# Healthcare Effectiveness Data and Information Set (HEDIS®)

Developed by the National Committee for Quality Assurance (NCQA), HEDIS is the most widely used set of performance measures in the managed care industry. It contains measures that show health plans in those areas where a stronger focus could lead to improvements in member health. HEDIS reporting is mandated by NCQA for compliance and accreditation.

<table>
<thead>
<tr>
<th>MEASURE</th>
<th>SERVICE NEEDED</th>
<th>WHAT TO REPORT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Adult Access to Preventive/Ambulatory Care (AAP)</strong>&lt;br&gt;Percentage of members 20 years and older who had an ambulatory or preventive care visit</td>
<td>Ambulatory or preventive care visit in 2012</td>
<td><strong>CPT Codes to Identify Office Visits:</strong>&lt;br&gt;CPT: 99201-99205, 99211-99215, 99241-99245&lt;br&gt;<strong>Codes to Identify Preventive Medicine:</strong>&lt;br&gt;CPT: 99385-99387, 99395-99397, 99401-99404, 99411, 99412, 99420, 99429&lt;br&gt;HPCPs: G0344, G0402, G0438, G0439</td>
</tr>
<tr>
<td><strong>Adult Body Mass Index (BMI) Assessment (ABA)</strong>&lt;br&gt;Percentage of members 18 to 74 years old who had an outpatient visit and who had a BMI documented during 2011 or 2012</td>
<td>Documented BMI and weight for outpatient visits in 2011 or 2012:&lt;br&gt;- BMI: Date and value&lt;br&gt;- Weight: Date and value</td>
<td><strong>CPT Codes to Identify Outpatient Visits:</strong>&lt;br&gt;CPT: 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99385-99387, 99395-99397, 99401-99404, 99411, 99412, 99420, 99429, 99445, 99456&lt;br&gt;<strong>ICD-9 Codes to Identify BMI:</strong>&lt;br&gt;V85.0-V85.5</td>
</tr>
<tr>
<td><strong>Annual Monitoring for Patients on Persistent Medications (MPM)</strong>&lt;br&gt;Percentage of members 18 years old and older and on the following medications who received annual therapeutic monitoring:&lt;br&gt;  - Angiotensin converting enzyme (ACE) inhibitors/angiotensin receptor blockers (ARB)&lt;br&gt;  - Digoxin&lt;br&gt;  - Diuretics&lt;br&gt;  - Anticonvulsants</td>
<td>For members on ACE/ARB, digoxin and diuretics, annual monitoring to include:&lt;br&gt;  - Serum potassium AND&lt;br&gt;  - Serum creatinine OR blood urea nitrogen&lt;br&gt;For members on anticonvulsants, annual monitoring to include:&lt;br&gt;  - Drug serum concentration level monitoring test</td>
<td><strong>CPT Codes to Identify Services:</strong>&lt;br&gt;Lab panel&lt;br&gt;CPT: 80047, 80048, 80050, 80053, 80069&lt;br&gt;  - Serum potassium (K+)&lt;br&gt;    CPT: 80051, 84132&lt;br&gt;  - Serum creatinine (Scr)&lt;br&gt;    CPT: 82565, 82575&lt;br&gt;  - Blood Urea Nitrogen (BUN)&lt;br&gt;    CPT: 84520, 84525&lt;br&gt;  - Drug serum concentration for phenobarbital&lt;br&gt;    CPT: 80184&lt;br&gt;  - Phenytoin&lt;br&gt;    CPT: 80185, 80186&lt;br&gt;  - Valproic acid or divalproex sodium&lt;br&gt;    CPT: 80164&lt;br&gt;  - Carbamazepine&lt;br&gt;    CPT: 80156, 80157</td>
</tr>
</tbody>
</table>

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### Antidepressant Medication Management (AMM)

The percentage of members 18 years and older with a diagnosis of major depression who were newly treated with antidepressant medication.

**Effective Acute Phase Treatment** measures the percentage of newly diagnosed and treated members continuing medication for 12 weeks.

**Effective Continuation Phase Treatment** measures the percentage of newly diagnosed and treated members continuing medication for at least 6 months.

**ICD-9 Codes to Identify Major Depression:** ICD-9: 296.20-296.25, 296.30-296.35, 298.0, 311


### Breast Cancer Screening (BCS)

Percentage of women 40-69 years old who had a screening mammogram.

**One or more mammograms during 2011 or 2012.**

**Codes to Identify Screenings:**
- CPT: 77055-77057
- HCPCS: G0202, G0204, G0206

### Care for Older Adult (COA) – Advanced Care Planning [Medicare Special Needs Plan (SNP) only]

Percentage of adults 66 years and older who had each of the following during the measurement year:

- Advance care planning (advance directive, living will, power of attorney, health care proxy, actionable medical order regarding forms of life sustaining treatments)

**Advanced care planning**

Documentation of advance care planning in 2012.

Evidence of advance care planning must include:
- An advance care plan in the medical record or
- Advanced care planning discussion with the provider documented and dated in 2012 or
- Notation that the member has previously executed an advance care plan that meets criteria

**Codes to Identify Advanced Care Planning:**
- CPT Cat. II: 1157F, 1158F

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### HEDIS® QUALITY MEASURES GUIDE 2013  
(Measurement Year 2012)*

<table>
<thead>
<tr>
<th>Care for Older Adults (COA) - Complete functional status assessment</th>
<th>Functional status assessment</th>
<th>Codes to Identify Functional Status Assessment</th>
</tr>
</thead>
</table>
| A functional status assessment limited to an acute or single condition, event or body system (e.g., lower back, leg) does not meet criteria for a comprehensive functional status assessment. | Documentation in the medical record of at least one complete functional status assessment in 2012 including the date performed. Notations for a complete functional status assessment may include: Assessment of instrumental activities of daily living (IADL) such as shopping for groceries, driving, using public transportation, using the telephone, meal preparation, housework, home repair, laundry, taking medications or handling finances or – Assessment of activities of daily living (ADL) such as bathing, dressing, eating, transferring (i.e., getting in and out of chairs), using toilet and walking or – Results using a standardized functional status assessment tool or – Assessment of three of the following four components:  
  – Cognitive status  
  – Ambulation status  
  – Sensory ability (hearing, vision, speech)  
  – Other functional independence (e.g., exercise, ability to perform job) |  
CPT Cat. II: 1170F  

<table>
<thead>
<tr>
<th>Care for Older Adults (COA) – Medication Review</th>
<th>Medication review</th>
<th>Codes to Identify Medication Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>At least one dated medication review conducted by a prescribing practitioner or clinical pharmacist along with a medication list or dated documentation of no medications.</td>
<td>Documentation of at least one dated medication review conducted by a prescribing practitioner or clinical pharmacist in 2012 along with a medication list present in the same medical record. If patient is not taking any medication, dated notation should be documented in the chart in 2012. A review of side effects for a single medication at the time of prescription alone is not sufficient.</td>
<td></td>
</tr>
</tbody>
</table>
CPT: 90862, 99605, 99606  
CPT Cat. II: 1160F  

<table>
<thead>
<tr>
<th>Care for Older Adults (COA) - Pain screening or pain management plan</th>
<th>Pain screening</th>
<th>Codes to Identify Pain Screening</th>
</tr>
</thead>
</table>
| Documentation in the medical record of at least one pain screening or a pain management plan in 2012, including the date it was performed. Notations can include:  
  – Notation of a comprehensive pain assessment or results of a screening using a standardized pain screening tool  
  – Evidence of a pain management plan such as notation of no pain intervention and the rationale, notation of plan for pain treatment (pain meds, psychological support and patient/family education) or notation of plan for reassessment of pain including time interval. A pain assessment or management plan limited to an acute or single condition, event or body system does not meet criteria for a comprehensive pain assessment or pain management plan. |  
CPT Cat. II: 0521F, 1125F, 1126F  

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Y0071_12_15906_1/2012  
32699MUPENMUB
### HEDIS® QUALITY MEASURES GUIDE 2013
(Measurement Year 2012)*

<table>
<thead>
<tr>
<th>Cholesterol Management (CMC)</th>
<th>LDL screening (date and result) in 2012 for all members discharged from a hospital with a cardiovascular related diagnosis in the last 2 years. AND The most recent* 2012 LDL value (should be &lt;100 mg/dL)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>*date and result of last LDL screening in 2012</td>
</tr>
<tr>
<td></td>
<td><strong>Codes to Identify Labs:</strong> CPT: 80061, 83700, 83701, 83704, 83721 CPT II: 3048F, 3049F, 3050F LOINC: 2089-1, 12773-8, 13457-7, 18261-8, 18262-6, 22748-8, 39469-2, 49132-4, 55440-2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Colorectal Cancer Screening (COL)</th>
<th>Fecal occult blood (FOBT, gFOBT or iFOBT) test in 2012 (guaiac from a digital rectal exam does not meet criteria) AND/OR Flexible sigmoidoscopy in the past 5 years AND/OR Colonoscopy in the past 10 years</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Codes to Identify Services:</strong> Fecal occult blood test between 1/1/2012 and 12/31/2012 CPT: 82270, 82274 HCPSC: G0328 Flexible sigmoidoscopy between 1/1/2008 and 12/31/2012 CPT: 45330-45335, 45337-45342, 45345 HCPSC: G0104 Colonoscopy between 1/1/2003 and 12/31/2012 CPT: 44388-44394, 44397, 45355, 45378-45387, 45391, 45392 HCPSC: G0105, G0121 AND/OR Chart documentation of previously performed colorectal screening tests including date and result Documentation of member</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>LDL testing LDL control (&lt;100 mg/dL)</th>
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</thead>
<tbody>
<tr>
<td></td>
<td><strong>Codes to Identify Labs:</strong></td>
</tr>
</tbody>
</table>

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Y0071_12_15906_1/2012 32699MUPENMUB
<table>
<thead>
<tr>
<th>Measure</th>
<th>Description</th>
<th>Calculation</th>
<th>Documentation</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Controlling High Blood Pressure (CBP)</strong></td>
<td>Percentage of members age 18-85 diagnosed with hypertension who have a blood pressure reading below 140/90 mmHg for the last visit of 2012</td>
<td>Chart documentation of: Hypertension diagnosis <strong>prior to June 30, 2012</strong> AND The most recent* blood pressure readings in <strong>2012</strong>. Readings must be dated and to be considered controlled must be &lt;140/90 mmHg</td>
<td>*last blood pressure readings in 2012</td>
<td></td>
</tr>
<tr>
<td><strong>Diabetes – Blood Pressure Control</strong></td>
<td>Percentage of members age 18-75 who have a blood pressure reading during 2012</td>
<td>The <strong>most recent</strong> blood pressure readings in <strong>2012</strong> including date To be considered controlled the blood pressure must be &lt;140/90</td>
<td>*Last 2 BP readings (date and result) in 2012</td>
<td></td>
</tr>
<tr>
<td><strong>Diabetes – Dilated or Retinal Eye Exam</strong></td>
<td>Percentage of diabetic members age 18-75 who have received a comprehensive eye exam in 2011 or 2012.</td>
<td>• Encourage and/or refer member to see an eye care professional for a comprehensive eye exam annually • A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in <strong>2012</strong>, OR • A negative retinal or dilated exam (no evidence of retinopathy) by an eye care professional in <strong>2011</strong>.</td>
<td>Claim or Encounter Submission: • From either an ophthalmologist or an optometrist in 2011 or 2012 • Obtain and place copy of eye exam report in the member’s medical record. Include any reports from 2011 or 2012.</td>
<td></td>
</tr>
</tbody>
</table>

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**HEDIS® QUALITY MEASURES GUIDE 2013**  
(Measurement Year 2012)*

<table>
<thead>
<tr>
<th>Measure</th>
<th>Criteria</th>
<th>Codes to Identify Labs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diabetes – HbA1c Screening</strong></td>
<td>Percentage of diabetic members age 18-75 who have evidence of:</td>
<td>CPT: 83036, 83037, 3044F, 3045F, 3046F, 4548-4, 4549-2, 17856-6, 59261-8, 62388-4</td>
</tr>
<tr>
<td></td>
<td>- HbA1c: Last A1c date and result in 2012</td>
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<tr>
<td></td>
<td>- For Compliance HbA1c should be &lt;9.0</td>
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<tr>
<td></td>
<td>OR HbA1c poor control &gt;9.0%</td>
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<td></td>
<td>OR HbA1c control &lt;8%</td>
<td></td>
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<td></td>
<td>OR HbA1c control &lt;7%</td>
<td></td>
</tr>
<tr>
<td><strong>Diabetes – LDL</strong></td>
<td>LDL testing on all diabetic patients in 2012 AND</td>
<td>CPT: 80061, 83700, 83701, 83704, 83721</td>
</tr>
<tr>
<td></td>
<td>To be compliant all members must have the date and result of the latest</td>
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<td></td>
<td>LDL &lt;100 mg/dL in 2012</td>
<td></td>
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<tr>
<td></td>
<td>AND/OR</td>
<td>CPT II: 3060F, 3061F, 3062F, 3063F, 3064F, 3065F, 3066F</td>
</tr>
<tr>
<td><strong>Diabetes – Nephropathy</strong></td>
<td>Percentage of diabetic members age 18-75 who received medical attention</td>
<td>CPT: 82042, 82043, 82044, 84156, 3060F, 3061F</td>
</tr>
<tr>
<td></td>
<td>for nephropathy (nephropathy screening test or evidence of nephropathy)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>in 2012</td>
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<tr>
<td></td>
<td>- Nephropathy screening testing in 2012 with at least one of the</td>
<td></td>
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<tr>
<td></td>
<td>following:</td>
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<td></td>
<td>- Timed, spot or 24-hour urine for microalbumin</td>
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<td>- 24-hour urine for total protein</td>
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<td>- Urine for microalbumin/creatinine ratio</td>
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<td></td>
<td>- Random urine for protein/creatinine ratio</td>
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<td></td>
<td>AND/OR</td>
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<td>- Documented evidence of nephropathy including:</td>
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<tr>
<td></td>
<td>- Documentation of a visit to a Nephrologist.</td>
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<td></td>
<td>- Documentation of a renal transplant.</td>
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<tr>
<td></td>
<td>- Documentation of medical attention for any of the following (no</td>
<td></td>
</tr>
<tr>
<td></td>
<td>restriction on provider type):</td>
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<tr>
<td></td>
<td>- Diabetic nephropathy</td>
<td></td>
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<td></td>
<td>- ESRD</td>
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<td></td>
<td>- CRF</td>
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<tr>
<td></td>
<td>- Chronic kidney disease (CKD)</td>
<td></td>
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<tr>
<td></td>
<td>- Renal insufficiency</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Proteinuria</td>
<td></td>
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<tr>
<td></td>
<td>- Albuminuria</td>
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<tr>
<td></td>
<td>- Renal dysfunction</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Acute renal failure (ARF)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Dialysis, hemodialysis or peritoneal dialysis</td>
<td></td>
</tr>
</tbody>
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### Disease-modifying Antirheumatic Drug (DMARD) Therapy for Rheumatoid Arthritis (ART)

Percentage of members who were diagnosed with rheumatoid arthritis and were dispensed at least one ambulatory prescription for a DMARD in 2012

- Assess all patients with diagnosis of rheumatoid arthritis for DMARD treatment in 2012
- All patients not currently treated with a DMARD should be referred for rheumatology consultation to confirm diagnosis and assess for DMARD therapy

#### Codes To Identify Rheumatoid Arthritis
- ICD-9 Codes: 714.0, 714.1, 714.2, 714.81

#### AND/OR
- Pharmacy claim for DMARD in 2012

DMARDS include:

- Aminoquinolines: Hydroxychloroquine
- 5-Aminosalicylates: Sulfasalazine
- Alkylating agents: Cyclophosphamide
- Antirheumatics: Auranofin, gold sodium thiomalate, leflunomide, methotrexate, penicillamine
- Immunomodulators: Abatacept, adalimumab, anakinra, certolizumab, certolizumab pegol, etanercept, golimumab, infliximab, rituximab, Tocilizumab
- Immunosuppressive agents: Azathioprine, cyclosporine, mycophenolate
- Tetracyclines: Minocycline

### Follow-up After Hospitalization for Mental Illness (FUH)

The percentage of discharges for members 6 years and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner.

- Two components are measured:
  - The percentage of discharges for which the member received follow-up within 30 days of discharge
  - The percentage of discharges for which the member received follow-up within 7 days of discharge

#### Codes to Identify Visits:
- ICD-9 codes: 295-299, 300.3, 300.4, 301, 308, 309, 311-314

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## (Measurement Year 2012)*

### Glaucoma Screening in Older Adults (GSO)
**Percentage of members 65 years old or older, without a prior diagnosis of glaucoma or glaucoma suspect, who received a glaucoma screening exam by an eye care professional in 2011 or 2012.**

- Refer and encourage members 65 years old and older who did not have a claim/encounter for glaucoma screening in 2011 to see an eye care professional for glaucoma screening in 2012.

**Must be done by an ophthalmologist or optometrist and submitted for 2011 or 2012**

**Codes to Identify Screening Exams:**
- CPT: 92002, 92004, 92012, 92014, 92081-92083, 92100, 92120, 92130, 92140, 99202-99205, 99213-99215, 99242-99245
- HCPCS: G0117, G0118, S0620, S0621

### Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)
**The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who received treatment from 1/1/2012-11/15/2012 for:**

- **Initiation of AOD treatment.** The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis.
- **Engagement of AOD Treatment.** The percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.

**Codes to Identify AOD Dependence:**
- ICD-9-CM: 291-292, 303.00-303.02, 303.90-303.92, 304.00-304.02, 304.10-304.12, 304.20-304.22, 304.30-304.32, 304.40-304.42, 304.50-304.52, 304.60-304.62, 304.70-304.72, 304.80-304.82, 304.90-304.92, 305.00-305.02, 305.20-305.22, 305.30-305.32, 305.40-305.42, 305.50-305.52, 305.60-305.62, 305.70-305.72, 305.80-305.82, 305.90-305.92, 535.3, 571.1

### Medication Reconciliation Post-Discharge (MRP)
**Medicare Special Needs Plan (SNP) only**

**The percentages of discharges in 2012 for members 66 years and older for whom medications were reconciled on or within 30 days of discharge.**

- Medication reconciliation may be completed by the prescribing practitioner, clinical pharmacist or registered nurse and must be documented including date performed and one of the following:
  - A notation in the outpatient record that the medications prescribed upon discharge were reconciled with the current medications **OR**
  - A medication list in a discharge summary that is present in the outpatient chart and evidence of a reconciliation with the current medications by one of the above providers **OR**
  - Notations that no medications were prescribed upon discharge.

**Codes to Identify Medication Reconciliation:**
- CPTII: 1111F

### Osteoporosis Screening and Management after Fracture (OMW)
**Percentage of females 67 years old and older who suffered a fracture and who had either a bone mineral density (BMD) test or prescription to treat or prevent osteoporosis within six months after the fracture.**

- Perform bone mineral density testing within six months on members 67 years old and older who experience a fracture. (Fractures of finger, toe, face and skull are not included in this measure.)

**AND/OR**
- Prescribe a medication to treat osteoporosis
  - FDA-Approved Osteoporosis Therapies
    - Biphosphonates
    - Estrogens
    - Other agents i.e., calcitonin, denosumab, raloxifene, teriparatide

**Codes to Identify Services:**
- CPT: 76977, 77078-77083, 78350, 78351
- Coding done by health care provider completing testing

**AND/OR**
- Pharmacy claim for osteoporosis drug therapy

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| Persistence of Beta-Blocker Treatment After A Heart Attack (PBH) | The percentage of members 18 years or older who were discharged from a hospital 7/1/11 - 6/30/12 with a diagnosis of AMI and who received persistent beta-blocker treatment for 6 months after discharge | Beta-Blockers: Acebutolol, Atenolol, Betaxolol, Bisoprolol, Carteolol, Carvedilol, Labetalol, Metoprolol, Nadolol, Nebivolol, Penbutolo, Pindolo, Propranolol, Timolol, Sotalol.  
**Antihypertensive combinations:** Atenolol-Chlorthalidon, Bendroflumethiazide-nadolok, Bisoprolol-hydrochlorothiazide, Hydrochlorothiazide-Metoprolol, Hydrochlorothiazide-Propranolol. |
| --- | --- | --- |
| Members discharged from a hospital due to AMI with a Betablocker prescription and persistent monitoring afterwards. | Two components are measured:  
• Dispensed a systemic corticosteroid within 14 days and/or  
• Dispensed a bronchodilator within 30 days. | Note: Identify different drugs using the Drug ID field located in the NDC list on NCQA’s Web site ([www.ncqa.org](http://www.ncqa.org)). |
| Pharmacotherapy Management of COPD Exacerbation (PCE) | The percentage of COPD exacerbations for members 40 years and older who had an acute inpatient discharge or ED visit between 1/1 and 11/30/12 who were dispensed appropriate medication. | Note: Identify different drugs using the Drug ID field located in the NDC list on NCQA’s Web site ([www.ncqa.org](http://www.ncqa.org)). |
| The percentage of COPD exacerbations for members 40 years and older who had an acute inpatient discharge or ED visit between 1/1 and 11/30/12 who were dispensed appropriate medication. | The following are measured:  
• A history of falls and prescription for tricyclic antidepressants, antipsychotics or sleep agents.  
• Dementia and a prescription for tricyclic antidepressants or anticholinergic agents.  
• CRF and prescription for nonaspirin NSAIDs or Cox-2 Selective NSAIDs. | Note: Identify different drugs using the Drug ID field located in the NDC list on NCQA’s Web site ([www.ncqa.org](http://www.ncqa.org)). |
| Potentially Harmful Drug-Disease Interactions in the Elderly (DDE) | The percentage of members 65 years and older who had evidence of an underlying disease, condition or health concern and who were dispensed an ambulatory prescription for a contraindicated medication concurrent with or after the diagnosis dated 1/1/2011 – 12/1/2012. | **Note:** Identify different drugs using the Drug ID field located in the NDC list on NCQA’s Web site ([www.ncqa.org](http://www.ncqa.org)). |
| The percentage of members 65 years and older who had evidence of an underlying disease, condition or health concern and who were dispensed an ambulatory prescription for a contraindicated medication concurrent with or after the diagnosis dated 1/1/2011 – 12/1/2012. | | |

*HEDIS codes can change from year to year. The codes in this document are for HEDIS 2013 (measurement year 2012). HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA). CPT® codes are the Current Procedural Terminology codes developed by the American Medical Association. HCPCS is the Healthcare Common Procedure Coding System used by the Centers for Medicare & Medicaid Services. LOINC® (Logical Observation Identifiers Names and Codes) is a set of universal names and ID codes for identifying laboratory and clinical test results.*
# Use of High-Risk Medications in the Elderly (DAE)

- The percentage of Medicare members 66 years of age and older who received at least one high-risk medication.
- The percentage of Medicare members 66 years of age and older who received at least two different high-risk medications.

For both rates, a lower rate represents better performance.

## The two components for this measure are:
- At least one prescription dispensed for any high-risk medication during 2012.
- At least two prescriptions dispensed for different high-risk medications during 2012.

## Note:
Identify different drugs using the Drug ID field located in the NDC list on NCQA’s Web site (www.ncqa.org).

## Use of Spirometry Testing in the Diagnosis of COPD (SPR)

Members 40 years and older with a new diagnosis of COPD or newly active COPD who received appropriate spirometry testing to confirm the diagnosis occurring 7/1/2011 to 6/30/2012.

Perform spirometry testing within 6 months after diagnosis of COPD or newly active COPD.

## Codes to Identify Spirometry testing:
- CPT: 94010, 94014-94016, 94060, 94070, 94375, 94620

## Codes to Identify COPD:
- ICD-9-CM: 491, 492, 493.2, 496

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