HEDIS®

HEALTHCARE EFFECTIVENESS DATA AND INFORMATION SET

2025 PROVIDER GUIDE

An Independent Licensee of the Blue Cross and Blue Shield Association

HEDIS®/ STAR PROVIDER GUIDE – HEDIS MY 25 (Measurement Year 2025)

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 a crucial factor in our accreditation.

Select 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.

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 and/or CPT codes, and medication fills, based on the NCQA Vol. 2 Technical Specifications & Value Sets (updated annually).
- Hybrid: A combination of Administrative data, and medical chart review.
- Survey: Member and Provider surveys.

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

This guide does not include every clinical quality measure, but rather ones that are NCQA sensitive for accreditation.

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. 4098, or email QualityManagement@fhcp.com.

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

Sincerely,
FHCP Quality Management

TABLE OF CONTENTS (Click for Link)

TABLE OF CONTENTS cont'd

Measure	Comments	More Tips
AAB **Avoidance of Antibiotic Treatment For Acute Bronchitis / Bronchiolitis** Members 3 months and older, who were diagnosed with acute bronchitis or bronchiolitis, should not be dispensed an antibiotic prescription. Please explain to your patients that viruses are not treated with antibiotics. Promote symptom control instead. Antibiotics filled on day of visit or within 3 days from visit, count in the measure as non-compliant. If you prescribe an antibiotic, please consider using an alternate code other than acute bronchitis/ bronchiolitis if appropriate, such as the suggested examples listed in Column 3.	Please do **not** use the following acute bronchitis / bronchiolitis 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 • **J21.0** Acute bronchiolitis due to respiratory syncytial virus • **J21.1** Acute bronchiolitis due to human metapneumovirus • **J21.8** Acute bronchiolitis due to other specified organisms • **J21.9** Acute bronchiolitis, unspecified Includes outpatient, Telephone, Telehealth, Urgent Care, and ED visits.	**Alternate Codes:** The following codes **are** acceptable with an antibiotic per the measure (not a complete list): • **H66.90**: Otitis media, unspec. • **J01.90:** Acute sinusitis, unspec. • **J02.9:** Acute pharyngitis (**perform strep test**) • **J03.90**: Acute tonsillitis (**perform strep test**) Also ok to give an antibiotic with an acute bronchitis or bronchiolitis diagnosis if these co-morbid conditions are coded at the visit or up to a year prior (not a complete list)**:** • Cancer • COPD • Cystic fibrosis • HIV • Pneumonia • Pulmonary edema • Respiratory failure • TB Members in hospice are excluded.

Measure	Comments	More Tips
ADD-E **Follow-Up Care for Children Prescribed ADHD Medication** Ages 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:** 1. **Initiation Phase:** One follow-up visit with a practitioner with prescribing authority during the 30-day Initiation Phase. 2. **Continuation and Maintenance (C&M) Phase.** Remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.	Types of follow-up visits include: • An outpatient visit with Outpatient POS (Place of Service). • A Behavioral Health outpatient visit. • A health and behavior assessment or intervention. • An intensive outpatient encounter or partial hospitalization (with POS code 52). • An intensive outpatient encounter or partial hospitalization. • A community mental health center visit (with POS Code 53). • A telehealth visit (with Telehealth POS). • A telephone visit. **For the C&M Phase, may also include:** • An e-visit or virtual check-in. Please note that only <u>one</u> of the two visits (during the C&M Phase) may be an e-visit or virtual check-in. • Ideally schedule the first follow-up visit within 21 days of the initial prescription while the patient is still in the office. This will allow time to reschedule missed appointments within the 30-day Initiation Phase compliance timeframe. • Consider prescribing the first ADHD medication for a 21- or 30-day supply to promote timely follow-up.	Please contact Quality Management for a list of CPT codes for follow-up visits if needed. **Exclusions**: •Hospice •Narcolepsy •Had an acute inpatient encounter or admission with a principal diagnosis for mental, behavioral, or neurodevelopmental disorder during either Phase. **<u>ADHD Medications</u>:** **CNS Stimulants:** •Dexmethylphenidate •Dexmethylphenidate-Serdexmethylphenidate •Dextroamphetamine •Lisdexamfetamine •Methylphenidate •Methamphetamine **Alpha-2 receptor agonists**: •Clonidine •Guanfacine **Miscellaneous ADHD Medication:** •Atomoxetine •Viloxazine

Measure	Comments	More Tips
AHU **Acute Hospital Utilization** For age 18 and older, the risk-adjusted ratio of observed-to-expected acute inpatient and observation stay discharges during the measurement year. Members in hospice are excluded.	Risk Adjustment Determination: • For each nonoutlier member in the eligible population, use the steps in the *Risk Adjustment Comorbidity Category Determination* section in the *Guidelines for Risk Adjusted Utilization Measures* to identify risk adjustment categories based on presence of comorbidities. Risk Adjustment Weighting & Calculation of Expected Events: • Calculation of risk-adjusted outcomes (counts of discharges) uses predetermined risk weights generated by two separate regression models. • Weights from each model are combined to predict how many discharges each member might have during the measurement year, given age, gender and presence or absence of a comorbid condition. • Weights are specific to product line.	For observation and inpatient discharges, exclude any with the following on the discharge claim: • A principal diagnosis of mental health or chemical dependency • A principal diagnosis of live-born infant, or a maternity related principal diagnosis or stay • A planned hospital stay for a principal diagnosis of maintenance chemotherapy • A principal diagnosis of rehabilitation • An organ transplant • A potentially planned procedure without a principal acute diagnosis • Patient death
AIS-E **Adult Immunization Status** The percentage of members 19 years and older who are up to date on recommended routine vaccines for influenza, tetanus and diphtheria (Td) or tetanus, diphtheria and acellular pertussis (Tdap), zoster and pneumococcal.	• The Advisory Committee on Immunization Practices recommends annual influenza vaccination; and Tdap and/or Td vaccine; herpes zoster vaccine; and pneumococcal vaccination for adults at various ages.	• Measurement period is January 1-December 31. • Members in hospice are excluded.

Measure	Comments	More Tips
AMR **Asthma Medication Ratio** Ages 5 to 64 with persistent asthma, should have a ratio of controller medications to *total* asthma medications (both controllers and relievers) **of 0.50 or greater during the measurement year.** The measure is intended to ensure members take an asthma controller consistently. The goal for our members is to take a controller daily, thus reducing the need for reliever medications. Adjust dosage so patient is well-controlled on asthma controller medications (see Column 2) without frequent use of asthma reliever medications (rescue inhalers). (Rescue inhalers include **short-acting, inhaled beta-2 agonists, beta2 adrenergic agonist-corticosteroid combination,** albuterol and levalbuterol, albuterol-budesonide).	**Asthma Controllers:** • **Antibody inhibitors**: omalizumab • **Anti-interleukin-4**: dupilumab • **Anti-interleukin-5**: benralizumab, mepolizumab, reslizumab • **Inhaled steroid combinations**: budesonide-formoterol, fluticasone-salmeterol, fluticasone-vilanterol, formoterol-mometasone • **Inhaled corticosteroids**: beclomethasone, budesonide, ciclesonide, flunisolide, fluticasone, mometasone • **Leukotriene modifiers**: montelukast, zafirlukast, zileuton • **Methylxanthines**: theophylline • **Long**-acting beta2-adrenergic agonist (LABA): **Fluticasone furoate**-umeclidinium-vilanterol, Salmeterol	• **Long**-acting muscarinic antagonists (LAMA): Tiotropium Members are excluded from the measure if the following are documented at a visit: • COPD • Chronic respiratory conditions due to chemicals, gases, fumes, vapors • Cystic fibrosis • Acute respiratory failure Also exclude members in hospice.
APM-E **Metabolic Monitoring for Children and Adolescents on Antipsychotics** Ages 1–17 who had two or more antipsychotic prescriptions should have metabolic testing during the measurement year.	Three rates are reported: The percentage of children and adolescents on antipsychotics who: 1. Received blood glucose testing. 2. Received cholesterol testing. 3. Received blood glucose and cholesterol testing.	The list of antipsychotic medications pertaining to this measure are contained in the APM Antipsychotic Medications list in the HEDIS Measurement Year 2024 Medication List Directory. Please contact Quality Management for more information if needed. Members in hospice are excluded.

Measure	Comments	More Tips
APP **Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics** Ages 1–17 that had a new prescription for an antipsychotic medication should have documentation of psychosocial care as first-line treatment. Numerator for compliance: • Psychosocial care or residential Behavioral Health treatment in the 121-day period from 90 days prior to the Index Prescription Start Date (IPSD) through 30 days after the IPSD.	Index Prescription Start Date: The earliest prescription dispensing date for an antipsychotic medication where the date is in the intake period (January 1 through December 1). Exclude members for whom first-line antipsychotic medications may be clinically appropriate, such as those diagnosed with the following (not a complete list): • schizophrenia • schizoaffective disorder • bipolar disorder • psychotic disorder • autism	**See Appendix 1** for the following medications which pertain to this measure: • Antipsychotic medications • Antipsychotic combination medications **Psychosocial Care CPT Codes:** 90832-90834, 90836-90840, 90845-90847, 90849, 90853, 90875-90876, 90880 **Residential Behavioral health Treatment Codes:** H0017-H0019, T2048 (HCPCS Code System) Members in hospice are excluded.

Measure	Comments	More Tips
BCS-E ☆ **Breast Cancer Screening** The percentage of members 50–74 years of age who were recommended for routine breast cancer screening and had a mammogram. The U.S. Preventive Services Task Force recommends screening women in this age group for breast cancer every 2 years. Numerator for compliance: One or more mammograms any time on or between October 1 two years prior to the measurement period, and the end of the measurement period. Measurement period is January 1-December 31. Members are covered for a **free annual mammogram.** Early detection is key. **Exclusions** (not a complete list): Members who had a bilateral mastectomy, or both right and left unilateral mastectomies any time during the member's history through the end of the measurement period. Any of the following meet the criteria for bilateral mastectomy: (continued):	1) Bilateral mastectomy 2) Unilateral mastectomy with a bilateral modifier (CPT Modifier code 50) (same procedure) 3) History of bilateral mastectomy 4) Any combination of codes from below that indicate a mastectomy on **both** the left **and** right side on the same date of service, or on different dates of service. **Left Mastectomy (any of the following):** ✓ Unilateral mastectomy with a left-side modifier (CPT Modifier code LT) (same procedure) ✓ Absence of the left breast ✓ Left unilateral mastectomy ✓ Unilateral mastectomy found in clinical ***with*** a left-sided qualifier value **Right Mastectomy (any of the following):** ✓ Unilateral mastectomy with a right-side modifier (CPT Modifier code RT) (same procedure) ✓ Absence of the right breast ✓ Right unilateral mastectomy ✓ Unilateral mastectomy found in clinical ***with*** a right-sided qualifier value	**Exclusions** (continued): • Hospice or palliative care • Frailty and advanced illness together if 65 or older. Multiple diagnoses apply and must be on a visit claim. For a frailty diagnosis, please be sure to document ICD 10 codes in a claim to include: pressure ulcers, sarcopenia, falls, muscle wasting or weakness, bed confinement, reduced mobility, or dependence on wheelchair or supplemental oxygen (not a complete list). **Mammogram CPT Codes:** 77061-77063, 77065-77067 **Exclusion Codes:** **Bilateral Mastectomy ICD10PCS Code:** 0HT0ZZ **History of Bilateral Mastectomy ICD10CM Code:** Z90.13 (Acquired absence of bilateral breasts & nipples) **Absence of Left Breast:** Z90.12 **Absence of Right Breast:** Z90.11 **Unilateral Mastectomy CPT Codes:** 19180, 19200, 19220, 19240, 19303-19307 **Unilateral Mastectomy Left:** 0HTU0ZZ (ICD10PCS) **Unilateral Mastectomy Right:** 0HTT0ZZ (ICD10PCS)

Measure	Comments	More Tips
BPD **Blood Pressure Control for Patients With Diabetes** Ages 18-75 with diabetes (Types 1 & 2) should have adequately controlled BP (**less than** 140/90 mm Hg) during the measurement year. Control within the year of **139/89 or below** should be **documented in the EHR if attained**.	Uses the most recent BP reading during the year. Exclude BPs in inpatient setting or ED visit. 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.	If you believe member does not have diabetes, please notify Quality Management. Hospital claims with a diabetes diagnosis are occasionally received (if glucose is elevated), and these can be corrected if not diabetic. Members in hospice are excluded. Also exclude age 66 and older with both frailty and advanced illness (must be documented).
CBP ★ **Controlling High Blood Pressure** Ages 18 to 85 with a diagnosis of hypertension (HTN) should have controlled BP during the measurement year. **Control** is based upon: • Ages 18 to 85 have BP controlled at **LESS THAN 140/90.** **Compliance is 139/89 or below.** Blood pressure should be routinely assessed as part of a physical exam at each visit. If BP is elevated, please retake BP and document in the chart. Treat as necessary. Chart all measurements, and efforts to obtain control. Control within the year of 139/89 or below should always be documented in the EHR if attained.	**The measure uses**: • The most recently documented BP on or after the second diagnosis of HTN. • BP readings taken or reported by the member using a digital device are now acceptable, **as long as result is documented by the provider in the note.** This includes Telephone and Telehealth visits. **Staff PCPs, please always add BP under Vital Signs** as well as in the note**.** If member reported result is not 139/89 or below, please have member retake, or bring member in to try to obtain a controlled BP, and document. **The measure does not use**: • BP from an acute inpatient stay or ED visit. • BP taken day of test/therapeutic procedure requiring change of diet or medication on or day before, such as colonoscopy, dialysis, infusions, chemotherapy, or albuterol nebulizer treatment. Fasting blood tests are acceptable.	Please schedule a follow-up visit if a controlled BP of 139/89 or below was not obtained (can be a nurse visit). **Essential (primary) Hypertension ICD 10 Code**: I10 **Most Recent Systolic BP Less than 140** **CPT-CAT-II Code (compliant):** 3074F (less than 130 mm Hg) 3075F (130-139 mm Hg) **Most Recent Diastolic BP Less than 90** **CPT-CAT-II Code (compliant):** 3078F (less than 80 mm Hg) 3079F (80-89 mm Hg) Members in hospice, and those with ESRD, dialysis, kidney transplant, or pregnancy are excluded. Also excluded are those age 66-80 with both frailty and advanced illness. Please document any exclusion.

Measure	Comments	More Tips
CCS **Cervical Cancer Screening** Ages 21 to 64 should be screened for cervical cancer using ***any one*** of the following: • Age 21–64 have cervical cytology (Pap smear) performed every 3 years. • Age 30–64 years of age have cervical high-risk human papillomavirus (hrHPV) testing performed every 5 years. • Age 30–64 years of age have cervical cytology/high-risk human papillomavirus (hrHPV) co-testing performed every 5 years.	Documentation in the medical record must include both of the following: • A note indicating the **date** the procedure was performed. • The **result** or **finding**. Lab results that indicate the sample contained "no endocervical cells" may be used if a valid result was reported for the test. Exclusion: Member does not need this screening if they had a hysterectomy with no residual cervix, cervical agenesis, or acquired absence of cervix. Documenting a hysterectomy alone does not exclude member; **the removal of cervix must also be documented.** Members in hospice, and members assigned male at birth are also excluded.	**Cervical Cytology Lab Test CPT codes**: 88141- 88143, 88147-88148, 88150, 88152-88153, 88164-88167, 88174-88175 **High Risk HPV Lab Test CPT codes**: 87624-87625 **Absence of Cervix Diagnosis codes**: Q51.5, Z90.710, Z90.712 **Hysterectomy With No Residual Cervix CPT codes:** 57530-57531, 57540, 57545, 57550, 57555-57556, 58150, 58152, 58200, 58210, 58240, 58260, 58262-58263, 58267, 58270, 58275, 58280, 58285, 58290-58294, 58548, 58550, 58552-58554, 58570-58573, 58575, 58951, 58953-58954, 58956, 59135 Do not count biopsies because they are diagnostic and therapeutic only and are not valid for primary cervical cancer screening.
CHL **Chlamydia Screening In Women** Sexually active females ages 16 to 24 should be screened for chlamydia at least once a year. Chlamydia screening can be a urine test.	Sexual activity identified by 2 methods: • Claim/encounter data: members who had a claim or encounter indicating sexual activity during the measurement year. • Pharmacy data: members who were dispensed contraceptives during the measurement year.	**Chlamydia Test CPT Codes**: 87110, 87270, 87320, 87490-87492, 87810, 0353U

Measure	Comments	More Tips
CIS-E – Combo 10 **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) (6 months or older) Immunizations must be completed **before** member turns age 2. Please educate office staff to schedule appointments **PRIOR** to 2nd birthday. For **MMR**, **VZV** and **HepA**, vaccinations must be on or between 1st and 2nd birthday. If prior to 1st birthday, will not count for the measure.	For DTaP, count any of the following: • Evidence of the antigen or combination vaccine. • Anaphylaxis due to the vaccine. • Encephalitis due to the vaccine. For MMR, VZV, hepatitis A, and hepatitis B, count any of the following: • Evidence of the antigen or combination vaccine. • Documented history of the illness. • Anaphylaxis due to the vaccine. For IPV, pneumococcal conjugate, influenza, HiB and rotavirus, count *either*: • Evidence of the antigen or combination vaccine. • Anaphylaxis due to the vaccine. For combination vaccinations that require more than one antigen (DTaP and MMR), the organization must find evidence of all the antigens. For history of illness or anaphylaxis, provide a note with date, which must have occurred by the 2nd birthday.	**DTaP Vaccine Procedure CPT Codes:** 90697, 90698, 90700, 90723 **HepA Vaccine Procedure CPT Code:** 90633 **HepB Vaccine Procedure CPT Codes:** 90697**,** 90723, 90740, 90744, 90747, 90748 **HiB Vaccine Procedure CPT Codes:** 90644, 90647, 90648, 90697, 90698, 90748 **Influenza Vaccine Procedure CPT Codes:** 90655, 90657, 90661, 90673, 90674, 90685-90689, 90756 **Influenza Virus LAIV Vaccine Procedure CPT Codes:** 90660, 90672 **IPV (Inactivated Polio Vaccine) Procedure CPT Codes:** 90697**,** 90698, 90713, 90723 **MMR Vaccine Procedure CPT Codes:** 90707, 90710 **Pneumococcal Conjugate Vaccine Procedure (PCV) CPT Codes:** 90670-90671 **Rotavirus Vaccine Procedure (2 dose) CPT Code:** 90681 **Rotavirus Vaccine Procedure (3 dose) CPT Code:** 90680 **Varicella Zoster (VZV) Vaccine Procedure CPT Codes:** 90710, 90716 Document in medical record by a note indicating name of the specific antigen and date of immunization, or a certificate of immunization prepared by an authorized provider or agency with dates and types of immunizations.

Measure	Comments	More Tips
COL-E ☆ **Colorectal Cancer Screening** Ages 45 to 75 should have appropriate screening for colorectal cancer. Any of the following meet criteria: • Fecal occult blood test (FOBT) during the measurement year. • Flexible sigmoidoscopy within the last 5 years. • Colonoscopy within the last 10 years. • CT colonography within the last 5 years. • Stool DNA (sDNA) with FIT test (*Cologuard*) during the last 3 years.	Documentation in the medical record must include a note indicating the **date** the colorectal cancer screening was performed within the time frame. Members who have had colorectal cancer or a total colectomy are excluded from this measure. • Exclusionary evidence in the medical record must include a note indicating colorectal cancer or total colectomy any time during the member's history, through December 31st of the measurement year.	Do not count digital rectal exams (DRE). Do not count FOBT tests performed in an office setting or performed on a sample collected via DRE. Members in hospice are excluded. Also excluded are those 66 and older or with frailty and advanced illness together. Multiple diagnoses apply and must be on a visit claim. For a frailty diagnosis, please be sure to document ICD 10 codes in a claim to include: pressure ulcers, sarcopenia, falls, muscle wasting or weakness, bed confinement, reduced mobility, or dependence on wheelchair or supplemental oxygen (not a complete list).
CWP **Appropriate Testing for Pharyngitis** Ages 3 and older diagnosed with pharyngitis and dispensed an antibiotic, should also 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), please be sure the Group A strep test CPT code is on the claim for the same visit.	**Pharyngitis ICD-10 Codes – Perform Strep Test**: • **J02.0** Streptococcal pharyngitis • **J02.8** Acute pharyngitis due to other specified organisms • **J02.9** Acute pharyngitis, unspecified • **J03.00** Acute streptococcal tonsillitis, unspec. • **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

Measure	Comments	More Tips
DAE **Use of High-Risk Medications in Older Adults** The percentage of Medicare members 67 years of age and older who had at least two dispensing events for the same high-risk medication during the measurement year. Three rates are reported: 1. At least two dispensing events for high-risk medications to avoid from the same drug class. 2. At least two dispensing events for high-risk medications to avoid from the same drug class, except for appropriate diagnoses. 3. Total rate (the sum of the two numerators divided by the denominator, deduplicating for members in both numerators).	Caution should be used in dispensing high-risk medications to the elderly. A ***lower*** rate represents better performance. The measure reflects potentially inappropriate medication use in older adults, both for: • Medications where **any** use is inappropriate (Rate 1); and • Medications where use **under all but specific indications** is potentially inappropriate (Rate 2). Members in hospice are excluded from this measure.	Please see Appendix 4 **for High-Risk Medications** for Rate 1, and for Rate 2. Rate 1: **High Risk Medications to Avoid**: • High-Risk Medications • High-Risk Medications With Days' Supply Criteria • High-Risk Medications With Average Daily Dose Criteria Rate 2: **High-Risk Medications to Avoid Except for Appropriate Diagnosis**: • High-Risk Medications Based on Prescription & Diagnosis Data
DDE **Potentially Harmful Drug–Disease Interactions in Older Adults** The percentage of Medicare members age 65 and older with evidence of an underlying disease, condition or health concern: • Who were dispensed an ambulatory prescription for a potentially harmful medication, concurrent with or after the diagnosis. Counts members with at least one disease, condition, or procedure within the last 2 years. Start date is the earliest diagnosis, procedure, or prescription between January 1 of the prior year, to December 1 of the current year.	**Avoid** the following conditions and drugs: • **A history of falls (accidental fall or hip fracture)** and a prescription for antiepileptics, anti-psychotics, benzodiazepines, non-benzodiazepine hypnotics or antidepressants (SSRIs, tricyclic antidepressants and SNRIs). • **Dementia** and a prescription for antipsychotics, benzodiazepines, nonbenzodiazepine hypnotics, tricyclic antidepressants, or anticholinergic agents. • **Chronic Kidney Disease** and a prescription for Cox-2 selective NSAIDs or non-aspirin NSAIDs. Total rate is sum of the 3 numerators divided by the sum of the 3 denominators.	A ***lower*** rate of these prescriptions with these conditions represents better performance. Always evaluate if the member has one of these conditions before dispensing these medications. Members in hospice are excluded from the measure. For falls, members with a diagnosis of psychosis, schizophrenia, schizoaffective disorder, bipolar disorder, major depression, or seizure disorder up to 2 years prior are excluded from the measure. For dementia, exclude members with a diagnosis of psychosis, schizophrenia, schizoaffective disorder, or bipolar disorder up to 2 years prior.

Measure	Comments	More Tips
EDU **Emergency Department Utilization** For members 18 and older, the risk-adjusted ratio of observed-to-expected Emergency Department (ED) visits during the measurement year. ***Lower*** rates signify better performance. Members in hospice are excluded. Also excluded are ED visits with a principal diagnosis of mental health or chemical dependency, psychiatry, or electroconvulsive therapy.	Assesses ED utilization by health plan members. Plans report observed rates of ED use and a predicted rate of ED use based on the health of the member population. • The observed and expected rates are used to calculate a calibrated observed-to-expected ratio that assesses whether plans had more, the same or less ED visits than expected, while accounting for incremental improvements across all plans over time. • The observed-to-expected ratio is multiplied by the ED visit rate across all health plans to produce a risk-standardized rate which allows for national comparison.	ED visits are a high-intensity service and a cost burden on the health care system, as well as on patients. Some ED events may be attributed **to preventable or treatable conditions**. A high rate of ED utilization may indicate care/medication management needing improvement, inadequate access to care, or poor patient choices, resulting in ED visits that could be prevented. Plans should try to ensure that members receive appropriate, coordinated primary care as well as education to address preventable ED visits.
EED ☆ **Eye Exam for Patients With Diabetes** Age 18-75 with diabetes (Types 1 and 2) should have a retinal eye exam, to include **one** of the following: 1. A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year. 2. A *negative* retinal or dilated eye exam (negative for retinopathy) by an eye care professional in the year prior to the measurement year. **3.** Bilateral eye enucleation any time during the member's history through December 31 of the measurement year.	Documentation in the medical record must include **one** of the following: (1) A note by an ophthalmologist, optometrist, PCP or other health care professional indicating **all** of the following: • An ophthalmoscopic exam was completed by an **optometrist or ophthalmologist**, the **date** of the procedure, and the **results**. **OR** (2) A chart or photograph indicating the date the fundus photography was performed and one of the following: • Evidence that an optometrist or ophthalmologist reviewed the **results**. • Evidence that **results** were read by a qualified reading center that operates under the direction of a medical director who is a retinal specialist.	If you believe member is in the EED measure population 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. Members in hospice are excluded. Also exclude age 66 and older with both frailty and advanced illness (must be documented).

Measure	Comments	More Tips
FMC **Follow-Up After ED Visit for People With Multiple High-Risk Chronic Conditions** Counts ED visits for age 18 and older with multiple high-risk chronic conditions, who had a follow-up service within 7 days of the 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 7 days after the ED visit, regardless of the principal diagnosis for admission.	ED visits requiring a follow-up service within 7 days apply to members who had two or more different chronic conditions **prior** to the ED visit, within the past 2 years. The following are eligible chronic conditions: • COPD and Asthma. • Alzheimer's Disease and related disorders. • Chronic Kidney Disease. • Depression. • Heart Failure. • Acute Myocardial Infarction. • Atrial Fibrillation. • Stroke and Transient Ischemic Attack.	May count follow-up visits that occur on the date of the ED visit. Follow-up outpatient visits can include Behavioral Health, Telehealth, Telephone, or Case Management visits. Members in hospice are excluded.
FRM ☆ **Fall Risk Management** The two components of this measure assess different facets of fall risk management: • **Discussing Fall Risk.** The percentage of Medicare members 65 years of age and older who were seen by a practitioner in the past 12 months and who discussed falls or problems with balance or walking with their current practitioner. • **Managing Fall Risk.** The percentage of Medicare members 65 years of age and older who had a fall or had problems with balance or walking in the past 12 months, who were seen by a practitioner in the past 12 months and who received a recommendation for how to prevent falls or treat problems with balance or walking from their current practitioner.	This measure is collected using the Medicare Health Outcomes Survey (HOS).	Members in hospice are excluded.

Measure	Comments	More Tips
FUA **Follow-Up After Emergency Department Visit for Substance Use** The percentage of ED visits for age 13 years and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow-up. **Two rates for follow-up are reported:** 1. The percentage of ED visits for which the member received follow-up within 7 days of the ED visit. 2. The percentage of ED visits for which the member received follow-up within 30 days of the ED visit.	• The follow-up visit can be with **any** practitioner, with any diagnosis of SUD, substance use, or drug overdose. • A pharmacotherapy dispensing event or medication treatment event also counts. • May include visits and pharmacotherapy events that occur on the date of the ED visit.	Exclude ED visits that result in an inpatient stay, and exclude ED visits followed by an 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. A Telehealth or Telephone visit can count for the measure.
FUH **Follow-Up After Hospitalization for Mental Illness** Members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses, should have a follow-up visit with a **mental health provider.** This measure counts an acute inpatient discharge with a principal diagnosis of mental illness or intentional self-harm on the discharge claim.	Two rates for follow-up are reported: 1. The member received follow-up within 7 days after discharge. 2. The member received follow-up within 30 days after discharge. Discharges followed by readmission or direct transfer to a nonacute inpatient care setting within the 30-day follow-up period are excluded, regardless of principal diagnosis for the readmission (as may prevent an outpatient follow-up visit from taking place).	A follow-up visit that occur on the date of discharge do not count towards measure. In addition to outpatient, and behavioral health visits, Telehealth and Telephone visits count for this measure. Please note: Visits that do occur with a mental health provider include a mental disorder diagnosis on the visit claim to count. This measure is based on discharges, not members. If more than 1 discharge, count all discharges between January 1 and December 1.

Measure	Comments	More Tips
FUI **Follow-Up After High-Intensity Care for Substance Use Disorder** Age 13 and older with an acute inpatient hospitalization, residential treatment or withdrawal management visit for a diagnosis of substance use disorder (SUD): • Should have a follow-up visit or service for substance use disorder.	**Two rates for follow-up are reported:** 1. The percentage of visits or discharges for which the member received follow-up for substance use disorder within the 7 days after the visit or discharge. 2. The percentage of visits or discharges for which the member received follow-up for substance use disorder within the 30 days after the visit or discharge.	The population (denominator) for this measure is based on episodes, not on members. If members have more than episode, include all that fall on or between January 1 and December 1 of the measurement year. Follow-up visit may be with any practitioner, but must have a **principal** diagnosis of **substance use disorder** on the claim for the visit to count.
FUM **Follow-Up After ED Visit for Mental Illness** Age 6 years and older who had an ED visit with a principal diagnosis of mental illness or intentional self-harm, should have a follow-up visit for mental illness. **Two rates for follow-up are reported:** 1. The percentage of ED visits for which the member received follow-up within 7 days of the ED visit. 2. The percentage of ED visits for which the member received follow-up within 30 days of the ED visit.	• Can be a follow-up visit with **any** practitioner, with a **principal diagnosis** of a mental health disorder, or with a **principal diagnosis** of intentional self-harm **and any diagnosis** of a mental health disorder. • May include visits that occur on the date of the ED visit. • May include Telehealth and Telephone visits.	If a member has more than one ED visit in a 31-day period, include only the first eligible ED visit. Exclude ED visits that result in an inpatient stay, and exclude 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. Members in hospice are excluded.

Measure	Comments	More Tips
GSD ☆ **Glycemic Status Assessment for Patients With Diabetes** (Formerly the HBD measure). The percentage of members 18–75 years of age with diabetes (Types 1 and 2) whose most recent glycemic status (HbA1c) or glucose management indicator (GMI) was at the following levels during the measurement year: • Glycemic Status <8.0% • Glycemic Status >9.0% These do not represent ideal levels, but rather a method of tracking the status of members with diabetes. **Note:** For Glycemic Status of >9.0%, a ***lower*** rate indicates better performance (i.e., low rates of Glycemic Status >9% indicate better care).	Members may be identified as having diabetes during the measurement year or the year prior to the measurement year through one of the following: • Claim/encounter data: Members who had at least two diagnoses of diabetes on different dates of service during the measurement year or the year prior to the measurement year. • Pharmacy data: Members who were dispensed insulin or hypoglycemics/ antihyperglycemics during the measurement year or the year prior to the measurement year and have at least one diagnosis of diabetes during the measurement year or the year prior to the measurement year. Do not include laboratory claims (claims with POS code 81)	Uses the most recent glycemic status assessment (HbA1c or GMI) during the measurement year. If there is no test performed during the measurement year, the member is noncompliant. Tests must have the **result** to count. Ranges and thresholds do not meet criteria for this indicator. Members in hospice, palliative care, or with both frailty and advanced illness are excluded (must be documented on visit claim).

Measure	Comments	More Tips
HFS **Hospitalization Following Discharge From a Skilled Nursing Facility (SNF)** For age 65 and older: • Tracks the percentage of SNF discharges to the community that were followed by an unplanned acute hospitalization for any diagnosis within 30 and 60 days.	The measure counts a SNF discharge between January 1 and November 1 of the measurement year. The population (denominator) is based on discharges, not on members. Excluded: Members living long-term in an institution any time during the measurement year, or are in hospice.	A hospital stay is considered planned if it meets the following criteria: • Pregnancy • A principal diagnosis of a condition originating in the perinatal period • A principal diagnosis of maintenance chemotherapy • An organ transplant • A potentially planned procedure without a principal acute diagnosis
HPC **Hospitalization for Potentially Preventable Complications** For age 67 and older: • The rate of discharges for ambulatory care sensitive conditions (ACSC) per 1,000 members and the risk-adjusted ratio of observed-to-expected discharges for ACSC by chronic and acute conditions. Excluded: Members living long-term in an institution any time during the measurement year, or are in hospice.	**Ambulatory care sensitive condition**: An acute or chronic health condition that can be managed or treated in an outpatient setting. The ambulatory care conditions included in this measure are: **Chronic ACSC:** • Diabetes short-term complications • Diabetes long-term complications • Uncontrolled diabetes • Lower-extremity amputation among patients with diabetes • COPD. • Asthma • Hypertension • Heart failure **Acute ACSC:** • Bacterial pneumonia • Urinary tract infection • Cellulitis • Pressure ulcer	Assesses hospital inpatient admissions and observation stays due to complications of ACSC. Health plans report observed ACSC hospitalization rates and expected ACSC hospitalization rates that take the member's health history into account. Rates are used to calculate a calibrated observed-to-expected ratio of hospitalizations for potentially preventable complications of ACSC that assesses whether plans had more, the same or less hospitalizations than expected, while accounting for incremental improvements across all plans over time. ACSCs can be acute or chronic. Hospitalizations for complications of ACSC can be prevented with appropriate access to ambulatory care services, timely delivery of care and high-quality care coordination. Reducing the rate of hospitalization for older adults will improve patient health, reduce costs and improve quality of life.

Measure	Comments	More Tips
IET **Initiation and Engagement of Substance Use Disorder Treatment** Age 13 and older who have a new substance use disorder (SUD) episode during the intake period with a diagnosis of SUD, should have treatment initiation and engagement. Two rates for follow-up are reported: • **Initiation of SUD Treatment**. The percentage of new SUD episodes that result in treatment initiation through an inpatient SUD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, Telehealth visit or medication treatment **within 14 days**. • **Engagement of SUD Treatment**. The percentage of new SUD episodes that have evidence of treatment engagement **within 34 days of initiation.** SUD episodes include diagnoses from one of the following Value Sets: (1) Alcohol Abuse and Dependence, (2) Opioid Abuse and Dependence, or (3) Other Drug Abuse and Dependence. When a new SUD diagnosis is detected, please immediately schedule the follow up visits to cover the required time frames.	Types of follow-up encounter include: • Outpatient visit • Behavioral health visit • Intensive outpatient encounter or partial hospitalization • Non-residential treatment facility visit • Community mental health center visit • Substance use disorder service • Telehealth of Telephone visit • Medication treatment event For SUD episodes in the alcohol and opioid use disorder cohorts, a medication treatment dispensing event of a medication administration event to count for the measure. **Alcohol Use Disorder Treatment Medications:** • Aldehyde dehydrogenase inhibitor: disulfiram (oral) • Antagonist: naltrexone (oral/injectable) • Other: acamprosate (oral; delayed-release tablet) **Opioid Use Disorder Treatment Medications:** • Antagonist: naltrexone (oral) • Antagonist: naltrexone (injectable) • Partial agonist: buprenorphine (sublingual tablet, injection, or implant) • Partial agonist: buprenorphine/naloxone (sublingual tablet, buccal film, sublingual film)	**The following categories with ICD 10 code "F" diagnoses place patients in this measure:** • Alcohol Abuse and Dependence • Opioid Abuse and Dependence • Other Drug Abuse and Dependence (Examples: cannabis, cocaine, stimulant, hallucinogen, inhalant, psychoactive substance) **Please do not use an "F" code to denote the use of a substance when a "Z" code can appropriately be utilized**. For example, someone who has been on medically supervised opioid therapy for chronic pain would fall under a Z code rather than an F code. **Please consider "Z" codes when appropriate** (indicates use of a substance but not necessarily a disorder), and patient will not be in the measure: Examples: • Z72.89 Alcohol Use / Caffeine use • Z71.41 Alcohol abuse counseling/surveillance of alcoholic • Z79.891 Long term (current) use of opiate analgesic • Z79.899 Medical marijuana use / Long-term (current) use of medication for ADHD / Long-term (current) use of benzodiazepine

Measure	Comments	More Tips
IMA-E **Immunizations for Adolescents** By age 13, member should have had: • One dose of meningococcal vaccine • One tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and • Completed the human papillomavirus (HPV) vaccine series. The measure calculates a rate for each vaccine and two combination rates.	Please educate staff to schedule prior to 13th birthday. Must be **completed by the 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.	**Meningococcal Vaccine Procedure CPT Codes**: 90619, 90733, 90734 **Tdap Vaccine Procedure CPT Code**: 90715 **HPV Vaccine Procedure CPT Codes**: 90649, 90650, 90651
KED **Kidney Health Evaluation for Patients With Diabetes** Members age 18-85 with diabetes (Types 1 and 2) should receive a **yearly kidney health evaluation** to include **both** of the following during the measurement year: 1. Estimated glomerular filtration rate (eGFR), **and** 2. Urine albumin-creatinine ratio (uACR). The above may be on the same dates of service.	Members must receive **both** an eGFR and a uACR during the year on the same or different dates of service: 1. At least one eGFR: • **eGFR Lab Test CPT Codes**: 80047, 80048, 80050, 80053, 80069, 82565 2. At least one uACR identified by either of the following: • Both a quantitative urine albumin lab test (**CPT Code 82043**) and a urine creatinine lab test (**CPT Code 82570**) with service dates four days or less apart. • A uACR lab test (LOINC codes available)	If you believe member is in the KED measure population 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. Members with ESRD, dialysis, or in hospice are excluded. Also exclude age 66 and older with both frailty and advanced illness (must be documented).

Measure	Comments	More Tips
LBP **Use of Imaging Studies for Low Back Pain** Ages 18–75 with a primary diagnosis of uncomplicated low back pain should **not** have an imaging study (plain x-ray, MRI, or CT scan) **within 28 days of the diagnosis**. Counts the following visits: Outpatient, ED, telephone, e-visit, physical therapy, osteopathic, and chiropractic. For ED, do not count visits resulting in inpatient stay. There are exclusions where imaging *may* be clinically appropriate within the first 28 days. Exclusion diagnoses (such as a fracture) must be submitted in a **claim** to count. Members in hospice, those with both frailty and advanced illness (must be documented) are excluded from the measure population (denominator).	**Exclusions** – Imaging acceptable within 28 days of a primary uncomplicated low back pain diagnosis if member had one of the following (please use a code on claim): **Cancer, HIV, major organ transplant, diagnosis of osteoporosis, osteoporosis therapy, lumbar surgery, or spondylopathy** any time during the member's history through 28 days after the low back pain diagnosis. **Recent trauma (fractures, fragility 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, or spinal infection** 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 corticosteroids any time during the 12 months prior to the low back pain diagnosis.	**Alternate codes:** Please consider if any of these apply in the primary position rather than one of the uncomplicated low back pain diagnoses, and then imaging within 28 days would be acceptable (**not a complete list**): • Discitis, unspecified, lumbar region (M46.46) • Discitis, unspecified, lumbosacral region (M46.47) • Muscle spasm of back (M62.830) • Contusion of lower back (S30.0XXA) • Unspecified superficial injury of lower back (S30.91XA) A higher score/rating for this measure indicates appropriate treatment of low back pain (imaging studies did **NOT** occur within the 28 days). See Appendix 4 for Uncomplicated Low Back Pain codes for which imaging within 28 days should be avoided.

Measure	Comments	More Tips
MSC **Medical Assistance With Smoking and Tobacco Use Cessation** For 18 and older, this measure assesses 3 different facets of providing medical assistance with smoking and tobacco use cessation: (1) **Advising Smokers and Tobacco Users to Quit.** The percentage of members who were current smokers or tobacco users and who received advice to quit during the measurement year.	(2) **Discussing Cessation Medications.** The percentage of members who were current smokers or tobacco users and who discussed or were recommended cessation medications during the measurement year. (3) **Discussing Cessation Strategies**. A rolling average represents the percentage of members 18 years of age and older who were current smokers or tobacco users and who discussed or were provided cessation methods or strategies during the measurement year.	**Commercial**: Collected annually as part of the CAHPS Health Plan Survey 5.1H, Adult Version using rolling average methodology. **Medicare**: Collected by CMS using the Medicare CAHPS Survey. Only the Advising Smokers and Tobacco Users to Quit rate is collected for the Medicare product line (no rolling average methodology is used).
OMW ☆ **Osteoporosis Management in Women Who Had a Fracture** Ages 67 to 85 who suffered a fracture (other than finger, toe, face, or skull), should have either one of the following **within the 6 months after the fracture**: • A bone mineral density (BMD) test, also known as a DEXA scan, **OR** • Fill a prescription for a drug to treat osteoporosis. **Reminder**: If your care of the fracture is not an initial encounter but rather a subsequent encounter, please use a fracture diagnosis code ending in "D" (subsequent encounter), rather than ending in "A" (initial encounter).	***Either*** a BMD test or the drug therapy within 6 months after the fracture meets the criteria. Drug therapy may be indicated (rather than another BMD test) if a previous test already shows osteoporosis. Members with either of the following are also considered compliant: (1) BMD test within the 24 months prior to the fracture; ***or*** (2) Osteoporosis drug therapy within the 12 months prior to the fracture. Members in hospice are excluded, as are age 67-80 with both frailty and advanced illness (must be documented), or on dementia medication.	Osteoporosis drug therapies: • **Bisphosphonates**: alendronate, alendronate-cholecalciferol, ibandronate, risedronate, zoledronic acid. • **Other agents**: abaloparatide, denosumab, raloxifene, romosozumab, teriparatide. **Reminder to Staff PCPs**: Please put in the BMD test Current Order after a fracture, and notify the patient how to call and schedule an appointment. (For example, FHCP Radiology in Daytona Beach does not call patients to schedule a BMD test, from an EHR Task or Current Order). **BMD Test CPT Codes**: 76977, 77078, 77080, 77081, 77085, 77086

Measure	Comments	More Tips
OSW **Osteoporosis Screening in Older Women** The percentage of women 65–75 years of age who received osteoporosis screening.	One or more osteoporosis screening tests should occur on or between the member's 65th birthday and December 31 of the measurement year.	Members in hospice are excluded, as are age 67-80 with both frailty and advanced illness (must be documented), or on dementia medication. **Osteoporosis Screening Tests CPT Codes**: 76977, 77078, 77080, 77081, 77085
PCE **Pharmacotherapy Management of COPD Exacerbation** Age 40 and older with an acute inpatient (INP) discharge or Emergency Department (ED) visit for a COPD exacerbation should fill a prescription for **both**: • **Systemic corticosteroid** within 14 days of discharge **And** • **Bronchodilator** within 30 days of discharge.	In addition to filling these medications timely after discharge from INP or ED, the member's medications will also count if: • Member has previously filled prescriptions for both medications, with enough days' supply to cover date of admission for inpatient stay, or to cover ED date of service. The eligible population is based on INP discharges and ED visits, so the member may appear more than once in the measure for the year.	**PCPs**: At the 7-day follow-up visit after an INP or ED hospital encounter for a COPD exacerbation, please ask the member when they last filled these medications. If not yet filled, please consider prescribing both a systemic corticosteroid and a bronchodilator (if there are no contraindications), and encourage patient to fill immediately. For example, the patient may tell the hospitalist they have a nebulizer at home; however, prescriptions for a bronchodilator have not been filled recently.

Measure	Comments	More Tips
PCR ☆ **Plan All-Cause Readmissions** For ages 18 and older, the number of acute inpatient and observation 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.	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. Members in hospice are excluded.	Also exclude hospital stays for the following reasons: • Pregnancy • A principal diagnosis of a condition originating in the perinatal period • Member died during hospital stay • A principal diagnosis of maintenance chemotherapy • An organ transplant
POD **Pharmacotherapy for Opioid Use Disorder** Age 16 and older with a diagnosis of OUD (Opioid Use Disorder) should have OUD pharmacotherapy for 180 or more days. See Column 3 for OUD pharmacotherapy.	Identify members with any diagnosis of OUD during July 1 of the prior year to June 30 of the measurement year. The Treatment Period of 180 calendar days should not contain any gaps in treatment of 8 or more consecutive days. Exclude any Treatment Period Start Dates where the member had an acute or nonacute inpatient stay of 8 or more days during the Treatment Period.	**OUD Pharmacotherapy:** • Antagonist: naltrexone (oral) • Antagonist: naltrexone (injectable) • Partial agonist: buprenorphine (sublingual tablet) • Partial agonist: buprenorphine (injection) • Partial agonist: buprenorphine (implant) • Partial agonist: buprenorphine/ naloxone (sublingual tablet, buccal film, sublingual film) Methadone (agonist) not included.

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**, on or before the enrollment start date or within 42 days of enrollment in the health care plan. • Postpartum Care: Members should have a postpartum visit **on or between 7 and 84 days after delivery.** Telephone visits or e-visits may be used for both prenatal and postpartum care. For prenatal care, please educate staff to schedule first appointment with the OB/GYN other prenatal care practitioner, or PCP in the first trimester. The measure uses deliveries of live births on or between October 8 of the year prior and October 7 of the current measurement year.	**Prenatal**: Prenatal visit to an OB/GYN or other prenatal care practitioner, or PCP. • For visits to a PCP, a diagnosis of pregnancy must be present. **Postpartum:** Postpartum visit to an OB/GYN or other prenatal care practitioner, or PCP. Do not include postpartum care in an acute inpatient setting, or visits on the date of delivery. Medical record note should include **date** of postpartum visit and *one* of the following: • Pelvic exam. • Evaluation of weight, BP, breasts and abdomen (notation of "breastfeeding" acceptable). • Notation of postpartum care, including, but not limited to: "postpartum care," "PP care," "PP check," or "6-week check." Or, a preprinted "Postpartum Care" form with documentation. • Perineal or cesarean incision/wound check. • Screening for depression, anxiety, tobacco, substance abuse, or mental health disorders. • Glucose test if gestational diabetes present. • Documentation of any of the following topics: ✓ Infant care or breastfeeding. ✓ Resumption of intercourse, birth spacing or family planning. ✓ Sleep/fatigue. ✓ Resumption of physical activity. ✓ Attainment of healthy weight.	**Prenatal Visits Codes:** 98966-98968**,** 98970-98972, 98980-98981**,** 99202-99205, 99211-99215, 99241-99245, 99421-99423, 99441-99443, 99457-99458, 99483, G0071, G0463, G2010, G2012, G2250-G2252, T1015. (Please also include a pregnancy related diagnosis code). **Stand Alone Prenatal Visits Codes:** 99500, 0500F, 0501F, 0502F, H1000-H1004 **Prenatal Bundled Services Codes:** 59400, 59425, 59426, 59510, 59610, 59618, H1005 **Postpartum Care Codes:** 57170, 58300, 59430, 99501, 0503F, G0101 **Postpartum Bundled Services Codes:** 59400, 59410, 59510, 59515, 59610, 59614, 59618, 59622 Members in hospice are excluded.

Measure	Comments	More Tips
PRS-E **Prenatal Immunization Status** The percentage of deliveries in the measurement year in which members had received the following: • Influenza and tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccinations. Clinical recommendation statement: Advisory Committee on Immunization Practices (ACIP) clinical guidelines recommend that all women who are pregnant or who might be pregnant in the upcoming influenza season receive inactivated influenza vaccines.	ACIP also recommends that pregnant women receive one dose of Tdap during each pregnancy, preferably during the early part of gestational weeks 27–36, regardless of prior history of receiving Tdap. The following are considered compliant in the measure (Numerators): **Numerator 1—Immunization Status: Influenza** • Deliveries where members received an adult influenza vaccine on or between July 1 of the year prior to the measurement period and the delivery date, ***or*** • Deliveries where members had anaphylaxis due to the influenza vaccine on or before the delivery date.	**Numerator 2—Immunization Status: Tdap** • Deliveries where members received at least one Tdap vaccine during the pregnancy (including on the delivery date), ***or*** • Deliveries where members had any of the following: – Anaphylaxis due to the diphtheria, tetanus or pertussis vaccine on or before the delivery date. – Encephalitis due to the diphtheria, tetanus or pertussis vaccine on or before the delivery date. **Numerator 3—Immunization Status: Combination** • Deliveries that met criteria for both numerator 1 and numerator 2. Exclude deliveries that occurred at less than 37 weeks gestation, or members were in hospice.
PSA **Non-Recommended PSA-Based Screening in Older Men** Ages **70 and older** should not be screened unnecessarily for prostate cancer, using prostate-specific antigen (PSA)-based screening. A ***lower*** rate indicates better performance. Members in hospice are excluded.	PSA-based screening for prostate cancer for men age 70 and older should not be used unless a clinically indicated diagnosis is present. The following are considered clinically appropriate indicators for PSA-based testing for age 70 and older: 1. Prostate cancer any time during the member's history. 2. Dysplasia of the prostate during the measurement year, or year prior.	(Cont'd) 3. A PSA test during the year prior to the measurement year, where lab data indicate an elevated result (>4.0 ng/mL). 4. An abnormal PSA test result or finding during the prior year. 5. Dispensed prescription for 5-alpha reductase inhibitor (finasteride or dutasteride) during the measurement year.

Measure	Comments	More Tips
RDM **Race / Ethnicity Diversity of Membership** An unduplicated count and percentage of members enrolled any time during the measurement year, by race and ethnicity. Report the number of members for whom data have been collected from each data source for race and ethnicity.	Reporting categories for race: • White • Black or African American • American Indian or Alaska Native • Asian • Native Hawaiian or Other Pacific Islander • Some Other Race • Two or More Races • Asked but No Answer • Unknown Reporting categories for ethnicity: • Hispanic or Latino • Not Hispanic or Latino • Asked but No Answer • Unknown	Data sources include data collected directly from members (direct data), or data generated indirectly. Direct data includes sources such as, surveys, health risk assessments, disease management registries, and CMS/state databases. Indirect data includes imputation methods such as surname analysis or geo-coding.
SAA **Adherence to Antipsychotic Medications for Individuals With Schizophrenia** Age 18 and older with schizophrenia or schizoaffective disorder: • Should be dispensed and remain on an antipsychotic medication for at least 80% of their treatment period.	The treatment period is the earliest prescription dispensing date for any antipsychotic medication during the year, through the last day of the year.	Members in hospice are excluded. Also excluded are those with dementia, and age 66 and older with both frailty and advanced illness (must be documented).

Measure	Comments	More Tips
SPC ☆ **Statin Therapy for Patients with Cardiovascular Disease** Males ages 21 to 75, and females ages 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 during the measurement year. • **Statin Adherence 80%:** Remained on a **high or moderate intensity** statin for at least 80% of the treatment period. Treatment period is the earliest prescription date for a high or moderate intensity statin, through the last day of the year.	Noncompliant with statin members can be **excluded** if they have a side effect of: • Myalgia, myositis, myopathy, or rhabdomyolysis. **IMPORTANT**: **Physicians**: If your patient cannot tolerate a statin due to one of the above, please document the diagnosis on a visit claim during the **current year**. This includes if patient had side effects from a statin in the past. **Please re-document the side effect diagnosis each year in a visit claim if patient is not on a statin.**	Other exclusions in addition to myalgia include: • End Stage Renal Disease (ESRD), cirrhosis, pregnancy, in vitro fertilization, hospice, and age 66 and older with both advanced illness and frailty. Please document the above in a visit claim during the current year if not on a statin. ASCVD includes members with MI, CABG, PCI, other revascularization, or a diagnosis of ischemic vascular disease (IVD) during the year or year prior. **See Appendix 2** for Statin Medications.
SPD ☆ **Statin Therapy for Patients with Diabetes** Ages 40 to 75 with **diabetes**, but **without** clinical atherosclerotic cardiovascular disease (ASCVD), should meet the following criteria: • **Received Statin Therapy:** Dispensed at least one statin of **any intensity** during the measurement year. • **Statin Adherence 80%:** Remained on a statin of **any intensity** for at least 80% of the treatment period. Treatment period is the earliest prescription date for a statin of any intensity, through the last day of the year.	Noncompliant with statin members can also be **excluded** if they have a side effect of: • Myalgia, myositis, myopathy, or rhabdomyolysis. **IMPORTANT**: **Physicians**: If your patient cannot tolerate a statin due to one of the above, please document the diagnosis on a visit claim during the **current year**. This includes if patient had side effects from a statin in the past. **Please re-document the side effect diagnosis each year in a visit claim if patient is not on a statin.**	Exclusion: ASCVD includes: MI inpatient, CABG, PCI, other revascularization, or ischemic vascular disease (IVD) during the year or year prior (removes member with diabetes from SPD population). Other exclusions in addition to ASCVD and myalgia include: • End Stage Renal Disease (ESRD), cirrhosis, pregnancy, in vitro fertilization, hospice, and age 66 and older with both advanced illness and frailty. Please document any of the above in a visit claim during the current year if not on a statin. **See Appendix 2** for Statin Medications.

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 – four rates are reported**). The record where documentation is expected is with the member's Primary Care Physician (PCP). However, if a practitioner other than the PCP manages the member's ongoing care, the health plan may use the medical record kept by that practitioner.	1. **Notification of Inpatient Admission.** Documentation of receipt of notification of inpatient admission on the day of admission through 2 days after the admission (3 total days). 2. **Receipt of Discharge Information.** Documentation of receipt of discharge information on the day of discharge through 2 days after the discharge (3 total days). At a minimum, must include the practitioner responsible for the member's care during the inpatient stay, procedures or treatment provided, diagnoses at discharge, current medication list, test results, and instructions for patient care post-discharge. 3. **Patient Engagement After Inpatient Discharge.** Documentation of patient engagement (e.g., office visits, visits to the home, Telehealth, Telephone) provided within 30 days after discharge. May not occur on date of discharge. 4. **Medication Reconciliation Post-Discharge.** Documentation of medication reconciliation on the date of discharge through 30 days after discharge. Conducted by a prescribing practitioner, Clinical Pharmacist, Physician Assistant, or RN. Patient does not have to be present.	Applies to discharges for acute and non-acute inpatient stays. A Telephone visit may count for the measure. May not use documentation that the member or the member's family notified the PCP or ongoing care provider of the admission or discharge. There must be a time frame or date when the documentation was received. Members in hospice excluded.

Measure	Comments	More Tips
URI **Appropriate Treatment for Upper Respiratory Infection** Age 3 months and older with a diagnosis of upper respiratory infection (URI) should not be dispensed an antibiotic prescription. URIs should be treated symptomatically, and not with an antibiotic.	**URI codes** (please do **not** give antibiotic): • **J00:** Acute nasopharyngitis (common cold) • **J06.0:** Acute laryngopharyngitis • **J06.9:** Acute upper respiratory infection, unspecified Antibiotics filled on or within 3 days of the visit with a diagnosis of URI, count in the measure as non-compliant. Outpatient, Telephone, Telehealth, and ED visits count in the measure (other than those ED visits resulting in an inpatient stay).	**Alternate Codes:** Acceptable with an antibiotic per the measure (**not a complete list**): **H66.90**: Otitis media, unspec. **J01.90:** Acute sinusitis, unspec. **J02.9:** Acute pharyngitis (**perform strep test**) **J03.90**: Acute tonsillitis (**perform strep test**) Also ok to give an antibiotic with an acute bronchitis or bronchiolitis diagnosis if these co-morbid conditions are coded at the visit or up to a year prior (**not** a complete list)**:** • Cancer • COPD • Cystic fibrosis • HIV • Pneumonia • Pulmonary edema • Respiratory failure • TB

Measure	Comments	More Tips
WCC **Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents** Ages 3 to 17 should have an outpatient visit with a PCP or OB/GYN annually, with evidence of the following during the measurement year: • **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, or noting a member with chronic knee pain can run without limping, do not count. *Percentile ranking based on the CDC's BMI-for-age growth charts, indicating relative position of the patient's BMI number among others of the same gender and age. Because BMI norms for youth vary with age and gender, this measure evaluates if BMI percentile is assessed rather than an absolute BMI value.	**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 (6) Weight or obesity counseling Documentation related to a member's "appetite" does not meet criteria for Counseling for Nutrition. Referral to WIC may be used. Services rendered for obesity or eating disorders may be used for both Nutrition & Physical Activity. Telephone visits, e-visits or virtual check-in meet criteria.	**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 (6) Weight or obesity counseling **BMI Percentile**: **ICD-10**: Z68.51-Z68.54 **Nutrition Counseling**: **CPT codes**: 97802-97804 **HCPCS**: G0270-G0271, G0447, S9449, S9452, S9470 **Physical Activity Counseling** **ICD-10**: Z02.5, Z71.82 (Encounter for) **HCPCS**: G0447, S9451

APPENDIX 1:

Antipsychotic Medications

Description	Prescription		
Miscellaneous antipsychotic agents	• Aripiprazole • Asenapine • Brexpiprazole • Cariprazine • Clozapine • Haloperidol	• Iloperidone • Loxapine • Lurisadone • Molindone • Olanzapine • Paliperidone	• Pimozide • Quetiapine • Risperidone • Ziprasidone
Phenothiazine antipsychotics	• Chlorpromazine • Fluphenazine • Perphenazine	• Thioridazine • Trifluoperazine	
Thioxanthenes	• Thiothixene		
Long-acting injections	• Aripiprazole • Aripiprazole lauroxil • Fluphenazine decanoate • Haloperidol decanoate	• Olanzapine • Paliperidone palmitate • Risperidone	

Antipsychotic Combination Medications

Description	Prescription	
Psychotherapeutic combinations	• Fluoxetine-olanzapine	• Perphenazine-amitriptyline

APPENDIX 2:

High, Moderate, & Low Intensity Statin Medications

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

APPENDIX 3: Use of High-Risk Medications in Older Adults

Rate 1: High-Risk Medications

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

Rate 1: High Risk Medications cont'd

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

Rate 1: High-Risk Medications With Days' Supply Criteria

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

Rate 1: High-Risk Medications With Average Daily Dose Criteria

Description	Prescription	Average Daily Dose Criteria
Alpha agonists, central	• Reserpine	>0.1 mg/day
Cardiovascular, other	• Digoxin	>0.125 mg/day
Tertiary TCAs (as single agent or as part of combination products)	• Doxepin	>6 mg/day

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

Drug Class	Prescription	Prescription cont'd
Antipsychotics, first (conventional) and second (atypical) generation	• Aripiprazole • Aripiprazole lauroxil • Asenapine • Brexpiprazole • Cariprazine • Chlorpromazine • Clozapine • Fluphenazine • Haloperidol • Iloperidone • Loxapine • Lurasidone • Molindone	• Olanzapine • Paliperidone • Perphenazine • Pimavanserin • Pimozide • Quetiapine • Risperidone • Thioridazine • Thiothixene • Trifluoperazine • Ziprasidone
Benzodiazepines, long, short and intermediate acting	• Alprazolam • Chlordiazepoxide • Clonazepam • Clorazepate • Diazepam • Estazolam • Flurazepam • Lorazepam	• Midazolam • Oxazepam • Quazepam • Temazepam • Triazolam

APPENDIX 4:

Uncomplicated Low Back Pain – LBP Trigger Codes – Do Not Use these Diagnosis Codes Along With Imaging Within 28 Days

Code	Definition
M47.26	Other spondylosis with radiculopathy, lumbar region
M47.27	Other spondylosis with radiculopathy, lumbosacral region
M47.28	Other spondylosis with radiculopathy, sacral and sacrococcygeal region
M47.816	Spondylosis without myelopathy or radiculopathy, lumbar region
M47.817	Spondylosis without myelopathy or radiculopathy, lumbosacral region
M47.818	Spondylosis without myelopathy or radiculopathy, sacral and sacrococcygeal region
M47.896	Other spondylosis, lumbar region
M47.897	Other spondylosis, lumbosacral region
M47.898	Other spondylosis, sacral and sacrococcygeal region
M48.061	Spinal stenosis, lumbar region without neurogenic claudication
M48.07	Spinal stenosis, lumbosacral region
M48.08	Spinal stenosis, sacral and sacrococcygeal region
M51.16	Intervertebral disc disorders with radiculopathy, lumbar region
M51.17	Intervertebral disc disorders with radiculopathy, lumbosacral region
M51.26	Other intervertebral disc displacement, lumbar region
M51.27	Other intervertebral disc displacement, lumbosacral region
M51.36	Other intervertebral disc degeneration, lumbar region
M51.37	Other intervertebral disc degeneration, lumbosacral region
M51.86	Other intervertebral disc disorders, lumbar region
M51.87	Other intervertebral disc disorders, lumbosacral region
M53.2X6	Spinal instabilities, lumbar region
M53.2X7	Spinal instabilities, lumbosacral region
M53.2X8	Spinal instabilities, sacral and sacrococcygeal region
M53.3	Sacrococcygeal disorders, not elsewhere classified
M53.86	Other specified dorsopathies, lumbar region
M53.87	Other specified dorsopathies, lumbosacral region
M53.88	Other specified dorsopathies, sacral and sacrococcygeal region
M54.16	Radiculopathy, lumbar region

M54.17	Radiculopathy, lumbosacral region
M54.18	Radiculopathy, sacral and sacrococcygeal region
M54.30	Sciatica, unspecified side
M54.31	Sciatica, right side
M54.32	Sciatica, left side
M54.40	Lumbago with sciatica, unspecified side
M54.41	Lumbago with sciatica, right side
M54.42	Lumbago with sciatica, left side
M54.5	Low back pain
M54.50	Low back pain, unspecified
M54.51	Vertebrogenic low back pain
M54.59	Other low back pain
M54.89	Other dorsalgia
M54.9	Dorsalgia, unspecified
M99.03	Segmental and somatic dysfunction of lumbar region
M99.04	Segmental and somatic dysfunction of sacral region
M99.23	Subluxation stenosis of neural canal of lumbar region
M99.33	Osseous stenosis of neural canal of lumbar region
M99.43	Connective tissue stenosis of neural canal of lumbar region
M99.53	Intervertebral disc stenosis of neural canal of lumbar region
M99.63	Osseous and subluxation stenosis of intervertebral foramina of lumbar region
M99.73	Connective tissue and disc stenosis of intervertebral foramina of lumbar region
M99.83	Other biomechanical lesions of lumbar region
M99.84	Other biomechanical lesions of sacral region
S33.100A	Subluxation of unspecified lumbar vertebra, initial encounter
S33.100D	Subluxation of unspecified lumbar vertebra, subsequent encounter
S33.100S	Subluxation of unspecified lumbar vertebra, sequela
S33.110A	Subluxation of L1/L2 lumbar vertebra, initial encounter
S33.110D	Subluxation of L1/L2 lumbar vertebra, subsequent encounter
S33.110S	Subluxation of L1/L2 lumbar vertebra, sequela
S33.120A	Subluxation of L2/L3 lumbar vertebra, initial encounter
S33.120D	Subluxation of L2/L3 lumbar vertebra, subsequent encounter
S33.120S	Subluxation of L2/L3 lumbar vertebra, sequela

S33.130A	Subluxation of L3/L4 lumbar vertebra, initial encounter
S33.130D	Subluxation of L3/L4 lumbar vertebra, subsequent encounter
S33.130S	Subluxation of L3/L4 lumbar vertebra, sequela
S33.140A	Subluxation of L4/L5 lumbar vertebra, initial encounter
S33.140D	Subluxation of L4/L5 lumbar vertebra, subsequent encounter
S33.140S	Subluxation of L4/L5 lumbar vertebra, sequela
S33.5XXA	Sprain of ligaments of lumbar spine, initial encounter
S33.6XXA	Sprain of sacroiliac joint, initial encounter
S33.8XXA	Sprain of other parts of lumbar spine and pelvis, initial encounter
S33.9XXA	Sprain of unspecified parts of lumbar spine and pelvis, initial encounter
S39.002A	Unspecified injury of muscle, fascia and tendon of lower back, initial encounter
S39.002D	Unspecified injury of muscle, fascia and tendon of lower back, subsequent encounter
S39.002S	Unspecified injury of muscle, fascia and tendon of lower back, sequela
S39.012A	Strain of muscle, fascia and tendon of lower back, initial encounter
S39.012D	Strain of muscle, fascia and tendon of lower back, subsequent encounter
S39.012S	Strain of muscle, fascia and tendon of lower back, sequela
S39.092A	Other injury of muscle, fascia and tendon of lower back, initial encounter
S39.092D	Other injury of muscle, fascia and tendon of lower back, subsequent encounter
S39.092S	Other injury of muscle, fascia and tendon of lower back, sequela
S39.82XA	Other specified injuries of lower back, initial encounter
S39.82XD	Other specified injuries of lower back, subsequent encounter
S39.82XS	Other specified injuries of lower back, sequela
S39.92XA	Unspecified injury of lower back, initial encounter
S39.92XD	Unspecified injury of lower back, subsequent encounter
S39.92XS	Unspecified injury of lower back, sequela