HEDIS® 2020

Hybrid Measure Quick Guide

L.A. Care HEALTH PLAN®

For All of L.A.

LA2498 11/19 ver.2

Quality Performance Management

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Child/Adolescent Health

Priority Measure	Measure Specification	How to Improve HEDIS Scores
Adolescent Well-Care Visits (AWC)	Adolescents 12 -21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner in 2019. Documentation in the medical record must include evidence of all of the following: • Health History • Physical Developmental History • Mental Developmental History • Physical Exam • Health Education/Anticipatory Guidance	• Use of Complete and accurate Value Set Codes **(Click to View)** • Timely submission of claims and encounter data • Do not include services rendered during an inpatient or ED visit. • Preventative services may be rendered on visits other than well-child visits. • Services that are specific to the assessment or treatment of an acute or chronic condition do not count toward the measure. • Services that occur over multiple visits count toward the measure as long as all the services occur in 2019. • **Note:** Assessment of allergies, medications, and immunization status meets criteria for Health History. Documentation of Tanner Stage/Scale meet criteria for Physical Developmental History.
Childhood Immunization Status (CIS)	Children 2 years of age who had the following **by their second birthday**: • Four (4) DTaP (Diphtheria, Tetanus and acellular pertussis) • Three (3) IPV (Inactivated Polio) • One (1) MMR (Measles, Mumps and Rubella) • Three (3) HiB (Haemophilus Influenza Type B) • Three (3) Hepatitis B • One (1) VZV (Varicella Zoster) • Four (4) PCV (Pneumococcal Conjugate) • One (1) Hepatitis A • Two (2) or three (3) RV (Rotavirus) • Two (2) Influenza	• Use of Complete and accurate Value Set Codes **(Click to View)** • Timely submission of claims and encounter data • A note indicating the name of the specific antigen and the date of the immunization, or a certificate of immunization prepared by an authorized health care provider or agency including the specific dates and types of immunizations administered. • Documentation that the member received the immunization "at delivery" or "in the hospital" meet criteria (e.g. Hep B). • Exclude children who had a contraindication for a specific vaccine. • Participate in CAIR registry
Immunizations for Adolescents (IMA)	Adolescents 13 years of age who had the following **by their thirteenth birthday:** • One (1) MCV (Meningococcal) between 11th – 13th birthday. • One (1) Tdap (Tetanus, Diptheria, Aceeular Pertussis) between 10th – 13th birthday. • Three (3) HPV (Human papillomavirus) between 9th – 13th birthday or two (2) HPV with at least 146 days between 1st and 2nd dose.	• Use of Complete and accurate Value Set Codes **(Click to View)** • Timely submission of claims and encounter data • A note indicating the name of the specific antigen and the date of the immunization, or a certificate of immunization prepared by an authorized health care provider or agency including the specific dates and types of immunizations administered • Participate in CAIR 2 registry

Priority Measure	Measure Specification	How to Improve HEDIS Scores
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents (WCC)	Children & adolescents 3 – 17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of the following in 2019: • BMI Percentile documentation • Counseling for nutrition • Counseling for physical activity	• Use of complete and accurate Value Set Codes **(Click to View)** • Timely submission of claims and encounter data • BMI Percentile can be documented as a value (e.g., 85th percentile) or plotted on a BMI-growth chart. Ranges and thresholds are not acceptable. A distinct BMI value or percentile is required. Documentation of >99% or <1% meets criteria. • Counseling for nutrition. Any one of the following meet criteria: discussion of current nutrition behaviors, checklist indicated nutrition was addressed, counseling or referral for nutrition education, member received educational materials on nutrition during a face-to-face visit, anticipatory guidance for nutrition, weight or obesity counseling. • Counseling for physical activity. Any one of the following meet criteria: discussion of current physical activity behaviors, checklist indicated physical activity was addressed, counseling or referral for physical activity, member received educational materials on physical activity during a face-to-face visit, anticipatory guidance specific to the child's physical activity, weight or obesity counseling.
Well-Child Visits in the First 15 Months of Life (W15)	Children who turned 15 months old in 2019 and had six (6) or more well-child visits with a PCP during their first 15 months of life. Documentation in the medical record must include evidence of all of the following: • Health History • Physical Developmental History • Mental Developmental History • Physical Exam • Health Education/Anticipatory Guidance	• Use of complete and accurate Value Set Codes **(Click to View)** • Timely submission of claims and encounter data • Do not include services rendered during an inpatient or ED visit. • Preventative services may be rendered on visits other than well-child visits. • Services that are specific to the assessment or treatment of an acute or chronic condition do not count toward the measure. • All services occur prior to age 15 months in 2019 or all services in 2018-2019. • **Note:** Assessment of allergies, medications, and immunization status meets criteria for Health History. Documentation of Tanner Stage/Scale meet criteria for Physical Developmental History.

Priority Measure	Measure Specification	How to Improve HEDIS Scores
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)	Children 3 – 6 years of age who had one or more well-child visits with a PCP in 2019. Documentation in the medical record must include evidence of all of the following: • Health History • Physical Developmental History • Mental Developmental History • Physical Exam • Health Education/Anticipatory Guidance	• Use of complete and accurate Value Set Codes **(Click to View)** • Timely submission of claims and encounter data • Do not include services rendered during an inpatient or ED visit. • Preventative services may be rendered on visits other than well-child visits. • Services that are specific to the assessment or treatment of an acute or chronic condition do not count toward the measure. • Services that occur over multiple visits count toward the measure as long as all the services occur in 2019. • **Note:** Assessment of allergies, medications, and immunization status meets criteria for Health History. Documentation of Tanner Stage/Scale meet criteria for Physical Developmental History.
Women's Health		
Cervical Cancer Screening (CCS)	Women 21 – 64 years of age who were screened for cervical cancer using either of the following: • Women 21-64 years of age who had cervical cytology performed within the last 3 years. • Women 30-64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed with the last 5 years. • Women 30-64 years of age who had cervical cytology/high risk human papillomavirus (hrHPV) cotesting within the last 5 years.	• Use of complete and accurate Value Set Codes **(Click to View)** • Timely submission of claims and encounter data • Documentation in the medical record must include a note indicating the date when the cervical cytology was performed and the result. • Biopsies and samples that indicate "no cervical cells were present" do not meet criteria. • Exclude members with history of hysterectomy. Documentation in medical record must indicate type of hysterectomy whether it is complete, total, radical (abdominal or vaginal).

Priority Measure	Measure Specification	How to Improve HEDIS Scores
Prenatal and Postpartum Care (PPC)	Women who delivered live births on or between 10/8/2018-10/7/2019 with the following facets of prenatal and postpartum care: • *Timeliness of Prenatal Care.* The percentage of deliveries that received a prenatal care in the first trimester, on the enrollment start date or within 42 days of enrollment in the organization. • Postpartum Care. The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery.	• Use of complete and accurate Value Set Codes **(Click to View)** • Timely submission of claims and encounter data • Prenatal care visit must include one of the following: i. Diagnosis of pregnancy ii. A basic OB exam that includes auscultation for fetal heart tone, or pelvic exam with OB observations, or measurement of fundus height. iii. Evidence that one of the following prenatal care procedures was performed: a. OB panel b. TORCH panel c. A rubella antibody test/titer with an ABO/Rh blood typing d. Ultrasound of a pregnant uterus iv. Documentation of LMP, EDD or gestational age in conjunction with either a prenatal risk assessment and counseling/education or a complete OB history. • Postpartum visit must include one of the following: • Pelvic exam • Evaluation of weight, BP, breasts and abdomen. - Notation of "breastfeeding" is acceptable for the "evaluation of breasts" component. • Notation of postpartum care including "PP care", " PP check", "6 week check". - a preprinted "Postpartum Care" form in which information was documented during visit • Perineal or cesarean incision/wound check • Screening for depression, anxiety, tobacco use, substance disorder, or preexisting mental health disorders. • Glucose screening for women with gestational diabetes. • Documentation of any of the following topics: - Infant care or breastfeeding. - Resumption of intercourse, birth spacing or family planning. - Sleep/fatigue - Resumption of physical activity and attainment of healthy weight.

Priority Measure	Measure Specification	How to Improve HEDIS Scores
Adult/Elderly Health		
Adult BMI Assessment (ABA)	Adults 18 – 74 years of age who had an outpatient visit and whose body mass index (BMI) was documented in 2018 or 2019. • ≥ 20 years: Weight and BMI value • < 20 years: Height, Weight, and BMI percentile	• Use of complete and accurate Value Set Codes **(Click to View)** • Timely submission of claims and encounter data • Weight and BMI value or percentile must be from the same data source and BMI percentile must be documented as a value (e.g., 85th percentile) or plotted on a BMI-growth chart. • Ranges and thresholds are not acceptable. A distinct BMI value or percentile is required. Documentation of >99% or <1% meets criteria.
Controlling High Blood Pressure (CBP)	Members 18 – 85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90 mm Hg) in 2019.	• Use of complete and accurate Value Set Codes **(Click to View)** • Timely submission of claims and encounter data • Include BP readings from remote monitoring devices that are digitally stored and transmitted to the provider. • The following BP readings do not meet criteria: BP readings taken during an acute inpatient stay, ED visit, on same day as a diagnostic test or procedure that requires a change in diet or medication on or one day before the day of the test or procedure (with the exception of fasting blood tests), and those reported or taken by the member. • Always recheck blood pressure if initial reading is 140/90 or greater.
Comprehensive Diabetes Care (CDC)	Members 18 – 75 years of age with diabetes (type 1 and type 2) who had each of the following in 2019: • Hemoglobin A1c (HbA1c) testing • Retinal Eye exam performed (a negative eye exam in 2018 also meets criteria) • Medical attention for nephropathy • BP control (<140/90 mm Hg)	• Use of complete and accurate Value Set Codes **(Click to View)** • Timely submission of claims and encounter data • Documentation in the medical record must include a note indicating the date when the HbA1c test was performed and the result. • Always recheck blood pressure if initial reading is 140/90 or greater. • Request from eye specialist a copy of retinal eye exam if not received. • Medical attention for nephropathy must include one of the following: i. A urine test for albumin or protein ii. Documentation of a visit to a nephrologist iii. Documentation of a renal transplant iv. Documentation of medical attention for any of the following: diabetic nephropathy, ESRD, CRF, CKD, renal insufficiency, proteinuria, albuminuria, renal dysfunction, ARF, or dialysis. v. Evidence of ACE inhibitor/ARB therapy

Priority Measure	Measure Specification	How to Improve HEDIS Scores
Care for Older Adults (COA)	Members 66 years and older who had each of the following: • Advance care planning • Medication review • Functional status assessment • Pain assessment	• Use of complete and accurate Value Set Codes **(Click to View)** • Timely submission of claims and encounter data • Advanced Care Planning may include: advance directive, actionable medical orders, living will, or a surrogate decision maker. • Advance care planning discussion may include a notation in the medical record or an oral statement. • Functional status assessment must include one of the following: notation of ADLs, IADLs, result of assessment of a standardized functional status assessment tool, or notation of at least 3 of the following (cognitive status, ambulation status, sensory ability, or other functional independence). • Medication Review to be done by prescribing provider and clinical pharmacist only. • Pain assessment may be completed by using numerical pain scale, facial pain scale, or documentation of "no pain" upon assessment.
Colorectal Cancer Screening (COL)	Members 50 – 75 years of age who had appropriate screening for colorectal cancer. Any of the following meet criteria: • Fecal occult blood test in 2019 • Flexible sigmoidoscopy between 2015-2019 • Colonoscopy between 2010 – 2019 • CT Colonography between 2015 - 2019 • FIT-DNA/Cologuard test between 2017 - 2019	• Use of complete and accurate Value Set Codes **(Click to View)** • Timely submission of claims and encounter data • FOBT test performed in an office setting or performed on a sample collected via a digital rectal exam (DRE) does not meet criteria. • Exclude members with history of colectomy or colorectal cancer.

Priority Measure	Measure Specification	How to Improve HEDIS Scores
Medication Reconciliation Post-Discharge (MRP)	Members 18 years of age and older for whom medications were reconciled on or within 30 days of discharge.	• Use of complete and accurate Value Set Codes **(Click to View)** • Timely submission of claims and encounter data • Documentation in the medical record must include any one of the following: i. Documentation of the current medications with a notation that the provider reconciled the current and discharge medications. ii. Documentation of the current medications with a notation that references the discharge medications (e.g., no changes in medications since discharge, same medications at discharge, discontinue all discharge medications). iii. Documentation of the member's current medications with a notation that the discharge medications were reviewed. iv. Documentation of a current medication list, a discharge medication list and notation that both lists were reviewed on the same date of service. v. Documentation of the current medications with evidence that the member was seen for post-discharge hospital follow-up with evidence of medication reconciliation or review. vi. Documentation in the discharge summary that the discharge medications were reconciled with the most recent medication list in the outpatient medical record. There must be evidence that the discharge summary was filed in the outpatient chart on the date of discharge through 30 days after discharge (31 total days). vii. Notation that no medications were prescribed or ordered upon discharge.
Transitions of Care (TRC)	Members 18 years of age and older who had each of the following: • *Notification of Inpatient Admission*. Documentation of receipt of notification of inpatient admission on the day of admission or the following day. • *Receipt of Discharge Information*. Documentation of receipt of discharge information on the day of discharge or the following day. • *Patient Engagement After Inpatient Discharge*. Documentation of patient engagement (e.g., office visits, visits to the home, telehealth) provided within 30 days after discharge. • *Medication Reconciliation Post-Discharge*. Documentation of medication reconciliation on the date of discharge through 30 days after discharge (31 total days).	• Use of complete and accurate Value Set Codes **(Click to View)** • Timely submission of claims and encounter data • Arrange for an outpatient visit, which may include office visits, home visits, or telehealth visits (via telephone or videoconferencing) within 30 days after discharge. • For Medication Reconciliation Post-Discharge, please refer to MRP documentation requirements. • For Notification of Inpatient Admission and Receipt of Discharge Information, information must come from the hospital, health information exchange, or member's health plan.

ADOLESCENT WELL CARE VISIT (AWC)

The percentage of enrolled members ***12-21 years of age*** who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.

AWC

Based on the American Academy of Pediatrics (AAP) recommendation of an annual comprehensive checkup for adolescents.

CPT	
New Patient Adolescent ***(age 12 through 17)*** Evaluation and management including age, gender, appropriate history, examination, counseling/anticipatory guidance/risk factor reduction, interventions, and the ordering of laboratory/diagnostic procedures.	99384
New Patient ***18-39 years of age***	99385
Established Patient ***Adolescent (age 12 through 17)*** Evaluation and management including age, gender, appropriate history, examination, counseling/anticipatory guidance/risk factor reduction, interventions, and the ordering of laboratory/diagnostic procedures.	99394
Established Patient ***18-39 years of age***	99395

ICD-10	
BMI, pediatric, **less than 5th percentile** for age	Z68.51
BMI, pediatric, **5th percentile to 85th percentile** for age	Z68.52
BMI, pediatric, **85th percentile to 95th percentile** for age	Z68.53
BMI, pediatric, **greater than or equal to 95th percentile** for age	Z68.54
Counseling for nutrition	Z71.3
Exercise counseling/Physical activity	Z71.82
Encounter for routine child health examination **with abnormal findings**	Z00.121
Encounter for routine child health examination **without abnormal findings**	Z00.129

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

CHILDHOOD IMMUNIZATION STATUS (CIS)

The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); there polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influencia type B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influencia (flu) vaccines by their second birthday.

CIS

Follows the CDC Advisory Committee on Immunization Practices (ACIP) guidelines for immunizations for children.

VACCINE	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
Hep-A (Hepatitis A)	90633
RV (Rota Virus)2 DOSE (Rotarix)	90681
RV (Rota Virus)3 DOSE (Rota Teq)	90680
FLU - TRIVALENT 0.25ML	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

VACCINE (Combination)	CPT
DTaP-IPV/Hib combo	90698
DTaP-HepB-IPV	90723
MMRV (Measles, Mumps, Rubella, Varicella)	90710
HIB/HEP B	90748

VACCINE	HCPCS
Administration of Hepatitis B vaccine	G0010
Administration of influenza virus vaccine	G0008
Administration of pneumococcal vaccine	G0009

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

IMMUNIZATIONS FOR ADOLESCENTS (IMA)

The percentage of adolescents 13 years of age who had one (1) dose of meningococcal vaccine, one (1) tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday. The measure calculates a rate for each vaccine and two (2) combination rates.

IMA

Follows the CDC Advisory Committee on Immunization Practices (ACIP) guidelines for immunizations for children.

VACCINE	CPT
Meningococcal conjugate vaccine, serogroups A, C, W, Y, quadrivalent, diphtheria toxoid carrier (MenACWY-D) or CRM197 carrier (MenACWY-CRM), for intramuscular use	90734
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.*

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)

The percentage of members ***3-17 years of age*** who had an outpatient visit with a PCP or OB/GYN and who had evidence of the following during the measurement year:

- BMI percentile
- Counseling for physical activity
- Counseling for nutrition.

WCC

Based on the American Academy of Pediatrics (AAP) recommendation of an annual comprehensive checkup for adolescents

CPT

Medical Nutrition Therapy; initial assessment and intervention, individual, face-to-face with patient, each 15 minutes	97802
Re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes	97803
Group (two (2) or more individual(s)), each 30 minutes	97804

HCPCS

Medical Nutrition Therapy; re-assessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face-to-face with patient, each **15 minutes**	G0270
Medical Nutrition Therapy; re-assessment and subsequent intervention(s) following second referral in same year for change of diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), group (two (2) or more individuals), each **30 minutes**	G0271
Face-to-face behavioral counseling for obesity, **15 minutes**	G0447
Weight management classes, non-physician provider, per session	S9449
Nutrition classes, non-physician provider, per session	S9452
Nutritional counseling, dietician visit	S9470

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)

Exercise classes, non-physician provider, per session	S9451
ICD-10	
BMI, pediatric, less than 5th percentile for age	Z68.51
BMI, pediatric, 5th percentile to 85th percentile for age	Z68.52
BMI, pediatric, 85th percentile to 95th percentile for age	Z68.53
BMI, pediatric, greater than or equal to 95th percentile for age	Z68.54
Counseling for nutrition	Z71.3
Exercise counseling/Physical activity	Z71.82

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

WELL- CHILD VISITS IN THE FIRST 15 MONTH OF LIFE (W15)

The percentage of members ***who turned 15 months*** old during the measurement year and who had ***0-6 well child visits*** with a PCP during their first 15 months of life.

All six (6) visits must be completed prior to the child turning 15 months

W15

Based on the American Academy of Pediatrics (AAP) recommendation of six (6) visits in the *first 15 months*

CPT

New Patient younger than one (1) year. Evaluation and management including age, and gender, appropriate history, examination, counseling/anticipatory guidance/risk factor reduction, interventions, and the ordering of laboratory/diagnostic procedures	99381
Established Patient younger than one (1) year. Evaluation and management including age, and gender, appropriate history, examination, counseling/anticipatory guidance/risk factor reduction, interventions, and the ordering of laboratory/diagnostic procedures	99391
Initial care, per day, for evaluation and management of normal newborn infant seen in other than hospital or birthing center	99461

ICD-10

Health examination for newborn **under eight (8) days old**	Z00.110
Health examination for newborn **8-28 days old**	Z00.111
Encounter for routine child health examination **with abnormal findings**	Z00.121
Encounter for routine child health examination **without abnormal findings**	Z00.129

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

WELL- CHILD VISITS IN THE THIRD, FOURTH, FIFTH AND SIXTH YEARS OF LIFE (W34)

The percentage of members ***3-6 years*** who had one (1) or more well-child visits with a PCP *during the measurement year.*

W34

Based on the American Academy of Pediatrics (AAP) recommendation of an annual visit.

CPT	
New Patient Early childhood ***(age 1 through 4)*** Evaluation and management including age, and gender, appropriate history, examination, counseling/anticipatory guidance/risk factor reduction, interventions, and the ordering of laboratory/diagnostic procedures	99382
New Patient Late childhood ***(age 5 through 11)***	99383
Established Patient Early childhood ***(age 1 through 4)*** Evaluation and management including age, and gender, appropriate history, examination, counseling/anticipatory guidance/risk factor reduction, interventions, and the ordering of laboratory/diagnostic procedures	99392
Established Patient Late childhood ***(age 5 through 11)***	99393
ICD-10	
BMI, pediatric, **less than 5th percentile** for age	Z68.51
BMI, pediatric, **5th percentile to 85th percentile** for age	Z68.52
BMI, pediatric, **85th percentile to 95th percentile** for age	Z68.53
BMI, pediatric, **greater than or equal to 95th percentile** for age	Z68.54
Counseling for nutrition	Z71.3
Exercise counseling/Physical activity	Z71.82
Encounter for routine child health examination **with abnormal findings**	Z00.121
Encounter for routine child health examination **without abnormal findings**	Z00.129

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

CERVICAL CANCER SCREENING (CCS)

Percentage of women 24–64 years of age as of December 31 of the measurement year who had cervical cytology **during the measurement year or the two (2) years prior (three (3) years total)** to the measurement year, or for women 30-64 years of age who had a cervical cytology and High Risk Human Papillomavirus (hrHPV) testing during the measurement year or the four (4) years prior (five (5) years total).

CCS

CCS	CPT
Cytopathology, cervical, or vaginal	88142
High-risk HPV Co-testing	87624
EXCLUSIONS	**CPT**
Acquired absence of both cervix and uterus	Z90.710
Acquired absence of cervix with remaining uterus	Z90.712

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

EXCLUSIONS (Optional)

Hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix any time during the member's history through December 31 of the measurement year.

- Partial Hysterectomy is not compliant.
- Hysterectomy needs more information if it was partial or total.
- TAH or Total Abdominal Hysterectomy is compliant

PRENATAL AND POSTPARTUM CARE (PPC)

The percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care.

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

PRENATAL CARE

CPT

Prenatal Visit Stand Alone Code: Home visit for prenatal monitoring and assessment to include fetal heart rate, non-stress test, uterine monitoring, and gestational diabetes monitoring	99500
New Patient: Office or other outpatient visit for the evaluation and management of a **new patient**, which requires these three (3) 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.	99201
New Patient: Office or other outpatient visit for the evaluation and management of a new patient, which requires these three (3) 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
Established Patient: Office or other outpatient visit for the evaluation and management of an **established patient**, which requires at least (two) 2 of these (three) 3 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
Established Patient: Office or other outpatient visit for the evaluation and management of an **established patient,** which requires at least two (2) of these three (3) 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
Established Patient: Office or other outpatient visit for the evaluation and management of an **established patient,** which requires at least two (2) of these three (3) 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
Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care	59400
Antepartum care only; 4-6 visits	59425
Antepartum care only; seven (7) or more visits	59426

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

CPT

Initial prenatal care visit (report at first prenatal encounter with health care professional providing obstetrical care. Report also date of visit and, in a separate field, the date of the last menstrual period [LMP]) (Prenatal)	0500F
Prenatal flow sheet documented in medical record by first prenatal visit (documentation includes at minimum blood pressure, weight, urine protein, uterine size, fetal heart tones, and estimated date of delivery). Report also: date of visit and, in a separate field, the date of the last menstrual period [LMP] (Note: If reporting 0501F Prenatal flow sheet, it is not necessary to report 0500F Initial prenatal care visit) (Prenatal)	0501F
Subsequent prenatal care visit (Prenatal) [Excludes: patients who are seen for a condition unrelated to pregnancy or prenatal care (eg, an upper respiratory infection; patients seen for consultation only, not for continuing care)]	0502F

HCPCS

Hospital outpatient clinic visit for assessment and management of a patient	G0463
Clinic visit/encounter, all-inclusive	T1015
Prenatal care, at-risk assessment	H1000
Prenatal care, at risk enhanced service; care coordination	H1002
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

POSTPARTUM CARE

CPT	
Diaphragm or cervical cap fitting with instructions	57170
Insertion of intrauterine device (IUD)	58300
Postpartum care only (separate procedure)	59430
Home visit for postnatal assessment and follow-up care	99501
Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care	59400
Vaginal delivery only (with or without episiotomy and/or forceps); including postpartum care	59410
Routine obstetric care including antepartum care, cesarean delivery, and postpartum care	59510
Cesarean delivery only; including postpartum care	59515
Prenatal care, at-risk enhanced service; follow-up home visit	H1004
Prenatal care, at-risk enhanced service package (includes h1001-h1004)	H1005
Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery	59610
Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps); including postpartum care	59614
Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery	59618
Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery; including postpartum care	59622
Postpartum care visit (Prenatal)	0503F

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

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
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

ICD-10

Encounter for gynecological examination (general) (routine) with abnormal findings	Z01.411
Encounter for gynecological examination (general) (routine) without abnormal findings	Z01.419
Encounter for cervical smear to confirm findings of recent normal smear following initial abnormal smear	Z01.42
Encounter for insertion of intrauterine contraceptive device	Z30.430
Encounter for care and examination of lactating mother	Z39.1
Encounter for routine postpartum follow-up	Z39.2

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

ADULT BMI ASSESSMENT (ABA)

The percentage of members 18–74 years of age who had an outpatient visit and whose body mass index (BMI) was documented during the measurement year or the year prior to the measurement year.

BMI for 18-19 years old *19 years old and below*

ICD-10	
BMI, Pediatric **less than 5th percentile** for age.	Z68.51
BMI, Pediatric, **5th percentile to 85th percentile** for age.	Z68.52
BMI, Pediatric, **85th percentile to 95th percentile** for age.	Z68.53
BMI, Pediatric, **greater than or equal to 95th percentile** for age.	Z68.54

Adult BMI *20 years and older*

ICD-10	
Body Mass Index 19.0-19.9 or less, adult	Z68.1
Body Mass Index 20.0-20.9, adult	Z68.20
Body Mass Index 21.0-21.9, adult	Z68.21
Body Mass Index 22.0-22.9, adult	Z68.22
Body Mass Index 23.0-23.9, adult	Z68.23
Body Mass Index 24.0-24.9, adult	Z68.24
Body Mass Index 25.0-25.9, adult	Z68.25
Body Mass Index 26.0-26.9, adult	Z68.26
Body Mass Index 27.0-27.9, adult	Z68.27
Body Mass Index 28.0-28.9, adult	Z68.28
Body Mass Index 29.0-29.9, adult	Z68.29
Body Mass Index 30.0-39.9, adult	Z68.30
Body Mass Index 31.0-31.9, adult	Z68.31
Body Mass Index 32.0-32.9, adult	Z68.32
Body Mass Index 33.0-33.9, adult	Z68.33
Body Mass Index 34.0-34.9, adult	Z68.34
Body Mass Index 35.0-35.9, adult	Z68.35
Body Mass Index 36.0-36.9, adult	Z68.36
Body Mass Index 37.0-37.9, adult	Z68.37
Body Mass Index 38.0-38.9, adult	Z68.38
Body Mass Index 39.0-39.9, adult	Z68.39
Body Mass Index 40.0-44.9, adult	Z68.41
Body Mass Index 45.0-49.9, adult	Z68.42
Body Mass Index 50.0-59.9, adult	Z68.43
Body Mass Index 60.0-69.9, adult	Z68.44
Body Mass Index 70 or greater, adult	Z68.45

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

CONTROLLING HIGH BLOOD PRESSURE (CBP)

The percentage of members 18-85 years of age who had a diagnosis of hypertension (HTN) and whose last BP of the year was adequately controlled (<140/90 mm Hg).

CBP

CPT

Systolic Blood Pressure ***less than*** **130 mm Hg**	3074F
Systolic Blood Pressure **130 - 139 mm Hg**	3075F
Systolic Blood Pressure ***Greater than or Equal*** to **140 mm Hg**	3077F
Diastolic Blood Pressure ***less than*** **80 mm Hg**	3078F
Diastolic Blood Pressure **80 - 89 mm Hg**	3079F
Diastolic Blood Pressure **Greater than or Equal** to 90 mm Hg	3080F

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

COMPREHENSIVE DIABETES CARE (CDC)

The percentage of members 18-75 years of age with diabetes (type 1 and type 2) who had each of the following:

- Hemoglobin A1c (HbA1c) testing
- Eye exam
- Medical attention to nephropathy
- BP control (<140/90)

CDC

EYE EXAM	CPT
Measure Year (Current year): Dilated eye exam with interpretation by an ophthalmologist or optometrist documented or reviewed; with evidence of retinopathy.	2022F
Measure Year (Current year): Dilated eye exam with interpretation by an ophthalmologist or optometrist documented or reviewed; without evidence of retinopathy.	2023F
Year Prior: Must be a Negative result to be compliant. Low risk for retinopathy (No evidence of retinopathy in the prior year) (DM). *Reported date should be the date the provider reviewed the patient's eye exam from the prior year.*	3072F
Seven (7) standard stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy.	2024F
Seven (7) standard stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy.	2025F
Eye imaging validated to match diagnosis from seven (7) standard field stereoscopic photos results documented and reviewed	2026F

NEPHROPATHY	CPT
Positive Microalbuminuria. Documented and reviewed (DM)	3060F
Negative Microalbuminuria. Documented and reviewed (DM)	3061F
Positive Macroalbuminuria. Documented and reviewed (DM)	3062F
Albumin/Creatinine ratio, Random Urine (lab reports)	82043

HbA1c	CPT
7.0%: Most recent hemoglobin A1c (HbA1c) level less than 7.0% (DM)2,4	3044F
9.0%: Most recent hemoglobin A1c level greater than 9.0% (DM)2,4	3046F
Most recent hemoglobin A1c (HbA1c) level greater than or equal to 7.0% and less than or equal to 8.0%	3051F
Most recent hemoglobin A1c (HbA1c) level greater than or equal to 8.0% and less than or equal to 9.0%	3052F
Glycosylated (A1C) hemoglobin analysis, by electrophoresis or chromatography, in the setting of an identified hemoglobin variant.	83036

HbA1c	LOINC
Hemoglobin A1c/Hemoglobin.total in Blood by Electrophoresis	4549-2
Hemoglobin A1c/Hemoglobin.total in Blood	4548-4
Hemoglobin A1c/Hemoglobin.total in blood by HPLC	17856-6

CDC-BP	CPT
Systolic Blood Pressure less than 130 mm Hg	3074F
Systolic Blood Pressure 130 - 139 mm Hg	3075F
Systolic Blood Pressure Greater than or Equal to 140 mm Hg	3077F
Diastolic Blood Pressure less than 80 mm Hg	3078F
Diastolic Blood Pressure 80 - 89 mm Hg	3079F
Diastolic Blood Pressure Greater than or Equal to 90 mm Hg	3080F

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

CARE FOR OLDER ADULTS (COA)

The percentage of adults 66 years and older who had each of the following during the measurement year:

- Advance care planning.
- Medication review.
- Functional status assessment.
- Pain assessment.

COA

COA	CPT II
Medication List	1159F
Medication Review	1160F
Pain present	1125F
No Pain present	1126F
Functional Status assessment ADL: five (5) Activities of Daily Living IADL: four (4) Instrumental Activities of Daily Living	1170F
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, 50 minutes are spent face-to-face with the patient and/or family or caregiver.	99483

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

COLORECTAL CANCER SCREENING (COL)

The percentage of members 50–75 years of age who had appropriate screening for colorectal cancer. One (1) or more screenings for colorectal cancer. Any of the following meet criteria:

- **Fecal occult blood test** (FOBT) during the measurement year. For administrative data, assume the required number of samples was returned, regardless of FOBT type.
- **Flexible sigmoidoscopy** during the measurement year or the four (4) years prior to the measurement year.
- **Colonoscopy** during the measurement year or the nine (9) years prior to the measurement year.
- **CT colonography** during the measurement year or the four (4) years prior to the measurement year.
- **FIT-DNA test** during the measurement year or the two (2) years prior to the measurement year.

COL

CPT

FOBT	82270
Flexible Sigmoidoscopy	45330
Colonoscopy thru anus	45378
FIT DNA	81528
CT-Colonography	74263

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

MEDICATION RECONCILIANTION POST DISCHARGE (MRP)

Members 18 years and older who had an acute or non-acute inpatient discharge on or between 01/01/2019 and 12/01/2019, and for whom medications were reconciled **on the date of discharge through 30 days after discharge (31 total days).**

MRP

CPT II

Discharge medications reconciled with the current medication list in outpatient medical record.	1111F

TRANSITIONS OF CARE (TRC)

The percentage of discharges for members 18 years of age and older who had each of the following. Four rates are reported:

- Notification of Inpatient admission
- Receipt of Discharge information
- Patient engagement after Inpatient Discharge
- Medication Reconciliation Post Discharge

TRC

Notification of Inpatient Admission: **Medical record documentation is necessary** for compliance and must include evidence of the receipt of notification of inpatient admission on the day of admission or the following day. Documentation must include evidence of the date when the documentation was received.

Receipt of Discharge Information: **Medical record documentation is necessary** for compliance and must include of receipt of discharge information on the day of discharge or the following day with evidence of the date when the documentation was received. At a minimum, the discharge information

CPT

Patient Engagement after Inpatient Discharge Transitional care management services with the following requirements: • Communication (Direct contact, telephone, electronic) with the patient and/or caregiver within two (2) business days of discharge. • Medical decision making of high complexity during the service period. • Face-to-face visit, within seven ***(7) calendar days of discharge.***	99496
Patient Engagement after Inpatient Discharge Transitional care management services with the following requirements: • Communication (Direct contact, telephone, electronic) with the patient and/or caregiver within two (2) business days of discharge. • Medical decision making of at least moderate complexity during the service period. • Face-to-face visit, within seven ***14 calendar days of discharge.***	99495

CPT II

Discharge medications reconciled with the current medication list in outpatient medical record. **(Medication reconciled within 30 days after discharge)**	1111F

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