2023 Quality Measure Resource Guide

EmblemHealth and ConnectiCare are committed to providing high-quality services for the membership we serve.

This reference guide provides a brief overview of national and state quality measures* that evaluate various domains of preventive, acute, and chronic care. We hope that you find this guide useful for the care of our shared members.

The information contained in this guide was compiled in March 2023 and is subject to change as the sources below update their specifications.

*Measures included in this guide are sourced from National Committee for Quality Assurance (NCQA) **www.ncqa.org/**, Centers for Medicare & Medicaid Services (CMS) https://www.cms.gov/, and New York State Department of Health (NYSDOH) **www.health.ny.gov/**.

NCQA HEDIS specifications and NYS Value Set Directory can be accessed at **www.ncqa.org/hedis/measures/**.

Please confirm with your EmblemHealth or ConnectiCare Network Representative to ensure suggested codes are payable per your specific contract.

Table of Contents

Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA) 1
Adult Immunization Status (AIS) 2
All-Cause Readmission (PCR) 3
Annual Wellness Visit (AWV) 4
Antidepressant Medication Management (AMM) 5
Asthma Medication Ratio (AMR) 6
Blood Sugar Control for Patients with Diabetes (HBD) 7
Breast Cancer Screening (BCS) 8
Care for Older Adults (COA) 9
Cervical Cancer Screening (CCS) 10
Child and Adolescent Well-Care Visits (WCV) 11
Childhood Immunization Status (CIS) 12
Chlamydia Screening (CHL) 13
Colorectal Cancer Screening (COL) 14
Controlling High Blood Pressure (CBP) 15
COVID-19 Immunization Status (CVS) 16
Depression Screening and Follow-Up for Adolescents and Adults (DSF-E) 17
Developmental Screening in First 3 years 18
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) 19
Eye Exam for Patient with Diabetes (EED) 20
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) 21
Follow-up After Emergency Department Visit for Mental Illness (FUM) 22
Follow-Up After Emergency Department (ED) Visit for People with Multiple High-Risk Chronic Conditions (FMC) 23
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI) 24
Follow-Up After Hospitalization for Mental Illness (FUH) 25
Follow-Up Care for Children Prescribed ADHD Medication (ADD) 26
Improving Member Satisfaction 27
Immunizations for Adolescents (IMA) 28
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET) 29
Initiation of Pharmacotherapy Upon New Episode of Opioid Dependence (POD-N) 30
Kidney Health Evaluation for Patients with Diabetes (KED) 31
Lead Screening in Children (LSC) 32
Medication Adherence Cholesterol 33
Medication Adherence Diabetes 34
Medication Adherence Hypertension 35
Member Satisfaction with Provider Survey 36
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) 37
Oral Evaluation, Dental Services (OED) 38
Osteoporosis Management in Women Who Had a Fracture (OMW) 39
Prenatal and Postpartum Care (PPC) 40
Prenatal Immunization Status (PRS-E) 41
Social Need Screening and Intervention (SNS-E) 42
Statin Therapy for Patients with Cardiovascular Disease (SPC) 43
Statin Use in Persons with Diabetes (SUPD) 44
Topical Fluoride for Children (TFC) 45
Transitions of Care — Medication Reconciliation Post Discharge (TRC) 46
Transitions of Care — Patient Engagement Post Inpatient 47
Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease (COPD) (SPR) 48
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) 49
Well-Child Visits in the First 30 Months of Life (W30) 50

Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)

Description

The percentage of patients 18 years of age and older during the measurement year with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.

Numerator/Denominator

Numerator: Patients in the denominator who remain on their prescribed antipsychotic medications for 80% of their treatment period.

Denominator: Patients diagnosed with schizophrenia or schizoaffective disorder during the measurement year.

Codes/Medications for Compliance

Applicable Codes	EmblemHealth and ConnectiCare use medication National Drug Codes (NDCs) from pharmacy data and HCPCS codes to calculate the rates.
Eligible Medications	**Miscellaneous oral medications** Aripiprazole, Lurasidone Asenapine, Molindone Brexpiprazole, Olanzapine Cariprazine, Paliperidone Clozapine, Quetiapine Haloperidol, Risperidone Iloperidone, Ziprasidone Loxapine, Lumateperone **Phenothiazine antipsychotics (oral)** Chlorpromazine, Prochlorperazine Fluphenazine, Thioridazine Perphenazine, Trifluoperazine **Psychotherapeutic oral combos** Amitriptyline-perphenazine Thioxanthenes (oral) Thiothixene **Long-Acting Injections** Risperidoe Aripiprazoe Fluphenaz decanoate Haloperidol decanoate Olanzapine Paliperidone palmitate

Exclusion Criteria:

- Diagnosis of dementia.
- Patients receiving hospice or palliative care at any time during the measurement year.
- Patient did not have at least two antipsychotic mediation dispensing events.
- Patients 66 years of age or older are either enrolled in an institutional special needs plan (I-SNP) or is living long-term in an institution.
- Patients age 66-80 years of age with frailty AND advanced illness.
- Patients 81 years of age and older with a diagnosis of frailty.

Documentation Requirements

- Compliance can only be achieved through prescription drug event (PDE) and medical claims data.

Telehealth

Telehealth is not sufficient for compliance.

Helpful Tips

- Educate on the importance of medication adherence and common side effects.
- Routinely arrange follow-up visits before the patient leaves the office.
- Refer to a behavioral health specialist if appropriate.
- Consider prescribing a 90-day supply.

Adult Immunization Status (AIS)

The percentage of members 19 years of age and older who are up to date on routine vaccines.

Numerator/Denominator

Numerator one — Immunization Status: Influenza: Members who received an influenza vaccine on or between July 1 of the year prior to the measurement period and June 30 of the measurement period, or members with anaphylaxis due to the influenza vaccine any time before or during the measurement period.

Numerator two — Immunization Status: Td/Tdap: Members who received at least one Td vaccine or one Tdap vaccine between nine years prior to the start of the measurement period and the end of the measurement period, or members with a history or contraindications of anaphylaxis or encephalitis due to the vaccine.

Numerator three — Immunization Status: Zoster: Members who received at least one dose of the herpes zoster live vaccine or two doses of the herpes zoster recombinant vaccine at least 28 days apart, any time on or after the member's 50th birthday and before or during the measurement period, or members with anaphylaxis due to the herpes zoster vaccine any time before or during the measurement period.

Numerator four — Immunization Status: Pneumococcal: Members who were administered at least one dose of an adult pneumococcal vaccine on or after the member's 19th birthday and before or during the measurement period, or members with anaphylaxis due to the pneumococcal vaccine any time before or during the measurement period.

Denominator: Members 19 years of age and older

Exclusion Criteria: Members in hospice or using hospice services any time during the measurement period.

Documentation Requirements

Vaccine administered or anaphylaxis/encephalitis; include date or vaccine administration or onset.

Telehealth

Not sufficient for this measure.

Codes for Compliance

Applicable Codes	
Adult Influenza Immunization: CVX 88, 135, 140, 141, 144, 150, 153, 155, 158, 166, 168, 171, 185, 186, 197, 205 **Adult Influenza Vaccine Procedure:** CPT 90630, 90653, 60654, 90656, 90658, 90661, 90662, 90673, 90674, 90682, 90686, 90688, 90689, 90694, 90756 **Influenza Virus LAIV Immunization:** CVX 111, 149 **Influenza Virus LAIV Vaccine Procedure:** CPT 90660, 90672 **Adult Pneumococcal Immunization:** CVX 33, 109, 133, 152, 215, 216 **Adult Pneumococcal Vaccine Procedure:** CPT 90670, 90671, 90677, 90732 HCPCS G0009 **Herpes Zoster Live Immunization:** CVX 121 **Herpes Zoster Live Vaccine Procedure:** CPT 90736	**Herpes Zoster Recombinant Immunization:** CVX 187 **Herpes Zoster Recombinant Vaccine Procedure:** CPT 90750 **Td Immunization:** CVX 09, 113 115 138 139 **Td Vaccine Procedure:** CPT 90714, 90718 **Tdap Immunization:** CVX 115 **Tdap Vaccine Procedure:** CPT 90715 **Anaphylaxis Due to Diphtheria, Tetanus or Pertussis Vaccine:** SNOMED CT US 428281000124107, 428291000124105 **Anaphylaxis Due to Herpes Zoster Vaccine:** SNOMED US CT 471371000124107, 471381000124105 **Encephalitis Due to Diphtheria, Tetanus or Pertussis Vaccine:** SNOMED CT US 192710009, 192711008, 192712001

Helpful Tips

- Assess vaccination status of patients at all visits and recommend vaccines that the patients need.
- Share tailored reasons why the vaccine is right for the patient and address patient concerns.
- Participate in your State immunization registry. For tips, visit Standards for Adult Immunization Practices | CDC.

All-Cause Readmission (PCR)

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

Numerator/Denominator

Numerator: Patients in the denominator with an acute inpatient or observation stay followed by an unplanned acute inpatient or observation readmission for any diagnosis within 30 days after discharge. Lower or no readmission rates demonstrate the better measure/preferred outcomes.

Denominator: Patients 18 years of age and older with an acute inpatient or observation stay with a discharge on or between Jan. 1 and Dec. 1 of the measurement year.

Exclusion Criteria:

- Died during the stay.
- Received hospice care at any time during the measurement period.
- Have a primary diagnosis of pregnancy.
- Had a primary diagnosis of a condition that originated in the perinatal period.

Additional Measure Information

Post-discharge planning and care coordination are essential in preventing unplanned readmissions. This measure is based on discharge events.

Telehealth

Medication reconciliation may be done over the phone.

Helpful Tips

- Document medication reconciliation (discharge medications reconciled with current medication list) in the member's medical record.
- Identify high utilizers and populations at risk.
- Partner with facility to improve care coordination upon discharge.
- Keep open appointments so patients can be seen promptly upon discharge.
- Work with patients and caregivers to ensure they understand discharge care plan, including their new medication regimen.
- Obtain hospital discharge summary and use to schedule post-discharge appointments.
- Contact patients within three days of discharge.
- Refer to Care Management if high risk patient and need coordination of care. For more information and/or for your referrals, call EmblemHealth's Care Management department at **800-447-0768** (TTY: **711**), or ConnectiCare's Case Managament department at **800-829-0696** (TTY: **711**), Monday through Friday, 9 a.m. to 5 p.m., or visit **emblemhealth.com/connectwithcaremanagement** or **connecticare.com/providers/resources/news/refer-patients-to-our-care-management-team**.

Annual Wellness Visit (AWV)

The percentage of patients ages 18 and older who had an annual physical exam in the measurement year.

Numerator/Denominator

Numerator: Patients in the denominator who had an annual wellness exam in the measurement year.

Denominator: Patients ages 18 and older.

Additional Measure Information

Visit includes:

- Physical assessment
- Physical exam
- Laboratory tests
- Immunizations
- Preventive screening
- Referrals
- Counseling

Codes/Medications for Compliance

Applicable Codes
Well Visit: HCPCS code of: • G0438 (Initial Medicare preventative visit) • G0439 (Subsequent annual wellness visit) • G0468 • G0402

Applicable Codes
Annual Physical Exam: CPT codes: • 99381-99387 • 99391-99397 • 99402-99404

Documentation Requirements

- For Medicare, when billing an annual wellness visit and annual physical exam on the same day, use a modifier code of 25 for the annual physical exam.

Telehealth

Telehealth can be used for compliance.

Helpful Tips

- Send reminders prior to the scheduled appointment date.
- Consider expanding early morning, evening, and weekend hours.
- Provide patient education regarding the importance of preventive health visits and completing the annual wellness visit.
- Utilize visit to address behavioral health needs and social determinants of health.
- Visits can be done annually based on calendar year in conjunction with an annual physical exam.
- Telehealth resources may be utilized to reach patients unable to schedule an in- office appointment. See the EmblemHealth and ConnectiCare Quality Measures and Risk Adjustment Telehealth Tip Sheet at **emblemhealth.com/providers/clinical-corner/quality** and **connecticare.com/providers/resources/clinical-information/quality-improvement** for more information (scroll to bottom of page, under Telehealth).
- Review office workflow to ensure time efficiencies.
- Offer block scheduling and/or AWV-specific appointment days.
- Provide patient education and resources regarding management of health conditions.

Antidepressant Medication Management (AMM)

Description

The percentage of patients 18 years of age and older who were treated with antidepressant medication, had a diagnosis or major depression, and who remained on an antidepressant medication treatment.

Numerator/Denominator

Numerator:

Acute Phase: The percentage of patients who remained on an antidepressant medication for at least 84 days (12 weeks).

Continuation Phase: The percentage of patients who remained on an antidepressant medication for at least 180 days (6 months).

Denominator: Patients 18 years of age and older who were treated with antidepressant medication and had a diagnosis of major depression.

Codes/Medications for Compliance

Applicable Codes	EmblemHealth and ConnectiCare use medication National Drug Codes (NDCs) from pharmacy data to calculate the rates.	
Eligible Medications	Bupropion Vortioxetine Phenelzine Tranylcypromine Trazodone Amitriptyline-perphenazine Desvenlafaxine Levomilnacipran Citalopram Fluoxetine Paroxetine Maprotiline Amitriptyline Clomipramine Doxepin (>6 mg) Nortriptyline Trimipramine	Vilazodone Isocarboxazid Selegiline Nefazodone Amitriptyline-chlordiazepoxide Fluoxetine-olanzapine Duloxetine Venlafaxine Escitalopram Fluvoxamine Sertraline Mirtazapine Amoxapine Desipramine Imipramine Protriptyline

Exclusion Criteria:

- Patients who did not have an encounter with a diagnosis of major depression during the 121-day period from 60 days prior to the Index Prescription Start Date (IPSD) through the IPSD and 60 days thereafter.
- Patients receiving hospice or palliative care at any time during the measurement year.

Documentation Requirements

- Compliance can only be achieved through prescription drug event (PDE) data. Claims that are filled through pharmacy discount programs will not result in compliance and patients may pay more for their medication than if they used their prescription drug coverage. Only final action PDE claims are used to calculate this measure.

Telehealth

Telehealth is not sufficient for compliance.

Helpful Tips

- Educate patients on medication options benefits and side effects.
- Discuss the importance of continuing medication as prescribed and the risks of stopping medication.
- Consider prescribing a 90-day supply when appropriate.
- Schedule follow-up visits to check progress, reassess symptoms and side effects, and adjust the type or dose of medication if needed.
- Refer to specialist if appropriate.
- Monitor medication prescriptions and do not allow the total gap days to be more than 31 days during the acute phase and 52 days during the continuation phase.

Asthma Medication Ratio (AMR)

Description

The percentage of patients ages 5-64 with persistent asthma who had a ratio of controller medications to total asthma medications of 50% or greater during the measurement year.

Numerator/Denominator

Numerator: Patients in the denominator who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 50% or greater during the measurement year.

Denominator: Patients ages 5-64 who have persistent asthma during both the measurement year and the year prior.

Additional Measure Information

Members are identified as having persistent asthma by one of the following ways:

- At least one ED visit with a principle diagnosis of asthma
- At least one inpatient encounter with a principle diagnosis of asthma
- At least one acute inpatient discharge with a principle diagnosis of asthma on the discharge claim
- At least four outpatient visits (including telephone, e-visit, or virtual check-ins with a principle diagnosis of asthma AND at least two asthma medication dispensing events.
- At least four asthma medication dispensing events for any controller or reliever medication.

Codes/Medications for Compliance

Applicable Codes	EmblemHealth and ConnectiCare use medication National Drug Codes (NDCs) from pharmacy data to calculate the rates.

Asthma Controller Medications		
Description	**Prescription**	**Route**
Antibody inhibitors	Omalizumab	Injection
Anti-interleukin-4	Dupilumab	Injection
Anti-interleukin-5	Benralizumab	Injection
Anti-interleukin-5	Mepolizumab	Injection
Anti-interleukin-5	Reslizumab	Injection
Inhaled steroid combinations	Budesonide-formoterol	Inhalation
Inhaled steroid combinations	Fluticasone-salmeterol	Inhalation
Inhaled steroid combinations	Fluticasone-vilanterol	Inhalation
Inhaled steroid combinations	Formoterol-mometasone	Inhalation
Inhaled corticosteroids	Beclomethasone	Inhalation
Inhaled corticosteroids	Budesonide	Inhalation
Inhaled corticosteroids	Ciclesonide	Inhalation
Inhaled corticosteroids	Flunisolide	Inhalation
Inhaled corticosteroids	Fluticasone	Inhalation
Inhaled corticosteroids	Mometasone	Inhalation
Leukotriene modifiers	Montelukast	Oral
Leukotriene modifiers	Zafirlukast	Oral
Leukotriene modifiers	Zileuton	Oral
Methylxanthines	Theophylline	Oral

Asthma Reliever Medications		
Description	**Prescription**	**Route**
Short-acting, inhaled beta-2 agonists	Albuterol	Inhalation
Short-acting, inhaled beta-2 agonists	Levalbuterol	Inhalation

Exclusion Criteria:

- Certain patients are excluded, e.g., if they have emphysema, COPD, cystic fibrosis, acute respiratory failure.
- Patients receiving hospice or palliative care at any time during the measurement year.

Documentation Requirements

Compliance can only be achieved through prescription drug event (PDE) and medical claims data.

Telehealth

Telehealth visits can be used to review, document, and prescribe medication, when appropriate.

Helpful Tips

- Emphasize the important role of controller medications in managing symptoms.
- Create an asthma action plan. Train patients on inhaler technique and encourage use of asthma spacers and peak flow meters.
- Consider prescribing a 90-day supply when appropriate and educate patients on pharmacy auto-refill program.
- Identify and resolve patient-specific adherence barriers (cost, refills, side effects).
- Consider more frequent visits until the patient is compliant.
- Ensure the patient is using controller medication more than half of the time to control their asthma.

Blood Sugar Control for Patients with Diabetes (HBD)

The percentage of patients 18-75 years of age with diabetes (types 1 and 2) whose hemoglobin A1c (HbA1c) was at the following levels during the measurement year:

HbA1c control (<=9.0%)

EmblemHealth and ConnectiCare are focused on driving the improvement of health disparities for this measure for the African American population and, therefore, has included a separate measure specific to this race.

Numerator/Denominator

Numerator: HbA1c control: Patients in the denominator who have an HbA1c level <=9.0% in the measurement year (most recent HbA1c level is used).

Denominator: Members between ages 18-75 who have diabetes, as evidenced by one acute inpatient encounter or two outpatient encounters or were dispensed insulin or hypoglycemics/ antihyperglycemics in the measurement year or year prior.

Exclusion Criteria:

- Patients receiving hospice or palliative care at any time during the measurement year.
- Members ages 66 and older as of Dec. 31 of the measurement year who meet both frailty and advanced illness criteria.
- Patients with a diagnosis of polycystic ovarian syndrome, gestational diabetes, or steroid-induced diabetes.

Codes/Medications for Compliance

Applicable Codes
HbA1c Lab Test: CPT: 83036, 83037 **HbA1c Test Results: CPT II:** • 3044F Most recent HbA1c level less than 7.0% • 3051F Most recent HbA1c level greater than or equal to 7.0% and less than 8.0% • 3052F Most recent HbA1c level greater than or equal to 8.0% and less than or equal to 9.0%

Documentation Requirements

Documentation must include screening results and date of service when the HbA1c test was performed. The most recent result is the ONLY result that is used to determine compliance. If the HbA1c result is >9.0 or missing the member will not be compliant for this measure.

Telehealth

Telehealth is not sufficient to complete screening, but documentation in telehealth visit of prior screening will count for compliance. Collect and document history of diabetes care.

Helpful Tips

- Identify early in the year who may need A1c testing. Frequency of visits should depend on level of A1c control. Members with elevated A1c levels need to be seen more frequently
- Emphasize importance of medication and insulin adherence in managing blood glucose.
- Adjust therapies to improve levels and recommend follow-up visits to monitor results.
- Create a diabetes checklist in your EMR/patient chart to monitor if patients are up to date with recommended screenings.
- The date of the latest A1c of the added "measurement" should be submitted (CPT and CPT II codes).

Breast Cancer Screening (BCS)

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

Numerator/Denominator

Numerator: Patients in the denominator who have had one or more mammograms between Oct. 1 two years prior to the measurement year and Dec. 31 of the measurement year.

Denominator: Women ages 50-74.

Exclusion Criteria:

- Patients with bilateral mastectomy.
- Patients receiving hospice or palliative care at any time during the measurement year.
- Do not count MRIs, ultrasounds, or biopsies toward the numerator. Although these procedures may be indicated for evaluating women at higher risk for breast cancer or for diagnostic purposes, they are performed as an adjunct to mammography and do not alone count toward the numerator.

Codes/Medications for Compliance

Codes
CPT: 77061-77063, 77065-77067
Exclusion Codes
Z90.13, All palliative care codes

Documentation Requirements

Date of screening and results in medical record. If patient is not sure on exact date, document closest possible timeframe (i.e., month/year).

Telehealth

CPT 98966, 98967, 98968, 99441, 99442, 99443: Telehealth not sufficient to complete screening; only to review and document history of screenings.

Helpful Tips

- Highlight the importance of early detection.
- Discuss common fears about testing. Inform them that currently available testing methods are less uncomfortable and require less radiation.
- Place a reminder in the patient's chart for when the next screening is due.
- Create "Standing Order" for ease of access.
- Share list of mammogram facilities with the patient.

Care for Older Adults (COA)

Description

The percentage of patients 66 years of age and older who had the following during the measurement year:

- One medication review conducted by a prescribing provider or clinical pharmacist and the presence of a medication list in the medical record.
- One pain assessment.
- One functional status assessment.

Numerator/Denominator

Numerator: Number of patients 66 years of age and older that received one medication review, pain assessment, and functional status assessment during the measurement year.

Denominator: Number of patients 66 years of age and older.

Codes/Medications for Compliance

Applicable Codes	
	Medication List CPTII: 1159F **HCPCS:** G8427 **Medication Review CPT:** 90863, 99483, 99605, 99606 **CPTII:** 1160F **Transitional Care Management CPT:** 99495, 99496 **Functional Status Assessment CPT:** 99483 **CPTII:** 1170F **HCPCS:** G0438, G0439 **Pain Assessment: CPT II:** 1125F, 1126F

Exclusion Criteria:

- Patients receiving hospice or palliative care at any time during the measurement year.
- Services rendered in an acute inpatient setting.

Documentation Requirements

Medication Review code and Medication List code both must be present for numerator compliance.

Telehealth

Telehealth can be used for compliance.

Helpful Tips

- Patient is not required to be present for medication review.
- Medication review must be completed by a prescribing practitioner or clinical pharmacist.
- Pain assessment may include positive or negative finding for pain.
- May use standardized assessment tools for pain and functional status assessments.
- Components of the functional status assessment may take place during separate visits within the measurement year.
- Take every opportunity to complete assessments when the patient is in the office for any visit type.

Cervical Cancer Screening (CCS)

The percentage of women 21-64 years of age who had an appropriate screening for cervical cancer in the required time frame.

Numerator/Denominator

Numerator: Patients in the denominator who have had one or more cervical cancer screenings in the time frame (depends on age).

Denominator: Women 21-64 years of age.

Exclusion Criteria:

- Patients with hysterectomy with no residual cervix, cervical agenesis, or acquired absence of the cervix.
- Patients receiving hospice or palliative care at any time during the measurement year.
- Patients in hospice.

Codes/Medications for Compliance

Applicable Codes
Cervical Cytology: **CPT:** 88141-88143, 88147, 88148, 88150, 88152-88154, 88164-88167, 88174, 88175 **HCPCS:** G0123, G0124, G0141, G0143, G0144, G0147, G0148, P3000, P3001, Q0091 **HPV Test:** **CPT:** 87620, 87621, 87622, 87624, 87625 **HCPCS:** G0476
Exclusion Codes
Z90.710, Z90.712, palliative care codes, hospice codes

Additional Measure Information

- **Women 21-64 years of age:** cervical cytology during the current year or two years prior to the current year (every three years).
- **Women 30-64 years of age:** who had cervical high-risk human papillomavirus (hrHPV) testing performed during the current year or four years prior to the current year (every five years).
- **Women 30-64 years of age:** cervical cytology/HPV co-testing during the current year or four years prior to the current year (every five years).

Documentation Requirements

Date cervical cytology was performed.
Result or finding.

Telehealth

Telehealth not sufficient to complete screening; only to review and document history of screenings.

Helpful Tips

- Highlight the importance of early detection, review barriers and stress importance of yearly screening.
- Place a reminder in the patient's chart for when the next screening is due.
- Conduct test at other visits, e.g., sick visits if opportunity presents.
- If patient has had hysterectomy, document, and code for this condition.
- Flag charts of patients after screening is performed to ensure timely follow-up of results and data capture for compliance.
- Refer patients to OBGYN as applicable.

Child and Adolescent Well-Care Visits (WCV)

The percentage of members ages 3-21 who had at least one comprehensive well-care visit with a primary care provider (PCP) or OB/GYN provider during the measurement year.

EmblemHealth and ConnectiCare are focused on driving the improvement of health disparities for this measure for the African American population and therefore has included a separate measure specific to this race.

Numerator/Denominator

Numerator: Patients in the denominator with one or more well-care visits with a PCP or OB/GYN during the measurement year.

Denominator: Patients aged 3-21 as of Dec. 31 of the measurement year.

Exclusion Criteria:

Patients receiving hospice or palliative care at any time during the measurement year.

Codes/Medications for Compliance

Applicable Codes
Well-Care Visit • **CPT:** 99381-99385, 99391-99395, 99461 • **HCPCS:** G0438, G0439, S0302 • **ICD-10:** Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.2, Z00.3, Z02.5, Z76.1, Z76.2

Telehealth

Telehealth can be used for compliance. (Appropriate CPT needs to be submitted with GT modifier.)

Documentation Requirements

- Well-child visits must occur with PCP but does not have to be the PCP assigned.
- This measure is based on the American Academy of Pediatrics Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents (published by the National Center for Education in Maternal and Child Health). Visit the Bright Futures website for more information about well-child visits (**brightfutures.aap.org/materials-and-tools/guidelines-and-pocket-guide/Pages/default.aspx**).

Helpful Tips

- Conduct or schedule well-care visits when patients present for illnesses, or other events. Add modifier for separate and distinct services.
- Document all the required elements of a well-child visit.
- Pre-schedule the next well-visit before the patient leaves the office. Relay the importance of returning even if the child is doing fine.
- Provide health education/anticipatory guidance.
- Take an opportunity to check and administer vaccines that are due at every visit.

Childhood Immunization Status (CIS)

The percentage of children who have received all recommended vaccines by their second birthday.

Numerator/Denominator

Numerator: Patients in the denominator who have had the following vaccines by their second birthday:

- 4 diphtheria/tetanus/acellular pertussis (DTaP) vaccines.
- Three polio (IPV) vaccines.
- One measles/mumps/rubella (MMR) vaccine†
- Three haemophilus influenza type B (HiB) vaccine.s
- Three hepatitis B (HepB) vaccines.
- One chicken pox (VZV) vaccine.†
- Four pneumococcal conjugate (PCV) vaccines.

†Must occur between the child's first and second birthday.

Denominator: Patients turning age two during the measurement year.

Exclusion Criteria:

- Patients using hospice services any time during the measurement year.
- Patients who had a severe combined immunodeficiency, severe disorder of the immune system, HIV, malignant neoplasm of lymphatic tissue, or intussusception on or before their second birthday.

Codes/Medications for Compliance

Applicable Codes
• **DTaP: CPT:** 90698, 90700, 90723 • **IPV: CPT:** 90698, 90713, 90723 • **MMR: CPT:** 90707, 90710 • **HIB: CPT:** 90644, 90647, 90648, 90698, 90748 • **Hep B: CPT:** 90723, 90740, 90744, 90747, 90748; • **HCPCS:** G0010 • **VZV: CPT:** 90710, 90716 • **Pneumococcal: CPT: 90670; HCPCS: G0009**

Documentation Requirements

- Collect and document history of immunizations. Documentation must include vaccine name and date administered.
- Children who had a contraindication for a specific vaccine (e.g.,anaphylactic reaction, immunodeficiency) are excluded.

Telehealth

Telehealth not sufficient to complete immunizations.

Helpful Tips

- Begin vaccination conversations as early as prenatal appointments.
- Present vaccination as the default option, presuming parents will immunize.
- Provide parents with records of their children's immunizations and ask them to bring the record to each visit.
- Schedule the next appointment at time of checkout and use every office visit as an opportunity to vaccinate.

Chlamydia Screening (CHL)

The percentage of women ages 16-24 who were identified as sexually active and who had at least one test for chlamydia during the current year.

Numerator/Denominator

Numerator: Patients in the denominator who have had a chlamydia screening in the measurement year.

Denominator: Women 16-24 years of age identified as sexually active.

Exclusion Criteria:

- Patients receiving hospice or palliative care at any time during the measurement year.
- Patients who qualified for the denominator based on a pregnancy test alone and who meet either of the following: pregnancy test and a prescription for Isotretinoin, or pregnancy test and an x-ray on the date of pregnancy test or six days after.

Codes/Medications for Compliance

Applicable Codes
Chlamydia Culture • **CPT:** 87110, 87270, 87320, 87490-87492, 87810, 87491, 87492, 87810
Exclusion Codes
All Hospice codes **CPT:** 81025, 84702, 84703 Diagnostic Radiology
Medications (as applicable)
If a member is on birth control, then they are included in the measure denominator.

Additional Measure Information

Women are identified as sexually active through claims/encounter and pharmacy data.

Documentation Requirements

Date of test and results.

Telehealth

Telehealth not sufficient to complete screening, only to review and document history of screenings.

Helpful Tips

- Discuss safe sex practices and sexually transmitted diseases with patients.
- Highlight the importance of early detection.
- Review/confirm all preventive health screenings at each visit.
- Consider universal urine screening approach as a method to help prevent gaps in test and unidentified sexually active women.
- Consider incorporating chlamydia test into normal process when completing a pap test.

Colorectal Cancer Screening (COL)

The percentage of Members ages 45-75 who have had an appropriate screening for colorectal cancer in required time frame (depends on screening type).

Numerator/Denominator

Numerator: Members in the denominator with colorectal cancer screening in required time frame (varies by type of screening).

Appropriate screenings for colorectal cancer:

- Fecal occult blood test (FOBT) during the measurement year
- Flexible sigmoidoscopy: current year or four years prior to the measurement year (five years).
- Colonoscopy: current year or nine years prior to the measurement year (10 years).
- CT colonography: current year or four years prior to the measurement year (five years).
- FIT-DNA: current year or two years prior to the measurement year (three years).

Denominator: Members between ages 45-75.

Exclusion Criteria:

- Patients with evidence of colorectal cancer or total colectomy.
- Patients receiving palliative or hospice care are not included in the measure.

Codes/Medications for Compliance

Applicable Codes
Colonoscopy: CPT: 44388-44394, 44397, 44401-44408, 45355, 45378-45393, 45398 HCPCS: G0105, G0121 ICD9: 45.22, 45.23, 45.25, 45.42, 45.43

Applicable Codes
FOBT: CPT: 82270, 82274; HCPCS: G0328
Stool DNA (FIT): CPT: 81528
CT Colonography: CPT: 74261-74263
Flexible Sigmoidoscopy: CPT: 45330-45335, 45337-45338, 45340- 45342, 45346-45347, 45349-45350 HCPCS: G0104; **ICD9: 45.24**

Documentation Requirements

- Report that indicates type of screening (test name), the date the screening was performed, and result.
- Member-reported colorectal cancer screenings are acceptable if the screening is documented in the patient's medical history.

Telehealth

Telehealth not sufficient to complete screening. Collect and document history of screenings

Helpful Tips

- Ensure that the patient's history is updated annually regarding prior colorectal cancer screening test(s).
- Discuss all options for screening, including FOBT and Stool DNA, for patients who may not want colonoscopy.
- Provide order for testing.
- Highlight the importance of early detection.
- Review/confirm all preventive health screenings at each visit.
- Place a reminder in the patient's chart for when the next screening is due.

Controlling High Blood Pressure (CBP)

The percentage of patients ages 18-85 diagnosed with hypertension whose blood pressure was adequately controlled (<140/90 mm Hg) during the measurement year.

Numerator/Denominator

Numerator: Patients in the denominator with a blood pressure reading of <140/90 Hg during the measurement year.

Denominator: Patients ages 18-85 diagnosed with hypertension at two or more visits between January 1 of the year prior to the measurement year and June 30 of the measurement year.

Exclusion Criteria:

Patients receiving hospice or palliative care at any time during the measurement year.

Codes/Medications for Compliance

Applicable Codes
Diastolic Blood Pressure: CPT II:
3078F - blood pressure less than 80 mmHg
3079F - blood pressure 80-89 mmHg
Systolic Blood Pressure: CPT II:
3074F - blood pressure less than 130 mmHg
3075F - blood pressure 130-139 mmHg

Additional Measure Information

Blood pressure readings that are member-reported and/or taken with remote digital monitoring device are reportable.

Documentation Requirements

- Utilize the most recent blood pressure (BP) reading during the measurement year, which must be taken on or after second diagnosis of hypertension

Telehealth

Telehealth can be used for compliance.

Helpful Tips

- If blood pressure reading is high when the patient arrives, re-check at the end of the visit.
- If patient is hypertensive during visit, review medication history and consider modifying treatment plan.
- Schedule a follow-up visit once treatment plan has been initiated.
- Record exact systolic and diastolic values; do not round a result.
- Review diet, medications, exercise regimen, and treatment adherence with the patient at each visit
- Conduct outreach to patients with hypertension who have not had a follow-up appointment.
- Partner with patients to help identify any barriers to effective management.
- Connect patients with care coordinators or other practice staff for available resources.
- Encourage patients to use the mail order pharmacy service to save on the cost of medications.
- Prescribe a digital device for these members and discuss how self-monitoring at home may help them lower their blood pressure.
- Members can report their blood pressure verbally during a telehealth (telephone, e-visit, virtual) or office visit and that will help close the gap.
- Encourage members with hypertension to self-monitor with a covered device.

COVID-19 Immunization Status (CVS)

The percentage of members ages 6 months and older who have received the primary series of the COVID-19 vaccine. Percentage of members ages five years and older who have received the primary series of the COVID-19 vaccine and a booster.

Numerator/Denominator

Numerator one - Fully Vaccinated:

- Members ages 5 to 64 in the denominator who received either one dose of the Janssen COVID-19 Vaccine or two doses of the Moderna, Pfizer, AstraZeneca, or Novavax COVID-19 Vaccine any time on or between Dec. 1, 2020, and Dec. 31, 2023.
- Members ages 6 months to 4 years in the denominator who have received three doses of the Pfizer vaccine any time or in between Dec. 1, 2020 – Dec. 31, 2023, or two doses of the Moderna vaccine any time or in between Dec. 1, 2020 – Dec. 31, 2023.

Numerator two - Fully Vaccinated with Booster:

- Members in the denominator who received either one dose of the Janssen COVID-19 Vaccine or two doses of the Moderna, Pfizer, or Novavax COVID-19 Vaccine any time on or between Dec. 1, 2020, and Dec. 31, 2023, and a booster dose of either the Janssen, Moderna, or Pfizer Vaccine.
- Note: members aged 6 months to 4 years, based on the member age on Jan. 1, 2023, are not included in the denominator for numerator two.

Denominator: Members ages six months and older

Documentation Requirements

See DOH QARR Specifications for more information: 2023 Quality Assurance Reporting Requirements Technical Specifications (**ny.gov**)

Codes for Compliance

Applicable Codes							
Numerator one				**Numerator two**			
CPT Code	**Administration Codes**	**Patient Age**	**Manufacturer**	**CPT Code**	**Administration Codes**	**Patient Age**	**Manufacturer**
91300	0001A (1st Dose) 0002A (2nd Dose)	12 years+	Pfizer	91300	0004A (Booster)	12 years+	Pfizer
91305	0051A (1st Dose) 0052A (2nd Dose)	12 years+	Pfizer	91305	0054A (Booster)	12 years+	Pfizer
91307	0071A (1st Dose) 0072A (2nd Dose)	5-11 years	Pfizer	91307	0074A (Booster)	5-11 years	Pfizer
91308	0081A (1st Dose) 0082A (2nd Dose) 0083A (3rd Dose)	6 months- 4 years	Pfizer	91312	0124A (Booster)	12 years+	Pfizer
91301	0011A (1st Dose) 0012A (2nd Dose)	12 years +	Moderna	91315	0154A (Booster)	5-11 years	Pfizer
91311	0111A (1st Dose) 0112A (2nd Dose)	6 months- 5 years	Moderna	91306	0064A (Booster)	18 years +	Moderna
91309	0091A (1st Dose) 0092A (2nd Dose)	6 months- 11 years	Moderna	91309	0094A (Booster)	18 years +	Moderna
91303	0031A (Single Dose)	18 years +	Janssen	91313	0134A (Booster)	18 years +	Moderna
91304	0041A (1st Dose) 0042A (2nd Dose)	18 years +	Novavax	91314	0144A (Booster)	6-11 years	Moderna
91302	0021A (1st Dose) 0022A (2nd Dose)	18 years +	AstraZeneca	91303	0034A (Booster)	18 years +	Janssen
				91310	0104A (Booster)	18 years +	Sanofi Pasteur

Please reference the following source for the full list of updated codes: https://www.ama-assn.org/system/files/covid-19-immunizations-appendix-q-table.pdf

Helpful Tips

- Assess COVID-19 vaccination status of patients at all visits and recommend vaccination/boosters as needed.
- If you do not have COVID-19 vaccines available, refer patients to another health care provider or pharmacy.
- Share tailored reasons why the vaccine is right for the patient and address patient concerns.

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

Description

The percentage of patients 12 years of age and older who were screened for clinical depression using a standardized instrument and, if screened positive, received follow-up care.

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

Numerator/Denominator

Numerator 1 & 2:

1. Patients with a documented result of a depression screening performed using an age-appropriate standardized instrument between January 1 and December 1 of the Measurement Period.
2. Patients who received follow-up care on or up to 30 days after the date of the first positive screen.

Denominator 1 & 2:

1. Patients 12 years of age and older at the start of the Measurement Period who also meet criteria for Participation.
2. All patients from Numerator 1 with a positive depression screen finding between January 1 and December 1 of the Measurement Period.

Exclusion Criteria:

- Patients with bipolar disorder in the year prior to the measurement period.
- Patients with depression that starts during the year prior to the Measurement Period.
- Patients receiving hospice or palliative care at any time during the measurement year.

Documentation Requirements

- **Numerator 1:** Patients with a documented result of a depression screening performed using an age-appropriate standardized instrument between January 1 and December 1 of the Measurement Period.
- **Numerator 2:** Patients who received follow-up care on or up to 30 days after the date of the first positive screen. Any of the following on or 30 days after the first positive screen: An outpatient, telephone, e-visit, or virtual check-in follow-up visit with a diagnosis of depression or other behavioral health condition. A depression case management encounter that documents assessment for symptoms of depression or a diagnosis of depression or other behavioral health condition. A behavioral health encounter, including assessment, therapy, collaborative care, or medication management. A dispensed antidepressant medication. Documentation of additional depression screening on a full- length instrument indicating either no depression or no symptoms that require follow-up (i.e., a negative screen) on the same day as a positive screen on a brief screening instrument.

Telehealth

- Telehealth can be used for follow-up visit with a diagnosis of depression or other behavioral health condition.

Helpful Tips

- Educate patients regarding the warning signs for depression and advise to seek early treatment.
- Screen patients 12 years of age and older for depression using a standardized instrument and document the result.
- Ensure that patients who screen positive receive follow-up care within 30 days of the positive screen.
- Use web-based platform to capture PHQ-9 results while patient is in waiting room.

Developmental Screening in First 3 years

Description

The percentage of patients between 1-3 years of age screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding or on their 1st, 2nd, or 3rd birthday.

Numerator/ Denominator

Numerator: Patients between the ages of 1-3 in the measurement year who were screened.

Denominator: All patients who turn 1, 2, or 3 years of age between January 1 and December 31 of the performance period.

Codes/Medications for Compliance

Applicable Codes	**CPT:** 96110 **ICD-10:** Z13.42 For more information, please refer to the American Academy of Pediatrics website: **www.aap.org**

Exclusion Criteria: Patients receiving hospice or palliative care at any time during the measurement year.

Documentation Requirements

Documentation must include a standardized developmental screening tool. The following must be included in the patient's medical record: indication of the standardized tool that was used, the date of the screening, and evidence that the tool was completed and scored.

Telehealth

Telehealth can be used for compliance.

Helpful Tips

- Educate parents and/or guardians to monitor for developmental milestones such as: taking a first step, smiling for the first time, waving "bye bye," crawling, walking, etc.
- Educate parents and/or guardians on risk factors for developmental delays that include preterm birth, low birth weight, lead exposure, long-lasting health problems or conditions.
- Advise parents and/or guardians that developmental screening tools will not provide a diagnosis but can assist in determining if a child is developing according to standard developmental milestones.
- Establish a "screening champion" in your office. This is anyone in your practice you designate to advocate for developmental screening with parents and/or guardians of young children.
- Refer the child to the appropriate specialist based on screening tool outcomes for follow-up and a more formal evaluation. These specialists can determine if a child needs more help with development: developmental pediatrician, child psychologist, speech-language pathologist, occupational therapist.

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

Description

The percentage of patients 18-64 years of age with schizophrenia, schizoaffective disorder, or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.

Numerator/Denominator

Numerator: Patients in the denominator who had a glucose test or an HbA1c test performed during the measurement year.

Denominator: Patients 18-64 years of age with schizophrenia, schizoaffective disorder, or bipolar disorder who were dispensed an antipsychotic medication during the measurement year.

Codes/Medications for Compliance

Applicable Codes	**Glucose Lab Test** **CPT:** 80047,80048, 80050, 80053, 80069, 82947, 82950, 82951 **HbA1c Lab Test CPT:** 83036, 83037 **HbA1c Test Results** **CPT II:** 3044F, 3046F, 3051F, 3052F

Exclusion Criteria:

- Patients with diabetes.
- Patients who had no antipsychotic medications dispensed during the measurement year.
- Patients receiving hospice or palliative care at any time during the measurement year.

Telehealth

Telehealth not sufficient for compliance.

Helpful Tips

- Consider drawing blood in the office or writing a lab script at the time the first prescription is written.
- Involve family and other supports to help patient complete blood work.
- Review results of metabolic testing with patients and discuss importance of coordination of care between behavioral health and primary care providers.
- Behavioral health practitioners: order metabolic screening for patients with limited contact with primary care provider.
- Utilize hospital reporting data to capture patients with inpatient stay who had metabolic testing.
- Inform behavioral health practitioners of patients still missing medical testing for further discussion during behavioral health visit.

Eye Exam for Patient with Diabetes (EED)

The percentage of members ages 18-75 with diabetes (type 1 or 2) who had a retinal eye exam.

Numerator/Denominator

Numerator: Members in the denominator who had a retinal or dilated eye exam during the measurement year or a negative retinal eye or dilated eye exam (negative for retinopathy) in the measurement year or year prior.

Denominator: Members between ages 18-75 who have diabetes, as evidenced by one or two acute inpatient encounters, or were dispensed insulin or hypoglycemics/ antihyperglycemics in the measurement year or year prior.

Exclusion Criteria:

- Members who do not have a diagnosis of diabetes.
- Members in hospice or using hospice services any time during the measurement year.
- Members receiving palliative care.

Codes/Medications for Compliance

Applicable Codes
Diabetic Retinal Screening
CPT: 67028, 67030, 67031, 67036, 67039-67043, 67101, 67105, 67107, 67108, 67110, 67113, 67121, 67141, 67145, 67208, 67210, 67218, 67220, 67221, 67227, 67228, 92002, 92004, 92012, 92014, 92018, 92201, 92202, 92019, 92134, 92229 , 92225-92228, 92230, 92235, 92240, 92250, 92260, 99204-99205, 99213, 99215, 99242-99245.
HCPCS: S0620, S0621, S3000
NOTE: These codes must be billed with an eye doctor specialty.

Applicable Codes
Eye Exam with Retinopathy:
CPT II: 2022F, 2024F, 2026F, 92229
Eye Exam without Retinopathy:
CPT II: 2023F, 2025F, 2033F
Diabetic Retinal Screening Negative:
CPT II: 3072F
NOTE: These codes may be billed by any provider type.

Documentation Requirements

- Documentation must include screening results and date of service.
- Eye exams can be performed by an optometrist or ophthalmologist.
- A bilateral eye enucleation counts for numerator compliance.
- Eye exams read by artificial intelligence system count for compliance.

Telehealth

Members can get into denominator with telehealth visits. Telehealth not sufficient to complete screening. Collect and document history of diabetes care.

Helpful Tips

- Explain the risk of impaired vision caused by diabetes and the importance of retinal eye exams.
- Ensure results are read by optometrist or ophthalmologist.
- Create a diabetes checklist in your EMR/patient chart to monitor if patients are up to date with recommended screenings.

Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)

Description

The percentage of emergency department (ED) visits among patients 13 years of age and older with a principal diagnosis of substance use disorder (SUD) or any diagnosis of drug overdose for which there was follow-up.

Numerator/Denominator

Numerator: Patients in the denominator with a follow-up visit or a pharmacotherapy dispensing event within 7 days after the ED visit (8 total days) and 30 days after the ED visit (31 total days).

Denominator: An ED visit with a principal diagnosis of SUD or any diagnosis of drug overdose on or between January 1 and December 1 of the measurement year where the patient was 13 years of age or older on the date of the visit.

Codes/Medications for Compliance

Applicable Codes	**Visit with Principal AOD Abuse or Dependence Diagnosis:** **CPT:** 98960-98962, 99078, 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397
Applicable Codes	**E-Visit or Virtual Check-In** **CPT:** 98969-98972, 99421-99444, 99458 **HCPCS:** G2010, G2012, G2061-G2063 † Additional codes qualify. See NCQA HEDIS specifications for additional information.

Exclusion Criteria:

- Exclude ED visits that result in an inpatient stay and 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.
- Patients receiving hospice or palliative care at any time during the measurement year.

Documentation Requirements

- Document SUD diagnosis as primary diagnosis in follow-up visit.

Telehealth

Telehealth visit with principal diagnosis of SUD can be used for compliance.

Helpful Tips

- Help patient schedule a follow-up visit with a health care professional within 7 days to help prevent emergency department readmission.
- Make sure the alcohol or other drug abuse (AOD) diagnosis is the primary diagnosis in the follow-up visit.
- Contact patient to confirm they attended follow-up visit.
- Increase utilization of telehealth visits for follow-up care appointments.
- Provide educational opportunities to patients and hospitals around importance of follow-up care appointment post-discharge.

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

Description

The percentage of emergency department (ED) visits for patients 6 years of age or older with a principal diagnosis of mental illness or intentional self-harm who had a follow-up visit for mental illness.

Numerator/Denominator

Numerator: 7-Day Follow-Up: Patients in the denominator with a follow-up visit with any provider, with a principal diagnosis of a mental health disorder or with a principal diagnosis of intentional self-harm and any diagnosis of a mental health disorder within 7 days after the ED visit.

30-Day Follow-up: Patients in the denominator with a follow-up visit with a follow-up visit with any provider, with a principal diagnosis of a mental health disorder or with a principal diagnosis of intentional self-harm and any diagnosis of a mental health disorder within 30 days after the ED visit.

Denominator: Patients 6 years of age and older as of the date of an emergency room visit with a principal diagnosis of mental illness or intentional self-harm.

Codes/Medications for Compliance

Applicable Codes	Visit with Principal Mental Health Diagnosis OR with Principal Intentional self- Harm Diagnosis: **CPT:** 98960-98962, 99078, 99201-99205,99211-99215, 99241-99245,99341-99345, 99347-99350,99381-99387, 99391-99397

Applicable Codes	**E-Visit or Virtual Check-In** **CPT:** 98969-98972, 99421-99423, 99444, 99457 **HCPCS:** G0071, G2010, G2012, G2061-G2063 **Telephone Visits:** **CPT:** 98966-98968, 99441-99443 † Additional codes qualify. See NCQA HEDIS specifications for additional information.

Exclusion criteria:

- Patients receiving hospice or palliative care at any time during the measurement year.
- Patients that had an ED visit that resulted in an inpatient stay or an ED visit followed by admission to an acute or non-acute inpatient care setting on the date of the ED visit or within 30 days after the ED visit.

Documentation Requirements

- Follow-up visit may occur on the date of the ED visit.

Telehealth

Telehealth with principal diagnosis of mental health disorder can be used for compliance.

Helpful Tips

- Help patient schedule a follow-up visit with a health care professional within 7 days to help prevent emergency department readmission.
- Provide educational opportunities to patients and hospitals around continuity of care and importance of follow-up post discharge.
- Make sure the mental health diagnosis is the primary focus of follow-up visit.
- Contact patient to confirm they went to follow-up visit.
- Help assist in coordination of care for behavioral health services.
- Increase utilization of telehealth visits when engaging patient with PCP/behavioral health (BH) provider if in-person visit is unavailable within appropriate time frame.

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

The percentage of ED visits for members 18 years of age and older with multiple high-risk chronic conditions who had a follow-up service within seven days of the ED visit.

Numerator/Denominator

Numerator: A follow-up service within seven days after the ED visit (eight total days). Include visits that occur on the date of the ED visit. The following meet criteria for follow-up: outpatient visit, telephone visit, transitional care management services, case management visits, complex care management services, outpatient or telehealth behavioral health visit, intensive outpatient encounter or partial hospitalization, community mental health center visit, electroconvulsive therapy, substance use disorder services, e-visit/virtual check-in, and domiciliary or rest home visit.

Denominator: Members 18 years and older who had an ED visit between Jan. 1 and Dec. 24 of the measurement year and have two or more chronic conditions. Conditions include: COPD and asthma, Alzheimer's and related disorders, chronic kidney disease, depression, heart failure, acute myocardial infarction, atrial fibrillation, stroke, and transient ischemic attack.

Exclusion Criteria:

- Members who died or were in hospice/using hospice services at any time during the measurement year.
- ED visits that resulted in an inpatient admission on day of the visit or within seven days after the ED visit.

Documentation Requirements

Evidence that the patient received a follow-up service within seven days after the ED visit.

Telehealth

Telehealth visit is sufficient.

Additional Measure Information

- Patients can be in this measure multiple times throughout the year.
- Transitions of Care measure guidance should be followed for ED visits that result in an inpatient stay.

Codes for Compliance

Applicable Codes	
Outpatient: CPT 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411-99412, 99429, 99455-99456, 99483 **HCPCS** G0402, G0438, G0439, G0463, T1015 **Telephone Visits: CPT** 98966-98968, 99441-99443 **Transitional Care Management: CPT** 99495, 99496 **Complex Care Management: CPT** 99439, 99487, 99489-99491 **HCPCS** G0506 **Outpatient or Telehealth behavioral health visit** **Visit Setting Unspecified: CPT** 90791-90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221-99223, 99231-99233, 99238, 99239, 99251-99255 **With Outpatient POS:** 03, 05, 07, 09, 11-20, 22, 33, 49, 50, 71, 72 **Behavioral Health Visit: CPT** 98960—98962, 99078, 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411-99412, 99483, 99492-99494, 99510 **HCPCS** G0155, G0176, G0177, G0409, G0463, G0512, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013-H2020, T1015	**Intensive Outpatient Encounter or Partial Hospitalization:** (visit setting unspecified) **With** **Partial Hospitalization POS:** 52 **OR HCPCS:** G0410, G0411, H0035, H2001, H2012, S9480, S9484, S9485 **Community Mental Health Center:** (visit setting unspecified) **With POS** 53 **Telehealth:** (visit setting unspecified) **With POS** 02, 10 **Observation Visit: CPT** 99217-99220 **Substance Use Disorder Service: CPT** 99408-99409, **HCPCS** G0396-G0397, G0443, H0001, H0005, H0007, H0015, H0016, H0022, H0047, H0050, H2035, H2036, T1006, T1012 **E-visit or Virtual Check-in: CPT** 9896, 98970-98972, 99421-99423, 99444, 99457, 99458 **HCPCS** G0071, G2010, G2012, G2061-G2063, G2250-G2252 **Domiciliary or rest home visit: CPT** 99324-99328, 99334-99337

Helpful Tips

- Ensure there are open appointments available so patients with an ED visit can be seen within seven days.
- Encourage the patient to bring their discharge summary to the appointment. Discuss the summary with the patient and ensure they understand their diagnosis and instructions.
- Discuss medicine instructions and ensure new medicines have been filled.
- Complete a thorough medicine reconciliation and ask the patient or caregiver to recite their new medicine regime back to you.
- Telehealth, telephone, virtual, or e-visit can be provided for follow-up within seven days.

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

Description

The percentage of acute inpatient hospitalizations, residential treatment, or withdrawal management. visits for a diagnosis of substance use disorder among patients 13 years of age and older that result in a follow-up visit within 7 or 30 days of substance use disorder.

Numerator/Denominator

Numerator: Patients in the denominator with a follow-up visit or event with any practitioner for a principal diagnosis of substance use disorder within the 30 days after an episode for substance use disorder.

Denominator: Patients 13 years of age and older as of the date of discharge, stay, or event with an acute inpatient hospitalization, residential treatment, or withdrawal management. visits for a diagnosis of substance use disorder.

Codes/Medications for Compliance

Applicable Codes	Visit with Principal AOD Abuse or Dependence Diagnosis
	CPT: 98960-98962, 99078, 99201-99205, 99211-99215, 99241-99245,99341-99345, 99347-99350,99384-99387, 99394-99397,99401-99404, 99408, 99409 † Additional codes qualify. See NCQA HEDIS specifications for additional information.

Exclusion Criteria:

- Patients receiving hospice or palliative care at any time during the measurement year.

Documentation Requirements

- Follow-up visit cannot occur on the same day as discharge.

Telehealth

Telehealth visit with principal diagnosis of SUD can be used for compliance.

Helpful Tips

- Help patient schedule a follow-up visit with a health care professional within 7 days of discharge to help prevent readmission.
- Make sure substance use is the primary focus of follow-up visit.
- Contact patient to make sure they went to follow-up visit or need additional support in rescheduling.
- Provide educational opportunities for patients around the importance of follow-up care appointments post-discharge.
- Engage health plans to act as the liaison between entities that have limitations around data sharing.

Follow-Up After Hospitalization for Mental Illness (FUH)

Description

The percentage of discharges for patients 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider.

Numerator/Denominator

Numerator: Patients who have been hospitalized for treatment and discharged who received a follow-up visit with a behavioral health provider within 7 and 30 days.

Denominator: Patients 6 years of age and older as of the date of an inpatient discharge with a principal diagnosis of mental illness or intentional self-harm.

Codes/Medications for Compliance

Applicable Codes	Follow-up Visit with a Mental Health Provider
	CPT: 98960-98962, 99078, 99201-99205, 99211-99215, 99241-99245,99341-99345, 99347-99350, 99381-99387, 99391-99397 **Telephone Visit** **CPT:** 98966-98968, 99441-99443 † Additional codes qualify. See NCQA HEDIS specifications for additional information.

Exclusion Criteria:

- Patients receiving hospice or palliative care at any time during the measurement year.
- Exclude discharges followed by readmission or direct transfer to nonacute inpatient care setting within 30 days of follow-up period.

Documentation Requirements

- Follow-up visit cannot occur on the same day as discharge.

Telehealth

Telehealth visit with a mental health provider can be used for compliance.

Helpful Tips

- Help patient schedule a follow-up visit with a health care professional within 7 days of discharge to help prevent readmission.
- Contact patient to make sure they went to follow-up visit or if they need additional support in rescheduling.
- Provide educational opportunities for patients around the importance of follow-up care appointments post discharge.
- Engage health plans to act as the liaison between entities that have limitations regarding data sharing.

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

Description

The percentage of patients 6-12 years of age newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed.

Numerator/Denominator

Numerator:
Initiation Phase:
The percentage of patients with a prescription for ADHD medication who had a follow-up visit with a prescribing provider within 30 days.

Continuation and Maintenance Phase: The percentage of patients who remained on the mediation for at least 210 days and who had at least two follow-up visits with a provider within 270 days.

Denominator: Patients 6-12 years of age who were dispensed a newly prescribed ADHD medication.

Codes/Medications for Compliance

Applicable Codes	**Behavioral Health Outpatient Visit:** **CPT:** 98960-98962, 99078, 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347 -99350,99381-99387, 99391-99397 **Telephone Visit** **CPT:** 98966-98968, 99441-99443 **For One of Two Continuation Phase Visits Only:** E-Visit or Virtual Check-In **CPT:** 98969-98972, 99421-99444, 99458 **HCPCS:** G2010, G2012, G2061-G2063 † Additional codes qualify. See NCQA HEDIS specifications for additional information.

Exclusion Criteria:

- Patients with a diagnosis of narcolepsy.
- Patients receiving hospice or palliative care at any time during the measurement year.

Documentation Requirements

- Remove patients who had an acute inpatient encounter for a mental, behavioral, or neurodevelopmental disorder during the 30 days after the index prescription start date.

Telehealth

- Telehealth can be used for compliance for acute sub-measure.
- Only one of the two visits can be e-visit or virtual check-in (for continuation and maintenance).

Helpful Tips

- Consider limiting the first prescription to a 21- or 30-day supply.
- Schedule follow-up visit at the time the first prescription is written.
- Schedule follow-up visit to occur before refill is authorized.
- Schedule a 30-, 60- and 180-day follow-up visit from initial visit prescribing ADHD medication.
- Proactively outreach to patients who are at risk for non-adherence.

Improving Member Satisfaction

Our network providers, their physical offices, staff, and office policies play a fundamental role in affecting patient perceptions surrounding their health care experiences. Every spring, the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey is sent to a random sample of Medicare, commercial, and Health Insurance Marketplace® (exchange) members to capture those patient experiences. Medicaid members receive the survey in the fall.

What is the purpose of the CAHPS survey?

The CAHPS survey provides a standardized understanding of patient experience and level of satisfaction with their personal providers and our health plan. There are some simple and effective ways that providers can positively influence their patients' impressions regarding their health care encounters.

The tips and techniques below may help you enhance your patients' health care experience.

Easy Ways to Provide a Positive Patient Experience Year-Round

Improvement Tips:

Patient Needs Care

- Limit telephone wait times.
- Implement online appointment scheduling.
- Offer same-day, weekend, and evening appointments.
- Offer appointments with nurse practitioners (NPs) or physician assistants (PAs) to patients who cannot be seen quickly by their doctor.
- Implement a nurse line to help answer patients' immediate questions and concerns.
- Offer telehealth visits.
- Target physicals within four weeks and sick visits within 48-72 hours of request.

Patient Arrives to Appointment

- Ensure a clean waiting area.
- Employ friendly and empathetic office staff.
- Offer a welcoming environment (e.g., television, water in waiting area, comfortable seating).
- Limit wait times to under 15 minutes. Acknowledge and explain longer wait times.
- If clinicians are running late, keep patients informed.
- Develop service standards for front desk staff.

Patient is Seen by Provider (Your Biggest Influence)

- Upon entering the room, introduce yourself to make an immediate connection.
- Listen carefully to your patient. Make eye contact.
- Be as respectful as possible about patients' thoughts and beliefs.
- Explains things in plain language. Avoid medical jargon. Consider asking patient to repeat back what they heard in their own words to ensure understanding.
- Discuss the care patients received at the emergency room and from other providers. Make sure they understand the information they may have received at those visits.
- Discuss test results and specialist reports. Inform patients of realistic test/report result timeframes and how the results will be communicated to them.
- Review medicines from all providers during office visits.
- Encourage them to get the flu shot, if indicated.
- Screen for social determinants of health (SDOH) (e.g., food, transportation, economic stability).

After Visit

- Help patients schedule follow-up and specialist appointments.
- Continue communication through various channels (text, email, interactive voice response (IVR)).
- Provide collateral materials about health conditions that reinforce topics discussed with provider.
- Educate patients on how to view their health records.
- Implement reminder and follow-up systems for test/report results.
- Help patients schedule appointments with specialists. Transfer records to specialist.
- Inform patients of realistic appointment wait times for seeing a specialist.

Immunizations for Adolescents (IMA)

Description

The percentage of patients 13 years of age who have had all required immunizations.

Numerator/Denominator

Numerator: Patients in the denominator who had the following vaccines by their 13th birthday:

- 1 Meningococcal conjugate vaccine
- 1 Tdap vaccine
- 2 or 3 HPV vaccines

Denominator: All patients who turn 13 years of age during the measurement year.

Codes/Medications for Compliance

Applicable Codes	Meningococcal Vaccine: **CPT:** 90734 Tdap Vaccine: **CPT:** 90715 HPV Vaccine: **CPT:** 90649, 90650, 90651
Exclusion Codes	Hospice codes: T80.52XA, T80.52XD, T80.52XS G04.32

Exclusion Criteria: Patients receiving hospice or palliative care at any time during the measurement year.

Additional Measure Information

- Optional exclusion criteria: Anaphylactic reaction, encephalopathy.
- Rates need to be stratified by race and ethnicity for each product line.

Documentation Requirements

- Documentation must include vaccine name and date administered.
- For the two-dose HPV vaccination series, there must be at least 146 days between the first and second dose of the HPV vaccine.

Telehealth

Telehealth not sufficient to complete immunizations. Telehealth is sufficient to review and document history of immunizations.

Helpful Tips

- Present vaccination as the default option, presuming parents and/or guardians will immunize.
- Provide parents and/or guardians with records of their children's immunizations and ask them to bring the record to each visit.
- Schedule the next appointment at time of checkout and use every office visit as an opportunity to vaccinate.
- Use automated text message reminders to outreach parents and/or guardians for scheduling reminders.
- Educate parents and/or guardians about HPV and the HPV vaccine.

Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)

Description

The percentage of patients 13 years of age and older as of a new substance use disorder (SUD) episode that resulted in treatment initiation and engagement.

Numerator/Denominator

Numerator:
Initiation of SUD Treatment: The percentage of new SUD episodes that result in treatment initiation within 14 days.

Engagement of SUD Treatment: The percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation.

Denominator: Patients 13 years of age and older as of the SUD episode date.

Codes/Medications for Compliance

Applicable Codes	**The following codes count for compliance for a follow-up visit (for Initiation and Engagement):** **CPT:** 98960-98962, 99078, 99201-99205, 99211-99215, 99241-99245,99341-99345, 99347-99350, 99384-99387, 99394-99397 **E-Visit or Virtual Check-In** **CPT:** 98969-98972, 99421-99444, 99458 **HCPCS:** G2010, G2012, G2061-G2063 **Telephone Visit** **CPT:** 98966-98968, 99441-99443 † Additional codes qualify. See NCQA HEDIS specifications for additional information.

Exclusion Criteria:

Patients receiving hospice or palliative care at any time during the measurement year.

Additional Measure Information

- SUD Episode: An encounter during the Intake Period with a diagnosis of SUD.

Telehealth

Telehealth visit with diagnosis that matches denominator event diagnosis can be used for compliance.

Helpful Tips

- Consider using a brief standardized screening tool to guide your diagnosis.
- Schedule follow-up visits upon new SUD diagnosis.
- Involve family and community resources in adherence strategies.
- Consider learning more about “stages of change” and “motivational interviewing” to incorporate into patient care.
- Assist patient in scheduling follow-up care visit and provide support if transportation is needed.
- Provide oversight and support cross-functionally between behavioral health, medical, and care coordination as appropriate.

Initiation of Pharmacotherapy Upon New Episode of Opioid Dependence (POD-N)

Description

The percentage of patients 18 years of age and older who initiate pharmacotherapy with at least 1 prescription or visit for opioid treatment medication within 30 days following a diagnosis of opioid dependence.

Numerator/Denominator

Numerator: Patients in the denominator who initiate pharmacotherapy within 30 days of diagnosis.

Denominator: Patients 18 years of age and older who are diagnosed with opioid abuse or dependence.

Codes/Medications for Compliance

Applicable Codes	EmblemHealth and ConnectiCare use medication National Drug Codes (NDCs) from pharmacy data and HCPCS J codes to calculate the rates.
Eligible Medications	Naltrexone • Oral tablet • Injectable Buprenorphine • Sublingual tablet • Injection • Implant Buprenorphine/naloxone • Sublingual tablet • Buccal film • Sublingual film

Exclusion Criteria:

- Exclude patients who had an index visit with a diagnosis of opioid abuse or dependence during the 60 days before the IESD (Index Episode Start Date).
- Patients receiving hospice or palliative care at any time during the measurement year.

Documentation Requirements

Compliance can only be achieved through prescription drug event (PDE) data. Claims that are filed through pharmacy discount programs will not result in compliance and patients may pay more for the medication than if they used their prescription drug coverage. Only final action PDE claims are used to calculate this measure.

Telehealth

Telehealth is not sufficient for compliance.

Helpful Tips

- Ensure pharmacotherapy treatment is started upon diagnosis.
- Consider using a brief standardized screening tool to guide your diagnosis.
- Help patients manage stressors and identify triggers for a return to illicit opioid use.
- Submit claims and encounter data in a timely manner.

Kidney Health Evaluation for Patients with Diabetes (KED)

The percentage of members ages 18-85 years of age with diabetes (type 1 and type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR), during the measurement year.

Numerator/Denominator

Numerator: Diabetic patients ages 18-85 who received both an Estimated Glomerular Filtration Rate (eGFR) and Urine Albumin-Creatinine Ratio (uACR)

Denominator: Diabetic patients ages 18-85 years of age.

Exclusion Criteria:

- Members with evidence of ESRD or dialysis any time during the member's history on or prior to the measurement year.
- Members receiving hospice or palliative care during the measurement year.

Codes/Medications for Compliance

Applicable Codes
eGFR **CPT Codes:** 80047, 80048, 80050, 80053, 80069, 82565 **Quantitative Urine Albumin Lab Test:** **CPT Code:** 82043 **Urine Creatine Lab Test:** **CPT Code:** 82570

Additional Measure Information

eGFR and uACR tests can be performed on the same date or different dates of service during the measurement year

Documentation Requirements

Quality data for this measure is collected from claims.

Telehealth

Telehealth is not sufficient to close quality care gap for this measure

Helpful Tips

- Create a diabetes checklist in your EMR/patient chart to monitor if patients are up to date with recommended screenings.
- Explain importance of detection and management of kidney disease for diabetic patients.
- Ensure lab tests are completed annually.

Lead Screening in Children (LSC)

Description

The percentage of children 2 years of age who had one or more capillary or venous lead blood tests for lead poisoning by their 2nd birthday.

Numerator/Denominator

Numerator: Patients in the denominator who had at least one lead capillary or venous blood test on or before the child's 2nd birthday.

Denominator: Patients who turn 2 years old during the measurement year.

Codes/Medications for Compliance

ApplicableCodes	**Lead Test CPT:** 83655

Exclusion Criteria: Patients receiving hospice or palliative care at any time during the measurement year.

Documentation Requirements

- A note indicating the date the test was performed.
- The result or finding.

Telehealth

Telehealth not sufficient for compliance.

Helpful Tips

- Educate parents and/or guardians about the risks of lead poisoning and the importance of screening.
- Identify children at higher risk and screen them earlier when appropriate.
- Ask parents and/or guardians about potential risk factors for lead poisoning such as the age of their home, caregiver occupations and hobbies, use of foods and spices, and hand-to-mouth activity.

Medication Adherence Cholesterol

The percentage of Medicare members with a prescription for a cholesterol medication (a statin drug) who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.

Numerator/Denominator

Numerator: Members in the denominator who fill their cholesterol medication at least 80% or more of the time they are supposed to be taking the medication in the year.

Denominator: Medicare members with at least two statin cholesterol prescriptions filled (on unique dates of service) during the year.

Exclusion Criteria:

- Members receiving palliative care and members with end stage renal disease (ESRD) are excluded from measure.

Codes/Medications for Compliance

Applicable Codes
EmblemHealth and ConnectiCare use medication National Drug Codes (NDCs) from pharmacy data to calculate the rates. **Only statin medications qualify.**
Medications
• Fluvastatin • Pitavastatin • Rosuvastatin • Pravastatin • Atorvastatin (+/- Amplodipine) • Simvastatin (+/- Ezetimibe, Niacin) • Lovastatin (+/- Niacin)

Documentation Requirements

Data from this measure comes from phosphodiesterases (PDE) data submitted by drug plans to Medicare. Only final action PDE claims are used to calculate this measure.

Telehealth

No benefits or inclusions around telehealth.

Helpful Tips

- Stress the importance of remaining on statin medication to lower blood cholesterol and reduce the risk of cardiovascular disease.
- Consider prescribing a 90-day supply when appropriate and educate patient on pharmacy auto-refill program.
- Schedule follow-up visits to check progress.
- Discuss medication adherence barriers and ask open-ended questions about concerns related to health benefits, side effects, and cost.
- Discuss medication adherence barriers and ask open-ended questions about concerns related to health benefits, side effects, and cost.

Medication Adherence Diabetes

The percentage of Medicare members with a prescription for diabetes medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.

Numerator/Denominator

Numerator: Members in the denominator who fill their diabetes medication at least 80% or more of the time they are supposed to be taking the medication in the year.

Denominator: Medicare members with at least

two filled prescriptions for diabetes medications (on unique dates of service) during the year.

Exclusion Criteria:

- Members receiving palliative/hospice care services.
- Members with an ESRD diagnosis or dialysis coverage dates.
- Members with one or more prescriptions for insulin.

Codes/Medications for Compliance

Applicable Codes
EmblemHealth and ConnectiCare use medication National Drug Codes (NDCs) from pharmacy data to calculate the rates.
Medications
• ACEI/ARB/direct renin inhibitor • ACEI/ARB/direct renin inhibitor combination

Documentation Requirements

Data from this measure comes from PDE data submitted by drug plans to Medicare. Only final action PDE claims are used to calculate this measure.

Telehealth

No benefits or inclusions around telehealth.

Helpful Tips

- Stress the importance of remaining on diabetes medication to control blood glucose and reduce the risk of diabetes- related illnesses.
- Consider prescribing a 90-day supply when appropriate and educate patient on pharmacy auto-refill program.
- Schedule follow-up visits to check progress.
- Discuss medication adherence barriers and ask open-ended questions about concerns related to health benefits, side effects, and cost.

Medication Adherence Hypertension

The percentage of Medicare members with a prescription for a blood pressure medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.

Numerator/Denominator

Numerator: Members in the denominator who fill their hypertension medication at least 80% or more of the time they are supposed to be taking the medication in the year.

Denominator: Medicare members with a prescription for a blood pressure medication.

Exclusion Criteria:

- Members receiving palliative/hospice care services.
- Members with an ESRD diagnosis or dialysis coverage dates.
- Members with one or more prescriptions for sacubitril/valsartan.

Codes/Medications for Compliance

Applicable Codes
• EmblemHealth and ConnectiCare use medication National Drug Codes (NDCs) from pharmacy data to calculate the rates. **Only RAS antagonists qualify.**
Medications
• ACEI/ARB/direct renin inhibitor • ACEI/ARB/direct renin inhibitor combination

Documentation Requirements

Data from this measure comes from PDE data submitted by drug plans to Medicare. Only final action PDE claims are used to calculate this measure.

Telehealth

No benefits or inclusions around telehealth.

Helpful Tips

- Stress the importance of remaining on renin-angiotensin system (RAS) antagonists to treat hypertension and proteinuria and reduce the risk of renal and heart disease.
- Consider prescribing a 90-day supply when appropriate and educate patient on pharmacy auto-refill program.
- Schedule follow-up visits to check progress.
- Discuss medication adherence barriers and ask open-ended questions about concerns related to health benefits, side effects, and cost.

Member Satisfaction with Provider Survey

Medicare, Medicaid, CHP and HARP members who had a recent PCP and completed a survey rating their overall experience 9.1 or better.

Numerator/Denominator

Numerator: Members who rated their overall experience with their recent PCP visit at a minimum of 9.1 or Better.

Denominator: Members who had a visit with their attributed PCP within the previous 6 months and completed a survey.

Member Experience Average

- Member experience is calculated based on the average rating of the following questions:

1. Using a number from 1 to 10, where 1 is the worst experience possible and 10 is the best experience possible, what number would you use to rate your overall **experience with the office from scheduling the appointment to completing the visit**?
2. Using a number from 1 to 10 where 1 is the worst provider possible and 10 is the best provider possible, what number would you use to rate just **the provider you saw during your visit**?
3. Using a number from 1 to 10, where 1 is the worst possible and 10 is the best possible, what number would you use to rate just **the nurse, office clerks and receptionists during your visit**?
4. Using a number from 1 to 10, where 1 means not at all likely and 10 means extremely likely, how likely are you to **recommend this office** to your family and friends?

Requirements

- Provider group must have an overall member experience average of 9.1 or better.
- Report cards will be available monthly through your network representative once the minimum number of 10 surveys is completed.

Helpful Tips

- Communicate your services standards with your staff.
- When you are behind schedule: Update patients often and explain the cause for the schedule delay; offer reasonable expectations of when the patient will be seen, showing respect for their time.
- Educate members on how to access care after office hours, including extended hours, weekend availability and use of urgent care centers.
- Reduce delays associated with specialty referrals by partnering with other primary care providers and specialists to create a cohesive system of care.
- Customer service should concentrate on connection, communication, consideration, and accountability.
- Notify patients individually and promptly of delays if their wait time surpasses the 15-minute standard timeframe to see their doctor.
- Focus on improving CAHPS scores all year-round, not just during the February to April survey period.
- Work to schedule well visits/routine physicals within 4 weeks and non-urgent sick visits within 48 to 72 hours of request.

Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)

Description

The percentage of children 1-17 years of age who had two or more antipsychotic prescriptions and had metabolic testing.

Numerator/Denominator

Numerator: Patients who received at least one HbA1c and one LDL-C test within the measurement year. Testing can be done on the same, or different days.

Denominator: Patients 1-17 years of age who had two or more antipsychotic prescriptions.

Codes/Medications for Compliance

Applicable Codes	**Glucose Lab Test** **CPT:** 80047, 80048, 80050, 80053, 80069, 82947, 82950, 82951 **HbA1c Lab Test CPT:** 83036, 83037 **HbA1c Test Result of Finding CPT II:** 3044F, 3046F, 3051F, 3052F **Cholesterol Lab Test** **CPT:** 82465, 83722, 83718, 84478 **LDL-C Lab Test** **CPT:** 80061, 83700, 83701, 83704, 83721 **LDL-C Test Result or Finding CPT II:** 3048F-3050F

Exclusion Criteria:

- Patients receiving hospice or palliative care at any time during the measurement year.

Telehealth

Telehealth is not sufficient for compliance.

Helpful Tips

- Consider drawing blood in the office or writing a lab script at the time the first prescription is written.
- Involve family and other supports to help patient complete blood work.
- Review results of metabolic testing with patients and discuss importance of coordination of care between behavioral health and primary care providers.
- Behavioral Health Providers: order metabolic screening for patients with limited contact with primary care provider.
- Utilize hospital reporting data to capture patients with inpatient stay who had metabolic testing.
- Inform behavioral health practitioners of patients still missing metabolic testing for further discussion during behavioral health visit.

Oral Evaluation, Dental Services (OED)

The percentage of patients under 21 who have received a comprehensive or periodic oral evaluation with a dental provider during the measurement year.

Numerator/Denominator

Numerator: Patients in the denominator with a comprehensive or periodic oral evaluation with a dental provider (DDS, DMD, or certified and licensed dental hygienists) during the measurement year.

Denominator: Patients under age 21 as of Dec. 31 of the measurement year.

Exclusion Criteria: Patients receiving hospice or palliative care at any time during the measurement year. Members who died any time during the measurement year.

Codes/Medications for Compliance

Applicable Codes
CDT: D0120 D0145 D0150

Documentation Requirements

Any periodic or comprehensive oral exam with a dental care provider.

Telehealth

Telehealth cannot be used for compliance.

Helpful Tips

- This is a first year measure.
- No referral is required.
- Inform family of link of oral health to overall health.
- Encourage routine visits beginning as early as age one or first tooth eruption.
- Send parents, guardians, patients' reminders every six months to schedule for periodic exams, prophylaxis (cleanings), and fluoride treatments.
- Services must be performed by a dental provider (DDS, DMD, or certified and licensed dental hygienists).
- For many one-year-olds, visits will be counted because the specification includes children whose second birthday occurs during the measurement year.

Osteoporosis Management in Women Who Had a Fracture (OMW)

Description

The percentage of women 67-85 years of age who suffered a fracture and who had either a bone mineral density (BMD) test or a prescription for a drug to treat osteoporosis in the 6 months after the fracture.

Numerator/Denominator

Numerator: Patients in the denominator who had a BMD test or a prescription to treat osteoporosis in the 6 months after the fracture.

Denominator: Women 67-85 years of age as of December 31 of the measurement year with a fracture.

Codes/Medications for Compliance

Applicable Codes	Bone Mineral Density Tests **CPT:** 76977, 77078, 77080-77081, 77085-77086 Long-Acting Osteoporosis **Medications HCPCS:** J0897, J1740, J3489 Osteoporosis Medications **HCPCS:** J0897, J1740, J3110, J3489

Exclusion Criteria:

- Patients receiving hospice or palliative care at any time during the measurement year.
- Patients who had a bone mineral density (BMD) test during the 730 days (24 months) prior to the episode.
- Patients who had a claim/encounter for osteoporosis therapy during the 365 days (12 months) prior to the episode.
- Patients who received a dispensed prescription or had an active prescription to treat osteoporosis during the 12 months prior to the episode.
- Patients who are enrolled in an institutional SNP (I-SNP) any time during the measurement year.
- Patients living long-term in an institution.

Documentation Requirements

- Bone density reports, dated with results, within 24 months before and/or 6 months after fracture.
- Medication list with osteoporosis medication, within 12 months before or 6 months after the fracture.
- Documentation when osteoporosis medication is administered in your office within 12 months before and/or 6 months after the fracture.

Telehealth

- Telehealth can be used for reviewing, documenting, and prescribing medication, when appropriate.

Helpful Tips

- Ask all female patients 67-85 years of age if they've had a fracture since their last visit.
- Consider writing a prescription for osteoporosis medication at time of fracture.
- If patients are unable or unwilling to have a BMD test, prescribe osteoporosis medications if appropriate.
- Place a reminder in the patient's chart for a BMD test.
- Educate patients on safety and fall prevention.
- Encourage providers to be proactive in scheduling BMD as a preventive tool.

Prenatal and Postpartum Care (PPC)

Description

The percentage of women with a live birth on or between October 8 of the year prior to the measurement year and October 7 of the measurement year who received timely prenatal and postpartum care.

Numerator/Denominator

Numerator: Patients in the denominator with live birth deliveries who had the following completed:

1. Timeliness of Prenatal Care: A prenatal care visit in the 1st trimester.
2. Postpartum Care: A postpartum visit on or between 7 and 84 days after delivery.

Denominator: Patients with a live birth on or between October 8 of the year prior to the measurement year and October 7 of the measurement year.

Codes/Medications for Compliance

Applicable Codes	
	Prenatal Visit CPT: 99201-99205, 99211-99215, 99241-99245, 99483 **HCPCS:** G0463, T1015 **Stand Alone Prenatal Visit CPT:** 99500 **HCPCS:** 1000, H1001, H1002, H1003, H1004 **Postpartum Visit CPT:** 57170, 58300, 59430, 99501 **HCPCS:** G0101ICD 10: Z01.411, Z01.419, Z01.42, Z30.430, Z39.1, Z39.2 **Telephone Visit CPT:** 98966-98968, 99441-99443 **E-Visit or Virtual Check-In CPT:** 98969, 98970, 98971, 98972, 99421, 99422, 99423, 99444, 99458 **HCPCS:** G2010, G2012, G2061, G2062, G2063

Exclusion Criteria:

- Patients receiving hospice or palliative care at any time during the measurement year.
- Non-live births.

Documentation Requirements

- Prenatal care visit to an OB/GYN or other prenatal care practitioner, or PCP.
- Documentation indicating the woman is pregnant or references to the pregnancy: Documentation in a standardized prenatal flow sheet, or documentation of last menstrual period (LMP), estimated date of delivery (EDD) or gestational age, or a positive pregnancy test result, or documentation of gravidity and parity, or documentation of complete obstetrical history, or documentation of prenatal risk assessment and counseling/education.
- A basic physical obstetrical examination that includes auscultation for fetal heart tone, or pelvic exam with obstetric observations, or measurement of fundus height.
- Evidence that a prenatal care procedure was performed.
- A postpartum visit on or between 7 and 84 days after delivery, as documented through either administrative data or medical record review.

Telehealth

Telehealth can be used for compliance.

Helpful Tips

- Use telephone visits, e-visits, and virtual check-ins to close gaps in timeliness of prenatal care.
- Encourage patients to contact the office as soon as they are aware of pregnancy.
- Ensure staff is aware that patients should be seen within the first trimester when scheduling appointments.
- Place a reminder in the patient’s chart for when the postpartum visit is due.
- Encourage patients to also schedule a postpartum visit when scheduling the baby’s first wellness visit.

Prenatal Immunization Status (PRS-E)

The percentage of deliveries in the measurement period (Jan. 1 to Dec. 31) in which women had received influenza and tetanus, diphtheria toxoids, and acellular pertussis (Tdap) vaccinations.

Numerator/Denominator

Numerator one—Immunization Status: Influenza

Deliveries where members received 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 vaccine on or before the delivery.

Numerator two—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 anaphylaxis or encephalitis due to the vaccine on or before delivery.

Numerator three—Immunization Status: Combination

Deliveries that met criteria for both numerator one and numerator two.

Denominator: Women with deliveries in measurement period.

Exclusion Criteria:

- Deliveries that occurred at less than 37 weeks gestation.
- Deliveries in which members were in hospice or using hospice services.

Additional Measure Information

Each separate pregnancy episode ending in a delivery is counted in the initial population. A pregnancy episode ending in a delivery with multiple live births is counted once.

Codes for Compliance

Applicable Codes
Adult Influenza: 90630; 90653; 90654; 90656; 90658; 90661; 90673; 90674; 90882; 90686; 90688; 90689;
90756. Tdap Vaccine: 90715

Helpful Tips

- Educate expectant mothers on the importance of vaccines during pregnancy.
- If you do not have flu vaccines available, refer the patient to another health care provider or pharmacy.
- Educate the mother on how the flu vaccine will protect both her and her baby.
- Educate mothers on passive immunity and how the maternal immunization will pass on to their newborns.
- The Tdap vaccine is recommended in the third trimester as this will boost the neonatal antibody levels in the baby. Babies whose mothers had the Tdap vaccine during pregnancy are better protected against whooping cough during the first two months of life.
- Explain to expectant mothers that the Tdap vaccine will protect them and their baby from pertussis and its life-threatening complications.

Social Need Screening and Intervention (SNS-E)

The percentage of patients who were screened using prespecified tools, at least once during the measurement period for unmet food, housing, and transportation needs, and received a corresponding intervention if they screened positive.

Numerator/Denominator

Numerator: Members who were screened in the measurement year.

Denominator: Members within the following age ranges:

- <= 17 years.
- 18-64 years.
- 65 and older.

Documentation Requirements

SDOH data must be documented using the prespecified screening tool and submitted claims.

Telehealth

No current benefits or inclusions around telehealth.

Codes for Compliance

Applicable Codes
See separate SDOH material.

Quality Measure — 2023 New HEDIS SDOH Measure

There are 6 separate metrics that are part of the new HEDIS SDOH Measure looking at screening and intervention.

Food Screening	Housing Screening	Transportation Screening	Food Intervention	Housing Intervention	Transportation Intervention
The percentage of members who were screened for food insecurity.	The percentage of members who were screened for housing instability, homelessness, or housing inadequacy.	The percentage of members who were screened for transportation insecurity.	The percentage of members who received a corresponding intervention within one month of screening positive for food insecurity.	The percentage of members who received a corresponding intervention within one month of screening positive for housing instability, homelessness, or housing inadequacy.	The percentage of members who received a corresponding intervention within one month of screening positive for transportation insecurity.

Helpful Tips

- Link members to behavioral health and/or other social service providers.
- Discuss/understand intersection between SDOH and preventive and chronic disease care.
- Keep track of and monitor social needs expressed by members that impact treatment adherence and health outcomes.
- EmblemHealth Neighborhood Care provides in-person and virtual customer support, access to community resources, and programming to help members and non-members alike. Find a location close to your patients at: **emblemhealth.com/about/neighborhood-care**.
- At ConnectiCare Centers, our friendly assistants share information with your patients to help them make decisions about doctors, coverage, and staying well. Find a location close to your patients at: **connecticare.com/about/care-centers**.

Statin Therapy for Patients with Cardiovascular Disease (SPC)

Description

The percentage of males 21-75 years of age and females 40-75 years of age during the measurement year have clinical atherosclerotic cardiovascular disease (ASCVD) that have received and remained adherent to at least one high-intensity or moderate-intensity statin during the measurement year.

Numerator/Denominator

Numerator:

1. Patients in the denominator dispensed at least one high-intensity or moderate-intensity statin during the measurement year.
2. Patients in the denominator that remained on a high-intensity or moderate-intensity statin for 80% of the treatment period.

Denominator: Males 21-75 years of age and females 40-75 years of age during the measurement year, identified as having ASCVD.

Codes/Medications for Compliance

Applicable Codes	EmblemHealth and ConnectiCare use medication National Drug Codes (NDCs) from pharmacy data to calculate the rates. **Only moderate- and high-intensity statin medications qualify.**

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

Exclusion Criteria:

- Diagnosis of pregnancy this year or the year prior
- Received IVF this year or the year prior
- Dispensed at least one prescription for clomiphene this year or the year prior
- Diagnosis of ESRD or were on dialysis this year or the year prior
- Diagnosis of Cirrhosis this year or the year prior
- Diagnosis of Myalgia, Myositis, or Rhabdomyolysis this year
- Recieving hospice or palliative care this year

Documentation Requirements

Data from this measure comes from prescription drug event data submitted by drug plans to Medicare. Only final action PDE claims are used to calculate this measure.

Telehealth

Telehealth is not sufficient for compliance.

Helpful Tips

- Remind patients to use their ID card at the pharmacy.
- Discuss with patient why they are on a statin and stress importance of remaining on statin medication to lower blood cholesterol and manage cardiovascular disease.
- Consider prescribing a 90-day supply when appropriate.
- Schedule follow-up visits to check progress.
- Refer to specialist if appropriate.
- Build quality care alerts in your electronic medial record (EMR).
- Identify and resolve patient-specific adherence barriers (cost, refills, side effects).

Statin Use in Persons with Diabetes (SUPD)

Description

The percentages of patients 40-75 years of age who were dispensed at least two diabetes medication fills and who received a statin medication fill during the measurement period.

Numerator/Denominator

Numerator: Patients in the denominator who received a statin mediation fill during the measurement period.

Denominator: Patients with diabetes defined as those who have at least two fills of diabetes medications during the measurement year.

Codes/Medications for Compliance

Applicable Codes	EmblemHealth and ConnectiCare use medication National Drug Codes (NDCs) from pharmacy data to calculate the rates.
Eligible Medications	atorvastatin (+/- amlodopine) pitavastatin rosuvastatin (+/- ezetimibe) fluvastatin pravastatin simvastatin (+/- ezetimibe, niacin) lovastatin (+/- niacin)

Exclusion Criteria:

- End-stage renal disease (esrd)
- Rhabdomyolysis and myopathy
- Pregnancy, lactation, fertility
- Liver disease
- Pre-diabetes
- Polycystic ovary syndrome
- Patients receiving hospice or palliative care at any time during the measurement year.

Documentation Requirements

- Compliance can only be achieved through prescription drug event (PDE) data. Claims that are filled through pharmacy discount programs will not result in compliance and patients may pay more for the statin than if they used their prescription drug coverage. Only final action PDE claims are used to calculate this measure.

Telehealth

Telehealth is not sufficient for compliance.

Helpful Tips

- Remind patients to use their ID card at the pharmacy.
- Educate patients with diabetes of their increased risk of cardiovascular disease and the benefits of statin mediation to prevent cardiovascular disease.
- Consider prescribing a 90-day supply when appropriate.
- Schedule follow-up visits to check progress.
- Refer to specialist if appropriate.
- Build quality care alerts in your electronic medical record (EMR).
- Identify and resolve patient-specific adherence barriers (cost, refills, side effects).
- Document in the medial record patient conditions that exclude them from taking a statin.

Topical Fluoride for Children (TFC)

The percentage of members 1 to 4 years of age who received at least two fluoride varnish applications during the measurement year.

Numerator/Denominator

Numerator: Members who receive two or more fluoride varnish applications during the measurement year on different dates of service.

Denominator: Members ages 1 to 4 as of Dec. 31 of the measurement year.

Additional Measure Information

This is a new HEDIS measure. There are two age stratifications (1 to 2 and 3 to 4 years of age) and a total rate.

Codes for Compliance

CPT 99188-Fluoride Varnish Value set
D1206

Helpful Tips

- Educate members that dental caries represent the most common chronic disease in children in the United States. (**https://www.cdc.gov/oralhealth/basics/childrens-oral-health/index.html**)
- Topical fluoride plays an important role in preventing tooth decay.
- This measure will allow pediatric members to receive fluoride varnish applications at both the PCP and dental offices.
- The American Academy of Pediatrics (AAP) recommends performing oral health risk assessments at routine well child visits.
- The AAP recommends fluoride application as a standard of care in the pediatric primary care setting.

Transitions of Care — Medication Reconciliation Post Discharge (TRC)

The percentage of inpatient discharges for members ages 18 and older who had a medication reconciliation within 30 days of inpatient discharge.

Numerator/Denominator

Numerator: Patients discharge medications were reconciled with the most recent medication list in the outpatient record on the date of discharge through 30 days after discharge.

Denominator: Members ages 18 and older who had an acute or nonacute inpatient discharge on or between Jan. 1 and Dec. 1 of the measurement year.

Codes/Medications for Compliance

Applicable Codes
Transitional Care Management: **CPT:** 99495, 99496 **Cognitive Assessment and Care Plan Services:** **CPT:** 99483 **CPTII:** 1111F – Discharge medications were reconciled with current medication list in outpatient medical record.

Additional Measure Information

- Care coordination is important when transitioning from the hospital setting back to home to ensure clear understanding of medication changes, diagnostic testing, and follow-up needs.
- Transitional care management visits using CPT codes 99495, 99496, and 99483 count as numerator compliance for patient engagement after discharge and medication reconciliation.
- Medication reconciliation can be conducted by a prescribing practitioner, clinical pharmacist, physician assistant, or registered nurse.

Documentation Requirements

Documentation in the outpatient medical record must include evidence of medication reconciliation and the date it was performed. Member does not need to be present.

Telehealth

Telehealth may be used for this measure.

Helpful Tips

- Ensure patient's discharge information is comprehensive and complete and used to schedule post-discharge appointments.
- Ensure patient has a follow-up visit within 30 days of discharge.
- Review discharge summary, including new medication regimen with patients and caregivers to ensure they understand diagnosis and care plan. Ensure patient has all medications and is able to take as prescribed.
- Contact patient within three days of discharge.
- Partner with facility to improve care coordination upon discharge.

Transitions of Care — Patient Engagement Post Inpatient

Discharge (TRC)

The percentage of discharges for patients 18 years of age and older who had patient engagement within 30 days after discharge.

Numerator/Denominator

Numerator: Patient engagement after inpatient discharge within 30 days after discharge (office visit, telehealth, home visit).

Denominator: Members ages 18 and older who had an acute or nonacute inpatient discharge on or between Jan. 1 and Dec. 1 of the measurement year.

Exclusion Criteria:

Members in hospice or using hospice services.

Codes/Medications for Compliance

Applicable Codes
Outpatient Visit **CPT Codes:** 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411-99412, 99429, 99455, 99456, 99483 **HCPCS:** G0402, G0438, G0439, G0463, T1015 **Telephone Visit:** **CPT:** 98966-98968, 99441-99443 **Transitional Care Management Services:** **CPT:** 99495, 99496 **Virtual Visit/Online Assessment:** **CPT:** 98969-98972, 99421-99423, 99457-99458 **HCPCS:** G0071, G2010, G2012, G2061-G2063, G2250-G2252

Additional Measure Information

Care coordination is important when transitioning from the hospital setting back to home to ensure clear understanding of follow-up needs.

Documentation Requirements

- Documentation of patient engagement (e.g., office visit, visit to the home or telehealth visit) provided within 30 days after discharge.
- **Note:** Do not include patient engagement that occurs on the same date of discharge.

Telehealth

Telehealth visit, telephone visit, e-visit, or virtual check-in count for compliance in patient engagement after inpatient discharge.

Helpful Tips

- Ensure patient's discharge information is comprehensive and complete.
- Ensure patient has a follow-up visit within 30 days of discharge.
- Review discharge summary, including new medication regimen with patients, and caregivers to ensure they understand diagnosis and care plan.
- Contact patient within three days of discharge.
- Ensure patient has all medications and can take as prescribed.
- Partner with facility to improve care coordination upon discharge.

Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease (COPD) (SPR)

Description

The percentage of patients 40 years of age and older with a new diagnosis of COPD or newly active COPD who received appropriate spirometry testing to confirm the diagnosis.

Numerator/Denominator

Numerator: At least one claim/encounter for spirometry during the 730 days (2 years) prior to the index episode start date through 180 days (6 months) after the index episode start date.

Denominator: Patients 40 years of age and older as of January 1 of the measurement year with a new diagnosis of COPD or newly active COPD.

Codes/Medications for Compliance

Applicable Codes	**COPD ICD-10 Codes:** J44.0, J44.1, J44.9, J41.0, J41.1, J41.8, J42, J43.0, J43.1, J43.2, J43.8, J43.9, J47.0, J47.1, J47.9 **ICD-9 Codes:** 493.20, 493.21, 493.22, 496 **Chronic Bronchitis ICD-10CM:** J41.0, J41.1, J41.8, J42 **ICD-9CM:** 491.0, 491.1, 491.20, 491.21, 491.22, 491.8, 491.9 **ICD-9 Codes:** 492.0, 492.8 **Emphysema ICD-10 CM Codes:** J43.0-J43.2, J43.8, J43.9 **Spirometry CPT Codes:** 94010, 94014-94016, 94060, 94070, 94375, 94620

Exclusion Criteria: Patients receiving hospice or palliative care at any time during the measurement year.

Documentation Requirements

- Document the date of spirometry testing and clear the spirometry results.
- Documented a spirometry test results confirming the COPD diagnosis during the previous two years or six months after the on-set of the episode.

Helpful Tips

- Proper diagnosis is essential to ensure patients receive appropriate short- and long-term treatment. Symptomatic and asymptomatic patients suspected to have COPD should have spirometry testing to document airway limitation and severity.
- Educate newly-diagnosed COPD patients about the importance of spirometry testing.
- Submit timely claims for spirometry testing performed in your office.
- Consider pre-visit chart review and planning to help manage patients' chronic conditions.

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

Description

The percentage of patients ages 3-17 who had an outpatient visit with a primary care provider (PCP) or OB/GYN, and who had evidence of the following in the measurement year: body mass index (BMI) percentile documentation, counseling for nutrition, counseling for physical activity.

Numerator/Denominator

Numerator: Patients 3-17 years of age who had an outpatient visit with a PCP or OBGYN and had evidence of the following during the measurement year: BMI percentile documentation, counseling for nutrition, and counseling for physical activity.

Denominator: Patients who turn 3-17 years of age in the measurement year and had an outpatient visit with a PCP or OBGYN in the measurement year.

Codes/Medications for Compliance

Applicable Codes	**BMI Percentile: ICD10CM:** Z68.51-Z68.54 **Counseling for Nutrition:** **CPT:** 97802-97804 **HCPCS:** G0270, G0271, S9449, S9452, S9470 **ICD10CM:** Z71.3 Counseling for physical activity: **HCPCS:** S9451, G0447 ICD10CM: Z02.5

Exclusion Criteria:

- Patients receiving hospice or palliative care at any time during the measurement year.
- Female patients who have a diagnosis of pregnancy during the current year.

Documentation Requirements

- BMI percentile documentation must indicate the height, weight, and BMI percentile, dated during the current or prior year. BMI percentile must include BMI percentile documented as a value (e.g., 85th percentile) or BMI percentile plotted on an age-growth chart.
- Nutritional counseling documentation must include a note indicating the date and at least one of the following: discussion of current nutrition behaviors, checklist indicating nutrition was addressed, counseling or referral for nutrition education, dissemination of educational materials on nutrition during a face-to-face visit, anticipatory guidance for nutrition.
- Physical activity counseling must include a note indicating the date and at least one of the following: discussion of current physical activity behaviors, checklist indicating physical activity was addressed, counseling or referral for physical activity, dissemination of educational materials on physical activity during a face-to-face visit, anticipatory guidance for physical activity, weight or obesity counseling.

Telehealth

Telehealth can be used to deliver nutrition counseling and weight counseling services on a separate date from the PCP/OBGYN visit. (PCP visit and counseling do not have to happen on the same date of service.

Helpful Tips

- Contact parents and/or guardians of patients to schedule their visits at least once a year.
- Use sick visits and sports physicals to complete this measure. Include and document all three measure components during a sick visit for a compliant WCC record.
- Consider using nutritionists to make calls to members to counsel over the phone after the PCP visit.
- When counseling for nutrition, discuss proper food intake, healthy eating habits, eating disorders, and issues such as body image.

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

The percentage of patients who had the following number of well-child visits during the last:

- **15 months: six or more well-child visits**
- **30 months: two or more well-child visits.**

Numerator/Denominator

Numerator:

Rate 1, eligible population: Six or more well child visits on or before 15 months of age.

Rate 2, eligible population: Two or more well child visits between 15-30 months of age.

Denominator:

Rate 1 eligible population — children who turned 15 months old during the measurement year.

Rate 2 eligible population — children who turned 30 months old during the measurement year.

Exclusion Criteria:

Patients receiving hospice or palliative care at any time during the measurement year.

Codes/Medications for Compliance

Applicable Codes
Well-Care Visit **CPT:** 99381-99385, 99391-99395, 99461 **HCPCS:** G0438, G0439, S0302 **ICD10:** Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.2, Z00.3, Z02.5, Z76.1, Z76.2

Telehealth

Telehealth can be used for compliance. (Appropriate CPT needs to be submitted with GT modifier.)

Documentation Requirements

- Well-child visits must occur with primary care provider (PCP) but does not have to be the PCP assigned.
- This measure is based on the American Academy of Pediatrics Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents (published by the National Center for Education in Maternal and Child Health). Visit the Bright Futures website for more information about well-child visits (**brightfutures.aap.org/materials-and-tools/guidelines-and-pocket-guide/Pages/default.aspx**).

Helpful Tips

- Conduct or schedule well-care visits when patients present for illnesses, or other events like sports physicals, accidental injuries, and colds. Add modifier for separate and distinct services.
- Document all the required elements of a well-child visit.
- Pre-schedule the next well visit before the patient leaves the office. Relay the importance of returning even if the child is doing fine.
- Provide health education/anticipatory guidance.
- Take an opportunity to check and administer vaccines that are due at every visit.
- Provide parents with recommended vaccine schedule from the **Centers for Disease Control and Prevention (CDC).**

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