Thank you for your participation in BlueCare Quality Improvement. With your help, we can improve the care and health outcomes for our members.

This guide includes standard HEDIS® measures and custom Division of TennCare℠ measures. By using the information and tips included, you’ll be able to maximize your performance for each quality measure.

If you need additional assistance, please reach out to BlueCare Clinical Improvement or Provider Service.

Thank you for all you do to care for our members each day.

Sincerely,
Jeanne James, MD, FAAP

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Phone: 1-888-433-8221

**BlueCare℠ Provider Service**
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Phone: 1-800-276-1978

The Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of NCQA.
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## Healthcare Effectiveness Data and Information Set (HEDIS)

Developed by the National Committee for Quality Assurance (NCQA), HEDIS® is the most widely used set of performance measures in the managed care industry. It contains measures that show health plans those areas where a stronger focus could lead to improvements in member health. HEDIS reporting is mandated by NCQA for compliance and accreditation. HEDIS codes can change from year to year. The codes in this document are from the HEDIS 2019 specifications.

### Measure | What Service Is Needed | What to Report (Sample of Codes and/or Diagnoses) | Exclusions
--- | --- | --- | ---
**Well-Child Visits in the First Fifteen Months of Life (W15)**

Percentage of members who turned 15 months old during the measurement year and who had six or more well-child visits with a primary care provider during their first 15 months of life

All well-care documentation must include a dated visit note with PCP provider type that includes:

- Comprehensive health and developmental history, including both physical and mental health development assessments
- Physical exam
- Age-appropriate immunizations
- Vision and hearing tests
- Age-appropriate dental exam/referral
- Laboratory tests, including blood lead-level assessments at certain ages
- Health education, including anticipatory guidance

Please document and code age-appropriate preventive care or general medical exam for full administrative compliance.

**CPT:** 99381, 99382, 99383, 99384, 99391, 99392, 99393, 99394, 99395, 99461

**HCPCS:** G0438, G0439 and/or

**ICD-10 Clinical Modification (CM):** Z00.00, Z00.01, Z00.10, Z00.11, Z00.12, Z00.129, Z00.5, Z00.8, Z02.0, Z02.1, Z02.2, Z02.3, Z02.4, Z02.5, Z02.6, Z02.7, Z02.79, Z02.81, Z02.82, Z02.83, Z02.89, Z02.9, Z76.1, Z76.2

**Well-Child Visits in the 18th, 24th and 30th months (TennCare Custom Measure)**

The percentage of members who turned 35 months old during the measurement timeframe who had at least one well-child visit within each of the following intervals:

- Two weeks before 18 months up to two weeks before 24 months
- Two weeks before 24 months up to two weeks before 30 months
- Two weeks before 30 months up to 35 months
- Total: at least one visit during each of the three intervals above

Common Documentation Errors to Avoid:

- Visits for acute or chronic conditions will not meet the measure intent but can be rendered during the same visit if you code for well-care during a problem-oriented visit by using a modifier 25 for the well-care visit.
- No documented health education or anticipatory guidance
- Documentation of well developed, well nourished will not meet the intent of the measure. It must be more specific.

**Helpful Tips:**

- Use your member roster to contact members who are due for an exam or are new to your practice, and use your EMR to help flag and track needed well-care visits.
- Schedule the next visit at the end of the appointment.
- Consider extending your office hours into the evening, early morning or weekend to provide more availability for appointments.
- Remember to include all applicable ICD-10 codes to help reduce the burden of HEDIS medical record review.

*HEDIS general guidelines specify that members in hospice are excluded from all HEDIS measures.
<table>
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</table>
| **Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life (W34)** | All well-care documentation must include a dated visit note with PCP provider type that includes:  
- Comprehensive health and developmental history, including both physical and mental health development assessments  
- Physical exam  
- Age-appropriate immunizations  
- Vision and hearing tests  
- Age-appropriate dental exam/referral  
- Laboratory tests, including blood lead-level assessments at certain ages  
- Health education, including anticipatory guidance | Please document and code age-appropriate preventive care or general medical exam for full administrative compliance.  
**CPT:** 99381, 99382, 99383, 99384, 99385, 99391, 99392, 99393, 99394, 99395, 99461  
**HCPCS:** G0438, G0439  
and/or  
**ICD-10 Clinical Modification (CM):** Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.5, Z00.8, Z02.0, Z02.1, Z02.2, Z02.3, Z02.4, Z02.5, Z02.6, Z02.71, Z02.79, Z02.81, Z02.82, Z02.83, Z02.89, Z02.9, Z76.1, Z76.2 | |
| **Well-Child Visits Ages 7-11 Years (TennCare Custom Measure)**        |                                                                                       |                                                  |            |
| The percentage of members ages 7-11 who had one or more well-care visits with a PCP during the measurement year |                                                                                       |                                                  |            |
| **Well-Child 12-21 Years (AWC)**                                       |                                                                                       |                                                  |            |
| The percentage of members ages 12-21 who had one or more well-care visits with a PCP during the measurement year |                                                                                       |                                                  |            |

**Helpful Tips:**
- Use your member roster to contact members who are due for an exam or are new to your practice, and use your EMR to help flag and track needed well-care visits.
- Schedule the next visit at the end of the appointment.
- Consider extending your office hours into the evening, early morning or weekend to provide more availability for appointments.
- Remember to include all applicable ICD-10 codes to help reduce the burden of HEDIS medical record review.
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<tr>
<td><strong>Childhood Immunization Status (CIS) Combo 10</strong>&lt;br&gt;The percentage of children immunized on or before their second birthday</td>
<td><strong>Immunization Description:</strong>&lt;br&gt;• 4 Diphtheria, tetanus and pertussis (DTaP)<em>&lt;br&gt;• 3 Polio (IPV)</em>&lt;br&gt;• 1 Measles, mumps and rubella (MMR)<em>&lt;br&gt;• 3 H influenza type B (HiB)</em>&lt;br&gt;• 3 Hepatitis B (HepB)<em>&lt;br&gt;• 1 Chicken pox (V2V)</em>&lt;br&gt;• 4 Pneumococcal (PCV)*&lt;br&gt;• 2 or 3 Rotavirus (RV) (required dosage)&lt;br&gt;• 2 Influenza (flu)&lt;br&gt;• 1 Hepatitis A (HepA)&lt;br&gt;*Immunization refusal will not remove a member from the denominator of this measure&lt;br&gt;<strong>Documentation:</strong>&lt;br&gt;A note indicating the name of the specific antigen and the date of the immunization, or a certificate of immunization including the name and date, prepared by an authorized health care provider or agency&lt;br&gt;<strong>Common Documentation Errors to Avoid:</strong>&lt;br&gt;• Immunization after second birthday&lt;br&gt;• No record in primary care physician (PCP) file when immunized elsewhere&lt;br&gt;• No documentation of contraindication, allergy or immunization refusal&lt;br&gt;• No documentation that the first HepB immunization was given at birth/hospital</td>
<td><strong>For children before or on their second birthday:</strong>&lt;br&gt;DTaP CPT: 90698, 90700, 90721, 90723&lt;br&gt;IPV CPT: 90698, 90713, 90723&lt;br&gt;MMR CPT: 90707, 90710, 90708, 90705, 90704, 90706&lt;br&gt;HiB CPT: 90644, 90645, 90646, 90647, 90648, 90698, 90721, 90748&lt;br&gt;HepB CPT: 90723, 90740, 90744, 90747, 90478&lt;br&gt;HepB ICD-10: B16.0, B16.1, B16.2, B16.9, B17.0, B18.0, B18.1, B19.10, B19.11, Z22.51&lt;br&gt;HepB HCPCS: G0010&lt;br&gt;HepB Administered ICD-10 Procedure Coding System (ICD-10-PCS): E0234Z, 99.55 (ICD-9-PCS)&lt;br&gt;VZV CPT: 90710, 90716&lt;br&gt;PCV CPT: 90669, 90670&lt;br&gt;PCV HCPCS: G0009&lt;br&gt;HepA CPT: 90633&lt;br&gt;RV (2-dose schedule) CPT: 90681&lt;br&gt;RV (3-dose schedule) CPT: 90680&lt;br&gt;Influenza CPT: 90655, 90657, 90661, 90662, 90673, 90685, 90686, 90687, 90688&lt;br&gt;Influenza HCPCS: G0008</td>
<td>Exclude children who had a contraindication for a specific vaccine from the denominator for all antigen rates and the combination rates.</td>
</tr>
<tr>
<td>Measure</td>
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| Adolescent Immunizations (IMA) | **For adolescents before they turn age 13:**  
- 1 meningococcal vaccine between ages 11 through 13  
- 1 Tdap (or 1 Td) between ages 10 and 13  
- 2 HPV vaccines at least 146 days apart between ages 9 and 13  
- 3 HPV vaccines with different dates of service between ages 9 and 13 | **HPV vaccination code:** 90649, 90650, 90651  
**Meningococcal vaccination code:** 90734  
**Td vaccination code:** 90715 | Exclude children who had a contraindication for a specific vaccine from the denominator for all antigen rates and the combination rates. |

**Documentation:**  
A note indicating the name of the specific antigen and the date of the immunization, or a certificate of immunization including the name and date prepared by an authorized health care provider or agency  

**Common Documentation Errors to Avoid:**  
- Immunization outside of required timeline  
- No record in PCP file when immunized elsewhere  
- No documentation of immunization refusal  
  - Immunization refusal will not remove a member from the denominator of this measure

**Helpful Tips:**  
- Recommend the HPV vaccine the same way and same day as other vaccines.  
- Discuss the HPV vaccine from the standpoint of cancer prevention.  
- Start discussing HPV vaccination early, as some parents will need extra time to decide to move forward with it.
<table>
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</table>
| **Weight Assessment and Counseling for Nutrition (WCC)** | Percentage who had an outpatient visit during the measurement year with documented evidence of:  
- Height, weight and BMI percentile (ranking based on CDC BMI-for-age growth chart)  
- Counseling for nutrition  
- Counseling for physical activity | **BMI Percentile:**  
- Z68.51 – BMI <5th percentile for age  
- Z68.52 – BMI 5th percentile – <85th percentile  
- Z68.53 – BMI 85th percentile – <95th percentile  
- Z68.54 – BMI ≥ 95th percentile | Exclusionary evidence in the medical record must include a note indicating pregnancy. The diagnosis must have occurred during the measurement year. |

**Documentation:**  
**BMI Percentile**  
- Dated height, weight and BMI percentile during the measurement year from same data source  
**Counseling for Nutrition Dated in Measurement Year**  
- Discussion of current nutrition behavior (e.g., eating or diet habits)  
- Checklist indicating nutrition was addressed  
- Counseling or referral for nutrition education  
- Documented face-to-face delivery of nutrition educational materials  
- Anticipatory guidance for nutrition  
- Weight or obesity counseling  
**Counseling for Physical Activity Dated in Measurement Year**  
- Discussion of current physical activity behavior (e.g., exercise routine, participation in sports activities, exam for sports participation)  
- Checklist indicating physical activity was addressed  
- Counseling or referral for physical activity counseling  
- Documented face-to-face delivery of physical activity educational materials  
- Anticipatory guidance for physical activity  
- Weight or obesity counseling |

**Helpful Tips:**  
- Document face-to-face discussions of current physical activity behaviors, like exercise routines, participation in sports activities or bike riding, referrals to physical activity, educational material that was provided, anticipatory guidance on physical activity, and obesity or overweight discussion.  
- Documentation of “decrease screen time” or “participates in after-school activity” does not meet the intent of the measure.  
- Guidance should include recommendations on types and amounts of physical activity – not counseling solely related to safety during physical activity.  
- Document face-to-face discussions of current nutritional behavior, such as appetite or meal patterns, eating and dieting habits.  
- Document any counseling or referral to nutrition education, any nutritional educational materials that were provided during the visit, anticipatory guidance for nutrition, eating disorders, nutritional deficiencies, and underweight, and obesity or overweight discussion.
<table>
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</table>
| Appropriate Treatment for Children with Upper Respiratory Infection (URI) | **Goal:** For antibiotics not to be prescribed for a URI-only diagnosis  
Treatment of uncomplicated acute bronchitis with antibiotics is not recommended, regardless of cough duration. Options for symptomatic therapy include:  
- Cough suppressants  
- First-generation antihistamines  
- Decongestants | Upper Respiratory Infection Diagnosis:  
ICD10: J00, J06.0, J06.9.  
If there is more than one diagnosis (competing diagnoses), where antibiotics are appropriate, please be sure to code these on your claim. Examples include:  
- Sinusitis (acute or chronic)  
- Tonsillitis  
- Otitis media  
- Pneumonia  
- Whooping cough | Members in hospice or using hospice services |
| Appropriate Testing for Children with Pharyngitis (CWP) | When prescribing an antibiotic, a group A streptococcus (strep) test should be completed. | Group A Strep Test:  
CPT: 87070, 87071, 87081, 87430, 87650, 87651, 87652, 87880  
LOINC: 11268-0, 17656-0, 17898-8, 31971-5, 49610-9, 5036-9, 60489-2, 626-2, 6557-3, 6558-1, 6559-9, 68954-7, 78012-2 | Members in hospice |

**Helpful Tips:**
- If the member’s condition doesn’t improve and an antibiotic is indicated, a gap will not occur if the antibiotic is given at least three days after the encounter when a URI was diagnosed.
- This measure is focused on getting a strep test before an antibiotic is prescribed.
- Include documentation of in-office strep test on the claim form.
- If the patient tests negative for group A strep but insists on an antibiotic, write a prescription for symptom relief such as an over-the-counter medication.
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<tr>
<td>Follow-Up Care for Children</td>
<td>This measure applies to patients ages 6 to 12 who are taking outpatient medication for ADHD, and to members ages 6 to 12 who have not taken ADHD medicine within the past four months.</td>
<td>Initiation requires visit to be with a provider with prescribing authority and includes all visits except Telehealth.</td>
<td>Exclude members with a diagnosis of narcolepsy: 347.00, 347.01, 347.10, 347.11, G47.411, G47.419, G47.421, G47.429</td>
</tr>
<tr>
<td>1. Initiation Phase</td>
<td>- Have an ambulatory prescription for ADHD medication, and - Had one follow-up visit with a practitioner with prescribing authority during the 30-day Initiation Phase</td>
<td></td>
<td>Members in hospice</td>
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<td>2. Continuation and Maintenance (C&amp;M) Phase</td>
<td>- Remained on the medication for at least 210 days, and - In addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after end of the Initiation Phase</td>
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</table>

Helpful Tips:
- Schedule no fewer than three follow-up visits within 10 months according to the following guidelines:
  - Schedule a follow-up visit with a practitioner that has prescribing authority for your patients taking ADHD medication within 30 days of their initial prescription or prescription restarted after a 120-day break, and schedule two additional visits within nine months following their initial follow-up visit (one may be conducted via telephone).
  - Make sure follow-up visits include the diagnosis of ADHD.
  - Explain to the parent/guardian the importance of follow-up care.
  - Encourage questions from parents/caregivers to gain a better understanding of ADHD.
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<td>Asthma Medication Ratio (AMR)</td>
<td>Members with persistent asthma are identified by meeting at least one of the following criteria during both the measurement year and the year prior to the measurement year. Criteria need not be the same across both years.</td>
<td>A member identified as having persistent asthma because of at least four asthma medication dispensing events where leukotriene modifiers or antibody inhibitors were the sole asthma medications dispensed that year must also have at least one diagnosis of asthma, in any setting, during the measurement year or year prior when these medications were dispensed to be included in this measure. <strong>This measure is based on a ratio.</strong></td>
<td>Members with emphysema, COPD, obstructive chronic bronchitis, chronic respiratory conditions due to fumes/vapors, cystic fibrosis, or acute respiratory failure, and members who had no asthma controller medications dispensed during the year Members in hospice</td>
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<td>• At least one Emergency Department visit with a principal diagnosis of asthma</td>
<td>Compliance will be determined based on how many members have an asthma controller ratio of 50 percent or more during the measurement period. This is determined by oral medication and inhaler prescription fills and injections.</td>
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<td>• At least one acute inpatient encounter with a principal diagnosis of asthma without telehealth</td>
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<td>• At least four outpatient visits or observation visits on different dates of service, with any diagnosis of asthma and at least two asthma medication dispensing events</td>
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<td>- Visit type need not be the same for the four visits. Only three of the four visits may be a telehealth visit, a telephone visit or an online assessment.</td>
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<td>• At least four asthma medication dispensing events for any controller medication or reliever medication</td>
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<td></td>
<td>Asthma Controller Descriptions:</td>
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<td></td>
<td>• Anti-asthmatic combinations</td>
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<tr>
<td></td>
<td>• Antibody inhibitor</td>
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<tr>
<td></td>
<td>• Inhaled steroid combinations</td>
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<td></td>
<td>• Inhaled corticosteroids</td>
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<td></td>
<td>• Leukotriene modifiers</td>
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<td></td>
<td>• Methxanthines</td>
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<td></td>
<td>• Short-acting inhaled beta-2 agonists</td>
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**Helpful Tips:**
- Encourage patients to continue filling and taking asthma controller medications even if they feel OK.
- Discuss the difference between asthma controller and asthma reliever medications.
- Encourage patients to call your office before discontinuing their asthma controller medications.
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<tr>
<td><strong>Breast Cancer Screening (BCS)</strong></td>
<td>All types and methods of mammograms (screening, diagnostic, film, digital or 3D tomosynthesis) qualify for numerator compliance. Screening is needed every two years. Do NOT count MRIs, Ultrasounds or Biopsies. These procedures are performed as an adjunct to mammography and do not meet measure compliance.</td>
<td>Mammography: CPT: 77055, 77056, 77057, 77061, 77062, 77063, 77065, 77066, 77067 HCPCS: G0202, G0204, G0206 Rev Code: 0401, 0403</td>
<td>Members in hospice Members with history of bilateral mastectomy Members with a unilateral mastectomy with a bilateral modifier Two unilateral mastectomies</td>
</tr>
</tbody>
</table>

**Helpful Tips:**
- Educate patients about the importance of early detection and encourage screening.
- Remind patients that an order is not needed for a screening mammogram.
- Discuss possible fears patients may have about mammograms and let them know that currently available testing methods are less uncomfortable and require less radiation.

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<tr>
<td><strong>Cervical Cancer Screening (CCS)</strong></td>
<td>Women 21-64 years of age should have a cervical cytology test within the last 3 years. - During the measurement year or the two years prior to the measurement year Women 30-64 years of age who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years</td>
<td>Cervical Cytology: CPT: 88141, 88142, 88143, 88147, 88148, 88150, 88152, 88153, 88154, 88164, 88165, 88166, 88167, 88174, 88175 HCPCS: G0123, G0124, G0141, G0143, G0144, G0145, G0147, G0148, P3000, P3001, 00091 Rev Code: 0923 LOINC: 10524-7, 18500-9, 19762-4, 19764-0, 19765-7, 19766-5, 19774-9, 33717-0, 47527-7, 47528-5</td>
<td>Hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix Members in hospice or using hospice services</td>
</tr>
</tbody>
</table>

**Helpful Tips:**
- Note in the chart if a patient has a history of hysterectomy with complete details: complete, total, radical or vaginal hysterectomy with no residual cervix.
- Include the year the surgical procedure was performed.
- Document history of cervical agenesis or acquired absence of cervix.
- Discuss the importance of well-woman exams, mammograms, Pap tests and HPV testing with all female members ages 21-64 years.
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| **Chlamydia Screening in Women (CHL)** | Percentage of women 16-24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year. Rates are reported as defined below:  
  - Age stratification 16-20 years of age  
  - Age stratification 21-24 years of age  
  - Total of both age stratifications  | Identify sexually active women by one of the following:  
  - Claims Data: Codes from any of the following value sets: Pregnancy Value Set, Sexual Activity Value Set, Pregnancy Tests Value Set  
  - Pharmacy Data: Members dispensed prescription for contraceptives during the measurement year  
  - Contraceptive Medication Description:  
    - Contraceptive  
    - Diaphragm  
    - Spermicide  
  Once identified as sexually active, the member must have one chlamydia test during the measurement year.  | Chlamydia Tests:  
  **CPT:** 87110, 87270, 87320, 87490, 87491, 87492, 87810  
  **LOINC:** 14463-4, 14464-2, 14470-9, 14471-7, 14509-4, 14510-2, 16600-9, 21189-6, 21190-4, 21613-5, 23838-6, 31771-9, 31772-7, 31774-6, 36902-5, 36903-3, 43304-5, 43404-3, 43405-0, 43406-8, 44807-6, 45067-6, 45068-4, 45069-2, 45073-0, 45073-7, 45078-3, 45080-9, 45084-1, 45081-6, 45085-7, 45091-4, 45091-8, 45095-6, 45096-3, 45096-8, 45098-3, 45100-4, 47211-8, 47212-6, 49036-1, 4993-2, 50387-0, 53920-2, 557-9, 560-3, 6349-5, 6354-5, 6355-2, 6356-0, 80361-9, 80362-7 | Members in hospice  |

**Helpful Tips:**
- Make chlamydia screening a standard lab for patients 16-24 years old to get as part of their annual well-care visit.
- Urine screening for chlamydia is acceptable to meet criteria for this measure.
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<td><strong>Prenatal and Postpartum Care (PPC)</strong></td>
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<td>Members in hospice or using hospice services</td>
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<tr>
<td>The percentage of deliveries of live births</td>
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<td>The measure assesses the following facets of</td>
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<tr>
<td>prenatal and postpartum care:</td>
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<tr>
<td>• <strong>Timeliness of Prenatal Care</strong> –</td>
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<tr>
<td>The percentage of deliveries that</td>
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<td>received a prenatal care visit within the</td>
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<td>first trimester, on the enrollment start</td>
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<td>date or within 42 days of enrollment in</td>
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<tr>
<td>the organization</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• <strong>Postpartum Care</strong> – The percentage of</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>deliveries that had a postpartum visit on</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>or between 21 and 56 days after delivery</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Compliance with Timeliness of Prenatal Care:</strong></td>
<td>For visits to a PCP, a diagnosis of pregnancy must be present. Documentation in the medical record must include a note indicating the date of the prenatal visit PLUS one of the following:</td>
<td>Preterm:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Basic physical OB examination that includes auscultation of fetal heart tone OR pelvic exam with obstetric observations OR measurement of fundus</td>
<td>Prenatal Stand-Alone Visits:</td>
<td>Prenatal:</td>
</tr>
<tr>
<td></td>
<td>• Evidence that a prenatal care procedure was performed, such as screening test in the form of obstetric panel OR TORCH antibody panel alone OR rubella antibody test/titer with an Rh incompatibility blood typing OR echography of a pregnant uterus</td>
<td></td>
<td>Preterm Stand-Alone Visits:</td>
</tr>
<tr>
<td></td>
<td>• Documentation of LMP or EDD in conjunction with either of the following: prenatal risk assessment and counseling/education OR complete obstetrical history</td>
<td></td>
<td>CPT: 99500</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>CPTII: 0500F, 0501F, 0502F</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>HCPCS: H1000, H1001, H1002, H1003, H1004</td>
</tr>
<tr>
<td><strong>Compliance with Postpartum Care:</strong></td>
<td>Postpartum visit must be on or between 21 and 56 days after delivery. Documentation in the medical record must include a note indicating the date when a postpartum visit occurred and one of the following:</td>
<td>Preterm Bundled Services:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Pelvic exam</td>
<td></td>
<td>CPT: 59400, 59425, 59426, 59510, 59610, 59618</td>
</tr>
<tr>
<td></td>
<td>• Evaluation of weight, blood pressure, and breasts and abdomen – notation of breastfeeding is acceptable for the evaluation of breasts</td>
<td></td>
<td>HCPCS: H1005</td>
</tr>
<tr>
<td></td>
<td>• Notation of postpartum care (postpartum care, postpartum check, six-week check or a pre-printed postpartum care form completed during the visit)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Prenatal:**
- **Prenatal Stand-Alone Visits:**
  - **CPT:** 99500
  - **CPTII:** 0500F, 0501F, 0502F
  - **HCPCS:** H1000, H1001, H1002, H1003, H1004
- **Prenatal Bundled Services:**
  - **CPT:** 59400, 59425, 59426, 59510, 59610, 59618
  - **HCPCS:** H1005
- **Prenatal Visits:**
  - **CPT:** 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99483
  - **HCPCS:** G0463, T1015
  - **Rev Code:** 0514

**Postpartum:**
- **Postpartum Visits:**
  - **CPT:** 57170, 58300, 59430, 99501
  - **CPTII:** 0503F
  - **HCPCS:** G0101
  - **ICD10:** Z01.411, Z01.419, Z01.42, Z30.430, Z39.1, Z39.2
- **Postpartum Bundled Services:**
  - **CPT:** 59400, 59410, 59415, 59510, 59515, 59610, 59614, 59610, 59622
- **Cervical Cytology:**
  - **CPT:** 88141, 88142, 88143, 88147, 88148, 88150, 88152, 88153, 88154, 88164, 88165, 88166, 88167, 88174, 88175
  - **HCPCS:** G0123, G0124, G0141, G0143, G0144, G0145, G0147, G0148, P3000, P3001, Q0091
  - **Rev Code:** 0923
- **LOINC:** 10524-7, 18500-9, 19762-4, 19764-0, 19765-7, 19766-5, 19774-9, 33717-0, 47527-7, 47528-5

**Women’s Health Measures**

Sample codes may change from year to year.
<table>
<thead>
<tr>
<th>Measure</th>
<th>What Service Is Needed</th>
<th>What to Report (Sample of Codes and/or Diagnoses)</th>
<th>Exclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Adult BMI (ABA)</strong></td>
<td>Percentage of members 18-74 years of age who had an outpatient visit and whose body mass index (BMI) was documented. The weight and BMI must be from the same data source.</td>
<td>Encounter/Claim with Codes:</td>
<td>Women who are pregnant during the measurement year or the year prior</td>
</tr>
<tr>
<td></td>
<td><strong>Percentage who had an outpatient visit during the measurement year or year prior</strong></td>
<td><strong>Adult BMI Percentile:</strong></td>
<td>Members in hospice or using hospice services</td>
</tr>
<tr>
<td></td>
<td><strong>Documentation:</strong></td>
<td><strong>BMI 19 or less:</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Documentation must indicate the dated weight/height and BMI value from the same data source.</td>
<td><strong>BMI 20.0 – 23.9:</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Members younger than age 20 on the date of service must have height, weight and BMI percentile recorded (e.g., 85th percentile) or documented on an age-growth chart.</td>
<td><strong>BMI 24.0 – 29.9:</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Members ages 20 or older on the date of service must have BMI value and weight documented.</td>
<td><strong>BMI 30.0 – 39.9:</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Common Documentation Errors to Avoid:</strong></td>
<td><strong>BMI 40.0 – 49.9:</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Height and/or weight documented without BMI calculation</td>
<td><strong>BMI 50 – 59.9:</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• BMI documented as a value instead of percentile for members younger than age 20</td>
<td><strong>BMI 60.0 – 69.9:</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• BMI ranges documented</td>
<td><strong>BMI 70 or greater:</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Pediatric BMI Percentile:</strong></td>
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<tr>
<td></td>
<td></td>
<td><strong>BMI &lt;5th percentile for age:</strong></td>
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<tr>
<td></td>
<td></td>
<td><strong>BMI 5th percentile – &lt;85th percentile:</strong></td>
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<td></td>
<td><strong>BMI 85th percentile – &lt;95th percentile:</strong></td>
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<tr>
<td></td>
<td></td>
<td><strong>BMI ≥ 95th percentile:</strong></td>
<td></td>
</tr>
<tr>
<td>Measure</td>
<td>What Service Is Needed</td>
<td>What to Report (Sample of Codes and/or Diagnoses)</td>
<td>Exclusions</td>
</tr>
<tr>
<td>---------</td>
<td>-----------------------</td>
<td>-----------------------------------------------</td>
<td>------------</td>
</tr>
</tbody>
</table>
| **Comprehensive Diabetes Care (CDC)** Percentage of members 18 to 75 years of age with diabetes (Type 1 and Type 2) who had each of the following on a yearly basis:  
- BP control (<140/90)  
- HbA1c testing  
- HbA1c poor control (>9.0 percent)  
- Retinal eye exam  
- Medical attention for nephropathy | **Percentage of members with diabetes (Type I and Type 2) who had each of the following on a yearly basis:**  
- Blood pressure less than 140/90 mm Hg at last recorded measurement in the measurement period  
- Retinal eye exam in measurement year or negative retinal exam in year prior to measurement year interpreted by an eye care professional  
- Medical attention for nephropathy  
- HbA1c testing in measurement year  
- HbA1c poor control (greater than 9.0 percent) at last measurement in measurement year (lower rate is better)  

**Documentation:**  
**Blood Pressure Measurement**  
- Latest documented blood pressure within the measurement year <140/90  
- Blood pressure readings taken from remote monitoring devices that are electronically submitted directly to the provider will count for numerator compliance.  

**Hemoglobin A1c Testing**  
- Claim indicating HbA1c testing with date of service in measurement year  

**HbA1c Control**  
- Claim administrative report of HbA1c result in measurement year with specific value greater than 9.0 percent (if no administrative evidence of testing in measurement year, control is recorded as >9)  

**Retinal Eye Exam**  
- Eye professional comprehensive eye exam in the measurement year or medical record documentation of exam findings with result documented in the measurement year or year prior | **Diabetes**  
- Members identified using specified claims, encounter or pharmacy data documenting or indicating diabetes during the measurement year and/or the year prior to the measurement year  

**BP Measurement – Systolic CPT Category II:**  
- 3074F – <130  
- 3075F – 130-139  
- 3077F – ≥140  

**BP Measurement – Diastolic CPT Category II:**  
- 3078F – <80  
- 3079F – 80-89  
- 3080F – ≥ 90  

**HbA1c Testing**  
- CPT: 83036, 83037  
- CPT Category II:  
  - 3044F – <7.0  
  - 3045F – 7.0-9.0  
  - 3046F – >9.0  

**Diabetic Retinal Screening – CPT Category II:**  
- 3072F – Negative retinal screen in prior year  
- 2022F – Dilated retinal exam interpreted by ophthalmologist or optometrist documented and reviewed  
- 2024F – Documented and reviewed – Seven standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist  
- 2026F – Documented and reviewed – Eye imaging validated to match diagnosis from seven standard field stereoscopic photos results  

Members who do not have a diagnosis of diabetes, in any setting, during the measurement year or the year prior to the measurement year and who had a diagnosis of gestational diabetes or steroid-induced diabetes, in any setting, during the measurement year or the year prior to the measurement year  

Patients in hospice or using hospice services | **Continued on next page**
<table>
<thead>
<tr>
<th>Measure</th>
<th>What Service Is Needed</th>
<th>What to Report (Sample of Codes and/or Diagnoses)</th>
<th>Exclusions</th>
</tr>
</thead>
</table>
| **Comprehensive Diabetes Care (CDC)** | Percentage of members 18 to 75 years of age with diabetes (Type I and Type 2) who had each of the following on a yearly basis:  
- BP control (<140/90)  
- HbA1c testing  
- HbA1c poor control (>9.0 percent)  
- Retinal eye exam  
- Medical attention for nephropathy | Medical Attention for Nephropathy  
Claim with dated service in the measurement year indicating any of the following:  
- Medical attention for nephropathy  
- Urinalysis or microalbumin urine screen in measurement year  
- Documented prescription of angiotensin-converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) in measurement year | Members who do not have a diagnosis of diabetes, in any setting, during the measurement year or the year prior to the measurement year and who had a diagnosis of gestational diabetes or steroid-induced diabetes, in any setting, during the measurement year or the year prior to the measurement year  
Patients in hospice or using hospice services |

**Diabetes**  
Members identified using specified claims, encounter or pharmacy data documenting or indicating diabetes during the measurement year and/or the year prior to the measurement year  
**Nephropathy Screening – CPT Category II:**  
- 3060F Positive microalbumin test documented/reviewed*  
- 3061F Negative microalbumin test documented/reviewed*  
- 3062F Positive Microalbumin Test*  
- 3066F Documentation of treatment for Nephropathy (dialysis, chronic renal failure, nephrology care)*  
- Dispensing event for ACE or ARB in measurement year  
*Administrative claims render the member compliant for nephropathy screening. These are supplemental documentation codes. |

**Helpful Tips:**  
- Ensure all lab results are documented and dated, including point of care.  
- Members need to have a diabetic eye exam every year with an eye care provider.  
- A digital eye exam must be read by an eye care professional – optometrist or ophthalmologist. If a member’s eye exam was negative or showed low risk of retinopathy in the prior year, using appropriate coding will count for compliance in this measurement year.  
- Use the lowest systolic and diastolic reading taken on the same day and use CPT Category II codes to document results.  
- Educate your members and their families, caregivers and guardians on diabetes care, including:  
  - Taking all prescribed medications as directed  
  - Adding regular exercise to daily activities  
  - Regularly monitoring blood sugar and blood pressure at home  
  - Maintaining healthy weight and ideal body mass index  
  - Eating heart-healthy, low-calorie and low-fat foods  
  - Stopping smoking and avoiding secondhand smoke  
  - Fasting prior to having blood sugar and lipid panels drawn to ensure accurate results  
  - Keeping all medical appointments and getting help with scheduling necessary appointments, screenings and tests to improve compliance  
- Include the applicable Category II reporting code above on the claim form to help reduce the burden of HEDIS medical record review.
### Measure
- **Medication Management for People with Asthma (MMA)**

Percentage of members 5 to 64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period.

**Two rates are reported based on a ratio of Days Covered by Controller Medication to Days in the Treatment Period:**

1. The percentage of members who remained on an asthma controller medication for at least 50 percent of their treatment period.
2. The percentage of members who remained on an asthma controller medication for at least 75 percent of their treatment period.

#### What Service Is Needed

**Members with persistent asthma are identified by meeting at least one of the following criteria during both the measurement year and the year prior to the measurement year. Criteria need not be the same across both years.**

- At least one Emergency Department visit with a principal diagnosis of asthma.
- At least one acute inpatient encounter with a principal diagnosis of asthma without telehealth.
- At least four outpatient observation visits on different dates of service, with any diagnosis of asthma and at least two asthma medication dispensing events for any controller medication or reliever medication.
- Visit type need not be the same for the four visits. Only three of the four visits may be a telehealth visit, a telephone visit or an online assessment.
- At least four asthma medication dispensing events for any controller medication or reliever medication.

#### What to Report (Sample of Codes and/or Diagnoses)

- A member identified as having persistent asthma because of at least four asthma medication dispensing events, where leukotriene modifiers or antibody inhibitors were the sole asthma medications dispensed in that year, must also have at least one diagnosis of asthma, in any setting, in the same year as the leukotriene modifier or antibody inhibitor (i.e., the measurement year or the year prior to the measurement year).

Members identified with persistent asthma are required to remain on their asthma controller medication for 75 percent of the treatment period.

**Compliance is based on medication adherence.**

Compliance will be determined by how many members remained on asthma controller medication for 75 percent of their treatment period based on pharmacy claim data.

#### Exclusions

- Members with emphysema, COPD, obstructive chronic bronchitis, chronic respiratory conditions due to fumes/vapors, cystic fibrosis, or acute respiratory failure, and members who had no asthma controller medications dispensed during the year.
- Members in hospice.

#### Helpful Tips:

- Educate members in identifying asthma triggers and taking controller medications.
- Educate patients on the difference between controller and reliever medications and when to take each.
- Remind members to get their controller medication filled regularly.
- Remind members not to stop taking the controller medications even if they are feeling better and are symptom free.
- Ensure proper documentation and coding to avoid coding asthma if the diagnosis is for an asthma-like symptom (e.g., wheezing during viral URI and acute bronchitis).
<table>
<thead>
<tr>
<th>Measure</th>
<th>What Service Is Needed</th>
<th>What to Report (Sample of Codes and/or Diagnoses)</th>
<th>Exclusions</th>
</tr>
</thead>
</table>
| **Controlling High Blood Pressure (CBP)**   | Members who had at least two visits on different dates of service with a diagnosis of hypertension during the measurement year or the year prior to the measurement year (count services that occur over both years)  
• Visit type need not be the same for the two visits. Only one of the two visits may be a telephone visit, online assessment or a telehealth visit.  
Any of the following code combinations meet criteria:  
• Outpatient visit with or without a telehealth modifier, with any diagnosis of hypertension  
• A telephone visit with any diagnosis of hypertension  
• An online assessment with any diagnosis of hypertension | **Blood Pressure Measurement – Systolic CPT**  
Category II:  
• 3074F – <130  
• 3075F – 130-139  
• 3077F – ≥140  
**Blood Pressure Measurement – Diastolic CPT**  
Category II:  
• 3078F – <80  
• 3079F – 80-89  
• 3080F – ≥ 90 | Members with end-stage renal disease or kidney transplant  
Pregnancy during the measurement year  
Members in hospice or using hospice services |

**Helpful Tips:**
- Use the lowest systolic and diastolic reading taken on the same day and use CPT Category II codes to document results.
- Blood pressure readings taken from remote monitoring devices that are electronically submitted directly to the provider will count for numerator compliance.
- Educate members on the importance of continuing hypertensive medication even when they are “feeling good.”
- Encourage members to call the office with any side effects from hypertensive medications before stopping the medication.
- The last reading in the measurement year will be used to meet compliance for this measure.
<table>
<thead>
<tr>
<th>Measure</th>
<th>What Service Is Needed</th>
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</tr>
</thead>
</table>
| Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB) | Treatment of uncomplicated acute bronchitis with antibiotics is not recommended, regardless of cough duration. Options for symptomatic therapy include:  
• Cough suppressants  
• First-generation antihistamines  
• Decongestants | Acute Bronchitis:  
ICD10: J20.3, J20.4, J20.5, J20.6, J20.7, J20.8, J20.9 | Documentation of a comorbid condition  
• COPD  
• Emphysema  
• HIV  
• Cancer  
• Cystic Fibrosis  
• Disorders of the immune system  
Members in hospice or using hospice services |

**Helpful Tips:**
- Educate members and their families about viral illnesses and how using antibiotics to treat viral infections can cause antibiotic resistance. Consider posting educational tools and materials from the CDC and BlueCross in your waiting room and treatment areas.
- Talk with patients about how they can ease their symptoms by:  
  - Getting extra rest and drinking plenty of fluids  
  - Treating the symptoms with over-the-counter medications  
  - Using a cool mist vaporizer/nasal spray for congestion
- If the member’s condition doesn’t improve and an antibiotic is indicated, a gap will not occur if the antibiotic is given at least three days after the encounter when bronchitis was diagnosed.

General Health Measures
<table>
<thead>
<tr>
<th>Measure</th>
<th>What Service Is Needed</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Avoidable ED (TennCare Custom Measure for reporting only)</td>
<td>ED visits are considered ambulatory sensitive if the primary diagnosis for the ED visit is included in any of the following value sets:</td>
<td>- ACSC Angina - Cancer (Cervix) - CHF - Dental Condition - Epilepsy - Gastroenteritis - Haemophilous Meningitis (ages 1-5 only) - Hypoglycemia - Hypertension - Kidney Urinary Infection - Pelvic Inflammatory Disease - Pulmonary Tuberculosis - Surgical Procedure - Tuberculosis (Non-pulmonary) - Vaccine Preventable Conditions - Severe ENT Infections - COPD</td>
<td>The measure does not include mental health or chemical dependency services. Exclude claims and encounters that indicate the encounter was for mental health or chemical dependency. Any of the following meet criteria: - A principal diagnosis of mental health or chemical dependency - Psychiatry - Electroconvulsive therapy</td>
</tr>
</tbody>
</table>

Helpful Tips:
- Educate members on what to do after hours before heading to the ED, such as calling your office to see if a provider is available for triage or calling the BlueCare Nurse Line.
- Ensure members are aware of all office hours including evening and weekend hours.
- Follow-up with members that recently had a trip to the ED as identified on the ADT feed in the Care Coordination tool and schedule them for an office visit.
<table>
<thead>
<tr>
<th>Measure</th>
<th>What Service Is Needed</th>
<th>What to Report (Sample of Codes and/or Diagnoses)</th>
<th>Exclusions</th>
</tr>
</thead>
</table>
| Pharmacotherapy Management of COPD Exacerbation (PCE) | Members with COPD Exacerbation are identified by:  
- An Emergency Department visit with a principal diagnosis of COPD, emphysema or chronic bronchitis  
- An acute inpatient discharge with a principal diagnosis of COPD, emphysema or chronic bronchitis.  
- Dispensed prescription for a systemic corticosteroid on or 14 days after the episode date  
- Dispensed prescription for a bronchodilator on or 30 days after the episode date | COPD  
**ICD10:** J44.0, J44.1, J44.9  
Chronic Bronchitis  
**ICD10:** J41.0, J41.1, J41.8, J42  
Emphysema  
**ICD10:** J43.0, J43.1, J43.2, J43.8, J43.9 | Members in hospice or using hospice services |
| | **COPD Systemic Corticosteroid Description:**  
**Glucocorticoids**  
- Cortisone-acetate  
- Dexamethasone  
- Methylprednisolone  
- Prednisone  
**COPD Bronchodilators Description:**  
**Anticholinergic Agents**  
- Albuterol-ipratropium  
- Ipratropium  
- Umeclidinium  
**Beta 2-agonists**  
- Albuterol  
- Budesonide-formoterol  
- Fluticasone-vilanterol  
- Formoterol-glycopyrrolate  
- Indacaterol-glycopyrrolate  
- Mometasone-formoterol  
- Olodaterol hydrochloride  
- Pirbuterol  
- Umeclidinium-vilanterol  
**Antiasthmatic Combinations**  
- Dyphylline-guaifenesin  
- Guaifenesin-theophylline | | |
## Use of Imaging Studies for Low Back Pain (LBP)

Percentage of members (18-50 years of age) with a primary diagnosis of low back pain who did not have an imaging study (plain x-ray, MRI, CT scan) within 28 days of diagnosis

### Members Identified By:
- Outpatient visit with a principal diagnosis of uncomplicated low back pain with or without telehealth modifier
- Observation visit or an ED visit with a principal diagnosis of uncomplicated low back pain
- Osteopathic or chiropractic manipulative treatment with a principal diagnosis of uncomplicated low back pain
- Physical therapy visit with a principal diagnosis of uncomplicated low back pain
- Telephone visit with a principal diagnosis of uncomplicated low back pain
- Online assessment with a principal diagnosis of uncomplicated low back pain

### Exclusions
- Exclude any member who had a diagnosis for which imaging is clinically appropriate:
  - **Cancer** – Cancer any time during the member’s history through 28 days after the Index Episode Start Date (IESD)
  - **Recent Trauma** – Any time during the 90 days prior to the IESD through 28 days after the IESD
  - **Intravenous Drug Abuse** – Any time during the 12 months prior to the IESD through 28 days after the IESD
  - **Neurologic impairment** – Any time during the 12 months prior to the IESD through 28 days after the IESD
  - **HIV** – Any time during the members history through 28 days after the IESD
  - **Spinal infection** – Any time during the 12 months prior to the IESD through 28 days after the IESD
  - **Major organ transplant** – Any time in the member’s history through 28 days after the IESD
  - **Prolonged use of corticosteroids** – 90 consecutive days of corticosteroid treatment any time during the 12 months prior to and including the IESD

### Helpful Tips:
- Avoid ordering diagnostic studies within 30 days of a diagnosis of new-onset back pain in the absence of red flags (e.g., cancer, recent trauma, neurologic impairment, or IV drug abuse).
- Code appropriately using low back pain codes and include codes for exclusionary diagnoses.

### Members (18-50 years of age) who have a primary diagnosis of uncomplicated low back pain should wait 28 days from the time of diagnosis to obtain imaging studies.

### ICD10 Codes:
<table>
<thead>
<tr>
<th>Measure</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Statin Therapy for Patients with Cardiovascular Disease (SPC)</strong></td>
<td><strong>Who Qualifies for the Measure:</strong>&lt;br&gt;Male members ages 21-75 and female members ages 40-75 who had one of the following during the previous year:&lt;br&gt;- Myocardial infarction (MI)&lt;br&gt;- Coronary artery bypass grafting (CABG)&lt;br&gt;- Percutaneous coronary intervention (PCI)&lt;br&gt;- Other revascularization&lt;br&gt;&lt;br&gt;<strong>OR</strong>&lt;br&gt;Ischemic vascular disease (IVD) diagnosis during the previous and current year</td>
<td>Measure is a medication receipt and adherence measure. The following statins qualify for compliance:&lt;br&gt;<strong>High-Intensity Statin Therapy:</strong>&lt;br&gt;- Atorvastatin 40-80 mg&lt;br&gt;- Amlodipine-atorvastatin 40-80 mg&lt;br&gt;- Ezetimibe-atorvastatin 40-80 mg&lt;br&gt;- Rosuvastatin 20-40 mg&lt;br&gt;- Simvastatin 80 mg&lt;br&gt;- Ezetimibe-simvastatin 80 mg&lt;br&gt;&lt;br&gt;<strong>Moderate-Intensity Statin Therapy:</strong>&lt;br&gt;- Atorvastatin 10-20 mg&lt;br&gt;- Amlodipine-atorvastatin 10-20 mg&lt;br&gt;- Ezetimibe-atorvastatin 10-20 mg&lt;br&gt;- Rosuvastatin 5-10 mg&lt;br&gt;- Simvastatin 20-40 mg&lt;br&gt;- Ezetimibe-simvastatin 20-40 mg&lt;br&gt;- Niacin-simvastatin 20-40 mg&lt;br&gt;- Sitagliptin-simvastatin 20-40 mg&lt;br&gt;- Pravastatin 40-80 mg&lt;br&gt;- Lovastatin 40 mg&lt;br&gt;- Niacin-lovastatin 40 mg&lt;br&gt;- Fluvastatin XL 80 mg&lt;br&gt;- Fluvastatin 40 mg bid&lt;br&gt;- Pitavastatin 2-4 mg</td>
<td>Female members with a diagnosis of pregnancy&lt;br&gt;Members in In vitro fertilization during the measurement year or previous year&lt;br&gt;Members dispensed at least one prescription for clomiphene during the measurement year or previous year&lt;br&gt;Members with end-stage renal disease (ESRD) during the measurement year or previous year&lt;br&gt;Members with cirrhosis during the measurement year or previous year&lt;br&gt;Members with myalgia, myositis, myopathy or rhabdomyolysis during the measurement year</td>
</tr>
</tbody>
</table>

**Who Qualifies for the Measure:**<br>Male members ages 21-75 and female members ages 40-75 who had one of the following during the previous year:<br>- Myocardial infarction (MI)<br>- Coronary artery bypass grafting (CABG)<br>- Percutaneous coronary intervention (PCI)<br>- Other revascularization<br><br>**OR**<br>Ischemic vascular disease (IVD) diagnosis during the previous and current year |

**Services Required:**<br>1. Member needs to receive high-intensity or moderate-intensity statin therapy medication during current year<br>2. Adherent to statin therapy for at least 80 percent of treatment period, which is defined by time period from first statin therapy dispensing event to the end of the year |

**Helpful Tips:**<br>- Educate members on the importance of medication and potential side effects.<br>- Encourage members to call the office with any side effects before stopping medication.
<table>
<thead>
<tr>
<th>Measure</th>
<th>What Service Is Needed</th>
<th>What to Report (Sample of Codes and/or Diagnoses)</th>
<th>Exclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Statin Therapy for Patients With Diabetes (SPD)</strong></td>
<td></td>
<td></td>
<td>Members with myocardial infarction (MI), coronary artery bypass grafting (CABG), percutaneous coronary intervention (PCI) or other revascularization in the previous year</td>
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<td></td>
<td>Ischemic vascular disease (IVD) diagnosis during the previous and current year</td>
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<td></td>
<td>Female members with a diagnosis of pregnancy</td>
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<td>Members in In vitro fertilization during the measurement year or previous year</td>
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<td>Members dispensed at least one prescription for clomiphene during the measurement year or previous year</td>
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<td>Members with end-stage renal disease (ESRD) during the measurement year or previous year</td>
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<td>Members with cirrhosis during the measurement year or previous year</td>
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<td></td>
<td>Members with myalgia, myositis, myopathy or rhabdomyolysis during the measurement year</td>
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<tr>
<td><strong>Who Qualifies for the Measure:</strong></td>
<td>Diabetic members ages 40-75 who had one of the following during the current or previous year:</td>
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<td></td>
<td>• Two outpatient visits with a diagnosis of diabetes</td>
<td>High-Intensity Statin Therapy:</td>
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<tr>
<td></td>
<td>• At least one inpatient encounter with a diagnosis of diabetes</td>
<td>• Atorvastatin 40-80 mg</td>
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<td></td>
<td>• Members dispensed one of the following:</td>
<td>• Amlodipine-atorvastatin 40-80 mg</td>
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<tr>
<td></td>
<td>- Alpha-glucosidase inhibitors</td>
<td>• Ezetimibe 40-80 mg</td>
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<td></td>
<td>- Amylin analogs</td>
<td>• Rosuvastatin 20-40 mg</td>
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<td></td>
<td>- Antidiabetic combinations</td>
<td>• Simvastatin 80 mg</td>
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<td></td>
<td>- Insulin</td>
<td>• Ezetimibe-simvastatin 80 mg</td>
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<td></td>
<td>- Meglitinides</td>
<td><strong>Moderate-Intensity Statin Therapy:</strong></td>
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<tr>
<td></td>
<td>- Glucagon-like peptide-1 (GLP1) agonists</td>
<td>• Atorvastatin 10-20 mg</td>
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<td></td>
<td>- Sodium glucose cotransporter 2 (SGLT2) inhibitor</td>
<td>• Amlodipine-atorvastatin 10-20 mg</td>
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<td></td>
<td>- Sulfonylureas</td>
<td>• Ezetimibe-simvastatin 20-40 mg</td>
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<td>- Thiazolidinediones</td>
<td>• Rosuvastatin 5-10 mg</td>
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<td></td>
<td>- Dipeptidyl peptidase-4 (DDP-4) inhibitors</td>
<td>• Simvastatin 20-40 mg</td>
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<tr>
<td><strong>Services Required:</strong></td>
<td>1. Member needs to receive high-intensity, moderate-intensity or low-intensity statin therapy medication during current year AND 2. Adherent to statin therapy for at least 80 percent of treatment period</td>
<td>Moderate-Intensity Statin Therapy:</td>
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<td></td>
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<td>• Niacin-simvastatin 20-40 mg</td>
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<td></td>
<td></td>
<td>• Sitagliptin-simvastatin 20-40 mg</td>
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<td>• Pravastatin 40-80 mg</td>
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<td>• Lovastatin 40 mg</td>
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<td>• Niacin-lovastatin 40 mg</td>
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<td>• Fluvastatin XL 80 mg</td>
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<td>• Fluvastatin 40 mg bid</td>
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<td>• Pitavastatin 2-4 mg</td>
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<tr>
<td><strong>Low-Intensity Statin Therapy:</strong></td>
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<td>Low-Intensity Statin Therapy:</td>
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<td></td>
<td>• Simvastatin 10 mg</td>
<td>• Simvastatin 10 mg</td>
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<td>• Ezetimibe-simvastatin 10 mg</td>
<td>• Sitagliptin-simvastatin 10 mg</td>
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<td>• Pravastatin 10-20 mg</td>
<td>• Simvastatin 20 mg</td>
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<td>• Lovastatin 20 mg</td>
<td>• Niacin-lovastatin 20 mg</td>
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<td>• Fluvastatin 20-40 mg</td>
<td>• Fluvastatin 20-40 mg</td>
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<tr>
<td></td>
<td>• Pitavastatin 1 mg</td>
<td>• Pitavastatin 1 mg</td>
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</tbody>
</table>

**Helpful Tips:**
- Educate members on the importance of medication and potential side effects.
- Encourage members to call the office with any side effects before stopping medication.
- Encourage members to refill prescription every month.
<table>
<thead>
<tr>
<th>Measure</th>
<th>What Service Is Needed</th>
<th>What to Report (Sample of Codes and/or Diagnoses)</th>
<th>Exclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use of Opioids at High Dosage (UOD)</td>
<td>Note: A lower rate indicates better performance. The proportion will be calculated and displayed as a permillage (multiplied by 1,000) instead of a percentage in reports.</td>
<td>Opioid Medications</td>
<td>Members in hospice or using hospice services. Members who had a diagnosis of cancer during the measurement year. Members who had a diagnosis of Sickle Cell during the measurement year. The Opioid Medications List excludes: Injectables Opioid cough and cold products Single-agent and combination buprenorphine products used to treat opioid use disorder for medication assisted treatment (i.e., buprenorphine sublingual tablets, buprenorphine subcutaneous implant and all buprenorphine/naloxone combination products) Ionsys® (fentanyl transdermal patch), because: - It is only for inpatient use. - It is only available through a restricted program under a Risk Evaluation and Mitigation Strategy (REMS).</td>
</tr>
</tbody>
</table>
### Use of Opioids from Multiple Providers (UOP)

The proportion of members 18 years and older, receiving prescription opioids for ≥15 days during the measurement year who received opioids from multiple providers.

**Three rates are reported:**

1. **Multiple Prescribers:** The proportion of members receiving prescriptions for opioids from four or more different prescribers during the measurement year.

2. **Multiple Pharmacies:** The proportion of members receiving prescriptions for opioids from four or more different pharmacies during the measurement year.

3. **Multiple Prescribers and Multiple Pharmacies:** The proportion of members receiving prescriptions for opioids from four or more different prescribers and four or more different pharmacies during the measurement year.

**Note:** A lower rate indicates better performance for all three rates. The proportion will be calculated and displayed as a permillage (multiplied by 1,000) instead of a percentage in reports.

**National Provider Identifier (NPI) will be used to identify prescribers.**

- Pharmacy claims are utilized to determine the eligible population.
- Denied claims will not be included.
- Supplemental data is not used for this measure.

**Opioid Medications:**

- Buprenorphine (transdermal patch and buccal film)
- Butorphanol
- Codeine
- Dihydrocodeine
- Fentanyl
- Hydrocodone
- Hydromorphone
- Levoerphanol
- Meperidine
- Methadone
- Morphine
- Opium
- Oxycodone
- Oxymorphone
- Pentazocine
- Tapentadol
- Tramadol

**Members in hospice or using hospice services**

**The Opioid Medications List Excludes:**

- Injectables
- Opioid cough and cold products
- Single-agent and combination buprenorphine products used to treat opioid use disorder for medication assisted treatment (i.e., buprenorphine sublingual tablets, buprenorphine subcutaneous implant and all buprenorphine/naloxone combination products)
- Ionsys® (fentanyl transdermal patch), because:
  - It is only for inpatient use.
  - It is only available through a restricted program under a Risk Evaluation and Mitigation Strategy (REMS).
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<tr>
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</table>
| Follow-Up After Hospitalization for Mental Illness (FUH) | A follow-up visit with a mental health practitioner within seven days/30 days after discharge. **Any of the following meets criteria for a seven-day follow-up visit:**  
- Visit with mental health practitioner with or without a telehealth modifier  
- Visit in behavioral health care setting with a mental health practitioner  
- Visit in non-behavioral health care setting with a mental health practitioner  
- Transitional care management services with or without telehealth modifier  
**The following meets criteria for a 30-day follow-up visit:**  
- Transitional care management services with or without telehealth modifier | Please note a THL visit does not count toward the clinic visit needed to close this gap. The visit needs to be with a licensed clinician: LPC, LCSW, Psychologist, MD, PA, APN, etc.  
**Sample Diagnoses:**  
- Dementia  
- Schizophrenia  
- Schizoaffective disorder  
- Manic episode  
- Bipolar disorder  
- Major depressive disorder  
- Post-traumatic stress disorder  
- Attention-deficit hyperactivity disorder  
- Mental illness  
- Intentional self-harm  
Visits may be billed with a telehealth modifier or POS code:  
**Telehealth Modifier:** 95, GT  
**Telehealth POS:** 02  
**Sample CPT Codes for Follow-Up with a Mental Health Practitioner:**  
**Transitional Care Management 7 Day:** 99496  
**Transitional Care Management 14 Day:** 99495 | Exclude discharges followed by readmissions or direct transfer to non-acute inpatient care setting within the 30-day follow-up period, regardless of principal diagnosis for the readmission.  
Exclude discharges followed by readmissions or direct transfer to an acute inpatient care setting within the 30-day follow-up period if the principal diagnosis was for non-mental health.  
Continued on next page
<table>
<thead>
<tr>
<th>Measure</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Follow-Up After Hospitalization for Mental Illness (FUH)</td>
<td>Percentage of discharges for members 6 years of age and older who were hospitalized for treatment of mental illness diagnosis or intentional self harm, and who had a follow-up visit with a mental health practitioner</td>
<td>- <strong>CPT with Outpatient or Partial Hospitalization</strong>&lt;br&gt;<strong>POS Code:</strong> 90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99251, 99252, 99253, 99254, 99255&lt;br&gt;<strong>Rev Code:</strong> 510, 513, 515, 516, 517, 519, 520, 521, 522, 523, 526, 527, 528, 529, 900, 902, 903, 904, 905, 907, 911, 912, 913, 914, 915, 916, 917, 919, 982, 983</td>
<td>Exclude discharges followed by readmissions or direct transfer to a non-acute inpatient care setting within the 30-day follow-up period, regardless of principal diagnosis for the readmission. Exclude discharges followed by readmissions or direct transfer to an acute inpatient care setting within the 30-day follow-up period if the principal diagnosis was for non-mental health.</td>
</tr>
<tr>
<td>Two rates are reported:</td>
<td>Percentage of discharges for which the member received follow-up within 30 days after discharge</td>
<td>Percentage of discharges for which the member received follow-up within seven days after discharge</td>
<td>Note: Additional codes may apply depending on provider type and point of service.</td>
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<tr>
<td></td>
<td>Percentage of discharges for which the member received follow-up within seven days after discharge</td>
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</tbody>
</table>

**Helpful Tips:**
- Help your patient gain access to follow-up care to help reduce readmission rates and improve outcomes for your patients who were hospitalized for mental health issues.
- Schedule seven-day follow-up visits before your patients leave the hospital.
- Call your patients regularly to discuss their medications, upcoming appointments, any possible medication side effects, and their physical and mental well-being.
- Educate your patients and their families about the importance of keeping follow-up appointments, taking medications as prescribed and staying engaged in behavioral health services.
<table>
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<tr>
<td><strong>Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)</strong></td>
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<td></td>
<td>Exclude members who had a claim/encounter with a diagnosis of AOD abuse/dependence or a medication treatment event during the 60 days (2 months) before the index episode start date (IESD) Members in hospice</td>
</tr>
<tr>
<td>Percentage of adolescent (13-17 years of age) and adult (18+ years of age) members with new episode of alcohol or other drug (AOD) abuse or dependence who received the following:</td>
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<tr>
<td>• <strong>Initiation of AOD treatment</strong> – Percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth or medication treatment within 14 days of the diagnosis</td>
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<tr>
<td>• <strong>Engagement of AOD Treatment</strong> – Percentage of members who initiated treatment and who had two or more additional AOD services or medication treatment within 34 days of the initiation visit</td>
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<tr>
<td>Compliance with Initiation of AOD Treatment:</td>
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<tr>
<td>• If the index episode was an inpatient discharge, the inpatient stay is considered initiation of treatment.</td>
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<tr>
<td>• If the index episode was an outpatient visit, intensive outpatient, partial hospitalization, telehealth, detoxification or ED visit, the member <strong>MUST</strong> have:</td>
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<tr>
<td>- Acute or nonacute inpatient admission</td>
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<td>- IET stand-alone visit with diagnosis matching the IESD diagnosis with or without telehealth modifier</td>
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<td>- IET visit group 1 with IET POS group 1 value set and diagnosis matching IESD diagnosis with or without telehealth modifier</td>
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<tr>
<td>- IET visit group 2 with IET POS group 2 value set and diagnosis matching IESD diagnosis with or without telehealth modifier</td>
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<tr>
<td>- Telephone visit diagnosis matching IESD diagnosis</td>
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<td>- Online assessment diagnosis matching IESD diagnosis</td>
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<tr>
<td>- If index episode was for alcohol/opioid abuse/dependence, need to have a MAT dispensing event</td>
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<tr>
<td>Compliance with Engagement of AOD Treatment:</td>
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<tr>
<td>• Two or more inpatient admissions, outpatient visits, telehealth, intensive outpatient encounters or partial hospitalizations with a diagnosis matching the IESD</td>
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<tr>
<td>• If initiation of AOD treatment was NOT a medication treatment dispensing event, one or more of the medication treatment dispensing events within 34 days of the initiation visit</td>
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<tr>
<td><strong>Sample Diagnoses for Alcohol or Other Drug Dependence (AOD)</strong></td>
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<tr>
<td>• Alcohol Abuse</td>
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<td>• Alcohol Dependence</td>
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<td>• Alcohol Use</td>
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<tr>
<td>• Opioid Abuse</td>
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<tr>
<td>• Opioid Dependence</td>
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<td>• Cannabis Abuse</td>
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<td>• Cannabis Dependence</td>
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<tr>
<td>• Sedative, hypnotic or anxiolytic Abuse</td>
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<tr>
<td>• Sedative, hypnotic or anxiolytic Dependence</td>
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<tr>
<td>• Cocaine Abuse</td>
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<td>• Cocaine Dependence</td>
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<tr>
<td>• Hallucinogen Abuse</td>
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<td>• Hallucinogen Dependence</td>
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<tr>
<td>• Inhalant Abuse</td>
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<td>• Inhalant Dependence</td>
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<tr>
<td>• Detoxification</td>
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<td>• Other Stimulant Abuse</td>
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<tr>
<td>• Other Stimulant Dependence</td>
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<tr>
<td>• Other Stimulant Use</td>
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<tr>
<td>For more information about this measure, including a list of sample codes, please visit: <a href="bcbs.com/docs/providers/quality-initiatives/15PED1074_Initiation_and_Engagement_of_Substance_Abuse.pdf">bcbs.com/docs/providers/quality-initiatives/15PED1074_Initiation_and_Engagement_of_Substance_Abuse.pdf</a></td>
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</table>

**Helpful Tips:**
- Schedule an initial follow-up visit within 14 days and two additional visits within 34 days.
- Involve your patient’s support system to encourage treatment participation.
- Screen all patients age 13 and older who are receiving mental health treatment for substance use.
- Educate your patients and their families about the importance of keeping follow-up appointments, taking medications as prescribed and staying engaged in behavioral health services.
**Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)**

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

<table>
<thead>
<tr>
<th>Measure</th>
<th>What Service Is Needed</th>
<th>What to Report (Sample of Codes and/or Diagnoses)</th>
<th>Exclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Who Qualifies for the Measure:</strong> Adults with</td>
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<tr>
<td><strong>OR</strong></td>
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<td><strong>AND</strong> Prescribed one of the following classes of antipsychotic medications:</td>
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</table>

**Antipsychotic Drug Class:**
- Miscellaneous antipsychotic agents
- Phenothiazine antipsychotics
- Thioxanthenes
- Long-acting injections
- Psychotherapeutic combinations

**What Service Is Needed?**
At least one glucose or HbA1c per measurement year

**Glucose Tests:**
- **CPT:** 80047, 80048, 80050, 80053, 80069, 82947, 82950, 82951
- **LOINC:** 10450-5, 1492-8, 1494-4, 1496-9, 1499-3, 1501-6, 1504-0, 1507-3, 1514-9, 1518-0, 1530-5, 1533-9, 1554-5, 1557-8, 1558-6, 17865-7, 20436-2, 20437-0, 20438-8, 20440-4, 26554-6, 41024-1, 49134-0, 6749-6, 9375-7

**HbA1c Tests:**
- **CPT:** 83036, 83037
- **CPTII:** 3044F, 3045F, 3046F
- **LOINC:** 17856-6, 4548-4, 4549-2

**Diabetics:**
Members who had met at least one of the following during the current or previous measurement year:
- At least two outpatient, observation, emergency department or nonacute inpatient visits on different dates of service with a diagnosis of diabetes
- At least one acute inpatient encounter with a diagnosis of diabetes
- Members dispensed one of the following on an ambulatory basis:
  - Alpha-glucosidase inhibitors
  - Amylin analogs
  - Antidiabetic combinations
  - Insulin
  - Meglitinides
  - Glucagon-like peptide-1 (GLP1) agonists
  - Sodium glucose cotransporter 2 (SGLT2) inhibitor
  - Sulfonylureas
  - Thiazolidinediones
  - Dipeptidyl peptidase-4 (DPP-4) inhibitors
- Members in hospice

**Helpful Tips:**
- Screen all your patients with schizophrenia, schizoaffective disorder and bipolar disorder that are taking antipsychotic medications yearly for diabetes.
- Explain the importance of completing lab work when ordered.
- Remember, you may be the only provider this patient sees regularly. Order these tests and also have results sent to the patient’s PCP.
<table>
<thead>
<tr>
<th>Measure</th>
<th>What Service Is Needed</th>
<th>What to Report (Sample of Codes and/or Diagnoses)</th>
<th>Exclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)</strong></td>
<td><strong>Who Qualifies for the Measure:</strong>&lt;br&gt;Children and adolescents who were dispensed antipsychotic medications with at least two unique dates of service</td>
<td><strong>Glucose Tests:</strong>&lt;br&gt;<strong>CPT:</strong> 80047, 80048, 80050, 80053, 80068, 82947, 82950, 82951&lt;br&gt;<strong>LOINC:</strong> 10450-5, 1492-8, 1494-4, 1496-9, 1499-3, 1501-6, 1504-0, 1507-3, 1514-9, 1518-0, 1530-5, 1533-9, 1554-5, 1557-8, 1558-6, 17865-7, 20436-2, 20437-0, 20438-8, 20440-4, 26554-6, 41024-1, 49134-0, 6749-6, 9375-7</td>
<td>Members in hospice</td>
</tr>
<tr>
<td></td>
<td><strong>Antipsychotic Drug Class:</strong>&lt;br&gt;• Miscellaneous antipsychotic agents&lt;br&gt;• Phenothiazine antipsychotics&lt;br&gt;• Thioxanthenes&lt;br&gt;• Long-acting injections&lt;br&gt;• Psychotherapeutic combinations</td>
<td><strong>HbA1c Tests:</strong>&lt;br&gt;<strong>CPT:</strong> 83036, 83037&lt;br&gt;<strong>CPTII:</strong> 3044F, 3045F, 3046F&lt;br&gt;<strong>LOINC:</strong> 17856-6, 4548-4, 4549-2</td>
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<tr>
<td></td>
<td><strong>What Service Is Needed?</strong>&lt;br&gt;At least one glucose or HbA1c per measurement year <strong>AND</strong> At least one LDL-C or any other cholesterol tests per measurement year</td>
<td><strong>LDL-C Tests:</strong>&lt;br&gt;<strong>CPT:</strong> 80061, 83700, 83701, 83704, 83721&lt;br&gt;<strong>CPTII:</strong> 3048F, 3049F, 3050F&lt;br&gt;<strong>LOINC:</strong> 12773-8, 13457-7, 18261-8, 18262-6, 2089-1, 49132-4, 55440-2</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td><strong>Cholesterol Tests:</strong>&lt;br&gt;<strong>CPT:</strong> 82465, 83718, 84478&lt;br&gt;<strong>LOINC:</strong> 2085-9, 2093-3, 2571-8, 3043-7, 9830-1</td>
<td></td>
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</tbody>
</table>

**Helpful Tips:**
- Help the parent or caregiver understand the importance of these tests.
- You may be the only provider this patient sees. Order these needed tests and coordinate with the PCP concerning the results.
- The 2004 recommendations from the ADA/APA include completing baseline BMI, waist circumference, blood pressure, fasting plasma glucose, and fasting lipid profile for patients on antipsychotic medications. These recommendations are upheld in a 2013 guideline from AACAP.
### Mental Health Measures

**Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)**

The percentage of members 19-64 years of age with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication at least 80 percent of their treatment period.

**Who Qualifies for the Measure:**

- Adults with at least one acute inpatient encounter with any diagnosis of schizophrenia or schizoaffective disorder.
- OR
- At least two visits in an outpatient, intensive outpatient, partial hospitalization, emergency department or nonacute inpatient setting, on different dates of service, with any diagnosis of schizophrenia or schizoaffective disorder.

**AND**

- Prescribed one of the following classes of antipsychotic medications:

  **Antipsychotic Drug Class:**
  - Miscellaneous antipsychotic agents
  - Phenothiazine antipsychotics
  - Thioxanthenes
  - Long-acting injections
  - Psychotherapeutic combinations

**Antipsychotic Medication Pharmacy Dispensing Events:**

- Miscellaneous antipsychotic agents
- Phenothiazine antipsychotics (oral)
- Psychotherapeutic combinations (oral)
- Thioxanthenes (oral)
- Long-acting injections (14-day supply)
- Long-acting injections (28-day supply)

**Long-Acting Injections:** J2794, J0401, J1631, J2358, J2426, J2680

**What to Report**

This measure is closed by pharmacy and claim data.

**Antipsychotic Medication Pharmacy Dispensing Events:**

- Miscellaneous antipsychotic agents
- Phenothiazine antipsychotics (oral)
- Psychotherapeutic combinations (oral)
- Thioxanthenes (oral)
- Long-acting injections (14-day supply)
- Long-acting injections (28-day supply)

**Exclusions**

- Members in hospice

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### Helpful Tips:

- Remind patients of the importance of medication continuation, as increased compliance could possibly prevent readmission to inpatient psychiatric facilities.
- Educate patients on potential side effects of medication.
- Encourage patients to call or come in for a visit before stopping the medication.
- Use correct diagnosis and procedure codes.
- Submit claims and encounter data in a timely manner.

### Diabetics:

Members who had met at least one of the following during the current or previous measurement year:

- At least two outpatient, observation, emergency department, or nonacute inpatient visits on different dates of service with a diagnosis of diabetes.
- At least one acute inpatient encounter with a diagnosis of diabetes.
- Members dispensed one of the following on an ambulatory basis:
  - Alpha-glucosidase inhibitors
  - Amylin analogs
  - Antidiabetic combinations
  - Insulin
  - Meglitinides
  - Glucagon-like peptide-1 (GLP1) agonists
  - Sodium glucose cotransporter 2 (SGLT2) inhibitor
  - Sulfonylureas
  - Thiazolidinediones
  - Dipeptidyl peptidase-4 (DDP-4) inhibitors

Members in hospice
<table>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Seven-and 30-Day Psychiatric Hospital / Residential Treatment Facility (RTF) Readmission Rate</strong>&lt;br&gt;The rate of readmissions within seven or 30 days of discharge from a psychiatric hospital or RTF&lt;br&gt;Two rates are calculated:&lt;br&gt;1. Seven-day&lt;br&gt;2. 30-day</td>
<td>• Inpatient psychiatric hospital claims are defined for purposes of this measure as facility claims with at least one detail line containing at least one revenue code that indicates the stay was in an inpatient psychiatric hospital. Inpatient psychiatric hospital readmissions are counted based on inpatient psychiatric hospital numerators and denominators <strong>ONLY</strong>.&lt;br&gt;• Residential treatment facility claims are defined for purposes of this measure as facility claims with at least one detail line with a revenue or procedure code indicating a residential treatment facility stay. Residential treatment facility readmissions are counted based on residential treatment facility numerators and denominators <strong>ONLY</strong>.&lt;br&gt;• Calculation for this measure is based on date of discharge to home or outpatient setting.</td>
<td>• In situations where a single claim contains both an inpatient psychiatric hospital revenue code and a residential treatment facility revenue code, the claim shall be counted as <strong>ONLY</strong> an inpatient psychiatric hospital readmission for the purpose of this metric. This rule applies to both the seven-day and 30-day readmission rates.&lt;br&gt;<strong>Follow-up appointments after discharge along with appropriate after care services will help impact readmission rates.</strong></td>
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### Mental Health Measures

<table>
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<tbody>
<tr>
<td><strong>Antidepressant Medication Management (AMM)</strong></td>
<td>The percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment.</td>
<td><strong>This measure is closed by pharmacy and claim data.</strong></td>
<td>Exclude members who did not have a diagnosis of major depression in an inpatient, outpatient, ED, intensive outpatient or partial hospitalization, or telehealth setting from 60 days prior to the IPSD, through the IPSD and 60 days after the IPSD.</td>
</tr>
</tbody>
</table>

#### Helpful Tips:

- Educate your patients and their families about the importance of keeping follow-up appointments, taking medicine as prescribed and staying engaged in behavioral health services.
- Align refills with follow-up visits to motivate patients to attend their appointments.
- Consider adding telehealth options for patients who may have trouble attending office visits due to living in a rural area or access to transportation.
- There are allowable gaps for the acute and continuation treatment phases (acute up to 31 days and continuation up to 52 days). This means you can close gaps, even if patients forget to refill their medication on schedule.
- Talk with your patients about the potential side effects of a medication. Encourage them to call or come in for a visit before stopping the medication.
- Use correct diagnosis and procedure codes, and submit claims and encounter data in a timely manner.
## Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)

The percentage of emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow-up visit for AOD.

### Two rates are reported:

1. The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days)
2. The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days)

<table>
<thead>
<tr>
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<th>Exclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)</strong></td>
<td>A follow-up visit with a principal diagnosis of alcohol and other drug dependence must be used to meet follow-up criteria within the specified time frame.</td>
<td>Standalone Visits: 98960, 98961, 98962, 99078, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, 99241, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99384, 99385, 99386, 99387, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99405, 99406, 99409, 99411, 99412, 99510</td>
<td>Members in hospice or using hospice services</td>
</tr>
</tbody>
</table>

### Helpful Tips:

- A principal diagnosis of alcohol and other drug dependence must be used to meet follow-up criteria.
- A telehealth visit with a principal diagnosis of alcohol and other drug dependence will meet criteria for a follow-up visit.
- Maintain appointment availability in your schedule to accommodate needed hospital discharge follow-up visits.
- Explain the importance of follow-up to your patients.
- Schedule the second appointment before the patient leaves your office and ensure that the next appointment is within 30 days of discharge.
- Reach out to patients that do not keep their initial follow-up appointment and reschedule the visit for as soon as possible.
- Visits that occur on the same day of the ED visit will meet criteria for this measure.
- This is an episodes-based measure. Members could enter this measure multiple times as long as ED visits are greater than 30 days apart.
- Follow-up is required within the specified time frame for measure compliance each time a member enters this measure.
### Measure

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

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

**Two rates are reported:**

1. The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days)
2. The percentage of ED visits for which the member received follow-up within seven days of the ED visit (8 total days)

### What Service Is Needed

A follow-up visit with any practitioner, with a principal diagnosis of a mental health disorder or with a principal diagnosis of intentional self-harm and any diagnosis of a mental health disorder, must be used to meet follow-up criteria within the specified time frame.

### What to Report

**(Sample of Codes and/or Diagnoses)**

**Sample Diagnoses:**
- Dementia
- Schizophrenia
- Schizoaffective disorder
- Manic episode
- Bipolar disorder
- Major depressive disorder
- Post-traumatic stress disorder
- Attention-deficit hyperactivity disorder
- Mental Illness

**CPT Codes:**
- 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99408-99409, 99411-99412, 99510

**HCPCS Codes:**

### Exclusions

Members in hospice or using hospice services

Exclude ED visits that result in an inpatient stay and ED visits followed by admission to an acute or nonacute inpatient care setting on the date of the ED visit or within the 30 days after the ED visit (31 total days), regardless of the principal diagnosis for the admission.

### Helpful Tips:

- A telehealth visit with a principal diagnosis of a mental health disorder or with a principal diagnosis of intentional self-harm and any diagnosis of a mental health disorder will meet criteria for a follow-up visit.
- Explain the importance of follow-up to your patients.
- Schedule the second appointment before the patient leaves your office and ensure that the next appointment is within 30 days of the ED visit.
- Reach out to patients that do not keep their initial follow-up appointment and reschedule the visit for as soon as possible.
- Visits that occur on the same day of the ED visit will meet criteria for this measure.
- This is an episodes-based measure. Members could be in this measure multiple times as long as ED visits are greater than 30 days apart.
- Follow-up is required within the specified time frame for measure compliance each time a member enters this measure.
### Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)

The percentage of children and adolescents 1-17 years of age who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment (90 days before up to 30 days after prescription was dispensed)

#### What Service Is Needed

Documentation of psychosocial care conducted (can be telehealth), sometime between 90 days prior to the member filling medication through 30 days after the member fills medication.

#### What to Report (Sample of Codes and/or Diagnoses)

- **Psychosocial Care CPT:** 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90846, 90847, 90849, 90853, 90875, 90876, 90880

#### Exclusions

Members in hospice or using hospice services

#### Helpful Tips:

- Providers should refer children/adolescents to behavioral health therapy and coordinate with the therapist prior to starting them on antipsychotics (except for children diagnosed with schizophrenia, bipolar disorder, or other psychotic disorder).

For more mental health resources, please visit: [https://www.bcbst.com/providers/Behavioral-Health-Toolkit/HEDIS.page?nav=calltoaction](https://www.bcbst.com/providers/Behavioral-Health-Toolkit/HEDIS.page?nav=calltoaction)
**Improving the Patient Experience with Care Coordination**

Every year, we ask our members to take the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. This annual check-in gives us a chance to find out about our members’ experiences with the health care system.

As part of the survey, your patients who are BlueCare Tennessee members rate their experiences with their health plan and providers. They also provide feedback on their ability to:

- Get needed care quickly
- Share in the decision-making process
- Communicate with their providers

CAHPS results highlight key areas where health plans and providers can work together to improve the patient experience. One example of this is care coordination, which helps improve patients’ health and wellness – and their overall health care experience. CAHPS data also shows that providers can address many patient concerns by using basic principles of care coordination, such as:

- Discussing care patients received at the emergency room and from other providers
- Following up with patients and their other providers to communicate test results
- Helping patients schedule appointments with specialists
- Providing timely appointments
- Reviewing current medications from all providers during office visits

The CAHPS survey is a requirement of the National Committee for Quality Assurance, and we mail the survey to our members between February and May. For more information about the survey and information collected, please visit [ahrq.gov](http://ahrq.gov) or [cms.gov](http://cms.gov).
## Contact Information

<table>
<thead>
<tr>
<th>24/7 Nurseline</th>
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</thead>
<tbody>
<tr>
<td><strong>Phone</strong></td>
<td>1-800-262-2873</td>
</tr>
</tbody>
</table>

### Customer Service/Provider Services – Authorizations, Benefits, Claims and Billing

<table>
<thead>
<tr>
<th>BlueCare™</th>
<th>1-800-468-9736</th>
</tr>
</thead>
<tbody>
<tr>
<td>TennCareSelect</td>
<td>1-800-276-1978</td>
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</table>

### Customer Service/Member Services

<table>
<thead>
<tr>
<th>BlueCare™</th>
<th>1-800-468-9698</th>
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<tbody>
<tr>
<td>TennCareSelect</td>
<td>1-800-263-5479</td>
</tr>
</tbody>
</table>

### Provider Incentive and Engagement Team – General Mailbox

<table>
<thead>
<tr>
<th>Email</th>
<th><a href="mailto:TennCarePCMH@bcbst.com">TennCarePCMH@bcbst.com</a></th>
</tr>
</thead>
</table>

### Transportation – For members to schedule a ride through Southeastrans*

<table>
<thead>
<tr>
<th>BlueCare™ East</th>
<th>1-866-473-7563</th>
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</thead>
<tbody>
<tr>
<td>BlueCare™ Middle</td>
<td>1-866-570-9445</td>
</tr>
<tr>
<td>BlueCare™ West</td>
<td>1-866-473-7564</td>
</tr>
<tr>
<td>TennCareSelect Statewide</td>
<td>1-866-473-7565</td>
</tr>
<tr>
<td>Online</td>
<td>member.southeastrans.com</td>
</tr>
</tbody>
</table>

*Rides are guaranteed only if scheduled 72 hours prior to the visit.

### Pharmacy Benefits: Magellan Health Services

<table>
<thead>
<tr>
<th><strong><a href="https://tenncare.magellanhealth.com/tenncare_portal/spring/main">https://tenncare.magellanhealth.com/tenncare_portal/spring/main</a></strong></th>
</tr>
</thead>
</table>

### Magellan Health Services Technical Call Center (Pharmacy Help Desk)

<table>
<thead>
<tr>
<th><strong>Phone</strong></th>
<th>1-866-434-5520</th>
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</thead>
</table>

### Magellan Health Services Clinical Call Center (Prior Authorizations)

<table>
<thead>
<tr>
<th><strong>Phone</strong></th>
<th>1-866-434-5524</th>
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<tbody>
<tr>
<td><strong>Fax</strong></td>
<td>1-866-434-5523</td>
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</tbody>
</table>

### For Technical Support

Contact our eBusiness team at 1-800-924-7141, Option 4, or at ebusiness_service@bcbst.com.

### For Program-Related Support

Contact a Customer Service Professional (CSP) in Provider Interplan Operations (PIO) or BlueCare Provider Service at 1-800-468-9736, and enter a Member ID or your Provider Identification Number in the IVR.

### For Tools and Resources

<table>
<thead>
<tr>
<th><strong>Website</strong></th>
<th>bluecare.bcbst.com/providers</th>
</tr>
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</table>
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