HEDIS® MY 2025

Administrative Measure Quick Guide with Codes

L.A. Care HEALTH PLAN®

For All of L.A.

HEDIS® MY 2025
Administrative Measure Quick Guide with Codes

L.A. Care Health Plan strives to provide quality healthcare to our membership as measured through Healthcare Effectiveness Data and Information Set (HEDIS®) quality metrics. We created the HEDIS® MY 2025 Administrative (Admin) Measure Quick Guide with Codes to help you increase your HEDIS® rates. These results are used to measure performance, identify quality initiatives, and provide educational programs for providers and members.

This guide is designed to help your practice increase your HEDIS® performance scores, understand the coding that will provide evidence of services rendered for your patients, and improve Quality Incentive Program earnings potential through the use of HEDIS® reference sheets that include:

- Measure descriptions
- Age ranges
- Billing and diagnosis codes for each measure
- Tips and strategies for improving measure performance
- Additional information regarding the HEDIS® measure requirements

As state and federal governments move toward a quality-driven healthcare industry, HEDIS® rates are becoming more important for both L.A. Care Health Plan and individual providers. State purchasers of healthcare use aggregated HEDIS® rates to evaluate health insurance companies' efforts to improve preventive health outcomes for members. Physician-specific scores are also used to measure your preventive care efforts.

HOW CAN I IMPROVE MY HEDIS® SCORES?

- Submit claim/encounter data for each and every service rendered
- Ensure that all claim/encounter data is submitted in an accurate and timely manner
- Make sure that chart documentation reflects all services billed
- Consider including CPT II codes to provide additional details and reduce medical records requests
- Bill (or report by encounter medical record requests submission) for all delivered services, regardless of contract status

VALUE OF HEDIS® TO YOU, OUR PROVIDERS

HEDIS® can help save you time while also potentially reducing healthcare costs. By proactively managing patients' care, you are able to effectively monitor their health, prevent further complications, and identify issues that may arise with their care.

HEDIS® can also help you:

- Identify noncompliant members to ensure they receive appropriate treatment and follow-up care
- Understand how you compare with other L.A. Care Health Plan providers as well as with the national average

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Child/Adolescent Health

Priority Measure	Measure Specification	How to Improve Score for HEDIS
APP - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	The percentage of children and adolescents 1-17 years of age who had a new prescription for an antipsychotic medication and has documentation of psychosocial care as first-line treatment during January 1 through December of the measurement year.	Use of complete and accurate Value Set Codes **(Click to view)** • Timely submission of claims and encounter data **Required Exclusions:** • Members for whom first-line antipsychotic medications may be clinically appropriate: members with a diagnosis of schizophrenia, schizoaffective disorder, bipolar disorder, other psychotic disorder, autism or other developmental disorder on at least two different dates of service during measurement year. • Members in hospice services or using hospice services during the measurement year. • Members who die any time during the measurement year.
APM - Metabolic Monitoring for Children and Adolescents on Antipsychotics	Members 1–17 years of age who had two or more antipsychotic prescriptions and had metabolic monitoring (blood glucose testing, cholesterol testing or both) in 2025.	Use of complete and accurate Value Set Codes **(Click to view)** • Timely submission of claims and encounter data • Order labs for glucose or A1c and low-density lipoproteins (LDL) during 2025. • Proper coding or documentation – to assist in excluding members from the HEDIS sample See below for exclusion criteria **Exclusions:** i. Members in hospice are excluded from the eligible population ii. Members who are enrolled in an Institutional Special Needs Plans (I-SNP) iii. Members who are living long term in an institution any time during 2025
CIS-E - Child Immunization Status	The percentage of children 2 years of age who had four diphtheria, tetanus and a cellular pertussis (DTaP), three polio (IPV), one measles, mumps and rubella (MMR), three heamophilis influenza type B (HiB), three hepatitis B(Hep B), one chicken pox (VZV), four pneumococcal conjugate (PCV), one Hepatitis A (Hep A), two or three rotavirus (RV), and two influenza (flu). Vaccines by their second birthday.	Use of complete and accurate Value Set Codes **(Click to view)** • Timely submission of claims and encounter data **Exclusions:** • Members in hospice services or using hospice services during the measurement year. • Members who die any time during the measurement year. • Members who had a contraindication to a childhood vaccine on or before their second birthday

CWP - Appropriate Testing for Pharyngitis	Children 3 years and older, who were diagnosed with pharyngitis, dispensed an antibiotic and received a group during any outpatient, telephone or ED visit, e-visit or virtual check in. A streptococcus (strep) test for the episode (7/1/24 - 6/30/25) during any outpatient or Emergency Department (ED) visit.	• Use of Complete and accurate Value Set Codes **(Click to view)** • Timely submission of claims and encounter data • Ensure proper documentation in medical record *** Members in Hospice or using Hospice services during measurement year are a required exclusion.**
IMA-E - Immunizations for Adolescents	The percentage of adolescents 13 years of age and older who had a dose of meningococcal vaccine, on tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday.	Use of complete and accurate Value Set Codes **(Click to view)** • Timely submission of claims and encounter data **Exclusions:** • Members in hospice services or using hospice services during the measurement year. • Members who die any time during the measurement year.
OED - Oral Evaluation, Dental Services	Members under 21 years of age who received a comprehensive or periodic oral evaluation with a dental provider during the measurement year. Report 4 ages ranges: • 0-2 years • 3-5 years • 6-14 years • 15-20 years • Total	Use of complete and accurate Value Set Codes **(Click to view)** **Exclusions :** • Members in hospice or using hospice services during measurement year • Members who died any time during measurement year
TFC/TFL - Topical Fluoride for Children	Members 1-4 years of age who received at least 2 fluoride varnish applications during the measurement year. Report 2 rates: • 1-2 years • 3-4 years • Total	Use of complete and accurate Value Set Codes **(Click to view)** **Exclusions:** • Members in hospice or using hospice services during measurement year • Members who died any time during measurement year
URI - Appropriate Treatment for Upper Respiratory Infection	Children 3 months -18 years of age who were given a diagnosis of upper respiratory infection (URI) and were not dispensed an antibiotic prescription in 2025. A higher rate indicates better performance.	Use of complete and accurate Value Set Codes **(Click to view)** • Timely submission of claims and encounter data • Ensure proper documentation in medical record • Exclude claims/encounters with more than one diagnosis code and ED visits or observation visits that result in an inpatient stay. *** Members in Hospice or using Hospice services during measurement year are a required exclusion.**

WCV - Child and Adolescent Well-Care Visits	Members 3-21 years of age who had a well-care visit in 2025 with a PCP or OB/GYN practitioner.	Use of Complete and accurate Value Set Codes **(Click to view)** • Timely submission of claims and encounter data • Proper documentation and coding ***Members in Hospice or using Hospice services during measurement year are a required exclusion.**
W30 - Well-Child in the First 30 Months of Life	Members who had the following number of well care visits during the last 15 months. Well-Child Visits in the First 15 Months. Children who turned 15 months old during the measurement year: Six or more well-child visits. Well-Child Visits for Age 15 Months–30 Months. Children who turned 30 months old during the measurement year: Two or more well-child visits.	Use of Complete and accurate Value Set Codes **(Click to view)** • Timely submission of claims and encounter data • Ensure proper documentation in medical record *** Members in Hospice or using Hospice services during measurement year are a required exclusion.**

Women's Health

BCS-E - Breast Cancer Screening	Women 40 - 74 years of age who had one or more mammograms to screen for breast cancer any time on or between 10/1/23 - 12/31/2025.	• Use of complete and accurate Value Set Codes **(Click to view)**
		• Timely submission of claims and encounter data
		• Note that mammograms do not need prior authorization and share list of nearby contracted imaging/mammography centers with member
		• Educate female members about the importance of early detection, address common barriers/fears, and encourage testing
		• Proper coding or documentation of mastectomy either bilateral or unilateral – to assist in excluding member from the HEDIS sample.
		See below for exclusion criteria:
		Exclusions for Breast Cancer Screening: (Use designated Value Set Code for each)
		Any of the following meet criteria for bilateral mastectomy:
		• Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following:
		  • Enrolled in an Institutional SNP (I-SNP) any time during the measurement year.
		  • Living long-term in an institution any time during the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the measurement year.
		• Bilateral Mastectomy
		• Unilateral Mastectomy with a bilateral modifier
		• Two unilateral mastectomies with service dates 14 days or more apart
		• Unilateral mastectomy with right-side modifier with same date of service
		• Unilateral mastectomy with left-side modifier with same date of service
		Note: Biopsies, breast ultrasounds and magnetic resonance imaging (MRI)s are not appropriate methods for breast cancer screening.

BPC-E - Blood Pressure Control For Patients With Hypertension	The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose most recent blood pressure (BP) was <140/90 mm Hg during the measurement period.	Use of Complete and accurate Value Set Codes **(Click to view)** • Timely submission of claims and encounter data • Ensure proper documentation in medical record **Exclusions:** • Members who die any time during the measurement period. • Members who use hospice services or elect to use a hospice benefit any time during the measurement period. • Members receiving palliative any time during the measurement period. • Members who had an encounter for palliative any time during the measurement period. Do not include laboratory claims • Members with a nonacute inpatient admission during the measurement period. To identify nonacute inpatient admissions: – Identify all acute and nonacute inpatient stays – Confirm the stay was for nonacute care based on the presence of a nonacute code on the claim. – Identify the admission date for the stay. • Members with a diagnosis that indicates end-stage renal disease (ESRD) any time during the member's history on or prior to the last day of the measurement period. Do not include laboratory claims • Members with a procedure that indicates ESRD: dialysis, nephrectomy or kidney transplant any time during the member's history on or prior to the last day of the measurement period. • Members with a diagnosis of pregnancy any time during the measurement period. Do not include laboratory claims • Medicare members 66 years of age and older as of the last day of the measurement period who meet either of the following: • Enrolled in an Institutional SNP (I-SNP) any time during the measurement period. • Living long-term in an institution any time during the measurement period as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an • LTI flag during the measurement period.

BPC-E - Blood Pressure Control For Patients With Hypertension (continued)	The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose most recent blood pressure (BP) was <140/90 mm Hg during the measurement period.	• Members 66–80 years of age as of the last day of the measurement period (all product lines) with frailty ***and*** advanced illness. Members must meet ***both*** frailty and advanced illness criteria to be excluded: – **Frailty**. At least two indications of frailty with different dates of service during the measurement period. – Do not include laboratory claims • **Advanced Illness**. Either of the following during the measurement period or the year prior to the measurement period: – Advanced illness on at least two different dates of service. Do not include laboratory claims (claims with POS code 81). – Dispensed dementia medication • Members 81 years of age and older as of the last day of the measurement period with at least two indications of frailty with different dates of service during the measurement period. Do not include laboratory claims
CCS-E - Cervical Cancer Screening	The percentage of members 21-64 years of age who were recommended for routine cervical cancer screening who were screened for cervical cancer during the measurement year.	Use of complete and accurate Value Set Codes **(Click to view)** • Timely submission of claims and encounter data **Exclusions:** • Members in hospice services or using hospice services during the measurement year. • Members receiving palliative care. • Members who die any time during the measurement year. • Hysterectomy with no residual cervix. • Cervical agenesis or acquired absence of cervix. • Members with Sex Assigned at Birth of Male.
CHL - Chlamydia Screening	Members 16-24 years of age who were identified as sexually active and who had at least one test for chlamydia in 2025. ***Exclude members who were assigned male at birth.** ***Members who use hospice services or elect to use a hospice benefit any time during the measurement year.** ***Members who die any time during the measure**	• Use of complete and accurate Value Set Codes **(Click to view)** • Timely submission of claims and encounter data • For all those on birth control pills, make chlamydia screening a standard lab • Remember that chlamydia screening can be performed through a simple urine test offer this as an option for your members • Proper coding or documentation will assist in excluding members from the HEDIS sample • Exclude members based on a pregnancy test alone and who meet either of the following: i. A pregnancy test in 2025 and a prescription for Isotretinoin (Retinoid) on the date of pregnancy test or the six days after the pregnancy test ii. A pregnancy test in 2025 and an x-ray on the date of the pregnancy test or the six days after the pregnancy test.

DBM-E - Documented Assessment After Mammogram	The percentage of episodes of mammograms documented in the forms of BI-RADS assessment within 14 days of the mammogram for members 40-74 years of age.	Use of Complete and accurate Value Set Codes **(Click to view)** • Timely submission of claims and encounter data Ensure proper documentation in medical record **Exclusions:** • Members who die any time during the measurement period. • Members who use hospice services or elect to use a hospice benefit any time during the measurement period.
FMA-E - Follow Up After Abnormal Mammogram Assessment	The percentage of episodes for members 40-74 years of age with inconclusive or high-risk BI-RADS assessments that received appropriate follow-up within 90 days of the assessment.	Use of Complete and accurate Value Set Codes **(Click to view)** • Timely submission of claims and encounter data Ensure proper documentation in medical record **Exclusions:** • Members who die any time during the measurement period. • Members who use hospice services or elect to use a hospice benefit any time during the measurement period.
OMW - Osteoporosis Management in Women Who Had a Fracture	Women 67-85 years of age who suffered a fracture (7/1/22024 - 6/30/2025), and who had either a bone mineral density (BMD) test or prescription for a drug to treat osteoporosis in the six months after the fracture.	• Use of complete and accurate Value Set Codes **(Click to view)** • BMD (bone mineral density) test, in any setting, on the Index Episode Start Date (IESD) or in the 180-day (six month) period after the IESD. • If IESD was an inpatient, a BMD test during inpatient stay. • Osteoporosis therapy on the IESD or in the 180-day (six month) period after IESD. • If the IESD was an inpatient, long-acting osteoporosis therapy during the inpatient stay. • A dispensed prescription to treat osteoporosis on the IESD or in the 180-day (six month) period after IESD • A dispensed prescription to treat osteoporosis • Fracture • Visit type
OSW - Osteoporosis Screening in Older Women	Women 65-75 years of age who received osteoporosis screening in 2025.	• Use of complete and accurate Value Set codes **(Click to view)** • Timely submissions of claims and encounter data • Proper documentation and coding—to assist in excluding members from the HEDIS sample • BMD (Bone Mineral Density) test, in any setting. **Exclusions:** • Members who were dispensed a prescription to treat osteoporosis anytime on or between January 1, 2024 through December 31, 2025. • Members in hospice are excluded from the eligible population Exclude Medicare members 66 and older as of December 31, 2025 who meet any of the following: • Enrolled in an Institutional SNP (I-SNP) • Living long-term in an institution in 2025

Men's Health

PSA - Non-Recommended PSA-Based Screening in Older Men	Men 70 years of age and older who were screened unnecessarily for prostate cancer using prostate-specific antigen (PSA)-based screening.	• Use of complete and accurate Value Set Codes **(Click to view)** • Timely submission of claims and encounter data • Proper coding or documentation – to assist in excluding members from the HEDIS sample See below for exclusion criteria Exclusions: • Men who had a diagnosis for which PSA-based testing is clinically appropriate. Any of the following meet criteria: • Prostate cancer diagnosis any time during the member's history through December 31, 2025. • Dysplasia of the prostate during 2025 or 2024. • A PSA test in 2025, where laboratory data indicate an elevated result (>4.0 nanograms/milliliter [ng/mL]). • Dispensed prescription for a 5-alpha reductase inhibitor in 2025.

Adult/Elderly Health

AAB - Avoidance of Antibiotic Treatment for Acute Bronchitis/ Bronchiolitis	Members ages 3 months and older with a diagnosis of acute bronchitis/bronchiolitis that were not dispensed an antibiotic treatment. • *The percentage of episodes for members ages 3 months and older with a diagnosis of acute bronchitis/ bronchiolitis that did not result in an antibiotic dispensing event.*	• Use of complete and accurate Value Set Codes **(Click to view)** • Timely submission of claims and encounter data *** Members in Hospice or using Hospice services during measurement year are a required exclusion**
AAP - Adult's Access to Preventive or Ambulatory Health Services	The percentage of members 20 years of age and older who had an ambulatory or preventive care visit.	Use of complete and accurate Value Set Codes **(Click to view)** • Timely submission of claims and encounter data **Exclusions:** • Members in hospice services or using hospice services during the measurement year. • Members who die any time during the measurement year.
ACP - Advance Care Planning	Members 66-88 years of age with advanced illness, an indication of frailty or who are receiving palliative care.	• Discussion or documentation about preferences **(Click to view)** os resuscitation, life sustaining treatment or end of life care. • Include members 66-80 who meet any of the following during measurement year: i. Acute and non-acute inpatient stays ii. A dispensed dementia medication iii. Frailty iv. Palliative care v. Members in hospice or using hospice anytime during measurement year.

AIS - Adult Immunization Status	The percentage of members 19 years of age and older who are up to date on Recommended routine vaccines for influenza, tetanus and diphtheria (Td) or Tetanus, diphtheria and acellular pertussis (Tdap), zoster and pneumococcal and hepatitis B given between January 1 through December 31 of Measurement Year.	Use of complete and accurate Value Set Codes **(Click to view)** • Timely submission of claims and encounter data **Exclusions:** • Members in hospice services or using hospice services during the measurement year. • Members who die any time during the measurement year.
AMR - Asthma Medication Ratio	Members 5-64 years old who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during MY.	Use of complete and accurate Value Set Codes **(Click to view)** • Timely submission of claims and encounter data *** Members in Hospice or using Hospice services during measurement year are a required exclusion.**
AXR - Antibiotic Utilization for Respiratory Conditions	The percentage of episodes for members 2 months of age and older with a diagnosis of a respiratory condition that resulted in an antibiotic dispensing event from July 1 of the year prior to the measurement year to June 30 of the measurement year.	Use of complete and accurate Value Set Codes **(Click to view)** • Timely submission of claims and encounter data

COL-E - Colorectal Cancer Screening	The percentage of members 45-75 years of age who had an appropriate screening for colorectal cancer.	Use of complete and accurate Value Set Codes **(Click to view)**
		• Timely submission of claims and encounter data
		Exclusions:
		Members in hospice services or using hospice services during the measurement year.
		• Members receiving palliative care.
		• Members who die any time during the measurement year.
		• Members who had colorectal cancer.
		• Members who had a total colectomy.
		• Medicare members 66 years of age and older by the end of the of measurement period who meet either of the following:
		  • Enrolled in an Institutional SNP
		  • Living long-term in an institution
		• Members 66 years of age or older by end of measurement period, with frailty and advanced illness. Members must meet BOTH frailty and advanced illness criteria to be excluded:
		  • **Frailty**—at least 2 indication of frailty
		  • **Advanced Illness**—on at least 2 different dates of service
		  • **Dispensed dementia medication**

COU - Risk of Continued Opioid Use	The percentage of members 18 years of age and older who have an episode of opioid use that puts them at risk for continued opioid use.	• Use of complete and accurate Value Set Codes **(Click to view)** • Timely submission of claims and encounter data **Exclusions:** • Exclude members who meet any of the following criteria: ◦ cancer ◦ Sickle cell disease • Palliative care • Members in hospice services or using hospice services during the measurement year. • Members who die any time during the measurement year.
CRE - Cardiac Rehabilitation	• Members 18 years and older, who attended cardiac rehabilitation following a qualifying cardiac event, including myocardial infarction, percutaneous coronary intervention, coronary artery bypass grafting, heart and heart/lung transplantation or heart valve repair/replacement. • 1. A 12 month window that begins on July 1, 2024 and ends June 30, 2025.	Use of complete and accurate Value Set codes **(Click to view)** • Timely submissions of claims and encounter data • Proper documentation and coding—to assist in excluding members from the HEDIS sample **Exclusions:** • Members in hospice are excluded from the eligible population
DAE - Use of High-Risk Medications in Older Adults	Medicare members 67 years and older who had: • At least one dispensing event for a high-risk medication in 2025 • At least two dispensing events for the same high-risk-medication	• Use of complete and accurate Value Set Codes **(Click to view)** • Timely submission of claims and encounter data • Proper coding or documentation – to assist in excluding members from the HEDIS sample See below for exclusion criteria **Exclusions:** • Members in hospice are excluded from the eligible population
DDE - Potentially Harmful Drug-Disease Interactions in Older Adults	Medicare members 65 years and older who have evidence of an underlying disease, condition or health concern and who were dispensed an ambulatory prescription for a potentially harmful medication, concurrent with or after the diagnosis.	• Use of complete and accurate Value Set Codes **(Click to view)** • Timely submission of claims and encounter data • Proper coding or documentation – to assist in excluding members from the HEDIS sample See below for exclusion criteria **Exclusions:** • Bipolar Disorder, Hospice, Other Bipolar Disorder Psychosis, Schizoaffective Disorder, Schizophrenia, or Seizure Disorder on or between January 1, 2025 and December 1, 2025 *** Members in Hospice or using Hospice services during measurement year are a required exclusion**

IET - Initiation and Engagement of Substance Use Disorder Treatment	Adolescent and adult members (13 years and older) in 2025 with a new episode of alcohol or other drug (SUD) substance use disorder or dependence who received the following: Members who initiate treatment through an inpatient SUD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth or medication treatment within 14 days of the diagnosis. • Members who initiated treatment and who were engaged in ongoing SUD treatment within 34 days of the initiation visit	• Use of complete and accurate Value Set Codes **(Click to view)** • Timely submission of claims and encounter data • Consider screening all members at office visits using a substance abuse screening tool • Perform SBIRT for members who answer positive for alcohol on the SHA or whom you suspect have an alcohol problem • Once a member is identified with SUD abuse or dependence diagnosis, initiate brief intervention or refer for treatment within 14 days. Then complete at least two brief interventions within 34 days of diagnosis • When referring members out to substance abuse providers, ensure an appointment is made within 14 days of diagnosis
KED - Kidney Health Evaluation for Patients with Diabetes	Members 18 to 85 years of age with diabetes (type 1 and type 2) who had a kidney evaluation in 2025. • Estimated glomerular filtration rate (eGFR) and • A urine albumin-creatinine ratio (uACR)	• Use of complete and accurate Value Set codes **(Click to view)** • Timely submissions of claims and encounter data • Proper documentation and coding—to assist in excluding members from the HEDIS sample **Exclusions:** • Members with ESRD or dialysis • Members receiving palliative care • Members in hospice are excluded from the eligible population • Exclude Medicare members 66 and older as of December 31, 2025 who meet any of the following: – Enrolled in an Institutional SNP (I-SNP) – Living long-term in an institution in 2025

LBP - Use of Imaging Studies for Low Back Pain	Members 18-75 years of age with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis from January 1- December 31, 2025.	• Use of complete and accurate Value Set Codes **(Click to view)** • Timely submission of claims and encounter data • Proper coding or documentation of any of the following diagnoses for which imaging is clinically appropriate – to assist in excluding members from the HEDIS sample. See below for exclusion criteria. **Exclusions:** (Use designated Value Set for each) • Any of the following meet criteria: i. Cancer ii. human immunodeficiency virus (HIV) iii. Recent Trauma iv. Spinal infection v. Intravenous drug abuse vi. Major organ transplant vii. Neurologic impairment viii. Prolonged use of corticosteroids ix. Osteoporosis x. Fragility Fracture xi. Lumbar Surgery xii. Spondylopathy xiii. Palliative Care/Hospice
PBH - Persistence of Beta-Blocker After a Heart Attack	The percentage of members 18 years of age and older during the measurement year who were hospitalized and discharged from July 1 of the year prior to the measurement year to June 30 of the measurement year with a diagnosis of AMI and who received persistent beta-blocker treatment for 180 days (6 months) are discharge.	• Use of Complete and accurate Value Set Codes (**Click to view**) • Timely submission of claims and encounter data • Ensure proper documentation in medical record **Required exclusions:** Exclude members who meet either of the following criteria: • Members who use hospice services or elect to use a hospice benefit any time during the measurement year. • Members who die any time during the measurement year. • Members with a medication dispensing event that indicates a contraindication to beta-blocker therapy (Asthma Exclusions Medications List) any time during the member's history through the end of the continuous enrollment period. • Members with a diagnosis that indicates a contraindication to beta-blocker therapy (Beta Blocker Contraindications Value Set) any time during the member's history through the end of the continuous enrollment period meet criteria. Do not include laboratory claims (claims with POS code 81).

PBH - Persistence of Beta-Blocker After a Heart Attack (continued)		• Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following: – Enrolled in an Institutional SNP (I-SNP) any time on or between July 1 of the year prior to the measurement year and the end of the measurement year. – Living long-term in an institution any time on or between July 1 of the year prior to the measurement year and the end of the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag any time on or between July 1 of the year prior to the measurement year and the end of the measurement year. • Members 66–80 years of age as of December 31 of the measurement year (all product lines) with frailty **and** advanced illness. Members must meet **both** frailty and advanced illness criteria to be excluded: 1. **Frailty**. At least two indications of frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) with different dates of service any time on or between July 1 of the year prior to the measurement year and the end of the measurement year. Do not include laboratory claims (claims with POS code 81). 2. **Advanced Illness**. Either of the following during the measurement year or the year prior to the measurement year: – Advanced illness (Advanced Illness Value Set) on at least two different dates of service. Do not include laboratory claims (claims with POS code 81). – Dispensed dementia medication (Dementia Medications List). • Members 81 years of age and older as of December 31 of the measurement year (all product lines) with at least two indications of frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) with different dates of service any time on or between July 1 of the year prior to the measurement year and the end of the measurement year. Do not include laboratory claims (claims with POS code 81).

PCE - Pharmacotherapy Management of COPD Exacerbation	Members 40 years of age and older with COPD exacerbations who had an acute inpatient discharge or ED visit on or between January 1, 2025 – November 30, 2025, and who were dispensed a systemic corticosteroid within 14 days of the event and/or a bronchodilator within 30 days of the event.	• Use of complete and accurate Value Set Codes **(Click to view)** • Timely submission of claims and encounter data *** Members in Hospice or using Hospice services during measurement year are a required exclusion.**
SPC - Statin Therapy for Patients With Cardiovascular Disease	Males 21–75 years of age and females 40–75 years of age who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and were dispensed at least one high or moderate-intensity statin medication in 2025 and remained on it for at least 80% of the treatment period	• Use of complete and accurate Value Set Codes **(Click to view)** • Timely submission of claims and encounter data • Proper coding or documentation – to assist in excluding members from the HEDIS sample See below for exclusion criteria **Exclusions:** • Medicare members 66 years of age and older as of December 31, 2025 of the measurement year who meet either of the following: - Enrolled in an Institutional SNP (I-SNP) any time during the measurement year. - Living long-term in an institution any time during the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the measurement year. • Palliative care. • Exclude members who meet any of the following criteria: i. Female members with a diagnosis of pregnancy during 2025 or 2024. ii. In vitro fertilization during 2025 or 2024 iii. Dispensed at least one prescription for clomiphene during 2025 or 2024 iv. ESRD during 2025 or 2024 v. Cirrhosis during 2025 or 2024 vi. Myalgia, myositis, myopathy or rhabdomyolysis in 2025. vii. Muscular reactions to statins

SPD - Statin Therapy for Patients With Diabetes	Members 40–75 years of age with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) and were dispensed at least one statin medication of any intensity in 2025 and remained on it for at least 80% of the treatment period: • *The percentage of members who were dispensed at least one statin medication of any intensity during 2025.* • *The percentage of members remained on a statin medication of any intensity for at least 80% of the treatment period.*	• Use of complete and accurate Value Set Codes **(Click to view)** • Timely submission of claims and encounter data • Proper coding or documentation – to assist in excluding members from the HEDIS sample See below for exclusion criteria Exclusions: • Exclude members who meet any of the following criteria: i. Members with cardiovascular disease during 2025 or 2024: ◦ Myocardial infarction (MI). Discharged from an inpatient setting with an MI. ◦ Coronary artery bypass grafting (CABG). Members who had CABG in any setting. ◦ Percutaneous Coronary Intervention (PCI). Members who had PCI in any setting. ◦ Other revascularization. Members who had any other revascularization procedure in any setting. ii. Members with ischemic vascular disease (IVD) who met at least one of the following criteria during 2025 or 2024. Criteria need not be the same across both years. ◦ At least one outpatient visit with an IVD diagnosis. ◦ A telephone visit with an IVD diagnosis. ◦ An online assessment with an IVD diagnosis. iii. Female members with a diagnosis of pregnancy during 2025 or 2024 ◦ In vitro fertilization during 2025 or 2024 ◦ Dispensed at least one prescription for clomiphene during 2025 or 2024 ◦ End-Stage renal disease (ESRD) during 2025 or 2024 ◦ Cirrhosis during 2025 or 2024 ◦ Myalgia, myositis, myopathy or rhabdomyolysis in 2025

Behavioral Health

ADD - Follow-Up Care for Children Prescribed ADHD Medication	Children 6-12 years of age newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication that had at least three follow-up care visits within a 10-month period; • One follow-up visit within 30 days of when the first ADHD medication was dispensed. • One follow-up visit with evidence that the member remained on ADHD medication for at least 210 days (7 months). • Member had 2 follow-up visits within 270 days (9 months) after the Initiation Phase ended.	• Use of complete and accurate Value Set Codes **(Click to view)** • Timely submission of claims and encounter data • Schedule 30-day follow-up for all children who are dispensed ADHD medication to assess how medication is working
ASF-E - Unhealthy Alcohol Use Screening and Follow-Up	• The percentage of members 18 years of age and older who were screened for unhealthy use using a standardized instrument and, if screened positive, received appropriate follow-up care.	Use of complete and accurate Value Set Codes **(Click to view)** • Timely submission of claims and encounter data **Exclusions:** • Members with alcohol use disorder that starts during the year prior to the measurement period. • Members with a history of dementia. • Members in hospice services or using hospice services during the measurement year. • Members who die any time during the measurement year.
DBO - Deprescribing of Benzodiazepines in Older Adults	Members 67 years of age and older who were dispensed benzodiazepines and achieved a 20% decrease or greater benzodiazepine dose during measurement year.	Use of complete and accurate Value Set Codes **(Click to view)** • Proper coding to identify anxiety disorder **Exclusions:** • Members with a diagnosis of seizure disorders, rapid eye movement sleep behavior, benzodiazepine withdrawal or ethnol withdrawal • Members in hospice or using hospice services during measurement year • Members receiving palliative care during measurement year
DMH - Diagnosed Mental Health Disorders	• The percentage of members 1 year of age and older who were diagnosed with a mental health disorder during the measurement year.	Use of complete and accurate Value Set Codes **(Click to view)** • Timely submission of claims and encounter data **Exclusions:** • Members in hospice services or using hospice services during the measurement year. • Members who die any time during the measurement year.

DRR-E - Depression Remission or Response for Adolescents and Adults	The percentage of members 12 years of age and older with a diagnosis of depression and an elevated PHQ-9 score, who had evidence of response or remission within 4-8 months of the elevated score. • Follow-up PHQ-9. The percentage of members who have a follow-up PHQ-9 score documented within 4-8 months after the initial elevated PHQ-9 score. • Depression Remission. The percentage of members who achieved remission within 4-8 months after the initial elevated PHQ-9 score. • Depression Response. The percentage of members who showed response within 4-8 months after the initial elevated PHQ-9 score.	Use of complete and accurate Value Set Codes **(Click to view)** • Timely submission of claims and encounter data • Follow Practice Guidelines for the Treatment of Patients with Major Depressive Disorders • Treat members with diagnosis of major depression for at least six months • Utilize the PATIENT HEALTH QUESTIONNAIRE(PHQ-9) assessment tool in management of depression **Exclusions** • Bipolar disorder • Personality disorder • Psychotic disorder • Pervasive developmental disorder OR • Members in hospice or using hospice services any time during the measurement period.
DSF-E - Depression Screening and Follow-up for Adolescents and Adults	• The percentage of members 12 years of age and older who were screened for clinical depression using a standardized instrument and, if screened positive, received follow up care. • Depression Screening. The percentage of members who were screened for clinical depression using a standardized instrument. • Follow-up on Positive Screen. The percentage of members who received follow-up care within 30 days of a positive depression screen finding.	• Use of complete and accurate Value Set Codes **(Click to view)** • Timely submission of claims and encounter data • Follow Practice Guidelines for the Treatment of Patients with Major Depressive Disorders • Treat members with diagnosis of major depression for at least six months • Utilize the PATIENT HEALTH QUESTIONNAIRE(PHQ-9) assessment tool in management of depression **Exclusions** • Bipolar disorder • Depression OR • Members in hospice or using hospice services any time during the measurement period.
DSU - Diagnosed Substance Use Disorders	The percentage of members 13 years of age and older who were diagnosed a substance use disorder during the measurement year.	Use of complete and accurate Value Set Codes **(Click to view)** • Timely submission of claims and encounter data **Exclusions:** • Members in hospice services or using hospice services during the measurement year. • Members who die any time during the measurement year.

EED-E - Eye Exam For Patients With Diabetes	The percentage of members 18–75 years of age with diabetes (types 1 and 2) who had a retinal eye exam.	Use of Complete and accurate Value Set Codes **(Click to view)** • Timely submission of claims and encounter data • Ensure proper documentation in medical record **Exclude members who meet any of the following criteria:** • Bilateral eye enucleation any time during the member's history through December 31 of the measurement year: – Unilateral eye enucleation – Two unilateral eye enucleations with service dates 14 days or more apart. For example, if the service date for the first unilateral eye enucleation was February 1 of the measurement year, the service date for the second unilateral eye enucleation must be on or after February 15. – Left unilateral eye enucleation and right unilateral eye enucleation on the same or different dates of service. – A unilateral eye enucleation and a left unilateral eye enucleation with service dates 14 days or more apart. – A unilateral eye enucleation and a right unilateral eye with service dates 14 days or more apart • Members who use hospice services or elect to use a hospice benefit any time during the measurement year. • Members who die any time during the measurement year. • Members receiving palliative care any time during the measurement year. • Members who had an encounter for palliative care any time during the measurement year. Do not include laboratory claims • Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following: – Enrolled in an Institutional SNP (I-SNP) any time during the measurement year. – Living long-term in an institution any time during the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File. – Use the run date of the file to determine if a member had an LTI flag during the measurement year. • Members 66 years of age and older as of December 31 of the measurement year with frailty and advanced illness. Members must meet both frailty and advanced illness criteria to be excluded: 1. **Frailty**. At least two indications of frailty with different dates of service during the measurement year. Do not include laboratory claims 2. **Advanced Illness**. Either of the following during the measurement year or the year prior to the measurement year: – Advanced illness on at least two different dates of service. Do not include laboratory claims – Dispensed dementia medication

EDH - Emergency Department Visits for Hypoglycemia in Older Adults with Diabetes	Members 67 years of age and older with diabetes, 2 rates reported: The risk adjusted ratio observed to expected emergency department visits for hypoglycemia during the measurement year. For a subset of members 67 years of age and older who had at least one dispensing event of insulin within each 6 month treatment period.	• Use of complete and accurate Value Set Codes **(Click to view)** **Exclusions:** • Members who did not have a diagnosis of diabetes during the measurement year or the year prior.
FUA - Follow-up After Emergency Department Visit for Substance Abuse	The percentage of emergency department (ED) visits among members 13 years and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was a follow-up. 1. The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days). 2. The percentage of ED visits for which the member received follow-up within 7days of the ED visit (8 total days).	Use of complete and accurate Value Set Codes **(Click to view)** • Timely submission of claims and encounter data • Follow Practice Guidelines for the Treatment of Patients with • Major Depressive Disorders • Treat members with diagnosis of major depression for at least six months • Utilize the PATIENT HEALTH QUESTIONNAIRE(PHQ-9) assessment tool in management of depression • Exclude members who meet either of the following criteria: • Members in hospice or using hospice services any time during the measurement year. • Members who died any time during the measurement year.

FUH - Follow-Up After Hospitalization for Mental Illness	Members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow up visit with a mental health practitioner within 7-30 days after discharge.	• Use of complete and accurate Value Set Codes **(Click to view)** • Timely submission of claims and encounter data • Document hospice care for exclusion from the eligible population. Mental Health Practitioner: A practitioner who provides mental health services and meets any of the following criteria: • An MD or doctor of osteopathy (DO) who is certified as a psychiatrist or child psychiatrist by the American Medical Specialties Board of Psychiatry and Neurology or by the American Osteopathic Board of Neurology and Psychiatry; or, if not certified, who successfully completed an accredited program of graduate medical or osteopathic education in psychiatry or child psychiatry and is licensed to practice patient care psychiatry or child psychiatry, if required by the state of practice. • An individual who is licensed as a psychologist in his/her state of practice, if required by the state of practice. • An individual who is certified in clinical social work by the American Board of Examiners; who is listed on the National Association of Social Worker's Clinical Register; or who has a master's degree in social work and is licensed or certified to practice as a social worker, if required by the state of practice. • A registered nurse (RN) who is certified by the American Nurses Credentialing Center (a subsidiary of the American Nurses Association) as a psychiatric nurse or mental health clinical nurse specialist, or who has a master's degree in nursing with a specialization in psychiatric/mental health and two years of supervised clinical experience and is licensed to practice as a psychiatric or mental health nurse, if required by the state of practice. • An individual (normally with a master's or a doctoral degree in marital and family therapy and at least two years of supervised clinical experience) who is practicing as a marital and family therapist and is licensed or a certified counselor by the state of practice, or if licensure or certification is not required by the state of practice, who is eligible for clinical membership in the American Association for Marriage and Family Therapy. • An individual (normally with a master's or doctoral degree in counseling and at least two years of supervised clinical experience) who is practicing as a professional counselor and who is licensed or certified to do so by the state of practice, or if licensure or certification is not required by the state of practice, is a National Certified Counselor with a Specialty Certification in Clinical Mental Health Counseling from the National Board for Certified Counselors (NBCC). *** Members in Hospice or using Hospice services during measurement year are a required exclusion.**

FMC - 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 who have multiple high-risk chronic conditions who had a follow-up service within 7 days of the ED visit.	Use of complete and accurate Value Set Codes **(Click to view)** • Timely submission of claims and encounter data **Required Exclusions:** • Members in hospice services or using hospice services during the measurement year. • Members who die any time during the measurement year.
FUI - Follow-Up After High-Intensity Care for Substance Use Disorder	The percentage of acute inpatient hospitalizations, residential treatment or withdrawal management visits for a diagnosis of substance use disorder among members 13 years of age and older that result in a follow-up visit or service for substance use disorder.	Use of complete and accurate Value Set Codes **(Click to view)** • Timely submission of claims and encounter data **Required Exclusions:** • Members in hospice services or using hospice services during the measurement year. • Members who die any time during the measurement year.
FUM - Follow-Up After Emergency Department Visit for Mental Illness	The percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm who had a follow-up visit within 7 days and 30 days of the ED visit.	Use of complete and accurate Value Set Codes **(Click to view)** • Timely submission of claims and encounter data **Required Exclusions:** • Members in hospice services or using hospice services during the measurement year. • Members who die any time during the measurement year.
HDO - Use of Opioids at High Dosage	The percentage of members 18 years of age and older who received prescription opioids at a high dosage for > days during the measurement year.	Use of complete and accurate Value Set Codes **(Click to view)** • Timely submission of claims and encounter data **Required Exclusions:** • Cancer • Sickle cell disease • Members receiving palliative care • Members in hospice services or using hospice services during the measurement year. • Members who die any time during the measurement year.
PDS-E - Postpartum Depression Screening and Follow-Up	The percentage of deliveries in which members were screened for clinical depression during the postpartum period, and if screened positive, received follow-up care. • Depression Screening. The percentage of deliveries in which members were screened for clinical depression using a standardized instrument during the postpartum period. • Follow-Up on Positive Screen. The percentage of deliveries in which members received follow-up within 30 days of a positive depression screening finding.	Use of complete and accurate Value Set Codes **(Click to view)** • Timely submission of claims and encounter data • Document hospice care for exclusion from the eligible population **Exclusion** • Deliveries in which members were in hospice or using hospice services any time during the measurement period.

PND-E - Prenatal Depression Screening and Follow-Up	The percentage of deliveries in which members were screened for clinical depression while pregnant and, if screened positive, received follow-up care. • Depression Screening. The percentage of deliveries in which members were screened for clinical depression during pregnancy using a standardized instrument. • Follow-Up on Positive Screen. The percentage of deliveries in which members received follow-up care within 30 days of a positive depression screen finding.	Use of complete and accurate Value Set Codes **(Click to view)** • Timely submission of claims and encounter data • Document hospice care for exclusion from the eligible population **Exclusion** • Deliveries that occurred at less than 37 weeks gestation • Deliveries in which members were in hospice or using hospice services any time during measurement period.
POD - Pharmacotherapy For Opioid Use Disorder	The percentage of opioid use disorder (OUD) pharmacotherapy events that lasted at least 180 days among members 16 years of age and older with a diagnosis of OUD and a new OUD pharmacotherapy event. **Intake period** July 1 of the year prior to the measurement year to June 30 of the measurement year.	Use of Complete and accurate Value Set Codes **(Click to view)** • Timely submission of claims and encounter data • Ensure proper documentation in medical record **Required Exclusions:** Exclude members who meet either of the following criteria: • Members who use hospice services or elect to use a hospice benefit any time during the measurement year. • Members who die any time during the measurement year.
PRS-E - Postpartum Depression Screening	The percentage of deliveries in which members were screened for clinical depression during the postpartum period, and if screened positive, received follow-up care. • Depression Screening. The percentage of deliveries in which members were screened for clinical depression using a standardized instrument during the postpartum period. • Follow-Up on Positive Screen. The percentage of deliveries in which members received follow-up within 30 days of a positive depression screening finding.	Use of complete and accurate Value Set Codes **(Click to view)** • Timely submission of claims and encounter data • Document hospice care for exclusion from the eligible population **Exclusion** • Deliveries in which members were in hospice or using hospice services any time during the measurement period
SNS-E - Social Need Screening and Intervention	The percentage of members who were screened, using pre-specified instruments, at least once during the measurement period for unmet food, housing and transportation needs, and received a corresponding intervention if they screened positive.	Use of complete and accurate Value Set Codes **(Click to view)** Timely submission of claims and encounter data **Required Exclusions:** • Members in hospice services or using hospice services during the measurement year. • Members who die any time during the measurement year. • Medicare members 66 years of age and older who meet either of the following: – Enrolled in an Institutional SNP (I-SNP) – Living long-term in an institution

UOP - Use of Opioids From Multiple Providers	The percentage of members 18 years and older, receiving prescription opioids for >15 days during the measurement year, who received opioids from multiple providers.	Use of complete and accurate Value Set Codes **(Click to view)** • Timely submission of claims and encounter data **Required Exclusions:** • Members in hospice services or using hospice services during the measurement year. • Members who die any time during the measurement year.
SAA - Adherence to Antipsychotic Medications for Individuals With Schizophrenia	Members with schizophrenia or schizoaffective disorder who were 18 and older in 2025 and were dispensed and remained on an antipsychotic medication for at least 80 percent of the treatment period.	Use of complete and accurate Value Set Codes **(Click to view)** • Timely submission of claims and encounter data • Proper coding or documentation – to assist in excluding members from the HEDIS sample See below for exclusion criteria **Exclusions:** • Exclude members who met at least one of the following in 2025. i. A diagnosis of dementia. *** Members in Hospice or using Hospice services during measurement year are a required exclusion.**
SSD - Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	Members 18–64 years of age with schizophrenia, schizoaffective disorder or bipolar disorder, who were dispensed an antipsychotic medication and had a glucose test or an HbA1c test in 2025.	• Use of complete and accurate Value Set Codes **(Click to view)** • Timely submission of claims and encounter data • Order glucose test or HgA1c test at least once a year *** Members in Hospice or using Hospice services during measurement year are a required exclusion.**

Admin Measure Codes

List of codes include: Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS), International Classification of Diseases (ICD-10)

Please note: This resource is not all-inclusive, and is not intended to replace professional coding standards.

AVOIDANCE OF ANTIBIOTIC TREATMENT FOR ACUTE BRONCHITIS/BRONCHIOLITIS (AAB)

Members ages 3 months and older with a diagnosis of acute bronchitis/bronchiolitis that were not dispensed an antibiotic treatment.

CPT	
Office or other outpatient visit for the evaluation and management of a **new patient**, which requires these three key components: An expanded problem focused history; An expanded problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. **Typically, 20 minutes are spent face-to-face with the patient and/or family.**	99202
Office or other outpatient visit for the evaluation and management of a **new patient**, which requires these three key components: A detailed history; A detailed examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. **Typically, 30 minutes are spent face-to-face with the patient and/or family.**	99203
Office or other outpatient visit for the evaluation and management of an **established patient**, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal. **Typically, five minutes are spent performing or supervising these services.**	99211
Office or other outpatient visit for the evaluation and management of an **established patient**, which requires at least two of these three key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. **Typically, 10 minutes are spent face-to-face with the patient and/or family.**	99212
Office or other outpatient visit for the evaluation and management of an **established patient**, which requires at least two of these three key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. **Typically, 15 minutes are spent face-to-face with the patient and/or family.**	99213

*The codes listed above are not inclusive and do not represent a complete list of codes.

HCPCS	
Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of medicare enrollment	G0402
Annual wellness visit; includes a personalized prevention plan of service (pps), initial visit	G0438
Annual wellness visit, includes a personalized prevention plan of service (pps), subsequent visit	G0439
Hospital outpatient clinic visit for assessment and management of a patient	G0463
Clinic visit/encounter, all-inclusive	T1015

ADULT'S ACCESS TO PREVENTIVE OR AMBULATORY HEALTH SERVICES (AAP)

The percentage of members 20 years of age and older who had an ambulatory or preventive care visit.

CPT	
Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straight forward medical decision making. 10-19 minutes must be met or exceeded.	99212
Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level medical decision making. 20-29 minutes must be met or exceeded.	99213
Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. 30-39 minutes must be met or exceeded.	99214
Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. 40 minutes must be met or exceeded.	99215
Office or other outpatient consultation for a new or established patient, which requires medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.	99242
Office or other outpatient consultation for a new or established patient, which requires medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.	99243
Office or other outpatient consultation for a new or established patient, which requires medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.	99244
Office or other outpatient consultation for a new or established patient, which requires medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.	99245

*The codes listed above are not inclusive and do not represent a complete list of codes.

ADVANCE CARE PLANNING (ACP)

Members 66-80 years of age with advanced illness, an indication of frailty or who are receiving palliative care, and adults 81 years and older who had advance care planning during the measurement year.

CPTII	
Advance Care Planning discussed and documented advance care plan or surrogate decision maker documented in the medical record	1123F
Advance Care Planning discussed and documented in the medical record, patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.	1124F

CPT	
Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient, home or domiciliary or rest home, with all of the following required elements: Cognition-focused evaluation including a pertinent history and examination; Medical decision making of moderate or high complexity; Functional assessment (eg, basic and instrumental activities of daily living), including decision-making capacity; Use of standardized instruments for staging of dementia (eg, functional assessment staging test [FAST], clinical dementia rating [CDR]); Medication reconciliation and review for high-risk medications; Evaluation for neuropsychiatric and behavioral symptoms, including depression, including use of standardized screening instrument(s); Evaluation of safety (eg, home), including motor vehicle operation; Identification of caregiver(s), caregiver knowledge, caregiver needs, social supports, and the willingness of caregiver to take on caregiving tasks; Development, updating or revision, or review of an Advance Care Plan; Creation of a written care plan, including initial plans to address any neuropsychiatric symptoms, neuro-cognitive symptoms, functional limitations, and referral to community resources as needed (eg, rehabilitation services, adult day programs, support groups) shared with the patient and/or caregiver with initial education and support. **Typically, 10 minutes are spent face-to-face with the patient and/or family**.	99483

*The codes listed above are not inclusive and do not represent a complete list of codes.

FOLLOW-UP CARE FOR CHILDREN PRESCRIBED ADHD MEDICATION (ADD-E)

Children 6-12 years newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication that had at least three follow-up care visits within a 10-month period;

- One follow-up visit within 30 days of when the first ADHD medication was dispensed.
- One follow-up visit with evidence that the member remained on ADHD medication for at least 210 days (seven months).
- Member had two follow-up visits within 270 days (nine months) after the Initiation Phase ended.

CPT	
Health and behavior assessment (eg, health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; initial assessment	96150
Health and behavior assessment (eg, health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; re-assessment	96151
Health and behavior intervention, each 15 minutes, face-to-face; individual	96152
Health and behavior intervention, each 15 minutes, face-to-face; group (two or more patients)	96153
Health and behavior intervention, each 15 minutes, face-to-face; family (with the patient present)	96154
Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; individual patient	98960
Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 2-4 patients	98961
Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 5-8 patients	98962
Office or other outpatient visit for the evaluation and management of a **new patient**, which requires these three key components: An expanded problem focused history; An expanded problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. **Typically, 20 minutes are spent face-to-face with the patient and/or family.**	99202
Office or other outpatient visit for the evaluation and management of a **new patient**, which requires these three key components: A detailed history; A detailed examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. **Typically, 30 minutes are spent face-to-face with the patient and/or family.**	99203

*The codes listed above are not inclusive and do not represent a complete list of codes.

CPT	
Office or other outpatient visit for the evaluation and management of an **established patient**, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal. **Typically, five minutes are spent performing or supervising these services.**	99211
Office or other outpatient visit for the evaluation and management of an **established patient**, which requires at least two of these three key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. **Typically, 10 minutes are spent face-to-face with the patient and/or family.**	99212
Office or other outpatient visit for the evaluation and management of an **established patient**, which requires at least two of these three key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. **Typically, 15 minutes are spent face-to-face with the patient and/or family.**	99213

HCPCS	
Services of clinical social worker in home health or hospice settings, each 15 minutes	G0155
Activity therapy, such as music, dance, art or play therapies not for recreation, related to the care and treatment of patient's disabling mental health problems, per session (45 minutes or more)	G0176
Training and educational services related to the care and treatment of patient's disabling mental health problems per session (45 minutes or more)	G0177
Social work and psychological services, directly relating to and/or furthering the patient's rehabilitation goals, each 15 minutes, face-to-face; individual (services provided by a CORF-qualified social worker or psychologist in a CORF)	G0409
Group psychotherapy other than of a multiple-family group, in a partial hospitalization setting, approximately 45 to 50 minutes	G0410
Interactive group psychotherapy, in a partial hospitalization setting, approximately 45 to 50 minutes	G0411
Hospital outpatient clinic visit for assessment and management of a patient	G0463
Behavioral health screening to determine eligibility for admission to treatment program	H0002
Behavioral health counseling and therapy, per 15 minutes	H0004
Mental health assessment, by non-physician	H0031
Medication training and support, per 15 minutes	H0034
Mental health partial hospitalization, treatment, less than 24 hours	H0035
Community psychiatric supportive treatment, face-to-face, per 15 minutes	H0036
Community psychiatric supportive treatment program, per diem	H0037
Assertive community treatment, face-to-face, per 15 minutes	H0039
Assertive community treatment program, per diem	H0040

*The codes listed above are not inclusive and do not represent a complete list of codes.

HCPCS	
Comprehensive multidisciplinary evaluation	H2000
Rehabilitation program, per 1/2 day	H2001
Comprehensive medication services, per 15 minutes	H2010
Crisis intervention service, per 15 minutes	H2011
Behavioral health day treatment, per hour	H2012
Psychiatric health facility service, per diem	H2013
Skills training and development, per 15 minutes	H2014
Comprehensive community support services, per 15 minutes	H2015
Comprehensive community support services, per diem	H2016
Psychosocial rehabilitation services, per 15 minutes	H2017
Psychosocial rehabilitation services, per diem	H2018
Therapeutic behavioral services, per 15 minutes	H2019
Therapeutic behavioral services, per diem	H2020
Partial hospitalization services, less than 24 hours, per diem	S0201
Intensive outpatient psychiatric services, per diem	S9480
Crisis intervention mental health services, per hour	S9484
Crisis intervention mental health services, per diem	S9485
Clinic visit/encounter, all-inclusive	T1015

ADULT IMMUNIZATION STATUS (AIS-E)

The percentage of members 19 years of age and older who are up to date on Recommended routine vaccines for influenza, tetanus and diphtheria (Td) or Tetanus, diphtheria and acellular pertussis (Tdap), zoster and pneumococcal and hepatitis B given between January 1 through December 31of Measurement Year.

CPT	
Influenza accine, inactivated (IIV) subunit, adjuvanted, for intramuscular use.	90653
Influenza accine, trivalent (IIV3), split virus, preservative-free, for intradermal use.	90654
Influenza accine, trivalent (IIV3), split virus, preservative free, 0.5ml dosage, for intramuscular use.	90656
Influenza accine, trivalent (IIV3), split virus, 0.5ml dosage, for intramuscular use.	90658
Influenza accine, trivalent (ccIIV3), derived from cell cultures, subunit, preservative and antibiotic free, 0.5ml dosage, for intramuscular use.	90661
Pneumococcal conjugate vaccine, 13 valent (PCV13), for intramuscular use.	90670
Pneumococcal conjugate vaccine, 15 valent (PCV15), for intramuscular use.	90671
Pneumococcal conjugate vaccine, 20 valent (PCV20), for intramuscular use.	90677
Pneumococcal polysaccharide vaccine, 23-valent (PPSV23), adult or immunosuppressed patient dosage, when administered to individuals 2 years or older, for subcutaneous or intramuscular use.	90732
Tetanus dipththeria toxoids absorbed (Td), preservative free, when administered to individuals 7 years or older, for intramuscular use.	90714
Tetanus , diphtheria toxoids and acellular pertussis vaccine (Tdap), when administered to individuals 7 years or older, for intramuscular use.	90715

*The codes listed above are not inclusive and do not represent a complete list of codes.

ASTHMA MEDICATION RATIO (AMR)

Members 5-64 years old who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during MY.

CPT	
Office or other outpatient visit for the evaluation and management of a **new patient**, which requires these three key components: An expanded problem focused history; An expanded problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. **Typically, 20 minutes are spent face-to-face with the patient and/or family.**	99202
Office or other outpatient visit for the evaluation and management of a **new patient**, which requires these three key components: A detailed history; A detailed examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. **Typically, 30 minutes are spent face-to-face with the patient and/or family.**	99203
Office or other outpatient visit for the evaluation and management of an **established patient**, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal. **Typically, five minutes are spent performing or supervising these services.**	99211
Office or other outpatient visit for the evaluation and management of an **established patient**, which requires at least two of these three key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self-limited or minor. **Typically, 10 minutes are spent face-to-face with the patient and/or family.**	99212
Office or other outpatient visit for the evaluation and management of an **established patient**, which requires at least two of these three key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. **Typically, 15 minutes are spent face-to-face with the patient and/or family.**	99213

*The codes listed above are not inclusive and do not represent a complete list of codes.

HCPS	
Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of medicare enrollment	G0402
Annual wellness visit; includes a personalized prevention plan of service (pps), initial visit	G0438
Annual wellness visit, includes a personalized prevention plan of service (pps), subsequent visit	G0439
Hospital outpatient clinic visit for assessment and management of a patient	G0463
Remote assessment of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment	G2250
Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related e/m service provided within the previous 7 days nor leading to an e/m service or procedure within the next 24 hours or soonest available appointment	G2010
Clinic visit/encounter, all-inclusive	T1015

METABOLIC MONITORING FOR CHILDREN AND ADOLESCENTS ON ANTIPSYCHOTICS (APM)

Members 1–17 years of age who had two or more antipsychotic prescriptions and had metabolic monitoring (blood glucose testing, cholesterol testing or both) in MY.

CPT	
Basic metabolic panel (Calcium, ionized) This panel must include the following: Calcium, ionized (82330) Carbon dioxide (bicarbonate) (82374) Chloride (82435) Creatinine (82565) Glucose (82947) Potassium (84132) Sodium (84295) Urea Nitrogen (BUN) (84520)	80047
Basic metabolic panel (Calcium, total) This panel must include the following: Calcium, total (82310) Carbon dioxide (bicarbonate) (82374) Chloride (82435) Creatinine (82565) Glucose (82947) Potassium (84132) Sodium (84295) Urea nitrogen (BUN) (84520)	80048
General health panel This panel must include the following: Comprehensive metabolic panel (80053) Blood count, complete (CBC), automated and automated differential WBC count (85025 or 85027 and 85004) OR Blood count, complete (CBC), automated (85027) and appropriate manual differential WBC count (85007 or 85009) Thyroid stimulating hormone (TSH) (84443)	80050
Comprehensive metabolic panel This panel must include the following: Albumin (82040) Bilirubin, total (82247) Calcium, total (82310) Carbon dioxide (bicarbonate) (82374) Chloride (82435) Creatinine (82565) Glucose (82947) Phosphatase, alkaline (84075) Potassium (84132) Protein, total (84155) Sodium (84295) Transferase, alanine amino (ALT) (SGPT) (84460) Transferase, aspartate amino (AST) (SGOT) (84450) Urea nitrogen (BUN) (84520)	80053
Lipid panel This panel must include the following: Cholesterol, serum, total (82465) Lipoprotein, direct measurement, high density cholesterol (HDL cholesterol) (83718) Triglycerides (84478)	80061
Renal function panel This panel must include the following: Albumin (82040) Calcium, total (82310) Carbon dioxide (bicarbonate) (82374) Chloride (82435) Creatinine (82565) Glucose (82947) Phosphorus inorganic (phosphate) (84100) Potassium (84132) Sodium (84295) Urea nitrogen (BUN) (84520)	80069
Cholesterol, serum or whole blood, total	82465
Glucose; quantitative, blood (except reagent strip)	82947
Glucose; post glucose dose (includes glucose)	82950
Glucose; tolerance test (GTT), three specimens (includes glucose)	82951
Hemoglobin; glycosylated (A1C)	83036
Hemoglobin; glycosylated (A1C) by device cleared by Food And Drug Administration (FDA) for home use	83037
Lipoprotein, blood; electrophoretic separation and quantitation	83700

*The codes listed above are not inclusive and do not represent a complete list of codes.

CPTII	
Most recent hemoglobin A1c (HbA1c) level less than 7.0% Diabetes mellitus (DM)	3044F
Most recent hemoglobin A1c level greater than 9.0% (DM)	3046F
Most recent Low Density Lipoprotein (LDL-C) less than 100 mg/dL Coronary artery disease (CAD) (DM)	3048F
Most recent LDL-C 100-129 mg/dL (CAD) (DM)	3049F
Most recent LDL-C greater than or equal to 130 mg/dL (CAD) (DM)	3050F

LOINC	
Cholesterol in LDL [Units/volume] in Serum or Plasma by Electrophoresis	12773-8
Cholesterol in LDL [Mass/volume] in Serum or Plasma by calculation	13457-7
Glucose [Mass/volume] in Serum or Plasma --1.5 hours post 75 g glucose by mouth (PO)	1496-9
Glucose [Mass/volume] in Serum or Plasma -- one hour post 0.5 g/kg glucose intravenous (IV)	1499-3
Glucose [Mass/volume] in Serum or Plasma -- one hour post 100 g glucose PO	1501-6
Glucose [Mass/volume] in Serum or Plasma -- one hour post 50 g glucose PO	1504-0
Glucose [Mass/volume] in Serum or Plasma -- one hour post 75 g glucose PO	1507-3
Glucose [Mass/volume] in Serum or Plasma -- two hours post 100 g glucose PO	1514-9
Glucose [Mass/volume] in Serum or Plasma -- two hours post 75 g glucose PO	1518-0
Glucose [Mass/volume] in Serum or Plasma -- three hours post 100 g glucose PO	1530-5
Glucose [Mass/volume] in Serum or Plasma -- three hours post 75 g glucose PO	1533-9
Glucose [Mass/volume] in Serum or Plasma --12 hours fasting	1554-5
Fasting glucose [Mass/volume] in Serum or Plasma	1558-6
Hemoglobin A1c/Hemoglobin.total in Blood by High-performance liquid chromatography (HPLC)	17856-6
Glucose [Mass/volume] in Serum or Plasma -- eight hours fasting	17865-7
Cholesterol in LDL [Mass/volume] in Serum or Plasma by Direct assay	18262-6
Glucose [Mass/volume] in Serum or Plasma -- two hours post dose glucose	20436-2
Glucose [Mass/volume] in Serum or Plasma -- three hours post dose glucose	20437-0
Glucose [Mass/volume] in Serum or Plasma -- one hour post dose glucose	20438-8
Cholesterol in High Density Lipoprotein (HDL) [Mass/volume] in Serum or Plasma	2085-9
Cholesterol in LDL [Mass/volume] in Serum or Plasma	2089-1
Cholesterol [Mass/volume] in Serum or Plasma	2093-3
Triglyceride [Mass/volume] in Serum or Plasma	2571-8
Triglyceride [Mass/volume] in Blood	3043-7
Hemoglobin A1c/Hemoglobin.total in Blood	4548-4
Glucose [Mass/volume] in Blood -- two hours post dose glucose	49134-0
Cholesterol.total/Cholesterol in HDL [Mass Ratio] in Serum or Plasma	9830-1

*The codes listed above are not inclusive and do not represent a complete list of codes.

USE OF FIRST-LINE PSYCHOSOCIAL CARE AND ADOLESCENT ON ANTIPSYCHOTICS (APP)

The percentage of children and adolescents 1-17 years of age who had a new prescription for an antipsychotic medication and has documentation of psychosocial care as first-line t eatment during January 1 through December of the measurement year.

CPT	
Psychotherapy, 30 minutes with patient	90832
Psychotherapy, 30 minutes with patient performed with an evaluation and management service (List separately in addition to the code for primary procedure)	90833
Psychotherapy, 45 minutes with patient	90834
Psychotherapy, 45 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)	90836
Psychotherapy, 60 minutes with patient	90837
Psychotherapy, 60 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)	90838
Psychotherapy for crisis; first 60 minutes	90839
Each additional 30 minutes (List separately in addition to code for primary service)	90840
Psychoanalysis	90845
Family psychotherapy (without the patient present), 50 minutes	90846
Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes	90847

HCPCS	
Activity therapy, such as music, dance, art or play therapies not for recreation, related to the care and treatment of patient's disabling mental health problems, per session (45 minutes or more) (G0176)	G0176
Training and educational services related to the care and treatment of patient's disabling mental health problems per session (45 minutes or more) (G0177)	G0177
Social work and psychological services, directly relating to and/or furthering the patient's rehabilitation goals, each 15 minutes, face-to-face; individual (services provided by a CORF-qualified social worker or psychologist in a CORF) (G0409)	G0409
Group psychotherapy other than of a multiple-family group, in a partial hospitalization setting, approximately 45 to 50 minutes (G0410)	G0410
Interactive group psychotherapy, in a partial hospitalization or intensive outpatient setting, approximately 45 to 50 minutes (G0411)	G0411
Behavioral health counseling and therapy, per 15 minutes (H0004)	H0004

HCPCS	
Mental health partial hospitalization, treatment, less than 24 hours (H0035)	H0035
Community psychiatric supportive treatment, face-to-face, per 15 minutes (H0036)	H0036
Community psychiatric supportive treatment program, per diem (H0037)	H0037
Self-help/peer services, per 15 minutes (H0038)	H0038
Assertive community treatment, face-to-face, per 15 minutes (H0039)	H0039

*The codes listed above are not inclusive and do not represent a complete list of codes.

UNHEALTHY ALCOHOL USE SCREENING AND FOLLOW-UP (ASF-E)

The percentage of members 18 years of age and older who were screened for unhealthy alcohol use using a standardized instrument and, if screened positive, received appropriate follow-up care.

CPT	
Alcohol and/or substance (other than tobacco) abuse structured screening (eg, AUDIT, DAST), and brief intervention (SBI) services; 15 to 30 minutes	99408
greater than 30 minutes	99409

HCPCS	
Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., audit, dast), and brief intervention 15 to 30 minutes	G0396
Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., audit, dast), and intervention, greater than 30 minutes	G0397
Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes	G0443
Alcohol and/or substance (other than tobacco) misuse structured assessment (e.g., audit, dast), and brief intervention, 5-14 minutes	G2011
Alcohol and/or drug services; group counseling by a clinician	H0005
Alcohol and/or drug services; crisis intervention (outpatient)	H0007
Alcohol and/or drug services; intensive outpatient (treatment program that operates at least three hours/day and at least three days/week and is based on an individualized treatment plan), including assessment, counseling; crisis intervention, and activity therapies or education	H0015

*The codes listed above are not inclusive and do not represent a complete list of codes.

ANTIBIOTIC UTLIZATION FOR RESPIRATORY CONDITIONS (AXR)

The percentage of episodes for members 2 months of age and older with a diagnosis of a respiratory condition that resulted in an antibiotic dispensing event from July 1 of the year prior to the measurement year to June 30 of the measurement year.

CPT	
Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician or other qualified health care professional	99211
Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.	99212
Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.	99213
Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.	99214
Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.	99215
Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.	99202
Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.	99203
Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.	99204
Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.	99205

HCPCS	
Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of medicare enrollment	G0402
Annual wellness visit; includes a personalized prevention plan of service (pps), initial visit	G0438
Annual wellness visit, includes a personalized prevention plan of service (pps), subsequent visit	G0439

*The codes listed above are not inclusive and do not represent a complete list of codes.

BREAST CANCER SCREENING (BCS-E)

Women 40-74 years of age who had one or more mammograms to screen for breast cancer any time on or between 10/01/2023- 12/31/2025.

CPT	
Diagnostic mammography, including computer-aided detection (CAD) when performed; unilateral	77065
Diagnostic mammography, including computer-aided detection (CAD) when performed; bilateral	77066
Screening mammography, bilateral (2-view study of each breast), including computer-aided detection (CAD) when performed	77067
Screening digital breast tomosynthesis, bilateral (List separately in addition to code for primary procedure)	77063
Diagnostic digital breast tomosynthesis; unilateral	77061
Diagnostic digital breast tomosynthesis; bilateral	77062

EXCLUSION	
Acquired absence of bilateral breasts and nipples	Z90.13
Acquired absence of right breast and nipple	Z90.11
Acquired absence of left breast and nipple	Z90.12

*The codes listed above are not inclusive and do not represent a complete list of codes.

BLOOD PRESSURE CONTROL FOR PATIENTS WITH HYPERTENSION (BPC-E)

The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose most recent blood pressure (BP) was <140/90 mm Hg during the measurement period.

CPTII	
Most recent diastolic blood pressure **80-89 mm** Hg (HTN, CKD, CAD) (DM)	3079F
Most recent diastolic blood pressure **greater than or equal to 90 mm Hg** (HTN, CKD, CAD) (DM)	3080F
Most recent diastolic blood pressure **less than 80 mm Hg** (HTN, CKD, CAD) (DM)	3078F
Most recent systolic blood pressure **130-139 mm Hg** (DM) (HTN, CKD, CAD)	3075F
Most recent systolic blood pressure **greater than or equal to 140 mm Hg** (HTN, CKD, CAD) (DM)	3077F
Most recent systolic blood pressure **less than 130 mm Hg** (DM) (HTN, CKD, CAD)	3074F

*The codes listed above are not inclusive and do not represent a complete list of codes.

CERVICAL CANCER SCREENING (CCS-E)

The number of members recommended for routine cervical cancer screening who were screened for cervical cancer. Either of the following meets criteria:

- Members 24–64 years of age by the end of the measurement period who were recommended for routine cervical cancer screening and had cervical cytology (Cervical Cytology Lab Test Value Set; Cervical Cytology Result or Finding Value Set) during the measurement period or the 2 years prior to the measurement period.
- Members 30–64 years of age by the end of the measurement period who were recommended for routine cervical cancer screening and had cervical high-risk human papillomavirus (hrHPV) testing (High Risk HPV Lab Test Value Set; SNOMED CT code 718591004) during the measurement period or the 4 years prior to the measurement period, and who were 30 years or older on the test date.

Note: Evidence of hrHPV testing within the last 5 years also captures patients who had cotesting; therefore, additional methods to identify cotesting are not necessary.

CPT	
Cytopathology, cervical or vaginal (any reporting system), requiring interpretation by physician	88141
Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; manual screening under physician supervision	88142
with manual screening and rescreening under physician supervision	88143
Cytopathology smears, cervical or vaginal; screening by automated system under physician supervision	88147
screening by automated system with manual rescreening under physician supervision	88148
Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; screening by automated system, under physician supervision	88174
with screening by automated system and manual rescreening or review, under physician supervision	88175

*Codes listed are the most commonly used ICD-10, CPT and HCPCS codes. Please refer to HEDIS Value set for a more specific code.

CHLAMYDIA SCREENING (CHL)

Members 16-24 years of age who were identified as sexually active and who had at least one test for chlamydia in MY.

CPT	
Culture, chlamydia, any source	87110
Infectious agent antigen detection by immunofluorescent technique; Chlamydia trachomatis	87270
Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative, multiple-step method; Chlamydia trachomatis	87320
Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis, direct probe technique	87490
Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis, amplified probe technique	87491
Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis, quantification	87492
Infectious agent antigen detection by immunoassay with direct optical observation; Chlamydia trachomatis	87810
Urine pregnancy test, by visual color comparison methods	81025
Gonadotropin, chorionic (hCG); quantitative	84702
Gonadotropin, chorionic (hCG); qualitative	84703

HCPCS	
Cervical or vaginal cancer screening; pelvic and clinical breast examination	G0101
Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, screening by cytotechnologist under physician supervision	G0123
Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, requiring interpretation by physician	G0124
Screening cytopathology smears, cervical or vaginal, performed by automated system, with manual rescreening, requiring interpretation by physician	G0141
Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with manual screening and rescreening by cytotechnologist under physician supervision	G0143
Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with screening by automated system, under physician supervision	G0144
Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with screening by automated system and manual rescreening under physician supervision	G0145
Screening cytopathology smears, cervical or vaginal, performed by automated system under physician supervision	G0147
Screening cytopathology smears, cervical or vaginal, performed by automated system with manual rescreening	G0148
Prenatal care, at-risk assessment	H1000

*The codes listed above are not inclusive and do not represent a complete list of codes.

HCPCS	
Prenatal care, at-risk enhanced service; antepartum management	H1001
Prenatal care, at-risk enhanced service; education	H1003
Prenatal care, at-risk enhanced service; follow-up home visit	H1004
Prenatal care, at-risk enhanced service package (includes h1001-h1004)	H1005
Screening papanicolaou smear, cervical or vaginal, up to three smears, by technician under physician supervision	P3000
Screening papanicolaou smear, cervical or vaginal, up to three smears, requiring interpretation by physician	P3001
Screening papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory	Q0091
Medically induced abortion by oral ingestion of medication including all associated services and supplies (e.g., patient counseling, office visits, confirmation of pregnancy by hCG, ultrasound to confirm duration of pregnancy, ultrasound to confirm completion of abortion) except drugs	S0199
Insertion of levonorgestrel-releasing intrauterine system	S4981
Ultrasound guidance for multifetal pregnancy reduction(s), technical component (only to be used when the physician doing the reduction procedure does not perform the ultrasound, guidance is included in the CPT code for multifetal pregnancy reduction - 59866)	S8055

*The codes listed above are not inclusive and do not represent a complete list of codes.

CHILDHOOD IMMUNIZATION STATUS (CIS-E)

The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP), three polio (IPV), one measles, mumps and rubella (MMR), three haemophilus influenza ype B (HiB), three hepatitis B(Hep B), one chicken pox (VZV), four pneumococcal conjugate (PCV), one Hepatitis A (Hep A), two or three rotavirus (RV), and two influenza (flu Vaccines by their second birthday.

CPT	
DTaP (Diphtheria, Tetanus and acellular Pertussis)	90700
IPV (Polio)	90713
MMR (Measles, Mumps, Rubella)	90707
HIB (Haemophilus influenza type B)	90647
HIB 4 DOSE	90648
HEP B 3 DOSE - IMMUNOSUPPRESSED	90740
Hep-B (Hepatitis B)	90744
HEP B DIALYSIS OR IMMUNOSUPRESSED 4 DOSE	90747
VZV (Varicella Zoster Virus)	90716
PCV13 (Pneumococcal Conjugate)	90670
PCV20 (Pneumococcal Conjugate)	90677
Hep-A (Hepatitis A)	90633
RV (Rota Virus)2 DOSE (Rotarix)	90681
RV (Rota Virus)3 DOSE (Rota Teq)	90680
FLU - TRIVALENT 0.25ML (preservative free)	90655
FLU - TRIVALENT 0.25ML	90657
FLU - CELL CULTURES	90661
FLU - ENHANCED IMMUNOGENECITY	90662
FLU – Quadrivalent (IIV4), split virus, preservative free, 0.25mL dosage, IM	90685
FLU REVISED CODE .5ML	90686
FLU – Quadrivalent (IIV4), split virus, 0.25mL dosage, IM	90687
FLU – Quadrivalent (IIV4), split virus, 0.5 mL dosage, IM	90688
DTaP-IPV/Hib combo	90698
DTaP-HepB-IPV	90723
DTaP- IPV-Hib-HepB	90697
MMRV (Measles, Mumps, Rubella, Varicella)	90710
HIB/HEP B	90748

*Codes listed are the most commonly used ICD-10, CPT and HCPCS codes. Please refer to HEDIS Value set for a more specific code.

COLORECTAL CANCER SCREENING (COL-E)

The percentage of members 45-75 years of age who had an appropriate screening for colorectal cancer.

CPT	
FOBT	82270
Flexible Sigmoidoscopy 45330 45330	45330
FIT DNA 81528	81528
CT-Colonography	74263
Colonoscopy, fl xible; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)	45378
Colonoscopy through stoma; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)	44388
with biopsy, single or multiple	44389
with control of bleeding, any method	44391
with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps	44392
with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	44394
with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre-and post-dilation and guide wire passage, when performed)	44401

HCPCS	
Colorectal cancer screening; colonoscopy on individual at high risk	G0105
Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk	G0121

*Codes listed are the most commonly used ICD-10, CPT and HCPCS codes. Please refer to HEDIS Value set for a more specific code.

RISK OF CONTINUED OPIOID USE (COU)

The percentage of members 18 years of age and older who have an episode of opioid use that puts them at risk for continued opioid use.

EXCLUSION	
Supervision of a hospice patient (patient not present) requiring complex and multidisciplinary care modalities involving regular development and/or revision of care plans by that individual, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes	99377
Services performed by chaplain in the hospice setting, each 15 minutes (G9473)	G9473
Services performed by other counselor in the hospice setting, each 15 minutes (G9475)	G9475
Services performed by volunteer in the hospice setting, each 15 minutes (G9476)	G9476
Services performed by care coordinator in the hospice setting, each 15 minutes (G9477)	G9477
Services performed by other qualified therapist in the hospice setting, each 15 minutes (G9478)	G9478
Services performed by qualified pharmacist in the hospice setting, each 15 minutes (G9479)	G9479
Physician supervision of a patient under a medicare-approved hospice (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of laboratory and other studies, communication (including telephone calls) with other health care professionals involved in the patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month, 30 minutes or more (G0182)	G0182
Oncology; primary focus of visit; supervising, coordinating or managing care of patient with terminal cancer or for whom other medical illness prevents further cancer treatment; includes symptom management, end-of-life care planning, management of palliative therapies (for use in a medicare-approved demonstration project)	G9054

*Codes listed are the most commonly used ICD-10, CPT and HCPCS codes. Please refer to HEDIS Value set for a more specific code.

CARDIAC REHABILITATION (CRE)

Members 18 years and older, who attended cardiac rehabilitation following a qualifying cardiac event, including myocardial infarction, percutaneous coronary intervention, coronary artery bypass grafting, heart and heart/lung transplantation or heart valve repair/replacement.

CPT	
Office or other outpatient visit for the evaluation and management of a **new patient**, which requires these three key components: An expanded problem focused history; An expanded problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. **Typically, 20 minutes are spent face-to-face with the patient and/or family**.	99202
Office or other outpatient visit for the evaluation and management of a **new patient**, which requires these three key components: A detailed history; A detailed examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. **Typically, 30 minutes are spent face-to-face with the patient and/or family**.	99203
Office or other outpatient visit for the evaluation and management of a **new patient**, which requires these three key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. Counseling and/ or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. **Typically, 45 minutes are spent face-to-face with the patient and/or family**.	99204
Office or other outpatient visit for the evaluation and management of a **new patient**, which requires these three key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. **Typically, 60 minutes are spent face-to-face with the patient and/or family**.	99205
Office or other outpatient visit for the evaluation and management of an **established patient**, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal. **Typically, five minutes are spent performing or supervising these services**.	99211
Office or other outpatient visit for the evaluation and management of an **established patient**, which requires at least two of these three key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. **Typically, 10 minutes are spent face-to-face with the patient and/or family**.	99212
Office or other outpatient visit for the evaluation and management of an **established patient**, which requires at least two of these three key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. **Typically, 15 minutes are spent face-to-face with the patient and/or family**.	99213

CPT	
Office or other outpatient visit for the evaluation and management of an **established patient**, which requires at least two of these three key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. **Typically, 40 minutes are spent face-to-face with the patient and/or family**.	99215
Office consultation for a new or **established patient**, which requires these three key components: A problem focused history; A problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. **Typically, 15 minutes are spent faceto-face with the patient and/or family**.	99241
Office consultation for a new or **established patient**, which requires these three key components: An expanded problem focused history; An expanded problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. **Typically, 30 minutes are spent face-to-face with the patient and/or family**.	99242
Office consultation for a new or **established patient**, which requires these three key components: A detailed history; A detailed examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. **Typically, 40 minutes are spent face-to-face with the patient and/or family**.	99243

HCPCS	
Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of medicare enrollment (G0402)	G0402
Annual wellness visit; includes a personalized prevention plan of service (pps), initial visit (G0438)	G0438
Annual wellness visit, includes a personalized prevention plan of service (pps), subsequent visit (G0439)	G0439
Hospital outpatient clinic visit for assessment and management of a patient (G0463)	G0463
Clinic visit/encounter, all-inclusive (T1015)	T1015

EXCLUSION	
[I21.01] ST elevation (STEMI) myocardial infarction involving left main coronary artery	I21.01
[I21.02] ST elevation (STEMI) myocardial infarction involving left anterior descending coronary artery	I21.02
[I21.09] ST elevation (STEMI) myocardial infarction involving other coronary artery of anterior wall	I21.09
[I21.11] ST elevation (STEMI) myocardial infarction involving right coronary artery	I21.11
[I21.19] ST elevation (STEMI) myocardial infarction involving other coronary artery of inferior wall	I21.19
[I21.21] ST elevation (STEMI) myocardial infarction involving left circumflex coronary artery	I21.21
[I21.29] ST elevation (STEMI) myocardial infarction involving other sites	I21.29
[I21.3] ST elevation (STEMI) myocardial infarction of unspecified site	I21.3
[I21.4] Non-ST elevation (NSTEMI) myocardial infarction	I21.4
[I21.9] Acute myocardial infarction, unspecified	I21.9
[I21.A1] Myocardial infarction type 2	I21.A1
[I21.A9] Other myocardial infarction type	I21.A9
[I22.0] Subsequent ST elevation (STEMI) myocardial infarction of anterior wall	I22.0
[I22.1] Subsequent ST elevation (STEMI) myocardial infarction of inferior wall	I22.1
[I22.2] Subsequent non-ST elevation (NSTEMI) myocardial infarction	I22.2
[I22.8] Subsequent ST elevation (STEMI) myocardial infarction of other sites	I22.8
[I22.9] Subsequent ST elevation (STEMI) myocardial infarction of unspecified site	I22.9
[I23.0] Hemopericardium as current complication following acute myocardial infarction	I23.0
[I23.1] Atrial septal defect as current complication following acute myocardial infarction	I23.1
[I23.2] Ventricular septal defect as current complication following acute myocardial infarction	I23.2
[I23.3] Rupture of cardiac wall without hemopericardium as current complication following acute myocardial infarction	I23.3
[I23.4] Rupture of chordae tendineae as current complication following acute myocardial infarction	I23.4
[I23.5] Rupture of papillary muscle as current complication following acute myocardial infarction	I23.5
[I23.6] Thrombosis of atrium, auricular appendage, and ventricle as current complications following acute myocardial infarction	I23.6
[I23.7] Postinfarction angina	I23.7
[I23.8] Other current complications following acute myocardial infarction	I23.8
[I25.2] Old myocardial infarction	I25.2

*The codes listed above are not inclusive and do not represent a complete list of codes.

APPROPRIATE TESTING FOR PHARYNGITIS (CWP)

Children 3 years and older, who were diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode (07/01/2024 - 06/30/2025) during any outpatient or ED visit.

CPT	
Culture, bacterial; any other source except urine, blood or stool, aerobic, with isolation and presumptive identification of isolates	87070
Culture, bacterial; quantitative, aerobic with isolation and presumptive identification of isolates, any source except urine, blood or stool	87071
Culture, presumptive, pathogenic organisms, screening only	87081
Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative, multiple-step method; Streptococcus, group A	87430
Office or other outpatient visit for the evaluation and management of a **new patient**, which requires these three key components: An expanded problem focused history; An expanded problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. **Typically, 20 minutes are spent face-to-face with the patient and/or family.**	99202
Office or other outpatient visit for the evaluation and management of a **new patient**, which requires these three key components: A detailed history; A detailed examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. **Typically, 30 minutes are spent face-to-face with the patient and/or family.**	99203
Office or other outpatient visit for the evaluation and management of an **established patient**, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal. **Typically, five minutes are spent performing or supervising these services.**	99211
Office or other outpatient visit for the evaluation and management of an **established patient**, which requires at least two of these three key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self-limited or minor. **Typically, 10 minutes are spent face-to-face with the patient and/or family.**	99212
Office or other outpatient visit for the evaluation and management of an **established patient**, which requires at least two of these three key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. **Typically, 15 minutes are spent face-to-face with the patient and/or family.**	99213

*The codes listed above are not inclusive and do not represent a complete list of codes.

LOINC CODES

Bacteria identified in Throat by Aerobe culture	17898-8
Bacteria identified in Throat by Culture	626-2
Streptococcus pyogenes [Presence] in Specimen by Organism specific culture	17656-0
Streptococcus pyogenes [Presence] in Throat by Organism specific culture	11268-0
Streptococcus pyogenes Ag [Presence] in Specimen	31971-5
Streptococcus pyogenes Ag [Presence] in Specimen by Immunoassay	6558-1
Streptococcus pyogenes Ag [Presence] in Specimen by Immunofluorescence	6559-9
Streptococcus pyogenes Ag [Presence] in Throat	18481-2
Streptococcus pyogenes Ag [Presence] in Throat by Immunofluorescence	6557-3
Streptococcus pyogenes Ag [Presence] in Throat by Rapid immunoassay	78012-2
Streptococcus pyogenes DNA [Identifier] in Specimen by NAA with probe detection	49610-9
Streptococcus pyogenes DNA [Presence] in Specimen by NAA with probe detection	103627-6
Streptococcus pyogenes DNA [Presence] in Throat by NAA with non-probe detection	101300-2
Streptococcus pyogenes DNA [Presence] in Throat by NAA with probe detection	60489-2
Streptococcus pyogenes rRNA [Presence] in Specimen by Probe	5036-9
Streptococcus pyogenes rRNA [Presence] in Throat by Probe	68954-7

USE OF HIGH-RISK MEDICATIONS IN OLDER ADULTS (DAE)

The percentage of Medicare members 66 years of age and older who had at least two dispensing events for the same high-risk medication.

CPT	
Office or other outpatient visit for the evaluation and management of a **new patient**, which requires these three key components: An expanded problem focused history; An expanded problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. **Typically, 20 minutes are spent face-to-face with the patient and/or family.**	99202
Office or other outpatient visit for the evaluation and management of a **new patient**, which requires these three key components: A detailed history; A detailed examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. **Typically, 30 minutes are spent face-to-face with the patient and/or family.**	99203
Office or other outpatient visit for the evaluation and management of an **established patient**, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal. **Typically, five minutes are spent performing or supervising these services.**	99211
Office or other outpatient visit for the evaluation and management of an **established patient**, which requires at least two of these three key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. **Typically, 10 minutes are spent face-to-face with the patient and/or family.**	99212
Office or other outpatient visit for the evaluation and management of an **established patient**, which requires at least two of these three key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. **Typically, 15 minutes are spent face-to-face with the patient and/or family.**	99213
Office consultation for a new or **established patient**, which requires these three key components: An expanded problem focused history; An expanded problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. **Typically, 30 minutes are spent face-to-face with the patient and/or family.**	99242
Office consultation for a new or **established patient**, which requires these three key components: A detailed history; A detailed examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. **Typically, 40 minutes are spent face-to-face with the patient and/or family.**	99243

HCPCS	
Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of medicare enrollment (G0402)	G0402
Annual wellness visit; includes a personalized prevention plan of service (pps), initial visit (G0438)	G0438
Annual wellness visit, includes a personalized prevention plan of service (pps), subsequent visit (G0439)	G0439
Hospital outpatient clinic visit for assessment and management of a patient (G0463)	G0463
Clinic visit/encounter, all-inclusive (T1	T1015
Services performed by chaplain in the hospice setting, each 15 minutes	G9473
Services performed by dietary counselor in the hospice setting, each 15 minutes	G9474
Services performed by other counselor in the hospice setting, each 15 minutes	G9475
Services performed by care coordinator in the hospice setting, each 15 minutes	G9477
Services performed by other qualified therapist in the hospice setting, each 15 minutes	G9478
Services performed by qualified pharmacist in the hospice setting, each 15 minutes	G9479
Hospice care provided in nursing long term care facility (ltc) or non-skilled nursing facility (nf) (Q5003)	Q5003

*The codes listed above are not inclusive and do not represent a complete list of codes.

DEPRESCRIBING OF BENZODIAZEPEPINES IN OLDER ADULTS (DBO)

The percentage of members 67 years of age and older who were dispensed benzodiazepines and achieved a 20% decrease or greater benzodiazepine dose during measurement year.

EXCLUSION	
Physician supervision of a hospice patient (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (e.g., legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes.	99377
Supervision of a hospice patient (patient not present) requiring complex and multi-disciplinary care modalities involving regular development and/or revision of care plans by that individual, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 30 minutes or more.	99378
Hospice care provided in inpatient hospice facility	Q5006
Hospice care provided in inpatient hospital	Q5005
Hospice care provided in inpatient psychiatric facility	Q5008
Hospice care provided in long term care facility	Q5007
Hospice care provided in nursing long term care facility (ltc) or non-skilled nursing facility (nf)	Q5003
Hospice care provided in skilled nursing facility (snf)	Q5004
Hospice care, in the home, per diem	S9126
Hospice continuous home care; per hour	T2043
Hospice general inpatient care; per diem	T2045
Hospice home care provided in a hospice facility	Q5010
Hospice inpatient respite care; per diem	T2044
Hospice long term care, room and board only; per diem	T2046
Hospice routine home care; per diem	T2042

DOCUMENTED ASSESSMENT AFTER MAMMOGRAM (DBM-E)

The percentage of episodes of mammograms documented in the form of BI-RADS assessment within 14 days of the mammogram for members 40-74 years of age.

CPT	
Diagnostic digital breast tomosynthesis; bilateral	77062
Diagnostic digital breast tomosynthesis; unilateral	77061
Diagnostic mammography, including computer-aided detection (CAD) when performed; bilateral	77066
Diagnostic mammography, including computer-aided detection (CAD) when performed; unilateral	77065
Screening digital breast tomosynthesis, bilateral (List separately in addition to code for primary procedure)	77063
Screening mammography, bilateral (2-view study of each breast), including computer-aided detection (CAD) when performed	77067

RADLEX RADIOLOGY LEXICON	
BI-RADS 0: Incomplete	RID36036
BI-RADS 1: Negative	RID36028
BI-RADS 2: Benign finding	RID36029
BI-RADS 3: Probably benign	RID36041
BI-RADS 4: Suspicious abnormality	RID36030
BI-RADS 4A: Low level of suspicion for malignancy (> 2% and < 10%)	RID36031
BI-RADS 4B: Moderate suspicion for malignancy (> 10% and < 50%)	RID36032
BI-RADS 4C: High suspicion for malignancy (> 50% and < 95%)	RID36033
BI-RADS 5: Highly suggestive of malignancy	RID36034
BI-RADS 6: Known biopsy-proven malignancy	RID36035

*The codes listed above are not inclusive and do not represent a complete list of codes.

POTENTIALLY HARMFUL DRUG-DISEASE INTERACTIONS IN OLDER ADULTS (DDE)

The percentage of members 65 years of age who have evidence of an underlying disease, condition or health concern and who were dispensed an ambulatory prescription for a potentially harmful medication, concurrent with or after diagnosis.

EXCLUSION	
Hospice care provided in inpatient hospice facility	Q5006
Hospice care provided in inpatient hospital	Q5005
Hospice care provided in inpatient psychiatric facility	Q5008
Hospice care provided in long term care facility	Q5007
Hospice care provided in nursing long term care facility (ltc) or non-skilled nursing facility (nf)	Q5003
Hospice care provided in skilled nursing facility (snf)	Q5004
Hospice care, in the home, per diem	S9126
Hospice continuous home care; per hour	T2043
Hospice general inpatient care; per diem	T2045
Hospice home care provided in a hospice facility	Q5010
Hospice inpatient respite care; per diem	T2044
Hospice long term care, room and board only; per diem	T2046
Hospice routine home care; per diem	T2042

DIAGNOSED MENTAL HEALTH DISORDERS (DMH)

The percentage of members 1 year of age and older who were diagnosed with a mental health disorder during the measurement year.

EXCLUSION	
Supervision of a hospice patient (patient not present) requiring complex and multidisciplinary care modalities involving regular development and/or revision of care plans by that individual, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes	99377
Services performed by chaplain in the hospice setting, each 15 minutes	G9473
Services performed by dietary counselor in the hospice setting, each 15 minutes	G9474
Services performed by other counselor in the hospice setting, each 15 minutes	G9475
Services performed by volunteer in the hospice setting, each 15 minutes	G9476
Services performed by care coordinator in the hospice setting, each 15 minutes	G9477
Physician supervision of a patient under a medicare-approved hospice (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of laboratory and other studies, communication (including telephone calls) with other health care professionals involved in the patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month, 30 minutes or more	G0182

*Codes listed are the most commonly used ICD-10, CPT and HCPCS codes. Please refer to HEDIS Value set for a more specific code.

DEPRESSION REMISSION OR RESPONSE FOR ADOLESCENTS AND ADULTS (DRR-E)

The percentage of members 12 years of age and older with a diagnosis of depression and an elevated PHQ-9 score, who had evidence of response or remission within 4-8 months of the elevated score.

*Follow-up PHQ-9- The percentage of members who have had a follow-up PHQ-9 score documented within 4-8 months after initial evaluation.

*Depression Remission-The percentage of members who achieved remission within 4-8 months after initial PHQ-9 score.

*Depression Response- The percentage of members who showed response within 4-8 months after initial elevated PHQ-9 score.

LOINC CODES

Patient Health Questionaire (PHQ-9)	44261-6

EXCLUSION

Services performed by chaplain in the hospice setting, each 15 minutes	G9473
Services performed by dietary counselor in the hospice setting, each 15 minutes	G9474
Services performed by other counselor in the hospice setting, each 15 minutes	G9475
Services performed by volunteer in the hospice setting, each 15 minutes	G9476
Services performed by care coordinator in the hospice setting, each 15 minutes	G9477
Hospice care provided in nursing long term care facility (ltc) or non-skilled nursing facility (nf)	Q5003
Hospice care provided in skilled nursing facility (snf)	Q5004
Hospice care provided in inpatient hospital	Q5005
Hospice care provided in inpatient hospice facility	Q5006
Hospice care provided in long term care facility	Q5007

DEPRESSION SCREENING AND FOLLOW-UP FOR ADOLESCENTS AND ADULTS (DSF-E)*

The percentage of members 12 years of age and older who were screened for clinical depression using a standardized instrument and, if screened positive, received follow-up care.

- Depression Screening. The percentage of members who were screened for clinical depression using a standardized instrument.
- Follow-Up on Positive Screen. The percentage of members who received follow-up care within 30 days of a positive depression screen finding.

LOINC CODES	
Patient Health Questionaire (PHQ-9)	44261-6
Patient Health Questionaire-2 (PHQ-2)	55758-7

DIAGNOSED SUBSTANCE USE DISORDERS (DSU)

The percentage of members 13 years of age and older who were diagnosed a substance use disorder during the measurement year.

EXCLUSION	
Supervision of a hospice patient (patient not present) requiring complex and multidisciplinary care modalities involving regular development and/or revision of care plans by that individual, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes	99377
Services performed by chaplain in the hospice setting, each 15 minutes	G9473
Services performed by dietary counselor in the hospice setting, each 15 minutes	G9474
Services performed by other counselor in the hospice setting, each 15 minutes	G9475
Services performed by volunteer in the hospice setting, each 15 minutes	G9476
Services performed by care coordinator in the hospice setting, each 15 minutes	G9477
Physician supervision of a patient under a medicare-approved hospice (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of laboratory and other studies, communication (including telephone calls) with other health care professionals involved in the patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month, 30 minutes or more	G0182

*Codes listed are the most commonly used ICD-10, CPT and HCPCS codes. Please refer to HEDIS Value set for a more specific code.

EYE EXAM FOR PATIENTS WITH DIABETES (EED)

The percentage of members 18 -75 years of age with diabetes (types 1 and 2) who had a retinal eye exam.

HCPCS	
7 standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; **with evidence of retinopathy (DM)**	2024F
Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; **with evidence of retinopathy (DM)**	2022F
Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed; **with evidence of retinopathy (DM)**	2026F
7 standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; **without evidence of retinopathy (DM)**	2025F
Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; **without evidence of retinopathy (DM)**	2023F
Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed; **without evidence of retinopathy (DM)**	2033F
Diabetic indicator; retinal eye exam, dilated, bilateral (S3000)	S3000
Routine ophthalmological examination including refraction; established patient (S0621)	S0621
Routine ophthalmological examination including refraction; new patient (S0620)	S0620

*The codes listed above are not inclusive and do not represent a complete list of codes.

EMERGENCY DEPARTMENT VISITS FOR HYPOGLYCEMIA IN OLDER ADULTS WITH DIABETES (EDH)

Members 67 years of age and older with diabetes, 2 rates reported:

*The risk adjusted ratio observed to expected emergency department visits for hypoglycemia during the measurement year.

*For a subset of members 67 years of age and older who had at least one dispensing event of insulin within each 6 month treatment period.

EXCLUSION	
Services performed by chaplain in the hospice setting, each 15 minutes (G9473)	G9473
Services performed by dietary counselor in the hospice setting, each 15 minutes (G9474)	G9474
Services performed by other counselor in the hospice setting, each 15 minutes (G9475)	G9475
Services performed by care coordinator in the hospice setting, each 15 minutes (G9477)	G9477
Services performed by other qualified therapist in the hospice setting, each 15 minutes (G9478)	G9478
Services performed by qualified pharmacist in the hospice setting, each 15 minutes (G9479)	G9479
Hospice care provided in nursing long term care facility (ltc) or non-skilled nursing facility (nf)	Q5003

FOLLOW-UP AFTER ABNORMAL MAMMOGRAM ASSESSMENT (FMA-E)

The percentage of episodes of members 40-74 years of age with inconclusive or high-risk BI-RADD assessments that received appropriate follow-up within 90 days of the assessment.

RadLex Radiology Lexicon	
BI-RADS 0: Incomplete	RID36036
BI-RADS 4: Suspicious abnormality	RID36030
BI-RADS 4A: Low level of suspicion for malignancy (> 2% and < 10%)	RID36031
BI-RADS 4B: Moderate suspicion for malignancy (> 10% and < 50%)	RID36032
BI-RADS 4C: High suspicion for malignancy (> 50% and < 95%)	RID36033
BI-RADS 5: Highly suggestive of malignancy	RID36034

CPT	
Biopsy of breast; open, incisional	19101
Biopsy of breast; percutaneous, needle core, not using imaging guidance (separate procedure)	19100
Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including magnetic resonance guidance	19085
Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including stereotactic guidance	19081
Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including ultrasound guidance	19083
Ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; complete	76641
Ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; limited	76642

LOINC CODES	
US Breast	24601-7
US Breast - left	26215-4
US Breast - left limited	26288-1
US Breast - right	26216-2
US Breast - right limited	26290-7
US Breast limited	24599-3
US Breast screening	42132-1

FOLLOW-UP AFTER EMERGENCY DEPARTMENT VISIT FOR PEOPLE WITH MULTIPLE HIGH-RISK CHRONIC CONDITIONS (FMC)

The percentage of emergency department (ED) visits for members 18 years of age who have multiple high-risk chronic conditions who had a follow-up service within 7 days of the ED visit.

CPT	
Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician or other qualified health care professional	99211
Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.	99212
Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.	99213
Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.	99214
Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.	99215
Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.	99202
Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.	99203
Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.	99204
Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.	99205

HCPCS	
Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of medicare enrollment	G0402
Annual wellness visit; includes a personalized prevention plan of service (pps), initial visit	G0438
Annual wellness visit, includes a personalized prevention plan of service (pps), subsequent visit	G0439

*Codes listed are the most commonly used ICD-10, CPT and HCPCS codes. Please refer to HEDIS Value set for a more specific code.

FOLLOW-UP AFTER EMERGENCY DEPARTMENT VISIT FOR SUBSTANCE USE (FUA)*

The percentage of emergency department(ED) visits among members age and older with a principal diagnosis fo substance abuse (SUD), or any diagnosis of drug overdose, for which there was a follow-up. Two rates are reported:

1. The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days).

2. The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days).

CPT	
Online assessment and management service provided by a qualified nonp ysician health care professional to an established patient or guardian, not originating from a related assessment and management service provided within the previous seven days, using the Internet or similar electronic communications network	98969
Telephone assessment and management service provided by a qualified nonp ysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous seven days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion	98966
Telephone assessment and management service provided by a qualified nonp ysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous seven days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion	98967
Telephone assessment and management service provided by a qualified nonp ysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous seven days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion	98968
Psychiatric diagnostic evaluation	90792
Psychotherapy, 30 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)	90833
Psychotherapy, 45 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)	90836
Psychotherapy, 60 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)	90838

HCPCS	
Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., audit, dast), and brief intervention 15 to 30 minutes	G0396
Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., audit, dast), and intervention, greater than 30 minutes	G0397
Annual alcohol misuse screening, 15 minutes	G0442
Alcohol and/or substance (other than tobacco) misuse structured assessment (e.g., audit, dast), and brief intervention, 5-14 minutes	G2011
Alcohol and/or drug assessment	H0001
Behavioral health screening to determine eligibility for admission to treatment program	H0002
Mental health assessment, by non-physician	H0031
Alcohol and/or drug screening	H0049
Alcohol and/or substance (other than tobacco) misuse structured assessment (e.g., audit, dast), and brief intervention 15 to 30 minutes	G0396
Alcohol and/or substance (other than tobacco) misuse structured assessment (e.g., audit, dast), and intervention, greater than 30 minutes	G0397

FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS (FUH)

Members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow up visit with a mental health practitioner within 7-30 days after discharge.

CPT	
Office or other outpatient visit for the evaluation and management of a **new patient**, which requires these three key components: An expanded problem focused history; An expanded problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. **Typically, 20 minutes are spent face-to-face with the patient and/or family.**	99202
Office or other outpatient visit for the evaluation and management of a **new patient**, which requires these three key components: A detailed history; A detailed examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. **Typically, 30 minutes are spent face-to-face with the patient and/or family.**	99203
Office or other outpatient visit for the evaluation and management of an **established patient**, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal. **Typically, five minutes are spent performing or supervising these services.**	99211
Office or other outpatient visit for the evaluation and management of an **established patient**, which requires at least two of these three key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self-limited or minor. **Typically, 10 minutes are spent face-to-face with the patient and/or family.**	99212
Office or other outpatient visit for the evaluation and management of an **established patient**, which requires at least two of these three key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. **Typically, 15 minutes are spent face-to-face with the patient and/or family.**	99213

*The codes listed above are not inclusive and do not represent a complete list of codes.

CPT	
Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; individual patient	98960
Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 2-4 patients	98961
Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 5-8 patients	98962
Physician or other qualified health are professional qualified y education, training, licensure/regulation (when applicable) educational services rendered to patients in a group setting (eg, prenatal, obesity, or diabetic instructions)	99078
Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient, home or domiciliary or rest home, with all of the following required elements: Cognition-focused evaluation including a pertinent history and examination; Medical decision making of moderate or high complexity; Functional assessment (eg, basic and instrumental activities of daily living), including decision-making capacity; Use of standardized instruments for staging of dementia (eg, functional assessment staging test [FAST], clinical dementia rating [CDR]); Medication reconciliation and review for high-risk medications; Evaluation for neuropsychiatric and behavioral symptoms, including depression, including use of standardized screening instrument(s); Evaluation of safety (eg, home), including motor vehicle operation; Identifi ation of caregiver(s), caregiver knowledge, caregiver needs, social supports, and the willingness of caregiver to take on caregiving tasks; Development, updating or revision, or review of an Advance Care Plan; Creation of a written care plan, including initial plans to address any neuropsychiatric symptoms, neuro-cognitive symptoms, functional limitations, and referral to community resources as needed (eg, rehabilitation services, adult day programs, support groups) shared with the patient and/or caregiver with initial education and support. Typically, 50 minutes are spent face-to-face with the patient and/or family or caregiver.	99483
Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 30 minutes	99402
Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 45 minutes	99403
Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 60 minutes	99404
Alcohol and/or substance (other than tobacco) abuse structured screening (eg, Alcohol Use Disorders Identifi ation Test (AUDIT), Drug Abuse Screening Test (DAST)), and Screening and brief intervention (SBI) services; 15 to 30 minutes	99408
Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 30 minutes	99411

*The codes listed above are not inclusive and do not represent a complete list of codes.

The percentage of acute inpatient hospitalizations, residential treatment or withdrawal management visits for a diagnosis of substance use disorder among members 13 years of age and older that result in a follow-up visit or service for substance use disorder.

HCPCS	
Services of clinical social worker in home health or hospice settings, each 15 minutes	G0155
Activity therapy, such as music, dance, art or play therapies not for recreation, related to the care and treatment of patient's disabling mental health problems, per session (45 minutes or more)	G0176
Training and educational services related to the care and treatment of patient's disabling mental health problems per session (45 minutes or more)	G0177
Social work and psychological services, directly relating to and/or furthering the patient's rehabilitation goals, each 15 minutes, face-to-face; individual (services provided by a CORF-qualified social worker or psychologist in a CORF)	G0409
Group psychotherapy other than of a multiple-family group, in a partial hospitalization setting, approximately 45 to 50 minutes	G0410
Interactive group psychotherapy, in a partial hospitalization setting, approximately 45 to 50 minutes	G0411
Hospital outpatient clinic visit for assessment and management of a patient	G0463
Behavioral health screening to determine eligibility for admission to treatment program	H0002
Behavioral health counseling and therapy, per 15 minutes	H0004
Mental health assessment, by non-physician	H0031
Medication training and support, per 15 minutes	H0034
Mental health partial hospitalization, treatment, less than 24 hours	H0035
Community psychiatric supportive treatment, face-to-face, per 15 minutes	H0036
Community psychiatric supportive treatment program, per diem	H0037
Assertive community treatment, face-to-face, per 15 minutes	H0039
Assertive community treatment program, per diem	H0040
Comprehensive multidisciplinary evaluation	H2000
Rehabilitation program, per 1/2 day	H2001
Comprehensive medication services, per 15 minutes	H2010
Crisis intervention service, per 15 minutes	H2011
Behavioral health day treatment, per hour	H2012
Psychiatric health facility service, per diem	H2013
Skills training and development, per 15 minutes	H2014
Comprehensive community support services, per 15 minutes	H2015
Comprehensive community support services, per diem	H2016
Psychosocial rehabilitation services, per 15 minutes	H2017
Psychosocial rehabilitation services, per diem	H2018
Therapeutic behavioral services, per 15 minutes	H2019
Therapeutic behavioral services, per diem	H2020
Partial hospitalization services, less than 24 hours, per diem	S0201
Intensive outpatient psychiatric services, per diem	S9480
Crisis intervention mental health services, per hour	S9484
Crisis intervention mental health services, per diem	S9485
Clinic visit/encounter, all-inclusive	T1015

*The codes listed above are not inclusive and do not represent a complete list of codes.

FOLLOW-UP AFTER HIGH-INTENSITY CARE FOR SUBSTANCE USE DISORDER (FUI)

CPT	
Alcohol and/or substance (other than tobacco) abuse structured screening (eg, AUDIT, DAST), and brief intervention (SBI) services; 15 to 30 minutes	99408
greater than 30 minutes	99409

HCPCS	
Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., audit, dast), and brief intervention 15 to 30 minutes	G0396
Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., audit, dast), and intervention, greater than 30 minutes	G0397
Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes	G0443
Alcohol and/or drug services; group counseling by a clinician	H0005
Alcohol and/or drug services; crisis intervention (outpatient)	H0007
Alcohol and/or drug services; intensive outpatient (treatment program that operates at least 3 hours/day and at least 3 days/week and is based on an individualized treatment plan), including assessment, counseling; crisis intervention, and activity therapies or education	H0015
Alcohol and/or drug services; medical/somatic (medical intervention in ambulatory setting)	H0016
Alcohol and/or drug intervention service (planned facilitation)	H0022
Alcohol and/or other drug abuse services, not otherwise specified	H0047
Alcohol and/or drug services, brief intervention, per 15 minutes	H0050
Alcohol and/or other drug treatment program, per hour	H2035
Alcohol and/or other drug treatment program, per diem	H2036
Alcohol and/or substance abuse services, family/couple counseling	T1006
Alcohol and/or substance abuse services, skills development	T1012

*Codes listed are the most commonly used ICD-10, CPT and HCPCS codes. Please refer to HEDIS Value set for a more specific code.

FOLLOW-UP AFTER EMERGENCY DEPARTMENT VISIT FOR MENTAL ILLNESS (FUM)

The percentage of emergency department (ED) visits for members 6 years and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness.

Two rates are reported:

- The percentage of ED visits for which the member received follow-up within the 30 days after the ED visit (31 total days).
- The percentage of ED visits for which the member received follow-up within the 7 days after the visit (8 total days).

CPT	
Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: An expanded problem focused history; An expanded problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health are professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family'sv needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 20 minutes are spent face-to-face with the patient and/or family.	99202
Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: A detailed history; A detailed examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health are professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent face-to-face with the patient and/or family.	99202
Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health are professional. Usually, the presenting problem(s) are minimal. Typically, fi e minutes are spent performing or supervising these services.	99211
Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health are professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self-limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.	99212
Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other physicians, other qualified health are professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family.	99213
Education and training for patient self-management by a qualifie , non-physician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; individual patient	98960
Education and training for patient self-management by a qualifie , non-physician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 2-4 patients	98961
Education and training for patient self-management by a qualifie , non-physician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 5-8 patients	98962

CPT	
Physician or other qualified health are professional qualified y education, training, licensure/regulation (when applicable) educational services rendered to patients in a group setting (eg, prenatal, obesity, or diabetic instructions)	99078
Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient, home or domiciliary or rest home, with all of the following required elements: Cognition-focused evaluation including a pertinent history and examination; Medical decision making of moderate or high complexity; Functional assessment (eg, basic and instrumental activities of daily living), including decision-making capacity; Use of standardized instruments for staging of dementia (eg, functional assessment staging test [FAST], clinical dementia rating [CDR]); Medication reconciliation and review for high-risk medications; Evaluation for neuropsychiatric and behavioral symptoms, including depression, including use of standardized screening instrument(s); Evaluation of safety (eg, home), including motor vehicle operation; Identifi ation of caregiver(s), caregiver knowledge, caregiver needs, social supports, and the willingness of caregiver to take on caregiving tasks; Development, updating or revision, or review of an Advance Care Plan; Creation of a written care plan, including initial plans to address any neuropsychiatric symptoms, neuro-cognitive symptoms, functional limitations, and referral to community resources as needed (eg, rehabilitation services, adult day programs, support groups) shared with the patient and/or caregiver with initial education and support. Typically, 50 minutes are spent face-to-face with the patient and/or family or caregiver.	99483
Education and training for patient self-management by a qualifie , non-physician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 5-8 patients	98962
Physician or other qualified health are professional qualified y education, training, licensure/regulation (when applicable) educational services rendered to patients in a group setting (eg, prenatal, obesity, or diabetic instructions)	99078
Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 30 minutes	99402
Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 45 minutes	99403
Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 60 minutes	99404
Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 30 minutes	99411

*Codes listed are the most commonly used ICD-10, CPT and HCPCS codes. Please refer to HEDIS Value set for a more specific code.

HCPCS	
Services of clinical social worker in home health or hospice settings, each 15 minutes	G0155
Activity therapy, such as music, dance, art or play therapies not for recreation, related to the care and treatment of patient's disabling mental health problems, per session (45 minutes or more)	G0176
Training and educational services related to the care and treatment of patient's disabling mental health problems per session (45 minutes or more)	G0177

HCPCS	
Social work and psychological services, directly relating to and/or furthering the patient's rehabilitation goals, each 15 minutes, face-to-face; individual (services provided by a CORF-qualified social worker or psychologist in a CORF)	G0409
Hospital outpatient clinic visit for assessment and management of a patient	G0463
Behavioral health screening to determine eligibility for admission to treatment program	H0002
Behavioral health counseling and therapy, per 15 minutes	H0004
Mental health assessment, by non-physician	H0031
Medication training and support, per 15 minutes	H0034
Community psychiatric supportive treatment, face-to-face, per 15 minutes	H0036
Community psychiatric supportive treatment program, per diem	H0037
Assertive community treatment, face-to-face, per 15 minutes	H0039
Assertive community treatment program, per diem	H0040
Comprehensive multidisciplinary evaluation	H2000
Comprehensive medication services, per 15 minutes	H2010
Crisis intervention service, per 15 minutes	H2011
Psychiatric health facility service, per diem	H2013
Skills training and development, per 15 minutes	H2014
Comprehensive community support services, per 15 minutes	H2015
Comprehensive community support services, per diem	H2016
Psychosocial rehabilitation services, per 15 minutes	H2017
Psychosocial rehabilitation services, per diem	H2018
Therapeutic behavioral services, per 15 minutes	H2019
Therapeutic behavioral services, per diem	H2020
Clinic visit/encounter, all-inclusive	T1015

*The codes listed above are not inclusive and do not represent a complete list of codes.

USE OF OPIOIDS AT HIGH DOSAGE (HDO)

The percentage of members 18 years of age and older who received prescription opioids at a high dosage for > days during the measurement year.

EXCLUSION	
Supervision of a hospice patient (patient not present) requiring complex and multidisciplinary care modalities involving regular development and/or revision of care plans by that individual, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes	99377
Services performed by chaplain in the hospice setting, each 15 minutes	G9473
Services performed by dietary counselor in the hospice setting, each 15 minutes	G9474
Services performed by other counselor in the hospice setting, each 15 minutes	G9475
Services performed by volunteer in the hospice setting, each 15 minutes	G9476
Services performed by care coordinator in the hospice setting, each 15 minutes	G9477
Physician supervision of a patient under a medicare-approved hospice (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of laboratory and other studies, communication (including telephone calls) with other health care professionals involved in the patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month, 30 minutes or more	G0182
Oncology; primary focus of visit; supervising, coordinating or managing care of patient with terminal cancer or for whom other medical illness prevents further cancer treatment; includes symptom management, end-of-life care planning, management of palliative therapies (for use in a medicare-approved demonstration project)	G9054

*Codes listed are the most commonly used ICD-10, CPT and HCPCS codes. Please refer to HEDIS Value set for a more specific code.

INITIATION AND ENGAGEMENT OF ALCOHOL AND OTHER DRUG ABUSE OR DEPENDENCE TREATMENT (IET)

Adolescent and adult members (13 years and older) in MY with a new episode of alcohol or other drug (AOD) abuse or dependence who received the following:

- Members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth or medication treatment within 14 days of the diagnosis.
- Members who initiated treatment and who were engaged in ongoing AOD treatment within 34 days of the initiation visit

CPT	
Office or other outpatient visit for the evaluation and management of a **new patient**, which requires these three key components: An expanded problem focused history; An expanded problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. **Typically, 20 minutes are spent face-to-face with the patient and/or family.**	99202
Office or other outpatient visit for the evaluation and management of a **new patient**, which requires these three key components: A detailed history; A detailed examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. **Typically, 30 minutes are spent face-to-face with the patient and/or family.**	99203
Office or other outpatient visit for the evaluation and management of an **established patient**, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal. **Typically, five minutes are spent performing or supervising these services.**	99211
Office or other outpatient visit for the evaluation and management of an **established patient**, which requires at least two of these three key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self-limited or minor. **Typically, 10 minutes are spent face-to-face with the patient and/or family.**	99212
Office or other outpatient visit for the evaluation and management of an **established patient**, which requires at least two of these three key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. **Typically, 15 minutes are spent face-to-face with the patient and/or family.**	99213
Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion	98967
Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion	98968

CPT	
Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion	98966
Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion	99442
Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion	99443
Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion	99441

*The codes listed above are not inclusive and do not represent a complete list of codes.

HCPCS	
Office-based treatment for opioid use disorder, including care coordination, individual therapy and group therapy and counseling; at least 60 minutes in a subsequent calendar month	G2087
Office-based treatment for opioid use disorder, including development of the treatment plan, care coordination, individual therapy and group therapy and counseling; at least 70 minutes in the first calendar month	G2086

IMMUNIZATIONS FOR ADOLESCENTS (IMA-E)

The percentage of adolescents 13 years of age and older who had a dose of meningococcal vaccine, on tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday.

CPT	
Meningococcal conjugate vaccine, serogroups A, C, W, Y, quadrivalent, diphtheria toxoid carrier (MenACWY-D) or CRM197 carrier (MenACWY-CRM), for intramuscular use	90734
Meningococcal polysaccharide vaccine, serogroups A, C, Y, W-135, quadrivalent (MPSV4), for subcutaneous use	90733
Tdap Tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap), when administered to individuals seven (7) years or older, for intramuscular use	90715
HPV vaccine, types 6, 11, 16, 18 Quadrivalent (4vHPV) three (3) dose for IM (intramuscular)	90649
HPV vaccine, types, 16, 18, Bivalent (2vHPV), three (3) dose schedule for IM (intramuscular)	90650
HPV vaccine, types 6, 11, 16, 18, 31, 33, 45, 52, 58, Nonavalent (9vHPV), three (3) dose schedule, for IM (intramuscular)	90651

*Codes listed are the most commonly used ICD-10, CPT and HCPCS codes. Please refer to HEDIS Value set for a more specific code.

KIDNEY HEALTH EVALUATION FOR PATIENTS WITH DIABETES (KED)

Members 18 to 85 years of age with diabetes (type 1 and type 2) who had a kidney evaluation in 2025.

CPT	
Basic metabolic panel (Calcium, ionized) This panel must include the following: Calcium, ionized (82330) Carbon dioxide (bicarbonate) (82374) Chloride (82435) Creatinine (82565) Glucose (82947) Potassium (84132) Sodium (84295) Urea Nitrogen (BUN) (84520)	80047
Basic metabolic panel (Calcium, total)	80048
Comprehensive metabolic panel This panel must include the following: Albumin (82040) Bilirubin, total (82247) Calcium, total (82310) Carbon dioxide (bicarbonate) (82374) Chloride (82435) Creatinine (82565) Glucose (82947) Phosphatase, alkaline (84075) Potassium (84132) Protein, total (84155) Sodium (84295) Transferase, alanine amino (ALT) (SGPT) (84460) Transferase, aspartate amino (AST) (SGOT) (84450) Urea nitrogen (BUN) (84520)	80053
Creatinine; blood	82565
General health panel This panel must include the following: Comprehensive metabolic panel (80053) Blood count, complete (CBC), automated and automated differential WBC count (85025 or 85027 and 85004) OR Blood count, complete (CBC), automated (85027) and appropriate manual differential WBC count (85007 or 85009) Thyroid stimulating hormone (TSH) (84443)	80050
Renal function panel This panel must include the following: Albumin (82040) Calcium, total (82310) Carbon dioxide (bicarbonate) (82374) Chloride (82435) Creatinine (82565) Glucose (82947) Phosphorus inorganic (phosphate) (84100) Potassium (84132) Sodium (84295) Urea nitrogen (BUN) (84520)	80069

HCPCS	
Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of medicare enrollment (G0402)	G0402
Annual wellness visit; includes a personalized prevention plan of service (pps), initial visit (G0438)	G0438
Annual wellness visit, includes a personalized prevention plan of service (pps), subsequent visit (G0439)	G0439
Hospital outpatient clinic visit for assessment and management of a patient (G0463)	G0463
Clinic visit/encounter, all-inclusive (T1015)	T1015

EXCLUSION	
[N18.5] Chronic kidney disease, stage 5	N18.5
[N18.6] End stage renal disease	N18.6
[Z99.2] Dependence on renal dialysis	Z99.2

*The codes listed above are not inclusive and do not represent a complete list of codes.

USE OF IMAGING STUDIES FOR LOW BACK PAIN (LBP)

Members 18-75 years of age with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis.

CPT	
Office or other outpatient visit for the evaluation and management of a **new patient**, which requires these three key components: An expanded problem focused history; An expanded problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. **Typically, 20 minutes are spent face-to-face with the patient and/or family.**	99202
Office or other outpatient visit for the evaluation and management of a **new patient**, which requires these three key components: A detailed history; A detailed examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. **Typically, 30 minutes are spent face-to-face with the patient and/or family.**	99203
Office or other outpatient visit for the evaluation and management of an **established patient**, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal. **Typically, five minutes are spent performing or supervising these services.**	99211
Office or other outpatient visit for the evaluation and management of an **established patient**, which requires at least two of these three key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self-limited or minor. **Typically, 10 minutes are spent face-to-face with the patient and/or family.**	99212
Office or other outpatient visit for the evaluation and management of an **established patient**, which requires at least two of these three key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. **Typically, 15 minutes are spent face-to-face with the patient and/or family.**	99213

*The codes listed above are not inclusive and do not represent a complete list of codes.

CPT	
Radiologic examination, spine, single view, specify level	72020
Radiologic examination, spine, cervical; six or more views	72052
Radiologic examination, spine, lumbosacral; two or three views	72100
Radiologic examination, spine, lumbosacral; minimum of four views	72110
Radiologic examination, spine, lumbosacral; complete, including bending views, minimum of six views	72114
Radiologic examination, spine, lumbosacral; bending views only, two or three views	72120
Computed tomography, lumbar spine; without contrast material	72131
Computed tomography, lumbar spine; with contrast material	72132
Computed tomography, lumbar spine; without contrast material, followed by contrast material(s) and further sections	72133
Magnetic resonance (eg, proton) imaging, spinal canal and contents, cervical; without contrast material	72141
Magnetic resonance (eg, proton) imaging, spinal canal and contents, cervical; with contrast material(s)	72142
Magnetic resonance (eg, proton) imaging, spinal canal and contents, thoracic; without contrast material	72146
Magnetic resonance (eg, proton) imaging, spinal canal and contents, thoracic; with contrast material(s)	72147
Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; without contrast material	72148
Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; with contrast material(s)	72149
Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; cervical	72156
Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; lumbar	72158
Radiologic examination, sacroiliac joints; less than three views	72200
Radiologic examination, sacroiliac joints; three or more views	72202
Radiologic examination, sacrum and coccyx, minimum of two views	72220

HCPCS	
Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of medicare enrollment	G0402
Annual wellness visit; includes a personalized prevention plan of service (pps), initial visit	G0438
Annual wellness visit, includes a personalized prevention plan of service (pps), subsequent visit	G0439
Hospital outpatient clinic visit for assessment and management of a patient	G0463
Clinic visit/encounter, all-inclusive	T1015

*The codes listed above are not inclusive and do not represent a complete list of codes.

HCPCS	
Services of clinical social worker in home health or hospice settings, each 15 minutes	G0155
Activity therapy, such as music, dance, art or play therapies not for recreation, related to the care and treatment of patient's disabling mental health problems, per session (45 minutes or more)	G0176
Training and educational services related to the care and treatment of patient's disabling mental health problems per session (45 minutes or more)	G0177
Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., audit, dast), and brief intervention 15 to 30 minutes	G0396
Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., audit, dast), and intervention, greater than 30 minutes	G0397
Social work and psychological services, directly relating to and/or furthering the patient's rehabilitation goals, each 15 minutes, face-to-face; individual (services provided by a Comprehensive Outpatient Rehabilitation Facility (CORF)-qualified social worker or psychologist in a CORF)	G0409
Group psychotherapy other than of a multiple-family group, in a partial hospitalization setting, approximately 45 to 50 minutes	G0410
Interactive group psychotherapy, in a partial hospitalization setting, approximately 45 to 50 minutes	G0411
Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes	G0443
Hospital outpatient clinic visit for assessment and management of a patient	G0463
Alcohol and/or drug assessment	H0001
Behavioral health screening to determine eligibility for admission to treatment program	H0002
Behavioral health counseling and therapy, per 15 minutes	H0004
Alcohol and/or drug services; group counseling by a clinician	H0005
Alcohol and/or drug services; crisis intervention (outpatient)	H0007
Alcohol and/or drug services; intensive outpatient (treatment program that operates at least three hours/day and at least three days/week and is based on an individualized treatment plan), including assessment, counseling; crisis intervention, and activity therapies or education	H0015
Alcohol and/or drug services; medical/somatic (medical intervention in ambulatory setting)	H0016
Alcohol and/or drug intervention service (planned facilitation)	H0022
Mental health assessment, by non-physician	H0031
Medication training and support, per 15 minutes	H0034
Mental health partial hospitalization, treatment, less than 24 hours	H0035
Community psychiatric supportive treatment, face-to-face, per 15 minutes	H0036
Community psychiatric supportive treatment program, per diem	H0037

*The codes listed above are not inclusive and do not represent a complete list of codes.

ORAL EVALUATION, DENTAL SERVICES (OED)

Members under 21 years of age who received a comprehensive or periodic oral evaluation with a dental provider during the measurement year.

CPT	
Periodic oral evaluation - established patient	D0120
Oral evaluation for a patient under three years of age and counseling with primary caregiver	D0145
Comprehensive oral evaluation - new or established patient	D0150

OSTEOPOROSIS MANAGEMENT IN WOMEN WHO HAD A FRACTURE (OMW)

Women 67-85 years of age who suffered a fracture (07/01/2024 - 06/30/2025), and who had either a bone mineral density (BMD) test or prescription for a drug to treat osteoporosis in the six months after the fracture.

CPT	
Ultrasound bone density measurement and interpretation, peripheral site(s), any method	76977
Computed tomography, bone mineral density study, one or more sites, axial skeleton (eg, hips, pelvis, spine)	77078
Dual-energy X-ray absorptiometry (DXA), bone density study, one or more sites; axial skeleton (eg, hips, pelvis, spine)	77080
Dual-energy X-ray absorptiometry (DXA), bone density study, one or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel)	77081
Dual-energy X-ray absorptiometry (DXA), bone density study, one or more sites; axial skeleton (eg, hips, pelvis, spine), including vertebral fracture assessment	77085
Vertebral fracture assessment via dual-energy X-ray absorptiometry (DXA)	77086

HCPCS	
Injection, denosumab, 1 mg	J0897
Injection, ibandronate sodium, 1 mg	J1740
Injection, zoledronic acid, 1 mg	J3489

*The codes listed above are not inclusive and do not represent a complete list of codes.

OSTEOPOROSIS SCREENING IN OLDER WOMEN (OSW)

Women 65-75 years of age who received osteoporosis screening in 2025.

CPT	
Ultrasound bone density measurement and interpretation, peripheral site(s), any method	76977
Ultrasound, targeted dynamic microbubble sonographic contrast characterization (non-cardiac); initial lesion	77078
Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine)	77080
Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel)	77081
Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine), including vertebral fracture assessment	77085

EXCLUSION	
Oncology; primary focus of visit; supervising, coordinating or managing care of patient with terminal cancer or for whom other medical illness prevents further cancer treatment; includes symptom management, end-of-life care planning, management of palliative therapies (for use in a Medicare-approved demonstration project)	G9054
Injection, denosumab, 1 mg	J0897
Injection, ibandronate sodium, 1 mg	J1740
Injection, teriparatide, 10 mcg	J3110
Injection, zoledronic acid, 1 mg	J3489
Home visit for mechanical ventilation care	99504
Home visit for assistance with activities of daily living and personal care	99509
Skilled services by a registered nurse (rn) for management and evaluation of the plan of care; each 15 minutes (the patient's underlying condition or complication requires an rn to ensure that essential non-skilled care achieves its purpose in the home health or hospice setting)	G0162
Direct skilled nursing services of a registered nurse (rn) in the home health or hospice setting, each 15 minutes	G0299
Direct skilled nursing services of a licensed practical nurse (lpn) in the home health or hospice setting, each 15 minutes	G0300
Skilled services of a registered nurse (rn) for the observation and assessment of the patient's condition, each 15 minutes (the change in the patient's condition requires skilled nursing personnel to identify and evaluate the patient's need for possible modification of treatment in the home health or hospice setting)	G0493
Skilled services of a licensed practical nurse (lpn) for the observation and assessment of the patient's condition, each 15 minutes (the change in the patient's condition requires skilled nursing personnel to identify and evaluate the patient's need for possible modification of treatment in the home health or hospice setting)	G0494

EXCLUSION	
Physician management of patient home care, hospice monthly case rate (per 30 days)	S0271
Comprehensive management and care coordination for advanced illness, per calendar month	S0311
Nursing care, in the home; by registered nurse, per hour (use for general nursing care only, not to be used when cpt codes 99500-99602 can be used)	S9123
Nursing care, in the home; by licensed practical nurse, per hour	S9124
Private duty / independent nursing service(s) - licensed, up to 15 minutes	T1000
Nursing assessment / evaluation	T1001
Rn services, up to 15 minutes	T1002
Lpn/lvn services, up to 15 minutes	T1003
Services of a qualified nursing aide, up to 15 minutes	T1004
Respite care services, up to 15 minutes	T1005
Personal care services, per 15 minutes, not for an inpatient or resident of a hospital, nursing facility, icf/mr or imd, part of the individualized plan of treatment (code may not be used to identify services provided by home health aide or certified nurse assistant)	T1019
Personal care services, per diem, not for an inpatient or resident of a hospital, nursing facility, icf/mr or imd, part of the individualized plan of treatment (code may not be used to identify services provided by home health aide or certified nurse assistant)	T1020
Home health aide or certified nurse assistant, per visit	T1021
Contracted home health agency services, all services provided under contract, per day	T1022
Nursing care, in the home, by registered nurse, per diem	T1030
Nursing care, in the home, by licensed practical nurse, per diem	T1031

*The codes listed above are not inclusive and do not represent a complete list of codes.

PERSISTENCE OF BETA-BLOCKER AFTER A HEART ATTACK (PBH)

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

HCPCS	
Skilled services by a registered nurse (rn) for management and evaluation of the plan of care; each 15 minutes (the patient's underlying condition or complication requires an rn to ensure that essential non-skilled care achieves its purpose in the home health or hospice setting) (G0162)	G0162
Direct skilled nursing services of a registered nurse (rn) in the home health or hospice setting, each 15 minutes (G0299)	G0299
Direct skilled nursing services of a licensed practical nurse (lpn) in the home health or hospice setting, each 15 minutes (G0300)	G0300
Skilled services of a registered nurse (rn) for the observation and assessment of the patient's condition, each 15 minutes (the change in the patient's condition requires skilled nursing personnel to identify and evaluate the patient's need for possible modification of treatment in the home health or hospice setting) (G0493)	G0493
Skilled services of a licensed practical nurse (lpn) for the observation and assessment of the patient's condition, each 15 minutes (the change in the patient's condition requires skilled nursing personnel to identify and evaluate the patient's need for possible modification of treatment in the home health or hospice setting) (G0494)	G0494
Physician management of patient home care, hospice monthly case rate (per 30 days) (S0271)	S0271
Comprehensive management and care coordination for advanced illness, per calendar month (S0311)	S0311
Nursing care, in the home; by registered nurse, per hour (use for general nursing care only, not to be used when cpt codes 99500-99602 can be used) (S9123)	S9123
Nursing care, in the home; by licensed practical nurse, per hour (S9124)	S9124
Private duty / independent nursing service(s) - licensed, up to 15 minutes (T1000)	T1000
Nursing assessment / evaluation (T1001)	T1001
Rn services, up to 15 minutes (T1002)	T1002
Lpn/lvn services, up to 15 minutes (T1003)	T1003
Services of a qualified nursing aide, up to 15 minutes (T1004)	T1004
Respite care services, up to 15 minutes (T1005)	T1005
Personal care services, per 15 minutes, not for an inpatient or resident of a hospital, nursing facility, icf/mr or imd, part of the individualized plan of treatment (code may not be used to identify services provided by home health aide or certified nurse assistant) (T1019)	T1019
Personal care services, per diem, not for an inpatient or resident of a hospital, nursing facility, icf/mr or imd, part of the individualized plan of treatment (code may not be used to identify services provided by home health aide or certified nurse assistant) (T1020)	T1020
Home health aide or certified nurse assistant, per visit (T1021)	T1021
Contracted home health agency services, all services provided under contract, per day (T1022)	T1022
Nursing care, in the home, by registered nurse, per diem (T1030)	T1030
Nursing care, in the home, by licensed practical nurse, per diem (T1031)	T1031
Services performed by chaplain in the hospice setting, each 15 minutes (G9473)	G9473
Services performed by dietary counselor in the hospice setting, each 15 minutes (G9474)	G9474

*Codes listed are the most commonly used ICD-10, CPT and HCPCS codes. Please refer to HEDIS Value set for a more specific code.

PHARMACOTHERAPY MANAGEMENT OF COPD EXACERBATION (PCE)

Members 40 years of age and older with COPD exacerbations who had an acute inpatient discharge or ED visit on or between January 1, 2025-November 30, 2025, and who were dispensed a systemic corticosteroid within 14 days of the event and/or a bronchodilator within 30 days of the event.

EXCLUSION	
Hospice care provided in inpatient hospice facility	Q5006
Hospice care provided in inpatient hospital	Q5005
Hospice care provided in inpatient psychiatric facility	Q5008
Hospice care provided in long term care facility	Q5007
Hospice care provided in nursing long term care facility (ltc) or non-skilled nursing facility (nf)	Q5003
Hospice care provided in skilled nursing facility (snf)	Q5004
Hospice care, in the home, per diem	S9126
Hospice continuous home care; per hour	T2043
Hospice general inpatient care; per diem	T2045
Hospice home care provided in a hospice facility	Q5010
Hospice inpatient respite care; per diem	T2044
Hospice long term care, room and board only; per diem	T2046
Hospice routine home care; per diem	T2042
Services performed by care coordinator in the hospice setting, each 15 minutes	G9477
Services performed by chaplain in the hospice setting, each 15 minutes	G9473
Services performed by dietary counselor in the hospice setting, each 15 minutes	G9474
Services performed by other counselor in the hospice setting, each 15 minutes	G9475
Services performed by other qualified therapist in the hospice setting, each 15 minutes	G9478
Services performed by qualified pharmacist in the hospice setting, each 15 minutes	G9479
Services performed by volunteer in the hospice setting, each 15 minutes	G9476

*The codes listed above are not inclusive and do not represent a complete list of codes.

POSTPARTUM DEPRESSION SCREENING AND FOLLOW-UP (PDS-E)*

The percentage of deliveries in which members were screened for clinical depression during the postpartum period, and if screened positive, received follow-up care.

- Depression Screening. The percentage of deliveries in which members were screened for clinical depression using a standardized instrument during the postpartum period.
- Follow-Up on Positive Screen. The percentage of deliveries in which members received follow-up care within 30 days of a positive depression screen finding.

LOINC CODES	
Patient Health Questionaire (PHQ-9)	44261-6
Patient Health Questionaire-2 (PHQ-2)	55758-7

CPT	
Office or other outpatient visit for the evaluation and management of an **established patient**, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal. **Typically, five minutes are spent performing or supervising these services**.	99211
Office or other outpatient visit for the evaluation and management of an **established patient**, which requires at least two of these	99212
three key components: A problem focused history; A problem focused examination; Straightforward medical decision making.	99213
Office or other outpatient visit for the evaluation and management of an **established patient**, which requires at least two of these three key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. **Typically, 25 minutes are spent face-to-face with the patient and/or family**.	99214
Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. **Typically, 40 minutes are spent face-to-face with the patient and/or family**.	99215
Office or other outpatient visit for the evaluation and management of a **new patient**, which requires these three key components:	99202
An expanded problem focused history; An expanded problem focused examination; Straightforward medical decision making.	99203
Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. **Typically, 45 minutes are spent face-to-face with the patient and/or family**.	99204
Office or other outpatient visit for the evaluation and management of a **new patient**, which requires these three key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. **Typically, 60 minutes are spent face-to-face with the patient and/or family**.	99205

HCPCS	
Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related e/m service provided within the previous 7 days nor leading to an e/m service or procedure within the next 24 hours or soonest available appointment	G2010
Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related e/m service provided within the previous 7 days nor leading to an e/m service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion	G2012
Clinic visit/encounter, all-inclusive	T1015
Comprehensive medication services, per 15 minutes	H2010
Crisis intervention service, per 15 minutes	H2011
Behavioral health day treatment, per hour	H2012
Psychiatric health facility service, per diem	H2013

PRENATAL DEPRESSION SCREENING AND FOLLOW-UP (PND-E)*

The percentage of deliveries in which members were screened for clinical depression while pregnant and, if screened positive, received follow-up care.

- *Depression Screening*. The percentage of deliveries in which members were screened for clinical depression during pregnancy using a standardized instrument..
- *Follow-Up on Positive Screen*. The percentage of deliveries in which members received follow-up care within 30 days of a positive depression screen finding.

LOINC CODES	
Patient Health Questionaire (PHQ-9)	44261-6
Patient Health Questionaire-2 (PHQ-2)	55758-7

CPT	
Office or other outpatient visit for the evaluation and management of an **established patient**, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal. **Typically, five minutes are spent performing or supervising these services**.	99211
Office or other outpatient visit for the evaluation and management of an **established patient**, which requires at least two of these	99212
three key components: A problem focused history; A problem focused examination; Straightforward medical decision making.	99213
Office or other outpatient visit for the evaluation and management of an **established patient**, which requires at least two of these three key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. **Typically, 25 minutes are spent face-to-face with the patient and/or family**.	99214
Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. **Typically, 40 minutes are spent face-to-face with the patient and/or family**.	99215
Office or other outpatient visit for the evaluation and management of a **new patient**, which requires these three key components:	99202
An expanded problem focused history; An expanded problem focused examination; Straightforward medical decision making.	99203
Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. **Typically, 45 minutes are spent face-to-face with the patient and/or family**.	99204
Office or other outpatient visit for the evaluation and management of a **new patient**, which requires these three key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. **Typically, 60 minutes are spent face-to-face with the patient and/or family**.	99205

HCPCS	
Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related e/m service provided within the previous 7 days nor leading to an e/m service or procedure within the next 24 hours or soonest available appointment	G2010
Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related e/m service provided within the previous 7 days nor leading to an e/m service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion	G2012
Clinic visit/encounter, all-inclusive	T1015
Comprehensive medication services, per 15 minutes	H2010
Crisis intervention service, per 15 minutes	H2011
Behavioral health day treatment, per hour	H2012
Psychiatric health facility service, per diem	H2013

PHARMACOTHERAPY FOR OPIOD USE DISORDER (POD)

The percentage of opioid use disorder (OUD) pharmacotherapy events that lasted at least 180 days among members 16 years of age and older with a diagnosis of OUD and a new OUD pharmacotherapy event.

Intake period:

- July 1 of the year prior to the measurement year to June 30 of the measurement year

To qualify for negative medication history, the following criteria must be met:

- A period of 31 days prior to the OUD dispensing event or OUD medication administration event when the member had no OUD dispensing events or OUD medication administration events.
- A period of 31 days prior to the OUD dispensing event or OUD medication administration event when the member was not already receiving OUD pharmacotherapy.

HCPCS	
Buprenorphine implant, 74.2 mg	J0570
Medication assisted treatment, buprenorphine (implant insertion and removal); weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a medicare-enrolled opioid treatment program)	G2072
Medication assisted treatment, buprenorphine (implant insertion); weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a medicare-enrolled opioid treatment program)	G2070
Injection, buprenorphine extended-release (sublocade), greater than 100 mg	Q9992
Injection, buprenorphine extended-release (sublocade), less than or equal to 100 mg	Q9991
Medication assisted treatment, buprenorphine (injectable); weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a medicare-enrolled opioid treatment program)	G2069
Buprenorphine/naloxone, oral, greater than 10 mg buprenorphine	J0575
Buprenorphine/naloxone, oral, greater than 3 mg, but less than or equal to 6 mg buprenorphine)	J0573
Buprenorphine/naloxone, oral, greater than 6 mg, but less than or equal to 10 mg buprenorphine	J0574
Buprenorphine/naloxone, oral, less than or equal to 3 mg buprenorphine	J0572
Buprenorphine, oral, 1 mg	J0571
Oral medication administration, direct observation	H0033
Medication assisted treatment, buprenorphine (oral); weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a medicare-enrolled opioid treatment program)	G2068
Take-home supply of buprenorphine (oral); up to 7 additional day supply (provision of the services by a medicare-enrolled opioid treatment program); list separately in addition to code for primary procedure	G2079
Alcohol and/or drug services; methadone administration and/or service (provision of the drug by a licensed program)	H0020

HCPCS	
Methadone, oral, 5 mg	S0109
Medication assisted treatment, methadone; weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing, if performed (provision of the services by a medicare-enrolled opioid treatment program)	G2067
Take-home supply of methadone; up to 7 additional day supply (provision of the services by a medicare-enrolled opioid treatment program); list separately in addition to code for primary procedure	G2078

*The codes listed above are not inclusive and do not represent a complete list of codes.

PRENATAL IMMUNITATION STATUS (PRS-E)*

The percentage of deliveries in the measurement period in which members had received influenza and tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccinations.

CPT	
Tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap)	90715
Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, for intradermal use	90630
Influenza vaccine, inactivated (IIV), subunit, adjuvanted, for intramuscular use	90653
Influenza virus vaccine, trivalent (IIV3), split virus, preservative-free, for intradermal use	90654
Influenza virus vaccine, trivalent (IIV3), split virus, preservative free, 0.5 mL dosage, for intramuscular use	90656
Influenza virus vaccine, trivalent (IIV3), split virus, 0.5 mL dosage, for intramuscular use	90658
Influenza virus vaccine, trivalent (ccIIV3), derived from cell cultures, subunit, preservative and antibiotic free, 0.5 mL dosage, for intramuscular use	90661
Influenza virus vaccine, quadrivalent (RIV4), derived from recombinant DNA, hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use	90662
Influenza virus vaccine, trivalent (RIV3), derived from recombinant DNA, hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use	90673
Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, preservative and antibiotic free, 0.5 mL dosage, for intramuscular use	90674

NON-RECOMMENDED PSA-BASED SCREENING IN OLDER MEN (PSA)

The percentage of men 70 years and older who were screened unnecessarily for prostate cancer using prostate-specific antigen (PSA)-based screening.

Note: A lower rate indicates better performance.

CPT	
Prostate specific antigen (PSA); complexed (direct measurement)	84152
Prostate specific antigen (PSA); free	84154

LOINC	
Prostate Specific Ag Free [Mass/volume] in Serum or Plasma	10886-0
Prostate Specific Ag Free/Prostate specific Ag.total in Serum or Plasma	12841-3
Prostate specific Ag protein bound [Mass/volume] in Serum or Plasma	33667-7
Prostate specific Ag [Mass/volume] in Serum or Plasma by Detection limit <= 0.01 ng/mL	35741-8

*The codes listed above are not inclusive and do not represent a complete list of codes.

ADHERENCE TO ANTIPSYCHOTIC MEDICATIONS FOR INDIVIDUALS WITH SCHIZOPHRENIA (SAA)

The percentage of members 19–64 years of age during the measurement year with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.

CPT	
Psychiatric diagnostic evaluation	90792
Psychotherapy, 30 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)	90833
Psychotherapy, 45 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)	90836
Psychotherapy, 60 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)	90838
Psychotherapy for crisis; first 60 minutes	90839
Psychoanalysis	90845
Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes	90847
Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (eg, insight oriented, behavior modifying or supportive psychotherapy); 45 minutes	90876
Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 2-4 patients	98961
Physician or other qualified health care professional qualified by education, training, licensure/regulation (when applicable) educational services rendered to patients in a group setting (eg, prenatal, obesity, or diabetic instructions)	99078
Office or other outpatient visit for the evaluation and management of a **new patient**, which requires these three key components: An expanded problem focused history; An expanded problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. **Typically, 20 minutes are spent face-to-face with the patient and/or family.**	99202
Office or other outpatient visit for the evaluation and management of a **new patient**, which requires these three key components: A detailed history; A detailed examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. **Typically, 30 minutes are spent face-to-face with the patient and/or family.**	99203
Office or other outpatient visit for the evaluation and management of a **new patient**, which requires these three key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. **Typically, 60 minutes are spent face-to-face with the patient and/or family.**	99205

*The codes listed above are not inclusive and do not represent a complete list of codes.

CPT

Office or other outpatient visit for the evaluation and management of an **established patient**, which requires at least two of these three key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. **Typically, 10 minutes are spent face-to-face with the patient and/or family.**	99212
Office or other outpatient visit for the evaluation and management of an **established patient**, which requires at least two of these three key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. **Typically, 25 minutes are spent face-to-face with the patient and/or family.**	99214

HCPCS

Social work and psychological services, directly relating to and/or furthering the patient's rehabilitation goals, each 15 minutes, face-to-face; individual (services provided by a CORF-qualified social worker or psychologist in a CORF)	G0409
Hospital outpatient clinic visit for assessment and management of a patient	G0463
Behavioral health screening to determine eligibility for admission to treatment program	H0002
Mental health partial hospitalization, treatment, less than 24 hours	H0035
Community psychiatric supportive treatment, face-to-face, per 15 minutes	H0036
Rehabilitation program, per 1/2 day	H2001
Crisis intervention service, per 15 minutes	H2011
Behavioral health day treatment, per hour	H2012
Comprehensive community support services, per diem	H2016
Psychosocial rehabilitation services, per 15 minutes	H2017
Psychosocial rehabilitation services, per diem	H2018
Therapeutic behavioral services, per 15 minutes	H2019
Therapeutic behavioral services, per diem	H2020
Injection, aripiprazole, extended release, 1 mg	J0401
Injection, haloperidol decanoate, per 50 mg	J1631
Injection, paliperidone palmitate extended release, 1 mg	J2426
Injection, risperidone, long acting, 0.5 mg	J2794
Partial hospitalization services, less than 24 hours, per diem	S0201
Clinic visit/encounter, all-inclusive	T1015

*The codes listed above are not inclusive and do not represent a complete list of codes.

SOCIAL NEED SCREENING AND INTERVENTION (SNS-E)

The percentage of members who were screened, using pre-specified instruments, at least once during the measurement period for unmet food, housing and transportation needs, and received a corresponding intervention if they screened positive.

CPT	
Health behavior assessment, or re-assessment (ie, health-focused clinical interview, behavioral observations, clinical decision making)	96156
Administration of patient-focused health risk assessment instrument (eg, health hazard appraisal) with scoring and documentation, per standardized instrument	96160
Administration of caregiver-focused health risk assessment instrument (eg, depression inventory) for the benefit of the patient, with scoring and documentation, per standardized instrument	96161
Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes	97802
re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes	97803
group (2 or more individual(s)), each 30 minutes	97804

HCPCS	
Home delivered meals, including preparation; per meal	S5170
Nutritional counseling, dietitian visit	S9470

*Codes listed are the most commonly used ICD-10, CPT and HCPCS codes. Please refer to HEDIS Value set for a more specific code.

STATIN THERAPY FOR PATIENTS WITH CARDIOVASCULAR DISEASE (SPC)

The percentage of males 21–75 years of age and females 40–75 years of age during the measurement year, who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and met the following criteria. The following rates are reported:

1. **Received Statin Therapy.** Members who were dispensed at least one high-intensity or moderate-intensity statin medication during the measurement year.
2. **Statin Adherence 80%.** Members who remained on a high-intensity or moderate-intensity statin medication for at least 80% of the treatment period.

EXCLUSION	
Hospice care provided in inpatient hospice facility	Q5006
Hospice care provided in inpatient hospital	Q5005
Hospice care provided in inpatient psychiatric facility	Q5008
Hospice care provided in long term care facility	Q5007
Hospice care provided in nursing long term care facility (ltc) or non-skilled nursing facility (nf)	Q5003
Hospice care provided in skilled nursing facility (snf) _ Q5	Q5004
Hospice care, in the home, per diem	S9126
Hospice continuous home care; per hour	T2043
Hospice general inpatient care; per diem	T2045
Hospice home care provided in a hospice facility	Q5010
Physician supervision of a patient under a medicare-approved hospice (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of laboratory and other studies, communication (including telephone calls) with other health care professionals involved in the patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month, 30 minutes or more	G0182
Oncology; primary focus of visit; supervising, coordinating or managing care of patient with terminal cancer or for whom other medical illness prevents further cancer treatment; includes symptom management, end-of-life care planning, management of palliative therapies (for use in a medicare-approved demonstration project)	G9054

*The codes listed above are not inclusive and do not represent a complete list of codes.

STATIN THERAPY FOR PATIENTS WITH DIABETES (SPD)

The percentage of members 40–75 years of age during the measurement year with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) who met the following criteria. Two rates are reported:

1. **Received Statin Therapy.** Members who were dispensed at least one statin medication of any intensity during the measurement year.
2. **Statin Adherence 80%.** Members who remained on a statin medication of any intensity for at least 80% of the treatment period.

CPT	
Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous seven days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion	98966
Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous seven days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion	98967
Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous seven days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion	98968
Online assessment and management service provided by a qualified nonphysician health care professional to an established patient or guardian, not originating from a related assessment and management service provided within the previous seven days, using the Internet or similar electronic communications network	98969
Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other quali ed health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family.	99204
Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal. Typically, ve minutes are spent performing or supervising these services.	99211
Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.	99212

CPT	
Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family	99214

*The codes listed above are not inclusive and do not represent a complete list of codes.

HCPCS	
Percutaneous transcatheter placement of drug eluting intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch	C9600
Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of drug-eluting intracoronary stent, atherectomy and angioplasty, including distal protection when performed; single vessel	C9604
Percutaneous transluminal revascularization of acute total/subtotal occlusion during acute myocardial infarction, coronary artery or coronary artery bypass graft, any combination of drug-eluting intracoronary stent, atherectomy and angioplasty, including aspiration thrombectomy when performed, single vessel	C9606
Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of drug-eluting intracoronary stent, atherectomy and angioplasty; single vessel	C9607
Unscheduled or emergency dialysis treatment for an ESRD patient in a hospital outpatient department that is not certified as an ESRD facility	G0257
Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of medicare enrollment	G0402
Hospital outpatient clinic visit for assessment and management of a patient	G0463

*The codes listed above are not inclusive and do not represent a complete list of codes.

DIABETES SCREENING FOR PEOPLE WITH SCHIZOPHRENIA OR BIPOLAR DISORDER WHO ARE USING ANTIPSYCHOTIC MEDICATIONS (SSD)

Members 18-64 years of age with schizophrenia, schizoaffective disorder or bipolar disorder, who were dispensed an antipsychotic medication and had a glucose test or an HbAlc test in MY.

CPT	
Basic metabolic panel (Calcium, ionized) This panel must include the following: Calcium, ionized (82330) Carbon dioxide (bicarbonate) (82374) Chloride (82435) Creatinine (82565) Glucose (82947) Potassium (84132) Sodium (84295) Urea Nitrogen (BUN) (84520)	80047
Basic metabolic panel (Calcium, total)	80048
Comprehensive metabolic panel This panel must include the following: Albumin (82040) Bilirubin, total (82247) Calcium, total (82310) Carbon dioxide (bicarbonate) (82374) Chloride (82435) Creatinine (82565) Glucose (82947) Phosphatase, alkaline (84075) Potassium (84132) Protein, total (84155) Sodium (84295) Transferase, alanine amino (ALT) (SGPT) (84460) Transferase, aspartate amino (AST) (SGOT) (84450) Urea nitrogen (BUN) (84520)	80053
General health panel This panel must include the following: Comprehensive metabolic panel (80053) Blood count, complete (CBC), automated and automated differential WBC count (85025 or 85027 and 85004) OR Blood count, complete (CBC), automated (85027) and appropriate manual differential WBC count (85007 or 85009) Thyroid stimulating hormone (TSH) (84443)	80050
glycosylated (A1C)	83036
glycosylated (A1C) by device cleared by FDA for home use	83037

*The codes listed above are not inclusive and do not represent a complete list of codes.

TOPICAL FLUORIDE FOR CHILDREN (TFC/TFL)

Members 1-4 years of age who received at least 2 fluoride varnish applications during the measurement year. (TFC)

Members 1-20 years of age who received at least 3 topical fluoride applications during the measurement year. (TFL)

CPT	
Application of topical fluoride varnish by a physician or other qualified health care professional	99188

CDT	
Topical application of fluoride varnish	D1206
Topical application of fluoride - excluding varnish	D1208

USE OF OPIOIDS FROM MULTIPLE PROVIDERS (UOP)

The percentage of members 18 years and older, receiving prescription opioids for >15 days during the measurement year, who received opioids from multiple providers.

EXCLUSIONS	
Supervision of a hospice patient (patient not present) requiring complex and multidisciplinary care modalities involving regular development and/or revision of care plans by that individual, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes	99377
Services performed by chaplain in the hospice setting, each 15 minutes	G9473
Services performed by dietary counselor in the hospice setting, each 15 minutes	G9474
Services performed by other counselor in the hospice setting, each 15 minutes	G9475
Services performed by volunteer in the hospice setting, each 15 minutes	G9476
Services performed by care coordinator in the hospice setting, each 15 minutes	G9477
Physician supervision of a patient under a medicare-approved hospice (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of laboratory and other studies, communication (including telephone calls) with other health care professionals involved in the patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month, 30 minutes or more	G0182

*Codes listed are the most commonly used ICD-10, CPT and HCPCS codes. Please refer to HEDIS Value set for a more specific code.

APPROPRIATE TREATMENT FOR UPPER RESPIRATORY INFECTION (URI)

Children 3 months-18 years of age who were given a diagnosis of upper respiratory infection (URI) and were not dispensed an antibiotic prescription in MY. A higher rate indicates better performance.

CPT	
Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: An expanded problem focused history; An expanded problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 20 minutes are spent face-to-face with the patient and/or family.	99202
Office or other outpatient visit for the evaluation and management of a **new patient**, which requires these three key components: A detailed history; A detailed examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. **Typically, 30 minutes are spent face-to-face with the patient and/or family**.	99203
Office or other outpatient visit for the evaluation and management of an **established patient**, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal. **Typically, five minutes are spent performing or supervising these services**.	99211
Office or other outpatient visit for the evaluation and management of an **established patient**, which requires at least two of these three key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self-limited or minor. **Typically, 10 minutes are spent face-to-face with the patient and/or family**.	99212
Office or other outpatient visit for the evaluation and management of an **established patient**, which requires at least two of these three key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. **Typically, 15 minutes are spent face-to-face with the patient and/or family**.	99213

*The codes listed above are not inclusive and do not represent a complete list of codes.

EXCLUSIONS	
Hospice care provided in inpatient hospice facility	Q5006
Hospice care provided in inpatient hospita	Q5005
Hospice care provided in inpatient psychiatric facility	Q5008
Hospice care provided in long term care facility	Q5007
Hospice care provided in nursing long term care facility (ltc) or non-skilled nursing facility (nf)	Q5003

*The codes listed above are not inclusive and do not represent a complete list of codes.

CHILD AND ADOLESCENT WELL-CARE VISITS (WCV)

Members 3-21 years of age who had a well-care visit in 2025 with a PCP or OB/GYN practitioner.

CPT	
Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; infant (age younger than 1 year)	99381
Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; early childhood (age 1 through 4 years)	99382
Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; late childhood (age 5 through 11 years)	99383
Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; adolescent (age 12 through 17 years)	99384
Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 18-39 years	99385
Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; infant (age younger than 1 year)	99391
Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; early childhood (age 1 through 4 years)	99392
Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; late childhood (age 5 through 11 years)	99393
Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; adolescent (age 12 through 17 years)	99394
Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 18-39 years	99395

*The codes listed above are not inclusive and do not represent a complete list of codes.

EXCLUSIONS

Supervision of a hospice patient (patient not present) requiring complex and multidisciplinary care modalities involving regular development and/or revision of care plans by that individual, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes	99377
Supervision of a hospice patient (patient not present) requiring complex and multidisciplinary care modalities involving regular development and/or revision of care plans by that individual, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 30 minutes or more	99378
Physician supervision of a patient under a medicare-approved hospice (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of laboratory and other studies, communication (including telephone calls) with other health care professionals involved in the patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month, 30 minutes or more (G0182)	G0182
Services performed by chaplain in the hospice setting, each 15 minutes (G9473)	G9473
Services performed by other counselor in the hospice setting, each 15 minutes (G9475)	G9475
Services performed by volunteer in the hospice setting, each 15 minutes (G9476)	G9476
Services performed by care coordinator in the hospice setting, each 15 minutes (G9477)	G9477
Services performed by other qualified therapist in the hospice setting, each 15 minutes (G9478)	G9478
Services performed by qualified pharmacist in the hospice setting, each 15 minutes (G9479)	G9479
Hospice care provided in inpatient hospital (Q5005)	Q5005
Hospice care, in the home, per diem (S9126)	S9126
Hospice routine home care; per diem (T2042)	T2042
Hospice inpatient respite care; per diem (T2044)	T2044
Hospice general inpatient care; per diem (T2045)	T2045

*The codes listed above are not inclusive and do not represent a complete list of codes.

WELL-CHILD VISITS IN THE FIRST 30 MONTHS OF LIFE (W30)

Well-Child Visits in the First 15 Months. Children who turned 15 months old during the measurement year: Six or more well-child visits.

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

CPT	
Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; infant (age younger than 1 year)	99381
Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; early childhood (age 1 through 4 years)	99382
Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; late childhood (age 5 through 11 years)	99383
Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; adolescent (age 12 through 17 years)	99384
Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 18-39 years	99385
Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; infant (age younger than 1 year)	99391
Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; early childhood (age 1 through 4 years)	99392
Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; late childhood (age 5 through 11 years)	99393
Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; adolescent (age 12 through 17 years)	99394
Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 18-39 years	99395
Initial care, per day, for evaluation and management of normal newborn infant seen in other than hospital or birthing center	99461

*The codes listed above are not inclusive and do not represent a complete list of codes.

HCPCS	
Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/ diagnostic procedures, new patient; infant (age younger than 1 year)	99381
Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/ diagnostic procedures, new patient; early childhood (age 1 through 4 years)	99382
Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/ diagnostic procedures, new patient; late childhood (age 5 through 11 years)	99383

ICD10	
[Z00.00] Encounter for general adult medical examination without abnormal findings	Z00.00
[Z00.01] Encounter for general adult medical examination with abnormal findings	Z00.01
[Z00.110] Health examination for newborn under 8 days old	Z00.110
[Z00.111] Health examination for newborn 8 to 28 days old	Z00.111
[Z00.121] Encounter for routine child health examination with abnormal findings	Z00.121
[Z00.129] Encounter for routine child health examination without abnormal findings	Z00.129
[Z00.2] Encounter for examination for period of rapid growth in childhood	Z00.2
[Z00.3] Encounter for examination for adolescent development state	Z00.3
[Z02.5] Encounter for examination for participation in sport	Z02.5
[Z76.1] Encounter for health supervision and care of foundling	Z76.1
[Z76.2] Encounter for health supervision and care of other healthy infant and child	Z76.2

*The codes listed above are not inclusive and do not represent a complete list of codes.

EXCLUSIONS

Services performed by chaplain in the hospice setting, each 15 minutes (G9473)	G9473
Services performed by dietary counselor in the hospice setting, each 15 minutes (G9474)	G9474
Services performed by other counselor in the hospice setting, each 15 minutes (G9475)	G9475
Services performed by care coordinator in the hospice setting, each 15 minutes (G9477)	G9477
Services performed by other qualified therapist in the hospice setting, each 15 minutes (G9478)	G9478
Services performed by qualified pharmacist in the hospice setting, each 15 minutes (G9479)	G9479
Hospice care provided in inpatient hospital (Q5005)	Q5005
Hospice care provided in inpatient hospice facility (Q5006)	Q5006
Hospice care, in the home, per diem (S9126)	S9126
Hospice routine home care; per diem (T2042)	T2042
Hospice inpatient respite care; per diem (T2044)	T2044
Hospice general inpatient care; per diem (T2045)	T2045

*The codes listed above are not inclusive and do not represent a complete list of codes.

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