Guide to HEDIS Measures

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L.A. Care
HEALTH PLAN®

For All of L.A.

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L.A. Care HEALTH PLAN®

For All of L.A.

Welcome to Guide to HEDIS Measures

L.A. Care Health Plan
For All of L.A.

L.A. Care Health Plan (L.A. Care) is an National Committee for Quality Assurance (NCQA) accredited health plan. HEDIS® is the gold standard for measuring quality health care performance, and is part of the NCQA accreditation process. Guide to HEDIS Measures is a reference guide designed to help your practice provide the best quality care, in alignment with the HEDIS® standards. This document is merely a tool and provides a general summary on some limited HEDIS® Program requirements. This document should not be used as legal advice or expert advice or comprehensive summary of the HEDIS® Program. Please refer to **ncqa.org** for HEDIS® Program measures and guidelines as well as relevant statutes.

The information provided in this document is for 2019 HEDIS® period and is current at the time this document was created. NCQA HEDIS® Program requirements, applicable laws, and L.A. Care's policy change from time to time, and information and documents requested from you may also change to comply with these requirements

L.A. Care is not affiliated with NCQA or its HEDIS® Program and does not receive any financial remuneration from it.

Guide to HEDIS Measures highlights 38 priority HEDIS® measures that can potentially have significant impact on Auto-assignment and Minimum Performance Level (MPL), NCQA Accreditation, and Cal Medi-Connect (CMC) Quality Performance Withhold. Additionally, if you participate in and qualify for Physician P4P, the information contained in this reference guide may help you maximize the incentives you receive as part of L.A. Care's Physician Pay-for-Performance Program for Medi-Cal and L.A. Care Covered members.

L.A. Care Health Plan collects data for HEDIS® reporting annually from January to May. The Reporting Year (RY) details the performance rates from the previous year or, the Measurement Year (MY). For example, HEDIS® 2018 (RY) reports data collected from services rendered from January 1, 2018 to December 31, 2018 (MY).

For HEDIS related inquiries, please contact **HEDIS_Ops@lacare.org**. *Note: All emails containing member PHI MUST be securely encrypted.*

Pay-for-Performance: Look for measures with Pay-for-Performance that are included in L.A. Care's Pay-for-Performance programs for Measurement Year 2018.

For more details contact **incentive_ops@lacare.org**. *Note: All emails containing member PHI MUST be securely encrypted.*

Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)

State Medicaid MPL (must achieve 25th percentile or greater)
Pay-for-Performance (P4P)
NCQA Accreditation Medicaid

Q: Which members are included in the sample?

A: Adults 18-64 years of age who had an outpatient or ED visit with a diagnosis of acute bronchitis, and were not dispensed an antibiotic prescription in 2018.

Q: What codes are used?

A: Please reference attached sample codes and Value Set Directory for additional codes.

Q: What documentation is needed in the medical record?

A: *None*. This measure requires claim/encounter data submission only using the appropriate Value Set Codes.

Q: What type of document is acceptable?

A: Evidence from claim/encounter data with a date of service for any outpatient or ED visit with an acute bronchitis diagnosis and no new or refill prescription for an antibiotic medication in 2018.

AAB Antibiotic Medications

Description	Prescription		
Aminoglycosides	• Amikacin • Gentamicin	• Streptomycin • Tobramycin	
Aminopenicillins	• Amoxicillin	• Ampicillin	
Beta-lactamase inhibitors	• Amoxicillin-clavulanate • Ampicillin-sulbactam	• Piperacillin-tazobactam	• Ticarcillin-clavulanate
First-generation cephalosporins	• Cefadroxil	• Cefazolin	• Cephalexin
Fourth-generation cephalosporins	• Cefepime		
Ketolides	• Telithromycin		
Lincomycin derivatives	• Clindamycin	• Lincomycin	
Macrolides	• Azithromycin • Clarithromycin	• Erythromycin • Erythromycin ethylsuccinate	• Erythromycin lactobionate • Erythromycin stearate
Miscellaneous antibiotics	• Aztreonam • Chloramphenicol • Dalfopristin-quinupristin	• Daptomycin • Erythromycin-sulfisoxazole • Linezolid	• Metronidazole • Vancomycin
Natural penicillins	• Penicillin G benzathine-procaine • Penicillin G potassium	• Penicillin G procaine • Penicillin G sodium	• Penicillin V potassium • Penicillin G benzathine
Penicillinase resistant penicillins	• Dicloxacillin	• Nafcillin	• Oxacillin
Quinolones	• Ciprofloxacin • Gemifloxacin	• Levofloxacin • Moxifloxacin	• Norfloxacin • Ofloxacin
Rifamycin derivatives	• Rifampin		
Second-generation cephalosporin	• Cefaclor • Cefotetan	• Cefoxitin • Cefprozil	• Cefuroxime
Sulfonamides	• Sulfadiazine	• Sulfamethoxazole-trimethoprim	
Tetracyclines	• Doxycycline	• Minocycline	• Tetracycline
Third-generation cephalosporins	• Cefdinir • Cefditoren • Cefixime	• Cefotaxime • Cefpodoxime • Ceftazidime	• Ceftibuten • Ceftriaxone
Urinary anti-infectives	• Fosfomycin • Nitrofurantoin • Nitrofurantoin macrocrystals	• Nitrofurantoin macrocrystals-monohydrate • Trimethoprim	

Q: How to improve score for this HEDIS measure?

A: Use of complete and accurate Value Set Codes.

☑ Timely submission of claim/encounter data

Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)

State Medicaid MPL (must achieve 25th percentile or greater)
Pay-for-Performance (P4P) NCQA Accreditation
Medicaid

SAMPLE CODES

The codes listed below are not inclusive and do not represent a complete list of codes.

ICD-10 codes	
Acute Bronchitis	J20.0-J20.9

CPT codes	
ED	99281-99285
Observation	99217-99220
Outpatient	99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99483, 99429, 99455, 99456

HCPCS codes	
Outpatient	G0402, G0438,G0439, G0463, T1015

Exclusion codes
Comorbid Conditions, Competing Diagnosis, COPD, Cystic Fibrosis, Disorders of Immune System, Emphysema, HIV, HIV Type 2, Malignant Neoplasms, Other Malignant Neoplasms of Skin, and Pharyngitis.

Adult BMI Assessment (ABA)

NCQA Accreditation
Medicaid

Q: Which members are included in the sample?

A: Members 18-74 years of age who had an outpatient visit and whose body mass index (BMI) was documented in 2017 or 2018.

Q: What codes are used?

A: Please reference attached sample codes and Value Set Directory for additional codes.

Q: What documentation is needed in the medical record?

A: Documentation in the medical record must include: a **note** indicating an outpatient visit, **date** visit occurred, and evidence of the following:

For members 20 years and older, medical record must indicate:

- ☑ Weight
- ☑ BMI Value

For members younger than 20 years old, medical record must indicate:

- ☑ Height
- ☑ Weight
- ☑ BMI Percentile *(Documented as a value (e.g., 85th percentile) or plotted on an age-growth chart)*

Q: What type of medical record is acceptable?

A: One or more of the following: (visit completed in **2017** or **2018**)

- ☑ PM 160
- ☑ Progress notes/Office visit notes
- ☑ Complete Physical Examination Form
- ☑ Dated BMI growth chart/log and weight

Note: *Ranges and thresholds do not meet criteria for this indicator*

Adult BMI Assessment (ABA)

NCQA Accreditation
Medicaid

Q: How to improve score for this HEDIS measure?

A:

- ☑ Use of complete and accurate Value Set Codes
- ☑ Timely submission of claim/encounter data
- ☑ Ensure presence of all components in the medical record documentation

Exclusion (optional): Female members with a diagnosis of pregnancy in 2017 or 2018

Adult BMI Assessment (ABA)

NCQA Accreditation
Medicaid

SAMPLE CODES

The codes listed below are not inclusive and do not represent a complete list of codes.

ICD-10 codes	
BMI	Z68.1, Z68.20-Z68.39, Z68.41-Z68.45
BMI Percentile	Z68.51-Z68.54

CPT codes	
Outpatient	99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99429, 99455, 99456, 99483

HCPCS codes	
Outpatient	G0402, G0438,G0439, G0463, T1015

Exclusion codes
Pregnancy

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

NCQA Accreditation Medicaid

Q: Which members are included in the sample?

A: Children 6-12 years newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication that had at least three follow-up care visits within a 10-month period;

- ☑ *One follow-up visit within 30 days of when the first ADHD medication was dispensed*
- ☑ *One follow-up visit with evidence that the member remained on ADHD medication for at least 210 days (7 months)*
- ☑ *Member had 2 follow-up visits within 270 days (9 months) after the Initiation Phase ended*

Q: What codes are used?

A: Please reference attached sample codes and Value Set Directory for additional codes.

Q: What documentation is needed in the medical record?

A: *None*. This measure requires claim/encounter data submission only using the appropriate Value Set Codes.

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

NCQA Accreditation Medicaid

Q: What type of document is acceptable?

A: Evidence from claim/encounter data:

1. Children in the specified age range who were dispensed an ADHD medication:

ADHD Medications

Description	Prescription		
CNS stimulants	• Amphetamine-dextroamphetamine • Dexmethylphenidate	• Dextroamphetamine • Lisdexamfetamine	• Methylphenidate • Methamphetamine
Alpha-2 receptor agonists	• Clonidine	• Guanfacine	
Miscellaneous ADHD medications	• Atomoxetine		

2. Member follow-up visit with a practitioner with prescribing authority, within 30 days of ADHD medication dispensing:
   - Of these members, in the following 9 months, who received at least 2 additional follow-up visits with any practitioner

Q: How to improve score for this HEDIS measure?

A:

☑ Use of complete and accurate Value Set Codes

☑ Timely submission of claim/encounter data

☑ Schedule 30-day follow-up for all children who are dispensed ADHD medication to assess how medication is working

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

NCQA Accreditation Medicaid

SAMPLE CODES

The codes listed below are not inclusive and do not represent a complete list of codes.

ICD-10 codes
Attention-Deficit Hyperactivity Disorder: F90.0-F90.2, F90.8-F90.9

CPT codes	
ADD Stand Alone Visits	96150-96154, 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99401-99404, 99411, 99412, 99510
ADD Visits Group 1	90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90875, 90876
ADD Visits Group 2	99221-99223, 99231-99233, 99238, 99239, 99251-99255
Telephone Visits	98966-98968, 99441-99443

HCPCS codes	
ADD Stand Alone Visits	G0155, G0176, G0177, G0409- G0411, G0463, H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, M0064, S0201, S9480, S9484, S9485, T1015

Exclusion codes
Acute Inpatient, Chemical Dependency, Mental Health Diagnosis, Narcolepsy.

Antidepressant Medication Management (AMM)

NCQA Accreditation – Medicaid
NCQA Accreditation – Medicare (CMC)

Q: Which members are included in the sample?

A: Adults 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment for at least 84 days (12 weeks) or for at least 180 days (6 months).

Q: What codes are used?

A: Please reference attached sample codes and Value Set Directory for additional codes.

Q: What documentation is needed in the medical record?

A: *None*. This measure requires claim/encounter data submission only using the appropriate Value Set Codes.

Antidepressant Medication Management (AMM)

NCQA Accreditation – Medicaid
NCQA Accreditation – Medicare (CMC)

Q: What type of document is acceptable?

A: Evidence from claim/encounter data:

1. Diagnosis of major depression and date of the earliest dispensing event for an antidepressant medication:

Antidepressant Medications

Description	Prescription		
Miscellaneous antidepressants	• Bupropion	• Vilazodone	• Vortioxetine
Monoamine oxidase inhibitors	• Isocarboxazid • Phenelzine	• Selegiline • Tranylcypromine	
Phenylpiperazine antidepressants	• Nefazodone	• Trazodone	
Psychotherapeutic combinations	• Amitriptyline-chlordiazepoxide • Amitriptyline-perphenazine		• Fluoxetine-olanzapine
SNRI antidepressants	• Desvenlafaxine • Duloxetine	• Levomilnacipran • Venlafaxine	
SSRI antidepressants	• Citalopram • Escitalopram	• Fluoxetine • Fluvoxamine	• Paroxetine • Sertraline
Tetracyclic antidepressants	• Maprotiline	• Mirtazapine	
Tricyclic antidepressants	• Amitriptyline • Amoxapine • Clomipramine	• Desipramine • Doxepin (>6 mg) • Imipramine	• Nortriptyline • Protriptyline • Trimipramine

2. Calendar days covered with prescriptions within the specified 180-day (6-month) measurement interval based on pharmacy claims.

Q: How to improve score for this HEDIS measure?

A:

- ☑ Use of complete and accurate Value Set Codes
- ☑ Timely submission of claim/encounter data
- ☑ Follow Practice Guidelines for the Treatment of Patients with Major Depressive Disorders
- ☑ Treat members with diagnosis of major depression for at least six months
- ☑ Utilize the PHQ-9 assessment tool in management of depression
- ☑ Educate members that it might take up to 4 weeks for therapeutic effect and of possible medication side effects

Antidepressant Medication Management (AMM)

NCQA Accreditation – Medicaid
NCQA Accreditation – Medicare (CMC)

SAMPLE CODES

The codes listed below are not inclusive and do not represent a complete list of codes.

ICD-10 codes	
Major Depression	F32.0-F32.4, F32.9, F33.0-F33.3, F33.41, F33.9

CPT codes	
AMM Stand Alone Visits	98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99391-99397, 99401-99404, 99411, 99412, 99483, 99510
AMM Visits	90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90867-90870, 90875, 90876, 99221-99223, 99231-99233, 99238, 99239, 99251-99255
ED	99281-99285

HCPCS codes	
AMM Stand Alone Visits	G0155, G0176, G0177, G0409-G0411, G0463, H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, M0064, S0201, S9480, S9484, S9485, T1015

Exclusion codes
Major Depression

Asthma Medication Ratio (AMR)

State Medicaid MPL (must achieve 25th percentile or greater)
Pay-for -Performance (P4P)
NCQA Accreditation – Medicaid

Q: Which members are included in the sample?

A: Members 5-64 identified as having persistent asthma who had a ratio of controller medications to total asthma medications of 0.50 or greater during 2018.

Q: What codes are used?

A: Please reference attached sample codes and Value Set Directory for additional codes.

Q: What documentation is needed in the medical record?

A: None. This measure requires claim/encounter data submission only using the appropriate Value Set Codes.

Q: What type of document is acceptable?

A: Evidence from claim/encounter data with documentation of all asthma medications for members identified as having persistent asthma during 2018.

Asthma Controller Medications

Description	Prescriptions		
Antiasthmatic combinations	• Dyphylline-guaifenesin	• Guaifenesin-theophylline	
Antibody inhibitors	• Omalizumab		
Anti-interleukin-5	• Mepolizumab	• Reslizumab	
Inhaled steroid combinations	• Budesonide-formoterol • Fluticasone-salmeterol	• Fluticasone-vilanterol • Mometasone-formoterol	
Inhaled corticosteroids	• Beclomethasone • Budesonide • Ciclesonide	• Flunisolide • Fluticasone CFC free • Mometasone	
Leukotriene modifiers	• Montelukast	• Zafirlukast	• Zileuton
Methylxanthines	• Dyphylline	• Theophylline	

Asthma Reliever Medications

Description	Prescriptions		
Short-acting, inhaled beta-2 agonists	• Albuterol	• Levalbuterol	• Pirbuterol

Q: How to improve score for this HEDIS measure?

A: Use of complete and accurate Value Set Codes.

☑ Timely submission of claim/encounter data

Asthma Medication Ratio (AMR)

State Medicaid MPL (must achieve 25th percentile or greater)
Pay-for-Performance (P4P)
NCQA Accreditation – Medicaid

SAMPLE CODES

The codes listed below are not inclusive and do not represent a complete list of codes.

ICD-10 codes - Asthma	
Mild Intermittent Asthma	J45.20-J45.22
Mild Persistent Asthma	J45.30-J45.32
Moderate Persistent Asthma	J45.40-J45.42
Severe Persistent Asthma	J45.50-J45.52
Other and Unspecified Asthma	J45.901-J45.902, J45.909, J45.990, J45.991, J45.998

CPT codes	
ED	99281-99285
Observation	99217-99220
Outpatient	99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99429, 99455, 99456, 99483

HCPCS codes	
Outpatient	G0402, G0438, G0439, G0463, T1015

Exclusion codes
Acute Respiratory Failure, Chronic respiratory Conditions Due to Fumes/Vapors, COPD, Cystic Fibrosis, Emphysema, Obstructive Chronic Bronchitis, Other Emphysema.

Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)

Q: Which members are included in the sample?

A: Adults 18 years and older with a diagnosis of rheumatoid arthritis and who were dispensed at least one ambulatory prescription for a disease-modifying anti-rheumatic drug (DMARD) in 2018.

Q: What codes are used?

A: Please reference attached sample codes and Value Set Directory for additional codes.

Q: What documentation is needed in the medical record?

A: *None*. This measure requires claim/encounter data submission only using the appropriate Value Set Codes.

Q: What documentation is needed in the medical record?

A: Evidence from claim/encounter or pharmacy data:

- A date of service for any outpatient visit or a non-acute inpatient discharge with a diagnosis of rheumatoid arthritis, and a prescription for DMARD in 2018

DMARD Medications

Description	Prescription		
5-Aminosalicylates	• Sulfasalazine		
Alkylating agents	• Cyclophosphamide		
Aminoquinolines	• Hydroxychloroquine		
Anti-rheumatics	• Auranofin • Leflunomide	• Methotrexate • Penicillamine	
Immunomodulators	• Abatacept • Adalimumab • Anakinra • Certolizumab	• Certolizumab pegol • Etanercept • Golimumab • Infliximab	• Rituximab • Tocilizumab
Immunosuppressive agents	• Azathioprine	• Cyclosporine	• Mycophenolate
Janus kinase (JAK) inhibitor	• Tofacitinib		
Tetracyclines	• Minocycline		

Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)

Q: How to improve score for this HEDIS measure?

A:

- ☑ Use of complete and accurate Value Set Codes
- ☑ Timely submission claim/encounter data
- ☑ Ensure presence of all components in the medical record documentation
- ☑ Evidence of a diagnosis of HIV or pregnancy - *documentation will assist in excluding members from the HEDIS sample*

Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)

SAMPLE CODES

The codes listed below are not inclusive and do not represent a complete list of codes.

ICD-10 codes
Refer to Rheumatoid Arthritis Value Set

CPT codes	
Outpatient	99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99429, 99455, 99456, 99483

HCPCS codes	
Outpatient	G0402, G0438, G0439, G0463, T1015
DMARD	J0129, J0135, J0717, J1438, J1600, J1602, J1745, J3262, J7502, J7515-J7518, J9250, J9260, J9310, Q5102-Q5104

Exclusion codes
Acute Inpatient, Advanced Illness, Frailty, HIV, HIV Type 2, Observation, Outpatient, Pregnancy.

Breast Cancer Screening (BCS)

State Medicaid MPL (must achieve 25th percentile or greater)
Pay-for -Performance (P4P)
NCQA Accreditation – Medicaid
NCQA Accreditation – Medicare (CMC)

Q: Which members are included in the sample?

A: Women 50 to 74 years of age who had one or more mammograms to screen for breast cancer any time on or between 10/1/2016 - 12/31/2018.

Q: What codes are used?

A: Please reference attached sample codes and Value Set Directory for additional codes.

Q: What documentation is needed in the medical record?

A: *None*. This measure requires claim/encounter data submission only using the appropriate Value Set Codes.

Q: What type of document is acceptable?

A: ***Evidence from claim/encounter data:***

- Screening Mammography between 10/1/2016 - 12/31/2018
- Digital Breast Tomosynthesis between 10/1/2016 - 12/31/2018

Q: How to improve score for this HEDIS measure?

A:

- ☑ Use of complete and accurate Value Set Codes
- ☑ Timely submission of claim/encounter data
- ☑ Note that mammograms do not need prior authorization and share list of nearby contracted imaging/ mammography centers with member
- ☑ Educate female members about the importance of early detection, address common barriers/fears, and encourage testing
- ☑ Proper coding or documentation of mastectomy either bilateral or unilateral – *to assist in excluding member from the HEDIS sample. See below for exclusion criteria:*

Exclusions for Breast Cancer Screening: (Use designated Value Set Code for each)
Any of the following meet criteria for bilateral mastectomy:

- Bilateral Mastectomy
- Unilateral Mastectomy with a bilateral modifier

Breast Cancer Screening (BCS)

State Medicaid MPL (must achieve 25th percentile or greater)
Pay-for-Performance (P4P)
NCQA Accreditation – Medicaid
NCQA Accreditation – Medicare (CMC)

Q: How to improve score for this HEDIS measure?

- Two unilateral mastectomies with service dates 14 days or more apart
- Unilateral mastectomy with right-side modifier with same date of service
- Unilateral mastectomy with left-side modifier with same date of service

Note: Biopsies, breast ultrasounds and MRIs are not appropriate methods for breast cancer screening.

Breast Cancer Screening (BCS)

State Medicaid MPL (must achieve 25th percentile or greater)
Pay-for-Performance (P4P)
NCQA Accreditation – Medicaid
NCQA Accreditation – Medicare (CMC)

SAMPLE CODES

The codes listed below are not inclusive and do not represent a complete list of codes.

ICD-10 codes
N/A

CPT codes	
Mammography	77055-77057, 77061-77063, 77065-77067

HCPCS codes	
Mammography	G0202, G0204, G0206

Exclusion codes
Absence of Left Breast, Absence of Right Breast, Acute Inpatient, Advanced Illness, Bilateral, Mastectomy, Frailty, History of Bilateral Mastectomy, Observation, Outpatient, Unilateral Mastectomy.

Controlling High Blood Pressure (CBP)

State Medicaid Auto-Assignment
State Medicaid MPL (must achieve 25th percentile or greater)
NCQA Accreditation - Medicaid
NCQA Accreditation - Medicare (CMC)
Cal Medi-Connect (CMC) Quality Performance Withhold

Q: Which members are included in the sample?

A: Members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled in 2018 based on the following criteria:

- Members 18–85 years of age whose BP was <140/90 mm Hg

Q: What codes are used?

A: Please reference attached sample codes and Value Set Directory for additional codes.

Q: What documentation is needed in the medical record?

A: Notation of the lowest systolic and lowest diastolic BP reading from the most recent BP notation in the medical record in 2018.
BP reading must occur on or after the date when the second diagnosis of hypertension occurred. BP readings from remote monitoring devices that are digitally stored and transmitted to the provider are acceptable.

Q: What type of medical record is acceptable?

A: All progress notes in 2018

Controlling High Blood Pressure (CBP)

State Medicaid Auto-Assignment
State Medicaid MPL (must achieve 25th percentile or greater)
NCQA Accreditation - Medicaid
NCQA Accreditation - Medicare (CMC)
Cal Medi-Connect (CMC) Quality Performance Withhold

Q: How to improve score for this HEDIS measure?

A:

- ☑ Use of complete and accurate Value Set Codes
- ☑ Timely submission of claim/encounter data
- ☑ Ensure presence of all components in the medical record documentation
- ☑ Submit any documentation with ESRD, Pregnancy, Kidney transplant or dialysis - *documentation will assist in excluding members from the HEDIS sample*
- ☑ Exclusion (optional): Female members with diagnosis of pregnancy in 2018.
- ☑ Exclusion (required): For Medicare - members 66 years and older living in long term in institutional settings

Controlling High Blood Pressure (CBP)

State Medicaid Auto-Assignment
State Medicaid MPL (must achieve 25th percentile or greater)
NCQA Accreditation - Medicaid
NCQA Accreditation - Medicare (CMC)
Cal Medi-Connect (CMC) Quality Performance Withhold

SAMPLE CODES

The codes listed below are not inclusive and do not represent a complete list of codes.

ICD-10 codes	
Essential Hypertension	I10
Diabetes	Refer to Diabetes Value Set

CPT codes	
Outpatient	99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99429, 99455, 99456, 99483
Observation	99217-99220
ED	99281-99285
CPT II codes	3074F—Systolic <130 3075F—Systolic 130-139 3078F—Diastolic <80 3079F—Diastolic 80-89 3077F—Systolic 140 or greater 3080F—Diastolic 90 or greater

HCPCS codes	
Outpatient	G0402, G0438, G0439, G0463, T1015

Exclusion codes
Acute Inpatient, Advanced Illness, ESRD, ESRD Obsolete, Frailty, Inpatient Stay, Kidney, Transplant, Non-acute Inpatient Stay, Observation, Outpatient, Pregnancy.

Cervical Cancer Screening (CCS)

State Medicaid Auto-Assignment
State Medicaid MPL (must achieve 25th percentile or greater)
Pay-for-Performance (P4P)
NCQA Accreditation - Medicaid

Q: Which members are included in the sample?

A:

- ☑ Women 21-64 years of age, and
- ☑ Had a Pap smear (cervical cytology) in **2016, 2017, or 2018**

Or

- ☑ Women 30-64 years of age, and
- ☑ Had cervical cytology/human papillomavirus (HPV) co-testing on the same date of service in **2014, 2015, 2016, 2017,** or **2018**

Q: What codes are used?

A: Please reference attached sample codes and Value Set Directory for additional codes.

Q: What documentation is needed in the medical record?

A: Documentation must include both of the following criteria:

- ☑ a note indicating the date test was performed, ***and***
- ☑ the result or finding

Q: What type of medical record is acceptable?

A: Acceptable document:

- ☑ Cervical cytology report/HPV report
- ☑ Chronic Problem List with documentation of Pap smear with or without HPV, including date and result
- ☑ Any documentation of history of hysterectomy with no residual cervix
- ☑ Progress note or consultation - notation of date and result of Pap smear
- ☑ Documentation of a "vaginal pap smear" in conjunction with documentation of hysterectomy
- ☑ Documentation of hysterectomy in combination with documentation that the patient no longer needs pap testing/cervical cancer screening

Cervical Cancer Screening (CCS)

State Medicaid Auto-Assignment
State Medicaid MPL (must achieve 25th percentile or greater)
Pay-for-Performance (P4P)
NCQA Accreditation - Medicaid

Q: How to improve score for this HEDIS measure?

A:

- ☑ Use of complete and accurate Value Set Codes
- ☑ Timely submission of claim/encounter data
- ☑ Ensure proper documentation in medical record
- ☑ Request results of screenings be sent to you if done at OB/GYN visit
- ☑ Hysterectomy with no residual cervix, cervical agenesis, or acquired absence of cervix - *documentation will assist in excluding member from the HEDIS sample*

Cervical Cancer Screening (CCS)

State Medicaid Auto-Assignment
State Medicaid MPL (must achieve 25th percentile or greater)
Pay-for-Performance (P4P)
NCQA Accreditation - Medicaid

SAMPLE CODES

The codes listed below are not inclusive and do not represent a complete list of codes.

ICD-10 codes
N/A

CPT codes	
Cervical Cytology	88141-88143, 88147, 88148, 88150, 88152-88154, 88164-88167, 88174, 88175
HPV Tests	87620-87622, 87624, 87625

HCPCS codes	
Cervical Cytology	G0123, G0124, G0141, G0143-G0145, G0147, G0148, P3000, P3001, Q0091
HPV Tests	G0476

Exclusion codes
Absence of Cervix.

Comprehensive Diabetes Care (CDC)

State Medicaid Auto-Assignment (HbA1c Testing)
State Medicaid MPL (must achieve 25th percentile or greater)
Pay-for-Performance (P4P)
NCQA Accreditation – Medicaid
NCQA Accreditation – Medicare (CMC)

Q: Which members are included in the sample?

A: Members 18-75 years of age with diabetes (Type 1 & 2) who had ***each*** of the following:

- ☑ Hemoglobin A1c (HbA1c) testing in 2018 (P4P)
- ☑ HbA1c Control (<8.0%) (Pay-for-Performance (P4P))
- ☑ HbA1c Poor Control (>9.0%)
- ☑ Retinal eye exam in 2017 or 2018 (Pay-for-Performance (P4P))
- ☑ Medical attention for nephropathy in 2018 (Pay-for-Performance (P4P))
- ☑ Blood pressure (BP) control (<140/90 mmHg) in 2018

Q: What codes are used?

A: Please reference attached sample codes and Value Set Directory for additional codes.

Q: What documentation is needed in the medical record?

A: **Hemoglobin A1c (HbA1c) Testing and Control in 2018**

- Date of the most recent HbA1c test and the result
- Glycohemoglobin, glycated hemoglobin, and glycosylated hemoglobin are acceptable HbA1c tests

Medical Attention for Nephropathy in 2018

- Urine microalbumin test with the date performed, and result/finding
- Evidence of nephropathy (e.g., renal transplant, ESRD, visit to nephrologist)
- Any urine protein testing or monitoring in 20178 (positive or negative result)
- Evidence of ACE inhibitor/ARB therapy

Blood Pressure (BP) Control (<140/90 mmHg)

- The most recent BP reading during an outpatient visit or a nonacute inpatient encounter in 2018 (use the lowest systolic and lowest diastolic BP on the same date of service)

Comprehensive Diabetes Care (CDC)

State Medicaid Auto-Assignment (HbA1c Testing)
State Medicaid MPL (must achieve 25th percentile or greater)
Pay-for-Performance (P4P)
NCQA Accreditation – Medicaid
NCQA Accreditation – Medicare (CMC)

Q: What documentation is needed in the medical record?

Retinal Eye Exam

- A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in 2018
- A negative retinal or dilated eye exam (negative for retinopathy) by an eye care professional in 2017
- Bilateral eye enucleation anytime during the member's history through December 31, 2018
- A note or letter from an ophthalmologist, optometrist, PCP or other healthcare professional indicating that an ophthalmoscopic exam was completed by an eye care professional, the date when the procedure was performed and the results
- A chart or photograph of retinal abnormalities indicating the date when the fundus photography was performed and evidence that an eye care professional reviewed the results

Note: Notation limited to a statement that indicates "diabetes without complications" does not meet criteria.

Q: What type of document is acceptable?

A:

- ☑ Progress notes
- ☑ Health Maintenance Log
- ☑ Lab reports
- ☑ Eye exam report from eye care professional (optometrist or ophthalmologist)
- ☑ Nephrology consult report
- ☑ Medication list
- ☑ Blood Pressure Log from the medical record

Q: How to improve score for this HEDIS measure?

A:

- ☑ Use of complete and accurate Value Set Codes.
- ☑ Timely submission of claim/encounter data
- ☑ Review diabetes services needed at each office visit
- ☑ HbA1c control – schedule regular follow-up with patients to monitor changes and adjust therapies as needed
- ☑ BP control – measure and document BP at each office visit and if elevated (>140/90), measure BP again at end of the visit

Comprehensive Diabetes Care (CDC)

State Medicaid Auto-Assignment (HbA1c Testing)
State Medicaid MPL (must achieve 25th percentile or greater)
Pay-for-Performance (P4P)
NCQA Accreditation – Medicaid
NCQA Accreditation – Medicare (CMC)

Q: How to improve score for this HEDIS measure?

A:

☑ Ensure proper documentation in medical record. For example:

- Coding is for *diabetic* retinal eye exam vs. general retinal eye exam
- Date, time, and result of each BP taken

Note: Members who did not have a diagnosis of diabetes, in any setting and who had a diagnosis of gestational diabetes and steroid-induced diabetes, in any setting in 2017 or 2018 can be excluded from the HEDIS sample.

Comprehensive Diabetes Care (CDC)

State Medicaid Auto-Assignment (HbA1c Testing)
State Medicaid MPL (must achieve 25th percentile or greater)
Pay-for-Performance (P4P)
NCQA Accreditation – Medicaid
NCQA Accreditation – Medicare (CMC)

SAMPLE CODES

The codes listed below are not inclusive and do not represent a complete list of codes.

ICD-10 codes	
Diabetes Diagnosis	Refer to Diabetes Value Set

CPT codes	
Outpatient	99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99429, 99455, 99456, 99483
Diabetic Retinal Screening	67028, 67030, 67031, 67036, 67039-67043, 67101, 67105, 67107, 67108, 67110, 67112, 67113, 67121, 67141, 67145, 67208, 67210, 67218, 67220, 67221, 67227, 67228, 92002, 92004, 92012, 92014, 92018, 92019, 92134, 92225-92228, 92230, 92235, 92240, 92250, 92260, 99203-99205, 99213-99215, 99242-99245
Urine Protein Tests	81000-81003, 81005, 82042-82044, 84156
HbA1c Tests	83036, 83037

CPT II codes	
BP Testing	3074F, 3075F, 3077F, 3078F, 3079F, 3080F
Diabetic Retinal Screening with Eye Care Professional	2022F, 2024F, 2026F
Diabetic Retinal Screening Negative	3072F

Comprehensive Diabetes Care (CDC)

State Medicaid Auto-Assignment (HbA1c Testing)
State Medicaid MPL (must achieve 25th percentile or greater)
Pay-for-Performance (P4P)
NCQA Accreditation – Medicaid
NCQA Accreditation – Medicare (CMC)

SAMPLE CODES

The codes listed below are not inclusive and do not represent a complete list of codes.

CPT II codes	
Urine Protein Tests	3060F, 3061F, 3062F
HbA1c	3044F, 3045F, 3046F
Nephropathy Treatment	3066F, 4010F

HCPCS codes
Diabetic Retinal Screening: S0620, S0621, S3000

Exclusion codes
Advanced Illness, Diabetes Exclusions, Frailty.

Chlamydia Screening in Women (CHL)

Pay-for-Performance (P4P)
NCQA Accreditation - Medicaid

Q: Which members are included in the sample?

A: Women 16-24 years of age who were identified as sexually active and who had at least one test for chlamydia in **2018**.

Q: What codes are used?

A: Please reference attached sample codes and Value Set Directory for additional codes.

Q: What documentation in the medical record is acceptable?

A: *None*. This measure requires claim/encounter data submission only using the appropriate Value Set Codes.

Q: What type of document is acceptable?

A: Evidence from claim/encounter data

- One chlamydia test in **2018**

Q: How to improve score for this HEDIS measure?

A:

- ☑ Use of complete and accurate Value Set Codes
- ☑ Timely submission of claim/encounter data
- ☑ For all those on birth control pills, make chlamydia screening a standard lab
- ☑ Remember that chlamydia screening can be performed through a simple urine test-offer this as an option for your members
- ☑ Proper coding or documentation will assist in excluding members from the HEDIS sample
- ☑ Exclude members based on a pregnancy test alone ***and*** who meet either of the following:
  - A pregnancy test in 2018 ***and*** a prescription for isotretinoin (Retinoid) on the date of pregnancy test or the 6 days after the pregnancy test
  - A pregnancy test in 2018 ***and*** an x-ray on the date of the pregnancy test or the 6 days after the pregnancy test

Chlamydia Screening in Women (CHL)

Pay-for-Performance (P4P)
NCQA Accreditation - Medicaid

SAMPLE CODES

The codes listed below are not inclusive and do not represent a complete list of codes.

ICD-10 codes
Refer to Pregnancy Value Set
Refer to Sexual Activity Value Set

CPT codes	
Chlamydia Tests	87110, 87270, 87320, 87490-87492, 87810
Pregnancy Tests	81025, 84702, 84703
Sexual Activity	Refer to Sexual Activity Value Set

HCPCS codes	
Sexual Activity	G0101, G0123, G0124, G0141, G0143-G0145, G0147, G0148, H1000, H1001, H1003-H1005, P3000, P3001, Q0091, S0199, S4981, S8055

Exclusion codes
Diagnostic radiology and Pregnancy Tests.

Childhood Immunization Status (CIS)

State Medicaid Auto - Assignment (Combo 3)
State Medicaid MPL (must achieve 25th percentile or greater)
Pay-for-Performance (P4P)
NCQA Accreditation - Medicaid

Q: Which members are included in the sample?

A: Children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines **by their second birthday**.

Q: What codes are used?

A: Please reference attached sample codes and Value Set Directory for additional codes.

Q: What documentation is needed in the medical record?

A: Documentation must include <u>any</u> of the following:

*Specific for**: MMR, HepB, VZV, and HepA***

☑ Evidence of the antigen or combination vaccine (include specific dates)

☑ Documented history of the illness

☑ A seropositive test result

*Specific for: **DTaP, HiB, IPV, PCV, rotavirus, and influenza***

☑ Evidence of the antigen or combination vaccine (include specific dates)

<u>OR</u>

☑ Notation indicating contraindication for a specific vaccine:
(Use designated Value Set Codes for each)

Any Particular Vaccine	• Anaphylactic reaction to the vaccine or its components
DTaP	• Encephalopathy ***with*** a vaccine adverse-effect code
MMR, VZV, and Influenza	• Immunodeficiency • HIV • Anaphylactic reaction to neomycin • Lymphoreticular cancer, Multiple Myeloma, or Leukemia
Rotavirus	• Severe combined immunodeficiency • History of intussusception

Childhood Immunization Status (CIS)

State Medicaid Auto - Assignment (Combo 3)
State Medicaid MPL (must achieve 25th percentile or greater)
Pay-for-Performance (P4P)
NCQA Accreditation - Medicaid

Q: What documentation is needed in the medical record?

OR

☑ Notation indicating contraindication for a specific vaccine:
(Use designated Value Set for each)

IPV	Anaphylactic reaction to streptomycin, polymyxin B or neomycin
Hepatitis B	Anaphylactic reaction to common baker's yeast

Q: What type of medical record is acceptable?

A: One or more of the following:

- ☑ Certificate of immunization including specific dates and types of vaccines
- ☑ Hospital record with notation of HepB
- ☑ Immunization Record and Health History Form
- ☑ Health Maintenance Form
- ☑ Lab report for seropositive test
- ☑ Print out of LINK/CAIR registry
- ☑ Progress/office notes with notations of vaccines given
- ☑ Medical History Form

Q: How to improve score for this HEDIS measure?

A:

- ☑ Upload immunizations on to California Immunizations Registry (**http://cairweb.org**)
- ☑ Use the Childhood and Adolescent Wellness Flyers for Providers as a guideline of recommended health services for certain age groups (**http://www.lacare.org/sites/default/files/LA1401_0815.pdf**)
- ☑ Educate parents about the importance of timely vaccinations and share the immunization schedule
- ☑ Use of complete and accurate Value Set Codes
- ☑ Timely submission of claim/encounter data
- ☑ Ensure proper documentation of dates and types of immunizations, test results, history of illness, or contraindication for a specific vaccine

Childhood Immunization Status (CIS)

State Medicaid Auto - Assignment (Combo 3)
State Medicaid MPL (must achieve 25th percentile or greater)
Pay-for-Performance (P4P)
NCQA Accreditation - Medicaid

SAMPLE CODES

The codes listed below are not inclusive and do not represent a complete list of codes.

ICD-10 PC code	
Newborn Hepatitis B	3E0234Z

CPT codes	
DTap Vaccine	90698, 90700, 90721, 90723
Haemophilus Influenzae Type B (HiB) Vaccine	90644-90648, 90698, 90721, 90748
Hepatitis A Vaccine	90633
Hepatitis B Vaccine	90723, 90740, 90744, 90747, 90748
Inactivated Polio Vaccine (IPV)	90698, 90713, 90723
Influenza Vaccine	90655, 90657, 90661, 90662, 90673, 90685-90688
Measles Vaccine	90705
Measles, Mumps and Rubella Vaccine	90707, 90710
Measles/Rubella Vaccine	90708
Mumps Vaccine	90704
Pneumococcal Conjugate Vaccine	90670
Rotavirus Vaccine (2 dose)	90681
Rotavirus Vaccine (3 dose)	90680
Rubella Vaccine	90706
Varicella Zoster Vaccine	90710, 90716

Childhood Immunization Status (CIS)

State Medicaid Auto - Assignment (Combo 3)
State Medicaid MPL (must achieve 25th percentile or greater)
Pay-for-Performance (P4P)
NCQA Accreditation - Medicaid

HCPCS codes	
Influenza	G0008
Pneumococcal	G0009
Hepatitis B Vaccine	G0010

Exclusion codes

Anaphylactic Reaction Due to Vaccination, Disorders of Immune System, Encephalopathy Due to Vaccination, HIV, Intussusception, Malignant Neoplasm of Lymphatic Tissue, Severe Combined Immunodeficiency, Vaccine Causing Adverse Effect.

Care for Older Adults (COA)

Q: Which members are included in the sample?

A: Adults 66 years and older who had ***each*** of the following in **2018**:

- ☑ Advance care planning
- ☑ Medication review
- ☑ Functional status assessment
- ☑ Pain assessment

Q: What codes are used?

A: Please reference attached sample codes and Value Set Directory for additional codes.

Q: What documentation is needed in the medical record?

A:

- ☑ **Advanced Care Planning** – evidence must include either the presence of advanced care plan in the medical record ***or*** documentation of advance care planning discussion with the provider and the date when it was discussed
- ☑ **Evidence of Medication Review** – must include medication list in the medical record, and evidence of a medication review and the date when it was performed ***or*** notation that the member is not taking any medication and the date when it was noted
- ☑ **Evidence of Functional Status Assessment** – documentation must include evidence of functional status assessment ***and*** the date when it was performed
- ☑ **Evidence of Pain Assessment** – documentation must include evidence of a pain assessment (may include positive or negative findings for pain) and the date when it was performed

Q: What type of medical record is acceptable?

A:

Advanced Care Planning:

- ☑ Advance Directives
- ☑ Actionable medical orders
- ☑ Copy of Living Wills, Medical Power of Attorney
- ☑ Copy of documentation of surrogate decision maker
- ☑ Notation of advance care planning discussion with a provider in 2018
- ☑ Evidence of oral statements noted in the medical record in 2018
- ☑ Notation that a member declined to discuss advanced care planning in 2018

Medication Review:

- ☑ Current medication list in 2018
- ☑ Notation of medication review in 2018
- ☑ Date and notation that the member is not taking any medication in 2018

Functional Status Assessment:

- ☑ Progress notes, IHSS forms, HRA forms, AWE form
- ☑ Notation that Activities of Daily Living (ADL) were assessed or that at least 5 of the following were assessed: bathing, dressing, eating, transferring [e.g., getting in and out of chairs], using toilet, walking
- ☑ Notation that Instrumental Activities of Daily Living (IADL) were assessed or at least 4 of the following were assessed: shopping for groceries, driving or using public transportation, using the telephone, meal preparation, housework, home repair, laundry, taking medications, handling finances
- ☑ Result of assessment using a standardized functional status assessment tool
- ☑ Notation of cognitive status, ambulation status, sensory ability (hearing, vision and speech) and, other functional independence (e.g., exercise)

Care for Older Adults (COA)

Q: What type of medical record is acceptable?

A: Pain Assessment:

- ☑ Progress notes – notation of a pain assessment (which may include positive or negative findings for pain)
- ☑ Result of assessment using a standardized pain assessment tool
- ☑ Numeric rating scales (verbal or written)
- ☑ Pain Thermometer
- ☑ Pictorial Pain Scales
- ☑ Visual Analogue Scale
- ☑ Brief Pain Inventory
- ☑ Chronic Pain Grade
- ☑ PROMIS Pain Intensity Scale
- ☑ Pain Assessment in Advanced Dementia (PAINAD) Scale

Q: How to improve score for this HEDIS measure?

A:

- ☑ Use of complete and accurate Value Set Codes
- ☑ Timely submission of claim/encounter data
- ☑ Ensure presence of all components in the medical record documentation
- ☑ Timely submission of complete and accurate AWE Forms
- ☑ Exclude services provided in an acute inpatient setting

Care for Older Adults (COA)

SAMPLE CODES

The codes listed below are not inclusive and do not represent a complete list of codes.

ICD-10 Codes
N/A

CPT Codes	
Advance Care Planning	99497, 99483
Medication Review	90863, 99483, 99605, 99606
TCM 14 day	99495
TCM 7 day	99496

CPT II Codes	
Pain Assessment	1125F, 1126F
Advance Care Planning	1123F, 1124F, 1157F, 1158F
Medication List	1159F
Medication Review	1160F
Functional Status Assessment	1170F

Care for Older Adults (COA)

SAMPLE CODES

The codes listed below are not inclusive and do not represent a complete list of codes.

HCPCS codes	
Medication List	G8427
Advance Care Planning	S0257

Exclusions codes
Acute Inpatient, Acute Inpatient POS

Colorectal Cancer Screening (COL)
NCQA Accreditation - Medicare

Q: Which members are included in the sample?

A: Members 50-75 years of age who had one or more appropriate screenings for colorectal cancer.

Q: What codes are used?

A: Please reference attached sample codes and Value Set Directory for additional codes.

Q: What documentation is needed in the medical record?

A: Documentation in the medical record must include a note indicating the **date** the colorectal cancer screening was performed. Appropriate screenings are defined by **any** of the following:

- ☑ Fecal Occult Blood Test in **2018**; guaiac (gFOBT) or immunochemical (FIT)
- ☑ Flexible sigmoidoscopy performed in **2014, 2015, 2016, 2017,** or **2018**
- ☑ Colonoscopy in **2018** *or* ***within 9 years prior to 2018***
- ☑ CT colonography performed in **2014, 2015, 2016, 2017,** or **2018**
- ☑ FIT-DNA Test in **2016**, **2017** or **2018**

Q: What type of medical record is acceptable?

A: One or more of the following:

- ☑ Health Maintenance Form
- ☑ Progress notes/Office visits notes
- ☑ Problem List
- ☑ Laboratory/Pathology Reports
- ☑ Pathology report that indicates the type of screening (e.g., colonoscopy or flexible sigmoidoscopy)
- ☑ Pathology report without indicating the type of screening but has evidence that the scope advanced beyond the splenic flexure or sigmoid colon
- ☑ Medical History Forms
- ☑ X-ray Reports
- ☑ GI Consults/ Reports/ Flowcharts
- ☑ Complete Physical Examination Form

Note: Do not count digital rectal exams (DRE), FOBT tests performed in an office setting or performed on a sample collected via DRE.

Colorectal Cancer Screening (COL)
NCQA Accreditation - Medicare

Q: How to improve score for this HEDIS measure?

A:

- ☑ Use of complete and accurate Value Set Codes
- ☑ Timely submission of claim/encounter data
- ☑ Prior to each visit for members 50 years and older, review chart to determine if COL screening has been completed, if not, discuss options with member, as colonoscopy every 10 years and stool testing done yearly are shown to have similar effectiveness in identifying colon cancer
- ☑ Request a supply of stool screening test kits from your contracted lab(s) to have on hand to share with members when at office visits
- ☑ If a member had a colonoscopy, the provider's office should ask the member for a copy of the report or the rendering provider's contact information to request the report and save a copy in the member's medical record
- ☑ Timely submission of claim/encounter data
- ☑ Ensure presence of all components in the medical record documentation
- ☑ *Exclude members with diagnosis of colorectal cancer or total colectomy*
- ☑ *Exclusions: hospice care, advanced illness, and frailty*

Colorectal Cancer Screening (COL)
NCQA Accreditation - Medicare

SAMPLE CODES

The codes listed below are not inclusive and do not represent a complete list of codes.

ICD-10 codes
N/A

CPT codes	
FOBT	82270, 82274
Flexible Sigmoidoscopy	45330-45335, 45337-45342, 45345-45347, 45349, 45350
Colonoscopy	44388-44394, 44397, 44401-44408, 45355, 45378-45393, 45398
CT Colonography	74261-74263
FIT-DNA	81528

HCPCS codes	
FOBT	G0328
Flexible Sigmoidoscopy	G0104
Colonoscopy	G0105, G0121
Colorectal Cancer (PET scan)	G0213-G0215, G0231
FIT-DNA	G0464

Exclusion codes
Advanced Illness, Colorectal Cancer, Frailty, Hospice, Total Colectomy.

Appropriate Testing for Children with Pharyngitis (CWP)

Pay-for-Performance (P4P)
NCQA Accreditation - Medicaid

Q: Which members are included in the sample?

A: Children 3-18 years of age, who were diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode (**7/1/2017 - 6/30/2018**) during any outpatient or ED visit.

Q: What codes are used?

A: Please reference attached sample codes and Value Set Directory for additional codes.

Q: What documentation is needed in the medical record?

A: *None*. This measure requires claim/encounter data submission only using the appropriate Value Set Codes.

Q: What type of document is acceptable?

A: Evidence of claim/encounter data:

- ☑ Date of service for an outpatient or ED visit with a diagnosis of pharyngitis
- ☑ Throat culture lab report
- ☑ Date and result of strep test with a diagnosis of pharyngitis
- ☑ Antibiotic prescription for the episode

Appropriate Testing for Children with Pharyngitis (CWP)

Pay-for-Performance (P4P)
NCQA Accreditation - Medicaid

Antibiotic Medications:

Description	Prescription		
Aminopenicillins	• Amoxicillin	• Ampicillin	
Beta lactamase inhibitors	• Amoxicillin-clavulanate		
First generation cephalosporins	• Cefadroxil • Cefazolin	• Cephalexin	
Folate antagonist	• Trimethoprim		
Lincomycin derivatives	• Clindamycin		
Macrolides	• Azithromycin • Clarithromycin • Erythromycin	• Erythromycin ethylsuccinate • Erythromycin lactobionate • Erythromycin stearate	
Miscellaneous antibiotics	• Erythromycin-sulfisoxazole		
Natural penicillins	• Penicillin G potassium • Penicillin G sodium	• Penicillin V potassium	
Penicillinase-resistant penicillins	Dicloxacillin		
Quinolones	• Ciprofloxacin • Levofloxacin	• Moxifloxacin • Ofloxacin	
Second generation cephalosporins	• Cefaclor • Cefprozil	• Cefuroxime	
Sulfonamides	• Sulfamethoxazole-trimethopin		
Tetracyclines	• Doxycycline • Minocycline	• Tetracycline	
Third generation cephalosporins	• Cefdinir • Cefixime	• Cefpodoxime • Ceftibuten	• Cefditoren • Ceftriaxone

Q: How to improve score for this HEDIS measure?

A:

- ☑ Use of complete and accurate Value Set Codes
- ☑ Timely submission of claim/encounter data
- ☑ Ensure presence of all components in the medical record documentation

Appropriate Testing for Children with Pharyngitis (CWP)

Pay-for-Performance (P4P)
NCQA Accreditation - Medicaid

SAMPLE CODES

The codes listed below are not inclusive and do not represent a complete list of codes.

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

CPT codes	
Group A Strep Tests	87070, 87071, 87081, 87430, 87650-87652, 87880
ED	99281-99285
Observation	99217-99220
Outpatient	99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99429, 99455, 99456, 99483

HCPCS codes	
Outpatient	G0402, G0438, G0439, G0463, T1015

Exclusion codes
Hospice, Inpatient Stay

Use of High-Risk Medications in the Elderly (DAE)

NCQA Accreditation – Medicare (CMC)

Q: Which members are included in the sample?

A: Medicare members 66 years and older who had:

- At least one dispensing event for a high-risk medication
- At least two dispensing events for the same high-risk-medication

*For both rates, a lower rate indicates better performance.

Q: What codes are used?

A: Please reference attached sample codes and Value Set Directory for additional codes.

Q: What documentation is needed in the medical record?

A: *None*. This measure requires claim/encounter data submission only using the appropriate Value Set Codes.

Q: What type of documentation is acceptable?

A: Evidence from a claim/encounter data:

☑ One or two dispensing event(s) for a high-risk medication in 2018

Use of High-Risk Medications in the Elderly (DAE)

NCQA Accreditation – Medicare (CMC)

High-Risk Medications

Description	Prescription	
Anticholinergics, first-generation antihistamines	• Brompheniramine • Carbinoxamine • Chlorpheniramine • Clemastine • Cyproheptadine • Dexbrompheniramine • Dexchlorpheniramine	• Diphenhydramine (oral) • Dimenhydrinate • Doxylamine • Hydroxyzine • Meclizine • Promethazine • Triprolidine
Anticholinergics, anti-Parkinson agents	• Benztropine (oral)	• Trihexyphenidyl
Antispasmodics	• Atropine (exclude ophthalmic) • Belladonna alkaloids • Clidinium-chlordiazepoxide • Dicyclomine	• Hyoscyamine • Propantheline • Scopolamine
Antithrombotics	• Dipyridamole, oral short-acting (does not apply to the extended-release combination with aspirin)	• Ticlopidine
Cardiovascular, alpha agonists, central	• Guanfacine	• Methyldopa
Cardiovascular, other	• Disopyramide	• Nifedipine, immediate release
Central nervous system, antidepressants	• Amitriptyline • Clomipramine • Amoxapine • Desipramine • Imipramine	• Trimipramine • Nortriptyline • Paroxetine • Protriptyline
Central nervous system, barbiturates	• Amobarbital • Butabarbital • Butalbital	• Pentobarbital • Phenobarbital • Secobarbital
Central nervous system, vasodilators	• Ergot mesylates	• Isoxsuprine
Central nervous system, other	• Meprobamate	
Endocrine system, estrogens with or without progestins; include only oral and topical patch products	• Conjugated estrogen • Esterified estrogen	• Estradiol • Estropipate
Endocrine system, sulfonylureas, long-duration	• Chlorpropamide	• Glyburide
Endocrine system, other	• Desiccated thyroid	• Megestrol
Pain medications, skeletal muscle relaxants	• Carisoprodol • Chlorzoxazone • Cyclobenzaprine	• Metaxalone • Methocarbamol • Orphenadrine
Pain medications, other	• Indomethacin • Ketorolac, includes parenteral	• Meperidine • Pentazocine

Use of High-Risk Medications in the Elderly (DAE)

NCQA Accreditation – Medicare (CMC)

High-Risk Medications

High-Risk Medications With Days Supply Criteria Medications

Description	Prescription		Days Supply Criteria
Anti-Infectives, other	• Nitrofurantoin • Nitrofurantoin macrocrystals	• Nitrofurantoin macrocrystals-monohydrate	>90 days
Nonbenzodiazepine hypnotics	• Eszopiclone • Zaleplon	• Zolpidem	>90 days

High-Risk Medications With Average Daily Dose Criteria Medications

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

Q: How to improve score for this HEDIS measure?

A:

- ☑ Use of complete and accurate Value Set Codes
- ☑ Timely submission of claim/encounter data

Use of High-Risk Medications in the Elderly (DAE)

NCQA Accreditation – Medicare (CMC)

SAMPLE CODES

The codes listed below are not inclusive and do not represent a complete list of codes.

CPT codes	
Outpatient services:	
Office/other outpatient services:	99201-99205, 99211-99215
Consultations	99241-99245
Preventive medicine services	99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99429

HCPCS codes	
Outpatient	G0402, G0438, G0439, G0463, T1015

Exclusion codes
Hospice

Potentially Harmful Drug-Disease Interactions in the Elderly (DDE)

NCQA Accreditation – Medicare (CMC)

Q: Which members are included in the sample?

A: Medicare members 65 years and older who have evidence of an underlying disease, condition or health concern and who were dispensed an ambulatory prescription for a potentially harmful medication, concurrent with or after the diagnosis.

Q: What codes are used?

A: Please reference attached sample codes and Value Set Directory for additional codes.

Q: What documentation is needed in the medical record?

A: *None*. This measure requires claim/encounter data submission only using the appropriate Value Set Codes.

Q: What type of documentation is acceptable?

A: Evidence from claim/encounter data for:

1 Drug-Disease Interactions – History of accidental Fall or Fracture between January 1, 2017 – December 1, 2018. Dispensed an ambulatory prescription for Anticonvulsants, SSRIs, Antipsychotics, Benzodiazepines, Nonbenzodiazepine Hypnotics or Tricyclic Antidepressants on or between the Index Episode Start Date (IESD) which is the earliest diagnosis, procedure or prescription between January 1, 2017 and December 31, 2018.

Potentially Harmful Drugs—Rate 1 Medications

Description	Prescription			
Anticonvulsants	• Carbamazepine • Clobazam • Divalproex sodium • Ethosuximide • Ethotoin • Ezogabine • Felbamate	• Fosphenytoin • Gabapentin • Lacosamide • Lamotrigine • Levetiracetam • Methsuximide • Oxcarbazepine	• Phenobarbital • Phenytoin • Pregabalin • Primidone • Rufinamide • Tiagabine HCL • Topiramate	• Valproate sodium • Valproic acid • Vigabatrin • Zonisamide
SSRIs	• Citalopram • Escitalopram	• Fluoxetine • Fluvoxamine	• Paroxetine • Sertraline	

Potentially Harmful Drugs—Rate 1 and Rate 2 Medications

Description	Prescription			
Antipsychotics	• Aripiprazole • Asenapine • Brexpiprazole • Cariprazine • Chlorpromazine • Clozapine	• Fluphenazine • Haloperidol • Iloperidone • Loxapine • Lurasidone • Molindone	• Olanzapine • Paliperidone • Perphenazine • Pimozide Quetiapine • Risperidone	• Thioridazine • Thiothixene • Trifluoperazine • Ziprasidone
Benzodiazepines	• Alprazolam • Chlordiazepoxide products • Clonazepam	• Clorazepate-dipotassium Diazepam • Estazolam	• Flurazepam HCL • Lorazepam • Midazolam HCL • Oxazepam	• Quazepam • Temazepam • Triazolam
Nonbenzodiazepine hypnotics	• Eszopiclone	• Zaleplon	• Zolpidem	
Tricyclic antidepressants	• Amitriptyline • Amoxapine • Clomipramine	• Desipramine • Doxepin (>6 mg) • Imipramine	• Nortriptyline • Protriptyline • Trimipramine	

Q: What type of documentation is acceptable?

2 Drug-Disease Interactions – Dementia. Dispensed an ambulatory prescription for Antipsychotics, Benzodiazepines, Nonbenzodiazepine Hypnotics, Tricyclic Antidepressants, H2 Receptor Antagonist, or Anticholinergic Agents on or between the Index Episode Start Date (IESD) which is the earliest diagnosis, procedure or prescription between January 1, 2017 and December 31, 2018.

Dementia Medications

Description	Prescription
Cholinesterase inhibitors	• Donepezil • Galantamine • Rivastigmine
Miscellaneous central nervous system agents	• Memantine

Potentially Harmful Drugs—Rate 2 Medications

Description	Prescription
H_2 receptor antagonists	• Cimetidine • Famotidine • Nizatidine • Ranitidine
Anticholinergic agents, antiemetics	• Prochlorperazine • Promethazine
Anticholinergic agents, antihistamines	• Carbinoxamine • Chlorpheniramine • Hydroxyzine • Brompheniramine • Clemastine • Triprolidine • Cyproheptadine • Dimenhydrinate • Diphenhydramine • Meclizine • Dexbrompheniramine • Dexchlorpheniramine • Doxylamine
Anticholinergic agents, antispasmodics	• Atropine • Homatropine • Belladonna alkaloids • Dicyclomine • Hyoscyamine • Propantheline • Scopolamine • Clidinium-chlordiazepoxide
Anticholinergic agents, antimuscarinics (oral)	• Darifenacin • Fesoterodine • Solifenacin • Trospium • Flavoxate • Oxybutynin • Tolterodine
Anticholinergic agents, anti-Parkinson agents	• Benztropine • Trihexyphenidyl
Anticholinergic agents, skeletal muscle relaxants	• Cyclobenzaprine • Orphenadrine
Anticholinergic agents, SSRIs	• Paroxetine
Anticholinergic agents, antiarrhythmic	• Disopyramide

3. Drug-Disease Interactions – Chronic Kidney Disease. Dispensed an ambulatory prescription for Cox-2 Selective NSAIDs or Nonaspirin NSAIDs on or between the Index Episode start Date (IESD) which is the earliest diagnosis, procedure or prescription between January 1, 2017 and December 31, 2018.

Cox-2 Selective NSAIDs and Nonaspirin NSAIDs Medications

Description	Prescription			
Cox-2 Selective NSAIDs	• Celecoxib			
Nonaspirin NSAIDs	• Diclofenac potassium • Diclofenac sodium • Etodolac • Fenoprofen • Flurbiprofen	• Ibuprofen • Indomethacin • Ketoprofen • Ketorolac • Meclofenamate	• Mefenamic acid • Meloxicam • Nabumetone • Naproxen • Naproxen sodium	• Oxaprozin • Piroxicam • Sulindac • Tolmetin

Q: How to improve score for this HEDIS measure?

A:

- ☑ Use of complete and accurate Value Set Codes
- ☑ Timely submission of claim/encounter data

Potentially Harmful Drug-Disease Interactions in the Elderly (DDE)

NCQA Accreditation – Medicare (CMC)

SAMPLE CODES

The codes listed below are not inclusive and do not represent a complete list of codes.

CPT codes	
Hip Fractures	27230, 27232, 27235, 27236, 27238, 27240, 27244-27246, 27248, 27254,27267-27269, 27767-27769
ESRD	90935, 90937, 90940, 90945, 90947, 90951 - 90959, 90960 – 90969, 90970, 90989, 90993, 90997, 90999, 99512 36147, 36800, 36810, 36815, 36819, 36820, 36821, 36831, 36833,
Outpatient	
E&M, office/other outpatient services	99201-99205, 99211-99215
E&M, hospital observation services	99217-99220
E&M, consultations	99241-99245
E&M, preventive medicine services	99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99429

ICD10 CM codes	
Dementia	G30.0, G30.1, G30.8, G30.9, G31.83, 290.0, 290.10 - 290.13, 290.20, 290.21, 290.3, 290.40 – 290.43, 290.8, 290.9, 291.2, 292.82, 294.0, 294.10, 294.11, 294.20
ESRD	Z91.15, Z99.2
Fall/Hip Fracture	Refer to Value Set Directory

Potentially Harmful Drug-Disease Interactions in the Elderly (DDE)

NCQA Accreditation – Medicare (CMC)

SAMPLE CODES

The codes listed below are not inclusive and do not represent a complete list of codes.

HCPCS Code	
ESRD	G0257, S9339
Outpatient	G0402, G0438, G0439, G0463, T1015

Exclusion:
Bipolar Disorder, Hospice, Other Bipolar Disorder Psychosis, Schizoaffective Disorder, Schizophrenia, or Seizure Disorder on or between January 1, 2018 and December 1, 2018.

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

Q: Which members are included in the sample?

A: Members 12 years of age and older who were screened for clinical depression using a standardized instrument, and received follow-up care within 30 days of positive screened test.

Q: What codes are used?

A: Please reference attached sample codes and Value Set Directory for additional codes.

Q: What documentation is needed in the medical record?

A: None. This measure requires claim/encounter data submission only using the appropriate Value Set Codes.

Q: What type of documentation is acceptable?

A: Evidence from a claim/encounter data:

- Documentation of standardized age appropriate tool for screening clinical depression.
- Documentation of a follow-up care on or 30 days after the date of the first positive screen (31 days total) from any one of the following.
  - a follow-up behavioral health encounter with or without a telehealth modifier including assessment, therapy, collaborative care, medication management, acute care and health encounters
  - a follow up outpatient visit with a diagnosis of depression or other behavioral health condition, with or without telehealth modifier
  - a telephone visit with diagnosis of depression or other behavioral health condition
  - a follow-up with a case manager with documented assessment of depression symptoms
  - dispensed an antidepressant medication

Q: How to improve score for this HEDIS measure?

- Use of complete and accurate Value Set Codes
- Timely submission of claim/encounter data

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

SAMPLE CODES

The codes listed below are not inclusive and do not represent a complete list of codes.

ICD 10 Codes:	
Depression or Other Behavioral Health Condition:	F01.51, F20.0-F20.5, F20.81, F20.89, F20.9

CPT Codes:	
Behavioral Health Encounter:	90791, 90792, 90832, 90833, 90834, 90836, 90837-90839, 90845-90847, 90849, 90853, 90865, 90867-90870, 90875, 90876, 90880, 90887
Depression Case Management Encounter:	99366
Follow-Up Visit:	98960-98962, 99078, 99201-99205, 99211 – 99215, 99217-99220, 99241 – 99245, 99341 – 99345, 99347 -99350, 99381 – 99387, 99391 – 99397, 99401 – 99404, 99411, 99412,

HCPCS codes	
Depression Case Management Encounter:	T1016, T1017, T2022, T2023, G0463, T1015

Exclusion Codes:
Bipolar Disorder, Depression, Hospice

Follow-Up After Hospitalization for Mental Illness (FUH)

NCQA Accreditation – Medicaid
NCQA Accreditation – Medicare (CMC)
Cal Medi-Connect (CMC) Quality Performance Withhold

Q: Which members are included in the sample?

A: Members 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 practitioner within 7-30 days after discharge.

Q: What codes are used?

A: Please reference attached sample codes and Value Set Directory for additional codes.

Q: What documentation is needed in the medical record?

A: None. This measure requires claim/encounter data submission only using the appropriate Value Set Codes.

Q: What type of documentation is acceptable?

A: Evidence from a claim/encounter data:

- Documentation of a follow-up visit in 2018 with a mental health practitioner within 7-30 days of discharge from hospitalization for treatment of mental illness
- Include all discharges on or between January 1 and December 1 of 2018

*Follow-up visits that occur on the date of discharge do not count.

Follow-Up After Hospitalization for Mental Illness (FUH)

NCQA Accreditation – Medicaid
NCQA Accreditation – Medicare (CMC)
Cal Medi-Connect (CMC) Quality Performance Withhold

Q: How to improve score for this HEDIS measure?

A:

- Use of complete and accurate Value Set Codes
- Timely submission of claim/encounter data
- Document hospice care readmission/direct transfer to acute setting for exclusion from the eligible population
- Mental Health Practitioner: A practitioner who provides mental health services and meets any of the following criteria:
    - An MD or (DO) who is certified or who successfully completed an accredited program in psychiatry or child psychiatry.
    - A licensed psychologist in his/her state of practice
    - A licensed or certified social worker with master's degree and is listed on the National Association of Social Worker's Clinical Register
    - A registered nurse (RN) certified as a psychiatric nurse or mental health clinical nurse specialist and has a master's degree in psychiatric/mental health
    - An individual with a master's or a doctoral degree in marital and family therapy and at least two years of supervised clinical experience who is practicing as a marital and family therapist
    - An individual with a master's or doctoral degree in counseling and at least two years of supervised clinical experience who is practicing as a professional counselor and licensed on the National Board for Certified Counselors (NBCC)

Follow-Up After Hospitalization for Mental Illness (FUH)

NCQA Accreditation – Medicaid
NCQA Accreditation – Medicare (CMC)
Cal Medi-Connect (CMC) Quality Performance Withhold

SAMPLE CODES

The codes listed below are not inclusive and do not represent a complete list of codes.

ICD-10 Codes

Refer to Mental Health Diagnosis Value Set and Mental Illness Value Set

CPT Codes

FUH Stand Alone Visits:	98960-98962, 99078, 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99384-99397, 99401-99404, 99408, 99411, 99412, 99483, 99510
FUH Visits Group 1:	90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90875, 90876
FUH Visits Group 2:	99221-99223, 99231-99233, 99238, 99239, 99251-99255
TCM 14 Day:	99495
TCM 7 Day:	99496
Telehealth Modifier:	95, GT

HCPCS Codes

FUH Stand Alone Visits:	G0155, G0176, G0177, G0409, G0410, G0411, G0463, H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, M0064, S0201, S9480, S9484, S9485, T1015

CPCS Codes

Hospice, Nonacute Inpatient Stay

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

NCQA Accreditation – Medicaid
NCQA Accreditation – Medicare (CMC)

Q: Which members are included in the sample?

A: Adolescent and adult members (13 years and older) in 2018 with a new episode of alcohol or other drug (AOD) abuse or dependence who received the following:

- ☑ Members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth or medication treatment within 14 days of the diagnosis
- ☑ Members who initiated treatment and who had two or more additional AOD services or within 34 days of the initiation visit

Q: What codes are used?

A: Please reference attached sample codes and Value Set Directory for additional codes.

Q: What documentation is needed in the medical record?

A: *None*. This measure requires claim/encounter data submission only using the appropriate Value Set Codes.

Q: What type of document is acceptable?

A: Evidence from a claim/encounter data

1. New diagnosis of alcohol or other drug (AOD) abuse or dependence and date
2. Initiation of member treatment within 14 days of the AOD abuse or dependence diagnosis
    a. Of these members who initiated treatment, evidence of two or more additional services (inpatient admissions, outpatient visits, telehealth, intensive outpatient encounters or partial hospitalizations with any AOD abuse or dependence diagnosis) within 34 days of the initiation treatment
        i. Note that multiple engagement visits may occur on the same day, but they must be with different providers in order to count

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

NCQA Accreditation – Medicaid
NCQA Accreditation – Medicare (CMC)

Q: How to improve score for this HEDIS measure?

A:

- ☑ Use of complete and accurate Value Set Codes
- ☑ Timely submission of claim/encounter data
- ☑ Consider screening all members at office visits using a substance abuse screening tool
- ☑ Perform SBIRT for members who answer positive for alcohol on the SHA or whom you suspect have an alcohol problem
- ☑ Once a member is identified with AOD abuse or dependence diagnosis, initiate brief intervention or refer for treatment within 14 days. Then complete at least two brief interventions within 34 days of diagnosis
- ☑ When referring members out to substance abuse providers, ensure an appointment is made within 14 days of diagnosis
- ☑ Exclude members from both Initiation of AOD Treatment and Engagement of AOD Treatment if the initiation of treatment event is an inpatient stay with a discharge date of November 27, 2018

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

NCQA Accreditation – Medicaid
NCQA Accreditation – Medicare (CMC)

SAMPLE CODES

The codes listed below are not inclusive and do not represent a complete list of codes.

ICD-10 codes
Refer to AOD Abuse and Dependence Value Set, AOD Alcohol Abuse and Dependence Value Set Value Set, Detoxification Value Set

CPT codes	
ED	99281-99285
IET Stand Alone Visits	98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99408, 99409, 99411, 99412, 99483, 99510
IET Visits Group 1	90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90875, 90876
IET Visits Group 2	99221-99223, 99231-99233, 99238, 99239, 99251-99255

HCPCS codes	
IET Stand Alone Visits	G0155, G0176, G0177, G0396, G0397, G0409-G0411, G0443, G0463, H0001, H0002, H0004, H0005, H0007, H0015, H0016, H0022, H0031, H0034-H0037, H0039, H0040, H0047, H2000, H2001, H2010-H2020, H2035, H2036, M0064, S0201, S9480, S9484, S9485, T1006, T1012, T1015
Detoxification	H0008-H0014

Exclusion codes
AOD Abuse and Dependence, AOD Medication Treatment, Hospice

Immunizations for Adolescents (IMA)

State Medicaid MPL (must achieve 25th percentile or greater)
Pay-for-Performance (P4P) (Combo 1)
NCQA Accreditation – Medicaid

Q: Which members are included in the sample?

A: Adolescents who had one dose of meningococcal conjugate vaccine (MCV), one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) and 2 or 3 doses of the human papillomavirus (HPV) vaccines **by their 13th birthday**.

- ☑ Combo 1 - (Meningococcal, Tdap)
- ☑ Combo 2 - (Meningococcal, Tdap, HPV)

Note: The minimum interval for the two-dose HPV vaccination schedule is 150 days (5 months), with a 4-day grace period (146 days).

Q: What codes are used?

A: Please reference attached sample codes and Value Set Directory for additional codes.

Q: What documentation is needed in the medical record?

A: Must include any of the following:

- ☑ A note indicating the name of specific antigen and the date of the immunization
- ☑ A certificate of immunization that includes specific dates and types of immunizations administered
- ☑ Anaphylactic reaction to the vaccine or its components any time on or before the member's 13th birthday
- ☑ Anaphylactic reaction to the vaccine or its components with a date of service prior to October 1, 2011
- ☑ Encephalopathy with a vaccine adverse-effect anytime on or before the member's 13th birthday. (Tdap)

Meningococcal vaccine – given between member's 11th and 13th birthday

Tdap vaccine – given between member's 10th and 13th birthday

HPV vaccine – 2-doses (given 146 days apart) or 3 doses given between member's 9th and 13th birthday

Q: What type of medical record is acceptable?

A: One or more of the following:

- ☑ Certificate of immunization including specific dates and types of vaccines
- ☑ Immunization Record and health History Form
- ☑ Health Maintenance Form/Report
- ☑ Print out of CAIR registry
- ☑ Progress note/Office visit – with notations of vaccines given
- ☑ Notation of anaphylactic reaction to serum or vaccination

Immunizations for Adolescents (IMA)

State Medicaid MPL (must achieve 25th percentile or greater)
Pay-for-Performance (P4P) (Combo 1)
NCQA Accreditation – Medicaid

Q: How to improve score for this HEDIS measure?

A:

- ☑ Upload immunizations on to California Immunizations Registry (**http://cairweb.org**)
- ☑ Use the Childhood and Adolescent Wellness Flyers for Providers as a guideline of recommended health services for certain age groups (**http://www.lacare.org/sites/default/files/LA1401_0815.pdf**)
- ☑ Use every office visit (including sick visits) to provide immunizations and well-care visits
- ☑ Educate parents about the importance of timely vaccinations and share the immunization schedule
- ☑ Use EHR alerts to notify parents about needed immunizations
- ☑ Use of complete and accurate Value Set Codes
- ☑ Timely submission of claim/encounter data
- ☑ Ensure presence of all components in the medical record documentation of dates and types of immunizations, or contraindication for a specific vaccine

Immunizations for Adolescents (IMA)

State Medicaid MPL (must achieve 25th percentile or greater)
Pay-for-Performance (P4P) (Combo 1)
NCQA Accreditation – Medicaid

SAMPLE CODES

The codes listed below are not inclusive and do not represent a complete list of codes.

ICD-10 codes

N/A

CPT codes

Meningococcal Vaccine	90734
Tdap Vaccine	90715
HPV Vaccine	90649-90651

HCPCS codes

N/A

Exclusion codes

Anaphylactic Reaction Due To Serum, Anaphylactic Reaction Due To Vaccination, Encephalopathy Due To Vaccination, Hospice, Vaccine Causing Adverse Effect

Use of Imaging Studies for Low Back Pain (LBP)

State Medicaid MPL (must achieve 25th percentile or greater)
NCQA Accreditation – Medicaid

Q: Which members are included in the sample?

A: Members 18-50 years of age with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis.

Q: What codes are used?

A: Please reference attached sample codes and Value Set Directory for additional codes.

Q: What documentation is needed in the medical record?

A: *None*. This measure requires claim/encounter data submission only using the appropriate Value Set Codes.

Q: What type of document is acceptable?

A: Evidence from claim/encounter data

- Imaging study with uncomplicated diagnosis of low back pain on the IESD or in the 28 days following the IESD. ***Index Episode Start Date (IESD):*** The earliest date of service for an outpatient or ED encounter during the Intake Period (January 1, 2018 – December 3, 2018) with a principal diagnosis of low back pain.

Q: How to improve score for this HEDIS measure?

A:

- ☑ Use of complete and accurate Value Set Codes
- ☑ Timely submission of claim/encounter data
- ☑ Proper coding or documentation of any of the following diagnoses for which imaging is clinically appropriate – *to assist in excluding members from the HEDIS sample. See below for exclusion criteria.*

Exclusions : (*Use designated Value Set for each*)

Any of the following meet criteria:

- Cancer
- Recent Trauma
- Intravenous drug abuse
- Neurologic impairment
- HIV
- Spinal infection
- Major organ transplant
- Prolonged use of corticosteroids

Use of Imaging Studies for Low Back Pain (LBP)

State Medicaid MPL (must achieve 25th percentile or greater)
NCQA Accreditation – Medicaid

SAMPLE CODES

The codes listed below are not inclusive and do not represent a complete list of codes.

ICD-10 codes
Refer to Uncomplicated Low Back Pain Value Set

CPT codes	
ED	99281-99285
Imaging Study	72020, 72052, 72100, 72110, 72114, 72120, 72131-72133, 72141, 72142, 72146-72149, 72156, 72158, 72200, 72202, 72220
Observation	99217-99220
Osteopathic and Chiropractic Manipulative Treatment	98925-98929, 98940-98942
Outpatient	99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99429, 99455, 99456

HCPCS *codes*	
Outpatient	G0402, G0438, G0439, G0463, T1015

Exclusion codes
History of Malignant Neoplasm, HIV, Hospice, Intravenous Drug Abuse, Major Organ Transplant, Malignant Neoplasms, Neurologic Impairment, Other Malignant Neoplasm of Skin, Other Neoplasms, Prolonged Use of Corticosteroids, Recent Trauma, Spinal Infection

Medication Management for People With Asthma (MMA)

NCQA Accreditation – Medicaid

Q: Which members are included in the sample?

A: Members 5–64 years of age, who were identified as having persistent asthma and who were dispensed asthma controller medication that they remained on for at least 50% or 75% of their treatment period in 2018.

Q: What codes are used?

A: Please reference attached sample codes and Value Set Directory for additional codes.

Q: What documentation is needed in the medical record?

A: *None*. This measure requires claim/encounter data submission only using the appropriate Value Set Codes.

Q: What type of document is acceptable?

A: Evidence from 2018 claims/encounter data:

1. Compliant with asthma controller medication for at least 50% of treatment period
2. Compliant with asthma controller medication for at least 75% of treatment period

Asthma Controller Medications

Description	Prescriptions		
Antiasthmatic combinations	• Dyphylline-guaifenesin	• Guaifenesin-theophylline	
Antibody inhibitor	• Omalizumab		
Anti-interleukin-5	• Mepolizumab	Reslizumab	
Inhaled steroid combinations	• Budesonide-formoterol	• Fluticasone-salmeterol • Fluticasone-vilanterol	• Mometasone-formoterol
Inhaled corticosteroids	• Beclomethasone • Budesonide	• Ciclesonide • Flunisolide	• Fluticasone CFC free • Mometasone
Leukotriene modifiers	• Montelukast	• Zafirlukast	• Zileuton
Methylxanthines	• Aminophylline	• Dyphylline	• Theophylline

Q: How to improve score for this HEDIS measure?

A:

- ☑ Use of complete and accurate Value Set Codes
- ☑ Timely submission of claim/encounter data
- ☑ Ensure presence of all components in the medical record documentation
- ☑ Proper coding or documentation – *to assist in excluding members from the HEDIS sample*
  See below for exclusion criteria

Required Exclusions:

- Members who had any of the following diagnoses (documented) any time during the member's history through 2018:
  - Emphysema
  - Other Emphysema
  - COPD
  - Obstructive Chronic Bronchitis
  - Chronic Respiratory Conditions Due to Fumes/Vapors
  - Cystic Fibrosis
  - Acute Respiratory Failure
- Members who had no asthma controller medications dispensed in 2018

SAMPLE CODES

The codes listed below are not inclusive and do not represent a complete list of codes.

ICD-10 codes	
Asthma	J45.20, J45.21, J45.22, J45.30-J45.32, J45.40-J45.42, J45.50-J45.52, J45.901, J45.902, J45.909, J45.990, J45.991, J45.998

CPT codes	
Outpatient	99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99456
Acute Inpatient	99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291
ED	99281-99285
Observation	99217-99220

HCPCS codes	
Outpatient	G0402, G0438, G0439, G0463, T1015

Exclusion codes
Acute Respiratory Failure, Asthma Controller Medication List, Chronic Respiratory Conditions Due to Fumes/Vapors, COPD, Cystic Fibrosis, Emphysema, Hospice, Obstructive Chronic Bronchitis, Other Emphysema

Annual Monitoring for Patients on Persistent Medications (MPM)

State Medicaid MPL (must achieve 25th percentile or greater)
Pay-for-Performance (P4P) - Diuretics

Q: Which members are included in the sample?

A: Members 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent [angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB)] and diuretics in **2018**, and at least one therapeutic monitoring event for the therapeutic agent in **2018**.

Q: What codes are used?

A: Please reference attached sample codes and Value Set Directory for additional codes.

Q: What documentation is needed in the medical record?

A: *None*. This measure requires claim/encounter data submission only using the appropriate Value Set Codes.

Annual Monitoring for Patients on Persistent Medications (MPM)

State Medicaid MPL (must achieve 25th percentile or greater)
Pay-for-Performance (P4P) - Diuretics

Q: What type of document is acceptable?

A: Evidence from claim/encounter data for **each** of the following rates in **2018**:

Rate 1: Annual Monitoring for Members on ACE Inhibitors or ARBs

- ☑ A lab panel test, **or**
- ☑ A serum potassium test **and** a serum creatinine test

ACE Inhibitor/ARB Medications

Description	Prescription				
Angiotensin converting enzyme inhibitors	• Benazepril • Captopril	• Enalapril • Fosinopril	• Lisinopril • Moexipril	• Perindopril • Quinapril	• Ramipril • Trandolapril
Angiotensin II inhibitors	• Azilsartan • Candesartan	• Eprosartan • Irbesartan	• Losartan • Olmesartan	• Telmisartan • Valsartan	
Antihypertensive combinations	• Aliskiren-valsartan • Amlodipine-benazepril • Amlodipine-hydrochlorothiazide-valsartan • Amlodipine-hydrochlorothiazide-olmesartan • Amlodipine-olmesartan • Amlodipine-perindopril • Amlodipine-telmisartan • Amlodipine-valsartan	• Azilsartan-chlorthalidone • Benazepril-hydrochlorothiazide • Candesartan-hydrochlorothiazide • Captopril-hydrochlorothiazide • Enalapril-hydrochlorothiazide • Eprosartan-hydrochlorothiazide • Fosinopril-hydrochlorothiazide • Hydrochlorothiazide-irbesartan • Hydrochlorothiazide-lisinopril • Hydrochlorothiazide-losartan	• Hydrochlorothiazide-moexipril • Hydrochlorothiazide-olmesartan • Hydrochlorothiazide-quinapril • Hydrochlorothiazide-telmisartan • Hydrochlorothiazide-valsartan • Sacubitril-valsartan • Trandolapril-verapamil		

Rate 3: Annual Monitoring for Members on Diuretics

- ☑ A lab panel test, **or**
- ☑ A serum potassium test **and** a serum creatinine test

Diuretic Medications

Description	Prescription			
Antihypertensive combinations	• Aliskiren-hydrochlorothiazide • Aliskiren-hydrochlorothiazide-amlodipine • Amiloride-hydrochlorothiazide • Amlodipine-hydrochlorothiazide-olmesartan • Amlodipine-hydrochlorothiazide-valsartan • Atenolol-chlorthalidone • Azilsartan-chlorthalidone • Benazepril-hydrochlorothiazide • Bendroflumethiazide-nadolol • Bisoprolol-hydrochlorothiazide • Candesartan-hydrochlorothiazide • Captopril-hydrochlorothiazide • Chlorthalidone-clonidine • Enalapril-hydrochlorothiazide • Eprosartan-hydrochlorothiazide	• Fosinopril-hydrochlorothiazide • Hydrochlorothiazide-irbesartan • Hydrochlorothiazide-lisinopril • Hydrochlorothiazide-losartan • Hydrochlorothiazide-methyldopa • Hydrochlorothiazide-metoprolol • Hydrochlorothiazide-moexipril • Hydrochlorothiazide-olmesartan • Hydrochlorothiazide-propranolol • Hydrochlorothiazide-quinapril • Hydrochlorothiazide-spironolactone • Hydrochlorothiazide-telmisartan • Hydrochlorothiazide-triamterene • Hydrochlorothiazide-valsartan		
Loop diuretics	• Bumetanide • Ethacrynic acid	• Furosemide • Torsemide		
Potassium-sparing diuretics	• Amiloride • Eplerenone	• Spironolactone • Triamterene		
Thiazide diuretics	• Chlorothiazide • Chlorthalidone	• Hydrochlorothiazide • Indapamide	• Methyclothiazide • Metolazone	

Q: How to improve score for this HEDIS measure?

A:

- ☑ Use of complete and accurate Value Set Codes
- ☑ Timely submission of claim/encounter data
- ☑ Exclude members who had an inpatient (acute or non-acute) claim/encounter in 2018

Annual Monitoring for Patients on Persistent Medications (MPM)

State Medicaid MPL (must achieve 25th percentile or greater)
Pay for Performance (P4P) - Diuretics

SAMPLE CODES

The codes listed below are not inclusive and do not represent a complete list of codes.

ICD-10 codes
N/A

CPT codes	
Lab Panel	80047, 80048, 80050, 80053, 80069
Serum Creatinine	82565, 82575
Serum Potassium	80051, 84132

HCPCS codes
N/A

Exclusion CPT codes
Acute Inpatient, Nonacute Inpatient, Hospice

Medication Reconciliation Post-Discharge (MRP)

Q: Which members are included in the sample?

A: Members 18 years and older who had an acute or non-acute inpatient discharge **on or between 01/01/2018 and 12/01/2018**, and for whom medications were reconciled on the date of discharge through 30 days after discharge (31 total days).

Q: What codes are used?

A: Please reference attached sample codes and Value Set Directory for additional codes.

Q: What documentation is needed in the medical record?

A: Documentation in the medical record must include evidence of medication reconciliation and the date when it was performed. Any of the following meets criteria:

- ☑ Documentation that the provider reconciled the current and discharge medications
- ☑ Documentation of the current medications with a notation that references the discharge medications (e.g., no changes in medications since discharge, same medications at discharge, discontinue all discharge medications)
- ☑ Documentation of the member's current medications with a notation that the discharge medications were reviewed
- ☑ Documentation of a current medication list, a discharge medication list and notation that both lists were reviewed on the same date of service
- ☑ Documentation of the current medications with evidence that the member was seen for post-discharge hospital follow-up with evidence of medication reconciliation or review
- ☑ Documentation in the discharge summary that the discharge medications were reconciled with the most recent medication list in the outpatient medical record. There must be evidence that the discharge summary was filed in the outpatient chart on the date of discharge through 30 days after discharge (31 total days).
- ☑ Notation that no medications were prescribed or ordered upon discharge

Q: What type of medical record is acceptable?

A:

- ☑ A medication list in the discharge summary found in the outpatient chart
- ☑ Hospital Discharge Summary
- ☑ Progress note with evidence of review of current and discharged medications

Q: How to improve score for this HEDIS measure?

A:

- ☑ Use of complete and accurate Value Set Codes
- ☑ Timely submission of claim/encounter data
- ☑ Ensure presence of all components in the medical record documentation

Medication Reconciliation Post-Discharge (MRP)

SAMPLE CODES

The codes listed below are not inclusive and do not represent a complete list of codes.

ICD-10 codes
N/A

CPT codes	
Medication Reconciliation	99483, 99495, 99496

CPT II codes	
Medication Reconciliation	1111F

HCPCS codes
N/A

Exclusion codes
Hospice

Osteoporosis Management in Women Who Had a Fracture (OMW)

NCQA Accreditation – Medicare (CMC)

Q: Which members are included in the sample?

A: Women 67-85 years of age who suffered a fracture (7/1/2017 - 6/30/2018), and who had either a bone mineral density (BMD) test or prescription for a drug to treat osteoporosis in the six months after the fracture.

Q: What codes are used?

A: Please reference attached sample codes and Value Set Directory for additional codes.

Q: What documentation is needed in the medical record?

A: None. This measure requires claim/encounter data submission only using the appropriate Value Set Codes.

Q: What type of document is acceptable?

A: Evidence of claim/encounter data:

- ☑ Bone Mineral Density (BMD) test, in any setting, on the Index Episode Start Date (IESD) or in the 180-day (6 month) period after the IESD
- ☑ If IESD was an inpatient, a BMD test during inpatient stay
- ☑ Osteoporosis therapy on the IESD or in the 180-day (6 month) period after IESD
- ☑ If the IESD was an inpatient, long-acting osteoporosis therapy during the inpatient stay
- ☑ A dispensed prescription to treat osteoporosis on the IESD or in the 180-day (6 month) period after IESD
- ☑ A dispensed prescription to treat osteoporosis
- ☑ Fracture
- ☑ Visit type

Osteoporosis Medications

Description	Prescription	
Biphosphonates	• Alendronate • Alendronate-cholecalciferol • Ibandronate	• Risedronate • Zoledronic acid
Other agents	• Albandronate • Calcitonin • Denosumab	• Raloxifene • Teriparatide

Osteoporosis Management in Women Who Had a Fracture (OMW)

NCQA Accreditation – Medicare (CMC)

Q: How to improve score for this HEDIS measure?

A:

- ☑ Use of complete and accurate Value Set Codes
- ☑ Timely submission of claim/encounter data
- ☑ Ensure presence of all components in the medical record documentation
- ☑ ***Required Exclusions:***
  - Members who had a BMD test during the 730 days (24 months) prior to IESD*
  - Members who had a claim/encounter for osteoporosis therapy during the 365 days (12 months) prior to IESD*
  - Member who received a dispensed prescription or had an active prescription to treat osteoporosis during the 365 days (12 months) prior to IESD*
  - Members who are enrolled in an Institutional SNP (I-SNP) any time during the measurement year
  - Members living long-term in an institution any time during the measurement year

  Note: ***Fractures of finger, toe, face and skull are not included.***

*IESD: Index Episode Start Date [The earliest date of service for any encounter during the Intake Period (7/1/2017 – 6/30/2018) with a diagnosis of fracture]

Osteoporosis Management in Women Who Had a Fracture (OMW)

NCQA Accreditation – Medicare (CMC)

SAMPLE CODES

The codes listed below are not inclusive and do not represent a complete list of codes.

ICD-10 codes
Refer to Fractures Value Set

CPT codes	
Bone Mineral Density Tests	76977, 77078, 77080, 77081, 77082, 77085, 77086
Fractures	Refer to Fractures Value Set
Observation	99217-99220
Outpatient	99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99429, 99455, 99456, 99483
ED	99281-99285

HCPCS codes	
Bone Mineral Density Test	G0130
Fractures	S2360
Long-Acting Osteoporosis Medications	J0897, J1740, J3489

Osteoporosis Management in Women Who Had a Fracture (OMW)

NCQA Accreditation – Medicare (CMC)

SAMPLE CODES

The codes listed below are not inclusive and do not represent a complete list of codes.

HCPCS codes	
Osteoporosis Medications	J0630, J0897, J1740, J3110, J3489,
Outpatient	G0402, G0438, G0439, G0463, T1015

Exclusion codes
Advanced Illness, Bone Mineral Density Tests, Frailty, Hospice, Osteoporosis Medications

Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)

NCQA Accreditation – Medicare (CMC)

Q: Which members are included in the sample?

A: Members 18 years of age and older who were hospitalized and discharged from July 1, 2017 to June 30, 2018 with a diagnosis of AMI and who received persistent beta-blocker treatment for six months after discharge.

Q: What codes are used?

A: Please reference attached sample codes and Value Set Directory for additional codes.

Q: What documentation is needed in the medical record?

A: *None*. This measure requires claim/encounter data submission only using the appropriate Value Set Codes.

Q: What type of document is acceptable?

A: Evidence from claim/encounter data of an acute inpatient discharge with any diagnosis of AMI from July 1, 2017 – June 30, 2018 and at least 135 days of treatment with beta-blockers during the 180-day measurement interval.

Beta-Blocker Medications

Description	Prescription		
Noncardioselective beta-blockers	• Carvedilol • Labetalol • Nadolol	• Penbutolol • Pindolol • Propranolol	• Timolol • Sotalol
Cardioselective beta-blockers	• Acebutolol • Atenolol	• Betaxolol • Bisoprolol	• Metoprolol • Nebivolol
Antihypertensive combinations	• Atenolol-chlorthalidone • Bendroflumethiazide-nadolol • Bisoprolol-hydrochlorothiazide		• Hydrochlorothiazide-metoprolol • Hydrochlorothiazide-propranolol

Q: How to improve score for this HEDIS measure?

A: Use of complete and accurate Value Set Codes.

Timely submission of claim/encounter data.

Exclude members identified as having intolerance or allergy to beta blocker therapy. Any of the following meet criteria:

- ☑ Asthma
- ☑ COPD
- ☑ Obstructive chronic bronchitis
- ☑ Chronic respiratory conditions due to fumes and vapors
- ☑ Hypotension, heart block >1 degree or sinus bradycardia
- ☑ A medication dispensing event indicative of a history or asthma
- ☑ Intolerance or allergy to beta-blocker therapy

Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)

NCQA Accreditation – Medicare (CMC)

SAMPLE CODES

The codes listed below are not inclusive and do not represent a complete list of codes.

ICD-10 codes	
AMI	121.01, 121.02, 121.09, 121.11, 121.19, 121.21, 121.29, 121.3, 121.4, 121.9

UBREV codes
Refer to Inpatient Stay Value Set

Exclusion codes
Advanced Illness, Adverse Effects of Beta-Adrenoreceptor Antagonists, Asthma, Beta-Blockers Contraindications, Chronic Respiratory Conditions Due to Fumes/Vapors, COPD, Frailty, Obstructive Chronic Bronchitis

Pharmacotherapy Management of COPD Exacerbation (PCE)

NCQA Accreditation – Medicaid
NCQA Accreditation – Medicare (CMC)

Q: Which members are included in the sample?

A: Members 40 years of age and older with COPD exacerbations who had an acute inpatient discharge or ED visit on or between January 1, 2018 – November 30, 2018, and who were dispensed a systemic corticosteroid within 14 days of the event and/or a bronchodilator within 30 days of the event.

Q: What codes are used?

A: Please reference attached sample codes and Value Set Directory for additional codes.

Q: What documentation is needed in the medical record?

A: *None*. This measure requires claim/encounter data submission only using the appropriate Value Set Codes.

Q: What type of document is acceptable?

A: Evidence from claim/encounter data

1. Dispensed prescription for systemic corticosteroid on or 14 days after the Episode Date.

Systemic Corticosteroid Medications

Description	Prescription		
Glucocorticoids	• Cortisone-acetate • Dexamethasone	• Hydrocortisone • Methylprednisolone	• Prednisolone • Prednisone

2. Dispensed prescription for a bronchodilator on or 30 days after the Episode Date.

Bronchodilator Medications

Description	Prescription		
Anticholinergic agents	• Albuterol-ipratropium • Aclidinium-bromide	• Ipratropium • Tiotropium	• Umeclidinium
Beta 2-agonists	• Albuterol • Arformoterol • Budesonide-formoterol • Fluticasone-salmeterol • Fluticasone-vilanterol • Formoterol	• Formoterol-glycopyrrolate • Indacaterol • Indacaterol-glycopyrrolate • Levalbuterol • Mometasone-formoterol • Metaproterenol	• Olodaterol hydrochloride • Olodaterol-tiotropium • Pirbuterol • Salmeterol • Umeclidinium-vilanterol
Antiasthmatic combinations	• Dyphylline-guaifenesin	• Guaifenesin-theophylline	

Q: How to improve score for this HEDIS measure?

A:

- ☑ Use of complete and accurate Value Set Codes
- ☑ Timely submission of claim/encounter data

Pharmacotherapy Management of COPD Exacerbation (PCE)

NCQA Accreditation – Medicaid
NCQA Accreditation – Medicare (CMC)

SAMPLE CODES

The codes listed below are not inclusive and do not represent a complete list of codes.

ICD-10 codes	
Chronic Bronchitis	J41.0, J41.1, J41.8, J42
Emphysema	J43.0, J43.1, J43.2, J43.8, J43.9
COPD	J44.0, J44.1, J44.9

CPT codes	
ED	99281-99285

HCPCS codes
N/A

Exclusion codes
Inpatient Stay, Nonacute Inpatient Stay

Plan All-Cause Readmissions (PCR) Star Measure

NCQA Accreditation - Medicare (CMC)
Cal Medi-Connect (CMC) Quality Performance Withhold

Q: Which members are included in the sample?

A: For members 18 years of age and older, the number of acute inpatient stays with a discharge on or between January 1 and December 1, 2018 that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission.

- Count of Index Hospital Stays (IHS) (denominator)
- Count of Observed 30-Day Readmissions (numerator)
- Count of Expected 30-Day Readmissions

Q: What codes are used?

A: Please reference attached sample codes and Value Set Directory for additional codes.

Q: What documentation is needed in the medical record?

A: *None*. This measure requires claim/encounter data submission only using the appropriate Value Set Codes.

Q: What type of document is acceptable?

A: Evidence from claim/encounter data of at least one acute readmission for any diagnosis within 30 days of the Index Discharge Date (on or between January 1 and December 1, 2018).

Q: How to improve score for this HEDIS measure?

A:

- ☑ Use of complete and accurate Value Set Codes
- ☑ Timely submission of claim/encounter data
- ☑ Review discharges and verify that they are for acute IP stays. Some maybe sub-acute, transitional care, rehab, etc.
- ☑ Schedule a follow-up once member has been discharged from the hospital to assess how the member doing to avoid possible readmission
- ☑ Capture all diagnoses as this is a case mix adjusted rate. *The sicker the member, the higher probability of a readmission*

Plan All-Cause Readmissions (PCR) Star Measure

NCQA Accreditation - Medicare (CMC)
Cal Medi-Connect (CMC) Quality Performance Withhold

SAMPLE CODES

The codes listed below are not inclusive and do not represent a complete list of codes.

ICD-10 codes

None

UBREV codes

Refer to Inpatient Stay Value Set

CPT codes

None

Exclusion codes

Acute Condition, Bone Marrow Transplant, Chemotherapy, Introduction of Autologous Pancreatic Cells, Kidney Transplant, Nonacute Inpatient Stay, Organ Transplant Other Than Kidney, Perinatal Conditions, Potentially Planned Procedures, Pregnancy, Rehabilitation

Proportion of Days Covered (PDC)

Q: Which members are included in the sample?

A: Members 18 years and older who met the Proportion of Days Covered (PDC) threshold of 80 percent during 2018 for the following rates:

- Renin Angiotensin System (RAS) Antagonists
- Diabetes All Class
- Statins

Q: What codes are used?

A: N/A

Q: What documentation is needed in the medical record?

A: *None*. This measure requires claim/encounter data submission only using the appropriate Value Set Codes.

Q: What type of document is acceptable?

A: Evidence from a claim/encounter data

1. *Renin Angiotensin System (RAS) Antagonists.* Members who filled at least two prescriptions for a RAS Antagonist on different dates of service during the treatment period.

Table PDC-B: Renin Angiotensin System (RAS) Antagonists

Direct Renin Inhibitor Medications			
• aliskiren			
ARB Medications			
• candesartan • eprosartan	• irbesartan • losartan	• olmesartan • telmisartan	• valsartan • azilsartan
ACE Inhibitor Medications			
• benazepril • captopril • enalapril	• fosinopril • lisinopril • moexipril	• perindopril • quinapril • ramipril	• trandolapril
ACE Inhibitor Combination Products			
• amlodipine & benazepril • benazepril & HCTZ • captopril & HCTZ	• enalapril & HCTZ • fosinopril & HCTZ • perindopril & amlodipine	• lisinopril & HCTZ • moexipril & HCTZ • quinapril & HCTZ	• trandolapril-verapamil HCL
ARB Combination Products			
• candesartan & HCTZ • eprosartan & HCTZ • telmisartan & amlodipine	• irbesartan & HCTZ • losartan & HCTZ • amlodipine & olmesartan • azilsartan & chlorthalidone	• olmesartan & HCTZ • telmisartan & HCTZ • nebivolol & valsartan • olmesartan & amlodipine & HCTZ	• valsartan & HCTZ • amlodipine & valsartan • amlodipine & valsartan & HCTZ
Direct Renin Inhibitor Combination Products			
• aliskiren & amlodipine	• aliskiren & amlodipine & HCTZ	• aliskiren & HCTZ	

Q: What type of documentation is acceptable?

EXCLUSION:

Table PDC-B: Exclusion

ARB/Neprilysin Inhibitor Combination Medication
• sacubitril/valsartan

2. *Diabetes All Class.* Members who filled at least two prescriptions for any of the diabetes medications listed below on different dates of service during the treatment period who met the PDC threshold in 2018.

Table PDC-D: Biguanide Medications

Biguanides	
• metformin	
Biguanide & Sulfonylurea Combination Products	
• glipizide & metformin	• glyburide & metformin
Biguanide & Thiazolidinedione Combination Products	
• rosiglitazone & metformin	• pioglitazone & metformin
Biguanide & Meglitinide Combinations	
• repaglinide & metformin	
Biguanide & SGLT2 Inhibitor Combinations	
• dapagliflozin & metformin • canagliflozin & metformin	• empagliflozin & metformin
Biguanide & DPP-IV Inhibitor Combinations	
• sitagliptin & metformin IR & SR • saxagliptin & metformin SR	• linagliptin & metformin • alogliptin & metformin

Table PDC-E: Sulfonylurea Medications

Sulfonylureas	
• chlorpropamide • glimepiride • glipizide	• glyburide • tolazamide • tolbutamide
Sulfonylurea & Biguanide Combination Products	
• glipizide & metformin	• glyburide & metformin
Sulfonylurea & Thiazolidinedione Combination Products	
• rosiglitazone & glimepiride	• pioglitazone & glimepiride

Q: What type of documentation is acceptable? *continued*

Table PDC-F: Thiazolidinedione Medications

Thiazolidinediones	
• pioglitazone	• rosiglitazone
Thiazolidinedione & Biguanide Combination Products	
• rosiglitazone & metformin	• pioglitazone & metformin
Thiazolidinedione & Sulfonylurea Combination Products	
• rosiglitazone & glimepiride	• pioglitazone & glimepiride
Thiazolidinedione & DPP IV Inhibitor Combination Products	
• alogliptin & pioglitazone	

Table PDC-G: DPP-IV Inhibitor Medications

DPP-IV Inhibitors		
• sitagliptin • linagliptin	• saxagliptin • alogliptin	
DPP-IV Inhibitor Combination Products		
• sitagliptin & metformin IR & SR • saxagliptin & metformin SR	• sitagliptin & simvastatin • linagliptin & metformin	• alogliptin & metformin • alogliptin & pioglitazone • linagliptin & empagliflozin

Table PDC-J: Incretin Mimetic Agents

Incretin Mimetic Agents	
• exenatide • albiglutide	• liraglutide • dulaglutide • lixisenatide

Table PDC-K: Meglitinides

Meglitinides	
• nateglinide	• repaglinide • repaglinide & metformin

Table PDC-L: Sodium glucose co-transporter2 (SGLT2) Inhibitors

SGLT2 Inhibitors		
• canagliflozin	• dapagliflozin	• empagliflozin
SGLT2 Inhibitor Combination Products		
• canigliflozin & metformin	• dapagliflozin & metformin	• empagliflozin & linagliptin • empagliflozin & metformin

Q: What type of documentation is acceptable? *continued*

EXCLUSION:

Table PDC-H: Insulins (Exclusion Table)

Human Insulins		
• insulin aspart	• insulin isophane & regular human insulin	• insulin lispro Protamine & Insulin lispro
• insulin aspart Protamine & Aspart	• insulin isophane (human N)	• insulin regular (human R)
• insulin detemir	• insulin regular (human) inhalation powder	• insulin degludec
• insulin glargine	• insulin lispro	• insulin degludec & liraglutide
• insulin glulisine		• insulin glargine & lixisenatide

3. *Statins.* Members who filled at least two prescriptions for a statin or statin combination on different dates of service during the treatment period.

Table PDC-I: Statin Medications

Statin Medications			
• lovastatin	• fluvastatin	• pravastatin	• simvastatin
• rosuvastatin	• atorvastatin	• pitavastatin	
Statin Combination Products			
• niacin & lovastatin	• niacin & simvastatin	• ezetimibe & simvastatin	
• atorvastatin & amlodipine	• sitagliptin & simvastatin	• ezetimibe & atorvastatin	

Q: How to improve score for this HEDIS measure?

A:

☑ Timely submission of claim/encounter data

Prenatal and Postpartum Care (PPC)

State Medicaid Auto-Assignment (Timeliness of Prenatal Care)
State Medicaid MPL (must achieve 25th percentile or greater)
Pay-for-Performance (P4P)
NCQA Accreditation – Medicaid

Q: Which members are included in the sample?

A:

- ☑ Women who delivered (EDD) between November 6, 2017 and November 5, 2018, ***and***
- ☑ Had a prenatal care visit in the 1st trimester, on date of enrollment, or within 42 days of enrollment in the health plan, ***and***
- ☑ Had a postpartum visit on or between 21 and 56 days after delivery

Q: What codes are used?

A: Please reference attached sample codes and Value Set Directory for additional codes.

Q: What documentation is acceptable?

Prenatal Care Visit
(First Trimester, on date of enrollment, or within 42 days of enrollment)

- ☑ ACOG
- ☑ Progress notes with basic physical OB exam that includes auscultation for fetal heart tone or pelvic exam with OB observations or measurement of fundus height
- ☑ Lab report – OB panel (must include all labs within the panel), TORCH antibody panel, or ABO/Rh blood typing with an office visit
- ☑ Echography of a pregnant uterus/Pelvic ultrasound with an office visit
- ☑ Documentation of LMP, EDD or gestational age in conjunction with either: prenatal risk assessment and counseling /education or complete OB history

Post-partum Visit
(21-56 days after delivery)

Progress note with documentation of:

- ☑ Pelvic exam
- ☑ Evaluation of weight, BP, breasts and abdomen
- ☑ Any documentation of: Post-Partum Care, PP care, PP check, 6-week check, or a preprinted "postpartum

Q: How to improve score for this HEDIS measure?

A:

- ☑ Use of complete and accurate Value Set Codes
- ☑ Timely submission of claims/encounter data
- ☑ Ensure presence of all components in the medical record documentation
- ☑ May use EDD to identify the first trimester for Timeliness of Prenatal Care and use the date of delivery for the Postpartum rate
- ☑ Documentation of deliveries **NOT** resulting in a Live Birth – *proper coding or documentation will assist in excluding members from the HEDIS sample*

Prenatal and Postpartum Care (PPC)

State Medicaid Auto-Assignment (Timeliness of Prenatal Care)
State Medicaid MPL (must achieve 25th percentile or greater)
Pay-for -Performance (P4P)
NCQA Accreditation – Medicaid

SAMPLE CODES

The codes listed below are not inclusive and do not represent a complete list of codes.

ICD-10 Pregnancy codes

Refer to Pregnancy Diagnosis Value Set

CPT Delivery codes

59400, 59409, 59410, 59510, 59514, 59515, 59610, 59612, 59614, 59618, 59620, 59622

PRENATAL CARE

CPT Laboratory codes

Obstetric Panel	80055, 80081
ABO	86900
Cytomegalovirus Antibody	86644
Herpes Simplex Antibody	86694, 86695, 86696
Rh	86901
Rubella Antibody	86762
Toxoplasma Antibody	86777, 86778

CPT Prenatal Ultrasound codes

76801, 76805, 76811, 76813, 76815-76821, 76825-76828

Prenatal and Postpartum Care (PPC)

State Medicaid Auto-Assignment (Timeliness of Prenatal Care)
State Medicaid MPL (must achieve 25th percentile or greater)
Pay-for-Performance (P4P)
NCQA Accreditation – Medicaid

SAMPLE CODES

The codes listed below are not inclusive and do not represent a complete list of codes.

CPT Stand Alone Prenatal Visit code
99500

CPT Prenatal Visit codes
99201-99205, 99211-99215, 99241-99245, 99483

CPT II Stand Alone Prenatal Visit codes
0500F, 0501F, 0502F

CPT Prenatal Bundled Service codes
59400, 59425, 59426, 59510, 59610, 59618

HCPCS Prenatal codes	
Prenatal Visits	G0463, T1015
Stand Alone Prenatal Visits	H1000-H1004
Prenatal Bundled Services	H1005

POSTPARTUM CARE

ICD-10 Postpartum Visit codes
Z01.411, Z01.419, Z01.42, Z30.430, Z39.1, Z39.2

SAMPLE CODES

The codes listed below are not inclusive and do not represent a complete list of codes.

CPT Postpartum Visit codes

57170, 58300, 59430, 99501

CPT II Postpartum Visit codes

0503F

CPT Postpartum Bundled Service codes

59400, 59410, 59510, 59515, 59610, 59614, 59618, 59622

HCPCS Postpartum codes

Postpartum Visits	G0101
Cervical Cytology	G0123, G0124, G0141, G0143, G0144, G0145, G0147, G0148, P3000, P3001, Q0091

Exclusion ICD-10CM codes

Non-Live Births

Statin Therapy for Patients With Cardiovascular Disease (SPC)

NCQA Accreditation – Medicaid
NCQA Accreditation – Medicare (CMC)

Q: Which members are included in the SAMPLE?

A: Males 21 – 75 years of age and females 40 – 75 years of age who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and were dispensed at least one high or moderate-intensity statin medication in 2018 and remained on it for at least 80% of the treatment period.

Q: What codes are used?

A: Please reference attached sample codes and Value Set Directory for additional codes.

Q: What documentation is needed in the medical record?

A: *None*. This measure requires claim/encounter data submission only using the appropriate Value Set Codes.

Q: What type of document is acceptable?

A: Evidence from claim/encounter data:

1. *Received Statin Therapy.* Dispensed prescription for a high or moderate-intensity statin medication in 2018

High- and Moderate-Intensity Statin Medications:

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

Q: What type of documentation is acceptable?

2. *Statin Adherence 80%.* Proportion of days covered (PDC) by prescription medication for at least 80% of the treatment period based on pharmacy claims from earliest dispensing event in 2018.

Q: How to improve score for this HEDIS measure?

A:

- ☑ Use of complete and accurate Value Set Codes
- ☑ Timely submission of claim/encounter data

Statin Therapy for Patients With Cardiovascular Disease (SPC)

NCQA Accreditation – Medicaid
NCQA Accreditation – Medicare (CMC)

SAMPLE CODES

The codes listed below are not inclusive and do not represent a complete list of codes.

ICD-10 codes
Refer to IVD Value Set and MI Value Set

CPT codes	
Acute Inpatient	99221 – 99223, 99231 – 99233, 99238, 99239, 99251-99255, 99291
CABG	33510 – 33514, 33516 – 33519, 33521 – 33523, 33533 – 33536
Other Revascularization	37220, 37221, 37224 – 37231
Outpatient	99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99429, 99455, 99456, 99483
PCI	92920, 92924, 92928, 92933, 92937, 92941, 92943, 92980, 92982, 92995

HCPCS codes	
CABG	S2205 – S2209
PCI	C9600, C9602, C9604, C9606, C9607

Exclusion codes
Advanced Illness, Cirrhosis, ESRD, Frailty, IVF, Muscular Pain and Disease, Pregnancy

Statin Therapy for Patients With Diabetes (SPD)

NCQA Accreditation – Medicaid
NCQA Accreditation – Medicare (CMC)

Q: Which members are included in the SAMPLE?

A: Members 40 – 75 years of age with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) and were dispensed at least one statin medication of any intensity in 2018 and remained on it for at least 80% of the treatment period.

Q: What codes are used?

A: Please reference attached sample codes and Value Set Directory for additional codes.

Q: What documentation is needed in the medical record?

A: *None*. This measure requires claim/encounter data submission only using the appropriate Value Set Codes.

Q: What type of document is acceptable?

A: Evidence from claim/encounter data

1. *Received Statin Therapy.* Dispensed prescription for a high, moderate, or low-intensity statin medication in 2018

High- and Moderate-Intensity Statin Medications:

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

Q: What type of document is acceptable?

Low-Intensity Statin Medications

Description	Prescription	
Low-intensity statin therapy	• Simvastatin 10 mg • Ezetimibe-simvastatin 10 mg • Sitagliptin-simvastatin 10 mg • Pravastatin 10–20 mg	• Lovastatin 20 mg • Niacin-lovastatin 20 mg • Fluvastatin 20–40 mg • Pitavastatin 1 mg

2. *Statin Adherence 80%.* **Proportion of days covered (PDC) by prescription medication for at least 80% of the treatment period based on pharmacy claims from earliest dispensing event in 2018.**

Q: How to improve score for this HEDIS measure?

A:

- ☑ Use of complete and accurate Value Set Codes
- ☑ Timely submission of claim/encounter data

Statin Therapy for Patients With Diabetes (SPD)

NCQA Accreditation – Medicaid
NCQA Accreditation – Medicare (CMC)

SAMPLE CODES

The codes listed below are not inclusive and do not represent a complete list of codes.

ICD-10 codes	
Refer to Diabetes Value Set	
CPT codes	
Acute Inpatient	99221 – 99223, 99231 – 99233, 99238, 99239, 99251 – 99255, 99291
Outpatient	99201 – 99205, 99211 – 99215, 99241 – 99245, 99341 – 99345, 99347 – 99350, 99381 – 99387, 99391 – 99397, 99401 – 99404, 99411, 99412, 99429, 99455, 99456, 99483
ED	99281 – 99285
Nonacute Inpatient	99304 – 99310, 99315, 99316, 99318, 99324 – 99328, 99334 – 99337
Observation	99217 – 99220
Exclusion codes	
Advanced Illness, CABG, Cirrhosis, Diabetes, Diabetes Exclusions, ESRD, Frailty, IVD, IVF, MI, Muscular Pain and Disease, Other Revascularization, PCI, Pregnancy	

Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)

Q: Which members are included in the SAMPLE?

A: Members 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.

Q: What codes are used?

A: Please reference attached sample codes and Value Set Directory for additional codes.

Q: What documentation is needed in the medical record?

A: *None*. This measure requires claim/encounter data submission only using the appropriate Value Set Codes.

Q: What type of document is acceptable?

A: Evidence from claim/encounter data:

- At least one spirometry test confirming diagnosis of Chronic Obstructive Pulmonary Disease (COPD) during the 730 days (2 years) prior to the IESD through 180 days (6 months) after the IESD.
  Index Episode Start Date (IESD): The earliest date of service for an eligible visit (outpatient, ED, or acute inpatient) during the Intake Period (July 1, 2017 - June 30, 2018) with any diagnosis of COPD.

Q: How to improve score for this HEDIS measure?

A:

- ☑ Use of complete and accurate Value Set Codes
- ☑ Timely submission of claim/encounter data

Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)

SAMPLE CODES

The codes listed below are not inclusive and do not represent a complete list of codes.

ICD-10 codes	
Chronic Bronchitis	J41.0, J41.1, J41.8, J42
Emphysema	J43.0, J43.1, J43.2, J43.8, J43.9
COPD	J44.0, J44.1, J44.9

CPT codes	
Spirometry	94010, 94014-94016, 94060, 94070, 94375, 94620
ED	99281-99285
Observation	99217-99220
Outpatient	99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99429, 99455, 99456, 99483

HCPCS codes	
Outpatient	G0402, G0438, G0439, G0463, T1015

Exclusion codes
Chronic Bronchitis, COPD, Emphysema, Inpatient Stay, Nonacute Inpatient Stay, Telehealth Modifier, Telehealth POS

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

NCQA Accreditation – Medicaid

Q: Which members are included in the sample?

A: Adults 18- 64 years of age with schizophrenia, schizoaffective disorder or bipolar disorder, who were dispensed an antipsychotic medication and had a glucose test or an HbA1c test in 2018.

Q: What codes are used?

A: Please reference attached sample codes and Value Set Directory for additional codes.

Q: What documentation is needed in the medical record?

A: *None.* This measure requires claim/encounter data submission only using the appropriate Value Set Codes and pharmacy data.

Q: What type of document is acceptable?

A: Evidence from claim/encounter or lab data:

- Glucose test in 2018
- HbA1c test in 2018

Q: How to improve score for this HEDIS measure?

A:

- Use of complete and accurate Value Set Codes
- Timely submission of claim/encounter data

Q: Which members are excluded?

A:

- Members with diabetes identified by claim/encounter and pharmacy data in 2017 or 2018
- Members who were dispensed insulin or oral hypogycemics/antihyperglycemics in 2017 or 2018
- Members who had no antipsychotic medications dispensed in 2018

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

NCQA Accreditation – Medicaid

Antipsychotic Medications

Diabetes Medications

Description	Prescription		
Alpha-glucosidase inhibitors	• Acarbose	• Miglitol	
Amylin analogs	• Pramlintide		
Antidiabetic combinations	• Alogliptin-metformin • Alogliptin-pioglitazone • Canagliflozin-metformin • Dapagliflozin-metformin • Empagliflozin-linagliptin • Empagliflozin-metformin	• Glimepiride-pioglitazone • Glimepiride-rosiglitazone • Glipizide-metformin • Glyburide-metformin • Linagliptin-metformin	• Metformin-pioglitazone • Metformin-repaglinide • Metformin-rosiglitazone • Metformin-saxagliptin • Metformin-sitagliptin • Sitagliptin-simvastatin
Insulin	• Insulin aspart • Insulin aspart-insulin aspart protamine • Insulin degludec • Insulin detemir • Insulin glargine • Insulin glulisine	• Insulin isophane human • Insulin isophane-insulin regular • Insulin lispro • Insulin lispro-insulin lispro protamine • Insulin regular human • Insulin human inhaled	
Meglitinides	• Nateglinide	• Repaglinide	
Glucagon-like peptide-1 (GLP1) agonists	• Dulaglutide • Exenatide		• Albiglutide • Liraglutide
Sodium glucose cotransporter 2 (SGLT2) inhibitor	• Canagliflozin	• Dapagliflozin	• Empagliflozin
Sulfonylureas	• Chlorpropamide • Glimepiride	• Glipizide • Glyburide	• Tolazamide • Tolbutamide
Thiazolidinediones	• Pioglitazone	• Rosiglitazone	
Dipeptidyl peptidase-4 (DDP-4) inhibitors	• Alogliptin • Linagliptin	• Saxagliptin • Sitagliptin	

SSD Antipsychotic Medications

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

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

NCQA Accreditation – Medicaid

SAMPLE CODES

The codes listed below are not inclusive and do not represent a complete list of codes

ICD-10 codes
F20.9 Schizophrenia, unspecified
F31.9 Bipolar disorder, unspecified
F30.9 Manic episode, unspecified

CPT codes	
ED	99281 - 99285
Observation	99217 - 99220
Non Acute Inpatient	99304-99310, 99315, 99316, 99318, 99324-99328, 99334-99337
Acute Inpatient	99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291

HCPCS codes	
Annual wellness visit; includes a personalized prevention plan of service, initial visit	G0438
Behavioral health counseling and therapy, per 15 minutes	H0004
Mental health assessment, by non-physician	H0031
Comprehensive medication services, per 15 minutes	H2010
Skills training and development, per 15 minutes	H2014
Therapeutic behavioral services, per 15 minutes	H2019

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

NCQA Accreditation – Medicaid

SAMPLE CODES

The codes listed below are not inclusive and do not represent a complete list of codes.

Exclusion codes

Diabetes, Long-Acting Injections, SSD Antipsychotic Medications List

Transitions of Care (TRC)

Q: Which members are included in the sample?

A: Members 18 years and older who were discharged and had each of the following:

- Notification of Inpatient Admission
- Receipt of Discharge Information
- Patient Engagement After Inpatient Discharge
- Medication Reconciliation Post-Discharge

Q: What codes are used?

A: Please reference attached sample codes and Value Set Directory for additional codes.

Q: What documentation is needed in the medical record?

A: Documentation in the medical record must include evidence of the following:

- Documentation of receipt of notification of inpatient admission on the day of admission or the following day.
- Documentation of receipt of discharge information on the day of discharge or the following day.
- Documentation of patient engagement (e.g., office visits, visits to the home, telehealth) provided within 30 days after discharge.
- Documentation of medication reconciliation on the date of discharge through 30 days after discharge (31 total days).

Q: What type of document is acceptable?

A: All of the following documentation in 2018:

- Notification of Inpatient Admission
- Receipt of Discharge Information
- Patient Engagement After Inpatient Discharge
- Medication Reconciliation
- All progress notes
- Current medication list
- All correspondence (phone call, email, fax) between inpatient provider and member's PCP
- All Hospital/SNF/Rehab discharge summaries

Transitions of Care (TRC)

Q: How to improve score for this HEDIS measure?

A:

- ☑ Use of complete and accurate Value Set Codes
- ☑ Timely submission of claim/encounter data
- ☑ Ensure presence of all components in the medical record documentation

Transitions of Care (TRC)

SAMPLE CODES

The codes listed below are not inclusive and do not represent a complete list of codes

CPT codes	
Outpatient	99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99429, 99455, 99456
Telephone Visits	98966, 98967, 98968, 99441, 99442, 99443
Transitional Care Management Services	99495, 99496
Medication Reconciliation	99483, 99495, 99496

CPTII	
Medication Reconciliation	111F

Modifier	
Telehealth	95, GT

Appropriate Treatment for Children with Upper Respiratory Infection (URI)

NCQA Accreditation – Medicaid

Q: Which members are included in the sample?

A: Children 3 months -18 years of age who were given a diagnosis of upper respiratory infection (URI) and were not dispensed an antibiotic prescription in **2017** or **2018**.

Q: What codes are used?

A: Please reference attached sample codes and Value Set Directory for additional codes.

Q: What type of document is acceptable?

A: Evidence from claim/encounter data with a date of service for any outpatient or ED visit with **only** a URI diagnosis and no new or refill prescription for an antibiotic on or three days after the Index Episode Start Date (IESD).
Index Episode Start Date (IESD): The earliest date of service for an eligible visit (outpatient, observation, or ED) during Intake Period (July 1, 2017 - June 30, 2018).

Q: How to improve score for this HEDIS measure?

A:

- ☑ Use of complete and accurate Value Set Codes
- ☑ Timely submission of claim/encounter data
- ☑ Ensure presence of all components in the medical record documentation
- ☑ Exclude claim/encounter data with more than one diagnosis code and ED visits or observation visits that result in an inpatient stay

Appropriate Treatment for Children with Upper Respiratory Infection (URI)

NCQA Accreditation – Medicaid

SAMPLE CODES

The codes listed below are not inclusive and do not represent a complete list of codes.

ICD-10 codes	
URI	J00, J06.0, J06.9

CPT codes	
ED	99281-99285
Observation	99217-99220
Outpatient	99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99429, 99455, 99456, 99483

HCPCS codes	
Outpatient	G0402, G0438, G0439, G0463, T1015

Exclusion codes
Competing Diagnosis, Inpatient Stay, Phayngitis

Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)

State Medicaid Auto-Assignment
State Medicaid MPL (must achieve 25th percentile or greater)
Pay-for -Performance (P4P)

Q: Which members are included in the sample?

A: Members 3-6 years of age who had one or more well-child visits with a primary care practitioner in **2018**.

Q: What codes are used?

A: Please reference attached sample codes and Value Set Directory for additional codes.

Q: What documentation is needed in the medical record?

A: Documentation in the medical record must include a **note** indicating a visit with a primary care practitioner, the **date** when the well-child visit occurred and evidence of **all** of the following:

- ☑ A health/interval history
- ☑ A physical developmental history
- ☑ A mental developmental history
- ☑ A physical exam
- ☑ Health education/anticipatory guidance

Physical Exam	Health History	Physical Health Development	Mental Health Development	Anticipatory Guidance
Weight	Interval history	Developing appropriately for age	Making good grades in school	Safety (car seats, swimming lessons, seat belts, helmets, knee and elbow pads, strangers, etc.)
Height	Active problems	Can skip	Understands and responds to commands	Nutrition (vitamins, frequency of eating, snacks, ideal weight)
Chest	Past medical history	Hops on one foot	Learning alphabet and numbers	Discussion on fitness and the importance of exercise
Heart	Surgical history	Runs and climbs well	Competent with fork and spoon	Oral health (Dental visits, eating habits, need for orthodontics, etc.)
Lungs	Family history	Rides a tricycle	Very imaginative play	Mental Health (confidence, self-esteem, etc.)
Tanner Stage	Social history with above	Stands on one foot for 3-5 seconds	Knows own sex	Preparing for school

Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)

State Medicaid Auto-Assignment
State Medicaid MPL (must achieve 25th percentile or greater)
Pay-for-Performance (P4P)

Q: What type of medical record is acceptable?

A:

- ☑ Progress notes/Office visit notes with dated growth chart
- ☑ Complete Physical Examination Form
- ☑ Anticipatory Guidance/Developmental Milestone Form

Q: How to improve score for this HEDIS measure?

A:

- ☑ Use every office visit (including sick visits) to provide a well-child visit and immunizations
- ☑ Use standardized templates for W34 in EHRs
- ☑ Use W34 self-inking stamps for paper charts that capture all 5 components of the visit (order via email to **quality@lacare.org**. *Note: All emails containing member PHI MUST be securely encrypted.*)
- ☑ Use the Childhood and Adolescent Wellness Flyers for Providers as a guideline of recommended health services for certain age groups (http://www.lacare.org/sites/default/files/LA1401_0815.pdf)
- ☑ Use of complete and accurate Value Set Codes
- ☑ Timely submission of claim/encounter data
- ☑ Ensure presence of all components in the medical record documentation where preventative services are rendered/addressed

Note: Services specific to the assessment or treatment of an acute chronic condition do not count toward the measure.

The following notations or examples of documentation do not count as numerator compliant:

- ***Health History***
  - *Notation of allergies or medications or immunization status alone. If all three (allergies, medications, immunization status) are documented it meets criteria.*
- ***Physical Developmental History***
  - *Notation of Tanner Stage/Scale.*
  - *Notation of "appropriate for age" without specific mention of development.*
  - *Notation of "well-developed/nourished/appearing."*
- ***Mental Developmental History***
  - *Notation of "appropriately responsive for age."*
  - *Notation of "neurological exam."*
- ***Physical Exam***
  - *Vital signs alone.*
- ***Health Education/Anticipatory Guidance***
  - *Information regarding medications or immunizations or their side effects.*

Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)

State Medicaid Auto-Assignment
State Medicaid MPL (must achieve 25th percentile or greater)
Pay-for-Performance (P4P)

SAMPLE CODES

The codes listed below are not inclusive and do not represent a complete list of codes.

ICD-10 codes	
Well-Care	Z00.121, Z00.129, Z00.8

CPT codes	
Well-Care	99381-99385, 99391-99395, 99461

HCPCS codes	
Well-Care	G0438, G0439

Exclusion codes
N/A

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

State Medicaid MPL (must achieve 25th percentile or greater)
NCQA Accreditation – Medicaid

Q: Which members are included in the sample?

A: Members 3-17 years of age who had an outpatient visit with a PCP or OB/GYN and had evidence of BMI percentile with height and weight documentation, counseling for nutrition, and counseling for physical activity in **2018**.

Q: What codes are used?

A: Please reference attached sample codes and Value Set Directory for additional codes.

Q: What documentation is needed in the medical record?

A: Documentation in the medical record must include a note indicating the **date** of the office visit and evidence of the following:

- ☑ BMI percentile ***or*** BMI percentile plotted on age-growth chart
- ☑ Height and weight
- ☑ Counseling for nutrition or referral for nutrition education
- ☑ Counseling for physical activity or referral for physical activity

Q: What type of medical record is acceptable?

A: One or more of the following:

- ☑ Progress notes/Office visits notes
- ☑ Anticipatory Guidance Form
- ☑ Staying Healthy Assessment Form
- ☑ Complete Physical Examination Form
- ☑ Dated growth chart/log
- ☑ Nutrition and Physical Activity Assessment Form
- ☑ What Does Your Child Eat Form

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

State Medicaid MPL (must achieve 25th percentile or greater)
NCQA Accreditation – Medicaid

Q: How to improve score for this HEDIS measure?

A:

- ☑ Use of complete and accurate Value Set Codes
- ☑ Timely submission of claim/encounter data
- ☑ Ensure presence of all components in the medical record documentation

Exclusion (optional): A diagnosis of pregnancy in 2018 for female members only.

Note: Services specific to the assessment or treatment of an acute or chronic condition do not count toward the "Counseling for nutrition" and "Counseling for physical activity" indicators.

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

State Medicaid MPL (must achieve 25th percentile or greater)
NCQA Accreditation – Medicaid

SAMPLE CODES

The codes listed below are not inclusive and do not represent a complete list of codes.

ICD-10 codes	
BMI Percentile	Z68.51-Z68.54
Nutrition Counseling	Z71.3
Physical Activity Counseling	Z02.5, Z71.82

CPT codes	
Outpatient	99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99429, 99455, 99456, 99483
Nutrition Counseling	97802-97804

HCPCS codes	
Outpatient	G0402, G0438, G0439, G0463, T1015
Nutrition Counseling	G0270, G0271, G0447, S9449, S9452, S9470
Physical Activity Counseling	G0447, S9451

Exclusion codes
Pregnancy