HEDIS® Measurement Year (MY) 2023

Guidance for Providers

PacificSource HEALTH PLANS

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✪ = HEDIS® measure is part of the Medicare Stars Program ☎ = Gap in care can be closed via a telehealth visit

What's new for HEDIS®[1] 2023MY provider guidance

Measures added or revised for 2023MY

- Topical Fluoride for Children (TFC)
- Oral Evaluation, Dental Services (OED)
- Deprescribing of Benzodiazepines in Older Adults (DBO)
- Emergency Department Visits for Hypoglycemia in Older Adults with Diabetes (EDH)
- Cervical Cancer Screening (CCS-E)
- Social Need Screening and Intervention (SNS-E)

Retired measures for 2023MY

- Breast Cancer Screening (BCS)*
- Annual Dental Visit (ADV)
- Frequency of Selected Procedures (FSP)
- Flu Vaccinations for Adults Ages 18–64 (FVA)
- Flu Vaccinations for Adults Ages 65 and Older (FVO)
- Pneumococcal Vaccination Status for Older Adults (PNU)

*Only the BCS-E measure will be reported

Overall guidance

- Moved all optional exclusions to required exclusions.

Hybrid measure guidance

Additional details included in this guide on properly documenting hybrid measure requirements for compliance

[1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Purpose of PacificSource HEDIS® 2023MY Guidance for Providers

This document is designed to help providers and their staff with quality-improvement efforts driven by HEDIS® measures. In this guide, you'll find information about:

- HEDIS® timelines
- How HEDIS® timelines align with other quality initiatives
- Audit (or medical record review) tips, tricks, and expectations
- HEDIS® measures
- Required documentation
- Common codes

This document is not intended as an all-inclusive list of all reportable HEDIS® measures or applicable codes. The measures included in this document are those that PacificSource targets for provider and/or member initiatives. For a full list of HEDIS® measures or other information about the data set, visit NCQA.org/HEDIS/Measures.

This information was current at the time it was distributed, and was prepared as a tool to assist providers, coders, and other community partners. Although every reasonable effort has been made to ensure the accuracy of this information, it is the provider's responsibility to ensure the correct claims and medical records submission. The content provides a general summary that explains some aspects of the NCQA HEDIS® Program, but is not a legal document.

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Tips to save you time and resources

We have created icons so you can quickly identify information to help save time and resources.

Star Icon: Keep an eye out for measures that have a star icon after their name. This icon allows you to quickly identify which HEDIS® measures are part of the Medicare Stars Program.

Clock Icon: This icon quickly identifies opportunities to reduce your administrative burden. These tips walk you through how to reduce the amount of chart requests you may receive throughout the year but mainly during the HEDIS® audit from all payers. Examples:

- Blood Pressure (BP) and Diabetes A1C codes can be billed to identify members' BP/A1C readings.
- Z Codes—these can be billed to reflect historical information, such as history of mastectomy and/or colectomy.

Phone Icon: These measures allow for gaps in care to be closed via a provider telehealth (telephone or video) visit with member self-reporting. Examples include (but are not limited to):

- Controlling High Blood Pressure (CBP)
- Hemoglobin A1c Control for Patients with Diabetes (HBD)
- Well-Child Visits (WCV and W30)

Providing this information can further reduce the number of members who have gaps in care on your monthly gap-in-care list, as well as reduce chart requests.

HEDIS® basics

What is HEDIS®?

The Healthcare Effectiveness Data and Information Set (HEDIS®) is a set of standardized performance measures developed and maintained by the National Committee for Quality Assurance (NCQA), and is used by both the NCQA and the Centers for Medicare & Medicaid Services (CMS) to monitor the performance of managed care organizations.

HEDIS® measures impact Commercial, Marketplace, Medicare, and Medicaid plans. PacificSource only reports HEDIS® data to NCQA for Commercial, Marketplace, and Medicare; and to CMS for Medicare. PacificSource does not report HEDIS® data to NCQA or CMS for Medicaid plans.

PacificSource Medicaid plans are currently in Oregon only and are measured via a set of Quality Incentive Measures (QIM) by the Oregon Health Authority (OHA). (For more information about the different quality improvement programs, see the FAQ section of this document.)

HEDIS® and HIPAA

Under the Health Insurance Portability and Accountability Act (HIPAA), data collection for HEDIS® is permitted, and the release of this information requires no special patient consent or authorization. Please be assured that PacificSource maintains member protected health information (PHI) in accordance with all federal and state laws.

How is measure data collected?

Measure data collection methods include Administrative, Hybrid, Survey, and Electronic Clinical Data Systems (ECDS).

- **Administrative** measures collect data from claims, encounter, enrollment, and provider systems. This includes supplemental data received from our provider partners and vendor programs.
- **Hybrid** measures collect data from both administrative data and medical record review.
- **ECDS** measures collect data directly from electronic databases, such as provider electronic medical records (EMRs).

How is measure data reported?

Measure data is reported to our provider partners on a monthly basis and as requested. We send gap-in-care reports to our provider partners by the 20th of each month. These reports reflect members with gaps in care.

Provider role with HEDIS®

Providers play a key role in how HEDIS® data collection functions. PacificSource is committed to working with you to make the process as painless as possible while promoting the best care outcomes for your patients and our members.

Throughout the year, the PacificSource quality team offers training opportunities addressing such topics as Risk Adjustment 101, Documentation Enhancement, Coding, STARS and HEDIS® 101, Smoking Cessation, Colorectal Cancer Screening, Women's Cancer Screenings, and more.* Contact QualityImprovement@PacificSource.com for more information on educational opportunities.

*Some of these training opportunities may provide professional development units or continuing education units. Please contact your quality representative at PacificSource for more information.

Claims

The information submitted on your claim will either include or exclude the member from the eligible population for a given measure. In addition, claims information could immediately close the gap in care. Timely submission and accurate coding of claims help provide a detailed reflection of a provider's performance.

Remote EMR access

Allowing PacificSource remote access to your electronic medical records (EMRs) allows our quality team to perform medical-record review for measures and helps close gaps in care. Not only does this improve gap-list quality, it also saves your team time and resources.

Why is HEDIS® important?

HEDIS® is a tool that allows providers to ensure appropriate and timely care for their patients by identifying and eliminating gaps in patient care. Participation in providing HEDIS® data through claims, coding, and medical record review translates to improved measure rates. As these measure rates increase, there is potential for providers to earn additional incentive revenue, experience decreased administrative burden, and enhance patient care.

Provide a data file

Another way to ensure that your gap lists contain only members who have a true care gap is to provide PacificSource with a data file from your EMRs. Providing a data file will close care gaps when applied to our database without the need for chart retrieval or medical record review. Measures commonly used in data files from providers include:

- Hemoglobin A1c Control for Patients with Diabetes
- Colorectal Cancer Screening
- Breast Cancer Screening
- Controlling High Blood Pressure
- And many more

HEDIS® audit and timeline

The HEDIS® product life cycle lasts eighteen months, beginning January 1 of the measurement year 2023 through June 15 of the submission year 2024. The 2023 HEDIS® measures referenced in this guide apply to services from January 1, 2023, and ending December 31, 2023* and the HEDIS® audit between January 1 and June 15, 2024.

*Certain HEDIS® measures have a varying measurement period determined by technical specification, diagnosis and/or event date(s).

Chart retrieval and medical record review for HEDIS® audit

PacificSource contracts with a vendor partner during the HEDIS® audit for chart retrieval, chart abstraction, and medical record review. When the vendor contacts you for charts, you will have several methods by which you can return the requested charts:

1. If there is a large volume, the vendor can send a field agent to your facility to collect charts. They will schedule a date and time for retrieval. Depending on the volume of the charts requested, they could be at your facility one or more days.
2. Grant remote EMR access to the vendor retrieval team. The vendor is bound by the terms of our Business Associate Agreement (BAA) and complies with all state and federal laws, including HIPAA, in the handling of PHI.
3. Someone from your facility collects and returns the charts to the vendor by mail, fax, or secure portal.
4. Providers who use the Datavant (formerly CiOX) ROI product for medical record management will deliver charts through their Datavant ROI representative.

Once the vendor makes the request, please return the charts within five business days. The HEDIS® timeline for chart retrieval is brief. The earlier we receive charts, the better opportunity we have to fully abstract and review the record for measure compliance and, if necessary, re-chase the record at another facility if compliance is not found.

PacificSource does its best to use chart logic that directs us to the best source of the member record for the measure in question. We understand that we are not the only payer asking for charts, and it is our goal to work with our providers to minimize requests and unnecessary stress during this time.

Optum and Datavant provide a portal through which charts can be securely uploaded. Please see Appendix 1 for an example of the portal.

HEDIS® audit FAQs

Is the HEDIS® audit the only time PacificSource will ask for medical records?

No. PacificSource may also ask for medical records throughout the year as an attempt to close gaps prospectively. In addition, HEDIS® is one of several quality initiatives in which PacificSource is required to participate. Requests made for HEDIS® charts will clearly state they are for the HEDIS® Medical Record Review.

Should I allow a record review for a member who is no longer with PacificSource or for a member who is deceased?

Yes. Medical record reviews may require data collection on services obtained over multiple years.

Am I required to provide medical records for a member who was seen by a physician who has since retired, died, or moved?

Yes. HEDIS® data collection includes reviewing medical records as far back as 10 years. Archived medical records/data may be required to complete data collection.

What is my responsibility regarding HEDIS® data collection?

The vendor will contact you to establish a date for onsite, fax, portal, or mail data delivery. A patient list will be faxed to you so the requested medical records can be made available for the appointment or for faxing/mailing the documentation to the vendor. If a chart for a patient included on the vendor list is not available at your practice location, please notify the vendor immediately.

As a contracted PacificSource provider, your provider agreement requires that you participate in quality improvement activities, including HEDIS.® Our participating provider contract states that providers must provide access to members' records for these purposes at no cost and without requiring a signed release.*

*Contracts vary between provider groups and/or state statutes that allow payment to providers for charts.

Who is responsible for coordinating this process in my office?

Your office manager or another employee you designate should be responsible for making records available. In offices with a medical record department, your designee should coordinate with the medical records contact so they know that the request is authorized.

When will the vendor, or internal health plan staff, need the records?

HEDIS® data collection is time-sensitive. Medical records should be made available on the date of the on-site review, or by the delivery date agreed on with the vendor's representative.

Chart retrieval will begin in late January and will be completed by the end of the first week of May.

It is imperative that you respond to a request for medical records within five business days to ensure we are able to report complete and accurate rates to state and federal regulatory bodies, as well as NCQA.

Tip: By granting EMR access to our third-party retrieval vendor Datavant, your office can decrease its administrative burden. You can do this at any point in the year. EMR access allows vendor "self-retrieval" of chase list charts with minimal provider intervention compared to faxing or mailing options. Additionally, Datavant offers a web portal that allows providers to upload charts securely if direct EMR access is not a preferred or allowed method of retrieval.

HEDIS® year-round FAQs

Is PacificSource able to help providers manage their gap reports?

Yes! There are two simple ways to make this happen: Provide remote EMR access to our HEDIS® audit nurses, and provide PacificSource with a monthly data extraction from your EMR. You may contact QualityImprovement@PacificSource.com for more information.

Can performance-gap reports be more actionable?

With your help, they can. There are several ways that gap reports can be pared down to include the gaps most likely to be actionable.

1. Make sure claims are submitted in a timely manner and are coded correctly. Claims data drives most measure-eligible populations, which means that members are either included or excluded from the denominator based on certain healthcare events throughout the year.
2. Include applicable codes in claims reporting so gaps in care can be closed with the member claim. For example, if you have a patient with a gap in Controlling High Blood Pressure (CBP), you can close that gap if the member claim is coded to include the blood pressure range or codes. Or if a member has a Breast Cancer Screening gap and they have a history of double mastectomy, you can have them excluded from the measure by using the appropriate ICD-10 code.
3. Provide PacificSource with remote EMR access. Our HEDIS® audit nurses can help—contact QualityImprovement@PacificSource.com to find out how.
4. Provide PacificSource with a data file that we can apply to our database to close care gaps you might otherwise have to provide a chart to close. Contact QualityImprovement@PacificSource.com to find out how.

How can I submit chart documentation to PacificSource to close a HEDIS® gap in care?

Please send your charts with a list of who and what we should expect to see, either by secure email to HEDIScharts@PacificSource.com or by secure fax to 541-322-6426. If you would like an email confirmation that your charts were received, please include where we can send confirmation.

What happens after I submit a chart?

The chart is reviewed within 48 hours and compliant data is abstracted if applicable.

What if the chart I sent does not create compliance?

Each month, PacificSource analyzes charts received to identify trends and areas of opportunity, and feedback is shared with our providers. Please note not all noncompliant charts are captured. If you anticipated a member would drop from a gap report and the member is on the following month's gap report, please reach out to your Population Health Strategist.

When can I anticipate compliance reflected in a gap report after I send a chart to HEDIScharts@PacificSource.com?

Compliant charts should fall off the gap report the month following receipt. Gap reports are distributed to our providers on or around the 15th of each month. For example, if we received a chart on November 17, the chart will be reviewed and data abstracted, if applicable, within 48 hours. If the chart is compliant, the gap report distributed around December 15 will reflect the compliance. Please note: charts submitted after January 10 may not be reflected on your December gap-in-care report.

Are there any measures that do not receive year-round chart review?

Yes, certain HEDIS® measures require the most recent and/or last reading of the measurement year to create compliance, or their specifications do not allow for efficient review and abstraction. Generally, these charts will only be abstracted and applied for compliance in the third quarter of the measurement year through the end April of the submission year. These measures include:

- Controlling High Blood Pressure (CBP)
- Hemoglobin A1c Control for Patients with Diabetes (HBD)
- Transitions of Care (TRC)

When will the first gap reports of the year be available?

The HEDIS® gap reports should be distributed to our providers in April and will reflect noncompliant members through end of March.

What is the benefit for our clinic to submit this chart documentation throughout the year?

Submitting charts will improve the actionability of your monthly gap report as well as reduce the chart-retrieval burden during the HEDIS® audit. Additionally, submitting charts directly to our HEDIS® core team allows for chart review by our year-round audit nurses outside of the traditional HEDIS® retrieval "season."

When can we expect a final performance report from the previous year?

After the HEDIS® data collection and submission is completed and results have been verified by NCQA. Finalized results are generally available in late September of each year.

HEDIS® Measurement Year 2023MY

Administrative Only Measures

Chlamydia Screening in Women (CHL)

Population	Members 16–24 years of age as of December 31 of the measurement year
Product Lines	Commercial, Medicaid
What's Reported	The percentage of women who were identified as sexually active and who had at least one test for chlamydia during the measurement year. Report two age stratifications and a total rate: • Women 16–20 years of age • Women 21–24 years of age • Total (The total is the sum of the age stratifications.)
Measurement Period	Measurement year (2023)
Exclusions	• Members in hospice or using hospice services any time during the measurement year • Members who had a pregnancy test during the measurement year and a prescription for isotretinoin on the date of the pregnancy test or six days after the pregnancy test; or a pregnancy test during the measurement year and an x-ray on the date of the pregnancy test or six days after the pregnancy test • Members who died any time during the measurement year
Common Codes Used for Compliance	**CPT®:** Chlamydia Tests – 87110, 87270, 87320, 87490, 87491, 87492, and 87810 Use of these codes could reduce gaps without chart submission.
Supplemental Data Eligible	Yes, providers may share supplemental data files from their EMR with PacificSource to close this care gap. This may reduce chart asks during the chart-retrieval season.

Cardiac Rehabilitation (CRE)

Population	Members 18 years and older with qualifying cardiac event
Product Lines	Commercial, Medicaid, and Medicare
What's Reported	The percentage of members 18 years and older who attended cardiac rehabilitation sessions following a qualifying cardiac event (coronary artery bypass grafting, heart and lung transplant, heart valve replacement or repair, myocardial infarction or percutaneous coronary intervention). Four rates are reported: • Initiation – Members who attend 2 or more cardiac rehab sessions within 30 days of event • Engagement 1 – Members who attend 12 or more cardiac rehab sessions within 90 days of event • Engagement 2 – Members who attend 24 or more cardiac rehab sessions within 180 days of event • Achievement – Members who attend 36 or more cardiac rehab sessions within 180 days of event
Intake Period	12-month window starting July 1 of year prior to measurement year (2022) and ending June 30 of measurement year (2023).
Measurement Period	Measurement year (2023)
Exclusions	• Discharged from IP with any of the following within 180 days after Episode Date: MI, CABG, Heart or Heart/Lung Transplant, or Heart Valve Repair or Replacement • PCI in any setting, within 180 days after Episode Date • Hospice – Members in hospice or using hospice services any time during the measurement period • Palliative Care – Members who are receiving palliative care any time during the intake period through the end of the measurement year (ICD-10-CM code Z51.5) • Institutional SNP (I-SNP) – Members who were enrolled in an I-SNP or long-term institution any time during the measurement year • Frailty and Advanced Illness – Members with frailty and advanced illness • Members who died any time during the measurement year
Common Codes Used for Compliance	**CPT®:*** • Cardiac Rehabilitation – 93797 and 93798 **HCPCS:** • Cardiac Rehabilitation – G0422, G0423 and S9472 *CPT® is a registered trademark of the American Medical Association (AMA).
Supplemental Data Eligible	Yes, providers may share supplemental data files from their EMR with PacificSource to close this care gap. This may reduce chart asks during the chart-retrieval season. Supplemental Data may not be used to identify I-SNP, Frailty, and/or Advanced Illness exclusions.

Appropriate Testing for Pharyngitis (CWP)

Population	Members 3 years and older
Product Lines	Commercial, Medicaid, and Medicare
What's Reported	The percentage of episodes where the member was diagnosed with pharyngitis, dispensed an antibiotic, and received a group A streptococcus (strep) test for the episode. Report three age stratifications and total rate: • 3–17 years • 18–64 years • 65 years and older • Total (The total is the sum of the age stratifications.)
Measurement Period	July 1 of the year prior to the measurement year (2022) through June 30 of the measurement year (2023)
Exclusions	• Members in hospice or using hospice services any time during the measurement year • Members who died any time during the measurement year
Common Codes Used for Compliance	**CPT®:** Group A Strep Tests – 87070, 87071, 87081, 87430, 87650, 87651, 87652, and 87880 Use of these codes could reduce gaps without chart submission.
Supplemental Data Eligible	Yes, providers may share supplemental data files from their EMR with PacificSource to close this care gap. This may reduce chart asks during the chart-retrieval season.

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

Population	Members 18 years and older who have multiple high-risk chronic conditions who have visited the Emergency Department (ED)
Product Lines	Medicare
What's Reported	The percentage of members 18 years as of the ED visit with multiple high-risk chronic conditions who had a follow-up service within seven (7) days of the ED visit (8 total days). Report two age stratifications and total rate: • 18–64 years • 65 years and older • Total (The total is the sum of the age stratifications.)
Measurement Period	January 1 of measurement year (2023) to December 24 of the measurement year when the member was 18 years or older on the date of the ED visit.
Eligible Chronic Condition Diagnosis	• COPD and Asthma • Heart Failure • Alzheimer's Disease (and related disorders) • Stroke and transient ischemic attack • Chronic Kidney Disease • Atrial Fibrillation • Depression • Acute myocardial infarction Note: Eligible chronic condition diagnosis can occur in measurement year (2023) or year prior (2022), but diagnosed prior to ED visit date
Exclusions	• Hospice – Members in hospice or using hospice services any time during the measurement year • Members who died any time during the measurement year

Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions (FMC) ✪ *continued*

Common Codes Used for Compliance	**CPT®:*** • BH Outpatient – 98960, 98961, 98962, 96978, 99201, 99211, 99241, 99342, 99381, 99391, 99401, 99411, 99483, 99492, 99493, 99494, and 99510 • Case Management – 99366 • Complex Care Management – 99439, 99487, 99489, 99490 and 99491 • Outpatient – 99201, 99211, 99241, 99341, 99381, 99391, 99401, 99411. 99429, 99455 and 99483 • Telehealth Visits – 98966, 98967, 98968, 99441, 99442 and 99443 • Transitional Care Management – 99495 and 99496 **HCPCS:** • BH Outpatient – G0512, G0177, G0409, G0463, H0004, H0037, H2010, H2015, H2019 and T1015 • Case Management – T1016, T1017, T2022, T2023 • Complex Care Management – G0506 • Outpatient – G0402, G0438, G0439, G0463, T1015 *CPT® is a registered trademark of the American Medical Association (AMA).
Supplemental Data Eligible	Yes, providers may share supplemental data files from their EMR with PacificSource to close this care gap. This may reduce chart asks during the chart-retrieval season.

Kidney Evaluation for Patients with Diabetes (KED) ✪

Population	Members 18–85 years of age with a diagnosis of diabetes (Type 1 and Type 2)
Product Lines	Commercial, Medicaid, and Medicare
What's Reported	The percentage of members with diabetes who received a kidney health evaluation utilizing a urine albumin-creatinine ratio (uACR) and an estimated glomerular filtration rate (eGFR) during the measurement year. Note: Members must receive all test types in order to be compliant (three total – see compliance codes). The quantitative urine albumin test and urine creatinine test must be performed within four days of each other.
Measurement Period	The measurement year (2023)
Exclusions	• Hospice – Members in hospice or using hospice services any time during the measurement year • End Stage Renal Disease (ESRD) and Dialysis – Members with evidence of ESRD or Dialysis in their history on or prior to December 31 of the measurement year • Palliative Care – Members receiving palliative care any time during the measurement year (ICD-10-CM code Z51.5) • Institutional SNP (I-SNP) – Members who were enrolled in an I-SNP or long-term institution any time during the measurement year • Frailty and Advanced Illness – Members with frailty and advanced illness • Members who died during the measurement year
Common Codes Used for Compliance	**CPT®:*** • Estimated Glomerular Filtration Rate Lab Test – 80047, 80048, 80050, 80053, 80069, and 82565 AND • Quantitative Urine Albumin Lab Test – 82043 – Must be performed within four days of Urine Creatinine Test • Urine Creatinine Lab Test – 82570 – Must be performed within four days of Quantitative Urine Albumin Test Use of these codes could reduce gaps without chart submission. *CPT® is a registered trademark of the American Medical Association (AMA).
Supplemental Data Eligible	Yes, providers may share supplemental data files from their EMR with PacificSource to close this care gap. This may reduce chart asks during the chart-retrieval season. Supplemental Data may not be used to identify I-SNP, Frailty and/or Advanced Illness exclusions for this measure.

Use of Imaging Studies for Low Back Pain (LBP)

Population	Members 18–75 years of age
Product Lines	Medicare, Commercial, and Medicaid
What's Reported	The percentage of members with a primary diagnosis of low back pain who did not have an imaging study (x-ray, MRI, CT scan) within 28 days of the diagnosis. The measure is reported as an inverted rate. A higher score indicates appropriate treatment of low back pain. Report two age stratifications and a total rate: • 18 - 64 • 65 - 75 • Total The total is the sum of the two age stratifications
Measurement Period	January 1 – December 3 of the measurement year (2023)
Exclusions	• Members in hospice or using hospice services any time during the measurement year • Members receiving palliative care any time during the measurement year (ICD-10-CM code Z51.5) • Members who died any time during the measurement year • Members who had any of the following: – Cancer any time during the member's history through 28 days after the IESD – Trauma any time during the 3 months (90 days) prior to the IESD through 28 days after the IESD – Intravenous drug abuse any time during the 12 months (1 year) prior to the IESD through 28 days after the IESD – Neurologic impairment any time during the 12 months (1 year) prior to the IESD through 28 days after the IESD – HIV any time during the member's history through 28 days after the IESD – Spinal infection any time during the 12 months (1 year) prior to the IESD through 28 days after the IESD – Major organ transplant any time during the 12 months (1 year) prior to the IESD through 28 days after the IESD – Prolonged use of corticosteroids for 90 consecutive days during any period 366 days prior to IESD – Osteoporosis therapy or a dispensed prescription to treat osteoporosis any time during the member's history through 28 days after the IESD – Fragility fracture any time during the 3 months (90 days) prior to the IESD through 28 days after the IESD – Lumbar surgery any time during the member's history through 28 days after the IESD – Spondylopathy any time during the member's history through 28 days after the IESD • Members with frailty and advanced illness

Common Codes Used for Compliance	**ICD-10:** • Uncomplicated Low Back Pain – M47.26, M47.816, M47.817, M48.061, M51.16, M51.26 M51.36, M51.37, M53.3, M54.16, M54.17, M54.31, M54.32, M54.41, M54.42, M54.5, M54.9, M99.03, M99.04, and S39.012A **CPT®:** • Imaging Study – 72020, 72052, 72100, 72110, 72114, 72120, 72131, 72132, 72133, 72141, 72142, 72146, 72147, 72148, 72149, 72156, 72158, 72200, 72202, and 72220 Use of these codes could reduce gaps without chart submission.
Supplemental Data Eligible	Yes, providers may share supplemental data files from their EMR with PacificSource to close this care gap. This may reduce chart asks during the chart-retrieval season.

Osteoporosis Management in Women Who Had a Fracture (OMW) ✪

Population	Women 67–85 years of age
Product Lines	Medicare
What's Reported	The percentage of women diagnosed with a fracture and who had either a bone mineral density (BMD) test or prescription for a drug to treat osteoporosis within six months, or 180 days of the fracture.
Measurement Period	July 1 of the year prior to the measurement year (2022) through June 30 of the measurement year (2023)
Exclusions	• Members in hospice or using hospice services any time during the measurement year • Members receiving palliative care any time during the measurement year (ICD-10-CM code Z51.5) • Members who had a bone mineral density test during the 24 months prior to the episode date • Members who had a claim/encounter for osteoporosis therapy during the 12 months prior to the episode date • Members who received a dispensed prescription or had an active prescription to treat osteoporosis during the 12 months prior to the episode date. (Examples include bisphosphonates or other agents. Does not include calcium + D.) • Members who were enrolled in an I-SNP or long-term institution any time during the measurement year • Members with frailty and advanced illness • Members who died any time during the measurement year
Common Codes Used for Compliance	**CPT®:** • Bone Mineral Density Tests – 76977, 77078, 77080, 77081, 77085, and 77086 – Compliant test types include: Ultrasonography, Plain Radiography, DEXA Scan, Bone Density Scan, Heel Ultrasound, or CT Bone Density Study **HCPCS:** • Long-Acting Osteoporosis Medications – J0897, J3489, J1740 • Osteoporosis Medication Therapy - J0897, J1740, J3110, J3111, and J3489
Supplemental Data Eligible	Yes, providers may share supplemental data files from their EMR with PacificSource to close this care gap. This may reduce chart asks during the chart-retrieval season. Supplemental Data may not be used to identify I-SNP, Frailty, and/or Advanced Illness exclusions.

Plan All-Cause Readmissions (PCR) ✪

Population	Members 18 years and older
Product Lines	Commercial, Medicaid, and Medicare
What's Reported	The number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. For Commercial and Medicaid, report only members 18–64 years of age. Data are reported in the following categories: • Count of Index Hospital Stays (IHS) • Count of Observed 30-Day Readmissions • Count of Expected 30-Day Readmissions
Measurement Period	January 1 through December 1 of the measurement year (2023)
Exclusions	• Death of member during stay • Members in hospice • Members with any of the following: – A principle diagnosis of pregnancy – A principal diagnosis for a condition originating in the perinatal period • A planned hospital stay for any of the following: – A planned admission using a principle diagnosis of maintenance chemotherapy – A principal diagnosis of rehabilitation – An organ transplant – A potentially planned procedure without a principal acute diagnosis
Supplemental Data Eligible	No

Statin Therapy for Patients with Cardiovascular Disease (SPC) ✪

Population	Males 21–75 years of age and females 40–75 years of age
Product Lines	Commercial, Medicaid, and Medicare
What's Reported	The percentage of members who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and met the following criteria. The following rates are reported: • Received Statin Therapy. Members who were dispensed at least one high-intensity or moderate-intensity statin medication during the measurement year. • Statin Adherence 80%. Members who remained on a high-intensity or moderate-intensity statin medication for at least 80% of the treatment period.
Measurement Period	• Measurement year (2023) • Year prior to the measurement year (2022)
Exclusions	• Members in hospice or using hospice services any time during the measurement year • Members receiving palliative care any time during the measurement year (ICD-10-CM code Z51.5) • Members with a diagnosis of pregnancy during the measurement year or the year prior to the measurement year • In vitro fertilization in the measurement year or year prior to the measurement year • Dispensed at least one prescription for clomiphene during the measurement year or the year prior to the measurement year • ESRD or dialysis during the measurement year or the year prior to the measurement year—example ICD 10 codes include N18.5, N18.6, V45.11 • Cirrhosis during the measurement year or the year prior to the measurement year—example ICD codes include K70.30, K70.31, K71.7, K74.3, K74.4, K74.5, K74.60, K74.69 • Myalgia, myositis, myopathy, or rhabdomyolysis during the measurement year—example ICD-10 codes include G72.0, G72.9, M60.9, M62.82, M60.80 • Members who died any time during the measurement year • Members who were enrolled in an I-SNP or long-term institution any time during the measurement year
Supplemental Data Eligible	Yes, providers may share supplemental data files from their EMR with PacificSource to close this care gap. This may reduce chart asks during the chart-retrieval season. Supplemental Data may not be used to identify I-SNP, Frailty, and/or Advanced Illness exclusions for this measure.

Statin Therapy for Patients with Diabetes (SPD) ☎

Population	Members 40 - 75 years of age
Product Lines	Commercial, Medicaid, and Medicare
What's Reported	The percentage of members age 40–75 during the measurement year who had a diagnosis of diabetes but did not have a diagnosis of atherosclerotic cariovascular disease (ASCVD). The following two rates are reported: 1. Received Statin Therapy. Members who were dispensed at least one statin of any grade intensity, during the measurement year. 2. Statin Adherence 80%. Members who remained on statin medication for at least 80% of the treatment period.
Measurement Period	• Measurement year (2023) • Year prior to the measurement year (2022)
Exclusions	• Members without a diagnosis of diabetes in any setting, during the measurement year or the year prior to the measurement year, **and** a diagnosis of polycystic ovarian syndrome (PCOS), gestational diabetes, and/or steroid-induced diabetes, in any setting during the measurement year or the year prior to the MY • Members in hospice or using hospice services any time during the measurement year • Members receiving palliative care any time during the measurement year (ICD CM code Z51.5) • Members with a diagnosis of pregnancy during the measurement year or the year prior to the measurement year • In vitro fertilization in the measurement year or year prior to the measurement year • Dispensed at least one prescription for clomiphene during the measurement year or the year prior to the measurement year • ESRD or dialysis during the measurement year or the year prior to the measurement year—example ICD codes include N18.5, N18.6, V45.11 • Cirrhosis during the measurement year or the year prior to the measurement year—example ICD codes include K70.30, K70.31, K71.7, K74.3, K74.4, K74.5, K74.60, K74.69 • Myalgia, myositis, myopathy, or rhabdomyolysis during the measurement year—example ICD codes include G72.0, G72.9, M60.9, , M62.82, M60.80 • Members with frailty and advanced illness • Members who were enrolled in an I-SNP or long-term institution any time during the measurement year
Supplemental Data Eligible	Yes, providers may share supplemental data files from their EMR with PacificSource to close this care gap. This may reduce chart asks during the chart-retrieval season. Supplemental Data may not be used to identify I-SNP, Frailty, and/or Advanced Illness exclusions for this measure.

Child and Adolescent Well-Care Visits (WCV)

Population	Members 3 to 21 years of age in the measurement year
Product Lines	Commercial and Medicaid
What's Reported	The percentage of members 3 to 21 years of age who had one or more well-care visit with a PCP or OB/GYN provider within the measurement year Report three age stratifications and a total rate: • 3–11 years • 12–17 years • 18–21 years • Total (the sum of the age stratifications)
Measurement Period	Measurement year (2023)
Exclusions	• Members in hospice or using hospice services any time during the measurement year • Members who died any time during the measurement year
Common Codes Used for Compliance	**CPT®:** • Well-Care – 99381, 99382, 99383, 99384, 99385, 99391, 99392, 99393, 99394, 99395, and 99461 **HCPCS:** • Well-Care – G0438, G0439, S0610, S0612, S0613, and S0302
Supplemental Data Eligible	Yes, providers may share supplemental data files from their EMR with PacificSource to close this care gap. This may reduce chart asks during the chart-retrieval season.

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

Population	Members who either turn 15 months in the measurement year (rate 1); or members 15–30 months (rate 2) in the measurement year
Product Lines	Commercial and Medicaid
What's Reported	• The percentage of members who had a specific number of well-child visits with a PCP during the last 15 months. • Rate 1: Children who turned 15 months in the measurement year and had 6 or more well-child visits. • Rate 2: Children who turned 30 months during the measurement year with 2 or more well-child visits.
Measurement Period	Measurement year (2023)
Exclusions	• Members in hospice or using hospice services any time during the measurement year • Members who died any time during the measurement year
Common Codes Used for Compliance	**CPT®:** • Well-Care—99381, 99382, 99383, 99384, 99385, 99391, 99392, 99393, 99394, 99395, and 99461 **HCPCS:** • Well-Care—G0438, G0439, S0610, S0612, S0613, and S0302
Supplemental Data Eligible	Yes, providers may share supplemental data files from their EMR with PacificSource to close this care gap. This may reduce chart asks during the chart-retrieval season.

HEDIS® Measurement Year 2023MY

Hybrid Measures

Controlling High Blood Pressure (CBP) ✪☎

Population	Members 18–85 years of age with hypertension
Product Lines	Commercial, Medicaid, and Medicare
What's Reported	The percentage of members who had a diagnosis of hypertension and whose BP was adequately controlled (<140/90 mm Hg) during the measurement year. The most recent blood pressure reading during the measurement year taken on or after the second diagnosis of hypertension.
Measurement Period	Event Diagnosis – January 1 of the year prior to the measurement year (2022) and June 30 of the measurement year (2023) Compliant Readings – The measurement year (2023)
Documentation	• Notation of the lowest systolic and lowest diastolic from the most recent BP reading in the medical record for the measurement year (2023) • Member reported BP values from telehealth visit, e-visit, or virtual check-in are allowed using digital devices (member readings with manual stethoscope and BP cuff disallowed) Note: Average BP readings are compliant but BP ranges are disallowed
Exclusions	• Members in hospice or using hospice services any time during the measurement year • Members who died any time during the measurement year • Members receiving palliative care any time during the measurement year (ICD-10-CM code Z51.5) • Members who were enrolled in an I-SNP or long-term institution any time during the measurement year • Members with frailty or advanced illness • Members with evidence of ESRD, dialysis, nephrectomy, or kidney transplant any time during the member's history on or prior to December 31 of the measurement year • Members with a diagnosis of pregnancy during the measurement year • Members who had a nonacute inpatient admission during the measurement year
Common Codes Used for Compliance	**CPT® II:** • Systolic Less Than 140 – 3074F, 3075F • Diastolic Less Than 80 – 3078F • Diastolic 80-89 – 3079F Use of CPT-II codes are highly encouraged to reduce chart burden and increase patient monitoring to ensure gap closure.
Common Chart Deficiencies	• Documented BP is out of control with no evidence of additional BP taken during the office visit • BP readings are not valid if taken on the same day as a diagnostic or therapeutic procedure that requires a medication regimen, a change in diet, or a change in medication

Supplemental Data Eligible	Yes, providers may share supplemental data files from their EMR with PacificSource to close this care gap. This may reduce chart asks during the chart-retrieval season. Supplemental Data may not be used to identify I-SNP, Frailty, and/or Advanced Illness exclusions for this measure.
Time-saving Tips	Submitting claims using the above CPT® II codes will reduce the number of chart asks you receive during the HEDIS® chart-retrieval season. It will also allow you to better track your performance throughout the year.

Cervical Cancer Screening (CCS)

Population	Women 24–64 years as of the measurement year (2023)
Product Lines	Commercial and Medicaid
What's Reported	The percentage of women who were screened for cervical cancer using any of the following criteria: • Women 21–64 years of age who had cervical cytology performed within the past 3 years • Women 30–64 years of age who had cervical high-risk human papillomavirus testing performed within the past 5 years • Women 30–64 years of age who had cervical cytology/high-risk human papillomavirus co-testing within the past 5 years
Measurement Period	• Commercial: The measurement year (2023) and the two years prior to the measurement period • Medicaid: The measurement year (2023)
Documentation	• Date of cervical cytology with result or finding • Date of hrHPV test with result or finding
Exclusions	• Members in hospice or using hospice services any time during the measurement period • Members receiving palliative care any time during the measurement year (ICD-10-CM code Z51.5) • Hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix any time during the member's history through December 31 of the measurement year
Common Codes Used for Compliance	**CPT®:** • Cervical Cytology – 88141, 88142, 88143, 88147, 88148, 88150, 88152, 88153, 88164, 88165, 88166, 88167, 88174 and 88175 • High Risk HPV Tests – 87624 and 87625 **HCPCS:** • Cervical Cytology – G0123, G0124, G0141, G0143, G0144, G1047, G0145, Q0091, and P3001 • High Risk HPV Tests – G0476 Use of these codes could reduce gaps without chart submission.
Common Chart Deficiencies	• Documentation of hysterectomy that does not state removal of the cervix. • Must state "complete" or "vaginal hysterectomy" to meet criteria for hysterectomy with no residual cervix. • Biopsies may not be included in compliance as they are diagnostic and therapeutic only and not valid for primary cervical cancer screening(s)
Supplemental Data Eligible	Yes, providers may share supplemental data files from their EMR with PacificSource to close this care gap. This may reduce chart asks during the chart-retrieval season.
Time-saving Tips	Submit a claim with the appropriate code to indicate absence of cervix. Common Z codes are Z90.710 and Z90.712. The member will be excluded from the measure for as long as she is a member of our plan. Chart notes may also be submitted to confirm history of hysterectomy.

Hemoglobin A1c Control for Patients with Diabetes (HBD) ✪☎

Population	Members 18–75 years of age with diabetes (type 1 or type 2)
Product Lines	Commercial, Medicaid, and Medicare
What's Reported	Members in the population with hemoglobin A1c (HbA1c) levels of: **HbA1c poor control (>9.0%) or HbA1c control (<8.0%).** An HbA1c test during the measurement year. Use codes to identify the most recent HbA1c testing during the measurement year.
Measurement Period	Measurement year (2023)
Documentation	Date indicating when HbA1c test was performed and the result or finding – test type notation can include any of the following: • A1c • HbA1c • HgbA1c
Exclusions	• Members without a diagnosis of diabetes in the measurement year, or year prior **and** have a PCOS, gestational diabetes, or steroid-induced diabetes diagnosis • Members in hospice or using hospice services any time during the measurement year • Members who died any time during the measurement year • Members receiving palliative care any time during the measurement year (ICD-10-CM code Z51.5) • Members who were enrolled in an I-SNP or long-term institution any time during the measurement year • Member with frailty and advanced illness • Additional exclusions apply
Common Codes Used for Compliance	**CPT®:** • HbA1c Lab Test – 83036 and 83037 **CPT® II:** • Most recent HbA1c Level Greater Than or Equal to 7.0 and Less Than 8.0 – 3051F • Most recent HbA1c Less Than 7.0 – 3044F • Most recent HbA1c Level Greater Than or Equal to 8.0 and Less Than or Equal to 9.0 – 3052F • Most recent HbA1c Level Greater Than 9.0 – 3046F We highly encourage use of CPT-II codes to reduce chart burden, increase patient monitoring, and close gaps.
Supplemental Data Eligible	Yes, providers may share supplemental data files from their EMR with PacificSource to close this care gap. This may reduce chart asks during the chart-retrieval season. Supplemental Data may not be used to identify I-SNP, Frailty, and/or Advanced Illness exclusions for this measure.
Time-saving Tips	Submitting claims using the above CPT® II codes will reduce the number of chart asks you receive during the HEDIS® chart-retrieval season. It will also allow you to better track your performance throughout the year.

Eye Exam for Patients with Diabetes (EED) ✪

Population	Members 18–75 years of age with diabetes (type 1 or type 2)
Product Lines	Commercial, Medicaid, and Medicare
What's Reported	• Members in the population who have had an eye exam (retinal) performed • A retinal or dilated eye exam by an eye-care professional in the measurement year (2023), a negative retinal or dilated eye exam (negative for retinopathy) by an eye-care professional in the year prior to the measurement year (2022), or a bilateral eye enucleation any time during the member's history through December 31 of the measurement year.
Measurement Period	• Measurement year (2023) • Year prior to the measurement year (2022)
Documentation	• Retinal or dilated eye exam in the measurement year, performed by an eye-care professional (optometrist or ophthalmologist) in the measurement year (2023) • A negative retinal or dilated exam (negative for retinopathy) by an eye-care professional in the year prior to the measurement year (2022) • Bilateral eye enucleation any time during the member's history through December 31st of the measurement year (2023)
Exclusions	• Members without a diagnosis of diabetes in the measurement year or year prior **and** have a PCOS, gestational diabetes, or steroid-induced diabetes diagnosis. • Members in hospice or using hospice services any time during the measurement year • Members receiving palliative care any time during the measurement year (ICD-10-CM code Z51.5) • Institutional SNP (I-SNP) – Members who were enrolled in an I-SNP or long-term institution any time during the measurement year • Members with frailty and advanced illness • Members who died any time during the measurement year
Common Codes Used for Compliance	**CPT®:** • Diabetic Retinal Screening – 67028, 67030, 67031, 67228, 92002, 92004, 92012, 92014, 92134, 92235, 92250, 99203, 99204, 99205, 99213, 99214, 99215, 99243, 99244, and 99245 • Unilateral Eye Enucleation – 65091, 65093, 65101, 65103, 65105, 65110, 65112 and 65114 **CPT® II:** • Diabetic Retinal Screening Negative In Prior Year – 3072F • Eye Exam With Evidence of Retinopathy – 2022F, 2024F and 2026F • Eye Exam Without Evidence of Retinopathy – 2023F, 2025F and 2033F **HCPCS:** • Diabetic Retinal Screening – S3000, S0620, and S0621 Use of these codes could reduce gaps without chart submission.

Eye Exam for Patients with Diabetes (EED) ✪ *continued*

Common Chart Deficiencies	• The month/day/year is required • Evidence that an eye-care professional performed the exam is required (a letter, the exam report, notation of the eye-care provider's name or practice) – Evidence that the eye-care professional interpreted the results of fundal photography is acceptable • The results must be noted – For a plus (+) retinopathy result, the exam is required to have been performed during this year – For a negative (–) retinopathy result, the exam may have been performed this year or last year
Supplemental Data Eligible	Yes, providers may share supplemental data files from their EMR with PacificSource to close this care gap. This may reduce chart asks during the chart-retrieval season. Supplemental Data may not be used to identify I-SNP, Frailty, and/or Advanced Illness exclusions for this measure.
Time-saving Tips	Submitting a claim with 3072F may indicate that the member's retinal eye-exam results were negative for retinopathy for the year prior to the measurement year. If billed with this information, the member would be considered compliant for the current measurement year.

Blood Pressure Control for Patients with Diabetes (BPD) ☎

Population	Members 18–75 years of age with diabetes (type 1 or type 2)
Product Lines	Commercial, Medicaid, and Medicare
What's Reported	• Members in the population who have BP control (<140/90 mm Hg) • Identify the most recent BP reading taken during an outpatient visit or a nonacute inpatient encounter, or remote monitoring event during the measurement year.
Measurement Period	Measurement year (2023)
Documentation	• Identify the lowest systolic and lowest diastolic BP reading from the most recent BP notation in the medical record. If multiple readings were taken during the visit, use the lowest systolic and lowest diastolic BP on that date as the representative reading. • The systolic and diastolic results do not need to be from the same reading if taken on the same day. – Average BP is eligible, but BP ranges are disallowed
Exclusions	• Members without a diagnosis of diabetes in the measurement year, or year prior **and** have a PCOS, gestational diabetes, or steroid-induced diabetes diagnosis • Members in hospice or using hospice services any time during the measurement year • Members who died any time during the measurement year • Members receiving palliative care any time during the measurement year (ICD-10-CM code Z51.5) • Members who were enrolled in an I-SNP or long-term institution any time during the measurement year • Member with frailty and advanced illness
Common Codes Used for Compliance	**CPT® II:** • Diastolic Less Than 80 – 3078F • Systolic Less Than 140 – 3074F and 3075F Use of these codes could reduce gaps without chart submission.
Common Chart Deficiencies	• Documented BP is out of control with no evidence of additional BP taken during the office visit • BP readings are not valid if taken on the same day as a diagnostic or therapeutic procedure that requires a medication regimen, a change in diet, or a change in medication
Supplemental Data Eligible	Yes, providers may share supplemental data files from their EMR with PacificSource to close this care gap. This may reduce chart asks during the chart-retrieval season. Supplemental Data may not be used to identify I-SNP, Frailty and/or Advanced Illness exclusions for this measure.
Time-saving Tips	Submitting claims using the above CPT® II codes will reduce the number of chart asks you receive during the HEDIS® chart-retrieval season. It will also allow you to better track your performance throughout the year.

Childhood Immunization Status (CIS)

Population	Children 2 years of age during the measurement year
Product Lines	Commercial and Medicaid
What's Reported	The percentage of children who had four DTaP, three IPV, one MMR, three HiB, three HepB, one VZV, four PCV, one HepA, two or three RV, and two flu vaccines by their second birthday. Note: Influenza vaccination must be administered no earlier than six months of age, and no later than the child's second birthday. One of these may be an LAIV (influenza) vaccine administered only *on* the child's second birthday. LAIV administered prior to the child's second birthday will not be considered compliant.
Measurement Period	Measurement year (2023)
Documentation	Immunization evidence obtained from the medical record, count members where there is evidence that the antigen was rendered from one of the following: • Note indicating the name of the specific antigen(s) and the date of the immunization • Certification of immunization prepared by an authorized healthcare provider or health agency including the specific dates and types of the immunizations administered
Exclusions	• Members in hospice or using hospice services any time during the measurement period • Any of the following on or before the child's second birthday: – Severe combined immunodeficiency – Immunodeficiency – HIV – Lymphoreticular cancer, multiple myeloma or leukemia – Intusseusception

Childhood Immunization Status (CIS) *continued*

Common Codes Used for Compliance	**CPT®:** • DTaP Vaccine – 90697, 90698, 90700, and 90723 • Haemophilus Influenzae Type B (HiB) Vaccine – 90644, 90647, 90648, 90697, 90698, and 90748 • Hepatitis A Vaccine – 90633 • Hepatitis B Vaccine – 90697, 90723, 90740, 90744, 90747 and 90748 • Inactivated Polio Vaccine (IPV) – 90697, 90698, 90713, and 90723 • Influenza Vaccine – 90655, 90657, 90661, 90673, 90674, 90685, 90686, 90687, 90688, 90689, and 90756 • Influenza (LAIV) Vaccine – 90660 and 90672 • Measles, Mumps and Rubella (MMR) Vaccine – 90707 and 90710 • Pneumococcal Conjugate Vaccine – 90670 • Rotavirus Vaccine (2 Dose Schedule) – 90681 • Rotavirus Vaccine (3 Dose Schedule) – 90680 • Varicella Zoster (VZV) Vaccine – 90710 a n d 90716 **HCPCS:** • Hepatitis B Vaccine Administered – G0010 • Influenza Vaccine Administered – G0008 • Pneumococcal Conjugate Vaccine Administered – G0009 Use of these codes could reduce gaps without chart submission.
Supplemental Data Eligible	Yes, providers may share supplemental data files from their EMR with PacificSource to close this care gap. This may reduce chart asks during the chart-retrieval season.

Immunizations for Adolescents (IMA)

Population	Adolescents who turn 13 years of age during the measurement year
Product Lines	Commercial and Medicaid
What's Reported	The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine, one Tdap, and have completed the HPV vaccine series by their 13th birthday. The measure calculates a rate for each vaccine and two combination rates.
Measurement Period	Measurement year (2023)
Documentation	Immunization evidence obtained from the medical record, count members where there is evidence that the antigen was rendered from one of the following: • Note indicating the name of the specific antigen(s) and the date of the immunization • Certification of immunization prepared by an authorized healthcare provider or health agency including the specific dates and types of the immunizations administered
Exclusions	• Members in hospice or using hospice services any time during the measurement period • Individual Vaccines Contraindication for a specific vaccine including but not limited to: • Anaphylactic Reaction due to Vaccine • Anaphylactic Reaction due to Serum • Encephalopathy due to Vaccine
Common Codes Used for Compliance	**CPT®:** • HPV Vaccine – 90649, 90650, and 90651 • Meningococcal Vaccine – 90619, 90733, and 90734 • Tdap Vaccine – 90715 Use of these codes could reduce gaps without chart submission.
Supplemental Data Eligible	Yes, providers may share supplemental data files from their EMR with PacificSource to close this care gap. This may reduce chart asks during the chart-retrieval season.

Care for Older Adults (COA) ✪☎

Population	Members 66 years and older during the measurement year
Product Lines	Medicare (only SNP or MMP plans)
What's Reported	The percentage of adults 66 years and older who had each of the following services during the measurement year: • Medication Review • Functional Status Assessment • Pain Assessment Note: Exclude any of these services provided in an acute inpatient setting.
Measurement Period	Measurement year (2023)
Documentation	There is no specific setting required for these assessments and may be completed via telehealth, e-visit, or telephone appointment • Medication Review – at least one date-notated medication review conducted by a prescribing provider or pharmacist during the MY and a medication list present in the medical record • Functional Status Assessment – Notation in medical record of a functional status assessment and the date it was performed, including one of the following: – Documentation of Daily Activities where five of the following are assessed: • Walking • Dressing • Bathing • Toileting • Eating • Transferring (in and out of chairs) Documentation of Instrumental Activities of Daily Living (IADL) and must include at least four of the following: • Laundry • Grocery shopping • Taking medication(s) • Home repair • Housework • Driving or public transportation • Telephone use • Managing finances • Cooking and meal preparation

Care for Older Adults (COA) ✪☎ *continued*

Documentation ***continued***	Documentation of standardized functional status assessment tool: • SF-36® • Bayer ADL Scale • Extended ADL Scale • Katz Index of Independence • Kohlman Eval of Living Skills • ALSAR • Barthel Index • Groningen Frailty Index • Kenny Self-Care Eval • Lawton & Brody IADL • ADLS Scale • Edmonton Frail Scale • Independent Living Scale • Klein-Bell ADL Scale • PROMIS or Physical Function Scale Note: Functional assessment limited to a specific acute condition, event or body system (e.g. lower back) does not meet criteria for a functional status assessment Pain Assessment: Notation in medical record including documentation of pain assessment and the date it was performed • Documentation of pain assessment (including results or findings of assessment) • Notation of pain treatment or pain management alone is not sufficient for compliance Result of assessment utilizing a standardized assessment tool including: • Numeric Rating Scales (verbal or written) • FLACC Scale • PROMIS Pain Intensity Scale • Brief Pain Inventory • Pain Thermometer • PAINAD (Advance Dementia) Scale • Chronic Pain Grade • Verbal descriptor scales • Visual Analogue Scale • Pictorial Pain Scales
Exclusions	• Members in hospice or using hospice services any time during the measurement year • Members who died any time during the measurement year • Acute Care Settings – exclude assessments that take place in an acute inpatient care setting.

Care for Older Adults (COA) ✪☎ *continued*

Common Codes Used for Compliance	**CPT®:** • Medication Review: – Transitional Care Management Services (single code for compliance) - 99495 or 99496 • Medication Review CPT must be paired with Medication List code for compliance: – Medication Review – 90863, 99483, 99605, and 99606 • Functional Status Assessment – 99483 **HCSPS:** • Medication List – G8427 (must be paired with Medication Review code) • Functional Status – G0438 or G0439 **CPT® II:** • Medication Review – 1160F – Must be paired with medication list • Medication List – 1159F – Must be paired with medication review • Functional Status – 1170F • Pain Assessment – 1125F or 1126F
Supplemental Data Eligible	Yes, providers may share supplemental data files from their EMR with PacificSource to close this care gap. This may reduce chart asks during the chart-retrieval season.

Colorectal Cancer Screening (COL) ✪

Population	Members 46–75 years of age
Product Lines	Commercial and Medicare, Medicaid administrative data only
What's Reported	Members who had appropriate screening for colorectal cancer: FOBT (measurement year only), Flexible Sigmoidoscopy, Colonoscopy, CT Colonography, or FIT-DNA.
Measurement Period	• Measurement year (2023) • Flexible Sigmoidoscopy (2019-2023), Colonoscopy (2013 - 2023), CT Colonography (2019-2023), FIT-DNA test (2021 - 2023), or FOBT (2023)
Documentation	Note in medical record must include indication of date when the colorectal cancer screening was performed. Result of screening so long as the documentation is part of the members medical history. Pathology report(s) that indicate the type of screening (colonoscopy, flex sigmoidology) and the date screening was performed. Pathology reports that do not indicate screening type or incomplete procedures must include: • Colonoscopy: Evidence scope advanced beyond the splenic flexure • Flexible Sigmoidoscopy: Evidence scope advanced into the sigmoid colon FOBT Tests: the two compliant types of FOBT include immunochemical (FIT) and guaiac (gFOBT). The different test types require a differing number of samples in order to be compliant. • If medical record does not note the type of tests nor the quantity of samples returned, assume the required number were retrieved. The member will be considered numerator complaint. • If medical record does not note the type of tests and the quantity of samples returned is specified, the member will only be considered compliant if the number of samples is greater than or equal to three. If fewer than three samples are recorded, the member is considered noncomplaint for the numerator. • FIT tests may require fewer than three samples – if the record indicated FIT was performed the member will be considered numerator compliant. • Guaiac gFOBT
Exclusions	• Members in hospice or using hospice services any time during the measurement period • Members receiving palliative care any time during the measurement year (ICD-10 CM code Z51.5) • Members who were enrolled in an I-SNP or long-term institution any time during the measurement year • Members with frailty and advanced illness • Members with history of colorectal cancer or total colectomy any time during the member's history through the end of the measurement period

Colorectal Cancer Screening (COL) ✪ *continued*

Common Codes Used for Compliance	**CPT®:** • Colonoscopy – 44388, 44389, 44390, 44391, 44392, 44393, 44394, 44397, 44401, 44402, 45378, 45380, 45381, 45382,45385, 45384, 45388, and 45390 • CT Colonography – 74261, 74263, and 74262 • FIT DNA Lab Test – 81528 • Flexible Sigmoidoscopy – 45330, 45331, 45332, 45341, 45335, and 45338 • FOBT Lab Test – 82270 and 82274 **HCPCS:** • Colonoscopy – G0121 or G0105 • Flexible Sigmoidoscopy – G0104 • FOBT Lab Test – G0328 Use of these codes could reduce gaps without chart submission.
Common Chart Deficiencies	• Medical history documentation of colorectal cancer screening must include the date of the screening and the test that was completed (notation of only the year is acceptable) • Colonoscopy and flexible sigmoidoscopy are the only procedures that do not require the results to be noted • All other screenings require a result (FIT, FOBT, CT Colonography, Cologuard®) • Abbreviation of colonoscopy is not adequate (cscope, col, cscopy, etc.)
Supplemental Data Eligible	Yes, providers may share supplemental data files from their EMR with PacificSource to close this care gap. This may reduce chart asks during the chart-retrieval season. Supplemental Data may not be used to identify I-SNP, Frailty, and/or Advanced Illness exclusions for this measure.
Time-saving Tips	Submit a claim with the appropriate code(s) to indicate history of colon cancer. Common Z codes are Z85.038 and Z85.048. The member will be excluded from the measure for as long as they are a member of our plan. Chart notes may also be submitted to confirm history of colon cancer.

Prenatal and Postpartum Care (PPC)

Population	Members who delivered a live birth
Product Lines	Commercial and Medicaid
What's Reported	The percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year. For these members, the measure assesses the following facets of prenatal and postpartum care: • Timeliness of Prenatal Care. The percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment. • Postpartum Care. The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery. Note: If services occur over multiple visits, the member is still compliant so long as they occur within measure-designated time frames for prenatal and postpartum care
Measurement Period	October 8 of the year prior to the measurement year (2022) and October 7 of the measurement year (2023)

Documentation	Prenatal care: Visit to an OB/GYN or other prenatal care provider, including PCP, within the prenatal measurement time period. PCP visits must include a diagnosis of pregnancy. Note in the record the date of the prenatal care visit and evidence of one of the following:
	Pathology reports that do not indicate screening type or incomplete procedures must include:
	• Basic physical obstetrical exam that includes auscultation for fetal heart tones, or pelvic exam with obstetric observations, or measurement of fundus height (standard prenatal flow sheet may be used)
	• Documentation or reference to pregnancy or member who is pregnant (for example):
	  • Standard prenatal flow sheet
	  • Gravidity or parity
	  • LMP, EDD, or gestational age
	  • Obstetrical history
	  • Positive pregnancy test result
	  • Prenatal risk assessment
	Evidence of prenatal care procedure was performed including (but not limited to one of the following):
	• Screening or obstetric panel (must include hematocrit, platelet count, WBC count, RBC count, hep B surface antigen, rubella antibody, syphilis test, Rh and ABO blood typing); or
	• Rubella antibody titer/test with an Rh incompatibility (ABO/Rh) blood typing; or
	• TORCH antibody panel alone; or
	• Ultrasound of pregnant uterus

Prenatal and Postpartum Care (PPC) *continued*

Documentation *continued*	Postpartum care: Visit to an OB/GYN or other prenatal care provider, including PCP, within 7 to 84 days after live birth delivery. Do not include care performed in an acute inpatient setting. Note in the record the date of the postpartum care visit and one of the following: • Pelvic exam • Evaluation of BP, weight, abdomen and breasts (Breastfeeding notation is sufficient for 'evaluation of breasts') • Perineal or cesarean wound/incision check • Screening for depression, anxiety, substance use disorder, tobacco use, or preexisting mental health disorders • Notation of postpartum care (including but not limited to): – Glucose screening of members with gestational diabetes – Preprinted postpartum care form with visit details documented – "PP care", "Postpartum Care", or "6-week check"
Exclusions	• Members in hospice or using hospice services any time during the measurement year • Members who died any time during the measurement year
Common Codes Used for Compliance	**ICD-10:** • Postpartum Visits – Z01.411, Z01.419, Z01.42, Z30.430, Z39.1, and Z39.2 **CPT®:** • Cervical Cytology – 88141, 88142, 88143, 88147, 88148, 88150, 88152, 88153, 88164, 88165, 88166, 88167, 88174, and 88175 • Postpartum Bundled Services – 59400, 59410, 59510, 59610, 59614, 59618, and 59622 • Postpartum Visits – 57170, 58300, 59430, and 99501 • Prenatal Bundled Services – 59400, 59425, 59426, 59510, 59610, and 59618 • Prenatal Visits – 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245 and 99483 • Telephone Visits – 98966, 98967, 98968, 99441, 99442, and 99443 **CPT® II:** • Postpartum Visits – 0503F • Stand-Alone Prenatal – 0500F, 0501F, and F0502F **HCPCS:** • Cervical Cytology – G0123, G0124, G0141, G0143, G0144, G0145, G0147, G0148, P3000, P3001, and Q0091 • Postpartum Visits – G0101 • Prenatal Visits – T1015 • Prenatal Bundled Services – H1005 • Stand-Alone Prenatal – H1000, H1001, H1002, H1003 and H1004 Use of these codes could reduce gaps without chart submission.
Common Chart Deficiencies	If the PCP is providing prenatal and postpartum care, there must be a diagnosis of pregnancy in each chart note.
Supplemental Data Eligible	Yes, providers may share supplemental data files from their EMR with PacificSource to close this care gap. This may reduce chart asks during the chart-retrieval season.

Transitions of Care (TRC) ✪☎

Population	Medicare members 18 years of age and older as of December 31 of the measurement year
Product Lines	Medicare
What's Reported	The percentage of discharges for members who had each of the following. Four rates are reported: • Notification of Inpatient Admission. Documentation of receipt of notification of inpatient admission on the day of admission through two days after the admission. **Medical Record Review Only. Administrative data disallowed.** • Receipt of Discharge Information. Documentation of receipt of discharge information on the day of discharge through two days after the discharge. **Medical Record Review Only. Administrative data disallowed.** • Patient Engagement after Inpatient Discharge. Documentation of patient engagement provided within 30 days after discharge. • Medication Reconciliation Post-Discharge. Documentation of medication reconciliation on the date of discharge through 30 days after discharge. Report two age stratifications and a total rate: • 18–64 years • 65 years and older • Total
Measurement Period	January 1 through December 1 of the measurement year (2023)

Documentation	Note: Documentation must include reference to inpatient stay, e.g. "admission", "hospitalization", "inpatient stay". References such as "post op" or "follow-up" are insufficient to meet hybrid specification.
	Notification of Inpatient Admission:
	• Documentation in medical record that includes evidence of notification of inpatient admission to member's PCP on the day of admission or within two days after admission (3 days total)
	Receipt of Discharge Information:
	• Documentation in medical record including evidence of receipt of discharge information on the day of discharge through two days after the discharge (3 days total). Can include (but not limited to) discharge summary or summary of care record, and must include at a minimum the following elements:
	  • Practitioner responsible during member's care
	  • Current Medication List
	  • Procedures or treatments
	  • Diagnosis at discharge
	  • Post-Discharge Care Instructions
	  • Test results, or notation of pending testing result(s), or documentation of no test(s) pending
	If PCP is managing, inpatient provider discharge information must be documented on the day of discharge through two days after discharge (3 days total)

Transitions of Care (TRC) ✪☎ *continued*

Documentation ***continued***	Patient Engagement After IP Discharge:
	• Documentation in the medical record of patient engagement evidence no later than 30 days after discharge. Engagement can include any of the following modalities:
	  • Office or home outpatient visit
	  • Telephone visit
	  • E-visit or virtual visit (asynchronous telehealth not in real time with both member and provider engaged)
	  • Telehealth visit in real time (synchronous) utilizing audio and/or video modality
	Note: If member is unable to communicate with provider, engagement with the member's caregiver and provider is sufficient for compliance
	Medication Reconciliation Post Discharge:
	• Documentation in medical record of medication reconciliation and notation of the date it was performed. Can include any of the following:
	  • Current medication list with reference to current and post-discharge medication reconciled by provider
	  • Current medication list with notation or additions of post-discharge medication (e.g. discontinue all discharge medication, no changes since discharge, same medications at discharge)
	  • Post-discharge medication list, current medication list and notation both lists were reviewed with a date of service

Exclusions	• Members in hospice or using hospice services any time during the measurement year • Members who died any time during the measurement year
Common Codes Used for Compliance	**CPT®:** • Medication Reconciliation – 99483, 99495 and 99496 • Telephone Visits – 98966, 98967, 98968, 99441, 99442, and 99443 • Transitional Care Management – 99495 and 99496 **CPT® II:** • Medication Reconciliation – 1111F **HCPCS:** • Online Assessment – G0071, G2010, G2012, G2061, G2062, and G2063 • Outpatient – G0402, G0438, G0439 and G0463 Use of these codes could reduce gaps without chart submission.
Supplemental Data Eligible	Yes, providers may share supplemental data files from their EMR with PacificSource to close this care gap. This may reduce chart asks during the chart-retrieval season.

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)

Population	Members 3–17 years of age
Product Lines	Commercial and Medicaid
What's Reported	The percentage of members who had an outpatient visit with a PCP or OB/GYN and who had evidence of the following during the measurement year: • BMI percentile documentation • Counseling for nutrition • Counseling for physical activity
Measurement Period	Measurement year (2023)
Documentation	BMI Percentile • Notation of all the following elements: weight, height, and BMI percentile in the measurement year – BMI percentile as value (e.g. 60th percentile); or – BMI percentile documented within an age-growth chart • All measure elements must be included in the same data source Counseling for Nutrition • Notation of provider counseling for nutrition or a documented referral for nutritional education, and including one of the following: – Counseling or referral for nutrition education – Anticipatory guidance for nutrition – Checklist including nutrition counseling – Discussion of nutrition behavior including eating habits or dieting behaviors – Obesity counseling – Weight counseling – Documentation of educational materials on nutrition provided during visit Counseling for Physical Activity • Notation of date of visit and including one of the following: – Checklist including physical activity – Counseling or referral for physical activity – Discussion of physical activity habits (routines, exercise, sport activities or participation)
Exclusions	• Members in hospice or using hospice services any time during the measurement year • Pregnancy – Members with a diagnosis of pregnancy during the measurement year (not optional, now required)

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) *continued*

Common Codes Used for Compliance	**ICD-10:** • BMI Percentile – Z68.51, Z68.52, Z68.53, and Z68.54 • Nutrition Counseling – Z71.3 • Physical Activity Counseling – Z02.5 and Z71.82 **CPT®:** • Nutrition Counseling – 97802, 97803, and 97804 **HCPCS:** • Nutrition Counseling – G0270, G0271, G0447, S9449, S9452 and S9470 • Physical Activity Counseling – G0447 and S9451 Use of these codes could reduce gaps without chart submission.
Common Chart Deficiencies	• A distinct BMI percentile (ranges and thresholds will not meet requirements) • Specific documentation that calls out nutritional counseling/education or discussion of current dietary habits is required • Specific documentation that calls out physical activity counseling/education or discussion of current physical activity is required
Supplemental Data Eligible	Yes, providers may share supplemental data files from their EMR with PacificSource to close this care gap. This may reduce chart asks during the chart-retrieval season.

HEDIS® Measurement Year 2023MY

ECDS Measures

Breast Cancer Screening (BCS-E) ✪

Population	Women 52 – 74 years as of December 31 of the measurement year, who also meet the criteria for participation
Product Lines	Commercial, Medicaid, and Medicare
What's Reported	The percentage of women ages 52 – 74 who had a mammogram to screen for breast cancer. This measure assesses the use of imaging to detect early breast cancer in women. Because the measure denominator does not remove women at higher risk of breast cancer, all types and methods of mammograms qualify for numerator compliance.
Measurement Period	October 1 two years prior to the measurement year (2021) through December 31 of the measurement year (2023)
Documentation	• Document and code screenings in medical record with dates, result(s), and type of screening • Measure compliance does not include breast ultrasounds, biopsies, or MRIs
Exclusions	• Members in hospice or using hospice services any time during the measurement period • Members receiving palliative care any time during the measurement period (ICD-10-CM code Z51.5) • Members who were enrolled in an I-SNP or long-term institution any time during the measurement year • A dispensed dementia medication • Members 66 years of age or older by the end of the measurement period, with frailty and advanced illness • Members who had a bilateral mastectomy, or both right and left unilateral mastectomies, any time during the member's history through December 31 of the measurement year
Common Codes Used for Compliance	**CPT®:*** • Mammography – 77061, 77062, 77063, 77065, 77066 and 77067 **HCPCS:** • Mammography – G0202, G0204, G0206 *CPT® is a registered trademark of the American Medical Association (AMA).
Supplemental Data Eligible	Yes, providers may share supplemental data files from their EMR with PacificSource to close this care gap. • Supplemental or medical record data may not be used for required exclusions (hospice, palliative card, frailty, dementia medications) for this measure; only claims data may be used • Optional exclusions (bilateral mastectomy) are allowed to utilize supplemental or medical record data provided
Time-saving Tips	Submit a claim with the appropriate code to indicate history of double/bilateral mastectomy. A common Z code is Z90.13. The member will be excluded from the measure for as long as they are a member of our plan. Chart notes may also be submitted to confirm history of mastectomy.

Cervical Cancer Screening (CCS-E)

Population	Women 24–64 years as of the measurement year (2023)
Product Lines	Commercial and Medicaid
What's Reported	The percentage of women who were screened for cervical cancer using any of the following criteria: • Women 21–64 years of age who had cervical cytology performed within the past 3 years • Women 30–64 years of age who had cervical high-risk human papillomavirus testing performed within the past 5 years • Women 30–64 years of age who had cervical cytology/high-risk human papillomavirus co-testing within the past 5 years
Measurement Period	• Commercial: The measurement year (2023) and the two years prior to the measurement period • Medicaid: The measurement year (2023)
Documentation	• Date of cervical cytology with result or finding • Date of hrHPV test with result or finding
Exclusions	• Members in hospice or using hospice services any time during the measurement period • Members receiving palliative care any time during the measurement year (ICD-10-CM code Z51.5) • Hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix any time during the member's history through December 31 of the measurement year
Common Codes Used for Compliance	**CPT®:** • Cervical Cytology – 88141, 88142, 88143, 88147, 88148, 88150, 88152, 88153, 88164, 88165, 88166, 88167, 88174 and 88175 • High Risk HPV Tests – 87624 and 87625 **HCPCS:** • Cervical Cytology – G0123, G0124, G0141, G0143, G0144, G1047, G0145, Q0091, and P3001 • High Risk HPV Tests – G0476 Use of these codes could reduce gaps without chart submission.
Common Chart Deficiencies	• Documentation of hysterectomy that does not state removal of the cervix. • Must state "complete" or "vaginal hysterectomy" to meet criteria for hysterectomy with no residual cervix. • Biopsies may not be included in compliance as they are diagnostic and therapeutic only and not valid for primary cervical cancer screening(s)
Supplemental Data Eligible	Yes, providers may share supplemental data files from their EMR with PacificSource to close this care gap.
Time-saving Tips	Submit a claim with the appropriate code to indicate absence of cervix. Common Z codes are Z90.710 and Z90.712. The member will be excluded from the measure for as long as she is a member of our plan. Chart notes may also be submitted to confirm history of hysterectomy.

Childhood Immunization Status (CIS-E)

Population	Children 2 years of age during the measurement year
Product Lines	Commercial and Medicaid
What's Reported	The percentage of children who had four DTaP, three IPV, one MMR, three HiB, three HepB, one VZV, four PCV, one HepA, two or three RV, and two flu vaccines by their second birthday. Note: Influenza vaccination must be administered no earlier than six months of age, and no later than the child's second birthday. One of these may be an LAIV (influenza) vaccine administered only *on* the child's second birthday. LAIV administered prior to the child's second birthday will not be considered compliant.
Measurement Period	Measurement year (2023)
Documentation	Immunization evidence obtained from the medical record, count members where there is evidence that the antigen was rendered from one of the following: • Note indicating the name of the specific antigen(s) and the date of the immunization • Certification of immunization prepared by an authorized healthcare provider or health agency including the specific dates and types of the immunizations administered
Exclusions	• Members in hospice or using hospice services any time during the measurement period • Any of the following on or before the child's second birthday: – Severe combined immunodeficiency – Immunodeficiency – HIV – Lymphoreticular cancer, multiple myeloma or leukemia – Intusseusception

Childhood Immunization Status (CIS-E) *continued*

Common Codes Used for Compliance	**CPT®:** • DTaP Vaccine – 90697, 90698, 90700, and 90723 • Haemophilus Influenzae Type B (HiB) Vaccine – 90644, 90647, 90648, 90697, 90698, and 90748 • Hepatitis A Vaccine – 90633 • Hepatitis B Vaccine – 90697, 90723, 90740, 90744, 90747 and 90748 • Inactivated Polio Vaccine (IPV) – 90697, 90698, 90713, and 90723 • Influenza Vaccine – 90655, 90657, 90661, 90673, 90674, 90685, 90686, 90687, 90688, 90689, and 90756 • Influenza (LAIV) Vaccine – 90660 and 90672 • Measles, Mumps and Rubella (MMR) Vaccine – 90707 and 90710 • Pneumococcal Conjugate Vaccine – 90670 • Rotavirus Vaccine (2 Dose Schedule) – 90681 • Rotavirus Vaccine (3 Dose Schedule) – 90680 • Varicella Zoster (VZV) Vaccine – 90710 and 90716 **HCPCS:** • Hepatitis B Vaccine Administered – G0010 • Influenza Vaccine Administered – G0008 • Pneumococcal Conjugate Vaccine Administered – G0009 Use of these codes could reduce gaps without chart submission.
Supplemental Data Eligible	Yes, providers may share supplemental data files from their EMR with PacificSource to close this care gap. This may reduce chart asks during the chart-retrieval season.

Colorectal Cancer Screening (COL-E) ✪

Population	Members 46–75 years of age
Product Lines	Commercial and Medicare, Medicaid administrative data only
What's Reported	Members who had appropriate screening for colorectal cancer: FOBT (measurement year only), Flexible Sigmoidoscopy, Colonoscopy, CT Colonography, or FIT-DNA
Measurement Period	• Measurement year (2023) • Flexible Sigmoidoscopy (2019-2023), Colonoscopy (2013 - 2023), CT Colonography (2019-2023), FIT-DNA test (2021 - 2023), or FOBT (2023)
Documentation	Note in medical record must include indication of date when the colorectal cancer screening was performed. Result of screening is acceptable, so long as the documentation is part of the member's medical history. Pathology report(s) that indicate the type of screening (colonoscopy, flex sigmoidology) and the date screening was performed. Pathology reports that do not indicate screening type or incomplete procedures must include: • Colonoscopy: Evidence scope advanced beyond the splenic flexure • Flexible Sigmoidoscopy: Evidence scope advanced into the sigmoid colon FOBT Tests: the two compliant types of FOBT include immunochemical (FIT) and guaiac (gFOBT). The different test types require a differing number of samples in order to be compliant. • If medical record does not note the type of tests nor the quantity of samples returned, assume the required number were retrieved. The member will be considered numerator complaint. • If medical record does not note the type of tests, and the quantity of samples returned is specified, the member will only be considered compliant if the number of samples is greater than or equal to three. If fewer than three samples are recorded, the member is considered noncomplaint for the numerator. • FIT tests may require fewer than three samples – if the record indicated FIT was performed the member will be considered numerator compliant. • Guaiac gFOBT
Exclusions	• Members in hospice or using hospice services any time during the measurement period • Members receiving palliative care any time during the measurement year (ICD-10 CM code Z51.5) • Members who were enrolled in an I-SNP or long-term institution any time during the measurement year • Members with frailty and advanced illness • Members with history of colorectal cancer or total colectomy any time during the member's history through the end of the measurement period

Colorectal Cancer Screening (COL-E) ✪ *continued*

Common Codes Used for Compliance	**CPT®:** • Colonoscopy – 44388, 44389, 44390, 44391, 44392, 44393, 44394, 44397, 44401, 44402, 45378, 45380, 45381, 45382,45385, 45384, 45388, and 45390 • CT Colonography – 74261, 74263, and 74262 • FIT DNA Lab Test – 81528 • Flexible Sigmoidoscopy – 45330, 45331, 45332, 45341, 45335, and 45338 • FOBT Lab Test – 82270 and 82274 **HCPCS:** • Colonoscopy – G0121 or G0105 • Flexible Sigmoidoscopy – G0104 • FOBT Lab Test – G0328 Use of these codes could reduce gaps without chart submission.
Common Chart Deficiencies	• Medical history documentation of colorectal cancer screening must include the date of the screening and the test that was completed (notation of only the year is acceptable) • Colonoscopy and flexible sigmoidoscopy are the only procedures that do not require the results to be noted • All other screenings require a result (FIT, FOBT, CT Colonography, Cologuard®) • Abbreviation of colonoscopy is not adequate (cscope, col, cscopy, etc.)
Supplemental Data Eligible	Yes, providers may share supplemental data files from their EMR with PacificSource to close this care gap. Supplemental Data may not be used to identify I-SNP, Frailty, and/or Advanced Illness exclusions for this measure.
Time-saving Tips	Submit a claim with the appropriate code(s) to indicate history of colon cancer. Common Z codes are Z85.038 and Z85.048. The member will be excluded from the measure for as long as they are a member of our plan. Chart notes may also be submitted to confirm history of colon cancer.

Immunizations for Adolescents (IMA-E)

Population	Adolescents who turn 13 years of age during the measurement year
Product Lines	Commercial and Medicaid
What's Reported	The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine, one Tdap, and have completed the HPV vaccine series by their 13th birthday. The measure calculates a rate for each vaccine and two combination rates.
Measurement Period	Measurement year (2023)
Documentation	Immunization evidence obtained from the medical record, count members where there is evidence that the antigen was rendered from one of the following: • Note indicating the name of the specific antigen(s) and the date of the immunization • Certification of immunization prepared by an authorized healthcare provider or health agency including the specific dates and types of the immunizations administered
Exclusions	• Members in hospice or using hospice services any time during the measurement period • Individual Vaccines Contraindication for a specific vaccine including but not limited to: • Anaphylactic Reaction due to Vaccine • Anaphylactic Reaction due to Serum • Encephalopathy due to Vaccine
Common Codes Used for Compliance	**CPT®:** • HPV Vaccine – 90649, 90650, and 90651 • Meningococcal Vaccine – 90619, 90733, and 90734 • Tdap Vaccine – 90715 Use of these codes could reduce gaps without chart submission.
Supplemental Data Eligible	Yes, providers may share supplemental data files from their EMR with PacificSource to close this care gap. This may reduce chart asks during the chart-retrieval season.

Social Need Screening and Intervention (SNS-E)

Population	Age (as of the start of the measurement period, for each product line): • ≤17 years. • 18–64 years. • 65 and older
Product Lines	Commercial, Medicaid, and Medicare
Description	The percentage of members who were screened, using prespecified instruments, at least once during the measurement period for unmet food, housing, and transportation needs, and received a corresponding intervention if they screened positive. • Food Screening: The percentage of members who were screened for food insecurity. • Food Intervention: The percentage of members who received a corresponding intervention within one month of screening positive for food insecurity. • Housing Screening: The percentage of members who were screened for housing instability, homelessness, or housing inadequacy. • Housing Intervention: The percentage of members who received a corresponding intervention within one month of screening positive for housing instability, homelessness, or housing inadequacy. • Transportation Screening: The percentage of members who were screened for transportation insecurity. • Transportation Intervention: The percentage of members who received a corresponding intervention within one month of screening positive for transportation insecurity.
Measurement Period	January 1–December 3
Detailed Descriptions	• Food insecurity: Uncertain, limited or unstable access to food that is: adequate in quantity and in nutritional quality; culturally acceptable; safe and acquired in socially acceptable ways. • Housing instability: Currently consistently housed but experiencing any of the following circumstances in the past 12 months: being behind on rent or mortgage, multiple moves, cost burden, or risk of eviction. • Homelessness: Currently living in an environment that is not meant for permanent human habitation (e.g., cars, parks, sidewalks, abandoned buildings, on the street), not having a consistent place to sleep at night, or because of economic difficulties, currently living in a shelter, motel, temporary or transitional living situation. • Housing inadequacy: Housing does not meet habitability standards. • Transportation insecurity: Uncertain, limited or no access to safe, reliable, accessible, affordable, and socially acceptable transportation infrastructure and modalities necessary for maintaining one's health, well-being or livelihood.
Exclusions	• Members in hospice or using hospice services any time during the measurement period

Screening Codes	Food Insecurity: 88122-7, 88123-5, 88122-7, 88123-5, 95251-5, 88124-3, 93031-3, 95400-8, 95399-2, 95264-8, 96434-6, 93668-2 Housing Instability and Homelessness: 71802-3, 99550-6, 98976-4, 98977-2, 98978-0, 99550-6, 93033-9, 71802-3, 96441-1, 93669-0 Housing Inadequacy: 96778-6 Transportation Insecurity: 93030-5, 99594-4, 89569-8, 99553-0, 93030-5, 92358-1, 93671-6
Interventions	An intervention corresponding to the type of need identified on or up to 30 days after the date of the first positive screening during the measurement period. • A positive food insecurity screen finding must be met by a food insecurity intervention. • A positive housing instability or homelessness screen finding must be met by a housing instability or homelessness intervention. • A positive housing inadequacy screen finding must be met by a housing inadequacy intervention. • A positive transportation insecurity screen finding must be met by a transportation insecurity intervention. Intervention may include any of the following intervention categories: assistance, assessment, counseling, coordination, education, evaluation of eligibility, provision, or referral.

HEDIS® 2023MY measures at a glance (administrative)

HEDIS Measure	Age Range	Requirement	Date Range
Chlamydia Screening in Women	16–24	Identified as sexually active and had at least one test for chlamydia	2023
Appropriate Testing for Pharyngitis	3 years and older	Diagnosed with pharyngitis, dispensed an antibiotic and received strep test	7/1/2022–6/30/2023
Use of Imaging Studies for Low Back Pain	18–50	Primary diagnosis of low back pain who did not have an imaging study within 28 days of the diagnosis	Initial Diagnosis Dates: 1/1/2023–12/3/2023
Osteoporosis Management in Women Who Had a Fracture	67–85	Bone mineral density test within 6 months of fracture	7/1/2022–6/30/2023
		Osteoporosis therapy within 6 months of fracture	7/1/2022–6/30/2023
		Dispensed medication for osteoporosis within 6 months of fracture	7/1/2022–6/30/2023
Plan All-Cause Readmissions	18+	Reduce incidence of readmissions for acute inpatient hospital stays	1/1/2023–12/1/2023
Statin Therapy for Patients with Cardiovascular Disease	Males: 21–75 Females: 40–75	At least one statin medication dispensing event	2023
Statin Therapy for Patients with Diabetes	40–75	At least one statin medication dispensing event	2023
Kidney Evaluation for Diabetics	18–85	Kidney evaluation utilizing estimated glomerular filtration rate and a urine creatinine ration	2023
Cardiac Rehabilitaion	18+	Attending cardiac rehabilitation sessions	7/1/2022–12/31/2023

HEDIS® 2023MY measures at a glance (hybrid)

HEDIS Measure	Age Range	Requirement	Date Range
Controlling High Blood Pressure	18–85	BP < 140/90 mm Hg	2023 (last recorded)
Cervical Cancer Screening	21–64	Cervical cytology	2021–2023
	30–64	Cervical high risk HPV	2019–2023
	24–64	Cervical cytology and HPV co-testing	2019–2023
Hemoglobin A1c Control for Patients with Diabetes	18–75	HbA1c test and result <9.0%	2023 (last recorded)
Eye Exam for Patients with Diabetes		Positive retinal or dilated eye exam by an eye-care professional	2023
		Negative retinal or dilated eye exam by an eye-care professional	2022–2023
		Bilateral eye enucleation any time during the patient's history	Patient history through 12/31/2023
Blood Pressure Control for Patients with Diabetes		BP<140/90 mm Hg	2023 (last recorded)
Childhood Immunization Status	Turn age 2 during measurement year	By second birthday: • Four DTaP • Three IPV • One MMR • Three HiB • Three HepB • One VZV • Four PCV • One HepA • Two or three RV • Two flu vaccines	2023

HEDIS Measure	Age Range	Requirement	Date Range
Colorectal Cancer Screening	45–75	Colonoscopy	2014–2023
		CT Colonography	2019–2023
		FIT-DNA	2021–2023
		Flexible Sigmoidoscopy	2019–2023
		FOBT/FIT	2023
Immunizations for Adolescents	Turn age 13 during the measurement year	One dose of meningococcal vaccine, one Tdap, and have completed the HPV vaccine series by 13th birthday	2023
Prenatal and Postpartum Care	18+	Delivered a live birth	10/8/2022–10/7/2023
Transitions of Care	18+	Notification of inpatient admission, receipt of discharge information, patient engagement after inpatient discharge, and medication reconciliation post-discharge	Discharge Dates: 1/1/2023–12/1/2023
Weight Assessment and Counseling for Nutrition and Physical Activity for Children / Adolescents	3–17	BMI percentile documented in medical record	2023
		Nutritional counseling documented in medical record	
		Counseling for physical activity documented in medical record	

HEDIS® 2023MY measures at a glance (ECDS)

HEDIS Measure	Age Range	Requirement	Date Range
Breast Cancer Screening	50–74	Mammogram	10/1/2021–12/31/2023
Cervical Cancer Screening	21–64	Cervical cytology	2021–2023
	30–64	Cervical high risk HPV	2019–2023
	24–64	Cervical cytology and HPV co-testing	2019–2023
Colorectal Cancer Screening	45–75	Colonoscopy	2014–2023
		CT Colonography	2019–2023
		FIT-DNA	2021–2023
		Flexible Sigmoidoscopy	2019–2023
		FOBT/FIT	2023
Social Need Screening and Intervention	All	Members screened, using pre-specified instruments, at least once during the measurement period for unmet food, housing, and transportation needs, and received a corresponding intervention if they screened positive	2023

Appendix 1: Communication samples

Sample PacificSource letter

PacificSource HEALTH PLANS

January 16, 2024

Provider Name
Provider Address
Provider City, State, ZIP

HEDIS® Measurement Year 2023 Medical Records Request
Your participation is important

Dear Provider:

In collaboration with our network physicians and providers, PacificSource is committed to improving the quality of care provided to our members. Our data collection effort for the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data Information Set (HEDIS®) MY 2023 Clinical Effectiveness of Care Measures is one way in which we strive to accomplish this goal.

We have contracted with Optum to conduct a medical record review on our behalf. Optum has entered into a Business Associate Agreement with us and is bound by federal and state privacy and confidentiality requirements in conducting this service on our behalf.

Optum works with Datavant (formerly CiOX), a health technology company

For the MY 2023 HEDIS® season, Optum has engaged the services of Datavant Health for the retrieval of medical records. Optum requires Datavant Health to comply with all applicable federal and state privacy and confidentiality requirements.

Datavant will contact you

A Datavant representative will contact your office to arrange for retrieval of medical records.

After a Datavant representative has contacted you, you can submit records through one of the following five options:

1. Provider portal. Upload the medical records to Datavant's secure provider portal at cioxlink.com. You'll be asked to log in using your username and password.
2. Remote EMR retrieval. Set up a secure remote connection from a provider site's EMR directly to Datavant for timely off-site retrieval of records. For help, a trained Datavant associate is available by calling 877-445-9293.
3. Onsite chart retrieval. Schedule onsite retrieval with a complimentary Datavant Chart Retrieval Specialist of review any aspects of the onsite retrieval services at Datavant by calling 877-445-9293.

1. Fax. Send secure faxes to 972-957-2222.
2. Mail. Write or stamp "Confidential" on the envelope, and address the medical records to: Datavant Health, Attn: Optum, 2222 W. Dunlap Ave.,

   Phoenix AZ 85021

We've enclose information to help prepare for the medical records request

Included with this letter:

1. Medical Records Member List. A list of patients for whom we are requesting medical record documentations.
2. HEDIS® MY 2023 Recommended Minimum Documentations to Copy. A document that outlines specific measures and data elements we ask for.

If you have any questions about the medical record retrieval, please call CiOX directly at 877-445-9293.

Importance of privacy regulations

Health Insurance Portability and Accountability Act of 1996 (HIPAA): Care quality studies are permissible under privacy regulations, including HIPAA. Specific authorization is NOT required from our members prior to releasing medical records to us. Section 164.506 indicates the routine form you obtain is sufficient for disclosures to carry out healthcare operations. Section 164.501 defines healthcare operations to include quality assessment and improvement activities.

PacificSource is a covered entity under HIPAA and has implemented procedures to protect the privacy of health information received. Other safeguards have also been implemented and are listed below for your reference.

Medical record confidentiality

PacificSource strictly maintains the confidentiality of any records, and records are only accessed by authorized persons adhering to the following guidelines:

- Records are kept in a safe and secure location
- Records are appropriately destroyed when they are no longer needed for the purpose requested
- Records are not further disclosed or otherwise distributed

We are not asking for, nor do we want, any medical record information related to psychotherapy, HIV, substance abuse, or developmental disabilities.

Further, your PacificSource Provider Agreement stipulates that copies of members' medical records may be provided to PacificSource, or its respective designees, for quality improvement activities (for example, HEDIS®).

Thank you for your cooperation and participation in this important quality effort.

Sincerely,

PacificSource

CiOX portal information

CIOX HEALTH

Outreach ID:	Site ID:

Chart Review Request

To: _____ Date: _____

Fax Number: _____ Phone Number: _____

Ciox Health has been contracted to retrieve the medical records included in the attached pull list. Please review the attached health plan letter for more information and a list of components required for these records.

Medical records can be sent by any of the following options:

1. **Provider Portal:** Upload the medical records to Ciox Health's secure provider portal at www.cioxlink.com using the following credentials:
   - Username:
   - Password:
2. **Fax:** Send faxes to 1-972-957-2174
3. **Mail:** Mail medical records to:
   Attn: Chart Retrieval
   HEDIS
   15458 N. 28th Ave. Suite D
   Phoenix, AZ 85053

If sending by fax or mail, please include the pull list. Mark each record as Pull or CNA (chart not available) by marking the associated circle. If CNA, please provide a reason in the notes section.

Please submit all records by **<<XX/XX/XXXX>>**. If you have any questions, please contact Ciox Health at (877) 445-9293 and reference your Outreach ID.

We sincerely appreciate your efforts to complete this chart review and will work to minimize disruptions to your patient care activities.

Thank You,
CIOX
Representative
(877) 445-9293

VERIFICATION OF RECEIPT OF FAX:

This communication may contain confidential Protected Health Information. This information is intended only for the use of the individual or entity to which it is addressed. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation and is required to destroy the information after its stated need has been fulfilled. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is STRICTLY PROHIBITED by Federal law. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents.

CiOX portal information

The New Portal...Ciox Link

A fast, easy and secure way to electronically submit medical records.

Want to save time, maximize patient care outcomes, meet the increasing Health Plan demands of chart reviews and drive down administrative burdens?

UPLOAD RECORDS IN 3 EASY STEPS!

Join over 100,000 providers who already use Ciox Link!

3 Easy Steps:

1. In your Internet browser type: **www.cioxlink.com**
2. Enter your username and password – See cover page of Request Package
3. Upload the requested medical record(s)

Save time
Save money
Fewer calls

Increase productivity
Protect the environment
Track submissions

Users are automatically registered to win a gift card with EVERY upload!

Questions? Contact us at 1-877-445-9293 or cioxlinksupport@cioxhealth.com & reference your Outreach ID.