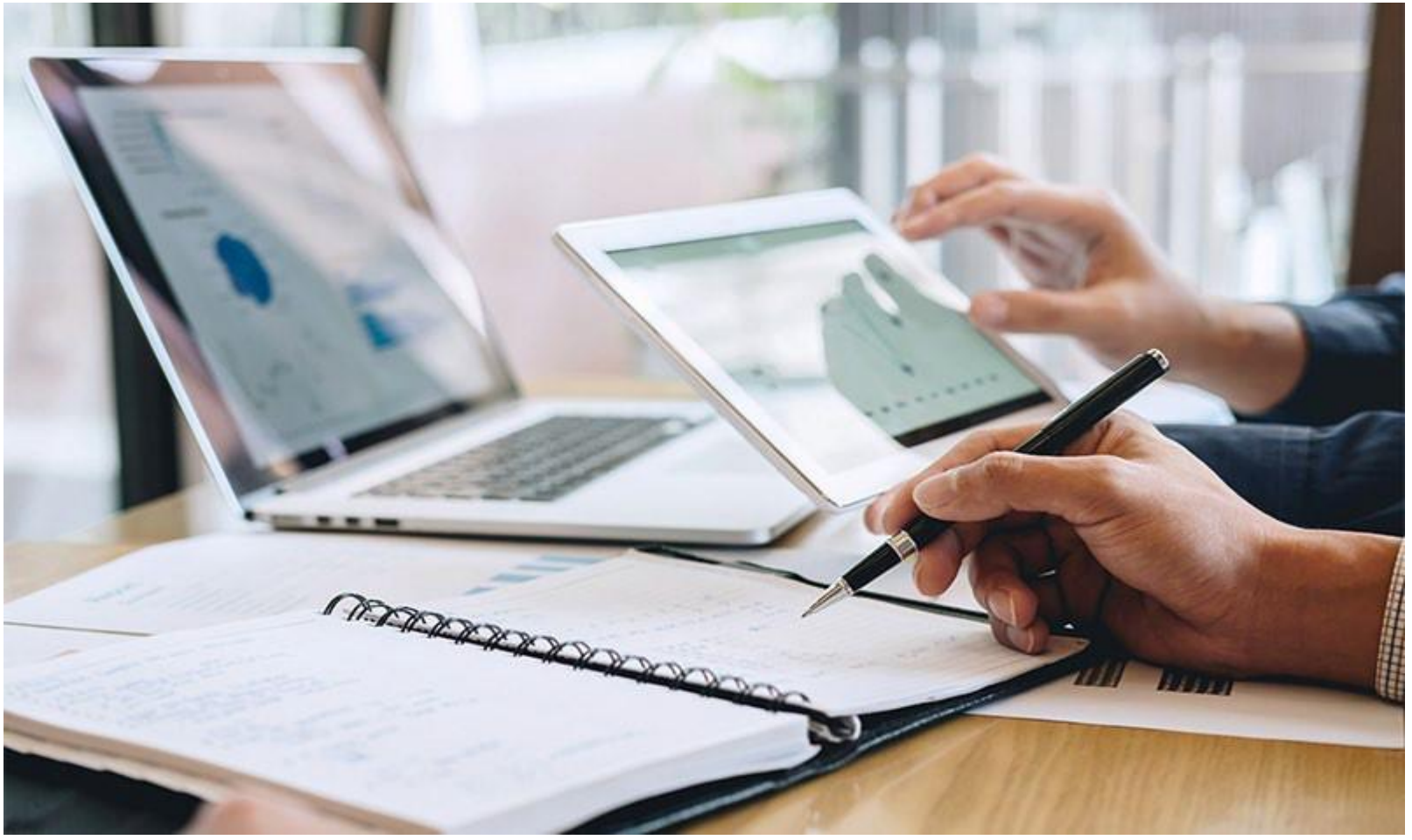
2024 HEDIS ® Coding & Reference Guide

BCBSKS 2024 QBRP and PCMH Measures



BlueCross BlueShield Kansas

www.bcbsks.com

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Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)- QBRP and PCMH measure

Description
The percentage of episodes for members ages 3 months and older with a diagnosis of acute bronchitis/ bronchiolitis that did not result in an antibiotic dispensing event.

Calculation
The measure is reported as an inverted rate [1– (numerator/eligible population)]. A higher rate indicates appropriate acute bronchitis/bronchiolitis treatment, (i.e., the proportion for episodes that did not result in an antibiotic dispensing event).

Eligible Population
Members 3 months and older as of July 1 of the year prior to June 30 of the measurement year with continuous enrollment, (30 days prior to Episode Date through 3 days after Episode Date).

Event/Diagnosis
Identify all members who had an outpatient visit, a telephone visit, an online assessment, an observation visit or an ED visit during the Intake Period, with a diagnosis of acute bronchitis/bronchiolitis.

Coding [1]
Click here to go to the Coding and Value Set Guide

Denominator
The eligible population (Member must have BCBSKS Medical and Pharmacy benefits). If a member has more than one eligible episode in a 31-day period, include only the first eligible episode.

Numerator
Dispensed prescription for an antibiotic (**Table 3**: AAB Antibiotic Medication List) on or three days after the Index Episode Start Date (IESD- The date of service for any outpatient or ED visit during the intake period with a diagnosis of acute bronchitis).

This measure is reported as 4 rates:

- 3 months-17 years
- 18-64 years
- 65 years and older
- Total

Required Exclusions

- A period of 30 days prior to the episode date, when the member had no pharmacy claims for either new or refill prescriptions for a listed antibiotic drug. No prescriptions that were filled more than 30 days prior to the episode date and are active on the episode date.
- Exclude members who had claims/encounters with a competing diagnosis on or three days following the episode date (Pharyngitis, etc.) Do not include laboratory claims (claims with place of service 81).
- Remove episode dates where the member had a claim/encounter with any diagnosis for a comorbid condition during the 12 months prior to or on the episode date. Do not include laboratory claims (claims with place of service 81).
- Exclude visits that resulted in an inpatient stay.
- Members in hospice or using hospice services anytime during the measurement year.
- Members who die any time during the measurement year.

1) Coding may change periodically without notification

Table 3: Antibiotic Medications (AAB)

Description	Prescription		
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	• Erythromycin	• Clarithromycin
Miscellaneous antibiotics	• Aztreonam • Chloramphenicol • Dalfopristin-quinupristin	• Daptomycin • Linezolid	• Metronidazole • Vancomycin
Natural penicillin's	• Penicillin G benzathine-procaine • Penicillin G potassium	• Penicillin G procaine • Penicillin G sodium	• Penicillin V potassium • Penicillin G benzathine
Penicillinase resistant penicillin's	• Dicloxacillin	• Nafcillin	• Oxacillin
Quinolones	• Ciprofloxacin • Gemifloxacin	• Levofloxacin • Moxifloxacin	• Ofloxacin
Rifamycin derivatives	• Rifampin		
Second generation cephalosporin	• Cefaclor • Cefotetan	• Cefoxitin • Cefprozil	• Cefuroxime
Sulfonamides	• Sulfadiazine	• Sulfamethoxazole-trimethoprim	
Tetracyclines	• Doxycycline	• Minocycline	• Tetracycline
Third generation cephalosporins	• Cefdinir • Cefditoren • Cefixime	• Cefotaxime • Cefpodoxime • Ceftazidime	• Ceftibuten • Ceftriaxone
Urinary anti-infectives	• Fosfomycin • Nitrofurantoin	• Nitrofurantoin macrocrystals-monohydrate	• Trimethoprim

1) Coding may change periodically without notification

Description
The percentage of women 50-74 years of age who were recommended for routine breast cancer screening and had a mammogram to screen for breast cancer.

Eligible Population
Women 50–74 years of age as of December 31 of the measurement year with continuous enrollment (no more than one enrollment gap of less than 45 days in each full calendar year) from the measurement year and the year prior to the measurement year.
No gaps in enrollment are allowed from October 1 two years before the measurement period through December 31 two years before the measurement period. The member must be enrolled on the last day of the measurement period.

Event/Diagnosis
None

Coding[1]
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Denominator
The eligible population.

Numerator
One or more mammograms any time on or between October 1 two years prior to the measurement year and December 31 of the measurement year.

Required Exclusions
Exclude members who have had a bilateral mastectomy at any time during the member's history through December 31 of the measure year. That includes:

- Bilateral mastectomy
- Unilateral mastectomy with a bilateral modifier
- Clinical Unilateral Mastectomy with a bilateral modifier
- History of bilateral mastectomy
- A history of mastectomy on both the left and right side on the same of different date of service.

- Members who had gender-affirming chest surgery (CPT code 19318) with a diagnosis of gender dysphoria any time during the member's history through the end of the measurement period.
- Members 66 years of age as of December 31 of the measurement year with criteria of frailty and advanced illness. Member must mee BOTH frailty and advanced illness criteria to be excluded. **Frailty**: At least two indications and two different dates of service during the measurement year and **Advanced Illness**: Either of the following during the measurement period or the year prior to the measurement period. Advanced illness on at least two different date of service (not including laboratory claims-Place of service 81) or dispensed dementia medication of the measurement year.
- Members receiving or had an encounter for palliative care (ICD-10 code Z51.5) anytime during the measurement year.
- Members in hospice or using hospice services anytime during the measurement year.
- Members who die any time during the measurement period.

1) Coding may change periodically without notification

Description

The percentage of women 21–64 years of age who were screened for cervical cancer using either of the following criteria:

- Women 21–64 years of age who had cervical cytology performed every 3 years.
- Women 30–64 years of age who had cervical high – risk human papillomavirus (hrHPV) co-testing performed every 5 years.
- Women 30–64 years of age who had a cervical cytology/high-risk human papillomavirus (hrHPV) co-testing within the last 5 years.

Eligible Population

Women 24-64 years of age as of December 31 of the measurement year with continuous enrollment (no more than one enrollment gap of less than 45 days in each full calendar year) from the measurement year and the two years prior to the measurement year.

Coding[1]

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Denominator

The eligible population.

Numerator

The number of women recommended and screened for cervical cancer and meet the following criteria:

- Women 24–64 years of age as of December 31 of the measurement year who had cervical cytology during the measurement year or the two years prior to the measurement year.
- Women 30–64 years of age as of December 31 of the measurement year who had cervical high-risk human papillomavirus (hrHPV) testing during the measurement year or the four years prior to the measurement year and who were 30 years or older on the date of the test.
- Sex assigned at birth as gender female at any time in the members history. Sex parameter for clinical use of female during the measurement period.

Required Exclusions

- Exclude members from each eligible population if evidence of hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix any time during the member's history through December 31 of the measurement year.
- Members receiving palliative care anytime during the measurement year.
- Members had an encounter for palliative care (ICD-10- CM Code Z51.50) anytime during the measurement year. Do not include laboratory claims (claims with place of service 81).
- Members in hospice or using hospice services anytime during the measurement year.
- Members with sex assigned at birth of male at any time during the patient's history.
- Members who die any time during the measurement year.

1) Coding may change periodically without notification

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

Eligible Population
Members 46–75 years of age as of December 31 of the measurement year with continuous enrollment (no more than one enrollment gap of less than 45 days in each full calendar year) from the measurement year and the year prior to the measurement year.

Coding[1]
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Denominator
The eligible population.

Numerator
Members with one or more screenings for colorectal cancer. Any of the following meet criteria:

- Fecal occult blood test during the measurement year. For administrative data, assume the required number of samples were returned, regardless of FOBT type.
- Flexible sigmoidoscopy during the measurement year or the four years prior to the measurement year.
- Colonoscopy during the measurement year or the nine years prior to the measurement year.
- CT colonography during the measurement year or the four years prior to the measurement year.
- Stool DNA with FIT test during the measurement year or the two years prior to the measurement year.

Required Exclusions

- Exclude members from the eligible population if either colorectal cancer or total colectomy are included in a member's history through December 31 of the measurement year.
- Members receiving palliative care anytime during the measurement year.
- Members had an encounter for palliative care (ICD-10- CM Code Z51.50) anytime during the measurement year. Do not include laboratory claims (claims with place of service 81).
- Members in hospice or using hospice services anytime during the measurement year.
- Members 66 years of age as of December 31 of the measurement year with criteria of frailty and advanced illness. Member must meet BOTH frailty and advanced illness criteria to be excluded. **Frailty**: At least two indications and two different dates of service during the measurement year and **Advanced Illness**: Either of the following during the measurement period or the year prior to the measurement period. Advanced illness on at least two different date of service (not including laboratory claims-Place of service 81) or dispensed dementia medication of the measurement year.
- Members who die any time during the measurement year.

1) Coding may change periodically without notification

Appropriate Testing for Pharyngitis (CWP)
QBRP and PCMH measure

Description
The percentage of episodes for members 3 years and older where the member was diagnosed with pharyngitis, dispensed an antibiotic, and received a group A streptococcus (strep) test for the episode.

Eligible Population
Children 3 years of age as of July 1 of the year prior to the measurement year as of June 30 of the measurement year with an Outpatient, Telephone, Online Assessment, Observation or ED visit with only a diagnosis of pharyngitis and a dispensed antibiotic for that episode of care.

Event/Diagnosis
Outpatient, ED, Telephone, e-visit, or virtual check-in visit during the intake period with only a diagnosis of pharyngitis and a dispensed antibiotic for that episode of care during Intake Period (12-month window that begins July 1 of the year prior to the measurement year and ends on June 30 of the measurement year).

Coding[1]
Click here to go to the Coding and Value Set Guide

Denominator
The eligible population. (Member must have BCBSKS medical and pharmacy benefits). If a member has more than one eligible episode in a 31-day period, include only the first eligible episode.

Numerator
A group A streptococcus test in the seven-day period from three days prior to the Episode Date through three days after the Episode Date. Index Episode Start Date. The earliest Episode Date during the Intake Period that meets all the following criteria:

- Linked to a dispensed antibiotic prescription (Table 1) on or during the three days after the Episode Date.
- A 30-day Negative Medication History prior to the Episode Date.
- The member was continuously enrolled without a gap in coverage during the 30 days prior to the Episode Date through 3 days after the Episode Date.
- This measure is reported as 4 rates:
    - 3-17 years
    - 18-64 years
    - 65 years and older
    - Total

Required Exclusions
A period of 30 days prior to the episode date, when the member had no pharmacy claims for either new or refill prescriptions for a listed antibiotic drug. No prescriptions that were filled more than 30 days prior to the episode date and are active on the episode date.

- Exclude episode dates if the member did not receive antibiotics on or up to three days after the episode date with only a diagnosis of pharyngitis.
- Exclude visits that result in an inpatient stay.
- Members in hospice or using hospice services anytime during the measurement year.
- Remove episode dates where the member had a claim/encounter with any diagnosis for a comorbid condition during the 12 months prior to or on the episode date. Do not include laboratory claims (claims with place of service 81).
- Exclude visits when the member has claims/encounters with a competing diagnosis on or 3 days following the episode date. Do not include laboratory claims (claims with place of service 81).
- Members who die any time during the measurement year.

1) Coding may change periodically without notification

Table 1: Antibiotic Medications (CWP)

Description	Prescription	
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

1) Coding may change periodically without notification

Description
The percentage of members 18–75 years of age with diabetes (types 1 and 2) who had a retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist).

Eligible Population
Members 18-75 years of age as of December 31 of the measurement year, with a diagnosis of diabetes, and continuous enrollment (no more than one enrollment gap of less than 45 days in each full calendar year) in the measurement year.

Event/Diagnosis:
Members with diabetes can be identified by claim/encounter data and/or pharmacy data. The organization must use both methods to identify the eligible population, but a member only needs to be identified by one method to be included in the measure. Members may be identified as having diabetes during the measurement year or the year prior to the measurement year.

1. **Claim/encounter data –** Members who had at least two diagnoses of diabetes on different dates of service during the measurement year or the year prior to the measurement year (count services that occur over both years).
2. **Pharmacy data –** Members who were dispensed insulin or hypoglycemics/antihyperglycemics during the measurement year or the year prior to the measurement year and have at least one diagnosis of diabetes during the measurement year or the year prior to the measurement year.

Coding[1]
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Denominator
The eligible population.

Numerator
Any of the following meet the criteria of screening for diabetic retinal eye disease:

- A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist).
- A negative retinal or dilated eye exam (negative for retinopathy) by an eye care professional in the year prior to the measurement year.
- A bilateral eye enucleation anytime during the member's history through December 31 of the measurement year.

Required Exclusions

- Members in hospice or using hospice services anytime during the measurement year.
- Members receiving palliative care anytime during the measurement year.
- Members had an encounter for palliative care (ICD-10- CM Code Z51.50) anytime during the measurement year. Do not include laboratory claims (claims with place of service 81).
- Members 66 years of age as of December 31 of the measurement year with criteria of frailty and advanced illness. Member must meet BOTH frailty and advanced illness criteria to be excluded. **Frailty**: At least two indications and two different dates of service during the measurement year and **Advanced Illness**: Either of the following during the measurement period or the year prior to the measurement period. Advanced illness on at least two different date of service (not including laboratory claims-Place of service 81) or dispensed dementia medication of the measurement year.
- Members who die any time during the measurement year.

1) Coding may change periodically without notification

Description

The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider. Two rates are reported:

- The percentage of discharges for which the member received follow-up within 30 days after discharge.
- The percentage of discharges for which the member received follow-up within 7 days after discharge.

Eligible Population

Members aged 6 and older as of the date of discharge with a continuous enrollment of the date of discharge through 30 days after discharge.

Coding[1]

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Event/Diagnosis

- An acute inpatient discharge with a principal diagnosis of mental illness or intentional self-harm on the discharge claim on or between January 1 and December 1 of the measurement year.
- To identify acute inpatient discharges, identify all acute and nonacute inpatient stays, exclude nonacute inpatient stays, then identify the discharge date for the stay.
- The denominator for this measure is based on discharges, not members. If members have more than one discharge, include all discharges on or between January 1 and December 1 of the measurement year.

Acute Readmission or Direct Transfer

- Identify readmissions and direct transfers to an acute inpatient care setting during the 30-day follow-up period. Identify all acute and nonacute inpatient stays, exclude nonacute inpatient stays, identify the admission date for the stay, then identify the discharge date for the stay.
- Exclude both the initial discharge and the readmission/direct transfer discharge if the last discharge occurs after December 1 of the measurement year.
- If the readmission/direct transfer to the acute inpatient care setting was for a principal diagnosis of mental health disorder or intentional self-harm, count only the last discharge.
- If the readmission/direct transfer to the acute inpatient care setting was for any other principal diagnosis, exclude both the original and the readmission/direct transfer discharge.

Nonacute Readmission or Direct Transfer

- Exclude discharges followed by readmission or direct transfer to a nonacute inpatient care setting within the 30-day follow-up period, regardless of the principal diagnosis for readmission. These discharges are excluded from the measure because rehospitalization or direct transfer may prevent an outpatient follow-up visit from taking place.
- To identify readmissions and direct transfers to a nonacute inpatient care setting, identify all acute and nonacute inpatient stays, confirm the stay was for nonacute care based on the presence of a nonacute code on the claim, then identify the admission date for the stay.

Denominator

The eligible population.

Numerator

Members with:

1. A follow-up visits with a mental health provider within 30 days after discharge. Do not include visits that occur on the date of discharge.
2. A follow-up visits with a mental health provider within 7 days after discharge. Do not include visits that occur the date of discharge.

Required Exclusions

- Members in hospice or using hospice services anytime during the measurement year.
- Members who die any time during the measurement year.

1) Coding may change periodically without notification

Description
The percentage of members 18-75 years of age 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.

Calculation
The measure is reported as an inverted rate [1- (numerator/eligible population)]. A higher score indicates appropriate treatment of low back pain (i.e., the proportion for whom imaging studies did not occur).

Eligible Population
Members 18 years of age as of January 1 of the measurement year to members 75 years of age as of December 31 of measurement year with continuous enrollment of 180 days (6 months) prior to the IESD (no gaps in enrollment allowed during the continuous enrollment period) through 28 days after the IESD who had an outpatient, ED, telephone, e-visit, virtual check-in, physical therapy, osteopathic, or chiropractic manipulative treatment with a principal diagnosis of uncomplicated low back pain.

Coding [1]

Click here to go to the Coding and Value Set Guide

Denominator
The eligible population. Determine the earliest episode of low back pain. If the member had more than one encounter, include only the first encounter.

Numerator
An imaging study with a diagnosis of uncomplicated low back pain on the IESD or in the 28 days following the IESD.

Required Exclusions
Remove members with a diagnosis of uncomplicated low back pain in a period of 180 days (6 months) prior to the IESD. Do not include visits that result in an inpatient stay.
Exclude any member who had a diagnosis for which imaging is clinically appropriate. Any of the following meet criteria:

- Cancer any time during the member's history through 28 days after the IESD. Any of the following meet criteria: Malignant Neoplasms, Other Neoplasms, History of Malignant Neoplasm. And Other Malignant Neoplasm of Skin
- Trauma any time during the 3 months (90 days) prior to the IESD through 28 days after the IESD. Do not include laboratory claims (claims with PLACE OF SERVICE code 81).
- IV drug abuse any time during the 12 months (1 year) prior to the IESD through 28 days after the IESD.
- Neurologic impairment any time during the 12 months (1 year) prior to the IESD through 28 days after the IESD.
- HIV any time during the member's history through 28 days after the IESD.
- Spinal infection any time during the 12 months (1 year) prior to the IESD through 28 days after the IESD.
- Major organ transplant or history of major organ transplant at any time in the member's history through 28 days after the IESD.
- Prolonged use of corticosteroids. 90 consecutive days of corticosteroid treatment any time during the 366-day period that begins 365 days prior to the IESD and ends on the IESD.
- Osteoporosis therapy or a dispensed prescription to treat osteoporosis any time during the member's history through 28 days after the IESD.
- Fragility fractures any time during the 3 months (90 days) prior to the IESD through 28 days after the IESD.
- Lumbar surgery any time during the member's history through 28 days after the IESD.
- Spondylopathy any time during the member's history through 28 days after the IESD.
- Members receiving palliative care anytime during the measurement year.
- Members had an encounter for palliative care (ICD-10- CM Code Z51.50) anytime during the measurement year. Do not include laboratory claims (claims with place of service 81).
- Members in hospice or using hospice services anytime during the measurement year.
- Members who die any time during the measurement year.

1) Coding may change periodically without notification

Description

The percentage of males 21-75 years of age and females 40-75 years of age during the measurement year, who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and met the following criteria.

1. **Received Statin Therapy**. Members who were dispensed at least one high-intensity or moderate-intensity statin medication (Table 4) during the measurement year.
2. **Statin Adherence 80 percent**. Members who remained on a high-intensity or moderate-intensity statin medication (Table 4) for at least 80 percent of the treatment period.

Eligible Population

Male members 21-75 years of age and female members 40-75 years of age as of December 31 of the measurement year with continuous enrollment of no more than one gap in enrollment of up to 45 days.

Event/Diagnosis

Eligible members are identified by event or diagnosis. The organization must use BOTH methods to identify in the eligible population but one method to be included in the measure. Events include:

- Discharged from an inpatient setting with a myocardial infarction (identify acute and nonacute inpatients stays and discharge date).
- Members that have had a CABG, PCI, or other revascularization procedure.
- Members who have at least one encounter (outpatient visit, telephone visit, e-visit, virtual check-in, or acute inpatient encounter) with a diagnosis of IVD during both the measurement year and the year prior to it.
- At least one acute inpatient discharge with an IVD diagnosis is required on the discharge claim (identify all acute and nonacute inpatient stays; exclude nonacute inpatient stays and identify the discharge dates for the stay).

Coding [1]

Click here to go to the Coding and Value Set Guide

Denominator

The Eligible Population (Member must have BCBSKS Medical and Pharmacy benefits).

Numerator

The number of members who had at least one dispensing event for a high-intensity or moderate-intensity statin medication during the measurement year.

Required Exclusions

Exclude members from the eligible population with a diagnosis of pregnancy, dispensed at least one prescription for clomiphene, ESRD, Cirrhosis, Myalgia, Myositis, Myopathy, Rhabdomyolysis as well as those members undergoing dialysis or in vitro fertilization.

- Members receiving palliative care anytime during the measurement year.
- Members had an encounter for palliative care (ICD-10- CM Code Z51.50) anytime during the measurement year. Do not include laboratory claims (claims with place of service 81).
- Members in hospice or using hospice services anytime during the measurement year.
- Members who die any time during the measurement year.
- Members 66 years of age as of December 31 of the measurement year with criteria of frailty and advanced illness. Member must meet BOTH frailty and advanced illness criteria to be excluded. **Frailty**: At least two indications and two different dates of service during the measurement year and **Advanced Illness**: Either of the following during the measurement period or the year prior to the measurement period. Advanced illness on at least two different date of service (not including laboratory claims-Place of service 81) or dispensed dementia medication of the measurement year.

1) Coding may change periodically without notification

Table 4: High- and Moderate-Intensity Statin Medications

Description	Prescription	
High-intensity statin therapy	• Atorvastatin 40-80 mg • Amlodipine-atorvastatin 40-80 mg • Ezetimibe-simvastatin 80 mg	• Rosuvastatin 20-40 mg • 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

1) Coding may change periodically without notification

Description

The percentage of member 40-75 years of age during the measurement year with diabetes who do not have atherosclerotic cardiovascular disease (ASCVD)

Statin Adherence 80%. Members who remained on a statin medication of any intensity for at least 80 percent of the treatment period.

Eligible Population

Members 40-75 years of age during the measurement year with continuous enrollment of no more than one gap in enrollment of up to 45 days.

Event/Diagnosis:

Members with diabetes can be identified by claim/encounter data and/or pharmacy data. The organization must use both methods to identify the eligible population, but a member only needs to be identified by one method to be included in the measure. Members may be identified as having diabetes during the measurement year or the year prior to the measurement year.

- **Claim/encounter data –** Members who had at least two diagnoses of diabetes on different dates of service during the measurement year or the year prior to the measurement year (count services that occur over both years).
- **Pharmacy data –** Members who were dispensed insulin or hypoglycemics/antihyperglycemics during the measurement year or the year prior to the measurement year and have at least one diagnosis of diabetes during the measurement year or the year prior to the measurement year.

Coding [1]

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Denominator

The Eligible Population (Member must have BCBSKS Medical and Pharmacy benefits)

Numerator

The number of members who had at least one dispensing event for a high-intensity, moderate intensity, or low-intensity statin medication during the measurement year.

Required Exclusions

- Members with at least one of following: Myocardial Infarction on a discharge claim; CABG, PCI, or any other revascularization procedure in any other setting.
- Members who had at least one encounter with a diagnosis of IVD during both the measurement year and the previous measurement year (exclude nonacute inpatient stays).
- Members with a diagnosis of pregnancy, IVF, a prescription for clomiphene, ESRD, dialysis, cirrhosis, myalgia, myositis, myopathy, or rhabdomyolysis during the measurement year.
- Members receiving palliative care anytime during the measurement year.
- Members had an encounter for palliative care (ICD-10- CM Code Z51.50) anytime during the measurement year. Do not include laboratory claims (claims with place of service 81).
- Members in hospice or using hospice services anytime during the measurement year.
- Members who die any time during the measurement year.
- Members 66 years of age as of December 31 of the measurement year with criteria of frailty and advanced illness. Member must meet BOTH frailty and advanced illness criteria to be excluded. **Frailty**: At least two indications and two different dates of service during the measurement year and **Advanced Illness**: Either of the following during the measurement period or the year prior to the measurement period. Advanced illness on at least two different date of service (not including laboratory claims-Place of service 81) or dispensed dementia medication of the measurement year.

1) Coding may change periodically without notification

Table 5: Statin Medications

Description	Prescription	
High-intensity statin therapy	• Atorvastatin 40-80 mg • Amlodipine-atorvastatin 40-80 mg • Ezetimibe-simvastatin 80 mg	• Rosuvastatin 20-40 mg • 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
Low-intensity statin therapy	• Simvastatin 5-10 mg • Ezetimibe-simvastatin 10 mg • Pravastatin 10–20 mg	• Lovastatin 10-20 mg • Fluvastatin 20 mg

1) Coding may change periodically without notification

Description
The percentage of episodes for members 3 months of age and older with a diagnosis of upper respiratory infection (URI) that did not result in an antibiotic dispensing event.

Calculation
The measure is reported as an inverted rate [1 – (numerator/eligible population)]. A higher rate indicates appropriate URI treatment of children with URI (i.e., the proportion of episodes that did not result in an antibiotic dispensing event.

Eligible Population
Members 3 months of age as of July 1 of the year prior to June 30 of the measurement year with continuous enrollment (30 days prior to Episode Date through 3 days after Episode Date) and an Outpatient, Telephone, Online Assessment, Observation or ED visit with only a diagnosis of URI.

Event/Diagnosis
- Identify all members who had an outpatient visit, a telephone visit, an online assessment, or an ED visit during the Intake Period, with a diagnosis of URI. Exclude outpatient, ED or observation visits that result in an inpatient stay.
- Determine all URI Episode Dates. For each member identified in step 1, determine all outpatient, telephone, online assessments, or ED visits with a URI diagnosis.
- Test for negative comorbid condition history. Remove episode dates where the member had a claim/counter with any diagnosis for comorbid condition during the 12 months prior to episode date.
- Test for Negative Medication History. Exclude Episode Dates where a new or refill prescription for an antibiotic medication (Table 3) was filled 30 days prior to the Episode Date or was active on the Episode Date.
- Test for Negative Competing Diagnosis. Exclude Episode Dates where the member had a claim/encounter with a competing diagnosis on or three days after the Episode Date. A code from either of the following meets criteria for a competing diagnosis:
  - Pharyngitis Value Set.
  - Competing Diagnosis Value Set.
- Calculate continuous enrollment. The member must be continuously enrolled without a gap in coverage from 30 days prior to the Episode Date through 3 days after the Episode Date (34 total days).
- Deduplicate eligible episodes. If a member has more than one eligible episode in a 31-day period, include only the first eligible episode. For example, if a member has an eligible episode on January 1, include the January 1 visit and do not include eligible episodes that occur on or between January 2 and January 31; then, if applicable, include the next eligible episode that occurs on or after February 1. Identify visits chronologically, including only one per 31-day period.

Coding[1]
Click here to go to the Coding and Value Set Guide

Denominator
The eligible population (Member must have BCBSKS medical and pharmacy benefit). If a member has more than one eligible episode in a 31-day period, include only the first eligible episode.

Numerator
Dispensed prescription for an antibiotic medication from the URI Antibiotic Medications list (T**able 2**) on or 3 days after the Episode Date.

Required Exclusions
- A period of 30 days prior to the episode date, when the member had no pharmacy claims for either new or refill prescriptions for a listed antibiotic drug. No prescriptions that were filled more than 30 days prior to the episode date and are active on the episode date.
- Exclude members who had claims/encounters with a competing diagnosis on or three days following the episode date (Pharyngitis, etc.) Do not include laboratory claims (claims with place of service 81).
- Remove episode dates where the member had a claim/encounter with any diagnosis for a comorbid condition during the 12 months prior to or on the episode date. Do not include laboratory claims (claims with place of service 81).
- Exclude visits that resulted in an inpatient stay.
- Members in hospice or using hospice services anytime during the measurement year.
- Members who die any time during the measurement year.

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Table 2: Antibiotic Medications (URI)

Description	Prescription		
Aminoglycosides	• Amikacin • Gentamicin	• Streptomycin	• Tobramycin
Aminopenicillins	• Amoxicillin	• Ampicillin	
Beta-lactamase inhibitors	• Amoxicillin-clavulanate	• Piperacillin-tazobactam	• Ampicillin-sulbactam
First-generation cephalosporins	• Cefadroxil	• Cephalexin	• Cefazolin
Fourth-generation cephalosporins	• Cefepime		
Ketolides	• Telithromycin		
Lincomycin derivatives	• Clindamycin	• Lincomycin	
Macrolides	• Azithromycin	• Erythromycin	• Clarithromycin
Miscellaneous antibiotics	• Aztreonam • Chloramphenicol • Dalfopristin-quinupristin	• Daptomycin • Linezolid	• Vancomycin • Metronidazole
Natural penicillin's	• Penicillin G benzathine-procaine • Penicillin G potassium	• Penicillin G procaine • Penicillin G sodium	• Penicillin V potassium • Penicillin G benzathine
Penicillinase resistant penicillin's	• Dicloxacillin	• Oxacillin	• Nafcillin
Quinolones	• Ciprofloxacin • Gemifloxacin	• Levofloxacin • Moxifloxacin	• Ofloxacin
Rifamycin derivatives	• Rifampin	•	
Second-generation cephalosporin	• Cefaclor • Cefotetan	• Cefoxitin • Cefprozil	• Cefuroxime
Sulfonamides	• Sulfadiazine	• Sulfamethoxazole-trimethoprim	
Tetracyclines	• Doxycycline	• Tetracycline	• Minocycline
Third generation cephalosporins	• Cefdinir • Cefditoren • Cefixime	• Cefotaxime • Cefpodoxime • Ceftazidime	• Ceftibuten • Ceftriaxone
Urinary Anti-infectives	• Fosfomycin • Nitrofurantoin	• Nitrofurantoin macrocrystals-monohydrate	• Trimethoprim

Description
The percentage of members 3–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.

Note: *This measure has the same structure as measures in the Effectiveness of Care domain. The organization must follow the Guidelines for Effectiveness of Care Measures when calculating this measure.*

Eligible Population
Children and adolescents aged 3-21 as of December 31 of the measurement year with continuous enrollment, (no more than one gap in enrollment of up to 45 days in the measurement year).

Coding[1]
Click here to go to the Coding and Value Set Guide

Denominator
The eligible population.

Numerator
- One or more well care visits during the measurement year. Any of the following meet the criteria:
- An encounter for well-care. Do not include laboratory claims (claims with place of service code 81).
- The well care visit must occur with a PCP or an OB/GYN practitioner, but the practitioner does not have to be the practitioner assigned to the member.

Required Exclusions
- Members in hospice or using hospice services anytime during the measurement year.
- Members who die at any time during the measurement period.

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Description

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

1. Well-Child Visits in the First 15 Months. Children who turned 15 months during the measurement year: Six or more well-child visits.
2. Well-Child Visits for Age 15 Months-30 Months. Children who turned 30 months old during the measurement year: Two or more well-child visits.

Eligible Population

- Children who turn 15 months old during the measurement year with continuous enrollment of no more than one gap in enrollment of up to 45 days from when turning 31 days of age to 15 months of age. Calculate the 15-month birthday as the child's first birthday plus 90 days.
- Children who turn 30 months old during the measurement year with continuous enrollment from 15 months plus 1 day to 30 months of age with no more than 1 gap of up to 45 days. Calculate the 30-month birthday as the second birthday plus 180 days.

Coding[1]

Click here to go to the Coding and Value Set Guide

Denominator

The eligible population.

Numerator

Members who the following number of well-child visits with a PCP during the last 15 months.

- Well-Child Visits in the First 15 Months: Children who turned 15 months old during the measurement year. Six or more well-child visits on different dates of service on or before the 15- month birthday. Do not include laboratory claims (claims with place of service code 81).
- Well-Child Visits for Age 15 Months-30 Months: Children who turned 30 months old during the measurement year. Two or more well-child visits on different dates of service between the child's 15-month birthday plus 1 day and the 30-monrth birthday. Do not include laboratory claims (claims with place of service code 81).
- The well-child visit must occur with a PCP, but the PCP does not have to be the practitioner assigned to the child.

Required Exclusions

- Members in hospice or using hospice services anytime during the measurement year.
- Members who die anytime during the measurement period.

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Appendix A: Definitions

Denominator - Eligible members of the population

Numerator - Members who met the criteria of a measure.

HEDIS (Healthcare Effectiveness Data and Information Set) - Tool used by more than 90% of America's health plans to measure performance on important dimensions of care and service.

Intake Period - The time-period (typically the measurement year) used to identify the first eligible encounter.

Index Episode Start Date (IESD) - The earliest date of service for an eligible encounter during the intake period.

Anchor Date - The specific date the member is required to be enrolled to be eligible for the measure.

Measurement Year - The twelve-month time frame of data used to support the calculation of the bi-annual QBRP performance scores. For BCBSKS' QBRP HEDIS-based performance scores, the Jan.1 thru Dec. 31 measurement year is used to support the July 1 thru Dec. 31 QBRP scores of the following bi-annual QBRP cycle, and the July 1 thru June 30 measurement year is used to support the Jan. 1 thru June 30 QBRP scores of the following bi-annual QBRP cycle.

Continuous Enrollment - A period during the measurement timeline, where a member must be enrolled to be counted towards the measure.

Primary Care Physician (PCP) - A physician or non-physician (e.g., nurse practitioner, physician assistant) who offers primary care medical services.

- LPNs and RNs are not considered PCPs

Episode Date - The date of service for any outpatient or ED visit during the intake period.

Appendix B: Changes

Version	Description	Effective Date
2018.v1	Initial Release	March-17
2018.v2	Updated with new coding value sets and formatting changes.	June-17
2019.v1	Updated to include 2019 QBRP measures including code sets. Added negative conditions to CWP, AAB, LBP.	July-18
2019.v2	General updates to Title Page, AWC, CWP, CDC, CCS, LBP, and Appendix A.	October-18
2020.v1	Updated with new coding value sets and addition of new measures. Added CPT II and ICD-10 'history of' codes where applicable. Removed LOINC code sets.	January-19
2020.v2	Updated with addition of new measures CDC-EYE, CDC-NEPH, SPC, and SPD.	August-19
2020.v3	Updated with specification changes for HEDIS 2020 and coding set updates. Changes include: · **CWP**- Expanded age range from 3-18 years of age to 3 years of age and older. · **URI**- Expanded age range from 3 months-18 years of age (children) to 3 months of age and older. · **AAB**- Expanded age range from 18-64 years of age (adults) to members 3 months of age and older · **CCS**- Updated screening methods to include primary high-risk human papillomavirus testing.	August-20
2022.v1	Updated measure set to remove AWC, CDC-NEPH, W15, W34, SPC-80%, SPD-80% and replaced with W30 (2 rates), WCV, SPD-Received Statin Therapy, SPC- Received Statin Therapy. Updated value code sets. Added Appendix C: Potential Future Changes Added Appendix D: Supplemental Code Sets Changed Appendix B 'Dates' to 'Effective Date'	January-22
2023.v1	Updated with specification changes for HEDIS 2023 and coding set updates. The following changes was made. · **CDC**- Split into two measures. 1. EED -Eye Exam for Patients with Diabetes (EED) 2. HBD -Hemoglobin A1c for Patients with Diabetes Updated value code sets and Medication list. Updated Appendix C: Supplemental Code Sets (added additional codes) Added Appendix E: Stratification by Race and Ethnicity	August-22
2024.v1	Updated with specification changes for HEDIS 2024 and coding set, Removed HBD-Hemoglobin A1c for Patients with Diabetes Moved FUH out of future measures into the current measures. Changed COL to COL-E. Updated value code sets. Updated Appendix E: Stratification by Race and Ethnicity Added HEDIS Copyright Notice and Disclaimer	January-24

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Appendix C: Supplemental Code Sets: Z Codes and CPT Category II Codes

BCBSKS is promoting the use of ICD-10 Z codes and CPT Category II code sets. By using these codes, BCBCKS can better identify Social Determinants of Health, history of mastectomy, hysterectomy and colectomy, and lab result codes which will ultimately result in the reduction of medical record requests.

ICD-10 Z Codes

Persons with potential Health Hazards related to socioeconomic and psychosocial circumstances (Z55-Z65)

Social Determinant	***ICD-10-CM Code and description***
Problems related to education and literacy (Z55)	Z55.0 Illiteracy and low-level literacy Z55.1 Schooling unavailable and unattainable Z55.2 Failed school examinations Z55.3 Underachievement in school Z55.4 Educational maladjustment and discord with teachers and classmates Z55.8 Other problems related to education and literacy Z55.9 Problems related to education and literacy, unspecified
Problems related to employment and unemployment (Z56)	Z56.0 Unemployment, unspecified Z56.1 Change of Job Z56.2 Threat of job loss Z56.3 Stressful work schedule Z56.4 Discord with boss and workmates Z56.5 Uncongenial work environment Z56.6 Other physical and mental strain related to work Z56.81 Sexual harassment on the job Z56.82 Military deployment status Z56.89 Other problems related to employment Z56.9 Unspecified problems related to employment
Occupational exposure to risk factors (Z57)	Z57.0 Occupational exposure to noise Z57.1 Occupational exposure to radiation Z57.2 Occupational exposure to dust Z57.31 Occupational exposure to environmental tobacco smoke Z57.39 Occupational exposure to other air contaminants Z57.4 Occupational exposure toxic agents in agriculture Z57.5 Occupational exposure to toxic agents in other industries Z57.6 Occupational exposure to extreme temperature Z57.7 Occupational exposure to vibration Z57.8 Occupational exposure to other risk factors Z57.9 Occupational exposure to unspecified risk factor

Problems related to housing and economic circumstances (Z59)	Z59.0 Homelessness Z59.1 Inadequate housing Z59.2 Discord with neighbors, lodgers, and landlord Z59.3 Problems related to living in residential institution Z59.4 Lack of adequate food and safe drinking water 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 Z59.9 Problem related to housing and economic circumstances, unspecified
Problems related to social environment (Z60)	Z60.0 Problems of adjustment to life-cycle transitions Z60.2 Problems related to living alone Z60.3 Acculturation difficulty Z60.4 Social exclusion and rejection Z60.5 Target of (perceived) adverse discrimination and persecution Z60.8 Other problems related to social environment Z60.9 Problems related to social environment, unspecified
Problems related to upbringing (Z62)	Z62.0 Inadequate parental supervision and control Z62.1 Parental overprotection Z62.21 Child in welfare custody Z62.22 Institutional upbringing Z62.29 Other upbring away from parents Z62.3 Hostility towards and scapegoating of child Z62.6 Inappropriate (excessive) parental pressure Z62.81 Personal history of abuse in childhood Z62.810 Personal history of physical and sexual abuse in childhood Z62.811 Personal history of psychological abuse in childhood Z62.812 Personal history of neglect in childhood Z62.813 Personal history of forced labor or sexual exploitation in childhood Z62.819 Personal history of unspecified abuse in childhood Z62.820 Parent-biological child conflict Z62.821 Parent-adopted child conflict Z62.822 Parent-foster child conflict Z62.890 Parent-child estrangement NEC Z62.891 Sibling rivalry Z62.898 Other specified problems related to upbringing

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Other problems related to primary support group, including family circumstances (Z63)	Z63.0 Problems in relationship with spouse or partner Z63.1 Problems in relationship with in-laws Z63.31 Absence of family member due to military deployment Z63.32 Other absence of family member Z63.4 Disappearance and death of family member Z63.5 Disruption of family by separation and divorce Z63.6 Dependent relative needing care at home Z63.71 Stress on family due to return of family member from military deployment Z63.72 Alcoholism and drug addiction in family Z63.79 Other stressful life events affecting family and household Z63.8 Other specified problems related to primary support group Z63.9 Problem related to primary support group, unspecified
Problems related to certain psychosocial circumstances (Z64)	Z64.0 Problems related to unwanted pregnancy Z64.1 Problems related to multiparity Z64.4 Discord with counselor
Problems related to other psychosocial circumstances (Z65)	Z65.0 Conviction in civil and criminal proceedings without imprisonment Z65.1 Imprisonment and other incarceration Z65.2 Problems related to release from prison Z65.3 Problems related to other legal circumstances Z65.4 Victim of crime and terrorism Z65.5 Exposure to disaster, war, and other hostilities Z65.8 Other specified problems related to psychosocial circumstances Z65.9 Problem related to unspecified psychosocial circumstances
Problems related to medical facilities and other health care (Z75)	Z75.0 Medical services not available at home Z75.1 Person awaiting admission to adequate facility elsewhere Z75.2 Other waiting period for investigation and treatment Z75.3 Unavailability and inaccessibility of health care facilities Z75.4 Unavailability and inaccessibility of other helping agencies Z75.5 Holiday relief care Z75.8 Other problems related to medical facilities and other health care Z

This list should not be considered comprehensive of all available codes. The codes listed are those commonly used codes.

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Other ICD-10CM Z-Codes for HEDIS

History of Mastectomy	Z90.13 Acquired absence of bilateral breasts and nipples
History of Hysterectomy	Z90.710 Acquired absence of both cervix and uterus Z90.712 Acquired absence of cervix with remaining uterus
Pregnancy Diagnosis	Z03.71 Encounter for suspected problem with amniotic cavity and membrane ruled out Z03.72 Encounter for suspected placental problem ruled out Z03.73 Encounter for suspected fetal anomaly ruled out Z03.74 Encounter for suspected problem with fetal growth ruled out Z03.75 Encounter for suspected cervical shortening ruled out Z03.79 Encounter for other suspected maternal and fetal conditions ruled out Z32.01 Encounter for pregnancy test, result positive Z34.00 Encounter for supervision of normal first pregnancy, unspecified trimester Z34.01 Encounter for supervision of normal first pregnancy, first Trimester Z34.02 Encounter for supervision of normal first pregnancy, second trimester Z34.03 Encounter for supervision of normal first pregnancy, third trimester Z34.80 Encounter for supervision of other normal pregnancy, unspecified trimester Z34.81 Encounter for supervision of other normal pregnancy, first trimester Z34.82 Encounter for supervision of other normal pregnancy, second trimester Z34.83 Encounter for supervision of other normal pregnancy, third trimester Z34.90 Encounter for supervision of normal pregnancy, unspecified, unspecified trimester Z34.91 Encounter for supervision of normal pregnancy, unspecified, first trimester Z34.92 Encounter for supervision of normal pregnancy, unspecified, second trimester Z34.93 Encounter for supervision of normal pregnancy, unspecified, third trimester Z36 Encounter for antenatal screening of mother
Postpartum Care	Z39.2 Encounter for routine place of postpartum follow-up Z39.1 Encounter for care and examination of lactating mother

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CPT-II Codes

Measure	CPT-II Code	Description
PPC	0500F	Initial prenatal care visit (report at first prenatal encounter with health care professional providing obstetrical care. Report also date of visit and, in a separate field, the date of the last menstrual period [LMP]) (Prenatal)
	0501F	Prenatal flow sheet documented in medical record by first prenatal visit (documentation includes at minimum blood pressure, weight, urine protein, uterine size, fetal heart tones, and estimated date of delivery). Report also: date of visit and, in a separate field, the date of the last menstrual period [LMP] (Note: If reporting 0501F Prenatal flow sheet, it is not necessary to report 0500F Initial prenatal care visit) (Prenatal)
	0502F	Subsequent prenatal care visit (Prenatal) [Excludes: patients who are seen for a condition unrelated to pregnancy or prenatal care (eg, an upper respiratory infection; patients seen for consultation only, not for continuing care)]
	0503F	Postpartum care visit (Prenatal)
EED	2022F	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy (DM)
	2023F	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy (DM)
	2024F	7 standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed: with evidence of retinopathy (DM)
	2025F	7 standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed: without evidence of retinopathy (DM)
	2026F	Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed: with evidence of retinopathy (DM)
	2033F	Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed: without evidence of retinopathy (DM)
	3072F	Low risk for retinopathy (no evidence of retinopathy in the prior year) (DM)

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Measure	CPT-II Code	Description
HBD	3044F	Most recent hemoglobin A1c (HbA1c) level less than 7.0% (DM)
	3046F	Most recent hemoglobin A1c level greater than 9.0% (DM)
	3048F	Most recent LDL-C less than 100 mg/dL (CAD) (DM)
	3049F	Most recent LDL-C 100-129 mg/dL (CAD) (DM)
	3050F	Most recent LDL-C greater than or equal to 130 mg/dL (CAD) (DM)
	3051F	Most recent hemoglobin A1c (HbA1c) level greater than or equal to 7.0% and less than 8.0% (DM)
	3052F	Most recent hemoglobin A1c (HbA1c) level greater than or equal to 8.0% and less than or equal to 9.0% (DM)
CBP	3074F	Most recent systolic blood pressure less than 130 mm Hg (DM) (HTN, CKD, CAD)
	3075F	Most recent systolic blood pressure 130-139 mm Hg (DM) (HTN, CKD, CAD)
	3077F	Most recent systolic blood pressure greater than or equal to 140 mm Hg (HTN, CKD, CAD) (DM)
	3078f	Most recent diastolic blood pressure less than 80 mm Hg
	3079f	Most recent diastolic blood pressure 80-89 mm Hg
	3080F	Most recent diastolic blood pressure greater than or equal to 90 mm Hg
		This list should not be considered comprehensive of all available codes. The codes listed are those commonly used codes.

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Appendix D: Potential Future Measures

These potential measure additions are being communicated as changes that may occur in the upcoming year. This will allow providers to become educated on the measures prior to being implemented into QBRP.

Antidepressant Medication Management (AMM) -PCMH Measure

Description
The percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment. Two rates are reported.

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

Eligible Population
Members 18 years and older as of April 30 of the measurement year with continuous enrollment of 105 days prior to the IPSD through 231 days after the IPSD. Only one gap in enrollment of up to 45 days.

Coding[1]
Click here to go to the Coding and Value Set Guide

Denominator
The eligible population (Member must have BCBSKS Medical and Pharmacy benefits).

Numerator
At least 84 days (12 weeks) of treatment with antidepressant medication, beginning on the IPSD through 114 days after the IPSD (115 total days). This allows gaps in medication treatment up to a total of 31 days during the 115-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication.

Required Exclusions
- Exclude members who did not have an encounter with a diagnosis of major depression during the 121-day period from 60 days prior to the IPSD, through the IPSD and the 60 days after the IPSD.
- Members in hospice or using hospice services anytime during the measurement year.
- Members who die during the measurement period.

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Description
Member ages 5-64 as of December 31 of the measurement year with continuous enrollment (no more than one gap in enrollment of up to 45 days in the measurement year).

Eligible Population
Members 5-64 as of December 31 of the measurement year with continuous enrollment (no more than one gap in enrollment of up to 45 days in the measurement year).

Denominator
The eligible population.

Numerator
The number of members who have a medication ratio of 0.50 or greater during the measurement year. Follow the steps below to calculate the ratio.
Use all the medication lists in the Asthma Controller Medications (Table 7) to identify asthma controller medications. Use all the medication lists in the Asthma Reliever Medications (Table 7) to identify asthma reliever medications.
Step 1- For each member, count the units of asthma controller medications dispensed during the measurement year. *Step 2*- For each member, count the units of asthma reliever medications dispensed during the measurement year. *Step 3*- For each member, sum the units calculated in step 1 and step 2 to determine units of total asthma medications.
Step 4- For each member, calculate the ratio of controller medications to total asthma medications using the following formula. Round (using the .5 rule) to the nearest whole number.

$$\frac{\text{Units of Controller Medications (step 1)}}{\text{Units of Total Asthma Medications (step 3)}}$$

Step 5- Sum the total number of members who have a ratio of 0.50 or greater in step 4.

Required Exclusions
- Exclude members with the following diagnosis: Emphysema, COPD, Obstructive Chronic Bronchitis, Chronic Respiratory Conditions due to Fumes, Cystic Fibrosis, Acute Respiratory Failure.
- Exclude members who had no asthma controller or reliever medications dispensed during the measurement year.
- Exclude members in hospice or using hospice services anytime during the measurement year.
- Exclude members who die anytime during the measurement year.

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Description

The percentage of emergency department (ED) visits among members age 13 years and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow-up. Two rates are reported:

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

Eligible Population

Members aged 13 and older as of the ED visit with a continuous enrollment of the date of the ED visit through 30 days after the ED visit. (31 total days)

Event/Diagnosis

An ED visit with a principal diagnosis of SUD ***or*** any diagnosis of drug overdose on or between January 1 and December 1 of the measurement year, where the member was 13 years or older on the date of the visit.

The denominator for this measure is based on ED visits, not on members. If a member has more than one ED visit, identify all eligible ED visits between January 1 and December 1 of the measurement year and do not include more than one visit per 31-day period, as described below.

If a member has more than one ED visit in a 31-day period, include only the first eligible ED visit. For example, if a member has an ED visit on January 1, include the January 1 visit and do not include ED visits that occur on or between January 2 and January 31; then, if applicable, include the next ED visit that occurs on or after February 1. Identify visits chronologically, including only one per 31-day period.

Denominator

The eligible population.

Numerator

1. A follow-up visits or a pharmacotherapy dispensing event within **30 days** after the ED visit (31 total days). Include visits and pharmacotherapy events that occur on the date of the ED visit.
2. A follow-up visits or a pharmacotherapy dispensing event within **7 days** after the ED visit (8 total days). Include visits and pharmacotherapy events that occur on the date of the ED visit

Required Exclusions

- Exclude ED visits that result in an inpatient stay and ED visits followed by an admission to an acute or nonacute inpatient care setting on the date of the ED visit or within the 30 days after the ED visit, regardless of the principal diagnosis for the admission.
- To identify admissions to an acute or nonacute inpatient care setting:
  - Identify all acute and nonacute inpatient stay.
  - Identify the admission date for the stay.
- These events are excluded from the measure because admission to an acute or nonacute inpatient setting may prevent an outpatient follow-up visit from taking place.
- Members in hospice or using hospice services anytime during the measurement year.
- Exclude members who die anytime during the measurement year.

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

Description
The percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness. Two rates are reported:

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

Eligible Population
Members aged 6 and older as of the ED visit with a continuous enrollment of the date of the ED visit through 30 days after discharge.

Event/Diagnosis
An ED visit with a principal diagnosis of mental illness or intentional self-harm on or between January 1 and December 1 of the measurement year where the member was 6 years or older on the date of the visit.

The denominator for this measure is based on ED visits, not on members. If a member has more than one ED visit, identify all eligible ED visits between January 1 and December 1 of the measurement year and do not include more than one visit per 31-day period as described below.

If a member has more than one ED visit in a 31-day period, include only the first eligible ED visit. For example, if a member has an ED visit on January 1, include the January 1 visit and do not include ED visits that occur on or between January 2 and January 31; then, if applicable, include the next ED visit that occurs on or after February 1. Identify visits chronologically, including only one per 31-day period.

Denominator
The eligible population.

Numerator

1. A follow-up visit with any practitioner, with a principal diagnosis of a mental health disorder or with a principal diagnosis of intentional self-harm and any diagnosis of a mental health disorder within 30 days after the ED visit (31 total days). Include visits that occur on the date of the ED visit.

2. A follow-up visit with any practitioner, with a principal diagnosis of a mental health disorder or with a principal diagnosis of intentional self-harm and any diagnosis of a mental health disorder within 7 days after the ED visit (8 total days). Include visits that occur on the date of the ED visit.

Required Exclusions
Exclude ED visits that result in an inpatient stay and ED visits followed by an admission to an acute or nonacute inpatient care setting on the date of the ED visit or within the 30 days after the ED visit, regardless of the principal diagnosis for the admission.

- To identify admissions to an acute or nonacute inpatient care setting:
  - Identify all acute and nonacute inpatient stays.
  - Identify the admission date for the stay.
- These events are excluded from the measure because admission to an acute or nonacute inpatient setting may prevent an outpatient follow-up visit from taking place.
- Members in hospice or using hospice services anytime during the measurement year.
- Members who die any time during the measurement year.

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Appendix E: Stratifications by Race and Ethnicity

Race	White Black or African American American Indian and Alaska Native Asian Native Hawaiian and Other Pacific Islander Some Other Race Two or More Races Asked but No Answer Unknown
Ethnicity	Hispanic/Latino Not Hispanic/Latino Asked but No Answer Unknown

Measures reporting Race and Ethnicity stratifications:

AIS-E	Adult Immunizations
AMR	Asthma Medication Ratio
BCS	Breast Cancer Screening
CBP	Controlling High Blood Pressure
COL	Colorectal Cancer Screening
FUA	Emergency Department Visits for Substance Use Disorder
HBD	Hemoglobin A1c Control Patients with Diabetes
IMA	Immunizations for Adolescents
POD	Pharmacotherapy for Opioid Use Disorder
PPC	Prenatal and Place of service partum Care
W30	Well Child Visits up to 36 Months
WCV	Child and Adolescent Well-Care Visits

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