Commonwealth Care Alliance

2025 Quality Measure Reference Guide

cca commonwealth care alliance®

REFERENCE GUIDE PURPOSE

This reference guide outlines the process for documenting quality measures, including pertinent information on HEDIS and MassHealth.

1.1 DEFINITIONS & ACRONYMS

A	Administrative data
Administrative Data	Transaction or other administrative data used to identify the eligible population and numerator. This information includes claims, other transaction data, and supplemental data.
Clinical Staff	RN
Date of Service	The date a rendered service was provided
DOS	Date of service
Denominator	All members with qualifying events defined by a measure cohort to make them a part of the eligible population
H	Hybrid data
HEDIS	Health Effectiveness Data and Information Set
Hybrid Data	Medical record data used to identify eligible numerator events
Measure Cohort	All the details that create a measure, whether a specific set of diagnoses, an age range, or other parameters defined to calculate a measure population
Measurement Year	The year from which quality measure data is collected
MY	Measurement year
Non-clinical Staff	Non-licensure holding staff, including, but not limited to, health information management specialists, and health outreach workers
Numerator	All the members within a specified measure denominator who have had a qualifying event, such as diagnosis code, event code, or whatever is detailed in the measure that shows the member has had a qualifying event to be counted as having the service of interest
Numerator Compliant Member	A member with a qualifying event for a measure
Ongoing Care Providers	Clinicians who manage the member's ongoing care, such as NP, PA, MD, DO
Qualifying Event	Specified events, such as diagnosis code or event code, as detailed per measure, will count toward a member's compliance.
Supplemental Data	Data used to capture missing service data not received through administrative sources (claims or encounters) or by standard electronically generated files from the service providers
Transaction Data	Data created and updated within operational systems collects information related to intake, service, diagnostic testing, procedures, purchasing, billing, accounts receivable, and accounts payable. It can be from claims, electronic health record (EHR) data exports, etc.

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1.2 WHAT IS HEDIS, AND WHY IS IT IMPORTANT TO CCA AND OUR MEMBERS?

Healthcare Effectiveness Data and Information Set (HEDIS) is a set of standardized performance measures used to track how well healthcare organizations provide or facilitate the use of health services to their enrolled population. HEDIS data is vital to Commonwealth Care Alliance to identify improvement opportunities and monitor our success in improving the quality and effectiveness of care provided to members. By comparing our performance to that of other health plans, we can set realistic targets for improvement and track our progress internally. Consumers can also use quality rating information to make informed decisions about their healthcare coverage. Additionally, the Centers for Medicare & Medicaid Services (CMS) utilizes some HEDIS performance ratings to incentivize excellence in quality care. CMS incorporates critical measures into the star rating quality bonus program for Medicare and the One Care quality withhold measures. HEDIS results are based on statistically valid samples of members and are audited by certified auditors using a process determined by the National Committee for Quality Assurance (NCQA). HEDIS measures are categorized into domains that allow for evaluation of the quality of services, overuse, inappropriate care, performance between plans, and adjustments based on identified areas of improvement.

1.2.1 Domains of Care

HEDIS MY 2025 includes 87 measures across 6 domains of care.

1. Effectiveness of Care
2. Access/Availability of Care
3. Experience of Care
4. Utilization and Risk Adjusted Utilization
5. Health Plan Descriptive Information
6. Measures Reported Using ECDS
   (Electronic Clinical Data Systems)

1.3 BEST PRACTICE TIPS

- ✓ Routinely screen patients for preventive health services following the guidelines below for minimum requirements for routine screenings
- ✓ Submit claims and encounter data for rendered services promptly
- ✓ Utilize CPT II codes to provide detailed quality information
- ✓ Submit data files to CCA, including HEDIS-pertinent services
- ✓ Ensure accurate and detailed documentation in the legal health record
- ✓ Grant CCA HEDIS reviewers remote electronic health record (EHR) access to reduce the burden of medical record requests

HEDIS data is collected during the measurement year and reported to NCQA during the reporting year.

Measurement Year (MY)
HEDIS data reflects the delivery of services during the measurement year.

Reporting Year (RY)
Data collected from the measurement year is reported to NCQA in June of the following year.

1.4 METHODS OF DATA COLLECTION

Administrative Data Method: Transaction or other administrative data are used to identify the eligible population and numerators such as claims, enrollment, and pharmacy. The reported rate is based on all members who meet the eligible population criteria (after optional exclusions, if applicable) and are found through administrative data to have received the service required for the numerator.

Supplemental Data: These data are considered administrative data sources. Any data is considered a supplemental data hit if the member would not be in compliance for the measure/indicator without the data source. For administrative-only measures, medical record data are considered supplemental data.

Supplemental Data Uses: Organizations may find information about services for their members in administrative data, medical records, and other data sources. A hierarchy is applied when evidence to support the measure is found in multiple data sources, and supplemental data are considered last:

- **Standard Supplemental Data*:** These are electronically generated files that come from service providers. The production of these files follows clear policies and procedures, with standard file layouts remaining stable from year to year.
- **Audit Requirements:** All standard supplemental data must be substantiated by proof- of-service documentation from the legal health record. Proof-of-service documentation is required for only a sample, selected by the auditor, as part of the audit's annual primary source verification, for all first-year sources and internal verification for all subsequent years.

  **Prior years validated historic hybrid medical record result files are loaded as administrative data.*

- **Nonstandard Supplemental Data:** These data are used to capture missing service data not received through administrative sources (claims or encounters) or in the standard electronically generated files described above. Whether collected by a plan, an organization, a provider, or a contracted vendor, these types of data might be collected from sources on an irregular basis and could be in files or formats that are not stable over time.
- **Requirements:** Organizations must have clear policies and procedures that describe how the data are collected and by whom, how they are validated, and how they are used for HEDIS reporting. Organizations may not conduct phone calls to members or providers to collect information about services already rendered.

- **Audit Requirements:** All nonstandard supplemental data must be substantiated by proof-of-service documentation from the legal health record. Proof-of-service documentation is required for only a sample, selected by the auditor, as part of the audit's annual primary source verification.

Medical Record Data (Hybrid Method): Organizations look for numerator compliance in administrative and medical records. The denominator is a systematic sample of members drawn from the measure's eligible population. Organizations review administrative data to determine if members in the systematic sample received the service and review medical record data for members who do not meet the numerator criteria through administrative data. The reported rate is based on members in the sample who received the service required for the numerator. *(Note: Medical record review applies to hybrid measures, which include administrative, supplemental, and medical record data.)*

Electronic Clinical Data Systems (ECDS) data: ECDS is the network of data containing a plan member's personal health information and records of their experiences within the healthcare system. They may also support other care-related activities directly or indirectly, including evidence-based decision support, quality management, and outcome reporting. Data in these systems are structured so automated quality measurement queries can be consistently and reliably executed, providing results quickly and efficiently to the team responsible for the care of health plan members. This data is collected from various clinical systems to identify numerator events, including EHRs, health information exchanges (HIEs), care management software, and claims data.

Survey Data: Organizations collect data through a survey.

COMMONWEALTH CARE ALLIANCE REPORTING REQUIREMENTS

Acronym	Plan Name	Plan Type	Plan State
SCO	Senior Care Options	FIDE SNP HMO	Massachusetts
ICO	One Care	MMP HMO	Massachusetts

Quality Measures		Medicare SCO, ICO	SNP SCO	MMP ICO
Effectiveness of Care				
Prevention and Screening				
COA	Care for Older Adults		***H***	***H***
OED	Oral Evaluation, Dental Services	A	A	A
Respiratory Conditions				
CWP	Appropriate Testing for Pharyngitis	A		
SPR	Use of Spirometry Testing in the Assessment and Diagnosis of COPD	A	A	A
PCE	Pharmacotherapy Management of COPD Exacerbation	A	A	A
Cardiovascular Conditions				
CBP	Controlling High Blood Pressure	***H***	***H***	***H***
PBH	Persistence of Beta-Blocker Treatment After a Heart Attack	A	A	A
SPC	Statin Therapy for Patients with Cardiovascular Disease	A		
CRE	Cardiac Rehabilitation	A		
Diabetes				
GSD	Glycemic Status Assessment for Patients with Diabetes	***H***		
BPD	Blood Pressure Control for Patients with Diabetes	***H***		
EED	Eye Exam for Patients with Diabetes	A		
KED	Kidney Health Evaluation for Patients with Diabetes	A		
SPD	Statin Therapy for Patients with Diabetes	A		
Musculoskeletal Conditions				
OMW	Osteoporosis Management in Women Who Had a Fracture	A	A	A
OSW	Osteoporosis Screening in Older Women	A		
Behavioral Health				
DMH	Diagnosed Mental Health Disorders	A		
AMM	Antidepressant Medication Management	A	A	A
FUH	Follow-Up After Hospitalization for Mental Illness	A	A	A
FUM	Follow-Up After Emergency Department Visits for Mental Illness	A		
DSU	Diagnosed Substance Use Disorder	A		
FUI	Follow-Up After High-Intensity Care for Substance Use Disorder	A		
FUA	Follow-Up After Emergency Department Visits for Substance Use	A		
POD	Pharmacotherapy for Opioid Use Disorder	A		
SAA	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	A		
Care Coordination				
ACP	Advance Care Planning	A	A	A
TRC	Transitions of Care	***H***	***H***	***H***
FMC	Follow-Up After Emergency Department Visit for People with High-Risk Multiple Chronic Conditions	A		
Overuse/Appropriateness				
PSA	Non-recommended PSA-Based Screening in Older Men	A		
URI	Appropriate Treatment for Upper Respiratory Infection	A		
AAB	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis	A		
LBP	Use of Imaging Studies for Low Back Pain	A		
DDE	Potentially Harmful Drug-Disease Interactions in Older Adults	A	A	A
DAE	Use of High-Risk Medications in Older Adults	A	A	A
HDO	Use of Opioids at High Dosage	A		

UOP	Use of Opioids from Multiple Providers	A		
COU	Risk of Continued Opioid Use	A		
Access/Availability of Care				
AAP	Adults' Access to Preventive/Ambulatory Health Services	A		
IET	Initiation and Engagement of Substance Use Disorder	A		
PPC	Prenatal and Postpartum Care			***H***
	Timeliness of Prenatal Care			***H***
	Postpartum Care			***H***
Utilization and Risk Adjusted Utilization				
Utilization				
FSP	Frequency of Selected Procedures	A		
AXR	Antibiotic Utilization for Respiratory Conditions	A		
Risk Adjusted Utilization				
PCR	Plan All-Cause Readmission	A	A	A
HFS	Hospitalization Following Discharge from a Skilled Nursing Facility	A		
AHU	Acute Hospital Utilization	A		
EDU	Emergency Department Utilization	A		
HPC	Hospitalization for Potentially Preventable Complications	A		
EDH	Emergency Department Visits for Hypoglycemia in Older Adults with Diabetes	A		
Health Plan Descriptive Information				
ENP	Enrollment by Product Line	A		
LDM	Language Diversity of Membership	A		
RDM	Race/Ethnicity Diversity of Membership	A		
Measures Reported Using Electronic Clinical Data Systems				
BCS-E	Breast Cancer Screening	A		
DBM-E	Documented Assessment After Mammogram	A	A	A
FMA-E	Follow-Up After Abnormal Breast Cancer Assessment	A	A	A
BPC-E	Blood Pressure Control for Patients with Hypertension	A	A	A
CCS-E	Cervical Cancer Screening			A
COL-E	Colorectal Cancer Screening	A	A	A
DSF-E	Depression Screening and Follow-Up for Adolescents and Adults	A		
DMS-E	Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults	A		
DRR-E	Depression Remission or Response for Adolescents and Adults	A		
ASF-E	Unhealthy Alcohol Use Screening and Follow-Up	A		
AIS-E	Adult Immunization Status	A		
PRS-E	Prenatal Immunization Status			A
PND-E	Prenatal Depression Screening and Follow-Up			A
PDS-E	Postpartum Depression Screening and Follow-Up			A
Measures Reported to MassHealth				
MA 4.2	Unhealthy Alcohol Use Screening and Follow-Up			***H***
MA 4.3	Tobacco Use Screening and Cessation			***H***
MA 4.5	Care for Adults			***H***
MA 4.6	Depression Screening and Follow-Up			***H***

1.5 HEDIS ADVANCED ILLNESS AND FRAILTY EXCLUSIONS

Some HEDIS measures include provisions for excluding patients who meet specific advanced illness and frailty criteria. This exclusion is designed to ensure that our quality measurements reflect the most appropriate standards of care for the general adult and older adult populations. We align our measurements more closely with the clinical guidelines' intent by excluding patients with limited life expectancy or severe illness.

Guidelines summarize the current medical knowledge, weigh the benefits and harms of diagnostic procedures and treatments, give specific recommendations based on this information, and provide scientific* evidence supporting the recommendations. Clinical practice guidelines must be updated regularly. Documented exceptions allow providers to indicate why they don't think the clinical guideline suits certain patients, and deviations from guidelines must be justified and documented.

** https://www.ncbi.nlm.nih.gov/books/NBK390308*

1.5.1 Exclusions and Their Related Measures

Exclusion	Measure
Members 66 years of age and older as of December 31 of the MY with frailty **and** advanced illness	Breast Cancer Screening – ECDS (BCS-E) Colorectal Cancer Screening – ECDS (COL-E) Glycemic Status Assessment for Patients with Diabetes (GSD) Blood Pressure Control for Patients with Diabetes (BPD) Eye Exam for Patients with Diabetes (EED) Kidney Health Evaluation for Patients with Diabetes (KED) Statin Therapy for Patients with Cardiovascular Disease (SPC) Statin Therapy for Patients with Diabetes (SPD) Osteoporosis Screening in Older Women (OSW) Use of Imaging Studies for Low Back Pain (LBP)
Members 66–80 years of age as of December 31 of the MY with frailty **and** advanced illness	Controlling Blood Pressure (CBP) Persistence of Beta-Blocker Treatment After a Heart Attack (PBH) Cardiac Rehabilitation (CRE) Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)
Members 67–80 years of age as of December 31 of the MY with frailty **and** advanced illness	Osteoporosis Management in Women Who Had a Fracture (OMW)
Members 81 years of age and older as of December 31 of the MY with frailty	Osteoporosis Management in Women Who Had a Fracture (OMW) Controlling Blood Pressure (CBP)

1.6 DEMENTIA MEDICATIONS LIST

A dispensed dementia medication during the MY or the year before the MY is considered evidence of advanced illness. This supportive evidence is found in Pharmacy claims.

Description	Prescription		
Cholinesterase inhibitors	Donepezil	Galantamine	Rivastigmine
Miscellaneous central nervous system agents	Memantine		
Dementia combinations	Donepezil-memantine		

1.7 ADVANCED ILLNESS DIAGNOSIS CODES AND DEFINITIONS

At least two indications of advanced illness diagnosis on two different dates of service during the MY or the year prior is considered evidence. This supportive evidence is submitted through claims.

Definition	Advanced Illness Diagnosis Codes
Acute lymphoblastic leukemia	C91.00, C91.02
Acute monoblastic/monocytic leukemia	C93.00, C93.02
Acute myeloblastic leukemia	C92.00, C92.02
Alcohol use or dependence	F10.27, F10.96, F10.97
Alcoholic hepatic disease	K70.10, K70.11, K70.2, K70.30, K70.31, K70.40, K70.41, K70.9
Alzheimer's disease	G30.0, G30.1, G30.8, G30.9
Amnestic disorder due to physiological condition	F04
Amyotrophic lateral sclerosis	G12.21
Chronic kidney disease	I12.0, I13.0, I13.11, I13.2, N18.5
Chronic respiratory conditions due to chemicals, gases, fumes, and vapors	J68.4
Creutzfeldt-Jakob disease	A81.00, A81.01, A81.09
Dementia	F01.50, F01.511, F01.518, F01.52, F01.53, F01.54, F01.A0, F01.A11, F01.A18, F01.A2, F01.A3, F01.A4, F01.B0, F01.B11, F01.B18, F01.B2, F01.B3, F01.B4, F01.C0, F01.C11, F01.C18, F01.C2, F01.C3, F01.C4, F02.80, F02.811, F02.818, F02.82, F02.83, F02.84, F02.A0, F02.A11, F02.A18, F02.A2, F02.A3, F02.A4, F02.B0, F02.B11, F02.B18, F02.B2, F02.B3, F02.B4, F02.C0, F02.C11, F02.C18, F02.C2, F02.C3, F02.C4, F03.90, F03.911, F03.918, F03.92, F03.93, F03.94, F03.A0, F03.A11, F03.A18, F03.A2, F03.A3, F03.A4, F03.B0, F03.B11, F03.B18, F03.B2, F03.B3, F03.B4, F03.C0, F03.C11, F03.C18, F03.C2, F03.C3, F03.C4
Emphysema	J43.0, J43.1, J43.2, J43.8, J43.9, J98.2, J98.3
End-stage renal disease	N18.6
Heart failure	I09.81, I11.0, I50.20, I50.21, I50.22, I50.23, I50.30, I50.31, I50.32, I50.33, I50.40, I50.41, I50.42, I50.43, I50.810, I50.811, I50.812, I50.813, I50.814, I50.82, I50.83, I50.84, I50.89, I50.9
Hepatic disease and cirrhosis	K74.00, K74.01, K74.02, K74.1, K74.2, K74.4, K74.5, K74.60, K74.69
Huntington's disease	G10
Left ventricular failure, unspecified	I50.1
Malignant neoplasm of brain	C71.0, C71.1, C71.2, C71.3, C71.4, C71.5, C71.6, C71.7, C71.8, C71.9
Malignant neoplasm of pancreas	C25.0, C25.1, C25.2, C25.3, C25.4, C25.7, C25.8, C25.9
Mast cell leukemia	C94.30, C94.32
Monocytic leukemia	C93.90, C93.92, C93.Z0, C93.Z2
Multiple sclerosis	G35
Neurocognitive disorder with Lewy bodies	G31.83
Other frontotemporal neurocognitive disorder	G31.09

Parkinson's disease	G20
Pick's disease	G31.01
Pulmonary fibrosis	J84.10, J84.112, J84.170, J84.178
Respiratory failure	J96.10, J96.11, J96.12, J96.20, J96.21, J96.22, J96.90, J96.91, J96.92
Secondary and unspecified malignant neoplasm of lymph nodes	C77.0, C77.1, C77.2, C77.3, C77.4, C77.5, C77.8, C77.9
Secondary malignant neoplasm of adrenal gland	C79.70, C79.71, C79.72
Secondary malignant neoplasm of bladder and urinary organs	C79.10, C79.11, C79.19
Secondary malignant neoplasm of bone	C79.51
Secondary malignant neoplasm of bone marrow	C79.52
Secondary malignant neoplasm of brain	C79.31
Secondary malignant neoplasm of breast	C79.81
Secondary malignant neoplasm of cerebral meninges	C79.32
Secondary malignant neoplasm of genital organs	C79.82
Secondary malignant neoplasm of kidney and renal pelvis	C79.00, C79.01, C79.02
Secondary malignant neoplasm of large intestine and rectum	C78.5
Secondary malignant neoplasm of liver and intrahepatic bile duct	C78.7
Secondary malignant neoplasm of lung	C78.00, C78.01, C78.02
Secondary malignant neoplasm of mediastinum	C78.1
Secondary malignant neoplasm of other specified sites	C79.89
Secondary malignant neoplasm of ovary	C79.60, C79.61, C79.62, C79.63
Secondary malignant neoplasm of pleura	C78.2
Secondary malignant neoplasm of retroperitoneum and peritoneum	C78.6
Secondary malignant neoplasm of skin	C79.2
Secondary malignant neoplasm of small intestine	C78.4
Secondary malignant neoplasm of unspecified and other digestive organ	C78.80, C78.89
Secondary malignant neoplasm of unspecified and other nervous system	C79.40, C79.49
Secondary malignant neoplasm of unspecified and other respiratory organ	C78.30, C78.39
Secondary malignant neoplasm of unspecified site	C79.9

1.8 FRAILTY DIAGNOSIS CODES

At least **two** frailty indications on two different service dates during the MY are considered evidence. All supportive evidence is submitted through claims.

Definition	Frailty Diagnosis Codes
Abnormal weight loss	R63.4
Abnormalities of gait and mobility	R26.89, R26.9
Adult failure to thrive	R62.7
Age-related physical debility	R54
Bed confinement status	Z74.01
Cachexia	R64
Dependence on other enabling machines and devices	Z99.89
Dependence on respirator (ventilator) status	Z99.11
Dependence on supplemental oxygen	Z99.81
Dependence on wheelchair	Z99.3
Difficulty in walking, not elsewhere classified	R26.2

Falls	R29.6, W01.0XXA, W01.0XXD, W01.0XXS, W01.10XA, W01.10XD, W01.10XS, W01.110A, W01.110D, W01.110S, W01.111A, W01.111D, W01.111S, W01.118A, W01.118D, W01.118S, W01.119A, W01.119D, W01.119S, W01.190A, W01.190D, W01.190S, W01.198A, W01.198D, W01.198S, W06.XXXA, W06.XXXD, W06.XXXS, W07.XXXA, W07.XXXD, W07.XXXS, W08.XXXA, W08.XXXD, W08.XXXS, W10.0XXA, W10.0XXD, W10.0XXS, W10.1XXA, W10.1XXD, W10.1XXS, W10.2XXA, W10.2XXD, W10.2XXS, W10.8XXA, W10.8XXD, W10.8XXS, W10.9XXA, W10.9XXD, W10.9XXS, W18.00XA, W18.00XD, W18.00XS, W18.02XA, W18.02XD, W18.02XS, W18.09XA, W18.09XD, W18.09XS, W18.11XA, W18.11XD, W18.11XS, W18.12XA, W18.12XD, W18.12XS, W18.2XXA, W18.2XXD, W18.2XXS, W18.30XA, W18.30XD, W18.30XS, W18.31XA, W18.31XD, W18.31XS, W18.39XA, W18.39XD, W18.39XS, W19.XXXA, W19.XXXD, W19.XXXS
History of falling	Z91.81
Limitation of activities due to disability	Z73.6
Muscle wasting and atrophy, not elsewhere classified, unspecified site	M62.50
Muscle weakness (generalized)	M62.81
Need for assistance at home and no other household member able to render care	Z74.2
Need for assistance with personal care	Z74.1
Need for continuous supervision	Z74.3
Other malaise	R53.81
Other problems related to care provider dependency	Z74.8
Other reduced mobility	Z74.09
Pressure ulcer	L89.000, L89.001, L89.002, L89.003, L89.004, L89.006, L89.009, L89.010, L89.011, L89.012, L89.013, L89.014, L89.016, L89.019, L89.020, L89.021, L89.022, L89.023, L89.024, L89.026, L89.029, L89.100, L89.101, L89.102, L89.103, L89.104, L89.106, L89.109, L89.110, L89.111, L89.112, L89.113, L89.114, L89.116, L89.119, L89.120, L89.121, L89.122, L89.123, L89.124, L89.126, L89.129, L89.130, L89.131, L89.132, L89.133, L89.134, L89.136, L89.139, L89.140, L89.141, L89.142, L89.143, L89.144, L89.146, L89.149, L89.150, L89.151, L89.152, L89.153, L89.154, L89.156, L89.159, L89.200, L89.201, L89.202, L89.203, L89.204, L89.206, L89.209, L89.210, L89.211, L89.212, L89.213, L89.214, L89.216, L89.219, L89.220, L89.221, L89.222, L89.223, L89.224, L89.226, L89.229, L89.300, L89.301, L89.302, L89.303, L89.304, L89.306, L89.309, L89.310, L89.311, L89.312, L89.313, L89.314, L89.316, L89.319, L89.320, L89.321, L89.322, L89.323, L89.324, L89.326, L89.329, L89.40, L89.41, L89.42, L89.43, L89.44, L89.45, L89.46, L89.500, L89.501, L89.502, L89.503, L89.504, L89.506, L89.509, L89.510, L89.511, L89.512, L89.513, L89.514, L89.516, L89.519, L89.520, L89.521, L89.522, L89.523, L89.524, L89.526, L89.529, L89.600, L89.601, L89.602, L89.603, L89.604, L89.606, L89.609, L89.610, L89.611, L89.612, L89.613, L89.614, L89.616, L89.619, L89.620, L89.621, L89.622, L89.623, L89.624, L89.626, L89.629, L89.810, L89.811, L89.812, L89.813, L89.814, L89.816, L89.819, L89.890, L89.891, L89.892, L89.893, L89.894, L89.896, L89.899, L89.90, L89.91, L89.92, L89.93, L89.94, L89.95, L89.96

Problem related to care provider dependency, unspecified	Z74.9
Problems related to living in residential institution	Z59.3
Sarcopenia	M62.84
Underweight	R63.6
Unspecified place in other specified residential institution as the place of occurrence of the external cause	Y92.199
Weakness	R53.1

1.8.1 Frailty Encounter CPT Codes

Definition	CPT
Home visit for mechanical ventilation care	99504
Home visit for assistance with activities of daily living and personal care	99509

1.8.2 Frailty Encounter HCPCS Codes

Definition	HCPCS
Monthly comprehensive management and care coordination for advanced illness	S0311
Daily contracted home health agency services, all services provided	T1022
Direct skilled nursing services	G0300, G0299
Home health aide or certified nurse assistant, per visit	T1021
Licensed practical nurse (LPN) or licensed vocational nurse (LVN) services, up to 15 minutes	T1003
Nursing assessment/evaluation	T1001
Nursing care, in the home	T1031, T1030, S9124, S9123
Personal care services	T1019, T1020
Physician management of patient home care, hospice monthly case rate	S0271
Private duty/independent nursing service(s)-licensed, up to 15 minutes	T1000
Respite care services, up to 15 minutes	T1005
RN services, up to 15 minutes	T1002
Services of a qualified nursing aide, up to 15 minutes	T1004
Skilled services by an RN for management and evaluation of the plan of care, each 15 minutes (the patient's underlying condition or complication requires an RN to ensure that essential non-skilled care achieves its purpose in the home health or hospice setting)	G0162
Skilled services of an LPN for the observation and assessment of the patient's condition, each 15 minutes (the change in the patient's condition requires skilled nursing personnel to identify and evaluate the patient's need for possible modification of treatment in the home health or hospice setting)	G0494
Skilled services of an RN for the observation and assessment of the patient's condition, each 15 minutes (the change in the patient's condition requires skilled nursing personnel to identify and evaluate the patient's need for possible modification of treatment in the home health or hospice setting)	G0493

1.8.3 Frailty Device HCPCS Codes

Definition	HCPCS
Cane	E0100, E0105
Commode chair	E0170, E0171, E0168, E0165, E0163
Home ventilator	E0465, E0466
Hospital bed	E0304, E0302, E0250, E0251, E0290, E0291, E0303, E0301, E0270, E0260, E0261, E0294, E0295, E0265, E0266, E0296, E0297, E0255, E0256, E0292, E0293
Portable and stationary oxygen system	E0443, E0444, E0441, E0442, E0430, E0431, E0435, E0433, E0434, E0425, E0424, E0440, E0439
Respiratory assistance device	E0472, E0471, E0470
Rocking bed with or without side rails	E0462
Walker	E0144, E0135, E0143, E0147, E0149, E0148, E0130, E0141, E0140
Wheelchair	E1190, E1180, E1172, E1170, E1200, E1171, E1280, E1290, E1295, E1195, E1285, E1260, E1240, E1270, E1250, E1161, E1298, E1297, E1296, E1130, E1150, E1140, E1160, E1220
Pail or pan for use with commode chair, replacement only	E0167

EFFECTIVENESS OF CARE

This domain measures how well a health plan provides members with preventive and chronic care services. It includes metrics for vaccinations, cancer screenings, diabetes management, and cardiovascular care. It is divided into 8 subdomains: Prevention and Screening, Respiratory Conditions, Cardiovascular Conditions, Diabetes, Musculoskeletal Conditions, Behavioral Health, Care Coordination, and Overuse/Appropriateness.

1.9 PREVENTION AND SCREENING

To ensure that health plan members receive timely and appropriate preventive services, including immunizations and cancer screenings, to detect and prevent illnesses early, promoting long-term health and well-being.

1.9.1 Care for Older Adults

HEDIS	Stars	Withhold	Mass Health
✓	✓		✓

1.9.1.1 Medication Review

What is the measure description?

Members who had a medication review with a prescribing practitioner during the MY

What is the intent of this measure?

Older adults may have more complex medication regimens; therefore, a prescribing practitioner should do a comprehensive review of all medications **at least** annually.

Who should be screened?

Members 66+ years of age

When should it be completed?

January 1, 2025, through December 31, 2025

What are the HEDIS documentation requirements, and by whom?

Credentials	Acceptable Documentation
Prescribing practitioner (MD, DO, NP, PA) Clinical pharmacist (PharmD)	Annual review of all medications and an updated medication list

Best Practice Tips:

- ✓ Schedule annual comprehensive visits.
- ✓ Medications can be reviewed without the member present, virtually or over the phone.
- ✓ Ensure that all clinical notes are completed and signed in a timely fashion.
- ✓ Ensure an updated medication list is included in the visit note.

Which codes should I use to document this service?

Definition		Codes	System
Medication list (must be in conjunction with the medication review code)		1159F	CPT-CAT-II
Medication review (must be in conjunction with the medication list code)		1160F	CPT-CAT-II
Medication review		90863, 99483, 99605, 99606	CPT
Transitional care management services	7 days	99495	CPT
	30 days	99495	CPT

What are the exclusions for this measure?

Hospice services during the MY; death during the MY or before—document hospice and death in the legal health record.

For HEDIS and advanced illness and frailty exclusions, please see page 10.

1.9.2 Functional Status Assessment

What is the measure description?

Members who had a functional status assessment during the MY.

HEDIS	Stars	Withhold	Mass Health
✓			✓

What is the intent of this measure?

As the population ages, physical and cognitive function can decline. Screening of elderly patients is effective in identifying functional decline.

Who should be screened?

Members 66+ years of age

When should it be completed?

January 1, 2025, through December 31, 2025

Acceptable Documentation
✓ Notation that Activities of Daily Living or Instrumental Activities of Daily Living were assessed ✓ Assessment of **at least 5**: bathing, dressing, eating, transferring, using the toilet, walking ✓ Assessment of **at least 4**: shopping for groceries, driving or using public transportation, telephone, cooking or meal preparation, housework, home repair, laundry, taking medications, handling finances
Examples of a functional status assessment tool include but are not limited to: ✓ SF-36 ✓ ALSAR (Assessment of Living Skills and Resources) ✓ Barthel ADL Index Physical Self-Maintenance (ADLS) Scale ✓ Bayer ADL Scale ✓ Katz Index of Independence in ADL ✓ PROMIS (Patient-Reported Outcome Measurement Information System) ✓ Independent Living Scale (ILS)

Best Practice Tips:

- ✓ Schedule annual comprehensive visits for patients.
- ✓ Screening can be completed during separate visits throughout the year.
- ✓ A functional status assessment can be performed during an office, telephone, or virtual visit
- ✓ Sensory assessments such as hearing, speech, and vision or cranial nerve assessments are not valid functional status assessments

Which codes should I use to document this service?

Definition	Codes	Code System
Functional status assessed	1170F	CPT-CAT-II
Functional status assessed	99483	CPT

What are the exclusions for this measure?

Hospice services during the MY; death during the MY or before—document hospice and death in the legal health record.

For HEDIS and advanced illness and frailty exclusions, please see page 10.

1.10 CARDIOVASCULAR CONDITIONS

To ensure the effective management and treatment of cardiovascular conditions, including hypertension and post–heart attack care, by providing evidence-based interventions, regular monitoring, and patient education to reduce the risk of complications and improve overall cardiovascular health.

1.10.1 Controlling High Blood Pressure

HEDIS	Stars	Withhold	Mass Health
✓	✓	✓	

What is the measure description?

Hypertensive members whose latest blood pressure was controlled (<140/<90)

What is the intent of this measure?

Proper hypertension management is essential to reduce the risk of complications and prolong life.

Who should be screened?

Members with a diagnosis of hypertension, 18–85 years of age

When should it be completed?

January 1, 2025, through December 31, 2025

Acceptable Documentation
✓ In-office blood pressure reading <140/<90
✓ Member-reported blood pressure reading or average BP value

Best Practice Tips:

- ✓ Readings must have a distinct systolic and diastolic values; ranges do not count
- ✓ If patient's blood pressure is ≥140 and/or ≥90:
  - Repeat their reading at the end of the visit
  - Schedule a follow-up for a blood pressure check
  - Encourage at-home monitoring with a BP log; ask them to share their readings at each visit
- ✓ Ensure the cuff is calibrated, is the correct size, and is on the bare arm
- ✓ Arm should be supported with the elbow at chest height, not dangling, with legs uncrossed

Which codes should I use to document this service?

Definition	Codes	Code System
Systolic blood pressure < 130	3074F	CPT-CAT-II
Systolic blood pressure 130–139	3075F	CPT-CAT-II
Systolic blood pressure ≥ 140	3077F	CPT-CAT-II
Diastolic blood pressure < 80	3078F	CPT-CAT-II
Diastolic blood pressure 80–89	3079F	CPT-CAT-II
Diastolic blood pressure ≥ 90	3080F	CPT-CAT-II

What are the exclusions for this measure?

Definition	Codes
Chronic kidney disease, stage 5	N18.5
End-stage renal disease	N18.6
Dependence on renal dialysis	Z99.2

For pregnancy exclusions, refer to Exhibit 1, Pregnancy Code Set HEDIS MY25.

Refer to Exhibit 2, History of Nephrectomy or Kidney Transplant Code Set HEDIS MY25.

Hospice or palliative care services during the MY; death during the MY or before—document hospice or palliative services and death in the legal health record.

For HEDIS and advanced illness and frailty exclusions, please see page 10.

1.10.2 Statin Therapy for Patients with Cardiovascular Disease

What is the measure description?

Members who were dispensed at least one high-intensity or moderate-intensity statin medication

HEDIS	Stars	Withhold	Mass Health
✓	✓		

What is the intent of this measure?

Cardiovascular disease is the leading cause of death in the United States. American College of Cardiology and American Heart Association (ACC/AHA) guidelines state that moderate or high-intensity statins are recommended for adults with established clinical ASCVD.

Who should be screened?

Female individuals 40–75 years of age and male individuals 21–75 years of age with ASCVD

When should it be completed?

January 1, 2025, through December 31, 2025

Which medications can I prescribe to prevent cardiovascular disease?

High-Intensity Statin Therapy	Moderate-Intensity Statin Therapy
Atorvastatin 40–80 mg	Atorvastatin 10-20 mg
Amlodipine-atorvastatin 40–80 mg	Amlodipine-atorvastatin 10–20 mg
Amlodipine 2.5 mg / Atorvastatin 40 mg	Amlodipine 2.5 mg / Atorvastatin 10 mg
Amlodipine 5 mg / Atorvastatin 40 mg	Amlodipine 2.5 mg / Atorvastatin 20 mg
Amlodipine 5 mg / Atorvastatin 80 mg	Amlodipine 5 mg / Atorvastatin 10 mg
Amlodipine 10 mg / Atorvastatin 40 mg	Amlodipine 5 mg / Atorvastatin 20 mg
Amlodipine 10 mg / Atorvastatin 80 mg	Amlodipine 10 mg / Atorvastatin 10 mg
Rosuvastatin 20–40 mg	Amlodipine 10 mg / Atorvastatin 20 mg
Rosuvastatin Calcium 20–40 mg	Rosuvastatin 5–10 mg
Simvastatin 80 mg	Rosuvastatin Calcium 5–10 mg
Ezetimibe-simvastatin 80 mg	Simvastatin 20–40 mg
Ezetimibe 10 mg / Simvastatin 80 mg	Ezetimibe-simvastatin 20–40 mg
	Ezetimibe 10 mg / Simvastatin 20 mg
	Ezetimibe 10 mg / Simvastatin 40 mg
	Pravastatin 40–80 mg
	Pravastatin Sodium 40 mg
	Pravastatin Sodium 80 mg
	30-day combination packet: Aspirin 325 mg / Pravastatin sodium 80
	30-day combination packet: Aspirin 81 mg / Pravastatin sodium 40 mg
	Lovastatin 40–60 mg
	Lovastatin 40–60 mg (24 HR extended release)
	Fluvastatin 40–80 mg
	Fluvastatin 80 mg (24 HR extended release)
	Pitavastatin 1–4 mg
	Pitavastatin Calcium 1–4 mg
	Pitavastatin Magnesium 1–4 mg
	Pitavastatin Sodium 1–4 mg

Best Practice Tips:

- ✓ Routine visits every 3–6 months to review LDL and cholesterol panels, blood pressure, and medications
- ✓ Chart prep before appointments to review for labs and medication refills
- ✓ Encourage members to call the office if they experience any side effects to discuss alternative medications or other cholesterol-lowering therapies
- ✓ Review grapefruit/grapefruit juice interactions with Atorvastatin, Lovastatin, and Simvastatin
- ✓ Advise member to take statins at bedtime, if possible, to improve absorption and effectiveness
- ✓ Reinforce the importance of low-sodium and low-carbohydrate diet, increased physical activity, smoking cessation, and medication adherence at every visit

What are the exclusions for this measure?

Definition	Code	System
Chronic kidney disease, stage 5	N18.5	ICD10
End-stage renal disease	N18.6	ICD10
Dependence on renal dialysis	Z99.2	ICD10
Alcoholic cirrhosis of liver without ascites	K70.30	ICD10
Alcoholic cirrhosis of liver with ascites	K70.31	ICD10
Toxic liver disease with fibrosis and cirrhosis of liver	K71.7	ICD10
Primary biliary cirrhosis	K74.3	ICD10
Secondary biliary cirrhosis	K74.4	ICD10
Biliary cirrhosis, unspecified	K74.5	ICD10
Unspecified cirrhosis of liver	K74.60	ICD10
Other cirrhosis of liver	K74.69	ICD10
Congenital cirrhosis (of liver)	P78.81	ICD10
Myocardial infarction	I21.01-02, I21.09, I 21.11, I21.19, I21.21, I21.29, I21.3-4, I21.9, I21.A1, I21.A9, I21.B, I22.0-2.2, I22.8-3.8, I25.2	ICD10
Myalgia	M79.10-12, M79.18	ICD10
Drug-induced myopathy	G72.0	ICD10
Myopathy due to other toxic agents	G72.2	ICD10
Myopathy, unspecified	G72.9	ICD10
Myositis	M60.80, M60.811-12, M60.819, M60.821-22, M60.829, M60.831-32, M60.839, M60.841-42, M60.849, M60.851-52, M60.859, M60.861-62, M60.869, M60.871-72, M60.879, M60.88-89, M60.9	ICD10
Rhabdomyolysis	M62.82	ICD10
CABG	33510-14, 33516-19, 33521-23, 33530, 33533-36	CPT
Dialysis procedure	90935, 90937, 90945, 90947, 90997, 90999, 99512	CPT
PCI	92920, 92924, 92928, 92933, 92937, 92941, 92943	CPT
Revascularization (other)	37220-21, 37224-31	CPT
Pregnancy	Refer to Exhibit 1, Pregnancy Code Set HEDIS MY25	
IVD	Refer to Exhibit 7, IVD Code Set HEDIS MY25	

Hospice or palliative care services during the MY; death during the MY or before—document hospice or palliative services and death in the legal health record.

For HEDIS and advanced illness and frailty exclusions, please see page 10.

1.11 DIABETES

To provide comprehensive and effective management of diabetes, including regular HbA1c testing, eye exams, and blood pressure control, ensuring that members receive the necessary care and support to manage their condition, prevent complications, and maintain a high quality of life.

1.11.1 Glycemic Status Assessment for Patients with Diabetes

HEDIS	Stars	Withhold	Mass Health
✓	✓	✓	

What is the measure description?

Diabetic members whose most recent glycemic Status is ≤9.0% Hemoglobin A1c (HbA1c) or glucose management indicator (GMI) test

What is the intent of this measure?

Proper diabetes management is essential to control blood glucose.

Who should be screened?

Diabetic members, 18–75 years of age

When should it be completed?

January 1, 2025, through December 31, 2025

What are the HEDIS documentation requirements, and by whom?

Credentials	Acceptable Documentation
Primary care or ongoing provider	Latest HbA1c or GMI result with the date of service and test name
Clinical or non-clinical staff	HbA1c or HMI lab report uploaded in the legal health record

Best Practice Tips:

- ✓ Consider scheduling all routine appointments for diabetic patients at the beginning of the year
- ✓ Recommend office visits every three months for diabetes management
- ✓ Chart prep before appointments to ensure that labs and screenings were completed
- ✓ Consider implementing standing lab orders
- ✓ For point-of-care testing, ensure results are documented and all codes are submitted (see below)
- ✓ Discuss goals with members and openly discuss any barriers
- ✓ Assess behavioral or social health needs that may be creating barriers to diabetes management

Which codes should I use to document this service?

Definition	Codes	Code System
HbA1c level < 7.0%	3044F	CPT-CAT-II
HbA1c level ≥ 7.0% and < 8.0%	3051F	CPT-CAT-II
HbA1c level ≥ 8.0% and ≤ to 9.0%	3052F	CPT-CAT-II
HbA1c level > 9.0%	3046F	CPT-CAT-II

What are the exclusions for this measure?

Hospice or palliative care services during the MY; death during the MY or before—document hospice or palliative services and death in the legal health record.

For HEDIS and advanced illness and frailty exclusions, please see page 10.

1.11.2 Blood Pressure Control for Patients with Diabetes

What is the measure description?
Diabetic members whose most recent blood pressure was controlled (<140/<90)

HEDIS	Stars	Withhold	Mass Health
✓			

What is the intent of this measure?
Proper diabetes management is essential to reduce the risk of complications and prolong life.

Who should be screened?
Diabetic members, 18–75 years of age

When should it be completed?
January 1, 2025, through December 31, 2025

Acceptable Documentation
✓ In-office blood pressure reading <140/<90
✓ Member-reported blood pressure reading or average BP value

Best Practice Tips:
- ✓ Readings must have a distinct systolic and diastolic values; ranges do not count
- ✓ If patient's blood pressure is ≥140 and/or ≥90:
  - Repeat their reading at the end of the visit
  - Schedule a follow-up for a blood pressure check
  - Encourage at-home monitoring with a BP log; ask them to share their readings at each visit
- ✓ Ensure the cuff is calibrated, is the correct size, and is on the bare arm
- ✓ Arm should be supported with the elbow at chest height, not dangling, with legs uncrossed

Which codes should I use to document this service?

Definition	Codes	Code System
Systolic blood pressure < 130	3074F	CPT-CAT-II
Systolic blood pressure 130–139	3075F	CPT-CAT-II
Systolic blood pressure ≥ 140	3077F	CPT-CAT-II
Diastolic blood pressure < 80	3078F	CPT-CAT-II
Diastolic blood pressure 80–89	3079F	CPT-CAT-II
Diastolic blood pressure ≥ 90	3080F	CPT-CAT-II

What are the exclusions for this measure?
Hospice or palliative care services during the MY; death during the MY or before—document hospice or palliative services and death in the legal health record.

For HEDIS and advanced illness and frailty exclusions, please see page 10.

1.11.3 Eye Exam for Patients with Diabetes

What is the measure description?
Diabetic members who had a retinal eye exam

HEDIS	Stars	Withhold	Mass Health
✓	✓		

What is the intent of this measure?
Proper diabetes management is essential to reduce the risk of complications and prolong life.

Who should be screened?
Diabetic members, 18–75 years of age

When should it be completed?

Every 2 Years	Annually
No history of diabetic retinopathy	History of diabetic retinopathy

What are the HEDIS documentation requirements, and by whom?

Credentials	Acceptable Documentation
Primary care or ongoing care provider	History of a retinal eye exam with an eye care specialist and date of service
Non-clinical or clinical staff	Diabetic or retinal eye exam in the legal health record

Best Practice Tips:
- ✓ During chart prep, review the most recent retinal eye exam
- ✓ Ask members to have their eye specialist send eye exam results and include request on the referral
- ✓ CCA has a standard Eye Exam Report form you can use (Exhibit 3)
- ✓ Blindness is not an exclusion for a diabetic retinal eye exam
- ✓ If members had a unilateral enucleation, continue annual retinal screening of remaining eye
- ✓ Utilize codes to reduce the burden of medical record review

Which codes should I use to document this service?

Definition	Retinopathy	No Retinopathy
Dilated retinal eye exam	2022F	2023F
Seven standard field stereoscopic photos	2024F	2025F
Eye imaging matches diagnosis from standard field stereoscopic photos	2026F	2033F

Negative Diabetic Retinal Screening in prior year

Definition	No Retinopathy
Diabetic Retinal screening negative in prior year Can be billed by any provider type	3072F

Optometrists or ophthalmologists can bill for the following codes:

Definition	Codes	Code System
*Diabetic retinal screening	92002, 92004, 92012, 92014, 92018, 92019, 92134, 92137, 92201, 92202, 92227, 92228, 92229, 92230, 92235, 92250, 99203-05, 99213-15, 99242-45	CPT

***Submit diabetic ICD-10 codes without complications to capture diabetic retinal eye exam through claims for the year prior to the measurement year; acceptable codes include E10.9, E11.9, and E13.9.**

Any combination of codes that indicates findings from a diabetic retinal exam where one eye is enucleated, and the other was examined:

Eye	Retinal Exam Finding	Diabetic Severity Level	
Left	Retinopathy LOINC 71490-7	No apparent retinopathy Mild non-proliferate retinopathy Moderate non-proliferate retinopathy Severe non-proliferate retinopathy Proliferative retinopathy	LA18643-9 LA18644-7 LA18645-4 LA18646-2 LA18648-8
	No Retinopathy LOINC 71490-7	No retinopathy	LA18643-9
	Enucleation ICD-10-PCS 08T1XZZ		
Right	Retinopathy LOINC 71491-5	No apparent retinopathy Mild non-proliferate retinopathy Moderate non-proliferate retinopathy Severe non-proliferate retinopathy Proliferative retinopathy	LA18643-9 LA18644-7 LA18645-4 LA18646-2 LA18648-8
	No Retinopathy LOINC 71491-5	No retinopathy	LA18643-9
	Enucleation ICD-10-PCS 08T1XZZ		

Autonomous eye exams can be billed by any provider type during the measurement year with the following:

Definition	Code	
Autonomous eye exam	CPT	92229
Seven standard field stereoscopic photos	LOINC	105914-6 With result

What are the exclusions for this measure?

Bilateral eye enucleation anytime in member's history; hospice or palliative care services during the MY; death during the MY or before—document hospice or palliative services and death in the legal health record.

For HEDIS and advanced illness and frailty exclusions, please see page 10.

1.11.4 Kidney Health Evaluation for Patients with Diabetes

What is the measure description?

Diabetic members who received a kidney health evaluation

HEDIS	Stars	Withhold	Mass Health
✓	✓		

What is the intent of this measure?

Proper diabetes management is essential to reduce the risk of complications and prolong life.

Who should be screened?

Diabetic members, 18–85 years of age

When should it be completed?

January 1, 2025, through December 31, 2025

Acceptable Documentation
✓ Estimated glomerular filtration rate (eGFR) ✓ Urine albumin-creatinine ratio (uACR)

Best Practice Tips:

- ✓ Chart prep prior to the appointment to review for labs
- ✓ Consider implementing standing diabetic lab orders
  - eGFR usually is part of the basic and comprehensive metabolic panel
  - A uACR test combines both urine creatinine and quantitative urine albumin labs and automatically calculates a ratio
    - If urine creatinine and quantitative urine albumin labs are scheduled separately, ensure they are completed within four days of each other so a ratio can be calculated

Which codes should I use to document this service?

Definition		Codes	System
eGFR		80047-80048, 80050, 80053, 80069, 82565	CPT
These tests must be completed within four days of each other	Urine creatinine	82570	CPT
	Urine albumin	82043	CPT

What are the exclusions for this measure?

Definition	Codes
Chronic kidney disease, stage 5	N18.5
End-stage renal disease	N18.6
Dependence on renal dialysis	Z99.2

Hospice or palliative care services during the MY; death during the MY or before—document hospice or palliative services and death in the legal health record.

For HEDIS and advanced illness and frailty exclusions, please see page 10.

1.11.5 Statin Therapy for Patients with Diabetes

What is the measure description?

Diabetic members who were dispensed at least one statin medication

HEDIS	Stars	Withhold	Mass Health
✓			

What is the intent of this measure?

The American Diabetes Association and ACC/AHA guidelines recommend statins for primary prevention of cardiovascular disease in patients with diabetes.

Who should be screened?

Diabetic members, 40–75 years of age

When should it be completed?

January 1, 2025, through December 31, 2025

Which medications can I prescribe to prevent cardiovascular disease?

High-Intensity Statin Therapy	Moderate-Intensity Statin Therapy	Low-Intensity Statin Therapy
Atorvastatin 40–80 mg	Atorvastatin 10–20 mg	Ezetimibe-simvastatin 10 mg
Amlodipine-atorvastatin 40–80 mg	Amlodipine-atorvastatin 10–20 mg	Fluvastatin 20 mg
Amlodipine 2.5 mg / Atorvastatin 40 mg	Amlodipine 2.5 mg / Atorvastatin 10 mg	Lovastatin 10-20 mg
Amlodipine 5 mg / Atorvastatin 40 mg	Amlodipine 2.5 mg / Atorvastatin 20 mg	Lovastatin 20 mg (24 HR extended release)
Amlodipine 5 mg / Atorvastatin 80 mg	Amlodipine 5 mg / Atorvastatin 10 mg	Pravastatin 10-20 mg
Amlodipine 10 mg / Atorvastatin 40 mg	Amlodipine 5 mg / Atorvastatin 20 mg	Pravastatin Sodium 10-20 mg
Amlodipine 10 mg / Atorvastatin 80 mg	Amlodipine 10 mg / Atorvastatin 10 mg	Simvastatin 5-10 mg
Rosuvastatin 20–40 mg	Amlodipine 10 mg / Atorvastatin 20 mg	
Rosuvastatin Calcium 20–40 mg	Rosuvastatin 5–10 mg	
Simvastatin 80 mg	Rosuvastatin Calcium 5–10 mg	
Ezetimibe-simvastatin 80 mg	Simvastatin 20–40 mg	
Ezetimibe 10 mg / Simvastatin 80 mg	Ezetimibe-simvastatin 20–40 mg	
	Ezetimibe 10 mg / Simvastatin 20 mg	
	Ezetimibe 10 mg / Simvastatin 40 mg	
	Pravastatin 40–80 mg	
	Pravastatin Sodium 40 mg	
	Pravastatin Sodium 80 mg	
	30-day combination packet: Aspirin 325 mg / Pravastatin sodium 80	
	30-day combination packet:	

	Aspirin 81 mg / Pravastatin sodium 40 mg	
	Lovastatin 40–60 mg	
	Lovastatin 40–60 mg (24 HR extended release)	
	Fluvastatin 40–80 mg	
	Fluvastatin 80 mg (24 HR extended release)	
	Pitavastatin 1–4 mg	
	Pitavastatin Calcium 1–4 mg	
	Pitavastatin Magnesium 1–4 mg	
	Pitavastatin Sodium 1–4 mg	

Best Practice Tips:

- ✓ Schedule visits every 3–6 months to review LDL and cholesterol panels, blood pressure, and medications
- ✓ Chart prep before the appointment to review for diabetic labs and medication refills
- ✓ Encourage members to call the office if they experience any side effects to discuss alternative medications or other cholesterol-lowering therapies
  - Review grapefruit/grapefruit juice interactions with Atorvastatin, Lovastatin, and Simvastatin
  - Advise member to take statins at bedtime, if possible, to improve medication absorption and effectiveness
- ✓ Reinforce the importance of low-sodium and low-carbohydrate diet, increased physical activity, smoking cessation, and medication adherence at every visit

What are the exclusions for this measure?

See page 21, Statin Therapy for Patients with Cardiovascular Disease (Exclusions)

Hospice or palliative care services during the MY; death during the MY or before—document hospice or palliative services and death in the legal health record.

For HEDIS and advanced illness and frailty exclusions, please see page 10.

1.12 MUSCULOSKELETAL CONDITIONS

To optimize the diagnosis and treatment of musculoskeletal conditions and low back pain, ensuring that members receive appropriate care that avoids unnecessary imaging studies and promotes effective pain management and recovery.

1.12.1 Osteoporosis Management in Women Who Had a Fracture

What is the measure description?

The percentage of women who suffered a fractur and had either a bone mineral density (BMD) test or prescription for a drug to treat osteoporosis

HEDIS	Stars	Withhold	Mass Health
✓	✓		

What is the intent of this measure?

Osteoporotic fractures, particularly hip fractures, are associated with chronic pain and disability, loss of independence, decreased quality of life, and increased mortality.
Appropriate screening and treatment can reduce the risk of osteoporosis-related fractures.

Who should be screened?

Women, 67–85 years of age

When should it be completed?

Within six months of a fracture

What are the HEDIS documentation requirements, and by whom?

Credentials	Acceptable Documentation
Primary care provider	✓ History of a BMD test with the date of service ✓ Prescription to treat osteoporosis
Non-clinical or clinical staff	Imaging report in the legal health record

Best Practice Tips:

- ✓ When a member has a recent fracture, understand the etiology to identify the root cause of the injury
  - Offer assistance and available resources to avoid any additional potential fractures
- ✓ Bone mineral density tests can be completed in the member's home
- ✓ Ensure that you are coding initial and subsequent visits appropriately, as they have new meaning in ICD-10-CM, initial is perceived as active treatment whereas subsequent is post-treatment care; neither has to do with if the provider has seen this patient for their fracture before.

Which medications can I prescribe to treat osteoporosis?

Bisphosphonates	Other agents
Alendronate Alendronate-cholecalciferol Ibandronate Risedronate Zoledronic acid	Abaloparatide Denosumab Raloxifene Romosozumab Teriparatide

What are the exclusions for this measure?

Hospice or palliative care services during the MY; death during the MY or before—document hospice or palliative services and death in the legal health record.

For HEDIS and advanced illness and frailty exclusions, please see page 10.

1.12.2 Osteoporosis Screening in Older Women

What is the measure description?

The percentage of women who received osteoporosis screening

HEDIS	Stars	Withhold	Mass Health
✓			

What is the intent of this measure?

Osteoporosis is a serious disease in the elderly that can impact their quality of life. Osteoporosis is a bone disease characterized by low bone mass, leading to bone fragility and increased susceptibility to hip, spine, and wrist fractures.

Who should be screened?

Women, 65–75 years of age

When should it be completed?

Any time between the member's 65th birthday and December 31, 2025

What are the HEDIS documentation requirements, and by whom?

Credentials	Acceptable Documentation
Primary care provider	✓ History of a BMD test with the date of service ✓ Prescription to treat osteoporosis
Non-clinical or clinical staff	Imaging report in the legal health record

Best Practice Tips:

- ✓ Chart prep before appointment and review for osteoporosis screenings or medications
- ✓ BMD screening can be done in a member's home
- ✓ Offer support and encourage screenings for early detection
- ✓ Osteoporosis often progresses without symptoms in the early stages of bone loss. As people age, bone mass is lost faster than it's created. Screening will enable preventive measures to slow the progression before serious damage occurs
  https://www.mayoclinic.org/diseases-conditions/osteoporosis/symptoms-causes/syc-20351968

Which medications can I prescribe to treat osteoporosis?

Bisphosphonates	Other agents
Alendronate	Abaloparatide
Alendronate-cholecalciferol	Denosumab
Ibandronate	Raloxifene
Risedronate	Romosozumab
Zoledronic acid	Teriparatide

What are the exclusions for this measure?

Hospice or palliative care services during the MY; death during the MY or before—document hospice or palliative services and death in the legal health record.

For HEDIS and advanced illness and frailty exclusions, please see page 10.

1.13 BEHAVIORAL HEALTH

To enhance the identification, treatment, and follow-up care for behavioral health conditions, including depression and mental illness, ensuring that members receive continuous and effective mental health support and medication management.

1.13.1 Follow-Up After Hospitalization for Mental Illness

What is the measure description?

Members with a follow-up visit for mental health within 30 days of discharge

HEDIS	Stars	Withhold	Mass Health
✓		✓	

What is the intent of this measure?

There are over 2 million hospitalizations annually for mental illness in the United States. Patients hospitalized for mental health issues are vulnerable after discharge, and follow-up care is critical for their health and well-being.

Who should be screened?

Members hospitalized for treatment of selected *mental illness, phobia, anxiety, and intentional self-harm diagnoses (*See Exhibit 6, Mental Illness and Intentional Self-Harm Code Set HEDIS MY25.*)

When should it be completed?

Within 30 days of their discharge between January 1, 2025, and December 31, 2025

Best Practice Tips:

- ✓ Coordinate with the inpatient case manager
- ✓ Ensure a follow-up appointment is scheduled, and identify any barriers to ensure the member has appropriate supports in place, such as transportation

Which codes should I use to document this service?

Definition	Codes	System
Transitional care management	99495, 99496	CPT
Psychotherapy with any diagnosis of a mental health disorder	90791-90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90875, 90876 ***With*** Place of Service: 3, 5, 7, 9, 11-20, 22, 33, 49-50, 52-53, 56, 71-72	CPT
Electroconvulsive Therapy	90870 ***With*** Place of Service: 3, 5, 7, 9, 11-20, 22, 24, 33, 49-50, 52-53, 71-72	CPT
An outpatient visit with any diagnosis of a mental health disorder	98000-98007, 98960-62, 99078, 99202-05, 99211-15, 99242-45, 99341, 99342, 99344, 99345, 99347-50, 99381-87, 99391-97, 99401-04, 99411, 99412, 99483, 99492, 99493, 99494, 99510	CPT
	G0155, G0176-G0177, G0409, G0463, G0512, G0560, H0002, H0004, H0031, H0034, H0036-H0037, H0039-H0040, H2000, H2010-H2011, H2013-H2020, T1015	CPT
Telephonic visit with any diagnosis of a mental health disorder	98008-98015, 98966-98968, 99441-99443	HCPCS
Psychiatric collaborative care management	99492-99494	CPT
	G0512	HCPCS

Definition	Codes	System
Peer support services with any diagnosis of a mental health disorder	G0140, G0177, H0024-H0025, H0038-H0040, H0046, H2014, H2023, S9445, T1012, T1016, T1017	HCPCS
Residential behavioral health treatment	H0017-H0019, T2048	HCPCS
An intensive outpatient encounter or partial hospitalization	G0410-G0411, H0035, H2001, H2012, S0201, S9480, S9484, S9485	HCPCS
Behavioral Healthcare Setting	513, 900-905, 907, 911-917, 919, 1001	UBREV
Inpatient or Consultive Care	99221-99223, 99231-99233, 99238-99239, 99252-99255 ***With*** Place of Service: 3, 5, 7, 9, 11-20, 22, 33, 49-50, 52-53, 56, 71-72	CPT

What are the exclusions for this measure?

Hospice services during the MY; death during the MY or before—document hospice and death in the legal health record.

For HEDIS and advanced illness and frailty exclusions, please see page 10.

1.14 CARE COORDINATION

To ensure seamless and effective coordination of care across various healthcare providers and settings, promoting comprehensive care management and communication to improve patient outcomes, reduce hospital readmissions, and enhance the overall healthcare experience for members.

1.14.1 Advance Care Planning

What is the measure description?

Members who had a discussion or documentation of advanced care plan

HEDIS	Stars	Withhold	Mass Health
✓			

What is the intent of this measure?

An individual's choices about end-of-life care should be considered, and advanced care plans should be executed.

Who should be screened?

Members 66+ years of age

When should it be completed?

January 1, 2025, through December 31, 2025

What are the HEDIS documentation requirements, and by whom?

Acceptable Documentation
✓ Dated documentation of an advanced care planning discussion
✓ Living will, MOLST, healthcare proxy, power of attorney in the legal health record

Best Practice Tips:

- ✓ Train all clinicians in communication skills and how to manage sensitive conversations
- ✓ Ensure training for all clinicians includes capacity, competency, and documentation requirements
- ✓ Use a team-based approach involving the entire healthcare team (nurses, social workers, care coordinators)
- ✓ Standardize documentation within your EHR to make advanced care planning information easily accessible in emergent situations

Which codes should I use to document this service?

Definition	Codes	System
Do not resuscitate	Z66	ICD10
Cognitive assessment and care plan services	99483	CPT
Assessment of and care planning	99497	CPT
Advance care planning discussed and documented; advance care plan or surrogate decision-maker documented	1123F	CPT-CAT-II
Advance care planning was discussed and documented in the medical record; the patient did not wish or was not able to name a surrogate decision-maker or provide an advance care plan	1124F	CPT-CAT-II
Advance care planning discussion documented in the medical record	1158F	CPT-CAT-II
Advance care plan or similar legal document present in the medical record	1157F	CPT-CAT-II

What are the exclusions for this measure?

Hospice services during the MY; death during the MY or before—document hospice and death in the legal health record.

For HEDIS and advanced illness and frailty exclusions, please see page 10.

1.14.2 Transitions of Care

1.14.2.1 Notification of Admission

HEDIS	Stars	Withhold	Mass Health
✓	✓		

What is the measure description?
Communication of notification of inpatient admission sent from the inpatient facility to the primary care provider or ongoing care provider with the date of receipt documented

What is the intent of this measure?
Transitioning from inpatient to home often leads to poor coordination, including communication breakdown between inpatient and outpatient providers. The transition from the inpatient setting to home care often results in intentional and unintentional medication changes, incomplete diagnostic workups, and inadequate understanding of diagnoses, medications, and follow-up needs among patients, caregivers, and providers.

Who should be screened?
Members 18+ years of age who were admitted to an inpatient setting.

When should it be completed?
On the day of admission through 2 days after the admission (3 days total)

Acceptable Documentation
Dated communication of admission between the hospital and provider via EHR, email, fax, phone, etc. filed and integrated in the outpatient provider record

Best Practice Tips:
- ✓ Educate office staff and care team about the importance of care coordination to reduce fragmentation
- ✓ Work with local hospitals, where your members are seen to streamline effective communication
- ✓ Verify office information to verify fax and phone are up to date for notifications

What are the exclusions for this measure?
Hospice services during the MY; death during the MY or before—document hospice and death in the legal health record.

For HEDIS and advanced illness and frailty exclusions, please see page 10.

1.14.2.2 Receipt of Discharge

What is the measure description?

Communication of discharge between the inpatient facility and primary care provider or ongoing care provider

HEDIS	Stars	Withhold	Mass Health
✓	✓		

When should it be completed?

On the day of discharge through 2 days after the discharge (3 days total)

Receipt of Discharge

Acceptable Documentation
Dated discharge communication between the hospital and provider via EHR, email, fax, phone, etc. filed and integrated in the outpatient provider record **Discharge information must include**: ☑ The practitioner responsible for the member's care during the inpatient stay ☑ Procedures or treatment provided ☑ Diagnoses at discharge ☑ Current medication list ☑ Testing results, pending tests, or no tests ordered ☑ Instructions for patient care post-discharge

1.14.2.3 Medication Reconciliation Post Discharge

What is the measure description?

Members who had a comprehensive medication reconciliation after an inpatient stay

HEDIS	Stars	Withhold	Mass Health
✓	✓		

When should it be completed?

On the day of discharge through 30 days after discharge (31 total days)

What are the HEDIS documentation requirements, and by whom?

Credentials	Acceptable Documentation
RN, NP, PA, DO, MD, PharmD	A post-discharge follow-up with a medication reconciliation or review **(evidence requires that the provider was aware of the member's hospitalization or discharge)**

Best Practice Tips:

- ✓ Ensure member has a post-discharge follow-up within 7 days
  - This pertains to all inpatient stays, including but not limited to hospital, skilled nursing facility, rehabilitation center, and mental health facility
- ✓ Documentation in member's legal health record must mention recent inpatient stay
- ✓ Medication management post-discharge is crucial for patient safety and an effective treatment plan
  - Members may be prescribed new medications or have changes to their existing medications, which can be confusing
  - A thorough review of all medications can prevent complications and readmissions
- ✓ Utilize codes to reduce the burden of medical record review (see below)

Which codes should I use to document this service?

Definition		Codes	Code System
Medication reconciliation intervention		1111F	CPT-CAT-II
Transitional care management services	7 days	99495	CPT
	14 days	99496	CPT
Cognitive assessment and care plan services		99483	CPT

1.14.3 Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions

What is the measure description?

High-risk members who had a follow-up after an emergency department (ED) visit

HEDIS	Stars	Withhold	Mass Health
✓	✓		

What is the intent of this measure?

Members with multiple high-risk chronic conditions are particularly vulnerable following ED visits because of their functional limitations, audio and visual impairments, and use of multiple medications, which puts them at a greater risk for ED readmission and inpatient hospitalization.

Who should be screened?

Members 18+ years of age who have multiple high-risk chronic conditions

When should it be completed?

Within 7 days of ED visit

What are the eligible chronic conditions?

Chronic Condition	Codes
COPD	J41.0, J41.1, J41.8, J42, J43.0-3.2, J43.8-J44.1, J44.9, J47.0-7.1, J47.9
Asthma	J45.21-5.22, J45.31-5.32, J45.41-5.42, J45.51-5.52, J45.901-5.902, J45.990-5.991, J45.998
Dementia	F01.50-.51, F01.511, F01.518, F01.52-.54, F01.A0, F01.A11, F01.A18, F01.A2-.A4, F01.B0, F01.B11, F01.B18, F01.B2-.B4, F01.C0, F01.C11, F01.C18, F01.C2-.C4, F02.80-.81, F02.811, F02.818, F02.82-.84, F02.A0, F02.A11, F02.A18, F02.A2-.A4, F02.B0, F02.B11, F02.B18, F02.B2-.B4, F02.C0, F02.C11, F02.C18, F02.C2 -.C4, F03.90-.91, F03.911, F03.918, F03.92-3.94, F03.A0, F03.A11, F03.A18, F03.A2-.A4, F03.B0, F03.B11, F03.B18, F03.B2-.B4, F03.C0, F03.C11, F03.C18, F03.C2-.C4, F04, F10.27, F10.97, F13.27, F13.97, F18.17, F18.27, F18.97, F19.17, F19.27, F19.97, G30.0-.1, G30.8-.9, G31.01, G31.09, G31.83
Chronic kidney disease	A18.11, A52.75, B52.0, C64.1-.2, C64.9, C68.9, D30.00-.02, D41.00-.02, D41.10-.12, D41.20-.22, D59.30-.32, D59.39, E08.21-.22, E08.29, E08.65, E09.21-.22, E09.29, E10.21-.22, E10.29, E10.65, E11.21-.22, E11.29, E11.65, E13.21-.22, E13.29, E74.8, E74.810, E74.818-.820, E74.89, I12.0, I13.11, I13.2, I70.1, I72.2, K76.7, M10.30, M10.31-12, M10.319, M10.321-22, M10.329, M10.331-32, M10.339, M10.341-42, M10.349, M10.351-.352, M10.359, M10.361-.362, M10.369, M10.371-.372, M10.379, M10.38-.39, M32.14-.15, M35.04, N00.0-N09, N00.A-N07.A, N02.B1-N02.B6, N02.B9, N04.20-N04.22, N04.29, N13.1-2, N13.30, N13.39, N14.0-.11, N14.19, N14.2-.4, N15.0, N15.8-.9, N16, N17.0-.2, N17.8-.9, N18.1-.3, N18.30-.32, N18.4-.6, N18.9, N19, N25.0-.1, N25.81, N25.89, N25.9, N26.1, N26.9, Q61.02, Q61.11, Q61.19, Q61.2-.5, Q61.8, Q62.0, Q62.10-.12, Q62.2, Q62.31-.32, Q62.39, R94.4
Depression	F32.0-F32.4, F32.9, F33.0-F33.3, F33.41, F33.9
Heart failure	I09.81, I11.0, I13.0, I13.2, I42.0-143, I50.1, I50.20-I50.23, I50.30-I50.33, I50.40-I50.43, I50.810-I50.814, I50.82-I50.84, I50.89, I50.9
Acute myocardial infarction	I21.01-.02, I21.09, I21.11, I21.19, I21.21, I21.B, I21.29, I21.3-.4, I21.A9, I22.0-.2, I22.8-.9, I23.0-.8, I25.6, I25.2
Atrial fibrillation	I48.0, I48.11, I48.19, I48.20-.21, I48.91

Stroke and transient ischemic attack	G45.0-.2, G45.8-.9, G46.0-.2, G97.31-.32, I60.00-.02, I61.0-.6, I61.8-.9, I63.00-.012, I63.019, I63.02, I63.031-.032, I63.039, I63.09-.113, I63.119, I63.12, I63.131-.133, I63.139, I63.19-.213, I63.219, I63.22, I63.231-.233, I63.239, I63.29-.313, I63.319, I63.321-.323, I63.329, I63.331-.333, I63.339, I63.341-.343, I63.349, I63.39-.413, I63.419, I63.421-.423, I63.429, I63.431-.433, I63.439, I63.441-.443, I63.449, I63.49, I63.50, I63.511-.513, I63.519, I63.521-.523, I63.529, I63.531-.533, I63.539, I63.541-.543, I63.549, I63.59, I63.6, I63.81, I63.89, I63.9, I66.01-.03, I66.09, I66.11-.13, I66.19, I66.21-.23, I66.29, I66.3, I66.8-.9, I67.841, I67.848, I67.89, I97.810-.811, I97.820-.821

Acceptable Documentation
An outpatient, telephone, virtual, transitional care, or case management visit

Best Practice Tips:

- ✓ It's important to discuss the discharge care plan, review prescription changes, verify understanding, and identify any challenges the member may have
- ✓ Encourage members to call you before going to the emergency department
- ✓ Consider enrolling your practice in an admission, discharge, and transfer alert system to ensure timely receipt of information and create provider alerts and tracking for follow-up

Which codes should I use to document this service?

Definition		Codes	Code System
Transitional care management services	7 days	99495	CPT
	14 days	99496	CPT
Case management encounter		99366	CPT
Outpatient and telehealth encounter		98966-8, 98970-2, 98980-1, 99202-5, 99211-5, 99241-5, 99341-5, 99347-0, 99381-7, 99391- 7, 99401-4, 99411-2, 99421-3, 99429, 99441-3, 99455-8, 99483	CPT
Complex care management		99439, 99487, 99489, 99490, 99491	CPT
Outpatient visit		98960-2, 99078, 99202-5, 99211-5, 99242-5, 99341, 99342, 99344, 99345, 99347, 99348-50, 99381-7, 99391-7, 99401-4, 99411, 99412, 99483, 99492-4, 99510	CPT

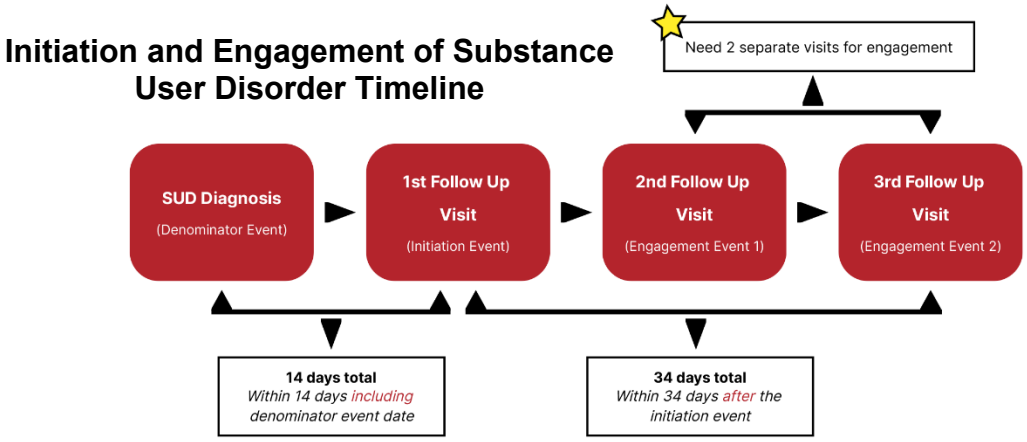
What are the exclusions for this measure?

Hospice services during the MY; death during the MY or before—document hospice and death in the legal health record.

For HEDIS and advanced illness and frailty exclusions, please see page 10.

This domain assesses the ease with which members can obtain the care they need, including measures related to the availability of primary care providers and specialists and the timeliness of care.

1.14.4 Initiation and Engagement of Substance Use Disorder Treatment



1.14.4.1 Initiation

HEDIS	Stars	Withhold	Mass Health
✓		✓	

What is the measure description?

Members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication treatment

What is the intent of this measure?

Despite strong evidence, less than 20% of individuals with substance use disorder receive treatment.

Who should be screened?

Individuals 13+ years of age who have a substance use disorder diagnosis with a negative diagnosis history

What is a negative diagnosis history?

194 days (about six months) without any active substance use disorder diagnosis in the same cohort

When should it be completed?

Within 14 days of their new diagnosis, between November 15, 2024, through November 14, 2025

Acceptable Documentation
✓ Outpatient follow-up visit for substance use disorder (SUD)

Best Practice Tips:

- ✓ Ensure appointment is scheduled and that member has appropriate support such as transportation
- ✓ Consider case management to help with members' needs and coordination of care
- ✓ If a member screens positive and is given a new SUD diagnosis, please ensure that a follow-up appointment is scheduled to occur within 7 days to check in on the member and the progress of their goals (primary care provider or behavioral health provider)

Which codes should I use to document this service?*

Definition	Codes	System
Psychotherapy; 30, 45, 60 minutes	90832, 90834, 90837	CPT

Outpatient visit	98960-62, 99078, 99202-05, 99211-15, 99242-45, 99341, 99342, 99344, 99345, 99347-50, 99381-87, 99391-97, 99401-04, 99411, 99412, 99483, 99492, 99493, 99494, 99510	CPT

***Submit the same SUD ICD-10 code or a code from the same cohort from the initial diagnosis to ensure the IET follow-up is captured through claims.**

What are the exclusions for this measure?

Hospice services during the MY; death during the MY or before—document hospice and death in the legal health record. For HEDIS and advanced illness and frailty exclusions, please see page 10.

Additional Information on IET

See the IET FAQ document for more detailed measure information.
See the IET tip sheet for information on best practices and SBIRT.

1.14.4.2 Engagement

HEDIS	Stars	Withhold	Mass Health
✓		✓	

What is the measure description?

The percentage of members who are engaged in ongoing AOD treatment

When should it be completed?

At least **two** engagement visits within 34 days of their initiation visit.

Acceptable Documentation
✓ Outpatient visit for SUD follow-up ✓ Prescription for SUD treatment medication

Best Practice Tips:

- ✓ Ensure appointment is scheduled, and identify any barriers to ensure member has appropriate supports such as transportation
- ✓ Consider case management to help with members' needs and coordination of care
- ✓ If a member has an initiation visit to check in and initiate care for their SUD, please ensure that a follow-up appointment is scheduled to occur within 30 days to check in on the member and the progress of their goals (primary care provider or behavioral health provider)

Which codes should I use to document this service?*

Definition	Codes	System
Psychotherapy; 30, 45, 60 minutes	90832, 90834, 90837	CPT
Outpatient visit	98960-62, 99078, 99202-05, 99211-15, 99242-45, 99341, 99342, 99344, 99345, 99347-50, 99381-87, 99391-97, 99401-04, 99411, 99412, 99483, 99492, 99493, 99494, 99510	CPT

***Submit the same SUD ICD-10 code from the initial diagnosis and initiation visit to ensure the IET follow-up is captured through claims.**

Which SUD treatment medications can I prescribe as an engagement medication?

	Treatment Medications	
Alcohol use disorder	Aldehyde dehydrogenase inhibitor	Disulfiram (oral)
	Antagonist	Naltrexone (oral and injectable)
	Other	Acamprosate (oral; delayed-release tablet)
Opioid use disorder	Antagonist	Naltrexone (oral) Naltrexone (injectable)
	Partial agonist	Buprenorphine (sublingual tablet) Buprenorphine (injection) Buprenorphine (implant) Buprenorphine/naloxone (sublingual tablet, buccal film, sublingual film)

Additional Information on IET

See the IET FAQ document for more detailed measure information.
See the IET tip sheet for information on best practices and SBIRT.

1.14.5 Prenatal and Postpartum Care

1.14.5.1 *Prenatal Care*

HEDIS	Stars	Withhold	Mass Health
✓			

What is the measure description?

The percentage of deliveries of live births that received a prenatal care visit in the first trimester, with an obstetrician (OB), midwife, or family/primary care provider.

What is the intent of this measure?

Appropriate perinatal services and education are crucial components of a healthy birth. Understanding how to stay healthy is important for preventing complications that can affect the health of both mother and baby before, during, and after pregnancy.

Who should be screened?

Pregnant women

When should it be completed?

The first trimester of pregnancy

What are the HEDIS documentation requirements, and by whom?

Credentials	Acceptable Documentation
OB, midwife, or family/primary care provider	✓ Documentation or reference to pregnancy, expected delivery date, or last menstrual period ✓ Basic physical obstetrical examination with fetal heart tone, pelvic exam with obstetric observations, or measurement of fundus height ✓ Prenatal care procedures, including obstetric panels, TORCH, Rh blood typing, and ultrasound of the pregnant uterus

Best Practice Tips:

- ✓ Refer to a prenatal care practitioner; if you need assistance finding an in-network provider or one accepting new patients, **contact CCA for additional support and resources**
- ✓ Services can be completed across multiple appointments during the first trimester
- ✓ Sign prenatal form and file with obstetric panels and ultrasound in the legal health record
- ✓ Identify barriers to the member's routine prenatal care, such as transportation issues
- ✓ Provide education on the importance of prenatal care and support the member to ensure their needs are met; **if needs are identified, contact CCA for additional support and resources**

Which codes should I use to document this service?

Prenatal Visit Codes			
Initial visit	0500F	Standalone visit (submit with pregnancy-related ICD-10 on claim)	98966-68, 98970-72, 98980-81, 99202-05, 99211-15, 99241-45, 99421-23, 99441-43, 99457-58, 99483
Flowsheet in record (by the first prenatal visit)	0501F		
Subsequent visit	0502F	Bundled service (submit service date on claim)	59400, 59425-59426, 59510, 59610, 95618
Home visit	99500		

What are the exclusions for this measure?

Pregnancy that did not result in a live birth; hospice services during the MY; death during the MY or before—document hospice and death in the legal health record. For HEDIS and advanced illness and frailty exclusions, please see page 10.

1.14.5.2 Postpartum Care

When should it be completed?

Between 7 and 84 days postpartum, after delivery of a live birth

HEDIS	Stars	Withhold	Mass Health
✓			

What are the HEDIS documentation requirements, and by whom?

Credentials	Acceptable Documentation
OB, midwife, or family/primary care provider	✓ Notation of postpartum care (abbreviations acceptable, e.g., "PP care") ✓ Pelvic exam or perineal or cesarean wound/incision check ✓ Evaluation of weight, BP, abdomen, and breasts (or notation of breastfeeding) ✓ Glucose screening for members with gestational diabetes ✓ Screening for depression, anxiety, tobacco use, substance use, or preexisting mental health disorders ✓ Discussion about infant care or breastfeeding, resumption of intercourse, birth spacing or family planning, sleep/fatigue, resumption of physical activity, or attainment of healthy weight

Best Practice Tips:

- ✓ Consider coordinating postpartum visit(s) while member is in the hospital
- ✓ Postpartum visit should include a full assessment of physical, social, and psychological well-being
- ✓ Use appropriate codes for postpartum care to reduce the burden of medical record review
- ✓ Identify barriers the member may have to receive postpartum care, such as transportation issues
- ✓ Provide education on the importance of postpartum care and support the member to ensure their needs are met; **if needs are identified, contact CCA for additional support and resources**

Which codes should I use to document this service?

Definition	Codes	System
Postpartum visit	Z01.411, Z01.419, Z01.42, Z30.430, Z39.1, Z39.2	ICD10
	57170, 58300, 59430, 99501	CPT
Postpartum bundled services (submit service date on claim)	59400, 59410, 59510, 59515, 59610, 59614, 59618, 59622	CPT
Cervical cytology	88141-43, 88147-48, 88150, 88152-53, 88164-67, 88174-75	CPT

MEASURES REPORTED USING ELECTRONIC CLINICAL DATA SYSTEMS (ECDS)

This domain focuses on the use of EHRs and other clinical data systems to collect and report measures, emphasizing the importance of accurate and efficient data collection for quality improvement.

1.14.6 Breast Cancer Screening

What is the measure description?

Members who were recommended for routine breast cancer screening and had a mammogram

HEDIS	Stars	Withhold	Mass Health
✓	✓		

What is the intent of this measure?

Second to skin cancer, breast cancer is the most prevalent form of cancer affecting women.

Who should be screened?

Women, 40–74 years of age

When should it be completed?

October 1, 2023, through December 31, 2025

What are the HEDIS documentation requirements, and by whom?

Credentials	Acceptable Documentation
Primary care provider	History of a mammogram with the date of service
Non-clinical or clinical staff	Imaging report uploaded in the legal health record

Best Practice Tips:

- ✓ Chart prep before the appointment and review the previous mammogram
- ✓ Offer support and educate members about the importance of early detection, openly discuss any concerns the member has, and encourage screening
- ✓ Avoid ambiguous language like “thinks” or “around” when documenting history of mammogram
- ✓ **MRI is not recommended as a screening test by itself** *
  *https://www.cancer.org/cancer/types/breast-cancer/screening-tests-and-early-detection/breast-mri-scans.html
- ✓ A unilateral mastectomy is not an eligible exclusion; it is considered best clinical practice to continue screening on the remaining breast

Which codes should I use to document this service?

Definition	Codes	Code System
Mammogram	77061, 77062, 77063, 77065, 77066, 77067	CPT

What are the exclusions for this measure?

Definition		Code	Code System
Members who had gender-affirming chest surgery		19318	CPT
Acquired absence of bilateral breasts and nipples		Z90.13	ICD10
Acquired absence of breast and nipple (to be eligible for exclusion, left and right must both be documented)	**Left**	Z90.12	ICD10
		429009003 137671000119105	SNOMED
	Right	Z90.11	ICD10
		429242008 137681000119108	SNOMED

SNOMED codes can only be shared through data exchange, such as HIE, API, and data files, or through mapping to relevant code systems like ICD-10 and submission through claims. Hospice or palliative care services during the MY; death during the MY or before—document hospice or palliative services and death in the legal health record.

For HEDIS and advanced illness and frailty exclusions, please see page 10.

1.14.7 Documented Assessment after Mammogram

What is the measure description?

Members who had a mammogram and had a BI-RADS assessment documented within 14 days of the screening

HEDIS	Stars	Withhold	Mass Health
✓			

What is the intent of this measure?

Timely documentation of breast cancer screening with diagnostic results allows appropriate and timely follow-up care.

Who should be screened?

Women, 40–74 years of age

When should it be completed?

BI-RADS assessment should be documented within 14 days of a completed mammogram.

What are the HEDIS documentation requirements?

**SNOMED codes can only be shared through data exchange, such as HIE, API, and data files, or through mapping to relevant code systems like ICD-10 and submission through claims.*

BI-RADS Assessment	SNOMED Code*
Category 0:** Need additional imaging evaluation	397138000
Category 1: Negative finding	397140005
Category 2: Benign finding	397141009
Category 3: Probably benign finding	397143007
Category 4:** 4A, 4B, and 4C: Suspicious abnormality, biopsy should be considered	39714401 612100179106 6131000179108 6141000179100
Category 5:** highly suggestive of malignancy	397145000
Category 6: Known biopsy, proven malignancy	6111000179101

Best Practice Tips:

- ✓ Add the diagnostic mammogram with assessment to the member's health record
- ✓ Update completed screenings with BI-RADS results using the appropriate SNOMED code
- ✓ Members with BI-RADS Category 1 and 2 should be encouraged for routine screenings
- ✓ Members with BI-RADS Category 0: Incomplete screening and should be encouraged for additional imaging for evaluation
- ✓ Members with BI-RADS Category 4 and 5 should be managed using core needle biopsy and should be encouraged to continue evaluation
- ✓ Review mammogram results as soon as they are available and make appropriate decisions for further care
- ✓ If initial abnormal results are inconclusive, ensure there is clear guidance for next steps and why they are important

What are the exclusions for this measure?

Hospice services during the MY; death during the MY or before—document hospice and death in the legal health record. For HEDIS and advanced illness and frailty exclusions, please see page 10.

1.14.8 Follow-Up After Abnormal Mammogram Assessment

What is the measure description?

Members who had an inconclusive or high-risk BI-RADS assessments that received appropriate follow-up within 90 days of assessment

HEDIS	Stars	Withhold	Mass Health
✓			

What is the intent of this measure?

Appropriate and timely follow-up after inconclusive or high-risk BI-RADS assessments facilitates accurate diagnosis and effective treatment.

Who should be screened?

Women, 40–74 years of age

When should it be completed?

Within 90 days of the inconclusive or high-risk assessment

What are the HEDIS documentation requirements?

BI-RADS Assessment	Documentation Required
Category 0: Inconclusive *Need additional imaging evaluation and/or prior mammograms for comparison*	Documentation of mammogram or ultrasound with date of service and BI-RADS assessment Imaging report uploaded in the legal health record
Categories 4: Suspicious Category 5: Highly suggestive *Managed using core needle biopsy*	Documentation of a breast biopsy with the date of service Breast biopsy assessment in the legal health record

Best Practice Tips:

- ✓ Add the diagnostic mammogram with assessment to the member's health record
- ✓ Update completed screenings with BI-RADS results using the appropriate SNOMED code.
- ✓ Review mammogram results as soon as they are available and make appropriate decisions for further care
- ✓ If initial abnormal results are inconclusive, ensure there is clear guidance for next steps and why they are important
- ✓ Understand the emotional impact of abnormal results on patients, offer support, and address any concerns they may have about the results and/or next steps

Which codes should I use to document these services?

BI-RADS Assessment	Test	CPT Codes
Category 0: Inconclusive	Mammogram	77062, 77061, 77066, 77065, 77063, 77067
	Breast Ultrasound	76641, 76642
Categories 4: Suspicious	Breast Biopsy	19101, 19100, 19085, 19081, 19083
Category 5: Highly suggestive		

What are the exclusions for this measure?

Hospice Services during the MY; death during the MY or before—document hospice and death in the legal health record. For HEDIS and advanced illness and frailty exclusions, please see page 10.

1.14.9 Cervical Cancer Screening

What is the measure description?

Members recommended for routine cervical cancer screening who were screened

HEDIS	Stars	Withhold	Mass Health
✓			

What is the intent of this measure?

Early detection has reduced cervical cancer mortality by 50% over the past 30 years.

Who should be screened?

Members recommended for routine cervical cancer screening, 21–64 years of age

When should it be completed?

< 30 Years of Age; Every 3 Years	≥ 30 Years of Age; Every 5 Years
Cervical cytology testing	HPV testing

What are the HEDIS documentation requirements, and by whom?

Credentials	Acceptable Documentation
Primary care or ongoing care provider	History of screening with date of service and test name
Non-clinical or clinical staff	Pathology report in the legal health record

Best Practice Tips:

- ✓ Chart prep before appointment and review for cervical cancer screening
- ✓ Offer support and encourage screenings for early detections
- ✓ Ensure coding and billing are submitted if screenings are performed in your office
- ✓ Testing for HPV under age 30 is not recommended* *https://www.mayoclinic.org/tests-procedures/hpv-test/about/pac-20394355
- ✓ Avoid documenting "cervical cancer screening"; be specific, as test expiration time frames vary
- ✓ Avoid using ambiguous references to "hysterectomy"
  - Use specific language such as "complete," "total," "radical"
  - Document that the patient no longer needs pap testing/cervical cancer screening
  - Include appropriate ICD-10 code and submit on a billing claim at least annually

Which codes should I use to document this service?

Definition	Codes
Cervical cytology	88141-43, 88147-48, 88150, 88152-53, 88164-67, 88174-75
High-risk HPV	87624-25

What are the exclusions for this measure?

Definition	Codes
Acquired absence of cervix	Z90.712
Acquired absence of cervix and uterus	Z90.710
Agenesis and aplasia of cervix	Q51.5
Sex assigned male at birth	76689-9 and LA2-8

Hospice or palliative care services during the MY; death during the MY or before—document in the legal health record.

For HEDIS and advanced illness and frailty exclusions, please see page 10.

1.14.10 Colorectal Cancer Screening

What is the measure description?

Members who had appropriate screening for colorectal cancer

HEDIS	Stars	Withhold	Mass Health
✓	✓		

What is the intent of this measure?

Colorectal cancer treatment in its earliest stage can lead to a 90% survival rate after five years.

Who should be screened?

Members 45–75 years of age

When should it be completed?

Every 10 Years	Every 5 Years	Every 5 Years	Every 3 Years	Annually
Colonoscopy	Flexible Sigmoidoscopy	CT colonography	sDNA (Cologuard)	FOBT/FIT

What are the HEDIS documentation requirements, and by whom?

Credentials	Acceptable Documentation
Primary care or ongoing care provider	History of screening with date of service and test type
Non-clinical or clinical staff	Report of service uploaded in the legal health record

Best Practice Tips:

- ✓ Chart prep before appointment and review for colon cancer screenings
- ✓ Offer support and encourage screenings for early detection
- ✓ Provide options for at-home testing, such as FIT or stool DNA for patients who may prefer this method
- ✓ Avoid documenting "colorectal cancer screening"; note the specific test type, as expiration time frames vary
- ✓ If a member had a partial colectomy, screen the remaining colon routinely for colon cancer

What are the exclusions for this measure and their codes?

Definition	Codes
Malignant neoplasm of cecum	C18.0
Malignant neoplasm of appendix	C18.1
Malignant neoplasm of ascending colon	C18.2
Malignant neoplasm of hepatic flexure	C18.3
Malignant neoplasm of transverse colon	C18.4
Malignant neoplasm of splenic flexure	C18.5
Malignant neoplasm of descending colon	C18.6
Malignant neoplasm of sigmoid colon	C18.7
Malignant neoplasm of overlapping sites of colon	C18.8
Malignant neoplasm of colon, unspecified	C18.9
Malignant neoplasm of rectosigmoid junction	C19
Malignant neoplasm of rectum	C20
Malignant neoplasm of cloacogenic zone	C21.2
Malignant neoplasm of overlapping sites of rectum, anus and anal canal	C21.8
Secondary malignant neoplasm of large intestine and rectum	C78.5
Personal history of other malignant neoplasm of large intestine	Z85.038
Personal history of other malignant neoplasm of rectum, rectosigmoid junction, and anus	Z85.048
Total Colectomy	119771000119101

Hospice or palliative care services during the MY; death during the MY or before—document hospice or palliative services and death in the legal health record.

For HEDIS and advanced illness and frailty exclusions, please see page 10.

1.14.11 Depression Screening and Follow-Up for Adolescents and Adults

What is the measure description?

Members screened for clinical depression and, if positive, received follow-up care

HEDIS	Stars	Withhold	Mass Health
✓			

Who should be screened?

Members 18+ years of age

When should it be completed?

January 1, 2025, through December 31, 2025

Eligible screening tools, their codes, and what is considered a positive finding

Screening Tool	LOINC	Positive Finding
Patient Health Questionnaire (PHQ-9)	44261-6	Total score ≥10
Patient Health Questionnaire (PHQ2)	55758-7	Total score ≥3
Beck Depression Inventory-Fast Screen (BDI-FS)	89208-3	Total score ≥8
Beck Depression Inventory (BDI-II)	89209-1	Total score ≥20
Center for Epidemiologic Studies Depression Scale-Revised (CESDR-R)	89025-9	Total score ≥17
Duke Anxiety-Depression Scare (DUKE-AD)	90853-3	Total score ≥30
Geriatric Depression Scale Short Form (GDS)	48545-8	Total score ≥5
Geriatric Depression Scale Long Form (GDS)	48544-1	Total score ≥10
Edinburgh Postnatal Depression Scale (EPDS)	48544-1	Total score ≥10
My Mood Monitor (M-3)	71777-7	Total score ≥5
PROMIS Depression	71965-8	Total score ≥60
Clinical Useful Depression Outcome Scale (CUDOS)	90221-3	Total score ≥31

Best Practice Tips for Depression Screening:

- ✓ Treat depression screening as a vital sign and record results at every visit
- ✓ Document date of screening and results
- ✓ For any screenings completed by the member on a paper form, be sure to scan a copy and enter the results into the member's legal health record
- ✓ When you submit LOINC codes, please also ensure submission of the numeric screening result

What are the exclusions for this measure?

For depression, please see Exhibit 5 (Depression Code Set HEDIS MY25).
Hospice Services during the MY; death during the MY or before—document hospice and death in the legal health record.

For HEDIS and advanced illness and frailty exclusions, please see page 10.

What are the DSF-E follow-up documentation requirements, and by whom?

Credentials	Acceptable Documentation
Primary care, ongoing care or behavioral health provider	✓ Discuss symptoms, treatment options, coping strategies; assist members in getting the help they need and document in chart visit notes ✓ If a brief screening tool was used, further evaluate the member for depression using a full-length tool ○ For example, if the PHQ-2 is positive, completion of a PHQ-9 performed on the same day qualifies as evidence of follow-up ✓ Referral to specialist for further evaluation and management

Best Practice Tips for Positive Depression Screening Follow-Up:

- ✓ Schedule regular follow-up visits at 30 days to review progress with treatment
- ✓ Refer to a behavior health specialist for further evaluation and treatment
- ✓ Coordinate care with behavioral health providers
- ✓ If you need assistance with identifying acceptable providers in the network, please contact CCA

Which codes should I use to document a positive screening follow-up?*

Definition	Codes	Code System
Follow-up visit	98960-62, 98966-68, 98970-72, 98980, 98981, 99078, 99202-05, 99211-15, 99242-45, 99341, 99342, 99344, 99345, 99347-50, 99381-87, 99391-97, 99401-04, 99411, 99412, 99421-23, 99441-43, 99457, 99458, 99483	CPT
Behavioral health encounter	90791, 90792, 90832-34, 90836-39, 90845-47, 90849, 90853, 90865, 90867-70, 90875, 90876, 90880, 90887, 99484, 99492, 99493	CPT
Depression case management	99366, 99492, 99493, 99494	CPT

***Submit with appropriate ICD-10 diagnosis of depression or other behavioral health condition**

Which medications can I prescribe to treat depression?

Definition	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, Desipramine, Nortriptyline, Amoxapine, Clomipramine, Doxepin (>6 mg), Imipramine, Protriptyline, Trimipramine

1.14.12 Unhealthy Alcohol Use Screening and Follow-Up

What is the measure description?

Members screened for unhealthy alcohol use and, if positive, received appropriate follow-up care

HEDIS	Stars	Withhold	Mass Health
✓			

Who should be screened?

Members 18+ years of age

When should it be completed?

January 1, 2025, through December 31, 2025

Eligible screening tools, their codes, and what is considered unhealthy alcohol use

Screening Tool and Details		LOINC	Positive Finding
AUDIT	Men and Women	75624-7	Total score ≥8
AUDIT-C	Men	75626-2	Total score ≥4
	Women		Total score ≥3
SINGLE QUESTION How many times in the past year have you had…	Men <65 5 or more drinks in a day	88037-7	Response ≥1
	All Women Women & Men ages 65+ 4 or more drinks in a day	75889-6	

Best Practice Tips for unhealthy alcohol screening:

- ✓ Treat alcohol screening as a vital sign and record usage at every visit
- ✓ Document the date of screening and the results
- ✓ When you submit LOINC codes, please also ensure submission of the numeric screening result

What are the exclusions for this measure?

For alcohol use disorder, please see Exhibit 4 (Alcohol Use Disorder Code Set HEDIS MY25).
Hospice services during the MY; death during the MY or before—document hospice and death in the legal health record.

For HEDIS and advanced illness and frailty exclusions, please see page 10.

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What are the ASF-E follow-up documentation requirements, and by whom?

Credentials	Acceptable Documentation
Ongoing care provider or behavioral health clinician	✓ Document in encounter notes that feedback was provided on alcohol use and its harms, high-risk situations for drinking and coping strategies, and assist members in increasing motivation to reduce drinking ✓ When a member expresses readiness, assist in developing a personal plan to reduce drinking ✓ If a member requires additional support, refer to a specialist for alcohol misuse treatment and document this in the legal health record

Best Practice Tips for Positive Screening Follow-up:

- ✓ Ask about the typical weekly drinking pattern.
  - The more frequent the heavy drinking days, and the greater the weekly volume, the greater the risk of having alcohol use disorder (AUD). To learn the typical weekly pattern, ask, "On average, how many days a week do you drink alcohol?" and "On a typical drinking day, how many drinks do you have?" Multiply the answers to get the typical weekly amount, which will serve as a baseline for follow-up
  - Keep in mind that heavy weekly drinking is defined as 8 or more drinks for women and 15 or more for men
- ✓ For patients who drink heavily and do not have AUD: Offer brief advice to cut back to the dietary guidelines levels or to quit if medically indicated
  - If a patient is hesitant to accept that drinking goal at first, negotiate an individualized, initial goal for reduced consumption
  - Follow up at the next visit to check in and monitor progress toward goal
- ✓ For patients who have AUD: Advise abstinence and emphasize the importance of cutting down gradually because suddenly stopping can result in alcohol withdrawal, which can be life threatening (see Core article on AUD*).
  - Be cautious and consider the need for medically managed withdrawal
  - If the patient is hesitant to abstain, negotiate individualized drinking goals
  - Discuss evidence-based professional treatment as well as mutual support group options
  - Consider support with FDA-approved AUD medications, which are easy to prescribe, and regular follow-ups
  - Consider referral to specialty care, especially for patients with mental health comorbidities or more severe AUD
  - Follow up at the next visit

  *https://www.niaaa.nih.gov/health-professionals-communities/core-resource-on-alcohol/screen-and-assess-use-quick-effective-methods
- ✓ Evaluate member for other behavioral health needs that may affect their readiness or willingness to create a reduction goal
- ✓ Determine if the member has other needs that may impact their ability to succeed in their goal, such as lack of transportation or social supports

Which codes should I use to document alcohol screening follow-up?

Definition	Codes	Code System
Alcohol counseling or other follow-up care	99408-99409	CPT
Alcohol abuse counseling and surveillance	Z71.41	ICD10

1.14.13 Blood Pressure Control for Patients with Hypertension

What is the measure description?

Hypertensive members whose latest blood pressure was controlled (<140/<90)

HEDIS	Stars	Withhold	Mass Health
✓			

What is the intent of this measure?

Hypertension management is essential to reduce the risk of complications and prolong life.

Who should be screened?

Members with a diagnosis of hypertension, 18–85 years of age

When should it be completed?

January 1, 2025, through December 31, 2025

Acceptable Documentation
✓ In-office blood pressure reading <140/<90

Best Practice Tips:

- ✓ Readings must have a distinct systolic and diastolic values; ranges do not count
- ✓ If patient's blood pressure is ≥140 and/or ≥90:
  - Repeat their reading at the end of the visit
  - Schedule a follow-up for a blood pressure check
  - Encourage at-home monitoring with a BP log; ask them to share their readings at each visit
- ✓ Ensure the cuff is calibrated, is the correct size, and is on the bare arm
- ✓ Arm should be supported with the elbow at chest height, not dangling, with legs uncrossed

Which codes should I use to document this service?

Definition	Codes	Code System
Systolic blood pressure <130	3074F	CPT-CAT-II
Systolic blood pressure 130–139	3075F	CPT-CAT-II
Systolic blood pressure ≥140	3077F	CPT-CAT-II
Diastolic blood pressure <80	3078F	CPT-CAT-II
Diastolic blood pressure 80–89	3079F	CPT-CAT-II
Diastolic blood pressure ≥90	3080F	CPT-CAT-II

What are the exclusions for this measure?

Definition	Codes
Chronic kidney disease, stage 5	N18.5
End-stage renal disease	N18.6
Dependence on renal dialysis	Z99.2
History of kidney transplant	Z94.0

For pregnancy exclusions, please see Exhibit 1, Pregnancy Code Set HEDIS MY25.

Refer to Exhibit 2, History of Nephrectomy or Kidney Transplant Code Set HEDIS MY25.

Hospice or palliative care services during the MY; death during the MY or before—document hospice or palliative services and death in the legal health record.

For HEDIS and advanced illness and frailty exclusions, please see page 10.

1.14.14 Adult Immunization Status

What is the measure description?

Members who are up to date on recommended routine vaccinations for influenza, Td or Tdap, zoster, pneumococcal and hepatitis B

HEDIS	Stars	Withhold	Mass Health
✓			

What is the intent of this measure?

Immunizations help protect adults from diseases such as influenza, pneumonia, and hepatitis, which can lead to severe complications, especially in those who have underlying health conditions.

Who should be screened?

Members 19 years or older: Influenza, Td/Tdap, and hepatitis B
Members 50 years or older: Influenza, Td/Tdap, hepatitis B, zoster, and pneumococcal

When should it be completed?

January 1, 2025, through December 31, 2025

Best Practice Tips:

- ✓ Share all vaccinations with the Massachusetts Immunization Information System (MIIS)
- ✓ Assess patient's immunization status at every visit
- ✓ Share the reasons why a patient should get vaccinations:
  - Vaccines protect them and their loved ones from serious illness and complications
  - Explain that the disease a vaccine is trying to prevent is potentially very harmful
  - Address any concerns and questions, including side effects, safety, and debunk any myths
  - Encourage compliance with statements like "a vaccine is reserved and waiting for you"
- ✓ Send simple reminders to let patients know it's time to get a vaccine

Which codes should I use to document this service?

Definition	Codes	Code System
Influenza July 1, 2024 – Jun 30, 2025	88, 111, 135, 140, 141, 144,149, 150, 153,155. 158, 166, 168, 171, 185, 186, 197, 205	CVX
Influenza July 1, 2024 – Jun 30, 2025	90630, 90653-90654, 90656, 90658, 90660-90662, 90672-90674, 90682, 90686, 90688-90689, 90694, 90756	CPT
Td/Tdap Jan 1, 1917 – Jun 30, 2025	09, 113, 115, 138-139	CVX
Td/Tdap Jan 1, 1917 – Jun 30, 2025	90714-90715	CPT
Zoster Oct 20, 2017 – Dec 31, 2025 *2 doses at least 28 days apart*	90750	CPT
Zoster Oct 1, 2017 – Dec 31, 2025 *2 doses at least 28 days apart*	187	CVX
Pneumococcal Age 19+	33, 109, 133, 152, 215-216	CVX
Pneumococcal Age 19+	90670-90671, 90677, 90732 G0009	CPT HCPCS
Hepatitis B Age 19+ *2 doses at least 28 days apart*	90739, 90743 189	CPT CVX

Hepatitis B Age 19+ *3 doses on separate days*	43-45, 104, 220	CVX
Hepatitis B Age 19+ *3 doses on separate days*	90740, 90744, 90746-90747, 90759	CPT

What are the contraindications for specific vaccinations?

**SNOMED codes can only be shared through data exchange, such as HIE, API, and data files, or through mapping to relevant code systems like ICD-10 and submission through claims.*

Vaccination	Definition	SNOMED Code*
Influenza	Anaphylaxis due to influenza vaccine	471361000124100
Td/Tdap	Anaphylaxis due to diphtheria, tetanus, or pertussis vaccine	428981000124107 42891000124105
Td/Tdap	Encephalitis due to diphtheria, tetanus, or pertussis vaccine	192710009, 192711008, 192712001
Zoster	Anaphylaxis due to herpes zoster vaccine	471371000124107 471381000124105
Pneumococcal	Anaphylaxis due to pneumococcal vaccine	471141000124102
Hepatitis B	Anaphylaxis due to hepatitis B vaccine	428321000124101
Hepatitis B	Positive hepatitis B immunity	10828004, 165806002, 260373001, 271511000, 313234004, 406117000, 736687002, 105811000119100
Hepatitis B	History of hepatitis B illness	1116000, 13265006, 26206000, 38662009, 50167007, 53425008, 60498001, 61977001, 66071002, 76795007, 111891008, 165806002, 186624004, 186626002, 186639003, 235864009, 235865005, 235869004, 235871004, 271511000, 313234004, 406117000, 424099008, 424340000, 442134007, 442374005, 446698005, 838380002, 1230342001, 16859701000119109, 153091000119109, 551621000124109
Hepatitis B	History of hepatitis B illness	*CPT Codes* B16.0-B16. B16.9B17.0, B18.0-B18.1, B19.10-B19.11

Hospice services during the MY; death during the MY or before—document hospice services and death in the legal health record. For HEDIS and advanced illness and frailty exclusions, please see page 10.

1.14.15 MA 4.2 Unhealthy Alcohol Use Screening and Follow-Up

1.14.15.1 Screening

HEDIS	Stars	Withhold	Mass Health
			✓

What is the measure description?

Members who were screened for unhealthy alcohol use

Who should be screened?

Members 21+ years of age

When should it be completed?

January 1, 2024, through December 31, 2025

Acceptable Documentation
✓ Examples of alcohol screenings ○ Alcoholic drinks per week or drinking day ○ AUDIT ○ AUDIT-C ○ SASQ (Single Alcohol Screening Questionnaire)

What is considered unhealthy alcohol use?

	Use on a Drinking Day	Weekly Use
Men	5 or more	>14
Women	4 or more	>7

Best Practice Tips:

- ✓ Treat alcohol screening as a vital sign and record usage at every visit
- ✓ Document date of screening and results
- ✓ For adults, the U.S. Preventive Services Task Force recommends using one of the following two brief tools, noting that they have good sensitivity and specificity across the spectrum of unhealthy alcohol use*:
  - AUDIT-C
  - SASQ

*https://www.niaaa.nih.gov/health-professionals-communities/core-resource-on-alcohol/screen-and-assess-use-quick-effective-methods

What are the exclusions for this measure?

Members diagnosed with a terminal illness; who refuse to participate in the tobacco use screening; whose functional capacity or motivation to improve may impact the accuracy of the results; or who are in an urgent or emergent situation due to a medical reason where time is of the essence and to delay treatment would jeopardize the member's health status.

1.14.15.2 Follow-Up

HEDIS	Stars	Withhold	Mass Health
			✓

What is the measure description?

Members who had brief counseling or follow-up care for unhealthy alcohol use

When should it be completed?
Within 30 days of a positive screening

Acceptable Documentation*
✓ Distribution of educational materials, anticipatory guidance, feedback on alcohol use and harms, motivation to reduce drinking, how to identify high-risk situations, and coping strategies ✓ Referral to other services for unhealthy alcohol use

**Please see the best practice tips on pages 50–51 ASF-E.*

1.14.16 MA 4.3 Tobacco use Screening and Cessation

1.14.16.1 *Screening*

What is the measure description?
Members who were screened for tobacco use

HEDIS	Stars	Withhold	Mass Health
			✓

Who should be screened?
Members 21+ years of age

When should it be completed?
January 1, 2024, through December 31, 2025

Acceptable Documentation
Dated tobacco use screening with the result in the legal health record

Best Practice Tips:
- ✓ Treat smoking status as a vital sign and record smoking status at every visit
- ✓ Tobacco use is identified as use of cigarettes, cigars, pipe smoking, and smokeless tobacco
- ✓ If a member is a former tobacco user, calculate pack years to assess previous exposure and risk
- ✓ Identify any barriers to quitting and provide resources

What are the exclusions for this measure?
Members diagnosed with a terminal illness; who refuse to participate in the tobacco use screening; whose functional capacity or motivation to improve may impact the accuracy of the results; or who are in an urgent or emergent situation due to a medical reason where time is of the essence and to delay treatment would jeopardize the member's health status.

1.14.16.2 Follow-Up

What is the measure description?
Members who had tobacco cessation treatment or counseling

HEDIS	Stars	Withhold	Mass Health
			✓

When should it be completed?
Within 30 days of a positive tobacco screening

Acceptable Documentation
✓ Distribution of educational materials, anticipatory guidance, or tobacco cessation counseling or treatment ✓ Prescription of smoking cessation medication(s)

Best Practice Tips:

- ✓ The 5 As:
  1. Ask about tobacco use
  2. Advise to quit through clear, personalized messages
  3. Assess willingness to quit
  4. Assist in quitting
  5. Arrange follow-up and support
- ✓ For additional information, refer to A Practical Guide to Help Your Patients Quit Using Tobacco https://www.cdc.gov/tobacco/patient-care/pdfs/hcp-conversation-guide.pdf

1.14.17 MA 4.6 Depression Screening and Follow-Up

1.14.17.1 Screening

What is the measure description?
Members screened for clinical depression at least once during the MY

HEDIS	Stars	Withhold	Mass Health
			✓

Who should be screened?
Members 21+ years of age

When should it be completed?
January 1, 2025, through December 31, 2025

Acceptable Documentation
✓ Examples of depression screenings include but are not limited to: ○ Patient Health Questionnaire (PHQ-2 or PHQ-9) ○ Beck Depression Inventory (BDI or BDI-II) ○ Center for Epidemiologic Studies Depression Scale (CES-D) ○ Depression Scale (DEPS) ○ Duke Anxiety-Depression Scale (DADS) ○ Geriatric Depression Scale (GDS)

Best Practice Tips:
- ✓ Treat depression screening as a vital sign and record results at every visit
- ✓ For screenings completed on paper, scan and enter the results into the member's legal health record

What are the exclusions for this measure?

Definition	Codes	Code System
Bipolar disorders	F30.10-.13, F30.2-.4, F30.8-.9, F31.0, F31.10-.13, F31.2, F31.30-.32, F31.4-.5, F31.60-.64, F31.70-.78, F31.81, F31.89-.9	ICD10
Major depression	F32.0-.4, F32.9, F33.0-.3, F33.9, F33.41	ICD10

Members diagnosed with a terminal illness; who refuse to participate in the tobacco use screening; whose functional capacity or motivation to improve may impact the accuracy of the results; or who are in an urgent or emergent situation due to a medical reason where time is of the essence and to delay treatment would jeopardize the member's health status.

1.14.17.2 Follow-Up

What is the measure description?

Brief counseling or follow-up care after a positive depression screening

HEDIS	Stars	Withhold	Mass Health
			✓

When should it be completed?

Within 30 days of a positive screening

Acceptable Documentation
✓ Counseling, education, or distribution of educational materials, and where to get help ✓ Referral to a practitioner who is qualified to diagnose and treat depression ✓ Prescription of antidepressant medications ✓ Suicide risk assessment

Best Practice Tips:

- ✓ Schedule a follow-up visit within 30 days to review adherence to treatment
- ✓ If needed, refer to a behavior health specialist for further evaluation and treatment
- ✓ If you need assistance with identifying providers in the network, contact CCA for assistance