BlueCare Tennessee

QUALITY

Quality Program Measures

BLUECARE TENNESSEE

Thank you for your participation in BlueCare Tennessee 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,
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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 2020 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 (PCP) during their first 15 months of life **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	**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 **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. If handouts are provided, documentation must include the discussion of the materials to meet criteria. • Documentation of **well developed, well nourished** will **not** meet the intent of the measure. It must be more specific.	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 **Note:** Services provided via telehealth won't count for measure compliance.	Members in hospice or using hospice services

Helpful Tips:

- Use your member roster to contact members who are due for an exam or are new to your practice, and use your electronic medical record (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.
- Follow the Bright Futures schedule available at https://www.aap.org/en-us/Documents/periodicity_schedule.pdf.
- Explain the importance of the 30-month visit to parents during the 24-month visit.

*HEDIS general guidelines specify that members in hospice are excluded from all HEDIS measures.

Measure	What Service Is Needed	What to Report (Sample of Codes and/or Diagnoses)	Exclusions
Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life (W34) The percentage of members who were 3, 4, 5 or 6 years of age who received one or more well-child visits with a primary care provider during the measurement year **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 or OB/GYN during the measurement year	**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 **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. If handouts are provided, documentation must include the discussion of the materials to meet criteria. • Documentation of **well developed, well nourished** will **not** meet the intent of the measure. It must be more specific.	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 **Note:** Services provided via telehealth won't count for measure compliance.	Members in hospice or using hospice services

Helpful Tips:

- Use sick visits to remind parents about needed well-care visits and schedule a follow-up appointment if you're unable to combine an acute visit and well-care visit on the same day.
- Convert sports physicals to well-care visits.

Measure	What Service Is Needed	What to Report (Sample of Codes and/or Diagnoses)	Exclusions
Childhood Immunization Status (CIS) Combo 10 The percentage of children 2 years of age who completed all specified vaccines by their second birthday	All doses of each series must be completed on or before the child's second birthday. **Immunization Description:** • 4 Diphtheria, tetanus and pertussis (DTaP)* • 3 Polio (IPV)* • 1 Measles, mumps and rubella (MMR)* • 3 H influenza type B (HiB)* • 3 Hepatitis B (HepB)* • 1 Varicella (chicken pox) (VZV)* • 4 Pneumococcal (PCV)* • 2 or 3 Rotavirus (RV) (required dosage) • 2 Influenza (flu) • 1 Hepatitis A (HepA) *Immunization refusal will not remove a member from the denominator of this measure **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 after second birthday • No record in primary care physician file when immunized elsewhere • No documentation of contraindication, allergy or immunization refusal • No documentation that the first HepB immunization was given at birth/hospital	For children before or on their second birthday: **DTaP CPT®:** 90698, 90700, 90721, 90723 **IPV CPT®:** 90698, 90713, 90723 **HiB CPT®:** 90644, 90645, 90646, 90647, 90648, 90698, 90721, 90748 **HepB CPT®:** 90723, 90740, 90744, 90747, 90478 **HepB HCPCS:** G0010 **VZV CPT®:** 90710, 90716 **PCV CPT®:** 90670 **PCV HCPCS:** G0009 **HepA CPT®:** 90633 **RV (2-dose schedule) CPT®:** 90681 **RV (3-dose schedule) CPT®:** 90680 **Influenza CPT®:** 90655, 90657, 90661, 90662, 90673, 90685, 90686, 90687, 90688, 90689 **Influenza HCPCS:** G0008 **Influenza CPT® - LAIV for 2 years and older only:** 90660, 90672 **MMR vaccine:** 90707, 90710 **Measles vaccine:** 90705 **Measles/rubella vaccine:** 90708 **Mumps vaccine:** 90704 **Rubella vaccine:** 90706	Exclude children who had a contraindication for a specific vaccine from the denominator for all antigen rates and the combination rates. Members in hospice or using hospice services

Helpful Tips:

- The flu vaccine should be given after the member is 6 months of age.
- Members who are too young to receive a flu shot during their first year of life still need to receive two flu shots before their second birthday. These vaccines can be provided 30 days apart.
- A live attenuated influenza vaccine (LAIV) can be given if the member receives the vaccine on their second birthday.

Measure	What Service Is Needed	What to Report (Sample of Codes and/or Diagnoses)	Exclusions
Adolescent Immunizations (IMA) Percentage of adolescents 13 years of age who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday	**For adolescents before they turn age 13:** • 1 meningococcal vaccine between ages 11 through 13 • 1 Tdap between ages 10 and 13 • 2 HPV vaccines at least 146 days apart between ages 9 and 13 **OR** • 3 HPV vaccines with different dates of service between ages 9 and 13 **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	**HPV:** 90649, 90650, 90651 **Meningococcal:** 90734 **Tdap:** 90715	Exclude children who had a contraindication for a specific vaccine from the denominator for all antigen rates and the combination rates. Members in hospice or using hospice services

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 move forward with vaccination.
- Discuss the importance of annual well-child visits for adolescents, which will provide an opportunity to discuss and administer vaccines.

Measure	What Service Is Needed	What to Report (Sample of Codes and/or Diagnoses)	Exclusions
Weight Assessment and Counseling for Nutrition (WCC) Percentage of members 3-17 years of age who had an outpatient visit with a PCP or OB/GYN and had evidence of body mass index (BMI) percentile documentation, counseling for nutrition, and counseling for physical activity during the measurement year	**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 **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 Referral to WIC may be used to meet this criteria. **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	BMI Percentile: **ICD-10:** **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** Nutrition Counseling: **Dietary counseling and surveillance ICD-10:** Z71.3 **Medical nutrition therapy and counseling visits (dietitian professionals) CPT® and HCPCS:** G0270, G0271, 97802, 97803, 97804, S9470 **Face-to-face behavioral counseling for obesity HCPCS:** G0447 **Weight management and nutrition classes (non-physician) HCPCS:** S9449, S9452 Counseling for Physical Activity: **Exercise counseling ICD-10:** Z71.82 **Face-to-face behavioral counseling for obesity HCPCS:** G0447 **Exercise classes (non-physician provider) HCPCS:** S9451 **Encounter for examination for participation in sport ICD-10:** Z02.5	Female members who have a diagnosis of pregnancy during the measurement year. There must be documentation in the medical record indicating a pregnancy diagnosis. Members in hospice or using hospice services

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.
- Use shared decision-making to involve the member when you discuss physical activity and nutrition changes. For more information, see: https://www.ahrq.gov/health-literacy/curriculum-tools/shareddecisionmaking/index.html.

Measure	What Service Is Needed	What to Report (Sample of Codes and/or Diagnoses)	Exclusions
Breast Cancer Screening (BCS) Percentage of women, 50-74 years of age, who have had a mammogram to screen for breast cancer **Screening is needed every two years.**	**All types and methods of mammograms (screening, diagnostic, film, digital or 3D tomosynthesis) qualify for numerator compliance.** **Do NOT count MRIs, Ultrasounds or Biopsies.** These procedures are performed as an adjunct to mammography and do not meet measure compliance.	Mammography: **CPT®:** 77055, 77056, 77057, 77061, 77062, 77063, 77065, 77066, 77067 **HCPCS:** G0202, G0204, G0206 **Rev Code:** 0401, 0403	Members in hospice or using hospice services Members with a history of mastectomy (bilateral, two unilateral, or unilateral with a bilateral modifier) Members 66 years of age and older with frailty **and** advanced illness

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.
- Use flu season as an opportunity to promote screening.
- Identify an office champion who will lead outreach efforts for members in need of a mammogram.

Measure	What Service Is Needed	What to Report (Sample of Codes and/or Diagnoses)	Exclusions
Cervical Cancer Screening (CCS) The percentage of women 21-64 years of age who were screened for cervical cancer	**One of the following is needed to meet measure criteria:** • Women 21-64 years of age who had cervical cytology performed within the last 3 years • Women 30-64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years • Women 30-64 years of age who had cervical cytology/high-risk human papillomavirus (hrHPV) cotesting within the last 5 years	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	Hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix Members in hospice or using hospice services

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.
- Use flu season as an opportunity to promote screening.
- Identify an office champion who will lead outreach efforts for members in need of screening.

Measure	What Service Is Needed	What to Report (Sample of Codes and/or Diagnoses)	Exclusions
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	**Test for Chlamydia:** Urine test or cervical cell sample during the measurement year Members are identified as sexually active based on pharmacy and claim/encounter data. Members using any form of contraception are considered sexually active.	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, 31777-6, 36902-5, 36903-3, 43304-5, 43404-3, 43405-0, 43406-8, 44807-6, 45067-6, 45068-4, 45069-2, 45070-0, 45076-7, 45078-3, 45080-9, 45084-1, 45091-6, 45095-7, 45098-1, 45100-5, 47211-8, 47212-6, 49096-1, 4993-2, 50387-0, 53926-2, 557-9, 560-3, 6349-5, 6354-5, 6355-2, 6356-0, 80361-9, 80362-7	Members in hospice or using hospice services

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.
- Use flu season as an opportunity to promote screening.
- Identify an office champion who will lead outreach efforts for members in need of screening.

Measure	What Service Is Needed	What to Report (Sample of Codes and/or Diagnoses)	Exclusions
Prenatal and Postpartum Care (PPC) The percentage of deliveries of live births on or between Oct. 8 of the year prior to the measurement year and Oct. 7 of the measurement year that received the following facets of prenatal and postpartum care: • **Timeliness of Prenatal Care –** The percentage of deliveries that received a prenatal care visit within the first trimester, on or before the enrollment start date, or within 42 days of enrollment in the organization • **Postpartum Care**: The percentage of deliveries that had a postpartum visit on or between seven and 84 days after delivery	**Compliance with Timeliness of Prenatal Care:** Prenatal care visit to an OB/GYN or other prenatal care practitioner, or PCP, during the first trimester. 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: • Basic physical OB examination that includes auscultation of fetal heart tone **OR** pelvic exam with obstetric observations **OR** measurement of fundus height • 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 • Documentation of LMP or EDD in conjunction with either of the following: prenatal risk assessment and counseling/ education **OR** complete obstetrical history • Prenatal care visit to an OB/GYN or other prenatal care practitioner or PCP during the first trimester **Compliance with Postpartum Care:** Postpartum visit to an OB/GYN or other prenatal care practitioner, or PCP, on or between 7 and 84 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: • Pelvic exam • Evaluation of weight, blood pressure, and breasts and abdomen – notation of breastfeeding is acceptable for the evaluation of breasts • Notation of postpartum care (postpartum care, postpartum check, six-week check or a pre-printed postpartum care form completed during the visit) • Perineal or cesarean incision/wound check • Screening for depression, anxiety, tobacco use, substance use disorder, or preexisting mental health disorders • Glucose screening for women with gestational diabetes • Documentation of any of the following topics: - Infant care or breastfeeding - Resumption of intercourse, birth spacing or family planning - Sleep/fatigue - Resumption of physical activity and attainment of healthy weight	Prenatal: **Prenatal Stand-Alone Visits:** **CPT®:** 99500 **CPT®II:** 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 **CPT®II:** 0503F **HCPCS:** G0101 **ICD-10:** Z01.411, Z01.419, Z01.42, Z30.430, Z39.1, Z39.2 **Postpartum Bundled Services:** **CPT®:** 59400, 59410, 59510, 59515, 59610, 59614, 59618, 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 *Do not include care provided in an acute inpatient setting.	Members in hospice or using hospice services

Measure	What Service Is Needed	What to Report (Sample of Codes and/or Diagnoses)	Exclusions
Adult BMI (ABA) Percentage of members 18-74 years of age who had an outpatient visit and whose body mass index (BMI) was documented during the measurement year or year prior to the measurement year	**Percentage who had an outpatient visit during the measurement year or year prior** **Documentation:** • Documentation must indicate the dated weight/height and BMI value from the same data source. • 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. • Members ages 20 or older on the date of service must have BMI value and weight documented. **Common Documentation Errors to Avoid:** • Height and/or weight documented without BMI calculation • BMI documented as a value instead of percentile for members younger than age 20 • BMI ranges documented	Encounter/Claim with Codes: **Adult BMI:** **BMI 19 or less:** Z68.1 **BMI 20.0 – 23.9:** Z68.20-Z68.23 **BMI 24.0 – 29.9:** Z68.24-Z68.29 **BMI 30.0 – 39.9:** Z68.30-Z68.39 **BMI 40.0 – 49.9:** Z68.41-Z68.42 **BMI 50 – 59.9:** Z68.43 **BMI 60.0 – 69.9:** Z68.44 **BMI 70 or greater:** Z68.45 **Pediatric BMI Percentile:** **BMI <5th percentile for age:** Z68.51 **BMI 5th percentile – <85th percentile:** Z68.52 **BMI 85th percentile – <95th percentile:** Z68.53 **BMI ≥ 95th percentile:** Z68.54	Members in hospice or using hospice services Female members who have a diagnosis of pregnancy during the measurement year or year prior to the measurement year

Measure	What Service Is Needed	What to Report (Sample of Codes and/or Diagnoses)	Exclusions
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	**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 • 3051F – ≥ 7.0 - < 8.0 • 3052F – ≥ 8.0 - ≤ 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 Members in hospice or using hospice services

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Measure	What Service Is Needed	What to Report (Sample of Codes and/or Diagnoses)	Exclusions
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	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.	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 Members in hospice or using hospice services

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.
- 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 codes on the claim form to help reduce the burden of medical record review.
- Use CPT® II codes to document the lowest blood pressure results from readings taken on the same day.
- Use clinical guidelines to inform disease management and prescribing decisions:
  - https://care.diabetesjournals.org/content/42/Supplement_1
  - https://www.aace.com/disease-state-resources/diabetes/guidelines
- Consider referring patients to their local health department to find and register for a Diabetes Self-Management Program. You can learn more about these programs here: https://www.tn.gov/health/health-program-areas/mch-diabetes/d/take-charge-of-your-diabetes.html.
- Collaboration between the primary care providers and specialist providers managing members' care can help identify and close gaps in care.

Measure	What Service Is Needed	What to Report (Sample of Codes and/or Diagnoses)	Exclusions
Controlling High Blood Pressure (CBP) Percentage of members 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mm Hg) during the measurement year	The most recent blood pressure reading during the measurement year on or after the second diagnosis of hypertension • If multiple blood pressure measurements occur on the same date, or are noted in the chart on the same date, use the lowest systolic and lowest diastolic blood pressure reading • If no blood pressure is recorded during the measurement year, assume that the member is "not controlled." Any of the following code combinations meet criteria: • Outpatient visit 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	Pregnancy during the measurement year Members in hospice or using hospice services Members with evidence of end-stage renal disease, dialysis, nephrectomy or kidney transplant on or before Dec. 31 of the measurement year Members who had a nonacute inpatient admission during the measurement year

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.
- The last reading in the measurement year will be used to meet compliance for this measure.
- 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.
- Review evidence-based guidelines to stay up to date on treatment recommendations: https://jamanetwork.com/journals/jama/fullarticle/1791497.

Measure	What Service Is Needed	What to Report (Sample of Codes and/or Diagnoses)	Exclusions
Asthma Medication Ratio (AMR) Percentage of members 5 to 64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 50 percent or greater during the measurement year (Units of Controller Medication) (Units of Controller Medication + Units of Reliever Medication)	**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.** • One emergency department (ED) visit, with a principal diagnosis of asthma • One Inpatient visit, with a principal diagnosis of asthma without telehealth • Four outpatient visits, observation visits, telephone visits or online assessments, on different dates of service, with any diagnosis of asthma* plus two asthma medication dispensing events - controller or reliever • Four Medication-dispensing events - controller or reliever • One acute inpatient discharge, with a principal diagnosis of asthma *Only 3 of the 4 visits may be an outpatient telehealth visit, a telephone visit or an online assessment.	**This measure is based on a ratio.** 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. **Asthma Controller Descriptions:** • Anti-asthmatic combinations • Antibody inhibitor • Anti-interleukin-5 • Inhaled steroid combinations • Inhaled corticosteroids • Leukotriene modifiers • Methlxanthines Visits containing the following asthma diagnoses will qualify a patient for this measure: • **Mild intermittent asthma** - with (acute) exacerbation or with status asthmaticus • **Mild, moderate or severe persistent asthma** - with (acute) exacerbation or with status asthmaticus • **Unspecified asthma** - with (acute) exacerbation or status asthmaticus • **Exercise-induced bronchospasm** • **Cough variant asthma** • **Other asthma**	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 or reliever medications dispensed during the year Members in hospice or using hospice services

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.
- Create or review an Asthma Action plan for members with asthma to help reduce or prevent flare-up and ED visits. You can learn more at: https://www.nhlbi.nih.gov/files/docs/public/lung/asthma_actplan.pdf or https://cdc.gov/asthma/actionplan.html.
- Review evidence-based guidelines to stay up to date with appropriate treatment recommendations: https://www.nhlbi.nih.gov/sites/default/files/publications/08-5846.pdf.
- Collaboration between the primary care providers and specialist providers managing members' care can help identify and close gaps in care.

Measure	What Service Is Needed	What to Report (Sample of Codes and/or Diagnoses)	Exclusions
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	**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 ED visit with a principal diagnosis of asthma • At least one acute inpatient encounter with a principal diagnosis of asthma **without** telehealth • At least one acute inpatient discharge with a principal diagnosis of asthma • At least four outpatient visits, observation visits, telephone visits or online assessments, 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 **Asthma Controller Medications:** • Anti-asthmatic combinations: Dyphylline-guaifenesin; Guaifenesin-theophylline • Antibody inhibitor: Omalizumab • Anti-interleukin-5: Mepolizumab, Reslizumab, Benralizumab • Inhaled steroid combinations: Budesonide-formoterol, Fluticasone-salmeterol, Fluticasone-vilanterol, Mometasone-formoterol • Inhaled corticosteroids: Beclomethasone, Budesonide, Ciclesonide, Flunisolide, Fluticasone CFC free, Mometasone • Leukotriene modifiers: Montelukast, Zafirlukast, Zileuton • Methlxanthines: Dyphylline, Theophylline **Asthma Reliever Medications:** • Short-acting inhaled beta-2 agonists: Albuterol, Levalbuterol	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. **Measure 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.	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 or using hospice services

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).
- Develop a written Asthma Action plan in partnership with the member/family to enhance self-management and education. Learn more about writing these plans here: https://www.nhlbi.nih.gov/sites/default/files/publications/07-5251.pdf.
- Stay up to date with TennCare formulary updates to make any needed changes to patients' regimens to ensure their access to medication isn't interrupted.
- Collaboration between the primary care providers and specialist providers managing members' care can help identify and close gaps in care.

Measure	What Service Is Needed	What to Report (Sample of Codes and/or Diagnoses)	Exclusions
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB) The percentage of episodes for members ages 3 months and older with a diagnosis of acute bronchitis/bronchiolitis that did not result in an antibiotic dispensing event	**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: **ICD-10:** J20.3, J20.4, J20.5, J20.6 ,J20.7, J20.8, J20.9, J21.0, J21.1, J21.8, J21.9	Documentation of a comorbid condition during the 12 months prior to or on the Episode Date: • COPD • Emphysema • HIV • Cancer • 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 Centers for Disease Control and Prevention and BlueCross BlueShield of Tennessee in your waiting room and treatment areas.
- If the member's condition doesn't improve and an antibiotic is indicated, a gap will not occur if the antibiotic is given more than three days after the encounter when bronchitis was diagnosed.
- 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

Measure	What Service Is Needed	What to Report (Sample of Codes and/or Diagnoses)	Exclusions
Appropriate Treatment for Upper Respiratory Infection (URI) The percentage of episodes for members 3 months of age and older with a diagnosis of upper respiratory infection (URI) that didn't result in an antibiotic-dispensing event	**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: **ICD-10:** 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 Any members with a claim/encounter with a diagnosis for the following comorbid conditions during the 12 months prior to or on the Episode Date: • HIV or HIV Type 2 • Emphysema • COPD • Cancer • Disorders of the immune system

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 more than three days after the encounter when a URI was diagnosed.

Appropriate Testing for Pharyngitis (CWP) The percentage of episodes for members 3 years old and older where the member was diagnosed with pharyngitis, dispensed an antibiotic, and received a group A streptococcus (strep) test for the episode	**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, 18481-2, 31971-5, 49610-9, 5036-9, 60489-2, 626-2, 6557-3, 6558-1, 6559-9, 68954-7, 78012-2	Members in hospice or using hospice services Any members with a claim/encounter with a diagnosis for the following comorbid conditions during the 12 months prior to or on the Episode Date: • HIV or HIV Type 2 • Emphysema • COPD • Cancer • Disorders of the immune system

Helpful Tips:
- 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.
- Educate members about the difference between viral and bacterial infections.
- If the patient receives a negative group A strep test but still wants treatment with medication, consider writing a prescription for an over-the-counter (OTC) medication for symptom control.
  - TennCare covers OTC products for children under 21, which may be subject to prior authorization requirements.
  - Refer to https://www.tn.gov/tenncare/providers/pharmacy.html for TennCare-covered OTC products.

Measure	What Service Is Needed	What to Report (Sample of Codes and/or Diagnoses)	Exclusions
Pharmacotherapy Management of COPD Exacerbation (PCE) Percentage of COPD Exacerbations for members 40 years of age and older who had an acute inpatient discharge or ED visit on or between Jan. 1-Nov. 30 of the measurement year and who were dispensed appropriate medications	**Members need to be prescribed and fill the following medications:** • A systemic corticosteroid (or have evidence of an active prescription) within 14 days of an inpatient discharge or ED visit • A bronchodilator (or have evidence of an active prescription) within 30 days of an inpatient discharge or ED visit **Members with COPD Exacerbation are identified by:** • An ED 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. **COPD Systemic Corticosteroid Description:** • **Glucocorticoids** - Cortisone-acetate - Dexamethasone - Hydrocortisone - Methylprednisolone - Prednisolone - Prednisone **COPD Bronchodilators Description:** • **Anticholinergic Agents** - Albuterol-ipratropium - Aclidinium-bromide - Ipratropium - Tiotropium - Umeclidinium • **Beta 2-agonists** - Albuterol - Arformoterol - Budesonide-formoterol - Fluticasone-salmeterol - Fluticasone-vilanterol - Formoterol - Formoterol-glycopyrrolate - Indacaterol - Indacaterol-glycopyrrolate - Levalbuterol - Mometasone-formoterol - Metaproterenol - Olodaterol hydrochloride - Olodaterol-tiotropium - Salmeterol - Umeclidinium-vilanterol • **Antiasthmatic Combinations** - Dyphylline-guaifenesin	COPD **ICD-10:** J44.0, J44.1, J44.9 Chronic Bronchitis **ICD-10:** J41.0, J41.1, J41.8, J42 Emphysema **ICD-10:** J43.0, J43.1, J43.2, J43.8, J43.9	Members in hospice or using hospice services

Helpful Tips:

- Contact members who've recently received care in the ED or been discharged from the hospital to determine if they were given prescriptions to fill or if they've encountered any problems getting their medications filled (e.g., member was given a prescription for albuterol nebulizer solution, but doesn't have a nebulizer at home or the prescription requires a prior authorization).
- Refer to current evidence-based guidelines to inform any treatment decisions: https://goldcopd.org/wp-content/uploads/2018/11/GOLD-2019-v1.7-FINAL-14Nov2018-WMS.pdf.
- Educate members about symptom triggers.
- Collaboration between the primary care providers and specialist providers managing members' care can help identify and close gaps in care.

Measure	What Service Is Needed	What to Report (Sample of Codes and/or Diagnoses)	Exclusions
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 (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.** **Members Identified By:** • Outpatient visit with a principal diagnosis of uncomplicated low back pain • 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	Uncomplicated Low Back Pain **ICD-10:** M47.26, M47.27, M47.28, M47.816, M47.817, M47.818, M47.896, M47.897, M47.898, M48.06, M48.07, M48.08, M51.16, M51.17, M51.26, M51.27, M51.36, M51.37, M51.86, M51.87, M53.2X6, M53.2X7, M53.2X8, M53.3, M53.86, M53.87, M53.88, M54.16, M54.17, M54.18, M54.30, M54.31, M54.32, M54.40, M54.41, M54.42, M54.5, M54.89, M54.9, M99.03, M99.04, M99.23, M99.33, M99.4, M99.53, M99.63, M99.73, M99.83, M99.84, S33.100A, S33.100D, S33.100S, S33.110A, S33.110D, S33.110S, S33.120A, S33.120D, S33.120S, S33.130A, S33.130D, S33.130S, S33.140A, S33.140D, S33.140S, S33.5XXA, S33.6XXA, S33.8XXA, S33.9XXA, S39.002A, S39.002D, S39.002S, S39.012A, S39.012D, S39.012S, S39.092A, S39.092D, S39.092S, S39.82XA, S39.82XD, S39.82XS, S39.92XA, S39.92XD, S39.92XS	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 28 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.
- Consider using one of these Red Flags screening tools when determining if imaging is appropriate:
  - https://www.jacr.org/article/S1546-1440(17)30308-3/fulltext
  - https://www.jospt.org/doi/full/10.2519/jospt.2011.3618
- Encourage patients to try conservative treatments, such as:
  - Ice or heat
  - OTC pain relief
  - Stretching or back strengthening exercises
  - Safe back habits

Measure	What Service Is Needed	What to Report (Sample of Codes and/or Diagnoses)	Exclusions
Statin Therapy for Patients with Cardiovascular Disease (SPC) The percentage of males 21-75 years of age and females 40-75 years of age during the measurement year, who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and met the following criteria **Two rates are reported:** **1. Received Statin Therapy:** Members who were dispensed at least one high-intensity or moderate-intensity statin medication during the measurement year **2. Statin Adherence 80 percent:** Members who remained on a high-intensity or moderate-intensity statin medication for at least 80 percent of the treatment period	**Who Qualifies for the Measure:** **Male members ages 21-75 and female members ages 40-75 who had one of the following during the previous year:** • Myocardial infarction (MI) • Coronary artery bypass grafting (CABG) • Percutaneous coronary intervention (PCI) • Other revascularization **OR** Ischemic vascular disease (IVD) diagnosis during the previous and current year **Services Required:** 1. Member needs to receive high-intensity or moderate-intensity statin therapy medication during current year **AND** 2. Remain adherent to statin therapy for at least 80 percent of the treatment period, which is defined by time period from first statin therapy dispensing event to the end of the year	This is a medication receipt and adherence measure. The following statins qualify for compliance: **High-Intensity Statin Therapy:** • Atorvastatin 40-80 mg • Amlodipine-atorvastatin 40-80 mg • Rosuvastatin 20-40 mg • Simvastatin 80 mg • Ezetimibe-simvastatin 80 mg **Moderate-Intensity Statin Therapy:** • Atorvastatin 10-20 mg • Amlodipine-atorvastatin 10-20 mg • Rosuvastatin 5-10 mg • Simvastatin 20-40 mg • Ezetimibe-simvastatin 20-40 mg • Pravastatin 40-80 mg • Lovastatin 40 mg • Fluvastatin 40-80 mg • Pitavastatin 2-4 mg	Members in hospice or receiving hospice services Members with myalgia, myositis, myopathy or rhabdomyolysis during the measurement year Any of the following during the measurement year or year prior to the measurement year: • Female members with a diagnosis of pregnancy • Members in In vitro fertilization • Members dispensed at least one prescription for clomiphene • Members with end-stage renal disease (ESRD) or dialysis • Members with cirrhosis

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 their prescription every month.
- Refer to current evidence-based guidelines to inform treatment decisions about secondary prevention and risk reduction for patients with ASCVD:
  - http://www.onlinejacc.org/content/accj/58/23/2432.full.pdf?_ga=2.68030998.623068092.1570741812-1843331403.1570741812.
- If a member cannot tolerate a statin due to myalgia, myositis or myopathy, a claim with this diagnosis must be submitted during each year the member experiences this condition and remains eligible for this measure.
- Collaboration between the primary care providers and specialist providers managing members' care can help identify and close gaps in care.
- Try to avoid concurrent use of statins and drugs known to increase the risk of rhabdomyolysis and myopathy. Monitor your patient closely if concurrent use is warranted. Examples include:
  - Strong CYP3A4 Inhibitors (Clarithromycin, Itraconazole, Protease Inhibitors)
  - Cyclosporine
  - Fibric Acid Derivatives (e.g., gemfibrozil)
  - Niacin (≥ 1g/day)
- For assistance with managing patients with possible statin intolerance, use the Statin Intolerance Tool developed by the American College of Cardiology (ACC): https://tools.acc.org/StatinIntolerance/?_ga=2.18511097.1791122370.1547228822-414277823.1547228822#!/content/home/.

Measure	What Service Is Needed	What to Report (Sample of Codes and/or Diagnoses)	Exclusions
Statin Therapy for Patients With Diabetes (SPD) The percentage of members 40-75 years of age during the measurement year with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) who met the following criteria **Two rates are reported:** **1. Received Statin Therapy:** Members who were dispensed at least one statin medication of any intensity during the measurement year **2. Statin Adherence 80 percent:** Members who remained on a statin medication of any intensity for at least 80 percent of the treatment period	**Who Qualifies for the Measure:** **Diabetic members ages 40-75 who had one of the following during the current or previous year:** • Two outpatient visits with a diagnosis of diabetes • At least one inpatient encounter with a diagnosis of diabetes • Members dispensed one of the following: - 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 **Services Required:** 1. Member needs to receive high-intensity, moderate-intensity or low-intensity statin therapy medication during current year **AND** 2. Remain adherent to statin therapy for at least 80 percent of the treatment period, which is defined by time period from first statin therapy dispensing event to the end of the year	Measure is a medication receipt and adherence measure. The following statins qualify for compliance: **High-Intensity Statin Therapy:** • Atorvastatin 40-80 mg • Amlodipine-atorvastatin 40-80 mg • Rosuvastatin 20-40 mg • Simvastatin 80 mg • Ezetimibe-simvastatin 80 mg **Moderate-Intensity Statin Therapy:** • Atorvastatin 10-20 mg • Amlodipine-atorvastatin 10-20 mg • Rosuvastatin 5-10 mg • Simvastatin 20-40 mg • Ezetimibe-simvastatin 20-40 mg • Pravastatin 40-80 mg • Lovastatin 40 mg • Fluvastatin 40-80 mg • Pitavastatin 2-4 mg **Low-Intensity Statin Therapy:** • Simvastatin 5-10 mg • Ezetimibe-simvastatin 10 mg • Pravastatin 10-20 mg • Lovastatin 10-20 mg • Fluvastatin 20 mg • Pitavastatin 1 mg	Members in hospice or receiving hospice services Members with myalgia, myositis, myopathy or rhabdomyolysis during the measurement year Members with myocardial infarction (MI), coronary artery bypass grafting (CABG), percutaneous coronary intervention (PCI) or other revascularization during the year prior to the measurement year Members with ischemic vascular disease (IVD) during both the measurement year and year prior to the measurement year Any of the following during the measurement year or year prior to the measurement year: • Female members with a diagnosis of pregnancy • Members in In vitro fertilization • Members dispensed at least one prescription for clomiphene • Members with end-stage renal disease (ESRD) or dialysis • Members with cirrhosis.

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.
- Refer to current evidence-based guidelines to inform treatment decisions regarding primary prevention and risk reduction of ASCVD in diabetics:
  - https://care.diabetesjournals.org/content/diacare/42/Supplement_1/S103.full.pdf
- For assistance with managing patients with possible statin intolerance, use the Statin Intolerance Tool developed by the American College of Cardiology (ACC):
  - https://tools.acc.org/StatinIntolerance/?_ga=2.18511097.1791122370.1547228822-414277823.1547228822#!/content/home/
- Collaboration between the primary care providers and specialist providers managing members' care can help identify and close gaps in care.
- If a member cannot tolerate a statin due to myalgia, myositis or myopathy, a claim with this diagnosis must be submitted during each year the member experiences this condition and remains eligible for this measure.
- Try to avoid concurrent use of statins and drugs known to increase the risk of rhabdomyolysis and myopathy. Monitor your patient closely if concurrent use is warranted. Examples include:
  - Strong CYP3A4 Inhibitors (Clarithromycin, Itraconazole, Protease Inhibitors)
  - Cyclosporine
  - Fibric Acid Derivatives (e.g., gemfibrozil)
  - Niacin (≥ 1g/day)

Measure	What Service Is Needed	What to Report (Sample of Codes and/or Diagnoses)	Exclusions
Use of Opioids at High Dosage (HDO) The proportion of members 18 years and older, receiving prescription opioids for ≥ 15 days during the measurement year at a high dosage (average milligram morphine dose - MME≥ 90mg)	**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.**	Opioid Medications • Butorphanol • Codeine • Dihydrocodeine • Fentanyl • Hydrocodone • Hydromorphone • Levorphanol • Meperidine • Methadone* • Morphine • Opium • Oxycodone • Oxymorphone • Pentazocine • Tapentadol • Tramadol *Use of methadone for the treatment of opioid use disorder is excluded from this measure.	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 • 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). • Methadone for the treatment of opioid use disorder

Helpful Tips:

- Check the Controlled Substances Monitoring Database (CSMD) routinely before prescribing opioids to members. You can find the database here: www.tncsmd.com.
- Refer to the Tennessee Clinical Practice Guidelines for Outpatient Management of Chronic Non-malignant Pain published by the Tennessee Department of Health: https://www.tn.gov/content/dam/tn/health/healthprofboards/pain-management-clinic/ChronicPainGuidelines.pdf.
- Evaluate the risks and benefits of dose reduction or discontinuation of long-term opioid analgesics in patients receiving ≥90 MME of opioids. For appropriate tapering and discontinuation strategies, refer to guidance published by the Department of Health and Human Services: https://www.hhs.gov/opioids/sites/default/files/2019-10/Dosage_Reduction_Discontinuation.pdf.

Measure	What Service Is Needed	What to Report (Sample of Codes and/or Diagnoses)	Exclusions
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 (i.e., the proportion of members who are numerator compliant for both the Multiple Prescribers and Multiple Pharmacies rates)	**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 • Levorphanol • Meperidine • Methadone* • Morphine • Opium • Oxycodone • Oxymorphone • Pentazocine • Tapentadol • Tramadol *Use of methadone for the treatment of opioid use disorder is excluded from this measure.	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). • Methadone for the treatment of opioid use disorder.

Helpful Tips:

- Check the Controlled Substances Monitoring Database (CSMD) routinely before prescribing opioids to members. You can find it here: www.tncsmd.com.
- Consider reviewing other websites you may find helpful, including:
  - https://www.samhsa.gov/ebp-resource-center
  - https://www.samhsa.gov/medication-assisted-treatment
  - https://www.tn.gov/tenncare/tenncare-s-opioid-strategy.html

Measure	What Service Is Needed	What to Report (Sample of Codes and/or Diagnoses)	Exclusions
Risk of Continued Opioid Use (COU) The percentage of members 18 years of age and older who have a new episode of opioid use that puts them at risk for continued opioid use	This measure identifies members with a **new** opioid prescription that puts them at risk for continued use. Pharmacy claims data for opioid medications will be used to identify members that fall into this measure. **Two rates are reported:** 1. The percentage of members with at least 15 days of prescription opioids in a 30-day period 2. The percentage of members with at least 31 days of prescription opioids in a 62-day period Note: A lower rate indicates better performance. Measurement Period: Begins Nov. 1 of the year prior to the measurement year and ends on Oct. 31 of the measurement year	**Opioid Medications** • Buprenorphine (transdermal patch and buccal film) • Butorphanol • Codeine • Dihydrocodeine • Fentanyl • Hydrocodone • Hydromorphone • Levorphanol • Meperidine • Methadone • Morphine • Opium • Oxycodone • Oxymorphone • Pentazocine • Tapentadol • Tramadol	Members in hospice or using hospice services Exclude members who filled a prescription for an opioid medication within 180 days prior to the earliest prescription dispensing date in the measurement period. Exclude members with a diagnosis of cancer or sickle cell disease at any time during the 12 months (1 year) prior to the earliest prescription dispensing date for an opioid through 61 days after the dispensing date in the measurement period. • Denied claims and supplemental data will not be used for compliance measurement. • The following opioid medications are excluded from this measure: - Injectables - Opioid-containing cough and cold products - Single-agent and combination buprenorphine products used as part of medication-assisted treatment of opioid use disorder (buprenorphine sublingual tablets, buprenorphine subcutaneous implant and all buprenorphine/naloxone combination products) - Ionsys® (fentanyl transdermal patch) ▪ This is for inpatient use only and is available only through a restricted program under a Risk Evaluation and Mitigation Strategy (REMS). - Methadone for the treatment of opioid use disorder.
Pharmacotherapy for Opioid Use Disorder (POD) The percentage of new opioid use disorder (OUD) pharmacotherapy events with OUD pharmacotherapy for 180 or more days among members age 16 and older with a diagnosis of OUD			Members in hospice or using hospice services

Helpful Tips:

- Refer to the National Institute on Drug Abuse for information on opioid addiction treatments:
  - https://www.drugabuse.gov/publications/effective-treatments-opioid-addiction/effective-treatments-opioid-addiction
- Check the Controlled Substances Monitoring Database regularly to gather information that will help guide treatment decisions, learn patients' current MME (morphine milligram equivalents) dosages and identify multiple providers' episodes:
  - https://www.tncsmd.com
- Refer to evidence-based best practice and pain medication recommendations to improve acute pain management following musculoskeletal injury:
  - https://journals.lww.com/jorthotrauma/Fulltext/2019/05000/Clinical_Practice_Guidelines_for_Pain_Management.11.aspx#epub-link
- Agents dispensed by a retail pharmacy are subject to prior authorization requirements, quantity limits, or both. To minimize any delays in starting treatment, initiate prescription authorizations as soon as possible. You can find Prior Authorization forms and the Preferred Drug List (PDL) on the Division of TennCare's pharmacy page:
  - https://www.tn.gov/tenncare/providers/pharmacy.html
  - NOTE: Methadone dispensed by OTPs (opioid treatment programs) are not subject to prescription authorization requirements.

Measure	What Service Is Needed	What to Report (Sample of Codes and/or Diagnoses)	Exclusions
Avoidable ED (TennCare Custom Measure for reporting only) Events – Number of ED visits for ambulatory care sensitive conditions (ACSC), per 1,000 member months, based on ACSCs as defined by the Institute of Medicine	**ED visits are considered ambulatory sensitive if the primary diagnosis for the ED visit is included in any of the following value sets:** • 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 • Asthma • Cellulitis • Convulsions • Diabetes Failure to thrive AND age < 1 year on the date of the ED visit Bacterial Pneumonia: EXCLUDE where secondary diagnosis is in the ACSC_sickle_cell_exclusion value set OR patient is < 2 months of age by the date of the ED visit. Congenital Syphilis for patients under one year: Check for ACSC_congenital_syphilis in primary OR secondary diagnosis. For patients age ≥ 1, check for ACSC_congenital_syphilis in primary diagnosis only. Secondary diagnosis of: Acute Bronchitis, Dehydration, Iron Deficiency Anemia, Nutritional Deficiencies		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

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 admission-discharge-transfer (ADT) feed in the Care Coordination tool and schedule them for an office visit.

Measure	What Service Is Needed	What to Report (Sample of Codes and/or Diagnoses)	Exclusions
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	**Who Qualifies for the Measure:** **Adults with** • At least one acute inpatient encounter with any diagnosis of schizophrenia, schizoaffective disorder or bipolar disorder **OR** • At least two of the following visit types, on different dates of service, with any diagnosis of schizophrenia, schizoaffective disorder or bipolar disorder: - Outpatient visit, intensive outpatient encounter, partial hospitalization, community mental health center visit, electroconvulsive therapy, an observation visit, ED visit, nonacute inpatient encounter or telehealth visit **AND** Prescribed one of the following classes of antipsychotic medications: **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 **CPT®II:** 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, ED, 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 or using hospice services

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.
- Collaboration between the primary care providers and specialist providers managing members' care can help identify and close gaps in care.

Measure	What Service Is Needed	What to Report (Sample of Codes and/or Diagnoses)	Exclusions
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) The percentage of children and adolescents 1-17 years of age who had two or more antipsychotic prescriptions and had metabolic testing	**Who Qualifies for the Measure:** Children and adolescents who were dispensed antipsychotic medications with at least two unique dates of service **Antipsychotic Drug Class:** • Miscellaneous antipsychotic agents • Phenothiazine antipsychotics • Thioxanthenes • Long-acting injections • Psychotherapeutic combinations • Prochlorperazine medications **What Service Is Needed?** At least one glucose or HbA1c per measurement year **AND** At least one LDL-C or any other cholesterol tests per measurement year *These lab tests can be on the same or different dates of service.	**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 **CPT®II:** 3044F, 3045F, 3046F **LOINC:** 17856-6, 4548-4, 4549-2 **LDL-C Tests:** **CPT®:** 80061, 83700, 83701, 83704, 83721 **CPT®II:** 3048F, 3049F, 3050F **LOINC:** 12773-8, 13457-7, 18261-8, 18262-6, 2089-1, 49132-4, 55440-2 **Cholesterol Tests:** **CPT®:** 82465, 83718, 84478 **LOINC:** 2085-9, 2093-3, 2571-8, 3043-7, 9830-1	Members in hospice or using hospice services

Helpful Tips:

- Refer to practice parameters regarding the use of atypical antipsychotic medications in children and adolescents: https://www.aacap.org/App_Themes/AACAP/docs/practice_parameters/Atypical_Antipsychotic_Medications_Web.pdf.
- Collaborate with any specialists prescribing antipsychotic medication to make sure any needed metabolic testing is completed.

Measure	What Service Is Needed	What to Report (Sample of Codes and/or Diagnoses)	Exclusions
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)	**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.**	**Psychosocial Care CPT®:** 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90846, 90847, 90849, 90853, 90875, 90876, 90880 **Psychosocial Care HCPCS:** G0176, G0177, G0409, G0410, G0411, H0004, H0035, H0036, H0037, H0038, H0039, H0040, H2000, H2001, H2011, H2012, H2013, H2014, H2017, H2018, H2019, H2020, S0201, S9480, S9484, S9485 **May be billed with or without telehealth modifier or POS code:** **Telehealth Modifier:** 95, GT **Telehealth POS:** 02	Members in hospice or using hospice services

Helpful Tips:

- Before prescribing an antipsychotic for any reason (**except** for schizophrenia, bipolar disorder or psychotic disorder):
  - Confirm the child has been referred to a therapist **AND**
  - Confirm the child has received therapy within the past 30 days **AND**
  - Refer the child to a therapist if they haven't received a therapy referral.

For more mental health resources, please visit:
https://www.bcbst.com/providers/Behavioral-Health-Toolkit/HEDIS.page??nav=calltoaction

Measure	What Service Is Needed	What to Report (Sample of Codes and/or Diagnoses)	Exclusions
Antidepressant Medication Management (AMM) The percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and remained on an antidepressant medication treatment	The goal for this measure is medication compliance. **Two rates are reported:** **1. Effective Acute Phase Treatment –** The percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks) **2. Effective Continuation Phase Treatment –** The percentage of members who remained on an antidepressant medication for at least 180 days (6 months)	**This measure is closed by pharmacy and claim data.**	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. Members in hospice or using hospice services

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.
- 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.
- Reach out to members within two weeks after they start antidepressant treatment to ask if they have questions or are experiencing any side effects. This can identify any medication treatment barriers, strengthen the provider-patient relationship and encourage early adherence.
- Before a diagnosis of major depressive disorder is made, complete an in-depth medical history to determine if a member is experiencing a depressive episode in the context of bipolar disorder.
- Consider using Bipolar Disorder screening tools within the STABLE Resource Toolkit to help differentiate between bipolar disorder (I and II) and major depressive disorder. The toolkit can be accessed here: http://www.cqaimh.org/pdf/STABLE_toolkit.pdf.
- Collaborate with specialist providers managing members attributed to your practice to identify and close gaps in care.

Measure	What Service Is Needed	What to Report (Sample of Codes and/or Diagnoses)	Exclusions
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA) The percentage of members 18 years of age and older 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, ED 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	This measure is closed by pharmacy and claim data. **Antipsychotic Medication Pharmacy Dispensing Events:** • Miscellaneous antipsychotic agents (oral) • Phenothiazine antipsychotics (oral) • Psychotherapeutic combinations (oral) • Thioxanthenes (oral) • Long-acting injections (14-day supply) • Long-acting injections (28-day supply) • Long-acting injections (30-day supply) **OR** **Long-Acting Injections:** J2794, J0401, J1631, J2358, J2426, J2680	Members in hospice or using hospice services Members with a diagnosis of dementia

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.
- Try to prescribe long-acting injectables when appropriate to potentially increase a member's likelihood of remaining on the medication.

Measure	What Service Is Needed	What to Report (Sample of Codes and/or Diagnoses)	Exclusions
Follow-Up Care for Children Prescribed ADHD Medication (ADD) The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication and who had at least three follow-up care visits within a 10-month period *The first visit must occur within 30 days of the medication dispense date.	**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.** ***Please note:** A lapse in prescription refill greater than 120 days should be considered a new prescription and requires an additional 30-day follow-up visit. This is more common after a summer break. **Initial follow-up visit**: Within 30 days of filling the prescription **Continuation follow-up visit**: Two or more visits within nine months (270 days) *One of the two required visits during the continuation and maintenance phase can be conducted via telephone.	Initiation requires visit to be with a provider with prescribing authority and includes all visits except Telehealth. **CPT®:** 96150, 96151, 96152, 96153, 96154, 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, 99381, 99382, 99383, 99384, 99391, 99392, 99393, 99394, 99401, 99402, 99403, 99404, 99411, 99412, 99510 **CPT® with Outpatient or Partial Hospitalization Place of Service (POS) Code:** 90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99251, 99252, 99253, 99254, 99255 **HCPCS:** G0155, G0176, G0177, G0409, G0410, G0411, G0463, H0002, H0004, H0031, H0034, H0035, H0036, H0037, H0039, H0040, H2000, H2001, H2010, H2011, H2012, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, M0064, S0201, S9480, S9484, S9485, T1015 **Rev Code:** 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 **All codes listed above** **Telephone CPT® Visits:** 98966, 98967, 98968, 99441, 99442, 99443 **Telehealth Modifier:** 95, GT **Telehealth POS:** 02	Members in hospice or using hospice services Exclude members with a diagnosis of narcolepsy any time during their history through Dec. 31 of the measurement year: 99385-99387, 99395-99397, 99483

Helpful Tips:

- Schedule all three follow-up visits over the next 10 months before the patient leaves the office. The first three visits must meet the following criteria:
  - **First Visit**: Must be with a provider with prescriptive authority within 30 days of the first prescription dispensing or prescription restart
  - **Second and Third Visits**: Must occur within nine months after the initial visit. This visit can be with any practitioner because no prescriptive authority is required.
- Use the ADHD resource tool kit, which includes tools for clinicians and parents, to support follow-up care: https://www.aap.org/en-us/pubserv/adhd2/Pages/kit/data/monitorfollowframe.html.
- Collaboration between the primary care providers and specialist providers managing members' care can help identify and close gaps in care.
- Explain to the parent/guardian the importance of follow-up care.
- Encourage questions from parents/caregivers to gain a better understanding of ADHD.

Measure	What Service Is Needed	What to Report (Sample of Codes and/or Diagnoses)	Exclusions
Follow-Up After Hospitalization for Mental Illness (FUH) Percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health practitioner **Two rates are reported:** - Percentage of discharges for which the member received follow-up within 30 days after discharge - Percentage of discharges for which the member received follow-up within 7 days after discharge	A follow-up visit with a mental health practitioner within 7 days/30 days after discharge. **Any of the following meets criteria for the 7-day and 30-day follow-up visit:** • An outpatient visit with a mental health practitioner • An intensive outpatient encounter or partial hospitalization with a mental health practitioner • A community mental health center visit with a mental health practitioner • Electroconvulsive therapy with a mental health practitioner • A telehealth visit with a mental health practitioner • An observation visit with a mental health practitioner • Transitional care management services with a mental health practitioner	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. 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:** **CPT®:** 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:** G0155, G0176-G0177, G0409-G0411, G0443, G0463, H0001-H0002, H0004-H0005, H0007, H0015-H0016, H0020, H0022, H0031, H0034-H0037, H0039-H0040, H2000-H2001, H2010-H2020, H2035-H2036, H0064, S0201, S9480, S9484-S9485, T1006, T1012, T1015 **Transitional Care Management 7 Day:** 99496 **Transitional Care Management 14 Day:** 99495 **CPT® with Outpatient or Partial Hospitalization POS Code:** 90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99251, 99252, 99253, 99254, 99255 **Rev Code:** 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 **Note**: Additional codes may apply depending on provider type and point of service.	Exclude discharges followed by readmissions or direct transfer to a non-acute inpatient care setting within the 30-day follow-up period, regardless of the 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. Members in hospice or using hospice services

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

Measure	What Service Is Needed	What to Report (Sample of Codes and/or Diagnoses)	Exclusions
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) The percentage of 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	**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.** **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)	**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, 99408, 99409, 99411, 99412, 99510 **Standalone HCPCS:** G0155, G0176, G0177, G0396, G0397, G0409, G0410, G0411, G0443, G0463, H0001, H0002, H0004, H0005, H0007, H0015, H0016, H0022, H0031, H0034, H0035, H0036, H0037, H0039, H0040, H0047, H2000, H2001, H2010, H2011, H2012, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, H2035, H2036, M0064, S0201, S9480, S9484, S9485, T1006, T1012, T1015 **Standalone Rev Codes:** 0510, 0513, 0515, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0526, 0527, 0528, 0529, 0900, 0902, 0903, 0904, 0905, 0906, 0907, 0911, 0912, 0913, 0914, 0915, 0916, 0917, 0919, 0944, 0945, 0982, 0983 **Visits billed with Place of Service Codes:** (02, 52,53) 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99251, 99252, 99253, 99254, 99255 **Visits billed with Place of Service Codes:** (02, 03, 05, 07, 09, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 22, 33, 49, 50, 52, 53, 57, 71, 72) 90791, 90792, 90832, 90833,90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876 **Online Assessment:** 98969, 99444 **Telephone Visit CPT®:** 98966, 98967, 98968, 99441, 99442, 99443	Members in hospice or using hospice services Exclude ED visits that result in an inpatient stay and ED visits followed by an admission to an acute or nonacute inpatient care setting on the date of the ED visit or within 30 days after the ED visit, regardless of the principal diagnosis for the admission.

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	What Service Is Needed	What to Report (Sample of Codes and/or Diagnoses)	Exclusions
Follow-Up After Emergency Department Visit for Mental Illness (FUM) The percentage of 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	**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.** **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)	**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:** G0155, G0176-G0177, G0409-G0411, G0443, G0463, H0001-H0002, H0004-H0005, H0007, H0015-H0016, H0020, H0022, H0031, H0034-H0037, H0039-H0040, H2000-H2001, H2010-H2020, H2035-H2036, H0064, S0201, S9480, S9484-S9485, T1006, T1012, T1015	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.

Measure	What Service Is Needed	What to Report (Sample of Codes and/or Diagnoses)	Exclusions
Follow-Up After High-Intensity Care for Substance Abuse Disorder (FUI) The percentage of acute inpatient hospitalizations, residential treatment or detoxification visits for a diagnosis of substance use disorder among members 13 years of age and older that result in a follow-up visit or service for substance use disorder	A follow-up visit within 7 and 30 days **Two rates are reported:** 1. The percentage of visits or discharges for which the member received follow-up for substance use disorder within the 30 days after the visit or discharge 2. The percentage of visits or discharges for which the member received follow-up for substance use disorder within the 7 days after the visit or discharge For both indicators, any of the following meet criteria for a follow-up visit: • An acute or nonacute inpatient admission or residential behavioral health stay with a principal diagnosis of substance use disorder • An outpatient visit, telehealth, intensive outpatient visit or partial hospitalization with a principal diagnosis of substance use disorder. Any of the following code combinations meet criteria: - Residential behavioral health treatment with a principal diagnosis of substance use disorder - A telephone visit with a principal diagnosis of substance use disorder - An online assessment with a principal diagnosis of substance use disorder - A pharmacotherapy dispensing event or medication treatment event *Note: Follow-up does not include detoxification. Exclude all detoxification events when identifying follow-up care for compliance.		Members in hospice or using hospice services

Helpful Tips:

- Follow-up care can be delivered in a variety of settings to reduce barriers to receiving care. Examples include:
  - Outpatient visits
  - Partial hospitalizations
  - Observation stays
  - Telehealth encounters
  - Inpatient hospitalization
  - Residential treatment
  - Dispensed Pharmacotherapy for OUD/AUD treatment
  - Administered Pharmacotherapy for OUD/AUD treatment
- Provide a list of places where members can seek treatment so they are aware of the options available to them.
- Intensify monitoring for substance use during periods when the risk of relapse is high, such as:
  - During early stages of treatment
  - At times of transition to a less intensive level of care
  - After the first year of treatment ends

Measure	What Service Is Needed	What to Report (Sample of Codes and/or Diagnoses)	Exclusions
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET) 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: • **Initiation of AOD treatment –** 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 • **Engagement of AOD Treatment –** 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	**Compliance with Initiation of AOD Treatment:** • If the index episode was an inpatient discharge, the inpatient stay is considered initiation of treatment. • If the index episode was an outpatient visit, intensive outpatient, partial hospitalization, telehealth, detoxification or ED visit, the member **MUST** have: - Acute or nonacute inpatient admission with appropriate diagnosis - IET stand-alone visit with diagnosis matching the IESD diagnosis - IET visit group 1 with IET POS group 1 value set and diagnosis matching IESD diagnosis with or without telehealth modifier - IET visit group 2 with IET POS group 2 value set and diagnosis matching IESD diagnosis with or without telehealth modifier - Telephone visit diagnosis matching IESD diagnosis - Online assessment diagnosis matching IESD diagnosis - If index episode was for alcohol/opioid abuse/dependence, need to have a MAT dispensing event - Observation visit with diagnosis matching IESD diagnosis	**Sample Diagnoses for Alcohol or Other Drug Dependence (AOD)** • Alcohol Abuse • Alcohol Dependence • Alcohol Use • Opioid Abuse • Opioid Dependence • Cannabis Abuse • Cannabis Dependence • Sedative, Hypnotic or Anxiolytic Abuse • Sedative, Hypnotic or Anxiolytic Dependence • Cocaine Abuse • Cocaine Dependence • Hallucinogen Abuse • Hallucinogen Dependence • Inhalant Abuse • Inhalant Dependence • Detoxification • Other Stimulant Abuse • Other Stimulant Dependence • Other Stimulant Use For more information about this measure, including a list of sample codes, please visit: bcbst.com/docs/providers/quality-initiatives/15PED1074_Initiation_and_Engagement_of_Substance_Abuse.pdf.	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

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.
- Consider referring members to the Substance Abuse and Mental Health Services Administration as a resource: https://www.samhsa.gov/find-help/national-helpline.

Measure	What Service Is Needed	What to Report (Sample of Codes and/or Diagnoses)	Exclusions
7-and 30-Day Psychiatric Hospital / Residential Treatment Facility (RTF) Readmission Rate The rate of readmissions within 7 or 30 days of discharge from a psychiatric hospital or RTF **Two rates are calculated:** 1. 7-day 2. 30-day	• 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 **ONLY.** • 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 **ONLY.** • Calculation for this measure is based on date of discharge to home or outpatient setting.	• 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 **ONLY** an inpatient psychiatric hospital readmission for the purpose of this metric. This rule applies to both the seven-day and 30-day readmission rates. **Follow-up appointments after discharge along with appropriate aftercare services will help impact readmission rates.**	

Helpful Tips:

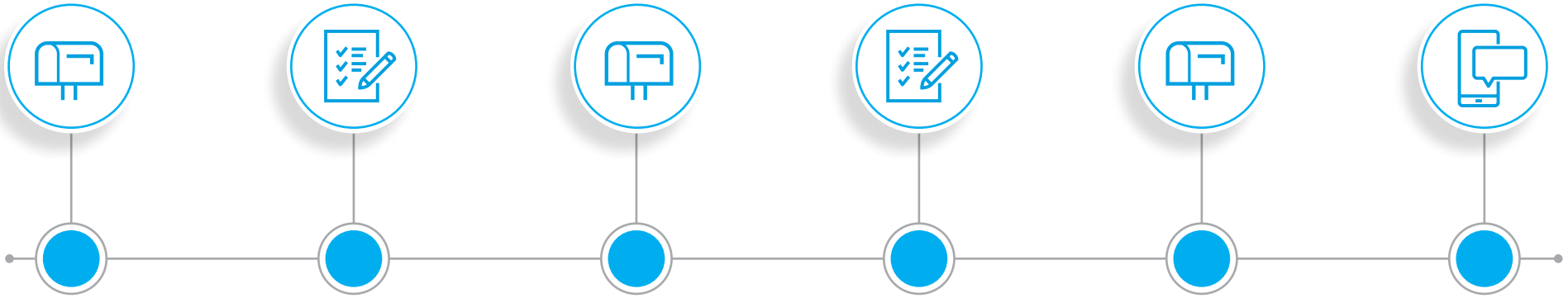
- Engage patients and their support system in the plan of care/shared decision-making.
- Frequently reassess risk for readmission.
- Schedule follow-up visits before patient is discharged.
- Consider early follow-up calls post-discharge.

Best Practices and Processes Behind the CAHPS Survey

The Consumer Assessment of Healthcare Providers and Systems – or CAHPS – is a survey used to capture member perceptions of their care from their personal providers and their health plan. Each year, from February to May, we work with an NCQA certified vendor to send the survey and collect responses from randomly selected members.

Protocol Process

BlueCross BlueShield of Tennessee chose mail/telephone/Internet protocol with pre-notification postcard



Pre-notification postcard mailed (optional)

Questionnaire with cover letter and business reply envelope (BRE) mailed

First reminder postcard mailed

Replacement questionnaire with cover letter and BRE to all non-responders

Internet link included on cover letter (optional)

Second reminder postcard mailed

Telephone interviews conducted with non-responders (minimum of three/ max of six attempts)

Survey Questionnaire Examples

In the last 12 months, did you get care from a doctor or other health provider besides your personal doctor?

___Yes ___No > If No, Go to question 23

In the last 12 months, how often did your personal doctor seem informed and up-to-date about the care you got from these doctors or other health providers?

___Never ___Sometimes ___Usually ___Always

Categories Included in the Survey

- Getting Care Quickly
- Shared Decision-Making
- How Well Doctors Communicate
- Getting Needed Care
- Care Coordination
- Rating of Health Care
- Rating of Personal Doctor
- Rating of Specialist
- Rating of Health Plan

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

Contact Information

24/7 Nurseline	
Phone	1-800-262-2873

Customer Service/Provider Services – Authorizations, Benefits, Claims and Billing	
BlueCare℠	1-800-468-9736
TennCare*Select*	1-800-276-1978

Customer Service/Member Services	
BlueCare℠	1-800-468-9698
TennCare*Select*	1-800-263-5479

Provider Incentive and Engagement Team – General Mailbox	
Email	TennCare_PCMH@bcbst.com

Transportation – For members to schedule a ride through Southeastrans*	
BlueCare℠	1-855-735-4660
TennCare*Select*	1-866-473-7565
Online	member.southeastrans.com

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

Pharmacy Benefits	
https://www.tn.gov/tenncare/providers/pharmacy.html	
Technical Call Center (Pharmacy Help Desk)	1-866-434-5520
Clinical Call Center (Prior Authorizations)	Phone: 1-866-434-5524 Fax: 1-866-434-5523

For Technical Support
Contact our eBusiness team at (423) 535-7717, Option 2, 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	
Website	bluecare.bcbst.com/providers

Notes:

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