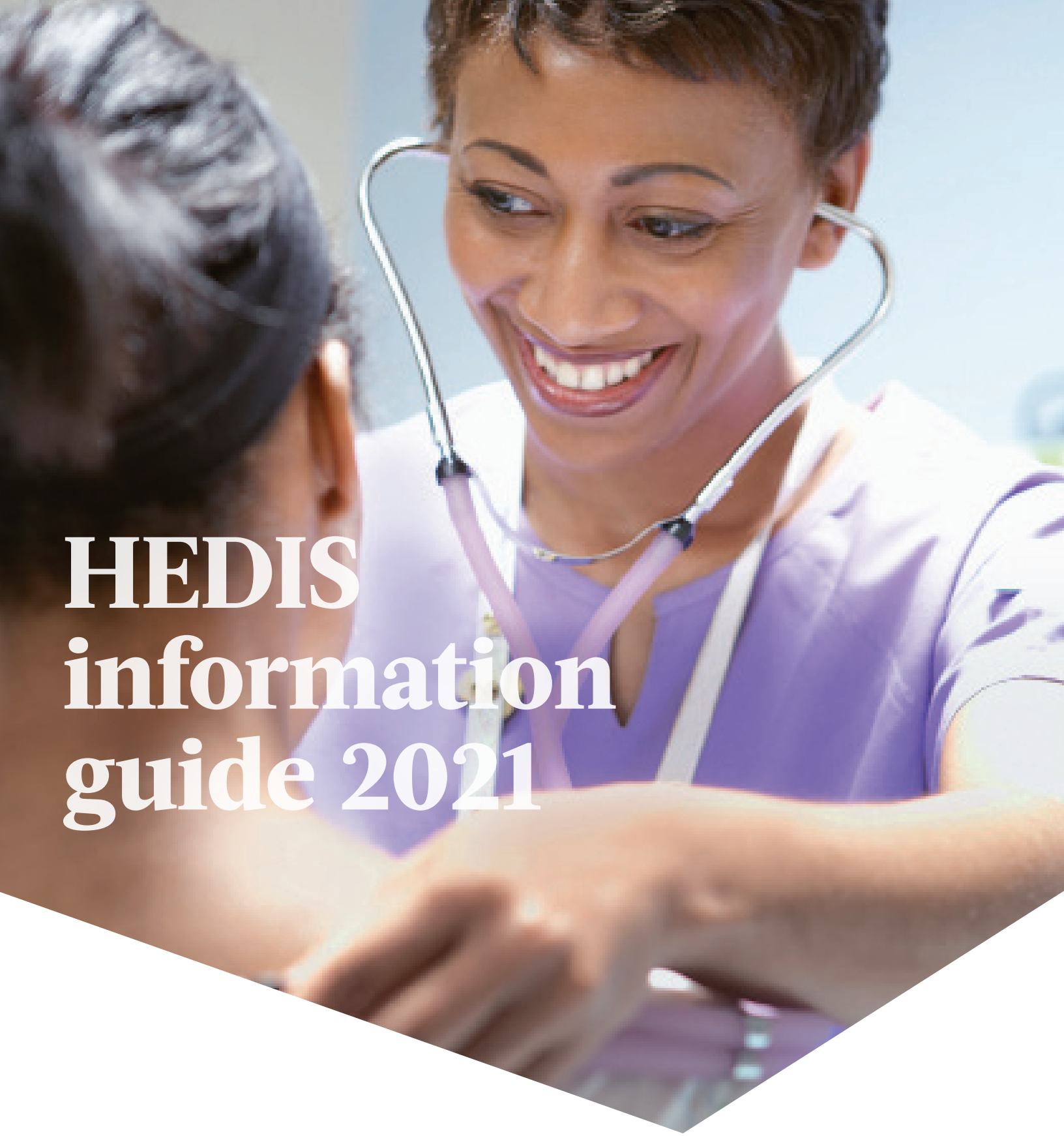

HEDIS information guide 2021

Geisinger

Questions? Here's who to call.

Online services

NaviNet® for provider information and resources — *NaviNet.navimedix.com*

Instamed for electronic claim submission and payment transactions..... 866-467-8263
Instamed.com

Claims

Call the customer care team with claims questions that cannot be resolved through NaviNet or Instamed.

Provider claims..... 800-447-4000

Benefits and eligibility

Call for member benefits and eligibility unable to be found via NaviNet®.

HMO/PPO..... 800-447-4000

PPO/TPA..... 800-504-0443

Geisinger Gold..... 800-498-9731

GHP Family..... 855-227-1302

GHP Kids (CHIP)..... 866-621-5235

EMHS TPA..... 855-863-2429

AtlantiCare TPA..... 866-379-4465

St. Luke's TPA..... 866-580-3531

Exchange..... 866-379-4489

Geisinger employees..... 844-568-5229

Wise Foods..... 844-260-8028

AON..... 844-390-8332

Performance Guarantee..... 844-863-6850
(Bucknell, FEDS, PA Trst, PEBTF, Walmart)

Behavioral health 888-839-7972

Quality and accreditation

Call for medical record chart review and HEDIS specification questions.

Quality and accreditation..... 866-847-1216

Provider account management

Talk to your provider account manager about your contract, pay-for-quality programs and educational opportunities.

Provider account management 800-876-5357
GHPAccountMngt@Geisinger.edu

Medical management

Contact medical management to request precertification/prior authorization for things like inpatient admissions, outpatient rehabilitation, home health & hospice, SNF or DME.

Medical management..... 800-544-3907

Non-emergent ambulance..... 844-749-5860

Pharmacy department

Call the pharmacy department for formulary exceptions, drug authorization and prescription drug information.

Pharmacy department..... 800-988-4861

GHP Family pharmacy department..... 855-552-6028

Case management

Contact case management for assistance with care coordination.

Case management..... 800-883-6355

GHP Family Special Needs Program (SNP) unit..... 855-214-8100

PA Relay 711 for hearing impaired

What is HEDIS?

HEDIS® (Healthcare Effectiveness Data and Information Set) is a set of standardized performance measures, developed by the National Committee for Quality Assurance (NCQA), which allows direct, objective comparison of quality across health plans. NCQA develops the HEDIS measures through a committee represented by purchasers, consumers, health plans, healthcare providers and policymakers. HEDIS allows for standardized measurement, standardized reporting and accurate objective side-by-side comparisons. For more information, visit **ncqa.org.**

Annual HEDIS timeline

February to early May	June	September/October	January
Quality department staff collects and reviews HEDIS data through on-site provider office chart abstraction and fax requests for previous year.	HEDIS results are certified and reported to NCQA.	NCQA releases Quality Compass results nationwide.	First Friday in January, all data provided to Geisinger Health Plan.

How are the rates calculated?

HEDIS rates can be calculated in two ways: administrative data or hybrid data. Administrative data consists of claim or encounter data submitted to the health plan. Hybrid data consists of both administrative data and a sample of medical record data. Hybrid data requires review of a random sample of member medical records to abstract data for services rendered, but not reported to the health plan through claims/encounter data. **Accurate and timely claim/encounter data reduces the necessity of medical record review.**

How to be a Medicare quality superstar

What is the Medicare star rating program?

The Medicare star rating program was created by the Centers for Medicare & Medicaid Services (CMS). It evaluates the relative quality of private health plans that offer services to Medicare beneficiaries. CMS scores health plans on a one- to five-star rating system. Five stars represents the highest quality a plan can achieve. Members can use this rating system to gauge a plan's quality rating, ease of access to care, provider responsiveness and members' satisfaction with the health plan.

Quick tips to help you boost your star ratings

Don't keep your members waiting too long.

- Has the member been in the waiting room for more than 30 minutes?

Get to know your members' special needs.

- Accommodate those who are frail, elderly, non-English-speaking or who have a disability.

Keep in touch with your members.

- Reach out to members who have not been seen.
- Allow extra time during appointments for questions and answers.
- Make sure each member has an annual wellness visit and completes all needed tests and screenings.
- Follow up with all test results and future appointments.

Scheduling appointments appropriately.

- Urgent care – less than 24 hours
- Non-urgent care – within 1 week
- Routine/preventive care – within 1 month

Schedule all important screenings as soon as possible.

- Colorectal cancer screening
- Breast cancer screening
- Diabetes care
- Controlling hypertension

Why is the Medicare star rating system so important?

- Helps members make informed decisions about healthcare plans
- Provides richer benefits for members
- Promotes a higher quality of care for members

What is the CAHPS survey?

What is the Medicare star rating program?

NCQA and CMS require health plans to administer a member satisfaction survey (Consumer Assessment of Healthcare Providers and Systems, or CAHPS). Survey results are collected annually and compared to national benchmarks. The surveys are conducted in early spring by mail and followed up by phone to non-responders. Results are made available later in the summer for commercial and Medicaid health plans and later in the year for Medicare.

The CAHPS survey asks members and consumers to report on and evaluate their experiences with healthcare. The survey covers topics that are important to consumers
and focuses on aspects of quality consumers are most qualified to address. Each member is surveyed to gauge member satisfaction with services provided by the health plan and member perceptions of healthcare provider accessibility, the member-physician relationship and healthcare provider communication.

There are multiple questions that relate to member satisfaction with physicians. These might be of interest, as they pertain to the member-physician relationship and might highlight opportunities for improvement in everyday practice.

The CAHPS survey also contains effectiveness-of-care measures. Members are asked whether they received a flu shot, if they got direction from their physician on aspirin usage and if their physician discussed tobacco cessation.

Medical record documentation

Document **all** current and past:

- Screenings (e.g., mammograms, colonoscopy)
- Immunizations (e.g., HPV, flu, MMR, hep A)
- Test results (e.g., A1C, nephrology, FOBT kits, lit)
- Treatments
- Health education
- Rationale
- Prescriptions

The details of good documentation

Who received the care?

- Member information should be on all pages of the medical record (front and back).
- Document who provided the care for tests, cancer screenings, etc.

Who provided the care?

- Provider should always sign and date with professional designation on every entry.

What care or service was provided?

- Be specific.
- Avoid subjective descriptions (e.g., well, better).
- Never leave blank spaces or lines, this will help prevent any altering of the notes.
- Use the appropriate diagnosis and CPT codes for all services rendered.
- Bill CPT II codes when test results, etc. are reviewed.

When was the care provided to the member?

- Give the date and time of all treatments, appointments, screenings and care.

Why is good medical documentation so important?

- Defines the purpose for each encounter and the clinical circumstances.
- Creates consistent ongoing communication among healthcare providers.
- Helps to plan a basic course of treatment.
- Helps support and improve quality of member care.
- Improves medical chart reviews for HEDIS clinical care gap closures.

Where should you send documentation?

- Fax medical record information to the Geisinger Health Plan Quality Department at 570-214-1380.

What is the Health Outcomes Survey?

The Health Outcomes Survey is conducted annually by CMS in May, June and July. CMS surveys our Medicare population, evaluating our ability to maintain or improve the health of our members. Significant improvement in these measures requires a joint effort by Geisinger Health Plan and our provider network.

Health Outcomes Survey measures

Improve or maintain physical health

- Regularly evaluate a member's pain and functional status.
- Provide interventions to improve physical health, pain management, disease management, case management and physical therapy referrals.
- Develop goals and action plans for the member to take an active role in improving their health.

Improve or maintain mental health

- Routinely gauge a member's emotional problems, depression, anxiety and addictions; determine how these affect their daily life and social interactions.
- Provide referrals for behavioral health services, depression management services and treatment centers.
- Integrate motivational interviewing to improve treatment engagement and mental health outcomes.

Improve bladder control

- Regularly assess a member's urinary incontinence issues in the last 6 months.
- Evaluate the severity of these conditions, the impact they are having on the member's quality of life and discuss the treatment options (Kegel exercises, bladder training, pharmaceuticals, surgical procedures).
- Provide informational brochures and materials to member to help educate and initiate the discussion.

Monitor physical activity

- Consistently evaluate the member's level of physical activity.
- Discuss the health benefits of increasing their level of physical activity, develop physical activity plans that match their health status and encourage participation in exercise programs.
- Inform member that a gym membership and other programs, such as Silver Sneakers, may be a benefit of their health plan.

Reduce risk of falling

- Regularly gauge a member's risk of falls, gait and balance problems and document these concerns.
- Provide fall prevention intervention, such as exercise, balance and strengthening activities (tai chi or yoga), review member's medication and promote regular eye exams.
- Emphasize home safety (e.g., removing throw rugs, installing handrails on stairs, grab bars in the bathroom, nightlights in hallways and non-slip mats in the tub and shower).

What is a provider's role in HEDIS?

Providers play an essential role in promoting the health of our members. Your office can help increase HEDIS scores by discussing the importance of preventive health screenings and exams with our members. Some HEDIS measures are included in our pay-for-performance programs, so increasing scores may positively impact your payout for these programs. Most importantly, reinforcing preventive care compliance with our members will ultimately improve their health outcomes.

You can assist by doing the following:

- Submit claim/encounter data for each service rendered.
- Chart documentation must reflect services billed.
- Accurately code all claims. Since HEDIS measures are linked to specific coding criteria, accurate coding is critical. Providing accurate information may also reduce the number of records requested.
- Consider including CPT II codes to reduce medical record requests. These codes provide details currently only found in the chart such as BMI screenings and lab results.
- Avoid missed opportunities by taking advantage of sick care visits; combine the well visit components and use a modifier and proper codes to bill for both the sick and well visit.
- Routinely schedule a member's next appointment while in the office for the visit.
- Periodically review your Member Health Alerts report on navinet.net to identify any gaps in care and reach out to members identified as noncompliant.
- Respond promptly to our requests for medical records.
- Encourage our members to get preventive screenings, such as cervical cancer screening, mammography and colorectal cancer screening.

Tips for documenting in the medical record

During your member's annual visit, consider the following:

- Record your member's weight and BMI.
- Order HbA1C and nephropathy for diabetic members and record the value.
- Do a complete functional status assessment.
- Discuss the benefits of screening for cancer with your members and encourage mammogram, or colonoscopy.
- Immunize against influenza and pneumococcus, or document contraindications and refusals.
- Review member's medication at least annually and document in the chart, even if no changes were made.
- Review member's discharge status after hospitalization and document medication reconciliation in the chart.
- Encourage your member to have their vision examined and/or refer to an ophthalmologist or optometrist for annual dilated eye exam, if diabetic.
- For elderly members at risk for osteoporosis, consider doing bone mineral density exam on women over 65 years old.
- Encourage members to get at least 120 to 150 minutes of exercise per week.
- Discuss the importance of nutrition.
- Remind members to continue taking their maintenance medication as prescribed.
- Perform a mental health assessment and follow up as appropriate.

Measures key

Each measure included in this document is divided into sections for easy use.

Color-coded banners — This section contains the name of the measure and abbreviation. Some measures have an associated code on the right side with the following meanings:

- **Yellow star** ★ represents a Medicare star measure reported to CMS.
- **PCMH** indicates patient-centered medical home.

Frequently utilized provider best practices – These are what we look for in the documentation for the measure. These items are based on compliant members and provider best practices.

Common codes for this measure – This section provides codes identified in the HEDIS specification which make a member compliant for the measure. *For payment of these codes, make sure the codes are covered under the member's benefits and listed on your contracted provider fee schedule.* If you are not sure whether a particular code is on your fee schedule, contact your account manager.

Common chart deficiencies – This section lists the most common areas for improvement in chart documentation.

Exclusions – Codes or diagnoses are listed that exclude members from the measure.

Medical record documentation – This lists information needed by the health plan to show the member is compliant and gives information on where to send it.

HEDIS measures

Prevention and screenings

Children and adolescents

Perinatal screenings

Behavioral health

Medication management

Chronic conditions

Overuse/appropriateness

Access/availability of care

Measures collected through the CAHPS® health plan survey

Annual wellness visit (AWV) — Medicare

The percentage of members that had one annual well visit as of Dec. 31 of the measurement year.

Frequently utilized provider best practices

- Allow enough time for the visit.
- CMS requires the provider to, at a minimum, collect and document the member's medical and surgical and procedural history:
  - Illnesses
  - Hospital stays
  - Operations
  - Allergies
  - Injuries and treatments
  - Medication and supplement (including calcium and vitamins) utilization
  - Opioid use
  - Behavioral risks
  - Activities of daily living (ADLs)
  - Instrumental ADLs (IADLs)
  - Pain assessment
- Assess cognitive function of member.
- Risk factors for depression or other mood disorders (depression screenings)
- Review member's functional ability and level of safety by observing or screening the following:
  - Ability to successfully perform ADLs
  - Fall risk
  - Hearing impairment
  - Home safety
  - Urinary incontinence
- Discuss advance care planning services.
- Discuss preventive services.
- Monitoring a member's physical activity, discuss the health benefits of increasing physical activity, develop activity action plans and exercise programs.

Common codes for this measure
(Note: Codes listed are subject to plan coverage and contracted fee schedule.)

Description		Codes	Description
Annual well visit	**HCPCS:**	G0438	Annual wellness visit; includes a personalized prevention plan of service (PPS), initial visit
		G0439	Annual wellness visit includes a personalized prevention plan of service (PPS), subsequent visit
		G0468	Federally qualified health center (FQHC) visit, IPPE or AWV; a FQHC visit that includes an initial preventive physical examination (IPPE) or annual wellness visit (AWV) and includes a typical bundle of Medicare-covered services that would be furnished per diem to a member receive an IPPE or AWV. (Only valid when billed with location code 50, for our contracted FQHC providers)

Common chart deficiencies

Exclusions	Members in hospice are excluded.
Medical record documentation	Medical record dates: Jan. 1, 2021 – Dec. 31, 2021 (must be capture in billing) Fax medical record information to Geisinger Health Plan Quality Department at 570-214-1380.

Breast cancer screening (BCS)

Commercial, Medicare, Medicaid

Percentage of women 50 – 74 years of age who had a mammogram between October, 2 years prior to the measurement year, through Dec. 31 of the measurement year.

Frequently utilized provider best practices

- Educate female members about the importance of early detection and encourage testing.
- Document a bilateral or unilateral mastectomy in the medical record.
- Do not miss the opportunity to schedule a mammogram for the member while at the office visit.
- Have a list of facilities available for members to choose where they would like to have the mammogram scheduled.
- Discuss possible fears the member may have about mammograms and explain current testing process are less uncomfortable and require less radiation.
- Transgender population should be counted.

Common codes for this measure
(Note: Codes listed are subject to plan coverage and contracted fee schedule.)

Description	Codes	
Mammography	**CPT:**	77055, 77056, 77057, 77061, 77062, 77063, 77065, 77066, 77067
	HCPCS:	G0202, G0204, G0206

Common chart deficiencies

- No discussion of scheduling a mammogram
- No documentation of mammogram date
- Not ordering mammogram for transgender population

Exclusions

- Women who had a bilateral mastectomy, unilateral mastectomy with bilateral modifier. Two unilateral mastectomies, or a history of bilateral mastectomy (include date).
- Members in hospice
- Members under palliative care
- Any member age 66 years of age or older:
  - In a long-term care facility
  - With advanced illness and frailty diagnosis
  - On dementia medication

For a complete list of frailty exclusion codes and dementia medications, see Appendix 1

Medical record documentation

Medical record dates: Oct. 1, 2019 – Dec. 31, 2021
Fax medical record information to Geisinger Health Plan Quality Department at 570-214-1380.

- Bilateral mammogram
- Unilateral mammogram with documentation of mastectomy of opposite side
- Documentation of a bilateral mastectomy
- Digital breast tomosynthesis

Cervical cancer screening (CCS)

Commercial, Medicaid

Percentage of women 21 - 64 years of age who were screened for cervical cancer

Frequently utilized provider best practices

- Request to have results of Pap tests sent to you, if done at OB/GYN visits.
- Document in the medical record if the member has had a hysterectomy with no residual cervix, and fax us the chart.

Common codes for this measure
(Note: Codes listed are subject to plan coverage and contracted fee schedule.)

Description	Codes	
Cervical Cytology	**CPT:**	88141, 88142, 88143, 88147, 88148, 88150, 88152, 88153, 88154, 88164, 88165, 88166, 88167, 88174, 88175
	HCPCS:	G0123, G0124, G0141, G0143, G0144, G0145, G0147, G0148, P3000, P3001, Q0091
HPV	**CPT:**	87620, 87621, 87622, 87624, 87625
	HCPCS:	G0476

Common chart deficiencies

- Documentation of hysterectomy alone does not meet guidelines.
- Do not use active cancer codes for screenings, unless member is actively being treated for cancer.

Exclusions

- Members in hospice are excluded
- Members under palliative care
- Members who had a hysterectomy with no residual cervix

Excluded codes*		
Absence of cervix	**CPT:**	51925, 56308, 57540, 57545, 57550, 57555, 57556, 58150, 58152, 58200, 58210, 58240, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290, 58291, 58292, 58293, 58294, 58548, 58550, 58552, 58553, 58554, 58570, 58571, 58572, 58573, 58575, 58951, 58953, 58954, 58956, 59135
	ICD10:	0UTC0ZZ, 0UTC4ZZ, 0UTC7ZZ, 0UTC8ZZ
Abdominal hysterectomy	**CPT:**	51925, 58150, 58152, 58180, 58200, 58210, 58240, 58541, 58542, 58543, 58544, 58951, 58953, 58954, 58956, 59135, 59525
	ICD10:	0UT90ZL, 0UT90ZZ, 0UT94ZL, 0UT94ZZ, 0UTC0ZZ, 0UTC4ZZ

*For a more comprehensive list of excluded codes, contact your account manager.

Medical record documentation

Medical record dates:
Fax medical record information to Geisinger Health Plan Quality Department at 570-214-1380.

- Women 21 – 29 must have Pap smear between 1/1/19 and 12/31/21
- Women 30 – 64 – documentation of HPV or HPV with cervical Pap 1/1/17 – 12/31/21
- Provide documentation of hysterectomy with no residual cervix (total hysterectomy, vaginal hysterectomy, complete hysterectomy or radical hysterectomy)

Colorectal cancer screening (COL)

Commercial, Medicaid ★

The percentage of members 50 – 75 years of age who had appropriate screening for colorectal cancer

Frequently utilized provider best practices

- Update member history annually regarding colorectal cancer screening (test done and date).
- Recommend FOBT/FIT-DNA as an alternative to colonoscopy.
- Provide ongoing outreach and education to non-compliant members.
- Use standing orders and empower office staff to distribute FOBT or FIT kits to members who need colorectal cancer screening or prepare referral for colonoscopy.

Common codes for this measure
(Note: Codes listed are subject to plan coverage and contracted fee schedule.)

Description	Codes	
FOBT	**CPT:**	82270, 82274
	HCPCS:	G0328
Flexible Sigmoidoscopy	**CPT:**	45330, 45331, 45332, 45333, 45334, 45335, 45337, 45338, 45339, 45340, 45341, 45342, 45345, 45346, 45347, 45349, 45350
	HCPCS:	G0104
Colonoscopy	**CPT:**	44394, 44397, 44401, 44402, 44403, 44404, 44405, 44406, 44407, 44408, 45355, 45378, 45379, 45380, 45381, 45382, 45383, 45384, 45385, 45386, 45387, 45388, 45389, 45390, 45391, 45392, 45393, 45398
	HCPCS:	G0105, G0121
CT Colonograpy	**CPT:**	74261, 74262, 74263
FIT - DNA (Cologuard)	**CPT:**	81528
	HCPCS:	G0464

Common chart deficiencies

- Charting the date of the conversation about having a colonoscopy in the surgical history
- Not labeling scanned colonoscopies in EMR appropriately
- Not documenting and updating dates of screenings/colonoscopies in chart

Exclusions

- Diagnosis of colorectal cancer or total colectomy any time prior to Dec. 31 of measurement year.
- Members enrolled in an institutional SNP any time during the year
- Members living long-term in an institution anytime during MY, identified by LTI flag
- Members in hospice
- Members under palliative care
- Members with a frailty diagnosis

*__For a complete list of frailty exclusion codes and dementia medications, see Appendix 1.__

(Cont. on next page.)

Colorectal cancer screening (COL) (continued)

Commercial, Medicaid ★

Exclusions *(cont.)*	**Excluded codes***		
	Colorectal Cancer	**CPT:**	G0213, G0214, G0215, G0231
		ICD10:	C18.0, C18.1, C18.2, C18.3, C18.4, C18.5, C18.6, C18.7, C18.8, C18.9, C19, C20, C21.2, C21.8, C78.5, Z85.038, Z85.048
	Total Colectomy	**CPT:**	44150, 44151, 44152, 44153, 44155, 44156, 44157, 44158, 44210, 44211, 44212
		HCPCS:	0DTE0ZZ, 0DTE4ZZ, 0DTE7ZZ, 0DTE8ZZ
Medical record documentation	Medical record dates: Fax medical record information to Geisinger Health Plan Quality Department at 570-214-1380. • Colonoscopy between 2012 and 2021 • Flexible sigmoidoscopy or CT colonography between 2017 and 2021 • Fecal occult blood test in 2021 • FIT/DNA Cologuard between 2019 and 2021 • **Dated** documentation of a colon screening on a medical history form, problem list or health maintenance form • If applicable, documentation of colorectal cancer or a total colectomy with date of occurrence.		

Care for older adults (COA)

Medicare ★

The percentage of adults 66 years and older who had each of the following during the measurement year:
- Advance care planning
- Medication review
- Functional status assessment
- Pain assessment

Frequently utilized provider best practices

- Use CPT II codes to capture completed services.
- Services rendered during a telephone visit, e-visit or virtual check-in meet criteria for advanced care plan, functional status and pain assessment
- Remember the medication review measure requires medications are listed in the chart, plus the review.
- Incorporate a standardized template to capture these measures for members 66 years and older, if on EMR.

Common codes for this measure
(Note: Codes listed are subject to plan coverage and contracted fee schedule.)

Description	Codes	
Advance care planning	**CPT:**	99483, 99497
	CPT II:	1123F, 1124F, 1157F, 1158F
	HCPCS:	S0257
	ICD10:	Z66
Medication review	**CPT:**	90863, 99483, 99605, 99606
	CPT II:	1160F
Medication list	**CPT II:**	1159F
	HCPCS:	G8427
Transitional care management services	**CPT:**	99495, 99496
Acute inpatient	**CPT:**	99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99251, 99252, 99253, 99254, 99255, 99291
Functional status assessment	**CPT:**	99483
	CPT II:	1170F
	HCPCS:	G0438, G0439
Pain assessment	**CPT:**	1125F, 1126F

Common chart deficiencies
- Not documenting conversations that take place during visits
- Not documenting how the patient ambulates into the office, arrives, etc.
- Not documenting hearing, vision, etc. under review of systems; stating "normal" under eyes, nose, etc. does not count

Exclusions

- Members in hospice

Medical record documentation

Medical record dates: Jan. 1, 2021– Dec. 31, 2021
Fax medical record information to Geisinger Health Plan Quality Department at 570-214-1380.

Chlamydia screening in women (CHL)

Commercial, Medicaid

The percentage of women 16 – 24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year

Frequently utilized provider best practices

- Perform chlamydia screening every year on every female age 16 – 24 years (use any visit opportunity).
- Add chlamydia screening as a standard lab for women 16 – 24 years old. Use well-child exams and well women exams for this purpose.
- Remember that chlamydia screening can be performed through a urine test.

Common codes for this measure
(Note: Codes listed are subject to plan coverage and contracted fee schedule.)

Description	Codes	
Chlamydia screening	**CPT:**	87110, 87270, 87320, 87490, 87491, 87492, 87810

The list of additional commonly used codes (pregnancy, sexual activity, pregnancy tests) is very large, see your account manager for a complete list.

Contraceptive medications

Description	Prescription	
Contraceptives	**CPT:**	Desogestrel-ethinyl estradiol Dienogest-estradiol multiphasic Drospirenone-ethinyl estradiol Drospirenone-ethinyl estradiol-levomefolate biphasic Ethinyl estradiol-ethynodiol Ethinyl estradiol-etonogestrel Ethinyl estradiol-folic acid-levonorgestrel Ethinyl estradiol-levonorgestrel Ethinyl estradiol-norelgestromin Ethinyl estradiol-norethindrone Ethinyl estradiol-norgestimate Ethinyl estradiol-norgestrel Etonogestrel Levonorgestrel Medroxyprogesterone Mestranol-norethindrone Norethindrone
Diaphragm		Diaphragm
Antiasthmatic combinations		Nonxynol 9

Common chart deficiencies

- Not collecting a urine sample routinely at well visits throughout the year

Exclusions

- Pregnancy test during measurement year and a prescription for Isotretinoin on the date of the pregnancy test or the 6 days after the pregnancy test

Retinoid Medications

Description	Prescription
Retinoid	Isotretinoin

Medical record documentation

Medical record dates: Jan. 1, 2021 – Dec. 31, 2021
Fax medical record information to Geisinger Health Plan Quality Department at 570-214-1380.

Controlling high blood pressure (CBP)

Commercial, Medicare, Medicaid

Percentage of members 18 – 85 years of age who had a diagnosis of hypertension and whose BP was adequately controlled (<140/90) during the measurement year.

Frequently utilized provider best practices

- Do not round up a BP result.
- Use CPT II codes when billing office visits to capture blood pressure result
- Telephone visits, e-visits and virtual check-ins are appropriate settings for BP readings and allow member-reported BPs taken with a digital device

Common codes for this measure

(Note: Codes listed are subject to plan coverage and contracted fee schedule.)

Description	Codes	
Essential Hypertension	ICD10:	I10
	CPT II:	3078F, 3079F, 3080F, 3074F, 3075F, 3077F
Outpatient	CPT:	99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 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, 99429, 99455, 99456, 99483
	HCPCS:	G0402, 0438, G0439, G0463, T1015
Telehealth	Modifier:	95, GT
Telephone visits	CPT:	98966, 98967, 98968, 99441, 99442, 99443
Nonacute inpatient stay	CPT:	99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99318, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337
Remote blood pressure monitoring	CPT:	93784, 93788, 93790, 93791
Online assessments	CPT:	98969, 99444

Common chart deficiencies

- Not using CPT II codes
- BP not taken during the visit
- Elevated blood pressure (R03.0) is not a confirmed case of hypertension

(Continued on next page.)

Controlling high blood pressure (CBP) (continued)

PQ4
Commercial, Medicare, Medicaid

Exclusions

- Members with evidence of end-stage renal disease (ESRD) or kidney transplant on or prior to Dec. 31 of the measurement year
- Female members with a diagnosis of pregnancy during the measurement year
- Members in hospice
- Members under palliative care
- Any member age 66 years of age or older
  - In a long-term care facility
  - With advanced illness and frailty diagnosis
  - Taking dementia medication

Excluded codes*

ESRD	**CPT:**	36147, 36800, 36810, 36815, 36818, 36819, 36820, 36831, 36832, 36833, 90935, 90937, 90940, 90945, 90947, 90951, 90952, 90953, 90954, 90955, 90956, 90957, 90958, 90959, 90960, 90961, 90962, 90963, 90964, 90965, 90966, 90967, 90968, 90969, 90970, 90989, 90993, 90997, 90999, 99512, 36145, 90919, 90920, 90921, 90923, 90924, 90925
	HCPCS:	G0257, S9339, G0308, G0309, G0310, G0311, G0312, G0314, G0315, G0316, G0317, G0318, G0319, G0321, G0322, G0323, G0325, G0326, G0327, G0392, G0393
	ICD10:	N18.5, N18.6, Z91.15, Z99.2, 3E1M39Z, 5A1D00Z, 5A1D60Z, 5A1D80Z, 5A1D90Z
ESRD Obsolete	**CPT:**	36145, 90919, 90920, 90921, 90923, 90924, 90925
	HCPCS:	G0308, G0309, G0310, G0311, G0312, G0313, G0314, G0315, G0316, G0317, G0318, G0319, G0321, G0322, G0323, G0325, G0326, G0327, G0392, G0393
Kidney Transplant	**CPT:**	50300, 50320, 50340, 50360, 50365, 50370, 50380,
	HCPCS:	S2065
	ICD10:	Z94.0, 0TY00Z0, 0TY00Z1, 0TY00Z2, 0TY10Z0, 0TY10Z1, 0TY10Z2

*Contact your account manager for additional exclusion codes for this measure.

Medical record documentation

Medical record dates: Jan. 1, 2021 – Dec. 31, 2021
Fax medical record information to Geisinger Health Plan Quality Department at 570-214-1380.

- Vitals/blood pressure Jan. 1, 2020 – Dec. 31, 2020
- Only the last BP of the year counts to close HEDIS care gap

Social determinants of health screening (SDOH)

PCMH
Medicaid

Social determinants of health identifies the member's needs and any deterrents to receiving quality care.

Frequently utilized provider best practices

- Complete a social determinants of health assessment annually at the member's first visit of the year and submit ICD-10 for all members. **https://www.aafp.org/member-care/social-determinants-of-health/everyone-project/neighborhood-navigator.html**
- Have the member complete a questionnaire upon check-in. **https://www.aafp.org/dam/AAFP/documents/member_care/everyone_project/hops19-physician-form-sdoh.pdf**
- Address the following with the assessment;
  - Education, literacy and language
  - Employment
  - Housing security
  - Social and mental health
  - Experience with crime and violence, including domestic violence
  - Family and social support issues
  - Economic hardship
- If screening is positive, screen again at next visit and update ICD-10 code as necessary.
- Ask member if they desire assistance with any positive findings and document member response.
- **Connect member with community resources.**
- Warm handoff to care coordinator or behavioral health consultant.

Education, literacy and language

Code	Description
Z55.0	Illiteracy and low-level literacy
Z55.1	Schooling unavailable or unattainable
Z55.2	Failed school examinations
Z55.3	Underachievement in school
Z55.4	Educational maladjustment and discord with teachers and classmates
Z55.8	Other problems related to education and literacy
Z55.9	Problems related to education and literacy, unspecified

Employment

Code	Description
Z56	Problems related to employment and unemployment
Z56.0	Unemployment
Z56.1	Change of job
Z56.2	Threat of job loss
Z56.3	Stressful work schedule
Z56.4	Discord with boss and workmates
Z56.6	Other physical and mental strain related to work
Z56.82	Military deployment status
Z56.89	Other problems related to employment
Z56.9	Unspecified problems related to employment

(Continued on next page.)

Social determinants of health screening (SDOH) (continued)

PCMH
Medicaid

	Code	Description
Housing security	Z59.0	Homelessness
	Z59.1	Inadequate housing
	Z59.2	Discord with neighbors, lodgers or landlord
	Z59.8	Other problems related to housing and economic circumstances
	Z59.9	Problem related to housing and economic circumstances, unspecified
Economic hardships (resources and materials)	**Code**	**Description**
	Z59	Problems related to housing and economic circumstances
	Z59.4	Lack of adequate food and safe drinking water
	Z59.5	Extreme poverty (100% FPL or below)
	Z59.6	Low income (200% FPL or below)
	Z59.7	Insufficient social insurance and welfare support
	Z91.120	Member intentionally under-dosing medication regimen due to financial hardship
Social health	**Code**	**Description**
	Z60	Problems related to social environment
	Z60.0	Problems of adjustment to life-cycle transitions
	Z60.2	Problems related to living alone
	Z60.3	Acculturation difficulty
	Z60.4	Social exclusion and rejection
	Z60.5	Target of (perceived) adverse discrimination/persecution
	Z60.8	Other problems related to social environment
Psychosocial and stress	**Code**	**Description**
	Z64	Problems related to certain psychosocial circumstances
	Z65	Problems related to other psychosocial circumstances
	Z73	Problems related to life management difficulty
	Z73.3	Stress, not elsewhere classified
Experiences with crime, violence and the judicial system	**Code**	**Description**
	Z65.0	Conviction in civil and criminal proceedings without imprisonment
	Z65.1	Imprisonment and other incarceration
	Z65.2	Problems related to release from prison
	Z65.3	Problems related to other legal circumstances
	Z65.4	Victim of crime and terrorism
	Z65.5	Exposure to disaster, war and other hostilities

(Continued on next page.)

Social determinants of health screening (SDOH) (continued)

PCMH
Medicaid

Safety and domestic violence

Code	Description
Z60.4	Social exclusion and rejection
Z62.8	Other specified problems related to upbringing
Z62.81	Personal history of abuse in childhood
Z62.810	Personal history of physical and sexual abuse in childhood
Z62.811	Personal history of psychological abuse in childhood
Z62.812	Personal history of neglect in childhood
Z62.819	Personal history of unspecified abuse in childhood
Z91.41	Personal history of adult abuse
Z91.410	Personal history of adult physical and sexual abuse

Family and social support issues

Code	Description
Z63	Other problems related to primary support group, including family circumstances
Z63.0	Problems in relationship with spouse or partner
Z63.1	Problems in relationship with in-laws
Z63.31	Absence of family member due to military deployment
Z63.32	Other absence of family member
Z63.4	Disappearance and death of family member
Z63.5	Disruption of family by separation and divorce
Z63.6	Dependent relative needing care at home
Z63.71	Stress on family due to return of family member from military deployment
Z63.72	Alcoholism and drug addiction in family
Z63.79	Other stressful life events affecting family and household
Z63.8	Other specified problems related to primary support group
Z63.9	Problem related to primary support group, unspecified

Common chart deficiencies
- Not coding with the ICD-10 for the assessment

Medical record documentation

Medical record dates: Jan. 1, 2021 – Dec. 31, 2021
- Must be captured via ICD-10

Well-child visits in the first 30 months of life (W30) — Commercial, Medicaid

Percentage of children who had the following number of well-child visits with a PCP during the first 30 months of life
- 6+ visits in the first 15 months
- 2+ visits between 15 months and 30 months

Documentation guidelines:
- Visits with a nurse practitioner or physician assistant count

*For more information on EPSDT well visits, see Appendix 5 (Medicaid only).

Frequently utilized provider best practices

- Submit proper codes for a well visit in person or e-visit
- Complete and code for developmental screening (Medicaid - use EP modifier)
- Complete and code for lead testing prior to 24 months (Medicaid - use EP modifier)
- Complete and code for fluoride application at 24 months and older
- A sick visit and well-child visit can be performed on the same day by using modifier 25
- Schedule child's next well visit before member leaves the office
- For more information on well visits, visit **BrightFutures.org**.
- See Appendix 5 for more information on EPSDT

Common codes for this measure
(Note: Codes listed are subject to plan coverage and contracted fee schedule.)

Description	Codes	
Well care	**CPT:**	99381, 99382, 99383, 99384, 99385, 99391, 99392, 99393, 99394, 99395, 99461
	HCPCS:	G0438, G0439, S0302
	ICD10:	Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.2, Z00.3, Z02.5, Z76.1, Z76.2

Common chart deficiencies
- Not using the 25 modifier when appropriate
- Not coding for developmental screenings and using EP modifier
- Not capturing a lead level on children prior to 24 months
- Not applying fluoride or referring to a dentist at 24 months or older

Exclusions

- Members in hospice

Medical record documentation

Medical record dates: first 30 months of life (prior to the 30th month)
- Coding for all services rendered eliminates the need to submit medical records

Fax medical record information to Geisinger Health Plan Quality Department at 570-214-1380.
- Documentation of anticipatory guidance discussion or topics
- Health history
- Mental developmental history
- Physical development history
- Physical exam

Child and adolescent well-care visits (WCV) — Commercial, Medicaid

Percentage of members 3 – 21 years of age who had at least one comprehensive well visit with a PCP or an OB/GYN

Documentation guidelines:
- Visits with a nurse practitioner or physician assistant count

*For more information on EPSDT well visits, see Appendix 5 (Medicaid only).

Frequently utilized provider best practices

- Submit proper codes for well care visits, in person or e-visits.
- Complete and code for developmental screening (Medicaid - use EP modifier)
- Complete and code for fluoride application annually
- Complete and code for hearing, vision, depression screenings, etc.
- A sick visit and well-child visit can be performed on the same day by using the 25 modifier
- Perform T-Dap and Meningococcal vaccines at age 11 and second HPV at age 12
- For more information on well visits, visit **BrightFutures.org.**
- Schedule next well visit at the end of each appointment.

See appendix 5 for more information on EPSDT.

Common codes for this measure
(Note: Codes listed are subject to plan coverage and contracted fee schedule.)

Description	Codes	
Well care	**CPT:**	99381, 99382, 99383, 99384, 99385, 99391, 99392, 99393, 99394, 99395, 99461
	HCPCS:	G0438, G0439, S0302
	ICD10:	Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.2, Z00.3, Z02.5, Z76.1, Z76.2

Common chart deficiencies
- Not using the 25 modifier
- Not coding for developmental screenings and using EP modifier
- Not coding for hearing, vision and depression screenings
- Not completing all immunizations prior to age 13

Exclusions

- Members in hospice

Medical record documentation

Medical record dates: Jan. 1, 2021 – Dec. 31, 2021 for commercial plans; prior to the child's next birthday for Medicaid

Fax medical record information to Geisinger Health Plan Quality Department at 570-214-1380.
- Documentation of anticipatory guidance discussion or topics
- Health history
- Mental developmental history
- Physical developmental history
- Physical exam

Weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)

Commercial, Medicaid

The percentage of members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of the following during the measurement year:

- 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 rather than an absolute BMI value.

Frequently utilized provider best practices

- Use appropriate HEDIS codes to avoid medical record review.
- Avoid missed opportunities by taking advantage of every office visit (including sick visits and sport physicals) to capture BMI percentile, counsel on nutrition and physical activity.
- Services rendered during telephone, e-visit or virtual check-in are acceptable for physical activity and nutrition counseling. Self-reported weights and heights are acceptable.

Common codes for this measure
(Note: Codes listed are subject to plan coverage and contracted fee schedule.)

Description	Codes	
BMI percentile <5% for age	**ICD10:**	Z68.51
BMI percentile 5% to 85% for age		Z68.52
BMI percentile 85% to 95% for age		Z68.53
BMI percentile >95% for age		Z68.54
Nutrition counseling	**CPT:**	97802, 97803, 97804
	HCPCS:	G0270, G0271, G0447, S9449, S9452, S9470
	ICD10:	Z71.3
Physical activity counseling	**HCPCS:**	G0447, S9451
	ICD10:	Z02.5, Z71.82

Common chart deficiencies

- Using only the term “active” (not stating physically active)
- Using the term “good appetite” (does not state what the member is eating)

Exclusions

- Members in hospice
- Any diagnosis of pregnancy during the measurement year

Medical record documentation

Medical record dates: Jan. 1, 2021 – Dec. 31, 2021
Fax medical record information to Geisinger Health Plan Quality Department at 570-214-1380.

- Vitals (height, weight, BMI percent documented or plotted on growth chart
- Nutrition counseling – documentation of discussion or anticipatory guide on nutrition or a referral for nutritional counseling that occurred in 2021, or referral to WIC
- Physical activity counseling – documentation of discussion or anticipatory guidance on physical activity or referral for physical activity that occurred in 2021

Childhood immunization status (CIS)

Commercial, Medicaid

The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB); one chickenpox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday

The measure calculates a rate for each vaccine and nine separate combination rates.

Frequently utilized provider best practices

- Review a child's immunization record before every visit and administer needed vaccines.
- Recommend immunizations to parents. Parents are more likely to agree with vaccinations when supported by the provider. Address common misconceptions about vaccinations.
- Have a system for member reminders.
- Document 2-dose or 3-dose vaccination for rotavirus.

Common codes for this measure
(Note: Codes listed are subject to plan coverage and contracted fee schedule.)

Description	Codes	
DTaP vaccine	CPT:	90698, 90700, 90721, 90723
Inactivated polio vaccine (IPV)	CPT:	90698, 90713, 90723
LAIV Live influenza intranasal vaccine (on second birthday only)	CPT:	90672
Measles, mumps and rubella (MMR)	CPT:	90707, 90710
Measles/rubella vaccine	CPT:	90708
Measles vaccine	CPT:	90705
Measles	ICD10:	B05.0, B05.1, B05.2, B05.3, B05.4, B05.81, B05.89, B05.9
Rubella vaccine	CPT:	90706
Rubella	ICD10:	B06.00, B06.01, B06.02, B06.09, B06.81, B06.82, B06.89, B06.9
Haemophilus influenza type B (HiB)	CPT:	90644, 90645, 90646, 90647, 90648, 90698, 90721, 90748
Hepatitis B vaccine	CPT:	90723, 90740, 90744, 90747, 90748
Hepatitis B	HPCS:	G0010
Hepatitis B	ICD10:	B16.0, B16.1, B16.2, B16.9, B17.0, B18.0, B18.1, B19.10, B19.11, Z22.51
Varicella (VZV) vaccine	CPT:	90710, 90716
Varicella	ICD10:	B01.0, B01.11, B01.12, B01.2, B01.81, B01.89, B01.9, B02.0, B02.1, B02.21, B02.22, B02.23, B02.24, B02.29, B02.30, B02.31, B02.32, B02.33, B02.34, B02.39, B02.7, B02.8, B02.9
Pneumococcal conjugate vaccine	CPT:	90670
	HCPCS:	G0009
Hepatitis A vaccine	CPT:	90633
Hepatitis A	ICD10:	B15.0, B15.9

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Childhood immunization status (CIS) (continued)

Commercial, Medicaid

Common codes for this measure
(Note: Codes listed are subject to plan coverage and contracted fee schedule.)

(Cont.)

Description	Codes	
Rotavirus 2-dose vaccine	**CPT:**	90681
Rotavirus 3-dose vaccine	**CPT:**	90680
Influenza vaccine	**CPT:**	90655, 90657, 90660, 90661, 90662, 90672, 90673, 90685, 90686, 90687, 90688, 90689
	HCPCS:	G0008

Common chart deficiencies
- Giving immunizations after the member's second birthday
- Records not obtained from previous locations
- Not using state registries

Exclusions

- Members in hospice
- Children who had a contraindication for a specific vaccine

Description	Codes	
Any vaccine		
Anaphylactic reaction due to vaccination	**ICD10:**	T80.52XA, T80.52XD, T80.52XS
Dtap		
Encephalopathy due to vaccination	**ICD10:**	G04.32
Vaccine causing adverse effect	**ICD10:**	T50.A15A, T50.A15D, T50.A15S
MMR, VZV and influenza		
Disorders of the immune system	**ICD10:**	D80.0, D80.1, D80.2, D80.3, D80.4, D80.5, D80.6, D80.7, D80.8, D80.9, D81.0, D81.1, D81.2, D81.4, D81.6, D81.7, D81.89, D81.9, D82.0, D82.1, D82.2, D82.3, D82.4, D82.8, D82.9, D83.0, D83.1, D83.2, D83.8, D83.9, D84.0, D84.1, D84.8, D84.9, D89.3, D89.810, D89.811, D89.812, D89.813, D89.82, D89.89, D89.9

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Childhood immunization status (CIS) (continued)

Commercial, Medicaid

Exclusions *(cont.)*

Description	Codes	
HIV	ICD10:	B20, Z21
HIV type 2	ICD10:	B97.35
Malignant neoplasm of lymphatic tissue	ICD10:	C81.00, C81.01, C81.02, C81.03, C81.04, C81.05, C81.06, C81.07, C81.08, C81.09, C81.10, C81.11, C81.12, C81.13, C81.14, C81.15, C81.16, C81.17, C81.18, C81.19, C81.20, C81.21, C81.22, C81.23, C81.24, C81.25, C81.26, C81.27, C81.28, C81.29, C81.30, C81.31, C81.32, C81.33, C81.34, C81.35, C81.36, C81.37, C81.38, C81.39, C81.40, C81.41, C81.42, C81.43, C81.44, C81.45, C81.46, C81.47, C81.48, C81.49, C81.70, C81.71, C81.72, C81.73, C81.74, C81.75, C81.76, C81.77, C81.78, C81.79, C81.90, C81.91, C81.92, C81.93, C81.94, C81.95, C81.96, C81.97, C81.98, C81.99, C82.00, C82.01, C82.02, C82.03, C82.04, C82.05, C82.06, C82.07, C82.08, C82.09, C82.10, C82.11, C82.12, C82.13, C82.14, C82.15, C82.16, C82.17, C82.18, C82.19, C82.20, C82.21, C82.22, C82.23, C82.24, C82.25, C82.26, C82.27, C82.28, C82.29, C82.30, C82.31, C82.32, C82.33, C82.34, C82.35, C82.36, C82.37, C82.38, C82.39, C82.40, C82.41, C82.42, C82.43, C82.44, C82.45, C82.46, C82.47, C82.48, C82.49, C82.50, C82.51, C82.52, C82.53, C82.54, C82.55, C82.56, C82.57, C82.58, C82.59, C82.60, C82.61, C83.02, C83.03, C83.04, C83.05, C83.06, C83.07, C83.08, C83.09, C83.10, C83.11, C83.12, C83.13, C83.14, C83.15, C83.16, C83.17, C83.18, C83.19, C83.30, C83.31, C83.32, C83.33, C83.34, C83.35,

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Childhood immunization status (CIS) (continued)			Commercial, Medicaid
Exclusions *(cont.)*	**Malignant neoplasm of lymphatic tissue** *(cont.)*	**ICD10:**	C83.36, C83.37, C83.38, C83.39, C83.50, C83.51, C83.52, C83.53, C83.54, C83.55, C83.56, C83.57, C83.58, C83.59, C83.70, C83.71, C83.72, C83.73, C83.74, C83.75, C83.76, C83.77, C83.78, C83.79, C83.80, C83.81, C83.82, C83.83, C83.84, C83.85, C83.86, C83.87, C83.88, C83.89, C83.90, C83.91, C83.92, C83.93, C83.94, C83.95, C83.96, C83.97, C83.98, C83.99, C84.00, C84.01, C84.02, C84.03, C84.04, C84.05, C84.06, C84.07, C84.08, C84.09, C84.10, C84.11, C84.12, C84.13, C84.14, C84.15, C84.16, C84.17, C84.18, C84.19, C84.40, C84.41, C84.42, C84.43, C84.44, C84.45, C84.46, C84.47, C84.48, C84.49, C84.60, C84.61, C84.62, C84.63, C84.64, C84.65, C84.66, C84.67, C84.68, C84.69, C84.70, C84.71, C84.72, C84.73, C84.74, C84.75, C84.76, C84.77, C84.78, C84.79, C84.90, C84.91, C84.92, C84.93, C84.94, C84.95, C84.96, C84.97, C84.98, C84.99, C84.A0, C84.A1, C84.A2, C84.A3, C84.A4, C84.A5, C84.A6, C84.A7, C84.A8, C84.A9, C84.Z0, C84.Z1, C84.Z2, C84.Z3, C84.Z4, C84.Z5, C84.Z6, C84.Z7, C84.Z8, C84.Z9, C85.10, C85.11, C85.12, C85.13, C85.14, C85.15, C85.16, C85.17, C85.18, C85.19, C85.20, C85.21, C85.22, C85.23, C85.24, C85.25, C85.26, C85.27, C85.28, C85.29, C85.80, C85.81, C85.82, C85.83, C85.84, C85.85, C85.86, C85.87, C85.88, C85.89, C85.90, C85.91, C85.92, C85.93, C85.94, C85.95, C85.96, C85.97, C85.98, C85.99, C86.0, C86.1, C86.2, C86.3, C86.4, C86.5, C86.6, C88.2, C88.3, C88.4, C88.8, C88.9, C90.00, C90.01, C90.02, C90.10, C90.11, C90.12, C90.20, C90.21, C90.22, C90.30, C90.31, C90.32, C91.00, C91.01, C91.02, C91.10, C91.11, C91.12, C91.30, C91.31, C91.32, C91.40, C91.41, C91.42, C91.50, C91.51, C91.52, C91.60, C91.61, C91.62, C91.90, C91.91, C91.92, C91.A0, C91.A1, C91.A2, C91.Z0, C91.Z1, C91.Z2, C92.00, C92.01, C92.02, C92.10, C92.11, C92.12, C92.20, C92.21, C92.22, C92.30, C92.31, C92.32, C92.40, C92.41, C92.42, C92.50, C92.51, C92.52, C92.60, C92.61, C92.62, C92.90, C92.91, C92.92, C92.A0, C92.A1, C92.A2, C92.Z0, C92.Z1, C92.Z2, C93.00, C93.01, C93.02, C93.10, C93.11, C93.12, C93.30, C93.31, C93.32, C93.90, C93.91, C93.92, C93.Z0, C93.Z1, C93.Z2, C94.00, C94.01, C94.02, C94.20, C94.21, C94.22, C94.30, C94.31, C94.32, C94.80, C94.81, C94.82, C95.00, C95.01, C95.02, C95.10, C95.11, C95.12, C95.90, C95.91, C95.92, C96.0, C96.2, C96.20, C96.21, C96.22, C96.29, C96.4, C96.9, C96.A, C96.Z

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Childhood immunization status (CIS) (continued)			Commercial, Medicaid
Exclusions *(cont.)*	**Rotavirus**		
	Severe combined immunodeficiency	**ICD10:**	D81.0, D81.1, D81.2, D81.9
	Intussusception	**ICD10:**	K56.1
	IPV		
	Anaphylactic reaction to streptomycin, polymyxin B or neomycin.		
	Hepatitis B		
	Anaphylactic reaction to common baker's yeast.		
Medical record documentation	Medical record dates: date of birth to second birthday Fax medical record information to Geisinger Health Plan Quality Department at 570-214-1380. • Immunization records (copies of Department of Health Immunization records are acceptable) • Documentation of contraindication to immunization or parental refusal, if applicable • Copy of birth record indicating if immunization was given "at delivery" or "in hospital" • LAIV/Flu Mist counts		

Immunizations for adolescents (IMA)

Commercial, Medicaid

The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday

Frequently utilized provider best practices

- Use of state registries
- Tdap, meningococcal and first HPV given at age 11 and second HPV before age 13
- Address that HPV causes 6 types of cancer and the vaccine is used as cancer prevention

Common codes for this measure
(Note: Codes listed are subject to plan coverage and contracted fee schedule.)

Description	Codes	
Meningococcal vaccine	**CPT:**	90734
TDaP vaccine	**CPT:**	90715
HPV vaccine	**CPT:**	90649, 90650, 90651

Common chart deficiencies

- Immunizations given after 13th birthday do not count towards compliance.
- Document immunizations given elsewhere (i.e., health departments).

Exclusions

- Members in hospice
- Adolescents who had a contraindication for a specific vaccine

Description	Codes	
Any vaccine		
Anaphylactic reaction due to vaccination	**ICD10:**	T80.52XA, T80.52XD, T80.52XS
Any vaccine		
Encephalopathy due to vaccination	**ICD10:**	G04.32
Vaccine causing adverse effect	**ICD10:**	T50.A15A, T50.A15D, T50.A15S

Medical record documentation

Medical record dates:
Fax medical record information to Geisinger Health Plan Quality Department at 570-214-1380.

- Documentation of immunization administration with date
- 1 TDAP between 10th and 13th birthday
- 1 Meningococcal between 11th and 13th birthday
- 2 (146 days apart) or 3 HPV between 9th and 13th birthday
- If applicable, provide documentation of contraindication to immunization or parental refusal

Lead screening in children (LSC) — Medicaid

Percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday

Documentation guidelines:
- Documentation indicating the date of the lead test
- The result of the lead test

Frequently utilized provider best practices

- Avoid missed opportunities by taking advantage of every office visit to perform lead testing.
- Order lead test at 1-year well visit and revisit this at 18-month well visit.
- Consider a standing order for in-office lead testing.
- Educate parents about the dangers of lead poisoning and the importance of testing.
- If level is great than 5, **refer to GHP's Special Needs Unit (SNU) 855-214-8100** for environmental investigation & collaboration with our team to help with resources.
- Lead test is considered late if performed after the child turns 2 years of age.
- **A lead risk assessment does not satisfy the blood lead test requirement for Medicaid members** regardless of the risk score.
- Communicate options for in-office lead testing, including blood lead analyzer and MedTox filter paper testing.

Common codes for this measure
(Note: Codes listed are subject to plan coverage and contracted fee schedule.)

Description	Codes	
Lead tests	**CPT:**	83655

Common chart deficiencies
- Waiting too long to order the lead test
- Missed opportunity in performing a lead level while child is in the office
- Not documenting the results of the lead screening in members PCP chart

Exclusions

- Members in hospice

Medical record documentation

Members turning age 2 by Dec. 31, 2021
Fax medical record information to Geisinger Health Plan Quality Department at 570-214-1380.
- Lead testing (Pb) – need test result and date (capillary or venous)
- Must be done before member's 2nd birthday

Annual dental visit (ADV) — Medicaid

Percentage of members 2 – 20 years of age who had a least one dental visit during the measurement year; this measure applies only if dental care is a covered benefit in the member's Medicaid contract.

Documentation guidelines:
- One or more dental visits with dental practitioner during the measurement year.
- Any visit with a dental practitioner during the measurement year
- Visits with 1-year-olds may be counted if their second birthday occurs during the measurement year
- Visits for many 1-year-olds will be counted, because the specification includes children whose second birthday occurs during the measurement year.

Frequently utilized provider best practices

- Providers can request to take a one-hour course to be able to bill for certain dental procedures such as fluoride and assessment.
- Educate member and/or family regarding importance of dental/oral health.
- Ask when the last dental appointment was during every well visit.
- Educate and discuss with member and/or family the importance of topical fluoride application.
- Educate member and/or family regarding importance of dental/oral referral.
  - Document history of dental evaluation and/or fluoride application.
  - Have a list of providers for referral.

Healthy Teeth Healthy Children: HealthyTeethHealthyChildren.org
This program of the Pennsylvania Chapter of the American Academy of Pediatrics is a state-wide educational program focused on improving oral healthcare for children by providing education to medical providers.

Smiles for Life Program: SmilesForLifeOralHealth.org
This is a national oral health curriculum that provides educational resources to ensure the integration of oral health and primary care.

Common codes for this measure
(Note: Codes listed are subject to plan coverage and contracted fee schedule.)

Description		Codes	Description
Annual dental visit	**CPT:**	**99188**	Application of topical fluoride varnish by a physician or other qualified health professional *Requires a one-hour training session
		96152	Health and behavior intervention
		96154	Health and behavior intervention with family
	HCPCS:	**KO2.9**	

Common chart deficiencies
- No discussion of oral health importance
- No discussion of fluoride importance
- No documentation of dental visit
- No documentation of fluoride application
- Refer to dentists

Exclusions

- Members in hospice

Medical record documentation

Medical record dates: Jan. 1, 2021 – Dec. 31, 2021
Fax medical record information to Geisinger Health Plan Quality Department at 570-214-1380.

Prenatal care (PPC)

Commercial, Medicaid

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 following facets of prenatal care:

Timeliness of prenatal care — The percentage of deliveries that received a prenatal care visit as a member of the organization during the first trimester, on the enrollment start date or within 42 days of enrollment in the organization

- Prenatal care visit in which the practitioner type is and OB/GYN or other prenatal care practitioner, or a PCP (not a nurse visit)
- A basic physical obstetrical exam including auscultation for fetal heart tone, or pelvic exam with obstetric observations or measurement of fundus height
- Evidence that a prenatal care procedure was performed, such as;
  - A screening test in the form of an obstetric panel (must include hematocrit, differential WBC count, platelet count, hepB surface antigen, rubella antibody, syphilis test, RBC antibody screen, Rh [D] and ABO blood typing); or
  - TORCH antibody panel alone or a Rubella antibody test/titer with a Rh incompatibility (ABO/Rh) blood typing; or
  - Echography of pregnant uterus
- Documentation of LMP, EDD, or gestational age in conjunction with either a complete obstetrical history or a prenatal risk assessment and counseling/education
- If enrollment was after 219 days prior to delivery (21 days into the pregnancy), any visit to a practitioner with a principal diagnosis of pregnancy

Frequently utilized provider best practices

- Schedule prenatal care visits starting in the first trimester or within 42 days of enrollment.
- Ask front office staff to prioritize a new pregnant member and ensure prompt appointments for any member calling for a pregnancy visit to make sure the appointment is in the first trimester or within 42 days of enrollment.
- Have a direct referral process to OB/GYN in place.

Common codes for this measure

(Note: Codes listed are subject to plan coverage and contracted fee schedule.)

Note: The list of pregnancy diagnosis codes is listed in Appendix 7.

Description	Codes	
Deliveries	**CPT:**	59400, 59409, 59410, 59510, 59514, 59515, 59610, 59612, 59614, 59618, 59620, 5962
Prenatal bundled services	**CPT:**	59400, 59425, 59426, 59510, 59610, 59618
	HCPCS:	H1005
Prenatal visits	**CPT:**	99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99483
	HCPCS:	G0463, T1015
Stand-alone prenatal visits	**CPT:**	99500
	CPT II:	0500F, 0501F, 0502F
	HCPCS:	H1000, H1001, H1002, H1003, H1004
Obstetric panel	**CPT:**	80055, 80081
Prenatal ultrasound	**CPT:**	76801, 76805, 76811, 76813, 76815, 76816, 76817, 76818, 76819, 76820, 76821, 76825, 76826, 76827, 76828
	ICD10:	BY49ZZZ, BY4BZZZ, BY4CZZZ, BY4DZZZ, BY4FZZZ, BY4GZZZ

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Prenatal care (PPC) (continued)

Commercial, Medicaid

Common codes for this measure
(Note: Codes listed are subject to plan coverage and contracted fee schedule.)

(Cont.)

Description	Codes	
Toxoplasma antibody	CPT:	86777, 86778
Rubella antibody	CPT:	86762
ABO	CPT:	86900
RH	CPT:	86901
Cytomegalovirus antibody	CPT:	86644
Herpes simplex antibody	CPT:	86694, 86695, 86696

Common chart deficiencies

- Genetic counseling alone does not count as prenatal visit.
- Maternal fetal medicine must contain appropriate components of prenatal visit to count ultrasound and labs alone not considered a visit; must be combined with office visit with appropriate provider
- Visits must be with appropriate provider; doctor, nurse practitioner or midwife

Exclusions

- Members in hospice
- Non-live births

Description	Codes	
Non-live births	ICD10:	O00.0, O00.00, O00.01, O00.1, O00.10, O00.101, O00.102, O00.109, O00.11, O00.111, O00.112, O00.119, O00.2, O00.20, O00.201, O00.202, O00.209, O00.21, O00.211, O00.212, O00.219, O00.8, O00.80, O00.81, O00.9, O00.90, O00.91, O01.0, O01.1, O01.9, O02.0, O02.1, O02.81, O02.89, O02.9, O03.0, O03.1, O03.2, O03.30, O03.31, O03.32, O03.33, O03.34, O03.35, O03.36, O03.37, O03.38, O03.39, O03.4, O03.5, O03.6, O03.7, O03.80, O03.81, O03.82, O03.83, O03.84, O03.85, O03.86, O03.87, O03.88, O03.89, O03.9, O04.5, O04.6, O04.7, O04.80, O04.81, O04.82, O04.83, O04.84, O04.85, O04.86, O04.87, O04.88, O04.89, O07.0, O07.1, O07.2, O07.30, O07.31, O07.32, O07.33, O07.34, O07.35, O07.36, O07.37, O07.38, O07.39, O07.4, O08.0, O08.1, O08.2, O08.3, O08.4, O08.5, O08.6, O08.7, O08.81, O08.82, O08.83, O08.89, O08.9, Z37.1, Z37.4, Z37.7

Medical record documentation

Medical record dates: Oct. 8, 2020 – Oct. 7, 2021
Fax medical record information to Geisinger Health Plan Quality Department at 570-214-1380.

Postpartum care (PPC)

Commercial, Medicaid

A postpartum visit for a pelvic exam or postpartum care on or between 7 and 84 days after delivery. Any of the following meet criteria:

- A postpartum visit
- Cervical cytology
- Pelvic exam
- Evaluation of blood pressure, breasts, and abdomen
- Perineal or cesarean incision/wound check
- Screening for depression anxiety, tobacco use, substance use disorder, or preexisting mental health disorder
- Glucose screening for women with gestational diabetes
- Documentation of the following:
- Infant care or breastfeeding, resumption of intercourse
- Birth spacing or family planning
- Sleep/fatigue
- Resumption of physical activities and attainment of healthy weight
- A bundled service where the organization can identify the date when postpartum care was rendered

Frequently utilized provider best practices

- Schedule your member for postpartum visit within 7 to 84 days from delivery (please note that staple removal following a cesarean section does not count as a postpartum visit for HEDIS.)
- Documentation in the medical record must include a note with the date when the postpartum visit occurred and one of the following:
  - Pelvic exam
  - Evaluation of weight, BP, breast and abdomen
  - Notation of "postpartum care," PP check, PP care, 6-week check, or pre-printed "Postpartum Care" form, on which information was documented during the visit
  - Perineal or cesarean incision/wound check
  - Screening for depression, anxiety, tobacco use, substance use disorder, or preexisting mental health disorders.
  - Glucose screening for women with gestational diabetes
  - Documentation of any of the following:
    - Infant care or breastfeeding
    - Resumption of intercourse
    - Birth spacing or family planning
    - Sleep/fatigue
    - Resumption of physical activities and attainment of healthy weight

Common codes for this measure

(Note: Codes listed are subject to plan coverage and contracted fee schedule.)

Note: The list of pregnancy diagnosis codes is listed in Appendix 7.

Description	Codes	
Postpartum visits	**CPT:**	57170, 58300, 59430, 99501
	CPT II:	0503F
	HCPCS:	G0101
	ICD10:	Z01.411, Z01.419, Z01.42, Z30.430, Z39.1, Z39.2
Cervical cytology	**CPT:**	88141, 88142, 88143, 88147, 88148, 88150, 88152, 88153, 88154, 88164, 88165, 88166, 88167, 88174, 88175
	HCPCS:	G0123, G0124, G0141, G0143, G0144, G0145, G0147, G0148, P3000, P3001, Q0091
Postpartum bundled services	**CPT:**	59400, 59410, 59510, 59515, 59610, 59614, 59618, 59622

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Postpartum care (PPC) (continued)

Commercial, Medicaid

Common chart deficiencies
- If the member had a non-live birth, document that in the medical record.

Exclusions	• Members in hospice
Medical record documentation	Medical record dates: Oct. 8, 2020 – Oct. 7, 2021 Fax medical record information to Geisinger Health Plan Quality Department at 570-214-1380.

Perinatal depression screening

Medicaid

The percentage of enrollees who were;
- Screened for depression during a prenatal care visit
- Screened for depression during a prenatal care visit using a validated depression screening tool
- Screened for depression during the time frame of the first two prenatal care visits
- Screened positive for depression during a prenatal care visit
- Screened positive for depression during a prenatal care visit and had evidence of further evaluation or treatment or referral for further treatment
- Screened for depression during a postpartum care visit
- Screened for depression during postpartum care visit using a validated depression screening tool
- Screened positive for depression during a postpartum care visit
- Screened positive for depression during a postpartum care visit and had evidence of further evaluation or treatment or referral for further treatment

Frequently utilized provider best practices

- Acceptable screening tools:
  - The Edinburgh Postnatal Depression Scale (EPDS)
  - Beck Depression Inventory (BDI 1a, II)
  - Member Health Questionnaire (PHQ) – 2 and PHQ-9 Tools
  - Hamilton Rating Scale for Depression (HRSD)
  - General Health Question (GHQ-D)
  - Postpartum Depression Screening Scale (PDSS)
  - Hospital Anxiety and Depression Scale (HADS)
  - Generalized Contentment Scale
- Positive screening for depression must be referred and receive further follow up.
- Document evidence of current active or postpartum depression treatment for depression.
- Affirmative answers to self-harm, thoughts about death or suicidal ideation.
- Affirmative answers on a depression assessment of suicide risk assessment checklist

Common codes for this measure

(Note: Codes listed are subject to plan coverage and contracted fee schedule.)

Contact your account manager for a list of pregnancy diagnosis codes.

Description	Codes	
Deliveries	**CPT:**	59400, 59409, 59410, 59510, 59514, 59515, 59610, 59612, 59614, 59618, 59620, 5962
Prenatal bundled services	**CPT:**	59400, 59425, 59426, 59510, 59610, 59618
	HCPCS:	H1005
Prenatal visits	**CPT:**	99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99483
	HCPCS:	G0463, T1015
Stand-alone prenatal visits	**CPT:**	99500
	CPT II:	0500F, 0501F, 0502F
	HCPCS:	H1000, H1001, H1002, H1003, H1004
Obstetric panel	**CPT:**	80055, 80081
Prenatal ultrasound	**CPT:**	76801, 76805, 76811, 76813, 76815, 76816, 76817, 76818, 76819, 76820, 76821, 76825, 76826, 76827, 76828

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Perinatal depression screening (continued)

Medicaid

Common codes for this measure
(Note: Codes listed are subject to plan coverage and contracted fee schedule.)

(Cont.)

Description	Codes	
Deliveries	CPT:	59400, 59409, 59410, 59510, 59514, 59515, 59610, 59612, 59614, 59618, 59620, 5962
Prenatal bundled services	CPT:	59400, 59425, 59426, 59510, 59610, 59618
	HCPCS:	H1005
Prenatal visits	CPT:	99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99483
	HCPCS:	G0463, T1015
Stand-alone prenatal visits	CPT:	99500
	CPT II:	0500F, 0501F, 0502F
	HCPCS:	H1000, H1001, H1002, H1003, H1004
Obstetric panel	CPT:	80055, 80081
Prenatal ultrasound	CPT:	76801, 76805, 76811, 76813, 76815, 76816, 76817, 76818, 76819, 76820, 76821, 76825, 76826, 76827, 76828
Toxoplasma antibody	CPT:	86777, 86778
Rubella antibody	CPT:	86762
ABO	CPT:	86900
RH	CPT:	86901
Cytomegalovirus antibody	CPT:	86644
Herpes simplex antibody	CPT:	86694, 86695, 86696

Postpartum coding:

Description	Codes	
Postpartum visits	CPT:	57170, 58300, 59430, 99501
	CPT II:	0503F
	HCPCS:	G0101
	ICD10:	Z01.411, Z01.419, Z01.42, Z30.430, Z39.1, Z39.2
Cervical cytology	CPT:	88141, 88142, 88143, 88147, 88148, 88150, 88152, 88153, 88154, 88164, 88165, 88166, 88167, 88174, 88175
	HCPCS:	G0123, G0124, G0141, G0143, G0144, G0145, G0147, G0148, P3000, P3001, Q0091
Postpartum bundled services	CPT:	59400, 59410, 59510, 59515, 59610, 59614, 59618, 59622

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Perinatal depression screening (continued)

Commercial, Medicaid

Common chart deficiencies

- Documentation of "N/A" will not count as a screening.
- Postpartum depression screenings done prior to discharge will not be counted mental health evaluation for conditions other than depression (e.g., bipolar, ADHD)

Exclusions	**Description**	**Codes**	
	Non-live births	**ICD10:**	O00.0, O00.00, O00.01, O00.1, O00.10, O00.101, O00.102, O00.109, O00.11, O00.111, O00.112, O00.119, O00.2, O00.20, O00.201, O00.202, O00.209, O00.21, O00.211, O00.212, O00.219, O00.8, O00.80, O00.81, O00.9, O00.90, O00.91, O01.0, O01.1, O01.9, O02.0, O02.1, O02.81, O02.89, O02.9, O03.0, O03.1, O03.2, O03.30, O03.31, O03.32, O03.33, O03.34, O03.35, O03.36, O03.37, O03.38, O03.39, O03.4, O03.5, O03.6, O03.7, O03.80, O03.81, O03.82, O03.83, O03.84, O03.85, O03.86, O03.87, O03.88, O03.89, O03.9, O04.5, O04.6, O04.7, O04.80, O04.81, O04.82, O04.83, O04.84, O04.85, O04.86, O04.87, O04.88, O04.89, O07.0, O07.1, O07.2, O07.30, O07.31, O07.32, O07.33, O07.34, O07.35, O07.36, O07.37, O07.38, O07.39, O07.4, O08.0, O08.1, O08.2, O08.3, O08.4, O08.5, O08.6, O08.7, O08.81, O08.82, O08.83, O08.89, O08.9, Z37.1, Z37.4, Z37.7
Medical record documentation	Medical record dates: Oct. 8, 2019 – Oct. 7, 2020 Fax medical record information to Geisinger Health Plan Quality Department at 570-214-1380.		

Prenatal screening for smoking and treatment discussion during a prenatal visit

Medicaid

This performance measure assesses the percentage of pregnant enrollees who were:

- Screened for smoking during the time frame of one of their first two prenatal visits or during the time frame of their first two visits on or following initiation of eligibility with the managed care organization (MCO)
- Screened for environmental tobacco smoke exposure during the time frame of one of their first two prenatal visits or during the time frame of their first two visits on or following initiation of eligibility with the MCO
- Screened for smoking in one of the first two prenatal visits and who smoke (i.e., smoked 6 months prior to or anytime during the current pregnancy), who were given counseling/advice or a referral regarding during the time frame of any prenatal visit during pregnancy
- Screened for environmental tobacco smoke exposure in one of their first two prenatal visits and found to be exposed, that were given counseling/advice or a referral during the time frame or any prenatal visit during pregnancy
- Screened for smoking in one of their first two prenatal visits and found to be a smoker and stopped smoking anytime during their pregnancy

Frequently utilized provider best practices

- Screening and counseling do not have to occur with the same provider or on the same DOS.
- Documentation of a discussion about the risks of smoking and exposure to ETS
- Document "smoker" or "non-smoker."
- Documentation of e-cigarette use and vaping are appropriate screenings.
- Document environmental smoke exposure, not including member's own smoking.

Common codes for this measure

(Note: Codes listed are subject to plan coverage and contracted fee schedule.)

Contact your account manager for a list of pregnancy diagnosis codes.

Description	Codes	
Deliveries	**CPT:**	59400, 59409, 59410, 59510, 59514, 59515, 59610, 59612, 59614, 59618, 59620, 5962
Prenatal bundled services	**CPT:**	59400, 59425, 59426, 59510, 59610, 59618
	HCPCS:	H1005
Prenatal visits	**CPT:**	99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99483
	HCPCS:	G0463, T1015
Stand alone prenatal visits	**CPT:**	99500
	CPT II:	0500F, 0501F, 0502F
	HCPCS:	H1000, H1001, H1002, H1003, H1004
Obstetric panel	**CPT:**	80055, 80081
Prenatal ultrasound	**CPT:**	76801, 76805, 76811, 76813, 76815, 76816, 76817, 76818, 76819, 76820, 76821, 76825, 76826, 76827, 76828
Toxoplasma antibody	**CPT:**	86777, 86778
Rubella antibody	**CPT:**	86762
ABO	**CPT:**	86900
RH	**CPT:**	86901
Cytomegalovirus antibody	**CPT:**	86644
Herpes simplex antibody	**CPT:**	86694, 86695, 86696

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Prenatal screening for smoking and treatment discussion during a prenatal visit (continued)

Medicaid

Common chart deficiencies

- Documentation of "N/A" will not count as a screening.

Exclusions	**Description**	**Codes**	
	Non-live births	**ICD10:**	O00.0, O00.00, O00.01, O00.1, O00.10, O00.101, O00.102, O00.109, O00.11, O00.111, O00.112, O00.119, O00.2, O00.20, O00.201, O00.202, O00.209, O00.21, O00.211, O00.212, O00.219, O00.8, O00.80, O00.81, O00.9, O00.90, O00.91, O01.0, O01.1, O01.9, O02.0, O02.1, O02.81, O02.89, O02.9, O03.0, O03.1, O03.2, O03.30, O03.31, O03.32, O03.33, O03.34, O03.35, O03.36, O03.37, O03.38, O03.39, O03.4, O03.5, O03.6, O03.7, O03.80, O03.81, O03.82, O03.83, O03.84, O03.85, O03.86, O03.87, O03.88, O03.89, O03.9, O04.5, O04.6, O04.7, O04.80, O04.81, O04.82, O04.83, O04.84, O04.85, O04.86, O04.87, O04.88, O04.89, O07.0, O07.1, O07.2, O07.30, O07.31, O07.32, O07.33, O07.34, O07.35, O07.36, O07.37, O07.38, O07.39, O07.4, O08.0, O08.1, O08.2, O08.3, O08.4, O08.5, O08.6, O08.7, O08.81, O08.82, O08.83, O08.89, O08.9, Z37.1, Z37.4, Z37.7
Medical record documentation	Medical record dates: Oct. 8, 2020 – Oct. 7, 2021 Fax medical record information to Geisinger Health Plan Quality Department at 570-214-1380.		

Antidepressant medication management (AMM) — Commercial, Medicare, Medicaid

The percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment; two rates are reported:

- **Effective acute phase treatment** — The percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks)
- **Effective continuation phase treatment** — The percentage of members who remained on an antidepressant medication for at least 180 days (6 months)

Frequently utilized provider best practices

- Monitoring member's adherence with antidepressant RX is important, and providers are a critical link in ensuring the member is compliant.
- Members with chronic medical conditions should be screened for depression. The Member Health Questionnaire (PHQ-9) is a simple and well-recognized tool. The PHQ-9 should be repeated 4 - 8 months after initial elevated PHQ-9.
- Educate members on the following:
  - Most antidepressants take 1 – 6 weeks to work before the member starts to feel better
  - The importance of staying on the antidepressant for a minimum of 6 months
  - Strategies for remembering to take the antidepressant daily
  - The connection between taking an antidepressant and signs and symptoms of improvement
  - What to do if the member has a crisis or has thoughts of self-harm
  - Never stop taking the medication without consulting the provider

Common codes for this measure

(Note: Codes listed are subject to plan coverage and contracted fee schedule.)

Contact your account manager for a list of pregnancy diagnosis codes.

Description	Codes	
Major depression	**ICD10:**	F32.0, F32.1, F32.2, F32.3, F32.4, F32.9, F33.0, F33.1, F33.2, F33.3, F33.41, F33.9

Antidepressant Medications

Description	Prescription	
Miscellaneous antidepressants	Bupropion Vilazodone Vortioxetine	
Monoamine oxidase inhibitors	Isocarboxazid Phenelzine	Selegiline Tranylcypromine
Phenylpiperazine antidepressants	Nefazodone Trazodone	
Psychotherapeutic combinations	Amitriptyline-chlordiazepoxide Amitriptyline-perphenazine Fluoxetine-olanzapine	
SNRI antidepressants	Desvenlafaxine Duloxetine	Levomilnacipran Venlafaxine
SSRI antidepressants	Citalopram Escitalopram Fluoxetine	Fluvoxamine Paroxetine Sertraline

Common codes for this measure (Note: Codes listed are subject to plan coverage and contracted fee schedule.)	**Tetracyclic antidepressants**	Maprotiline Mirtazapine	
	Tricyclic antidepressants	Amitriptyline Amoxapine Clomipramine Desipramine Doxepin (>6 mg) Imipramine Nortriptyline Protriptyline Trimipramine	

Common chart deficiencies

Exclusions	• Members who did not have an encounter with a diagnosis of major depression during the 121-day period from 60 days prior to the IPSD, through the IPSD and the 60 days after the IPSD. • Members in hospice *For a complete list of exclusion codes, contact your account manager.
Medical record documentation	Medical record dates: May 1, 2020 – April 30, 2021 Fax medical record information to Geisinger Health Plan Quality Department at 570-214-1380. **Documentation guidelines:** • Document diagnosis • Educate member about medication compliance - How antidepressants work, benefits, how long they should be used - Length of time on medication before member should expect to feel better • Educate member about depression • Submit claims for continued antidepressant treatment of major depression with 12 weeks of medication management and 6 months of consistent medication management. • Two rates are reported: - Ensure member demonstrates 84 days (12 weeks) of treatment with antidepressant medication - Ensure member demonstrates 180 days (6 months) of treatment with antidepressant medication

Follow-up care for children prescribed ADHD medication (ADD)

Commercial, Medicaid

The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least 3 follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed; 2 rates are reported.

- **Initiation phase** — The percentage of members 6 – 12 years of age as of the IPSD (Index Prescription Start Date) with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with practitioner with prescribing authority during the 30-day initiation phase
- **Continuation and maintenance (C&M) phase** — The percentage of members 6 – 12 years of age as of the IPSD with an ambulatory 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 (9 months) after the initiation phase ended

Frequently utilized provider best practices

- When prescribing a new medication to your member, be sure to schedule a follow-up visit within 30 days.
- Add telehealth and telephone visits in the initiation phase.
- Add e-visits and virtual check-ins to the engagement phase and modified telehealth restrictions.
- Assess how the medication is working. Schedule this visit while your member is still in the office.
- Schedule 2 more visits in the 9 months after the first 30 days, to continue to monitor your member's progress.
- Use a phone visit for one of the visits after the first 30 days. This may help you and your members if getting to the office is difficult.
- Allow no refills until the initial follow up visit is complete.
- Getting to a visit can be difficult. Only one phone visit is allowed during the continuation and maintenance phase. If a phone visit is done, at least one face-to-face visit should be completed. Make sure the visits are coded properly.

Common codes for this measure

(Note: Codes listed are subject to plan coverage and contracted fee schedule.)

Initiation phase

Description	Codes	
Follow-up visits	**CPT:**	90832, 90833, 90834, 90835, 90837, 90838, 90839, 90785, 96150, 96151, 96152, 96153, 96154, 99078, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, 99241, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383,99384, 99391, 99392, 99393, 99394, 99401
Telephone visits	**CPT:**	99441, 99442, 99443 (Can use for one continuation and maintenance phase visit.)

Continuation and maintenance phase

Description	Codes	
Follow-up visits	**CPT:**	90785, 90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90845, 90847, 90849, 90853, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239,99251, 99252, 99253, 99254, 99255

(Continued on next page.)

Follow-up care for children prescribed ADHD medication (ADD) (cont.)

Commercial, Medicaid

Common codes for this measure
(Note: Codes listed are subject to plan coverage and contracted fee schedule.)

ADHD Medications

Description	Codes
CNS stimulants	Amphetamine-dextroamphetamine Dextroamphetamine Dexmethylphenidate Lisdexamfetamine Methylphenidate Methamphetamine
Alpha-2 receptor agonists	Clonidine Guanfacine
Miscellaneous ADHD medications	Atomoxetine

*For additional follow up codes, see your account manager.

Common chart deficiencies
- Using incorrect billing codes
- No documented follow-up within 30 days; no follow-up visits documented within 9 months of the first 30 days

Exclusions

- Members with a diagnosis of narcolepsy any time during their history through Dec. 31 of measurement year
- Members in hospice

Description	Codes	
Narcolepsy	**ICD10:**	G47.411, G47.419, G47.421, G47.429, 347.00, 347.10, 347.11

Medical record documentation

Medical record dates: March 1, 2020 – Feb. 28, 2021
Fax medical record information to Geisinger Health Plan Quality Department at 570- 214-1380.

Documentation guidelines:
- Follow-up visit within 30 days of initial dispensing date to assess how the medication is working and address side effect issues
- 30-day follow-up must be scheduled with a practitioner with prescribing authority
- Two additional follow-up visits for member and family within 9 months of the 30-day (31–300 days) follow-up visit to monitor member's progress on the medication.
- The 2 additional follow-up appointments can be with any practitioner.

Initiation and engagement of alcohol and other drug dependence treatment (IET)

Commercial, Medicare, Medicaid

The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) abuse or dependence who received the following.

- **Initiation of AOD treatment** — The percentage of members who initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth or medication treatment within 14 days of the diagnosis
- **Engagement of AOD treatment** — The percentage of members who initiated treatment and who had two or more additional AOD services or medication treatment within 34 days of the initiation visit

Documentation guidelines:

- Schedule follow-up appointment within 14 days for members with a new episode of alcohol or other drug (AOD) diagnosis.
- Schedule 2 follow-up visits within 34 days of the initial 14-day follow-up visit.
- Include the initial alcohol or other drug dependence diagnosis on every claim when treating a member for issues related to that diagnosis.
- Provide member education on available AOD services in the area.
- Follow-up visits may be with initial provider or substance use disorder provider.

Defined terms:

- *Use* — consumption of drugs or alcohol, can lead to addiction
- *Abuse* — the excessive use of a substance
- *Dependence* — neurons adapt to repeated substance exposure and only function normally in the presence of the substance; when the drug is withdrawn, physiologic reactions occur
- *In remission* — physiologic and psychological readjustments made when the use of a substance is stopped

Frequently utilized provider best practices	• Use screening tools like AUDIT and CAGE to identify substance abuse issues in members. • Document identified substance use disorder in the member chart and submit a claim with the appropriate codes. • Avoid inappropriate use of diagnosis codes that are the result of alcohol or drug dependency, as these also qualify members for the measure. • Schedule a follow up visit to initiate treatment within 14 days of an AOD diagnosis. • Schedule at least 2 additional visits within 34 days after initiation of treatment. • Refer members to substance use disorder providers when appropriate. • Provide members educational material and resources about drug and alcohol treatment options. • Work collaboratively with behavioral health case managers. • Continue ongoing discussions with members about treatment to help increase their willingness to commit to the process, as the timeframe for initiating treatment is brief (14 days). • Ensure progress notes are closed out with provider signature. • Member on therapy for pain management is not classified as “dependence.”

(Continued on next page.)

Initiation and engagement of alcohol and other drug dependence treatment (IET) (cont.)

Commercial, Medicare, Medicaid

Common codes for this measure
(Note: Codes listed are subject to plan coverage and contracted fee schedule.)

Description	Codes	
IET stand-alone visits	**CPT:**	98960, 98961, 98962, 99078, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99384, 99385, 99386, 99387, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99408, 99409, 99411, 99412, 99483, 99510
Telephone visits	**HCPCS:**	G0155, G0176, G0177, G0396, G0397, G0409, G0410, G0411, G0443, G0463, H0001, H0002, H0004, H0005, H0007, H0015, H0016, H0022, H0031, H0034, H0035, H0036, H0037, H0039, H0040, H0047, H2000, H2001, H2010, H2011, H2012, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, H2035, H2036, M0064, S0201, S9480, S9484, S9485, T1006, T1012, T10115
IET visits Group 1	**CPT:**	90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876
IET visits Group 2	**CPT:**	99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99251, 99252, 99253, 99254, 99255

* For alcohol abuse and dependence, AOD dependence, opioid abuse and other drug abuse and dependence codes, contact your account manager.

Common chart deficiencies
- Inappropriate diagnosis codes
- No documented follow-up appointments with appropriate codes
- If member is on therapy for pain management (i.e., methadone), use a code from category Z79.8. If member is taking a drug (i.e., methadone) for heroin addiction use a code from category F11.
- Use remission code if member isn't actively dependent.

Exclusions

- Members in hospice
- Members who had an encounter with a diagnosis of AOD abuse or dependence, AOD medication treatment or an alcohol or opioid dependency treatment medication dispensing event during the 60 days before the IESD

Medical record documentation

Medical record dates: Jan. 1, 2021 – Nov. 14, 2021
Fax medical record information to Geisinger Health Plan Quality Department at 570- 214-1380.

Documentation guidelines:
- Follow-up appointment scheduled within 14 days for members with a new episode of alcohol or other drug (AOD) diagnosis
- Two follow-up visits within 34 days of the initial 14-day follow-up visit
- Include the initial alcohol or other drug dependence diagnosis on every claim when treating a member for issues related to that diagnosis
- Add value sets for opioid treatment services that are billed weekly or monthly to the denominators and numerators
- Provide member education on available AOD services in the area
- Follow-up visits may be with initial provider or substance use disorder provider
- For ED visits resulting in an inpatient stay, the inpatient discharge is the index date

Adherence to antipsychotic medications for individuals with schizophrenia (SAA)

Commercial, Medicare, Medicaid

The percentage of members 19 — 64 years of age 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

Frequently utilized provider best practices

- Schedule appropriate follow-up with the members to evaluate if medication is taken as prescribed.
- Document reason for prescribed medication and member's response.
- Add telephone visits and e-visits to step 1 of the event/diagnosis
- Code to the highest specificity using guidelines.
- Review missing pharmacy refills to ensure members are getting timely refills.
- Place reminder calls to remind members of their appointment.
- Educate members on the importance of staying on the medication.
- Suggest strategies for remembering to take the antidepressant daily.
- Provide education about common side effects, how long the side effects may last and how to manage them.
- Code appropriately using the above codes as guidelines.
- Ensure progress note is closed out with a provider signature.

Common codes for this measure
(Note: Codes listed are subject to plan coverage and contracted fee schedule.)

Description	Codes	
Schizophrenia	**ICD10:**	F20.0, F20.1, F20.2, F20.3, F20.5, F20.81, F20.89, F20.9, F25.0, F25.1, F25.8, F25.9
Long-acting injections	**HPCS:**	J0401, J1631, J2358, J2426, J2680, J2794, J0401, J1631, J2358, J2426, J2680

Antipsychotic Medications

Description	Prescription	
Miscellaneous antipsychotic agents (oral)	Aripiprazole Asenapine Brexpiprazole Cariprazine Clozapine Haloperidol Iloperidone Loxapine	Lurisadone Molindone Olanzapine Paliperidone Quetiapine Quetiapine fumarate Risperidone Ziprasidone
Phenothiazine antipsychotics (oral)	Chlorpromazine Fluphenazine Perphenazine	Prochlorperazine Thioridazine Trifluoperazine
Psychotherapeutic combinations (oral)	Amitriptyline-perphenazine	
Thioxanthenes (oral)	Thiothixene	
Long-acting injections, 14-day supply	Risperidone	
Long-acting injections, 28-day supply	Aripiprazole Fluphenazine decanoate Haloperidol decanoate	Olanzapine Paliperidone palmitate

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Adherence to antipsychotic medications for individuals with schizophrenia (SAA) (continued)

Commercial, Medicare, Medicaid

Common chart deficiencies
- No documentation of appointments to provide education around adherence

Exclusions	• Members with a diagnosis of dementia (refer to Appendix 1) • Members in hospice • Members with advanced illness or frailty enrolled in an I-SNP or living long term in an institutional setting • Members did not have two antipsychotic medication dispensing events, by claim data and by pharmacy data • Use both methods to identify dispensing events, but an event need only be identified by one method to be counted
Medical record documentation	Medical record dates: Jan. 1, 2021 – Dec. 31, 2021 Fax medical record information to Geisinger Health Plan Quality Department at 570- 214-1380. **Documentation guidelines:** • Documentation of schizophrenia diagnosis • Claim documentation of dispensed medication • Claim documentation of continued medication for at least 80% of treatment period • Encourage members with schizophrenia to discuss any side effects • Encourage medication compliance • Telehealth may be used

Metabolic monitoring for children and adolescents on antipsychotics (APM)

Commercial, Medicaid

The percentage of children and adolescents 1 – 17 years of age who had two or more antipsychotic prescriptions on different dates and had metabolic testing (one diabetes screening test and one cholesterol screening test)

Frequently utilized provider best practices

- Document member's response to medication, including the order for glucose and cholesterol levels.
- Document lab results and any action that may be required.
- Use supplemental lab data to update medical records, when applicable.
- Monitor the glucose and cholesterol levels of children and adolescents on antipsychotic medication. Metabolic monitoring is recommended by The American Academy of Child and Adolescent Psychiatry.
- Monitor children on antipsychotic medications to help to avoid metabolic health complications such as weight gain and diabetes.
- Establish a baseline and continuously monitor metabolic indices to ensure appropriate management of side-effects of antipsychotic medication therapy.
- Code appropriately.
- Ensure progress note is closed out with a provider signature.

Common codes for this measure
(Note: Codes listed are subject to plan coverage and contracted fee schedule.)

Description	Codes	
Glucose tests	CPT:	80047, 80048, 80050, 80053, 80069, 82947, 82950, 82951
HbA1c	CPT:	83036, 83037
	CPT II:	3044F, 3045F, 3046F
LDL- C	CPT:	80061, 83700, 83701, 83704, 83721
	CPT II:	3048F, 3049F, 3050F
Cholesterol tests other than LDL	CPT:	82465, 83718, 84478

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Metabolic monitoring for children and adolescents on antipsychotics (APM) (continued)

Commercial, Medicaid

Common codes for this measure
(Note: Codes listed are subject to plan coverage and contracted fee schedule.)

(Cont.)

Antipsychotic Medications

Description	Prescription	
Miscellaneous antipsychotic agents (oral)	Aripiprazole Asenapine Brexpiprazole Cariprazine Clozapine Haloperidol Iloperidone Loxapine	Lurisadone Molindone Olanzapine Paliperidone Quetiapine Quetiapine fumarate Risperidone Ziprasidone
Phenothiazine antipsychotics (oral)	Chlorpromazine Fluphenazine Perphenazine	Prochlorperazine Thioridazine Trifluoperazine
Thioxanthenes (oral)	Thiothixene	
Psychotherapeutic combinations (oral)	Fluoxetine-olanzapine	Perphenazine -amitriptyline
Long-acting injections, 14-day supply	Aripiprazole Fluphenazine decanoate Haloperidol decanoate	Olanzapine Paliperidone palmitate Risperidone

Common chart deficiencies

Exclusions

- Members in hospice

Medical record documentation

Medical record dates: Jan. 1, 2021 – Dec. 31, 2021
Fax medical record information to Geisinger Health Plan Quality Department at 570- 214-1380.

Documentation guidelines:

- Documentation of diagnosis
- Member education of medication compliance
  - How antipsychotics work, benefits, how long they should be used
  - Length of time on medication before member should expect to feel better
  - Importance of continuing medication, even if feeling better
  - Common side effects, how long they may last and how to manage
  - Who to contact with questions and concerns
- Documentation of a diabetic screening test
- Documentation of a cholesterol screening

Follow-up after hospitalization for mental illness (FUH)

Commercial, Medicare, Medicaid

The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health practitioner

Two rates are reported:
- The percentage of discharges for which the member received follow-up within 30 days after discharge
- The percentage of discharges for which the member received follow-up within 7 days after discharge

Frequently utilized provider best practices

- Ensure the member has a plan for follow-up visit with a mental health practitioner within 7 and 30 days after discharge. Do not include visits that occur on the date of discharge.
- Schedule the member's aftercare appointment prior to discharge
- Educate inpatient and outpatient providers about the measure and the clinical practice guidelines
- Attempt to alleviate barriers to attending appointments prior to discharge
- Review medications with members to ensure they understand the purpose, appropriate frequency and method of administration.

Common codes for this measure
(Note: Codes listed are subject to plan coverage and contracted fee schedule.)

Description	Codes	
Visit setting unspecified	**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, 99251, 99252, 99253, 99254, 99255
Telehealth modifier	**Modifier**	95, GT
BH outpatient	**CPT:**	98960, 98961, 98962, 99078, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 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, 99510
	HCPCS:	G0155, G0176, G0177, G0409, G0463, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, M0064, T1015
Partial hospitalization/ intensive outpatient	**HCPCS:**	G0410, G0411, H0035, H2001, H2012, S0201, S9480, S9484, S9485
Electroconvulsive therapy	**CPT:**	90870
	ICD10:	GZB0ZZZ, GZB1ZZZ, GZB2ZZZ, GZB3ZZZ, GZB4ZZZ
Observation	**CPT:**	99217, 99218, 99219, 99220
Transitional care management services	**CPT:**	99495, 99496

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Follow-up after hospitalization for mental illness (FUH) (continued)	Commercial, Medicare, Medicaid
Common chart deficiencies	
Exclusions	• Members in hospice • Discharges followed by readmission or direct transfer to a non-acute inpatient care setting within the 30-day follow-up period, regardless of principal diagnosis for the readmission • Both the initial discharge and the readmission/direct transfer discharge, if the last discharge occurs after Dec. 1 of the measurement year
Medical record documentation	Medical record dates: Jan. 1, 2021 – Dec. 31, 2021 Fax medical record information to Geisinger Health Plan Quality Department at 570- 214-1380.

Asthma medication ratio (AMR)

Commercial, Medicaid

The percentage of members 5 – 64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year

Frequently utilized provider best practices

- Integrate review of proper inhaler usage into every encounter with an asthma member
- Review medication list to ensure member has prescriptions for both controller and reliever medications
- Document reason for prescribed medication and member's response
- Schedule proper follow-up with the members to evaluate if medications are taken as prescribed
- Convert member's controller medication to a 90-day supply at mail order or retail pharmacy to boost adherence
- Review missing pharmacy refills to ensure members are getting timely refills
- Educate members on the importance taking the controller medications regularly
- Code to the highest specificity using guidelines
- Provide medication compliance education

Common codes for this measure

(Note: Codes listed are subject to plan coverage and contracted fee schedule.)

Description	Codes	
Asthma	**ICD10:**	J45.20, J45.21, J45.22, J45.30, J45.31, J45.32, J45.40, J45.41, J45.42, J45.50, J45.51, J45.52, J45.901, J45.902, J45.909, J45.990, J45.991, J45.998
ED	**CPT:**	99281, 99282, 99283, 99284, 99285
Acute inpatient	**CPT:**	99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99251, 99252, 99253, 99254, 99255, 99291
Outpatient	**CPT:**	99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 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, 99429, 99455, 99456, 99483
	HCPCS:	G0402, G0438, G0439, G0463, T1015
Telephone visit	**CPT:**	98966, 98967, 98968, 99441, 99442, 99443
Telehealth modifiers	**Modifier:**	95, GT

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Asthma medication ratio (AMR) (continued)

Commercial, Medicaid

Common codes for this measure
(Note: Codes listed are subject to plan coverage and contracted fee schedule.)

(cont.)

Asthma Controller Medications

Description	Prescription	
Antiasthmatic combinations	Dyphylline-guaifenesin	
Antibody inhibitors	Omalizumab	
Anti-interleukin-4	Dupilumab	
Anti-interleukin-5	Benralizumab Mepolizumab	Reslizumab
Inhaled steroid combinations	Budesonide-formoterol Fluticasone-salmeterol	Fluticasone-vilanterol Mometasone-formoterol
Inhaled corticosteroids	Beclomethasone Budesonide Ciclesonide	Flunisolide Fluticasone CFC free Mometasone
Leukotriene modifiers	Montelukast Zafirlukast	Zileuton
Methylxanthines	Theophylline	

Asthma reliever medications

Short-acting, inhaled beta-2 agonists	Albuterol	Levalbuterol

Common chart deficiencies
- No documentation of review of medications at every visit
- No documentation of conversation about the importance of medication compliance

Exclusions

- Members who had any diagnosis from any of the following value sets, anytime during the member's history through Dec. 31 of the measurement year:

Description	Codes	
Emphysema	**ICD10:**	J43.0, J43.1, J43.2, J43.8, J43.9, J98.2, J98.3
COPD	**ICD10:**	J44.0, J44.1, J44.9
Obstructive chronic bronchitis		No ICD10 Codes only ICD9
Chronic respiratory conditions due to fumes/ vapors	**ICD10:**	J68.4
Cystic fibrosis	**ICD10:**	E84.0, E84.11, E84.19, E84.8, E84.9
Acute respiratory failure	**ICD10:**	J96.00, J96.01, J96.02, J96.20, J96.21, J96.22

- Members who had no asthma medications dispensed during the measurement year
- Members in hospice

Medical record documentation

Medical record dates: Jan. 1, 2020 – Dec. 31, 2020
Fax medical record information to Geisinger Health Plan Quality Department at 570- 214-1380.

Cardiac rehabilitation (CRE)

Commercial, Medicare, Medicaid

The percentage of mnembers 18 years and older who attended cardiac rehabilitation following a qualifying cardiac event, including myocardial infarction, percutaneous coronary intervention, coronary artery bypass grafting, heart and heart/lung transplantation and heart valve repair/replacement

Frequently utilized provider best practices	• Schedule cardiac rehabilitation for up to 36 sessions within the first 180 days from the cardiac event. • Code correctly for rehabilitation sessions.
Common codes for this measure (Note: Codes listed are subject to plan coverage and contracted fee schedule.)	

Common chart deficiencies

- Sessions not scheduled in a timely manner after cardiac event
- Sessions not coded appropriately

Exclusions	• Refer to Appendix 1 for frailty, advanced illness and dementia medication exclusions • Members under palliative care *For a complete list of exclusion codes, contact your account manager.
Medical record documentation	Medical record dates: Jul. 1, 2020 – Jun. 30, 2021 Fax medical record information to Geisinger Health Plan Quality Department at 570- 214-1380.

Statin therapy for members with cardiovascular disease (SPC)

Commercial, Medicare, Medicaid

The percentage of males 21–75 years of age and females 40–75 years of age during the measurement year, who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and met the following criteria.

The following rates are reported:

- **Received statin therapy** — Members who were dispensed at least one high-intensity or moderate-intensity statin medication during the measurement year
- **Statin Adherence 80%** — Members who remained on a high-intensity or moderate-intensity statin medication for at least 80% of the treatment period

Frequently utilized provider best practices

- Integrate statin therapy evaluation into every encounter with a cardiovascular member.
- Review member medication list to ensure current statin therapy and to determine statin use history.
- Re-trial members on statins, when appropriate, and document true member intolerance to statins accurately.
- Document reason for prescribed medication and member's response.
- Schedule proper follow-up with the members to evaluate if medication is taken as prescribed.
- Convert member's statin medication to a 90-day supply at mail order or retail pharmacy to boost adherence.
- Review missing pharmacy refills to ensure members are getting timely refills.
- Educate members on the importance of staying on the medication.
- Code to the highest specificity using guidelines.

Common codes for this measure

(Note: Codes listed are subject to plan coverage and contracted fee schedule.)

High- and moderate-intensity statin medications

Description	Prescription	
High-intensity statin therapy	Atorvastatin 40-80 mg Amlodipine-atorvastatin 40-80 mg G46	Rosuvastatin 20-40 mg Simvastatin 80 mg Ezetimibe-simvastatin 80 mg
Moderate-intensity statin therapy	Atorvastatin 10-20 mg Amlodipine-atorvastatin 10-20 mg Rosuvastatin 5-10 mg Simvastatin 20-40 mg Ezetimibe-simvastatin 20-40 mg	Pravastatin 40-80 mg Lovastatin 40 mg Fluvastatin XL 80 mg Fluvastatin 40 mg bid Pitavastatin 2–4 mg

Common chart deficiencies

- No documentation of review of medications at every visit
- No documentation of conversation about the importance of medication compliance

Exclusions

- Refer to Appendix 1 for frailty, advanced illness and dementia medication exclusions.
- Members in hospice
- Exclude members who meet any of the following criteria:
  - Female members with a diagnosis of pregnancy during the measurement year or the year prior to the measurement year
  - In vitro fertilization in the measurement year or year prior to the measurement year
  - Dispensed at least one prescription for clomiphene during the measurement year or the year prior to the measurement year
  - ESRD during the measurement year or the year prior to the measurement year
  - Cirrhosis during the measurement year or the year prior to the measurement year
  - Myalgia, myositis, myopathy or rhabdomyolysis during the measurement year

*For a complete list of exclusion codes, contact your account manager.

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Statin therapy for members with cardiovascular disease (SPC) (continued)

Commercial, Medicare, Medicaid

Exclusions

- Refer to Appendix 1 for frailty, advanced illness and dementia medication exclusions.
- Members in hospice
- Exclude members who meet any of the following criteria:
  - Female members with a diagnosis of pregnancy during the measurement year or the year prior to the measurement year
  - In vitro fertilization in the measurement year or year prior to the measurement year
  - Dispensed at least one prescription for clomiphene during the measurement year or the year prior to the measurement year
  - ESRD during the measurement year or the year prior to the measurement year
  - Cirrhosis during the measurement year or the year prior to the measurement year
  - Myalgia, myositis, myopathy or rhabdomyolysis during the measurement year

*For a complete list of exclusion codes, contact your account manager.

Medical record documentation

Medical record dates: Jan. 1, 2020 – Dec. 31, 2020
Fax medical record information to Geisinger Health Plan Quality Department at 570- 214-1380.

Description	Codes	
MI	ICD10:	I21.01, I21.02, I21.09, I21.11, I21.19, I21.21, I21.29, I21.3, I21.4, I21.9, I21.A1, I21.A9, I22.0, I22.1, I22.2, I22.8, I22.9, I23.0, I23.1, I23.2, I23.3, I23.4, I23.5, I23.6, I23.7, I23.8, I25.2
CABG	CPT:	33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33533, 33534, 33535, 33536
	HCPCS:	S2205, S2206, S2207, S2208, S2209
	ICD10:	0210083, 0210088, 0210089, 0210093, 0210098, 0210099, 0211083, 0211088, 0211089, 0211093, 0211098, 0211099, 0212083, 0212088, 0212089, 0212093, 0212098, 0212099, 0213083, 0213088, 0213089, 0213093, 0213098, 0213099, 021008C, 021008F, 021008W, 021009C, 021009F, 021009W, 02100A3, 02100A8, 02100A9, 02100AC, 02100AF, 02100AW, 02100J3, 02100J8, 02100J9, 02100JC, 02100JF, 02100JW, 02100K3, 02100K8, 02100K9, 02100KC, 02100KF, 02100KW, 02100Z3, 02100Z8, 02100Z9, 02100ZC, 02100ZF, 021108C, 021108F, 021108W, 021109C, 021109F, 021109W, 02110A3, 02110A8, 02110A9, 02110AC, 02110AF, 2110AW, 02110J3, 02110J8, 02110J9, 02110JC, 02110JF, 02110JW, 02110K3, 02110K8, 02110K9, 02110KC, 02110KF, 02110KW, 02110Z3, 02110Z8, 02110Z9, 02110ZC, 02110ZF, 021208C, 021208F, 021208W, 021209C, 021209F, 021209W, 02120A3, 02120A8, 02120A9, 02120AC, 02120AF, 02120AW, 02120J3, 02120J8, 02120J9, 02120JC, 02120JF, 02120JW, 02120K3, 02120K8, 02120K9, 02120KC, 02120KF, 02120KW, 02120Z3, 02120Z8, 02120Z9, 02120ZC, 02120ZF, 021308C, 021308F, 021308W, 021309C, 021309F, 021309W, 02130A3, 02130A8, 02130A9, 02130AC, 02130AF, 02130AW, 02130J3, 02130J8, 02130J9, 02130JC, 02130JF, 02130JW, 02130K3, 02130K8, 02130K9, 02130KC, 02130KF, 2130KW, 02130Z3, 02130Z8, 02130Z9, 02130ZC, 02130ZF

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Statin therapy for members with cardiovascular disease (SPC) (continued)

Commercial, Medicare, Medicaid

Description	Codes	
PCI	CPT:	92920, 92924, 92928, 92933, 92937, 92941, 92943, 92980, 92982, 92995
	HCPCS:	C9600, C9602, C9604, C9606, C9607
	ICD-10:	0270346, 0270356, 0270366, 0270376, 0270446, 0270456, 0270466, 0270476, 0271346, 0271356, 0271366, 0271376, 0271446, 0271456, 0271466, 0271476, 0272346, 0272356, 0272366, 0272376, 0272446, 0272456, 0272466, 0272476, 0273346, 0273356, 0273366, 0273376, 0273446, 0273456, 0273466, 0273476, 02703E6, 02704E6, 02713E6, 02714E6, 02723E6, 02724E6, 02733E6, 02734E6, 027034Z, 027035Z, 027036Z, 027037Z, 02703D6, 02703DZ, 02703EZ, 02703F6, 02703FZ, 02703G6, 02703GZ, 02703T6, 02703TZ, 02703Z6, 02703ZZ, 027044Z, 027045Z, 027046Z, 027047Z, 02704D6, 02704DZ, 02704EZ, 02704F6, 02704FZ, 02704G6, 02704GZ, 02704T6, 02704TZ, 02704Z6, 02704ZZ, 027134Z, 027135Z, 027136Z, 027137Z, 02713D6, 02713DZ, 02713EZ, 02713F6, 02713FZ, 02713G6, 02713GZ, 02713T6, 02713TZ, 02713Z6, 02713ZZ, 027144Z, 027145Z, 027146Z, 027147Z, 02714D6, 02714DZ, 02714EZ, 02714F6, 02714FZ, 02714G6, 02714GZ, 02714T6, 02714TZ, 02714Z6, 02714ZZ, 027234Z, 027235Z, 027236Z, 027237Z, 02723D6, 02723DZ, 02723EZ, 02723F6, 02723FZ, 02723G6, 02723GZ, 02723T6, 02723TZ, 02723Z6, 02723ZZ, 027244Z, 027245Z, 027246Z, 027247Z, 02724D6, 02724DZ, 02724EZ, 02724F6, 02724FZ, 02724G6, 02724GZ, 02724T6, 02724TZ, 02724Z6, 02724ZZ, 027334Z, 027335Z, 027336Z, 027337Z, 02733D6, 02733DZ, 02733EZ, 02733F6, 02733FZ, 02733G6, 02733GZ, 02733T6, 02733TZ, 02733Z6, 02733ZZ, 027344Z, 027345Z, 027346Z, 027347Z, 02734D6, 02734DZ, 02734EZ, 02734F6, 02734FZ, 02734G6, 02734GZ, 02734T6, 02734TZ, 02734Z6, 02734ZZ
Other revascularization	CPT:	37220, 37221, 37224, 37225, 37226, 37227, 37228, 37229, 37230, 37231

Statin therapy for members with diabetes (SPD)

Commercial, Medicare, Medicaid

The percentage of members 40 – 75 years of age during the measurement year with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) who met the following criteria

Two rates are reported:

- **Received Statin Therapy** — Members who were dispensed at least one statin medication of any intensity during the measurement year
- **Statin Adherence 80%** — Members who remained on a statin medication of any intensity for at least 80% of the treatment period

Frequently utilized provider best practices

- Integrate statin therapy evaluation into every encounter with a diabetic member.
- Review member medication list to ensure current statin therapy and to determine statin use history
- Re-trial members on statins when appropriate and document true member intolerance to statins accurately.
- Document reason for prescribed medication and member's response.
- Schedule proper follow-up with the members to evaluate if medication is taken as prescribed.
- Convert member's statin medication to a 90-day supply at mail order or retail pharmacy to boost adherence.
- Review missing pharmacy refills to ensure members are getting timely refills.
- Educate members on the importance of staying on the medication.
- Code to the highest specificity using guidelines.

Common codes for this measure

(Note: Codes listed are subject to plan coverage and contracted fee schedule.)

Description	Codes	
Diabetes	**ICD10:**	E10.10, E10.11, E10.21, E10.22, E10.29, E10.311, E10.319, E10.321, E10.3211, E10.3212, E10.3213, E10.3219, E10.329, E10.3291, E10.3292, E10.3293, E10.3299, E10.331, E10.3311, E10.3312, E10.3313, E10.3319, E10.339, E10.3391, E10.3392, E10.3393, E10.3399, E10.341, E10.3411, E10.3412, E10.3413, E10.3419, E10.349, E10.3491, E10.3492, E10.3493, E10.3499, E10.351, E10.3511, E10.3512, E10.3513, E10.3519, E10.3521, E10.3522, E10.3523, E10.3529, E10.3531, E10.3532, E10.3533, E10.3539, E10.3541, E10.3542, E10.3543, E10.3549, E10.3551, E10.3552, E10.3553, E10.3559, E10.359, E10.3591, E10.3592, E10.3593, E10.3599, E10.36, E10.37X1, E10.37X2, E10.37X3, E10.37X9, E10.39, E10.40, E10.41, E10.42, E10.43, E10.44, E10.49, E10.51, E10.52, E10.59, E10.610, E10.618, E10.620, E10.621, E10.622, E10.628, E10.630, E10.638, E10.641, E10.649, E10.65, E10.69, E10.8, E10.9, E11.00, E11.01, E11.10, E11.11, E11.21, E11.22, E11.29, E11.311, E11.319, E11.321, E11.3211, E11.3212, E11.3213, E11.3219, E11.329, E11.3291, E11.3292, E11.3293, E11.3299, E11.331, E11.3311, E11.3312, E11.3313, E11.3319, E11.339, E11.3391, E11.3392, E11.3393, E11.3399, E11.341, E11.3411, E11.3412, E11.3413, E11.3419, E11.349, E11.3491, E11.3492, E11.3493, E11.3499, E11.351, E11.3511, E11.3512, E11.3513, E11.3519, E11.3521, E11.3522, E11.3523, E11.3529, E11.3531, E11.3532, E11.3533, E11.3539, E11.3541, E11.3542, E11.3543, E11.3549, E11.3551, E11.3552, E11.3553, E11.3559,

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Statin therapy for members with diabetes (SPD) (continued)

Commercial, Medicare, Medicaid

Common codes for this measure

(Note: Codes listed are subject to plan coverage and contracted fee schedule.)

(Continued)

Description	Codes	
Diabetes	ICD10:	E11.359, E11.3591, E11.3592, E11.3593, E11.3599, E11.36, E11.37X1, E11.37X2, E11.37X3, E11.37X9, E11.39, E11.40, E11.41, E11.42, E11.43, E11.44, E11.49, E11.51, E11.52, E11.59, E11.610, E11.618, E11.620, E11.621, E11.622, E11.628, E11.630, E11.638, E11.641, E11.649, E11.65, E11.69, E11.8, E11.9, E13.00, E13.01, E13.10, E13.11, E13.21, E13.22, E13.29, E13.311, E13.319, E13.321, E13.3211, E13.3212, E13.3213, E13.3219, E13.329, E13.3291, E13.3292, E13.3293, E13.3299, E13.331, E13.3311, E13.3312, E13.3313, E13.3319, E13.339, E13.3391, E13.3392, E13.3393, E13.3399, E13.341, E13.3411, E13.3412, E13.3413, E13.3419, E13.349, E13.3491, E13.3492, E13.3493, E13.3499, E13.351, E13.3511, E13.3512, E13.3513, E13.3519, E13.3521, E13.3522, E13.3523, E13.3529, E13.3531, E13.3532, E13.3533, E13.3539, E13.3541, E13.3542, E13.3543, E13.3549, E13.3551, E13.3552, E13.3553, E13.3559, E13.359, E13.3591, E13.3592, E13.3593, E13.3599, E13.36, E13.37X1, E13.37X2, E13.37X3, E13.37X9, E13.39, E13.40, E13.41, E13.42, E13.43, E13.44, E13.49, E13.51, E13.52, E13.59, E13.610, E13.618, E13.620, E13.621, E13.622, E13.628, E13.630, E13.638, E13.641, E13.649, E13.65, E13.69, E13.8, E13.9, O24.011, O24.012, O24.013, O24.019, O24.02, O24.03, O24.111, O24.112, O24.113, O24.119, O24.12, O24.13, O24.311, O24.312, O24.313, O24.319, O24.32, O24.33, O24.811, O24.812, O24.813, O24.819, O24.82, O24.83
Acute inpatient	CPT:	99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99251, 99252, 99253, 99254, 99255, 99291
	CPT:	99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 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, 99429, 99455, 99456, 99483
Outpatient	HCPCS:	G0402, G0438, G0439, G0463, T1015
Observation	CPT:	99217, 99218, 99219, 99220
Nonacute inpatient	CPT:	99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99318, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337

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Statin therapy for members with diabetes (SPD) (continued)

Commercial, Medicare, Medicaid

Common codes for this measure

(Note: Codes listed are subject to plan coverage and contracted fee schedule.)

(Continued)

Diabetes medications

Description	Prescription	
Alpha-glucosidase inhibitors	Acarbose	Miglitol
Amylin analogs	Pramlinitide	
Antidiabetic combinations	Alogliptin-metformin Alogliptin-pioglitazone Canagliflozin-metformin Dapagliflozin-metformin Empaglifozin-linagliptin Empagliflozin-metformin Glimepiride-pioglitazone Glipizide-metformin	Glyburide-metformin Linagliptin-metformin Metformin-pioglitazone Metformin-repaglinide Metformin-rosiglitazone Metformin-saxagliptin Metformin-sitagliptin
Insulin	Insulin aspart Insulin aspart-insulin aspart protamine Insulin degludec Insulin detemir Insulin glargine Insulin glulisine	Insulin isophane human Insulin isophane-insulin regular Insulin lispro Insulin lispro-insulin lispro protamine Insulin regular human Insulin human inhaled
Meglitinides	Nateglinide	Repaglinide
Glucagon-like peptide-1 (GLP1) agonists	Dulaglutide Exenatide	Albiglutide Liraglutide
Sodium glucose cotransporter 2 (SGLT2) inhibitor	Canagliflozin Dapagliflozin	Empagliflozin
Sulfonylureas	Chlorpropamide Glimepiride Glipizide	Glyburide Tolazamide Tolbutamide
Thiazolidinediones	Pioglitazone	Rosiglitazone
Dipeptidyl peptidase-4 (DDP-4) inhibitors	Alogliptin Linagliptin	Saxagliptin Sitagliptin

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Statin therapy for members with diabetes (SPD) (continued)

Commercial, Medicare, Medicaid

Common codes for this measure

(Note: Codes listed are subject to plan coverage and contracted fee schedule.)

(Continued)

High- and Moderate-Intensity Statin Medications

Description	Prescription	
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 Pitavastatin 1 mg	Pitavastatin 2–4 mg Pravastatin 40-80 mg Lovastatin 40 mg Fluvastatin XL 80 mg Fluvastatin 40 mg bid
Low-intensity statin therapy	Simvastatin 10 mg Ezetimibe-simvastatin 10 mg Pravastatin 10–20 mg	Lovastatin 20 mg Fluvastatin 20–40 mg

*For more follow up codes, see your account manager.

Common chart deficiencies

- No documentation of review of medications at every visit
- No documentation of conversation about the importance of medication compliance.

Exclusions

- Refer to Appendix 1 for frailty, advanced illness and dementia medication, exclusions.
- Members who do not have a diagnosis of diabetes, in any setting, during the measurement year or the year prior to the measurement year and who had a diagnosis of gestational diabetes or steroid-induced diabetes, in any setting, during the measurement year or the year prior to the measurement year
- Members with cardiovascular disease identified in by event or by diagnosis
- Members in hospice

*For a complete list of exclusion codes, see your account manager.

Medical record documentation

Medical record dates: Jan. 1, 2020 – Dec. 31, 2020
Fax medical record information to Geisinger Health Plan Quality Department at 570- 214-1380.

Persistence of beta blocker treatment after a heart attack (PBH)

Commercial, Medicare, Medicaid

Percentage of members 18 years of age and older during the measurement year who were hospitalized and discharged from July 1 of the year prior to the measurement year to June 30 of the measurement year with a diagnosis of acute myocardial infarction (AMI), and who received beta blocker treatment for 6 months after discharge

Documentation guidelines:

- Identify all acute and nonacute inpatient stays
- Identify the admission and discharge dates for the stay
- Exclude all nonacute inpatient stays
- Identify the discharge date for the stay
- Direct transfer to an acute inpatient care setting
- Exclude all direct transfers to a nonacute inpatient care setting
- Direct transfers (discharge date from the first inpatient setting precedes the admission date to a second inpatient setting by one day or less)

Frequently utilized provider best practices

- Integrate beta-blocker therapy evaluation into every encounter with a recent heart attack member
- Review member medication list to ensure current beta-blocker therapy and determine beta-blocker use history
- Document true member intolerance to beta-blockers accurately
- Document reason for prescribed medication and member's response
- Schedule proper follow-up with the members to evaluate if medications are taken as prescribed
- Convert member's beta-blocker medication to a 90-day supply at mail order or retail pharmacy to boost adherence
- Review missing pharmacy refills to ensure members are getting timely refills
- Educate members on the importance of staying on the medication
- Code to the highest specificity using guidelines

Common codes for this measure

(Note: Codes listed are subject to plan coverage and contracted fee schedule.)

AMI	**ICDM10:**	I21.01, I21.02, I21.09, I21.11, I21.19, I21.21, I21.29, I21.3, I21.4, I21.9, I21.A1, I21.A9
Nonacute inpatient stay	**CPT:**	99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99318, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337

Beta-Blocker Medications

Description	Prescription	
Noncardioselective beta-blockers	Carvedilol Propranolol Labetalol Timolol	Nadolol Sotalol Pindolol
Cardioselective beta-blockers	Acebutolol Bisoprolol Atenolol	Metoprolol Betaxolol Nebivolol
Antihyertensive combinations	Atenolol-chlorthalidone Bendroflumethiazide-nadolol Bisoprolol-hydrochlorothiazide Hydrochlorothiazide-metoprolol Hydrochlorothiazide-propranolol	

(Continued on next page.)

Persistence of beta blocker treatment after a heart attack (PBH) (continued)

Commercial, Medicare, Medicaid

Common chart deficiencies

- Use the incorrect admission/discharge.
- Review medication list at every visit.
- Educate patient about the importance of medication compliance.
- Obtain admission/discharge information.
- For encounters occurring while the myocardial infarction is equal to or less than 4 weeks old, including transfers to another acute setting or a post-acute setting, codes from category I21 may continue to be reported.
- For encounters after the 4-week timeframe in which the member is still receiving care related to the MI, the appropriate after care code should be assigned, rather than a code from category I21.
- For an old or healed (history of) MI that is older than 4 weeks and no longer requires care, assign code I25.2, old myocardial infarction.

Exclusions

- Members identified as having an intolerance or allergy to beta-blocker therapy
- Members in hospice
- Members with the following diagnoses in their medical history:
  - History of asthma
  - Chronic respiratory conditions due to fumes/vapors
  - COPD
  - Obstructive chronic bronchitis
  - Hypotension
  - Heart block >1st degree
  - Sinus bradycardia, medication dispensing event indicative of a history of asthma

Asthma exclusions medications

Description	Prescription	
Bronchodilator combinations	Budesonide-formoterol Fluticasone-salmeterol	Fluticasone-vilanterol Mometasone-formoterol
Inhales corticosteroids	Beclomethasone Flunisolide Mometasone Budesonide	Fluticasone Ciclesonide Fluticasone CFC free

Refer to Appendix 1 for exclusion codes and dementia medications.
For more exclusion codes for persistent of beta blocker treatment after a heart attack measure, contact your account manager.

Medical record documentation

Medical record dates: Jan. 1, 2020 – Dec. 31, 2020
Fax medical record information to Geisinger Health Plan Quality Department at 570-214-1380.

Potentially harmful drug-disease interactions in the elderly (DDE) — Medicare

The percentage of Medicare members 65 years of age and older who have evidence of an underlying disease, condition or health concern and who were dispensed an ambulatory prescription for a potentially harmful medication, concurrent with or after the diagnosis

Report each of the three rates separately and as a total rate.

- A history of falls and a prescription for antiepileptics, antipsychotics, benzodiazepines, nonbenzodiazepine hypnotics or antidepressants (SSRIs, tricyclic antidepressants and SNRIs)
- Dementia and a prescription for antipsychotics, benzodiazepines, nonbenzodiazepine hypnotics, tricyclic antidepressants, or anticholinergic agents
- Chronic kidney disease and prescription for Cox-2 selective NSAIDs or non-aspirin NSAIDs
- Total rate (the sum of the three numerators divided by the sum of the three denominators)

Members with more than one disease or condition may appear in the measure multiple times (i.e., in each indicator for which they qualify). A lower rate represents better performance for all rates.

Frequently utilized provider best practices

- Integrate a disease state review and medication review into every encounter with an elderly member.
- Review member diagnoses for history of falls, dementia and chronic kidney disease and avoid respective harmful drug classes.
- Replace harmful drug classes with appropriate alternatives when one of these diagnoses are present.
- Before prescribing a new medication for an elderly member with one of these diagnoses, check first that it is not in a potentially harmful class for the member condition.
- Document reason for prescribed medication and member's response.
- Code to the highest specificity using guidelines.

Common codes for this measure
(Note: Codes listed are subject to plan coverage and contracted fee schedule.)

Potentially Harmful Drugs Rate 1
Rate 1: Drug-disease interactions — history of falls and antiepileptics, SSRIs, antipsychotics, benzodiazepines, nonbenzodiazepine hypnotics or tricyclic antidepressants

Description	Prescription	
Antiepileptics	Carbamazepine Fosphenytoin Phenobarbital Clobazam Gabapentin Phenytoin Divalproex sodium Lacosamide Pregabalin Ethosuximide Lamotrigine Primidone	Ethotoin Levetiracetam Rufinamide Ezogabine Methsuximide Tiagabine HCL Valproate sodium Valproic acid Vigabatrin Zonisamide
SNRIs	Desvenlafaxine Duloxetine	Levomilnacipran Venlafaxine
SSRIs	Citalopram Fluoxetine Paroxetine	Escitalopram Fluvoxamine Sertraline

(Continued on next page.)

Potentially harmful drug-disease interactions in the elderly (DDE) (continued)

Medicare

Common codes for this measure

(Note: Codes listed are subject to plan coverage and contracted fee schedule.)

(Cont.)

Potentially harmful drugs, Rate 1 and Rate 2

Description	Prescription	
Antipsychotics	Aripiprazole Fluphenazine Olanzapine Asenapine Haloperidol Paliperidone Brexpiprazole Iloperidone Perphenazine Cariprazine Loxapine	Pimozide Quetiapine Chlorpromazine Lurasidone Risperidone Clozapine Molindone Thioridazine Thiothixene Trifluoperazine Ziprasidone
Benzodiazepines	Alprazolam Clorazepate-dipotassium Diazepam Flurazepam HCL Chlordiazepoxide products Lorazepam	Clonazepam Estazolam Midazolam HCL Oxazepam Quazepam Temazepam
Nonbenzodiazepine hypnotics	Eszopiclone Zaleplon	Zolpidem
Tricyclic antidepressants	Amitriptyline Amoxapine Clomipramine Desipramine Doxepin (>6 mg)	Imipramine Nortriptyline Protriptyline Trimipramine

Rate 2

Drug-disease interactions — dementia and antipsychotics, benzodiazepines, nonbenzodiazepine hypnotics, tricyclic antidepressants, H2 receptor antagonists or anticholinergic agents

Dementia medications

Description	Prescription	
Cholinesterase inhibitors	Donepezil Galantamine	Rivastigmine
Miscellaneous central nervous system agents	Memantine	

(Continued on next page.)

Potentially harmful drug-disease interactions in the elderly (DDE) (continued)

Medicare

Common codes for this measure

(Note: Codes listed are subject to plan coverage and contracted fee schedule.)

(Cont.)

Potentially harmful drugs rate 2

Anticholinergic agents, antiemetics	Prochlorperazine	Promethazine
Anticholinergic agents, antihistamines	Carbinoxamine Chlorpheniramine Hydroxyzine Brompheniramine Clemastine Triprolidine Cyproheptadine	Dimenhydrinate Diphenhydramine Meclizine Dexbrompheniramine Dexchlorpheniramine Doxylamine
Anticholinergic agents, antispasmodics	Atropine Homatropine Belladonna alkaloids Dicyclomine	Hyoscyamine Propantheline Scopolamine Clidinium-chlordiazepoxide
Anticholinergic agents, antimuscarinics (oral)	Darifenacin Fesoterodine Solifenacin Trospium	Flavoxate Oxybutynin Tolterodine
Anticholinergic agents, anti-Parkinson agents	Benztropine	Trihexyphenidyl
Anticholinergic agents, skeletal muscle relaxants	Cyclobenzaprine	Orphenadrine
Anticholinergic agents, SSRIs	Paroxetine	
Anticholinergic agents, antiarrhythmic	Disopyramide	

Rate 3: Drug-disease interactions — chronic kidney disease and cox-2 selective NSAIDs or non-aspirin NSAIDs

Cox-2 Selective NSAIDs and non-aspirin NSAIDs medications

Description	Prescription	
Cox-2 selective NSAIDs	Celecoxib	
Non-aspirin NSAIDs	Diclofenac potassium Diclofenac sodium Etodolac Fenoprofen Flurbiprofen Ibuprofen Indomethacin Ketoprofen Ketorolac Meclofenamate	Mefenamic acid Meloxicam Nabumetone Naproxen Piroxicam Naproxen sodium Oxaprozin Sulindac Tolmetin

(Continued on next page.)

Potentially harmful drug-disease interactions in the elderly (DDE) (continued)

Medicare

Common codes for this measure
(Note: Codes listed are subject to plan coverage and contracted fee schedule.)

(Cont.)

Description		Codes
Use for rate 1, rate 2, rate 3		
Falls	ICD10:	W01.0XXA, W01.0XXD, W01.0XXS, W01.10XA, W01.10XD, W01.10XS, W01.110A, W01.110D, W01.110S, W01.111A, W01.111D, W01.111S, W01.118A, W01.118D, W01.118S, W01.119A, W01.119D, W01.119S, W01.190A, W01.190D, W01.190S, W01.198A, W01.198D, W01.198S, W06.XXXA, W06.XXXD, W06.XXXS, W07.XXXA, W07.XXXD, W07.XXXS, W08.XXXA, W08.XXXD, W08.XXXS, W10.0XXA, W10.0XXD, W10.0XXS, W10.1XXA, W10.1XXD, W10.1XXS, W10.2XXA, W10.2XXD, W10.2XXS, W10.8XXA, W10.8XXD, W10.8XXS, W10.9XXA, W10.9XXD, W10.9XXS, W18.00XA, W18.00XD, W18.00XS, W18.01XA, W18.01XD, W18.01XS, W18.02XA, W18.02XD, W18.02XS, W18.09XA, W18.09XD, W18.09XS, W18.11XA, W18.11XD, W18.11XS, W18.12XA, W18.12XD, W18.12XS, W18.2XXA, W18.2XXD, W18.2XXS, W18.30XA, W18.30XD, W18.30XS, W18.31XA, W18.31XD, W18.31XS, W18.39XA, W18.39XD, W18.39XS, W18.40XA, W18.40XD, W18.40XS, W18.41XA, W18.41XD, W18.41XS, W18.42XA, W18.42XD, W18.42XS, W18.43XA, W18.43XD, W18.43XS, W18.49XA, W18.49XD, W18.49XS, W19.XXXA, W19.XXXD, W19.XXXS
Hip fractures	CPT:	27230, 27232, 27235, 27236, 27238, 27240, 27244, 27245, 27246, 27248, 27254, 27267, 27268, 27269
	ICD10:	M97.01XA, M97.02XA, S72.001A, S72.001B, S72.001C, S72.002A, S72.002B, S72.002C, S72.009A, S72.009B, S72.009C, S72.011A, S72.011B, S72.011C, S72.012A, S72.012B, S72.012C, S72.019A, S72.019B, S72.019C, S72.021A, S72.021B, S72.021C, S72.022A, S72.022B, S72.022C, S72.023A, S72.023B, S72.023C, S72.024A, S72.024B, S72.024C, S72.025A, S72.025B, S72.025C, S72.026A, S72.026B, S72.026C, S72.031A, S72.031B, S72.031C, S72.032A, S72.032B, S72.032C, S72.033A, S72.033B, S72.033C, S72.034A, S72.034B, S72.034C, S72.035A, S72.035B, S72.035C, S72.036A, S72.036B, S72.036C, S72.041A, S72.041B, S72.041C, S72.042A, S72.042B, S72.042C, S72.043A, S72.043B, S72.043C, S72.044A, S72.044B, S72.044C, S72.045A, S72.045B, S72.045C, S72.046A, S72.046B, S72.046C, S72.051A, S72.051B, S72.051C, S72.052A, S72.052B, S72.052C, S72.059A, S72.059B, S72.059C, S72.061A, S72.061B, S72.061C, S72.062A, S72.062B, S72.062C, S72.063A, S72.063B, S72.063C, S72.064A, S72.064B, S72.064C, S72.065A, S72.065B, S72.065C, S72.066A, S72.066B, S72.066C, S72.091A, S72.091B, S72.091C, S72.092A, S72.092B, S72.092C, S72.099A, S72.099B, S72.099C, S72.101A, S72.101B, S72.101C, S72.102A, S72.102B, S72.102C, S72.109A, S72.109B, S72.109C, S72.111A, S72.111B, S72.111C, S72.112A, S72.112B, S72.112C,

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Potentially harmful drug-disease interactions in the elderly (DDE) (continued)

Medicare

Common codes for this measure
(Note: Codes listed are subject to plan coverage and contracted fee schedule.)

(Cont.)

Description		Codes
Use for rate 1, rate 2, rate 3		
Hip fractures *(Cont.)*	ICD10: *(Cont.)*	S72.113A, S72.113B, S72.113C, S72.114A, S72.114B, S72.114C, S72.115A, S72.115B, S72.115C, S72.116A, S72.116B, S72.116C, S72.121A, S72.121B, S72.121C, S72.122A, S72.122B, S72.122C, S72.123A, S72.123B, S72.123C, S72.124A, S72.124B, S72.124C, S72.125A, S72.125B, S72.125C, S72.126A, S72.126B, S72.126C, S72.131A, S72.131B, S72.131C, S72.132A, S72.132B, S72.132C, S72.133A, S72.133B, S72.133C, S72.134A, S72.134B, S72.134C, S72.135A, S72.135B, S72.135C, S72.136A, S72.136B, S72.136C, S72.141A, S72.141B, S72.141C, S72.142A, S72.142B, S72.142C, S72.143A, S72.143B, S72.143C, S72.144A, S72.144B, S72.144C, S72.145A, S72.145B, S72.145C, S72.146A, S72.146B, S72.146C, S72.21XA, S72.21XB, S72.21XC, S72.22XA, S72.22XB, S72.22XC, S72.23XA, S72.23XB, S72.23XC, S72.24XA, S72.24XB, S72.24XC, S72.25XA, S72.25XB, S72.25XC, S72.26XA, S72.26XB, S72.26XC
Outpatient	CPT:	99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 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, 99429, 99455, 99456, 99483
ED	CPT:	99281, 99282, 99283, 99284, 99285
Observation	CPT:	99217, 99218, 99219, 99220
Use for Rate 3		
ESRD	CPT:	36147, 36800, 36810, 36815, 36818, 36819, 36820, 36821, 36831, 36832, 36833, 90935, 90937, 90940, 90945, 90947, 90951, 90952, 90953, 90954, 90955, 90956, 90957, 90958, 90959, 90960, 90961, 90962, 90963, 90964, 90965, 90966, 90967, 90968, 90969, 90970, 90989, 90993, 90997, 90999, 99512
	HCPCS:	G0257, S9339
	ICD10:	N18.5, N18.6, Z91.15, Z99.2, 3E1M39Z, 5A1D00Z, 5A1D60Z, 5A1D70Z, 5A1D80Z, 5A1D90Z
CKD stage 4	ICD10:	N18.4
Kidney transplant	CPT:	50300, 50320, 50340, 50360, 50365, 50370, 50380
	HCPCS:	S2065
	ICD10:	Z94.0, 0TY00Z0, 0TY00Z1, 0TY00Z2, 0TY10Z0, 0TY10Z1, 0TY10Z2

Potentially harmful drug-disease interactions in the elderly (DDE) (continued)

Medicare

Common chart deficiencies

Exclusions

- Members in hospice
- Members with the following diagnosis between Jan. 1 of the year prior to Dec. 1 of measurement year

Description	Codes	
Psychosis	ICD10:	F06.0, F06.1, F06.2, F06.30, F06.31, F06.32, F06.33, F06.34, F06.4, F06.8, F22, F23, F24, F28, F29, F30.2, F31.2, F31.5, F31.64, F32.3, F33.3, F44.89
Schizophrenia	ICD10:	F20.0, F20.1, F20.2, F20.3, F20.5, F20.81, F20.89, F20.9, F25.0, F25.1, F25.8, F25.9
Bipolar disorder	ICD10:	F30.10, F30.11, F30.12, F30.13, F30.2, F30.3, F30.4, F30.8, F30.9, F31.0, F31.10, F31.11, F31.12, F31.13, F31.2, F31.30, F31.31, F31.32, F31.4, F31.5, F31.60, F31.61, F31.62, F31.63, F31.64, F31.70, F31.71, F31.72, F31.73, F31.74, F31.75, F31.76, F31.77, F31.78, F31.81, F31.89, F31.9
Seizure disorders	ICD10:	G40.001, G40.009, G40.011, G40.019, G40.101, G40.109, G40.111, G40.119, G40.201, G40.209, G40.211, G40.219, G40.301, G40.309, G40.311, G40.319, G40.401, G40.409, G40.411, G40.419, G40.501, G40.509, G40.801, G40.802, G40.803, G40.804, G40.811, G40.812, G40.813, G40.814, G40.821, G40.822, G40.823, G40.824, G40.89, G40.901, G40.909, G40.911, G40.919, G40.A01, G40.A09, G40.A11, G40.A19, G40.B01, G40.B09, G40.B11, G40.B19,

Medical record documentation

Medical record dates: Jan. 1, 2020 – Dec. 1, 2020
Fax medical record information to Geisinger Health Plan Quality Department at 570-214-1380.

Use of high-risk medication in older adults (DAE) — Medicare

- The percentage of Medicare members 67 years of age and older who had at least two dispensing events for the same high-risk medication

Three rates are reported:

1. The percentage of Medicare members 67 years of age and older who had at least two dispensing events for high-risk medications to avoid from the same drug class
2. The percentage of Medicare members 67 years of age and older who had at least two dispensing events for high-risk medications to avoid from the same drug class, except for appropriate diagnoses
3. Total rate (the sum of the two numerators divided by the denominator, deduplicating for members in both numerators)

The measure reflects potentially inappropriate medication use in older adults, both for medications for which any use is inappropriate (rate 1) and for medications for which use under all but specific indications is potentially inappropriate (rate 2)

For both rates, a lower rate represents better performance.

Frequently utilized provider best practices

- Integrate a high-risk medication review into every encounter with an elderly member.
- Review member medication list to ensure it does not include any high-risk medications.
- Replace high-risk medications with appropriate alternatives.
- Before prescribing a new medication for an elderly member, check first that it is not a high-risk medication.
- Document reason for prescribed medication and member's response.
- Code to the highest specificity using guidelines.

Common codes for this measure

(Note: Codes listed are subject to plan coverage and contracted fee schedule.)

Description	Prescription	
High-risk medications		
Anticholinergics, first-generation antihistamines	Brompheniramine Carbinoxamine Chlorpheniramine Clemastine Cyproheptadine Dexbrompheniramine Dexchlorpheniramine	Diphenhydramine (oral) Dimenhydrinate Doxylamine Hydroxyzine Meclizine Promethazine Triprolidine
Anticholinergics, anti-Parkinson agents	Benztropine (oral)	Trihexyphenidyl
Antispasmodics	Atropine (exclude ophthalmic) Belladonna alkaloids Clidinium-chlordiazepoxide Dicyclomine	Hyoscyamine Propantheline Scopolamine
Antithrombotics	Dipyridamole, oral short-acting	Ticlopidine (does not apply to the extended-release combination with aspirin)
Cardiovascular, alpha agonists, central	Guanfacine	Methyldopa
Cardiovascular, other	Disopyramide	Nifedipine, immediate release
Central nervous system, antidepressants	Amitriptyline Clomipramine Amoxapine Desipramine Imipramine	Trimipramine Nortriptyline Paroxetine Protriptyline

(Continued on next page.)

Use of high-risk medication in older adults (DAE) (continued)

Medicare

Common codes for this measure

(Note: Codes listed are subject to plan coverage and contracted fee schedule.)

(Cont.)

Description	Prescription	
High-risk medications		
Central nervous system, barbiturates	Amobarbital Butabarbital Butalbital	Pentobarbital Phenobarbital Secobarbital
Central nervous system, vasodilators	Ergot mesylates	Isoxsuprine
Central nervous system, other	Meprobamate	
Endocrine system, estrogens with or without progestins; include only oral and topical patch products	Chlorpropamide	Glyburide
Endocrine system, other	Desiccated thyroid	Megestrol
Endocrine system, sulfonylureas, long-duration	Chlorpropamide Glimepiride Glyburide	
Nonbenzodiazepine hypnotics	Eszopiclone Zaleplon Zolpidem	
Pain medications, skeletal muscle relaxants	Carisoprodol Chlorzoxazone Cyclobenzaprine	Metaxalone Methocarbamol Orphenadrine
Pain medications, other	Indomethacin Pentazocine	Ketorolac, includes parenteral Meperidine
High-risk medications with days' supply criteria	**Days' supply criteria**	
Anti-Infectives, other	Nitrofurantoin Nitrofurantoin macrocrystals Nitrofurantoin macrocrystals-monohydrate	>90 days
High-risk medications with average daily dose criteria medication	**Average Daily Dose Criteria**	
Alpha agonists, central	Reserpine	>0.1 mg/day
Cardiovascular, other	Digoxin	>0.125 mg/day
Tertiary TCAs (as single agent or as part of combination products)	Doxepin	>6 mg/day

(Continued on next page.)

Use of high-risk medication in older adults (DAE) (continued)

Medicare

Common chart deficiencies
- No documentation of review of medications at every visit
- No documentation of conversation about the importance of medication compliance.

Exclusions	• Members in hospice
Medical record documentation	Medical record dates: Jan. 1, 2020 – Dec. 31, 2020 Fax medical record information to Geisinger Health Plan Quality Department at 570- 214-1380.

Use of opioids at high dosage (HDO)

Commercial, Medicare, Medicaid

The proportion of members 18 years and older, receiving prescription opioids for ≥15 days during the measurement year at a high dosage (average milligram morphine dose [MME] >90 mg)

Frequently utilized provider best practices

- Integrate a review of the necessity and appropriateness of opioid therapy into every encounter with a member taking an opioid medication.
- Before prescribing an opioid medication, consider first line or non-pharmacologic treatment options.
- Prior to prescribing an opioid medication, check the Prescription Drug Monitoring Program (PDMP) at pennsylvania.pmpaware.net/login to avoid duplication of therapy and diversion.
- Limit prescriptions to the shortest duration needed to treat condition (<15 days duration).
- Limit dose to the lowest effective dose needed to treat condition (<90 MME).
- Schedule proper follow-up with the members to evaluate if dose can be decreased via taper or medication can be discontinued.
- Document reason for prescribed medication and member's response.
- Code to the highest specificity using guidelines.

Common codes for this measure

(Note: Codes listed are subject to plan coverage and contracted fee schedule.)

UOD Opioid Medications

Benzhydrocodone	Hydromorphone	Oxycodone
Butorphanol	Levorphanol	Oxymorphone
Codeine	Meperidine	Pentazocine
Dihydrocodeine	Morphine	Tapentadol
Fentanyl	Opium	Tramadol
Hydrocodone		

Type of opioid	Milligram morphine equivalent (MME) conversion factor
Benzhydrocodone	1.2
Butorphanol	7
Codeine	0.15
Dihydrocodeine	0.25
Fentanyl buccal, SL tablets or lozenge/ troche (mcg)3	0.13
Fentanyl film or oral spray (mcg)4	0.18
Fentanyl nasal spray (mcg)5	0.16
Fentanyl transdermal patch (mcg/hr)6	7.2
Hydrocodone	1
Hydromorphone	4
Levorphanol tartrate	11
Meperidine hydrochloride	0.1
Methadone7	3
Morphine	1
Opium	1
Oxycodone	1.5
Oxymorphone	3
Pentazocine	0.37
Tapentadol	0.4
Tramadol	0.1

(Continued on next page.)

Use of opioids at high dosage (HDO) (continued)

Medicare

Common chart deficiencies
- No documentation of review of medications at every visit
- No documentation of conversation about the importance of medication compliance.

Exclusions	• Members in hospice • Use of methadone treatment
Medical record documentation	Medical record dates: Jan. 1, 2020 – Dec. 31, 2020 Fax medical record information to Geisinger Health Plan Quality Department at 570-214-1380. **Documentation guidelines:** • Identification of member being prescribed opioids • Ensure supply is not for more than 15 days, unless due to malignant neoplasms or sickle cell anemia • Identification of members being prescribed opioids by multiple providers

Risk of continued opioid use (COU)

Commercial, Medicare, Medicaid

The percentage of members 18 years of age and older who have a new episode of opioid use that puts them at risk for continued opioid use

Two rates are reported:
- The percentage of members whose new episode of opioid use lasts at least 15 days in a 30-day period
- The percentage of members whose new episode of opioid use lasts at least 31 days in a 62-day period

Frequently utilized provider best practices	• Integrate a review of the necessity and appropriateness of opioid therapy into every encounter with a member taking an opioid medication. • Before prescribing an opioid medication, consider first line or non-pharmacologic treatment options. • Prior to prescribing an opioid medication, check the Prescription Drug Monitoring Program (PDMP) at pennsylvania.pmpaware.net/login to avoid duplication of therapy and diversion. • Limit prescriptions to the shortest duration needed to treat condition (<15 days duration). • Schedule proper follow-up with the members to evaluate if dose can be decreased via taper or medication can be discontinued. • Document reason for prescribed medication and member's response. • Code to the highest specificity using guidelines.
Common codes for this measure (Note: Codes listed are subject to plan coverage and contracted fee schedule.)	**HDO Opioid Medications** Benzhydrocodone Buprenorphine (transdermal patch and buccal film) Butorphanol Codeine Dihydrocodeine Fentanyl Hydrocodone Hydromorphone Levorphanol Meperidine Methadone Morphine Opium Oxycodone Oxymorphone Pentazocine Tapentadol Tramadol
Common chart deficiencies	
Exclusions	• Members in hospice • Use of methadone
Medical record documentation	Medical record dates: Jan. 1, 2020 – Dec. 31, 2020 Fax medical record information to Geisinger Health Plan Quality Department at 570-214-1380.

Pharmacotherapy management of COPD (PCE)

Commercial, Medicare, Medicaid

The percentage of COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or ED visit on or between Jan. 1 – Nov. 30 of the measurement year, and who were dispensed appropriate medications

Two rates are reported:
- Dispensed a systemic corticosteroid (or there was evidence of an active prescription) within 14 days of the event
- Dispensed a bronchodilator (or there was evidence of an active prescription) within 30 days of the event

Frequently utilized provider best practices

- Review medication list to ensure member has prescriptions for both a systemic corticosteroid and a bronchodilator
- Document reason for prescribed medication and member's response
- Schedule proper follow-up with the patents to evaluate if medications are taken as prescribed
- Convert member's systemic corticosteroid medication to a 90-day supply at mail order or retail pharmacy to boost adherence
- Educate members on the importance taking the systemic corticosteroid regularly
- Code to the highest specificity using guidelines

Common codes for this measure
(Note: Codes listed are subject to plan coverage and contracted fee schedule.)

Description	Codes	
COPD	ICD10:	J44.0, J44.1, J44.9
ED	CPT:	99281, 99282, 99283, 99284, 99285
Emphysema	ICD10:	J43.0, J43.1, J43.2, J43.8, J43.9, J98.2, J98.3
Outpatient	CPT:	99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 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, 99429, 99455, 99456, 99483
	HCPCS:	G0402, G0438, G0439, G0463, T1015
Chronic Bronchitis	ICD10:	J41.0, J41.1, J41.8, J42
Nonacute Inpatient	CPT:	99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99318, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337

Systemic corticosteroid medications

Description	Prescription	
Glucocorticoids	Cortisone-acetate Dexamethasone Hydrocortisone	Methylprednisolone Prednisolone Prednisone

(Continued on next page.)

Pharmacotherapy management of COPD (PCE) (continued)

Commercial, Medicare, Medicaid

Common codes for this measure
(Note: Codes listed are subject to plan coverage and contracted fee schedule.)

(cont.)

Bronchodilator medications

Description	Prescription	
Anticholinergic agents	Aclidinium-bromide Ipratropium	Tiotropium Umeclidinium
Beta 2-agonists	Albuterol Arformoterol Formoterol Formoterol-glycopyrrolate	Indacaterol Levalbuterol Metaproterenol Salmeterol
Bronchodilator combinations	Albuterol-ipratropium Budesonide-formoterol Dyphylline-guaifenesin Fluticasone-salmerterol Fluticasone-vilanterol Fliticasone furoate-umeclidinium-vilanterol	Formoterol-aclidinium Formoterol-glycopyrrolate Formoterol-mometasone Indacaterol-glycopyrrolate Olodaterol hydrochloride Umeclidinium-vilanterol

Common chart deficiencies

- Acute COPD exacerbations codes are only to be used if it is current at that visit. Once it has resolved, only code the COPD (codes from categories J44-J45).

Exclusions

- Members in hospice are excluded from the eligible population.
- Members in hospice are excluded.

Medical record documentation

Medical record dates: Jan. 1, 2020 – Nov. 30, 2020
Fax medical record information to Geisinger Health Plan Quality Department at 570-214-1380.

Transitions of care (TRC)

Medicare

The percentage of discharges for members 18 years of age and older who had each of the following

Four rates are reported:

- **Notification of inpatient admission** — Documentation of receipt of notification of inpatient admission on the day of admission through two days after admission (3 total days)
- **Receipt of discharge information** — Documentation of receipt of discharge information on the day of discharge through two days after the admission (3 total days)
- **Member engagement after inpatient discharge** — Documentation of member engagement (e.g., office visits, visits to the home, telehealth) provided within 30 days after discharge
- **Medication reconciliation post-discharge** — Documentation of medication reconciliation on the date of discharge through 30 days after discharge (31 total days)

(MEDICARE ONLY)

Frequently utilized provider best practices

- Identify all acute and nonacute inpatient stays.
- Identify the discharge date for the stay.
- Identify the admission date for the stay.
- Member engagement provided within 30 days after discharge. Do not include member engagement that occurs on the date of discharge.
- Medication reconciliation conducted by a prescribing practitioner, clinical pharmacist or registered nurse on the date of discharge through 30 days after discharge.

Common codes for this measure
(Note: Codes listed are subject to plan coverage and contracted fee schedule.)

Description	Codes	
Acute inpatient	**CPT:**	99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99251, 99252, 99253, 99254, 99255, 99291

Common chart deficiencies

Exclusions

- Members in hospice
- Exclude both the initial and the readmission/direct transfer discharge if the last discharge occurs after Dec. 1 or the measurement year.

Medical record documentation

Medical record dates: Jan. 1, 2020 – Dec. 1, 2020
Fax medical record information to Geisinger Health Plan Quality Department at 570-214-1380.

- Notification of inpatient admission to the member's PCP or ongoing care provider
- Documentation of discharge information to the member's PCP or ongoing care provider
- Documentation of member follow up or member engagement within 30 days of discharge (e.g., office visits, home visits, telehealth) to the member's PCP or ongoing care provider
- Medication reconciliation within 30 days of discharge (31 total days) to the member's PCP or ongoing care provider

Comprehensive diabetes care (CDC)

Commercial, Medicare, Medicaid ★

The percentage of members 18 – 75 years of age with diabetes (type 1 and type 2) who had each of the following:
- Hemoglobin A1c (HbA1c) testing.
- HbA1c poor control (>9.0%) lower is better
- HbA1c control (<8.0%)
- Eye exam (retinal) performed
- Medical attention for nephropathy (Medicare)
- BP control (<140/90 mm Hg)

Frequently utilized provider best practices

- Bill for point of care testing if completed in office and ensure HbA1c result and date are documented in the chart.
- Adjust therapy to improve HbA1c and BP levels; follow-up with members to monitor changes.
- Make sure digital eye exam, remote imaging and fundus photography are read by an eye care professional (optometrist or ophthalmologist) so the results count.
- Member's blood pressure <140/90; retake at end of appointment.
- Use 3072F if member's eye exam was negative or showed low risk for retinopathy in the prior year.
- Nephropathy screening test — any of the following urine tests for albumin or protein or treatment in measurement year;
  - 24- hour urine for albumin or protein
  - Timed urine for albumin or protein
  - Spot urine for albumin or protein and result
  - Urine for albumin/creatinine ratio
  - 24-hour urine for total protein result
  - Random urine for protein/creatine ratio or evidence of nephropathy
  - Evidence ACE/ARB currently taken during measurement year

Common codes for this measure
(Note: Codes listed are subject to plan coverage and contracted fee schedule.)

Refer to Appendix 2 and Appendix 3 for diabetes medication and ACE/ARB medications.

HBA1c Tests		
HBA1c Tests	**CPT:**	83036, 83037
	CPT II:	3051F – Most recent HGBA1C level 7.0% - 8.0% 3052F – Most recent HGBA1C level 8.0%- 9.0% 3046F – Most recent HGBA1C level > 9.0%
Diabetic retinal screening (eye exam)	**CPT:**	67028, 67030, 67031, 67036, 67039, 67040, 67041, 67042, 67043, 67101, 67105, 67107, 67108, 67110, 67113, 67121, 67141, 67145, 67208, 67210, 67218, 67220, 67221, 67227, 67228, 92002, 92004, 92012, 92014, 92018, 92019, 92134, 92225, 92226, 92227, 92228, 92230, 92235, 92240, 92250, 92260, 99203, 99204, 99205, 99213, 99214, 99215, 99242, 99243, 99244, 99245
	CPT II:	3072F (negative screening), 2022F, 2024F, 2026F
	HCPCS:	S0620, S0621, S3000

(Continued on next page.)

Comprehensive diabetes care (CDC) (continued)

Commercial, Medicare, Medicaid ★

Common codes for this measure
(Note: Codes listed are subject to plan coverage and contracted fee schedule.)

Eye Exam		
Unilateral eye encleation	**CPT:**	65091, 65093, 65101, 65103, 65105, 65110, 65112, 65114
Urine Protein Tests	**CPT:**	81000, 81001, 81002, 81003, 81005, 82042, 82043, 82044, 84156
	CPT II:	3060F, 3061F, 3062F
Nephropathy Treatment	**CPT II:**	3066F, 4010F
	ICD10:	E08.21, E08.22, E08.29, E09.21, E09.22, E09.29, E10.21, E10.29, E11.21, E11.22, E11.29, E13.21, E13.22, E13.29, I12.0, I12.9, I13.0, I13.10, I13.11, I13.2, I15.0, I15.1, N00.0, N00.1, N00.2, N00.3, N00.4, N00.5, N00.6, N00.7, N00.8, N00.9, N01.0, N01.1, N01.2, N01.3, N01.4, N01.5, N01.6, N01.7, N01.8, N01.9, N02.0, N02.1, N02.2, N02.3, N02.4, N02.5, N02.6, N02.7, N02.8, N02.9, N03.0, N03.1, N03.2, N03.3, N03.4, N03.5, N03.7, N03.8, N03.9, N04.0, N04.1, N04.2, N04.3, N04.4, N04.5, N04.6, N04.7, N04.8, N04.9, N05.0, N05.1, N05.2, N05.3, N05.4, N05.5, N05.6, N05.7, N05.8, N05.9, N06.0, N06.1, N06.2, N06.3, N06.4, N06.5, N06.6, N06.7, N06.8, N06.9, N07.0, N07.1, N07.2, N07.3, N07.4, N07.5, N07.6, N07.7, N07.8, N07.9, N08, N14.0, N14.1, N14.2, N14.3, N14.4, N17.0, N17.1, N17.8, N17.9, N18.1, N18.2, N18.3, N18.4, N18.5, N18.6, N18.9, N19, N25.0, N25.1, N25.81, N25.89, N25.9, N26.1, N26.2, N26.9, Q60.0, Q60.1, Q60.2, Q60.3, Q60.4, Q60.5, Q60.6, Q61.00, Q61.01, Q61.02, Q61.11, Q61.19, Q61.2, Q61.3, Q61.4, Q61.5, Q61.8, Q61.9, R80.0, R80.1, R80.2, R80.3, R80.8, R80.9
Chronic Kidney Disease, Stage 4	ICD10:	N18.4
ESRD	CPT:	36147, 36800, 36810, 36815, 36818, 36819, 36820, 36831, 36832, 36833, 90935, 90937, 90940, 90945, 90947, 90951, 90952, 90953, 90954, 90955, 90956, 90957, 90958, 90959, 90960, 90961, 90962, 90963, 90964, 90965, 90966, 90967, 90968, 90969, 90970, 90989, 90993, 90997, 90999, 99512, 36145, 90919, 90920, 90921, 90923, 90924, 90925
	HCPCS:	G0257, S9339, G0308, G0309, G0310, G0311, G0312, G0314, G0315, G0316, G0317, G0318, G0319, G0321, G0322, G0323, G0325, G0326, G0327, G0392, G0393
	ICD10:	N18.5, N18.6, Z91.15, Z99.2
Kidney Transplant	CPT:	50300, 50320, 50340, 50360, 50365, 50370, 50380
	HCPCS:	S2065
	ICD10:	Z94.0

(Continued on next page.)

Comprehensive diabetes care (CDC) (continued)

Commercial, Medicare, Medicaid ★

Common codes for this measure
(Note: Codes listed are subject to plan coverage and contracted fee schedule.)

Blood pressure control		
Blood pressure monitoring	**CPT:**	93784, 93788, 93790, 99091
Outpatient	**CPT:**	99201, 99202, 99203, 99204, 99205, 99211, 99212, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 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, 99429, 99455, 99456, 99483
	HCPCS:	G0402, G0438, G0439, G0463
Nonacute inpatient stay	CPT:	99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99318, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337

Common chart deficiencies
- Failure to order lab tests (urine screening) for nephropathy screening
- Failure to document monitoring for nephropathy
- Incomplete or missing information from specialists who may be monitoring nephropathy.

Exclusions

- Members who do not have a diagnosis of diabetes, in any setting during measurement year or year prior and who meet either of the following criteria:
  - Diagnosis of gestational diabetes, not pregnant with DM or steroid-induced diabetes, in any setting, during measurement year or year prior with no encounters in any setting with a diagnosis of diabetes
- Deceased prior to Dec. 31 of measurement year.
- Members in hospice
- Members enrolled in an Institutional SNP anytime during MY
- Members living long-term in an institution anytime during MY, identified by LTI flag
- Members under palliative care

Refer to **Appendix 1** for frailty, advanced illness and dementia medication exclusions.

*For a complete list of exclusion codes, contact your account manager.

Medical record documentation

Medical record dates: Jan. 1, 2021 – Dec. 31, 2021

Fax medical record information to Geisinger Health Plan Quality Department at 570-214-1380.
- Blood pressures
- HbA1c lab reports
- Urine tests consultation reports from nephrologist (Medicare)
- Retinal eye exam or dilated eye exam results by an eye care provider, dates 1/1/2019 – 12/31/2020

Kidney health evaluation for patients with diabetes (KED)

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

Frequently utilized provider best practices

- Collect appropriate testing in a timely manner.

Common codes for this measure
(Note: Codes listed are subject to plan coverage and contracted fee schedule.)

Description	Codes	
Estimated glomerular filtration rate lab test	CPT	80047, 80048, 80050, 80053, 80069, 82565
Quantitative urine albumin lab test	CPT	82043
Urine creatinine lab test	CPT	82570

Common chart deficiencies

- Failure to collect testing within the measurement year

Exclusions

- Members with evidence of ESRD
- Members under palliative care

*For a complete list of exclusion codes, contact your account manager.

Medical record documentation

Medical record dates: Jan. 1, 2021 – Dec. 31, 2021

Fax medical record information to Geisinger Health Plan Quality Department at 570-214-1380.

Osteoporosis management in women who had a fracture (OMW)

Medicare ★

The percentage of women 67 – 85 years of age who suffered a fracture and who had either a bone mineral density (BMD) test or prescription for a drug to treat osteoporosis in the six months after the fracture

- Women who suffer a fracture are at increased risk of additional fractures and more likely to have osteoporosis.
- Fractures of the finger, toe, face or skull are not included in this measure.
- Osteoporosis therapy on the index episode start date (IESD) (fracture date) or in the 180-day period after the IESD.
- Dispensed prescription to treat osteoporosis on IESD or 180-day period after IESD.

Frequently utilized provider best practices

- Order a BMD test on all women with a diagnosis of a fracture within 6 months OR prescribe medication to prevent osteoporosis.
- BMD test during inpatient stay for fracture.
- Educate member on safety and fall prevention.
- Note, aggressive risk adjustment can overstate osteoporosis by confusing lower Z scores/ osteopenia with osteoporosis.
- Encourage hospital to perform BMD tests prior to discharging member.
- If the member had more than one fracture, identify all fractures and assess eligibility.

Common codes for this measure

(Note: Codes listed are subject to plan coverage and contracted fee schedule.)

Description	Codes	
Bone mineral density test	**CPT:**	76977, 77078, 77080, 77081, 77082, 77085, 77086
	HCPCS:	G0130
	ICD10:	BP48ZZ1, BP49ZZ1, BP4GZZ1, BP4HZZ1, BP4LZZ1, BP4MZZ1, BP4NZZ1, BP4PZZ1, BQ00ZZ1, BQ01ZZ1, BQ03ZZ1, BQ04ZZ1, BR00ZZ1, BR07ZZ1, BR09ZZ1, BR0GZZ1
Osteoporosis medications	**HCPCS:**	J0630, J0897, J1740, J3110, J3489
Long-acting osteoporosis medications	**HCPCS:**	J0897, J1740, J3489

Osteoporosis medications

Description	Prescription	
Biphosphonates	Alendronate Alendronate-cholecalciferol Ibandronate	Risedronate Zoledronic acid
Other agents	Abaloparatide Calcitonin Denosumab	Raloxifene Teriparatide

(Continued on next page.)

Osteoporosis management in women who had a fracture (OMW) (continued)

Medicare ★

Good examples

- Initial fractures should use the 7th character "A" for active care, which is generally diagnosed during:
  - Emergency room care
  - Surgical care
  - Evaluation/treatment by the same/different physician

*To use the 7th character A, it must be the first time the member is diagnosed for the fracture.

Example: The member was seen in the ED last week by Dr. Smith but is now seeing Dr. Jones for an orthopedic referral. Dr. Jones would not use the 7th character "A", because it is not the first time the fracture is being diagnosed.

- Subsequent fracture codes use the 7th character "D" for routine healing and recovery which can include:
  - X-rays to monitor fracture healing
  - Cast change/removal
  - Internal/external fixation device removal
  - Adjustment of medication

*Sometimes a patient with a high frailty factor can have compression fractures as an ongoing issue. Each time they are seen, this is not considered a new fracture and the 7th character "D" should be used.

Exclusions	• Members who received a dispensed prescription or had an active prescription to treat osteoporosis, or a claim/encounter for osteoporosis therapy during 365 days prior to fracture • Members who had a BMD test during the 730 days (24 months) prior to fracture • Members enrolled in an Institutional SNP anytime during MY • Members living long-term in an institution anytime during MY, identified by LTI flag • Members in hospice • Refer to Appendix 1 for frailty, advanced illness and dementia medication exclusions. *For a complete list of exclusion codes, contact your account manager.
Medical record documentation	Medical record dates: Fax medical record information to Geisinger Health Plan Quality Department at 570-214-1380. • Member must have a dexa scan done within 180 days of initial fracture or within 730 days (2 years) prior to date of fracture • Fractures from 7/1/2020 to 6/30/2021 will be pulled into this measure

Osteoporosis screening in older women (OSW)

The percentage of women 65 – 75 years of age who received osteoporosis screening

Frequently utilized provider best practices

- Assist member with scheduling testing
- Order testing within an appropriate time frame

Common codes for this measure
(Note: Codes listed are subject to plan coverage and contracted fee schedule.)

Description	Codes	
Osteoporosis screening test	CPT	76977, 77078, 77080, 77081, 77085

Common chart deficiencies

- Failure to order testing for members within the age bracket

Exclusions

- Refer to Appendix 1 for frailty, advanced illness and dementia medication exclusions
- Members under palliative care

*For a complete list of exclusion codes, contact your account manager.

Medical record documentation

Medical record dates: Jan. 1, 2021 - Dec. 31, 2021
Fax medical record information to Geisinger Health Plan Quality Department at 570-214-1380.

Appropriate testing for children with pharyngitis (CWP)

Commercial, Medicare, Medicaid

Percentage of children 3 – 18 years of age who were diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode

Frequently utilized provider best practices

- Document all discussions to members on the inappropriate use of antibiotics.
- Perform a rapid strep test or throat culture to confirm diagnosis before prescribing antibiotics.
- Never treat "red throats" empirically, even in children with a long history of strep.
- Submit any co-morbid diagnosis coded that apply on claim/encounter.

Common codes for this measure
(Note: Codes listed are subject to plan coverage and contracted fee schedule.)

Description	Codes	
Pharyngitis	**ICD10:**	J02.0, J02.8, J02.9, J03.00, J03.01, J03.80, J03.81, J03.90, J03.91
Outpatient	**CPT:**	99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 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, 99429, 99455, 99456, 99483
	HCPCS:	G0402, 0438, G0439, G0463, T1015
Observation visit	**CPT:**	99217, 99218, 99219, 99220
ED visit	**CPT:**	99281, 99282, 99283, 99284, 99285
Group A strep tests	**CPT:**	87070, 87071, 87081, 87430, 87650, 87651, 87652, 87880

Common chart deficiencies

- Perform a group A strep test on all children before treating with an antibiotic Incorrect billing of a co-morbid conditions while prescribing an antibiotic
- Documentation of a discussion on the proper use of antibiotics

Exclusions

- Members in hospice

*For a complete list of exclusions, contact your account manager.

Medical record documentation

Medical record dates: July 1, 2020 – June 30, 2021
Fax medical record information to Geisinger Health Plan Quality Department at 570- 214-1380.

- Document rapid strep test done in the office
- Document any secondary diagnosis (i.e., otitis media, sinusitis, pneumonia, etc.); this will ensure that antibiotics prescribed without a strep test are excluded from the measure.

Avoidance of antibiotic treatment in adults with acute bronchitis (AAB)

The percentage of adults 18 – 64 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription (Appendix 5).

Frequently utilized provider best practices

- Document competing diagnoses or co-morbid condition (such as COPD) in addition to the bronchitis code.
- Provide member education materials on antibiotic resistance, comfort measures and realistic expectations for recovery time.
- If a prescription is filled after office visit, claim will be denied.

Common codes for this measure
(Note: Codes listed are subject to plan coverage and contracted fee schedule.)

Outpatient value set, observation value set and ED value set — see Appendix 1
AAB antibiotic medication list — see Appendix 4

Description	Codes	
Acute bronchitis	**ICD10:**	J20.3, J20.4, J20.5, J20.6, J20.7, J20.8, J20.9

Common chart deficiencies

- Code for co-morbid conditions and competing diagnosis

Exclusions

- Diagnosis of pharyngitis or another competing diagnosis 30 days prior to or 7 days after the acute bronchitis diagnosis; the list of competing diagnosis includes all types of infections that would require treatment with an antibiotic
- Members with a comorbid condition diagnosis in the 12 months prior to the acute bronchitis diagnosis; the comorbid diagnoses for this measure include HIV, malignant neoplasms, emphysema, COPD, cystic fibrosis, tuberculosis and other lung diseases
- Members in hospice

*For a complete list of exclusion codes, contact your account manager.

Medical record documentation

Medical record dates: Jan. 1, 2021 – Dec. 24, 2021
Fax medical record information to Geisinger Health Plan Quality Department at 570- 214-1380.

Appropriate treatment for children with upper respiratory infection (URI)

The percentage of children 3 months – 18 years of age who were given a diagnosis of upper respiratory infection (URI) and were not dispensed an antibiotic prescription

Frequently utilized provider best practices

- Provide education materials on antibiotic resistance, comfort measures to parent/guardian and realistic expectations of recovery time.
- Document a second diagnosis code for any competing diagnosis (e.g., pharyngitis, otitis media, enteritis, whopping cough, etc.) in addition to the URI code.

Common codes for this measure
(Note: Codes listed are subject to plan coverage and contracted fee schedule.)

Outpatient value set, observation value set and ED value set — see Appendix 1
AAB antibiotic medication list — see Appendix 4

Description	Codes	
URI	**ICD10:**	J00, J06.0, J06.9
Outpatient	**CPT:**	99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 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, 99429, 99455, 99456, 99483
ED	**CPT:**	99281, 99282, 99283, 99284, 99285
Observation	**CPT:**	99217, 99218, 99219, 99220
Pharyngitis	**ICD10:**	J02.0, J02.8, J02.9, J03.00, J03.01, J03.80, J03.81, J03.90, J03.91

Description	Prescription	
CWP antibiotic medications		
Aminopenicillins	Amoxicillin	Ampicillin
Beta-lactamase inhibitors	Amoxicillin-clavulanat	
First generation cephalosporins	Cefadroxil Cephalexin	Cefazolin
Folate antagonist	Trimethoprim	
Lincomycin derivatives	Clindamycin	
Macrolides	Azithromycin Erythromycin ethylsuccinate Clarithromycin	Erythromycin lactobionate Erythromycin Erythromycin stearate
Natural penicillins	Penicillin G potassium Penicillin V potassium	Penicillin G sodium

(Continued on next page.)

Appropriate treatment for children with upper respiratory infection (URI) (continued)

Common codes for this measure
(Note: Codes listed are subject to plan coverage and contracted fee schedule.)

(Cont.)

Description	Prescription	
CWP antibiotic medications (cont.)		
Penicillinase-resistant penicillins	Dicloxacillin	
Quinolones	Ciprofloxacin Moxifloxacin	Levofloxacin Ofloxacin
Second generation cephalosporins	Cefaclor Cefuroxime	Cefprozil
Sulfonamides	Sulfamethoxazole-trimethoprim	
Tetracyclines	Doxycycline Tetracycline	Minocycline
Third generation cephalosporins	Cefdinir Ceftibuten Cefixime	Cefditoren Cefpodoxime Ceftriaxone

Common chart deficiencies

Exclusions	• Members in hospice • ED visits or observation visits that result in an inpatient stay • Episode dates when the member had any diagnoses other than those listed in the URI codes above, on the same date of service, in any setting
Medical record documentation	Medical record dates: July 1, 2020 – June 30, 2021 Fax medical record information to Geisinger Health Plan Quality Department at 570-214- 1380.

Use of spirometry testing in the assessment and diagnosis of COPD (SPR)

The percentage of members 40 years of age and older with a new diagnosis of COPD or newly active COPD diagnosis (no diagnosis in past two years), who received appropriate spirometry testing to confirm the diagnosis

Frequently utilized provider best practices

- Integrate use of spirometry testing into newly diagnosed members with COPD.
- Make sure members are taking the appropriate medication and retest spirometry.

Common codes for this measure
(Note: Codes listed are subject to plan coverage and contracted fee schedule.)

Outpatient value set, observation value set and ED value set — see Appendix 1
AAB antibiotic medication list — see Appendix 4

Description	Codes	
COPD	**ICD10:**	J44.0, J44.1, J44.9
ED	**CPT:**	99281, 99282, 99283, 99284, 99285
Emphysema	**ICD10:**	J43.0, J43.1, J43.2, J43.8, J43.9, J98.2, J98.3
Outpatient	**CPT:**	99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 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, 99429, 99455, 99456, 99483
	HCPCS:	G0402, G0438, G0439, G0463, T1015
Spirometry	**CPT:**	94010, 94014, 94015, 94016, 94060, 94070, 94375, 94620
Chronic bronchitis	**ICD10:**	J41.0, J41.1, J41.8, J42

Common chart deficiencies

Exclusions

- Members in hospice
- ED visits or observation visits that result in an inpatient stay
- Nonacute inpatient stays
- Telehealth modifiers

Description	Codes	
Nonacute inpatient	**CPT:**	99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99318, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337

Medical record documentation

Medical record dates: Jan. 1, 2019 – Nov. 30, 2020
Fax medical record information to Geisinger Health Plan Quality Department at 570-214- 1380.

Adults' access to preventive/ambulatory health services (AAP)

The percentage of members 20 years and older who had an ambulatory or preventive care visit.

- Medicaid and Medicare members who had an ambulatory or preventive care visit during the measurement year
- Commercial members who had an ambulatory or preventive care visit during the measurement year or the two years prior to the measurement year

Frequently utilized provider best practices

- Educate members on the importance of having at least one preventive care visit during each calendar year.
- Contact members on Member Health Alerts who have not had a visit.
- Consider offering expanded office hours to increase access to care.
- Make reminder calls to members who have appointments to decrease no-show rates.

Common codes for this measure
(Note: Codes listed are subject to plan coverage and contracted fee schedule.)

Description	Codes	
Ambulatory visits	**CPT:**	99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 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, 99429, 99483
	HCPCS:	G0402, G0438, G0439, G0463, T1015
	ICD10:	Z00.00, Z00.01, Z00.121, Z00.129, Z00.3, Z00.5, Z00.8, Z02.0, Z02.1, Z02.2, Z02.3, Z02.4, Z02.5, Z02.6, Z02.71, Z02.79, Z02.81, Z02.82, Z2.83, Z02.89, Z02.9, Z76.1, Z76.2
Other ambulatory visits	**CPT:**	92002, 92004, 92012, 92014, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99318, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337
	HCPCS:	S0620, S0621
Telephone visits	**CPT:**	98966, 98967, 98968, 99441, 99442, 99443
Online assessments	**CPT:**	98969, 99444

Common chart deficiencies

Exclusions

- Members in hospice are excluded.

*For a complete list of exclusion codes, contact your account manager.

Medical record documentation

Medical record dates:
At least one visit billed through GHP insurance between the following dates will meet compliance

- Medicaid and Medicare: Jan. 1, 2020 – Dec. 31, 2020
- Commercial: Jan. 1, 2019 – Dec. 31, 2020

Fax medical record information to Geisinger Health Plan Quality Department at 570-214- 1380.

Pneumococcal vaccination status for older adults (PNU)

Medicare

Percentage of members 65 years of age and older who have ever received one or more pneumococcal vaccinations

Frequently utilized provider best practices

- Document any discussion or educational handouts given to member about the vaccine.
- Avoid missed opportunities by taking advantage of every office visit to encourage the member to get the pneumococcal vaccine.

Common codes for this measure
(Note: Codes listed are subject to plan coverage and contracted fee schedule.)

Description	Codes	
Pneumococcal conjugate vaccine 13 administered	**CPT:**	90670
Pneumococcal conjugate vaccine administered	**HCPCS:**	G0009
Pneumococcal polysaccharide vaccine 23	**CPT:**	90732

Common chart deficiencies

- No documentation of a discussion about the pneumococcal vaccine
- Missed opportunity of giving the vaccine while member had an office visit
- No documentation of a discussion or educational handouts given

Exclusions

- Members active in chemotherapy
- Members who had a bone marrow transplant
- History of immunocompromising conditions, cochlear implants, anatomic or functional asplenia, sickle cell anemia & HB-S disease or cerebrospinal fluid leaks
- Members in hospice

For more exclusion codes for pneumococcal vaccination and adult immunization status, contact your account manager.

Medical record documentation

Medical record dates: Jan. 1, 2021 – Dec. 31, 2021
Document date pneumococcal vaccine was given in member's chart.
Fax medical record information to Geisinger Health Plan Quality Department at 570-214-1380.

Appendix

Geisinger

Appendix 1 — Frailty exclusions, dementia medications

Exclusions			
Frailty	**CPT:**	99504, 99509	
	HCPCS:	E0100, E0105, E0130, E0135, E0140, E0141, E0143, E0144, E0147, E0148, E0149, E0163, E0165, E0167, E0168, E0170, E0171, E0250, E0251, E0255, E0256, E0260, E0261, E0265, E0266, E0270, E0290, E0291, E0292, E0293, E0294, E0295, E0296, E0297, E0301, E0302, E0303, E0304, E0424, E0425, E0430, E0431, E0433, E0434, E0435, E0439, E0440, E0441, E0442, E0443, E0444, E0462, E0465, E0466, E0470, E0471, E0472, E0561, E0562, E1130, E1140, E1150,E1160, E1161, E1240, E1250, E1260, E1270, E1280, E1285, E1290, E1295, E1296, E1297, E1298, G0162, G0299, G0300, G0493, G0494, S0271, S0311, S9123, S9124, T1000, T1001, T1002, T1003, T1004, T1005, T1019, T1020, T1021, T1022, T1030	
	ICD10	L89.119, L89.139, L89.149, L89.159, L89.209, L89.309, L89.899, L89.90, M62.50, M62.81, M62.84, R26.0, R26.1, R26.2, R26.89, R26.9, R41.81, R53.1, R53.81, R53.83, R54, R62.7, R63.4, R63.6, R64, W01.0XXA, W01.0XXD, W01.0XXS, W01.10XA, W01.10XD, W01.10XS, W01.110A, W01.110D, W01.110S, W01.111A, W01.111D, W01.111S, W01.118A, W01.118D, W01.118S, W01.119A, W01.119D, W01.119S, W01.190A, W01.190D, W01.190S, W01.198A, W01.198D, W01.198S, W06.XXXA, W06.XXXD, W06.XXXS, W07.XXXA, W07.XXXD, W07.XXXS, W08.XXXA, W08.XXXD, W08.XXXS, W10.0XXA, W10.0XXD, W10.0XXS, W10.1XXA, W10.1XXD, W10.1XXS, W10.2XXA, W10.2XXD, W10.2XXS, W10.8XXA, W10.8XXD, W10.8XXS, W10.9XXA, W10.9XXD, W10.9XXS, W18.00XA, W18.00XD, W18.00XS, W18.02XA, W18.02XD, W18.02XS, W18.09XA, W18.09XD, W18.09XS, W18.11XA, W18.11XD, W18.11XS, W18.12XA, W18.12XD, W18.12XS, W18.2XXA, W18.2XXD, W18.2XXS, W18.30XA, W18.30XD, W18.30XS, W18.31XA, W18.31XD, W18.31XS, W18.39XA, W18.39XD, W18.39XS, W19.XXXA, W19.XXXD, W19.XXXS, Y92.199, Z59.3, Z73.6, Z74.01, Z74.09, Z74.1, Z74.2, Z74.3, Z74.8, Z74.9, Z91.81, Z99.11, Z99.3, Z99.81, Z99.89	

(Continued on next page.)

Appendix 1 — Frailty exclusions, dementia medications (continued)

Outpatient	**CPT:**	99201, 99202, 99203, 99204, 99205, 99211, 99212, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 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, 99429, 99455, 99456, 99483	To be considered an exclusion, the following conditions must be met: • At least two outpatient visits, observation visits, or nonacute inpatient encounters on different dates of service, with an advanced illness diagnosis; visit type need not be the same for the two visits • At least one acute inpatient encounter with an advanced illness diagnosis
	HCPCS:	G0402, G0438, G0439, G0463	
Observation visit	**CPT:**	99217, 99218, 99219, 99220	
ED visit	**CPT:**	99281, 99282, 99283, 99284, 99285	
Nonacute inpatient stay	**CPT:**	99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99318, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337	
Advanced illness	**ICD10:**	A81.00, A81.01, A81.09, C25.0, C25.1, C25.2, C25.3, C25.4, C25.7, C25.8, C25.9, C71.9, C77.0, C77.1, C77.2, C77.3, C77.4, C77.5, C77.8, C77.9, C78.00, C78.1, C78.2, C78.39, C78.4, C78.5, C78.6, C78.7, C78.89, C79.00, C79.11, C79.19, C79.2, C79.31, C79.32, C79.49, C91.00, C91.02, C92.00, C92.02, C93.00, C93.02, C93.90, C93.92, C93.Z0, C93.Z2, C94.30, C94.32, F01.50, F01.51, F02.80, F02.81, F03.90, F03.91, F04, F10.27, F10.96, F10.97, G10, G12.21, G20, G30.0, G30.1, G30.8, G30.9, G31.01, G31.09, G31.83, I09.81, I11.0, I12.0, I13.0, I13.11, I13.2, I50.1,I50.20, I50.21, I50.22, I50.23, I50.30, I50.31, I50.32, I50.33, I50.40, I50.41, I50.42, I50.43, I50.810, I50.811, I50.812, I50.813, I50.814, I50.82, I50.83, I50.84, I50.89, I50.9, J43.0, J43.1, J43.2, J43.8, J43.9, J68.4, J84.10, J84.112, J84.17, J96.10, J96.11, J96.12, J96.20,D26 J96.21, J96.22, J96.90, J96.91, J96.92, J98.2, J98.3, K70.10, K70.11, K70.2, K70.30, K70.31, K70.40, K70.41, K70.9, K74.0, K74.1, K74.2, K74.4, K74.5, K74.60, K74.69, N18.5, N18.6	
Acute inpatient stay	**CPT:**	99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99251, 99252, 99253, 99254, 99255, 99291	

Dementia medications		
Description	**Prescription**	
Cholinesterase inhibitors	Donepezil Galantamine	Rivastigmine
Miscellaneous central nervous system agents	Memantine	

Appendix 2 — Diabetes medications

Diabetes medications		
Description	**Prescription**	
Alpha-glucosidase inhibitors	Acarbose	Miglitol
Amylin analogs	Pramlinitide	
Antidiabetic combinations	Alogliptin-metformin Alogliptin-pioglitazone Canagliflozin-metformin Dapagliflozin-metformin Empaglifozin-linagliptin Empagliflozin-metformin Glimepiride-pioglitazone Glipizide-metformin	Glyburide-metformin Linagliptin-metformin Metformin-pioglitazone Metformin-repaglinide Metformin-rosiglitazone Metformin-saxagliptin Metformin-sitagliptin
Insulin	Insulin aspart Insulin aspart-insulin aspart protamine Insulin degludec Insulin detemir Insulin glargine Insulin glulisine	Insulin isophane human Insulin isophane-insulin regular Insulin lispro Insulin lispro-insulin lispro protamine Insulin regular human Insulin human inhaled
Meglitinides	Nateglinide	Repaglinide
Glucagon-like peptide-1 (GLP1) agonists	Dulaglutide Exenatide	Albiglutide Liraglutide
Sodium glucose cotransporter 2 (SGLT2) inhibitor	Canagliflozin Dapagliflozin	Empagliflozin
Sulfonylureas	Chlorpropamide Glimepiride Glipizide	Glyburide Tolazamide Tolbutamide
Thiazolidinediones	Pioglitazone	Rosiglitazone
Dipeptidyl peptidase-4 (DDP-4) inhibitors	Alogliptin Linagliptin	Saxagliptin Sitagliptin

Appendix 3 — ACE inhibitor/ARB medications

ACE inhibitor/ARB medications		
Description	**Prescription**	
Angiotensin converting enzyme inhibitors	Benazepril Captopril Enalapril Fosinopril Lisinopril	Moexipril Perindopril Quinapril Ramipril Trandolapril
Angiotensin II inhibitors	Azilsartan Candesartan Eprosartan Irbesartan	Losartan Olmesartan Telmisartan Valsartan
Antihypertensive combinations	Amlodipine-benazepril lodipine-hydrochlorothiazide-valsartan Amlodipine-hydrochlorothiazide-olmesartan Amlodipine-olmesartan Amlodipine-perindopril Amlodipine-telmisartan Amlodipine-valsartan Azilsartan-chlorthalidone Benazepril-hydrochlorothiazide Candesartan-hydrochlorothiazide Captopril-hydrochlorothiazide	Enalapril-hydrochlorothiazide Eprosartan-hydrochlorothiazide Fosinopril-hydrochlorothiazide Hydrochlorothiazide-irbesartan Hydrochlorothiazide-lisinopril Hydrochlorothiazide-losartan Hydrochlorothiazide-moexipril Hydrochlorothiazide-olmesartan Hydrochlorothiazide-quinapril Hydrochlorothiazide-telmisartan Hydrochlorothiazide-valsartan Sacubitril-valsartan Trandolapril-verapamil

Appendix 4 — AAB antibiotic medications

AAB antibiotic medications		
Description	**Prescription**	
Aminoglycosides	Amikacin Gentamicin	Streptomycin Tobramycin
Aminopenicillins	Amoxicillin	Ampicillin
Beta-lactamase inhibitors	Amoxicillin-clavulanate Ampicillin-sulbactam	Piperacillin-tazobactam
First-generation cephalosporins	Cefadroxil Cefazolin	Cephalexin
Fourth-generation cephalosporins	Cefepime	
Ketolides	Telithromycin	
Lincomycin derivatives	Clindamycin	Lincomycin
Macrolides	Azithromycin Clarithromycin Erythromycin	Erythromycin ethylsuccinate Erythromycin lactobionate Erythromycin stearate
Miscellaneous antibiotics	Aztreonam Chloramphenicol Dalfopristin-quinupristin Daptomycin	Linezolid Metronidazole Vancomycin
Natural penicillins	Penicillin G benzathine-procaine Penicillin G potassium Penicillin G procaine	Penicillin G sodium Penicillin V potassium Penicillin G benzathine
Penicillinase resistant penicillins	Dicloxacillin Nafcillin	Oxacillin
Quinolones	Ciprofloxacin Gemifloxacin Levofloxacin	Moxifloxacin Ofloxacin
Rifamycin derivatives	Rifampin	
Second-generation cephalosporin	Cefaclor Cefotetan Cefoxitin	Cefprozil Cefuroxime
Sulfonamides	Sulfadiazine	Sulfamethoxazole-trimethoprim
Tetracyclines	Doxycycline Minocycline	Tetracycline
Third-generation cephalosporins	Cefdinir Cefditoren Cefixime Cefotaxime	Cefpodoxime Ceftazidime Ceftibuten Ceftriaxone
Urinary anti-infectives	Fosfomycin Nitrofurantoin Nitrofurantoin macrocrystals	Trimethoprim Nitrofurantoin macrocrystals-monohydrate

Appendix 5 — Early childhood screenings

Early and periodic screening, diagnostic and treatment billing guide

Early and periodic screening, diagnostic and treatment (EPSDT) services are federally mandated services intended to provide preventive healthcare to children and young adults under the age of 21 at periodic intervals which are based on the recommendations of the American Academy of Pediatrics (AAP) and the Centers for Disease Control and Prevention (CDC). All primary care providers (PCPs) who provide services to members under the age of 21 are required to provide comprehensive healthcare, screenings, and preventive services. GHP Family requires participating PCPs to provide all EPSDT services in compliance with federal and state regulations and periodicity schedules.

EPSDT screens for any new member under the age of 21 must be scheduled within 45 days from the effective date of enrollment unless the child is already under the care of a PCP and the child is current with screens and immunizations.

GHP Family will make quarterly lists available to each PCP that identify members who have not had an encounter during the first 6 months of enrollment or members who have not complied with EPSDT periodicity and immunization schedules for children. It is the PCP's responsibility to contact all members who have not had an encounter during the previous 12 months or within the MA appointment time frames. These EPSDT member lists are also available upon request from GHP Family.

These screenings offer a unique opportunity to perform a comprehensive evaluation of a child's health and provide appropriate and timely follow-up diagnostic and treatment services. To encourage providers to perform complete EPSDT screens, support the additional time needed to perform such screens and increase the number of screens performed, EPSDT rates have been established.

To be considered a complete visit, all required components listed on the Department of Human Services (DHS) periodicity schedule must be completed. See (Exhibit A) for the complete DHS periodicity schedule.

If the visit is considered incomplete, the provider will receive the incomplete visit rate. Incomplete EPSDT screens are office visits during which the provider did not complete all the required components listed on the periodicity schedule for the child's screening period. This may include the use of applicable modifiers, diagnosis codes and required referral codes.

What services are included in an EPSDT exam?

- Comprehensive health and developmental history
- Comprehensive unclothed physical exam
- Appropriate immunizations according to age and health history
- Appropriate laboratory tests including lead toxicity screening
- Health education (anticipatory guidance including child development, healthy lifestyles, and accident and disease prevention)

After completion of a comprehensive screen, members are entitled to all services included in the approved DHS State Plan for diagnosing and treating a discovered condition. These services include:

Vision services

At a minimum, diagnosis and treatment for defects in vision, including eyeglasses. Vision services must be provided according to a distinct periodicity schedule developed by the state and at other intervals as medically necessary. Coding is as follows:

Patient age	Procedure code and description	Modifier 1	Modifier 2
Required at ages 3, 4, 5, 6, 8, 10, 12 and 15	99173 - Visual Acuity Screen	EP	52 – if service not completed
	99174 or 99177- Instrument-based screening		
Risk assessment to be done at ages 7, 9, 11 ,13, 14, 16, 17, 18, 19 and 20			

Appendix 5 — Early childhood screenings (continued)

Dental services

At minimum, dental services include relief of pain and infections, restoration of teeth and maintenance of dental health. Dental services may not be limited to emergency services.

Dental risk assessment has been added to the EPSDT requirement for patients 6 – 8 months of age and again between the ages of 9 – 11 months of age.

YD referral code for dental referrals is required for all complete EPSDT screens delivered to children ages 3 through 20. Report the YD referral code in block 10d.

Hearing services

At a minimum, hearing services include diagnosis and treatment for defects in hearing, including hearing aids. Coding is as follows:

Patient age	Procedure code and description	Modifier 1	Modifier 2
Required at the following ages: Newborn Screen (If not completed as part of the newborn screen, must be done at 3–5 days, 1 month or 2–3 months)	Appropriate CPT code	EP	52 – if service not completed
Required at the following ages: Ages 4, 5, 6, 8 and 10 Once during ages 11 – 14, once during ages 15 – 17 and once during ages 18 – 20	92551 – audio screen 92552 – pure-tone air only	EP	52 – if service not completed
Risk Assessment to be done at ages 3, 7 and 9			

Immunizations

During these visits, vaccines recommended by the **Childhood and Adolescent Immunization Schedule** are administered. The *Recommended Immunization Schedule for Persons Aged 0 Through 18 Years, The Catch-up Immunization Schedule for Persons Aged 4 Months Through 18 Years Who Start Late or Who Are More Than 1 Month Behind and The Vaccines That Might Be Indicated For Children And Adolescents Aged 18 Years Or Younger Based On Medical Indications* can be found here.

Note: Providers who see Medicaid or uninsured patients should utilize the Vaccine for Children Program (VFC) offered by the Department of Health. Providers would receive the vaccine directly from the VFC program at no cost to them. If a VFC vaccine is given during the visit, the provider is reimbursed for the administration of the vaccine. **The provider should submit a claim to GHP Family reporting the appropriate CPT code for the vaccine given.** This process effects children from birth through age 18 (until their 19th birthday) whether they have only Medicaid or Medicaid as a secondary carrier. More information regarding this program can be found on the Department of Health's website.

When reporting immunizations for members not included in the Vaccine for Kids program, as defined by DHS, providers should report both the applicable immunization and administration code **without the use of the EP modifier** and will receive separate reimbursement for both codes. **NDC codes for vaccines should be present on all EPSDT claims.**

Other necessary healthcare services

Diagnostic services

When a screening examination indicates the need for further evaluation of an individual's health, diagnostic services must be provided. Necessary referrals should be made without delay and there should be follow-up to ensure the enrollee receives a complete diagnostic evaluation.

Treatment

Necessary healthcare services must be made available for treatment of all physical and mental illnesses or conditions discovered by any screening and diagnostic procedures.

Tobacco, alcohol or drug use assessment

For patients 11 through 20 years of age, a tobacco, alcohol or drug use risk assessment is to be performed during an EPSDT screening.

Autism screening

Autism — or more precisely the autism spectrum disorders (ASDs) — represents a broad group of developmental disorders characterized by impaired social interactions, problems with verbal and nonverbal communication and repetitive behaviors or severely limited activities and interests. Coding is as follows:

Patient age	Procedure code and description	Modifier 1	Modifier 2
Required at ages 18 and 24 months	96110 – Autism screening	EP	U1**

** The U1 modifier distinguishes the autism screening from the developmental screening.

Developmental screening

Developmental delay is defined as a condition which represents a significant delay in the process of development. More precisely, children may have skills deficits including specific delays in language, perception, meta-cognition and social, emotional and/or motor development. Early identification and quality early intervention services can improve outcomes for children, families and communities.

Coding is as follows:

Patient age	Procedure code and description	Modifier
Required at 9 – 11 months, 18 months and 30 months	96110 – developmental screening	EP

Reporting developmental screening

When a child is referred to another practitioner as a result of the developmental delay screen, the YO EPSDT referral code must be populated in block 10d of the CMS-1500 form. In addition, members with suspected developmental delays under the age of 5 are required to be referred by their PCP to local Early Intervention Program services through the CONNECT Helpline at (800) 692-7288 and should be referred to the GHP Family Special Needs Unit (SNU) for additional comprehensive management.

Appendix 5 — Early childhood screenings (continued)

Resources for developmental screening

Several resources are available to assist providers in educating themselves about surveillance and structured screening and in remaining up to date on validated screening tools. Providers may refer to the following resources for additional information:

- The National AAP Policy Statement: Identifying Infants and Young Children With Developmental Disorders in the Medical Home: An Algorithm for Developmental Surveillance and Screening may be found online at **http://pediatrics.aappublications.org/content/118/1/405.**
- The 2017 Bright Futures Guidelines may be found on the AAP Bright Futures web site on-line at: **https://brightfutures.aap.org/materials-and-tools/guidelines-and-pocket-guide/Pages/default.aspx**
- The Centers for Disease Control and Prevention Child Development Web site online at: **https://www.cdc.gov/ncbddd/childdevelopment/facts.html**
- The Pennsylvania Medical Assistance Bulletin (MAB) 99-09-07 Structured Screening for Developmental Delays and Autism Spectrum Disorder may be found online at: **http://www.dhs.pa.gov/publications/bulletinsearch/bulletinselected/index.htm?bn=99-09-07**

Anemia screening

Anemia is a condition that develops when your blood lacks enough healthy red blood cells or hemoglobin. Coding is as follows:

Patient age	Procedure code and description	Modifier 1	Modifier 2
Required at 9 – 11 months (If not completed at 9 – 11 months, must be done at 12 months)	85013 – Hematocrit 85018 – Hemoglobin	EP	52– if service not completed 90 – if member referred to outside lab
If indicated by risk assessment and/or symptoms, ages 15 months thru 20 years			

Dyslipidemia

Dyslipidemia screening is now required for children between the ages of 9 and 11 years of age. Coding is as follows:

Patient age	Procedure code and description	Modifier 1	Modifier 2
Required at age 9 years (If not completed at 9 years, must be done at next screening opportunity of 10 or 11 years) and 17 years (If not completed at 17 years, must be done at next screening opportunity of 18, 19 or 20	80061 –Dyslipidemia	EP	52 – if service not completed 90 – if member referred to outside lab
Risk assessment at 6, 8 and 12 thru 16 years			

Appendix 5 — Early childhood screenings (continued)

Lead screening

Protecting children from exposure to lead is important to lifelong good health. Even low levels of lead in blood have shown to affect IQ, ability to pay attention and academic achievement. Effects of lead exposure cannot be corrected. All GHP Family children are considered at risk for lead toxicity.

Risk questions should be asked at every visit. Coding is as follows:

Patient age	Procedure code and description	Modifier 1	Modifier 2
Required at age 9 –11 months (If not completed at 9 –11 months, must be done at next screening opportunity of 12, 15 or 18 months) and 24 months (If not completed at 24 months, must be done at next screening opportunity of 30 months, 3, 4, 5 or 6 years	83655 – Lead	EP	52 – if service not completed 90 – if member referred to outside lab

Maternal depression screening

Providers are to use a standardized health risk assessment instrument when screening for maternal depression. Providers may use a standardized screening instrument that is the most suitable tool for the provider's practice. Coding is as follows:

Patient age	Procedure code and description	Modifier 1	Modifier 2
Required by 1 month and at months 2, 4 and 6.	96161 – Maternal depression screening	EP	52 – if service not completed

Additional risk assessment testing to be done if indicated by history and/or symptoms:

Sickle cell

Sickle cell disease (SCD) is an inherited group of red blood cell disorders. Among people with SCD, "sickle" or abnormally shaped red blood cells get stuck in small blood vessels and block the flow of blood and oxygen to organs in the body. These blockages can cause repeated episodes of severe pain, organ damage, and serious infections, or even stroke.

Tuberculin (TB) test

Tuberculosis (TB) is a contagious bacterial infection that usually affects the lungs. In rare cases, it may spread to other body tissues or organs (extrapulmonary TB).

Sexually transmitted diseases (STDs)

STDs can include gonorrhea, syphilis, chlamydia, and more. Any sexually active person can be infected with an STD.

HIV screening – 15 – 18 years of age

Depression screening – 12 – 20 years of age

Appendix 5 — Early childhood screenings (continued)

Reporting EPSDT services

Providers submitting for a complete EPSDT screening, including immunizations, on the CMS 1500 or UB-04 claim form or the 837-electronic format must report:

- Primary diagnosis code: Z00110, Z00111, Z00121, Z00129, Z761, Z762, Z0000 or Z0001
- Visit code 03 EPSDT
- Claim modifiers:
  - EP – Complete EPSDT exam; report EP modifier on all lines of the claim
  - 52 – Incomplete exam; service not provided
  - 90 – Referred child to an outside laboratory
  - U1 – Autism

Age-appropriate evaluation and management codes

Newborn care: 99460 Newborn care (during the admission) 99463 Newborn (same day discharge)

Patient age	New patient	Established patient	Modifier
Age < 1 year	99381	99391	EP
Age 1 – 4 years	99382	99392	EP
Age 5 – 11 years	99383	99393	EP
Age 12 – 17 years	99384	99394	EP
Age 18 – 20 years	99385	99395	EP

EP modifier

The EP modifier is required on the assessment code and this line will be the only line to receive payment. Failure to use the EP modifier on the assessment code may cause the claim to deny or to price per component instead of at the complete screening fee schedule rate. **GHP Family asks that you use the EP modifier on all lines of the claim.**

Billing example 1: A 1-month-old new patient comes into the office for an EPSDT screen. As per the periodicity schedule, the required components for a 1-month EPSDT screen are:

- New patient visit code – 99381
- Maternal depression screening – 96161
- Hearing screen (if not completed at newborn screen) – appropriate CPT code
- Modifiers: EP on all lines of the claim.

Billing example 2: A 4-year-old established patient comes into the office for an EPSDT screen. As per the periodicity schedule, the required components for a 4-year EPSDT screen are:

- Established patient visit code – 99392
- Visual acuity screen – 99173, 99174, and 99177
- Hearing screen – 92551 or 92552
- Venous lead (if not done at 24 months, 30 months or 3 year screen) – 83655
- Referral to a dental provider – Enter YD referral code in Block 10d
- Modifiers: EP on all lines of the claim

Billing example 3: A 9-month-old established patient comes into the office for an EPSDT screen. As per the periodicity schedule, the required components for a 9 –11 month EPSDT screen are:

- Established patient visit code – 99391
- Developmental screen – 96110; if a developmental delay is suspected, enter YO referral code in block 10d and contact the CONNECT Helpline at (800) 692-7288
- Anemia (hemoglobin/hematocrit) – 85018 or 85013
- Venous lead – 83655
- Dental assessment
- Modifiers: EP on all lines of the claim

Note for an incomplete EPSDT:

For providers who were unable to provide a required EPSDT service, please use the appropriate procedure code with modifier 52. Providers should make every effort possible to complete that service at the next screening opportunity. For all procedure codes reported with modifiers 52 or 90, a zero dollar ($0) billed amount must be reported.

Referrals:

When a member is referred to another practitioner as a result of an EPSDT, a two-character referral code must be populated on the claim form (block 10d). An appropriate diagnosis code must be included for each referral.

- YM – Medical referral
- YD – Dental referral (Required component for all children 3 years of age and above)
- YV – Vision referral
- YH – Hearing referral
- YB – Behavioral health referral
- YO – Other referral

Miscellaneous

Coordination of Benefits:

GHP Family will act as the primary payer (unless existing primary coverage is available and known at the time of service) for preventive pediatric care (including EPSDT services to children) and services to children having medical coverage under a Title IV-D child support order.

As mandated by DHS, GHP Family will process and pay claims for the services above, even when records indicate GHP Family is the secondary payer to an existing primary plan. GHP Family may initiate subsequent recovery efforts once the primary plan appropriately processes claims for these services. Providers must always ensure GHP Family receives encounter data for all covered services provided to members, even when third party insurance is primary and GHP Family is the payer of last resort and even when no additional payment from GHP Family is expected.

GHP Family is the payer of last resort on all other services. Providers must bill third party insurance before submitting a claim to GHP Family. GHP Family will pay the difference between the primary insurance payment and GHP Family allowable amount. Providers cannot balance bill members. If the primary insurance carrier denies the claim as a non-covered service, the claim with the denial may be submitted to GHP Family for a coverage determination under the member's program.

It is the provider's responsibility to obtain the primary insurance carrier's explanation of benefits (EOB) or the remittance advice for services rendered to members that have insurance in addition to GHP Family. The primary carrier's EOB or remittance advice should accompany any claims submitted for payment. A detailed explanation of how the claim was paid or denied should be included if not evident from the primary carrier's EOB or the remittance advice. This information is essential for GHP Family to coordinate benefits.

[1] A complete screen must include the following: a comprehensive history; relevant measurements (for assessment of growth), physical examination, anticipatory guidance/counseling/risk factor reduction interventions, all assessments/screenings as indicated on the periodicity schedule and the ordering of appropriate laboratory/diagnostic procedures as recommended by the current AAP guidelines, found at:
https://brightfutures.aap.org/materials-and- tools/guidelines-and-pocket-guide/Pages/default.aspx.

[2] Beginning at 2 years of age, weight for length measurement should be replaced by calculation of body mass index. Age-appropriate nutrition counseling should be provided regarding promotion of healthy weight, healthy nutrition and physical activity.

[3] Blood pressure should be measured as indicated by child's risk status from infant to 3 years of age, when measurement should be universal.

[4] Procedure code 99460 and modifier EP are to be used for a newborn screen performed in the hospital, but not on the same day as hospital discharge.

[5] Procedure code 99463 and modifier EP are to be used for a newborn screen performed in the hospital on the same day as hospital discharge.

Appendix 5 — Early childhood screenings (continued)

[6] Pennsylvania Newborn Screening Panel should be done according to state law, prior to newborn's discharge from hospital. Confirm screen was completed, verify results and follow up as appropriate.

[7] Verify results of Pennsylvania Newborn Screening Panel as soon as possible and follow up as appropriate.

[8] Newborns should be screened for critical congenital heart disease using pulse oximetry before leaving the hospital.

[9] Developmental surveillance is required at each visit for a complete screen, except when developmental screening is required.

[10] Psychosocial/behavioral assessment should be family centered and may include an assessment of child social/emotional health, caregiver depression and social determinants of health, including both risk factors and strengths/protective factors.

[11] If testing for maternal depression and objective vision/hearing testing, anemia, lead, tuberculin or dyslipidemia is not completed, use CPT code for standard testing method plus CPT modifier 52 EPSDT (screening services/components not completed). If a screening service/ component is reported with modifier 52, the provider must complete the screening service/ component during the next screening opportunity, according to the periodicity schedule.

[12] Instrument-based screening may be completed to detect amblyopia, strabismus and/or high refractive error in children who are unable or unwilling to cooperate with traditional visual acuity screening.

[13] All newborns should receive an initial hearing screening before being discharged from hospital. If the hearing screening was not completed in hospital, the hearing screening should occur by 3 months of age.

[14] Screening must be provided at times noted, unless done previously.

[15] At 6 – 8 and 9 –11 months, an oral health risk assessment is to be administered and the need for fluoride supplementation assessed. The first dental examination is recommended at the time of the eruption of the first tooth and no later than 12 months of age. At 12, 18, 24 and 30 months, determine if child has a dental home. If not, complete assessments and refer to dental home.

[16] Beginning at 3 years of age, referral to a dental home is a required screening component and must be reported using the YD referral code.

[17] When laboratory procedures are performed by a party other than the treating or reporting physician, use CPT code plus CPT modifier 90 (reference outside lab).

[18] Initial measurement of hemoglobin or hematocrit to assess for iron-deficiency anemia is recommended between 9 and 12 months of age by the Centers for Disease Control and Prevention. Additionally, the AAP recommends risk assessment for anemia at 4 months of age, 15 months of age and then each periodicity thereafter.

[19] Capillary samples may be used for blood lead testing; however, elevated blood lead results based on capillary samples are presumptive and must be confirmed using a venous sample.

[20] All sexually active patients should be screened for sexually transmitted infections (STI).

[21] Those at increased risk of HIV infection, including those who are sexually active, participate in injection drug use, or are being tested for other STIs, should be tested for HIV and reassessed annually.

Pennsylvania's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program Periodicity Schedule and Coding Matrix – effective May 26, 2020

Services	Newborn (inpatient)	3-5 d	By 1 mo	2-3 mo	4-5 mo	6-8 mo	9-11 mo	12 mo	15 mo	18 mo	24 mo	30 mo	3 y	4 y
Complete Screen: [1,2,3]	A complete screen requires all codes indicated for each periodicity be completed and reported. Report only one CPT code if multiple CPT codes are listed per service, except for immunizations.													
New Patient	99460 EP[4]/ 99463 EP[5]	99381 EP	99381 EP	99381 EP	99381 EP	99381 EP	99381 EP	99382 EP	99382 EP	99382 EP	99382 EP	99382 EP	99382 EP	99385 EP
Established Patient		99391 EP	99391 EP	99391 EP	99391 EP	99391 EP	99391 EP	99392 EP	99392 EP	99392 EP	99392 EP	99392 EP	99392 EP	99385 EP
Pennsylvania newborn screening panel	•[6]	•[7] →												
Newborn bilirubin	•													
Critical Congenital Heart Defect Screening[8]	•													
Developmental Surveillance[9]	•	•	•	•	•	•		•	•		•		•	•
Psychosocial/Behavioral Assessment[10]	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Tobacco, Alcohol or Drug Use Assessment														
Maternal Depression Screening[10,11]			96161	96161	96161	96161								
Developmental Screening							96110			96110		96110		
Autism Screening							96110 U1	96110 U1						
Vision[11]	Assessed through observation or through health history/physical													
• Visual acuity screen													99173	99173
• Instrument-based screening[12]													99174 99177	99174 99177
Hearing[11]	•	•[14] →			Assessed through observation or through health history/physical									
• Audio Screen													★	99173
• Pure tone-air only														99174 99177
Oral Health[15]						•	•	★		★	★	★	♦[16]	♦[16]
Anemia[11,17]														
• Hematocrit (spun)					★[18]		85013[18]	85013[18]	If indicated by risk assessment and/or symptoms					
• Hemoglobin							85018[18]	85018[18]						
Lead[11,17,19]						★	83655	83655[14]	83655[14]	83655[14]	83655	83655[14]	83655[14]	83655[14]
Tuberculin Test[11]	If indicated by history and/or symptoms													
Sickle Cell														
Sexually Transmitted Infections[20]														
Dyslipidemia[11,17]														
Immunizations	Administer immunizations according to the ACIP schedule. Every visit should be considered an opportunity to bring a child's immunizations up to date. Refer to ACIP's Recommended Childhood and Adolescent Immunization Schedules: https://www.cdc.gov/vaccines/schedules/hcp/child-adolescent.html													

Pennsylvania's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program Periodicity Schedule and Coding Matrix – Aug. 1, 2018

Services	5 y	6 y	7 y	8 y	9 y	10 y	11 y	12 y	13 y	14 y	15 y	16 y	17 y	18 y	19 y	20 y
Complete Screen: [1,2,3]	A complete screen requires all codes indicated for each periodicity be completed and reported. Report only one CPT code if multiple CPT codes are listed per service, except for immunizations.															
New Patient	99383 EP	99383 EP	99383 EP	99383 EP	99383 EP	99383 EP	99383 EP	99384 EP	99384 EP	99384 EP	99384 EP	99384 EP	99384 EP	99385 EP	99385 EP	99385 EP
Established Patient	99383 EP	99383 EP	99383 EP	99383 EP	99383 EP	99383 EP	99383 EP	99384 EP	99384 EP	99384 EP	99384 EP	99384 EP	99384 EP	99385 EP	99385 EP	99385 EP
Developmental Surveillance [9]	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Psychosocial/Behavioral Assessment [10]	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Tobacco, Alcohol or Drug Use Assessment							★	★	★	★	★	★	★	★	★	★
Developmental Screening	If indicated by risk assessment and/or symptoms.															
Autism Screening																
Depression Screening								•	•	•	•	•	•	•	•	•
Vision [11]																
• Visual acuity screen	99173	99173	★	99173	★	99173	★	99173	★	★	99173	★	★	★	★	★
• Instrument-based screening [12]	99174 99177	99174 99177		99174 99177		99174 99177		99174 99177			99174 99177					
Hearing [11]																
• Audio Screen	92551	92551	★	92551	★	92551			92551	→	←	92551				92551
• Pure tone-air only	92552	92552		92552		92552			92552			92552				92552
Oral Health	♦ [16]	♦ [16]	♦ [16]	♦ [16]	♦ [16]	♦ [16]	♦ [16]	♦ [16]	♦ [16]	♦ [16]	♦ [16]	♦ [16]	♦ [16]	♦ [16]	♦ [16]	♦ [16]
Anemia [11,17]	If indicated by risk assessment and/or symptoms. See Recommendations to prevent and control iron deficiency in the United States. *MMWR*. 1998;47(RR-3):1-36. Beginning at 12 years of age for females, do once after onset of menses and if indicated by history and/or symptoms.															
• Hematocrit (spun)																
• Hemoglobin																
Lead [11,17,19]	83655 [14]	83655 [14]														
Tuberculin Test [11]	If indicated by history and/or symptoms.															
Sickle Cell																
Sexually Transmitted Infections [20]																
HIV Screening [21]							★	★	★	★			•		★	★
Dyslipidemia [11,17]		★		★	80061	80061 [14]	80061 [14]	If indicated by history and/or symptoms.					80061	80061 [14]	80061 [14]	80061 [14]
Immunizations	Administer immunizations according to the ACIP schedule. Every visit should be considered an opportunity to bring a child's immunizations up to date. Refer to ACIP's Recommended Childhood and Adolescent Immunization Schedules: **https://www.cdc.gov/vaccines/schedules/hcp/child-adolescent.html**															

Appendix 6 — Documentation quick reference

HEDIS 2020 required medical record documentation guide (adult)

Refer to the HEDIS medical record request list to identify the targeted HEDIS components/measures and provide the following documentation for only those measure(s) listed next to each member's name.

Patient information/registration form (which includes name & date of birth) should accompany every record sent

HEDIS measure identifier	Send all the following medical record documentation for each measure
CBP: Controlling high blood pressure	Medical record dates: 1/1/2021 – 12/31/2021 • Most recent blood pressure in PCP chart in the current year
CCS: Cervical cancer screening	Medical record dates: • Women 24 – 29 must have pap smear between 1/1/2019 – 12/31/2021 • Women 30 – 64 documentation of HPV or HPV with a cervical pap 1/1/2017 – 12/31/2021 • Provide documentation of hysterectomy with no residual cervix
CDC: Comprehensive diabetes care	Medical record dates: 1/1/2020 – 12/31/2021 • Medication list (ACE or ARB) (Medicare only) • Blood pressures • Diabetic flow sheet • HbA1c lab reports • Urine tests consultation reports from nephrologist (Medicare only) • Retinal eye exam or dilated eye exam results by an eye care provider date: 1/1/2020 – 12/31/2021
COA: Care of older adults	Medical record dates: 1/1/2021 – 12/31/2021 • Office notes including an advanced care planning discussion • Medication lists • Documentation of all functional status assessments completed (IADL, ADL, etc.) • Documentation of all pain assessments • Most recent documented date on or before end of measurement year of any active advance care plans, living wills, end of life orders
COL: Colorectal cancer screening	Medical record dates: • Colonoscopy between 1/1/2012 - 12/31/2021 • Flexible sigmoidoscopy or CT Colonography between 1/1/2017 – 12/31/2021 • Fecal occult blood test between 1/1/2021 - 12/31/2021 • Fit/DNA Cologuard between 1/1/2019 - 12/31/2021 • Dated documentation of a colon screening on a medical history form, problem list, or health maintenance form • If applicable, documentation of colorectal cancer or a total colectomy with date of occurrence

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Appendix 6 — Documentation quick reference (continued)

TRC: Transition of care	Medical record dates: 1/1/2021 – 12/31/2021 Notification of inpatient admission (admission date will be provided); include evidence of receipt with date stamp, unless shared EMR • Communication from inpatient provider (e.g., phone call, email, or fax) • Communication from ED (e.g., phone call, email, fax) • Communication thru health information exchange (e.g., KeyHIE) or an ADT alert system. • Documentation provider admitted member • Notification specialist admitted member • Documentation provider placed orders for tests/treatments during inpatient stay • Documentation provider performed a preadmission exam Receipt of discharge information (discharge date will be provided); include evidence of receipt with date stamp unless shared EMR • Discharge summary • Summary of care record Patient engagement after inpatient discharge (within 30 days after discharge) • Progress and/or home visit notes • Telehealth visits Med reconciliation post discharge (within 30 days after discharge) • Progress notes should include medication lists and documentation of med reconciliation post discharge • Documentation of all discharge medications and discharge summary *Note: Documentation if member was readmitted or transferred within 30 days*
CHL: Chlamydia screening in women	Medical record dates: 1/1/2021 – 12/31/2021 • Documentation of chlamydia lab result
BCS: Breast cancer screening	Medical record dates: 10/1/2019 – 12/31/2021 • Bilateral mammogram • Unilateral mammogram with documentation of mastectomy of opposite side • Documentation of a bilateral mastectomy • Digital breast tomosynthesis

Appendix 6 — Documentation quick reference (continued)

HEDIS 2020 required medical record documentation guide (child)

Refer to the HEDIS medical record request list to identify the targeted HEDIS components/measures and provide the following documentation for only those measure(s) listed next to each member's name.

Patient information/registration form (which includes name & date of birth) should accompany every record sent	
HEDIS measure identifier	**Send all the following medical record documentation for each measure**
WCV: Well child visits age 3 through 21 years of age	Medical record dates: 1/1/2021 – 12/31/2021 • Health history • Physical developmental history • Mental developmental history • Physical exam • Discussion of education/anticipatory guidance
W30: Well child visits in the first 30 months of life **6+ visits during first 15 months** **2+ visits between 15 months and 30 months**	Medical record dates: Date of birth – 30 months of age (include all visits within the timeframe • Health history • Physical developmental history • Mental developmental history • Physical exam • Discussion of education/anticipatory guidance
CDC: Comprehensive diabetes care	Medical record dates: 1/1/2021 – 12/31/2021 • Medication list • Blood pressures • Diabetic flow sheet • HbA1c lab reports • Urine tests consultation reports from nephrologist • Retinal eye exam or dilated eye exam results by an eye care provider date: 1/1/2020 – 12/31/2021
CIS: Childhood immunization status	Medical record dates: DOB – second birthday • Immunization record – copies of Department of Health immunization records are acceptable • Copy of birth record documenting Hep B, if available • Progress notes for immunizations not recorded in the immunization record • Documentation of contraindication to immunization or parental refusal, if applicable
IMA: Immunizations for adolescents **Tdap, Meningococcal, HPV**	Medical record dates: • Documentation of immunization administration with date • 1 TDAP between 10th and 13th birthday • 1 meningococcal between 11th and 13th birthday • 2 (146 days apart) or 3 HPV between 9th and 13th birthday • Documentation of contraindication to immunization or parental refusal, if applicable
LSC: Lean screening in children	Medical record dates: DOB – second birthday • Lead testing – test result and date (capillary or venous)

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Appendix 6 — Documentation quick reference (continued)

WCC: Weight assessment and counseling for nutrition and physical activity	Medical record dates: 1/1/2021 – 12/31/2021 • Vitals (weight, height, BMI value or BMI percentile) • BMI growth charts • Nutrition counseling — current nutrition behaviors, nutrition education, weight or obesity counseling • Physical activity counseling — current physical activity behaviors, physical activity education, weight or obesity counseling
CHL: Chlamydia screening in women	Medical record dates: 1/1/2021 – 12/31/2021 • Documentation of chlamydia lab result

Appendix 6 — Documentation quick reference (continued)

HEDIS 2020 required medical record documentation guide (PNPP)

Refer to the HEDIS medical record request list to identify the targeted HEDIS components/measures and provide the following documentation for only those measure(s) listed next to each member's name.

Patient information/registration form (which includes name & date of birth) should accompany every record sent	
HEDIS measure identifier	**Send all the following medical record documentation for each measure**
PPC: Prenatal care	Live birth deliveries: 10/8/20 – 10/7/21 During first trimester or within first 42 days of enrollment • Visit with an OB/GYN or other prenatal care provider (not a nurse visit) • A basic physical obstetrical exam including auscultation for fetal heart tone, or pelvic exam with obstetric observations or measurement of fundus height • Evidence of a prenatal procedure performed; refer to page on prenatal care in provider guide • Documentation of LMP, EDD or gestational age in conjunction with either a complete obstetrical history or a prenatal risk assessment and counseling/education

PPC: Postpartum care	Live birth deliveries: 10/8/20 – 10/7/21
	On or between 7 and 84 days post delivery date
	• Delivery summary, including documentation of live birth and discharge summary
	• Date and documentation of visit being "postpartum visit"
	• Pelvic exam, cervical cytology
	• Perineal or cesarean incision/wound check
	• Weight, BP, breast exam or documentation of breast feeding
	• Screening for depression, anxiety, tobacco use, substance use or other preexisting mental health issue
	• Documentation of:
	  • Infant care or breastfeeding, resumption of intercourse
	  • Birth spacing or family planning
	  • Sleep/fatigue
	  • Resumption of physical activities and attainment of healthy weight

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Appendix 6 — Documentation quick reference (continued)

Perinatal depression screening	Live birth deliveries: 10/8/20 – 10/7/21 • Screened for depression during a prenatal care visit • Screened for depression during a prenatal care visit using a validated depression screening tool: - The Edinburgh Postnatal Depression Scale (EPDS) - Beck Depression Inventory (BDI 1a, II) - Patient Health Questionnaire (PHQ) – 2 and PHQ-9 Tools - Hamilton Rating Scale for Depression (HRSD) - General Health Question (GHQ-D) - Postpartum Depression Screening Scale (PDSS) - Hospital Anxiety and Depression Scale (HADS) - Generalized Contentment Scale • Screened for depression during the time frame of the first two prenatal care visits • Screened positive for depression during a prenatal care visit • Screened positive for depression during a prenatal care visit and had evidence of further evaluation or treatment or referral for further treatment • Screened for depression during a postpartum care visit • Screened for depression during postpartum care visit using a validated depression screening tool - The Edinburgh Postnatal Depression Scale (EPDS) - Beck Depression Inventory (BDI 1a, II) - Patient Health Questionnaire (PHQ) – 2 and PHQ-9 Tools - Hamilton Rating Scale for Depression (HRSD) - General Health Question (GHQ-D) - Postpartum Depression Screening Scale (PDSS) - Hospital Anxiety and Depression Scale (HADS) - Generalized Contentment Scale • Screened positive for depression during a postpartum care visit • Screened positive for depression during a postpartum care visit and had evidence of further evaluation or treatment or referral for further treatment
Prenatal smoking screening	Live birth deliveries: 10/8/20 – 10/7/21 • Screened for smoking during one of their first two prenatal visits or during their first two visits on or following initiation of eligibility with the managed care organization (MCO) • Screened for environmental tobacco smoke exposure during one of their first two prenatal visits or during their first two visits on or following initiation of eligibility with the MCO • Screened for smoking in one of the first two prenatal visits and who smoke (i.e., smoked 6 months prior to or anytime during the current pregnancy) and were given counseling/advice or a referral regarding during the time frame of any prenatal visit during pregnancy • Screened for environmental tobacco smoke exposure in one of their first two prenatal visits and found to be exposed, and were given counseling/advice or a referral during the time frame or any prenatal visit during pregnancy • Screened for smoking in one of their first two prenatal visits, found to be a smoker and stopped smoking anytime during their pregnancy

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Appendix 6 — Documentation quick reference (continued)

HEDIS 2020 required medical record documentation guide (behavioral health)

Refer to the HEDIS medical record request list to identify the targeted HEDIS components/measures and provide the following documentation for only those measure(s) listed next to each member's name.

Patient information/registration form (which includes name & date of birth) should accompany every record sent	
HEDIS measure identifier	**Send all the following medical record documentation for each measure**

AMM: Antidepressant medication management (ages 18 and older)	Medical record dates: 5/1/2020 – 04/30/2021
	• Documentation of diagnosis
	• Patient education of medication compliance
	  • How antidepressants work, benefits, how long they should be used
	  • Length of time on medication before patient should expect to feel better
	• Patient education about depression
	• Claims for continued antidepressant treatment of major depression with 12 weeks of medication management and 6 months of consistent medication management
	• Ensure member demonstrates 84 days (12 weeks) of treatment with antidepressant medication

ADD: Follow up care for children (ages 6 – 12)	Medical record dates: 1/1/2021 – 12/31/2021 • Members 6 – 12 years of age with a newly prescribed ADHD medication • Follow-up visit within 30 days of initial dispensing date to assess how the medication is working and address side effect issues • 30-day follow-up must be scheduled with a practitioner with prescribing authority, face-to-face • Two additional follow-up visits for patient and family within 9 months of the 30-day (31 – 300 days) follow-up visit to monitor patient's progress on the medication; the two additional follow-up appointments can be with any practitioner; only one of the two may be a telephonic visit
IET: Initiation and engagement of alcohol and other drug dependence treatment (ages 13 and older as of Dec. 31 of measurement year)	Medical record dates: 1/1/2021 – 11/15/2021 Members with newly assigned AOD diagnosis • Follow up appointment scheduled within 14 days for members with a new episode of alcohol or other drug (AOD) diagnosis • Two follow up visits within 34 days of the initial 14-day follow-up visit • Include the alcohol or other drug dependence diagnosis on every claim when treating a patient for issues related to that diagnosis • Provide patient education on available AOD services in the area • Follow up visits may be with initial provider or substance abuse provider • For ED visits resulting in an inpatient stay, the inpatient discharge is the index date
SAA: Adherence to antipsychotic medication for members with schizophrenia (ages 19 – 64)	Medical record dates: 1/1/2021 – 12/31/2021 • Documentation of schizophrenia diagnosis • Claim documentation of dispensed medication • Claim documentation of continued medication for at least 80 percent of treatment period • Encourage members with schizophrenia to discuss any side effects, take medication as prescribed and refill medication on time • Telehealth may be used

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Appendix 6 — Documentation quick reference (continued)

APM: Metabolic monitoring for children and adolescents on antipsychotics	Medical record dates: 1/1/2020 – 12/31/2020 • Documentation of diagnosis • Patient education of medication compliance • How antipsychotics work, benefits and how long they should be used • Length of time on medication before patient should expect to feel better • Importance of continuing medication, even if feeling better • Common side effects, how long they may last and how to manage • Who to contact with questions and concerns • A lower rate of concurrent antipsychotics indicates better performance