## Effectiveness of care: prevention and screening

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| **Adult BMI assessment (ABA)**
  Code the visit + a ICD-9 BMI code | Members ages 18 – 74 years who had an outpatient visit and whose body mass index (BMI) was documented during the measurement year or the year prior to the measurement year. | Weight and BMI value, dated during the measurement year or year prior to the measurement year. The weight and BMI must be from the same data source. Members < 19 years on the date of service, the following also meets criteria: BMI percentile documented as a value (e.g., 85th percentile) or BMI percentile plotted on an age-growth chart. **Common chart deficiencies:**
  • Height and/or weight are documented but there is no calculation of the BMI.
  • Ranges and thresholds are no longer acceptable for this measure. A distinct BMI value or percentile is required. |
  **BMI ICD-9:** V85.0 – V85.45  
  **Office/outpatient visit**
  **Rev:** 510 – 517, 519 – 523, 526 – 529, 982 – 983 |

| **Weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)**
  Code the visit + each appropriate component | **BMI percentile**
  Documentation must include height, weight and BMI percentile during the measurement year. The height, weight and BMI must be from the same data source. **Counseling for nutrition**
  Documentation of counseling for nutrition or referral for nutrition education during the measurement year. Documentation must include a note indicating the date and at least one of the following:
  • Discussion of current nutrition behaviors (e.g., eating habits, dieting behaviors).
  • Checklist indicating 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. **Counseling for physical activity**
  Documentation of counseling for physical activity or referral for physical activity during the measurement year. Documentation must include a note indicating the date and at least one of the following:
  • Discussion of current physical activity behaviors (e.g., exercise routine, participation in sports activities, exam for sports participation).
  • Checklist indicating physical activity was addressed.
  • Counseling or referral for physical activity.
  • Member received educational materials on physical activity during a face-to-face visit.
  • Anticipatory guidance for physical activity.
  • Weight or obesity counseling. **Common chart deficiencies:**
  • BMI documented as number not percentile based on height, weight, age and gender.
  • Anticipatory guidance does not always specify what areas were addressed and are not always age appropriate.
  • Developmental milestones do not constitute anticipatory guidance or education for physical activity.
  • Preprinted forms do not always address nutrition and physical activity. |
  **BMI percentiles**
  ICD-9: V85.51 – V85.54  
  **Counseling for nutrition**
  CPT: 97802  
  ICD-9: V65.3  
  **Counseling for physical activity**
  ICD-9: V65.41  
  **Office/outpatient visit**
  **Rev:** 510 – 517, 519 – 523, 526 – 529, 982 – 983 |
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<td><strong>Childhood immunization status (CIS)</strong>&lt;br&gt;When coding E&amp;M and vaccine administration services on the same date you must append modifier 25 to the E&amp;M code effective 1/1/14.</td>
<td>Children 2 years of age who had 4 DTAP; 3 IPV; 1 MMR; 3 Hib; 3 Hep B; 1 VZV; 4 PCV; 1 Hep A; 2 or 3 RV; and 2 flu vaccines by their second birthday.</td>
<td>A note indicating the name of the specific antigen and the date of the immunization, or a certificate of immunization prepared by an authorized health care provider or agency, including the specific dates and types of immunizations administered. Initial HepB given “at birth” or “nursery/hospital” should be documented in the medical record or indicated on the immunization record as appropriate. <strong>Common chart deficiencies:</strong>&lt;br&gt;• Immunizations received after the 2nd birthday.&lt;br&gt;• PCP charts do not contain immunization records if received elsewhere.&lt;br&gt;• Health departments.&lt;br&gt;• Immunizations given in the hospital at birth.&lt;br&gt;• No documentation of contraindications or allergies.</td>
<td>Use applicable vaccination code or diagnosis indicating history of disease. DTAP CPT: 90698, 90700, 90721, 90723 IPV CPT: 90698, 90713, 90723 MMR CPT: 90710 ICD-9: 72 – 79.9, 56 – 56.9 Hib CPT: 90648, 90698, 90721 HepB CPT: 90723, 90740, 90744, 90747 VZV CPT: 90710, 90716 ICD-9: 52 – 53.9 PCV CPT: 90669, 90670 HepA ICD-9: 70 – 70.1 RV CPT: 90680, 90681 Flu CPT: 90655, 90657</td>
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<td><strong>Immunizations for adolescents (IMA)</strong>&lt;br&gt;When coding E&amp;M and vaccine administration services on the same date you must append modifier 25 to the E&amp;M code effective 1/1/14.</td>
<td>Adolescents 13 years of age who had one dose of each:&lt;br&gt;• Meningococcal MCV (between 11th – 13th birthday).&lt;br&gt;• Tdap or TD (between 10th – 13th birthday) by their 13th birthday.</td>
<td>A note indicating the name of the specific antigen and the date of the immunization, or a certificate of immunization prepared by an authorized health care provider or agency, including the specific dates and types of immunizations administered. <strong>Common chart deficiencies:</strong>&lt;br&gt;• Immunizations not administered during appropriate time frames.&lt;br&gt;• PCP charts do not contain immunization records if received elsewhere, such as from health departments.</td>
<td>MCV CPT: 90734 Td CPT: 90714, 90718 Tdap CPT: 90715</td>
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<td><strong>Human papillomavirus vaccine for female adolescents (HPV)</strong></td>
<td>Female adolescents 13 years of age who had three doses of the human papillomavirus (HPV) vaccine by their 13th birthday.</td>
<td>A note indicating the name of the specific antigen and the date of the immunization, or a certificate of immunization prepared by an authorized health care provider or agency, including the specific dates and types of immunizations administered. <strong>Common chart deficiencies:</strong>&lt;br&gt;• Lack of documentation related to women's health in PCP charts.&lt;br&gt;• Incomplete documentation related to hysterectomy.</td>
<td>CPT: 90649, 90650</td>
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<td><strong>Lead screening children (LSC)</strong></td>
<td>Children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.</td>
<td>Documentation in the medical record must include both of the following:&lt;br&gt;• A note indicating the date the test was performed.&lt;br&gt;• The result or finding. <strong>Common chart deficiencies:</strong>&lt;br&gt;• Lead assessment does not constitute a lead screening.</td>
<td>CPT: 83655 LOINC: 10368 – 9, 10912 – 4, 14807 – 2, 17052 – 2, 25459 – 9, 27129 – 6, 32325 – 3, 5671 – 3, 5674 – 7</td>
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<td><strong>Breast cancer screening (BCS)</strong></td>
<td>Women 50 – 74 years of age who had a mammogram to screen for breast cancer during the measurement year or the year prior to the measurement year.</td>
<td>Administrative claim for a mammogram between 1/1/2013 and 12/31/2014.</td>
<td>CPT: 77055 – 77057 HCPCS: G0202, G0204, G0206 ICD-9: 87.36, 87.37 Rev: 401, 403</td>
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## Effectiveness of care: prevention and screening

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| **Cervical cancer screening (CCS)** | Women 21 – 64 years of age who were screened for cervical cancer using either of the following criteria:  
- Age 21 – 64 who had cervical cytology performed every 3 years.  
- Age 30 – 64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years. | Documentation in the medical record must include both of the following: Ages 21 – 64 (back 3 years)  
- A note indicating the date the cervical cytology was performed.  
- The result or finding.  
Ages 30 – 64, who do not meet first requirement (back 5 years).  
- A note indicating the date the cervical cytology and the HPV test was performed.  
- The result or finding. | **Cervical cytology (Pap)**  
CPT: 88141 – 88143, 88147, 88148, 88150, 88152 – 88154, 88164 – 88167, 88174, 88175  
LOINC: 10524 – 7, 18500 – 9, 19762 – 4, 19764 – 0, 19765 – 7, 19766 – 5, 19774 – 9, 33717 – 0, 47527 – 7, 47528 – 5  
Rev: 923  
HPV  
CPT: 87620 – 87622  
LOINC: 21440 – 3, 30167 – 1, 38372 – 9, 49896 – 4, 59420 – 0 |

### Common chart deficiencies:  
- Lack of documentation related to women’s health in PCP charts.  
- Incomplete documentation related to hysterectomy.

| **Chlamydia screening in women (CHL)** | Women 16 – 24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year. | Administrative claim for at least one chlamydia test during the measurement year for women 16 – 24 who are identified as sexually active. Two methods identify sexually active: pharmacy data (dispensed contraceptives during the measurement year) and claim/encounter data. | **CPT**: 87110, 87270, 87320, 87490 – 87492, 87810  

### Use of services:  
When coding E&M and vaccine administration services on the same date, you must append modifier 25 to the E&M code, effective 1/1/14.

## Effectiveness of care: utilization

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| **Frequency of ongoing prenatal care (FPC)** | Live births between November 6 of the year prior to the measurement year and November 5 of the measurement year. Members who had > 81% of expected visits. | Prenatal care visit to an OB/GYN or other prenatal care practitioner or PCP. For visits to a PCP, a diagnosis of pregnancy must be present. Documentation in the medical record must include a note indicating the date when the prenatal care visit occurred, and evidence of one of the following:  
- A basic physical obstetrical examination that includes auscultation for fetal heart tone, or pelvic exam with obstetric observations, or measurement of fundus height.  
- Evidence that a prenatal care procedure was performed (such as OB panel or ultrasound).  
- Documentation of LMP or EDD in conjunction with either a prenatal risk assessment and education and counseling, or a complete obstetrical history.  
- Visit does not apply if RN conducts the visit. | **CPT**: 59400, 59425, 59426, 59510, 59610 and 59618 |
### Effectiveness of care: utilization

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| **Well-child visits in the first 15 months of life (W15)** | Members who turned 15 months old during the measurement year and who had six or more well-child visits with a PCP during their first 15 months of life. | Documentation from the medical record must include a note indicating a visit with a PCP (PCP or OB/GYN for adolescent), the date when the well-child visit occurred and evidence of all of the following:  
- A health and developmental history (physical and mental).  
- A physical exam.  
- Health education and anticipatory guidance.  
**Common chart deficiencies:**  
- Lack of documentation of education and anticipatory guidance.  
- Children or adolescents being seen for sick visits only and no documentation related to well visits. | **Use age-appropriate preventive E&M**  
CPT: 99381 – 99385, 99391 – 99395, 99461 and/or  
**ICD-9:** V20.2, V20.3, V20.31, V20.32, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9 |
| **Well-child visits in the third, fourth, fifth and sixth years of life (W34)** | Members 3 – 6 years of age who had one or more well-child visits with a PCP during the measurement year. |  |  |
| **Adolescent well-care visits (AWC)** | Members 12 – 21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year. |  |  |

### Effectiveness of care: access and availability

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<tr>
<td><strong>Adults’ access to preventive/ambulatory health services (AAP)</strong></td>
<td>Members 20 years and older who had an ambulatory or preventive care visit.</td>
<td>Administrative claim for at least one ambulatory or preventive care visit during the measurement year.</td>
<td>Administrative claim for at least one ambulatory or preventive care visit during the measurement year.</td>
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| **Children’s and adolescents’ access to primary care practitioners (CAP)** | Members 7 – 11 years of age who had a visit with a PCP during the measurement year or the year prior. | Administrative claim for at least one PCP visit during the measurement year or the year prior (1/1/2013 – 12/31/2014). | **Codes to identify outpatient visits**  
CPT: 99201 – 99205, 99211 – 99215, 99241 – 99245  
**UB revenue:** 0510 – 0517, 0519 – 0523, 0526 – 0528, 0982, 0983  
**Codes to identify home services**  
CPT: 99341 – 99345, 99347 – 99350  
**Codes to identify preventive medicine**  
CPT: 99381 – 99385, 99391 – 99395, 99401 – 99404, 99411 – 99412, 99420, 99429  
**HCPCS:** G0402, G0438, G0439  
**Codes to identify general medical exams**  
| **Annual dental visit (ADV)** | Members 2 – 21 years of age who had at least one dental visit during the measure measurement year. | Administrative claim for at least one ambulatory or preventive care visit during the measurement year. | Administrative claim for at least one ambulatory or preventive care visit during the measurement year. |
| **Prenatal and postpartum care (PPC) timeliness of prenatal care** | Live births between November 6 of the year prior to the measurement year and November 5 of the measurement year.  
*Prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment in the organization.* | Prenatal care visit to an OB/GYN or other prenatal care practitioner or PCP. For visits to a PCP, a diagnosis of pregnancy must be present. Documentation in the medical record must include a note indicating the date when the prenatal care visit occurred, and evidence of one of the following:  
- A basic physical obstetrical examination that includes auscultation for fetal heart tone, or pelvic exam with obstetric observations, or measurement of fundus height.  
- Evidence that a prenatal care procedure was performed (such as OB panel or ultrasound).  
- Documentation of LMP or EDD in conjunction with either a prenatal risk assessment and education and counseling, or a complete obstetrical history.  
- Visit does not apply if RN conducts the visit. | **Prenatal visit during first trimester CPT:** 99201 – 99205, 99211 – 99215  
**Rev:** 514  
**Pregnancy-related diagnosis ICD-9:** V22, V23, V28, 640 – 679  
**OB/GYN:** Visit must be billed with one of the following: a pregnancy diagnosis, obstetric panel, prenatal ultrasound, rubella/RH or rubella/PBO. Or a prenatal visit billed with all of the following: toxoplasma antibody, rubella, cytomegalovirus and herpes simplex.  
**PCP:** Visit must be billed with pregnancy diagnosis in addition to one of the other combinations listed above.  
**CPT:** Bundled 59510, 59610, 59618 procedure codes meet requirements when billed by either OB/GYN or PCP. |
### Effectiveness of care: access and availability

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| **Prenatal and postpartum care (PPC)** | Live births between November 6 of the year prior to the measurement year and November 5 of the measurement year. Postpartum visit on or between 21 and 56 days after delivery. | Documentation in the medical record must include a note indicating the date when a postpartum visit occurred, and one of the following: - Pelvic exam. - Evaluation of weight, BP, breasts and abdomen. - Notation of postpartum care, including, but not limited to: - Notation of "postpartum care," "PP care," "PP check," "6-week check," or preprinted "postpartum care" form. **Common chart deficiencies:** - Incision check for post C-section does not constitute a postpartum visit. | **Postpartum visit CPT:** 58300, 59430  
**Cat II:** 0503F ICD – 9: V24.1, V24.2, V25.1, V25.11 – V25.13, V72.3, V72.31, V72.32, V76.2  
**Cervical cytology (Pap) CPT:** 88141 – 88143, 88147, 88148, 88150, 88152 – 88154, 88164 – 88167, 88174, 88175  
**LOINC:** 10524 – 7, 18500 – 9, 19762 – 4, 19764 – 0, 19765 – 7, 19766 – 5, 19767 – 9, 33717 – 0, 47527 – 7, 47528 – 5  
**Rev:** 923  
**Bundled codes meet compliance CPT:** 59410, 59510, 59515, 59610, 59614, 59618, 59622 |

### Effectiveness of care: respiratory conditions

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| **Use of spirometry testing in the assessment and diagnosis of COPD (SPR)** | Members 40 years of age and older with a new diagnosis of COPD or newly active COPD who received appropriate spirometry testing to confirm the diagnosis. | At least one claim or encounter for spirometry during the two years prior to the event or diagnosis of COPD through 6 months afterward. | **Compliance = Spirometry testing**  
**CPT:** 94010, 94014 – 94016, 94060, 94070, 94375, 94620  
**COPD ICD-9:** 493.2, 493.21, 493.22, 496  
**Chronic bronchitis ICD-9:** 491  
**Emphysema ICD-9:** 492, 492.8 |
| **Pharmacotherapy management of COPD exacerbation (PCE)** | Members 40 years of age and older who had an acute inpatient discharge or ED visit on or between 1/1/2014 – 11/30/2014 and who were dispensed the appropriate medications:  - A systemic corticosteroid within 14 days of the event.  - A bronchodilator within 30 days of the event. | At least one inpatient or ED claim or encounter where the member was dispensed a systemic corticosteroid within 14 days of the event and/or a bronchodilator within 30 days of the event. | **Population = Any one of the following diagnoses sets received on an ED or IP visit:**  
**COPD ICD-9:** 493.2, 493.21, 493.22, 496  
**Chronic bronchitis ICD-9:** 491  
**Emphysema ICD-9:** 492, 492.8 |
| **Use of appropriate medications for people with asthma (ASM)** | Members 5 – 64 years of age during the measurement year who were identified as having persistent asthma and who were appropriately prescribed medication during the measurement year. | Dispensed at least one prescription for a preferred therapy during the measurement year. | **Population includes:** ED, IP and/or observation visits billed with asthma diagnosis or 4 noncontroller asthma medication dispensing events during the measurement year and the year prior:  
**Asthma diagnoses ICD-9:** 493, 493.1, 493.11, 493.8, 493.9 |
| **Medication management for people with asthma (MMA)** | Members 5 – 64 years of age during the measurement year who were identified as having persistent asthma and who were dispensed an asthma controller medication for at least 75% of their treatment period. | Dispensed at least one prescription for 75% of their treatment period during the measurement year. | **Population and controller medications are the same as ASM.** |
### Effectiveness of care: cardiovascular conditions

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| **Controlling high blood pressure (CBP)** | Members 18 – 85 years of age who had a dx of hypertension (HTN) and whose BP was adequately controlled during the measurement year based on the following criteria:  
- Members 18 – 59 years of age whose BP was < 140/90 mm Hg.  
- Members 60 – 85 years of age with a dx of diabetes whose BP was < 140/90 mm Hg.  
Members 60 – 85 years of age without a dx of diabetes whose BP was < 150/90 mm Hg.  
Use the Hybrid Method (medical record review) for this measure.  
*Note:* Members are identified by claims indicating at least one OP visit with a hypertension dx during the first 6 months of measurement year. | **Confirmatory dx documentation:**  
Notation or problem list of diabetes, HTN, high BP, elevated BP, border HTN, intermittent HTN. Hx of HTN, HVD, hyperpiesia or hyperpiesis on or before June 30 of the measurement year.  
**Representative or most recent BP reading:**  
The most recent BP reading noted during the measurement year. The reading must occur after the date when the dx was confirmed (after date of confirmatory documentation).  
The member is not compliant if the BP reading is > 140/90 (for members 18 – 59 or 60 – 85 with diabetes), ≤ 140/90 (members 60 – 85 without dx of diabetes) or is missing, or if there is no BP reading during the measurement year or if the dx is incomplete (e.g., the systolic or diastolic level is missing).  
**Common chart deficiencies:**  
- Rechecked elevated pressures during the same visit not documented.  
- Diagnosis date of hypertension is not clearly documented. | **Compliance**  
Both a representative (most recent during measurement year) systolic BP < 140 mm Hg and a representative diastolic BP < 90 mm Hg (BP in the normal or high-normal range) identified in documentation via medical record review.  
**CPT:** 99201 – 99205, 99211 – 99215, 99381 – 99387, 99391 – 99397, 99429  
**Hypertension diagnosis:**  
ICD-9-CM: 401, 401.0, 401.1, 401.9 |

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### Effectiveness of care: diabetes

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| **Comprehensive diabetes care (CDC) HbA1c testing** | Members 18 – 75 years of age with diabetes (Type 1 and Type 2). | HbA1c test: Documentation in the medical record must include a note indicating the date when the HbA1c test was performed and the result or finding. | HbA1c/HbA1c level (Cat II)  
**CPT:** 83036  
**Cat II:** 3044F – 3046F |
| **Comprehensive diabetes care (CDC) HbA1c adequate control HbA1c poor control** | Members 18 – 75 years of age with diabetes (Type 1 and Type 2) who had the following during the measurement year:  
- Hemoglobin A1c (HbA1c) adequate control = < 8%.  
- Poor control = HbA1c > 9%.  
**CDC**  
Members are identified any of the following ways during the measurement year or the prior year:  
- 2 outpatient, observation or nonacute IP visits on different dates with a dx of diabetes.  
- 1 acute inpatient visit with a dx of diabetes.  
- 1 ED visit with a dx of diabetes.  
- Dispensed insulin or hypoglycemic antihyperglycemics. | HbA1c test and level: Documentation in the medical record must include a note indicating the date when the HbA1c test was performed and the result or finding.  
**Poor control:**  
The most recent HbA1c level (performed during the measurement year) is > 9.0% or is missing, or was not done during the measurement year, as documented through automated laboratory data or medical record review.  
**Note:** A lower rate indicates better performance for this indicator (i.e., low rates of poor control indicate better care).  
**Adequate control:** The most recent HbA1c level (performed during the measurement year) is < 8.0% during the measurement year, as documented through automated laboratory data or medical record review. | **Diabetes ICD-9:** 250, 357.2, 362.0 – 362.07, 366.41, 648.0 – 648.04 |
| **Comprehensive diabetes care (CDC) eye exam** | Members 18 – 75 years of age with diabetes (Type 1 and Type 2) who had the following during the measurement year:  
- Eye exam (retinal) performed (year prior to the measurement year) systolic BP < 140 mm Hg and a representative diastolic BP < 90 mm Hg (BP in the normal or high-normal range) identified in documentation via medical record review.  
- A chart or photograph of retinal abnormalities indicating the date when the fundus photography was performed and evidence that an eye care provider reviewed the results during the measurement year.  
- Documentation of a negative (or normal) retinal or dilated exam by an ophthalmologist, optometrist, PCP or other health care provider indicating that an ophthalmoscopic exam was completed by an eye care provider, the date when the procedure was performed and the results.  
- A note or letter during the measurement year prepared by an ophthalmologist, optometrist, PCP or other health care provider indicating that an ophthalmoscopic exam was completed by an eye care provider, the date when the procedure was performed and the results.  
- A note or letter during the measurement year prepared by an ophthalmologist, optometrist, PCP or other health care provider indicating that an ophthalmoscopic exam was completed by an eye care provider, the date when the procedure was performed and the results.  
- A chart or photograph of retinal abnormalities indicating the date when the fundus photography was performed and evidence that an eye care provider reviewed the results during the measurement year.  
- Documentation of a negative (or normal) retinal or dilated exam by an eye care provider in the year prior to the measurement year, where results indicate retinopathy was not present. | **Eye exam**  
Optometrist or ophthalmologist → CPT: 67028, 67030, 67031, 67036, 67039 – 67043, 67101, 67105, 67107, 67108, 67110, 67112, 67113, 67121, 67141, 67145, 67208, 67210, 67218, 67220, 67221, 67227, 67228, 92002, 92004, 92012, 92014, 92018, 92019, 92134, 92225, 99226, 92230, 92235, 92240, 92250, 92260, 99203 – 99205, 99213 – 99215  
**Any provider type → Cat II:** 3072F = negative for retinopathy, 2022F, 2024F, 2026F |

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### Effectiveness of care: diabetes

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<td><strong>Comprehensive diabetes care (CDC) monitoring for nephropathy</strong></td>
<td>Members 18 – 75 years of age with diabetes (Type 1 and Type 2) who had the following during the measurement year:</td>
<td>Documentation during the measurement year indicating the date when the urine micro albumin test was performed and the results, documentation indicating evidence of nephropathy (i.e., renal transplant, ESRD, nephrologist visit or positive micro albumin test) or documentation with a note indicating that the member received a prescription for ACE inhibitors/ARBs in the measurement year.</td>
<td>Monitoring for nephropathy</td>
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<td>• Medical attention for nephropathy (nephropathy test, evidence of nephropathy, urine macro albumin tests, or at least one ACE inhibitor or ARB dispensing event).</td>
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<td>CPT: 81000 – 81005, 82042 – 82044, 84156</td>
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<td>• Documentation during the measurement year indicating the date when the urine microalbumin test was performed and the results, documentation indicating evidence of nephropathy (i.e., renal transplant, ESRD, nephrologist visit or positive micro albumin test) or documentation with a note indicating that the member received a prescription for ACE inhibitors/ARBs in the measurement year.</td>
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<td>Cat II: 3060F – 3062F, 3066F, 4010F</td>
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<td><strong>Comprehensive diabetes care (CDC) BP control</strong></td>
<td>Members 18 – 75 years of age with diabetes (Type 1 and Type 2) who had the following during the measurement year:</td>
<td>The most recent BP reading noted during the measurement year. The member is not compliant if the BP reading is ≥ 140/90 or is missing, or if there is no BP reading during the measurement year or if the reading is incomplete (e.g., the systolic or diastolic level is missing).</td>
<td>BP control</td>
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<td>• BP control (&lt; 140/90 mm Hg).</td>
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<td>Cat II: 3074F, 3075F, 3377F – 3080F</td>
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### Effectiveness of care: musculoskeletal conditions

<table>
<thead>
<tr>
<th>Measure and coding tips</th>
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<th>Coding</th>
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</thead>
<tbody>
<tr>
<td><strong>Disease-modifying anti-rheumatic drug therapy for rheumatoid arthritis (ART)</strong></td>
<td>Members who were diagnosed with rheumatoid arthritis and who were dispensed at least one ambulatory prescription for a disease-modifying anti-rheumatic drug (DMARD).</td>
<td>Members who had at least one ambulatory prescription dispensed for a DMARD during the measurement year. There are two ways to identify members who received a DMARD: by claim/encounter data and by pharmacy data.</td>
<td>Codes to identify rheumatoid arthritis:</td>
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<td></td>
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<td></td>
<td>ICD-9-CM: 714.0, 714.1, 714.2, 714.81</td>
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<td></td>
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<td>And/or pharmacy claim for DMARD in 2013</td>
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### Effectiveness of care: behavioral health

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<td><strong>Antidepressant medication management (AMM)</strong></td>
<td>Members 18 years of age and older who were treated with an antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment.</td>
<td>Members dispensed an antidepressant medication with a dx of major depression who remained on their medication for at least 84 days (acute phase) or 120 days (continuation phase).</td>
<td>Compliance = At least 84 days of continuous treatment of antidepressant medication during the acute phase and at least 180 days of continuous treatment during the continuation phase.</td>
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<td>• Acute phase treatment: Members who remained on an antidepressant medication for at least 84 days (12 weeks).</td>
<td></td>
<td>Major depression diagnoses</td>
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<td>• Continuation phase treatment: Members who remained on an antidepressant medication for at least 180 days (6 months).</td>
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<td>ICD-9: 296.2, 296.3, 298, 311</td>
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| **Follow-up care for children prescribed ADHD medication (ADD)** | Children newly prescribed ADHD medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. | **Initiation phase:** Members 6 – 12 years of age at the prescription dispensing date who had one follow-up visit with practitioner during 30 days of initiation phase.  
**Continuation phase:** Members 6 – 12 years of age at the prescription dispensing date who had remained on the medication for at least 210 days and who, in addition to the visit in the initiation phase, had at least two follow-up visits within 270 days after the initiation phase ended. | Compliance = 1 follow-up visit during the 30-day initiation phase and 2 additional visits within the next 9 months or continuation phase.  
Follow-up visit  
Any outpatient, intensive outpatient or partial hospitalization follow-up visit meets criteria. |
| **Follow-up after hospitalization for mental illness (FUH)** | Members 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Follow-up within 7 and 30 days of discharge. | At least one claim or encounter for a follow-up visit within 7 days of discharge. At least one claim or encounter for a follow-up visit within 30 days of discharge. | ICD-9-CM: 295 – 299, 300.3, 300.4, 301, 308, 309, 311 – 314 |
| **Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications (SSD)** | The percentage of members 18 – 64 years of age with schizophrenia or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year. | At least one inpatient, outpatient, partial hospitalization or ED encounter with any diagnosis of schizophrenia or bipolar disorder along with a claim for a glucose test or HbA1c test during the measurement year. | At least one inpatient, outpatient, partial hospitalization or ED encounter with any diagnosis of schizophrenia or bipolar disorder along with a claim for a glucose test or HbA1c test during the measurement year. |
| **Diabetes monitoring for people with diabetes and schizophrenia (SMD)** | The percentage of members 18 – 64 years of age with schizophrenia and diabetes who had both an LDL-C test and an HbA1c test during the measurement year. | | At least one claim or encounter of an HbA1c test and LDL-C test during the measurement year. |
| **Cardiovascular monitoring for people with cardiovascular disease and schizophrenia (SMC)** | The percentage of members 18 – 64 years of age with schizophrenia and cardiovascular disease, who had an LDL-C test during the measurement year. | At least one claim or encounter of an LDL-C test during the measurement year. | LDL C screen CPT: 80061, 83700, 83701, 83704, 83721  
CPT Cat II: 3048F, 3049F, 3050F |
| **Adherence to antipsychotic medications for individuals with schizophrenia (SAA)** | The percentage of members 19 – 64 years of age during the measurement year with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period. | Dispersed at least one antipsychotic medication from 1/1/2014 – 9/30/2014. | Dispersed at least one antipsychotic medication from 1/1/2014 – 9/30/2014. |

### Effectiveness of care: medication management

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<td><strong>Annual monitoring for patients on persistent medications (MPM)</strong></td>
<td>Members 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent (ACE inhibitors, ARB, digoxin and diuretics) during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year.</td>
<td>Dispensed at least one ACE inhibitor, ARB, digoxin or diuretic during the measurement year and had at least one therapeutic monitoring event during the measurement year.</td>
<td>Dispensed at least one ACE inhibitor, ARB, digoxin or diuretic during the measurement year and had at least one therapeutic monitoring event during the measurement year.</td>
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