BlueCross BlueShield Arizona

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Medicare Advantage and Federal Employee Program

Provider Tool Kit

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Purpose of Tool Kit

This tool kit servers as quick reference guide to quality measurements and can be used as a resource for your claims department.

Contents cover:

- The HEDIS® Focused Measure for Medicare Advantage and the Federal Employee program
- How to improve your claims, supplemental data, and medical record documentation to maximize your rates
- Best practices and who to contact for additional support

Medicare Advantage Stars HEDIS Cut-points - 2022MY, 2024RY

HEDIS Measure	Abbreviation	4 Stars Rate	5 Stars Rate
Breast Cancer Screening	BCS – E	71%	79%
Colorectal Cancer Screening	COL	71%	80%
Glycemic Status Assessment for Patients with Diabetes	GSD	80%	87%
Eye Exam for Patients with Diabetes	EED	73%	81%
Controlling Blood Pressure	CBP	74%	82%
Statin Therapy for Patients with Cardiovascular Disease	SPC	86%	90%
Osteoporosis Management in Women who had a Fracture	OMW	55%	71%

Federal Employee Program HEDIS Measures Benchmark

HEDIS Measure	Abbreviation	50th Percentile Rate	75th Percentile Rate
Breast Cancer Screening	BCS – E	73.05%	76.84%
Colorectal Cancer Screening	COL	62.46%	67.97%
Cervical Cancer Screening	CCS	74.00%	77.68%
Glycemic Status Assessment for Patients with Diabetes	GSD	61.31%	65.69%
Controlling Blood Pressure	CBP	63.67%	69.73%
Prenatal and Postpartum	PPC	85.32%	90.00%
Childhood Immunizations Combo	CIS	56.08%	64.44%
Avoidance of Antibiotic Treatment for Acute Bronchitis	AAB	48.84%	55.91%
Use of Imaging Studies for Low Back Pain	LBP	76.41%	79.99%
Use of Opioids from Multiple Providers	UOP	13.47%	11.07%
Antidepressant Medication Management	AMM	60.83%	65.40%
Asthma Medication Ratio	AMR	84.32%	87.84%

Patient Experience

Applicable line of business	
Medicare Advantage (MA)	Federal Employee Program (FEP)

Consumer Assessment of Healthcare Providers and Systems (CAHPS®) is an Agency for Healthcare Research and Quality (AHRQ) program that began in 1995. Its purpose is to advance our scientific understanding of patient experience with healthcare. A sample of patients is selected, and a nationally standardized survey is conducted by an external organization. Each plan has rates for the various sections of the surveys. The results are submitted to NCQA, who submits them to CMS. CMS may adjust scores slightly based on population characteristics, and then the plan's Performance and Star ratings are calculated based on their respective survey scores. The CAHPS survey remains voluntary and anonymous for the MA and FEP population. CAHPS scores represent 22% of the plan's overall MA Star rating and 14% of the FEP Quality Rating. The official survey submitted to regulatory entities does not provide patient-level data to the plan or provider specific performance ratings. BCBSAZ will be surveying patients who have completed a PCP visit. The results of this off-cycle survey will be loaded into Provider Performance CAHPS scorecards and shared with eligible VBP's and PCP Groups. You can view the survey instruments here. AHRQ has free webinars and tools to improve patient experience.

Getting Needed Care (CAHPS Survey)

This measures how often patients surveyed indicate they were able to get the care, tests, and treatment they needed easily.

Getting Appointments and Care Quickly (CAHPS Survey)

This measures how often patients answered survey questions positively related to obtaining care and appointments as soon as they needed, as well as being able to see the provider within 15 minutes of the appointment time.

Rating of Healthcare Quality (CAHPS Survey)

This measures patients' overall perception of their health care on a scale from 0- 10

Care Coordination (CAHPS Survey)

This measures how often patients surveyed indicate they were able to get the follow up care, tests, and treatment they needed easily and if their provider was aware of other specialty care and prescriptions prescribed.

About HOS Survey Measure

Applicable line of business
Medicare Advantage

CMS monitors the quality of care provided by Medicare Advantage Organizations (MAOs). To better evaluate the quality of care provided by Medicare Advantage plans and their contracted providers, CMS and NCQA conduct the Medicare Health Outcomes Survey (HOS), implemented in 1998. HOS is worth 7% of the overall Star Rating for each Medicare Advantage contract. HOS is focused on the following measures: Improving Bladder Control, Reducing the Risk of Falling, Monitoring Physical Activity, Improving or Maintaining Physical Health, and Improving or Maintaining Mental Health. You can view the survey instruments here.

Improving Bladder Control (HOS)

This measures the patient with a urine leakage problem in the last 6 months and the patient discussed treatment options with a provider.

Reducing the Risk of Falling (HOS)

This measures the patients with a problem falling, walking, or balancing and the patient reports discussing it with their provider and received a recommendation for how to prevent falls during the year.

Monitoring Physical Activity (HOS)

This measures the patients indicating that their doctor discussed exercise with them, and the patient was advised to start, increase, or maintain their physical activity during the year.

Improving or Maintaining Physical Health (HOS)

This measures patients whose physical health was the same or better than expected after two years.

Improving or Maintaining Mental Health (HOS)

This measures patients whose mental health was the same or better than expected after two years.

Prevention and Screening

Breast Cancer Screening (BCS-E)

Applicable line of business	
Medicare Advantage	Federal Employee Program

Definition: This measures the percent of women aged 50-74 who had a mammogram to screen for breast cancer from October 1 two years prior to the measurement year through December 31 of the measurement year. It includes women with and without higher risk of breast cancer.

Commonly Used Codes:

*Codes below are examples only and not recommendations

Mammography Codes

CPT 77055-77057, 77061-77063, 77065-77067
HCPCS G0202, G0204, G0206, G9054, M1017

Exclusion Codes must be coded yearly

ICD-10 Diagnosis Z90.13, Z90.11, Z90.12

Note: To exclude the patient, the plan must have a claim or medical record coding frailties and advanced illnesses on claims may exclude patients from this measure.

Best Practices

- This measure evaluates primary screening only. This does not count biopsies, breast ultrasounds, or MRIs.
- Document the month and year mammogram was completed, including for self-reported mammograms.
- Documentation for patients with mastectomies should include the type of surgery performed.
- Educate patients about the importance of early detection and screening. Address any fears or concerns expressed and assist in overcoming barriers.

Colorectal Cancer Screening (COL-E)

Applicable line of business	
Medicare Advantage	Federal Employee Program

Description: This measures the percent of patients 45-75 who had screening for colorectal cancer.

Any of the following qualify:

Fecal occult blood test (FOBT) during the measurement year	FIT-DNA test during the measurement year or the 2 years prior to the measurement year
Flexible sigmoidoscopy during the measurement year or the 4 years prior to the measurement year	Colonoscopy during the measurement year or the 9 years prior to the measurement year

Can also have a CT Colonography during Measurement year or 4 years prior to the measurement year

Commonly Used Codes:

*Codes below are examples only and not recommendations

Colorectal Screening Codes

CPT FOBT Test- 82270 – current measurement year FIT immunoassay (iFOBT)- 82274 – current measurement year Colonoscopy- 45380, 45385, 45378 – current measurement year or the nine years prior FIT-DNA – Cologuard – 81528 – during the measurement year measurement year of the two years prior to the measurement year

Exclusion Codes must be coded yearly

ICD-10 Diagnosis C18.0 – C18.9, C19, C20, C21.2, C21.8, C78.5, Z85.038, Z85.048

Best Practices

- Standing orders and FIT Kits available in the office increase compliancy.
- Test result is not required if the documentation is clearly a part of the medical history section of the record and includes date performed. At minimum, documentation should include month and year.
- Results must be documented for FIT-DNA and iFOBT.

Cervical Cancer Screening (CCS)

Applicable line of business
Federal Employee Program

Description: The percentage of women 21–64 years of age who were screened for cervical cancer in the previous 3–5 years. Document date of latest pap smear and/or HPV and result (patient reported is acceptable).

Commonly Used Codes:

*Codes below are examples only and not recommendations

Cervical Cytology and HPV Testing Codes

CPT 88175, 87624, 87625, 58571, 58552, 58150

Exclusion Codes must be coded yearly

CPT 58571, 58552, 58150

Best Practices

- Medical record must include the date test performed and results.
- Biopsy is considered a diagnostic test and not a screening test.
- Educate patients on the importance of preventative screenings and early detection.
- Documentation must state complete, total, or radical hysterectomy to meet exclusion criteria.

Diabetes

Glycemic Status Assessment for Patients with Diabetes (GSD) *previously HBD*

Applicable line of business	
Medicare Advantage	Federal Employee Program

Description: The percentage of members 18–75 years of age with diabetes (types 1 and 2) whose most recent glycemic status (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) was at the following levels during the measurement year:

- Glycemic Status <8.0% FEP
- Glycemic Status >9.0% MA NOTE: A lower rate indicates better performance for this indicator

Commonly Used Codes:

*Codes below are examples only and not recommendations

Exclusion Codes must be coded yearly

E28.2, O24.410

CPTII Hemoglobin A1c Tests	
3044F	Most recent hemoglobin A1c (HbA1c) level < 7.0%
3046F	Most recent hemoglobin A1c (HbA1c) level > 9.0%
3051F	Most recent hemoglobin A1c (HbA1c) level ≥ 7.0% and < 8.0%
3052F	Most recent hemoglobin A1c (HbA1c) level ≥ 8.0% and ≥ 9.0%

LOINC code 97506-0 (accounts for the GMI if calculated at office)

Best Practices

- Utilizing CPT II codes is the best way to ensure compliance is met for the measure.
- A patient is considered to have poor control if:
  - MA HbA1c test result is >9.0%.
  - FEP HbA1c test result is >8.0%.
  - HbA1c test is not completed.
  - HbA1c test date or result is missing.
- Aim for <8% with all patients, regardless of line of business
- Utilize point of care testing during office visits or in-home testing kits.
- Implement a process to retest the patient after 90 days.
- Cannot use "most recent a1c was..." or "a1c in April was..." BCBS needs a date (at least month and year) plus the result

Kidney Health Evaluation for Patients with Diabetes (KED)

Applicable line of business
Medicare Advantage

Description: The percentage of patients 18-85 years of age with diabetes (type 1 and type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR), during the measurement year.

Commonly Used Codes:

*Codes below are examples only and not recommendations

Codes

CPT Estimated Glomerauler Filtration Rate Lab (eGFR): 80053, 80048, 80050
Quantitative Urine Albumin Lab test: 82043
Urine Creatinine Lab Test: 82570

Best Practices

- Blood Test: Estimated glomerular filtration rate (eGFR) Urine Test: Urine albumincreatinine ratio (uACR) OR Combo Test- Complete BOTH quantitative urinealbumin test AND a urine creatinine test within 4 or less days apart

Eye Exam for Patients with Diabetes (EED)

Applicable line of business
Medicare Advantage

Description: The percentage of patients 18–75 years of age with diabetes (types 1 and 2) who had a retinal eye exam completed by an ophthalmologist or optometrist.

- Had bilateral eye enucleation any time through December 31 of the measurement year, OR
- A retinal or dilated eye exam by any provider during the measurement year, OR
- A negative retinal or dilated eye exam (negative for retinopathy) by an eye care professional in the year prior to the measurement year

Commonly Used Codes:

*Codes below are examples only and not recommendations

Diabetic Eye Exam Code Specs

ICD-10 Diagnosis E11.621, E11.21, E11.9

CPT II 2022F, 2023F, 2024F, 2025F, 2026F, 2033F, 3072F

Exclusion Codes must be coded yearly must be coded yearly

ICD-10 Diagnosis E09.65, E09.9

Best Practices

- Utilizing CPT II codes is the best way to ensure compliance is met for the measure.
- Documentation must include who completed the procedure or reviewed the results, date of procedure, and results.
  - Note: an eye exam result documented as "unknown" does not meet criteria
- Eye exams positive for retinopathy require an annual exam, otherwise exams are only needed every other year.
- Fundal photography can be used
- Documentation of hypertensive retinopathy counts as POSITIVE result of retinopathy.
- Blindness is not an exclusion

Controlling Blood Pressure (CBP)

Applicable line of business	
Medicare Advantage	Federal Employee Program

Description: This measures the percentage of patients 18–85 years of age who had a diagnosis of hypertension (HTN) and whose last BP reading during the measurement year showed adequate control (<140/90 mm Hg). Please refer to this section for resources and tips.

Commonly Used Codes:

*Codes below are examples only and not recommendations

	Codes	Compliant Result*	Definition
Diastolic Readings	3078F	✓	Most recent diastolic BP < 80 mm Hg
	3079F	✓	Most recent diastolic BP 80-89 mm Hg
	3080F	X	Most recent diastolic BP ≥ 90 mm Hg
Systolic Readings	3074F	✓	Most recent systolic BP < 130 mm Hg
	3075F	✓	Most recent systolic BP 130-139 mm Hg
	3077F	X	Most recent systolic BP ≥ 140 mm Hg

Best Practices

- Utilizing CPT II codes is the best way to ensure compliance is met for the measure.
- Patient is considered uncontrolled if there is no BP reading in the record during the MY.
- Retake BP at least 20 minutes later if ≥ 140/90 and document results.
- Documentation of patient reported BP readings does not count if the patient is using a manual device.
- Refer patient to nephrology or cardiology if unable to achieve a lower blood pressure after repeated attempts and medication treatment.
- Cannot use ranges or thresholds such as... "bp runs 120s-130s/80s. But you can use an average...-"average bp is 122/76"

Statin Therapy for Patients with Cardiovascular Disease (SPC) – Received Statin Therapy

Applicable line of business	
Medicare Advantage	Federal Employee Program

Description: The percentage of males 21–75 years of age and females 40–75 years of age during the measurement year who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) who meet following criteria

1. Received Statin therapy- patients were dispensed at least one statin of any intensity during the measurement year. (Medicare)
2. Statin Adherence 80%- patients who remained on a statin medication of any intensity for at least 80% of the treatment period. (FEP)

Commonly Used Codes:

*Codes below are examples only and not recommendations

Exclusion Codes must be coded yearly

G72.0, G72.9, M60.8 OR M60.9: Myalgia, myopathy or rhabdomyolysis (Muscular Pain and Disease Value Set) during the measurement year.

B17.0-B19.9 or K70.0-K75.4: Cirrhosis (Cirrhosis Value Set) during the measurement year of the year prior to the measurement year.

N18.5, N18.6 or Z99.2: ESRD (ESRD Diagnosis Value Set) or dialysis (Dialysis Procedure Value Set) during the measurement year or the year prior to the measurement year.

*Pre-Diabetes & Polycystic Ovarian Syndrome are SUPD ONLY exclusions

Best Practices

- Pre-schedule follow-up and lab visits when writing/dispensing new medications.
- Educate patients that statin therapy can reduce the risk of heart attack and stroke.

Musculo-Skeletal

Osteoporosis Management in Women Who Had a Fracture (OMW)

Applicable line of business
Medicare Advantage

Description: This measures the percentage of women 67–85 years of age who had a fracture and either a bone mineral density (BMD) test or prescription fill for a drug to treat osteoporosis in the six months after the fracture; the test or treatment must occur no later than 180 days after the fracture.

Osteoporosis Medications

Description	Prescription	
Bisphosphonates	Alendronate Alendronate-cholecalciferol Ibandronate	Risedronate Zoledronic acid

Commonly Used Codes:

*Codes below are examples only and not recommendations

Osteoporosis Testing Codes

ICD-10 Diagnosis G20, E0431

CPT Bone Mineral Density: 77080, 77081, 77085

Best Practices

- Consider ordering a DEXA scan or BMD screening on all women 65 years of age and older every two years.

Note: Ensure coding accurately distinguishes old fractures vs. new fractures. Coding as a new fracture causes the patient to have a gap in care for osteoporosis screening or treatment.

Family Planning & Well Childcare

Timeliness of Prenatal Care (PPC)

Applicable line of business
Federal Employee Program

Description: Percentage of live births where patient received a prenatal care visit in the first trimester (280-176 days prior to delivery or estimated delivery date) of the pregnancy or within 42 days of enrollment.

Commonly Used Codes:

*Codes below are examples only and not recommendations

Prenatal Codes

ICD-10 Diagnosis Z34.91

CPT 59400, 99201

CPT II 0500F, 0501F, 0502F

Best Practices

- Utilizing CPT II codes is the best way to ensure compliance is met for the measure.
- PCP's must include pregnancy diagnosis code AND the prenatal visit code or the appropriate CPTII code when submitting claims. Medical record documentation must indicate when the prenatal care visit occurred and evidence of one of the following: 1. Indicates the member is pregnant or have references to the pregnancy or 2. Include a basic physical obstetrical exam that includes fetal heart tone or pelvic exam with obstetric observations, or measurement of fundus height (a standardized prenatal flow sheet may be used) or 3. Evidence that a prenatal care procedure was performed during the visit. Visit notes should include name and title of OB/GYN or PCP.

Note: Measurement year: Live births on or between October 8 of the year prior to the measurement year and October 7 of the current measurement year.

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

Applicable line of business
Federal Employee Program

Description: The percentage of patients who had the following number of well-child visits with a PCP during the last 15 months. The following rates are reported:

1. Well-Child Visits in the First 15 Months. Children who turned 15 months old during the measurement year: Six or more well-child visits.
2. Well-Child Visits for Age 15 Months–30 Months. Children who turned 30 months old during the measurement year: Two or more well-child visits.

Commonly Used Codes:

*Codes below are examples only and not recommendations

Codes

New patient well visit: 99381-99385

Established patient well visit: 99391-99395

Best Practices

- Visits with a nurse practitioner or physician assistant meet the measure.
- Utilize sick visits as an opportunity to complete screenings and immunizations as needed.
- Schedule the next well child visit appointment during discharge

Childhood Immunizations Combo 10 (CIS)

Applicable line of business
Federal Employee Program

Description: The percentage of children 2 years of age who had all combo 10 vaccines by their second birthday, including 2 does of flu vaccine. All immunizations must be logged in ASIIS. If multiple immunizations are administered on the same visit, ensure that all immunizations are included on the claim.

Commonly Used Codes:

*Codes below are examples only and not recommendations

Vaccination Codes

CPT DTaP- 90698, 90723, 90700; IPV- 90698, 90723; MMR- 90707, 90710; HiB- 90698, 90648, 90647; HepB- 90723; VZV- 90716, 90710; PCV- 90670; HepA- 90633; RV- 90681 (2 dose), 90680 (3 dose); Flu- 90686, 90688 (2 dose)

CVX DTaP – 120 IPV- 120, 110; MMR- 03, 94; HiB- 120; HepB- 110; VZV- 31, 83, 85; PCV- 133, 152, 33; HepA- 31, 83, 85; RV- 122, 116 (3 dose), 119 (2 dose); Flu- 158, 150, 153

HCPCS HepB- G0010; PCV- G0009; Flu- G0008

Best Practices

- Infants and children who are getting their flu shot for the first time may need two doses, given at least four weeks apart.
- Complete all recommended vaccines before 2yrs of age
- Upload immunizations to Arizona State Immunization Information System (ASIIS)
- Educate parents on the importance of vaccinations and provide an immunization schedule.

Appropriate Service and Utilization

Avoidance of Antibiotic Treatment for Acute Bronchitis (AAB)

Applicable line of business
Federal Employee Program

Description: The percentage of episodes for patients ages 3 months and older with a diagnosis of acute bronchitis/ bronchiolitis that did not result in an antibiotic dispensing event on or 3 days after the episode date.

Best Practices

- Avoid prescribing antibiotics for acute bronchitis/bronchiolitis
- Educate patients on inappropriate use of antibiotic treatments
- If a prescription is need post date the script 3 days after visit date

EXAMPLE: If patient is seen on Monday and diagnosed with bronchitis and is not prescribed or does not fill an antibiotic prescription until or after Friday of that same week = compliant

Use of Imaging Studies for Low Back Pain (LBP)

Applicable line of business
Federal Employee Program

Description: The percentage of patients 18–75 years of age with a principal diagnosis of low back pain who did NOT have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis.

Commonly Used Codes:

*Codes below are examples only and not recommendations

Exclusion Codes must be coded yearly must be coded yearly

Recent Trauma: Trauma any time during the 3 months (90 days) prior to the IESD through 28 days after the IESD. G89.11, ICD-10 S codes for trauma/fractures

Cancer: Cancer any time during the patient's history through 28 days after the IESD. ICD-10 C and D codes (active) / Z codes (history of)

Best Practices

- Avoid imaging studies for acute back pain if not medically indicated.
- Educate patients on comfort measures, pain control, and other alternative treatments schedule a follow up appointment after 28 days if pain persist to conduct a imaging study if needed

Example: If patient is seen May 1 and diagnosed with lower back pain, an imaging study can be rendered May 29

Use of Opioids from Multiple Providers (UOP)

Applicable line of business
Federal Employee Program

Description: The percentage of patients 18 years and older, receiving prescription opioids for ≥15 days during the measurement year, who received opioids from multiple providers (4 or more different prescribers). Suggested workflow for Pain Clinics: Assign no more than 2 prescribers for opioid prescriptions per patient per year.

Commonly Used Codes:

*Codes below are examples only and not recommendations

Exclusion

Medication:	
Injectables	Opioid cough and cold products
Methadone for the treatment of Opioid use disorder	Lonsys (fentanyl transdermal patch)
Single-agent and combination buprenorphine products used as a part of medication assisted treatment	

Best Practices

- Centers of Disease Control (CDC) prescribing guidelines for opioid use for chronic, nonmalignant pain recommend the use of additional precautions when prescribing dosages greater than 50 MME or to carefully justify dosages greater than 90 MME.
- Explain in a non-judgmental manner the risks and benefits of high-dosage opioids and encourage patients to taper to a lower, safer dose.

Medication Management RX

Antidepressant Medication Management (AMM)

Applicable line of business
Federal Employee Program

Description: The percentage of patients 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 for at least 180 days.

Antidepressant Medications

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

Best Practices

- Review patient's antidepressant therapy regimen to ensure medication adherence.
- Educate patients that it can take several weeks before symptoms improve.

Measurement Year: A 12-month window starting on May 1 of the year prior to the measurement year and ending on April 30 of the measurement year. Suggested Workflow: Providers should prescribe and fill 90-day prescriptions to reduce gaps in treatment.

Asthma Medication Ratio (AMR)

Applicable line of business
Federal Employee Program

Description: The percentage of patients 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year. The goal of this measure is to decrease asthma reliever medications (i.e., short-acting, inhaled beta-2 agonists Albuterol or Levalbuterol) in favor of asthma controller medications.

Asthma Controller Medications (Prescription on these meds help your rate)

Description	Prescriptions	Medication Lists	Route
Antibody inhibitors	• Omalizumab	Omalizumab Medications List	Injection
Anti-interleukin-4	• Dupilumab	Dupilumab Medications List	Injection
Anti-interleukin-5	• Benralizumab	Benralizumab Medications List	Injection
Anti-interleukin-5	• Mepolizumab	Mepolizumab Medications List	Injection
Anti-interleukin-5	• Reslizumab	Reslizumab Medications List	Injection
Inhaled steroid combinations	• Budesonide-formoterol	Budesonide Formoterol Medications List	Inhalation
Inhaled steroid combinations	• Fluticasone-salmeterol	Fluticasone Salmeterol Medications List	Inhalation
Inhaled steroid combinations	• Fluticasone-vilanterol	Fluticasone Vilanterol Medications List	Inhalation
Inhaled steroid combinations	• Formoterolmometasone	Formoterol Mometasone Medications List	Inhalation
Inhaled corticosteroids	• Beclomethasone	Beclomethasone Medications List	Inhalation
Inhaled corticosteroids	• Budesonide	Budesonide Medications List	Inhalation
Inhaled corticosteroids	• Ciclesonide	Ciclesonide Medications List	Inhalation
Inhaled corticosteroids	• Flunisolide	Flunisolide Medications List	Inhalation
Inhaled corticosteroids	• Fluticasone	Fluticasone Medications List	Inhalation
Inhaled corticosteroids	• Mometasone	Mometasone Medications List	Inhalation
Leukotriene modifiers	• Montelukast	Montelukast Medications List	Oral
Leukotriene modifiers	• Zafirlukast	Zafirlukast Medications List	Oral
Leukotriene modifiers	• Zileuton	Zileuton Medications List	Oral
Methylxanthines	• Theophylline	Theophylline Medications List	Oral

Asthma Reliever Medications (Over prescribing on these meds does not help your rate)

Description	Prescriptions	Medication Lists	Route
Short-acting, inhaled beta-2 agonists	Albuterol	Albuterol Medications List	Inhalation
Short-acting, inhaled beta-2 agonists	Levalbuterol	Levalbuterol Medications List	Inhalation

Best Practices

- Appropriate monitoring of asthma medication ratio can assist with a decrease in asthma related ED visits and inpatient hospitalizations.
- Encourage regular and consistent use of controller medication to help decrease use of rescue medications for breakthrough occurrences.

Hospitalization Follow - Up

Acute Hospitalization Utilization (AHU)

Applicable line of business
Federal Employee Program

Description: For patients 18 years of age and older, the risk-adjusted ratio of observed-to-expected acute inpatient and observation stay discharges during the measurement year.

Best Practices

- Focus on chronic disease control with patients, including regular care provider visits, to help prevent and minimize condition complications and exacerbations.
- Encourage patients to come in for annual wellness visits to promote early diagnosis of any conditions, and to help them complete preventive screenings and health promotion activities such as immunizations.

Emergency Department Utilization (EDU)

Applicable line of business
Federal Employee Program

Description: For patients 18 years of age and older, the risk-adjusted ratio of observed-to-expected emergency department (ED) visits during the measurement year.

Best Practices

Talk with patients about appropriate ED use and other options including:

- Asking for same-day appointments
- Going to urgent care
- Calling your office's after-hours line
- Telehealth options Exclusions:
- Principal diagnosis of mental health or chemical dependency
- Results in an inpatient stay
- Psychiatry

Follow - Up After ED Visit for Mental Illness (FUA)

Applicable line of business
Federal Employee Program

Description: The percentage of emergency department (ED) visits for patients 13 years and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow-up within 30 days of the ED visit (31 total days).

Follow-up includes:

Visits and pharmacotherapy Follow-up includes events that occur on or within 30 days of the date of the ED visit. An outpatient, telephone, e-visit, or virtual check-in follow-up visit with a diagnosis of SUD, substance use, or drug overdose.
A mental health case management encounter or non-residential substance abuse treatment facility visit that documents assessment for symptoms with a diagnosis of SUD, substance use, or drug overdose.

Best Practices

- Follow-up appointments within seven days of discharge are key to reducing readmissions.
- If the patient is not seen within 7 days after discharge, ensure a follow-up appointment occurs within 30 days of discharge.

Follow - Up After ED Visit for Mental Illness (FUM)

Applicable line of business
Federal Employee Program

Description: The percentage of emergency department (ED) visits for patients 6 years and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness within 30 days of the ED visit (31 total days).

Follow-up includes:

Visits that occur on or within 30 days of the date of the ED visit: An outpatient, telephone, e-visit, or virtual check-in follow-up visit with a diagnosis of depression or other behavioral health condition.
A mental health case management encounter that documents assessment for symptoms with a diagnosis of depression or other behavioral health condition.that documents assessment for symptoms with a diagnosis of SUD, substance use, or drug overdose.

Best Practices

- Follow-up appointments within seven days of discharge are key to reducing readmissions.
- If the patient is not seen within 7 days after discharge, ensure a follow-up appointment occurs within 30 days of discharge.

Plan All - Cause Readmission (PCR)

Applicable line of business
Federal Employee Program

Description: For patients 18 years and older, the number of acute inpatient and observation stays with a discharge on or between January 1 and December 1 of the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days.

Follow-up phone call after discharge
Follow-up appointment within 7 days of discharge

For more information or additional provider support please contact		
For questions or additional Quality support:	Email	MA-FEPQualityImprovement@azblue.com
To send medical records or lab results	FAX	602-916-8225
To send medical records or lab results for FEP	Email	FEP-HEDIS-Medical-Records@azblue.com
To send medical records or lab results for MA	Email	HEDIS@azblue.com
For up to date best practices, tip sheets, resources and support visit her	Website	Provider | Resources | Standards for Quality Care | AZ Blue

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