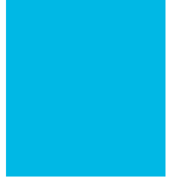
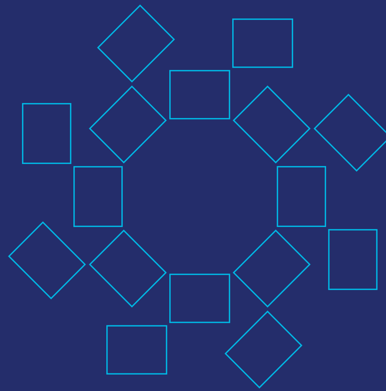
2024 HACKENSACK MERIDIAN *HEALTH* PARTNERS COMMERCIAL AND MEDICARE CLINICAL MEASURES

Hackensack
Meridian *Health*
Partners





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PREFACE

The Population Health Team is pleased to provide you a copy of the updated 2024 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 reportable clinical measures in Medicare plans for the ambulatory providers of Hackensack Meridian *Health* Partners (HMHP) active in HMH's Clinically Integrated Network (CIN). This guide is accessible and downloadable via HMH Maestro.

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.

The goal of this reference guide is to improve quality metric documentation and assist you in getting credits or incentives for your quality performance. For HMHP providers, who are not employed with HMH, we DO NOT report your MIPS CQMs or eCQMs. Please work with your EMR company to update the measure specifications and interoperability functionalities for CMS reporting standards. We recommend establishing clinical data exchange from your EMR to HMH data warehouse for better quality reporting. 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 2023 Guide as we update this guide on an annual basis. We welcome your feedback so that we can continue to improve.

FOR ADDITIONAL INFORMATION AND FEEDBACK, email us at **HMHPCINSupport@hmhn.org**.

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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.*

(Please refer Page 6 for detailed grid of payer measures and Page 32 for HEDIS Benchmarks and HMH Targets)

Quality Measure Performance Year 2024 (Commercial and Medicare Advantage Measures)
Controlling High Blood Pressure (CBP)
Breast Cancer Screening (BCS-E)
Colorectal Cancer Screening (COL-E)
Cervical Cancer Screening (CCS-E)
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-E)
Adolescent Well Care Visits 3 to 21 years old (WCV)
Glycemic Status Assessment for Patients with Diabetes (GSD) ≤8%
Glycemic Status Assessment for Patients with Diabetes (GSD) ≥9%
Diabetes: Eye Exam (EED)
Statin Use with Patients with Diabetes (SPD)
Kidney Health Evaluation for Patients with Diabetes (KED)
Osteoporosis in Women who had a fracture (OMW)
Medication Adherence of Oral Diabetes, Cholesterol (Statin) and Hypertension RAS Antagonist Medications
Asthma Medication Ratio (AMR)
All-Cause Readmissions (within 30 days)

MSSP QUALITY METRICS

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

Quality Measure Grid Performance Year 2024	AmeriHealth	Aetna	Cigna	Horizon	Aetna Medicare Advantage (TBD)	Braven
Controlling Blood Pressure						X
Breast Cancer Screening	X	X	X	X		X
Colorectal Cancer Screening	X	X		X		X
Cervical Cancer Screening	X			X		
Statin Therapy for Patients with CAD - Statin Therapy			X			
Statin Therapy for Patients with CVD - Adherence only				X		
Statin Use for Persons with Diabetes	X		X			X
Depression Screening - 12 years and older			X			
Child and Adolescent Well Care - 3 to 21 years old			X	X		
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)				X		
Diabetes Care: Eye Exam						X
Diabetes: HbA1C < 8%			X			
Diabetes: HbA1C >9% (Poor Control-Inverse Measure)		X				X
Glycemic Status Assessment for Patients with Diabetes (GSD) - Glycemic Status ≤8%	X					
Glycemic Status Assessment for Patients with Diabetes (GSD) - Glycemic Status ≥9% (Poor Control-Inverse Measure)				X		X
Kidney Health Evaluation for Patients With Diabetes	X	X		X		X
Asthma Medication Ratio		X		X		
Medication Adherence of Oral Diabetes Medication						X
Medication Adherence for Cholesterol (Statins)						X
Medication Adherence for Hypertension (RAS Antagonists)						X

ANYONE THAT QUALIFIES FOR THE MEASURE

The denominator statement describes the population evaluated by the performance measure.

ANYONE WHO MEETS THE MEASURE

This is a clinical action counted as meeting the measure's requirements (i.e., a patient who received a particular clinical service or obtained a particular outcome that is being measured).

☼ 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.
MSSP ONLY: Updated to women 40 - 74 years of age.

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 period and two outpatient claims with advanced illness during the measurement period or year prior to 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 period.	Must meet **BOTH** Frailty and Advanced Illness Refer **Frailty and Advanced Illness Codes** on Page 26 Refer **Dementia Medications Table** on Page 30
Palliative Care Services received during the measurement year	Z51.5

Commercial and Medicare Advantage 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. Use the appropriate codes for advanced illness and frailty which include 2024 Frailty Device, Frailty Diagnosis, Frailty Encounter and Frailty Symptoms.
Medicare Fee for Services report the appropriate CPT II or HCPCs code.

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 during the measurement period and a dispensed medication for dementia during the measurement period or year prior to 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 or year prior to 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.
4. Date documented in the EMR should be the date of the exam and not date scanned into the chart.

Tips for Success:

- Expectation: Scripts are given during Annual Wellness/Physical Exams/Office Visits
- Follow-up with patients if the reports are not received.
- Documenting in the chart and additionally, billing exclusion codes will remove the patients from your denominator: Bilateral Mastectomy (Z90.13) or 2 Unilateral Mastectomies (Z90.11 R/Z90.12L). Bilateral/left/right Unilateral Mastectomies G9708
- 66 yrs and older as noted above
- Advanced Illness examples: Cancer/Parkinson's/Emphysema/Pressure Ulcers/CHF/Alzheimer's/ESRD/CKD Stage 5

CERVICAL CANCER SCREENING

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

1. Members aged 21-64 who had a cervical cytology performed within the last 3 years.
2. Members aged 30-64 who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years.
3. Members 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 members 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 members 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
Members with Sex Assigned at Birth of Male	LOINC Code LA2-8

Tips for Success:

- Members age 21-64 are referred to Ob/Gyn for Cervical Cancer Screening.
- Follow-up with patients if the reports are not received.
- Documenting in the chart and additionally, billing exclusion codes will remove the patients from your denominator; see documentation requirements and exclusion codes above in the table.

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.**

Tips for Success:

- Members age 21-64 are referred to Ob/Gyn for Cervical Cancer Screening.
- Follow-up with patients if the reports are not received.
- Documenting in the chart and additionally, billing exclusion codes will remove the patients from your denominator; see documentation requirements and exclusion codes above in the table.

COLORECTAL CANCER SCREENING

Percentage of Members age 45–75 who were screened for Colorectal cancer using one or more of the following:

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 or Stool DNA (sDNA with FIT test) during the measurement year or the 2 years prior to the measurement year.
6. Fecal Immunochemical testing (FIT) during measurement year.

HEDIS Required Coding	
FOBT Lab Test/Result	CPT-82270; 82274. HCPCS-G0328
Stool DNA	CPT 81528
Exclusions	
Colorectal Cancer	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 or year prior to 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 period.	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 or year prior to 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 or year prior to the measurement period.
G9993 Denominator Exclusion	Palliative Care services provided to patient any time during the measurement period.
Palliative Care	Z51.5

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 2024 **Updated Exclusion Codes** for patients 66 years and older with both Frailty AND Advanced Illness. Refer to **Dementia Medications Table** on Page 30.

2024 updated codes for Frailty include Frailty Device, Frailty Diagnosis, Frailty Encounter, Frailty Symptoms.

Documentation requirements in EMR (confirm with your vendor):

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.

4. Date documented in the EMR should be the date of the exam and not date scanned into the chart.

Tips for Success:

- Expectation: PCP should order - Cologuard Screening or provide screening cards for FOBT; Patients should be referred to GI for Colorectal Screening. Follow-up with patient if results are not received.
- Exclusions: Patients with a diagnosis or past history of total Colectomy or Colorectal cancer Code: G9711 66 yrs and older as noted above. Advanced Illness examples: Cancer/Parkinson's/Emphysema/Pressure Ulcers/CHF/Alzheimer's/ESRD/CKD Stage 5
- Documenting in the chart and additionally, billing exclusion codes will remove the patients from your denominator

CONTROLLING HIGH BLOOD PRESSURE

Percentage of members 18 - 85 years of age who had a diagnosis of hypertension and whose most recent 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

CPT II Codes Can Be Used for Horizon and Cigna - Commercial	*HCPCS Codes Can Be Used for Medicare Patients*
3074F	Most recent systolic blood pressure less than 130 mm Hg
3075F	Most recent systolic blood pressure 130-139 mm Hg
3077F	Most recent systolic blood pressure greater than or equal to 140 mm Hg
3078F	Most recent diastolic blood pressure less than 80 mm Hg
3079F	Most recent diastolic blood pressure 80-89 mm Hg
3080F	Most recent diastolic blood pressure greater than or equal to 90 mm Hg
G8752	Most recent systolic BP ≤140mmHg
G8753	Most recent systolic BP ≥140mmHg
G8754	Most recent diastolic BP ≤90 mmHg
G8755	Most recent diastolic BP ≥90 mmHg
G9740/Denominator Exclusion	Hospice services given any time during the measurement period.
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 during the measurement period and a dispensed medication for dementia during the measurement period or year prior to the measurement period.
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 or year prior to the measurement period.
G2118/Denominator Exclusion	Patients 81 years of age & older with at least one claim/encounter for frailty during the measurement period.
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 period and two outpatient claims with advanced illness during the measurement period or year prior to 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 period. ■ 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

Tips for Success:

- Use the appropriate CPTII codes to report BP reading on every visit.
- Only blood pressure readings performed by a clinician or an automated blood pressure monitor or device are acceptable for numerator compliance with this measure. ie: self reporting using a non-digital device such as with a manual blood pressure cuff and a stethoscope are not accepted.
- Documenting in the chart and additionally, billing exclusion codes will remove the patients from your denominator; see tables above for appropriate coding.

GLYCEMIC STATUS ASSESSMENT FOR PATIENTS WITH DIABETES

The percentage of members 18–75 years of age with diabetes (types 1 and 2) whose most recent glycemic status (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) was at the following levels during the measurement year.

- Glycemic Status ≤8.0%
- Glycemic Status ≥9.0%.

There are two ways to identify members with diabetes by claim/encounter data and/or by pharmacy data, payers use both methods to identify the eligible population.

A member only needs to be identified by one method to be included in the measure.
Members may be identified as having diabetes during the measurement year or the year prior to the measurement year.

The member is numerator compliant if the most recent glycemic status assessment has a result of <8.0%. The member is not numerator compliant if the result of the most recent glycemic status assessment is ≥8.0% or is missing a result, or if a glycemic status assessment was not done during the measurement year. If there are multiple glycemic status assessments on the same date of service, use the lowest result.

The member is numerator compliant if the most recent glycemic status assessment has a result of ≥9.0% or is missing a result, or if a glycemic status assessment was not done during the measurement year. The member is not numerator compliant if the result of the most recent glycemic status assessment during the measurement year is ≤9.0%. This is an INVERSE MEASURE - lower rate for this measure indicates better care or control.

At a minimum, documentation in the medical record must include a note indicating the date when the glycemic status assessment (HbA1c or GMI) was performed, and the result.

When identifying the most recent glycemic status assessment (HbA1c or GMI),GMI values must include documentation of the continuous glucose monitoring data date range used to derive the value. At a minimum the Continuous Glucose Monitor (CGM) must be worn for 14 days consecutively with continuous activation at least 70% of the time.

The terminal date (14th day) in the range should be used to assign an assessment date.

Numerator Quality Data Options	
3046F	Most recent hemoglobin A1c level greater than 9.0% (DM)
3052F	Most recent hemoglobin A1c (HbA1c) level greater than or equal to 8.0% and less than or equal to 9.0% (DM)
3044F	Most recent hemoglobin A1c (HbA1c) level less than 7.0% (DM)
3051F	Most recent hemoglobin A1c (HbA1c) level greater than or equal to 7.0% and less than 8.0% (DM)
83037	Testing and interpretation of results during a patient encounter using a CGM device cleared by the FDA for home use.

Exclusions	
66 years of age and older enrolled in SNP anytime during the measurement year or Living in a Long Term Care facility	Administrative Claims
Members 66 years and older with following status: ▪ At least one claim/encounter for frailty during the measurement period and two outpatient claims with advanced illness during the measurement period or year prior to 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 period.	Must meet BOTH Frailty and Advanced Illness Refer Frailty and Advanced Illness Codes on Page 26 Refer Dementia Medications Table on Page 30
Palliative Care Services received during the measurement year	Z51.5

MSSP ONLY

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.

Tips for Success

- All eligible patients have a HgA1c testing ordered from a lab.
- Medical record indicating CGM date range (14 consecutive days with continuous activation at least 70% of the time) and GMI.
  - If supplied by the patient, the provider must access the device portal, download the result and scan into the EMR.
- Documenting in the chart and additionally, billing exclusion codes will remove the patients from your denominator; see tables above for appropriate coding.

Note: *GMI is the average (mean) glucose value based on the data collected by the CGM (healthline.com).*

STATIN THERAPY FOR PATIENTS WITH CARDIOVASCULAR DISEASE

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 (SPD): 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 period. ▪ At least two outpatient visits with an advanced illness. (Two outpatient claims/encounter with Advanced Illness can be during the measurement period or year prior to the measurement period. 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 during the measurement period or year prior to the measurement period. ▪ 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)
Palliative Care	Z51.5

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.
G9779 Denominator Exclusion	Patients who are breastfeeding.
G9780 Denominator Exclusion	Patients who have a diagnosis of rhabdomyolysis during the measurement period.

Tips for Success:

Documenting in the chart and additionally, billing exclusion codes will remove the patients from your denominator; see tables above for appropriate coding.

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

DEPRESSION SCREENING AND FOLLOW UP FOR ADOLESCENTS AND ADULTS

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;
- 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

Tips for Success:

- Use a standardized tool, see list above; if using the PHQ-9 see tool screen below. Document if the results of the screen are positive or negative.

PHQ-9 Screening Tool Scoring
Total Score **1-4** Minimal Depression, **5-9** Mild Depression,
10-14 Moderate Depression, **15-19** Moderately Severe Depression,
20-27 Severe Depression

Interpreting PHQ-9 Scores
1-4 Patient may not need depression treatment,
5-14 Physician uses clinical judgement about treatment
>14 Warrants treatment for depression

- Cigna Only

  Use HCPC code G0444 with Modifier 59 for reporting Annual depression screening up to 15 minutes using any standardized instrument (e.g., PHQ-9)

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	
67 yrs and older SNP	Administrative Claims Only
Members 67-80 years and older with following status: ▪ At least one claim/encounter for frailty during the measurement period and two outpatient claims with advanced illness during the measurement period or year prior to 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 on Page 30)
81 or older with at least two Frailty indicators	Refer to Frailty Codes on Page 26

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	
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 period. ■ At least two outpatient visits with an advanced illness during the measurement period or year prior to the measurement period. (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 during the measurement period or year prior to the measurement period. ■ 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 period.	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

Tips for Success:

- Document bilateral eye enucleation any time during the member's history through the end of the measurement year.
- Document an eye exam in the member's past medical history with the date performed, optometrist/ophthalmologist name and result.
- Meet compliance with a retinal or dilated eye exam by an optometrist or ophthalmologist during the measurement year or a negative exam by an eye care professional in the year prior to the measurement year.
- You can use eye exam results read by a system with artificial intelligence.
- Documentation of hypertensive retinopathy is considered the same as diabetic retinopathy.
- Blindness is NOT an exclusion for a diabetic eye exam.
- Consider closing this gap in care during a Telehealth visit.
- Use the following codes to report dilated retinal exam outcomes:
- 2022F Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy (DM)
- 2023F Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy (DM)

KIDNEY HEALTH EVALUATION FOR PATIENTS WITH DIABETES

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	
Chronic Kidney Disease Stage 5	N18.5
ESRD	N18.6
Dialysis	Z99.2
Medicare Patients 66 or older enrolled in SNP	Administrative Claims Only
Members 66 - 80 years of age as of December 31 of the measurement period with following: ■ At least one claim/encounter for frailty during the measurement period. ■ At least two outpatient visits with an advanced illness during the measurement period or year prior to the measurement period. (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 during the measurement period or year prior to the measurement period. ■ 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 period.	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 at least two indications of Frailty during the measurement year	Refer to Frailty Codes on page 26.
Palliative Care	Z51.5

Tips for Success:

The following test numbers can be used if you are only ordering a Kidney Profile which meets the guidelines for the KED Measure:

Quest Diagnostics: Test Number 39165

LabCorp: Test Number 140301

If other testing is ordered, the following can be used to capture the testing that meets the KED Measure:

LabCorp:
- #322758, Metabolic Panel 8 basic, CPT: 80043
- #322000, Metabolic Panel 14 Comprehensive, CPT: 80053
- #140285, Albumin/Creatinine Ratio, Urine, Loinc: 9318-7; CPT: 82043, 82570

Quest
- #100768, eGFR, Loinc: 98979-8; CPT: 82565
- #92739, Albumin, Creatinine Ratio, Timed Urine; CPT: 82043, 82570

At least one uACR identified by either of the following:
- Both a quantitative urine albumin test and a urine creatinine test with service dates four years or less apart. For example, if the service date for the quantitative urine albumin test was December 1 of the measurement year, then the urine creatinine test must have a service date on or between November 27 and December 5 of the measurement year.
- A uACR

ASTHMA MEDICATION RATIO

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. ■ At least one acute inpatient discharge with a principal diagnosis of asthma on the discharge claim. ■ At least four outpatient visits, telephone visits or e-visits or virtual check-ins, on different dates of service, with any diagnosis of asthma (Asthma Value Set) and at least two asthma medication dispensing events for any controller or reliever medication. Visit type need not be the same for the four visits. ■ At least four asthma medication dispensing events for any controller or reliever medication.
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. ■ Members who had no asthma controller or reliever medications dispensed during the measurement year.
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	J45.22, J45.30-J45.32, J45.40-J45.42, J45.50- J45.52, J45.901-J45.902, J45.909, J45.991, J45.998
	SNOMED	There are over 100 SNOMED codes (one example is 11641008 Millers' asthma disorder)
Chronic Respiratory Conditions Due to Fumes/Vapors	ICD10	J68.4, 506.4
	SNOMED	15908004, 31803008, 32544004, 43098002, 61233003, 66110007, 69454006, 72163003, 74800004, 196025000, 196026004, 308905009
COPD	ICD10	J44.0-J44.1, J44.9
	SNOMED	13645005, 135836000, 195951007, 196001008, 285381006, 313296004, 313297008, 313299006, 1751000119100, 106001000119101
Cystic Fibrosis	ICD10	E84.0, E84.11, E84.19, E84.8-E84.9
	SNOMED	81423003, 86092005, 86555001, 190905008, 190909002, 235978006, 720401009, 762269004, 762270003, 762271004
ED	ICD10	99281-99285
	SNOMED	4525004
Emphysema	ICD10	J43.0-J43.2, J43.8-J43.9
	SNOMED	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	491.20-491.22
	SNOMED	185086009, 2932410000119100
Other Emphysema	ICD10	J98.2-J98.3
	SNOMED	33325001, 77690003

PHARMACY CLAIM MEASURES

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

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

Note: Providing a patient samples of medications will hinder the capture of 80% adherence.
See Quality Measure Grid Year 2024 on Page 6.

Medicare Measure Exclusion Criteria			
Patients 66 and older can be excluded from these measures if they have BOTH advanced illness and frailty	Patients 66–80 can be excluded from this measure if they have BOTH advanced illness and frailty	Patients 67–80 can be excluded from this measure if they have BOTH advanced illness and frailty	Patients 81 and older can be excluded from these measures if they have 2 indications for frailty
▪ Breast cancer screening (BCS-E) ▪ Colorectal cancer screening (COL-E) ▪ Eye exam for patients with diabetes (EED) ▪ Glycemic Status assessment for patients with Diabetes (GSD) ▪ Kidney health evaluation for patients with diabetes (KED) ▪ Statin therapy for patients with cardiovascular disease (SPC)	Controlling high blood pressure (CBP)	Osteoporosis management in women who had a fracture (OMW)	▪ Controlling high blood pressure (CBP) ▪ Kidney health evaluation for patients with diabetes (KED) ▪ Osteoporosis management in women who had a fracture (OMW)

FRAILTY AND ADVANCED ILLNESS CODES

2024 updated codes are added for the classification of Frailty device, Frailty symptoms, Frailty encounter and Frailty diagnosis.

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 ICD codes, CPT &; HCPCS for Advanced Illness exclusions, Frailty exclusions and Dementia medications exclusions

Telehealth, telephone visits, e-visits and virtual check-ins are acceptable when used to exclude a patient using the advanced illness and frailty category when documented and the exclusion code is billed properly. Other components of the specification must be met, such as claims with advanced illness diagnosis on two different dates of service in the prior year or measurement year and frailty claims in the measurement year, as well as measure-specific ages.

Since codes in this guide are given in ranges to guide you, please verify for accuracy of anatomical sites and other variants.

Advanced Illness (2024) ICD 10-CM	
Definition	ICD-10 code
Creutzfeldt-Jakob disease (Unspecified/Variant/Other)	A81.00-01, A81.09
Malignant neoplasm of pancreas/pancreatic duct/other parts of pancreas	C25.0-4, 7-9
Malignant neoplasm of cerebrum/lobes/brain stem/unspecified	C71.0-9
Secondary and unspecified malignant neoplasm of lymph nodes	C77.0-5, 8-9
Secondary malignant neoplasm of lung/mediastinum/pleura/peritoneum/unspecified	C78.00-2; C78.1-2; C78.30, C78.39
Secondary malignant neoplasm of small intestine/large intestine/rectum//liver/bile duct/other digestive organs	C78.4-78.89
Secondary malignant neoplasm of kidney and renal pelvis	C79.00-79.2
Secondary malignant neoplasm of bladder and other urinary organs	C79.10-1, C79.19
Secondary malignant neoplasm of skin	C79.2
Secondary malignant neoplasm of brain/cerebral meninges/unspecified or other parts of nervous system	C79.31; C79.32; C79.40, C79.49
Secondary malignant neoplasm of bone or bone marrow	C79.51-2
Secondary malignant neoplasm of ovary	C79.60-3
Secondary malignant neoplasm of adrenal gland	C79.70-2
Secondary malignant neoplasm of breast/ genital organs	C79.81/ C79.82
Secondary malignant neoplasm of unspecified or other sites	C79.89, C79.9
Leukemia not having achieved remission/ In relapse. Various types of Leukemia included.	C91.00, C92.00, C93.00, C93.90, C93. Z0, C94.30/ C91.02, C92.02, C93.02, C93.92, C93.Z2, C94.32
Vascular Dementia/Dementia in other diseases	F01.50, F01.51, F02.80, F02.81, F03.90, F03.91, F10.27, F10.97, G31.09, G31.83
Amnestic disorder due to known physiological condition/ Alcohol-induced persisting amnestic disorder	F04; F10.96
Huntington's disease	G10
Amyotrophic lateral sclerosis	G12.21
Parkinson's disease	G20
Alzheimer's disease//other/unspecified	G30.0, G30.1, G30.8, G30.9
Pick's disease	G31.01
Other Frontotemporal Neurocognitive disorder/ with Lewy bodies	G31.09; G31.83

Advanced Illness (2024) ICD 10-CM	
Description	ICD-10 code
Multiple Sclerosis	G35
Heart failure (Rheumatic/Hypertensive/Unspecified/Other)	I09.81, I11.0, I13.0, I13.11, I13.2, I50.1, 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
Heart Failure with Chronic kidney disease, stages 1- 5	I12.0, I13.11, I13.2, N18.5
Left ventricular failure, unspecified	I50.1
Emphysema (panlobular/unilateral/other/unspecified)	J43.0, J43.1, J43.2, J43.8, J43.9, J98.2,J98.3
Chronic respiratory conditions due to chemicals, gasses, fumes and vapors	J68.4
Pulmonary fibrosis (interstitial/other)	J84.10, J84.112, J84.17. J84.170, J84.178
Acute/Chronic Respiratory failure	J96.10, J96.11, J96.12, J96.20, J96.21, J96.22, J96.90, J96.91, J96.92
Interstitial/ Compensatory Emphysema	J98.2; J98.3
Alcoholic hepatic disease/ Hepatic disease/Hepatic fibrosis/unspecified.	K70.10, K70.11, K70.2, K70.30, K70.31, K70.40, K70.41, K70.9; K74.0, K74.1, K74.2, K74.4, K74.5, K74.60, K74.69
End stage renal disease	N18.5; N18.6

Frailty Device 2024	
Description	HCPCS Code
Amputee wheelchair (Eligible Types)	E1190, E1180, E1172, E1170, E1200, E1171
Cane, includes canes of all materials, adjustable or fixed, with tips	E0100, E0105
Commode chair with integrated mechanisms	E0170, E0171, E0168, E0165, E0163
Heavy duty wheelchair with adjustments	E1280, E1290, E1295, E1195, E1285
Home ventilator, various types	E0465, E0466
Hospital bed, depending on approved types	E0304, E0302, E0250, E0251, E0290, E0291, E0303, E0301, E0270, E0260, E0261, E0294, E0295, E0265, E0266, E0296, E0297, E0255, E0256, E0292, E0293
Lightweight wheelchair,	E1260, E1240, E1270, E1250
Manual adult size wheelchair	E1161
Pail or pan for use with commode chair, replacement only	E0167
Portable gaseous oxygen system various approved types	E0430, E0431, E0435, E0433, E0434, E0443, E0444
Respiratory assist devices	E0472, E0471, E0470
Rocking bed with or without side rails	E0462
Special wheelchair seat/Standard Wheelchair	E1298, E1297, E1296, E1130
Stationary compressed gas system, purchase; includes regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing	E0425, E0424, E0440, E0439, E0441, E0442
Walker, enclosed, framed, wheeled, adjustable	E0144, E0135, E0143, E0147, E0149, E0148, E0130, E0141, E0140
Wheelchair, detachable arms/fixed frames/special construction	E1150, E1140, E1160, E1220

Frailty Symptoms 2024	
Description	ICD10 CM Codes
Difficulty in walking, not elsewhere classified	R26.2
Other abnormalities of gait and mobility	R26.89
Unspecified abnormalities of gait and mobility	R26.9
Weakness	R53.1
Other malaise	R53.81
Age-related physical debility	R54
Adult failure to thrive	R62.7
Abnormal weight loss	R63.4
Underweight	R63.6
Cachexia	R64

Frailty Encounter 2024	R64
Description	CPT Codes
Home visit for mechanical ventilation care	99504
Home visit for assistance with activities of daily living and personal care	99509
Description	HCPCS Codes
Skilled services by a registered nurse (RN) for management and evaluation of the plan of care; each 15 minutes	G0162
Direct skilled nursing services of a registered nurse (RN) in the home health or hospice setting, each 15 minutes	G0299
Direct skilled nursing services of a licensed practical nurse (LPN) in the home health or hospice setting, each 15 minutes	G0300
Skilled services of a registered nurse (RN) for the observation and assessment of the patient's condition, each 15 minutes	G0493
Skilled services of a licensed practical nurse (LPN) for the observation and assessment of the patient's condition, each 15 minutes	G0494
Physician management of patient home care, hospice monthly case rate	S0271
Comprehensive management and care coordination for advanced illness, per calendar month	S0311
Nursing care, in the home; by registered nurse, per hour	S9123
Nursing care, in the home; by licensed practical nurse, per hour	S9124
Private duty / independent nursing service(s) - licensed, up to 15 minutes	T1000
Nursing assessment / evaluation	T1001
RN services, up to 15 minutes	T1002
LPN/LVN services, up to 15 minutes	T1003
Services of a qualified nursing aide, up to 15 minutes	T1004
Respite care services, up to 15 minutes	T1005
Personal care services, per 15 minutes, not for an inpatient or resident of a hospital, nursing facility, ICF/MR or IMD	T1019
Personal care services, per diem, not for an inpatient or resident of a hospital, nursing facility, ICF/MR or IMD	T1020
Home health aide or certified nurse assistant, per visit	T1021
Contracted home health agency services, all services provided under contract, per day	T1022
Nursing care, in the home, by registered nurse, per diem	T1030
Nursing care, in the home, by licensed practical nurse, per diem	T1031

Frailty Diagnosis	R64
Description	ICD10CM Codes
Pressure ulcers of unspecified elbow, unstageable/stageable or deep tissue, right or left elbow	L89.000--L89.004; L89.006--L89.029
Pressure ulcer of unspecified part of back, unstageable/stageable or deep tissue, right upper, left upper back; right lower back, left lower back	L89.100--L89.149
Pressure ulcer of sacral region, unstageable/stageable, or deep tissue	L89.150--L89.159
Pressure ulcer of unspecified hip, unstageable/stageable, deep tissue, right hip, left hip	L89.200--L89.229
Pressure ulcer of unspecified buttock, unstageable/stageable, deep tissue, right buttock, left buttock.	L89.300--L89.329
Pressure ulcer of contiguous site of back, buttock and hip, unspecified stage/stageable or deep tissue of these sites	L89.40--L89.46
Pressure ulcer of unspecified ankle, unstageable/stageable, right ankle, left ankle, deep tissue sites	L89.500--L89.529.
Pressure ulcer of unspecified heel, unstageable/stageable, deep tissue, left heel, right heel	L89.600--L89.629
Pressure ulcer of head, unstageable/stageable,deep tissue, unspecified	L89.810--L89.819
Pressure ulcer of other site, unstageable/stageable, deep tissue, unspecified	L89.890--L89.899
Pressure ulcer of unspecified site, unspecified stage/stageable, deep tissue sites	L89.90--L89.96
Muscle wasting and atrophy, not elsewhere classified, unspecified site	M62.50
Muscle weakness (generalized)	M62.81
Sarcopenia	M62.84
Fall on same level from slipping, tripping and stumbling, and sequelae, subsequent encounters	W01.0XXA, W01.0XXD, W01.0XXS, W01.10XA, W01.10XD, W01.10XS, W01.110A, W01.110D, W01.110S, W01.111A, W01.111D, W01.111S, W01.118A, W01.118D, W01.118S, W01.119A, W01.119D, W01.119S, W01.190A, W01.190D, W01.190S, W01.198A, W01.198D, W01.198S
Fall from bed, initial encounter, subsequent encounter, sequela	W06.XXXA, W06.XXXD, W06.XXXS
Fall from chair, initial encounter, subsequent, sequela	W07.XXXA, W07.XXXD, W07.XXXS
Fall from other furniture, initial encounter, subsequent, sequela	W08.XXXA, W08.XXXD, W08.XXXS
Fall (on)(from) escalator, initial encounter, subsequent, sequela	W10.0XXA, W10.0XXD, W10.0XXS
Fall (on)(from) sidewalk curb, initial encounter, subsequent, sequela	W10.1XXA, W10.1XXD, W10.1XXS
Fall (on)(from) incline, initial encounter, subsequent, sequela	W10.2XXA, W10.2XXD, W10.2XXS
Fall (on) (from) other stairs and steps,or unspecified stairs, steps--initial encounter, subsequent, sequela	W10.8XXA, W10.8XXD, W10.8XXS W10.9XXA, W10.9XXD, W10.9XXS
Striking against unspecified object with subsequent fall, initial encounter, subsequent, sequela	W18.00XA, W18.00XD, W18.00XS
Striking against glass or other objects with subsequent fall, initial encounter, subsequent, sequela	W18.02XA, W18.02XD, W18.02XS W18.09XA, W18.09XD, W18.09XS
Fall from or off toilet without subsequent striking against object, initial encounter, subsequent encounter, sequela	W18.11XA, W18.11XD, W18.11XS, W18.12XA, W18.12XD, W18.12XS
Fall in (into) shower or empty bathtub, initial encounter, subsequent encounter, sequela	W18.2XXA, W18.2XXD, W18.2XXS
Fall on same level, unspecified, initial encounter, subsequent, sequela or Fall on same level due to stepping or Other fall on same level, unspecified fall.	W18.30XA, W18.30XD, W18.30XS,W18.31XA, W18.31XD, W18.31XS, W18.39XA, W18.39XD, W18.39XS, W19.XXXA, W19.XXXD, W19.XXXS
Unspecified place in other specified residential institution as the place of occurrence of the external cause	Y92.199
Problems related to living in residential institution	Z59.3
Limitation of activities due to disability	Z73.6
Bed confinement status	Z74.01
Other reduced mobility	Z74.09
Need for assistance with personal care, at home, continuous supervision, other care provider dependency	Z74.1, Z74.2, Z74.3, Z74.8, Z74.9
History of falling	Z91.81
Dependence on respirator [ventilator] status	Z99.11
Dependence on wheelchair	Z99.3
Dependence on supplemental oxygen	Z99.81
Dependence on other enabling machines and devices	Z99.89

DEMENTIA MEDICATIONS

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

TELEHEALTH/TELEMEDICINE involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care.
Telehealth seeks to improve a patient's health by permitting two-way, real-time interactive communication between the patient and the physician or practitioner at the distant site. This communication often requires the use of interactive telecommunications equipment that can include both audio and video components, but can also be conducted via audio-only, as states deem appropriate.

CMS Eligible providers - Medicare limits the types of health care professionals who can provide telehealth-delivered services. The small group of eligible professionals are:

- Physicians
- Nurse practitioners
- Physician assistants
- Nurse midwives;
- Clinical nurse specialists
- Certified registered nurse anesthetists
- Clinical psychologists and clinical social workers (these professionals cannot bill for psychotherapy services that include medical evaluation and management services)
- Registered dietitians or nutrition professionals.
- Audiologists
- Occupational Therapist
- Physical Therapist
- Speech language pathologist
- Mental Health Counselors (MHC) - Starting on or after January 1, 2024
- Marriage Family Therapists (MFT) - Starting on or after January 1, 2024

AMBULATORY - OFFICE

The times for new & established office visits will be changed from time intervals to Time Thresholds (time spent before, during and after the visit on the date of encounter

Synchronous (Video/Audio)Visits		
CPT	**Medical Decision Making**	**Time Length (2024)**
	New Patient	
99202	Straightforward	15
99203	Low	30
99204	Moderate	45
99205	High	60
	Established Patient	
99211		
99212	Straightforward	10
99213	Low	20
99214	Moderate	30
99215	High	40

When billing telehealth claims, it is important to understand the place of service (POS) codes as it affects reimbursement.

NOTE: Check with your payor to determine the appropriate Place of Service (POS) code for your telehealth visits. Some commercial payers 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.

****Video/Audio visits should be the main way to connect to the patient****

****Not all payers reimburse for audio-only visits****

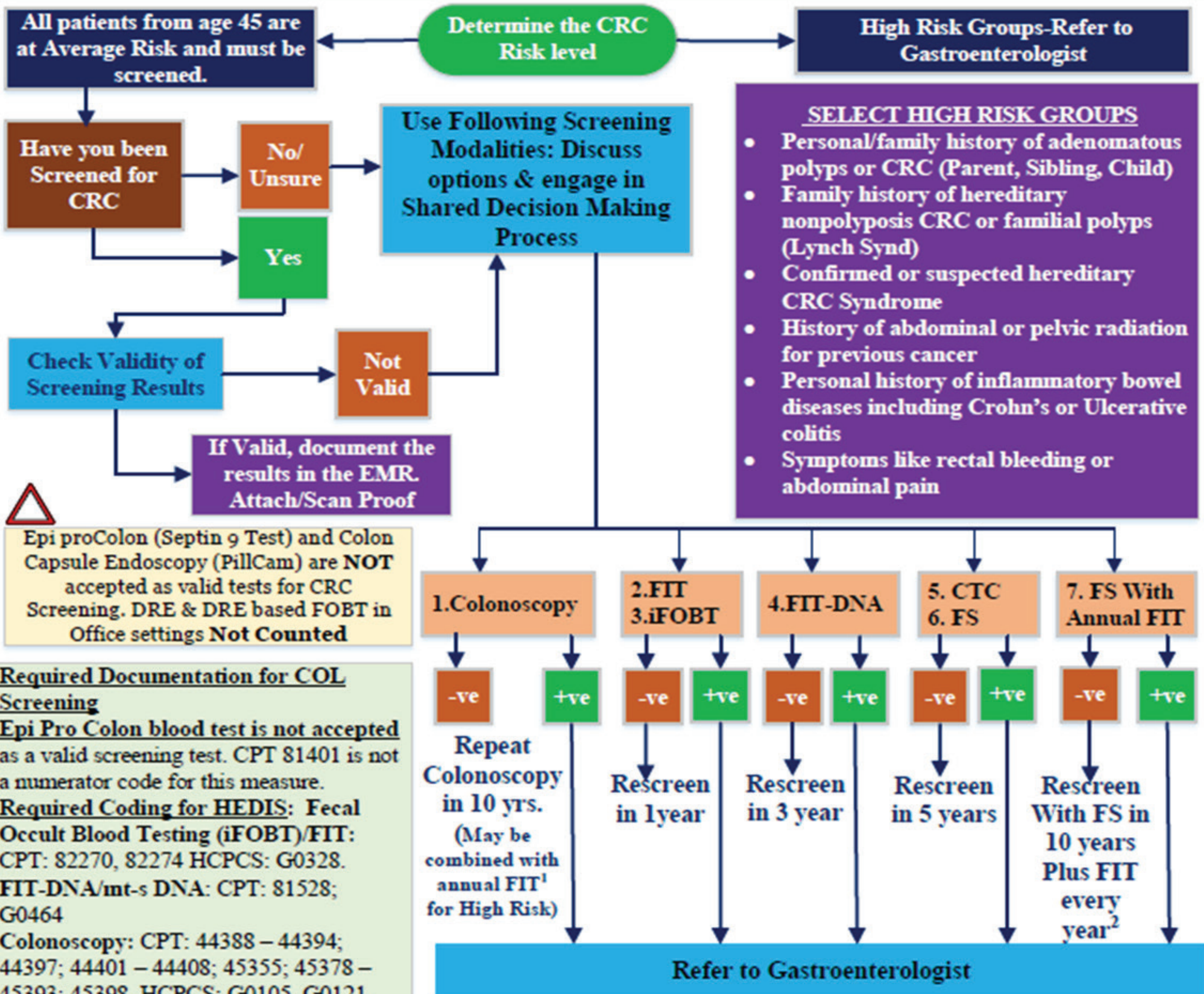
Audio Only/Telephone Visits	
CPT	**Description**
99441	Telephone E&M service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E&M service provided within 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.
99442	11-20 minutes of medical discussion
99443	21-30 minutes of medical discussion

2024 HMHP QUALITY MEASURE BENCHMARKS

Measure	LOB	2024 Goal	RED (Below National Average)	YELLOW (National Average to Goal)	GREEN (At goal or above)
Breast Cancer Screening	Commercial	83%	0.00-70.53%	70.54-82.99%	83.00-100%
	MA	80%	0.00-70.99%	72.00-79.99%	80.00-100%
Colorectal Cancer Screening	Commercial	68%	0.00-62.75%	62.76-67.99%	68.00-100%
	MA	71%	0.00-70.99%	71.00-71.00%	71.00-100%
Glycemic Status Assessment for Patients with Diabetes: Glycemic Status >9% Poor Control (inverse measure)	Commercial	28%	100-35.56%	35.55-28.01%	28.00-0%
	MA	23%	100.00-27.01%	27.00-23.01%	23.00-0.00%
Kidney Health Evaluation for Patient with Diabetes	Commercial	53%	0.00-42.09%	42.10-52.99%	53.00-100%
	MA	53%	0.00-43.16%	43.17-52.99%	53.00-100%
Eye Exam for Patients with Diabetes	MA	73%	0.00-72.29%	72.30-72.99%	73.00-100%
Controlling High Blood Pressure	Commercial	57%	0.00-56.30%	56.30-56.99%	57.00-100%
	MA	71%	0.00-69.48%	69.49-70.99%	71.00-100%
Medication Adherence: Diabetes	MA	90%	0.00-85.99%	86.00-89.99%	89.00-100%
Medication Adherence: RAS Antagonists	MA	91%	0.00-87.99%	88.00-90.99%	91.00-100%
Medication Adherence: Statins (PQA)	MA	88%	0.00-86.99%	87.00-87.99%	88.000-100%
Osteoporosis Mgmt in Women who had a fracture	MA	55%	0.00-43.99%	44.00-54.99%	55.00-100%
Plan All Cause Readmission	MA	8.00%	100.00-11.01%	11.00-8.01%	8.00-0.00%

2024 HMH CRC SCREENING GUIDELINES *(for HMH Internal Use Only)*

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 screening test. CPT 81401 is not a numerator code for this measure.

Required Coding for HEDIS: Fecal Occult Blood Testing (iFOBT)/FIT: CPT: 82270, 82274 HCPCS: G0328.

FIT-DNA/mt-s 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.

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; DRE-Digital (Finger) Rectal Exam

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

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.

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. Work with your EMR company to make sure it is Office of the National Coordinator for Health Information Technology (ONC) certified and meet the CMS requirements as 2024 is the last year for manual submission of Clinical Quality Measures via CMS Web interface. From 2025 onwards your EMR must be capable of either electronically reporting to CMS registry or reporting via third-party intermediary certified by CMS.

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.

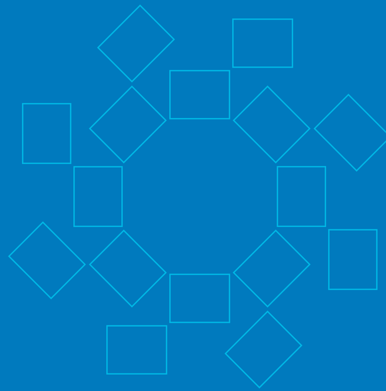
3. This guide has included only the most common compliance codes that would help you in documenting the necessary codes to measure your performance. This is just a tool for your assistance. Additional value sets are required and your EMR companies (if 2015 CEHRT certified) should have the capability 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.

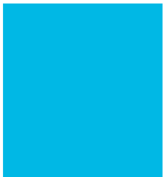
5. Sharing data with HMH directly from your EMR facilitates the meeting of quality metrics in a more expedited and efficient manner. It also addresses the lag time in the receipt of claims. Labs, screenings, vitals are all examples of the types of data that can be transfered. It is most effective to utilize the appropriate ICD-10 and CPT II and HCPCs codes to satisfy quality metrics.

6. If you have not set up an HMH email account please contact DTS help desk.
   DTS Service Desk Email: DTSServiceDesk@hmhn.org
   Internal Extension: x3333
   External Phone Number: 848-237-3333

7. If you have any questions about your quality performance status, please contact:
   Richard Morris, Director, CIN Operations
   Richard.Morris@hmhn.org



KEEP GETTING BETTER



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