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2025 Top Ten Quality Metrics Quick Reference

— POWER OUR —

Population Health Strategy

Population Health Services Organization (PHSO)—an optimized, physician-partnered operations entity that powers a system to improve health outcomes, promote economies of scale and coordination, and reduce variation across the continuum.

McLaren Physician Partners through its members will be the best value in health care as defined by quality outcomes and cost.

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Dear McLaren Physician Partners Member,

MPP is dedicated to providing the highest value care to our patients and support to our providers and practices.

One of the ways we do this is through success in Population Health Management. The ultimate goal is to improve the quality of care while reducing costs.

Essential components of our strategy include:

- Use of communication technologies to deliver care like telehealth and remote patient monitoring
- Continuously improving performance on HEDIS Quality metrics, meeting or exceeding the 90th percentile in performance
- Providing Patient-Centric care consistent with the Patient-Centered Medical Home (PCMH, PCMH-N) model
- Delivery of coordinated patient care through Transitional Care Management (TCM) and Chronic Disease Management services and addressing social determinants of health
- Adoption and use of evidence-based guidelines

To assist with Population Health Management and HEDIS performance we are pleased to present the 2025 MPP Top Ten Quick Reference Guide. We have made some updates throughout the book, including new coding tips, updates to metrics such as the BMI Percentile for children, and added a section on Team Based Care. Working together with a multidisciplinary team of clinicians provides the most patient-centered model for population health.

As patient centric care continues to evolve, MPP has incorporated several focused strategies into our Clinical Integration (CI) Program and MPP Payment Distribution Methodology. Providers will continue to be rewarded on integration and performance in these metrics. Additional success in payer value-based revenue programs will also be realized with high performance on these metrics because it is no longer about just participation in a program but individual and group performance in a program.

We have identified five main activities that are common among MPP top performing providers and ensure success with Top Ten metric performance and other revenue metrics. These activities include:

- Patient outreach for annual and/or chronic disease management visits
- Pre-visit planning
- Use of a point of care tool to identify patient care gaps (i.e., Persivia Population Health registry or CareTrak)
- Applying evidence-based screening guidelines at all visit types, not just those designated for health maintenance
- Continuous interaction with the MPP Quality Performance Staff

One common comment we receive is the variation of recommendations among differing medical/surgical societies. High value care is one of the many concepts MPP endorses to promote conversations between providers and patients on high value care. Throughout this guide you will find that the HEDIS metrics do not always reflect current cancer screening or professional organization guidelines in terms of age groups or frequency of testing. We have provided you with the HEDIS specifications needed to meet the measure requirements. We have also provided you with the professional societal recommendations so that you can make the best choices with your patients.

If you have any questions regarding the content of this guide, please feel free to contact any one of us. Your MPP Quality Performance Specialist and Practice Coach (field team) are also available to assist you with practice transformation to ensure success in this year's program.

Michael Ziccardi, Jr., D.O.
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Chairperson, Quality & CI Subcommittee

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2024 Top Quality Performing Physicians

In 2024, MPP Recognized Their Top Performing Physicians In Population Health.

Awardees:

Mohamad Alasbahi, MD (Flint)

Terry Ball, DO (Central)

Richard Chalmers, DO (Macomb)

Scott Hotchkiss, MD (Northern)

Gregory Koby, DO (Macomb)

Laura Lucio-Reincke (Port Huron)

Shannon McMann, DO (Macomb)

Albert Przybylski, DO (Macomb)

Edward Swisher, MD (Lansing)

Kenneth Thompson, MD (Lansing)

Lauren Vocke, DO (Lansing)

Jason Whateley, DO (Port Huron)

Mohamed Ali, MD (Bay)

Jeffrey Borgeson, MD (Flint)

Gary Holloway, DO (Oakland)

Kurtis Kieleszewski, DO (Macomb)

Jill Larkin, MD (Lansing)

Brian Mahany, DO (Lansing)

Samuel Minor, MD (Northern)

Brahmaiah Rajesh, MD (Lansing)

Veronica Takov, DO (Macomb)

Ashok Vashishta, MD (Central)

Beth Wendt, DO (Macomb)

Kristina Wixon, DO (Macomb)

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Care Management Services

MPP Offers A Variety Of Care Management Programs To Meet The Needs Of Your Patients

Our programs cover all McLaren regions for Transitional and Comprehensive Care Management services, and we accept referrals from practices, providers, hospitals, and patient self-referrals, into any of our programs. Patients are also given our department line number at discharge for questions or issues arising after discharge.

Department Contact: Andrea.Phillips1@mclaren.org

REFERRING FOR CARE MANAGEMENT SERVICES

Referral forms from hospitals, practices, providers are accepted via **Fax to (810) 600-7924** or via **Cerner to: MHC McLaren Physician Partners Care Management**

Patients can self-refer via our **Department Referral line at (844) 368-1817**. This line is designed to support patients after discharge, and during extended hours, to support patients who may have questions or issues after normal business hours. This line is monitored Monday-Friday, 8:00 am–8:00 pm and Saturdays, 9:00 am–1:00 pm.

All complete referrals are reviewed and processed within one (1) business day of being received.

CM Referral Form

TRANSITIONAL CARE MANAGEMENT (TCM)

Patients discharged from Inpatient, Observation or post-acute settings are most vulnerable the first seven (7) days after discharge. TCM is a best practice that reduces readmissions, improves compliance with follow-up care, and supports a smooth transition “home”.

Services:

- Discharge instruction and medication review, risk-stratification, SDOH screening for resource needs.
- Assistance scheduling follow-up appointments with 7-14-days of discharge.
- Patients with chronic disease are referred to care management services (CCMS/CCM) based on need.
- Assist providers/practices with billing.

Population: All attributed members (MPP, MHPN) | **Contact:** Jacquelyne.Helgeson@mclaren.org

COMPREHENSIVE CARE MANAGEMENT SERVICES (CCMS)

This program offers care coordination and disease management, oversight and organization of care, monitoring conditions, and providing educational activities by health professionals. This program assigns a Care Coordinator (RN/LMSW) to each patient, focusing on serving at-risk populations and maintaining regular contact until patient goals are met or they can effectively self-manage.

Services:

- Patient motivational interviewing and developing patient-centered goals.
- Removing barriers to care, providing education and resources based on patient needs.
- Offers **MyCare remote patient monitoring** to high-risk patients (CHF, COPD, HTN, DM, ESRD, Discharge).
- Offers **ED High-Utilizer support services** for real-time review of activity, provider notification and patient engagement to educate on appropriate utilization and reduce avoidable ED visits.
- Care Maintenance, Gaps in Care/Preventative care and screening, PDCM outreach, etc.
- Discussing disease progression and end-of-life options.

Population: Any referred patient from within McLaren health care system | **Contact:** Holly.McLean@mclaren.org

MPP Top Ten Quality Metrics 2025

Category	Measure Title	Specifications
Pharmacy	Statin Therapy for Patients with Cardiovascular Disease*	Percentage of males 21-75 and females 40-75 identified as having atherosclerotic cardiovascular disease (ASCVD) and were dispensed at least one moderate or high intensity statin medication during 2025
Screening Measures	Child and Adolescent Well-Care Visit	Patients 3-21 years of age who had a comprehensive Well-Care visit with PCP, Pediatrician or OB/GYN in 2025
	Breast Cancer Screening*	Women 50- 74 years of age who had one or more mammograms any time during current or prior year (October 1, 2023– December 31, 2025) Exclusion: Bilateral mastectomy
	Chlamydia Screening in Women	Women 16-24 years of age identified as sexually active who had at least one chlamydia test during 2025
	Colorectal Cancer Screening*	Patients age 45-75 with one of the following: • FOBT during current year (may not use sample from digital rectal exam (2025) • Flexible sigmoidoscopy in last 5 years (2021-2025) • Colonoscopy in the last 10 years (2016-2025) • CT Colonography in last 5 years (2021-2025) • FIT-DNA (Cologuard) in last 3 years (2023, 2024, 2025) Exclusion: colorectal cancer, total colectomy
	Cervical Cancer Screening	Women 21-64 years of age who were screened for cervical cancer using either of the following: • 21-64 who had a pap smear in the last 3 years (2023- 2025) • 30-64 who had PAP and HPV co-testing during the last 5 years (2021- 2025). (HPV reflex testing results do not count) • 30-64 who had High-risk (hrHPV) testing (without cytology) during the last 5 years (2021-2025) Exclusion: Hysterectomy with no residual cervix.
Cardiovascular Conditions	Controlling High Blood Pressure*	Patients age 18-85 with a diagnosis of hypertension and whose blood pressure was adequately controlled (139/89 or lower) during measurement year
Comprehensive Diabetes Care	Diabetes Care: Retinal Eye Exam*	Patients age 18-75 who had a diabetic retinal eye exam in current year (may be 2 years if negative)
	Glycemic Status Assessment for Patients with Diabetes*	Patients age 18-75 whose most recent glycemic status (HbA1c) or glucose management indicator (GMI) is less than 8% in 2025
	Diabetes Care: Kidney Health Evaluation for Patients with Diabetes*	Adults ages 18 to 85 of age with diabetes who received a kidney health evaluation during the measurement year as evidenced by both of the following: 1. eGFR: estimated glomerular filtration rate 2. uACR: urine albumin-creatinine ratio

*Commercial and Medicare Metrics. (Note: HbA1C value is ≤ 9% for Medicare patients)

MPP Pediatrics Top Eight Quality Metrics 2025

<table>
<tr><th>Category</th><th>Measure Title</th><th>Specifications</th></tr>
<tr><td rowspan="6">Preventative Screenings and Well Child Visit</td><td>Adolescent Well Visits</td><td>Patients 12-17 years of age who had a comprehensive well-care visit with PCP, Pediatrician or OB/GYN in 2025</td></tr>
<tr><td>Well-Child Visits</td><td>Patients 3-11 years of age who had at least one well- child visit with a PCP during 2025</td></tr>
<tr><td>BMI Percentile</td><td>Patients ages 3-17 with a BMI percentile documented annually (either numeric or plotted on a growth chart.) Documentation must include height, weight, and BMI value</td></tr>
<tr><td>Chlamydia Screening</td><td>Women 16-24 years of age identified as sexually active who has at least one chlamydia test during 2025</td></tr>
<tr><td>Counseling for Nutrition</td><td>Patients ages 3-17 who have had counseling for nutrition during 2025. Documentation must include a note indicating the date and at least one of the following: discussion of current nutrition behaviors (e.g., eating habits, dieting behaviors), checklist indicating nutrition was addressed, counseling or referral for nutrition education, patient received educational materials on nutrition during a face-to-face visit, anticipatory guidance for nutrition, weight or obesity counseling.
CODE: Z71.3 Dietary Surveillance and Counseling</td></tr>
<tr><td>Counseling for Physical Activity</td><td>Patients ages 3-17 who have had counseling for physical activity during 2024. Documentation must include a note indicating the date and at least one of the following: discussion of current physical activity behaviors (e.g., exercise routine, participation in sports activities, exam for sports participation), checklist indicating physical activity was addressed, counseling or referral for physical activity, member received educational materials on physical activity during a face-to-face visit, anticipatory guidance specific to the child’s physical activity, weight or obesity counseling.
CODE: Z71.82 Exercise Counseling or Z02.5 Sports Physical</td></tr>
<tr><td rowspan="2">Behavioral Health</td><td>Follow-up Care for Children Prescribed ADHD Medication: Initiation Phase (6-12 Years)</td><td>Patients newly prescribed ADHD medication who had one follow-up visit within 30 days of first ADHD medication prescription</td></tr>
<tr><td>Depression Screening (ages 12 and older)</td><td>Percentage of patients 12 years and older who are screened for depression using a standardized tool. If positive screen (PHQ-9 of 5 or greater) receives follow-up care within 30 days
<table>
<tr><th colspan="2">Interpreting PHQ-9 Scores</th><th colspan="2">Actions Based on PHQ-9 Score</th></tr>
<tr><td>Mild depression</td><td>5-9</td><td rowspan="2">>5-14</td><td rowspan="2">Physician uses clinical judgement about treatment, based on patient’s duration of symptoms and functional impairment</td></tr>
<tr><td>Moderate depression</td><td>10-14</td></tr>
<tr><td>Moderately severe depression</td><td>15-19</td><td>>15</td><td>Warrants treatment for depression, using antidepressant, psychotherapy, and/or combination of both</td></tr>
</table></td></tr>
</table>

STATIN USE FOR PATIENTS WITH CARDIOVASCULAR DISEASE

HEDIS Measure description:

- Patients with Cardiovascular Disease:
  - Male Patients ages 21-75
  - Female Patients ages 40-75
  - Identified as having clinical atherosclerotic cardiovascular disease and dispensed at least one moderate or high intensity statin medication
  - Only drug claims processed through the patient's pharmacy benefit are counted

EXCLUSIONS TO CODE:

- End Stage Renal Disease or Dialysis in previous or current measurement year
- Cirrhosis/Liver Disease in previous or current measurement year
- Female patients who are pregnant, receiving IVF or prescription for clomiphene (estrogen agents) during previous or current measurement year
- Cannot tolerate statin medication, as diagnosed by a claim for myalgia, myositis, myopathy, or rhabdomyolysis during the measurement year
- Patients aged 66 and older living in skilled nursing facility.
- Patient receiving Hospice or Palliative Care Services
- Advanced illness and frailty

Tips for Statin Metrics:

Encourage the importance of statin regardless of LDL Levels

Try more hydrophilic statins or reduce the dose/frequency if patient thinks there are adverse effects such as myalgia

Encourage patients to submit insurance info when using RX discount programs

Encourage use of 90-day or 100-day Rx

Forward exclusion documentation to the health plan, ***Z78.9 is not an approved exclusion.***

Repatha alone does not close this gap.

Common Exclusion Codes for Statin Metrics	
Myopathy	G72.0
Myositis	M60.9
These two ICD 10 Codes will exclude the patient from CVD and DM Statin Metrics.	

NOTE: Exclusions of patients for Statin Therapy **must** be documented and coded every calendar year.

High Intensity Statin Therapy	
Atorvastatin 40-80 mg	Amlodipine-atorvastatin 40-80 mg
Ezetimibe-simvastatin 80 mg	Rosuvastatin 20-40 mg
Simvastatin 80 mg	
Moderate Intensity Statin Therapy	
Atorvastatin 10-20 mg	Amlodipine-atorvastatin 10-20 mg
Ezetimibe-simvastatin 20-40 mg	Fluvastatin 40-80 mg
Lovastatin 40 mg	Pitavastatin 1–4 mg
Pravastatin 40-80 mg	Rosuvastatin 5-10 mg
Simvastatin 20-40 mg	

CONTROLLING HIGH BLOOD PRESSURE

HEDIS Measure description:

- The percentage of patients 18–85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (139/89 or lower) during the measurement year.

EXCLUSIONS TO CODE:

- Patients with evidence of ESRD, dialysis, nephrectomy, or kidney transplant anytime during the member's history on or prior to Dec. 31 of the measurement year
- Patients who were pregnant during the measurement year
- Patients aged 66 and older living in skilled nursing facility.
- Patients receiving hospice or palliative care services
- Advanced illness and frailty

	CPT II CODE	READING
Systolic	3074F	Less Than 130
	3075F	130-139
	3077F	Greater than or equal to 140
Diastolic	3078F	Less than 80
	3079F	80-89
	3080F	Greater than or equal to 90

Ways to improve Controlling High Blood Pressure rates:

BP is last reading of the year

Have patient return for nurse/MA visit by the end of the year

Repeat any BP measurement that is 140/90 or above and DOCUMENT all repeat measurements

Establish a protocol for retaking high BPs

Review proper technique for taking a blood pressure

Document patient reading of home BP from digital device during telehealth visit. Ranges will not satisfy the measure

BP can be counted from any visit including specialists. Obtain specialist visit consult notes for manual entry

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HEDIS QUICK REFERENCE 2025

GLYCEMIC STATUS ASSESSMENT FOR PATIENTS WITH DIABETES

HEDIS Measure description:

- Percentage of diabetic patients ages 18-75 whose most recent glycemic status (hemoglobin A1C) or glucose management indicator (GMI) is less than 8% during 2025.

EXCLUSIONS TO CODE:

- Polycystic ovarian syndrome (PCOS), gestational diabetes or steroid-induced diabetes in 2024 or 2025.
- Patients aged 66 and older living in skilled nursing facility.
- Patients receiving hospice or palliative care services
- Advanced illness and frailty

Description	CPT/CPTII Code for A1C Testing
A1C less than 7%	3044F
A1C greater than equal to 7% to less than 8%	3051F
A1C greater than equal to 8% to less than 9%	3052F
A1C greater than 9%	3046F
Point of Care A1C Test (claim will also need code result)	83036

Ways to improve A1C < 8% rates:

Utilize MPP gaps in care reporting to identify patients with A1C < 8% gaps.

Ensure diabetes medication compliance.

Refer patients for Self-Management or Nutritional Counseling.

Utilize Diabetic or Chronic Care Flow sheets to document testing.

Utilize test tracking methods to ensure patient compliance and that lab reports are received.

For waived testing at the office, ensure testing is documented in the medical record and CPT II codes are included on the claim.

Review hospital medical records for lab results.

Forward exclusion documentation to the health plan.

GMI is a calculation derived from continuous glucose monitoring (CGM) that assesses average blood sugar values. This is a recognized surrogate for A1C when used for ≥ 14 days, 70% CQM use.

(BIMAL V. PATEL, GABRIEL ALENCAR, SHARON M. WANG, SCOTT LEAS, LAUREL H. MESSER, JORDAN E. PINSKER; 154-LB: HEDIS Glycemic Goals Achieved by Control-IQ Technology Users across All Payer Types. *Diabetes* 20 June 2023; 72 (Supplement_1): 154–LB. https://doi.org/10.2337/db23-154-LB

COMPREHENSIVE DIABETES CARE: KIDNEY HEALTH EVALUATION

HEDIS Measure description:

- The percentage of adults 18–85 years of age with diabetes who received a Kidney Health Evaluation during 2025 on the same or different dates of service.
- A Kidney Health Evaluation is defined by completion of both:
  1. An estimated glomerular filtration rate (eGFR) and
  2. A urine albumin-creatinine ratio (uACR)
     a. Quantitative urine albumin CPT 82043 and Urine creatinine CPT 82570. Must be from same specimen.

EXCLUSIONS

- Patients with evidence of ESRD or dialysis any time during the member's history
- Patients aged 66 and older living in skilled nursing facility.
- Patients receiving hospice or palliative care services
- Advanced illness and frailty

Ways to improve Kidney Health Evaluation rates:

If possible, order both eGFR and uACR on the same date of service, but can be done on separate dates of service within current year.

Urine Albumin Creatinine Ratio Lab Test Value Set is the preferred lab to order. Must write out for non-Cerner orders.

Point of Care Strip Albumin tests or semi-quantitative tests **do not** meet metric (CPT 82044)

Utilize the first diabetic exam of the year to order the appropriate testing.

Utilize MPP gaps in care reporting to identify patients with kidney health evaluation open gaps.

Utilize Diabetic or Chronic Care Flow sheets to document testing.

Utilize Test Tracking process to ensure patient completed testing and lab reports are received.

COMPREHENSIVE DIABETES CARE: RETINAL EYE EXAM

HEDIS Measure description:

- Percentage of diabetic patients ages 18-75 who had a retinal or dilated eye exam during 2025 or a negative retinal eye exam in 2024.

EXCLUSIONS TO CODE:

- Bilateral eye enucleation.
- Polycystic ovarian syndrome (PCOS), gestational diabetes or steroid induced diabetes in 2024 or 2025.
- Patients age 66 and older living in skilled nursing facility.
- Patients receiving hospice or palliative care services
- Advanced illness and frailty

* Patient self-reported exams can be captured in medical record for gap closure (must include result, date, and name of eye care professional).

Ways to improve Retinal Eye Exam rates:

Remind patients that retinal eye exams are covered under their medical insurance.

Utilize a retinal eye exam referral form.

Utilize MPP gaps in care reporting to identify patients with retinal eye exam gaps.

Utilize Diabetic or Chronic Care Flow sheets to document exam results.

Partner with PCMH- Neighborhood eye care specialists to enhance communication.

Utilize referral tracking methods to ensure patient compliance and that specialist reports are received.

Forward exclusion documentation to the health plan.

Diabetic Retinopathy Evaluation

Patient Instructions: Please take this form to your eye care professional and have them complete and return.
Diabetic Eye exams are covered under medical insurance and may be subject to your specialist co-pay and/or deductible.

Patient Name: _____ DOB: _____

Date of Exam: _____ Health Plan ID: _____

Primary Care Physician Information

Physician: _____ Fax: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

FINDINGS

❑ No diabetic retinopathy is found in either eye. OR

❑ RETINAL EXAM ABNORMALITIES DETECTED, AS FOLLOWS:

- ❑ Background changes noted in:
  - ❑ Right *(Circle Grade)* Mild Moderate Severe
    Clinically significant diabetic macular edema? Yes No
  - ❑ Left *(Circle Grade)* Mild Moderate Severe
    Clinically significant diabetic macular edema? Yes No
- ❑ Proliferative changes noted in:
  - ❑ Right *(Circle Grade)* Active Regressed/Stable
  - ❑ Left *(Circle Grade)* Active Regressed/Stable

FOLLOW UP

❑ Routine follow-up exam is recommended in one year. OR

❑ Follow-up of abnormalities in my office is recommended in _____ (timeframe).

❑ Referral to Dr._____ is recommended in _____(timeframe).

❑ Cataracts or Glaucoma detected OR laser treatment is needed. Letter to follow.

Codes to Indicate HEDIS Compliance:

92004 – Ophthalmological services: Medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient, one or more visits.

92014 – Ophthalmological services: Medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; comprehensive, established patient, one or more visits.

2022F – Dilated eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; **with evidence of retinopathy**

2023F – Dilated eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed **without evidence of retinopathy**

M1220 – Dilated eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; **with evidence of retinopathy (Medicare ONLY)**

M1221 - Dilated eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed **without evidence of retinopathy (Medicare ONLY)**

2025F – Seven (7) standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist documented and reviewed **without evidence of retinopathy**

2033F – Eye imaging validated to match diagnosis from seven (7) standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist documented and reviewed **without evidence of retinopathy**

_____ Eye Care Professional Signature

_____ Eye Care Professional Printed Last Name

Office Name: _____

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HEDIS QUICK REFERENCE 2025

COLORECTAL CANCER SCREENING

HEDIS Measure description:

- **Percentage of patients ages 45-75 with one of the following:**
  - FOBT (Fecal immunochemical - FIT) during 2025
  - Flexible sigmoidoscopy between 2021 through 2025
  - Colonoscopy between 2016 through 2025
  - CT colonography between 2021 through 2025
  - FIT-DNA (Cologuard) between 2023-2025

EXCLUSIONS TO CODE:

- Colon Cancer or Total Colectomy
- Patients age 66 and older living in skilled nursing facility
- Patients receiving hospice or palliative care services
- Advanced illness and frailty

NOTE: Tests performed on a sample collected via a digital rectal exam <u>do not</u> meet criteria.

Health Equity & Colorectal Cancer Screening: Colorectal cancer has a greater than 90% survival rate with early detection and treatment. Disparities limit access to equitable screening and treatment for Black Americans, American Indian/Alaska Native and underserved Americans, who are disproportionately affected by the disease.

Source/Resources:

Ways to improve Colorectal Cancer Screening rates:

Encourage patients resistant to having a colonoscopy to complete a FOBT or FIT-DNA test at home.

Utilize MPP gaps in care reports to identify patients with Colorectal Cancer Screening gaps.

Utilize test and specialist referral tracking methods to ensure compliance.

On the patient problem list in the medical record, document test/ surgical history and include date.

A pathology report that indicates the type of screening (e.g., colonoscopy) and the date when the screening was performed meets criteria.

For pathology reports that do not indicate the type of screening and for incomplete procedures, evidence that the scope advanced beyond the splenic flexure meets criteria for a completed colonoscopy.

Document the date of total colectomy in the medical record.

Forward exclusion documentation to the health plan.

BREAST CANCER SCREENING

HEDIS Measure description:

- Percentage of Women ages 50 to 74 who had a mammogram between October 1, 2023 and December 31, 2025. All types and methods of mammograms (screening, diagnostic, film, digital or digital breast tomosynthesis) will qualify.

EXCLUSIONS TO CODE:

- Bilateral mastectomy
- Patients age 66 and older living in skilled nursing facility
- Patients receiving hospice or palliative care services
- Advanced illness and frailty

Screening Recommendations

Breast cancer screening recommendations for women at average risk		
American Cancer Society	**Barbara Ann Karmanos Cancer Institute, Wayne State University National Comprehensive Cancer Network**	**U.S. Preventive Services Task Force**
Annual screening for women 45-54 (women should have the option to begin annual screening between 40 – 44) Women 55 and older can switch to every 2 years (or every year if a woman chooses to do so), for as long as a woman is in good health and is expected to live at least 10 more years.	Women aged 40-74 should have a physical exam and a mammogram annually. Consider tomosynthesis (3-D mammography)	Every 2 years For women aged 40-74

Health Equity & Breast Cancer Screening: Among Michigan women, breast cancer is the most commonly diagnosed cancer and the second leading cause of cancer death. Black females have the lowest five-year survival rate at 79.5% (National average is 98.7%). Factors that may contribute to the higher death rate include; lack of medical coverage, barriers to early detection and screening, unequal access to clinical trials and more likely to be diagnosed with a more aggressive form of cancer.

Source/Resources: MDHHS, scan this QR Code for Michigan resources to improve access to screening and treatment.

Ways to improve breast cancer screening rates:

Document date of mastectomy in the medical record and code history of bilateral mastectomy (Z90.13).

Educate female patients about the importance of early detection and screening.

Breast cancer awareness activities during the month of October.

Utilize MPP gaps in care reporting to identify patients with breast cancer screening gaps.

Utilize test tracking methods to ensure compliance.

Use standing orders for mammograms.

Partner with McLaren Regional Breast Centers, which offer free or discounted screening and other services such as transportation and reminder programs.

Forward exclusion documentation to the health plan.

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HEDIS QUICK REFERENCE 2025

CERVICAL CANCER SCREENING

HEDIS Measure description:

- Women aged 21-64 years who were screened for cervical cancer using either of the following:
  - 21-64 who had a pap smear in the last 3 years (2023, 2024, 2025)
  - 30-64 who had PAP and HPV co-testing during the last 5 years (2021, 2022, 2023, 2024, 2025)
  - 30-64 who had High-risk HPV (hrHPV) testing (without cytology) during the last 5 years (2021, 2022, 2023, 2024, 2025)

NOTE: HPV reflex testing results do not satisfy the measure for 5 years

EXCLUSIONS TO CODE:

- Hysterectomy with no residual cervix. Document: Total, Complete, or Radical Abdominal or Vaginal hysterectomy and the year of the surgery.
- Documentation of hysterectomy in combination with documentation that the patient no longer needs pap testing/cervical cancer screening will also meet this measure.
- Patients receiving hospice or palliative care services

Ways to improve Cervical Cancer Screening rates:

Document date of hysterectomy in the medical record and code absence of cervix and uterus (Z90.710).

For Pap and HPV co-testing, do not order "Reflex" testing as the lab will only run the HPV test if the PAP test is abnormal.

Educate female patients about the importance of early detection and screening.

Utilize MPP gaps in care reporting to identify patients with cervical cancer screening gaps.

For patients who have testing done by their OB/GYN, request a copy of the test results from the specialist's office (see OB/GYN Services Referral Form).

Suggestion is for OB/GYN's to use Z01.411 or Z01.419 encounter codes instead of Z00.00 or Z00.01 to prevent billing issues for family practice.

Forward exclusion documentation to the health plan.

Health Equity & Cervical Cancer Screening: The Breast and Cervical Cancer Navigation Program provides low-income women access to breast and cervical cancer screening services and follow-up care. Disparities limit access to equitable screening and treatment for Black Americans, American Indian/Alaska Native and underserved Americans, who are disproportionately affected by the disease.

Source/Resources: MDHHS, scan this QR Code for Michigan resources to improve access to screening and treatment.

OB/GYN Services

Patient Information

Patient Name: _____ DOB: _____

Date of Exam: _____ Health Plan ID: _____

Primary Care Physician Information

Physician: _____ Fax: _____

Address: _____ Phone: _____

City: _____ State: MI Zip: _____

FINDINGS

	Date of service	Result
Cervical Cancer Screening	_____	_____
Primary HPV Testing	_____	_____
HPV Co-Testing	_____	_____
Chlamydia Screening	_____	_____
Breast Cancer Screening	_____	_____

Please check any that apply:

☐ Hysterectomy with no residual cervix

Date of procedure: _____

☐ Pregnancy Test performed in current measurement year to screen for pregnancy before X-ray or Isotretinoin prescription

☐ Bilateral Mastectomy

Date of procedure: _____

Please return with a copy of the test results/reports to the fax number above

OB/Gyn Signature _____

OB/Gyn Printed Name Office Name: _____

Date: _____

CHLAMYDIA SCREENING

Ways to improve Chlamydia Screening rates:

Utilize MPP gaps in care reports to identify patients with chlamydia screening gaps.

Perform chlamydia urine test for patients aged 16-24 when they present for pregnancy testing, dysuria, or birth control prescription/refill.

Utilize test tracking methods to ensure compliance.

Forward exclusion documentation to the health plan.

Perform chlamydia urine test for patients aged 16 – 24 when they present for any condition, discussion or reason.

HEDIS Measure description:

- Percentage of women ages 16-24 who were identified as sexually active (through claims for birth control pills, STD testing, or pregnancy testing) who has at least one chlamydia test during 2025.
  NOTE: screening may be performed by swab or urine.

- **EXCLUSIONS:** Women who were included in the measure based on pregnancy test alone and the member had a prescription for Isotretinoin or an X-ray on the date of the pregnancy test or the 6 days after the pregnancy test.
-

Talking points:

- All women who are prescribed birth control are considered sexually active according to the healthcare payers even if prescribed for acne or menses.
- This exam is recommended for women between the ages of 16-24 because the rates of infection are very high. Chlamydia is the most commonly reported bacterial sexually transmitted disease in the United States.
- This test can be as simple as a urine test.
- If left untreated, infected women that do not receive treatment can experience future complications including: Pelvic Inflammatory Disease, Infertility or Ectopic pregnancy.

CHILD AND ADOLESCENT WELL-CARE VISITS

HEDIS Measure description:

- Percentage of patients ages 3 to 21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN during 2025.
- NOTE: Services specific to the assessment or treatment of an acute or chronic condition do not count towards this measure

Documentation:

Documentation in the medical record must include a note indicating a visit to a PCP, Pediatrician or OB/GYN practitioner, the date when the well-care visit occurred and evidence of all of the following: (elements may be combined from multiple visits)

- A health history
- A physical developmental history
- A mental developmental history
- A physical exam
- Health education/anticipatory guidance
- Counseling for nutrition & physical activity; ICD10 codes Z71.3 & Z71.82 (MHP, UHC, and Priority GAPS only close when billed on claims)
- Chlamydia screening for 16 and older
- Depression screening (PHQ2 & PHQ9); ICD10 code Z13.31, CPT code 96127

Description	Codes for Well-care Visits
Child and Adolescent Well-care Visits	CPT: 99382-4, 99392-4
	ICD-10: Z00.121, Z00.129, Z00.5, Z00.8, Z02.0-Z02.6, Z02.71, Z02.82

Ways to improve Child and Adolescent Well-care visits:

Avoid missed opportunities by taking advantage of every office visit (including sick visits) to provide a Well Care Visit, immunizations, and BMI value/ percentile calculations.

Use pre-visit planning to ensure correct well care visit template document is used.

Convert sports/day care physicals into well-care visits by performing the required services and submitting appropriate codes.

Use standardized templates in charts and in EMRs that allow checkboxes for standard counseling activities.

A sick visit and well-child visit can be performed on the same day by adding a modifier 25 to the sick visit, and billing for the appropriate preventive visit.

Utilize MPP gaps in care reporting to identify patients with gaps.

CHILDHOOD AND ADOLESCENT IMMUNIZATIONS

Childhood Immunization Series Combo 10 HEDIS Measure Description:

- Percentage of children who receive the following vaccines **before age 2 years**

Immunizations included in Combo 10:

- 4 DTaP (diphtheria, tetanus, acellular pertussis)
- 3 IPV (polio)
- 1 MMR (measles, mumps, rubella)
- 3 HiB (haemophilus influenza type B)
- 3 HepB (hepatitis B)
- 1 VZV (chicken pox)
- 4 PCV (pneumococcal conjugate)
- 1 HepA (hepatitis A)
- 2 or 3 RV (rotavirus)
- 2 Flu (influenza)

Adolescent Immunization Series Combo 2 HEDIS Measure Description:

- Percentage of adolescents who receive the following vaccines **before age 13 years**

Immunizations included in Combo 2:

- 1 meningococcal vaccine, administered between 11-13 years
- 1 TDaP (tetanus, diphtheria, pertussis), administered between 10-13 years
- Complete HPV (human papillomavirus) series, administered between 9-13 years

These two HEDIS metrics have strict age requirements (before 2 years and before 13 years). After those dates, the metric is not met, but it is still important to complete immunizations.

For more resources visit the McLaren Physician Partners webpage using the QR code:

Ways to improve Vaccine Series Completion:

Recommend and encourage vaccines at all appointments, not just well-visits

Utilize MCIR to run reports, review for completion, and to make sure vaccines you administered were uploaded

Have a standardized approach throughout your office. Each team member from front desk to back office to check out has the same pro-vaccine stance and is aware of schedules

Start HPV at age 9 and Flu at six months to help with metric completion

Schedule next appointment at current appointment to stay on schedule

Outreach before age 2 and 13 to catch patients who have fallen behind

Use personal touches and stories, “I vaccinated my child.” Or “I just got my own flu shot for this year”

For patients who go to the health department for vaccines, add them into your test tracking

Never stop recommending vaccines, even if a parent declines today

BMI ASSESSMENT

- Patients ages 20 - 74 with a BMI value documented in 2024 or 2025-
- Patients ages 3 to 17 with BMI percentile documented in the measurement year (either numeric or plotted on a growth chart).
- Documentation in the medical record must indicate the height, weight and BMI value.
- This may occur in any outpatient visit type (PCP or Specialist).
- Once a year place BMI Assessment Z-code on the claim.

Description	ICD-10 Code for ages 21 years and older (use BMI percentile if less than 21)
BMI 19 or less	Z68.1
BMI 20.0-20.9	Z68.20
BMI 21.0-21.9	Z68.21
BMI 22.0-22.9	Z68.22
BMI 23.0-23.9	Z68.23
BMI 24.0-24.9	Z68.24
BMI 25.0-25.9	Z68.25
BMI 26.0-26.9	Z68.26
BMI 27.0-27.9	Z68.27
BMI 28.0-28.9	Z68.28
BMI 29.0-29.9	Z68.29
BMI 30.0-30.9	Z68.30
BMI 31.0-31.9	Z68.31
BMI 32.0-32.9	Z68.32
BMI 33.0-33.9	Z68.33
BMI 34.0-34.9	Z68.34
BMI 35.0-35.9	Z68.35
BMI 36.0-36.9	Z68.36
BMI 37.0-37.9	Z68.37
BMI 38.0-38.9	Z68.38
BMI 39.0-39.9	Z68.39
BMI 40.0-44.9*	Z68.41
BMI 45.0-49.9*	Z68.42
BMI 50.0-59.9*	Z68.43
BMI 60.0-69.9*	Z68.44
BMI >=70*	Z68.45

Pediatric BMI Percentile	
Description	ICD 10 Code
BMI less than 5th percentile for age	Z68.51
BMI 5th to less than 85th percentile for age	Z68.52
BMI 85th to less than 95th percentile for age	Z68.53
BMI 95th percentile for age to less than 120% of the 95th percentile for age	Z68.54
BMI 120% of the 95th percentile for age to less than 140% of the 95th percentile for age	Z68.55
BMI Greater than or equal to 140% of the 95th percentile for age	Z68.55

***BMI greater than 40 = Morbid (severe) Obesity:**

Also code from this overweight/obesity category:

E66.01	Morbid (severe) obesity due to excess calories
E66.1	Drug-induced obesity
E66.3	Overweight
E66.09	Obesity due to excessive calories

RISK OF CONTINUED OPIOID USE – 15 DAYS

HEDIS Measure description:

- The percentage of adults 18 years and older with:
  - ≥ 15 days of a new prescription for opioids in a 30-day period.
  - at least 31 days of prescription opioids in a 62-day period.
- Includes patients that were dispensed an opioid medication sometime between November 1, 2024 through October 31 of 2025.
- New episode of opioid use that puts patients at risk of continued opioid use.
- Providers (primary care and specialists), please communicate your decision to initiate or renew an opioid medication on a common patient. This will help reduce utilization and improve collaborative care.

NOTE: A lower rate indicates better performance

INCLUSIONS:

The following opioid medications are included in this measure:

- Benzhydrocodone
- Buprenorphine (transdermal patch and buccal film)
- Butorphanol
- Codeine
- Dihydrocodeine
- Fentanyl
- Hydrocodone
- Hydromorphone
- Levorphanol
- Meperidine
- Methadone
- Morphine
- Opium
- Oxycodone
- Oxymorphone
- Pentazocine
- Tapentadol
- Tramadol

EXCLUSIONS

- The following opioid medications are excluded from this measure:
  - Injectables
  - Opioid-containing cough and cold products
  - Ionsys® (fentanyl transdermal patch) – this is for inpatient use only and is available only through a restricted program under a Risk Evaluation and Mitigation Strategy (REMS)
  - Methadone for the treatment of opioid use disorder
  - Single agent and combination buprenorphine products used as part of medication-assisted treatment of opioid use disorder
- Patients with Cancer or Sickle cell disease diagnoses
- Patients receiving hospice of palliative care services

Opioid facts

- Long-term opioid use often begins with the treatment of acute pain
- A significant relationship exists between early prescribing patterns and long-term use of opioids
- There is a consistent link between increasing days' supply of the first prescription with the probability of continued opioid use
- Older adults are at a higher risk of accidental misuse or abuse because they typically have multiple prescriptions and chronic disease

For additional information, please use this link:

MEDICATION ADHERENCE: PROPORTION OF DAYS COVERED

HEDIS Measure Description:

- Patients who were dispensed and remained on medication during the measurement year for 80% of the treatment period.

Measures included:

Proportion of Days Covered **Diabetes** (All Class) – Patients 18 years or older with a prescription for a diabetes medication (e.g.-non-insulin antidiabetics) who were dispensed and remained on the medication during the measurement year for at least 80% of the treatment period.

Proportion of Days Covered **RAS Antagonists** (ACE/ARB) - Patients 18 years and older with a prescription for blood pressure medication who were dispensed and remained on an ACE/ARB during the measurement year for at least 80% of the treatment period.

Proportion of Days Covered **Statins** – Patients 18 years and older with a prescription for a statin who were dispensed and remained on the medication during the measurement year for at least 80% of the treatment period.

EXCLUSIONS:

- Received hospice services anytime during the measurement year.
- Patients with end-stage renal disease diagnosis
- Diabetes measure only: Prescription for insulin
- Hypertension measure only: Prescription for sacubitril/valsartan

Ways to improve Medication Adherence:

Encourage patients to submit insurance information when using RX discount programs.

Encourage use of 90-day or 100-day Rx supplies and/or mail order.

Forward exclusion documentation to the health plan.

Patients must fill the RX, in order for it to count towards the 80%.

If a patient has a preexisting prescription going into a new year the 80% adherence would be 80% of the entire year. (Example: 80% of 365 days = 292 days)

If a patient is starting a new medication, the treatment period starts on the first day the patient picks up the prescription.

MEDICATIONS INCLUDED IN EACH MEASURE

Diabetes	Hypertension	Cholesterol
• Biguanides • Sulfonylureas • Thiazolidinediones • Dipeptidyl peptidase (DPP)-IV inhibitors • Incretin mimetics • Meglitinides • Sodium glucose cotransporter 2 (SGTLT2) inhibitors	Renin-angiotensin system (RAS) antagonists: • Angiotensin converting enzyme (ACE) inhibitors • Angiotensin II receptor blockers (ARBs) • Direct renin inhibitors	Statins

SOCIAL DETERMINANTS OF HEALTH

Social Determinants of Health are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

Purpose: Standardized approach to screening for, documenting and coding social needs enabling healthcare systems to:

- Track the social needs that impact their patients, allowing for personalized care that addressed patients medical and social needs
- Aggregate data across patients to determine how to focus a social determinants strategy
- Identify population health trends and guide community partnerships

Use this QR code for a complete list of SDOH Codes

Who can screen? Clinicians including, but not limited to, social workers, community health workers, case managers, or nurses.

Required Documentation: use of standardized screening tool documented in the patient's medical record with evidence of review. Must minimally include these five categories: Food, transportation, utility, living situation, and safety (refer to SDoH screening form or Cerner SDoH screening tool)

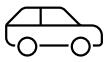
Refer patient to Care Management for positive screenings : **1-844-368-1817**

ICD-10 Code	Category	Description	Z-Code
Z59: Problems related to housing and economic circumstances:	Housing	Homelessness Unspecified	Z59.00
	Housing	Homeless, stays in shelter	Z59.01
	Safety	Inadequate Housing; includes feeling unsafe in home/ household/neighborhood	Z59.1
	Utilities	Inadequate housing utilities	Z59.12
	Food	Food Insecurity	Z59.14
	Living Situation	Extreme Poverty	Z59.5
	Transportation	Transportation Insecurity	Z59.82
Z91: Problems related to personal risk factors	Safety	Personal history of adult physical and sexual abuse	Z91.410
	Safety	Person history of adult intimate partner abuse	Z91.414

McLaren HEALTH CARE

Social Determinants of Health Screening Tool

Today's Date:	**Physician/Provider Name:**	
Patient Name:	**Date of Birth:**	
Address:	**Zip Code:**	**Phone Number:**
Office use only: Referral sent to: ☐MPP Care Coordination ☐Community Resource ☐Other_____		

Patient Screening Questions		
	**What is your living situation today?**	☐ I have a steady place to live. ☐ I have a place to live today, but I am worried about losing it in the future. ☐ I do not have a steady place to live
	**In the past 12 months, have you ever eaten less than you feel you should because there is not enough food?**	☐ Yes ☐ No
	**In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?**	☐ Yes ☐ No
	**In the past 12 months has the electric, gas, oil or water company threatened to shut off services in your home?**	☐ Yes ☐ No ☐ Already shut off
	**Do you have a history of or are you currently in an abusive or neglectful situation?**	☐ Yes ☐ No
	**Would you like to speak to a member of our Care Management department to assist you with any resources or needs indicated above?**	☐ Yes ☐ No
	**Are any of your needs urgent?** *For example: I do not have food today, I don't have a place to sleep tonight.*	☐ Yes ☐ No

☐ Declined to answer screening questions.

ADDITIONAL HEDIS MEASURES AT A GLANCE

Category	Measure Title	Specifications
Respiratory Conditions	Appropriate Testing for Pharyngitis*	Patients ages 3 years and older diagnosed with pharyngitis and dispensed an antibiotic should have received a strep test within 3 days prior to diagnosis through 3 days after diagnosis. POC strep test completed in your office, you can bill CPT 87880.
	Appropriate Treatment for Upper Respiratory Infection*	Patients ages 3 months and older diagnosed with URI who were NOT dispensed an antibiotic 30 days prior through 3 days after the diagnosis.
	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis*	Patients ages 3 months and older diagnosed with acute bronchitis/bronchiolitis who were NOT dispensed an antibiotic.
	Medication management for people with Asthma	Patients 5-64 years of age, dispensed controller medication and remained on for at least 50% of the time during 2024.
Behavioral Health	Antidepressant Medication Management: Acute Phase	Patients ages 18 and older diagnosed with new episode of major depression, treated with antidepressant medication, and who remained on an antidepressant medication treatment for at least 84 days (12 weeks).
	Antidepressant Medication Management: Continuation Phase	Patients ages 18 and older diagnosed with new episode of major depression, treated with antidepressant medication, and who remained on an antidepressant medication treatment for at least 84 days (12 weeks).
	Follow-up Care for Children Prescribed ADHD Medication: Continuation and Maintenance (C&M) Phase (6-12 years)	Patients newly prescribed ADHD medication who remained on the medication for at least 210 days and who in addition to the visit in the initiation phase, had at least 2 follow-up visits within 270 days (9 months) after the initiation phase ended.
Transition of Care	Post Hospital Follow-up	Post hospital follow-up visit within 7 or 14 calendar days of discharge. Higher risk patients may need to be seen sooner.
Prevention Screening	Medical assistance with smoking cessation	Patients 18 years and older who are screened and are identified to use tobacco; receive face-to-face cessation advice, information on medication and strategies to help them quit.
	Influenza Immunization	Patients aged 6 months and older with a visit between August 1, 2024 and March 31, 2025 who received an influenza immunization OR who reported previous receipt of an influenza immunization. Document refusal.
Utilization	Imaging for Low Back	Patients aged 18 to 75 (not including palliative care or hospice) with a primary diagnosis of low back pain who did not have imaging study (plain x-ray, MRI, CT scan) with 28 days of the diagnosis.
Pharmacy	Statin use for persons with Diabetes	Patients 40-75 years of age with diabetes who do not have atherosclerotic cardiovascular disease who were dispensed at least two diabetes medication fills in a year and were dispensed a statin medication at any time during the measurement year.
Diabetes	Blood Pressure Control for Patients with Diabetes	Patients 18-75 years of age with diabetes whose blood pressure was adequately controlled less than 140/90 during the measurement year.

***Metric is attributed to primary care provider even if ordered by another provider. Episodes are excluded if there is a history of a competing diagnosis or positive antibiotic history in the prior 30 days.**

MEDICATION RECONCILIATION POST DISCHARGE

Purpose:

- Reconciliation helps patients understand any medication changes that occurred as a result of the hospitalization and helps prevent adverse drug events and other medication issues that may arise after discharge.

Measure Description:

- Patients 18 years and older whose hospital discharge medications were reconciled with the most recent medication list in the outpatient medical record on the date of discharge through 30 days after discharge.
- Emergency room or Urgent Care visits do not count as a hospital discharge.

Documentation

- Documentation must include evidence of medication reconciliation within outpatient medical record
- Performed by the prescribing practitioner, registered nurse or clinical pharmacist.

Acceptable documentation examples:

- Documentation of current medications with a notation that references the discharge medications. e.g. no changes in meds since discharge, same meds at discharge, discontinue all discharge meds
- Documentation of the patient's current medications with a notation that the discharge medications were reviewed.
- Documentation that the provider "reconciled the current and discharge meds".
- Document of the current medication list, discharge medication list and notation that the appropriate practitioner reviewed both lists on the same date of service.
- Notation that no medications were prescribed or ordered upon discharge.
- Documentation that patient was seen for post-discharge follow-up with evidence of medication reconciliation or review.
- Documentation in the discharge summary that the discharge medications were reconciled with the current medications; the discharge summary must be in the outpatient chart.

Codes for Medication Reconciliation	Description
1111F	Discharge medications reconciled with current medication list in the outpatient medical record within 30 days of discharge. Does not need to be billed with 99495 or 99496, it is included in these codes.
99495	Transitional Care Management; communication with a patient/caregiver within two business days of discharge and a decision- making at least moderate-complexity within 14 days
99496	Transitional Care Management; communication with a patient/caregiver within two business days of discharge and a decision-making of at least high complexity within 7 days
99212-99215 + 1111F	If you do not have TCM documentation to bill TCM codes, please add 1111F with Office Visit E&M codes 99212-99215. During the 30 days post hospital discharge- bill 1111F Medication Reconciliation code with Office Visit E&M 99212-99215.

NOTE: Codes listed above cannot be billed simultaneously or on the date of discharge.

ANNUAL WELLNESS VISIT

Purpose: Yearly personalized structured preventive appointment providing primary care providers the ability to create age-appropriate plans that can lead to identifying risk factors and offering recommended evidence- based referrals.

Ways to improve AWV rates:

Increase communication efforts through a pro-active approach using forms/letters, in-office or phone staff scripting including appointment reminders.

Utilize MPP list to identify patients needing AWVs.

Utilize Health risk assessment forms or documentation templates to ensure compliance.

Schedule future appointments as an AWV with appropriate time allotted.

Convert annual physical exam to AWVs in schedule.

Conduct AWV during a Telehealth Visit

For additional information, please see a document on this topic at:

Medicare Learning Network Educational Tool - Medicare Wellness Visits - Updated November 2024

Benefits

- Quality Improvements and sustainable revenue stream
  - Opportunity to complete in-depth conversation on the importance of preventive services.
  - Incorporates gaps in care influencing performance within multi-payer value-based programs.
  - Alignment with key initiatives and reporting requirements
  - National reimbursement rate is $165.44 for the initial year and $130.15 for subsequent years.
  - Additional reimbursement may be available for covered Medicare preventive services (See QR code below)
  - Decrease cost of care
  - Reduces spending on acute care and outpatient utilization
    - Reduction in duplication and unnecessary care
    - Beneficiary engagement and patient attribution
  - Ability to report yearly risk-adjusted diagnosis (RAF)
    - Increases accuracy and specificity by focusing on capturing patient diagnosis
  - Patient satisfaction
    - Zero-dollar expense with a full comprehensive evaluation focused on overall wellness and prevention
    - Advanced Care Planning completed during the visit has zero copay

Who can perform AWV?

Doctor of Medicine or Osteopathy, physician assistant (PA), nurse practitioner, certified clinical nurse specialist, or medical professional, including a health educator, registered dietician, nutrition professional or other licensed practitioner, or a team of medical professionals working under the direct supervision of a physician.

Source: Medicare Processing Manual - Chapter 18 - Preventive and Screening Services

Description	Code
"Welcome to Medicare" (IPPE) One-time exam performed within the first 12 months of a patient's enrollment	G0402
Initial Annual Wellness Visit (AWV) Performed 12 months after a patient's initial enrollment or after he/she receives IPPE	G0438
Subsequent AWV (Annual)	G0439

MEDICARE MEASURES

Category	Measure Title	Specifications
Adult Prevention and Screening Measures	Breast Cancer Screening (A)	Reference Page #13
	Colorectal Cancer Screening (A)	Reference Page # 12
	Falls: Screening for Future Fall Risk (A) Use this QR code for a Fall Risk Assessment Tool that may be used during a telehealth visit:	Patients 65 years of age and older who were screened for future fall risk during 2025. Screening for Future Fall Risk: Assessment of whether an individual has experienced a fall or problems with gait or balance. A specific screening tool is not required for this measure (Example screening tool: Get-Up-And-Go test.) • Documentation of "no falls" is sufficient • Medical record must include documentation of screening performed • Any history of falls screening during the measurement period is acceptable • A gait or balance assessment meets the intent of the measure.
	Tobacco Use: Screening and Cessation Intervention (A)	Patients 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user. **Tobacco Use** – Includes any type of tobacco, including smokeless/e-cigs/vaping **Tobacco Cessation Intervention** – Includes brief counseling (3 minutes or less), and/or pharmacotherapy. Written self-help materials (eg, brochures, pamphlets) and complementary/alternative therapies **do not** qualify for the numerator.
	Screening for Depression and Follow-Up Plan (A)	Percentage of patients aged 12 years and older screened for depression on the date of the encounter or up to 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool (examples: PHQ-2, PHQ-9) AND if positive, a follow-up plan is documented on the date of the eligible encounter. A **follow-up plan** must include one of the following: referral to a provider for additional evaluation and assessment, pharmacologic interventions, or other interventions or follow up for the diagnosis or treatment of depression. Codes: Administration of Screen: **G0444**, Positive PHQ-9 (5 or greater) AND a follow-up plan is documented **G8431**, Negative PHQ-9 (4 or less): **G8510**
Mental Health	Depression Remission at Twelve Months (A)	Patients 12 to 17 years of age and adult patients 18 years of age or older with major depression or dysthymia who reached remission 12 months (+/- 60 days) after an index event date. **Index Event Date:** The date in which the first instance of elevated PHQ-9 greater than nine **AND** diagnosis of depression or dysthymia occurs. **Remission:** defined as a PHQ-9 score of less than five. **Exclusions:** Patients with an active diagnosis of bipolar disorder, personality disorder, schizophrenia or psychotic disorder, pervasive developmental disorder any time prior to the end of the measurement period, patients who died, patients who received hospice or palliative care, or who were permanent nursing home residents any time during the denominator identification period or the measure assessment period.
Comprehensive Diabetes Care	Diabetes Care: Retinal Eye Exam	Reference Page # 10
	Glycemic Status Assessment for Patient with Diabetes (GSD) (A) NOTE: For ACO, can not use results from continuous glucose monitoring system	Percentage of diabetic patients ages 18-75 whose most recent glycemic status (hemoglobin A1c) or glucose management indicator (GMI) is **less than or equal to 9%** during 2025. Exclusion: Patients receiving hospice or palliative care services, in a long term care facility, or advanced illness & frailty
	Diabetes Care: Kidney Health Evaluation for Patient with Diabetes	Reference Page # 9
Transitions of Care	Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions	The percentage of emergency department (ED) visits for members 18 years of age and older who have multiple high-risk chronic conditions who had a follow-up service within 7 days of the ED visit.

(A) – This measure is reported for ACO/MIPS Quality performance

McLaren PHYSICIAN PARTNERS

HEDIS QUICK REFERENCE 2025

MEDICARE MEASURES

Category	Measure Title	Specifications
Care for Older Adults The percentage of adults 66 years of age and older who had each of the following during the measurement year	Medication Review	A review of all a patient's medications, including prescription medications, OTC medications and herbal or supplemental therapies.
	Pain Assessment	At least one pain assessment is documented each year. Documentation must include either: • that the patient was assessed for pain (positive or negative findings) or • patient was assessed for pain using a standardized assessment tool. For example, the Numeric Pain Rating Scale (NPRS) or the Wong-Baker FACES Pain Rating Scale.
	Functional Assessment	At least one functional assessment is documented each year. Documentation must include one of the following: • 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. • 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. • Result of assessment using a standardized functional status assessment tool
Transitions of Care	Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions	The percentage of emergency department (ED) visits for members 18 years of age and older who have multiple high-risk chronic conditions who had a follow-up service within 7 days of the ED visit.
Cardiovascular Conditions	Controlling High Blood Pressure (A) The BP value in this measure meets the HEDIS specifications to close the gap. According to NCQA, for a member's BP to be controlled the systolic and diastolic BP must be <140/90mm Hg (adequate control).	Patients ages 18 – 85 with diagnosis of hypertension and whose blood pressure is adequately controlled, ≤139/89 (if hypertension is treated by a specialist, may obtain BP from their record). Blood pressure should be last one of the calendar year. Repeat any BP measurement that is above 140/90. Blood pressure may be patient-reported taken with a digital device and documented. Claim date and date for compliant BP have to match. Systolic Blood Pressure CPT II codes: - **3074F** SBP less than 130 - **3075F** SBP 130-139 -**3077F** SBP greater than or equal to 140 Diastolic Blood Pressure CPT II codes: - **3078F** DBP less than 80 - **3079F** DBP 80-89BP -**3080F** DBP greater than or equal to 90 Exclusions: ESRD, kidney transplant, dialysis, pregnancy during 2025, non-acute inpatient admission during 2025, hospice or palliative care services, or living in a skilled nursing facility, advanced illness or frailty.
Patient Experience Patient experience (satisfaction) is being measured by the insurance companies. This is an example of the questions on the survey. Visit the MPP. org website to view our Patient Experience Training:	Getting Needed Care (A)	In the last 6 months, how often was it easy to get the care, tests, or treatment you needed?
	Getting Care Quickly (A)	• In the last 6 months, when you contacted this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed? • In the last 6 months, when you made an appointment for a checkup or routine care with this provider, how often did you get an appointment as soon as you needed? Wait time includes time spent in the waiting room and exam room. In the last 6 months, how often did you see the person you came to see within 15 minutes of your appointment time?
	Care Coordination (A)	• In the last 6 months, how often did this provider seem to know the important information about your medical history? • In the last 6 months, when this provider ordered a blood test, X-ray, or other test for you, how often did someone from this provider's office follow up to give you those results? • In the last 6 months, how often did you and someone from this provider's office talk about all the prescription medicines that you were taking? In the last 6 months, did you get the help you needed from this provider's office to manage your care among these different providers and services?

(A) – This measure is reported for ACO/MIPS Quality performance

Category	Measure Title	Specifications
Pharmacy	*NEW Polypharmacy: Use of Multiple Anticholinergic Medications in Older Adults	Percentage of patients 65 and older with concurrent use of 2 or more unique anticholinergic medications. Concurrent use means overlapping prescriptions for anticholinergic medications adding up to at least 30 cumulative days during measurement period. **Lower rates mean better performance.** Exclusions: Patients who were admitted into hospice care any time during the measurement year.
	*NEW Concurrent Use of Opioids and Benzodiazepines (COB)	Percentage of patients 18 years and older with concurrent use of prescription opioids and benzodiazepines. This means two or more prescription claims for opioids filled on 2 or more different dates of service with a cumulative days' supply of 15 or more days during the measurement year. **Lower rates mean better performance.** Exclusions: Cancer diagnosis, sickle cell disease, hospice care during the measurement year.
	Influenza Immunization (A)	Patients aged 6 months and older with a visit between August 1, 2024 and March 31, 2025 who received an influenza immunization OR who reported previous receipt of an influenza immunization. Document refusal.
	Statin Therapy for Patients with Cardiovascular Disease (A)	Percentage of males 21-75 and females 40-75 identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and were dispensed at least one high-intensity or moderate-intensity statin medication during the year Also includes patients: - 20 years and older who have ever had a LDL level greater that equal to 190 or were previously diagnosed with or currently have an active diagnosis of familial hypercholesterolemia; OR - Patients aged 40-75 with a diagnosis of diabetes Exclusions/Exceptions: pregnancy, IVF, breastfeeding, prescription for clomiphene, diagnosis of myalgia, myositis, myopathy, or rhabdomyolysis; patients with cirrhosis; patients with end-stage renal disease (ESRD); hospice or palliative care, living in a skilled nursing facility; advanced illness or frailty.
	Statin Therapy for Patients with Diabetes	Patients aged 40-75 with diabetes who do not have clinical atherosclerotic cardiovascular disease and were dispensed a statin medication during the year. Exclusions: Myocardial Infarction, CABG, PCI or other revascularization, IVD, pregnancy, IVF, prescription for clomiphene, ESRD, cirrhosis, myalgia, myositis, myopathy or rhabdomyolysis, hospice or palliative care, enrolled in long term facility, advanced illness and frailty
	Osteoporosis Management in Women Who Had a Fracture	The percentage of women ages 67-85 years of age and older who suffered a fracture and who had either a bone density test or a prescription or a drug to treat or prevent osteoporosis six months after the date of the fracture. **Code: 4005F** (pharmacologic therapy [other than vitamins/minerals] for osteoporosis prescribed) Exclusions: Patients who had a bone mineral test, encounter for osteoporosis therapy, received a prescription to treat osteoporosis, use of hospice or palliative care, enrolled in long term care, or advanced illness and frailty ***Osteoporosis Medications*** **Description** / **Prescription** Bisphosphonates: • Alendronate • Alendronate-cholecalciferol • Ibandronate • Risedronate • Zoledronic acid Other Agents: • Abaloparatide • Denosumab • Raloxifene •Romosozumab •Teriparatide

(A) – This measure is reported for ACO/MIPS Quality performance

ASSESSMENT

Timed Up & Go (TUG)

Patient _____

Date _____

Time ☐ AM ☐ PM

Purpose: To assess mobility

Equipment: A stopwatch

Directions: Patients wear their regular footwear and can use a walking aid, if needed. Begin by having the patient sit back in a standard arm chair and identify a line 3 meters, or 10 feet away, on the floor.

NOTE: Always stay by the patient for safety.

① Instruct the patient:

When I say "Go," I want you to:

1. Stand up from the chair.
2. Walk to the line on the floor at your normal pace.
3. Turn.
4. Walk back to the chair at your normal pace.
5. Sit down again.

② On the word "Go," begin timing.

③ Stop timing after patient sits back down.

④ Record time.

Time in Seconds: _____

An older adult who takes ≥12 seconds to complete the TUG is at risk for falling.

OBSERVATIONS

Observe the patient's postural stability, gait, stride length, and sway.

Check all that apply:

- ☐ Slow tentative pace
- ☐ Loss of balance
- ☐ Short strides
- ☐ Little or no arm swing
- ☐ Steadying self on walls
- ☐ Shuffling
- ☐ En bloc turning
- ☐ Not using assistive device properly

These changes may signify neurological problems that require further evaluation.

CDC's STEADI tools and resources can help you screen, assess, and intervene to reduce your patient's fall risk. For more information, visit www.cdc.gov/steadi

Centers for Disease Control and Prevention
National Center for Injury Prevention and Control

2017

STEADI Stopping Elderly Accidents, Deaths & Injuries

Patient Name: _____
Date of Birth:_____

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

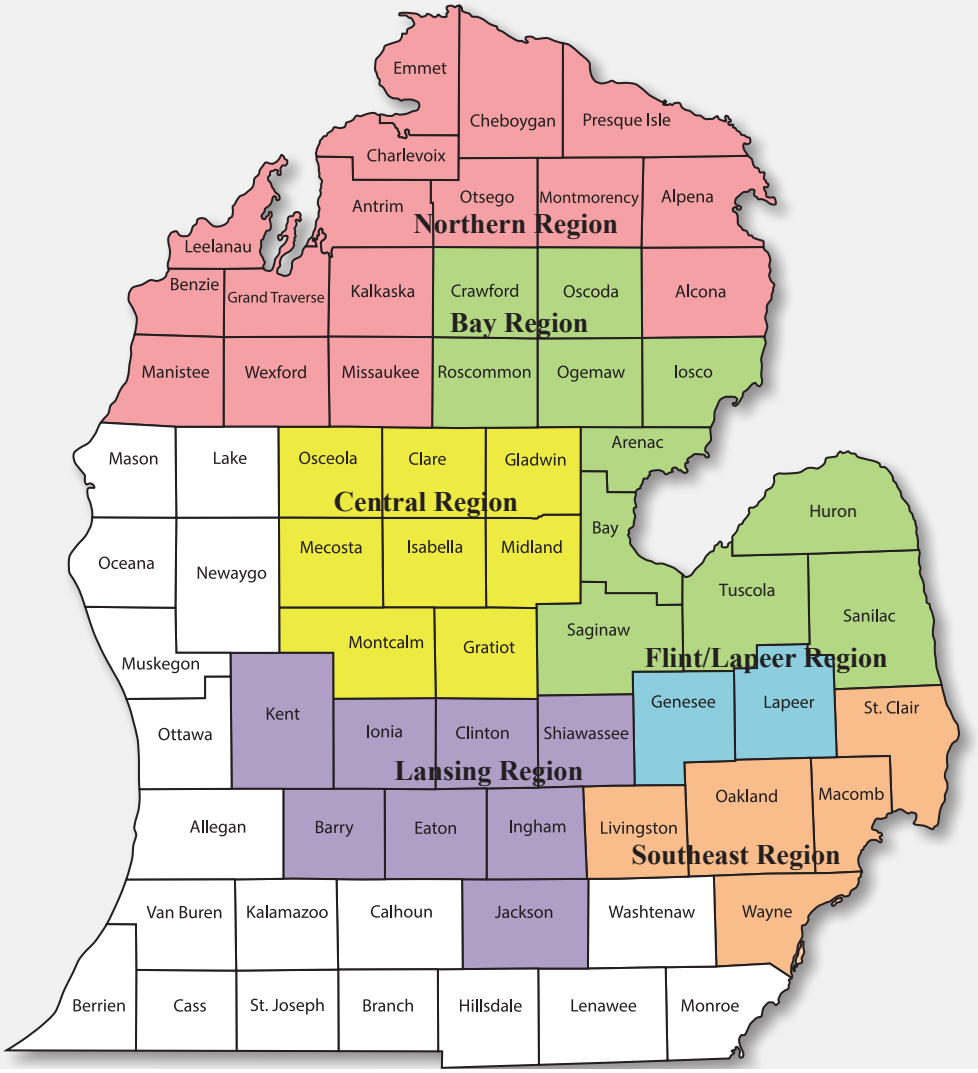
=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

For PHQ screening tools in different languages; please go to www.phqscreeners.com

MPP QUALITY REGIONS - 2025



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