2022 HACKENSACK MERIDIAN *HEALTH* PARTNERS
COMMERCIAL AND MEDICARE CLINICAL MEASURES

Hackensack Meridian
Partners

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PREFACE

The Population Health and the Physician Services Division are pleased to provide you a copy of the updated 2022 Hackensack Meridian *Health* Partners (HMHP) Commercial and Medicare Clinical Measures Guide. This guide is intended to be a reference for HMHP Board Approved HEDIS measures and relevant clinical measures in Medicare plans for the ambulatory providers in Hackensack Meridian *Health* Partners (HMHP), HMH's Clinically Integrated Network (CIN). Due to the COVID public health emergency this guide is published only in electronic form for PY 2022.

Quality measures and specifications may change occasionally. The payor-plans may differ as a result of customization of outcomes and population-specific measures implemented by payors. For commercial payors, except Medicare Advantage plans, the HMHP Board Approved Measures are the HEDIS measures and the NCQA national benchmarks are used to set targets. The measures are selected as per the contractual obligations of HMHP with commercial payors. For all Medicare Plans, the benchmarks/targets are set by the CMS.

If your electronic medical record (EMR) is not exchanging clinical data with HMH Datawarehouse, we require both billable and non-billable CPT/ HCPCS/ ICD/ LOINC/ UBREV codes via your claims data to measure quality performance. Exclusion codes must be applied to exclude patients who are not eligible for respective measures. The goal of this reference guide is to improve quality metric documentation and assist you in getting credits or incentives for your quality performance. Please work with your EMR company to update the measure specifications and establish data exchange with HMHP's data warehouse. We can provide you with additional information about measure mapping, and directions in setting up clinical data exchange with HMH. Thank you for all the feedback you provided for the 2022 Guide as we update this guide on an annual basis. We welcome your feedback so that we can continue to improve.

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Please note: This guide is prepared for informational purposes only and is not intended to grant rights or impose obligations or guarantee reimbursements. The information provided is only to give relevant insights into improving your clinical documentation and quality performance. It is not intended for replacing NCQA-HEDIS or CMS guidelines. We encourage you to review the HEDIS Manual/CMS measure registries for a full and detailed review of its contents.

MEASURE BENCHMARKS AND TARGETS

For HMHP Commercial payers each measure has targets set using national benchmarks of NCQA-HEDIS at 50th, 75th and 90th Percentiles. The HMHP target is 75th Percentile and the expectation is to achieve 90th Percentile or above.

For CMS programs like MSSP ACO and MIPS the benchmarks/ targets are set by the CMS. Please refer to the Appendices of this guide to know the 2022 targets and benchmarks of all HMHP commercial and CMS programs.

For non-employed HMH providers, using different EMRs, please ensure that scanned documents of lab results and imaging results are documented in your EMR and documented in the claims using the appropriate codes given in this guide. Contact your EMR companies and billing companies to make the clinical documentation updates so that all lab results and scanned documents necessary to satisfy the quality measures are coded appropriately and transmitted to HMH via the claims data or by the clinical data exchange via HIE (Health Information Exchange). If your EMRs have real time quality dashboards, we recommend updating them with updated targets and benchmarks in this guide.

For those still on paper medical records, we strongly encourage you to adopt an EMR since all ACO programs and value-based programs are data-driven and the EMR is the source of truth for all kinds of clinical documentation. Please ensure that all measure-based CPT II/HCPCS/ICD/LOINC codes are documented in the claims files and transmitted to HMH.

For HMH employed providers, who are on Epic, additional resources on scanning workflow or enter/edit results workflow can be found in the Knowledge Builders (KBs) available on the Epic Learning Dashboard. Please refer to the pages in this guide for HEDIS Benchmarks and Targets.

2022 HMHP COMMERCIAL MEASURES

(Please refer Page 5 for detailed grid of payer measures and Page 32 for HEDIS Benchmarks and HMH Targets)

Quality Measure Performance Year 2022 (Commercial and Medicare Advantage Measures)
Controlling High Blood Pressure (CBP)
Breast Cancer Screening (BCS)
Colorectal Cancer Screening (COL)
Cervical Cancer Screening (CCS)
Statin Therapy for Patients with Cardiovascular Disease (SPC): Statin Therapy and Adherence
Statin Therapy for Patients with CAD (SPC): Statin Therapy (For Cigna)
Statin Therapy for Patients with Cardiovascular Disease (SPC): Adherence only
Depression Screening and Follow up for Adolescents and Adults (DSF)
Adolescent Well Care Visits 3 to 21 years old (WCV)
Diabetes: HbA1C < 8% (CDC)
Diabetes: HbA1C >9% (Poor Control-Inverse Measure) (HBD)
Diabetes: HbA1c Testing (CDC)
Diabetes: Medical Attention for Nephropathy (CDC)
Diabetes: Eye Exam (EED)
Statin Use with Patients with Diabetes (SUPD)
Kidney Health Evaluation for Patients with Diabetes (KED)
Osteoporosis in Women who had a fracture
Diabetes: Adherence of Oral Diabetes Medication
Medication Adherence of Oral Diabetes, Cholesterol (Statin) and Hypertension RAS Antagonist Medications
Asthma Medication Ratio (AMR)
All-Cause Readmissions (within 30 days)

Domain	Measure #	Description
Care Coordination/ Patient Safety	ACO-8	Risk-Standardized, All Condition Readmission (Inverse Measure)
Care Coordination/ Patient Safety	ACO-38	Risk-Standardized Acute Admission Rates for Patients with Multiple Chronic Conditions (Inverse Measure)
Care Coordination/ Patient Safety	ACO-13	Screening for Future Fall Risk
Preventive Health	ACO-14	Influenza Immunization
Preventive Health	ACO-17	Tobacco Use: Screening and Cessation Intervention
Preventive Health	ACO-18	Screening for Depression and Follow-up Plan
Preventive Health	ACO-19	Colorectal Cancer Screening
Preventive Health	ACO-20	Breast Cancer Screening
Preventive Health	ACO-42	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease
At-Risk Population	ACO-40	Depression Remission at Twelve Months
At-Risk Population	ACO-27	Hemoglobin A1c Poor Control (Inverse Measure)
At-Risk Population	ACO-28	Controlling High Blood Pressure

*MSSP MEASURES

Quality Measure Grid Performance Year 2022	Horizon Alliance	Aetna	Cigna	Horizon Medicare Advantage	Aetna Medicare Advantage	Braven Medicare Advantage
Controlling Blood Pressure (BP)*			X	X		X
Breast Cancer Screening*	X	X	X	X	X	X
Colorectal Cancer Screening*	X	X		X	X	X
Cervical Cancer Screening	X					
Statin Therapy for Patients with CVD (SPC) - Statin Therapy and Adherence		X				
Statin Therapy for Patients with CVD (SPC) - Statin Therapy*					X	
Statin Therapy for Patients with CAD (SPC) - Statin Therapy*			X			
Statin Therapy for Patients with CVD (SPC) - Adherence only	X					
Statin Use for Persons with Diabetes (SUPD)*					X	
Osteoporosis in Women who had a fracture					X	
Depression Screening - 12 years and older*			X			
Adolescent Well Care- 3 to 21 years old			X			
Diabetes Care: Eye Exam	X			X	X	X
Diabetes: Testing		X				
Diabetes: HbA1C < 8%			X			
Diabetes Care: HbA1C </= 9% (Controlled)					X	
Diabetes: HbA1C >9% (Poor Control-Inverse Measure)*	X	X		X		X
Kidney Health Evaluation for Patients With Diabetes (KED)	X			X		X
Diabetes: Medical Attention for Nephropathy					X	
Asthma Medication Ratio	X					
Medication Adherence of Oral Diabetes Medication					X	
Medication Adherence for Cholesterol (Statins)					X	
Medication Adherence for Hypertension (RAS Antagonist)					X	
Plan All-Cause Readmission				X		X
HEDIS 2021: Adolescent Well-Care Visits (3 - 21 years of life)						
HEDIS 2021: Appropriate Testing for Pharyngitis						
HEDIS 2021: Weight Assessment and Counseling for Nutrition and Physical for Childhood/Adolescents-BMI Percentile						
HEDIS 2021: Weight Assessment and Counseling for Nutrition and Physical for Childhood/Adolescents - Counseling for Nutrition						
HEDIS 2021: Well-Child Visits in the First 30 Months of Life (Two submeasures:0-15 months is 6 or more visits; 15-30 months is 2 or more visits)						
HEDIS 2021: Asthma Medication Ratio (5 - 64 years of life)						

Yellow shading indicates CIN Pediatric measures.

BREAST CANCER SCREENING

Percentage of Women aged 50 – 74 who had one or more mammograms to screen for breast cancer anytime on or between October 1 two years prior to the measurement year and December 31 of the measurement year.

For All Payors: MRIs, USG or biopsies DO NOT meet measure compliance. They are performed as an adjunct to mammography and do not alone count toward the numerator.

Digital Breast Tomosynthesis meets the measure.

HEDIS Required Screening Mammography Coding	
Exclusions	
Bilateral or Absence of Left/Right breast (Acquired/Prophylactic)	Z90.11 (R), Z90.12 (L), Z90.13 Bilateral
Medicare Advantage members 66 years and older enrolled in Institutional SNP and Long-Term Care Centers	Medicare CPT-G9898 Medicare Advantage: Administrative Claims
Members 66 years and older with following status: ■ At least one claim/encounter for frailty during the measurement year and two outpatient claims with advanced illness during the measurement period. *(Two outpatient claims/encounter with Advanced Illness can be Outpatient visits, Observations, ED visits, Telephone visits, Online assessments or Non-acute inpatient encounters or discharges)* ■ At least one claim/encounter for frailty during the measurement period AND a dispensed medication for dementia during the measurement period or the year prior to the measurement.	Must meet **BOTH** Frailty and Advanced Illness Refer **Frailty and Advanced Illness Codes** on Page 26 Refer **Dementia Medications Table** in Page 30
Palliative Care Services received during the measurement year	Z51.1

Commercial patients report the appropriate ICD-10 codes for Mastectomy or any combination of a mastectomy on both left AND right side on the same or different dates of service. 2022 updated codes for Frailty include Frailty Device, Frailty Diagnosis, Frailty Encounter and Frailty Symptoms.

Additional Quality Data Options for Medicare Patients	
Mammogram PERFORMED and REVIEWED **G9899**	Screening, diagnostic, film, digital or digital Breast Tomosynthesis (3d) mammography results documented and reviewed, for Medicare patients.
Mammogram NOT PERFORMED, Patient NOT Eligible. **Denominator Exclusion G9708**	Women who had a bilateral mastectomy or who have a history of a bilateral mastectomy or for whom there is evidence of a right and a left unilateral mastectomy.
Patient receiving Hospice Services, Patient Not Eligible. **Denominator Exclusion: G9709**	Hospice services used by patient any time during the measurement period.
G9898 Denominator Exclusion	Patients aged 66 or older in institutional special needs plans (SNP) or residing in long-term care for more than 90 consecutive days with POS code 32, 33, 34, 54, or 56 for more than 90 consecutive days during the measurement period.
G2098 Denominator Exclusion	66 years of age and older with at least 1 claim encounter for frailty and a dispensed medication for dementia during the measurement period.
G2099 Denominator Exclusion	66 years of age and older with 1 claim encounter for Frailty during the measurement year and two outpatient claims with advanced illness during the measurement period.
G9992 Palliative Care Exclusion	Palliative Care services provided to patient any time during the measurement period.

Documentation Requirements in EMR (confirm with your vendor):

1. Order a Mammogram as required.
2. Document Mammogram results after scanning the document into your EMR as proof. Ensure all appropriate codes are documented in the EMR and the Claims file.
3. If done in the past (within October 1 two years prior to December 31 of measurement year) obtain the historical report and scan it as an external order to prove screening is done and document.

CERVICAL CANCER SCREENING (CCS)

The percentage of women ages 21-64 years of age, who were screened for cervical cancer using either of the following criteria:

1. Women aged 21-64 who had a cervical cytology performed within the last 3 years.
2. Women aged 30-64 who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years.
3. Women 30-64 years of age who had cervical cytology/high-risk human papillomavirus (hrHPV) co-testing within the last 5 years.

Do not count biopsies because they are diagnostic and therapeutic only and are not valid for primary cervical cancer screening.

HEDIS Required Coding	
Cervical Cytology Lab Test	CPT-88141-88143; 88147-88148; 88150; 88152-88154; 88164-88167; 88174-88175
	HCPCS-G0123-G0124; G0141; G0143-G0145; G0147-G0148; P3000-3001; Q0091
High Risk HPV Lab Test	CPT-87624-87625; 87624-87625.
	HCPCS- G0476

Cervical Cytology Lab tests or results or findings should be documented using appropriate codes—CPT, HCPCS, LOINC or SNOMED CT— during the measurement year or the two years prior to the measurement year for women 24-64 years of age.

High Risk HPV Lab tests, results or findings should be documented using appropriate codes-CPT, HCPCS, LOINC or SNOMED CT-during the measurement year or the four years prior to the measurement year for women 30-64 years.

For Commercial Patients - Denominator Exclusions	
Agenesis and Aplasia of Cervix	Q51.5
Encounter for Palliative Care	Z51.5
Acquired Absence of Both Cervix and Uterus	Z90.710
Acquired Absence of Cervix With Remaining Uterus	Z90.712

Chart Documentation of Exclusions:

The following examples meet criteria for documentation of hysterectomy with no residual cervix:

- Documentation of "complete," "total" or "radical" hysterectomy (abdominal, vaginal or unspecified).
- Documentation of "vaginal hysterectomy."
- Documentation of "vaginal pap smear" in conjunction with documentation of "hysterectomy."
- Documentation of "hysterectomy" in combination with documentation that the patient no longer needs pap testing/ cervical cancer screening.
- **Documentation of hysterectomy alone does not meet the criteria, because it is not sufficient evidence that the cervix was removed.**
- Evidence of hrHPV testing within the last 5 years also captures patients who had co-testing, therefore additional methods to identify co-testing **are not necessary.**

(For Cervical Cancer screening the national average of Commercial HMO performance of 2017, 2018 & 2019 are taken)

COLORECTAL CANCER SCREENING

Percentage of Members age 50–75 who were screened for Colorectal cancer using one or more of the following:

Note: Patients of age 45–75 are eligible for Colorectal cancer screening, according to 2021 updated recommendation from USPSTF and American College of Gastroenterology. Please see Page 34 for the **2022 HMH CRC Screening Campaign Guideline.** For payor-based quality reporting purpose the denominator is limited to age 45-75 as per HEDIS definition.

1. Fecal occult blood testing (FOBT) during measurement year. (At least one stool sample result must be documented with CPT/HCPCS codes).
2. Colonoscopy during measurement year or 9 years prior to measurement year.
3. Flexible sigmoidoscopy during measurement year or 4 years prior to measurement year.
4. CT Colonography during measurement year or 4 years prior to measurement year.
5. FIT DNA during measurement year or 2 years prior to measurement year.
6. Fecal Immunochemical testing (FIT) during measurement year.

HEDIS Required Coding	
FOBT Lab Test/Result	CPT-82270; 82274. HCPCS-G0328
Exclusions	
Colorectal Cancer	HCPCS-G0213-G0215; G0231. IC10CM-C18.0-C18.9; C19-C20; C21.2; C21.8; C78.5; Z85,038; Z85.048
Medicare Advantage members 66 year years and older enrolled in Institutional SNP and Long-Term Care Centers	Medicare: CPT-G9898 Medicare Advantage: Administrative Claims Only
Members 66 years and older with following: ■ At least one claim/encounter for frailty during the measurement year and two outpatient claims with advanced illness during the measurement period. *(Two outpatient claims/encounter with Advanced Illness can be Outpatient visits, Observations, ED visits, Telephone visits, Online assessments or Nonacute inpatient encounters or discharges).* ■ At least one claim/encounter for frailty during the measurement period AND a dispensed medication for dementia during the measurement period or the year prior to the measurement.	Must meet **BOTH** Frailty and Advanced Illness Refer **Frailty and Advanced Illness Codes** on Page 26 Refer **Dementia Medications Table** on Page 30

Additional Quality Data Options for Medicare Patients	
Colonoscopy Performed and Reviewed 3017F	Colorectal cancer screening results documented and reviewed.
Patient receiving Hospice Services, Patient Not Eligible. Denominator Exclusion: G9710	Hospice services used by patient any time during the measurement period.
G9711 Denominator Exclusion	Patients with a diagnosis or past history of total colectomy or colorectal cancer.
G9901 Denominator Exclusion	Patients aged 66 or older in institutional special needs plans (SNP) or residing in long-term care for more than 90 consecutive days with POS code 32, 33, 34, 54, or 56 for 13 more than 90 consecutive days during the measurement period.
G2100 Denominator Exclusion	Exclusion 66 years of age and older with at least 1 claim encounter for frailty and a dispensed medication for dementia during the measurement period.
G2101 Denominator Exclusion	Exclusion 66 years of age and older with 1 claim encounter for Frailty during the measurement year and two outpatient claims with advanced illness during the measurement period.
G9993 Denominator Exclusion	Palliative Care services provided to patient any time during the measurement period.

Note: Do not count: Digital Rectal Exams (DRE), FOBT tests performed in an office setting or performed on a sample collected via DRE.

Epi Pro Colon (Septin-9) blood test and Colon Capsule (PillCam) are NOT valid tests.

Members 66 years of age and older as of December 31 of the measurement year (all product lines) with frailty and advanced illness. Members **must meet BOTH** of the frailty and advanced illness criteria to be excluded.

Refer Page 26 of this guide for 2022 **Updated Exclusion Codes** for patients 66 years and older with both Frailty AND Advanced Illness. Refer to **Dementia Medications Table** on Page 30.

2022 updated codes for Frailty include Frailty Device, Frailty Diagnosis, Frailty Encounter, Frailty Symptoms.

Documentation requirements:

1. Order a Colorectal Cancer Screening test as required. Any test mentioned on the previous page will meet the measure if done in the appropriate time frame.

2. Results must be scanned into EMR, documented with appropriate codes and reviewed if done in the past. Make sure test dates meet the appropriate time frame.

3. Document all FOBT tests done in the office or at home with dates and test results.

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 mmHg) during the measurement period AND documented Diagnosis for hypertension **(ICD-10-CM): I10**

The BP reading must occur on or after the date of the second diagnosis of hypertension. If multiple BP measurements occur on the same date, or are noted in the chart on the same date, use the lowest systolic and lowest diastolic BP reading. If no BP is recorded during the measurement year, assume that the member is "not controlled." The member is numerator compliant if the BP is <140/90 mm Hg. The member is not compliant if the BP is ≥140/90 mm Hg, if there is no BP reading during the measurement year or if the reading is incomplete (e.g., the systolic or diastolic level is missing).

HEDIS Required Coding		
Systolic Blood Pressure	Most recent systolic blood pressure greater than or equal to 140 mmHg	G8753
Diastolic Blood Pressure	Most recent diastolic blood pressure greater than or equal to 90 mmHg	G8755
Essential Hypertension	Essential Primary Hypertension	ICD10CM-I10

Additional Quality Data Options for Medicare Patients	***These codes to report BP are also valid for Cigna-Exclusion codes are Medicare specific.***
G8752 *3074F or 3075F Cigna Only*	Most recent systolic BP <140
G8753 *3077F Cigna Only*	Most recent systolic BP > or = 140
G8754	Most recent diastolic BP < 90
G8755 *3077F Cigna Only*	Most recent diastolic BP > or = 90
G9273	Most recent BP Systolic < 140 and diastolic < 90 *Cigna Only*
G9740/Denominator Exclusion	Hospice services given any time during the calendar year.
G9231/Denominator Exclusion	Documentation of end stage renal disease (ESRD), dialysis, renal transplant before or during the measurement period or pregnancy during the measurement period.
G9910/Denominator Exclusion	Patients aged 66 and older in Institutional Special Needs Plans (SNP) or residing in long-term care with a POS code 32, 33, 34, 54 or 56 for more than 90 consecutive days during the measurement period.
G2115/Denominator Exclusion	Patients 66 - 80 years of age and older with at least 1 claim encounter for frailty and a dispensed medication for dementia during the measurement year.
G2116/Denominator Exclusion	Patients 66 - 80 years of age & older with at least one claim/encounter for frailty during the measurement period AND two outpatient encounters on different dates of service with an advanced illness diagnosis during the measurement period.
G2118/Denominator Exclusion	Patients 81 years of age & older with at least one claim/encounter for frailty during the measurement.
G0031 Palliative Care Exclusion	Palliative Care services provided to patient any time during the measurement period.

Exclusions	
End Stage Renal Disease Diagnosis	ICD10CM-N18.5; N18.6
Dialysis Procedure	Z99.2
Nephrectomy	Z90.5
Kidney Transplant	Z94.0
Pregnancy Diagnosis	Use ICD-10 Coding
Palliative Care	Z51.5
Hospice Encounter/Intervention	
Medicare Advantage members 66 years and older enrolled in Institutional SNP and Long-Term Care Centers	Administrative Claims
Members 66-80 years with following: ■ At least one claim/encounter for frailty during the measurement year and two outpatient claims with advanced illness during the measurement period. *(Two outpatient claims/encounter with Advanced Illness can be Outpatient visits, Observations, ED visits, Telephone visits, Online assessments or Non acute inpatient encounters or discharges).* ■ At least one claim/encounter for frailty during the measurement period AND a dispensed medication for dementia during the measurement period or the year prior to the measurement. ■ Members 81 years of age and older as of December 31 of the measurement year (all product lines) with one claim/encounter with frailty during the measurement period.	Must meet **BOTH** Frailty and Advanced Illness Refer **Frailty and Advanced Illness Codes** on Page 26 Refer **Dementia Medications Table** on Page 30

HbA1C TESTING

The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had Hemoglobin A1c (HbA1c) testing during the measurement year.

Other Quality Data Options for all CDC measures	
3044F	Most Recent Hemoglobin A1C Level <7.0%.
3046F	Most Recent Hemoglobin A1C Level >9% .
3051F	Most recent hemoglobin A1c (HbA1c) level greater than or equal to 7.0% and less than 8.0%.
3052F	Most recent hemoglobin A1c (HbA1c) level greater than or equal to 8.0% and less than or equal to 9.0%.
	Hospice services given any time during the calendar year.
Administrative Claims	Patients aged 66 or older in institutional special needs plans (SNP) or residing in long-term care for more than 90 consecutive days with POS code 32, 33, 34, 54, or 56 for more than 90 consecutive days during the measurement period.
Refer to Dementia Medications Table on Page 30	66 years of age and older with at least 1 claim encounter for frailty and a dispensed medication for dementia during the measurement period.
Refer to Frailty and Advanced Illness Codes on Page 26	66 years of age and older with 1 claim encounter for Frailty during the measurement year and two outpatient claims with advanced illness during the measurement period.

Exclusions for all CDC measures	
Palliative Care	Z51.5
Hospice Encounter/Intervention	
Gestational Diabetes in Pregnancy	O24.410
Steroid Induced Diabetes	E90.9
Polycystic Ovarian Syndrome	E28.2
Medicare Advantage members 66 years and older enrolled in Institutional SNP and Long-Term Care Centers	Administrative Claims
Members 66 years and older as of December 31 of the measurement period with following: ■ At least one claim/encounter for frailty during the measurement year ■ At least two outpatient visits with an advanced illness. (Two outpatient claims/encounter with Advanced Illness can be Outpatient visits, Observations, ED visits, Telephone visits, Online assessments or Non-acute inpatient encounters or discharges) ■ At least one acute inpatient encounter/discharge with an advanced illness ■ At least one claim/encounter for frailty during the measurement period AND a dispensed medication for dementia during the measurement period or the year prior to the measurement.	Must meet **BOTH** Frailty and Advanced Illness (Refer **Frailty and Advanced Illness Codes** on Page 26) Visit type need not be the same. (Refer **Dementia Medications Table** on Page 30)

Documentation requirements:
1. Document the lab results in the EMR and use the corresponding CPT code in claims to match the HbA1c value.

HbA1C POOR CONTROL (>9%)

Members 18-75 years of age with diabetes who had Hemoglobin A1c > 9.0% during the measurement period.
A distinct numeric result is required for numerator compliance.

Poor Control **IS AN INVERSE MEASURE** - Lower rate for this measure indicates better care or control.

The member is numerator compliant if the most recent HbA1c level is >9.0% or is missing a result, or if an HbA1c test was not done during the measurement year. The member is not numerator compliant if the result for the most recent HbA1c test during the measurement year is ≤9.0%.

Exclusions: Please refer to the same Exclusions table for CDC measures.

Documentation requirements:
1. Document the lab results in the EMR and use the corresponding CPT code in claims to match the HbA1c value. Most recent HbA1C level is considered for this measure.

HBA1C CONTROL (<8%)

Members 18-75 years of age with diabetes who had the most recent HbA1c level <8.0%. The member is not numerator compliant if the result for the most recent HbA1c test is ≥8.0% or is missing a result, or if an HbA1c test was not done during the measurement year.

Exclusions: Please refer to the same Exclusions table for CDC measures.

Documentation requirements:

1. Document the lab results in the EMR and use the corresponding CPT code in claims to match the HbA1c value. Most recent HbA1C level is considered for this measure.

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. The following rates are reported through pharmacy claims:

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%. Members who remained on a high-intensity or moderate-intensity statin medication for at least 80% of the treatment period.

Identify members having ischemic vascular disease (IVD) who met 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: MI, CABG, PCI, IVD, and other Revascularization Procedures.

Note: Please refer to the High and Moderate-Intensity Statin Medications List on page 18. All Cholesterol Meds DO NOT meet this measure.

Statin Use for Persons with Diabetes (SUPD): Patients aged 40 to 75 years at the beginning of the measurement period with Type 1 or Type 2 diabetes.

Statin Adherence Rate 80%: Pharmacy claims will capture two age/gender stratifications and a total rate:

- Males 21–75 years as of December 31 of the measurement year.
- Females 40–75 years as of December 31 of the measurement year.
- Total Rate.

Exclusions for SPC Measures	
Pregnancy and breastfeeding	Pregnancy diagnosis codes
In vitro fertilization	ICD codes
Patients on Clomiphene	Codes for Estrogen Agonists Medications
ESRD	ESRD diagnosis and Dialysis procedure codes
Cirrhosis	Cirrhosis codes
Myalgia, Myositis, Myopathy or Rhabdomyolysis	Muscular pain and disease codes
Medicare Advantage members 66 years and older enrolled in Institutional SNP and Long-Term Care Centers	Administrative Claims Only
Members 66 years and older as of December 31 of the measurement period with following: ■ At least one claim/encounter for frailty during the measurement year. ■ At least two outpatient visits with an advanced illness. (Two outpatient claims/encounter with Advanced Illness can be Outpatient visits, Observations, ED visits, Telephone visits, Online assessments or Nonacute inpatient encounters or discharges). ■ At least one acute inpatient encounter/discharge with an advanced illness. ■ At least one claim/encounter for frailty during the measurement period AND a dispensed medication for dementia during the measurement period or the year prior to the measurement.	Must meet **BOTH** Frailty and Advanced Illness (Refer **Frailty and Advanced Illness Codes** on Page 26) Visit type need not be the same. (Refer **Dementia Medications Table** on Page 30)

Additional Quality Data Options for Medicare Patients	
G9664	Patients who are currently statin therapy users or received an order (prescription) for statin therapy.
G9781 Denominator Exception	Documentation of a medical reason(s) for not currently being a statin therapy user or receiving an order (prescription) for statin therapy (e.g., patients with adverse effects, allergy or intolerance to statin medication therapy, hospice or palliative care, active liver disease or hepatic disease or insufficiency, and patient w/ end stage renal disease (ESRD). Statin-Associated Muscle Symptoms SAMS: myalgia, myositis, myopathy, or statin-associated autoimmune myopathy. Patients who experience significant or repeated statin-associated muscle symptoms may prefer not to take or continue statin therapy and therefore may be removed from the denominator. The following ICD-10-CM codes are included in the Denominator Exception (G9781) to define SAMS: G72.0, G72.9, M60.9, M79.10.
G9778 Denominator Exclusion	Patients who have a diagnosis of pregnancy.
G9779 Denominator Exclusion	Patients who are breastfeeding.
G9780 Denominator Exclusion	Patients who have a diagnosis of rhabdomyolysis.

STATIN THERAPY FOR PATIENTS WITH CARDIOVASCULAR DISEASE (SPC)

STATIN MEDICATIONS LIST:

(Only High and Moderate Intensity Medications are counted for this measure)

High, Moderate and Low-Intensity Statin Medications	
Description	Prescription
High-intensity statin therapy	Atorvastatin 40-80 mg
High-intensity statin therapy	Amlodipine-atorvastatin 40-80 mg
High-intensity statin therapy	Rosuvastatin 20-40 mg
High-intensity statin therapy	Simvastatin 80 mg
High-intensity statin therapy	Ezetimibe-simvastatin 80 mg
Moderate-intensity statin therapy	Atorvastatin 10-20 mg
Moderate-intensity statin therapy	Amlodipine-atorvastatin 10-20 mg
Moderate-intensity statin therapy	Rosuvastatin 5-10 mg
Moderate-intensity statin therapy	Simvastatin 20-40 mg
Moderate-intensity statin therapy	Ezetimibe-simvastatin 20-40 mg
Moderate-intensity statin therapy	Pravastatin 40-80 mg
Moderate-intensity statin therapy	Lovastatin 40 mg
Moderate-intensity statin therapy	Fluvastatin 40-80 mg
Moderate-intensity statin therapy	Pitavastatin 1–4 mg
Low-intensity statin therapy	Ezetimibe-simvastatin 10 mg
Low-intensity statin therapy	Fluvastatin 20 mg
Low-intensity statin therapy	Lovastatin 10-20 mg
Low-intensity statin therapy	Pravastatin 10–20 mg
Low-intensity statin therapy	Simvastatin 5-10 mg

❄DEPRESSION SCREENING AND FOLLOW UP FOR ADOLESCENTS AND ADULTS (DSF)

The percentage of members 12 years of age and older who were screened for clinical depression using an age-appropriate standardized tool during the measurement year.

Note: This measure requires an age-appropriate tool. There are two age stratifications for the selection of tools: Adolescents (12–17 years) and Adults (18 years and older). Please see the Standard Tool List below.

Exclusions and Exemptions for all Payers:
Hospice Services. Patients with diagnosis of following:

- Bipolar disorder during the measurement year or the year prior to the measurement year;
- Depression during the year prior to the measurement year; and
- Other Bipolar disorders.

Acceptable Screening Tools for Adolescent Population:
Patient Health Questionnaire (PHQ-9)®; Patient Health Questionnaire Modified for Teens (PHQ-9M)®; PRIME MD-PHQ2®; Beck Depression Inventory-Fast Screen (BDI-FS)®; Mood Feeling Questionnaire (MFQ); Center for Epidemiologic Studies Depression Scale (CES-D); PROMIS Depression.

Acceptable Screening Tools for Adult Population:
Patient Health Questionnaire (PHQ-9)®; PRIME MD-PHQ2®; Beck Depression Inventory (BDI-II or BDI-FS)®; Center for Epidemiologic Studies Depression Scale (CES-D); Depression Scale (DEPS); Duke Anxiety-Depression Scale (DADS)®; Geriatric Depression Scale (GDS); Cornell Scale for Depression in Dementia (CSDD).

Required Codes for HEDIS:

For Medicare Patients: Numerator Quality Data Options	
G8431	Positive Screening and follow-up documented
G8510	Negative Screening. Follow-up not required.
G8433	Screening NOT completed, documented Reason.
G9717-Denominator Exclusion	Documentation stating the patient has an active diagnosis of depression or has a diagnosed bipolar disorder, therefore screening or follow-up not required

OSTEOPOROSIS MANAGEMENT IN WOMEN WHO HAD A FRACTURE

The percentage of women 67 - 85 years of age who suffered a fracture and who had either a bone mineral density (BMD) test or prescription for a drug to treat osteoporosis in the six months after the fracture. NOTE: Patients with any fracture except fractures of the finger, toe, face or skull should have a bone mineral density (BMD) measurement performed or pharmacologic therapy prescribed. The management (BMD performed or pharmacologic therapy prescribed) should occur within six months of the fracture.

U.S. Food and Drug Administration approved pharmacologic options for osteoporosis prevention and/or treatment of postmenopausal osteoporosis include: bisphosphonates, alendronate, alendronate-cholecalciferol, ibandronate, risedronate, zoledronic acid, teriparatide, denosumab, abaloparatide, romosozumab and raloxifine.

For Commercial Patients: Denominator Exclusions	
66 yrs and older SNP	Administrative Claims Only
Members 66-80 years and older with following status: ■ At least one claim/encounter for frailty during the measurement year and two outpatient claims with advanced illness during the measurement period. (Two outpatient claims/encounter with Advanced Illness can be outpatient visits, observations, ED visits, telephone visits, online assessments or non-acute inpatient encounters or discharges). ■ At least one claim/encounter for frailty during the measurement period and a dispensed medication for dementia during the measurement period or the year prior to the measurement.	Must meet BOTH Frailty and Advanced Illness (Refer to Frailty and Advanced Illness Codes on Page 26) (Refer to Dementia Medications Table in Page 30)
81 or older with Frailty	Refer to Frailty Codes on Page 26

❄COMPREHENSIVE DIABETES CARE MEDICAL ATTENTION FOR NEPHROPATHY (CDC)

The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who received medical attention for nephropathy by one of the following:

1. A nephropathy screening or monitoring test (Any Urine Protein Tests: 24 hr. Urine or Timed Urine or Spot Urine or Urine Alb/Cr Ratio or 24 hr. Total protein).
2. Evidence of treatment for nephropathy or ACE/ARB therapy
3. Evidence of stage 4 chronic kidney disease
4. Evidence of Nephrectomy/Kidney Transplant
5. A visit to nephrologist, as identified by provider codes
6. At least one ACE/ARB dispensing event

Required Codes:

For Commercial Patients: Numerator Quality Data Options	
Refer to CPT or CPT II coding	Nephropathy Screening test
Refer to CPT or CPT II coding	Urine Microalbumin test
3060F	Positive microalbuminuria test result documented and reviewed (DM)
3061F	Negative microalbuminuria test result documented and reviewed (DM)
3062F	Positive microalbuminuria test result documented and reviewed (DM)
G8506	Angiotensin Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) therapy prescribed or currently being taken (CAD, CKD, HF) (DM)
3066F	Documentation of treatment for nephropathy (eg, patient receiving dialysis, patient being treated for ESRD, CRF, ARF, or renal insufficiency, any visit to a nephrologist) (DM)
N18.5 Chronic Kidney Disease Stage 5 N18.6 End Stage Renal Disease Z99.2 Dependence on renal dialysis	ESRD or dialysis during the measurement year or the year prior to the measurement year.

Exclusions	
Patients who use Hospice Services anytime during the measurement period	G9715
Patients who use Palliative Care Services anytime during the measurement period	Z51.1
Gestational Diabetes in Pregnancy	ICD10CM-O24.410 (use other O24 ICDs)
Medicare Advantage members 66 years and older enrolled in Institutional SNP and Long-Term Care Centers	Administrative Claims Only
Members 66 years and older as of December 31 of the measurement period with following: ■ At least one claim/encounter for frailty during the measurement year. ■ At least two outpatient visits with an advanced illness. (Two outpatient claims/encounters with Advanced Illness can be Outpatient visits, Observations, ED visits, Telephone visits, Online assessments or Non-acute inpatient encounters or discharges). ■ At least one acute inpatient encounter/discharge with an advanced illness. ■ At least one claim/encounter for frailty during the measurement period AND a dispensed medication for dementia during the measurement period or the year prior to the measurement.	Must meet BOTH Frailty and Advanced Illness (Refer **Frailty and Advanced Illness Codes** on Page 26) Visit type need not be the same. (Refer **Dementia Medications Table** on Page 30)

Documentation requirements:

1. Document all exclusion codes in your EMR and Claims for this measure.
2. Document the ACE/ARB prescriptions using the appropriate CPT code in your claims.
3. Make sure all urine protein tests done are documented in EMR/Claims using the appropriate CPT codes to meet the measure criteria.

EYE EXAM FOR PATIENTS WITH DIABETES

The percentage of members 18–75 years of age with diabetes (types 1 and 2) who had a retinal eye exam. A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the Measurement Year; A negative retinal or dilated eye exam (negative for retinopathy) by an eye care professional in the Year Prior to the Measurement Year.

For Commercial Patients: Denominator Exclusions	
Polycystic Ovarian Syndrome	E28.2
Gestational Diabetes	O24.410
Steroid Induced Diabetes	E99.09
Medicare Advantage 66 Yrs. and Older Special Needs Plan	Administrative Claims Only
Members 66 years and older as of December 31 of the measurement period with following: ■ At least one claim/encounter for frailty during the measurement year. ■ At least two outpatient visits with an advanced illness. (Two outpatient claims/encounters with Advanced Illness can be Outpatient visits, Observations, ED visits, Telephone visits, Online assessments or Non-acute inpatient encounters or discharges). ■ At least one acute inpatient encounter/discharge with an advanced illness. ■ At least one claim/encounter for frailty during the measurement period AND a dispensed medication for dementia during the measurement period or the year prior to the measurement.	Must meet BOTH Frailty and Advanced Illness (Refer **Frailty and Advanced Illness Codes** on Page 26) Visit type need not be the same. (Refer **Dementia Medications Table** on Page 30)
Bilateral Eye Enucleation	08T1XZZ (Left); 08T0XZZ (Right)
Palliative Care	Z51.5

The percentage of members 18–85 years of age with diabetes (type 1 and type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR), during the Measurement Year.

For Commercial Patients: Denominator Exclusions	
ESRD	N18.5, N18.6
Dialysis	Z99.2
Medicare Patients 66 or older enrolled in SNP	Administrative Claims Only
Members 66 years and older as of December 31 of the measurement period with following: ■ At least one claim/encounter for frailty during the measurement year. ■ At least two outpatient visits with an advanced illness. (Two outpatient claims/encounters with Advanced Illness can be Outpatient visits, Observations, ED visits, Telephone visits, Online assessments or Non-acute inpatient encounters or discharges). ■ At least one acute inpatient encounter/discharge with an advanced illness. ■ At least one claim/encounter for frailty during the measurement period AND a dispensed medication for dementia during the measurement period or the year prior to the measurement.	Must meet BOTH Frailty and Advanced Illness (Refer **Frailty and Advanced Illness Codes** on Page 26) Visit type need not be the same. (Refer **Dementia Medications Table** on Page 30)
81 yrs or older with Frailty during the Measurement Year	Refer to Frailty Codes on page 26.
Polycystic Ovarian Syndrome	E28.2
Gestational Diabetes	O24.410
Steroid Induced Diabetes	E90.9
Palliative Care	Z51.5

ASTHMA MEDICATION RATIO (AMR)

Measure Description Measure Source: HEDIS®	The percentage of members 5-64 years of age 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. Report the following age stratifications and total rate: ■ 5-11 years ■ 12-18 years ■ 19-50 years ■ 51-64 years ■ Total Rate Members are identified as having persistent asthma: ■ 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 patient discharge with a principal diagnosis of asthma. ■ At least four outpatient visits or 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, telephone visit, or online assessment. ■ At least four asthma medication dispensing events.
Exclusions	Members who had no asthma medications dispensed during the measurement year. ■ Members in hospice. ■ Members with emphysema, COPD, obstructive chronic bronchitis, chronic respiratory conditions related to fumes/vapors, cystic fibrosis, and acute respiratory failure.
Medications	Antiasthmatic combinations: Dyphylline-guaifenesin Antibody inhibitors: Omalizumab Anti-interleukin-4: Dupilumab Anti-interleukin-5: Benralizumab, Mepolizumab, Resilzumab Inhaled corticosteroids: Beclomethasone, Budesonide, Ciclesonide, Flunisolide, Fluticasone, Mometasone Inhaled steroid combinations: Budesonide-formoterol, Fluticasone-vilanterol, Fluticasone-salmeterol, Formoterol-mometasone Leukotriene modifiers: Montelukast, Zafirlukast, Zileuton Methylxanthines: Theophylline Short-acting, inhaled beta-2 agonists: Albuterol, Levalbuterol
Documentation	Claims based measure only. Link any medications used to treat asthma or other respiratory conditions with the applicable diagnosis.
Considerations	Educate patients about the difference between controller and reliever medication. Consider using 90-day prescriptions.

CODES:		
Acute Respiratory Failure	ICD10	J96.00-J96.02, J96.20-J96.22
Asthma	ICD10 SNOMED	J45.22, J45.30-J45.32, J45.40-J45.42, J45.50- J45.52, J45.901-J45.902, J45.909, J45.991, J45.998 There are over 100 SNOMED codes (one example is 11641008 Millers' asthma disorder)
Chronic Respiratory Conditions Due to Fumes/Vapors	ICD10 SNOMED	J68.4, 506.4 15908004, 31803008, 32544004, 43098002, 61233003, 66110007, 69454006, 72163003, 74800004, 196025000, 196026004, 308905009
COPD	ICD10 SNOMED	J44.0-J44.1, J44.9 13645005, 135836000, 195951007, 196001008, 285381006, 313296004, 313297008, 313299006, 1751000119100, 106001000119101
Cystic Fibrosis	ICD10 SNOMED	E84.0, E84.11, E84.19, E84.8-E84.9 81423003, 86092005, 86555001, 190905008, 190909002, 235978006, 720401009, 762269004, 762270003, 762271004
ED	ICD10 SNOMED	99281-99285 4525004
Emphysema	ICD10 SNOMED	J43.0-J43.2, J43.8-J43.9 2912004, 4981000, 16003001, 16838000, 16846004, 23851004, 23958009, 31898008, 45145000, 47895001, 54288002, 57686001, 60805002, 68328006, 86680006, 87433001, 195957006, 195958001, 195959009, 195963002, 196026004, 233674008, 233675009, 233677001, 266355005, 266356006, 708030004
Obstructive Chronic Bronchitis	ICD10 SNOMED	491.20-491.22 185086009, 2932410000119100
Other Emphysema	ICD10 SNOMED	J98.2-J98.3 33325001, 77690003

Only patients with pharmacy coverage with the respective payors will be included in the Denominators for the following measures:

Medication Adherence of Oral Diabetes Medications	Percentage of members with a prescription for Non-Insulin Diabetic medication who fill their prescription often enough to cover 80% or more of the time.
Medication Adherence for Cholesterol (Statins)	Members who remained on a high-intensity or moderate-intensity statin medication for at least 80% of the treatment period.
Medication Adherence for Hypertension (RAS Antagonist)	Percent of plan members with a prescription for a RAS blood pressure medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.
Asthma Medication Ratio	The percentage of members 5-64 years of age 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.
Statin Use for Persons with Diabetes (SUPD)	Percent of Medicare Part D beneficiaries 40-75 years old who were dispensed at least two diabetes medication fills and received a statin medication fill during the measurement period.
Statin Therapy for Patients with CVD (SPC)	Members who remained on a high-intensity or moderate-intensity statin medication for at least 80% of the treatment period.
Statin Therapy for Patients with CAD (SPC)	Members who remained on a high-intensity or moderate-intensity statin medication for at least 80% of the treatment period.

See Quality Measure Grid Year 2022 on Page 5

Medicare Measure Exclusion Criteria	
66 and older can be excluded from these measures if they have both advanced illness and frailty	81 and older can be excluded from these measures if they only have frailty
Breast Cancer Screening (BCS)	Controlling Blood Pressure (CBP)
Colorectal Cancer Screening (COL)	Osteoporosis Management in Women Who Had a Fracture (OMW)
Controlling Blood Pressure (CBP)	Kidney Health Evaluation (KED)
Osteoporosis Management in Women Who Had a Fracture (OMW)	
Statin Therapy for Patients with Cardiovascular Disease (SPC)	
Statin Use in Patients with Diabetes (SUPD)	
Kidney Health Evaluation (KED)	
Diabetic Eye Exam	
Medical Attention for Nephropathy	

FRAILTY AND ADVANCED ILLNESS CODES

In 2018, the National Committee for Quality Assurance (NCQA) allowed additional exclusions to Healthcare Effectiveness Data and Information Set (HEDIS) star measures for patients with advanced illness and frailty. NCQA recognizes that some medical services may not be appropriate in older adults with advanced illness and limited life expectancy. Also, unnecessary tests or treatments could burden them or even be harmful.

This guide includes: Exclusion Criteria, Billing codes for Advanced Illness exclusions, Dementia medication descriptions and Frailty exclusions

Advanced Illness Codes	These sample codes include conditions, such as metastatic cancer, heart failure, late-stage kidney disease and medications such as medications for dementia.
ICD-10 code	Definition
A81.00-01, A81.09	Creutzfeldt-Jakob disease
C25.0-4,7-9	Malignant neoplasm of pancreas
C71.9	Malignant neoplasm of brain, unspecified
C77.0-5,8-9	Secondary and unspecified malignant neoplasm of lymph nodes
C78.00	Secondary and unspecified malignant neoplasm of unspecified lung
C78.1	Secondary and unspecified malignant neoplasm of mediastinum
C78.2	Secondary and unspecified malignant neoplasm of pleura
C78.39	Secondary and unspecified malignant neoplasm of other respiratory organs
C78.4	Secondary and unspecified malignant neoplasm of small intestine
C78.5	Secondary and unspecified malignant neoplasm of large intestine and rectum
C78.6	Secondary and unspecified malignant neoplasm of retroperitoneum and peritoneum
C78.7	Secondary and unspecified malignant neoplasm of liver and intrahepatic bile duct
C78.89	Secondary malignant neoplasm of other digestive organs
C79.00	Secondary malignant neoplasm of unspecified kidney and renal pelvis
C79.11	Secondary malignant neoplasm of bladder
C79.19	Secondary malignant neoplasm of other urinary organs
C79.2	Secondary malignant neoplasm of skin
C79.31	Secondary malignant neoplasm of brain
C79.32	Secondary malignant neoplasm of cerebral meninges
C79.49	Secondary malignant neoplasm of other parts of nervous system
C91.00, C92.00, C93.00, C93.90, C93.Z0, C94.30	Leukemia not having achieved remission
C91.02, C92.02, C93.02, C93.92, C93.Z2, C94.32	Leukemia in relapse

Advanced Illness Codes	These sample codes include conditions, such as metastatic cancer, heart failure, late-stage kidney disease and medications such as medications for dementia.
ICD-10 code	Definition
F01.50, F01.51, F02.80, F02.81, F03.90, F03.91, F10.27, F10.97, G31.83	Dementia
F04	Amnestic disorder due to known physiological condition
F10.96	Alcohol-induced persisting amnestic disorder
G30.0, G30.1, G30.8, G30.9	Alzheimer's disease
G10	Huntington's disease
G12.21	Amyotrophic lateral sclerosis
G20	Parkinson's disease
G31.01	Pick's disease
G31.09	Other frontotemporal dementia
I09.81, I11.0, I13.0, I13.2, I50.20, I50.21, I50.22, I50.23, I50.30, I50.31, I50.32, I50.33, I50.40, I50.41, I50.42, I50.43, I50.810, I50. 811, I50.812, I50.813, I50.814, I50.82, I50.83, I50.84, I50.89, I50.9, I12.0, I13.11, I13.2, N18.5	Heart failure
I12.0, I13.11, I13.2, N18.5	Chronic kidney disease, stage 5, end stage renal disease
I50.1	Left ventricular failure, unspecified
J43.0, J43.1, J43.2, J43.8, J43.9, J98.2, J98.3	Emphysema
J68.4	Chronic respiratory conditions due to chemicals, gases, fumes and vapors
J84.10, J84.112, J84.17	Pulmonary fibrosis
J96.10, J96.11, J96.12, J96.20, J96.21, J96.22, J96.90, J96.91, J96.92	Respiratory failure
K70.10, K70.11, K70.2, K70.30, K70.31, K70.40, K70.41, K70.9	Alcoholic hepatic disease
K74.0, K74.1, K74. 2, K74.4, K74.5, K74.60, K74.69	Hepatic disease
N18.6	End stage renal disease

Frailty Codes	These sample codes include equipment that is typically submitted on claims such as hospital beds, wheelchairs and oxygen. However, there are ICD-10 codes that are not routinely included on these claims, for example weakness, fatigue and falls.
CPT II code	Definition
99504	Home visit for mechanical ventilation care
99509	Home visit for assistance with activities of daily living and personal care
HCPCS code	Definition
Z74.09	Cane
Z74.09	Walker
Z99.81	Oxygen
Z74.01	Hospital bed
Z99.11	Home ventilator
Z99.11	Respiratory assist device
Z99.89	BiPAP, CPAP
Z99.3	Wheelchair
L89.119, L89.139, L89.149, L89.159, L89.209, L89.309, L89.899, L89.90	Pressure ulcer
M62.50	Muscle wasting and atrophy, not elsewhere classified, unspecified site
M62.81	Muscle weakness (generalized)
M62.84	Sarcopenia

Frailty Codes (continued)	
ICD10CM Codes	Definition
R26.0	Ataxic gait
R26.1	Paralytic gait
R26.2	Difficulty in walking, not elsewhere classified
R26.89	Other abnormalities of gait and mobility
R26.9	Unspecified abnormalities of gait and mobility
R41.81	Age-related cognitive decline
R53.1	Weakness
R53.81	Other malaise
R53.83	Other fatigue
R54	Age-related physical debility
R62.7	Adult failure to thrive
R63.4	Abnormal weight loss
R63.6	Underweight
R64	Cachexia
R41.81	Age-related cognitive decline
R53.1	Weakness
R53.81	Other malaise
R53.83	Other fatigue
R54	Age-related physical debility
R62.7	Adult failure to thrive
R63.4	Abnormal weight loss
R63.6	Underweight
R64	Cachexia
W01.0XXA – W01.198S W06.XXXA – W10.9XXS W18.00XA – W19.XXXS, Z91.81	Fall
Y92.199, Z59.3	Residential institution
Z59.3	Problems related to living in residential institution
Z73.6	Limitation of activities due to disability
Z74.1	Need for assistance with personal care
Z74.2	Need for assistance at home and no other household member able to render care
Z74.3	Need for continuous supervision
Z74.8	Other problems related to care provider dependency
Z74.9	Problem related to care provider dependency, unspecified

DEMENTIA MEDICATIONS

Description	Prescription		
Cholinesterase inhibitors	Donepezil	Galantamine	Rivastigmine
Miscellaneous central nervous system agents	Memantine		
Dementia combinations	Donepezil-memantine		

TELEHEALTH VISITS –CODING AND BILLING UPDATES

Ever since the COVID-19 Public Health Emergency (PHE) was declared on January 21, 2020, CMS has been issuing temporary telehealth policies, new coding and billing guidelines to improve access to care and support health care providers. Some changes have become permanent and some still remain temporary. This page is intended to give you informational assistance regarding the expanded telehealth visits that are billable and counted for reporting quality measures. The tips listed here can change anytime and we recommend you check with CMS and the commercial ACO payors. This page is provided as a guide and should not be considered legal advice nor a guarantee of reimbursement.

Telehealth Definitions: Telehealth definitions vary on the federal, state and individual payer level. The scope of the following terms may differ between Medicare and Medicaid plans, and you may have to modify your claims, whether billed via the CMS 1500 (professional fee claim form), or the UB-04 (facility fee claim form) based on the payor. CMS has expanded access to telemedicine services for all Medicare beneficiaries, not just those that have novel coronavirus, for the duration of the COVID-19 Public Health Emergency. In addition to existing coverage for originating sites including physician offices, skilled nursing facilities and hospitals, Medicare will now make payments for telehealth services furnished in any healthcare facility and in the home.

NOTE: Check with your payor to determine the appropriate Place of Service (POS) code for your telehealth visits. Some commercial payors are requiring the use of POS 02 for Telehealth (The location where health services and health related services are provided or received, through a telecommunication system). This is important to ensure your telehealth E&M visits are accurately associated with the care of patients.

Common CPT codes for Telemedicine services are listed below:

Telehealth Visits :	Synchronous audio/visual visit between a patient and clinician for evaluation and management (E&M)
Code	Description
CPT Code 99201-99205	Office or other outpatient visit for the evaluation and management of a new patient.
CPT Code 99211-99215	Office or other outpatient visit for the evaluation and management of an established patient.

Online Digital Visits ▶ ▶	Digital visits and/or brief check-in services furnished using communication technology that are employed to evaluate whether or not an office visit is warranted (via patient portal, smartphone)
Code	Description
CPT Code 99421	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes.
CPT Code 99422	11-20 minutes.
CPT Code 99423	21 or more minutes.
CPT Code 98970*	Qualified non-physician health care professional online digital assessment and management, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes.
CPT Code 98971*	11-20 minutes.
CPT Code 98972*	21 or more minutes.
HCPCS Code G2061	Qualified non-physician health care professional online assessment and management, for an established patient, for up to seven days, cumulative time during the 7days; 5-10 minutes.
HCPCS Code G2062	11-20 minutes.
CPT Code 98972*	21 or more minutes.
HCPCS Code G2061	Qualified non-physician health care professional online assessment and management, for an established patient, for up to seven days, cumulative time during the 7days; 5-10 minutes.
HCPCS Code G2062	11-20 minutes.
HCPCS Code G2063	21 or more minutes.
HCPCS Code G 2012	Brief communication technology-based service, e.g., virtual check-in, by a physician or other qualified health care professional who can report E&M services, provided to an established patient, not originating from a related E&M service provided within the previous 7 days nor leading to an E&M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion.
HCPCS Code G2010	Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related E7M service provided within the previous 7 days nor leading to an E&M service or procedure within the next 24 hours or soonest available appointment.
	NOTE: * CPT codes 98970-98971 were modified in 2020 to match the CMS language captured in HCPCS code G2061-G2063

Remote Patient Monitoring ▶ ▶ ▶	Collecting and interpreting physiologic data digitally stored and/or transmitted by the patient and/or caregiver to the physician or qualified health care professional.
Code	Description
CPT Code 99453	Remote monitoring of physiologic parameter (s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial set-up and patient education on use of equipment. (Initial set-up and patient education of monitoring equipment).
CPT Code 99454	Device(s) supply with daily recording (s) or programmed alert (s) transmission, each 30 days. (Initial collection, transmission, and report/summary services to the clinician managing the patient).
CPT Code 99457	Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; first 20 minutes.
CPT Code 99458	Each additional 20 minutes (List separately in addition to code for primary procedure).
CPT Code 99091	Collection and interpretation of physiologic data (e.g., ECG, blood pressure, glucose monitoring) digitally stored and /or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, qualified by education, training, licensure/regulation (when applicable) requiring a minimum of 30 minutes of time, each 30 days).
	NOTE: Leverage CPT Codes 99453 (if patient education is performed) and 99457 to manage pulse oximetry data from the patient's home to keep them out of the emergency room and the inpatient hospital, unless it becomes necessary.

Self-Measured Blood Pressure (SMBP) (Home BP Monitoring)	
Code	Description
CPT Code 99473	Self-measured blood pressure using a device validated for clinical accuracy; patient education/training and device calibration.
CPT Code 99474	Separate self-measurements of two readings one minute apart, twice daily over a 30-day period (minimum of 12 readings), collection of data reported by the patient and/or caregiver to the physician or other qualified health care professional, with report of average systolic and diastolic pressures and subsequent communication of a treatment plan to the patient.

Telephone Evaluation and Management Service ▶ ▶ ▶	Evaluation and management visits via audio-only telephone communications
Code	Description
CPT Code 99441	Telephone E&M service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E&M service provided within the previous 7 days nor leading to an E7M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion.
CPT Code 99442	11-20 minutes of medical discussion
CPT Code 99443	21-30 minutes of medical discussion

2022 HMHP QUALITY MEASURE BENCHMARKS

National Percentiles	50th	66.67th	75th	90th
Breast Cancer Screening	72.75	75.09	76.68	79.43
Colorectal Cancer Screening	63.68	67.19	69.59	75.39
HbA1C Testing	91.47	92.38	93.19	94.40
HbA1C Poor Control (Inverse Measure)	29.93	26.76	25.30	21.41
Controlling High Blood Pressure	60.10	65.56	68.37	74.29
Statin Therapy for Patients with Cardiovascular Disease Received Statin Therapy - Total	82.30	84.26	85.17	88.06

Created (Nov. 2021) from HEDIS Quality Compass.
HMH Threshold is set at 75th percentile for all adult quality measures. The target is to achieve 90th percentile and above.
This is a confidential document and should not be shared outside HMH.

2022 CMS MIPS QUALITY BENCHMARKS FOR HMH EMPLOYED PROVIDERS

Measure Title	Threshold	Target	Max	2021 published (QPP.gov) National Avg	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10
Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)	90.50 -47.70	47.71 - 23.57	<= 23.56	47.71	90.50 - 69.43	69.42 - 53.61	44.7 - 54.85	42.11 - 34.07	34.06 - 28.33	28.32 - 23.57	23.56 - 19.11	<=19.1
Colorectal Cancer Screening	0.0 - 47.21	47.22 - 67.54	>=67.55	47.22	0.0 - 15.14	15.15 - 27.51	27.52 - 38.73	38.74 - 49.04	49.05 - 58.3	58.31 - 67.54	67.55 - 76.05	>= 76.06
Controlling High Blood Pressure	0.07 - 62.8	62.9 - 72.03	>=72.04	62.89	0.07 - 51.68	51.69 - 57.07	57.08 - 61.32	61.33 - 64.79	64.8 - 68.44	68.45 - 72.03	72.04 - 76.35	>= 76.36
Breast Cancer Screening	0.01 - 49.60	49.61-67.22	>=67.23	49.61	0.01 - 24.43	24.44 - 37.13	37.14 - 46.31	46.32 - 54.4	54.41 - 61.1	61.11 - 67.22	67.23 - 73.94	>= 73.95
Pneumococcal Vaccination Status for Older Adults	0.01 - 49.19	49.20 - 71.0	>= 71.1	49.20	0.01 - 20.43	20.44 - 33.71	33.72 - 44.69	44.7 - 54.85	54.86 - 63.21	63.22 - 71.09	71.1 - 78.79	>= 78.8
Diabetes: Medical Attention for Nephropathy	0.02 - 80.88	80.89 - 91.40	>= 91.41	80.89	0.02 - 70.3	70.31 - 76.91	76.92 - 81.54	81.55 - 85.22	85.23 - 88.23	88.24 - 91.4	91.41 - 94.77	>= 94.78
Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	0.01 - 50.21	50.21 - 69.26	>= 69.27	50.21	0.01 - 23.25	23.26 - 27.41	27.42 - 32.64	32.65 - 40.9	40.91 - 53.42	53.43 - 69.26	69.27 - 83.79	>= 83.8
Preventive Care and Screening: Screening for Depression and Follow-Up Plan ** deciles transcribed from 2020 benchmarks because deciles not published for 2021	0.08 - 26.73	26.74 - 95.65	>= 95.66	33.30	0.08 - 1.82	1.83 - 8.03	8.04 - 26.73	26.74 - 65.2	65.21 - 88.6	88.61 - 95.65	95.66 - 99.99	100
Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	0.42 - 62.45	68.57 - 76.07	>= 76.08	68.57	0.42 - 62.46	62.47 - 66.21	66.22 - 68.96	68.97 - 71.36	71.37 - 73.74	73.75 - 76.07	76.08 - 79.56	>= 79.57

Key: range 1 to 10 deciles range based on performance of all providers reporting MIPS
Threshold: Performance between the 3rd decile and the national average
Target: Performance at the National Average (decile) to the top of the 8th decile
Max: Performance falling into the 9th and 10th decile

2022 HMH CRC SCREENING GUIDELINES

Hackensack Meridian *Health*

2022 Colorectal Cancer Screening Guideline

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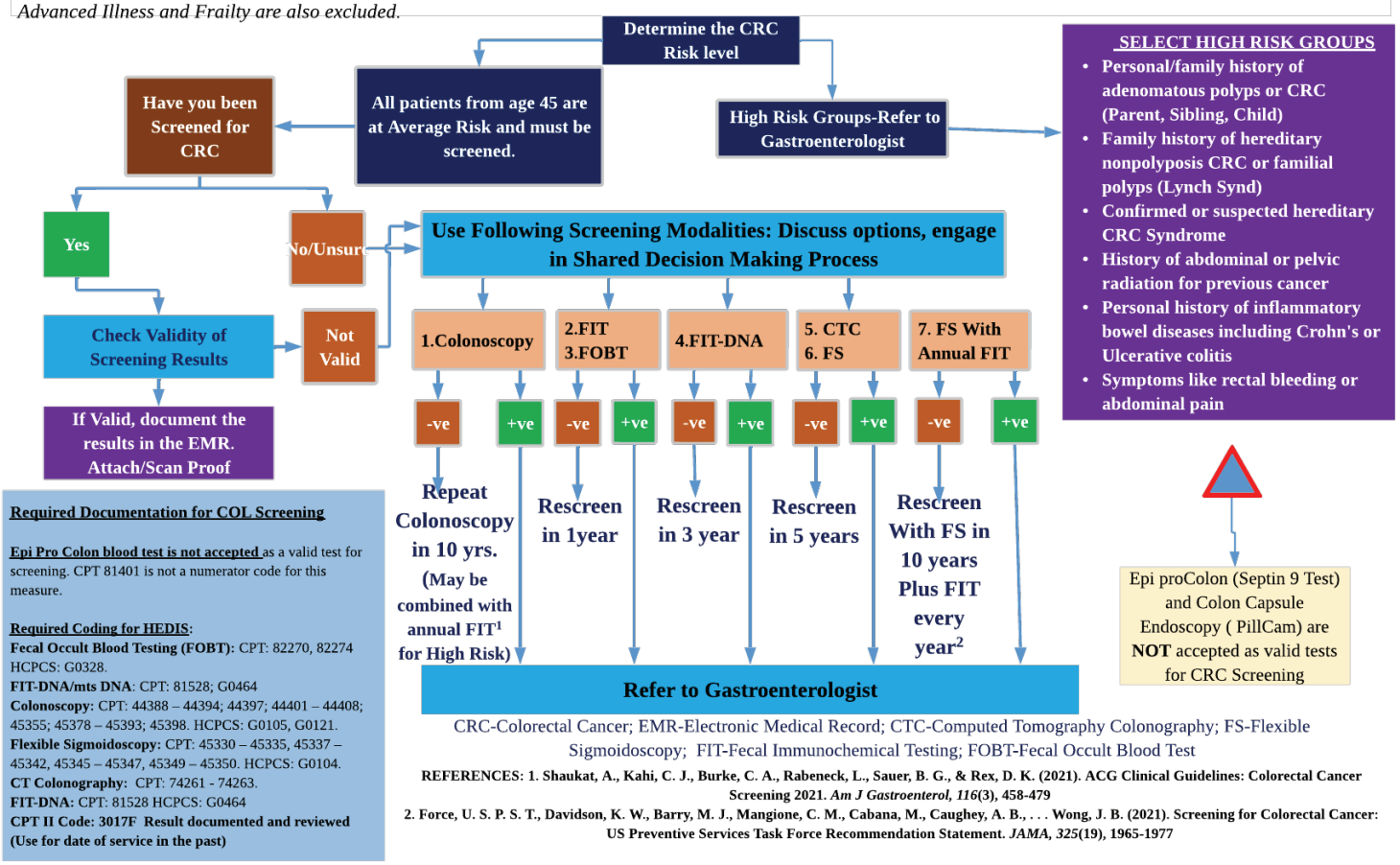
Patients of age 45 – 75 are eligible for Colorectal cancer screening[2]. Individuals with certain risk factors (see Box: Select High Risk Groups) should begin screening before age 45. Consult with a gastroenterologist if further guidance required. **Colonoscopy is the gold standard of testing. Colonoscopy and FIT are the primary screening modalities[1]**. However, when patients decide against a colonoscopy the following less optimal options may be advised—FIT Test, Multi-target Stool DNA (FIT-DNA), FOBT, CT Colonography and Flexible Sigmoidoscopy. Provide patients with choices and discuss best fit screening. The best screening is the test that gets done. ***Exclusions:*** *History of Total Colectomy or Colorectal Cancer, Hospice/Palliative Care, Institutional Special Needs Plan or LTC. Patients 66 & older with* ***both*** *Advanced Illness and Frailty are also excluded.*



Required Documentation for COL Screening

Epi Pro Colon blood test is not accepted as a valid test for screening. CPT 81401 is not a numerator code for this measure.

Required Coding for HEDIS:
Fecal Occult Blood Testing (FOBT): CPT: 82270, 82274 HCPCS: G0328.
FIT-DNA/mts DNA: CPT: 81528; G0464
Colonoscopy: CPT: 44388 – 44394; 44397; 44401 – 44408; 45355; 45378 – 45393; 45398. HCPCS: G0105, G0121.
Flexible Sigmoidoscopy: CPT: 45330 – 45335, 45337 – 45342, 45345 – 45347, 45349 – 45350. HCPCS: G0104.
CT Colonography: CPT: 74261 - 74263.
FIT-DNA: CPT: 81528 HCPCS: G0464
CPT II Code: 3017F Result documented and reviewed (Use for date of service in the past)

CRC-Colorectal Cancer; EMR-Electronic Medical Record; CTC-Computed Tomography Colonography; FS-Flexible Sigmoidoscopy; FIT-Fecal Immunochemical Testing; FOBT-Fecal Occult Blood Test

REFERENCES: 1. Shaukat, A., Kahi, C. J., Burke, C. A., Rabeneck, L., Sauer, B. G., & Rex, D. K. (2021). ACG Clinical Guidelines: Colorectal Cancer Screening 2021. *Am J Gastroenterol, 116*(3), 458-479
2. Force, U. S. P. S. T., Davidson, K. W., Barry, M. J., Mangione, C. M., Cabana, M., Caughey, A. B., . . . Wong, J. B. (2021). Screening for Colorectal Cancer: US Preventive Services Task Force Recommendation Statement. *JAMA, 325*(19), 1965-1977

DIRECTIONS FOR HMHP PRACTICES USING NON-EPIC EMRS

1. HMH follows a hybrid approach for measuring ambulatory quality measures. This includes both clinical data from your Electronic Medical Records (EMRs) and the administrative data from your claim files. Currently HMH's analytical platform is designed to consider clinical data first and if not available takes into account your claims data.

2. HMH receives your claims data from the payors regularly. But lack of quality compliance codes in the claims data can cause low performance rate if you are not documenting all required compliance codes or not sending the clinical data from your EMR to HMH.

3. This guide has included only the most common compliance codes that would help you in documenting the necessary codes to measure your performance. This is just a tool for your assistance. Additional value sets are required and your EMR companies (if 2015 CEHRT certified) should have the capability to do the mapping of codes. If not please contact us.

4. There are different types of codes that are used to measure clinical quality which include ICD, CPT, LOINC, SNOMED, UBREV, NDC and other revenue codes. Your EMR companies and billing companies should be contacted to see if they have updated these codes and are sending them to HMH via the claim files.

5. To exchange clinical data with HMH your EMR company should contact the NJHIN (New Jersey Health Information Network) which is the State Health Information Exchange (HIE). HMH has an agreement with NJHIN to exchange data from NJHIN to the HMH Data warehouse. Once you set up a data transfer with NJHIN, they will exchange your clinical data to HMH. If you need more information, please contact us and we can guide you in this process.

6. If you have not set up an HMH email account please contact IT help desk.
   - IT Service Desk Email: **itservicedesk@hmhn.org**
   - IT Help Desk – North (Bergen, Essex, Hudson, Passaic counties): 551-996-4357
   - IT Help Desk– South (Middlesex, Monmouth, Ocean counties): 732-776-3333

7. HMHP leadership strongly recommends you set up access to your Quality Performance Status in HMH HealtheRegistries. If you have not set up your access please contact: **hmhpcinsupport@hmhn.org**

Hackensack Meridian
Partners

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