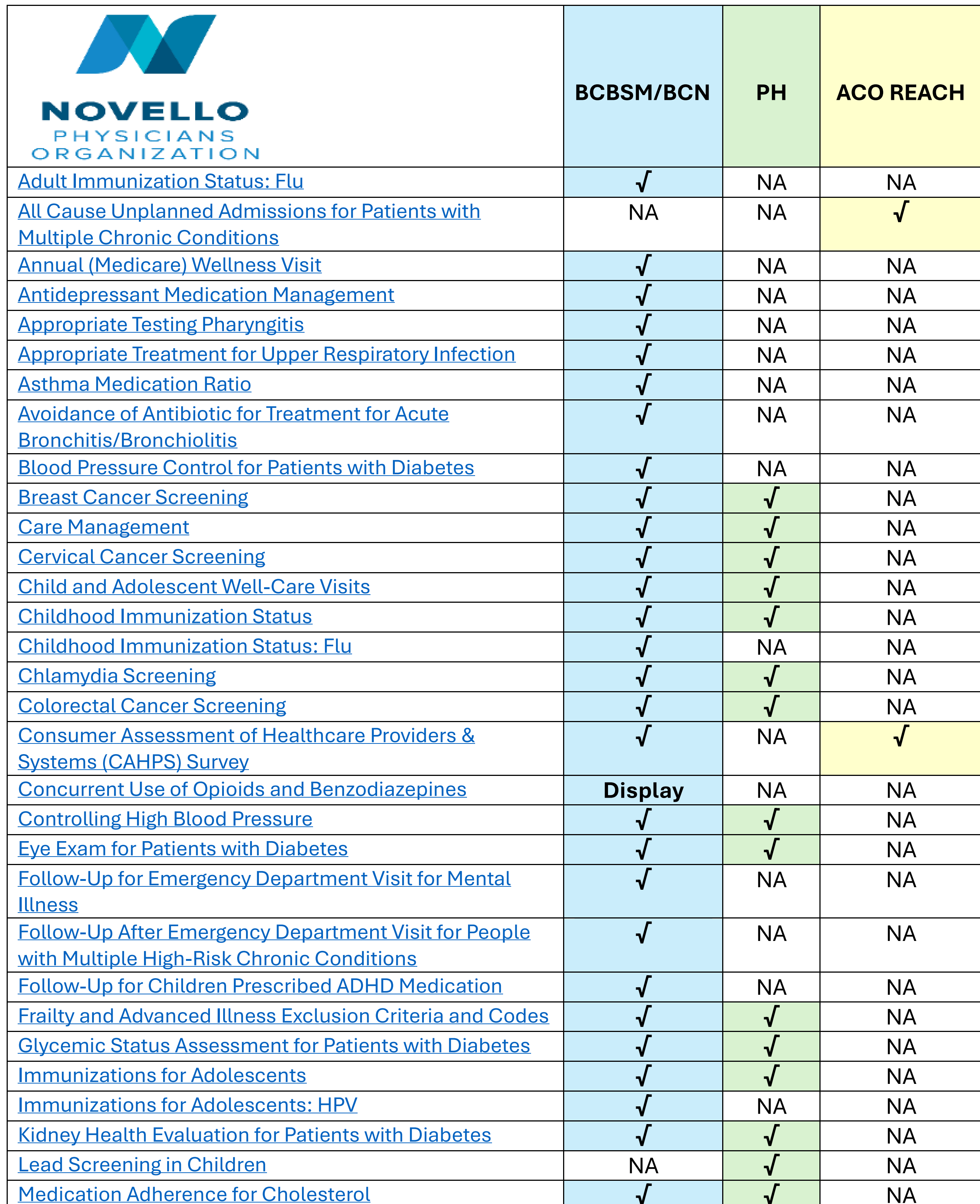
NOVELLO
PHYSICIANS ORGANIZATION

2025 Quality Measures Guide

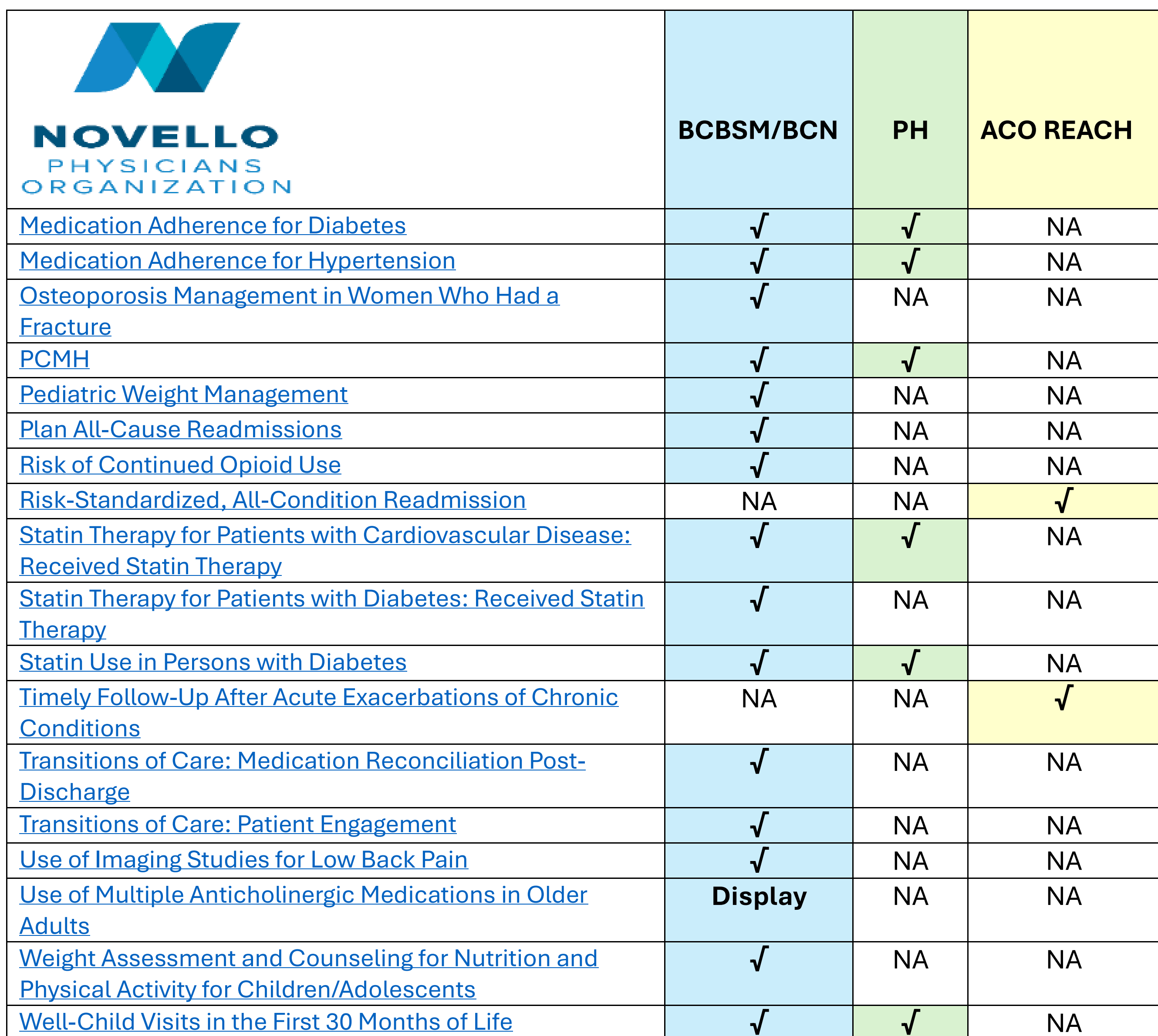
Updated February 2025

(originated February 2, 2014)

Summary



NOVELLO PHYSICIANS ORGANIZATION	BCBSM/BCN	PH	ACO REACH
Adult Immunization Status: Flu	√	NA	NA
All Cause Unplanned Admissions for Patients with Multiple Chronic Conditions	NA	NA	√
Annual (Medicare) Wellness Visit	√	NA	NA
Antidepressant Medication Management	√	NA	NA
Appropriate Testing Pharyngitis	√	NA	NA
Appropriate Treatment for Upper Respiratory Infection	√	NA	NA
Asthma Medication Ratio	√	NA	NA
Avoidance of Antibiotic for Treatment for Acute Bronchitis/Bronchiolitis	√	NA	NA
Blood Pressure Control for Patients with Diabetes	√	NA	NA
Breast Cancer Screening	√	√	NA
Care Management	√	√	NA
Cervical Cancer Screening	√	√	NA
Child and Adolescent Well-Care Visits	√	√	NA
Childhood Immunization Status	√	√	NA
Childhood Immunization Status: Flu	√	NA	NA
Chlamydia Screening	√	√	NA
Colorectal Cancer Screening	√	√	NA
Consumer Assessment of Healthcare Providers & Systems (CAHPS) Survey	√	NA	√
Concurrent Use of Opioids and Benzodiazepines	**Display**	NA	NA
Controlling High Blood Pressure	√	√	NA
Eye Exam for Patients with Diabetes	√	√	NA
Follow-Up for Emergency Department Visit for Mental Illness	√	NA	NA
Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions	√	NA	NA
Follow-Up for Children Prescribed ADHD Medication	√	NA	NA
Frailty and Advanced Illness Exclusion Criteria and Codes	√	√	NA
Glycemic Status Assessment for Patients with Diabetes	√	√	NA
Immunizations for Adolescents	√	√	NA
Immunizations for Adolescents: HPV	√	NA	NA
Kidney Health Evaluation for Patients with Diabetes	√	√	NA
Lead Screening in Children	NA	√	NA
Medication Adherence for Cholesterol	√	√	NA



NOVELLO PHYSICIANS ORGANIZATION	BCBSM/BCN	PH	ACO REACH
Medication Adherence for Diabetes	√	√	NA
Medication Adherence for Hypertension	√	√	NA
Osteoporosis Management in Women Who Had a Fracture	√	NA	NA
PCMH	√	√	NA
Pediatric Weight Management	√	NA	NA
Plan All-Cause Readmissions	√	NA	NA
Risk of Continued Opioid Use	√	NA	NA
Risk-Standardized, All-Condition Readmission	NA	NA	√
Statin Therapy for Patients with Cardiovascular Disease: Received Statin Therapy	√	√	NA
Statin Therapy for Patients with Diabetes: Received Statin Therapy	√	NA	NA
Statin Use in Persons with Diabetes	√	√	NA
Timely Follow-Up After Acute Exacerbations of Chronic Conditions	NA	NA	√
Transitions of Care: Medication Reconciliation Post-Discharge	√	NA	NA
Transitions of Care: Patient Engagement	√	NA	NA
Use of Imaging Studies for Low Back Pain	√	NA	NA
Use of Multiple Anticholinergic Medications in Older Adults	**Display**	NA	NA
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	√	NA	NA
Well-Child Visits in the First 30 Months of Life	√	√	NA

Adult Immunization Status: Flu

The following is a high-level summary of the measure. The referenced measure source should be consulted for specific questions/details.

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Summary of Changes

- No changes have been made to this measure.

Measure Source(s)

- HEDIS: "Adult Immunization Status" (AIS)

Description

The percentage of patients, 19 years of age and older, who received an Influenza vaccination on or between July 1st of the year prior to the measurement year (i.e., 07/01/2024) and June 30th of the measurement year (i.e. 06/30/2025)

- The following codes identify Influenza vaccination:
  - Influenza vaccination CPT codes: **90630, 90653, 90654, 90656, 90658, 90661, 90662, 90673, 90674, 90682, 90686, 90688, 90689, 90694, 90756**
  - Influenza CVX codes: **88, 135, 140, 141, 144, 150, 153, 155, 158, 166, 168, 171, 185, 186, 197, 205**
  - Live Attenuated Influenza Vaccine (LAIV) vaccination CPT codes: **90660, 90672**
  - Live Attenuated Influenza Vaccine (LAIV) CVX codes: **111, 149**
- Anaphylaxis due to the Influenza vaccine any time on or before the end of the measurement year also satisfies criteria for compliance (i.e., on or before 12/31//2025).
  - Anaphylaxis due to Influenza SNOWMED code: **471361000124100**

Exclusion(s)

Exclude patients who died, or were in hospice or using hospice services, anytime during the measurement year (i.e., 01/01/2025-12/31/2025).

Denominator

Patients 19 years of age or older at the start of the measurement year (i.e., as of 01/01/2025), not otherwise excluded

Numerator

Patients, from the Denominator, who received an Influenza vaccine between July 1st of the year prior to the measurement year (i.e., 07/01/2024) and June 3oth of the measurement year (i.e., 06/30/2025), as defined above

- Documentation in the EMR must include the date of administration of the vaccine.

- ✓ Documentation that the patient is "up to date for Flu vaccination" without a corresponding administration date does NOT meet the criteria for compliance.
- ✓ Patient refusal also does NOT meet the criteria for compliance.

Method(s) of Measurement

- BCBSM/BCN: Claims processed and immunization data in MCIR
  - Immunization data is downloaded from the state of Michigan monthly

Tip(s)

- Strongly recommend Influenza vaccination to patients
  - Explain the impact of getting Influenza
    - ✓ Serious health effects
    - ✓ Missed work/obligations
    - ✓ Financial cost of needed medical care
    - ✓ Potential exposure of others
  - Explain the benefits of vaccination
    - ✓ Reduced risk of disease, both to patients and others
    - ✓ Mitigation of severity of symptoms and flu-related complication
  - Use plain and understandable language
  - Offer patients a copy of the Vaccine Information Sheet (VIS) from the CDC.
- Make sure all immunizations (even historical ones) are documented in the "Immunization" section of the EHR AND in MCIR.
  - Inquire about vaccines received elsewhere (e.g., Health Department, pharmacy)
  - Request previous immunization records for new or recently transferred patients.
  - Obtain a record of the vaccines, if possible.
  - AND update both the patient's outpatient chart and MCIR accordingly.

All Cause Unplanned Admissions for Patients with Multiple Chronic Conditions

The following is a high-level summary of the measure. The referenced measure source should be consulted for specific questions/details.

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Summary of Changes

- ACO REACH:
  - The codes in the diagnosis and procedure value sets were updated.

Measure Source(s)

- ACO Recognizing Equity, Access, and Community Health (REACH) Measure Information Form: "All Cause Unplanned Admissions for Patients with Multiple Chronic Conditions." (Effective 01/01/2025)

Description

Rate of risk-standardized, acute, unplanned hospital admissions, per 100 person-years, among Medicare beneficiaries, 66 years of age and older and with multiple chronic conditions (MCCs), who are aligned with an Accountable Care Organization (ACO) participating in the ACO REACH model

- This is an event-based measure; a patient may be counted more than once in the Denominator.
- **Note:** Lower readmission rates indicate better performance.

Exclusions

Exclude the following **patients**:

- Those lacking continuous enrollment in Medicare Parts A & B:
  - In the year prior to the measurement year. (i.e., 2024)
  - OR for the duration of the measurement year. (i.e., 01/01/2025-12/31/2025)
  - OR until death or hospice enrollment during the measurement year. (i.e., 2024)
- Those enrolled in hospice at the start of the measurement year (i.e., as of 01/01/2025) or during the year prior. (i.e., 2024)
- Those with no encounters (E&M or other) with an ACO REACH provider during the measurement year AND the year prior. (i.e., no visits 01/01/2024-12/31/2025)
- Those not at risk for hospitalization any time during the measurement year (i.e., 01/01/2025-12/31/2025)
  - Patients are considered to be at-risk for hospitalization if they are:
    - ✓ Alive
    - ✓ Enrolled in Medicare FFS
    - ✓ Not admitted to an acute care hospital

Exclude the following types of **admission events**:

- Planned hospital admissions
- Direct admissions from a skilled nursing (SNF) or acute rehabilitation facility
- Those occurring within 10 days after discharge from a hospital, SNF or acute rehabilitation facility
    - This 10-day "buffer period" allows time for a patient to be seen for a Transitional Care Management visit at the ambulatory practice.
    - It also allows time for the ambulatory provider's plan of care to take effect.
- Those occurring after the patient has entered hospice
- Those related to complications from procedures or surgeries
- Those related to accidents or injuries
- Those that occur prior to the first visit with an ACO REACH provider. (i.e., establishment of care)

Denominator

ACO REACH-aligned Medicare FFS beneficiaries, aged 66 years of age and older during the measurement year (i.e., 2025) whose combination of chronic conditions put them at elevated risk of hospitalization and whose admit rates could be lowered through better care.

- Hospitalization risk is adjusted for:
    - Demographics, including age
    - Chronic disease diagnoses, with 2 or more concurrent diagnoses from any of the following nine condition groups below indicating elevated risk
        - ✓ Concurrent chronic disease conditions act together to increase medical complexity and affect health outcomes.
            - Acute Myocardial Infarction (AMI)
            - Alzheimer's Disease and related disorders or Senile Dementia
            - Atrial Fibrillation
            - Chronic Kidney Disease (CKD)
            - Chronic Obstructive Pulmonary Disease (COPD) and Asthma
            - Depression
            - Diabetes
            - Heart Failure
            - Stroke and Transient Ischemic Attack (TIA)
    - Clinical comorbidities, including disabilities and frailty
    - Socioeconomic factors such as education level and employment

Numerator

For patients from the Denominator: The number of acute, unplanned admissions, per 100 person-years, at risk for admission during the measurement year (i.e., 2025)

Method(s) of Measurement

- CMS Medicare: Claims processed

Tips

Ambulatory care providers can act to lower patients' risk or a wide variety of acute illness requiring admission in several ways:

- Provide optimal and accessible chronic disease management.
  - Support healthy lifestyle behavior.
  - Act early to address chronic problems.
  - Coordinate care with other providers.
- Anticipate and manage the interactions between chronic conditions.
- Provide optimal primary prevention of acute illnesses, such as immunizations and screenings.
- Empower patients to recognize symptoms and seek timely, accessible care.
  - Facilitate rapid, ambulatory interventions when patients do get sick.
  - Consider alternative options (e.g., weekend or evening hours, telehealth, etc.) to increase access to care.
- Partner with community organizations to improve support for patients with chronic illness:
  - E.g., collaborate with home nursing programs
  - Provide outreach or services to senior centers.
  - Partner with businesses to stress healthy lifestyle options for their employees.
  - Promote self-care at home.

Annual (Medicare) Wellness Visit

The following is a high-level summary of the measure. The referenced measure source should be consulted for specific questions/details.

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Summary of Changes

- Priority Health: This measure has been removed from the 2025 PIP incentive program.

Measure Source(s)

- CMS Medicare Learning Network (MLN): "Medicare Wellness Visits"

Description

The number of patients who receive an annual Medicare preventive visit during the measurement year (i.e., 01/01/2025 - 12/31/2025)

Definition(s)

Initial Preventive Physical Exam (IPPE or "Welcome to Medicare" visit)

- Available to patients within the first 12 months of enrollment in a Medicare plan
- Consists of the following components:
  - Review of patient's medical and social history, with attention to modifiable risk factors
    - ✓ Past medical and surgical history
    - ✓ Current medications (including supplements)
    - ✓ Family medical history, including hereditary factors
    - ✓ Diet
    - ✓ Physical activity
    - ✓ Social activities and engagement
  - Depression Screen
  - Functional ability and safety assessment
    - ✓ Ability to perform activities of daily living (ADLs), such as dressing, feeding, bathing, shopping, laundry, handling finances, housekeeping, mode of transportation, etc.)
    - ✓ Fall Risk
    - ✓ Hearing Impairment
    - ✓ Home and community safety, including driving
  - Measurements of height, weight, BMI, blood pressure, visual acuity and other clinical factors, as appropriate
  - End-of-life planning
  - Review of current opioid prescriptions
  - Screening for substance use disorders (alcohol, tobacco, illegal drugs)

    - Education, counseling, and referrals for preventive services, as appropriate
        - ✓ Provide a written plan for the patient, including a list of preventive services needed

First and Subsequent AWVs

- Available to patients who have been enrolled in a Medicare plan for at least 12 months
- Billed one-time only, 12 months after the IPPE (HCPCS code: **G0438**)
- Consists of the following components:
    - Administer/Review/Update a Health Risk Assessment (HRA)
        - ✓ Demographics
        - ✓ Self-assessment of Health Status, Frailty, and Physical Functioning
        - ✓ Assessment of Psychosocial Risk (e.g., depression/life satisfaction, stress, anger, loneliness/social isolation, pain, and fatigue)
        - ✓ Assessment of Behavioral Risk (e.g., tobacco use, physical activity, nutrition and oral health, alcohol consumption, sexual health, seat belt use, home safety)
        - ✓ Assessment of Instrumental Activities of Daily Living (IADLs)
    - Establish/Review/Update the patient's medical and family history
    - Establish/Review/Update the patient's Circle of Care
    - Screen for cognitive impairment (include observations from family members and caregivers)
    - Screen for Depression
    - Review/Update the Patient's Functional Ability and Level of Safety
    - Provide a written screening schedule for age-appropriate health services, including preventive services. (5–10-year time frame)
    - Establish/Review/Update a list of the patient's risk factors and treatment options
    - Furnish personalized health advice/education/counseling
        - ✓ Weight Loss
        - ✓ Smoking Cessation
        - ✓ Fall Prevention
        - ✓ Nutrition
    - Provide advance care planning services, if necessary and desired
    - Review current opioid prescriptions
    - Screen for potential substance use disorders
    - Any other element deemed appropriate

Exclusions

Exclude patients who died or were in hospice, or using hospice or palliative care services, any time during the measurement year (i.e., 01/01/2025 -12/31/2025)

- ICD-10 code **Z51.5** can be used to identify a palliative care encounter.

Denominator

Eligible Medicare patients

- This measure is only incented for BCBSM MA and BCNA patients

Numerator

Patients, from the Denominator, who received an Annual Wellness Visit during the measurement year. (i.e., 01/01/2025 - 12/31/2025)

- Services can be delivered by any of the following provider types:
    - Physician (IPPE and AWV)
    - Qualified Non-Physician Practitioner (NPP) including Physician Assistants (PA), Nurse Practitioners (NP) and Certified Clinical Nurse Specialists (CCNS) (IPPE and AWV)
    - Other medical professionals, including health educators, registered dieticians, nutrition professionals, other licensed practitioners, or a team of medical professionals directly supervised by a physician (AWV only)
- Billing frequencies and codes
    - IPPE
        - ✓ Billed one-time only, within the first 12 months of Medicare enrollment (All Insurers)
            - Use HCPCS code: **G0402** or **G0468** (FQHCs only)
- First and Subsequent AWVs
    - Billable once each calendar year
    - BCBSM MA and BCNA patients can now have an AWV any time during the calendar year.
    - For DCE Medicare patients, subsequent AWVs must occur at least 12 months after the date of the previous AWV (or IPPE)
    - Use HCPCS code **G0438** (first AWV following the IPPE) or **G0439** (all subsequent AWVs)

Method(s) of Measurement

- BCBSM/BCN: Claims processed (G codes only)
    - This is a "No-Entry" measure in Health-e Blue.

Tips

- If an IPPE (G0402) or AWV (G0438 or G0439) is provided on the same date as an E&M Service:
    - Both services are eligible for reimbursement (but cost-sharing may be applied to the E&M component).
    - When billing, include modifier -25
- Schedule next year's AWV before the patient leaves the office after this year's appointment.
- Address and code all active chronic disease conditions for the patient during the Annual Wellness Visit.

Antidepressant Medication Management

The following is a high-level summary of the measure. The referenced measure source should be consulted for specific questions/details.

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Summary of Changes

- HEDIS: This measure has been retired by NCQA and is not included in the MY2025 HEDIS guide.
  - BCBSM/BCN is still including this measure in their incentive programs.

Measure Source(s)

- HEDIS: "Antidepressant Medication Management (AMM)" (MY 2024)

Description

The percentage of patients 18 years of age and older and with a diagnosis of Major Depression who were both treated with an antidepressant medication and remained on an antidepressant medication during the measurement year. (i.e., 2025)

- Two rates are reported:
  - **Effective Acute Phase Treatment:** The percentage of patients who remained on an antidepressant medication for at least 84 days (12 weeks)
  - **Effective Continuation Phase Treatment**: The percentage of patients who remained on an antidepressant medication for at least 180 days (6 months)

Definition(s)

- **Intake Period**: The 12-month window starting on May 1st of the year prior to the measurement year (i.e. 05/01/2024) and ending on April 30th of the measurement year (i.e. 04/30/2025)
- **IPSD** (Index Prescription Start Date): The earliest prescription dispensing date for an antidepressant medication where the date is in the Intake Period and there is a Negative Medication History
- **Negative Medication History**: A period of 105 days prior to the IPSD when the patient had no pharmacy claims for either new or refill prescriptions for an antidepressant medication
- **Treatment Days**: The actual number of calendar days covered with prescriptions within the specified measurement interval

Exclusion(s)

Exclude patients who:

- Did not have an encounter with a diagnosis of Major Depression during the 121-day period from the 60 days prior to the IPSD through 60 days after the IPSD (including the ISPD)
- Filled a prescription for an antidepressant medication within the 105 days prior to the IPSD

- Died or were in hospice, or used hospice services, any time during the measurement year (i.e., 01/01/2025 - 12/31/2025)

Denominator

Adult patients, 18 years of age and older, who had a diagnosis of Major Depression and were dispensed an antidepressant medication between May 1st of the prior year (i.e. 05/01/2024) and April 30th of the measurement year (i.e., 04/30/2025), not otherwise excluded

Numerator(s)

- **Effective Acute Phase Treatment**: Patients who remain on an antidepressant medication for at least 84 days (12 weeks) of treatment, in the 115-day period beginning on the IPSD through 114 days after the IPSD
- **Effective Continuation Phase Treatment**: Patients who remain on an antidepressant medication for at least 180 days (6 months) of treatment, in the 232-day period beginning on the IPSD through 231 days after the IPSD

Method of Measurement

- BCBSM/BCN: Pharmacy claims processed
  - This is a "No-Entry" measure in Health-e Blue.

Tip(s)

- Documentation of the event/diagnosis/exclusion may occur via telehealth, telephone visits, e-visits or virtual check-ins.
- Use age-appropriate, standardized screening tools to aid with diagnosis and treatment and to monitor the patient's symptoms of depression at various points (baseline and progression through treatment).
- Patients with mild depression often don't stay on antidepressant medication.
  - Consider a referral for counseling services as an alternative to medication treatment.
- Educate patients on the following:
  - How antidepressants work, their benefits, and how long they should be used
  - Length of time on medication before the patient should expect to feel better
  - Strategies for remembering to take the antidepressant daily
  - Never stop taking the medication without consulting the provider.
  - What to do if the patient has a crisis or thoughts of self-harm
    - ✓ 24/7 access for calls, texts and chats with trained crisis counselors is available through the following services:
      - National Suicide Prevention Lifeline (1-800-273-TALK)
      - 988 Suicide Crisis Lifeline)
- Encourage monthly follow-up and/or the use of telehealth appointments to answer questions and discuss medication side effects.

- Consider non-adherence or inadequate dosing in cases of limited or no response to treatment.
- Treat with a combination of medication and therapy, especially with cases of severe depression.

Appropriate Treatment for Upper Respiratory Infection

The following is a high-level summary of the measure. The referenced measure source should be consulted for specific questions/details.

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Summary of Changes

- No changes have been made to this measure.

Measure Source

- HEDIS: "Appropriate Treatment for Upper Respiratory Infection (URI)"

Description

The percentage of episodes for patients, 3 months of age and older and with a diagnosis of Upper Respiratory Infection (URI), that did NOT result in dispensation of an antibiotic

- This is an episode-based measure.
  - Patients may be counted in the Denominator more than once.
- This measure is reported as an inverse rate [1-(Numerator/Denominator)]
  - A higher rate indicates better performance and appropriate treatment (i.e., the proportion of URI episodes for which antibiotics were NOT dispensed).

Definition(s)

- **Intake Period** (captures eligible episodes of treatment):
  - **BCBSM**: A 12-month window that begins on July 1st of the year prior to the measurement year (i.e., 07/01/2024) and ends on June 30th of the measurement year (i.e., 06/30/2025)
  - **BCN**: A 12-month window that begins on January 1st of the measurement year (i.e., 01/01/2025) and ends on December 31st of the measurement year (i.e., 12/31/2025)
- **Episode Date:** The date of service for any outpatient, telephone, ED, or e-visit, observation stay, or online assessment (e.g., virtual check-in) during the Intake Period with a diagnosis of URI

Exclusion(s)

- **Exclude episodes**:
  - That resulted in an inpatient stay
  - Where the patient had a competing diagnosis (i.e., evidence of a co-existing bacterial infection, such as Pharyngitis, Otitis Media, Pneumonia, Acute or Chronic Sinusitis, etc.) on, or within three days after, the Episode Date
    - Do not include laboratory claims.

    - Where the patient had a diagnosis for a comorbid condition (i.e., HIV, immune system disorders, malignant neoplasms, chronic respiratory diseases such as Emphysema or COPD) on, or within 12 months prior to, the Episode Date.
        - Do not include laboratory claims.
    - Where an antibiotic prescription was filled/refilled within 30 days prior to, or was active on, the Episode Date
- Only one eligible episode per 31-day period is included in the measure
    - If multiple eligible episodes occur during a 31-day period, only the first eligible episode (chronologically) is used.
- **Exclude <u>patients</u>** who died or were in hospice, or using hospice services, any time during the measurement year (i.e., 01/01/2025 - 12/31/2025).

Denominator

Episodes during the Intake Period for patients, age 3 months and older, who received a URI diagnosis at the encounter, not otherwise excluded

- The following ICD-10 codes can be submitted on a claim to indicate a diagnosis of URI:
  J00, J06.0, J06.9

Numerator

Episodes, from the Denominator, where the patient was dispensed a prescription for an antibiotic medication on, or within three days after, the Episode Date

Method(s) of Measurement

- <u>BCBSM/BCN</u>: Claims processed
    - This is a "No-Entry" measure in Health-e Blue

Tip(s)

- Proper coding is key as data for this measure is captured from claims!
    - Be sure to include the diagnosis code for any competing bacterial infection or co-existing comorbid condition, in addition to the diagnosis code for URI, on the claim for the encounter.
    - This provides documentation confirming that an antibiotic is necessary.
    - Exclusion diagnoses should be coded on an E&M claim annually.
- Talk to parents about the ineffectiveness of antibiotic treatment on viral infections.
    - NPO can provide Choosing Wisely patient materials regarding this, if requested.
- Educate patients about proper handwashing and hygiene to prevent the spread of illness.
- Suggest comfort measures without antibiotics, such as OTC medications (e.g., acetaminophen, ibuprofen), fluids, rest, humidifier, saline nasal drops, and saltwater gargle.
- Encourage the patient/family to contact your office if symptoms worsen.

Asthma Medication Ratio

The following is a high-level summary of the measure. The referenced measure source should be consulted for specific questions/details.

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Summary of Changes

- HEDIS: Albuterol-budesonide has been added as an asthma reliever medication.

Measure Source

- HEDIS: "Asthma Medication Ratio (AMR)"

Description

The percentage of patients, 5-64 years of age and identified as having Persistent Asthma, who had a ratio of controller medications to total Asthma medications of 0.50 or greater during the measurement year (i.e., 2025)

Definition(s)

- **Oral Medication Dispensing Event:**
  - One dispensing event = one prescription of an amount lasting 30 days or less
  - For prescriptions longer than 30 days, calculate the number of dispensing events by dividing the days' supply by 30 and rounding down.
    - I.e., a 100-day prescription = 3 dispensing events
  - For multiple prescriptions of the same medication dispensed on the same day, calculate the number of dispensing events by summing the total days' supply and dividing it by 30.
  - Multiple prescriptions for different medications dispensed on the same day are counted as different dispensing events.
- **Inhaler Dispensing Event:**
  - All inhalers (i.e., cannisters) of the same medication dispensed on the same day count as one dispensing event.
  - Inhalers of different medications, dispensed on the same day, count as different dispensing events.
    - E.g., a patient who received three cannisters of Medication A and two cannisters of Medication B on the same day had two dispensing events.
- **Injection or Intravenous Dispensing Event:**
  - Each injection or intravenous infusion counts as one dispensing event.
  - Multiple dispensed injections of the same or different medications count as separate dispensing events.
- **Medication Units:**

- One medication unit = one < 30-days' supply of an oral medication, one inhaler cannister, one injection or one infusion
  - E.g., the patient who received three cannisters of Medication A and two cannisters of Medication B, as in the above example, received five medication units in two dispensing events

Exclusion(s)

<u>Exclude the following patients:</u>

- Those who had any of the following diagnoses any time during the patient's history through December 31st of the measurement year (i.e., as of 12/31/2025):
  - Emphysema
    - ✓ ICD-10 codes **J43.0**, **J43.1**, **J43.3**, **J43.8**, **J43.9**, **J98.2**, **J98.3**
  - COPD
    - ✓ ICD-10 codes : **J44.0, J44.1, J44.89, J44.9**
  - Obstructive Chronic Bronchitis
    - ✓ ICD-10 code: **J44.81**
  - Chronic Respiratory Conditions Due to Fumes/Vapors
    - ✓ ICD-10 code: **J68.4**
  - Cystic Fibrosis
    - ✓ ICD-10 codes: **E48.0, E84.11, E84.19, E84.8, E84.9**
  - Acute Respiratory Failure
    - ✓ ICD-10 codes: **J96.00, J96.01, J96.02, J96.20, J96.21, J96.22**
  - Do not include laboratory claims.
- Those who had no Asthma controller or reliever medications dispensed during the measurement year (i.e., 2025)
- Those who died or were in hospice, or using hospice services, any time during the measurement year (i.e., 01/01/2025 - 12/31/2025)

Denominator

Patients, 5–64 years of age by December 31st of the measurement year (i.e., as of 12/31/2025), with a diagnosis of Persistent Asthma, not otherwise excluded

- Patients are identified as having Persistent Asthma if they meet at least one of the following criteria during both the measurement year (i.e., 2025) and the year prior (i.e., 2024); criteria may differ across both years:
  - At least one ED visit with a principal diagnosis of Asthma
  - <u>OR</u> at least one acute inpatient encounter (without telehealth) with a principal diagnosis of Asthma
  - <u>OR</u> at least one acute inpatient stay with a principal diagnosis of Asthma on the discharge claim
  - <u>OR</u> at least four outpatient, telephone, or e-visits, observation stays, or online assessments (e.g., virtual check-ins), on different dates of service, with any diagnosis of Asthma <u>AND</u> at

least two Asthma medication dispensing events (controller or reliever medications); visit type may differ for the four visits.
    - OR at least four Asthma medication dispensing events for any controller or reliever medication
        - If the sole Asthma medication dispensed was a leukotriene modifier or antibody inhibitor, the patient must also have at least one diagnosis of Asthma, in any setting, in that same year.
        - Do not include diagnosis codes on laboratory claims.
- The following diagnosis codes identify Asthma:
  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, J45.991, J45.998

Numerator

Patients who have an Asthma medication ratio (controller/total) ≥ 0.50 during the measurement year (i.e., 2025)

To Calculate the Asthma Medication Ratio:

- For each patient, count the number of units of Asthma Controller Medications dispensed during the measurement year (i.e., 01/01/2025 - 12/31/2025).
- For each patient, count the number of units of Asthma Reliever Medications dispensed during the measurement year (i.e. 01/01/2025 - 12/31/2025).
- For each patient, sum the number of Asthma Controller and Reliever medication units to determine the total number of Asthma medication units dispensed.
- For each patient, calculate: (Units of Controller Medications)/ (Units of Total Asthma Medications).
- Sum the total number of patients who have a ratio of ≥ 0.50.

Method(s) of Measurement

- BCBSM/BCN: Pharmacy claims processed
    - This is a "No-Entry" measure in Health-e Blue.

Tip(s)

- Identification of the event/diagnosis/exclusion may occur via telehealth visits, telephone visits, e-visits or online assessments (e.g., virtual check-ins).
- Ensure proper coding of the Asthma diagnosis.
- Code any diagnoses on the exclusion list above on an annual basis.
- Develop, and make sure each patient has, an Asthma Action Plan.
- Discuss how to identify and avoid triggers (household, environmental, etc.).
- Discuss the following with your patient/family regarding medication:
    - How to use an inhaler (have patient demonstrate)
    - How to use, and how long to use, the medication(s)

- How the drugs work
- Common side effects
- Importance of continuing medication
- What to do if the medication is not effective

- Document a review of medications at every visit.
  - Educate patients on the importance of taking controller medications regularly and refilling prescriptions in a timely manner.
  - Educate patients to always show their insurance card at the pharmacy so a pharmaceutical claim is generated.
    - ✓ Pharmacies can submit $0.01 claims to the insurance company for free or cash-pay medication fills.
  - Be aware that medication samples, when given, could interfere with pharmacy claims and produce false non-adherence results.

Breast Cancer Screening

The following is a high-level summary of the measure. The referenced measure source should be consulted for specific questions/details.

Return to Summary Page

Summary of Changes

- Priority Health: Performance will be measured at the practice level for MY 2025.

Measure Source:

- HEDIS: "Breast Cancer Screening (BCS-E)"

Description

The percentage of patients, 50–74 years of age and recommended for breast cancer screening, who had a mammogram to screen for breast cancer in the 27 months prior to the end of the measurement year (i.e., 10/01/2023- 12/31/2025)

Definition(s)

"Patients recommended for routine breast cancer screening" are defined as:

- Those with "Sex Defined at Birth" (LOINC code = **76689-9**) of Female (LOINC code **LA3-6**) at any time in the patient's history (i.e., any time up to and including 12/31/2025)
- Those with an "Administrative Gender Assignment of Female" (Administrative Gender code **F**) at any time in the patient's history (i.e., any time up to and including 12/31/2025)
- Those with a "Sex Parameter for Clinical Use" of Female (Sex Parameter for Clinical Use code **Female-typical**) during the measurement year (i.e., 01/01/2025 - 12/31/2025)

Exclusion(s)

Exclude the following patients:

- Those who had a bilateral mastectomy, or two unilateral mastectomies, any time prior to, and including, December 31st of the measurement year (i.e., as of 12/31/2025)
  - The following ICD-10 codes identify patients for exclusion:
    - **Z90.13** (Acquired Absence of Bilateral Breasts and Nipples)
    - **Z90.12** (Acquired Absence of Left Breast and Nipple) AND
    - **Z90.11** (Acquired Absence of Right Breast and Nipple)
- Those who had gender-affirming chest surgery (CPT code **19318**) with a diagnosis of gender dysphoria as of December 31st of the measurement year (i.e., as of 12/31/2025)
  - The following codes identify gender dysphoria:
    - ✓ ICD-10: **F64.1, F64.2, F64.8, F64.9, Z87.890**
  - Do not include laboratory claims.

- Those, 66 years of age or older as of December 31st of the measurement year (i.e., as of 12/31/2025) who:
    - Were Medicare members enrolled in an Institutional Special Needs Plan (I-SNP) any time during the measurement year (i.e., 01/01/2025 - 12/31/2025)
    - Were Medicare members residing in Long-Term Care any time during the measurement year (i.e., 01/01/2025 - 12/31/2025)
    - Had <u>both</u> Frailty <u>AND</u> Advanced Illness
        - ✓ Criteria for both conditions must be met
        - ✓ Do not include laboratory claims

  <u>Frailty</u>: At least two indications of Frailty, on different dates of service, during the measurement year (i.e., 2025)
    - Refer to the "Frailty and Advanced Illness Criteria and Codes" section of this guide.

  <u>Advanced Illness</u>: Either of the following during the measurement year (i.e., 2025) or the year prior (i.e., 2024)
    - Advanced Illness on at least two different dates of service
    - <u>OR</u> dispensed Dementia medication
    - Refer to the "Frailty and Advanced Illness Criteria and Codes" section of this guide
- Those who died or were in hospice, or using hospice or palliative care services, any time during the measurement year (i.e., 01/01/2025 - 12/31/2025)
    - ICD-10 code **Z51.5** can be used to identify a palliative care encounter
    - Do not include laboratory claims

Denominator

Patients 52–74 years of age, as of December 31st of the measurement year (i.e., 12/31/2025), who were recommended for routine breast cancer screening, as defined above and not otherwise excluded

Numerator

Patients, from the Denominator, having at least one mammogram any time on or between Oct. 1 two years prior to the measurement year and December 31 of the measurement year (i.e.,10/01/2023-12/31/2025)

- This measure evaluates primary screening.
    - Count screening, diagnostic, film, digital or digital breast tomosynthesis (3D) mammograms.
    - A bilateral screen or unilateral screen with documentation of history of mastectomy of the opposite breast meet criteria.
- Do not count MRIs, ultrasounds, or biopsies toward 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.
- Documentation, in the medical record, must include the date of the screening and the result/findings (e.g., Normal or Abnormal).

Method(s) of Measurement

Note: This measure is now an ECDS (Electronic Clinical Data System) measure.

  - Data for ECDS measures is to be reported by electronic means only.
  - ECDS measures do not allow for unstructured data; data must be recorded in a structured data field for accurate reporting.

- BCBSM/BCN: Claims processed, electronic supplemental data feeds (e.g., Health Focus, MiHIN, MCIR) and Health-e Blue data entry
  - Note: Despite the ECDS requirement, BCBSM/BCN is allowing manual data entry into Health-e Blue for the 2025 performance year.
- Priority Health: Claims processed and electronic supplemental data feeds.
  - Note: Priority Health will calculate 2025 performance rates for this measure at the practice level.

Tip(s)

- Educate patients about the importance of routine screening.
  - Many women with breast cancer do not have symptoms, which is why regular screenings are important.
- Utilize all types of visits (e.g., AWVs, physical exams, office visits, telehealth visits) to encourage patients, overdue for a mammogram, to complete the screening prior to year's end.
  - Hand/mail a mammogram order to the patient with the location and phone number of the testing facility.
  - Share a list of nearby contracted imaging/mammography centers.
  - Conduct direct outreach (text/voice/email/web message or letter) to patients overdue for a mammogram.
- Ensure that the PCP is copied on the Mammography report, so results are shared as soon as the test is interpreted.
- Telehealth, telephone visits, e-visits and virtual check-ins can be used to document the event/exclusion.
  - Document mammograms in the patient's chart in the EMR; include the date of service and result (Normal/Abnormal, Positive/Negative or BI-RADS Score).
    - ✓ The Breast Imaging Reporting and Data System (BI-RADS) is a standard system used to describe breast imaging test results.
    - ✓ The BI-RADS score is usually found at the bottom of the mammography report in the "Impressions" section
    - ✓ The BI-RADS scale has seven categories, each with specific meaning and suggested follow-up care
      - **Category 0**: Incomplete Results > Additional imaging required
      - **Category 1**: Negative Results with no significant abnormalities
      - **Category 2:** Benign Results (e.g., cyst or benign calcification)
      - **Category 3**: Probable Benign Results > Diagnostic mammogram recommended
      - **Category 4:** Suspicious results > Core needle biopsy recommended

        - **Category 5:** Highly suggestive of malignancy > Core needle or excisional biopsy recommended
        - **Category 6:** Known Biopsy-proven malignancy > Recommendation depends on multiple factors including tumor size and metastasis
    - Document bilateral or unilateral mastectomies in the History section of the patient's chart in the EMR; include the approximate date of the procedure (month/year).
    - Document the diagnosis code(s) for a history of bilateral mastectomy (Z90.13) or absence of right or left breast (Z90.11 and Z90.12, respectively) in the patient's Problem List in the EMR AND report the diagnosis code(s) annually via claim.
    - Document data manually entered into the EMR (e.g., patient-reported information, outside test dates and results, etc.) in structured data fields to facilitate accurate reporting from electronic supplemental data feeds (e.g., by Health Focus).

Care Management

The following is a high-level summary of the measure. The referenced measure source should be consulted for specific questions/details.

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Summary of Changes

- Priority Health:
  - The quality measure performance component for the Priority Health Care Management incentive has been removed.
  - Clinical staff members can work as Care Managers if training requirements are met.
  - Telephone codes (98966, 98967, 98968) can only be used for one of the two required patient touchpoints.
  - The ASO/PPO product line is excluded from this measure.

Measure Source(s):

- BCBSM: Provider Delivered Care Management (PDCM)

- Priority Health: 2025 PCP Incentive Program (PIP) manual -"Transformation of Care: Care Management"

Description

The percentage of eligible, unique patients with at least two billed care management claims on different dates of service during the measurement year (i.e., 2025)

- Additional requirements apply (see below)
- BCBSM and Priority Health have distinct care management incentive programs with different requirements.

BCBSM Provider-Delivered Care Management (PDCM):

- **Who can deliver (and bill for) care management services?**
  - All BCBSM PCMH-designated providers (including PAs, NPs, FNPs, CNPs, CNMs, CRNAs, RNs, and LPNs) and PGIP specialists with the five required PCMH-N capabilities in place (4.3, 4.5, 4.10, 4.19 and 4.20) are eligible to bill for (PDCM) services.
  - Care Teams are comprised of physicians and licensed (e.g., social workers, nurses) or unlicensed (e.g., MAs, CHWs) care team members.
- **Care Team members delivering PDCM services have specified training requirements.**
  - Care team members must take the "Introduction to Team-Based Care" class within 6 months of billing PDCM codes.
  - Care Team members must accrue up to 8 additional hours of care management education/training during each calendar year.
  - NPO offers care management training courses to satisfy these requirements.

- Please contact NPO for more details.

The PDCM Program:

- There are two types of PDCM VBRs:

PDCM Outcomes VBR

  - Eligible practices must deliver PDCM services to at least 1% of their eligible BCBSM PDCM population (two care management encounters on different dates of service billing one of the 12 PDCM codes) in the year prior to the current measurement year (i.e., 2024)
  - Practices reaching the 1% engagement threshold in the prior year (i.e., 2024) are scored on quality measure performance during the current measurement year (i.e., 2025)
  - PDCM engagement rates are calculated at the practice level.

The PDCM Outcomes quality measures are:

Adult Measures	Pediatric Measures
• Blood Pressure Control	• Follow- Up After ED Visit for Mental Illness
• HbA1c Control	• Follow up for Children Prescribed ADHD Medication (C&M Phase)
• ED Use	• Asthma Medication Ratio ->50%
• Inpatient Discharge	• Pediatric Obesity- Weight Management
	• ED Use
	• Inpatient Discharge

  - PDCM Outcomes VBR is paid as a monthly PaMPM amount beginning September 1st of the year following the current measurement year (i.e., 09/01/2026 - 08/31/2027)

PDCM Population Management VBR

  - Eligible practices must deliver PDCM services to at least 4% of their eligible BCBSM PDCM population (two care management encounters on different dates of service billing one of the 15 care management codes) in the current measurement year (i.e., 2025)
  - The 1% engagement threshold must first be met, billing as above, for the PDCM Outcomes VBR.
  - Earned PDCM Population Management VBR (7% VBR) is applied to eligible BCBSM claims beginning September 1st of the year following the current measurement year (i.e., 09/01/2026 - 08/31/2027).

- **Billing Codes**
  - The 12 PDCM codes are:
    - ✓ HCPCS **G9001** (Initial Assessment**)**
    - ✓ HCPCS **G9002** (Maintenance or follow-Up)
    - ✓ HCPCS **G9007**: (Team Conference)
    - ✓ HCPCS **G9008** (Physician Coordinated Care Oversight/Referral)
    - ✓ HCPCS **S0257** (Advance Directive Counseling)
    - ✓ CPT **98961** and **98962** (Group Education for 30 minutes, 2-4 or 5-8 patients, respectively.)
    - ✓ CPT **98966, 98967**, and **98968** (Phone services, 5-10 minutes, 11-20 minutes, and 21-30 minutes, respectively)

        - ✓ CPT **99487** and **99489** (Care Coordination, 31-75 minutes, and 30-minute add-on code, respectively)
    - The 15 Care Management codes are the 12 PDCM codes, above, PLUS:
        - ✓ CPT **99495** and **99496** (Transitional Care Management Services, moderate and high complexity, respectively)
        - ✓ CPT II **1111F** (Medication Reconciliation)
- BCN reimburses the above care management billing codes but does not yet participate in the PDCM incentive program.

Priority Health Care Management Incentive Program

Practices must meet the requirements for each of the following components of the Priority Health Care Management incentive program:

Component 1: PCMH Designation

- PCPs must be practicing at a PCMH-designated practice during the measurement year (i.e., 2025).
    - Priority Health honors the following PCMH recognition programs:
        - ✓ BCBSM
        - ✓ NCQA
        - ✓ URAC
        - ✓ Joint Commission
    - NPO reports the PCMH designation status to Priority Health for member PCPs.

Component 2: Care Manager Qualifications and Training

- A practice must have at least one part-time or full-time Care Manager actively working with Priority Health patients.
- Care Managers may be licensed (i.e., Qualified Health Professionals or QHPs) OR unlicensed staff members.
    - The following provider types are licensed staff members (QHPs):
        - ✓ Registered Nurse (RN)
        - ✓ Nurse Practitioner (NP)
        - ✓ Physician Assistant (PA)
        - ✓ Licensed Master Social Worker (LMSW)
        - ✓ Certified Diabetes Educator (CDE)
        - ✓ Asthma Educator - Certified (AE-C)
        - ✓ Pharmacist
        - ✓ Respiratory Therapist (RT)
        - ✓ Registered Dietician (RD)
        - ✓ Registered Dietician Nutritionist, master's level in Nutrition
    - Unlicensed clinical staff members are defined as follows:
        - ✓ "A person who works under the supervision of a physician, NP or PA and who is allowed by law, regulation and facility policy to perform or assist in the performance of a specified professional service but who doesn't individually report that professional service"
        - ✓ E.g., Medical Assistants (MAs)

        - ✓ E.g., Community Health Workers (CHWs)
- Unlicensed clinical staff members working as Care Managers must complete initial training, using a recognized training program, within the first 6 months of providing/billing care management services.
    - See the 2025 PCP Incentive Program (PIP) manual for a list of approved training programs.
    - The MiCMRC PDCM online training course DOES NOT meet this training requirement.
    - BUT, the MICMT "Introduction to Team-Based Care" course (taught twice each year by NPO staff members endorsed as MICMT-approved trainers) DOES meet the training requirement.
- Care Managers must complete an additional 8 hours of continuing education during the measurement year (i.e., 2025)

Component 3: Claims

- Priority Health will continue to calculate care management engagement rates at the PO- (i.e., NPO-), not the practice-, level in 2025.
    - NPO, as a whole, must meet or exceed a 2% target of unique Priority Health patients receiving care management services.
    - Patients only need to be active Priority Health members on the date care management services are provided.
    - Patients must be seen for two separate care management encounters, on different dates of service, to count towards the care management engagement threshold.
- Claims submitted with care management billing codes (HCPCS and CPT) will be used to identify patients receiving care management services.
    - Priority Health care management incentive program recognizes the BCBSM care management billing codes, above, with the exception of the 1111F medication reconciliation code.
        - ✓ Only one telephone billing code (98966, 98967, 98968) may be used towards the required patient touchpoints.
    - In addition, Priority Health recognizes the following care management billing codes:
        - ✓ G0511 (Care coordination services and payment for RHCs and FQHCs only)
        - ✓ 99484 (General behavioral health integration)
        - ✓ 99490 (Chronic care management services)
        - ✓ 99497 and 99498 (Advanced Care Planning)
    - The care management thresholds only apply to the commercial HMO/PPO, Medicare, and Medicaid product lines; the commercial ASO/PPO product line is excluded from this measure.
    - See the Care Management section of Priority Health's 2025 Provider Manual for more billing information.

Exclusion(s)

Practices that do not have a Care Management program implemented are excluded from this incentive.

Denominator

Average number of NPO-assigned/attributed member months for BCBSM or Priority Health patients in the measurement year (i.e. 2025)

Numerator

Two billed care management claims, on different dates of service in the measurement year (i.e., 2025), per unique patient

Method(s) of Measurement

- BCBSM: Claims processed
  - BCBSM calculates care management engagement rates at the practice-level.
- Priority Health: Claims processed
  - Priority Health will continue to calculate care management engagement rates at the ACN- (NPO-) level in 2025.

Tip(s)

- Be aware: Multiple care management codes billed on the same DOS only count as one care management encounter.
- Keep a "Care Management" audit file, with documentation of all licensures and completed initial training and continuing education courses.

Cervical Cancer Screening

The following is a high-level summary of the measure. The referenced measure source should be consulted for specific questions/details.

Return to Summary Page

Summary of Changes

- Priority Health: Performance will be measured at the practice level for MY 2025.

Measure Source(s)

- HEDIS: "Cervical Cancer Screening (CCS-E)"

Description

The percentage of patients, 21–64 years of age and recommended for routine cervical cancer screening, who were screened for cervical cancer using one of the following criteria:

- **21–64 years of age:** A cervical cytology performed within the last three years (the measurement year and the two years prior, or 01/01/2023 - 12/31/2025)
- **30-64 years of age:** A cervical high-risk human papillomavirus (hrHPV) test or cervical cytology/high- risk human papillomavirus (hrHPV) cotest performed within the last five years (the measurement year and the four years prior, or 01/01/2021 - 12/31/2025)

Definitions

"Patients recommended for routine cervical cancer screening" are defined as:

- Those with "Sex Defined at Birth" (LOINC code = **76689-9**) of Female (LOINC code **LA3-6**) at any time in the patient's history (i.e., any time up to and including 12/31/2025)
- Those with an "Administrative Gender Assignment of Female" (Administrative Gender code **F**) at any time in the patient's history (i.e., any time up to and including 12/31/2025)
- Those with a "Sex Parameter for Clinical Use" of Female (Sex Parameter for Clinical Use code **Female-typical**) during the measurement year (i.e., 01/01/2025 - 12/31/2025)

Exclusion(s)

Exclude the following patients:

- Those who have had a hysterectomy with no residual cervix, cervical agenesis, or acquired absence of cervix as of December 31st of the measurement year (i.e., as of 12/31/2025). The following documentation meets the criteria for hysterectomy with no residual cervix:
  - Documentation of "complete," "total" or "radical" abdominal or vaginal hysterectomy.
  - Documentation of a "vaginal pap smear" in conjunction with documentation of "hysterectomy."
  - Documentation of hysterectomy in combination with documentation that the patient no longer needs pap testing/cervical cancer screening or has no residual cervix.

    - **<u>Note:</u>** Documentation of "hysterectomy" alone does NOT meet the criteria for exclusion because it does not indicate that the cervix was removed.
- The ICD-10 codes below can be used to identify a patient for exclusion:
    - **Z90.710** (Acquired absence of both cervix and uterus)
    - **Z90.712** (Acquired absence of cervix with remaining uterus)
    - **Q51.5** (Agenesis and aplasia of cervix)
    - Do not include laboratory claims.
- Those who died or were in hospice, or using hospice or palliative care services, anytime during the measurement year (i.e., 01/01/2025 - 12/31/20245
    - ICD-10 code **Z51.5** can be used to identify a palliative care encounter.
- Those with "Sex Defined at Birth" (LOINC code **76689-9**) of Male (LOINC code **LA2-8**) at any time in the patient's history (i.e., any time up to and including 12/31/2025)
- Patients "transitioning from male to female" or who have undergone sex reassignment surgery from male to female

Denominator

Patients 24–64 years of age as of December 31st of the measurement year (i.e., as of 12/31/2024) recommended for routine cervical cancer screening, not otherwise excluded.

Numerator

Patients, from the Denominator, who were screened for cervical cancer, as described above.
- For screens consisting of **<u>cervical cytology</u>** only:
    - Documentation in the medical record must include the date the cervical cytology was performed as well as the result/finding (e.g., Normal/Abnormal), preferably the cytology report.
    - The result or finding of "Unknown" does not meet measure criteria.
    - Count any cervical cancer screening method that includes collection and analysis of cervical cells, but do not count lab results that explicitly state the sample was inadequate.
    - Lab results that indicate the sample contained "no endocervical cells" may be used only if a valid result was reported for the test.
    - The following billing and EHR codes identify **<u>cervical cytology</u>** tests:
      <u>CPT:</u> **88141, 88142, 88143, 88147, 88148, 88150, 88152, 88153, 88164, 88165, 88166, 88167, 88174, 88175**
      <u>HCPCS</u>: **G0123, G0124, G0141, G0143, G0144, G0145, G0147, G0148, P3000, P3001, Q0091**
      <u>LOINC:</u> **10524-7, 18500-9, 19762-4, 19764-0, 19765-7, 19766-5, 19774-9, 33717-0, 47527-7, 47528-5**
- For screens including **<u>hrHPV</u>** testing:
    - Documentation in the medical record must include both the date the hrHPV test was performed and the result or findings.
    - Evidence of hrHPV testing within the last five years also captures patients who had co-testing; therefore, additional methods to identify co-testing are not necessary.

- The following billing and EHR codes identify **high-risk HPV** tests:
  CPT: **87624, 87625**
  HCPCS**: G0476**
  LOINC**: 21440-3, 30167-1, 38372-9, 59263-4, 59264-2, 59420-0, 69002-4, 71431-1, 75694-0, 77379-6, 77399-4, 77400-0, 82354-2, 82456-5, 82675-0, 95539-3**
- For all screening methods: Biopsies are diagnostic and therapeutic and are NOT considered valid for primary cervical cancer screening.

Method(s) of Measurement

Note: This measure is now an ECDS (Electronic Clinical Data System) measure.

- Data for ECDS measures is to be reported by electronic means only.
- ECDS measures do not allow for unstructured data; data must be recorded in a structured data field for accurate reporting.

- BCBSM/BCN: Claims processed, electronic supplemental data feeds (e.g., Health Focus, MiHIN, MCIR) and Health-e Blue data entry
  - Note: Despite the ECDS requirement, BCBSM/BCN is allowing manual data entry into Health-e Blue for the 2025 performance year.
- Priority Health: Claims processed and electronic supplemental data feeds
  - Note: Priority Health will calculate 2025 performance rates for this measure at the practice level.

Tip(s)

- Educate patients about the importance of routine screening.
- Utilize all types of visits (e.g., AWVs, physical exams, office visits, telehealth visits) to encourage patients overdue for screening to complete the test prior to year's end.
- Request information from specialists, for those patients who test through their OB/GYN.
- Ensure complete documentation in the patient's chart in the EMR
  - Documentation of lab tests must include both the date and result of the test.
  - Documentation of hysterectomy must include the approximate date of the procedure (year, at minimum) AND clearly state that the cervix is absent.
  - Patient-reported information is acceptable if:
    - ✓ It is documented in the patient's chart by a care provider
    - ✓ It includes the date and result of the test of date of hysterectomy and documentation of no residual cervix
  - An exclusion diagnosis code (i.e., Z90.710, Z90.712, Q51.5) should be included in the patient's Problem List in the chart in the EMR AND reported via claim annually.
  - Document data manually entered into the EMR (e.g., patient-reported information, outside test dates and results, etc.) in structured data fields to facilitate accurate reporting from electronic supplemental data feeds (e.g., by Health Focus).
- Documentation of "binary", "non-binary", "transgender" or "transexual" do NOT meet criteria for exclusion.
- Be aware that biopsy-only reports do not count for cervical cancer screening.

Child and Adolescent Well-Care Visits

The following is a high-level summary of the measure. The referenced measure source should be consulted for specific questions/details.

Return to Summary Page

Summary of Changes

- Priority Health: The age range for measure inclusion has been expanded from 3-11 years to 3-21 years.
- Priority Health: Performance will be measured at the practice level for MY 2025
- HEDIS: Telehealth well-visits (telehealth visits, telephone visits, and online assessments) no longer meet criteria for Numerator compliance.

Measure Source(s)

- HEDIS: "Child and Adolescent Well-Care Visits (WCV)"

Description

The percentage of patients, 3-21 years of age, who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year (i.e., 2025)

Exclusion(s)

Exclude patients who died or were in hospice, or utilizing hospice services, any time during the measurement year (i.e., 01/01/2025 - 12/31/2025)

Denominator

Children/adolescents 3-21 years of age as of December 31st of the measurement year (i.e., as of 12/31/2025), not otherwise excluded

Numerator

Children/adolescents, from the Denominator, having at least one well-child visit during the measurement year (i.e. 01/01/2025- 12/31/2025)

- The visit must occur with a PCP or OB/GYN, but the practitioner does not have to be the one assigned to the patient
- The visit must be in-person
  - Telehealth visits (including telephone visits and online assessments) no longer meet criteria for Numerator compliance
- Documentation of the components (below) of the well-care visit:
  - Can be completed any time during the measurement year

- Can be completed on separate visits,
    - ✓ BUT services specific to the assessment or treatment of an acute or chronic condition do not count towards the measure
    - ✓ If a sick patient comes in and is due for a well-child visit, document the components of the well-child visit in the encounter and report the problem-oriented E&M service with the 25-modifier.
    - ✓ Documentation must support that both services were provided distinctly and in their entirety.

- Documentation must include:
  - A note indicating a visit to a PCP or OB/GYN
  - The date when the well-child visit occurred
  - AND evidence of all of the following:

Health History:

- Note past illnesses, surgeries, hospitalizations, and family history of disease.
- Documentation of all three of the following components is needed to constitute a comprehensive health history:
    - ✓ Allergies
    - ✓ Medications,
    - ✓ Immunization status

Physical Developmental History:

- Assess age-appropriate physical developmental milestones
- Documentation of "well-developed", "well-nourished", "well-appearing", or "appropriate for age", without specific mention of physical developmental milestones, does not meet compliance criteria

Mental Developmental History:

- Assess age-appropriate mental developmental milestones and progress toward developing needed skills
- Documentation of "behavior appropriate for age", "neurological exam", or "well-developed", without specific mention of mental developmental milestones, does not meet compliance criteria.

Physical Exam:

- Comprehensive physical assessment, including height, weight, and BMI percentile
- Documentation of just vital signs does not meet compliance criteria

Health Education or Anticipatory Guidance:

- Information given to parents/guardians in anticipation of emerging issues the child/family may face
- However, this does not include information pertaining to medications, immunizations, or their side effects.
- Handouts given, without evidence of discussion, also do not meet compliance criteria

- The following codes can be used to identify **Well-Care Visits**:
  - ICD-10CM: **Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.2, Z00.3, Z01.411, Z01.419, Z02.5, Z02.84, Z76.1, Z76.2**
  - CPT: **99381, 99382, 99383, 99384, 99385, 99391, 99392, 99393, 99394, 99395, 99461**
  - HCPCS: **G0438, G0439, S0302, S0610, S0612, S0613**

    - Do not include laboratory claims
    - Do not include telehealth visits.

Method(s) of Measurement

- BCBSM/BCN: Claims processed
    - This is a "No Entry" measure in Health-e Blue.
- Priority Health: Claims processed
    - Note: Priority Health will calculate 2025 performance rates for this measure at the practice level.

Tip(s)

- Patient/parent reported height and weight are acceptable if documented by the Provider in the patient's medical record.
- Templates or checklists ensure that all care components get completed during the measurement year.
- Services rendered during an inpatient or ED visit do not count.

Additional Note(s)

- This is a pediatric focus measure for the 2025 Priority Health PIP incentive program.

Childhood Immunization Status

The following is a high-level summary of the measure. The referenced measure source should be consulted for specific questions/details.

Return to Summary Page

Summary of Changes

- Priority Health: Performance will be measured at the practice level for MY 2025.
- HEDIS: Organ and Bone Marrow transplants have been added to the Exclusions section.

Measure Source(s)

- HEDIS: "Childhood Immunization Status (CIS-E)"

Description

The percentage of children, turning two years of age during the measurement period (i.e., 01/01/2025 - 12/31/2025), who completed the Combination 10 (BCBSM/BCN) or Combination 3 (Priority Health) vaccine series by the time of their second birthday.

- Vaccines must be administered on or before the child's second birthday to meet criteria
- Anaphylaxis and/or history of disease must occur on or before the child's second birthday to meet criteria.
- Multiple doses for any vaccine must be administered on different dates of service at least 14 days apart
- See the table below for the specific vaccines included in each Combination series.
- Combination 3 (Priority Health) consists of the Combination 10 vaccines, as described above, MINUS Hep A, RV and Flu.

DTaP (Combo 3, Combo 10) - Any of the following meet criteria:

- At least **4 DTaP** (Diphtheria, Tetanus and acellular Pertussis) vaccinations
  - DTaP vaccination CPT codes: **90697, 90698, 90700, 90723**
  - DTaP CVX codes: **20, 50, 106,107, 110, 120, 146, 198**
  - Administer at least 42 days after birth.
  - Anaphylaxis or Encephalitis due to Diphtheria, Tetanus or Pertussis vaccine

IPV (Combo 3, Combo 10) - Either of the following meets criteria:

- At least **3 IPV** (Inactivated Polio Vaccine) vaccinations
  - IPV vaccination CPT codes: **90697, 90698, 90713, 90723**
  - IPV CVX codes: **10, 89, 110, 120, 146**
  - Administer at least 42 days after birth
- Anaphylaxis due to IPV vaccine

MMR (Combo 3, Combo 10) - Any of the following meets criteria:

- At least **1 MMR** (Measles, Mumps and Rubella) vaccination
  - MMR vaccination CPT codes: **90707, 90710**
  - MMR CVX codes: **03, 94**

    - Administer on or between the child's first and second birthdays.
- All of the following:
    - History of Measles illness ICD-10 codes: **B05.0, B05.1, B05.2, B05.3, B05.4, B05.81, B05.89, B05.9**
    - History of Mumps illness ICD-10 codes: **B26.0, B26.1, B26.2, B26.3, B26.81, B26.82, B26.83, B26.84, B26.85, B26.89, B26.9**
    - History of Rubella illness ICD-10 codes**: B06.00, B06.01, B06.02, B06.09, B06.81, B06.82, B06.89, B06.9**
    - Do not include laboratory claims.
- Anaphylaxis due to the MMR vaccine.

HiB (Combo 3, Combo 10) - Either of the following meets criteria:

- At least **3 HiB** (Haemophilus Influenza type B) vaccinations
    - HiB vaccination CPT codes: **90644, 90647, 90648, 90697, 90698, 90748**
    - HiB CVX codes**: 17, 46, 47, 48, 49, 50, 51, 120, 146, 148, 198**
    - Administer at least 42 days after birth
- Anaphylaxis due to the HiB vaccine

Hep B (Combo 3, Combo 10) - Any of the following meets criteria:

- At least **3 HepB** (Hepatitis B) vaccinations
    - Hep B vaccination CPT codes: **90697, 90723, 90740, 90744, 90747, 90748;** HCPCS code **G0010**
    - Hep B CVX codes**: 08, 44, 45, 51, 110, 146, 198**
- One of the three vaccinations can be a newborn vaccination given within the first 8 days of life.
- History of Hepatitis B illness:
    - History of Hepatitis B illness ICD-10 codes: **B16.0, B16.1, B16.2, B16.9, B17.0, B18.0, B18.1, B19.10, B19.11**
    - Do not include laboratory claims
- Anaphylaxis due to the Hepatitis B vaccine

VZV (Combo 3, Combo 10) - Any of the following meets criteria:

- At least **1 VZV** (Varicella Zoster Vaccine) vaccination
    - VZV vaccination CPT codes: **90710, 90716**
    - VZV CVX codes**: 21, 94**
    - Administer on or between the child's first and second birthdays.
- History of Varicella Zoster illness
    - History of Varicella Zoster illness ICD-10 codes: **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**
    - Do not include laboratory claims.
- Anaphylaxis due to the VZV vaccine.

PCV (Combo 3, Combo 10) - Either of the following meets criteria:

- At least **4 PCV** (Pneumococcal Conjugate Vaccine) vaccinations
    - PCV vaccination CPT codes: **90670**; HCPCS code **G0009**
    - PCV CVX codes: **109, 133, 152, 215, 216**
    - Administer at least 42 days after birth
- Anaphylaxis due to the PCV vaccine

Hep A (Combo 10 only) - Any of the following meet criteria

- At least **1 HepA (Hepatitis A)** vaccination
  - Hep A vaccination CPT code: **90633**
  - Hep A CVX codes: **31, 83, 85**
  - Administer on or between the child's first and second birthdays.
- History of Hepatitis A illness
  - History of Hepatitis A illness ICD-10 codes: **B15.0, B15.9**
  - Do not include laboratory claims.
- Anaphylaxis due to the Hepatitis A vaccine

RV (Combo 10 only) - Any of the following meet criteria:

- At least **2 doses of the two-dose RV** (Rotavirus) vaccine
- OR **3 doses of the three-dose RV** Vaccine
- OR **1 dose of the two-dose RV vaccine** AND **2 doses of the three-dose RV vaccine**
  - Rotavirus vaccination (2-dose vaccine) CPT code: **90681**
  - Rotavirus (2-dose vaccine) CVX code: **119**
  - Rotavirus vaccination (3-dose vaccine) CPT code: **90680**
  - Rotavirus (3-dose vaccine) CVX codes: **116, 122**
  - Administer at least 42 days after birth
- Anaphylaxis due to the RV vaccine.

Flu (Combo 10 only) - Either of the following meets criteria:

- At least **2 Flu** (Influenza) vaccinations
  - Influenza vaccination CPT codes: **90655, 90657, 90661, 90673, 90674, 90685, 90686, 90687, 90688, 90689, 90756**
  - Influenza CVX codes**: 88,140, 141, 150, 153, 155, 158, 161, 171, 186**
  - One of the two vaccinations can be an LAIV (Live Attenuated Influenza Vaccine, e.g., FluMist)
    - ✓ LAIV CPT codes: **90660, 90672**
    - ✓ LAIV CVX codes: **111, 149**
    - ✓ LAIV must be administered on, but not before, the 2nd birthday.
  - Administer at least 180 days after birth
- Anaphylaxis due to the FLU vaccine

Exclusion(s)

Exclude the following patients:

- Those who had any of the following on or before their 2nd birthday.
  - Contradictions to childhood vaccines, including, but not limited to:
    - ✓ Immunodeficiency
    - ✓ HIV
    - ✓ Lymphoreticular Cancer, Multiple Myeloma, or Leukemia
    - ✓ Anaphylactic reaction to neomycin
    - ✓ History of Intussusception
    - ✓ Severe Combined Immunodeficiency
  - Organ or bone marrow transplants

  - Do not include laboratory claims
- Those who died or were in hospice, or using hospice services, any time during the measurement period (i.e., 01/01/2025 - 12/31/2025)

Denominator

Patients turning 2 years of age by the end of the measurement year (i.e., as of 12/31/2025), not otherwise excluded

- Parent refusal of immunizations does not remove an eligible patient from the Denominator.

Numerator

Patients, from the Denominator, with completed vaccinations, as defined above and in the table below.

- Documentation in the medical record must include the name of the vaccination and the date administered.
- Different vaccinations may be given on the same date of service (DOS), but multiple doses of the same vaccine must be given on different dates of service at least 14 days apart.

Method(s) of Measurement

- BCBSM/BCN: Claims processed and immunization data in MCIR
  - MCIR data is downloaded from the State of Michigan monthly.
  - This is a "No Entry" measure in HeB.
- Priority Health: Claims processed and immunization data in MCIR
  - MCIR data is downloaded from the State of Michigan monthly.
  - Note: Priority Health will calculate 2025 performance rates for this measure at the practice level.

Tip(s)

- Use every opportunity to vaccinate;
  - Immunizations given even one day after the child's second birthday will NOT be valid for HEDIS purposes.
  - Review the immunization record before every visit.
  - If applicable, administer needed vaccines at sick visits if the child is behind schedule.
- Make sure all immunizations (even historical ones) are documented in the "Immunization" section of the EHR AND in MCIR.
  - Inquire about vaccines received elsewhere (e.g., Health Department, hospital at birth)
  - Request previous immunization records for new or recently transferred patients.
  - Obtain a record of the vaccines, if possible.
  - AND update both the patient's outpatient chart and MCIR accordingly.
- Documentation that the patient is "up to date with vaccinations" without a corresponding list of vaccination names and administration dates does NOT meet the criteria for compliance.

- Recommend immunizations to parents. Parents are more likely to agree to vaccinations when recommended by the provider.
- Schedule the appointment for the patient's next vaccination before they leave the office.
- Reminders by mail, email and text have been shown to be effective in increasing immunization rates.
- Parental refusal does NOT meet the criteria for compliance.

Additional Note(s)

- Combination 3 is incented by Priority Health, but NOT BCBSM/BCN, for the 2025 measurement year.
- Combination 10 is incented by BCBSM/BCN, but NOT Priority Health, for the 2025 measurement year.

HEDIS

Combination Vaccinations for Childhood Immunization Status

Combination	DTaP	IPV	MMR	HiB	Hep B	VZV	PCV	Hep A	RV	Influenza
Combination 3	✓	✓	✓	✓	✓	✓	✓			
Combination 10	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Childhood Immunization Status: Flu

The following is a high-level summary of the measure. The referenced measure source should be consulted for specific questions/details.

Return to Summary Page

Summary of Changes

- HEDIS: Organ and Bone Marrow transplants have been added to the Exclusions section.

Measure Source(s):

- HEDIS: "Childhood Immunization Status (CIS)"

Description

The percentage of children, turning two years of age during the measurement period (i.e., 01/01/2025-12/31/2025), who had at least 2 Flu (Influenza) vaccinations by the time of their second birthday.

- Vaccines must be administered on or before the child's second birthday to meet criteria, unless indicated otherwise.
- Anaphylaxis and/or history of disease must occur on or before the child's second birthday to meet criteria.
- Multiple doses must be administered on different dates of service at least 14 days apart.
- Either of the following meets criteria:
    - At least **2 Flu** (Influenza) vaccinations
        - ✓ Influenza vaccination CPT codes: **90655, 90657, 90661, 90673, 90674, 90685, 90686, 90687, 90688, 90689, 90756**
        - ✓ Influenza CVX codes: **88,140, 141, 150, 153, 155, 158, 161, 171, 186**
        - ✓ One of the two vaccinations can be an LAIV (Live Attenuated Influenza Vaccine, e.g., FluMist)
            - LAIV CPT codes: **90660, 90672**
            - LAIV CVX codes: **111, 149**
            - LAIV must be administered on, but not before, the 2nd birthday.
        - ✓ Administer at least 180 days after birth.
    - Anaphylaxis due to the FLU vaccine

Exclusion(s)

Exclude the following patients:

- Those who had any of the following on or before their 2nd birthday.
    - Contradictions to childhood vaccines, including, but not limited to:
        - ✓ Immunodeficiency
        - ✓ HIV
        - ✓ Lymphoreticular Cancer, Multiple Myeloma, or Leukemia
        - ✓ Anaphylactic reaction to neomycin
        - ✓ History of Intussusception
        - ✓ Severe Combined Immunodeficiency

- Organ or bone marrow transplants
- Do not include laboratory claims

- Those who died or were in hospice, or using hospice services, any time during the measurement period (i.e., 01/01/2025 - 12/31/2025)

Denominator

Patients turning 2 years of age by the end of the measurement year (i.e., as of 12/31/2025), not otherwise excluded

- Parent refusal of immunizations does not remove an eligible patient from the Denominator.

Numerator

Patients, from the Denominator, with completed Flu vaccinations, as defined above.

- Documentation in the medical record must include the name of the vaccination and the date administered.
- Different vaccinations may be given on the same date of service (DOS), but multiple doses of the same vaccine must be given on different dates of service at least 14 days apart.

Method(s) or Measurement

- BCBSM/BCN: Claims processed and update of immunization data in MCIR
  - MCIR data is downloaded from the State of Michigan monthly.
  - This is a “No Entry” measure in HeB.

Tip(s)

- Use every opportunity to vaccinate;
  - Immunizations given even one day after the child's second birthday will NOT be valid for HEDIS purposes.
  - Review immunization record before every visit.
  - If applicable, administer needed vaccines at sick visits if the child is behind schedule.
- Make sure all immunizations (even historical ones) are documented in the “Immunization” section of the EHR AND in MCIR.
  - Inquire about vaccines received elsewhere (E.G., Health Department, hospital at birth)
  - Request previous immunization records for new or recently transferred patients.
  - Obtain a record of the vaccines, if possible.
  - AND update both the patient's outpatient chart and MCIR accordingly.
- Documentation that the patient is "up to date with vaccinations" without a corresponding list of vaccination names and administration dates does NOT meet the criteria for compliance.
- Recommend immunizations to parents. Parents are more likely to agree to vaccinations when recommended by the provider.
- Schedule the appointment for the patient's next vaccination before they leave the office.
- Reminders by mail, email and text have been shown to be effective in increasing immunization rates.

- Parental refusal does NOT meet the criteria for compliance.

Additional Note(s)

- In addition to Combo 10, BCBSM/BCN is separately incenting Flu vaccination.

Chlamydia Screening

The following is a high-level summary of the measure. The referenced measure source should be consulted for specific questions/details.

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Summary of Changes

- Priority Health: Performance will be measured at the practice level for MY 2025.
- HEDIS: The title was changed from "Chlamydia Screening in Women" to "Chlamydia Screening"
- HEDIS: All references to "women" were replaced with "members recommended for routine Chlamydia screening".
- HEDIS: An exclusion was added for patients defined at birth as male.

Measure Source(s)

- HEDIS: "Chlamydia Screening (CHL)"

Description

The percentage of patients, 16–24 years of age and recommended for routine Chlamydia screening, who were identified as sexually active and had at least one test for Chlamydia during the measurement year (i.e., 01/01/2025 - 12/31/2025)

Definitions

"Patients recommended for routine Chlamydia screening" are defined as:

- Those with "Sex Defined at Birth" (LOINC code = **76689-9**) of Female (LOINC code **LA3-6**) at any time in the patient's history (i.e., any time up to and including 12/31/2025)
- Those with an "Administrative Gender Assignment of Female" (Administrative Gender code **F**) at any time in the patient's history (i.e., any time up to and including 12/31/2025)
- Those with a "Sex Parameter for Clinical Use" of Female (Sex Parameter for Clinical Use code **Female-typical**) during the measurement year (i.e., 01/01/2025 - 12/31/2025)

Patients recommended for routine Chlamydia screening are then identified as sexually active through both pharmacy and claim/encounter data. A patient only needs to be identified in one method to be eligible for the measure.

- **Pharmacy claims data**: The patient filled a prescription for a contraceptive medication during the measurement year (i.e., 2025).
- **Claim/encounter data**: The patient had an encounter indicating sexual activity (e.g., at least one claims with a diagnosis and/or procedure code pertaining to pregnancy, pregnancy testing, or STD testing/disease
    - Do not include laboratory claims.

Exclusion(s)

<u>Exclude the following patients:</u>

- Those who were dispensed a prescription for isotretinoin (Accutane) on the date of, or within six days after, a pregnancy test during the measurement year (i.e., 01/01/2025 - 12/31/2025)
- Those who received an x-ray on the day of, or within 6 days after, a pregnancy test during the measurement year (i.e., 01/01/2025 - 12/31/2025)
- Those who died or were in hospice, or using hospice services, any time during the measurement year (i.e., 01/01/2025 - 12/31/2025)
- Those with "Sex Assigned at Birth" (LOINC code = **76689-9**) of Male (LOINC code **LA2-8**) at any time in the patient's history (i.e., any time up to and including 12/31/2025)

Denominator

Sexually active patients, 16-24 years of age as of December 31st of the measurement year (i.e., as of 12/31/2025) and recommended for routine Chlamydia screening, as identified above and not otherwise excluded

Numerator

Patients, from the Denominator, having at least one Chlamydia test during the measurement year (i.e., 01/01/2025- 12/31/2025)

- The following billing codes indicate **<u>Chlamydia screening</u>:**
  <u>CPT</u>**: 87110, 87270, 87320, 87490, 87491, 87492, 87810**

Method(s) of Measurement

- <u>BCBSM/BCN</u>: Claims processed, electronic supplemental data feeds (e.g., Health Focus, MiHIN, MCIR) and Health-e Blue data entry
- <u>Priority Health</u>: Claims processed and electronic supplemental data feeds only
  - Note: Priority Health will calculate 2025 performance rates for this measure at the practice level.

Tip(s)

- Take a sexual history of all teens.
- Screen all recommended patients for Chlamydia annually (simple urine test or cervical sample).
  - Utilize both sick and preventive visits as opportunities to obtain urine samples.
  - Establish a standing order for Chlamydia screening and automatically screen patients on their first visit of the year.
- Educate patients that infection may be asymptomatic and that infertility, ectopic pregnancy and passing infection to the baby during pregnancy are among the risks of untreated Chlamydia infections.

- Documentation of parental/patient refusal, or that the patient is “not sexually active” does NOT meet criteria for measure compliance or exclusion.

Colorectal Cancer Screening

The following is a high-level summary of the measure. The referenced measure source should be consulted for specific questions/details.

Return to Summary Page

Summary of Changes

- Priority Health: Performance will be measured at the practice level for MY 2025.

Measure Source(s)

- HEDIS: “Colorectal Cancer Screening (COL-E)"

Description

The percentage of patients 45–75 years of age who had appropriate screening for colorectal cancer.

- Appropriate Screening is defined by any of the following procedures/labs:
    - **Fecal Occult Blood Test (FOBT** during the measurement period (i.e., 01/01/2025 - 12/31/2025)
    - **Fecal Immunochemical Test with stool DNA analysis (FIT-DNA**; e.g., Cologuard) during the measurement year or the two years prior (i.e., 01/01/2023 - 12/31/2025)
    - **Flexible Sigmoidoscopy** during the measurement year or the four years prior (i.e., 01/01/2021 - 12/31/2025)
    - **CT Colonography** during the measurement year of the four years prior (i.e., 01/01/2021 - 12/31/2025)
    - **Colonoscopy** during the measurement year or the nine years prior (i.e., 01/01/2016 - 12/31/2025)

Exclusion(s)

Exclude the following patients:

- Those with a diagnosis, or past history, of colorectal cancer or total colectomy as of December 31st of the measurement year (i.e., 12/31/2025)
    - Cancer of the small intestine and partial or hemicolectomies do not count.
    - The following codes identify colorectal cancer:
        - ✓ ICD-10: **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**
    - The following codes identify history of colorectal cancer
        - ✓ ICD-10: **Z85.038** (Personal History of Other Malignant Neoplasm of Large Intestine) and **Z85.048** (Personal History of Other Malignant Neoplasm of Rectum, Rectosigmoid Junction and Anus)
    - Do not include laboratory claims.
- Those who died or were in hospice, or using hospice or palliative care services, any time during the measurement year (i.e., 01/01/2025 - 12/31/2025)

- ICD-10 code **Z51.5** can be used to identify a palliative care encounter
    - ✓ Do not include laboratory claims
- Those, 66 years of age or older as of December 31st of the measurement year (i.e., as of 12/31/2025), who:
  - Were Medicare members enrolled in an Institutional Special Needs Plan (I-SNP) any time during the measurement year (i.e., 01/01/2024- 12/31/2024)
  - Were Medicare members residing in Long-Term Care any time during the measurement year (i.e., 01/01/2025 - 12/31/2025)
  - Had both Frailty and Advanced Illness
    - ✓ Criteria for both conditions must be met
    - ✓ Do not include laboratory claims

  Frailty: At least two indications of Frailty, on different dates of service, during the measurement year (i.e., 2025)
    - ✓ Refer to the "Frailty and Advanced Illness Criteria and Codes" section of this guide

  Advanced Illness: Either of the following during the measurement year (i.e., 2025) or the year prior (i.e., 2024)
    - ✓ Advanced Illness on at least two different dates of service
    - ✓ OR dispensed Dementia medication
    - ✓ Refer to the "Frailty and Advanced Illness Criteria and Codes" section of this guide

Denominator

Patients 45 - 75 years of age, not otherwise excluded

Numerator

Patients from the Denominator that had one or more screenings for colorectal cancer, as described above and below.

- **FOBT completed 01/01/2025 - 12/31/2025**
  - The following billing and EHR codes identify FOBT tests:
    - ✓ CPT: **82270** and **82274**
    - ✓ HCPCS: **G0328**
    - ✓ LOINC: **12503-9, 12504-7, 14563-1, 14564-9, 14565-6, 2335-8, 27396-1, 27401-9, 27925-7, 27926-5, 29771-3, 56490-6, 56491-4, 57905-2, 58453-2, 80372-6**
- OR **FIT-DNA** (e.g. Cologuard) completed 01/01/2023 - 12/31/2025
  - The following billing and EHR codes identify the FIT-DNA lab test:
    - ✓ CPT: **81528**
    - ✓ LOINC: **77353-1, 77354-9**
- OR **Flexible Sigmoidoscopy** completed 01/01/2021 - 12/30/2025
  - The following billing codes identify Flexible Sigmoidoscopy:

- ✓ CPT: **45330, 45331, 45332, 45333, 45334, 45335, 45337, 45338, 45340, 45341, 45342, 45346, 45347, 45349, 45350**
- ✓ HCPCS: **G0104**

- OR **CT Colonography** (virtual colonoscopy) completed 01/01/2021 - 12/31/2025
  - The following billing and EHR codes identify CT Colonography:
    - ✓ CPT: **74261, 74262, 74263**
    - ✓ LOINC: **60515-4, 72531-7, 79069-1, 79071-7, 79101-2, 82688-3**
- OR **Colonoscopy** completed 01/01/2016 - 12/31/2025
  - Evidence that the scope advanced to the cecum meets criteria for a completed colonoscopy.
  - The following billing codes identify Colonoscopy Screening:
    - ✓ CPT: **44388, 44389, 44390, 44391, 44392, 44394, 44401, 44402, 44403, 44404, 44405, 44406, 44407, 44408, 45378, 45379, 45380, 45381, 45382, 45384, 45385, 45386, 45388, 45389, 45390, 45391, 45392, 45393, 45398**
    - ✓ HCPCS: **G0105 and G0121**
  - Documentation in the medical record must include the type of test, date of test and results/findings.
  - A pathology report which indicates the type of screening (e.g., colonoscopy, flexible sigmoidoscopy), the date the screening was performed and the results, meets criteria.
  - For incomplete procedures to count towards measure compliance, there must be evidence that the scope advanced past the splenic flexure or into the sigmoid colon.

Method(s) of Measurement

Note: This measure is now an ECDS (Electronic Clinical Data System) measure.

  - Data for ECDS measures is supposed to be reported by electronic means only.
  - ECDS measures do not allow for unstructured data; data must be recorded in a structured data field for accurate reporting.
- BCBSM/BCN: Claims processed, electronic supplemental data feeds (e.g., Health Focus, MiHIN, MCIR) and Health-e Blue data entry
  - Note: Despite the ECDS requirement, BCBSM/BCN is allowing manual data entry into Health-e Blue for the 2025 performance year.
- Priority Health: Claims processed and electronic supplemental data feeds.
  - Note: Priority Health will calculate 2025 performance rates for this measure at the practice level.

Tip(s)

- Educate patients about the importance of early detection.
  - Colorectal cancer doesn't typically cause noticeable symptoms.
  - Colorectal cancer can be prevented by removing growths before they become cancerous.
- Utilize all types of visits (e.g., AWVs, physical exams, office visits, telehealth visits) to encourage patients, overdue for screening, to complete a screening prior to year's end.

- Telehealth, telephone visits, e-visits and virtual check-ins can be used to document an event/exclusion.
    - Document colorectal cancer screenings in the patient's chart in the EMR; all screening documentation must include the date of the lab/test and the result/findings.
    - Document total colectomies in the History section of the patient's chart in the EMR; make sure the documentation specifies total colectomy and includes the approximate date of the procedure (year, at minimum)
    - Document colon cancer or history of colon cancer diagnoses in the Problem List of the patient's chart in the EMR AND report the diagnosis code(s) annually via claim
    - Document data manually entered into the EMR (e.g., patient-reported information, outside test dates and results, etc.) in structured data fields to facilitate accurate reporting from electronic supplemental data feeds (e.g., by Health Focus).
- Order FIT-DNA (Cologuard), or FOBT home kits for patients who are resistant to, or fearful of, colonoscopies.
- Do NOT count Digital Rectal Exams (DRE) or FOBT tests performed on samples collected from DREs or on stool samples collected in an office setting.

Consumer Assessment of Healthcare Providers & Systems (CAHPS) Survey

The following is a high-level summary of the measure. The referenced measure source should be consulted for specific questions/details.

Return to Summary Page

Summary of Changes

- There are no changes to this measure.

Measure Source(s)

- CAHPS: Consumer Assessment of Healthcare Providers & Systems (CAHPS) Survey
- ACO Realizing Equity, Access, and Community Health (REACH) Model: PY2025 Quality Measure Methodology

Description

A summary of patient experience of care; patients are surveyed about their experience with primary care services received from their provider during a specified lookup period. Domains in the questionnaire focus on the patient's ability to get needed care, the ability to get care quickly, care coordination, and communication from the provider, to name a few.

- This measure pertains to Medicare FFS ACO REACH-aligned beneficiaries and BCBSM Medicare Plus Blue patients.
- Surveys are NOT conducted by the practice unit but by a contracted CAHPS Survey Vendor procured by the inquiring entity (i.e., ACO REACH, BCBSM/BCN).
- Surveys are conducted by mail with telephone non-response follow-up; eligible participants are randomly selected.
- Surveys will be administered September - December of the measurement year (i.e., 09/01/2025 - 12/31/2025).

Exclusion(s)

Exclude the following **patients**:

- Those that received care in recent visits but are now deceased
- Those who are less than 18 years of age
- Those who are institutionalized
- Those in hospice or using hospice services
- Those sampled for some other concurrent CAHPS survey
- Those residing outside of the United States, Puerto Rico or the Virgin Islands

- Those that have received less than two primary care visits with an ACO REACH provider during the lookup period
- Those who have a language or disability barrier that prevents them from completing the survey (and nobody to assist or proxy for them)

Denominator

Medicare patients (ACO REACH-aligned, BCBSM Medicare Plus Blue) who have had at least two primary care visits within the past 12 months and answered survey questions, not otherwise excluded

Numerator

Survey respondents answering in the most positive way

- The percentage of most positive responses to all component questions in each survey domain is calculated.
- Patients who elect to not answer a question are excluded from the score calculation for that survey domain.
- Patients who screen out of a question (i.e., the question does not apply) are excluded from the score calculation for that survey domain.

Method(s) of Measurement

- Medicare FFS (ACO REACH: Survey responses
- BCBSM Medicare Plus Blue: Survey responses

Tip(s)

To create a more positive health care experience for patients:

- Acknowledge, and update patients about, appointment delays.
- Consider leaving a few appointment slots open each day to accommodate urgent visits.
- Help the patient understand why you are recommending certain types of care, tests, or treatments.
- Set realistic expectations around how long it may take to schedule an appointment with a specialist.

Concurrent Use of Opioids and Benzodiazepines

The following is a high-level summary of the measure. The referenced measure source should be consulted for specific questions/details.

Return to Summary Page

Summary of Change(s)

- BCBSM/BCN: This is a new Pharmacy measure.
    - This measure is "DISPLAY ONLY" for 2025.

Measure Source(s)

- Pharmacy Quality Alliance (PQA): PQA Quality Measures (2024)
- BCBSM/BCN: 2025 BCBSM Star Tip Sheet "Concurrent Use of Opioids and Benzodiazepines (COB)"

Description

The percentage of patients, 18 years of age and older, with concurrent use of prescription opioids and benzodiazepines during the measurement year (i.e., 2025)

- Athis is an inverse measure; a lower rate indicates better performance.
- The measurement period begins with the first opioid prescription claim.

Exclusion(s)

Exclude the following patients:

- Those with a diagnosis of cancer or sickle cell disease
- Those in hospice or using hospice services during the measurement year (i.e., 01/01/2025-12/31/2025)

Denominator

Patients, 18 years of age and older, who meet BOTH of the following conditions during the measurement year (i.e., 2025):

- **≥ 2 opioid prescriptions filled on different dates of service AND**
- **Received a cumulative supply of opioids for ≥ 15 days**

Numerator

Patients, from the denominator, that meet BOTH of the following criteria during the measurement year (i.e., 2025):

- **≥ 2 benzodiazepine prescriptions filled on different dates of service AND**
- **Concurrent use of both benzodiazepines and opioids for ≥30 days (cumulative)**
    - As written, this is an inverse measure; a lower rate indicates better performance
    - Compliance is determined by avoiding 30 or more days of overlapping prescription fills

Method(s) of Measurement

- BCBSM/BCN: Pharmacy claims processed

Tip(s)

- Patients concurrently taking opioids and benzodiazepines have increased risk of respiratory depression and fatal overdose.
  - Provide rescue medication (naloxone) to high-risk patients.
  - Monitor patients closely for use and abuse.
- Review the necessity and appropriateness of opioid and benzodiazepine use at every encounter with patients using these medications.
  - Discuss the risks and benefits of using these medications, both alone and in combination.
  - Consider other options (i.e., first-line or non-pharmacologic agents) for pain management before prescribing an opioid medication.
    - ✓ Refer patients to pain management specialists when indicated.
  - Use the lowest effective opioid dose for the shortest period possible.
  - Use the Michigan Automated Prescription System (MAPS) to ensure patients are not receiving opioid prescriptions from multiple providers.
- Report exclusion diagnosis codes via claim annually.
- Refer to the "CDC Guideline for Prescribing Opioids" (cdc.gov) for the latest opioid research and guidelines.

Controlling High Blood Pressure

The following is a high-level summary of the measure. The referenced measure source should be consulted for specific questions/details.

Return to Summary Page

Summary of Changes

- Priority Health: Performance will be measured at the practice level for MY 2025.

Measure Source(s)

- HEDIS: "Controlling High Blood Pressure (CBP)"

Description

Patients, 18 - 85 years of age and with a diagnosis of Hypertension (HTN), whose blood pressure (BP) was adequately controlled (<140/90 mmHg) as of December 31st of the measurement year (i.e., as of 12/31/2025)

- Only the most recent (i.e., last) blood pressure reading of the measurement year (i.e., 2025) is considered.

Exclusion(s)

Exclude the following patients:*(Codes reported on laboratory claims are excluded from consideration)*:

- Those with evidence of End-Stage Renal Disease (ESRD), dialysis, nephrectomy, or kidney transplant as of December 31st of the measurement year (i.e., on or prior to 12/31/2025)
  - ICD-10 code **Z94.0** can be used to report the history of kidney transplant
- Those with a diagnosis of pregnancy any time during the measurement year (i.e., 01/01/2025 - 12/31/2025)
- Those with a non-acute inpatient admission during the measurement year (i.e., 01/01/2025-12/31/2025)
- Those, 66 years of age or older, as of December 31st of the measurement year (i.e., as of 12/31/2025), who:
  - Were Medicare members enrolled in an Institutional Special Needs Plan (I-SNP) any time during the measurement year (i.e., 01/01/2025- 12/31/2025)
  - Were Medicare members residing in Long-Term Care any time during the measurement year (i.e., 01/01/2025 - 12/31/2025)
- Those 66-80 years of age, as of December 31st of the measurement year (i.e., as of 12/31/2025), with both Frailty and Advanced Illness (Criteria for both conditions must be met)
  - **Frailty**: At least two indications of Frailty, on different dates of service, during the measurement year (i.e., 2025)
    - ✓ Refer to the "Frailty and Advanced Illness Criteria and Codes" section of this guide.
  - **Advanced Illness**: Either of the following during the measurement year (i.e., 2025) or the year prior (i.e., 2024)

            - ✓ Advanced Illness on at least two different dates of service
            - ✓ OR dispensed Dementia medication
            - ✓ Refer to the "Frailty and Advanced Illness Criteria and Codes" section of this guide
- Those 81 years of age or older, as of December 31st of the measurement year (i.e., as of 12/31/2025), who had Frailty during the measurement year (i.e., 01/01/2025 - 12/31/2025)
- Those who died or were in hospice, or using hospice or palliative care services, any time during the measurement year (i.e., 01/01/2025- 12/31/2025)
    - ICD-10 code **Z51.5** can be used to identify a palliative care encounter.

Denominator

Patients, 18-85 years old as of December 31st of the measurement year (i.e., as of 12/31/2025) who had at least two visits with a diagnosis of Hypertension, on different dates of service, on or between January 1st of the year prior to the measurement year and June 30th of the measurement year (i.e., 01/01/2024 - 06/30/2025), not otherwise excluded.

- Count services that occur over both years.
- Combinations of any of the following, with any diagnosis of Hypertension, meet criteria:
    - Outpatient visits (with or without telehealth modifier)
    - Telephone visits, e-visits, or online assessments (e.g., virtual check-ins)
- Visit type need not be the same for the two visits.

Numerator

Patients, from the Denominator, whose most recent (last) BP reading during the measurement year (01/01/2025 - 12/31/2025) is adequately controlled (systolic BP <140 mm Hg AND diastolic BP < 90 mm Hg)

- The blood pressure reading must occur on or after the date of the second diagnosis of Hypertension.
- Blood pressure readings do not need to be associated with a billable visit.
- The following blood pressure readings qualify:
    - Those taken by a PCP or specialist provider during an in-person, telehealth, or urgent care visit
    - Those taken by clinical staff (e.g., RN, MA etc.) during a non-provider visit (e.g., Blood Pressure check)
    - Those taken and reported by the patient using a digital device
    - Those taken during remote monitoring
- The BP reading must be documented in the patient's medical record to be eligible for this measure.
    - The systolic and diastolic results don't need to be from the same reading.
    - If multiple BP measurements occur on the same date or are noted in the chart on the same date, report the lowest systolic and the lowest diastolic result.
- The patient is non-compliant for the measure if:
    - No BP is recorded during the measurement year
    - The reading is incomplete (e.g., the systolic or diastolic result is missing
    - The systolic value is ≥140

    - And/or the diastolic value is ≥ 90
- Do NOT include blood pressure readings that meet the following criteria:
    - Taken during an acute inpatient stay or an ED visit
    - Taken on the same day as a diagnostic test or procedure that requires a change in diet or medication on, or one day before, the day of the test or procedure, with the exception of fasting blood tests
        - ✓ E.g., colonoscopy, dialysis, infusions, chemotherapy, or nebulizer treatments with albuterol
    - Taken by the member using a non-digital device, such as a manual blood pressure cuff and stethoscope
- The following CPT II codes can be submitted on claims to report Blood Pressure values:
    - **3074F** (systolic < 130 mm Hg)
    - **3075F** (systolic 130-139 mm Hg)
    - **3077F** (systolic > 140 mm Hg)
    - **3078F** (diastolic < 80 mm Hg)
    - **3079F** (diastolic 80-89 mm Hg)
    - **3080F** (diastolic > 90 mm Hg)

Method(s) of Measurement

- BCBSM/BCN: Claims processed, electronic supplemental data feeds (e.g., Health Focus, MiHIN, MCIR) and Health-e Blue data entry
- Priority Health: Claims processed and electronic supplemental data feeds
    - Note: Priority Health will calculate 2025 performance rates for this measure at the practice level.

Tip(s)

- If an initial BP reading is ≥ 140/90, repeat the BP measurement later in the visit, as the subsequent reading will often be lower than the initial.
- For patients with continued abnormal BP readings, schedule follow-up appointments for blood pressure readings until their blood pressure is controlled.
- Document ALL BP readings taken during a visit, including retakes.
    - Record the lowest systolic and lowest diastolic values in the structured “Vitals” field in your EMR.
    - Do NOT document the systolic and diastolic BP values as ranges in patient’s chart in the EMR.
- BP readings taken with a digital device can be patient-reported during a telehealth, telephone or e-visit or an online assessment (e.g., virtual check-in); the measurement(s) must be documented in the patient's medical record along with the date the BP was taken.
- Encourage blood pressure monitoring at home and ask patients to bring a log of their readings to all visits.
- Provide cardiac diet education and encourage lifestyle changes, such as exercise, smoking cessation, and stress reduction.

- Discuss the importance of medication adherence and advise patients not to discontinue blood pressure medication before contacting your office.
    - If they experience side effects, another medication can be prescribed.
- Include CPT II codes on claims to report BP results to insurers.

Eye Exam for Patients with Diabetes

The following is a high-level summary of the measure. The referenced measure source should be consulted for specific questions/details.

Return to Summary Page

Summary of Changes

- Priority Health: Performance will be measured at the practice level for MY 2025.
- HEDIS:
  - Bilateral eye enucleation has been moved from the Numerator and to (required) Exclusions
  - This is an ECDS (Electronic Clinical Data Set) measure as 0f 01/01/2025.

Measure Source(s):

- HEDIS: "Eye Exam for Patients with Diabetes (EED)"

Description

The percentage of patients, 18-75 years of age and with a diagnosis of Diabetes (Type I or Type II), who had a retinal or dilated eye exam in the measurement year (i.e., 01/01/2025 - 12/31/2025) or a negative retinal eye exam (no evidence of retinopathy) in the year prior to the measurement year (i.e., 01/01/2024 - 12/31/2024)

Definition(s)

Patients are identified as having Diabetes by claim/encounter and/or pharmacy data

- A patient only needs to be identified as having Diabetes by one of the two methods to be included in the measure
- A patient may be identified as diabetic based on data from the current measurement year (i.e., 2025) and/or the year prior (i.e., 2024)
  - **Claim/Encounter Data**
    - ✓ At least two diagnoses of Diabetes, on different of service, during the measurement year (i.e., 2025) or the year prior (i.e., 2024)
    - ✓ Do not include diagnoses reported on laboratory claims
  - **Pharmacy Data**
    - ✓ Patients who were dispensed insulin or hypoglycemics/antihyperglycemics during the measurement year (i.e., 2025) or the year prior (i.e., 2024)
    - ✓ AND have at least one diagnosis of Diabetes during the measurement year (I.e., 2025) or the year prior (i.e., 2024)
    - ✓ Do not include diagnoses reported on laboratory claims

Exclusion(s)

Exclude the following patients:

- Those with bilateral eye enucleation any time on or before December 31st of the measurement year (i.e., as of 12/31/2025)
    - o Includes two unilateral eye enucleations (performed at least 14 days apart)
    - o Includes acquired absence of both eyes.
    - o Blindness is not an exclusion for this measure due to the difficulty in distinguishing legally blind patients (who still require retinal eye exams) from completely blind patients (who do not require retinal eye exams).
- Those who died or were in hospice, or using hospice or palliative care services, any time during the measurement year (i.e., 01/01/2025 - 12/31/2025)
    - o ICD-10 code **Z51.5** can be used to identify a palliative care encounter
    - o Do not include laboratory claims
- o Those, 66 years of age or older as of December 31st of the measurement year (i.e., as of 12/31/2025), who:
    - o Were Medicare members enrolled in an Institutional Special Needs Plan (I-SNP) any time during the measurement year (i.e., 01/01/2025 - 12/31/2025)
    - o Were Medicare members residing in Long-Term Care any time during the measurement year (i.e., 01/01/2024 - 12/31/2024)
    - o Had BOTH Frailty AND Advanced Illness
        - ✓ Criteria for both conditions must be met
        - ✓ Do not include laboratory claims

    Frailty: At least two indications of Frailty, on different dates of service, during the measurement year (i.e., 2025)

    - o Refer to the "Frailty and Advanced Illness Criteria and Codes" section of this guide.

    Advanced Illness: Either of the following during the measurement year (i.e., 2025) or the year prior. (i.e., 2024)

    - o Advanced Illness on at least two different dates of service.
    - o OR dispensed Dementia medication
    - o Refer to the "Frailty and Advanced Illness Criteria and Codes" section of this guide

Denominator

Patients, 18-75 years of age with a diagnosis of Diabetes, as defined above, not otherwise excluded

Numerator

Patients, from the Denominator, who had any one of the following:

- **A retinal or dilated eye exam performed by an eye care professional (Optometrist or Ophthalmologist) during the measurement year** (i.e., 01/01/2025 - 12/31/2025**)**
    - o The following CPTII codes can be submitted on a claim to report that a dilated eye exam was performed in the current measurement year and resulted by an optometrist or ophthalmologist:
        - ✓ With evidence of retinopathy: **2022F, 2024F, 2026F**

    - ✓ <u>Without evidence of retinopathy</u>: **2023F, 2025F, 2033F**
- **<u>OR</u> a negative retinal or dilated eye exam (no evidence of retinopathy) by an eye care professional (Optometrist or Ophthalmologist) during the year prior to the measurement year** (i.e., 01/01/2024 - 12/31/2024)
  - Submit CPTII code **3072F** on a claim to report a negative diabetic eye exam performed in the prior year (i.e., 2024)
- Retinal imaging, with interpretation and reporting by a qualified reading center, during the measurement year (01/01/2025 – 12/31/2025)
  - The fundus/retinal photography must have the date, result, and signature of the reviewing eye care professional for compliance
- Automated eye exam during the measurement year (01/01/2025 – 12/31/2025)
- Documentation must include all of the following (includes patient-reported exams):
  - Date of retinal exam
  - Type of exam (dilated, retinal; exam must be performed bilaterally)
  - Name of eye care professional performing and reading exam (optometrist ophthalmologist)
  - Result of exam (negative or positive for retinopathy)
    - ✓ Documentation of an eye exam with an "unknown" result does not meet the criteria for compliance.
    - ✓ An indeterminate result, because one eye is inaccessible, also does not meet the criteria for compliance
    - ✓ Documentation does not need to explicitly state "no diabetic retinopathy" to be considered a negative exam, but it must be clear that the patient had a retinal or dilated exam by an eye care professional AND that retinopathy was not present
    - ✓ Documentation of "Diabetes without Complications", on its own, does not meet the criteria for compliance
    - ✓ Hypertensive retinopathy results are equivalent to diabetic retinopathy results when reporting this measure.
      - An eye exam positive for hypertensive retinopathy is considered positive for diabetic retinopathy
      - An eye exam negative for hypertensive retinopathy is counted as negative for diabetic retinopathy
    - ✓ A dilated or retinal exam that shows normal fundus or posterior exam, where the components that make up the back of the eye (vitreous, macula, retina, vessels and periphery) are within normal limits (WNL) or normal or clear, is considered negative for retinopathy
- Documentation can include any of the following:
  - A copy of the exam or a letter from a credentialed eye care professional
  - A bilateral retinal photograph with evidence that the fundus photography was read by a credentialed eye care professional, along with date and results
  - Evidence that exam results were read by a qualified reading center that operates under the direction of a retinal specialist, or by a system that provides Artificial intelligence (AI) interpretation.

  - A progress note in the medical record that includes all of the essential documentation listed above (date, type of exam, result and eye care professional who performed and/or interpreted the exam.)

Method(s) of Measurement

Note: This measure is now an ECDS (Electronic Clinical Data System) measure.

  - Data for ECDS measures is supposed to be reported by electronic means only.
  - ECDS measures do not allow for unstructured data; data must be recorded in a structured data field for accurate reporting.

- BCBSM/BCN: Claims processed, electronic supplemental data feeds (e.g., Health Focus, MiHIN, MCIR) and Health-e Blue data entry
  - Note: Despite the ECDS requirement, BCBSM/BCN is allowing manual data entry into Health-e Blue for the 2025 performance year.
- Priority Health: Claims processed and electronic supplemental data feeds.
  - Note: Priority Health will calculate 2025 performance rates for this measure at the practice level.

Tip(s)

- Submit CPT II codes on claims to report diabetic retinal eye screenings with eye care professionals.
- Always document the date of service, type of test, result, and eye care professional's name and credentials in the patient's chart.
  - Document data manually entered into the EMR (e.g., patient-reported information, outside test dates and results, etc.) in structured data fields to facilitate accurate reporting from electronic supplemental data feeds (e.g., by Health Focus).
- Review diabetic services needed at each office visit.
- Refer patients annually to an optometrist or ophthalmologist for a dilated retinal eye exam and explain the difference between this exam and a regular screening for glasses or contacts.
- Most common reason for audit mismatch: absence of documentation, showing that the patient received a dilated or retinal exam by an eye care professional during calendar year 2025 or, if not since 2024, if that retinal exam was negative for retinopathy.

Follow-Up After Emergency Department Visit for Mental Illness - 7 Days

The following is a high-level summary of the measure. The referenced measure source should be consulted for specific questions/details.

Return to Summary Page

Summary of Changes

- HEDIS: The **Denominator** criteria has been modified, as follows:
  - Intentional Self Harm diagnoses no longer need to be principal diagnoses for Denominator events
  - Phobia, Anxiety, and additional Intentional Self-Harm diagnoses have been added as identifiers for Denominator events

- HEDIS: The **Numerator** criteria has been modified, as follows:
  - A mental health diagnosis no longer needs to be the principal diagnosis for a follow-up visit
  - Follow-up visits with an Intentional Self-Harm diagnosis no longer require an associated mental health diagnosis
  - A mental health diagnosis is no longer required for partial hospitalization/intensive outpatient, community health center, and electroconvulsive therapy Numerator encounters.
  - Peer support, residential treatment, and psychiatric collaborative care management services have been added as Numerator-compliant encounters.
  - Visits in a behavioral healthcare setting have been added as Numerator-compliant encounters.

Measure Source(s):

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

Description

Only the following rate is reported: The percentage of Emergency Department (ED) visits for patients 6-17 years of age, with a principal diagnosis of mental illness or any diagnosis of intentional self-harm, for which the patient received a follow-up visit for mental illness within 7 days of the ED encounter (8 total days.)

- This is an episode-based measure; patients may be counted in the Denominator more than once.

Exclusion(s)

- **Exclude patients** who died or were in hospice, or utilizing hospice services, any time during the measurement year (i.e., 01/01/2025 - 12/31/2025)

- **Exclude ED visits**:
  - That resulted in an acute or nonacute inpatient admission, on the date of the ED visit or within 30 days after the ED visit (31 total days), regardless of the principal diagnosis for the admission
  - These events are excluded because admission to an inpatient setting may prevent an outpatient follow-up visit from taking place.

Denominator

Patients with an ED visit, with a principal diagnosis of mental illness or any diagnosis of intentional self-harm occurring on or between 01/01/2025 and 12/01/2025, for patients 6 - 17 years of age on the date of the visit, not otherwise excluded

- The Denominator is based on ED visits (not patients).
- If a patient has more than one ED visit in a 31-day period, include only the first eligible visit.
  - Identify ED visits chronologically, including only 1 per 31-day period.

Numerator

ED visits, from the Denominator with a follow-up service for mental health within 7 days after the ED visit (8 total days)

- Includes follow-up visits occurring on the date of the ED visit
- Any of the following visit types, with any diagnosis of a mental health disorder, meet the criteria for a follow-up visit:
  - An outpatient visit in any setting (including, but not limited to, school, home, office, worksite, or urgent care facility)
  - A behavioral health outpatient visit including, but not limited to:
    - ✓ Social work
    - ✓ Psychological services
    - ✓ Behavioral health screening, counseling, and therapy
    - ✓ Hospital outpatient clinic visit for assessment and management
    - ✓ Crisis intervention service
    - ✓ Psychiatric health facility service
    - ✓ Mental health support groups
  - An intensive outpatient or partial hospitalization encounter
  - A community mental health center visit
  - Electroconvulsive therapy
  - A telehealth or telephone visit, e-visit, or virtual check-in
  - Psychiatric collaborative care management or residential treatment
  - Peer support services

Method(s) of Measurement

- BCBSM: Claims processed

- This is a "No-Entry" measure in Health-e Blue.

Tip(s)

- Begin discharge planning upon admission to ensure that follow-up appointments occur within 7 days of discharge. (Monitor ADT notifications).
- Have the hospital send the discharge plan so it can be reviewed during the follow-up appointment.
- Keep open appointments so patients with ED encounters can be scheduled for follow-up visits within 7 days of discharge.
- Utilize telehealth and telehealth/virtual visits to follow-up with patients who have difficulty coming into the office.
- Provide Care Management outreach to patients to assess barriers to a follow-up appointment and assistance, if needed.
- Coordinate care with specialist providers and other members of the patient's care team.
- Place reminder calls to patients before visits.
- Inform patients that 24/7 access for calls, texts and chats with trained crisis counselors is available through the following services:
  - National Suicide Prevention Lifeline (1-800-273-TALK)
  - 988 Suicide Crisis Lifeline

Additional Note(s)

- This measure is part of the pediatric composite for the BCBSM PDCM Outcomes incentive.

Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions

The following is a high-level summary of the measure. The referenced measure source should be consulted for specific questions/details.

Return to Summary Page

Summary of Changes

- HEDIS: Lab claims have been excluded from the "Substance Use Disorder Counselling and Surveillance" value set

Measure Source(s)

- HEDIS: "Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions (FMC)"

Description

The percentage of Emergency Department (ED) visits, for patients 18 years of age and older with multiple high-risk conditions, where the patient was seen for a follow-up visit within 7 days of the ED encounter

- This is an episode-based measure; patients may be counted in the Denominator more than once.

Exclusion(s)

- **Exclude ED visits** that resulted in an acute or nonacute inpatient admission, or within 7 days after, the date of the ED visit, regardless of the principal diagnosis for the admission.
  - These events are excluded because admission to an inpatient setting may prevent an outpatient follow-up visit from taking place.
- **Exclude patients** that have died or were in hospice, or using hospice services, any time during the measurement year (i.e., 01/01/2025 - 12/31/2025).

Denominator

Eligible ED visits, for patients 18 years of age and older on the date of the visit and with multiple high-risk chronic conditions, as defined below and not otherwise excluded

Eligible ED visits are determined as follows:

- The ED visit occurred on or between January 1st and December 24th of the measurement year (i.e., 01/01/2025-12/24/2025)
- The patient was at least 18 years old on the date of the ED visit.
- The patient had at least 2 or more different chronic disease diagnoses from the following list of eligible conditions:

    - COPD, Asthma, or Unspecified Bronchitis
    - Alzheimer's Disease, Dementia, and related disorders
    - Chronic Kidney Disease
    - Depression or Dysthymia
    - Heart Failure
    - Acute Myocardial Infarction
    - Atrial Fibrillation
    - Stroke and Transient Ischemic Attack
        - ✓ Not including concussion with loss of consciousness or skull fracture
        - ✓ Not including visits with a principal diagnosis of "Other Specified Aftercare"
- The patient's chronic disease conditions were diagnosed PRIOR to the ED visit, as defined by occurrence of any of following during measurement year (i.e., 2025) or the year prior (i.e., 2024)
    - At least two outpatient, ED, telephone, or e-visits, virtual check-ins, or nonacute inpatient encounters or discharges (with the diagnosis on the discharge claim) on different dates service for the same eligible chronic condition.
        - ✓ Visit types may differ
        - ✓ Count services that occur over both years
    - At least one acute inpatient encounter with an eligible condition
    - At least one acute inpatient discharge with the eligible condition diagnosis code on the discharge claim
- If multiple ED visits occur within an 8-day period, only the first eligible visit within that time period is included.

Numerator

ED visits, from the Denominator, with a subsequent follow-up visit on, or within 7 days after, the date of the ED visit

- The following visit types meet the criteria for a follow-up visit:
    - Outpatient visit
    - Telephone visit
    - Transitional Care Management (TCM) services
    - Case Management visits
    - Complex Care Management services
    - Behavioral Health visit (outpatient or telehealth)
    - Intensive outpatient encounter or partial hospitalization
    - Community Mental Health Center visit
    - Electroconvulsive therapy
    - Telehealth visit
    - Observation visit
    - Substance Use Disorder service or Substance Abuse Counselling and Surveillance
        - ✓ Exclude laboratory claims
    - e-visit or virtual check-in

Method(s) of Measurement

- BCBSM/BCN: Claims processed
    - This is a "No-Entry" measure in Health-e Blue.

Tip(s)

- Begin discharge planning upon admission to ensure that follow-up appointments occur within 7 days of discharge (Monitor ADT notifications).
- Have the hospital send the discharge plan so it can be reviewed during the follow-up appointment.
- Keep open appointments so patients with ED encounters can be scheduled for follow-up visits within 7 days of discharge.
- Utilize telephone and telehealth/virtual visits to follow-up with patients who have difficulty coming into the office.
- Provide Care Management outreach to patients to assess barriers to a follow-up appointment and assistance, if needed.
- Coordinate care with specialist providers and other members of the patient's care team.
- Place reminder calls to patients before visits.

Follow-Up Care for Children Prescribed ADHD Medication

The following is a high-level summary of the measure. The referenced measure source should be consulted for specific questions/details.

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Summary of Changes

- HEDIS: The following ADHD medications have been added:
  - Dexmethylphenidate-Serdexmethylphenidate
  - Viloxazine

Measure Source(s)

- HEDIS: "Follow-Up Care for Children Prescribed ADHD Medication (ADD-E)"

Description

The percentage of children, 6-12 years of age, who were newly prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) medication and had at least three follow-up care visits within a 300-day (10-month) period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported:

- **Initiation Phase Rate**: The percentage of children, 6–12 years of age with a new prescription for ADHD medication, who had one follow-up visit with a practitioner with prescribing authority during the first 30 days after prescription dispensation
- **Continuation & Maintenance (C&M) Phase Rate**: The percentage of children, 6–12 years of age with a new prescription for ADHD medication, who remained on the medication for at least 210 days and who had at least two additional follow-up visits with a practitioner within 270 days (9 months) after the end of the Initiation Phase

Definition(s)

- **Intake Period**: The 12-month window starting on March 1st of the year prior to the measurement year (i.e., 03/01/2024) and ending the last calendar day of February of the measurement year (i.e., 02/28/2025)
- **IPSD (Index Prescription Start Date**: The earliest prescription dispensing date for an ADHD medication where the date is in the Intake Period (defined above) and there is a Negative Medication History (defined below)
- **Negative Medication History**: A period of 120 days (4 months) prior to the IPSD, when the patient had no ADHD medications dispensed for either new or refill prescriptions
- **Initiation Phase**: The 30 days following the IPSD
- **C&M Phase**: The 300 days (10 months) following the IPSD
- **Continuous Medication Treatment**: The number of medication treatment days during the 10-month follow-up period must be ≥ 210 days (i.e., 301 treatment days – 91 gap days)

- **Treatment Days**: The number of calendar days covered with prescriptions within the specified 301-day period
  - To determine the number of Treatment Days:
    - ✓ Identify each dispensing event for ADHD medication.
      - If multiple prescriptions for the same ADHD medication are dispensed with overlapping days' supply, assume the patient will take one prescription at a time and sum the total days' supply
      - For all others, assume the patient will take different medications concurrently
    - ✓ Identify the start and end dates.
      - Start Date: The date of the earliest medication dispensing event
      - End Date: Start Date + total days' supply -1
    - ✓ Count the covered calendar days (Start Date through end Date).
    - ✓ Consider each calendar day covered by one or more ADHD medication to be 1 covered day.
  - The following ADHD medication classes are included in this measure:
    - ✓ Dexmethylphenidate medications
    - ✓ Dextroamphetamine medications
    - ✓ Lisdexamfetamine medications
    - ✓ Methylphenidate medications
    - ✓ Methamphetamine medications
    - ✓ Clonidine medications
    - ✓ Guanfacine medications
    - ✓ Atomoxetine medications
    - ✓ Dexmethylphenidate Serdexmethylphenidate medications
    - ✓ Viloxazine medications

Exclusion(s)

Exclude the following patients:

- Those who had an acute inpatient encounter for a mental, behavioral, or neurodevelopmental disorder (includes chemical dependency) during the 30 days (Initiation Phase) or 300 days (Continuation and Maintenance phase) after the IPSD
  - Either of the following meet criteria:
    - ✓ An acute patient encounter with a principal diagnosis of mental, behavioral, or neurodevelopmental disorder
    - ✓ An acute inpatient admission with a principal diagnosis mental, behavioral, or neurodevelopmental disorder on the discharge claim
- Those with a diagnosis of Narcolepsy any time during their history through December 31 of the measurement year (i.e., as of 12/31/2025)
  - Do not include laboratory claims.
  - The following ICD-10 codes identify Narcolepsy: **G47.411, G47.419, G47.421, G47.429**
- Those who died or were in hospice, or using hospice services, any time during the measurement year (i.e., 01/01/2025 - 12/31/2025)

Denominator

Children, 6 to12 years of age and with a Negative Medication History, who were dispensed ADHD medication during the 12-month Intake Period, not otherwise excluded.

Numerator

- ***Initiation Phase*: Patients, from the Denominator, with documentation in the medical record of at least one follow-up visit with a practitioner with prescribing authority within 30 days after the IPSD**
  - Documentation in the medical record must include the date of the follow-up visit.
  - Do not count a visit on the IPSD as the Initiation Phase visit.
  - Eligible follow-up visits include:
    - ✓ Outpatient Visits
    - ✓ Health and Behavior Assessments or Interventions
    - ✓ Intensive Outpatient Encounters or Partial Hospitalizations
    - ✓ Community Mental Health Center Visits
    - ✓ Telehealth or Telephone visits
- ***C&M Phase***: Patients who meet **ALL** of the following criteria:
  - **Had an Initiation Phase Visit in the first 30 days**
  - **Remained on the ADHD medication for at least 210 days**
  - **Had at least two follow-up visits from 31–300 days after the Index Prescription Start Date**
    - ✓ C&M visits must be on different dates of service but can be with any practitioner.
    - ✓ Eligible follow-up visits include e-visits or virtual check-ins in addition to the visit types listed for the Initiation Phase, above.
    - ✓ Only one of the two visits during days 31–300 may be an e-visit or virtual check-in (Online Assessment);
      - The following billing codes identify Online Assessments:
CPT: **98970, 98971, 98972, 98980, 9898199421, 99422, 99423, 99457, 99458**
HCPCS: **G0071, G2010, G2012, G2250, G2251, G2252**

Method(s) of Measurement

- BCBSM: Claims processed
  - This is a "No-Entry" measure in Health-e Blue.

Tip(s)

- The 30-day follow-up visit must be scheduled with a provider with prescribing authority.
  - When prescribing a new ADHD medication, schedule the 30-day follow-up before the patient leaves the office.

- Use this visit to assess how the medication is working and address side effects.
- The two additional C&M visits may be scheduled with any provider.
    - Use these visits to monitor the patient's progress on the medication.
- If you prescribe a medication for ADHD, consider limiting the first prescription to 30 days.
    - Allow no refills until the initial follow-up visit is complete.
    - Plan to see the child for face-to-face visits for medication refills.
- Consider a telephone or telehealth visit if the patient is unable to come to the office;
    - The following billing codes identify Telephone Visits:
      CPT: **98966,98967,98968,99441,99442, 99443**
- Use EMR alerts for patients due for follow-up appointments.

Additional Note(s)

- This measure is part of the pediatric composite for the BCBSM PDCM Outcomes incentive.

Frailty and Advanced Illness Exclusion Criteria and Codes

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Frailty and Advanced Illness Exclusion Criteria:
Patients, 66 years of age and older, as of December 31st of the measurement year (i.e., as of 12/31/2025), who:

- Had at least TWO indications of Frailty, on different dates of service, during the measurement year (i.e., 2025)
- AND any of the following during the measurement year (i.e., 2025) or the year prior (i.e., 2024):
  - Advanced Illness on at least TWO different dates of service
  - Dispensed a Dementia medication

Frailty Only Exclusion Criteria
Patients 81 years of age or older, as of December 31st of the measurement year (i.e., as of 12/31/2025) who had at least TWO indications of Frailty, on different dates of service, during the measurement year (i.e., 2025)

Frailty and Advanced Illness Diagnosis and Billing Codes*
** from HEDIS MY 2025 Volume 2 Value Set Directory*

Measure Set	Code	Code Type	Description
Advanced Illness	A81.00	ICD10CM	[A81.00] Creutzfeldt-Jakob disease, unspecified
Advanced Illness	A81.01	ICD10CM	[A81.01] Variant Creutzfeldt-Jakob disease
Advanced Illness	A81.09	ICD10CM	[A81.09] Other Creutzfeldt-Jakob disease
Advanced Illness	C25.0	ICD10CM	[C25.0] Malignant neoplasm of head of pancreas
Advanced Illness	C25.1	ICD10CM	[C25.1] Malignant neoplasm of body of pancreas
Advanced Illness	C25.2	ICD10CM	[C25.2] Malignant neoplasm of tail of pancreas
Advanced Illness	C25.3	ICD10CM	[C25.3] Malignant neoplasm of pancreatic duct
Advanced Illness	C25.4	ICD10CM	[C25.4] Malignant neoplasm of endocrine pancreas
Advanced Illness	C25.7	ICD10CM	[C25.7] Malignant neoplasm of other parts of pancreas
Advanced Illness	C25.8	ICD10CM	[C25.8] Malignant neoplasm of overlapping sites of pancreas
Advanced Illness	C25.9	ICD10CM	[C25.9] Malignant neoplasm of pancreas, unspecified
Advanced Illness	C71.0	ICD10CM	[C71.0] Malignant neoplasm of cerebrum, except lobes and ventricles
Advanced Illness	C71.1	ICD10CM	[C71.1] Malignant neoplasm of frontal lobe
Advanced Illness	C71.2	ICD10CM	[C71.2] Malignant neoplasm of temporal lobe
Advanced Illness	C71.3	ICD10CM	[C71.3] Malignant neoplasm of parietal lobe
Advanced Illness	C71.4	ICD10CM	[C71.4] Malignant neoplasm of occipital lobe
Advanced Illness	C71.5	ICD10CM	[C71.5] Malignant neoplasm of cerebral ventricle
Advanced Illness	C71.6	ICD10CM	[C71.6] Malignant neoplasm of cerebellum
Advanced Illness	C71.7	ICD10CM	[C71.7] Malignant neoplasm of brain stem
Advanced Illness	C71.8	ICD10CM	[C71.8] Malignant neoplasm of overlapping sites of brain

Measure Set	Code	Code Type	Description
Advanced Illness	C71.9	ICD10CM	[C71.9] Malignant neoplasm of brain, unspecified
Advanced Illness	C77.0	ICD10CM	[C77.0] Secondary and unspecified malignant neoplasm of lymph nodes of head, face and neck
Advanced Illness	C77.1	ICD10CM	[C77.1] Secondary and unspecified malignant neoplasm of intrathoracic lymph nodes
Advanced Illness	C77.2	ICD10CM	[C77.2] Secondary and unspecified malignant neoplasm of intra-abdominal lymph nodes
Advanced Illness	C77.3	ICD10CM	[C77.3] Secondary and unspecified malignant neoplasm of axilla and upper limb lymph nodes
Advanced Illness	C77.4	ICD10CM	[C77.4] Secondary and unspecified malignant neoplasm of inguinal and lower limb lymph nodes
Advanced Illness	C77.5	ICD10CM	[C77.5] Secondary and unspecified malignant neoplasm of intrapelvic lymph nodes
Advanced Illness	C77.8	ICD10CM	[C77.8] Secondary and unspecified malignant neoplasm of lymph nodes of multiple regions
Advanced Illness	C77.9	ICD10CM	[C77.9] Secondary and unspecified malignant neoplasm of lymph node, unspecified
Advanced Illness	C78.00	ICD10CM	[C78.00] Secondary malignant neoplasm of unspecified lung
Advanced Illness	C78.01	ICD10CM	[C78.01] Secondary malignant neoplasm of right lung
Advanced Illness	C78.02	ICD10CM	[C78.02] Secondary malignant neoplasm of left lung
Advanced Illness	C78.1	ICD10CM	[C78.1] Secondary malignant neoplasm of mediastinum
Advanced Illness	C78.2	ICD10CM	[C78.2] Secondary malignant neoplasm of pleura
Advanced Illness	C78.30	ICD10CM	[C78.30] Secondary malignant neoplasm of unspecified respiratory organ
Advanced Illness	C78.39	ICD10CM	[C78.39] Secondary malignant neoplasm of other respiratory organs
Advanced Illness	C78.4	ICD10CM	[C78.4] Secondary malignant neoplasm of small intestine
Advanced Illness	C78.5	ICD10CM	[C78.5] Secondary malignant neoplasm of large intestine and rectum
Advanced Illness	C78.6	ICD10CM	[C78.6] Secondary malignant neoplasm of retroperitoneum and peritoneum
Advanced Illness	C78.7	ICD10CM	[C78.7] Secondary malignant neoplasm of liver and intrahepatic bile duct
Advanced Illness	C78.80	ICD10CM	[C78.80] Secondary malignant neoplasm of unspecified digestive organ
Advanced Illness	C78.89	ICD10CM	[C78.89] Secondary malignant neoplasm of other digestive organs
Advanced Illness	C79.00	ICD10CM	[C79.00] Secondary malignant neoplasm of unspecified kidney and renal pelvis
Advanced Illness	C79.01	ICD10CM	[C79.01] Secondary malignant neoplasm of right kidney and renal pelvis
Advanced Illness	C79.02	ICD10CM	[C79.02] Secondary malignant neoplasm of left kidney and renal pelvis
Advanced Illness	C79.10	ICD10CM	[C79.10] Secondary malignant neoplasm of unspecified urinary organs

Measure Set	Code	Code Type	Description
Advanced Illness	C79.11	ICD10CM	[C79.11] Secondary malignant neoplasm of bladder
Advanced Illness	C79.19	ICD10CM	[C79.19] Secondary malignant neoplasm of other urinary organs
Advanced Illness	C79.2	ICD10CM	[C79.2] Secondary malignant neoplasm of skin
Advanced Illness	C79.31	ICD10CM	[C79.31] Secondary malignant neoplasm of brain
Advanced Illness	C79.32	ICD10CM	[C79.32] Secondary malignant neoplasm of cerebral meninges
Advanced Illness	C79.40	ICD10CM	[C79.40] Secondary malignant neoplasm of unspecified part of nervous system
Advanced Illness	C79.49	ICD10CM	[C79.49] Secondary malignant neoplasm of other parts of nervous system
Advanced Illness	C79.51	ICD10CM	[C79.51] Secondary malignant neoplasm of bone
Advanced Illness	C79.52	ICD10CM	[C79.52] Secondary malignant neoplasm of bone marrow
Advanced Illness	C79.60	ICD10CM	[C79.60] Secondary malignant neoplasm of unspecified ovary
Advanced Illness	C79.61	ICD10CM	[C79.61] Secondary malignant neoplasm of right ovary
Advanced Illness	C79.62	ICD10CM	[C79.62] Secondary malignant neoplasm of left ovary
Advanced Illness	C79.63	ICD10CM	[C79.63] Secondary malignant neoplasm of bilateral ovaries
Advanced Illness	C79.70	ICD10CM	[C79.70] Secondary malignant neoplasm of unspecified adrenal gland
Advanced Illness	C79.71	ICD10CM	[C79.71] Secondary malignant neoplasm of right adrenal gland
Advanced Illness	C79.72	ICD10CM	[C79.72] Secondary malignant neoplasm of left adrenal gland
Advanced Illness	C79.81	ICD10CM	[C79.81] Secondary malignant neoplasm of breast
Advanced Illness	C79.82	ICD10CM	[C79.82] Secondary malignant neoplasm of genital organs
Advanced Illness	C79.89	ICD10CM	[C79.89] Secondary malignant neoplasm of other specified sites
Advanced Illness	C79.9	ICD10CM	[C79.9] Secondary malignant neoplasm of unspecified site
Advanced Illness	C91.00	ICD10CM	[C91.00] Acute lymphoblastic leukemia not having achieved remission
Advanced Illness	C91.02	ICD10CM	[C91.02] Acute lymphoblastic leukemia, in relapse
Advanced Illness	C92.00	ICD10CM	[C92.00] Acute myeloblastic leukemia, not having achieved remission
Advanced Illness	C92.02	ICD10CM	[C92.02] Acute myeloblastic leukemia, in relapse
Advanced Illness	C93.00	ICD10CM	[C93.00] Acute monoblastic/monocytic leukemia, not having achieved remission
Advanced Illness	C93.02	ICD10CM	[C93.02] Acute monoblastic/monocytic leukemia, in relapse
Advanced Illness	C93.90	ICD10CM	[C93.90] Monocytic leukemia, unspecified, not having achieved remission
Advanced Illness	C93.92	ICD10CM	[C93.92] Monocytic leukemia, unspecified in relapse
Advanced Illness	C93.Z0	ICD10CM	[C93.Z0] Other monocytic leukemia, not having achieved remission
Advanced Illness	C93.Z2	ICD10CM	[C93.Z2] Other monocytic leukemia, in relapse
Advanced Illness	C94.30	ICD10CM	[C94.30] Mast cell leukemia not having achieved remission
Advanced Illness	C94.32	ICD10CM	[C94.32] Mast cell leukemia, in relapse
Advanced Illness	F01.50	ICD10CM	[F01.50] Vascular dementia without behavioral disturbance

Measure Set	Code	Code Type	Description
Advanced Illness	F01.511	ICD10CM	[F01.511] Vascular dementia, unspecified severity, with agitation
Advanced Illness	F01.518	ICD10CM	[F01.518] Vascular dementia, unspecified severity, with other behavioral disturbance
Advanced Illness	F01.52	ICD10CM	[F01.52] Vascular dementia, unspecified severity, with psychotic disturbance
Advanced Illness	F01.53	ICD10CM	[F01.53] Vascular dementia, unspecified severity, with mood disturbance
Advanced Illness	F01.54	ICD10CM	[F01.54] Vascular dementia, unspecified severity, with anxiety
Advanced Illness	F01.A0	ICD10CM	[F01.A0] Vascular dementia, mild, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety
Advanced Illness	F01.A11	ICD10CM	[F01.A11] Vascular dementia, mild, with agitation
Advanced Illness	F01.A18	ICD10CM	[F01.A18] Vascular dementia, mild, with other behavioral disturbance
Advanced Illness	F01.A2	ICD10CM	[F01.A2] Vascular dementia, mild, with psychotic disturbance
Advanced Illness	F01.A3	ICD10CM	[F01.A3] Vascular dementia, mild, with mood disturbance
Advanced Illness	F01.A4	ICD10CM	[F01.A4] Vascular dementia, mild, with anxiety
Advanced Illness	F01.B0	ICD10CM	[F01.B0] Vascular dementia, moderate, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety
Advanced Illness	F01.B11	ICD10CM	[F01.B11] Vascular dementia, moderate, with agitation
Advanced Illness	F01.B18	ICD10CM	[F01.B18] Vascular dementia, moderate, with other behavioral disturbance
Advanced Illness	F01.B2	ICD10CM	[F01.B2] Vascular dementia, moderate, with psychotic disturbance
Advanced Illness	F01.B3	ICD10CM	[F01.B3] Vascular dementia, moderate, with mood disturbance
Advanced Illness	F01.B4	ICD10CM	[F01.B4] Vascular dementia, moderate, with anxiety
Advanced Illness	F01.C0	ICD10CM	[F01.C0] Vascular dementia, severe, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety
Advanced Illness	F01.C11	ICD10CM	[F01.C11] Vascular dementia, severe, with agitation
Advanced Illness	F01.C18	ICD10CM	[F01.C18] Vascular dementia, severe, with other behavioral disturbance
Advanced Illness	F01.C2	ICD10CM	[F01.C2] Vascular dementia, severe, with psychotic disturbance
Advanced Illness	F01.C3	ICD10CM	[F01.C3] Vascular dementia, severe, with mood disturbance
Advanced Illness	F01.C4	ICD10CM	[F01.C4] Vascular dementia, severe, with anxiety
Advanced Illness	F02.80	ICD10CM	[F02.80] Dementia in other diseases classified elsewhere without behavioral disturbance
Advanced Illness	F02.811	ICD10CM	[F02.811] Dementia in other diseases classified elsewhere, unspecified severity, with agitation
Advanced Illness	F02.818	ICD10CM	[F02.818] Dementia in other diseases classified elsewhere, unspecified severity, with other behavioral disturbance

Measure Set	Code	Code Type	Description
Advanced Illness	F02.82	ICD10CM	[F02.82] Dementia in other diseases classified elsewhere, unspecified severity, with psychotic disturbance
Advanced Illness	F02.83	ICD10CM	[F02.83] Dementia in other diseases classified elsewhere, unspecified severity, with mood disturbance
Advanced Illness	F02.84	ICD10CM	[F02.84] Dementia in other diseases classified elsewhere, unspecified severity, with anxiety
Advanced Illness	F02.A0	ICD10CM	[F02.A0] Dementia in other diseases classified elsewhere, mild, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety
Advanced Illness	F02.A11	ICD10CM	[F02.A11] Dementia in other diseases classified elsewhere, mild, with agitation
Advanced Illness	F02.A18	ICD10CM	[F02.A18] Dementia in other diseases classified elsewhere, mild, with other behavioral disturbance
Advanced Illness	F02.A2	ICD10CM	[F02.A2] Dementia in other diseases classified elsewhere, mild, with psychotic disturbance
Advanced Illness	F02.A3	ICD10CM	[F02.A3] Dementia in other diseases classified elsewhere, mild, with mood disturbance
Advanced Illness	F02.A4	ICD10CM	[F02.A4] Dementia in other diseases classified elsewhere, mild, with anxiety
Advanced Illness	F02.B0	ICD10CM	[F02.B0] Dementia in other diseases classified elsewhere, moderate, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety
Advanced Illness	F02.B11	ICD10CM	[F02.B11] Dementia in other diseases classified elsewhere, moderate, with agitation
Advanced Illness	F02.B18	ICD10CM	[F02.B18] Dementia in other diseases classified elsewhere, moderate, with other behavioral disturbance
Advanced Illness	F02.B2	ICD10CM	[F02.B2] Dementia in other diseases classified elsewhere, moderate, with psychotic disturbance
Advanced Illness	F02.B3	ICD10CM	[F02.B3] Dementia in other diseases classified elsewhere, moderate, with mood disturbance
Advanced Illness	F02.B4	ICD10CM	[F02.B4] Dementia in other diseases classified elsewhere, moderate, with anxiety
Advanced Illness	F02.C0	ICD10CM	[F02.C0] Dementia in other diseases classified elsewhere, severe, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety
Advanced Illness	F02.C11	ICD10CM	[F02.C11] Dementia in other diseases classified elsewhere, severe, with agitation
Advanced Illness	F02.C18	ICD10CM	[F02.C18] Dementia in other diseases classified elsewhere, severe, with other behavioral disturbance
Advanced Illness	F02.C2	ICD10CM	[F02.C2] Dementia in other diseases classified elsewhere, severe, with psychotic disturbance
Advanced Illness	F02.C3	ICD10CM	[F02.C3] Dementia in other diseases classified elsewhere, severe, with mood disturbance

Measure Set	Code	Code Type	Description
Advanced Illness	F02.C4	ICD10CM	[F02.C4] Dementia in other diseases classified elsewhere, severe, with anxiety
Advanced Illness	F03.90	ICD10CM	[F03.90] Unspecified dementia without behavioral disturbance
Advanced Illness	F03.911	ICD10CM	[F03.911] Unspecified dementia, unspecified severity, with agitation
Advanced Illness	F03.918	ICD10CM	[F03.918] Unspecified dementia, unspecified severity, with other behavioral disturbance
Advanced Illness	F03.92	ICD10CM	[F03.92] Unspecified dementia, unspecified severity, with psychotic disturbance
Advanced Illness	F03.93	ICD10CM	[F03.93] Unspecified dementia, unspecified severity, with mood disturbance
Advanced Illness	F03.94	ICD10CM	[F03.94] Unspecified dementia, unspecified severity, with anxiety
Advanced Illness	F03.A0	ICD10CM	[F03.A0] Unspecified dementia, mild, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety
Advanced Illness	F03.A11	ICD10CM	[F03.A11] Unspecified dementia, mild, with agitation
Advanced Illness	F03.A18	ICD10CM	[F03.A18] Unspecified dementia, mild, with other behavioral disturbance
Advanced Illness	F03.A2	ICD10CM	[F03.A2] Unspecified dementia, mild, with psychotic disturbance
Advanced Illness	F03.A3	ICD10CM	[F03.A3] Unspecified dementia, mild, with mood disturbance
Advanced Illness	F03.A4	ICD10CM	[F03.A4] Unspecified dementia, mild, with anxiety
Advanced Illness	F03.B0	ICD10CM	[F03.B0] Unspecified dementia, moderate, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety
Advanced Illness	F03.B11	ICD10CM	[F03.B11] Unspecified dementia, moderate, with agitation
Advanced Illness	F03.B18	ICD10CM	[F03.B18] Unspecified dementia, moderate, with other behavioral disturbance
Advanced Illness	F03.B2	ICD10CM	[F03.B2] Unspecified dementia, moderate, with psychotic disturbance
Advanced Illness	F03.B3	ICD10CM	[F03.B3] Unspecified dementia, moderate, with mood disturbance
Advanced Illness	F03.B4	ICD10CM	[F03.B4] Unspecified dementia, moderate, with anxiety
Advanced Illness	F03.C0	ICD10CM	[F03.C0] Unspecified dementia, severe, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety
Advanced Illness	F03.C11	ICD10CM	[F03.C11] Unspecified dementia, severe, with agitation
Advanced Illness	F03.C18	ICD10CM	[F03.C18] Unspecified dementia, severe, with other behavioral disturbance
Advanced Illness	F03.C2	ICD10CM	[F03.C2] Unspecified dementia, severe, with psychotic disturbance
Advanced Illness	F03.C3	ICD10CM	[F03.C3] Unspecified dementia, severe, with mood disturbance
Advanced Illness	F03.C4	ICD10CM	[F03.C4] Unspecified dementia, severe, with anxiety

Measure Set	Code	Code Type	Description
Advanced Illness	F04	ICD10CM	[F04] Amnestic disorder due to known physiological condition
Advanced Illness	F10.27	ICD10CM	[F10.27] Alcohol dependence with alcohol-induced persisting dementia
Advanced Illness	F10.96	ICD10CM	[F10.96] Alcohol use, unspecified with alcohol-induced persisting amnestic disorder
Advanced Illness	F10.97	ICD10CM	[F10.97] Alcohol use, unspecified with alcohol-induced persisting dementia
Advanced Illness	G10	ICD10CM	[G10] Huntington's disease
Advanced Illness	G12.21	ICD10CM	[G12.21] Amyotrophic lateral sclerosis
Advanced Illness	G20	ICD10CM	[G20] Parkinson's disease
Advanced Illness	G30.0	ICD10CM	[G30.0] Alzheimer's disease with early onset
Advanced Illness	G30.1	ICD10CM	[G30.1] Alzheimer's disease with late onset
Advanced Illness	G30.8	ICD10CM	[G30.8] Other Alzheimer's disease
Advanced Illness	G30.9	ICD10CM	[G30.9] Alzheimer's disease, unspecified
Advanced Illness	G31.01	ICD10CM	[G31.01] Pick's disease
Advanced Illness	G31.09	ICD10CM	[G31.09] Other frontotemporal dementia
Advanced Illness	G31.83	ICD10CM	[G31.83] Dementia with Lewy bodies
Advanced Illness	G35	ICD10CM	[G35] Multiple sclerosis
Advanced Illness	I09.81	ICD10CM	[I09.81] Rheumatic heart failure
Advanced Illness	I11.0	ICD10CM	[I11.0] Hypertensive heart disease with heart failure
Advanced Illness	I12.0	ICD10CM	[I12.0] Hypertensive chronic kidney disease with stage 5 chronic kidney disease or end stage renal disease
Advanced Illness	I13.0	ICD10CM	[I13.0] Hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease
Advanced Illness	I13.11	ICD10CM	[I13.11] Hypertensive heart and chronic kidney disease without heart failure, with stage 5 chronic kidney disease, or end stage renal disease
Advanced Illness	I13.2	ICD10CM	[I13.2] Hypertensive heart and chronic kidney disease with heart failure and with stage 5 chronic kidney disease, or end stage renal disease
Advanced Illness	I50.1	ICD10CM	[I50.1] Left ventricular failure, unspecified
Advanced Illness	I50.20	ICD10CM	[I50.20] Unspecified systolic (congestive) heart failure
Advanced Illness	I50.21	ICD10CM	[I50.21] Acute systolic (congestive) heart failure
Advanced Illness	I50.22	ICD10CM	[I50.22] Chronic systolic (congestive) heart failure
Advanced Illness	I50.23	ICD10CM	[I50.23] Acute on chronic systolic (congestive) heart failure
Advanced Illness	I50.30	ICD10CM	[I50.30] Unspecified diastolic (congestive) heart failure
Advanced Illness	I50.31	ICD10CM	[I50.31] Acute diastolic (congestive) heart failure
Advanced Illness	I50.32	ICD10CM	[I50.32] Chronic diastolic (congestive) heart failure
Advanced Illness	I50.33	ICD10CM	[I50.33] Acute on chronic diastolic (congestive) heart failure
Advanced Illness	I50.40	ICD10CM	[I50.40] Unspecified combined systolic (congestive) and diastolic (congestive) heart failure

Measure Set	Code	Code Type	Description
Advanced Illness	I50.41	ICD10CM	[I50.41] Acute combined systolic (congestive) and diastolic (congestive) heart failure
Advanced Illness	I50.42	ICD10CM	[I50.42] Chronic combined systolic (congestive) and diastolic (congestive) heart failure
Advanced Illness	I50.43	ICD10CM	[I50.43] Acute on chronic combined systolic (congestive) and diastolic (congestive) heart failure
Advanced Illness	I50.810	ICD10CM	[I50.810] Right heart failure, unspecified
Advanced Illness	I50.811	ICD10CM	[I50.811] Acute right heart failure
Advanced Illness	I50.812	ICD10CM	[I50.812] Chronic right heart failure
Advanced Illness	I50.813	ICD10CM	[I50.813] Acute on chronic right heart failure
Advanced Illness	I50.814	ICD10CM	[I50.814] Right heart failure due to left heart failure
Advanced Illness	I50.82	ICD10CM	[I50.82] Biventricular heart failure
Advanced Illness	I50.83	ICD10CM	[I50.83] High output heart failure
Advanced Illness	I50.84	ICD10CM	[I50.84] End stage heart failure
Advanced Illness	I50.89	ICD10CM	[I50.89] Other heart failure
Advanced Illness	I50.9	ICD10CM	[I50.9] Heart failure, unspecified
Advanced Illness	J43.0	ICD10CM	[J43.0] Unilateral pulmonary emphysema [MacLeod's syndrome]
Advanced Illness	J43.1	ICD10CM	[J43.1] Panlobular emphysema
Advanced Illness	J43.2	ICD10CM	[J43.2] Centrilobular emphysema
Advanced Illness	J43.8	ICD10CM	[J43.8] Other emphysema
Advanced Illness	J43.9	ICD10CM	[J43.9] Emphysema, unspecified
Advanced Illness	J68.4	ICD10CM	[J68.4] Chronic respiratory conditions due to chemicals, gases, fumes and vapors
Advanced Illness	J84.10	ICD10CM	[J84.10] Pulmonary fibrosis, unspecified
Advanced Illness	J84.112	ICD10CM	[J84.112] Idiopathic pulmonary fibrosis
Advanced Illness	J84.170	ICD10CM	[J84.170] Interstitial lung disease with progressive fibrotic phenotype in diseases classified elsewhere
Advanced Illness	J84.178	ICD10CM	[J84.178] Other interstitial pulmonary diseases with fibrosis in diseases classified elsewhere
Advanced Illness	J96.10	ICD10CM	[J96.10] Chronic respiratory failure, unspecified whether with hypoxia or hypercapnia
Advanced Illness	J96.11	ICD10CM	[J96.11] Chronic respiratory failure with hypoxia
Advanced Illness	J96.12	ICD10CM	[J96.12] Chronic respiratory failure with hypercapnia
Advanced Illness	J96.20	ICD10CM	[J96.20] Acute and chronic respiratory failure, unspecified whether with hypoxia or hypercapnia
Advanced Illness	J96.21	ICD10CM	[J96.21] Acute and chronic respiratory failure with hypoxia
Advanced Illness	J96.22	ICD10CM	[J96.22] Acute and chronic respiratory failure with hypercapnia
Advanced Illness	J96.90	ICD10CM	[J96.90] Respiratory failure, unspecified, unspecified whether with hypoxia or hypercapnia
Advanced Illness	J96.91	ICD10CM	[J96.91] Respiratory failure, unspecified with hypoxia
Advanced Illness	J96.92	ICD10CM	[J96.92] Respiratory failure, unspecified with hypercapnia

Measure Set	Code	Code Type	Description
Advanced Illness	J98.2	ICD10CM	[J98.2] Interstitial emphysema
Advanced Illness	J98.3	ICD10CM	[J98.3] Compensatory emphysema
Advanced Illness	K70.10	ICD10CM	[K70.10] Alcoholic hepatitis without ascites
Advanced Illness	K70.11	ICD10CM	[K70.11] Alcoholic hepatitis with ascites
Advanced Illness	K70.2	ICD10CM	[K70.2] Alcoholic fibrosis and sclerosis of liver
Advanced Illness	K70.30	ICD10CM	[K70.30] Alcoholic cirrhosis of liver without ascites
Advanced Illness	K70.31	ICD10CM	[K70.31] Alcoholic cirrhosis of liver with ascites
Advanced Illness	K70.40	ICD10CM	[K70.40] Alcoholic hepatic failure without coma
Advanced Illness	K70.41	ICD10CM	[K70.41] Alcoholic hepatic failure with coma
Advanced Illness	K70.9	ICD10CM	[K70.9] Alcoholic liver disease, unspecified
Advanced Illness	K74.00	ICD10CM	[K74.00] Hepatic fibrosis, unspecified
Advanced Illness	K74.01	ICD10CM	[K74.01] Hepatic fibrosis, early fibrosis
Advanced Illness	K74.02	ICD10CM	[K74.02] Hepatic fibrosis, advanced fibrosis
Advanced Illness	K74.1	ICD10CM	[K74.1] Hepatic sclerosis
Advanced Illness	K74.2	ICD10CM	[K74.2] Hepatic fibrosis with hepatic sclerosis
Advanced Illness	K74.4	ICD10CM	[K74.4] Secondary biliary cirrhosis
Advanced Illness	K74.5	ICD10CM	[K74.5] Biliary cirrhosis, unspecified
Advanced Illness	K74.60	ICD10CM	[K74.60] Unspecified cirrhosis of liver
Advanced Illness	K74.69	ICD10CM	[K74.69] Other cirrhosis of liver
Advanced Illness	N18.5	ICD10CM	[N18.5] Chronic kidney disease, stage 5
Advanced Illness	N18.6	ICD10CM	[N18.6] End stage renal disease
Frailty Device	E0100	HCPCS	Cane, includes canes of all materials, adjustable or fixed, with tip (E0100)
Frailty Device	E0105	HCPCS	Cane, quad or three prong, includes canes of all materials, adjustable or fixed, with tips (E0105)
Frailty Device	E0130	HCPCS	Walker, rigid (pickup), adjustable or fixed height (E0130)
Frailty Device	E0135	HCPCS	Walker, folding (pickup), adjustable or fixed height (E0135)
Frailty Device	E0140	HCPCS	Walker, with trunk support, adjustable or fixed height, any type (E0140)
Frailty Device	E0141	HCPCS	Walker, rigid, wheeled, adjustable or fixed height (E0141)
Frailty Device	E0143	HCPCS	Walker, folding, wheeled, adjustable or fixed height (E0143)
Frailty Device	E0144	HCPCS	Walker, enclosed, four sided framed, rigid or folding, wheeled with posterior seat (E0144)
Frailty Device	E0147	HCPCS	Walker, heavy duty, multiple braking system, variable wheel resistance (E0147)
Frailty Device	E0148	HCPCS	Walker, heavy duty, without wheels, rigid or folding, any type, each (E0148)
Frailty Device	E0149	HCPCS	Walker, heavy duty, wheeled, rigid or folding, any type (E0149)
Frailty Device	E0163	HCPCS	Commode chair, mobile or stationary, with fixed arms (E0163)
Frailty Device	E0165	HCPCS	Commode chair, mobile or stationary, with detachable arms (E0165)

Measure Set	Code	Code Type	Description
Frailty Device	E0167	HCPCS	Pail or pan for use with commode chair, replacement only (E0167)
Frailty Device	E0168	HCPCS	Commode chair, extra wide and/or heavy duty, stationary or mobile, with or without arms, any type, each (E0168)
Frailty Device	E0170	HCPCS	Commode chair with integrated seat lift mechanism, electric, any type (E0170)
Frailty Device	E0171	HCPCS	Commode chair with integrated seat lift mechanism, non-electric, any type (E0171)
Frailty Device	E0250	HCPCS	Hospital bed, fixed height, with any type side rails, with mattress (E0250)
Frailty Device	E0251	HCPCS	Hospital bed, fixed height, with any type side rails, without mattress (E0251)
Frailty Device	E0255	HCPCS	Hospital bed, variable height, hi-lo, with any type side rails, with mattress (E0255)
Frailty Device	E0256	HCPCS	Hospital bed, variable height, hi-lo, with any type side rails, without mattress (E0256)
Frailty Device	E0260	HCPCS	Hospital bed, semi-electric (head and foot adjustment), with any type side rails, with mattress (E0260)
Frailty Device	E0261	HCPCS	Hospital bed, semi-electric (head and foot adjustment), with any type side rails, without mattress (E0261)
Frailty Device	E0265	HCPCS	Hospital bed, total electric (head, foot and height adjustments), with any type side rails, with mattress (E0265)
Frailty Device	E0266	HCPCS	Hospital bed, total electric (head, foot and height adjustments), with any type side rails, without mattress (E0266)
Frailty Device	E0270	HCPCS	Hospital bed, institutional type includes: oscillating, circulating and stryker frame, with mattress (E0270)
Frailty Device	E0290	HCPCS	Hospital bed, fixed height, without side rails, with mattress (E0290)
Frailty Device	E0291	HCPCS	Hospital bed, fixed height, without side rails, without mattress (E0291)
Frailty Device	E0292	HCPCS	Hospital bed, variable height, hi-lo, without side rails, with mattress (E0292)
Frailty Device	E0293	HCPCS	Hospital bed, variable height, hi-lo, without side rails, without mattress (E0293)
Frailty Device	E0294	HCPCS	Hospital bed, semi-electric (head and foot adjustment), without side rails, with mattress (E0294)
Frailty Device	E0295	HCPCS	Hospital bed, semi-electric (head and foot adjustment), without side rails, without mattress (E0295)
Frailty Device	E0296	HCPCS	Hospital bed, total electric (head, foot and height adjustments), without side rails, with mattress (E0296)
Frailty Device	E0297	HCPCS	Hospital bed, total electric (head, foot and height adjustments), without side rails, without mattress (E0297)

Measure Set	Code	Code Type	Description
Frailty Device	E0301	HCPCS	Hospital bed, heavy duty, extra wide, with weight capacity greater than 350 pounds, but less than or equal to 600 pounds, with any type side rails, without mattress (E0301)
Frailty Device	E0302	HCPCS	Hospital bed, extra heavy duty, extra wide, with weight capacity greater than 600 pounds, with any type side rails, without mattress (E0302)
Frailty Device	E0303	HCPCS	Hospital bed, heavy duty, extra wide, with weight capacity greater than 350 pounds, but less than or equal to 600 pounds, with any type side rails, with mattress (E0303)
Frailty Device	E0304	HCPCS	Hospital bed, extra heavy duty, extra wide, with weight capacity greater than 600 pounds, with any type side rails, with mattress (E0304)
Frailty Device	E0424	HCPCS	Stationary compressed gaseous oxygen system, rental; includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing (E0424)
Frailty Device	E0425	HCPCS	Stationary compressed gas system, purchase; includes regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing (E0425)
Frailty Device	E0430	HCPCS	Portable gaseous oxygen system, purchase; includes regulator, flowmeter, humidifier, cannula or mask, and tubing (E0430)
Frailty Device	E0431	HCPCS	Portable gaseous oxygen system, rental; includes portable container, regulator, flowmeter, humidifier, cannula or mask, and tubing (E0431)
Frailty Device	E0433	HCPCS	Portable liquid oxygen system, rental; home liquefier used to fill portable liquid oxygen containers, includes portable containers, regulator, flowmeter, humidifier, cannula or mask and tubing, with or without supply reservoir and contents gauge (E0433)
Frailty Device	E0434	HCPCS	Portable liquid oxygen system, rental; includes portable container, supply reservoir, humidifier, flowmeter, refill adaptor, contents gauge, cannula or mask, and tubing (E0434)
Frailty Device	E0435	HCPCS	Portable liquid oxygen system, purchase; includes portable container, supply reservoir, flowmeter, humidifier, contents gauge, cannula or mask, tubing and refill adaptor (E0435)
Frailty Device	E0439	HCPCS	Stationary liquid oxygen system, rental; includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask, & tubing (E0439)
Frailty Device	E0440	HCPCS	Stationary liquid oxygen system, purchase; includes use of reservoir, contents indicator, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing (E0440)
Frailty Device	E0441	HCPCS	Stationary oxygen contents, gaseous, 1 month's supply = 1 unit (E0441)
Frailty Device	E0442	HCPCS	Stationary oxygen contents, liquid, 1 month's supply = 1 unit (E0442)

Measure Set	Code	Code Type	Description
Frailty Device	E0443	HCPCS	Portable oxygen contents, gaseous, 1 month's supply = 1 unit (E0443)
Frailty Device	E0444	HCPCS	Portable oxygen contents, liquid, 1 month's supply = 1 unit (E0444)
Frailty Device	E0462	HCPCS	Rocking bed with or without side rails (E0462)
Frailty Device	E0465	HCPCS	Home ventilator, any type, used with invasive interface, (e.g., tracheostomy tube) (E0465)
Frailty Device	E0466	HCPCS	Home ventilator, any type, used with non-invasive interface, (e.g., mask, chest shell) (E0466)
Frailty Device	E0470	HCPCS	Respiratory assist device, bi-level pressure capability, without backup rate feature, used with noninvasive interface, e.g., nasal or facial mask (intermittent assist device with continuous positive airway pressure device) (E0470)
Frailty Device	E0471	HCPCS	Respiratory assist device, bi-level pressure capability, with back-up rate feature, used with noninvasive interface, e.g., nasal or facial mask (intermittent assist device with continuous positive airway pressure device) (E0471)
Frailty Device	E0472	HCPCS	Respiratory assist device, bi-level pressure capability, with backup rate feature, used with invasive interface, e.g., tracheostomy tube (intermittent assist device with continuous positive airway pressure device) (E0472)
Frailty Device	E1130	HCPCS	Standard wheelchair, fixed full length arms, fixed or swing away detachable footrests (E1130)
Frailty Device	E1140	HCPCS	Wheelchair, detachable arms, desk or full length, swing away detachable footrests (E1140)
Frailty Device	E1150	HCPCS	Wheelchair, detachable arms, desk or full-length swing away detachable elevating leg rests (E1150)
Frailty Device	E1160	HCPCS	Wheelchair, fixed full length arms, swing away detachable elevating leg rests (E1160)
Frailty Device	E1161	HCPCS	Manual adult size wheelchair, includes tilt in space (E1161)
Frailty Device	E1170	HCPCS	Amputee wheelchair, fixed full length arms, swing away detachable elevating leg rests (E1170)
Frailty Device	E1171	HCPCS	Amputee wheelchair, fixed full length arms, without footrests or leg rest (E1171)
Frailty Device	E1172	HCPCS	Amputee wheelchair, detachable arms (desk or full length) without footrests or legrest (E1172)
Frailty Device	E1180	HCPCS	Amputee wheelchair, detachable arms (desk or full length) swing away detachable footrests (E1180)
Frailty Device	E1190	HCPCS	Amputee wheelchair, detachable arms (desk or full length) swing away detachable elevating legrests (E1190)
Frailty Device	E1195	HCPCS	Heavy duty wheelchair, fixed full length arms, swing away detachable elevating legrests (E1195)

Measure Set	Code	Code Type	Description
Frailty Device	E1200	HCPCS	Amputee wheelchair, fixed full length arms, swing away detachable footrest (E1200)
Frailty Device	E1220	HCPCS	Wheelchair; specially sized or constructed, (indicate brand name, model number, if any) and justification (E1220)
Frailty Device	E1240	HCPCS	Lightweight wheelchair, detachable arms, (desk or full length) swing away detachable, elevating legrest (E1240)
Frailty Device	E1250	HCPCS	Lightweight wheelchair, fixed full length arms, swing away detachable footrest (E1250)
Frailty Device	E1260	HCPCS	Lightweight wheelchair, detachable arms (desk or full length) swing away detachable footrest (E1260)
Frailty Device	E1270	HCPCS	Lightweight wheelchair, fixed full length arms, swing away detachable elevating legrests (E1270)
Frailty Device	E1280	HCPCS	Heavy duty wheelchair, detachable arms (desk or full length) elevating legrests (E1280)
Frailty Device	E1285	HCPCS	Heavy duty wheelchair, fixed full length arms, swing away detachable footrest (E1285)
Frailty Device	E1290	HCPCS	Heavy duty wheelchair, detachable arms (desk or full length) swing away detachable footrest (E1290)
Frailty Device	E1295	HCPCS	Heavy duty wheelchair, fixed full length arms, elevating legrest (E1295)
Frailty Device	E1296	HCPCS	Special wheelchair seat height from floor (E1296)
Frailty Device	E1297	HCPCS	Special wheelchair seat depth, by upholstery (E1297)
Frailty Device	E1298	HCPCS	Special wheelchair seat depth and/or width, by construction (E1298)
Frailty Diagnosis	L89.000	ICD-10CM	[L89.000] Pressure ulcer of unspecified elbow, unstageable
Frailty Diagnosis	L89.001	ICD-10CM	[L89.001] Pressure ulcer of unspecified elbow, stage 1
Frailty Diagnosis	L89.002	ICD-10CM	[L89.002] Pressure ulcer of unspecified elbow, stage 2
Frailty Diagnosis	L89.003	ICD-10CM	[L89.003] Pressure ulcer of unspecified elbow, stage 3
Frailty Diagnosis	L89.004	ICD-10CM	[L89.004] Pressure ulcer of unspecified elbow, stage 4
Frailty Diagnosis	L89.006	ICD-10CM	[L89.006] Pressure-induced deep tissue damage of unspecified elbow
Frailty Diagnosis	L89.009	ICD-10CM	[L89.009] Pressure ulcer of unspecified elbow, unspecified stage
Frailty Diagnosis	L89.010	ICD-10CM	[L89.010] Pressure ulcer of right elbow, unstageable
Frailty Diagnosis	L89.011	ICD-10CM	[L89.011] Pressure ulcer of right elbow, stage 1
Frailty Diagnosis	L89.012	ICD-10CM	[L89.012] Pressure ulcer of right elbow, stage 2
Frailty Diagnosis	L89.013	ICD-10CM	[L89.013] Pressure ulcer of right elbow, stage 3
Frailty Diagnosis	L89.014	ICD-10CM	[L89.014] Pressure ulcer of right elbow, stage 4
Frailty Diagnosis	L89.016	ICD-10CM	[L89.016] Pressure-induced deep tissue damage of right elbow
Frailty Diagnosis	L89.019	ICD-10CM	[L89.019] Pressure ulcer of right elbow, unspecified stage
Frailty Diagnosis	L89.020	ICD-10CM	[L89.020] Pressure ulcer of left elbow, unstageable
Frailty Diagnosis	L89.021	ICD-10CM	[L89.021] Pressure ulcer of left elbow, stage 1
Frailty Diagnosis	L89.022	ICD-10CM	[L89.022] Pressure ulcer of left elbow, stage 2

Measure Set	Code	Code Type	Description
Frailty Diagnosis	L89.023	ICD-10CM	[L89.023] Pressure ulcer of left elbow, stage 3
Frailty Diagnosis	L89.024	ICD-10CM	[L89.024] Pressure ulcer of left elbow, stage 4
Frailty Diagnosis	L89.026	ICD-10CM	[L89.026] Pressure-induced deep tissue damage of left elbow
Frailty Diagnosis	L89.029	ICD-10CM	[L89.029] Pressure ulcer of left elbow, unspecified stage
Frailty Diagnosis	L89.100	ICD-10CM	[L89.100] Pressure ulcer of unspecified part of back, unstageable
Frailty Diagnosis	L89.101	ICD-10CM	[L89.101] Pressure ulcer of unspecified part of back, stage 1
Frailty Diagnosis	L89.102	ICD-10CM	[L89.102] Pressure ulcer of unspecified part of back, stage 2
Frailty Diagnosis	L89.103	ICD-10CM	[L89.103] Pressure ulcer of unspecified part of back, stage 3
Frailty Diagnosis	L89.104	ICD-10CM	[L89.104] Pressure ulcer of unspecified part of back, stage 4
Frailty Diagnosis	L89.106	ICD-10CM	[L89.106] Pressure-induced deep tissue damage of unspecified part of back
Frailty Diagnosis	L89.109	ICD-10CM	[L89.109] Pressure ulcer of unspecified part of back, unspecified stage
Frailty Diagnosis	L89.110	ICD-10CM	[L89.110] Pressure ulcer of right upper back, unstageable
Frailty Diagnosis	L89.111	ICD-10CM	[L89.111] Pressure ulcer of right upper back, stage 1
Frailty Diagnosis	L89.112	ICD-10CM	[L89.112] Pressure ulcer of right upper back, stage 2
Frailty Diagnosis	L89.113	ICD-10CM	[L89.113] Pressure ulcer of right upper back, stage 3
Frailty Diagnosis	L89.114	ICD-10CM	[L89.114] Pressure ulcer of right upper back, stage 4
Frailty Diagnosis	L89.116	ICD-10CM	[L89.116] Pressure-induced deep tissue damage of right upper back
Frailty Diagnosis	L89.119	ICD-10CM	[L89.119] Pressure ulcer of right upper back, unspecified stage
Frailty Diagnosis	L89.120	ICD-10CM	[L89.120] Pressure ulcer of left upper back, unstageable
Frailty Diagnosis	L89.121	ICD-10CM	[L89.121] Pressure ulcer of left upper back, stage 1
Frailty Diagnosis	L89.122	ICD-10CM	[L89.122] Pressure ulcer of left upper back, stage 2
Frailty Diagnosis	L89.123	ICD-10CM	[L89.123] Pressure ulcer of left upper back, stage 3
Frailty Diagnosis	L89.124	ICD-10CM	[L89.124] Pressure ulcer of left upper back, stage 4
Frailty Diagnosis	L89.126	ICD-10CM	[L89.126] Pressure-induced deep tissue damage of left upper back
Frailty Diagnosis	L89.129	ICD-10CM	[L89.129] Pressure ulcer of left upper back, unspecified stage
Frailty Diagnosis	L89.130	ICD-10CM	[L89.130] Pressure ulcer of right lower back, unstageable
Frailty Diagnosis	L89.131	ICD-10CM	[L89.131] Pressure ulcer of right lower back, stage 1
Frailty Diagnosis	L89.132	ICD-10CM	[L89.132] Pressure ulcer of right lower back, stage 2
Frailty Diagnosis	L89.133	ICD-10CM	[L89.133] Pressure ulcer of right lower back, stage 3
Frailty Diagnosis	L89.134	ICD-10CM	[L89.134] Pressure ulcer of right lower back, stage 4
Frailty Diagnosis	L89.136	ICD-10CM	[L89.136] Pressure-induced deep tissue damage of right lower back
Frailty Diagnosis	L89.139	ICD-10CM	[L89.139] Pressure ulcer of right lower back, unspecified stage
Frailty Diagnosis	L89.140	ICD-10CM	[L89.140] Pressure ulcer of left lower back, unstageable
Frailty Diagnosis	L89.141	ICD-10CM	[L89.141] Pressure ulcer of left lower back, stage 1
Frailty Diagnosis	L89.142	ICD-10CM	[L89.142] Pressure ulcer of left lower back, stage 2
Frailty Diagnosis	L89.143	ICD-10CM	[L89.143] Pressure ulcer of left lower back, stage 3
Frailty Diagnosis	L89.144	ICD-10CM	[L89.144] Pressure ulcer of left lower back, stage 4

Measure Set	Code	Code Type	Description
Frailty Diagnosis	L89.146	ICD-10CM	[L89.146] Pressure-induced deep tissue damage of left lower back
Frailty Diagnosis	L89.149	ICD-10CM	[L89.149] Pressure ulcer of left lower back, unspecified stage
Frailty Diagnosis	L89.150	ICD-10CM	[L89.150] Pressure ulcer of sacral region, unstageable
Frailty Diagnosis	L89.151	ICD-10CM	[L89.151] Pressure ulcer of sacral region, stage 1
Frailty Diagnosis	L89.152	ICD-10CM	[L89.152] Pressure ulcer of sacral region, stage 2
Frailty Diagnosis	L89.153	ICD-10CM	[L89.153] Pressure ulcer of sacral region, stage 3
Frailty Diagnosis	L89.154	ICD-10CM	[L89.154] Pressure ulcer of sacral region, stage 4
Frailty Diagnosis	L89.156	ICD-10CM	[L89.156] Pressure-induced deep tissue damage of sacral region
Frailty Diagnosis	L89.159	ICD-10CM	[L89.159] Pressure ulcer of sacral region, unspecified stage
Frailty Diagnosis	L89.200	ICD-10CM	[L89.200] Pressure ulcer of unspecified hip, unstageable
Frailty Diagnosis	L89.201	ICD-10CM	[L89.201] Pressure ulcer of unspecified hip, stage 1
Frailty Diagnosis	L89.202	ICD-10CM	[L89.202] Pressure ulcer of unspecified hip, stage 2
Frailty Diagnosis	L89.203	ICD-10CM	[L89.203] Pressure ulcer of unspecified hip, stage 3
Frailty Diagnosis	L89.204	ICD-10CM	[L89.204] Pressure ulcer of unspecified hip, stage 4
Frailty Diagnosis	L89.206	ICD-10CM	[L89.206] Pressure-induced deep tissue damage of unspecified hip
Frailty Diagnosis	L89.209	ICD-10CM	[L89.209] Pressure ulcer of unspecified hip, unspecified stage
Frailty Diagnosis	L89.210	ICD-10CM	[L89.210] Pressure ulcer of right hip, unstageable
Frailty Diagnosis	L89.211	ICD-10CM	[L89.211] Pressure ulcer of right hip, stage 1
Frailty Diagnosis	L89.212	ICD-10CM	[L89.212] Pressure ulcer of right hip, stage 2
Frailty Diagnosis	L89.213	ICD-10CM	[L89.213] Pressure ulcer of right hip, stage 3
Frailty Diagnosis	L89.214	ICD-10CM	[L89.214] Pressure ulcer of right hip, stage 4
Frailty Diagnosis	L89.216	ICD-10CM	[L89.216] Pressure-induced deep tissue damage of right hip
Frailty Diagnosis	L89.219	ICD-10CM	[L89.219] Pressure ulcer of right hip, unspecified stage
Frailty Diagnosis	L89.220	ICD-10CM	[L89.220] Pressure ulcer of left hip, unstageable
Frailty Diagnosis	L89.221	ICD-10CM	[L89.221] Pressure ulcer of left hip, stage 1
Frailty Diagnosis	L89.222	ICD-10CM	[L89.222] Pressure ulcer of left hip, stage 2
Frailty Diagnosis	L89.223	ICD-10CM	[L89.223] Pressure ulcer of left hip, stage 3
Frailty Diagnosis	L89.224	ICD-10CM	[L89.224] Pressure ulcer of left hip, stage 4
Frailty Diagnosis	L89.226	ICD-10CM	[L89.226] Pressure-induced deep tissue damage of left hip
Frailty Diagnosis	L89.229	ICD-10CM	[L89.229] Pressure ulcer of left hip, unspecified stage
Frailty Diagnosis	L89.300	ICD-10CM	[L89.300] Pressure ulcer of unspecified buttock, unstageable
Frailty Diagnosis	L89.301	ICD-10CM	[L89.301] Pressure ulcer of unspecified buttock, stage 1
Frailty Diagnosis	L89.302	ICD-10CM	[L89.302] Pressure ulcer of unspecified buttock, stage 2
Frailty Diagnosis	L89.303	ICD-10CM	[L89.303] Pressure ulcer of unspecified buttock, stage 3
Frailty Diagnosis	L89.304	ICD-10CM	[L89.304] Pressure ulcer of unspecified buttock, stage 4
Frailty Diagnosis	L89.306	ICD-10CM	[L89.306] Pressure-induced deep tissue damage of unspecified buttock
Frailty Diagnosis	L89.309	ICD-10CM	[L89.309] Pressure ulcer of unspecified buttock, unspecified stage
Frailty Diagnosis	L89.310	ICD-10CM	[L89.310] Pressure ulcer of right buttock, unstageable

Measure Set	Code	Code Type	Description
Frailty Diagnosis	L89.311	ICD-10CM	[L89.311] Pressure ulcer of right buttock, stage 1
Frailty Diagnosis	L89.312	ICD-10CM	[L89.312] Pressure ulcer of right buttock, stage 2
Frailty Diagnosis	L89.313	ICD-10CM	[L89.313] Pressure ulcer of right buttock, stage 3
Frailty Diagnosis	L89.314	ICD-10CM	[L89.314] Pressure ulcer of right buttock, stage 4
Frailty Diagnosis	L89.316	ICD-10CM	[L89.316] Pressure-induced deep tissue damage of right buttock
Frailty Diagnosis	L89.319	ICD-10CM	[L89.319] Pressure ulcer of right buttock, unspecified stage
Frailty Diagnosis	L89.320	ICD-10CM	[L89.320] Pressure ulcer of left buttock, unstageable
Frailty Diagnosis	L89.321	ICD-10CM	[L89.321] Pressure ulcer of left buttock, stage 1
Frailty Diagnosis	L89.322	ICD-10CM	[L89.322] Pressure ulcer of left buttock, stage 2
Frailty Diagnosis	L89.323	ICD-10CM	[L89.323] Pressure ulcer of left buttock, stage 3
Frailty Diagnosis	L89.324	ICD-10CM	[L89.324] Pressure ulcer of left buttock, stage 4
Frailty Diagnosis	L89.326	ICD-10CM	[L89.326] Pressure-induced deep tissue damage of left buttock
Frailty Diagnosis	L89.329	ICD-10CM	[L89.329] Pressure ulcer of left buttock, unspecified stage
Frailty Diagnosis	L89.40	ICD-10CM	[L89.40] Pressure ulcer of contiguous site of back, buttock and hip, unspecified stage
Frailty Diagnosis	L89.41	ICD-10CM	[L89.41] Pressure ulcer of contiguous site of back, buttock and hip, stage 1
Frailty Diagnosis	L89.42	ICD-10CM	[L89.42] Pressure ulcer of contiguous site of back, buttock and hip, stage 2
Frailty Diagnosis	L89.43	ICD-10CM	[L89.43] Pressure ulcer of contiguous site of back, buttock and hip, stage 3
Frailty Diagnosis	L89.44	ICD-10CM	[L89.44] Pressure ulcer of contiguous site of back, buttock and hip, stage 4
Frailty Diagnosis	L89.45	ICD-10CM	[L89.45] Pressure ulcer of contiguous site of back, buttock and hip, unstageable
Frailty Diagnosis	L89.46	ICD-10CM	[L89.46] Pressure-induced deep tissue damage of contiguous site of back, buttock and hip
Frailty Diagnosis	L89.500	ICD-10CM	[L89.500] Pressure ulcer of unspecified ankle, unstageable
Frailty Diagnosis	L89.501	ICD-10CM	[L89.501] Pressure ulcer of unspecified ankle, stage 1
Frailty Diagnosis	L89.502	ICD-10CM	[L89.502] Pressure ulcer of unspecified ankle, stage 2
Frailty Diagnosis	L89.503	ICD-10CM	[L89.503] Pressure ulcer of unspecified ankle, stage 3
Frailty Diagnosis	L89.504	ICD-10CM	[L89.504] Pressure ulcer of unspecified ankle, stage 4
Frailty Diagnosis	L89.506	ICD-10CM	[L89.506] Pressure-induced deep tissue damage of unspecified ankle
Frailty Diagnosis	L89.509	ICD-10CM	[L89.509] Pressure ulcer of unspecified ankle, unspecified stage
Frailty Diagnosis	L89.510	ICD-10CM	[L89.510] Pressure ulcer of right ankle, unstageable
Frailty Diagnosis	L89.511	ICD-10CM	[L89.511] Pressure ulcer of right ankle, stage 1
Frailty Diagnosis	L89.512	ICD-10CM	[L89.512] Pressure ulcer of right ankle, stage 2
Frailty Diagnosis	L89.513	ICD-10CM	[L89.513] Pressure ulcer of right ankle, stage 3
Frailty Diagnosis	L89.514	ICD-10CM	[L89.514] Pressure ulcer of right ankle, stage 4
Frailty Diagnosis	L89.516	ICD-10CM	[L89.516] Pressure-induced deep tissue damage of right ankle

Measure Set	Code	Code Type	Description
Frailty Diagnosis	L89.519	ICD-10CM	[L89.519] Pressure ulcer of right ankle, unspecified stage
Frailty Diagnosis	L89.520	ICD-10CM	[L89.520] Pressure ulcer of left ankle, unstageable
Frailty Diagnosis	L89.521	ICD-10CM	[L89.521] Pressure ulcer of left ankle, stage 1
Frailty Diagnosis	L89.522	ICD-10CM	[L89.522] Pressure ulcer of left ankle, stage 2
Frailty Diagnosis	L89.523	ICD-10CM	[L89.523] Pressure ulcer of left ankle, stage 3
Frailty Diagnosis	L89.524	ICD-10CM	[L89.524] Pressure ulcer of left ankle, stage 4
Frailty Diagnosis	L89.526	ICD-10CM	[L89.526] Pressure-induced deep tissue damage of left ankle
Frailty Diagnosis	L89.529	ICD-10CM	[L89.529] Pressure ulcer of left ankle, unspecified stage
Frailty Diagnosis	L89.600	ICD-10CM	[L89.600] Pressure ulcer of unspecified heel, unstageable
Frailty Diagnosis	L89.601	ICD-10CM	[L89.601] Pressure ulcer of unspecified heel, stage 1
Frailty Diagnosis	L89.602	ICD-10CM	[L89.602] Pressure ulcer of unspecified heel, stage 2
Frailty Diagnosis	L89.603	ICD-10CM	[L89.603] Pressure ulcer of unspecified heel, stage 3
Frailty Diagnosis	L89.604	ICD-10CM	[L89.604] Pressure ulcer of unspecified heel, stage 4
Frailty Diagnosis	L89.606	ICD-10CM	[L89.606] Pressure-induced deep tissue damage of unspecified heel
Frailty Diagnosis	L89.609	ICD-10CM	[L89.609] Pressure ulcer of unspecified heel, unspecified stage
Frailty Diagnosis	L89.610	ICD-10CM	[L89.610] Pressure ulcer of right heel, unstageable
Frailty Diagnosis	L89.611	ICD-10CM	[L89.611] Pressure ulcer of right heel, stage 1
Frailty Diagnosis	L89.612	ICD-10CM	[L89.612] Pressure ulcer of right heel, stage 2
Frailty Diagnosis	L89.613	ICD-10CM	[L89.613] Pressure ulcer of right heel, stage 3
Frailty Diagnosis	L89.614	ICD-10CM	[L89.614] Pressure ulcer of right heel, stage 4
Frailty Diagnosis	L89.616	ICD-10CM	[L89.616] Pressure-induced deep tissue damage of right heel
Frailty Diagnosis	L89.619	ICD-10CM	[L89.619] Pressure ulcer of right heel, unspecified stage
Frailty Diagnosis	L89.620	ICD-10CM	[L89.620] Pressure ulcer of left heel, unstageable
Frailty Diagnosis	L89.621	ICD-10CM	[L89.621] Pressure ulcer of left heel, stage 1
Frailty Diagnosis	L89.622	ICD-10CM	[L89.622] Pressure ulcer of left heel, stage 2
Frailty Diagnosis	L89.623	ICD-10CM	[L89.623] Pressure ulcer of left heel, stage 3
Frailty Diagnosis	L89.624	ICD-10CM	[L89.624] Pressure ulcer of left heel, stage 4
Frailty Diagnosis	L89.626	ICD-10CM	[L89.626] Pressure-induced deep tissue damage of left heel
Frailty Diagnosis	L89.629	ICD-10CM	[L89.629] Pressure ulcer of left heel, unspecified stage
Frailty Diagnosis	L89.810	ICD-10CM	[L89.810] Pressure ulcer of head, unstageable
Frailty Diagnosis	L89.811	ICD-10CM	[L89.811] Pressure ulcer of head, stage 1
Frailty Diagnosis	L89.812	ICD-10CM	[L89.812] Pressure ulcer of head, stage 2
Frailty Diagnosis	L89.813	ICD-10CM	[L89.813] Pressure ulcer of head, stage 3
Frailty Diagnosis	L89.814	ICD-10CM	[L89.814] Pressure ulcer of head, stage 4
Frailty Diagnosis	L89.816	ICD-10CM	[L89.816] Pressure-induced deep tissue damage of head
Frailty Diagnosis	L89.819	ICD-10CM	[L89.819] Pressure ulcer of head, unspecified stage
Frailty Diagnosis	L89.890	ICD-10CM	[L89.890] Pressure ulcer of other site, unstageable
Frailty Diagnosis	L89.891	ICD-10CM	[L89.891] Pressure ulcer of other site, stage 1
Frailty Diagnosis	L89.892	ICD-10CM	[L89.892] Pressure ulcer of other site, stage 2
Frailty Diagnosis	L89.893	ICD-10CM	[L89.893] Pressure ulcer of other site, stage 3
Frailty Diagnosis	L89.894	ICD-10CM	[L89.894] Pressure ulcer of other site, stage 4

Measure Set	Code	Code Type	Description
Frailty Diagnosis	L89.896	ICD-10CM	[L89.896] Pressure-induced deep tissue damage of another site
Frailty Diagnosis	L89.899	ICD-10CM	[L89.899] Pressure ulcer of other site, unspecified stage
Frailty Diagnosis	L89.90	ICD-10CM	[L89.90] Pressure ulcer of unspecified site, unspecified stage
Frailty Diagnosis	L89.91	ICD-10CM	[L89.91] Pressure ulcer of unspecified site, stage 1
Frailty Diagnosis	L89.92	ICD-10CM	[L89.92] Pressure ulcer of unspecified site, stage 2
Frailty Diagnosis	L89.93	ICD-10CM	[L89.93] Pressure ulcer of unspecified site, stage 3
Frailty Diagnosis	L89.94	ICD-10CM	[L89.94] Pressure ulcer of unspecified site, stage 4
Frailty Diagnosis	L89.95	ICD-10CM	[L89.95] Pressure ulcer of unspecified site, unstageable
Frailty Diagnosis	L89.96	ICD-10CM	[L89.96] Pressure-induced deep tissue damage of unspecified site
Frailty Diagnosis	M62.50	ICD-10CM	[M62.50] Muscle wasting and atrophy, not elsewhere classified, unspecified site
Frailty Diagnosis	M62.81	ICD-10CM	[M62.81] Muscle weakness (generalized)
Frailty Diagnosis	M62.84	ICD-10CM	[M62.84] Sarcopenia
Frailty Diagnosis	R29.6	ICD10CM	[R29.6] Repeated falls
Frailty Diagnosis	W01.0XXA	ICD-10CM	[W01.0XXA] Fall on same level from slipping, tripping, and stumbling without subsequent striking against object, initial encounter
Frailty Diagnosis	W01.0XXD	ICD-10CM	[W01.0XXD] Fall on same level from slipping, tripping, and stumbling without subsequent striking against object, subsequent encounter
Frailty Diagnosis	W01.0XXS	ICD-10CM	[W01.0XXS] Fall on same level from slipping, tripping, and stumbling without subsequent striking against object, sequela
Frailty Diagnosis	W01.10XA	ICD-10CM	[W01.10XA] Fall on same level from slipping, tripping, and stumbling with subsequent striking against unspecified object, initial encounter
Frailty Diagnosis	W01.10XD	ICD-10CM	[W01.10XD] Fall on same level from slipping, tripping, and stumbling with subsequent striking against unspecified object, subsequent encounter
Frailty Diagnosis	W01.10XS	ICD-10CM	[W01.10XS] Fall on same level from slipping, tripping, and stumbling with subsequent striking against unspecified object, sequela
Frailty Diagnosis	W01.110A	ICD-10CM	[W01.110A] Fall on same level from slipping, tripping, and stumbling with subsequent striking against sharp glass, initial encounter
Frailty Diagnosis	W01.110D	ICD-10CM	[W01.110D] Fall on same level from slipping, tripping, and stumbling with subsequent striking against sharp glass, subsequent encounter
Frailty Diagnosis	W01.110S	ICD-10CM	[W01.110S] Fall on same level from slipping, tripping, and stumbling with subsequent striking against sharp glass, sequela
Frailty Diagnosis	W01.111A	ICD-10CM	[W01.111A] Fall on same level from slipping, tripping, and stumbling with subsequent striking against power tool or machine, initial encounter

Measure Set	Code	Code Type	Description
Frailty Diagnosis	W01.111D	ICD-10CM	[W01.111D] Fall on same level from slipping, tripping, and stumbling with subsequent striking against power tool or machine, subsequent encounter
Frailty Diagnosis	W01.111S	ICD-10CM	[W01.111S] Fall on same level from slipping, tripping, and stumbling with subsequent striking against power tool or machine, sequela
Frailty Diagnosis	W01.118A	ICD-10CM	[W01.118A] Fall on same level from slipping, tripping, and stumbling with subsequent striking against another sharp object, initial encounter
Frailty Diagnosis	W01.118D	ICD-10CM	[W01.118D] Fall on same level from slipping, tripping, and stumbling with subsequent striking against another sharp object, subsequent encounter
Frailty Diagnosis	W01.118S	ICD-10CM	[W01.118S] Fall on same level from slipping, tripping, and stumbling with subsequent striking against another sharp object, sequela
Frailty Diagnosis	W01.119A	ICD-10CM	[W01.119A] Fall on same level from slipping, tripping, and stumbling with subsequent striking against unspecified sharp object, initial encounter
Frailty Diagnosis	W01.119D	ICD-10CM	[W01.119D] Fall on same level from slipping, tripping, and stumbling with subsequent striking against unspecified sharp object, subsequent encounter
Frailty Diagnosis	W01.119S	ICD-10CM	[W01.119S] Fall on same level from slipping, tripping, and stumbling with subsequent striking against unspecified sharp object, sequela
Frailty Diagnosis	W01.190A	ICD-10CM	[W01.190A] Fall on same level from slipping, tripping, and stumbling with subsequent striking against furniture, initial encounter
Frailty Diagnosis	W01.190D	ICD-10CM	[W01.190D] Fall on same level from slipping, tripping, and stumbling with subsequent striking against furniture, subsequent encounter
Frailty Diagnosis	W01.190S	ICD-10CM	[W01.190S] Fall on same level from slipping, tripping, and stumbling with subsequent striking against furniture, sequela
Frailty Diagnosis	W01.198A	ICD-10CM	[W01.198A] Fall on same level from slipping, tripping, and stumbling with subsequent striking against another object, initial encounter
Frailty Diagnosis	W01.198D	ICD-10CM	[W01.198D] Fall on same level from slipping, tripping and stumbling with subsequent striking against another object, subsequent encounter
Frailty Diagnosis	W01.198S	ICD-10CM	[W01.198S] Fall on same level from slipping, tripping and stumbling with subsequent striking against another object, sequela
Frailty Diagnosis	W06.XXXA	ICD-10CM	[W06.XXXA] Fall from bed, initial encounter
Frailty Diagnosis	W06.XXXD	ICD-10CM	[W06.XXXD] Fall from bed, subsequent encounter
Frailty Diagnosis	W06.XXXS	ICD-10CM	[W06.XXXS] Fall from bed, sequela
Frailty Diagnosis	W07.XXXA	ICD-10CM	[W07.XXXA] Fall from chair, initial encounter
Frailty Diagnosis	W07.XXXD	ICD-10CM	[W07.XXXD] Fall from chair, subsequent encounter

Measure Set	Code	Code Type	Description
Frailty Diagnosis	W07.XXXS	ICD-10CM	[W07.XXXS] Fall from chair, sequela
Frailty Diagnosis	W08.XXXA	ICD-10CM	[W08.XXXA] Fall from other furniture, initial encounter
Frailty Diagnosis	W08.XXXD	ICD-10CM	[W08.XXXD] Fall from other furniture, subsequent encounter
Frailty Diagnosis	W08.XXXS	ICD-10CM	[W08.XXXS] Fall from other furniture, sequela
Frailty Diagnosis	W10.0XXA	ICD-10CM	[W10.0XXA] Fall (on)(from) escalator, initial encounter
Frailty Diagnosis	W10.0XXD	ICD-10CM	[W10.0XXD] Fall (on)(from) escalator, subsequent encounter
Frailty Diagnosis	W10.0XXS	ICD-10CM	[W10.0XXS] Fall (on)(from) escalator, sequela
Frailty Diagnosis	W10.1XXA	ICD-10CM	[W10.1XXA] Fall (on)(from) sidewalk curb, initial encounter
Frailty Diagnosis	W10.1XXD	ICD-10CM	[W10.1XXD] Fall (on)(from) sidewalk curb, subsequent encounter
Frailty Diagnosis	W10.1XXS	ICD-10CM	[W10.1XXS] Fall (on)(from) sidewalk curb, sequela
Frailty Diagnosis	W10.2XXA	ICD-10CM	[W10.2XXA] Fall (on)(from) incline, initial encounter
Frailty Diagnosis	W10.2XXD	ICD-10CM	[W10.2XXD] Fall (on)(from) incline, subsequent encounter
Frailty Diagnosis	W10.2XXS	ICD-10CM	[W10.2XXS] Fall (on)(from) incline, sequela
Frailty Diagnosis	W10.8XXA	ICD-10CM	[W10.8XXA] Fall (on) (from) other stairs and steps, initial encounter
Frailty Diagnosis	W10.8XXD	ICD-10CM	[W10.8XXD] Fall (on) (from) other stairs and steps, subsequent encounter
Frailty Diagnosis	W10.8XXS	ICD-10CM	[W10.8XXS] Fall (on) (from) other stairs and steps, sequela
Frailty Diagnosis	W10.9XXA	ICD-10CM	[W10.9XXA] Fall (on) (from) unspecified stairs and steps, initial encounter
Frailty Diagnosis	W10.9XXD	ICD-10CM	[W10.9XXD] Fall (on) (from) unspecified stairs and steps, subsequent encounter
Frailty Diagnosis	W10.9XXS	ICD-10CM	[W10.9XXS] Fall (on) (from) unspecified stairs and steps, sequela
Frailty Diagnosis	W18.00XA	ICD-10CM	[W18.00XA] Striking against unspecified object with subsequent fall, initial encounter
Frailty Diagnosis	W18.00XD	ICD-10CM	[W18.00XD] Striking against unspecified object with subsequent fall, subsequent encounter
Frailty Diagnosis	W18.00XS	ICD-10CM	[W18.00XS] Striking against unspecified object with subsequent fall, sequela
Frailty Diagnosis	W18.02XA	ICD-10CM	[W18.02XA] Striking against glass with subsequent fall, initial encounter
Frailty Diagnosis	W18.02XD	ICD-10CM	[W18.02XD] Striking against glass with subsequent fall, subsequent encounter
Frailty Diagnosis	W18.02XS	ICD-10CM	[W18.02XS] Striking against glass with subsequent fall, sequela
Frailty Diagnosis	W18.09XA	ICD-10CM	[W18.09XA] Striking against another object with subsequent fall, initial encounter
Frailty Diagnosis	W18.09XD	ICD-10CM	[W18.09XD] Striking against another object with subsequent fall, subsequent encounter
Frailty Diagnosis	W18.09XS	ICD-10CM	[W18.09XS] Striking against another object with subsequent fall, sequela

Measure Set	Code	Code Type	Description
Frailty Diagnosis	W18.11XA	ICD-10CM	[W18.11XA] Fall from or off toilet without subsequent striking against object, initial encounter
Frailty Diagnosis	W18.11XD	ICD-10CM	[W18.11XD] Fall from or off toilet without subsequent striking against object, subsequent encounter
Frailty Diagnosis	W18.11XS	ICD-10CM	[W18.11XS] Fall from or off toilet without subsequent striking against object, sequela
Frailty Diagnosis	W18.12XA	ICD-10CM	[W18.12XA] Fall from or off toilet with subsequent striking against object, initial encounter
Frailty Diagnosis	W18.12XD	ICD-10CM	[W18.12XD] Fall from or off toilet with subsequent striking against object, subsequent encounter
Frailty Diagnosis	W18.12XS	ICD-10CM	[W18.12XS] Fall from or off toilet with subsequent striking against object, sequela
Frailty Diagnosis	W18.2XXA	ICD-10CM	[W18.2XXA] Fall in (into) shower or empty bathtub, initial encounter
Frailty Diagnosis	W18.2XXD	ICD-10CM	[W18.2XXD] Fall in (into) shower or empty bathtub, subsequent encounter
Frailty Diagnosis	W18.2XXS	ICD-10CM	[W18.2XXS] Fall in (into) shower or empty bathtub, sequela
Frailty Diagnosis	W18.30XA	ICD-10CM	[W18.30XA] Fall on same level, unspecified, initial encounter
Frailty Diagnosis	W18.30XD	ICD-10CM	[W18.30XD] Fall on same level, unspecified, subsequent encounter
Frailty Diagnosis	W18.30XS	ICD-10CM	[W18.30XS] Fall on same level, unspecified, sequela
Frailty Diagnosis	W18.31XA	ICD-10CM	[W18.31XA] Fall on same level due to stepping on an object, initial encounter
Frailty Diagnosis	W18.31XD	ICD-10CM	[W18.31XD] Fall on same level due to stepping on an object, subsequent encounter
Frailty Diagnosis	W18.31XS	ICD-10CM	[W18.31XS] Fall on same level due to stepping on an object, sequela
Frailty Diagnosis	W18.39XA	ICD-10CM	[W18.39XA] Other fall on same level, initial encounter
Frailty Diagnosis	W18.39XD	ICD-10CM	[W18.39XD] Other fall on same level, subsequent encounter
Frailty Diagnosis	W18.39XS	ICD-10CM	[W18.39XS] Other fall on same level, sequela
Frailty Diagnosis	W19.XXXA	ICD-10CM	[W19.XXXA] Unspecified fall, initial encounter
Frailty Diagnosis	W19.XXXD	ICD-10CM	[W19.XXXD] Unspecified fall, subsequent encounter
Frailty Diagnosis	W19.XXXS	ICD-10CM	[W19.XXXS] Unspecified fall, sequela
Frailty Diagnosis	Y92.199	ICD-10CM	[Y92.199] Unspecified place in other specified residential institution as the place of occurrence of the external cause
Frailty Diagnosis	Z59.3	ICD-10CM	[Z59.3] Problems related to living in residential institution
Frailty Diagnosis	Z73.6	ICD-10CM	[Z73.6] Limitation of activities due to disability
Frailty Diagnosis	Z74.01	ICD-10CM	[Z74.01] Bed confinement status
Frailty Diagnosis	Z74.09	ICD-10CM	[Z74.09] Other reduced mobility
Frailty Diagnosis	Z74.1	ICD-10CM	[Z74.1] Need for assistance with personal care
Frailty Diagnosis	Z74.2	ICD-10CM	[Z74.2] Need for assistance at home and no other household member able to render care
Frailty Diagnosis	Z74.3	ICD-10CM	[Z74.3] Need for continuous supervision

Measure Set	Code	Code Type	Description
Frailty Diagnosis	Z74.8	ICD-10CM	[Z74.8] Other problems related to care provider dependency
Frailty Diagnosis	Z74.9	ICD-10CM	[Z74.9] Problem related to care provider dependency, unspecified
Frailty Diagnosis	Z91.81	ICD-10CM	[Z91.81] History of falling
Frailty Diagnosis	Z99.11	ICD-10CM	[Z99.11] Dependence on respirator [ventilator] status
Frailty Diagnosis	Z99.3	ICD-10CM	[Z99.3] Dependence on wheelchair
Frailty Diagnosis	Z99.81	ICD-10CM	[Z99.81] Dependence on supplemental oxygen
Frailty Diagnosis	Z99.89	ICD-10CM	[Z99.89] Dependence on other enabling machines and devices
Frailty Encounter	99504	CPT	Home visit for mechanical ventilation care
Frailty Encounter	99509	CPT	Home visit to help a patient with activities of daily living (ADLs) and personal care
Frailty Encounter	G0162	HCPCS	Skilled services by a registered nurse (RN) for management and evaluation of the plan of care; each 15 minutes (the patient's underlying condition or complication requires an RN to ensure that essential non-skilled care achieves its purpose in the home health or hospice setting) (G0162)
Frailty Encounter	G0299	HCPCS	Direct skilled nursing services of a registered nurse (RN) in the home health or hospice setting, each 15 minutes (G0299)
Frailty Encounter	G0300	HCPCS	Direct skilled nursing services of a licensed practical nurse (LPN) in the home health or hospice setting, each 15 minutes (G0300)
Frailty Encounter	G0493	HCPCS	Skilled services of a registered nurse (RN) for the observation and assessment of the patient's condition, each 15 minutes (the change in the patient's condition requires skilled nursing personnel to identify and evaluate the patient's need for modification of treatment in the home health or hospice setting) (G0493)
Frailty Encounter	G0494	HCPCS	Skilled services of a licensed practical nurse (LPN) for the observation and assessment of the patient's condition, each 15 minutes (the change in the patient's condition requires skilled nursing personnel to identify and evaluate the patient's need for modification of treatment in the home health or hospice setting) (G0494)
Frailty Encounter	S0271	HCPCS	Physician management of patient home care, hospice monthly case rate (per 30 days) (S0271)
Frailty Encounter	S0311	HCPCS	Comprehensive management and care coordination for advanced illness, per calendar month (S0311)
Frailty Encounter	S9123	HCPCS	Nursing care, in the home; by registered nurse, per hour (use for general nursing care only, not to be used when CPT codes 99500-99602 can be used) (S9123)
Frailty Encounter	S9124	HCPCS	Nursing care, in the home; by licensed practical nurse, per hour (S9124)
Frailty Encounter	T1000	HCPCS	Private duty / independent nursing service(s) - licensed, up to 15 minutes (T1000)
Frailty Encounter	T1001	HCPCS	Nursing assessment / evaluation (T1001)

Measure Set	Code	Code Type	Description
Frailty Encounter	T1002	HCPCS	Rn services, up to 15 minutes (T1002)
Frailty Encounter	T1003	HCPCS	LPN services, up to 15 minutes (T1003)
Frailty Encounter	T1004	HCPCS	Services of a qualified nursing aide, up to 15 minutes (T1004)
Frailty Encounter	T1005	HCPCS	Respite care services, up to 15 minutes (T1005)
Frailty Encounter	T1019	HCPCS	Personal care services, per 15 minutes, not for an inpatient or resident of a hospital, nursing facility, icf/mr or imd, part of the individualized plan of treatment (code may not be used to identify services provided by home health aide or certified nurse assistant) (T1019)
Frailty Encounter	T1020	HCPCS	Personal care services, per diem, not for an inpatient or resident of a hospital, nursing facility, icf/mr or imd, part of the individualized plan of treatment (code may not be used to identify services provided by home health aide or certified nurse assistant) (T1020)
Frailty Encounter	T1021	HCPCS	Home health aide or certified nurse assistant, per visit (T1021)
Frailty Encounter	T1022	HCPCS	Contracted home health agency services, all services provided under contract, per day (T1022)
Frailty Encounter	T1030	HCPCS	Nursing care, in the home, by registered nurse, per diem (T1030)
Frailty Encounter	T1031	HCPCS	Nursing care, in the home, by licensed practical nurse, per diem (T1031)
Frailty Symptom	R26.2	ICD-10CM	[R26.2] Difficulty in walking, not elsewhere classified
Frailty Symptom	R26.89	ICD-10CM	[R26.89] Other abnormalities of gait and mobility
Frailty Symptom	R26.9	ICD-10CM	[R26.9] Unspecified abnormalities of gait and mobility
Frailty Symptom	R53.1	ICD-10CM	[R53.1] Weakness
Frailty Symptom	R53.81	ICD-10CM	[R53.81] Other malaise
Frailty Symptom	R54	ICD-10CM	[R54] Age-related physical debility
Frailty Symptom	R62.7	ICD-10CM	[R62.7] Adult failure to thrive
Frailty Symptom	R63.4	ICD-10CM	[R63.4] Abnormal weight loss
Frailty Symptom	R63.6	ICD-10CM	[R63.6] Underweight
Frailty Symptom	R64	ICD-10CM	[R64] Cachexia

Glycemic Status Assessment for Patients with Diabetes

The following is a high-level summary of the measure. The referenced measure source should be consulted for specific questions/details.

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Summary of Changes

- Priority Health: Performance will be measured at the practice level for MY 2025.

Measure Source(s):

- HEDIS: "Glycemic Status Assessment for Patients with Diabetes (GSD)"

Description

Percentage of patients, 18-75 years of age and with a diagnosis of Diabetes (Type I or Type II), whose most recent glycemic status [Hemoglobin A1c (HbA1c) or Glucose Management Indicator (GMI)] was at the following levels during the measurement year (i.e., 2025):

- Glycemic Status < 8.0% (BCBSM/BCN only)
- Glycemic Status ≤ 9.0% (BCBSM/BCN, Priority Health)
  - Note: Only the last glycemic status result of the measurement year is considered.

Definition(s)

Patients are identified as having Diabetes by claim/encounter and/or pharmacy data.

- A patient only needs to be identified as having Diabetes by one of the two methods to be included in the measure.
- A patient may be identified as diabetic based on data from the current measurement year (i.e., 2025) and/or the year prior (i.e., 2024).
  - **Claim/Encounter Data**
    - ✓ At least two diagnoses of Diabetes, on different dates of service, during the measurement year (i.e., 2025) or the year prior (i.e., 2024)
    - ✓ Do not include diagnoses reported on laboratory claims.
  - **Pharmacy Data**
    - ✓ Patients who were dispensed insulin or hypoglycemics/antihyperglycemics during the measurement year (i.e., 2025) or the year prior (i.e., 2024)
    - ✓ AND have at least one diagnosis of Diabetes during the measurement year (i.e., 2025) or the year prior (i.e., 2024)
    - ✓ Do not include diagnoses reported on laboratory claims.
- **Glucose Management Indicator (GMI)** approximates the lab A1c level expected based on average glucose measured using continuous glucose monitoring (CGM) values.

Exclusion(s)

<u>Exclude the following patients</u>:

- Those who died or were in hospice, or using hospice or palliative care services, any time during the measurement year (i.e., 01/01/2025 - 12/31/2025)
  - ICD-10 code **Z51.5** can be used to identify a palliative care encounter.
  - Do not include laboratory claims.
- Those, 66 years of age or older as of December 31st of the measurement year (i.e., as of 12/31/2025) who:
  - Were Medicare members enrolled in an Institutional Special Needs Plan (I-SNP) any time during the measurement year (i.e., 01/01/2025 - 12/31/2025)
  - Were Medicare members residing in Long-Term Care any time during the measurement year (i.e., 01/01/2025 - 12/31/2025)
  - Had <u>both</u> Frailty <u>and</u> Advanced Illness
    - ✓ Criteria for both conditions must be met.
    - ✓ Do not include laboratory claims.

  <u>Frailty:</u> At least two indications of Frailty, on different dates of service, during the measurement year (i.e., 2025)
    - ✓ Refer to the "Frailty and Advanced Illness Criteria and Codes" section of this guide.

  <u>Advanced Illness</u>: Either of the following during the measurement year (i.e., 2025) or the year prior (i.e., 2024)
    - ✓ Advanced Illness on at least two different dates of service
    - ✓ <u>OR</u> dispensed Dementia medication
    - ✓ Refer to the "Frailty and Advanced Illness Criteria and Codes" section of this guide.

Denominator

Patients, 18-75 years of age and with a diagnosis of Diabetes, as defined above, not otherwise excluded

Numerator

Patients, from the Denominator, who had a glycemic status lab test, with a documented result, during the measurement year (i.e., 01/01/2025 - 12/31/2025)

- Only the most recent (i.e., last) HbA1c lab or GMI result of the measurement year is considered.
  - The value of the result determines which Numerator(s), if any, is/are satisfied.
  - If there are multiple glycemic status assessments on the same date, use the lowest result.
- Patients are non-compliant if:
  - The glycemic status assessment result is > 8% (BCBSM/BCN only)
  - The glycemic status result is > 9% (BCBSM/BCN & Priority Health.)
  - A glycemic status assessment was not done during the measurement year (i.e., 2025) (BCBSM/BCN &Priority Health)
- Documentation in the medical record should include a dated copy of the lab report.

- In the absence of a lab report, documentation in the medical record must include the date the glycemic status assessment was performed and the result.
- GMI values must include the data date range used to determine the result; the final rate in the range should be used as the date the glycemic status assessment was performed.
- GMI results collected by the patient are acceptable if recorded in the medical record.
- "Unknown" is not considered a valid result.

- The following codes identify the HbA1c lab test:
  - CPT: **83036, 83037**
  - LOINC**: 17855-8, 17856-6, 4548-4, 4549-2, 96595-4**
- The following LOINC code identifies **GMI: 97506-0**
- The following CPT II codes can be added to a claim to report an HbA1c lab value:
  - **3044F** (HbA1c < 7%)
  - **3046F** (HbA1c > 9%)
  - **3051F** (HbA1c > 7% and < 8%)
  - **3052F** (HbA1c > 8% and < 9%)

Method(s) of Measurement

- BCBSM/BCN: Claims processed, electronic supplemental data feeds (e.g., Health Focus, MiHIN, MCIR) and Health-e Blue data entry.
- Priority Health: Claims processed and electronic supplemental data feeds.
  - Note: Priority Health will calculate 2025 performance rates for this measure at the practice level.

Tip(s)

- Review diabetic lab results and services needed at each office visit.
  - Order labs to be completed prior to patient appointments.
  - If possible, provide point-of-care testing in your office to avoid missed lab opportunities.
  - Consider Care Management for patients in poor control.
- Ensure Diabetes Medication Compliance:
  - Determine if the patient is taking medications as ordered.
  - If the patient is missing doses, is there another regimen that may make compliance easier?
  - Is the patient having side effects?
  - Will another treatment regimen reduce side effects?
- Review notes from other providers for outside HbA1c lab results.
  - E.g., if a patient sees an Endocrinologist, check consult notes for fingerprick HbA1c results,
  - Enter the outside lab result AND date of service in a structured data field in your EMR (e.g., lab order).
- Add CPTII codes to claims to report HbA1c values to insurers.
  - This is the quickest and easiest way to close HbA1c gaps with an insurer.

Additional Note(s)

- Priority Health does not incent the A1c <8% component of this measure.

Immunizations for Adolescents

The following is a high-level summary of the measure. The referenced measure source should be consulted for specific questions/details.

Return to Summary Page

Summary of Changes

- HEDIS: The pentavalent meningococcal vaccine was added to the meningococcal vaccine numerator.
- HEDIS: The age range for meningococcal vaccination was extended to 10-13 years.
- Priority Health: Performance will be measured at the practice level for MY 2025.

Measure Source(s)

- HEDIS: "Immunizations for Adolescents (IMA)"

Description

The percentage of adolescents, turning 13 years of age during the measurement year (i.e., 01/01/2025 - 12/31/2025), who completed the Combination 2 vaccine series by the time of their 13th birthday

- Vaccines must be administered on or before the child's 13th birthday to meet criteria, unless indicated otherwise.
- Anaphylaxis and/or history of disease must occur on or before the child's thirteenth birthday to meet criteria.
- Multiple doses for any vaccine must be administered on different dates of service.

Combination 2 consists of the following:

Meningococcal

- Any of the following meet criteria:
  - **1 dose** of quadrivalent meningococcal vaccine (serogroups A, C, W, and Y)
  - OR **1 dose** of pentavalent meningococcal Vaccine (serogroups A, B, C, W, and Y)
    - ✓ Meningococcal vaccination CPT codes: **90619, 90623, 90733, and 90734**
    - ✓ Meningococcal CVX codes: **32, 108, 114, 136, 147, 167, 203, 316**
    - ✓ Administer on or between the patient's 10th and 13th birthdays.
  - OR **Anaphylaxis** due to meningococcal vaccine
- Generic documentation of administration of "meningococcal vaccine", "meningococcal conjugate vaccine", or "meningococcal polysaccharide vaccine" meets criteria.

Tdap

- Any of the following meet criteria:
  - **1 dose** of Tdap (tetanus, diphtheria toxoids and acellular pertussis) vaccine
    - ✓ Tdap vaccination CPT code: **90715**
    - ✓ Tdap CVX code: **115**
    - ✓ Administer on or between the patient's 10th and 13th birthdays.

- OR **Anaphylaxis** due to the tetanus, diphtheria or pertussis vaccine
    - ✓ Tdap Anaphylaxis SNOWMED codes: **428291000124105** and **428281000124107**
- OR **Encephalitis** due to the tetanus, diphtheria or pertussis vaccine
    - ✓ Tdap Encephalitis SNOWMED codes: **192711008**, **192712001**, and **192710009**

HPV

- Any of the following meet criteria:
    - **2 or 3 doses** of the human papillomavirus (HPV) vaccine
        - ✓ HPV vaccination CPT codes: **90649, 90650, 90651**
        - ✓ HPV CVX codes: **62, 118, 137, 165**
        - ✓ Administer on or between the patient's 9th and 13th birthdays.
        - ✓ Valid for both male and female adolescent patients.
        - ✓ For the two-dose HPV vaccination series, there must be at least 146 days between the first and second dose of the HPV vaccine.
    - OR **Anaphylaxis** due to HPV vaccine

Exclusion(s)

Exclude patients who died or were in hospice, or using hospice services, any time during the measurement year (i.e., 01/01/2025-12/31/2025).

Denominator

Adolescent patients 13 years of age by the end of the measurement year (i.e., as of 12/31/2025), not otherwise excluded

- Parent refusal of immunizations does not remove an eligible patient from the Denominator.

Numerator

Patients, from the Denominator, with completed immunizations, as described above

- Documentation in the medical record must include both the name of the vaccination and the date administered.

Method(s) of Measurement

- BCBSM/BCN: Claims processed and immunization data in MCIR
    - MCIR data is downloaded from the State of Michigan monthly.
    - This is a "No Entry" measure in HeB.
- Priority Health:
    - MCIR data is downloaded from the State of Michigan monthly.
    - Note: Priority Health will calculate 2025 performance rates for this measure at the practice level.

Tip(s)

- Use every opportunity to vaccinate;
  - Immunizations given outside of the indicated age range will NOT be valid for HEDIS purposes.
  - Pay attention to birthdates when scheduling vaccination appointments.
  - Review the immunization record before every visit.
  - If applicable, administer needed vaccines at sick visits if the child is behind schedule.
- Make sure all immunizations (even historical ones) are documented in the “Immunization” section of the EHR AND in MCIR.
  - Inquire about vaccines received elsewhere (e.g., Health Department, previous provider)
  - Request previous immunization records for new or recently transferred patients.
  - Obtain a record of the vaccines, if possible.
  - AND update both the patient's outpatient chart and MCIR accordingly.
- Documentation that the patient is "up to date with vaccinations" without a corresponding list of vaccination names and administration dates does NOT meet the criteria for compliance.
- Recommend immunizations to parents. Parents are more likely to agree to vaccinations when recommended by the provider.
- Schedule the appointment for the patient's next vaccination before they leave the office.
- Reminders by mail, email and text have been shown to be effective in increasing immunization rates.
- Parental refusal does NOT meet the criteria for compliance.
- Td (Tetanus, Diphtheria toxoids) does NOT meet the criteria for Tdap.

Immunizations for Adolescents: HPV

The following is a high-level summary of the measure. The referenced measure source should be consulted for specific questions/details.

Return to Summary Page

Summary of Changes

- No changes have been made to this measure.

Measure Source(s):

- HEDIS: "Immunizations for Adolescents (IMA)"

Description

The percentage of adolescents, turning 13 years of age during the measurement year (i.e.,01/01/2025-12/31/2025), who completed the HPV vaccine series by the time of their 13th birthday.

- Vaccines must be administered on or before the child's 13th birthday to meet criteria, unless indicated otherwise.
- Anaphylaxis and/or history of disease must occur on or before the child's thirteenth birthday to meet criteria.
- Multiple doses for the vaccine must be administered on different dates of service.

HPV

- Any of the following meet criteria:
  - **2 or 3 doses** of the human papillomavirus (HPV) vaccine
    - ✓ HPV vaccination CPT codes: **90649, 90650, 90651**
    - ✓ HPV CVX codes: **62, 118, 137, 165**
    - ✓ Administer on or between the patient's 9th and 13th birthdays.
    - ✓ Valid for both male and female adolescent patients.
    - ✓ For the two-dose HPV vaccination series, there must be at least 146 days between the first and second dose of the HPV vaccine.
  - OR **Anaphylaxis** due to HPV vaccine

Exclusion(s)

Exclude patients who died or were in hospice, or using hospice services, any time during the measurement year (i.e., 01/01/2025-12/31/2025).

Denominator

Adolescent patients 13 years of age by the end of the measurement year (i.e., as of 12/31/2025), not otherwise excluded

- Parent refusal of immunizations does not remove an eligible patient from the Denominator.

Numerator

Patients, from the Denominator, with completed HPV immunizations, as described above.

- Documentation in the medical record must include both the name of the vaccination and the date administered.

Method(s) or Measurement

- BCBSM/BCN : Claims processed and update of immunization data in MCIR
    - MCIR data is downloaded from the State of Michigan monthly.
    - This is a "No Entry" measure in HeB.

Tip(s)

- Use every opportunity to vaccinate;
    - Immunizations given outside of the indicated age range will NOT be valid for HEDIS purposes.
    - Pay attention to birthdates when scheduling vaccination appointments.
    - Review the immunization record before every visit.
    - If applicable, administer needed vaccines at sick visits if the child is behind schedule.
- Make sure all immunizations (even historical ones) are documented in the "Immunization" section of the EHR AND in MCIR.
    - Inquire about vaccines received elsewhere (e.g., Health Department, previous provider)
    - Request previous immunization records for new or recently transferred patients.
    - Obtain a record of the vaccines, if possible.
    - AND update both the patient's outpatient chart and MCIR accordingly.
- Documentation that the patient is "up to date with vaccinations" without a corresponding list of vaccination names and administration dates does NOT meet the criteria for compliance.
- Recommend immunizations to parents. Parents are more likely to agree to vaccinations when recommended by the provider.
- Schedule the appointment for the patient's next vaccination before they leave the office.
- Reminders by mail, email and text have been shown to be effective in increasing immunization rates.
- Parental refusal does NOT meet the criteria for compliance.

Additional Note(s)

- In addition to Combo 2, BCBSM/BCN is separately incenting HPV vaccination.

Kidney Health Evaluation for Patients with Diabetes

The following is a high-level summary of the measure. The referenced measure source should be consulted for specific questions/details.

Return to Summary Page

Summary of Changes:

- Priority Health: Performance will be measured at the practice level for MY 2025.

Measure Source(s):

- HEDIS: "Kidney Health Evaluation for Patients with Diabetes (KED)"

Description

The percentage of patients, 18-85 years of age as of December 31st of the measurement year (i.e., as of 12/31/2025) and with a diagnosis of Diabetes (Type I or Type II), who received a kidney health evaluation during the measurement year (i.e., 01/01/2025 - 12/31/2025)

- A kidney health evaluation is defined as follows:
    - o An estimated glomerular filtration rate **(eGFR)** AND
    - o A urine albumin-creatinine ratio **(µACR)** OR
    - o BOTH a quantitative urine microalbumin AND a quantitative urine creatinine

Definition(s)

Patients are identified as having Diabetes by claim/encounter and/or pharmacy data

- A patient only needs to be identified as having Diabetes by one of the two methods to be included in the measure.
- A patient may be identified as diabetic based on data from the current measurement year (i.e., 2025) and/or the year prior (i.e., 2024).
    - o **Claim/Encounter Data**
        - ✓ At least two diagnoses of Diabetes, on different dates of service, during the measurement year (i.e., 2025) or the year prior (i.e., 2024)
        - ✓ Do not include diagnoses reported on laboratory claims
    - o **Pharmacy Data**
        - ✓ Patients who were dispensed insulin or hypoglycemics/antihyperglycemics during the measurement year (i.e., 2025) or the year prior (i.e., 2024)
        - ✓ AND have at least one diagnosis of Diabetes during the measurement year (i.e., 20245) or the year prior (i.e., 2024)
        - ✓ Do not include diagnoses reported on laboratory claims.

Exclusion(s)

Exclude the following patients:

- Those with ESRD, or receiving dialysis services as of December 31st of the measurement year (i.e., on or before 12/31/2025)
    - Do not include laboratory claims
- Those who died or were in hospice, or using hospice or palliative care services, any time during the measurement year (i.e., 01/01/2025 - 12/31/2025)
    - ICD-10 code **Z51.5** can be used to identify a palliative care encounter.
    - Do not include laboratory claims
- Those, 66 years of age or older as of December 31st of the measurement year (i.e., as of 12/31/2025) who:
    - Were Medicare members enrolled in an Institutional Special Needs Plan (I-SNP) any time during the measurement year (i.e., 01/01/2025 - 12/31/2025)
    - Were Medicare members residing in Long-Term Care any time during the measurement year (i.e., 01/01/2025 - 12/31/2025)
- Those 66-80 years of age who had both Frailty and Advanced Illness
    - Criteria for both conditions must be met
    - Do not include laboratory claims

  Frailty: At least two indications of Frailty, on different dates of service, during the measurement year (i.e., 2025)
    - Refer to the "Frailty and Advanced Illness Criteria and Codes" section of this guide.

  Advanced Illness: Either of the following during the measurement year (i.e., 2025) or the year prior (i.e., 2024)
    - Advanced Illness on at least two different dates of service.
    - OR dispensed Dementia medication.
    - Refer to the "Frailty and Advanced Illness Criteria and Codes" section of this guide
- Those 81 years of age and older, as of December 31st of the measurement year (i.e., as of 12/31/20245) who had Frailty alone, as defined above

Denominator

Patients, 18-85 years of age, as of December 31st of the measurement year (i.e., as of 12/31/2025), and with a diagnosis of Diabetes (Type I or Type II), not otherwise excluded

Numerator

Patients, from the Denominator, who received a kidney health evaluation during the measurement year (i.e., 01/01/2025 - 12/31/2025), as evidenced by BOTH of the following:

- **A serum eGFR** (estimated Glomerular Filtration Rate)
    - The following codes identify an eGFR lab test**:**
        - ✓ CPT**: 80047, 80048, 80050, 80053, 80069, 82565**
        - ✓ LOINC**: 50044-7, 50210-4, 50384-7, 62238-1, 69405-9, 70969-1, 77147-7, 94677-2, 98979-8, 98980-6, 102097-3**
- AND a **Urine uACR** (urine albumin-creatinine ratio), which includes BOTH of the following:
    - The following codes identify a urine albumin-creatinine ratio lab test:

    - ✓ LOINC: **13705-9, 14958-3, 14959-1, 30000-4, 44292-1, 59159-4, 76401-9, 77253-3, 77254-1, 89998-9, 9318-7**
- OR a **Quantitative urine albumin** test AND a **urine creatinine test**
  - The following codes identify a quantitative urine albumin test:
    - ✓ CPT: **82043**
    - ✓ LOINC: **100158-5, 14957-5, 1754-1, 21059-1, 30003-8, 43605-5, 53530-2, 53531-0, 57369-1, 89999-7**
  - The following codes identify a urine creatinine test:
    - ✓ CPT: **82570**
    - ✓ LOINC: **20624-3, 2161-8, 35674-1, 39982-4, 57344-4, 57346-9, 58951-5**
  - The service dates for the urine albumin and urine creatinine tests must be less than four days apart.

Method(s) of Measurement

Note: This measure is now an ECDS (Electronic Clinical Data System) measure.

  - Data for ECDS measures is to be reported by electronic means only.
  - ECDS measures do not allow for unstructured data; data must be recorded in a structured data field for accurate reporting
- BCBSM/BCN: Claims processed, electronic supplemental data feeds (e.g., Health Focus, MiHIN, MCIR) and Health-e Blue data entry
  - Note: Despite the ECDS requirement, BCBSM/BCN is allowing manual data entry into Health-e Blue for the 2025 performance year.
- Priority Health: Claims processed and electronic supplemental data feeds.
  - Note: Priority Health will calculate 2025 performance rates for this measure at the practice level.

Tip(s)

- Review diabetic services needed at each office visit.
- Educate patients about the importance of routine screening.
- Order labs to be completed prior to patient appointments.
- Coordinate care with specialists (e.g., endocrinologist, nephrologist), as needed.

Lead Screening in Children

The following is a high-level summary of the measure. The referenced measure source should be consulted for specific questions/details.

Return to Summary Page

Summary of Changes

- Priority Health: Performance will be measured at the practice level for MY 2025.

Measure Source(s):

- HEDIS: "Lead Screening in Children (LSC)"

Description

The percentage of children, two years of age as of December 31st of the measurement year (i.e., as of 12/31/2025), who had one or more capillary or venous lead blood tests for lead poisoning by their second birthday

Exclusion(s)

Exclude patients who died or were in hospice, or using hospice services, any time during the measurement year (i.e., 01/01/2025- 12/31/2025).

Denominator

All children turning 2 years old during the measurement year (i.e., as of 12/31/2024), not otherwise excluded

- This measure applies to Medicaid patients

Numerator

Patients, from the denominator, having at least one capillary or venous blood test to screen for lead poisoning on or before the child's second birthday (i.e., 01/01/2025 - 12/31/2025)

- The following billing and EHR codes identify lead tests:
  - CPT: **83655**
  - LOINC: **10368-9, 10912-4, 14807-2, 17052-2, 25459-9, 27129-6, 32325-3, 5674-7, 77307-7**
- Documentation in the medical record must include both of the following:
  - The date the test was performed
  - The result of the test
  - “Unknown” is not considered a result/finding

Method(s) of Measurement

- Priority Health: Claims processed and electronic supplemental data feeds (e.g., Health Focus, MiHIN, MCIR)
    - Note: Priority Health will calculate 2025 performance rates for this measure at the practice level.

Tip(s)

- Take advantage of every office visit to perform lead testing.
- Consider a standing order for lead testing.
- Order the lead test at the child's one-year well visit and revisit at the 18-month visit, to make sure it gets done before the 2nd birthday.
    - Tests performed AFTER the child's 2nd birthday are NOT valid for HEDIS purposes.
- Document the results of screenings performed at an outside lab, health department, or WIC office in the patient's chart in the EMR.
    - Document data manually entered into the EMR (e.g., patient-reported information, outside test dates and results, etc.) in structured data fields to facilitate accurate reporting from electronic supplemental data feeds (e.g., by Health Focus).
- Educate parents about the dangers of lead poisoning and the importance of testing.

Medication Adherence for Cholesterol

The following is a high-level summary of the measure. The referenced measure source should be consulted for specific questions/details.

Return to Summary Page

Summary of Changes

- Priority Health: Performance will be measured at the practice level for MY 2025.

Measure Source(s)

- 2025 CMS Medicare 5 Star Manual (Medicare 2025 Part C & D Star Ratings Technical Notes)

Description

The percentage of patients, 18 years of age and older and with a prescription for a cholesterol medication (statin drug), who fill their prescription often enough to cover at least 80% of the time they are supposed to be taking the medication

Exclusion(s)

- Exclude patients if any of the following occur, at any time, during the measurement year (i.e., 01/01/2025 - 12/31/2025):
    - They had a diagnosis of End-Stage Renal Disease (ESRD) or received dialysis.
    - They were in hospice or used hospice services.
- Exclusions must be reported annually via claim.

Denominator

Patients, 18 years of age or older, with at least two billed fills of a statin medication on unique dates of service during the measurement year (i.e., 01/01/2025 - 12/31/2025), not otherwise excluded

- Patients are only included in this measure if the first fill of statin medication occurs at least 91 days prior to the end of the enrollment period, measurement period, or death (whichever comes first).
- Prescriptions may be obtained via telehealth, but the patient must still fill the script.

Numerator

Patients, from the Denominator, with a proportion of days covered (PDC) of at least 80% for statin cholesterol medications during the measurement year (i.e., 01/01/2025- 12/31/2025)

- The "proportion of days covered" (PDC) is the percentage of days in the measurement period "covered" by prescription claims for either the same medication or another in its therapeutic class category.

- Days supply that extend into the beginning of the measurement year from a fill from the previous year are not included in the count of percentage of days covered.
- The patient must present his health insurance card with pharmacy benefit at the time of the prescription fill to ensure a pharmaceutical claim is generated.

Method(s) of Measurement

- BCBSM/BCN: Pharmacy claims processed
  - This is a "No-Entry" measure in Health-e Blue.
- Priority Health: Pharmacy claims processed
  - Note: Priority Health will calculate 2025 performance rates for this measure at the practice level.

Tip(s)

- Educate patients about why the medication is being prescribed.
  - Discuss the importance of taking medications as prescribed.
- Use motivational interviewing techniques and open-ended questions to encourage medication adherence and identify barriers to taking medications.
  - Encourage patients to take their medications at the same time each day.
  - Suggest pillboxes and technology such as text messages or reminder apps to help with forgetfulness.
  - Write 90-day supplies of maintenance medications and have your patients use a mail-order pharmacy.
  - Write prescriptions with refills for patients who are stable on their medications to reduce the risk of any time lapse between fills.
- Schedule a follow-up visit within 30 days when prescribing new medication to assess how the medication is working.
  - Instruct patients to call the PCP if they experience adverse medication effects.
- Educate patients to always show their insurance card when filling a prescription.
  - This measure utilizes data from pharmacy claims only.
    - ✓ The prescription must be filled using the patient's health plan pharmacy benefit.
    - ✓ The pharmacy must submit a claim to the insurance company so pharmaceutical data can be captured.
    - ✓ Pharmacies can submit $0.01 claims to the insurance company for free or cash-pay medication fills.
  - Be aware that free medication samples, cash claims, or claims filled through a pharmacy discount program do not satisfy this measure.
    - ✓ The insurer does not receive a pharmacy claim.

Medication Adherence for Diabetes

The following is a high-level summary of the measure. The referenced measure source should be consulted for specific questions/details.

Return to Summary Page

Summary of Changes

- Priority Health: Performance will be measured at the practice level for MY 2025.
- CMS: Incretin Mimetics has been removed from the list of Diabetes drug classes.

Measure Source(s)

- 2025 CMS Medicare 5 Star Manual (Medicare 2025 Part C & D Star Ratings Technical Notes)

Description

The percentage of patients, 18 years of age and older and with a prescription for a Diabetes medication, who fill their prescription often enough to cover at least 80% of the time they are supposed to be taking the medication

- This measure looks at adherence to prescribed drug therapy across the following classes of oral Diabetes medications:
  - Biguanides
  - Dipeptidyl Peptidase 4 (DPP-4) Inhibitors
  - GIP/GLP-1 Receptor Agonist
  - Meglitinides
  - Sodium Glucose Cotransporter (SGLT2) Inhibitors
  - Sulfonylureas
  - Thiazolidinediones

Exclusion(s)

- Exclude patients if any one of the following occurred, at any time, during the measurement year (i.e., 01/01/2024 - 12/31/2024):
  - They filled one or more prescriptions for insulin.
  - They had an End-Stage Renal Disease (ESRD) diagnosis and/or received dialysis.
  - They were in hospice or used hospice services.
- Exclusions must be reported annually via claim.

Denominator

Patients, 18 years of age and older, with at least two billed fills of Diabetes medication(s) (across any of the drug classes of oral diabetes drugs) on unique dates of service during the measurement year (i.e., 01/01/2025 - 12/31/2025), not otherwise excluded

- Patients are only included in this measure if the first fill of Diabetes medication occurs at least 91 days before the end of the enrollment period, measurement period, or death (whichever comes first).
- Prescriptions may be obtained via telehealth, but the patient must still fill the script.

Numerator

Patients, from the Denominator, that have a "proportion of days covered" (PDC) of at least 80% across the classes of oral Diabetes medications during the measurement year (i.e., 01/01/2025 - 12/31/2025)

- The proportion of days covered (PDC) is the percentage of days in the measurement period "covered" by prescription claims for the same medication or another in its therapeutic category.
- Days supply that extend into the beginning of the measurement year from a fill from the previous year are not included in the count of percentage of days covered.
- The patient must present his health insurance card with pharmacy benefit at the time of the prescription fill to ensure a pharmaceutical claim is generated.

Method(s) of Measurement

- BCBSM/BCN: Pharmacy claims processed
  - This is a "No-Entry" measure in Health-e Blue.
- Priority Health: Pharmacy claims processed
  - Note: Priority Health will calculate 2025 performance rates for this measure at the practice level.

Tip(s)

- Educate patients about why the medication is being prescribed.
  - Discuss the importance of taking medications as prescribed.
- Use motivational interviewing techniques and open-ended questions to encourage medication adherence and identify barriers to taking medications.
  - Encourage patients to take their medications at the same time each day.
  - Suggest pillboxes and technology such as text messages or reminder apps to help with forgetfulness.
  - Write 90-day supplies of maintenance medications and have your patients use a mail-order pharmacy.
  - Write prescriptions with refills for patients who are stable on their medications to reduce the risk of any time lapse between fills.
- Schedule a follow-up visit within 30 days when prescribing new medication to assess how the medication is working.
  - Instruct patients to call the PCP if they experience adverse medication effects.
- Educate patients to always show their insurance card when filling a prescription.
  - This measure utilizes data from pharmacy claims only.
    - ✓ The prescription must be filled using the patient's health plan pharmacy benefit.

- ✓ The pharmacy must submit a claim to the insurance company so pharmaceutical data can be captured.
- ✓ Pharmacies can submit $0.01 claims to the insurance company for free or cash-pay medication fills.

- o Be aware that free medication samples, cash claims, or claims filled through a pharmacy discount program do not satisfy this measure.
  - ✓ The insurer does not receive a pharmacy claim.

Medication Adherence for Hypertension

The following is a high-level summary of the measure. The referenced measure source should be consulted for specific questions/details.

Return to Summary Page

Summary of Changes

- Priority Health: Performance will be measured at the practice level for MY 2025.

Measure Source(s):

- 2025 CMS Medicare 5 Star Manual (Medicare 2025 Part C & D Star Ratings Technical Notes)

Description

The percentage of patients, 18 years of age and older and with a prescription for blood pressure medication, who fill their prescription often enough to cover at least 80% of the time they are supposed to be taking the medication

- This measure looks at adherence to prescribed drug therapy across the following classes of renin angiotensin system (RAS) antagonists:
  - Angiotensin Converting Enzyme Inhibitor (ACEI)
  - Angiotensin Receptor Blocker (ARB)
  - Direct Renin Inhibitor

Exclusion(s)

- Exclude patients if any one of the following occur at any time, during the measurement year (i.e., 01/01/2025 - 12/31/2025):
  - They filled one or more prescriptions for sacubitril/valsartan.
  - They had an End-Stage Renal Disease (ESRD) diagnosis or received dialysis.
  - They were in hospice or used hospice services.
- Exclusions must be reported annually via claim.

Denominator

Patients, 18 years of age or older, with at least two fills of blood pressure medication (either the same medication or medications in the same drug class) on unique dates of service during the measurement year (i.e., 01/01/2025 - 12/31/2025), not otherwise excluded

- Patients are only included in this measure if the first fill of RAS antagonist blood pressure medication occurs at least 91 days before the end of the enrollment period, measurement period, or death (whichever comes first).
- Prescriptions may be obtained via telehealth, but the patient must still fill the script.

Numerator

Patients, from the Denominator, with a “proportion of days covered” (PDC) of at least 80% for RAS antagonist blood pressure medications during the measurement year (i.e.,01/01/2025 - 12/31/2025)

- The proportion of days covered (PDC) is the percentage of days in the measurement year "covered" by prescription claims for the same medication or another in its therapeutic category.
- Days’ supply that extend into the beginning of the measurement year from a fill from the previous year are not included in the count of percentage of days covered.
- The patient must present his health insurance card with pharmacy benefit at the time of the prescription fill to ensure a pharmaceutical claim is generated.

Method(s) of Measurement

- BCBSM/BCN: Pharmacy claims processed
  - This is a "No-Entry" measure in Health-e Blue.
- Priority Health: Pharmacy claims processed
  - Note: Priority Health will calculate 2025 performance rates for this measure at the practice level.

Tip(s)

- Educate patients about why the medication is being prescribed.
  - Discuss the importance of taking medications as prescribed.
- Use motivational interviewing techniques and open-ended questions to encourage medication adherence and identify barriers to taking medications.
  - Encourage patients to take their medications at the same time each day.
  - Suggest pillboxes and technology such as text messages or reminder apps to help with forgetfulness.
  - Write 90-day supplies of maintenance medications and have your patients use a mail-order pharmacy.
  - Write prescriptions with refills for patients who are stable on their medications to reduce the risk of any time lapse between fills.
- Schedule a follow-up visit within 30 days when prescribing new medication to assess how the medication is working.
  - Instruct patients to call the PCP if they experience adverse medication effects.
- Educate patients to always show their insurance card when filling a prescription.
  - This measure utilizes data from pharmacy claims only.
    - ✓ The prescription must be filled using the patient’s health plan pharmacy benefit.
    - ✓ The pharmacy must submit a claim to the insurance company so pharmaceutical data can be captured.
    - ✓ Pharmacies can submit $0.01 claims to the insurance company for free or cash-pay medication fills.
  - Be aware that free medication samples, cash claims, or claims filled through a pharmacy discount program do not satisfy this measure.

- ✓ The insurer does not receive a pharmacy claim.

Osteoporosis Management in Women Who Had a Fracture

The following is a high-level summary of the measure. The referenced measure source should be consulted for specific questions/details.

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Summary of Change(s)

- BCBSM/BCN: This measure has been added to the Performance Recognition Program (PRP)

Measure Source(s)

- HEDIS: "Osteoporosis Management in Women Who Had a Fracture (OMW)"

Description

The percentage of women, 67-85 years of age who suffered a fracture, who had either a bone mineral density (BMD) test OR were dispensed a prescription for an osteoporosis medication in the 180 days (6 months) following the date of the fracture

Definition(s)

- Intake Period: July 1st of the year prior to the measurement year (i.e., 07/01/2024) to June 30th of the measurement year (i.e., 06/30/2025)
  - The intake period is used to capture the first fracture.
- Index Episode Start Date (IESD):The earliest date of fracture during the intake period

Exclusion(s)

- Exclude episodes:
  - For fractures of fingers, toes, face or skull
  - Where the patient had another fracture within the 60-day (2-month) period prior to the episode date
    - ✓ Do not include laboratory claims
  - Where the patient had a BMD test within the 730-day (2-year) period prior to the episode date
  - Where the member had an encounter for osteoporosis therapy (i.e., received an injection of an osteoporosis medication) in the 365-day (1-year) period prior to the episode date
  - Where the member received a prescription, or had an active prescription, for an osteoporosis medication in the 365-day (1-year) period prior to the episode date
- Exclude patients:
  - Who died or were in hospice, or using hospice or palliative care services, any time during the measurement year (i.e., 01/01/2025 - 12/31/2025)
    - ✓ ICD-10 code **Z51.5** can be used to identify a palliative care encounter.
    - ✓ Do not include laboratory claims.
- Who were 67-80 years of age and older by the end of the measurement year (i.e., as of 12/31/2025), and:

- Were Medicare members enrolled in an Institutional Special Needs Plan (I-SNP) any time during the measurement year (i.e., 01/01/2025 - 12/31/2025)
- Were Medicare members residing in Long-Term Care any time during the measurement year (i.e., 01/01/2025 - 12/31/2025)
- Had BOTH Frailty AND Advanced Illness

Frailty: At least two indications of Frailty, on different dates of service, during the intake periods through the end of the measurement year (i.e., 07/01/2024 – 12/31/2025)

- ✓ Do not use laboratory claims.
- ✓ Refer to the "Frailty and Advanced Illness Criteria and Codes" section of this guide

Advanced Illness: Either of the following during the measurement year (i.e., 2025) or the year prior (i.e., 2024)

- ✓ Advanced Illness on at least two different dates of service
- ✓ OR dispensed Dementia medication
- ✓ Do not use laboratory claims.
- ✓ Refer to the "Frailty and Advanced Illness Criteria and Codes" section of this guide

- Who were 81 years of age or older by the end of the measurement year (i.e., as of 12/31/2025) with Frailty alone, as defined above, during the intake period through the end of the measurement year (i.e., 07/01/2024 – 12/31/2025)

Denominator

Women, 67-85 years old as of the end of the measurement year (i.e., as of 12/31/2025) who had a fracture during the Intake Period (07/01/2024 – 06/30/2025), not otherwise excluded

Numerator

Patients, from the Denominator who received one of the following on, or within the 180-day (6-month) period following, the date of the eligible fracture (IESD):

- **A bone mineral density test (BMD) in any setting**
  - The following codes identify BMD tests:
    - ✓ ICD-10: **BP48ZZ1, BP49ZZ1, BP4GZZ1, BP4HZZ1, BP4LZZ1, BP4MZZ1, BP4NZZ1, BP4PZZ1, BQ00ZZ1, BPQ01ZZ1, BQ03ZZ1, BQ04ZZ1, BR00ZZ1, BR07ZZ1, BR09ZZ1, BR0GZZ1**
    - ✓ CPT: **76977, 77078, 77080, 77081, 77085, 77086**
- **Receipt of long-acting osteoporosis therapy**
  - The following billing codes identify Osteoporosis medication therapy
    - ✓ HCPCS: **J0897, J1740, J3110, J3111, J3489**
- **A dispensed prescription for an Osteoporosis medication**
  - The following medications are Osteoporosis medications:
    - ✓ Bisphosphanates
      - Alendronate
      - Alendronate-Cholecalciferol
      - Ibandronate
      - Risedronate
      - Zoledronic Acid

- ✓ Other Agents
  - Abaloparatide
  - Denosumab
  - Raloxifene
  - Romosozumab
  - Teriparatide

Method(s) of Measurement

- BCBSM/BCN: Claims processed, electronic supplemental data feeds (e.g., Health Focus, MiHIN, MCIR) and Health-e Blue data entry
  - BMD service dates can be manually entered into HeB.

Tip(s)

- Educate patients on safety and fall prevention.
- Order BMD tests and/or prescribe Osteoporosis medications within 6 months of a fracture.
  - Follow-up with patients who have overdue BMD orders.
  - Help patients resolve barriers to testing.
- If the patient is an inpatient, ask the hospital to perform a BMD test or administer Osteoporosis drug therapy.

PCMH

The following is a high-level summary of the measure. The referenced measure source should be consulted for specific questions/details.

Return to Summary Page

Summary of Changes:

- There are no changes to this measure.

Measure Source(s):

- BCBSM: Internal Designation Program

Description

Patient Centered Medical Home-designated providers are expected to implement infrastructure tools, such as patient registries and test tracking systems, for all patients, regardless of payer. Care processes and services are expected to be made available to all patients whose benefits cover such services.

- An incentive (increase in BCBSM claim reimbursement) is available for practices that become formally recognized as BCBSM PCMH-designated.
  - Practices implement PCMH capabilities
  - A PO nominates a practice for recognition
  - BCBSM analyzes data (including quality and utilization metrics) and assigns a PCMH score to each practice
  - 50% of the score is based on these metrics, and 50% is based on PCMH capabilities.
  - Practices that are nominated for PCMH receive a site-visit from BCBSM to ensure capabilities are in place, as noted.
- BCBSM announces in August of the following year who has received the PCMH designation.
- The PCMH incentive is then effective from 9/1 - 8/31

Tip(s)

- Contact NPO for assistance

Pediatric Weight Management

The following is a high-level summary of the measure. The referenced measure source should be consulted for specific questions/details.

Return to Summary Page

Summary of Changes:

- There are no changes to this measure.

Measure Source(s):

- BCBSM: 12/15/2021 PO Collaboration Call Slide Deck (Custom BCBS measure)

Description

Percentage of patients, 5-17 years of age at the end of the measurement period (i.e., as of 12/31/2025) and an initial diagnosis of "Ever Obese" during the 2-year measurement period (i.e., 01/01/2024 - 12/31/2025) whose subsequent and most recent diagnosis, during the final year of the measurement period (i.e., 01/01/2025 - 12/31/2025) is of a lower, non-obese weight class.

- This measure is a PDCM Outcomes VBR opportunity for pediatric practices.
  - Only pediatric practices achieving at least a 1% PDCM engagement threshold in 2024 are eligible to earn this VBR.
  - Practices reaching the 1% engagement threshold in the prior year (i.e., 2024) are scored on measure performance during the current measurement year (i.e., 2025)
  - PDCM Outcomes VBR is paid as a monthly PaMPM amount beginning September 1st of the year following the current measurement year (i.e., 09/01/2026 - 08/31/2027)
- Eligible pediatric practices may earn VBR for meeting either the performance or improvement goals.
  - Performance Goal: 20% of Ever Obese patients move into the non-obese category year over year.
  - Improvement Goal: 5% improvement (i.e., decrease in diagnosis rate of Ever Obese patients) in current versus previous 2-year measurement period.

Definition(s)

- **Ever Obese**: Patients, 5-17 years of age at the end of the measurement period (i.e., as of 12/31/2025) who had a professional claim submitted with a diagnosis of Pediatric BMI > 95th percentile (ICD-10: **Z68.54**)

- **No Longer Obese**: Patients identified as Ever Obese (during a two-year measurement period) with a subsequent and most recent diagnosis of a lower non-obese weight class (ICD-10: **Z68.51 - Z68.53**) during the final year of the measurement period (i.e., 2025)

- **Measurement Period (Current):** The 2-year period comprised of the current calendar year and the year prior (i.e., 01/01/2024 -12/31/2025)

- **Measurement Period (Baseline):** The 2-year period comprised of the two years prior to the current calendar year (i.e., 01/01/2023 - 12/31/2024)

Performance (Current) Rate = No Longer Obese / Ever Obese

Quality Improvement Rate = (Current Rate - Baseline Rate) / (Potential Highest Rate* - Baseline Rate)

*Potential Highest Rate is determined by the highest performance rate achieved during the previous

Denominator

Patients, 5-17 years of age at the end of the measurement period (i.e., as of 12/31/2025) who had a professional claim submitted with a diagnosis of Pediatric BMI > 95th percentile (ICD-10: Z68.54) during the two-year measurement period (i.e. 01/01/2024 - 12/31/2025)

Numerator

Ever Obese patients, from the Denominator, whose most recent pediatric BMI diagnosis, during the final year of the measurement period (i.e., 01/01/2025 - 12/31/2025) is No Longer Obese (ICD-10: Z68.51 - Z68.53)

Method(s) or Measurement

- BCBSM: Claims processed (BMI Z Codes only)

Tip(s)

- Continue with nutrition and physical activity counseling during well-child visits, as these measures align.

Plan All-Cause Readmissions

The following is a high-level summary of the measure. The referenced measure source should be consulted for specific questions/details.

Return to Summary Page

Summary of Changes

- No changes have been made to this measure.

Measure Source(s)

- HEDIS: "Plan All-Cause Readmissions (PCR)"

Description

The number of acute inpatient and observation stays in the measurement year (I.e., 2025), for patients 18 years of age and older, that were followed by an unplanned readmission, for any diagnosis, within 30 days of the discharge date

- This is an event-based measure; a patient may be counted more than once in the Denominator.
- Note: Lower readmission rates indicate better performance.

Definition(s)

- **Index Hospital Stay (IHS)**: An acute inpatient or observation stay with a discharge occurring between January 1st and December 1st of the measurement year (i.e., 01/01/2025-12/01/2025)

- **Index Readmission Stay**: An acute inpatient or observation stay, for any diagnosis, with an admission date within 30 days of the discharge date for the previous IHS

Exclusion(s)

- **Exclude patients** in hospice, or using hospice services, any time during the measurement year (i.e., 01/01/2025-12/31/2025)

- **Exclude admissions**:
  - That are nonacute inpatient stays (E.g., nursing facility, domiciliary care, rest home and assisted living visits, palliative care, respite care, long-term care, etc.)
  - That have discharge or transfer dates after December 1st of the measurement year (i.e., after 12/01/2025)
  - Where the admission date is the same as the discharge date
  - Where patients died during the hospital stay

    - For patients with a principal diagnosis of pregnancy, or a condition originating in the perinatal period, on the discharge claim
    - That are planned stays for rehabilitation, chemotherapy, or organ transplants
    - That are potentially planned procedures without an acute diagnosis (e.g., bypasses, dilations, drainings, excisions, extractions, etc.)

Denominator

The number of Index Hospital Stays during the measurement year (i.e., 2024) for patients 18 years of age and older, not otherwise excluded

- Distinct inpatient or observation stays are defined by at least 2 calendar days separating the discharge date of the first setting from the admission date of the second setting.

Numerator

The number of Index Hospital Stays (IHS), from the Denominator, where the patient was readmitted, for any reason, within 30 days of the IHS discharge date

Method(s) of Measurement

- BCBSM/BCN: Claims processed

Tip(s)

- Use ADT notifications to monitor patient admissions and discharges.
    - Coordinate with hospitals for effective discharge planning.
    - Obtain patients' discharge summary and test results prior to a follow-up call or visit.
- Follow-up with patients, upon discharge, to provide transitional care and help the patient avoid readmission.
    - Follow-up with patients within 1 week of discharge (or sooner).
    - Keep open appointments so patients who are discharged from the hospital can be seen in a timely manner.
    - Schedule same-day appointments when possible.
    - Utilize telehealth for follow-up visits if appropriate.
- Review discharge instruction and medications with patients and caregivers.
    - Review when/how to take medications.
    - Instruct patients when to call the provider.
    - Discuss any challenges the patient may have post-discharge and assist them as needed.
        - ✓ E.g., transportation issues
        - ✓ E.g., DME needs
- Consider Care Management services for patients with frequent Urgent Care or Emergency Room visits or hospitalizations.

Risk of Continued Opioid Use

The following is a high-level summary of the measure. The referenced measure source should be consulted for specific questions/details.

Return to Summary Page

Summary of Changes

- There are no changes to this measure.

Measure Source(s)

- HEDIS: "Risk of Continued Opioid Use (COU)"

Description

The percentage of patients, 18 years of age and older, who are at risk for continued opioid use due to a new episode of opioid use

- The following rate is reported: The percentage of patients with at least 15 days of prescription opioids in a 30-day period

Definition(s)

- Intake Period: The 12-month period starting on November 1st of the year prior to the measurement year (i.e., 11/01/2024) and ending on October 31st of the measurement year (i.e., 10/31/2025)

- IPSD (Index Prescription Start Date): The earliest opioid prescription dispensation date during the Intake Period

- Negative Medication History: The 6 months (180 days) prior to the IPSD during which the patient had no claims for opioid medication fills/refills

Exclusion(s)

Exclude the following patients:

- Those who were dispensed a prescription opioid medication in the 6 months (180 days) prior to the IPSD (positive medication history)
- Those who had any of the following in the 365 days prior to, through 61 days after, the IPSD:
  - Cancer
  - Sickle Cell Disease
  - Do not include laboratory claims.

- Those who died or were in hospice, or using hospice or palliative care services, any time during the measurement year (i.e., 01/01/2025- 12/31/2025)
    - ICD-10 code **Z51.5** can be used to identify a palliative care encounter.
    - Do not include laboratory claims.

Denominator

Patients, 18 years of age or older and with a negative medication history, who were dispensed a prescription opioid medication during the Intake Period (IPSD), not otherwise excluded

Numerator

Patients, from the Denominator, who had 15 or more calendar days covered by a prescription opioid medication during the 30 days beginning on, and through 29 days after, the IPSD

- To calculate the number of days covered by an opioid medication:
    - Identify each dispensing event for an Opioid medication.
        - ✓ If multiple prescriptions for the same opioid medication are dispensed with overlapping days' supply, assume the patient will take one prescription at a time and sum the total days' supply.
        - ✓ For all others, assume the patient will take different medications concurrently.
    - Identify the start and end dates for each unique dispensation event.
        - ✓ Start Date: The date of the earliest medication dispensing event
        - ✓ End Date: Start Date + total days' supply -1
    - Count the covered calendar days (Start Date through End Date).
    - Consider each calendar day covered by one or more opioid medication to be 1 covered day.
- The following opioid medications are EXCLUDED from this measure:
    - Injectables
    - Opioid-containing cough and cold products
    - Buprenorphine products used as part of medication-assisted treatment (MAT) for opioid use disorder
    - Ionsys® (fentanyl transdermal patch)
    - Methadone for treatment of opioid use disorder

Method(s) of Measurement

- BCBSM/BCN: Pharmacy claims processed
    - This is a "No Entry" measure in Health-e Blue.

Tip(s)

- Review the necessity and appropriateness of opioid use at every encounter with patients using these medications.
    - Consider other options (i.e., first-line or non-pharmacologic agents) for pain management before prescribing an opioid medication.
    - Use the lowest effective opioid dose for the shortest period possible.
    - Use the Michigan Automated Prescription System (MAPS) to ensure patients are not receiving opioid prescriptions from multiple providers.
    - Educate patients on opioid safety and the risks associated with use.
- Report exclusion diagnosis codes via claim annually.
- Refer to the "CDC Guideline for Prescribing Opioids" (cdc.gov) for the latest opioid research and guidelines.

Risk-Standardized, All-Condition Readmission

The following is a high-level summary of the measure. The referenced measure source should be consulted for specific questions/details.

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Summary of Changes

- ACO REACH:
  - The codes in the diagnosis and procedure value sets were updated.

Measure Source(s):

- ACO Realizing Equity, Access and Community Health (REACH) Measure Information Form: "Risk-Standardized, All-Condition Readmission" (Effective 01/01/2025)

Description

The risk-adjusted percentage of hospitalizations during the measurement year (i.e., 2025), for ACO REACH-aligned Medicare FFS beneficiaries 65 years of age and older, that resulted in an unplanned readmission to a hospital with 30 days of a previous discharge.

- This is an event-based measure; a patient may be counted more than once in the Denominator.
- Note: Lower readmission rates indicate better performance.

Exclusion(s)

- **Exclude** the following **patients**:
  - Non-claims-based-aligned ACO REACH patients that voluntarily aligned after 01/01/2025
- **Exclude** the following types of **admissions** (Denominator exclusions):
  - Those for patients without 30 days of post-discharge data
  - Those for patients not continuously enrolled in Medicare Part A for the 12 months prior to the date of admission
  - Those for patients discharged "Against Medical Advice (AMA)"
  - Those for patients admitted for cancer treatments, psychiatric conditions, or rehabilitation
  - Those for patients who died during the stay
- **Exclude** the following types of **readmissions** (Numerator exclusion)
  - Those for planned procedures (e.g., transplants, chemotherapy, and other cancer treatments, etc.)
  - Those to psychiatric or rehabilitation facilities

Denominator

All eligible hospitalizations, for ACO REACH patients 65 years of age and older, at non-federal, short-stay, acute-care or critical access hospitals during the measurement year (i.e., 2025), not otherwise excluded

- Admissions are eligible for inclusion in the Denominator if the following criteria are met:
  - The patient is 65 years of age or older and an ACO REACH aligned Medicare FFS beneficiary.
  - The patient was discharged, alive, from a non-federal acute-care hospital.
  - The patient was not transferred to another acute care facility upon discharge.
  - The patient was enrolled in Medicare Part A on, and for the 12 months prior to, the date of the index admission.
- Multiple continuous hospitalizations are considered a single acute episode of care.

Numerator

The number of risk-adjusted, unplanned readmissions, at a non-federal, short-stay, acute-care or critical access hospital, occurring within 30 days of the discharge date for the hospitalization event included in the Denominator.

- Readmission to the index hospital, on the same date of discharge and with the <u>same</u> principal diagnosis, is considered a single continuous admission event.
- However, readmission to the index hospital, on the same date of discharge and with a <u>different</u> principal diagnosis, is considered a readmission event.
- Readmissions for transferred patients are attributed to the hospital that discharges the patient to a non-acute-care setting.

Method(s) or Measurement

- <u>ACO REACH Medicare</u>: Claims processed.

Tip(s)

- Use ADT notifications to monitor patient admissions and discharges and coordinate transition of care.
  - Coordinate with hospitals for effective discharge planning.
  - Obtain patients' discharge summary with medication list, test results, and discharge instructions prior to a follow-up call or visit.
- Follow-up with patients, upon discharge, to provide transitional care and help the patient avoid readmission.
  - Follow-up with patients within 1 week of discharge (or sooner).
  - Keep open appointments so patients who are discharged from the hospital can be seen in a timely manner.
  - Schedule same-day appointments when possible.

    - Utilize telehealth for follow-up visits if appropriate.
- Review discharge instruction and medications with patients and caregivers.
    - Ensure the patient understands the discharge instructions.
    - Review when/how to take medications.
    - Instruct patients when to call the provider.
    - Discuss any challenges the patient may have post-discharge and assist them as needed.
        - ✓ E.g., transportation issues
        - ✓ E.g., DME needs
- Consider Care Management services for patients with frequent Urgent Care or Emergency Room visits or hospitalizations.

Statin Therapy for Patients with Cardiovascular Disease: Received Statin Therapy

The following is a high-level summary of the measure. The referenced measure source should be consulted for specific questions/details.

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Summary of Changes

- Priority Health: Performance will be measured at the practice level for MY 2025.
- HEDIS: “Muscular Reactions to Statins” have been added as exclusions.
    - These conditions are identified by SNOWMED codes.
    - These are lifetime statin exclusions.

Measure Source(s)

- HEDIS "Statin Therapy for Patients with Cardiovascular Disease (SPC)"

Description

The percentage of male patients, 21–75 years of age, and female patients, 40–75 years of age, who were identified as having clinical Atherosclerotic Cardiovascular Disease (ASCVD) and received Statin therapy (had at least one dispensing event for a high- or moderate-intensity statin medication) during the measurement year (i.e., 01/01/2025 - 12/31/2025)

Definition(s)

Clinical Atherosclerotic Cardiovascular Disease (ASCVD) includes:

- Acute coronary syndromes
- History of myocardial infarction (MI)
- Stable or unstable angina
- Coronary or other arterial revascularization
- Stroke or transient ischemic attack (TIA)
- Peripheral artery disease of atherosclerotic origin

Patients are identified as having ASCVD by the following methods:

- **Events** - Patients which had one of the following during the year prior to the measurement year: (i.e., 01/01/20254 - 12/31/2024)
    - Discharge from an inpatient setting with an MI on the discharge claim
    - A Coronary Bypass Artery Grafting (CABG), Percutaneous Coronary Intervention (PCI) or revascularization procedure in any setting
    - Do not include laboratory claims.
- **Diagnosis** - Patients with a diagnosis of Ischemic Vascular Disease (IVD) who had at least one of the following during both the measurement year (2025) and the year prior (2024):

- At least one outpatient, telephone, or e-visit, or online assessment (e.g., virtual check-in) with an IVD diagnosis
- At least one inpatient encounter with an IVD diagnosis (without telehealth)
- At least one acute inpatient discharge with a diagnosis of IVD on the discharge claim
- Criteria may differ across years.
- Do not include laboratory claims.

Exclusion(s)

Exclude the following patients:

- Those with a diagnosis of pregnancy or undergoing in vitro fertilization during the measurement year (i.e., 2025) or the year prior (i.e., 2024)
    - Do not include laboratory claims.
- Those dispensed at least one prescription for clomiphene during the measurement year (i.e., 2025) or the year prior (i.e., 2024)
- Those with ESRD or receiving dialysis during the measurement year (i.e., 2025) or the year prior (i.e., 2024)
    - Do not include laboratory claims.
- Those with Cirrhosis during the measurement year (i.e., 2025) or the year prior (i.e., 2024)
    - Do not include laboratory claims.
- Those with Rhabdomyolysis, myalgia, myositis or myopathy during the measurement year (i.e., 2025)
    - Do not include laboratory claims.
    - The following ICD-10 codes identify patients unable to tolerate statin medications:
        - ✓ Myalgia: **M79.10, M79.11, M79.12, M79.18**
        - ✓ Myositis: **M60.80, M60.811, M60.812, M60.819, M60.821, M60.822, M60.829, M60.831, M60.832, M60.839, M60.841, M60.842, M60.849, M60.851, M60.852, M60.859, M60.861, M60.862, M60.869, M60.871, M60.872, M60.879, M60.88, M60.80, M60.9**
        - ✓ Myopathy: **G72.0, G72.2, G72.9**
        - ✓ Rhabdomyolysis: **M62.82**
- Those with Myalgia or Rhabdomyolysis CAUSED by a statin any time in the patient's history through December 31st of the measurement year (i.e., as of 12/31/2025)
    - The following SNOWMED codes identify Muscular Reactions to Statins:
        - ✓ **16524291000119105** (History of Myalgia Caused by Statin – Situation),
        - ✓ **16524331000119104** (History of Rhabdomyolysis Due to Statin – Situation),
        - ✓ **16462851000119106** (Myalgia Caused by Statin – Finding), and
        - ✓ **787206005** (Rhabdomyolysis Due to Statin – Disorder)
- Those 66 years of age and older during the measurement year (i.e., as of 12/31/2025), who:
    - Were Medicare members enrolled in an Institutional Special Needs Plan (I-SNP) any time during the measurement year (i.e., 01/01/2025 - 12/31/2025)
    - Were Medicare members residing in Long-Term Care any time during the measurement year (i.e., 01/01/2025 - 12/31/2025)
    - Had BOTH Frailty AND Advanced Illness

- ✓ Do not include laboratory claims.

Frailty: At least two indications of Frailty, on different dates of service, during the measurement year (i.e., 2025)

- ✓ Refer to the "Frailty and Advanced Illness Criteria and Codes" section of this guide

Advanced Illness: Either of the following during the measurement year (i.e., 2025) or the year prior (i.e., 2024)

- ✓ Advanced Illness on at least two different dates of service
- ✓ OR dispensed Dementia medication
- ✓ Refer to the "Frailty and Advanced Illness Criteria and Codes" section of this guide

- Those who died or were in hospice, or using hospice or palliative care services, any time during the measurement year (i.e., 01/01/2025 - 12/31/2025)
  - ICD-10 code **Z51.5** can be used to identify a palliative care encounter.
  - Do not include laboratory claims.

Denominator

Patients (males 21-75 years of age and females 40-75 years of age) with a diagnosis of ASCVD, as described above and not otherwise excluded

Numerator

Patients, from the Denominator, who had at least one dispensing event for a high- or moderate-intensity statin medication during the measurement year (i.e., 01/01/2025 - 12/31/2025)

- Only statin therapy (NOT other cholesterol-lowering medications) meets the criteria for the Numerator.
- Statin prescription or order does not need to be linked to an encounter or visit; it may be called to a pharmacy.
- Prescriptions may also be obtained via telehealth (but the patient must fill the script).
- The patient must present his health insurance card with pharmacy benefit at the time of the prescription fill to ensure a pharmaceutical claim is generated.

Method(s) of Measurement

- BCBSM/BCN: Pharmacy claims processed
- Priority Health: Pharmacy claims generated
  - Note: Priority Health will calculate 2025 performance rates for this measure at the practice level.

Tip(s)

- Consider placing all ASCVD patients on a statin medication.

    - Review medications at every visit.
    - Integrate statin therapy into encounters with ASCVD patients.
- Educate patients on the benefits of statin therapy in preventing cardiac events.
- Discuss the importance of medication compliance.
    - Let patients know that side effects may go away, or lessen, after they take the medication for a while.
    - Patients should call the Provider's office if side effects continue to be bothersome, as dosage may need to be reduced, or medication changed.
    - Try a different statin medication, or a brief period of discontinuation, if the patient reports myalgias.
    - Pravastatin, Fluvastatin and Rosuvastatin may present fewer side effects.
- Write prescriptions for 90-day supplies for patients able to tolerate the statin therapy.
    - Encourage the use of a mail-order pharmacy.
    - Be aware that free medication samples, cash claims, or claims filled through a pharmacy discount program do not satisfy this measure, as the insurer does not receive a pharmacy claim).
    - Educate patients to always have the pharmacy submit a claim to the insurance company when a prescription is filled so insurers can capture the pharmaceutical data.
    - Pharmacies can submit $0.01 claims to the insurance company for free or cash-pay medication fills.
- Documentation of the exclusion(s) can occur via Telehealth, telephone visits, e-visits or online assessments (e.g., virtual check-in).
    - Document in the medical record, any reason for which the patient was NOT prescribed, or is NOT taking a statin medication.
    - Report the exclusion diagnosis codes via claim on an annual basis.

Statin Therapy for Patients with Diabetes: Received Statin Therapy

The following is a high-level summary of the measure. The referenced measure source should be consulted for specific questions/details.

Return to Summary Page

Summary of Changes

- HEDIS: “Muscular Reactions to Statins” have been added as exclusions.
    - These conditions are identified by SNOWMED codes.
    - These are lifetime statin exclusions.

Measure Source(s)

- HEDIS "Statin Therapy for Patients with Diabetes (SPD)"

Description

The percentage of patients, 40-75 years of age and with a diagnosis of Diabetes (Type I or Type II) but NOT clinical Atherosclerotic Cardiovascular Disease (ASCVD), who were dispensed at least one statin medication of any intensity during the measurement year (i.e., 01/01/2025 - 12/31/2025)

Definition(s)

Patients are identified as having Diabetes by claim/encounter and/or pharmacy data.

- A patient only needs to be identified as having Diabetes by one of the two methods to be included in the measure.
- A patient may be identified as diabetic based on data from the current measurement year (i.e., 2025) and/or the year prior (i.e., 2024).
    - **Claim/Encounter Data**
        - ✓ At least two diagnoses of Diabetes, on different dates of service, during the measurement year (i.e., 2025) or the year prior (i.e., 2024)
        - ✓ Do not include diagnoses reported on laboratory claims.
    - **Pharmacy Data**
        - ✓ Patients who were dispensed insulin or hypoglycemics/antihyperglycemics during the measurement year (i.e., 2025) or the year prior (i.e., 2024)
        - ✓ AND have at least one diagnosis of Diabetes during the measurement year (I.e., 2025) or the year prior (i.e., 2024)
        - ✓ Do not include diagnoses reported on laboratory claims.

Exclusion(s)

Exclude the following patients:

- Those who had a diagnosis of Polycystic Ovarian syndrome, Steroid-Induced Diabetes, or Gestational Diabetes, but no diagnosis of Diabetes (Type I or II) in the measurement year (i.e., 2025) or the year prior (i.e., 2024)
- Those who had at least one of the following during the year prior to the measurement year (i.e., 2024):
  - An MI (discharged from an inpatient setting with an MI diagnosis on the discharge claim)
  - A CABG, PCI, or other revascularization procedure in any setting
- Those who had at least one encounter with a diagnosis of Ischemic Vascular Disease (IVD) during both the measurement year (i.e., 2025) and the year prior to the measurement year (i.e., 2024):
  - The following encounter types meet criteria:
    - ✓ An acute inpatient encounter
    - ✓ An acute inpatient discharge with a diagnosis of IVD on the discharge claim
    - ✓ An outpatient visit, telephone visit, e-visit, or online assessment (i.e., virtual check-in)
- Those with a diagnosis of ESRD, cirrhosis or pregnancy during the measurement year (i.e., 2025) or the year prior (i.e., 2024)
  - Do not include laboratory claims
- Those receiving dialysis or in vitro fertilization during the measurement year (i.e., 2025) or the year prior (i.e., 2024)
- Those dispensed at least one prescription for clomiphene during the measurement year (i.e., 2025) or the year prior (i.e., 2024)
- Those with Myalgia, Myositis, Myopathy or Rhabdomyolysis during the measurement year (i.e., 2025)
  - Do not include laboratory claims.
  - The following ICD-10 codes identify patients unable to tolerate statin medications:
    - ✓ Myalgia: **M79.10, M79.11, M79.12, M79.18**
    - ✓ Myositis: **M60.80, M60.811, M60.812, M60.819, M60.821, M60.822, M60.829, M60.831, M60.832, M60.839, M60.841, M60.842, M60.849, M60.851, M60.852, M60.859, M60.861, M60.862, M60.869, M60.871, M60.872, M60.879, M60.88, M60.80, M60.9**
    - ✓ Myopathy: **G72.0, G72.2, G72.9**
    - ✓ Rhabdomyolysis**: M62.82**
- Those with Myalgia or Rhabdomyolysis CAUSED by a statin any time in the patient's history through December 31st of the measurement year (i.e., as of 12/31/2025)
  - The following SNOWMED codes identify Muscular Reactions to Statins:
    - ✓ **16524291000119105** (History of Myalgia Caused by Statin – Situation),
    - ✓ **16524331000119104** (History of Rhabdomyolysis Due to Statin – Situation),
    - ✓ **16462851000119106** (Myalgia Caused by Statin – Finding), and
    - ✓ **787206005** (Rhabdomyolysis Due to Statin – Disorder)
- Those, 66 years of age and older, as of December 31st of the measurement year (i.e., as of 12/31/2024), who:
  - Were Medicare members enrolled in an Institutional Special Needs Plan (I-SNP) any time during the measurement year (i.e., 01/01/2025- 12/31/2025)

   - Were Medicare members residing in Long-Term Care any time during the measurement year (i.e., 01/01/2025 - 12/31/2025)
   - Had BOTH Frailty AND Advanced Illness
     - ✓ Do not include laboratory claims.

   Frailty: At least two indications of Frailty, on different dates of service, during the measurement year (i.e., 2025)
     - ✓ Refer to the "Frailty and Advanced Illness Criteria and Codes" section of this guide

   Advanced Illness: Either of the following during the measurement year (i.e., 2025) or the year prior (i.e., 2024)
     - ✓ Advanced Illness on at least two different dates of service
     - ✓ OR dispensed a Dementia medication
     - ✓ Refer to the "Frailty and Advanced Illness Criteria and Codes" section of this guide
- Those who died or were in hospice, or using hospice or palliative care services, any time during the measurement year (i.e., 01/01/2025 - 12/31/2025)
   - Do not include laboratory claims.
   - ICD-10 code **Z51.5** can be used to identify a palliative care encounter.

Denominator

The number of patients, 40-75 years of age and with a diagnosis of Diabetes but not ASCVD, not otherwise excluded

Numerator

The number of patients, from the Denominator, who had at least one dispensing event for a high, moderate, or low-intensity, statin medication during the measurement year (i.e., 01/01/2025 - 12/31/2025)

- Only statin therapy (NOT other cholesterol-lowering medications) meets the criteria for the Numerator.
- The statin prescription or order does not need to be linked to an encounter or visit; it may be called to a pharmacy.
- Prescriptions may also be obtained via telehealth (but the patient must fill the script).
- The patient must present their health insurance card with pharmacy benefit at the time of the prescription fill to ensure a pharmaceutical claim is generated.

Method(s) of Measurement

- BCBSM: Pharmacy claims processed

Tip(s)

- Consider placing all diabetic patients on a statin medication.

- Review medications at every visit.
- Integrate statin therapy into encounters with diabetic patients.

- Educate patients on the benefits of statin therapy in preventing cardiac events.
- Discuss the importance of medication compliance.
  - Let patients know that side effects may go away, or lessen, after they take the medication for a while.
  - Patients should call the Provider's office if side effects continue to be bothersome, as dosage may need to be reduced, or medication changed.
  - Try a different statin medication, or a brief period of discontinuation, if the patient reports myalgias.
  - Pravastatin, Fluvastatin and Rosuvastatin may present fewer side effects.
- Write prescriptions for 90-day supplies for patients able to tolerate the statin therapy.
  - Encourage the use of a mail-order pharmacy.
  - Be aware that free medication samples, cash claims, or claims filled through a pharmacy discount program do not satisfy this measure, as the insurer does not receive a pharmacy claim).
  - Educate patients to always have the pharmacy submit a claim to the insurance company when a prescription is filled so insurers can capture the pharmaceutical data.
  - Pharmacies can submit $0.01 claims to the insurance company for free or cash-pay medication fills.
- Documentation of the exclusion(s) can occur via Telehealth, telephone visits, e-visits or online assessments (e.g., virtual check-in).
  - Document in the medical record, any reason for which the patient was <u>NOT</u> prescribed, or is <u>NOT</u> taking a statin medication.
  - Report the exclusion diagnosis codes via claim on an annual basis.

Statin Use in Persons with Diabetes

The following is a high-level summary of the measure. The referenced measure source should be consulted for specific questions/details.

Return to Summary Page

Summary of Changes

- Priority Health: Performance will be measured at the practice level for MY 2025.

Measure Source(s)

- 2025 CMS Medicare 5 Star Manual (Medicare 2025 Part C & D Star Ratings Technical Notes)

Description

Patients, 40-75 years of age, who were dispensed at least two Diabetes medication fills (on different dates of service) AND received a statin medication fill (dispensed at least one statin medication of any intensity) during the measurement year (i.e., 2025)

Exclusion(s)

- **Exclude patients** with any of the following, at any time, during the measurement year (i.e., 2025):
  - ESRD - ICD-10: **I12.0, I13.11, I13.2, N18.5, N18.6, N19, Z91.15, Z99.2)** or Dialysis
  - Rhabdomyolysis and Myopathy - ICD-10: **G72.0, G72.89, G72.9, M60.80, M60.819, M60.829, M60.839, M60.849, M60.859, M60.869, M60.879, M60.9, M62.82**
  - Polycystic Ovarian Syndrome (PCOS) - ICD-10: **E28.2**
  - Pre-Diabetes - ICD-10: **R73.03, R73.09**
  - Cirrhosis/Liver Disease - ICD-10: **K70.30, K70.31, K71.7, K74.3, K74.4, K74.5, K74.60. K74.69**
  - Pregnancy – ICD-10: **O00.101-O9A.519, Z33.1, Z33.3, Z34.00, Z34.01, Z34.02, Z34.03, Z34.80, Z34.81, Z34.82, Z34.83, Z34.90, Z34.91, Z34.92, Z34.93**
  - Lactation and Fertility (ICD-10**: O91.03, O91.13, O91.23, O92.03, O92.13, O92.5, O92.70, O92.79, Z39.1**
  - Hospice enrollment, or use of hospice services
- Exclusions must be reported annually via claim.

Denominator

Patients, 40-75 years of age and with Medicare coverage, with at least two Diabetes medication fills on different dates of service during the measurement year (i.e., 01/01/2025 - 12/31/2025), not otherwise excluded

- Patients are only included if the first fill of their Diabetes medication occurs at least 90 days prior to the end of the measurement period or enrollment episode.

Numerator

Patients, from the Denominator, who received a statin medication fill (any intensity) during the measurement year (i.e., 01/01/2025 - 12/31/2025)

- Only statin therapy (NOT other cholesterol-lowering medications) meets the criteria for the Numerator.
- The statin prescription or order does not need to be linked to an encounter or visit; it may be called to a pharmacy.
- Prescriptions may also be obtained via telehealth (but the patient must fill the script).
- The patient must present their health insurance card with pharmacy benefit at the time of the prescription fill to ensure a pharmaceutical claim is generated.

Method(s) of Measurement

- BCBSM/BCN: Pharmacy claims processed
  - This is a "No-Entry" measure in Health-e Blue.
- Priority Health: Pharmacy claims processed
  - Note: Priority Health will calculate 2025 performance rates for this measure at the practice level.

Tip(s)

- Consider placing all diabetic patients on a statin medication.
  - Review medications at every visit.
  - Integrate statin therapy into encounters with diabetic patients.
- Educate patients on the benefits of statin therapy in preventing cardiac events.
- Discuss the importance of medication compliance.
  - Let patients know that side effects may go away, or lessen, after they take the medication for a while.
  - Patients should call the Provider's office if side effects continue to be bothersome, as dosage may need to be reduced, or medication changed.
  - Try a different statin medication, or a brief period of discontinuation, if the patient reports myalgias.
  - Pravastatin, Fluvastatin and Rosuvastatin may present fewer side effects.
- Write prescriptions for 90-day supplies for patients able to tolerate the statin therapy.
  - Encourage the use of a mail-order pharmacy.
  - Be aware that free medication samples, cash claims, or claims filled through a pharmacy discount program do not satisfy this measure, as the insurer does not receive a pharmacy claim).
  - Educate patients to always have the pharmacy submit a claim to the insurance company when a prescription is filled so insurers can capture the pharmaceutical data.

    - Pharmacies can submit $0.01 claims to the insurance company for free or cash-pay medication fills.
- Documentation of the exclusion(s) can occur via Telehealth, telephone visits, e-visits or online assessments (e.g., virtual check-in).
    - Document in the medical record, any reason for which the patient was NOT prescribed, or is NOT taking a statin medication.
    - Report the exclusion diagnosis codes via claim on an annual basis.

Timely Follow-Up After Acute Exacerbations of Chronic Conditions

The following is a high-level summary of the measure. The referenced measure source should be consulted for specific questions/details.

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Summary of Changes

- ACO REACH:
  - Acute events for patients participating in the "Guiding an Improved Dementia Experience"(GUIDE) model are excluded.
  - CPT codes for additional outpatient follow-up visit types have been added (e.g., telephone services, online assessments).

Measure Source(s)

- ACO Realizing Equity, Access and Community Health (REACH) Measure Information Form: Timely Follow-Up After Acute Exacerbations of Chronic Conditions (Effective 01/01/2025)

Description

The percentage of acute exacerbation events that require an ED visit, observation or inpatient hospital stay for treatment of any of 6 chronic disease conditions (Asthma, CAD, COPD, Diabetes, HF, HTN), for Medicare FFS ACO REACH-aligned beneficiaries, where the patient received a follow-up visit within the timeframe recommended by clinical practice guidelines, as follows:

- Asthma
  - Follow-up within **14 days** of the date of discharge
- Coronary Artery Disease (CAD)
  - Follow-up within **7 days** of the date of discharge for **high**-acuity patients
  - Follow-up within **6 weeks** of the date of discharge for **low**-acuity patients
- Chronic Obstructive Pulmonary Disease (COPD)
  - Follow-up within **30 days** of the date of discharge
- Diabetes
  - Follow-up within **14 days** of the date of discharge for **high**-acuity patients
    - ✓ Only high-acuity Diabetes conditions are included in this measure.
- Heart Failure (HF)
  - Follow-up within **14 days** of the date of discharge
- Hypertension (HTN)
  - Follow-up within **14 days** of the date of discharge for **high**-acuity patients
  - Follow-up within **30 days** of the date of discharge for **medium**-acuity patients
    - ✓ Only high- and medium-acuity Hypertension conditions are included in this measure.

Exclusion(s)

- **Exclude** the following **events**:
  - Subsequent acute events, for the same condition, which occur up to 2 days after, but still during the follow-up period for, the initial event
    - ✓ To prevent double counting, only the first event is included in the Denominator.
  - Acute events after which the patient does not have continuous enrollment for two months
    - ✓ All conditions except low-acuity CAD, which requires three months of continuous enrollment
  - Acute events where the discharge status is not "to community"
    - ✓ E.g., the patient "left against medical advice"
  - Acute events for which the calendar year ends before the follow-up window ends
  - Acute events where the patient enters a skilled nursing facility (SNF) or non-acute care or hospice care within the follow-up interval
  - Acute events for non-claims-based-aligned patients who voluntarily aligned to an ACO REACH entity after 01/01/2025
  - Acute events for patients participating in the "Guiding an Improved Dementia Experience" (GUIDE) model

Denominator

The sum of ACO REACH-level acute exacerbation events, for any of the 6 chronic conditions listed above and occurring during the current measurement year (i.e., 2025), that required either an ED visit, observation visit, or inpatient hospital stay, not otherwise excluded

- If a discharge for an acute exacerbation event is followed by another acute exacerbation event on, or within 1 day after, the date of discharge, the discharges are considered part of the same continuous event.
  - The final discharge date marks the start of the follow-up period.
  - If multiple events comprising one continuous acute exacerbation event are assigned to different chronic disease conditions, the follow-up period for the final event is recognized.

Numerator

The sum of events, from the Denominator, where follow-up was received within the timeframe recommended by clinical practice guidelines, as detailed above

- A timely follow-up visit is defined as a non-emergency outpatient visit for the same unique patient after the acute event discharge.
- Follow-up visits include general office or home visits (face-to-face or telehealth), chronic care management services and transitional care management services.
- CPT and HCPCS codes identifying services that, when provided within the chronic disease-specific follow-up timeframe, satisfy the Numerator for this measure include, but are not limited to, the following:

CPT/HCPCS	Description
[90957-90962, 90965, 90966, 90969, 90970]*	End-Stage Renal Disease (ESRD)-related services
96160*	Administration of patient-focused health risk assessment instrument
[96164, 96165, 96167, 9616]*	Health behavior intervention, group/family
[97129, 97130]*	Therapeutic interventions that focus on cognitive function
[97151, 97152]*	Behavior identification assessment
[97802-97804]*	Medical nutrition therapy, individual/group
[98960-98962, G0270]*	Education and training for patient self-management, individual/group
[98966-98968]*	Telephone assessment and management services
[98970-98972]*	Nonphysician online digital assessment and management services
99091*	Collection and interpretation of physiologic data (e.g., blood pressures, glucose monitoring) transmitted by the patient/caregiver to the provider
[99202-99205]*	Office or outpatient E&M, new patient
[99211-99215]*	Office or outpatient E&M, established patient
99242-99245	Office consultation, new or established patient
99381-99387	Initial comprehensive preventive medicine E&M
99391-99397	Periodic comprehensive preventive medicine E&M
99401-99404, 99411, 99412	Preventive medicine counseling, individual/group
[99421-99423, G2061-G2063]*	Online digital E&M service
99429	Unlisted preventive medicine service
[99441-99443]*	Telephone E&M service conducted by provider
[99453, 99454, 99457, 99458]*	Remote monitoring of physiological parameters
99455-99456	Work-related or medical disability exam
[99473, 99474]*	Self-measured blood pressure- education and treatment
99487, 99489	Complex chronic care management services
99490, 99491	Chronic care management services
[99495, 99496]*	Transitional care management services
[99497, 99498]*	Advance Care Planning
[G0108, G0109]*	Diabetes outpatient self-management training, individual/group
G0402, [G0438-G0439]**	Annual Wellness Visit
[G0406-G0408]*	Follow-up inpatient consultation
[G0425 – G0427]*	Telehealth consultation, ED or initial inpatient
G0463	Hospital outpatient clinic visit
G0511	General care management, RHC/FQHC
G0512	Psychiatric collaborative care management, RHC/FQHC
G2001-G2009, G2013	Post-discharge home visits
G2014, G2015	Post-discharge care plan
T1015	Clinic visit/encounter, all-inclusive

* Some or all components may be completed by telehealth

Method(s) of Measurement

- ACO REACH Medicare: Claims processed

Tip(s)

- Use ADT notifications to monitor patient admissions and discharges and coordinate transition of care.
    - Coordinate with hospitals for effective discharge planning.
    - Obtain patients' discharge summary with medication list, test results, and discharge instructions prior to a follow-up call or visit.
- Follow-up with patients, upon discharge, to provide transitional care and help the patient avoid readmission.
    - Follow-up with patients within 1 week of discharge (or sooner).
    - Keep open appointments so patients who are discharged from the hospital can be seen in a timely manner.
    - Schedule same-day appointments when possible.
    - Utilize telehealth for follow-up visits if appropriate.
- Review discharge instruction and medications with patients and caregivers.
    - Ensure the patient understands the discharge instructions.
    - Review when/how to take medications.
    - Instruct patients when to call the provider.
    - Discuss any challenges the patient may have post-discharge and assist them as needed.
        - ✓ E.g., transportation issues
        - ✓ E.g., DME needs
- Consider Care Management services for patients with frequent Urgent Care or Emergency Room visits or hospitalizations.

Transitions of Care: Medication Reconciliation Post-Discharge

The following is a high-level summary of the measure. The referenced measure source should be consulted for specific questions/details.

Return to Summary Page

Summary of Changes

- No changes have been made to this measure.

Measure Source(s):

- HEDIS: "Transitions of Care (TRC)".

Description

The following rate is reported: The percentage of inpatient discharges in the measurement year (i.e., 2025), for patients 18 years of age and older, where medications were reconciled on, or within 30 days of, the date of discharge (31 days total.)

- Note: This is an event-based measure; patients may appear in the denominator more than once.
- For patients with multiple eligible discharges, medication reconciliation must be performed after each discharge event.

Definition(s)

- Medication Reconciliation: A type of review in which the discharge medications are reconciled with the most recent medication list in the outpatient medical record.

Exclusion(s)

Exclude patients who died or were in hospice, or using hospice services, any time during the measurement year (i.e., 01/01/2025 - 12/31/2025).

Denominator

Patients, 18 years of age and older as of December 31st of the measurement year (i.e.,12/31/2025) who had an acute or non-acute inpatient discharge between January 1st and December 1st of the measurement year (i.e., 01/01/2025 - 12/01/2025), not otherwise excluded

- If a discharge is followed by a readmission or direct transfer to an acute or non-acute inpatient care setting on the date of, or within 30 days after, the date of discharge, count only the last discharge.
- If the admission and discharge date(s) for an acute inpatient stay occur between the admission and discharge dates for a non-acute inpatient stay, count only the non-acute discharge.

- Exclude both the initial and readmission/direct transfer discharges if the final discharge for the event occurs after December 1st of the measurement year (i.e., after 12/01/2025).

Numerator

Patients, from the Denominator, for which medication reconciliation was conducted by a prescribing practitioner, clinical pharmacist, or registered nurse (RN) on the date of discharge through 30 days after discharge (31 total days)

- Documentation in the medical record must include:
  - Evidence that inpatient and outpatient medication lists were reconciled
  - Date the medication reconciliation was completed
  - Name and credentials of staff member completing medication reconciliation
  - Signature of prescribing practitioner, clinical pharmacist, or registered nurse, if medication reconciliation was performed by an unlicensed staff member (e.g., MA, CNA etc.)
  - Current medication list and documentation that the medications were compared to the discharge medication list and reconciled.
- Examples include, but are not limited to, any of the following:
  - Documentation of current medication list with notation stating that both current and discharge medications were reconciled.
  - Documentation of current medication list with a notation that references the discharge medications (e.g., "no change in medications since discharge", same medications at discharge, "discontinue all discharge medications")
  - Documentation of the current medication list plus discharge medication list plus notation stating both lists were reviewed on the same date of service.
  - Documentation of the current medication list with evidence that the patient was seen for a post-hospitalization follow-up with evidence of medication reconciliation
    - ✓ There must also be evidence in the medical record that the provider was aware of the hospitalization/discharge.
  - Notation that no medications were prescribed or ordered upon discharge.
  - Discharge summary with notation that medication reconciliation was performed between discharge medication list and most recent medication list in the patient's outpatient chart
    - ✓ The discharge summary must be filed in the patient's chart within 30 days of discharge.
- Other practice staff can complete the medication reconciliation as long as one of the above provider types reviews and signs off on it in the medical record.
- Medication reconciliation/review performed without the member present meets criteria.
- The following CPT codes, when billed on a claim for a DOS within 30 days of discharge, will close this measure gap:
  - **1111F**: Discharge medications are reconciled with the current medication list in the outpatient medical record; face-to-face visit not required for billing
  - **99483**: Assessment and care planning for a patient with cognitive impairment; requires an array of assessments and evaluations, including medication reconciliation and review

- **99495**: Transitional care management - moderate complexity; requires communication with patient within 2 business days of discharge and a face-to-face visit within 14 days of discharge
- **99496**:Transitional care management - high complexity; requires communication with patient within 2 business days of discharge and a face-to-face visit within 7 days of discharge

Method(s) of Measurement

- BCBSM/BCN: Claims processed and electronic supplemental data feeds (e.g., Health Focus)
  - This is a "No Entry" measure in Health-e Blue.

Tip(s)

- Use ADT notifications to monitor patient admissions and discharges and coordinate transition of care.
  - Coordinate with hospitals for effective discharge planning.
  - Obtain patients' discharge summary with medication list, test results, and discharge instructions prior to a follow-up call or visit.
- Review discharge instructions and medications with patients and caregivers.
  - Ensure the patient understands the discharge instructions.
  - Review when/how to take medications.
  - Medication reconciliation does NOT require a face-to-face visit.
    - ✓ It can be completed via telehealth or telephone.
    - ✓ However, e-visits and virtual check-ins are NOT allowed.
  - Any clinical staff member can perform medication reconciliation.
    - ✓ Ensure the medication reconciliation is reviewed and/or completed and signed by a prescribing provider, clinical pharmacist, PA, NP or RN.
- Submit code **1111F** on a claim whenever medication reconciliation is completed.
  - Don't wait for all components of a TCM (99495, 99496) or care planning (99483) visit to be completed before reporting medication reconciliation.
  - There is nothing restricting the billing of both a TCM or care planning code and the 1111F medication reconciliation code for the same discharge event.
  - If a TCM or care planning code is billed after the 1111F code has already been submitted on a claim, the care services will still be eligible for reimbursement.
  - The codes to report medication reconciliation must be submitted on a claim with a date of service no later than 30 days post-discharge.
  - If TCM services are being provided, medication reconciliation must be completed on, or prior to, the date of the face-to-face visit.
  - Billing the medication reconciliation CPT code (1111F)can reduce the number of HEDIS medical record requests from a health plan.
- The TCM (CPT **99495, 99496**) and Care Planning service (CPT **99483**) codes will satisfy BOTH the Patient Engagement and Medication Reconciliation Post-Discharge TRC requirements.

Transitions of Care: Patient Engagement

The following is a high-level summary of the measure. The referenced measure source should be consulted for specific questions/details.

Return to Summary Page

Summary of Changes

- No changes have been made to this measure.

Measure Source(s):

- HEDIS: "Transitions of Care (TRC)"

Description

The following rate is reported: The percentage of discharges in the measurement year (i.e., 2025), for patients 18 years of age and older, where there is documentation of patient engagement (e.g., office visits, visits to the home, telehealth, etc.) provided within 30 days after, but NOT including, the discharge date

- Note: This is an event-based measure; patients may appear in the denominator more than once.

Exclusion(s)

Exclude patients who died or were in hospice, or using hospice services, any time during the measurement year (i.e., 01/01/2025 - 12/31/2025)

Denominator

Patients, 18 years of age and older as of December 31st of the measurement year (i.e., 12/31/2025) who had an acute or non-acute inpatient discharge between January 1st and December 1st of the measurement year (i.e., 01/01/2025 - 12/01/2025), not otherwise excluded

- If a discharge is followed by a readmission or direct transfer to an acute or non-acute inpatient care setting on the date of, or within 30 days after, the date of discharge, count only the last discharge.
- If the admission and discharge dates for an acute inpatient stay occur between the admission and discharge dates for a non-acute inpatient stay, count only the non-acute discharge.
- Exclude both the initial and readmission/direct transfer discharges if the final discharge for the event occurs after December 1st of the measurement year (i.e., after12/01/2025).

Numerator

Discharge events, from the Denominator, where patient engagement occurred within the 30 days post-discharge.

- Do NOT include patient engagement that occurs on the date of discharge.
- Any of the following meets the criteria for patient engagement:
  - Outpatient visit (office or home)
  - Transitional Care Management (TCM) services
  - Telephone visit
  - Telehealth Visit (real-time audio and video interaction) between the provider and patient/caregiver
  - E-visit or virtual check-in (two-way interaction that was not real-time) between the provider and patient/caregiver
  - CPT and HCPCS codes identifying services that, when provided within the chronic disease- specific follow-up timeframe, satisfy the Numerator for this measure include, but are not limited to, the following:

CPT/HCPCS	Description
98966-98968	Telephone assessment and management services
98970-98972	Nonphysician online digital assessment and management services
98980-98981	Remote therapeutic monitoring/treatment
99202-99205	Office or outpatient E&M, new patient
99211-99215	Office or outpatient E&M, established patient
99242-99245	Office consultation, new or established patient
99341, 99342, 99344, 99345, 99347-99350	Home visit E&M, new/established patient
99381-99387	Initial comprehensive preventive medicine E&M
99391-99397	Periodic comprehensive preventive medicine E&M
99401-99404, 99411, 99412	Preventive medicine counseling, individual/group
99421-99423	Online digital E&M service
99429	Unlisted preventive medicine service
99441-99443	Telephone E&M service conducted by provider
99455, 99456	Work-related or medical disability exam
99457, 99458	Remote patient monitoring service
99483	Assessment/care planning for a patient with cognitive impairment
99495, 99496	Transitional care management services
G0071	Payment for communication technology-based services, RHC/FQHC
G0402, G0438, G0439	Annual Wellness Visit
G0463	Hospital outpatient clinic visit
G2010, G2250	Remote evaluation/assessment of recorded video and/or images submitted by an established patient
G2012, G2251, G2252	Brief communication technology-based service, e.g. virtual check-in
T1015	Clinic visit/encounter, all-inclusive

- Documentation in the medical record that indicates a live conversation was had with the patient will meet criteria, regardless of provider type.
  - For example, Medical Assistants (MAs) and RNs may perform the patient engagement.

    - If the provider is unable to communicate with the patient, interaction with the patient's caregiver will meet criteria.

Method(s) of Measurement

- BCBSM/BCN: Claims processed
    - This is a "No-Entry" measure in Health-e Blue.

Tip(s)

- Use ADT notifications to monitor patient admissions and discharges and coordinate transition of care.
    - Coordinate with hospitals for effective discharge planning.
    - Obtain patients' discharge summary with medication list, test results, and discharge instructions prior to a follow-up call or visit.
- Follow-up with patients, upon discharge, to provide transitional care and help the patient avoid readmission.
    - Follow-up with patients within 1 week of discharge (or sooner).
        - ✓ The TCM (CPT **99495**, **99496**) and Care Planning service (CPT **99483**) codes will satisfy BOTH the Patient Engagement and Medication Reconciliation Post-Discharge TRC requirements.
        - ✓ TCM codes do not have to be held until the end of the service period; they can be billed as early as the date of the face-to-face visit.
    - Keep open appointments so patients who are discharged from the hospital can be seen in a timely manner.
    - Schedule same-day appointments when possible.
    - Utilize telehealth for follow-up visits if appropriate.
- Review discharge instruction and medications with patients and caregivers.
    - Ensure the patient understands the discharge instructions.
    - Review when/how to take medications.
    - Instruct patients when to call the provider.
    - Discuss any challenges the patient may have post-discharge and assist them as needed.
        - ✓ E.g., transportation issues
        - ✓ E.g., DME needs
- Consider Care Management services for patients with frequent hospitalizations.

Use of Imaging Studies for Low Back Pain

The following is a high-level summary of the measure. The referenced measure source should be consulted for specific questions/details.

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Summary of Changes

- HEDIS: Specific visit types have been removed from identification of the Denominator population.
  - A diagnosis of Uncomplicated Low Back Pain, in conjunction with any outpatient encounter type (that does not result in an inpatient stay), now qualifies the patient for the Denominator.
- HEDIS: Osteoporosis diagnoses have been added as measure exclusions.

Measure Source(s)

- HEDIS: "Use of Imaging Studies for Low Back Pain (LBP)"

Description

The percentage of patients, 18-75 years of age and with a primary diagnosis of Uncomplicated Low Back Pain, who did NOT have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis

- This is an inverse measure.
  - If the rate is reported as Numerator/Denominator, a lower score indicates better performance (i.e., fewer patients DID HAVE an imaging study for low back pain).
  - If the rate is reported as [1-(Numerator/Denominator)], a higher score indicates better performance (i.e., more patients DID NOT HAVE an imaging study for low back pain).

Definition(s)

- Intake Period: January 1-December 3 of the measurement year (i.e., 01/01/2025- 12/03/2025)
  - The Intake Period is used to identify the first eligible encounter with a primary diagnosis of Uncomplicated Low Back Pain.
- IESD (Index Episode Start Date): The earliest date of service for any eligible encounter during the Intake Period with a primary diagnosis of Uncomplicated Low Back Pain
- Negative Diagnosis History: The 6 months (180 days) prior to the IESD where the patient had no claims/encounters with a diagnosis of Uncomplicated Low Back Pain

Exclusion(s)

Exclude the following patients:

- Those with a diagnosis of Uncomplicated Low Back Pain during the 180 days (6 months) prior to the IESD (positive diagnosis history)
  - Do not include laboratory claims.

- Those for which imaging is clinically appropriate, as defined below (*Do not include laboratory claims*):
  - Those with any of the following occurring any time in the patient's history through 28 days after the IESD:
    - ✓ Cancer
    - ✓ HIV
    - ✓ Osteoporosis (disease and/or prescription dispensation)
    - ✓ Major Organ Transplant
    - ✓ Lumbar Surgery
    - ✓ Spondylopathy
  - Those with any of the following occurring any time from 365 days prior, through 28 days after, the IESD:
    - ✓ Intravenous Drug Abuse
    - ✓ Neurologic Impairment
    - ✓ Spinal Infection
  - Those with Prolonged Use of Corticosteroids
    - ✓ Prolonged Corticosteroid treatment is defined as 90 consecutive days of corticosteroid use any time during the 365 days prior to, and ending on, the IPSD.
  - Those with any of the following occurring any time from 90 days prior, through 28 days after, the IESD:
    - ✓ Recent Trauma
    - ✓ Fragility Fracture
- Those 66 years of age or older as of December 31st of the measurement year (i.e., as of 12/31/2025), who had BOTH Frailty AND Advanced Illness
  - Criteria for both conditions must be met.
  - Do not include laboratory claims.

  Frailty: At least two indications of Frailty, on different dates of service, during the measurement year (i.e., 2025)
  - Refer to the "Frailty and Advanced Illness Criteria and Codes" section of this guide.

  Advanced Illness: Either of the following during the measurement year (i.e., 2025) or the year prior (i.e., 2024)
  - Advanced Illness on at least two different dates of service
  - OR dispensed a Dementia medication
  - Refer to the "Frailty and Advanced Illness Criteria and Codes" section of this guide.
- Those who died or were in hospice, or using hospice or palliative care services, any time during the measurement year (i.e., 01/01/2025 - 12/31/2025)
  - ICD-10 code **Z51.5** can be used to indicate the provision of palliative care services.
  - Do not include laboratory claims.

Exclude encounters that result in an inpatient stay.

Denominator

Patients, 18 to 75 years of age as of December 31st of the measurement year (i.e., as of 12/31/2025) and with a negative diagnosis history, who had an encounter with a primary diagnosis of Uncomplicated Low Back Pain during the Intake Period (IESD), not otherwise excluded

- Eligible encounters for the IESD include any of the following (with a principal diagnosis of Uncomplicated Low Back Pain)
  - An outpatient or ED visit
  - An osteopathic or chiropractic manipulative treatment
  - A physical therapy visit
  - A telephone visit, e-visit or virtual check-in

Numerator

Patients, from the Denominator, with documentation in the medical record of an imaging study (plain X-ray, MRI, CT scan) conducted on, or within 28 days after, the IESD

- Documentation of an imaging study must include the date and result of the study.

Method(s) of Measurement

- BCBSM/BCN: Claims processed
  - This is a "No Entry" measure in Health-e Blue.

Tip(s)

- Utilize NPO Low Back Pain Protocol: https://www.npoinc.org/for-physicians/physician-clinical-education/ (scroll down as necessary)
- Avoid imaging for Low Back Pain for patients with no indication of an underlying condition.
- Have the patient make a one-month follow-up, as most patients with low back pain improve in one month.
- Consider self-care treatments (heat/ice, non-narcotic pain relievers, stretches etc.) and/or physical therapy referral before ordering imaging studies.
- If ordering an imaging study within 6 weeks of the onset of back pain, and an exclusion applies, be sure to code the exclusion in addition to the diagnosis of low back pain.
  - Exclusion codes need to be reported, via claim, annually.

Use of Multiple Anticholinergic Medications in Older Adults

The following is a high-level summary of the measure. The referenced measure source should be consulted for specific questions/details.

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Summary of Change(s)

- BCBSM/BCN: This is a new Pharmacy measure.
  - This measure is "DISPLAY ONLY" for 2025

Measure Source(s)

- Pharmacy Quality Alliance (PQA): "PQA Quality Measures" (2024)
- BCBSM/BCN: 2025 STAR Measure Tip Sheet "Polypharmacy: Use of Multiple Anticholinergic Medications in Older Adults (Poly-ACH)"

Description

The percentage of patients, 65 years of age and older, with an overlapping days' supply (≥ 30 days) of two or more unique anticholinergic medications

- This is an inverse measure; a lower rate indicates better performance.

Exclusion(s)

- Exclude patients in hospice or receiving hospice services any time during the measurement year (i.e., 2025)

Denominator

The number of patients, 65 years of age and older during the measurement year (i.e., 2025) with ≥2 claims for the same anticholinergic medication, not otherwise excluded

Numerator

Patients, from the Denominator, with concurrent use of ≥2 unique anticholinergic medications filled for a ≥30-day supply on different dates of service

- Compliance is determined by avoiding 30 or more days of overlapping prescription fills
- The following medications are included in this measure:
  - Antidepressants
    - ✓ Amitriptyline
    - ✓ Amoxapine
    - ✓ Clomipramine
    - ✓ Desipramine
    - ✓ Doxepin (>6 mg/day)
    - ✓ Imipramine
    - ✓ Nortriptyline

        - ✓ Paroxetine
    - Antiemetics
        - ✓ Prochlorperazine
        - ✓ Promethazine
    - Antihistamines
        - ✓ Brompheniramine
        - ✓ Chlorpheniramine
        - ✓ Cyproheptadine
        - ✓ Dimenhydrinate
        - ✓ Diphenhydramine (oral)
        - ✓ Doxylamine
        - ✓ Hydroxyzine
        - ✓ Meclizine
        - ✓ Triprolidine
    - Antimuscarinics
        - ✓ Darifenacin
        - ✓ Fesoterodine
        - ✓ Flavoxate
        - ✓ Oxybutynin
        - ✓ Solifenacin
        - ✓ Tolterodine
        - ✓ Trospium
    - Antiparkinsonian agents
        - ✓ Benztropine
        - ✓ Trihexyphenidyl
    - Antipsychotics
        - ✓ Chlorpromazine
        - ✓ Clozapine
        - ✓ Olanzapine
        - ✓ Perphenazine
    - Antispasmodics
        - ✓ Atropine
        - ✓ Clidinium-Chlordiazepoxide
        - ✓ Dicyclomine
        - ✓ Homatropine
        - ✓ Hyoscyamine
        - ✓ Scopolamine
    - Skeletal muscle relaxants
        - ✓ Cyclobenzaprine
        - ✓ Orphenadrine

Method(s) of Measurement

- BCBSM/BCN: Pharmacy claims processed

Tip(s)

- Older adults taking multiple anticholinergic medications concurrently have increased risk for cognitive decline (e.g., Dementia) and falls.
- Review the patient's medications at every visit.
  - Discuss the risks and side effects of anticholinergic medications.
  - Discontinue anticholinergics that are not medically necessary.
  - Evaluate potential adverse effects of anticholinergic medications
    - ✓ Confusion
    - ✓ Dry mouth
    - ✓ Blurry vision
    - ✓ Constipation
    - ✓ Urinary retention
    - ✓ Decreased perspiration
    - ✓ Excess sedation
  - Use non-anticholinergic alternatives, when possible, for medical issues such as musculoskeletal pain and overactive bladder.
  - Continue long-term co-prescribing only if necessary, and monitor patients closely.

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

The following is a high-level summary of the measure. The referenced measure source should be consulted for specific questions/details.

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Summary of Changes:

- No changes have been made to this measure.

Measure Source(s):

- HEDIS: "Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)"

Description

The percentage of patients, 3–17 years of age, who had an outpatient visit with a PCP or OB/GYN during the measurement year (i.e., 2025) AND had had evidence of the following:

- **Documentation of BMI percentile**
- **Counseling for nutrition or referral for nutrition education**
- **Counseling for physical activity or referral for physical activity**

Definition(s)

- BMI (Body mass index): A statistical measure of the weight of a person scaled according to height
- BMI Percentile: The percentile ranking based on the CDC's BMI-for-age growth charts, which indicates the relative position of the patient's BMI number among those of the same age and gender.

Exclusion(s)

Exclude the following patients:

- Those with a pregnancy diagnosis during the measurement year (i.e., 01/01/2025 - 12/31/2025)
- Those who died or were in hospice, or using hospice services, any time during the measurement year (i.e., 01/01/2025 - 12/31/2025)

Denominator

Patients, 3-17 years of age as of December 31st of the measurement year (i.e., as of 12/31/2025), who had an outpatient visit with a PCP or OB/GYN during the measurement year (i.e., 01/01/2025 - 12/31/2025), not otherwise excluded

Numerator

Patients, from the Denominator, who had evidence of each of the following during the measurement year (i.e., 01/01/2024 - 12/31/2024):

BMI Percentile

- Documentation must include:
    - Date of the visit,
    - Height
    - Weight
    - BMI percentile
        - ✓ The height, weight and BMI percentile must be from the same data source.
- The following, when present in the patient's medical record, meets the criteria for BMI percentile:
    - BMI percentile documented as a distinct value
        - ✓ E.g., 85th percentile or 85%
    - BMI percentile plotted on an age-growth chart
        - ✓ Note: Ranges and thresholds do NOT meet the Numerator criteria with the exception of >99% or <1% because a distinct BMI percentile is evident (i.e., 100% or 0%, respectively).
- Height and weight measurements, reported by the patient/parent during a telehealth or telephone visit, e-visit or online assessment (i.e., virtual check-in), are acceptable if documented, by the Provider, in the patient's medical record.
- The following ICD-10 codes can be submitted, on a claim, to identify BMI percentile:
    - **Z68.51**: BMI percentile <5% for age
    - **Z68.52**: BMI percentile 5% to < 85% for age
    - **Z68.53**: BMI percentile 85% to 95% for age
    - **Z68.54**: BMI percentile >95% for age
    - Do not include laboratory claims.
- Common documentation errors include:
    - Not documenting height, weight, and BMI percentile at least once each year
    - Documenting BMI percentile without height and/or weight
    - Documenting height and weight only without BMI percentile
    - Documenting the BMI as a value instead of as a percentile
    - Documenting BMI percentile as a range or threshold
    - BMI percentile plotted on an age-growth chart missing the patient's name, DOB, and/or date of visit

Counseling for Nutrition

- Documentation must include a note indicating the date and at least one of the following:
    - Discussion of current nutrition behaviors (e.g., eating habits, dieting behaviors)
    - Checklist indicating that nutrition was addressed
    - Counseling or referral for nutrition education (includes referrals to WIC)
    - Patient received educational materials on nutrition during a face-to-face visit
    - Anticipatory guidance for nutrition

- Weight, eating disorder or obesity counseling

- Counseling may be delivered during a telehealth or telephone visit, e-visit, or online assessment (e.g., virtual check-in).
- Submit any of the following codes, on a claim, to identify nutrition counseling:
    - ICD-10: **Z71.3**
    - CPT: **97802, 97803, 97804**
    - HCPCS: **G0270-G0271, G0447, S9449, S9452, S9470**
    - Do not include laboratory claims.
- Common documentation errors include:
    - Documentation of "well-nourished", or other descriptions related to a patient's "appetite" without specific mention of nutrition counseling
    - Documentation of encouragement for a "healthy lifestyle" without reference to nutrition
    - Notation of "health education" or "anticipatory guidance" provided without specific reference to nutrition
    - Documentation specific to the treatment of an acute or chronic condition does not meet criteria for compliance
        - ✓ E.g., patient has decreased appetite due to the flu
    - Not coding for nutrition counselling provided during a sick visit
    - Screening forms or checklists that are not completed or missing references to nutrition counseling

Counseling for Physical Activity

- Documentation must include a note indicating the date and at least one of the following:
    - Discussion of current physical activity behaviors
        - ✓ E.g., exercise routine
        - ✓ E.g., participation in sports activities
        - ✓ E.g., exam for sports participation
    - Checklist indicating that physical activity was addressed
    - Counseling or referral for physical activity.
    - Educational materials on physical activity provided and reviewed during a face-to-face visit
    - Anticipatory guidance specific to the child's physical activity
    - Weight, eating disorder or obesity counseling
- Counseling may be delivered during a telehealth or telephone visit, e-visit, or online assessment (e.g., virtual check-in)
- Submit any of the following codes, on a claim, to identify physical activity counseling:
    - ICD-10: **Z02.5, Z71.82**
    - HCPCS: **G0447, S9451**
    - Do not include laboratory claims.
- Common documentation errors include:
    - Notations such as "cleared for gym class", or those solely related to screen time (computer or television), without mention of, or discussion about, physical activity recommendations
    - Counseling on safety (e.g., "wears helmet") without reference to physical activity recommendations

- Documentation of encouragement for a “healthy lifestyle” without reference to physical activity education or guidelines
- Notation on “screen time” limits without specific reference to physical activity
- Documentation of developmental milestones without reference to physical activity
- Notation of “health education” or “anticipatory guidance” provided without specific reference to physical activity
- Documentation specific to the treatment of an acute or chronic condition does not meet criteria for compliance
  - ✓ E.g., patient cannot run due to exercise-induced asthma
- Not coding for physical activity counseling provided during a sick visit
- Screening forms or checklists that are not completed or missing references to physical activity counseling

Method(s) of Measurement

- BCBSM/BCN: Claims processed, electronic supplemental data feeds (e.g., Health Focus, MiHIN, MCIR) and Health-e Blue data entry

Tip(s)

- Weight assessment and counseling for physical activity and nutrition can be completed at any appointment (preventive or sick), including telephone, telehealth, or e-visits.
- Document height, weight, and BMI percentile in the note for every visit.
- For patients aged 3-17 years, a BMI percentile plotted on a growth chart, NOT a BMI value, meets compliance criteria.
- Add the appropriate billing (CPT, HCPCS) and diagnosis (ICD-10) codes to claims to report services rendered.

Well-Child Visits in the First 30 Months of Life

The following is a high-level summary of the measure. The referenced measure source should be consulted for specific questions/details.

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Summary of Changes:

- Priority Health: Both rates are incented for the 2025 measurement year.
- Priority Health: Performance will be measured at the practice level for MY 2025
- HEDIS: Telehealth well-visits (telehealth visits, telephone visits, and online assessments) no longer meet criteria for Numerator compliance.

Measure Source(s):

- HEDIS: "Well-Child Visits in the First 30 Months of Life (W30)"

Description

The percentage of patients who had the following number of well-child visits with a PCP during the last 15 months. The following rates are reported:

- **Well-Child Visits for Age 0 - 15 Months**
  - Children who turned 15 months of age during the measurement year (i.e., 2025)
  - **Six or more well-child visits,** on different dates of service, on or before the child's 15-month birthday
- **Well-Child Visits for Age 15 - 30 Months**
  - Children who turned 30 months of age during the measurement year (i.e., 2025)
  - **Two or more well-child visits**, on different dates of service, between the child's 15-month birthday (plus 1 day) and the 30-month birthday

Exclusion(s)

Exclude patients who died or were in hospice, or using hospice services, anytime during the measurement year (i.e., 01/01/2025 - 12/31/2025).

Denominator

Children turning either 15 months or 30 months of age during the measurement year (i.e., 01/01/2025 - 12/31/2025), not otherwise excluded

Numerator

Patients, from the Denominator, who had the requisite number of well-child visits, as defined above

- The well-child visit must occur with a PCP, but the PCP does not have to be the assigned practitioner.
- The visit must be in-person
  - Telehealth visits (including telephone visits and online assessments) no longer meet criteria for Numerator compliance.
- Documentation of the components (below) of the well-care visit:
  - Can be completed any time during the measurement year
  - Can be completed on separate visits,
    - ✓ BUT services specific to the assessment or treatment of an acute or chronic condition do not count towards the measure
    - ✓ If a sick patient comes in and is due for a well-child visit, document the components of the well-child visit in the encounter and report the problem-oriented E&M service with the 25-modifier.
    - ✓ Documentation must support that both services were provided distinctly and in their entirety.
    - ✓ Visits must be at least 14 days apart to count as separate events.
- Documentation must include:
  - A note indicating a visit to a PCP
  - The date when the well-child visit occurred
  - AND evidence of all of the following

Health History:

- Note past illnesses, surgeries, hospitalizations, and family history of disease.
- Documentation of all three of the following components is needed to constitute a comprehensive health history:
  - ✓ Allergies
  - ✓ medications,
  - ✓ Immunization status

Physical Developmental History:

- Assess age-appropriate physical developmental milestones.
- Documentation of "well-developed", "well-nourished", "well-appearing", or "appropriate for age", without specific mention of physical developmental milestones, does not meet compliance criteria.
- Notation of just the Tanner stage or scale does not meet compliance criteria.

Mental Developmental History:

- Assess age-appropriate mental developmental milestones.
- Documentation of "behavior appropriate for age", "neurological exam", or "well-developed", without specific mention of mental developmental milestones, does not meet compliance criteria.

Physical Exam:

- Comprehensive physical assessment, including height, weight, and BMI percentile.
- Documentation of just vital signs does not meet compliance criteria.

Health Education or Anticipatory Guidance:

- Information given to parents/guardians in anticipation of emerging issues the child/family may face.

- However, this does not include information pertaining to medications, immunizations, or their side effects.
    - Handouts given, without evidence of discussion, also do not meet compliance criteria.
- The diagnosis and billing codes below can be used to identify **Well-Child Visits**:
    - ICD-10CM: **Z00.00, Z00.01**, **Z00.110, Z00.111, Z00.121, Z00.129, Z00.2, Z00.3, Z01.411, Z01.419, Z02.5, Z02.84, Z76.1, Z76.2**
    - CPT: **99381, 99382, 99391, 99392, 99461**
    - HCPCS**: S0302. G0438, G0439**
    - Do not include laboratory claims.
    - Do not include telehealth visits.

Method(s) of Measurement

- BCBSM/BCN: Claims processed
    - This is a "No Entry" measure in Health-e Blue.
- Priority Health: Claims processed
    - Note: Priority Health will calculate 2025 performance rates for this measure at the practice level.

Tip(s)

- Patient/parent reported height and weight are acceptable if documented by the Provider in the patient's medical record.
- Templates or checklists can help ensure that all care components get completed during the year.
- Services rendered during an inpatient or ED visit do not count.

Additional Note(s)

- This is a pediatric focus measure for the 2025 Priority Health PIP incentive program.