HEDIS®

HEALTHCARE EFFECTIVENESS DATA AND INFORMATION SET

(MEMBERS TO AGE 21)

PROVIDER GUIDE

An Independent Licensee of the Blue Cross and Blue Shield Association

HEDIS® / STAR PROVIDER GUIDE – HEDIS 2019 – Members to Age 21 Version

HEDIS® (**H**ealthcare **E**ffectiveness **D**ata and **I**nformation **S**et) is a performance measurement tool developed by the National Committee for Quality Assurance (NCQA) to assess the quality of healthcare and improve patient health and outcomes, and is an important factor in our accreditation.

Selected HEDIS® measures are also part of the Star Rating System managed by the federal Centers for Medicare & Medicaid Services (CMS), which evaluates health care plans based on a 5-Star rating system.

HEDIS® quality measures consist of the following categories:

- Effectiveness of Care
- Accessibility and Availability of Care
- Experience of Care
- Utilization (Use of Services)

Adherence to these guidelines:

- Ensures health plans are offering quality preventive care and services.
- Provides a comparison to other plans.
- Identifies opportunities for quality improvement.
- Measures the plan's progress from year to year.

HEDIS® data collection is permitted under HIPAA and is performed three ways:

- Administrative: Pertaining to diagnosis codes (in our claims database) and medication fills, based on the NCQA Vol. 2 Technical Specifications & Value Sets updated annually.
- Hybrid: A combination of the above and medical chart reviews in offices.
- Survey: Member and provider surveys.

Included within for your convenience are selected HEDIS®/Star measures and their description and requirements. ***Star measures are designated with a star symbol*** (☆).

If you would like the complete list of diagnosis codes or medication lists for any measure, or have questions, please call (386) 676-7100 Ext. 7258, or email QualityManagement@fhcp.com.

We hope you find this guide useful in your daily practice.

Sincerely,
FHCP Quality Management

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General

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Mental/Behavioral Health

Appendix

Measure	Comments	More Tips
AAB **Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis** Age **18 to 64** who were diagnosed with **acute bronchitis**, should not be dispensed an antibiotic prescription. Explain to your patients that viruses are not treated with antibiotics. Promote symptom control instead. If you prescribe an antibiotic, please use an alternate code other than Acute Bronchitis, such as the examples listed in Column 3.	Do **not** use the following acute bronchitis diagnoses with an antibiotic: • **J20.3** Acute bronchitis due to coxsackievirus • **J20.4** Acute bronchitis due to parainfluenza virus • **J20.5** Acute bronchitis due to respiratory syncytial virus • **J20.6** Acute bronchitis due to rhinovirus • **J20.7** Acute bronchitis due to echovirus • **J20.8** Acute bronchitis due to other specified organisms • **J20.9** Acute bronchitis, unspecified Antibiotics filled on day of visit or within 3 days from visit, count in the measure.	**Alternate Codes:** The following codes are acceptable with an antibiotic per the measure (not a complete list): • **J40:** Bronchitis, not specified as acute or chronic • **J01.90:** Acute sinusitis, unspec. • **J03.90:** Acute tonsillitis, unspec. Ok to give antibiotic with acute bronchitis if these **co-morbid conditions** are also coded at the visit (or up to year prior): • Cancer • COPD • Cystic fibrosis • HIV • Pulmonary edema • Respiratory failure • TB
AAP **Adult Access to Preventive / Ambulatory Health Services** Every patient age 20 years and older should be seen once yearly.	Compliance is met by: **Medicare** members - a visit during the measurement year. **Commercial** members - a visit during the measurement year, or the two years prior to the measurement year.	Encourage patient to come in for a checkup as required.

Measure	Comments	More Tips
ABA ★ **Adult BMI Assessment** Age 18 to 74 had body mass index (BMI) documented in the measurement year, or the year prior.	Perform and document HT/WT/BMI calculation at **any** visit (does not have to be well visit). For members younger than 20 at **any** visit, include BMI *percentile*.	Pregnant members in the current year or prior year are excluded. Ensure vital signs are captured.
ADD **Follow-Up Care for Children Prescribed ADHD Medication** Children age 6 to 12 with newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication should have: • At least 3 follow-up care visits within a 10-month period. • ***One of the visits should be within 30 days*** of when the first ADHD medication was dispensed.	Two rates are tracked: Initiation Phase: • 1 follow-up visit during the 30-day initiation phase. Continuation & Maintenance (C&M) Phase: • Remained on the medication for at least 210 days; and • In addition to the visit in the Initiation Phase, had at least 2 follow-up visits within 270 days (9 months) after the Initiation Phase ended. • Telehealth is eligible for one visit for the C&M Phase.	Members with narcolepsy are excluded.
ADH-MED-CHOL ★ **Medication Adherence for Cholesterol (Statins)** Age 18 and older with a prescription for a cholesterol medication (statin) fill their prescription often enough to cover 80% of the time they are supposed to be taking the medication.	One of the most important ways members with high cholesterol can manage their health is by taking cholesterol medication as directed.	Prescribe 90-day supply of statins.

Measure	Comments	More Tips
ADH-MED-DM ☆ **Medication Adherence for Diabetes Medications** Age 18 and older with a prescription for a diabetes medication fill their prescription often enough to cover 80% of the time they are supposed to be taking the medication.	One of the most important ways members with diabetes can manage their health is by taking diabetes medication as directed.	If a member fills a prescription at a non-FHCP pharmacy, **please document where filled**. Plan members who take insulin are not included.
ADH-MED-HTN ☆ **Medication Adherence for Hypertension (RAS antagonists)** Age 18 and older with a prescription for a blood pressure medication (ACE, ARB, or direct renin inhibitor) fill their prescription often enough to cover 80% of the time they are supposed to be taking the medication.	One of the most important ways members with high blood pressure can manage their health is by taking blood pressure medication as directed.	Blood pressure medication in this measure refers to an ACE (angiotensin converting enzyme) inhibitor, an ARB (angiotensin receptor blocker), or a direct renin inhibitor drug.
AMM **Antidepressant Medication Management** Members 18 and older with a diagnosis of major depression should be prescribed an anti-depressant medication, and should remain on the medication for treatment.	Two rates are tracked for remaining on the anti-depressant medication: Effective Acute Phase Treatment: • At least 84 days (12 weeks). Effective Continuation Phase Treatment: • At least 180 days (6 months).	Applies to a diagnosis of major depression. Please consider using PHQ-9. If a patient has a PHQ-9 score of 5 or greater, this qualifies for a diagnosis of major depression. The anti-depressant medication must be filled to count for the quality measure.

Measure	Comments	More Tips
AMR **Asthma Medication Ratio** For age 5 to 64 with persistent asthma, the ratio of controller medications to total asthma medications is 0.50 or greater during the measurement year.	Adjust dosage so the patient is well-controlled without frequent use of rescue medication.	Examines whether or not controller medication prescriptions exceeded reliever (rescue) medication prescriptions. Members are excluded from the measure if they have COPD; chronic respiratory conditions due to chemicals, gases, fumes, vapors; cystic fibrosis; acute respiratory failure; or are in hospice.
APC **Use of Multiple Concurrent Antipsychotics in Children and Adolescents** The percentage of children and adolescents (age 1 to 17) who were on two or more concurrent antipsychotic medications.	A lower rate indicates better performance.	Applies to members who are on 2 or more concurrent antipsychotic medications for at least 90 consecutive days during the measurement year.
APM **Metabolic Monitoring for Children and Adolescents on Antipsychotics** Age 1–17 who had two or more antipsychotic prescriptions should have metabolic testing.	Should have both of the following during the year: • At least one test for blood glucose or HbA1c • At least one test for LDL-C or cholesterol	Includes First and Second Generation Antipsychotics, and Combinations.
APP **Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics** Age 1–17 that had a new prescription for an antipsychotic medication should have documentation of psychosocial care as first-line treatment.	Exclude members for whom first-line antipsychotic medications may be clinically appropriate, such as those diagnosed with schizophrenia, schizoaffective disorder, bipolar disorder, other psychotic disorder, autism, or other developmental disorder, from at least 1 acute inpatient encounter, or at least 2 visits in an outpatient or partial hospitalization setting in the measurement year.	Includes First and Second Generation Antipsychotics, and Combinations

Measure	Comments	More Tips
ART ☆ **Disease-Modifying Anti-Rheumatic Drug (DMARD) Therapy for Rheumatoid Arthritis** Members 18 and older diagnosed with Rheumatoid Arthritis (RA) should fill at least one prescription for a DMARD during the same year.	RA codes are M05.0 – M06.9: **DMARD recommended**. **Please verify patient actually has RA before assigning an RA diagnosis code.** Members with RA who have HIV or who are pregnant do not require a DMARD per the quality measure.	Below are related codes which do **NOT** require a DMARD. **Please consider if one of these alternate diagnoses are appropriate instead of RA if no DMARD is prescribed**: • **M06.4**: Inflammatory polyarthropathy (inflammatory arthritis of multiple joints) • **M13.0:** Polyarthritis, unspecified • **Z87.39:** Personal history of other diseases of the musculoskeletal system & connective tissue
AWC **Adolescent Well-Care Visits** Age 12 to 21 should have at least one comprehensive well-care visit with a Primary Care Physician (PCP) or an OB/GYN practitioner during the measurement year. The practitioner does not have to be assigned to the member.	Documentation must include: • Health history • Physical developmental history • Mental developmental history • Physical exam • Health education / anticipatory guidance. May be done during a sick visit **or** well child exam. Services that are specific to the assessment or treatment of an acute or chronic condition do not count toward the measure.	Recommended codes to identify AWC through claims: **ICD-10 Codes**: • Z00.00-Z00.01, Z00.121-Z00.129, Z00.5, Z00.8, Z02.0-Z02.9 **CPT Codes**: • 99381-99385, 99391-99395, 99461

Measure	Comments	More Tips
CAHPS ★ **Flu Vaccination** **Flu Vaccinations Age 18-64 (FVU)** **Flu Vaccinations Age 65 & Older (FVO)**	**CAHPS** is **Consumer Assessment of Healthcare Providers and Systems.** Patients are asked in a survey whether they received their annual flu vaccine. Encourage your patients to receive their annual flu vaccine.	Age 18–64 are asked if they received an influenza vaccination between July 1 and the date when the CAHPS survey is completed. Age 65 & older are asked if they received an influenza vaccination between July 1 and the date when the CAHPS survey is completed.
CAP **Children & Adolescents' Access to Primary Care Practitioners** Children 12 months to 6 years should have a PCP visit during the measurement year. Children and adolescents ages 7 to 19 should have a PCP visit during the measurement year, or year prior to the measurement year.	Complete physical exam, including but not limited to: height, weight, BMI, vital signs, history & physical, review of systems, age-appropriate screening tests, immunizations administered, all specific topics for which anticipatory guidance was given, etc.	Includes members who had an ambulatory or preventive care visit to ***any*** PCP. Excludes specialist visits.

Measure	Comments	More Tips
CBP ★ **Controlling High Blood Pressure** Age 18 to 85 with a diagnosis of hypertension (HTN) should have adequately controlled blood pressure (BP) during the measurement year. **Control** is based upon: • Ages 18 to 85 have BP controlled at less than 140/90. If elevation persists, **retake BP** and document in the chart. Treat as necessary. Chart all measurements, and efforts to obtain BP control. **Control within the measurement year should be documented in the EHR if attained.**	Blood pressure should be routinely assessed as part of a physical exam at each outpatient visit. **The measure uses**: • The most recently documented BP at an outpatient visit; a nonacute inpatient encounter; or remote monitoring event if taken by an electronic device and digitally stored and transmitted to and interpreted by the provider. • The BP reading to be used must occur **on or after the second diagnosis of HTN.** **Do not use**: • BP readings from an acute inpatient stay or ED visit. • BP readings taken same day as a diagnostic test or therapeutic procedure requiring a change of diet or medication on or one day before (other than fasting blood tests). • BP reading taken or reported by the member.	If a member demonstrates a high blood pressure, ***a second blood pressure should always be taken at the same visit and documented in the chart.*** Schedule follow-up visit (can be a nurse visit). **ICD-10 Codes**: I10 **BP CPT II Codes** : Systolic BP < 140: 3074F, 3075F Diastolic <90 3078F, 30709F **Hypertension CPT II Codes**: 3077F, 3074F, 3075F Excluded members: End-Stage Renal Disease, kidney transplant, hospice, or pregnancy during the measurement year.

Measure	Comments	More Tips
CCS **Cervical Cancer Screening** Age 21 to 64 should be screened for cervical cancer using ***either*** of the following: • Age 21–64 have cervical cytology (Pap smear) performed every 3 years. • Age 30–64 have cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years.	Member does not need this screening if they had a complete, total, or radical hysterectomy (acquired absence of cervix), or a diagnosis of cervical agenesis. Documenting a hysterectomy alone does not exclude member; **the removal of cervix must also be documented.** The examples below can be taken from an office note: • Documentation of "complete," "total" or "radical" abdominal or vaginal hysterectomy. • Documentation of a "vaginal Pap smear" in conjunction with documentation of "hysterectomy." • Documentation of hysterectomy in combination with documentation that the patient no longer needs Pap testing/cervical cancer screening. Please document in chart and/or notify Quality Management if total hysterectomy was outside of FHCP and where occurred.	**Cervical Cytology** **CPT Codes:** 88141-88143, 88147, 88148, 88150-88154, 88164-88167, 88174, 88175 **HPV** **CPT Codes:** 87620-87622, 87624, 87625 **Total Hysterectomy Code:** 58150 **ICD-10 (Absence of Cervix):** Q51.5, Z90.710, Z90.712 Cervical cancer screening results (Pap smear alone or Pap smear/HPV co-testing) must be in the EHR; a date alone is not compliant. For co-testing, the Pap smear and HPV test must be from the same date of service.

Measure	Comments	More Tips
CDC **Comprehensive Diabetes Care** Age 18 to 75 with diabetes (type 1 and type 2) are monitored for the following annually: 1. HbA1c testing 2. HbA1c poor control (>9.0%) ★ 3. HbA1c control (<8.0%) 4. HbA1c control (<7.0% selected population) 5. Eye Exam - one of the following: ★ a. Retinal or dilated eye exam by optometrist or ophthalmologist in the measurement year. b. A negative retinal or dilated eye exam (negative for retinopathy) in the year prior to the measurement year. c. Bilateral eye enucleation anytime during the member's history through December 31 of the measurement year. 6. Medical attention for nephropathy ★ 7. BP control (<140/90 most recent measurement)	Any member with gestational diabetes or steroid-induced diabetes is not counted in the measure. Members with the following are not included in the **HbA1c control <7.0%** portion of the measure: • 65 or older, CABG, PCI, ischemic vascular disease (IVD), thoracic aortic aneurysm, CHF or cardio-myopathy, prior MI, ESRD, chronic kidney disease-stage 4, dementia, blindness, or amputation of lower extremity. Any of the following count as compliant with **medical attention for nephropathy**: • Urine test • ACE/ARB therapy • A visit with a nephrologist. • Evidence of stage 4 chronic kidney disease • Evidence of ESRD • Evidence of kidney transplant.	If a member is in the CDC measure inappropriately, please notify Quality Management. Hospital claims with a diabetes diagnosis are occasionally received (if glucose is elevated), and these claims can be corrected if the member does not have diabetes. Please document in chart and/or notify Quality Management if **any** of these tests occurred outside of FHCP, and where occurred. For diabetic retinal exams, the results must be in the EHR.
CHL **Chlamydia Screening In Women** Sexually active females age 16 to 24 should be screened for chlamydia at least once a year.	Chlamydia screening can be a urine test.	**CPT Codes**: 87110, 87270, 87320, 87490-87492, 87810

Measure	Comments	More Tips
CIS **Childhood Immunization Status** By their 2nd birthday, children should receive all of the following: • Four: Diphtheria, tetanus, and acellular pertussis (DTaP) • Three: Polio (IPV) • One: Measles, mumps, and rubella (MMR) • Three: Haemophilus influenza type B (HiB) • Three: Hepatitis B (HepB) • One: Chicken pox (VZV) • Four: Pneumococcal conjugate (PCV) • One: Hepatitis A (HepA) • Two or Three: Rotavirus (RV) • Two: Influenza (flu) Immunizations must be completed **before** member turns age 2.	Educate office staff to schedule appointments **PRIOR** to 2nd birthday. Document in medical record if member has evidence of the disease for which immunization is intended, or contraindication due to anaphylactic reaction. For MMR, HepB VZV and HepA, count any of the following: • 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, count only: • Evidence of the antigen or combination vaccine. For combination vaccinations that require more than one antigen (i.e., DTaP and MMR), the organization must find evidence of *all* the antigens.	**DTaP Procedure Codes:** 90698, 90700, 90721, 90723 **IPV Procedure Codes:** 90698, 90713, 90723 **HiB Procedure Codes:** 90645-90648, 90698, 90721, 90748 **HepB Procedure Codes:** 90723, 90740, 90744, 90747, 90748 **Diagnosis Code:** B16.0-B16.9, B17.0, B18.0, B18.1, B19.10, B19.11, Z22.5 **Pneumococcal Procedure Codes:** 90669, 90670 **MMR Procedure Codes:** 90707, 90710 **Measles Procedure Code:** 90705 **Diagnosis Code:** B05.0-B05.4, B05.81-B05.9 **Measles/Rubella Procedure Code:** 90708 **Mumps Procedure Code:** 90704 **Diagnosis Code:** B26.0-B26.3, B26.81-B26.9 **Rubella Procedure Code:** 90706 **Diagnosis Code:** B06.00-B06.09, B06.81-B06.9 **VZV Procedure Code:** 90710, 90716 **Diagnosis Code:** B01.0, B01.11-B01.2, B01.81-B01.9, B02.0, B02.1, B02.21-B02.29, B02.30-B02.39, B02.7-B02.9 **Rotavirus 2 dose Procedure Code:** 90681 **Rotavirus 3 dose Procedure Code:** 90680 **HepA Procedure Code:** 90633 **Diagnosis Code:** B15.0, B15.9 **Flu Procedure Code:** 90655, 90657, 90661, 90662, 90673, 90685, 90687, 90688

Measure	Comments	More Tips
CWP **Appropriate Testing for Children with Pharyngitis** **Age 3 to 18** If diagnosed with pharyngitis **and** dispensed an antibiotic, member should receive a **Group A streptococcus (strep) test** for the episode.	A higher rate is better performance (i.e., appropriate strep test when an antibiotic is given for pharyngitis). **Group A Strep Tests:** **CPT Codes**: 87070, 87071, 87081, 87430, 87650, 87651, 87652, 87880 **For a diagnosis of pharyngitis (see Column 3), be sure the Group A strep test is coded for the same visit.**	**Pharyngitis ICD-10 Codes**: • **J02.0** Streptococcal pharyngitis • **J02.8** Acute pharyngitis due to other specified organisms • **J02.9** Acute pharyngitis, unspecified • **J03.00** Acute streptococcal tonsillitis, unspecified • **J03.01** Acute recurrent streptococcal tonsillitis • **J03.80** Acute tonsillitis due to other specified organisms • **J03.81** Acute recurrent tonsillitis due to other specified organisms • **J03.90** Acute tonsillitis, unspecified • **J03.91** Acute recurrent tonsillitis, unspecified
FUH **Follow-Up After Hospitalization for Mental Illness** Age 6 and older who are hospitalized for treatment of selected mental illness or intentional self-harm diagnoses should have a follow-up visit with a ***mental health practitioner***.	Two rates are reported: • Member received follow-up within 30 days after discharge. • Member received follow-up within 7 days after discharge.	A follow-up visit with a mental health practitioner no longer includes visits that occur on the date of discharge. Telehealth counts as a visit.

Measure	Comments	More Tips
FUM **Follow-Up After Emergency Department Visit for Mental Illness** Age 6 and older with an emergency department (ED) visit with a principal diagnosis of mental illness or intentional self-harm, should have a follow-up visit for mental illness.	Two rates are reported: • Member received follow-up within 30 days of the ED visit. • Member received follow-up within 7 days of the ED visit. If a member has more than 1 ED visit in a 31-day period, include only the first ED visit.	Exclude ED visits that result in an inpatient stay, and ED visits followed by admission to an acute or nonacute inpatient care setting on the date of the ED visit or within the 30 days after the ED visit, regardless of principal diagnosis for the admission. The above events are excluded because admission to an acute or nonacute inpatient setting may prevent an outpatient follow-up visit.
IET **Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment** Age 13 and older with a new episode of alcohol or other drug (AOD) abuse or dependence should receive the following: • **Initiation of AOD Treatment** via an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth or medication treatment within 14 days of the diagnosis. • **Engagement of AOD Treatment**. Members who initiated treatment should have 2 or more additional AOD services or within 34 days of the initiation visit.	Medication Treatment for Alcohol Abuse or Dependence Medications: • Aldehyde dehydrogenase inhibitor: Disulfiram (oral) • Antagonist: Naltrexone (oral and injectable) • Other: Acamprosate (oral; delayed-release tablet) Medication Treatment for Opioid or Dependence Medications: • Antagonist: Naltrexone (oral and injectable) • Partial Agonist: Buprenorphine (sublingual tablet and implant); Buprenorphine/naloxone (sublingual tablet, buccal film, sublingual film)	The measure counts the earliest date of service for an eligible encounter during the Intake Period with a diagnosis of AOD abuse or dependence. For an outpatient, intensive outpatient, partial hospitalization, observation, telehealth, detoxification or ED visit (not resulting in an inpatient stay), the measure counts the date of service. For an inpatient stay, the measure counts the date of discharge. For ED and observation visits that result in an inpatient stay, the measure counts the date of the inpatient discharge (an AOD diagnosis is not required for the inpatient stay; use the diagnosis from the ED or observation visit).

Measure	Comments	More Tips
IMA **Immunizations for Adolescents** Age 13 years of age should have: • One dose of meningococcal conjugate vaccine • One tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine and • Two doses of the human papillomavirus (HPV) vaccine. Must be completed **by the 13th birthday.**	Educate staff to schedule **PRIOR** to 13th birthday. Document and submit timely with correct code. Offer HPV Vaccine to members age 9 to age 13. Two doses should be completed prior to age 13. For meningococcal, Tdap and HPV count *only* evidence of the antigen or combination vaccine.	**Tdap Procedure Code**: 90715 **Meningococcal Procedure Code**: 90734 **HPV Procedure Codes**: 90649, 90650, 90651
LBP **Use of Imaging Studies for Low Back Pain** Age 18-50 with a primary diagnosis of **uncomplicated** low back pain should not have an imaging study (plain x-ray, MRI, or CT scan) ordered for the low back pain **within 28 days of the diagnosis**. There are exclusions where imaging may be clinically appropriate within the first 28 days.	**Exclusions** – Imaging acceptable within 28 days of a primary low back pain diagnosis: **Cancer, or major organ transplant** any time during the member's history through 28 days after the low back pain diagnosis. **Recent trauma (fractures, dislocations, lacerations, internal injuries, etc.).** Trauma any time during the 3 months prior to the low back pain diagnosis through 28 days after. **Intravenous drug abuse, neurologic impairment (cauda equina syndrome), spinal infection, or HIV** any time during the 12 months prior to the low back pain diagnosis through 28 days after. **Prolonged use of corticosteroids.** 90 consecutive days of corticosteroid treatment any time during the 12 months prior the low back pain diagnosis. **A low back pain diagnosis within the last 6 months.** Imaging within 28 days of the current low back pain diagnosis is acceptable if there is a previous low back pain diagnosis within the past 6 months.	Exclusion diagnoses (such as a fracture) must be submitted in a **claim** to count. For example, cannot be a phone call to member with the results. **Alternate codes:** Consider if any of these apply as the **primary** diagnosis, and imaging within 28 days is acceptable (not a complete list): • Discitis, unspecified, lumbar region (M46.46) • Discitis, unspecified, lumbosacral region (M46.47) • Discitis, unspecified, sacral and sacrococcygeal region (M46.48) • Other specified inflammatory spondylopathies, lumbar region (M46.86) • Unspecified thoracic, thoracolumbar and lumbosacral intervertebral disc disorder; herniated intervertebral disc (M51.9) • Muscle spasm of back (M62.830) • Contusion of lower back (S30.0XXA) • Unspecified superficial injury of lower back (S30.91XA)

Measure	Comments	More Tips
MMA **Medication Management for People with Asthma** Age 5 to 64 with persistent asthma should be prescribed controller medications, and use them consistently.	While the measure tracks 75%, our goal is that members remain on the controller for 100% of their treatment period. The treatment period begins with the earliest prescription for a controller filled by the member during the measurement year, through the end of that year.	Consistent use is the key, and will assist in decreasing the use of rescue medications. Advise your patients to refill their controller prescription ***immediately***, and do **not** skip days. Consider a 90-day supply of the controller med. Generic Air Duo (same ingredients as Advair) generally costs under $10 a month.
MPM **Annual Monitoring for Patients on Persistent Medications** Age 18 and older with 180 or more treatment days on one of the following medications received at least one therapeutic monitoring event during the measurement year: • Angiotensin converting enzyme (ACE) inhibitors, or angiotensin receptor blockers (ARB) • Digoxin • Diuretics	**Annual Monitoring for ACE Inhibitors or ARBs**: At least one serum potassium test ***and*** a serum creatinine therapeutic monitoring test in the measurement year. Either meet criteria: • A lab panel test • A serum potassium test ***and*** a serum creatinine test. **Annual Monitoring for Digoxin**: At least one serum potassium test, at least one serum creatinine, ***and*** at least one serum digoxin therapeutic monitoring test in the measurement year. Either meet criteria: • A lab panel test ***and*** a serum digoxin test. • A serum potassium test ***and*** a serum creatinine test ***and*** a serum digoxin test.	**Annual Monitoring for Diuretics**: At least one serum potassium test ***and*** a serum creatinine therapeutic monitoring test in the measurement year. Any of the following during the measurement year meet criteria: • A lab panel test. • A serum potassium test ***and*** a serum creatinine test. **Note:** The tests do not need to occur on the same service date, only within the measurement year.
NCS **Non-Recommended Cervical Cancer Screening in Females** Age 16 to 20 should not be unnecessarily screened for cervical cancer.	Cervical cytology or HPV testing should **not** be performed on females age 16 to 20, unless they have a history of cervical cancer, HIV, or immunodeficiency.	The USPSTF found that screening in the younger age group may lead to more harm than benefit because abnormal test results are likely to be transient and to resolve on their own. Resulting treatment may have an adverse effect on future child-bearing.

Measure	Comments	More Tips
PBH **Persistence of Beta Blocker Treatment after a Heart Attack** Age 18 and older hospitalized and discharged with a diagnosis of Acute Myocardial Infarction (AMI) should receive **persistent** beta-blocker treatment for **6 months** after discharge.	Please be sure these patients have a beta-blocker prescription (if not contraindicated), and that they are refilling it **consistently** and **on-time**. Consider a 90-day supply of the beta-blocker.	Excluded from the measure are those with: Asthma, COPD, chronic respiratory conditions due to chemicals/gases/ fumes/vapors, hypotension, heart block >1 degree, or sinus bradycardia. Also excluded are patients with an intolerance or allergy to beta-blocker therapy.
PCR ☆ **Plan All-Cause Readmissions** For age 18 and older, the number of acute inpatient stays during the year, that were followed by an unplanned acute readmission for any diagnosis within 30 days, and the predicted probability of an acute readmission. The following are reported: • Count of Index Hospital Stays • Count of Observed 30-Day Readmissions • Count of Expected 30-Day Readmissions	Discharge from the hospital is a critical transition point in a patient's care. Hospital readmission is associated with longer lengths of stay and higher mortality for patients. Hospital readmissions are commonly related to CHF, Acute MI, COPD, and pneumonia. The measure includes acute discharges from any type of facility (including behavioral healthcare facilities).	Members excluded from the measure: • Hospice • Pregnancy • A principal diagnosis of a condition originating in the perinatal period • Member died during hospital stay

Measure	Comments	More Tips
PPC **Prenatal & Postpartum Care** For members with live births: • Timeliness of Prenatal Care: Members should receive a prenatal care visit in the first trimester, ***or*** within 42 days of enrollment in the health care plan. • Postpartum Care: Members should have a postpartum visit on or between 21 and 56 days after delivery.	**Prenatal**: Educate staff to schedule first appointment with the OB/GYN, other prenatal care practitioner, or PCP in the first trimester. For visits to a PCP, a diagnosis of pregnancy must be present. RN visits for education do not count in HEDIS®. The member must see a prescribing provider. Documentation in the medical record of gestational age with either prenatal risk assessment and counseling/education, or complete obstetrical history meets criteria for the Timeliness of Prenatal Care. **Postpartum:** Encourage attendance for the postpartum visit. The member must return for the full postpartum checkup on or between 21 and 56 days after delivery. The visit should include a pelvic exam or other postpartum care. A C-section incision check is not a postpartum visit.	**Prenatal**: Prenatal care visit to an OB/GYN or other prenatal care practitioner, or Primary Care Physician (PCP). For visits to a PCP, a diagnosis of pregnancy must be present. **Postpartum**: Postpartum visit for a pelvic exam or postpartum care meets the requirement. **Prenatal CPT Codes :** 99201-99205, 99211-99215, 99241-99245, 99500, 0500F, 0501F, 0502F **Stand Alone Prenatal Visits:** 99500, 0500F, 0501F, 0502F **Bundled Prenatal Service Codes:** 59400, 59425, 59426, 59510, 59610, 59618 **UB Rev Code:** 0514 **Postpartum Bundled Services:** 59400, 59410, 59510, 59515, 59610, 59614, 59618, 59622 **Procedure Codes:** 57170, 58300, 59430, 99501, 0503F **Diagnosis Codes:** Z01.411-Z01.42, Z30.430, Z39.1, Z39.2

Measure	Comments	More Tips
SPC **Statin Therapy for Patients with Cardiovascular Disease** Males age 21 to 75, and females age 40 to 75 who were identified with clinical atherosclerotic cardiovascular disease (ASCVD), should meet the following criteria: • **Received Statin Therapy:** Dispensed at least one high or moderate-intensity statin medication during the measurement year. • **Statin Adherence 80%:** Remained on a high or moderate-intensity statin medication for at least 80% of the treatment period.	The treatment period is the earliest prescription dispensing date for any high or moderate-intensity statin medication, through the last day of the year. **See Appendix 1 for:** • **High Intensity Statins** • **Moderate Intensity Statins** Members in the measure **include** those with MI, CABG, PCI, other revascularization, or a diagnosis of ischemic vascular disease (IVD) with treatment during the year or year prior.	Members are not included in this measure if they have the following: • End Stage Renal Disease (ESRD), cirrhosis, pregnancy, in vitro fertilization, or a prescription for clomiphene during the measurement year or year prior. • Myalgia, myositis, myopathy, or rhabdomyolysis during the measurement year. If not compliant due to myalgia, please document diagnosis in record.

Measure	Comments	More Tips
TRC **Transitions of Care** The percentage of discharges for members 18 years of age and older who had each of the following during the measurement year (see second column). (Applies to discharges for acute and non-acute inpatient stays. Members in Hospice excluded).	➢ **Notification of Inpatient Admission:** The PCP or ongoing care provider receives notification of inpatient admission on the day of admission or day after. ➢ **Receipt of Discharge Information**: Discharge summary is received by FHCP on the day of discharge, or day after. ➢ **Patient Engagement After Inpatient Discharge**: An outpatient office visit, telephone call, telehealth encounter or transitional care management (i.e. home or assisted living visit) occurs within 30 days after discharge. (May not include date of discharge). ➢ **Medication Reconciliation Post-Discharge**: Medication reconciliation is done on the date of discharge through 30 days after discharge.	**Notification of inpatient admission** may not be from a family member. **Discharge summary** must include: • Doctor responsible during inpatient stay • Procedures or treatment • Diagnoses at discharge • Current medication list • Allergies • Test results, pending tests, or no tests pending • Instructions for patient care **Patient engagement** may be any type of provider. **Medication reconciliation** post-discharge conducted by a practitioner, clinical pharmacist, or RN. An outpatient visit is not required, but there must be documentation in the outpatient chart.
UOD **Use of Opioids at High Dosage** For members 18 and older: The proportion of members 18 years and older, receiving prescription opioids for ≥15 days during the measurement year at a high dosage (average milligram morphine dose [MME] >120 mg). Note: **A lower rate indicates better performance.** The proportion will be calculated and displayed as a permillage (multiplied by 1,000) instead of a percentage in reports.	Includes members with at least two or more opioid dispensing events on different dates. Excludes members with at least one of the following during the measurement year: • Hospice • Cancer • Sickle Cell disease **See Appendix 2 for:** • **Opioid Medication List**	**See Appendix 3 for:** • **Opioid Morphine Milligram Equivalent Conversion Factors.** MME - Milligram morphine equivalent: The dose of oral morphine that is the analgesic equivalent of a given dose of another opioid analgesic. Table UOD-A in Appendix 3 provides conversion factors to determine the MMEs for the opioids included in the measure. See measure specifications for more details.

Measure	Comments	More Tips
UOP **Use of Opioids From Multiple Providers** For members 18 and older: The proportion of members 18 years and older, receiving prescription opioids for ≥15 days during the measurement year who received opioids from multiple providers. Three rates are reported (see second column). The proportion will be calculated and displayed as a permillage (multiplied by 1,000) instead of a percentage in reports.	Three rates are reported: • **Multiple Prescribers:** Receiving prescriptions for opioids from four or more different prescribers during the measurement year. • **Multiple Pharmacies:** Receiving prescriptions for opioids from four or more different pharmacies during the measurement year. • **Multiple Prescribers and Multiple Pharmacies:** Receiving prescriptions for opioids from four or more different prescribers ***and*** four or more different pharmacies during the measurement year.	**See Appendix 2 for:** • **Opioid Medication List** A lower rate indicates better performance for all three rates. Members in Hospice are excluded.
URI **Appropriate Treatment for Children with Upper Respiratory Infection** Age **3 months to 18 years of age** with a diagnosis of upper respiratory infection (URI) should ***not*** be dispensed an antibiotic prescription. URI as a stand-alone diagnosis should be treated symptomatically, and not with an antibiotic.	Member should ***not*** receive an antibiotic with the following upper respiratory infection diagnosis codes: **URI codes** • **J00** Acute nasopharyngitis (common cold) • **J06.0** Acute laryngopharyngitis • **J06.9** Acute upper respiratory infection, unspecified	**Alternate diagnoses** for which an antibiotic ***is*** appropriate (not a complete list): • Sinusitis • Otitis media • Certain ear disorders • Pharyngitis (remember to do strep test per CWP measure) • Whooping cough • Tonsillitis • Tracheitis • Laryngotracheitis • Epiglottitis • Pneumonia

Measure	Comments	More Tips
WCC **Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents** Age 3 to 17 should have an outpatient visit with a PCP or OB/GYN annually. The visit should include: • **BMI Percentile documentation** • **Counseling for Nutrition** • **Counseling for Physical Activity** Service may be rendered at other than a well-child visit, but notation/services specific to an acute or chronic condition may not count toward Counseling for Nutrition or Physical Activity. For example, noting a member with diarrhea is following the BRAT diet would not count.	**BMI Percentile:** Must include height, weight, and a distinct BMI percentile, from the same data source. BMI percentile can be a value (e.g., 85th percentile), or plotted on an age-growth chart. **Counseling for Nutrition:** Must include a note with date and at least one of the following: (1) Discussion of current nutrition behaviors (eating habits, dieting behaviors, etc.) (2) Checklist that nutrition was addressed (3) Counseling or referral for nutrition education (4) Received nutrition educational materials in a face-to-face visit (5) Anticipatory guidance for nutrition or (6) Weight or obesity counseling. Documentation related to a member's "appetite" does not meet criteria for Counseling for Nutrition. Services rendered for obesity or eating disorders may be used for both Nutrition & Physical Activity.	**Counseling for Physical Activity:** Must include a note with date and at least one of the following: (1) Discussion of current physical activity behaviors (exercise routine, participation in sport, exam for sport participation etc.) (2) Checklist indicating physical activity was addressed (3) Counseling or referral for physical activity (4) Received physical activity education materials in face-to-face visit (5) Anticipatory guidance specific to child's physical activity; or (6) Weight or obesity counseling. **BMI**: **ICD-10**: Z68.51-Z68.54 **Nutrition**: **ICD-10**: Z71.3 **Physical Activity**: **ICD-10**: Z02.5, Z71.82
W15 **Well-Child Visits in the First 15 Months of Life** Children should have 6 or more well-child visits by the age of 15 months. Well-child visits are recommended at the following ages: 1 month, 2 months, 4 months, 6 months, 9 months, 12 months, and 15 months.	Documentation **must** include: • Health history • Physical developmental history • Mental developmental history • Physical exam • Health education / anticipatory guidance. May be done during a sick visit **or** well child exam. Services that are specific to the assessment or treatment of an acute or chronic condition do not count toward the measure.	**Diagnosis Codes:** Z00.110-Z00.129, Z00.5, Z00.8, Z02.1-Z02.9 **Procedure Codes:** 99381-99385, 99391-99395, 99461 Do not include services rendered during an ED or inpatient visit.

Measure	Comments	More Tips
W34 **Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life** Age 3-6 years of age should have at least one well-child visit with a PCP during the measurement year.	Documentation **must** include: • Health history • Physical developmental history • Mental developmental history • Physical exam • Health education/ anticipatory guidance. May be done during a sick visit **or** well child exam. Services that are specific to the assessment or treatment of an acute or chronic condition do not count toward the measure.	**Diagnosis Codes:** Z00.110 -Z00.129, Z00.5, Z00.8, Z02.1-Z02.9 **Procedure Codes:** 99381-99385, 99391-99395, 99461 Do not include services rendered during an ED or inpatient visit.

APPENDIX 1: Statin Medications

Description	Prescription	
High-intensity statin therapy	Atorvastatin 40–80 mg Amlodipine-atorvastatin 40–80 mg Ezetimibe-atorvastatin 40–80 mg	Rosuvastatin 20–40 mg Simvastatin 80 mg Ezetimibe-simvastatin 80 mg
Moderate-intensity statin therapy	Atorvastatin 10–20 mg Amlodipine-atorvastatin 10–20 mg Ezetimibe-atorvastatin 10–20 mg Rosuvastatin 5–10 mg Simvastatin 20–40 mg Ezetimibe-simvastatin 20–40 mg Niacin-simvastatin 20–40 mg	Sitagliptin-simvastatin 20–40 mg Pravastatin 40–80 mg Lovastatin 40 mg Niacin-lovastatin 40 mg Fluvastatin XL 80 mg Fluvastatin 40 mg bid Pitavastatin 2–4 mg
Low-intensity statin therapy	Simvastatin 10 mg Ezetimibe-simvastatin 10 mg Sitagliptin-simvastatin 10 mg Pravastatin 10–20 mg	Lovastatin 20 mg Niacin-lovastatin 20 mg Fluvastatin 20–40 mg Pitavastatin 1 mg

APPENDIX 2: UOD Opioid Medications

Opioid Medications			
• Butorphanol	• Hydrocodone	• Methadone	• Oxymorphone
• Codeine	• Hydromorphone	• Morphine	• Pentazocine
• Dihydrocodeine	• Levorphanol	• Opium	• Tapentadol
• Fentanyl	• Meperidine	• Oxycodone	• Tramadol

APPENDIX 3: Table UOD-A: Opioid Morphine Milligram Equivalent Conversion Factors[1]

Type of Opioid	Milligram Morphine Equivalent (MME) Conversion Factor
Butorphanol	7
Codeine	0.15
Dihydrocodeine	0.25
Fentanyl buccal, SL tablets or lozenge/ troche (mcg)[3]	0.13
Fentanyl film or oral spray (mcg)[4]	0.18
Fentanyl nasal spray (mcg)[5]	0.16
Fentanyl transdermal patch (mcg/hr)[6]	7.2
Hydrocodone	1
Hydromorphone	4
Levomethadyl acetate	8
Levorphanol tartrate	11
Meperidine hydrochloride	0.1
Methadone[7]	3
Morphine	1
Opium	1
Oxycodone	1.5
Oxymorphone	3
Pentazocine	0.37
Tapentadol	0.4
Tramadol	0.1

Note: Organizations must use the Medication List Directory posted to the NCQA website to confirm the strength and appropriate conversion factor associated with the opioid product. Use strength listed; no additional conversion needed prior to use of conversion factors.

[1] National Center for Injury Prevention and Control. CDC compilation of benzodiazepines, muscle relaxants, stimulants, zolpidem, and opioid analgesics with oral morphine milligram equivalent conversion factors, 2017 version. Atlanta, GA: Centers for Disease Control and Prevention; 2017. Available at https://www.cdc.gov/drugoverdose/resources/data.html

[2] MME conversion factor for buprenorphine patches is 12.6 based on the assumption that one milligram of parenteral buprenorphine is equivalent to 75 milligrams of oral morphine and that one patch delivers the dispensed micrograms per hour over a 24 hour day and remains in place for 7 days. Using the formula, Strength per Unit * (Number of Units/ Days Supply) * MME conversion factor = MME/Day: 5 µg/hr. buprenorphine patch * (4 patches/28 days) * 12.6 = 9 MME/day.

[3] MME conversion factor for fentanyl buccal tablets, sublingual tablets, and lozenges/troche is 0.13. This conversion factor should be multiplied by the number of micrograms in a given tablet or lozenge/troche.

[4] MME conversion factor for fentanyl films and oral sprays is 0.18. This reflects a 40% greater bioavailability for films compared to lozenges/tablets and 38% greater bioavailability for oral sprays compared to lozenges/tablets.

[5] MME conversion factor for fentanyl nasal spray is 0.16, which reflects a 20% greater bioavailability for sprays compared to lozenges/tablets.

[6] MME conversion factor for fentanyl patches is 7.2 based on the assumption that one milligram of parenteral fentanyl is equivalent to 100 milligrams of oral morphine and that one patch delivers the dispensed micrograms per hour over a 24 hour day and remains in place for 3 days. Using the formula, Strength per Unit * (Number of Units/ Days Supply) * MME conversion factor = MME/Day: 25 µg/hr. fentanyl patch * (10 patches/30 days) * 7.2 = 60 MME/day.

[7] Adapted from Von Korff M, Saunders K, Ray GT, et al. Clin J Pain 2008;24:521–7 and Washington State Interagency Guideline on Prescribing Opioids for Pain (http://www.agencymeddirectors.wa.gov/Files/2015AMDGOpioidGuideline.pdf).