other psychotic disorder, autism or other developmental disorder on at least two different dates of service during the measurement year		
Test, service or procedure to close care opportunity	• This measure focuses on referring to psychosocial treatment prior to prescribing an antipsychotic medication to children • Psychosocial care must occur in the 121-day period from 90 days prior to the IPSD through 30 days after the IPSD (by December 31 of the measurement year) to count towards compliance		

<table>
<tr><td>Medical record documentation (including but not limited to)</td><td>Medical record dates: 01/01/2024 - 12/31/2024
• Consultation reports
• Diagnostic reports
• Health history and physical

Submit medical record documentation to Priority Health HEDIS department
• Electronically uploading medical records – contact HEDIS@PriorityHealth.com to get a file set up or for more information
• Email: HEDIS@PriorityHealth.com
• Fax: 616.975.8897
• Mail: HEDIS at 1231 E Beltline, NE Mail Stop 1280, Grand Rapids, MI, 49525</td></tr>
<tr><td colspan="2">Tips and best practices:
✓ Check your Gaps in Care Report to identify your patients with open care opportunities
✓ This measure focuses on referring to psychosocial treatment prior to prescribing an antipsychotic medication to children
✓ Make sure children and adolescents received a psychosocial care appointment at least 90 days prior to prescribing medication or within 30 days of starting an initial prescription if there is an urgent need for medication
✓ Psychosocial treatments (interventions) include structured counseling, case management, care coordination, psychotherapy and relapse prevention
✓ Refer your patients to a mental health professional
✓ If you need to refer your patient to a behavioral health specialist or need to request coordination of care, please call the Behavioral Health department at 800.673.8043
✓ Psychosocial care visits supplemental data can be accepted for this measure</td></tr>
</table>

Non-Recommended PSA-Based Screening in Older Men (PSA)

The Non-Recommended PSA-Based Screening in Older Men measure evaluates men 70 years of age and older who were unnecessarily screened for prostate cancer during the measurement year. A lower calculated performance rate for this measure indicates better clinical care.

A lower calculated performance rate for this measure indicates better clinical care.

Product Lines	Quality programs affected	Collection and reporting method
• **Medicare**		Administrative • Claim data

Numerator compliance	A PSA-based screening test performed during the measurement year
To comply with this measure, male patients 70 years of age and older should not have a PSA screening if patient does not have a history of elevated PSA or history of prostate cancer.	
Exclusions	• History of prostate cancer • Men who had a diagnosis for which PSA-based testing is clinically appropriate – any of the following meet criteria: ➢ Prostate cancer diagnosis ➢ Dysplasia of the prostate during the measurement year or the year prior to the measurement year ➢ A PSA test during the year prior to the measurement year, where laboratory data indicate an elevated result [> 4.0 {ng/mL] ➢ An abnormal PSA test result or finding during the year prior to the measurement year ➢ Dispensed prescription for a 5-alpha reductase inhibitor during the measurement year
Medical record documentation (including but not limited to)	History of prostate cancer or any of the exclusions above: • Consultation reports • Diagnostic reports • Health history and physical Submit medical record documentation for evidence of exclusion to Priority Health HEDIS department • Electronically uploading medical records – contact ***HEDIS@PriorityHealth.com*** to get a file set up or for more information • Email: ***HEDIS@PriorityHealth.com*** • Fax: 616.975.8897 • Mail: HEDIS at 1231 E Beltline, NE Mail Stop 1280, Grand Rapids, MI, 49525
Tips and best practices: ✓ Avoid testing for low-risk men if patient is over 70 years of age and: ❖ Has no prior family history of prostate cancer ❖ Has no prior history of elevated PSA test value ([>4.0 [ng/mL])	

Appropriate Treatment for Upper Respiratory Infection (URI)

The Appropriate Treatment for Children with Upper Respiratory Infection measure evaluates patients 3 months of age and older who had a diagnosis of upper respiratory infection (URI) and were **not** dispensed an antibiotic prescription.

This measure addresses appropriate treatment for upper respiratory infections without prescribing an antibiotic.

A higher rate indicates appropriate URI treatment.

Product lines	Quality programs affected	Collection and reporting method
• **Commercial** • **Medicaid** • **Medicare**	• NCQA Health Plan Ratings • State Performance Measure	Administrative • Claim data • Pharmacy data

Numerator compliance	Dispensed prescription for an antibiotic medication on or 3 days after the episode date		
To comply with this measure, the following antibiotic medications should not be prescribed upon diagnosis of acute bronchitis:			
Drug Category	**Medications**		
Aminoglycosides	• Amikacin • Gentamicin	• Streptomycin	• Tobramycin
Aminopenicillins	• Amoxicillin	• Ampicillin	
Beta-lactamase inhibitors	• Amoxicillin-clavulanate	• Ampicillin-sulbactam	• Piperacillin-tazobactam
First-generation cephalosporins	• Cefadroxil	• Cefazolin	• Cephalexin
Fourth generation cephalosporins	• Cefepime		
Lincomycin derivatives	• Clindamycin	• Lincomycin	
Macrolides	• Azithromycin • Clarithromycin	• Erythromycin •	
Miscellaneous antibiotics	• Aztreonam • Chloramphenicol • Dalfopristin-quinupristin	• Daptomycin • Linezolid	• Metronidazole • Vancomycin
Natural penicillins	• Penicillin G benzathine • Penicillin G benzathine-procaine	• Penicillin G potassium • Penicillin G procaine	• Penicillin G sodium • Penicillin V potassium
Penicillinase-resistant penicillins	• Dicloxacillin	• Nafcillin	• Oxacillin
Quinolones	• Ciprofloxacin • Gemifloxacin	• Levofloxacin • Moxifloxacin	• Ofloxacin

Rifamycin derivatives	• Rifampin		
Second generation cephalosporins	• Cefaclor • Cefotetan	• Cefoxitin • Cefprozil	• Cefuroxime

Drug Category	**Medications**		
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
Test, service or procedure to close care opportunity	This measure addresses appropriate treatment for upper respiratory infections without prescribing an antibiotic		

Tips and best practices:

- ✓ Provide education materials on antibiotic resistance, comfort measures to patient and realistic expectations of recovery time
- ✓ Document a second diagnosis code for any competing diagnosis (e.g., pharyngitis, otitis media, enteritis, whopping cough, etc.) in addition to the URI code

Details on the appropriate treatment of URIs are available at cdc.gov and Rreference the **Treatment Recommendations for Common Illnesses**

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

The Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis measure evaluates patients 3 months of age and older who had a diagnosis of acute bronchitis/bronchiolitis who were **not** dispensed an antibiotic medication on or 3 days after the episode.

A higher rate indicates appropriate treatment for bronchitis/bronchiolitis.

Product lines	Quality programs affected	Collection and reporting method
• **Commercial** • **Medicaid** • **Medicare**	• NCQA Health Plan Ratings • State Performance Measure	Administrative • Claim data • Pharmacy data

Numerator compliance	Dispensed prescription for an antibiotic medication on or 3 days after the episode date		
To comply with this measure, the following antibiotic medications should not be prescribed upon diagnosis of acute bronchitis:			
Drug category	**Medications**		
Aminoglycosides	• Amikacin • Gentamicin	• Streptomycin	• Tobramycin
Aminopenicillins	• Amoxicillin	• Ampicillin	
Beta-lactamase inhibitors	• Amoxicillin-clavulanate	• Ampicillin-sulbactam	• Piperacillin-tazobactam
First-generation cephalosporins	• Cefadroxil	• Cefazolin	• Cephalexin
Fourth generation cephalosporins	• Cefepime		
Lincomycin derivatives	• Clindamycin	• Lincomycin	
Macrolides	• Azithromycin • Clarithromycin	• Erythromycin •	
Miscellaneous antibiotics	• Aztreonam • Chloramphenicol • Dalfopristin-quinupristin	• Daptomycin • Linezolid	• Metronidazole • Vancomycin
Natural penicillins	• Penicillin G benzathine • Penicillin G benzathine-procaine	• Penicillin G potassium • Penicillin G procaine	• Penicillin G sodium • Penicillin V potassium
Penicillinase-resistant penicillins	• Dicloxacillin	• Nafcillin	• Oxacillin

Drug category	Medications
Quinolones	• Ciprofloxacin • Gemifloxacin • Levofloxacin • Moxifloxacin • Ofloxacin
Rifamycin derivatives	• Rifampin
Second generation cephalosporins	• Cefaclor • Cefotetan • Cefoxitin • Cefprozil Cefuroxime
Sulfonamides	• Sulfadiazine • Sulfamethoxazole-trimethoprim
Tetracyclines	• Doxycycline • Minocycline • Tetracycline
Third generation cephalosporins	• Cefdinir • Cefixime • Cefotaxime • Cefpodoxime • Ceftazidime • Ceftriaxone
Urinary anti-infectives	• Fosfomycin • Nitrofurantoin • Nitrofurantoin macrocrystals-monohydrate • Trimethoprim
Test, service or procedure to close care opportunity	This measure addresses appropriate treatment for upper respiratory infections without prescribing an antibiotic.

Tips and best practices:

- ✓ Document competing diagnoses or co-morbid condition (such as COPD) in addition to the bronchitis code
- ✓ Provide patient education materials on antibiotic resistance, comfort measures and realistic expectations for recovery time
- ✓ Acute bronchitis/bronchiolitis almost always gets better on its own; therefore, individuals without other health problems shouldn't be prescribed an antibiotic. Ensuring the appropriate use of antibiotics for individuals with acute bronchitis/bronchiolitis will help them avoid harmful side-effects and possible resistance to antibiotics over time
- ✓ An episode for bronchitis/bronchiolitis won't count toward the measure denominator if the member was diagnosed with one of these conditions within 12 months of the event:
  - ❖ Cancer or HIV
  - ❖ Chronic obstructive pulmonary disease (COPD), cystic fibrosis, or emphysema
  - ❖ Immune system disorders
  - ❖ Pneumonia, tuberculosis or pertussis
  - ❖ Other bacterial infections

Use of Imaging Studies for Low Back Pain (LBP)

The Use of Imaging Studies for Low Back Pain measure evaluates patients 18-75 years of age with a principal diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis.

A lower calculated performance rate for this measure indicates better clinical care.

Product lines	Quality programs affected	Collection and reporting method
• **Commercial** • **Medicaid** • **Medicare**	• NCQA Health Plan Ratings	Administrative • Claim data

Numerator compliance	An imaging study with a diagnosis of uncomplicated low back pain on the IESD or in the 28 days following the IESD	
Codes to identify uncomplicated low back pain	ICD10 Diagnosis	M47.26 - M47.28, M47.816 - M47.818, M47.896 - M47.898, M48.06 - M48.08, M51.16, M51.17, M51.26, M51.27, M51.36, M51.37, M51.86, M51.87, M53.2X6, M53.2X7, M53.2X8, M53.3, M53.86-M53.88, M54.16 - M54.18, M54.30 - M54.32, M54.40 - M54.42, M54.5, M54.89, M54.9, M99.03, M99.04, M99.23, M99.33, M99.43, M99.53, M99.63, M99.73, M99.83, M99.84, S33.100A, S33.100D, S33.100S, S33.110A, S33.110D, S33.110S, S33.120A, S33.120D, S33.120S, S33.130A, S33.130D, S33.130S, S33.140A, S33.140D, S33.140S, S33.5XXA, S33.6XXA, S33.8XXA, S33.9XXA, S39.002A, S39.002D, S39.002S, S39.012A, S39.012D, S39.012S, S39.092A, S39.092D, S39.092S, S39.82XA, S39.82XD, S39.82XS, S39.92XA, S39.92XD, S39.92XS
To comply with this measure, the following CPT codes are imaging studies that should be avoided with a diagnosis of uncomplicated low back pain:		
Imaging study	CPT	72020, 72052, 72100, 72110, 72114, 72120, 72131, 72132, 72133, 72141, 72142, 72146, 72147, 72148, 72149, 72156, 72158, 72200, 72202, 72220
Exclusions	Any patient who had a diagnosis where imaging is clinically appropriate including: • History of cancer, HIV, major organ transplant • Recent trauma any time 90 days prior to the index episode start date (IESD) • Intravenous drugs abuse, neurologic impairment, or spinal infection any time 12 months prior to the principal diagnosis of low back pain • Prolonged use of corticosteroids for 90 consecutive days dispensed any time 12 months prior	
Tests, services or procedures to avoid	• CT scan • MRI • Plain X-ray	

	The imaging studies listed above aren't clinically appropriate for a diagnosis of uncomplicated low back pain.

Tips and best practices:

- ✓ Avoid imaging for LBP for patients when there is no indication of an underlying condition
- ✓ Consider more conservative measures such as referral for physical therapy evaluation before X-rays are ordered
- ✓ Recommend self-care home treatment such as use of heat/ice, non-narcotic pain relievers, remaining active and stretching
- ✓ Avoiding imaging for patients when there is no indication of an underlying condition can prevent unnecessary harm and unintended consequences to patients and can reduce health care costs
- ✓ **Supplemental and medical record data cannot be accepted for the exclusions in this measure**

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

The Potentially Harmful Drug-Disease Interactions in the Older Adults measure evaluates patients 65 years of age and older who have evidence of an underlying disease, condition or health concern (chronic kidney disease, dementia, history of falls) and were dispensed an ambulatory prescription for a potentially harmful medication, concurrent with or after the diagnosis during the measurement year.

This measure assesses the following:

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

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

A lower calculated performance rate for this measure indicates better clinical care.

Product lines	Quality programs affected	Collection and reporting method
• **Medicare**		Administrative • Claim data • Pharmacy data

Numerator compliance	• Dispensed an ambulatory prescription for an antiepileptic, SSRI, or SNRI or antipsychotic, benzodiazepine, nonbenzodiazepine hypnotic or tricyclic antidepressant on or between the IESD and December 31 of the measurement year • Dispensed an ambulatory prescription for an antipsychotic, benzodiazepine, nonbenzodiazepine hypnotic or tricyclic antidepressant or anticholinergic agent on or between the IESD and December 31 of the measurement year • Dispensed an ambulatory prescription for a Cox-2 selective NSAID or nonaspirin NSAID on or between the IESD and December 31 of the measurement year

Rate 1: Drug-Disease Interactions—History of Falls and Antiepileptics, Antipsychotics, Benzodiazepines, Nonbenzodiazepine Hypnotics or Antidepressants (SSRIs, Tricyclic Antidepressants and SNRIs)

Potentially harmful drugs—History of falls medications

Description	Medications			
Antiepileptics	• Carbamazepine	• Felbamate	• Methsuximide	• Rufinamide

	• Clobazam • Divalproex sodium • Ethosuximide • Ethotoin • Ezogabine	• Fosphenytoin • Gabapentin • Lacosamide • Lamotrigine • Levetiracetam	• Oxcarbazepine • Phenobarbital • Phenytoin • Pregabalin • Primidone	• 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	Medications			
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

Rate 2: Drug-Disease Interactions—Dementia and Antipsychotics, Benzodiazepines, Nonbenzodiazepine Hypnotics, Tricyclic Antidepressants or Anticholinergic Agents

Dementia medications

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

Potentially harmful drugs—Dementia medications

Descriptions	Medications		
Anticholinergic agents, antiemetics	• Prochlorperazine	• Promethazine	
Anticholinergic agents, antihistamines	• Brompheniramine • Carbinoxamine • Chlorpheniramine • Clemastine • Cyproheptadine	• Dexbrompheniramine • Dexchlorpheniramine • Dimenhydrinate • Diphenhydramine • Doxylamine	• Hydroxyzine • Meclizine • Pyrilamine • Triprolidine •
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		

Rate 3: Drug-Disease Interactions—Chronic Kidney Disease and Cox-2 Selective NSAIDs or Nonaspirin NSAIDs

Cox-2 selective NSAIDs and nonaspirin NSAID medications

Descriptions	Medications			
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

Exclusions	• Patients in hospice or using hospice services anytime during the measurement year • Patients with the following diagnosis between January 1 of the year prior to December 1 of the measurement year: ❖ Bipolar disorder ❖ Psychosis ❖ Schizoaffective disorder ❖ Schizophrenia
Medical record documentation (including but not limited to)	N/A Administrative data only

Tips and best practices:

- ✓ Integrate a disease state review and medication review into every encounter with an elderly patient
- ✓ Review patient diagnoses for history of falls, dementia and chronic kidney disease and avoid respective harmful drug classes
- ✓ Replace harmful drug classes with appropriate alternatives when one of these diagnoses are present
- ✓ Before prescribing a new medication for an elderly patient with one of these diagnoses, check first that it isn't in a potentially harmful class for the patient condition
- ✓ Document the reason for prescribed medication and patient's response
- ✓ Code to the highest level of specificity using guidelines
- ✓ **Supplemental data can be accepted for evidence of exclusions for this measure**

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

The Use of High-Risk Medication in Older Adults measure evaluates patients 67 years of age and older who had at least two dispensing events for the same high-risk medication during the measurement year.

This measure assesses the following:

- Medicare patients 67 years of age and older who had at least two dispensing events for high-risk medications to avoid from the same drug class
- The percentage of Medicare patients 67 years of age and older who had at least two dispensing events for high-risk medications to avoid from the same drug class, except for appropriate diagnoses

The measure reflects potentially inappropriate medication use in older adults, both for medications where any use is inappropriate (Rate 1) and for medications where use under all, but specific indications is potentially inappropriate (Rate 2). A lower calculated performance rate for this measure indicates better clinical care.

A lower calculated performance rate for this measure indicates better clinical care.

Product lines	Quality programs affected	Collection and reporting method
• **Medicare**		Administrative • Claim data • Pharmacy data

Numerator compliance	Patients who received at least two dispensing events for high-risk medications from the same drug class during the measurement year and who had at least two dispensing events for high-risk medications from the same drug class except for appropriate diagnosis during the measurement year.		
High risk medications to avoid			
Drug class	**Prescription**		
Anticholinergics, first-generation antihistamines	• Brompheniramine • Carbinoxamine • Chlorpheniramine • Clemastine • Cyproheptadine	• Dexbrompheniramine • Dexchlorpheniramine • Diphenhydramine (oral) • Dimenhydrinate	• Doxylamine • Hydroxyzine • Meclizine • Promethazine • Pyrilamine • Triprolidine
Anticholinergics, anti-Parkinson agents	• Benztropine (oral)	• Trihexyphenidyl	
Antispasmodics	• Atropine (exclude ophthalmic) • Belladonna alkaloids	• Chlordiazepoxide-clidinium • Dicyclomine • Hyoscyamine	• Methscopolamine • Propantheline • Scopolamine

Antithrombotic	• Dipyridamole, (oral, excluding extended release)	
Cardiovascular, alpha agonists, central	• Guanfacine	• Methyldopa
Cardiovascular, other	• Disopyramide	• Nifedipine (excluding extended release)

Central nervous system, antidepressants	• Amitriptyline • Amoxapine Clomipramine	• Desipramine • Imipramine Nortriptyline	• Paroxetine • Protriptyline Trimipramine
Drug class	**Prescription**		
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, sulfonylureas, long-duration	• Chlorpropamide	• Glimepiride	• Glyburide
Endocrine system, other	• Desiccated thyroid	• Megestrol	
Nonbenzodiazepine hypnotics	• Eszopiclone	• Zaleplon	• Zolpidem
Pain medications, skeletal muscle relaxants	• Carisoprodol • Chlorzoxazone	• Cyclobenzaprine • Metaxalone	• Methocarbamol • Orphenadrine
Pain medications, other	• Indomethacin	• Ketorolac, includes parenteral	• Meperidine
Frequency/occurrence	Review medication list at every patient visit (office, telehealth)		
Test, service or procedure to close care opportunity	• Integrate a high-risk medication review into every encounter with an elderly patient • Review patient medication list to ensure it doesn't include any high-risk medications		
Medical record documentation (including but not limited to)	N/A administrative data only		
Common chart deficiencies	• No documentation of review or medication at every visit • No documentation of the discussion about deprescribing of benzodiazepines		
Tips and best practices: ✓ Replace high-risk medications with appropriate alternatives			

- ✓ Before prescribing a new medication for an elderly patient, check first that it isn't a high-risk medication
- ✓ Document reason for prescribed medication and patient's response

Deprescribing of Benzodiazepines in Older Adults (DBO)

The Deprescribing of Benzodiazepines in Older Adults measure evaluates patients 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.

Benzodiazepines are common anxiolytic and sedative medications whose primary pharmacologic properties and side effects carry increased risk in older patients. This measure aims to assess and ensure appropriate and safe tapering for patients with inappropriate and routine use.

Product lines	Quality programs affected	Collection and reporting method
• **Medicare**		Administrative • Claim data • Pharmacy data

Numerator compliance	Patients who achieved a 20% decrease or greater in DME daily benzodiazepine dosage		
Oral benzodiazepine medications			
Type of benzodiazepine	• Alprazolam (oral) • Chlordiazepoxide (oral) • Clonazepam (oral) • Clorazepate (oral) • Diazepam (oral)	• Estazolam (oral) • Flurazepam (oral) • Lorazepam (oral) • Midazolam (oral)	• Oxazepam (oral) • Quazepam (oral) • Temazepam (oral) • Triazolam (oral)
Frequency/occurrence	Every filled prescription of benzodiazepines		
Exclusions	• Patients with a diagnosis of seizure disorders • Patients with a diagnosis rapid eye movement (REM) sleep behavior disorder • Patients with a diagnosis benzodiazepine withdrawal • Patients with a diagnosis of ethanol withdrawal		
Test, service or procedure to close care opportunity	Deprescribing of benzodiazepines		
Medical record documentation (including but not limited to)	N/A administrative data only		
Common chart deficiencies	• No documentation of review or medication at every visit • No documentation of the discussion about deprescribing of benzodiazepines		
Tips and best practices: ✓ Review the use of benzodiazepines, given the patient safety risks associated with the use of this medication in patients with advanced age ✓ Describe a strategy to partner with patients and develop options for decreasing and possibly deprescribing benzodiazepines			

- ✓ Engage patients in developing a clear plan for tapering or lowering the dose, incorporating goals and preferences
- ✓ Monitor every 1-2 weeks for duration of tapering
- ✓ **Supplemental data can be accepted for evidence of exclusions for this measure**

Use of Opioids at High Dosage (HDO)

The Use of Opioids at High Dosage measure evaluates patients 18 years of age and older who received prescription opioids for greater than 15 days at a high dosage (average milligram morphine does [MME] > 90 mg) during the measurement year.

This measure focuses on using low dosage for opioids. A lower calculated performance rate for this measure indicates better clinical care.

Product lines	Quality programs affected	Collection and Reporting Method
• **Commercial** • **Medicaid** • **Medicare**	• NCQA Health Plan Ratings • State Performance Measure	Administrative • Claim data • Pharmacy data

Numerator compliance	Patients whose average MME was ≥90 during the treatment period
To be included in this measure, a patient must have been prescribed one of the following opioid medications at a MME ≥ 90 mg for ≥ 15 days:	
Opioid medications	• Benzhydrocodone • Butorphanol • Codeine • Dihydrocodeine • Fentanyl • Hydrocodone • Hydromorphone • Levorphanol • Meperidine • Methadone • Morphine • Opium • Oxycodone • Oxymorphone • Pentazocine • Tapentadol • Tramadol
The following opioid medications are excluded as dispensing events for this measure: • Injectables • Ionsys® (fentanyl transdermal patch) – For inpatient use only and is available only through a restricted program under a Risk Evaluation and Mitigation Strategy (REMS) • Methadone for the treatment of opioid use disorder • Opioid cough and cold products	
Frequency/occurrence	Every filled prescription of high dosage opioid at a MME ≥ 90 mg for ≥ 15 days
Required exclusions	• Patients with cancer anytime during the measurement year • Patients with sickle cell disease during the measurement year
Medical record documentation (including but not limited to)	Medical record dates: 01/01/2024 - 12/31/2024 • Consultation reports • Progress notes Documentation guidelines: • Identification of patient being prescribed opioids • Ensure supply is not for more than 15 days, unless due to malignant neoplasms or sickle cell disease • Identification of patients being prescribed opioids by multiple providers

Medical record documentation (including but not limited to) (continued)	Submit medical record documentation for evidence of exclusion to Priority Health HEDIS department: • Electronically uploading medical records – contact ***HEDIS@PriorityHealth.com*** to get a file set up or for more information • Email: ***HEDIS@PriorityHealth.com*** • Fax: 616.975.8897 • Mail: HEDIS at 1231 E Beltline, NE Mail Stop 1280, Grand Rapids, MI, 49525
Common chart deficiencies	• No documentation of review of medications at every visit • No documentation of conversation about the importance of medication compliance

Tips and best practices:

- ✓ Ensure patients have not received multiple opioid prescriptions. Prescriptions that have been filled for an opioid can be found in the **Michigan Automated Prescription System** application. All pharmacies are required to report data on the dispensing of opioid products there, including the name of drug, strength, quantity, day supply, day filled, provider, etc. When prescribing opioids, access this application to ensure patients don't have multiple opioid prescriptions.
- ✓ Integrate a review of the necessity and appropriateness of opioid therapy into every encounter with a patient taking an opioid medication
- ✓ For treatment of acute pain using opioids, guidelines recommend immediate-release opioids be used at a dosage as low as possible and for as few days as needed
- ✓ For treatment of chronic pain and prescribing an opioid medication, guidelines recommend clinicians consider non-pharmacologic and non-opioid therapies first, and only in cases where the benefits outweigh the risks, initiation of opioid therapy
- ✓ Limit prescriptions to the shortest duration needed to treat condition (<15 days duration)
- ✓ Limit dose to the lowest effective dose needed to treat condition (<90 MME)
- ✓ Schedule proper follow-up with the patients to evaluate if dose can be decreased, tapered or if medication can be discontinued
- ✓ Document reason for prescribed medication and patient's response
- ✓ Information to help you stay informed about the latest opioid research and guidelines is available at cdc.gov. Reference the **CDC Guideline for Prescribing Opioids**.
- ✓ At Priority Health, we're partnering with our health care providers statewide to reduce opioid use and abuse among our local communities. Following CDC guidelines, we're asking doctors and pharmacists to limit the number of opioids prescribed and the amount of medication within each prescription fill. We're also asking them to prescribe non-opioid alternatives for pain relief, when possible.
- ✓ If you need to refer your patients to a behavioral health specialist, please call the Behavioral Health department at **800.673.8043**

Use of Opioids From Multiple Providers (UOP)

The Use of Opioids from Multiple Providers measure evaluates patients 18 years of age and older receiving prescription opioids for greater than or equal to 15 days at a high dosage from multiple providers during the measurement year. This measure assesses potentially high-risk opioid analgesic prescribing practice during the measurement year. This measure focuses on taking caution with patients using multiple prescribers and/or pharmacies.

A lower calculated performance rate for this measure indicates better clinical care.

Product lines	Quality programs affected	Collection and reporting method
• **Commercial** • **Medicaid** • **Medicare**	• NCQA Health Plan Ratings • State Performance Measure	Administrative • Claim data • Pharmacy data

Numerator compliance	• Identify all opioid medication dispensing events for patients who received opioids from four or more different prescribers during the measurement year • Identify all opioid medication dispensing events for patients who received opioids from four or more different pharmacies during the measurement year • Identify all opioid medication dispensing events for patients who received opioids from four or more different prescribers and four or more different pharmacies during the measurement year
To be included in this measure, a patient must have been prescribed one of the following opioid medications at an MME ≥ 90 mg for ≥ 15 days:	
Opioid medications	• Benzhydrocodone • **Buprenorphine** • Butorphanol • Codeine • Dihydrocodeine • Fentanyl • Hydrocodone • Hydromorphone • Levorphanol • Meperidine • Methadone • Morphine • Opium • Oxycodone • Oxymorphone • Pentazocine • Tapentadol • Tramadol
The following opioid medications are excluded as dispensing events for this measure: • Injectables • Ionsys® (fentanyl transdermal patch) – For inpatient use only and is available only through a restricted program under a Risk Evaluation and Mitigation Strategy (REMS) • Methadone for the treatment of opioid use disorder • Opioid cough and cold products	
Frequency/occurrence	Every filled opioid prescription
Medical record documentation (including but not limited to)	N/A administrative data only

Tips and best practices:

- ✓ Prescriptions that have been filled for an opioid can be found in the **Michigan Automated Prescription System** application. All pharmacies are required to report data on the dispensing of opioid products there, including name of drug, strength, quantity, day supply, day filled, provider, etc. When prescribing opioids, use this application to ensure patients don't have multiple opioid prescriptions.
- ✓ Coordinate care with the patient's other providers
- ✓ Provide education to the patient regarding the safe use and risks of opioids
- ✓ If you need to refer your patients to a behavioral health specialist, please call the Behavioral Health department at **800.673.8043**

Risk of Continued Opioid Use (COU)

The Risk of Continued Opioid Use measure evaluates patients 18 years of age and older who have a new episode of opioid use in the measurement year that puts them at risk for continued opioid use. There are two rates reported:

1. Patients with at least 15 days of prescription opioids in a 30-day period
2. Patients with at least 31 days of prescription opioids in a 62-day period

A lower calculated performance rate for this measure indicates better clinical care.

Product lines	Quality programs affected	Collection and reporting method
• **Commercial** • **Medicaid** • **Medicare**	• NCQA Health Plan Ratings	Administrative • Claim data • Pharmacy data

Numerator compliance	• Patients who had 15 or more calendar days covered by an opioid medication during the 30-day period beginning on the IPSD through 29 days after the IPSD • Patients who had 31 or more calendar days covered by an opioid medication during the 62-day period beginning on the IPSD through 61 days after the IPSD
To be included in this measure, a patient must have been prescribed one of the following opioid medications at a MME ≥ 90 mg for ≥ 15 days:	
Opioid medications	• Benzhydrocodone • Buprenorphine • Butorphanol • Codeine • Dihydrocodeine • Fentanyl • Hydrocodone • Hydromorphone • Levorphanol • Meperidine • Methadone • Morphine • Opium • Oxycodone • Oxymorphone • Pentazocine • Tapentadol • Tramadol
Required exclusions	• History of cancer 12 months prior to the index prescription start date • Sickle cell disease diagnosis 12 months prior to the index prescription start date
Medical record documentation (including but not limited to)	• Consultation reports • Progress notes Submit medical record documentation for evidence of exclusions to Priority Health HEDIS department: • Electronically uploading medical records – please contact ***HEDIS@PriorityHealth.com*** to get a file set up or for more information • Email: ***HEDIS@PriorityHealth.com*** • Fax: 616.975.8897 • Mail: HEDIS at 1231 E Beltline, NE Mail Stop 1280, Grand Rapids, MI, 49525

Tips and best practices:

- ✓ Integrate a review of the necessity and appropriateness of opioid therapy into every encounter with the patient taking an opioid medication
- ✓ Before prescribing an opioid medication, consider first line or non-pharmacologic treatment options
- ✓ Use the lowest effective dose of opioids for the shortest period necessary
- ✓ Educate patient on opioid safety and risks associated with use of multiple opioids and having multiple prescribers and/or pharmacies
- ✓ Information to help you stay informed about the latest opioid research and guidelines is available at cdc.gov. Reference the **CDC Guideline for Prescribing Opioids**.
- ✓ Ensure patients have not received multiple opioid prescriptions. Prescriptions that have been filled for an opioid can be found in the **Michigan Automated Prescription System** application. All pharmacies are required to report data on the dispensing of opioid products there, including name of drug, strength, quantity, day supply, day filled, provider, etc. When prescribing opioids, use this application to ensure patients don't have multiple opioid prescriptions.
- ✓ If you need to refer your patients to a behavioral health specialist, please call the Behavioral Health department at **800.673.8043**
- ✓ **Supplemental data can be accepted for evidence of exclusions for this measure**

Initiation and Engagement of Substance Use Disorder Treatment (IET)

The Initiation and Engagement of Substance Use Disorder Treatment measure evaluates adolescent and adult patients 13 years and older with a new episode of substance use disorder (SUD) that result in treatment initiation and engagement. There are two rates reported:

- **Initiation of Substance Use Disorder (SUD) Treatment** – Patients who initiated treatment through an inpatient SUD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication treatment within 14 days of the diagnosis
- **Engagement of Substance Use Disorder (SUD) Treatment** – Patients who initiated treatment and who had two or more additional SUD services or medication treatment within 34 days of the initiation visit

Product lines	Quality programs affected	Collection and reporting method
• **Commercial** • **Medicaid** • **Medicare**	• NCQA Health Plan Ratings	Administrative • Claim data

Use the visit codes below and POS (if applicable) along with a diagnosis code associated with alcohol, opioid, and other drug abuse and dependence to capture initiation and engagement of SOD treatment.

All the following scenarios must include a diagnosis of one of the cohorts below on the claim:

- Alcohol use disorder
- Opioid use disorder
- Other substance use disorder

Numerator compliance	• Initiation of SUD treatment: Initiation of SUD treatment within 14 days of the SUD episode date • Engagement of SUD treatment: If Initiation of SUD Treatment was an inpatient admission, the 34-day period for engagement begins the day after discharge

Scenario 1: Inpatient stay

Acute or Nonacute Inpatient Visit - For numerator compliance for engagement of treatment, at least two of the following scenarios must have been met on the day after the initiation encounter through 34 days after. Two engagement visits can be on the same date but must be with different providers.

Billing codes	Description	Code type	Codes
	Inpatient stay	**UBREV**	0100, 0101, 0110, 0111, 0112, 0113, 0114, 0116, 0117, 0118, 0119, 0120, 0121, 0122, 0123, 0124, 0126, 0127, 0128, 0129, 0130, 0131, 0132, 0133, 0134, 0136, 0137, 0138, 0139, 0140,

			0141, 0142, 0143, 0144, 0146, 0147, 0148, 0149, 0150, 0151, 0152, 0153, 0154, 0156, 0157, 0158, 0159, 0160, 0164, 0167, 0169, 0170, 0171, 0172, 0173, 0174, 0179, 0190, 0191, 0192, 0193, 0194, 0199, 0200, 0201, 0202, 0203, 0204, 0206, 0207, 0208, 0209, 0210, 0211, 0212, 0213, 0214, 0219, 1000, 1001, 1002

Scenario 2: Outpatient visits with outpatient place of service code

Billing Codes	**Description**	**Code type**	**Codes**
	Visit Setting Unspecified and Outpatient POS	**CPT®**	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99251, 99252, 99253, 99254, 99255, 90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876
		POS	03, 05, 07, 09, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 22, 33, 49, 50, 71, 72

Scenario 3: Behavioral health outpatient visit

Billing codes	**Description**	**Code type**	**Codes**
	Behavioral health 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, 99384, 99385, 99386, 99387, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99483, 99492, 99493, 99494, 99510
		HCPCS	G0155, G0176, G0177, G0409, G0463, G0512, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, T1015
		UBREV	0510, 0513, 0515, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0526, 0527, 0528, 0529, 0900, 0902, 0901, 0903, 0904, 0905, 0906, 0907, 0911, 0912, 0913, 0914, 0915, 0916, 0917, 0919, 0944, 0945, 0982, 0983

Scenario 4: Intensive outpatient encounter or partial hospitalization with partial hospitalization place of service code

Billing codes	Description	Code type	Codes
	Visit setting unspecified and partial hospitalization POS	**CPT**	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99251, 99252, 99253, 99254, 99255
		POS	52

Scenario 5: Intensive outpatient encounter or partial hospitalization

Billing codes	Description	Code type	Codes
	Intensive outpatient or partial hospitalization	**HCPCS**	G0410, G0411, H0035, H2001, H2012, S0201, S9480, S9484, S9485
		UBREV	0905, 0907, 0912, 0913

Scenario 6: Non-residential substance abuse treatment facility with non-residential substance abuse treatment facility place of service code

Billing codes	Description	Code type	Codes
	Visit setting unspecified and non-residential substance abuse treatment facility POS	**CPT**	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99251, 99252, 99253, 99254, 99255
		POS	57, 58

Scenario 7: Community mental health center visit with community mental health place of service code

Billing codes	Description	Code type	Codes
	Visit setting unspecified and community mental health POS	**CPT**	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99251, 99252, 99253, 99254, 99255
		POS	53

Scenario 8: Telehealth visit with telehealth place of service code

Billing codes	Description	Code type	Codes
	Visit setting unspecified and telehealth POS	**CPT**	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221, 99222, 99223, 99231, 99232,

			99233, 99238, 99239, 99251, 99252, 99253, 99254, 99255
		POS	02

Scenario 9: Substance use disorder services

Billing codes	**Description**	**Code type**	**Codes**
	Substance use disorder services	**CPT**	99408, 99409
		HCPCS	G0396, G0397, G0443, H0001, H0005, H0007, H0015, H0016, H0022, H0047, H0050, H2035, H2036, T1006, T1012
		UBREV	0906, 0944, 0945

Scenario 10: Observation wait

Billing codes	**Description**	**Code type**	**Codes**
	Observation	**CPT**	99217, 99218, 99219, 99220

Scenario 11: Telephone visit

Billing codes	**Description**	**Code type**	**Codes**
	Telephone Visit	**CPT**	98966, 98967, 98968, 99441, 99442, 99443

Scenario 12: E-visit or virtual check-in

Billing codes	**Description**	**Code type**	**Codes**
	Online assessments	**CPT**	98969, 98970, 98971, 98972, 99421, 99422, 99423, 99444, 99457
		HCPCS	G0071, G2010, G2012, G2061, G2062, G2063, G2250, G2251, G2252

Scenario 13: Opioid treatment service (weekly or monthly)

Billing codes	**Description**	**Code type**	**Codes**
	OUD weekly non-drug service	**HCPCS**	G2071, G2074, G2075, G2076, G2077, G2080
	OUD weekly drug treatment service	**HCPCS**	G2067, G2068, G2069, G2070, G2072, G2073
	OUD monthly office-based treatment	**HCPCS**	G2086, G2087

Test, service or procedure to close care opportunity	Initiation and engagement of substance use disorder through: • Acute or non-acute inpatient stay • Group visits with an appropriate place of service code and diagnosis code • Medication dispensing event • Medication treatment • Online assessment with diagnosis code

	• Stand-alone visits with an appropriate place of service code and diagnosis code • Telephone visit with diagnosis code
Medical record documentation (including but not limited to)	• Health history and physical • Progress notes Submit medical record documentation to Priority Health HEDIS department • Electronically uploading medical records – contact ***HEDIS@PriorityHealth.com*** to get a file set up or for more information • Email: ***HEDIS@PriorityHealth.com*** • Fax: 616-975-8897 • Mail: HEDIS at 1231 E Beltline, NE Mail Stop 1280, Grand Rapids, MI, 49525

Tips and best practices:

✓ Document identified substance abuse in the patient chart and provide the appropriate diagnosis code on all relevant claims, including associated follow-up visits and treatment services. Claims must include the visit code, original episode diagnosis and when applicable, a place of service code. (Include the initial alcohol or other drug dependence diagnosis on every claim when treating a patient for issues related to that diagnosis.)
✓ Schedule follow-up appointment within 14 days for patients with a new episode of alcohol or other drug (AOD) diagnosis
✓ Schedule a follow-up visit within 34 days of the initial 14-day follow-up visit
✓ Provide patient education on available AOD services in the area
✓ Follow-up visits may be with initial provider or substance use disorder provider
✓ Encourage the use of telehealth appointments when appropriate
✓ Ask the patient for written consent to collaborate with their mental health provider, to support coordination of care and treatment
✓ If you need to refer your patients to a behavioral health specialist or need to request coordination of care, please call the Behavioral Health department at **800.673.8043**
✓ Use EHR/EMR alerts for patients due for initiation and engagement of AOD treatment

Antidepressant Medication Management (AMM)

The Antidepressant Medication Management measure evaluates patients 18 years of age and older who were treated with antidepressant medication treatment during the measurement year. This measure assesses the following:

1. **Effective Acute Phase Treatment** – Patients who remained on an antidepressant medication for at least 84 days (12 weeks)
2. **Effective Continuation Phase Treatment** – Patients who remained on an antidepressant medication for at least 180 days (6 months)

Product lines	Quality programs affected	Collection and reporting method
• **Commercial** • **Medicaid** • **Medicare**	• CMS Quality Rating System • NCQA Health Plan Ratings • State Performance Measure	Administrative • Claim data • Pharmacy data

Numerator compliance	At least 84 days of treatment with antidepressant medication, beginning on the IPSD through 114 days after the IPSD (115 total days)		
Billing codes	**Description**	**Code type**	**Codes**
	Major depression diagnoses	**ICD-10 diagnosis**	F32.0, F32.1, F32.2, F32.3, F32.4, F32.9, F33.0, F33.1, F33.2, F33.3, F33.41, F33.9
To comply with this measure, a patient must remain on any of the following antidepressant medications for the required duration of time:			
Drug category	**Medications**		
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

Test, service or procedure to close care opportunity	Prescription data for patients with a diagnosis of major depression indicating they filled prescriptions as outlined in both the acute and continuation phases
Medical record documentation (including but not limited to)	Patients with a filled prescription for these medications are administratively compliant with the measure

Tips and best practices:

- ✓ Use screening tools to aid in diagnosing and treatment. Many patients with mild depression who are prescribed antidepressants don't stay on medication. Consider a referral or a consultation for talk therapy as an alternative to medication.
- ✓ Screening tools (e.g., PHQ-9) may provide objective assessment and better identify who would or would not benefit from medication
- ✓ Assess patient's symptoms of depression using an age-appropriate standardized assessment at baseline and various points in the patient's progression
- ✓ Educate patient about depression and medication compliance
  - ❖ How antidepressants work, benefits, how long they should be used
  - ❖ Length of time on medication before patient should expect to feel better
- ✓ Submit claims for continued antidepressant treatment of major depression with 12 weeks of medication management and 6 months of consistent medication management
- ✓ Monitoring patient's adherence with antidepressant RX is important, and providers are a critical link in ensuring the patient is compliant
- ✓ Encourage the use of telehealth appointments to discuss side effects and answer questions about the medication
- ✓ Educate patients on the following:
  - ❖ Most antidepressants take 1-6 weeks to work before the patient starts to feel better
  - ❖ 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
  - ❖ What to do if the patient has a crisis or has thoughts of self-harm
  - ❖ Never stop taking the medication without consulting the provider
- If you need to refer your patient to a behavioral health specialist or need to request coordination of care, please call the Behavioral Health department at **800.673.8043**

Follow-Up After Hospitilization for Mental Illness (FUH)

The Follow-Up After Hospitalization for Mental Illness measure evaluates patients 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 provider. Timely follow-up visits with qualified mental health providers are critical for their well-being.

This measure assesses the following:

1. Patient received follow-up within 30 days after discharge with a mental health provider
2. Patient received follow-up within 7 days after discharge with a mental health provider

Note: The follow-up visit must be on a different date than the discharge date.

Product lines	Quality programs affected	Collection and reporting method
• **Commercial** • **Medicaid** • **Medicare**	• NCQA Health Plan Ratings	Administrative • Claim data

Numerator compliance	A follow-up visit with a mental health provider within 7 days or within 30 days after discharge		
Billing codes	**Description**	**Code type**	**Code**
	Behavioral health outpatient visit with a mental health provider behavioral health visits		
	Behavioral health 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. 99383, 99384, 99385, 99386, 99387, 99393, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99483, 99492, 99493, 95510
		HCPCS	G0155, G0176, G0177, G0409, G0463, G0512, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, T1015
		UBREV	0510, 0513, 0515, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0526, 0527, 0528, 0529, 0900, 0902, 0903, 0904, 0911, 0914, 0915, 0916, 0917, 0919, 0982, 0983

	Intensive outpatient or partial hospitalization		
	Partial hospitalization or intensive outpatient visits	**HCPCS**	G0410, G0411, H0035, H2001, H2012, S0201, S9480, S9484, S9485
		UBREV	0905, 0907, 0912, 0913
	Outpatient visit with a mental health provider and with appropriate outpatient place of service code		
	Visit setting unspecified	**CPT**	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876
		POS	03, 05, 07, 09, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 22, 33, 49, 50, 71, 72
	Description	**Code type**	**Code**
	Intensive outpatient or partial hospitalization with a mental health provider and with appropriate place of service		
	Visit setting unspecified	**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, 99253, 99254, 99255
		POS	52
	Intensive outpatient or partial hospitalization with a community mental health center and with appropriate place of service		
	Visit setting unspecified	**CPT**	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876
	Behavioral health 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. 99383, 99384, 99385, 99386, 99387, 99393, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99483, 99492, 99493, 95510
	Observation visit	**CPT**	99217, 99218, 99219, 99220
	Transitional care management services	**CPT**	99495, 99496
		POS	53

	Electroconvulsive therapy with ambulatory surgical center POS/community mental health center POS/outpatient POS, partial hospitalization POS		
	Electroconvulsive therapy	**CPT**	90870
		Ambulatory POS	24
		Community mental health POS	53
		Outpatient POS	03, 05, 07, 09, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 22, 33, 49, 50, 71, 72
		Partial hospitalization	52
	Transitional care management services with a mental health provider		
	Transitional care management services	**CPT**	99495, 99496
	Telehealth visit with a mental health provider		
	Visit setting unspecified	**CPT**	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876
		POS	02, 10
	Behavioral healthcare setting visit		
	Behavioral healthcare setting	**UBREV**	0513, 0900, 0901, 0902, 0903, 0904, 0905, 0907, 0911, 0912, 0913, 0914, 0915, 0916, 0917, 0919
	Telephone visit with a mental health provider		
	Telephone visits	**CPT**	98966, 98967, 98968, 99441, 99442, 99443
	Psychiatric collaborative care management		
	Psychiatric collaborative care management	**CPT**	99492, 99493, 99494, G0512
Frequency/occurrence	Every mental health discharge		
Test, service or procedure to close care opportunity	Medical record dates: 01/01/2024 - 12/31/2024 Follow-up care after hospitalization for mental illness		
Medical record documentation (including but not limited to)	• Consultation notes • Progress notes Submit medical record documentation to Priority Health HEDIS department • Electronically uploading medical records – contact **HEDIS@PriorityHealth.com** to get a file set up or for more information • Email: **HEDIS@PriorityHealth.com**		

	• Fax: 616-975-8897Mail: HEDIS at 1231 E Beltline, NE Mail Stop 1280, Grand Rapids, MI, 49525

Tips and best practices:

- ✓ **Review the MiHIN admission, discharge or transfer service report**
- ✓ Refer patient to a mental health provider to be seen within seven days of discharge
- ✓ Even patients receiving medication from their primary care provider still need post-discharge supportive therapy with a licensed mental health clinician such as a therapist or social worker
- ✓ Ensure the patient has a plan for follow-up visit with a mental health provider within 7 and 30 days after discharge. Don't include visits that occur on the date of discharge.
- ✓ Schedule the patient's aftercare appointment prior to discharge
- ✓ Educate inpatient and outpatient providers about the measure and the clinical practice guidelines
- ✓ Attempt to alleviate barriers to attending appointments prior to discharge
- ✓ Review medications with patients to ensure they understand the purpose, appropriate Frequency/Occurrence and method of administration
- ✓ If you need to refer your patient to a behavioral health specialist or need to request coordination of care, please call the Behavioral Health department at **800.673.8043**
- ✓ Use EHR/EMR alerts for patients due for a follow-up visit after hospitalization for a mental illness

Hospitalization follow-up visits can be accepted as supplemental data

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

The Follow-Up After Emergency Department Visit for Mental Illness measure evaluates patients 6 years of age and older who had a principal diagnosis of a mental health disorder or intentional self-harm diagnoses and who had a follow-up visit for mental illness with a practitioner.

This measure assesses the following:

1. Patient received follow-up with any practitioner within 7 days after emergency department visit
2. Patient received follow-up with any practitioner within 30 days after emergency department visit

Note: The follow-up visit must be on a different date than the discharge date.

Product lines	Quality programs affected	Collection and reporting method
• **Commercial** • **Medicaid** • **Medicare**	• NCQA Health Plan Ratings	Administrative • Claim data

Numerator compliance	A follow-up visit with any practitioner, with a principal diagnosis of a mental health disorder or with a principal diagnosis of intentional self-harm and any diagnosis of a mental health disorder within 7 days after the ED visit (8 total days) or within 30 days after the ED visit (31 total days)		
Billing codes	**Description**	**Code type**	**Code**
	Mental health disorder diagnosis codes		
	Principal diagnosis of mental health disorder	**ICD-10 diagnosis**	**F03.90 – F99**
	Behavioral health outpatient visit with a principal diagnosis of a mental health disorder with any provider type		
	Behavioral health 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. 99383, 99384, 99385, 99386, 99387, 99393, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99483, 99492, 99493, 95510
		HCPCS	G0155, G0176, G0177, G0409, G0463, , G0512, H0002, H0004, H0031, H0034, H0036, H0037,

			H0039, H0040, H2000, H2010, H2011, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, T1015
		UBREV	0510, 0513, 0515, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0526, 0527, 0528, 0529, 0900, 0902, 0903, 0904, 0911, 0914, 0915, 0916, 0917, 0919, 0982, 0983
	Behavioral health outpatient visit with a principal diagnosis of intentional self-harm with any diagnosis of a mental health disorder with any provider type		
	Behavioral health outpatient	**CPTf**	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. 99383, 99384, 99385, 99386, 99387, 99393, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99483, 99492, 99493, 95510
		HCPCS	G0155, G0176, G0177, G0409, G0463, G0512, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, T1015
		UBREV	0510, 0513, 0515, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0526, 0527, 0528, 0529, 0900, 0902, 0903, 0904, 0911, 0914, 0915, 0916, 0917, 0919, 0982, 0983
	Intentional self-harm diagnosis	**ICD-10 Diagnosis**	T14.91XA, T14.91XD, T14.91XS; and all codes ending with 2A, 2D, or 2S from T36.0X-T71.23
	Intensive outpatient encounter or partial hospitalization with a principal diagnosis of a mental health disorder with any provider		
	Partial hospitalization or intensive outpatient visits	**HCPCS**	G0410, G0411, H0035, H2001, H2012, S0201, S9480, S9484, S9485
		UBREV	0905, 0907, 0912, 0913
	Visit setting unspecified	**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, 99253, 99254, 99255
	Partial hospitalization	**POS**	52

	Intensive outpatient encounter or partial hospitalization with partial hospitalization place of service, with a principal diagnosis of intentional self-harm, with any diagnosis of a mental health disorder		
	Visit setting unspecified	**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, 99253, 99254, 99255
	Partial hospitalization	**POS**	52
	Intentional self-harm	**ICD-10 Diagnosis**	T14.91XA, T14.91XD, T14.91XS; and all codes ending with 2A, 2D, or 2S from T36.0X-T71.23
	Intensive outpatient encounter or partial hospitalization with a principal diagnosis of intentional self-harm, with any diagnosis of a mental health disorder		
	Partial hospitalization or intensive outpatient visit	**HCPCS**	G0410, G0411, H0035, H2001, H2012, S0201, S9480, S9484, S9485
		UBREV	0905, 0907, 0912, 0913
	Intentional self-harm	**ICD-10 Diagnosis**	T14.91XA, T14.91XD, T14.91XS; and all codes ending with 2A, 2D, or 2S from T36.0X-T71.23
	Outpatient visit with appropriate outpatient place of service code and a principal diagnosis of a metal health disorder		
	Visit setting unspecified	**CPT**	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876
	Outpatient POS	**POS**	03, 05, 07, 09, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 22, 33, 49, 50, 71, 72
	Outpatient visit with any provider and with appropriate outpatient place of service code with a principal diagnosis of intentional self-harm, with any diagnosis of a mental health disorder		
	Visit setting unspecified	**CPT**	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876
	Intentional self-harm	**ICD-10 Diagnosis**	T14.91XA, T14.91XD, T14.91XS; and all codes ending with 2A, 2D, or 2S from T36.0X-T71.23
	Community mental health center visit with any provider type and with appropriate place of service code with a principal diagnosis of a mental health disorder		

	Visit setting unspecified	**CPT**	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876
	Community mental health POS	**POS**	53
	Community mental health center visit with any provider type and with appropriate place of service code with a principal diagnosis of intentional self-harm with any diagnosis mental health disorder		
	Visit setting unspecified	**CPT**	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876
	Community mental health POS	**POS**	53
	Intentional self-harm	**ICD-10 Diagnosis**	T14.91XA, T14.91XD, T14.91XS; and all codes ending with 2A, 2D, or 2S from T36.0X-T71.23
	Electroconvulsive therapy and ambulatory surgical center POS/community mental health center POS/outpatient POS/ or partial hospitalization POS with a principal diagnosis of a mental health disorder		
	Electroconvulsive therapy	**CPT**	90870
	Ambulatory surgical center POS	**POS**	24
	Community mental health POS		53
	Outpatient POS		03, 05, 07, 09, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 22, 33, 49, 50, 71, 72
	Partial hospitalization POS		52
	Electroconvulsive therapy and ambulatory surgical center POS/community mental health center POS/outpatient POS/ or partial hospitalization POS with a principal diagnosis of a mental health disorder with a principal diagnosis of intentional self-harm with any diagnosis of a mental health disorder		
	Electroconvulsive therapy	**CPT**	90870
	Ambulatory surgical center POS	**POS**	24
	Community mental health POS		53
	Outpatient POS		03, 05, 07, 09, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 22, 33, 49, 50, 71, 72
	Partial hospitalization POS		52

	Intentional self-harm	**ICD-10 diagnosis**	T14.91XA, T14.91XD, T14.91XS; and all codes ending with 2A, 2D, or 2S from T36.0X-T71.23
	E-visit or virtual check-in with any provider type with a principal diagnosis of a mental health disorder		
	Online assessment (e-visit / virtual check-in)	**CPT**	98969, 98970, 98971, 98972, 99421, 99422, 99423, 99444, 99457
		HCPCS	G0071, G2010, G2012, G2061, G2062, G2063
	E-visit or virtual check-in with any provider type with a principal diagnosis of intentional self-harm, with any diagnosis of a mental health disorder		
	Online assessment (e-visit / virtual check-in)	**CPT**	98969, 98970, 98971, 98972, 99421, 99422, 99423, 99444, 99457
		HCPCS	G0071, G2010, G2012, G2061, G2062, G2063
	Intentional self-harm	**ICD-10 diagnosis**	T14.91XA, T14.91XD, T14.91XS; and all codes ending with 2A, 2D, or 2S from T36.0X-T71.23
	Telehealth visit with any provider type and the appropriate place of service with a principal diagnosis of a mental health disorder		
	Visit setting unspecified	**CPT**	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876
	Telehealth POS	**POS**	02, 10
	Telehealth visit with any provider type and the appropriate place of service with a principal diagnosis of intentional self-harm, with any diagnosis of a mental health disorder		
	Visit setting unspecified	**CPT**	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876
	Telehealth POS	**POS**	02, 10
	Intentional self-harm	**ICD-10 diagnosis**	T14.91XA, T14.91XD, T14.91XS; and all codes ending with 2A, 2D, or 2S from T36.0X-T71.23
	Telephone visit with any provider type with a principal diagnosis of a mental health disorder		
	Telephone visits	**CPT**	98966, 98967, 98968, 99441, 99442, 99443
	Telephone visit with any provider type with a principal diagnosis of intentional self-harm, with any diagnosis of a mental health disorder		
	Telephone visits	**CPT**	98966, 98967, 98968, 99441, 99442, 99443
	Intentional self-harm	**ICD-10 diagnosis**	T14.91XA, T14.91XD, T14.91XS;

			and all codes ending with 2A, 2D, or 2S from T36.0X-T71.23
Frequency/occurrence	Every mental health emergency department visit discharge		
Test, service or procedure to close care opportunity	Medical record dates: 01/01/2024 - 12/31/2024 • Follow-up care after emergency department visit for mental illness		
Medical record documentation (including but not limited to)	• Consultation notes • Progress notes Submit medical record documentation to Priority Health HEDIS department • Electronically uploading medical records – contact ***HEDIS@PriorityHealth.com*** to get a file set up or for more information • Email: ***HEDIS@PriorityHealth.com*** • Fax: 616.975.8897 • Mail: HEDIS at 1231 E Beltline, NE Mail Stop 1280, Grand Rapids, MI, 49525		

Tips and best practices:

✓ Ensure the patient has a plan for follow-up visit with a mental health practitioner within 7 and 30 days after discharge. Don't include visits that occur on the date of discharge.

✓ Encourage the use of telehealth appointments when appropriate

✓ Use EHR/EMR alerts for patients due for a follow-up visit after hospitalization for a mental illness. If you need to refer your patient to a behavioral health specialist or need to request coordination of care, please call the Behavioral Health department at **800.673.8043**

✓ **Mental Health visits can be accepted as supplemental data**

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

The Follow-up After High-Intensity Care for Substance Use Disorder measure evaluates patients 13 years of age and older who had a follow-up visit or service after an acute inpatient hospitalization, residential treatment or detoxification visit with a principal discharge diagnosis of substance use disorder during the measurement year.

This measure assesses the following:

1. Patients who received follow-up visit with any practitioner for a principal diagnosis of substance abuse disorder within **7 days** after the visit or discharge
2. Patients who received follow-up visit with any practitioner for a principal diagnosis of substance abuse disorder within **30 days** after the visit or discharge

Note: Follow-up visits may not occur on the same date as the inpatient or residential treatment discharge or detoxification visit.

Product lines	Quality programs affected	Collection and reporting method
• **Commercial** • **Medicaid** • **Medicare**	• NCQA Health Plan Ratings	Administrative • Claim data

Numerator compliance	A follow-up visit or event with any practitioner for a principal diagnosis of substance use disorder within the 7 days after an episode for substance use disorder or within the 30 days after an episode for substance use disorder		
Billing codes	**Description**	**Code type**	**Code**
	Outpatient visit with a principal diagnosis of substance use disorder		
	Behavioral health 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. 99383, 99384, 99385, 99386, 99387, 99393, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99483, 99492, 99493, 95510
		HCPCS	G0155, G0176, G0177, G0409, G0463, , G0512, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, T1015

		UBREV	0510, 0513, 0515, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0526, 0527, 0528, 0529, 0900, 0902, 0903, 0904, 0911, 0914, 0915, 0916, 0917, 0919, 0982, 0983

	Description	**Code type**	**Code**
	Outpatient visit with appropriate place of service and a principal diagnosis of substance abuse disorder		
	Visit setting unspecified	**CPT**	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876
	Outpatient POS	**POS**	03, 05, 07, 09, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 22, 33, 49, 50, 71, 72
	Intensive outpatient encounter or partial hospitalization with a principal diagnosis of substance use disorder		
	Partial hospitalization or intensive outpatient	**HCPCS**	**G0410, G0411, H0035, H2001, H2012, S0201, S9480, S9485**
	Intensive outpatient encounter or partial hospitalization with appropriate place of service and a principal diagnosis of substance use disorder		
	Visit setting unspecified	**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, 99253, 99254, 99255
	Partial hospitalization POS	**POS**	52
	Non-residential substance abuse treatment facility visit with the appropriate place of service and a principal diagnosis of substance use disorder		
	Visit setting unspecified	**CPT**	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876
	Non-residential substance abuse treatment facility POS	**POS**	57, 58
	Residential behavioral health treatment with a principal diagnosis of substance use disorder		

	Residential behavioral health treatment	**HCPCS**	H0017, H0018, H0019, T2048
	OUD Weekly drug treatment service	**HCPCS**	G2067, G2068, G2069, G2070, G2072, G2073
	OUD Weekly non-drug treatment service	**HCPCS**	G2071, G2074, G2075, G2076, G2077, G2080
	OUD Monthly office-based treatment	**HCPCS**	G2086, G2087
	Community mental health center visit with appropriate place of service and a principal diagnosis of substance use disorder		
	Visit setting unspecified	**CPT**	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876
	Community mental health POS	**POS**	53
	E-visit or virtual check-in and a principal diagnosis of substance abuse disorder		
	Online assessments	**CPT**	98969, 98970, 98971, 98972, 99421, 99422, 99423, 99444, 99457
		HCPCS	G0071, G2010, G2012, G2061, G2062, G2063, G2250, G2251, G2252
	Telehealth visit with the appropriate place of service and a principal diagnosis of substance use disorder		
	Visit setting unspecified	**CPT**	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876
	Telehealth POS	**POS**	02, 10
	Telephone visit and a principal diagnosis of substance use disorder		
	Telephone visits	**CPT**	98966, 98967, 98968, 99441, 99442, 99443
	A pharmacotherapy dispensing event or medication treatment event for alcohol or other drug abuse or dependence		
	AOD medication treatment	**HCPCS**	G2069, G2070, G2072, G2073, H0020, H0033, J0570, J0571, J0572, J0573, J0574, J0575, J2315, Q9991, Q9992, S0109

	OUD Weekly Drug Treatment Service	**HCPCS**	G2067, G2068, G2069, G2070, G2072, G2073
	Opioid use disorder treatment medications	**Antagonist**	• Naltrexone (oral and injectable)
		Partial agonist	• Buprenorphine (sublingual tablet, injection, implant) • Buprenorphine/naloxone (sublingual tablet, buccal file, sublingual film)
	Alcohol use disorder treatment medications	**Aldehyde dehydrogenase inhibitor**	• Disulfiram (oral)
		Antagonist	• Naltrexone (oral and injectable)
		Other	• Acamprosate (oral and delayed-release tablet)
	Substance use disorder service with a principal diagnosis of substance use disorder		
	Substance use disorder services	**CPT**	99408, 99409
		HCPCS	G0396, G0397, G0443, H0001, H0005, H0007, H0015, H0016, H0022, H0047, H0050, H2035, H2036, T1006, T1012
	Use any of the above CPT or HCPCS codes with a principal diagnosis of substance use disorder below		
	AOD abuse and dependence	**ICD-10 diagnosis**	F10.10, F10.120, F10.121, F10.129, F10.14, F10.150, F10.151, F10.159, F10.180-F10.182, F10.188, F10.19, F10.20, F10.220, F10.221, F10.229, F10.230-F10.232, F10.239, F10.24, F10.250, F10.251, F10.259, F10.26, F10.27, F10.280-F10.282, F10.288, F10.29, F11.10, F11.120-F11.122, F11.129, F11.14, F11.150, F11.151, F11.159, F11.181, F11.182, F11.188, F11.19, F11.20, F11.220-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-F12.122, F12.129, F12.150
	Use any of the above CPT or HCPCS codes with a principal diagnosis of substance use disorder below		
	AOD abuse and dependence (continued)	**ICD-10 diagnosis**	F12.151, F12.159, F12.180, F12.188, F12.19, F12.20, F12.220-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, F13.14, F13.150, F13.151, F13.159, F13.180-F13.182, F13.188, F13.19, F13.20, F13.220, F13.221, F13.229, F13.230-F13.232, F13.239, F13.24, F13.250, F13.251, F13.259, F13.26, F13.27, F13.280-F13.282, F13.288, F13.29, F14.10, F14.120-F14.122, F14.129, F14.14, F14.150, F14.151, F14.159, F14.180-F14.182, F14.188, F14.19, F14.20, F14.220-F14.222, F14.229, F14.23, F14.24, F14.250, F14.251, F14.259, F14.280-F14.282, F14.288, F14.29, F15.10, F15.120-F15.122, F15.129, F15.14, F15.150, F15.151, F15.159, F15.180-F15.182, F15.188, F15.19, F15.20, F15.220-F15.222, F15.229, F15.23, F15.24, F15.250, F15.251, F15.259, F15.280-F15.282, F15.288, F15.29, F16.10, F16.120-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-F19.122, F19.129, F19.14, F19.150, F19.151, F19.159-F19.182, F19.188, F19.19, F19.20, F19.220-F19.222, F19.229, F19.230-F19.232, F19.239, F19.24, F19.250, F19.251, F19.259, F19.26-F19.282, F19.288, F19.29
Frequency/occurrence	Every mental health emergency department visit discharge		

Test, service or procedure to close care opportunity	Medical record dates: 01/01/2024 - 12/31/2024
	• Follow-up care after emergency department visit for mental illness
	• Follow-up for substance use disorder can be any of the following:
	   • Group visits with an appropriate place of service code and diagnosis code
	   • Medication dispensing event with diagnosis code
	   • Medication treatment with diagnosis code
	   • Online assessment with diagnosis code
	   • Stand-alone visits with an appropriate place of service code and diagnosis code
	   • Telephone visit with diagnosis code		

Medical record documentation (including but not limited to)	• Consultation notes • Progress notes Submit medical record documentation to Priority Health HEDIS department • Electronically uploading medical records – contact ***HEDIS@PriorityHealth.com*** to get a file set up or for more information • Email: ***HEDIS@PriorityHealth.com*** • Fax: 616.975.8897 • Mail: HEDIS at 1231 E Beltline, NE Mail Stop 1280, Grand Rapids, MI, 49525

Tips and best practices:

- ✓ **Review the MiHIN admission, discharge or transfer service report**
- ✓ Ensure the patient has a plan for a follow-up visit with a mental health practitioner within 7 and 30 days after discharge. Don't include visits that occur on the date of discharge.
- ✓ Encourage the use of telehealth appointments when appropriate
- ✓ Use EHR/EMR alerts for patients due for a follow-up visit after hospitalization for a mental illness
- ✓ If you need to refer your patient to a behavioral health specialist or need to request coordination of care, please call the Behavioral Health department at **800.673.8043**
- ✓ **Mental health visits can be accepted as supplemental data**

Follow-up After Emergency Department Visit for Substance Use (FUA)

The Follow-up After Emergency Department Visit for Substance Abuse measure evaluates patients 13 years of age and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose and who had a follow-up visit.

This measure assesses the following:

1. Patients who received a follow-up visit within the 7 days after the emergency department visit discharge
2. Patients who received a follow-up visit within 30 days after the emergency department visit discharge

Note: Follow-up visits may not occur on the same date of inpatient or residential treatment discharge or detoxification visit.

Product lines	Quality programs affected	Collection and reporting method
• **Commercial** • **Medicaid** • **Medicare**	• NCQA Health Plan Ratings	Administrative • Claim data

Numerator compliance	A follow-up visit or a pharmacotherapy dispensing event within 7 days after the ED visit (8 total days) or within 30 days after the ED visit (31 total days)		
Billing codes	**Description**	**Code type**	**Code**
	Outpatient visit with a mental health provider		
	Behavioral health 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. 99383, 99384, 99385, 99386, 99387, 99393, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99483, 99492, 99493, 95510
		HCPCS	G0155, G0176, G0177, G0409, G0463, , G0512, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, T1015
		UBREV	0510, 0513, 0515, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0526, 0527, 0528, 0529, 0900, 0902, 0903, 0904, 0911, 0914, 0915, 0916, 0917, 0919, 0982, 0983

	Outpatient visit with any diagnosis of substance use disorder, substance use, or drug overdose		
	Behavioral health 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. 99383, 99384, 99385, 99386, 99387, 99393, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99483, 99492, 99493, 95510
		HCPCS	G0155, G0176, G0177, G0409, G0463, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, T1015
		UBREV	0510, 0513, 0515, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0526, 0527, 0528, 0529, 0900, 0902, 0903, 0904, 0911, 0914, 0915, 0916, 0917, 0919, 0982, 0983
	Outpatient visit with appropriate place of service with any diagnosis of substance use disorder, substance use, or drug overdose		
	Visit setting unspecified	**CPT**	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876
	Outpatient POS	**POS**	03, 05, 07, 09, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 22, 33, 49, 50, 71, 72
	Outpatient visit with appropriate place of service with a mental health provider		
	Visit setting unspecified	**CPT**	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876
	Outpatient POS	**POS**	03, 05, 07, 09, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 22, 33, 49, 50, 71, 72
	Intensive outpatient encounter or partial hospitalization with appropriate place of service with any diagnosis of substance use disorder, substance use, or drug overdose		
	Visit setting unspecified	**CPT**	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876
	Partial hospitalization POS	**POS**	52
	Intensive outpatient encounter or partial hospitalization with appropriate place of service with a mental health provider		

	Visit setting unspecified	**CPT**	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876
	Partial hospitalization POS	**POS**	52
	Intensive outpatient encounter or partial hospitalization with appropriate place of service with any diagnosis of substance use disorder, substance use, or drug overdose		
	Partial hospitalization or intensive outpatient	**HCPCS**	G0410, G0411, H0035, H2001, H2012, S0201, S9480, S9484, S9485
	Intensive outpatient encounter or partial hospitalization with a mental health provider		
	Partial hospitalization or intensive outpatient	**HCPCS**	G0410, G0411, H0035, H2001, H2012, S0201, S9480, S9484, S9485

Billing codes	Description	Code type	Code
	Non-residential substance abuse treatment facility visit with appropriate place of service with any diagnosis of substance use disorder, substance use, or drug overdose		
	Visit setting unspecified	**CPT**	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876
	Non-residential substance abuse treatment facility POS	**POS**	57, 58
	Non-residential substance abuse treatment facility visit with appropriate place of service with a mental health provider		
	Visit setting unspecified	**CPT**	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876
	Non-residential substance abuse treatment facility POS	**POS**	57, 58
	Community mental health center visit with appropriate place of service with any diagnosis of substance use disorder, substance use, or drug overdose		

	Visit setting unspecified	**CPT**	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876
	Community mental health POS	**POS**	53
	Community mental health center visit with appropriate place of service with a mental health provider		
	Visit setting unspecified	**CPT**	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876
	Community mental health POS	**POS**	53
	Peer support service with any diagnosis of substance use disorder, substance use, or drug overdose		
	Peer support service	**HCPCS**	G0177, H0024, H0025, H0038, H0039, H0040, H0046, H2014, H2023, S9445, T1012, T1016
	Opioid treatment service that bills monthly or weekly with any diagnosis of substance use disorder, substance use, or drug overdose		
	OUD weekly non-drug service	**HCPCS**	G2071, G2074, G2075, G2076, G2077, G2080
	OUD monthly office-based treatment	**HCPCS**	G2086, G2087
	Telehealth visit with appropriate place of service with any diagnosis of substance use disorder, substance use, or drug overdose		
	Visit setting unspecified	**CPT**	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876
	Telehealth POS	**POS**	02, 10
	Telehealth visit with appropriate place of service with a mental health provider		
	Visit setting unspecified	**CPT**	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876
	Telehealth POS	**POS**	02, 10
	Telephone visit with any diagnosis any diagnosis of substance use disorder, substance use, or drug overdose		

	Telephone visits	**CPT**	98966, 98967, 98968, 99441, 99442, 99443
	Telephone visit <u>with</u> a mental health provider		
	Telephone visits	**CPT**	98966, 98967, 98968, 99441, 99442, 99443
	E-visit or virtual check-in <u>with</u> any diagnosis of substance use disorder, substance use, or drug overdose		
	Online assessments	**CPT**	98969, 98970, 98971, 98972, 99421, 99422, 99423, 99444, 99457, 99458
		HCPCS	G0071, G2010, G2012, G2061, G2062, G2062, G2063, G2250, G2251, G2252
	E-visit or virtual check-in <u>with</u> a mental health provider		
	Online assessments	**CPT**	98969, 98970, 98971, 98972, 99421, 99422, 99423, 99444, 99457, 99458
		HCPCS	G0071, G2010, G2012, G2061, G2062, G2062, G2063, G2250, G2251, G2252
	Substance use disorder service		
	Substance use disorder services	**CPT**	99408, 99409
		HCPCS	G0396, G0397, G0443, H0001, H0005, H0007, H0015, H0016, H0022, H0047, H0050, H2035, H2036, T1006, T1012
	Substance use service		
	Substance use services	**HCPCS**	H0006, H0028
	A behavioral health screening or assessment for substance use disorder or mental health disorders		
	Behavioral health assessment	**CPT**	99408, 99409
		HCPCS	G0396, G0397, G0442, G2011, H0001, H0002, H0031, H0049
	A pharmacotherapy dispensing event or medication treatment event		
	Alcohol use disorder treatment medications	**Description**	**Prescription**
		Aldehyde dehydrogenzse inhibitor	• Disulfiram (oral)
		Antagonist	• Naltrexone (oral and injectable)
		Other	• Acamprosate (oral; delayed-release tablet)
	Opioid use disorder treatment medications	**Description**	**Prescription**
		Antagonist	• Naltrexone (injectable) • Naltrexone (oral)
		Partial agonist	• Buprenorphine (implant) • Buprenorphine (injection)

			• Buprenorphone (sublingual tablet)
	Medication treatment event	**HCPCS**	G2069, G2070, G2072, G2073, H0020, H0033, J0570, J0571, J0572, J0573, J0574, J0575, J2315, Q9991, Q9992, S0109
	Weekly drug treatment service	**HCPCS**	G2067, G2068, G2069, G2070, G2072, G2073
	Substance Use Disorder	**ICD10 Diagnosis**	F10.10, F10.120, F10.121, F10.129, F10.14, F10.150, F10.151, F10.159, F10.180-F10.182, F10.188, F10.19, F10.20, F10.220, F10.221, F10.229, F10.230-F10.232, F10.239, F10.24, F10.250, F10.251, F10.259, F10.26, F10.27, F10.280-F10.282, F10.288, F10.29, F11.10, F11.120-F11.122, F11.129, F11.14, F11.150, F11.151, F11.159, F11.181, F11.182, F11.188, F11.19, F11.20, F11.220-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-F12.122, F12.129, F12.150, F12.151, F12.159, F12.180, F12.188, F12.19, F12.20, F12.220-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, F13.14, F13.150, F13.151, F13.159, F13.180-F13.182, F13.188, F13.19, F13.20, F13.220, F13.221, F13.229, F13.230-F13.232, F13.239, F13.24, F13.250, F13.251, F13.259, F13.26, F13.27, F13.280-F13.282, F13.288, F13.29, F14.10, F14.120-F14.122, F14.129, F14.14, F14.150, F14.151, F14.159, F14.180-F14.182, F14.188, F14.19, F14.20, F14.220-F14.222, F14.229, F14.23, F14.24, F14.250, F14.251, F14.259, F14.280-F14.282, F14.288, F14.29, F15.10, F15.120-F15.122, F15.129, F15.14, F15.150, F15.151, F15.159, F15.180, F15.182, F15.188, F15.19, F15.20, F15.220-F15.222, F15.229, F15.23, F15.24, F15.250, F15.251, F15.259, F15.280-F15.282, F15.288, F15.29, F16.10, F16.120-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-F19.122, F19.129, F19.14, F19.150, F19.151, F19.159-F19.182, F19.188, F19.19, F19.20, F19.220-F19.222, F19.229, F19.230-F19.232, F19.239, F19.24, F19.250, F19.251, F19.259, F19.26-F19.282, F19.288, F19.29
	Substance Use	**ICD10 Diagnosis**	F10.920, F10.921, F10.929, F10.930, F10.931, F10.932, F10.939, F10.84, G10.950, F10.951, F10.959, F10.96. F10.97, F10.980, F10.981, F10.982, F10.988, F10.99, F11.90, F11.920, F11.921, F11.922, F11.929, F11.93, F11.94, F11.950, F11.951, F11.959, F11.981, F11.982, F11.988, F11.99, F12.90, F12.920, F12.921, F12.922, F12.929, F12.93, F12.950, F12.951, F12.959, F12.980, F12.988, F12.99, F13.90, F13.920, F13.921, F13.921, F13.929, F13.930, F13.931, F13.932, F13.930, F13.931, F13.932, F13.939, F13.94, F13.950, F13.951, F13.959, F13.96, F13.97, F13.980, F13.981, F13.982, F13.988, F13.99, F14.90, F14.920, F14.921, F14.922, F14.929, F14.93, F14.94, F14.950, F14.951, F14.959, F14.980, F14.981, F14.982, F14.988, F14.99, F15.90, F15.920, F15.920, F15.921, F15.922, F15.929, F15.93, F15.94, F15.950, F15.951, F15.959, F15.980, F15.981, F15.982, F15.988, F15.99, F16.90, F16.920, F16.921, F16.929, F18.94, F18.950, F18.951, F18.959, F18.97, F18.980, F18.988, F18.99, F19.90, F19.920, F19.921, F19.922, F19.929, F19.930, F19.931, F19.939, F19.94, F19.950, F19.951, F19.959, F19.96, F19.97, F19.980, F19.981, F19.982, F19.988, F19.99
	Drug Overdose	**ICD10 Diagnosis**	T40.0X1A, T40.0X1D, T40.0X1S, T40.0X4A, T40.0X4D, T40.0X4S, T40.1X1A, T40.1X1D,

			T40.1X1S, T40.1X4A, T40.1X4D, T40.1X4S, T40.2X1A, T40.2X1D, T40.2X1S, T40.2X4A, T40.2X4D, T40.2X4S, T40.3X1A, T40.3X1D, T40.3X1S, T40.3X4A, T40.3X4D, T40.3X4S, T40.411A, T40.411D, T40.411S, T40.414A, T40.414D, T40.414S, T40.421A, T40.421D, T40.421S, T40.424A, T40.424D, T40.424S, T40.491A, T40.491D, T40.491S, T40.494A, T40.494D, T40.494S, T40.5X1A, T40.5X1D, T40.5X1S, T40.5X4A, T40.5X4D, T40.5X4S, T40.601A, T40.601D, T40.601S, T40.604A, T40.604D, T40.604S, T40.691A, T40.691D, T40.691S, T40.694A, T40.694D, T40.694S, T40.711A, T40.711D, T40.711S, T40.714A, T40.714D, T40.714S, T40.721A, T40.721D, T40.721S, T40.724A, T40.724D, T40.724S, T40.7X1A, T40.7X1D, T40.7X1S, T40.7X4A, T40.7X4D, T40.7X4S, T40.8X1A, T40.8X1D, T40.8X1S, T40.8X4A, T40.8X4D, T40.8X4S, T40.901A, T40.901D, T40.901S, T40.904A, T40.904D, T40.904S, T40.991A, T40.991D, T40.991S, T40.994A, T40.994D, T40.994S, T41.0X1A, T41.0X1D, T41.0X1S, T41.0X4A, T41.0X4D, T41.0X4S, T41.1X1A, T41.1X1D, T41.1X1S, T41.1X4A, T41.1X4D, T41.1X4S, T41.201A, T41.201D, T41.201S, T41.204A, T41.204D, T41.204S, T41.291A, T41.291D, T41.291S, T41.294A, T41.294D, T41.294S, T41.3X1A, T41.3X1D, T41.3X1S, T41.3X4A, T41.3X4D, T41.3X4S, T41.41XA, T41.41XD, T41.41XS, T41.44XA, T41.44XD, T41.44XS, T41.5X1A, T41.5X1D, T41.5X1S, T41.5X4A, T41.5X4D, T41.5X4S, T42.3X1A, T42.3X1D, T42.3X1S, T42.3X4A, T42.3X4D, T42.3X4S, T42.4X1A, T42.4X1D, T42.4X1S, T42.4X4A, T42.4X4D, T42.4X4S, T43.601A, T43.601D, T43.601S, T43.604A, T43.604D, T43.604S, T43.621A, T43.621D,

			T43.621S, T43.624A, T43.624D, T43.624S, T43.631A, T43.631D, T43.631S, T43.634A, T43.634D, T43.634S, T43.641A, T43.641D, T43.641S, T43.644A, T43.644D, T43.644S, T43.691A, T43.691D, T43.691S, T43.694A, T43.694D, T43.694S, T51.0X1A, T51.0X1D, T51.0X1S, T51.0X4A, T51.0X4D, T51.0X4S
Frequency/occurrence	Every mental health emergency department visit discharge		

Test, service or procedure to close care opportunity	Medical record dates: 01/01/2024 - 12/31/2024
	• Follow-up care after emergency department visit for mental illness
	• Follow-up for substance use disorder can be any of the following:
	  • Group visits with an appropriate place of service code and diagnosis code
	  • Medication dispensing event with diagnosis code
	  • Medication treatment with diagnosis code
	  • Online assessment with diagnosis code
	  • Stand-alone visits with an appropriate place of service code and diagnosis code
	  • Telephone visit with diagnosis code		

Medical record documentation (including but not limited to)	• Consultation notes • Progress notes Submit medical record documentation to Priority Health HEDIS department • Electronically uploading medical records – contact ***HEDIS@PriorityHealth.com*** to get a file set up or for more information • Email: ***HEDIS@PriorityHealth.com*** • Fax: 616.975.8897 • Mail: HEDIS at 1231 E Beltline, NE Mail Stop 1280, Grand Rapids, MI, 49525		
Tips and Best Practices to Help Close This Care Opportunity ✓ **Review the MiHIN admission, discharge or transfer service report** ✓ Schedule follow-up appointment within seven days of discharge ✓ Encourage the use of telehealth appointments when appropriate ✓ If you need to refer your patient to a behavioral health specialist or need to request coordination of care, please call the Behavioral Health department at **800.673.8043** ✓ **Mental health visits can be accepted as supplemental data**			

Pharmacotherapy for Opiod Use Disorder (POD)

The Pharmacotherapy for Opioid Use Disorder (OUD) measure evaluates patients 16 years of age and older with new opioid use disorder pharmacotherapy events with OUD pharmacotherapy for 180 or more days.

The medications the NCQA lists in the HEDIS specifications are below. This is a general list and should not replace the advice or care you provide your patients regarding what is optimal to meet their healthcare needs.

Product lines	Quality programs affected	Collection and reporting method
• **Commercial** • **Medicaid** • **Medicare**	• NCQA Health Plan Ratings	Administrative • Pharmacy data

Numerator compliance	New OUD pharmacotherapy events with OUD pharmacotherapy for 180 or more days without a gap in treatment of 8 or more consecutive days		
Description	**Medication**		
Antagonist	• Naltrexone (oral)	• Naltrexone (injectable)	
Partial agonist	• Buprenorphine (sublingual tablet) • Buprenorphine/ naloxone (sublingual tablet, buccal film, sublingual film)	• Buprenorphine (implant)	• Buprenorphine (injection)
Agonist	• Methadone (oral)*		
NOTE: Methadone is not included on the medication lists for this measure. Methadone for OUD administered or dispensed by federally certified opioid treatment programs (OTP) is billed on a medical claim. A pharmacy claim for methadone would be indicative of treatment for pain rather than OUD.			
Billing Codes	**Description**	**Code Type**	**Codes**
	Naltrexone injection	HCPCS	G2073, J2315
	Buprenorphine implant	HCPCS	G2070, G2072, J0570
	Buprenorphine injection	HCPCS	G2069, Q9991, Q9992
	Buprenorphine naloxone	HCPCS	J0572, J0573, J0574, J0575
	Buprenorphine oral	HCPCS	H0033, J0571
Test, service or procedure to close care opportunity	Adherence for the POD measure is determined by the patient remaining on their prescribed opioid use disorder treatment medication for at least 180 days after their medication was prescribed		
Medical record documentation	• Consultation notes • Progress notes		

(including but not limited to)	

Tips and best practices:

- ✓ Closely monitor medication prescriptions and don't allow any gap in treatment of 8 or more consecutive days
- ✓ Medication regiment adherence is essential for the patient's treatment
- ✓ Patients with OUD should be informed of the risks and benefits of pharmacotherapy, treatment without medication and no treatment
- ✓ Engage parent/guardians/family/support system and/or significant others in the treatment plan. Advise them about the importance of treatment and attending appointments.
- ✓ Identify and address any barriers to patient keeping appointment
- ✓ Provide reminder calls to confirm appointment
- ✓ Reach out proactively within 24 hours if the patient doesn't keep scheduled appointment to schedule another
- ✓ Care should be coordinated between providers. Encourage communication between the behavioral health providers and PCP.
- ✓ Transitions in care should be coordinated between providers. Ensure that the care transition plans are shared with the PCP.
- ✓ If you need to refer your patient to a behavioral health specialist or need to request coordination of care, please call the Behavioral Health department at **800.673.8043**

Supplemental Data Accepted

Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

The Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications measure evaluates patients 18-64 years of age with schizophrenia, schizoaffective disorder, or bipolar disease who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.

Product lines	Quality programs affected	Collection and reporting method
• **Medicaid**	• NCQA Health Plan Ratings • State Performance Measure	Administrative • Claim data • Pharmacy data

The medications the NCQA lists in the HEDIS specifications are below. This is a general list and shouldn't replace the advice or care you provide your patients regarding what's optimal to meet their healthcare needs. For more information on medications covered by Priority Health, see the Approved Drug List Formulary.

SSD Antipsychotic medications				
	Mischellaneous antipsychotic agents	• Aripiprazole • Asenapine • Brexpiprazole • Cariprazine • Clozapine • Haloperidol	• Iloperidone • Loxapine • Lumateperone • Lurasidone • Molindone	• Olanzapine • Paliperidone • Quetiapine • Risperidone • Ziprasidone
	Phenothiazine antipsychotics	• Chlorpromazine • Fluphenazine	• Perphenazine • Prochlorperazine	• Thioridazine • Trifluoperazine
	Psychotherapeu tic combinations	• Amitriptyline-perphenazine		
	Thioxanthenes	• Thiothixene		
	Long-acting injections	• Aripiprazole • Aripiprazole lauroxil • Fluphenazine decanoate	• Haloperidol decanoate • Olanzapine	• Paliperidone palmitate • Risperidone
Numerator compliance	A glucose test **or** an HbA1c test performed during the measurement year			

Billing codes	**Description**	**Code type**	**Codes**
	HbA1c lab tests	CPT	83036, 83037
		LOINC	17855-8, 17856-6, 4548-4, 4549-2, 96595-4
		SNOWMED	43396009. 313835008
	HcA1c test result or finding	CPT II	3044F, 3046F, 3051F, 3052F
		SNOWMED	165679005, 451061000124104
	Glucose lab tests	CPT	80047, 80048, 80050, 80053, 80069, 82947, 82950, 82951
		LOINC	10450-5, 1492-8, 1494-4, 1496-9, 1499-3,

			1501-6, 1504-0, 1507-3, 1514-9, 1518-0, 1530-5, 1533-9, 1554-5, 1557-8, 1558-6, 17865-7, 20436-2, 20437-0, 20438-8, 20440-4, 26554-6, 41024-1, 49134-0, 6749-6, 9375-7
		SNOWMED	22569008, 33747003, 52302001, 72191006, 73128004, 88856000, 104686004, 167086002, 167087006, 167088001, 167095005, 167096006, 167097002, 250417005, 271061004, 271062006, 271063001, 271064007, 271065008, 275810004, 302788006, 302789003, 308113006, 313474007, 313545000, 313546004, 313624000, 313626003, 313627007, 313628002, 313630000, 313631001, 313697000, 313698005, 313810002, 412928005, 440576000, 443780009, 444008003, 444127006
	Glucose test result or finding	SNOWMED	166890005, 166891009, 166892002, 166914001, 166915000, 166916004, 166917008, 166918003, 166919006, 166921001, 166922008, 166923003, 442545002, 444780001
Frequency/occurrence	Every year		
Exclusions	Patients with a history of diabetes in the measurement year or year prior to the measurement year		
Test, service or procedure to close care opportunity	• Glucose test • HbA1c test		
Medical record documentation (including but not limited to)	• Glucose or HbA1c lab results • Consultation notes with date of test and results • Progress notes with date of test and results Submit medical record documentation to Priority Health HEDIS department • Electronically uploading medical records – contact ***HEDIS@PriorityHealth.com*** to get a file set up or for more information • Email: ***HEDIS@PriorityHealth.com*** • Fax: 616.975.8897 • Mail: HEDIS at 1231 E Beltline, NE Mail Stop 1280, Grand Rapids, MI, 49525		
Claim submission deficiencies	Not submitting CPT II codes		

Tips and best practices:

- ✓ A good time to schedule or address SSD is during a well visit or annual wellness visit. This is the perfect time to close out all preventive health and mental health care opportunities.
- ✓ If possible, provide point-of-care testing in your office to reduce missed laboratory opportunities
- ✓ Order HbA1c for diabetic patients and record the value
- ✓ If the HbA1c is performed in the office, bill the appropriate CPT II code to report the lab results
- ✓ Always list the date of service, result and test together

- ✓ If test result(s) are documented in the vitals section of your progress notes, include the date of the blood draw with the result
- ✓ When managing patients with schizophrenia or bipolar disorder, consider:
  - ❖ The normal range and goal for the diabetes screening test
  - ❖ Utilizing practice workflows
  - ❖ Empowering patients with the appropriate tools
  - ❖ Making non-pharmacologic therapy a core to your care planning
  - ❖ Listening to your patient's experience
  - ❖ Evaluating barriers such as social determinants of health
- ✓ Use EHR/EMR alerts for patients due for a glucose or HbA1c test or if the previous test was greater than 8.0%
- ✓ Make sure the medical record contains the contact information of all the patient's current providers for follow-up and care coordination
- ✓ **Glucose and HbA1c test results can be accepted as supplemental data**

Supplemental Data Accepted

Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)

The Diabetes Monitoring for People with Diabetes and Schizophrenia measure evaluates patients 18-64 years of age with schizophrenia or schizoaffective disorder and diabetes who had both a hemoglobin, glycosylated (HbA1c) test and a low-density lipoprotein cholesterol (LDL-C) test during the measurement year.

Product Lines	Quality programs affected	Collection and reporting method
• **Medicaid**		Administrative • Claim data

Numerator compliance	An HbA1c test **and** an LDL-C test		
Billing codes	**Description**	**Code type**	**Codes**
	HbA1c lab test	**CPT**	83036, 83037
		LOINC	17855-8, 17856-6, 4548-4, 4549-2, 96595-4
		SNOWMED	43396009, 313835008
	HbA1c test result or finding	**CPT II**	3044F, 3046F, 3051F, 3052F
		SNOWMED	165679005, 451061000124104
	LDL-C lab test	**CPT**	80061, 83700, 83701, 83704, 83721
		LOINC	2089-1,12773-8, 13457-7, 18261-8, 18262-6, 49132-4 55440-2, 96259-7
		SNOWMED	113079009, 166833005 166840006, 166841005 167074000, 167075004 314036004
	LDL-C lab result or finding	**CPT II**	3048F, 3049F, 3050F
Frequency/occurrence	Every year		
Test, service or procedure to close care opportunity	• HbA1c test and results • LDL-C test and results		
Medical record documentation (including but not limited to)	Medical record dates: 01/01/2024 - 12/31/2024 • Lab reports Submit medical record documentation to Priority Health HEDIS department • Electronically uploading medical records – contact ***HEDIS@PriorityHealth.com*** to get a file set up or for more information		

	• Email: ***HEDIS@PriorityHealth.com*** • Fax: 616.975.8897 • Mail: HEDIS at 1231 E Beltline, NE Mail Stop 1280, Grand Rapids, MI, 49525
Common chart deficiencies	• No HbA1c test for measurement year • No LDL-C test for measurement year
Claim submission deficiencies	• Not submitting CPT® II codes to report A1c and LDL-C test results

Tips and best practices:

- ✓ **Check your Gaps in Care Report to identify your patients with open care opportunities**
- ✓ Order HbA1c and LDL-C test for patients and record the date of service and value together
- ✓ If possible, provide point-of-care testing in your office to reduce missed laboratory opportunities.
- ✓ If the HbA1c and LDL-C tests are performed in the office, bill the appropriate CPT II code to report the results
- ✓ **HbA1c and lipid profile test results can be accepted as supplemental data**

Supplemental Data Accepted

Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)

The Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia measure evaluates patients 18-64 years of age with schizophrenia or schizoaffective disorder and cardiovascular disease who had a low-density lipoprotein cholesterol (LDL-C) test during the measurement year.

Product lines	Quality programs affected	Collection and reporting method
• **Medicaid**		Administrative • Claim data

Numerator compliance	An LDL-C test performed during the measurement year		
Billing codes	**Description**	**Code type**	**Codes**
	LDL-C lab tests	CPT	80061, 83700, 83701, 83704, 83721
		LOINC	2089-1,12773-8, 13457-7, 18261-8, 18262-6, 49132-4, 55440-2, 96259-7
		SNOWMED	113079009, 166833005, 166840006, 166841005, 167074000, 167075004, 314036004
	LDL-C test result	CPT	3048F, 3049F, 3050F
Frequency/occurrence	Every year		
Test, service or procedure to close care opportunity	Glucose test (LDL-C)		
Medical record documentation (including but not limited to)	• Glucose (LDL-C) lab results • Consultation notes with date of test and results • Progress notes with date of test and results Submit medical record documentation to Priority Health HEDIS department • Electronically uploading medical records – contact ***HEDIS@PriorityHealth.com*** to get a file set up or for more information • Email: ***HEDIS@PriorityHealth.com*** • Fax: 616.975.8897 • Mail: HEDIS at 1231 E Beltline, NE Mail Stop 1280, Grand Rapids, MI, 49525		
Common chart deficiencies	No LDL-C lab report for the measurement year		
Claim submission deficiencies	Not submitting CPT II codes		

Tips and best practices:
- ✓ Schedule an annual LDL-C screening
- ✓ Use CPT II codes to report clinical outcomes such as limit profile and LDL-C test results

- ✓ Use EHR/EMR alerts for patients due for an LDL-test
- ✓ **Lipid profiles and results can be accepted as supplemental data**

Supplemental Data Accepted

Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)

The Adherence to Antipsychotic Medications for Individuals with Schizophrenia measure evaluates patients aged 18 years and older with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80% of the treatment period during the measurement year.

Product lines	Quality programs affected	Collection and reporting method
• **Commercial** • **Medicaid** • **Medicare**	• NCQA Health Plan Ratings	Administrative • Claim data • Pharmacy data

Numerator compliance	Patients who achieved a PDC of at least 80% for their antipsychotic medications during the measurement year		
To comply with this measure, a patient must have remained on one of the following antipsychotic medications for at least 80% of the treatment period.			
Oral antipsychotic medications			
Drug Category	**Medications**		
Miscellaneous antipsychotic agents (oral)	• Aripiprazole • Asenapine • Brexpiprazole • Cariprazine • Clozapine	• 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			
Long-acting injections 14-day supply	• Risperidone (excluding Perseris®)		
Long-acting injections 28-day supply	• Aripiprazole • Aripiprazole lauroxil	• Fluphenazine decanoate • Haloperidol decanoate	• Olanzapine • Paliperidone palmitate
Long-acting injections 30-day supply	• Risperidone (Perseris®)		
Required exclusions	Diagnosis of dementia any time during the measurement year		
Test, service or procedure to close care opportunity	• A filled prescription of one of the medications listed above with at least 80% adherence		
Tips and best practices:			

✓ Encourage patients to take medications as prescribed
✓ Offer tips to patients such as:
  – Take medication at the same time each day
  – Use a pill box
  – Enroll in a pharmacy automatic-refill program

Electronic Clinical Data Systems (ECDS) Measures

Electronic clinical data systems (ECDS) are the network of data containing a plan member's personal health information and records of their experiences within the health care system. They may also support other care-related activities directly or indirectly, including evidence-based decision support, quality management and outcome reporting. Data in these systems are structured such that automated quality measurement queries can be consistently and reliably executed.

The ECDS reporting standard represents a step forward in adapting HEDIS to accommodate the expansive information available in electronic clinical datasets used for patient care and quality improvement.

HEDIS quality measures reported using ECDS is a secure sharing of patient medical information electronically between systems. Measures that leverage clinical data captured routinely during the care delivery can reduce the burden on providers to collect data for quality reporting. Helpful tips:

- Contact the HEDIS department to establish an electronic data transfer with the plan if your organization does not have one already
- Make full use of CPT II codes to submit care quality findings, many HEDIS gaps could be closed via claims if CPT II codes were fully utilized
- Ensure the HER/EMR systems are set up to link the clinical and behavior health entries to LOINC codes and SNOMED codes
    - Ensure that the extracts are inclusive of LOINC codes for behavioral health screenings among other things and SNOMED codes

Types of ECDS data

Data sources are categorized using the following criteria:

EHR/PHR	EHRs and PHRs are transactional systems that store clinically relevant information collected directly from or managed by a patient. An EHR contains the medical and treatment histories of patients; a PHR includes both the standard clinical data collected in a provider's office or another care setting, in addition to information curated directly in the PHR by the patient though an application programming interface (API). This data category includes biometric information and clinical samples obtained directly from a patient as well as clinical findings resulting from samples collected from a patient (e.g., pathology, laboratory and pharmacy records generated from entities not directly connected to the patient's EHR).
HIE / clinical registry	HIEs and clinical registries eligible for this reporting category include state HIEs, IIS, public health agency systems, regional HIEs (RHIO), Patient-Centered Data

	Homes™ or other registries developed for research or to support quality improvement and patient safety initiatives. Doctors, nurses, pharmacists, other health care providers and patients can use HIEs to access and share vital medical information, with the goal of creating a complete patient record. HIEs used for ECDS reporting must use standard protocols to ensure security, privacy, data integrity, sender and receiver authentication and confirmation of delivery. Clinical registries collect information about people with a specific disease or condition, or patients who may be willing to participate in research about a disease. Registries can be sponsored by a government agency, nonprofit organization, health care facility or private company, and decisions regarding use of the data in the registry are the responsibility of the registry's governing committee.
Case management system	A shared database of member information collected through a collaborative process of member assessment, care planning, care coordination or monitoring of a member's functional status and care experience. Case management systems eligible for this category of ECDS reporting include any system developed to support the organization's case/disease management activities, including activities performed by delegates.
Administrative	Includes data from administrative claims processing systems for all services incurred (paid, suspended, pending and denied) during the period defined by each measure's participation as well as member management files, member eligibility and enrollment files, electronic member rosters, internal audit files, and member call service databases.

[1] https://www.healthit.gov/providers-professionals/health-information-exchange/what-hie

[2] https://www.nih.gov/health-information/nih-clinical-research-trials-you/list-registries

Supplemental Data Accepted

Childhood Immunization Status (CIS-E)

The Childhood Immunization Status measure evaluates children turning two years during the measurement year who had received the following immunizations on or before their second birthday:

Four diphtheria, tetanus, and acellular pertussis (DTaP)	Three polio (IPV)
One measles, mumps, and rubella (MMR)	Three hepatitis B (HepB)
Three haemophilus influenza type B (HiB)	One varicella zoster (VZV)
Four pneumococcal conjugate (PCV)	One hepatitis A (HepA)
Two or three rotavirus (RV)	Two influenza (flu)

CIS assesses receipt of these ACIP-recommended vaccines by the second birthday and includes a rate for each type of vaccine and the following combination rates:

CIS Combination	DTaP	IPV	MMR	HiB	HepB	VZV	PCV	HepA	RV	Influenza
Combination 3	✓	✓	✓	✓	✓	✓	✓			
Combination 7	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Combination 10	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Product lines	Quality programs affected	Collection and reporting method
• **Commercial** • **Medicaid**	• State Performance Measure (combination 3 only)	Hybrid • Claim data • Medical record review

Immunization billing codes

DTaP **Number of Doses: 4** **Special Circumstances:** Don't count dose administered from birth through 42 days	
CPT	90697, 90698, 90700, 90723
CVX	20, 50, 106, 107, 110, 120, 146
SNOWMED	310306005, 310307001, 310308006, 312870000, 313383003, 390846000, 390865008, 399014008, 412755006, 412756007, 412757003, 412762002, 412763007, 412764001, 414001002, 414259000, 414620004, 415507003, 415712004, 770608009, 770616000, 770617009, 770618004, 787436003, 866158005, 866159002, 866226006, 868273007, 868274001, 868276004, 868277008, 1162640003, 428251000124104, 571571000119105, 572561000119108, 16290681000119103

Polio **Number of Doses: 3** **Special Circumstances:** Don't count dose administered from birth through 42 days	
CPT	90697, 90698, 90713, 90723

CVX	10, 89, 110, 120, 146
SNOWMED	310306005, 310307001, 310308006, 312869001, 312870000, 313383003, 390865008, 396456003, 412762002, 412763007, 412764001, 414001002, 414259000, 414619005, 414620004, 415507003, 415712004, 416144004, 416591003, 417211006, 417384007, 417615007, 866186002, 866227002, 868266002, 868267006, 868268001, 868273007, 868274001, 868276004, 868277008, 870670004, 572561000119108, 16290681000119103

MMR **Number of Doses: 1** **Special Circumstances:** Vaccine must be administered on or between a child's first and second birthdays	
CPT	90707, 90710
CVX	03, 94
SNOWMED	38598009, 170431005, 170432003, 170433008, 432636005, 433733003, 871909005, 571591000119106, 572511000119105
History of Measles	
ICD-10 Diagnosis	B05.0, B05.1, B05.2, B05.3, B05.4, B05.81, B05.89, B05.9
SNOWMED	14189004, 28463004, 38921001, 60013002, 74918002, 111873003, 161419000, 186561002, 186562009, 195900001, 240483006, 240484000, 359686005, 371111005, 406592004, 417145006, 424306000, 105841000119101
History of Mumps	
ICD-10 Diagnosis	B26.0, B26.1, B26.2, B26.3, B26.81, B26.82, B26.83, B26.84, B26.85, B26.89, B26.9
SNOWMED	10665004, 17121006, 31524007, 31646008, 36989005, 40099009, 44201003, 63462008, 72071001, 74717002, 75548002, 78580004, 89231008, 89764009, 111870000, 161420006, 235123001, 236771002, 237443002, 240526004, 240527008, 240529006, 371112003. 1163539003, 105821000119107
History of Rubella	
ICD-10 Diagnosis	B06.00, B06.01, B06.02, B06.09, B06.81, B06.82, B06.89, B06.9
SNOWMED	10082001, 13225007, 19431000, 36653000, 51490003, 64190005, 79303006, 128191000, 161421005, 165792000, 186567003, 186570004, 192689006, 231985001, 232312000, 240485004, 253227001, 406112006, 406113001, 1092361000119109, 10759761000119100

Hep B **Number of Doses: 3**	
CPT	90697, 90723, 90740, 90744, 90747, 90748
HCPCS	G0010
CVX	08, 44, 45, 51, 110, 146
SNOWMED	16584000, 170370000, 170371001, 170372008, 170373003, 170374009, 170375005, 170434002, 170435001, 170436000, 170437009, 312868009, 396456003, 416923003, 770608009, 770616000, 770617009, 770618004, 786846001, 1162640003, 572561000119108
History of Hepatitis B	
ICD-10 Diagnosis	B16.0, B16.1, B16.2, B16.9, B17.0, B18.0, B18.1, B19.10, B19.11
SNOWMED	1116000, 13265006, 26206000, 38662009, 50167007, 53425008, 60498001,

	61977001, 66071002, 76795007, 111891008, 165806002, 186624004, 186626002, 186639003, 235864009, 235865005, 235869004, 235871004, 271511000, 313234004, 406117000, 424099008, 424340000, 442134007, 442374005, 446698005, 838380002, 153091000119109, 551621000124109

Hib **Number of Doses: 3** **Special Circumstances:** Don't count dose administered from birth through 42 days	
CPT	90644, 90647, 90648, 90697, 90698, 90748
CVX	17, 46, 47, 48, 49, 50, 51, 120, 146, 148
SNOWMED	127787002, 170343007, 170344001, 170345000, 170346004, 310306005, 310307001, 310308006, 312869001, 312870000, 313383003, 414001002, 414259000, 415507003, 415712004, 428975001, 712833000, 712834006, 770608009, 770616000, 770617009, 770618004, 786846001, 787436003, 1119364007, 1162640003, 16292241000119109

Varicella (VZV) **Number of Doses: 1** **Special Circumstances:** Vaccine must be administered on or between a child's first and second birthdays	
CPT	90710, 90716
CVX	21, 94
SNOWMED	425897001, 428502009, 432636005, 433733003, 737081007, 871898007, 871899004, 871909005, 572511000119105
History of Varicella Zoster	
ICD-10 Diagnosis	B01.0, B01.11, B01.12, B01.2, B01.81, B01.89, B01.9, B02.0, B02.1, B02.21, B02.22, B02.23, B02.24, B02.29, B02.30, B02.31, B02.32, B02.33, B02.34, B02.39, B02.7, B02.7, B02.9
SNOWMED	4740000, 10698009, 21954000, 23737006, 24059009, 36292003, 38907003, 42448002, 49183009, 55560002, 87513003, 111859007, 111861003, 161423008, 186524006, 186525007, 195911009, 230176008, 230198004, 230262004, 230536009, 232400003, 235059009, 240468001, 240470005, 240471009, 240472002, 240473007, 240474001, 309465005, 371113008, 397573005, 400020001, 402897003, 402898008, 402899000, 410500004, 410509003, 421029004, 422127002, 422446008, 422471006, 422666006, 423333008, 423628002, 424353002, 424435009, 424801004, 424941009, 425356002, 426570007, 428633000, 713250002, 713733003, 713964006, 715223009, 723109003, 838357005, 1163465001, 1163483009, 1179456002, 12551000132107, 12561000132105, 12571000132104, 98541000119101, 331071000119101, 681221000119108, 1087131000119102, 15678761000119105, 15678801000119102, 15678841000119100, 15680201000119106, 15680241000119108, 15680281000119103, 15685081000119102, 15685121000119100, 15685201000119100, 15685281000119108, 15936581000119108, 15936621000119108, 15989271000119107, 15989311000119107, 15989351000119108, 15991711000119108, 15991751000119109, 15991791000119104, 15992351000119104, 16000751000119105, 16000791000119100, 16000831000119106

Pneumococcal Conjugate (PCV) **Number of Doses: 4** **Special Circumstances:** Don't count dose administered from birth through 42 days	
CPT	90670
HCPCS	G0009
CVX	109, 133, 152
SNOWMED	1119368005, 434751000124102

Hep A **Number of Doses: 1** **Special Circumstances:** Vaccine must be administered on or between a child's first and second birthdays	
CPT	90633
CVX	31, 83, 85
SNOWMED	170378007, 170379004, 170380001, 170381002, 170434002, 170435001, 170436000, 170437009, 243789007, 312868009, 314177003, 314178008, 314179000, 394691002, 871752004, 871753009, 871754003, 571511000119102
History of Hepatitis A	
ICD-10 Diagnosis	B15.0, B15.9
SNOWMED	16060001, 18917003, 25102003, 40468003, 43634002, 79031007, 111879004, 165997004, 206373002, 278971009, 310875001, 424758008, 428030001, 105801000119103

Rotavirus **Number of Doses: 2 or 3** **Special Circumstances:** Vaccine must be administered on or between a child's first and second birthdays	
2 Dose Vaccine	
CPT	90681
CVX	119
SNOWMED	434741000124104
3 Dose Vaccine	
CPT	90680
CVX	116, 122
SNOWMED	434731000124109

Influenza **Number of Doses: 2** **Special Circumstances:** Don't count dose administered prior to age 6 months	
CPT	90655, 90657, 90661, 90673, 90674, 90685, 90686, 90687, 90688, 90689, 90756
HCPCS	G0008
CVX	88, 140, 141, 150, 153, 155, 158, 161, 171, 186
SNOWMED	86198006

Live Addenuated Influenza Virus (LAIV) **Number of Doses: 2** **Special Circumstances:** • Must be administered on the second birthday • Only 1 of the 2 required vaccinations can be LAIV	
CPT	90660, 90672
CVX	111, 149
SNOWMED	78706008

Anaphylaxis billing codes	**Description**	**Code type**	**Code**
	Anaphylaxis due to Hepatitis B vaccine (disorder)	SNOWMED	428321000124101
	Anaphylaxis due to rotavirus vaccine (disorder)	SNOWMED	428331000124103
	Anaphylaxis due to Haemophilus influenzae type b vaccine (disorder)	SNOWMED	
	Anaphylaxis caused by vaccine product containing Streptococcus pneumoniae antigen (disorder)	SNOWMED	471141000124102
	Anaphylaxis caused by vaccine product containing Hepatitis A virus antigen (disorder)	SNOWMED	471311000124103
	Anaphylaxis caused by vaccine product containing human poliovirus antigen (disorder)	SNOWMED	471321000124106
	Anaphylaxis caused by vaccine product containing Measles morbillivirus and Mumps orthobulavirus and Rubella virus antigens (disorder)	SNOWMED	471331000124109
	Anaphylaxis caused by vaccine containing Human alphaherpesvirus 3 antigen (disorder)	SNOWMED	471341000124104
	Anaphylaxis caused by vaccine product containing Influenza virus antigen (disorder)	SNOWMED	471361000124100

Required exclusions	Any vaccine	Anaphylactic reaction to the vaccine or its components
	DTaP	Encephalopathy <u>with</u> a vaccine adverse-effect code
	Hepatitis B	Anaphylactic reaction to common baker's yeast
	IPV	Anaphylactic reaction to streptomycin, polymyxin B or neomycin
	MMR, VZV and Influenza	• Immunodeficiency • HIV

<table>
<tr><td rowspan="2"></td><td></td><td>• Lymphoreticular cancer, multiple myeloma, or leukemia
• Anaphylactic reaction to neomycin</td></tr>
<tr><td>Rotavirus</td><td>• History of intussusception
• Severe combined immunodeficiency</td></tr>
<tr><td></td><td>History of</td><td>• Hepatitis A
• Hepatitis B
• Measles
• Mumps
• Rubella
• Varicella Zoster</td></tr>
<tr><td>Test, service or procedure to close care opportunity</td><td colspan="2">• An immunization record or document that includes the name of the specific antigen <u>and</u> the date the vaccine was administered
• For Hep A, Hep B, MMR and VZV, documented history of the illness counts as a numerator event and must occur on or before the child’s second birthday
• Provide documentation of contraindication to immunization or parental refusal if applicable
❖ Parental refusal of vaccinations doesn’t remove an eligible patient from the denominator</td></tr>
<tr><td>Medical record documentation (including but not limited to)</td><td colspan="2">Medical record dates: 01/01/2022 – 12/31/2024
• Immunization record
• Progress notes with documented immunizations given
• Problem list with illnesses dated

Submit medical record documentation to Priority Health HEDIS department
• Electronically uploading medical records – please contact
• HEDIS@PriorityHealth.com to get a file set up or for more information
• Email: HEDIS@PriorityHealth.com
• Fax: 616.975.8897
• Mail: HEDIS at 1231 E Beltline, NE Mail Stop 1280, Grand Rapids, MI, 49525</td></tr>
<tr><td>Common chart deficiencies</td><td colspan="2">Immunization records not obtained from previous primary care providers</td></tr>
<tr><td colspan="3">Tips and best practices:
✓ Check your Gaps in Care Report to identify your patients with open care opportunities
✓ Review immunization record before every visit (preventive and sick) and administer needed vaccines
✓ If applicable, give immunizations during a sick visit if the child’s immunizations are behind
✓ Recommend immunizations to parents. Parents are more likely to agree with vaccinations when supported by the provider. Address common misconceptions and concerns about vaccinations.
✓ Annual influenza vaccinations two between 6 months and 2 years of age are an important part of the recommended childhood vaccination series
✓ Schedule appointments for your patient’s next vaccination before they leave your office
✓ Remind parents the importance of keeping immunizations on track
✓ Use phone calls, emails, text messages and/or postcards/letters to help keep parents engaged</td></tr>
</table>

- ✓ Offer options such as nurse visits for immunizations only, extended hours, walk-in or drive-up vaccination clinics
- ✓ Make sure all immunizations are recorded in the Michigan Care Improvement Registry (MCIR)
- ✓ For Hep A, Hep B, MMR or VZV, documented history of the illness counts as numerator compliance events – but they must occur on or before a child's second birthday
- ✓ For Rotavirus, Hep A, Hep B, HIB and DTAP, documented history of anaphylaxis due to the vaccine count as numerators compliance
- ✓ Documentation that a member is up to date with all immunizations but doesn't include a list of the immunizations and dates they were administered, will not meet compliance.
- ✓ **Immunization records can be accepted as supplemental data**

Immunizations for Adolescents (IMA-E)

The Immunizations for Adolescents measure evaluates children turning thirteen years of age during the measurement year who had received the following immunizations on or before their thirteenth birthday:

- One diphtheria, toxoids, and acellular pertussis (Tdap)
- One meningococcal vaccine
- Twp human papillomavirus (HPV)

Product lines	Quality programs affected	Collection and reporting method
• **Commercial** • **Medicaid**	• NCQA Health Plan Ratings	Hybrid • Claim data • Medical record review

Immunization billing codes

Tdap **Number of Doses: 1** **Special Circumstances:** Vaccine must be administered between on or between the 10th and 13th birthday	
CPT	90715
CVX	115
SNOWMED	390846000, 412755006, 412756007, 412757003, 428251000124104, 571571000119105

Meningococcal **Number of Doses: 1** **Special Circumstances:** Vaccine must be administered between on or between the 11th and 13th birthday	
CPT	90619, 90733, 90734
CVX	32, 108, 114, 136, 147, 167, 203
SNOWMED	871874000, 428271000124109, 16298691000119102

HPV **Number of Doses: 2** **Special Circumstances:** Vaccine must be administered between on or between the 9th and 13th birthday	
CPT	90649, 90650, 90651
CVX	62, 118, 137, 165
SNOWMED	428741008, 428931000, 429396009, 717953009, 724332002, 734152003, 761841000

Exclusions	• Anaphylactic reaction to the vaccine or its components • Anaphylactic reaction to vaccine serum • Encephalopathy with a vaccine adverse-effect code
Test, service or procedure to close care opportunity	• An immunization record or document that includes the **name of the specific antigen and the date** the vaccine was administered • Provide documentation of contraindication to immunization or parental refusal if applicable
Medical record documentation (including but not limited to)	Medical record dates: 1/01/2022 – 12/31/2024 • Health history and physical • Immunization record • Progress notes with documented immunizations given • If applicable, provide documentation of contraindication to immunization • Documentation of parental refusal ➢ Parental refusal of vaccinations does not remove an eligible patient from the denominator Submit medical record documentation to Priority Health HEDIS department • Electronically uploading medical records – contact ***HEDIS@PriorityHealth.com*** to get a file set up or for more information • Email: ***HEDIS@PriorityHealth.com*** • Fax: 616.975.8897 • Mail: HEDIS at 1231 E Beltline, NE Mail Stop 1280, Grand Rapids, MI, 49525
Common chart deficiencies	Immunization records not obtained from previous primary care providers

Tips and best practices:

- ✓ **Check your Gaps in Care Report to identify your patients with open care opportunities**
- ✓ Review immunization record before every visit (preventive and sick) and administer needed vaccines
- ✓ Recommend immunizations to parents. Parents are more likely to agree with vaccinations when supported by the provider. Address common misconceptions and concerns about vaccinations.
- ✓ If applicable, give immunizations during a sick visit if the patient's immunizations are behind
- ✓ Schedule appointments for your patient's next vaccination before they leave your office
- ✓ Remind parents the importance of keeping immunizations on track
- ✓ Use phone calls, emails, text messages and/or postcards/letters to help keep parents engaged
- ✓ Offer options such as nurse visits for immunizations only, extended hours, walk-in vaccination clinics or drive-up immunization sites
- ✓ Make sure all immunizations are recorded in the Michigan Care Improvement Registry (MCIR)
- ✓ **Immunization records can be accepted as supplemental data**

Breast Cancer Screening (BCS-E)

The Breast Cancer Screening measure evaluates women 50-74 years of age who had a mammogram screening between October 1 two years prior to the measurement year through December 31 of the measurement year.

Product lines	Quality programs affected	Collection and reporting method
• **Commercial** • **Medicaid** • **Medicare**	• CMS Star Ratings	Administrative • Claim data

Billing Codes	Description	Code type	Codes
	Absence of Left Breast	**ICD10 Diagnosis**	Z90.12
		SNOMED	429009003, 137671000119105
	Absence of Right Breast	**ICD10 Diagnosis**	Z90.11
		SNOWMED	429242008, 137681000119108
	Bilateral Mastectomy	**SNOWMED**	14693006, 14714006, 17086001, 22418005, 27865001, 52314009, 60633004, 76468001, 456903003, 726636007,836436008, 870629001
	History of Bilateral Mastectomy	**ICD10 Diagnosis**	Z90.13
		SNOWMED	428529004, 136071000119101
	Clinical Unilateral Mastectomy	**SNOWMED**	66398006, 70183006, 172043006, 237367009, 237368004, 274957008, 287653007, 287654001, 318190001, 359728003, 359731002, 359734005, 359740003, 384723003, 395702000, 406505007, 428564008, 446109005, 446420001, 447135002, 447421006
	Mammography	**CPT**	77061, 77062, 77063, 77065, 77066, 77067
		LOINC	24604-1, 24605-8, 24606-6, 24610-8, 26175-0, 26176-8, 26177-6, 26287-3, 26289-9, 26291-5, 26346-7, 26347-5, 26348-3, 26349-1, 26350-9, 26351-7, 36319-2, 36625-2, 36626-0, 36627-8, 36642-7, 36962-9, 37005-6, 37006-4, 37016-3, 37017-1, 37028-8, 37029-6, 37030-4, 37037-9, 37038-7, 37052-8, 37053-6, 37539-4, 37542-8, 37543-6, 37551-9, 37552-7, 37553-5, 37554-3, 37768-9, 37769-7, 37770-5, 37771-3, 37772-1, 37773-9, 37774-7,

			37775-4, 38070-9, 38071-7, 38072-5, 38090-7, 38091-5, 38807-4, 38820-7, 38854-6, 38855-3, 39150-8, 39152-4, 39153-2, 39154-0, 42168-5, 42169-3, 42174-3, 42415-0, 42416-8, 46335-6, 46336-4, 46337-2, 46338-0, 46339-8, 46342-2, 46350-5, 46351-3, 46354-7, 46355-4, 46356-2, 46380-2, 48475-8, 48492-3, 69150-1, 69251-7, 69259-0, 72137-3, 72138-1, 72139-9, 72140-7, 72141-5, 72142-3, 86462-9, 86463-7, 91517-3, 91518-1, 91519-9, 91520-7, 91521-5, 91522-3
		SNOWMED	12389009, 24623002, 43204002, 71651007, 241055006, 241057003, 241058008, 258172002, 439324009, 450566007, 709657006, 723778004, 723779007, 723780005, 726551006, 833310007, 866234000, 866235004, 866236003, 866237007, 384151000119104, 392521000119107, 392531000119105, 566571000119105, 572701000119102
	Unilateral Mastectomy	**CPT**	19180, 19200, 19220, 19240, 19303, 19304, 19305, 19306, 19307
	Unilateral Mastectomy Left	**SNOWMED**	428571003, 726429001, 726435001, 726437009, 741009001, 741018004, 836437004, 451211000124109
	Unilateral Mastectomy Right	**SNOWMED**	429400009, 726430006, 726434002, 726436000, 741010006, 741019007, 836435007, 451201000124106
Frequency/occurrence	Every 2 years		
Required exclusions	• Unilateral mastectomy on both the left and right side • History of bilateral mastectomy		
Test, service or procedure to close care opportunity	• Mammography screening or digital breast tomosynthesis • History of unilateral mastectomy with documentation of mastectomy ofopposite side with date (month/year) any time in a patient's history • History of a bilateral mastectomy (month/year) any time in a patient's history		
Medical record documentation (including but not limited to)	Medical record dates: 10/01/2021 – 12/31/2024 • Consultation reports • Diagnostic reports • Health history and physical Submit medical record documentation to Priority Health HEDIS department • Electronically uploading medical records –contact		

	HEDIS@PriorityHealth.com to get a file set up or for more information • Email: **HEDIS@PriorityHealth.com** • Fax: 616.975.8897 • Mail: HEDIS at 1231 E Beltline, NE Mail Stop 1280, Grand Rapids, MI, 49525

Tips and best practices:

- ✓ **Check your Gaps in Care Report to identify your patients with open care opportunities**
- ✓ Educate patients about the importance of early detection and encourage testing during preventive and sick visits
- ✓ Don't miss the opportunity to schedule a mammogram for the patient while at the office visit
- ✓ Share a list of nearby contracted imaging/mammography centers
- ✓ Document mammograms in patient history with date and findings
- ✓ Document a bilateral or unilateral mastectomy history with date (month/year) in the medical record
- ✓ As an administrative measure, it's important to submit the appropriate ICD-10 diagnosis code that reflects a patient's history of bilateral mastectomy – Z90.13 or absence of right or left breast – Z90.11, Z90.12 respectively
- ✓ Use EMR alerts for patients due for a mammogram
- ✓ Follow up with patients who have overdue mammogram referral orders and help resolve their barriers to getting screened
- ✓ Submit data in a timely manner

Supplemental Data Accepted

Cervical Cancer Screening (CCS-E)

The Cervical Cancer Screening measure evaluates women 21-64 years of age who had a cervical cancer screening using either of the following criteria:

- Women 21-64 years of age who had a cervical cytology performed in the measurement year or two years prior
- Women 30-64 years of age who had a cervical cytology/high risk papillomavirus (hrHPV) co-testing performed in the measurement year or four years prior
- Women 30-64 years of age who had a cervical high-risk human papillomavirus (hrHPV) testing performed in the measurement year or four years prior

Product lines	Quality programs affected	Collection and reporting method
• **Commercial** • **Medicaid**	• NCQA Health Plan Ratings	Administrative • Claim data • ECDS Hybrid • Claim data • Medical record review

Numerator compliance	**Women who were screened for cervical cancer**		
Billing codes	**Description**	**Code type**	**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
		LOINC	10524-7, 18500-9, 19762-4, 19764-0, 19765-7, 19766-5, 19774-9, 33717-0, 47527-7, 47528-5
		SNOWMED	171149006, 416107004, 417036008, 440623000, 448651000124104
	Cervical cytology result or finding	**SNOWMED**	168406009, 168407000, 168408005, 168410007, 168414003, 168415002, 168416001, 168424006, 250538001, 268543007, 269957009, 269958004, 269959007, 269960002, 269961003, 269963000, 275805003, 281101005, 309081009, 310841002, 310842009, 416030007, 416032004, 416033009, 439074000, 439776006, 439888000, 441087007, 441088002, 441094005, 441219009, 441667007, 700399008,

			700400001, 1155766001, 62051000119105, 62061000119107, 98791000119102
	High risk HPV test	**CPT**	87624, 87625
		HCPCS	G0476
		LOINC	21440-3, 30167-1, 38372-9, 59263-4, 59264-2, 59420-0, 69002-4, 71431-1, 75694-0, 77379-6, 77399-4, 77400-0, 82354-2, 82456-5, 82675-0, 95539-3
		SNOWMED	35904009, 448651000124104
	Cytology examination positive for high-risk human papillomavirus (finding)	**SNOWMED**	718591004
	Absence of cervix diagnosis	**ICD-10 Diagnosis**	Q51.5, Z90.710, Z90.712
		SNOWMED	37687000, 248911005, 428078001, 429290001, 429763009, 473171009, 723171001, 10738891000119107
	Hysterectomy with no residual cervix	**CPT**	57530, 57531, 57540, 57545, 57550, 57555, 57556, 58150, 58152, 58200, 58210, 58240, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290, 58291, 58292, 58293, 58294, 58548, 58550, 58552, 58553, 58554, 58570, 58571, 58572, 58573, 58575, 58951, 58953, 58954, 58956, 59135
		IDC10PCS	0UTC0ZZ, 0UTC4ZZ, 0UTC7ZZ, 0UTC8ZZ
		SNOWMED	24293001, 27950001, 31545000, 35955002, 41566006, 46226009 59750000, 82418001, 86477000 88144003, 116140006, 116142003, 116143008, 116144002, 176697007, 236888001, 236891001, 287924009, 307771009, 361222003, 361223008, 387626007, 414575003, 440383008, 446446002, 446679008, 708877008, 708878003, 739671004, 739672006, 739673001, 739674007, 740514001, 740515000, 767610009, 767611008, 767612001, 1163275000
Frequency/occurrence	• Cervical cytology – every three years • hrHPV – every five years • Cervical cytology and hrHPV co-testing – every five years		
Required exclusions	• History of hysterectomy with no residual cervix		

	• History of acquired absence of cervix any time in a patient's history • History of cervical agenesis
Test, service or procedure to close care opportunity	• Cervical pap and results or finding for women 21–64 years of age • HPV testing for women 30–64 years of age • Provide documentation of history of hysterectomy with no residual cervix (complete hysterectomy, radical hysterectomy, total hysterectomy, vaginal hysterectomy)
Medical record documentation (including but not limited to)	Medical record dates: 01/01/2022 – 12/31/2024 for pap 01/01/2020 – 12/31/2024 for HPV • Consultation reports with results • Diagnostic reports with results • Lab reports with results • Health history and physical Submit medical record documentation to Priority Health HEDIS department • Electronically uploading medical records – contact ***HEDIS@PriorityHealth.com*** to get a file set up or for more information • Email: ***HEDIS@PriorityHealth.com*** • Fax: 616.975.8897 • Mail: HEDIS at 1231 E Beltline, NE Mail Stop 1280, Grand Rapids, MI 49525
Common chart deficiencies	• Documentation of hysterectomy alone does not meet criteria for exclusion ❖ Documentation must include the words "total", "complete" or "radical" abdominal or vaginal hysterectomy ❖ Documentation of a "vaginal pap smear" with documentation of "hysterectomy"

Tips and best practices:

- ✓ **Check your Gaps in Care Report to identify your patients with open care opportunities**
- ✓ Educate patients about the importance of screenings and early detection and encourage screening during preventive and sick visits
- ✓ Discuss existing barriers to regular cervical cancer screening
- ✓ Request to have results of pap tests sent to you if screening was performed by an OB/GYN or another provider
- ✓ Patient-reported information documented in the patient's medical record is acceptable if there is a date and result of the test or a date of the hysterectomy and acceptable documentation of no residual cervix. The patient reported information must be documented in the patient's chart by a care provider.
- ✓ Use EHR/EMR alerts for patients due for a cervical cancer screening
- ✓ Follow up with patients who have overdue cervical cancer screenings
- ✓ Help resolve patient barriers to getting screened
- ✓ Timely submission of claim data
- ✓ **Lab results for cervical cancer screening or procedure codes for hysterectomy can be accepted as supplemental data**

Colorectal Cancer Screening (COL-E)

The Colorectal Cancer Screening measure evaluates patients 45-75 years of age who had appropriate screening for colorectal cancer.

NOTE: The CMS Star Ratings specifications for the Medicare population differs from the HEDIS specifications and assesses patients 50-75 years of age.

Product lines	Quality programs affected	Collection and reporting method
• **Commercial** • **Medicaid** • **Medicare**	• CMS Star Ratings • NCQA Health Plan Ratings	Administrative (Medicaid only) • Claim data • ECDS Hybrid (Commercial & Medicare) • Claim data • Medical record review

Numerator compliance	One or more screenings for colorectal cancer		
Billing Codes	**Description**	**Code type**	**Codes**
	Colonoscopy screening	**CPT**	44388, 44389, 44390, 44391, 44392, 44401, 44402, 44403, 44404, 44405, 44406, 44407, 44408, 45355, 45378, 45379, 45380, 45381, 45382, 45384, 45385, 45386, 45388, 45389, 45390, 45391, 45392, 45393, 45398
		HCPCS	G0105, G0121
		SNOWMED	8180007, 12350003, 25732003, 34264006,73761001, 174158000, 174185007, 235150006, 235151005, 275251008, 302052009, 367535003, 443998000, 444783004, 446521004, 446745002, 447021001, 709421007, 710293001, 711307001, 789778002, 1209098000
	CT colonography	**CPT**	74261, 74262, 74263
		LOINC	60515-4, 72531-7, 79069-1, 79071-7, 79101-2, 82688-3
		SNOWMED	418714002
	FIT lab test	**CPT**	81528
		HCPCS	77353-1, 77354-9
		SNOWMED	
	Flexible sigmoidoscopy	**CPT**	45330, 45331, 45332, 45333, 45334, 45335, 45337, 45338, 45340, 45341, 45342, 45346, 45347, 45349, 45350

		HCPCS	G0104
		SNOWMED	44441009, 396226005, 425634007
	Fecal Occult Blood Test (FOBT)	**CPT**	82270, 82274
		HCPCS	G0328
		LOINC	12503-9, 12504-7, 14563-1, 14564-9, 14565-6, 2335-8, 27396-1, 27401-9, 27925-7, 27926-5, 29771-3, 56490-6, 56491-4, 57905-2, 58453-2, 80372-6
		SNOWMED	104435004, 441579003, 442067009, 442516004, 442554004, 442563002
	FOBT test result	**SNOWMED**	59614000, 167667006, 389076003
	History of colorectal cancer	**ICD-10 Diagnosis**	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
		SNOWMED	93683002, 93761005, 93771007, 93826009, 93980002, 93984006, 94006002, 94072004, 94105000, 94179005, 94260004, 94271003, 94328005, 94509004, 94513006, 94538001, 94604000, 94643001, 109838007, 109839004, 187757001, 187760008, 254582000, 254586002, 269533000, 269544008, 276822007, 285312008, 285611007, 285612000, 301756000, 312111009, 312112002, 312113007, 312114001, 312115000, 314965007, 314966008, 315058005, 363351006, 363406005, 363407001, 363408006, 363409003, 363410008, 363412000, 363413005, 363414004, 363510005, 369448007, 369449004, 369450004, 369451000, 369452007, 369453002, 369454008, 369455009, 369456005, 369457001, 369458006, 369459003, 369460008, 369461007, 395705003, 422375001, 422581008, 422985007, 425178004, 425213009, 429084005, 429699009, 443488001, 447886005, 448994001, 449218003, 713573006, 721695008, 721696009, 721697000, 721698005, 721699002, 721700001, 721701002, 726654006, 737058005, 766979005, 766981007, 1156783003, 1156788007, 1156795003, 1156797006, 1163568002, 1701000119104, 96281000119107, 96981000119102, 123701000119104, 123721000119108, 130381000119103, 133751000119102, 184881000119106, 286771000119106, 286791000119107, 681601000119101, 681651000119102,

			10987871000119109,16636051000119105, 16636101000119105
	Stool DNA-based colorectal cancer screening positive (finding)	**SNOWMED**	708699002
	History of flexible sigmoidography (situation)	**SNOWMED**	841000119107
	History of colonoscopy (situation)	**SNOWMED**	851000119109
	History of total colectomy (situation)	**SNOWMED**	119771000119101
Frequency/occurrence	• Colonoscopy – every 10 years • Flexible Sigmoidoscopy/CT Colonography – every 5 years • FIT-DNA – every 3 years • FIT/FOBT – every year		
Required exclusions	• Diagnosis of colorectal cancer any time in a patient's history • Total colectomy any time in a patient's history		
Test, service or procedure to closecare opportunity	• Colonoscopy – Performed in the measurement year or 9 years prior • CT colonography – Performed in the measurement year or 4 years prior • FIT/FIT DNA test – Performed in the measurement year or 2 years prior • Flexible sigmoidoscopy – Performed in the measurement year or 4 years prior • FOBT – Measurement year • Documentation of colorectal cancer or a total colectomy with date of occurrence		
Medical record documentation (including but not limited to)	Medical record dates: Colonoscopy: 01/01/2013 – 12/31/2023 FIT/DNA: 01/01/2021 – 12/31/2023 Flexible Sigmoidoscopy or CT: 01/01/2019 – 12/31/2023 FOBT: 01/01/2023 – 12/31/2023 • Consultation reports with results • Diagnostic reports with results • Health history and physical • Laboratory reports with results • Pathology reports The report must indicate the type of screening (e.g., colonoscopy, flexible sigmoidoscopy) and the date the screening was performed		

	• For incomplete procedures evidence that the scope advanced beyond the splenic flexure or into the sigmoid colon to meet compliance criteria • Documentation in the medical record must include a note indicating the date when the colorectal cancer screening was performed. • A result is not required if the documentation is clearly part of the patient's "medical history"; if this isn't clear, the result or finding must also be present (this ensures that the screening was ordered and performed) Submit medical record documentation to Priority Health HEDIS department • Electronically uploading medical records –contact ***HEDIS@PriorityHealth.com*** to get a file set up or for more information • Email: ***HEDIS@PriorityHealth.com*** • Fax: 616.975.8897 • Mail: HEDIS at 1231 E Beltline, NE Mail Stop 1280, Grand Rapids, MI, 49525

Tips and best practices:

- ✓ **Check your Gaps in Care Report to identify your patients with open care opportunities**
- ✓ Educate patients about the importance of early detection and encourage testing during preventive and sick visits and assist patients in scheduling appointments
- ✓ Update patient history every year regarding colorectal cancer screening with testing date (documenting the year of the procedure is acceptable)
- ✓ Recommend FOBT/FIT kit as an alternative to colonoscopy
- ✓ Digital Rectal Exams (DRE) or FOBT performed in the office setting won't meet compliance
- ✓ Use EHR/EMR alerts for patients due for a colorectal screening
- ✓ Timely submission of claim data
- ✓ Lab results/consultation reports for colorectal cancer screening can be accepted as supplemental data

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

The Follow-Up Care for Children Prescribed ADHD Medication measure evaluates patients 6-12 years of age who are newly prescribed attention-deficit hyperactivity disorder (ADHD) medication who had at least three (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 during the measurement year.

Attention-deficit hyperactivity disorder (ADHD) is one of the most common behavioral health disorders in children. To ensure medication is prescribed and managed correctly, it's essential that children be carefully monitored by a practitioner with prescribing authority. This measure assesses the following:

1. **Initiation Phase** – Patients ages 6-12 years of age with an ambulatory prescription dispensed for ADHD medication who had one follow-up visit with a practitioner with prescribing authority during the 30-day Initiation Phase. A patient must be between ages 6-12 when the first prescription for ADHD medicine was dispensed.
2. **Continuation and Maintenance Phase** – Patients 6-12 years of age with a prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended. A patient must be between ages 6-12 when the first prescription for ADHD medicine was dispensed.

Product lines	Quality programs affected	Collection and reporting method
• **Commercial** • **Medicaid**	• NCQA Health Plan Ratings	Administrative • Claim data • Pharmacy data

Numerator compliance	A follow-up visit with a practitioner with prescribing authority, within 30 days after the IPSD and at least two follow-up visits on different dates of service with any practitioner, from 31–300 days (9 months) after the IPSD

Initiation phase coding – Use any of the following codes billed by a provider with a practitioner with prescribing authority will meet criteria for the Initiation Phase of ADD.

Scenario 1: Outpatient visits with outpatient place of service code

Billing codes	Description	Code type	Codes
	Visit setting unspecified and outpatient POS	**CPT**	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876,
		POS	03, 05, 07, 09, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 22, 33, 49, 50, 71, 72

Scenario 2: Behavioral health outpatient visit with a practitioner with prescribing authority

Billing codes	Description	Code type	Codes
	Behavioral health 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, 99383, 99384, 99385, 99386, 99387, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99483, 99492, 99493, 99494, 99510
		HCPCS	G0155, G0176, G0177, G0409, G0463, G0512, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, T1015
		UBREV	0510, 0513, 0515, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0526, 0527, 0528, 0529, 0900, 0902, , 0903, 0904, , 0911, , , 0914, 0915, 0916, 0917, 0919, , 0982, 0983

Scenario 3: Health and behavior assessment or intervention

Billing codes	Description	Code type	Codes
	Health and behavior assessment or intervention	**CPT**	96150, 96151,96152, 96153, 96154, 96156, 96158, 96159, 96164, 96165, 96167, 96168, 96170, 96171

Scenario 4: Intensive outpatient encounter or partial hospitalization with appropriate place of service code (place of service code must be billed with visit code)

Billing codes	Description	Code type	Codes
	Visit setting unspecified and partial hospitalization POS	**CPT**	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99251, 99252, 99253, 99254, 99255
		POS	52

Scenario 5: Intensive outpatient encounter or partial hospitalization

Billing codes	Description	Code type	Codes
	Partial hospitalization or intensive outpatient	**HCPCS**	G0410, G0411, H0035, H2001, H2012, S0201, S9480, S9484, S9485
		UBREV	0905, 0907, 0912, 0913

Scenario 6: Community mental health center visit with appropriate place of service code

Billing codes	Description	Code type	Codes
	Visit setting unspecified and community mental health center POS	**CPT**	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876
		POS	53

Scenario 7: Telehealth with appropriate place of service code

Billing codes	Description	Code type	Codes
	Visit setting unspecified and telehealth POS	**CPT**	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876
		POS	02, 10

Scenario 8: Telephone visit with a practitioner with prescribing authority

Billing codes	Description	Code type	Codes
	Telephone visits	**CPT**	98966, 98967, 98968, 99441, 99442, 99443

Continuation Phase Coding – Use any of the following codes billed by a practitioner with prescribing authority will meet criteria for the Continuation Phase of ADD.

Scenario 1: Outpatient visits with outpatient place of service code

Billing codes	Description	Code type	Codes
	Visit setting unspecified and outpatient POS	**CPT**	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876,
		POS	03, 05, 07, 09, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 22, 33, 49, 50, 71, 72

Scenario 2: Behavioral health outpatient visit with a practitioner with prescribing authority

Billing codes	Description	Code type	Codes
	Behavioral health 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, 99383, 99384, 99385, 99386, 99387, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99483, 99492, 99493, 99494, 99510
		HCPCS	G0155, G0176, G0177, G0409, G0463, G0512, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, T1015
		UBREV	0510, 0513, 0515, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0526, 0527, 0528, 0529, 0900, 0902, , 0903, 0904, , , 0911, , 0914, 0915, 0916, 0917, 0919, , 0982, 0983

Scenario 3: Health and behavior assessment or intervention

Billing codes	Description	Code type	Codes
	Health and behavior assessment or intervention	**CPT**	96150, 96151,96152, 96153, 96154, 96156, 96158, 96159, 96164, 96165, 96167, 96168, 96170, 96171

Scenario 4: Intensive outpatient encounter or partial hospitalization with appropriate place of service code (place of service code must be billed with visit code)

Billing codes	Description	Code type	Codes
	Visit setting unspecified and partial hospitalization POS	**CPT**	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99251, 99252, 99253, 99254, 99255
		POS	52

Scenario 5: Intensive outpatient encounter or partial hospitalization

Billing codes	Description	Code type	Codes
	Partial hospitalization or intensive outpatient	**HCPCS**	G0410, G0411, H0035, H2001, H2012, S0201, S9480, S9484, S9485
		UBREV	0905, 0907, 0912, 0913

Scenario 6: Community mental health center visit with appropriate place of service code

Billing codes	Description	Code type	Codes
	Visit setting unspecified and community mental health center POS	**CPT**	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876
		POS	53

Scenario 7: Telehealth visit with appropriate place of service code

Billing codes	Description	Code type	Codes
	Visit setting unspecified and telehealth POS	**CPT**	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876
		POS	02

Scenario 8: Telephone visit with a practitioner with prescribing authority

Billing codes	Description	Code type	Codes
	Telephone visits	**CPT**	98966, 98967, 98968, 99441, 99442, 99443

Scenario 9: E-visit or virtual check-in with a practitioner with prescribing authority

Note: Only one of the two visits (during the 31-300 days after the index prescription start date) may be an e-visit or virtual check-in.

Billing codes	Description	Code type	Codes
	Online assessments	**CPT**	98969, 98970, 98971, 98972, 99421, 99422, 99423, 99444, 99457, 99458
		HCPCS	G0071, G2010, G2012, G2061, G2062, G2063, G2250, G2251, G2252

Required Exclusions	History of Narcolepsy
Test, Service, or Procedure to Close Care Opportunity	• One follow-up visit (outpatient, doctor's office, or other behavioral health visit) during the 30-day initiation phase and two additional visits within the next nine months or continuation phase. • 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.
Medical record documentation (including but not limited to)	Documentation Guidelines: • Follow-up visit within 30 days of initial dispensing date to assess how the medication is working and address side effect issues • 30-day follow-up must be scheduled with a practitioner with prescribing authority • Two additional follow-up visits for patient and family within 9 months of the 30-day (31-300 days) follow-up visit to monitor patient's progress on the medication • The 2 additional follow-up appointments can be with any practitioner Submit medical record documentation to Priority Health HEDIS department: • Electronically uploading medical records – contact ***HEDIS@PriorityHealth.com*** to get a file set up or for more information • Email: ***HEDIS@PriorityHealth.com*** • Fax: 616.975.8897 • Mail: HEDIS at 1231 E Beltline, NE Mail Stop 1280, Grand Rapids, MI, 49525
Common chart deficiencies	Follow-up visit more than 30 days after the initial medication dispensed date

Tips and Best Practices to Help Close This Care Opportunity ✓ When prescribing a new medication to your patient, be sure to schedule a follow-up visit within 30-days ✓ Add telehealth or telephone visits in the initiation phase ✓ Assess how the medication is working. Schedule this visit while your patient is still in the office. ✓ Schedule 2 more visits in the 9 months after the first 30 days to continue to monitor your patient's progress ✓ Use a phone visit for one of the visits after the first 30 days. This may help you and your patients if getting to the office is difficult. ✓ Allow no refills until the initial follow up visit is complete ✓ If you need to refer your patient to a behavioral health specialist or need to request coordination of care, please call the Behavioral Health department at **800.673.8043** ✓ Use EHR/EMR alerts for patients due for initiation and continuation and maintenance phase	

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

The Metabolic Monitoring for Children and Adolescents on Antipsychotics measure evaluates children and adolescents 1-17 years of age who had two or more antipsychotic prescriptions and had metabolic testing. Three rates are reported for this measure:

1. Children and adolescents on antipsychotics who received blood glucose testing
2. Children and adolescents on antipsychotics who received cholesterol testing
3. Children and adolescents on antipsychotics who received blood glucose and cholesterol testing

Product lines	Quality programs affected	Collection and reporting method
• **Commercial** • **Medicaid**	• NCQA Health Plan Ratings	Administrative • Claim data • Pharmacy data

Numerator compliance	Patients who received at least one test for blood glucose and one test for LDL-C		
Billing codes	**Description**	**Code type**	**Codes**
	Blood glucose lab test	CPT	80047, 80048, 80050, 80053, 80069, 82947, 82950, 82951
		LOINC	10450-5, 1492-8, 1494-4, 1496-9, 1499-3, 1501-6, 1504-0, 1507-3, 1514-9, 1518-0, 1530-5, 1533-9, 1554-5, 1557-8, 1558-6, 17865-7, 20436-2, 20437-0, 20438-8, 20440-4, 26554-6, 41024-1, 49134-0, 6749-6, 9375-7
		SNOWMED	22569008, 33747003, 52302001, 72191006, 73128004, 88856000, 104686004, 167086002, 167087006, 167088001, 167095005, 167096006, 167097002, 250417005, 271061004, 271062006, 271063001, 271064007, 271065008, 275810004, 302788006, 302789003, 308113006, 313474007, 313545000, 313546004, 313624000, 313626003, 313627007, 313628002, 313630000, 313631001, 313697000, 313698005, 313810002, 412928005, 440576000, 443780009, 444008003, 444127006
	Blood glucose test result	SNOWMED	166890005, 166891009, 166892002, 166914001, 166915000, 166916004,

			166917008, 166918003, 166919006, 166921001, 166922008, 166923003, 442545002, 444780001
	HbA1c lab test	CPT	83036, 83037
		LOINC	17856-6, 4548-4, 4549-2, 96595-4
		SNOWMED	43396009, 313835008
	HbA1c test result	CPT II	3044F, 3046F, 3051F, 3052F
		SNOWMED	165679005, 451061000124104
	Cholesterol lab test	CPT	82465, 83718, 83722, 84478
		LOINC	2085-9, 2093-3, 2571-8, 3043-7, 9830-1
		SNOWMED	14740000, 28036006, 77068002, 104583003, 104584009, 104586006, 104784006, 104990004, 104991000, 121868005, 166832000, 166838001, 166839009, 166849007, 166850007, 167072001, 167073006, 167082000, 167083005, 167084004, 271245006, 275972003, 314035000, 315017003, 390956002, 412808005, 412827004, 443915001
	Cholesterol test result	SNOWMED	166830008, 166831007, 166848004, 259557002, 365793008, 365794002, 365795001, 365796000, 439953004, 442193004, 442234001, 442350007, 442480001, 707122004, 707123009, 67991000119104
	LDL-C lab test	CPT	80061, 83700, 83701, 83704, 83721
		LOINC	12773-8, 13457-7, 18261-8, 18262-6, 2089-1, 49132-4, 55440-2, 96259-7
		SNOWMED	113079009, 166833005, 166840006, 166841005, 167074000, 167075004, 314036004
	LDL-C test result	CPT II	3048F, 3049F, 3050F
Frequency/occurrence	Every year		
Test, service or procedure to close care opportunity	• Glucose test or HbA1c and • Cholesterol lab test or LDL-C test		
Medical record documentation (including but not limited to)	• Glucose test or HbA1c test and lab results • Cholesterol test or LDL-C test and lab results • Consultation notes with date of test and results • Progress notes with date of test and results Submit medical record documentation to Priority Health HEDIS department • Electronically uploading medical records – contact ***HEDIS@PriorityHealth.com*** to get a file set up or for more information • Email: ***HEDIS@PriorityHealth.com***		

	• Fax: 616.975.8897 • Mail: HEDIS at 1231 E Beltline, NE Mail Stop 1280, Grand Rapids, MI, 49525
Common chart deficiencies	No glucose or HbA1ccholesterol, or LDL-C lab report for the measurement year
Claim submission deficiencies	Not submitting CPT II codes

Tips and best practices:

✓ Schedule an annual glucose or HbA1c and LDL-C or other cholesterol test
✓ Stress the importance in understanding the importance of annual screening to parents or caregivers
✓ Use CPT II codes to report clinical outcomes such as HbA1c and LDL-C test results
✓ Use EHR/EMR alerts for patients due for an LDL-test
✓ **Lab tests and results can be accepted as supplemental data**

Important notes:

- A patient must have metabolic screening tests that measure both blood glucose and cholesterol
- Individual tests to measure cholesterol and blood glucose levels can be done on the same or different date of service

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

The Depression Screening and Follow-Up for Adolescents and Adults measure assess patients 12 years of age and older who were screened for clinical depression using a standardized instrument and, if screened positive, received follow-up care during the measurement year.

- Depression Screening. Patients who were screened for clinical depression using a standardized instrument.
- Follow-Up on Positive Screen. Patients who received follow-up care within 30 days of a positive depression screen finding.

Product lines	Quality programs affected	Collection and reporting method
• **Commercial** • **Medicaid** • **Medicare**		Administrative • Claim data

Eligible Screening Tools

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

Instruments for Adolescents (≤17 years)	Positive Finding
Patient Health Questionnaire (PHQ-9)®	Total score ≥10
Patient Health Questionnaire Modified for Teens (PHQ-9M)®	Total score ≥10
Patient Health Questionnaire-2 (PHQ-2)®[1]	Total score ≥3
Beck Depression Inventory-Fast Screen (BDI-FS)®[1,2]	Total score ≥8
Center for Epidemiologic Studies Depression Scale—Revised (CESD-R)	Total score ≥17
Edinburgh Postnatal Depression Scale (EPDS)	Total score ≥10
PROMIS Depression	Total score (T Score) ≥60

Instruments for Adults (18+ years)	Positive Finding
Patient Health Questionnaire (PHQ-9)®	Total score ≥10
Patient Health Questionnaire-2 (PHQ-2)®[1]	Total score ≥3
Beck Depression Inventory-Fast Screen (BDI-FS)®[1,2]	Total score ≥8
Beck Depression Inventory (BDI-II)	Total score ≥20

Instruments for Adults (18+ years)	Positive Finding
Center for Epidemiologic Studies Depression Scale-Revised (CESD-R)	Total score ≥17
Duke Anxiety-Depression Scale (DUKE-AD)®[2]	Total score ≥30
Geriatric Depression Scale Short Form (GDS)[1]	Total score ≥5
Geriatric Depression Scale Long Form (GDS)	Total score ≥10
Edinburgh Postnatal Depression Scale (EPDS)	Total score ≥10
My Mood Monitor (M-3) ®	Total score ≥5
PROMIS Depression	Total score (T Score) ≥60
Clinically Useful Depression Outcome Scale (CUDOS)	Total score ≥31

[1]Brief screening instrument. All other instruments are full-length.
[2]Proprietary; may be cost or licensing requirement associated with use.

Numerator compliance	Numerator 1—Depression Screening Patients with a documented result for depression screening, using an age-appropriate standardized instrument, performed between January 1 and December 1 of the measurement period Numerator 2—Follow-Up on Positive Screen Patients who received follow-up care on or up to 30 days after the date of the first positive screen (31 total days) Any of the following on or up to 30 days after the first positive screen: • An outpatient, telephone, e-visit or virtual check-in follow-up visit with a diagnosis of depression or other behavioral health condition • A depression case management encounter that documents assessment for symptoms of depression or a diagnosis of depression or other behavioral health condition • A behavioral health encounter, including assessment, therapy, collaborative care or medication management • A dispensed antidepressant medication OR • Documentation of additional depression screening on a full-length instrument indicating either no depression or no symptoms that require follow-up (i.e., a negative screen) on the same day as a positive screen on a brief screening instrument Note: For example, if there is a positive screen resulting from a PHQ-2 score, documentation of a negative finding from a PHQ-9 performed on the same day qualifies as evidence of follow-up	
Description	**Code type**	**Codes**

Behavioral health encounter	**CPT**	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839,90845, 90846, 90847, 90849, 90853, 90865, 90867, 90868, 90869, 90870, 90875, 90876, 90880, 90887, 99484, 99492, 99493
	HCPCS	G0155, G0176, G0177, G0409, G0410, G0411, G0511, G0512, H0002, H0004, H0031, H0034, H0035, H0036, H0037, H0039, H0040, H2000, H2001, H2010, H2011, H2012, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, S0201, S9480, S9484, S9485
	UBREV	0900, 0901, 0902, 0903, 0904, 0905, 0907, 0911, 0912, 0913, 0914, 0915, 0916, 0917, 0919
	SNOWMED	5694008, 10197000, 10997001, 38756009, 45392008, 79094001, 88848003, 90407005, 91310009, 165171009, 165190001, 225337009, 370803007, 372067001, 385721005, 385724002, 385725001, 385726000, 385727009, 385887004, 385889001,385890005, 401277000, 410223002, 410224008, 410225009, 410226005, 410227001, 410228006, 410229003, 410230008, 410231007, 410232000, 410233005, 410234004, 439141002
Depression case management encounter	**CPT**	99366, 99492, 99493, 99494
	HCPCS	G0512, T1016, T1017, T2022, T2023
	SNOWMED	182832007, 225333008, 385828006, 386230005, 409022004, 410216003, 410219005, 410328009, 410335001, 410346003, 410347007, 410351009, 410352002, 410353007, 410354001, 410356004, 410360001, 410363004, 410364005, 410366007, 416341003, 416584001, 424490002, 425604002, 737850002
Follow-up visit	**CPT**	98960, 98961, 98962, 98966, 98967, 98968, 98969, 98970, 98971, 98972, 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, 99384, 99385, 99386, 99387, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99421, 99422, 99423, 99441, 99442,99443, 99444, 99457, 99483
	HCPCS	G0071, G0463, G2010, G2012, G2061, G2062, G2063, G2250, G2251, G2252, T1015
	UBREV	0510, 0513, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0526, 0527, 0528, 0529, 0982, 0983
	SNOWMED	42137004, 50357006, 86013001, 90526000, 108220007, 108221006, 185317003, 185389009, 281036007, 314849005, 386472008, 386473003, 390906007, 401267002, 406547006, 870191006
Exercise counseling	ICD10 diagnosis	Z71.82

Patient Health Questionnaire 9 item (PHQ-9) total score [Reported]	LOINC	44261-6
Geriatric depression scale (GDS) total		LOINC
Geriatric depression scale (GDS) short version total	LOINC	48545-8
Patient Health Questionnaire 2 item (PHQ-2) total score [Reported]	LOINC	55758-7
Edinburgh Postnatal Depression Scale [EPDS]	LOINC	71354-5
Total score [M3]	LOINC	71777-7
PROMIS-29 Depression score T-score	LOINC	71965-8
Patient Health Questionnaire-9: Modified for Teens total score [Reported.PHQ.Teen]	LOINC	89204-2
Center for Epidemiologic Studies Depression Scale-Revised total score [CESD-R]	LOINC	89205-9
Beck Depression Inventory Fast Screen total score [BDI]	LOINC	89208-3
Beck Depression Inventory II total score [BDI]	LOINC	89209-1
Total Score [CUDOS]	LOINC	90221-3
Exclusions	• Patients with a history of bipolar disorder any time during the member's history through the end of the year prior to the measurement period • Patients with depression that starts during the year prior to the measurement period	

Tips and best practices:

- ✓ Screen patients 12 years of age and older for depression using a standardized instrument and document the result
- ✓ Whenever possible, depression screening and treatment are culturally appropriate and offered in the patient’s first language
- ✓ Educate patients regarding the warning signs for depression and advise to seek early treatment
- ✓ Options for community counselors and psychiatry are available for patients interested in that option if screened positive
- ✓ If screened positive, ensure that appropriate follow-up is established for the patient within 30 days

Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS-E)

The Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults measure assess patients 12 years of age and older with a diagnosis of major depression or dysthymia, who had an outpatient encounter with a PHQ-9 score present in their record in the same assessment period as the encounter during the measurement.

The Measurement Period is divided into three assessment periods with specific dates of service:

- Assessment Period 1: January 1–April 30
- Assessment Period 2: May 1–August 31
- Assessment Period 3: September 1–December 31

Product lines	Quality programs affected	Collection and reporting method
• **Commercial** • **Medicaid** • **Medicare**		Administrative • Claim data

Numerator compliance	A PHQ-9 score in the patient's medical record		
Billing Codes	**Description**	**Code type**	**Codes**
	Behavioral health encounter	**CPT**	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839,90845, 90846, 90847, 90849, 90853, 90865, 90867, 90868, 90869, 90870, 90875, 90876, 90880, 90887, 99484, 99492, 99493
		HCPCS	G0155, G0176, G0177, G0409, G0410, G0411, G0511, G0512, H0002, H0004, H0031, H0034, H0035, H0036, H0037, H0039, H0040, H2000, H2001, H2010, H2011, H2012, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, S0201, S9480, S9484, S9485
		UBREV	0900, 0901, 0902, 0903, 0904, 0905, 0907, 0911, 0912, 0913, 0914, 0915, 0916, 0917, 0919
		SNOWMED	5694008, 10197000, 10997001, 38756009, 45392008, 79094001, 88848003, 90407005, 91310009, 165171009, 165190001, 225337009, 370803007, 372067001, 385721005, 385724002, 385725001, 385726000, 385727009, 385887004, 385889001,385890005, 401277000, 410223002, 410224008, 410225009,

			410226005, 410227001, 410228006, 410229003, 410230008, 410231007, 410232000, 410233005, 410234004, 439141002
	Depression case management encounter	**CPT**	99366, 99492, 99493, 99494
		HCPCS	G0512, T1016, T1017, T2022, T2023
		SNOWMED	182832007, 225333008, 385828006, 386230005, 409022004, 410216003, 410219005, 410328009, 410335001, 410346003, 410347007, 410351009, 410352002, 410353007, 410354001, 410356004, 410360001, 410363004, 410364005, 410366007, 416341003, 416584001, 424490002, 425604002, 737850002
	Follow-up visit	**CPT**	98960, 98961, 98962, 98966, 98967, 98968, 98969, 98970, 98971, 98972, 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, 99384, 99385, 99386, 99387, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99421, 99422, 99423, 99441, 99442,99443, 99444, 99457, 99483
		HCPCS	G0071, G0463, G2010, G2012, G2061, G2062, G2063, G2250, G2251, G2252, T1015
		UBREV	0510, 0513, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0526, 0527, 0528, 0529, 0982, 0983
		SNOWMED	42137004, 50357006, 86013001, 90526000, 108220007, 108221006, 185317003, 185389009, 281036007, 314849005, 386472008, 386473003, 390906007, 401267002, 406547006, 870191006
Exclusions	Patients with any of the following any time during the member's history through the end of the measurement period: • Bipolar disorder • Personality disorder • Psychotic disorder • Pervasive developmental disorder		
Medicare record documentation	A bi-directional communication that is face-to-face, phone-based, an e-visit or virtual check-in, or via secure electronic messaging. *This does not include communications for scheduling appointments.		
Tips and best practices:			

- ✓ Screen patients 12 years of age and older for depression using a standardized instrument and document the result
- ✓ Whenever possible, depression screening and treatment are culturally appropriate and offered in the patient’s first language
- ✓ Educate patients regarding the warning signs for depression and advise to seek early treatment
- ✓ Options for community counselors and psychiatry are available for patients interested in that option if screened positive
- ✓ If screened positive, ensure that appropriate follow-up is established for the patient within 30 days

Depression Remission or Response for Adolescents and Adults (DRR-E)

The Depression Remission or Response for Adolescents and Adults measure assesses patients 12 years of age and older with a diagnosis of depression and an elevated PHQ-9 score, who had evidence of response or remission within 4–8 months of the elevated score.

The DRR measure rates the following:

- *Follow-Up PHQ-9*: Patients who have a follow-up PHQ-9 score documented within 4–8 months after the initial elevated PHQ-9 score
  - Elevated PHQ-9 scores are >9
- *Depression Remission:* Patients who achieved remission within 4–8 months after the initial elevated PHQ-9 score
  - This is demonstrated by the most recent PHQ-9 total score of <5 documented during the Depression Follow-Up Period
- *Depression Response*: Patients who showed response within 4–8 months after the initial elevated PHQ-9 score
  - This is demonstrated by the most recent PHQ-9 total score being at least 50 percent lower than the PHQ-9 score associated with the initial elevated PHQ-9 total score >9, documented during the Depression Follow-Up Period.

Product lines	Quality programs affected	Collection and reporting method
• **Commercial** • **Medicaid** • **Medicare**		Administrative • Claim data

Eligible Screening Tools

Selection of the appropriate PHQ-9 assessment should be based on the member's age

Screening Instrument:
PHQ-9: 12 years of age and older
PHQ-9 Modified for Teens: 12–17 years of age

*The PHQ-9 assessment does not need to occur during a face-to-face encounter; it may be completed over the telephone or through a web-based portal.

Numerator compliance	**Depression follow-up** - A PHQ-9 total score in the patient's record during the depression follow-up period **Depression remission** - Patients who achieve remission of depression symptoms, as demonstrated by the most recent PHQ-9 score of <5 during the depression follow-up period

	Depression response - Patients who indicate a response to treatment for depression, as demonstrated by the most recent PHQ-9 total score being at least 50 percent lower than the PHQ-9 score associated with the IESD, documented during the depression follow-up period		
Billing codes	**Description**	**Code type**	**Codes**
	Behavioral health encounter	**CPT**	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839,90845, 90846, 90847, 90849, 90853, 90865, 90867, 90868, 90869, 90870, 90875, 90876, 90880, 90887, 99484, 99492, 99493
		HCPCS	G0155, G0176, G0177, G0409, G0410, G0411, G0511, G0512, H0002, H0004, H0031, H0034, H0035, H0036, H0037, H0039, H0040, H2000, H2001, H2010, H2011, H2012, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, S0201, S9480, S9484, S9485
		UBREV	0900, 0901, 0902, 0903, 0904, 0905, 0907, 0911, 0912, 0913, 0914, 0915, 0916, 0917, 0919
		SNOWMED	5694008, 10197000, 10997001, 38756009, 45392008, 79094001, 88848003, 90407005, 91310009, 165171009, 165190001, 225337009, 370803007, 372067001, 385721005, 385724002, 385725001, 385726000, 385727009, 385887004, 385889001, 385890005, 401277000, 410223002, 410224008, 410225009,410226005, 410227001, 410228006, 410229003, 410230008, 410231007, 410232000, 410233005, 410234004, 439141002
	Depression case management encounter	**CPT**	99366, 99492, 99493, 99494
		HCPCS	G0512, T1016, T1017, T2022, T2023
		SNOWMED	182832007, 225333008, 385828006, 386230005, 409022004, 410216003, 410219005, 410328009, 410335001, 410346003, 410347007, 410351009, 410352002, 410353007, 410354001, 410356004, 410360001, 410363004, 410364005, 410366007, 416341003, 416584001, 424490002, 425604002, 737850002
	Follow-up visit	**CPT**	98960, 98961, 98962, 98966, 98967, 98968, 98969, 98970, 98971, 98972, 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, 99384, 99385, 99386, 99387, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99421, 99422, 99423, 99441, 99442,99443, 99444, 99457, 99483
		HCPCS	G0071, G0463, G2010, G2012, G2061, G2062, G2063, G2250, G2251, G2252, T1015
		UBREV	0510, 0513, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0526, 0527, 0528, 0529, 0982, 0983
		SNOWMED	42137004, 50357006, 86013001, 90526000, 108220007, 108221006, 185317003, 185389009, 281036007, 314849005, 386472008, 386473003, 390906007, 401267002, 406547006, 870191006
	Patient Health Questionnaire 9 item (PHQ-9) total score [Reported]	**LOINC**	44261-6
	Patient Health Questionnaire 9: Modified for Teens total score [Reported PHQ, Teen]	**LOINC**	89204-2
Exclusions	Patients with any of the following any time during the member's history through the end of the measurement period: • Bipolar disorder • Personality disorder • Psychotic disorder • Pervasive developmental disorder		

Tips and best practices:

- ✓ Screen patients 12 years of age and older for depression using a standardized instrument and document the result
- ✓ Whenever possible, depression screening and treatment are culturally appropriate and offered in the patient's first language
- ✓ Educate patients regarding the warning signs for depression and advise to seek early treatment
- ✓ Options for community counselors and psychiatry are available for patients interested in that option if screened positive

- ✓ If screened positive, ensure that appropriate follow-up is established for the patient within 30 days

Unhealthy Alcohol Use Screening and Follow-Up (ASF-E)

The Unhealthy Alcohol Use Screening and Follow-Up measure assesses patients 18 years of age and older who were screened for unhealthy alcohol use using a standardized instrument and, if screened positive, received appropriate follow-up care.

ASF measures the following:

- Unhealthy Alcohol Use Screening - Patients who had a systematic screening for unhealthy alcohol use.

  - The member's age is used to select the appropriate depression screening instrument.

Alcohol Counseling or Other Follow-up Care – Patients receiving brief counseling or other follow-up care within two months of screening positive for unhealthy alcohol use. The follow up must include one of the following:

- Feedback on alcohol use and harms
- Identification of high-risk situations for drinking and coping strategies
- Increase the motivation to reduce drinking
- Development of a personal plan to reduce drinking
- Documentation of receiving alcohol misuse treatment

Product lines	Quality programs affected	Collection and reporting method
• **Commercial** • **Medicaid** • **Medicare**		Administrative • Claim data

Eligible Screening Tools Standard assessment instruments with thresholds for positive findings include:

Screening Instrument	**Positive Finding**
Alcohol Use Disorders Identification Test (AUDIT) Screening Instrument	Total Score ≥8
Alcohol Use Disorders Identification Test Consumption (AUDIT-C) Screening Instrument	Total Score ≥4 for men Total Score ≥3 for women
Single-question screen: "How many times in the past year have you had 5 (for men) or 4 (for women and all adults older than 65 years) or more drinks in a day?"	Total score ≥1

Numerator compliance	Alcohol counseling or other follow-up care within two months of screening positive for unhealthy alcohol use		
Billing codes	**Description**	**Code type**	**Codes**
		CPT	99408, 99409

	Alcohol counseling or other follow-up care	**HCPCS**	G0396, G0397, G0443, G2011, H0005, H0007, H0015, H0016, H0022, H0050, H2035, H2036, T1006, T1012
		ICD10 Diagnosis	Z71.41
		LOINC	75624-7, 75626-2, 75889-6, 88037-7
		SNOWMED	20093000, 23915005, 24165007, 64297001, 386449006, 408945004, 408947007, 408948002, 413473000, 707166002, 429291000124102
Exclusions	• Patients with alcohol use disorder that starts during the year prior to the measurement period • Patients with history of dementia any time during the member's history through the end of the measurement period • Patients in hospice or using hospice services any time during the measurement period		

Tips and best practices:

A patient's primary care provider (PCP) is often the first in the initial assessment of the addicted patient. Use some of the following tips to identify, treat, and make referrals for patients that have substance abuse disorders.

- ✓ Routinely screen adults 18 years and older for alcohol misuse and provide brief behavioral counseling interventions to those who misuse alcohol
- ✓ Bring awareness to the patient of his/her alcohol misuse and the associated consequences
- ✓ Respectfully broach the subject of drinking with the patient and ask the following types of questions:
  - ➢ Would it be okay to take some time to talk about your drinking?
  - ➢ Has anyone ever talked to you before about your drinking?
- ✓ Let the patient know the connections between alcohol and health problems such as cancer, hypertension, cirrhosis, liver disease, pancreatitis, etc.
- ✓ Assess the patient's readiness to change their drinking habits Ask specific questions: - Example: "On a scale from 1-10, with 1 being not ready and 10 being very ready, how ready are you to make a change to any aspect of your drinking?"
- ✓ Develop a plan with the patient to decrease their alcohol consumption - Develop goals - Provide written educational materials - Discuss the importance of having a support system (family and friends) - Answer any questions or concerns that the patient may have - Establish a follow-up plan for the patient
- ✓ To combat withdrawal, refer the patient to local treatment programs - Withdrawal can lead to relapse - Program use group therapy, behavioral therapy, and medications to assist patient cope with withdrawal and recovery

Adult Immunization Status (AIS-E)

The Adult Immunization Status measure assesses patients 19 years of age and older who are up to date on recommended routine vaccines for influenza, tetanus and diphtheria (Td) or tetanus, diphtheria and acellular pertussis (Tdap), zoster and pneumococcal.

Product lines	Quality programs affected	Collection and reporting method
• **Commercial** • **Medicaid** • **Medicare**		Administrative • Claim data

Numerator compliance	Influenza • Patients who received an influenza vaccine on or between July 1 of the year prior to the measurement period and June 30 of the measurement period, ***or*** • Patients with anaphylaxis due to the influenza vaccine any time before or during the measurement period Td/Tdap • Patients who received at least one Td vaccine or one Tdap vaccine between nine years prior to the start of the measurement period and the end of the measurement period, ***or*** • Patients with a history of at least one of the following contraindications any time before or during the measurement period: o Anaphylaxis due to the diphtheria, tetanus or pertussis vaccine o Encephalitis due to the diphtheria, tetanus or pertussis vaccine Zoster • Patients who received at least one dose of the herpes zoster live vaccine or two doses of the herpes zoster recombinant vaccine at least 28 days apart, any time on or after the member's 50th birthday and before or during the measurement period, ***or*** • Patients with anaphylaxis due to the herpes zoster vaccine any time before or during the measurement period Pneumococcal • Patients who were administered at least one dose of an adult pneumococcal vaccine on or after the member's 19th birthday and before or during the measurement period, ***or***

	• Patients with anaphylaxis due to the pneumococcal vaccine any time before or during the measurement period		
Billing codes	**Description**	**Code type**	**Codes**
	Adult influenza immunization	**CPT**	90630, 90653, 90654, 90656, 90658, 90661, 90662, 90673, 90674, 90682, 90686, 90688, 90689, 90694, 90756
		CVX	88, 135, 140, 141, 144, 150, 153, 155, 158, 166, 168, 171, 185, 186, 197, 205
		SNOWMED	86198006
	Influenza virus LAIV	**CPT**	90660, 90672
		CVX	111, 149
		SNOWMED	787016008
	Td	**CPT**	90714, 90718
		CVX	09, 113, 115, 138, 139
		SNOWMED	73152006, 312869001, 395178008, 395179000, 395180002, 395181003, 414619005, 416144004, 416591003, 417211006, 417384007, 417615007, 866161006, 866184004, 866185003, 866186002, 866227002, 868266002, 868267006, 868268001, 870668008, 870669000, 870670004, 871828004, 632481000119106
	Tdap	**CPT**	90715
		CVX	115
		SNOWMED	390846000, 412755006, 412756007, 412757003, 428251000124104, 571571000119105
	Herpes zoster	**CPT**	90736
		CVX	121
		SNOWMED	871898007, 871899004
	Herpes zoster recombinant	**CPT**	90750
		SNOWMED	722215002
		CVX	187
	Adult pheumococcal immunization	**CPT**	90670, 90671, 90677, 90732
		HCPCS	G0009
		CVX	33, 109, 133, 152, 215, 216
		SNOWMED	12866006, 394678003, 871833000, 1119366009, 1119367000, 1119368005, 434751000124102
	Anaphylaxis due to diphtheria, tetanus or pertussis vaccine	**SNOWMED**	428281000124107, 428291000124105
	Anaphylaxis due to herpes zoster vaccine	**SNOWMED**	471371000124107, 471381000124105

	Encephalitis due to diphtheria, tetanus or pertussis vaccine	**SNOWMED**	192710009, 192711008, 192712001
	Anaphylaxis caused by vaccine product containing Streptococcus pneumoniae antigen (disorder)	**SNOWMED**	471141000124102
	Anaphylaxis caused by vaccine product containing Influenza virus antigen (disorder)	**SNOWMED**	471361000124100

Tips and best practices:

Make a strong vaccine recommendation to patients to motivate patients to get vaccinated

- ✓ Explain why vaccines are right for the patient based on age, health status, lifestyle, occupation, or other risk factors
- ✓ Explain why vaccines are important and beneficial to the patient's health
- ✓ Address all patient questions regarding vaccine, side effects, effectiveness, and safety
    - Be sure to use plain and understandable language
    - Offer patient a copy of the Vaccine Information Sheet (VIS) from the CDC
    - Have translators or handouts in other languages available

Flu Specific

- ✓ Explain the impacts of getting influenza
    - Serious health effects, cost of missing work or obligations, financial costs due to medical care needed
- ✓ Explain that the vaccine protects the patients and loved ones from not just the flu, but flu related complications

Prenatal Immunization Status (PRS-E)

Women who had a delivery and received influenza and tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccinations during their pregnancy.

Product lines	Quality programs affected	Collection and reporting method
• **Commercial** • **Medicaid**	• NCQA Health Plan Ratings	Administrative • Claim data

Numerator compliance	**Depression Screening** • Deliveries where patients received an adult influenza vaccine on or between July 1 of the year prior to the measurement period and the delivery date, or • Deliveries where patients had anaphylaxis due to the influenza vaccine on or before the delivery date **Tdap** • Deliveries where patients received at least one Tdap vaccine during the pregnancy (including on the delivery date), or • Deliveries where patients had any of the following: o Anaphylaxis due to the diphtheria, tetanus or pertussis vaccine on or before the delivery date o Encephalitis due to the diphtheria, tetanus or pertussis vaccine on or before the delivery date		
Billing codes	**Description**	**Code type**	**Codes**
	Adult influenza immunization	**CPT**	90630, 90653, 90654, 90656, 90658, 90661, 90662, 90673, 90674, 90682, 90686, 90688, 90689, 90694, 90756
		CVX	88, 135, 140, 141, 144, 150, 153, 155, 158, 166, 168, 171, 185, 186, 197, 205
		SNOWMED	86198006
	Tdap	**CPT**	90715
		CVX	115
		SNOWMED	390846000, 412755006, 412756007, 412757003, 428251000124104, 571571000119105
	Anaphylaxis due to diphtheria, tetanus or pertussis vaccine	**SNOWMED**	428281000124107, 428291000124105
	Encephalitis due to diphtheria,	**SNOWMED**	192710009, 192711008, 192712001

	tetanus or pertussis vaccine		
	Length of gestation at birth (observable entity)	**SNOWMED**	412726003
	Anaphylaxis caused by vaccine product containing influenza virus antigen (disorder)	**SNOWMED**	471361000124100

Tips and best practices:

Educate expectant mothers on the importance of vaccines during pregnancy

- ✓ If you do not have flu vaccines available, refer the patient to another health care provider, pharmacy, or community vaccination center
- ✓ Educate mothers on how the flu vaccine will protect both her and her baby
- ✓ Educate mothers on passive immunity the maternal immunization will pass on to their newborns

Prenatal Depression Screening and Follow-Up (PND-E)

Women who had a delivery and were screened for clinical depression while pregnant, and if screened positive, received follow-up care within 30 days of a positive finding.

Two rates are reported for the PND-E measure:

- Depression Screening: Deliveries in which patients were screened for clinical depression using a standardized instrument with recorded result during pregnancy.
- Follow-Up on Positive Screen: Deliveries in which patients received follow-up care within 30 days of a positive depression screen finding.

Product lines	Quality programs affected	Collection and reporting method
• **Commercial** • **Medicaid**		Administrative • Claim data

The American College of Obstetricians and Gynecologists (ACOG) recommends that clinicians screen patients at least once during pregnancy or the postpartum period for depression and anxiety symptoms using a standardized, validated tool.

Screening Instrument for adolescents (≤ 17 years)	**Positive Finding**
Patient Health Questionnaire (PHQ-9)®	Total Score ≥ 10
Patient Health Questionnaire Modified for Teens (PHQ- 9M)®	Total Score ≥ 10
Patient Health Questionnaire-2 (PHQ-2)®[1]	Total score ≥ 3
Beck Depression Inventory-Fast Screen (BDI-FS)®[1,2]	Total score ≥ 8
Center for Epidemiologic Studies Depression Scale- Revised (CESD-R)	Total score ≥ 17
Edinburgh Postnatal Depression Scale (EPDS)	Total score ≥ 10
PROMIS Depression	Total score (T score) ≥ 60
Screening Instrument for adolescents (18 years+)	**Positive Finding**
Patient Health Questionnaire (PHQ-9)®	Total score ≥ 10
Patient Health Questionnaire-2 (PHQ-2)®1	Total score ≥ 3
Beck Depression Inventory-Fast Screen (BDI-FS)®[1,2]	Total score ≥ 8
Beck Depression Inventory (BDI-II)	Total score ≥ 20
Center for Epidemiologic Studies Depression Scale- Revised (CESD-R)	Total score ≥ 17
Duke Anxiety-Depression Scale (DUKE-AD)®[2]	Total score ≥ 30
Edinburgh Postnatal Depression Scale (EPDS)	Total score ≥ 10
My Mood Monitor (M-3)®	Total score ≥ 5
PROMIS Depression	Total score (T score) ≥ 60
Clinically Useful Depression Outcome Scale (CUDOS)	Total score ≥ 31

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

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

- ✓ Whenever possible, depression screening and treatment are culturally appropriate and offered in the
- ✓ patient's first language
- ✓ Refer patients to the appropriate resources (counselors, psychiatry) if screened positive
- ✓ Follow-up with patients that screen positive
- ✓ Continue to screen patients during pregnancy and postpartum

Numerator compliance	**Depression screening** • Deliveries where patients had a documented depression screening and the result of the screening, using an age-appropriate standardized instrument, performed during pregnancy **Follow-up on positive screen** • Deliveries where patients received follow-up care on or up to 30 days after the date of the first positive screen (31 days total) o Any of the following on or up to 30 days after the first positive screen meet criteria: ➢ An outpatient or telephone follow-up visit with a diagnosis of depression or other behavioral health condition ➢ A depression case management encounter that documents assessment for symptoms of depression or a diagnosis of depression or other behavioral health condition ➢ A behavioral health encounter, including assessment, therapy, collaborative care or medication management ➢ A dispensed antidepressant medication **or** ➢ Documentation of additional depression screening indicating either no depression or no symptoms that require follow-up (i.e., a negative screen) on the same day qualifies as evidence of follow-up		
Billing codes	**Description**	**Code type**	**Codes**
	Behavioral health encounter	**CPT**	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90845, 90846, 90847, 90849, 90853, 90865, 90867, 90868, 90869, 90870, 90875, 90876, 90880, 90887, 99484, 99492, 99493
		HCPCS	G0155, G0176, G0177, G0409, G0410, G0411, G0511, G0512, H0002, H0004, H0031, H0034, H0035, H0036, H0037,

			H0039, H0040, H2000, H2001, H2010, H2011, H2012, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, S0201, S9480, S9484, S9485
		SNOWMED	5694008, 10197000, 10997001, 38756009, 45392008, 79094001, 88848003, 90407005, 91310009, 165171009, 165190001, 225337009, 370803007, 372067001, 385721005, 385724002, 385725001, 385726000, 385727009, 385887004, 385889001, 385890005, 401277000, 410223002, 410224008, 410225009, 410226005, 410227001, 410228006, 410229003, 410230008, 410231007, 410232000, 410233005, 410234004, 439141002
		UBREV	0900, 0901, 0902, 0903, 0904, 0905, 0907, 0911, 0912, 0913, 0914, 0915, 0916, 0917, 0919
	Depression case management encounter	**CPT**	99366, 99492, 99493, 99494
		HCPCS	G0512, T1016, T1017, T2022, T2023
		SNOWMED	182832007, 225333008, 385828006, 386230005, 409022004, 410216003, 410219005, 410328009, 410335001, 410346003, 410347007, 410351009, 410352002, 410353007, 410354001, 410356004, 410360001, 410363004, 410364005, 410366007, 416341003, 416584001, 424490002, 425604002, 737850002
	Follow-up visit	**CPT**	98960, 98961, 98962, 98966, 98967, 98968, 98969, 98970, 98971, 98972, 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, 99383, 99384, 99385, 99386, 99387, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99421, 99422, 99423, 99441, 99442, 99443, 99444, 99457, 99483
		HCPCS	G0071, G0463, G2010, G2012, G2061, G2062, G2063, G2250, G2251, G2252, T1015
		SNOWMED	42137004, 50357006, 86013001, 90526000, 108220007, 108221006, 185317003, 185389009, 281036007,

			314849005, 386472008, 386473003, 390906007, 401267002, 406547006, 870191006
		UBREV	0510, 0513, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0526, 0527, 0528, 0529, 0982, 0983
Exclusions	Deliveries that occurred at less than 37 weeks gestation		

Tips and best practices:

Perinatal depression refers to minor and major depression episodes during pregnancy and/or the first 12 months after childbirth and is a common condition that affects functional outcomes both for affected women and for their families.

Women with untreated depression during pregnancy are at risk for developing sever postpartum depression and suicidality, and of delivering premature or low birth-weight infants. It is important to routinely assess mom for issues such as depression and detect depression early if finding screen positive.

- ✓ All staff received training on depression screening and care
- ✓ All staff recognize risk factors and versed in strategies to engage patients on completing and understanding the standardized screening tool
- ✓ Whenever possible, depression screening and treatment are culturally appropriate and offered in the patient's first language
- ✓ Refer patients to the appropriate resources (counselors, psychiatry) if screened positive
- ✓ Follow-up with patients that screen positive
- ✓ Continue to screen patients during pregnancy and postpartum

Postpartum Depression Screening and Follow-Up (PDS-E)

Women who had a delivery and were screened for clinical depression during the postpartum period, and if screened positive, received follow-up care within 30 days of a positive finding.

Two rates are reported for the PDS-E measure:

- Depression Screening: Deliveries in which patients were screened for clinical depression using a standardized instrument with recorded result during pregnancy.
- Follow-Up on Positive Screen: Deliveries in which patients received follow-up care within 30 days of a positive depression screen finding.

Product lines	Quality programs affected	Collection and reporting method
• **Commercial** • **Medicaid**		Administrative • Claim data

The American College of Obstetricians and Gynecologists (ACOG) recommends that clinicians screen patients at least once during pregnancy or the postpartum period for depression and anxiety symptoms using a standardized, validated tool.

Screening Instrument for adolescents (≤ 17 years)	**Positive Finding**
Patient Health Questionnaire (PHQ-9)®	Total Score ≥ 10
Patient Health Questionnaire Modified for Teens (PHQ- 9M)®	Total Score ≥ 10
Patient Health Questionnaire-2 (PHQ-2)®[1]	Total score ≥ 3
Beck Depression Inventory-Fast Screen (BDI-FS)®[1,2]	Total score ≥ 8
Center for Epidemiologic Studies Depression Scale- Revised (CESD-R)	Total score ≥ 17
Edinburgh Postnatal Depression Scale (EPDS)	Total score ≥ 10
PROMIS Depression	Total score (T score) ≥ 60
Screening Instrument for adolescents (18 years+)	**Positive Finding**
Patient Health Questionnaire (PHQ-9)®	Total score ≥ 10
Patient Health Questionnaire-2 (PHQ-2)®1	Total score ≥ 3
Beck Depression Inventory-Fast Screen (BDI-FS)®[1,2]	Total score ≥ 8
Beck Depression Inventory (BDI-II)	Total score ≥ 20
Center for Epidemiologic Studies Depression Scale- Revised (CESD-R)	Total score ≥ 17
Duke Anxiety-Depression Scale (DUKE-AD)®[2]	Total score ≥ 30
Edinburgh Postnatal Depression Scale (EPDS)	Total score ≥ 10
My Mood Monitor (M-3)®	Total score ≥ 5
PROMIS Depression	Total score (T score) ≥ 60
Clinically Useful Depression Outcome Scale (CUDOS)	Total score ≥ 31

[1] Brief screening instrument. All other instruments are full-length.
[2] Proprietary; may be cost or licensing requirement associated with use.

<table>
<tr><td rowspan="1">Numerator compliance</td><td colspan="3">Depression screening
Deliveries where patients had a documented depression screening and the result of the screening, using an age-appropriate standardized instrument, performed during the 7 – 84 days following the date of delivery
Follow-up on positive screen
Deliveries where patients received follow-up care on or up to 30 days after the date of the first positive screen (31 days total)
Any of the following on or up to 30 days after the first positive screen meet criteria:
An outpatient or telephone follow-up visit with a diagnosis of depression or other behavioral health condition
A depression case management encounter that documents assessment for symptoms of depression or a diagnosis of depression or other behavioral health condition
A behavioral health encounter, including assessment, therapy, collaborative care or medication management
or
Receipt of an assessment on the same day and subsequent to the positive screen
Documentation of additional depression screening indicating either no depression or no symptoms that require follow-up
For example, if the initial positive screen resulted from a PHQ-2 score, documentation of a negative finding from a subsequent PHQ-9 performed on the same day qualifies as evidence of follow-up</td></tr>
<tr><td rowspan="2">Billing codes</td><td>Description</td><td>Code type</td><td>Codes</td></tr>
<tr><td>Behavioral health encounter</td><td>CPT</td><td>90791, 90792, 90832, 90833, 90834,
90836, 90837, 90838, 90839, 90845,
90846, 90847, 90849, 90853, 90865,
90867, 90868, 90869, 90870, 90875,</td></tr>
</table>

			90876, 90880, 90887, 99484, 99492, 99493
		HCPCS	G0155, G0176, G0177, G0409, G0410, G0411, G0511, G0512, H0002, H0004, H0031, H0034, H0035, H0036, H0037, H0039, H0040, H2000, H2001, H2010, H2011, H2012, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, S0201, S9480, S9484, S9485
		SNOWMED	5694008, 10197000, 10997001, 38756009, 45392008, 79094001, 88848003, 90407005, 91310009, 165171009, 165190001, 225337009, 370803007, 372067001, 385721005, 385724002, 385725001, 385726000, 385727009, 385887004, 385889001, 385890005, 401277000, 410223002, 410224008, 410225009, 410226005, 410227001, 410228006, 410229003, 410230008, 410231007, 410232000, 410233005, 410234004, 439141002
		UBREV	0900, 0901, 0902, 0903, 0904, 0905, 0907, 0911, 0912, 0913, 0914, 0915, 0916, 0917, 0919
	Depression case management encounter	**CPT**	99366, 99492, 99493, 99494
		HCPCS	G0512, T1016, T1017, T2022, T2023
		SNOWMED	182832007, 225333008, 385828006, 386230005, 409022004, 410216003,

			410219005, 410328009, 410335001, 410346003, 410347007, 410351009, 410352002, 410353007, 410354001, 410356004, 410360001, 410363004, 410364005, 410366007, 416341003, 416584001, 424490002, 425604002, 737850002
	Patient Health Questionnaire 9 item (PHQ-9) total score [Reported]	LOINC	44261-6
	Patient Health Questionnaire 2 item (PHQ-2) total score [Reported]	LOINC	55758-7
	Edinburgh Postnatal Depression Scale [EPDS]	LOINC	71354-5
	Total score [M3]	LOINC	71777-7
	PROMIS-29 Depression score T-score	LOINC	71965-8
	Patient Health Questionnaire-9: Modified for Teens total score [Reported.PHQ.Teen]	LOINC	89204-2
	Center for Epidemiologic Studies Depression Scale-Revised total score [CESD-R]	LOINC	89205-9
	Beck Depression Inventory Fast Screen total score [BDI]	LOINC	89208-3
	Beck Depression Inventory II total score [BDI]	LOINC	89209-1
	Total Score [CUDOS]	LOINC	90221-3
	Final score [DUKE-AD]	LOINC	90853-3
Tips and best practices:			

Perinatal depression refers to minor and major depression episodes during pregnancy and/or the first 12 months after childbirth and is a common condition that affects functional outcomes both for affected women and for their families.

Women with untreated depression during pregnancy are at risk for developing sever postpartum depression and suicidality, and of delivering premature or low birth-weight infants. Routine postpartum care has the potential to improve health outcomes and promote ongoing health and well-being for women, infants, and their families.

- ✓ All staff received training on depression screening and care
- ✓ Normally following childbirth, a new mom may experience the following: difficulty sleeping, appetite changes, excessive fatigue, decreased libido, and frequent mood changes
  - ➢ However, with clinical depression these could also be heightened and/or accompanied by other symptoms such as feelings of hopelessness and helplessness, depressed mood, thoughts of death or suicide or thoughts of hurting someone else
- ✓ Whenever possible, depression screening and treatment are culturally appropriate and offered in the patient's first language
- ✓ Provide mom tips for coping after childbirth
  - ➢ Encourage mom to ask for help
  - ➢ Be realistic about expectations
  - ➢ Expect some good days and some bad days
- ✓ Refer patients to the appropriate resources (counselors, psychiatry) if screened positive
- ✓ Follow-up with patients that screen positive
- ✓ Continue to screen patients during pregnancy and postpartum

Social Need Screening and Intervention (SNS-E)

Members who were screened, using prespecified instruments, at least once during the measure period for unmet food, housing and transportation needs, and received a corresponding intervention if they screened positive.

Six rates are reported for the SNS-E measure:

- Food screening: Members who were screened for food insecurity
- Food intervention: Members who received a corresponding intervention within 1 month of screening positive for food insecurity
- Housing screening: Members who were screened for housing instability, homelessness or housing inadequacy
- Housing intervention: Members who received a corresponding intervention within 1 month of screening positive for housing instability, homelessness or housing inadequacy
- Transportation screening: Members who were screened for transportation insecurity
- Transportation intervention: Members who received a corresponding intervention within 1 month of screening positive for transportation insecurity

Product lines	Quality programs affected	Collection and reporting method
• **Commercial** • **Medicaid** • **Medicare**		Administrative • Claim data

Definitions	
Food insecurity	Uncertain, limited or unstable access to food that is: adequate in quantity and in nutritional quality; culturally acceptable; safe and acquired in socially acceptable ways
Housing instability	Currently consistently housed but experiencing any of the following circumstances in the past 12 months: being behind on rent or mortgage, multiple moves, cost burden or risk of eviction
Homelessness	Currently living in an environment that is not meant for permanent human habitation (e.g., cars, parks, sidewalks, abandoned buildings, on the street), not having a consistent place to sleep at night, or because of economic difficulties, currently living in a shelter, motel, temporary or transitional living situation
Housing inadequacy	Housing does not meet habitability standards
Transportation insecurity	Uncertain, limited or no access to safe, reliable, accessible, affordable and socially acceptable transportation infrastructure and modalities necessary for maintaining one's health, well-being or livelihood

Food insecurity eligible screening instruments with thresholds for positive findings include:

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

Housing instability, homelessness and housing inadequacy eligible screening instruments with thresholds for positive findings include:

Housing Instability and Homelessness Instruments	Screening Item LOINC Codes	Positive Finding LOINC Codes
Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool	71802-3	LA31994-9 LA31995-6
American Academy of Family Physicians (AAFP) Social Needs Screening Tool	99550-6	LA33-6

Children’s Health Watch Housing Stability Vital Signs™1	98976-4	LA33-6
	98977-2	≥3
	98978-0	LA33-6
Health Leads Screening Panel®1	99550-6	LA33-6
Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences [PRAPARE]®1	93033-9	LA33-6
	71802-3	LA30190-5
We Care Survey	96441-1	LA33-6
WellRx Questionnaire	93669-0	LA33-6

Transportation insecurity eligible screening instruments with thresholds for positive findings include:

Transportation Insecurity Instruments	Screening Item LOINC Codes	Positive Finding LOINC Codes
Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool	93030-5	LA33-6
American Academy of Family Physicians (AAFP) Social Needs Screening Tool	99594-4	LA33-6
Comprehensive Universal Behavior Screen (CUBS)	89569-8	LA29232-8 LA29233-6 LA29234-4
Health Leads Screening Panel®1	99553-0	LA33-6
Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences [PRAPARE]®1	93030-5	LA30133-5 LA30134-3
PROMIS®1	92358-1	LA30024-6 LA30026-1 LA30027-9
WellRx Questionnaire	93671-6	LA33-6

Numerator compliance	**Food screening** • Patients had a documented result for food insecurity screening performed in the measurement period **Food intervention** • Patients who screened positive for food insecurities and received a food insecurity intervention on or up to 30 days after the first positive food insecurity screen (31 days total) **Housing Screening**

- Patients who had a document result for housing instability, homelessness or housing inadequacy screening performed in the measurement period

Housing Intervention

- Patients who screened positive for housing instability, homelessness or housing inadequacy and received an intervention corresponding to the type of housing need identified on or up to 30 days after the date of the first positive housing screen (31 days total)

Transportation Screening

- Patients had a documented result for transportation insecurity screening performed in the measurement period

Transportation Intervention

- Patients who screened positive for transportation insecurity and received a transportation insecurity intervention on or up to 30 days after the first positive transportation screen (31 days total)

An intervention corresponding to the type of need identified on or up to 30 days after the date of the first positive screening during the measurement period.

- A positive food insecurity screen finding must be met by a food insecurity intervention.
- A positive housing instability or homelessness screen finding must be met by a housing instability or homelessness intervention.
- A positive housing inadequacy screen finding must be met by a housing inadequacy intervention.
- A positive transportation insecurity screen finding must be met by a transportation insecurity intervention.

Intervention may include any of the following intervention categories: assistance, assessment, counseling, coordination, education, evaluation of eligibility, provision or referral.

Billing codes	Description	Code type	Codes
	Food insecurities	**CPT**	96156, 96160, 96161, 97802, 97803, 97804
		HCPCS	S5170, S9470
		SNOWMED	1759002, 61310001, 103699006, 308440001, 385767005, 710824005, 710925007, 711069006, 713109004, 1002223009, 1002224003, 1002225002, 1004109000, 004110005, 1148446004, 441041000124100, 441201000124108, 441231000124100, 441241000124105, 441251000124107,

			441261000124109, 441271000124102, 441281000124104, 441291000124101, 441301000124100, 441311000124102, 441321000124105, 441331000124108, 441341000124103, 441351000124101, 445291000124103, 445301000124102, 445641000124105, 462481000124102 462491000124104, 464001000124109, 464011000124107, 464021000124104, 464031000124101, 464041000124106, 464051000124108, 464061000124105, 464071000124103, 464081000124100, 464091000124102, 464101000124108, 464111000124106, 464121000124103, 464131000124100, 464141000124105, 464151000124107, 464161000124109, 464171000124102, 464181000124104, 464191000124101, 464201000124103 464211000124100, 464221000124108, 464231000124106, 464241000124101, 464251000124104, 464261000124102, 464271000124109, 464281000124107, 464291000124105, 464301000124106, 464311000124109, 464321000124101, 464331000124103, 464341000124108,

			464351000124105, 464361000124107, 464371000124100, 464401000124102, 464411000124104, 464421000124107, 464431000124105, 464611000124102, 464621000124105, 464631000124108, 464641000124103, 464651000124101, 464661000124104, 464671000124106, 464681000124109, 464691000124107, 464701000124107, 464721000124102, 467591000124102, 467601000124105, 467611000124108, 467621000124100, 467631000124102, 467641000124107, 467651000124109, 467661000124106, 467671000124104, 467681000124101, 467691000124103, 467711000124100, 467721000124108, 467731000124106, 467741000124101, 467751000124104, 467761000124102, 467771000124109, 467781000124107, 467791000124105, 467801000124106, 467811000124109, 467821000124101, 470231000124107, 470591000124109, 470601000124101, 470611000124103, 471111000124101, 471121000124109, 471131000124107, 472151000124109, 472331000124100
	Homelessness	**CPT**	96156, 96160, 96161

		SNOWMED	308440001, 710824005, 711069006, 1148446004, 1148447008, 1148812007, 1148814008, 1148817001, 1148818006, 462481000124102, 462491000124104, 464001000124109, 464011000124107, 464021000124104, 464131000124100, 464161000124109, 464291000124105, 464301000124106, 464311000124109, 464611000124102, 470231000124107, 470471000124109, 470481000124107, 470491000124105, 470501000124102, 470581000124106, 470591000124109, 470601000124101, 470611000124103, 470781000124104, 470791000124101, 470801000124100, 470811000124102, 470821000124105, 470831000124108, 470841000124103, 471021000124108, 471031000124106, 471041000124101, 471071000124109, 471081000124107, 471091000124105, 471101000124104, 471111000124101, 471121000124109, 471131000124107, 472031000124103 472041000124108, 472051000124105, 472081000124102, 472091000124104, 472101000124105, 472111000124108, 472121000124100, 472131000124102,

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	Housing instability	**CPT**	96156, 96160, 96161
		SNOWMED	308440001, 710824005, 711069006, 1148446004, 1148447008, 1148812007, 1148814008, 1148817001, 1148818006, 462481000124102, 462491000124104, 464001000124109, 464011000124107, 464021000124104, 464131000124100, 464161000124109, 464291000124105, 464301000124106, 464311000124109, 464611000124102, 470231000124107, 470471000124109, 470481000124107, 470591000124109, 470601000124101, 470611000124103, 471041000124101,

			471051000124104, 471061000124102, 471071000124109, 471111000124101, 471121000124109, 471131000124107, 472081000124102, 472091000124104, 472131000124102, 472151000124109, 472161000124106, 472191000124103 472221000124105, 472241000124103, 472261000124104, 472271000124106, 472281000124109, 472291000124107, 472331000124100, 472381000124104, 480841000124109, 480851000124106, 480861000124108, 480901000124101
	Inadequate housing	**CPT**	96156, 96160, 96161
		SNOWMED	49919000, 308440001, 710824005, 711069006, 1148446004, 1148813002, 1148815009, 1148823006, 462481000124102, 462491000124104, 464001000124109, 464011000124107, 464021000124104, 464131000124100, 464161000124109, 464291000124105, 464301000124106, 464311000124109, 464611000124102, 470231000124107, 470431000124106, 470441000124101, 470451000124104, 470461000124102, 470591000124109, 470601000124101, 470611000124103, 471111000124101,

			471121000124109, 471131000124107, 472151000124109, 472201000124100, 472211000124102, 472231000124108, 472251000124101, 472331000124100, 472371000124102, 480881000124103, 480891000124100, 480911000124103, 480951000124102
	Transportation insecurity	**CPT**	96156, 96160, 96161
		SNOWMED	308440001, 710824005, 711069006, 1148446004, 462481000124102, 462491000124104, 464001000124109, 464011000124107, 464021000124104, 464131000124100, 464161000124109, 464291000124105, 464301000124106, 464311000124109, 464611000124102, 470231000124107, 470591000124109, 470601000124101, 470611000124103, 471111000124101, 471121000124109, 471131000124107, 472151000124109, 472331000124100
	Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living [CMS Assessment]	**LOINC**	101351-5
	Housing status	**LOINC**	71802-3
	Within the past 12 months we worried whether our food would run out before	**LOINC**	88122-7

	we got money to buy more [U.S. FSS]		
	Within the past 12 months the food we bought just didn't last and we didn't have money to get more [U.S. FSS]	**LOINC**	88123-5
	Food insecurity risk [HVS]	**LOINC**	88124-3
	Access to transportation/mobility status [CUBS]	**LOINC**	89569-8
	Current level of confidence I can use public transportation [PROMIS]	**LOINC**	92358-1
	Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living	**LOINC**	93030-5
	Have you or any family members you live with been unable to get any of the following when it was really needed in past 1 year [PRAPARE]	**LOINC**	93031-3
	Are you worried about losing your housing [PRAPARE]	**LOINC**	93033-9
	Did you or others you live with eat smaller meals or skip meals because you didn't have money for food in the past 2 months [WellRx]	**LOINC**	93668-2
	Are you homeless or worried that you might be in the future [WellRx]	**LOINC**	93669-0
	Do you have trouble finding or paying for transportation [WellRx]	**LOINC**	93671-6
	In the last 12 months, did you ever eat less than you felt you	**LOINC**	95251-5

	should because there wasn't enough money for food [U.S. FSS]		
	Food security status [U.S. FSS]	**LOINC**	95264-8
	Within the past 12 months the food we bought just didn't last and we didn't have money to get more Caregiver [U.S. FSS]	**LOINC**	95399-2
	Within the past 12 months we worried whether our food would run out before we got money to buy more Caregiver [U.S. FSS]	**LOINC**	95400-8
	Always has enough food for family Caregiver	**LOINC**	96434-6
	At risk of becoming homeless Caregiver	**LOINC**	96441-1
	Problems with place where you live	**LOINC**	96778-6
	Behind on rent or mortgage in past 12 months	**LOINC**	98976-4
	Number of residential moves in past 12 months	**LOINC**	98977-2
	Homeless in past 12 months	**LOINC**	98978-0
	You or your families' health is affected by enviromental conditions at home	**LOINC**	99134-9
	Enviromental conditions in the home that affect you or your families' health	**LOINC**	99135-6
	Worried about housing stability in next 2 months	**LOINC**	99550-6
	Went without health care due to lack of transportation in last 12 months	**LOINC**	99553-0
	Delayed medical care due to distance or lack of transportation	**LOINC**	99594-4

	At risk	**LOINC**	LA19952-3
	Often true	**LOINC**	LA28397-0
	Mold	**LOINC**	LA28580-1
	My transportation is available and reliable, but limited and/or inconvenient; drivers are licensed and minimally insured	**LOINC**	LA29232-8
	My transportation is available, but unreliable, unpredictable, unaffordable; may have car but no insurance, license, etc.	**LOINC**	LA29233-6
	I have no access to transportation, public or private; may have car that is inoperable	**LOINC**	LA29234-4
	I am not at all confident	**LOINC**	LA30024-6
	I am a little confident	**LOINC**	LA30026-1
	I am somewhat confident	**LOINC**	LA30027-9
	Food	**LOINC**	LA30125-1
	Yes, it has kept me from medical appointments or from getting my medications	**LOINC**	LA30133-5
	Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need	**LOINC**	LA30134-3
	I do not have housing (staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, or in a park)	**LOINC**	LA30190-5
	Low food security	**LOINC**	LA30985-8
	Very low food security	**LOINC**	LA30986-6
	I have a place to live today, but I am worried about losing it in the future	**LOINC**	LA31994-9

	I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)	**LOINC**	LA31995-6
	Pests such as bugs, ants, or mice	**LOINC**	LA31996-4
	Lead paint or pipes	**LOINC**	LA31997-2
	Lack of heat	**LOINC**	LA31998-0
	Oven or stove not working	**LOINC**	LA31999-8
	Smoke detectors missing or not working	**LOINC**	LA32000-4
	Water leaks	**LOINC**	LA32001-2
	Bug infestation	**LOINC**	LA32691-0
	Lead paint/pipes	**LOINC**	LA32693-6
	Inadequate heat	**LOINC**	LA32694-4
	Non-functioning oven/stove	**LOINC**	LA32695-1
	No or non-working smoke detectors	**LOINC**	LA32696-9
	No	**LOINC**	LA32-8
	Yes, it has kept me from medical appointments or getting medications	**LOINC**	LA33093-8
	Yes	**LOINC**	LA33-6
	Sometimes true	**LOINC**	LA6729-3

Tips and best practices:

- ✓ Create a culture of health equity and a team-based approach to address SDOH within your practice
- ✓ Screen your patients for social needs and identify local resources to address their challenges
- ✓ Engage with your community to address the underlying drivers of health equities

Measures collected through the Medicare Health Outcomes Survey

The Medicare Health Outcomes Survey (HOS) provides a general indication of how well a Medicare Advantage Organization (MAO) manages the physical and mental health of its members.

The survey measures physical and mental health status at the beginning of a 2-year period and again at the end of the 2-year period. Each member's health status is categorized as "better than expected," "the same as expected," or "worse than expected," and results are assigned as percentages of members whose health status was better, the same or worse than expected

Product lines	Quality programs affected	Collection and reporting method
• **Medicare**		Health Outcomes Survey

Fall Risk Management (FRM)

This measure is collected using the Medicare Health Outcomes Survey (HOS). The two components of this measure assess different facets of fall risk management in older adults.

- **Discussing Fall Risk -** Medicare patients 65 years of age and older who were seen by a practitioner in the past 12 months and who discussed falls or problems with balance or walking with their current practitioner.
- **Managing Fall Risk** - Medicare patients 65 years of age and older who had a fall or had problems with balance or walking in the past 12 months, who were seen by a practitioner in the past 12 months and who received a recommendation for how to prevent falls or treat problems with balance or walking from their current practitioner.

Management of Urinary Incontinence in Older Adults (MUI)

This measure is collected using the Medicare Health Outcomes Survey (HOS) and assesses the management of urinary incontinence in older adults.

- **Discussing Urinary Incontinence**. Medicare patients 65 years of age and older who reported having urine leakage in the past 6 months and who discussed their urinary leakage problem with a health care provider.
- **Discussing Treatment of Urinary Incontinence -** Medicare patients 65 years of age and older who reported having urine leakage in the past 6 months and who discussed treatment options for their current urine leakage problem.
- **Impact of Urinary Incontinence** - Medicare patients 65 years of age and older who reported having urine leakage in the past 6 months and who reported that urine leakage made them change their daily activities or interfered with their sleep a lot.

  Note: *A lower rate indicates better performance for this indicator.*

Physical Activity in Older Adults (PAO)

This measure is collected using the Medicare Health Outcomes Survey (HOS) and assesses different facets of promoting physical activity in older adults.

- **Discussing Physical Activity -** Medicare patients 65 years of age and older who had a doctor's visit in the past 12 months and who spoke with a doctor or other health provider about their level of exercise or physical activity.
- **Advising Physical Activity** - Medicare patients 65 years of age and older who had a doctor's visit in the past 12 months and who received advice to start, increase or maintain their level exercise or physical activity.

Measures collected through the CAHPS Survey

Medical Assistance with Smoking and Tobacco Use Cessation (MSC)

The following components of this measure assess different facets of providing medical assistance with smoking and tobacco use cessation:

- Advising Smokers and Tobacco Users to Quit. A rolling average represents the percentage of patients 18 years of age and older who were current smokers or tobacco users and who received advice to quit during the measurement year.
- Discussing Cessation Medications. A rolling average represents the percentage of patients 18 years of age and older who were current smokers or tobacco users and who discussed or were recommended cessation medications during the measurement year.
- Discussing Cessation Strategies. A rolling average represents the percentage of patients 18 years of age and older who were current smokers or tobacco users and who discussed or were provided cessation methods or strategies during the measurement year.

Product lines	Quality programs affected	Collection and reporting method
• **Commercial** • **Medicaid** • **Medicare**		CAHPS Survey

CAHPS Measures

Consumer Assessment of Healthcare Providers and Systems (CAHPS®) is an annual survey that asks consumers and patients to report on and evaluate their experiences with health care. Your patient's experience is often measured by the CAHPS survey and is governed by CMS and NCQA.

What topics does the CAHPS survey cover?

The survey assesses the quality of patients' experience with their providers and accessing care. The key topics covered are:

1. Rating of all health care
2. Rating of health plan
3. Rating of personal doctor
4. Rating of specialists

Key areas such as getting care quickly, getting needed care, and how well doctors communicate are also surveyed.

Below are the survey questions your patients answer that are tied to their experience with you, their health care provider, on both the Adult CAHPS Survey and the Child CAHPS Survey.

The survey **assesses patients' experiences** with access to care, prescription medications and care coordination. The results provide **valuable insights into how they perceive their care** and experience from providers and health plans. Working together, we can use these insights to identify areas of improvement and lead to healthier and happier patients and patients.

Adult CAHPS Survey

Getting Needed Care

The Getting Needed Care survey questions assess patients on how easy it was for them to get appointments with specialists and get the care, tests or treatment they needed. They also assess how often patients were able to get a specialist appointment scheduled when needed.

Getting Needed Care	In the last six months, how often did you get an appointment to see a specialist as soon as you needed?
	In the last six months, how often was it easy to get the care, tests, or treatment you needed?
Products	• Commercial • Medicaid • Medicare
Quality programs affected	• CMS Star Ratings

Tips and best practices:

- Assist patients to make specialist appointments before they leave the office
- Ask patients if they've had any delays in receiving care
- Review authorization and referral processes to remove patient barriers to access to care
- Follow-up with patients to confirm that referrals to specialists are completed and assist with any issues

- Discuss care plan and/or barriers with patient's Priority Health Care Manager if applicable
- Be proactive and schedule tests, screenings, follow-up, or annual well/preventive visits for your patients ahead of time
- Include the patient in decision-making about their care regarding tests, referrals, and treatment options
- In addition to in-person office appointments, implement phone or video appointments as an option

Getting Care Quickly

The Getting Care Quickly survey questions assesses health plan patients on how often they got care as soon as needed when sick or injured and how often appointment wait times exceeded 15 minutes.

Getting Care Quickly	In the last six months, when you needed care right away, how often did you get care as soon as you needed?
	In the last six months, how often did you get an appointment for a check-up or routine care as soon as you needed?
	How often did you see the person you came to see within 15 minutes of your appointment time?
Products	• Commercial • Medicaid • Medicare
Quality programs affected	• CMS Star Ratings

Tips and best practices:

- Leave some open appointment slots each day for urgent visits and post-inpatient or emergency department discharges to support continuity of care
- Ideal patient wait times are 15 minutes or less – shorten perceived wait time by assigning staff to perform preliminary work-up activities (weight, blood pressure, temperature)
- Encourage patients to schedule routine visits in advance or before they leave office
- Make sure patients are supported by staff and excessive wait times are explained
  - ❖ Patients are more tolerant of appointment delays if they know the reasons for the delay
  - ❖ Provide brief and frequent updates for any provider delays and offer options to reschedule or be seen by another provider
- Survey your patients and ask how you can improve their health care experience

Care Coordination

The Care Coordination survey questions assesses health plan patients on the member's primary care provider assistance with managing the primary and specialty care, timely follow-up on test results, and education on prescription medications.

Care Coordination	In the last six months, when you visited your personal doctor for a scheduled appointment, how often did he or she have your medical records or other information about your care?
	In the last six months, when your personal doctor ordered a blood test, X-ray, or other test for you, how often did someone from your personal doctor's office follow up to give you those results?
	In the last six months, when your personal doctor ordered a blood test, E-ray, or other test for you, how often did you get those results as soon as you needed them?
	In the last six months, how often was it easy to use your prescription drug plan to get the medicines your doctor prescribed?
	In the last six months, did you get the help you needed from your personal doctor's office to manage your care among these different providers and services?
	In the last six months, how often did your personal doctor seem informed and up to date about the care you got from specialists?
Products	Medicare
Quality programs affected	CMS Star Ratings

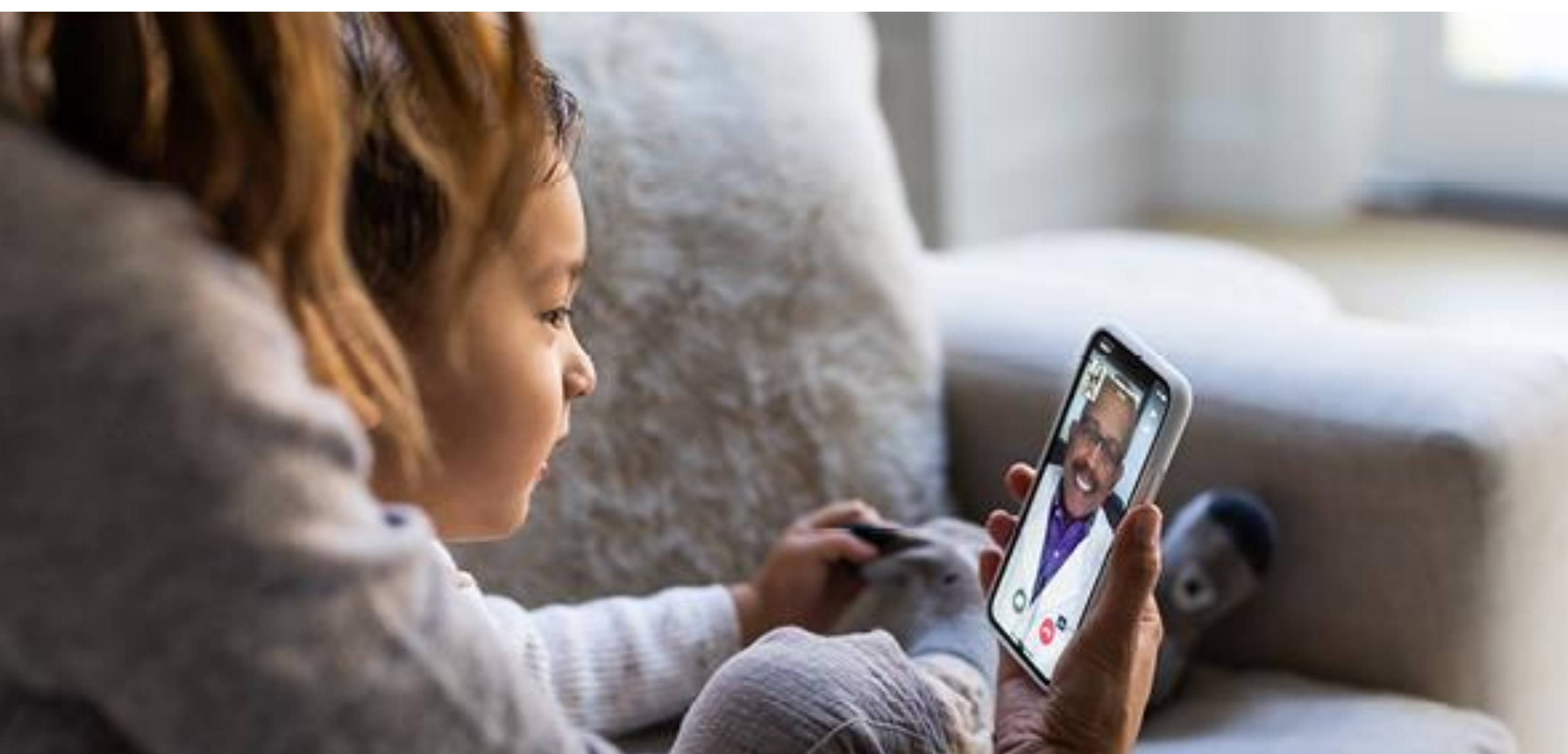
Tips and best practices:

- Have open available appointments for patients recently discharged from an inpatient or emergency department visit
- Have relevant information and medical history, including appointments with specialists, at hand during patient office visits
- Ensure you are sharing pertinent clinical information with your patient's other providers
- Integrate PCP and specialty practices through EHR/EMR or Fax: get reports promptly
- Offer to assist with setting up tests and referral appointments
- Encourage patients to bring in their medications to each visit and update the patient's medication list at each visit
- Encourage patients to bring in their medications to each visit and update the patient's medication list at each visit
- Implement process for patients to access test results easily and securely
- Follow-up with your patient on test results (such as bloodwork or an X-ray) in a timely manner, even if results are normal
- Provide additional support to patients with multiple needs to coordinate and monitor delivery of health services

How Well Doctors Communicate

The How Well Doctors Communicate survey questions assesses health plan patients on the member's perception of the quality of communication with their doctor.

<table>
<tr><td rowspan="4">How Well Doctors Communicate</td><td>In the last six months, how often did your personal doctor explain things in a way that was easy to understand?</td></tr>
<tr><td>In the last six months, how often did your personal doctor listen carefully to you?</td></tr>
<tr><td>In the last six months, how often did your personal doctor show respect for what you had to say?</td></tr>
<tr><td>In the last six months, how often did your personal doctor spend enough time with you?</td></tr>
<tr><td>Products</td><td>• Commercial
• Medicaid</td></tr>
<tr><td colspan="2">Tips and best practices:
• Ensure provider and office staff are trained to handle sensitive situations
• Treat patients with empathy and respect
  • Make eye contact,
  • Listen carefully and
  • Express understanding
• Use visual aids and plain language guidelines to provide patients with information they can understand and use to make informed decisions for their health
• Sitting down during an appointment gives improved patient perception of care or interaction and a perception that the duration of the visit is longer
• Visit www.cdc.gov for cultural competency and health literacy tools and resources that promote effective communication</td></tr>
</table>



Annual Flu Vaccine

The Annual Flu Vaccine survey question assesses if the member received a flu vaccine during the flu season each year.

Influenza (flu) is a contagious respiratory illness caused by influenza viruses. It can cause mild to severe illness. Serious outcomes of flu infection can result in hospitalization or death. Some people, such as older people, young children, and people with certain health conditions, are at high risk of serious flu complications.

The best available protection is an annual influenza vaccination for all patients six months old and older. It is recommended that patients are vaccinated each year.

Annual Flu Vaccine	Have you had a flu shot?
Products	• Commercial • Medicaid • Medicare
Quality programs affected	• CMS Star Ratings

Tips and best practices:

- Recommend and administer flu shot as soon as it's available each fall September-December
- Recommend flu shot to all eligible patients and provide during appointment
- Eliminate barriers to accessing flu shots and offer multiple options for patients to get their shot (walk-in appointments, flu shot clinics, making flu shots available at every appointment)
- Visit cdc.gov for additional information and resources and tools for **influenza vaccination** resources for techniques on how to talk to your patients about the flu vaccine and make a strong recommendation

Rating of Health Care Quality

The Rating of Health Care Quality survey questions assesses health plan patients on the member's perception of the overall quality of their health care.

Health Care Quality	In the last six months, how often did your personal doctor explain things in a way that was easy to understand?
	In the last six months, how often did your personal doctor listen carefully to you?
	In the last six months, how often did your personal doctor show respect for what you had to say?
	In the last six months, how often did your personal doctor spend enough time with you?
Products	• Commercial • Medicaid • Medicare
Quality programs affected	• CMS Star Ratings

Tips and best practices:

- Encourage patients to make routine appointments for checkups or follow-up as soon as they can = weeks or even months in advance
- Ensure that open care gaps are addressed during each patient visit

Child CAHPS Survey

The Child Consumer Assessment of Healthcare Providers and Systems (Child CAHPS) Survey assesses the perceptions and experiences of patients enrolled in health plans as a part of a process to evaluate the quality of health care services provided to children enrolled in health plans based on the responses of parents or caretakers. The goal of the CAHPS Health Plan Survey is to provide performance feedback that is actionable and that will aid in improving patients' overall experiences.

Your Child's Health Care

The Your Child's Health Care survey questions assesses the parents of health plan patients on how easy it was for them to get appointments for their child with their primary provider and specialists and get the care, tests, or treatment the child needed through their health plan.

Getting Needed Care from Specialists	In the last six months, did your child have an illness, injury, or condition that needed care right away?
	In the last six months, when your child needed care right away, how often did your child get care as soon as he or she needed?
	In the last six months, how often was it easy to get care, tests, or treatment your child needed?
Products	• Commercial • Medicaid

Tips and best practices:

- Assist patients to make specialist appointments before they leave the office
    - ❖ Call the specialist to coordinate the soonest appointment date. Provide appropriate summary to specialist office – reason for referral, brief introduction of patient/problem and any testing already done.
- Offer suggestions of more than one specialist
- Ask patients if they have had any delays in receiving care
- Review authorization and referral processes to remove patient barriers to access to care
- Follow-up with patients to confirm that referrals to specialists are completed and assist with any issues
- Discuss care plan and/or barriers with patient's Priority Health Care Manager if applicable
- Be proactive and schedule tests, screenings, follow-up, or annual well visits for your patients ahead of time
- Include the patient in decision-making about their care regarding tests, referrals, and treatment options

Getting Care Quickly

The Getting Care Quickly survey questions assesses the parents of health plan patients on how often their child got care as soon as needed when sick or injured.

Getting Care Quickly	In the last six months, did you make any in-person, phone, or video appointments for a check-up or routine care for your child?
	In the last six months, how often did you get an appointment for a check-up or routine care as soon as your child needed?
	In the last six months, how many times did he or she get health care in person, by phone, or by video?
Products	• Commercial • Medicaid

Tips and best practices:

- Leave some open appointment slots each day for sick visits
- Consider offering early morning walk-ins, evening appointments and/or weekend appointments Encourage patients to schedule routine visits in advance or before they leave office
- Make sure patients are supported by staff and excessive wait times are explained
  - ❖ Patients are more tolerant of appointment delays if they know the reasons for the delay
  - ❖ Provide brief and frequent updates for any provider delays and offer options to reschedule or be seen by another provider
- Survey your patients and ask how you can improve their health care experience
- In addition to in-person office appointments, implement phone or video appointments as an option

How Well Doctors Communicate

The How Well Doctors Communicate survey questions assesses the parents of health plan patients on how often their child's personal doctor explained things clearly both to the parent and to the child, listened carefully, showed respect, and spent enough time with the child.

How Well Doctors Communicate	In the last six months, how often did your personal doctor explain things about your child's personal health in a way that was easy to understand?
	In the last six months, how often did your child's personal doctor listen carefully to you?
	In the last six months, how often did your child's personal doctor show respect for what you had to say?
	In the last six months, how often did your personal doctor spend enough time with you?
Products	• Commercial • Medicaid

Tips and best practices:

- Ensure provider and office staff are trained to handle sensitive situations
- Treat patients and parents with empathy and respect
  - Make eye contact,
  - Listen carefully and
  - Express understanding

- Use visual aids and plain language guidelines to provide patients with information they can understand and use to make informed decisions for their health
- Sitting down during an appointment gives improved patient perception of care or interaction and a perception that the duration of the visit is longer
- Visit **www.cdc.gov** for **cultural competency and health literacy tools** and resources that promote effective communication

Best Practices and Tips to Improve CAHPS Measures

Checklist for CAHPS Success

Here are ways you can improve your patients' experience and help with the CAHPS survey.

	Actions to take
Before appointments	• Offer convenient appointment times by keeping blocks of time open for same-day, weekend and early morning or evening slots
	• Consider offering telehealth service (by phone or video chat) as an alternative to in-person appointments
	• Confirm appointments with patients one day prior to visit by text message, a live call and/or an automated call messaging system
	• Provide options for registering in advance either by a patient portal or set up an online scheduling system so that patients can provide their information before coming in
	• Obtain any prior authorization ahead of visit to expedite care
During appointments	• Do your best to see patients within 15 minutes of their appointment time
	• Recommend flu vaccination for patients six months old and older to protect against the flu season (September to December) each year
	• Address patient questions and concerns about the flu vaccine, including side effects, safety, and vaccine effectiveness, in plain and easy-to-understand language
	• Review patient's prescriptions, make sure they understand the importance of their medications and alert them to any possible adverse drug interactions
	• Communicate when patient's test results will be available and set reminders to review results with patients in a timely manner
	• Ask patients if they have any questions or concerns regarding their care
End of appointments	• Immediately schedule patients' follow-up and/or diagnostic appointments to ensure continuous care
	• Account for specialist care by making sure specialist appointments were made or help patients schedule appointments if needed
	• Encourage patients to use the patient portal, which allows them access to their health records and ask providers questions.
	• Share health records with patients' other providers to keep everyone up to date

HOS (Health Outcomes Survey)

The health plan HOS survey measures Medicare patients' perception of their health outcomes. Providers have a direct impact on HOS because patients' perceptions of their health outcomes are primarily driven by how well the providers communicate with patients.

Improving Bladder Control

Improving Bladder Control measure assesses whether patients who had urinary incontinence in the last six months have discussed treatment options with their provider. The measure assesses patients who:

- Reported having urine leakage in the past six months and who discussed their urinary leakage problem with a healthcare provider
- Reported having urine leakage in the past six months and who discussed treatment options for their urinary incontinence with a healthcare provider
- Reported having urine leakage in the past six months and who reported that urine leakage made them change their daily activities or interfered with their sleep a lot

Connect with your patients by asking:

- Have you experienced urine leakage or "accidents" in the past six months?
- How often and when do the leakage problem occur?
- Does urinary incontinence affect your daily life (such as leading to school withdrawals, depression, or sleep deprivation)?
- Are you currently receiving any treatment?

Tips and best practices:

- Explain that treatment can improve bladder control and reduce urinary incontinence
- If the patient isn't receiving treatment, explain their options, which include many ways to control or manage symptoms, such as bladder training exercises, medicine, or surgery
- When necessary, recommend appropriate treatment

Reducing the Risk of Falling

Reducing the Risk of Falling measures whether the patient has a problem with falling, walking, or balancing and has discussed it with their PCP and received treatment for it. The Fall Risk Management measure assesses patients who:

- Were seen by a doctor in the past 12 months and who discussed falls or problems with balance or walking with their current doctor
- Had a fall or had problems with balance or walking in the past 12 months, who were seen by a doctor in the past 12 months, and who received a recommendation for how to prevent falls or treat problems with balance or walking from their current doctor

Connect with your patients by asking:
- Have you had a fall in the past year?
- What were the circumstances of the fall?
- How do you think a fall could have been prevented?
- Have you felt dizzy, or had problems with balance or walking in the past year?
- Do you have any vision problems? Have you had a recent eye exam?

Tips and best practices:
If the patient is at risk of falling, recommend a preventive course of action, such as:
- Proper use of a cane or walker
- Exercise or a physical therapy program to improve leg strength and balance
- Modification of home to make it safer (e.g., safety bars)
- Review of medications
- Annual vision or hearing test

Recommend the following:
- SilverSneakers® fitness benefits and features
- Physical activity programs at local senior centers/other community settings

Monitoring Physical Activity

This measure assesses whether a patient has discussed physical activity with their primary care provider (PCP) and whether the PCP gave advice about the patient's level of physical activity. The Physical Activity in Older Adults measure assesses patients who:

- Had a doctor's visit in the past 12 months and who spoke with a doctor or other health provider about their level of exercise or physical activity
- Had a doctor's visit in the past 12 months and who received advice to start, increase, or maintain their level of exercise or physical activity

Quality programs affected: CMS Star Ratings

Connect with your patients by asking:
- What's your daily activity level?
- What activities do you enjoy?
- Do you feel better when you are more active?

Tips and best practices:
- Recommend starting, increasing, or maintaining patient's level of physical activity
- Explain the importance of physical activity for
  - ❖ muscle strength and balance
  - ❖ reduced risk of falls
  - ❖ mental well-being
  - ❖ healthy aging
- Recommend patient utilize:
  - ❖ SilverSneakers® fitness benefits and features
  - ❖ Physical activity programs at local senior. Centers/ other community settings

Improving or Maintaining Physical Health

The Improving or Maintaining Mental Health measure assesses patients whose physical health is the same or better after two years.

Connect with your patients by asking:

- How far can you walk?
- Do you have any trouble climbing up or down stairs?
- Are you able to shop for and cook your own food?
- Does pain limit your activities?

Tips and best practices:

- Assess patients' physical activity level
- Use Annual Wellness Visits to talk with patients about their health and document changes that have occurred in the past year
- Recommend relevant physical activity and provide educational materials, suggested exercises and information on fitness programs such as SilverSneakers® and other community resources
- Refer patients with limited mobility to physical therapy if appropriate
- Assess and address pain issues that patients may be experiencing

Improving or Maintaining Mental Health

The Improving or Maintaining Mental Health measure assesses patients whose mental health is the same or better after two years.

Connect with your patients by asking:

- Describe your energy level.
- Do you get to socialize?

Tips and best practices:

- Assess patients' mental health using a Patient Health Questionnaire-3(PHQ-2) and if appropriate, a PHQ-9
- Conduct a reconciliation of medication at every visit to ensure the patient is taking medications correctly
- For patients experiencing depression or anxiety, talk with them about how they can get help.
- If you need to refer your patient to a behavioral health specialist or need to request coordination of care, please call the Behavioral Health department at 800.673.8043
- Discuss and address issues of substance abuse and illegal drug use

For more information about the CAHPS and HOS surveys, please contact Ian Straayer, Director, Quality Improvement (Medicare 5-Star, HEDIS, Health Plan Quality) at ***ian.straayer@priorityhealth.com.***

Resources

Medication Therapy Management (MTM) Program

Medicare patients, including DSNP members, may be targeted for a free medication review (Commercial and Medicaid/Healthy Michigan Plan members are not eligible) with a specially trained Medication Therapy Management pharmacist. To be targeted members must meet the following targeting criteria:

- Have three or more specific health conditions (Asthma, CHF, COPD, Diabetes, Dyslipidemia, and Hypertension) AND
- Take 8 or more chronic or maintenance drugs, AND
- Spend $4,935 per year on prescriptions, OR
- Be identified as an At-Risk Beneficiary through Priority Health's Drug Management Program

Members that meet targeting criteria will receive an offer via mail or phone to complete their review from our MTM partner, Arine. For more information, visit the Medication Therapy Management webpage. Targeted members can contact Arine at 616.303.1014 to complete their annual medication review.

PCP Incentive Program (PIP) Report

We're always working on ways to positively impact the time you spend with your patients who are Priority Health plan patients. That's one reason why the PCP Incentive Program (PIP) Report was created – to help you quickly see who may be due for screenings and tests, and who may be at risk for non-adherence to their medications. The PCOR is available online monthly and is compiled from medical and pharmacy claims data and supplemental data. You can check it daily to view care opportunities tied to measures included in this reference guide such as CMS Star Ratings, HEDIS and Pharmacy compliance.

For more information, please contact your Provider Network Performance representative.

SilverSneakers® Medicare Advantage Benefit

SilverSneakers is a fitness and lifestyle program benefit for Medicare Advantage and Medicare DSNP plan patients at no additional cost, giving them access to fitness centers and helping them remain active and socially connected.

SilverSneakers includes:

- Memberships to thousands of participating SilverSneakers fitness locations, including locally owned gyms and nationally recognized brands
- Group exercise classes designed for all abilities
- Access to online educational programs and SilverSneakers On-Demand™ workout videos so you can exercise when and where you choose
- Easy access to workout programs, location finder and more with the **SilverSneakers GO™ fitness app**

Learn more about the SilverSneakers health and fitness Program:

- To find a participating fitness center, visit ***www.silversneakers.com***
- Call SilverSneakers toll-free at **833.236.0190** (TTY/TDD **711**), Monday – Friday 8 a.m. – 8 p.m. (Eastern time). For assistance on Saturday or Sunday, call Priority Health Medicare .m.

Appendix 1: Glossary of Terms

Term	Description
Administrative	Measures reported as administrative use the total eligible population for the denominator. Medical, pharmacy and encounter claims count toward the numerator. In some instances, health plans use approved supplemental data for the numerator.
Care Opportunity	Patients/patients in a denominator for a HEDIS measure who show in Priority Health's records as not yet meeting the measure's numerator criteria. For most measures, providers may close a care opportunity by completing a service related to preventive care, chronic care, or care transitions and submitting claims or supplemental data with billing codes that meet the numerator's criteria.
CMS	Centers for Medicare & Medicaid Services (CMS), the federal regulator of Medicare and Medicaid.
Denominator	The number of patients who qualify for the measure criteria, based on NCQA technical specifications.
Exclusions	Patients are excluded from a measure denominator based on a diagnosis and/or procedure captured in their claim/ encounter/pharmacy data. If applicable, the required exclusion is applied after the claims data is processed within certified HEDIS® software based on the measure specifications while the measure denominator is being created. For example: • Patients with end-stage renal disease (ESRD) during the measurement year or year prior will be excluded from the statin therapy for patients with cardiovascular disease (SPC) measure denominator.
Hybrid	Measures reported as hybrid use a random sample of 411 patients from a health plan's total eligible population for the denominator. The numerator includes medical and pharmacy claims, encounters, and medical record data. In some cases, health plans use auditor approved supplemental data for the numerator.
Index Prescription Start Date (IPSD)	The earliest prescription dispensing date for an opioid medication during the intake period.
MCIR	The Michigan Care Improvement Registry (MCIR) is an electronic immunization registry and is available to private and public providers for maintenance of immunization records for all citizens in the state of Michigan. MCIR calculates a patient's age, provides an immunization history, and determines which immunizations may be due. Priority Health receives monthly data downloads from the Michigan Department of Community Health (MDCH) and displays this data within monthly reports.
Measurement Year	Unless stated otherwise within the measure description, the measurement year is January 1 through December 31. This 12-month time frame is where data is collected for submission during the reporting year

Medical Record Data	The information taken directly from a patient's medical record to validate services rendered that weren't captured through medical or pharmacy claims, encounters, or supplemental data.
MiHIN	The Michigan Health Information Network (MiHIN) is a public-private nonprofit collaboration dedicated to improving the health care experience, improving quality, and decreasing cost for Michigan's people by supporting the statewide exchange of health information.
NCQA Accreditation	NCQA developed the first set of standards for health plan quality. Its Health Plan Accreditation program is based on a set of evidenced-based requirements that measure plan performance and provide employers with a way to evaluate current and prospective plans. NCQA Health Plan Accreditation is a widely recognized, evidence-based program dedicated to quality improvement and measurement. It provides a comprehensive framework for organizations to align and improve operations in areas that are most important to states, employers and consumers. It's the only evaluation program that bases results on actual measurement of clinical performance (HEDIS measures) and consumer experience (CAHPS measures).
Numerator	The number of patients who meet compliance criteria based on NCQA technical specifications for appropriate care, treatment, or service.
Performance Measure	An evidence-based, nationally vetted method to measure how good a health plan is at getting its patients good care in certain targeted areas.
Proportion of Days Covered (PDC)	The number of days the member is covered by at least one medication prescription of appropriate intensity, divided by the number of days in the treatment period.
State Performance Measure	Measures selected by the Michigan Department of Health and Human Services (MDHHS) to evaluate Michigan Medicaid Health Plans (MHPs)
Supplemental Data	Standardized process in which clinical data is collected by health plans for purposes of HEDIS improvement. Supplemental clinical data is additional data beyond claims data. Throughout the year, this data could be standard submissions to the plan such as lab files. Supplemental data could also be nonstandard, such as health risk assessment data submitted to the plan.
Treatment Period	The earliest prescription dispensing date in the measurement year for any statin medication of at least moderate intensity through the last day of the measurement year.

Appendix 2: Supplemental Data Submissions

Priority Health accepts supplemental encounter and lab data to help close care opportunities.

Priority Health defines supplemental data as anything that is submitted to Priority Health beyond what is included on a claim form. There are four approved methods of submitting supplemental data:

- HL7
- Patient profile
- Report #70
- All Payer Supplemental (APS) File Michigan Health Information Network Shared Services (MiHIN)

How we audit supplemental data

Audits ensure the accuracy of our PCP Incentive Program (PIP) payouts.

Priority Health audits the supplemental data provided by practices for the PCP Incentive Program measure requirements. This annual audit randomly selects practices throughout the network.

At the year end, each audited practice is given a partial list of supplemental data provided to Priority Health. Practices are required to return a copy of the medical record that documents the supplemental data piece. Example: If lab value data was supplied, the practice would submit a printed copy of office visit notes with the lab value.

FileMart
A Priority Health application within our website's provider center. FileMart is the available mechanism to receive standard incentive program and membership reports. If you would like to learn more about FileMart reporting, please contact your Provider Performance Specialist at ***priorityhealth.com/provider/center/contact-us/representatives.***

Appendix 3: CPT II Codes

CPT II codes are **supplemental tracking codes that can be used for performance measurement**. The use of CPT II codes for HEDIS performance measures will decrease the need for record abstraction and chart review, and thereby minimize administrative burdens on physicians and other health care professionals.

CPT II codes describe:

- Clinical components, such as those typically included in evaluation, management, or other clinical services
- Results from clinical laboratory or radiology tests and other procedures; or
- Identified processes intended to address patient safety practices

Benefits of using CPT II codes

1. **Fewer medical record requests**
   When you add CPT® Category II codes, we won't have to request charts from your office to confirm care you've already completed.
2. **Enhanced performance**
   With better information, we can work with you to help identify opportunities to improve patient care. This may lead to better performance on HEDIS® measures for your practice.
3. **Improved health outcomes**
   With more precise data, we can refer Priority Health plan members to our programs that may be appropriate for their health situation to help support your plan of care.
4. **Less mail for members**
   With more complete information, we can avoid sending reminders to patients to get screenings they may have already completed.

The following table lists the HEDIS quality measure, indicator description, and the CPT II codes that are recognized in the HEDIS specifications.

Quality Measure	Indicator Description	CPT II Code	CPT II Description
Care for Older Adults	Advance Care Planning	1123F	Advance Care Planning discussed and documented advance care plan or surrogate decision maker documented in the medical record
		1124F	Advance Care Planning discussed and documented in the medical record, patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan
		1157F	Advance care plan or similar legal document present in the medical record
		1158F	Advance care planning discussion documented in the medical record

Quality Measure	Indicator Description	CPT II Code	CPT II Description
	Functional Status Assessment	1170F	Functional status assessed
	Medication List	1159F	Medication list documented in medical record (must be billed with CPT II 1160F)
	Medication Review	1160F	Review of all medications by a prescribing practitioner or clinical pharmacist (such as, prescriptions, OTCs, herbal therapies, and supplements) documented in the medical record
	Pain Assessment	1125F	Pain severity quantified; pain present
		1126F	Pain severity quantified; no pain present
Controlling High Blood Pressure	Blood Pressure Control	3078F	Diastolic less than 80
		3079F	Diastolic between 80-89
		3080F	Diastolic greater than/equal to 90
		3074F	Systolic less than 130
		3075F	Systolic between 130-139
		3077F	Systolic greater than/equal to 140
Diabetes Care	Blood Pressure Control	3078F	Diastolic less than 80
		3079F	Diastolic between 80-89
		3080F	Diastolic greater than/equal to 90
		3074F	Systolic less than 130
		3075F	Systolic between 130-139
		3077F	Systolic greater than/equal to 140
	Hemoglobin A1c Control	3044F	HbA1c level less than 7.0%
		3051F	HbA1c level greater than or equal to 7.0% and less than 8.0%
		3052F	HbA1c level greater than or equal to 8.0% and less than or equal to 9.0%
		3046F	HbA1c greater than or equal to 9.0%
	Eye Exam with Evidence of Retinopathy	2022F	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy
		2024F	7 standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed: with evidence of retinopathy
		2026F	Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed; with evidence of retinopathy

Quality Measure	Indicator Description	CPT II Code	CPT II Description
	Eye Exam without Evidence of Retinopathy	2023F	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy
		2025F	7 standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy
		2033F	Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed; without evidence of retinopathy
		3072F	Low risk for retinopathy (no evidence of retinopathy in the prior year
Prenatal and Postpartum Care	Prenatal Visit	0500F	Initial prenatal care visit
		0501F	Prenatal flow sheet documented in medical record by first prenatal visit (documentation includes at minimum blood pressure, weight, urine protein, uterine size, fetal heart tones, and estimated date of delivery).
		0502F	Subsequent prenatal care visit
	Postpartum Visit	0503F	Postpartum care visit
Transition of Care	Medication Reconciliation Post-Discharge	1111F	Discharge medications reconciled with the current medication list in outpatient medical record

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

CPT® is a registered trademark of the American Medical Association.

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Priority Health will make the final determination regarding reimbursement upon receipt of a claim. Submitting a claim with a code included in this document is not a guarantee of payment. Payment of covered services is contingent upon coverage within an individual member's benefit plan, your eligibility for payment, any claim processing requirements, and your participation agreement with Priority Health.