Capital Blue Cross

Comprehensive Performance Measures Guide

Version 7.0 Requirements for closing quality and utilization gaps in care

PH-2 (10/30/23)

Data submission methods for closing care opportunities

Capital Blue Cross uses NCQA's Healthcare Effectiveness Data and Information Set (HEDIS®) to help monitor and ensure members are receiving the necessary clinical care and services. HEDIS standardized measures relate to many significant population health issues including cardiovascular disease, cancer, diabetes, and immunizations. HEDIS performance data allows the health plan to measure success and track improvement. Data can be submitted to Capital in three ways:

- CPT codes, CPT II codes, and diagnosis codes can be submitted on claims. **Measure-specific coding specifications** are included in each section.
- Medical record documentation can be submitted through Theon® Care Collaborator. Measure-specific medical record specifications are included in each section.
- Clinical Data Integration (CDI) feeds allow information to pass from the electronic health record to Capital. Measure-specific **CDI Summary Sheets** provide both Numerator and Exclusion Summary Sheets. Please refer to the **Capital Blue Cross HEDIS Data Collection Playbook Version 1.0** for details.

Frequently Asked Questions are answered in the Provider Welcome Kits found in Theon:

- **CapBlueCross.com/care-optimizer.**
- **CapBlueCross.com/care-collaborator.**

Table of Contents

CARDIOVASCULAR CONDITIONS 2

CONTROLLING HIGH BLOOD PRESSURE (CBP)* 2

PREVENTION AND SCREENING 2

COLORECTAL CANCER SCREENING (COL)* 2

CERVICAL CANCER SCREENING (CCS) 4

BREAST CANCER SCREENING (BCS-E)* 6

CHLAMYDIA SCREENING IN WOMEN (CHL) 7

CHILD AND ADOLESCENT WELL-CARE VISITS (WCV) 8

WELL-CHILD VISITS IN THE FIRST 30 MONTHS OF LIFE (W30) 9

WEIGHT ASSESSMENT & COUNSELING FOR NUTRITION AND PHYSICAL ACTIVITY FOR CHILDREN/ADOLESCENTS (WCC) – NUTRITION COUNSELING 10

WEIGHT ASSESSMENT & COUNSELING FOR NUTRITION AND PHYSICAL ACTIVITY FOR CHILDREN/ADOLESCENTS (WCC) – PHYSICAL ACTIVITY 11

WEIGHT ASSESSMENT & COUNSELING FOR NUTRITION AND PHYSICAL ACTIVITY FOR CHILDREN/ADOLESCENTS (WCC) – BMI PERCENTILE 12

CHILDHOOD IMMUNIZATION STATUS (CIS) 13

COMMON CHILDHOOD AND ADOLESCENT VACCINATION GENERIC AND BRAND NAMES 18

COMMON CHILDHOOD AND ADOLESCENT VACCINATION COMBINATIONS GENERIC AND BRAND NAMES 20

IMMUNIZATIONS FOR ADOLESCENTS (IMA)* 21

LEAD SCREENING IN CHILDREN (LSC) 23

DIABETES 24

BLOOD PRESSURE CONTROL FOR PATIENTS WITH DIABETES (BPD)* 24

HEMOGLOBIN A1C CONTROL FOR PATIENTS WITH DIABETES (HBD)* 26

EYE EXAM FOR PATIENTS WITH DIABETES (EED) 27

KIDNEY HEALTH EXAM FOR PATIENTS WITH DIABETES (KED) 29

MUSCULOSKELETAL CONDITIONS 31

OSTEOPOROSIS MANAGEMENT IN WOMEN WHO HAD A FRACTURE (OMW) 31

OSTEOPOROSIS SCREENING IN OLDER WOMEN (OSW) 33

OVERUSE/APPROPRIATENESS 34

USE OF IMAGING STUDIES FOR LOW BACK PAIN (LBP)* 34

CARE COORDINATION 37

TRANSITIONS OF CARE-NOTIFICATION OF INPATIENT ADMISSION (TRC) 37

TRANSITIONS OF CARE-RECEIPT OF DISCHARGE INFORMATION (TRC) 37

TRANSITIONS OF CARE-PATIENT ENGAGEMENT AFTER INPATIENT DISCHARGE (TRC) 39

TRANSITIONS OF CARE-MEDICATION RECONCILIATION POST-DISCHARGE (TRC) 40

FOLLOW-UP AFTER ED VISIT FOR PEOPLE WITH MULTIPLE HIGH-RISK CHRONIC CONDITIONS (FMC) 42

RESPIRATORY CONDITIONS 45
APPROPRIATE TESTING FOR PHARYNGITIS (CWP) 45
USE OF SPIROMETRY TESTING IN THE ASSESSMENT AND DIAGNOSIS OF COPD (SPR) 47
BlueHPN 48

Disclaimer - Capital Blue Cross will make the final determination regarding reimbursement upon receipt of a claim. Submitting a claim with a code included in this document is not a guarantee of payment. Payment of covered services is contingent upon coverage determined by the member's benefits and eligibility.

HEDIS specifications may be updated or changed during the measurement year. Capital Blue Cross will communicate any changes to the specifications when received.

*This measure is also included into the Blue High Performance Network (BlueHPN) program. The Blue Cross Blue Shield Association can make changes to the BlueHPN quality performance measures at their discretion. The measures are reviewed annually. A table of the BlueHPN quality measure set can be found at the end of this guide.

CARDIOVASCULAR CONDITIONS

CONTROLLING HIGH BLOOD PRESSURE (CBP)*

LINE OF BUSINESS: Commercial and Medicare	
This measure evaluates the percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) within the measurement year.	

Numerator compliant	The **most recent BP reading during the current measurement** year.
	• If multiple readings were recorded for a single date, use the lowest systolic and lowest diastolic BP on that date. The systolic and diastolic results do not need to be from the same reading.
	• A BP reading taken by a member with a digital device during a telehealth or telephone visit is acceptable and will count towards compliance. A BP reading taken by the member with a non-digital device will not meet criteria.
	  ○ Digital device: a battery-operated cuff that is placed on your upper arm or wrist, the device is inflated, the pressure will slowly drop on its own. The screen will show a digital readout of your systolic and diastolic BP. After showing your BP, the cuff will deflate on its own.
	• A BP documented as an “average BP” (e.g., “average BP: 139/70”) is eligible for use.
	• Acceptable BP readings.
	  ○ Outpatient visit including telehealth, telephone, and e-visits.

Numerator noncompliant	• The member is not compliant if the BP is ≥140/90 mmHg, if there is no BP reading during the measurement year or if the reading is incomplete (e.g., the systolic or diastolic level is missing).
	• Note: If an additional blood pressure value is received within the measurement year that is considered noncompliant it may reopen a previously closed gap
	• Do not include BP readings that meet the following criteria:
	  ○ Emergency room (ER) visit.
	  ○ Acute-inpatient stay.
	  ○ Taken same day as a diagnostic or therapeutic procedure that requires a change in diet or medication on or one day before the BP reading with exceptions of fasting blood tests.
	• Taken by the member using a non-digital device such as with a manual blood pressure cuff and a stethoscope.
	• Ranges and thresholds do not meet the criteria for this measure. A distinct numeric result for both the systolic and diastolic BP reading is required for the numerator compliance.

Exclusions	• Members who died during the measurement year. • Evidence of end-stage renal disease (ESRD), dialysis, nephrectomy, kidney transplant. • Members 66 years of age and older living in long-term institution settings, advanced illness, and/or frailty are excluded from this measure. • In hospice or using hospice services anytime during the measurement year. • Receiving palliative care during the measurement year. • A diagnosis of pregnancy any time during the measurement year.
Theon document attachment	• Member's name. • 2nd identifier (e.g., Date of Birth, DOB). • Date of Service (DOS). • Systolic value. • Diastolic value. • If multiple readings for same day DOS is used, the record must indicate it is in an appropriate setting. • If there is a recent name change for the member and or the name in Theon does not match, a third identifier, such as the member's address, subscriber ID, or last 4 digits of Social Security Number is required.
May be closed by CPT II codes, medical record documentation viaTheon, or CDI feed.	
Procedure 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: G0402, G0438, G0439, G0463, T1015. • Telephone: 98966, 98967, 98968, 99441, 99442, 99443. • Online assessment: 98969-98972, 99421, 99422, 99423, 99444, 99457, G0071, G2010, G2012, G2061, G2062, G2063. • Nonacute inpatient: 99304-99310, 99315, 99316, 99318, 99324-99328, 99334-99337.
CPT II	• Systolic: 3074F, 3075F, 3077F. • Diastolic: 3078F, 3079F, 3080F.
LOINC	• Systolic: 75997-7, 8459-0, 8460-8, 8461-6, 8480-6, 8508-4, 8546-4, 8547-2, 89268-7. • Diastolic:75995-1, 8453-3, 8454-1, 8455-8, 8462-4, 8496-2, 8514-2, 8515-9, 89267-9.

PREVENTION AND SCREENING

COLORECTAL CANCER SCREENING (COL)*

LINE OF BUSINESS: Commercial and Medicare	
This measure evaluates the percentage of members 45-75 years of age who had appropriate screening for colorectal cancer using one of the following criteria.	

Numerator compliant	• Fecal Occult Blood Test (FOBT) during the measurement year.
	• Flexible Sigmoidoscopy during the measurement year or four years prior to measurement year.
	• Stool DNA (sDNA) with FIT, i.e.,Cologuard, test during the measurement year or two years prior to the measurement year.
	• Colonoscopy during the measurement year or nine years prior to the measurement year.
	• CT Colonography during the measurement year or four years prior to the measurement year.
	• There are two acceptable types of FOBT tests.
	  ○ Guaiac (gFOBT)
	  ○ Immunochemical (IFOBT or FIT)
	  ○ If the record does not specify which type of test was given, three samples must be listed.
	Note: For a pathology report that does not indicate the type of screening (e.g., colonoscopy, or flexible sigmoidoscopy) or for incomplete procedures, evidence must exist that the scope advanced beyond the splenic flexure (colonoscopy) or into the sigmoid colon (flexible sigmoidoscopy).

Numerator noncompliant	• Digital Rectal Exams (DREs) or FOBTs performed in an office setting or performed on a sample collected via digital rectal exam cannot be counted. • Patient's refusal of a colonoscopy does not exclude him/her from this measure.
Exclusions	• Diagnosis of colorectal cancer at any time in the member's history through December 31 of the measurement year. • Documentation of total colectomy at any time in the member's history through December 31 of the measurement year. • Members who died during the measurement year. • Members 66 years of age and older living in long-term institution settings, advanced illness, and/or frailty are excluded from this measure. • In hospice or using hospice services anytime during the measurement year. • Receiving palliative care during the measurement year.

Theon document attachment	• Member's Name. • 2nd identifier (e.g., DOB). • DOS. • Type of testing. • Result/finding. • FOBT must include the number of samples if available. • If there is a recent name change for the member and or the name in Theon does not match, a third identifier, such as the member's address, subscriber ID, or last 4 digits of Social Security Number is required.
May be closed by diagnosis and procedure codes on a claim or upload of documentation via Theon or CDI feed.	
FOBT Test	82270, 82274, G0328 LOINC: 27396-1, 2335-8, 14563-1, 14564-9, 14565-6, 12503-9, 12504-7, 27401-9, 27925-7, 27926-5, 80372-6, 58543-2, 29771-3, 57905-2, 56490-6, 56491-4
sDNA FIT Lab Test	81528 LOINC: 77353-1, 77354-9
Colonoscopy	44388-44394, 44401-44408, 45378-45382, 45384-45393, 45398, G0105, G0121, 44397, 45398, 45355, 45383
Flexible sigmoidoscopy	45330-45335, 45337, 45338, 45340, 45341, 45342, 45346, 45347, 45349, 45350, G0104
CT colonography	74261-74263 LOINC: 79101-2, 79069-1, 60515-4, 72531-7, 82688-3, 79071-7
Exclusions	Total Colectomy: 44150, 44151, 44152, 44153, 44155, 44156, 44157, 44158, 44210, 44211, 44212, 0DTE0ZZ, 0DTE4ZZ, 0DTE7ZZ, 0DTE8ZZ Colorectal Cancer: G0213, G0214, G0215, G0231, C18.0, C18.1, C18.2, C18.3, C18.4, C18.5, C18.6, C18.8, C18.9, C19, C20, C21.2, C21.8, C78.5, Z85.038, Z85.048

CERVICAL CANCER SCREENING (CCS)

LINE OF BUSINESS: Commercial	
This measure evaluates the percentage of women 21-64 years of age who were appropriately screened for cervical cancer using any of the critiera as listed below.	
Numerator compliant	• Women age 21-64 who had cervical cytology performed within the measurement year or two years prior to the measurement year. • Women age 30-64 who had cervical high-risk human papillomavirus (hrHPV) testing within the measurement year or four years prior to the measurement year. • Women age 30-64 who had cervical cytology/high-risk human papillomavirus (hrHPV) co-testing within the measurement year or four years prior to the measurement year. • Lab results that indicate the sample contained "no endocervical cells" may be used **if** a valid result was reported for the test.
Numerator noncompliant	• Lab results that explicitly state the sample was inadequate or that "no cervical cells were present." • Do not count biopsies because they are diagnostic and therapeutic only and are not valid for primary cervical cancer screening.
Exclusions	• Members who died during the measurement year. • Members 66 years of age and older living in long-term institutional settings, advanced illness, and/or frailty are excluded from this measure. • In hospice or using hospice services anytime during the measurement year. • Receiving palliative care during the measurement year. • Documentation of a hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix anytime during the members' history through December 31 of the measurement year. • Documentation of "complete," "total," or "radical hysterectomy" (abdominal, vaginal, or unspecified). • Documentation of "vaginal hysterectomy." • Documentation of "vaginal pap smear" in conjunction with documentation of hysterectomy. • Documentation of "hysterectomy" in combination with documentation that a patient no longer needs a pap testing/cervical cancer screening. • **Documentation of hysterectomy alone does not meet the criteria because it is not sufficient evidence that the cervix was removed.**

Theon document attachment	• Member's name. • 2nd identifier (e.g., DOB). • Type of test. • Specimen collected date/reported date. • Result or finding. • If there is a recent name change for the member and or the name in Theon does not match, a third identifier, such as the member's address, subscriber ID, or last 4 digits of Social Security Number is required.
May be closed by diagnosis and procedure codes on a claim or upload of documentation via Theon or CDI feed.Theon	
Cervical cytology screening	88141–88143, 88147, 88148, 88150, 88152, 88153, 88164-88167, 88174, 88175, 88154 G0123, G0124, G0141, G0143-G0145, G0147, G0148, P3000, P3001, Q0091. LOINC: 33717-0, 47528-5, 47527-7, 19774-9, 19762-4, 19765-7, 19766-5, 10524-7, 18500-9, 19764-0.
HPV testing	87624, 87625, G0476. LOINC: 77379-6, 82354-2, 77399-4, 59263.4, 82456-5, 82675-0, 59420-0, 30167-1, 21440-3, 77400-0, 59264-2, 75694-0, 95539-3, 71431-1, 38372-9, 69002-4.
Hysterectomy w/no residual cervix	51925, 56308, 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, 58951, 58953, 58954, 58956, 59135, 57530, 57531, 58575. ICD10PCS: 0UTC0ZZ, 0UTC4ZZ, 0UTC7ZZ, 0UTC8ZZ ICD9PCS: 68.61, 68.71, 68.41, 68.51, 68.69, 68.79, 68.49, 68.59, 68.8
Absence of Cervix Diagnosis	ICD10CM: Q51.1, Z90.710, Z790.712 ICD9CM: V88.01, V88.03, 752.43
Palliative Care	HCPCS: G9054, M1017

BREAST CANCER SCREENING (BCS-E)*

LINE OF BUSINESS: Commercial and Medicare	
This measure evaluates the percentage of women 50–74 years of age who had a mammogram to screen for breast cancer.	
Numerator compliant	• Medical record must document the date the mammogram was performed and the result or finding. • One or more mammograms any time on or between October 1 two years prior to the measurement period and the end of the measurement period.
Numerator noncompliant	• Do not count biopsies, breast ultrasounds, or MRIs.
Exclusions	• Medical record documenting evidence of a bilateral mastectomy or two unilateral mastectomies on the same date of service or on different DOS. • Members 66 years of age and older living in long-term institutional settings, advanced illness, and/or frailty are excluded from this measure. • In hospice or using hospice services anytime during the measurement year. • Receiving palliative care during the measurement year.
Theon document attachment	• Member's name. • 2nd identifier (e.g., DOB). • DOS. • Evidence a bilateral mammography was performed and findings/results. • If there is a recent name change for the member and or the name in Theondoes not match, a third identifier, such as the member's address, subscriber ID, or last 4 digits of Social Security Number is required.
May be closed by diagnosis and procedure codes on a claim or upload of documentation via Theon or CDI feed.Theon	
PLEASE NOTE: All codes require either a bilateral modifier 50 or 09950 or a LT and RT modifier. Members 66 years of age and older living in long-term in institutional settings, advanced illness, and/or frailty are excluded from this measure.	
Mammography procedure codes	77061, 77062, 77063, 77065, 77066, 77067, G0202, G0204, G0206.
ICD10	Bilateral Mastectomy: 0HTV0ZZ. History of Bilateral Mastectomy: Z90.13. Unilateral Mastectomy: 0HTU0ZZ, 0HTT0ZZ. Absence of L Breast: Z90.12. Absence of R Breast: Z90.11.
CPT	Unilateral Mastectomy: 19180, 19200, 19220, 19240, 19303,19304, 19305, 19306, 19307. Bilateral Modifier: LT, RT.

CHLAMYDIA SCREENING IN WOMEN (CHL)

LINE OF BUSINESS: Commercial	
This measure evaluates the percentage of members - women 16–24 years of age identified as sexually active who had at least one test for chlamydia during the measurement year.	
Numerator compliant	• Medical record must document evidence of a chlamydia screening test, dated during the measurement year.
Exclusions	• Women who had a pregnancy test and a prescription for isotretinoin on the date of the pregnancy test or up to six days after the pregnancy test. • Women who had a pregnancy test and an X-ray on the date of the pregnancy test or up to six days after the pregnancy test. • In hospice or using hospice services anytime during the measurement year. • Members who died during the measurement year. • Retinoid medication/Isotrentinoin, this medication, along with a pregnancy test, dispensed on exclude the member from the measure. • A pregnancy test during the measurement year and an x-ray on the date of the pregnancy test or 6 days after the pregnancy test.
Theon document attachment	• Member's name. • 2nd identifier (ex: DOB). • DOS. • Medical record must document evidence of a chlamydia screening test, dated during the measurement year • If there is a recent name change for the member and or the name in Theon does not match, a third identifier, such as the member's address, subscriber ID, or last 4 digits of Social Security Number is required.
Procedure codes	Chlamydia tests: 87110, 87270, 87320, 87490, 87491, 87492, 87810, 0353U. **LOINC:** 45093-2, 80367-6, 14463-4, 45095-7, 89648-0, 87950-2, 14465-9, 14467-5, 14464-2, 34710-4, 45091-6, 91860-7, 91873-0, 6353-7, 31775-0, 14474-1, 14513-6, 45090-8, 80363-5, 21190-4, 6356-0, 88221-7, 87949-4, 21191-2, 6357-8, 45084-1, 57287-5, 45089-0, 80364-3, 50387-0, 23838-6, 16600-9, 82306-2, 53925-4, 42931-6, 53926-2, 45068-4, 44807-6, 44806-8, 45072-6, 80365-0, 80361-9, 45069-2, 45073-4, 45075-9, 80360-1, 80362-7.

CHILD AND ADOLESCENT WELL-CARE VISITS (WCV)

LINE OF BUSINESS: Commercial	
This measure evalutates the percentage of members 3–21 years of age who had at least one comprehensive well-care visit.	
Numerator compliant	• One or more well-child visits from age 3–21. • The well-care visit must occur The well-care visit must occur with a PCP or an OB/GYN practitioner assigned to the member.
Exclusions	• In hospice or using hospice services anytime during the measurement year. • Receiving palliative care during the measurement year.
Theon document attachment	• Member's name. • 2nd identifier (ex: DOB). • DOS. • Well-child visit. • If there is a recent name change for the member and or the name in Theon does not match, a third identifier, such as the member's address, subscriber ID, or last 4 digits of Social Security Number is required.
Procedure codes	Well-Care: CPT: 99381-99385 99391-99395 99461 HCPCS—G0438, G0439, S0302, S0610, S0612, S0613.
ICD10	Well-Care: Z00.00 Z00.01 Z00.110 Z00.111, Z00.121, Z00.129, Z00.2, Z00.3, Z01.411, Z01.419, Z02.5, Z76.1, Z76.2.

WELL-CHILD VISITS IN THE FIRST 30 MONTHS OF LIFE (W30)

LINE OF BUSINESS: Commercial	
This measure evaluates the percentage of members who had the following number of well-child visits with a Primary Care Physician (PCP) during the last 15 months: • **Children who turned 15 months old during the measurement year and had six or more well-child visits.** • **Children who turned 30 months old during the measurement year and had two or more well-child visits.**	
Numerator compliant	• Six or more well-child visits on different dates of service on or before the 15-month birthday. • The well-child visit must occur with a Primary Care Physician (PCP),
Exclusions	• In hospice or using hospice services anytime during the measurement year. • Receiving palliative care during the measurement year.
Theon document attachment	• Member's name. • 2nd identifier (e.g., DOB). • DOS. • Two or more well-child visits on different dates of service between the child's 15-month birthday plus 1 day and the 30-month birthday. • If there is a recent name change for the member and or the name in Theon does not match, a third identifier, such as the member's address, subscriber ID, or last 4 digits of Social Security Number is required.
Procedure codes	Well-Care: CPT: 99381-99385 99391-99395 99461 HCPCS: G0438, G0439, S0302, S0610, S0612, S0613.
ICD10	Well-Care: Z00.00 Z00.01 Z00.110 Z00.111, Z00.121, Z00.129, Z00.2, Z00.3, Z01.411, Z01.419, Z02.5, Z76.1, Z76.2.

WEIGHT ASSESSMENT & COUNSELING FOR NUTRITION AND PHYSICAL ACTIVITY FOR CHILDREN/ADOLESCENTS (WCC) – NUTRITION COUNSELING

LINE OF BUSINESS: Commercial	
This measure evaluates the percentage of members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of counseling for nutrition during the measurement year.	
Numerator compliant	Medical record that includes the date of service and documentation of at least one of the following: • Discussion of current nutrition behaviors (e.g., eating habits, dieting behaviors). • Checklist indicating nutrition was addressed. • Counseling or referral for nutrition education. • Receipt of educational materials on nutrition during a face-to-face visit. • Anticipatory guidance for nutrition. • Weight or obesity counseling. • Referral to WIC.
Numerator noncompliant	• Notation of “health education” or “anticipatory guidance” without specific mention of nutrition. • A physical exam finding or observation alone (e.g., well nourished) is not compliant because it does not indicate counseling for nutrition. • Documentation related to a member’s “appetite” does not meet criteria. • A sports physical without mention of nutritional counseling.
Exclusions	• A diagnosis of pregnancy during the measurement year. • In hospice or using hospice services anytime during the measurement year. • Members who died during the measurement year.
Theon document attachment	• Member’s name. • 2nd identifier (e.g., DOB). • DOS. • Components for numerator compliance for nutrition. • If there is a recent name change for the member and or the name in Theon does not match, a third identifier, such as the member’s address, subscriber ID, or last 4 digits of Social Security Number is required.
Procedure codes	97802–97804, G0270, G0271, G0447, S9449, S9452, S9470.
ICD10	Z71.3

WEIGHT ASSESSMENT & COUNSELING FOR NUTRITION AND PHYSICAL ACTIVITY FOR CHILDREN/ADOLESCENTS (WCC) – PHYSICAL ACTIVITY

LINE OF BUSINESS: Commercial	
This measure evaluates the percentage of members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of counseling for physical activity during the measurement year.	
Numerator compliant	Medical record that includes the date of service and documentation of at least one of the following: • Discussion of current physical activity behaviors (e.g., exercise routine, participation in sports activities, exam for sports participation). • Checklist indicating physical activity was addressed. • Counseling or referral for physical activity. • Receipt of educational materials on physical activity during a face-to-face visit. • Anticipatory guidance specific to the child's physical activity. • Weight or obesity counseling.
Numerator noncompliant	• Notation of "cleared for gym class" alone without documentation of a discussion. • Notation of "health education" or "anticipatory guidance" without specific mention of physical activity. • Notation of anticipatory guidance related solely to safety (e.g., wears helmet or water safety) without specific mention of physical activity recommendations. • Notation solely related to screen time (computer or television) without specific mention of physical activity.
Exclusions	• A diagnosis of pregnancy during the measurement year. • In hospice or using hospice services anytime during the measurement year (required exclusion). • Members who died during the measurement year.
Theon document attachment	• Member's name. • 2nd identifier (e.g., DOB). • DOS. • Components for numerator compliance for physical activity. • If there is a recent name change for the member and or the name in Theon does not match, a third identifier, such as the member's address, subscriber ID, or last 4 digits of Social Security Number is required.
HCPCS	S9451, G0447.
ICD10	Z71.82, Z02.5

WEIGHT ASSESSMENT & COUNSELING FOR NUTRITION AND PHYSICAL ACTIVITY FOR CHILDREN/ADOLESCENTS (WCC) – BMI PERCENTILE

LINE OF BUSINESS: Commercial	
This measure evaluates the percentage of members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of height, weight, and BMI percentile during the measurement year.	
Numerator compliant	• Medical record must include the date of service, height, weight, BMI percentile and be from the same data source. ◦ If part of sports physical exam, please send the office notes that correspond with the exam. • The BMI must be documented as a percentile (e.g., 85th percentile), or plotted on a BMI age-growth chart. • A value of <1 or >99 is acceptable because they represent a distinct percentile.

Numerator noncompliant	• A plotted BMI chart alone without height, weight, and BMI percentile value will be considered noncompliant.
	• Notation of BMI value only.
	• Notation of height and weight only.
	• Ranges and thresholds do not meet criteria. BMI percentile must be a specific value.
	  ◦ Acceptable 89th percentile.
	  ◦ Not acceptable 85-90th percentile.

Exclusions	• A diagnosis of pregnancy during the measurement year. • In hospice or using hospice services anytime during the measurement year (required exclusion). • Members who died during the measurement year.
Theon document attachment	• Member's name. • 2nd identifier (e.g., DOB). • DOS. • Components for numerator compliance for the BMI percentile • If there is a recent name change for the member and or the name in Theon does not match, a third identifier, such as the member's address, subscriber ID, or last 4 digits of Social Security Number is required.
Coding	ICD10CM: Z68.51, Z68.52, Z68.53, Z68.54. LOINC: 59574-4, 59575-1, 59576-9

CHILDHOOD IMMUNIZATION STATUS (CIS)

LINE OF BUSINESS: Commercial	
This measure assesses the percentage of children who turned two years old during the measurement year and who had received the designated ten vaccinations on or before two years of age: four diphtheria-tetanus-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 doses of pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines.	

Numerator compliant	• **For MMR, hepatitis B, VZV and hepatitis A, count any of the following**:
	  • Evidence of the antigen or combination vaccine, or
	  • Documented history of the illness, or
	  • A seropositive test result for each antigen.
	• **For DTaP, IPV, HiB, pneumococcal conjugate, rotavirus and influenza, count only:**
	  ○ Evidence of the antigen or combination vaccine.
	For combination vaccinations that require more than one antigen (DTaP and MMR), the organization must find evidence of all the antigens.
	• **DTaP** at least **four** DTaP vaccinations with different DOS on or before the child's second birthday. Do not count a vaccination administered prior to 42 days after birth.
	• **IPV** at least **three** IPV vaccinations with different DOS on or before the child's second birthday. Do not count a vaccination administered prior to 42 days after birth.
	• **MMR any of the following meet criteria:**
	  • At least **one** MMR vaccination on or between the child's first and second birthdays.
	  ▪ History of measles, mumps, and rubella illness any time on or before the child's second birthday.
	• **HiB** at least **three** HiB vaccinations with different DOS on or before the child's second birthday. Do not count a vaccination administered prior to 42 days after birth.

	• **Hepatitis B any of the following on or before the child's second birthday meet criteria:**
	  • At least **three** hepatitis B vaccinations with different DOS.
	  ▪ One of the three vaccinations can be a newborn hepatitis B vaccination during the eight-day period that begins on the date of birth and ends seven days after the date of birth. For example, if the member's date of birth is December 1, the newborn hepatitis B vaccination must be on or between December 1 and December 8.
	  ▪ History of hepatitis illness.
	• **VZV either of the following meets criteria:**
	  • At least **one** VZV vaccination with a date of service on or between the child's first and second birthdays.
	  • History of varicella zoster (e.g., chicken pox) illness on or before the child's second birthday.
	• **Pneumococcal conjugate** at least **four** pneumococcal conjugate vaccinations with different dates of service on or before the child's second birthday. Do not count a vaccination administered prior to 42 days after birth.
	• **Hepatitis A either of the following meets criteria:**
	  • At least one hepatitis A vaccination with a date of service on or between the child's first and second birthdays.
	  • History of hepatitis A illness on or before the child's second birthday.
	• **Rotavirus any of the following on or before the child's second birthday meet criteria. Do not count a vaccination administered prior to 42 days after birth.**
	  • At least **two** doses of the two-dose rotavirus vaccine on different DOS.
	  • At least **three** doses of the three-dose rotavirus vaccine on different DOS.
	  • At least one dose of the two-dose rotavirus vaccine and at least two doses of the three-dose rotavirus vaccine all on different DOS.
	• **Influenza** at least **two** influenza vaccinations with different dates of service on or before the child's second birthday. Do not count a vaccination administered prior to six months (180 days) after birth.
	  • One of the two vaccinations can be an LAIV vaccination administered on the child's second birthday. Do not count an LAIV vaccination administered before the child's second birthday.
	• Parent refusal is not a valid exclusion.

Exclusions	• Members who died during the measurement year.
	• In hospice or using hospice services anytime during the measurement year.
	• Exclude children who had a contraindication for a specific vaccine from the denominator for all antigen rates and the combination rates.
	• Any of the following on or before the child's second birthday meet optional exclusion criteria:
	  ○ 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.
	  ▪ Lymphoreticular cancer, multiple myeloma, or leukemia.
	  ▪ Anaphylactic reaction to neomycin.
	  ○ Rotavirus.
	  ▪ Severe combined immunodeficiency.
	  ▪ History of intussusception.
	  ○ IPV.
	  ▪ Anaphylactic reaction to streptomycin, polymyxin B, or neomycin.
	  ○ Hepatitis B.
	  ▪ Anaphylactic reaction to common baker's yeast.

Theon document attachment	• Member's name.
	• 2nd identifier (e.g., DOB).
	• For immunization evidence obtained from the medical record, count members where there is evidence that the antigen was rendered from one of the following:
	  ○ A note indicating the name of the specific antigen and the date of the immunization.
	  ○ A certificate of immunization prepared by an authorized health care provider or agency including the specific dates and types of immunizations administered.
	  ○ For documented history of illness or a seropositive test result, there must be a note indicating the date of the event, which must have occurred by the member's second birthday.
	  ○ Notes in the medical record indicating that the member received the immunization "at delivery" or "in the hospital" may be counted toward the numerator only for immunizations that do not have minimum age restrictions (e.g., before 42 days after birth). A note that the "member is up to date" with all immunizations but which does not list the dates of all immunizations and the names of the immunization agents does not constitute sufficient evidence of immunization for HEDIS reporting.
	  ○ For rotavirus, if documentation does not indicate whether the two-dose schedule or three-dose schedule was used, assume a three-dose schedule and find evidence that three doses were administered.
	  ○ If there is a recent name change for the member and or the name in Theon does not match, a third identifier, such as the member's address, subscriber ID, or last 4 digits of Social Security Number is required.

May be closed by diagnosis and procedure codes on a claim or upload of documentation via Theon platform	
Procedure codes	**DTaP:** 90697, 90698, 90700, 90723. **HepA:** 90633. **HepB:** 90697, 90723, 90740, 90744, 90747, 90748, G0010. **HiB:** 90644, 90647, 90648, 90697, 90698, 90748. **Influenza:** 90655, 90657, 90661, 90673, 90685, 90686, 90687, 90688, 90689, G0008. **Influenza LAIV Vaccine:** 90660, 90672. **IPV:** 90697, 90698, 90713, 90723. **MMR:** 90707, 90710. • (Deleted individual Measles, Mumps, and Rubella codes). **PCV:** 90670, 90671, G0009. **RV:** 90680, 90681. **VZV:** 90710, 90716.
ICD10	**Newborn HepB vaccine:** 3E0234Z introduction of serum, toxoid, and vaccine into muscle, percutaneous approach). **Exclusions:** **HepA:** B15.0, B15.9. **HepB:** B16.0, B16.1, B16.2, B16.9, B17.0, B18.0, B18.1, B19.10, B19.11. **MMR:** B26.0, B26.1, B26.3, B26.81-B26.85, B26.89, B26.9. **Measles:** B05.0, B05.1, B05.2, B05.3, B05.4, B05.81, B05.89, B05.9.

	Rubella: B06.00, B06.01, B06.02, B06.09, B06.81, B06.82, B06.89, B06.9. **Mumps:** B26.0, B26.1, B26.2, B26.3, B26.81, B28.82, B28.83, B26.84, B26.85, B26.89, B26. **VZV:** 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-B02.34, B02.39, B02.7, B02.8, B02.9. • **Diagnosis codes applying to all vaccines:** o Anaphylactic Reaction Due to Vaccination: T80.52XA, T80.52XD, T80.52XS. • **Diagnosis code applying to DTaP: G04.32.** o Must be billed WITH: E948.4, E948.5, E948.6, T50.A15A, T50.A15D, T50.A15S. • **Diagnosis code applying to Flu/MMR/VZV:** Diagnoses signaling immunodeficiency, HIV, lymphoreticular cancer, multiple myeloma or leukemia, or anaphylactic reaction to neomycin. • **Diagnosis code applying to IPV:** Diagnoses signaling anaphylactic reaction to neomycin, streptomycin, or polymyxin B. • **Diagnosis code applying to RV:** D81.0–D81.2, D81.9. **Disorders of the immune system:** D81.0–D81.2, D81.4, D81.6, D81.7, D81.89, D81.9, D82.0-D82.4, D82.8, D82.9 D83.0-83.9, D84.0, D84.1, D84.81, D84.821, D84.822, D84.89, D84.9, D89.3, D89.810, D89.810, D89.811, D89.812, D89.813, D89.82, D89.831, D89.832, D89.833, D89.834, D89.835, D89.89, D89.9. **Encephalopathy due to vaccine:** G04.32, 323.51. **Intussusception:** K56.1.

Common Childhood and Adolescent Vaccination Generic and Brand Names	
Antigen Generic Name	**Product Brand Names**
DTaP diphtheria and tetanus toxoids and acellular pertussis vaccine	Daptacel® Infanrix®
DTaP-Hib diphtheria and tetanus toxoids and acellular pertussis and *Haemophilus influenzae* type b vaccine	ActHIB Hiberix PedvaxHIB
Hepatitis A vaccine	Havrix Vaqta
Hepatitis B vaccine	Engerix-B® Recombivax HB®
Human papillomavirus vaccine	Gardasil 9®
Tetanus Toxoid, Reduced Diphtheria Toxoid and Acellular Pertussis Vaccine Adsorbed (Tdap)	Adacel Boostrix
Influenza Vaccine	Afluria Quadrivalent Fluarix Quadrivalent Flucelvax Quadrivalent FluLaval Quadrivalent Fluzone Quadrivalent
Influenza Vaccine, Intranasal (nasal spray)	FluMist Quadrivalent
Measles, Mumps, and Rubella Vaccine	M-M-R II

Antigen Generic Name	Product Brand Names
Meningococcal Vaccine	Bexsero Menactra Menveo Trumenba
Pneumococcal 13-valent Conjugate Vaccine	Prevnar 13
Poliovirus Vaccine	Ipol
Rotavirus Vaccine	Rotarix RotaTeq
Varicella Virus Vaccine	Varivax

Common Childhood and Adolescent Vaccination Combinations Generic and Brand Names	
Antigen Generic Name	**Product Brand Names**
diphtheria, tetanus, pertussis, and polio in children 4 through 6 years of age (prior to 7th birthday).	Kinrix
diphtheria, tetanus, pertussis, hepatitis B and polio in children 6 weeks of age through 6 years of age	Pediarix
diphtheria, tetanus, pertussis, polio, and invasive Hib disease in children 6 weeks through 4 years of age	Pentacel
measles, mumps, rubella (German measles), and varicella (chicken pox) in children 12 months through 12 years of age.	ProQuad
diphtheria, tetanus, pertussis, and polio in children 4 through 6 years of age.	Quadracel
diphtheria, tetanus, pertussis, (whooping cough), hepatitis B, polio, and invasive disease caused by *Haemophilus influenzae* type b (Hib) in children 6 weeks through 4 years of age.	Vaxelis

IMMUNIZATIONS FOR ADOLESCENTS (IMA)*

LINE OF BUSINESS: Commercial	
This measure assesses the percentage of adolescents 13 years of age during the measurement year who received the following three vaccinations on or before their 13th birthday: one dose of meningococcal vaccine and one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series.	

Numerator compliant	• **For meningococcal, Tdap, and HPV** count only evidence of the antigen or combination vaccine.
	• **Meningococcal serogroups A, C, W, Y-** At least **one** meningococcal vaccine with a date of service on or between the member's 11th and 13th birthdays.
	  • For meningococcal, do not count meningococcal recombinant (serogroup B) (MenB) vaccines. Immunizations documented under a generic header of "meningococcal" and generic documentation that "meningococcal vaccine," "meningococcal conjugate vaccine," or "meningococcal polysaccharide vaccine" were administered meet criteria.
	• **Tdap -** At least **one** Tdap vaccine with a date of service on or between the member's 10th and 13th birthdays.
	• **HPV**
	  • At least **two** HPV vaccines with dates of service at least 146 days apart on or between the member's 9th and 13th birthdays.
	  • At least **three** HPV vaccines with different dates of service on or between the member's 9th and 13th birthdays.
	• Parental refusal is not a valid exclusion.

Exclusions	• Members who died during the measurement year. • Members in hospice or using hospice services anytime during the measurement year (required exclusion).

Theon document attachment	• Member's name. • 2nd identifier (e.g., DOB). • For immunization information obtained from the medical record, count members where there is evidence that the antigen was rendered from either of the following: o A note indicating the name of the specific antigen and the date of the immunization. o A certificate of immunization prepared by an authorized health care provider or agency, including the specific dates and types of immunizations administered. o For the two-dose HPV vaccination series, there must be at least 146 days between the first and second dose of the HPV vaccine. o o Immunizations documented using a generic header of "Tdap/Td" can be counted as evidence of Tdap. The burden on organizations to substantiate the Tdap antigen is excessive compared to a risk associated with data integrity. o If there is a recent name change for the member and or the name in Theon does not match, a third identifier, such as the member's address, subscriber ID, or last 4 digits of Social Security Number is required.
May be closed by diagnosis and procedure codes on a claim or upload of documentation via Theon Platform	
CPT codes	**Meningococcal:** 90619, 90733, 90734. **Tdap:** 90715. **HPV:** 90649, 90650, 90651.
Exclusions SNOMED CT	Anaphylaxis due to the meningococcal vaccine (SNOMED CT code 428301000124106) any time on or before the member's 13th birthday. Anaphylaxis due to the tetanus, diphtheria, or pertussis vaccine any time on or before the member's 13th birthday (SNOMED CT US 428281000124107, 428291000124105) Encephalitis due to the tetanus, diphtheria, or pertussis vaccine any time on or before the member's 13th birthday (SNOMED CT US 192711008, 192712001, 192710009). Anaphylaxis due to the HPV vaccine (SNOMED CT code 428241000124101) any time on or before the member's 13th birthday.

LEAD SCREENING IN CHILDREN (LSC)

LINE OF BUSINESS: CHIP	
ADMINISTRATIVE SPECIFICATIONS	
This measure evaluates the percentage of children two years of age who had one or more capillary or venous lead blood tests for lead poisoning on or before the child's second birthday.	
Numerator compliant	At least **one** lead capillary or venous blood test with the result or finding, on or before the child's second birthday.
Exclusions	• In hospice or using hospice services anytime during the measurement year. • Members who died during the measurement year. • Documentation of "no risk" is not a valid exclusion.
Theon document attachment	• Member's full name. • 2nd identifier (ex: DOB). • The date the test was performed and the result or finding. • If there is a recent name change for the member and or the name in Theon does not match, a third identifier, such as the member's address, subscriber ID, or last 4 digits of Social Security Number is required.
CPT	Lead test value: 83655
LOINC	10368-9, 10912-4, 14807-2, 17052-2, 25459-9, 27129-6, 32325-3, 5671-3, 77307-7

DIABETES

BLOOD PRESSURE CONTROL FOR PATIENTS WITH DIABETES (BPD)*

LINE OF BUSINESS: Commercial and Medicare	
This measure evaluates the percentage of members 18-75 years of age with type 1 or type 2 diabetes whose most recent BP was adequately controlled (<140/90 mm Hg) during the measurement year.	

Numerator compliant	• **Identify the most recent BP** reading noted during the measurement year.
	  • The member is numerator compliant if the BP is controlled per NCQA specifications (<140/90 mmHg).
	  • If multiple readings were recorded in a single date, use the lowest systolic and lowest diastolic BP on that date.
	  • The systolic and diastolic results do not need to be from the same reading.
	  • A blood pressure reading taken by a member with a digital device during a telehealth or telephone visit is acceptable and will count towards compliance.
	
	Digital device: a battery-operated cuff that is placed on your upper arm or wrist, the device is inflated, the pressure will slowly drop on its own. The screen will show a digital readout of your systolic and diastolic BP. After showing your BP, the cuff will deflate on its own.

Numerator noncompliant	Do not include the following BP readings: • Emergency Department visits. • Acute inpatient stays. • Taken same day as a diagnostic or therapeutic procedure that requires a change in diet or medication on or one day before the BP reading with exceptions of fasting blood tests. • Taken by the member using a nondigital device such as with a manual BP cuff and a stethoscope. • If an additional value is received within the measurement year that is considered noncompliant, it may reopen a previously closed gap.

Exclusions	• Members without a diagnosis of diabetes **AND** who had a diagnosis during the measurement year or the prior year of: • polycystic ovarian syndrome. • gestational diabetes, **OR** • steroid induced diabetes. • Members who died during the measurement year. • Evidence of end-stage renal disease, dialysis, nephrectomy, or kidney transplant. • A diagnosis of pregnancy. • Members 66 years of age and older living in long-term institution settings, advanced illness, and/or frailty are excluded from this measure. • In hospice or using hospice services anytime during the measurement year. • Receiving palliative care during the measurement year.
Theon document attachment	• Member's name. • 2nd identifier (ex: DOB). • DOS. • Systolic value and diastolic value. • If there is a recent name change for the member and or the name in Theon does not match, a third identifier, such as the member's address, subscriber ID, or last 4 digits of Social Security Number is required.
May be closed by CPT II codes, medical record documentation viaTheon, or CDI feed.	
Procedure codes	• OUTPT w/o UBREV: 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99429, 99455, 99456, 99483. • HCPCS: G0402, G0438, G0439, G0463, T1015. • TELEPHONE: 98966, 98967, 98968, 99441, 99442, 99443. • Online assessment: 98969-98972, 994212, 99422, 99423, 99444, 99457, G0071, G2010, G2012, G2061, G2062, G2063, G2250, G2251, G2252. • Nonacute inpatient: 99304-99310, 99315, 99316, 99318, 99324-99328, 99334-99337.
CPT II	• SYSTOLIC: 3074F, 3075F, 3077F. • DIASTOLIC: 3078F, 3079F, 3080F.
LOINC	• Systolic: 75997-7, 8459-0, 8460-8, 8461-6, 8480-6, 8508-4, 8546-4, 8547-2, 89268-7. • Diastolic: 75995-1, 8453-3, 8454-1, 8455-8, 8462-4, 8496-2, 8514-2, 8515-9, 89267-9.

HEMOGLOBIN A1C CONTROL FOR PATIENTS WITH DIABETES (HBD)*

LINE OF BUSINESS: Commercial and Medicare	
This measure evaluates the percentage of members 18–75 years with diabetes (types 1 and 2) whose hemoglobin A1c (HbA1c) level during the measurement year was: • **Controlled at less than 8% (<8.0%).** • **Poorly controlled at greater than 9% (>9.0%).**	
Numerator compliant	• Identify the most recent HbA1c test and result.
Numerator noncompliant	• If an additional value is received within the measurement year that is considered noncompliant, it may reopen a previously closed gap. • Ranges and thresholds do not meet criteria for this indicator.

Exclusions	• Members without a diagnosis of diabetes **AND** who had a diagnosis during the measurement year or the prior year of:
	  • polycystic ovarian syndrome.
	  • gestational diabetes, **OR**
	  • steroid induced diabetes.
	• Members who died during the measurement year.
	• Evidence of end-stage renal disease, dialysis, nephrectomy, or kidney transplant.
	• A diagnosis of pregnancy.
	• Members 66 years of age and older living in long-term institution settings, advanced illness, and/or frailty are excluded from this measure.
	• In hospice or using hospice services anytime during the measurement year.
	• Receiving palliative care during the measurement year.

Theon document attachment	• Member's name. • 2nd identifier (e.g., DOB). • Date of HbA1c test. • Test value. • If there is a recent name change for the member and or the name in Theon does not match, a third identifier, such as the member's address, subscriber ID, or last 4 digits of Social Security Number is required.
May be closed by CPT II codes, medical record documentation viaTheon, or CDI feed.	
Procedure codes	HBA1C LAB TEST: 83036, 83037
CPT II	3044F, 3051F, 3046F, 3052F
LOINC	17855-8, 17856-6, 4548-4, 4549-2, 96595-4

EYE EXAM FOR PATIENTS WITH DIABETES (EED)

LINE OF BUSINESS: Commercial and Medicare	
This measure evaluates the percentage of members 18–75 years of age with diabetes (type 1 or type 2) who have had screening or monitoring for diabetic retinal disease.	
Numerator compliant	Screening or monitoring by an optometrist or ophthalmologist for diabetic retinal disease by one of the following: • A retinal or dilated eye exam in the measurement year – any result. • A negative retinal or dilated exam (negative for retinopathy)in the year prior to the measurement year. OR Bilateral eye enucleation any time during the member's history through December 31 of the measurement year. **NOTE:** Documentation does not have to state specifically "no diabetic retinopathy" to be considered negative for retinopathy; however, it must be clear that the patient had a dilated or retinal eye exam by an eye care professional (optometrist or ophthalmologist) and that retinopathy was not present. Notation limited to a statement that indicates "diabetes without complications" does not meet criteria. Hypertensive retinopathy is not handled differently from diabetic retinopathy when reporting this measure; for example, an eye exam documented as positive for hypertensive retinopathy is counted as positive for diabetic retinopathy, and an eye exam documented as negative for hypertensive retinopathy is counted as negative for diabetic retinopathy. The intent of this measure is to ensure that members with evidence of any type of retinopathy have an eye exam annually, while members who remain free of retinopathy (i.e., the retinal exam was negative for retinopathy) are screened every other year.
Numerator noncompliant	• An eye exam missing a signature by an optometrist or ophthalmologist.

Exclusions	• Members without a diagnosis of diabetes **AND** who had a diagnosis during the measurement year or the prior year of:
	  • polycystic ovarian syndrome.
	  • gestational diabetes, **OR**
	  • steroid induced diabetes.
	• Members 66 years of age and older living in long-term institutional settings, advanced illness, and/or frailty are excluded from this measure.
	• In hospice or using hospice services anytime during the measurement year.
	• Receiving palliative care during the measurement year.
	• Members who died during the measurement year.
	NOTE: Blindness is not an exclusion for a diabetic eye exam because it is difficult to distinguish between individuals who are legally blind but require a retinal exam and those who are completely blind and therefore do not require an exam.

Theon document attachment	• Member's name. • 2nd identifier (ex: DOB). • DOS. • Numerator compliant documentation as defined above • If there is a recent name change for the member and or the name in Theon does not match, a third identifier, such as the member's address, subscriber ID, or last 4 digits of Social Security Number is required.
May be closed by diagnosis and procedure CPTII codes on a claim or upload of documentation via Theon platform	
Procedure codes	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, 92227, 92228, 92229, 92230, 92235, 92240, 92250, 92260, 99203–99205, 99213, 99214, 99215, 99242–99245, 92201, 92202, S0620, S0621, S3000. **Unilateral eye enucleation:** CPT: 65091, 65093, 65101, 65103, 65105, 65110, 65112, 65114 ICD10PCS: 08TIXZZ(right eye), 08T0ZZ(left eye) • Must be billed with bilateral modifier '50' unless there are codes with service dates 14 days or more apart billed. • Must be billed with a code from the opposite eye on the same or different dates of service. Codes require screening be done by an eye care professional—optometrist or ophthalmologist.
CPT II	**Eye exam with evidence of retinopathy**: 2022F, 2024F, 2026F (specifies exam was done by an eye care professional). **Eye exam without evidence of retinopathy:** 2023F, 2025F, 2033F. **Diabetic retinal screening negative result in prior year:** 3072F (specifies exam was negative).

KIDNEY HEALTH EXAM FOR PATIENTS WITH DIABETES (KED)

LINE OF BUSINESS: Commercial and Medicare	
This measure evaluates the percentage of members age 18–85 years old with type 1 or type 2 diabetes who received a kidney health evaluation, including both an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR), during the measurement year.	
Numerator compliant	Members must receive both an eGFR **AND** a uACR (with both quantitative urine albumin and urine creatinine) during the measurement year on the same or different dates of service.

Exclusions	• Members without a diagnosis of diabetes **AND** who had a diagnosis during the measurement year or the prior year of:
	  ◦ polycystic ovarian syndrome.
	  ◦ gestational diabetes, **OR**
	  ◦ steroid induced diabetes.
	• Members with evidence of ESRD or Dialysis any time during the members history on or prior to December 31 of the measurement year.
	• Members receiving palliative care during the measurement year.
	  ◦ Members 66 - 80 years of age and older as of December 31 of the measurement year.
	  ◦ Enrolled in an SNP(I-SNP) during the measurement year.
	  ◦ Living long-term in an institution any time during the measurement year.
	  ◦ Members dispenses a Dementia medication.
	• Members 66 – 80 years of age and older as of December 31 of the measurement year with frailty and advanced illness.
	• Members 81 years of age and older as of December 31 of the measurement year with frailty during the measurement year.
	• In hospice or using hospice services anytime during the measurement year.
	• Receiving palliative care during the measurement year.

Theon document attachment	• Member's name. • 2nd identifier (ex: DOB). • DOS. • At least 1 eGFR. • At least 1 uACR with both quantitative urine albumin and a urine creatinine. If there is a recent name change for the member and or the name in Theon does not match, a third identifier, such as the member's address, subscriber ID, or last 4 digits of Social Security Number is required.
Dementia medications	• Donepezil. • Galantamine. • Rivastigmine.

	• Memantine. • Donepezil-memantine.
eGFR	CPT: 80047, 88048, 80050, 80053, 80069, 82565 LOINC: 69405-9, 98980-6, 94677-2, 98979-8, 62238-1, 77147-7, 50384-7, 50210-4, 50044-7, 70969-1
uACR CPT	Quantitative Urine Albumin Lab Test – CPT: 82043 LOINC: 21059-1, 1754-1, 57369-1, 30003-8, 53530-2, 43605-5, 14957-5, 53531-0, 89999-7, 100158-5 Urine Creatinine Lab Test: CPT: 82570 LOINC: 57346-9, 57344-4, 20624-3, 2161-8, 58951-5, 39982-4, 35674-1 Urine Albumin Creatinine Ratio Lab Test: LOINC: 13705-9, 9318-7, 76401-9, 32294-1, 44292-1, 14958-3, 14959-1, 59159-4, 77254-1, 30000-4, 77253-3, 89998-9

MUSCULOSKELETAL CONDITIONS

OSTEOPOROSIS MANAGEMENT IN WOMEN WHO HAD A FRACTURE (OMW)

<table>
<tr><th colspan="2">LINE OF BUSINESS: Medicare</th></tr>
<tr><td colspan="2">This measure evaluates the percentage of women between 67–85 who suffered a fracture and had evidence of either a bone mineral density test or a prescription for a drug to treat osteoporosis in the six months after the fracture.
Diagnoses that will place the member in the denominator: fracture (multiple diagnoses qualify EXCEPT for fractures of the finger, toe, face, and skull).</td></tr>
<tr><td>Numerator compliant</td><td>Appropriate testing or treatment for osteoporosis within 6 months after the fracture defined by any of the following criteria:
A bone mineral density (BMD) test in any setting.
Osteoporosis medication therapy in any setting.
A dispensed prescription to treat osteoporosis.
✶ For supplemental data purposes, therapy and prescription to treat osteoporosis must be shown as an injection in the record. Oral medications do not count for supplemental data purposes as they require proof of fulfilment via a pharmacy claim to close the gap.</td></tr>
<tr><td>Exclusions</td><td>A BMD in any setting during the 24 months prior to the date of the fracture.
Members 12 months prior to the fracture who:
Had claims or encounters for Osteoporosis therapy, OR
Were dispensed prescription medication or had an active therapy to treat Osteoporosis.
Members 66 years of age and older living in long-term in institutional settings.
Advanced illness, and/or frailty are excluded from this measure.
In hospice or using hospice services anytime during the measurement year.
Receiving palliative care during the measurement year.
Members who died during the measurement year.</td></tr>
<tr><td>Theon document attachment</td><td>Member’s name.
2nd identifier (e.g., DOB).
Bone Mineral Density (BMD) test.
Osteoporosis therapy.
Dispensed osteoporosis medications.
If there is a recent name change for the member and or the name in Theon does not match, a third identifier, such as the member’s address, subscriber ID, or last 4 digits of Social Security Number is required.</td></tr>
<tr><td colspan="2">May be closed by procedure codes on a claim or upload of documentation via Theon platform</td></tr>
</table>

Procedure codes	76977, 77078, 77080, 77081, 77085, 77086
HCPCS long-acting med	J0897, J1740, J3489
HCPCS osteoporosis medication	J0897, J1740, J3110, J3111, J3489

OSTEOPOROSIS SCREENING IN OLDER WOMEN (OSW)

LINE OF BUSINESS: Medicare	
This measure evaluates the percentage of women 65–75 years of age who received osteoporosis screening during the measurement year.	
Numerator compliant	• One or more osteoporosis screening tests on or between the members 65th birthday and December 31 of the measurement year.
Theon document attachment	• Member's name. • 2nd identifier (e.g., DOB). • DOS. • Documentation of Osteoporosis screening. • If there is a recent name change for the member and or the name in Theon platform does not match, a third identifier, such as the member's address, subscriber ID, or last 4 digits of Social Security Number is required.
Exclusions	• A claim for osteoporosis therapy any time in the member's history through December 31 of the year prior to the measurement year. • A dispensed prescription to treat osteoporosis any time on or between January 1 three years prior to the measurement year through December 31 of the year prior to the measurement year. • Frailty and advanced illness. • A dispensed prescription to treat dementia. • Hospice or using hospice services anytime during the measurement year. • Died during the measurement year. • Palliative care any time during the measurement year.
Osteoporosis medication	HCPCS: J0897, J1740, J3110, J3111, J3489
Long-acting medication	HCPCS: J0897, J1740, J3489
Osteoporosis screening	CPT: 76977, 77078, 77080, 77081, 77085

OVERUSE/APPROPRIATENESS

USE OF IMAGING STUDIES FOR LOW BACK PAIN (LBP)*

LINE OF BUSINESS: Commercial and Medicare	
This measure evaluates the percentage of members 18–75 years of age with a primary diagnosis of low back pain who did NOT have an imaging study (plain X-ray, MRI, or CT scan) on or within the 28 days after the date of the low back pain diagnosis. **This is a deviation of care measure.**	
Numerator compliant	*The measure is used to determine whether imaging studies are overused to evaluate members with low back pain.* The measure is reported as an inverted rate. A higher score indicates appropriate treatment for low back pain (i.e., the proportion for whom imaging studies did NOT occur.*)*
Numerator noncompliant	Member's receiving imaging (plain X-ray, MRI, CT scan) for low back pain within 28 days of the diagnosis of low back pain
Exclusions	Supplemental data can be used only for required exclusions—see numerator complaint notes. **Exclude members who meet any of the following criteria:** • Cancer any time during the member's history through 28 days after the low back pain diagnosis. • Recent trauma any time during the 3 months (90 days) prior to the IESD through 28 days after the low back pain diagnosis. • Intravenous drug abuse. IV drug abuse any time during the 12 months (one year) prior to the IESD through 28 days after the low back pain diagnosis. • Neurologic impairment. Neurologic impairment any time during the 12 months (one year) prior to the low back pain diagnosis through 28 days after the low back pain diagnosis. • HIV any time during the member's history through 28 days after the low back pain diagnosis. • Spinal infection. Spinal infection any time during the 12 months (one year) prior to the low back pain diagnosis through 28 days after the diagnosis. • Major organ transplant any time in the member's history through 28 days after the low back pain diagnosis. • Prolonged use of corticosteroids. 90 consecutive days of corticosteroid treatment any time during the 366-day period that begins 365 days prior to the low back pain diagnosis and ends on the date of the low back pain diagnosis. • Osteoporosis therapy or a dispensed prescription to treat osteoporosis any time during the member's history through 28 days after the low back pain diagnosis. • Fragility fractures any time during the 3 months (90 days) prior to the low back pain diagnosis through 28 days after the diagnosis. • Lumbar surgery any time during the member's history through 28 days after the low back pain diagnosis. • Spondylopathy any time during the member's history through 28 days after the low back pain diagnosis. • Receiving palliative care during the measurement year.

	• In hospice or using hospice services anytime during the measurement year. • Members who died during the measurement year.
Theon document attachment	• Member's name • 2nd identifier (ex: DOB). • Only exclusions can be submitted for this measure via supplemental data (Please see Numerator compliant). • If there is a recent name change for the member and or the name in Theon does not match, a third identifier, such as the member's address, subscriber ID, or last 4 digits of Social Security Number is required.
Procedure codes	Imaging study value set: 72020, 72040, 72050, 72052, 72070, 72072, 72074, 72080, 72081-72084, 72100, 72110, 72114, 72120, 72125-72133, 72141, 72142, 72146, 72147, 72148, 72149, 72156-72158, 72200, 72202, 72220.

Corticosteroid Medications

Description	Prescription	
Corticosteroid	• Hydrocortisone • Cortisone • Prednisone • Prednisolone	• Methylprednisolone • Triamcinolone • Dexamethasone • Betamethasone/Betamethasone acetate

Osteoporosis Medications

Description	Prescription	
Bisphosphonates	• Alendronate • Alendronate-cholecalciferol • Ibandronate	• Risedronate • Zoledronic acid
Other agents	• Abaloparatide • Denosumab • Raloxifene	• Romosozumab • Teriparatide

ICD 10	Uncomplicated low back pain: M47.26, M47.27, M47.28, M47.816, M47.817, M47.818, M47.896, M47.897, M47.897, M47.898, M48.06, M48.061, M48.062, M48.07, M48.08, M51.16, M51.17, M51.26, M51.27, M51.36, M51.37, M51.86, M51.87, M53.2X6, M53.2X7, M53.2X8, M53.3, M53.86, M53.87, M53.88, M54.16, M54.17, M54.18, M54.30, M54.31, M54.32, M54.40, M54.41, M54.42, M54.5, M54.50, M54.51, M54.59, M54.89, M54.9, M99.03, M99.04, M99.23, M99.33, M99.43, M99.53, M99.63, M99.73, M99.83, M99.84, S33.100A, S33.100D, S33.100S, S33.100A, S33.110D, S33.110S, S33.110A, S33.110A, S33.110D, S33.110S, S33.120A, S33.120D, S33.120S, S33.130A, S33.130D, S33.130S, 33.140A, S33.140D, S33.140S, S33.5XXA, S33.6XXA, S33.8XXA, S33.9XXA, S39.002A, S39.002A, S39.002D, S39.002S, S39.012A, S39.012A, S39.012D, S39.012S, S39.092A, S39.092D, S39.092S, S39.82XA, S39.82XD, S39.82XS, S39.92XA, S39.92XD, S39.92XS
Exclusion codes	Members can be excluded by claim with the following diagnoses (multiple diagnosis codes qualify for each). Spinal Infections: A17.81, G06.1, M46.25-M46.28, M46.35-M46.38, M46.46-M46.48. Neurologic Impairment: G83.4. IV Drug Abuse: (30)F11 codes, (38)F13 codes, (32)F14 codes, (32) F15 codes. HIV Value Set ICD10CM: B20, Z21. Recent trauma; Cancer—Malignant Neoplasm, other Neoplasm, history of Malignant Neoplasm, other Malignicies. Neoplasm; organ transplant other than kidney, kidney transplant, history of kidney transplant. Prolonged use of Corticosteroids. Osteoporosis. Fragility fracture. Lumbar surgery. Spondylopathy. Palliative care.

CARE COORDINATION

TRANSITIONS OF CARE-NOTIFICATION OF INPATIENT ADMISSION (TRC)

LINE OF BUSINESS: Medicare	
This measure evaluates the percentage of members that have documentation of receipt of inpatient admission on the day of admission or on the day of admission through 2 days after the admission (3 total days). **Note: Administrative reporting is not available for this indicator.**	
Numerator compliant	Documentation in the outpatient medical record must include the following evidence: • Receipt of notification of inpatient admission, AND • The date when the documentation was received. Examples of documentation communications that meet criteria: • Phone call, email, fax between inpatient providers or staff and the member's PCP. • Communication about admission between emergency department and the member's PCP or ongoing care provider (e.g., phone call, email, fax). • Communication about admission to the member's PCP or ongoing care provider through a health information exchange; an automated admission, or discharge and transfer (ADT) alert system. • Communication about admission with the member's PCP or ongoing care provider through a shared electronic medical record (EMR) system. • Communication about admission to the member's PCP or ongoing care provider from the member's health plan. • Indication that the member's PCP or ongoing care provider admitted the member to the hospital. • Indication that a specialist admitted the member to the hospital and notified the member's PCP or ongoing care provider. • Indication that the PCP or ongoing care provider placed orders for tests and treatments any time during the member's inpatient stay. • Documentation that the PCP or ongoing care provider performed a preadmission exam or received communication about a planned inpatient admission. The planned admission documentation or preadmission exam must clearly pertain to the denominator event.
Theon document attachment	○ Member's name. ○ 2nd identifier (e.g., date of birth). ○ Date of Service (DOS). ○ See numerator compliant section for documentation requirements. If there is a recent name change for the member and or the name in Theon does not match, a third identifier, such as the member's address, subscriber ID, or last 4 digits of Social Security Number is required.
Exclusions	• In hospice or using hospice services anytime during the measurement year. • Receiving palliative care during the measurement year.

TRANSITIONS OF CARE-RECEIPT OF DISCHARGE INFORMATION (TRC)

LINE OF BUSINESS: Medicare	
This measure evaluates the percentage of members that have documentation of the receipt of discharge information on the day of discharge through 2 days after the discharge (3 total days). **Note: Administrative reporting is not available for this indicator.**	
Numerator compliant	Documentation in the outpatient medical record must include evidence of receipt of discharge information on the day of discharge through 2 days after the discharge (3 total days) **WITH** evidence of the date when the documentation was received. Discharge information may be included in, but not limited to, a discharge summary or be located in structured fields in an EHR. Discharge information must include all of the following***:*** • The practitioner responsible for the member's care during the inpatient stay. • Procedures or treatment provided. • Diagnoses at discharge. • Current medication list. • Testing results, or documentation of pending tests or no tests pending. • Instructions for patient care post-discharge.
Theon document attachment	• Member's name. • 2nd identifier (e.g., date of birth). • Date of Service (DOS) • See Numerator compliant section for documentation requirements.
Exclusions	• In hospice or using hospice services anytime during the measurement year. • Receiving palliative care during the measurement year.

TRANSITIONS OF CARE-PATIENT ENGAGEMENT AFTER INPATIENT DISCHARGE (TRC)

LINE OF BUSINESS: Medicare	
This measure evaluates the percentage of members that receive patient engagement (e.g., office visits, visits to the home, or telehealth) within 30 days after discharge.	
Numerator compliant	Patient engagement documented in the outpatient medical record provided within 30 days after discharge. Any of the following meets compliance: • An outpatient visit. • A telephone visit. • Transitional care management services. • An e-visit or virtual check-in.
Numerator noncompliant	• Members who had engagement on the date of discharge.
Theon document attachment	• Member's name. • 2nd identifier (e.g., date of birth). • Date of Service (DOS). • See Numerator compliant section for documentation requirements. If there is a recent name change for the member and or the name in Theon does not match, a third identifier, such as the member's address, subscriber ID, or last 4 digits of Social Security Number is required.
Excluded	• In hospice or using hospice services during the measurement year. • Members who died during the measurement year.
Procedure codes	Outpatient: CPT: 99201, 99202, 99203,99204,99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99429, 99455, 99456, 99483 HCPCS: G0402, G0438, G0439, G0463, T1015 Telephone: 98966, 98967, 98968, 99441, 99442, 99443 Transitional care management: 99495, 99496 Online assessment: CPT: 98969, 98970, 98971, 98972, 98980, 98981, 99421, 99422, 99423, 99444, 99457, 99458 HCPCS: G0071, G2010, G2012, G2061, G2062, G2063, G2250, G2251, G2252

TRANSITIONS OF CARE-MEDICATION RECONCILIATION POST-DISCHARGE (TRC)

LINE OF BUSINESS: Medicare	
This measure evaluates the percentage of discharges for members 18 years of age and older who had documentation of medication reconciliation on the date of discharge through 30 days after discharge (31 total days) between January 1 and December 1 of the measurement year.	
Numerator compliant	• Medication reconciliation conducted by a prescribing practitioner, clinical pharmacist, physician assistant, or registered nurse on the date of discharge through 30 days after discharge (31 total days). • Proof that medications upon discharge are reconciled with the most recent medication list in the outpatient medical record. • Documentation of the current medications with a notation 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. Evidence that the member was seen for post-discharge hospital follow-up requires documentation that indicates the provider was aware of the member's hospitalization or discharge. • 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
Theon document attachment	• Member's name. • 2nd identifier (e.g., DOB). • DOS. • See Numerator compliant section for documentation requirements. If there is a recent name change for the member and or the name in Theon platform does not match, a third identifier, such as the member's address, subscriber ID, or last 4 digits of Social Security Number is required.
Excluded	• In hospice or using hospice services anytime during the measurement year. • Receiving palliative care during the measurement year.
Medication reconciliation	CPT: 99483, 99495, 99496 CPTII: 1111F

FOLLOW-UP AFTER ED VISIT FOR PEOPLE WITH MULTIPLE HIGH-RISK CHRONIC CONDITIONS (FMC)

LINE OF BUSINESS: Medicare	
This measure evaluates the percentage of emergency department (ED) visits for members 18 years of age and older who have multiple high-risk chronic conditions who had a follow-up service within 7 days of the ED visit.	
Numerator compliant	**A follow-up service within 7 days after the ED visit (8 total days). This includes visits that occur on the date of the ED visit. The following visits meet criteria for the measure:** • An outpatient visit. • A telephone visit. • Transitional care management services. • Case management visits. • Complex Care Management Services. • An outpatient or telehealth behavioral health visit. • An intensive outpatient encounter or partial hospitalization. • A community mental health center visit. • Electroconvulsive therapy with any one of the following: Ambulatory Surgical Center POS, Community Mental Health POS, Outpatient POS, Partial Hospitalization POS. • A telehealth visit. • An observation visit. • A substance use disorder service. • An e-visit or virtual check-in. • A domiciliary or rest home visit.
Note	The following chronic conditions are eligible: • COPD and asthma. • Alzheimer's disease and related disorders. • Chronic kidney disease. • Depression. • Heart failure. • Acute myocardial infarction. • Atrial fibrillation. • Stroke and transient ischemic attack.
Theon document attachment	This measure is currently not available for supplemental data submission in Theon.

Exclusions	• ED visits that result in an inpatient stay. • ED visits followed by admission to an acute or nonacute inpatient care setting on the date of the ED visit or within seven days after the ED visit, regardless of principal diagnosis for the admission. • In hospice or using hospice services any time during the measurement year. • Members who died during the measurement year.
Codes	• OUTPT w/o UBREV: 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99429, 99455, 99456, 99483. • POS: 03, 05, 07, 09, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 22, 33, 49, 50, 71, 72. • HCPCS: G0402, G0438, G0439, G0463, T1015. • Telephone: 98966, 98967, 98968, 99441, 99442, 99443. • Online assessment: 98969-98972, 98980, 98981, 99421, 99422, 99423, 99444, 99457, 99458, G0071, G2010, G2012, G2061, G2062, G2063, G2250-G2252. • Transitional care management: CPT 99495, 99496. • Ambulatory surgical center POS: 24. • BH outpatient: CPT: 98960, 98961, 98962, 99078, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99483, 99492, 99493, 99494, 99510. HCPCS—G0155, G0176, G0177, G0409, G0463, G0512, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, T1015. • Care management: CPT: 99366. HCPCS: T1016, T1017, T2022, T2023. • Community health center POS: 53. • Complex care management services: CPT—99439, 99487, 99489, 99490, 99491, 99495, 99496. HCPCS: G0506. • Electroconvulsive therapy: CPT: 90870. ICD10PCS: GZB0ZZZ, GBZ1ZZZ, GZB2ZZZ, GZB3ZZZ, GBZ4ZZZ. • Observation: CPT: 99217, 99218, 99219, 99220. • Partial hospitalization or intensive outpatient: HCPCS: G0410, G0411, H0035, H2001, H2012, S0201, S9480, S9484, S9485. • Partial hospitalization POS: 52.

	• Substance use disorder services: CPT: 99408, 99409. HCPCS: G0396, G0397, G0443, H0001, H0005, H0007, H0015, H0016, H0022, H0047, H0050, H2035, H2036, T1006, T1012. • Telehealth POS: 02,10. • Visit setting unspecified: CPT: 90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99251, 99252, 99253, 99254, 99255 • A domiciliary or rest home visit – 99324-99328, 99334-99337

RESPIRATORY CONDITIONS

APPROPRIATE TESTING FOR PHARYNGITIS (CWP)

LINE OF BUSINESS: Commercial and Medicare	
This measure evaluates the percentage of episodes for members 3 years and older where the member was diagnosed with pharyngitis, dispensed an antibiotic, and received a group A streptococcus (strep) test. • **Intake period: 7/1 prior year (PY) through 6/30 of the measurement year (MY).**	
Numerator compliant	• Members who had a group A streptococcus test in the seven-day period from three days prior to the episode date through three days after the episode date. Visits include: o Outpatient visit. o Telephone visit. o Online assessment. o Observation visit. o ED visit.
Compliant antibiotic prescriptions	• Amoxicillin, Ampicillin, Amoxicillin-clavulanate. • Cefadroxil, Cephalexin, Cefazolin. • Trimethoprim. • Clindamycin. • Azithromycin, Clarithromycin, Erythromycin. • Penicillin G benzathine, Penicillin G potassium, Penicillin G sodium, Penicillin V potassium. • Ciprofloxacin, Levofloxacin, Moxifloxacin, Ofloxacin. • Cefaclor, Cefprozil, Cefuroxime. • Sulfamethoxazole-trimethoprim. • Doxycycline, Minocycline, Tetracycline. • Cefdinir, Cefixime, Cefpodoxime, Ceftriaxone.
Exclusions	• In hospice or using hospice services during measurement year. • Members who died during the measurement year.
Theon document attachment	• Member's name. • 2nd identifier (e.g., DOB). • DOS. • Strep test and result. • If there is a recent name change for the member and or the name in Theon • does not match, a third identifier, such as the member's address, subscriber ID, or last 4 digits of Social Security Number is required.
May be closed by diagnosis and procedure codes on a claim or upload of documentation via Theon	

Group A streptococcus (strep) test	87070, 87071, 87081, 87430, 87650, 87651, 87652, 87880
Pharyngitis	J02.0, J02.8, J02.9, J03.00, J03.01, J03.80, J03.81, J03.90, J03.91

USE OF SPIROMETRY TESTING IN THE ASSESSMENT AND DIAGNOSIS OF COPD (SPR)

LINE OF BUSINESS: Commercial and Medicare	
This measure evaluates the percentage of 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. • **Intake period: 7/1 prior year (PY) through 6/30 of the measurement year (MY).**	
Numerator compliant	• Spirometry testing: at least one claim/encounter for spirometry during the two years prior or six months after the COPD diagnosis date as listed in Theon. • Utilize the spirometry start and end date as specified in Theon
Exclusions	○ In hospice or using hospice services during the measurement year. ○ Members who died during the measurement year.
Theon document attachment	• Member's name. • 2nd identifier (e.g., DOB). • DOS. • Spirometry result. • If there is a recent name change for the member and or the name in Theon does not match, a third identifier, such as the member's address, subscriber ID, or last 4 digits of Social Security Number is required.
May be closed by diagnosis and procedure codes on a claim or upload of documentation via Theon Platform	
COPD	J44.0, J44.1, J44.9 ICD9CM: 493.20, 493.21, 493.22, 496
Emphysema	J43.0, J43.1, J43.2, J43.8, J43.9 ICD9CM: 492.0, 492.8
Chronic bronchitis	J41.0, J41.1, J41.8, J42 ICD9CM: 491.0,491.1, 491.20, 491.21, 491.22, 491.8, 491.9
Spirometry	94010, 94014, 94015, 94016, 94060, 94070, 94375.

BlueHPN

The following measures are monitored and tracked in Capital's BlueHPN service areas at the aggregate level.

BlueHPN Quality	
Domain	**Measure**
Appropriateness	Asthma medication ratio
	Use of imaging for low back pain
	Avoidance of antibiotic Tx for acute bronchitis/bronchiolitis
	Emergency department utilization
Best practice adherence	Elective delivery (CMS)
	Engagement and initiation of alcohol/drug/dependence TX
	Controlling high blood pressure
	Statin therapy for patients with diabetes – adherence 80%
Health management	Breast cancer screening
	Statin therapy for patients with cardiovascular disease
	Colorectal cancer screening
	Immunizations for adolescents
Outcomes	Hospital-wide all-cause unplanned readmission (CMS)
	Methicillin-resistant staphylococcus aureus (CMS)
	Comprehensive diabetes care – blood pressure control
	Comprehensive diabetes care – HbA1c control (<8%)