2020 Quality Measures and Coding Checklist

Premier MANAGEMENT COMPANY

Pop	Measure	What to Document	Codes to Use
MSSP MA Cml	**Breast Cancer Screening** Women ages 50-74 who have had a mammogram in measure year or the 15 months prior	Obtain mammogram report from servicing provider If unable to obtain report, document **date**, **type of screening**, and **result** (normal/abnormal) in medical record If exclusion applies, document **bilateral mastectomy** or **two unilateral mastectomies** and **date(s)**	G9899 = Screening, diagnostic, film, digital or digital breast tomosynthesis (3D) mammography results documented and reviewed G9708 = NOT ELIGIBLE- Documentation of bilateral mastectomy or two unilateral mastectomies
MSSP MA Cml		Obtain report/result from servicing provider If unable to obtain report, document **date**, **type of screening**, and **result** (normal/abnormal) in medical record Screenings accepted: • Colonoscopy in measure year or prior 9 years • Fecal immunochemical DNA test (ex: Cologuard) in measure year or prior 2 years • FOBT during the measurement year • Flexible Sigmoidoscopy in measure year or prior 4 years • CT colonography in measure year or prior 4 years If exclusion applies, document **date of total colectomy** or history **of colorectal cancer**	3017F = Colorectal cancer screening results documented/reviewed G9711 = NOT ELIGIBLE- Documentation of diagnosis of past history of colorectal cancer or total colectomy
MSSP Cml	**Controlling High Blood Pressure** BP: <140/90	Document date and value of BP reading, if not in control schedule member for recheck	3074F = SBP < 130 3075F = SBP 130-139 3077F = SBP > 140 3078F = DBP < 80 3079F = DBP 80-89 3080F = DBP >9 0 For Medicare Only: G8752 = SBP < 140 G8753 = SBP >= 140 G8754 = DBP < 90 G8755 = DBP >= 90
MSSP	**Screening for Future Fall Risk**	Assessment of whether a patient has experienced a fall OR problems with gait or balance **during the measure year** A specific screening tool is not required, however potential tools include the Morse Fall scale and the Get-Up-And-Go test	1101F = No falls or 1 fall without injury within the past year 1100F & 3288F = Falls risk assessment documented, 2 or more falls without injury or 1 or more falls with injury
MSSP	**Clinical Depression Screening and Follow-up** Patients screened for depression using a standardized tool AND, if positive, a follow-up plan is documented	Document the **name of screening**, **date** and **result** of the age appropriate screening tool used (most commonly used is PHQ-2/9) **during the measure year** The screening must be reviewed and addressed by the provider Documented **follow-up for a positive depression screening** must include one or more of the following: • Additional evaluation for depression • Suicide Risk Assessment • Referral to a practitioner qualified to diagnose and treat depression • Pharmacological interventions • Other interventions or follow-up for the diagnosis or treatment of depression	G8431 = Screen for depression is documented as being positive and a follow-up plan documented G8433 = Screening for Depression not Completed, Documented Reason (Patient refuses, urgent or emergent situation, patients functional capacity impacting the accuracy of results) G8510 = Screen performed, negative for depression, no follow up required G9717 = NOT ELIGIBLE– Patient has an active diagnosis of depression or bipolar disorder
MSSP	**Tobacco Use Screening and Cessation**	Document **date** and **result** of query of patient's tobacco use and **cessation intervention** if identified as a tobacco user **during the measure year** or previous 12 months	4004F = Patient screened for tobacco use AND received tobacco cessation intervention 1036F = Current tobacco non-user
MSSP	**Influenza Immunization**	Document **date** of immunization administered or the prior receipt date (typically, compliant prior vaccination includes vaccine given since August 1st the prior year) If influenza vaccination is not given, you must document the reason, such as: allergy, member refusal, etc.	G8482 = Annual influenza vaccination administered or previously rec'd G8483 = Influenza vaccine not administered for documented reasons (Declined, allergy, or other medical reasons)

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MSSP MA Cml	**Comprehensive Diabetes Care - HbA1c Control** Patients whose most recent HbA1c level is controlled • MSSP/MA: <9 • Cml: <8	Document date and **value** of HbA1c screen, if not in control schedule member for recheck	3044F = HbA1c level less than 7.0% 3051F = HbA1c level 7.0%—8.0% 3052F = HbA1c level 8.0%—9.0% 3045F = HbA1c level 7.0%—9.0% 3046F = HbA1c level greater than 9.0%

MA	**Comprehensive Diabetes Care - Medical Attention for Nephropathy**
	Diabetic members with nephropathy screening or monitoring test or evidence of nephropathy
		Acceptable screenings / documentation **during the measurement year**:
		• A nephropathy screening or monitoring test (Urine Protein Tests)
		• Evidence of treatment for nephropathy with at least one ACE inhibitor or ARB dispensing event
		• A visit with a nephrologist
		• Documentation of medical attention for:
		  • Diabetic nephropathy
		  • ESRD, dialysis (Hemodialysis or peritoneal)
		  • CRF, CKD, renal insufficiency, renal dysfunction
		  • Evidence of nephrectomy or kidney transplant
		  • Proteinuria, Albuminuria
		  • acute renal failure
			3060F = Positive **micro**albuminuria test result reviewed and documented
			3061F = Negative **micro**albuminuria test result reviewed and documented
			3062F = Positive **macro**albuminuria test result reviewed and documented
			3066F = Documentation for treatment of nephropathy
			4010F = ACE inhibitor or ARB therapy prescribed or currently being taken

MA	**Comprehensive Diabetes Care - Eye Exam** A retinal or dilated eye exam by an eye care professional in the measure year or a negative retinal or dilated eye exam (no evidence of retinopathy) by an eye care professional in the year prior to measure year	Obtain report from Optometry/Ophthalmology provider If unable to obtain report, document **date**, **type of screening**, **result** (normal/abnormal) and **performing provider** in medical record	2022F = Dilated eye exam w/ interpretation by opth or optom documented and reviewed **with evidence of retinopathy** 2023F = Dilated eye exam w/ interpretation by opth or optom documented and reviewed **without evidence of retinopathy** 2024F = Seven standard field stereoscopic retinal photos w/ interpretation by opth or optom documented and reviewed **with evidence of retinopathy** 2025F = Seven standard field stereoscopic retinal photos w/ interpretation by opth or optom documented and reviewed **without evidence of retinopathy** 2026F = Eye imaging validated to match diagnosis from seven standard field stereoscopic retinal photos results documented and reviewed **with evidence of retinopathy** 2033F = Eye imaging validated to match diagnosis from seven standard field stereoscopic retinal photos results documented and reviewed **without evidence of retinopathy** 3072F = Low risk for retinopathy (no evidence of retinopathy in the prior year exam)
MA	**Medication Reconciliation Post-Discharge** Med Rec conducted by a prescribing practitioner, clinical pharmacists or registered nurse	Discharge medication list must be reconciled with the current medication list in the outpatient medical record **within 30 days of discharge** Documentation notation examples: • No changes in meds since discharge • Same meds as discharge • Reconciled the current and discharge meds • No medications prescribed or ordered upon discharge	1111F = Discharge medications reconciled with the current medication list in outpatient medical record

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MA	**Care for Older Adults - Functional Status**	Notations for a complete functional status assessment must include one of the following **during the measurement year**:
		• Result of assessment using a standardized functional status assessment tool
		• Notation that Activities of Daily Living (ADL) were assessed or that at least five of the following were assessed:
		  ◦ Bathing
		  ◦ Dressing
		  ◦ Eating
		  ◦ Transferring [e.g., getting in and out of chairs]
		  ◦ Using toilet
		  ◦ Walking
		• Notation that Instrumental Activities of Daily Living (IADL) were assessed or at least four of the following were assessed:
		  ◦ Shopping for groceries
		  ◦ Driving or using public transportation
		  ◦ Using the telephone
		  ◦ Cooking or meal preparation
		  ◦ Housework
		  ◦ Home repair
		  ◦ Laundry
		  ◦ Taking medications
		  ◦ Handling finances
		• Notation that at least three of the following four components were assessed:
		  ◦ Cognitive status
		  ◦ Ambulation status
		  ◦ Hearing, vision and speech (i.e., sensory ability)
		  ◦ Other functional independence (e.g., exercise))
			1170F = Functional status assessed

MA	**Care for Older Adults - Med Review**	At least one medication review conducted by a prescribing practitioner or clinical pharmacist **during the measurement year** and the presence of a medication list in the medical record	1159F + 1160F = Medication list documented and reviewed by prescribing care provider or clinical pharmacist
MA	**Care for Older Adults - Pain Screen**	Documentation that the patient was assessed for pain **during the measurement year**, standardized pain assessment tools include but not limited to: • Numeric rating scales • Visual analogue scale • Brief Pain Inventory • Chronic Pain Grade *Notation alone of a pain management plan or chest pain does not meet criteria	1125F = Pain assessment — Pain documented 1126F = Pain assessment — No pain documented
MA	**Adult BMI Assessment**	BMI documented **during the measure year** or previous 12 months	ICD-10 Codes Z68.20-Z68.45
MA	**Osteoporosis Management for Women with Fracture** Women ages 67-85 who have suffered a fracture	Appropriate testing or treatment for osteoporosis after the fracture defined by any of the following criteria: • A Bone Mineral Density test in the 180-day period after the fracture or within 24 months prior to the fracture • Osteoporosis therapy with dispensed prescription in the 180-day period after the fracture or within 12mo prior to fracture	3095F = DXA Scan results documented 4005F = Pharmacologic therapy (other than minerals/vitamins) for osteoporosis prescribed
MA	**Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis**	Members diagnosed with rheumatoid arthritis must have at least one ambulatory prescription for a DMARD dispensed *If unsure of diagnosis of RA, refer to rheumatology for evaluation	4187F = Disease-modifying anti-rheumatic drug therapy prescribed or dispensed
Cml	**Cervical Cancer Screening**	Women 24–64 who had cervical cytology during the measurement year or the two years prior to the measurement year Women 30–64 who had cervical hrHPV testing during the measurement year or the four years prior to the measurement year Documentation in the medical record must include both the date when the cervical cytology was performed and the result or finding *Documentation of "HPV test" can be counted as evidence of hrHPV test *Do not count biopsies because they are diagnostic and therapeutic only and are not valid for primary cervical cancer screening	