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Adult Access to Preventive/Ambulatory Health Services (AAP)	CPT	HCPCS	ICD 10
Measure: The percentage of members 20 years and older who had an ambulatory or preventive care visit during the measurement year.	99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99214, 99304-99310, 99315, 99316, 99318, 99324-99328, 99334-99337	G0402, G0438, G0439, G0463, T1015	Z00.00, Z00.01, Z00.121, Z00.129, Z00.5, Z00.8, Z02.0-Z02.6, Z02.71, Z02.79, Z02.81, Z02.82, Z02.83, Z02.89, Z02.9
Documentation required: None (Administrative only. This measure is derived strictly from claims).			

Adult BMI Assessment (ABA)	CPT	ICD 10
Measure: The percentage of members 18–74 years of age who had an outpatient visit and whose body mass index (BMI) was documented during the measurement year or the year prior to the measurement year.	99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99456	Z68.1, Z68.20-Z68.29, Z68.30-Z68.39, Z68.41-Z68.45
Documentation required: Indicate in the medical record the weight and BMI value dated during the measurement year or year prior to the measurement year. For members 20 years or older, the BMI value and weight from the measurement year or year prior must be documented. For members younger than 20 years: • BMI percentile documented as a value (e.g., 85th percentile) **or** • BMI percentile plotted on an age-growth chart • Height • Weight **Exclusions:** *Members with diagnosis of pregnancy during the measurement year or year prior.*		

Controlling High Blood Pressure (CBP)	ICD 10
Measure: The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled during the measurement year based on the following criteria: • Members 18–59 years of age whose BP was <140/90 mm Hg. • Members 60–85 years of age with a diagnosis of diabetes whose BP was <140/90 mm Hg. • Members 60–85 years of age without a diagnosis of diabetes whose BP was <150/90 mm Hg.	I10
Documentation required: Documentation of diagnosis of hypertension (HTN) prior to 6/30 of the measurement year and whose BP was adequately controlled during the measurement year. Diagnosis and documented BP ideally would come from the same medical practitioner, but it is not limited to that provider. The representative BP from the most recent practitioner/specialist seen by the member should be used. **This measure is Medical Record Review only.** Identify the most recent BP reading noted during the measurement year. The reading must occur after the date when the diagnosis of hypertension was confirmed. BP readings at the following types of visits, do not count:	

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Controlling High Blood Pressure (CBP)	ICD 10
• Taken during an acute inpatient stay or an ED visit. • Taken during an outpatient visit which was for the sole purpose of having a diagnostic test or surgical procedure performed (e.g., sigmoidoscopy, removal of a mole). • Obtained the same day as a major diagnostic or surgical procedure (e.g., stress test, administration of IV contrast for a radiology procedure, endoscopy). • Reported by or taken by the member. If initial BP is high, and multiple blood pressure readings are taken, the lowest reading will be abstracted during medical record review. **Exclusions**: • *Members with evident ESRD* • *Members who have had a Kidney Transplant or Dialysis* • *Members with diagnosis of pregnancy during the measurement year* • *Members with a nonacute inpatient stay*	

Comprehensive Diabetes Care (CDC) Diabetic HbA1c Testing	CPT	CPT II
Measure: The percentage of members 18–75 years of age with diabetes (type 1 or type 2) who had Hemoglobin A1c (HbA1c) testing.	83036, 83037	3044F (<7.0%) 3045F (7.0-9.0%) 3046F (<9.0%)
Documentation required: An HbA1c test performed during the measurement year, as identified by administrative data or medical record review. This can be a copy of the HBA1C Test result or at a minimum, documentation in the medical record of a note indicating the date when the HbA1c test was performed and the result.		

Comprehensive Diabetes Care: Diabetic eye exam (retinal)	CPT	CPT II	HCPCS	ICD 10
Measure: The percentage of members 18–75 years of age with diabetes (type 1 or type 2) who had a retinal eye exam performed.	67227, 67228, 92002, 92004, 92012, 92014, 92134, 92225–92228, 92230, 92235, 92240, 92250, 92260, 99203–99205, 99213, 99214, 99215, 99242–99245	2022F, 2024F, 2026F, 3072F	S0620, S0621, S0625, S3000	E10.311, E10.319, E10.321, E10.329, E10.331, E10.339, E10.341, E10.349, E10.351, E10.359, E10.39, E11.311, E11.319, E11.321, E11.329, E11.331, E11.339, E11.341, E11.349, E11.351, E11.359, E11.36, E11.39, E13.311, E13.319, E13.321, E13.329, E13.331, E13.339, E13.341, E13.349, E13.351, E13.359, E13.36, E13.39
Documentation required: Requires an optometrist/ophthalmologist **dilated eye** exam annually for members with diabetic retinopathy **or** every two years for patients without retinopathy. At a minimum, documentation in the medical record must include **one** of the following: • A letter prepared by an optometrist, ophthalmologist, PCP or other health care professional indicating that an ophthalmoscopic exam was completed, the date when the procedure was performed, and the results. • A chart or photograph of retinal abnormalities indicating the date when the fundus photography was performed and evidence that an eye care professional reviewed the results. Alternatively, results may be read by a qualified reading center that operates under the direction of a medical director who is a retinal specialist. • Documentation of a negative retinal or dilated exam by an eye care professional in the year prior to the measurement year, where results indicate retinopathy was not present (e.g., documentation of normal findings for a dilated or retinal eye exam performed by an eye care professional meets criteria). **Provider specialty:** Ophthalmologist, Optometrist				

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Comprehensive Diabetes Care: Medical Attention for Nephropathy	CPT	CPT II	ICD 10
Measure: The percentage of members 18–75 years of age with diabetes (type 1 or type 2) who had medical attention for nephropathy.	**Nephropathy Screening test:** 82042, 82043, 82044, 84156 **Urine Macroalbumin test:** 81000–81003, 81005	**ACE inhibitor/ARB:** 4009F **Nephropathy Screening Test:** 3060F, 3061F, 3062F **Urine Macroalbumin test:** 3066F	Z13.89
Documentation required: A nephropathy screening test, medical attention for nephropathy, a visit to a nephrologist **or** treatment with ACE/ARB medications during the measurement year as documented through either administrative data or medical record review. Any of the following meet criteria for a nephropathy screening or monitoring test or evidence of nephropathy. (At a minimum, documentation must include a note indicating the date when a urine test was performed, and the result or finding). • 24-hour urine for albumin or protein. Timed urine for albumin or protein. • Spot urine for albumin or protein. Urine for albumin/creatinine ratio. • 24-hour urine for total protein. Random urine for protein/creatinine ratio. Documentation of: • a visit to a nephrologist • medical attention for any of the following (no restriction on provider type): Diabetic nephropathy, ESRD, chronic renal failure (CRF), chronic kidney disease (CKD), renal insufficiency, proteinuria, albuminuria, renal dysfunction, acute renal failure (ARF), dialysis, hemodialysis or peritoneal dialysis. • a renal transplant • treatment with ACE/ARB medication			

Breast Cancer Screening (BCS)	CPT	HCPCS
Measure: The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer in the measurement year or prior year.		
Documentation required: None (Administrative only). **Exclusions:** *Bilateral Mastectomy or two unilateral mastectomies*	**Mammogram:** 77055–77057	**Mammogram:** G0202, G0204, G0206

Chlamydia Screening in Women (CHL)	CPT	ICD 10
Measure: The percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.	87110, 87270, 87320, 87490–87492, 87810	Z11.8
Documentation required: None (Administrative only) **Exclusions:** *Members who had a pregnancy test during the measurement year followed within seven days (inclusive) by either a prescription for isotretinoin (Accutane) or x-ray.* **Pregnancy test alone does not exclude member.**		

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Cervical Cancer Screening (CCS)	CPT	HCPCS	ICD 10
Measure: The percentage of women 21–64 years of age who were screened for cervical cancer using either of the following criteria: • Women age 21–64 who had cervical cytology performed every 3 years. • Women age 30–64 who had cervical cytology **and** human papillomavirus (HPV) **co-testing** performed every 5 years.	88141–88143, 88147, 88148, 88150, 88152–88154, 88164–88167, 88174, 88175 **HPV test:** 87620-87622	G0123, G0124, G0141, G0143–G0145, G0147, G0148, P3000, P3001, Q0091	Z12.4
Documentation required: There must be a lab report or result documented in the medical record. The following **do not** qualify: • Lab results that indicate inadequate sample or no cervical cells • Referral to OB/GYN alone • Biopsies (are considered diagnostic, rather than screening). Two-year look-back includes Paps given at age 21. **Exclusions:** *Acquired absence of both cervix & uterus. Documentation of total, complete or radical abdominal or vaginal hysterectomy.* **Partial Hysterectomy can only be used if Absence of Cervix is documented.**			

Timeliness of Prenatal Care	CPT	HCPCS
Measure: The percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these women, the measure assesses the percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment in the organization.	59400, 59425, 59426, 59510, 59610, 59618 99201-99205, 99211-99215, 99241-99245, 99500	H1005
Documentation required: Basic Physical OB Exam (FHT, FH, or Pelvic Exam with OB observations) **OR** notation of LMP or EDD with **either** • prenatal risk assessment and counseling/education **or** • complete obstetrical history Documentation of the visit on a prenatal flow sheet or **ACOG** form. Evidence that a prenatal care procedure was performed, such as: • Screening test in the form of an obstetric panel (must include all of the following: hematocrit, differential WBC count, platelet count, hepatitis B surface antigen, rubella antibody, syphilis test, RBC antibody screen, Rh and ABO blood typing) • TORCH antibody panel alone, ***or*** a rubella antibody test/titer with an Rh incompatibility (ABO/Rh) blood typing • Echography of a pregnant uterus **Provider Specialty: Prenatal Care Provider, Primary Care Provider (services delivered by an RN do not count)**		

Postpartum Care	CPT	CPT II	HCPCS	ICD 10
Measure: The percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these women, the measure assesses the percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.	59400, 59410, 59510, 59515, 59610, 59614, 59618, 59622			

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Postpartum Care	CPT	CPT II	HCPCS	ICD 10
Documentation required: A visit that occurs on or between 21–56 days after delivery. Components of a postpartum exam visit note: • Pelvic exam, **or** • Weight, BP, breasts and abdominal evaluation, **or** • PP check, PP Care, six-week check notation, or completed pre-printed "Postpartum Care" form **Provider Specialty: Prenatal Care Provider, Primary Care Provider (services delivered by an RN do not count)**	57170, 58300, 59430, 99501	0503F	G0101	Z01.411, Z01.419, Z01.42, Z30.430, Z39.1, Z39.2

Frequency of Prenatal Care	CPT	HCPCS
Measure: The percentage of Medicaid deliveries between November 6 of the year prior to the measurement year and November 5 of the measurement year that had the following number of expected prenatal visits: • <21 percent of expected visits. • 21 percent–40 percent of expected visits. • 41 percent–60 percent of expected visits. • 61 percent–80 percent of expected visits. • 81 percent of expected visits.	59400, 59425, 59426, 59510, 59610, 59618 99201-99205, 99211-99215, 99241-99245, 99500	H1005
Documentation required: Basic Physical OB Exam (FHT, FH, or Pelvic Exam with OB observations) OR notation of LMP or EDD with **either** • prenatal risk assessment and counseling/education **or** • complete obstetrical history Documentation of the visit on a prenatal flow sheet or **ACOG** form. Evidence that a prenatal care procedure was performed, such as: • Screening test in the form of an obstetric panel (must include all of the following: hematocrit, differential WBC count, platelet count, hepatitis B surface antigen, rubella antibody, syphilis test, RBC antibody screen, Rh and ABO blood typing) • TORCH antibody panel alone, ***or*** a rubella antibody test/titer with an Rh incompatibility (ABO/Rh) blood typing • Echography of a pregnant uterus **Provider Specialty: Prenatal Care Provider, Primary Care Provider (services delivered by an RN do not count)**		

Human Papillomavirus Vaccine for Female Adolescents	CPT	ICD 10
Measure: The percentage of female adolescents 13 years of age who had three doses of the human papillomavirus (HPV) vaccine by their 13th birthday.	90649, 90650, 90651	T80.52XA, T80.52.XD, T80.52XS
Documentation required: 3 Human Papillomavirus vaccines (HPV) on or between 9th and 13th birthdays, preferably on an Immunization Record/flow sheet. PLEASE DOCUMENT ANY PARENT REFUSAL FOR IMMUNIZATIONS, AS WELL AS ANAPHYLACTIC REACTIONS.		

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Weight Assessment/Counseling for Nutrition & Phys. Activity for Children/Adolescents	CPT	HCPCS	ICD 10
Measure: The percentage of members 3–17 years of age 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. *Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed rather than an absolute BMI value.	**Counseling for Nutrition:** 97802–97804	**Counseling for Nutrition:** G0270, G0271, S9449, S9452, S9470 **Exercise counseling:** S9451, G0447	**BMI Percentile:** Z68.51, Z68.52, Z68.53, Z68.54 **Counseling for Nutrition:** Z71.3
Documentation required: Documentation of an outpatient visit, with evidence of the following, during the measurement year: • BMI percentile **or:** • BMI percentile plotted on age-growth chart **and** • Counseling for physical activity **and** • Counseling for nutrition **Provider specialty:** Primary Care Provider, OB/GYN			

Childhood Immunization Status	CPT	HCPCS
Measure: The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two **or** three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates.	**DTaP:** 90698, 90700, 90721, 90723 **Hep A:** 90633 **Hep B:** 90723, 90740, 90744, 90747, 90748 **HiB:** 90645–90648, 90698, 90721, 90748 **IPV:** 90698, 90713, 90723 **Measles:** 90705 **MMR:** 90707, 90710 **Measles/Rubella:** 90708 **Rubella:** 90706 **Mumps:** 90704 **PCV:** 90669, 90670 **VCV:** 90710, 90716 **Influenza:** 90655, 90657, 90661, 90662, 90673, 90685 **Rotavirus (2 dose schedule):** 90681 **Rotavirus (3 dose**	**Hep B:** G0010 **PCV:** G0009 **Influenza:** G0008
Documentation required: Complete immunizations on or before child's 2nd birthday preferably on an Immunization Record/flow sheet. <u>Combo 10 All (HEDIS)</u> • 4 doses – DTap/DT • 3 doses – IPV • 3 doses – Hep B • 3 doses – HiB • 4 doses – PCV • 1 dose – MMR • 1 dose – VZV • 1 dose – Hep A • 2 or 3 doses – Rotavirus (2 dose or 3 dose series) • 2 doses – Influenza		

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Childhood Immunization Status	CPT	HCPCS
	schedule): 90680	
Document all seropositive and illness history of chicken pox, measles, mumps, and rubella. Document the first Hep B vaccine given at the hospital or at birth when applicable, or–if unavailable–name of hospital where child was born. PLEASE DOCUMENT ANY PARENT REFUSAL FOR IMMUNIZATIONS, AS WELL AS ANAPHYLACTIC REACTIONS.		

Lead Screening in Children	CPT
Measure: The percentage of children 2 years of age who had one or more capillary or venous lead blood test(s) for lead poisoning by their second birthday.	83655
Documentation required: Lab report with result or documentation in office note of the date and result of lead screening test(s).	

Immunizations for Adolescents	CPT
Measure: The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine and one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) or one tetanus, diphtheria toxoids vaccine (Td) by their 13th birthday. The measure calculates a rate for each vaccine and one combination rate.	**Diphtheria:** 90719 **Meningococcal:** 90733, 90734 **Td:** 90714 **Tdap:** 90715 **Tetanus:** 90703
Documentation required: Complete immunizations preferably on an Immunization Record/flow sheet: • 1 dose – Meningococcal Conjugate or Meningococcal Polysaccharide Vaccine on or between the member's 11th and 13th birthdays • 1 dose – Tetanus, Diphtheria Toxoids Vaccine (Td or Tdap) on or between the member's 10th and 13th birthdays Document a note indicating the name of the specific antigen and the date of the immunization, **OR** document a certificate of immunization prepared by an authorized health care provider or agency, including the specific dates and types of immunizations administered. PLEASE DOCUMENT ANY PARENT REFUSAL FOR IMMUNIZATIONS, AS WELL AS ANAPHYLACTIC REACTIONS.	

Well-child Visits in the First 15 months of Life	CPT	HCPCS	ICD 10
Measure: The percentage of members who turned 15 months old during the measurement year and who had at least 6 well-child visits with a PCP during their first 15 months of life:	99381, 99382, 99391, 99392, 99461	G0438, G0439	Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.5, Z00.8, Z02.0, Z02.2, Z02.5, Z02.6, Z02.71, Z02.79, Z02.81, Z02.82, Z02.83, Z02.89, Z02.9
Documentation required: All five components of a Well Child Visit must be included: • Health History • Physical **developmental** history • Mental **developmental** history • Physical Examination • Health Education/Anticipatory Guidance Components of well visits can be performed in conjunction with sick visits, and can be performed anytime in the measurement/calendar year.			

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Well-child Visits in the First 15 months of Life	CPT	HCPCS	ICD 10
Services rendered during an inpatient or ED visit do not count. **Provider specialty:** PCP			

Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	CPT	HCPCS	ICD 10
Measure: The percentage of members 3–6 years of age who had one or more well-child visits with a PCP during the measurement year.	99382, 99383, 99392, 99393	G0438, G0439	Z00.121, Z00.129, Z00.5, Z00.8, Z02.0, Z02.2, Z02.5, Z02.6, Z02.71, Z02.79, Z04.81, Z02.82, Z02.83, Z02.89, Z02.9
Documentation required: One Well Child Visit with a PCP during the measurement year. **All five components of a Well Child Visit must be included:** • Health History • Physical **developmental** history • Mental **developmental** history • Physical Examination • Health Education/Anticipatory Guidance Components of well visits can be performed in conjunction with sick visits, and can be performed anytime in the measurement/calendar year. Services rendered during an inpatient or ED visit do not count. **Provider specialty:** PCP			

Adolescent Well-Care Visits	CPT	HCPCS	ICD 10
Measure: The percentage of enrolled members 12–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.	99384, 99385, 99394, 99395	G0438, G0439	Z00.00, Z00.01, Z00.121, Z00.129, Z00.8
Documentation required: One Well Child Visit with a PCP or OB/GYN during the measurement year. **All five components of an Adolescent Well Care Visit must be included:** • Health History • Physical **developmental** history • Mental **developmental** history • Physical Examination • Health Education/Anticipatory Guidance Components of well visits can be performed in conjunction with sick visits, and can be performed anytime in the measurement/calendar year. **Provider specialty:** PCP, OB/GYN			

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Children and Adolescents' Access to Primary Care Practitioners	CPT	HCPCS	ICD 10
Measure: The percentage of members 12 months–19 years of age who had a visit with a PCP. The organization reports four separate percentages for each product line. • Children 12–24 months and 25 months–6 years who had a visit with a PCP during the measurement year. Children 7–11 years and adolescents 12–19 years who had a visit with a PCP during the measurement year or the year prior to the measurement year.	99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99420, 99429	G0402, G0438, G0439, G0463, T1015, S0620, S0621	Z00.00, Z00.01, Z00.121, Z00.129, Z00.5, Z00.8, Z02.0-Z02.6, Z02.71, Z02.79, Z02.81, Z02.82, Z02.83, Z02.89
Documentation required: None (Administrative only)			

Annual Monitoring for Patients on Persistent Medications	CPT
Measure: The percentage of members 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year. Report each of the three rates separately and as a total rate. • Annual monitoring for members on angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB). • Annual monitoring for members on digoxin. • Annual monitoring for members on diuretics. • Total rate (the sum of the three numerators divided by the sum of the three denominators).	80162, 80047, 80048, 80050, 80053, 80069, 82565, 82575, 80051, 84132
Documentation required: None (Administrative only)	

Asthma Medication Ratio	CPT	HCPCS	ICD 10
Measure: The percentage of members 5–85 years of age who were identified as having **persistent asthma** (during the measurement year **and** the year prior) and had a **ratio of controller medications to total asthma medications of 0.50 or greater** NCQA Criteria for Persistent Asthma • 1 ED visit for principal dx Asthma **or** • 1 Acute in pt. encounter for principal dx of Asthma **or** • 4 out pt. visits or observation visits with any dx of Asthma and 2 asthma filled medication prescriptions **or** • at least 4 filled medication prescriptions	**Acute Inpatient:** 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99251-99255, 99291 **ED:** 99281-99285 **Observation:** 99217-99220 **Outpatient:** 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-	**Outpatient:** G0402, G0438, G0439, G0463, T1015	J45.20, J45.21, J45.22, J45.30, J45.31, J45.32, J45.40, J45.41, J45.42, J45.50, J45.51, J45.52, J45.901, J45.902, J45.909, J45.990, J45.991, J45.998
Documentation required: None (Administrative only) **Exclusions: Members who have any of the following conditions in their claims history are excluded from the measure:** • Emphysema, COPD, chronic respiratory conditions due to fumes/vapors, cystic fibrosis, acute respiratory failure. • Members who have had no asthma controller medications dispensed during measurement year			

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Asthma Medication Ratio	CPT	HCPCS	ICD 10
	99404, 99411, 99412, 99420, 99429, 99455, 99456		

Medication Management for People with Asthma	ICD 10
Measure: The percentage of members 5–85 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during at least 75% of their treatment period – i.e., the percentage of members who remained on an asthma controller medication for at least 75% of their treatment period.	J45.20-J45.22, J45.30-J45.32, J45.40-J45.42, J45.50-J45.52, J45.901, J45.902, J45.909, J45.991, J45.998
Documentation required: None (Administrative only) **Exclusions: Members who have any of the following conditions in their claims history are excluded from the measure:** • Emphysema, COPD, Chronic respiratory conditions due to fumes/vapors, cystic fibrosis, acute respiratory failure. • Members who have had no asthma controller medications dispensed during measurement year	

Preferred Controller Medications:	Prescription
Antiasthmatic combinations	Dyphylline-guaifenesin, Guaifenesin-theophylline
Antibody inhibitor	Omalizumab
Inhaled steroid combinations	Budesonide-formoterol, Fluticasone-salmeterol, Mometasone-formoterol,
Inhaled corticosteroids	Beclomethasone, Budesonide, Ciclesonide, Flunisolide, Fluticasone CFC free, Mometasone
Leukotriene modifiers	Montelukast, Zafirlukast, Zileuton
Mast cell stabilizers	Cromolyn
Methylxanthines	Aminophylline, Dyphylline, Theophylline

Antidepressant Medication Management	CPT	HCPCS	ICD 10
Measure: The percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of **major** depression and who remained on an antidepressant medication treatment. Two rates are reported. • *Effective Acute Phase Treatment.* The percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks). • *Effective Continuation Phase Treatment.* The percentage of members who remained on an antidepressant medication for at least 180 days (6 months).	**Stand-alone visits:** 90804-90815, 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99411, 99412, 99510	**Stand-alone visits:** G0155, G0176, G0177, G0409, G0410, G0411, G0463, H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, M0064, S0201, S9480, S9484, S9485, T1015	**Major Depression:** F32.0-F32.4, F32.9, F33.0-F33.3, F33.41, F33.9
Documentation required: None (Administrative only)			

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Antidepressant Medication Management	CPT	HCPCS	ICD 10
	Visits: 90791, 90792, 90801, 90802, 90816-90819, 90821-90824, 90826, 90827-90829, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90857, 90862, 90867-90870, 90875, 90876, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99251-99255 **ED:** 99281-99285		

Provider types (unless indicated, no provider specialty is required)

Primary Care Physician (PCP): Providers that may function as PCPs	**Prenatal Care Provider:**	**Mental Health Practitioner:**
• A physician or non-physician (e.g. nurse practitioner) who offers primary care medical services. • General physician of family practice • General internal medicine physician • General pediatrician • OB/GYN	• OB/GYN • Certified nurse midwife, nurse practitioner, or physician assistant under the direction of an OB/GYN certified provider.	• Psychiatry • Psychology • LCSW • Psychiatric Registered Nurse • Master's-prepared therapist (American Association for Marriage and Family Therapy)

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- **You will receive the highest scores if you document all services and procedures on a claim, as this ensures you will receive credit.**
- **Utilizing codes as outlined on this document may also decrease the number of chart reviews required during HEDIS data collection.**
- **Please note this document is not all inclusive and is not intended to replace professional coding standards**