Catalyst Quality Detail Reference Guide

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catalysthealthgroup.net

Catalyst
HEALTH NETWORK

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Breast cancer screening

The percentage of women ages 50 to 74 who had a mammogram to screen for breast cancer

Eligible Population	
Ages	Women 50–74 years
Measurement	27 months to identify the numerator

Administrative Specification	
Denominator	Female patient(s) 52–74 years of age
Numerator	A screening mammogram is recommended for women 50–74 years of age Patient(s) 52–74 years of age who had a screening mammogram in last 27 reported months **Codes to identify breast cancer screening:**

CPT	HCPCS	ICD-CM Procedure	Revenue	LOINC
77055-57, 77061-63, 77065-67	G0202, G0204, G0206	87.36, 87.37	0401, 0403	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, 42415-0, 42416-8, 46335-6, 46336-4, 46337-2, 46338-0, 46339-8, 46350-5, 46351-3, 46356-2, 46380-2 ,48475-8, 48492-3, 69150-1, 69251-7, 69259-0

Exclusions:

Members who meet any of the following criteria are excluded:

- Received hospice care during the measurement year
- Dispensed dementia medication
- Ages 66 and older as of Dec 31 of measurement year, with frailty and advanced illness. Members must meet both frailty and advanced illness criteria to be excluded
- Documentation in the medical record of bilateral mastectomy or two unilateral mastectomies at any time during the member's history

Codes to identify exclusions:

Description	CPT	ICD-CM Diagnosis	ICD-CM Procedure
Bilateral mastectomy	19180, 19200, 19220, 19240, 19303-19307 With Modifier 50 or modifier code 09950* modifier codes indicate the procedure was bilateral and performed during the same operative session	-	85.42, 85.44, 85.46, 85.48, 0HTV0ZZ
Unilateral mastectomy (members must have 2 separate occurrences on 2 different dates of service)	19180, 19200, 19220, 19240, 19303-19307	-	85.41, 85.43, 85.45, 85.47, 0HTU0ZZ, 0HTT0ZZ
Right Side Modifier	RT	-	-
Left side Modifier	LT	-	-
Absence of Left Breast	-	Z90.12	-
Absence of Right Breast	-	Z90.11	-
History of Bilateral Mastectomy	-	Z90.13	-

Best practices:

- Build care gap "alerts" in electronic medical records
- Discuss the importance of breast cancer screenings and ensure members are up-to-date with their annual mammogram
- Document screenings in the medical record. Indicate the specific date and result of the screening
- Document medical and surgical history in the medical record, including dates
- MRIs, ultrasounds and biopsies don't count in this measure. Although these procedures may be indicated for evaluating women at higher risk for breast cancer or for diagnostic purposes, they are performed as an adjunct to mammography and don't alone count toward the compliance
- Use correct diagnosis and procedure codes
- Submit claims and encounter data in a timely manner
- Assist patient with scheduling directly with Solis while in office or at checkout

Cervical cancer screening

The percentage of women 21–64 years of age who were screened for cervical cancer using either of the following criteria:

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

Eligible Population	
Ages	Women 21–64 years old
Measurement	36-months to identify the numerator age 21-29, 60 month for age 30-64

Administrative Specification	
Denominator	Women 21 to 64 years old at the end of the measurement year.
Numerator	The number of women who were screened for cervical cancer. Either of the following meets criteria:

- Women 21–64 years of age who had cervical cytology during the measurement year or the three years prior to the measurement year
- Women 30–64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing during the measurement year or the five years prior to the measurement year and who were 30 years or older on the date of the test

Codes to identify cervical cytology:

CPT	HCPCS	LOINC
88141-43, 88147-48, 88150, 88152-54, 88164-67, 88174-75	G0123-24, G0141, G0143-45, G0147-48, P3000, P3001, Q0091	10524-7, 18500-9, 19762-4, 19764-0, 19765-7, 19766-5, 19774-9, 33717-0, 47527-7, 47528-5

Codes to identify High Risk HPV Test:

CPT	HCPCS	LOINC
87620 -22, 87624-25	G0476	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

Exclusions:

Members who meet any of the following criteria are excluded:

- Received hospice and/or palliative care during the measurement year
- Women who had a hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix

Codes to identify exclusions:

Description	CPT	ICD-CM Diagnosis	ICD-CM Procedure
Hysterectomy	51925, 56308, 57540, 57545, 57550, 57555, 57556, 58150, 58152, 58200, 58210, 58240, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290-58294, 58548, 58550-58554, 58570-58573 , 58951, 58953, 58954, 58956, 59135	618.5, V67.01, V76.47, V88.01, V88.03, 752.43, Q51.5, Z90.710, Z90.712	68.4-68.8 0UTC0ZZ, 0UTC4ZZ, 0UTC7ZZ, 0UTC8ZZ

Best practices:

- Build care gap "alerts" in electronic medical records
- Review and document members' surgical and preventive screenings history with results
- Use correct diagnosis and procedure codes
- Submit claims and encounter data in a timely manner
- Consider performing the high-risk human papillomavirus (hrHPV) test on eligible patients since it covers a 5 year testing period

Colorectal cancer screening

The percentage of members ages 45 to 75 who had an appropriate screening test for colorectal cancer

NEW HEDIS REQUIREMENT FOR THIS MEASURE Document patients race and ethnicity within medical record

Eligible Population	
Ages	Members 45 - 75 years old
Measurement	Numerator measurement period is test dependent and ranges from 12 months to 120 months

Administrative Specification	
Denominator	Members 45 - 75 years old
Numerator	Members in the denominator who show evidence through claim/encounter data of 1 or more appropriate colorectal cancer screenings:

- Fecal occult blood test (FOBT) during the measurement year. Regardless of FOBT type, guaiac (gFOBT) or immunochemical (iFOBT), assume that the required number of samples was returned
- FIT-DNA testing (cologuard) during the measurement year or 2 years prior to the measurement period
- Flexible sigmoidoscopy or CT colonography during the measurement year or the 4 years prior to the measurement year
- Colonoscopy during the measurement year or the 9 years prior to the measurement year

Codes to identify colorectal cancer screening:

Description	CPT	HCPCS	ICD-CM Procedure	LOINC
FOBT	82270, 82274	G0328	-	2335-8, 12503-9, 12504-7, 14563-1, 14564-9, 14565-6, 27396-1, 27401-9, 27925-7, 27926-5, 29771-3, 56490-6, 56491-4, 57905-2, 58453-2, 80372-6
FIT-DNA testing	81528 (Cologuard)	G0464	-	77353-1, 77354-9
Flexible sigmoidoscopy, CT colonography	45330-45335, 45337, 45338, 45340-45342, 45346, 45347, 45349, 45350 74261-74263	G0104	45.24	60515-4, 72531-7, 79069-1, 79071-7, 79101-2, 82688-3
Colonoscopy	44388-44394, 44397, 45355, 45378-45393, 44401-44408, 45398	G0105, G0121	45.22, 45.23, 45.25, 45.42, 45.43	-

Exclusions:

Members who meet any of the following criteria are excluded:

- Age 66 or older with both frailty and advanced illness
- Received hospice and/or palliative care during the measurement year
- A known history of colorectal cancer
- A known history of a total colectomy

Codes to identify history of cancer or total colectomy:

Description	CPT	HCPCS	ICD-CM Diagnosis	ICD-CM Procedure
Colorectal cancer	-	G0213-G0215, G0231	153*, 154.0, 154.1, 197.5, V10.05, V10.06 C18.0, C18.1, C18.2, C18.3, C18.4, C18.5, C18.6, C18.7, C18.8, C18.9, C19, C20, C21.2, C21.8, C78.5, Z85.038, Z85.048	-
Total colectomy	44150-44153, 44155-44158, 44210-44212	-	-	45.8*, 0DTE0ZZ, 0DTE4ZZ, 0DTE7ZZ, 0DTE8ZZ

Best practices:

- Build care gap "alerts" in electronic medical records
- Discuss the importance of colorectal cancer screenings with members
- Ensure members are up to date on their screening
- Clearly document in the medical record past medical and surgical history, as well as all surgical and diagnostic procedures. Include dates and results
- Use correct diagnosis and procedure codes
- Submit claims and encounter data in a timely manner

Chlamydia screening in women

Percentage of female members ages 16–24 who were identified as sexually active and had at least one test to screen for chlamydia during the measurement year

UHC & CIGNA MEASURE ONLY

Eligible Population	
Ages	Women 16–24 years old
Measurement	12 Months

Administrative Specification	
Denominator	Patient(s) 16–24 years of age with a diagnosis of sexual activity or claim for birth control
Numerator	Patient(s) 16–24 years of age that had a chlamydia screening test in last 12 reported months During the 12-month report period did the patient have one or more claims with one of the following: • Diagnosis: 1) Sexual activity, 2) pregnancy • AND the service is NOT laboratory **Chlamydia Screening Test:**

CPT	LOINC
UHC: 87110, 87270, 87320, 87490 -92, 87810 Cigna: 87110	14463-4, 14464-2, 14467-5, 14474-1,14513-6, 16600-9, 21190-4, 21191-2, 21613-5, 23838-6, 31775-0, 31777-6, 36902-5, 36903-3, 42931-6, 43304-5, 43404-3, 43405-0, 43406-8, 44806-8, 44807-6, 45068-4, 45069-2, 45075-9, 45076-7, 45084-1, 45091-6, 45095-7, 45098-1, 45100-5, 47211-8, 47212-6, 49096-1, 4993-2, 50387-0, 53925-4, 53926-2, 557-9, 560-3, 6349-5, 6354-5, 6355-2, 6356-0, 6357-8, 80360-1, 80361-9, 80362-7, 91860-7

Exclusions:

Members who meet any of the following criteria are excluded:

- Received hospice and/or palliative care during the measurement year
- If a member qualified for the measure from a pregnancy test alone, they'll be excluded if they additionally have one of the following:
  - Prescription for Isotretinoin
  - An x-ray

Best practices:

- In assessing sexually active female patients ages 16-24 years, consider standard orders for chlamydia urine testing as part of the office visit
- Build care gap “alerts” in electronic medical records
- Chlamydia screening may not be captured via claims if the service is performed and billed under prenatal and postpartum global billing
- The Centers for Disease Control and Prevention recommends self-obtained vaginal specimens for asymptomatic females
- Self-obtained vaginal specimens are cleared by the U.S. Food & Drug Administration (FDA) for collection in a clinical setting
- Additional information on chlamydia screening is available at brightfutures.aap.org

Diabetes: Retinal eye exam

Percentage of members 18–75 years of age with diabetes (Type 1 and Type 2) who had an eye exam (retinal) performed

Eligible Population	
Ages	Members age 18 through 75 years
Measurement	12 Months

Administrative Specification

Denominator

Members 18–75 years of age having diabetes

Diagnosis codes to identify diabetes:

ICD-CM Diagnosis
250 – 250.93, 357.2, 362.0 – 362.07, 366.41, E10*, E11*, E13*, O24.011-O24.83

Numerator

Screening or monitoring for diabetic retinal disease as identified by administrative data. This includes diabetics who had one of the following:

- A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year
- A negative retinal or dilated eye exam (negative for retinopathy) by an eye care professional in the year prior to the measurement year
- Bilateral eye enucleation any time during the member's history through December 31 of the measurement year

Codes to Indicate retinal exam:

CPT	HCPCS
67028, 67030, 67031, 67036, 67039-67043, 67101, 67105, 67107, 67108, 67110, 67112, 67113, 67121, 67141, 67145, 67208, 67210, 67218, 67220, 67221, 67227, 67228, 92002, 92004, 92012, 92014, 92018, 92019, 92134, 92201, 92202, 92225-92228, 92229, 92230, 92235, 92240, 92250, 92260, 99203-99205, 99213-99215, 99242-99245	S0620, S0621, S3000

CPT/CPT II	
Diabetic Eye Exam without Evidence of Retinopathy in Prior Year	3072F
Diabetic Eye Exam without Evidence of Retinopathy	2023F, 2025F, 2033F
Diabetic Eye Exam with Evidence of Retinopathy	2022F, 2024F, 2026F
Unilateral Eye Enucleation	65091, 65093, 65101, 65103, 65105, 65110, 65112, 65114

Administrative Specification (Continued)		
Numerator (Continued)	**ICD-10 Procedure**	
	Unilateral Eye Enucleation – Left	08T1XZZ
	Unilateral Eye Enucleation – Right	08T0XZZ
	CPT Modifier	
	Bilateral Modifier	50

Exclusions:

Members who meet any of the following criteria are excluded:

- Received hospice and/or palliative care during the measurement year
- Members who have no diagnosis of diabetes and have a diagnosis of polycystic ovarian syndrome, gestational diabetes or steroid-induced diabetes during the measurement year or prior
- Age 66 or older with both frailty and advanced illness
- Medicare members ages 66 and older as of Dec. 31 of the measurement year who are either:
  - Enrolled in an Institutional Special Needs Plan (I-SNP)
  - Living long term in an institution*

Best practices:

- Build care gap “alerts” in electronic medical records
- Members without retinopathy should have an eye exam every 2 years
- Members with retinopathy should have an eye exam every year
- Consider the use of a retinal imaging device in your practice (results must be interpreted by an optometrist or ophthalmologist)
- Consider referring members to an optometrist or ophthalmologist for an annual retinal eye exam at checkout
- Document the provider who completed the screening, the result, and obtain eye exam report from performing provider

Diabetes: Hemoglobin A1c testing

The percentage of members 18 to 75 years old with diabetes mellitus who had an HbA1c test

Eligible Population	
Ages	Member age 18 -75 years old
Measurement	12 Months

Administrative Specification	
Denominator	Members 18 to 75 years old with diagnosis of type 1 or type 2 diabetes **Diagnosis codes to identify diabetes:** **ICD-CM Diagnosis** 250 – 250.93, 357.2, 362.0 – 362.07, 366.41, E10*, E11*, E13*, O24.011-O24.83
Numerator	HbA1c test during measurement year **Codes to identify HbA1c tests:**

CPT	CPT II	LOINC
83036, 83037	3044F, 3046F, 3051F, 3052F	4548-4, 4549-2, 17856-6

Exclusions:

Members who meet any of the following criteria are excluded:

- Received hospice and/or palliative care during the measurement year
- Age 66 or older with both frailty and advanced illness
- Members who have no diagnosis of diabetes in any setting and a diagnosis of polycystic ovarian syndrome, gestational or steroid-induced diabetes during measurement year or year prior

Codes to identify gestational or steroid induced diabetes:

Description	ICD-CM Diagnosis
Steroid induced	251.8, 962.0 E09.00, E09.01, E09.10, E09.11, E09.21, E09.22, E09.29, E09.311, E09.319, E09.321, E09.329, E09.331, E09.339, E09.341, E09.349, E09.351, E09.359, E09.36, E09.39, E09.40, E09.41, E09.42, E09.43, E09.44, E09.49, E09.51, E09.52, E09.59, E09.610, E09.618, E09.620, E09.621, E09.622, E09.628, E09.630, E09.638, E09.641, E09.649, E09.65, E09.69, E09.8, E09.9
Gestational diabetes	648.8 O24.210, O24.414, O24.419, O24.420, O24.424, O24.429, O24.430, O24.434, O24.439, O24.911, O24.912, O24.913, O24.919, O24.92, O24.93

Best practices:

- Build care gap “alerts” in electronic medical records
- Bill using appropriate Current Procedural Terminology (CPT®) II codes
- Order labs prior to patients appointments
- Adjust therapy to improve HbA1c levels and follow up with the patient to monitor changes
- Educate patients about the importance of routine screening and medication compliance. Review the need for diabetes education during office visits

Diabetes: Hemoglobin A1c control (<8.0%)

The percentage of members age 18 to 75 with diabetes that demonstrate glycemic control, based on a HbA1c level less than 8%.

*****NEW HEDIS REQUIREMENT FOR THIS MEASURE***** Document patients race and ethnicity within medical record

Eligible Population	
Ages	Member age 18 through 75 years old
Measurement	12 Months

Administrative Specification	
Denominator	Members 18 to 75 years old with diagnosis of type 1 or type 2 diabetes **Diagnosis codes to identify diabetes:** **ICD-CM Diagnosis** 250 – 250.93, 357.2, 362.0 – 362.07, 366.41, E10*, E11*, E13*, O24.011-O24.83
Numerator	Lab results with most recent HbA1c result value less than 8.0% **Codes to identify HbA1c levels <8.0%:** **CPT II**: 3044F, 3051F **LOINC**: 4548-4, 4549-2, 17856-6

Exclusions:

Members who meet any of the following criteria are excluded:

- Received hospice and/or palliative care during the measurement year
- Dispensed dementia medication (Donepezil, Galantamine, Rivastigmine, Memantine)
- Age 66 or older with both frailty and advanced illness
- Members who have no diagnosis of diabetes in any setting and a diagnosis of polycystic ovarian syndrome, gestational or steroid-induced diabetes during measurement year or year prior

Codes to identify gestational or steroid induced diabetes:

Description	ICD-CM Diagnosis
Steroid induced	251.8, 962.0 E09.00, E09.01, E09.10, E09.11, E09.21, E09.22, E09.29, E09.311, E09.319, E09.321, E09.329, E09.331, E09.339, E09.341, E09.349, E09.351, E09.359, E09.36, E09.39, E09.40, E09.41, E09.42, E09.43, E09.44, E09.49, E09.51, E09.52, E09.59, E09.610, E09.618, E09.620, E09.621, E09.622, E09.628, E09.630, E09.638, E09.641, E09.649, E09.65, E09.69, E09.8, E09.9
Gestational diabetes	648.8 O24.210, O24.414, O24.419, O24.420, O24.424, O24.429, O24.430, O24.434, O24.439, O24.911, O24.912, O24.913, O24.919, O24.92, O24.93

Best practices:

- Build care gap “alerts” in electronic medical records
- Order labs prior to appointments to allow results to be available for discussion on the day of the office visit
- Adjust therapy to improve HbA1c levels and follow up with the patient to monitor changes
- Educate patients about the importance of routine screening and medication compliance. Review the need for diabetes education during office visits
- Always document the date when HbA1c test was performed, result and test together

Diabetes: Kidney Health Evaluation (KED)

Percentage of members age 18 to 85 with diabetes (Type 1 and Type 2) who had a kidney health evaluation during the measurement year

Eligible Population	
Ages	Members age 18 through 85 years old
Measurement	12 Months

Administrative Specification	
Denominator	Members 18–85 years of age having diabetes **Diagnosis codes to identify diabetes:** **ICD-CM Diagnosis** 250 – 250.93, 357.2, 362.0 – 362.07, 366.41, E10*, E11*, E13*, O24.011-O24.83
Numerator	Documentation within the medical record of any of the following meet criteria for a kidney health evaluation: • At least 1 estimated glomerular filtration rate (eGFR); AND • At least 1 urine albumin-creatinine ratio (uACR) test identified by one of the following: – A quantitative urine albumin test AND a urine creatinine test 4 or less days apart; OR – A uACR

Exclusions:

Members who meet any of the following criteria are excluded:

- Received hospice and/or palliative care during the measurement year
- Age 66 or older with both frailty and advanced illness, or members ages 81 and older with frailty
- Members with End-Stage Renal Disease (ESRD), or who were on dialysis during the measurement year
- Medicare members ages 66 and older who were enrolled in an Institutional Special Needs Plan (I-SNP) or were living long-term in an institution during the measurement year
- Members who have no diagnosis of diabetes in any setting and a diagnosis of polycystic ovarian syndrome, gestational or steroid-induced diabetes during measurement year or year prior

Codes to identify exclusions:

Description	CPT	ICD-CM Diagnosis
Dialysis Procedure	90935, 90937, 90945, 90945, 90947, 90997, 90999, 99512	-
ESRD Diagnosis	-	N18.5-6, Z99.2
Steroid-induced Diabetes	-	E09.9
Gestational Diabetes	-	024.4
Polycystic Ovarian Syndrome Diagnosis	-	E28.2

Administrative Specification (Continued)

Numerator (Continued)

Estimated Glomerular Filtration Rate (eGFR) Lab Test:

CPT	LOINC
80047, 80048, 80050, 80053, 80069, 82565	48642-3, 48643-1, 50044-7, 50210-4, 50384-7, 62238-1, 69405-9, 70969-1, 77147-7, 88293-6, 88294-4, 94677-2, 96591-3, 96592-1,

Quantitative Urine Albumin Lab Test:

CPT	LOINC
82043	14957-5, 1754-1, 21059-1, 30003-8, 43605-5, 53530-2, 53531-0, 57369-1, 89999-7

Urine Creatinine Lab Test

CPT	LOINC
82570	20624-3, 2161-8, 35674-1, 39982-4, 57344-4, 57346-9, 58951-5

Urine Albumin Creatinine Ratio Test

LOINC
13705-9, 14958-3, 14959-1, 30000-4, 32294-1, 44292-1, 59159-4, 76401-9, 77253-3, 77254-1, 89998-9, 9318-7

Best practices:

- Discuss importance of regular kidney health evaluation with patients
- Submit claims and encounter data in a timely manner
- Order labs prior to appointments to allow results to be available for discussion on the day of the office visit
- Create automatic flags in EMR to alert staff to know when patients are due for screenings. Use EMR to send text reminders that labs are due
- Consider standardizing eGFR and uACR test orders for diabetic patients as part of office visits

Controlling high blood pressure

Patient(s) 18-85 years of age with hypertension and most recent blood pressure less than 140/90 mm Hg during the measurement

*****NEW HEDIS REQUIREMENT FOR THIS MEASURE***** Document patients race and ethnicity within medical record

Eligible Population	
Ages	Members age 18 through 85 years old
Measurement	12 Months

Administrative Specification		
Denominator	Patient(s) 18–85 years of age with a diagnosis of hypertension	
Numerator	Most recent blood pressure less than 140/90 mm Hg in the last 12 months	
	CPT II	**HCPCS**
	3074F, 3075F, 3076F, 3077F, 3078F, 3079F, 3080F	G8588, G8590, G8677, G8678, G8679, G8752, G8790, G8791, G8680, G8919, G9273

Exclusions:

Members who meet any of the following criteria are excluded:

- Received hospice and/or palliative care during the measurement year

Best practices:

- Build care gap “alerts” in electronic medical records
- Submit claims using the correct CPT II codes
- Document BP values in the patients medical record (date and result)
- Document BP readings taken or viewed during all outpatient visits, telephone visits, virtual visits, non-acute inpatient encounters or remote monitoring events
- Discuss importance of taking medications as prescribed, smoking cessation, increased physical activity and eating a low-sodium diet
- Encourage patients to return for follow up appointments
- Outreach to patients who cancel or miss appointments and assist them with rescheduling

Childhood Immunization Status (Combination 2)

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

- 1 dose – Meningococcal conjugate or meningococcal polysaccharide vaccine on or between the member's 11th and 13th birthdays.
- 1 dose – Tetanus, diphtheria toxoids vaccine, and acellular pertussis vaccine (Tdap) on or between the member's 10th and 13th birthdays.
- 2 dose series or 3 dose series of the HPV (human papilloma virus) vaccine with different dates of service between the members 9th and 13th birthdays.

Eligible Population	
Ages	Adolescents 13 years old
Measurement	12 Months

Administrative Specification	
Denominator	Adolescents who turn 13 years old during the measurement year.
Numerator	patient had an MCV vaccine between their 11th and 13th birthdays and patient had a Tdap vaccine between their 10th and 13th birthdays and patient had at least 2 HPV vaccines (with different dates of service) between their 9th and 13th birthdays. Vaccines must be at least 146 days apart.

Meningococcal CPT code: 90619, 90733, 90734	**CVX codes:** 114
Tdap CPT code: 90715	**CVX codes:** 115
HPV CPT code: 90649-90651	**CVX codes:** 165

Exclusions:

- Patient had evidence of a contraindication to a vaccine before their 13th birthday.
- Children with anaphylactic reaction to a vaccine or its components can be excluded from any particular vaccine.
- Anyone who is allergic to ingredients of GARDASIL 9 or GARDASIL [Human Papillomavirus Quadrivalent (Types 6, 11, 16 and 18) Vaccine Recombinant], including those severely allergic to yeast, should not receive the vaccine.
- Received hospice and/or palliative care during the measurement year.

Codes to identify exclusions:

Description	ICD-10 Diagnosis Codes*	ICD-9 Diagnosis Codes**
Anaphylactic Reaction Due to Vaccination Value Set	T8052XA, T8052XD, T8052XS	99942
Disorders of the Immune System Value Set	D800, D801, D802, D803, D804, D805, D806, D807, D808, D809, D810, D811, D812, D814, D816, D817, D8189, D819, D820, D821, D822, D823, D824 ,D828, D829, D830, D831, D832, D838, D839, D840, D841, D848, D849, D893, D89810, D89811, D89812, D89813, D8982, D8989, D899	27900, 27901, 27902, 27903, 27904, 27905, 27906, 27909 27910 27911, 27912, 27913, 27919, 2792, 2793, 27941, 27949, 27950, 27951, 27952, 27953, 2798, 2799

Best practices:

- Build care gap “alerts” in electronic medical records
- Report all immunizations through your state immunization registry
- Submit claims and encounter data in a timely manner
- Check for missing immunizations during every visit
- Schedule office visits to coincide with immunization requirements
- Use electronic medical record system for pre-visit planning and to set alerts
- Include in your medical records the patients immunization history from all sources, such as, the local health department and previous providers

Childhood immunization status (Combination 3)

The percentage of children 2 years of age who had One Measles, Mumps, Rubella (MMR); One Hepatitis A (Hep A); One Varicella (VZV); Two or Three Rotavirus (RV); Three Hepatitis B (Hep B); Three Polio (IPV); Three Haemophilus Influenza Type B (HiB); Four Diptheria, Tetanus, Acellular Pertussis (DTaP); Four Pneumococcal (PCV) vaccines by their second birthday

*****MMR, VZV and Hep A vaccinations must be administered on or between the child's first and second birthdays to meet this measure's criteria*****

Eligible Population	
Ages	Children 2 years old
Measurement	12 Months

Administrative Specification	
Denominator	Children who turn two years old during the measurement year
Numerator	Evidence of the antigen or combination vaccine **or** documented history of the illness **or** a seropositive test result for each antigen

Codes to identify Childhood Immunization Status (Combination 3):

Description	CPT/CPT II	CVX Codes	HCPCS	ICD-10 Procedure	SNOMED
DTaP **Number of Doses: 4** **Special Circumstances** Do not count dose administered from birth through 42 days	90698, 90700, 90723	20, 50, 106, 107, 110, 120	-	-	-
IPV **Number of Doses: 3** **Special Circumstances:** Do not count dose administered from birth through 42 days	90698, 90713, 90723	10, 89, 110, 120	-	-	-
MMR **Number of Doses: 1** **Special Circumstances** Any combination of measles, mumps and rubella vaccines must be administered on or between a child's first and second birthdays	90707, 90710	03, 94	-	-	-
Measles/Rubella **Number of Doses: 1**	90708	04	-	-	-

Administrative Specification (Continued)

Numerator (Continued)

Description	CPT/CPT II	CVX Codes	HCPCS	ICD-10 Procedure	SNOMED
Measles **Number of Doses: 1**	90705	05	-	-	-
Mumps **Number of Doses: 1**	90704	07	-	-	50583002
Rubella **Number of Doses: 1**	90706	06	-	-	82314000
HiB **Number of Doses: 3** **Special Circumstances:** Do not count dose administered from birth through 42 days	90644, 90647-4890698, 90698, 90748	17, 46-51, 120, 148	-	-	-
Hep B **Number of Doses: 3**	08, 44, 45, 51, 110	-	G0010	90723, 90740, 90744, 90747-48	-
Newborn Hep B **Number of Doses: 1 of 3 eligible**	-	-	-	3E0234Z	-
VZV **Number of Doses: 1** **Special Circumstances:** Must be administered on or between a child's first and second birthdays	90710, 90716	21, 94	-	-	-
PCV **Number of Doses: 4** **Special Circumstances:** Do not count dose administered from birth through 42 days	90670	133, 152	-	G0009	-

Exclusions:

Members who meet any of the following criteria are excluded:

- Children with a contraindication for a specific vaccine. For example, children with immunodeficiency may be excluded from MMR, VZV and Influenza
- Children with anaphylactic reaction to a vaccine or its components can be excluded from any particular vaccine.
- Received hospice and/or palliative care during the measurement year

Codes to identify exclusions:

Description	ICD-10 Diagnosis Codes*	ICD-9 Diagnosis Codes**
Anaphylactic Reaction Due to Vaccination Value Set	T8052XA, T8052XD, T8052XS	99942
Disorders of the Immune System Value Set	D800, D801, D802, D803, D804, D805, D806, D807, D808, D809, D810, D811, D812, D814, D816, D817, D8189, D819, D820, D821, D822, D823, D824 ,D828, D829, D830, D831, D832, D838, D839, D840, D841, D848, D849, D893, D89810, D89811, D89812, D89813, D8982, D8989, D899	27900, 27901, 27902, 27903, 27904, 27905, 27906, 27909 27910 27911, 27912, 27913, 27919, 2792, 2793, 27941, 27949, 27950, 27951, 27952, 27953, 2798, 2799
HIV Value Set	B20, Z21	042, V08
HIV Type 2 Value Set	B9735	07953
Malignant Neoplasm of Lymphatic Tissue Value Set	C8100-49, C8170- 79, C8190-269, C8280-319, C8330-39, C8350-59, C8370-419, C8440-49, C8460-79, C8490-99, C84A0-A9, C84Z0-Z9, C8510-29, C8580-99, C860-66, C882-84, C888-89, C9000-02, C9010-12, C9020-22, C9030-32, C9100-02, C9110-12, C9130-32, C9140-42, C9150-52, C9160-62, C9190-92, C91A0-A2, C91Z0-Z2, C9200-02, C9210-12, C9220-22, C9230-32, C9240-42, C9250-52, C9260-62, C9290-92, C92A0-A2, C92Z0-Z2, C9300-02, C9310-12, C9330-32, C9390-92, C93Z0-Z2, C9400-02, C9420-22, C9430-32, C9480-82, C9500-02, C9510-12, C9590-92, C960, C962, C964, C969, C96A, C96Z	

* Must be accompanied with an ICD Version Code='10'

** Must be accompanied with an ICD Version Code='09'

Best practices:

- Build care gap "alerts" in electronic medical records
- Report all immunizations through your state immunization registry
- Submit claims and encounter data in a timely manner
- Check for missing immunizations during every visit
- Schedule office visits to coincide with immunization requirements
- Use electronic medical record system for pre-visit planning and to set alerts
- Include in your medical records the patients immunization history from all sources, such as, the local health department and previous providers

Childhood Immunization Status (Combination 10)

The percentage of children who have received all the following vaccines (Combo 10) by their 2nd birthday.

Combination 10: DTaP, IPV, MMR, HiB, HepB, VZV, PCV, RV, HepA, Flu.

- 4 diphtheria, tetanus, and acellular pertussis (DTaP) (first dose after 42 days after birth) or anaphylaxis or encephalitis due to the diphtheria, tetanus or pertussis vaccine.
- 3 inactivated polio vaccine (IPV) (first dose after 42 days after birth).
- 1 measles, mumps and rubella (MMR) (on or between child's 1st and 2nd birthday) or history of measles, mumps and rubella illness.
- 3 haemophilus influenzae type b (Hib) (first dose after 42 days after birth) or anaphylaxis due to the Hib vaccine.
- 3 hepatitis B (HepB) (first dose 0-4 weeks), or anaphylaxis due to the Hepatitis B vaccine.
- 1 varicella (VZV)(on or between child's 1st and 2nd birthday) or history of varicella zoster (e.g. chicken pox) illness.
- 4 pneumococcal conjugate vaccine (PCV) (first dose after 42 days after birth).
- 2 or 3 rotavirus (RV)* (first dose after 42 days after birth) or anaphylaxis due to the rotavirus vaccine.
- 1 hepatitis A (HepA) (on or between child's 1st and 2nd birthday) or history of hepatitis A illness.
- 2 influenza (Flu)** (vaccines given after 180 days after birth up to or on the child's 2nd birthday).

*Members may need 2 or 3 rotavirus doses, depending on the brand of vaccine that was administered.

The following will make the member compliant for this vaccine:

- 3 doses for RotaTeq
- 2 doses Rotarix
- 1 Rotarix AND 2 RotaTeq

Eligible Population	
Ages	Children 2 years of age
Measurement	12 Months

<table>
<tr><th colspan="2">Administrative Specification</th></tr>
<tr><td>Denominator</td><td>Children who turn 2 years of age during the measurement year based on eligibility criteria.</td></tr>
<tr><td>Numerator</td><td>For MMR, Hepatitis B, VZV, and Hepatitis A.
• Evidence of the antigen or combination vaccine, or
• Documented history of the illness, or
• A seropositive test result for each antigen

For Dtap, IPV, HiB, pneumococcal conjugate, rotavirus and influenza.
• Evidence of the antigen or combination vaccine.
For combination vaccinations that require more than one antigen (DTaP and MMR), the organization must find evidence of all the antigens.

Codes to identify Childhood Immunization Status (Combination 3):

Description

DTaP
At least four DTaP vaccinations (DTaP Immunization Value Set; DTaP Vaccine Procedure Value Set), with different dates of service on or before the child’s second birthday. Do not count a vaccination administered prior to 42 days after birth.

IPV
At least three IPV vaccinations (Inactivated Polio Vaccine (IPV) Immunization Value Set; Inactivated Polio Vaccine (IPV) Procedure Value Set), with different dates of service on or before the child’s second birthday. Do not count a vaccination administered prior to 42 days after birth.

MMR
Any of the following meet criteria:
• At least one MMR vaccination (Measles, Mumps and Rubella (MMR) Immunization Value Set; Measles, Mumps and Rubella (MMR) Vaccine Procedure Value Set) on or between the child’s first and second birthdays.
• At least one measles and rubella vaccination (Measles Rubella Immunization Value Set; Measles Rubella Vaccine Procedure Value Set) on or between the child’s first and second birthdays and one of the following:
• At least one mumps vaccination (Mumps Immunization Value Set; Mumps Vaccine Procedure Value Set) on or between the child’s first and second birthdays.
• History of mumps illness (Mumps Value Set) any time on or before the child’s second birthday.
• Any combination of codes from the table below that indicates evidence of all three antigens (on the same or different date of service).</td></tr>
</table>

Administrative Specification (Continued)

Numerator (Continued)

Measles (any of the following)	Mumps (any of the following)	Rubella (any of the following)
At least one measles vaccination (Measles Immunization Value Set; Measles Vaccine Procedure Value Set) administered on or between the child's first and second birthdays.	At least one mumps vaccination (Mumps Immunization Value Set; Mumps Vaccine Procedure Value Set) administered on or between the child's first and second birthdays.	At least one rubella vaccination (Rubella Immunization Value Set; Rubella Vaccine Procedue Value Set) administered on or between the child's first and second birthdays.
History of measles (Measles Value Set) illness anytime on or before the child's second birthday.	History of mumps (Mumps Value Set) illness anytime on or before the child's second birthday.	History of rubella (Rubella Value Set) illness anytime on or before the child's second birthday.

HiB
At least three HiB vaccinations (Haemophilus Influenzae Type B (HiB) Immunization Value Set; Haemophilus Influenzae Type B (HiB) Vaccine Procedure Value Set), with different dates of service on or before the child's second birthday. Do not count a vaccination administered prior to 42 days after birth.

Hepatitis B

Any of the following on or before the child's second birthday meet criteria:

- At least three hepatitis B vaccinations (Hepatitis B Immunization Value Set; Hepatitis B Vaccine Procedure Value Set), with different dates of service.
- One of the three vaccinations can be a newborn hepatitis B vaccination (Newborn Hepatitis B Vaccine Administered Value Set) during the eight-day period that begins on the date of birth and ends seven days after the date of birth. For example, if the member's date of birth is December 1, the newborn hepatitis B vaccination must be on or between December 1 and December 8.
- History of hepatitis illness (Hepatitis B Value Set)

VZV Varicella:

- At least one VZV vaccination (Varicella Zoster (VZV) Immunization Value Set; Varicella Zoster (VZV) Vaccine Procedure Value Set), with a date of service on or between the child's first and second birthdays.
- History of varicella zoster (e.g., chicken pox) illness (Varicella Zoster Value Set) on or before the child's second birthday.

CPT codes:	CVX Codes:
Dtap: 90698, 90700, 90723	20, 50, 106, 107, 110, 120
IPV: 90698, 90713, 90723	10, 89, 110, 120
MMR: 90704-90708, 90710	03-07, 94
Hib: 90644-90648, 90698,	17, 46-51, 120, 148
Hep B: 90723, 90740, 90744, 90747-48	08, 44, 45, 51, 110
VZV: (varicella) 9710, 90716	21, 94
PCV: 90670, 90671, G0009	133, 152
RV (rotavirus): 90680, 90681	116, 119
Hep A: 90633, 90634	83
Influenza: 90672, 90674, 90686, 90687,	149, 150, 158, 171, 186
90688, 90756	

Codes to identify exclusions:

Description	ICD-10 Diagnosis Codes*
Anaphylactic Reaction Due to Vaccination value set.	T8052XA, T8052XD, T8052XS

Exclusions:

Members who meet any of the following criteria are excluded:

- Children with a contraindication for a specific vaccine. For example, children with immunodeficiency may be excluded from MMR, VZV and Influenza
- Children with anaphylactic reaction to a vaccine or its components can be excluded from any particular vaccine.
- Received hospice and/or palliative care during the measurement year

Best practices:

- Build care gap “alerts” in electronic medical records
- Report all immunizations through your state immunization registry
- Submit claims and encounter data in a timely manner
- Check for missing immunizations during every visit
- Schedule office visits to coincide with immunization requirements
- Use electronic medical record system for pre-visit planning and to set alerts
- Include in your medical records the patient’s immunization history from all sources, such as, the local health department and previous providers

Well child visits in the first 30 months of life

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

Eligible Population	
Ages	Birth to 30 months of life
Measurement	12 Months

Administrative Specification	
Denominator	Patient(s) who turned 15 or 30 months old during the measurement year
Numerator	1. Well-Child Visits in the First 15 Months. Children who turned 15 months old during the measurement year: Six or more well-child visits. Six(6) or more well-child visits in the first 15 months of life 2. Well-Child Visits for Age 15 Months to 30 Months. Children who turned 30 months old during the measurement year: Two or more well-child visits. Two (2) or more well-child visits between 15-30 months of age

Codes to identify well child visits:

CPT	HCPCS	ICD-10
99381-99385, 99391-99395, 99461	G0438-39, S0302, S0610, S061, S0613	Z00.00-Z00.01, Z00.110-Z00.111, Z00.121, Z00.129, Z00.2, Z00.3, Z01.411, Z01.419. Z02.5, Z76.1-Z76.2

Exclusions:

Members who meet any of the following criteria are excluded:

- Received hospice and/or palliative care during the measurement year

Best practices:

- Build care gap "alerts" in electronic medical records
- Use of appropriate billing codes supports measure adherence without additional workload to review patient records
- Create automatic flags in EMR to alert staff when well-care visits are overdue
- Use EMR tools to send patients/parents electronic reminders of the need for well-care visits
- Ensure medical records include all components for a comprehensive well-care visit
  - Health history (assess health & family history. Include all 3; allergies, medications and immunizations)
  - Physical development history (assess growth & development milestones)
  - Mental development history (assess mental developmental milestones)
  - Physical exam (completed head to toe exam, height, weight, BP & BMI)
  - Health education/anticipatory guidance

  Note: For telehealth, vitals must be documented "self-reported by patient."
- Convert sick visits and sports physicals into well-care visits by performing and submitting appropriate codes for well-care visit. You can then bill a well-care with a modifier for the sick visit or sports physical
- Consider extended/weekend hours to accommodate busy schedules

Child and Adolescent Well-Care Visits 3-21 years

Patient(s) 3 - 21 years of age that had one comprehensive well-care visit with a PCP or an OB/GYN during the measurement year

*****NEW HEDIS REQUIREMENT FOR THIS MEASURE***** Document patients race and ethnicity within medical record

Eligible Population	
Ages	Members 3 - 21 years of age by the end of the assessment year
Measurement	12 Months

Administrative Specification	
Denominator	Patient(s) 3 - 21 years of age that had one comprehensive well-care visit with a PCP or an OB/GYN during the measurement year
Numerator	• Patients ages 3 - 21 should receive at least one comprehensive well-care visit yearly with a PCP or an OB/GYN. • Patient(s) 3 - 21 years of age that had one comprehensive well-care visit with a PCP or an OB/GYN during the measurement year **Codes to identify well child visits:**

CPT	HCPCS	ICD-10
99381-99385, 99391-95, 99461	G0438, G0439, S0302, S0610, S0612, S0613	Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.2, Z00.3, Z01.411, Z01.419, Z02.5, Z76.1, Z76.2

Exclusions:

Members who meet any of the following criteria are excluded:

- Received hospice care during the measurement year

Codes to identify exclusions:

Description	ICD-10 Diagnosis Codes*	ICD-9 Diagnosis Codes**
Hospice	99381-99382	G0182, G9473-79, Q5003-08, Q5010, S9126, T2042-46

Best practices:

- Build care gap “alerts” in electronic medical records
- Use of appropriate billing codes supports measure adherence without additional workload to review patient records
- Create automatic flags in EMR to alert staff when well care visits are overdue
- Use EMR tools to send patients/parents electronic reminders of the need for adolescent well-care visits
- Ensure medical records include all components for a comprehensive adolescent well-care visit
  - Health history (assess health & family history)
  - Physical development history (assess growth & development)
  - Mental development history (assess mental developmental milestones)
  - Physical exam (completed head to toe exam, height, weight, BP & BMI)
  - Health education/anticipatory guidance

  Note: For telehealth, vitals must be documented “self-reported by patient”
- Convert sick visits and sports physicals into well-care visits by performing and submitting appropriate codes for well-care visit. You can then bill a well-care with a modifier for the sick visit or sports physical
- Consider extended/weekend hours to accommodate busy schedules

Coronary Artery Disease (CAD): Patients currently taking a statin

Patient(s) ages 18 years of age or older with a diagnosis of CAD, who had at least one dispensing event for a statin medication

Eligible Population	
Ages	Members 18 years of age and older
Measurement	12 Months

Administrative Specification	
Denominator	Patient(s) ages 18 years of age or older with a diagnosis of CAD, who had at least one dispensing event for a statin medication
Numerator	• **Statins are recommended for all patients with CAD unless contraindicated or not tolerated.** • Patient(s) currently taking a statin. During the last 120 days of the report period did the patient have one or more claims with any of the following criteria: – Statin-containing medication – Lipid-lowering therapy • No claim with a procedure code for lipid-lowering therapy with any exclusion modifiers that indicated the reason for not prescribing lipid lowering therapy. **All statins prescribed** Lipid lowering therapy prescribed

CPT	HCPCS
4002F, 4013F	G9664

Best practices:

- Build care gap “alerts” in electronic medical records
- Use of appropriate billing codes supports measure adherence without additional workload to review patient records
- Encourage patients to use their ID card at the pharmacy
- Educate each patient on why they are on a specific medication and explain the role and importance of statin therapy
- Work with patient to identify and resolve adherence barriers or concerns
- Recommend mail order and 90-day prescription of maintenance drugs
- Encourage lifestyle modifications focused on diet and weight loss to improve lipid panel

Statin therapy for patients with cardiovascular disease

The percentage of 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)

Eligible Population	
Ages	• Males 21–75 years of age • Females 40–75 years of age
Measurement	12 Months.

Administrative Specification	
Denominator	**Rate 1 — Received Statin Therapy: Report two age/gender stratifications and a total rate.** • Males 21–75 years as of December 31 of the measurement year • Females 40–75 years as of December 31 of the measurement year • Total **Rate 2 — Statin Adherence 80%: Report two age/gender stratifications and a total rate.** • Males 21–75 years as of December 31 of the measurement year • Females 40–75 years as of December 31 of the measurement year • Total
Numerator	• **Rate 1 —** Received Statin Therapy: Members who had at least one dispensing event for a high-intensity or moderate-intensity statin medication during the measurement year • **Rate 2 —** Statin Adherence 80%: Members who remain on a high-intensity or moderate-intensity statin medication for at least 80% of the treatment period

Statin		
High Intensity Statin Therapy	Atorvastatin 40-80 mg Rosuvastatin 20-40 mg Amlodipine-atorvastatin 40-80 mg	Simvastatin 80 mg Ezetimibe-simvastatin 80 mg
Moderate Intensity Statin Therapy	Atorvastatin 10-20 mg Rosuvastatin 5-10 mg Simvastatin 20-40 mg Ezetimibe-simvastatin 20-40 mg Amlodipine-atorvastatin 10-20 mg	Lovastatin 40 mg Pitavastatin 1-4 mg Pravastatin 40-80 mg Fluvastatin 40-80 mg

Exclusions:

Members who meet any of the following criteria are excluded:

Any time during the measurement year:

- Received hospice and/or palliative care
- Myalgia, myositis, myopathy or rhabdomyolysis diagnosis
- Medicare members age 66 and older with frailty and advanced illness
- Medicare members age 66 and older who are either enrolled in an Institutional Special Needs Plan (I-SNP) or is living long-term in an institution

Any time during the measurement year or the year prior to the measurement year:

- Cirrhosis
- End-stage renal disease (ESRD)
- Pregnancy; in vitro fertilization
- Dispensed at least one prescription for clomiphene

Best practices:

- Build care gap “alerts” in electronic medical records
- Encourage patients to use their ID card at the pharmacy
- Use of appropriate billing codes supports measure adherence without additional workload to review patient records
- Educate each patient on why they are on a specific medication and explain the role and importance of statin therapy
- Work with patient to identify and resolve adherence barriers or concerns
- Recommend mail order and 90-day prescription of maintenance drugs
- Encourage lifestyle modifications focused on diet and weight loss to improve lipid panel

Diabetes: Patients compliant with prescribed statin-containing medication

Patient(s) aged 40-75 years of age or older with a diagnosis of diabetes, who had at least one dispensing event for a high, moderate or low intensity statin medication

Eligible Population	
Ages	Members 40-75 years of age and older
Measurement	12 Months

Administrative Specification	
Denominator	Patient(s) aged 40-75 years of age or older with a diagnosis of diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD)
Numerator	Patients with a diagnosis of Diabetes should be prescribed statin medication and should adhere to the prescribed medication regimen (minimum compliance 80%) • **Rate 1** — Received Statin Therapy: Members who were dispensed at least one statin of any intensity during the measurement year • **Rate 2** — Statin Adherence 80%: Members who remained on a statin of any intensity for at least 80% of the treatment period

Statin		
High Intensity Statin Therapy	Atorvastatin 40-80 mg Ezetimibe-simvastatin 80 mg Amlodipine-atorvastatin 40-80 mg	Simvastatin 80 mg Ezetimibe-simvastatin 80 mg
Moderate Intensity Statin Therapy	Lovastatin 40 mg Fluvastatin 40-80 mg Atorvastatin 10-20 mg Amlodipine-atorvastatin 10-20 mg Ezetimibe-simvastatin 20-40 mg	Pitavastatin 1-4 mg Pravastatin 40-80 mg Rosuvastatin 5-10 m Simvastatin 20-40 m
Low-Intensity Statin Therapy	Fluvastatin 20 mg Lovastatin 10-20 mg Ezetimibe-simvastatin 10 mg	Simvastatin 5-10 mg Pravastatin 10-20 mg

Exclusions:

Members who meet any of the following criteria are excluded:

Any time during the measurement year:

- Received hospice and/or palliative care
- Myalgia, myositis, myopathy or rhabdomyolysis diagnosis
- Medicare members age 66 and older with frailty and advanced illness
- Medicare members age 66 and older who are either enrolled in an Institutional Special Needs Plan (I-SNP) or is living long-term in an institution

Any time during the measurement year or the year prior to the measurement year:

- Cirrhosis
- End-stage renal disease (ESRD)
- Pregnancy; in vitro fertilization
- Dispensed at least one prescription for clomiphene
- Ischemic vascular disease (IVD) must be in both years
- Members who have no diagnosis of diabetes in any setting and a diagnosis of polycystic ovarian syndrome, gestational or steroid-induced diabetes

Any time during the year prior to the measurement year:

- Coronary artery bypass grafting (CABG)
- Myocardial infarction (MI)
- Other revascularization
- Percutaneous coronary intervention (PCIMembers who have no diagnosis of diabetes in any setting and a diagnosis of polycystic ovarian syndrome, gestational or steroid-induced diabetes

Best practices:

- Build care gap “alerts” in electronic medical records
- Encourage patients to use their ID card at the pharmacy
- Use of appropriate billing codes supports measure adherence without additional workload to review patient records
- Educate each patient on why they are on a specific medication and explain the role and importance of statin therapy
- Work with patient to identify and resolve adherence barriers or concerns
- Recommend mail order and 90-day prescription of maintenance drugs
- Encourage lifestyle modifications focused on diet and weight loss to improve lipid panel

Asthma medication ratio

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

Eligible Population	
Ages	Members 5 - 64 years of age
Measurement	12 Months

Administrative Specification	
Denominator	Members ages 5-64 as of December 31 of the measurement year, who were identified as having persistent asthma
Numerator	The number of members who have a medication ratio of 0.50 or greater during the measurement year Member must have the appropriate ratio of controller medications to total asthma medications

Asthma Controller Medications

Drug Category	Medications	
Antiasthmatic combinations	Dyphylline-guaifenesin	
Antibody inhibitors	Omalizumab	
Anti-interleukin-4	Dupilumab	
Anti-interleukin-5	Benralizumab Mepolizumab	Reslizumab
Inhaled cortico steroids	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

Drug Category	Medications	
Short-acting, inhaled beta-2 agonists	Albuterol	Levalbuterol

Exclusions:

Members who meet any of the following criteria are excluded:

- Received hospice and/or palliative care
- Acute respiratory failure
- Chronic respiratory conditions due to fumes/vapors
- Cystic fibrosis
- Emphysema
- Obstructive chronic bronchitis

Best practices:

- Build care gap "alerts" in electronic medical record
- Encourage patients to use their ID card at the pharmacy
- Work with patient to identify and resolve barriers or concerns to filing prescriptions. Many drug manufacturers offer coupons on their websites
- Schedule follow-up appointments and ensure members receive prescriptions during checkout
- Use appropriate diagnosis codes for members conditions, including any codes for diagnosed conditions that may exclude members from this measures
- Help patients learn to identify and avoid asthma triggers

Persistence of beta-blocker treatment after heart attack

Patients 18 years of age and older during the measurement year who were hospitalized and discharged alive with a diagnosis of acute myocardial infarction and who received persistent beta-blocker treatment for six months after discharge

*Persistent beta-blocker treatment: at least 135 days during 180 days post discharge

Eligible Population	
Ages	Members 18 years of age and older
Measurement	12 Months

Administrative Specification	
Denominator	Patients 18 years of age and older during the measurement year who were hospitalized and discharged alive with a diagnosis of acute myocardial infarction
Numerator	Received persistent beta-blocker treatment for six months after discharge

Medications

To comply with this measure, a member must have completed a 135-day course of one of the following beta-blockers:

Drug Category	Medications	
Noncardioselective beta-blockers	Carvedilol Labetalol Nadolol Pindolol	Propanolol Timolol Sotalol
Cardioselective beta-blockers	Acebutolol Atenolol Betaxolol	Bisoprolol Metoprolol Nebivolol
Anti-hypertensive Combinations	Atenolol-chlorthalidone Bendroflumethiazide-nadolol Bisoprolol-hydrochlorothiazide	Hydrochlorothiazide-metoprolol Hydrochlorothiazide-propranolol

Exclusions:

Members who meet any of the following criteria are excluded:

- Diagnosis of Asthma
- Chronic obstructive pulmonary disease
- Chronic respiratory conditions due to fumes vapors
- Hypostension, heart block >1 degree or sinus bradycardia
- Intolerance or allergy to beta-blocker therapy
- Medication dispensing event indicative of a history of asthma
- Obstructive chronic bronchitis
- Received hospice and/or palliative care
- Medicare members age 66 and older with frailty and advanced illness
- Medicare members age 66 and older who are either enrolled in an Institutional Special Needs Plan (I-SNP) or is living long-term in an institution

Best practices:

- Build care gap “alerts” in electronic medical records
- Schedule follow-up appointments and ensure members receive prescriptions during checkout
- Review patients prescription patterns and reinforce education and reminders
- Work with patient to identify and resolve barriers or concerns to filing prescriptions. Many drug manufacturers offer coupons on their websites
- Use appropriate diagnosis codes for members conditions, including any codes for diagnosed conditions that may exclude members from this measures

Use of opioids at high dosage

Proportion of members ages 18 years of age and older receiving prescription opioids for ≥ 15 days during the measurement year at a high dosage, average milligram morphine equivalent (MME) dose ≥ 90 mg

Eligible Population	
Ages	Members 18 years of age and older
Measurement	12 Months

Administrative Specification	
Denominator	Members ages 18 and older receiving prescription opioids for ≥ 15 days during the measurement year at a high dosage, average milligram morphine equivalent (MME) dose ≥ 90 mg
Numerator	To be included in this measure, a member must have been prescribed one of the following opioid medications at an average 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 These medications are not included as dispensing events for this measure: • Cough and cold products with opioids • Injectables • Ionsys® –Fentanyl transdermal patch used in inpatient settings only • Methadone for the treatment of opioid use disorder

Exclusions:

Members who meet any of the following criteria are excluded:

- Received hospice and/or palliative care
- Cancer
- Sickle cell disease

Best practices:

- Build care gap “alerts” in electronic medical records
- Discuss benefits and risk and availability of non-opioid therapies with patient
- Review the prescription monitoring program whenever an opioid is prescribed
- Use a pain management agreement with members
- Prescribe the lowest dosage of opioids in the shortest length of time possible
- Evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation

Appropriate testing for pharyngitis

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

A higher rate indicates appropriate testing and treatment

Eligible Population	
Ages	3 years of age and older
Measurement	12 Months. The intake period is from six months priorto the beginning of the measurement year to six months priorto the end of the measurement year. The earliest episode during the intake period is the index episode start date

Administrative Specification

Denominator

All members, 3 years of age or older who had an outpatient, telephone, online assessment, observation, or emergency department encounter with a diagnosis of pharyngitis and were dispensed an antibiotic

All members 3 years of age and older during the intake period, who had a pharyngitis encounter with:

- An antibiotic prescribed within three days of the encounter
- No antibiotic medication prescribed or refilled within 30 days prior to the encounter or still active on the date of the encounter

Pharyngitis

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

Antibiotic medications:

Descripton	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	Erythromycin ethylsuccinate Erythromycin lactobionate Erythromycin stearate
Natural penicillins	Penicillin G potassium Penicillin G sodium	Penicillin V potassium Penicillin G benzathine
Penicillinase-resistant penicillins	Dicloxacillin	
Quinolones	Ciprofloxacin Levofloxacin	Moxifloxacin Ofloxacin

Administrative Specification (Continued)

Denominator(Continued)

Antibiotic medications (continued):

Description	Prescription	
Second generation cephalosporins	Cefaclor Cefprozil	Cefuroxime
Sulfonamides	Sulfamethoxazole-trimethoprim	
Tetracyclines	Doxycycline Minocycline	Tetracycline
Third generation cephalosporins	Cefdinir Cefixime Cefpodoxime	Ceftibuten Cefditoren Ceftriaxone

Numerator

A group A streptococcus test (Group A Strep Tests Value Set) in the seven-day period from three days prior to the Episode Date through three days after the Episode Date

Group A Strep Test

CPT/CPT II	LOINC	SNOMED
87070 -71, 87081, 87430, 87650 -52, 87880	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	1221210 04, 1222050 03, 1223030 07

Exclusions:

Members who meet any of the following criteria are excluded:

- Received hospice and/or palliative care
- Taking antibiotics in the 30 days before diagnosis of pharyngitis
- Exclude episode dates when the member had a claim with any of the below diagnoses:
  - HIV
  - Malignant Neoplasms
  - Malignant Neoplasms of the Skin
  - Emphysema
  - COPD
  - Disorders of the Immune Systems

Best practices:

- Build care gap “alerts” in electronic medical records
- Submit claims and encounter data in a timely manner.
- Use of appropriate billing codes supports measure adherence without additional workload to review patient records
- Use a point of care rapid Group A strep test or throat culture, when appropriate to confirm diagnosis of pharyngitis before prescribing an antibiotic

Appropriate treatment for upper respiratory infection (URI)

Percentage of episodes for members 3 months and older who were given a diagnosis of upper respiratory infection (URI) and were not dispensed an antibiotic prescription on or 3 days after the diagnosis day (4 days total)

A higher rate indicates appropriate testing and treatment (Update)

Eligible Population	
Ages	3 months of age and older
Measurement	12 Months

Administrative Specification	
Denominator	Episodes where the member had an outpatient, observation, telephone, online assessment, or ED visit with a diagnosis of URI Upper Respiratory Infection Codes That Do Not Need Antibiotics: **ICD-10 Diagnosis** J00, J06.0, J06.9
Numerator	Episodes with no antibiotic prescription on or in the three days following the episode date. The following antibiotic medications should not be prescribed for an upper respiratory infection:

Antibiotic Medications

Descripton	Prescription	
Aminoglycosides	Amikacin Gentamicin	Streptomycin Tobramycin
Aminopenicillins	Amoxicillin Ampicillin	
Beta-lactamase Inhibitors	Amoxicillin-clavulanate Ampicillin-sulbactam	Piperacillin-tazobactam
First generation cephalosporins	Cefadroxil Cefazolin	Cephalexin
Fourth generation cephalosporins	Cefepime	
Ketolides	Telithromycin	
Lincomycin derivatives	Clindamycin Lincomycin	
Macrolides	Azithromycin Clarithromycin	Erythromycin
Miscellaneous antibiotics	Aztreonam Chloramphenlcol Dalfopristin-quinupristin Daptomycin	Linezolid Metronidazole Vancomycin
Natural penicillins	Penicillin G benzathine- procaine Penicillin G potassium Penicillin G procaine	Penicillin G Sodium Penicillin V potassium Penicillin G benzathine

Administrative Specification (Continued)	
Numerator (Continued)	**Antibiotic medications (continued):**

Description	Prescription	
Penicillinase-resistant penicillins	Dicloxacillin Nafcillin	Oxacillin
Quinolones	Ciprofloxacin Gemifloxacin Levofloxacin	Moxifloxacin Ofloxacin
Rifamycin derivatives	Rifampin	
Second generation cephalosporins	Cefaclor Cefoxitin	Cefprozil Cefuroxime
Sulfonamides	Sulfadiazine Sulfamethoxazole-trimethoprim	
Tetracyclines	Doxycycline Minocycline	Tetracycline
Third generation cephalosporins	Cefdinir Cefditoren Cefixime Cefotaxime	Cefpodoxime Ceftibuten Ceftriaxone
Urinary anti-infectives	Fosfomycin Nitrofurantoin	Trimethoprim Nitrofurantoin macrocrystals-monohydrate

Exclusions:

Members who meet any of the following criteria are excluded:

- Received hospice and/or palliative care
- Exclude episode dates when the member had a claim with any of the below diagnoses:
  - HIV
  - Malignant Neoplasms
  - Malignant Neoplasms of the Skin
  - Emphysema
  - COPD
  - Disorders of the Immune Systems

Best practices:

- Build care gap “alerts” in electronic medical records
- Review and document the diagnosis with the member
- Schedule follow-up appointments
- Include the date of service for an outpatient or ED visit with only a URI diagnosis and no new or refill antibiotic prescription on or three days after episode

Avoid antibiotics for acute bronchitis/bronchiolitis

Percentage of episodes for members ages 3 months and older with a diagnosis of acute bronchitis/bronchiolitis between July 1 of the year prior to the measurement year through June 30 of the measurement year who were not dispensed an antibiotic medication on or 3 days after the episode

Eligible Population	
Ages	3 months of age and older
Measurement	12 Months

Administrative Specification	
Denominator	All members, 3 months of age or older, who had an outpatient, telephone, online assessment, observation, or emergency department encounter with a diagnosis of acute bronchitis/bronchiolitis
Numerator	Dispensed prescription for an antibiotic medication (AAB Antibiotic Medications List) on or three days after the Episode Date The following antibiotics should not be dispensed upon diagnosis of acute bronchitis:

Antibiotic medications:

Descripton	Prescription	
Aminoglycosides	Amikacin Gentamicin	Streptomycin Tobramycin
Aminopenicillins	Amoxicillin	Ampicillin
Beta-lactamase inhibitors	Amoxicillin-clavulanate Ampicillin-sulbactam Piperacillin-tazobactam	
First generation cephalosporins	Cefadroxil Cefazolin	Cephalexin
Fourth-generation cephalosporins	Cefepime	
Ketolides	Telithromycin	
Lincomycin derivatives	Clindamycin Lincomycin	
Macrolides	Azithromycin Clarithromycin Erythromycin	Erythromycin ethylsuccinate Erythromycin lactobionate Erythromycin stearate
Miscellaneous antibiotics	Aztreonam Chloramphenicol Dalfopristin-quinupristin Daptomycin	Linezolid Metronidazole Vancomycin

Administrative Specification (Continued)

Numerator (Continued)

Antibiotic medications (continued):

Description	Prescriptoin	
Natural penicillins	Penicillin G benzathine-procaine Penicillin G potassium Penicillin G procaine	Penicillin G sodium Penicillin V potassium Penicillin G benzathine
Penicillinase-resistant penicillins	Dicloxacillin Oxacillin	Nafcillin
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 Cefditoren Cefixime Cefotaxime	Cefpodoxime Ceftazidime Ceftibuten Ceftriaxone
Urinary anti-infectives	Fosfomycin Nitrofurantoin Nitrofurantoin macrocrystals	Nitrofurantoin macrocrystals-monohydrate Trimethoprim

Exclusions:

Members who meet any of the following criteria are excluded:

- Received hospice and/or palliative care
- Diagnosis of pharyngitis or a competing diagnosis on or 3 days after episode date
- Exclude episode dates when the member had a claim with any of the below diagnoses within 12 months of the event:
  - HIV
  - Malignant Neoplasms
  - Malignant Neoplasms of the Skin
  - Emphysema
  - COPD
  - Disorders of the Immune Systems

Best practices:

- Build care gap “alerts” in electronic medical records
- Submit a claim for all diagnosis, including co morbid and differential diagnoses, so members can be properly excluded from the measure
- Asthma and diabetes, tobacco use, fever or wheezing are not co morbid conditions or differential diagnosis exclusions for this measure
- Provide educational handouts explaining viruses, not bacteria, causes cold and flu (CDC has educational material)
- Delayed antibiotic prescribing as a strategy (CDC has educational material on antibiotic use and the delayed antibiotic prescribing strategy)

Imaging in uncomplicated low back pain

Percentage of members 18–75 years of age with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis

Eligible Population	
Ages	Members 18 - 75 years of age
Measurement	12 Months

Administrative Specification	
Denominator	All members, 18 years old as of January 1 of the measurement period to 50 years old as of December 31 of the measurement period, who had an outpatient or emergency department encounter with a principal diagnosis of uncomplicated low back pain
Numerator	An imaging study with a diagnosis of uncomplicated low back pain on the Index Event Start Date (IESD) or in the 28 days following the IESD **The following codes are imaging studies that should be avoided with a diagnosis of uncomplicated low back pain:** **CPT/CPT II** 72020, 72052, 72100, 72110, 72114, 72120, 72131-33, 72141-42, 72146-49, 72156, 72158, 72200, 72202, 72220

Exclusions:

Members who meet any of the following criteria are excluded:

- Received hospice and/or palliative care
- Recent trauma and/or fragility fractures 3 months prior to the episode start date through 28 days after the episode start date.
- Prolonged use of corticosteroids (90 consecutive days) dispensed any time 12 months prior to episode start date
- intravenous drug abuse, neurologic impairment or spinal infection any time 12 months prior to or 28 days after episode start date
- Members who had the following diagnosis at any time during the member's history through 28 days after the episode start date
  - Cancer
  - HIV
  - Major organ transplant
  - Osteoporosis or osteoporosis therapy
  - Lumbar Surgery
  - Spondylopathy

Best practices:

- Build care gap “alerts” in electronic medical records
- Submit claims and encounter data in a timely manner
- Educate members about conservative treatment and normal healing times.
- Be aware of the exclusions noted above, and use the correct exclusion code when indicated
- Use complete and accurate codes. Document telephone visits addressing primary uncomplicated back pain and code appropriately
- Avoid ordering diagnostic studies in the first four weeks of new-onset back pain if there aren’t indications ofunderlying conditions

Plan all-cause readmissions (actual to expected)

For members 18 to 64 years old, the number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days of the member's discharge and the predicted probability of an acute readmission

Eligible Population	
Ages	Members 18 - 64 years old
Measurement	12 Months

Administrative Specification	
Denominator	All acute inpatient and observation stays for members 18 to 64 years old (as of the discharge date) with a discharge date on or between January 1 and December 1 of the measurement year; include acute admissions to behavioral health care facilities
Numerator	Number of HEDIS-defined acute inpatient and observation stays during the measurement year that were followed by an observed unplanned acute readmission for any diagnosis within 30 days of the index discharge date

Additional Information:

Data are reported for the following indicators:

1. Count of index hospital stays (denominator)
2. Count of 30 day readmissions (numerator)
3. Expected readmissions rate

From this data, the ratio of the actual readmission rate to the expected readmissions rate is calculate

Exclusions:

Members who meet any of the following criteria are excluded:

- Received hospice and/or palliative care
- Planned re-admissions within 30 days (maintenance chemotherapy, principal diagnosis of rehabilitation, organ transplant, potentially planned procedure without a principal acute diagnosis)
- Stays for the following reasons:
  - Inpatient stays with discharges for death
  - Acute inpatient discharge with a principal diagnosis or pregnancy

Best practices:

- Build care gap "alerts" in electronic medical records
- Obtain hospital discharge summary and use to schedule post-discharge appointments within three to seven days or sooner to discuss:
  - Reason for hospitalization
  - Review discharge instructions to ensure the member understands them
  - Reconciliation of medications to prevent medication related readmissions
- Develop an action plan for chronic conditions, such as asthma and congestive heart failure, and discuss it with the member. Give clear instructions on changes that need immediate attention:
  - What symptoms should trigger the member to start "as needed", or PRN medications,
  - What symptoms should trigger a phone call to you (during and after office hours) and
  - When to go to the emergency room
- Ask about barriers or issues that might have contributed to members' hospitalization and discuss how to prevent them in the future
- Ask members if they completed or scheduled prescribed outpatient workups or other services. This could include physical therapy, home health care visits or obtaining durable medical equipment
- Consider telehealth or home health visits for discharged members, when appropriate

Depression screening

Patients 12 years of age and older screened for depression on the date of the encounter using an age appropriate standardized tool

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Eligible Population	
Ages	Members 12 years of age and older
Measurement	12 Months

Administrative Specification	
Denominator	Patients 12 years of age and older screened for depression on the date of the encounter using an age appropriate standardized tool
Numerator	Depression screening during an eligible encounter based on claims data or iCollaborate attestation (Cigna portal) **HCPCS** G0444

Best practices:

- Build care gap "alerts" in electronic medical records
- Submit all depression screenings via claims using HCPCS code G0444
- Attestation of depression screening can also be completed within Cigna's iCollaborate portal
- Code is paid annually when G0444 and modifier 59 is submitted