UnitedHealthcare® Quality Reference Guide

2023 HEDIS,® CMS Part D, CAHPS® and HOS Measures

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We have the same goal:

To help improve your patients' health outcomes by identifying and addressing open care opportunities.

Like you, we want your patients, who are UnitedHealthcare plan members, to be as healthy as possible. And a big part of that is making sure they get the preventive care and chronic care management they need. To help identify care opportunities, our PATH program provides information specific to UnitedHealthcare members who are due or overdue for specific services.

This reference guide can help you better understand the specifications for many of the quality measurement programs and tools used to address care opportunities, as well as how to report data and related billing codes.

For additional PATH resources or to access this guide online, please visit **UHCprovider.com/path.**

PCA-1-23-01669-Clinical-QRG_06072023

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By working together, we can achieve our shared goals.

HEDIS® measures

Healthcare Effectiveness Data and Information Set (HEDIS®) is a National Committee for Quality Assurance (NCQA tool used by more than 90% of America's health plans to measure performance on important dimensions of care and service.

- HEDIS® measures are reported as administrative or hybrid and are collected and reported annually by health plans.
- The data collection cycle, which includes gathering medical record information from care providers, generally happens in the first half of each year.
- The data is then used to evaluate quality of care, which is determined by dividing the measure numerator by the measure denominator.

HEDIS®-related terms are explained in the glossary.

CMS measures

Centers for Medicare & Medicaid Services (CMS) Part D medication adherence measures are used to help increase the number of Medicare members taking their cholesterol (statin), diabetes and/or hypertension (RAS antagonist) medications as prescribed. Members are eligible for a measure if their medication appears on a targeted list provided by the Pharmacy Quality Alliance (PQA). Their adherence is then evaluated using the proportion of days covered (PDC), which is defined in the Glossary.

- CMS considers Medicare members adherent if their PDC is 80% or more at the end of the measurement period.
- Member eligibility and performance within the Part D medication adherence measures is ***based entirely on prescription claims processed at the pharmacy under the Part D benefit.***
- Supplemental data from medical records or patient assessments can't be used to affect these measures.

CAHPS® measures

Consumer Assessment of Healthcare Providers and Systems (CAHPS) is an annual survey that asks consumers and members to report on and evaluate their experiences with health care. The CAHPS® survey is governed by CMS and NCQA.

- The survey is given annually between February and June to adults ages 18 and older who have been enrolled in a health plan during a continuous six-month period for Medicare and Medicaid, or a 12-month period for commercial. For Medicaid only, guardians of children ages 17 and younger are also given the survey if they've been enrolled in a plan for a continuous 6-month period.
- Respondents are asked a core set of questions determined by NCQA and CMS, in addition to a series of optional supplemental questions crafted by a health plan and approved by NCQA and CMS.
- Members are given the option to complete the survey by mail, phone or online.
- Results are calculated and released between July and October.

HOS measures

Health Outcomes Survey (HOS) is a health plan member survey by CMS that gathers health status data specific to the Medicare Advantage program. Respondents are given a baseline survey between late August to November and then asked to complete a follow-up survey 2 years later between August and November.

Baseline survey results are calculated and released in May of the following year, while results for the follow-up survey are provided during the summer of the following year.

Glossary of Terms

Measurement year

In most cases, the 12-month timeframe between which a service was rendered – generally Jan.1 – Dec. 31. Data collected from this timeframe is reported during the reporting year.

Reporting year

The timeframe when data is collected and reported. 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.

Example: The 2022 reporting year would include data from services rendered during the measurement year, which would be 2021 and/or any time prior. Results from the 2022 reporting year would likely be released in June 2022, depending on the quality program.

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.

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.

Collection and reporting method

- **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.
- **Supplemental data –** Standardized process in which clinical data is collected by health plans for purposes of HEDIS® improvement. Supplemental clinical data is additional data beyond claims data.
- Electronic Clinical Data Systems (ECDS) - Organizations may use several data sources to provide complete information about the quality of health services delivered to its members. Data systems that may be eligible for HEDIS® ECDS reporting include, but are not limited to:
  - Administrative claims
  - Member eligibility files
  - Electronic health records
  - Clinical registries
  - Health information exchanges
  - Administrative claims systems
  - Disease/case management registries

Required exclusion

New in 2023: Many exclusions listed as optional previously are now required. Members are excluded from a measure denominator based on a diagnosis and/or procedure captured in their claim/encounter/pharmacy data. If applicable, the required exclusion is applied after the claims data is processed within certified HEDIS® software while the measure denominator is being created. For example:

- Members with end-stage renal disease (ESRD) during the measurement year or year prior will be excluded from the statin therapy for patients with cardiovascular disease (SPC) measure denominator.
- Members with a claim for hospice services during the measurement year will be excluded from all applicable measures.
- **New for 2023:** Exclusions for hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix are now required exclusions.

Optional exclusion

New for 2023: All optional exclusions were replaced with required exclusions.

Proportion of days covered (PDC)

According to the Pharmacy Quality Alliance (PQA), 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.

Tools You Can Use

We aim to make it easier for your practice to successfully address care opportunities for UnitedHealthcare plan members. To help, we offer a range of resources – some of which are highlighted here – so you can share data with us more effectively, identify members due for tests and screenings, and much more.

If you have any questions, please talk with your UnitedHealthcare representative. They can give you updates on existing programs, and details on any innovations coming soon.

UnitedHealthcare Provider Portal

The UnitedHealthcare Provider Portal allows you to quickly get the answers you need, so you can save valuable time and get better documentation and visibility. Along with Application Programming Interface (API) and Electronic Data Interchange (EDI), you can get the information you need for most UnitedHealthcare benefit plan members.

To access the UnitedHealthcare Provider Portal:

- Go to **UHCprovider.com** and click Sign In
- Log in using your One Healthcare ID
- New users go to UHCprovider.com/newusers

UnitedHealthcare Provider Portal tools include:

- **Eligibility and benefits**
  - View detailed patient eligibility and benefits information for multiple plans
  - Search for covered members copay, coinsurance and deductible amounts
  - View referral and prior authorization requirements
  - View or print member's digital ID card
  - Determine network and tier status

  Go to **UHCprovider.com/eligibilitytool** for more information
- **Claims**
  - View claims information for multiple UnitedHealthcare plans
  - Access letters, remittance advice documents and reimbursement policies
  - Submit additional information requested on pended claims
  - Flag claims for future viewing
  - Submit corrected claims or claim reconsideration requests
  - Receive instant printable confirmation for your submissions
  - Look up fee schedules

  Go to **UHCprovider.com/claims** for more information
- **Optum Intelligent EDI**
  - You can use EDI to submit single or batch transactions for multiple members and multiple payers, reducing the need for manual data entry, phone calls and numerous logins for payer websites
  - EDI transactions are generated from your practice management system (PMS) or hospital information system (HIS), and then routed to a clearinghouse for submission to UnitedHealthcare
  - Information we send back to you for these transactions is automatically loaded back into your system

  Go to **UHCProvider.com/ediconnect** for more information
- **Referrals**
  - Determine if a referral is needed for your patient
  - Submit a referral request and receive confirmation number
  - Check referral request status
  - View, print or save confirmation numbers and timelines for submitted referrals

  Go to **UHCprovider.com/referralstool** for more information.

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Tools You Can Use

UnitedHealthcare Provider Portal (continued)

- **Prior authorization and notification**
  - Determine if prior authorization or notification is required
  - Determine requirements using the procedure code and plan type
  - Submit or check the status of notification and prior authorization requests
  - Get real-time authorization approvals for some requests
  - Upload medical notes, medical records or other attachments
  - Provide pertinent clinical information, which may allow for quicker decisions and improved efficiency
  - Access prior authorization letters in Document Library

Go to **UHCprovider.com/paan** for more information.

- **PreCheck MyScript**
  - Get real-time, accurate, patient-specific prescription data
  - See current prescription coverage and price, including out-of-pocket costs
  - Get information on lower cost prescriptions options, if available
  - Learn which prescriptions require prior authorization, or which aren't covered or preferred
  - Request prior authorization and receive status and results

Go to **UHCprovider.com/pcms** for more information.

- **Document library**
  - Access, flag and download physician rosters, claim letters and UnitedHealthcare reports, such as the Patient Care Opportunity Report (PCOR).
  - Request paperless delivery to opt out of paper copies of letters and documents available in your Document Library

Go to **UHCprovider.com/documentlibrary** for more

- **My Practice Profile**
  - View and update the demographic data UnitedHealthcare members see for your practice
  - View contracted UnitedHealthcare plans for care providers

Go to **UHCprovider.com/mpp** for more information.

To learn more about **UnitedHealthcare Provider Portal**, go to **UHCprovider.com/portal.** If you have questions about accessing the portal, call UnitedHealthcare Web Support at **866-842-3278**, option 1, 7 a.m. – 9 p.m. CT, Monday – Friday.

Tools You Can Use

UnitedHealthcare Provider Portal (continued)

Patient Care Opportunity Report – Check for preventive and chronic care management opportunities

We created the Patient Care Opportunity Report (PCOR) to help you quickly see who may be due for screenings and tests, and who may be at risk for non-adherence to their medications.

The PCOR is compiled monthly from medical and pharmacy claims data and supplemental data. You can check it daily to view care opportunities tied to the following measure types:

- CMS Star Ratings
- HEDIS®
- Pharmacy compliance
- Value-based contracting

To view your PCOR:

- Go to **UHCprovider.com/pcor**.
  - New user? Click **New User** and follow the registration instructions.
- Click on **Go to Reports** and enter your One Healthcare ID and password.
- Choose an account. If you have more than one, pick the account for which you'd like to view reports.
- Then, click on the **Physician Performance & Reporting** button and choose **Open My Reports**.
- Select the report you want to see.

If this is your first time accessing your report, please use your PIN to sign in. The PIN is the same for UnitedHealthcare Community Plan, Medicare Advantage and commercial members. If you don't know your PIN, contact your UnitedHealthcare representative or call UnitedHealthcare Web Support at **866-842-3278,** option 1, 7 a.m. – 9 p.m. CT, Monday – Friday.

If you have questions about viewing your report, click on Open My Reports and complete the Contact Us form. Or, call UnitedHealthcare Web Support at **866-842-3278,** option 1, 7 a.m. – 9 p.m. CT, Monday – Friday.

Point of Care Assist® – Compatible with Athena, Allscripts, eClinicalWorks, EPIC, Cerner and NextGen EMR systems

Point of Care Assist is a virtual assistant that gives health care professionals real-time data and insights within their EMR workflow. Point of Care Assist puts personalized, real-time patient data, including clinical, pharmacy, labs, prior authorization, eligibility and cost information, directly in your hands within your EMR at the point of care.. This additional information can help eliminate blind spots in care, avoid billing surprises and foster co-decisioning.

Point of Care Assist allows you to do the following within your own EMR system:

- Get insights on patient care needs, estimated out-of-pocket costs and coverage at the point of care within your electronic medical record (EMR) workflow
- Check cost information to help patients choose lower-cost care options and find UnitedHealth Premium® Care Physicians who have met quality and cost-efficient care criteria
- Get automated alerts to help identify gaps in care when you log in to a patient's account account
- - Information about a patient's health history reduces time spent on pre-visit planning and clinical staff's time with the patient reviewing their medical history
- Check prior authorization and referral requirements in real time
- Stay current on member plan benefit changes, providers in your patient's network and their expected-out pocket costs

Tools You Can Use

Practice Assist

Practice Assist is a convenient online tool that helps you identify and address open care opportunities for your patients who are UnitedHealthcare® Medicare Advantage plan members. It can help make it easier for you to meet quality standards for Healthcare Effectiveness Data and Information Set (HEDIS®) and Centers for Medicare & Medicaid Services (CMS) measures, as well as helping keep your patients on target with their medications, screenings and tests and your treatment plan.

Practice Assist allows you to:

- Identify and address open care opportunities for your patients (see Quality section)
- Keep your patients on target with their medications (see Medication Adherence section)
- Manage your patients who were admitted to or discharged from an inpatient stay at a hospital (see Hospital Events section)
- Review patients with suspect medical conditions so you can see who may have a health concern that needs to be assessed (see Suspect Conditions section)
- Meet quality standards for HEDIS® and Centers for Medicare & Medicaid Services (CMS) measures

To get started, go to UHCprovider.com and use your One Healthcare ID to sign in

- Once you're logged in, you'll be able to review member open care opportunities for Part C and Part D measures.
- If you aren't registered yet, select New User to begin registration.

If you don't have access or need more information, please contact your UnitedHealthcare representative.

Contact us to learn more.

For more information about how our programs can help support your patients who are UnitedHealthcare plan members, please contact your UnitedHealthcare representative. Thank you.

UnitedHealthcare Data Exchange Program

Share important member clinical data with our Clinical Data Services Management (CDSM) team to help us more easily:

- Identify and address care opportunities
- Report accurate data to CMS and NCQA
- Reach our goal of improving health care outcomes while lowering health care costs

For more information or to get started, please email **ecdiops@uhc.com.**

Healthcare professional education and training

We provide a full range of training resources including interactive-self paced courses and instructor-led sessions.

To get started, go to **UHCprovider.com/training**. The courses are divided by:

- Featured courses
- CME credit courses
- Clinical tools
- Coding Corner
- Delegated providers
- Digital solutions
- Instructor-led learning events
- Plans and products
- Smart Edits
- State specific training
- Veterans Affairs Community Care Network (VA CCN)

OptumHealth Education

OptumHealth Education, a UnitedHealth Group company offering solutions to help improve patient care delivery, provides continuing education classes with credits for several physical and mental health conditions.

Contact us to learn more. For more information about how our programs can help support your patients who are UnitedHealthcare plan members, please contact your **UnitedHealthcare representative**. Thank you.

UnitedHealthcare Social Determinants of Health (SDoH) Protocol

Improving the Lives of the Members We Serve

- Health care professionals can help patients overcome SDoH barriers by gaining a better understanding of the scope of factors influencing the treatment process.
- Using codes associated with these conditions allow health care professionals and UnitedHealthcare to collect data and identify solutions that more closely align with patients' needs.

Driving Change With Health Inequities

Investigate

- Conduct research and develop tools to measure disparities
- Surface differences in health where there should be none
- Pinpoint areas of inequity and disparities in need of solutions

Illuminate

- Recognize high-performing community-based organizations, vendor partners, technical platforms and thought leaders who have narrowed and eliminated disparities
- Learn from best practices
- Prioritize what can have an impact

Elevate

- Disseminate our consumer understandings through strategic communications and partnerships
- Implement, validate, and scale broadly data-driven, evidence-based solutions
- Work with policymakers to integrate lasting solutions and dismantle policies and practices that create harm or bias
- Influence and hold accountable care delivery systems and policymakers to eliminate the pervasive effects of racism

Calls to action

- As a result of this protocol, you are strongly encouraged to routinely screen, document and submit the appropriate ICD-10 code(s) when a patient is impacted by SDoH.
- We encourage you to remain current on using SDoH ICD-10 codes, as they may be updated.

Starting Oct. 1, 2020

We strongly encourage documenting Social Determinants of Health (SDoH) using ICD-10 diagnostic code(s) (or successor diagnostic codes) in the member's medical record.

Unless prohibited by federal or state law, this protocol applies to all UnitedHealthcare's members, including UnitedHealthcare Medicare Advantage, Medicaid and Individual Group Market plans.

SDoH are non-clinical societal and environmental conditions, such as lack of access to adequate food and health care, housing, transportation and education, along with unsafe environment, lack of adequate social support, employment and behavioral stability support that prevent individuals from accessing health care they need.

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UnitedHealthcare Social Determinants of Health (SDoH) Protocol

Read the Full UnitedHealthcare Protocol

You can find the full Social Determinants of Health Protocol at **UHCprovider.com** > Policies and Protocols. Under Additional Resources choose Protocols >Social Determinants of Health Protocol.

Coding guidelines; including, but not limited to:

Z55 Problems related to education and literacy (excludes disorders of psychological development F80–F89)

- Z55.0 Illiteracy and low-level literacy
- Z55.1 Schooling unavailable and unattainable Z55.2 Failed examinations
- Z55.3 Underachievement in school
- Z55.4 Educational maladjustment and discord w/teachers and classmates
- Z55.8 Other problems related to education and literacy (inadequate teaching)
- Z55.9 Problem related to education and literacy, unspecified

Z56 Problems related to employment and unemployment (excludes occupational exposure to risk factors Z57.- and problems related to housing and economic circumstances (Z59.-)

- Z56.0 Unemployment, unspecified
- Z56.1 Change of job
- Z56.2 Threat of job loss
- Z56.3 Stressful work situation
- Z56.4 Discord with boss and workmates
- Z56.5 Uncongenial work (difficult conditions at work)
- Z56.6 Other physical and mental strain related to work
- Z56.7 Other and unspecified problems related to employment

Z59 Problems related to housing and economic circumstances (excludes inadequate drinking water supply Z58.6)

- Z59.0 Homelessness
- Z59.1 Inadequate housing (lack of heating, restriction of space, technical defects in home preventing adequate care, unsatisfactory surroundings. Excludes problems related to physical environment Z58.-)
- Z59.2 Discord with neighbors, lodgers and landlord
- Z59.3 Problems related to living in a residential institution (boarding school resident. Excludes institutional upbringing Z62.2)
- Z59.4 Lack of adequate food (excludes effects of hunger T73.0, inappropriate diet or eating habits Z72.4, and malnutrition E40–E46)
- Z59.5 Extreme poverty
- Z59.6 Low income
- Z59.7 Insufficient social insurance and welfare support
- Z59.8 Other problems related to housing and economic circumstances (foreclosure on loan, isolated dwelling or problems with creditors)
- Z59.9 Problems related to housing and economic circumstances, unspecified

Contents

HEDIS® Measures

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Contents

CMS Part D Star Ratings Measures

Electronic Clinical Data Submission (ECDS) measures

CAHPS® Measures

HOS Measures

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Advance Care Planning

New for 2023

Added

- A direct reference code, Z51.5, for an encounter for palliative care

Updated

- Members who died during the measurement year is now a required exclusion

Yes!
Supplemental Data Accepted

Definition

Percentage of adults ages 66 to 80 with advanced illness, an indication of frailty or who are receiving palliative care, and adults ages 81 and older who had evidence of advance care planning in the measurement year.

Plan(s) Affected	Quality Program(s) Affected	Collection and Reporting Method
• Medicare	• None	**Administrative** • Claim/Encounter Data

Codes

The following codes can be used to close HEDIS® numerator gaps in care; they are not intended to be a directive of your billing practice.

Advance Care Planning	
CPT®/CPT II	99483, 99497, 1123F, 1124F, 1157F, 1158F
HCPCS	S0257
ICD-10 Diagnosis	Z66
SNOMED	310301000

Advance Care Planning

Required Exclusion(s)

Exclusion	Timeframe
• Members in hospice or using hospice services • Members who died	- Any time during the measurement year

Important Notes

	Test, Service or Procedure to Close Care Opportunity
Measurement year	• Advanced directive, actionable medical orders, living will, surrogate decision maker are all examples of advance care planning • Telehealth visits are acceptable to meet this numerator

Tips and Best Practices to Help Close This Care Opportunity

- The use of CPT® Category II codes helps UnitedHealthcare identify clinical outcomes such as advance care planning. It can also reduce the need for some chart review.
- Advance care plans can be accepted as supplemental data, reducing the need for some chart review. Please contact your UnitedHealthcare representative to discuss clinical data exchange opportunities.

Care for Older Adults (COA) – Functional Status Assessment

New for 2023

Updated

- Members who died during the measurement year is now a required exclusion

Yes!
Supplemental Data Accepted

Definition

Percentage of adults 66 and older who had evidence of a functional status assessment in the measurement year.

Plan(s) Affected	Quality Program(s) Affected	Collection and Reporting Method
• Medicare Special Needs Plans (SNP)	• CMS Star Ratings	**Hybrid** • Claim/Encounter Data • Medical Record Documentation

Codes

The following codes can be used to close HEDIS® numerator gaps in care; they are not intended to be a directive of your billing practice.

Functional Status Assessment	
CPT®/CPT II	1170F, 99483
HCPCS	G0438, G0439
SNOMED	304492001, 385880002

Care for Older Adults (COA) – Functional Status Assessment

Required Exclusion(s)

Exclusion	Timeframe
• Members in hospice or using hospice services • Members who died	- Any time during the measurement year

Important Notes

	Test, Service or Procedure to Close Care Opportunity	Medical Record Detail Including, But Not Limited To
Functional status assessment must occur within the measurement year. Functional status assessment conducted in an acute inpatient setting will **not** meet compliance. Telehealth visits are acceptable to meet this numerator.	Standardized functional status assessment tool and results	• Functional status assessment forms • Health history and physical • Home health records • Occupational therapy notes • Physical therapy notes • Progress notes • Skilled nursing facility minimum data set (MDS) form • SOAP notes
	Assessment of Instrumental Activities of Daily Living or at least 4 of the following assessed: • Chores, such as laundry • Cleaning/housework • Cooking/meal prep • Driving or using public transportation • Grocery shopping • Home repair • Paying bills or other financial tasks • Taking prescribed medications • Using a phone	
	Activities of Daily Living (ADLs) or at least 5 of the following assessed: • Bathing • Dressing • Eating meals/snacks • Getting up and down from sitting or lying position • Using the restroom • Walking	

Care for Older Adults (COA) – Functional Status Assessment

Tips and Best Practices to Help Close This Care Opportunity

- **Please check your Patient Care Opportunity Report (PCOR) often to see members with open care opportunities.** If you have questions, your UnitedHealthcare representative can help.
- **Always clearly document the date of service of the functional status assessment.**
- A functional status assessment done in an acute inpatient setting will **not** meet compliance.
- A functional status assessment limited to an acute or single condition, event or body system, such as lower back or leg, will **not** meet compliance.
- The following notations will **not** meet compliance:
  - "Functional status reviewed" doesn't indicate that a complete functional status assessment was performed.
- Documentation of "normal motor/sensory" during an exam or a checked box next to "normal motor/sensory" on a neurological exam isn't enough evidence for a functional status assessment.
- A functional status assessment may be conducted with the member in various manners (phone, in person, virtually, etc.) and is not limited to being completed by clinicians.
- The use of CPT® Category II codes helps UnitedHealthcare identify clinical outcomes such as functional status assessment. It can also reduce the need for some chart review.
- Functional status assessments can be accepted as supplemental data, reducing the need for some chart review. Please contact your UnitedHealthcare representative to discuss clinical data exchange opportunities.

Care for Older Adults (COA) – Medication Review

New for 2023

Updated

- Members who died during the measurement year is now a required exclusion.

Yes!
Supplemental Data Accepted

Definition

Percentage of adults ages 66 and older who had a medication review by a clinical pharmacist or prescribing practitioner and the presence of a medication list in the medical record or transitional care management services in the measurement year.

Plan(s) Affected	Quality Program(s) Affected	Collection and Reporting Method
• Medicare Special Needs Plans (SNP)	• CMS Star Ratings	**Hybrid** • Claim/Encounter Data • Medical Record Documentation

Codes

The following codes can be used to close HEDIS® numerator gaps in care; they are not intended to be a directive of your billing practice.

Medication List	
CPT®/CPT II	1159F This code (medication list documented) must be submitted with 1160F (review of all medications by a prescribing practitioner or clinical pharmacist documented) on the same date of service.
HCPCS	G8427
SNOMED	428191000124101

Medication Review	
CPT®/CPT II	99605, 99606, 90863, 99483, 1160F
SNOMED	719327002

Transitional Care Management	
CPT®/CPT II	99495, 99496

Required Exclusion(s)

Exclusion	Timeframe
• Members in hospice or using hospice services • Members who died	- Any time during the measurement year

Care for Older Adults (COA) – Medication Review

Important Notes

	Test, Service or Procedure to Close Care Opportunity	Medical Record Detail Including, But Not Limited To
• Medication list must be included in the medical record **and** medication review must be completed by a prescribing provider or clinical pharmacist. • A medication list, signed and dated during the measurement year by the appropriate practitioner type — prescribing practitioner or clinical pharmacist – meets compliance. • A notation within the record that the medications were reviewed. If a notation is included, the signature is not needed. • Documentation that the medications aren't tolerated isn't an exclusion for this measure. • A review of side effects for a single medication at the time of prescription alone does **not** meet compliance. • Medication review conducted in an acute inpatient setting will **not** meet compliance. • Practitioner is not required to be the member's primary or ongoing care provider; any provider meeting the requirement of prescribing practitioner or clinical pharmacist can complete the medication review.	Medication review **or** dated clinician's note that says the member is **not** taking any medications	• Health history and physical • Medication list • Progress notes • SOAP notes

Care for Older Adults (COA) – Medication Review

Tips and Best Practices to Help Close This Care Opportunity

- **Please check your Patient Care Opportunity Report (PCOR) often to see members with open care opportunities.** If you have questions, your UnitedHealthcare representative can help.
- **Always clearly document the date of service of the medication review or notation of no medications.**
- A medication review conducted in an acute inpatient setting will **not** meet compliance.
- A medication review may be conducted with a member over the phone if the clinician is a prescriber or clinical pharmacist. A registered nurse can collect the list of current medications from the member during the call, but there must be evidence that the appropriate practitioner reviewed the list.
  - For example: An electronic signature with credentials on the medication list
- The medication review must include all of the member's medications, including prescription and over-the-counter medications and herbal or supplemental therapies.
- A medication list signed and dated within the measurement year by the prescribing practitioner or clinical pharmacist meets the criteria.
  - The practitioner's signature along with a medication list in the member's chart is considered evidence that the medications were reviewed.
  - A review of side effects for a single medication at the time of prescription alone will **not** meet compliance.
- The use of CPT® Category II codes helps UnitedHealthcare identify clinical outcomes such as medication reviews. It can also reduce the need for some chart review.
- Medication reviews and the presence of a medication list can be accepted as supplemental data, reducing the need for some chart review. Please contact your UnitedHealthcare representative to discuss clinical data exchange opportunities.

Care for Older Adults (COA) – Pain Assessment

New for 2023

Updated

- Members who died during the measurement year is now a required exclusion.

Yes!
Supplemental Data Accepted

Definition

Percentage of adults ages 66 and older who were assessed for pain in the measurement year.

Plan(s) Affected	Quality Program(s) Affected	Collection and Reporting Method
• Medicare Special Needs Plans (SNP)	• CMS Star Ratings	**Hybrid** • Claim/Encounter Data • Medical Record Documentation

Codes

The following codes can be used to close HEDIS® numerator gaps in care; they are not intended to be a directive of your billing practice.

Pain Assessment	
CPT®/CPT II	1125F, 1126F
SNOMED	225399009

Required Exclusion(s)

Exclusion	Timeframe
• Members in hospice or using hospice services • Members who died	- Any time during the measurement year

Care for Older Adults (COA) – Pain Assessment

Important Notes

	Test, Service or Procedure to Close Care Opportunity	Medical Record Detail Including, But Not Limited To
• Pain assessment must be completed within the measurement year. • A pain assessment conducted in an acute inpatient setting will **not** meet compliance. • Documentation of pain management alone or pain treatment alone does **not** meet numerator criteria. • A pain assessment related to a single body part will meet compliance (with the exception of the chest)	• Standardized pain assessment tool and results • Date and notation of "no pain" in the medical record after the member's pain was assessed	• Health history and physical • Home health records • Occupational therapy notes • Pain assessment forms • Physical therapy notes • Progress notes • Skilled nursing facility minimum data set (MDS) form • SOAP notes

Care for Older Adults (COA) – Pain Assessment

Tips and Best Practices to Help Close This Care Opportunity

- **Please check your Patient Care Opportunity Report (PCOR) often to see members with open care opportunities.** If you have questions, your UnitedHealthcare representative can help.
- **Always clearly document the date of service of the pain assessment or the notation that the member's pain was assessed.**
- Documentation in a member's medical record of a pain management plan or pain treatment alone will **not** meet compliance.
- Documentation in a member's medical record of screening for chest pain or documentation of chest pain alone will **not** meet compliance.
- A pain assessment related to a single body part, with the exception of chest, meets compliance.
- Pain scales – numbers or faces – are an acceptable form of pain assessment and meet compliance.
- A pain assessment may be conducted with the member in various manners (phone, in person, virtually etc.) and is not limited to being completed by clinicians.
- The use of CPT® Category II codes helps UnitedHealthcare identify clinical outcomes such as pain assessment. It can also reduce the need for some chart review.
- Pain assessments can be accepted as supplemental data, reducing the need for some chart review. Please contact your UnitedHealthcare representative to discuss clinical data exchange opportunities.

Colorectal Cancer Screening (COL and COL-E)

New for 2023

Added

- A direct reference code, Z51.5, for an encounter for palliative care
- Frailty exclusion now requires 2 different dates of service during the measurement year

Updated

- Members who died during the measurement year is now a required exclusion
- Members who have had colorectal cancer and/or total colectomy are now required exclusions

This measure is also an ECDS measure

Yes!
Supplemental Data Accepted

Definition

Percentage of members ages 45–75 who had an appropriate screening for colorectal cancer.

Rates stratified for race and ethnicity.

Plan(s) Affected	Quality Program(s) Affected	Collection and Reporting Method
• Commercial • Exchange/Marketplace • Medicaid (admin only) • Medicare	• CMS Star Ratings • CMS Quality Rating System • Medicaid Select State Reporting • NCQA Accreditation • NCQA Health Plan Ratings	**Hybrid** • Claim/Encounter Data • Medical Record Documentation

Codes

The following codes can be used to close HEDIS® numerator gaps in care; they are not intended to be a directive of your billing practice.

Colonoscopy	
CPT®/CPT II	44388, 44389, 44390, 44391, 44392, 44393, 44394, 44397, 44401, 44402, 44403, 44404, 44405, 44406, 44407, 44408, 45355, 45378, 45379, 45380, 45381, 45382, 45383, 45384, 45385, 45386, 45387, 45388, 45389, 45390, 45391, 45392, 45393, 45398
HCPCS	G0105, G0121

History of Colonscopy	
SNOMED	851000119109

Computed Tomography (CT) Colonography	
CPT®/CPT II	74261, 74262, 74263 This service isn't covered for UnitedHealthcare Medicare Advantage members.
LOINC	60515-4, 72531-7, 79069-1, 79071-7, 79101-2, 82688-3
SNOWMED	418714002

(Codes continued)

Colorectal Cancer Screening (COL and COL-E)

Codes (continued)

The following codes can be used to close HEDIS® numerator gaps in care; they are not intended to be a directive of your billing practice.

Stool DNA (sDNA) with FIT Test	
CPT®/CPT II	81528 This code is specific to the Cologuard® FIT-DNA test.
LOINC	77353-1, 77354-9
SNOWMED	708699002

Flexible Sigmoidoscopy	
CPT®/CPT II	45330, 45331, 45332, 45333, 45334, 45335, 45337, 45338, 45340, 45341, 45342, 45346, 45347, 45349, 45350
HCPCS	G0104
SNOWMED	44441009

History of Flexible Sigmoidoscopy	
SNOMED	841000119107

FOBT	
CPT®/CPT II	82270
HCPCS	G0328
LOINC	12503-9, 12504-7, 14563-1, 14564-9, 14565-6, 2335-8, 27396-1, 27401-9, 27925-7, 27926-5, 29771-3, 56490-6, 56491-4, 57905-2, 58453-2, 80372-6
SNOMED	104435004, 441579003, 442067009, 442516004, 442554004, 442563002, 59614000, 167667006, 389076003

FIT	
CPT®/CPT II	82274

Colorectal Cancer Screening (COL and COL-E)

Required Exclusion(s)

Exclusion	Timeframe
• Members in hospice or using hospice services • Members receiving palliative care • Members who died	Any time during the measurement year
Members who had colorectal cancer or a total colectomy	Any time during the member's history through December 31 of the measurement year
Members ages 66 and older as of December 31 of the measurement year who 2 diagnoses of frailty on different dates of service and advanced illness. Advanced illness is indicated by one of the following: • Two or more outpatient, observation, emergency room, telephone, e-visits, virtual check-ins or non-acute inpatient encounters or discharge(s) on separate dates of service with a diagnosis of advanced illness • One or more acute inpatient encounter(s) with a diagnosis of advanced illness • One or more acute inpatient discharge(s) with a diagnosis of advanced illness on the discharge claim • Dispensed a dementia medication: Donepezil, Donepezil-memantine, galantamine, rivastigmine or memantine	**Frailty** diagnoses must be in the measurement year and on different dates of service **Advanced illness** diagnosis must be in the measurement year or year prior to the measurement year
Medicare members ages 66 and older as of Dec. 31 of the measurement year who are either: • Enrolled in an Institutional Special Needs Plan (I-SNP) • Living long term in an institution*	Any time during the measurement year

***Supplemental and medical record data may not be used for the frailty with advanced illness or institutional living exclusions.**

Colorectal Cancer Screening (COL and COL-E)

Important Notes

	Test, Service or Procedure to Close Care Opportunity	Medical Record Detail Including, But Not Limited To
Measurement year or 9 years prior	Colonoscopy	• Consultation reports • Diagnostic reports • Health history and physical • Lab reports • Pathology reports – For a colonoscopy, must indicate the type or screening or that the scope advanced beyond the splenic flexure. For a flexible sigmoidoscopy, must indicate the type or screening or that the scope advanced into the sigmoid colon.
Measurement year or 4 years prior	• Flexible sigmoidoscopy • CT colonography	
Measurement year or 2 years prior	Stool DNA (sDNA) with FIT Test	
Measurement year	iFOBT, gFOBT, FIT	

Colorectal Cancer Screening (COL and COL-E)

Tips and Best Practices to Help Close This Care Opportunity

- **Please check your Patient Care Opportunity Report (PCOR) often to see members with open care opportunities.** If you have questions, your UnitedHealthcare representative can help.
- **Always include a date of service – year only is acceptable – when documenting a colonoscopy, flexible sigmoidoscopy, Stool DNA (sDNA) with FIT Test, CT colonography or FOBT.**
- It's important to submit any codes that reflect a member's history of malignancy for colorectal cancer, Z85.038 and Z85.048.
  - If a member is new to the care provider and the diagnosis is discovered during the history and physical, the code should be submitted with the initial visit claim.
  - If a member isn't new to the care provider, but the member's chart has documented history of the diagnosis, the ICD-10 diagnosis code should be submitted on any visit claim.
- Member refusal will **not** make them ineligible for this measure.
  - Please recommend a flexible sigmoidoscopy, Stool DNA (sDNA) with FIT Test or FOBT if a member refuses or can't tolerate a colonoscopy.
- There are 2 types of acceptable FOBT tests – guaiac (gFOBT) and immunochemical (iFOBT).
- In October 2020 CMS announced that for Medicare members, evidence is sufficient to cover a blood-based biomarker test as an appropriate colorectal cancer screening test once every 3 years, or at the interval designated in the Food and Drug Administration (FDA) label if the FDA indicates a specific test interval. However, these tests have not yet been approved by NCQA to close HEDIS® gaps.
  - At this time, no blood biomarker test for colorectal cancer screening will meet numerator compliance for the COL HEDIS® measure
- Contact your laboratory services provider to procure iFOBT supplies for use in your office.
  - Physicians, nurse practitioners and physician assistants can provide the kit to the members during their routine office visits. Members can then collect the sample at home and send the specimen and requisition form directly to the laboratory services vendor in a post-paid envelope.
- USPSTF added CT colonography for colorectal cancer screening in July 2016. However, Medicare hasn't approved coverage for this colorectal cancer screening test, and it's not a covered benefit for UnitedHealthcare Medicare Advantage members.
  - **If you administer or refer out for this test, please confirm a member's eligibility and benefit coverage.**
- Digital Rectal Exams (DRE) or FOBT test performed in the office setting will **not** meet compliance
- Lab results and procedure codes for colorectal cancer screening can be accepted as supplemental data, reducing the need for some chart review. Please contact your UnitedHealthcare representative to discuss clinical data exchange opportunities.
- Sharing member demographic data is critical to understanding the cultural, linguistic and social needs of those we serve and decreasing health inequities across the care continuum. This data can include, but is not limited to, race, ethnicity, language, sexual orientation, gender identity, pronouns, sex assigned at birth and disability status. As part of UnitedHealthcare's clinical structured data exchange program, we encourage you to include this demographic data with any structured data file or CCD. Your information is confidential. UnitedHealthcare will keep personally identifiable information confidential and won't disclose any information without your written consent.

Cervical Cancer Screening (CCS and CCS-E)

New for 2023

Added

- A direct reference code, Z51.5, for an encounter for palliative care

Updated

- Members who died during the measurement year is now a required exclusion
- Members who have had a hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix are now a required exclusion

This measure is also an ECDS measure

Yes!
Supplemental Data Accepted

Definition

Percentage of women ages 21–64 who were screened for cervical cancer using either of the following criteria:

- Women ages 21–64 who had cervical cytology performed in the measurement year or 2 years prior
- Women ages 30–64 who had cervical cytology/high-risk human papillomavirus (hrHPV) co-testing performed in the measurement year or four years prior. The woman must have been at least age 30 on the date of the test.
- Women ages 30–64 who had cervical high-risk human papillomavirus (hrHPV) testing performed in the measurement year or four years prior

Plan(s) Affected	Quality Program(s) Affected	Collection and Reporting Method
• Commercial • Exchange/Marketplace • Medicaid	• CMS Quality Rating System • NCQA Accreditation • NCQA Health Plan Ratings	**Administrative** • Claim/Encounter Data **Hybrid** • Claim/Encounter Data • Medical Record Documentation

Codes

The following codes can be used to close HEDIS® numerator gaps in care; they are not intended to be a directive of your billing practice.

Cervical Cytology	
CPT®/CPT II	88141, 88142, 88143, 88147, 88148, 88150, 88152, 88153, 88164, 88165, 88166, 88167, 88174, 88175
HCPCS	G0123, G0124, G0141, G0143, G0144, G0145, G0147, G0148, P3000, P3001, Q0091
LOINC	10524-7, 18500-9, 19762-4, 19764-0, 19765-7, 19766-5, 19774-9, 33717-0, 47527-7, 47528-5
SNOMED	171149006, 416107004 417036008, 440623000, 448651000124104, 168406009, 168407000, 168408005, 168410007

(Codes continued)

Cervical Cancer Screening (CCS - and CCS-E)

Codes

The following codes can be used to close HEDIS® numerator gaps in care; they are not intended to be a directive of your billing practice.

High Risk HPV Test	
CPT®/CPT II	87624, 87625
HCPCS	G0476
LOINC	21440-3, 30167-1, 38372-9, 59263-4, 59264-2, 59420-0, 69002-4, 71431-1, 75694-0, 77379-6, 77399-4, 77400-0, 82354-2, 82456-5, 82675-0, 95539-3
SNOMED	35904009. 448651000124104, 718591004

Required Exclusion(s)

Exclusion	Timeframe
• Members in hospice or using hospice services • Members receiving palliative care • Members who died	Any time during the measurement year
Hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix	Any time in a member's history through December 31 of the measurement year

Important Notes

	Test, Service or Procedure to Close Care Opportunity	Medical Record Detail Including, But Not Limited To
Measurement year or 2 years prior	• Cervical cytology for women ages 21–64 • High Risk HPV test (hrHPV) with results or findings	• Consultation reports • Diagnostic reports • Health history and physical • Lab reports
Measurement year or 4 years prior – test must be performed when the woman is age 30 or older		

Cervical Cancer Screening (CCS - and CCS-E)

Tips and Best Practices to Help Close This Care Opportunity

- **Please check your Patient Care Opportunity Report (PCOR) often to see members with open care opportunities.** If you have questions, your UnitedHealthcare representative can help.
- Evidence of hrHPV testing within the last 5 years also captures patients who had cotesting.
  - Documentation of "HPV Test" can be counted as evidence of hrHPV Test, as long as the result is documented.
- Documentation of a "hysterectomy" alone will **not** meet the intent of the exclusion.
  - The documentation must include the words "total," "complete" or "radical" abdominal or vaginal hysterectomy.
  - Documentation of a "vaginal Pap smear" with documentation of "hysterectomy"
  - Documentation of hysterectomy and documentation that a member no longer needs Pap testing/cervical cancer screening
- Biopsies are diagnostic and therapeutic, and not valid for primary cervical cancer screening.
- Member reported information documented in the patient's medical record is acceptable as long as there is a date and result of the test or a date of the hysterectomy and acceptable documentation of no residual cervix. The member reported information must be logged in the patient's chart by a care provider.
- Lab results for cervical cancer screening or procedure codes for hysterectomy can be accepted as supplemental data, reducing the need for some chart review. Please contact your UnitedHealthcare representative to discuss clinical data exchange opportunities.

(Codes continued)

Chlamydia Screening in Women (CHL)

New for 2023

Updated

- Members who died during the measurement year is now a required exclusion
- Members identified for the denominator based on a pregnancy test will now be a required exclusion if they also had a prescription for isotretinoin or an x-ray on the date of the pregnancy test or 6 days after

Yes!
Supplemental Data Accepted

Definition

Percentage of female members ages 16–24 who were identified as sexually active and had at least one test to screen for chlamydia during the measurement year.

Plan(s) Affected	Quality Program(s) Affected	Collection and Reporting Method
• Commercial • Exchange/Marketplace • Medicaid	• CMS Quality Rating System • NCQA Accreditation • NCQA Health Plan Ratings	**Administrative** • Claim/Encounter Data

Codes

The following codes can be used to close HEDIS® numerator gaps in care; they are not intended to be a directive of your billing practice.

Chlamydia Screening Test	
CPT®/CPT II	87110, 87270, 87320, 87490, 87491, 87492, 87810
LOINC	14463-4, 14464-2, 14467-5, 14474-1,14513-6, 16600-9, 21190-4, 21191-2, 21613-5, 23838-6, 31775-0, 31777-6, 36902-5, 36903-3, 42931-6, 43304-5, 43404-3, 43405-0, 43406-8, 44806-8, 44807-6, 45068-4, 45069-2, 45075-9, 45076-7, 45084-1, 45091-6, 45095-7, 45098-1, 45100-5, 47211-8, 47212-6, 49096-1, 4993-2, 50387-0, 53925-4, 53926-2, 557-9, 560-3, 6349-5, 6354-5, 6355-2, 6356-0, 6357-8, 80360-1, 80361-9, 80362-7, 91860-7
SNOMED	104175002, 104281002, 104282009, 104290009, 117775008, 121956002, 121957006, 121958001, 121959009, 122173003, 122254005, 122321005, 122322003, 134256004, 134289004, 171120003, 285586000, 310861008, 310862001, 315087006, 315095005, 315099004, 390784004, 390785003, 395195000, 398452009, 399193003, 407707008, 442487003, 707982002

Chlamydia Screening in Women (CHL)

Required Exclusion(s)

Exclusion	Timeframe
• Members in hospice or using hospice services • Members who died	- Any time during the measurement year

Important Notes

	Test, Service or Procedure to Close Care Opportunity	Medical Record Detail Including, But Not Limited To
Test must be performed within the measurement year.	Chlamydia screening test	• Consultation reports • Health history and physical • Lab reports

Chlamydia Screening in Women (CHL)

Tips and Best Practices to Help Close This Care Opportunity

- **Please check your Patient Care Opportunity Report (PCOR) often to see members with open care opportunities.** If you have questions, your UnitedHealthcare representative can help.
- Chlamydia screening may not be captured via claims if the service is performed and billed under prenatal and postpartum global billing. Chlamydia screening can be captured as supplemental lab data using our Data Exchange Program.
- The Centers for Disease Control and Prevention recommends self-obtained vaginal specimens for asymptomatic females.
- Self-obtained vaginal specimens are cleared by the U.S. Food & Drug Administration (FDA) for collection in a clinical setting.
- Additional information on chlamydia screening is available at **brightfutures.aap.org.**
- In assessing sexually active female patients ages 16-24 years, consider standard orders for chlamydia urine testing as part of the office visit.
- According to the American Academy of Pediatrics (AAP), pediatric patients should be assessed for risk of chlamydia infection.
- Lab results for chlamydia screening can be accepted as supplemental data, reducing the need for some chart review. Please contact your UnitedHealthcare representative to discuss clinical data exchange opportunities.

Osteoporosis Management in Women Who Had a Fracture (OMW)

New for 2023

Added

- A direct reference code, Z51.5, for an encounter for palliative care
- Frailty exclusion now requires 2 different dates of service during the measurement year

Updated

- Members who died during the measurement year is now a required exclusion

Yes!
Supplemental Data Accepted

Definition

Percentage of women ages 67–85 who suffered a fracture and who had either a bone mineral density (BMD) test or prescription for a drug to treat osteoporosis within 6 months of the fracture (does not include fractures to the finger, toe, face or skull).

Plan(s) Affected	Quality Program(s) Affected	Collection and Reporting Method
• Medicare	• CMS Star Ratings	**Administrative** • Claim/Encounter Data • Pharmacy Data

Codes

The following codes can be used to close HEDIS® numerator gaps in care; they are not intended to be a directive of your billing practice.

Bone Mineral Density Tests	
CPT®/CPT II	76977, 77078, 77080, 77081, 77085, 77086
ICD-10 Procedure	BP48ZZ1, BP49ZZ1, BP4GZZ1, BP4HZZ1, BP4LZZ1, BP4MZZ1, BP4NZZ1, BP4PZZ1, BQ00ZZ1, BQ01ZZ1, BQ03ZZ1, BQ04ZZ1, BR00ZZ1, BR07ZZ1, BR09ZZ1, BR0GZZ1
SNOMED	22059005, 312681000, 385342005, 391057001, 391058006, 391059003, 391060008, 391061007, 391062000, 391063005, 391064004, 391065003, 391066002, 391069009, 391070005, 391071009, 391072002, 391073007, 391074001, 391076004, 391078003, 391079006, 391080009, 391081008, 391082001, 440083004, 440099005, 440100002, 449781000, 707218004, 4211000179102

Osteoporosis Medication Therapy	
HCPCS	J0897, J1740, J3110, J3111, J3489

(Codes continued)

Osteoporosis Management in Women Who Had a Fracture (OMW)

Codes (continued)

The following codes can be used to close HEDIS® numerator gaps in care; they are not intended to be a directive of your billing practice.

Long-Acting Osteoporosis Medications (during inpatient stay only)	
HCPCS	J0897, J1740, J3489

Dispensed at least one of the following osteoporosis medications within 180 days of their discharge for a fracture:

Drug Category	Medications	
Bisphosphonates	• Alendronate • Alendronate-cholecalciferol • Ibandronate	• Risedronate • Zoledronic acid
Other agents	• Abaloparatide • Denosumab	• Raloxifene • Romosozumab • Teriparatide

Osteoporosis Management in Women Who Had a Fracture (OMW)

Required Exclusion(s)

Exclusion	Timeframe
Members in hospice or using hospice services	Any time during the measurement year
Members receiving palliative care	During the intake period through the end of the measurement year
Members ages 81 and older as of December 31 of the measurement year who had at least 2 diagnoses of frailty*	**Frailty** diagnoses must be on different dates of service during the intake period through the end of the measurement year
Members ages 67-80 as of Dec. 31 of the measurement year who had at least 2 diagnoses of frailty on different date of service and advanced illness.* Advanced illness is indicated by one of the following: • Two or more outpatient, observation, emergency room, telephone, e-visits, virtual check-ins or non-acute inpatient encounters or discharge(s)on separate dates of service with a diagnosis of advanced illness • One or more acute inpatient encounter(s) with a diagnosis of advanced illness • One or more acute inpatient discharge(s) with a diagnosis of advanced illness on the discharge claim • Dispensed a dementia medication: Donepezil, Donepezil-memantine, galantamine, rivastigmine or memantine	**Frailty** diagnoses must be on two different dates of service during the intake period through the end of the measurement year **Advanced illness** diagnosis must be in the measurement year or year prior to the measurement year
Medicare members ages 67 and older as of Dec. 31 of the measurement year who are either: • Enrolled in an Institutional Special Needs Plan (I-SNP) • Living long term in an institution*	Any time during the measurement year
Members who had a BMD test	24 months prior to the fracture
Members who had osteoporosis therapy	12 months prior to the fracture
Members who were dispensed a medication or had an active prescription for the medication to treat osteoporosis	12 months prior to the fracture

***Supplemental and medical record data may not be used for the frailty, frailty with advanced illness or institutional living exclusions.**

Osteoporosis Management in Women Who Had a Fracture (OMW)

Important Notes

	Test, Service or Procedure to Close Care Opportunity	Medical Record Detail Including, But Not Limited To
• BMD test must take place within six months of the fracture. • If the fracture resulted in an inpatient stay, a BMD test administered during the stay will close the care opportunity.	BMD test	• Medication list • Progress notes
• Osteoporosis medication must be dispensed within 6 months of the fracture. • Documentation that the medications aren't tolerated is **not** an exclusion for this measure. • If the fracture resulted in an inpatient stay, long-acting osteoporosis therapy administered during the stay will close the care opportunity.	Osteoporosis therapies identified through pharmacy data	

Osteoporosis Management in Women Who Had a Fracture (OMW)

Tips and Best Practices to Help Close This Care Opportunity

- **Please check your Patient Care Opportunity Report (PCOR) often to see members with open care opportunities.** If you have questions, your UnitedHealthcare representative can help.
- The post-fracture treatment period to close this care opportunity is only 6 months. Please see members for an office visit as soon as possible after an event occurs.
- Osteoporosis medication must be filled using a member's Part D prescription drug benefit.
- To help prevent women from being included in this measure incorrectly, please check that fracture codes are used appropriately – and not before a fracture has been verified through diagnostic imaging. If a fracture code was submitted in error, please submit a corrected claim to fix the misdiagnosis and remove the member from this measure.
- A referral for a BMD will **not** close this care opportunity.
- Women at risk for osteoporosis should be prescribed a bone density screening every 2 years. At-risk women include those who are:
  - At increased risk for falls or have a history of falls
  - Being monitored to assess their response to, or efficacy of, a Federal Drug Administration (FDA) -approved osteoporosis drug therapy regime
  - Diagnosed with primary hyperparathyroidism
  - Estrogen deficient
  - On long-term steroid therapy
- Bone density screening is a covered benefit for most benefit plans.
- Bone mineral density testing codes can be accepted as supplemental data, reducing the need for some chart review. Please contact your UnitedHealthcare representative to discuss clinical data exchange opportunities.

Osteoporosis Management in Women Who Had a Fracture (OMW)

Example

Fracture Date: March 2, 2023
Important Note: The index episode start date (IESD) is the date you begin counting for the appropriate testing or treatment – IESD plus 180 days.

Scenario 1: Inpatient Hospital Stay With No Direct Transfer
Admission date: March 2, 2023
Discharge date with no direct transfer: March 4, 2023 IESD

Scenario 2: Inpatient Hospital Stay With Direct Transfer
Admission date to second facility: March 3, 2023
Discharge date from second facility: March 8, 2023 IESD

Scenario 3: Outpatient or Observation/Emergency Department (ED) Visit
Visit date: March 6, 2023 IESD
Important note: This scenario assumes the member didn't go to a hospital on the day of their fall and/or wasn't admitted for inpatient stay.

Fracture Date: March 2, 2023				
Fracture Diagnosis Setting	**IESD**	**Bone Mineral Density Test**	**Osteoporosis Therapy**	**Dispensed Rx to Treat Osteoporosis**
Scenario 1: Inpatient hospital stay with no direct transfer	**Discharge date:** March 4, 2023	**During inpatient stay:** March 2 – 4, 2023 **On IESD or within 180 days after IESD:** March 4 – Aug. 31, 2023	**During inpatient stay:** March 2 – 4, 2023 (long-acting osteoporosis medications only)	**On IESD or within 180 days after IESD:** March 4 – Aug. 31, 2023
Scenario 2: Inpatient hospital stay with direct transfer	**Discharge date from second facility:** March 8, 2023	**During inpatient stay:** March 2 – 8, 2023 **On IESD or within 180 days after IESD:** March 8 – Sept. 4, 2023	**During inpatient stay:** March 2 – 8, 2023 (long-acting osteoporosis medications only)	**On IESD or within 180 days after IESD:** March 8 – Sept. 4, 2023
Scenario 3: Outpatient or observation/ ED visit	**Visit date:** March 6, 2023	**On IESD or within 180 days after IESD:** March 6 – Sept. 2, 2023	**On IESD or within 180 days after IESD:** March 6 – Sept. 2, 2023	**On IESD or within 180 days after IESD:** March 6 – Sept. 2, 2023

Prenatal and Postpartum Care (PPC)

New for 2022

Added

- Rates stratified for race and ethnicity.

Updated

- Members who died during the measurement year is now a required exclusion

Yes!
Supplemental Data Accepted

Definition

Percentage of deliveries of live births on or between Oct. 8 of the year prior to the measurement year and Oct. 7 of the measurement year. The measure includes the following 2 indicators:

- **Timeliness of prenatal care –** Percentage of women who had a live birth that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in a UnitedHealthcare health plan
- **Postpartum care –** Percentage of women who had a live birth that had a postpartum visit on or between 7–84 days after delivery

Plan(s) Affected	Quality Program(s) Affected	Collection and Reporting Method
• Commercial • Medicaid	• CMS Quality Rating System • NCQA Accreditation • NCQA Health Plan Ratings	**Hybrid** • Claim/Encounter Data • Medical Record Documentation

Codes

The following codes can be used to close HEDIS® numerator gaps in care; they are not intended to be a directive of your billing practice.

Prenatal Bundled Services	
CPT®/CPT II	59400, 59425, 59426, 59510, 59610, 59618
HCPCS	H1005

Stand-Alone Prenatal Visits	
CPT®/CPT II	99500, 0500F, 0501F, 0502F
HCPCS	H1000, H1001, H1002, H1003, H1004
SNOMED	17629007, 18114009, 58932009, 66961001, 134435003, 135892000, 169712008, 169713003, 169714009, 169715005, 169716006, 169717002, 169718007, 169719004, 169720005, 169721009, 169722002, 169723007, 169724001, 169725000, 169726004, 169727008, 171054004, 171055003, 171056002, 171057006, 171058001, 171059009, 171060004, 171061000, 171062007, 171063002, 171064008, 386235000, 386322007, 397931005, 406145006, 409010002, 422808006, 424441002, 424525001, 424619006, 439165004, 439733009, 439816006, 439908001, 440047008, 440227005, 440309009, 440536005, 440638004, 440669000, 440670l004, 440671000, 441839001, 700256000, 702396006, 702736005, 702737001, 702738006, 702739003, 702740001, 702741002, 702742009, 702743004, 702744005, 710970004, 713076009, 713233004, 713234005, 713235006, 713237003, 713238008, 713239000, 713240003, 713241004, 713242006, 713386003, 713387007, 717794008, 717795009

(Codes continued)

Prenatal and Postpartum Care (PPC) (continued)

Codes

The following codes can be used to close HEDIS® numerator gaps in care; they are not intended to be a directive of your billing practice.

Prenatal Office Visits with Diagnosis of Pregnancy	
CPT®/CPT II	99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99483
HCPCS	G0463, T1015
SNOMED	77406008, 281036007

Pregnancy Diagnosis	
ICD -10 Diagnosis	Z34.90, Encounter for supervision of normal pregnancy, unspecified, unspecified trimester (see appendix for complete list of pregnancy diagnosis codes)

(Codes continued)

Prenatal and Postpartum Care (PPC)

Codes

The following codes can be used to close HEDIS® numerator gaps in care; they are not intended to be a directive of your billing practice.

Telephone Visit, E-visit or Online Assessment with a Diagnosis of Pregnancy Telephone Visit	
CPT®/CPT II	98966, 98967, 98968, 99441, 99442, 99443
SNOMED	185317003, 314849005, 386472008, 386473003, 401267002
Telephone Visit, E-visit or Online Assessment with a Diagnosis of Pregnancy Online Assessment (e-visit/virtual check-in)	
CPT®/CPT II	98969, 98970, 98971, 98972, 99421, 99422, 99423, 99444, 99457, 99458
HCPCS	G0071, G2010, G2012, G2061, G2062, G2063, G2250, G2251, G2252

Postpartum Bundled Services	
CPT®/CPT II	59400, 59410, 59510, 59515, 59610, 59614, 59618, 59622

Postpartum Visits	
CPT®/CPT II	57170, 58300, 59430, 99501, 0503F
HCPCS	G0101
ICD-10 Diagnosis	Z01.411, Z01.419, Z01.42, Z30.430, Z39.1, Z39.2
SNOMED	133906008, 133907004, 169762003, 169770008, 169771007, 169772000, 384634009, 384635005, 384636006, 408883002, 408884008, 408886005, 409018009, 409019001, 431868002, 440085006, 717810008

Cervical Cytology	
CPT®/CPT II	88141, 88142, 88143, 88147, 88148, 88150, 88152, 88153, 88164, 88165, 88166, 88167, 88174, 88175
HCPCS	G0123, G0124, G0141, G0143, G0144, G0145, G0147, G0148, P3000, P3001, Q0091
LOINC	10524-7, 18500-9, 19762-4, 19764-0, 19765-7, 19766-5, 19774-9, 33717-0, 47527-7, 47528-5
SNOMED	171149006, 416107004, 417036008, 440623000, 448651000124104, 168406009, 168407000, 168408005, 168410007, 168414003, 168415002, 168416001, 168424006, 250538001, 268543007, 269957009, 269958004, 269959007, 269960002, 269961003, 269963000, 275805003, 281101005, 309081009, 310841002, 310842009, 416030007, 416032004, 416033009, 439074000, 439776006, 439888000, 441087007, 441088002, 441094005, 441219009, 441667007, 700399008, 700400001, 1155766001, 62051000119105, 62061000119107, 98791000119102

Prenatal and Postpartum Care (PPC)

Acceptable Provider Types to Render Prenatal Care Services:

- OB-GYN
- Physician

Any of the following who delivery prenatal care services under the direction of an OB-GYN or certified provider:

- Certified Nurse Midwife (CNM)
- Nurse Practitioner (NP)
- Physician's Assistant (PA)

Required Exclusion(s)

Exclusion	Timeframe
• Members in hospice or using hospice services • Members who died	Any time during the measurement year
• Pregnancy didn't result in a live birth • Member wasn't pregnant • Delivery wasn't in date parameters	October 8 of the year prior to the measurement year through October 7 of the measurement year

Prenatal and Postpartum Care (PPC)

Important Notes

	Test, Service or Procedure to Close Care Opportunity	Medical Record Detail Including, But Not Limited To
• Prenatal care visit must take place in the first trimester, on or before the enrollment start date or within 42 days of enrollment with the health plan. • For prenatal visits with a primary care provider, a diagnosis of pregnancy must be included with any of the tests listed to the right. • A colposcopy alone does not meet numerator compliance for prenatal	Prenatal care visit with an OB-GYN or prenatal care provider, which must include one of the following: • A diagnosis of pregnancy • Auscultation for fetal heart tone • Documentation in a standard prenatal flowsheet • Documentation of last menstrual period (LMP), estimated date of delivery (EDD) or gestational age • Gravidity or parity • Complete obstetrical history • Prenatal risk assessment and counseling/education • Fundal height • Obstetric panel • Pelvic exam with obstetric observations • Prenatal lab results including hematocrit, differential WBC count, platelet count, hepatitis B surface antigen, rubella antibody, syphilis test, RBC antibody screen, Rh and ABO blood typing Rubella antibody test/titer with an Rh incompatibility (ABO/Rh) blood typing • TORCH antibody panel • Ultrasound of pregnant uterus	• Consultation reports • Diagnostic reports • Hospital delivery report • Medical history • Prenatal flow sheets/ACOG form • Progress notes • SOAP notes

(Important Notes continued)

Prenatal and Postpartum Care (PPC)

Important Notes

	Test, Service or Procedure to Close Care Opportunity	Medical Record Detail Including, But Not Limited To
	Postpartum visit, which must include one of the following: • Assessment of breasts or breast feeding, weight, blood pressure check and abdomen • Notation of postpartum care • Perineal or cesarean incision/ wound check • Screening for depression, anxiety, tobacco use, substance use disorder or preexisting mental health disorders • Pelvic exam • Glucose screening for women with gestational diabetes • Documentation of infant care or breastfeeding • Documentation of resumption of intercourse, birth spacing or family planning • Documentation of sleep/fatigue • Documentation of resumption of physical activity or attainment of healthy weight	• Consultation reports • Diagnostic reports • Hospital delivery report • Medical history • Prenatal flow sheets/ACOG form • Progress notes • SOAP notes

Prenatal and Postpartum Care (PPC)

Tips and Best Practices to Help Close This Care Opportunity

- **Please check your Patient Care Opportunity Report (PCOR) often to see members with open care opportunities.** If you have questions, your UnitedHealthcare representative can help.
- **When submitting a claim for bundled maternity services,** it is important to also submit separate claims for the pregnancy diagnosis office visit and postpartum visit with appropriate CPT® Category II Codes.
  - **Prenatal Care:** When submitting claim for initial pregnancy diagnosis visit (e.g., urine test, ultrasound), always include CPT® Category II 0500F as a no charge line item.
  - **Post-partum Care:** When submitting claim for first office post-partum visit, always include CPT® Category II 0503F as a no charge line item.

  If your electronic medical record (EMR) system allows macros that auto-populate CPT® Category II Codes when submitting a claim for diagnostic tests (e.g., pregnancy urine test, ultrasound), please **add 0500F (prenatal) when individual E/M codes are used.**
- Ultrasound and lab results alone aren't considered a visit. They must be linked to an office visit with an appropriate practitioner to count for this measure.
- A Pap test alone doesn't count as a prenatal care visit, but will count toward postpartum care as a pelvic exam.
- A visit with a registered nurse will **not** meet compliance. See acceptable provider types above.
- When the prenatal care visit is with a PCP, the claim must include the prenatal visit, and a diagnosis of pregnancy.
- The CDC, American College of Obstetricians and Gynecologists, American College of Nurse Midwives, and American Academy of Family Physicians all recommend that pregnant women receive the following immunizations:
  - A flu shot during any trimester of their pregnancy to protect themselves and their newborn babies from flu
  - 1 dose of Tdap every pregnancy, preferably during early part of gestational weeks 27–36
  - Visit **www.cdc.gov/vaccines/pregnancy** for patient and provider resources
- If your office submits CCDs to UnitedHealthcare via our clinical data exchange program, please ensure the CCD function within your EMR system is set up to send CPT II Codes in the extract.
- The use of CPT® Category II codes helps UnitedHealthcare identify clinical outcomes such as prenatal and postpartum care. It can also reduce the need for some chart review.
- The American College of Obstetricians and Gynecologists (ACOG) recommends implementation of the following clinical workflows:
  - Screen patients for depression/anxiety at least once during the prenatal and postpartum visit, with additional frequency for higher risk women
  - Use a screening tool validated for use during pregnancy and the postpartum period to measure the level of risk, (i.e., Edinburgh Postnatal Depression Scale (EPDS) or Patient Health Questionnaire 9)
  - Train all care team members on the importance of depression screening and follow-up care
  - Establish a system to ensure follow-up for diagnosis and treatment for positive screenings
- Prenatal and postpartum codes can be accepted as supplemental data, reducing the need for some chart review. Please contact your UnitedHealthcare representative to discuss clinical data exchange opportunities.
- Sharing member demographic data is critical to understanding the cultural, linguistic and social needs of those we serve and decreasing health inequities across the care continuum. This data can include, but is not limited to, race, ethnicity, language, sexual orientation, gender identity, pronouns, sex assigned at birth and disability status. As part of UnitedHealthcare's clinical structured data exchange program, we encourage you to include this demographic data with any structured data file or CCD. Your information is confidential. UnitedHealthcare will keep personally identifiable information confidential and won't disclose any information without your written consent.
- Services provided during a telephone visit or online assessment (e-visit/virtual check-in) will meet the criteria for numerator compliance.

Asthma Medication Ratio (AMR)

New for 2023

Added

- Rates will now include stratification by race and ethnicity

Updated

- Members who died during the measurement year is now a required exclusion
- Dyphylline Guaifenesin has been removed from the asthma controller medication list

Definition

Percentage of members ages 5–64 who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.

Plan(s) Affected	Quality Program(s) Affected	Collection and Reporting Method
• Commercial • Exchange/Marketplace • Medicaid	• CMS Quality Rating System • NCQA Health Plan Ratings	**Administrative** • Claim/Encounter Data • Pharmacy Data

Medications

To comply with this measure, a member must have the appropriate ratio of controller medications to total asthma medications.

Asthma Controller Medications

Drug Category	Medications	
Antibody inhibitors	• Omalizumab	
Anti-interleukin-4	• Dupilumab	
Anti-interleukin-5	• Benralizumab • Mepolizumab	• Reslizumab
Inhaled corticosteroids	• Beclomethasone • Budesonide • Ciclesonide	• Flunisolide • Fluticasone • Mometasone
Inhaled steroid combinations	• Budesonide-formoterol • Fluticasone-salmeterol	• Fluticasone-vilanterol • Formoterol-mometasone
Leukotriene modifiers	• Montelukast • Zafirlukast	• Zileuton
Methylxanthines	• Theophylline	

(Medications continued)

Asthma Medication Ratio (AMR)

Medications

To comply with this measure, a member must have the appropriate ratio of controller medications to total asthma medications.

Asthma Reliever Medications

Drug Category	Medications	
Short-acting, inhaled beta-2 agonists	• Albuterol	• Levalbuterol

Required Exclusion(s)

Exclusion	Timeframe
• Members in hospice or using hospice services • Members who died • Members who weren't dispensed an asthma controller or reliever medication	Any time during the measurement year
• Acute respiratory failure • Chronic obstructive pulmonary disease (COPD) • Chronic respiratory conditions due to fumes/vapors • Cystic fibrosis • Emphysema • Obstructive chronic bronchitis	Any time during a member's history through December 31 of the measurement year

Tips and Best Practices to Help Close This Care Opportunity

- **Please check your Patient Care Opportunity Report (PCOR) often to see members with open care opportunities.** If you have questions, your UnitedHealthcare representative can help.
- Simplify treatment regimen, when possible.
  - Use clear and simple language when providing directions on how to use inhalers.
  - Help patients learn to identify and avoid asthma triggers.
  - Educate patients on the difference between controller and reliever medications and applicable usage.
- National Institutes of Health guidelines recommend using tools such as the childhood and adult asthma control test along with an asthma action plan to help members manage their condition.
- Sharing member demographic data is critical to understanding the cultural, linguistic and social needs of those we serve and decreasing health inequities across the care continuum. This data can include, but is not limited to, race, ethnicity, language, sexual orientation, gender identity, pronouns, sex assigned at birth and disability status. As part of UnitedHealthcare's clinical structured data exchange program, we encourage you to include this demographic data with any structured data file or CCD. Your information is confidential. UnitedHealthcare will keep personally identifiable information confidential and won't disclose any information without your written consent.

Blood Pressure Control for Patients With Diabetes (BPD)

New for 2023

Added

- A direct reference code, Z51.5, for an encounter for palliative care
- Frailty exclusion now requires 2 different dates of service during the measurement year

Updated

- Members who died during the measurement year is now a required exclusion

Yes!
Supplemental Data Accepted

Definition

Percentage of members ages 18–75 with diabetes (Types 1 and 2) who have a blood pressure (BP) reading of <140/90 mmHg in the measurement year.

Plan(s) Affected	Quality Program(s) Affected	Collection and Reporting Method
• Commercial • Medicaid • Medicare	• CMS Star Ratings • NCQA Accreditation • NCQA Health Plan Ratings	**Hybrid** • Claim/Encounter Data • Medical Record Documentation

Codes

The following codes can be used to close HEDIS® numerator gaps in care; they are not intended to be a directive of your billing practice.

Diastolic Blood Pressure Levels	
CPT®/CPT II	3078F, 3079F, 3080*

Systolic Blood Pressure Levels	
CPT®/CPT II	3074F, 3075F, 3077*

***Please continue to code using CPT II codes for a blood pressure reading including a diastolic >90 and systolic >140, as it is important for tracking and addressing quality of care and health outcomes.**

Blood Pressure Control for Patients With Diabetes (BPD)

Required Exclusion(s)

Exclusion	Timeframe
• Members in hospice or using hospice services • Members receiving palliative care • Members who died	Any time during the measurement year
Members who have no diagnosis of diabetes and have a diagnosis of polycystic ovarian syndrome, gestational diabetes or steroid-induced diabetes	During the measurement year or year prior
Members ages 66 and older as of December 31 of the measurement year who had 2 diagnoses of frailty on different dates of service and advanced illness.* Advanced illness is indicated by one of the following: • Two or more outpatient, observation, emergency room, telephone, e-visits, virtual check-ins or non-acute inpatient encounters or discharge(s)on separate dates of service with a diagnosis of advanced illness • One or more acute inpatient encounter(s) with a diagnosis of advanced illness • One or more acute inpatient discharge(s) with a diagnosis of advanced illness on the discharge claim • Dispensed a dementia medication: Donepezil, Donepezil-memantine, galantamine, rivastigmine or memantine	**Frailty** diagnoses must be in the measurement year on 2 different dates of service **Advanced illness** diagnosis must be in the measurement year or year prior to the measurement year
Medicare members ages 66 and older as of December 31 of the measurement year who are either: • Enrolled in an Institutional Special Needs Plan (I-SNP) • Living long term in an institution*	Any time during the measurement year

***Supplemental and medical record data may not be used for the frailty with advanced illness or institutional living exclusions.**

Blood Pressure Control for Patients With Diabetes (BPD)

Important Notes

	Test, Service or Procedure to Close Care Opportunity	Medical Record Detail Including, But Not Limited To
• BP reading must be performed within the measurement year — **last** BP result of the year is the one measured. • BP readings taken on the same day the member receives a common low-intensity or preventive procedure can be used. Examples include, but aren't limited to: – Eye exam with dilating agents – Injections (e.g., allergy, Depo-Provera,® insulin, lidocaine, steroid, testosterone toradol or vitamin B-12) – Intrauterine device (IUD) insertion – Tuberculosis (TB) test – Vaccinations – Wart or mole removal	BP reading taken or reported and recorded during the measurement year via outpatient visits, telephone or telehealth visits, e-visits, virtual check-ins, or non-acute inpatient visits. Member-reported BP readings must be taken using a digital device in any of these visit settings and documented in member's medical record (must note "digital device").	• Consultation reports • Diabetic flow sheets • Progress notes • Vitals sheet

(Important Notes continued)

Blood Pressure Control for Patients With Diabetes (BPD)

Important Notes

	Test, Service or Procedure to Close Care Opportunity	Medical Record Detail Including, But Not Limited To
• BP readings taken in the following situations will **not** count toward compliance: – During an acute inpatient stay or an emergency department visit – On the same day as a diagnostic test, or diagnostic or therapeutic procedure that requires a change in diet or medication on or one day before the day of the test or procedure – with the exception of a fasting blood test. Examples include, but are not limited to: • Colonoscopy • Dialysis, infusions and chemotherapy • Nebulizer treatment with albuterol • BP readings taken by a member using a non-digital device, e.g., manual blood pressure cuff and stethoscope, **do not** meet numerator compliance.		• Consultation reports • Diabetic flow sheets • Progress notes • Vitals sheet

Blood Pressure Control for Patients With Diabetes (BPD)

Tips and Best Practices to Help Close This Care Opportunity

- **Please check your Patient Care Opportunity Report (PCOR) often to see members with open care opportunities.** If you have questions, your UnitedHealthcare representative can help.
- It is important to document patient reported vitals in the official medical record when conducting telehealth, telephone or online assessment visits. Please encourage patients to use a digital device to track and report their BP during every visit.
- **Always list the date of service and BP reading together.**
  - If BP is listed on the vital flow sheet, it must have a date of service.
- Members who have an elevated BP during an office visit in Aug., Sept. or Oct. should be brought back in for a follow-up visit before Dec. 31.
- Talk with members about what a lower goal is for a healthy BP reading.
  - For example: 130/80 mmHg
- Remind members who are NPO for a fasting lab they should continue to take their anti-hypertensive medications with a sip of water on the morning of their appointment.
- If your office uses manual blood pressure cuffs, don't round up the BP reading.
  - For example: 138/89 mmHg rounded to 140/90 mmHg
- If a member's initial BP reading is elevated at the start of a visit, you can take multiple readings during the same visit and use the lowest diastolic and lowest systolic to document the overall reading. Retake the member's BP after they've had time to rest.
  - For example: **If a member's first BP reading was 160/80 mmHg and the second reading was 120/90 mmHg, use the 120 systolic of the second reading and the 80 diastolic of the first reading to show a BP result of 120/80 mmHg.**
- If your office submits CCDs to UnitedHealthcare via our clinical data exchange program, please ensure the CCD function within your EMR system is set up to send CPT II Codes in the extract.
- The use of CPT® Category II codes helps UnitedHealthcare identify clinical outcomes such as diastolic and systolic readings. It can also reduce the need for some chart review.
- BP readings can be accepted as supplemental data, reducing the need for some chart review. Please contact your UnitedHealthcare representative to discuss clinical data exchange opportunities.
- Sharing member demographic data is critical to understanding the cultural, linguistic and social needs of those we serve and decreasing health inequities across the care continuum. This data can include, but is not limited to, race, ethnicity, language, sexual orientation, gender identity, pronouns, sex assigned at birth and disability status. As part of UnitedHealthcare's clinical structured data exchange program, we encourage you to include this demographic data with any structured data file or CCD. Your information is confidential. UnitedHealthcare will keep personally identifiable information confidential and won't disclose any information without your written consent.

Eye Exam for Patients With Diabetes (EED)

New for 2023

Added

- A direct reference code, Z51.5, for an encounter for palliative care
- Frailty exclusion now requires 2 different dates of service during the measurement year

Updated

- Members who died during the measurement year is now a required exclusion

Clarified

- An eye exam result listed as 'unknown' is considered non-compliant

Yes!
Supplemental Data Accepted

Definition

Percentage of members ages 18–75 with diabetes (Types 1 and 2) who had any one of the following:

- Retinal or dilated eye exam by an optometrist or ophthalmologist in the measurement year
- Negative retinal or dilated eye exam by an optometrist or ophthalmologist in the year prior to the measurement year
- Bilateral eye enucleations any time during their history through Dec. 31 of the measurement year

Plan(s) Affected	Quality Program(s) Affected	Collection and Reporting Method
• Commercial • Exchange/Marketplace • Medicaid • Medicare	• CMS Star Ratings • CMS Quality Rating System • NCQA Accreditation • NCQA Health Plan Ratings	**Hybrid** • Claim/Encounter Data • Medical Record Documentation

Codes

The following codes can be used to close HEDIS® numerator gaps in care; they are not intended to be a directive of your billing practice

Category 1 Coding Criteria: Any Provider
Eye Exam with Evidence of Retinopathy Value Set, Eye Exam Without Evidence of Retinopathy Value Set or Automated Eye Exam Value Set **billed** by **ANY PROVIDER** during MY

Eye Exam without Evidence of Retinopathy Value Set **billed** by **ANY PROVIDER** during PY

Diabetic Eye Exam without Evidence of Retinopathy in Prior Year	
CPT®/CPT II	3072F

Diabetic Eye Exam without Evidence of Retinopathy	
CPT®/CPT II	2023F, 2025F, 2033F

Diabetic Eye Exam with Evidence of Retinopathy	
CPT®/CPT II	2022F, 2024F, 2026F

Automated Eye Exam (Imaging of retina)	
CPT®/CPT II	92229

(Codes continued)

Eye Exam for Patients With Diabetes (EED)

Codes (continued)

The following codes can be used to close HEDIS® numerator gaps in care; they are not intended to be a directive of your billing practice.

Category 2 Coding Criteria: Eye Care Professional

Diabetic Retinal Screening Value Set billed by an **EYE CARE PROFESSIONAL** during MY

Diabetic Retinal Screening Value Set billed by an **EYE CARE PROFESSIONAL** during PY ***with*** a diagnosis of diabetes without complications (Diabetes Mellitus Without Complications Value Set)

Diabetic Eye Exam	
CPT®/CPT II	67028, 67030, 67031, 67036, 67039, 67040, 67041, 67042, 67043, 67101, 67105, 67107, 67108, 67110, 67113, 67121, 67141, 67145, 67208, 67210, 67218, 67220, 67221, 67227, 67228, 92002, 92004, 92012, 92014, 92018, 92019, 92134, 92201, 92202, 92225, 92226, 92227, 92228, 92230, 92235, 92240, 92250, 92260, 99203, 99204, 99205, 99213, 99214, 99215, 99242, 99243, 99244, 99245
HCPCS	S0620, S0621, S3000
SNOMED	274795007, 274798009, 308110009, 314971001, 314972008, 410451008, 410452001, 410453006, 410455004, 425816006, 427478009, 722161008

Diabetes Mellitus without Complications	
ICD-10 Diagnosis	E10.9, E11.9, E13.9
SNOMED	111552007, 190412005, 313435000, 313436004, 1481000119100, 31321000119102

Unilateral Eye Enucleation	
CPT®/CPT II	65091, 65093, 65101, 65103, 65105, 65110, 65112, 65114
SNOMED	59590004, 172132001, 205336009, 397800002, 397994004, 398031005

Unilateral Eye Enucleation – Left	
ICD-10 Procedure	08T1XZZ

Unilateral Eye Enucleation – Right	
ICD-10 Procedure	08T0XZZ

Bilateral Modifier	
CPT Modifier	50

Eye Exam for Patients With Diabetes (EED)

Required Exclusion(s)

Exclusion	Timeframe
• Members in hospice or using hospice services • Members receiving palliative care • Members who died • Medicare members ages 66 and older as of December 31 of the measurement year who are either: – Enrolled in an Institutional Special Needs Plan (I-SNP) – Living long term in an institution*	Any time during the measurement year
Members who have no diagnosis of diabetes and have a diagnosis of polycystic ovarian syndrome, gestational diabetes or steroid-induced diabetes	During the measurement year or year prior
Members ages 66 and older as of December 31 of the measurement year who had at least 2 diagnoses of frailty on different dates of service and advanced illness.* Advanced illness is indicated by one of the following: • Two or more outpatient, observation, emergency room, telephone, e-visits, virtual check-ins or non-acute inpatient encounters or discharge(s)on separate dates of service with a diagnosis of advanced illness • One or more acute inpatient encounter(s) with a diagnosis of advanced illness • One or more acute inpatient discharge(s) with a diagnosis of advanced illness on the discharge claim • Dispensed a dementia medication: Donepezil, Donepezil-memantine, galantamine, rivastigmine or memantine	**Frailty** diagnoses must be in the measurement year and on different dates of service **Advanced illness** diagnosis must be in the measurement year or year prior to the measurement year

Important Notes

	Test, Service or Procedure to Close Care Opportunity	Medical Record Detail Including, But Not Limited To
• Members without retinopathy should have an eye exam every 2 years. • Members with retinopathy should have an eye exam every year.	• Bilateral eye enucleation or acquired absence of both eyes • Dilated or retinal eye exam • Fundus photography	• Consultation reports • Diabetic flow sheets • Eye exam report • Progress notes

***Supplemental and medical record data may not be used for the frailty with advanced illness or institutional living exclusions.**

Eye Exam for Patients With Diabetes (EED)

Tips and Best Practices to Help Close This Care Opportunity

- **Please check your Patient Care Opportunity Report (PCOR) often to see members with open care opportunities.** If you have questions, your UnitedHealthcare representative can help.
- **Always list the date of service, test, result and eye care professional's name and credentials together if you're documenting the history of a dilated eye exam in a member's chart and don't have the eye exam report from an eye care professional.**
  - For example: "Last diabetic eye exam with John Smith, OD, was June 201X with no retinopathy."
- Documentation of a diabetic eye exam by an optometrist or ophthalmologist isn't specific enough to meet the criteria. The medical record must indicate that a **dilated or retinal exam** was performed. If the words "dilated" or "retinal" are missing in the medical record, a notation of "dilated drops used" and findings for macula and vessels will meet the criteria for a dilated exam.
- If history of a dilated retinal eye exam and result is in your progress notes, please ensure that a date of service, the test or result, and the care provider's credentials are documented. The care provider must be an optometrist or ophthalmologist, and including only the date of the progress note will not count.
- A slit-lamp examination will not meet the criteria for the dilated eye exam measure. There must be additional documentation of dilation or evidence that the retina was examined for a slit-lamp exam to be considered compliant.
- A chart or photograph of retinal abnormalities indicating the date when the fundus photography was performed and evidence that an optometrist or ophthalmologist reviewed the results will be compliant.
  - Alternatively, results may be read by:
    - A qualified reading center that operates under the direction of a medical director who is a retinal specialist.
    - A system that provides artificial intelligence (AI) interpretation
- If a copy of the fundus photography is included in your medical record it must include results, date and signature of the reading eye care professional for compliance
- To be reimbursable, billing of fundus photography code 92250 must be submitted globally by an optometrist or ophthalmologist and meet disease state criteria.
- Documentation of hypertensive retinopathy should be considered the same as diabetic retinopathy.
- If your office submits CCDs to UnitedHealthcare via our clinical data exchange program, please ensure the CCD function within your EMR system is set up to send CPT II Codes in the extract.
- The use of CPT® Category II codes helps UnitedHealthcare identify clinical outcomes such as diabetic retinal screening with an eye care professional. It can also reduce the need for some chart review.
- Dilated retinal eye exams with results can be accepted as supplemental data, reducing the need for some chart review. Please contact your UnitedHealthcare representative to discuss clinical data exchange opportunities.

Hemoglobin A1c Control for Patients With Diabetes (HBD)

New for 2023

Added

- A direct reference code, Z51.5, for an encounter for palliative care
- Frailty exclusion now requires 2 different dates of service during the measurement year

Updated

- Members who died during the measurement year is now a required exclusion
- Rates stratified for race and ethnicity

Yes!
Supplemental Data Accepted

Definition

Percentage of members ages 18–75 with diabetes (Types 1 and 2) who had an HbA1c lab test during the measurement year that showed their blood sugar is under control (good control is < 8.0%, poor control is > 9.0%).

Plan(s) Affected	Quality Program(s) Affected	Collection and Reporting Method
• Commercial • Exchange/Marketplace • Medicaid • Medicare	• CMS Star Ratings • CMS Quality Rating System • NCQA Accreditation • NCQA Health Plan Ratings	**Hybrid** • Automated Lab Data • Claim/Encounter Data • Medical Record Documentation

Codes

The following codes can be used to close HEDIS® numerator gaps in care; they are not intended to be a directive of your billing practice.

HbA1c Level < 7.0%	
CPT®/CPT II	3044F
SNOMED	165679005

HbA1c ≥ 7.0% and <8.0%	
CPT®/CPT II	3051F

HbA1c ≥ 8.0% and ≤ 9.0%	
CPT®/CPT II	3052F

HbA1c > 9.0%	
CPT®/CPT II	3046F
SNOMED	451061000124104

Hemoglobin A1c Control for Patients With Diabetes (HBD)

Required Exclusion(s)

Exclusion	Timeframe
• Members in hospice or using hospice services • Members receiving palliative care • Members who died	Any time during the measurement year
Members who have no diagnosis of diabetes and have a diagnosis of polycystic ovarian syndrome, gestational diabetes or steroid-induced diabetes	During the measurement year or year prior
Members ages 66 and older as of December 31 of the measurement year who had at least 2 diagnoses of frailty on different dates of service and advanced illness.* Advanced illness is indicated by one of the following: • Two or more outpatient, observation, emergency room, telephone, e-visits, virtual check-ins or non-acute inpatient encounters or discharge(s)on separate dates of service with a diagnosis of advanced illness • One or more acute inpatient encounter(s) with a diagnosis of advanced illness • One or more acute inpatient discharge(s) with a diagnosis of advanced illness on the discharge claim • Dispensed a dementia medication: Donepezil, Donepezil-memantine, galantamine, rivastigmine or memantine	**Frailty** diagnoses must be in the measurement year and on different dates of service **Advanced illness** diagnosis must be in the measurement year or year prior to the measurement year
Medicare members ages 66 and older as of Dec. 31 of the measurement year who are either: • Enrolled in an Institutional Special Needs Plan (I-SNP) • Living long term in an institution*	Any time during the measurement year

***Supplemental and medical record data may not be used for the frailty with advanced illness or institutional living exclusions.**

Hemoglobin A1c Control for Patients With Diabetes (HBD)

Important Notes

	Test, Service or Procedure to Close Care Opportunity	Medical Record Detail Including, But Not Limited To
HbA1c test must be performed during the measurement year. If multiple tests were performed in the measurement year, the result from the last test is used. Ranges and thresholds do not meet compliance.	• A1c, HbA1c, HgbA1c • Glycohemoglobin • Glycohemoglobin A1c • Glycated hemoglobin • Glycosylated hemoglobin • HB1c • Hemoglobin A1c	• Diabetic flow sheets • Consultation reports • Lab reports • Progress notes • Vitals sheet

Tips and Best Practices to Help Close This Care Opportunity

- **Please check your Patient Care Opportunity Report (PCOR) often to see members with open care opportunities.** If you have questions, your UnitedHealthcare representative can help.
- **Always list the date of service, result and test together.**
- If test result(s) are documented in the vitals section of your progress notes, please include the date of the blood draw with the result. The date of the progress notes will not count.
- Consider point of care A1c testing in the office setting, when applicable.
- The use of CPT® Category II codes helps UnitedHealthcare identify clinical outcomes such as HbA1c level. It can also reduce the need for some chart review.
- HbA1c tests and results can be accepted as supplemental data, reducing the need for some chart review. Please contact your UnitedHealthcare representative to discuss clinical data exchange opportunities.
  - Please remember to submit LOINCs for any point of care HbA1c tests done in addition to those completed at a lab or hospital facility.
- If your office submits CCDs to UnitedHealthcare via our clinical data exchange program, please ensure the CCD function within your EMR system is set up to send CPT II Codes in the extract.
- Sharing member demographic data is critical to understanding the cultural, linguistic and social needs of those we serve and decreasing health inequities across the care continuum. This data can include, but is not limited to, race, ethnicity, language, sexual orientation, gender identity, pronouns, sex assigned at birth and disability status. As part of UnitedHealthcare's clinical structured data exchange program, we encourage you to include this demographic data with any structured data file or CCD. Your information is confidential. UnitedHealthcare will keep personally identifiable information confidential and won't disclose any information without your written consent.

Kidney Health Evaluation for Patients With Diabetes (KED)

New for 2023

Added

- A direct reference code, Z51.5, for an encounter for palliative care
- Frailty exclusion now requires 2 different dates of service during the measurement year

Updated

- Members with no diagnosis of diabetes and a diagnosis of polycystic ovarian syndrome, gestational diabetes or steroid-induced diabetes are now required exclusions
- Members who died during the measurement year is now a required exclusion

Yes!
Supplemental Data Accepted

Definition

Percentage of members ages 18–85 with diabetes (Types 1 and 2) who had a kidney health evaluation in the measurement year. **Both** an eGFR and a uACR test are required on same or different dates of service.

- At least 1 estimated glomerular filtration rate (eGFR); **AND**
- At least 1 urine albumin-creatinine ratio (uACR) test identified by one of the following:
  - A quantitative urine albumin test **AND** a urine creatinine test 4 or less days apart; OR
  - A uACR

Plan(s) Affected	Quality Program(s) Affected	Collection and Reporting Method
• Commercial • Exchange/Marketplace • Medicaid • Medicare	• CMS Quality Rating System • NCQA Health Plan Ratings	**Administrative** • Claim/Encounter Data

Codes

The following codes can be used to close HEDIS® numerator gaps in care; they are not intended to be a directive of your billing practice.

Estimated Glomerular Filtration Rate Lab Test	
CPT®/CPT II	80047, 80048, 80050, 80053, 80069, 82565
LOINC	48642-3, 48643-1, 50044-7, 50210-4, 50384-7, 62238-1, 69405-9, 70969-1, 77147-7, 88293-6, 88294-4, 94677-2, 96591-3, 96592-1, 98979-8, 98980-6
SNOMED	12341000, 18207002, 241373003, 444275009, 444336003, 446913004, 706951006, 763355007

(Codes continued)

Kidney Health Evaluation for Patients With Diabetes (KED)

Codes (continued)

The following codes can be used to close HEDIS® numerator gaps in care; they are not intended to be a directive of your billing practice.

Quantitative Urine Albumin Lab Test	
CPT®/CPT II	82043
LOINC	14957-5, 1754-1, 21059-1, 30003-8, 43605-5, 53530-2, 53531-0, 57369-1, 89999-7
SNOMED	104486009, 104819000

Urine Creatinine Lab Test	
CPT®/CPT II	82570
LOINC	20624-3, 2161-8, 35674-1, 39982-4, 57344-4, 57346-9, 58951-5
SNOMED	8879006, 36793009, 271260009, 444322008

Urine Albumin Creatinine Ratio Test	
LOINC	13705-9,14958-3, 14959-1, 30000-4, 32294-1, 44292-1, 59159-4, 76401-9, 77253-3, 77254-1, 89998-9, 9318-7

Kidney Health Evaluation for Patients With Diabetes (KED)

Required Exclusion(s)

Exclusion	Timeframe
• Members in hospice or using hospice services • Members receiving palliative care • Members age 81 years or older who had at least 2 frailty diagnoses on different dates of service • Members who died	Any time during the measurement year
Members with evidence of ESRD or dialysis	Any time during the member's history on or prior to December 31 of the measurement year
Members ages 66-80 as of December 31 of the measurement year who had at least 2 diagnoses of frailty on different dates of service and advanced illness.* Advanced illness is indicated by one of the following: • Two or more outpatient, observation, emergency room, telephone, e-visits, virtual check-ins or non-acute inpatient encounters or discharge(s)on separate dates of service with a diagnosis of advanced illness • One or more acute inpatient encounter(s) with a diagnosis of advanced illness • One or more acute inpatient discharge(s) with a diagnosis of advanced illness on the discharge claim • Dispensed a dementia medication: Donepezil, Donepezil-memantine, galantamine, rivastigmine or memantine	**Frailty** diagnoses must be in the measurement year and on different dates of service **Advanced illness** diagnosis must be in the measurement year or year prior to the measurement year
Medicare members ages 66 and older as of December 31 of the measurement year who are either: • Enrolled in an Institutional Special Needs Plan (I-SNP) • Living long term in an institution*	Any time during the measurement year
Members with no diagnosis of diabetes and a diagnosis of polycystic ovarian syndrome, gestational diabetes or steroid-induced diabetes are now required exclusions	Any time during the measurement year or the year prior to the measurement year

***Supplemental and medical record data may not be used for the frailty with advanced illness or institutional living exclusions.**

Kidney Health Evaluation for Patients With Diabetes (KED)

Tips and Best Practices to Help Close This Care Opportunity

- **Please check your Patient Care Opportunity Report (PCOR) often to see members with open care opportunities.** If you have questions, your UnitedHealthcare representative can help.
- The American Diabetes Association (ADA) and National Kidney Foundation (NKF) guidelines recommend annual kidney health evaluation for patients with diabetes.
- Advise members that some complications from diabetes may be **asymptomatic**. For example, kidney disease is **asymptomatic** in its earliest stages and routine testing and diagnoses may help prevent/delay some life-threatening complications.
- Create automatic flags in EHR to alert staff to know when members are due for screenings. Use EHR to send text reminders that labs are due.
- Educate and remind members of the importance and rationale behind having these labs completed annually.
- Provide education to members about the disease process to help increase health literacy and improve management of the health condition.
- Foster a PCP-specialist collaboration to ensure labs are completed annually and to prevent duplicate labs or non-compliance.
- Order and request labs to have members complete prior to appointment to allow results to be available for discussion on the day of the office visit.
- Track and reach out to members who have missed appointments.

Controlling High Blood Pressure (CBP)

New for 2023

Added

- A direct reference code, Z51.5, for an encounter for palliative care
- Frailty exclusion now requires 2 different dates of service during the measurement year

Updated

- Members who died during the measurement year is now a required exclusion
- The following are now required exclusions:
  - ESRD, dialysis, nephrectomy, kidney transplant, or pregnancy

Yes!
Supplemental Data Accepted

Definition

Percentage of members ages 18–85 who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled at <140/90 mmHg during the measurement year.

Plan(s) Affected	Quality Program(s) Affected	Collection and Reporting Method
• Commercial • Exchange/Marketplace • Medicaid • Medicare	• CMS Quality Rating System • CMS Star Ratings • NCQA Accreditation • NCQA Health Plan Ratings	**Hybrid** • Claim/Encounter Data • Medical Record Documentation • Pharmacy Data

Codes

The following codes can be used to close HEDIS® numerator gaps in care; they are not intended to be a directive of your billing practice.

Systolic Blood Pressure Levels 130-139 mm Hg	
CPT®/CPT II	3075F
Systolic Blood Pressure Level <130 mmHg	
CPT®/CPT II	3074F
Systolic Blood Pressure Level >/=140 mmHg	
CPT®/CPT II	3077F
Diastolic Blood Pressure Level 80-89 mmHg	
CPT®/CPT II	3079F
Diastolic Blood Pressure Level <80 mmHg	
CPT®/CPT II	3078F
Diastolic Blood Pressure Level >/=90 mmHg	
CPT®/CPT II	3080F

***Please continue to code using CPT II codes for a blood pressure reading including a diastolic >90 and systolic >140, as it is important for tracking and addressing quality of care and health outcomes.**

Controlling High Blood Pressure (CBP)

Required Exclusion(s)

Exclusion	Timeframe
• Members in hospice or using hospice services • Members receiving palliative care • Members who died • Members with a diagnosis of pregnancy	Any time during the measurement year
Members ages 81 and older as of December 31 of the measurement year who had at least 2 diagnoses of frailty on different dates of service	**Frailty** diagnoses must be in the measurement year on different dates of service
Members ages 66–80 as of December 31 of the measurement year who had a at least 2 diagnoses of frailty on different dates of service and advanced illness.* Advanced illness is indicated by one of the following: • Two or more outpatient, observation, emergency room, telephone, e-visits, virtual check-ins or non-acute inpatient encounters or discharge(s)on separate dates of service with a diagnosis of advanced illness • One or more acute inpatient encounter(s) with a diagnosis of advanced illness • One or more acute inpatient discharge(s) with a diagnosis of advanced illness on the discharge claim • Dispensed a dementia medication: Donepezil, Donepezil-memantine, galantamine, rivastigmine or memantine	**Frailty** diagnoses must be in the measurement year on different dates of service **Advanced illness** diagnosis must be in the measurement year or year prior to the measurement year
Medicare members ages 66 and older as of Dec. 31 of the measurement year who are either: • Enrolled in an Institutional Special Needs Plan (I-SNP) • Living long term in an institution*	Any time during the measurement year on or before December 31 of the measurement year
• Dialysis • End-stage renal disease (ESRD) • Kidney transplant • Nephrectomy	On or before Dec. 31 of the measurement year

*** Supplemental and medical record data may <u>not</u> be used for the frailty, frailty with advanced illness or institutional living exclusions.**

Controlling High Blood Pressure (CBP)

Important Notes

	Test, Service or Procedure to Close Care Opportunity	Medical Record Detail Including, But Not Limited To
• BP reading must be the latest performed within the measurement year, and on or after the second hypertension diagnosis. • BP readings taken on the same day the member receives a common low-intensity or preventive procedure can be used. Examples include, but aren't limited to: – Eye exam with dilating agents – Injections (e.g., allergy, Depo-Provera®, insulin, lidocaine, steroid, testosterone toradol, or vitamin B-12) – Intrauterine device (IUD) insertion – Tuberculosis (TB) test – Vaccinations – Wart or mole removal	BP reading taken during the measurement year via: - Outpatient visits - Telephone or telehealth visits - Virtual check-ins or e-visits - Non-acute inpatient visits Member-reported BP readings must be taken using a digital device in any of these visit settings and documented in member's medical record. Ranges and threshold will not meet the intent of the measure. A specific BP result needs to be documented. Documentation of 'average BP' will meet the intent of the measure. If multiple BPs were taken on the same day, the lowest systolic and the lowest diastolic should represent the BP result for the date of service.	• Consultation reports • Progress notes • Medical history • SOAP notes • Vitals sheet • CPT II codes on claims

Controlling High Blood Pressure (CBP)

Important Notes

	Test, Service or Procedure to Close Care Opportunity	Medical Record Detail Including, But Not Limited To
• BP readings taken in the following situations will **not** count toward compliance: – During an acute inpatient stay or an emergency department visit – On the same day as a diagnostic test, or diagnostic or therapeutic procedure that requires a change in diet or medication on or one day before the day of the test or procedure – with the exception of a fasting blood test. Examples include, but are not limited to: – Colonoscopy – Dialysis, infusions and chemotherapy – Nebulizer treatment with albuterol • BP readings taken by a member using a non-digital device, e.g., manual blood pressure cuff and stethoscope, **do not** meet numerator compliance		• Consultation reports • Progress notes • Medical history • SOAP notes • Vitals sheet

Controlling High Blood Pressure (CBP)

Tips and Best Practices to Help Close This Care Opportunity

- Please check your Patient Care Opportunity Report (PCOR) often to see members with open care opportunities. If you have questions, your UnitedHealthcare representative can help.
- For additional resources on Blood Pressure rechaecks, go to UHCprovider.com > Resource Library > Healthcare Professional Education and Training > Clinical Tools
- It is important to document patient reported vitals in the official medical record when conducting telehealth, telephone or online assessment visits. Please encourage patients to use a digital device to track and report their BP during every visit.
- **Always list the date of service and BP reading together.**
  - If BP is listed on the vital flow sheet, it must have a date of service.
- It's critical to follow up with a member for a BP check after their initial diagnosis. Schedule member's follow-up visit prior to discharging from clinic.
  - Members who have an elevated BP during an office visit in Aug., Sep. or Oct. should be brought back in for a follow-up visit before Dec. 31.
- Talk with members about what a lower goal BP reading is.
  - For example: 130/80 mmHg
- Remind members who are NPO for a fasting lab they should continue to take their anti-hypertensive medications with a sip of water on the morning of their appointment.
- If your office uses manual blood pressure cuffs, don't round up the BP reading.
  - For example: 138/89 mmHg rounded to 140/90 mmHg
- If a member's initial BP reading is elevated at the start of a visit, you can take multiple readings during the same visit and use the lowest diastolic and lowest systolic to document the overall reading. Retake the member's BP after they've had time to rest.
  - For example: If a member's first BP reading was 160/80 mmHg and the second reading was 120/90 mmHg, use the 120 systolic of the second reading and the 80 diastolic of the first reading to show a BP result of 120/80 mmHg.
  - Place a BP Recheck reminder at exam room to recheck blood pressure if initial blood pressure was 140/90 or higher.
- If a member is seeing a cardiologist for their hypertension, please encourage them to also have their records transferred to their primary care provider's office.
- If a member is new to your office, please get their medical record from their previous care provider to properly document the transfer of care.
- If your office submits CCDs to UnitedHealthcare via our clinical data exchange program, please ensure the CCD function within your EMR system is set up to send CPT II Codes in the extract.
- The use of CPT® Category II codes helps UnitedHealthcare identify clinical outcomes such as systolic and diastolic BP readings. It can also reduce the need for some chart review.
- Place a BP Recheck reminder at exam room to recheck blood pressure if initial blood pressure was 140/90 or higher
- BP readings can be accepted as supplemental data, reducing the need for some chart review. Please contact your UnitedHealthcare representative to discuss clinical data exchange opportunities.
- Sharing member demographic data is critical to understanding the cultural, linguistic and social needs of those we serve and decreasing health inequities across the care continuum. This data can include, but is not limited to, race, ethnicity, language, sexual orientation, gender identity, pronouns, sex assigned at birth and disability status. As part of UnitedHealthcare's clinical structured data exchange program, we encourage you to include this demographic data with any structured data file or CCD. Your information is confidential. UnitedHealthcare will keep personally identifiable information confidential and won't disclose any information without your written consent.

Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)

New for 2023

Added

- Frailty exclusion now requires 2 different dates of service during the measurement year.

Updated

- Members who died during the measurement year is now a required exclusion.
- The following are now required exclusions: asthma, COPD, obstructive chronic bronchitis, chronic respiratory conditions due to flames or vapors, hypotension, heart block >1 degree or sinus bradycardia, medication dispensing event indicative of history of asthma or intolerance or allergy to beta-blocker therapy

Yes!
Supplemental Data Accepted

Definition

The percentage of members ages 18 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 AMI and who received persistent beta-blocker treatment for 6 months after discharge.

- Persistent beta-blocker treatment: at least 135 days during 180 days post discharge.

Plan(s) Affected	Quality Program(s) Affected	Collection and Reporting Method
• Commercial • Medicaid • Medicare	• Select Medicaid State Reporting	**Administrative** • (Claim/Encounter Data and Pharmacy Data)

Medications

To comply with this measure, a member must have completed a 135-day course of one of the following beta-blockers:

Drug Category	Medications		
Noncardioselective beta-blockers	• Carvedilol • Labetalol • Nadolol • Pindolol	• Propranolol • Timolol • Sotalol	
Cardioselective beta-blockers	• Acebutolol • Atenolol	• Betaxolol • Bisoprolol	• Metoprolol • Nebivolol
Antihypertensive combinations	• Atenolol-chlorthalidone • Bendroflumethiazide-nadolol • Bisoprolol-hydrochlorothiazide	• Hydrochlorothiazide-metoprolol • Hydrochlorothiazide-propranolol	

Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)

Required Exclusion(s)

Exclusion	Timeframe
• Members in hospice or using hospice services • Members who died	Any time during the measurement year
Medicare members ages 66 and older as of Dec. 31 of the measurement year who are either: • Enrolled in an Institutional Special Needs Plan (I-SNP) • Living long term in an institution • Members ages 81 and older as of December 31 of the measurement year had at least 2 diagnoses of frailty on different dates of service	Any time on or between July 1 of the year prior to the measurement year through the end of the measurement year
Members ages 66-80 as of December 31of the measurement year who had at least 2 diagnoses of frailty on different dates of service and advanced illness.* Advanced illness is indicated by one of the following: • Two or more outpatient, observation, emergency room, telephone, e-visits, virtual check-ins or non-acute inpatient encounters or discharge(s)on separate dates of service with a diagnosis of advanced illness • One or more acute inpatient encounter(s) with a diagnosis of advanced illness • One or more acute inpatient discharge(s) with a diagnosis of advanced illness on the discharge claim • Dispensed a dementia medication: Donepezil, Donepezil-memantine, galantamine, rivastigmine or memantine	**Frailty** diagnoses must be any time on or between July 1 of the year prior to the measurement year through the end of the measurement year and on different dates of service **Advanced illness** diagnosis must be in the measurement year or year prior to the measurement year
• Asthma • Chronic obstructive pulmonary disease • Chronic respiratory conditions due to fumes/vapors • Hypotension, heart block >1 degree or sinus bradycardia • Intolerance or allergy to beta-blocker therapy • Medication dispensing event indicative of a history of asthma (see list below) • Obstructive chronic bronchitis	Any time during the member's history through the end of their continuous enrollment period

Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)

Any of the following asthma medications dispensed during the member's history through the end of their continuous enrollment period denote a history of asthma as a required exclusion:

Drug Category	Medications	
Bronchodilator combinations	• Budesonide-formoterol • Fluticasone-vilanterol	• Fluticasone-salmeterol • Formoterol-mometasone
Inhaled corticosteroids	• Beclomethasone • Budesonide • Ciclesonide	• Flunisolide • Fluticasone • Mometasone

Tips and Best Practices to Help Close This Care Opportunity

As an administrative measure, it's important to submit codes that reflect a member's history of any exclusion noted in the preceding chart.

- If a member is new to your practice, you can submit the exclusion diagnoses through the initial visit claim.
- If a member isn't new to your practice, but their chart has documented history of 1 of the exclusion diagnoses, you can submit the diagnosis codes on any visit claim.

At each office visit, please talk with your patients about compliance and/or barriers to taking their medications and encourage adherence.

Please review your patients' prescription refill patterns and reinforce education and reminders. Consider:

- Which patients don't fill prescriptions, are always late to fill or quit refilling over time?
- Which patients are already motivated to fill and refill, but may skip an occasional dose and simply need reminders?

Pharmacotherapy Management of COPD Exacerbation (PCE)

New for 2023

Updated

- Members who died during the measurement year is now a required exclusion

Definition

Percentage of chronic obstructive pulmonary disease (COPD) exacerbations for members ages 40 and older who had an acute inpatient discharge or emergency department visit on or between January 1-November 30 of the measurement year and were dispensed appropriate medications

Two rates are reported:

1. Percentage of members dispensed a systemic corticosteroid – or with evidence of an active prescription – within 14 days of the event
2. Percentage of members dispensed a bronchodilator – or with evidence of an active prescription – within 30 days of the event

Plan(s) Affected	Quality Program(s) Affected	Collection and Reporting Method
• Commercial • Medicaid • Medicare	• NCQA Accreditation • NCQA Health Plan Ratings	**Administrative** • Claim/Encounter Data • Pharmacy Data

Medications

To comply with this measure, a member must have been dispensed, or have an active prescription for, one of the following systemic corticosteroids on or within 14 days of the COPD exacerbation:

Drug Category	Medications	
Glucocorticoids	• Cortisone • Dexamethasone • Hydrocortisone	• Methylprednisolone • Prednisolone • Prednisone
Anticholinergic agents	• Aclidinium-bromide • Ipratropium	• Tiotropium • Umeclidinium
Beta 2-agonists	• Albuterol • Arformoterol • Formoterol • Indacaterol	• Levalbuterol • Metaproterenol • Olodaterol • Salmeterol
Bronchodilator combinations	• Albuterol-ipratropium • Budesonide-formoterol • Fluticasone-salmeterol • Fluticasone-vilanterol • Fluticasone furoate-umeclidinium-vilanterol • Formoterol-aclidinium	• Formoterol-glycopyrrolate • Formoterol-mometasone • Glycopyrrolate-indacaterol • Olodaterol-tiotropium • Umeclidinium-vilanterol

(Medications continued)

Pharmacotherapy Management of COPD Exacerbation (PCE)

Required Exclusion(s)

Exclusion	Timeframe
• Members in hospice or using hospice services • Members who died	Any time during the measurement year

Tips and Best Practices to Help Close This Care Opportunity

- The denominator for this measure is based on discharges and not members specifically.
- Members with active prescriptions for these medications are administratively compliant with the measure.
  - An active prescription is one that's noted as having available medication left in the "days' supply" through the episode date or further.
  - The "episode date" for an acute inpatient discharge is the date of discharge.
  - The "episode date" for the emergency department visit is the date of service.
- Please follow up with members to make sure any new prescriptions are filled post-discharge.

Acute Hospitalization Utilization (AHU)

New for 2023

- No applicable changes for this measure.

Definition

For members ages18 and older, the risk-adjusted ratio of observed to expected acute inpatient and observation stay discharges during the measurement year.

Plan(s) Affected	Quality Program(s) Affected	Collection and Reporting Method
• Commercial • Medicare	• NCQA Accreditation • NCQA Health Plan Ratings	**Administrative** • Claim/Encounter

Required Exclusion(s)

Exclusion	Timeframe
Members in hospice or using hospice services	Any time during the measurement year

Tips and Best Practices to Help Close This Care Opportunity

- Focus on chronic disease control with members, including regular care provider visits, to help prevent and minimize condition complications and exacerbations.
- Encourage members to come in for annual wellness visits to promote early diagnosis of any conditions, and to help them complete preventive screenings and health promotion activities such as immunizations.
- Educate members on personal safety such as wearing seatbelts and avoiding falls, and on lifestyle choices including diet, exercise, smoking and appropriate alcohol intake.

Adult Access to Preventive/Ambulatory Health Services (AAP)

Yes!
Supplemental Data Accepted

New for 2023

Updated

- Members who died during the measurement year is now a required exclusion

Definition

Percentage of members ages 20 and older who had an ambulatory or preventive care visit

- **For Medicaid and Medicare members –** Visit must occur during the measurement year.
- **For commercial members –** Visit must occur during the measurement year or 2 years prior to the measurement year.

Plan(s) Affected	Quality Program(s) Affected	Collection and Reporting Method
• Commercial • Medicaid • Medicare	• Select state reporting	**Administrative** • Claim/Encounter

Codes

The following codes can be used to close HEDIS® numerator gaps in care; they are not intended to be a directive of your billing practice.

Ambulatory Visits	
CPT®/CPT II	99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99429, 99483
HCPCS	G0402, G0438, G0439, G0463, T1015
ICD-10 Diagnosis	Z00.00, Z00.01, Z00.121, Z00.129, Z00.3, Z00.5, Z00.8, Z02.0, Z02.1, Z02.2, Z02.3, Z02.4, Z02.5, Z02.6, Z02.71, Z02.79, Z02.81, Z02.82, Z02.83, Z02.89, Z02.9, Z76.1, Z76.2
SNOMED	962000, 2219003, 3089009, 4197006, 4708004, 4967002, 6391003, 11411001, 11867000, 11961000, 15195005, 16457003, 21695004, 22869000, 26377005, 27874004, 28652005, 30775000, 32511005, 34715004, 35090008, 36685002, 37051008, 39698007, 40361008, 47163004, 58634008, 59486003, 59983003, 61416008, 68658005, 71622008,74559003, 78909009, 82303003, 84497008, 84992006, 87838003, 88284004, 89430006, 91545002, 162651007, 162655003, 162666005, 162680003, 170107008, 170109006, 170110001, 170111002, 170112009, 170114005, 170118008, 170119000, 170120006, 170121005, 170123008, 170127009, 170128004, 170129007, 170130002, 170132005, 170136008, 170137004, 170138009, 170139001, 170141000, 170145009, 170146005, 170147001, 170148006, 170150003, 170154007, 170155008, 170156009, 170157000, 170159002, 170163009, 170164003, 170165002, 170166001, 170168000, 170172001, 170173006, 170174000, 170175004, 170181007, 170182000, 170183005, 170184004, 170250008, 170254004, 170258001, 170259009, 170260004, 170261000, 170263002, 170267001, 170268006, 170269003, 170270002, 170272005, 170276008, 170277004, 170278009, 170279001, 170281004, 170285008, 170286009, 170287000,170288005, 170290006

(Codes continued)

Adult Access to Preventive/Ambulatory Health Services (AAP) (Cont.)

Codes

The following codes can be used to close HEDIS® numerator gaps in care; they are not intended to be a directive of your billing practice.

Ambulatory Visits	
SNOMED	170294002, 170295001, 170296000, 170297009, 170300004, 170305009, 170306005, 170307001, 170308006, 170309003, 185351004, 243788004, 268563000, 268565007, 275725007, 275726008, 275923005, 281029006, 281031002, 310367004, 365857001, 401140000, 408485004, 408500009, 408502001, 408503006, 410620009, 410622001, 410623006, 410624000, 410625004, 410626003, 410627007, 410628002, 410629005, 410630000, 410631001, 410632008, 410633003, 410634009, 410635005, 410636006, 410637002, 410638007, 410639004, 410640002, 410641003, 410642005, 410643000, 410644006, 410645007, 410646008, 410647004, 410648009, 410649001, 410650001, 442162000, 699134002, 712791009, 713020001 783260003
UBREV	0510, 0511, 0512, 0513, 0514, 0515, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0526, 0527, 0528, 0529, 0982, 0983

Other Ambulatory Visits	
CPT®/CPT II	92002, 92004, 92012, 92014, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99318, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337
HCPCS	S0620, S0621
SNOMED	18170008, 19681004, 207195004, 209099002, 210098006
UBREV	0524, 0525

(Codes continued)

Adult Access to Preventive Ambulatory Health Services (AAP)

Codes (continued)

The following codes can be used to close HEDIS® numerator gaps in care; they are not intended to be a directive of your billing practice.

Telephone Visits	
CPT®/CPT II	98966, 98967, 98968, 99441, 99442, 99443
SNOMED	185317003, 314849005, 386472008, 386473003, 401267002

Online Assessment (e-visit/virtual check-in)	
CPT®/CPT II	98969, 98970, 98971, 98972, 99421, 99422, 99423, 99444, 99457, 99458
HCPCS	G0071, G2010, G2012, G2061, G2062, G2063, G2250, G2251, G2252

Required Exclusion(s)

Exclusion	Timeframe
• Members in hospice or using hospice services • Members who died	Any time during the mesaurement year

Tips and Best Practices to Help Close This Care Opportunity

- Please be sure to have members come in for an ambulatory or preventive care visit annually.
- **Please check your Patient Care Opportunity Report (PCOR) often to see members with open care opportunities that can be addressed during a well-care visit.** If you have questions, your UnitedHealthcare representative can help.

Emergency Department Utilization (EDU)

New for 2023

- No applicable changes for this measure.

Definition

For members ages 18 and older, the risk-adjusted ratio of observed to expected emergency department (ED) visits during the measurement year

Member ED visits for the following reasons will **not** be included in the denominator:

- Electroconvulsive therapy
- Principal diagnosis of mental health or chemical dependency
- Psychiatry
- Result in an inpatient stay

Plan(s) Affected	Quality Program(s) Affected	Collection and Reporting Method
• Commercial • Medicare	• NCQA Accreditation • NCQA Health Plan Ratings	**Administrative** • Claim/Encounter Data

Required Exclusion(s)

Exclusion	Timeframe
• Members in hospice or using hospice services	- Any time during the measurement year

Tips and Best Practices to Help Close This Care Opportunity

- Focus on chronic disease control with members, including regular care provider visits, to help prevent and minimize condition complications and exacerbations.
- Encourage members to come in for annual wellness visits to promote early diagnosis of any conditions, and to help them complete preventive screenings and health promotion activities such as immunizations.
- Educate members on personal safety such as wearing seatbelts and avoiding falls, and on lifestyle choices including diet, exercise, smoking and appropriate alcohol intake.
- Talk with members about appropriate ED use and other options including:
  - Asking for same-day appointments
  - Calling your office's after-hours line
  - Going to urgent care
  - Trying telehealth
  - Using their health plan's nurse line

Hospitalization for Potentially Preventable Complications (HPC)

New for 2023

- No applicable changes for this measure.

Definition

Rate of discharges for an ambulatory care sensitive condition (ACSC) per 1,000 for members ages 67 and older, taking into account the risk-adjusted ratio of observed to expected discharges for an ACSC by chronic and acute condition.

The rate is adjusted for factors such as a member's age, gender or comorbid condition(s).

Plan(s) Affected	Quality Program(s) Affected	Collection and Reporting Method
• Medicare	• CMS Star Ratings	**Administrative** • Claim/Encounter Data • Pharmacy Data

Required Exclusion(s)

Exclusion	Timeframe
• Members in hospice or using hospice services • Medicare members who are either: – Enrolled in an Institutional Special Needs Plan (I-SNP) – Living long term in an institution*	- Any time during the measurement year

*** Supplemental and medical record data may not be used for the frailty, frailty with advanced illness or institutional living exclusions.**

Hospitalization for Potentially Preventable Complications (HPC)

Important Notes

Acute inpatient hospitalizations and observation stays for an ACSC during the year count toward the measure. The primary diagnosis on the inpatient hospital claim is used to determine which hospitalizations are included.

NCQA defines ACSC as an acute or chronic health condition that can be managed or treated in an outpatient setting. There are 12 conditions that are considered as part of this measure – 4 acute and 8 chronic.

The 4 health conditions considered acute ACSC include:	The 8 health conditions meeting chronic ACSC criteria are:
• Bacterial pneumonia	• Diabetes short-term complications
• Cellulitis	• Diabetes long-term complications
• Pressure ulcers	• Uncontrolled diabetes
• Urinary tract infections	• Lower-extremity amputation among patients with diabetes
	• Chronic obstructive pulmonary disease (COPD)
	• Asthma
	• Hypertension
	• Heart failure

The classification period is the year prior to the measurement year.

Hospitalization for Potentially Preventable Complications (HPC)

Tips and Best Practices to Help Close This Care Opportunity

- **Please check your Patient Care Opportunity Report (PCOR) often to see members with open care opportunities.** If you have questions, your UnitedHealthcare representative can help.
- Some members may be at increased risk for complications from an ACSC. In these cases, it's important to make sure they're adhering to your treatment plan including following up on any referrals.
- Issues can arise despite your best interventions. If this happens, consider these suggestions:
  - **Urgent care –** If you can't immediately see a member and it's medically appropriate, direct them to a nearby in-network urgent care center. This can help prevent the member's health condition from getting worse and avoid a costly emergency department (ED) visit. Follow up with them as soon as possible and adjust their treatment plan as needed.
  - **Transitional care management (TCM) –** If recently discharged from a hospital or skilled nursing facility, provide the member with transitional care management (TCM) outreach and services. TCM, which includes medication reconciliation, can help prevent unnecessary inpatient readmissions.
- **Schedule follow-up appointments with members to manage and track their health status. At each visit, provide an opportunity for them to ask questions.**
- Create early intervention processes to help prevent complications and address exacerbations of ACSCs including diabetes, COPD, asthma and congestive heart failure.
- Make sure hospitalists you partner with are familiar with this measure.

Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions (FMC)

New for 2023

Added

- Domiciliary or rest home visits now count toward measure compliance

Updated

- Members who died during the measurement year is now a required exclusion

Definition

Percentage of emergency department (ED) visits for members ages 18 and older who have multiple high-risk chronic conditions who had a follow-up service within 7 days of the ED visit.

Plan(s) Affected	Quality Program(s) Affected	Collection and Reporting Method
• Medicare	• CMS Star Ratings	**Administrative** • Claim/Encounter Data

Codes

The following codes can be used to close HEDIS® numerator gaps in care; they are not intended to be a directive of your billing practice.

Scenario 1: Outpatient Visits	
CPT®/CPT II	99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99429, 99455, 99456, 99483
HCPCS	G0402, G0438, G0439, G0463, T1015
SNOMED	30346009, 37894004, 77406008, 84251009, 185463005, 185464004, 185465003, 281036007, 439740005, 3391000175108, 444971000124105
UBREV	0510, 0511, 0512, 0513, 0514, 0515, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0526, 0527, 0528, 0529, 0982, 0983

Scenario 2: Telephone Visits	
CPT®/CPT II	98966, 98967, 98968, 99441, 99442, 99443
SNOMED	185317003, 314849005, 386472008, 386473003, 401267002

Scenario 3: Transitional Care Management	
CPT®/CPT II	99495, 99496

(Codes continued)

Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions (FMC)

Codes

The following codes can be used to close HEDIS® numerator gaps in care; they are not intended to be a directive of your billing practice.

Scenario 4: Case Management Visits	
CPT®/CPT II	99366
HCPCS	T1016, T1017, T2022, T2023
SNOMED	386230005, 416341003, 425604002

Scenario 5: Complex Care Management	
CPT®/CPT II	99439, 99487, 99489, 99490, 99491
HCPCS	G0506

Scenario 6: Outpatient or Telehealth Behavioral Health Visit	
CPT®/CPT II	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99251, 99252, 99253, 99254, 99255

AND
Place of Service Code

Code	Location	Code	Location
03	School	**17**	Walk-in retail health clinic
05	Indian Health Service free-standing facility	**18**	Place of employment – worksite
07	Tribal 638 free-standing facility	**19**	Off-campus outpatient hospital
09	Prison/Correctional facility	**20**	Urgent care facility
11	Office	**22**	On-campus outpatient hospital
12	Home	**33**	Custodial care facility
13	Assisted living facility	**49**	Independent clinic
14	Group home	**50**	Federally qualified health center
15	Mobile unit	**71**	Public health clinic
16	Temporary lodging	**72**	Rural health clinic

(Codes continued)

Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions (FMC)

Codes (continued)

The following codes can be used to close HEDIS® numerator gaps in care; they are not intended to be a directive of your billing practice.

Scenario 7: Outpatient or Telehealth Behavioral Health Visit	
CPT®/CPT II	98960, 98961, 98962, 99078, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99483, 99492, 99493, 99494, 99510
HCPCS	G0155, G0176, G0177, G0409, G0463, G0512, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, T1015
SNOMED	77406008, 84251009, 185463005, 185464004, 185465003, 281036007, 391223001, 391224007, 391225008, 391233009, 391237005, 391239008, 391242002, 391257009, 391260002, 391261003, 439740005, 3391000175108, 444971000124105
UBREV	0510, 0513, 0515, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0526, 0527, 0528, 0529, 0900, 0902, 0903, 0904, 0911, 0914, 0915, 0916, 0917, 0919, 0982, 0983

(Codes continued)

Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions (FMC)

Codes (continued)

The following codes can be used to close HEDIS® numerator gaps in care; they are not intended to be a directive of your billing practice.

Scenario 8: Intensive Outpatient Encounter or Partial Hospitalization	
CPT®/CPT II	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99251, 99252, 99253, 99254, 99255

AND

Place of Service Code

Code	Location
52	Psychiatric facility – partial hospitalization

Scenario 9: Intensive Outpatient Encounter or Partial Hospitalization	
HCPCS	G0410, G0411, H0035, H2001, H2012, S0201, S9480, S9484, S9485
SNOMED	7133001, 305345009, 305346005, 305347001, 391038005, 391042008, 391043003, 391046006, 391047002, 391048007, 391054008, 391055009, 391056005, 391133003, 391150001, 391151002, 391152009, 391153004, 391170007, 391185001, 391186000, 391187009, 391188004, 391191004, 391192006, 391194007, 391195008, 391207001, 391208006, 391209003, 391210008, 391211007, 391228005, 391229002, 391232004, 391252003, 391254002, 391255001, 391256000
UBREV	0905, 0907, 0912, 0913

Scenario 10: Community Mental Health Center Visit	
CPT®/CPT II	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99251, 99252, 99253, 99254, 99255

AND

Place of Service Code

Code	Location
53	Community mental health center

Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions (FMC)

Codes

The following codes can be used to close HEDIS® numerator gaps in care; they are not intended to be a directive of your billing practice.

Scenario 11: Electroconvulsive Therapy With Any Provider Type and With Appropriate Place of Service Code

Electroconvulsive Therapy	
CPT®/CPT II	90870
ICD-10 Procedure	GZB0ZZZ, GZB1ZZZ, GZB2ZZZ, GZB3ZZZ, GZB4ZZZ
SNOMED	10470002, 11075005, 23835007, 231079005, 231080008, 284468008, 313019002, 313020008, 1010696002, 1010697006

AND

Place of Service Code

Code	Location	Code	Location
03	School	**19**	Off-campus outpatient hospital
05	Indian Health Service free-standing facility	**20**	Urgent care facility
07	Tribal 638 free-standing facility	**22**	On-campus outpatient hospital
09	Prison/correctional facility	**24**	Ambulatory surgical center
11	Office	**33**	Custodial care facility
12	Home	**49**	Independent clinic
13	Assisted living facility	**50**	Federally qualified health center
14	Group home	**52**	Psychiatric facility – partial hospitalization
15	Mobile unit	**53**	Community mental health center
16	Temporary lodging	**71**	Public health clinic
17	Walk-in retail health clinic	**72**	Rural health clinic
18	Place of employment – worksite		

Scenario 12: Telehealth Visit With Any Provider Type and the Appropriate Place of Service Code

Visit Setting Unspecified	
CPT®/CPT II	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99251, 99252, 99253, 99254, 99255

AND

Place of Service Code

Code	Location
02	Telehealth
10	Telehealth

(Codes continued)

Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions (FMC)

Codes

The following codes can be used to close HEDIS® numerator gaps in care; they are not intended to be a directive of your billing practice.

Scenario 13: Observation Visit	
CPT®/CPT II	99217, 99218, 99219, 99220

Scenario 14: Substance Use Disorder Services	
CPT®/CPT II	99408, 99409
HCPCS	G0396, G0397, G0443, H0001, H0005, H0007, H0015, H0016, H0022, H0047, H0050, H2035, H2036, T1006, T1012
SNOMED	20093000, 23915005, 56876005, 61480009, 64297001, 67516001, 87106005, 182969009, 266707007, 310653000, 370776007, 370854007, 385989002, 386449006, 386450006, 386451005, 414054004, 414056002, 414283008, 414501008, 415662004, 424589009, 445628007, 445662007, 450760003, 704182008, 707166002, 711008001, 713106006, 713107002, 713127001, 720174008, 720175009, 720176005, 720177001, 763104007, 763233002, 763302001, 772813001, 774090004, 774091000, 792901003, 792902005, 827094004, 865964007, 428211000124100
UBREV	0906, 0944, 0945

Scenario 16: Domiciliary or rest home visit	
CPT®/CPT II	99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337

Required Exclusion(s)

Exclusion	Timeframe
• Members in or using hospice services • Members who died	- Any time during the measurement year

Tips and Best Practices to Help Close This Care Opportunity

This measure focuses on follow up after an ED visit:

- See patients within 7 days
- If a situation arises where a patient is unable to be seen within 7 days, then they need to have an appointment within 30 days of discharge.
- Please use Practice Assist, POCA or Reports to identify members with 2 or more eligible chronic conditions and history of ED visits; increase engagement with patients with multiple chronic conditions to avoid unnecessary ED visits.
- Provide patients with alternative options to ED locations including urgent care, telehealth or in-person office visits.
- Remind patients to schedule an office visit or telehealth follow-up within 7 days post ED visit as a way to ensure all patients are engaged.
- Encourage the use of telehealth appointments when appropriate.
- If you need to refer your patient to a behavioral health specialist or need to request coordination of care, please call the number on the back of the patient's health plan ID card or search liveandworkwell.com.

(Codes continued)

Initiation and Engagement of Substance Use Disorder Treatment (IET)

The following codes can be used to close HEDIS® numerator gaps in care; they are not intended to be a directive of your billing practice.

New for 2023

Updated

- Members who died during the measurement year is now a required exclusion
- "Detoxification" has been replaced with "withdrawal management"
- Rates will now include stratification by race and ethnicity

Definition

Percentage of new episodes of substance use disorder (SUD) that result in one or both of the following:

- **Initiation of SUD Treatment –** Percentage of new SUD episodes that result in treatment through an inpatient SUD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth or medication treatment within 14 days of diagnosis
- **Engagement of SUD Treatment –** Percentage of new SUD episodes that result in treatment within 34 days of initiation visit

Plan(s) Affected	Quality Program(s) Affected	Collection and Reporting Method
• Commercial • Exchange/Marketplace • Medicaid • Medicare	• CMS Quality Rating System • NCQA Accreditation • NCQA Health Plan Ratings – IET Engagement Only	**Administrative** • Claim/Encounter Data

Codes

The following codes can be used to close HEDIS® numerator gaps in care; they are not intended to be a directive of your billing practice.

All of the following scenarios must include a diagnosis of 1 of the below on the claim:

- Alcohol use disorder
- Opioid use disorder
- Other drug abuse and dependence

Acute or Nonacute Inpatient Visit

For numerator compliance for engagement of treatment, at least two of the following scenarios must have been met on the day after the initiation encounter through 34 days after. Two engagement visits can be on the same date, but must be with different providers.

Scenario 1 : Inpatient Stay	
UBREV	0100, 0101, 0110, 0111, 0112, 0113, 0114, 0116, 0117, 0118, 0119, 0120, 0121, 0122, 0123, 0124, 0126, 0127, 0128, 0129, 0130, 0131, 0132, 0133, 0134, 0136, 0137, 0138, 0139, 0140, 0141, 0142, 0143, 0144, 0146, 0147, 0148, 0149, 0150, 0151, 0152, 0153, 0154, 0156, 0157, 0158, 0159, 0160, 0164, 0167, 0169, 0170, 0171, 0172, 0173, 0174, 0179, 0190, 0191, 0192, 0193, 0194, 0199, 0200, 0201, 0202, 0203, 0204, 0206, 0207, 0208, 0209, 0210, 0211, 0212, 0213, 0214, 0219, 1000, 1001, 1002

(Codes continued)

Initiation and Engagement of Substance Use Disorder Treatment (IET)

Codes

The following codes can be used to close HEDIS® numerator gaps in care; they are not intended to be a directive of your billing practice.

Scenario 2: Outpatient Visits with Outpatient Place of Service Code(s)	
CPT®/CPT II	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99251, 99252, 99253, 99254, 99255

AND

Place of Service Code

Code	Location		
03	School	**17**	Walk-in retail health clinic
05	Indian Health Service free-standing facility	**18**	Place of employment – worksite
07	Tribal 638 free-standing facility	**19**	Off-campus outpatient hospital
09	Prison/Correctional facility	**20**	Urgent care facility
11	Office	**22**	On-campus outpatient hospital
12	Home	**33**	Custodial care facility
13	Assisted living facility	**49**	Independent clinic
14	Group home	**50**	Federally qualified health center
15	Mobile unit	**71**	Public health clinic
16	Temporary lodging	**72**	Rural health clinic

(Codes continued)

Initiation and Engagement of Substance Use Disorder Treatment (IET)

Codes

The following codes can be used to close HEDIS® numerator gaps in care; they are not intended to be a directive of your billing practice.

Scenario 3: Behavioral Health Outpatient Visit	
CPT®/CPT II	98960, 98961, 98962, 99078, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99483, 99492, 99493, 99494, 99510
HCPCS	G0155, G0176, G0177, G0409, G0463, G0512, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, T1015
SNOMED	77406008, 84251009, 185463005, 185464004, 185465003, 281036007, 391223001, 391224007, 391225008, 391233009, 391237005, 391239008, 391242002, 391257009, 391260002, 391261003, 439740005, 3391000175108, 444971000124105
UBREV	0510, 0513, 0515, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0526, 0527, 0528, 0529, 0900, 0902, 0903, 0904, 0911, 0914, 0915, 0916, 0917, 0919, 0982, 0983

Scenario 4: Intensive Outpatient Encounter or Partial Hospitalization With Partial Hospitalization Place of Service Code	
CPT®/CPT II	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99251, 99252, 99253, 99254, 99255

AND

Place of Service Code

Code	Location
52	Psychiatric facility – partial hospitalization

Scenario 5: Intensive Outpatient Encounter or Partial Hospitalization	
HCPCS	G0410, G0411, H0035, H2001, H2012, S0201, S9480, S9484, S9485
SNOMED	7133001, 305345009, 305346005, 305347001, 391038005, 391042008, 391043003, 391046006, 391047002, 391048007, 391054008, 391055009, 391056005, 391133003, 391150001, 391151002, 391152009, 391153004, 391170007, 391185001, 391186000, 391187009, 391188004, 391191004, 391192006, 391194007, 391195008, 391207001, 391208006, 391209003, 391210008, 391211007, 391228005, 391229002, 391232004, 391252003, 391254002, 391255001, 391256000
UBREV	0905, 0907, 0912, 0913

(Codes continued)

Initiation and Engagement of Substance Use Disorder Treatment (IET)

Codes

Scenario 6: Non-Residential Substance Abuse Treatment Facility With Non-Residential Substance Abuse Treatment Facility Place of Service Code	
CPT®/CPT II	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99251, 99252, 99253, 99254, 99255

AND

Place of Service Code

Code	Location
57	Non-residential substance abuse treatment facility
58	Non-residential opioid treatment facility

Scenario 7: Community Mental Health Center Visit with Community Mental Health Place of Service Code	
CPT®/CPT II	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99251, 99252, 99253, 99254, 99255

AND

Place of Service Code

Code	Location
53	Community mental health center

Scenario 8: Telehealth Visit with Telehealth Place of Service Code	
CPT®/CPT II	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99251, 99252, 99253, 99254, 99255

AND

Place of Service Code

Code	Location
02	Telehealth
10	Telehealth

Scenario 9: Observation Visit	
CPT®/CPT II	99217, 99218, 99219, 99220

(Codes continued)

Initiation and Engagement of Substance Use Disorder Treatment (IET)

Codes

The following codes can be used to close HEDIS® numerator gaps in care; they are not intended to be a directive of your billing practice.

Scenario 10: Substance Use Disorder Services	
CPT®/CPT II	99408, 99409
HCPCS	G0396, G0397, G0443, H0001, H0005, H0007, H0015, H0016, H0022, H0047, H0050, H2035, H2036, T1006, T1012
SNOMED	20093000, 23915005, 56876005, 61480009, 64297001, 67516001, 87106005, 182969009, 266707007, 310653000, 370776007, 370854007, 385989002, 386449006, 386450006, 386451005, 414054004, 414056002, 414283008, 414501008, 415662004, 424589009, 445628007, 445662007, 450760003, 704182008, 707166002, 711008001, 713106006, 713107002, 713127001, 720174008, 720175009, 720176005, 720177001, 763104007, 763233002, 763302001, 772813001, 774090004, 774091000, 792901003, 792902005, 827094004, 865964007, 428211000124100
UBREV	0906, 0944, 0945

Scenario 11: E-Visit or Virtual Check-In	
CPT®/CPT II	98969, 98970, 98971, 98972, 99421, 99422, 99423, 99444, 99457
HCPCS	G0071, G2010, G2012, G2061, G2062, G2063, G2250, G2251, G2252

Scenario 12: Telephone Visit	
CPT®/CPT II	98966, 98967, 98968, 99441, 99442, 99443
SNOMED	185317003, 314849005, 386472008, 386473003, 401267002

Scenario 13: Online Assessment (e-visit/virtual check-in)	
CPT®/CPT II	98969, 98970, 98971, 98972, 99421, 99422, 99423, 99444, 99457, 99458
HCPCS	G0071, G2010, G2012, G2061, G2062, G2063, G2250, G2251, G2252

Scenario 14: Opioid Treatment Service

OUD Weekly Billing Non-Drug Treatment	
HCPCS	G2071, G2074, G2075, G2076, G2077, G2080

(Codes continued)

Initiation and Engagement of Substance Use Disorder Treatment (IET)

Codes

The following codes can be used to close HEDIS® numerator gaps in care; they are not intended to be a directive of your billing practice.

OUD Weekly Billing Drug Treatment	
HCPCS	G2067, G2068, G2069, G2070, G2072, G2073

OUD Monthly Office-Based Treatment	
HCPCS	G2086, G2087

Scenario 15: Medication Treatment for Alcohol Use Disorder	
HCPCS	J2315, G2073

One or more medication dispensing events for alcohol use disorder:

Drug Category	Medications
Aldehyde dehydrogenase inhibitor	• Disulfiram (oral)
Antagonist	• Naltrexone (oral and injectable)
Other	• Acamprosate (oral; delayed-release tablet)

Scenario 15: Medication Treatment for Opioid Use Disorder	
HCPCS	J2315, G2070, G2072, G2073, J0570, G2069, Q9991, Q9992, J0572, J0573, J0574, J0575, J0571, G2068, G2079, H0020, H0033, S0109, G2067, G2078
SNOMED	310653000

One or more medication dispensing events for opioid use disorder:

Drug Category	Medications
Antagonist	• Naltrexone (oral and injectable)
Partial agonist	• Buprenorphine (sublingual tablet, injection or implant) • Buprenorphine/naloxone (sublingual tablet, buccal film, sublingual film)

Initiation and Engagement of Substance Use Disorder Treatment (IET)

Required Exclusion(s)

Exclusion	Timeframe
• Members in hospice or using hospice services • Members who died	- Any time during the measurement year

Important Notes

	Test, Service or Procedure to Close Care Opportunity
Episode date is the earliest date of service for an observation, intensive outpatient, partial hospitalization, outpatient, telehealth, detoxification or ED visit not resulting in an inpatient stay with a substance use disorder diagnosis between Nov. 15 of the year prior to the measurement year through Nov. 14 of the measurement year.	
• Initiation of SUD Treatment must take place within 14 days of the episode date. • Claims must include the visit code, original episode diagnosis and, when applicable, a place of service code. • If the episode was an inpatient discharge or an ED visit resulting in an inpatient stay, the inpatient stay is considered initiation of treatment and the member is compliant.	Initiation of SUD Treatment through: • Acute or non-acute inpatient stay • Group visits with an appropriate place of service code and diagnosis code • Medication dispensing event • Medication treatment • Online assessment with diagnosis code • Stand-alone visits with an appropriate place of service code and diagnosis code • Telephone visit with diagnosis code
• Engagement of SUD treatment is compliance with the initiation treatment AND one of the following between the day after and 34 days after the initiation visit: - At least 2 inpatient, outpatient or medication treatment visits (excluding methadone billed on a pharmacy claim) - A long-acting SUD medication administration event (MAT) • Claims must include the visit code, original episode diagnosis and, when applicable, a place of service code. • For members who initiated treatment through an inpatient admission, the 34-day period for the two engagement visits begins the day after their discharge.	Engagement of SUD Treatment when a member meets the criteria for initiation of treatment and proceeds with two or more of the following: • Acute or non-acute inpatient stay • Group visits with an appropriate place of service code and diagnosis code • Medication dispensing event • Medication treatment • Online assessment with diagnosis code • Stand-alone visits with an appropriate place of service code and diagnosis code • Telephone visit with diagnosis code

Initiation and Engagement of Substance Use Disorder Treatment (IET)

Tips and Best Practices to Help Close This Care Opportunity

This measure focuses on follow-up treatment when diagnosing a patient with substance use disorder.

- Use screening tools to aid in diagnosing.
- Screening tools (e.g., SBIRT, AUDIT-PC, Audit C Plus 2, CAGE-AID CUDIT-R) assist in the assessment of substance use and can aid the discussion around referral for treatment. Code “Unspecified use” diagnoses sparingly. Screening tools available at **providerexpress.com** > Clinical Resources > Behavioral Health Toolkit for Medical Providers.
- Schedule a follow-up appointment prior to patient leaving the office with you or a substance use specialist to occur within 14 days and then 2 more visits with you or a substance use treatment provider within the next 34 days.
- When a patient is in remission, please remember to remove the original diagnosis and use remission codes:
  - Mild (abuse) F10.11
  - Moderate/severe (dependence) F10.21
- If patient has started MAT then they only need one MAT follow-up visit in 34 days
- Sharing member demographic data is critical to understanding the cultural, linguistic and social needs of those we serve and decreasing health inequities across the care continuum. This data can include, but is not limited to, race, ethnicity, language, sexual orientation, gender identity, pronouns, sex assigned at birth and disability status. As part of UnitedHealthcare's clinical structured data exchange program, we encourage you to include this demographic data with any structured data file or CCD. Your information is confidential. UnitedHealthcare will keep personally identifiable information confidential and won't disclose any information without your written consent.
- Encourage the use of telehealth appointments when appropriate
- Encourage newly diagnosed individuals to include their family in their treatment
- Although community supports, such as AA and NA, are beneficial, they do not take the place of professional treatment.
- Encourage newly diagnosed individuals to accept treatment by assisting them in identifying their own reasons for change.
- If you need to refer your patient to a substance use specialist or need to request coordination of care, please call the number on the back of the patient’s health plan ID card or search **liveandworkwell.com.**

Plan All-Cause Readmissions (PCR)

New for 2023

- No applicable changes for this measure.

Definition

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

A lower rate indicates a better score for this measure.

For Medicaid and commercial members – The included age range is 18–64 only.

Plan(s) Affected	Quality Program(s) Affected	Collection and Reporting Method
• Commercial • Exchange/Marketplace • Medicaid • Medicare	• CMS Star Ratings • CMS Quality Rating System • NCQA Accreditation • NCQA Health Plan Ratings	**Administrative** • Claim/Encounter Data

Required Exclusion(s)

Exclusion	Timeframe
• Members in hospice or using hospice services	- Any time during the measurement year
• Member died during the inpatient stay • Female with a principal diagnosis of pregnancy on the discharge claim • Principal diagnosis of a condition originating in the perinatal period on the discharge claim • Acute hospitalizations where the discharge claims has a diagnosis for: – Chemotherapy maintenance – Principle diagnosis of rehabilitation – Organ transplant – Potentially planned procedure without a principal acute diagnosis	Jan. 1 – Dec. 1 of the measurement year

Plan All-Cause Readmissions (PCR)

Tips and Best Practices to Help Close This Care Opportunity

- **Please check your Patient Care Opportunity Report (PCOR) often to see members with open care opportunities.** If you have questions, your UnitedHealthcare representative can help.
- The denominator for this measure is based on discharges and not members specifically.
- An acute discharge can be from any type of facility, including behavioral health facilities.
- Discharges are excluded if a direct transfer takes place after Dec. 1 of the measurement year.
- Starting Jan. 1, 2022, UnitedHealthcare's Healthy at Home Program for Medicare Advantage Group Retiree members can help meet member needs post-discharge and preventing readmissions. Healthy at Home focuses on post-discharge meals, transportation, personal care and more. Contact your UnitedHealthcare representative for more information.
- Please help members avoid readmission by:
  - Following up with them within 1 week of their discharge
  - Making sure they filled their new prescriptions post-discharge
  - Implementing a robust, safe discharge plan that includes a post-discharge phone call to discuss these questions:
    - Do you completely understand all the instructions you were given at discharge?
    - Do you completely understand the medications and your medication instructions? Have you filled all your prescriptions?
    - Have you made your follow-up appointments? Do you need help scheduling them?
    - Do you have transportation to the appointment and/or do you need help arranging transportation?
    - Do you have any questions?
- A lower readmission rate and comprehensive diagnosis documentation will drive better scores for this measure.
- Patients with multiple comorbidities are expected to return post inpatient or observation discharge at a higher rate. Ensure all suspect conditions are appropriately identified in the patient's medical record and claims.
- Encourage members to engage in palliative care or hospice programs as appropriate to drive lower readmissions for high risk patients to reduce hospitalizations.

Transitions of Care TRCRA – Inpatient Admission Notification

New for 2023

Updated

- Members who died during the measurement year is now a required exclusion

Definition

For members ages 18 and older, percentage of acute or non-acute inpatient discharges on or between January 1-December 1 of the measurement year with a notification of inpatient admission documented the day of or 2 days after the admission (3 days total).

Plan(s) Affected	Quality Program(s) Affected	Collection and Reporting Method
• Medicare	• CMS Star Ratings	**Hybrid** • This sub-measure is 100% hybrid. No administrative data is available.

Required Exclusion(s)

Exclusion	Timeframe
Members in hospice or using hospice services Members who died	Any time during the measurement year

Transitions of Care TRCRA – Inpatient Admission Notification

Important Notes

	Test, Service or Procedure to Close Care Opportunity	Medical Record Detail Including, But Not Limited To
Admission is defined as the date of the inpatient admission or the date of admission when an observation stay turns into an inpatient admission. Administrative data doesn't count toward the numerator for inpatient admission notification. Documentation that a care provider sent a member to the ED visit(s) that resulted in an inpatient admission does not meet compliance for the numerator. Documentation in the outpatient medical record must include evidence of receipt of notification of inpatient admission on the day of admission through 2 days after the admission (3 total days).	Medical record documentation must be about the admission and can include record of a discussion or information transfer between the following: • Inpatient staff/care provider and the member's PCP or ongoing care provider • Emergency department (ED) facility and the member's PCP or ongoing care provider • Health information exchange (HIE), automated admission/discharge transfer (ADT) alert system or shared electronic medical record (EMR) system and the member's PCP or ongoing care provider • A shared electronic medical record system and the member's PCP or ongoing care provider • The member's health plan and their • PCP or ongoing care provider • Evidence the PCP or ongoing care provider communicated with the ED about the admission meets criteria **OR** Medical record documentation that: • The member's PCP or ongoing care provider admitted the member to the hospital. • A specialist admitted the member to the hospital and notified the member's PCP or ongoing care provider. • The member's PCP or ongoing care provider ordered tests or treatments during the member's inpatient stay. • The PCP or ongoing care provider performed a preadmission exam or received communication about a planned inpatient admission.	• Health history and physical • Home health records • Progress notes • Skilled nursing facility minimum data set (MDS) form • SOAP notes

Transitions of Care TRCMRP – Medication Reconciliation Post-Discharge

New for 2023

Updated

- Members who died during the measurement year is now a required exclusion

Definition

For members ages 18 and older, percentage with an acute or non-acute inpatient discharge on or between January 1-December1 of the measurement year with medication reconciliation documented on the date of the discharge through 30 days after the discharge (31 days total).

Plan(s) Affected	Quality Program(s) Affected	Collection and Reporting Method
• Medicare	• CMS Star Ratings	**Hybrid** • Claim/Encounter Data

Codes

The following codes can be used to close HEDIS® numerator gaps in care; they are not intended to be a directive of your billing practice.

Medication Reconciliation	
CPT®/CPT II	1111F, 99483, 99495, 99496
SNOMED	430193006, 428701000124107

Transitions of Care TRCMRP – Medication Reconciliation Post-Discharge

Important Notes

	Test, Service or Procedure to Close Care Opportunity	Medical Record Detail Including, But Not Limited To
• The Medication Reconciliation Post-Discharge numerator assesses whether medication reconciliation occurred. It does not attempt to assess the quality of the medication list documented in the medical record or the process used to document the most recent medication list in the medical record. • Medication reconciliation can be conducted by a prescribing practitioner, clinical pharmacist, physician assistant or registered nurse. • A medication reconciliation performed without the member present meets compliance. • Medication reconciliation must be completed on the date of discharge or 30 days afterward. • Medication reconciliation can be documented if there is evidence that: – A member was seen for a post-discharge follow-up. – Medication review or reconciliation was completed at the appointment. • A medication list must be present in the outpatient record to fully comply with the measure. • Documentation of post-op/surgery follow-up without a reference to hospitalization, admission or inpatient stay does not imply a hospitalization and is not considered evidence that the provider was aware of a hospitalization.	• Discharge medications and outpatient medications reconciled and documented in the outpatient medical record • Current medications and medication list reviewed and documentation of any of the following: – Documentation in the discharge summary that states current and discharge medications were reconciled and filed in the outpatient medical record – Notation of current medications that also references discharge medications – Notation of current medications and that discharge medications were reconciled – Review of discharge medication list and current medication list on the same date of service – Notation if no medications were prescribed at discharge – Evidence the member was seen for a hospital post-discharge follow-up visit with evidence of medication reconciliation or review – Documentation and evidence the member was seen for post-discharge hospital follow-up indicating the provider was aware of the hospitalization or discharge	• Health history and physical • Home health records • Medication list • Progress notes • Skilled nursing facility minimum data set (MDS) form • SOAP notes

(Important Notes continued)

Transitions of Care TRCMRP–Medication Reconciliation Post-Discharge

Important Notes

	Test, Service or Procedure to Close Care Opportunity	Medical Record Detail Including, But Not Limited To
• Mediation reconciliation does not require the member to be present. • If the member is unable to communicate with provider, interaction between the member's caregiver and the provider meets numerator criteria. • The numerator assesses if medication reconciliation post discharge occurred. It does not attempt to assess of the quality of the medication list in the medical record or process used to document the most recent medication list in the medical record.		

Transitions of Care TRCPE – Patient Engagement After Inpatient Discharge

New for 2023

Updated

- Members who died during the measurement year is now a required exclusion

Definition

For members ages 18 and older, percentage of acute or non-acute inpatient discharges on or between January 1-December 1 of the measurement year with engagement documented within 30 days of the discharge. Do not include patient engagement that happens on the day of discharge.

Patient engagement can include any of the following:

- Outpatient visit (office or home)
- Telephone visit
- E-visit or virtual check-in between member and provider
- Telehealth visit
- Transitional care management

Plan(s) Affected	Quality Program(s) Affected	Collection and Reporting Method
• Medicare	• CMS Star Ratings	**Hybrid** • Claim/Encounter Data

Codes

The following codes can be used to close HEDIS® numerator gaps in care; they are not intended to be a directive of your billing practice.

Outpatient Visits	
CPT®/CPT II	99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99429, 99455, 99456, 99483
HCPCS	G0402, G0438, G0439, G0463, T1015
SNOMED	30346009, 37894004, 77406008, 84251009, 185463005, 185464004, 185465003, 281036007, 439740005, 3391000175108, 444971000124105
UBREV	0510, 0511, 0512, 0513, 0514, 0515, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0526, 0527, 0528, 0529, 0982, 0983

Telephone Visits	
CPT®/CPT II	98966, 98967, 98968, 99441, 99442, 99443
SNOMED	185317003, 314849005, 386472008, 386473003, 401267002

Transitions of Care TRCPE – Patient Engagement After Inpatient Discharge

Codes

The following codes can be used to close HEDIS® numerator gaps in care; they are not intended to be a directive of your billing practice.

Online Assessment (e-visit/virtual check-in)	
CPT®/CPT II	98969, 98970, 98971, 98972, 99421, 99422, 99423, 99444, 99457, 99458
HCPCS	G0071, G2010, G2012, G2061, G2062, G2063, G2250, G2251, G2252

Transitional Care Management	
CPT®/CPT II	99495, 99496

Transitions of Care TRCPE – Patient Engagement After Inpatient Discharge

Required Exclusion(s)

Exclusion	Timeframe
• Members in hospice or using hospice services • Members who died	- Any time during the measurement year

Important Notes

	Test, Service or Procedure to Close Care Opportunity	Medical Record Detail Including, But Not Limited To
• Member engagement must be completed within 30 days of the discharge. • Member engagement on the day of the discharge will **not** be compliant. • If the member is unable to communicate with the provider, interaction between the member's caregiver and the provider meets criteria.	Member engagement can include a: • Outpatient visit (e.g., in-home visit, office visit) • Telehealth visit – Must include real-time interaction with the care provider • E-visit or virtual check-in • Transitional care management	• Health history and physical • Home health records • Progress notes • Skilled nursing facility minimum data set (MDS) form • SOAP notes

Transitions of Care TRCRD – Receipt of Discharge Information

New for 2023

Updated

- Members who died during the measurement year is now a required exclusion

Definition

For members ages 18 and older, percentage of acute or non-acute inpatient discharges on or between Jan.1 – Dec. 1 of the measurement year with a receipt of discharge information documented the day of or 2 days after the discharge (3 days total).

Plan(s) Affected	Quality Program(s) Affected	Collection and Reporting Method
• Medicare	• CMS Star Ratings	**Hybrid** • This sub-measure is 100% hybrid. No administrative data is available.

Important Notes

	Test, Service or Procedure to Close Care Opportunity	Medical Record Detail Including, But Not Limited To
Administrative data doesn't count toward the numerator for discharge notification. In a shared electronic medical record system, a received date is not necessary to meet compliance for this numerator. As long as the PCP or ongoing provider has access to the discharge information on the day of discharge or 2 days after discharge meets the intent of the measure. Discharge information may be included in, but not limited to, a discharge summary or summary of care record or be located in structured fields in an EHR.	Discharge information must include all of the following in the outpatient medical record: • The name of the care provider responsible for the member's care during the inpatient stay • Services or treatments provided during the inpatient stay • Diagnoses at discharge • Test results or documentation that either test results are pending or no test results are pending • Directions on future patient care to the PCP or ongoing care provider • Current medication list	• Discharge care plan • Discharge summary • Health history and physical • Home health records • Progress notes • Skilled nursing facility minimum data set (MDS) form • SOAP notes

Tips and Best Practices to Help Close This Care Opportunity

- Transitions of care help to decrease readmissions and medication errors. It also helps with affordability and to improve communications between members and their providers.
- Transitions of care help to better coordinate care, decreasing issues before they occur and leading to better member health outcomes.

Use of Imaging Studies for Low Back Pain (LBP)

New for 2023

Added

- A direct reference code, Z51.5, for an encounter for palliative care
- Frailty exclusion now requires 2 different dates of service during the measurement year

Updated

- Members who died during the measurement year is now a required exclusion

Definition

Percentage of members ages 18–75 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.

This measure is reported as an inverted measure and a higher score indicates appropriate treatment of low back pain, where imaging studies did not occur.

Plan(s) Affected	Quality Program(s) Affected	Collection and Reporting Method
• Commercial • Medicaid • Medicare	• CMS Quality Rating System • NCQA Accreditation • NCQA Health Plan Ratings	**Administrative** • Claim/Encounter Data

Codes

The following codes can be used to close HEDIS® numerator gaps in care; they are not intended to be a directive of your billing practice.

The following codes are imaging studies that should be avoided with a diagnosis of uncomplicated **low back pain.**

Imaging Studies	
CPT®/CPT II	72020, 72052, 72100, 72110, 72114, 72120, 72131, 72132, 72133, 72141, 72142, 72146, 72147, 72148, 72149, 72156, 72158, 72200, 72202, 72220
SNOMED	2847006, 6238009, 6728003, 7812007, 21613005, 22791004, 24856003, 26537001, 35443000, 41333006,45554006, 46700000, 47987001, 48816001, 57235004, 60443006, 61368000, 66769009, 68862002, 72508000, 79760008, 86392000, 90523008, 90805008, 91333005, 91583001, 168573004, 168588009, 241092006, 241093001, 241094007, 241580002, 241592002, 241596004, 241646009, 241647000, 241648005, 276478001, 303935004, 419942003, 429860003, 429868005, 429871002, 430021001, 430507007, 431250008, 431496002, 431557005, 431613003, 431871005, 431892005, 432078003, 432244001, 432770001, 433140006, 433141005, 440450002, 443580006, 444634007, 448641007, 700319007, 700320001, 700321002, 702487007, 702488002, 702513003, 702514009, 702515005, 702516006, 702521009, 702522002, 702523007, 702607002, 702608007, 709652000, 709653005, 709698004, 711104001, 711184004, 711186002, 711224009, 711271003, 712970008, 713016000, 715290001, 715458009, 716830000, 717912001, 718542005, 718545007, 723646000, 726546000, 772220000, 783627007, 840361000, 868279006, 3721000087104, 3731000087102, 14871000087107, 17141000087101, 39445000119106, 396171000119100, 411571000119106, 411611000119102, 413001000119107, 495741000119105, 571891000119109, 572091000119106, 16328021000119109, 16384831000119100, 16554061000119109

Use of Imaging Studies for Low Back Pain (LBP)

Required Exclusion(s)

Exclusion	Timeframe
• Members in hospice or using hospice services • Members receiving palliative care • Members who died	- Any time during the measurement year
Members ages 66 and older as of December 31 of the measurement year who had at least 2 diagnoses of frailty on different dates of service and advanced illness.* Advanced illness is indicated by one of the following: • Two or more outpatient, observation, emergency room, telephone, e- visits, virtual check-ins or non-acute inpatient encounters or discharge(s) on separate dates of service with a diagnosis of advanced illness • One or more acute inpatient encounter(s) with a diagnosis of advanced illness • One or more acute inpatient discharge(s) with a diagnosis of advanced illness on the discharge claim • Dispensed a dementia medication: Donepezil, Donepezil- memantine, galantamine, rivastigmine or memantine	Frailty diagnoses must be in the measurement year and on different dates of service Advanced illness diagnosis must be in the measurement year or year prior to the measurement year
Any member who had a diagnosis where imaging is clinically appropriate including:	
• Cancer • HIV • Major organ transplant • Osteoporosis or osteoporosis therapy • Lumbar surgery • Spondylopathy	Any time in a member's history through 28 days after the principal diagnosis of low back pain between Jan. 1 – Dec. 3 of the measurement year
• Recent trauma • Fragility fractures	Any time 90 days prior to or 28 days after the principal diagnosis of low back pain between Jan. 1 – Dec. 3 of the measurement year
Prolonged use of corticosteroids – 90 consecutive days of corticosteroid treatment	Dispensed any time 12 months prior to the principal diagnosis of low back pain between Jan. 1 – Dec. 3 of the measurement year
• Intravenous drug abuse • Neurologic impairment	Any time 12 months prior to or 28 days after the principal diagnosis of low back pain between Jan. 1 – Dec. 3 of the measurement year
Spinal infection	Any time 12 months prior to or 28 days after the principal diagnosis of low back pain between Jan. 1 – Dec. 3 of the measurement year

Use of Imaging Studies for Low Back Pain (LBP)

Important Notes

	Test, Service or Procedure to Avoid	Test, Service or Procedure to Close Care Opportunity
The imaging studies listed in the column at right are not clinically appropriate for a diagnosis of **uncomplicated low back pain.**	• CT scan • MRI • Plain X-ray	
The principal diagnosis of **uncomplicated low back pain** can come from any of the services listed in the column at right for a member to be included in this measure.		• E-visit or virtual check-in • Osteopathic or chiropractic manipulative treatment • Outpatient visit • Physical therapy visit • Telephone visit

Tips and Best Practices to Help Close This Care Opportunity

- **Please check your Patient Care Opportunity Report (PCOR) often to see members with open care opportunities.** If you have questions, your UnitedHealthcare representative can help

Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)

New for 2023

Added

- Frailty exclusion now requires 2 different dates of service during the measurement year

Updated

- Members who died during the measurement year is now a required exclusion

Definition

Percentage of members ages 18 and older during the measurement year with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80% of the treatment period.

Plan(s) Affected	Quality Program(s) Affected	Collection and Reporting Method
• Commercial • Medicaid • Medicare	• NCQA Accreditation • NCQA Health Plan Ratings	**Administrative** • Claim/Encounter Data • Pharmacy Data

Medications

To comply with this measure, a member must have remained on one of the following antipsychotic medications for at least 80% of the treatment period.

Oral Antipsychotic Medications

Drug Category	Medications	
Miscellaneous antipsychotic agents (oral)	• Aripiprazole • Asenapine • Brexpiprazole • Cariprazine • Clozapine • Haloperidol • Iloperidone • Loxapine	• Lumateperone • Lurisadone • Molindone • Olanzapine • Paliperidone • Quetiapine • Risperidone • Ziprasidone
Phenothiazine antipsychotics (oral)	• Chlorpromazine • Fluphenazine • Perphenazine	• Prochlorperazine • Thioridazine • Trifluoperazine
Psychotherapeutic combinations (oral)	• Amitriptyline-perphenazine	
Thioxanthenes (oral)	• Thiothixene	

(Medications continued)

Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)

Medications (continued)

Long-Acting Injections 28-Day Supply Medications

Drug Category	Medications
Long-acting injections 28-day supply	• Aripiprazole • Aripiprazole lauroxil • Fluphenazine decanoate • Haloperidol decanoate • Olanzapine • Paliperidone palmitate

Long-Acting Injections 14-Day Supply Medications

Drug Category	Medications
Long-acting injections 14-day supply	• Risperidone (excluding Perseris®)

Long-Acting Injections 30-Day Supply Medications

Drug Category	Medications
Long-acting injections 30-day supply	• Risperidone (Perseris®)

Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)

Required Exclusion(s)

Exclusion	Timeframe
• Members in hospice or using hospice services • Members who died • Diagnosis of dementia • Members ages 81 and older as of Dec. 31 of the measurement year who had at least 2 diagnoses of frailty* on different dates of service	Any time during the measurement year
Members ages 66–80 as of Dec. 31 of the measurement year who had at least 2 diagnoses of frailty on different dates of service and advanced illness.* Advanced illness is indicated by one of the following: • Two or more outpatient, observation, emergency room, telephone, e-visits, virtual check-ins or non-acute inpatient encounters or discharge(s) on separate dates of service with a diagnosis of advanced illness • One or more acute inpatient encounter(s) with a diagnosis of advanced illness • One or more acute inpatient discharge(s) with a diagnosis of advanced illness on the discharge claim • Dispensed a dementia medication: Donepezil, Donepezil-memantine, galantamine, rivastigmine or memantine	**Frailty** diagnoses must be in the measurement year and on different dates of service **Advanced illness** diagnosis must be in the measurement year or year prior to the measurement year
Medicare members ages 66 and older as of December 31 of the measurement year who are either: • Enrolled in an Institutional Special Needs Plan (I-SNP) • Living long term in an institution*	Any time during the measurement year

Tips and Best Practices to Help Close This Care Opportunity

This measure focuses on medication compliance.

- Encourage patients to take medications as prescribed.
- Offer tips to patients such as:
  - Take medication at the same time each day
  - Use a pill box
  - Enroll in a pharmacy automatic-refill program

***Supplemental and medical record data may not be used for the frailty with advanced illness or institutional living exclusions.**

Antidepressant Medication Management (AMM)

New for 2023

Updated

- Members who died during the measurement year is now a required exclusion
- Members must meet the lower age limit for the measure, 18, as of the Index Prescription Start Date (IPSD)

Definition

Percentage of members ages 18 and older who were treated with antidepressant medication, had a diagnosis of major depression and remained on an antidepressant medication treatment.

Two rates are reported:

1. **Effective Acute Phase Treatment –** Percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks)
2. **Effective Continuation Phase Treatment –** Percentage of members who remained on an antidepressant medication for at least 180 days (6 months)

Plan(s) Affected	Quality Program(s) Affected	Collection and Reporting Method
• Commercial • Exchange/Marketplace • Medicaid • Medicare	• CMS Quality Rating System • NCQA Accreditation • NCQA Health Plan Ratings	**Administrative** • Claim/Encounter Data • Pharmacy Data

Medications

To comply with this measure, a member must remain on any of the following medications for the required duration of time:

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

(Medications continued)

Antidepressant Medication Management (AMM)

Medications (continued)

To comply with this measure, a member must remain on one of the following medications for the required duration of time:

Drug Category	Medications	
Tetracyclic antidepressants	• Maprotiline	• Mirtazapine
Tricyclic antidepressants	• Amitriptyline • Amoxapine • Clomipramine • Desipramine • Doxepin (>6 mg)	• Imipramine • Nortriptyline • Protriptyline • Trimipramine

Required Exclusion(s)

Exclusion	Timeframe
• Members in hospice or using hospice services	- Any time during the measurement year

Tips and Best Practices to Help Close This Care Opportunity

This measure focuses on medication compliance.

- Screening tools (e.g., PHQ-9) may provide objective assessment and better identify who would or would not benefit from medication. Screening tools available at providerexpress.com > Clinical Resources > Behavioral Health Toolkit for Medical Providers. Tools help to identify mild, moderate or severe depression. Use "unspecified" diagnoses sparingly.
- Many patients with mild depression who are prescribed antidepressants do not stay on medication. Consider referral or a consult for talk therapy as an alternative to medication.
- When prescribing antidepressants, ensure patients understand it may take up to 12 weeks for full effectiveness of medication and discuss side effects and the importance of medication adherence.
- Encourage the use of telehealth appointments to discuss side effects and answer questions about the medication.
- Encourage patients to accept a referral for psychotherapy and help them understand mental health diagnoses are medical illnesses, not character flaws or weaknesses.
- If you need to refer your patient to a behavioral health specialist or need to request coordination of care, please call the number on the back of the patient's health plan ID card or search **liveandworkwell.com.**
- Encourage use of Employer Assistance Program (EAP) if covered under benefit plan at no cost to member.

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

New for 2023

Updated

- Members who died during the measurement year is now a required exclusion

Yes!
Supplemental Data Accepted

Definition

Percentage of members ages 18–64 with schizophrenia or schizoaffective disorder and cardiovascular disease who had a low-density lipoprotein cholesterol (LDL-C) test during the measurement year.

Plan(s) Affected	Quality Program(s) Affected	Collection and Reporting Method
• Medicaid	• Select Medicaid State Reporting	**Administrative** • Claim/Encounter

Codes

The following codes can be used to close HEDIS® numerator gaps in care; they are not intended to be a directive of your billing practice.

LDL-C Test	
CPT®/CPT II	80061, 83700, 83701, 83704, 83721, 3048F, 3049F, 3050F
LOINC	12773-8, 13457-7, 18261-8, 18262-6, 2089-1, 49132-4, 55440-2, 96259-7
SNOMED	113079009, 166833005, 166840006, 166841005, 167074000, 167075004, 314036004

Required Exclusion(s)

Exclusion	Timeframe
• Members in hospice or using hospice services • Members who died	- Any time during the measurement year

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

Important Note

A calculated or direct LDL may be used to report compliance.

Tips and Best Practices to Help Close This Care Opportunity

This measure focuses on appropriate monitoring for members with schizophrenia or schizoaffective disorder and cardiovascular disease.

- Be sure to schedule an annual LDL-C screening.
- The use of CPT® Category II codes helps UnitedHealthcare identify clinical outcomes such as lipid profile and LDL-C test results. It can also reduce the need for some chart review.
- Lipid profiles and results can be accepted as supplemental data, reducing the need for some chart review. Please contact your UnitedHealthcare representative to discuss clinical data exchange opportunities.

Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)

New for 2023

Updated

- Members who died during the measurement year is now a required exclusion
- Polycystic ovarian syndrome, gestational diabetes or steroid-induced diabetes are now required exclusions

Yes!
Supplemental Data Accepted

Definition

Percentage of members ages 18–64 with schizophrenia or schizoaffective disorder and diabetes who had both an HbA1c test and a low-density lipoprotein cholesterol (LDL-C) test during the measurement year.

Plan(s) Affected	Quality Program(s) Affected	Collection and Reporting Method
• Medicaid	• Select Medicaid State Reporting	**Administrative** • Claim/Encounter Data

Codes

The following codes can be used to close HEDIS® numerator gaps in care; they are not intended to be a directive of your billing practice.

HbA1c Test	
CPT®/CPT II	83036, 83037, 3044F, 3046F, 3051F, 3052F
LOINC	17856-6, 4548-4, 4549-2, 96595-4
SNOMED	43396009, 313835008, 165679005, 451061000124104

LDL-C Test	
CPT®/CPT II	80061, 83700, 83701, 83704, 83721, 3048F, 3049F, 3050F
LOINC	12773-8, 13457-7, 18261-8, 18262-6, 2089-1, 49132-4, 55440-2, 96259-7
SNOMED	113079009, 166833005, 166840006, 166841005, 167074000, 167075004, 314036004

Required Exclusion(s)

Exclusion	Timeframe
• Members in hospice or using hospice services • Members who died	- Any time during the measurement year
Members who have no diagnosis of diabetes in any setting and a diagnosis of polycystic ovarian syndrome, gestational or steroid-induced diabetes	Any time between January 1-December 31 of the measurement year and the year prior

Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)

Important Notes

	Test, Service or Procedure to Close Care Opportunity
Individual tests to measure cholesterol and blood glucose levels can be done on the same or different dates of service. The member must have both tests to be compliant for this measure.	• HbA1c test • LDL-C test HbA1c tests may include: • A1c, HbA1c, HgbA1c • Glycohemoglobin • Glycohemoglobin A1c • Glycated hemoglobin • Glycosylated hemoglobin • HB1c • Hemoglobin A1c

Tips and Best Practices to Help Close This Care Opportunity

This measure focuses on appropriate monitoring for members with schizophrenia or schizoaffective disorder and diabetes.

- Be sure to schedule an annual HbA1c and LDL-C test.
- The use of CPT® Category II codes helps UnitedHealthcare identify clinical outcomes such as HbA1c and LDL-C test results. It can also reduce the need for some chart review.
- HbA1c and lipid profile test results can be accepted as supplemental data, reducing the need for some chart review. Please contact your UnitedHealthcare representative to discuss clinical data exchange opportunities.

Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

New for 2023

Updated

- Members who died during the measurement year is now a required exclusion

Yes!
Supplemental Data Accepted

Definition

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

Plan(s) Affected	Quality Program(s) Affected	Collection and Reporting Method
• Medicaid	• NCQA Accreditation • Select Medicaid state reporting	**Administrative** • Claim/Encounter Data

Codes

The following codes can be used to close HEDIS® numerator gaps in care; they are not intended to be a directive of your billing practice.

Glucose Test	
CPT®/CPT II	80047, 80048, 80050, 80053, 80069, 82947, 82950, 82951
LOINC	10450-5, 1492-8, 1494-4, 1496-9, 1499-3, 1501-6, 1504-0, 1507-3, 1514-9, 1518-0, 1530-5, 1533-9, 1554-5, 1557-8, 1558-6, 17865-7, 20436-2, 20437-0, 20438-8, 20440-4, 26554-6, 41024-1, 49134-0, 6749-6, 9375-7
SNOMED	22569008, 33747003, 52302001, 72191006, 73128004, 88856000, 104686004, 167086002, 167087006, 167088001, 167095005, 167096006, 167097002, 250417005, 271061004, 271062006, 271063001, 271064007, 271065008, 275810004, 302788006, 302789003, 308113006, 313474007, 313545000, 313546004, 313624000, 313626003, 313627007, 313628002, 313630000, 313631001, 313697000, 313698005, 313810002, 412928005, 440576000, 443780009, 444008003, 444127006, 166890005, 166891009, 166892002, 166914001, 166915000, 166916004, 166917008, 166918003, 166919006, 166921001, 166922008, 166923003, 442545002, 444780001

HbA1c Test	
CPT®/CPT II	83036, 83037, 3044F, 3046F, 3051F, 3052F
LOINC	17856-6, 4548-4, 4549-2
SNOMED	43396009, 313835008, 165679005, 451061000124104

Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

Required Exclusion(s)

Exclusion	Timeframe
• Members in hospice or using hospice services • Members who died	- Any time during the measurement year
Members with diabetes	Measurement year or year prior to measurement year

Important Notes

	Test, Service or Procedure to Close Care Opportunity
HbA1c test must be performed during the measurement year.	• Glucose test • HbA1c test HbA1c tests may include: • A1c, HbA1c, HgbA1c • Glycohemoglobin • Glycohemoglobin A1c • Glycated hemoglobin • Glycosylated hemoglobin • HB1c • Hemoglobin A1c

Tips and Best Practices to Help Close This Care Opportunity

This measure focuses on appropriate monitoring for members with schizophrenia or bipolar disorder.

- Be sure to schedule an annual screening for diabetes (HbA1c or blood glucose).
- The use of CPT® Category II codes helps UnitedHealthcare identify clinical outcomes such as HbA1c test results. It can also reduce the need for some chart review.
- HbA1c test results can be accepted as supplemental data, reducing the need for some chart review. Please contact your UnitedHealthcare representative to discuss clinical data exchange opportunities.

Follow-Up After Hospitalization for Mental Illness (FUH)

New for 2023

Updated

- Members who died during the measurement year is now a required exclusion

Definition

Percentage of discharges for members ages 6 and older who were hospitalized for treatment of select mental illness or intentional self-harm diagnoses and had a follow-up visit **with a mental health provider.**

Two rates are reported:

1. Percentage of discharges where the member received follow-up within 30 days of their discharge.
2. Percentage of discharges where the member received follow-up within 7 days of their discharge.

Plan(s) Affected	Quality Program(s) Affected	Collection and Reporting Method
• Commercial • Medicaid • Medicare	• CMS Quality Rating System (7-day only) • NCQA Health Plan Ratings (7-day only)	**Administrative** • Claim/Encounter Data

Follow-Up After Hospitalization for Mental Illness (FUH)

Code

The following codes can be used to close HEDIS® numerator gaps in care; they are not intended to be a directive of your billing practice.

Scenario 1: Behavioral Health Outpatient Visit With a Mental Health Provider

Behavioral Health Visits	
CPT®/CPT II	98960, 98961, 98962, 99078, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99483, 99492, 99493, 99494, 99510
HCPCS	G0155, G0176, G0177, G0409, G0463, G0512, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, T1015
SNOMED	77406008, 84251009, 185463005, 185464004, 185465003, 281036007, 391223001, 391224007, 391225008, 391233009, 391237005, 391239008, 391242002, 391257009, 391260002, 391261003, 439740005, 3391000175108, 444971000124105
UBREV	0510, 0513, 0515, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0526, 0527, 0528, 0529, 0900, 0902, 0903, 0904, 0911, 0914, 0915, 0916, 0917, 0919, 0982, 0983

Scenario 2: Intensive Outpatient or Partial Hospitalization

Partial Hospitalization/Intensive Outpatient Visits	
HCPCS	G0410, G0411, H0035, H2001, H2012, S0201, S9480, S9484, S9485
SNOMED	7133001, 305345009, 305346005, 305347001, 391038005, 391042008, 391043003, 391046006, 391047002, 391048007, 391054008, 391055009, 391056005, 391133003, 391150001, 391151002, 391152009, 391153004, 391170007, 391185001, 391186000, 391187009, 391188004, 391191004, 391192006, 391194007,391195008, 391207001, 391208006, 391209003, 391210008, 391211007, 391228005, 391229002, 391232004, 391252003, 391254002, 391255001, 391256000
UBREV	0905, 0907, 0912, 0913

Scenario 3: Observation Visit With a Mental Health Provider

Observation Visit	
CPT®/CPT II	99217, 99218, 99219, 99220

(Codes continued)

Follow-Up After Hospitalization for Mental Illness (FUH)

Codes

The following codes can be used to close HEDIS® numerator gaps in care; they are not intended to be a directive of your billing practice.

Scenario 4: Outpatient Visit With a Mental Health Provider and With Appropriate Place of Service Code

Visit Setting Unspecified	
CPT®/CPT II	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99251, 99252, 99253, 99254, 99255

AND

Place of Service Code

Code	Location		
03	School	**17**	Walk-in retail health clinic
05	Indian Health Service free-standing facility	**18**	Place of employment – worksite
07	Tribal 638 free-standing facility	**19**	Off-campus outpatient hospital
09	Prison/Correctional facility	**20**	Urgent care facility
11	Office	**22**	On-campus outpatient hospital
12	Home	**33**	Custodial care facility
13	Assisted living facility	**49**	Independent clinic
14	Group home	**50**	Federally qualified health center
15	Mobile unit	**71**	Public health clinic
16	Temporary lodging	**72**	Rural health clinic

Scenario 5: Intensive Outpatient Visit or Partial Hospitalization With Appropriate Place of Service Code

Visit Setting Unspecified	
CPT®/CPT II	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99251, 99252, 99253, 99254, 99255

(Codes continued)

Follow-Up After Hospitalization for Mental Illness (FUH)

Codes

The following codes can be used to close HEDIS® numerator gaps in care; they are not intended to be a directive of your billing practice.

AND

Place of Service Code

Code	Location
52	Psychiatric facility – partial hospitalization

Scenario 6: Community Mental Health Center Visit With Appropriate Place of Service Code

Visit Setting Unspecified	
CPT®/CPT II	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99251, 99252, 99253, 99254, 99255

AND

Place of Service Code

Code	Location
53	Community mental health center

Behavioral Health Visits	
CPT®/CPT II	98960, 98961, 98962, 99078, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99483, 99492, 99493, 99494, 99510
HCPCS	G0155, G0176, G0177, G0409, G0463, G0512, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, T1015
UBREV	0510, 0513, 0515, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0526, 0527, 0528, 0529, 0900, 0902, 0903, 0904, 0911, 0914, 0915, 0916, 0917, 0919, 0982, 0983

Observation Visit	
CPT®/CPT II	99217, 99218, 99219, 99220

(Codes continued)

Follow-Up After Hospitalization for Mental Illness (FUH)

Codes

The following codes can be used to close HEDIS® numerator gaps in care; they are not intended to be a directive of your billing practice.

Transitional Care Management Services	
CPT®/CPT II	99495, 99496

AND

Place of Service Code

Code	Location
53	Community mental health center

Scenario 7: Electroconvulsive Therapy With Appropriate Place of Service Code

Electroconvulsive Therapy	
CPT®/CPT II	90870
ICD-10 Procedure	GZB0ZZZ, GZB1ZZZ, GZB2ZZZ, GZB3ZZZ, GZB4ZZZ
SNOMED	10470002, 11075005, 23835007, 231079005, 231080008, 284468008, 313019002, 313020008, 1010696002, 1010697006

AND

Place of Service Code

Code	Location	Code	Location
03	School	**18**	Place of employment – worksite
05	Indian Health Service free-standing facility	**19**	Off-campus outpatient hospital
07	Tribal 638 free-standing facility	**20**	Urgent care facility
09	Prison/Correctional facility	**24**	Ambulatory surgical center
11	Office	**33**	Custodial care facility
12	Home	**49**	Independent clinic
13	Assisted living facility	**50**	Federally qualified health center
14	Group home	**52**	Psychiatric facility – partial hospitalization
15	Mobile unit	**53**	Community mental health center
16	Temporary lodging	**71**	Public health clinic
17	Walk-in retail health clinic	**72**	Rural health clinic

(Codes continued)

Follow-Up After Hospitalization for Mental Illness (FUH)

Codes

The following codes can be used to close HEDIS® numerator gaps in care; they are not intended to be a directive of your billing practice.

Scenario 8: Transitional Care Management Services With a Mental Health Provider

Transitional Care Management Services	
CPT®/CPT II	99495, 99496

Scenario 9: Telehealth Visit With a Mental Health Provider

Visit Setting Unspecified	
CPT®/CPT II	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99251, 99252, 99253, 99254, 99255

AND

Place of Service Code

Code	Location
02	Telehealth
10	Telehealth

Scenario 10: Behavioral Healthcare Setting Visit

Behavioral Healthcare Setting	
UBREV	0513, 0900, 0901, 0902, 0903, 0904, 0905, 0907, 0911, 0912, 0913, 0914, 0915, 0916, 0917, 0919

Scenario 11: Telephone Visit With a Mental Health Provider

Telephone Visits	
CPT®/CPT II	98966, 98967, 98968, 99441, 99442, 99443
SNOMED	9185317003, 314849005, 386472008, 386473003, 401267002

Scenario 12: Psychiatric Collaborative Care Management

Psychiatric Collaborative Care Management	
CPT®/CPT II	99492, 99493, 99494
HCPCS	G0512

Follow-Up After Hospitalization for Mental Illness (FUH)

Required Exclusion(s)

Exclusion	Timeframe
• Members in hospice or using hospice services • Members who died	- Any time during the measurement year

Important Notes

- Visits that occur on the date of discharge will **not** count toward compliance.
- Telehealth and telephone visits with a behavioral health provider are acceptable to address the care opportunity

Tips and Best Practices to Help Close This Care Opportunity

This measure focuses on follow-up treatment, which must be with a mental health provider.

- Refer patient to a mental health provider to be seen within 7 days of discharge.

  Even patients receiving medication from their primary care provider still need post-discharge supportive therapy with a licensed mental health clinician such as a therapist or social worker.

- Visits can be telehealth with a licensed mental health provider. Visits can include unlicensed staff with POS 53 onsite at a mental health center using the applicable CPT(R) codes.
- If a situation arises where a patient is unable to be seen within 7 days, then they need to have an appointment within 30 days of discharge.
- To refer your patient to a behavioral health specialist or to request coordination of care, please call the number on the back of the patient's health plan ID card or search **liveandworkwell.com**.

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

New for 2023

Updated

- Members who died during the measurement year is now a required exclusion
- 'Detoxification' now referred to as 'withdrawal management'

Yes!
Supplemental Data Accepted

Definition

The percentage of acute inpatient hospitalizations, residential treatment or withdrawal management visits for a diagnosis of substance use disorder among members ages 13 and older that result in a follow-up visit or service for substance use disorder.

Two rates are reported:

1. The percentage of visits or discharges for which the member received follow-up for substance use disorder within the **7 days** after the visit or discharge
2. The percentage of visits or discharges for which the member received follow-up for substance use disorder within the **30 days** after the visit or discharge.

Plan(s) Affected	Quality Program(s) Affected	Collection and Reporting Method
• Commercial • Medicaid • Medicare	• NCQA Health Plan Ratings (7-day only)	**Administrative** • Claim/Encounter Data

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

Codes

The following codes can be used to close HEDIS® numerator gaps in care; they are not intended to be a directive of your billing practice.

Any of the following scenarios will meet compliance for these numerators:

Scenario 1: Acute or nonacute inpatient admission or Residential Behavioral Health Stay With a Principal Diagnosis of Substance Use Disorder

Scenario 2: Outpatient Visit With a Principal Diagnosis of Substance Use Disorder

CPT®/CPT II	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99251, 99252, 99253, 99254, 99255

AND

Place of Service Code

Code	Location	Code	Location
03	School	**17**	Walk-in retail health clinic
05	Indian Health Service free-standing facility	**18**	Place of employment – worksite
07	Tribal 638 free-standing facility	**19**	Off-campus outpatient hospital
09	Prison/Correctional facility	**20**	Urgent care facility
11	Office	**22**	On-campus outpatient hospital
12	Home	**33**	Custodial care facility
13	Assisted living facility	**49**	Independent clinic
14	Group home	**50**	Federally qualified health center
15	Mobile unit	**71**	Public health clinic
16	Temporary lodging	**72**	Rural health clinic

(Codes continued)

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

Codes

The following codes can be used to close HEDIS® numerator gaps in care; they are not intended to be a directive of your billing practice.

Scenario 3: Behavioral Health Visit With Principal Diagnosis of Substance Use Disorder	
CPT®/CPT II	98960, 98961, 98962, 99078, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99483, 99492, 99493, 99494, 99510
HCPCS	G0155, G0176, G0177, G0409, G0463, G0512, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, T1015
SNOMED	77406008, 84251009, 185463005, 185464004, 185465003, 281036007, 391223001, 391224007, 391225008, 391233009, 391237005, 391239008, 391242002, 391257009, 391260002, 391261003, 439740005, 3391000175108, 444971000124105
UBREV	0510, 0513, 0515, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0526, 0527, 0528, 0529, 0900, 0902, 0903, 0904, 0911, 0914, 0915, 0916, 0917, 0919, 0982, 0983

Scenario 4: Intensive Outpatient Visit or Partial Hospitalization With Appropriate Place of Service Code

Visit Setting Unspecified	
CPT®/CPT II	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99251, 99252, 99253, 99254, 99255

AND

Place of Service Code

Code	Location
52	Psychiatric facility – partial hospitalization

Scenario 5: Intensive Outpatient or Partial Hospitalization

Partial Hospitalization/Intensive Outpatient Visits	
HCPCS	G0410, G0411, H0035, H2001, H2012, S0201, S9480, S9484, S9485
SNOMED	7133001, 305345009, 305346005, 305347001, 391038005, 391042008, 391043003, 391046006, 391047002, 391048007, 391054008, 391055009, 391056005, 391133003, 391150001, 391151002, 391152009, 391153004, 391170007, 391185001, 391186000, 391187009, 391188004, 391191004, 391192006, 391194007, 391195008, 391207001, 391208006, 391209003, 391210008, 391211007, 391228005, 391229002, 391232004, 391252003, 391254002, 391255001, 391256000
UBREV	0905, 0907, 0912, 0913

(Codes continued)

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

Codes

The following codes can be used to close HEDIS® numerator gaps in care; they are not intended to be a directive of your billing practice.

Scenario 6: Opioid Treatment Service
Claim must include diagnosis code matching the original episode diagnosis for:

- Substance use disorder

Weekly Non-Drug Treatment	
HCPCS	G2071, G2074, G2075, G2076, G2077, G2080

Monthly Office-Based Treatment	
HCPCS	G2086, G2087

Scenario 7: Transitional Care Management Services

Visit Setting Unspecified	
CPT®/CPT II	99495, 99496

Scenario 8: Telehealth Visit

Visit Setting Unspecified	
CPT®/CPT II	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99251, 99252, 99253, 99254, 99255

AND

Place of Service Code

Code	Location
02	Telehealth
10	Telehealth

Scenario 9: Community Mental Health Center Visit With Appropriate Place of Service Code

Visit Setting Unspecified	
CPT®/CPT II	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99251, 99252, 99253, 99254, 99255

AND

Place of Service Code

Code	Location
53	Community mental health center

(Codes continued)

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

Codes

The following codes can be used to close HEDIS® numerator gaps in care; they are not intended to be a directive of your billing practice.

Scenario 10: Non-Residential Substance Abuse Treatment Facility Visit With Appropriate Place of Service Code

Visit Setting Unspecified	
CPT®/CPT II	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99251, 99252, 99253, 99254, 99255

AND

Place of Service Code

Code	Location
57	Non-residential substance abuse treatment facility
58	Non-residential opioid treatment facility

Scenario 11: Observation Visit With a Principal Diagnosis of Substance Use Disorder

Observation Visit	
CPT®/CPT II	99217, 99218, 99219, 99220

Scenario 12: Substance Use Disorder Service With a Principal Diagnosis Of Substance Use Disorder	
CPT®/CPT II	99408, 99409
HCPCS	G0396, G0397, G0443, H0001, H0005, H0007, H0015, H0016, H0022, H0047, H0050, H2035, H2036, T1006, T1012
SNOMED	20093000, 23915005, 56876005, 61480009, 64297001, 67516001, 87106005, 182969009, 266707007, 310653000, 370776007, 370854007, 385989002, 386449006, 386450006, 386451005, 414054004, 414056002, 414283008, 414501008, 415662004, 424589009, 445628007, 445662007, 450760003, 704182008, 707166002, 711008001, 713106006, 713107002, 713127001, 720174008, 720175009, 720176005, 720177001, 763104007, 763233002, 763302001, 772813001, 774090004, 774091000, 792901003, 792902005, 827094004, 865964007, 428211000124100
UBREV	0906, 0944, 0945

(Codes continued)

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

Codes

The following codes can be used to close HEDIS® numerator gaps in care; they are not intended to be a directive of your billing practice.

Scenario 13: Residential Behavioral Health Treatment With a Principal Diagnosis of Substance Use Disorder

Residential Behavioral Health Treatment	
HCPCS	H0017, H0018, H0019, T2048

Scenario 14: Telephone Visit With a Principal Diagnosis of Substance Use Disorder

Telephone Visit	
CPT®/CPT II	98966, 98967, 98968, 99441, 99442, 99443
SNOMED	185317003, 314849005, 386472008, 386473003, 401267002

Scenario 15: E-Visit or Virtual Check-In With a Principal Diagnosis of Substance Use Disorder

Online Assessment (e-visit/virtual check-in)	
CPT®/CPT II	98969, 98970, 98971, 98972, 99421, 99422, 99423, 99444, 99457, 99458
HCPCS	G0071, G2010, G2012, G2061, G2062, G2063, G2250, G2251, G2252

Scenario 16: A Pharmacotherapy Dispensing Event or Medication Treatment Event for Alcohol or Other Drug Abuse or Dependencee

Medication Treatment	
HCPCS	G2069, G2070, G2072, G2073, H0020, H0033, J0570, J0571, J0572, J0573, J0574, J0575 , J2315, Q9991, Q9992, S0109
SNOMED	310653000

Opioid Treatment Service – Weekly Billing	
HCPCS	G2067, G2068, G2069, G2070, G2072, G2073

(Codes continued)

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

Medications

One or more medication dispensing events for alcohol abuse or dependence:

Drug Category	Medications
Aldehyde dehydrogenase inhibitor	• Disulfiram (oral)
Antagonist	• Naltrexone (oral and injectable)
Other	• Acamprosate (oral; delayed-release tablet)

One or more medication dispensing events for alcohol abuse or dependence:

Drug Category	Medications
Antagonist	• Naltrexone (oral and injectable)
Partial agonist	• Buprenorphine (sublingual tablet, injection, implant)* • Buprenorphine/naloxone (sublingual tablet, buccal film, sublingual film)

Required Exclusion(s)

Exclusion	Timeframe
• Members in hospice or using hospice services • Members who died	- Any time during the measurement year

* Buprenorphine administered via transdermal patch or buccal film are not included because they are FDA-approved for the treatment of pain, not for opioid use disorder.

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

Important Notes

	Test, Service or Procedure to Close Care Opportunity
Episode date is the date of service for any acute inpatient discharge, residential treatment discharge or detoxification visit with a principal diagnosis of substance use disorder with any provider type.	Follow-up for substance use disorder can be any of the following: • Group visits with an appropriate place of service code and diagnosis code • Medication dispensing event with diagnosis code • Medication treatment with diagnosis code • Online assessment with diagnosis code • Stand-alone visits with an appropriate place of service code and diagnosis code • Telephone visit with diagnosis code • Residential behavioral health treatment • Non-residential substance abuse treatment facility

Tips and Best Practices to Help Close This Care Opportunity

This measure focuses on follow-up treatment with any provider type.

- See patients within 7 days and bill with a substance use diagnosis.
- If a situation arises where a patient is unable to be seen within 7 days, then they need to have an appointment within 30 days of discharge.
- Encourage the use of telehealth appointments when appropriate.
- Available Resources:
  - Alcohol and Drug Use Screening Tools: providerexpress.com > Clinical Resources > Behavioral Health Toolkits for Medical Providers
  - Behavioral Health Tools and Information: providerexpress.com > Clinical Resources > Behavioral Health Toolkit for Medical Providers
  - Patient Education: liveandworkwell.com > Browse as a guest with company access code > Use access code “clinician” > Explore and Learn
- If you need to refer your patient to a substance use specialist or need to request coordination of care, please call the number on the back of the patient’s health plan ID card or search **liveandworkwell.com**.

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

New for 2023

Updated

- Members who died during the measurement year is now a required exclusion

Yes!
Supplemental Data Accepted

Definition

The percentage of ED visits for members ages 6 years and older with a principal diagnosis of mental illness or intentional self-harm, who then had a follow-up visit for mental illness with any practitioner type.

Two rates are reported:

1. The percentage of ED visits for which the member received follow-up for mental illness within the **7 days** after the visit (8 days total)
2. The percentage of ED visits for which the member received follow-up for mental illness within the **30 days** after the visit (31 days total)

Plan(s) Affected	Quality Program(s) Affected	Collection and Reporting Method
• Commercial • Exchange/Marketplace • Medicaid • Medicare	• CMS Quality Rating System • NCQA Accreditation • NCQA Health Plan Ratings	**Administrative** • Claim/Encounter Data

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

Codes

The following codes can be used to close HEDIS® numerator gaps in care; they are not intended to be a directive of your billing practice.

Any of the following scenarios will meet criteria for the measure with:

- A principal diagnosis of mental health disorder
- A principal diagnosis of intentional self-harm and any diagnosis of a mental health disorder

Scenario 1: Behavioral Health Outpatient Visit With Any Practitioner Type

Behavioral Health Visits	
CPT®/CPT II	98960, 98961, 98962, 99078, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99483, 99492, 99493, 99494, 99510
HCPCS	G0155, G0176, G0177, G0409, G0463, G0512, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, T1015
SNOMED	77406008, 84251009, 185463005, 185464004, 185465003, 281036007, 391223001, 391224007, 391225008, 391233009, 391237005, 391239008, 391242002, 391257009, 391260002, 391261003, 439740005, 3391000175108, 444971000124105
UBREV	0510, 0513, 0515, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0526, 0527, 0528, 0529, 0900, 0902, 0903, 0904, 0911, 0914, 0915, 0916, 0917, 0919, 0982, 0983

Scenario 2: Intensive Outpatient or Partial Hospitalization With Any Practitioner Type

Partial Hospitalization/Intensive Outpatient Visits	
HCPCS	G0410, G0411, H0035, H2001, H2012, S0201, S9480, S9484, S9485
SNOMED	7133001, 305345009, 305346005, 305347001, 391038005, 391042008, 391043003, 391046006, 391047002, 391048007, 391054008, 391055009, 391056005, 391133003, 391150001, 391151002, 391152009, 391153004, 391170007, 391185001, 391186000, 391187009, 391188004, 391191004, 391192006, 391194007, 391195008, 391207001, 391208006, 391209003, 391210008, 391211007, 391228005, 391229002, 391232004, 391252003, 391254002, 391255001, 391256000
UBREV	0905, 0907, 0912, 0913

Scenario 3: Observation Visit With Any Practitioner Type

Observation Visit	
CPT®/CPT II	99217, 99218, 99219, 99220

(Codes continued)

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

Codes

The following codes can be used to close HEDIS® numerator gaps in care; they are not intended to be a directive of your billing practice.

Scenario 4: Outpatient Visit With Any Practitioner Type and With Appropriate Place of Service Code

Visit Setting Unspecified	
CPT®/CPT II	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99251, 99252, 99253, 99254, 99255

AND

Place of Service Code

Code	Location	Code	Location
03	School	**17**	Walk-in retail health clinic
05	Indian Health Service free-standing facility	**18**	Place of employment – worksite
07	Tribal 638 free-standing facility	**19**	Off-campus outpatient hospital
09	Prison/Correctional facility	**20**	Urgent care facility
11	Office	**22**	On-campus outpatient hospital
12	Home	**33**	Custodial care facility
13	Assisted living facility	**49**	Independent clinic
14	Group home	**50**	Federally qualified health center
15	Mobile unit	**71**	Public health clinic
16	Temporary lodging	**72**	Rural health clinic

Scenario 5: Intensive Outpatient Visit or Partial Hospitalization With Any Practitioner Type and With Appropriate Place of Service Code

Visit Setting Unspecified	
CPT®/CPT II	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99251, 99252, 99253, 99254, 99255

AND

Place of Service Code

Code	Location
52	Psychiatric facility – partial hospitalization

(Codes continued)

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

Codes

The following codes can be used to close HEDIS® numerator gaps in care; they are not intended to be a directive of your billing practice.

Scenario 6: Community Mental Health Center Visit With Any Provider Type and With Appropriate Place of Service Code

Visit Setting Unspecified	
CPT®/CPT II	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99251, 99252, 99253, 99254, 99255

AND

Place of Service Code

Code	Location
53	Community mental health center

Scenario 7: Observation Visit

Observation Visit	
CPT®/CPT II	99217, 99218, 99219, 99220

Scenario 8: Electroconvulsive Therapy With Any Practitioner Type and With Appropriate Place of Service Code

Electroconvulsive Therapy	
CPT®/CPT II	90870
ICD-10 Procedure	GZB0ZZZ, GZB1ZZZ, GZB2ZZZ, GZB3ZZZ, GZB4ZZZ
SNOMED	10470002, 11075005, 23835007, 231079005, 231080008, 284468008, 313019002, 313020008, 1010696002, 1010697006

(Codes continued)

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

Codes

The following codes can be used to close HEDIS® numerator gaps in care; they are not intended to be a directive of your billing practice.

Place of Service Code

Code	Location		
03	School	19	Off-campus outpatient hospital
05	Indian Health Service free-standing facility	20	Urgent care facility
07	Tribal 638 free-standing facility	22	On-campus outpatient hospital
09	Prison/Correctional facility	24	Ambulatory surgical center
11	Office	33	Custodial care facility
12	Home	49	Independent clinic
13	Assisted living facility	50	Federally qualified health center
14	Group home	52	Psychiatric facility – partial hospitalization
15	Mobile unit	53	Community mental health center
16	Temporary lodging	71	Public health clinic
17	Walk-in retail health clinic	72	Rural health clinic
18	Place of employment – worksite		

(Codes continued)

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

Codes

The following codes can be used to close HEDIS® numerator gaps in care; they are not intended to be a directive of your billing practice.

Scenario 9: Telehealth Visit With Any Practitioner Type and the Appropriate Place of Service Code

Visit Setting Unspecified	
CPT®/CPT II	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99251, 99252, 99253, 99254, 99255

AND

Place of Service Code

Code	Location
02	Telehealth
10	Telehealth

Scenario 10: Telephone Visit With Any Practitioner Type

Telephone Visits	
CPT®/CPT II	98966, 98967, 98968, 99441, 99442, 99443
SNOMED	185317003, 314849005, 386472008, 386473003, 401267002

Scenario 11: E-Visit or Virtual Check-In With Any Practitioner Type

Online Assessment (e-visit/virtual check-in)	
CPT®/CPT II	98969, 98970, 98971, 98972, 99421, 99422, 99423, 99444, 99457, 99458
HCPCS	G0071, G2010, G2012, G2061, G2062, G2063, G2250, G2251, G2252

Required Exclusion(s)

Exclusion	Timeframe
• Members in hospice or using hospice services • Members who died	- Any time during the measurement year

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

Important Notes

- Visits that result in an inpatient stay are not included
- Telehealth visits are acceptable to address the care opportunity

Tips and Best Practices to Help Close This Care Opportunity

This measure focuses on follow-up treatment with a primary care provider or a behavioral health practitioner.

- See patients within 7 days and bill with a mental health diagnosis.
- If a situation arises where a patient is unable to be seen within 7 days, then they need to have an appointment within 30 days of discharge.
- Encourage the use of telehealth appointments when appropriate.
- If you need to refer your patient to a behavioral health specialist or need to request coordination of care, please call the number on the back of the patient's health plan ID card or search **liveandworkwell.com.**
- **Available Resources:**
  - **Behavioral Health Screening Tools and Resources: providerexpress.com**
  - **Patient Education: liveandworkwell.com** > Browse as a guest with company access code > Use access code "clinician" > Explore and Learn
- Mental Health visits can be accepted as supplemental data. Please contact your UnitedHealthcare representative to discuss clinical data exchange opportunities.

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

New for 2023

Added

- Rates will now include stratification by race and ethnicity

Updated

- Members who died during the measurement year is now a required exclusion
- ED visits followed by residential treatment (on or within 30 days of ED visit) is now an exclusion

Yes!
Supplemental Data Accepted

Definition

The percentage of ED visits for members ages 13 and older with a principal diagnosis of substance use disorder (SUD) or any drug overdose diagnosis and who had a follow-up visit.

Two rates are reported:

1. The percentage of ED visits for which the member received follow-up for SUD within the **7 days** after the visit (8 days total)
2. The percentage of visits or discharges for which the member received follow-up for SUD within the **30 days** after the visit (31 days total)

Plan(s) Affected	Quality Program(s) Affected	Collection and Reporting Method
• Commercial • Medicaid • Medicare	• NCQA Accreditation • NCQA Health Plan Ratings • ACO Quality Gate	**Administrative** • Claim/Encounter Data

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

Codes

The following codes can be used to close HEDIS® numerator gaps in care; they are not intended to be a directive of your billing practice.

Any of the following scenarios will meet criteria for the measure when the above diagnoses are present.

Scenario 1: Outpatient Visit With Mental Health Provider or With Diagnosis of Substance Use Disorder or Drug Overdose	
CPT®/CPT II	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99251, 99252, 99253, 99254, 99255

AND

Place of Service Code

Code	Location	Code	Location
03	School	**17**	Walk-in retail health clinic
05	Indian Health Service free-standing facility	**18**	Place of employment – worksite
07	Tribal 638 free-standing facility	**19**	Off-campus outpatient hospital
09	Prison/Correctional facility	**20**	Urgent care facility
11	Office	**22**	On-campus outpatient hospital
12	Home	**33**	Custodial care facility
13	Assisted living facility	**49**	Independent clinic
14	Group home	**50**	Federally qualified health center
15	Mobile unit	**71**	Public health clinic
16	Temporary lodging	**72**	Rural health clinic

(Codes continued)

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

Codes

The following codes can be used to close HEDIS® numerator gaps in care; they are not intended to be a directive of your billing practice.

Scenario 2: Behavioral Health Visit With a Mental Health Provider or With a Diagnosis of Substance Use Disorder or Drug Overdose	
CPT®/CPT II	98960, 98961, 98962, 99078, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99483, 99492, 99493, 99494, 99510
HCPCS	G0155, G0176, G0177, G0409, G0463, G0512, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, T1015
SNOMED	77406008, 84251009, 185463005, 185464004, 185465003, 281036007, 391223001, 391224007, 391225008, 391233009, 391237005, 391239008, 391242002, 391257009, 391260002, 391261003, 439740005, 3391000175108, 444971000124105
UBREV	0510, 0513, 0515, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0526, 0527, 0528, 0529, 0900, 0902, 0903, 0904, 0911, 0914, 0915, 0916, 0917, 0919, 0982, 0983

See Appendix for codes that include descriptions for substance use disorder or drug overdose diagnoses.

Scenario 3: Intensive Outpatient Visit or Partial Hospitalization With Appropriate Place of Service Code With a Mental Health Provider or With a Diagnosis of Substance Use Disorder or Drug Overdose

Visit Setting Unspecified	
CPT®/CPT II	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99251, 99252, 99253, 99254, 99255

AND

Place of Service Code

Code	Location
52	Psychiatric facility – partial hospitalization

(Codes continued)

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

Codes

The following codes can be used to close HEDIS® numerator gaps in care; they are not intended to be a directive of your billing practice.

Scenario 4: Intensive Outpatient or Partial Hospitalization With a Mental Health Provider or With a Diagnosis of Substance Use Disorder or Drug Overdose

Partial Hospitalization/Intensive Outpatient Visits	
HCPCS	G0410, G0411, H0035, H2001, H2012, S0201, S9480, S9484, S9485
SNOMED	7133001, 305345009, 305346005, 305347001, 391038005, 391042008, 391043003, 391046006, 391047002, 391048007, 391054008, 391055009, 391056005, 391133003, 391150001, 391151002, 391152009, 391153004, 391170007, 391185001, 391186000, 391187009, 391188004, 391191004, 391192006, 391194007, 391195008, 391207001, 391208006, 391209003, 391210008, 391211007, 391228005, 391229002, 391232004, 391252003, 391254002, 391255001, 391256000
UBREV	0905, 0907, 0912, 0913

Scenario 5: Opioid Treatment Service With a Diagnosis of Substance Use Disorder or Drug Overdose

Weekly Non-Drug Treatment	
HCPCS	G2071, G2074 , G2075 , G2076 , G2077 , G2080

Monthly Office-Based Treatment	
HCPCS	G2086, G2087

Scenario 6: Peer Support Service With a Diagnosis of Substance Use Disorder or Drug Overdose	
HCPCS	G0177, H0024, H0025, H0038, H0039, H0040, H0046, H2014, H2023, S9445, T1012, T1016

Scenario 7: Telehealth Visit With a Mental Health Provider or With a Diagnosis of Substance Use Disorder or Drug Overdose

Visit Setting Unspecified	
CPT®/CPT II	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99251, 99252, 99253, 99254, 99255

AND

Place of Service Code

Code	Location
02	Telehealth
10	Telehealth

(Codes continued)

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

Codes

The following codes can be used to close HEDIS® numerator gaps in care; they are not intended to be a directive of your billing practice.

Scenario 8: Community Mental Health Center Visit With Appropriate Place of Service Code With a Mental Health Provider or With a Diagnosis of Substance Use Disorder or Drug Overdose

Visit Setting Unspecified	
CPT®/CPT II	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99251, 99252, 99253, 99254, 99255

AND

Place of Service Code

Code	Location
53	Community mental health center

Scenario 9: Non-Residential Substance Abuse Treatment Facility Visit With Appropriate Place of Service Code With a Mental Health Provider or With a Diagnosis of Substance Use Disorder or Drug Overdose

CPT®/CPT II	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99251, 99252, 99253, 99254, 99255

AND

Place of Service Code

Code	Location
57	Non-residential substance abuse treatment facility
58	Non-residential opioid treatment facility

Scenario 10: Observation visit With a Mental Health Provider or With a Diagnosis of Substance Use Disorder or Drug Overdose

Observation Visit	
CPT®/CPT II	99217, 99218, 99219, 99220

(Codes continued)

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

Codes

The following codes can be used to close HEDIS® numerator gaps in care; they are not intended to be a directive of your billing practice.

Scenario 11: Substance Use Disorder Service or Substance Use

CPT®/CPT II	99408, 99409
HCPCS	G0396, G0397, G0443, H0001, H0005, H0007, H0015, H0016, H0022, H0047, H0050, H2035, H2036, T1006, T1012
SNOMED	40823001, 49474007, 58473000, 64792006, 89732002, 171208001, 314077000, 370854007, 391281002, 410223002, 410229003, 414283008, 414501008, 415662004, 439320000, 703257008, 713106006, 713107002, 713127001, 713132000, 713137006, 428211000124100
UBREV	0906, 0944, 0945

Scenario 12: Behavioral Health Screening or Assessment for Substance Use Disorder or Mental Health Disorders

Behavioral Health Assessment	
CPT®/CPT II	99408, 99409
HCPCS	G0396, G0397, G0442, G2011, H0001, H0002, H0031, H0049
SNOMED	40823001, 49474007, 58473000, 64792006, 89732002, 171208001, 314077000, 370854007, 391281002, 410223002, 410229003, 414283008, 414501008, 415662004, 439320000, 703257008, 713106006, 713107002, 713127001, 713132000, 713137006, 428211000124100

Scenario 13: Telephone Visit With a Mental Health Provider or With a Diagnosis of Substance Use Disorder or Drug Overdose

Telephone Visits	
CPT®/CPT II	98966, 98967, 98968, 99441, 99442, 99443
SNOMED	185317003, 314849005, 386472008, 386473003, 401267002

Scenario 14: E-Visit or Virtual Check-In with a Mental Health Provider or with a Diagnosis of Substance Use Disorder or Drug Overdose

Online Assessment (e-visit/virtual check-in)	
CPT®/CPT II	98969, 98970, 98971, 98972, 99421, 99422, 99423, 99444, 99457, 99458
HCPCS	G0071, G2010, G2012, G2061, G2062, G2063, G2250 G2251 G2252

(Codes continued)

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

Codes

The following codes can be used to close HEDIS® numerator gaps in care; they are not intended to be a directive of your billing practice.

Scenario 15: A Pharmacotherapy Dispensing Event or Medication Treatment for Substance Use Disorder

Medication Treatment	
HCPCS	G2069, G2070, G2072, G2073, H0020, H0033, J0570, J0571, J0572, J0573, J0574, J0575, J2315, Q9991, Q9992, S0109
SNOMED	310653000

Opioid Treatment Service Weekly Billing	
HCPCS	G2067, G2068, G2069, G2070, G2072, G2073

Medications

One or more medication dispensing events for alcohol abuse or dependence:

Drug Category	Medications
Aldehyde dehydrogenase inhibitor	• Disulfiram (oral)
Antagonist	• Naltrexone (oral and injectable)
Other	• Acamprosate (oral; delayed-release tablet)

One or more medication dispensing events for opioid abuse or dependence:

Drug Category	Medications
Antagonist	• Naltrexone (oral and injectable)
Partial agonist	• Buprenorphine (sublingual tablet, injection, implant)* • Buprenorphine/naloxone (sublingual tablet, buccal film, sublingual film)

Required Exclusion(s)

Exclusion	Timeframe
• Members in hospice or using hospice services • Members who died	- Any time during the measurement year

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

Important Notes

- Visits that result in an inpatient stay are not included
- Telehealth visits are acceptable to address the care opportunity

Tips and Best Practices to Help Close This Care Opportunity

This measure focuses on follow-up treatment with a primary care provider or a substance use specialist.

- See patients within 7 days and bill with a substance use diagnosis.
- If a situation arises where a patient is unable to be seen within 7 days, then they need to have an appointment within 30 days of discharge.
- Encourage the use of telehealth appointments when appropriate.
- The Mental Health Services Administration supports following the Screening, Brief Intervention and Referral to Treatment (SBIRT) guideline[1] at **samhsa.gov/sbirt.**
- If you are not going to treat the patient yourself, you will need to refer your patient to a substance use specialist. To request coordination of care, please call the number on the back of the patient's health plan ID card or search **liveandworkwell.com.**
- Sharing member demographic data is critical to understanding the cultural, linguistic and social needs of those we serve and decreasing health inequities across the care continuum. This data can include, but is not limited to, race, ethnicity, language, sexual orientation, gender identity, pronouns, sex assigned at birth and disability status. As part of UnitedHealthcare's clinical structured data exchange program, we encourage you to include this demographic data with any structured data file or CCD. Your information is confidential. UnitedHealthcare will keep personally identifiable information confidential and won't disclose any information without your written consent.
- **Available Resources:**
  - Alcohol and Drug Use Screening Tools: **providerexpress.com** > Clinical Resources > Behavioral Health Toolkits for Medical Providers
  - Patient Education: **liveandworkwell.com** > Browse as a guest with company access code > Use access code "clinician" > Explore and Learn
- SUD can be accepted as supplemental data. Please contact your UnitedHealthcare representative to discuss clinical data exchange opportunities.

[1]https://www.integration.samhsa.gov/clinical-practice/sbirt/referral-to-treatment

Appropriate Testing for Pharyngitis (CWP)

New for 2023

Updated

- Members who died during the measurement year is now a required exclusion

Yes!
Supplemental Data Accepted

Definition

Percentage of episodes for members age 3 years and older where the member was diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test within 3 days prior to or 3 days after the diagnosis day (7 days total).

A higher rate indicates appropriate testing and treatment.

Plan(s) Affected	Quality Program(s) Affected	Collection and Reporting Method
• Commercial • Exchange/Marketplace • Medicaid • Medicare	• CMS Quality Rating System • NCQA Health Plan Ratings	**Administrative** • Claim/Encounter Data • Pharmacy Data

Codes

The following codes can be used to close HEDIS® numerator gaps in care; they are not intended to be a directive of your billing practice.

Group A Strep Test	
CPT®/CPT II	87070, 87071, 87081, 87430, 87650, 87651, 87652, 87880
LOINC	11268-0, 17656-0, 17898-8, 18481-2, 31971-5, 49610-9, 5036-9, 60489-2, 626-2, 6557-3, 6558-1, 6559-9, 68954-7, 78012-2
SNOMED	122121004, 122205003, 122303007

Pharyngitis	
ICD-10 Diagnosis	J02.0, J02.8, J02.9, J03.00, J03.01, J03.80, J03.81, J03.90, J03.91
SNOMED	140004, 652005,1532007, 2365002, 10351008, 11461005, 14465002, 17741008, 27878001, 31309002, 39271004, 40766000, 41582007, 43878008, 51209006, 55355000, 58031004, 59471009, 63866002, 72430001, 76651006, 78430008, 78911000, 82228008, 87326000, 90176007, 90979004, 95885008, 111816002, 126664009, 126665005, 164256007, 164260005, 186659004, 186963008, 195655000, 195656004, 195657008, 195658003, 195659006, 195660001, 195662009, 195663004, 195666007, 195667003, 195668008, 195669000, 195670004, 195671000, 195672007, 195673002, 195676005, 195677001, 195709006, 195779005, 195780008, 195782000, 195803003, 195804009, 195924009, 232399005, 232400003, 232401004, 232402006, 232403001, 232405008, 232406009, 232417005, 240444009, 240547000, 302911003, 312422001, 363746003, 405737000, 415724006, 703468005, 721586007, 878818001, 133171000119105, 10629231000119109, 10629271000119107

Appropriate Testing for Pharyngitis (CWP)

Medications

The following antibiotic medications, in conjunction with a strep test, will meet compliance for this measure:

Drug Category	Medications	
Aminopenicillins	• Amoxicillin	• Ampicillin
Beta-lactamase inhibitors	• Amoxicillin-clavulanate	
First generation cephalosporins	• Cefadroxil • Cefazolin	• Cephalexin
Folate antagonist	• Trimethoprim	
Lincomycin derivatives	• Clindamycin	
Macrolides	• Azithromycin • Clarithromycin • Erythromycin	
Natural penicillins	• Penicillin G potassium • Penicillin G sodium	• Penicillin V potassium • Penicillin G benzathine
Quinolones	• Ciprofloxacin • Levofloxacin	• Moxifloxacin • Ofloxacin
Second generation cephalosporins	• Cefaclor • Cefprozil	• Cefuroxime
Sulfonamides	• Sulfamethoxazole-trimethoprim	
Tetracyclines	• Doxycycline • Minocycline	• Tetracycline
Third generation cephalosporins	• Cefdinir • Cefixime	• Cefpodoxime • Ceftriaxone

(Medications continued)

Appropriate Testing for Pharyngitis (CWP)

Required Exclusion(s)

Exclusion	Timeframe
• Members in hospice or using hospice services • Members who died	- Any time during the measurement year
• HIV • Malignant Neoplasms • Malignant Neoplasms of the Skin • Emphysema • COPD • Disorders of the Immune System	- 12 months prior to or on the episode date

Important Notes

This measure addresses appropriate diagnosis and treatment for pharyngitis with a strep test being completed three days before or three days after the primary diagnosis and prescribed antibiotics.

A pharyngitis diagnosis can be from an outpatient, telephone, e-visit, virtual check-in, observation or emergency department visit between July 1 of the year prior to the measurement year and June 30 of the measurement year.

Medical Record Detail Including, But Not Limited to

- History and physical
- Lab reports
- Progress notes

Tips and Best Practices to Help Close This Care Opportunity

- **Please check your Patient Care Opportunity Report (PCOR) often to see members with open care opportunities.** If you have questions, your UnitedHealthcare representative can help.
- Do not prescribe antibiotics until results of Group A Strep test are received.
- **Always bill using the LOINC codes previously listed with your strep test submission – not local codes.**
- Always use a point of care rapid Group A strep test or throat culture, when appropriate, to confirm diagnosis of pharyngitis before prescribing an antibiotic.
- Lab results can be accepted as supplemental data. Please contact your UnitedHealthcare representative to discuss clinical data exchange opportunities.

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

New for 2023

Updated

- Members who died during the measurement year is now a required exclusion

Definition

Percentage of episodes for members ages 3 months and older with a diagnosis of acute bronchitis/bronchiolitis between July 1 of the year prior to the measurement year through June 30 of the measurement year who were **not** dispensed an antibiotic medication on or 3 days after the episode. A higher rate indicates appropriate treatment (not prescribed an antibiotic).

Plan(s) Affected	Quality Program(s) Affected	Collection and Reporting Method
• Commercial • Exchange/Marketplace • Medicaid • Medicare	• CMS Quality Rating System • NCQA Accreditation • NCQA Health Plan Ratings	**Administrative** • Claim/Encounter Data • Pharmacy Data

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

Medications

To comply with this measure, the following antibiotics should **not** be dispensed upon diagnosis of acute bronchitis:

Drug Category	Medications	
Aminoglycosides	• Amikacin • Gentamicin	• Streptomycin • Tobramycin
Aminopenicillins	• Amoxicillin	• Ampicillin
Beta-lactamase inhibitors	• Amoxicillin-clavulanate • Ampicillin-sulbactam	• Piperacillin-tazobactam
First-generation cephalosporins	• Cefadroxil • Cefazolin	• Cephalexin
Fourth-generation cephalosporins	• Cefepime	
Lincomycin derivatives	• Clindamycin	• Lincomycin
Macrolides	• Azithromycin • Clarithromycin • Erythromycin	
Miscellaneous antibiotics	• Aztreonam • Chloramphenicol • Dalfopristin-quinupristin • Daptomycin	• Linezolid • Metronidazole • Vancomycin
Natural penicillins	• Penicillin G benzathine-procaine • Penicillin G potassium • Penicillin G procaine	• Penicillin G sodium • Penicillin V potassium • Penicillin G benzathine
Penicillinase resistant penicillins	• Dicloxacillin • Nafcillin	• Oxacillin
Quinolones	• Ciprofloxacin • Gemifloxacin • Levofloxacin	• Moxifloxacin • Ofloxacin
Rifamycin derivatives	• Rifampin	

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

Medications (continued)

To comply with this measure, the following antibiotics should not be dispensed upon diagnosis of acute bronchitis:

Drug Category	Medications	
Second-generation cephalosporin	• Cefaclor • Cefotetan • Cefoxitin	• Cefprozil • Cefuroxime
Sulfonamides	• Sulfadiazine	• Sulfamethoxazole-trimethoprim
Tetracyclines	• Doxycycline • Minocycline	• Tetracycline
Third-generation cephalosporins	• Cefdinir • Cefixime • Cefotaxime	• Cefpodoxime • Ceftazidime • Ceftriaxone
Urinary anti-infectives	• Fosfomycin • Nitrofurantoin	• Nitrofurantoin macrocrystals-monohydrate • Trimethoprim

Required Exclusion(s)

Exclusion	Timeframe
• Members in hospice or using hospice services • Members who died	- Any time during the measurement year

Tips and Best Practices to Help Close This Care Opportunity

- **Please check your Patient Care Opportunity Report (PCOR) often to see members with open care opportunities.** If you have questions, your UnitedHealthcare representative can help.
- An episode for bronchitis/bronchiolitis will **not** count toward the measure denominator if the member was diagnosed with one of these conditions within 12 months of the event:
  - Chronic obstructive pulmonary disease (COPD)
  - Disorders of the immune system
  - Emphysema
  - HIV
  - Malignant neoplasms
  - Other malignant neoplasms of the skin
- An episode for bronchitis/bronchiolitis will **not** count toward the measure denominator if the member was diagnosed with either pharyngitis or a competing diagnosis On or 3 days after the episode date

Appropriate Treatment for Upper Respiratory Infection (URI)

New for 2023

Updated

- Members who died during the measurement year is now a required exclusion

Definition

Percentage of episodes for members 3 months and older who were given a diagnosis of upper respiratory infection (URI) between July 1 of the year prior to the measurement year through June 30 of the measurement year and were **not** dispensed an antibiotic prescription on or 3 days after the diagnosis day (4 days total).

Plan(s) Affected	Quality Program(s) Affected	Collection and Reporting Method
• Commercial • Exchange/Marketplace • Medicaid • Medicare	• CMS Quality Rating System • NCQA Accreditation • NCQA Health Plan Ratings	**Administrative** • Claim/Encounter Data • Pharmacy Data

Codes

The following codes can be used to close HEDIS® numerator gaps in care; they are not intended to be a directive of your billing practice.

Upper Respiratory Infection Codes That Do Not Need Antibiotics	
ICD-10 Diagnosis	J00, J06.0, J06.9
SNOMED	43692000, 54398005, 82272006

Appropriate Treatment for Upper Respiratory Infection (URI)

Medications

The following antibiotic medications should **not** be prescribed for an upper respiratory infection:

Drug Category	Medications	
Aminoglycosides	• Amikacin • Gentamicin • Streptomycin • Tobramycin	
Aminopenicillins	• Amoxicillin • Ampicillin	
Beta-lactamase inhibitors	• Amoxicillin-clavulanate • Ampicillin-sulbactam • Piperacillin-tazobactam	
First generation cephalosporins	• Cefadroxil • Cefazolin	• Cephalexin
Fourth generation cephalosporins	• Cefepime	
Lincomycin derivatives	• Clindamycin • Lincomycin	
Macrolides	• Azithromycin • Clarithromycin • Erythromycin	
Miscellaneous antibiotics	• Aztreonam • Chloramphenicol • Dalfopristin-quinupristin • Daptomycin	• Linezolid • Metronidazole • Vancomycin
Natural penicillins	• Penicillin G benzathine-procaine • Penicillin G potassium • Penicillin G procaine	• Penicillin G sodium • Penicillin V potassium • Penicillin G benzathine
Penicillinase-resistant penicillins	• Dicloxacillin • Nafcillin • Oxacillin	

(Medications continued)

Appropriate Treatment for Upper Respiratory Infection (URI)

Medications

The following antibiotic medications should **not** be prescribed for an upper respiratory infection:

Drug Category	Medications	
Quinolones	• Ciprofloxacin • Gemifloxacin • Levofloxacin	• Moxifloxacin • Ofloxacin
Rifamycin derivatives	• Rifampin	
Second generation cephalosporins	• Cefaclor • Cefotetan • Cefoxitin	• Cefprozil • Cefuroxime
Sulfonamides	• Sulfadiazine • Sulfamethoxazole-trimethoprim	
Tetracyclines	• Doxycycline • Minocycline	• Tetracycline
Third generation cephalosporins	• Cefdinir • Cefixime • Cefotaxime	• Cefpodoxime • Ceftazidime • Ceftriaxone
Urinary anti-infectives	• Fosfomycin • Nitrofurantoin • Nitrofurantoin macrocrystals-monohydrate	• Trimethoprim

Appropriate Treatment for Upper Respiratory Infection (URI)

Required Exclusion(s)

Exclusion	Timeframe
• Members in hospice or using hospice services • Members who died	- Any time during the measurement year
Exclude episode dates when the member had a claim with any of the below diagnoses: • HIV • Malignant Neoplasms • Malignant Neoplasms of the Skin • Emphysema • COPD • Disorders of the Immune Systems	- During the 12 months prior to or on the episode date

Important Notes

	Medical Record Detail Including, But Not Limited to
This measure addresses appropriate diagnosis and treatment for upper respiratory infections **without** prescribing an antibiotic. An upper respiratory infection diagnosis can be from an outpatient, telephone, e-visit, virtual check-in, observation or emergency department visit between July 1 of the year prior to the measurement year and June 30 of the measurement year. Members who have a competing diagnosis of pharyngitis on or 3 days after the diagnosis of upper respiratory infection should be excluded.	• History and physical • Progress notes

Tips and Best Practices to Help Close This Care Opportunity

- **Please check your Patient Care Opportunity Report (PCOR) often to see members with open care opportunities.** If you have questions, your UnitedHealthcare representative can help.
- Details on the appropriate treatment of URIs are available at **cdc.gov.**

Statin Therapy for Patients With Cardiovascular Disease (SPC)

New for 2023

Added

- A direct reference code, Z51.5, for an encounter for palliative care
- Frailty exclusion now requires 2 different dates of service during the measurement year

Updated

- Members who died during the measurement year is now a required exclusion

Definition

Percentage of males ages 21–75 and females ages 40–75 during the measurement year who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and met the following criteria:

- **Received statin therapy –** Members who were dispensed at least 1 high- or moderate-intensity statin medication during the measurement year
- **Statin adherence 80% -** Members who remained on a high- or moderate-intensity statin medication for at least 80% of the treatment period.

  - Note: This adherence component does NOT apply to CMS Star Ratings for Medicare members; only the "Received statin therapy" component is required to be compliant for the SPC Star Measure.

SPC inclusion (event, diagnosis or both)	
Event	**Timeframe of event or diagnosis**
Myocardial infraction (MI)	Year prior to the measurement year
Coronary artery bypass graft (CABG)	Year prior to the measurement year
Percutaneous coronary intervention (PCI)	Year prior to the measurement year
Other revascularization	Year prior to the measurement year
Diagnosis	**Timeframe of event or diagnosis**
Ischemic vascular disease (IVD)	Both measurement year and year prior to the measurement year

Important note: The **treatment period** is defined as the earliest prescription dispensing date in the measurement year for any statin medication of at least moderate intensity through the last day of the measurement year.

Plan(s) Affected	Quality Program(s) Affected	Collection and Reporting Method
• Commercial • Medicaid • Medicare	• **CMS Star Ratings – Only includes the sub-measure for "Received Statin Therapy"** • NCQA Accreditation • NCQA Health Plan Ratings	**Administrative** • Claim/Encounter Data • Pharmacy Data

Statin Therapy for Patients With Cardiovascular Disease (SPC) (cont.)

Medications

To comply with this measure, one of the following medications must have been dispensed:

Drug Category	Medications	
High-intensity statin therapy	• Atorvastatin 40–80 mg • Amlodipine-atorvastatin 40–80 mg • Rosuvastatin 20–40 mg	• Simvastatin 80 mg • Ezetimibe-simvastatin 80 mg
Moderate-intensity statin therapy	• Atorvastatin 10–20 mg • Amlodipine-atorvastatin 10–20 mg • Rosuvastatin 5–10 mg • Simvastatin 20–40 mg • Ezetimibe-simvastatin 20–40 mg	• Pravastatin 40–80 mg • Lovastatin 40 mg • Fluvastatin 40–80 mg • Pitavastatin 1–4 mg

Statin Therapy for Patients With Cardiovascular Disease (SPC)

Required Exclusion(s)

Exclusion	Timeframe
• Members in hospice or using hospice services • Members who died • Members receiving palliative care: Z51.5 • Myalgia, myositis, myopathy or rhabdomyolysis diagnosis: G72.0, G72.2, G72.9, M60.80, M60.811, M60.812, M60.819, M60.821, M60.822, M60.829, M60.831, M60.832, M60.839, M60.841, M60.842, M60.849, M60.851, M60.852, M60.859, M60.861, M60.862, M60.869, M60.871, M60.872, M60.879, M60.88, M60.89, M60.9, M62.82, M79.10, M79.11, M79.12, M79.18	Any time during the measurement year
• Cirrhosis: K70.30, K70.31, K71.7, K74.3, K74.4, K74.5, K74.60, K74.69, P78.81 • Dispensed at least one prescription for clomiphene • End Stage Renal Disease (ESRD): I12.0, I13.11, I13.2, N18.5, N18.6, Z99.2 • Dialysis: Z99.2 • Members with a diagnosis of pregnancy: O00.101, O99.019, O99.210, O99.340, O99.810, O99.820, Z33.1, Z34.00, Z34.83, Z34.90, Z34.91, Z34.92, Z34.93 • In vitro fertilization	Any time during the measurement year or the year prior to the measurement year
Members ages 66 and older as of December 31 of the measurement year who had at least 2 diagnoses of frailty on different dates of service **AND** advanced illness.* Advanced illness is indicated by one of the following: • Two or more outpatient, observation, emergency room, telephone, e-visits, virtual check-ins or non-acute inpatient encounters or discharge(s) on separate dates of service with a diagnosis of advanced illness • One or more acute inpatient encounter(s) with a diagnosis of advanced illness • One or more acute inpatient discharge(s) with a diagnosis of advanced illness on the discharge claim • Dispensed a dementia medication: Donepezil, Donepezil-memantine, galantamine, rivastigmine or memantine	**Frailty** diagnoses must be in the measurement year and on different dates of service **Advanced illness** diagnosis must be in the measurement year or year prior to the measurement year
Medicare members ages 66 and older as of Dec. 31 of the measurement year who are either: • Enrolled in an Institutional Special Needs Plan (I-SNP) • Living long term in an institution*	Any time during the measurement year

*** Supplemental and medical record data may not be used for the frailty with advanced illness or institutional living exclusions.**

Statin Therapy for Patients With Cardiovascular Disease (SPC)

Tips and Best Practices to Help Close the "Received Statin Therapy" Care Opportunity for UnitedHealthcare Medicare Advantage Plan Members:

- **Please check your Patient Care Opportunity Report (PCOR) often. Look in the Member Adherence** tab to find members with open care opportunities.
- Log on to Practice Assist to review members with open care opportunities.
  - Select **Medication Adherence** to view your patient list.
  - Members without a high- or moderate-intensity statin fill this year will be marked with a "Gap" under the SPC measure.
- **Importance of taking a statin:** American Heart Association (AHA) and American College of Cardiology (ACC) suggest people with clinical atherosclerotic cardiovascular disease (ASCVD) take a high-intensity statin therapy or maximally tolerated statin therapy.[1] Statins can reduce the risk of heart attack and stroke, even in patients who do not have high cholesterol. Meta analysis with 5 randomized controlled trials have shown that high-intensity statins reduced major vascular events by 15% compared with moderate-intensity statin therapy in patients with clinical ascvd.[2] According to AHA/ACC, the larger the LDL-C reduction, the larger proportional reduction in major vascular events.
- If member has intolerance or side effects such as myalgias, if clinically appropriate consider
  - A different statin that is hydrophilic (e.g., rosuvastatin or pravastatin)
  - A lower dose such as a moderate-intensity dose statin than previously tried
    - Reducing the frequency
- For members who meet exclusion criteria, a claim using appropriate ICD-10 code must be submitted ANNUALLY if applicable
- Only statins satisfy the measure; other cholesterol medications such as ezetimibe or PCSK9 inhibitors do not satisfy the measure
- Consider extended day fills (e.g., 90 or 100 days supply) or send to home delivery
- **Consider prescribing a high- or moderate-intensity statin, as appropriate.** If you determine medication is appropriate, please send a prescription to the member's preferred pharmacy.*
  - To close the SPC care opportunity, a member must use their Part D insurance card to fill one of the statins or statin combinations in the strengths/doses listed in the "Medications" table on the previous page by the end of the measurement year. Prescriptions filled through cash claims, discount programs (such as GoodRx), and medication samples will not close the measure.

Reference:

1) Grundy SM, Stone NJ, Bailey AL, Beam C, Birtcher KK, Blumenthal RS, Braun LT, de Ferranti S, Faiella-Tommasino J, Forman DE, Goldberg R, Heidenreich PA, Hlatky MA, Jones DW, Lloyd-Jones D, Lopez-Pajares N, Ndumele CE, Orringer CE, Peralta CA, Saseen JJ, Smith SC Jr, Sperling L, Virani SS, Yeboah J. 2018 AHA/ACC/AACVPR/AAPA/ABC/ACPM/ADA/AGS/APhA/ASPC/NLA/PCNA Guideline on the Management of Blood Cholesterol: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines. J Am Coll Cardiol. 2019 Jun 25;73(24):e285-e350. doi: 10.1016/j.jacc.2018.11.003. Epub 2018 Nov 10. Erratum in: J Am Coll Cardiol. 2019 Jun 25;73(24):3237-3241. PMID: 30423393.

2) Baigent C, Blackwell L, Emberson J, et al. Efficacy and safety of more intensive lowering of LDL cholesterol: a meta-analysis of data from 170 000 participants in 26 randomised trials.Lancet. 2010; 376:1670 -81.

*Member may use any pharmacy in the network, but may not receive preferred retail pharmacy pricing. Pharmacies in the Preferred Retail Pharmacy Network may not be available in all areas. Co-pays apply after deductible.

Statin Therapy for Patients With Diabetes (SPD)

New for 2023

Added

- A direct reference code, Z51.5, for an encounter for palliative care
- Frailty exclusion now requires 2 different dates of service during the measurement year

Updated

- Members who died during the measurement year is now a required exclusion
- Polycystic ovarian syndrome, gestational diabetes or steroid-induced diabetes are now required exclusions

Definition

Percentage of members ages 40–75 during the measurement year with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) who met the following criteria:

- **Received statin therapy –** Members who were dispensed at least 1 statin medication of any intensity during the measurement year
- **Statin adherence 80% –** Members who remained on a statin medication of any intensity for at least 80% of the treatment period

Important note: The **treatment period** is defined as the earliest prescription dispensing date in the measurement year for any statin medication at any intensity through the last day of the measurement year.

Plan(s) Affected	Quality Program(s) Affected	Collection and Reporting Method
• Commercial • Medicaid • Medicare	• NCQA Accreditation • NCQA Health Plan Ratings	**Administrative** • Claim/Encounter Data • Pharmacy Data

Statin Therapy for Patients With Diabetes (SPD)

Medications

To comply with this measure, one of the following medications must have been dispensed:

Drug Category	Medications	
High-intensity statin therapy	• Amlodipine-atorvastatin 40–80 mg* • Atorvastatin 40–80 mg • Ezetimibe-simvastatin 80 mg**	• Rosuvastatin 20–40 mg • Simvastatin 80 mg
Moderate-intensity statin therapy	• Amlodipine-atorvastatin 10–20 mg* • Atorvastatin 10–20 mg • Ezetimibe-simvastatin 20–40 mg** • Fluvastatin 40–80 mg • Lovastatin 40 mg	• Pitavastatin 1–4 mg • Pravastatin 40–80 mg • Rosuvastatin 5–10 mg • Simvastatin 20–40 mg
Low-intensity statin therapy	• Ezetimibe-simvastatin 10 mg** • Fluvastatin 20 mg • Lovastatin 10–20 mg	• Pravastatin 10–20 mg • Simvastatin 5–10 mg

*The 10–80 mg is referring to atorvastatin strength.
**The 10–80 mg is referring to simvastatin strength.

Statin Therapy for Patients With Diabetes (SPD)

Required Exclusion(s)

Exclusion	Timeframe
• Members in hospice or using hospice services • Members who died • Members receiving palliative care • Myalgia, myositis, myopathy or rhabdomyolysis diagnosis • Medicare members ages 66 and older as of Dec. 31 of the measurement year who are either: – Enrolled in an Institutional Special Needs Plan (I-SNP) – Living long term in an institution*	Any time during the measurement year
Members ages 66 and older as of Dec. 31 of the measurement year who had a at least 2 diagnoses of frailty on different dates of service and advanced illness.* Advanced illness is indicated by one of the following: • Two or more outpatient, observation, emergency room, telephone, e-visits, virtual check-ins or non-acute inpatient encounters or discharge(s)on separate dates of service with a diagnosis of advanced illness • One or more acute inpatient encounter(s) with a diagnosis of advanced illness • One or more acute inpatient discharge(s) with a diagnosis of advanced illness on the discharge claim • Dispensed a dementia medication: Donepezil, Donepezil-memantine, galantamine, rivastigmine or memantine	**Frailty** diagnoses must be in the measurement year and on different dates of service **Advanced illness** diagnosis must be in the measurement year or year prior to the measurement year
• Cirrhosis: K70.30, K70.31, K71.7, K74.3, K74.4, K74.5, K74.60, K74.69, P78.81 • Dispensed at least one prescription for clomiphene • End Stage Renal Disease (ESDR): N18.5, N18.6, Z99.2 • Dialysis • Members with a diagnosis of pregnancy • In vitro fertilization • Members without a diagnosis of diabetes who had a diagnosis of polycystic ovarian syndrome, gestational diabetes or steroid-induced diabetes	Any time during the measurement year or the year prior to the measurement year
• Coronary artery bypass grafting (CABG) • Myocardial infarction • Other revascularization procedure • Percutaneous coronary intervention (PCI)	Any time during the year prior to the measurement year
A diagnosis of ischemic vascular disease (IVD) via outpatient visit, telephone visit, e-visit or virtual check-in, acute inpatient encounter without telehealth modifier or acute inpatient discharge	Any time during the year prior to the measurement year and the measurement year (must be in both years)

***Supplemental and medical record data may not be used for the frailty with advanced illness exclusion.**

Statin Therapy for Patients With Diabetes (SPD)

Tips and Best Practices to Help Close This Care Opportunity:

- **Please check your Patient Care Opportunity Report (PCOR) often. Look in the Member Adherence tab** to find members with open care opportunities.
- Log on to Practice Assist to review members with open care opportunities.
  - Select Medication Adherence to view your patient list.
  - Members without a high- or moderate-intensity statin fill this year will be marked with a “Gap” under the SPD measure.
- **Consider prescribing a high- or moderate-intensity statin, as appropriate.** If you determine medication is appropriate, please send a prescription to the member’s preferred pharmacy.*
  - To address the SPD care opportunity, a member must use their insurance card to fill one of the statins or statin combinations in the strengths/doses listed in the “Medications” table on the previous page by the end of the measurement year.

*Member may use any pharmacy in the network, but may not receive preferred retail pharmacy pricing. Pharmacies in the Preferred Retail Pharmacy Network may not be available in all areas. Co-pays apply after deductible.

Use of Opioids at High Dosage (HDO)

New for 2023

Added

- A direct reference code, Z51.5, for an encounter for palliative care

Updated

- Members who died during the measurement year is now a required exclusion
- Measure reported as a percentage, not a proportion

Yes!
Supplemental Data Accepted for required exclusions only.

Definition

Percentage of members ages 18 and older receiving prescription opioids for ≥ 15 days during the measurement year at a high dosage (average milligram morphine equivalent [MME] dose ≥ 90 mg).

A lower rate indicates a better score for this measure.

Plan(s) Affected	Quality Program(s) Affected	Collection and Reporting Method
• Commercial • Medicaid • Medicare	• NCQA Accreditation • NCQA Health Plan Ratings	**Administrative** • Claim/Encounter • Pharmacy Data

Medications

To be included in this measure, a member must have been prescribed one of the following opioid medications at an average MME ≥ 90 mg for ≥ 15 days:

Opioid Medications

- Benzhydrocodone
- Butorphanol
- Codeine
- Dihydrocodeine
- Fentanyl oral spray
- Fentanyl buccal or sublingual tablet, transmucosal lozenge
- Fentanyl transdermal film/patch
- Fentanyl nasal spray
- Hydrocodone
- Hydromorphone
- Levorphanol
- Meperidine
- Methadone
- Morphine
- Opium
- Oxycodone
- Oxymorphone
- Pentazocine
- Tapentadol
- Tramadol

These medications are not included as dispensing events for this measure:

- Cough and cold products with opioids
- Injectables
- Ionsys®
  - Fentanyl transdermal patch used in inpatient settings only
- Methadone for the treatment of opioid use disorder

Use of Opioids at High Dosage (HDO)

Required Exclusion(s)

Exclusion	Timeframe
• Members in hospice or using hospice services • Members who died • Cancer • Sickle cell disease • Members receiving palliative care	Any time during the measurement year

Tips and Best Practices to Help Close This Care Opportunity

This measure focuses on using low dosage for opioids.

- For treatment of acute pain using opioids, the guidelines recommend immediate-release opioids be used at a dosage as low as possible and for as few days as needed.
- For treatment of chronic pain, guidelines recommend clinicians consider non-pharmacologic and non-opioid therapies first, and only in cases where the benefits outweigh the risks, initiation of opioid therapy.
- UnitedHealthcare is committed to working with care providers to help:
  - **Prevent** opioid misuse and addiction.
  - **Treat** those who are addicted.
  - **Support** long-term recovery.

  For more information about our programs to help prevent opioid overuse, please visit **UHCprovider.com** > Resource Library > Drug Lists and Pharmacy > Opioid Programs and Resources.
- Information to help you stay informed about the latest opioid research and guidelines is also available at **cdc.gov, hhs.gov** or your state's public health department website. Here are a few suggestions to get you started:
  - **Prevention**
    - Centers for Disease Control and Prevention (CDC) Guideline for Prescribing Opioids for Chronic Pain available at: **cdc.gov >** CDC A - Z INDEX > D > Drug Overdose (OD) > Healthcare Providers > CDC's opioid prescribing guideline for chronic pain
    - U.S. Department of Health & Human Services (HHS) Prevent Opioid Abuse and Addiction available at: **hhs.gov/opioids >** Prevention
  - **Treatment**
    - Substance Abuse and Mental Health Services Administration (SAMHSA) Medication-Assisted Treatment (MAT) available at: **samhsa.gov >** Programs & Campaigns > Medication-Assisted Treatment
    - National Institute on Drug Abuse (NIDA) Effective Treatments for Opioid Addiction available at: **drugabuse.gov >** Drugs of Abuse > Opioids > Effective Treatments for Opioid Addiction
    - HHS Treatment for Opioid Use Disorder available at: **hhs.gov/opioids >** Treatment
    - American Society of Addiction Medicine (ASAM) Educational Resources available at: **asam.org >** Education > Educational Resources
  - **Recovery**
    - In-network MAT care provider search for UnitedHealthcare plan members available at: **provider.liveandworkwell.com**
      - To start a search, enter your ZIP code, then "Select an Area of Expertise." Choose "Substance Use Disorder" and "Search."
  - **Harm Reduction**
    - Harm Reduction Coalition Prescribe Naloxone! available at: **harmreduction.org >** Issues > Overdose Prevention > Prescribe Naloxone! Recent Resources
    - SAMHSA Opioid Overdose Preventive Toolkit available at: **samhsa.gov >** Publications > Substances > Opioids or Opiates > Opioid Overdose Prevention Toolkit (SMA16-4742)

Use of Opioids From Multiple Providers (UOP)

New for 2023

Updated

- Members who died during the measurement year is now a required exclusion
- Measure reported as a percentage, not a proportion

Yes!
Supplemental Data Accepted for required exclusions only.

Definition

Percentage of members ages 18 and older receiving prescription opioids for ≥ 15 days during the measurement year who received opioids from multiple providers.

Three rates are reported:

1. **Multiple Prescribers –** Percentage of members receiving prescriptions for opioids from 4 or more different prescribers during the measurement year.
2. **Multiple Pharmacies –** Percentage of members receiving prescriptions for opioids from 4 or more different pharmacies during the measurement year
3. **Multiple Prescribers and Multiple Pharmacies –** Percentage of members receiving prescriptions for opioids from 4 or more different prescribers **and** 4 or more different pharmacies during the measurement year

Plan(s) Affected	Quality Program(s) Affected	Collection and Reporting Method
• Commercial • Medicaid • Medicare	• NCQA Accreditation • NCQA Health Plan Ratings	**Administrative** • Claim/Encounter • Pharmacy Data

Use of Opioids From Multiple Providers (UOP)

Medications

To be included in this measure, a member must have met both of the following criteria in the measurement year:

- 2 or more dispensing events on different dates of service for the following opioid medications, **and**
- ≥ 15 days covered by an opioid prescription

Opioid Medications			
• Benzhydrocodone • Buprenorphine (transdermal patch and buccal film) • Butorphanol	• Codeine • Dihydrocodeine • Fentanyl • Hydrocodone • Hydromorphone	• Levorphanol • Meperidine • Methadone • Morphine • Opium	• Oxycodone • Oxymorphone • Pentazocine • Tapentadol • Tramadol

These medications are not included as dispensing events for this measure:

- Cough and cold products with opioids
- Injectables
- Ionsys®
  - Fentanyl transdermal patch used in inpatient settings only
- Methadone for the treatment of opioid use disorder
- Single-agent and combination buprenorphine products used as part of medication assisted treatment of opioid use disorder
  - Buprenorphine sublingual tablets
  - Buprenorphine subcutaneous implant
  - Buprenorphine/naloxone combination products

Required Exclusion(s)

Exclusion	Timeframe
• Members in hospice or using hospice services • Members who died	- Any time during the measurement year

Use of Opioids From Multiple Providers (UOP)

Tips and Best Practices to Help Close This Care Opportunity

This measure focuses on taking caution with patients using multiple pharmacies and/or prescribers.

- Evidence suggests people who see multiple prescribers and use multiple pharmacies are at higher risk of overdose.
- UnitedHealthcare is committed to working with care providers to help:
  - **Prevent** opioid misuse and addiction.
  - **Treat** those who are addicted.
  - **Support** long-term recovery.

  For more information about our programs to help prevent opioid overuse, please visit **UHCprovider.com** > Resource Library > Drug Lists and Pharmacy > Opioid Programs and Resources.
- Information to help you stay informed about the latest opioid research and guidelines is also available at **cdc.gov, hhs.gov** or your state's public health department website. Here are a few suggestions to get you started:
  - **Prevention**
    - Centers for Disease Control and Prevention (CDC) Guideline for Prescribing Opioids for Chronic Pain available at: **cdc.gov >** CDC A - Z INDEX > D > Drug Overdose (OD) > Healthcare Providers > CDC's opioid prescribing guideline for chronic pain
    - U.S. Department of Health & Human Services (HHS) Prevent Opioid Abuse and Addiction available at: **hhs.gov/opioids >** Prevention
  - **Treatment**
    - Substance Abuse and Mental Health Services Administration (SAMHSA) Medication-Assisted Treatment (MAT) available at: **samhsa.gov >** Programs & Campaigns > Medication-Assisted Treatment
    - National Institute on Drug Abuse (NIDA) Effective Treatments for Opioid Addiction available at: **drugabuse.gov >** Drugs of Abuse > Opioids > Effective Treatments for Opioid Addiction
    - HHS Treatment for Opioid Use Disorder available at: **hhs.gov/opioids >** Treatment
    - American Society of Addiction Medicine (ASAM) Educational Resources available at: **asam.org >** Education > Educational Resources
  - **Recovery**
    - In-network MAT care provider search for UnitedHealthcare plan members available at: **provider.liveandworkwell.com**
      - To start a search, enter your ZIP code, then "Select an Area of Expertise." Choose "Substance Use Disorder" and "Search."
  - **Harm Reduction**
    - Harm Reduction Coalition Prescribe Naloxone! available at: **harmreduction.org >** Issues > Overdose Prevention > Prescribe Naloxone! Recent Resources
    - SAMHSA Opioid Overdose Preventive Toolkit available at: **samhsa.gov >** Publications > Substances > Opioids or Opiates > Opioid Overdose Prevention Toolkit (SMA16-4742)

Pharmacotherapy for Opioid Use Disorder (POD)

New for 2023

Added

- Rates will now include stratification by race and ethnicity

Updated

- Members who died during the measurement year is now a required exclusion
- Members must meet the lower age limit for the measure, 16, as of the Treatment Period Start Date: the treatment period start date is the date of the opioid use disorder dispensing event or medication administration

Yes!
Supplemental Data Accepted for required exclusions only.

Definition

Percentage of new opioid use disorder pharmacotherapy events that lasted at least 180 days among members 16 years of age and older with a diagnosis of opioid use disorder and a new opioid use disorder pharmacotherapy event.

Plan(s) Affected	Quality Program(s) Affected	Collection and Reporting Method
• Commercial • Medicaid • Medicare	• NCQA Accreditation • NCQA Health Plan Ratings	**Administrative** • Claim/Encounter • Pharmacy Data

Medications

To be included in this measure, a member must have been dispensed one of the following opioid medications:

Drug Category	Medications
Antagonist	• Naltrexone (oral or injectable)
Partial agonist	• Buprenorphine (sublingual tablet, injection, implant)
Partial agonist	• Buprenorphine/naloxone (sublingual tablet, buccal film, sublingual film)
Agonist	• Methadone (oral)

Methadone is not included on the medication lists for this measure because a pharmacy claim for methadone indicates treatment for pain and not opioid use disorder.

Required Exclusion(s)

Exclusion	Timeframe
Any acute or nonacute inpatient stay of 8 or more days	180-day period beginning on the day of the opioid use disorder dispensing event through 179 days after
• Members in hospice or using hospice services • Members who died	- Any time during the measurement year

Pharmacotherapy for Opioid Use Disorder (POD)

Tips and Best Practices to Help Close This Care Opportunity

This measure focuses on treatment for members with opioid use disorder.

- Evidence suggests that people who see multiple prescribers and use multiple pharmacies are at higher risk of overdose.
- UnitedHealthcare is committed to working with care providers to help:
  - **Prevent** opioid misuse and addiction.
  - **Treat** those who are addicted.
  - **Support** long-term recovery.

  For more information about our programs to help prevent opioid overuse, please visit **UHCprovider.com >** Menu > Resource Library > Drug Lists and Pharmacy > Opioid Programs and Resources.
- Information to help you stay informed about the latest opioid research and guidelines is also available at **cdc.gov, hhs.gov** or your state's public health department website. Here are a few suggestions to get you started:
  - **Prevention**
    - Centers for Disease Control and Prevention (CDC) Guideline for Prescribing Opioids for Chronic Pain available at: **cdc.gov >** CDC A - Z INDEX > D > Drug Overdose (OD) > Healthcare Providers > CDC's opioid prescribing guideline for chronic pain
    - U.S. Department of Health & Human Services (HHS) Prevent Opioid Abuse and Addiction available at: **hhs.gov/opioids >** Prevention
  - **Treatment**
    - Substance Abuse and Mental Health Services Administration (SAMHSA) Medication-Assisted Treatment (MAT) available at: **samhsa.gov >** Programs & Campaigns > Medication-Assisted Treatment
    - National Institute on Drug Abuse (NIDA) Effective Treatments for Opioid Addiction available at: **drugabuse.gov >** Drugs of Abuse > Opioids > Effective Treatments for Opioid Addiction
    - HHS Treatment for Opioid Use Disorder available at: **hhs.gov/opioids >** Treatment
    - American Society of Addiction Medicine (ASAM) Educational Resources available at: **asam.org >** Education > Educational Resources
  - **Recovery**
    - In-network MAT care provider search for UnitedHealthcare plan members available at: **provider.liveandworkwell.com**
      - To start a search, enter your ZIP code, then "Select an Area of Expertise." Choose "Substance Use Disorder" and "Search."
  - **Harm Reduction**
    - Harm Reduction Coalition Prescribe Naloxone! available at: **harmreduction.org >** Issues > Overdose Prevention > Prescribe Naloxone! Recent Resources
    - SAMHSA Opioid Overdose Preventive Toolkit available at: **samhsa.gov >** Publications > Substances > Opioids or Opiates > Opioid Overdose Prevention Toolkit (SMA16-4742)
    - Sharing member demographic data is critical to understanding the cultural, linguistic and social needs of those we serve and decreasing health inequities across the care continuum. This data can include, but is not limited to, race, ethnicity, language, sexual orientation, gender identity, pronouns, sex assigned at birth and disability status. As part of UnitedHealthcare's clinical structured data exchange program, we encourage you to include this demographic data with any structured data file or CCD. Your information is confidential. UnitedHealthcare will keep personally identifiable information confidential and won't disclose any information without your written consent.

Risk of Continued Opioid Use (COU)

New for 2023

Added

- A direct reference code, Z51.5, for an encounter for palliative care **Updated**
- Members who died during the measurement year is now a required exclusion

Yes!
Supplemental Data Accepted for required exclusions only.

Definition

Percentage of members ages 18 and older with a new episode of opioid use that puts them at risk for continued use.

Two rates are reported:

- The percentage of members with at least 15 days of prescription opioids in a 30-day period.
- The Percentage of members with at least 31 days of prescription opioids in a 62-day period.

A lower rate indicates a better score for this measure.

Plan(s) Affected	Quality Program(s) Affected	Collection and Reporting Method
• Commercial • Medicaid • Medicare	• NCQA Accreditation • NCQA Health Plan Ratings	**Administrative** • Claim/Encounter • Pharmacy Data

Medications

To be included in this measure, a member must have been dispensed one of the following opioid medications:

Opioid Medications

- Benzhydrocodone
- Buprenorphine (transdermal patch and buccal film)
- Butorphanol
- Codeine
- Dihydrocodeine
- Fentanyl
- Hydrocodone
- Hydromorphone
- Levorphanol
- Meperidine
- Methadone
- Morphine
- Opium
- Oxycodone
- Oxymorphone
- Pentazocine
- Tapentadol
- Tramadol

These medications are not included as dispensing events for this measure:

- Cough and cold products with opioids
- Injectables
- Ionsys®
  - Fentanyl transdermal patch used in inpatient settings only
- Methadone for the treatment of opioid use disorder
- Single-agent and combination buprenorphine products used as part of medication assisted treatment of opioid use disorder
  - Buprenorphine sublingual tablets
  - Buprenorphine subcutaneous implant
  - Buprenorphine/naloxone combination products

Risk of Continued Opioid Use (COU)

Required Exclusion(s)

Exclusion	Timeframe
• Members in hospice or using hospice services • Members who died	– Any time during the measurement year
• Cancer • Sickle cell disease • Members receiving palliative care	Any time during the 12 months prior to the index prescription start date through 61 days after

Tips and Best Practices to Help Close This Care Opportunity

This measure focuses on taking caution with patients with a new prescription for opioids.

- Evidence suggests that people who see multiple prescribers and use multiple pharmacies are at higher risk of overdose.
- UnitedHealthcare is committed to working with care providers to help:
  - **Prevent** opioid misuse and addiction.
  - **Treat** those who are addicted.
  - **Support** long-term recovery.

  For more information about our programs to help prevent opioid overuse, please visit **UHCprovider.com >** Menu > Resource Library > Drug Lists and Pharmacy > Opioid Programs and Resources.
- Information to help you stay informed about the latest opioid research and guidelines is also available at **cdc.gov, hhs.gov** or your state's public health department website. Here are a few suggestions to get you started:
  - **Prevention**
    - Centers for Disease Control and Prevention (CDC) Guideline for Prescribing Opioids for Chronic Pain available at: **cdc.gov >** CDC A - Z INDEX > D > Drug Overdose (OD) > Healthcare Providers > CDC's opioid prescribing guideline for chronic pain
    - U.S. Department of Health & Human Services (HHS) Prevent Opioid Abuse and Addiction available at: **hhs.gov/opioids >** Prevention
  - **Treatment**
    - Substance Abuse and Mental Health Services Administration (SAMHSA) Medication-Assisted Treatment (MAT) available at: **samhsa.gov >** Programs & Campaigns > Medication-Assisted Treatment
    - National Institute on Drug Abuse (NIDA) Effective Treatments for Opioid Addiction available at: **drugabuse.gov >** Drugs of Abuse > Opioids > Effective Treatments for Opioid Addiction
    - HHS Treatment for Opioid Use Disorder available at: **hhs.gov/opioids >** Treatment
    - American Society of Addiction Medicine (ASAM) Educational Resources available at: **asam.org >** Education > Educational Resources
  - **Recovery**
    - In-network MAT care provider search for UnitedHealthcare plan members available at: **provider.liveandworkwell.com**
      - To start a search, enter your ZIP code, then "Select an Area of Expertise." Choose "Substance Use Disorder" and "Search."
  - **Harm Reduction**
    - Harm Reduction Coalition Prescribe Naloxone! available at: **harmreduction.org >** Issues > Overdose Prevention > Prescribe Naloxone! Recent Resources
    - SAMHSA Opioid Overdose Preventive Toolkit available at: **samhsa.gov >** Publications > Substances > Opioids or Opiates > Opioid Overdose Prevention Toolkit (SMA16-4742)

Childhood Immunization Status (CIS and CIS-E)

New for 2023

Updated

- Members who died during the measurement year is now a required exclusion
- Seropositive test results are no longer part of the hybrid numerator criteria

This measure is also an ECDS measure

Yes!
Supplemental Data Accepted

Definition

Percentage of children age 2 who had 4 doses of diphtheria, tetanus and a cellular pertussis (DTaP) vaccine; 1 hepatitis A (Hep A) vaccine; 3 doses of hepatitis B (Hep B) vaccine; 3 doses of haemophilus influenza type B (HiB) vaccine; 2 doses of influenza (flu) vaccine; 3 doses of polio (IPV) vaccine; 1 measles, mumps and rubella (MMR) vaccine;4 doses of pneumococcal conjugate (PCV) vaccine; 2 or 3 doses of rotavirus (RV) vaccine; and 1 chicken pox (VZV) vaccine on or before their second birthday

Plan(s) Affected	Quality Program(s) Affected	Collection and Reporting Method
• Commercial • Exchange/Marketplace • Medicaid	• CMS Quality Rating System (Combination 10) • NCQA Health Plan Ratings (Combination 10)	**Hybrid** • Claim/Encounter Data • Medical Record Documentation

Codes

The following codes can be used to close HEDIS® numerator gaps in care; they are not intended to be a directive of your billing practice.

DTaP Vaccine
Number of Doses: 4
Special Circumstances

- Do not count dose administered from birth through 42 days.
- If applicable, anaphylaxis or encephalitis due to vaccine and the date it occurred must be documented in the medical record to count toward the numerator using hybrid specifications.

CPT®/CPT II	90697, 90698, 90700, 90723
CVX Codes	20, 50, 106, 107, 110, 120, 146
SNOMED	310306005, 310307001, 310308006, 312870000, 313383003, 390846000, 390865008, 399014008, 412755006, 412756007, 412757003, 412762002, 412763007, 412764001, 414001002, 414259000, 414620004, 415507003, 415712004, 770608009, 770616000, 770617009, 770618004, 787436003, 866158005, 866159002, 866226006, 868273007, 868274001, 868276004, 868277008, 1162640003, 428251000124104, 571571000119105, 572561000119108, 16290681000119103

Anaphylaxis due to the diphtheria, tetanus or pertussis vaccine

SNOMED	428281000124107, 428291000124105

Encephalitis due to the diphtheria, tetanus or pertussis vaccine

SNOMED	192710009, 192711008, 192712001

Childhood Immunization Status (CIS and CIS-E)

Codes (continued)

The following codes can be used to close HEDIS® numerator gaps in care; they are not intended to be a directive of your billing practice.

Hep A Vaccine or History of Hepatitis A Illness
Number of Doses: 1
Special Circumstances

- Must be administered on or between a child's first and second birthdays
- If applicable, anaphylaxis due to vaccine and the date it occurred must be documented in the medical record tocount toward the numerator using hybrid specifications

CPT®/CPT II	90633
CVX Codes	31, 83, 85
SNOMED	170378007, 170379004, 170380001, 170381002, 170434002, 170435001, 170436000, 170437009, 243789007, 312868009, 314177003, 314178008, 314179000, 394691002, 871752004, 871753009, 871754003, 571511000119102

History of Hepatitis A

ICD-10 Diagnosis	B15.0, B15.9

Anaphylaxis due to the hepatitis A vaccine

SNOMED	471311000124103

Hep B Vaccine, History of Hepatitis B Illness
Number of Doses: 3
Special Circumstances

- One of the 3 can be the newborn Hepatitis B vaccine given at hospital on date of birth or 7 days after (see code below)
- If applicable, anaphylaxis due to vaccine and the date it occurred must be documented in the medical record to count toward the numerator using hybrid specifications.

CPT®/CPT II	90697, 90723, 90740, 90744, 90747, 90748
CVX Codes	08, 44, 45, 51, 110, 146
HCPCS	G0010
SNOMED	16584000, 170370000, 170371001, 170372008, 170373003, 170374009, 170375005, 170434002, 170435001, 170436000, 170437009, 312868009, 396456003, 416923003, 770608009, 770616000, 770617009, 770618004, 786846001, 1162640003, 572561000119108

Newborn Hep B
Number of Doses: 1 of 3 eligible

ICD-10 Procedure	3E0234Z

(Codes continued)

Childhood Immunization Status (CIS and CIS-E)

Codes (continued)

The following codes can be used to close HEDIS® numerator gaps in care; they are not intended to be a directive of your billing practice.

History of Hepatitis B	
ICD-10 Diagnosis	B16.0, B16.1, B16.2, B16.9, B17.0, B18.0, B18.1, B19.10, B19.11
SNOMED	153091000119109, 551621000124109
Anaphylaxis due to the hepatitis B vaccine	
SNOMED	1428321000124101
HiB Vaccine **Number of Doses: 3** **Special Circumstances** • Do not count dose administered from birth through 42 days. • If applicable, anaphylaxis due to vaccine and the date it occurred must be documented in the medical record to count toward the numerator using hybrid specifications.	
CPT®/CPT II	90644, 90647, 90648, 90697, 90698, 90748
CVX Codes	17, 46, 47, 48, 49, 50, 51, 120, 146, 148
Anaphylaxis due to the haemophilus B vaccine	
SNOMED	433621000124101
Influenza Vaccine **Number of Doses: 2** **Special Circumstances** • Do not count dose administered prior to 180 days after birth. • If applicable, anaphylaxis due to vaccine and the date it occurred must be documented in the medical record tocount toward the numerator using the hybrid specifications.	
CPT®/CPT II	90655, 90657, 90661, 90673, 90674, 90685, 90686, 90687, 90688, 90689, 90756
CVX Codes	88, 140, 141, 150, 153, 155, 158, 161, 171, 186
HCPCS	G0008
SNOMED	86198006
Anaphylaxis due to the influenza vaccine on or before the child's second birthday	
SNOMED	433621000124101

(Codes continued)

Childhood Immunization Status (CIS and CIS-E)

Codes

The following codes can be used to close HEDIS® numerator gaps in care; they are not intended to be a directive of your billing practice.

Live Attenuated Influenza Virus
Number of Doses: 2
Special Circumstances
- Must be administered on the second birthday.
- Only 1 of the 2 required vaccinations can be LAIV.

CPT®/CPT II	90660, 90672
CVX Codes	111, 149
SNOMED	787016008

IPV Vaccine
Number of Doses: 3
Special Circumstances
- Do not count dose administered from birth through 42 days.
- If applicable, anaphylaxis due to vaccine and the date it occurred must be documented in the medical record to count toward the numerator using the hybrid specifications.

CPT®/CPT II	90697, 90698, 90713, 90723
CVX Codes	10, 89, 110, 120, 146
SNOMED	1310306005, 310307001, 310308006, 312869001, 312870000, 313383003, 390865008, 396456003, 412762002, 412763007, 412764001, 414001002, 414259000, 414619005, 414620004, 415507003, 415712004, 416144004, 416591003, 417211006, 417384007, 417615007, 866186002, 866227002, 868266002, 868267006, 868268001, 868273007, 868274001, 868276004, 868277008, 870670004, 572561000119108, 16290681000119103

Anaphylaxis due to the inactivated polio vaccine

SNOMED	471321000124106

MMR Vaccine or History of Measles, Mumps or Rubella
Number of Doses: 1
Special Circumstances
- Must be administered on or between a child's first and second birthdays.
- If applicable, anaphylaxis due to vaccine and the date it occurred must be documented in the medical record tocount toward the numerator using the hybrid specifications.

CPT®/CPT II	90707, 90710
CVX Codes	03, 94
SNOMED	38598009, 170431005, 170432003, 170433008, 432636005, 433733003, 871909005, 571591000119106, 572511000119105

(Codes continued)

Childhood Immunization Status (CIS and CIS-E)

Codes

The following codes can be used to close HEDIS® numerator gaps in care; they are not intended to be a directive of your billing practice.

Anaphylaxis due to the measles, mumps and rubella vaccine on or before the child's second birthday	
SNOMED	471331000124109

History of Measles	
ICD-10 Diagnosis	B05.0, B05.1, B05.2, B05.3, B05.4, B05.81, B05.89, B05.9
SNOMED	14189004, 28463004, 38921001, 60013002, 74918002, 111873003, 161419000, 186561002, 186562009, 195900001, 240483006, 240484000, 359686005, 371111005, 406592004, 417145006, 424306000, 105841000119101

History of Mumps	
ICD-10 Diagnosis	B26.0, B26.1, B26.2, B26.3, B26.81, B26.82, B26.83, B26.84, B26.85, B26.89, B26.9
SNOMED	10665004, 17121006, 31524007, 31646008, 36989005, 40099009, 44201003, 63462008, 72071001, 74717002, 75548002, 78580004, 89231008, 89764009, 111870000, 161420006, 235123001, 236771002, 237443002, 240526004, 240527008, 240529006, 371112003, 1163539003, 105821000119107

History of Rubella	
ICD-10 Diagnosis	B06.00, B06.01, B06.02, B06.09, B06.81, B06.82, B06.89, B06.9
SNOMED	10082001, 13225007, 19431000, 36653000, 51490003, 64190005, 79303006, 128191000, 161421005, 165792000, 186567003, 186570004, 192689006, 231985001, 232312000, 240485004, 253227001, 406112006, 406113001, 1092361000119109, 10759761000119100

PCV Vaccine
Number of Doses: 4
Special Circumstances

- Do not count dose administered from birth through 42 days.
- If applicable, anaphylaxis due to vaccine and the date it occurred must be documented in the medical record to count toward the numerator using the hybrid specifications.

CPT®/CPT II	90670
CVX Codes	109, 133, 152
HCPCS	G0009
SNOMED	1119368005, 434751000124102

(Codes continued)

Childhood Immunization Status (CIS and CIS-E)

Codes

The following codes can be used to close HEDIS® numerator gaps in care; they are not intended to be a directive of your billing practice.

Anaphylaxis due to the pneumococcal conjugate vaccine	
SNOMED	471141000124102

Rotavirus Vaccine **Number of Doses: 2 or 3 (depending on vaccine manufacturer)** **Special Circumstances** • Do not count dose administered from birth through 42 days. • Can combine at least 1 dose of the 2-dose vaccine and at least 2 doses of the 3-dose vaccine. • If applicable, anaphylaxis due to vaccine and the date it occurred must be documented in the medical record to count toward the numerator using the hybrid specifications.	
CPT®/CPT II	Rotavirus 2 dose: 90681, Rotavirus 3 dose: 90680
CVX Codes	Rotavirus 2 dose: 119, Rotavirus 3 dose: 116, 122
SNOMED	Rotavirus 2 does: 434741000124104, Rotavirus 3 dose: 434731000124109

Anaphylaxis due to the rotavirus vaccine	
SNOMED	428331000124103

VZV Vaccine or History of Varicella Zoster **Number of Doses: 1** **Special Circumstances** • Must be administered on or between a child's first and second birthdays.	
CPT®/CPT II	90710, 90716
CVX Codes	21, 94

Anaphylaxis due to the varicella vaccine on or before the child's second birthday	
SNOMED	471141000124102

Childhood Immunization Status (CIS and CIS-E)

Codes

The following codes can be used to close HEDIS® numerator gaps in care; they are not intended to be a directive of your billing practice.

History of Varicella Zoster	
ICD-10 Diagnosis	B01.0, B01.11, B01.12, B01.2, B01.81, B01.89, B01.9, B02.0, B02.1, B02.21, B02.22, B02.23, B02.24, B02.29, B02.30, B02.31, B02.32, B02.33, B02.34, B02.39, B02.7, B02.8, B02.9
SNOMED	10698009, 21954000, 23737006, 24059009, 36292003, 38907003, 42448002, 49183009, 55560002, 87513003, 111859007, 111861003, 161423008, 186524006, 186525007, 195911009, 230176008, 230198004, 230262004, 230536009, 232400003, 235059009, 240468001, 240470005, 240471009, 240472002, 240473007, 240474001, 309465005, 371113008, 397573005, 400020001, 402897003, 402898008, 402899000, 410500004, 410509003, 421029004, 422127002, 422446008, 422471006, 422666006, 423333008, 423628002, 424353002, 424435009, 424801004, 424941009, 425356002, 426570007, 428633000, 713250002, 713733003, 713964006, 715223009, 723109003, 838357005, 1163465001, 1163483009, 1179456002, 12551000132107, 12561000132105, 12571000132104, 98541000119101, 331071000119101, 681221000119108, 1087131000119102, 15678761000119105, 15678801000119102, 15678841000119100, 15680201000119106, 15680241000119108, 15680281000119103, 15685081000119102, 15685121000119100, 15685201000119100, 15685281000119108, 15936581000119108, 15936621000119108, 15989271000119107, 15989311000119107, 15989351000119108, 15991711000119108, 15991751000119109, 15991791000119104, 15992351000119104, 16000751000119105, 16000791000119100, 16000831000119106

Required Exclusion(s)

Exclusion	Timeframe
• Members in hospice or using hospice services • Members who died	Any time during the measurement year
• Immunodeficiency • HIV • Lymphoreticular cancer, multiple myeloma or leukemia • Intussusception • Severe combined immunodeficiency	Any time on or before a member's second birthday

Childhood Immunization Status (CIS and CIS-E)

Important Notes

	Medical Record Detail Including, But Not Limited to
A member's medical record must include: • A note with the **name of the specific antigen and the date** the vaccine was administered. • An immunization record from an authorized health care provider or agency – for example, a registry – including the **name of the specific antigen and the date** the vaccine was administered. Documentation that a member is up-to-date with all immunizations, but doesn't include a list of the immunizations and dates they were administered, will **not** meet compliance. Documentation of physician orders, CPT codes or billing charges will **not** meet compliance. For Hep A, Hep B, MMR or VZV, documented history of the illness counts as numerator compliance events – but they must occur on or before a child's second birthday. For all 10 antigens documented history of anaphylaxis due to the vaccine counts as numerator compliance.	• History and physical • Immunization record • Lab results • Problem list with illnesses dated • Progress notes

Childhood Immunization Status (CIS and CIS-E)

Tips and Best Practices to Help Close This Care Opportunity:

- **Please check your Patient Care Opportunity Report (PCOR) often to see members with open care opportunities.** If you have questions, your UnitedHealthcare representative can help.
- When documenting the rotavirus vaccine, always include "Rotarix®" or "2-dose," or "RotaTeq®" or "3-dose" with the date of administration.
  - If medical record documentation doesn't indicate whether the 2-dose schedule or 3-dose schedule was used, it's assumed that the 3-dose regimen was used but only recorded for 2 dates. The vaccinations will then not count for HEDIS®.
- Annual influenza vaccinations – 2 between ages 6 months and 2 years – are an important part of the recommended childhood vaccination series.
  - Consider using standing orders, protocols and resources from **immunize.org.**
- Please record HepB vaccinations given at the hospital in the child's medical record.
- Parental refusal of vaccinations will **not** remove an eligible member from the denominator.
- When possible, please review vaccine status with parents and give immunizations at visits other than only well-child appointments.
  - Consider offering online appointment scheduling.
  - Help ensure safety by dedicating specific rooms for child immunizations only.
  - Offer options such as extended hours or walk-in vaccination clinics.
  - Consider setting up a drive-up immunization site.
- Schedule appointments for your patient's next vaccination before they leave your office.
  - Remind parents of the importance of keeping immunizations on track.
  - Use phone calls, emails, texts or postcards/letters to help keep parents engaged.
- If applicable, please consider participating in your state's immunization registry.
- Information to help parents choose to immunize is available at **cdc.gov** or your state's public health department website. The American Academy of Pediatrics immunization schedule can be found at **aap.org.**
- Immunizations can be accepted as supplemental data, reducing the need for some chart review. Please contact your UnitedHealthcare representative to discuss clinical data exchange opportunities.

Child and Adolescent Well-Care Visits (WCV)

New for 2023

Updated

- Members who died during the measurement year is now a required exclusion
- Rates include stratification by race and ethnicity

Yes!
Supplemental Data Accepted

Definition

Percentage of members ages ages 3-21 years who had one or more comprehensive well-care visits with a primary care provider or OB-GYN during the measurement year.

Plan(s) Affected	Quality Program(s) Affected	Collection and Reporting Method
• Commercial • Exchange/Marketplace • Medicaid	• CMS Quality Rating System • NCQA Accreditation • Select Medicaid State Reporting	**Administrative** • Claim/Encounter Data

Codes

The following codes can be used to close HEDIS® numerator gaps in care; they are not intended to be a directive of your billing practice.

Well-Care Visits	
CPT®/CPT II	99381, 99382, 99383, 99384, 99385, 99391, 99392, 99393, 99394, 99395, 99461
HCPCS	G0438, G0439, S0302, S0610, S0612, S0613
ICD-10 Diagnosis	Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.2, Z00.3, Z01.411, Z01.419, Z02.5, Z76.1, Z76.2
SNOMED	103740001, 170099002, 170107008, 170114005, 170123008, 170132005, 170141000, 170150003, 170159002, 170168000, 170250008, 170254004, 170263002, 170272005, 170281004, 170290006, 170300004, 170309003, 171387006, 171394009, 171395005, 171409007, 171410002, 171416008, 171417004, 243788004, 268563000, 270356004, 401140000, 410620009, 410621008, 410622001, 410623006, 410624000, 410625004, 410626003, 410627007, 410628002, 410629005, 410630000, 410631001, 410632008, 410633003, 410634009, 410635005, 410636006, 410637002, 410638007, 410639004, 410640002, 410641003, 410642005, 410643000, 410644006, 410645007, 410646008, 410647004, 410648009, 410649001, 410650001, 442162000, 783260I003, 444971000124105, 446301000124108, 446381000124104, 669251000168104, 669261000168102, 669271000168108, 669281000168106

Required Exclusion(s)

Exclusion	Timeframe
• Members in hospice or using hospice services • Members who died	- Any time during the measurement year

Child and Adolescent Well-Care Visits (WCV)

Important Notes

The well-child visit must be done by a primary care provider, but it doesn't have to be with the member's assigned primary care provider.

School-based health clinic visits count for this measure if they're for a well-care exam **and** the physician completing the exam is a primary care provider.

Tips and Best Practices to Help Close This Care Opportunity:

- **Please check your Patient Care Opportunity Report (PCOR) often to see members with open care opportunities.** If you have questions, your UnitedHealthcare representative can help.
- If provider is seeing a patient for Evaluation and Management (E/M) services and all well-child visit components are completed: Attach modifier 25 or 59 to the well-child procedure code so it's reviewed as a significant, separately identifiable procedure
  - Modifier 25 is used to indicate a significant and separately identifiable evaluation and management (E/M) service by the same physician on the same day another procedure or service was performed.
  - Modifier 59 is used to indicate that 2 or more procedures were performed at the same visit, but to different sites on the body.
- Helpful resources about the components of care are available at **brightfutures.aap.org.**
- Sharing member demographic data is critical to understanding the cultural, linguistic and social needs of those we serve and decreasing health inequities across the care continuum. This data can include, but is not limited to, race, ethnicity, language, sexual orientation, gender identity, pronouns, sex assigned at birth and disability status. As part of UnitedHealthcare's clinical structured data exchange program, we encourage you to include this demographic data with any structured data file or CCD. Your information is confidential. UnitedHealthcare will keep personally identifiable information confidential and won't disclose any information without your written consent.

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

New for 2023

Updated

- Members who died during the measurement year is now a required exclusion

This measure is also an ECDS measure

Definition

Percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication between March 1 of the year prior to the measurement year through the last day of February in the measurement year and who had at least 3 follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. A new prescription is defined as having no new or refill ADHD medications 120 days prior to an ADHD medication dispense date.

Yes!
Supplemental Data Accepted

Two rates are reported:

1. **Initiation Phase –** Percentage of members ages 6–12 with an ambulatory prescription dispensed for ADHD medication who had 1 follow-up visit with a practitioner with prescribing authority during the 30-day Initiation Phase. A member must be between ages 6–12 when the first prescription for an ADHD medicine was dispensed.
2. **Continuation and Maintenance Phase –** Percentage of members ages 6–12 with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least 2 follow-up visits with a practitioner on different dates of service within 270 days – 9 months – after the Initiation Phase ended. A member must be between ages 6–12 when the first prescription for an ADHD medicine was dispensed.

Plan(s) Affected	Quality Program(s) Affected	Collection and Reporting Method
• Commercial • Medicaid	• NCQA Accreditation • NCQA Health Plan Ratings (Continuation Only)	**Administrative** • Claim/Encounter Data • Pharmacy Data

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

Codes

The following codes can be used to close HEDIS® numerator gaps in care; they are not intended to be a directive of your billing practice.

Initiation Phase

Scenario 1: Outpatient Visit With a Practitioner With Prescribing Authority and With Appropriate Place of Service Code (Place of Service Code Must Be Billed With Visit Code.)

Visit Setting Unspecified	
CPT®/CPT II	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99251, 99252, 99253, 99254, 99255

AND

Place of Service Code

Code	Location		
03	School	**17**	Walk-in retail health clinic
05	Indian Health Service free-standing facility	**18**	Place of employment – worksite
07	Tribal 638 free-standing facility	**19**	Off-campus outpatient hospital
09	Prison/Correctional facility	**20**	Urgent care facility
11	Office	**22**	On-campus outpatient hospital
12	Home	**33**	Custodial care facility
13	Assisted living facility	**49**	Independent clinic
14	Group home	**50**	Federally qualified health center
15	Mobile unit	**71**	Public health clinic
16	Temporary lodging	**72**	Rural health clinic

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

Codes

The following codes can be used to close HEDIS® numerator gaps in care; they are not intended to be a directive of your billing practice.

Initiation Phase

Scenario 2: Behavioral Health Outpatient Visit With a Practitioner With Prescribing Authority

Behavioral Health Visits	
CPT®/CPT II	98960, 98961, 98962, 99078, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99483, 99492, 99493, 99494, 99510
HCPCS	G0155, G0176, G0177, G0409, G0463, G0512, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H0211, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, T1015
SNOMED	77406008, 84251009, 185463005, 185464004, 185465003, 281036007, 391223001, 391224007, 391225008, 391233009, 391237005, 391239008, 391242002, 391257009, 391260002, 391261003, 439740005, 3391000175108, 444971000124105
UBREV	0510, 0513, 0515, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0526, 0527, 0528, 0529, 0900, 0902, 0903, 0904, 0911, 0914, 0915, 0916, 0917, 0919, 0982, 0983

Scenario 3: Observation Visit With a Practitioner With Prescribing Authority

Observation Visit	
CPT®/CPT II	99217, 99218, 99219, 99220

Scenario 4: Intensive Outpatient Encounter or Partial Hospitalization With a Practitioner With Prescribing Authority and With Appropriate Place of Service Code (Place of Service Code Must Be Billed With Visit Code.)

Visit Setting Unspecified	
CPT®/CPT II	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99251, 99252, 99253, 99254, 99255

AND

Place of Service Code

Code	Location
52	Psychiatric facility – partial hospitalization

(Codes continued)

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

Codes

The following codes can be used to close HEDIS® numerator gaps in care; they are not intended to be a directive of your billing practice.

Initiation Phase

Scenario 5: A Health and Behavior Assessment/Intervention With a Practitioner With Prescribing Authority

A Health and Behavior Assessment/Intervention	
CPT®/CPT II	96150, 96151,96152, 96153, 96154, 96156, 96158, 96159, 96164, 96165, 96167, 96168, 96170, 96171

Scenario 6: Intensive Outpatient Encounter or Partial Hospitalization With a Practitioner With Prescribing Authority

Partial Hospitalization/Intensive Outpatient Visits	
HCPCS	G0410, G0411, H0035, H2001, H2012, S0201, S9480, S9484, S9485
SNOMED	07133001, 305345009, 305346005, 305347001, 391038005, 391042008, 391043003, 391046006, 391047002, 391048007, 391054008, 391055009, 391056005, 391133003, 391150001, 391151002, 391152009, 391153004, 391170007, 391185001, 391186000, 391187009, 391188004, 391191004, 391192006, 391194007, 391195008, 391207001, 391208006, 391209003, 391210008, 391211007, 391228005, 391229002, 391232004, 391252003, 391254002, 391255001, 391151002, 391152009, 391153004, 391170007, 391185001, 391186000, 391187009, 391188004, 391191004, 391192006, 391194007, 391195008, 391207001, 391208006, 391209003, 391210008, 391211007, 391228005, 391229002, 391232004, 391252003, 391254002, 391255001, 391256000
UBREV	0905, 0907, 0912, 0913

Scenario 7: Community Mental Health Center Visit With a Practitioner With Prescribing Authority and With Appropriate Place of Service Code

Visit Setting Unspecified	
CPT®/CPT II	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99251, 99252, 99253, 99254, 99255

AND

Place of Service Code

Code	Location
53	Community mental health center

(Codes continued)

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

Codes

The following codes can be used to close HEDIS® numerator gaps in care; they are not intended to be a directive of your billing practice.

Initiation Phase

Scenario 8: Telehealth With a Practitioner With Prescribing Authority and With Appropriate Place of Service Code

Visit Setting Unspecified	
CPT®/CPT II	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99251, 99252, 99253, 99254, 99255

AND

Place of Service Code

Code	Location
02	Telehealth
10	Telehealth

Scenario 9: Telephone With a Practitioner With Prescribing Authority

Telephone Visits	
CPT®/CPT II	98966, 98967, 98968, 99441, 99442, 99443
SNOMED	185317003, 314849005, 386472008, 386473003, 401267002

Continuation Phase – Initiation Phase scenarios 1-9 in addition to the following (only 1 of 2 follow-up visits during days 31-300 may be e-visit or virtual check-in):

Scenario 10: E-Visit or Virtual Check-In With a Practitioner With Prescribing Authority

Online Assessment (e-visit/virtual check-in) *Only 1 of the 2 visits for continuation may be an e-visit or virtual check-in.	
CPT®/CPT II	98969, 98970, 98971, 98972, 99421, 99422, 99423, 99444, 99457, 99458
HCPCS	G0071, G2010, G2012, G2061, G2062, G2063, G2250, G2251, G2252

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

Medications

The following ADHD medications dispensed during the 12-month window starting March 1 of the year prior to the measurement year and ending the last calendar day of Feb. of the measurement year identify members for this measure:

Drug Category	Medications	
CNS stimulants	• Dexmethylphenidate • Dextroamphetamine • Lisdexamfetamine	• Methylphenidate • Methamphetamine
Alpha-2 receptor agonists	• Clonidine	• Guanfacine
Miscellaneous ADHD medications	• Atomoxetine	

Required Exclusion(s)

Exclusion	Timeframe
• Members in hospice or using hospice services • Members who died	- Any time during the measurement year
Narcolepsy	Any time during a member's history through Dec. 31 of the measurement year
Members who had an acute inpatient encounter with principal diagnosis of mental, behavioral or neurodevelopmental disorder or those diagnoses on the discharge claim	During the 30 days after the earliest prescription dispensing date

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

Important Notes

	Medical Record Detail Including, But Not Limited to
• **Initiation Phase – When prescribing ADHD medication for the first time:** – Schedule a member's follow-up appointment within 21–28 days after they receive their initial prescription to assess effectiveness and address any side effects. – Write the initial prescription for the number of days until the follow-up appointment to increase the likelihood that a patient will come to the visit. – Use screening tools such as the Vanderbilt Assessment Scale to assist with diagnosing ADHD. • **Continuation and Maintenance Phase – When providing ongoing care:** – Schedule at least 2 more follow-up appointments within the next 9 months to help ensure the member is stabilized on an appropriate dose. – An e-visit or virtual check-in visit is eligible for 1 visit toward the Continuation and Maintenance Phase.	• Medication list • Progress notes

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

Tips and Best Practices to Help Close This Care Opportunity:

- Continue to monitor patient with 2 or more visits in the next 9 months.
- Encourage the use of telehealth appointments when appropriate.
- Screening tools such as the National Institute for Children's Health Quality (NICHQ) Vanderbilt Assessment Scale can help with diagnosing ADHD.
- When prescribing ADHD medication for the first time, make sure all members are scheduled for a follow-up visit within 30 days.
- Write the initial prescription for the number of days until a member's follow-up visit to increase the likelihood they'll come to the appointment.
- Schedule at least 3 follow-up visits at the time a member's diagnosed and gets their prescription.
  - The first appointment should be 21 to 28 days after they receive their initial prescription so you can assess the medication's effectiveness and address any side effects.
  - Schedule at least 2 or more follow-up appointments within the next 9 months to confirm the member's stable and taking the appropriate dose.
- Review members' history of prescription refill patterns and reinforce education and reminders to take their medication as prescribed.
- At each office visit, talk with members about following your treatment plan and/or barriers to taking their medications, and encourage adherence.
- ADHD follow-up visits can be accepted as supplemental data. Please contact your UnitedHealthcare representative to discuss clinical data exchange opportunities.

Immunizations for Adolescents (IMA and IMA-E)

New for 2023

Added

- Rates will now include stratification by race and ethnicity

Updated

- Members who died during the measurement year is now a required exclusion

This measure is also an ECDS measure

Yes!
Supplemental Data Accepted

Definition

Percentage of adolescents age 13 who had 1 dose of meningococcal vaccine, 1 tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and completed the human papillomavirus (HPV) vaccine series by their 13th birthday.

Plan(s) Affected	Quality Program(s) Affected	Collection and Reporting Method
• Commercial • Exchange/Marketplace • Medicaid	• CMS Quality Rating System • NCQA Health Plan Ratings (Combination 2)	**Administrative** • Claim/Encounter Data **Hybrid** • Claim/Encounter Data • Medical Record Documentation

Codes

The following codes can be used to close HEDIS® numerator gaps in care; they are not intended to be a directive of your billing practice.

HPV Vaccine
Number of Doses: 2
Special Circumstances

- Dose must be administered on or between the ninth and 13th birthdays.
- There must be at least 146 days between the first and second dose of HPV vaccine.
- If 3 HPV vaccines were given, they must only be on different dates of service.
- If applicable, anaphylaxis due to vaccine and the date it occurred must be documented in the medical record to count toward the numerator using the hybrid specifications.

CPT®/CPT II	90649, 90650, 90651
CVX Codes	62, 118, 137, 165
SNOMED	428741008, 428931000, 429396009, 717953009, 724332002, 734152003, 761841000

Anaphylaxis due to the human papillomavirus vaccine on or before the child's 13th birthday

SNOMED	4428241000124101

(Codes continued)

Immunizations for Adolescents (IMA and IMA-E)

Codes

The following codes can be used to close HEDIS® numerator gaps in care; they are not intended to be a directive of your billing practice.

Meningococcal Conjugate Vaccine
Number of Doses: 1
Special Circumstances

- Dose must be administered on or between the 11th and 13th birthdays.
- If applicable, anaphylaxis due to vaccine and the date it occurred must be documented in the medical record to count toward the numerator using the hybrid specifications.

CPT®/CPT II	90619, 90733, 90734
CVX Codes	32, 108, 114, 136, 147, 167, 203
SNOMED	871874000, 428271000124109, 16298691000119102

Anaphylaxis due to the meningococcal vaccine on or before the child's 13th birthday	
SNOMED	428301000124106

Tdap Vaccine
Number of Doses: 1
Special Circumstances

- Dose must be administered on or between the 10th and 13th birthdays.
- If applicable, encephalitis or anaphylaxis due to the vaccine and the date it occurred must be documented in the medical record to count toward the numerator using the hybrid specifications.

CPT®/CPT II	90715
CVX Codes	115
SNOMED	390846000, 412755006, 412756007, 412757003, 428251000124104, 571571000119105

Anaphylaxis due to tetanus, diphtheria or pertussis vaccine on or before the child's 13th birthday	
SNOMED	428281000124107, 428291000124105

Encephalitis due to the tetanus, diphtheria or pertussis vaccine on or before the child's 13th birthday	
SNOMED	192710009, 192711008, 192712001

Required Exclusion(s)

Exclusion	Timeframe
• Members in hospice or using hospice services • Members who died	- Any time during the measurement year

Immunizations for Adolescents (IMA and IMA-E)

Important Notes

A member's medical record must include:

- A note with the **name of the specific antigen and the date** the vaccine was administered.
- An immunization record from an authorized health care provider or agency – for example, a registry – including the **name of the specific antigen and the date** the vaccine was administered.

For meningococcal conjugate, meningococcal recombinant – serogroup B (MenB) – will **not** meet compliance.

Documentation that a member is up to date with all immunizations, but doesn't include a list of the immunizations and dates they were administered, will **not** meet compliance.

Documentation of physician orders, CPT codes or billing charges will **not** meet compliance.

For documented history of anaphylaxis or encephalitis, there must be a note indicating the date of the event, which must have occurred by the member's 13th birthday.

Medical Record Detail Including, But Not Limited to

- History and physical
- Immunization record
- Lab results
- Problem list
- Progress notes

Immunizations for Adolescents (IMA and IMA-E)

Tips and Best Practices to Help Close This Care Opportunity:

- **Please check your Patient Care Opportunity Report (PCOR) often to see members with open care opportunities.** If you have questions, your UnitedHealthcare representative can help.
- Parental refusal of vaccinations will **not** remove an eligible member from the denominator.
- When possible, please review vaccine status with parents and give immunizations at visits other than only well-child appointments.
  - Consider using standing orders, protocols and resources from **immunize.org.**
  - Consider offering online appointment scheduling.
  - Help ensure safety by dedicating specific rooms for child immunizations only.
  - Offer options such as extended hours or walk-in vaccination clinics.
  - Consider setting up a drive-up immunization site.
- Schedule appointments for your patient's next vaccination before they leave your office.
  - Remind parents of the importance of keeping immunizations on track.
  - Use phone calls, emails, texts or postcards/letters to help keep parents engaged.
- If applicable, please consider participating in your state's immunization registry.
- Information to help parents choose to immunize is available at **cdc.gov** or your state's public health department website. The American Academy of Pediatrics immunization schedule can be found at **aap.org.**
- The American Cancer Society offers information about the HPV vaccine to help prevent cervical cancer at **cancer.org.**
- Immunizations can be accepted as supplemental data, reducing the need for some chart review. Please contact your UnitedHealthcare representative to discuss clinical data exchange opportunities.
- Sharing member demographic data is critical to understanding the cultural, linguistic and social needs of those we serve and decreasing health inequities across the care continuum. This data can include, but is not limited to, race, ethnicity, language, sexual orientation, gender identity, pronouns, sex assigned at birth and disability status. As part of UnitedHealthcare's clinical structured data exchange program, we encourage you to include this demographic data with any structured data file or CCD. Your information is confidential. UnitedHealthcare will keep personally identifiable information confidential and won't disclose any information without your written consent.

Lead Screening in Children (LSC)

New for 2023

Updated

- Members who died during the measurement year is now a required exclusion

Yes!
Supplemental Data Accepted

Definition

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

Plan(s) Affected	Quality Program(s) Affected	Collection and Reporting Method
• Medicaid	• Select Medicaid State Reporting	**Administrative** • Claim/Encounter Data **Hybrid** • Claim/Encounter Data • Medical Record Documentation

Codes

The following codes can be used to close HEDIS® numerator gaps in care; they are not intended to be a directive of your billing practice.

Lead Test	
CPT®/CPT II	83655
LOINC	10368-9, 10912-4, 14807-2, 17052-2, 25459-9, 27129-6, 32325-3, 5671-3, 5674-7, 77307-7
SNOMED	8655006, 35833009

Required Exclusion(s)

Exclusion	Timeframe
• Members in hospice or using hospice services • Members who died	- Any time during the measurement year

Lead Screening for Children (LSC)

Important Notes

	Medical Record Detail Including, But Not Limited to
Date of service and result must be documented with the notation of the lead screening test.	• History and physical • Lab results • Progress notes

Tips and Best Practices to Help Close This Care Opportunity:

- Lab tests can be accepted as supplemental data, reducing the need for some chart review. Please contact your UnitedHealthcare representative to discuss clinical data exchange opportunities.

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

New for 2023

Updated

- Members who died during the measurement year is now a required exclusion

This measure is also an ECDS measure

Yes!
Supplemental Data Accepted

Definition

Percentage of children and adolescents ages 1–17 who had 2 or more antipsychotic prescriptions and had metabolic testing.

Three rates are reported:

- The percentage of children and adolescents on antipsychotics who received blood glucose testing
- The percentage of children and adolescents on antipsychotics who received cholesterol testing
- The percentage of children and adolescents on antipsychotics who received blood glucose and cholesterol testing

Plan(s) Affected	Quality Program(s) Affected	Collection and Reporting Method
• Commercial • Medicaid	• NCQA Accreditation • NCQA Health Plan Ratings • Select State Medicaid Reporting	**Administrative** • Claim/Encounter Data • Pharmacy Data

Codes

The following codes can be used to close HEDIS® numerator gaps in care; they are not intended to be a directive of your billing practice.

Glucose Test	
CPT®/CPT II	80047, 80048, 80050, 80053, 80069, 82947, 82950, 82951
LOINC	10450-5, 1492-8, 1494-4, 1496-9, 1499-3, 1501-6, 1504-0, 1507-3, 1514-9, 1518-0, 1530-5, 1533-9, 1554-5, 1557-8, 1558-6, 17865-7, 20436-2, 20437-0, 20438-8, 20440-4, 26554-6, 41024-1, 49134-0, 6749-6, 9375-7
SNOMED	22569008, 33747003, 52302001, 72191006, 73128004, 88856000, 104686004, 167086002, 167087006, 167088001, 167095005, 167096006, 167097002, 250417005, 271061004, 271062006, 271063001, 271064007, 271065008, 275810004, 302788006, 302789003, 308113006, 313474007, 313545000, 313546004, 313624000, 313626003, 313627007, 313628002, 313630000, 313631001, 313697000, 313698005, 313810002, 412928005, 440576000, 443780009, 444008003, 444127006, 166890005, 166891009, 166892002, 166914001, 166915000, 166916004, 166917008, 166918003, 166919006, 166921001, 166922008, 166923003, 442545002, 44478000

HbA1c Test	
CPT®/CPT II	83036, 83037, 3044F, 3046F, 3051F, 3052F
LOINC	17856-6, 4548-4, 4549-2
SNOMED	17856-6, 4548-4, 4549-2

(Codes continued)

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

Codes

The following codes can be used to close HEDIS® numerator gaps in care; they are not intended to be a directive of your billing practice.

Cholesterol Test Other Than LDL	
CPT®/CPT II	82465, 83718, 83722, 84478
LOINC	2085-9, 2093-3, 2571-8, 3043-7, 9830-1
SNOMED	214740000, 28036006, 77068002, 104583003, 104584009, 104586006, 104784006, 104990004, 104991000, 121868005, 166832000, 166838001,166839009, 166849007, 166850007, 167072001, 167073006, 167082000, 167083005, 167084004, 271245006, 275972003, 314035000, 315017003, 390956002, 412808005, 412827004, 443915001, 166830008, 166831007, 166848004, 259557002, 365793008, 365794002, 365795001, 365796000, 439953004, 442193004, 442234001, 442350007, 442480001, 707122004, 707123009, 67991000119104

LDL-C Test	
CPT®/CPT II	80061, 83700, 83701, 83704, 83721, 3048F, 3049F, 3050F
LOINC	12773-8, 13457-7, 18261-8, 18262-6, 2089-1, 49132-4, 55440-2, 96259-7
SNOMED	113079009, 166833005, 166840006, 166841005, 167074000, 167075004, 314036004

Required Exclusion(s)

Exclusion	Timeframe
• Members in hospice or using hospice services • Members who died	- Any time during the measurement year

Important Notes

	Medical Record Detail Including, But Not Limited to
• A member must have metabolic screening tests that measure **both** blood glucose and cholesterol. • Individual tests to measure cholesterol and blood glucose levels can be done on the same or different dates of service.	• Glucose test or HbA1c test **and** • Cholesterol lab test • LDL or LDL-C lab test

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

Tips and Best Practices to Help Close This Care Opportunity:

- This measure focuses on appropriate monitoring for children prescribed antipsychotic medications.
- Schedule an annual glucose or HbA1C and LDL-C or other cholesterol test.
- Assist caregiver in understanding the importance of annual screening.
- Behavioral Health Screening Tools and Resources: **providerexpress.com**
- Patient Education Information: **liveandworkwell.com** > Browse as a guest with company access code > Use access code “clinician" > Explore and Learn
- The use of CPT® Category II codes helps UnitedHealthcare identify clinical outcomes such as HbA1c level. It can also reduce the need for some chart review.
- Lab tests visits can be accepted as supplemental data. Please contact your UnitedHealthcare representative to discuss clinical data exchange opportunities.

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

New for 2023

Updated

- Members who died during the measurement year is now a required exclusion

Yes!
Supplemental Data Accepted

Definition

Percentage of children and adolescents ages 1–17 who had a new prescription for an antipsychotic and had psychosocial care as first line treatment in 121 days. 121 days includes 90 days before the earliest dispensing date to 30 days after.

Plan(s) Affected	Quality Program(s) Affected	Collection and Reporting Method
• Commercial • Medicaid	• NCQA Accreditation • NCQA Health Plan Ratings • Select State Medicaid Reporting	**Administrative** • Claim/Encounter Data • Pharmacy Data

Codes

The following codes can be used to close HEDIS® numerator gaps in care; they are not intended to be a directive of your billing practice.

Psychosocial Care	
CPT®/CPT II	90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90846, 90847, 90849, 90853, 90875, 90876, 90880
HCPCS	G0176, G0177, G0409, G0410, G0411, H0004, H0035, H0036, H0037, H0038, H0039, H0040, H2000, H2001, H2011, H2012, H2013, H2014, H2017, H2018, H2019, H2020, S0201, S9480, S9484, S9485
SNOMED	166001, 1555005, 2619005, 3518004, 5694008, 6227009, 7133001, 8411005, 9591001, 15142007, 15558000, 15711005, 17447008, 17914007, 18512000, 19997007, 21055002, 22900004, 24172008, 24621000, 25621005, 26693005, 26829003, 26890005, 27482005, 27591006, 28868002, 28988002, 30808008, 31408009, 31594000, 32051004, 33661004, 35358007, 36230009, 38592005, 38678006, 39697002, 41035007, 41653002, 41838008, 45565001, 46618005, 47805006, 50160009, 51484002, 51790004, 53508008, 53769000, 57070007, 57847003, 58771002, 59364003, 59585002, 59694001, 61436009, 62474003, 63386006, 65201004, 66060003, 73139001, 75516001, 76168009, 76740001, 77170008, 78493007, 79441000, 82309004, 83474000, 84892007, 85614001, 85925008, 88848003, 89909007, 90102008, 91172002, 91425008, 91481002, 108313002, 113141001, 113143003, 113144009, 171423009, 171424003, 171425002, 171426001, 183339004, 183381005, 183382003, 183383008, 183385001, 183387009, 183388004, 183389007, 183391004, 183393001, 183395008, 183396009, 183398005, 183399002, 183401008, 183402001, 183403006, 183405004, 183406003, 183408002, 183411001, 183413003, 183422002, 225160006, 225224008, 225225009, 225226005, 225227001, 225333008, 228546003, 228548002, 228549005, 228550005, 228551009, 228553007, 228554001, 228555000, 228557008, 228575009, 229216005, 229217001, 229218006, 229219003, 229220009, 229221008, 266744007, 299695005, 302230009, 302234000, 302235004, 302236003, 302238002, 302239005, 302240007, 302242004, 302243009, 302244003, 302245002, 302247005, 302248000, 302255003, 302259009, 302260004, 302262007, 304637004, 304638009, 304702006, 304814008, 304815009, 304816005, 304817001, 304818006, 304819003, 304820009, 304821008, 304822001, 304824000, 304825004, 304826003, 304851002, 304888004, 304889007, 304891004, 304892006, 304893001, 304894007, 311460008, 311461007, 311462000, 311510000, 311511001

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

Yes!
Supplemental Data Accepted

Codes

The following codes can be used to close HEDIS® numerator gaps in care; they are not intended to be a directive of your billing practice.

Psychosocial Care (continued)	
SNOMED	311522002, 311523007, 311884008, 312043006, 312044000, 313105004, 314034001, 361229007, 361230002, 385768000, 385769008, 385770009, 385771008, 385772001, 385773006, 385774000, 385893007, 385992003, 386255004, 386256003, 386257007, 386316003, 386367000, 386429002, 386522008, 386523003, 386524009, 386525005, 390773006, 391892008, 397074006, 401157001, 401162000, 405780009, 405792009, 405793004, 406165004, 406183007, 406184001, 406185000, 410112008, 410115005, 410118007, 410121009, 410124001, 410127008, 410130001, 425680009, 427954006, 429048003, 429159005, 429329005, 439330009, 439436002, 439741009, 439795004, 439805004, 439820005, 439916005, 440274001, 440582002, 440646003, 443119008, 443730003, 444175001, 449030000, 700445002, 700446001, 702471009, 702780005, 711078000, 711283001, 712558003, 718023002, 718026005, 720444008, 723528003, 723619005, 734278000, 736861004, 866252000, 868185009, 1163366004, 460891000124103, 460901000124104, 461561000124103

Required Exclusion(s)

Exclusion	Timeframe
• Members in hospice or using hospice services • Members who died • One or more acute inpatient encounter with a diagnosis of schizophrenia, schizoaffective disorder, bipolar disorder, other psychotic disorder, autism or other developmental disorder • Two or more visits in an outpatient, intensive outpatient or partial hospitalization setting, on different dates of service, with a diagnosis of schizophrenia, schizoaffective disorder, bipolar disorder, other psychotic disorder, autism or other developmental disorder	Any time during the measurement year

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

Tips and Best Practices to Help Close This Care Opportunity:

- This measure focuses on referring to psychosocial treatment prior to prescribing an antipsychotic medication to children. This measure excludes children and adolescents diagnosed with schizophrenia, schizoaffective disorder, bipolar disorder, other psychotic disorder, autism or other developmental disorder.
- Make sure children and adolescents receive a psychosocial care appointment at least 90 days prior to prescribing medication or within 30 days of starting an initial prescription if there is an urgent need for medication.
- Psychosocial treatments (interventions) include, but are not limited to, structured counseling, case management, care coordination, psychotherapy, crisis intervention services, individual, family and group psychotherapy, activity therapy (music, art or play therapy not for recreation) and relapse prevention.
- Refer patients to a mental health professional:
  - If you need to refer your patient to a behavioral health specialist or need to request coordination of care, please call the number on the back of the patient's health plan ID card or search **liveandworkwell.com.**
- Helpful resources for you and your practice include:
  - Behavioral Health Screening Tools and Resources: **providerexpress.com**
  - Patient Education Information: **liveandworkwell.com** > Browse as a guest with company access code > Use access code "clinician" > Explore and Learn

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)

New for 2023

Updated

- Members who died during the measurement year is now a required exclusion
- Members with a diagnosis of pregnancy is now a required exclusion

Yes!
Supplemental Data Accepted

Definition

Percentage of members ages 3–17 who had an outpatient visit with a primary care provider or OB-GYN and had evidence of the following during the measurement year:

- Body mass index (BMI) percentile
- Counseling for nutrition
- Counseling for physical activity

Plan(s) Affected	Quality Program(s) Affected	Collection and Reporting Method
• Commercial • Exchange/Marketplace • Medicaid	• CMS Quality Rating System • NCQA Accreditation • NCQA Health Plan Ratings (BMI Percentile Only)	**Hybrid** • Claim/Encounter Data • Medical Record Documentation

Codes

The following codes can be used to close HEDIS® numerator gaps in care; they are not intended to be a directive of your billing practice.

BMI Percentile	
ICD-10 Diagnosis	Z68.51, Z68.52, Z68.53, Z68.54
LOINC	59574-4, 59575-1, 59576-9

Counseling for Nutrition	
CPT®/CPT II	97802, 97803, 97804
HCPCS	G0270, G0271, G0447, S9449, S9452, S9470
ICD-10 Diagnosis	Z71.3

(Codes continued)

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)

Codes

The following codes can be used to close HEDIS® numerator gaps in care; they are not intended to be a directive of your billing practice.

Counseling for Nutrition	
SNOMED	11816003, 61310001, 183059007, 183060002, 183061003, 183062005, 183063000, 183065007, 183066008, 183067004, 183070000, 183071001, 226067002, 266724001, 275919002, 281085002, 284352003, 305849009, 305850009, 305851008, 306163007, 306164001, 306165000, 306626002, 306627006, 306628001, 313210009, 370847001, 386464006, 404923009, 408910007, 410171007, 410177006, 410200000, 429095004, 431482008, 443288003, 609104008, 698471002, 699827002, 699829004, 699830009, 699849008, 700154005, 700258004, 705060005, 710881000, 14051000175103, 428461000124101, 428691000124107, 441041000124100, 441201000124108, 441231000124100, 441241000124105, 441251000124107, 441261000124109, 441271000124102, 441281000124104, 441291000124101, 441301000124100, 441311000124102, 441321000124105, 441331000124108, 441341000124103, 441351000124101, 445291000124103, 445301000124102, 445331000124105, 445641000124105

Counseling for Physical Activity	
HCPCS	G0447, S9451
ICD-10 Diagnosis	Z02.5, Z71.82
SNOMED	103736005, 183073003, 281090004, 304507003, 304549008, 304558001, 310882002, 386291006, 386292004, 386463000, 390864007, 390893007, 398636004, 398752005, 408289007, 410200000, 410289001, 410335001, 429778002, 710849009, 435551000124105

Required Exclusion(s)

Exclusion	Timeframe
• Members in hospice or using hospice services • Members who died • Members with a diagnosis of pregnancy	- Any time during the measurement year

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)

Important Notes

- For ages 3–17, a BMI percentile or BMI percentile plotted on an age growth chart meets compliance. A BMI value will **not** meet compliance for this age range.
  - Always record height and weight in a member's medical record.
- BMI percentile ranges or thresholds will **not** meet compliance.
  - This is true even for single ranges – for example, 17–18 percent.
- Weight assessment and counseling for nutrition and physical activity can be completed at any appointment – not just a well-child visit. However, services specific to an acute or chronic condition will **not** meet compliance for counseling for nutrition or physical activity.
  - For example: Member has exercise-induced asthma or decreased appetite because of flu symptoms

Medical Record Detail Including, But Not Limited to

- Growth charts
- History and physical
- Progress notes
- Vitals sheet

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)

Tips and Best Practices to Help Close This Care Opportunity:

- **Please check your Patient Care Opportunity Report (PCOR) often to see members with open care opportunities.** If you have questions, your UnitedHealthcare representative can help.
- **If your electronic medical record (EMR) system documents a BMI value and translates it to a BMI percentile, or documents a BMI percentile in ranges, please work with your IT department to see if it's possible to document the data in singular values.**
- For example: 18 percent instead of 17–18 percent
- Please confirm your EMR includes a plotted age growth chart for BMI percentile with the service date and a member's height and weight.
- **Documentation of BMI percentile and counseling for nutrition or physical activity can be done at any time during the measurement year and on separate visits.**
- Including a checklist in a member's medical record is a good way to make sure all measure components are completed. For example:
  - A notation of "well nourished" during a physical exam will **not** meet compliance for nutritional counseling. However, a checklist indicating that "nutrition was addressed" will.
  - A notation of "cleared for gym class" or "health education" will **not** meet compliance for physical activity counseling. However, a checklist indicating "physical activity was addressed" or evidence of a sports physical will.
- Provide parents of children ages 4 and older with age appropriate handout(s) that include a section on physical activity outside of developmental milestones.
  For example:
  - Recommended guidelines for amount of activity per day or week.
- Discuss proper nutrition and promote physical activity with parents and members at every visit.
- Talk with parents and members about nutrition and physical activity for at least 15 minutes at each well-child visit.
- Be sure to document "MEAT" when counseling for obesity:
  - **M**anage the behavioral effects due to obesity.
  - **E**valuate the behavioral effects of obesity.
  - **A**ssess the level of obesity.
  - **T**reat obesity.
- If filing G0447 with a well-child visit, attach modifier 25 or 59 to the well-child procedure code so it's reviewed as a significant, separately identifiable procedure.
  - Modifier 25 is used to indicate a significant and separately identifiable evaluation and management (E/M) service by the same physician on the same day another procedure or service was performed.
  - Modifier 59 is used to indicate that 2 or more procedures were performed at the same visit, but to different sites on the body.
- BMI percentiles and evidence of counseling for nutrition and physical activity can be accepted as supplemental data, reducing the need for some chart review. Please contact your UnitedHealthcare representative to discuss clinical data exchange opportunities.

Counseling may include:

- Discussion of current nutrition behaviors (e.g., eating habits, dieting behaviors)
- Checklist indicating nutrition was addressed
- Counseling or referral for nutrition education
- Member received educational materials on nutrition during a face-to-face visit
- Anticipatory guidance for nutrition
- Weight or obesity counseling

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

New for 2023

Added

- Rates now include stratification by race and ethnicity

Updated

- Members who died during the measurement year is now a required exclusion

Yes!
Supplemental Data Accepted

Definition

Percentage of members who turned 15–30 months old during the measurement year and had the recommended number of well-child visits with a primary care provider.

- Children 0-15 months old during the measurement year: 6 or more well-child visits in the first 15 months of life.
- Children 15-30 months old during the measurement year: 2 or more well-child visits between 15–30 months of age.

Plan(s) Affected	Quality Program(s) Affected	Collection and Reporting Method
• Commercial • Exchange/Marketplace • Medicaid	• CMS Quality Rating System • Select Medicaid State Reporting	**Administrative** • Claim/Encounter Data

Codes

The following codes can be used to close HEDIS® numerator gaps in care; they are not intended to be a directive of your billing practice.

Well-Care Visits	
CPT®/CPT II	99381, 99382, 99383, 99384, 99385, 99391, 99392, 99393, 99394, 99395, 99461
HCPCS	G0438, G0439, S0302, S0610, S061, S0613
ICD-10 Diagnosis	Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.2, Z00.3, Z01.411, Z01.419, Z02.5 Z76.1, Z76.2
SNOMED	103740001, 170099002, 170107008, 170114005, 170123008, 170132005, 170141000, 170150003, 170159002, 170168000, 170250008, 170254004, 170263002, 170272005, 170281004, 170290006, 170300004, 170309003, 171387006, 171394009, 171395005, 171409007, 171410002, 171416008, 171417004, 243788004, 268563000, 270356004, 401140000, 410620009, 410621008, 410622001, 410623006, 410624000, 410625004, 410626003, 410627007, 410628002, 410629005, 410630000, 410631001, 410632008, 410633003, 410634009, 410635005, 410636006, 410637002, 410638007, 410639004, 410640002, 410641003, 410642005, 410643000, 410644006, 410645007, 410646008, 410647004, 410648009, 410649001, 410650001, 442162000, 783260003, 444971000124105, 446301000124108, 446381000124104, 669251000168104, 669261000168102, 669271000168108, 669281000168106

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

Required Exclusion(s)

Exclusion	Timeframe
• Members in hospice or using hospice services • Members who died	- Any time during the measurement year

Tips and Best Practices to Help Close This Care Opportunity:

- **Please check your Patient Care Opportunity Report (PCOR) often to see members with open care opportunities.** If you have questions, your UnitedHealthcare representative can help.
- If provider is seeing a patient for Evaluation and Management (E/M) services and all well-child visit components are completed: Attach modifier 25 or 59 to the well-child procedure code so it's reviewed as a significant, separately identifiable procedure.
  - Modifier 25 is used to indicate a significant and separately identifiable evaluation and management (E/M) service by the same physician on the same day another procedure or service was performed.
  - Modifier 59 is used to indicate that 2 or more procedures were performed at the same visit, but to different sites on the body.
- Helpful resources about the components of care are available at **brightfutures.aap.org.**
- Well-care visits can be accepted as supplemental data, reducing the need for some chart review. Please contact your UnitedHealthcare representative to discuss clinical data exchange opportunities.
- Sharing member demographic data is critical to understanding the cultural, linguistic and social needs of those we serve and decreasing health inequities across the care continuum. This data can include, but is not limited to, race, ethnicity, language, sexual orientation, gender identity, pronouns, sex assigned at birth and disability status. As part of UnitedHealthcare's clinical structured data exchange program, we encourage you to include this demographic data with any structured data file or CCD. Your information is confidential. UnitedHealthcare will keep personally identifiable information confidential and won't disclose any information without your written consent.information is confidential. UnitedHealthcare will keep personally identifiable information confidential and won't disclose any information without your written consent.

Medication Adherence for Cholesterol (MAC)

New for 2023

- No applicable changes for this measure.

Definition

Percentage of members ages 18 and older who adhere to their cholesterol (statin) medication at least 80% of the time in the measurement period

Plan(s) Affected	Quality Program(s) Affected	Collection and Reporting Method
• Medicare	• CMS Star Ratings	**Part D Prescription Claims** • Pharmacy Data

Compliance

To comply with this measure, a member must have a proportion of days covered (PDC) of 80 percent or higher for their statin medication in the measurement period.

Exclusion(s)

Exclusion	Timeframe
• Members in hospice or using hospice services • End Stage Renal Disease (ESRD): N18.5, N18.6, Z99.2 • Dailysis	Any time during the measurement year

Medication Adherence for Cholesterol (MAC)

Tips and Best Practices to Help Close This Care Opportunity

- **Please check your Patient Care Opportunity Report (PCOR) often to see members with open care opportunities.** If you have questions, your UnitedHealthcare representative can help.
  - **Focus on members marked yellow in your PCOR because they may be at risk for non-adherence.**
- Log on to Practice Assist to review members with open care opportunities.
  - Select **Medication Adherence** to view your patient list.
  - The list is updated every day and prioritizes members at highest risk for not taking their medications. You can also use the tool to document a member's progress.
- **Improve health literacy.** Talk with members about why they're on a statin medication, and how it's important to take their medication as prescribed and get timely refills.
- **Assess adherence barriers.** Discuss medication adherence barriers at each visit and ask open-ended questions about concerns related to health benefits, side effects and cost.
- **Discuss continued therapy.** If ongoing therapy is appropriate, talk with members about getting timely refills to prevent large gaps between fills. This is particularly important between the first and second fills to set up good habits for future fills.
  - **Members qualify for the measure with the second fill, but the measurement period starts with the date of the first fill.**
  - For members who qualified for the measure denominator:
    - Pay attention to allowable days remaining and days of therapy missed year-to-date (YTD) in your PCOR or in Practice Assist. Members should have a zero or greater allowable days remaining (ADR) at the end of the measurement period.
  - **Members can't achieve 80% PDC when the allowable days they can miss in the year is less than zero. ADR must be zero or higher for a member to be adherent.**
- **Consider extended days' supply prescriptions.** When clinically appropriate, consider writing 3-month supplies for prescriptions for chronic conditions to help improve adherence and minimize frequent trips to the pharmacy – especially if getting to the pharmacy is an issue. UnitedHealthcare Medicare Advantage benefit plans include coverage for a 3-month supply of prescriptions that can be delivered to a patient's home or picked up at a retail pharmacy.
  - For some health plans, members have $0 copays on Tier 1 drugs (1-month and 3-month supplies). A few health plans even have $0 copays for Tier 1 and Tier 2 drugs (1-month and 3-month supplies).
- **Prescribe low-cost generics.** When clinically appropriate, prescribe low-cost generic medications to help reduce out-of-pocket costs. For some health plans, members have $0 copays on Tier 1 drugs (1-month and 3-month supplies). A few health plans even have $0 copays for Tier 1 and Tier 2 drugs (1-month and 3-month supplies).
- **Confirm instructions.** Check that the directions on members' prescriptions match your instructions. **If the dose or frequency is changed, please void the old prescription and send a new one to the member's pharmacy.**
- **Use prescription benefit at the pharmacy.** Remind your patients who are UnitedHealthcare members to use their health plan ID card at the pharmacy to get the best value. **Only prescription fills processed with a member's health plan ID card can be used to measure a member's adherence to their medication.**
- **Try home delivery.** If getting to a pharmacy is difficult, ask members about the possibility of filling their prescriptions through a UnitedHealthcare network mail order pharmacy so they can get their medication delivered to their home. For more information, please call OptumRx® at **800-791-7658** or contact your UnitedHealthcare representative.
- **Stay organized.** Encourage members to use a pillbox to keep organized and to set an alarm on their phone or clock as a reminder to take their medication.
- **Join a reminder program.** Ask members to sign up for a refill reminder program at their pharmacy, if available.

Medication Adherence for Diabetes Medications (MAD)

New for 2023

- No applicable changes for this measure.

Definition

Percentage of members ages 18 or older who are adherent to their diabetes medications at least 80% of the time in the measurement period

Plan(s) Affected	Quality Program(s) Affected	Collection and Reporting Method
• Medicare	• CMS Star Ratings	**Part D Prescription Claims** • Pharmacy Data

Compliance

To comply with this measure, a member must have a proportion of days covered (PDC) of 80% or higher for their diabetes medication(s) in the measurement period. These classes of diabetes medications are included in this measure:

- Biguanides
- DPP-4 inhibitors
- GLP-1 receptor agonists
- Meglitinides
- SGLT2 inhibitors
- Sulfonylureas
- Thiazolidinediones

*Members who take insulin are not included in this measure.

Exclusion(s)

	Timeframe
• Members in hospice or using hospice services • End Stage Renal Disease (ESRD): N18.5, N18.6, Z99.2 • Dialysis • One or more prescription claim for insulin	Any time during the measurement year

Medication Adherence for Diabetes Medications (MAD)

Tips and Best Practices to Help Close This Care Opportunity

- **Please check your Patient Care Opportunity Report (PCOR) often to see members with open care opportunities.** If you have questions, your UnitedHealthcare representative can help.
  - **Focus on members marked yellow in your PCOR because they may be at risk for non-adherence.**
- Log on to Practice Assist to review members with open care opportunities.
  - Select **Medication Adherence** to view your patient list.
  - The list is updated every day and prioritizes members at highest risk for not taking their medications. You can also use the tool to document a member's progress.
- **Improve health literacy.** Talk with members about why they're on a statin medication, and how it's important to take their medication as prescribed and get timely refills.
- **Assess adherence barriers.** Discuss medication adherence barriers at each visit and ask open-ended questions about concerns related to health benefits, side effects and cost.
- **Discuss continued therapy.** If ongoing therapy is appropriate, talk with members about getting timely refills to prevent large gaps between fills. This is particularly important between the first and second fills to set up good habits for future fills.
  - **Members qualify for the measure with the second fill, but the measurement period starts with the date of the first fill.**
  - For members who qualified for the measure denominator:
    - Pay attention to allowable days remaining and days of therapy missed year-to-date (YTD) in your PCOR or in Practice Assist. Members should have zero or greater allowable days remaining (ADR) at the end of the measurement period.
  - **Members can't achieve 80% PDC when the allowable days they can miss in the year is less than zero. ADR must be zero or higher for a member to be adherent.**
- **Consider extended days' supply prescriptions.** When clinically appropriate, consider writing a 3-month supply of prescriptions for chronic conditions to help improve adherence and minimize frequent trips to the pharmacy – especially if getting to the pharmacy is an issue. UnitedHealthcare Medicare Advantage benefit plans include coverage for a 3-month supply of prescriptions that can be delivered to a patient's home or picked up at a retail pharmacy.
  - For some health plans, members have $0 copays on Tier 1 drugs (1-month and 3-month supplies). A few health plans even have $0 copays for Tier 1 and Tier 2 drugs (1-month and 3-month supplies).
- **Prescribe low-cost generics.** When clinically appropriate, prescribe low-cost generic medications to help reduce out-of-pocket costs. For some health plans, members have $0 copays on Tier 1 drugs (1-month and 3-month supplies). A few health plans even have $0 copays for Tier 1 and Tier 2 drugs (1-month and 3-month supplies).
- **Confirm instructions.** Check that the directions on members' prescriptions match your instructions. **If the dose or frequency is changed, please void the old prescription and send a new one to the member's pharmacy.**
- **Use prescription benefit at the pharmacy.** Remind your patients who are UnitedHealthcare members to use their health plan ID card at the pharmacy to get the best value. **Only prescription fills processed with a member's health plan ID card can be used to measure a member's adherence to their medication.**
- **Try home delivery.** If getting to a pharmacy is difficult, ask members about the possibility of filling their prescriptions through a UnitedHealthcare network mail order pharmacy so they can get their medication delivered to their home. For more information, please call OptumRx® at **800-791-7658** or contact your UnitedHealthcare representative.
- **Stay organized.** Encourage members to use a pillbox to keep organized and to set an alarm on their phone or clock as a reminder to take their medication.
- **Join a reminder program.** Ask members to sign up for a refill reminder program at their pharmacy, if available.

Medication Adherence for Hypertension (RAS Antagonists) (MAH)

New for 2023

- No applicable changes for this measure.

Definition

Percentage of members ages 18 or older who adhere to their hypertension (RAS antagonist) medication at least 80% of the time in the measurement period.

Plan(s) Affected	Quality Program(s) Affected	Collection and Reporting Method
• Medicare	• CMS Star Ratings	**Part D Prescription Claims** • Pharmacy Data

Compliance

To comply with this measure, a member must have a proportion of days covered (PDC) of 80 percent or higher for their hypertension (RAS antagonist) medication in the measurement period. RAS antagonist medications include:

- Angiotensin II receptor blockers (ARBs)
- Angiotensin-converting enzyme (ACE) inhibitors
- Direct renin inhibitors

Exclusion(s)

Exclusion	Timeframe
• Members in hospice or using hospice services • End Stage Renal Disease (ESRD): N18.5, N18.6, Z99.2 • Dialysis • One or more prescription claim for sacubitril/valsartan (Entresto®)	Any time during the measurement year

Medication Adherence for Hypertension (RAS antagonists) (MAH)

Tips and Best Practices to Help Close This Care Opportunity

- **Please check your Patient Care Opportunity Report (PCOR) often to see members with open care opportunities.** If you have questions, your UnitedHealthcare representative can help.
  - **Focus on members marked yellow in your PCOR because they may be at risk for non-adherence.**
- Log on to Practice Assist to review members with open care opportunities.
  - Select **Medication Adherence** to view your patient list.
  - The list is updated every day and prioritizes members at highest risk for not taking their medications. You can also use the tool to document a member's progress.
- **Improve health literacy.** Talk with members about why they're on a statin medication, and how it's important to take their medication as prescribed and get timely refills.
- **Assess adherence barriers.** Discuss medication adherence barriers at each visit and ask open-ended questions about concerns related to health benefits, side effects and cost.
- **Discuss continued therapy.** If ongoing therapy is appropriate, talk with members about getting timely refills to prevent large gaps between fills. This is particularly important between the first and second fills to set up good habits for future fills.
  - **Members qualify for the measure with the second fill, but the measurement period starts with the date of the first fill.**
  - For members who qualified for the measure denominator:
    - Pay attention to allowable days remaining and days of therapy missed year-to-date (YTD) in your PCOR or in Practice Assist. Members should have zero or greater allowable days remaining (ADR) at the end of the measurement period.
  - **Members can't achieve 80% PDC when the allowable days they can miss in the year is less than zero. ADR must be zero or higher for a member to be adherent.**
- **Consider extended days' supply prescriptions.** When clinically appropriate, consider writing a 3-month supply of prescriptions for chronic conditions to help improve adherence and minimize frequent trips to the pharmacy – especially if getting to the pharmacy is an issue. UnitedHealthcare Medicare Advantage benefit plans include coverage for a 3-month supply of prescriptions that can be delivered to a patient's home or picked up at a retail pharmacy.
  - For some health plans, members have $0 copays on Tier 1 drugs (1-month and 3-month supplies). A few health plans even have $0 copays for Tier 1 and Tier 2 drugs (1-month and 3-month supplies).
- **Prescribe low-cost generics.** When clinically appropriate, prescribe low-cost generic medications to help reduce out-of-pocket costs. For some health plans, members have $0 copays on Tier 1 drugs (1-month and 3-month supplies). A few health plans even have $0 copays for Tier 1 and Tier 2 drugs (1-month and 3-month supplies).
- **Confirm instructions.** Check that the directions on members' prescriptions match your instructions. **If the dose or frequency is changed, please void the old prescription and send a new one to the member's pharmacy.**
- **Use prescription benefit at the pharmacy.** Remind your patients who are UnitedHealthcare members to use their health plan ID card at the pharmacy to get the best value. **Only prescription fills processed with a member's health plan ID card can be used to measure a member's adherence to their medication.**
- **Try home delivery.** If getting to a pharmacy is difficult, ask members about the possibility of filling their prescriptions through a UnitedHealthcare network mail order pharmacy so they can get their medication delivered to their home. For more information, please call OptumRx® at **800-791-7658** or contact your UnitedHealthcare representative.
- **Stay organized.** Encourage members to use a pillbox to keep organized and to set an alarm on their phone or clock as a reminder to take their medication.
- **Join a reminder program.** Ask members to sign up for a refill reminder program at their pharmacy, if available.

Medication Therapy Management Program Completion Rate for Comprehensive Medication Reviews (CMR)

New for 2023

Updated

- Eligibility criteria expanded to include At-Risk Beneficiaries in a Drug Management Program to help better manage and safely use medications, such as those used for pain.

Definition

Percentage of members ages 18 or older who were enrolled in a medication therapy management (MTM) program for at least 60 days during the reporting period and received a comprehensive medication review (CMR)

Plan(s) Affected	Quality Program(s) Affected	Collection and Reporting Method
• Medicare Part D	• CMS Star Ratings	**Part D Prescription Claims** • Pharmacy Data • Medical Claim Data • Part D Reporting

Exclusion(s)

Exclusion	Timeframe
• Members in hospice or using hospice services • Members who were enrolled in a MTM program for less than 60 days during the reporting period and didn't receive a CMR	Any time during the measurement year

Medication Therapy Management Program Completion Rate for Comprehensive Medication Reviews (CMR)

Important Notes

	Timeframe
CMR must be completed by a pharmacist or other health care professional during a member's enrollment in a MTM program. • To be enrolled in UnitedHealthcare's MTM program, a member must meet certain eligibility requirements that include: – Diagnosis of 3 of these 5 chronic conditions: diabetes, heart failure, chronic obstructive pulmonary disease (COPD), high cholesterol or osteoporosis – Prescription fills of at least 8 Medicare Part D-covered medications for chronic conditions – Total prescription costs of at least $4,935 for Medicare Part D-covered drugs this year year; or – At-risk beneficiaries in a drug management program to help better manage and safely use medications, such as those used for pain • UnitedHealthcare identifies members who may be eligible every quarter, and automatically enrolls them in our MTM program. – Participants are contacted by mail, phone or in person, and asked to schedule a personal medication review with a pharmacist or other qualified care provider. A written summary including a personal medication list and action plan are sent following each CMR.	Within the reporting period

Medication Therapy Management Program Completion Rate for Comprehensive Medication Reviews (CMR)

Tips and Best Practices to Help Close This Care Opportunity:

- UnitedHealthcare's MTM program is offered at no additional cost to eligible plan members with Medicare Part D coverage. Once enrolled, members can complete a CMR with one of our pharmacists.
- To identify members who may be eligible for an annual medication review, check the CMR flag within the Practice Assist tool. Your UnitedHealthcare representative can show you how.
- At office visits, ask eligible members to call our MTM pharmacist team at **866-216-0198, TTY 711.** Or, call "live" during a visit so they can do their CMR right from your office or schedule for a later date.
  - Pharmacists are available Monday – Friday, 9 a.m. – 9 p.m. ET, and can often do a review right away.
- Let eligible members know the program can help them:
  - Take their medications as you prescribed.
  - Recognize the benefits of their medications.
  - Better understand side effects to help lower the risk for adverse reactions.
- If your practice has clinical pharmacists who are interested in completing CMRs, please contact our vendor partner, OutcomesMTM, at **clinics@outcomesmtm.com** to request a network agreement or learn more.
- At every appointment, remind members about the importance of taking their medications as prescribed.

Statin Use in Persons With Diabetes (SUPD)

New for 2023

- Liver disease exclusion now limited to cirrhosis.
- Removed Farxiga and Jardiance from drug list used to identify patients with diabetes.
- Added Tirzepatide to drug list to identify patients with diabetes.
- Removed T46.6X5A exclusion code

Definition

Percentage of Medicare members with diabetes ages 40–75 who receive at least 1 fill of a statin medication in the measurement year

Members with diabetes are defined as those who have at least 2 fills of diabetes medications during the measurement year.

Plan(s) Affected	Quality Program(s) Affected	Collection and Reporting Method
• Medicare	• CMS Star Ratings	**Part D Prescription Claims** • Pharmacy Data

Compliance

To comply with this measure, a member with diabetes must have a fill for at least 1 statin or statin combination medication in any strength or dose using their Part D benefit during the measurement year. The statins shown here are on a member's UnitedHealthcare Medicare Advantage formulary:[i,ii]

Formulary Tier	Medications		
Tier 1*	• Atorvastatin • Lovastatin • Pravastatin • Ezetimibe-simvastatin	• Simvastatin • Rosuvastatin • Amlodipine-atorvastatin	• Fluvastatin
Tier 3**	• Livalo®		

Required Exclusion(s)

Exclusion	Timeframe
• Members in hospice or using hospice services • End Stage Renal Disease: I12.0, I13.11, I13.2, N18.5, N18.6, N19, Z91.15, Z99.2 • Dialysis: Z91.15, Z99.2 • Beneficiaries with rhabdomyolysis or myopathy: G72.0, G72.89, G72.9, M60.80, M60.819, M60.829, M60.839, M60.849, M60.859, M60.869, M60.879, M60.9, M62.82 • Lactation: O91.03, O91.13, O91.23, O92.03, O92.5, O92.70, O92.79, Z39.1 • Pregnancy (1000+ codes) ***: O00.101, O09.00, O10.011, O20.0, O30.331, O99.019, O99.210, O99.340, O99.810, O99.820, Z33.1, Z34.00, Z34.83, Z34.90, Z34.91, Z34.92, Z34.93 • Cirrhosis: K70.30, K70.31, K71.7, K74.3, K74.4, K74.5, K74.60, K74.69 • Polycystic ovary syndrome (PCOS): E28.2 • Pre-diabetes: R73.03, R73.09	Any time during the measurement year

i All product names are registered ® trademarks of their respective holders. Use of them does not imply any affiliation with or endorsement by them.
ii The formulary and pharmacy network may change at any time.
*Lowest copay of all tier levels
**Tiers for these medications may be different for group retiree plans
*** not complete ICD 10 list

Statin Use in Persons With Diabetes (SUPD)

Tips and Best Practices to Help Close This Care Opportunity:

- **Please check your Patient Care Opportunity Report (PCOR) often.** Look in the Pharmacy Detail tab for members with open care opportunities.
- Log on to Practice Assist to review members with open care opportunities.
  - Select **Medication Adherence** to view your patient list.
  - Members without a statin fill this year will be marked with a "Gap" under the SUPD measure.
- **Importance of taking a statin:** American Diabetes Association (ADA), American Heart Association (AHA) and American College of Cardiology (ACC) suggest people with diabetes take a moderate statin therapy without calculating a 10-year ASCVD risk. In patients with diabetes and higher cardiovascular risk, a high-intensity statin is reasonable. Statins can reduce the risk of heart attack and stroke, even in patients who do not have high cholesterol. Patients with type 1 and type 2 diabetes have increased prevalence of lipid abnormalities that leads to increased risk of developing atherosclerotic cardiovascular disease (ASCVD).[1-2] Statin use in patients with diabetes has shown to decrease incidence of cardiovascular events by 21% per 39 mg/dL decrease in LDL and decrease mortality by 9% per 39 mg/dL.[3]
- **Consider prescribing a statin, as appropriate.** If you determine a statin medication is appropriate, please send a prescription to the member's preferred pharmacy.*
- Prescription must be filled through Part D insurance card to close this care opportunity. Prescriptions filled through cash claims, discount programs (such as GoodRx) and medication samples will not close the measure.
- If member has intolerance or side effects such as myalgias, if clinically appropriate, consider:
  - A different statin that is hydrophilic (e.g., rosuvastatin or pravastatin)
  - A lower dose statin than previously tried
  - Reducing the frequency
- For members who meet exclusion criteria, a claim using appropriate ICD-10 code must be submitted ANNUALLY if applicable
- Members turning 76 years old during the measurement year, a statin must be filled at least the month BEFORE their 76th birthday
- Only statins satisfy the measure; other cholesterol medications such as ezetimibe or PCSK9 inhibitors do not satisfy the measure
- Consider extended day fills (e.g., 90- or 100-day supply) or send to home delivery
- Unstructured/supplemental data cannot be submitted for gap closure for SUPD

References:

1. Grundy SM, Stone NJ, Bailey AL, et al. 2018 AHA/ACC/AACVPR/AAPA/ABC/ACPM/ADA/AGS/APhA/ASPC/NLA/PCNA Guideline on the Management of Blood Cholesterol. Circulation. 2018;139(25:e1046-e1081). doi:10.1161/cir.0000000000000625. Accessed February 24, 2023
2. Nuha A. ElSayed, Grazia Aleppo, Vanita R. Aroda, et al. on behalf of the American Diabetes Association, 10. Cardiovascular Disease and Risk Management: Standards of Care in Diabetes –2023. Diabetes Care 1 January 2023; 46 (Supplement_1): S158 -S190. https://doi.org/10.2337/dc23-S010. Accessed February 24, 2023
3. Naeem F, McKay G, Fisher M. Cardiovascular outcomes trials with statins in diabetes. British Journal of Diabetes. 2018; 18(1):7-13.

*Member may use any pharmacy in the network, but may not receive preferred retail pharmacy pricing. Pharmacies in the Preferred Retail Pharmacy Network may not be available in all areas. Co-pays apply after deductible.

Electronic Clinical Data Systems Measures

HEDIS® Electronic Clinical Data Systems (ECDS) measures are designed for payer or health system reporting. These measures use digital clinical data sources containing member information and allows for this information to be used to close gaps in care.

Why is ECDS important?

The National Committee for Quality Assurance (NCQA) implemented ECDS to help move measures towards a more digital future. There is potential for traditional reporting to transition to ECDS reporting, which may impact rates and incentives. That's why it's important for you to connect with your UnitedHealthcare representative if you're currently not sharing clinical data electronically. UnitedHealthcare prefers CCD files that comply with the most current HL7 standards.

What's the difference between traditional HEDIS® measures and ECDS measures?

ECDS is a streamlined approach to closing care gaps to help reduce the administrative burden and resources traditional reporting requires of providers and UnitedHealthcare.

Although these measures can be closed via administrative claims, this reporting category encourages pursuing clinical data often found in electronic medical record systems. The goal is to promote the integration of clinical information by automatically transferring needed data for gap closure. ECDS measures allow for plans to view quality care prospectively as opposed to reviewing quality care retrospectively.

What type of data gets collected for ECDS?

Organizations may use several data sources to provide complete information about the quality of health services delivered to its members. Data systems that may be eligible for HEDIS® ECDS reporting include, but are not limited to:

- Administrative claims
- Member eligibility files
- Electronic health records
- Clinical registries
- Health information exchanges
- Administrative claims systems
- Disease/case management registries

What are the requirements to report ECDS?

Per NCQA, to qualify for HEDIS® ECDS reporting, practitioners or practitioner groups that are accountable for clinical services provided to members must not be prevented from accessing any data used by a health plan for quality measure reporting, regardless of the initial Source System of Record (SSoR). Each SSoR is a database where, through integrity testing, the data structure is standardized so it can be electronically extracted for HEDIS® ECDS reporting.

The sources are prioritized into 4 categories:

- Electronic health record (EHR)/personal health record (PHR) (the system of data origin such as laboratory, pharmacy, pathology, radiology)
- Health information exchange (HIE)/clinical registry
- Case management registry
- Administrative

How many ECDS measures are there?

There are currently 14 ECDS measures. NCQA will increase ECDS reported measures by transitioning traditional measures. Out of those 14 ECDS measures, 6 are traditional HEDIS® measures. The 14 measures include:

*Member may use any pharmacy in the network, but may not receive preferred retail pharmacy pricing. Pharmacies in the Preferred Retail Pharmacy Network may not be available in all areas. Co-pays apply after deductible.

Electronic Clinical Data Systems Measures (continued)

ECDS-only measures

- Breast Cancer Screening (BCS-E)
- Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)
- Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS-E)
- Depression Remission or Response for Adolescents and Adults (DRR-E)
- Unhealthy Alcohol Use Screening and Follow-Up (ASF-E)
- Adult Immunization Status (AIS-E)
- Prenatal Immunization Status (PRS-E)
- Prenatal Depression Screening and Follow-Up (PND-E)
- Postpartum Depression Screening and Follow-Up (PDS-E)
- Social Need Screening and Intervention (SNS-E) – new in 2023

Traditional HEDIS® and ECDS Measures

- Avoidance of Antibiotic Treatment for Acute Bronchitis/ Bronchiolitis (AAB-E)
- Childhood Immunization Status (CIS-E)
- Immunizations for Adolescents (IMA-E)
- Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E)
- Colorectal Cancer Screening (COL-E)
- Follow-Up Care for Children Prescribed ADHD Medication (ADD-E)

*Member may use any pharmacy in the network, but may not receive preferred retail pharmacy pricing. Pharmacies in the Preferred Retail Pharmacy Network may not be available in all areas. Co-pays apply after deductible.

Adult Immunization Status (AIS-E)

Definition

Percentage of members ages 19 and older who have had the following vaccinations in the recommended time frame:

- 1 Influenza vaccine
- 1 Td/Tdap vaccine
- 1 (live) or 2 (recombinant) Herpes Zoster (Shingles)
- 1 Adult Pneumococcal vaccine

Plan(s) Affected	Quality Program(s) Affected	Collection and Reporting Method
• Medicare	• CMS Star Ratings	**Part D Prescription Claims** • Pharmacy Data

Plan(s) Affected	Quality Program(s) Affected	Collection and Reporting Method
• **Commercial** • **Medicaid** • **Medicare**	• NCQA Health Plan Ratings	• **Electronic Data Only**

Codes

If applicable, see appendix for codes and descriptions

Influenza Vaccine
Number of Doses: 1
Special Circumstances

- Members aged 19 and older
- Vaccine administered on or between July 1 of the year prior to measurement year and June 30 of the measurement year
- Anaphylaxis due to the influenza vaccine will count toward compliance

CPT®/CPT II	90630, 90653, 90654, 90656, 90658, 90661, 90662, 90673, 90674, 90682, 90686, 90688, 90689, 90694
CVX Codes	88, 135, 140, 141, 144, 150, 153, 155, 158, 166, 168, 171, 185, 186, 197, 205
SNOMED	86198006

Influenza Vaccine
Number of Doses 1
Special Circumstances

- Members aged 19 and older
- Vaccine administered on or between July 1 of the year prior to measurement year and June 30 of the measurement year

CPT®/CPT II	90660, 90672
CVX Codes	111, 149
SNOMED	787016008

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ii The formulary and pharmacy network may change at any time.

*Lowest copay of all tier levels

**Tiers for these medications may be different for group retiree plans

Adult Immunization Status (AIS-E)

Td/Tdap
Special Circumstances
- Members age 19 and older
- Vaccine administered between 9 years prior to the start of the measurement year and the end of the measurement year
- Anaphylaxis or encephalitis due to the diphtheria, tetanus or pertusis vaccine will count toward compliance

CPT®/CPT II	90714, 90715, 90718
CVX Codes	09.113.115.138, 139
SNOMED	73152006, 312869001, 395178008, 395179000, 395180002, 395181003, 414619005, 416144004, 416591003, 417211006, 417384007, 417615007, 866161006, 866184004, 866185003, 866186002, 866227002, 868266002, 868267006, 868268001, 870668008, 870669000, 870670004, 871828004, 390846000, 412755006, 412756007, 412757003, 428251000124104, 571571000119105

Encephalitis Due to Diphtheria, Tetanus or Pertussis Vaccine

SNOMED	192710009, 192711008, 192712001

Anaphylaxis Due to Diphtheria, Tetanus or Pertussis Vaccine

SNOMED	1428281000124107, 428291000124105

Adult Pneumococcal Vaccine
Number of Doses: 1
Special Circumstances
- Members age 66 and older
- Vaccine administered during the measurement year
- Anaphylaxis to the pneumococcal vaccine any time before or during the measurement year will count toward compliance

CPT®/CPT II	90670, 90671, 90677, 90732
CVX Codes	33, 109, 133, 152, 215, 216
SNOMED	12866006, 394678003, 871833000, 1119366009, 1119367000, 1119368005, 434751000124102

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ii The formulary and pharmacy network may change at any time.
*Lowest copay of all tier levels
**Tiers for these medications may be different for group retiree plans

Adult Immunization Status (AIS-E)

Herpes Zoster (Shingles)
Number of doses: 1 live vaccine or 2 doses of herpes zoster recombinant vaccine.
- Special Circumstances
- Members age 50 and older
- Vaccine administered on or after their 50th birthday
- The recombinant vaccine must be at least 28 days apart
- Anaphylaxis to the herpes zoster will count toward compliance

Anaphylaxis Due to Herpes Zoster Vaccine

SNOMED	471371000124107, 471381000124105

Tips and Best Practices to Help Close This Care Opportunity:

- **Standing orders** can help your office staff be part of the vaccination process
  - Offer vaccine information sheets (VIS) to read while patients wait
  - Medical assistants can verify interest and obtain the vaccine to be administered
  - Train staff to answer questions, administer and document in the patient's chart
  - Consider having front office staff offer VISs in the patient's preferred language
  - Immunize.org offers numerous translations that can be selected and printed, as needed
- Have **office staff wear pins** that show they've been vaccinated to help prompt patients to ask questions
  - Example: A 'Got my flu shot' button may prompt someone to ask if flu shots are available
- Provide patients **information about vaccines** based on timing and eligibility
  - As members are turning 50, share information about the shingles vaccine
  - Ask or check when patients received their last Tdap, has it been 10 years?
  - If they have a qualifying health condition or turning 65, share information about pneumonia vaccines
  - September through November provide information on influenza vaccines
- Stock vaccines in your office to make the visit a single stop for the patient and leverage trained staff to administer as part of their visit
- Consider which vaccines are most commonly needed based on your community
- Have a quick reference where patients can get vaccines not stocked at your office
- Place images and information about vaccinations throughout your office, including that they may be covered by the patient's health plan or low cost, on:
  - Posters
  - Placards
  - Stickers on charts

Breast Cancer Screening - Electronic (BCS-E)

New for 2023

Added

- Rates will not include stratification by race and ethnicity

Updated

- BCS will now be referred to as BCS-E and will be an electronic only measure
- Data for BCS-E can be obtained through electronic health records, personal health records, clinical registries, health information exchanges, administrative claims, immunization information systems or disease and case management registries

This measure is also an ECDS measure

Yes!
Supplemental Data Accepted

Definition

Percentage of female members ages 50-74 who had a mammogram screening completed on or by Oct. 1, two years prior to the measurement year through Dec. 31 of the measurement year.

Plan(s) Affected	Quality Program(s) Affected	Collection and Reporting Method
• Commercial • Exchange/Marketplace • Medicaid • Medicare	• CMS Star Ratings • CMS Quality Rating System • NCQA Accreditation • NCQA Health Plan Ratings	**Administrative** • Claim/Encounter Data

Codes

The following codes can be used to close HEDIS® numerator gaps in care; they are not intended to be a directive of your billing practice.

Mammography	
CPT®/CPT II	77061, 77062, 77063, 77065, 77066, 77067
LOINC	24604-1, 24605-8, 24606-6, 24610-8, 26175-0, 26176-8, 26177-6, 26287-3, 26289-9, 26291-5, 26346-7, 26347-5, 26348-3, 26349-1, 26350-9, 26351-7, 36319-2, 36625-2, 36626-0, 36627-8, 36642-7, 36962-9, 37005-6, 37006-4, 37016-3, 37017-1, 37028-8, 37029-6, 37030-4, 37037-9, 37038-7, 37052-8, 37053-6, 37539-4, 37542-8, 37543-6, 37551-9, 37552-7, 37553-5, 37554-3, 37768-9, 37769-7, 37770-5, 37771-3, 37772-1, 37773-9, 37774-7, 37775-4, 38070-9, 38071-7, 38072-5, 38090-7, 38091-5, 38807-4, 38820-7, 38854-6, 38855-3, 39150-8, 39152-4, 39153-2, 39154-0, 42168-5, 42169-3, 42174-3, 42415-0, 42416-8, 46335-6, 46336-4, 46337-2, 46338-0, 46339-8, 46342-2, 46350-5, 46351-3, 46354-7, 46355-4, 46356-2, 46380-2, 48475-8, 48492-3, 69150-1, 69251-7, 69259-0, 72137-3, 72138-1, 72139-9, 72140-7, 72141-5, 72142-3, 86462-9, 86463-7, 91517-3, 91518-1, 91519-9, 91520-7, 91521-5, 91522-3
SNOMED	12389009, 24623002, 43204002, 71651007, 241055006, 241057003, 241058008, 258172002, 439324009, 450566007, 709657006, 723778004, 723779007, 723780005, 726551006, 833310007, 866234000, 866235004, 866236003, 866237007, 384151000119104, 392521000119107, 392531000119105, 566571000119105, 572701000119102

Breast Cancer Screening (BCS-E)

Required Exclusion(s)

Exclusion	Timeframe
• Members in hospice or using hospice services • Members who died • Members receiving palliative care	Any time during the measurement year
Members ages 66 and older as of Dec. 31 of the measurement year who had at least 2 diagnoses of frailty on different dates of service and advanced illness.* Advanced illness is indicated by one of the following: • Two or more outpatient, observation, emergency room, telephone, e-visits, virtual check-ins or non-acute inpatient encounters or discharge(s) on separate dates of service with a diagnosis of advanced illness • One or more acute inpatient encounter(s) with a diagnosis of advanced illness • One or more acute inpatient discharge(s) with a diagnosis of advanced illness on the discharge claim • Dispensed a dementia medication: Donepezil, Donepezil-memantine, galantamine, rivastigmine or memantine	**Frailty** diagnoses must be in the measurement year and on different dates of service **Advanced illness** diagnosis must be in the measurement year or year prior to the measurement year
Medicare members ages 66 and older as of Dec. 31 of the measurement year who are either: • Enrolled in an Institutional Special Needs Plan (I-SNP) • Living long term in an institution*	Any time during the measurement year

***Supplemental and medical record data may not be used for the frailty with advanced illness or institutional living exclusions.**

Breast Cancer Screening (BCS-E)

Exclusion	Timeframe
Bilateral mastectomy • History of bilateral mastectomy • Unilateral mastectomy with a bilateral modifier – Documentation of unilateral mastectomy may come from claims or the medical record • Any combination of the following that indicate a mastectomy on both the left and right side: – Absence of the left and right breast – Unilateral mastectomy (claims or medical record) with a left-side modifier – Unilateral mastectomy (claims or medical record) with a right-side modifier – Left unilateral mastectomy – Right unilateral mastectomy	Any time in a member's history through Dec. 31 of the measurement year

Important Notes

	Test, Service or Procedure to Close Care Opportunity	Medical Record Detail Including, But Not Limited To
• This measure does not include biopsies, breast ultrasounds or MRIs. • If documenting a mammogram in a member's history, please include the month and year. The result is not required.	Mammogram – all types and methods including screening, diagnostic, film, digital or digital breast tomosynthesis	• Consultation reports • Diagnostic reports • Health history and physical

Breast Cancer Screening (BCS-E)

Tips and Best Practices to Help Close This Care Opportunity

- **Please check your Patient Care Opportunity Report (PCOR) often to see members with open care opportunities.** If you have questions, your UnitedHealthcare representative can help.
- **Always include a date of service – year and month is acceptable – when documenting a mammogram reported by a member.**
- Per the CDC, lymphadenopathy may occur 4-6 weeks after the COVID-19 vaccination. Please encourage your patients to wait the appropriate amount of time before scheduling their mammogram or complete the mammogram before receiving the COVID-19 vaccine, to account for lymphadenopathy. This will help prevent the vaccine impacting screening results.
- Thermography for any indication (including breast lesions which were excluded from Medicare coverage on July 20, 1984) is excluded from Medicare coverage.
- For MY 2023, NCQA has not added an exclusion code to the Value Set Directory for transgender females. These women must be manually excluded from outreach and HEDIS® denominators.
- As an administrative measure, it's important to submit the appropriate ICD-10 diagnosis code that reflects a member's history of bilateral mastectomy, Z90.13.
  - If a member is new to the care provider and the diagnosis is discovered during the history and physical, the code should be submitted with the initial visit claim.
  - If a member isn't new to the care provider, but the member's chart has a documented history of the diagnosis, the ICD-10 diagnosis code should be submitted on any visit claim.
- Breast cancer screening or mastectomy codes can be accepted as supplemental data, reducing the need for some chart review. Please contact your UnitedHealthcare representative to discuss clinical data exchange opportunities.
- Sharing member demographic data is critical to understanding the cultural, linguistic and social needs of those we serve and decreasing health inequities across the care continuum. This data can include, but is not limited to, race, ethnicity, language, sexual orientation, gender identity, pronouns, sex assigned at birth and disability status. As part of UnitedHealthcare's clinical structured data exchange program, we encourage you to include this demographic data with any structured data file or CCD. Your information is confidential. UnitedHealthcare will keep personally identifiable information confidential and won't disclose any information without your written consent.

Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)

Description

Members ages 12 and over as of January 1 of the measurement year who had:

- Depression Screening: Documented result of depression in the measurement year using a age-appropriate standardized instrument
- Follow-Up: Upon documentation of a positive depression screening, members receive follow-up (medication or treatment) within 30 days of the positive screening
  - Note: If a positive screen is followed up with a negative finding on the same day, that will count toward the numerator.

Plan(s) Affected	Quality Program(s) Affected	Collection and Reporting Method
• Commercial • Medicaid • Medicare	• Select State Reporting	• **Electronic Data Only**

Codes

If applicable, see appendix for codes and descriptions

Scenario 1 Outpatient visit with a diagnosis of depression or other behavioral health diagnosis

Behavioral Health Encounter	
CPT®/CPT II	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90845, 90846, 90847,90849, 90853, 90865, 90867, 90868, 90869, 90870, 90875, 90876, 90880, 90887, 99484, 99492, 99493
HCPCS	G0155, G0176, G0177, G0409, G0410, G0411, G0511, G0512, H0002, H0004, H0031, H0034, H0035, H0036, H0037, H0039, H0040, H2000, H2001, H2010, H2011, H2012, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, S0201, S9480, S9484, S9485
SNOMED	5694008, 10197000, 10997001, 38756009, 45392008, 79094001, 88848003, 90407005, 91310009, 165171009, 165190001, 225337009, 370803007, 372067001, 385721005, 385724002, 385725001, 385726000, 385727009, 385887004, 385889001, 385890005,401277000,410223002, 410224008, 410225009, 410226005, 410227001, 410228006, 410229003, 410230008, 410231007, 410232000, 410233005, 410234004, 439141002
UBREV	0900, 0901, 0902, 0903, 0904, 0905, 0907, 0911, 0912, 0913, 0914, 0915, 0916, 0917, 0919

i All product names are registered ® trademarks of their respective holders. Use of them does not imply any affiliation with or endorsement by them.

ii The formulary and pharmacy network may change at any time.

*Lowest copay of all tier levels

**Tiers for these medications may be different for group retiree plans

Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)

Codes

Depression Case Management Encounter	
CPT®/CPT II	99366, 99492, 99493, 99494
HCPCS	G0512, T1016, T1017, T2022, T2023
SNOMED	182832007, 225333008, 385828006, 386230005, 409022004, 410216003, 410219005, 410328009, 410335001, 410346003, 410347007, 410351009, 410352002, 410353007, 410354001, 410356004, 410360001, 410363004, 410364005, 410366007, 416341003, 416584001, 424490002, 425604002, 737850002
Follow-Up Visit	
CPT®/CPT II	98960, 98961, 98962, 98966, 98967, 98968, 98969, 98970,98971, 98972, 99078, 99201,99202, 99203, 99204,99205,99211, 99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, 99241, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99421, 99422, 99423, 99441, 99442, 99443, 99444, 99457, 99483
HCPCS	G0071, G0463, G2010, G2012, G2061, G2062, G2063, G2250, G2251,G2252, T1015
SNOMED	42137004, 50357006, 86013001, 90526000, 108220007, 108221006, 185317003, 185389009, 281036007, 314849005, 386472008, 386473003, 390906007, 401267002, 406547006, 870191006
UBREV	0510, 0513, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0526, 0527, 0528, 0529, 0982, 0983

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*Lowest copay of all tier levels

**Tiers for these medications may be different for group retiree plans

Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)

Codes

Scenario 2. Dispensed an antidepression medication

Required Exclusion If applicable, see Appendix for codes and descriptions.	Timeframe
• Members in hospice or using hospice services • History of bipolar diagnosis • Diagnosis of depression	- Any time during the measurement year - Anytime during the member's hsitory through the end of the measurment year - Any time during the year prior to the measurment year

Tips and Best Practices:

- To refer your patient to a behavioral health specialist or to request coordination of care, please call the number on the back of the patient's health plan ID card or search **liveandworkwell.com**
- Encourage the use of telehealth when appropriate

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*Lowest copay of all tier levels

**Tiers for these medications may be different for group retiree plans

Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS-E)

Definition

Members ages 12 and older with a diagnosis of major depression or dysthymia, who had an outpatient encounter with a PHQ-9 score present in their record in the same assessment period as the encounter. Three Assessment Periods include:

- Assessment period 1: January 1–April 30
- Assessment period 2: May 1–August 31
- Assessment period 3: September 1–December 31

This measure is episode based and not member based. Members may have an eligible encounter in all 3 assessment periods.

Plan(s) Affected	Quality Program(s) Affected	Collection and Reporting Method
• Commercial • Medicaid • Medicare	• Select State Reporting	• **Electronic Data Only**

Codes

If applicable, see appendix for codes and descriptions

Scenario 1 Outpatient visit with a diagnosis of depression or other behavioral health diagnosis

Interactive Outpatient Encounter	
CPT®/CPT II	90791, 90792, 90832, 90834, 90837, 98960, 98961, 98962, 98966, 98967, 98968, 98969, 98970, 98971, 98972, 99078, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, 99241, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99421, 99422, 99423, 99441, 99442, 99443, 99444, 99457, 99483, 99492, 99493, 99494, 99510
HCPCS	G0071, G0155, G0176, G0177, G0409, G0410, G0411, G0463, G0512, G2010, G2012, G2061, G2062, G2063, G2250, G2251, G2252, H0002, H0004, H0031, H0034, H0035, H0036, H0037, H0039, H0040, H2000, H2001, H2010, H2011, H2012, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, S0201, S9480, S9484, S9485, T1015
SNOMED	19681004, 90526000, 185317003, 185349003, 185463005, 185465003, 270427003, 270430005, 308335008, 314849005, 386472008, 386473003, 390906007, 401267002, 406547006, 439708006
UBREV	00510, 0513, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0526, 0527, 0528, 0529, 0900, 0901, 0902, 0903, 0904, 0905, 0907, 0911, 0912, 0913, 0914, 0915, 0916, 0917, 0919, 0982, 0983

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ii The formulary and pharmacy network may change at any time.

*Lowest copay of all tier levels

**Tiers for these medications may be different for group retiree plans

Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS-E)

Required Exclusion If applicable, see Appendix for codes and descriptions.	Timeframe
• Members in hospice or using hospice services • History of bipolar disorder, personality disorder, psychotic disorder or pervasive developmental disorder • Diagnosis of depression	- Any time during the measurement year - Anytime during the member's hsitory through the end of the measurment year - Any time during the year prior to the measurment year

Important Notes

	Test, Service or Procedure to Close Care Opportunity	Medical Record Detail Including, But Not Limited To
Use age appropriate PHQ-9 assessments: • PHQ-9: ages 12 years and older • PHQ-9 Modified for Teens: ages 12-17	The PHQ-9 can be conducted using telehealth, telephone or a web-based portal/application	• This measure is episode based and not member based

Tips and Best Practices:

- To refer your patient to a behavioral health specialist or to request coordination of care, please call the number on the back of the patient's health plan ID card or search **liveandworkwell.com**
- Encourage the use of telehealth or online assessments when appropriate

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

Definition

Members ages 12 and older with a diagnosis of depression and an elevated PHQ-9 score, who had evidence of response or remission within 4-8 months of the elevated score.

- Follow-Up PHQ-9: The percentage of members who have a follow-up PHQ-9 score documented within 4-8 months after the initial elevated PHQ-9 score
- Depression Remission: The percentage of members who achieved remission within 4-8 months after the initial elevated PHQ-9 score
- Depression Response: The percentage of members who showed response within 4-8 months after the initial elevated PHQ-9 score

Plan(s) Affected	Quality Program(s) Affected	Collection and Reporting Method
• Commercial • Medicaid • Medicare	• Select State Reporting	• **Electronic Data Only**

Codes

If applicable, see appendix for codes and descriptions

Scenario 1 Outpatient visit with a diagnosis of depression or other behavioral health diagnosis

Interactive Outpatient Encounter	
CPT®/CPT II	90791, 90792, 90832, 90834, 90837, 98960, 98961, 98962, 98966, 98967, 98968, 98969, 98970, 98971, 98972, 99078, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, 99241, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99421, 99422, 99423, 99441, 99442, 99443, 99444, 99457, 99483, 99492, 99493, 99494, 99510
HCPCS	G0071, G0155, G0176, G0177, G0409, G0410, G0411, G0463, G0512, G2010, G2012, G2061, G2062, G2063, G2250, G2251, G2252, H0002, H0004, H0031, H0034, H0035, H0036, H0037, H0039, H0040, H2000, H2001, H2010, H2011, H2012, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, S0201, S9480, S9484, S9485, T1015
SNOMED	19681004, 90526000, 185317003, 185349003, 185463005, 185465003, 270427003, 270430005, 308335008, 314849005, 386472008, 386473003, 390906007, 401267002, 406547006, 439708006
UBREV	0510, 0513, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0526, 0527, 0528, 0529, 0900, 0901, 0902, 0903, 0904, 0905, 0907, 0911, 0912, 0913, 0914, 0915, 0916, 0917, 0919, 0982, 0983

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ii The formulary and pharmacy network may change at any time.

*Lowest copay of all tier levels

**Tiers for these medications may be different for group retiree plans

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

Required Exclusion If applicable, see Appendix for codes and descriptions.	Timeframe
• Members in hospice or using hospice services • History of bipolar disorder, personality disorder, psychotic disorder or pervasive developmental disorder	- Any time during the measurement year - Anytime during the member's hsitory through the end of the measurment year

Important Notes

	Test, Service or Procedure to Close Care Opportunity
Use age appropriate PHQ-9 assessments: • PHQ-9: ages 12 years and older • PHQ-9 Modified for Teens: ages 12-17	The PHQ-9 can be conducted using telehealth, telephone or a web-based portal/application

Tips and Best Practices:

- To refer your patient to a behavioral health specialist or to request coordination of care, please call the number on the back of the patient's health plan ID card or search **liveandworkwell.com**
- Encourage the use of telehealth appointments when appropriate

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*Lowest copay of all tier levels

**Tiers for these medications may be different for group retiree plans

Prenatal Immunization Status (PRS-E)

Definition

Members who had a live birth in the measurement period (January 1 to December 1 of the measurment year) and who have had the following vaccinations in the recommended timeframe:

- 1 Influenza vaccine
- 1 Td/Tdap vaccine

Plan(s) Affected	Quality Program(s) Affected	Collection and Reporting Method
• Commercial • Medicaid	• NCQA Health Plan Ratings • Select State Reporting	• **Electronic Data Only**

Codes

If applicable, see appendix for codes and descriptions

Influenza Vaccine Number of Doses: 1

Special Circumstances

- Vaccine administered on or between July 1 of the year prior to measurement year and the delivery date
- Anaphylaxis due to the influenza vaccine will count toward compliance

CPT®/CPT II	90630, 90653, 90654, 90656, 90658, 90661, 90662, 90673, 90674, 90682, 90686, 90688, 90689, 90694, 90756
HCPCS	88, 135, 140, 141, 144, 150, 153, 155, 158, 166, 168, 171, 185, 186, 197, 205
SNOMED	86198006

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ii The formulary and pharmacy network may change at any time.

*Lowest copay of all tier levels

**Tiers for these medications may be different for group retiree plans

Prenatal Immunization Status (PRS-E)

Tips and Best Practices to Help Close This Care Opportunity

- **Standing orders** can help your office staff be part of the vaccination process
  - Offer vaccine information sheets (VIS) to read while patients wait
  - Medical assistants can verify interest and obtain the vaccine to be administered
  - Train staff to answer questions, administer and document in the patient's chart
  - Consider having front office staff offer VISs in the patient's preferred language
  - Immunize.org offers numerous translations that can be selected and printed, as needed
- Have **office staff wear pins** that show they've been vaccinated to help prompt patients to ask questions
  - Example: A 'Got my flu shot' button may prompt someone to ask if flu shots are available
- Provide patients **information about vaccines** based on timing and eligibility
  - As members are turning 50, share information about the shingles vaccin
  - Ask or check when patients received their last Tdap, has it been 10 years?
  - If they have a qualifying health condition or turning 65, share information about pneumonia vaccines
  - September through November provide information on influenza vaccines
- Stock vaccines in your office to make the visit a single stop for the patient and leverage trained staff to administer as part of their visit
- Consider which vaccines are most commonly needed based on your community
- Have a quick reference where patients can get vaccines not stocked at your office
- Place images and information about vaccinations throughout your office, including that they may be covered by the patient's health plan or low cost, on:
  - Posters
  - Placards
  - Stickers on charts

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ii The formulary and pharmacy network may change at any time.

*Lowest copay of all tier levels

**Tiers for these medications may be different for group retiree plans

Postpartum Depression Screening and Follow-Up (PDS-E)

Definition

Members who had a live birth from Sept. 8 of the year prior to the measurement period through Sept. 7 of the measurement period and who received the following during their postpartum period (7-84 days after the delivery):

- Depression Screening: Clinical depression screening using a standardized instrument
- Follow-up: Upon documentation of a positive depression screening, members receive follow-up within 30 days of the positive screening
  - Note: If a positive screen is followed up with a negative finding on the same day, that will count toward the numerator. Screening must have been done using a full-length instrument (e.g., PHQ-9, PROMIS Depression)

Plan(s) Affected	Quality Program(s) Affected	Collection and Reporting Method
• Commercial • Medicaid	• Select State Reporting	• **Electronic Data Only**

Codes

If applicable, see appendix for codes and descriptions

Scenario 1. Outpatient visit with a diagnosis of depression or other behavioral health diagnosis

Behavioral Health Encounter	
CPT®/CPT II	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90845, 90846, 90847, 90849, 90853, 90865, 90867, 90868, 90869, 90870, 90875, 90876, 90880, 90887, 99484, 99492, 99493
HCPCS	G0155, G0176, G0177, G0409, G0410, G0411, G0511, G0512, H0002, H0004, H0031, H0034, H0035, H0036, H0037, H0039, H0040, H2000, H2001, H2010, H2011, H2012, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, S0201, S9480, S9484, S9485
SNOMED	5694008, 10197000, 10997001, 38756009, 45392008, 79094001, 88848003, 90407005, 91310009, 165171009, 165190001, 225337009, 370803007, 372067001, 385721005, 385724002, 385725001, 385726000, 385727009, 385887004, 385889001, 385890005, 401277000, 410223002, 410224008, 410225009, 410226005, 410227001, 410228006, 410229003, 410230008, 410231007, 410232000, 410233005, 410234004, 439141002
UBREV	0900, 0901, 0902, 0903, 0904, 0905, 0907, 0911, 0912, 0913, 0914, 0915, 0916, 0917, 0919

Postpartum Depression Screening and Follow-Up (PDS-E)

Codes

If applicable, see appendix for codes and descriptions

Depression Case Management Encounter	
CPT®/CPT II	99366, 99492, 99493, 99494
HCPCS	G0512, T1016, T1017, T2022, T2023
SNOMED	182832007, 225333008, 385828006, 386230005, 409022004, 410216003, 410219005, 410328009, 410335001, 410346003, 410347007, 410351009, 410352002, 410353007, 410354001, 410356004, 410360001, 410363004, 410364005, 410366007, 416341003, 416584001, 424490002, 425604002, 737850002

Follow-Up Visit	
CPT®/CPT II	98960, 98961, 98962, 98966, 98967, 98968, 98969, 98970, 98971, 98972, 99078, 99201, 99202 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, 99241, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99421, 99422, 99423, 99441, 99442, 99443, 99444, 99457, 99483
HCPCS	G0071, G0463, G2010, G2012, G2061, G2062, G2063, G2250, G2251, G2252, T1015
SNOMED	42137004, 50357006, 86013001, 90526000, 108220007, 108221006, 185317003, 185389009, 281036007, 314849005, 386472008, 386473003, 390906007, 401267002, 406547006,870191006
UBREV	0510, 0513, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0526, 0527, 0528, 0529, 0982, 0983

Postpartum Depression Screening and Follow-Up (PDS-E)

Codes

Scenario 2. Dispensed an antidepression medication

Required Exclusion If applicable, see Appendix for codes and descriptions.	Timeframe
• Members in hospice or using hospice services	- Any time during the measurement year - Any time during the measurement period ((January 1 to December 1 of the measurmeent year)

Important Notes

	Test, Service or Procedure to Close Care Opportunity
Use age appropriate PHQ-9 assessments: • PHQ-9: ages 12 years and older • PHQ-9 Modified for Teens: ages 12-17	The PHQ-9 can be conducted using telehealth, telephone or a web-based portal/application

Tips and Best Practices:

- To refer your patient to a behavioral health specialist or to request coordination of care, please call the number on the back of the patient's health plan ID card or search **liveandworkwell.com.**
- Encourage the use of telehealth appointments when appropriate.

i All product names are registered ® trademarks of their respective holders. Use of them does not imply any affiliation with or endorsement by them.

ii The formulary and pharmacy network may change at any time.

*Lowest copay of all tier levels

**Tiers for these medications may be different for group retiree plans

Prenatal Depression Screening and Follow-Up (PND-E)

Definition

Members who had a live birth in the measurement year and who received the following during their pregnancy in the measurement period (January 1 to December 1 of the measurmeent year)

- Depression Screening: Clinical depression screening using a standardized instrument
- Follow-up: Upon documentation of a positive depression screening, members receive follow-up within 30 days of the positive screening
  - Note: If a positive screen is followed up with a negative finding on the same day, that will count toward the numerator. Screening must have been done using a full-length instrument (e.g., PHQ-9, PROMIS Depression

Plan(s) Affected	Quality Program(s) Affected	Collection and Reporting Method
• Commercial • Medicaid	• Select State Reporting	• **Electronic Data Only**

Codes

If applicable, see appendix for codes and descriptions

Scenario 1. Outpatient visit with a diagnosis of depression or other behavioral health diagnosis

Behavioral Health Encounter	
CPT®/CPT II	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90845, 90846, 90847, 90849, 90853, 90865, 90867, 90868, 90869, 90870, 90875, 90876, 90880, 90887, 99484, 99492, 99493
HCPCS	G0155, G0176, G0177, G0409, G0410, G0411, G0511, G0512, H0002, H0004, H0031, H0034, H0035, H0036, H0037, H0039, H0040, H2000, H2001, H2010, H2011, H2012, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, S0201, S9480, S9484, S9485
SNOMED	5694008, 10197000, 10997001, 38756009, 45392008, 79094001, 88848003, 90407005, 91310009, 165171009, 165190001, 225337009, 370803007, 372067001, 385721005, 385724002, 385725001, 385726000, 385727009, 385887004, 385889001, 385890005, 401277000, 410223002, 410224008, 410225009, 410226005, 410227001, 410228006, 410229003, 410230008, 410231007, 410232000, 410233005, 410234004, 439141002
UBREV	0900, 0901, 0902, 0903, 0904, 0905, 0907, 0911, 0912, 0913, 0914, 0915, 0916, 0917, 0919

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Prenatal Depression Screening and Follow-Up (PND-E)

Codes

If applicable, see appendix for codes and descriptions

Depression Case Management Encounter	
CPT®/CPT II	99366, 99492, 99493, 99494
HCPCS	G0512, T1016, T1017, T2022, T2023
SNOMED	182832007, 225333008, 385828006, 386230005, 409022004, 410216003, 410219005, 410328009, 410335001, 410346003, 410347007, 410351009, 410352002, 410353007, 410354001, 410356004, 410360001, 410363004, 410364005, 410366007, 416341003, 416584001, 424490002, 425604002, 737850002
UBREV	0900, 0901, 0902, 0903, 0904, 0905, 0907, 0911, 0912, 0913, 0914, 0915, 0916, 0917, 0919
Follow-Up Visit	
CPT®/CPT II	98960, 98961, 98962, 98966, 98967, 98968, 98969, 98970, 98971, 98972, 99078, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, 99241, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99421, 99422, 99423, 99441, 99442, 99443, 99444, 99457, 99483
HCPCS	GG0071, G0463, G2010, G2012, G2061, G2062, G2063, G2250, G2251, G2252, T1015
SNOMED	42137004, 50357006, 86013001, 90526000, 108220007, 108221006, 185317003, 185389009, 281036007, 314849005, 386472008, 386473003, 390906007, 401267002, 406547006, 870191006
UBREV	0510, 0513, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0526, 0527, 0528, 0529, 0982, 0983

*Lowest copay of all tier levels

**Tiers for these medications may be different for group retiree plans

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

This health plan member survey is a multi-year survey that evaluates consumer/member experiences. We use CAHPS results to compare data on members' experience of care between UnitedHealthcare and prescription drug plans.

The example survey questions here use the Medicare and Medicaid look-back period of 6 months. The questions for commercial members use a 12-month look-back.

Frequency: Annually between Feb. and June
Target Population: Medicare Advantage, commercial and Medicaid members
Measurement Year Look-Back: 6 months for Medicare and Medicaid, 12 months for commercial

Annual Flu Vaccine

Survey Question

- Have you had a flu shot since July 1 (of the previous year)?

Compliance Needed to Meet the Intent of the Measure
Percentage of sampled UnitedHealthcare members who received a flu vaccination during the measurement year

For the following survey questions, Medicare and Health Care Exchange members use the case-mix adjusted calculations. Commercial and Medicaid members don't use case-mix adjustment.

Care Coordination

Survey Questions Address:

- Whether the personal doctor is informed and up to date about care you received from other health care providers
- Whether the doctor had medical records and other information about the member's care (Medicare only)
- Whether there was follow-up with the member to provide test results (Medicare only)
- How quickly the member got the test results (Medicare only)
- Whether the doctor spoke with the member about prescription medicines (Medicare only)
- Whether the member received help managing care (Medicare only)

Compliance Needed to Meet the Intent of the Measure for Medicare Advantage Plan Members
This case-mix adjusted composite measure is used to assess care coordination. The CAHPS score uses the mean of the distribution of responses converted to a scale of 0 to 100.

Customer Service

Survey Questions

- How often did your health plan's customer service give you the information or help you needed?
- How often did your health plan's customer service treat you with courtesy and respect?
- How often were the forms for your health plan easy to fill out? (Medicare only)

Compliance Needed to Meet the Intent of the Measure
This case-mix adjusted composite measure is used to assess how easy it was for members to get information and help when needed. The CAHPS score uses the mean of the distribution of responses converted to a scale from 0 to 100.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

Getting Appointments and Care Quickly

Survey Questions

- When you needed care right away, how often did you get care as soon as you needed it?
- How often did you get an appointment for a check-up or routine care as soon as you needed?
- Wait time includes time spent in the waiting room and exam room. How often did you see the person you came to see within 15 minutes of your appointment time? (Medicare only)

Compliance Needed to Meet the Intent of the Measure
This case-mix adjusted composite measure is used to assess how quickly members were able to get appointments and care. The CAHPS score uses the mean of the distribution of responses converted to a scale from 0 to 100.

Getting Needed Care

Survey Questions

- How often did you get an appointment to see a specialist as soon as you needed?
- How often was it easy to get the care, tests or treatments you needed?)

Compliance Needed to Meet the Intent of the Measure
This case-mix adjusted composite measure is used to assess how easy it was for members to get needed care and see specialists. The CAHPS score uses the mean of the distribution of responses converted to a scale from 0 to 100.

Rating of Health Care

Survey Question

- Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care?

Compliance Needed to Meet the Intent of the Measure
This case-mix adjusted measure is used to assess members' view of the quality of care received from the health plan. The CAHPS score uses the mean of the distribution of responses converted to a scale from 0 to 100.

Rating of Health Plan

Survey Question

- Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your health plan?

Compliance Needed to Meet the Intent of the Measure
This case-mix adjusted measure is used to assess the overall view members have of their health plan. The CAHPS score uses the mean of the distribution of responses converted to a scale from 0 to 100.

Rating of Personal Doctor – Commercial and Medicaid Only

Survey Question

- Using any number from 0 to 10, where 0 is the worst personal doctor possible and 10 is the best personal doctor possible, what number would you use to rate your personal doctor?

Compliance Needed to Meet the Intent of the Measure
This measure is used to assess the overall view members have of their personal doctor.

Rating of Specialist Seen Most Often – Commercial and Medicaid Only

Survey Question

- We want to know your rating of the specialist you saw most often. Using any number from 0 to 10, where 0 is the worst specialist possible and 10 is the best specialist possible, what number would you use to rate that specialist?

Compliance Needed to Meet the Intent of the Measure
This measure is used to assess the overall view members have of the specialist they see most often.

Health Outcomes Survey (HOS)

This health plan member survey is used to gather valid, reliable and clinically meaningful health status data in the Medicare Advantage program for use in quality improvement activities, pay for performance, program oversight, public reporting and improving health. All managed care organizations with Medicare Advantage contracts must participate. The survey looks at physical and mental health outcomes measures, urinary incontinence in older adults, physical activity in older adults, fall risk management, and osteoporosis testing in older women.

Frequency: Annually between July and Nov.
Target Population: Medicare Advantage

Improving Bladder Control

HOS Data Only
Cohort follow-up data collection and cohort baseline data collection:

- **HOS Question 38:** Many people experience leakage of urine, also called urinary incontinence. In the past six months, have you experienced leaking of urine?
- **HOS Question 39:** During the past six months, how much did leaking of urine make you change your daily activities or interfere with your sleep?
- **HOS Question 41:** There are many ways to control or manage the leaking of urine, including bladder training exercises, medication and surgery. Have you ever talked with a doctor, nurse or other health care provider about any of these approaches?

Compliance Needed to Meet the Intent of the Measure
Percentage of Medicare members ages 65 and older who reported having urine leakage in the past six months (Question 38) and who discussed treatment options for their urinary incontinence with a health care provider (Question 41).

Improving or Maintaining Physical & Mental Health

HOS Data Only
Cohort follow-up data collection and cohort baseline data collection:

- **HOS Question 4a:** During the past four weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)? Accomplished less than you would like: None of the time, a little of the time, some of the time, most of the time, all of the time
- **HOS Question 4b:** During the past four weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)? Didn't do work or other activities as carefully as usual: None of the time, a little of the time, some of the time, most of the time, all of the time
- **HOS Question 6a:** How much of the time during the past four weeks have you felt calm and peaceful? None of the time, a little of the time, some of the time, most of the time, all of the time
- **HOS Question 6b:** How much of the time during the past four weeks did you have a lot of energy? None of the time, a little of the time, some of the time, most of the time, all of the time
- **HOS Question 6c:** How much of the time during the past four weeks have you felt downhearted and blue? None of the time, a little of the time, some of the time, most of the time, all of the time
- **HOS Question 7:** During the past four weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)? None of the time, a little of the time, some of the time, most of the time, all of the time

Compliance Needed to Meet the Intent of the Measure
Percentage of sampled Medicare members ages 65 and older whose mental health status was the same or better than expected (Questions 4a–b, 6a–c and 7).

Health Outcomes Survey (HOS)

Improving or Maintaining Physical Health

HOS Data Only
Cohort follow-up data collection and cohort baseline data collection:

- **HOS Question 1:** In general, would you say your health is excellent, very good, good, fair or poor?
- **HOS Question 2a:** The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much? Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling or playing golf: Limited a lot, limited a little, not limited at all
- **HOS Question 2b:** The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much? Climbing several flights of stairs: Limited a lot, limited a little, not limited at all
- **HOS Question 3a:** During the past four weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health? Accomplished less than you would like: None of the time, a little of the time, some of the time, most of the time, all of the time
- **HOS Question 3b:** During the past four weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health? Were limited in the kind of work or other activities: None of the time, a little of the time, some of the time, most of the time, all of the time
- **HOS Question 5:** During the past four weeks, how much did pain interfere with your normal work (including both work outside the home and housework)? Not at all, a little bit, moderately, quite a bit, extremely

Compliance Needed to Meet the Intent of the Measure
Percentage of sampled Medicare members ages 65 and older whose physical health status was the same, or better than expected (Questions 1, 2a-b, 3a-b and 5).

Contact us to learn more.

For more information about how our programs can help support your patients who are UnitedHealthcare plan members, please contact your UnitedHealthcare representative. Thank you.

Monitoring Physical Activity

HOS Data Only
Cohort follow-up data collection and cohort baseline data collection:

- **HOS Question 42:** In the past 12 months, did you talk with a doctor or other health provider about your level of exercise or physical activity? For example, a doctor or other health provider may ask if you exercise regularly or take part in physical exercise.
- **HOS Question 43:** In the past 12 months, did a doctor or other health care provider advise you to start, increase or maintain your level of exercise or physical activity? For example, in order to improve your health, your doctor or other health provider may advise you to start taking the stairs, increase walking from 10 to 20 minutes every day or maintain your current exercise program.

Compliance Needed to Meet the Intent of the Measure
Percentage of sampled Medicare members ages 65 and older who had a doctor's visit in the past 12 months and who received advice to start, increase, or maintain their level of exercise or physical activity (Question 43).

Reducing the Risk of Falling

HOS Data Only
Cohort follow-up data collection and cohort baseline data collection:

- **HOS Question 44:** A fall is when your body goes to the ground without being pushed. In the past 12 months, did your doctor or other health provider talk with you about falling or problems with balance or walking?
- **HOS Question 45:** Did you fall in the past 12 months?
- **HOS Question 46:** In the past 12 months, have you had a problem with balance or walking?
- **HOS Question 47:** Has your doctor or other health provider done anything to help prevent falls or treat problems with balance or walking? Some things they might do include:
  - Suggest you use a cane or walker.
  - Suggest you do an exercise or physical therapy program.
  - Suggest vision or hearing testing

Compliance Needed to Meet the Intent of the Measure
Percentage of Medicare members ages 65 and older who had a fall or had problems with balance or walking in the past 12 months (Question 46), who were seen by a practitioner in the past 12 months, and who received fall risk intervention from their current practitioner (Questions 45 and 47).

CPT® Category II Codes

Use to help achieve better outcomes for your patients and your practice.

CPT® Category II codes make it easier for you to share data with UnitedHealthcare quickly and efficiently. When you add them for certain preventive care services and test results, we can get a more complete picture of our plan members' health – and help you address care opportunities tied to Healthcare Effectiveness Data and Information Set (HEDIS®) quality measures.

Using CPT® Category II codes may also offer these benefits:

1. **Fewer medical record requests**
   When you add CPT® Category II codes, we won't have to request charts from your office to confirm care you've already completed.
2. **Enhanced performance**
   With better information, we can work with you to help identify opportunities to improve patient care. This may lead to better performance on HEDIS® measures for your practice.
3. **Improved health outcomes**
   With more precise data, we can refer UnitedHealthcare plan members to our programs that may be appropriate for their health situation to help support your plan of care.
4. **Less mail for members**
   With more complete information, we can avoid sending reminders to patients to get screenings they may have already completed.

List of CPT® Category II codes to report

The following chart shows which measures are tracked and which codes to use for each measure. For a complete list of CPT® Category II codes, please go to the American Medical Association website at **ama-assn.org** > Practice Management > CPT® (Current Procedural Terminology) > CPT Overview > Finding Coding Resources.

Measure	Code Descriptor	CPT® Category II Code
Advanced Care Planning – formerly COAACP	Advance care planning discussed and documented – advance care plan or surrogate decision-maker documented in medical record (DEM) (GER, Pall Cr)	1123F
	Advance care planning discussed and documented in medical record – patient didn't wish to or was unable to name a surrogate decision maker or provide an advance care plan (DEM) (GER, Pall Cr)	1124F
	Advance care plan or similar legal document in medical record	1157F
	Advance care planning discussion documented in the medical record	1158F
Care of Older Adults – Pain Assessment	Pain severity quantified; pain present	1125F
	Pain severity quantified; no pain present	1126F
Care of Older Adults – Medication Review	Medication list documented in medical record	1159F
	Review of all medications by a prescribing practitioner or clinical pharmacist (e.g., prescriptions, OTCs, herbal therapies and supplements) documented in the medical record	1160F
Care of Older Adults – Functional Assessment	Functional status assessed	1170F

CPT® Category II Codes

Measure	Code Descriptor	CPT® Category II Code
Eye Exam for Patients with Diabetes (EED) – formerly CDC EYE	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy	2022F
	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy	2023F
	7 standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy	2024F
	7 standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy	2025F
	Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed; with evidence of retinopathy (DM)	2026F
	Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed; without evidence of retinopathy	2033F
	Diabetic eye exam without evidence of retinopathy in prior year	3072F
Hemoglobin A1c Control for Patients with Diabetes (HBD) – formerly CDCA1C9, CDCA1C8 **Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)**	HbA1c level < 7.0%	3044F
	HbA1c level > 9.0%	3046F
	HbA1c level ≥ 7.0% & < 8.0%	3051F
	HbA1c level ≥ 8.0% & ≤ 9.0%	3052F
Blood Pressure Control for Patients with Diabetes (BPD) – formerly CDCBP **Controlling High Blood Pressure- (CBP)**	Systolic less than 130	3074F
	Systolic between 130 to 139	3075F
	Systolic greater than/equal to 140	3077F
	Diastolic less than 80	3078F
	Diastolic between 80 to 89	3079F
	Diastolic greater than/equal to 90	3080F
Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD) **Low-Density Lipoprotein Cholesterol (LDL-C) Tests**	LDL-C <100 mg/dL	3048F
	LDL-C 100-129 mg/dL	3049F
	LDL-C ≥ 130 mg/dL	3050F

CPT® Category II Codes

Measure	Code Descriptor	CPT® Category II Code
Medication Reconciliation Post-Discharge	Discharge medications reconciled with current medications in outpatient record	1111F
Postpartum Care	Postpartum care visit	0503F
Prenatal Care	Initial prenatal care visit	0500F
	Prenatal flow sheet	0501F
	Subsequent prenatal care	0502F

Reporting Reminders by Measure

- **COA Medication Review:** Document both medication list and medication review and report both CPT II codes. Medication review must be completed by a prescribing care provider or clinical pharmacist.
- **EED:** Any provider can report the appropriate CPT II code for the eye exam results. It does not have to be reported by only the ophthalmologist or optometrist.
- **HBD:** Report the appropriate CPT II code for the A1c result value with the date of test, not the date of the office visit when the test was reviewed.
- **BPD & CBP:** Report 2 CPT II codes. One for the lowest systolic value and the one for the lowest diastolic value measured during the encounter.
- **SMD:** Report the appropriate CPT II code for the A1c result value with the date of test, not the date of the office visit when the test was reviewed. Report the appropriate CPT II code for the LDL-C result value.
- **TRC:** Report the medication reconciliation post-discharge when performed either via a telephone call or during the Transitional Care Management office visit.

CPT Category II codes can be reported alone on a claim with $0.00 value (or $0.01 value if your system requires it in order for the codes to populate on a claim).