Arizona Care Network Quality Handbook

2026

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Introduction

This document is designed to support Arizona Care Network (ACN) providers in delivering high-quality care and improving performance on HEDIS® MY 2026 measures. Each section provides a concise overview of select quality measures, including documentation requirements, common gaps, best practices, and example codes that may support gap closure.

These tip sheets are intended to serve as a **quick reference** guide to help providers:

- Identify care opportunities during patient visits
- Improve documentation to support quality performance
- Understand how care and coding impact HEDIS measure compliance
- Close care gaps efficiently through clinical workflows and appropriate documentation

While this guide highlights key elements of each measure, it does not replace official HEDIS technical specifications. Some measures are **claims-based**, while others rely on **clinical data, pharmacy data, or patient-reported information**, and may not be closed through codes alone.

Important Notes

Codes listed are examples and may not be exhaustive. Refer to payer-specific guidance, HEDIS MY 2026 specifications, the HEDIS MY 2026 Value Set Directory, and Medicare CQM Version 10.0 guidance for complete and current measure requirements and code sets. Code submission alone may not be sufficient to close a gap.

Some measures may include payer-specific or Medicare-specific requirements that differ from standard HEDIS specifications.

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA). For full HEDIS® measure guidelines, visit NCQA.org.

Resources

For additional support with quality measures, documentation, or care gap closure, please contact your Clinical Performance Consultant or email practicetransformation@azcarenetwork.org.

Chlamydia Screening (CHL)

Members 16–24 years of age who were recommended for routine chlamydia screening, were identified as sexually active, and had at least one test for chlamydia during the measurement period.

Exclusions

- Persons with a sex assigned at birth of male.

Documentation Requirements

- Chlamydia screening must be completed during the measurement year.
- If a member is sexually active, make sure to document it in their record.
- Documentation must include:
  - Lab result
  - Date of service

Relevant Codes

The following codes may support gap closure through claims. Compliance depends on meeting HEDIS-defined criteria, including timing, documentation, and qualifying services—not code submission alone.

Code	Description
87110	Culture, chlamydia, any source
87270	Infectious agent antigen detection by immunofluorescent technique
87320	Infectious agent antigen detection by EIA, qualitative or semi-quantitative
87490	Infectious agent detection by nucleic acid direct probe
87810	Infectious agent detection by immunoassay with direct optical observation

Common Documentation Insufficiencies

- Chlamydia screening may not be captured via claims if the service is performed and billed under prenatal and postpartum global billing.
- Include a copy of lab results in the EMR.

Best Practices

- Enter results into your EMR and label clearly for easy identification.
- Ensure workflows are in place to notify and remind providers when a patient's next screening is due. Utilize Innovaccer Dashboards and/or InNote when chart prepping.
- Make follow-up phone calls if patients have not completed their screening. Utilize care gap lists to identify non-compliant patients.
- Educate patients on the risks of undetected chlamydia and available screening options (may be tested via urine, does not require pelvic exam).

Appropriate Testing for Pharyngitis (CWP)

Patients 3 years and older who were diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode.

Exclusions

- Comorbidities present at or within the 12 months prior to the encounter; including HIV, Malignant Neoplasms, Emphysema, COPD, and Disorders of the Immune System.
- Diagnosis of another infection requiring antibiotics on or within 3 days after the encounter.
- An antibiotic medication dispensed within the 30 days prior to the pharyngitis encounter.
- Encounters that result in an inpatient stay.

Relevant Codes

The following codes may support gap closure through claims. Compliance depends on meeting HEDIS-defined criteria, including timing, documentation, and qualifying services—not code submission alone.

Code	Description
J02.0, J02.8, J02.9, J03.0, J03.01, J03.80, J03.81, J03.90, J03.91 (ICD-10)	Qualifying Pharyngitis Diagnosis
87070-71, 87081, 87430, 87650-52, 87880 (CPT)	Group A Strep Test

Common Documentation Insufficiencies

- Rapid strep test or throat culture must be completed prior to prescribing antibiotics.
- Failing to document comorbidities and/or competing diagnoses.
- Clinical findings alone do not adequately confirm strep.

Documentation Requirements

- Documentation must include:
  - Test result
  - Date of service
- Diagnosis of pharyngitis with date and positive result of strep test/throat culture.
- Prescription dispensing data is captured via pharmacy claims.
- Antibiotics with a strep test that meet compliance for this quality measure:

Amoxicillin	Cefprozil	Minocycline
Amoxicillin-Clavulanate	Ceftibuten	Moxifloxacin
Ampicillin	Ceftriaxone	Ofloxacin
Azithromycin	Cefuroxime	Penicillin G Benzathine
Cefaclor	Cephalexin	Penicillin G Potassium
Cefadroxil	Ciprofloxacin	Penicillin G Sodium
Cefazolin	Clarithromycin	Penicillin V Potassium
Cefdinir	Clindamycin	Sulfamethoxazole-Trimethoprim
Cefditoren	Doxycycline	Tetracycline
Cefixime	Erythromycin	Trimethoprim
Cefpodoxime	Levofloxacin	

Best Practices

- Upload results of strep tests/throat cultures to EMR and label clearly for easy identification.
- A group A strep test or throat culture must be performed for episodes where antibiotics are dispensed.
- Review Innovaccer Dashboards and/or InNote for patients identified as non-compliant for this measure and provide education to clinicians as appropriate.
- For patients with negative group A strep results, educate patients and caregivers on appropriate antibiotic use and the risks of overuse (i.e., resistance to future bacterial strains), and instead recommend at-home treatments to help alleviate symptoms.

Controlling High Blood Pressure (CBP)

Patients 18-85 years of age with a diagnosis of hypertension who have their most recent blood pressure reading under control (<140/90 mm Hg).

Exclusions

- End-stage renal disease, dialysis, nephrectomy, or kidney transplant on or prior to the end of the measurement year.
- Pregnancy diagnosis during the measurement year.
- Nonacute inpatient admission during the measurement year.
- Dispensed dementia medication.

Relevant Codes

The following codes may support gap closure through claims. Compliance depends on meeting HEDIS-defined criteria, including timing, documentation, and qualifying services—not code submission alone.

- CBP requires an actual BP result; CPT II codes by themselves do not represent a BP value.

Code	Description
ICD-10-CM: I10	Essential HTN supporting diagnosis code
CPT/CPT II: 3079F	Diastolic 80-89 mm Hg
CPT/CPT II: 3078F	Diastolic Less than 80 mm Hg
CPT/CPT II: 3074F	Systolic Less Than 130 mm Hg
CPT/CPT II: 3075F	Systolic 130-139 mm Hg
G8752	Most recent systolic blood pressure < 140 mmHg
G8754	Most recent diastolic blood pressure < 90 mmHg
G9231	ESRD, dialysis, renal transplant and pregnancy before or during measurement period

Common Documentation Insufficiencies

- Failing to list date of service and blood pressure reading together.
- Do not round up blood pressure readings when using manual blood pressure cuffs.

Documentation Requirements

- A diagnosis of Essential (Primary) Hypertension on at least 2 visits within the first 6 months of the measurement year or during the year prior. Additionally, evidence of adequately controlled blood pressure at the last visit of the measurement year.
- Hypertension diagnosis and/or blood pressure results are counted from outpatient visits, telephone visits, e-visits, or virtual check-ins.
- If multiple readings are taken on the same date, use the lowest systolic and lowest diastolic values.
- Documentation must specify a diagnosis of Essential (Primary) Hypertension.
- Patient-reported blood pressure readings must be taken using an electronic device.
- BP readings taken by the member and documented in the member's medical record are eligible for use in reporting.
- Ranges and thresholds do not meet criteria; a specific numeric systolic and diastolic value is required.

Best Practices

- Outreach patients with hypertension who need a blood pressure check this year, or who did not have adequate control at their last visit. Utilize care gap lists to identify non-compliant patients.
- Perform additional blood pressure reading(s) during the visit if the first reading was high; the best diastolic reading can be combined with the best systolic reading for compliance.
- Follow best practices for taking accurate blood pressure readings, i.e., use the proper cuff size, ensure the elbow is at the same level as the heart, wait until the patient has been resting comfortably for several minutes.
- Educate patients on the risks of uncontrolled blood pressure, and counsel on medication adherence, healthy diet, and exercise.

Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)

Patients 18 years of age and older who were hospitalized and discharged from July 1 of the year prior to the measurement period to June 30 of the measurement period with a diagnosis of AMI and who received persistent beta-blocker treatment for 180 days (6 months) after discharge.

Exclusions

- Medicare enrollees, 66 years of age and older by the last day of the measurement period, in an institutional SNP (I-SNP) or living long-term in an institution (LTI).
- Persons 66–80 years of age by the last day of the measurement period, with both frailty and advanced illness.
- Persons 81 years of age and older as of the last day of the measurement period, with frailty.
- Persons with a contraindication to beta-blocker therapy.

Documentation Requirements

- Continuous beta-blocker therapy must be maintained for 6 months following myocardial infarction.
- Documentation should support prescription and ongoing therapy.
- Measure performance data is collected from Prescription Drug Event (PDE) data.
- Document any intolerance or allergies to beta-blocker therapy.
- For patients on beta-blockers prior to admission, those prescriptions are factored into adherence rates.

Included Beta-Blockers

Code	Description
Noncardioselective beta-blockers	Carvedilol, Labetalol, Nadolol, Pindolol, Propranolol, Timolol, Sotalol
Cardioselective beta-blockers	Acebutolol, Atenolol, Betaxolol, Bisoprolol, Metoprolol, Nebivolol
Antihypertensive combinations	Atenolol-chlorthalidone, Bendroflumethiazide-nadolol, Bisoprolol-hydrochlorothiazide, Hydrochlorothiazide-metoprolol, Hydrochlorothiazide-propranolol

Common Documentation Insufficiencies

- No documentation of beta-blocker therapy initiated at discharge following myocardial infarction.
- Gaps in therapy due to missed refills or discontinuation without documentation.
- Medication changes (e.g., switching beta-blockers) not updated in the medical record.
- Lack of documentation explaining contraindications or intolerance to beta-blocker therapy.
- Incomplete or missing medication reconciliation during follow-up visits.

Best Practices

- Outreach patients with prescriptions that have not been filled.
- Educate patients on the risks of not taking their medication. Discuss any potential side effects and management tips.
- Discuss any barriers to medication adherence. Advise on use of pill boxes and setting reminder alarms to help patients remember to take their medications.
- Utilize or distribute ACN's cost-saving resources for medications to assist patients minimize cost, including: providing patients with 90-day prescriptions, prescribing generics, and using savings or assistance programs (i.e., GoodRx, Blink Health).

Glycemic Status Assessment for Patients With Diabetes (GSD)

Patients 18-75 years of age with diabetes (type 1 or type 2) who had an HbA1c or GMI test performed during the measurement year, regardless of control level. HbA1c and glucose management indicator (GMI) control measures vary across payer contracts.

Relevant Codes

The following codes may support gap closure through claims. Compliance depends on meeting HEDIS-defined criteria, including timing, documentation, and qualifying services—not code submission alone.

Code	Description
83036	Hemoglobin; glycosylated (A1C)
3051F	Most recent hemoglobin A1c (HbA1c) level greater than or equal to 7.0% and less than 8.0%
3052F	Most recent hemoglobin A1c (HbA1c) level greater than or equal to 8.0% and less than or equal to 9.0%
3044F	Most recent hemoglobin A1c (HbA1c) level < 7.0% (less than 7.0%)

Documentation Requirements

- A note in the medical record indicating the date when the HbA1c or GMI test was performed (must be during the current measurement year), and the result, expressed as a specific numeric value (i.e., 6.0%, not a range or threshold).
- Documentation must include:
  - Numerical HbA1c result value
  - Collection date

Common Documentation Insufficiencies

- Failing to document the most recent HbA1c or GMI in the current measurement year and the result.
- Failing to document the date when the specimen/lab was drawn or collected (collection date).

Best Practices

- Follow-up calls to patients who have not completed their HbA1c or GMI test. Use care gap lists to identify non-compliant patients.
- Educate patients on risks of uncontrolled HbA1c.
- Upload reports with most recent HbA1c or GMI dates and results into your EMR and label clearly for easy identification.
- When providing Point of Care Testing, utilize CPT Category II Codes to capture HbA1c result information, which may support reporting when results are documented appropriately.
- Ensure workflows are in place to notify and remind providers of when a patient's next HbA1c or GMI test is due. Utilize Innovaccer Dashboards and/or InNote when chart prepping .

Eye Exam for Patients With Diabetes (EED)

Patients 18–75 years of age with diabetes (type 1 or type 2) who had a retinal eye exam. This includes persons with diabetes who had one of the following:

- A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement period; or
- A negative retinal or dilated eye exam (negative for retinopathy) by an eye care professional in the year prior to the measurement period.

Exclusions

- Members who do not have a diagnosis of diabetes, in any setting, during the measurement year or the year prior to the measurement year and who had a diagnosis of polycystic ovarian syndrome, gestational diabetes or steroid-induced diabetes in any setting, during the measurement year or year prior to the measurement year.
- Bilateral eye enucleation any time during the patient's history through the end of the measurement year is now a required exclusion.
- Blindness is NOT an exclusion.

Relevant Codes

The following codes may support gap closure through claims. Compliance depends on meeting HEDIS-defined criteria, including timing, documentation, and qualifying services—not code submission alone.

Code	Description
2022F	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy (DM)
2023F	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy (DM)

Common Documentation Insufficiencies

- Eye exam performed but results not documented in the EMR.

Documentation Requirements

At a minimum, documentation in the medical record must include one of the following:

- A note indicating that an ophthalmoscopic exam was completed by an optometrist or ophthalmologist, including the date when the procedure was performed and the results; or
- A chart or photography indicating the date when the fundus photography was performed, and evidence that results were reviewed by an optometrist, ophthalmologist, or other qualified provider.

Best Practices

- Follow-up calls to patients who have not completed their eye exam. Use care gap lists to identify non-compliant patients.
- Educate patients on risks of retinopathy.
- Upload eye exam notes into your EMR and label clearly for easy identification.
- Ensure workflows are in place to notify and remind providers of when a patient's next eye exam is due. Utilize Innovaccer Dashboards and/or InNote when chart prepping .
- Check in with patients regarding diabetes care at all visits, regardless of reason for visit.

Kidney Health Evaluation for Patients With Diabetes (KED)

Patients 18–85 years of age with diabetes (type 1 or 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 period.

Exclusions

- Patients receiving dialysis or have evidence of ESRD.

Relevant Codes

The following codes may support gap closure through claims. Compliance depends on meeting HEDIS-defined criteria, including timing, documentation, and qualifying services—not code submission alone.

Code	Description
80047, 80048, 80050, 80053, 80069, 82565	Estimated Glomerular Filtration Rate
82043	Quantitative Urine Albumin Lab Test
82570	Urine Creatinine Lab Test

Documentation Requirements

- Both an eGFR and a uACR must be completed during the measurement year (can be on the same or different dates of service).
    - At least one eGFR; and
    - At least one uACR identified by either of the following:
        - Both a quantitative urine albumin lab test and a urine creatinine lab test with service dates four days or less apart.
        - A urine albumin creatinine ratio lab test.
- Lab results must include numerical values and date of service.
- Results must be documented in the medical record.

Common Documentation Insufficiencies

- No date of service or only lab ordered date.
- No Diabetes diagnosis.
- Only one test instead of both eGFR and uACR.
- Only quantitative urine albumin lab test or a urine creatinine lab test.
- Albumin and creatinine tests completed more than 4 days apart.

Best Practices

- Use care gap lists to identify and outreach diabetic patients in need of kidney health evaluation.
- Educate patients about the effect of diabetes on kidneys and the importance of these tests.
- Ensure workflows are in place to notify and remind providers of when a patient's screening test is due. Utilize Innovaccer Dashboards and/or InNote when chart prepping .
- Check in with patients regarding diabetes care at all visits, regardless of reason for visit.
- Submit timely, accurate, and complete claims.

Osteoporosis Management in Women Who Had a Fracture (OMW)

Women 67–85 years of age who suffered a fracture and who had either:

- A bone mineral density (BMD) test; or
- A prescription for a drug to treat osteoporosis in the 180 days (6 months) after the fracture.

Exclusions

- Fractures of the finger, toe, face, and skull are not included in this measure.
- Patients who had a bone mineral density test within 24 months prior to the fracture.
- Patients who had a claim/encounter for osteoporosis therapy, OR who had an active or dispensed prescription within 12 months prior to the fracture.
- See HEDIS specification for further exclusions.

Relevant Codes

Item	Description
77080	Dxa bone density axial
77081	Dxa bone density/peripheral

Osteoporosis Medications

Medication Category	Medications
Bisphosphonates	Alendronate (Binosto, Fosamax) Alendronate-cholecalciferol (Fosamax Plus D) Ibandronate (Boniva) Risedronate (Actonel, Atelvia) Zoledronic acid (Reclast)
Other agents	Abaloparatide (Tymlos) Denosumab (Prolia, Xgeva) Raloxifene (Evista) Romosozumab (Evenity) Teriparatide (Forteo)

Documentation Requirements

Documentation must include the date and result of a completed bone mineral density test or prescription for a drug to treat osteoporosis (i.e., medication name with date prescribed) within the 6 months following the fracture.

- Fractures from July 1 of the year prior to the measurement year through June 30 of the measurement year are included in performance.

Best Practices

- Upload BMD test results into your EMR and label clearly for easy identification.
- Ensure workflows are in place to notify providers of patient eligibility for this measure; monitor HIE systems and/ or ADT feeds for notification of ED or inpatient visits, and ask patients if they have experienced a fracture or a fall. Utilize Innovaccer Dashboards and/or InNote when chart prepping.
- Complete fall risk assessments and osteoporosis screenings for women 65-75 years of age.
- Make follow-up phone calls to patients who have experienced fractures. Utilize care gap lists to identify non-compliant patients.
- Educate patients on the risks of osteoporosis, fall prevention strategies, and to notify your office if they experience a fracture.

Common Documentation Insufficiencies

- Treatment with Calcium or Vitamin D does not meet the intent of the measure.
- Documentation that osteoporosis medications are not tolerated is not considered an exclusion.
- Referral for a bone mineral density test will not close this quality measure; results should be available in the EMR.

Adherence to Antipsychotic Medications for Schizophrenia Patients (SAA)

Patients 18 years of age and older during the measurement period, with schizophrenia or schizoaffective disorder, who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.

Refer to the HEDIS MY 2026 Medication List Directory for the complete and current list of antipsychotic medications included in this measure.

Exclusions

- Medicare enrollees, 66 years of age and older by the last day of the measurement period, in an institutional SNP (I-SNP) or living long-term in an institution (LTI).
- Persons 66–80 years of age by the last day of the measurement period, with both frailty and advanced illness.
- Persons 81 years of age and older by the last day of the measurement period, with frailty.
- Persons with dementia.
- Persons who did not have at least two antipsychotic medication dispensing events.

Documentation Requirements

- This measure is calculated using pharmacy claims data and cannot be closed through a single visit or code submission.
- Document diagnosis of schizophrenia or schizoaffective disorder.
- Pharmacy claims showing:
    - ≥2 fills
    - Continuous coverage ≥80% of treatment period

Common Documentation Insufficiencies

- Assessing measure performance is limited by the need for the treatment period to complete (data is very limited for the first 9-10 months of the year).
    - Treatment period is: the period of time beginning on the index prescription start date through the last day of the measurement year.
- No follow-up after initial prescription or lack of ongoing monitoring or medication management.

Best Practices

- Improving adherence requires ongoing engagement, refill monitoring, and barrier reduction, not just prescribing the medication.
- Encourage patients to take medications as prescribed.
- Offer tips to patients such as:
    - Take medication at the same time each day.
    - Use a pill box.
    - Enroll in a pharmacy automatic-refill program.
- Educate patients and caregivers.
    - Reinforce the importance of daily adherence.
    - Discuss what to do if a dose is missed.

Appropriate Treatment for Upper Respiratory Infection (URI) – Inverse Measure

Patients 3 months of age and older with a diagnosis of upper respiratory infection (URI) that **did not** result in an antibiotic dispensing event.

Exclusions

- Comorbidities present at or within the 12 months prior to the encounter; including HIV, Malignant Neoplasms, Emphysema, COPD, Malignant Neoplasms of the Skin, and Disorders of the Immune System.
- Diagnosis of an infection for which an antibiotic prescription is appropriate – such as bacterial pharyngitis – on or within 3 days after the encounter.
- An antibiotic medication dispensed within the 30 days prior to the URI encounter.
- Encounters that result in an inpatient stay.

Documentation Requirements

This measure is not met if a prescription for an antibiotic is dispensed within 3 days of a diagnosis of Upper Respiratory Infection (URI) – barring any exclusions – and this data is captured via pharmacy claims.

Common Documentation Insufficiencies

- Failing to document comorbidities and/or competing diagnoses.
- These diagnoses/codes do not indicate necessity for antibiotic treatment:

Code	Description
J00	Acute nasopharyngitis (common cold)
J06.0	Acute laryngopharyngitis
J06.9	Acute upper respiratory infection, unspecified

Best Practices

- Review Innovaccer Dashboards and/or InNote for patients identified as non-compliant for this measure and provide education to clinicians as appropriate.
- Educate patients and caregivers on appropriate antibiotic use and the risks of overuse (i.e., resistance to future bacterial strains), and instead recommend at-home treatments to help alleviate symptoms.

Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB) – Inverse Measure

Patients 3 months of age and older with a diagnosis of acute bronchitis/bronchiolitis that **did not** result in an antibiotic dispensing event.

AAB is an **inverse measure**. This measure is met when antibiotics are **NOT** dispensed.

Exclusions

- Comorbidities present at or within the 12 months prior to the encounter; including HIV, Malignant Neoplasms, Emphysema, COPD, Cystic Fibrosis, Other Malignant Neoplasms of the Skin, and Disorders of the Immune System.
- Diagnosis of an infection for which an antibiotic prescription is appropriate – such as bacterial pharyngitis – on or within 3 days after the encounter.
- An antibiotic medication dispensed within the 30 days prior to the bronchitis/bronchiolitis encounter.
- Encounters that result in an inpatient stay.

Documentation Requirements

This measure is not met if an antibiotic is dispensed within 3 days of a diagnosis of acute bronchitis/bronchiolitis – barring any exclusions – and this data is captured via pharmacy claims

Best Practices

- Review Innovaccer Dashboards and/or InNote for patients identified as non-compliant for this measure and provide education to clinicians as appropriate.
- Educate patients and caregivers on appropriate antibiotic use and the risks of overuse (i.e., resistance to future bacterial strains), and instead recommend at-home treatments to help alleviate symptoms.

Common Documentation Insufficiencies

- Failing to document comorbidities and/or competing diagnoses.
- These diagnoses/codes do not indicate necessity for antibiotic treatment:

Code	Description
J20.3	Acute bronchitis due to coxsackievirus
J20.4	Acute bronchitis due to parainfluenza virus
J20.5	Acute bronchitis due to respiratory syncytial virus
J20.6	Acute bronchitis due to rhinovirus
J20.7	Acute bronchitis due to echovirus
J20.8	Acute bronchitis due to other specified organisms
J20.9	Acute bronchitis, unspecified
J21.0	Acute bronchiolitis due to respiratory syncytial virus
J21.1	Acute bronchiolitis due to human metapneumovirus
J21.8	Acute bronchiolitis due to other specified organisms
J21.9	Acute bronchiolitis, unspecified

Use of Imaging Studies for Low Back Pain (LBP)

Patients 18-75 with a principal diagnosis of low back pain who **did not** have an imaging study (i.e., plain x-ray, MRI, CT scan) within 28 days of the diagnosis.

Exclusions

- A diagnosis for which imaging is clinically appropriate, including: Cancer; Recent trauma (within the last 3 months); Intravenous drug abuse; Neurologic impairment; HIV; Spinal infection; Major organ transplant; Prolonged use of corticosteroids (90 consecutive days).
- Exclude members with a diagnosis of uncomplicated low back pain) during the 180 days (6 months) prior to the IESD.
- Osteoporosis or a dispensed prescription to treat osteoporosis (Osteoporosis Medication List) any time during the member's history through 28 days after the IESD.
- Fragility fracture any time during the 3 months (90 days) prior to the IESD through 28 days after the IESD.
- Lumbar surgery any time during the member's history through 28 days after the IESD.
- Spondylopathy any time during the member's history through 28 days after the IESD.

Documentation Requirements

- Supplemental data is not accepted for diagnosis or imaging services; this data is captured via claims. Supplemental data may only be utilized for exclusions.

Common Documentation Insufficiencies

- Failing to document exclusions.
- Ordering an imaging study within 28 days of a primary diagnosis of uncomplicated low back pain. Associated codes: M48.07-08; M51.16-17; M51.26-27; M51.36-37; M51.8687; M53.2X6-2X8; M53.3; M53.86-88; M54.16-18; M54.3032; M54.40-42; M54.50-59; M54.89; M54.9; M99.03-04; M99.23; M99.33; M99.43; M99.53; M99.63; M99.73; M99.83-84; S33.100A; S33.100D; S33.100S; S33.110A; S33.110D; S33110S; S33.120A; S33.120D; S33.120S; S33.130A; S33.130D; S33.130S; S33.140A; S33.140D; S33.140S; S33.5XXA; S33.6XXA; S33.8XXA; S33.9XXA; S39.002A; S39.002D; S39.002S; S39.012A; S39.012D; S39.012S; S39.092A; S39.092D; S39.092S; S39.82XA; S39.82XD; S39.82XS; S39.92XA; S39.92XD; S39.92XS.

Best Practices

- During the first 4 weeks after diagnosis, unless clinically indicated, educate and provide patients with alternative treatment options to imaging, such as pharmaceuticals, physical therapy, and/or at-home comfort care, such as stretching or low-impact exercise. Address any associated psychosocial issues (i.e., anxiety, depression).

Initiation and Engagement of Substance Use Disorder Treatment (IET)

For patients 13 years of age and older, percentage of new episodes of substance use disorder (SUD) that result in 1 or both of the following:

- **Initiation of SUD treatment**: Percentage of new SUD episodes that result in treatment through an inpatient SUD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth visit, or medication treatment within 14 days of diagnosis.
- **Engagement of SUD treatment**: Percentage of new SUD episodes that result in treatment within 34 days of initiation visit.

Documentation Requirements

- The patient must receive an initiation of substance use disorder treatment within 14 days; without this initiation visit, they are not eligible for closing the engagement care gap thereafter within 34 days.
- Avoid using "unspecified use" diagnoses when possible.
- Each visit must include a date of service and appropriate diagnosis documentation.

Relevant Codes

Compliance requires timely follow-up visits and qualifying services, not a single code submission.

- Important Requirements:
  - **Initiation Phase**: A follow-up visit must occur within 14 days of the initial substance use disorder diagnosis/visit.
  - **Engagement Phase**: At least 2 additional visits within 34 days after initiation.
- This measure is based on visit timing and frequency. Submitting a single claim or code does not close the gap. Multiple qualifying encounters within required time frames are necessary.

Common Documentation Insufficiencies

- When a patient is in remission, please remember to remove the original diagnosis and use remission codes:
  - Alcohol abuse in remission (F10.11)
  - Alcohol dependence in remission (F10.21)
  - Cannabis abuse in remission (F12.11)
  - Other psychoactive substance dependence in remission (F19.21)

Best Practices

- This measure focuses on follow-up treatment when diagnosing a patient with substance use disorder.
- Use screening tools to aid in diagnosing. Screening tools (e.g., SBIRT, AUDIT-PC, Audit C Plus 2, CAGE-AID and CUDIT-R) assist in the assessment of substance use and can aid the discussion around referral for treatment.
- Schedule a follow-up appointment prior to the patient leaving the office with you or a substance use specialist to occur within 14 days and then 2 more visits with you or a substance use treatment provider within the next 34 days.
- Encourage newly diagnosed individuals to include their family in their treatment.
- Encourage newly diagnosed individuals to accept treatment by assisting them in identifying their own reasons for change.
- Although community supports, such as AA and NA, are beneficial, they do not take the place of professional treatment.

Prenatal and Postpartum Care (PPC)

This measure assesses the following facets of prenatal and postpartum care:

- **Timeliness of Prenatal Care**: The percentage of deliveries that received a prenatal care visit in the first trimester on or before the enrollment start date or within 42 days of enrollment in the organization.
- **Postpartum Care**: The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery.

Relevant Codes

The following codes may support gap closure through claims. Compliance depends on meeting HEDIS-defined criteria, including timing, documentation, and qualifying services—not code submission alone.

Code	Description
99500, H1000-H1004 (HCPCS), 0500F-0502F (CPT-CAT_II)	Prenatal Stand-Alone Visit
59400, 59425, 59426, 59510, 59610, 59618, H1005 (HCPCS)	Prenatal Bundle Services
99202-99205, 99211-99215, 99242-99245, 99483, T1015, G0463 (HCPCS)	Prenatal Visit Codes (only with a code for pregnancy Dx)
Z01.411, Z01.419, Z01.42, Z30.430, Z39.1, Z39.2	Encounter for Postpartum Care
59400, 59410, 59510, 59515, 59610, 59614, 59618, 59622	Postpartum Bundled Services
57170, 58300, 59430, 99501, 0503F, G0101	Postpartum Care

Documentation Requirements

- Documentation must include the date of the prenatal care visit (in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the health plan).
- Example of documentation confirming pregnancy:
  - A positive pregnancy test result.
  - Documentation of last menstrual period (LMP), EDD or gestational age.
  - Documentation of standardized prenatal flow sheet.

Common Documentation Insufficiencies

- Failed to document prenatal care during the first trimester.
- Failed to document diagnosis of pregnancy.
- Documentation by a registered nurse alone does not meet compliance for HEDIS.

Best Practices

- Educate office staff to schedule the first appointment with the provider in the first trimester (ASAP if late entry to care).
- Proper documentation of prenatal care visit during the first trimester.

Child and Adolescent Well-Care Visits (W30 and WCV)

Based on age, completing the appropriate number of well-child/care visits, defined as:

Age	Well-Visit Guidance
0-15 months	6 or more well-child visits with a PCP within the first 15 months of life, at least 15 days apart
15-30 months	2 or more well-child visits with a PCP between 15 – 30 months of age
3-21 years	At least 1 well-care visit with a PCP or OB/GYN during the measurement year (annual basis)

Relevant Codes

The following codes may support gap closure through claims. Compliance depends on meeting HEDIS-defined criteria, including timing, documentation, and qualifying services—not code submission alone.

Code	Description
99381, 99391, 99461	0-12 months well-child visit
99382, 99392	1-4 years of age well-child visit
99383, 99393	5-11 years of age well-child visit
99384, 99394	12-17 years of age well-child visits
99385, 99395	18 years and older well-child visit
G0438, G0439	Well-Child/Adolescent Visit
S0610, S0612, S0613 (HCPCS)	Annual Gyno exam
Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.2, Z00.3, Z02.5, Z76.1, Z76.2, Z01.419, Z01.411 (ICD-10)	Well-Child/Adolescent Visit

Documentation Requirements

- Appropriate documentation for each of the components of a well-visit. The components of a well-child visit include, but are not limited to, an initial/interval medical history, physical exam, developmental assessment, immunization and anticipatory guidance (see American Academy of Pediatrics Bright Futures for further details).
- A well-care visit code must be submitted to close the measure.
- Visit must occur with a Primary Care Provider (or OB/GYN).
- In-person visits are required. Telehealth visits are no longer accepted.
- Each visit must occur on different dates of service.
- Preventive services count toward the measure, regardless of the primary reason for visit.
- This measure must be closed via claims; medical records are only reviewed for audit purposes.

Common Documentation Insufficiencies

- **Medical history**: allergies, medications, AND immunizations must be documented.
- **Physical exam**: verbiage of "appropriate for age", or Tanner stage/scale alone does not meet measure.
- **Developmental assessment**: verbiage of "appropriate for age", "well developed", "neurological exam" alone do not meet the measure.
- **Physical Exam**: vital signs alone do not meet the measure.
- **Immunization and anticipatory guidance (health education):** information on medications and immunization side effects alone does not meet the measure.

Best Practices

- Ensure workflows are in place to notify the care team before a patient becomes overdue for a visit; have patients complete their required visits prior to the end of year or designated age.
- Make follow-up phone calls if patients have not made appointments to be seen. Utilize care gap lists to identify non-compliant patients.
- Educate parents on the benefits of well-care visits and risks of not having their children seen regularly.
- Ensure well visit templates capture all required components, utilize proper codes, and complete needed well-visits during sick visits, as appropriate.

Childhood Immunization Status (CIS-E)

Children 2 years of age who had the following vaccines by their second birthday:

- 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)
- Two influenza (flu) vaccines

Exclusions

- Anaphylactic reaction to any vaccine or its components.
- Organ and bone marrow transplants.
- For DTap Vaccine: encephalopathy with a vaccine adverse effect code.
- For MMR, VZV, and Influenza Vaccines: Immunodeficiency, HIV, Lymphoreticular Cancer, Multiple Myeloma or Leukemia.

Relevant Codes

The following codes may support gap closure through claims. Compliance depends on meeting HEDIS-defined criteria, including timing, documentation, and qualifying services—not code submission alone.

90697, 90698, 90700, 90723	DTaP
90697, 90698, 90713, 90723	Inactivated Polio Vaccine (IVP)
90707, 90710	Measles, Mumps, and Rubella (MMR)
90644, 90647, 90648, 90697, 90698, 90748	Haemophilus Influenzae Type B (HiB)
90697, 90723, 90740, 90744, 90747, 90748, G0010	Hepatitis B (HepB)
90710, 90716	Varicella Zoster (VZV)
90670, 90671, 90677, G0009	Pneumococcal Conjugate (PCV)
90633	Hepatitis A (HepA)
90681 (2-dose), 90680 (3-dose)	Rotavirus (RV)
90655, 90656, 90657, 90658, 90661, 90674, 90685, 90686, 90687, 90688, 90689, 90756	Influenza

Documentation Requirements

- Documentation must include vaccine type and dates of administration.
    - **For Hep A, Hep B, MMR, or VZV**: Documented history of the illness or a seropositive test result meets compliance (if occurs prior to a child's second birthday).
    - **For Rotavirus**: Always specify with "Rotarix®", "two-dose", "RotaTeq®", or "three-dose".
- Immunizations administered outside the practice must be recorded in the medical record.

Common Documentation Insufficiencies

- Immunizations received after the second birthday.
- Documentation of "up-to-date with all immunizations" does not meet measure compliance unless it includes all immunizations and the dates administered.
- No documentation of allergies, contraindications, or illness.

Best Practices

- Set patients up on a schedule as soon as possible after birth to prevent them from falling behind. Identify and outreach patients who are behind on immunizations. Utilize Innovaccer Dashboards and/or InNote for assistance.
- Educate parents on the importance of immunizations. Discuss any concerns and myths surrounding vaccinations.
- Review immunizations at every visit. Implement workflow for identifying when immunizations are due and setting up reminders for providers.

Breast Cancer Screening (BCS-E)

Patients 40–74 years of age who had a mammogram to screen for breast cancer any time on or between October 1 two years prior to the measurement period and the last day of the measurement period.

Exclusions

- Members who had a bilateral mastectomy; or who have a history of a bilateral mastectomy; or for whom there is evidence of a right and a left unilateral mastectomy.

Relevant Codes

The following codes may support gap closure through claims. Compliance depends on meeting HEDIS-defined criteria, including timing, documentation, and qualifying services—not code submission alone.

Code	Description
19303	Unilateral Mastectomy
77062	Breast Tomosynthesis BI
77063	Breast Tomosynthesis BI
77065	DX MAMMO INCL CAD UNI
77066	DX MAMMO INCL CAD BI
77067	SCR MAMMO BI INCL CAD
G9899	Ages 40-74 every 27 months (Medicare only)
G9708	Bilateral mastectomy or evidence of a right and a left unilateral mastectomy (Medicare only)

Documentation Requirements

A note in the medical record indicating the date and result of the breast cancer screening.

- Compliant screening types include: screening, diagnostic, film, digital or digital breast tomosynthesis (3D) mammography.
- Do not count biopsies, breast ultrasounds, or MRIs.
- Documentation can be completed during telehealth encounters.
- Mammography report may be provided by the patient for clinician review during the visit and should be documented in the medical record.

Common Documentation Insufficiencies

- Utilizing patient questionnaires that do not capture type of screening; or patient does not provide complete information.
- Failing to document findings/results (i.e., “mammo 10/2022”).

Best Practices

- On annual wellness visit forms, include breast cancer screening questions with screening type, date (month/year), and findings (including patient name and date of birth).
- If a patient received a wellness evaluation within the last year, Z-code Z12.31 (Encounter for screening mammogram) may be used in place of a follow-up appointment. The patient can call the rendering provider to request an order and go straight to diagnostic imaging for a screening.
- Upload mammography reports into your EMR and label clearly for easy identification.
- Set reminders for providers when a patient’s next screening is due and discuss with patients in advance.
- Make follow-up phone calls if patients have not completed their screening. Utilize care gap lists to identify non-compliant patients.
- Educate patients on the risks of breast cancer.

Cervical Cancer Screening (CCS-E)

Patients 21-64 years of age screened for cervical cancer using any of the following criteria:

Age	Criteria
21-64 years of age	Had cervical cytology performed within the last 3 years
30-64 years of age	• Had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years; **OR** • Had cervical cytology/high-risk human papillomavirus (hrHPV) cotesting within the last 5 years

Exclusions

- Persons with sex assigned at birth of male.
- Persons with a hysterectomy with no residual cervix, cervical agenesis, or acquired absence of cervix.
    - ICD-10 Diagnosis Codes to Report Past Hysterectomy History:
        - Z90.710: acquired absence of both cervix and uterus
        - Z90.712 acquired absence of cervix with remaining uterus

Relevant Codes

The following codes may support gap closure through claims. Compliance depends on meeting HEDIS-defined criteria, including timing, documentation, & qualifying services—not code submission alone.

88141 (CPT)	Cytopathology, cervical or vaginal
P3000 (HCPCS)	Screening Papanicolaou smear, cervical or vaginal
G0147 (HCPCS)	Screening cytopathology smears, cervical or vaginal
G0476 (HCPCS)	Infectious agent detection by nucleic acid
87624 (CPT)	Infectious agent detection by nucleic acid
87626	Self-collection in office or patient service center, high risk Human Papillomavirus (HPV) with genotyping, vaginal swab
87491, 87591	Self-collection in office or patient service center, Chlamydia/Gonococcus, NAA, swab
87563	Self-collection in office or patient service center, Mycoplasma genitalium, NAA, swab
87661	Self-collection in office or patient service center, Trichomonas vaginalis, NAA, swab

Documentation Requirements

A note in the medical record indicating the date and result of cervical cancer screening.

- For cervical cytology, count any screening method that includes collection and microscopic analysis of cervical cells. Do not count lab results that explicitly state the sample was inadequate or that "no cervical cells were present."
- For hrHPV tests, generic documentation of "HPV" tests can be counted.

A note in the medical record indicating the date of the hysterectomy and the following:

- Documentation of a "vaginal Pap smear" with documentation of "hysterectomy."
- Patient attestation is acceptable as long as there is a date and results of the test or a date of the total hysterectomy and acceptable documentation of no residual cervix.
- Documentation of hysterectomy and documentation that a member no longer needs Pap testing/cervical cancer screening.

Common Documentation Insufficiencies

- For hysterectomy exclusion, documentation must indicate that the cervix was removed; documentation of "hysterectomy" alone will NOT meet the intent of the exclusion.
- Failed to include the words "Total", "complete" or "radical" abdominal or vaginal hysterectomy.
- Do not count biopsies as these are diagnostic and therapeutic in nature only.

Best Practices

- Upload lab reports into your EMR and label clearly for easy identification.
- Ensure workflows are in place to notify and remind providers of when a patient's next screening is due and to discuss with patients in advance. Utilize Innovaccer Dashboards and/or InNote when chart prepping.
- Make follow-up phone calls if patients have not completed their screening. Utilize care gap lists to identify non-compliant patients.
- Educate patients on the risks of cervical cancer.
- Assess and address member barriers to regular cervical cancer screening (e.g., access to care, transportation, cost, fear/anxiety).
- Identify patients who would benefit from self-collect HPV & STI screening.
    - Patients may be good candidates if they:
        - Have missed recommended STI or cervical cancer screening.
        - Have a history of trauma or anxiety around pelvic exams.
        - Cannot provide a cervical sample from a Pap smear.

Colorectal Cancer Screening (COL-E)

Patients 45-75 years of age who had an appropriate screening for colorectal cancer.

Exclusions

- Patients with a diagnosis or past history of total colectomy or colorectal cancer.

Relevant Codes

The following codes may support gap closure through claims. Compliance depends on meeting HEDIS-defined criteria, including timing, documentation, and qualifying services—not code submission alone.

Screening Type	Frequency	Codes
Fecal occult blood test (FOBT)	Within the current year	82270, 82274, G0328
Stool DNA (sDNA) with FIT test	Within the last 3 years	81528, 0464U
Flexible sigmoidoscopy	Within the last 5 years	45330, 45331, 45332, 45333, 45334, 45335, 45337, 45338, 45340, 45341, 45342, 45346, 45347, 45349, 45350, G0104
CT colonography	Within the last 5 years	74261, 74262, 74263
Colonoscopy	Within the last 10 years	44388, 44389, 44390, 44391, 44392, 44394, 44401 through 44408, 45378, 45379, 45380

Documentation Requirements

- A note in the medical record indicating the date, type, and result of colorectal cancer screening.
- A result is not required if the documentation is clearly part of the member's medical history/ documented in the medical history section.
    - Pathology reports are acceptable.
    - Documentation can be completed during a telehealth encounter.
    - Result/Findings: documentation of "normal" or "abnormal" is acceptable.

Common Documentation Insufficiencies

- Utilizing patient questionnaires that do not capture type of screening; or patient does not provide complete information.
- Visit note documentation does not specify type of screening and date, i.e., “Col Screening 1/19”, “Colorectal Cancer Screening is current.”
- Failing to document findings/results i.e., documenting “Colonoscopy 2016”, or “Colonoscopy is current” in the assessment and plan section of the note.
- Digital Rectal Exams (DRE) or FOBT tests performed in an office setting, or performed on a sample collected via DRE do not meet the intent of this measure.

Best Practices

- On annual wellness visit forms, include colorectal cancer screening questions with screening type, date (year), and findings. Ensure this form contains the patient name and date of birth and is scanned into their medical record.
- Upload colorectal cancer screening reports and/ or notes into your EMR and label clearly for easy identification.
- Document colorectal cancer screenings in the patient’s medical history section with type of screening, date, and result.
- Ensure workflows are in place to notify and remind providers of when a patient’s next screening is due and to discuss with patients in advance. Utilize Innovaccer Dashboards and/or InNote when chart prepping.
- Make follow-up phone calls if patients have not completed their screening. Utilize care gap lists to identify non-compliant patients.
- Educate patients on the risks of colorectal cancer and various screening types.

Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)

Patients 12 years of age and older who were screened for clinical depression using a standardized instrument and, if screened positive, received follow-up care within 30 days (MSSP only – the same day or within 2 days) of a positive depression screen finding.

Exclusions

- Active diagnosis for depression (not applicable to Medicare).
- Active diagnosis for bipolar disorder.

Relevant Codes

The following codes may support gap closure through claims. Compliance depends on meeting HEDIS-defined criteria, including timing, documentation, and qualifying services—not code submission alone.

Code	Description
G8431	Depression screening positive with follow-up plan
G8510	Depression screening negative follow-up not required
G0444 (Cigna and Intel require this code)	Annual depression screening, 15 minutes (Satisfies gap closure for depression screening only, but not follow up)

When supporting medical documentation is available for depression screening, submit this information to the ACN Quality Data Abstractor assigned to the practice in order to close the quality gap if coding is unavailable.

To close this gap with Cigna (code is paid annually when G0444 and modifier 59 is submitted):

- Submit G0444 via claims
- Attestation in iCollaborate
- Submission of flat file with greater than or equal to 25% completion of total opportunities

Documentation Requirements

- Screening may occur on the date of the encounter or up to 14 days prior to the date of the encounter.
- Clinician interpretation of "positive" or "negative" must be documented on the date of the encounter. A score alone is not sufficient.
- The name of the age-appropriate standardized depression screening tool must be documented.
- If positive, a follow-up plan must be documented. A follow-up plan includes at least one of the following:
    - Additional evaluation or assessment for depression; suicide risk assessment; referral to a practitioner who is qualified to diagnose and treat depression; pharmacological interventions; or other interventions or follow-up for the diagnosis or treatment of depression.
- Screening and follow-up plan documentation may be completed during a telehealth encounter

Common Documentation Insufficiencies

- Failing to include a clinician interpretation such as "positive" or "negative."
- Utilizing PHQ-9 forms that do not include patient first and last name, date of birth, and encounter date.
- Failing to document the name of the screening tool.

Best Practices

- Utilize a PHQ-9 screening form, labeled as such, which includes a prompt for clinician interpretation (positive or negative) and signature. Ensure this form contains the patient's first and last name, date of birth, and encounter date, and upload to the EMR, labeled clearly for easy identification.
- Ensure workflows are in place to notify and remind providers when a patient's next screening or follow-up is due. Utilize Innovaccer Dashboards and/or InNote when chart prepping.
- Utilize care gap lists to identify non-compliant patients.