2019 Blue Cross NC
Provider Quality Pocket Guide

BlueCross BlueShield
of North Carolina

Requirements for Meeting Clinical Goals - Last Updated October 2018

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This reference guide is not intended to be a complete guide for all HEDIS measures and requirements. For additional details and specifications for HEDIS measures, please go to *https://www.ncqa.org/hedis/measures/* or contact Blue Cross NC Quality Management at *qualitymanagement@bcbsnc.com* or 919-765-4809.

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DEFINITIONS
Administrative Measure - Measure calculation is achieved from claims
Hybrid Measure - Measure calculation is achieved from claims and medical records for full assessment of measure compliance

HEDIS QUALITY MEASURE	CLINICAL GOAL	CRITERIA TO MEET THE GOAL
AAB – Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis MIPS Measure #116 Administrative Measure The percentage of adults 18-64 years of age with a diagnosis of acute bronchitis who were **NOT** dispensed an antibiotic prescription. The intake period is 1/1 to 12/24 each year.	Members treated for acute bronchitis (J20.3-J20.9) should **NOT** be prescribed antibiotics unless there are co-morbid conditions (see table) or competing diagnoses that require antibiotic therapy. ***NOTE:*** *Asthma (J45), Tobacco use (F17 or Z72.0) wheezing (R06.2), fever (R50.9) and Diabetes (E08 - E13) are not co-morbid or competing diagnosis exclusions.*	**Claims:** • Submit a claim with all appropriate diagnosis codes including any competing conditions (i.e. cellulitis, pharyngitis) and any co-morbid condition diagnoses. Telehealth visits are allowed for this measure. **Medical Record documentation not applicable.**

EXCLUSIONS/CO-MORBID CONDITIONS	ICD -10 CM
HIV	B20, Z21, B97.35
Malignant Neoplasms	C00.0 – C96.Z; Z85.0 – Z85.9
Emphysema	J43.0 – J43.9
COPD	J44.0 – J44.9
Cystic Fibrosis	E84.0 – E84.9
Chronic Bronchitis	J41.0 – J42
Disorders of the Immune System	D80.0 – D84.9, D89.3 – D89.9
Other respiratory diagnoses	J22; J47.0, J47.1, J47.9, J60 – J96.92; J99, M30.1, M32.13, M33.01, M33.11, M33.21, M33.91, M34.81, M35.02
TB	A15 – A19.9; O98.011-O98.03
Aspergillosis	B44.81
Sickle Cell Disease with Acute Chest	D57.01, D57.211, D57.411, D57.811

NCQA will post a comprehensive list of medications and NDC codes to ***www.ncqa.org*** in November of the measurement year.

HEDIS QUALITY MEASURE	CLINICAL GOAL	CRITERIA TO MEET THE GOAL
ABA – Adult BMI Assessment Hybrid Measure The percentage of members 18-74 years of age whose body mass index (BMI) or BMI percentile, was documented during the measurement year or the year prior to the measurement year. The measurement period is 1/1 to 12/31 each year. Similar to MIPS Measure #128; see Appendix 4 for details.	For patients 18-19 years of age, **document height, weight and BMI percentile** at least every 2 years. For patients 20-74 years of age document **weight and BMI value**, at least every 2 years.	**Claims:** • Submit a claim for patients 18 and 19 with the appropriate ICD10 CM code for **BMI percentile** Z68.51 to Z68.54* • Submit a claim for patients 20-74 with the appropriate ICD10 CM code for BMI Z68.1 – Z68.45* * These codes are not currently eligible for reimbursement; correct coding guidelines still apply. **Medical Record documentation of:** • **Weight, Height, and BMI percentile** (for agents 18-19), or **Weight and BMI value** (for ages 20-74) within the measurement year or the prior year. *See Appendix 1 for ICD-10-CM BMI and BMI percentile codes.*

HEDIS QUALITY MEASURE	CLINICAL GOAL	CRITERIA TO MEET THE GOAL
ADD – Follow Up Care for Children Prescribed ADHD Medication MIPS Measure #366 Administrative Measure The percentage of children (6-12 years of age as of the Prescription Date) newly prescribed, *or restarting a medication commonly used for ADHD following a lapse of 120 days*, who had at least three follow-up care visits within a 10-month period, *one of which was with a prescribing provider within 30 days of when the medication was dispensed.* The Intake period is 3/1 of the prior year to 2/29 of the current year.	**Initiation Phase:** The member must have an appointment with a provider with prescribing authority for a follow up visit within 30 days of starting or restarting a medication commonly used to treat ADHD. **Continuation and Maintenance Phase:** Then the member must have at least 2 additional follow up visits after the Initiation visit within the next 9 months.	**Claims:** • Submit a claim for a follow up visit with a prescribing provider and the appropriate CPT and ICD10 ADHD codes within 30 days of starting the medication and then at least 2 additional visits with a provider in the 9 months following the 30 day visit. Telehealth visits are allowed for Continuation and Maintenance Phase visits only – not allowed for the Initiation Phase visit. • Please use the Patient Care Summary to verify the date of medication fills and refills. **Medical record documentation not applicable.** *NCQA will post a comprehensive list of medications and NDC codes to **www.ncqa.org** in November of the measurement year.*

HEDIS QUALITY MEASURE	CLINICAL GOAL	CRITERIA TO MEET THE GOAL
AMM – Antidepressant Medication Management MIPS Measure #9 Administrative Measure The percentage of members 18 years of age and older with a diagnosis of major depression who were treated with antidepressant medication and who remained on the medication treatment for: • 84 days (12 weeks) - Acute Phase. • 180 days (6 months) - Continuation Phase. The Intake period is 5/1 of the prior year to 4/30 of the current year.	Members with a **diagnosis of major depression** will remain on medication therapy for at least 180 days (6 months) - **Continuation Phase**	**Claims:** • Submit a claim for the appropriate member diagnosis (major depression). • Receipt of pharmacy claims for 6 months of medication fills. **Medical record documentation not applicable.** *Members placed on antidepressant therapy for other disorders such as episodic mood disorders, anxiety disorders, acute reaction to stress, or adjustment disorder are not included in this measure.* *NCQA will post a comprehensive list of medications and NDC codes to **www.ncqa.org** in November of the measurement year.*

HEDIS QUALITY MEASURE	CLINICAL GOAL	CRITERIA TO MEET THE GOAL
AMR – Asthma Medication Ratio Administrative Measure 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. The measurement period is 1/1 to 12/31 each year.	Patients with persistent asthma will receive Asthma controller prescriptions that account for at least 50% of their total asthma medications. (Controller meds versus rescue medications.)	**Claims:** • Receipt of claims for any exclusions that apply. • Receipt of claims for asthma controller medications that account for at least 50% of all asthma medication prescriptions filled. **EXCLUSIONS** Emphysema – J43.0 – J43.9, J98.2, J98.3 COPD – J44.0 – J44.9 Chronic conditions due to inhaled fumes/vapors – J68.4 Cystic Fibrosis – E84.0 – E84.9 Acute Respiratory Failure – J96.00 – J96.22 **Medical record documentation not applicable.** **Not applicable to Medicare patients.** *NCQA will post a comprehensive list of medications and NDC codes to **www.ncqa.org** in November of the measurement year.*

HEDIS QUALITY MEASURE	CLINICAL GOAL	CRITERIA TO MEET THE GOAL
ART – Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis Administrative Measure The percentage of members who were diagnosed with rheumatoid arthritis & who were dispensed at least 1 prescription for a DMARD medication. The measurement period is 1/1 to 12/31 of the current year. See Appendix 4 for MIPS Measure #180 information	Member will receive at least one ambulatory prescription for Disease-Modifying Anti-Rheumatic Drug (DMARD) Therapy. All patients with RA diagnosis not currently treated with a DMARD should be referred for a rheumatology consult to confirm diagnosis & assess for DMARD therapy.	**Claims:** • Receipt of a claim for at least one ambulatory prescription medication to treat Rheumatoid Arthritis. • Submit a claim for exclusions that apply. > HIV anytime during the member's history to 12/31 of the measurement year. > Pregnancy anytime during the measurement year. **Medical record documentation:** • A visit note showing evidence of DMARD therapy during the measurement year. • A visit note showing exclusionary evidence (HIV positive, or pregnancy during the measurement year). *NCQA will post a comprehensive list of medications and NDC codes to **www.ncqa.org** in November of the measurement year.* *Medicare excludes members 65 years of age and older living in long-term in institutional settings, advanced illness, and/or frailty from this measure.

HEDIS QUALITY MEASURE	CLINICAL GOAL	CRITERIA TO MEET THE GOAL
AWC – Adolescent Well-Care Visits Administrative Measure The percentage of enrolled members 12-21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year. The measurement period is 1/1 to 12/31 of the current year.	Every adolescent between ages 12 and 21 will have at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner every year.	**Claims:** • Submit a claim for all member visits with proper coding for the visit service. **Medical record documentation not applicable.**

HEDIS QUALITY MEASURE	CLINICAL GOAL	CRITERIA TO MEET THE GOAL
BCS – Breast Cancer Screening MIPS Measure #112 Administrative Measure The percentage of women 50-74* years of age who had a mammogram to screen for breast cancer. The measurement period is 1/1 – 12/31 of the current year. There is a 27 month look back period from 10/1 two years prior to 12/31 of the current year.	Members between the age of 50 and 74 years will have one or more mammograms at least every 2 years. Educate your patients on the importance of breast cancer screening.	**Claims:** • Receipt of a claim for mammogram from the radiology facility where the mammogram was performed anytime between October 1st 2 years prior to the measurement year and 12/31 of the measurement year. • Submit a claim for exclusions: > ICD10 Z90.13 for history of bilateral mastectomy or > Z90.11 Absence of right breast AND Z90.12 Absence of left breast. **Medical Record Documentation:** • A visit note that indicates the date of service of the most recent mammogram test. • A visit note that indicates patient has had a bilateral mastectomy. *This measure assesses the use of imaging to detect early breast cancer in women. Because the measure denominator does not remove women at higher risk of breast cancer, all types and methods of mammograms (screening, diagnostic, film, digital or digital breast tomosynthesis) qualify for numerator compliance.* ***Do not count MRIs, ultrasounds or biopsies towards the numerator;*** *although they may be indicated for evaluating women at higher risk for breast cancer or for diagnostic purposes. These procedures are performed as an adjunct to mammography and do not alone count toward the numerator.* *Medicare excludes members 65 years of age and older living in long-term in institutional settings, advanced illness, and/or frailty from this measure.

HEDIS QUALITY MEASURE	CLINICAL GOAL	CRITERIA TO MEET THE GOAL
CBP – Controlling High Blood Pressure MIPS Measure #236 Hybrid Measure The percentage of members 18-85* years of age who had a diagnosis of hypertension (HTN) and whose BP was controlled during the measurement year. • BP goal <140/90 mm Hg The measurement period is 1/1 to 12/31 of the current year.	Control of high BP <140/90 is extremely important to prevent additional cardiovascular conditions. **Educate** on risk factors associated with poor control. **Assess** medication compliance. **Inform** patients of their goal BP. **Encourage** patient to obtain a BP cuff and log BP at least 3 times a week.	**Claims:** • Submit a claim with the 2 appropriate CPTII codes to report results of the BP at **each routine office visit**: Systolic BP greater than/equal to 140 mm Hg – CPT II – 3077F – Not controlled Diastolic BP greater than/equal to 90 mm Hg – CPT II – 3080F – Not controlled Systolic BP 130-139 mg Hg – CPT II – 3075F – Controlled Systolic BP less than 130 mg Hg – CPT II – 3074F – Controlled Diastolic BP 80-89 mm Hg – CPT II – 3079F – Controlled Diastolic BP less than 80 mm Hg – CPT II – 3078F – Controlled **Medical record documentation not applicable.** *Medicare excludes members 65 years of age and older living in long-term in institutional settings, advanced illness, and/or frailty from this measure.

HEDIS QUALITY MEASURE	CLINICAL GOAL	CRITERIA TO MEET THE GOAL
CCS – Cervical Cancer Screening MIPS Measure #309 Hybrid Measure The percentage of women 21-64 years of age who were screened for cervical cancer. The measurement period is 1/1 – 12/31 of the current year.	Women 21-64 will have a cervical cytology (Pap smear) every 3 years **OR** Women age 30-64 will have cervical cytology with HPV every 5 years. (Note: HPV reflex testing does not count for the 5 year timeframe)	**Claims:** • Submit a claim for procedures completed with appropriate codes. • Submit a claim using appropriate ICD10 code for history of exclusion. **ICD-10-CM CODES FOR EXCLUSIONS** Agenesis and Aplasia of Cervix – Q51.5 Acquired Absence of cervix and uterus – Z90.710 Acquired Absence of cervix with remaining uterus – Z90.712 **Medical Record documentation of:** • Screening and results from appropriate testing completed in the last 3-5 yrs. • Exclusions (documentation of "total", "radical", "complete" abdominal or vaginal hysterectomy, or any of above listed conditions).

CDC – Comprehensive Diabetes Care

Hybrid Measures - The percentage of members 18-75 years of age with diabetes (type 1 and type 2) who had the following during the measurement period (1/1 - 12/31 of the current year):

*Medicare excludes members 65 years of age and older living in long-term institutional settings, advanced illness, and/or frailty from all of this measure.

HEDIS QUALITY MEASURE	CLINICAL GOAL	CRITERIA TO MEET THE GOAL
CDC – HbA1c Three rates are reported: 1. HbA1c Testing 2. HbA1c Poor Control >9% 3. HbA1c Good Control <8% MIPS Measure #1 = CDC HbA1c Poor Control >9%	• Members will have a **HbA1c test** performed during the measurement year. • HbA1c value – poor control ≥9% (reported in PQR as inverted rate <9%) • HbA1c value good control <8%. Medicare patients – goal HbA1c <9 Non-Medicare patients – goal HbA1c <8%	**Claims:** • Submit a claim identifying the results of the HbA1c utilizing one of the following three CPT II codes **> 3046F** - HbA1c greater than 9%. **> 3045F** - HbA1c between 7.0 - 9.0%.* **> 3044F** - HbA1c less than 7.0%. ** CPTII code 3045F (HbA1c 7.0-9.0%) is not specific enough to denote numerator compliance. Blue Cross NC will need to use other sources (laboratory value, chart reviews) to identify if the HbA1c was <8%. **Medical Record documentation of:** • Date and value of **most recent** HbA1c result during the measurement year. ***Please note*** *– when submitting any CPTII codes,* ***do not use*** *the modifiers 1P, 2P, 3P, or 8P. These modifiers indicate that the service was not done and will exclude the CPTII code from care gap calculations.*

HEDIS QUALITY MEASURE	CLINICAL GOAL	CRITERIA TO MEET THE GOAL
CDC – Medical Attention for Nephropathy MIPS Measure #119 Annual screening test or evidence of treatment for nephropathy with ACE/ARB therapy.	Members will have an annual urine screen for albumin/ protein done during the measurement year. **OR** Evidence of treatment for nephropathy. **OR** ACE/ARB therapy.	**Claims:** • Submit a claim for appropriate nephropathy screening test or evidence of nephropathy during the measurement year. Also can accomplish by utilizing one of the following CPTII codes: > **3060F or 3061F** - Screening tests for nephropathy > **3062F** - positive macroalbuminuria > **3066F** - documentation of treatment for nephropathy > **4010F** - patient prescribed or taking ACE or ARB **Medical record documentation of:** • Results of nephropathy screen during the measurement year • Evidence of nephropathy during the measurement year • ACE/ARB Therapy prescribed during the measurement year ***Please note** – when submitting any CPTII codes, **do not use** the modifiers 1P, 2P, 3P, or 8P. These modifiers indicate that the service was not done and will exclude the CPTII code from care gap calculations.* *NCQA will post a comprehensive list of medications and NDC codes to **www.ncqa.org** in November of the measurement year.*

HEDIS QUALITY MEASURE	CLINICAL GOAL	CRITERIA TO MEET THE GOAL
CDC – BP Control <140/90	Members with diabetes will have blood pressure control of <140/90 mm Hg.	**Claims:** • Submit a claim with the 2 appropriate CPTII codes to report results of the BP at **each** office visit:

Systolic BP greater than/equal to 140 mm Hg	CPT II – 3077F	Not controlled
Diastolic BP greater than/equal to 90 mm Hg	CPT II – 3080F	Not controlled
Systolic BP 130-139 mg Hg	CPT II – 3075F	Controlled
Systolic BP less than 130 mg Hg	CPT II – 3074F	Controlled
Diastolic BP 80-89 mm Hg	CPT II – 3079F	Controlled
Diastolic BP less than 80 mm Hg	CPT II – 3078F	Controlled

Medical record documentation not applicable.

***Please note** – when submitting any CPTII codes, **do not use** the modifiers 1P, 2P, 3P, or 8P. These modifiers indicate that the service was not done and will exclude the CPTII code from care gap calculations.*

HEDIS QUALITY MEASURE	CLINICAL GOAL	CRITERIA TO MEET THE GOAL
CDC – Annual Eye Exam MIPS Measure #117	Member will have: • A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year. • A negative retinal or dilated eye exam (negative for retinopathy) by an eye care professional in the year prior to the measurement year. • Bilateral eye enucleation anytime during the member's history through December 31 of the measurement year.	**Claims:** **If you have or reviewed a report from the patient's ophthalmologist or optometrist:** • Submit a claim with the appropriate CPTII code: > **2022F** - Dilated eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed. > **2024F** - Seven (7) standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist documented and reviewed. > **2026F** - Eye Imaging validated to match diagnosis from seven (7) standard field stereoscopic photos results documented and reviewed. > **3072F** - Low risk for retinopathy (no evidence of retinopathy in the prior year). **Medical record documentation of:** • Results of most recent eye exam **by an eye care professional** within the measurement year or within 2 years if documented low risk of retinopathy or evidence of bilateral eye enucleation/acquired absence in both eyes anytime in member's history. ***Please note** – when submitting any CPTII codes, **do not use** the modifiers 1P, 2P, 3P, or 8P. These modifiers indicate that the service was not done and will exclude the CPTII code from care gap calculations.*

HEDIS QUALITY MEASURE	CLINICAL GOAL	CRITERIA TO MEET THE GOAL
CHL – Chlamydia Screening in Women ages 16-24 MIPS Measure #310 Administrative Measure 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. The measurement year is 1/1 to 12/31 of the current year.	Annual screening for chlamydia is required for all sexually active females ages 16-24. Obtain a urine sample or obtain a direct sample (i.e. cervix, urethra, vagina) for chlamydia culture yearly.	**Claims:** • Receipt of a Microbiology claim for chlamydia screening with appropriate CPT or LOINC codes. **Medical record documentation:** • A visit note indicating date of service and lab results showing chlamydia screening was performed. ***Please note:*** *Sexual activity is determined by the HEDIS specifications. There are no exclusions for this measure and patients cannot be removed from denominator.*

HEDIS QUALITY MEASURE	CLINICAL GOAL	CRITERIA TO MEET THE GOAL
CIS – Childhood Immunization Status MIPS Measure #240 Hybrid Measure The percentage of children 2 years of age who had all the listed immunizations. The measurement period is 1/1 – 12/31 of the current year.	By the 2nd birthday children will have the following vaccinations: • 4 DTaP • 3 IPV • 1 MMR • 3 HiB • 3 HepB • 1 VZV • 4 PCV • 1 HepA • 2 or 3 Rotavirus • 2 flu vaccinations Combo 7 = all except Flu Combo 10 = all	**Claims:** • Report all immunizations to the North Carolina Immunization registry. • Submit **a claim** for all immunizations given. > **Exclude** children who had a **contraindication for a specific vaccine,** or **anaphylactic reaction** to the vaccine or its components any time on or before the member's 2nd birthday. **Medical record documentation:** • A visit note indicating the name of the specific antigen & the date of the immunization • A certificate of immunization prepared by an authorized health care provider or agency including the specific dates and types of immunizations administered. • A visit note indicating contradiction or allergy to any of the vaccinations. ***Please note:*** *for measure compliance, MMR, HepA, and VZV vaccines should be given between the child's 1st and 2nd birthdays.*

HEDIS QUALITY MEASURE	CLINICAL GOAL	CRITERIA TO MEET THE GOAL
COL – Colorectal Cancer Screening MIPS Measure #113 Hybrid Measure The percentage of members 50-75* years of age who had appropriate screening for colorectal cancer. The measurement period is 1/1 to 12/31 of the current year.	The member will have one of the following screening tests during the indicated period. • Fecal occult blood test (FOBT or FIT) between 1/1 and 12/31 of the measurement year** • Colonoscopy performed between 1/1 nine (9) years prior to the measurement year and 12/31 • Flexible sigmoidoscopy performed between 1/1 four (4) years prior to the measurement year and 12/31 of the measurement year. • CT Colonography performed between 1/1 four (4) years prior to the measurement year and 12/31 of the measurement year. • FIT-DNA test done between 1/1 two (2) years prior to the measurement year and 12/31 of the measurement year **FOBT tests performed on a sample collected from a digital rectal exam do not meet the measure requirements	**Claims:** • Submit claims for 3 Fecal Occult Blood (FOBT) or 1 Fecal Immunochemical (FIT) test using code 82270, 82274, or G0328 • Receipt of a claim for a sigmoidoscopy • Receipt of a claim for a colonoscopy • Receipt of a claim for CT colonography • Receipt of a claim for FIT-DNA testing using code 85128 or G0464 • Submit a claim for exclusion (Personal History of Other Malignant Neoplasm of the Large Intestines (ICD 10 =Z85.038)* or Personal History of Other Malignant Neoplasm of the rectum, rectosigmoid junction and anus (ICD10 Z85.048)* ***Please note – for FIT-DNA testing, please verify with customer service the patient's availability of coverage for the test.*** **Medical record documentation of:** • FOBT (3) done during the measurement year • FIT (1) done during the measurement year • Colonoscopy done within 9 years prior to the measurement year and 12/31 of the measurement year • Sigmoidoscopy done within 4 years prior to the measurement year and 12/31 of the measurement year • CT Colonography done within 4 years prior to the measurement year and 12/31 of the measurement year. • FIT-DNA test done within 2 years prior to the measurement year and 12/31 of the measurement year • Documentation of exclusion: colorectal cancer or a total colectomy at any time during the member's history through 12/31 of the measurement year *Medicare excludes members 65 years of age and older living in long-term in institutional settings from this measure.

HEDIS QUALITY MEASURE	CLINICAL GOAL	CRITERIA TO MEET THE GOAL
CWP – Appropriate Testing for Children with Pharyngitis MIPS Measure #66 Administrative Measure The percentage of children 3-18 years of age who were diagnosed with pharyngitis dispensed an antibiotic **and** had a group A streptococcus (strep) test. The measurement period is 7/1 of the prior year to 6/30 of the current year.	Children 3-18 years of age diagnosed with pharyngitis/ tonsillitis must receive a strep test prior to receiving a prescription for antibiotics. *Other family members with strep, parental refusal or clinical exam are not exclusions to this measure.*	**Claims:** • Submit a claim for a rapid strep test done in your office or send specimen for culture. • Submit a claim for all additional competing diagnoses that would require antibiotic therapy. **Medical record documentation:** • A visit note with date of service and lab results showing strep test was completed.

CWP VALUE SET	
ICD10 CWP value set	J02 all codes - Pharyngitis J03 all codes - Tonsillitis
IF YOU USE ONE OF THE CODES ABOVE THE MEASURE REQUIRES A STREP TEST.	
CPT strep test codes (LOINC codes also accepted)	87070, 87071, 87081, 87430, 87650, 87651, 87652, 87880

HEDIS QUALITY MEASURE	CLINICAL GOAL	CRITERIA TO MEET THE GOAL
FUH – Follow-Up After Hospitalization for Mental Illness MIPS Measure #391 Administrative Measure The percentage of discharges for members 6 years & older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported: 1) Follow up within 7 days after discharge (cannot count day of discharge visits). 2) Follow up within 30 days of discharge. The Intake period is 1/1 to 12/1 each year.	The goal is: 1) Members that had an inpatient hospitalization for a mental health diagnoses will be seen by a mental health practitioner within **7 days of discharge**. 2) Members that had an inpatient hospitalization for a mental health diagnoses will be seen by a mental health practitioner within **30 days of discharge**. *Follow up with a PCP does not meet the measure. The visit must be with a **mental health practitioner**.*	**Claims:** • Receipt of a claim for an outpatient visit, intensive outpatient visit or partial hospitalization **with a mental health practitioner** within 7 days after discharge, and again within 30 days of discharge. Telehealth modifiers are also allowed. **Medical record documentation not applicable.**

HEDIS QUALITY MEASURE	CLINICAL GOAL	CRITERIA TO MEET THE GOAL
IET – Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment MIPS Measure #394 Administrative Measure The percentage of adolescent and adult members, 13 years and older with a new episode of alcohol or other drug (AOD) dependence who received the following: **Initiation -** The percentage of members who initiate treatment through an outpatient visit, inpatient AOD admission, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis. **Engagement:** The percentage of members who initiated treatment and had **two or more** additional services with a diagnosis of AOD within 30 days of the initiation visit. The Intake period is 1/1 to 11/14 each year.	Members who are diagnosed with alcohol or drug dependence will be referred immediately to an appropriate provider for treatment of alcohol or other drug dependence. **OR** Schedule a follow up visit within 14 days at your practice, to initiate treatment of AOD dependence and then 2 additional follow up visits for AOD treatment in the 30 days following the Initiation visit. ***If member is noncompliant with Initiation within 14 days the member is then noncompliant for both Initiation and Engagement.***	**Claims:** • Receipt of a claim for a visit to a behavioral health provider, **OR** • Receipt of a claim for follow up visit with the provider who diagnosed the AOD dependence within 14 days of the AOD diagnosis, utilizing an appropriate treatment code for AOD diagnosis. • Receipt of a claim for 2 additional visits for AOD treatment in the 30 days following the first treatment visit. *Inform the behavioral health provider they are required to use an AOD dependence diagnosis code to meet the measure. (i.e. anxiety [F41] does not meet the measure for AOD treatment. The provider needs to use alcohol induced anxiety disorder [F10.280]).* **Medical record documentation not applicable.** **CODES TO IDENTIFY AOD DEPENDENCE** / **NOT INCLUDED REMISSION AND OTHER CODES** F10.10 - 10.29, F11.10 - 11.29, F12.10 - 12.29 / F10.21, F10.9, F11.21, F11.9, F12.21, F12.9 F13.10 - 13.29, F14.10 - 14.29, F15.10 - 15.29 / F13.21, F13.9, F14.21, F14.9, F15.21, F15.9 F16.10 - 16.29, F18.10 - 18.29, F19.10 - 19.29 / F16.21, F16.9, F18.21, F18.9, F19.21, F19.9 Primary care clinicians can provide and bill for counseling without conducting a review of systems, and should use Counseling codes in place of E/M codes in place of E/M codes (99211-15).

HEDIS QUALITY MEASURE	CLINICAL GOAL	CRITERIA TO MEET THE GOAL
IMA – Immunizations for Adolescents Hybrid Measure The percentage of adolescents 13 years of age who had the listed vaccinations. The measurement period is 1/1 to 12/31 each year.	By the 13th birthday, members will have received: • 1 meningococcal vaccine on or between 11th and 13th birthdays • 1 DTaP vaccine on or between 10th and 13th birthdays • 2 or 3 HPV vaccines with different dates of service on or between the member's 9th and 13th birthdays If reporting only 2 vaccines, there must be at least 146 days between the first and second dose of the HPV vaccine.	**Claims:** • Submit **a claim** for all vaccinations members receive. • Report all Immunizations to the North Carolina Immunization Registry. • Submit **a claim** for exclusion if appropriate. > **Exclude adolescents** who had a contraindication for a specific vaccine. > **Anaphylactic reaction** to the vaccine or its components or anaphylactic reaction – serum any time on or before the member's 13th birthday. **Medical record documentation of:** • A visit note indicating the name of the specific antigen & the date of the immunization ***or*** • A certificate of immunization prepared by an authorized health care provider or agency, including the specific dates and types of immunizations administered. • A visit note indicating contraindication or allergy to any of the vaccinations.

HEDIS QUALITY MEASURE	CLINICAL GOAL	CRITERIA TO MEET THE GOAL
MMA – Medication Management for People With Asthma MIPS Measure #444 Administrative Measure The percentage of members 5-64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period. Two rates are reported: • 50% adherence with controller medication • 75% adherence with controller medication The measurement period is 1/1 to 12/31 of each year.	Members with persistent asthma will be dispensed asthma control medications and will be compliant with use of the medication at least **75%** of the treatment period. Assess member compliance with use of medication as prescribed. Consider refill x 11 (1 per month) or 90 day supply. **Treatment period begins on the 'earliest prescription dispensing date for any asthma controller medication during the measurement year through the last day (12/31) of the measurement year'.*	**Claims:** • Receipt of claims for asthma controller medication throughout the measurement year that will total 75% compliance. **Medical record documentation not applicable.** **Not applicable to Medicare patients.** *NCQA will post a comprehensive list of medications and NDC codes to **www.ncqa.org** in November of the measurement year.*

HEDIS QUALITY MEASURE	CLINICAL GOAL	CRITERIA TO MEET THE GOAL
MPM – Annual Monitoring for Patients on Persistent Medications Administrative Measure The percentage of members ≥ 18 years of age who received 180 + days of medication for a select therapeutic agent (ACE/ARB or diuretics) & at least one monitoring event in the measurement year. The measurement period is 1/1 to 12/31 of each year.	Members ≥ 18 years old who remain on an ACE/ ARB, or a diuretic medication for 180 days will have potassium and creatinine checked at least once annually.	**Claims:** • Receipt of a claim for laboratory testing for required labs during the measurement year. > At least one serum potassium and creatinine **Medical record documentation not applicable.** **Not applicable to Medicare patients.**

HEDIS QUALITY MEASURE	CLINICAL GOAL	CRITERIA TO MEET THE GOAL
MRP – Medication Reconciliation Post-Discharge Hybrid Measure The percentage of discharges from January 1 – December 1 of the measurement year for members 18 years of age and older for whom medications were reconciled the date of discharge through 30 days after discharge (31 total days).	Members 18 years of age or older will have all medications reviewed and reconciled within 30 days of discharge from an inpatient setting. *This measure assesses whether medication reconciliation occurred. It does not attempt to assess the quality of the medication list documented in the medical record or the process used to document the most recent medication list in the medical record. **Medication reconciliation must be conducted by a prescribing practitioner, clinical pharmacist or registered nurse.*	**Claims:** • Receipt of claims with Medication Reconciliation visit codes – 99495, 99496, 1111F **Medical Record Documentation:** Documentation in the outpatient medical record must include evidence of medication reconciliation and the date when it was performed. Any of the following meets criteria: • Documentation of the current medications with a notation that the provider reconciled the current and discharge medications. • Documentation of the current medications with a notation that references the discharge medications (e.g., no changes in medications since discharge, same medications at discharge, discontinue all discharge medications). • Documentation of the member's current medications with a notation that the discharge medications were reviewed. • Documentation of a current medication list, a discharge medication list and notation that both lists were reviewed on the same date of service. • Documentation of the current medications with evidence that the member was seen for post-discharge hospital follow-up with evidence of medication reconciliation or review. • Documentation in the discharge summary that the discharge medications were reconciled with the most recent medication list in the outpatient medical record. There must be evidence that the discharge summary was filed in the outpatient chart on the date of discharge through 30 days after discharge (31 total days). • Notation that no medications were prescribed or ordered upon discharge.

HEDIS QUALITY MEASURE	CLINICAL GOAL	CRITERIA TO MEET THE GOAL
OMW – Osteoporosis Management in Women Who Had a Fracture MIPS Measure #418 Administrative Measure The percentage of women 67-85* years of age who suffered a fracture and had either a bone mineral density (BMD) test or prescription for a drug to treat osteoporosis in the six months after the fracture. The measurement period is 7/1 of the prior year to 6/30 of the current year.	Members 67-85 years of age, who had a fracture, will have a BMD within 6 months of the date of fracture. Consider BMD every 2 years in this age group. **Medicare only**	**Claims:** • Receipt of a claim for BMD within 6 months of a fracture. • Receipt of a claim for medication to treat osteoporosis within 6 months of the fracture. **Medical Record documentation:** • A visit note with evidence of BMD test in the appropriate timeframe. • A visit note with evidence of medication given within the appropriate timeframe. **Exclusions:** • Members who have had a bone density test during the 24 months prior to the fracture. • Members who during the 12 months prior to the fracture received a dispensed prescription or had an active prescription to treat osteoporosis. • Members who had a claim/encounter for osteoporosis therapy in the 12 months prior to the fracture. • Members 65 years of age and older living in long-term in institutional settings. *NCQA will post a comprehensive list of medications and NDC codes to **www.ncqa.org** in November of the measurement year.*

HEDIS QUALITY MEASURE	CLINICAL GOAL	CRITERIA TO MEET THE GOAL
PBH – Persistence of Beta Blocker Treatment After a Heart Attack MIPS Measure #442 Administrative Measure The percentage of members ≥ 18 years of age who were hospitalized and discharged with a diagnosis of AMI and who remained on beta-blocker treatment for six months after discharge. The Intake period is 7/1 of the prior year to 6/30 of the current year annually.	Members ≥ 18 years of age with new diagnosis of AMI will remain on beta-blocker treatment for six months after hospital discharge. Consider 90 day supply or refills x 6 if appropriate.	**Claims:** • Receipt of pharmacy claims for 180-day supply of a beta blocker medication. • Submit **a claim** if member has one of the following exclusions. **Medical record documentation not applicable.**

EXCLUSIONS: ICD-10-CM DIAGNOSIS	
Asthma	J45.20 – J45.52; J45.901 – J45.998
Hypotension	I95.0 – 953; I95.81 – I95.89
Heart block >1 degree	I44.1 – I44.7 (excluding I44.3); I45.0 – I45.3; I45.6, I49.5; I95.0
Sinus bradycardia	R00.1
COPD	J44.0 – J44.9
Obstructive Chronic Bronchitis	J41.0 – J42
Chronic conditions due to inhaled fumes/vapors	J68.4

HEDIS QUALITY MEASURE	CLINICAL GOAL	CRITERIA TO MEET THE GOAL
PCE – Pharmacotherapy Management of COPD Exacerbation The percentage of COPD exacerbations for members ≥ 40 years old who had an inpatient or ED visit and were dispensed appropriate medications. Two rates are reported: 1. **Systemic Corticosteroid** dispensed within 14 days of discharge date. 2. **Bronchodilator** dispensed within 30 days of discharge date. The measurement period is 1/1 to 11/30 of the current year.	Assess if patient was given appropriate medication prescription at the time of discharge. **AND** has filled the prescription **AND** is taking medications as prescribed. Prescribe appropriate systemic corticosteroid within 14 days of the discharge date and bronchodilator within 30 days of discharge **IF** member was not given prescription at the time of discharge.	**Claims:** ▪ Receipt of pharmacy claims. > For a systemic steroid within 14 days of date of discharge and a bronchodilator within 30 days from inpatient stay or ER visit OR > An adequate supply of either medication for treatment after discharge from ER or Acute Inpatient stay. **There are no exclusions to this measure.** **Medical record documentation not applicable.** *NCQA will post a comprehensive list of medications and NDC codes to **www.ncqa.org** in November of the measurement year.*

HEDIS QUALITY MEASURE	CLINICAL GOAL	CRITERIA TO MEET THE GOAL
PCR – Plan All-Cause Readmissions For members 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. ***Note:*** *For non-Medicare reporting only includes members 18-64 years of age.*	Members will not have unnecessary/avoidable readmissions. This is a risk adjusted measure - that calculates 30 day readmission rates utilizing the following components: ▪ Count of Index Hospital Stays (IHS) (denominator). ▪ Count of 30-Day Readmissions (numerator). ▪ Expected Readmissions - risk adjusted	**Claims and Medical Record Documentation instructions are not applicable to this measure. This is a risk-adjusted utilization measure.**

HEDIS QUALITY MEASURE	CLINICAL GOAL	CRITERIA TO MEET THE GOAL
PPC – Prenatal and Postpartum Care Hybrid measure **Timeliness of Prenatal Care** The percentage of deliveries that received a prenatal visit in the first trimester. **Postpartum Care** The percentage of deliveries that had a postpartum visit on or between 21 & 56 days after delivery. The Intake period is 11/6 of the prior year to 11/5 of the current year.	Members will receive a prenatal visit in the first trimester of pregnancy (or within 45 days of enrollment in Blue Cross NC plan). Members will receive a post-partum visit with their provider between day 21 and day 56 postpartum.	**Claims:** • All providers must submit **a claim** for the **prenatal visit on the date of service** using the following codes: **0500F or 0501F** and the appropriate ICD-10 diagnosis. • All providers must submit **a claim** for the **post partum visit on the date of service** using the following code: **0503F and the ICD 10 diagnosis code** for Postpartum Care **Z39.2**. • **For Global Billing** - You **must** submit an additional claim with the dates of the prenatal and postpartum visits. Refer to Corporate Reimbursement Policy (CRP). **Medical record documentation:** **OR** • Date service rendered • Service Rendered • EDC or LMP or Date of delivery ***Please note** – when submitting any CPTII codes, **do not use** the modifiers 1P, 2P, 3P, or 8P. These modifiers indicate that the service was not done and will exclude the CPTII code from care gap calculations.*

HEDIS QUALITY MEASURE	CLINICAL GOAL	CRITERIA TO MEET THE GOAL
SPC – Statin Therapy for Patients With Cardiovascular Disease Administrative Measure 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. Two rates are reported: 1. *Received Statin Therapy.* Members who were dispensed at least one high-intensity or moderate-intensity statin medication during the measurement year. 2. *Statin Adherence 80%.* Members who remained on a high-intensity or moderate-intensity statin medication for at least 80% of the treatment period. The measurement period is 1/1 – 12/31 of the current year.	Members identified as having clinical atherosclerotic cardiovascular disease (ASCVD) will be prescribed and then maintain 80% adherence on a Statin Medication.	**Claims:** • Receipt of pharmacy claims for a high intensity or moderate intensity statin medication during the measurement year • Receipt of pharmacy claims for high intensity or moderate intensity statin medication throughout the measurement year that will total 80% compliance. **There are no exclusions to this measure.** **Medical record documentation not applicable.** *NCQA will post a comprehensive list of medications and NDC codes to **www.ncqa.org** in November of the measurement year.*

HEDIS QUALITY MEASURE	CLINICAL GOAL	CRITERIA TO MEET THE GOAL
SPD – Statin Therapy for Patients With Diabetes Administrative Measure 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: 1. *Received Statin Therapy.* Members who were dispensed at least one statin medication of any intensity during the measurement year. 2. *Statin Adherence 80%.* Members who remained on a statin medication of any intensity for at least 80% of the treatment period. The measurement period is 1/1 – 12/31 of the current year.	Members identified as having Diabetes who do not have atherosclerotic cardiovascular disease (ASCVD) will be prescribed and then maintain 80% adherence on a statin medication.	**Claims:** • Receipt of pharmacy claims for a statin medication during the measurement year. • Receipt of pharmacy claims for a statin medication throughout the measurement year that will total 80% compliance. **There are no exclusions to this measure.** **Medical record documentation not applicable.** *NCQA will post a comprehensive list of medications and NDC codes to **www.ncqa.org** in November of the measurement year.*

HEDIS QUALITY MEASURE	CLINICAL GOAL	CRITERIA TO MEET THE GOAL
SPR – Use of Spirometry Testing in the Assessment and Diagnosis of COPD MIPS Measure #51 Administrative Measure The percentage of members ≥ 40 years of age with a new diagnosis of COPD who received spirometry testing to confirm the diagnosis. The Intake period is 7/1 of the prior year to 6/30 of the current year.	Members ≥ 40 years old with a new or newly active diagnosis of COPD will have spirometry testing completed to confirm the diagnosis.	**Claims:** • Submit a claim for spirometry testing on the date of service using appropriate CPT code. **Medical record documentation not applicable.**

HEDIS QUALITY MEASURE	CLINICAL GOAL	CRITERIA TO MEET THE GOAL
URI – Appropriate Treatment for Children With Upper Respiratory Infection MIPS Measure #65 Administrative Measure The percentage of children 3 months-18 years of age who were diagnosed with upper respiratory infection (URI) and were **NOT** dispensed an antibiotic prescription. The Intake period is 7/1 of the prior year to 6/30 of the current year.	Antibiotics will **NOT** be prescribed to children who are diagnosed with URI only. If there is another diagnosis that requires antibiotic treatment you need to add that coding information to your claim.	**Claims:** • Submit **a claim** for all additional competing diagnoses requiring antibiotic therapy on or within 3 days after the date of claim for URI. **Medical record documentation not applicable.**

HEDIS QUALITY MEASURE	CLINICAL GOAL	CRITERIA TO MEET THE GOAL
W15 – Well-Child Visits in the First 15 Months of Life Administrative Measure The percentage of members who turned 15 months old during the measurement year and who had: none, one, 1, 2, 3, 4, 5, 6, or more well-child visits during the first 15 months of life.* *Calculated by adding 90 days to the first birthday. The measurement period is 1/1 – 12/31 of the current year.	Children should have 6 or more well-child visits during the first 15 months of life.	**Claims:** • Submit a claim for all member visits with proper coding for the visit service. **Medical record documentation not applicable.**

HEDIS QUALITY MEASURE	CLINICAL GOAL	CRITERIA TO MEET THE GOAL
W34 – Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life Administrative Measure The percentage of members 3-6 years of age who had one or more well-child visits with a PCP during the measurement year. The measurement period is 1/1 – 12/31 of the current year.	Every child between 3 and 6 years of age will have a well-child visit at least annually.	**Claims:** • Submit a claim for all member visits with proper coding for the visit service. **Medical record documentation not applicable.**

WCC – Weight Assessment & Counseling for Nutrition & Physical Activity for Children & Adolescents

MIPS Measure #239
Hybrid Measure

The percentage of members 3-17 years of age who had an outpatient visit with a PCP or OB/GYN & had the following during the measurement year (1/1 - 12/31):

HEDIS QUALITY MEASURE	CLINICAL GOAL	CRITERIA TO MEET THE GOAL
WCC – BMI Percentile The percentage of members 3-17 years of age who had an outpatient visit with a PCP or OB/GYN & had the following during the measurement year: BMI percentile. The measurement period is 1/1 to 12/31 of the current year.	Members ages 3-17 will be assessed for **height, weight, and BMI percentile** during the measurement year.	**Claims:** • Submit a claim including the appropriate code below. **Medical record documentation of:** • Height, Weight & **BMI percentile** or **BMI percentile plotted on age-growth chart** during the measurement year. The height, weight & BMI percentile must be from the same data source.

ICD-10-CM CODES	PERCENTILE
Z68.51	Pediatric < 5th
Z68.52	Pediatric ≥ 5th - < 85th
Z68.53	Pediatric ≥ 85th ≤ 95th
Z68.54	Pediatric ≥ 95th

HEDIS QUALITY MEASURE	CLINICAL GOAL	CRITERIA TO MEET THE GOAL
WCC – Counseling for Nutrition Documentation of counseling for nutrition or referral for nutrition education during the measurement (**current**) year as identified by administrative data or medical record review.	Members ages 3-17 will be counseled on nutrition during the measurement year.	**Claims:** • Submit **a claim** with the appropriate code: **Z71.3** Dietary Counseling and surveillance. **G0447** Face to Face behavioral counseling for obesity - 15 minutes. **Medical record documentation of:** • A note indicating the date of service and at least **one** of the following: > Anticipatory guidance for physical activity discussion of nutrition behavior (i.e. eating or diet behaviors) > Checklist indicating nutrition was addressed > Educational materials on nutrition given to the member during face-to-face visits > Anticipatory guidance for nutrition > Counseling or referral for nutrition education > Weight or obesity counseling

HEDIS QUALITY MEASURE	CLINICAL GOAL	CRITERIA TO MEET THE GOAL
WCC – Counseling for Physical Activity Documentation of counseling for physical activity or referral for physical activity during the measurement year as identified by administrative data or medical record review.	Members ages 3-17 will be counseled on physical activity during the measurement year.	**Claims:** • Submit a claim with the appropriate code if applicable. **G0447** Face to face behavioral counseling for obesity - 15 minutes. **Medical record documentation:** • A note indicating the date of service and at least **one** of the following: > Discussion of current physical activity behaviors (i.e. exercise routine, sports activities, exam for sports participation) > Checklist indicating physical activity was addressed > Counseling or referral for physical activity > Member received educational materials on physical activity during a face-to-face visit > Anticipatory guidance for physical activity

MEDICARE PART D PHARMACY MEASURES

MEDICARE PART D PHARMACY MEASURES	CLINICAL GOAL	CRITERIA TO MEET THE GOAL
HRM – High Risk Medications Administrative Measure The percentage of Medicare Part D beneficiaries 65 years and older who receive 2 or more prescriptions for the same HRM drug with high risk of side effects in the elderly. The measurement period is 1/1 – 12/31 of the current year.	Patients 65 and older will **NOT** receive 2 or more prescriptions for HRM. If an HRM is indicated, limit use to the shortest time and lowest dose possible without refills.	**Claims:** • Information for this measure is based on claims data for prescription drugs filled by the members through December 31 of the measurement year. **There is no reporting required from the provider.** **Medical Record documentation not applicable.**

MEDICARE PART D PHARMACY MEASURES	CLINICAL GOAL	CRITERIA TO MEET THE GOAL
Rx – Cholesterol Adherence **Medication Adherence for Cholesterol (Statins)** Administrative Measure The percentage of Medicare Part D beneficiaries 18 years or older who adhere to their prescribed drug therapy for statin cholesterol medications during the measurement period. The measurement period is 1/1 – 12/31 of the current year.	**Consider** 90 day supply of medication. **Educate** your patient re: medication compliance & risk factors. **Assess** compliance and remove barriers to compliance.	**Claims:** • Information for this measure is based on claims data for prescription drugs filled by the members through December 31 of the measurement year. **There is no reporting required from the provider.** **Medical Record documentation not applicable.** **Adherence defined as:** *a proportion of days covered (PDC) at **80%** or over for statin cholesterol medication(s) during the measurement period.*

MEDICARE PART D PHARMACY MEASURES

MEDICARE PART D PHARMACY MEASURES	CLINICAL GOAL	CRITERIA TO MEET THE GOAL
Rx – Hypertension Adherence **Medication Adherence for Hypertension (RAS antagonists)** Administrative Measure The percentage of Medicare Part D beneficiaries 18 years or older who adhere to their prescribed drug therapy for renin angiotensin system (RAS) antagonists [angiotensin converting enzyme inhibitor (ACEI), angiotensin receptor blocker (ARB), or direct renin inhibitor medications]. The measurement period is 1/1 – 12/31 of the current year.	**Consider** 90 day supply of medication. **Educate** your patient re: medication compliance and risk factors. **Assess** compliance and remove barriers to compliance.	**Claims:** • Information for this measure is based on claims data for prescription drugs filled by the members through December 31 of the measurement year. **There is no reporting required from the provider.** **Medical Record documentation not applicable.** **Adherence defined as:** *a proportion of days covered (PDC) at **80%** or over for appropriate medication(s) during the measurement period.*

MEDICARE PART D PHARMACY MEASURES

MEDICARE PART D PHARMACY MEASURES	CLINICAL GOAL	CRITERIA TO MEET THE GOAL
Rx – Diabetes Medication Adherence **Medication Adherence for Diabetes Medications** Administrative Measure The percent of Medicare Part D beneficiaries 18 years or older who adhere to their prescribed drug therapy across classes of diabetes medications: biguanides, sulfonylureas, thiazolidinediones, and DiPeptidyl Peptidase (DPP)-IV Inhibitors, incretin mimetics, and meglitinides. The measurement period is 1/1 – 12/31 of the current year.	**Consider** 90 day supply of medication. **Educate** your patient re: medication compliance and risk factors. **Assess** compliance and remove barriers to compliance.	**Claims:** • Information for this measure is based on claims data for prescription drugs filled by the members through December 31 of the measurement year. **There is no reporting required from the provider.** **Medical Record documentation not applicable.** **Adherence defined as:** *a proportion of days covered (PDC) at **80%** or over for appropriate medication(s) during the measurement period.* **Exclusion:** Members who take insulin are not included in this measure.

MEDICARE PART D PHARMACY MEASURES	CLINICAL GOAL	CRITERIA TO MEET THE GOAL
Rx – Statin Use in Persons with Diabetes (SUPD) Administrative Measure The percentage of Medicare Part D beneficiaries between 40 and 75 years old who received at least two diabetes medication fills and also received a statin medication during the measurement period.	**Educate** your patient re: medication compliance & risk factors. **Assess** compliance and remove barriers to compliance.	**Claims:** • Information for this measure is based on claims data for prescription drugs filled by the members through December 31 of the measurement year. **There is no reporting required from the provider.** **Medical Record documentation not applicable.** **Exclusion:** Members who are in Hospice are not included in this measure.

APPENDIX 1.

BMI CODE CHART

Z68.1	Body mass index (BMI)	19 or less	adult
Z68.20	Body mass index (BMI)	20.0-20.9	adult
Z68.21	Body mass index (BMI)	21.0-21.9	adult
Z68.22	Body mass index (BMI)	22.0-22.9	adult
Z68.23	Body mass index (BMI)	23.0-23.9	adult
Z68.24	Body mass index (BMI)	24.0-24.9	adult
Z68.25	Body mass index (BMI)	25.0-25.9	adult
Z68.26	Body mass index (BMI)	26.0-26.9	adult
Z68.27	Body mass index (BMI)	27.0-27.9	adult
Z68.28	Body mass index (BMI)	28.0-28.9	adult
Z68.29	Body mass index (BMI)	29.0-29.9	adult
Z68.30	Body mass index (BMI)	30.0-30.9	adult
Z68.31	Body mass index (BMI)	31.0-31.9	adult
Z68.32	Body mass index (BMI)	32.0-32.9	adult
Z68.33	Body mass index (BMI)	33.0-33.9	adult
Z68.34	Body mass index (BMI)	34.0-34.9	adult
Z68.35	Body mass index (BMI)	35.0-35.9	adult
Z68.36	Body mass index (BMI)	36.0-36.9	adult
Z68.37	Body mass index (BMI)	37.0-37.9	adult
Z68.38	Body mass index (BMI)	38.0-38.9	adult
Z68.39	Body mass index (BMI)	39.0-39.9	adult
Z68.41	Body mass index (BMI)	40.0-44.9	adult
Z68.42	Body mass index (BMI)	45.0-49.9	adult
Z68.43	Body mass index (BMI)	50.0-59.9	adult
Z68.44	Body mass index (BMI)	60.0-69.9	adult
Z68.45	Body mass index (BMI)	70 or >	adult

ICD-10-CM CODES FOR ABA AGES 18-19 AND WCC AGES 3-17 PER HEDIS SPECIFICATIONS

Z68.51	Body mass index (BMI) pediatric	less than 5th percentile for age
Z68.52	Body mass index (BMI) pediatric	5th percentile to less than 85th percentile for age
Z68.53	Body mass index (BMI) pediatric	85th percentile to less than 95th percentile for age
Z68.54	Body mass index (BMI) pediatric	greater than or equal to 95th percentile for age

APPENDIX 2.

MEASURES THAT CAN ACCEPT MEDICAL RECORDS FOR CARE GAP CLOSURE

MEASURE ABBREVIATION	MEASURE NAME
ABA	ADULT BMI ASSESSMENT
ART	DISEASE-MODIFYING ANTI-RHEUMATIC DRUG THERAPY FOR RHEUMATOID ARTHRITIS
BCS	BREAST CANCER SCREENING
CCS	CERVICAL CANCER SCREENING
CDC – A1C	COMPREHENSIVE DIABETES CARE – A1C
CDC – EYE	COMPREHENSIVE DIABETES CARE – EYE EXAM
CDC – NEPH	COMPREHENSIVE DIABETES CARE – MEDICAL ATTENTION FOR NEPHROPATHY
CHL	CHLAMYDIA TESTING IN WOMEN
CIS	CHILDHOOD IMMUNIZATION STATUS
COL	COLORECTAL CANCER SCREENING
CWP	APPROPRIATE TESTING FOR CHILDREN WITH PHARYNGITIS
IMA	IMMUNIZATIONS FOR ADOLESCENTS
MRP	MEDICATION RECONCILIATION POST-DISCHARGE
OMW	OSTEOPOROSIS MANAGEMENT IN WOMEN WHO HAD A FRACTURE
PPC – PRENATAL	TIMELINESS OF PRENATAL CARE
PPC – POSTPARTUM	POSTPARTUM CARE
WCC – BMI	WEIGHT COUNSELING AND COUNSELING FOR NUTRITION AND PHYSICAL ACTIVITY IN CHILDREN AND ADOLESCENTS – BMI PERCENTILE
WCC – NUTRITION	WEIGHT COUNSELING AND COUNSELING FOR NUTRITION AND PHYSICAL ACTIVITY IN CHILDREN AND ADOLESCENTS – NUTRITION
WCC – PHYSICAL ACTIVITY	WEIGHT COUNSELING AND COUNSELING FOR NUTRITION AND PHYSICAL ACTIVITY IN CHILDREN AND ADOLESCENTS – PHYSICAL ACTIVITY

APPENDIX 3.
MEASURES USED IN MEDICARE STAR RATINGS

The Centers for Medicare & Medicaid Services (CMS) uses a five-star quality rating system to promote improvement in quality. The following weighted measures are utilized when calculating an overall Medicare Star Rating:

MEASURE		WEIGHT
Rx	Cholesterol Adherence (Statins)	3
Rx	Hypertension Adherence	3
Rx	Diabetes Medication Adherence	3
CDC	HbA1c Poor Control >9%	3
CBP	Controlling High Blood Pressure	3
PCR	Plan All-Cause Readmissions	3
OMW	OMW – Osteoporosis Management	1
COL	Colorectal Cancer Screening	1
CDC	Medical Attention for Nephropathy	1
ABA	Adult BMI Assessment	1
ART	Drug Therapy for Rheumatoid Arthritis	1
BCS	BCS – Breast Cancer Screening	1
CDC	Eye Exam	1
MRP	Medication Reconciliation Post Discharge	1
SPC	Statin Use in Patients with Cardiovascular Disease	1
SUPD	Statin Use in Persons with Diabetes	1

APPENDIX 4.
MIPS-HEDIS MEASURE CROSSWALK

HEDIS MEASURE	MIPS MEASURE NUMBER	MIPS MEASURE NUMBER	MIPS MEASURE TYPE	MEASURE COMPARISON INFO
AAB	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	#116	Process	Exact match
ABA	Adult BMI Assessment	#128	Process	**MIPS: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan** Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous six months AND with a BMI outside of normal parameters, a follow up plan is documented during the encounter or during the previous six months of the current encounter. Normal Parameters: Age 18 years and older BMI è 18.5 and < 25 kg/m2
ADD	Follow-up Care for Children Prescribed ADHD Medication	#366	Process	Exact match
AMM	Antidepressant Medication Management	#9	Process	Exact match
ART	Disease-Modifying Anti-Rheumatic Drug Therapy Rheumatoid Arthritis	#180	Process	**MIPS: Rheumatoid Arthritis (RA): Glucocorticoid management** Percentage of patients aged 18 years and older with a diagnosis of rheumatoid arthritis (RA) who have been assessed for glucocorticoid use and, for those on prolonged doses of prednisone >= 10 mg daily (or equivalent) with improvement or no change in disease activity, documentation of glucocorticoid management plan within 12 months.
BCS	Breast Cancer Screening	#112	Process	Exact match
CBP	Controlling High Blood Pressure	#236	Outcome	HEDIS allows <150/90 for ages 60-85 without diabetes, MIPS is <140/90
CCS	Cervical Cancer Screening	#309	Process	Exact match
CDC	Comprehensive Diabetes Care			Exact matches
	• Eye Exam Performed	#117	Process	
	• HbA1c Poor Control >9%	#1	Outcome	
	• Medical Attention for Nephropathy	#119	Process	

APPENDIX 4.
MIPS-HEDIS MEASURE CROSSWALK

HEDIS MEASURE	MIPS MEASURE NUMBER	MIPS MEASURE NUMBER	MIPS MEASURE TYPE	MEASURE COMPARISON INFO
CHL	Chlamydia Screening for Women	#310	Process	Exact match
CIS	Childhood Immunization Status Combo 10	#240	Process	Exact match
COL	Colorectal Cancer Screening	#113	Process	Exact match
CWP	Appropriate Testing for Children with Pharyngitis	#66	Process	Exact match
FUH	Follow-up After Hospitalization for Mental Illness – 7-day and 30-day rates	#391	Process	Exact match
IET	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	#394	Process	Exact match
LBP	Use of Imaging Studies for Low Back Pain	#312	Process	Exact match
MMA	Medication Management for People With Asthma – 75% rate	#444	Process	Exact match
NCS	Non-Recommended Cervical Cancer Screening for Adolescent Females	#443	Process	Exact match
OMW	Osteoporosis Management in Women Who Had a Fracture	#418	Process	MIPS age criteria 50-85; HEDIS age criteria 67-85, Medicare only.
PBH	Persistence of a Beta Blocker after Heart Attack	#442	Process	Exact match
SPR	Use of Spirometry Testing in the Assessment and Diagnosis of COPD	#51	Process	MIPS age criteria ≥18; HEDIS age criteria ≥40
URI	Appropriate Treatment of Children with Upper Respiratory Infection	#65	Process	Exact match
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents – all 3 rates	#239	Process	Exact match

APPENDIX 5.
CAHPS AND MEDICARE HOS INFORMATION

CAHPS (Consumer Assessment of Healthcare Providers and Systems) Survey: Evaluating the Patient's Experience

The CAHPS® survey evaluates the consumer's perspective of the quality of health services provided by Commercial, Medicare Advantage and Part D programs. Below are some tips to addressing the CAHPS-specific patient experience factors:

- Be familiar with the questions members are being asked on the survey.
- Schedule members for Annual Wellness Visits prior to March.
- Encourage members to get a flu shot each year.
- Understand members' costs for prescribed drugs based on their plan formulary.
- Follow up with members promptly regarding test results, regardless of whether the results require additional care.
- Prioritize timely appointment scheduling, for both routine and specialty care.

Medicare Health Outcomes Survey (HOS) 101: For Providers

The HOS member survey assesses the physical and mental health of patients over a two year period. Responses to this survey contribute to the plan's overall Star Rating. Many of the survey questions ask the patient if they have had conversations with their doctor or nurse about activity level, falls, and bladder control.

Best Practices for Providers:

- Be familiar with the questions members are being asked on the survey.
- Place reminders in your EMR to speak with patients at each visit regarding these topics:
  - Patients' activity level and their current exercise program.
  - Problems with falls, balance or walking
    - ‡ Suggest that they use a cane or walker if needed
  - Lying or standing blood pressure
  - Exercise or physical therapy program recommendations
  - Vision or hearing test (if necessary)
- Advise patients on ways to manage the leaking of urine, including bladder training exercises, medication and surgery.

APPENDIX 6.

MEDICARE MEDICATIONS WITH $0 COPAY*

2019 Value Stars Tier 6 Formulary Medications
*$0 copay at Preferred Retail Pharmacies & AllianceRx Walgreens Prime Mail Order Pharmacy
Non-preferred pharmacies have copays of $1 (for PPO and HMO Enhanced) and $3 (for HMO Essential)

ACE INHIBITORS	ARBs	STATINS	DIABETES
Benazepril	Irbesartin	Atorvastatin	Glimepiride
Benazepril/HCTZ	Irbesartin/HCTZ	Lovastatin	Glipizide
Captopril	Losartan	Pravastatin	Glipizide ER
Enalapril	Losartan/HCTZ	Rosuvastatin	Glipizide XL
Enalapril/HCTZ	Olmesartan	Simvastatin	Metformin
Fosinopril	Olmesartan/HCTZ	Ezetimibe/Simvastatin	Metformin ER
Lisinopril	Valsartan		Nateglinide
Lisinopril/HCTZ	Valsartan/HCTZ		Pioglitazone
Quinapril	Valsartan/Amlodipine		
Ramipril	Valsartan/Amlodipine/HCTZ		

Full Medicare formulary information can be found at:
https://www.bluecrossnc.com/medicare/medicare-member-drug-information

APPENDIX 7.
HELPFUL LINKS AND RESOURCES

Online version of Provider Quality Pocket Guide:
https://www.bluecrossnc.com/sites/default/files/document/attachment/providers/public/pdfs/pqn_pocket_guide.pdf

Provider Quality Report Job Aids:
https://www.bluecrossnc.com/providers/quality-based-programs/provider-quality-reports

How to order additional pocket guides:
https://www.bluecrossnc.com/providers/forms-and-documentation/provider-tools-and-patient-education-materials-0

Blue Physician Quality Program:
https://www.bluecrossnc.com/blue-quality-physician-program

Sign up for Provider E-briefs:
https://www.bluecrossnc.com/providers/forms-and-documentation/provider-email-registry

Provider Blueline[SM]: **1-800-214-4844** (toll free)

Network Management: **1-800-777-1643** (toll free); **(919) 765-4349** (fax); ***NMSpecialist@bcbsnc.com***

RISK ADJUSTMENT CONTACTS

PROSPECTIVE RISK ADJUSTMENT PROGRAM	PROSPECTIVE RISK ADJUSTMENT INCENTIVES	RETROSPECTIVE RISK ADJUSTMENT CHART REQUESTS
Joe Richard, Program Manager	**Willia Barber, Financial Analyst**	**George Taylor**
Joseph.Richard@bcbsnc.com	***Willia.Barber@bcbsnc.com***	***George.Taylor@bcbsnc.com***
919-765-1497	**336-201-4261**	**919-287-5623**

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