HEDIS Guidebook

Measurement Year 2025

US FAMILY HEALTH PLAN
A TRICARE Prime® Option

Contents

What is HEDIS®?

HEDIS® (Healthcare Effectiveness Data and Information Set) is a tool created by the National Committee for Quality Assurance (NCQA) in the 1980s to standardize how health plans are assessed. It includes a range of measures across six key areas of care, covering both preventive services and treatment for specific conditions. HEDIS is essential for health plans seeking or maintaining NCQA accreditation.

How is data for HEDIS collected?

HEDIS data is gathered using several methods depending on the specific measure. These include administrative or claims data, supplemental provider files, medical record reviews, surveys, and Electronic Clinical Data Systems (ECDS). Each measure has specific guidelines detailing what data to collect, any exclusions, and the approved collection methods. For accurate reporting, it's recommended to follow the General Guidelines and review individual Measure Descriptions.

- **Administrative Method**
  The administrative method relies solely on claims and encounter data that health plans, providers, or billing systems submit—rather than reviewing medical records

- **Hybrid Method**
  It combines claims/encounter data with medical record reviews to provide a more complete and accurate assessment of healthcare quality

- **Survey Method**
  The Survey Method involves collecting data directly from members through standardized questionnaires, typically administered by mail, phone, or online. These surveys assess members' experiences with their health plan, providers, and care services

- **ECDS Method**
  The ECDS method is a modern HEDIS data collection approach that utilizes electronic clinical data systems—including EHRs, registries, health information exchanges (HIEs), case management platforms, and patient portals—to report specific HEDIS measures. It enables health plans to submit data from digital, structured clinical sources, extending beyond traditional claims data and manual chart reviews

HEDIS Terminology

Compliant: A medical record is compliant (i.e. counts as meeting the measure) when it clearly and accurately documents that the specific care or outcome required by the HEDIS measure has occurred, within the correct timeframe, and in a format that meets audit standards

Non-Compliant: A medical record is non-compliant (i.e. counts as not meeting the measure) when it fails to clearly and accurately document that the specific care or outcome required by the HEDIS measure has occurred or it is too vague to conclude that the service occurred according to the measure specification, and/or it is not within the correct timeframe, and/or it is not in a format that meets audit standards

Continuous enrollment: Specifies the minimum period a member must be enrolled in a health plan to be eligible for a measure. This ensures the organization has adequate time to deliver the necessary services. The required length of continuous enrollment—and any allowable gaps in coverage— varies by measure

Denominator: The number of members who meet the criteria defined by NCQA technical specifications

Eligible population: All members who meet all defined criteria for the measure, including age, continuous enrollment, benefit eligibility, a relevant event or diagnosis, and enrollment on the anchor date

Measurement year (MY): Refers to the year prior to the Reporting Year, as defined in NCQA specifications. It is used in determining measure requirements and anchor dates

Numerator: The number of members who meet compliance criteria for appropriate care, treatment, or services, as defined by NCQA technical specifications

Prior year (PY): Year prior to measurement year

Supplemental data (non-standard): Data collected prospectively which is not in a standard file layout. Medical record reviews are an example

Supplemental data (standard): Standardized file process used to collect data from sites to close gaps

General HEDIS Guidelines and Measure Descriptions

New Measures

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

The percentage of individuals aged 18 to 85 with a documented diagnosis of hypertension whose most recent blood pressure reading during the measurement period was below 140/90 mm Hg.

Intent: This new measure introduces two key changes compared to the Controlling High Blood Pressure (CBP) HEDIS measure, which uses the Hybrid reporting method (including medical record review) and a denominator that may exclude many individuals with hypertension who should be included:

- It adopts the Electronic Clinical Data Systems (ECDS) reporting method
- It expands the denominator to include individuals identified through pharmacy data in combination with a hypertension diagnosis

Eye Exam for Patients with Diabetes (EED):

NCQA has retired the Hybrid Method; this measure is now reported exclusively using the Administrative Method

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

NCQA has revised the denominator criteria to include the diagnoses of phobias, anxiety, intentional self-harm (X-chapter codes), and the suicidal ideation code (R45.851). The numerator criteria have also been expanded to allow for additional follow-up options, including a broader range of provider types, psychiatric residential treatment, and peer support services for mental health

Well-Child Visits in the First 30 Months of Life (W30); Child and Adolescent Well-Care Visits (WCV):

NCQA is removing telehealth visits from the measures. These visits were temporarily included in response to the COVID-19 pandemic. Their removal aligns the measures with updated clinical guideline recommendations

Best Practices and Measure Tips

Improving HEDIS scores involves a combination of clinical best practices, accurate data reporting, and proactive patient engagement. Here are key strategies:

- Ensure complete and timely documentation in electronic health records (EHR)
- Use appropriate diagnosis and procedure codes for all services rendered
- Submit accurate claims/encounter data in a timely manner
- Use Care Gap reports to identify patients due or overdue for screenings, immunizations, or follow-up care
- Implement reminder systems (calls, texts, portal alerts) for patients and providers
- Educate patients on the importance of preventive care and follow-ups
- Promote team-based care with coordination between primary care, specialists, and behavioral health providers
- Utilize care managers or navigators to assist patients with chronic conditions or complex needs
- Prioritize measures with the greatest health benefits to the Patient
- Address common gaps such as blood pressure control, diabetes management, cancer screenings, and behavioral health follow-up
- Stay current with NCQA updates, as measure specifications and codes can change
- Document medical and detailed surgical history with dates and use of appropriate coding. (Example: Documentation of Colectomy will not exclude member from COL Measure because it needs to specifically say the member had a Total Colectomy)
- Respond to medical record request in a timely manner
- Ask open-ended questions to determine any barriers to care or treatment
- Improve care coordination by sharing data feeds with payers to reduce duplication of services

Measure Codes

The measure code lists provided in this guide are not comprehensive and may be updated in accordance with the latest NCQA specifications.
This guide includes commonly used value sets for quick reference. The National Committee for Quality Assurance (NCQA) maintains a Value Set Directory that organizes the relevant codes associated with each measure. These include Current Procedural Terminology (CPT) codes, which are copyrighted by the American Medical Association (AMA) as of 2024. Please note that both measure specifications and codes are subject to change until NCQA finalizes them on March 31 of the measurement year. An official update reflecting any revisions will be published on the NCQA website: https://www.ncqa.org/hedis/measures/

Telephone Visits

- CPT: 98966, 98967, 98968, 99441, 99442, 99443

Telehealth (E-visit or virtual check-in)

- CPT: 98970, 98971, 98972, 98980, 98981, 99421, 99422, 99423, 99457, 99458
- HCPCS: G0071, G2010, G2012, G2250, G2251, G2252

Telehealth Place of Service (POS) (Telehealth POS Value Set): 02, 10

- 02: Telehealth Provided Other than in Patient's Home
- 10: Telehealth Provided in Patient's Home

Outpatient Visit (Outpatient Value Set)

- CPT: 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99242, 99243, 99244, 99245, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99429, 99455, 99456, 99457, 99458, 99483
- HCPCS: G0402, G0438, G0439, G0463, T1015**
- UBREV: 0510, 0511, 0513, 0514, 0515, 0516, 0517, 0519, 0520, 0521,0522, 0523, 0526, 0527, 0528, 0529, 0982, 0983

Place of Service (POS) codes

- 03 School
- 05 Indian Health Service Free-standing Facility
- 07 Tribal 638 Free-standing Facility
- 09 Prison/Correctional Facility
- 11 Office
- 12 Home
- 13 Assisted Living Facility
- 14 Group Home
- 15 Mobile Unit
- 16 Temporary Lodging
- 17 Walk-in Retail Health Clinic
- 18 Place of Employment-Worksite
- 19 Off Campus-Outpatient Hospital
- 20 Urgent Care Facility
- 22 On Campus-Outpatient Hospital
- 24 Ambulatory Surgical Center (For FUH Measure only)
- 33 Custodial Care Facility
- 49 Independent Clinic

- 50 Federally Qualified Health Center
- 52 Psychiatric Facility-Partial Hospitalization (For FUH Measure only)
- 53 Community Mental Health Center (For FUH Measure only)
- 56 Psychiatric Residential Treatment Center (For FUH Measure only)
- 71 Public Health Clinic
- 72 Rural Health Clinic

Ambulatory Outpatient Visit Value Set

- CPT: 92002, 92004, 92012, 92014, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99242, 99243, 99244, 99245, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404 99411, 99412, 99421, 99422, 99423, 99429, 99483
- HCPCS: G0463, G0071, G0402, G0438, G0439, G0463, G2010, G2012, G2250, G2251, G2252, S0620, S0621, T1015**
  NOTE: **T1015 HCPCS code identifies an all-inclusive clinic visit for services rendered at Federally Qualified Health Center (FQHC)
- UBREV: 0510, 0511, 0513, 0514, 0515, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0524, 0525, 0526, 0527, 0528, 0529, 0982, 0983

Telephone/Telehealth visits codes (listed above) are also part of the Ambulatory Outpatient Visit Value Set

Measure Exclusion Codes

Hospice Encounter

- HCPCS: G9473, G9474, G9475, G9476, G9477, G9478, G9479, Q5003, Q5004, Q5005, Q5006, Q5007, Q5008, Q5010, S9126, T2042, T2043, T2044, T2045, T2046
- UBREV: 0115, 0125, 0135, 0145, 0155, 0235, 0650, 0651, 0652, 0655, 0656, 0657, 0658, 0659

Hospice Intervention

- CPT: 99377-99378
- HCPCS: G0182

Palliative Care Encounter

- G9054 Oncology
- M1017 Patient admitted to palliative care services
- Z51.5 Encounter for palliative care

Direct Reference Code for the following measures

CBP, CCS, COL, EED, KED, LBP

Frailty Device

- HCPCS: E0261, E0294, E0295, E0265, E0266, E0296, E0297, E0255, E0256, E0292, E0293, E1260, E1240, E1270, E1250, E1161, E0167, E0430, E0431, E0435, E0433, E0434, E0443, E0444, E0472, E0471, E0470, E0462, E1298, E1297, E1296, E1130, E0425, E0424, E0440, E0439, E0441, E0442, E0144, E0135, E0143, E0147, E0149, E0148, E0130, E0141, E0140, E1150, E1140, E1160, E1220

Frailty Encounter

- CPT: 99504, 99509
- HCPCS: G0162, G0299, G0300, G0493, G0494, S0271, S0311, S9123, S9124, T1000, T1001, T1002, T1003, T1004, T1005, T1019, T1020, T1021, T1022, T1030, T1031

Frailty Diagnosis

- [R26.2] Difficulty in walking, not elsewhere classified
- [R26.89] Other abnormalities of gait and mobility
- [R26.9] Unspecified abnormalities of gait and mobility
- [R29.6] Repeated falls
- [R53.1] Weakness
- [R53.81] Other malaise
- [R54] Age-related physical debility
- [R62.7] Adult failure to thrive
- [R63.4] Abnormal weight loss
- [R63.6] Underweight
- [R64] Cachexia
- [L89.xxx] Pressure ulcer
- [M62.50] Muscle wasting and atrophy, not elsewhere classified, unspecified site
- [M62.81] Muscle weakness (generalized)
- [M62.84] Sarcopenia
- [W01.0XXA] Fall
- [W19.XXXA] Unspecified fall, initial encounter
- [W19.XXXD] Unspecified fall, subsequent encounter
- [W19.XXXS] Unspecified fall, sequela
- [Y92.199] Unspecified place in other specified residential institution as the place of occurrence of the external cause
- [Z59.3] Problems related to living in residential institution

- [Z73.6] Limitation of activities due to disability
- [Z74.01] Bed confinement status
- [Z74.09] Other reduced mobility
- [Z74.1] Need for assistance with personal care
- [Z74.2] Need for assistance at home & no other household member able to render care
- [Z74.3] Need for continuous supervision
- [Z74.8] Other problems related to care provider dependency
- [Z74.9] Problem related to care provider dependency, unspecified
- [Z91.81] History of falling
- [Z99.11] Dependence on respirator [ventilator] status
- [Z99.3] Dependence on wheelchair
- [Z99.81] Dependence on supplemental oxygen
- [Z99.89] Dependence on other enabling machines and devices

NOTE: Please refer to the HEDIS MY 2025 Volume 2 Value Set Directory for Frailty Diagnosis Value Set for the complete list of ICD-10-CM codes

Advanced Illness

- ICD-10-CM: A81.00, A81.01, A81.09, C25.0, C25.1, C25.2, C25.3, C25.4,C25.7, C25.8, C25.9, C71.0, C71.1, C71.2, C71.3, C71.4, C71.5, C71.6, C71.7, C71.8, C71.9, C77.0, C77.1, C77.2, C77.3, C77.4, C77.5, C77.8, C77.9, C78.00, C78.01, C78.02, C78.1, C78.2, C78.30, C78.39, C78.4, C78.5, C78.6, C78.7, C78.80, C78.89, C79.00, C79.01, C79.02, C79.10, C79.11, C79.19, C79.2, C79.31, C79.32, C79.40, C79.49, C79.51, C79.52, C79.60, C79.61, C79.62, C79.63, C79.70, C79.71, C79.72, C79.81, C79.82, C79.89, C79.9, C91.00, C91.02, C92.00, C92.02, C93.00, C93.02, C93.90, C93.92, C93.Z0, C93.Z2, C94.30, C94.32, F01.50, F01.51, F01.511, F01.518, F01.52, F01.53, F01.54, F01.A0, F01.A11, F01.A18, F01.A2, F01.A3, F01. A4, F01.B0, F01.B11, F01.B18, F01.B2, F01.B3, F01.B4, F01.C0, F01.C11, F01. C18, F01.C2, F01.C3, F01.C4, F02.80, F02.81, F02.811, F02.818, F02.82, F02.83, F02.84, F02.A0, F02.A11, F02.A18, F02.A2, F02.A3, F02.A4, F02. B0, F02.B11, F02.B18, F02.B2, F02.B3, F02.B4, F02.C0, F02.C11, F02.C18, F02.C2, F02.C3, F02.C4, F03.90, F03.91, F03.911, F03.918, F03.92, F03.93, F03.94, F03.A0, F03.A11, F03.A18, F03.A2, F03.A3, F03.A4, F03.B0, F03. B11, F03.B18, F03.B2, F03.B3, F03.B4, F03.C0, F03.C11, F03.C18, F03.C2, F03.C3, F03.C4, F04, F10.27, F10.96, F10.97, G10, G12.21, G20, G30.0, G30.1, G30.8, G30.9, G31.01, G31.09, G31.83, G35, I09.81, I11.0, I12.0, I13.0, I13.11, I13.2, I50.1, I50.20, I50.21, I50.22, I50.23, I50.30, I50.31, I50.32, I50.33, I50.40, I50.41, I50.42, I50.43, I50.810, I50.811, I50.812, I50.813, I50.814, I50.82, I50.83, I50.84, I50.89, I50.9, J43.0, J43.1, J43.2, J43.8, J43.9, J68.4, J84.10, J84.112, J84.17, J84.170, J84.178, J96.10, J96.11, J96.12, J96.20, J96.21, J96.22, J96.90, J96.91, J96.92, J98.2, J98.3, K70.10, K70.11, K70.2, K70.30, K70.31, K70.40, K70.41, K70.9, K74.0, K74.00, K74.01, K74.02, K74.1, K74.2, K74.4, K74.5, K74.60, K74.69, N18.5, N18.6

- ICD-10-CM: A81.00, A81.01, A81.09, C25.0, C25.1, C25.2, C25.3, C25.4, C25.7, C25.8, C25.9, C71.0, C71.1, C71.2, C71.3, C71.4, C71.5, C71.6, C71.7, C71.8, C71.9, C77.0, C77.1, C77.2, C77.3, C77.4, C77.5, C77.8, C77.9, C78.00, C78.01, C78.02, C78.1, C78.2, C78.30, C78.39, C78.4, C78.5, C78.6, C78.7, C78.80, C78.89, C79.00, C79.01, C79.02, C79.10, C79.11, C79.19, C79.2, C79.31, C79.32, C79.40, C79.49, C79.51, C79.52, C79.60, C79.61, C79.62, C79.63, C79.70, C79.71, C79.72, C79.81, C79.82, C79.89, C79.9, C91.00, C91.02, C92.00, C92.02, C93.00, C93.02, C93.90, C93.92, C93.Z0, C93.Z2, C94.30, C94.32, F01.50, F01.51, F01.511, F01.518, F01.52, F01.53, F01.54, F01.A0, F01.A11, F01.A18, F01.A2, F01.A3, F01. A4, F01.B0, F01.B11, F01.B18, F01.B2, F01.B3, F01.B4, F01.C0, F01.C11, F01. C18, F01.C2, F01.C3, F01.C4, F02.80, F02.81, F02.811, F02.818, F02.82, F02.83, F02.84, F02.A0, F02.A11, F02.A18, F02.A2, F02.A3, F02.A4, F02. B0, F02.B11, F02.B18, F02.B2, F02.B3, F02.B4, F02.C0, F02.C11, F02.C18, F02.C2, F02.C3, F02.C4, F03.90, F03.91, F03.911, F03.918, F03.92, F03.93, F03.94, F03.A0, F03.A11, F03.A18, F03.A2, F03.A3, F03.A4, F03.B0, F03. B11, F03.B18, F03.B2, F03.B3, F03.B4, F03.C0, F03.C11, F03.C18, F03.C2, F03.C3, F03.C4, F04, F10.27, F10.96, F10.97, G10, G12.21, G20, G30.0, G30.1, G30.8, G30.9, G31.01, G31.09, G31.83, G35, I09.81, I11.0, I12.0, I13.0, I13.11, I13.2, I50.1, I50.20, I50.21, I50.22, I50.23, I50.30, I50.31, I50.32, I50.33, I50.40, I50.41, I50.42, I50.43, I50.810, I50.811, I50.812, I50.813, I50.814, I50.82, I50.83, I50.84, I50.89, I50.9, J43.0, J43.1, J43.2, J43.8, J43.9, J68.4, J84.10, J84.112, J84.17, J84.170, J84.178, J96.10, J96.11, J96.12, J96.20, J96.21, J96.22, J96.90, J96.91, J96.92, J98.2, J98.3, K70.10, K70.11, K70.2, K70.30, K70.31, K70.40, K70.41, K70.9, K74.0, K74.00, K74.01, K74.02

Ambulatory/Preventative Care Visits

- CPT: 92002, 92004, 92012, 92014, 98966, 98967, 98968, 98970, 98971, 98972, 98980, 98981, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99242, 99243, 99244, 99245, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99421, 99422, 99423, 99429, 99441, 99442, 99443, 99457, 99458, 99483
- HCPCS: G0071, G0402, G0438, G0439, G0463, G2010, G2012, G2250, G2251, G2252, S0620, S0621, T1015
- UBREV: 0510, 0511, 0513, 0514, 0515, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0524, 0525, 0526, 0527, 0528, 0529, 0982, 0983

Reason for Ambulatory/Preventative Care Visit

- ICD-10-CM: 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, Z02.84, Z02.89, Z02.9, Z76.1, Z76.2

Appropriate Testing for Pharyngitis (CWP)

Eligible Population

Members 3 years of age and older by December 31 of the measurement year

Definition

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

Best Practice and Measure Tips

- Prescribe an antibiotic within three days of a positive strep test
- A pharyngitis diagnosis may come from an outpatient visit, online assessment, telehealth visit, emergency department visit, or observation stay that occurs between July 1, 2024, to June 30, 2025, provided it did not result in an inpatient admission
- Perform a rapid strep test or throat culture to confirm diagnosis **Before** prescribing antibiotics
- Educate patients about 'superbugs' and the risk of antibiotic resistance caused by the overuse of antibiotics
- Educate patients on the importance of finishing the entire course of the antibiotic as prescribed, even if they start feeling better

Required Exclusions

- Members in hospice or using hospice services anytime during the measurement year
- Members who died any time during the measurement year

Exclusion Codes

Comorbid Conditions

- ICD-10-CM: A15.0, A17.0, A18.01, A19.0, B44.81, D57.01, D61.810, D70.0, D71, D72.0, D75.81, D76.1, D86.0, E84.0, J22, J41.0, J42, J47.0, J60, J61, J62.0, J63.0, J64, J65, J66.0, J67.0, J68.0, J69.0, J70.0, J80, J81.0, J82, J84.01, J85.0, J86.0, J90, J91.0, J92.0, J93.0, J94.0, J95.00, J95.01, J96.00, J98.51, J99, M05.10, M30.1, M32.13, M33.01, M34.81, M35.02, O98.011, P27.0, Q25.45, Q30.0, Q31.0, Q32.0, Q33.0, Q34.0, Q34.1, Q39.0, Q89.01

Competing Diagnosis

- ICD-10-CM: A00.0, A02.0, A03.0, A04.0, A05.0, A06.0, A07.0, A08.0, A09, A37.00, A44.0, A50.01, A54.00, A55, A56.00, A57, A58, A59.00, A59.9, A63.0, A64, A69.0, A69.9, B60.0, B64, B78.1, B96.89, E83.2, H66.001, H67.1, H70.001, H95.00, J01.00, J04.10, J05.0, J13, J14, J15.0, J16.0, J17, J18.0, J20.0, J32.0, J35.01, J38.7, J39.0, K05.20, K12.2, L01.00, L03.011, L04.0, L08.1, L92.8, L98.0, M46.20, M89.00, M90.80, N10, N12, N13.0, N15.1, N16, N30.00, N39.0, N41.0, N70.01, N71.0, N72, N73.0, N74, N75.0, N76.0, N77.0, Z20.2, Z22.4

Measure Codes

Group A Strep Test

- CPT: 87070, 87071, 87081, 87430, 87650-87652, 87880
- LOINC: 17898-8, 626-2, 17656-0, 11268-0, 31971-5, 6558-1, 6559-9, 18481-2, 6557-3, 78012-2, 49610-9, 103627-6, 101300-2, 60489-2, 5036-9, 68954-7

Pharyngitis

- ICD-10-CM: J02.0, J02.8, J02.9, J03.00, J03.01, J03.80, J03.81, J03.90, J03.91

Measure Medications

Description	Prescription
Aminopenicillins	Amoxicillin Ampicillin
Beta-lactamase inhibitors	Amoxicillin-clavulanate
First generation cephalosporins	Cefadroxil Cefazolin Cephalexin
Folate antagonist	Trimethoprim
Lincomycin derivatives	Clindamycin
Macrolides	Azithromycin Clarithromycin Erythromycin
Natural penicillins	Penicillin G benzathine Penicillin G sodium Penicillin G potassium Penicillin V potassium
Quinolones	Ciprofloxacin Levofloxacin

Quinolones (continued)	Moxifloxacin Ofloxacin
Second generation cephalosporins	Cefaclor Cefprozil Cefuroxime
Sulfonamides	Sulfamethoxazole-trimethoprim
Tetracyclines	Doxycycline Minocycline Tetracycline
Third generation cephalosporins	Cefdinir Cefixime Cefpodoxime Ceftriaxone

Appropriate Treatment for Upper Respiratory Infection (URI)

Eligible Population

Members who were 3 months of age or older as of the episode date

Definition

The percentage of episodes for members 3 months of age and older with a diagnosis of upper respiratory infection (URI) that did not result in an antibiotic prescription being filled

Best Practice and Measure Tips

- Ensure appropriate diagnosis codes are used and clearly document any competing diagnosis when prescribing an antibiotic for a member diagnosed with a URI
- A higher rate indicates appropriate URI treatment. i.e. the proportion of episodes that did not result in an antibiotic prescription being filled

Required Exclusions

- Members in hospice or using hospice services anytime during the measurement year
- Members who died any time during the measurement year

Measure Medications

Description	Prescription
Aminoglycosides	Amikacin Gentamicin Streptomycin Tobramycin
Aminopenicillins	Amoxicillin Ampicillin
Beta-lactamase inhibitors	Amoxicillin-clavulanate
First generation cephalosporins	Cefadroxil Cefazolin Cephalexin
Fourth generation cephalosporins	Cefepime
Folate antagonist	Trimethoprim
Lincomycin derivatives	Clindamycin Lincomycin

Macrolides	Azithromycin Clarithromycin Erythromycin
Natural penicillins	Penicillin G benzathine Penicillin G sodium Penicillin G potassium Penicillin V potassium
Penicillinase resistant penicillins	Dicloxacillin Nafcillin Oxacillin
Quinolones	Ciprofloxacin Levofloxacin Moxifloxacin Ofloxacin
Rifamycin derivatives	Rifampin
Second generation cephalosporins	Cefaclor Cefoxitin Cefprozil Cefuroxime Cefotetan
Sulfonamides	Sulfadiazine Sulfamethoxazole-trimethoprim
Tetracyclines	Doxycycline Minocycline Tetracycline
Third generation cephalosporins	Cefdinir Cefixime Cefpodoxime Ceftriaxone
Urinary anti-infectives	Fosfomycin Nitrofurantoin macrocrystals-monohydrate Nitrofurantoin Trimethoprim

Breast Cancer Screening (BCS-E)

Eligible Population

Women 42–74 years of age as of December 31 of the measurement year

Definition

Women 40-74 years of age who had a mammogram to screen for breast cancer on or between October 1, 2023, to December 31, 2025

Include members who are recommended for routine breast cancer screening based on any of the following criteria:

- Administrative Gender of Female (Administrative Gender code female) at any time in the member's history
- Sex Assigned at Birth (LOINC code 76689-9) of Female (LOINC code LA3-6) at any time in the member's history
- Sex Parameter for Clinical Use of Female (Sex Parameter for Clinical Use code female-typical) during the measurement period

Best Practice and Measure Tips

- Clear documentation of the Mammogram being completed and not just ordered
- When documenting a mammogram in a member's history, be sure to include both the type of mammogram and the date of service; Results are not required
- Submit the appropriate ICD-10 diagnosis code that reflects a member's history of bilateral mastectomy, Z90.13
- Educate members on the importance of screening mammograms for the early detection of breast cancer, especially when no symptoms are present

Acceptable Screening

- Bilateral or Unilateral mammograms performed during the measurement period
- Types of mammograms that are compliant: Screening, Diagnostic, Film, Digital or Digital Breast Tomosynthesis (3D Mammogram)

Non-Compliant Screening

- Biopsies, Breast Ultrasounds or MRIs

Required Exclusions

- Members in hospice or using hospice services anytime during the measurement year
- Members who died any time during the measurement year
- Palliative care any time during the measurement year
- Members 66 years of age and older by the end of the measurement period with Frailty and Advanced Illness
- Documentation of bilateral mastectomy anytime in member's history through December 31 of the Measurement year. Any of the following meet criteria for bilateral mastectomy:
    - A bilateral mastectomy
    - A unilateral mastectomy on both the left and right side on the same or different dates of service
    - Two unilateral mastectomies, which do not specify left and right, must be performed 14 days or more apart
- Members who have undergone gender-affirming chest surgery and have a documented diagnosis of gender dysphoria at any time from their medical history through the end of the measurement period

Exclusion Codes

Bilateral mastectomy

- ICD10PCS: 0HTV0ZZ

Mastectomy (History of Bilateral Mastectomy Value Set)

- ICD-10-CM: [Z90.13] Acquired absence of bilateral breasts and nipples

Unilateral mastectomy

- CPT: 19180, 19200, 19220, 19240, 19303, 19304, 19305, 19306, 19307
- Modifiers: 50, LT, RT
- ICD-10-CM:
    - [Z90.12] Acquired absence of left breast and nipple
    - [Z90.11] Acquired absence of right breast and nipple
- ICD-10-PCS:
    - [0HTU0ZZ] Resection of Left Breast, Open Approach
    - [0HTT0ZZ] Resection of Right Breast, Open Approach

Gender-affirming chest surgery with a diagnosis of gender dysphoria

- CPT: 19318
- ICD-10-CM: F64.1, F64.2, F64.8, F64.9, Z87.890

Measure Codes

Mammography

- CPT: 77062, 77061, 77066, 77065, 77063, 77067
- LOINC: 86463-7, 72139-9, 91519-9, 91522-3, 72142-3, 72138-1, 91518-1, 91521-5, 72141-5, 72137-3, 91517-3, 91520-7, 72140-7, 86462-9, 103892-6, 38090-7, 26346-7, 48475-8, 26349-1, 46351-3, 26287-3, 37554-3, 37543-6, 37006-4, 37016-3, 26175-0, 48492-3, 46335-6, 37552-7, 37029-6, 37038-7, 36626-0, 38071-7, 42415-0, 37052-8, 36642-7, 38091-5, 26347-5, 69150-1, 26350-9, 26289-9, 37005-6, 38854-6, 37017-1, 26176-8, 103885-0, 46336-4, 37553-5, 37030-4, 38855-3, 36627-8, 38072-5, 42416-8, 37053-6, 37768-9, 26348-3, 69259-0, 26351-7, 26291-5, 37773-9, 37769-7, 37775-4, 26177-6, 103886-8, 46337-2, 38807-4, 37770-5, 37771-3, 37774-7, 38820-7, 37772-1, 46350-5, 46356-2, 46338-0, 46339-8, 46380-2, 36319-2, 36962-9, 24605-8, 103894-2, 24604-1, 37539-4, 24610-8, 37542-8, 24606-6, 103893-4, 37551-9, 37028-8, 37037-9, 36625-2, 38070-9, 69251-7

Cervical Cancer Screening (CCS-E)

Eligible Population

Female members 21 to 64 years of age as of December 31 of the measurement year

Definition

Members 21–64 years of age who were recommended for routine cervical cancer screening and were screened for cervical cancer using any of the following criteria:

- Age 24–64 who had cervical cytology performed within the last 3 years
- Age 30–64 who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years
- Age 30–64 who had cervical cytology/hrHPV co-testing performed within the last 5 years

Best Practice and Measure Tips

- Biopsies or Lab results that indicate inadequate sample or no cervical cells are not compliant and will need to be redone
- Educate members on the importance of early detection and encourage routine screening
- Biopsies are considered diagnostic and do not meet the measure requirement
- hrHPV Home testing results are acceptable for women 30-64 years of age
- Documentation may be found in the surgical history and physical exam notes and are reviewed by the HEDIS team (Documentation of no cervix may be mentioned in the physical portion of the exam)
- Update and document the member's medical history annually, including the type and date of any cervical cancer screening tests, as well as any history of a hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix

Required Exclusions

- Palliative care any time during the measurement year
- Members in hospice or using hospice services anytime during the measurement year
- Hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix any time during the member's history through December 31 of the measurement year
- Documentation of "complete," "total" or "radical" hysterectomy (abdominal, vaginal or unspecified) — implies no residual cervix
- Members who died any time during the measurement year

Exclusion Documentation

- Documentation of “vaginal hysterectomy” without further specification
- Documentation of hysterectomy and documentation that a member no longer needs Pap testing/cervical cancer screening. Documentation must be from the same provider
- Documentation of “complete,” “total” or “radical” hysterectomy (abdominal, vaginal or unspecified) — implies no residual cervix
- Documentation of cervical agenesis
- CLARIFICATON: Documentation that indicates the cervix has been removed is needed; “hysterectomy” alone does NOT meet the criteria and supracervical hysterectomy is not acceptable, because the cervix remains intact

Exclusion Codes

Absence of Cervix Diagnosis

- ICD-10: Q51.5, Z90.710, Z90.712

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, 58290-58294, 58548, 58550, 58552-58554, 58570-58573, 58575,58951, 58953, 58954, 59856, 59135
- ICD-10:
  [0UTC0ZZ] Resection of Cervix, Open Approach
  [0UTC4ZZ] Resection of Cervix, Percutaneous Endoscopic Approach
  [0UTC7ZZ] Resection of Cervix, Via Natural or Artificial Opening
  [0UTC8ZZ] Resection of Cervix, Via Natural or Artificial Opening Endoscopic

Measure Codes

Cervical Cytology Lab Test

- CPT: 88141-88143, 88147-88148, 88150, 88152, 88153, 88164-88167,88174-88175
- HCPCS: G0123, G0124, G0141, G0143, G0144, G0145, G0147, G0148, P3000, P3001, Q0091
- LOINC: 10524-7, 18500-9, 19762-4, 19764-0, 19765-7, 19766-5, 19774-9,33717-0, 47527-7, 47528-5

HPV Tests

- 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, 104132-6, 104170-6

Child and Adolescent Well-Care Visit (WCV)

Eligible Population

Members 3–21 years of age as of December 31 of the measurement year

Definition

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

Best Practice and Measure Tips

- Visits must be conducted with a primary care provider (PCP); however, the PCP does not need to be assigned to the child
- Documentation in the well-care visits must include physical development/growth chart and age-appropriate health education
- Assessment or treatment of an acute or chronic condition does not count towards the measure
- This measure is based on the American Academy of Pediatrics Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents (published by the National Center for Education in Maternal and Child Health). The Bright Futures website for more information about well-child visits. (https:// brightfutures.aap.org/materials-and-tools/guidelines-and-pocket-guide/)
- Be sure to use age-appropriate codes
- Well-care visits can be done in conjunction with sick visits, as long as they are billed appropriately
    - If the provider is seeing a patient for Evaluation and Management (E/M) services and all well-care visits components are completed: Attach modifier 25 or 59 to the well-child procedure code so it's reviewed as a significant, separately identifiable procedure
    - Modifier 25 is used to indicate a significant and separately identifiable evaluation and management (E/M) service by the same physician on the same day another procedure or service was performed
    - Modifier 59 is used to indicate that 2 or more procedures were performed at the same visit, but to different sites on the body
    - Be sure to give anticipatory guidance that is not related to the sick visit
    - If anticipatory handouts are given, document evidence of the discussions

Required Exclusion

- Members in hospice or using hospice services anytime during the measurement year
- Members who died any time during the measurement year

Measure Codes

Well-Care

- CPT: 99382, 99383, 99384, 99385, 99392, 99393, 99394, 99395
- HCPCS: S0302, S0610, S0612, S0613
- ICD-10-CM: Z00.00, Z00.01, Z00.121, Z00.129, Z00.2, Z00.3, Z01.411, Z01.419, Z02.5, Z02.84, Z76.1, Z76.2

Colorectal Cancer Screening (COL-E)

Eligible Population

Members age 45–75 years as of December 31 of the measurement year

Definition

Members age 45–75 who received one or more of the following screenings for colorectal cancer:

- Colonoscopy (also known as lower endoscopy) during the MY or the (9) years prior
- Flexible sigmoidoscopy during the MY or the four (4) years prior
- CT Colonography (Virtual colonoscopy) during the MY or the four (4) years prior
- Stool DNA (sDNA) with FIT test (Cologuard) during the MY or two (2) years prior
- Fecal occult blood test (FOBT) during the MY: gFOBT (guaiac), FIT/iFOBT (immunochemical)

Best Practice and Measure Tips

- It is ideal to include both the screening test and its results. However, the result is not required if the medical record clearly documents that the screening was completed—not just ordered. If this distinction is unclear, then the result or finding must also be documented. Examples of compliant documentation:
  - "Colonoscopy 8/2024"
  - "Last colonoscopy was 2 years ago"
  - "H/O Flex sigmoidoscopy 2023"
  - "Pt reports last colonoscopy in 2019 WNL"
  - "Cologuard done earlier this year"
- Documentation in the medical record of "Colon Cancer Screening Done in 2025" without notation of type of screening can only be used as evidence of FOBT
- Always include a date of service and place of service if known
- Members refusing screening will not exclude them from the measure
- Educate the member on the importance of early detection of colorectal cancer. If the patient refuses or is unable to have a colonoscopy, recommend alternative screenings
- Have FIT kits available to give members during the visit with instructions to return them to the office or mail them to the lab
- Update and document the member's medical history annually, including the type and date of any colorectal cancer screening tests, as well as any history of total colectomy or colorectal cancer

- If a pathology report does not indicate the type of screening, or if the procedure report indicates an incomplete exam or poor prep, look for evidence of where scope advanced to:
    - To the cecum = colonoscopy
    - To the sigmoid colon = flexible sigmoidoscopy

Compliant Screenings

Two types of FOBT tests: guaiac (gFOBT) and immunochemical (iFOBT/FIT). Depending on the type of FOBT test, a certain number of samples are required.

- The fecal immunochemical test (FIT) (iFOBT) uses antibodies to detect blood in the stool. Regardless of how many samples were returned and as long as the medical record indicates that a FIT was done, the member meets criteria
- The guaiac-based fecal occult blood test (gFOBT) uses the chemical guaiac to detect blood in the stool. For gFOBT and unspecified type of test:
    - If the medical record does not indicate the number of samples (assume correct number returned) OR indicates three or more samples were returned, the member meets criteria
    - If the medical record indicates one or two samples were returned, the member DOES NOT meet criteria

Non-Compliant Screenings

- Tests performed in an office setting or from any specimen collected during a digital rectal exam (DRE)
- CT scan of the abdomen and pelvis (It is not the same as a CT colonography and is not acceptable)
- Unclear documentation in medical record as “COL” or “COLON 20XX” by provider without mention of the actual screening test completed
- Colonoscopy indicating “poor bowel prep” or “incomplete exam” without documentation scope advanced to cecum for a colonoscopy or into the sigmoid colon for flexible sigmoidoscopy

Required Exclusions

- Palliative care any time during the measurement year
- Members in hospice or using hospice services anytime during the measurement year
- Members 66 years of age and older as of December 31 of the measurement year with frailty and advanced illness
- Members who had colorectal cancer or a total colectomy any time during the member’s history through December 31 of the measurement year
- Members who died any time during the measurement year

Exclusion Codes

Colorectal Cancer

- ICD-10-CM: C18.0-C18.9, C19, C20, C21.2, C21.8, C78.5, Z85.038, Z85.048

Total Colectomy

- CPT: 44150-44153, 44155-44158, 44210-44212
- ICD-10-PCS Resection of Large Intestine:
    - [0DTE0ZZ] Open Approach
    - [0DTE4ZZ] Percutaneous Endoscopic Approach
    - [0DTE7ZZ] Via Natural or Artificial Opening
    - [0DTE8ZZ] Via Natural or Artificial Opening Endoscopic
- SNOMED CT code: 119771000119101

Measure Codes

Colonoscopy

- CPT: 44388, 44389, 44390, 44391, 44392, 44394, 44401-44408, 45378, 45379, 45380, 45381, 45382, 45384, 45385, 45386, 45388, 45389, 45390, 45391, 45392, 45393, 45398
- HCPCS: G0105, G0121
- SNOMED CT: 851000119109, 8180007, 12350003, 25732003, 34264006, 73761001, 174158000, 174185007, 235150006, 235151005, 275251008, 302052009, 367535003, 443998000, 444783004, 446521004, 446745002, 447021001, 709421007, 710293001, 711307001, 789778002, 1209098000, 48021000087103, 48031000087101

Flexible Sigmoidoscopy

- CPT: 45330-45335, 45337, 45338, 45340-45342, 45346,45347, 45349, 45350
- HCPCS: G0104
- SNOMED CT: 841000119107, 44441009, 396226005, 425634007

FOBT Lab Test Guaiac Test (gFOBT)

- CPT: 82270

FIT Test Immunochemical (iFOBT/FIT)

- CPT: 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
- SNOMED CT: 104435004, 441579003, 442067009, 442516004, 442554004, 442563002

FOBT Test Result or Finding

- SNOMED CT: 59614000, 167667006, 389076003, 71711000112103

Computed Tomography (CT) Colonography

- CPT: 74261-74263
- LOINC: 60515-4, 72531-7, 79069-1, 79071-7, 79101-2, 82688-3
- SNOMED CT: 418714002

Stool DNA (sDNA) with FIT Test

- CPT: 81528 This code is specific to the Cologuard® sDNA with FIT test
- LOINC: 77353-1, 77354-9
- SNOMED CT: 708699002

Controlling High Blood Pressure (CBP)

Eligible Population

Members 18–85 years old as of December 31 of the measurement year

Definition

Members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (systolic and diastolic both LESS THAN 140/90 mm HG) during the measurement year

Best Practice and Measure Tips

- Document the patient's blood pressure at each visit
- If patient's blood pressure is uncontrolled upon arrival, recheck the blood pressure before the patient leaves the clinic
- Document all blood pressure readings if taken multiple times during a visit
- ***DO NOT ROUND blood pressure readings***

Guidelines for Member Reported BP Readings Documented in the Medical Record

- Only blood pressure readings reported by the member using a digital device are considered valid. If the documentation does not indicate the method used, it can be assumed that a digital device was utilized
- Blood pressure readings can be collected during telephone visits, e-visits, or virtual check-ins. However, the date and time the member recorded the reading must be documented; otherwise, the member-reported blood pressure is not acceptable

Non-Compliant Readings

- BP taken during an acute inpatient stay or an ED visit
- BPs documented as a range or threshold
- An incomplete BP reading (systolic or diastolic only)
- An aortic systolic/diastolic noninvasive central blood pressure measurement
- A systolic blood pressure reading of 140 or higher is considered non-compliant
- A diastolic blood pressure reading of 90 or higher is considered non-compliant

Required Exclusions

- Palliative care any time during the measurement year
- Members in hospice or using hospice services anytime during the measurement year
- Members who died any time during the measurement year
- Frailty: Members 81 years of age and older as of December 31 of the measurement year
- Members 66 years- 80 of age as of December 31 of the measurement year with frailty and advanced illness
- End-stage renal disease (ESRD): dialysis, nephrectomy or kidney transplant any time during the member's history on or prior to December 31 of the measurement year
- Members with a diagnosis of pregnancy anytime during the measurement year

Exclusion Codes

ESRD Diagnosis

- ICD-10-CM: N18.5, N18.6, Z99.2

History of Kidney

- ICD-10-CM: Z94.0

Dialysis Procedure

- CPT: 90947, 90945, 90937, 90935, 90997, 99512, 90999
- HCPCS: S9339, G0257
- ICD-10-PCS: 3E1M39Z, 5A1D00Z, 5A1D60Z, 5A1D70Z, 5A1D80Z, 5A1D90Z

Total Nephrectomy

- CPT: 50548, 50546, 50543, 50545, 50234, 50236, 50220, 50225, 50230, 50340, 50370
- ICD-10-PCS: 0TT00ZZ, 0TT04ZG, 0TT04ZZ, 0TT10ZZ, 0TT14ZG, 0TT14ZZ, 0TT20ZZ, 0TT24ZG, 0TT24ZZ

Partial Nephrectomy

- CPT: 50240
- ICD-10-PCS: 0TB00ZZ, 0TB03ZZ, 0TB04ZZ, 0TB07ZZ, 0TB08ZZ, 0TB10ZZ, 0TB13ZZ, 0TB14ZZ, 0TB17ZZ, 0TB18ZZ

Kidney Transplant

- CPT: 50365, 50360, 50380
- ICD-10-PCS: 0TY00Z0, 0TY00Z1, 0TY00Z2, 0TY10Z0, 0TY10Z1, 0TY10Z2

Measure Codes

Essential Hypertension

- ICD-10-CM: I10

Diastolic Less than 80

- CPT-CAT-II: 3078F

Diastolic 80-89

- CPT-CAT-II: 3079F

Diastolic Greater than/Equal to 90

- CPT-CAT-II: 3080F

Systolic Less than 130

- CPT-CAT-II: 3074F

Systolic 130-139

- CPT-CAT-II: 3075F

Systolic Greater than/Equal to 140

- CPT-CAT-II: 3077F

Eye Exam for Patients with Diabetes (EED)

Eligible Population

Members 18—75 years old as of December 31 of the measurement year

Definition

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

- A diagnosis of retinopathy or an eye exam with an unknown retinal status requires an annual exam
- If negative for retinopathy, a bi-annual exam meets criteria

Best Practice and Measure Tips

- Educate the member about the risks associated with diabetic eye disease and encourage them to schedule a yearly retinal exam
- The dilated or retinal exam should be performed bilaterally, unless the member has a history of unilateral eye enucleation
- Documentation can be provided as a note or letter and should include the date of service, the type of test performed (specifying whether it was a dilated or retinal exam), or the test result. For example:
    - "Last diabetic retinal exam with Jane Thomas, OD, was May 2025 with no retinopathy"
- For a slit-lamp examination to be considered compliant, documentation must show that dilation was performed or there is evidence the retina was examined
- An examination of the macula, blood vessels, and peripheral retina without eye dilation qualifies as a retinal exam
- A chart or photograph with date of fundus photography or retinal imaging (Example: Computerized Ophthalmic Imaging such as Optical Coherence Tomography, OCT) and one of the following is acceptable:
    - Results read by a qualified reading center or by a system that provides artificial intelligence (AI) interpretation
    - Results reviewed by an eye care professional
    - Results read by a qualified reading center operating under the direction of a medical director who is a retinal specialist
- Prior year exam results must indicate retinopathy was not present

- Acceptable AI reports
    - "Negative for more than mild diabetic retinopathy": This is only considered a negative result when it is a result of an exam read by AI (IDx- DR imaging system)
- Documentation of provider type for AI reports
    - If it is noted that an optometrist or ophthalmologist reviewed the AI results, then choose the appropriate provider type in the drop-down
    - If a report indicates it was read by AI and does not list a provider, select the provider option from the drop-down menu labeled, "Results read by a system that provides an artificial intelligence (AI) interpretation"

Non-Compliant

- Routine fundoscopic exam without examination of macula, vessels and periphery
- Documentation of "diabetes without complications"
- Refractive only exams
- Exams in which only the anterior (A) chamber of the eye is examined
- Glaucoma pressure checks

Required Exclusions

- Palliative care any time during the measurement year
- Members in hospice or using hospice services anytime during the measurement year
- Members who died any time during the measurement year
- Members 66 years of age and older as of December 31 of the measurement year with frailty ***and*** advanced illness
- Bilateral eye enucleation any time during the member's history through December 31 of the measurement year

NOTE: Blindness is not considered an exclusion for a diabetic eye exam because it can be challenging to differentiate between individuals who are legally blind but still need a retinal exam and those who are completely blind and do not require one

Exclusion Codes

Unilateral Eye Enucleation

- CPT: 65091, 65093, 65101, 65103, 65105, 65110, 65112, 65114

Unilateral Eye Enucleation - Left

- ICD10PCS: Diagnosis 08T1XZZ

Unilateral Eye Enucleation – Right

- ICD10PCS: Diagnosis 08T0XZZ

Bilateral Modifier

- CPT Modifier 50

Measure Codes

Codes that can only be billed by an Eye Care Professional (optometrist or ophthalmologist):

Retinal Eye Exams

- CPT: 92002, 92004, 92012, 92014, 92018, 92019, 92134, 92201, 92202, 92230, 92235, 92250, 99203, 99204, 99205, 99213, 99214, 99215, 99242, 99243, 99244, 99245
- HCPCS: S3000, S0621, S0620

Diabetes Mellitus Without Complications

- ICD-10-CM: E10.9, E11.9, E13.9

Codes that can be billed by ANY provider type:

Eye Exam with Evidence of Retinopathy

- CPT-CAT-II: 2022F, 2024F, 2026F

Eye Exam Without Evidence of Retinopathy during current year or prior year

- CPT-CAT-II: 2023F, 2025F, 2033F

Diabetic retinal screening negative in prior year

- CPT-CAT-II: 3072F

Automated Eye Exam

- CPT: 92229

Retinal Imaging

- CPT: 92227, 92228, 92137

Retinal Exam for Diabetic Retinopathy

Any combination that indicates findings from a retinal exam for diabetic retinopathy performed in both the left and right eye:

Left Eye

- During the measurement year:
  - Any level of retinopathy LOINC code 71490-7 with Diabetic Retinopathy Severity Level LOINC code LA18644-7, LA18645-4, LA18643-9, LA18648-8, LA18646-2
- In the year prior to the measurement year:
  - No retinopathy LOINC code 71490-7 with LOINC code LA18643-9

Right Eye

- During the measurement year:
  - Any level of retinopathy LOINC code 71491-5 with Diabetic Retinopathy Severity LA18644-7, LA18645-4, LA18643-9, LA18648-8, LA18646-2
- In the year prior to the measurement year:
  - No retinopathy LOINC code 71491-5 with LOINC code LA18643-9

Medication List

Prescription	Medication Lists
Alpha-glucosidase inhibitors	Acarbose Miglitol
Amylin analogs	Pramlintide
Antidiabetic combinations	Alogliptin-metformin Alogliptin-pioglitazone Canagliflozin-metformin Dapagliflozin-metformin Dapagliflozin-saxagliptin Empagliflozin-linagliptin Empagliflozin-metformin Empagliflozin-linagliptin-metformin Ertugliflozin-metformin Ertugliflozin-sitagliptin Glimepiride-pioglitazone Glipizide-metformin Glyburide-metformin Linagliptin-metformin Metformin-pioglitazone Metformin-repaglinide Metformin-rosiglitazone Metformin-saxagliptin Metformin-sitagliptin

Biguanides	Metformin
Dipeptidyl peptidase-4 (DDP-4) inhibitors	Alogliptin Linagliptin Saxagliptin Sitagliptin
Glucagon-like peptide-1 (GLP1) agonists	Albiglutide Dulaglutide Exenatide Liraglutide Lixisenatide Semaglutide Tirzepatide
Insulin	Insulin aspart Insulin aspart-insulin aspart protamine Insulin degludec Insulin degludec-liraglutide Insulin detemir Insulin glargine Insulin glargine-lixisenatide Insulin glulisine Insulin isophane human Insulin isophane-insulin regular Insulin lispro Insulin lispro-insulin lispro protamine Insulin regular human Insulin human inhaled
Meglitinides	Nateglinide Repaglinide
Sodium glucose cotransporter 2 (SGLT2) inhibitor	Canagliflozin Dapagliflozin Empagliflozin Ertugliflozin
Sulfonylureas	Chlorpropamide Glimepiride Glipizide Glyburide Tolazamide Tolbutamide
Thiazolidinediones	Pioglitazone Rosiglitazone

Follow-Up After Hospitalization for Mental Illness (FUH)

Eligible Population

Members 6 years and older as of December 31 of the measurement year

Definition

Members six years of age and older who were hospitalized for a principal diagnosis of mental illness, or any diagnosis of intentional self-harm, and had a mental health (MH) follow-up service during the following timeframes:

1. 7-Day Follow-Up Hospital discharges for which the Member received a mental health follow-up service within seven days after discharge. Do not include visits that occur on the date of discharge.
2. 30-Day Follow-Up Hospital discharges for which the Member received a mental health follow-up service within 30 days after discharge. Do not include visits that occur on the date of discharge.

For both indicators, any of the following meet criteria for a follow-up visit:

- Outpatient, BH outpatient visit, telehealth, telephone or transitional care management services
- Intensive outpatient encounter, partial hospitalization, community mental health center visits
- Electroconvulsive therapy
- Telehealth, telephone or transitional care management services
- Visit in a behavioral healthcare setting
- Psychiatric collaborative care management
- Peer support services
- Psychiatric residential treatment

Best Practice and Measure Tips

- Visits that occur on the date of discharge will not count toward compliance
- While patient is in inpatient care, help them coordinate care by:
    - Helping them schedule an in-office or telehealth appointment within 7 days of discharge
    - Identify and address any barriers that may prevent the member from making the appointment
    - Making sure member has a good support system by engaging parents/guardians or significant others in the treatment plan, stressing the importance of treatment and attending to their appointment
- Educate member on:
    - The importance of medication adherence
    - Possible medication side effects, including what to do if they become severe, may impact adherence to the prescribed medication regimen and overall treatment plan
- Maintain appointment availability for members with recent inpatient discharge
- Provide reminder calls to confirm appointment within 24 hours
- Reach out to members who cancel appointments and help them reschedule as soon as possible
- Psychiatric collaborative care management counts toward compliance
- Use a diagnosis consistent with the reason for the mental health admission at each follow-up visit. A non-mental illness diagnosis code won't fulfill this measure

Required Exclusions

- Members in hospice or using hospice services anytime during the measurement year
- Members who died any time during the measurement year

Measure Codes

Outpatient visit with outpatient POS with a mental health provider ***or*** outpatient visit with any provider ***and*** diagnosis of mental health disorder

Visit Setting Unspecified

- CPT: 90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221-99223, 99231-99233, 99238, 99239, 99252-99255

Place of Service (POS): Outpatient Setting Codes or POS 24, 52, 53, 56

Mental Health Disorder Diagnosis

- ICD10: F03.90, F03.911, F03.918, F03.92, F03.93, F03.94, F03.A0, F03.A11, F03.A18, F03.A2, F03.A3, F03.A4, F03.B0, F03.B11, F03.B18, F03.B2, F03.B3, F03.B4, F03.C0, F03.C11, F03.C18, F03.C2, F03.C3, F03.C4, F20.0, F20.1, F20.2, F20.3, F20.5, F20.81, F20.89, F20.9, F21, F22, F23, F24, F25.0, F25.1, F25.8, F25.9, F28, F29, F30.10, F30.11, F30.12, F30.13, F30.2, F30.3, F30.4, F30.8, F30.9, F31.0, F31.10, F31.11, F31.12, F31.13, F31.2, F31.30, F31.31, F31.32, F31.4, F31.5, F31.60, F31.61, F31.62, F31.63, F31.64, F31.70, F31.71, F31.72, F31.73, F31.74, F31.75, F31.76, F31.77, F31.78, F31.81, F31.89, F31.9, F32.0, F32.1, F32.2, F32.3, F32.4, F32.5, F32.81, F32.89, F32.9, F32.A, F33.0, F33.1, F33.2, F33.3, F33.40, F33.41, F33.42, F33.8, F33.9, F34.0, F34.1, F34.81, F34.89, F34.9, F39, F40.00, F40.01, F40.02, F40.10, F40.11, F40.210, F40.218, F40.220, F40.228, F40.230, F40.231, F40.232, F40.233, F40.240, F40.241, F40.242, F40.243, F40.248, F40.290, F40.291, F40.298, F40.8, F40.9, F41.0, F41.1, F41.3, F41.8, F41.9, F42.2, F42.3, F42.4, F42.8, F42.9, F43.0, F43.10, F43.11, F43.12, F43.20, F43.21, F43.22, F43.23, F43.24, F43.25, F43.29, F43.81, F43.89, F43.9, F44.0, F44.1, F44.2, F44.4, F44.5, F44.6, F44.7, F44.81, F44.89, F44.9, F45.0, F45.1, F45.20, F45.21, F45.22, F45.29, F45.41, F45.42, F45.8, F45.9, F48.1, F48.2, F48.8, F48.9, F50.00, F50.010, F50.011, F50.012, F50.013, F50.014, F50.019, F50.020, F50.021, F50.022, F50.023, F50.024, F50.029, F50.20, F50.21, F50.22, F50.23, F50.24, F50.25, F50.810, F50.811, F50.812, F50.813, F50.814, F50.819, F50.82, F50.83, F50.84, F50.89, F50.9, F51.01, F51.02, F51.03, F51.04, F51.05, F51.09, F51.11, F51.12, F51.13, F51.19, F51.3, F51.4, F51.5, F51.8, F51.9, F52.0, F52.1, F52.21, F52.22, F52.31, F52.32, F52.4, F52.5, F52.6, F52.8, F52.9, F53.0, F53.1, F59, F60.0, F60.1, F60.2, F60.3, F60.4, F60.5, F60.6, F60.7, F60.81, F60.89, F60.9, F63.0, F63.1, F63.2, F63.3, F63.81, F63.89, F63.9, F64.0, F64.1, F64.2, F64.8, F64.9, F65.0, F65.1, F65.2, F65.3, F65.4, F65.50, F65.51, F65.52, F65.81, F65.89, F65.9, F66, F68.10, F68.11, F68.12, F68.13, F68.8, F68.A, F69, F80.0, F80.1, F80.2, F80.4, F80.81, F80.82, F80.89, F80.9, F81.0, F81.2, F81.81, F81.89, F81.9, F82, F84.0, F84.2, F84.3, F84.5, F84.8, F84.9, F88, F89, F90.0, F90.1, F90.2, F90.8, F90.9, F91.0, F91.1, F91.2, F91.3, F91.8, F91.9, F93.0, F93.8, F93.9, F94.0, F94.1, F94.2, F94.8, F94.9, F95.0, F95.1, F95.2, F95.8, F95.9, F98.0, F98.1, F98.21, F98.29, F98.3, F98.4, F98.5, F98.8, F98.9, F99

Outpatient Visit with a MH Provider or any provider + Diagnosis of MH disorder

- CPT: 98960-98962, 99078, 99202-99205, 99211-99215, 99242-99245, 99341, 99342, 99344, 99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99483, 99492, 99493, 99494, 99510
- HCPCS: G0155, G0176, G0177, G0409, G0463, G0512, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013-H2020, T1015**

  NOTE: **T1015 HCPCS code which identifies an all-inclusive clinic visit for services rendered at a Federally Qualified Health Center (FQHC)
- 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

Partial Hospitalization or Intensive Outpatient

- HCPCS: G0410, G0411, H0035, H2001, H2012, S0201, S9480, S9484, S9485
- UBREV: 0905, 0907, 0912, 0913

Community mental health center visit with place of service (POS) 53:

- 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, 99252, 99253, 99254, 99255

- CPT: 98960, 98961, 98962, 99078, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99483, 99492, 99493, 99494, 99510

- HCPCS: G0155, G0176, G0177, G0409, G0463, G0512, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, T1015

- 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

Transitional Care Management Services

- CPT: 99495, 99496

Electroconvulsive Therapy with (POS) 24, 52, 53

- CPT: 90870
- ICD-10-PCS: GZB0ZZZ, GZB1ZZZ, GZB2ZZZ, GZB3ZZZ, GZB4ZZZ

Psychiatric Collaborative Care Management

- CPT: 99492, 99493, 99494
- HCPCS: G0512

Telehealth Visit with a Mental Health Provider or with any provider + Diagnosis of Mental Health Disorder (POS): 02, 10

- 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, 99252, 99253, 99254, 99255

Telephone Visit with a Mental Health Provider or any provider + Diagnosis of Mental Health Disorder

- CPT: 98966, 98967, 98968, 99441, 99442, 99443

Behavioral Health

- UBREV: 0513, 0900, 0901, 0902, 0903, 0904, 0905, 0907, 0911, 0912, 0913, 0914, 0915, 0916, 0917, 0919, 1001

Transitional Care Management with a Mental Health Provider or any provider + Diagnosis of Mental Health Disorder

- CPT: 99495, 99496

Telephone Visits

- CPT: 98966, 98967, 98968, 99441, 99442, 99443

Peer Support Services with any Diagnosis of Mental Health Disorder

- HCPCS: G0140, G0177, H0024, H0025, H0038, H0039, H0040, H0046, H2014, H2023, S9445, T1012, T1016

Psychiatric Residential Treatment

- HCPCS: T2048, H0017, H0018, H0019

Psychiatric Residential Treatment with POS Code 56

- 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, 99252, 99253, 99254, 99255

Glycemic Status Assessment for Patients With Diabetes (GSD)

Eligible Population

Members 18–75 years of age as of December 31 of the measurement year

Definition

Percentage of members 18–75 years of age with diabetes (types 1 and 2) whose most recent glycemic status (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) was <8.0% during the measurement year

Best Practice and Measure Tips

- When multiple tests are performed within the measurement year, the result from the most recent test must be used
- Because the last value recorded in the year is used, ensure the member repeats any elevated test before the year ends
- Documentation in the medical record must include the date when the HbA1c test or GMI was performed and the result
- GMI values must be accompanied by documentation of the CGM data date range used to calculate value. The end date of this range should be used as the assessment date
- If multiple glycemic status assessments are documented for the same date, use the lowest recorded value
- If test results are documented in the vitals section of the progress notes, be sure to include the blood draw date alongside the result. The date of the progress note alone will not be accepted
- Educate members on the A1c target and the CGM goals
- Refer members to case management to help members manage chronic health conditions

Measure Exclusions

- Palliative care any time during the measurement year
- Members in hospice or using hospice services anytime during the measurement year
- Members who died any time during the measurement year
- Members 66 years of age and older as of December 31 of the measurement year with frailty and advanced illness

Measure Codes

HbA1C Lab Test

- CPT: 83036, 83037
- LOINC: 4548-4, 17855-8, 4549-2, 17856-6, 96595-4

HbA1c Level Less than 7.0

- CPT-CAT-II: 3044F

HbA1c Level Greater than/Equal to 7 and less than 8

- CPT-CAT-II: 3051F

HbA1c Level Greater than/Equal to 8 and less than/Equal to 9

- CPT-CAT-II: 3052F

HbA1C Greater than 9.0

- CPT-CAT-II: 3046F

Medication List

Prescription	Medication Lists
Alpha-glucosidase inhibitors	Acarbose Miglitol
Antidiabetic combinations	Alogliptin-metformin Alogliptin-pioglitazone Canagliflozin-metformin Dapagliflozin-metformin Dapagliflozin-saxagliptin Empagliflozin-linagliptin Empagliflozin-metformin Empagliflozin-linagliptin-metformin Ertugliflozin-metformin Ertugliflozin-sitagliptin Glimepiride-pioglitazone Glipizide-metformin Glyburide-metformin Linagliptin-metformin Metformin-pioglitazone Metformin-repaglinide Metformin-rosiglitazone Metformin-saxagliptin Metformin-sitagliptin

Amylin analogs	Pramlintide
Biguanides	Metformin
Dipeptidyl peptidase-4 (DDP-4) inhibitors	Alogliptin Linagliptin Saxagliptin Sitagliptin
Glucagon-like peptide-1 (GLP1) agonists	Albiglutide Dulaglutide Exenatide Liraglutide Lixisenatide Semaglutide Tirzepatide
Insulin	Insulin aspart Insulin aspart-insulin aspart protamine Insulin degludec Insulin degludec-liraglutide Insulin detemir Insulin glargine Insulin glargine-lixisenatide Insulin glulisine Insulin isophane human Insulin isophane-insulin regular Insulin lispro Insulin lispro-insulin lispro protamine Insulin regular human Insulin human inhaled
Meglitinides	Nateglinide Repaglinide
Sodium glucose cotransporter 2 (SGLT2) inhibitor	Canagliflozin Dapagliflozin Empagliflozin Ertugliflozin
Sulfonylureas	Chlorpropamide Glimepiride Glipizide Glyburide Tolazamide Tolbutamide
Thiazolidinediones	Pioglitazone Rosiglitazone

Plan All-Cause Readmissions (PCR)

Eligible Population

Members 18 years of age and older as of December 1 of the measurement year

Definition

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

- Index hospital stay (IHS): An acute inpatient or observation stay with a discharge on or between January 1 and December 1 of the measurement year
- Index Discharge Date: The IHS discharge date. The Index Discharge Date must occur on or between January 1 and December 1 of the measurement year
- Index Readmission Stay: An acute inpatient or observation stay for any diagnosis with an admission date within 30 days of a previous Index Discharge Date
- Index Readmission Date: The admission date associated with the Index Readmission Stay

Best Practice and Measure Tips

- An acute discharge may originate from any type of facility, including behavioral health facilities
- Implement a robust and safe discharge plan.
- Plan includes a post-discharge phone call within 3 days of discharge focused on conducting medication reconciliation and coordinating follow-up with the Primary Care Provider (PCP) or Other Care Provider (OCP) as appropriate

  During the call, be sure to address the following questions:
  - Have you picked up your prescriptions?
  - Are you taking your medications as prescribed?
  - Do you understand your medication and its purpose?
  - Are you experiencing any side effects or issues with your medication?
  - Do you have a follow-up appointment scheduled with your PCP/OCP?
  - Do you have any questions or concerns about your discharge instructions or care plan?
- Patients with multiple comorbidities have a higher rate of readmission following inpatient or observation discharge. Ensure all suspected conditions are accurately documented in the patient's medical record and claims
- Initiate a discussion about palliative care or hospice services and assist with making a referral when appropriate

Required Exclusions

- Members in hospice or using hospice services anytime during the measurement year
- Exclude acute hospitalizations for the following reasons:
    - Member died during the inpatient stay
    - Member with a principal diagnosis of pregnancy on the discharge claim
    - Principal diagnosis of a condition originating in the perinatal period on the discharge claim
- Planned admissions for:
    - Chemotherapy maintenance
    - Principal diagnosis of rehabilitation
    - Organ transplant
    - Potentially planned procedure without a principal acute diagnosis
- Exclude the hospital stay if the direct transfer discharge date occurs after December 1 of the measurement year
- Exclude hospital stays where the Index Admission Date is the same as the Index Discharge Date

Use of Imaging Studies for Low Back Pain (LBP)

Eligible Population

Members 18–75 years as of December 31 of the measurement year

Definition

The percentage of members 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

- Intake Period: Identifies the first eligible encounter with a primary diagnosis of low back pain between January 1 and December 3 of the measurement year
- Index Episode Start Date (IESD): Earliest date of service for an eligible encounter during the Intake Period with a principal diagnosis of low back pain
- Negative Diagnosis History: A period of 180 days (6 months) prior to the IESD when the member had no claims/encounters with any diagnosis of low back pain

Best Practice and Measure Tips

- Unless exclusions apply, avoid ordering diagnostic studies within 30 days of a new-onset back pain diagnosis
- Use correct exclusion codes as applicable
- Conservative measures should be prioritized as the first-line treatment
- Educate the patient on careful and responsible pain management, maintaining appropriate activity levels, performing stretching exercises, and using heat therapy
- Refer to physical therapy, which may include massage, stretching, strengthening exercises, and manipulation
- Comorbid conditions like sleep disorders, anxiety, or depression should be treated, and psychosocial concerns should be addressed

Required Exclusion

- Cancer, HIV, osteoporosis or spondylopathy any time during the member's history through 28 days after the IESD
- Organ transplant, lumbar surgery or medication treatment for osteoporosis any time during the member's history 28 days after the IESD
- IV drug abuse, neurologic impairment or spinal infection any time during the 365 days prior to the IESD through 28 days after the IESD

- Trauma or a fragility fracture any time during the 90 days prior to the IESD through 28 days after the IESD
- Members in hospice or using hospice services anytime during the measurement year
- Palliative Care anytime during the measurement year
- Members 66 years of age and older as of December 31 of the measurement year with frailty and advanced illness
- Members who died any time during the measurement year
- Prolonged use of corticosteroids: 90 consecutive days of corticosteroid treatment any time during the 366-day period that begins 365 days prior to the IESD and ends on the IESD
- A dispensed prescription to treat osteoporosis any time during the member's history through 28 days after the IESD

Corticosteroid Medications

Prescription	Medication Lists
Corticosteroid	Hydrocortisone Cortisone Prednisone Prednisolone Methylprednisolone Triamcinolone Dexamethasone Betamethasone/Betamethasone acetate

Osteoporosis Medications

Prescription	Medication Lists
Bisphosphonates	Alendronate Alendronate-cholecalciferol Ibandronate Risedronate Zoledronic acid
Other agents	Abaloparatide Denosumab Raloxifene Romosozumab Teriparatide

Cancer

ICD-10 C and D Codes (active) / Z Codes (history of)- Examples include:

Malignant Neoplasms

- ICD-10-CM: C00.0-C00.6, C00.8, C00.9, C01, C02.0-C02.4, C02.8, C02.9, C03.0, C03.1, C03.9, C04.0, C04.1, C04.8, C04.9, C05.0, C05.1, C05.2, C05.8, C05.9, C06.0, C06.1, C06.2, C06.80, C06.89, C06.9, C07, C08.0, C08.1, C08.9, C09.0, C09.1, C09.8, C09.9, C10.0- C10.4, C10.8, C10.9, C11.0-C11.3, C11.8, C11.9, C12, C13.0, C13.1, C13.2, C13.8, C13.9, C14.0, C14.2, C14.8, C15.3, C15.4, C15.5, C15.8, C15.9, C16.0-C16.6, C16.8, C16.9, C17.0-C17.3, C17.8, C17.9, C18.0-C18.9, C19, C20, C21.0; C92.60, C93.92, C93.Z0, C93.Z1, C93.Z2, C94.00, C94.01, C94.02, C94.20, C94.21, C94.22, C94.30, C94.31, C94.32, C94.40, C94.41, C94.42, C94.6, C94.80, C94.81, C94.82, C95.00, C95.01, C95.02, C95.10, C95.11, C95.12, C95.90, C95.91, C95.92 C96.0, C96.2, C96.20, C96.21, C96.22, C96.29, C96.4, C96.5, C96.6, C96.9, C96.A, C96.Z;

Other Neoplasms

- ICD-10-CM: D00.00- D00.08, D00.1, D00.2, D01.0- D01.3, D01.40, D01.49, D01.5, D01.7, D01.9, D02.0, D02.1, D02.20-D02.22, D02.3, D02.4, D03.0, D03.10, D03.11, D03.111, D03.112, D03.121, D03.122, D03.20, D03.21, D03.22, D03.30, D03.39, D03.4, D03.51, D03.52, D03.59, D03.60, D03.61, D03.62, D03.70, D03.71, D03.72, D03.8, D03.9, D04.0, D04.10, D04.11, D04.111, D04.112, D04.12, D04.121, D04.122, D04.20, D04.21, D04.22, D04.30, D04.39, D04.4, D04.5, D04.60, D04.61, D04.62, D04.70, D04.71, D04.72, D04.8, D04.9, D05.00, D05.01, D05.02, D05.10, D05.11, D05.12, D05.80, D05.81, D05.82, D05.90, D05.91, D05.92, D06.0, D06.1, D06.7, D06.9, D07.0, D07.1, D07.2, D07.30, D07.39, D07.4, D07.5, D07.60, D07.61, D07.69, D09.0, D09.10, D09.19, D09.20, D09.21, D09.22, D09.3, D09.8, D09.9, D37.01, D37.02, D37.030, D37.031, D37.032, D37.039, D37.04, D37.05, D37.09, D37.1- D37.6, D37.8, D37.9, D38.0-D38.6, D39.0, D39.10, D39.11, D39.12, D39.2, D39.8, D39.9, D40.0, D40.10, D40.11, D40.12, D40.8, D40.9, D41.00, D41.01, D41.02, D41.10, D41.11, D41.12, D41.20, D41.21, D41.22, D41.3, D41.4, D41.8, D41.9, D42.0, D42.1, D42.9, D43.0-D43.4, D43.8, D43.9, D44.0, D44.10, D44.11, D44.12, D44.2-D44.7, D44.9, D45, D46.0, D46.1, D46.20, D46.21, D46.22, D46.4, D46.9, D46.A, D46.B, D46.C, D46.Z, D47.0, D47.01, D47.02, D47.09-D47.4, D47.9, D47.Z1, D47.Z2, D47.Z9, D48.0-D48.5, D48.60, D48.61, D48.62, D48.7, D48.9, D49.0, D49.1, D49.2, D49.3, D49.4, D49.5, D49.511, D49.512, D49.519, D49.59, D49.6, D49.7, D49.81, D49.89, D49.9

History of Malignant Neoplasm

- ICD-10-CM: Z85.00, Z85.01, Z85.020

Other Malignant Neoplasm of Skin

- ICD-10-CM: C44.00-C44.02

HIV

- ICD-10-CM: B20, Z21

Kidney / Major organ transplant

History of Kidney Transplant

- ICD-10-CM: Z94.0

Kidney Transplant

- CPT: 50360, 50365, 50380,
- HCPCS: S2065
- ICD-10-PCS: 0TY00Z0, 0TY00Z1, 0TY00Z2, 0TY10Z0, 0TY10Z1, 0TY10Z2

Organ Transplant Other Than Kidney:

- CPT: 32850, 32851, 32852, 32853, 32854, 32855, 32856

Osteoporosis

Diagnosis of osteoporosis ICD-10-CM:

- M80.XXXX- Age-related osteoporosis with current pathological fracture, unspecified site/specified body site, initial/ subsequent encounter/sequela for fracture (with routine healing, delayed healing, malunion, nonunion). Not all codes in the M80 ICD-10-CM are listed
- [M81.0] Age-related osteoporosis without current pathological fracture
- [M81.6] Localized osteoporosis [Lequesne]
- [M81.8] Other osteoporosis without current pathological fracture

Osteoporosis therapy or a dispensed prescription to treat osteoporosis

- HCPCS: J0897, J1740, J3110, J3111, J3489

Lumbar surgery

- CPT: 22114, 22207, 22214, 22224, 22511, 22512, 22514, 22515, 22533, 22534, 22558, 22612, 22630, 22632, 22633, 22634, 22857, 22860, 22862, 22865, 22867, 22868, 22869, 22870, 62287, 62380, 63005, 63012, 63017, 63030, 63035, 63042, 63044, 63047, 63048, 63052, 63053, 63056, 63057, 63087, 63088, 63090, 63091, 63102, 63103, 63170, 63200, 63252, 63267, 63272, 63277, 63282, 63287
- HCPCS: S2348, S2350
- ICD-10-PCS Examples
    - [005Y0ZZ] Destruction of Lumbar Spinal Cord, Open Approach
    - [008Y0ZZ] Division of Lumbar Spinal Cord, Open Approach
    - [009Y00Z] Drainage of Lumbar Spinal Cord with Drainage Device, Open Approach
    - [00BY0ZX] Excision of Lumbar Spinal Cord, Open Approach, Diagnostic
    - [00CY0ZZ] Extirpation of Matter from Lumbar Spinal Cord, Open Approach
    - [00NY0ZZ] Release Lumbar Spinal Cord, Open Approach
    - [00QY0ZZ] Repair Lumbar Spinal Cord, Open Approach

- [00SY0ZZ] Reposition Lumbar Spinal Cord, Open Approach
- [0Q500ZZ] Destruction of Lumbar Vertebra, Open Approach
- [0Q800ZZ] Division of Lumbar Vertebra, Open Approach
- [0QH004Z] Insertion of Internal Fixation Device into Lumbar Vertebra, Open Approach
- [0QR03KZ] Replacement of Lumbar Vertebra with Nonautologous Tissue Substitute, Percutaneous Approach
- [0QU007Z] Supplement Lumbar Vertebra with Autologous Tissue Substitute, Open Approach
- [0SG037J] Fusion of Lumbar Vertebral Joint with Autologous Tissue Substitute, Posterior Approach, Anterior Column, Percutaneous Approach
- [0SW4XKZ] Revision of Nonautologous Tissue Substitute in Lumbosacral Disc, External Approach

Spondylopathy

- ICD-10-CM: M45.0, M45.3, M45.4, M45.5, M45.6, M45.7, M45.8, M45.9, M48.10, M48.13, M48.14, M48.15, M48.16, M48.17, M48.18, M48.19

Any time during the 365 days (1 year) prior to the IESD through 28 days after the IESD

Neurologic impairment

- ICD-10-CM: G83.4, K59.2, M48.062, R26.2, R29.2

Spinal infection

- ICD-10-CM: A17.81, G06.1, M46.25-M46.28, M46.35-M46.38, M46.46-M46.48

Intravenous drug abuse

- ICD-10-CM: F11.10, F11.11, F11.120- F11.122, F11.129, F11.13, F11.14, F11.150, F11.151, F11.159, F11.181, F11.182, F11.188, F11.19, F11.20, F11.21, F11.220, F11.221, F11.222, F11.229, F11.23, F11.24, F11.250, F11.251, F11.259, F11.281, F11.282, F11.288, F11.29, F13.10, F13.11, F13.120, F13.121, F13.129, F13.130, F13.131, F13.132, F13.139, F13.14, F13.150, F13.151, F13.159, F13.180, F13.181, F13.182, F13.188, F13.19, F13.20, F13.21, F13.220, F13.221, F13.229, F13.230, F13.231, F13.232, F13.239, F13.24, F13.250, F13.251, F13.259, F13.26, F13.27, F13.280, F13.281, F13.282, F13.288, F13.29, F14.10, F14.11, F14.120, F14.121, F14.122, F14.129, F14.13, F14.14, F14.150, F14.151, F14.159, F14.180, F14.181, F14.182, F14.188, F14.19, F14.20, F14.21, F14.220, F14.221, F14.222, F14.229, F14.23, F14.24, F14.250, F14.251, F14.259, F14.280, F14.281, F14.282, F14.288, F14.29, F15.10, F15.11, F15.120, F15.121, F15.122, F15.129, F15.13, F15.14, F15.150, F15.151, F15.159, F15.180, F15.181, F15.182, F15.188, F15.19, F15.20, F15.21, F15.220, F15.221, F15.222, F15.229, F15.23, F15.24, F15.250, F15.251, F15.259, F15.280, F15.281, F15.282, F15.288, F15.29

Any time during the 3 months (90 days) prior to the IESD through 28 days after the IESD:

Recent trauma

- ICD-10-CM: G89.11 and S codes for trauma/fractures

Fragility fracture

- ICD-10-CM: M48.40XA, M48.40XD, M48.40XG,M48.40XS, M48.41XA, M48.41XD, M48.41XG, M48.41XS, M48.42XA, M48.42XD, M48.42XG, M48.42XS, M48.43XA, M48.43XD, M48.43XG, M48.43XS, M48.44XA, M48.44XD, M48.44XG, M48.44XS, M48.45XA, M48.45XD, M48.45XG, M48.45XS, M48.46XA, M48.46XD, M48.46XG, M48.46XS, M48.47XA, M48.47XD, M48.47XG, M48.47XS, M48.48XA, M48.48XD, M48.48XG, M48.48XS, M80.08XA, M80.08XD, M80.08XG, M80.08XK, M80.08XP, M80.08XS, M80.88XA, M80.88XD, M80.88XG, M80.88XK, M80.88XP, M80.88XS, M84.359A, M84.359D, M84.359G, M84.359K, M84.359P, M84.359S, M97.01XA, M97.01XD, M97.01XS, M97.02XA, M97.02XD, M97.02XS

Measure Codes

Principal diagnosis of uncomplicated low back pain in an outpatient setting

Uncomplicated Low Back Pain

- ICD-10-CM: M47.26, M47.27, M47.28, M47.816, M47.817, M47.818, M47.896, M47.897, M47.898, M48.061, M48.07, M48.08, M51.16, M51.17, M51.26, M51.27, M51.36, M51.37, M51.86, M51.87, M53.2X6, M53.2X7, M53.2X8, M53.3, M53.86, M53.87, M53.88, M54.16, M54.17, M54.18, M54.30, M54.31, M54.32, M54.40, M54.41, M54.42, M54.5, M54.50, M54.51, M54.59, M54.89, M54.9, M99.03, M99.04, M99.23, M99.33, M99.43, M99.53, M99.63, M99.73, M99.83, M99.84, S33.100A, S33.100D, S33.100S, S33.110A, S33.110D, S33.110S, S33.120A, S33.120D, S33.120S, S33.130A, S33.130D, S33.130S, S33.140A, S33.140D, S33.140S, S33.5XXA, S33.6XXA, S33.8XXA, S33.9XXA, S39.002A, S39.002D, S39.002S, S39.012A, S39.012D, S39.012S, S39.092A, S39.092D, S39.092S, S39.82XA, S39.82XD, S39.82XS, S39.92XA, S39.92XD, S39.92XS

Avoid the below Imaging Study Codes during the first 30 days of a diagnosis of uncomplicated back pain:

- CPT: 72020, 72040, 72050, 72052, 72070, 72072, 72074, 72080, 72081, 72082, 72083, 72084, 72100, 72110, 72114, 72120, 72125, 72126, 72127
- CPT: 72020, 72040, 72050, 72052, 72070, 72072, 72074, 72080, 72081, 72082, 72083, 72084, 72100, 72110, 72114, 72120, 72125, 72126, 72127,72128, 72129, 72130, 72131, 72132, 72133, 72141, 72142, 72146, 72147, 72128, 72129, 72130, 72131, 72132, 72133, 72141, 72142, 72146, 72147, 72148, 72149, 72156, 72157, 72158, 72200, 72202, 72220

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

Eligible Population

Member ages 15–30 months during measurement year

Definition

Percentage of members who had the following number of well-child visits with a PCP during the last 15 months:

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

Best Practice and Measure Tips

- Visits must be conducted with a primary care provider (PCP); however, the PCP does not need to be assigned to the child
- There must be a minimum interval of two weeks between each well-child visit
- Assessment or treatment of an acute or chronic condition does not count towards the measure
- Be sure to use age-appropriate codes
- Well-care visits can be done in conjunction with sick visits, if they are billed appropriately
    - If the provider is seeing a patient for Evaluation and Management (E/M) services and all well-care visits components are completed: Attach modifier 25 or 59 to the well-child procedure code so it's reviewed as a significant, separately identifiable procedure
    - Modifier 25 is used to indicate a significant and separately identifiable evaluation and management (E/M) service by the same physician on the same day another procedure or service was performed
    - Modifier 59 is used to indicate that 2 or more procedures were performed at the same visit, but to different sites on the body
    - Be sure to give anticipatory guidance that is not related to the sick visit
    - If anticipatory handouts are given, be sure to document evidence of the discussions

- This measure is based on the American Academy of Pediatrics Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents (published by the National Center for Education in Maternal and Child Health). The Bright Futures website for more information about well-child visits. (https:// brightfutures.aap.org/materials-and-tools/guidelines-and-pocket-guide/)

Required Exclusion

- Members in hospice or using hospice services anytime during the measurement year
- Members who died any time during the measurement year

Measure Codes

- CPT: 99381, 99382, 99391, 99392, 99461
- HCPCS: S0302
- ICD-10-CM: Z00.110, Z00.111, Z00.121, Z00.129, Z00.2, Z02.84, Z76.1, Z76.2

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