HEDIS® Measure Reference Guide

CountyCare
A MEDICAID HEALTH PLAN

Medicaid and Medicare
NCQA Technical Specifications 2023

April 2023

What is HEDIS®?

HEDIS (Healthcare Effectiveness Data and Information Set) is a set of standardized performance measures developed by the National Committee of Quality Assurance (NCQA) to objectively measure, report, and compare quality across health plans. NCQA develops HEDIS measures through a committee represented by purchasers, consumers, health plans, health care providers, and policy makers.

What are HEDIS scores used for?

As state and federal governments move toward a quality-driven healthcare industry, HEDIS rates are becoming more important for both health plans and individual providers. State purchasers of healthcare use aggregated HEDIS rates to evaluate health insurance companies; efforts to improve preventative care health outreach for members.

How are HEDIS rates calculated?

HEDIS rates can be calculated in two ways: administrative date or hybrid data. Administrative data consists of claim or encounter data submitted to the health plan. Hybrid data consists of both administrative data and a sample of medical record data. Hybrid data requires review of a random sample of member medical records to abstract data for services rendered, but were not reported to the health plan through claims or encounter data. Accurate and timely claim submission/encounter data reduces the need for medical record review. If services are not billed or not billed accurately, they are not included in the calculation.

How can provider HEDIS scores be improved using coding, billing and supplemental data?

- Submit claim/encounter data for each and every service rendered
- Make sure that chart documentation reflects all services billed
- Bill (or report by encounter submission) for all delivered services, regardless of contract status
- Ensure that all claim/encounter data is submitted in an accurate and timely manner
- Consider including CPT II codes to provide additional details and reduce medical record requests
  - Work with the CountyCare Quality Team to learn about submitting supplemental data year-round. You can contact us at CountyCarepophealth@cookcountyhhs.org.

Who to outreach for more information about HEDIS?

Contact the Population Health and Performance Improvement Department by email at countycarepophealth@cookcountyhhs.org or reach out to your assigned Provider Relations representative. You can also contact Provider Services by calling 312-864-8200.

The guide will serve as a helpful reference tool and is not intended to replace professional coding standards or billing practices. Measures and codes in the HEDIS Measure Reference Guide are not all-inclusive and can be changed, deleted or removed at any time. Measures are derived from the NCQA HEDIS Measurement Year 2023 Technical Specifications.

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Definitions and HEDIS Timeline

1. **Measurement Year (2023)** – The 12-month timeframe between which a service was rendered – generally January 1 through December 31. Data collected from this timeframe is reported during the reporting year (2024).
2. **Reporting Year** – The timeframe when data is collected and reported. The service dates are from the measurement year, which is usually the year prior 3. In some cases, the service dates may go back more than one year. For example: The 2024 reporting year would include data from services rendered during the measurement year, which would be 2023 and/or any time prior.

Results from the 2024 reporting year would likely be released in June 2024.

3. **Denominator** – The number of members who qualify for the measure criteria, based on NCQA technical specifications.
4. **Numerator** – The number of members who meet compliance criteria based on NCQA technical specifications for appropriate care, treatment or service.
5. **Medical Record Data** – The information taken directly from a member's medical record to validate services rendered that weren't captured through medical or pharmacy claims, encounters, or supplemental data.
6. **Required Exclusion** – Members are excluded from a measure denominator based on their diagnosis and/or procedure captured in claim/encounter data. A determination is made after the claim is processed within certified HEDIS software while the measure denominator is being created.

For example:

a. Members with a claim for hospice services during the measurement year will be excluded from all applicable measures.
b. Members who die any time during the measurement year will be excluded from all applicable measures.
c. **Optional Exclusion** – Members are excluded from a measure denominator manually using certified HEDIS software during the hybrid review process, also known as medical records review.

Annual HEDIS Timeline

January to early May	June	September/October
Performance Improvement and Population Health department staff collect and request and review medical records from previous year.	HEDIS results are certified and reported to NCQA	NCQA release Quality Compass results nationwide

Preventive Screenings

Adults' Access to Preventive/Ambulatory Health Services (AAP)

The percentage of adults who had an outpatient or preventive care visit during the measurement year.

- Medicaid and Medicare members ages 20 and older as of December 31 of the measurement year who had one or more outpatient or preventive care visits
- Medicaid members ages 20 and older as of December 31 of the measurement year who had one or more outpatient or preventive care visit during the measurement.

Required Exclusions apply. See Page 3.

Can be in-person or Telephone visit

Codes	CPT	CPT Modifier	HCPCS	ICD-10
Ambulatory visits	99201–99205, 99211–99215, 99241–99245, 99341–99345, 99347–99350, 99381–99387, 99391–99397, 99401–99404, 99411, 99412, 99429, 99483, 92002, 92004, 92012, 92014, 99304–99310, 99315, 99316, 99318, 99324–99328, 99334–99337, 98966–98968, 99441–99443, 98969, 99444, 99483	95, GT	G0402, G0438, G0439, G0463, T1015, S0620, S0621	Z00.00, Z00.01, Z00.121, Z00.129, Z00.3, Z00.5, Z00.8, Z02.0–Z02.6, Z02.71, Z02.79, Z02.81–Z02.83, Z02.89, Z02.9, Z76.1, Z76.2
Telephone visits	98966–98968, 99441–99443			
Online assessments (e-visit or virtual check-in)	98969–98972, 99421–99423, 99444, 99457, 99458		G0071, G2010, G2012, G2061-G2063, G2250-G2252	

Colorectal Cancer Screening (COL)

The percentage of members who had appropriate screening for colorectal cancer. Any of the following meet criteria:

- Fecal occult blood test (FOBT) during the measurement year: guaiac based (gFOBT) / immunochemical FOBT or fecal immunological test (FIT)
- Flexible sigmoidoscopy during the measurement year or the **four years** prior to the measurement year.
- Colonoscopy during the measurement year or the **nine years** prior.
- Computerized tomography (CT) colonography during the measurement year or **four years** prior.
- Fecal immunochemical test (FIT)-DNA (Cologuard®) test during the measurement year or **two years** prior.
- Measure population: Medicaid Medicare members ages 45–75 as of December 31 of the measurement year.

Exclusions:

- *Required Exclusions apply. See Page 3.*
- Members who have a history of colorectal cancer (cancer of the small intestine does not count).
- Members who had a total colectomy (partial or hemicolectomies do not count).
- Medicare members ages 66 and older enrolled in I-SNP or living long-term in an institution.
- Members age 66 and older with frailty and advanced illness.

Codes	CPT	HCPCS	ICD-10
Colonoscopy	44388–44394, 44397, 44401–44408, 45355, 45378–45393, 45398	G0105, G0121	
CT colonography	74261–74263		
FIT-DNA test	81528	G0464	
Flexible sigmoidoscopy	45330–45335, 45337–45342, 45346, 45347, 45349–45350	G0104	
Fecal occult blood test (FOBT)	82270, 82274	G0328	
Exclusion: Colorectal cancer			C18.0–C18.9, C19, C20, C21.2, C21.8, C78.5, Z85.038, Z85.048
Exclusion: Total colectomy	44150–44153, 44155–44158, 44210–44212		0DTE0ZZ, 0DTE4ZZ, 0DTE8ZZ, 0DTE7ZZ

Keeping Kids Healthy

Child and Adolescent Well-Care Visits (WCV)

The percentage of children and adolescents who had one or more comprehensive well-care visits with a PCP or an OB/GYN practitioner during the measurement year.

Measure population: Medicaid members ages 3–21 as of December 31 of the measurement year.

Required Exclusions apply. See Page 3.

Codes	CPT	HCPCS	ICD-10
Well-care visit	99382, 99383, 99384, 99385–99392, 99393, 99394, 99395	G0438, G0439, S0302, S0610, S0612, S0613	Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.2, Z00.3, Z02.5, Z76.1, Z76.2, Z01.411, Z01.419

Childhood Immunization Status (CIS)

The percentage of children age 2 who receive the required childhood immunization status Combination 10 vaccinations.

Measure population: Children with Medicaid who become two years old during the measurement year.

Note: Refer to the Illinois Comprehensive Automated Registry Exchange (I-CARE) at I-CARE (illinois.gov) for information on tracking and submitting patient immunization records.

- **Combination 10.** The percentage of 2-year-old children 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 2nd birthday.

Exclusions:

- *Required Exclusions apply. See Page 3.*
- Members or who had a contraindication for a specific vaccine from the denominator for all antigen rates and the combination rates. Exclusion must be met prior to the child's 2nd birthday.

Codes	CPT	HCPCS	ICD-10
DTaP	90697, 90698, 90700, 90723		
HiB	90644, 90647, 90648, 90697, 90698, 90748		
HepB	90697, 90723, 90740, 90744, 90747, 90748	G0010	3E0234Z, B16.0, B16.1, B16.2, B16.9, B17.0, B18.0, B18.1, B19.0, B19.11
IPV	90697, 90698, 90713, 90723		
MMR	90707, 90710		B05.0, B05.1, B05.2, B05.3, B05.4, B05.81, B05.89, B05.9, B26.0, B26.1, B26.2, B26.3, B26.81, B26.82, B26.83, B26.84, B26.85, B26.89, B26.9, B06.00, B06.01, B06.02, B06.09, B06.81, B06.82, B06.89, B06.9
PCV	90670	G0009	
VZV	90710, 90716		B01.0, B01.11, B01.12, B01.2, B01.81, B01.89, B01.9, B02.0, B02.1, B02.21, B02.22, B02.23, B02.24, B02.29, B02.30, B02.31, B02.32, B02.33, B02.34, B02.39, B02.7, B02.8, B02.9
HepA	90633		B15.0, B15.9
Flu (one of the two flu vaccines can be a LAIV vaccine administered when child turns 2)	90655, 90657, 90660, 90661, 90672, 90674, 90685–90689, 90756	G0008	
RV two-dose schedule	90681		
RV three-dose schedule	90680		

Immunizations for Adolescents (IMA)

The percentage of adolescents who received the required combination 1 and combination 2 vaccinations by their 13th birthday.

Measure population: Medicaid members who turn age 13 during the measurement year.

Note: Refer to the Illinois Comprehensive Automated Registry Exchange (I-CARE) at I-CARE (illinois.gov) for information on tracking and submitting patient immunization records.

- **Combination 1.** The percentage of adolescents age 13 who had at least one dose of meningococcal vaccine and one dose of tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine.
- **Combination 2.** The percentage of adolescents age 13 who had at least one dose of meningococcal vaccine, one dose tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and the complete human papillomavirus (HPV) vaccine series by their 13th birthday.

Exclusions:

- Members who are in hospice.
- Members who have an anaphylactic reaction to any particular vaccine or its components anytime on or before their 13th birthday.
- Tdap: Members who have encephalopathy with a vaccine adverse-effect code.

Codes	CPT
Meningococcal serogroups A, C, W, Y vaccine (between member's 11th and 13th birthdays)	90619, 90733, 90734
Tdap vaccine (between member's 10th and 13th birthdays)	90715
2 HPV vaccines (at least **146 days** apart on or between the member's 9th and 13th birthdays) Or 3 HPV vaccines (with different dates of service on or between the member's 9th and 13th birthdays)	90649–90651

Lead Screening in Children (LSC)

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

Labs and health care providers should report all positive results electronically to the Illinois Department of Public Health's (IDPH's) Illinois Lead Program. Refer to the IDPH website for more information on reporting blood lead levels as required.

Measure population: Children should be tested for lead at ages 12 months and 24 months, or when there is no documented lead testing for children up to ages 72 months.

Required Exclusions apply. See Page 3.

Codes	CPT
Lead test	83655

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

The percentage of children and adolescents who had an outpatient visit with a PCP or OB/GYN and who had evidence of the following during the measurement year.

- **BMI percentile documentation.** Medical record documentation must include height, weight and the BMI percentile as a specific value (e.g., 80th percentile) or plotted on an age-growth chart.
- **Counseling for Nutrition.*** Medical record documentation must include either discussion or counseling of nutrition.
- **Counseling for Physical Activity.*** Medical record documentation must include either discussion or counseling of physical activity.

* Services rendered do not require specific settings, a telephone visit, e-visit or virtual check-in meet criteria.

Measure population: Medicaid children and adolescents ages 3–17 as of December 31 of the measurement year.

Required Exclusions apply. See Page 3.

Codes	CPT	HCPCS	ICD-10
BMI percentile documentation			Z68.51–Z68.54
Nutrition counseling	97802–97804	G0270, G0271, G0447, S9449, S9452, S9470	Z71.3
Physical activity counseling		G0447, S9451	Z02.5, Z71.82
Outpatient	99201–99205, 99211–99215, 99241–99245, 99341–99345, 99347–99350, 99381–99387, 99391–99397, 99401–99404, 99411–99412, 99429, 99455, 99456, 99483		

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

The percentage of children who had the required number of comprehensive well-child visits with a PCP during the first 30 months of life.

- **Well-Child Visits in the First 15 Months.** Children who turned 15 months old during the measurement year with six or more well- child visits.
- **Well-Child Visits for Ages 15–30 Months**. Children who turned 30 months old during the measurement year with two or more well- child visits.

Measure population: Medicaid children who turn 15 or 30 months of age during the measurement year.

Required Exclusions apply. See Page 3.

	CPT	HCPCS	ICD-10
Well Child Visit	99381, 99382, 99391, 99392–99395, 99461	G0438, G0439, S0302	Z00.110, Z00.111, Z00.121, Z00.129, Z00.2, Z76.1, Z76.2

Women's Health

Breast Cancer Screening (BCS)

*Reported as an ECDS measure for 2023

The percentage of members who screened for breast cancer with a mammogram anytime during, on or between October 1 **two years** prior to the measurement year and December 31 of the measurement year.

Measure Population: Medicaid and Medicare members ages 50–74 as of December 31 of the measurement year.

Note: Diagnostic screenings are not compliant.

Exclusions:

- *Required Exclusions apply. See Page 3.*
- Members who have had a history of bilateral mastectomy.
- Medicare members ages 66 and older as of December 31 of the measurement year who were enrolled in I-SNP or living long term in an institution.
- Members ages 66 and older as of December 31 of the measurement year with frailty and advanced illness.

Codes	CPT	Modifier	HCPCS	ICD-10
Mammography	77061–77063, 77065–77067			
Exclusion: Bilateral mastectomy				0HTV0ZZ
Exclusion: History of Bilateral mastectomy				Z90.13
Exclusion: Unilateral mastectomy with a bilateral modifier	19180, 19200, 19220, 19240, 19303–19307	50		
Exclusion: Unilateral mastectomy with left/right side modifier	19180, 19200, 19220, 19240, 19303–19307	LT, RT		
Exclusion: Left and right unilateral mastectomy				0HTU0ZZ, 0HTT0ZZ
Exclusion: Absence of both right and left breast				Z90.11, Z90.12
Palliative care encounter			G9054, M1017	Z51.5

Cervical Cancer Screening (CCS)

The percentage of women who were screened for cervical cancer with age-appropriate cervical cytology and/or high-risk human papillomavirus (hrHPV) testing performed.

Exclusions:

- *Required Exclusions apply. See Page 3.*
- Women who are pregnant, in hospice, received palliative care during the measurement year are excluded.

Codes	CPT	HCPCS	ICD-10
For ages 21–64, a cervical cytology is performed every three years	88141–88143, 88147, 88148, 88150, 88152–88154, 88164–88167, 88174, 88175	G0123, G0124, G0141, G0143, G0144, G0145, G0147, G0148, P3000, P3001, Q0091	
For ages 30–64, a cervical cytology/hrHPV co-testing is performed every five years	87624, 87625	G0476	
Exclusion: Members with a hysterectomy without a residual cervix are exempt from this measure	51925, 56308, 57530, 57531, 57540, 57545, 57550, 57555, 57556, 58150, 58152, 58200, 58210, 58240, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290–58294, 58548, 58550, 58552–58554, 58570–58573, 58575, 58951, 58953, 58954, 58956, 59135		Q51.5, Z90.710, Z90.712, 0UTC0ZZ, 0UTC4ZZ, 0UTC7ZZ, 0UTC8ZZ
Exclusion: Palliative care encounter		G9054, M1017	Z51.5

Chlamydia Screening in Women (CHL)

The percentage of women identified as sexually active and had one or more chlamydia tests performed during the measurement year.

Measure population: Women ages 16–24 as of December 31 of the measurement year.

Exclusions:

- *Required Exclusions apply. See Page 3.*
- Women who have received a hysterectomy and do not have a cervix are excluded.

Codes	CPT
Chlamydia tests	87110, 87270, 87320, 87490–87492, 87810

Prenatal and Postpartum Care (PPC)

The percentage of deliveries of live births that received timely perinatal care visits.

Measure population: Members who had deliveries or live birth that occurred between October 8 of the year prior to October 7 of the measurement year.

- **Timeliness of Prenatal Care.** The percentage of deliveries that received a prenatal care visit in the first trimester, on the enrollment start date or within **42 days** of enrollment in the organization.

Can be in-person or Telephone visit

Codes	CPT	CPT-CAT-II	HCPCS	ICD-10
Standalone prenatal visits	99500	0500F, 0501F, 0502F	H1000–H1004	
Prenatal visits	99201–99205, 99211–99215, 99241–99245, 99483		G0463, T1015	
Pregnancy diagnosis				Refer to the current ICD–10 manual for the appropriate pregnancy diagnosis codes.
Prenatal bundle services	59400, 59425, 59426, 59510, 59618		H1005	
Telephone visits with a pregnancy related diagnosis code	98966–98968, 99441–99443			
Online assessments (e-visits or virtual check-ins) with pregnancy-related diagnosis code	98969–98972, 99421–99423, 99444, 99457, 99458		G0071, G2010, G2012, G2061–G2063, G2250–G2252	

- **Postpartum Care.** The percentage of deliveries that had a postpartum visit on or between **21** and **84 days** after delivery.

Codes	CPT	CPT-CAT-II	HCPCS	ICD-10
Postpartum visits	57170, 58300, 59430, 99501	0503F	G0101	Z01.411, Z01.419, Z01.42, Z30.430, Z39.1, Z39.2
Cervical cytology	88141–88143, 88147, 88148, 88150, 88152–88154, 88164–88167, 88174, 88175		G0123, G0124, G0141, G0143–G0148, P3000, P3001, Q0091	
Postpartum bundled services	59400, 59410, 59510, 59515, 59610, 59614, 59618, 59622			

Living with Illness

Cardiac Rehabilitation (CRE)

The percentage of members who completed rehabilitation sessions following a severe or acute qualifying cardiac event.

Four rates are reported:

- **Initiation.** The percentage of members who attended two or more cardiac rehabilitation sessions within **30 days**.
- **Engagement 1.** The percentage of members who attended 12 or more cardiac rehabilitation sessions within **90 days**.
- **Engagement 2.** The percentage of members who attended 24 or more cardiac rehabilitation sessions within **180 days**.
- **Achievement.** The percentage of members who attended 36 or more cardiac rehabilitation sessions within **180 days**.

Measure population: Medicaid and Medicare members ages 18 and older as of the qualifying cardiac event that occurred on July 1 of the year prior to June 30 of the measurement year. The date of the most recent cardiac event is used.

Exclusions:

- *Required Exclusions apply. See Page 3.*
- Members who had additional discharges due to cardiac event within 180 days from qualifying event.
- Members who are in hospice or receiving palliative care during measurement year.
- Medicare members ages 66 and older as of December 31 of the measurement year who were enrolled in I-SNP or living long term in an institution.
- Members ages 66–80 as of December 31 of the measurement year with frailty and advanced illness.
- Members ages 81 and older as of December 31 with frailty.

Codes	CPT	HCPCS	ICD-10
Cardiac rehabilitation	93797, 93798	G0422, G0423, S9472	
Myocardial infarction (MI)			I21.01, I21.02, I21.09, I21.11, I21.19, I21.21, I21.29, I21.3, I21.4, I21.9, I21.A1, I21. A9, I22.0–I22.2, I22.8, I22.9, I23.0–I23.8, I25.2
Coronary artery bypass grafting (CABG)	33510–33519, 33521–33523, 33530, 33533–33536	S2205–S2209	
Heart transplant	33927, 33928, 33935, 33945		
Heart valve repair or replacement	33361–33369, 33390, 33391, 33404–33406, 33410–33420, 33422, 33425–33427, 33430, 33440, 33460, 33463–33465, 33468, 33470, 33471, 33474, 33475, 33476, 33477, 33478		
Percutaneous coronary intervention (PCI)	92920, 92924, 92928, 92933, 92937, 92941, 92943	C9600, C9602, C9604, C9606, C9607	
Palliative care encounter		G9054, M1017	Z51.5

Controlling Blood Pressure (CBP)

The percentage of members with a diagnosis of hypertension (HTN) whose blood pressure was adequately controlled (< 140/90 mm Hg) during the measurement year. Members had at least two outpatient visits on or between January 1 of the year prior to the measurement year and June 30 of the measurement year.

Measure population: Medicaid and Medicare members ages 18–85 with hypertension as of December 31 of the measurement year.

Note: Remote measurements by any digital device are acceptable.

Exclusions:

- *Required Exclusions apply. See Page 3.*
- Members who are in hospice or received palliative care in the measurement year.
- Medicare members ages 66 and older as of December 31 of the measurement year who were enrolled in I-SNP or living long term in an institution. Members ages 66–80 as of December 31 of the measurement year with frailty and advanced illness.
- Members ages 81 and older as of December 31 with frailty.
- Members who have evidence of end-stage renal disease or had a kidney transplant or dialysis.
- Members who have a diagnosis of pregnancy.
- Members who had nonacute inpatient admission during the measurement year.

Can be in-person or Telephone visit

Codes	CPT	CPT-CAT-II	HCPCS	ICD-10
Essential hypertension				I10
Systolic < 140		3074F, 3075F		
Systolic ≥ 140 mm Hg		3077F		
Diastolic < 80 mm Hg		3078F		
Diastolic 80–89 mm Hg		3079F		
Diastolic ≥ 90 mm Hg		3080F		
Outpatient visit with a hypertension diagnosis	99201–99205, 99211–99215, 99241–99245, 99341–99345, 99347–99350, 99381–99387, 99391–99397, 99401–99404, 99411, 99412, 99429, 99455, 99456, 99483		G0402, G0438, G0439, G0463, T1015	
Exclusion: Nonacute inpatient	99304–99310, 99315, 99316, 99318, 99324–99328, 99334–99337			
Telephone visits with a hypertension diagnosis	98966–98968, 99441–99413			
Online assessments (e-visits or virtual check-ins) with a hypertension diagnosis	98969–98972, 99421–99423, 99444, 99457, 99458		G0071, G2010, G2012, G2061, G2062, G2063, G2250–G2252	
Exclusion: Palliative care encounter		G9054, M1017	Z51.5	

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

The percentage of members hospitalized and discharged from July 1 of the year prior to the measurement year to June 30 of the measurement year due to acute myocardial infarction (AMI) and who received persistent beta-blocker treatment for six months after discharge. This measure is based on a calculation and there are no codes associated with beta-blocker medications.

Measure population: Medicaid and Medicare members ages 18 and older as of December 31 of the measurement year.

Exclusions

- *Required Exclusions apply. See Page 3.*
- Members ages 66–80 as of December 31 of the measurement year with frailty and advanced illness,
- Member ages 81 and older as of December 31 with frailty during the measurement year.
- Members having the following:
  - Asthma.
  - Chronic obstructive pulmonary disease (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 of asthma.
  - Intolerance or allergy to beta-blocker therapy.

Codes	ICD-10
Acute myocardial infraction (AMI)	I21.01, I21.02, I21.09, I21.11, I21.19, I21.21, I21.29, I21.3, I21.4

Pharmacotherapy Management of COPD Exacerbation (PCE)

The percentage of chronic obstructive pulmonary disease (COPD) exacerbations resulting in an acute inpatient discharge or emergency department (ED) visit for the member and had appropriate medications dispensed.

The inpatient discharge or ED visit due to COPD occurred between January 1–November 30 of the measurement year with the following actions:

- Dispensed a systemic corticosteroid (or there was evidence of an active prescription) within **14 days** of the event.
- Dispensed a bronchodilator (or there was evidence of an active prescription) within **30 days** of the event.

Measure population: Medicaid and Medicare members ages 40 or older as of January 1 of the measurement year.

There are no codes for numerator compliance; this is the reason why the list of bronchodilator medications was the only information in previous QRGs.

Required Exclusions apply. See Page 3.

Plan All – Cause Readmission (PCR)

The number of acute inpatient stay discharges between January 1 and December 1 during the measurement year that were followed by an unplanned acute readmission within **30 days**. Includes the predicted probability of an acute readmission.

Data for this measure are reported in the following categories:

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

Measure population:

- Medicaid members ages 18-64 as of January 1 of the measurement year
- Medicare members ages 18 and older as of January 1 of the measurement year.

Note: A lower rate indicates better performance.

This measure is based on a calculation and there are no codes associated.

Required Exclusions apply. See Page 3.

Statin Therapy for Patients with Cardiovascular Disease (SPC)

The percentage of members who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and who received and adhered to statin therapy.

- **Received Statin Therapy.** Members who were dispensed at least one high-intensity or moderate-intensity statin medication during the measurement year.
- **Statin Adherence 80%.** Members who remained on a high- intensity or moderate-intensity statin medication for at least 80% of the treatment period.

Measure population: Medicaid and Medicare males ages 21–75 and females ages 40–75 as of December 31 of the measurement year.

Exclusions:

- ***Required Exclusions apply. See Page 3.***
- Members diagnosed with myalgia, myositis, myopathy or rhabdomyolysis, or receiving palliative care during the measurement year.
- Members diagnosed with cardiovascular disease, pregnancy, cirrhosis, ESRD or dialysis, in vitro fertilization, or who were dispensed one or more prescriptions for clomiphene during the measurement year and the year prior.
- Medicare members ages 66 and older as of December 31 of the measurement year who were enrolled in I-SNP or living long term in an institution.
- Members ages 66 and older as of December 31 of the measurement year with frailty and advanced illness.

There are no codes for numerator compliance, just that the member be on a high- or moderate-intensity statin medication during the measurement year.

Diabetes Management

Blood Pressure Control for Patients with Diabetes (BPD)*

The percentage of members with diabetes who had BP control (< 140/90 mm Hg).

Eye Exam for Patients With Diabetes (EED)*

The percentage of members with diabetes who had an eye exam (retinal) performed.

Hemoglobin A1c Control for Patients with Diabetes (HBD)*

The percentage of members with diabetes who had HbA1c testing.

- **HbA1c control (< 8.0%).** The percentage of members with diabetes who had HbA1c control (< 8.0%).
- **HbA1c poor control (> 9.0%).** The percentage of members with diabetes who had HbA1c poor control (> 9.0%).

* Measure population: Medicaid and Medicare members ages 18–75 as of December 31 of the measurement year.

Required Exclusions apply. See Page 3.

Optional exclusions: Members who had a diagnosis of polycystic ovarian syndrome, gestational diabetes or steroid-induced diabetes during the measurement year.

Can be in-person or Telephone visit

Codes	CPT	CPT-CAT-II	HCPCS
Systolic blood pressure		3074F, 3075F, 3077F	
Diastolic blood pressure		3078F–3080F	
Outpatient visit with a diagnosis of Diabetes	99201–99205, 99211–99215, 99241–99245, 99341–99350, 99381–99387, 99391–99397, 99401–99404, 99411, 99412, 99429, 99455, 99456, 99483		G0402, G0438, G0439, G0463, T1015
Exclusion: Nonacute inpatient visit	99304–99310, 99315, 99316, 99318, 99324–99328, 99334–99337		
Telephone visits (Only BPD) with a diagnosis of Diabetes	98966–98968, 99441–99443		
Online assessments (e-visits or virtual check-ins) with a diagnosis of Diabetes	98969–98972, 99421–99444, 99458	G2010, G2012, G2061–G2063	

Codes	CPT	Modifier	CPT-CAT-II	ICD–10	HCPCS
Diabetic retinal screening with eye care professional	67028, 67030, 67031, 67036, 67039–67043, 67101, 67105, 67107, 67108, 67110, 67113, 67121, 67141, 67145, 67208, 67210, 67218, 67220, 67221, 67227, 67228, 92002, 92004, 92012, 92014, 92018, 92019, 92134, 92201, 92225–92228, 92230, 92235, 92240, 92250, 92260, 99203–99205, 99213–99215, 99242–99245				S0620, S0621, S3000
Diabetic retinal screening **negative** in prior year			3072F		
Eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy			2022F, 2024F, 2026F		
Eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy			2023F, 2025F, 2033F		
Unilateral eye enucleation (Unilateral Eye Enucleation Value Set) with a bilateral modifier (Bilateral Modifier Value Set)	65091, 65093, 65101, 65103, 65105, 65110, 65112, 65114				
Unilateral eye enucleation left				08T1XZZ	
Unilateral eye enucleation right				08T0XZZ	
Bilateral Modifier		50			

Codes	CPT	CPT-CAT-II
HbA1c tests	83036, 83037	
HbA1c test level less than 7.0%		3044F
HbA1c test level ≥ 7.0% and < 8.0		3051F
HbA1c tests level < 9.0%		3046F

Note: A lower HbA1c poor control (> 9.0%) rate indicates better performance.

Kidney Health Evaluation for Patients with Diabetes (KED)

The percentage of members with type 1 and type 2 diabetes who received a kidney health evaluation during the measurement year, with evidence of BOTH of the following:

- An estimated glomerular filtration rate (eGFR)
- Both a quantitative urine albumin lab test and a urine creatinine lab test with service dates four days apart or less

Measure population: Medicaid and Medicare members ages 18–85 with diabetes as of December 31 of the measurement year.

Exclusions:

- *Required Exclusions apply. See Page 3.*
- Members with ESRD, dialysis or palliative care.
- Medicare members ages 66 and older as of December 31 of the measurement year who were enrolled in I-SNP or living long term in an institution.
- Members ages 66–80 as of December 31 of the measurement year with frailty and advanced illness.
- Members ages 81 and older as of December 31 with frailty.

Can be in-person or Telephone visit

Codes	CPT	HCPCS	ICD-10CM
eGFR	80047, 80048, 80050, 80053, 80069, 82565		
Quantitative urine albumin lab test	82043		
Urine creatinine lab test	82570		
Exclusion: ESRD			N18.5, N18.6, Z99.2
Exclusion: Dialysis	90935, 90937, 90945, 90947, 90997, 90999, 99512	G0257, S9339	
Palliative care		G9054, M1017	Z51.5

Statin Therapy for Patients with Diabetes (SPD)

The percentage of adults with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) who met the following criteria.*

- **Received Statin Therapy:** Members who were dispensed at least one statin medication of any intensity during the measurement year.*
- **Statin Adherence 80%:** Members who remained on a statin medication of any intensity for at least 80% of the treatment period.*

Measure population: Medicaid and Medicare members ages 40–75 as of December 31 of the measurement year.

Exclusions:

- *Required Exclusions apply. See Page 3.*
- Members diagnosed with myalgia, myositis, myopathy or rhabdomyolysis, or receiving palliative care during the measurement year.
- Members diagnosed with cardiovascular disease, pregnancy, cirrhosis, ESRD or dialysis, in vitro fertilization, or was dispensed one or more prescriptions for clomiphene during the measurement year and the year prior.
- Medicare members ages 66 and older as of December 31 of the measurement year who were enrolled in I-SNP or living long term in an institution.
- Members ages 66 or older as of December 31 of the measurement year with frailty and advanced illness.

** There are no codes for numerator compliance, just that the member be on a statin medication during the measurement year.*

Behavioral Health

Antidepressant Medication Management (AMM)

The percentage of adults diagnosed with major depression who were treated with an antidepressant medication and remained on their medication treatment. Two rates are reported:

- **Effective Acute Phase Treatment.** The percentage of members who remained on an antidepressant medication treatment for at least **84 days** (12 weeks) within **114 days** from earliest prescription dispense date.
- **Effective Continuation Phase Treatment.** The percentage of members who remained on an antidepressant medication treatment for at least **180 days** (six months) within **232 days** from earliest prescription dispense date.

Measure population: Medicaid and Medicare members ages 18 and older as of April 30 of the measurement year.

Exclusions:

- *Required Exclusions apply. See Page 3.*
- Members who did not have an encounter with a diagnosis of major depression during the 121-day period: from **60 days** prior to the Index Prescription Start Date (IPSD) through the IPSD and **60 days** after.
- Members who filled a prescription for antidepressant medication **105 days** before the IPSD.

Codes	ICD-10
Major depression	F32.0–F32.4, F32.9, F33.0–F33.3, F33.41, F33.9

Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC)

The percentage of adults diagnosed with schizophrenia and heart disease who had a cholesterol test during the measurement year.

Measure population: Medicaid members ages 18-64 as of December 31 of the measurement year.

Required Exclusions apply. See Page 3.

Codes	CPT	CPT-CAT-II	HCPCS
LDL-C test	80061, 83700, 83701, 83704, 83721	3048F, 3049F, 3050F	
Schizophrenia	F20.0, F20.1, F20.2, F20.3, F20.5, F20.81, F20.89, F20.9, F25.0, F25.1, F25.8, F25.9		

Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)

The percentage of adults diagnosed with schizophrenia or schizoaffective disorder and diabetes who had both diabetes and cholesterol level tests during the measurement year.

Measure population: Medicaid members ages 18–64 as of December 31 of the measurement year.

Required Exclusions apply. See Page 3.

Codes	CPT	CPT-CAT-II	HCPCS
HbA1c tests	83036, 83037	3044F, 3046F, 3051F, 3052F	
LDL-C tests	80061, 83700, 83701, 83704, 83721	3048F–3050F	

Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medications (SSD)

The percentage of adults diagnosed with schizophrenia, schizoaffective disorder or bipolar disorder, who were dispensed an antipsychotic medication and had a test for diabetes during the measurement year.

Measure population: Medicaid members ages 18–64 as of December 31 of the measurement year.

Required Exclusions apply. See Page 3..

Codes	CPT	CPT-CAT-II	HCPCS
HbA1c tests	83036, 83037	3044F, 3046F, 3051F, 3052F	
Glucose tests	80047, 80048, 80050, 80053, 80069, 82947, 82950, 82951		

Follow-Up After Emergency Department Visit for Substance Use Disorder or Dependence (FUA)

The measure focuses on follow-up visits for alcohol or other drug (AOD) abuse or dependence in members 13 years and older after a principal diagnosis of AOD abuse or dependence during an ED visit.

Two rates are reported for follow-up visits after an ED visit:

- Within **7 days** of the ED visit (**8 total days**)
- Within **30 days** of the ED visit (**31 total days**)

The follow-up visit may occur on the date of discharge and be **with any practitioner with a principal diagnosis of AOD**. If the first follow-up visit is within **seven days** after discharge, then both rates are counted for this measure.

Medical Record Documentation and Best Practices

Emergency departments can improve their quality score and help our members by:

- Assisting members with scheduling an in-person or telehealth visit within **7 days**
- Educating members about the importance of following up with treatment
- Focusing on member preferences for treatment, allowing the member to take ownership of the treatment process

Providers can improve their quality score and help our members by:

- Encouraging the patient to bring their discharge paperwork to their first appointment
- Educating the patient about the importance of follow-up and adherence to treatment recommendations
- Using the same diagnosis for mental illness at each follow up (a non-mental illness diagnosis code will not fulfill this measure)
- Coordinating care between behavioral health and primary care physicians by:
- Including the diagnosis for substance use
- Reaching out to members who cancel appointments and assisting them with rescheduling as soon as possible

Required Exclusions apply. See Page 3.

Outpatient Follow-Up Visit

CPT: 90791, 90792, 90832-34, 90836-90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99251-55

BH Outpatient Visit

CPT: 98960-62, 99078, 99201-5, 99211-5, 99241-5, 99341-50, 99381-7, 99391-7, 99401-4, 99408-9, 99411-2, 99483, 99492, 99493, 99494, 99510

Telephone Visit

CPT: 98966, 98967, 98968, 99441, 99442, 99443

Online Assessment

CPT: 98969, 98970, 98971, 98972, 99421, 99422, 99423, 99444, 99457, 99458

HCPCS: G0071, G2010, G2012, G2061, G2062, G2063, G2250, G2251, G2252

AOD Medication Treatment

HCPCS: G2067-70, G2072, G2073, H0020, H0033, J0570, J0571-5, J2315, Q9991-2, S0109

Substance Use Disorder Diagnosis

ICD-10: F10.xx-16.xx, F18.xx-19.xx

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

The measure focuses on follow-up visits for mental illness after an ED visit for a diagnosis of mental illness or intentional self-harm in members six years and older.

Two rates are reported for follow-up visits after an ED visit:

- Within **7 days** of the ED visit (**8 total days**)
- Within **30 days** of the ED visit (**31 total days**)

If the first follow-up visit is within **seven days** after discharge, then both rates are counted for this measure.

Medical Record Documentation and Best Practices

Emergency departments can improve their quality score and help our members by:

- Assisting members with scheduling an in-person or telehealth visit within **7 days**
- Educating members about the importance of following up with treatment
- Focusing on member preferences for treatment, allowing the member to take ownership of the treatment process

Providers can improve their quality score and help our members by:

- Encouraging the patient to bring their discharge paperwork to their first appointment
- Educating the patient about the importance of follow-up and adherence to treatment recommendations
- Using the same diagnosis for mental illness at each follow-up visit (a non-mental illness diagnosis code will not fulfill this measure)
- Coordinating care between behavioral health and primary care physicians by:
  - Including a primary mental health disorder diagnosis
  - Reaching out to members who cancel appointments and assisting them with rescheduling as soon as possible

Required Exclusions apply: See Page 3.

Outpatient Follow-Up Visit

CPT: 90791, 90792, 90832-34, 90836-40, 90845, 90847, 90849, 90853, 90875, 90876, 99221-33, 99231-3, 99238, 99239, 99251-99255

BH Outpatient Visit

CPT: 99211-5, 99241-5, 99341-50, 99381-7, 99391-7, 99401-4, 99408-9, 99411-2, 99483, 99492, 99493, 99494, 99510

HCPCS: G0155, G0176, G0177, G0409, G0463, G0512, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013-20, T1015

Telephone Visit

CPT: 98966, 98967, 98968, 99441, 99442, 99443

Online Assessment

CPT: 98969, 98970, 98971, 98972, 99421, 99422, 99423, 99444, 99457, 99458

HCPCS: G0071, G2010, G2012, G2061, G2062, G2063, G2250, G2251, G2252

Mental Health Diagnosis Codes

ICD-10: F03.9x, F20-25.xx, F20.81, F20.89, F20.9, F28-34.xx, F39-45.xx, F48.xx, F50-53.xx, F59-60.xx, F63-66.xx, F68-69.xx, F80-82.xx, F84.xx, F88-93.xx, F94.xx, F95.xx, F98-99.xx

Intentional Self-Harm Diagnosis Codes

Exclusions: Members in hospice are excluded from the eligible population.

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

Measure Description: This measure looks at the percentage of acute inpatient hospitalizations, residential treatment or detoxification visits for a diagnosis of substance use disorder among members 13 years of age and older that result in a follow-up visit or service for substance use disorder.

Two rates are reported:

- The percentage of visits or discharges for which the member received follow-up for substance use disorder within the **30 days** after the visit or discharge.
- The percentage of visits or discharges for which the member received follow-up for substance use disorder within the **7 days** after the visit or discharge.

Required Exclusions Apply: Members in hospice are excluded from the eligible population.

The follow-up visit or event may be **with any practitioner for a principal diagnosis of substance use disorder**. Do not include visits that occur on the date of discharge.

Members 13 years of age and older as of the ED visit. Report three age stratifications and a total rate:

- 13–17 years
- 18 – 64 years
- 65 years and older
- Total

Medical Record Documentation and Best Practices:

- Referring the member to a provider or service right away is essential in treating the substance use disorder.
- Coordinate care with all who are involved in the treatment process.
- Provide credible sources in order to address any fears and stigma surrounding treatment.

Outpatient Follow-Up Visit

CPT: 90791, 90792, 90832-34, 90836-90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99251-55

BH Outpatient Visit

CPT: 98960-62, 99078, 99201-5, 99211-5, 99241-5, 99341-50, 99381-7, 99391-7, 99401-4, 99408-9, 99411-2, 99483, 99492, 99493, 99494, 99510

Telephone Visit

CPT: 98966, 98967, 98968, 99441, 99442, 99443

Online Assessment

CPT: 98969, 98970, 98971, 98972, 99421, 99422, 99423, 99444, 99457, 99458

HCPCS: G0071, G2010, G2012, G2061, G2062, G2063, G2250, G2251, G2252

Substance Use Disorder Diagnosis

ICD-10: F10.xx-16.xx, F18.xx-19.xx

Follow Up After Hospitalization for Mental Illness (FUH)

The percentage of discharges for members who were hospitalized due to mental illness or intentional self-harm and who had a timely follow-up visit with a mental health provider.

Two rates are reported for:

- Follow-up care with a mental health provider within **7 days** after discharge.
- Follow-up care with a mental health provider within **30 days** after discharge.

Do not include visits that occur on the date of discharge.

Providers can improve their quality score and help our members by:

- Encouraging the patient to bring their discharge paperwork to their first appointment
- Educating the patient about the importance of follow-up and adherence to treatment recommendations

Can be in-person, Telephone or Telehealth visit

Visit Type	CPT	HCPCS	ICD-10	POS
An outpatient visit (Visit Setting Unspecified Value Set with Outpatient POS Value Set) with a behavioral health provider	90791, 90792, 90832–90834, 90836–90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221–99223, 99231–99233, 99238, 99239, 99251–99255			03, 05, 07, 09, 11–20, 22, 33, 49, 50, 71, 72
A behavioral health (BH) outpatient visit) (Behavioral Health Outpatient Value Set with a behavioral health provider)	98960–98962, 99078, 99201–99205, 99211–99215, 99241–99245, 99341–99345, 99347, 99350, 99381–99387, 99391–99397, 99401–99404, 99411,99412, 99483, 99510	G0155, G0176, G0177, G0409, G0463, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013–H2020, T1015		
A telehealth or telephone visit with a behavioral health provider (use POS value for telehealth)	98966–98968, 99441–99443			02
Transitional care management services (Transitional Care Management Services Value Set), with a behavioral health provider, with or without a telehealth modifier (Telehealth Modifier Value Set)	99495, 99496			
Collaborative Care Management	99492, 99493, 99494	G0512		
Mental Health Diagnosis			F03.9x, F20-25.xx, F20.81, F20.89, F20.9, F28-34.xx, F39-45.xx, F48.xx, F50-53.xx, F59-60.xx, F63-66.xx, F68-69.xx, F80-82.xx, F84.xx, F88-93.xx, F94.xx, F95.xx, F98-99.xx	

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

The percentage of children newly prescribed with attention deficit/hyperactivity disorder (ADHD) medication who received follow-up care. Two rates are reported.

- **Initiation Phase.** The percentage of members with an outpatient prescription dispensed for ADHD medication, who had one follow-up visit with a prescribing practitioner within **30 days** following the IPSD.
- **Continuation and Maintenance (C&M) Phase.** The percentage of members with an outpatient prescription dispensed for ADHD medication, who remained on the medication for **210 days** or more, and who had two additional follow-up visits with a practitioner within **270 days** after the end of the Initiation Phase.

Measure population: Members ages 6–12 as of the Index Prescription Start Date (IPSD), the earliest ADHD medication dispense date.

Required Exclusions apply: See Page 3.

Can be in-person, Telephone or Telehealth visit

Codes	CPT	HCPCS	POS
An outpatient visit (Visit Setting Unspecified Value Set with Outpatient POS Value Set)	90791, 90792, 90832–90834, 90836–90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221–99223, 99231–99233, 99238, 99239, 99251–99255		03, 05, 07, 09, 11–20, 22, 33, 49, 50, 71, 72
An outpatient visit (Behavioral Health Outpatient Value Set)	98960–98962, 99078, 99201–99205, 99211–99215, 99241–99245, 99341–99345, 99347–99350, 99381–99387, 99391–99397, 99401–99404, 99411, 99412, 99510, 99483	G0155, G0176, G0177, G0409, G0463, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013–H2020, T1015	
Telehealth or telephone visits (use POS value for telehealth)	98966–98968, 99441–99443		02

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

The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) abuse or dependence who received the following:

- **Initiation of AOD Treatment.** Initiated dependence treatment within **14 days** of their diagnosis.
- **Engagement of AOD Treatment.** Continued treatment with two or more additional services within **34 days** of the initiation visit.

Measure population: Medicaid and Medicare members ages 13 or older as of December 31 of the measurement year.

For the follow-up treatments, include an ICD-10 diagnosis for alcohol or other drug dependence from the Mental, Behavioral and Neurodevelopmental Disorder Section of ICD-10 along with a procedure code for the preventive service, evaluation and management consultation or counseling service.

Exclusions: Members in hospice are excluded from the eligible population.

Can be in-person or Telephone visit

Codes	CPT	CPT Modifier	HCPCS	POS	ICD-10
Telephone visit and Telehealth Visit	98966–98968, 99441–99443			02	
Online assessment	98969–98972, 99421–99423, 99444, 99458		G2010, G2012, G2061–G2063		
Alcohol and other drug medication treatment	98970–98972, 99421, 99422, 99423, 99458		H0020, H0033, J0570, J0571–J0575, J2315, Q9991, Q9992, S0109		
Substance Use Disorder Diagnosis					F10.xx-16.xx, F18.xx-19.xx

Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)

The percentage of children and adolescents who had two or more antipsychotic prescriptions and had metabolic testing.

Measure population: Medicaid members ages 1–17 as of December 31 of the measurement year.

Three rates are reported:

- Blood glucose or HbA1c testing.
- Cholesterol or LDL-C testing.
- Blood glucose and cholesterol testing.

Required Exclusions apply. See Page 3.

Test Types	CPT	CPT-CAT-II
HbA1c	83036, 83037	3044F, 3046F, 3051F, 3052F
Glucose	80047, 80048, 80050, 80053, 80069, 82947, 82950, 82951	
LDL-C	80061, 83700, 83701, 83704, 83721	3048F, 3049F, 3050F
Cholesterol	82465, 83718, 83722, 84478	

Pharmacotherapy for Opioid Use Disorder (POD)

This measure captures the percentage of new opioid use disorder (OUD) pharmacotherapy events with OUD pharmacotherapy for **180 or more days** among members age 16 and older with a diagnosis of OUD.

- The OUD dispensing event will be captured between a 12-month period that begins on July 1 of the year prior to the measurement year and ends on June 30 of the measurement year (Intake Period). This ensures capture of pharmacotherapy compliance by December 31 of the measurement year.
- Members must have a Negative Medication History (no OUD pharmacotherapy medications captured on pharmacy claims) as of **31 days** prior to the new OUD pharmacotherapy to be included in the measure population.

6 years and older as of December 31 of the measurement year. Report two age stratifications and total rate:

- 16–64 years
- 65 years and older
- Total

Required Exclusions apply. See Page 3.

Medical Record Documentation and Best Practices:

Build a partnership on trust and understanding with the patient.

- Medication regiment adherence is essential for the patient's treatment.
- Provide credible sources in order to address any fears and stigma surrounding treatment.
- Recognize that the patient might want to participate at varying levels, so meet them where they are.
- Decision making should include the patient and their family.

Description	Prescription	Value Sets and Days Supply
Antagonist	Naltrexone (oral)	NA—Codes do not exist
Antagonist	Naltrexone (injectable)	Naltrexone Injection Value Set (31 days supply)
Partial agonist	Buprenorphine (sublingual tablet)	Buprenorphine Oral Value Set (1 day supply) Buprenorphine Oral Weekly Value Set (7 days supply)
Partial agonist	Buprenorphine (injection)	Buprenorphine Injection Value Set (31 days supply)
Partial agonist	Buprenorphine (implant)	Buprenorphine Implant Value Set (180 days supply)
Partial agonist	Buprenorphine/ naloxone (sublingual tablet, buccal film, sublingual film)	Buprenorphine Naloxone Value Set (1 day supply)
Agonist	Methadone (oral)	Methadone Oral Value Set (1 day supply) Methadone Oral Weekly Value Set (7 days supply)

Methadone is not included on the medication lists for this measure. Methadone for OUD administered or dispensed by federally certified opioid treatment programs (OTP) is billed on a medical claim. A pharmacy claim for methadone would be indicative of treatment for pain rather than OUD.

Telehealth & In-Person Visits

The following measures can be met via an in-person, telephone, or telehealth visit:

HEDIS Measure	In-person Visit	Telephone Visit	Telehealth Visit
Adults' Access to Preventive/Ambulatory Health Services (AAP)	✓	✓	
Follow-Up Care for Children Prescribed ADHD Medication (ADD – Continuation)	✓	✓	✓
Blood Pressure for Patients with Diabetes (BPD)	✓	✓	✓
Controlling Blood Pressure (CBP)	✓	✓	✓
Follow Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)	✓		✓
Follow Up After Hospitalization for Mental Illness (FUH)	✓	✓	✓
Follow Up After High-Intensity Care for Substance Use Disorder (FUI)	✓	✓	✓
Initiation & Engagement of Alcohol and Other Drug Abuse or Independence Treatment (IET)	✓	✓	✓
Transitions of Care (TRC)	✓	✓	✓
Prenatal and Postpartum Care (PPC)	✓	✓	

Additional measures are under review for Telehealth


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