HEDIS®/STARS REFERENCE GUIDE 2023

REVISED 4/2023

MedPOINT MANAGEMENT

What's New for Measurement Year 2023

The future of HEDIS® is becoming clearer. As part of a quality improvement ecosystem that allows electronic data exchange among clinical care teams, payers, public health agencies and researchers, NCQA envisions that health plans will increasingly be able to exchange HEDIS® data with provider EHRs, health information exchanges, health registries, and other health plans. The technology that will enable these computer systems to talk to each other is called the FHIR API.

This transition will occur over many years. NCQA is trying to nudge the process forward by gradually converting HEDIS® measures to ECDS (Electronic Clinical Data System) measures or e-measures. Although the e-measures include technical specifications for how data will be exchanged within the ecosystem, what's important for provider offices to know now is that these measures cannot be reported with encounter data (CPT and ICD-10 codes) alone. Some of the first measures to become e-measures are cancer screenings because it has always been the case that historical and patient- reported cancer screenings cannot be reported through the regular encounter submission process. Provider offices must submit supplemental data (medical records or EHR extracts) to report that data. Provider offices that have the data in a structured format that can be easily extracted are at a significant advantage. Sometime in the future, health plans will query the EHRs for HEDIS® data using the FHIR API and supplemental data will be eliminated.

The need for provider offices to have their EHR data in a structured format has taken on new urgency as the Department of Health Care Services (DHCS) has announced its intention to hold two depression screening e-measures which cannot be reported without PHQ-9 scores to the national Medicaid 50th percentile in 2024. Provider offices that can't produce an EHR extract of their patient's PHQ-9 scores will have great difficulty meeting these measures. In this guide we describe how to report the PHQ-9 score as supplemental data using LOINC codes and we encourage provider offices to confirm that these scores are consistently being stored as structured data in their EHRs.

The increasing number of e-measures is just one of the ways that NCQA is challenging the healthcare system to improve. To improve health equity, some HEDIS® measures will now be reported with race and ethnicity stratification. There are 13 measures that require stratification by race and ethnicity with an additional 14 proposed for MY2024. NCQA has also introduced the first HEDIS® measure for Social Determinants of Health Screening. Meanwhile, measure benchmarks are increasing back to pre-pandemic levels. We hope this background and the information contained in this guide will help provider offices rise to the challenge. As always, please fully utilize the Cozeva platform which is intended to help provider offices be successful with HEDIS® and reach out to your HEDIS/ Stars specialist for assistance at any time.

Thank you.

ADULTS

HEDIS® MEASURE	AGE	LOB	REQUIREMENT AND DOCUMENTATION	SAMPLE CODES / EXCLUSIONS
Colorectal Cancer Screening (COL)	45-75 years as of 12/31/2023	Commercial, Medicare, Medi-Cal (2024)	**Members who had appropriate screening for colorectal cancer:** •Fecal occult blood test FOBT in 2023 •or Colonoscopy in past 10 years (2014-2023) Also acceptable for this measure: •Flexible Sigmoidoscopy (2019-2023) •FIT-DNA (requires prior authorization) •Computed Tomography (CT) Colonography **Best Practices:** • Clearly document previous colonoscopy, including year. • Proof of service for point-of-care FOBT/FIT testing must specify “spontaneous bowel movement” or “not DRE.” If screening was done by another provider or in another country, document what type of test was done, the date screening was completed (month/ year) and the result to submit as supplemental data. • If creating a lab requisition online, check if your contracted lab requires that the sample be submitted to the lab within 14 days of the requisition date to avoid rejection of the specimens. • If giving a FOBT kit, do not create an online requisition.	**iFOBT/FIT - CPT: 82274** **HCPCS: G0328** **CPT Codes: 45378** **Exclusions:** Colorectal cancer or total colectomy, members age 66+ in institutional SNP or long-term institution or with frailty and advanced illness or dementia. Other exclusions apply. **Note:** CPT II Code 3017F does not close the HEDIS® measure.
Controlling High Blood Pressure (CBP)	18-85 years & Hypertensive as of 12/31/2023	Commercial, Medi-Cal, Medicare	Members with >=2 diagnoses of hypertension between 01/01/2022 - 06/30/2023 whose last blood pressure of 2023 was **<140/90.** **Best Practices:** • Most recent BP value counts. • If there are multiple readings on the same date, the lowest values from both notations can be used. • Use CPT II outcome codes on encounters and consider automating codes in your EMR. • Retake BP at end of appointment if reading is high during initial vitals. • BP from non-medical providers can be used if they are using the medical provider’s EMR (such as dentists and optometrists). **Telehealth:** • BP readings from patient’s digital BP monitoring devices during telehealth visits are acceptable.	**CPT II Codes:** **3074F** – Systolic <= 129 **3075F** – Systolic = 130 - 139 **3077F** – Systolic >= 140 (non-compliant) **3078F** – Diastolic <= 79 **3079F** – Diastolic = 80 - 89 **3080F** – Diastolic >= 90 (non-compliant) **Exclusions:** Members in hospice, with evident ESRD; kidney transplant, diagnosis of pregnancy; had a non-acute inpatient admission, all in 2023. Age 66+ in institutional SNP or long-term institution or with frailty and advanced illness or dementia. Other exclusions apply.

HEDIS® MEASURE	AGE	LOB	REQUIREMENT AND DOCUMENTATION	SAMPLE CODES / EXCLUSIONS
Transitions of Care (TRC) Includes MRP - Medication Reconciliation Post- Discharge - 1111F	Documentation for members aged 18 and above with inpatient admission that includes notification of inpatient admission, discharge, patient engagement, and medication reconciliation in 2023	Medicare	Documentation of the following four rates: **1. Notification of Inpatient Admission** Documentation of receipt of notification with date of inpatient admission on the day of admission through 2 days after the admission (3 total days). • Medical record examples include phone call, email or fax, ER notification, electronic exchange, ADT alert system, shared EMR, health plan, PCP or care provider, specialist, orders for tests and treatments or planned inpatient admission. • This component is determined by health plan medical record sample. **2. Receipt of Discharge Information** Documentation of receipt of discharge information with date on the day of discharge through 2 days after the discharge (3 total days) via phone call, email or fax. • Medical record must include discharge summary or in EMR in structured fields, practitioner responsible during stay, procedures and treatments, diagnoses at discharge, current medication list, testing documentation and results, and post-care instructions. • This component is determined by health plan medical record sample. **3. Patient Engagement After Inpatient Discharge** Documentation of patient engagement (e.g., office visits, visits to the home, telehealth) provided within 30 days after discharge. • Document either outpatient visit with office or home visit, telephone, real-time audio and video telehealth visit or e-visit, or virtual check-in (not real-time). • This component is determined by encounter data. **4. Medication Reconciliation Post-Discharge** Documentation of medication reconciliation by PCP, registered nurse, or pharmacist on the date of discharge through 30 days after discharge (31 total days). Use CPT II code 1111F. • Document either that medications were reconciled, no changes, same, discontinued reviewed or member was seen post-discharge with reconciliation or review. • This component is determined by encounter data.	**CPT** Codes for #3 and #4: 99495/99496 – Transitions of care management for moderate/high complexity. **CPT II** Code for MRP (#4): 1111F – Discharge medications reconciled with the current medication list in outpatient medical record. **Best Practices:** • Add internal workflows to document notification of inpatient admission (#1) and discharge (#2) in the medical record as these components are validated through medical record review. • The use of 99495 or 99496 for patient engagement (#3) and medication post discharge (#4) are compliant for both components without additional codes. • Each sub measure is rated separately so meet as many components as possible.

ADULTS

HEDIS® MEASURE	AGE	LOB	REQUIREMENT AND DOCUMENTATION	SAMPLE CODES / EXCLUSIONS
Follow UP After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions (FMC)	18 years & older as of the ED Visit, 18-64 years, 65 years & older	Medicare	**Step 1 -** An ED visit on or between January 1st & December 24 of the measurement year, where the member was 18 years or older on date of visit. • Denominator based on ED visits & not on members. **Step 2 -** Exclude ED visits that result in an inpatient stay. Exclude ED visits followed by admission to an acute or nonacute inpatient care setting on the date of the ED visit or within 7 days after the ED visit, regardless of the principal diagnosis for admission. To identify admissions to an acute or nonacute inpatient care setting: **Step 3 -** Identify ED visits where the member had a chronic condition prior to the ED Visits. Chronic Conditions Consist of: • COPD and asthma. • Alzheimer's disease and related disorders. • Chronic kidney disease. • Depression. • Heart failure. • Acute myocardial infarction. • Atrial fibrillation. • Stroke and transient ischemic attack. • Remove any visit with a principal diagnosis of encounter for other specified aftercare. • Remove any visit with any diagnosis of concussion with loss of consciousness or fracture of vault of skull, initial encounter. **Step 4 -** Identify ED visits where the member had two or more different chronic conditions prior to the ED visits, that meet the criteria included in Step 3 above. **Step 5 -** Multiple Visits in 8-day period. If a member has more than one ED visit in an 8-day period, include only the first eligible ED visit. A follow-up service within 7 days after the ED visit (8 total days). Include visits that occur on the date of the ED visit. • An outpatient visit. • A telephone visit. **Cont'd**	• Transitional care management services. • Case management visits. • Complex Care Management Services. • An outpatient or telehealth behavioral health visit. • An outpatient or telehealth behavioral health visit. • An intensive outpatient encounter or partial hospitalization. • An intensive outpatient encounter or partial hospitalization. • A community mental health center visit. • Electroconvulsive therapy. • A telehealth visit. • An observation visit. • A substance use disorder service. • An e-visit or virtual check-in. • A domiciliary or rest home visit. **Best Practices:** • Having notification process to be alerted of members that were seen in an ER 1-2 days after being seen. • Understanding what chronic conditions are eligible. Identifying members with multiple chronic conditions

HEDIS® MEASURE	AGE	LOB	REQUIREMENT AND DOCUMENTATION	SAMPLE CODES / EXCLUSIONS
Child and Adolescent Well-Care Visits (WCV)	3-21 years as of 12/31/2023 Age stratifications: 3-11 years 12-17 years 18-21 years	Commercial, Medi-Cal	The documentation must match the CPT or ICD-10 code definition. If the visit matches the code definition for CPT 99381-99395 (“Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/ diagnostic procedures” - equivalent to a CHDP health assessment), submit that CPT code to receive HEDIS® credit. If the visit includes a significant component of well- care but does not meet the full definition for CPT 99381- 99395, submit office visit CPT 99202-99215 together with a matching well-care ICD-10 Z-code to receive HEDIS® credit. The preferred documentation has the ICD10 Z-code plus the code definition printed in the assessment/plan where it can be easily seen by reviewers. A key phrase like “preventive care,” “wellness visit,” “well care,” “well-child,” or “routine health examination” should be included, along with a notation if there are abnormal findings. **Best Practices:** • If no labs or diagnostic procedures are ordered, indicate “no labs/procedures ordered” to make clear this was intentional. • Proper coding is essential so make sure age-specific CPT code is billed. Refer to http://www.aap.org or http:// www.Brightfutures.org for age-appropriate guidance. • Well care can be done during sick visits by adding a well-care ICD-10 Z-code. **Telehealth:** • All components except physical exam can be completed by telehealth. • Use the wellness visit procedure code for the telehealth visit and include documentation in the record stating “in- person visit with physical exam planned by 12/31/2023.” The preventive visit procedure code should not be submitted again for the in-person physical exam. • Physical exams can be completed during sick visits.	**ICD-10:** Z00.121 / Z00.129 – Encounter for routine child health examination with / without abnormal findings (age 0-17) Z00.00 or Z00.01 (age 18+) Z02.5 – Sports Physical **CPT Preventive Codes:** 99381 – age <1-year, new patient 99391 – age <1 year, established patient 99382 – age 1-4, new patient 99392 – age 1-4, established patient 99383 – age 5-11, new patient 99393 – age 5-11, established patient 99384 – age 12-17, new patient 99394 – age 12-17, established patient 99385 – age 18+, new patient 99395 – age 18+, established patient 99381 – age <1-year, new patient 99391 – age <1 year, established patient

HEDIS® MEASURE	AGE	LOB	REQUIREMENT AND DOCUMENTATION	SAMPLE CODES / EXCLUSIONS
Childhood Immunization Status (CIS) (Combo 10)	Children aged 2 years in 2023 who had all immunizations by their 2nd birthday	Commercial, Medi-Cal	Children 2 years of age in 2023 who received these vaccines on or before their second birthday: 4 DTaP 3 Polio (IPV) 1 MMR 3 Haemophilus Influenzae Type B (HIB) 3 Hepatitis B 1 Chicken pox (VZV) 4 Pneumococcal conjugate (PCV) 1 Hepatitis A 2 Rotavirus (Rotarix) or 3 Rotavirus (RotaTeq) 2 Influenza vaccines **Best Practices:** • Always use CAIR2 -California Immunization Registry - cairweb.org. • Make sure 1-year-olds are current with vaccines to avoid noncompliance next year. • Keep in mind flu vaccines are not available year-round. • Proper coding of Rota if Rota (NOS) default to 3 doses.	**Exclusions:** Please refer to the HEDIS® Value Set Directory (VSD) for specific exclusion codes for contradictions including Anaphylactic reaction, Encephalopathy, Adverse Effects for DTaP, Disorders of the Immune System, HIV, Malignant Neoplasm of Lymphatic Tissue, Severe 3 **CPT Codes:** DTaP – 90697, 90698, 90700, 90723 IPV – 90697, 90698, 90713, 90723 MMR – 90707, 90710 HIB – 90644, 90647, 90648, 90697,90698, 90748 Hepatitis A – 90633 Hepatitis B – 90697, 90723, 90740, 90744, 90747, 90748 VZV – 90710, 90716 PCV – 90670 Rotavirus (2 dose schedule) – 90681 Rotavirus (3 dose schedule) – 90680 Influenza – 90655, 90657, 90661, 90673, 90674, 90685, 90686, 90687, 90688, 90689, 90756, 90660, 90672
Immunizations for Adolescents (IMA) (Combo 2)	Adolescents aged 13 in 2023 who had immunizations before 13th birthday	Commercial, Medi-Cal	**The percentage of adolescents 13 years of age who had:** • 1 dose of meningococcal conjugate vaccine (MCV) given between member's 11th and 13th birthday and • 1 tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine given between 10th and 13th birthday • 2 or 3 doses of the human papillomavirus (HPV) vaccine given between 9th and 13th birthday. Two doses at least 146 days apart meets criteria.	**Exclusions:** Please refer to the HEDIS® Value Set Directory (VSD) for specific exclusion codes for contradictions including: Anaphylactic reaction, Encephalopathy and Adverse Effect of Tdap. The exclusion must have occurred on or before the member's 13th birthday. **CPT Codes:** Meningococcal – 90619, 90733, 90734 Tdap – 90715 HPV – 90649, 90650, 90651 **Best Practices:** • Always use CAIR2 – California Immunization Registry – cairweb.org. • Note child's age and group vaccines against meningitis, HPV cancers, and whooping cough accordingly. Allow 146 days between HPV 1 and HPV 2 (give on or between member's 9th and 13th birthdays). • Start recommending HPV vaccination at age 9 to increase the success of completing the series by 13.

HEDIS® MEASURE	AGE	LOB	REQUIREMENT AND DOCUMENTATION	SAMPLE CODES / EXCLUSIONS
Lead Screening in Children (LSC)	Children who turn 2 years of age during the measurement year	Medi-Cal	The percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday **Best Practices:** • Ensure templates include word “counseling.” • Be specific about health education given and to pics discussed.	**Exclusions** – Members in hospice or using hospice services during the measurement year. **CPT codes:** 83655 – Venous blood withdrawal test for lead level screening. **Best Practice:** Test Lead with HGB, per Bright Futures Z02.5 – sports physical
Well-Child Visits in the First 15 Months of Life (W30A) -6 or more well child visits on different dates of service on or before 15 months. **Well-Child Visits in the First 15-30 Months of Life (W30B)- two or more well-child visits on different dates of service between 15- and 30-month birthdays**	0-15 months old in 2023 15-30 months old in 2023	Commercial, Medi-Cal	The documentation must match the CPT or ICD-10 code definition. If the visit matches the code definition for CPT 99381-99395 (“Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/ diagnostic procedures” - equivalent to a CHDP health assessment), submit that CPT code to receive HEDIS® credit. If the visit includes a significant component of well-care but does not meet the full definition for CPT 99381-99395, submit office visit CPT 99202-99215 together with a matching well-care ICD-10 Z-code to receive HEDIS® credit. The preferred documentation has the ICD10 Z-code plus the code definition printed in the assessment/ plan where it can be easily seen by reviewers. A key phrase like “preventive care,” “wellness visit,” “well care,” “well-child,” or “routine health examination” should be included, along with a notation if there are abnormal findings. Visits must be with a PCP but does not need to be the practitioner assigned to the child. **Best Practices:** • If no labs or diagnostic procedures are ordered, indicate “no labs/procedures ordered” to make clear this was intentional. • Schedule visits ahead of time. • Proper coding is essential so make sure age-specific CPT code is billed.	**ICD-10:** Z00.121 / Z00.129 – Encounter for routine child health examination with / without abnormal findings (age 0-17) Z00.110 – Health Examination for newborns under 8 days old **CPT Preventive codes:** 99381 – age <1-year new patient 99391 – age <1-year established patient 99382 – age 1-4 new patient 99392 – age 1-4 established patient Visits must be with a PCP but does not need to be the practitioner assigned to the child.

	HEDIS® MEASURE	AGE	LOB	REQUIREMENT AND DOCUMENTATION	SAMPLE CODES / EXCLUSIONS
CHILDREN & ADOLESCENTS	**Developmental Screening in the First Three Years of Life (DEV)**	1-3 years of age as of 12/31/2023	Medi-Cal	The percentage of children screened for risk of developmental, behavioral, and social delays using standardized screening tool in the 12 months preceding or on their first, second, or third birthday. The preferred documentation must include all of the following: Date of service when screening test was completed, and the standardized tool used and evidence of screening result or screening score. **Best Practices:** The following domains must be included in the standardized development screening: • Motor • Language • Cognitive • Social-emotional	**CPT:** 91660 – Developmental Screening in the first three (3) years of life **Note:** The following tools do not meet criteria: • Child's social-emotional development (ASQ-SE) or • Autism Screening (M-CHAT)
	Topical Fluoride for Children (TFC)	1-20 years as of 12/31/2023	Medi-Cal	The percentage of children 1-20 years old who receive at least two fluoride varnish applications on different dates of service during 2023.	**CPT Code:** 99188 – Application of fluoride varnish **CDT code:** D1206 – Topical application of fluoride varnish Exclusions – Members in hospice or using hospice services during the measurement year.
DIABETES CARE	**Hemoglobin A1c Control for Patients with Diabetes (HBD)**	18-75 years as of 12/31/2023 (Type I or Type II Diabetics)	Commercial, Medi-Cal, Medicare	Documentation of a hemoglobin A1c (HbA1c) blood test in 2023 with date and result. **Includes:** **1.** Control <8% – higher rate is better **2.** Poor Control >9% – lower rate is better • Most recent reading during the year counts.	**HbA1c Tests CPT:** 83036 3044F - HbA1c Level <7.0 3051F – HbA1c Level = 7.0 - 7.9 3052F – HbA1c Level = 8.0 - 9.0 3046F – HbA1c Level >9.0 (non-compliant) **Exclusions for all CDC components:** Members in hospice, gestational diabetes, steroid induced diabetes, members age 66+ in institutional SNP or long- term institution or with frailty and advanced illness or dementia. **NOTE:** Do not use discontinued code 3045F.

HEDIS® MEASURE	AGE	LOB	REQUIREMENT AND DOCUMENTATION	SAMPLE CODES / EXCLUSIONS
Kidney Health Evaluation for Patients with Diabetes (KED)	18-85 years as of 12/31/2023	Commercial, Medi-Cal, Medicare	Members with diabetes (type 1 and type 2) who received both of the following: • At least one **eGFR** (estimated glomerular filtration rate) blood test **and** • At least one **uACR** (urine albumin-creatinine ratio) urine test.	**Lab CPT codes:** 82043 – Albumin; urine (e.g., microalbumin), quantitative 82570 – Creatinine; urine 82565 – Creatinine; serum **Exclusions:** Evidence of ESRD, member in palliative care, enrolled in an institutional SNP or long-term institution, have frailty and advanced illness.
Eye Exam for Patients with Diabetes (EED)	18-75 years as of 12/31/2023 (Type I or Type II Diabetics)	Commercial, Medi-Cal, Medicare	Diabetics who had one of the following with an eye care professional (optometrist or ophthalmologist): • A retinal or dilated eye exam by an eye care professional during 2023. • A negative retinal or dilated eye exam (negative for retinopathy) by an eye care professional in 2022. **Best Practices:** • Use CPT II codes in current measurement year to indicate "without retinopathy" for compliance in current and following year. • CPT II code 3072F can be used to indicate no retinopathy in prior year. • For retinal photos, the most common code for Eye Care Professionals to use is 92250 (not to be coded by PCP). • Other codes for eye professionals are available on the Retinal Eye Coding Guide.	**Diabetic Retinal Screening CPT:** 67028 - 99245 – limited to eye care professionals **Diabetic Retinal Screening Negative CPT II:** 3072F (negative in 2021) **Diabetic Retinal Screening done by Eye Care Professional and coded by any Provider type CPT II:** **2022F** – Face to face dilated exam with interpretation documented & reviewed, with evidence of retinopathy. **2023F** – Face to face dilated exam; without evidence of retinopathy. **2024F** – 7 standard photos with interpretation documented & reviewed: with evidence of retinopathy. **2025F** – 7 standard photos; without evidence of retinopathy. **2026F** – Retinal telemedicine (e.g., EyePACS) eye imaging validated to match diagnosis from 7 standard field stereoscopic photos: with evidence of retinopathy. **2033F** – Retinal telemedicine (e.g., EyePACS) eye imaging validated to match diagnosis from 7 standard field stereoscopic photos: without evidence of retinopathy.

	HEDIS® MEASURE	AGE	LOB	REQUIREMENT AND DOCUMENTATION	SAMPLE CODES / EXCLUSIONS
DIABETES CARE	**Blood Pressure Control for Patients with Diabetes (BPD)**	18-75 years as of 12/31/2023 (Type I or Type II Diabetics)	Commercial, Medi-Cal, Medicare	Members with diagnosis of diabetes whose blood pressure was <140/90 by the end of 2023. **Best Practices:** • Most recent BP value counts. • Use CPT II outcome codes to avoid Medi-Cal record requests. • Retake BP at end of appointment if reading is high during initial vitals – lowest values count. • Electronically submitted BP readings from patient monitoring devices are acceptable. **Telehealth:** • BP readings from patient digital BP monitoring device during telehealth visits are acceptable. • For Medicare, video should be used but still document reading if audio only.	**CPT II Codes:** 3074F – Systolic <= 129 3075F – Systolic = 130-139 3077F – Systolic>= 140 (non-compliant) 3078F – Diastolic <= 79 mm Hg 3079F – Diastolic = 80-89 mm Hg 3080F – Systolic>= 90 mm Hg (non-compliant)
SENIORS	**Advance Care Planning (ACP)**	66-80 years with advanced illness, an indication of frailty, or who are receiving palliative care, and those 81 years and older as of 12/31/2023	Medicare	Documentation for an Advance Care Plan must include the date that a discussion occurred, that an Advance Care Plan was executed, or a note that a plan is in the medical record.	**Document Present CPT II:** 1157F **Discussion Documented CPT II:** 1158F
	Care for Older Adults (COA)	66 years and older as of 12/31/2023	Medicare SNP (Special Needs Plan) and MMP (Medicare-Medicaid Plan)	Members who had each of the following during 2023. • Medication review and reconciliation • Functional status assessment • Pain Assessment **Best Practice:** • Code for all 3 components above as there is a separate rate for each. • Documentation for Medication Review must include medication list and date it was reviewed or note of no medications. **Cont'd**	**Medication Review:** CPT II: 1160F **Medication List:** CPT II: 1159F Both codes must be used. **Functional Status Assessment:** CPT II: 1170F **Pain Assessment:** Pain Present CPT II: 1125F Pain not Present CPT II: 1126F

HEDIS® MEASURE	AGE	LOB	REQUIREMENT AND DOCUMENTATION	SAMPLE CODES / EXCLUSIONS
			• Complete Annual Wellness Exam (AWE) for all eligible patients and code for COA. • Functional Status documentation must specify • "ADLs were assessed" or "IADLs were assessed" or reference the standardized tool used or display the questions with the answers. • Documentation for Advance Care Plan must include note of discussion and date, or note that advance care plan was executed, or note that plan is in the medical record. **Telehealth:** • The COA measure can be completed during any medically necessary visit including telephone visits. • The functional status and pain assessments can be conducted by phone by any care provider type, including registered nurses and medical assistants. • Medication review can be done by a prescribing clinician or clinical pharmacist, or a nurse practitioner signed by the clinician or pharmacist to document the list was reviewed (code CPT II codes). • Take advantage of every phone call or visit to complete this measure. • More details are available on the "Care for Older Adults 2020-21 Coding and Documentation Guide."	
Osteoporosis Screening and Management after Fracture (OMW)	Women 67-85 years as of 12/31/2023	Medicare	Women with a fracture date between 07/01/2022 – 06/3/2023 and who had either a bone mineral density (BMD) test or dispensed prescription for a drug to treat osteoporosis **in the 6 months (180 days) after the fracture.** • Does not include fractures to the fingers, toe, face, or skull.	**Medications:** Alendronate, Alendronate-cholecalciferol, Ibandronate, Risedronate, Zoledronic acid. Albandronate, Denosumab, Raloxifene, Romosozumab, Teriparatide. **Exclusions:** Members age 66+ in institutional SNP or long-term institution or with frailty and advanced illness or dementia or in palliative care (can be through telehealth encounters). Other exclusions apply.
Osteoporosis Screening in Older Women (OSW)	Women age 66-75 years as of 12/31/2023	Medicare	• Women who received one osteoporosis screening between their 65th birthday and12/31 of the measurement year. • There is no event/diagnosis for this measure.	**Osteoporosis screening test** **CPT codes:** 76977, 77078, 77080, 77081, 77085 **Exclusions:** Members already diagnosed with osteoporosis, receiving palliative care, enrolled in an institutional SNP or long-term institution, have frailty and advanced illness, dementia.

	HEDIS® MEASURE	AGE	LOB	REQUIREMENT AND DOCUMENTATION	SAMPLE CODES / EXCLUSIONS
SENIORS	**Use of High-Risk Medications in the Elderly (DAE)**	67 years and older as of 12/31/2023	Medicare SNP (Special Needs Plan) and MMP (Cal Medi Connect)	Medicare members aged 67 and older who received at least: • Two dispensing events for high-risk medications to avoid from the same drug class, or • Two dispensing events for high-risk medications to avoid from the same drug class, except for appropriate diagnosis.	**Note:** • Some medication classes are considered high-risk in any amount, while others have a day's supply or average daily dose threshold to be considered high-risk. • A lower rate represents better performance.
WOMEN ONLY	**Breast Cancer Screening (BCS)**	Women ages 50-74 by 12/31/2023	Commercial, Medi-Cal, Medicare	Women who had a mammogram to screen for breast cancer between 10/01/2021 and 12/31/2023 (at least every 27 months). **Best Practices:** • MRIs, breast ultrasounds or biopsies DO NOT meet standards for this measure. Breast tomosynthesis does count. • Screen every other year.	**CPTs:** 77067, 77066, 77065 **Exclusions:** Bilateral Mastectomy: Z90.13. • Best practice is to code exclusions every year during any outpatient encounter submission, especially if the member changed health plans.
	Cervical Cancer Screening (CCS)	Women 21-64 years as of 12/31/2023	Commercial, Medi-Cal	**Women 21-64 years of age who were screened for cervical cancer using either of the following criteria:** • Women age 21-64 who had cervical cytology performed during the measurement year or two years prior (every 3 years). • Women age 30-64 who had cervical high-risk human papillomavirus (hrHPV) testing performed during the measurement year or four years prior (every 5 years) and who were 30 years or older on the date of the test. • Women age 30-64 who had cervical cytology/high-risk human papillomavirus (hrHPV) co-testing performed during the measurement year or four years prior (every 5 years) and who were 30 years or older on the date of the test. **Best Practices for Over Age 30:** • HPV test alone will count for this measure. If testing cytology and HPV, it is important to order. • Co-testing (cytology and HPV). • Do not order Reflex testing where HPV is only tested if the cytology result is positive - a HPV test is required for compliance. • Self-reported screening from other provider or other countries that documents date (or month/year) and result in the medical record is acceptable.	**Cervical Cytology only CPT:** 88142 HPV **Test CPT:** 87624 HPV LOINC: 8675-0 **Exclusions:** Documentation of total hysterectomy with absence of cervix, cervical agenesis or acquired absence of cervix. **Z90.710** – Acquired absence of cervix and uterus **Z90.712** – Acquired absence of cervix with remaining uterus (rare) **Q51.5** – Agenesis and aplasia of cervix (including transgender male) • Document exclusions every year. • Document "TAH," "total (or complete or radical) hysterectomy" or "no cervix" or "vaginal hysterectomy" or exclusion will not count. • Documentation of hysterectomy alone will not count.

WOMEN ONLY

HEDIS® MEASURE	AGE	LOB	REQUIREMENT AND DOCUMENTATION	SAMPLE CODES / EXCLUSIONS
Chlamydia Screening in Women (CHL)	16-24 years as of 12/31/2023	Commercial, Medi-Cal	Women identified as sexually active who had at least one test for chlamydia during 2023. Two methods identify sexually active: **1.** Pharmacy data (dispensed contraceptives during the measurement year) **2.** Encounter data	**CPT: 87491** **Best Practice:** • Offer testing to all young women who turn 16 years or older by 12/31/2023. • Chlamydia can be tested by urine or gynecological exam.
Prenatal Care, Timeliness of (PPC-Pre)	Live births between 10/08/2022 - 10/07/2023 Prenatal care visit in the first trimester or within 42 days of enrollment First trimester is defined as 280-176 days prior to delivery (or EDD).	Commercial, Medi-Cal, Medicare	After a pregnancy test is confirmed, the PCP should code the visit as a Prenatal Visit and include the following: • Diagnosis of pregnancy • Last menstrual period (LMP) or estimated date of delivery (EDD) or gestational age • Date of service **Best Practice:** • Documenting the prenatal care visit on the same day of the positive pregnancy test helps meet the timing requirements of this measure. • Ensure that pregnant and recently delivered patients get priority for OB appointments. • Services may be provided by a PCP, OBGYN, other family care practitioner or Midwife. • Physical requirements such as a basic physical or OB exam or pelvic exam or fundus height, OB panel, TORCH panel, blood typing test or ultrasound of pregnant uterus can also be done in person to close this measure. **Telehealth:** • Prenatal visits can be completed by telehealth by documenting the items above.	**Procedure codes:** **Prenatal visit during first trimester CPT:** 99201-99205, 99211-99215, 99241-99245 **CPT II:** 0500F **OB panel:** 80055 **Prenatal ultrasound:** 76801, 76805, 76811, 76813, 76815-76821, 76825-76828 **NOTE:** • CPSP (Comprehensive Perinatal Services Program) codes will be cross walked to appropriate CPT code.

	HEDIS® MEASURE	AGE	LOB	REQUIREMENT AND DOCUMENTATION	SAMPLE CODES / EXCLUSIONS
WOMEN ONLY	**Postpartum Care (PPC-Post)**	Live births between 10/08/2022 - 10/07/2023 Postpartum visit between **7 and 84 days** after delivery.	Commercial, Medi-Cal	Documentation of a postpartum visit on or between 7 to 84 days after delivery and must include one of the following acceptable notations: • Postpartum care • PP care • PP check • 6-week check (Other notations may apply). **Best Practices:** • Schedule both early (2nd week) and late (4-8 weeks) postpartum visits before mother and baby leave the hospital. • Offer home visit for postpartum. • Incision check for post C-section does not constitute a postpartum visit. • Physical requirements such as a basic physical or OB exam or pelvic exam or fundus height, OB panel, TORCH panel, blood typing test or ultrasound of pregnant uterus can also be done in person to close his measure. **Telehealth:** • Postpartum visit can be completed by telehealth with notations above.	**Postpartum CPT II:** 0503F **Postpartum Visit ICD-10CM:** Z39.2 **NOTE:** • CPSP (Comprehensive Perinatal Services Program) codes will be cross walked to appropriate CPT code. • Global CPT codes may not reflect when postpartum care was rendered. • Z39.2 is the preferred ICD10 code that can be attached to any E&M code. Other Prenatal/Postpartum measures include: **1.** Prenatal Depression Screening and Follow-Up (PND) **2.** Postpartum Depression Screening and Follow-Up (PDS) **3.** Prenatal Immunization Status (PRS) (first year measure)
PHARMACY MEASURES	**Asthma Medication Ratio (AMR)**	5-64 years as of 12/31/2023	Commercial, Medi-Cal	Members who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.	Pharmacy data determines this measure. **ICD10CM:** J45.21, J45.22, J45.30-J45.32, J45.40-J45.42, J45.50-J45.52, J45.901, J45.902, J45.909, J45.991, J45.998 **Exclusions:** Members with any the following conditions during their medical history through the measurement year. • Emphysema • Chronic obstructive pulmonary disease (COPD) • Obstructive Chronic Bronchitis • Chronic Respiratory Conditions due to fumes or vapors • Cystic Fibrosis • Acute respiratory failure • Cystic Fibrosis

DEPRESSION SCREENING

HEDIS® MEASURE	AGE	LOB	REQUIREMENT AND DOCUMENTATION	SAMPLE CODES / EXCLUSIONS
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	6 years and older (with a diagnosis on or between January 1 and December 1 of the current year)	Commercial, Medicare, Medi-Cal	The percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit with any practitioner for mental illness. Two rates are reported: **1.** The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days). **2.** The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days). **Telehealth:** Follow-up visit after ED visit for mental illness can be completed by telehealth.	**Mental Illness Diagnosis Codes ICD-10:** F20.0 – F94.9 **Best practice:** • Use a diagnosis code for mental illness at each follow-up (a non-mental illness diagnosis code will not fulfill this measure).
Follow-up After Emergency Department Visit for Substance Use (FUA)	13 years and older (with a diagnosis on or between January 1 and December 1 of the current year)	Commercial, Medicare, Medi-Cal	The percentage of emergency department (ED) visits among members ages 13 years and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of a drug overdose, for which there was the follow-up. 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). **Telehealth:** Follow-up visit after ED visit for mental illness can be completed by telehealth.	**Substance Use Disorder Diagnosis ICD-10:** F10.920 – F19.99 **Best Practice:** • Use a diagnosis code for substance use at each follow-up visit (a non-substance diagnosis code will not fulfill this measure).

DEPRESSION SCREENING

HEDIS® MEASURE	AGE	LOB	REQUIREMENT AND DOCUMENTATION	SAMPLE CODES / EXCLUSIONS
Depression Remission or Response for Adolescents (DRR-E) **Coming in 2024**	12 years and older (with a diagnosis of depression and an elevated PHQ-9 on or between May 1 of the year prior through December 31 of the current year)	Commercial, Medicare, Medi-Cal	The percentage of members 12 years of age and older with a diagnosis of depression and an elevated PHQ-9 score, who had evidence of response or remission within 4- 8 months of the elevated score. **1.** Follow-up PHQ-9. The percentage of members who have a follow-up PHQ-9 score documented within 4-8 Months after the initial elevated PHQ-9 score (elevated PHQ-9 scores are >9). **2.** Depression Remission. The percentage of member who achieved remission within 4-8 months after the initial elevated PHQ-9 Score. **3.** Depression Response. The percentage of members who showed response to treatment for depression within 4-8 months **Telehealth:** Telehealth and telephone follow-up are acceptable. **Eligible screening tools:** • PHQ-9 12 years of age and older. • PHQ-9 Modified for teens 12-17 years of age.	LONIC CODE: (PHQ-9): 442616 (PHQ-9 Teen): 89204-2 **Note:** PHQ are supplemental data, please contact MedPOINT's Quality Dept. to discuss the submission process at: QualitySpecialists@medpointmanagement.com **Best practice:** • Depression follow-up – a PHQ-9 total score in the member's record during the depression follow-up period. • Depression Remission – members who achieve remission symptoms, as demonstrated by the most recent PHQ-9 score of <5 during the depression follow-up period. • Depression Response – members who indicate a response to treatment for depression, as demonstrated by the most recent PHQ-9 total score being at least 50 percent lower than the PHQ-9 score associated with the initial elevated PHQ-9 total score >9, documented during the depression follow-up period. **Exclusions:** Members with any of the following: • Bipolar disorder • Personality disorder • Psychotic disorder • Pervasive developmental disorder • Hospice
Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)	12 years and older (who were screened for clinical depression using a standardized instrument on or between January 1 and December 1 of the current year)	Commercial, Medicare, Medi- Cal	The percentage of members 12 years of age and older who were screened for clinical depression using a standardized instrument and, if screened positive, received follow-up care within 30 days. **1.** Depression Screening. The percentage of members who were screened for clinical depression using an age-appropriate standardized instrument. **2.** Follow-Up on Positive Screen. The percentage of members who received follow-up care within 30 days of the first positive depression screen finding. **Telehealth:** Follow-up.	LONIC CODE: (PHQ-9): 44261-6 (PHQ-9 Teen): 89204-2 **Note:** PHQ are supplemental data, please contact MedPOINT's Quality Dept. to discuss the submission process at: QualitySpecialist@medpointmanagement.com **Best Practice**: • An outpatient, telephone, e-visit, or virtual check-in- a follow-up visit with a diagnosis of depression or other behavioral health condition. • A depression case management encounter that documents assessment for symptoms of depression or a diagnosis of depression or other behavioral health conditions. • A dispensed antidepressant medication.

PLEASE NOTE

Information above is subject to change.

This list is not a complete list of all HEDIS® measures. The codes listed above are SAMPLE CODES.

Please refer to HEDIS® Measurement Year 2023 Volume 2 Technical Specifications for Health Plans and NCQA's HEDIS® Value Set Directory for a complete list.

Member Satisfaction Surveys (CAHPS) are part of HEDIS® and some P4P Programs.

MedPOINT MANAGEMENT

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