2024 Quality Best Practice Guide

Updated August 16, 2024

ENSURE THAT EVERY PATIENT VISIT IS DOUMENTED AND BILLED

MEASURE	WHO IT APLLIES TO	FREQUENCY	QUALIFIED EVENT(S) & ACCEPTED CODES	ACCECPTED DOCUMENTATION
Breast Cancer screening (BCS-E)	Females **50-74 years**	Every 2 years	Mammogram **77055, 77067, 77065**	Screening report or notation in medical record of bilateral mammogram completed with date of service
Colorectal Cancer Screening (COL)	Members ages 45-75	Annually	FOBT **82270, 82274**	Lab report or notation of completed screening with date of service and result
		Every 5 years	Felxible Sigmoidoscopy **45330**	Lab report or notation of completed screening with date of service and result
		Every 10 years	Colonoscopy **45378**	Lab report or notation of completed screening with date of service and result
Blood Pressure Control for Patients with Diabetes (BPD)	Membes ages 18-75 with Type 1 and Type 2 diabetes whose BP was controlled, <140/90 mmHg	Annually	Systolic - <130 - **3074F**, 103-139 - **3075F**, ≥140 - **3077F**	BP result and date of sevice in medical record or vitals sheet
			Diastolic - <80 - **3078F**, 80-90 - **3079F**, ≥90 - **3080F**	
Eye Exam for Patients with Diabetes (EED)	Members ages 18-75 with Type 1 and Type 2 diabetes who require a retinal or dilated eye exam	Annually or Biennial	Diabetic Eye Exam: **2022F** Positive for Diabetic Retinopathy, **2023F** Negative for Diabetic Retinopathy	Eye exam report with documentation of completed retinal or dilated exam and whether patietnt is postiive or negative for diabetic retinopathy
Hemoglobin A1c Control for Patients with Diabetes (HBD)	Members ages 18-75 with Type 1 or Type 2 diabetes who had HbA1c lab test	Annually	HbA1c Control <7.0% - **3044F**, >7.0% & <8.0% - **3051F,** >8.0% & <9.0% - **3052F,** >9.0% - **3046F**	Lab report showing A1c result and date of service
Kidney Health Evaluation for Patients with Diabetes (KED)	Members ages 18-75 with Type 1 or Type 2 diabetes who kidney health evaulation	Annually	eGFR **80047, 80048;** uACR **82570;** Urine Creatinine **82043**; Urine Albumin **82043**	Lab report showing result and date of service
Controlling Blood Pressure (CBP)	Members 18-85 with hypertension whose BP was controlled, <140/90 mmHg	Annually	Systolic - <130 - **3074F**, 103-139 - **3075F**, ≥140 - **3077F**	BP result and date of sevice in medical record or vitals sheet
			Diastolic - <80 - **3078F**, 80-90 - **3079F**, ≥90 - **3080F**	
			Hypertension Dx Code: **I10**	
Care of Older Adults [SNP and Medicare only]	Members 66+ on Medical Special Needs Plan (SNP)	Annually	Advance Care Planning **1157F, 1158F**	Advanced directive, living will, or surrogate decision on file and discussed in medical record
			Medication List (present) & Review **1159F, 1160F**	Medication list and notation of medication being reviewed/reconciled
			Functional Status Assessment **1170F**	Documenation of assessment of daily living OR activities of daily living (ADLs)
			Pain Screening or Pain Management plan **1125F** w/ pain present **1126F** w/out pain present	Documentation of "no pain" or "has pain" to single part part (with the exception of chest pain)
Osteoporosis Management in Women Who Had a Fracture (OMW) [Medicare only]	Females 67-85 who had a fracture	Within **6 months** of fracture date	**Bone mineral density** (BMD) test or **osteoporisis medication** dispensed	BMD report or pharmacy claim for dispensed medication
Transitions of Care (TRC) [Medicare only]	Members ages 18+	Annually	**Inpatient Admission Notification**- Documentation the day of or 2 days after the admission (3 total)	Medical record documentation of admission
			Medication Reconciliation Post-Discharge (1111F) - Documentation 30 days after discharge (31 total)	Documentation of current medications **and** discharge medications reconciled and reviewed on the same date of service
			Patient Engagement After Inpatient Discharge - Documentation include any of following Outpatient Visit, Transitional Care Management, Synchronous telephone, e-visit or virtual check in within 30 days after discharge	Outpatient, telephone, telehealth, or virtual visit
			Receipt of Discharge Information - Documentation the day or 2 days after the discharge (3 total)	Provider has access to dischrage information via discharge summary, summary or care record or notes in EMR
Cervical Cancer Screening (CCS) [Commercial only]	Females ages 21-64	Females 21-64 cervical cytology every 3 years		Medical record documenation or lab report with results and findings
		Females 30-64 cervical cytology/hrHPV co-testing every 5 years	**Cervical Cytology** 88141, 88142, 88143	
		Femlaes 30-64 hrHPV every 5 years	**High Risk HPV Test (hrHPV)** 87624, 87625	
Chlamydia Screening in Women (CHL) [Commercial only]	Females 16-24 years identified as sexually active	Annually	**Chlamydia Screening Test** 87110, 87270, 87320, 87490, 87491, 87492, 87810	Medical record documentation or lab report with results and findings
Childhood Immunization Status (CIS) [Commercial only]	Children age 2	4	**DTaP** 90697, 90698, 90700, 90723	Medical record or immunication record
		3	**IPV** 90698, 90713, 90723	
		1	**MMR** 90707 or 90710	
		3	**HiB** 90644, 90647, 90648, 90697, 90698, 90748	
		3	**Hep B** 90697, 90723, 90740, 90744, 90747, 90748	
		1	**VZV** 90710 or 90716	
		4	**PCV** 90677	
		1	**Hep A** 90633	
		2 or 3	**Rotavirus** 90681 or 90680	
Immunizations for Adolescents (IMA) [Commercial only]	Adolescents age 13	1	**Meningococcal** 90619, 90733, 90734	
		1	**Tdap** 90715	
		2 or 3	**HPV series** 90649, 90650, 90651	