



AETNA

Quality Reference Guide

(QRG) 2025

Our QRG has been developed to help our network providers navigate & understand HEDIS, reference commonly used codes, and maintain patient safety & preventative care through simplified measures.

The QRG serves educational purposes and may not encompass all details about HEDIS Measures. The content within this document is sourced from the National Committee for Quality Assurance (NCQA) Technical Specifications for HEDIS Measures. Its primary aim is to equip providers and their affiliates with a comprehensive grasp of HEDIS measures and associated information.

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Quality HEDIS®

What is HEDIS?

The Healthcare Effectiveness Data and Information Set (HEDIS®) comprises standardized performance metrics established by the National Committee for Quality Assurance (NCQA) to assess, report, and benchmark quality within healthcare plans. NCQA formulates HEDIS® measures through a committee composed of purchasers, consumers, health plans, healthcare providers, and policymakers.

HEDIS Scores:

The significance of scores lies in their role within the evolving landscape of healthcare quality standards. With state and federal healthcare systems shifting towards quality-driven practices, HEDIS rates hold increasing importance for both healthcare plans and individual practitioners. State healthcare purchasers utilize compiled HEDIS rates to assess the effectiveness of health insurance providers in enhancing preventive health initiatives for their members. Additionally, these scores are employed to gauge the efficacy of preventive care efforts at the physician level. HEDIS scores play a pivotal role in determining the rates for incentive programs that reward providers and practices with enhanced premiums.

Strategies to Enhance HEDIS Performance:

- Ensure the prompt and accurate submission of claim/encounter data for all services provided.
- Document services in the relevant section of the medical or electronic health record, ensuring alignment with the date of service and any pertinent results.
- Utilize CPT II billing codes to optimize scores for laboratory work, screenings, and tests.
- Deliver timely and suitable healthcare services, including scheduling annual wellness appointments and providing necessary preventative screenings based on gender, age, and medical condition.
- Proactively reach out to members overdue for care, arrange necessary services, and offer telehealth consultations when face-to-face appointments are not viable.
- Participate in existing initiatives and health plan programs to leverage available resources.
- Maintain up-to-date provider information to facilitate efficient communication exchanges.



Aetna Data Integration: Healthcare providers produce structured data files from electronic medical record (EMR) extracts to send “standard” supplemental data to Aetna via File Transfer Protocol (FTP). These files are subject to Primary Source Verification (PSV) audits. Files generally contain codes such as CPT, LOINC, or SNOMED, although DI can program coding based off lab test or procedure names in most instances.

Electronic Clinical Data Systems (ECDS): Healthcare organizations utilize Electronic Clinical Data Systems (ECDS) to consolidate diverse data sources, offering comprehensive insights into the healthcare services rendered to their clientele. Eligible data sources for ECDS reporting encompass Electronic Health Records, Health Information Exchange, and Registries, among others. [The Future of HEDIS](#)

Medical Record Data: The information taken directly from a member’s medical record to validate services rendered that weren’t captured through medical or pharmacy claims/encounters, or supplemental data.

Required Exclusion: Members are excluded from the denominator of a measure based on specific diagnoses and/or procedures documented in their claims, encounters, or pharmacy data. This exclusion is implemented during the creation of the measure denominator within certified HEDIS software after processing the claims data.

Proportion of Days Covered (PDC): According to the Pharmacy Quality Alliance (PQA), the PDC is the preferred method to measure medication adherence. The PDC is the percent of days in the measurement period covered by prescription claims for the same medication or another in its therapeutic category. The Medication Possession Ratio (MPR) is based on the sum of dispensed ‘days supplied’ over a period, whereas PDC is based on evaluation of available supply for each individual day in the period.

Continuity of Care Documents (CCD): Are used for the electronic exchange of clinical data without loss of meaning. The files provide a summary of a member’s care as a snapshot in time, but they are not a replacement for an electronic health record (EHR). These files are typically Extensible Markup Language (XML)-based and are considered nonstandard supplemental data for at least the first year of use. The organization must demonstrate the accuracy of these (through primary source verification [PSV]) to ensure that the data in the file match the EHR.

CCD documents are programmatically created (and thus subject to human error) and are not considered the legal health record. As a result, it is not allowable to use CCD documents for data abstraction or as proof of service.

Medical record submission methods may not be applicable to all plan types. For more details, you can reach out to your Aetna representative.



Line of Business/Product line

Line of Business (LOB): Identifies the reporting population

- **Commercial:** Health insurance coverage by employer sponsored insurance, private company, or entity, not by the government.
- **Federal Employees Health Benefits (FEHB):** A group health insurance program that provides medical, dental, and vision coverage to eligible federal employees, retirees, and their families. FEHB is included and sponsored by the government office of personnel management (OPM), but it's not fully funded by OPM (there is eligible employee (EE) premium cost share like a traditional employer group).
- **Medicaid:** A joint federal, state program designed to offer healthcare coverage to eligible individuals. While each state administers its own Medicaid program, they must adhere to federal regulations set by the government. Moreover, the federal government contributes a minimum of fifty percent of the funding required for Medicaid programs across states.
- **Dual Special Needs Plans (D-SNP):** Type of Medicare Advantage plan that covers hospitalization, outpatient medical care, and prescriptions; the costs of the plan are covered by federal and state funds. D-SNPs are for members who are eligible for both Medicare and Medicaid.
- **Individual & Family Plans (IFP):** Is a policy that individuals can purchase independently to cover their medical expenses, including doctor visits, hospitalization, and prescription drugs.
- **Medicare:** A federal system of health insurance for people over 65 years of age and for people with disabilities.
- **Medicare Star:** The Star Ratings system, established by the Centers for Medicare & Medicaid Services (CMS), evaluates Medicare Advantage (Part C) and prescription drug (Part D) plans on a five-star scale, where 1 indicates the lowest score and 5 signifies the highest rating. These assessments primarily assess the quality of health plans in terms of customer satisfaction and healthcare delivery. The overarching objective of the Star Ratings system is to enhance care quality and promote better health outcomes among Medicare beneficiaries. Furthermore, this rating system aligns with CMS's mission to enhance accountability in healthcare delivery by healthcare professionals, hospitals, and other providers.



The content in the QRG is subject to modifications in line with directives from the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS), as well as state regulations and suggestions. It is advisable to consult the relevant agency for further billing guidance to ascertain the eligibility of codes before submission. The provided list of codes is not exhaustive and remains susceptible to alterations, deletions, or removals. This document does not serve as a substitute for professional coding standards, and additional codes that fulfill exclusion criteria or ensure numerator compliance may be necessary.

Quality HEDIS® Measures A-Z

The table below facilitates navigation to the relevant HEDIS measure page, offering a breakdown of the lines of businesses associated with each measure.

Acronym	Quality Measure	Medicare	Medicaid	FEHB	Commercial	Dual-SNP	IFP	Medicare Star	Page
AAB	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis	♥	♥	♥	♥	♥	♥		7
AAP	Adults' Access to Preventive/ Ambulatory Health Services	♥	♥		♥	♥			8
ACP	Advanced Care Planning	♥				♥			9
ADD-E	Follow-up Care for Children Prescribed ADHD Medication		♥		♥				10
ADH-DIAB	Medication Adherence for Diabetes Medications	♥	♥		♥	♥	♥	♥	11
ADH- RASA	Medication Adherence for Hypertension	♥	♥		♥	♥	♥	♥	11
ADH- STATIN	Medication Adherence for Cholesterol	♥	♥		♥	♥	♥	♥	12
AMM	Antidepressant Medication Management						♥		13
AMO	Annual Monitoring for Persons on Long-Term Opioid Therapy						♥		14
AMR	Asthma Medication Ratio		♥	♥	♥		♥		15

Acronym	Quality Measure	Medicare	Medicaid	FEHB	Commercial	Dual-SNP	IFP	Medicare Star	Page
APM-E	Metabolic Monitoring for Children and Adolescents on Antipsychotic Medication		♥		♥				15
BCS-E	Breast Cancer Screening	♥	♥	♥	♥	♥	♥	♥	16-17
BPD	Blood Pressure Control for Patients with Diabetes	♥	♥		♥	♥			17-18
CBP	Controlling High Blood Pressure	♥	♥	♥	♥	♥	♥	♥	18-19
CCS-E	Cervical Cancer Screening		♥	♥	♥		♥		20
CHL	Chlamydia Screening		♥		♥		♥		21
CIS-E	Childhood Immunization Status		♥	♥	♥		♥		21
COA	Care for Older Adults	♥				♥		♥	22
COB	Concurrent Use of Opioids and Benzodiazepines	♥	♥		♥	♥		♥	23
COL-E	Colorectal Cancer Screening	♥	♥	♥	♥	♥	♥	♥	23-24
COU	Risk of Continued Opioid Use	♥	♥	♥	♥	♥			25
CWP	Appropriate Testing for Pharyngitis	♥	♥		♥	♥			26
DSF-E	Depression Screening and Follow-Up for Adolescents and Adults	♥	♥		♥	♥	♥		26
EDU	Emergency Department Utilization	♥		♥	♥	♥			27
EED	Eye Exam for Patients with Diabetes	♥	♥		♥	♥	♥	♥	27-28
FMC	Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions	♥				♥		♥	29
FUA	Follow-Up After Emergency Department Visit for Substance Use	♥	♥	♥	♥				30
FUH	Follow-up After Hospitalization for Mental Illness	♥	♥		♥	♥	♥		30
FUI	Follow-up after high-intensity care for substance use disorder	♥	♥		♥	♥			31
FUM	Follow-Up After Emergency Department Visit for Mental Illness	♥	♥	♥	♥	♥			31
GSD	Glycemic Status Assessment for Patients with Diabetes	♥	♥	♥	♥	♥	♥	♥	32
HDO	Use of Opioids at High Dosage	♥	♥		♥	♥			33
IMA-E	Immunizations for Adolescents		♥		♥		♥		34
INR	International Normalized Ratio Monitoring for Individuals on Warfarin						♥		35
KED	Kidney Health Evaluation for Patients with Diabetes	♥	♥		♥	♥	♥	♥	35-36

Acronym	Quality Measure	Medicare	Medicaid	FEHB	Commercial	Dual-SNP	IFP	Medicare Star	Page
LBP	Use of Imaging Studies for Low Back Pain	♥	♥	♥	♥	♥	♥		37-38
LSC	Lead Screening in Children		♥						39
OMW	Osteoporosis Management in Women Who Had a Fracture	♥				♥		♥	39-40
PBH	Persistence of Beta-Blocker Treatment After a Heart Attack	♥	♥		♥	♥			41-42
PCE	Pharmacotherapy Management of COPD Exacerbation	♥	♥		♥	♥			42
PCR	Plan All Cause Readmission	♥	♥	♥	♥	♥	♥	♥	43
POD	Pharmacotherapy for opioid use disorder	♥	♥		♥	♥			43
POLY-ACH	Polypharmacy: Use of Multiple Anticholinergic Medications in Older Adults	♥	♥		♥	♥		♥	44
PPC	Prenatal and Postpartum Care		♥	♥	♥		♥		45
SAA	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	♥	♥		♥	♥			46-47
SMD	Diabetes Monitoring for People with Diabetes and Schizophrenia		♥						47
SNS-E	Social Need Screening and Intervention	♥	♥		♥	♥	♥		48
SPC	Statin Therapy for Patients with Cardiovascular Disease	♥	♥	♥	♥	♥		♥	49-50
SPD	Statin Therapy for Patients with Diabetes	♥	♥		♥	♥			50-51
SSD	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications		♥						52
SUPD	Statin Use in Persons with Diabetes	♥	♥		♥	♥		♥	53
TRC	Transition of Care	♥				♥		♥	54
UOP	Use of Opioids from Multiple Providers	♥	♥	♥	♥	♥			55
URI	Appropriate treatment for Upper Respiratory Infection	♥	♥		♥	♥	♥		56
W30	Well-Child Visits in the First 30 Months of Life		♥	♥	♥		♥		56
WCC	Weight Assessment and Counseling for Nutrition/Physical Activity for Children/Adolescents		♥		♥		♥		57
WCV	Child and Adolescent Well-Care Visits		♥		♥				58

Aetna Quality Reference Guide

Quality Measure	Measure Definition	Measure Requirements	Commonly Used Codes*
AAB – Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis 3 months of age and older	Member diagnosed with acute bronchitis/bronchiolitis and not prescribed antibiotics <i>*Supplemental data may not be used for this measure, except for required exclusions</i>	Requirements: No unique requirements Service date range: Begins on July 1 of the year prior to the measurement year and ends June 30 of the measurement year Required exclusions: - Members in hospice or using hospice services during the measurement year - Members who died any time during the measurement year	Claims data only: Dispensing of antibiotics Acute bronchitis, unspecified: J20.9 Exclusions: Comorbid conditions Human immunodeficiency virus (HIV): B20 Inpatient stay: 0100

*FOR COMMONLY USED CODES: Not a comprehensive list of codes.

*FOR CLAIMS DATA ONLY: For measures that require claims data only we cannot accept supplemental data sources such as data feeds and medical record collection methods.

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Quality Measure	Measure Definition	Measure Requirements	Commonly Used Codes*
AAP – Adults’ Access to Preventive/ Ambulatory Health Services 20 years of age and older	Members who had an ambulatory or preventive care visit The organization reports three separate percentages for each product line Medicare and Medicaid: Members who had an ambulatory or preventive care visit during the measurement year Commercial: Members who had an ambulatory or preventive care visit during the measurement year or two years prior to the measurement year	Requirements: Date of service required and appropriate code Service date range: - Medicaid and Medicare: Measurement year - Commercial: Measurement year and the two years prior to the measurement year Required exclusions: - Members in hospice or using hospice services during the measurement year - Members who have died during the measurement year	Claims data: Ambulatory visits: 99401, 99402

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Quality Measure	Measure Definition	Measure Requirements	Commonly Used Codes*
ACP – Advanced Care Planning - Adults 66–80 years of age with advanced illness, an indication of frailty or who are receiving palliative care - Adults 81 years of age and older who had advance care planning	Documentation or discussion about preferences for resuscitation, life-sustaining treatment and end of life care - Include members 66–80 years of age as of December 31 of the measurement year who meet any of the following criteria: - Advanced illness on at least two different dates of service - Dispensed dementia medication - Frailty during the measurement year - Received palliative care or had an encounter for palliative care anytime during the measurement year (Do not include laboratory claims) - Include members 81 years of age and older who had advance care planning during the measurement year	Requirements: Evidence of advance care planning, date of service and appropriate code. Do not include laboratory claims Service date range: Measurement year Required exclusions: - Members in hospice or using hospice services during the measurement year - Members who have died during the measurement year	Advance care planning: CPT: 99483, 99497 CPT-CAT-II: 1123F, 1124F, 1157F, 1158F

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Quality Measure	Measure Definition	Measure Requirements	Commonly Used Codes*
ADD-E – Follow-up Care for Children Prescribed ADHD Medication 6–12 years of age	Percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 300-day (10 month) period, one of which was within 30 days of when the first ADHD medication was dispensed Two phases reported: Initiation phase: The percentage of members with a prescription dispensed for ADHD medication, who had one follow-up visit with a practitioner with prescribing authority during the 30-day initiation phase Continuation and maintenance phase: The percentage of members with a prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the initiation phase, had at least two follow-up visits with a practitioner within 270 days after the initiation phase ended	Requirements: Visit service dates, place of service code and provider type or exclusion code Service date range: January 1–December 31 Intake period: March 1 of the year prior to the measurement period through the last calendar day of February of the measurement period Required exclusions: - Members who use hospice services or elect to use a hospice benefit any time during the measurement period - Members with a diagnosis of narcolepsy any time during the member's history through the end of the measurement period. Do not include laboratory claims - Members who have died any time during the measurement period	Electronic Clinical Data Systems (ECDS) BH outpatient: 98960 Health and behavior assessment or intervention: 96156, 96158, 96159, 96164, 96165 Telephone visit: 99442 Exclusions: Narcolepsy: G47.411 Hospice encounter: G9473

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Quality Measure	Measure Definition	Measure Requirements	Commonly Used Codes*
ADH- DIAB - Medication Adherence for Diabetes Medications 18 years of age and older	The percent of individuals who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the diabetes medication Members with at least 2 prescription claims for a non-insulin diabetes medication on different dates of service and meet the Proportion of Days Covered (PDC) threshold of 80% for the measurement year <i>*May not use supplemental data for this measure</i>	Requirements: Prescription claims only Service date range: Measurement year; ≥18 years of age as of the first day of the measurement year Required exclusions: - Members with ESRD diagnosis or dialysis treatment - One or more prescriptions for insulin - Members in hospice or using hospice services during the measurement year	Claims data only Paid, non-reversed claims for diabetes medication
ADH- RASA - Medication Adherence for Hypertension (RAS antagonists) 18 years of age and older	The percent of individuals who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the RAS antagonist medication Members with at least 2 prescription claims for a RAS antagonist medication on different dates of service and meet the PDC threshold of 80% for the measurement year <i>*May not use supplemental data for this measure</i>	Requirements: Prescription claims only Service date range: Measurement year; ≥18 years of age as of the first day of the measurement year Required exclusions: - Members with ESRD diagnosis or dialysis treatment - One or more prescriptions for sacubitril/valsartan - Members in hospice or using hospice services during the measurement year	Claims data only Paid, non-reversed claims for RAS antagonist medication

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Quality Measure	Measure Definition	Measure Requirements	Commonly Used Codes*
ADH- STATIN – Medication Adherence for Cholesterol (Statins) 18 years of age and older	The percent of individuals who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the statin medication Members with at least 2 prescription claims for a statin medication on different dates of service and meet the PDC threshold of 80% for the measurement year <i>*May not use supplemental data for this measure</i>	Requirements: Prescription claims only Service date range: Measurement year; ≥18 years of age as of the first day of the measurement year Required exclusions: - Members with ESRD diagnosis or dialysis treatment - Members in hospice or using hospice services during the measurement year	Claims data only Paid, non-reversed claims for statin medication

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Quality Measure	Measure Definition	Measure Requirements	Commonly Used Codes*
AMM – Antidepressant Medication Management 18 years of age and older	Members treated with antidepressant medication, diagnosed with major depression, and remained on antidepressant medication treatment Two rates reported: 1. Effective acute phase treatment: Members that stayed on an antidepressant medication for at least 84 days (12 weeks) 2. Effective continuation phase treatment: Members that stayed on an antidepressant medication for at least 180 days (6 months)	Requirements: No special requirements Service date range: May 1 of the year prior to the measurement year to April 30 of the measurement year Required exclusions: - Members who did not have an encounter with the diagnosis of major depression during the 121-day period from 60 days prior to the Index prescription start date (IPSD) through IPSD, and 60 days after IPSD - Members in hospice or using hospice services during the measurement year - Members who have died during the measurement year	Claims data: Dispensing of antidepressant medication

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Quality Measure	Measure Definition	Measure Requirements	Commonly Used Codes*
AMO – Annual Monitoring for Persons on Long-Term Opioid Therapy 18 years of age and older	Members who are prescribed long-term opioid therapy and have not received a drug test at least once during the measurement year	Requirements: At least one drug test performed during the measurement year Service date range: Measurement year Required exclusions: - Members in hospice or using hospice services during the measurement year - Members with a diagnosis of cancer during the measurement year	Drug test definitive, qualitative or quantitative, not otherwise specified: (1-3): 80375 (4-6): 80376 (7 or more): 80377 Exclusions: Hospice care, in the home, per diem: S9126 Hospice encounter: 0115, 0125, 0135, 0145, 0155

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AMR – Asthma Medication Ratio 5–64 years of age	Members identified as having persistent asthma and had 0.50 or greater ratio of controller medications to total asthma medications	Requirements: No special requirements Service date range: Measurement year Required exclusions: - Members who had a diagnosis that requires a different treatment approach than members with asthma any time during the member's history through December 31 of the measurement year. Do not include laboratory claims - Members who had no asthma controller medication dispensed during the measurement year - Members in hospice or using hospice services during the measurement year - Members who have died during the measurement year	Claims data: Dispensing of asthma controller medication Asthma, other asthma: J45.998 Exclusions: COPD: J44.9 Emphysema: J43.9 Cystic fibrosis: E84.9 Acute respiratory failure: J96.00
APM-E – Metabolic Monitoring for Children and Adolescents on Antipsychotics 1–17 years of age	Children and adolescents who had two or more antipsychotic prescriptions and received metabolic testing Three rates reported: - Blood glucose testing - Cholesterol testing - Blood glucose testing and cholesterol testing	Requirements: Received at least one test for blood glucose or HbA1c or at least one test for LDL-C or cholesterol or compliant for both the blood glucose and cholesterol indicators Service date range: Measurement year Required exclusions: - Members in hospice or using hospice services two or more antipsychotic prescriptions during the measurement year - Members who have died during the measurement year	Electronic Clinical Data Systems (ECDS) Glucose test: 82947 HbA1C lab test: 83036, 83037 CPTII: 3044F, 3046F, 3051F, 3052F LDL lab test: 80061, 83721 CPTII: 3048F, 3049F, 3050F

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BCS-E – Breast Cancer Screening 40–74 years of age	Members recommended for routine breast cancer screening and had a mammogram to screen for breast cancer	Requirements: Mammogram(s) or exclusion code and service date Service date range: Measurement year plus prior 15 months - October 1 two years prior to the measurement period through the end of the measurement period Required exclusions: - Members who use hospice services or elect to use a hospice benefit any time during the measurement period - Members who have died any time during the measurement period - Members who had a bilateral mastectomy or both right and left unilateral mastectomies any time during the member's history through the end of the measurement period - Members receiving palliative care anytime during the measurement period - Members who had gender-affirming chest surgery with a diagnosis of gender dysphoria any time during the member's history through the end of the measurement period - Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following: - Enrolled in an institutional SNP (I-SNP) any time during the measurement period. - Living long-term in an institution any time during the measurement period, as identified by the LTI flag in the Monthly Membership	Electronic Clinical Data Systems (ECDS) Mammography: 77061, 77062, 77065, 77066, 77067 Mammography LOINC: Bilateral: 26175-0 Left: 26176-8 Right: 26177-6 Exclusions: History of bilateral mastectomy: Z90.13 Gender dysphoria, unspecified: F64.9 Gender-affirming chest surgery: 19318

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Quality Measure	Measure Definition	Measure Requirements	Commonly Used Codes*
BCS-E <i>continued</i>		Detail Data File - Members 66 years of age and older with BOTH frailty and advanced illness criteria. Members must meet both frailty and advanced illness criteria to be excluded: - Frailty. At least two indications of frailty with different dates of service during the measurement period - Advanced Illness. Either of the following during the measurement period or the year prior to the measurement period: - Advanced illness on at least two different dates of service - Dispensed dementia medication	
BPD – Blood Pressure Control for Patients with Diabetes 18–75 years of age	Members with a diagnosis of type 1 or type 2 diabetes whose blood pressure is adequately controlled (<140/90 mm Hg)	Requirements: Most recent systolic and diastolic blood pressure reading and service date Service date range: Measurement year Required exclusions: - Members who have died during the measurement year - Members in hospice or using hospice services during the measurement year - Members receiving palliative care any time during the measurement year - Members who had an encounter for palliative care any time during the measurement year - Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following:	Claims data: Systolic B/P: 3075F: 130-139 mm Hg 3074F: < 130 mm Hg 3077F: ≥ 140 mm Hg Diastolic B/P: 3079F: < than 90 (80-89 mm Hg) 3078F: < than 80 mm Hg 3080F: ≥ 90 mm Hg LOINC: 8480-6: Systolic BP 8462-4: Diastolic BP

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BPD <i>continued</i>		- Enrolled in an institutional SNP (I-SNP) any time during the measurement year - Living long-term in an institution any time during the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File - Members 66 years of age and older by the end of the measurement year with BOTH frailty and advanced illness criteria to be excluded: - Frailty. At least two indications of frailty with different dates of service during the measurement year - Advanced Illness. Either of the following during the measurement period or the year prior to the measurement year: - Advanced illness on at least two different dates of service - Dispensed dementia medication	Exclusions: Acute inpatient: 99221, 99222, 99223, 99231, 99232 Frailty encounter: 99504, 99509 ED: 99281, 99282, 99283
CBP – Controlling High Blood Pressure 18–85 years of age	Members with a diagnosis of hypertension (HTN) and adequately controlled blood pressure (<140/90 mm HG)	Requirements: <i>Most recent</i> systolic and diastolic blood pressure reading and service date or exclusion code Service date range: Measurement year Required exclusions: - Members with a diagnosis, history or evidence of a procedure that indicates ESRD, dialysis, Nephrectomy or kidney transplant any time during the member's history on or prior to December 31 of the measurement year - Members with a diagnosis of pregnancy anytime during the measurement year	Claims data: Systolic B/P: 3075F: 130-139 mm Hg 3074F: < 130 mm Hg 3077F: ≥ 140 mm Hg Diastolic B/P: 3079F: < than 90 (80-89 mm Hg) 3078F: < than 80 mm Hg 3080F: ≥ 90 mm Hg

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Quality Measure	Measure Definition	Measure Requirements	Commonly Used Codes*
CBP <i>continued</i>		- Members who have died during the measurement year - Members in hospice or using hospice services during the measurement year - Members receiving palliative care anytime during the measurement year - Members who had an encounter for palliative care anytime during the measurement year - Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following: - Enrolled in an institutional SNP (I-SNP) any time during the measurement year - Living long-term in an institution any time during the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File - Members 66–80 years of age and older by the end of the measurement year with BOTH frailty and advanced illness criteria to be excluded: - Frailty. At least two indications of frailty with different dates of service during the measurement period - Advanced Illness. Either of the following during the measurement period or the year prior to the measurement period: - Advanced illness on at least two different dates of service - Dispensed dementia medication - Members 81 years of age and older as of December 31 of the measurement year with at least two indications of frailty with different dates of service during the measurement year	LOINC: 8480-6: Systolic BP 8462-4: Diastolic BP Exclusions: End stage renal disease: N18.6 Kidney transplant: 50360 Dialysis procedure: 90935 Dependence on renal dialysis: Z99.2

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Quality Measure	Measure Definition	Measure Requirements	Commonly Used Codes*
CCS-E – Cervical Cancer Screening Members 21–64 years of age	Members screened for cervical cancer using any of the following criteria: 21–64 years of age who had cervical cytology performed within the last three years OR 30–64 years of age who had within the past five years either cervical high-risk human papillomavirus testing OR 30–64 years of age recommended for routine cervical cancer screening and had cervical cytology/high-risk human papillomavirus (hrHPV) cotesting within the last 5 years	Requirements: Pap and/or HPV test or exclusion code and service date Service date range: Measurement year plus prior four years contingent upon screening Required exclusions: - Hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix any time during the member’s history through the end of measurement period - Members who have died during the measurement period - Members in hospice or using hospice services during the measurement period - Members receiving palliative care anytime during the measurement period - Members who had an encounter for palliative care anytime during the measurement period - Members with sex assigned at birth of a male at any time in member’s history	Electronic Clinical Data Systems (ECDS) Cervical cytology: 88175 -or- High risk HPV test: 87624 Cervical cytology test (procedure): SNOMED 416107004 Smear: no abnormality detected - no endocervical cells (finding): SNOMED 281101005 Exclusions: Hysterectomy with no residual cervix: 58291, 57530 Total abdominal hysterectomy (procedure): SNOMED 116143008

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Quality Measure	Measure Definition	Measure Requirements	Commonly Used Codes*
CHL – Chlamydia Screening Members 16–24 years of age	Sexually active members who had at least one chlamydia test during the measurement year	Requirements: Test code and service date Service date range: Measurement year Required exclusions: - Members in hospice or using hospice services during the measurement year - Members who have died during the measurement year - Members assigned male at birth	Chlamydia lab test: 87110 Exclusion: Pregnancy tests: 81025 (If paired with a retinoid medication list code or diagnostic radiology code)
CIS-E – Childhood Immunization Status Children 2 years of age	Members who had the following vaccines by their second birthday: - Four diphtheria, tetanus, and acellular pertussis (DTaP) - Three polio (IPV) - Three hepatitis B (Hep B) - One measles, mumps, and rubella (MMR) - Three haemophilus influenza type B (HIB) - One chicken pox (VZV) - Four pneumococcal conjugates (PCV) - One hepatitis A (Hep A) - Two or three rotaviruses (RV) - Two influenza vaccines (Flu) For documented history of illness or anaphylaxis, there must be a note indicating the date of the event, which must have occurred by the member's second birthday	Requirements: Vaccine code or exclusion code and service date Service date range: Child's birth up to two years of age Required exclusions: - Members in hospice or using hospice services during the measurement period - Members who have died during the measurement period - Members who had a contraindication to a childhood vaccine (Do not include laboratory claims) or organ and bone marrow transplants on or before their second birthday	Electronic Clinical Data Systems (ECDS) Human immunodeficiency virus [HIV]: B20 Post tetanus vaccination encephalitis: SNOMED 192710009 Anaphylaxis due to diphtheria, tetanus or pertussis vaccine: SNOMED 428281000124107

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Quality Measure	Measure Definition	Measure Requirements	Commonly Used Codes*
COA – Care for Older Adults – Functional Stats Assessment Special needs plans only 66 years of age and older and part of the Dual-Eligible Special Needs Population	Members who had a functional status assessment (FSA) documented within the measurement year	Requirements: Codes and service dates - Do not include services provided in an acute inpatient setting Service date range: Measurement year Required exclusions: - Members in hospice or using hospice services during the measurement year - Members who have died during the measurement year	Functional status assessment: 99483, 1170F Exclusions: Acute inpatient: 99221, 99222, 99223, 99233
COA – Care for Older Adults – Medication review Special needs plans only 66 years of age and older and part of the Dual-Eligible Special Needs Population	Members who had a medication review (MR) documented within the measurement year	Requirements: Codes, service dates, provider type (prescribing practitioner or clinical pharmacist) and the presence of a medication list in the medical record. Transitional care management services during the measurement year meets criteria - Do not include services provided in an acute inpatient setting Service date range: Measurement year Required exclusions: - Members in hospice or using hospice services during the measurement year - Members who have died during the measurement year	Medication review: 90863, 99483, 99605 Medication review of all medications by a prescribing practitioner or clinical pharmacist: 1160F Medication list documented in medical record: 1159F Transitional care management services: 99495, 99496 Exclusions: Acute inpatient: 99221, 99222, 99223, 99233

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Quality Measure	Measure Definition	Measure Requirements	Commonly Used Codes*
COB – Concurrent Use of Opioids and Benzodiazepines 18 years of age and older	The percent of individuals with concurrent use of prescription opioids and benzodiazepines Medicare Part D members with overlapping days' supply for an opioid and a benzodiazepine for 30 or more cumulative days and 2 or more prescription claims for both opioid (minimum cumulative 15 days' supply) and benzodiazepine on different dates of service during measurement year <i>*May not use supplemental data for this measure</i>	Requirements: Prescription claims only Service date range: Measurement year; ≥18 years of age as of the first day of the measurement year Required exclusions: - Members with diagnosis of cancer and/or sickle cell disease - Members in hospice or palliative care or using hospice/palliative care services during the measurement year - Members with cancer-related pain treatment	Claims data only
COL-E – Colorectal Cancer Screening 45–75 years of age	Members who had appropriate screening for colorectal cancer as defined by one of the following: - Fecal occult blood test during the measurement period - Stool DNA (sDNA) with FIT test/ Cologuard® during the measurement period or 2 years prior to the measurement period - Flexible sigmoidoscopy during the measurement period or 4 years prior to the measurement period - CT colonography during the measurement period or 4 years prior to the measurement period - Colonoscopy during the measurement period or 9 years prior to the measurement period	Requirements: Test/screening or exclusion code and service date Service date range: Measurement year plus prior nine years contingent upon screening Required exclusions: - Members who had colorectal cancer any time during the member's history through December 31 of the measurement period - Members who had a total colectomy any time during the member's history through December 31 of the measurement period - Members in hospice or using hospice services during the measurement period - Members who have died during the measurement period - Members receiving palliative care anytime during the measurement period	Electronic Clinical Data Systems (ECDS) <i>Any one of the following:</i> FOBT: 82270, 82274 sDNA FIT lab test/ Cologuard®: 81528 LOINC: 77353-1 Flexible sigmoidoscopy: 45330, 45331, 45332, 45350 Colonoscopy: 45378, 44404 CT colonography: 74262 Exclusion: Colorectal cancer: C18.0 Total colectomy: 44150, 44151

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Quality Measure	Measure Definition	Measure Requirements	Commonly Used Codes*
COL <i>continued</i>		- Members who had an encounter for palliative care anytime during the measurement year - Medicare members 66 years of age and older as of December 31 of the measurement period who meet either of the following: - Enrolled in an institutional SNP (I-SNP) anytime during the measurement period - Living long-term in an institution any time during the measurement period as identified by the LTI flag in the Monthly Membership Detail Data File - Members 66 years of age and older by the end of the measurement period, with frailty and advanced illness. Members must meet BOTH frailty and advanced illness criteria to be excluded: - Frailty. At least two indications of frailty with different dates of service during the measurement period - Advanced Illness. Either of the following during the measurement period or the year prior to the measurement period: - Advanced illness on at least two different dates of service - Dispensed dementia medication	

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Quality Measure	Measure Definition	Measure Requirements	Commonly Used Codes*
COU – Risk of continued opioid use 18 years of age and older	The percentage of members who have a new episode of opioid use that puts them at risk for continued opioid use Two rates reported: 1. Within a 30-day period at least 15 days of prescribed opioids 2. Within a 62-day period at least 31 days of prescribed opioids <i>*Supplemental data can be used for only required exclusions for this measure</i>	Requirements: Prescription claims only Service date range: 12-month period starting November 1 of the year prior to the measurement year and ending on October 31 of the measurement year Required exclusions: - Members who had cancer, received or had an encounter for palliative care or sickle cell disease any time during the 365 days prior to the index prescription start date (IPSD) through 61 days after the IPSD - Members in hospice or using hospice services during the measurement year - Members who have died during the measurement year	Claims data: Pharmacy claims only Exclusion: Sickle cell anemia: D57.00

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Quality Measure	Measure Definition	Measure Requirements	Commonly Used Codes*
CWP – Appropriate Testing for Pharyngitis 3 years of age and older	The percentage of episodes where the member was diagnosed with pharyngitis, dispensed an antibiotic, and received a group A streptococcus (strep) test for the episode	Requirements: Test code and service date Service date range: July 1 of the year prior to the measurement year to June 30 of the measurement year Required exclusions: - Members in hospice or using hospice services during the measurement year - Members who have died during the measurement year	Claims data: Group A strep tests: 87070, 87071, 87081, 87430, 87650, 87651, 87652, 87880 Streptococcus (presence) by rapid immunoassay: 78012-2 Streptococcus pyogenes antigen assay: 122121004
DSF-E – Depression Screening and Follow-Up for Adolescents and Adults 12 years of age and older	Members who were screened for clinical depression using a standardized instrument and , if screened positive, received follow-up care Depression screening: The percentage of members who were screened for clinical depression using a standardized instrument Follow-up on positive screen: The percentage of members who received follow-up care within 30 days of a positive depression screen finding	Requirements: Documented result for depression screening, using an age-appropriate standardized instrument performed and received follow-up care on or up to 30 days after the date of the first positive screen Service date range: January 1 and December 1 of the measurement period Required exclusions: - Members with a history of bipolar disorder any time during the member's history through the end of the year prior to the measurement period - Members with depression that starts during the year prior to the measurement period - Members who use hospice services or elect to use a hospice benefit any time during the measurement period - Members who die any time during the measurement period	Electronic Clinical Data Systems (ECDS) Behavioral health encounter: 90833, 90834, 90836 Follow Up Visit: 98960, 98961, 98962, 99442, 99443 Exclusions: Bipolar disorder, unspecified: F31.9 Bipolar disorder, other manic episodes: F30.8 Depression, other specified depressive episodes: F32.89 Depression, unspecified: F32.A

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Quality Measure	Measure Definition	Measure Requirements	Commonly Used Codes*
EDU – Emergency Department Utilization 18 years of age and older	The risk-adjusted ratio of observed-to-expected emergency department (ED) visits during the measurement year <i>*Supplemental data may not be used for this measure, except for required exclusions</i>	Requirements: No special requirements Service date range: The year prior to the measurement year Required exclusions: Members in hospice or using hospice services during the measurement year	Claims data: ED visit: 99281 ED procedure: 10004
EED – Eye Exam for Patients with Diabetes 18–75 years of age	Members with diabetes (type 1 or type 2) who had a retinal eye exam performed during the measurement year or a negative retinal eye exam year prior <i>*Removed from the hybrid data collection method</i>	Requirements: Diabetic Eye Exam or exclusion code, provider specialty in optometry or ophthalmology, retinopathy status and service date Service date range: Measurement year plus prior year Required exclusions: - Bilateral eye enucleation or bilateral absence of eyes any time during the member's history through December 31 of the measurement year - Members who have died during the measurement year - Members in hospice or using hospice services during the measurement year - Members receiving palliative care anytime during the measurement year - Members who had an encounter for palliative care anytime during the measurement year	Claims data: Any of the following: Diabetes mellitus w/o complications: E10.9 Eye exam w/retinopathy: 2022F, 2024F, 2026F Eye exam w/o retinopathy: 2023F, 2025F, 2033F Retinal imaging: 92227, 92228 Autonomous eye exam: 92229 or LOINC code 105914-6 with a result Exclusions: Unilateral eye enucleation: 65091, 65093, 65101, 65110 (Two DOS or bilateral modifier included)

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Quality Measure	Measure Definition	Measure Requirements	Commonly Used Codes*
EED continued		• <i>Medicare</i> members 66 years of age and older as of December 31 of the measurement year who meet either of the following: – Enrolled in an institutional SNP (I-SNP) any time during the measurement year – Living long-term in an institution any time during the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File • Members 66 years of age and older by the end of the measurement year with BOTH frailty and advanced illness criteria to be excluded: – Frailty. At least two indications of frailty with different dates of service during the measurement year. Do not include laboratory claims – Advanced Illness. Either of the following during the measurement period or the year prior to the measurement period: • Advanced illness on at least two different dates of service • Dispensed dementia medication	

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Quality Measure	Measure Definition	Measure Requirements	Commonly Used Codes*
FMC – Follow-Up After Emergency Department (ED) Visit for People with Multiple High-Risk Chronic Conditions 18 years of age and older Denominator is based on ED visits, not on members Members may have more than one ED visit and can be in measure for multiple dates of service (DOS)	Members with multiple high-risk chronic conditions who visited the ED and who had a follow-up visit on the day of discharge or seven days after discharge (total of eight days) Two or more eligible high-risk chronic conditions: - COPD/asthma/unspecified bronchitis - Alzheimer’s disease and related disorders - Kidney disease - Major depression/dysthymic disorder - Heart failure and cardiomyopathy - Myocardial infarction - Atrial fibrillation - Stroke/transient ischemic attack	Requirements: Two or more eligible high-risk chronic conditions diagnosed prior to the ED visit during the measurement year or year prior to the measurement year and a documented/claims coded follow-up visit within seven days post discharge or on discharge date Service date range: Members need to have reached 18 years or older on the date of an ED visit which occurs on or between January 1 and December 24 of the measurement year Required exclusions: - Members in hospice or using hospice services during the measurement year - Members who have died during the measurement year Claims only: - Exclude ED visits that result in an inpatient stay - Exclude ED visits followed by admission to an acute or nonacute inpatient care setting on the date of the ED visit or within 7 days after the ED visit, regardless of the principal diagnosis for admission - Remove any visit with any diagnosis of concussion with loss of consciousness or fracture of vault of skull, initial encounter	Claims data: Outpatient, ED, telehealth and nonacute inpatient: 98966 BH outpatient: 99078 Transitional care: 99496 Care management: 99489 Case management: 99366 Exclusions: Inpatient stay: 0100, 0101 Acute inpatient: 99221, 99222, 99234, 99235, 99255

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Quality Measure	Measure Definition	Measure Requirements	Commonly Used Codes*
FUA – Follow-Up After Emergency Department Visit for Substance Use 13 years of age and older	Members who visited the emergency department (ED) with a principal diagnosis of substance use disorder (SUD) or any diagnosis of drug overdose, for which there was follow-up Two rates reported: - Follow-up visit within 30 days of the ED visit (31 total days) - Follow-up within seven days of the ED visit (8 total days)	Requirements: Diagnosis of SUD or any diagnosis of drug overdose and ED visit code and date of service 30-day follow-up: A follow-up visit or a pharmacotherapy dispensing event within 30 days after the ED visit (31 total days) 7-day follow-up: A follow-up visit or a pharmacotherapy dispensing event within 7 days after the ED visit (8 total days) Both: Include visits and pharmacotherapy events that occur on the date of the ED visit Service date range: January 1 through December 1 of the measurement year; the member being 13 years or older on the date of the visit Required exclusions: - Members in hospice or using hospice services during the measurement year - Members who have died during the measurement year	Claims data: Alcohol use, unspecified, uncomplicated: F10.90 Opioid use, unspecified, uncomplicated: F11.90 Cannabis use, unspecified, uncomplicated: F12.90 Substance use disorder services: 99408, 00409 Telephone visits: 98967, 98968, 99441
FUH – Follow-up After Hospitalization for Mental Illness 6 years of age and older	Members who were hospitalized for a principal diagnosis of mental illness, or any diagnosis of intentional self-harm, and had a mental health follow-up service Two rates reported: - Follow-up within 30 days after discharge - Follow-up within 7 days after discharge Do not include services that occur on the date of discharge	Requirements: Acute inpatient discharge with a diagnosis of mental illness or intentional self-harm and a follow-up service for mental health Service date range: January 1 through December 1 of the measurement year Required exclusions: - Members in hospice or using hospice services during the measurement year - Members who have died during the measurement year	Claims data: Electroconvulsive therapy: 90870 Visit setting unspecified: 99222 BH outpatient: 99483, 98961 Telephone visit: 99442 Peer support services, mental health services, not otherwise specified: H0046

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Quality Measure	Measure Definition	Measure Requirements	Commonly Used Codes*
FUI – Follow-up after high-intensity care for substance use disorder 13 years of age and older	Members who have had acute inpatient hospitalizations, residential treatments or withdrawal management visits for a diagnosis of substance use disorder that result in a follow-up visit or service for substance use disorder Two rates reported: 1. Within 30 days after visit or discharge member received a follow-up for substance use disorder 2. Within 7 days after visit or discharge member received follow-up for substance use disorder Do not include visits that occur on the date of the denominator episode	Requirements: After an episode of substance use disorder, a visit or event within 7 days and 30 days with any practitioner with diagnosis of substance use disorder Service date range: January 1 through December 1 of the measurement year Required exclusions: - Members in hospice or using hospice services during the measurement year - Members who have died during the measurement year	Claims data: Substance use disorder services: 99408, 00409 Visit setting unspecified: 90847, 90853, 99238 BH outpatient: 99483, 98961 Telephone visit: 99442 Online assessment: 99422
FUM – Follow-Up After Emergency Department Visit for Mental Illness 6 years of age and older	Emergency department visits with a principal diagnosis of mental illness or any diagnosis of intentional self-harm and had a mental health follow-up service. Two rates reported: 1. Follow-up visits within 30 days (31 total days) 2. Follow-up visits within seven days (8 total days) Include services that occur on the date of the ED visit	Requirements: Date of service and diagnosis of mental health disorder required for all submitted data. Outpatient, partial hospitalization, community health, telehealth or ECT (POS required for ECT) Service date range: January 1 through December 1 of the measurement year Required exclusions: - Members in hospice or using hospice services during the measurement year - Members who have died during the measurement year	Claims data: Visit setting unspecified: 90847, 90853, 99222 Electroconvulsive therapy: 90870 BH outpatient: 99483, 99344 Telephone visit: 99442 Online assessment: 99421, 99422, 99423

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Quality Measure	Measure Definition	Measure Requirements	Commonly Used Codes*
GSD – Glycemic Status Assessment for Patients with Diabetes 18–75 years of age	Members with a diagnosis of diabetes type 1 or type 2 whose most recent glycemic status hemoglobin A1c (HbA1c) or glucose management indicator (GMI) was at the following levels during the measurement year: HEDIS: - Glycemic status <8.0% (passing rate) - HbA1c control <8.0% (passing rate) Medicare STARS: - Glycemic status ≤9.0% (passing rate) - HbA1c poor control ≤9.0% (passing rate)	Requirements: Most recent HbA1c test or GMI results and result date Service date range: Measurement year Required exclusions: - Members in hospice or using hospice services during the measurement year - Members who died during measurement year - Members who had an encounter or receiving palliative care anytime during the measurement year - Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following: - Enrolled in an Institutional SNP (I-SNP) any time during the measurement year - Living long-term in an institution any time during the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File - Members 66 years of age and older by the end of the measurement year with frailty and advanced illness. Members must meet BOTH frailty and advanced illness criteria to be excluded: - Frailty. At least two indications of frailty with different dates of service during the measurement year - Advanced Illness. Either of the following during the measurement year or the year prior to the measurement year: - Advanced illness on at least two different dates of service - Dispensed dementia medication	Claims data: Diabetes: E10.10 , E10.11 HbA1c: 83036: HbA1c lab test with CPT value 3044F: HbA1c < 7.0% 3046F: HbA1c > 9.0% 3051F: HbA1c ≥ 7.0% and < 8.0% 3052F: HbA1c ≥ to 8.0% and ≤ 9.0% Exclusion: Hospice encounter: 0115

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Quality Measure	Measure Definition	Measure Requirements	Commonly Used Codes*
HDO – Use of opioids at high dosage 18 years of age and older	Members who for 15 or more days received prescription opioids at a high dosage during the measurement year <i>*Supplemental data can be used for only required exclusions for this measure</i>	Requirements: Two or more events with opioid dispensed on two different dates of service and were given for fifteen or more total days Dosing stats (average morphine milligram equivalent dose [MME] ≥90) Service date range: Measurement year Required exclusions: - Members who had at least one of the following any time within the measurement year: cancer, sickle cell disease, received or had an encountered for palliative care - Members in hospice or using hospice services during the measurement year - Members who died any time during the measurement year	Claims data: Pharmacy claims only Exclusions: Hb-sickle cell disease with crisis, unspecified: D57.00 Hospice care management: 385765002 Hospice encounter: 0650

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Quality Measure	Measure Definition	Measure Requirements	Commonly Used Codes*
IMA-E -Immunizations for Adolescents Adolescents turning 13 years of age	Percentage of adolescents who had the following vaccinations by their 13th birthday: - One dose of meningococcal vaccine between 10th and 13th birthdays - One tetanus, diphtheria, toxoids and acellular pertussis (Tdap) vaccine between 10th and 13th birthdays - Anaphylaxis due to the tetanus, diphtheria or pertussis vaccine any time on or before the member's 13th birthday - Encephalitis due to the tetanus, diphtheria or pertussis vaccine any time on or before the member's 13th birthday - Completed the human papillomavirus (HPV) vaccine series between 9th and 13th birthdays - If two doses, there must be 146 days between the first and second dose of the HPV vaccine - Anaphylaxis due to the HPV vaccine any time on or before the member's 13th birthday	Requirements: Vaccine code and service date or anaphylaxis due to vaccine for specific indicators Service date range: January 1–December 31 Required exclusions: - Members in hospice or using hospice services during the measurement period - Members who die any time during the measurement period	Electronic Clinical Data Systems (ECDS) Tdap vaccine procedure: 90715 Meningococcal vaccine procedure: 90734, 90733 HPV vaccine procedure: 90649, 90650, 90651 Anaphylaxis caused by diphtheria and tetanus vaccine: SNOMED 428281000124107, 428291000124105

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Quality Measure	Measure Definition	Measure Requirements	Commonly Used Codes*
INR - International Normalized Ratio Monitoring for Individuals on Warfarin 18 years of age and older	Members who had at least one 56-day interval of warfarin therapy and who received at least one international normalized ratio (INR) monitoring test during each 56-day interval with active warfarin therapy	Requirements: Active warfarin therapy and at least one INR test in a 56-day interval Service date range: Measurement year Required exclusions: Members with INR home monitoring during the measurement year	Exclusion: INR home monitoring: 93792, 93793
KED - Kidney Health Evaluation for Patients with Diabetes 18-85 years of age	Members with diabetes (type 1 or type 2) who received both of the following during the measure year: Estimated glomerular filtration rate (eGFR) -and- Urine albumin-creatinine ratio (uACR) – Both a quantitative urine albumin test and a urine creatinine test with service dates four days or less apart	Requirements: eGFR and uACR test code and result date Service date range: Measurement year Required exclusions: - Members with evidence of ESRD - Members who had dialysis - Members who have died during the measurement year - Members in hospice or using hospice services during the measurement year - Members receiving palliative care anytime during the measurement year - Members who had an encounter for palliative care anytime during the measurement year <i>Medicare</i> Members 66 years of age and older as of December 31 of the measurement year who meet either of the following - Enrolled in an institutional SNP (I-SNP) any time during the measurement year - Living long-term in an institution anytime during the measurement year	Claims data: eGFR: 80047, 80048, 80050 -and- Quantitative urine albumin test: 82043 Urine creatinine lab test: 82570 Urine albumin creatinine ratio lab test: 9318-7 Exclusions: ESRD: N18.6 Chronic kidney disease, stage 5: N18.5 Dependence on renal dialysis: Z99.2 Dialysis procedure: 90999

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Quality Measure	Measure Definition	Measure Requirements	Commonly Used Codes*
<i>KED continued</i>		- Members 66-80 years of age and older by the end of the measurement year with frailty and advanced illness. Members must meet BOTH frailty and advanced illness criteria to be excluded: - Frailty. At least two indications of frailty with different dates of service during the measurement year - Advanced Illness. Either of the following during the measurement year or the year prior to the measurement year: - Advanced illness on at least two different dates of service - Dispensed dementia medication - Members 81 years of age and older as of December 31 of the measurement year with at least two indications of frailty with different dates of service during the measurement year	

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Quality Measure	Measure Definition	Measure Requirements	Commonly Used Codes*
LBP – Use of Imaging Studies for Low Back Pain 18–75 years of age	Members with a principal diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis <i>*Supplemental data can be used for only required exclusions for this measure</i>	Requirements: An imaging study with a diagnosis of uncomplicated low back pain on the Index episode start date (IESD) or in the 28 days following the IESD Service date range: January 1 through December 3 of the measurement year Required exclusions: - Cancer, HIV, history of organ transplant, osteoporosis or spondylopathy any time during the member's history through 28 days after the IESD. Do not include laboratory claims - Organ transplant, lumbar surgery or medication treatment for osteoporosis any time during the member's history through 28 days after the IESD - IV drug abuse, neurologic impairment or spinal infection any time during the 365 days prior to the IESD through 28 days after the IESD. Do not include laboratory claims - Trauma or a fragility fracture any time during the 90 days prior to the IESD through 28 days after the IESD. Do not include laboratory claims - Prolonged use of corticosteroids. 90 consecutive days of corticosteroid treatment any time during the 366-day period that begins 365 days prior to the IESD and ends on the IESD - A dispensed prescription to treat osteoporosis any time during the member's history through 28 days after the IESD	Claims data: Low back pain: M54.5 Low back pain, unspecified: M54.50 Sciatica, unspecified side: M54.30 Unspecified injury of lower back, initial encounter: S39.92XA Unspecified injury of lower back, sequela: S39.92XS Dorsalgia, unspecified: M54.9 Vertebrogenic low back pain: M54.51 Spinal stenosis, lumbosacral region: M48.07 Imaging study: 72020, 72040, 72050, 72070 Magnetic resonance imaging of lumbar spine (procedure): 241648005 X-ray of lumbar spine and pelvis (procedure): 431892005 X-ray tomography of lumbar spine (procedure): 718542005

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Quality Measure	Measure Definition	Measure Requirements	Commonly Used Codes*
LBP <i>continued</i>		- Members who died any time during the measurement year - Members receiving palliative care or who had an encounter for palliative care any time during the measurement year - Members who use hospice services or elect to use a hospice benefit any time during the measurement year - Members 66 years of age and older as of December 31 of the measurement year with frailty and advanced illness. Members must meet BOTH frailty and advanced illness criteria to be excluded: - Frailty. At least two indications of frailty with different dates of service during the measurement year - Advanced Illness. Either of the following during the measurement year or the year prior to the measurement year: - Advanced illness on at least two different dates of service - Dispensed dementia medication	Exclusions: Postmenopausal osteoporosis (disorder): 102447009 Age-related osteoporosis without current pathological fracture: M81.0 Kaposi's sarcoma, unspecified: C46.9 Asymptomatic human immunodeficiency virus [HIV] infection status: Z21 Kidney transplant status: Z94.0 Liver transplant status: Z94.4

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Quality Measure	Measure Definition	Measure Requirements	Commonly Used Codes*
LSC – Lead Screening in Children Before second birthday	Children who had one or more lead blood test for lead poisoning by their second birthday	Requirements: One capillary or venous blood lead screening test and the date the test was performed. A lead risk questionnaire does not count Service date range: Birth to second birthday Required exclusions: - Members in hospice or using hospice services during the measurement year - Members who have died during the measurement year	Claims data: Lead screening: 83655
OMW – Osteoporosis Management in Women Who Had a Fracture Women 67–85 years of age	Women who had a fracture and either a bone mineral density (BMD) test or received a prescription to treat osteoporosis after six months of the fracture <i>Fractures of finger, toe, face and skull are not included in this measure</i> Intake period: July 1 of the year prior to the measurement year to June 30 of the measurement year. The intake period is used to capture the first fracture Remove episode dates where any of the following are met: - Members who had a BMD test during the 730 days prior to the episode date - Members who had a claim/encounter for osteoporosis therapy during the 365 days prior	Requirements: Test, prescription and service date Service date range: Six months after fracture Required exclusions: - Members in hospice or using hospice services during the measurement year - Members who have died during the measurement year - Members who had a palliative care encounter or who received palliative care any time during the intake period through the end of the measurement year - Members 67 years of age and older as of December 31 of the measurement year who meet either of the following: - Enrolled in an Institutional SNP (I-SNP) any time during the intake period through the end of the measurement year - Living long-term in an institution any time during the intake period through the end of measurement year identified by the LTI flag	Claims data: BMD test: 77080, 77081, 77085 Osteoporosis medication therapy: - Injection, denosumab, 1 mg: J0897 - Injection, ibandronate sodium, 1 mg: J1740 - Injection, teriparatide, 10 mcg: J3110 - Injection, romosozumab-aqqg, 1 mg: J3111 - Injection, zoledronic acid, 1 mg: J3489

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Quality Measure	Measure Definition	Measure Requirements	Commonly Used Codes*
OMW <i>Continued</i>	to the episode date Members who received a dispensed prescription or had an active prescription to treat osteoporosis during the 365 days prior to the episode date	in the Monthly Membership Detail Data File - Members 67–80 years of age and older by the end of the measurement year with frailty and advanced illness. Members must meet BOTH frailty and advanced illness criteria to be excluded: - Frailty. At least two indications of frailty with different dates of service during the intake period through the end of the measurement year. Do not include laboratory claims - Advanced Illness. Either of the following during the measurement year or the year prior to the measurement year: - Advanced illness on at least two different dates of service. Do not include laboratory claims - Dispensed dementia medication - Members 81 years of age and older as of December 31 of the measurement year with at least two indications of frailty during the intake period through the end of the measurement year. Do not include laboratory claims	

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Quality Measure	Measure Definition	Measure Requirements	Commonly Used Codes*
PBH – Persistence of Beta-Blocker Treatment After a Heart Attack 18 years of age and older	The percentage of members 18 years of age and older during the measurement year who: - Were hospitalized and discharged from July 1 of the year prior to the measurement year to June 30 of the measurement year with a diagnosis of acute myocardial infarction (AMI) - and- - Received persistent beta- blocker treatment for six months after discharge	Requirements: No special requirements Service date range: Begins on July 1 of the year prior to the measurement year and ends on June 30 of the measurement year Required exclusions: - Members with a medication dispensing even or with a diagnosis that indicates a contraindication to beta-blocker therapy any time during the member's history through the end of the continuous enrollment period - Members in hospice or using hospice services during the measurement year - Members who have died during the measurement year - Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following: - Enrolled in an institutional SNP (I-SNP) any time on or between July 1 of the year prior to the measurement year and the end of the measurement year - Living long-term in an institution any time on or between July 1 of the year prior to the measurement year and the end of the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File - Members 66–80 years of age and older by the end of the measurement year with frailty and advanced illness. Members must meet BOTH frailty and advanced illness criteria to be excluded:	Claims data: Dispensing of a beta blocker medication Exclusions: Adverse beta antagonist: T44.7X5A Asthma: 493.90 Other asthma: J45.998 Chronic obstructive pulmonary disease, unspecified: J44.9

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Quality Measure	Measure Definition	Measure Requirements	Commonly Used Codes*
PBH <i>Continued</i>		- Frailty. At least two indications of frailty with different dates of service any time on or between July 1 of the year prior to the measurement year and the end of the measurement year. Do not include laboratory claims - Advanced Illness. Either of the following during the measurement year or the year prior to the measurement year: • Advanced illness on at least two different dates of service • Dispensed dementia medication • Members 81 years of age and older as of December 31 of the measurement year with at least two indications of frailty with different dates of service any time on or between July 1 of the year prior to the measurement year and the end of the measurement year	
PCE- Pharmacotherapy Management of COPD Exacerbation • 40 years or older as of January 1 of the measurement year	Members with a COPD exacerbation who had an acute inpatient discharge or ED visit were dispensed the appropriate medications Two rates reported: 1. Dispensed a systemic corticosteroid (or there was evidence of an active prescription) within 14 days of the event 2. Dispensed a bronchodilator (or there was evidence of an active prescription) within 30 days of the event	Requirements: No special requirements Service date range: Begins on January 1 of the measurement year through November 30 of the measurement year Required exclusions: • Members in hospice or using hospice services during the measurement year • Members who have died during the measurement year	Claims data: Dispensing of a systemic corticosteroid and bronchodilator Other specified chronic obstructive pulmonary disease: J44.89 Nonacute inpatient stay: 0022, 0024, 0118, 0180 Inpatient stay: 0100, 0101, 0110, 0111, 0112, 0113 ED: 99281, 99282, 99283

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Quality Measure	Measure Definition	Measure Requirements	Commonly Used Codes*
PCR – Plan All Cause Readmission 18 years of age and older	The number of acute inpatient and observation stays followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission <i>*Supplemental data may not be used for this measure, except for required exclusions</i>	Requirements: No special requirements Service date range: January 1 through December 1 of the measurement year Required exclusions: Members in hospice or using hospice services during the measurement year	Claims data only: Observation Stay: - UBREV: 0760 - UBREV: 0762 - UBREV: 0769 Exclusion: Outpatient, ED, acute inpatient and nonacute inpatient: 99304
POD – Pharmacotherapy for opioid use disorder (OUD) 16 years of age and older	Pharmacotherapy events that lasted at least 180 days with a diagnosis of OUD and a new OUD pharmacotherapy event	Requirements: Pharmacy claims only Service date range: July 1 of the year prior to the measurement year to June 30 of the measurement year Required exclusions: - Members who use hospice services or elect to use a hospice benefit any time during the measurement year - Members who die any time during the measurement year	Pharmacy claims

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Quality Measure	Measure Definition	Measure Requirements	Commonly Used Codes*
POLY-ACH – Polypharmacy: Use of Multiple Anticholinergic Medications in Older Adults 65 years of age and older	The percent of individuals with concurrent use of at least 2 unique anticholinergic medications Members with at least two prescription claims for the same anticholinergic medication on different dates of service with overlap for 30 or more cumulative days of 2 or more unique anticholinergic medications, each with 2 or more claims on different dates of service during the measurement year <i>*May not use supplemental data for this measure</i>	Requirements: Prescription claims only Service date range: Measurement year; ≥65 years of age as of the first day of the measurement year Required exclusions: Members in hospice or using hospice services during the measurement year	Claims data only

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Quality Measure	Measure Definition	Measure Requirements	Commonly Used Codes*
PPC – Prenatal and Postpartum Care The percentage of deliveries of live births	Delivery of a live birth on or between October 8 of the year prior and October 7 of the measurement year. The measure assesses the following facets of prenatal and postpartum care: Timeliness of prenatal care: The percentage of deliveries that received a prenatal care visit in the first trimester on or before the enrollment start date or within 42 days of enrollment in the organization. First trimester is defined as 280–176 days prior to delivery Postpartum care: The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery Women are counted twice if they had two separate deliveries (different dates of service) between October 8 of the year prior and October 7 of the measurement year	Requirements: No special requirements Anchor date: Date of delivery Service date range: October 8 of the year prior to the measurement year and October 7 of the measurement year Required exclusions: - Members in hospice or using hospice services during the measurement year - Members who have died during the measurement year	Deliveries: 59400, 59410 Pregnant - blood test confirms: 169561007 Pregnant - urine test confirms: 169560008 Prenatal bundled services: 59400, 59410, 59510, 59515 Stand-alone prenatal visits: 0500F, 0501F, 0502F, CPT 99500 Prenatal visits: 98966, 98967, 98970, 98980, 99211 Postpartum care: 57170, 58300, 59430, 99501, 0503F Routine postpartum follow-up: 717810008 Cervical cytology lab test: 88141, 88142, 88143 Prenatal & Postpartum bundled services: 59400 Postpartum care assessment (procedure): 409018009 Cervical or vaginal cancer screening; pelvic and clinical breast examination: G0101 Exclusion: Single stillbirth: Z37.1

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Quality Measure	Measure Definition	Measure Requirements	Commonly Used Codes*
SAA – Adherence to Antipsychotic Medications for Individuals with Schizophrenia 18 years of age and older	Members with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period	Requirements: Prescription claims only Service date range: Measurement year Index prescription start date (IPSD): The earliest prescription dispensing date for any antipsychotic medication during the measurement year Required exclusions: - Members with a diagnosis of dementia - Members who did not have at least two antipsychotic medication dispensing events - Members in hospice or using hospice services during the measurement year - Members who have died during the measurement year - Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following: - Enrolled in an institutional SNP (I-SNP) anytime during the measurement year - Living long-term in an institution any time during the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File - Members 66-80 years of age as of December 31 of the measurement year with BOTH frailty and advanced illness criteria to be excluded: - Frailty. At least two indications of frailty with different dates of service during the measurement year - Advanced Illness. Either of the following during the measurement year or the year prior to the measurement year: - Advanced illness on at least two	Claims data: Paranoid schizophrenia: F20.0, 64905009 Schizophrenia (disorder): F20.81, 58214004 Other schizophrenia: F20.89 Exclusions: Dementia: 52448006 Vascular dementia, unspecified severity, without behavioral, psychotic, mood disturbances or anxiety: F01.50 Alzheimer's disease, unspecified: G30.9

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Quality Measure	Measure Definition	Measure Requirements	Commonly Used Codes*
SAA <i>Continued</i>		- different dates of service - Dispensed dementia medication - Members 81 years of age and older as of December 31 of the measurement year with at least two indications of frailty with different dates of service during the measurement year	
SMD – Diabetes Monitoring for People with Diabetes and Schizophrenia 18–64 years of age	Members with schizophrenia or schizoaffective disorder and diabetes who had both an LDL-C test and an HbA1c test	Requirements: HbA1c and LDL-C test and results on the same or different dates of service - The member must have both tests to be included in the numerator Service date range: Measurement year Required exclusions: - Members in hospice or using hospice services during the measurement year - Members who have died during the measurement year	Claims data: Type 1 diabetes mellitus with ketoacidosis without coma: E10.10 Diabetes mellitus without complication: 111552007 Telephone visits: 99441 Schizophrenia, unspecified: F20.9 Schizophreniform disorder: F20.81 <u>HbA1c:</u> 83036: HbA1c lab test with CPT value 3044F: HbA1c < 7.0% 3046F: HbA1c > 9.0% 3051F: HbA1c ≥ to 7.0% and < 8.0% 3052F: HbA1c ≥ to 8.0% and ≤ 9.0% <u>LDL-C:</u> 80061, 83700, 83721: LDL-C lab test with CPT value 3048F: LDL-C < 100 mg/dL 3049F: LDL-C 100-129 mg/dL 3050F: LDL-C ≥ to 130 mg/dL

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Quality Measure	Measure Definition	Measure Requirements	Commonly Used Codes*
SNS-E – Social Need Screening and Intervention Age Stratification: ≤17 18-64 65+	Members who were screened, using prespecified instruments, at least once during the measurement period for unmet food, housing, and transportation needs, and received a corresponding intervention if they screened positive Food screening/intervention: - Positive for food insecurity and food. Intervention received within 30 days of positive screen (31 days total) House screening/intervention: - Positive for housing instability, homelessness, or housing inadequacy and housing. Intervention received within 30 days of positive screen (31 days total) Transportation screening/intervention: - Positive for transportation insecurities and transportation. Intervention received within 30 days of positive screen (31 days total)	Requirements: A positive screen with a prespecified instrument and a corresponding intervention Service date range: Measurement year - Insecurity screen findings between January 1 and December 1 of the measurement period - Interventions must be received within 30 days post positive screen (31 days total) Required exclusions: - Members who use hospice services or elect to use a hospice benefit any time during the measurement period. - Members who died any time during the measurement period <i>Medicare</i> members 66 years of age and older by the end of the measurement period who meet either of the following: - Enrolled in an Institutional SNP (I-SNP) any time during the measurement period - Living long-term in an institution any time during the measurement period	Electronic Clinical Data Systems Food insecurity procedures: 96156, 96160 Housing instability procedures: 96156, 96160 Transportation insecurity procedures: 96156, 96160

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Quality Measure	Measure Definition	Measure Requirements	Commonly Used Codes*
SPC – Statin Therapy for Patients with Cardiovascular Disease Males 21–75 years of age and females 40–75 years of age	Percentage of members who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and met the following criteria: Received statin therapy: Members who were dispensed at least one high-intensity or moderate-intensity statin medication in the measurement year Statin adherence 80 percent: Members who remained on a high-intensity or moderate-intensity statin medication for at least 80% of the treatment period	Requirements: No special requirements Service date range: Measurement year - The period of time beginning on the Index prescription start date (IPSD) through the last day of the measurement year Required exclusions: - Members with a diagnosis of pregnancy, IVF, dispensed prescription for clomiphene, ESRD, Dialysis, cirrhosis in the measurement year or year prior to the measurement year - Members with myalgia, myositis, myopathy, or rhabdomyolysis during the measurement year - Myalgia or rhabdomyolysis caused by a statin any time during the member's history through December 31 of the measurement year - Members who died during the measurement year - Members in hospice or using hospice services during the measurement year - Members receiving palliative care anytime during the measurement year - Members who had an encounter for palliative care anytime during the measurement year - Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following: - Enrolled in an institutional SNP (I-SNP) anytime during the measurement year - Living long-term in an institution any time during the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File	Claims data: Dispensing of one high or moderate intensity statin medication Non-ST elevation (NSTEMI) myocardial infarction: I21.4 Acute myocardial infarction, unspecified: I21.9 Silent myocardial ischemia: I25.6 CABG: 33510, 33511, 33530 PCI: 92920, 92941 Exclusions: ESRD: N18.6 Abdominal pregnancy without intrauterine pregnancy: O00.0 Unspecified cirrhosis of liver: K74.60 Cirrhosis of liver due to hepatitis B (disorder): 103611000119102 Myalgia, unspecified site: M79.10 Myalgia of mastication muscle: M79.11 Rhabdomyolysis due to statin: 787206005

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Quality Measure	Measure Definition	Measure Requirements	Commonly Used Codes*
SPC <i>Continued</i>		- Members 66 years of age and older by the end of the measurement year with BOTH frailty and advanced illness criteria to be excluded: - Frailty. At least two indications of frailty with different dates of service during the measurement year - Advanced Illness. Either of the following during the measurement period or the year prior to the measurement period: - Advanced illness on at least two different dates of service - Dispensed dementia medication	IVF In-vitro fertilization pregnancy: 10231000132102 Dialysis procedure: 90935, 90937, 90945, 90947, 90997, 90999, 99512
SPD – Statin Therapy for Patients with Diabetes 40–75 years of age	Percentage of members with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) and meet these criteria: Two rates are reported: 1. Received statin therapy: Members who were dispensed at least one statin of any intensity during the measurement year 2. Statin adherence 80 percent: Members who remained on a statin of any intensity for at least 80% of the treatment period	Requirements: No special requirements Service date range: Measurement year - The period of time beginning on the Index prescription start date (IPSD) through the last day of the measurement year Required exclusions: - Members with one of the following during the year prior to the measurement year: MI, CABG, PCI or another revascularization - Members who had at least one encounter with a diagnosis of IVD during both the measurement year and the year prior to the measurement year: outpatient visit, telephone visit, e-visit or virtual visit, acute inpatient encounter, or inpatient discharge - Members with a diagnosis of pregnancy, IVF, dispensed prescription for clomiphene, ESRD, Dialysis or cirrhosis in the measurement year or year prior to the measurement year	Claims data: Dispensing of one high, moderate, or low intensity statin medication Exclusions: Non-ST elevation (NSTEMI) myocardial infarction: I21.4 CABG: 33510, 33511, 33522 PCI: 92920, 92924 Abdominal pregnancy without intrauterine pregnancy: O00.0 ESRD: N18.6 Cirrhosis of liver (disorder): 19943007

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Quality Measure	Measure Definition	Measure Requirements	Commonly Used Codes*
SPD <i>Continued</i>		• Myalgia or rhabdomyolysis caused by a statin any time during the member's history through December 31 of the measurement year • Members with myalgia, myositis, myopathy, or rhabdomyolysis during the measurement year • Members who have died during the measurement year • Members in hospice or using hospice services during the measurement year • Members receiving palliative care anytime during the measurement year • Members who had an encounter for palliative care anytime during the measurement year • Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following: – Enrolled in an institutional SNP (I-SNP) anytime during the measurement year – Living long-term in an institution any time during the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File • Members 66 years of age and older by the end of the measurement year with BOTH frailty and advanced illness criteria to be excluded: – Frailty. At least two indications of frailty with different dates of service during the measurement year – Advanced Illness. Either of the following during the measurement period or the year prior to the measurement period: • Advanced illness on at least two different dates of service • Dispensed dementia medication	Unspecified cirrhosis of liver: K74.60 Myalgia, unspecified site: M79.10 Myalgia of mastication muscle: M79.11 Rhabdomyolysis due to statin: 787206005 Dialysis procedure: 90935, 90937, 90945, 90947, 90997, 90999, 99512 IVF In-vitro fertilization pregnancy: 10231000132102

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Quality Measure	Measure Definition	Measure Requirements	Commonly Used Codes*
SSD – Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications 18–64 years of age	Members with schizophrenia, schizoaffective disorder, or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year	Requirements: A glucose test or an HbA1c test or one diabetic screening code and service date for members diagnosed with schizophrenia or bipolar disorder that are taking antipsychotic medications Service date range: Measurement year Required exclusions: - Members who had no antipsychotic medication dispensed during the measurement year - Members in hospice or using hospice services during the measurement year - Members who have died during the measurement year - Members with a diagnosis of diabetes in the measurement year or year prior. There are two ways to identify members with diabetes: Claim/encounter data: Members who had at least two diagnoses of diabetes on different dates of service during the measurement year or the year prior to the measurement year Pharmacy data: Members who were dispensed insulin or hypoglycemics/ antihyperglycemics during the measurement year or the year prior to the measurement year and have at least one diagnosis of diabetes during the measurement year or the year prior to the measurement year	Type 1 diabetes mellitus with ketoacidosis without coma: E10.10 Type 2 diabetes mellitus without complications: E11.9 Diabetes mellitus without complication: 111552007 Schizophrenia, unspecified: F20.9 Paranoid schizophrenia: F20.0 Schizoaffective disorder, bipolar type: F25.0 Telephone visits: 99441, 99442, 99443, 98966 Visit setting unspecified: 90791, 90792 Glucose test: 80047, 80048, 80050, 80053, 80069, 82947, 82950, 82951 HbA1c: 83036: HbA1c lab test w/CPT value 3044F: HbA1c < 7.0% 3046F: HbA1c > 9.0% 3051F: HbA1c ≥ to 7.0% and < 8.0% 3052F: HbA1c ≥ to 8.0% and ≤ 9.0%

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Quality Measure	Measure Definition	Measure Requirements	Commonly Used Codes*
SUPD – Statin Use in Persons with Diabetes 40–75 years old	Percentage of patients who were dispensed a diabetes medication and are receiving statin therapy Members with at least 2 prescription claims on different dates of service for any diabetes medication and at least one statin medication claim during the measurement year <i>*May not use supplemental data for this measure</i>	Requirements: Prescription claims only Service date range: Measurement year; 40–75 years of age as of the first day of the measurement year Required exclusions: Members with any of the following: - Myositis, myopathy or rhabdomyolysis during the measurement year - Prediabetes - End stage renal disease (ESRD) - Cirrhosis - Pregnant, lactating or undergoing fertility treatment - Polycystic ovarian syndrome (PCOS) - Received hospice services anytime during the measurement year	Claims data only Paid, non-reversed claim for statin medication

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Quality Measure	Measure Definition	Measure Requirements	Commonly Used Codes*
TRC – Transition of Care 18 years of age and older	Members who had a discharge and require the following: Notification of inpatient admission: Documentation of receipt of notification of inpatient admission or evidence that the information was integrated in the appropriate medical record and is accessible to the PCP or ongoing care provider on the day of admission through 2 days after admission (3 total days) Receipt of discharge information: Documentation of discharge information or evidence that the information was integrated in the appropriate medical record and is accessible to the PCP or ongoing care provider on the day of discharge through 2 days after discharge (3 total days) Patient engagement after inpatient discharge: Documentation of patient engagement provided within 30 days after discharge. Do not include patient engagement that occurs on the date of discharge Medication reconciliation post-discharge: Documentation of medication reconciliation on the date of discharge through 30 days after discharge (31 total days) <i>Documentation must be in the outpatient medical record and evident accessible to the PCP or ongoing care provider</i>	Requirements: Code, provider type, inpatient admission date, discharge date/information and service date Members who have more than one discharge, include all discharges on or between January 1 and December 1 of the measurement year Service date range: January 1 and December 1 of the measurement year Required exclusions: - Members in hospice or using hospice services during the measurement year - Members who have died during the measurement year	<i>Any one of the following:</i> Outpatient and telehealth: 98970, 99202, 99401, 99442 Transitional care: 99496 Medication reconciliation encounter or intervention: 99483, 1111F Medication reconciliation by pharmacist (procedure): 428701000124107 Medication reconciliation (procedure): 430193006

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Quality Measure	Measure Definition	Measure Requirements	Commonly Used Codes*
UOP – Use of opioids from multiple providers 18 years of age and older	The percentage of members receiving prescription opioids for greater than 15 days from multiple providers during the measurement year Three rates reported: - Prescriptions for opioids from four or more different prescribers during the measurement year - Prescriptions for opioids from four or more different pharmacies during the measurement year - Prescription for opioids from four or more different prescribers and four or more different pharmacies during the measurement year <i>*May not use supplemental data for this measure, except required exclusions</i>	Requirements: Pharmacy claims only Service date range: The measurement year Required exclusions: - Members in hospice or using hospice services during the measurement year - Members who have died during the measurement year	Claims data only: Pharmacy claims only Exclusion: Hospice intervention: 99377

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Quality Measure	Measure Definition	Measure Requirements	Commonly Used Codes*
URI – Appropriate treatment for Upper Respiratory Infection 3 months of age and older	Members with a diagnosis of upper respiratory infection who were not dispensed an antibiotic <i>*May not use supplemental data for this measure, except required exclusions</i>	Requirements: Submit all diagnoses on claims if more than one diagnosis is present when prescribing antibiotics Service date range: July 1 of the year prior to the measurement year and ends on June 30 of the measurement year Required exclusions: - Members in hospice or using hospice services during the measurement year - Members who have died during the measurement year	Claims data only: Inpatient stay: UBREV 0100, 0101, 0111, 1000, 1001, 1002 Acute laryngopharyngitis: J06.0 Acute upper respiratory infection, unspecified: J06.9 Acute nasopharyngitis: J00 Human immunodeficiency virus: B20 Emphysema, unspecified: J43.9
W30 – Well-Child Visits in the First 30 Months of Life Children who turned 15–30 months of age	Children in the measurement year who had the following number of well-child visits with a primary care physician - Children who turned 15 months old during the measurement year: 6 or more well-child visits - Children who turned 30 months old during the measurement year: 2 or more well-child visits	Requirements: Visit code, provider type and service date Service date range: Measurement year Required exclusions: - Members in hospice or using hospice services during the measurement year - Members who have died during the measurement year	Well child checks: 99381, 99382, 99383, 99384, 99385, 99461

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Quality Measure	Measure Definition	Measure Requirements	Commonly Used Codes*
WCC – Weight Assessment and Counseling for Nutrition/Physical Activity for Children/Adolescents 3–17 years of age	Members who had an outpatient visit with a PCP or ob/gyn and who had evidence of the following: - Body mass index (BMI) percentile - Counseling for nutrition - Counseling for physical activity	Requirements: Visit code, provider type and service date Service date range: Measurement year Required exclusions: - Members diagnosed with pregnancy during the measurement year - Members in hospice or using hospice services during the measurement year - Members who have died during the measurement year	BMI percentile: 59574-4 Nutrition counseling: 97802, 97803, 97804 Nutritional counseling, dietitian visit: S9470 Face-to-face behavioral counseling for obesity, 15 minutes: G0447 Exclusion: Abdominal pregnancy without intrauterine pregnancy: O00.00

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Quality Measure	Measure Definition	Measure Requirements	Commonly Used Codes*
WCV – Child and Adolescent Well-Care Visits 3–21 years of age	Members with a visit to a primary care physician (PCP) or an ob/gyn practitioner for at least one comprehensive well-care visit during the measurement year	Requirements: Well-care visit with a PCP (does not have to be with assigned PCP) or ob/gyn including the following: A health history, physical development history, mental development history, physical exam, and health education/anticipatory guidance Service date range: Measurement year Required exclusions: - Members in hospice or using hospice services during the measurement year - Members who have died during the measurement year	Well child checks: 99381, 99382, 99383, 99384, 99385, 99461

Learn more about this chart

- Electronic supplemental data via data integration team: The comments in the “measure requirements” column identify what is needed to submit supplemental data files electronically. Refer to guidelines and data specs: Aetna Standard HEDIS MY2025 Supplemental Data Reference Guide.xlsx. Contact your engagement manager or HEDIS representative for more details.

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The above information is not a complete list of services for this measure. For a complete list please refer to the NCQA website at **NCQA.org**. HEDIS 2025 Volume 2: Technical Specifications for Health Plans by the National Committee for Quality Assurance (NCQA). HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

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Appendix

HEDIS[®] Terms

- **Measurement year:** The measurement year is the calendar year (in many cases January 1 – December 31) where data is collected and reported during the reporting year.
- **Reporting year:** The reporting year is the year after the measurement year. The service dates are from the measurement year, which is usually, the year prior. In some cases, the service dates may go back more than one year.
- **Denominator:** The number of members who qualify for the measure criteria based on NCQA technical specifications.
- **Numerator:** The number of members who meet compliance criteria based on NCQA technical specifications for appropriate care treatment, or service.

Collection Methods

- **Administrative:** Measures reported as administrative use the total eligible population for the denominator. Medical, pharmacy and encounter claims count toward the numerator. In some instances, health plans use approved supplemental data for the numerator.
- **Hybrid:** Measures reported as hybrid use a random sample of 411 members from a health plan's total eligible population for the denominator. The numerator includes medical and pharmacy claims, encounters, and medical record data. In some cases, health plans use auditor approved supplemental data for the numerator.