2025 Quality Program Measures Guide

Information and Tips To Maximize Your Quality Measure Performance

Thank you for your participation in BlueCare Tennessee's Quality Improvement efforts. We value your dedication to enhancing care and health outcomes for our members. Providing quality care is essential to our mission of Peace of Mind through Better Health® to those we serve.

This guide features standard HEDIS® measures and custom Division of TennCare measures. We hope the information and tips included will help you maximize and optimize your performance for each quality measure.

If you have questions about the Quality Program Measures Guide, please contact the Provider Service line for your patient’s plan. You can also find additional contact information on the back of this guide.

Thank you, again, for the exceptional care you provide to our members every day.

Sincerely,
Your BlueCare Tennessee Quality Improvement Team.

BlueCare℠ Provider Service
Phone: 1-800-468-9736

TennCare*Select* Provider Service
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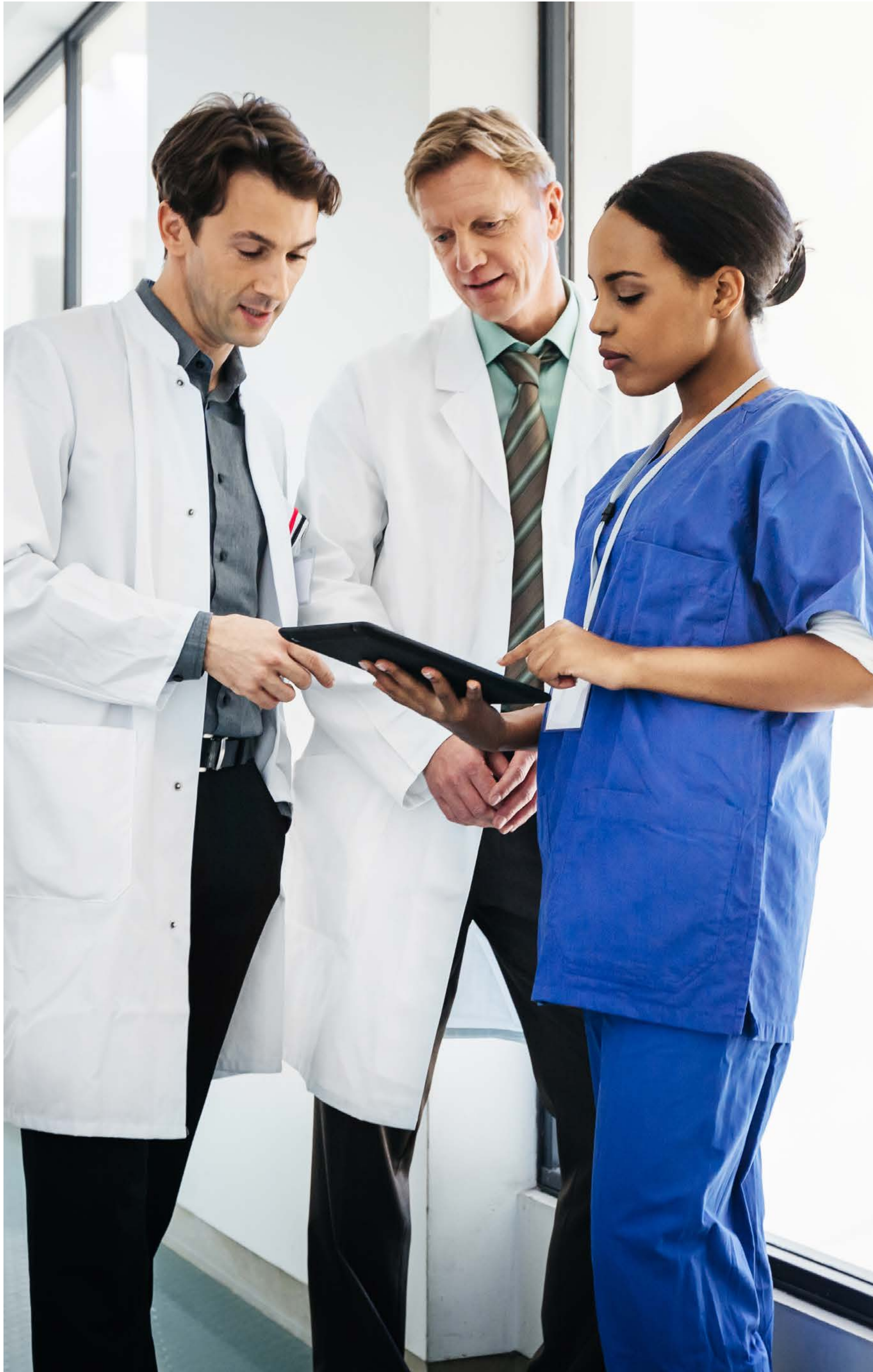

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Quality Measures Quick Reference

Immunization Measures

(AIS-E) Adult Immunization Status

Members 19 years and older should be up to date on recommended routine vaccines for influenza (flu), tetanus and diphtheria (Td) or tetanus, diphtheria and acellular pertussis (Tdap), zoster, hepatitis B, and pneumococcal.

(CIS-E) Childhood Immunization Status Combination 10

Members should complete the entire series of all immunizations before they turn 2 years old:

- Four DTaP (diphtheria, tetanus and pertussis)
- Three IPV (polio)
- One MMR (measles, mumps and rubella)
- Three HiB (haemophilus influenza type B)
- Three Hep B (hepatitis B)
- One Hep A (hepatitis A)
- One VZV (varicella)
- Four PCV (pneumococcal conjugate)
- Two or three RV (rotavirus)
- Two Flu (influenza)

(IMA-E) Immunizations for Adolescents Combination 2

Members should complete the entire series of all immunizations before they turn 13 years old:

- One meningococcal given between 10 and 13 years old
- One Tdap (tetanus, diphtheria toxoids and acellular pertussis) given between 10 and 13 years old
- Completed HPV series between 9 and 13 years old

(PRS-E) Prenatal Immunization Status

Members who have a delivery, at 37 weeks or later, during the measurement year should have received vaccines for influenza (flu), and tetanus, diphtheria and acellular pertussis (Tdap) during that pregnancy.

Diabetes-Related Measures

(BPD) Blood Pressure Control for Patients with Diabetes

Members 18-75 years old identified with diabetes (types 1 or 2) should have a controlled blood pressure of less than 140/90 as their most recent documented result during the measurement year.

(EED) Eye Exam for Patients with Diabetes

Members 18-75 years old identified with diabetes (types 1 or 2) should have a retinal or dilated eye exam by an eye care professional, or imaging with interpretation and reporting by a qualified reading center billed by any provider type during the measurement year.

(GSD) Glycemic Status Assessment for Patients with Diabetes

Members 18-75 years old identified with diabetes (types 1 or 2) should have a controlled HbA1c or glucose management indicator (GMI) of less than 8 as their most recent documented result during the measurement year.

(KED) Kidney Health Evaluation for Patients with Diabetes

Members 18-85 years old identified with diabetes (types 1 or 2) should have an estimated glomerular filtration rate (eGFR) **and** a urine albumin-creatinine ratio (uACR) during the measurement year.

(SPD) Statin Therapy for Patients with Diabetes – Received Statin Therapy

Members 40-75 years old identified with diabetes (types 1 or 2) and don't have clinical atherosclerotic cardiovascular disease (ASCVD) should be placed on a statin medication of any intensity during the measurement year.

(SPD) Statin Therapy for Patients with Diabetes – Statin Adherence 80%

Members 40-75 years old identified with diabetes (types 1 or 2) that don't have clinical ASCVD should remain on their statin medication for at least 80% of their treatment period during the measurement year.

Quality Measures Quick Reference (cont.)

Cardiac and Respiratory Measures

(AMR) Asthma Medication Ratio

Members 5 to 64 years old who were identified as having persistent asthma should have a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.

(AXR) Antibiotic Utilization for Respiratory Conditions

Members 3 months and older who were diagnosed with a respiratory condition that resulted in an antibiotic dispensing event.

(CBP) Controlling High Blood Pressure

Members 18-85 years old with a diagnosis of hypertension should have a controlled blood pressure level of less than 140/90 as their most recent documented result during the measurement year.

(BPC-E) Blood Pressure Control for Patients with Hypertension

The percentage of members 18-85 years of age who had a diagnosis of hypertension (HTN) and whose recent blood pressure was <140/90 during the measurement period.

(SPC) Statin Therapy for Patients with Cardiovascular Disease — Received Statin Therapy

Male members 21-75 years old and female members 40-75 years old who were identified as having clinical ASCVD should be placed on a moderate- to high-intensity statin medication during the measurement year.

(SPC) Statin Therapy for Patients with Cardiovascular Disease — Statin Adherence 80%

Male members 21-75 years old and female members 40-75 years old who were identified as having clinical ASCVD should be placed on a moderate- to high-intensity statin medication and should remain on the statin medication for at least 80% of their treatment period during the measurement year.

Preventive Screening

(BCS-E) Breast Cancer Screening

Members 40-74 years old should have a mammogram to screen for breast cancer every two years.

(CCS-E) Cervical Cancer Screening

Members 21-64 years old should be screened for cervical cancer using either of the following criteria:

- Age 21-64: Cervical cytology every three years
- Age 30-64: Cervical cytology and high-risk human papillomavirus infection (HPV) testing every five years

OR

- Age 30-64: Cervical high-risk HPV testing every five years

(CHL) Chlamydia Screening

Members ages 16-24 years old who were identified as sexually active should have at least one chlamydia screening each year. This can be done by urine specimen.

(COL-E) Colorectal Cancer Screening

Members 45-75 years old should have a colorectal cancer screening by one of the screening methods below as appropriate:

- Colonoscopy every 10 years
- Flexible sigmoidoscopy every five years
- CT colonography every five years
- Stool-DNA (sDNA) with FIT test every three years
- Fecal occult blood testing (FOBT) yearly (if using guaiac-based testing, three samples are required)

(TFC) Topical Fluoride in Children

Members between 1-4 years of age should have at least two fluoride varnish applications during the measurement year.

Quality Measures Quick Reference (cont.)

Pregnancy Health

(PPC) Prenatal Care

Members that received a prenatal care visit in the first trimester for live births on or between Oct. 8th of the year prior to Oct. 7th of the measurement year.

(PPC) Postnatal Care

Members that receive a postpartum visit on or between 7 and 84 days after delivery for live births on or between Oct. 8th of the year prior to Oct. 7th of the measurement year.

Behavioral Health

(ADD-E) Follow-Up Care for Children Prescribed ADHD Medications

Members ages 6 to 12 who are newly prescribed ADHD medications should have at least three follow-up visits within 10 months with the first follow up with a prescriber within 30 days.

(APM-E) Metabolic Monitoring for Children and Adolescents on Antipsychotics

Members ages 1 to 17 who are on antipsychotic medication should have both blood sugar/A1C and cholesterol/LDL testing once a year.

(APP) Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics

Members ages 1 to 17 must have at least one visit with a mental health professional either 90 days before or within 30 days after filling an antipsychotic medication.

(DMH) Diagnosed Mental Health Disorders

Members 1 year of age and older who were diagnosed with a mental health disorder during the measurement year.

(DRR-E) Depression Remission or Response for Adolescents and Adults

Members 12 years of age and older with a diagnosis of depression and an elevated PHQ-9 score, who had evidence of response or remission within 120–240 days (4–8 months) of the elevated score.

DSF-E) Depression Remission or Response for Adolescents

Members 12 years of age and older who were screened for clinical depression using a standardized instrument and, if screened positive, received follow-up care.

(FUH) Follow-up After Hospitalization for Mental Illness

Members 6 years and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnosis and had a mental health follow-up service within seven days of discharge and 30 days of discharge.

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

Members 6 years and older who had an emergency oom (ER) visit with a principal diagnosis of mental illness or intentional self harm should have a follow-up visit within seven days of an ER visit and within 30 days of an ER visit. Telehealth visits may be used, and the visit can be with any practitioner, as long as the claim includes an appropriate behavioral health diagnosis.

(FUA) Follow-up After Emergency Department Visit for Substance Use Disorder

Members 13 years and older who were seen in the ER with the principal diagnosis of substance use disorder or any diagnosis of drug overdose, should have a follow-up visit for SUD within seven days of the ER visit and within 30 days of the ER visit. Telehealth visits may be used, and the visit can be with any practitioner, as long as the claim includes an SUD diagnosis.

(FUI) Follow-Up After High-Intensity Care for Substance Use Disorder

The percentage of acute inpatient hospitalizations, residential treatment or withdrawal management visits for a diagnosis of substance use disorder among members 13 years and older that result in a follow-up visit or service for substance use disorder. A follow-up visit should be made within seven days after the visit or discharge and within 30 days after the visit or discharge. The follow-up visits can be with any practitioner as long as the claim includes a substance use disorder diagnosis.

Quality Measures Quick Reference (cont.)

Behavioral Health (cont.)

(HDO) Use of Opioids at High Dosage

Members 18 years of age and older who received prescription opioids at a high dosage (average morphine milligram equivalent dose [MME] ≥90) for ≥15 days during the measurement year.

(IET) Initiation and Engagement of Substance Use Disorder Treatment

Members 13 years and older with new substance use disorder episodes that result in treatment and engagement should have Initiation of SUD treatment within 14 days and Engagement of SUD treatment within 34 days of initiation.

(POD) Pharmacotherapy for Opioid Use Disorder

Members, ages 16 and older, who begin a new medication assisted treatment for OUD at least 180 days with no breaks in treatment for eight or more consecutive days.

(RTF) 7- and 30-Day Psychiatric Hospital/Residential Treatment Facility Rate

Members 6 years of age and older with readmissions within 7 or 30 days of discharge from a psychiatric hospital or RTF.

(SAA) Adherence to Antipsychotic Medication for Individuals with Schizophrenia

Members 18 years and older with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.

(SNS-E) Social Needs Screening and Intervention

The percentage of members who were screened, using prespecified instruments, at least once during the measurement period for unmet food, housing, and transportation needs, and received a corresponding intervention if they screened positive.

(SMC) Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia

Members 18–64 years of age with schizophrenia or schizoaffective disorder and cardiovascular disease, who had an LDL-C test during the measurement year.

(SSD) Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication

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

Effectiveness of Care/Over-Use Measures

(AAB) Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis

The percentage of episodes for members ages 3 months and older with a diagnosis of acute bronchitis/ bronchiolitis that did not result in an antibiotic dispensing event.

(URI) Appropriate Treatment for Upper Respiratory Infection

The percentage of episodes for members 3 months of age and older with a diagnosis of upper respiratory infection (URI) that didn’t result in an antibiotic-dispensing event.

Risk Adjusted Utilization

(PCR) Plan All-Cause Readmission

For members 18 years of age and older, the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission.

Quality Measures Quick Reference (cont.)

Well Child Visits

(W30) Well-Child Visits in the First 15 Months of Life (age: 0-15 months)

Members should have at least six well-child visits before turning 15 months old.

(W30) Well-Child Visits in the First 30 Months of Life (age: 15-30 months)

Members should have at least two or more well-child visits between 15 and 30 months old.

(WCV) Child and Adolescent Well-Care Visits

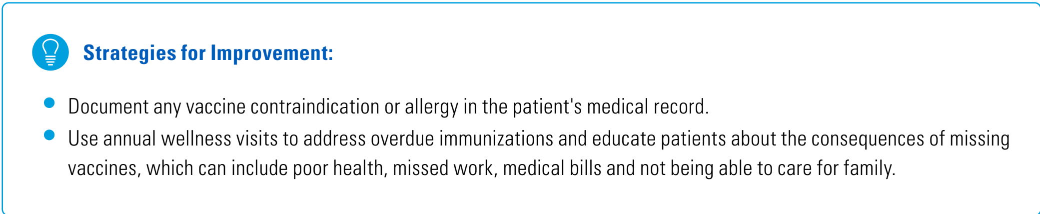
Members 3 to 21 years old should have one or more comprehensive well-care visits with a primary care physician (PCP) or obstetrician-gynecologist (OB/GYN) every year.

(WCC-BMI) Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Body Mass Index (BMI) Percentile Documentation

Members 3 to 17 years old should have an outpatient visit with a PCP or OB/GYN and should have chart documentation of a BMI percentile every year. This may be plotted on a BMI age-growth chart or documented in the record as a percentile. Use specific BMI percentiles that account for age and gender rather than absolute BMI.

2025 HEDIS Quality Measures

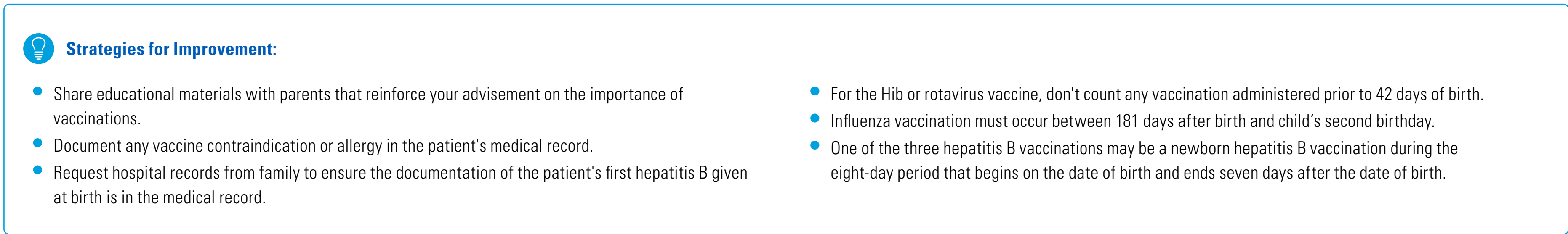
Measure	Goal of the Measure	What to Report (Sample of Codes and/or Diagnoses)	Exclusions
Adult Immunization Status (AIS-E) >19 years	Patients 19 years of age and older who are up to date on recommended vaccines: • One Influenza — on or between July1 of the year prior to the measurement period and June 30 of the measurement period or anaphylaxis to the influenza vaccine • One Tdap and/or Td — (diphtheria, tetanus, and acellular pertussis or tetanus and diphtheria) between 9 years prior to through the end of measurement year or anaphylaxis or encephalitis from the Tdap or Td vaccine • Two Herpes zoster recombinant — at least 28 days apart, on Oct. 20, 2017, through the end of the measurement year or anaphylaxis to the herpes zoster vaccine • One Adult Pneumococcal — on or after the 19th birthday through the end of the measurement year or anaphylaxis to the pneumococcal vaccine • Three Childhood Hepatitis B doses — different dates of service on or before the 19th birthday **OR** • Two Adult Hepatitis B doses — administered at least 28 days apart, on or after the 19th birthday **OR** • Three Adult Hepatitis B — on different dates of service on or after 19th birthday • Patients who had a hepatitis B surface antigen, hepatitis B surface antibody or total antibody to hepatitis core antigen test with + result any time before or during the measurement period, any of the following meet criteria: - A test with a result greater than 10mIU/mL - A test with a finding of immunity • Patients with a history of hepatitis B illness any time before or during the measurement period or anaphylaxis to the Hepatitis B vaccine	**Influenza Vaccine** **CPT®:** 90653, 90656, 90658, 90661, 90662, 90673, 90674, 90682, 90686, 90689, 90688, 90694, 90756, 90660, 90672 **Tdap** **CPT®:** 90715, 90714 **Zoster** **CPT®:** 90750 **Pneumococcal** **CPT®:** 90670, 90671, 90677, 90684, 90732, G0009	Patients who use hospice services or elect to use a hospice benefit any time during the measurement year Patients who die any time during the measurement year Contraindication due to encephalitis due to the diphtheria, tetanus or pertussis vaccination


Strategies for Improvement:

- Document any vaccine contraindication or allergy in the patient's medical record.
- Use annual wellness visits to address overdue immunizations and educate patients about the consequences of missing vaccines, which can include poor health, missed work, medical bills and not being able to care for family.

HEDIS codes can change from year to year. The codes in this document are from the HEDIS MY2025 specifications.

Measure	Goal of the Measure	What to Report (Sample of Codes and/or Diagnoses)	Exclusions
Childhood Immunization Status (CIS-E) <2 years Combination 7 immunizations include: DTaP, IPV, MMR, HiB, hepatitis B, VZV, pneumococcal, hepatitis A and rotavirus. Influenza immunization includes influenza vaccinations Combination 10 immunizations include: DTaP, IPV, MMR, HiB, hepatitis B, VZV, pneumococcal, hepatitis A, rotavirus and influenza vaccinations.	Patients turning 2 years of age during the measurement year should have all the following immunizations before their second birthday: • Four DTaP (diphtheria, tetanus, and acellular pertussis) or anaphylaxis or encephalitis due to DTaP vaccine • Three IPV (polio) or anaphylaxis due to IPV vaccine • One MMR (measles, mumps and rubella) between the patient's first and second birthday or history of measles, mumps, or rubella or anaphylaxis due to MMR vaccine • Three HiB (haemophilus influenza type B) or anaphylaxis due to the HiB vaccine. • Three hepatitis B or history of hepatitis B illness or anaphylaxis due to hepatitis B vaccine. • One hepatitis A between the child's first and second birthday, a history of hepatitis A illness, or anaphylaxis due to the hepatitis A vaccine. • One VZV (varicella — chicken pox) between the child's first and second birthday, a history of varicella zoster illness or anaphylaxis due to the VZV vaccine • Four PCV (pneumococcal) or anaphylaxis due to PCV vaccine. • Two dose or three dose schedule RV (rotavirus) or anaphylaxis due to the rotavirus vaccine. • Two flu (influenza) on different dates of service or anaphylaxis due to flu vaccination.	For children before or on their second birthday: **Diphtheria, tetanus and pertussis (DTaP) CPT®:** 90697, 90698, 90700, 90723 **Polio (IPV) CPT®:** 90697, 90698, 90713, 90723 **Haemophilus influenza type B (HiB) CPT®:** 90644, 90647, 90648, 90697, 90698, 90748 **Hepatitis B (HepB) CPT®:** 90697, 90723, 90740, 90744, 90747, 90748 **HepB HCPCS:** G0010 **Vaxelis® (combination drug for DTaP, IPV, HiB, HepB) CPT®:** 90697 **Varicella (chicken pox) (VZV) CPT®:** 90710, 90716 **Pneumococcal (PCV) CPT®:** 90670, 90671, 90677 **PCV HCPCS:** G0009 **Hepatitis A (HepA) CPT®:** 90633 **Rotavirus (RV) (2-dose schedule) CPT®:** 90681 **RV (3-dose schedule) CPT®:** 90680 **Influenza CPT®:** 90655, 90656, 90657, 90658, 90661, 90674, 90685, 90686, 90687, 90688, 90689, 90756 **Influenza CPT® – LAIV for 2 years and older only:** 90660, 90672 **Measles, Mumps and Rubella (MMR) vaccine:** 90707, 90710	Patients who use hospice services or elect to use a hospice benefit any time during the measurement year Patients who die any time during the measurement year **Patients who had a contraindication to a childhood vaccine on or before their second birthday. Either of the following meet criteria:** • Contraindication to Childhood Vaccines Value Set • Organ and Bone Marrow Transplant Value Set These value sets include some of the following: • Severe combined immunodeficiency • Immunodeficiency • HIV • Lymphoreticular cancer, multiple myeloma, or leukemia • Intussusception



Strategies for Improvement:

- Share educational materials with parents that reinforce your advisement on the importance of vaccinations.
- Document any vaccine contraindication or allergy in the patient's medical record.
- Request hospital records from family to ensure the documentation of the patient's first hepatitis B given at birth is in the medical record.
- For the Hib or rotavirus vaccine, don't count any vaccination administered prior to 42 days of birth.
- Influenza vaccination must occur between 181 days after birth and child's second birthday.
- One of the three hepatitis B vaccinations may be a newborn hepatitis B vaccination during the eight-day period that begins on the date of birth and ends seven days after the date of birth.

HEDIS codes can change from year to year. The codes in this document are from the HEDIS MY2025 specifications.

Vaccines Required by the Second Birthday

Childhood Vaccine	# of Doses	OR Documented Anaphylaxis	Documented Encephalitis	Documented History of Prior Illness
DTaP	4	✓	✓	—
IPV	3	✓	—	—
MMR	1	✓	—	✓
HiB	3	✓	—	—
Hepatitis B	3	✓	—	✓
VZV	1	✓	—	✓
Pneumococcal	4	✓	—	—
Hepatitis A	1	✓	—	✓
Rotavirus	2 or 3*	✓	—	—
Influenza	2	✓	—	—

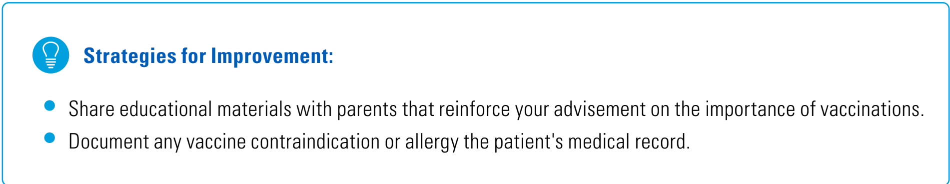
*At least two doses of the two-dose rotavirus vaccine or two doses of the three-dose rotavirus vaccine.

For more information, please visit the U.S. Centers for Disease Control and Prevention's Vaccines for Your Children webpage.

Vaccines for Your Children webpage should be a hyperlink to: **Vaccines for Your Children | Childhood Vaccines | CDC**

HEDIS codes can change from year to year. The codes in this document are from the HEDIS MY2025 specifications.

Measure	Goal of the Measure	What to Report (Sample of Codes and/or Diagnoses)	Exclusions
Immunizations for Adolescents (IMA-E) <13 years of age	Patients who are 13 years of age and had: • One meningococcal vaccine with a date of service on or between the member's 10th and 13th birthday or anaphylaxis to the meningococcal vaccine • One Tdap (tetanus, diphtheria toxoids and acellular pertussis) with a date of service on or between the member's 10th and 13th birthday or anaphylaxis or encephalitis following the Tdap vaccine • Two HPV (human papillomavirus) vaccines on or between the member's 9th and 13th birthday with dates of service at least 146 days apart or anaphylaxis to the HPV vaccine OR • Three HPV vaccines with different dates of service on or between the member's 9th and 13th birthday or anaphylaxis to the HPV vaccine	**HPV:** 90649, 90650, 90651 **Meningococcal:** 90734, 90619, 90623, 90733 **Tdap:** 90715	Patients who use hospice services or elect to use a hospice benefit any time during the measurement year Patients who die any time during the measurement year



Strategies for Improvement:

- Share educational materials with parents that reinforce your advisement on the importance of vaccinations.
- Document any vaccine contraindication or allergy the patient's medical record.

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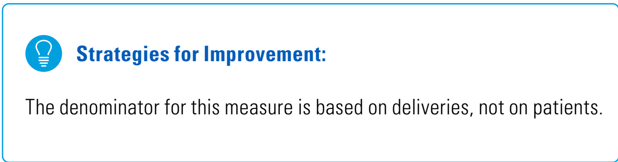
Measure	Goal of the Measure	What to Report (Sample of Codes and/or Diagnoses)	Exclusions
Prenatal Immunization Status (PRS-E)	The percentage of deliveries in the measurement period in which patients received the following vaccinations: • One Influenza – on or between July 1 of the year prior to the measurement period and the delivery date or deliveries where patients had anaphylaxis or encephalitis due to the diptheria, tetanus or pertussis vaccine on or before the delivery date **AND** • One Tdap (Tetanus, diphtheria, and acellular pertussis) during the pregnancy (including on the delivery date) or deliveries where patients had anaphylaxis or encephalitis due to the diptheria, tetanus or pertussis vaccine on or before the delivery date **OR** • Anaphylaxis due to the influenza or diphtheria, tetanus or pertussis vaccine on or before the delivery date • Encephalitis due to the diphtheria, tetanus or pertussis vaccine	**Sample CPT® and HCPCS Codes** **Influenza vaccine:** 90653, 90656, 90658, 90661, 90662, 90673, 90674, 90682, 90686, 90688, 90689, 90694, 90756 **Tdap vaccine:** 90715 (CVX code: 115)	Deliveries that occurred at less than 37 weeks. Length of gestation in weeks is identified by one of the two methods: • Gestational age assessment • Gestational age diagnosis Patients that are in hospice or using hospice service at any time during the measurement year Patients who die any time during the measurement period



Strategies for Improvement:

The denominator for this measure is based on deliveries, not on patients.

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Measure	Goal of the Measure	What to Report (Sample of Codes and/or Diagnoses)	Exclusions
Blood Pressure Control for Patients with Diabetes (BPD) 18-75 years of age	There are two ways to identify patients with diabetes: **Claim/Encounter Data:** Patients who had at least two diagnoses of diabetes on different dates of service during the measurement year or the year prior to the measurement year **Pharmacy Data:** Patients who were dispensed insulin or hypoglycemics/ antihyperglycemics and have at least one diagnosis of diabetes during the measurement year or the year prior to the measurement year The percentage of patients with diabetes (Type 1 and 2) whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the measurement year	Patients identified using specified claims, encounter or pharmacy data documenting or indicating diabetes during the measurement year and/or the year prior to the measurement year **BP Measurement – Systolic CPT® Category II:** • 3074F – <130 • 3075F – 130-139 • 3077F – ≥140 **BP Measurement – Diastolic CPT® Category II:** • 3078F – <80 • 3079F – 80-89 • 3080F – ≥ 90 **LOINC:** 75995-1, 8453-3, 8462-4, 8496-2, 8514-2, 8515-9, 75997-7, 8459-0, 8480-6, 8508-4, 8546-4, 8547-2	Patients 66-80 years of age as of December 31 of the measurement year with frailty and advanced illness • **Frailty:** At least two indications of frailty with different dates of service. • **Advanced illness:** Either of the following: - Advanced illness on at least two different dates of service - Dispensed dementia medication Patients who use hospice services or elect to use a hospice benefit any time during the measurement year Patients who die any time during the measurement year Patients receiving palliative care or who had an encounter for palliative care any time during the measurement year

Strategies for Improvement:

The most recent blood pressure (value) must be used (latest value in the measurement year). This information is found through administrative, supplemental data or medical record review.

Don't include blood pressures taken during an acute inpatient setting or ER visit.

Don't include blood pressures that are taken the same day as a diagnostic or therapeutic procedure that requires a change in medication regimen or diet, with the exception of fasting blood tests. For example:

- A colonoscopy requires a change in diet (NPO on the day of procedure) and a medication change (a medication taken to prep the colon).
- Dialysis, infusions and chemotherapy (including oral chemotherapy) are all therapeutic procedures that require a medication regimen (the albuterol).
- A patient forgetting to take regular medications on the day of the procedure isn't considered a required change in medication, so the BP reading is eligible.

BP readings taken on the same day that the patient receives a common low-intensity or preventive procedure can be used. For example:

- Injections (i.e., allergy, vitamin B-12, insulin, steroid, Toradol, Depo-Provera, testosterone, lidocaine)
- Vaccinations
- TB test
- IUD insertion
- Eye exam with dilating agents
- Wart or mole removal

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Measure	Goal of the Measure	What to Report (Sample of Codes and/or Diagnoses)	Exclusions
Eye Exam for Patients with Diabetes (EED) 18-75 years of age	There are two ways to identify patients with diabetes: **Claim/Encounter Data:** Patients who had at least two diagnoses of diabetes on different dates of service during the measurement year or the year prior to the measurement year **Pharmacy Data:** Patients who were dispensed insulin or hypoglycemics/antihyperglycemics and have at least one diagnosis of diabetes during the measurement year or the year prior to the measurement year The percentage of patients with diabetes (Type 1 and 2) who had: • A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year • A negative retinal or dilated exam (negative for retinopathy) by an eye care professional **(optometrist or ophthalmologist)** in the year prior to the measurement year	**Diabetic Retinal Screening** **CPT® Category II:** • 2022F — Dilated retinal exam interpreted by an ophthalmologist or optometrist documented and reviewed • 2023F — Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed, without evidence of retinopathy (DM) • 2024F — Documented and reviewed —Seven standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist • 2025F — Seven standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed, without evidence of retinopathy (DM) • 2026F — Documented and reviewed — Eye imaging validated to match diagnosis from seven standard field stereoscopic photo results • 2033F — Eye imaging validated to match diagnosis from seven standard field stereoscopic retinal photo results documented and reviewed, without evidence of retinopathy (DM) • 3072F — Negative retinal screen in the prior year **CPT®:** 92002, 92004, 92012, 92014, 92018, 92019, 92134, 92137, 92201, 92202, 92227, 92228, 92230, 92235, 92250, 99203, 99204, 99205, 99213, 99214, 99215, 99242, 99243, 99244, 99245 **HCPCS:** S0620, S0621, S3000	Bilateral or two unilateral eye enucleation any time during the patient's history throughout December 31st of the measurement year Bilateral absence of eyes any time during the member's history through the measurement year Patients who use hospice services or elect to use a hospice benefit any time during the measurement year Patients who die any time during the measurement year Patients receiving palliative care or who've had an encounter for palliative care during the measurement year Patients 66 years of age and older who meet criteria for Advanced Illness and Frailty. • **Frailty:** At least two indications of frailty with different dates of service. • **Advanced Illness:** Either of the following: - Advanced Illness on at least two different dates of service - Dispensed Dementia medication

Strategies for Improvement:

Blindness isn't an exclusion for a diabetic eye exam.

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Measure	Goal of the Measure	What to Report (Sample of Codes and/or Diagnoses)	Exclusions
Glycemic Status Assessment for Patients with Diabetes (GSD) 18-75 years of age	There are two ways to identify patients with diabetes: **Claim/Encounter Data:** Patients who had at least two diagnoses of diabetes on different dates of service during the measurement year or the year prior to the measurement year **Pharmacy Data:** Patients who were dispensed insulin or hypoglycemics/antihyperglycemics and have at least one diagnosis of diabetes during the measurement year or the year prior to the measurement year The percentage of patients with diabetes (Type 1 and 2) whose most recent glycemic status (hemoglobin A1C [HbA1c] or glucose management indicator [GMI]) was at the level of < 8.0% during the measurement year	**HbA1c Testing** **CPT®:** 83036, 83037 **CPT®** Category II: • 3044F – <7.0 • 3051F – ≥ 7.0 - < 8.0 • 3052F – ≥ 8.0 - ≤ 9.0 • 3046F – >9.0 **LOINC:** 17855-8, 17856-6, 4548-4, 4549-2, 96595-4	Patients 66-80 years of age as of December 31 of the measurement year with fraility and advanced illness • **Frailty:** At least two indications of frailty with different dates of service. • **Advanced Illness:** Either of the following: - Advanced Illness on at least two different dates of service - Dispensed Dementia medication Patients who use hospice services or elect to use a hospice benefit any time during the measurement year Patients who die any time during the measurement year Patients receiving palliative care or who had an encounter for palliative care any time during the measurement year

Strategies for Improvement:

- The most recent glycemic status assessment (value) must be used (the latest value in the measurement year). You can find this information during laboratory data or medical record review.
- The medical record must include a note indicating the date when the glycemic status assessment was performed and the result.
- When identifying the most recent glycemic status assessment (HbA1c or glucose management indicator (GMI)), GMI values must include documentation of the continuous glucose monitoring data date range used to derive the value. The terminal date in the range should be used to assign the assessment date.
- If multiple glycemic status assessments were recorded for a single date, use the lowest result.
- GMI results collected by the patient and documented in the patient's medical record are eligible for use in reporting (provided the GMI doesn't meet any exclusion criteria). There's no requirement that there be evidence the GMI was collected by a PCP or specialist.
- Ranges and thresholds don't meet criteria for this measure. A distinct numeric result is required for numerator compliance.
- A result of unknown or no value isn't considered a result or finding.

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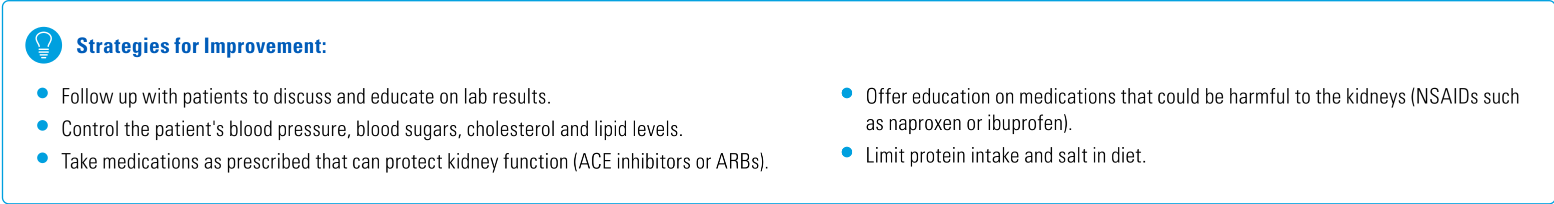
Measure	Goal of the Measure	What to Report (Sample of Codes and/or Diagnoses)	Exclusions
Kidney Health Evaluation for Patients with Diabetes (KED) 18-85 years of age	There are two ways to identify patients with diabetes: **Claim/Encounter Data:** Patients who had at least two diagnoses of diabetes on different dates of service during the measurement year or the year prior to the measurement year **Pharmacy Data:** Patients who were dispensed insulin or hypoglycemics/antihyperglycemics and have at least one diagnosis of diabetes during the measurement year or the year prior to the measurement year The percentage of patients with diabetes (Type 1 and 2) who received a kidney health evaluation during the measurement year, defined by: • At least one estimated glomerular filtration rate (eGFR) **AND** • At least one urine albumin-creatinine ratio (uACR) identified by either of the following: - Both a quantitative urine albumin test and a urine creatinine test with service dates four or fewer days apart - Urine albumin creatinine ratio lab test	Encounter/Claim with Codes: **Estimated Glomerular Filtration Rate (eGFR)** **CPT®:** 80047, 80048, 80050, 80053, 80069, 82565 **LOINC:** 50044-7, 50210-4, 50384-7, 62238-1, 69405-9, 70969-1, 77147-7, 94677-2, 98979-8, 98980-6 **Quantitative Urine Albumin Test** **CPT®:** 82043 **LOINC:** 14957-5, 1754-1, 21059-1, 30003-8, 43605-5, 53530-2, 53531-0, 57369-1, 89999-7, 100158-5 **Urine Creatinine Lab Test** **CPT®:** 82570 **LOINC:** 20624-3, 2161-8, 35674-1, 39982-4, 57344-4, 57346-9, 58951-5 **Urine Albumin-Creatinine Ratio Lab Test** **LOINC:** 13705-9, 14958-3, 14959-1, 30000-4, 44292-1, 59159-4, 76401-9, 77253-3, 77254-1, 89998-9, 9318-7 At least one eGFR (Estimated Filtration Rate) — Sample codes: 80047, 80048, 80050, 80053, 80069 **AND** At least one uACR identified by both a quantitative urine albumin test — sample code: 82043 — and a urine creatinine test — sample code: 82570.	Advanced illness on at least two different dates of service Patients who use hospice services or elect to use a hospice benefit any time during the measurement year Patients who die any time during the measurement year Patients receiving palliative care or who've had an encounter for palliative care any time during the measurement year Patients with a diagnosis of end-stage renal disease or dialysis any time during the patient's history on or prior to Dec. 31 of the measurement year Patients 66-80 years of age as of December 31 of the measurement year with fraility and advanced illness • **Frailty:** At least two indications of frailty with different dates of service. • **Advanced Illness:** Either of the following: - Advanced Illness on at least two different dates of service - Dispensed Dementia medication



Strategies for Improvement:

- Follow up with patients to discuss and educate on lab results.
- Control the patient's blood pressure, blood sugars, cholesterol and lipid levels.
- Take medications as prescribed that can protect kidney function (ACE inhibitors or ARBs).
- Offer education on medications that could be harmful to the kidneys (NSAIDs such as naproxen or ibuprofen).
- Limit protein intake and salt in diet.

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Measure	Goal of the Measure	What to Report (Sample of Codes and/or Diagnoses)	Exclusions
Statin Therapy for Patients With Diabetes (SPD) 40-75 years of age	There are two ways to identify patients with diabetes: **Claim/Encounter Data:** Patients who had at least two diagnoses of diabetes on different dates of service during the measurement year or the year prior to the measurement year **Pharmacy Data:** Patients who were dispensed insulin or hypoglycemics/antihyperglycemics and have at least one diagnosis of diabetes during the measurement year or the year prior to the measurement year The percentage of patients during the measurement year with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) who met the following criteria **Two rates are reported:** **1. Received Statin Therapy:** Members who were dispensed at least one statin medication of any intensity during the measurement year **2. Statin Adherence 80%:** Members who remained on a statin medication of any intensity for at least 80% of the treatment period **Calculated by:** Total Days Covered by a Statin Medication in the Treatment Period Total Days in Treatment Period	Measure is a medication receipt and adherence measure. The following statins qualify for compliance: **High-Intensity Statin Therapy:** • Atorvastatin 40-80 mg • Amlodipine-atorvastatin 40-80 mg • Rosuvastatin 20-40 mg • Simvastatin 80 mg • Ezetimibe-simvastatin 80 mg **Moderate-Intensity Statin Therapy:** • Atorvastatin 10-20 mg • Amlodipine-atorvastatin 10-20 mg • Rosuvastatin 5-10 mg • Simvastatin 20-40 mg • Ezetimibe-simvastatin 20-40 mg • Pravastatin 40-80 mg • Lovastatin 40-60 mg • Fluvastatin 40-80 mg • Pitavastatin 1-4 mg **Low-Intensity Statin Therapy:** • Simvastatin 5-10 mg • Ezetimibe-simvastatin 10 mg • Pravastatin 10-20 mg • Lovastatin 10-20 mg • Fluvastatin 20 mg	Patients who use hospice services or elect to use a hospice benefit any time during the measurement year Patients receiving palliative care or who had an encounter for palliative care (Z51.5) during the measurement year Patients who die any time during the measurement year Patients 66-80 years of age as of December 31 of the measurement year with fraility and advanced illness • **Frailty:** At least two indications of frailty with different dates of service. • **Advanced Illness:** Either of the following: - Advanced Illness on at least two different dates of service - Dispensed Dementia medication Any of the following during the measurement year: Myalgia, myositis, myopathy or rhabdomyolysis Any time during the patient's history: Myalgia or rhabdomyolysis caused by a statin Patients with at least one of the following during the year prior to the measurement year: • Myocardial Infarction • CABG • PCI • Other revascularization Patients who had at least one encounter with a diagnosis of IVD during both the measurement year and the year prior to the measurement year Any of the following during the measurement year or year prior to the measurement year: • Patients with a diagnosis of pregnancy • Patients with ESRD or dialysis • Patients with cirrhosis • Patients in in vitro fertilization • Patients who were dispensed at least one prescription for clomiphene

Strategies for Improvement:

- Educate patients on the importance of medication and potential side effects. Discuss how the benefits of the medication outweigh the potential risk of side effects.
- Encourage patients to refill their prescription every month.
- If a patient cannot tolerate a statin due to myalgia, myositis or myopathy, a claim with this diagnosis must be submitted during each year the patient experiences this condition and remains eligible for this measure.

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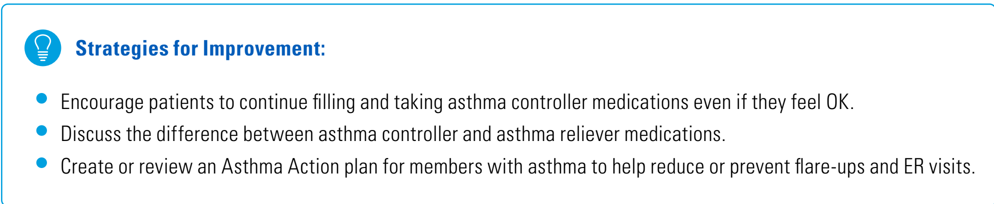
Measure	Goal of the Measure	What to Report (Sample of Codes and/or Diagnoses)	Exclusions
Asthma Medication Ratio (AMR) 5-64 years of age	(Units of Controller Medication) / (Units of Controller Medication + Units of Reliever Medication) The percentage of patients who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year The following events identify patients with persistent asthma during both the measurement year and the year prior to the measurement year: • One ER visit or acute inpatient encounter with a principal diagnosis of asthma • One acute inpatient discharge with a principal diagnosis of asthma on the discharge claim • At least four outpatient visits, telephone visits or e-visit or virtual checkins, on different dates of service, with any diagnosis of asthma and at least two asthma medication-dispensing events – controller or reliever • At least four medication-dispensing events for any controller or reliever medication Patients with persistent asthma because of at least four asthma medication-dispensing events, where leukotriene modifiers or antibody inhibitors were the sole asthma medication dispensed in that year, must also have at least one diagnosis of asthma, in any setting, in the measurement year or the year prior. Criteria need not be the same across both years.	**This measure is based on a ratio.** Compliance will be determined based on how many patients have an asthma controller ratio of 50% or more during the measurement period. This is determined by oral medication and inhaler prescription fills and injections. **Asthma Controller Medications:** • Antibody inhibitor • Anti-interleukin-4 • Anti-interleukin-5 • Inhaled steroid combinations • Inhaled corticosteroids • Leukotriene modifiers • Long-acting beta2-adrenergic agonist (LABA) • Methylxanthines **Asthma Reliever Medications:** • Beta-2 adrenergic agonist — corticosteroid combination • Short-acting, inhaled beta-2 agonists **Visits containing the following asthma diagnoses will qualify a patient for this measure:** • **Mild, moderate or severe persistent asthma** – with (acute) exacerbation or with status asthmaticus • **Unspecified asthma** – with (acute) exacerbation or status asthmaticus • **Cough variant asthma** • **Other asthma**	Patients who use hospice services or elect to use a hospice benefit any time during the measurement year Patients who die any time during the measurement year Patients who had no asthma controller or reliever medications dispensed during the measurement year Patients who had a diagnosis that requires a different treatment approach than members with asthma any time during the member's history



Strategies for Improvement:

- Encourage patients to continue filling and taking asthma controller medications even if they feel OK.
- Discuss the difference between asthma controller and asthma reliever medications.
- Create or review an Asthma Action plan for members with asthma to help reduce or prevent flare-ups and ER visits.

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Measure	Goal of the Measure	What to Report (Sample of Codes and/or Diagnoses)	Exclusions
Antibiotic Utilization for Respiratory Conditions (AXR) 3 months of age and older	The percentage of episodes of members 3 months of age and older with a diagnosis of respiratory conditions that resulted in antibiotic dispensing events. This measure is designed to capture the frequency of antibiotic utilization for respiratory conditions. **Intake period:** July 1st of the year prior to the measurement year to June 30th of the measurement year **Episode Date:** The date of service for any outpatient, telephone or ER visit, e-visit or virtual check-in during the intake period with a diagnosis of a respiratory condition Numerator reflects the members who were dispensed a prescription for an antibiotic medication from the antibiotic medication list on or 3 days after the episode date.	**AXR Antibiotic Medications:** • Absorbable sulfonamides • Aminoglycoside • Amoxicillin/clavulanate • Azithromycin and clarithromycin • Cephalosporin (first generation) • Cephalosporin (second, third, fourth generation) • Clindamycin • Lincosamide (other than clindamycin) • Macrolide (other than azithromycin and clarithromycin) • Penicillin (other than amoxicillin/clavulanate) • Tetracyclines • Quinolones • Miscellaneous antibiotics	Patients who use hospice services or elect to use a hospice benefit any time during the measurement year

Strategies for Improvement:

This measure is designed to capture the frequency of antibiotic utilization for respiratory conditions. NCQA does not view higher or lower service counts as indicating better or worse performance.

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Measure	Goal of the Measure	What to Report (Sample of Codes and/or Diagnoses)	Exclusions
Controlling High Blood Pressure (CBP) 18-85 years of age	Patients with hypertension are identified by having at least two outpatient visits, telephone visits, e-visits or virtual check-ins on different dates of service with a diagnosis of hypertension on or between Jan. 1 of the year prior to the measurement year and June 30 of the measurement year. The percentage of patients who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the measurement year Don't include BPs that are taken the same day as a diagnostic or therapeutic procedure that requires a change in medication regimen or diet. For example: • A colonoscopy requires a change in diet (NPO on the day of procedure) and a medication change (a medication taken to prep the colon). • Dialysis, infusions and chemotherapy (including oral chemotherapy) are all therapeutic procedures that require a medication regimen (the albuterol). • A patient forgetting to take regular medications on the day of the procedure isn't considered a required change in medication, so the BP reading is eligible. BP readings taken on the same day that the patient receives a common low-intensity or preventive procedure can be used. For example: • Injections (i.e., allergy, vitamin B-12, insulin, steroid, Toradol, Depo-Provera, testosterone, lidocaine) • TB test • IUD insertion • Eye exam with dilating agents • Wart or mole removal	The BP reading must occur on or **after** the date of the second diagnosis of hypertension. The patient is compliant if the BP is <140/90 mm Hg. The patient isn't compliant if the BP is ≥140/90 mm Hg, there's no BP reading during the measurement year, or the reading is incomplete (e.g., the systolic or diastolic level is missing). If there are multiple BPs on the same date of service, use the lowest systolic and lowest diastolic BP on that date as the representative BP. **Systolic CPT® Category II:** • 3074F – <130 • 3075F – 130-139 • 3077F – ≥140 **Diastolic CPT® Category II:** • 3078F – <80 • 3079F – 80-89 • 3080F – ≥90 **LOINC:** 75995-1, 8453-3, 8462-4, 8496-2, 8514-2, 8515-9, 75997-7, 8459-0, 8480-6, 8508-4, 8546-4, 8547-2, 89268-7	Patients who use hospice services or elect to use a hospice benefit any time during the measurement year Patients who die any time during the measurement year Patients receiving palliative care or who've had an encounter for palliative care during the measurement year Patients with a diagnosis of end-stage renal disease or dialysis any time during the patient's history on or prior to the last day of the measurement year Patients with a procedure that indicates ESRD: dialysis, nephrectomy or kidney transplant any time during the member's history on or prior to Dec. 31 of the measurement year Patients with a diagnosis of pregnancy any time during the measurement year Patients 66-80 years of age as of December 31 of the measurement year with frailty and advanced illness

Strategies for Improvement:

- Educate patients on the importance of continuing hypertensive medication even when they're feeling good.
- Encourage patients to call the office with any side effects from hypertensive medication before stopping the medication.
- Don't include BPs taken in an acute inpatient setting or during an ER visit.
- When identifying the most recent BP reading, all eligible BP readings in the appropriate medical record should be considered, regardless of practitioner type and setting, excluding acute inpatient and ER visit settings.
- An EMR can be used to identify the most recent BP reading if it meets the criteria for appropriate medical record.
- BP readings taken by the patient and documented in their medical record are eligible for use in reporting (provided the BP doesn't meet any exclusion criteria). There's no requirement that there be evidence the BP was collected by a PCP or specialist.

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Measure	Goal of the Measure	What to Report (Sample of Codes and/or Diagnoses)	Exclusions
Blood Pressure Control for Patients with Hypertension (BPC-E) 18-85 years of age	Members with hypertension are identified by: • Having at least two outpatient visits, telephone visits, e-visits or virtual check-ins on different dates of service with a diagnosis of hypertension on or between Jan. 1 of the year prior to the measurement year and June 30 of the measurement year. **OR** • Having at least one outpatient visit, telephone visit, e-visit or virtual check-in with a diagnosis of hypertension and at least one dispensed antihypertensive medication on or between Jan. 1 of the year prior to the measurement period and June 30 of the measurement period The percentage of patients who had a diagnosis of hypertension (HTN) and whose most recent blood pressure (BP) was <140/90 mm HG during the measurement year.	The BP reading must occur on or after the date of the second diagnosis of hypertension The patient is compliant if the BP is <140/90 mm Hg. The patient 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). If there are multiple BPs on the same date of service, use the lowest systolic and lowest diastolic BP on that date as the representative BP. **Systolic CPT® Category II:** • 3074F – <130 • 3075F – 130-139 • 3077F – ≥140 **Diastolic CPT® Category II:** • 3078F – <80 • 3079F – 80-89 • 3080F – ≥90 **LOINC:** 75995-1, 8453-3, 8462-4, 8496-2, 8514-2, 8515-9, 75997-7, 8459-0, 8480-6, 8508-4, 8546-4, 8547-2, 89268-7	Patients who use hospice services or elect to use a hospice benefit any time during the measurement year Patients who die any time during the measurement year Patients receiving palliative care or who have had an encounter for palliative care during the measurement year Patients with a diagnosis of end-stage renal disease or dialysis any time during the member's history on or prior to the last day of the measurement year Patient with the diagnosis of pregnancy any time during the measurement year Patients 66-80 years of age as of December 31 of the measurement year with fraility and advanced illness Patients with nonacute inpatient admission during the measurement period.

Strategies for Improvement:

- Do not include BPs taken in an acute inpatient setting or ER visit.
- Encourage patients to call the office with any side effects from hypertensive medication before stopping the medication.
- Educate patients on the importance of continuing hypertensive medication even when they're feeling good.
- When identifying the most recent BP reading, all eligible BP readings in the appropriate medical record should be considered, regardless of practitioner type and setting, excluding acute inpatient and ER visit settings.
- An EMR can be used to identify the most recent BP reading if it meets the criteria for appropriate medical record

HEDIS codes can change from year to year. The codes in this document are from the HEDIS MY2025 specifications.

Measure	Goal of the Measure	What to Report (Sample of Codes and/or Diagnoses)	Exclusions
Statin Therapy for Patients with Cardiovascular Disease (SPC) Males 21-75 years of age Females 40-75 years of age	Both event and diagnosis claims/codes are used to identify the population. Any of the following events in the year prior to the measurement year: • MI • CABG • PCI • Other revascularization Any of the following diagnoses during the measurement year or year prior to the measurement year: Outpatient visit, telephone visit, e-visit, virtual check in or acute inpatient encounter with an IVD diagnosis The percentage of patients during the measurement year who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and met the following criteria **Two rates are reported:** **1. Received Statin Therapy:** Patients who were dispensed at least one high-intensity or moderate-intensity statin medication during the measurement year **2. Statin Adherence 80%:** Patients who remained on a high-intensity or moderate-intensity statin medication for at least 80% of the treatment period **Calculated by:** $\frac{\text{Total Days Covered by a Statin Medication in the Treatment Period}}{\text{Total Days in Treatment Period}}$	This is a medication receipt and adherence measure. The following statins qualify for compliance: **High-Intensity Statin Therapy:** • Atorvastatin 40-80 mg • Amlodipine-atorvastatin 40-80 mg • Rosuvastatin 20-40 mg • Simvastatin 80 mg • Ezetimibe-simvastatin 80 mg **Moderate-Intensity Statin Therapy:** • Atorvastatin 10-20 mg • Amlodipine-atorvastatin 10-20 mg • Rosuvastatin 5-10 mg • Simvastatin 20-40 mg • Ezetimibe-simvastatin 20-40 mg • Pravastatin 40-80 mg • Lovastatin 40-60 mg • Fluvastatin 40-80 mg • Pitavastatin 1-4 mg	Patients receiving palliative care or who've had an encounter for palliative care (Z51.5) during the measurement year Patients who use hospice services or elect to use a hospice benefit any time during the measurement year Patients who die any time during the measurement year Patients 66-80 years of age as of December 31 of the measurement year with frailty and advanced illness Patients who had at least one encounter with a diagnosis of IVD during both the measurement year and the year prior to the measurement year Any of the following during the measurement year: Myalgia, myositis, myopathy or rhabdomyolysis Any of the following during the patient's history: Myalgia or rhabdomyolysis caused by a statin Any of the following during the measurement year or year prior to the measurement year: • Patients with a diagnosis of pregnancy • In vitro fertilization • Patients dispensed at least one prescription for clomiphene • Patients with ESRD or dialysis • Patients with cirrhosis

Strategies for Improvement:

- Educate patients on the importance of medication and potential side effects. Discuss how the benefits of the medication outweigh the potential risk of side effects.
- Encourage members to refill their prescription every month.
- If a patient cannot tolerate a statin due to myalgia, myositis or myopathy, a claim with this diagnosis must be submitted during each year the member experiences this condition and remains eligible for this measure.

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Measure	Goal of the Measure	What to Report (Sample of Codes and/or Diagnoses)	Exclusions
Breast Cancer Screening (BCS-E) 40-74 years of age	Percentage of members 40-74 years of age who were recommended for routine breast cancer screening and had a mammogram to screen for breast cancer Patients recommended for routine breast cancer screening must meet the following criteria: • Administrative Gender of Female at any time in the member's history • Sex Assigned at Birth of Female at any time in the member's history • Sex Parameter for Clinical Use of Female during the measurement period **All types and methods of mammograms (screening, diagnostic, film, digital or 3D tomosynthesis) qualify for numerator compliance.** **Do NOT count MRIs, Ultrasounds or Biopsies.** These procedures are performed as an adjunct to mammography and don't meet measure compliance. One or more mammograms any time on or between Oct. 1 two years prior to the measurement period and the end of the measurement period	**Mammography** **LOINC:** 24604-1, 24605-8, 24606-6, 24610-8, 26175-0, 26176-8, 26177-6, 26287-3, 26289-9, 26291-5, 26346-7, 26347-5, 26348-3, 26349-1, 26350-9, 26351-7, 36319-2, 36625-2, 36626-0, 36627-8, 36642-7, 36962-9, 37005-6, 37006-4, 37016-3, 37017-1, 37028-8, 37029-6, 37030-4, 37037-9, 37038-7, 37052-8, 37053-6, 37539-4, 37542-8, 37543-6, 37551-9, 37552-7, 37553-5, 37554-3, 37768-9, 37769-7, 37770-5, 37771-3, 37772-1, 37773-9, 37774-7, 37775-4, 38070-9, 38071-7, 38072-5, 38090-7, 38091-5, 38807-4, 38820-7, 38854-6, 38855-3, 42415-0, 42416-8, 46335-6, 46336-4, 46337-2, 46338-0, 46339-8, 46350-5, 46351-3, 46356-2, 46380-2, 48475-8, 48492-3, 69150-1, 69251-7, 69259-0, 72137-3, 72138-1, 72139-9, 72140-7, 72141-5, 72142-3, 86462-9, 86463-7, 91517-3, 91518-1, 91519-9, 91520-7, 91521-5, 91522-3 **Bilateral mastectomy (Bilateral Mastectomy Value Set)** **Unilateral mastectomy (Unilateral Mastectomy Value Set) with a bilateral modifier (CPT® Modifier code 50) (same procedure)** **Unilateral mastectomy found in clinical data (Clinical Unilateral Mastectomy Value Set) with a bilateral qualifier value (SNOMED CT Modifier code 51440002) (same procedure)**	Members who die any time during the measurement year Patients receiving palliative care or who had an encounter for palliative care during the measurement year Patients who use hospice services or elect to use a hospice benefit any time during the measurement year Patients who had a bilateral mastectomy or both right and left unilateral mastectomies any time during the measurement period Patients 66-80 years of age as of December 31 of the measurement year with fraility and advanced illness Patients who had gender-affirming chest surgery (CPT® code 19318) with a diagnosis of gender dysphoria any time during the member's history through the end of the measurement period Patients who die during the measurement year

Strategies for Improvement:

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

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Measure	Goal of the Measure	What to Report (Sample of Codes and/or Diagnoses)	Exclusions
Cervical Cancer Screening (CCS-E) 21-64 years of age	**The percentage of patients who were recommended for routine cervical cancer who were screened for cervical cancer using any of the following criteria:** • Patients 21-64 years of age who were recommended for routine cervical cancer screening and had cervical cytology performed within the last three years • Patients 30-64 years of age who were recommended for routine cervical cancer screening and had cervical cytology/high-risk human papillomavirus (hrHPV) cotesting within the last five years • Patients 30–64 years of age who were recommended for routine cervical cancer screening and had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years (This one doesn't include cervical cytology)	**Cervical Cytology** **CPT®:** 88141, 88142, 88143, 88147, 88148, 88150, 88152, 88153, 88164, 88165, 88166, 88167, 88174, 88175 **LOINC:** 10524-7, 18500-9, 19762-4, 19765-7, 19766-5, 19774-9, 33717-0, 47527-7, 47528-5, 104866-9 **HCPCS:** G0123, G0124, G0141, G0143, G0144, G0145, G0147, G0148, P3000, P3001 **Rev Code:** 0923 **High-Risk HPV Lab Test** **CPT®:** 87624, 87625, 87626, 0502U **HCPCS:** G0476 **LOINC Codes:** 21440-3, 30167-1, 38372-9, 59263-4, 59264-2, 59420-0, 69002-4, 71431-1, 75694-0, 77379-6, 77399-4, 77400-0, 82354-2, 82456-5, 82675-0, 95539-3, 104132-6, 104170-6, 104752-1, 104766-1, 104783-6 **Note:** Evidence of hrHPV testing within the last five years also captures patients who had co-testing, so additional methods to identify co-testing aren't necessary.	Hysterectomy with no residual cervix any time during the patient's history through Dec. 31 of the measurement year Cervical agenesis or acquired absence of cervix any time during the patient's history through the measurement period Patients who use hospice services or elect to use a hospice benefit any time during the measurement year Patients receiving palliative care or who've had an encounter for palliative care during the measurement year Patients who die any time during the measurement year Patients with Sex Assigned at Birth (LOINC code 76689-9) of Male (LOINC code LA2-8) any time during their history

Strategies for Improvement:

- Note in the chart if a patient has a history of hysterectomy with complete details: complete, total, radical or vaginal hysterectomy with no residual cervix.
- Document history of cervical agenesis or acquired absence of cervix.
- Identify an office champion who will lead outreach efforts for members in need of screening.

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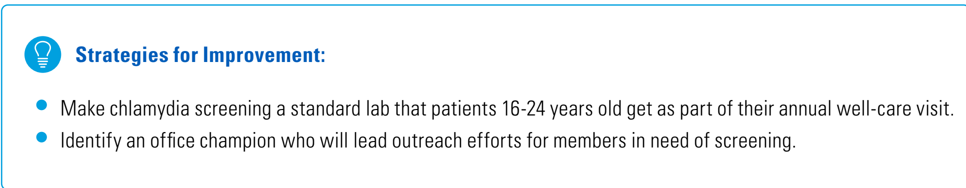
Measure	Goal of the Measure	What to Report (Sample of Codes and/or Diagnoses)	Exclusions
Chlamydia Screening in Women (CHL) 16-24 years of age	The percentage of patients who were recommended for routine chlamydia screening, were identified as sexually active and had at least one test for chlamydia during the measurement year	Identify patients who were recommended for routine chlamydia screening and are sexually active by pharmacy data and claim/encounter data. Sexually active is determined by: Pregnancy value set, sexual activity value set, or pregnancy test value set **OR** Patients dispensed prescription contraceptives from the medication list **Chlamydia Tests** **CPT®:** 87110, 87270, 87320, 87490, 87491, 87492, 87810 **LOINC:** 14463-4, 14464-2, 14465-9, 14467-5, 14474-1, 14513-6, 16600-9, 21190-4, 21191-2, 21613-5, 23838-6, 31775-0, 34710-4, 42931-6, 43304-5, 43404-3, 44806-8, 44807-6, 45068-4, 45069-2, 45072-6, 45073-4, 45075-9, 45084-1, 45089-0, 45090-8, 45091-6, 45093-2, 45095-7, 4993-2, 50387-0, 53926-2, 53925-4, 57287-5, 6356-0, 6357-8, 80360-1, 80361-9, 80362-7, 80363-5, 80364-3, 80365-0, 80367-6, 82306-2, 87949-4, 87950-2, 88221-7, 89648-0, 91860-7, 91873-0	Patients who use hospice services or elect to use a hospice benefit any time during the measurement year Patients who die any time during the measurement year Sex Assigned at Birth: (LOINC code 76689-9) Male (LOINC code LA2-8) any time in the patient's history



Strategies for Improvement:

- Make chlamydia screening a standard lab that patients 16-24 years old get as part of their annual well-care visit.
- Identify an office champion who will lead outreach efforts for members in need of screening.

HEDIS codes can change from year to year. The codes in this document are from the HEDIS MY2025 specifications.

Measure	Goal of the Measure	What to Report (Sample of Codes and/or Diagnoses)	Exclusions
Colorectal Cancer Screening (COL-E) 45-75 years of age	The percentage of patients who had an appropriate screening for colorectal cancer. Includes one of the below: • Fecal occult blood test during the measurement year, assume the required number of samples were returned, regardless of FOBT type • Stool DNA with FIT test during the measurement year or the two years prior • Flexible sigmoidoscopy during the measurement year or the four years prior • CT colonography during the measurement year or four years prior • Colonoscopy during the measurement year or the nine years prior	• Colonoscopy during the measurement year or the nine years prior: 44388-44392, 44394, 44401-44408, 45398 (every 10 years) • Flexible sigmoidoscopy during the measurement year or the four years prior: 45330-45335, 45337-45338 (every five years), 45340, 45341, 45342, 45346, 45347, 45349, 45350 • CT colonography during the measurement year or the four years prior: 74261-74263 (every five years) • Stool DNA (sDNA) with FIT test during the measurement year or the two years prior: 81528, 0464U (every three years). This is different from the plain FIT testing — this testing uses DNA. • Fecal occult blood testing (FOBT), including fecal immunochemical testing (FIT): 82270, 82274 requires only one stool sample (annually) • If using guaiac testing, three samples are required	Patients who had colorectal cancer any time during the member's history through Dec. 31 of the measurement year. Patients who had a total colectomy any time during the member's history through Dec. 31 of the measurement period. Patients who use hospice services or elect to use a hospice benefit any time during the measurement year Patients who die any time during the measurement year. Patients receiving palliative care or who have had an encounter for palliative care during the measurement year. Patients 66-80 years of age as of December 31 of the measurement year with fraility and advanced illness

Strategies for Improvement:

- Always include a date of service and place of service if known.
- Patient refusal will not make them ineligible for this measure.
- Educate patients about the importance of early detection and recommend a different screening if a member refuses or can't tolerate a colonoscopy.
- A best practice is to have the actual screening test and result. However, the result is not required as long as documentation is part of the medical record and clearly indicates screening was completed and not merely ordered. If this is not clear, the result or finding must also be present.
- Update and document the patient's history annually, including type and date of colon cancer screening tests, history of total colectomy or history of colon cancer.

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Measure	Goal of the Measure	What to Report (Sample of Codes and/or Diagnoses)	Exclusions
Topical Fluoride in Children (TFC) 1-4 years of age	The percentage of members who received at least two fluoride varnish applications during the measurement year	Two or more fluoride varnish applications during the measurement year, on different dates of service **Application of Fluoride Varnish Value Set**	Patients who use hospice services or elect to use a hospice benefit any time during the measurement year Patients who die any time during the measurement year.

Strategies for Improvement:

- According to the American Academy of Pediatric Dentistry, topical fluoride is a safe and effective way to prevent dental cavities in children. It is a fluoride solution that is applied directly to the teeth, where it strengthens the enamel and makes it more resistant to decay.
- Children, particularly young children, may receive topical fluoride application from "non-dental" providers, such as medical primary care providers
- The Dental Quality Alliance Measures User Guide provides additional information on the categorization of "dental" and "oral health" services.

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Measure	Goal of the Measure	What to Report (Sample of Codes and/or Diagnoses)	Exclusions
Prenatal Care (PPC)	The percentage of deliveries of live births on or between Oct. 8 of the year prior to the measurement year and Oct. 7 of the measurement year. The measure assesses the timeliness of prenatal and postpartum care: • **Timeliness of Prenatal Care:** The percentage of deliveries that received a prenatal care visit in the first trimester on or before the enrollment start date or within 42 days of enrollment Achor Date: • **Date of Delivery:** Do not count visits that occur on or after the date of delivery.	Identify prenatal visits that occurred during the required timeframe. Any of the following, where the practitioner type is an OB/GYN or other prenatal care practitioner or PCP, meets criteria for a prenatal visit: • A bundled service where the organization can identify the date when prenatal care was initiated (because bundled service codes are used on the date of delivery, these codes may be used only if the claim form indicates when prenatal care was initiated). • A visit for prenatal care. • A prenatal visit with a pregnancy-related diagnosis code. Prenatal: **Prenatal Stand-Alone Visits** **CPT®:** 99500 **CPT®II:** 0500F, 0501F, 0502F **HCPCS:** H1000, H1001, H1002, H1003, H1004 **Prenatal Bundled Services** **CPT®:** 59400, 59425, 59426, 59510, 59610, 59618 **Prenatal Visits** **CPT®:** 98966, 98967, 98968, 98970, 98971, 98972, 98980, 98981, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99242, 99243, 99244, 99245, 99421, 99422, 99423, 99457, 99458, 99483 **HCPCS:** G0071, G0463, G2010, G2250, G2251, G2252, H1005, T1015	Patients who use hospice services or elect to use a hospice benefit any time during the measurement year Patients who die any time during the measurement year)

Strategies for Improvement:

A prenatal visit with an OB/GYN or other prenatal care practitioner or PCP, documented in the medical record during the required timeframe, meets criteria:

For visits to a PCP, a diagnosis of pregnancy must be present. Documentation in the medical record must include a note indicating the date when the prenatal care visit occurred and evidence of **one** of the following.

- Documentation indicating the member is pregnant or references to the pregnancy, for example:
  - Documentation in a standardized prenatal flow sheet, **or**
  - Documentation of last menstrual period (LMP), EDD or gestational age, **or**
  - A positive pregnancy test result, **or**
  - Documentation of gravidity and parity, **or**
  - Documentation of complete obstetrical history, **or**
  - Documentation of prenatal risk assessment and counseling/education.
  - A basic physical obstetrical examination that includes auscultation for fetal heart tone, **or** pelvic exam with obstetric observations, or measurement of fundus height (a standardized prenatal flow sheet may be used).

Evidence that a prenatal care procedure was performed, such as:

- Screening test in the form of an obstetric panel (must include all the following: hematocrit, differential WBC count, platelet count, hepatitis B surface antigen, rubella antibody, syphilis test, RBC antibody screen, Rh and ABO blood typing), **or**
- TORCH antibody panel alone, **or**
- A rubella antibody test/titer with an Rh incompatibility (ABO/Rh) blood typing, **or**
- Ultrasound of a pregnant uterus.

The intent is that a prenatal visit is with a PCP or OB/GYN or other prenatal care practitioner.

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Measure	Goal of the Measure	What to Report (Sample of Codes and/or Diagnoses)	Exclusions
Postpartum Care (PPC)	The percentage of deliveries of live births on or between Oct. 8 of the year prior to the measurement year and Oct. 7 of the measurement year. The measure assesses the timeliness of prenatal and postpartum care: • **Postpartum Care:** The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery Achor Date: • **Date of Delivery:** Do not include care provided in an acute inpatient setting. Ultrasound and lab results alone are not considered a visit; they must be combined with an office visit with an appropriate practitioner in order to count for this measure.	A postpartum visit on or between 7 and 84 days after delivery Any of the following meet criteria: • A postpartum visit. Do not include codes with a modifier. • An encounter for postpartum care. Do not include laboratory claims (claims with POS code 81). • Cervical cytology • A bundled service where the organization can identify the date when postpartum care was rendered (because bundled service codes are used on the date of delivery, not on the date of the postpartum visit, these codes may be used only if the claim form indicates when postpartum care was rendered). **Postpartum Visits** **CPT®:** 57170, 58300, 59430, 99501 **CPT®II:** 0503F **HCPCS:** G0101 **ICD-10:** Z01.411, Z01.419, Z01.42, Z30.430, Z39.1, Z39.2 **Postpartum Bundled Services** **CPT®:** 59400, 59410, 59510, 59515, 59610, 59614, 59618, 59622 **Cervical Cytology** **CPT®:** 88141, 88142, 88143, 88147, 88148, 88150, 88152, 88153, 88164, 88165, 88166, 88167, 88174, 88175 **HCPCS:** G0123, G0124, G0141, G0143, G0144, G0145, G0147, G0148, P3000, P3001 **LOINC:** 10524-7, 18500-9, 19762-4, 19765-7, 19766-5, 19774-9, 33717-0, 47527-7, 47528-5, 104866-9	Patients who use hospice services or elect to use a hospice benefit any time during the measurement year Patients who die any time during the measurement year

Strategies for Improvement:

A postnatal visit with an OB/GYN or other prenatal care practitioner, or PCP, documented in the medical record during the required timeframe meets criteria:

Documentation in the medical record must include a note indicating the date when a postpartum visit occurred and one of the following:

- Pelvic exam.
- Evaluation of weight, BP, breasts and abdomen.
- Notation of “breastfeeding” is acceptable for the “evaluation of breasts” component
- Notation of postpartum care, including but not limited to:
- Notation of “postpartum care,” “PPcare,” “PP check,” “6-week check.”
- A preprinted “Postpartum Care” form in which information was documented during the visit
- Perineal or cesarian incision/wound check
- Screening for depression, anxiety, tobacco use, substance use disorder, or preexisting mental health disorders
- Glucose screening for members with gestational diabetes

Documentation of any of the following topics:

- Infant care or breastfeeding
- Resumption of intercourse, birth spacing or family planning
- Sleep/fatigue
- Resumption of physical weight
- Attainment of healthy weight

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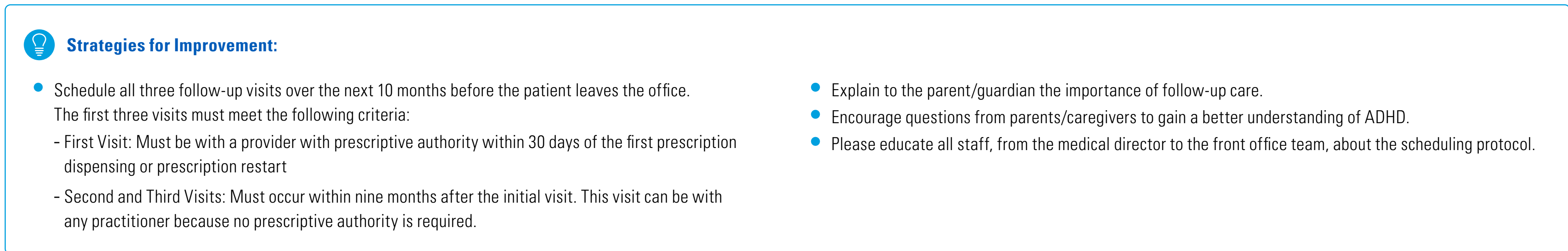
Measure	Goal of the Measure	What to Report (Sample of Codes and/or Diagnoses)	Exclusions
Follow-Up Care for Children Prescribed ADHD Medication (ADD-E) 6-12 years of age	The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 300-day (10-month) period, one of which was within 30 days of when the first ADHD medication was dispensed* 1. **Initiation Phase –** The percentage of patients 6-12 years of age with a prescription dispensed for ADHD medication, who had one follow-up visit with a practitioner with prescribing authority during the 30-day Initiation Phase 2. **Continuation and Maintenance Phase –** The percentage of patients with a prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (nine months) after the Initiation Phase ended Any of the following code combinations billed by a practitioner with prescribing authority meet criteria: • An outpatient visit. • A behavioral health outpatient visit. • A health and behavior assessment or intervention. • An intensive outpatient encounter or partial hospitalization. • A community mental health center visit. • A telehealth visit. • A telephone visit. Only one of the two visits (during the 31–300 days after the IPSD) may be an e-visit or virtual check-in. **Note:** Don't count a visit on the IPSD (earliest prescription dispensing date) as the Initiation Phase visit.	Initiation requires the visit to be with a provider with prescribing authority and includes telehealth. **CPT®:** 96156, 96158, 96159, 96164, 96165, 96167, 96168, 96170, 96171, 98960, 98961, 98962, 99078, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99242, 99243, 99244, 99245, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99483, 99492, 99493, 99494, 99510 **CPT® with Outpatient or Partial Hospitalization Place of Service (POS) Code:** 90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99252, 99253, 99254, 99255 **HCPCS:** G0155, G0176, G0177, G0409, G0410, G0411, G0463, G0512, H0002, H0004, H0031, H0034, H0035, H0036, H0037, H0039, H0040, H2000, H2001, H2010, H2011, H2012, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, S0201, S9480, S9484, S9485, T1015 **Rev Code:** 510, 513, 515, 516, 517, 519, 520, 521, 522, 523, 526, 527, 528, 529, 900, 902, 903, 904, 905, 907, 911, 912, 913, 914, 915, 916, 917, 919, 982, 983 **All codes listed above** **Telephone CPT® Visits:** 98966, 98967, 98968 **Telehealth Modifier:** 95, GT **Telehealth POS:** 02 or 10	Patients with a diagnosis of narcolepsy any time during their history through the end of the measurement period Patients who use hospice services or elect to use a hospice benefit any time during the measurement year Patients who die any time during the measurement year



Strategies for Improvement:

- Schedule all three follow-up visits over the next 10 months before the patient leaves the office. The first three visits must meet the following criteria:
  - First Visit: Must be with a provider with prescriptive authority within 30 days of the first prescription dispensing or prescription restart
  - Second and Third Visits: Must occur within nine months after the initial visit. This visit can be with any practitioner because no prescriptive authority is required.
- Explain to the parent/guardian the importance of follow-up care.
- Encourage questions from parents/caregivers to gain a better understanding of ADHD.
- Please educate all staff, from the medical director to the front office team, about the scheduling protocol.

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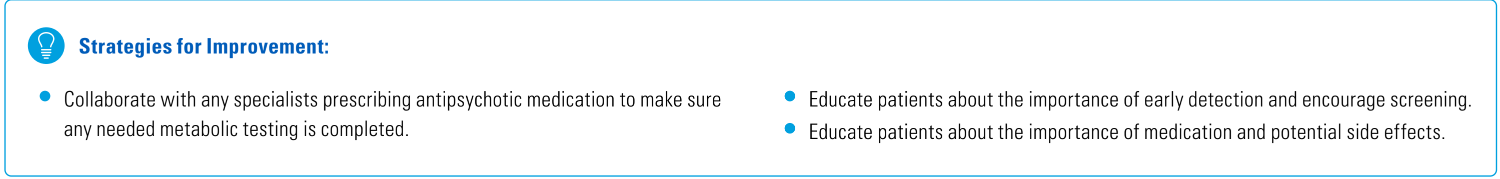
Measure	Goal of the Measure	What to Report (Sample of Codes and/or Diagnoses)	Exclusions
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E) 1-17 years of age	The percentage of children and adolescents 1-17 years of age who had two or more antipsychotic prescriptions and had metabolic testing **The following rates are reported:** **1.** The percentage of children and adolescents on antipsychotics who received blood glucose testing **2.** The percentage of children and adolescents on antipsychotics who received cholesterol testing **3.** The percentage of children and adolescents on antipsychotics who received blood glucose and cholesterol testing **Antipsychotic Drug Class:** • Miscellaneous antipsychotic agents • Phenothiazine antipsychotics • Thioxanthenes • Long-acting injections • Psychotherapeutic combinations	**Glucose Tests** **CPT®:** 80047, 80048, 80050, 80053, 80069, 82947, 82950, 82951 **LOINC:** 10450-5, 1492-8, 1494-4, 1496-9, 1499-3, 1501-6, 1504-0, 1507-3, 1514-9, 1518-0, 1530-5, 1533-9, 1554-5, 1557-8, 1558-6, 2345-7, 17865-7, 20436-2, 20437-0, 20438-8, 20440-4, 26554-6, 41024-1, 49134-0, 6749-6, 9375-7 **HbA1c Tests** **CPT®:** 83036, 83037 **CPT®II:** 3044F, 3046F, 3051F, 3052F **LOINC:** 17856-6, 17855-8, 96595-4, 4548-4, 4549-2 **LDL-C Tests** **CPT®:** 80061, 83700, 83701, 83704, 83721 **CPT®II:** 3048F, 3049F, 3050F **LOINC:** 12773-8, 13457-7, 18261-8, 18262-6, 2089-1, 49132-4, 55440-2, 96259-7 **Cholesterol Tests** **CPT®:** 82465, 83718, 83722, 84478 **LOINC:** 2085-9, 2093-3, 2571-8, 3043-7, 9830-1	Patients who use hospice services or elect to use a hospice benefit any time during the measurement year Patients who die any time during the measurement year



Strategies for Improvement:

- Collaborate with any specialists prescribing antipsychotic medication to make sure any needed metabolic testing is completed.
- Educate patients about the importance of early detection and encourage screening.
- Educate patients about the importance of medication and potential side effects.

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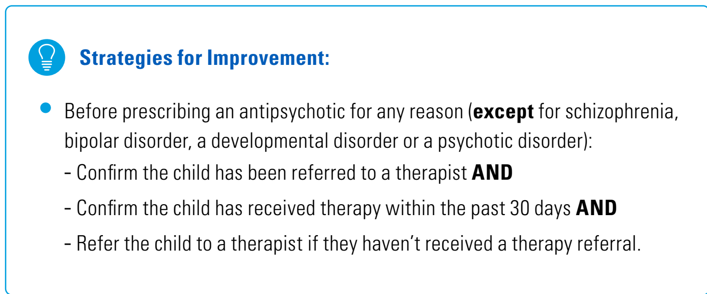
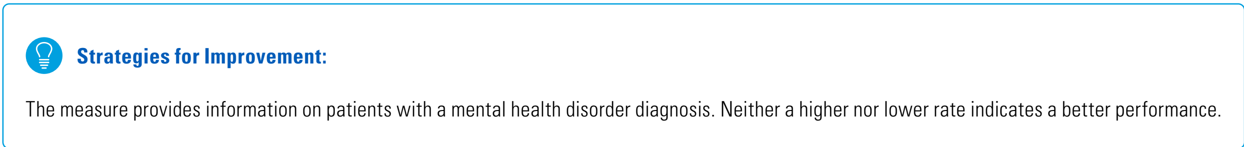
Measure	Goal of the Measure	What to Report (Sample of Codes and/or Diagnoses)	Exclusions
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP) 1-17 years of age	The percentage of children and adolescents who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment	Psychosocial care or residential behavioral health treatment in the 121-day period from 90 days prior to the IPSD through 30 days after the IPSD **Psychosocial Care CPT®:** 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90846, 90847, 90849, 90853, 90875, 90876, 90880 **Psychosocial Care HCPCS:** G0176, G0177, G0409, G0410, G0411, H0004, H0035, H0036, H0037, H0038, H0039, H0040, H2000, H2001, H2011, H2012, H2013, H2014, H2017, H2018, H2019, H2020, S0201, S9480, S9484, S9485 **Residential Behavioral Health Treatment HCPCS:** H0017, H0018, H0019, T2048	Patients who use hospice services or elect to use a hospice benefit any time during the measurement year Patients who die any time during the measurement year Patients for whom first-line antipsychotic medications may be clinically appropriate: patients with a diagnosis of schizophrenia, schizoaffective disorder, bipolar disorder, other psychotic disorder, autism or other developmental disorder on at least two different dates of service during the measurement year



Strategies for Improvement:

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

Measure	Goal of the Measure	What to Report (Sample of Codes and/or Diagnoses)	Exclusions
Diagnosed Mental Health Disorders (DMH) Age 1 year and older	The percentage of patients aged 1 year and older who were diagnosed with a mental health disorder during the measurement year.	Refer to the Mental Health Disorder codes for more information.	Patients who use hospice services or elect to use a hospice benefit any time during the measurement year Patients who die any time during the measurement year.



Strategies for Improvement:

The measure provides information on patients with a mental health disorder diagnosis. Neither a higher nor lower rate indicates a better performance.

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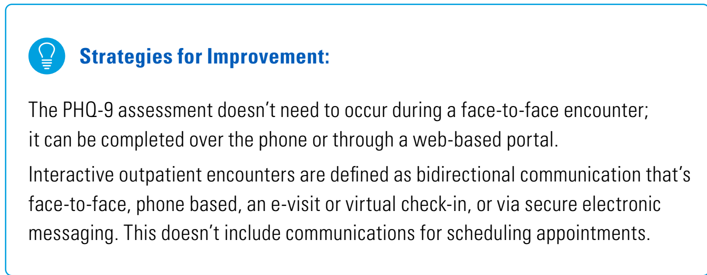
Measure	Goal of the Measure	What to Report (Sample of Codes and/or Diagnoses)	Exclusions
Depression Remission or Response for Adolescents and Adults (DRR-E) Age 12 years and older	The percentage of patients aged 12 years and older with a diagnosis of depression and an elevated PHQ-9 score, who had evidence of response or remission within 120–240 days (4–8 months) of the elevated score • **Follow-up PHQ-9.** The percentage of patients who have a follow-up PHQ-9 score documented within 120–240 days (4–8 months) after the initial elevated PHQ-9 score. • **Depression Remission.** The percentage of patients who achieved remission within 120–240 days (4–8 months) after the initial elevated PHQ-9 score. • **Depression Response.** The percentage of patients who showed response within 120–240 days (4–8 months) after the initial elevated PHQ-9 score.	**Intake Period:** May 1 of the prior measurement year through April 30 of the current measurement year. **Index Episode Start Date (IESD):** The earliest date during the intake period when a patient has a PHQ-9 total score >9 documented within a 31-day period, including and around (15 days before and 15 days after) an interactive outpatient encounter with a diagnosis of major depression or dysthymia. **Depression Follow-Up (Follow-Up PHQ-9) Period:** A PHQ-9 score in the patient's record during the 120-240 day period after the Index Episode Start Date (IESD). **Depression Remission:** Patients who achieve remission of depression symptoms, as demonstrated by the most recent PHQ-9 total score of <5 during the depression follow-up period. **Depression Response:** Patients who indicate a response to treatment for depression, as demonstrated by the most recent PHQ-9 total score at least 50% lower than the PHQ-9 score associated with the IESD, documented during the depression follow-up period. **Sample codes for PHQ-9 test:** **LOINC code-12 years and older:** 44261-6 **LOINC code-12 - 17years:** 89204-2 or 44261-6	Patients with any of the following in their history: • Bipolar disorder • Personality disorder • Psychotic disorder • Pervasive development disorder Patients who use hospice services or elect to use a hospice benefit any time during the measurement year Patients who die any time during the measurement year.


Strategies for Improvement:

The PHQ-9 assessment doesn't need to occur during a face-to-face encounter; it can be completed over the phone or through a web-based portal.

Interactive outpatient encounters are defined as bidirectional communication that's face-to-face, phone based, an e-visit or virtual check-in, or via secure electronic messaging. This doesn't include communications for scheduling appointments.

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Measure	Goal of the Measure	What to Report (Sample of Codes and/or Diagnoses)	Exclusions
Depression Screening and Follow-up for Adolescents and Adults (DSF-E) 12 years and older	The percentage of patients who were screened for clinical depression using a standardized instrument and, if screened positive, received follow-up care. **Depression Screening:** The percentage of patients who were screened for clinical depression using a standardized instrument. **Follow-Up on Positive Screen:** The percentage of patients who received follow-up care within 30 days of a positive depression screen finding.	**Depression Screening:** Patients with a documented result for depression screening using an age-appropriate standardized instrument **Follow-Up on Positive Screening:** Patients who received follow-up care on or up to 30 days after the date of the first positive screen (31 total days). Any of the following on or up to 30 days after the first positive screen: • An outpatient, telephone, e-visit or virtual check-in follow-up visit with a diagnosis of depression or other behavioral health condition • A depression case management encounter that documents assessment for symptoms of depression or a diagnosis of depression or other behavioral health condition • A behavioral health encounter, including assessment, therapy, collaborative care or medication management • A diagnosis of encounter for exercise counseling • A dispensed antidepressant medication **OR** • Documentation of additional depression screening on a full-length instrument indicating either no depression or no symptoms that require follow up (i.e., a negative screen) on the same day as a positive screen on a brief screening instrument.	Patients with any of the following in their history: • Bipolar disorder • Depression that starts during the year prior to the measurement year Patients who use hospice services or elect to use a hospice benefit any time during the measurement year Patients who die any time during the measurement year

Strategies for Improvement:

Depression screening instruments include:

- **Adolescents:** Patient Health Questionnaire (PHQ-9)®; Patient Health Questionnaire Modified for Teens (PHQ-9M)®; Patient Health Questionnaire-2 (PHQ-2)®1; Beck Depression Inventory-Fast Screen (BDI-FS)®1,2; Center for Epidemiologic Studies; Depression Scale—Revised (CESD-R); Edinburgh Postnatal Depression Scale (EPDS); PROMIS Depression
- **Adults (18+):** Patient Health Questionnaire (PHQ-9)®; Patient Health Questionnaire-2 (PHQ-2)®1; Beck Depression Inventory-Fast Screen (BDI-FS)®1,2; Beck Depression Inventory (BDI-II); Center for Epidemiologic Studies; Depression Scale—Revised (CESD-R); Duke Anxiety—Depression Scale (DUKE-AD)®2; Geriatric Depression Scale Short Form (GDS)1; Geriatric Depression Scale Long Form (GDS); Edinburgh Postnatal Depression Scale (EPDS); My Mood Monitor (M3)® ; PROMIS Depression; Clinically Useful Depression Outcome Scale (CUDOS)

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Measure	Goal of the Measure	What to Report (Sample of Codes and/or Diagnoses)	Exclusions
Follow-Up After Hospitalization for Mental Illness (FUH) 6 years of age and older	The percentage of discharges for patients 6 years of age and older who were hospitalized for a principal diagnosis of mental illness, or any diagnosis of intentional self-harm, and had a mental health follow-up service. Two rates are reported: • The percentage of discharges for which the patient received follow-up within 7 days after discharge • The percentage of discharges for which the patient received follow-up within 30 days after discharge	An outpatient visit **with** a mental health provider An outpatient visit **with** any diagnosis of mental health disorder An intensive outpatient encounter or partial hospitalization with POS code 52 A community mental health center visit **with** POS code 53. Electroconvulsive therapy with Outpatient POS or POS codes 24, 52, 53 A telehealth visit: **with** a mental health provider A telehealth visit: **with** any diagnosis of mental health disorder Transitional care management services **with** a mental health provider. Transitional care management services **with** any diagnosis of mental health disorder A visit in a behavioral health care setting A telephone visit **with** a mental health provider A telephone visit **with** any diagnosis of mental health disorder Psychiatric collaborative care management Peer support services **with** any diagnosis of mental health disorder Psychiatric residential treatment Psychiatric residential treatment **with** POS code 56	Patients who use hospice services or elect to use a hospice benefit any time during the measurement year Patients who die any time during the measurement year

Strategies for Improvement:

- Incorporate the ADT feeds into the practice workflow to capture patients discharges from inpatient facilities.
- Follow up is crucial for sustained recover and preventing rehospitalization, focusing on medication management, therapy, and support systems.
- Follow-up appointments provide opportunities to address medication side effects, adjust dosages, and ensure adherence.
- Follow-up care can include crisis intervention options and ensure patients have access to support systems in case of emergencies.

HEDIS codes can change from year to year. The codes in this document are from the HEDIS MY2025 specifications.

Measure	Goal of the Measure	What to Report (Sample of Codes and/or Diagnoses)	Exclusions
Follow-Up After Emergency Department Visit for Mental Illness (FUM) 6 years of age and older	The percentage of emergency room (ER) visits for patients 6 years of age and older with a principal diagnosis of mental illness, or any diagnosis of intentional self-harm, and who had a mental health follow-up service Two rates are reported: • The percentage of ER visits for which the patient received follow up within 7 days of the ER visit (8 total days) • The percentage of ER visits for which the patient received follow up within 30 days of the ER visit (31 total days)	• An outpatient visit **with** any diagnosis of a mental health disorder • An outpatient visit **with** any diagnosis of a mental health disorder • An intensive outpatient encounter or partial hospitalization with POS code 52 • An intensive outpatient encounter or partial hospitalization **with** any diagnosis of a mental health disorder • A community mental health center visit with POS code 53 • Electroconvulsive therapy with Outpatient POS or POS codes 24, 52, 53 • A telehealth visit **with** any diagnosis of a mental health disorder • A telephone visit **with** any diagnosis of a mental health disorder • An e-visit or virtual check-in **with** any diagnosis of a mental health disorder • Psychiatric collaborative care management • Peer support services **with** any diagnosis of mental health disorder • Psychiatric residential treatment with POS code 56 • A visit in a behavioral healthcare setting	Patients who use hospice services or elect to use a hospice benefit any time during the measurement year Patients who die any time during the measurement year

Strategies for Improvement:

- Incorporate the ADT feeds into the practice workflow to capture patient discharges from inpatient facilities.
- Follow up is crucial for sustained recovery and preventing rehospitalization, focusing on medication management, therapy, and support systems.
- Follow-up appointments provide opportunities to address medication side effects, adjust dosages, and ensure adherence.
- Follow-up care can include crisis intervention options and ensure patients have access to support systems in case of emergencies.

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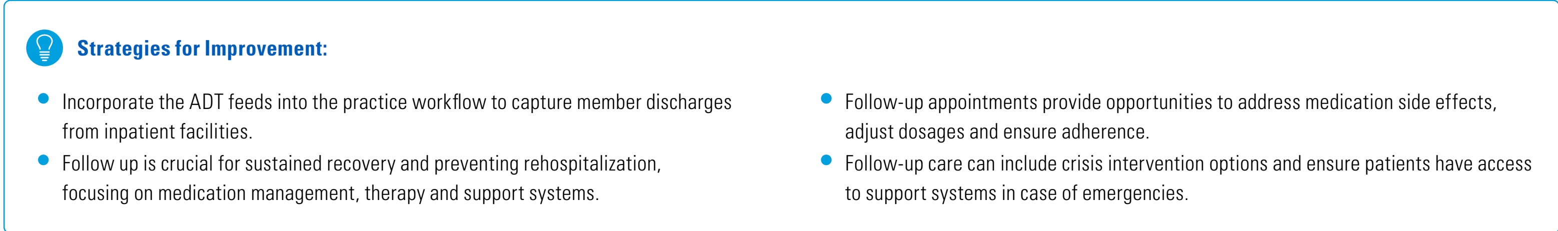
Measure	Goal of the Measure	What to Report (Sample of Codes and/or Diagnoses)	Exclusions
Follow-Up After Emergency Department Visit for Substance Use (FUA) 13 years of age and older on the date of the ED visit	The percentage of ER visits for patients with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was a follow up. Two rates are reported: • The percentage of ER visits for which the patient received follow up within 7 days of the ER visit (8 total days) • The percentage of ER visits for which the patient received follow up within 30 days of the ER visit (31 total days)	• An outpatient visit **with** any diagnosis of SUD, substance use or drug overdose • An outpatient visit **with** a mental health provider • An intensive outpatient encounter or partial hospitalization **with** any diagnosis of SUD, substance use or drug overdose (with POS code 52) • An intensive outpatient encounter or partial hospitalization **with** a mental health provider (with POS code 52) • An intensive outpatient encounter or partial hospitalization **with** any diagnosis of SUD, substance use • A non-residential substance abuse treatment facility visit **with** any diagnosis of SUD, substance use or drug overdose • A non-residential substance abuse treatment facility visit **with** a mental health provider • A community mental health center visit **with** POS code 53 **with** any diagnosis of SUD, substance use or drug overdose • A community mental health center visit **with** a mental health provider. • A peer support service **with** any diagnosis of SUD, substance use or drug overdose. • An opioid treatment service that bills monthly or weekly **with** any diagnosis of SUD, substance use or drug overdose. • A telehealth visit **with** any diagnosis of SUD, substance use or drug overdose • A telehealth visit **with** a mental health provider • A telephone visit **with** any diagnosis of SUD, substance use or drug overdose • A telephone visit **with** a mental health provider • An e-visit or virtual check-in **with** any diagnosis of SUD, substance use or drug overdose • An e-visit or virtual check-in **with** a mental health provider • A SUD service • SUD counseling and surveillance • A BH screening or assessment for SUD or mental health disorders • A pharmacotherapy dispensing event or medication treatment event	Patients who use hospice services or elect to use a hospice benefit any time during the measurement year Patients who die any time during the measurement year



Strategies for Improvement:

- Incorporate the ADT feeds into the practice workflow to capture member discharges from inpatient facilities.
- Follow up is crucial for sustained recovery and preventing rehospitalization, focusing on medication management, therapy and support systems.
- Follow-up appointments provide opportunities to address medication side effects, adjust dosages and ensure adherence.
- Follow-up care can include crisis intervention options and ensure patients have access to support systems in case of emergencies.

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Measure	Goal of the Measure	What to Report (Sample of Codes and/or Diagnoses)	Exclusions
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI) 13 years of age and older	The percentage of acute inpatient hospitalizations, residential treatment or withdrawal management visits for a diagnosis of substance use disorder among patients that result in a follow-up visit or service for substance use disorder Two rates are reported: • The percentage of visits or discharges for which the patient received follow up for substance use disorder within the seven days after the visit or discharge • The percentage of visits or discharges for which the patient received follow up for substance use disorder within the 30 days after the visit or discharge	A follow-up visit or event with any practitioner for a principal diagnosis of substance use disorder within the seven or 30 days after an episode for substance use disorder Don't include visits that occur on the date of the denominator episode. For both indicators, any of the following meet criteria for a follow-up visit: • An acute or non-acute inpatient admission or residential behavioral health stay **with** a principal diagnosis of substance use disorder on the discharge claim. To identify acute and nonacute inpatient admissions: - Identify all acute and nonacute inpatient stays - Identify the admission date for the stay • An outpatient **visit** with a principal diagnosis of substance use disorder • An intensive outpatient encounter or partial hospitalization **with** a principal diagnosis of substance use disorder • A non-residential substance abuse treatment facility visit **with** a principal diagnosis of substance use disorder • A community mental health center visit **with** POS code 53 **with** a principal diagnosis of substance use disorder • A telehealth visit **with** a principal diagnosis of substance use disorder • A substance use disorder service **with** a principal diagnosis of substance use disorder • Substance use disorder counseling and surveillance **with** a principal diagnosis of substance use disorder • An opioid treatment service that bills monthly or weekly **with** a principal diagnosis of substance use disorder • Residential behavioral health treatment **with** a principal diagnosis of substance use disorder • A telephone visit (**Telephone Visits Value Set**) **with** a principal diagnosis of substance use disorder • An e-visit or virtual check-in **with** a principal diagnosis of substance use disorder • A pharmacotherapy dispensing event or medication treatment event.	Patients who use hospice services or elect to use a hospice benefit any time during the measurement year Patients who die any time during the measurement year

Strategies for Improvement:

- Incorporate the ADT feeds into the practice workflow to capture member discharges from inpatient facilities.
- Follow up is crucial for sustained recovery and preventing rehospitalization, focusing on medication management, therapy, and support systems.
- Follow-up appointments provide opportunities to address medication side effects, adjust dosages, and ensure adherence.
- Follow-up care can include crisis intervention options and ensure patients have access to support systems in case of emergencies.

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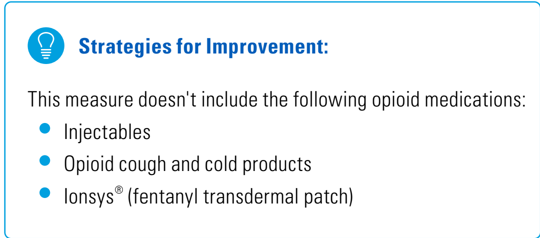
Measure	Goal of the Measure	What to Report (Sample of Codes and/or Diagnoses)	Exclusions
Use of Opioids at High Dosage (HDO) 18 years of age and older	The percentage of patients 18 years of age and older who received prescription opioids at a high dosage (average morphine milligram equivalent dose [MME] ≥90) for ≥15 days during the measurement year Lower rate indicates better performance. Morphine milligram equivalent (MME) — The dose of oral morphine that is the analgesic equivalent of a given dose of another opioid analgesic	**Opioid Medications:** • Benzhydrocodone • Butorphanol • Codeine • Dihydrocodeine • Fentanyl buccal • Fentanyl oral spray • Fentanyl transdermal patch • Hydrocodone • Hydromorphone • Levorphanol • Meperidine • Methadone • Morphine • Opium • Oxycodone • Oxymorphone • Pentazocine • Tapentadol • Tramadol	Any of the following during the measurement year: • Cancer • Sickle Cell Disease Patients who use hospice services or elect to use a hospice benefit any time during the measurement year Patients who die any time during the measurement year Patients receiving palliative care or who have had an encounter for palliative care during the measurement year



Strategies for Improvement:

This measure doesn't include the following opioid medications:
- Injectables
- Opioid cough and cold products
- Ionsys® (fentanyl transdermal patch)

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Measure	Goal of the Measure	What to Report (Sample of Codes and/or Diagnoses)	Exclusions
Initiation and Engagement of Substance Use Disorder Treatment (IET)	The percentage of new substance use disorder (SUD) episodes that result in treatment initiation and engagement **Two rates are reported:** 1. **Initiation of SUD treatment –** Percentage of new SUD episodes that result in treatment through an inpatient SUD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, a telehealth visit or medication treatment within 14 days of the diagnosis 2. **Engagement of SUD Treatment –** Percentage of new SUD episodes that have evidence of treatment engagement within 34 days of the initiation visit Intake Period to capture new SUD episode: • Nov. 15 of the prior year to Nov. 14 of the measurement year • SUD Episode Date: The date of service for an encounter during the intake period with a diagnosis of SUD	**Initiation of SUD Treatment:** Initiation of SUD treatment within 14 days of the the SUD episode date The intake period is Nov. 15 of the year prior to the measurement year–Nov. 14 of the measurement year. The intake period is used to capture new SUD episodes. **Any of the following combinations meet criteria for initiation:** • An acute or nonacute inpatient admission **with** a diagnosis (on the discharge claim) of one of the following: - Alcohol Abuse and Dependence - Opioid Abuse and Dependence - Other Drug Abuse and Dependence • An outpatient visit, intensive outpatient encounter or partial hospitalization, non-residential substance abuse treatment facility visit, community mental health center visit, telehealth visit, substance use disorder service, telephone visit, e-visit or virtual check-in (online assessment, or weekly or monthly opioid treatment service **with** a diagnosis of one of the following: - Alcohol Abuse and Dependence - Opioid Abuse and Dependence - Other Drug Abuse and Dependence **Either of the following meets criteria for an engagement medication treatment event:** • For SUD episodes in the alcohol use disorder cohort, an alcohol use disorder medication treatment dispensing event or a medication administration event. • For SUD episodes in the opioid disorder cohort, an opioid use disorder medication treatment dispensing event or a medication administration event. **Medication Administration:** **SUD episodes that had at least one weekly or monthly opioid treatment service with medication administration:** **HCPCS:** G0533, G2086, G2087, G2067, G2068, G2069, G2073 **SUD episodes with long-acting SUD medication administration events:** **HCPCS:** G2073, J2315, G2069, Q9991, Q9992	Patients who use hospice services or elect to use a hospice benefit any time during the measurement year Patients who die any time during the measurement year

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Measure	Goal of the Measure	What to Report (Sample of Codes and/or Diagnoses)	Exclusions
Initiation and Engagement of Substance Use Disorder Treatment (IET) (cont.)	The percentage of new substance use disorder (SUD) episodes that result in treatment initiation and engagement **Two rates are reported:** **1. Initiation of SUD treatment –** Percentage of new SUD episodes that result in treatment through an inpatient SUD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, a telehealth visit or medication treatment within 14 days of the diagnosis **2. Engagement of SUD Treatment –** Percentage of new SUD episodes that have evidence of treatment engagement within 34 days of the initiation visit Intake Period to capture new SUD episode: • Nov. 15 of the prior year to Nov. 14 of the measurement year • SUD Episode Date: The date of service for an encounter during the intake period with a diagnosis of SUD	**Engagement visits:** Any of the following beginning on the day after the initiation encounter through 34 days after the initiation event (total of 34 days) meet criteria for an engagement visit: • An acute or nonacute inpatient admission with a diagnosis (on the discharge claim) of one of the following: - Alcohol Abuse and Dependence - Opioid Abuse and Dependence - Other Drug Abuse and Dependence • An outpatient visit, intensive outpatient encounter or partial hospitalization, non-residential substance abuse treatment facility visit, community mental health center visit, telehealth visit, substance use disorder service, telephone visit, e-visit or virtual check-in (online assessment), or weekly opioid treatment service ***with*** a diagnosis of one of the following: - Alcohol Abuse and Dependence - Opioid Abuse and Dependence - Other Drug Abuse and Dependence Either of the following meets criteria for an engagement medication treatment event: • For SUD episodes in the alcohol use disorder cohort, an alcohol use disorder medication treatment dispensing event (from the Alcohol Use Disorder Treatment Medications List). • For SUD episodes in the opioid disorder cohort, an opioid use disorder medication treatment dispensing event or a medication administration event (from the Opioid Use Disorder Treatment Medications List).	Patients who use hospice services or elect to use a hospice benefit any time during the measurement year Patients who die any time during the measurement year

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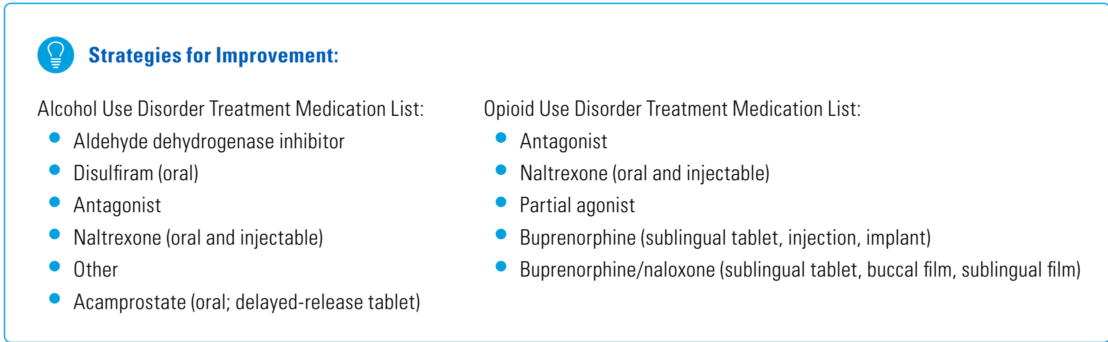
Measure	Goal of the Measure	What to Report (Sample of Codes and/or Diagnoses)	Exclusions
Initiation and Engagement of Substance Use Disorder Treatment (IET) (cont.)	The percentage of new substance use disorder (SUD) episodes that result in treatment initiation and engagement **Two rates are reported:** 1. **Initiation of SUD treatment –** Percentage of new SUD episodes that result in treatment through an inpatient SUD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, a telehealth visit or medication treatment within 14 days of the diagnosis 2. **Engagement of SUD Treatment –** Percentage of new SUD episodes that have evidence of treatment engagement within 34 days of the initiation visit Intake Period to capture new SUD episode: • Nov. 15 of the prior year to Nov. 14 of the measurement year • SUD Episode Date: The date of service for an encounter during the intake period with a diagnosis of SUD	**Naltrexone injection medications, Buprenorphine injection or implant medications OR TWO of the following visits (any combination) paired with a diagnosis of alcohol abuse and dependence, opioid abuse and dependence, or other drug abuse and dependence:** **IP admission must be paired with diagnosis of alcohol abuse and dependence, opioid abuse and dependence, or other drug abuse and dependence:** **Rev Code:** 0100, 0101, 0110, 0111, 0112, 0113, 0114, 0116, 0117, 0118, 0119, 0120, 0121, 0122, 0123, 0124, 0126, 0127, 0128, 0129, 0130, 0131, 0132, 0133, 0134, 0136, 0137, 0138, 0139, 0140, 0141, 0142, 0143, 0144, 0146, 0147, 0148, 0149, 0150, 0151, 0152, 0153, 0154, 0156, 0157, 0158, 0159, 0160, 0164, 0167, 0169, 0170, 0171, 0172, 0173, 0174, 0179, 0190, 0191, 0192, 0193, 0194, 0199, 0200, 0201, 0202, 0203, 0204, 0206, 0207, 0208, 0209, 0210, 0211, 0212, 0213, 0214, 0219, 1000, 1001, 1002 **OP visit must be paired with place of service and diagnosis of alcohol abuse and dependence, opioid abuse and dependence, or other drug abuse and dependence:** **CPT®:** 90791, 90792, 90832, 90833, 90834, 90836, 90837,90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221,99222, 99223, 99231, 99232, 99233, 99238, 99239, 99252, 99253, 99254, 99255 **POS:** 03, 05, 07, 09, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 22, 33, 49, 50, 71, 72, 52, 53, 57, 58, 02, 10	Patients who use hospice services or elect to use a hospice benefit any time during the measurement year Patients who die any time during the measurement year



Strategies for Improvement:

Alcohol Use Disorder Treatment Medication List:

- Aldehyde dehydrogenase inhibitor
- Disulfiram (oral)
- Antagonist
- Naltrexone (oral and injectable)
- Other
- Acamprostate (oral; delayed-release tablet)

Opioid Use Disorder Treatment Medication List:

- Antagonist
- Naltrexone (oral and injectable)
- Partial agonist
- Buprenorphine (sublingual tablet, injection, implant)
- Buprenorphine/naloxone (sublingual tablet, buccal film, sublingual film)

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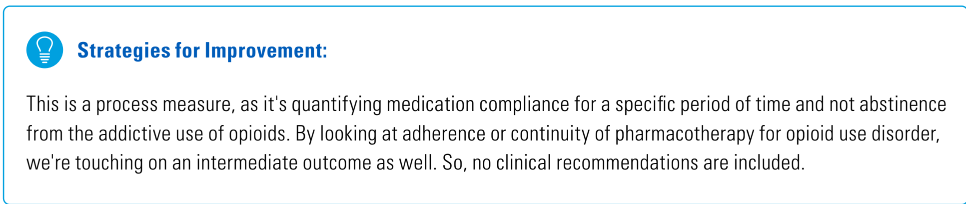
Measure	Goal of the Measure	What to Report (Sample of Codes and/or Diagnoses)	Exclusions
Pharmacotherapy for Opioid Use Disorder (POD) 16 years of age and older	The percentage of opioid use disorder (OUD) pharmacotherapy events that lasted at least 180 days among patients 16 years of age and older with a diagnosis of OUD and a new OUD pharmacotherapy event Intake Period: July 1 of the year prior to the measurement year to June 30 of the measurement year	Patients who meet the following criteria during the measurement year: • New OUD pharmacotherapy events with OUD pharmacotherapy for 180 or more days without a gap in treatment of eight or more consecutive days If the treatment period doesn't contain any gaps in treatment of eight or more consecutive calendar days, the event is numerator compliant. **Opioid Use Disorder Treatment Medications:** • Naltrexone (oral and injectable) • Buprenorphine (sublingual tablet, injection, and implant) • Buprenorphine/naloxone (sublingual tablet, buccal film, sublingual film) **Note**: Methadone isn't included on the medication lists for this measure. Methadone for OUD administered or dispensed by federally certified opioid treatment programs (OTPs) is billed on a medical claim. A pharmacy claim for methadone would be indicative of treatment for pain, rather than OUD.	Patients who use hospice services or elect to use a hospice benefit any time during the measurement year Patients who die any time during the measurement year



Strategies for Improvement:

This is a process measure, as it's quantifying medication compliance for a specific period of time and not abstinence from the addictive use of opioids. By looking at adherence or continuity of pharmacotherapy for opioid use disorder, we're touching on an intermediate outcome as well. So, no clinical recommendations are included.

HEDIS codes can change from year to year. The codes in this document are from the HEDIS MY2025 specifications.

Measure	Goal of the Measure	What to Report (Sample of Codes and/or Diagnoses)	Exclusions
7-Day and 30-Day Psychiatric Hospital / Residential Treatment Facility (RTF) Readmission Rate 6 years of age and older	The rate of readmissions within 7 or 30 days of discharge from a psychiatric hospital or RTF **Two rates are calculated:** **1.** 7-day **2.** 30-day Members with a long-term RTF stay, defined as those with one or more residential RTF claim(s) that covers more than 90 consecutive days and is ongoing as of the eligibility update start date, aren't included in the Health Link performance evaluation. Members must be discharged to home from a previous RTF stay to regain Health Link performance evaluation eligibility. For more information about this THL core metric (THL Provider Manual), visit **https://www.tn.gov/content/dam/tn/tenncare/documents2/THLProviderOperatingManual2025.pdf**.	• Inpatient psychiatric hospital claims are defined for purposes of this measure as facility claims with at least one detail line containing at least one revenue code that indicates the stay was in an inpatient psychiatric hospital. Inpatient psychiatric hospital readmissions are counted based on inpatient psychiatric hospital numerators and denominators **ONLY.** • Residential treatment facility claims are defined for purposes of this measure as facility claims with at least one detail line with a revenue or procedure code indicating a residential treatment facility stay. Residential treatment facility readmissions are counted based on residential treatment facility numerators and denominators **ONLY.** • Calculation for this measure is based on date of discharge to home or outpatient setting.	Patients who use hospice services or elect to use a hospice benefit any time during the measurement year Patients who die any time during the measurement year

Strategies for Improvement:

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

HEDIS codes can change from year to year. The codes in this document are from the HEDIS MY2025 specifications.

Measure	Goal of the Measure	What to Report (Sample of Codes and/or Diagnoses)	Exclusions
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA) 18 years of age and older	The percentage of patients during the measurement year with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period	**Who Qualifies for the Measure** **Adults with:** • At least one acute inpatient encounter with any diagnosis of schizophrenia or schizoaffective disorder **OR** • At least two visits in an outpatient, intensive outpatient, partial hospitalization, ER or nonacute inpatient setting, on different dates of service, with any diagnosis of schizophrenia or schizoaffective disorder **AND** • Prescribed one of the following classes of antipsychotic medications: **Antipsychotic Drug Class** • Miscellaneous antipsychotic agents • Phenothiazine antipsychotics • Thioxanthenes • Long-acting injections • Psychotherapeutic combinations The index prescription start date is the earliest prescription dispensing date for any antipsychotic medication during the measurement year. **This measure is closed by pharmacy and claim data.** **Antipsychotic Medication Pharmacy Dispensing Events:** • Miscellaneous antipsychotic agents (oral) • Phenothiazine antipsychotics (oral) • Psychotherapeutic combinations (oral) • Thioxanthenes (oral) • Long-acting injections (14-day supply) • Long-acting injections (28-day supply) • Long-acting injections (30-day supply) • Long-acting injections (35-day supply) • Long-acting injections (104-day supply) • Long-acting injection (201-day supply) **OR** **Long-Acting Injections:** J2794, J1631, J1943, J1944, J2358, J2426, J2680, J2798, J2801, J0401	Patients who use hospice services or elect to use a hospice benefit any time during the measurement year Patients who die any time during the measurement year Patients with a diagnosis of dementia Patients who didn't have at least two antipsychotic medication dispensing events Patients 66-80 years of age as of December 31 of the measurement year with fraility and advanced illness

Strategies for Improvement:

- Adherence to APMs has been associated with lower rates of preventable diabetes hospitalizations and lower rates of ER use among patients with schizophrenia.
- A large body of evidence has shown that antipsychotic medications (APMs) are effective in treating acute psychotic exacerbations of schizophrenia and in reducing the likelihood of relapse. Guidelines from the National Institute for Clinical Excellence (NICE) and the American Psychiatric Association (APA) emphasize the importance of treatment adherence and uninterrupted antipsychotic regimens to prevent symptoms and relapse.

HEDIS codes can change from year to year. The codes in this document are from the HEDIS MY2025 specifications.

Measure	Goal of the Measure	What to Report (Sample of Codes and/or Diagnoses)	Exclusions
Social Need Screening and Intervention (SNS-E)	The percentage of members who were screened, using prespecified instruments, at least once during the measurement period for unmet food, housing, and transportation needs, and received a corresponding intervention if they screened positive **Note:** A higher rate indicates better performance. **Food Screening:** The percentage of patients who were screened for food insecurity **Food Intervention:** The percentage of patients who received a corresponding intervention within one month of screening positive for food insecurity **Housing Screening:** The percentage of patients who were screened for housing instability, homelessness or housing inadequacy **Housing Intervention:** The percentage of patients who received a corresponding intervention within 30 days (one month) of screening positive for housing instability, homelessness or housing inadequacy **Transportation Screening:** The percentage of patients who were screened for transportation insecurity **Transportation Intervention:** The percentage of patients who received a corresponding intervention within 30 days (one month) of screening positive for transportation insecurity	**Screening Instruments (Documented via LOINC Codes)** • Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool • AAFP Social Needs Screening Tool • Health Leads Screening Panel® • Hunger Vital Sign™ • PRAPARE® • Safe Environment for Every Kid (SEEK)® • We Care Survey • WellRx Questionnaire • Children's Health Watch Housing Stability Vital Signs™ • Norwalk Community Health Center Screening Tool (NCHC) • Comprehensive Universal Behavior Screen (CUBS) • Outcome and Assessment Information Set (OASIS) form – Version E • PROMIS® • U.S. Household, Adult or Child Food Security Survey (U.S. FSS) **Note:** Only screenings documented using specific LOINC codes count towards the measure numerator. **Interventions captured with CPT® and SNOMED CT codes** • Assessment • Assistance • Coordination • Counseling • Education • Evaluation of eligibility • Provision • Referral	Patients who use hospice services or elect to use a hospice benefit any time during the measurement year Patients who die any time during the measurement period.

Strategies for Improvement:

- The American Diabetes Association (ADA) recommends assessing food insecurity, housing insecurity/homelessness, financial barriers and social capital/social community support to inform treatment decisions, with referral to appropriate local community resources.
- The American Academy of Pediatrics (AAP) recommends surveillance for risk factors related to social determinants of health during all patient encounters.
- Interventions may include any of the following categories: adjustment, assistance, coordination, counseling, education, evaluation of eligibility, evaluation/assessment, provision or referral.

HEDIS codes can change from year to year. The codes in this document are from the HEDIS MY2025 specifications.

Measure	Goal of the Measure	What to Report (Sample of Codes and/or Diagnoses)	Exclusions
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC) 18-64 years of age	The percentage of members with schizophrenia or schizoaffective disorder and cardiovascular disease, who had an LDL-C test during the measurement year. An LDL-C test performed during the measurement year. Either of the following meets criteria: • **LDL-C Lab Test** • **LDL-C Test Result or Finding** Identify members with cardiovascular disease by: • Discharge from inpatient setting with AMI diagnosis • Members who had CABG in any setting • Member who had PCI in any setting • IVD diagnosis during the measurement year and the year prior to the measurement year Identify patients with schizophrenia or schizoaffective disorder by: • At least one acute inpatient encounter with any diagnosis of schizophrenia or schizoaffective disorder • At least two visits in an outpatient, intensive outpatient, partial hospitalization, ED or nonacute inpatient setting, on different dates of service, with any diagnosis of schizophrenia or schizoaffective disorder.	An LDL-C test performed during the measurement year. Either of the following meets criteria: • **LDL-C Lab Test Value Set.** • **LDL-C Test Result or Finding Value Set.** • Do not include codes with a modifier (**CPT® CAT II Modifier Value Set**) or from laboratory claims (claims with POS code 81).	Patients who use hospice services or elect to use a hospice benefit any time during the measurement year Patients who die any time during the measurement year.

Strategies for Improvement:

The significantly increased cardiovascular risk associated with Serious Mental Illness is evident even in young adults. This suggests the importance of addressing uncontrolled major cardiovascular risk factors in those with Serious Mental Illness at as early an age as possible.

HEDIS codes can change from year to year. The codes in this document are from the HEDIS MY2025 specifications.

<table>
<tr><th>Measure</th><th>Goal of the Measure</th><th>What to Report
(Sample of Codes and/or Diagnoses)</th><th>Exclusions</th></tr>
<tr>
<td>Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)
18-64 years of age</td>
<td>The percentage of patients with schizophrenia, schizoaffective disorder or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year</td>
<td>Identify members with schizophrenia or bipolar disorder who were dispensed an antipsychotic medication.

SSD Antipsychotic Medications
<table>
<tr><th>Description</th><th>Prescription</th></tr>
<tr><td>Miscellaneous antipsychotic agents</td><td>• Aripiprazole
• Asenapine
• Brexpiprazole
• Cariprazine
• Clozapine
• Haloperidol
• Iloperidone
• Loxapine
• Lumateperone
• Lurasidone
• Molindone
• Olanzapine</td></tr>
<tr><td>Phenothiazine antipsychotics</td><td>• Chlorpromazine
• Fluphenazine
• Perphenazine
• Prochlorperazine</td></tr>
<tr><td>Psychotherapeutic combinations</td><td>• Amitriptyline-perphenazine</td></tr>
<tr><td>Thioxanthenes</td><td>• Thiothixene</td></tr>
<tr><td>Long-acting injections</td><td>• Aripiprazole
• Aripiprazole lauroxil
• Fluphenazine decanoate
• Haloperidol decanoate
• Olanzapine</td></tr>
</table>
Diabetes Screening: A glucose test or an HbA1c test performed during the measurement year.

Any of the following meet criteria:
• Glucose Lab Test
• Glucose Test Result or Finding
• HbA1c Lab Test
• HbA1c Test Result or Finding</td>
<td>Patients with diabetes, identifying diabetic member by two diagnoses on different dates of service during the measurement year or the year prior to the measurement year
OR
Patients who were dispensed insulin or hypoglycemics/antihyperglycemics during the measurement year or the year prior to the measurement year and have at least one diagnosis of diabetes during the measurement year or the year prior to the measurement year

Patients who had no antipsychotic medications dispensed during the measurement year

Patients who use hospice services or elect to use a hospice benefit any time during the measurement year

Patients who die any time during the measurement year</td>
</tr>
</table>

Strategies for Improvement:

Diabetes screening can lead to earlier identification and treatment of diabetes, which can improve physical health and quality of life.

HEDIS codes can change from year to year. The codes in this document are from the HEDIS MY2025 specifications.

Measure	Goal of the Measure	What to Report (Sample of Codes and/or Diagnoses)	Exclusions
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB) 3 months of age and older	The percentage of episodes for members ages 3 months and older with a diagnosis of acute bronchitis/bronchiolitis that didn't result in an antibiotic-dispensing event **Note:** This measure is reported as an inverted rate. A higher rate indicates appropriate acute bronchitis/bronchiolitis treatment *(i.e., the proportion for episodes that didn't result in an antibiotic-dispensing event).*	**Treatment of uncomplicated acute bronchitis with antibiotics isn't recommended, regardless of cough duration. Options for symptomatic therapy include:** • Cough suppressants • First-generation antihistamines • Decongestants **Acute Bronchitis** **ICD-10:** J20.3, J20.4, J20.5, J20.6, J20.7, J20.8, J20.9, J21.0, J21.1, J21.8, J21.9	Patients who use hospice services or elect to use a hospice benefit any time during the measurement year Patients who die anytime during the measurement year

Strategies for Improvement:

Educate patients and their families about viral illnesses and how using antibiotics to treat viral infections can cause antibiotic resistance.

HEDIS codes can change from year to year. The codes in this document are from the HEDIS MY2025 specifications.

Measure	Goal of the Measure	What to Report (Sample of Codes and/or Diagnoses)	Exclusions
Appropriate Treatment for Upper Respiratory Infection (URI) 3 months of age and older	The percentage of episodes for members 3 months of age and older with a diagnosis of upper respiratory infection (URI) that didn't result in an antibiotic-dispensing event **Note:** This measure is reported as an inverted rate. A higher rate indicates appropriate URI treatment (i.e., the proportion of episodes that didn't result in an antibiotic-dispensing event).	**Goal: For antibiotics not to be prescribed for a URI-only diagnosis** Treatment of an upper respiratory infection with antibiotics is not recommended, regardless of cough duration. Options for symptomatic therapy include: • Cough suppressants • First-generation antihistamines • Decongestants **Upper Respiratory Infection Diagnosis:** **ICD-10:** J00, J06.0, J06.9	Patients who use hospice services or elect to use a hospice benefit any time during the measurement year Patients who die any time during the measurement year

Strategies for Improvement:

If the patient's condition doesn't improve and an antibiotic is indicated, measure compliance won't be impacted if the antibiotic is given more than three days after the encounter when a URI was diagnosed.

HEDIS codes can change from year to year. The codes in this document are from the HEDIS MY2025 specifications.

Measure	Goal of the Measure	What to Report (Sample of Codes and/or Diagnoses)	Exclusions
Plan All-Cause Readmissions (PCR) 18 – 64 years of age	The number of acute inpatient and observation stays for patients during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission Patients may have been readmitted back to the same hospital or to a different one.	An acute inpatient or observation stay discharge on or between Jan. 1 and Dec. 1 of the measurement year This measure is based on discharges, not members. Inpatient and observation stays where the discharge date from the first setting and the admission date to the second setting are two or more calendar days apart must be considered distinct stays. The measure includes acute discharges from any type of facility (including behavioral health care facilities). Hospital stays for the following reasons are excluded: • Member died during the stay • Members with a principal diagnosis of pregnancy on the discharge claim • A principal diagnosis of a condition originating in the perinatal period on the discharge claim **Note:** Supplemental data isn't used for this measure.	Patients who use hospice services or elect to use a hospice benefit any time during the measurement year

Strategies for Improvement:

- Work with hospitals to get notifications of your patients' admissions and discharges. Ensure a comprehensive follow-up visit, including medication reconciliation, is completed within 7-10 days post-discharge.
- Use your ADT feed to identify admissions, discharges and transfers.

HEDIS codes can change from year to year. The codes in this document are from the HEDIS MY2025 specifications.

Measure	Goal of the Measure	What to Report (Sample of Codes and/or Diagnoses)	Exclusions
Well-Child Visits in the First 30 Months of Life (W30)	The percentage of members who had the following number of well-child visits with a PCP during the last 15 months Two rates are reported: 1. **Well-Child Visits in the First 15 Months:** Children who turned 15 months old during the measurement year and had six or more well-child visits 2. **Well-Child Visits for Age 15 Months-30 Months:** Children who turned 30 months old during the measurement year and had two or more well-child visits	**Well-Child Visits in the First 15 Months** Children who turned 15 months old during the measurement year Six or more well-child visits include: • A well-care visit • An encounter for well-care **Well-Child Visits for Age 15 Months-30 Months** Two or more well-child visits on different dates of service between the child's 15-month birthday plus 1 day and the 30-month birthday: • A well-care visit • An encounter for well-care	Patients who use hospice services or elect to use a hospice benefit any time during the measurement year Patients who die any time during the measurement year Don't include telehealth visits or telephone visits.

Strategies for Improvement:

- This measure is based on the CMS and American Academy of Pediatrics guidelines for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) visits. Please refer to the American Academy of Pediatrics Guidelines for Health Supervision at **aap.org**.

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

- Comprehensive health (physical and mental) and developmental history
  - Initial and interval history
  - Developmental/behavioral assessment
- Comprehensive unclothed physical exam
- Vision screening
- Hearing screening
- Lab tests
- Immunizations
- Health education/anticipatory guidance
- Age-appropriate dental exam/referra

Claims submitted for EPSDT visits must

- Match your patient's medical records and contain codes for all parts
- Match the EPSDT medical records sent to us

HEDIS codes can change from year to year. The codes in this document are from the HEDIS MY2025 specifications.

Measure	Goal of the Measure	What to Report (Sample of Codes and/or Diagnoses)	Exclusions
Child and Adolescent Well-Care Visits (WCV) 3-21 years of age	Patients in this age range should have at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the year	One or more well care visits during the measurement year. The well-care visit must occur with a PCP or an OB/GYN practitioner, but the practitioner doesn't have to be the practitioner assigned to the patient.	Patients who use hospice services or elect to use a hospice benefit any time during the measurement year Patients who die any time during the measurement year Don't include telehealth visits or telephone visits.

Strategies for Improvement:

- This measure is based on the CMS and American Academy of Pediatrics guidelines for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) visits. Please refer to the American Academy of Pediatrics Guidelines for Health Supervision at **aap.org**.

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

- Comprehensive health (physical and mental) and developmental history
  - Initial and interval history
  - Developmental/behavioral assessment
- Comprehensive unclothed physical exam
- Vision screening
- Hearing screening
- Lab tests
- Immunizations
- Health education/anticipatory guidance
- Age-appropriate dental exam/referra

Claims submitted for EPSDT visits must

- Match your patient's medical records and contain codes for all parts
- Match the EPSDT medical records sent to us

HEDIS codes can change from year to year. The codes in this document are from the HEDIS MY2025 specifications.

Measure	Goal of the Measure	What to Report (Sample of Codes and/or Diagnoses)	Exclusions
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) 3-17 years of age	Patients who are 13-17 years old who had an outpatient visit with a PCP or OB/GYN and had evidence of the following during the measurement year: • Body mass index (BMI) percentile documentation* • Counseling for nutrition • Counseling for physical activity * Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed instead of an absolute BMI value.	**BMI Percentile** **Z68.51 – BMI <5th percentile for age** **Z68.52 – BMI 5th percentile – <85th percentile** **Z68.53 – BMI 85th percentile – <95th percentile** **Z68.54 – BMI ≥ 95th percentile** **Nutrition Counseling** **Dietary counseling and surveillance ICD-10:** Z71.3 **Dietary counseling and surveillance CPT®:** 97802, 97803, 97804 **Medical nutrition therapy and counseling visits (dietitian professionals) CPT® and HCPCS:** G0270, G0271, 97802, 97803, 97804, S9470 **Face-to-face behavioral counseling for obesity HCPCS:** G0447 **Weight management and nutrition classes (non-physician) HCPCS:** S9449, S9452 **Counseling for Physical Activity** **Exercise counseling ICD-10:** Z71.82 **Face-to-face behavioral counseling for obesity HCPCS:** G0447 **Exercise classes (non-physician provider) HCPCS:** S9451 **Encounter for examination for participation in sport ICD-10:** Z02.5	Patients who use hospice services or elect to use a hospice benefit any time during the measurement year Patients who die any time during the measurement year Patients who have a diagnosis of pregnancy any time during the measurement year

Strategies for Improvement:

BMI Percentile:

- Dated height, weight and BMI percentile during the measurement year from the same data source
- Either of the following meets criteria for BMI percentile:
  - BMI percentile documented as a value (e.g., 85th percentile)
  - BMI percentile plotted on an age-growth chart
- Ranges and thresholds don't meet criteria for this measure. A distinct BMI percentile is required for measure compliance.
- Patient-reported biometric values that meet requirements can be used for reporting. Patient-reported services and biometric values (height, weight and BMI percentile) are acceptable only if the information is collected by a PCP or specialist when providing a primary care service related to the condition being assessed while taking a patient's history. The information must be recorded, dated and maintained in the patient's legal health record.

HEDIS codes can change from year to year. The codes in this document are from the HEDIS MY2025 specifications.

Measure	Goal of the Measure	Components of EPSDT exams include	Recommended age for Preventative Visits
Early and Screening, Diagnosis and Treatment (EPSDT)	A program of check-ups and treatment and/or referrals for needed services for all TennCare-eligible children from birth through age 20.	• Comprehensive Health and Developmental History • Comprehensive Unclothed Physical Exam • Vision Screening • Hearing Screening • Laboratory Tests/Procedures • Immunizations • Health Education/Anticipatory Guidance	• **Prenatal:** 12 Month, 6 Year, 14 Year • **Newborn:** 15 Month, 7 Year, 15 Year • **3-5 Day:** 18 Month, 8 Year, 16 Year • **1 Month:** 24 Month, 9 Year, 17 Year • **2 Month:** 30 Month, 10 Year, 18 Year • **4 Month:** 3 Year, 11 Year, 19 Year • **6 Month:** 4 Year, 12 Year, 20 Year • **9 Month:** 5 Year, 13 Year

Strategies for Improvement:

- For more information about EPSDT visits, including coding information, please see our Partners in Prevention Booklet: **https://bluecare.bcbst.com/providers/BlueCare_EPSDT_Provider_Booklet.pdf**
- Children and adolescents enrolled in BlueCare or TennCare*Select* are eligible for TennCare Kids exams until they turn 21
- The schedule for EPSDT exams follows the Bright Futures/American Academy of Pediatrics Periodicity Schedule. **The fiscal year for EPSDT visits begins Oct. 1 and ends Sept. 30 of the following year.**
- For more information, visit **bluecare.bcbst.com/providers** and select **Well-Child - EPSDT and Vaccines for Children**.

HEDIS codes can change from year to year. The codes in this document are from the HEDIS MY2025 specifications.

Best Practices and Processes Behind the CAHPS Survey

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

Survey Questionnaire Examples

In the last six months, did your child get care from a doctor or other health provider besides their personal doctor?

___Yes ___No > If No, Go to question 36

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

___Never ___Sometimes ___Usually ___Always

Categories Included in the Survey

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

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

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

Cultural Competency's Role in Quality Care

Sometimes, people from different cultures have different perceptions about illness and competent treatment. These beliefs may be based on religious ideas, folklore or their own common-sense explanations.

People's perceptions of health care can influence clinical encounters and their willingness to take medication or have surgery. Those who've had a bad experience with the health system in the past may also feel mistrustful or hesitant. Acknowledging your patients' beliefs, perceptions about illness and self-care practices is an important part of delivering quality, culturally competent care.

Consider these tips to help promote culturally competent care in your practice:

Support health literacy. Ask yourself and others in your practice, "If I spoke a different language or had a language barrier, would I feel comfortable with this treatment/facility/provider?" Then, find ways to help promote health literacy, especially among those who may have limited English proficiency (LEP), such as:

- Communicating clearly.
- Slowing down the pace of the conversation.
- Using plain language to explain information about health conditions and treatments.
- Helping patients find ways to communicate that will allow you to assess their health needs.
- Using an interpreter. Providers are required to make an interpreter available to those with LEP at no charge. Note: A person's family members, including their minor children, shouldn't serve as the interpreter during medical visits.
- Using the teach-back method and asking questions to assess patients' understanding of the information presented.

Adapt service delivery to help meet the diverse needs of patients. Moving towards culturally appropriate service delivery means being:

- Knowledgeable about cultural differences and their impact on attitudes and behaviors
- Sensitive, understanding, non-judgmental and respectful in conversations with people whose culture differs from your own
- Flexible and skillful in responding and adapting to different cultural contexts and circumstances

Make cultural knowledge a key part of your practice's policies and procedures. Please ensure employees are trained on appropriate communication methods.

Find ways to ask open-ended questions, when possible. Acknowledge the person's perception of illness and self-care practices. Talk with them about how the medical system works and explain that asking many questions about their health and symptoms is often necessary to get an accurate diagnosis.

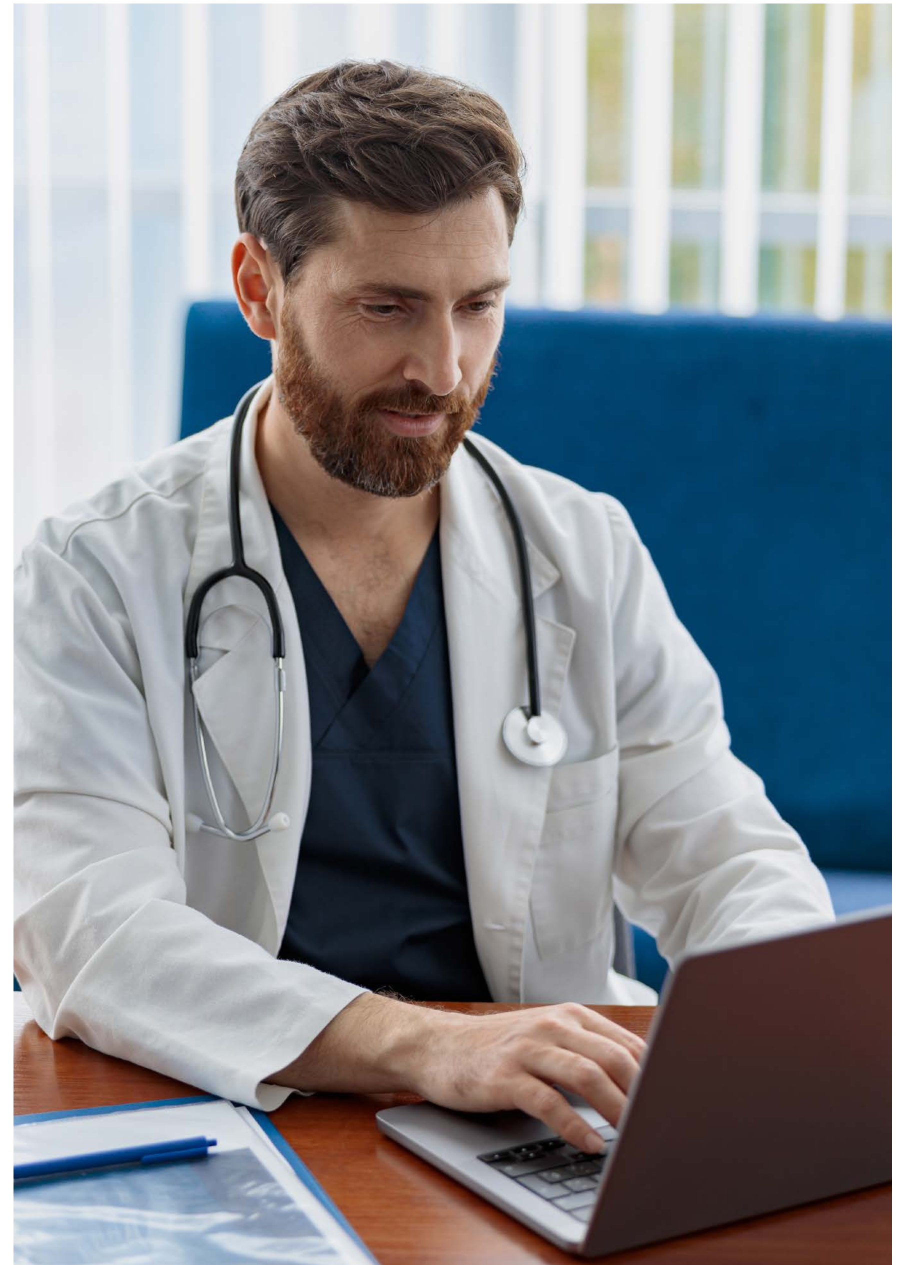
Schedule more time for appointments with those who have LEP, which may take twice as long. During these visits, talk directly to the patient (not their interpreter).

Consider involving extended family members in care planning. In many cultures, families are deeply involved in individuals' medical decisions.

Note: Please use your clinical judgment to determine if this is appropriate. Make sure you have your patient's consent to discuss their health information with others.

BlueCare Tennessee Provider Resource Page

- News and Updates
- Clinical Practice Guidelines
- Availity Portal
- THCII-PCMH & THL Program
- Quality Care Quarterly
- Population Health Program
- Behavioral Health Program
- Maternity Support Program
- Home Health Services
- Well Child Care Services (EPSDT)
- Provider Documents and Forms
- BlueCare Tennessee Main Page
- Culturally Competent Care
- Partners in Prevention (EPSDT)
- Telehealth Resources
- NCQA Electronic Clinical Data Systems (ECDS) Reporting



Contact Information

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

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

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

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

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

*Rides are guaranteed only if scheduled two business days prior to the visit.

Pharmacy Benefits	
https://www.optumrx.com/oe_tenncare/landing	
Technical Call Center (Pharmacy Help Desk)	1-866-434-5520
Clinical Call Center (Prior Authorizations)	Phone: 1-866-434-5524 Fax: 1-866-434-5523

For Technical Support
Contact our eBusiness team at (423) 535-5717, Option 2, or at **eBusiness_service@bcbst.com**.

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

For Tools and Resources	
Website	**bluecare.bcbst.com/providers**
Tennessee Mental Health Crisis Hotline	1-855-274-7471

BlueCare Tennessee

1 Cameron Hill Circle | Chattanooga, TN 37402 | bluecare.bcbst.com

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