2024 HEDIS® Coding & Reference Guide

BCBSKS 2024 Value-Based Measures

12/2023

BlueCross BlueShield Kansas

Appropriate Testing for Pharyngitis (CWP)

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, E-Visit, Virtual Check-In, 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/ Negative Conditions

- 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 POS 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 POS 81).
- Members who died any time during the measurement year.

1) Coding may change periodically without notification

Table 1: Antibiotic Medications (CWP)*

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

*Medication updates change periodically without notification

Appropriate Testing for Upper Respiratory Infections (URI)

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 the 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, 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 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).

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 antibiotic medication from the URI Medications List (Table 2) on or the three days following the IESD.

Required Exclusions/ Negative Conditions

- 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 POS 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 POS 81).
- Exclude visits that resulted in an inpatient stay.
- Members in hospice or using hospice services anytime during the measurement year.
- Members who died any time during the measurement year.

1) Coding may change periodically without notification

Table 2: Antibiotic Medications (URI)*

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

*Medication updates change periodically without notification

Avoidance of Antibiotics for Bronchitis/Bronchiolitis (AAB)

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 of age and older with a diagnosis of acute bronchitis/bronchiolitis 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, 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 antibiotic medication (Table 3) on or the three days following 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/ Negative Conditions
- 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 POS 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 POS 81).
- Exclude visits that resulted in an inpatient stay.
- Members in hospice or using hospice services anytime during the measurement year.
- Members who died any time during the measurement year.

1) Coding may change periodically without notification

Table 3: Antibiotic Medications (AAB)*

Description	Prescription
Aminoglycosides	• Amikacin • Streptomycin • Tobramycin • Gentamicin
Aminopenicillins	• Ampicillin • Amoxicillin
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	• Penicillin G benzathine-procaine • Penicillin G procaine• Penicillin G potassium • Penicillin V potassium • Penicillin G sodium • Penicillin G benzathine
Penicillinase-resistant penicillins	• Dicloxacillin • Nafcillin • Oxacillin
Quinolones	• Ciprofloxacin • Levofloxacin • Ofloxacin • Moxifloxacin • Gemifloxacin
Rifamycin Derivatives	• Rifampin
Second Generation Cephalosporins	• Cefaclor • Cefotetan • Cefoxitin • Cefprozil • Cefuroxime
Sulfonamides	• Sulfamethoxazole-trimethoprim • Sulfadiazine
Tetracyclines	• Doxycycline • Tetracycline • Minocycline
Third Generation Cephalosporins	• Cefdinir • Cefotaxime • Cefpodoxime • Ceftriaxone • Cefixime • Ceftazidime
Urinary Anti-infectives	• Fosfomycin • Nitrofurantoin • Nitrofurantoin macrocrystals-monohydrate • Trimethoprim

*Medication updates change periodically without notification

Breast Cancer Screening (BCS-E)

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.

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

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/ Negative Conditions
- Exclude members who have had a bilateral mastectomy 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
  - For members with a history of mastectomy Acquired can be documented administratively on claims via ICD-10 code: Z90.13.
- 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 who die any time during the measurement period.
- Members 66 years of age and older by end of the measurement period with two indications of frailty with two different dates of service AND advanced illness or dispensed dementia medication (No lab claims.).
- 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.

1) Coding may change periodically without notification

Cervical Cancer Screening (CCS)

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

Denominator
The eligible population.

Numerator
The number of women who were 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/ Negative Conditions
- 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 or had an encounter for palliative care (ICD-10-CM code Z51.5) during the measurement year.
- 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 died any time during the measurement year.

1) Coding may change periodically without notification

Colorectal Cancer Screening (COL-E)

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

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.
- 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/ Negative Conditions
- 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 or palliative encounter (ICD-10- CM Code Z51.50) anytime during the measurement year.
- Members in hospice or using hospice services anytime during the measurement year.
- Members who died any time during the measurement year.
- Members aged 66 years of age and older by the end of the measurement period diagnosed with at least (2) indications of frailty and advanced illness (on two separate DOS) or dispensed dementia medication.

1) Coding may change periodically without notification

Eye Exam for Patients with Diabetes (EED)

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.
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]
Click here to go to the Coding and Value Set Guide

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 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/ Negative Conditions.
- Members receiving palliative care or have had an encounter for palliative care (ICD-10-CM Code Z51.5) during the measurement year. Do not include laboratory claims (POS 81).
- Members in hospice or using hospice services anytime during the measurement year.
- Members who died any time during the measurement year.
- Members 66 years of age as of December 31 with diagnosis of frailty (two indicators) AND advanced illness (two different DOS) or dispensed dementia medication of the measurement year. Do not include laboratory claims (POS 81).

1) Coding may change periodically without notification

Statin Therapy for Patients with Cardiovascular Disease (SPC)

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 women 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 procedures.
- Members who has 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/ Negative Conditions

- 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.
- For those members ages 66 and higher, exclude those with a diagnosis of frailty accompanied with an inpatient stay or nonacute inpatient stay.
- Members receiving palliative care or had a palliative encounter (ICD-10-CM Code Z51.5) during the measurement year.
- Members in hospice or using hospice services anytime during the measurement year.
- Members who died any time during the measurement year.
- Members 66 years of age as of December 31 of the measurement year with criteria of frailty (two indications and two different DOS) AND advanced illness (two different DOS) 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 bid • Pitavastatin 1–4 mg

*Medication updates change periodically without notification

Statin Therapy for Patients with Diabetes (SPD)

Description

The percentage of members 40-75 years of age during the measurement year with diabetes who do not have atherosclerotic cardiovascular disease (ASCVD) and were dispensed at least one statin medication (Table 5) of any intensity during the measurement year.

1. ***Received Statin Therapy.*** **Members who were dispensed at least one statin medication of any intensity during the measurement year.**
2. ***Statin Adherence 80 percent.*** **Members who remained on a statin medication for at least 80 percent of the treatment period.**

Eligible Population

The number of members aged 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

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]

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, moderate intensity, or low-intensity statin medication during the measurement year.

Required Exclusions/ Negative Conditions

- 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 or have had an encounter for palliative care (ICD-10-CM Code Z51.5) during the measurement year. Do not include laboratory claims (POS 81).
- Members in hospice or using hospice services anytime during the measurement year.
- Members who died any time during the measurement year.
- Members 66 years of age as of December 31 with diagnosis of frailty (two indicators) AND advanced illness (two different DOS) or dispensed dementia medication of the measurement year. Do not include laboratory claims (POS 81).

1) Coding may change periodically without notification

Table 5: 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
Low-intensity statin therapy	• Simvastatin 5-10 mg • Ezetimibe-simvastatin 10 mg • Pravastatin 10–20 mg • Lovastatin 10-20 mg • Fluvastatin 20 mg

*Medication updates change periodically without notification

Use of Imaging Studies for Low Back Pain (LBP)

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/ Negative Conditions
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. 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
- Recent trauma. Trauma any time during the 3 months (90 days) prior to the IESD through 28 days after the IESD.
- Intravenous drug abuse. IV drug abuse any time during the 12 months (1 year) prior to the IESD through 28 days after the IESD.
- Neurologic Impairment. Neurologic impairment any time during the 12 months (1 year) prior to the IESD through 28 days after the IESD.
- HIV. HIV any time during the member's history through 28 days after the IESD.
- Spinal infection. 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. Osteoporosis therapy or a dispensed prescription to treat osteoporosis any time during the member's history through 28 days after the IESD
- Fragility fracture. Fragility fracture any time during the 3 months (90 days) prior to the IESD through 28 days after the IESD.
- Lumbar surgery. Lumbar surgery any time during the member's history through 28 days after the IESD.
- Spondylopathy. Spondylopathy any time during the member's history through 28 days after the IESD.
- Palliative care. Members receiving palliative care any time during the measurement year.
- Members in hospice or using hospice services anytime during the measurement year.
- Members who died any time during the measurement year.

1) Coding may change periodically without notification

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

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

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

1. 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.
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 on different dates of service between the child's 15-month birthday plus 1 day and the 30-monrth birthday.

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/ Negative Conditions

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

1) Coding may change periodically without notification

Child and Adolescent Well-Care Visits (WCV)

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.

Eligible Population
Children and adolescents ages 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.
- 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/ Negative Conditions
- Members in hospice or using hospice services anytime during the measurement year.
- Member who dies at any time during the measurement period

1) Coding may change periodically without notification

Antidepressant Medication Management (AMM)

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 (Table 6), 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/ Negative Conditions

- 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 died during the measurement period.

1) Coding may change periodically without notification

Table 6: Antidepressant Medications*

Description	Prescription
Miscellaneous antidepressants	• Bupropion • Vilazodone • Vortioxetine
Monoamine oxidase inhibitors	• Isocarboxazid • Phenelzine • Selegiline • Tranylcypromine
Phenylpiperazine antidepressants	• Nefazodone • Trazodone
Psychotherapeutic combinations	• Amitriptyline-chlordiazepoxide • Amitriptyline-perphenazine • Fluoxetine-olanzapine
SNRI antidepressants	• Desvenlafaxine • Duloxetine • Levomilnacipran • Venlafaxine
SSRI antidepressants	• Citalopram • Escitalopram • Fluoxetine • Fluvoxamine • Paroxetine • Sertraline
Tetracyclic antidepressants	• Maprotiline • Mirtazapine
Tricyclic antidepressants	• Amitriptyline • Amoxapine • Clomipramine • Desipramine • Doxepin (>6 mg) • Imipramine • Nortriptyline • Protriptyline • Trimipramine

*Medication updates change periodically without notification

Asthma Medication Ratio (AMR)

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

Eligible Population
Members 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).

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

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/ Negative Conditions
- 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 died anytime during the measurement year.

1) Coding may change periodically without notification

Table 7: Asthma Medications*

Description	Prescription
Controller Medications	• Omalizumab • Dupilumab • Benralizumab • Mepolizumab • Reslizumab • Budesonide-formoterol • Fluticasone-salmeterol • Fluticasone-vilanterol • Formoterol-mometasone • Beclomethsone • Budesonide • Ciclesonide • Flunisolide • Mometasone • Montelukast • Zafirlukast • Zileuton • Theophylline
Reliever Medications	• Albuterol • Levalbuterol

*Medication updates change periodically without notification

Acute Hospital Utilization (AHU)

Description
This measure assesses the risk-adjusted ratio of observed-to-expected acute inpatient admission and observation stay discharges during the measurement year among members 18 years of age and older.

Eligible Population
Members 18 years and older as of December 31 of the measurement year with no more than one gap in enrollment of up to 45 days during each year of continuous enrollment.

Observed Events – Count all acute inpatient and observation discharges during the measurement year for non-outlier members, excluding non-acute inpatient stays or inpatient and observation discharges with any of the following:
- Discharge claim that has a principal diagnosis of mental health or chemical dependency, live-born infant, or maternity-related.
- A planned hospital stay with a principal diagnosis of maintenance chemotherapy, rehabilitation, or organ transplant.
- A potentially planned procedure without a principal acute diagnosis.
- Inpatient and observation stays with a discharge for death.

For discharges with more than one direct transfer, use the last discharge.

Expected Events - For each of those non-outlier member in the eligible population, identify the HCC category, age and gender to which they belong. With this information there are two calculations made that are made using risk weights associated with the HCC and with the age-gender categories: Predicted Probability of Discharge (PPD) and Predicted Unconditional Count of Discharge (PUCD). NCQA® defines the risk weights. The final Expected Events calculation is derived from multiplying these two numbers together.

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

- **Outlier**: Members with three or more inpatient or observation stay discharges during the measurement year.
- **Non-outlier**: Members with two or less inpatient or observation stay discharges during the measurement year.

Required Exclusions/ Negative Conditions
- Members in hospice or using hospice services anytime during the measurement year.
- Excluded nonacute inpatient stays

1) Coding may change periodically without notification

Emergency Department Utilization (EDU)

Description
Assesses emergency department (ED) utilization among health plan members (18 and older) through an observed-to-expected ratio. Plans report observed rates of ED use and a predicted rate of ED use based on the health of the member population and factors.

Eligible Population
For members 18 years of age and older, the risk-adjusted ratio of observed-to-expected emergency department (ED) visits during the measurement year. No more than one gap in enrollment of up to 45 days during each year of continuous enrollment.

Observed Events: Count all ED visits during the measurement year for non-outlier members, excluding them if they result in an inpatient stay/observation or have a principal diagnosis of mental health or chemical dependency, psychiatry encounter, or electroconvulsive therapy.

Expected Events – For each of those non-outlier members in the eligible population, identify the HCC category, age and gender to which they belong. With this information there are two calculations made that are made using risk weights associated with the HCC and with the age-gender categories: Predicted Probability of a Visit (PPV) and Predicted Unconditional Count of Visits (PUCV). NCQA® defines the risk weights. The final Expected Events calculation is derived from multiplying these two numbers together.
An observed/expected (O/E) ratio also will be calculated.

Observed Visits per 1,000 NonOutlier Members: The number of observed ED visits divided by the number of non-outlier members in the eligible population, multiplied by 1,000 for each age and gender group and totals. Calculated by IDSS as the Observed Rate.
Expected Visits per 1,000 NonOutlier Members: The number of expected ED visits divided by the number of non-outlier members in the eligible population, multiplied by 1,000 for each age and gender group and totals. Calculated by IDSS as the Expected Rate.
O/E Ratio: The number of observed events among non-outlier members divided by the number of expected events among non-outlier members for each age and gender group and totals. Calculated by IDSS as the OE.

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

- **Outlier**: Members 18 years of age and older with four or more ED visits during the measurement year.
- **NonOutlier**: Members 18 years of age and older with three or less ED visits during the measurement year.

Required Exclusions/ Negative Conditions
- Members in hospice or using hospice services anytime during the measurement year.
- ED visits that result in an inpatient stay or observation stay.
- A principal diagnosis of mental health or chemical dependency, psychiatry, or electroconvulsive therapy

1) Coding may change periodically without notification

Follow-up After Hospitalization for Mental Illness (FUH)

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. The following rates are reported:
1. The percentage of discharges for which the member received follow-up within 30 days after discharge.
2. The percentage of discharges for which the member received follow-up within 7 days after discharge.

Eligible Population
Members 6 years and older as of the date of discharge.

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

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 visit 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 visit with a mental health provider within 7 days after discharge. Do not include visits that occur the date of discharge.

Required Exclusions/ Negative Conditions
- Members in hospice or using hospice services anytime during the measurement year.
- Members who died any time during the measurement year.

1) Coding may change periodically without notification

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 period of time (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.
- Index Prescription Start Date (IPSD) - The date of the first fill for any target medication.
- Anchor Date - The specific date the member is required to be enrolled to be eligible for the measure
- Continuous Enrollment - A period of time, during the measurement timeline, where a member must be enrolled in order 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.

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